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March 1, 2021

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

Re: In the Matter of Hope Health Systems Application
Matter No. 20-03-2444

Dear Ms. Potter:

On behalf of interested party Sheppard Pratt Health System, Inc., we are submitting three copies its interested party comments addressing the Certificate of Need Application filed by Hope Health Systems, Inc. in the above-referenced matter.

I hereby certify that a copy of this submission has been forwarded to the appropriate local health planning agency as noted below. Thank you for your assistance.

Sincerely,

James Buck

JB:blr
Enclosures
cc: Kevin McDonald, Chief, Certificate of Need
Paul Parker, Director, Center for Health Care Facilities Planning & Development, MHCC
Suellen Wideman, Esq., Assistant Attorney General, MHCC
Dr. Nilesh Kalyanaraman, Health Officer, Anne Arundel County
Dr. Letitia Dzirasa, Health Commissioner, Baltimore City
Gregory W. Branch, M.D., Health Officer, Baltimore County
Edwin F. Singer, Health Officer, Carroll County
Dr. Maura J. Rossman, Health Officer, Howard County
Dr. Russell Moy, Health Officer, Harford County
Mr. Yinka Fadiora, Hope Health Systems
Mr. Biran Niehaus
Ella R. Aiken, Esq.

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IN THE MATTER OF	*	BEFORE THE
HOPE HEALTH SYSTEMS APPLICATION	*	MARYLAND HEALTH
Docket No. 20-03-2444	*	CARE COMMISSION

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SHEPPARD PRATT HEALTH SYSTEM'S COMMENTS ON HOPE HEALTH SYSTEMS' CON APPLICATION PROPOSING TO ESTABLISH A SPECIAL PSYCHIATRIC HOSPITAL FOR CHILDREN AND ADOLESCENTS

Sheppard Pratt Health System, Inc. ("Sheppard Pratt"), by its undersigned counsel and pursuant to COMAR § 10.24.01.08F, submits these comments addressing the Certificate of Need ("CON") Application and related materials filed by Hope Health Systems, Inc. ("Hope Health") seeking to establish a special psychiatric hospital for children and adolescents in Baltimore County (the "Application"). For the reasons described below, Sheppard Pratt requests that the Commission recognize it as an interested party and deny Hope Health's Application.

Statement of Interested Party Status

Sheppard Pratt is an "interested party" within the meaning of COMAR § 10.24.01.01B(20) because it is authorized to provide the same service as the applicant, in the same planning region used for purposes of determining need under the State Health Plan. Sheppard Pratt first began providing services to children and adolescents at the Sheppard and Enoch Pratt Hospital, located in Baltimore County, Maryland, in 1891, and began providing services at its Sheppard Pratt at Ellicott City location in Howard County in 2002.

Introduction

As the Applicant, Hope Health bears the burden of demonstrating its compliance with the project review criteria. COMAR § 10.24.01.08G(1) ("[T]he burden of proof that the project

meets the applicable criteria for review, by a preponderance of the evidence, rests with the applicant.") As discussed more fully below, Hope Health has failed to meet this burden for a number of review criteria. Most fundamentally, Hope Health fails to establish that its project will be financially viable. It significantly overstates projected revenue and grossly understates its staffing costs. Additionally, Hope Health's project will not be cost effective. Indeed, its projected charges will exceed those of existing providers by more than 30%. Hope Health also fails to demonstrate need for its proposed project with verifiable data and projections capable of being replicated. Finally, if approved, Hope Health's project will increase the cost of care on the health care delivery system, and threatens access overall in Maryland to the extent it imposes an adverse impact on other providers. The Commission should exercise its "gatekeeping" function and deny Hope Health's Application.

ARGUMENT

I. HOPE HEALTH DOES NOT DEMONSTRATE THAT ITS PROPOSED PROGRAM IS FINANCIALLY VIABLE, COMAR § 10.24.01.08G(3)(d).

As required under COMAR § 10.24.01.08G(3)(d), "the Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project." In recent CON reviews involving special psychiatric hospitals, the Commission has recognized that this standard requires that an applicant demonstrate that the project will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation) if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations. *See*, *e.g.*, *In re: Anne Arundel Med. Ctr. Mental Health*

Hospital, No. 16-02-2375, Decision at p. 32 (Mar. 26, 2018); *In re: Sheppard Pratt at Elkridge*, No 15-152367, Decision at p. 20 (Sept. 20, 2016).[1]

In its Application, Hope Health significantly overestimates its revenue projections. On the other hand, Hope Health grossly underestimates its operating costs, including expenses for staffing and management of the proposed facility. Because of these erroneous considerations, Hope Health's project, if approved, would be unlikely to ever generate revenue in excess of expenses. Given that Hope Heath is a for-profit provider of services with limited operating income and capital reserves, Hope Health also lacks the resources necessary to sustain the proposed project.

A. Hope Health's revenue projections are unreasonable and not consistent with the experience of existing special hospitals.

In its revenue projections, Hope Health estimates that its "average rate" per patient day will be $1,658 in 2022. (App. at Ex. 1, p. 19.) Hope Health further projects that its revenues for inpatient care services will increase annually by 2.77%. (*Id*.)

Hope Health has sought CON approval to establish a special psychiatric hospital. Hope Health's inpatient rates will be subject to approval by the Health Services Cost Review Commission ("HSCRC").[2] In Sheppard Pratt's experience, Hope Health's revenue estimates are significantly overstated and inconsistent with the rates approved for the existing special psychiatric hospitals treating children and adolescents.

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[1] *See also*, Draft State Health Plan for Facilities and Services: Acute Psychiatric Hospital Services, COMAR §§ 10.24.07.05(B)(12)(b) ("Each applicant must document that . . . (iv) The hospital will generate excess revenues over total expenses, including debt service expenses and plant and equipment depreciation, within five years or less of initiating operations, if utilization forecasts are achieved for the specific services affected by the project. (approved for formal public comment (Feb. 18, 2021)).

[2] It unclear whether Hope Health has filed a rate application with the HSCRC.

Sheppard Pratt is the largest private, nonprofit provider of mental health, substance use, developmental disability, special education, and social services in the country. *U.S. News & World Report* has ranked Sheppard Pratt among the nation's leading psychiatric hospitals for more than thirty years.[3] For fiscal year 2021, Sheppard Pratt's HSCRC-approved daily rate for inpatient child and adolescent psychiatric services is $1,259. Brook Lane is the only other existing special psychiatric hospital providing services to children and adolescents in Maryland. For fiscal year 2021, Brook Lane's HSCRC-approved inpatient rate for children and adolescent psychiatric services is $1,137.

In the Application, Hope Health's per-day revenue estimate of $1,658 for 2022 is 25% and 32% higher than the current HSCRC-rates approved for Sheppard Pratt and Brook Lane, respectively. Given the limited size of the proposed facility, its expenses, and staffing, Sheppard Pratt believes Hope Health overstates its first year revenue estimates by at least 30%. Even assuming Hope Health were able to capture the market share it projects, which it cannot as described in Section III below, Table 1 below demonstrates that Hope Health would generate a net loss in its first year of operations if its approved rates were consistent with the rates of existing providers. All of Hope Health's assumptions remaining unchanged, Table 1 reflects that Hope Health would generate an initial year net loss of between $695,750 if its per-day rates equaled those of Sheppard Pratt and a $1,145,411 net loss if its per-day rates equaled those of Brook Lane. Nothing in the Application suggests that the HSCRC would approve charges for a new market entrant that exceed those of the two established Maryland special psychiatric hospitals caring for children and adolescents.

[3] In 2020, *U.S. News & World Report* ranked Sheppard Pratt as one of the nation's top five psychiatric hospitals.

Table 1
Hope Health's Revenue and Utilization Projections at its Projected Rate in Comparison to Sheppard Pratt's and Brook Lane's Current HSCRC-Approved Rates[4]

	Hope Health's Projected Rate 2022	Sheppard Pratt's Actual Rate 2021	Brook Lane's Actual Rate 2021
Patient Per-Day Rate	$1,658.36	$1,259	$1,137
Projected Patient Days	4,672	4,672	4,672
Gross IP Services Revenue	$7,747,858	$5,882,048	$5,312,064
Net IP Services Revenue	$6,112,302	$4,640,347	$4,190,687
HH Projected Total Operating Expenses	$5,336,098	$5,336,098	$5,336,098
Net Income (Loss)	$776,204	(-$695,750)	(-$1,145,411)

Moreover, Hope Health's projection that the HSCRC will increase its rates by 2.77% annually is inconsistent with the HSCRC's past practice. A realistic annual revenue increase would be between 1.7% and 2.3%. Hope Health's overestimation of its annual revenue increases compounds the over-inflation of its revenues, and consequently, its net losses year-after-year.

Notwithstanding Hope Health's understatement of its operational costs, the proposed project will never generate revenue in excess of expenses at realistic HSCRC-approved rates. Additionally, Hope Health's financial statements reflect that it generated net income of only $444,727 and $567,091 in the calendar years ended December 31, 2018 and December 31, 2019, respectively. (App. at Ex. 7.) This enterprise-wide operating income is insufficient to cover the losses associated with the proposed project assuming a realistic HSCRC-approved rate. As a result, Hope Health lacks the resources necessary to sustain the proposed project.

[4] Hope Health's per-day patient rate is taken from its Application Exhibit 1, page 19. The assumptions regarding net inpatient services revenue also assume a 6% Medicaid contractual allowance, 4.11% charity care, and 11% bad debt in accordance with Hope Health's assumptions. Patient days and operating expenses are taken from Hope Health's Exhibit 1, Table J, K, and I.

B. Hope Health grossly underestimates operating expenses, including staffing costs.

Hope Health seeks to establish a specialty psychiatric hospital to provide inpatient psychiatric services to children and adolescents. Hope Health's workforce and staffing projections, however, are wholly bereft of the numerous departments and staff a hospital requires to operate. Indeed, the entire project's expense projections and facility design suggest the project will be an outpatient provider. Hope Health does not project to employ a single person for any of following departments necessary to operate a special psychiatric hospital:

- non-psychiatric medical care, including pediatrician coverage and intake assessment;
- pharmacy and/or pharmacists;
- infection control / health and safety;
- health information management / medical records;
- patient services / accounts;
- purchasing / supplies / materials management;
- information technology;
- human resources;
- physical plant management / maintenance;
- dietary / kitchen staff; or
- general services – e.g., housekeeping, environmental services, and laundry.

While Hope Health projects additional "contractual services" of more than $600,000 annually based on its review of Sheppard Pratt's most recently filed Medicare Cost Report, Hope Health failed to support its projection by describing the specific costs or roles of contracted services as required by Commission regulations.[5] More significantly, Hope Health failed to take into consideration that Sheppard Pratt employs individuals in many of above-listed capacities at

[5] For example, Hope Health projects no specific expense for pediatric medical care coverage for its patients, including staff necessary to perform a history and physical of each patient within 24 hours of admission in accordance with the standard of care and COMAR 10.24.07, Standard AP5, or for providing chemotherapy or recreational therapies, Standard AP 3a. Hope Health only identifies an occupational therapist and no additional contractual staff. (*See* App. at Ex. 1, Table L.)

substantial costs in excess of Hope Health's estimates for "contractual services." Hope Health does not even identify staff or staffing costs to prepare or serve meals to its residents, much less to clear tables or clean dishes and silverware.

Even for the staff Hope Health budgets to employ, its projections are egregiously understated. For example, Hope Health identifies a need to employ four (4) full-time-equivalent ("FTE") psychiatrists. (App. at Ex. 1, Table L.) This is the minimum necessary to staff a 16-bed facility, 24 hours per day, seven days per week. Hope Health's projected average cost to employ a child and adolescent psychiatric specialist is only $195,260. In Sheppard Pratt's experience, however, the fair market value base compensation for such specialists is in excess of $230,000, with an additional signing bonus in some cases.[6] Standing alone, Hope Health understates its employment costs for its four psychiatrists by between $140,000 and $370,000 per year.

Enclosed as **Exhibit 1**, is a revision to Hope Health's Table L reflecting low estimates of additional staffing costs Hope Health would need to incur to operate a 16-bed special psychiatric hospital service children and adolescents. Changes are highlighted in yellow. Conservatively, Hope Health's staffing costs, not including dietary and service staff, are understated by $240,540. These additional costs would only add to the losses Hope Health's program would generate were it approved for realistic HSCRC rates such as those currently approved for Sheppard Pratt and Brook Lane. *See* Table 1 *supra*.[7]

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[6] The Application is unclear whether Hope Health intends to recruit four additional child and adolescent psychiatrists or rely upon the four providers it currently employs to provide outpatient services. Operating an inpatient psychiatric hospital, however, is not a part-time job. It would conservatively take Hope Health an average of six to nine months to recruit a single full-time inpatient child and adolescent psychiatrist to staff the proposed project.

[7] Sheppard Pratt's conservative staffing estimates for a 16-bed special psychiatric hospital are supported by the recently approved CON application filed by Anne Arundel Medical Center. In its second year of operation, 2020, Anne Arundel projected $5,190,324 in direct employment costs for a 16-

II. HOPE HEALTH DOES NOT DEMONSTRATE THAT ITS PROPOSED PROGRAM IS COST EFFECTIVE, COMAR § 10.24. 01.08G(3)(f).

COMAR § 10.24.01.08G(3)(c) requires that the Commission "compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities[.]" Hope Health fails to demonstrate that its proposed project is cost effective. On the contrary, Hope Health's revenue estimates for 2022 are 25% and 32% higher than the currently approved rates for Sheppard Pratt and Brook Lane, the two existing private psychiatric hospitals providing care children and adolescents. *See* Table 1, *supra*.

To the same end, Hope Health's charge projections fail to comply with Standard AP 11 of the State Health Plan, COMAR § 10.24.07, which requires that:

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

As demonstrated in Tables 3 and 4 below, Hope Health's average total cost-per-case of $15,256 in 2022 (9.2 ALOS x 1,658 per day charge) exceeds that of acute general hospitals in the planning region for child and adolescent psychiatric discharges in FY 2019 by $493 and $2,576, respectively. Hope Health's Application should be denied for this reason alone.

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bed special psychiatric hospital. *See In re: Anne Arundel Med. Ctr. Mental Health Hospital*, Docket No. 16-02-2375, Amended Tables J & K (April 1, 2016). Combined, Hope Health's projected direct employment costs of $3,832,782 and unexplained contractual services costs of $656,817 in its second year of operation are still $700,000 less than Anne Arundel's salaries and wages.

Table 2
Inpatient Discharges, Mental Health APR-DRGs 740-776
Pediatric Discharges from Acute Care Hospitals in Central Planning Region, Ages 0-12[8]

	Children Ages 0-12								
	Discharges			Total Gross Charges			Average Gross Charge		
Provider Name	Acute	LOS >=30	Total	Acute	LOS >=30	Total	Acute	LOS >=30	Total
UMMC	435	1	436	$7,030,116	$169,806	$7,199,922	$16,161	$169,806	$16,514
JOHNS HOPKINS	157	1	158	1,887,364	129,056	2,016,420	12,021	129,056	12,762
MEDSTAR FRANKLIN SQ.	42	1	43	442,392	58,258	500,651	10,533	58,258	11,643
Total	**634**	**3**	**637**	**$9,359,872**	**$357,121**	**$9,716,993**	**$14,763**	**$119,040**	**$15,254**

Table 3
Inpatient Discharges, Mental Health APR-DRGs 740-776
Pediatric Discharges from Acute Care Hospitals in Central Planning Region, Ages 13-17

	Adolescents Ages 13-17								
	Discharges			Total Gross Charges			Average Gross Charge		
Provider Name	Acute	LOS >=30	Total	Acute	LOS >=30	Total	Acute	LOS >=30	Total
UMMC	11	0	11	$199,887	$0	$199,887	$18,172	n/a	$18,172
JOHNS HOPKINS	433	12	445	5,944,364	1,655,182	7,599,546	13,728	137,932	17,078
MEDSTAR FRANKLIN SQ.	290	7	297	3,043,808	498,308	3,542,116	10,496	71,187	11,926
LIFEBRIDGE CARROLL CO.	72	3	75	1,032,371	480,711	1,513,082	14,338	160,237	20,174
Total	**806**	**22**	**828**	**$10,220,430**	**$2,634,201**	**$12,854,631**	**$12,680**	**$119,736**	**$15,525**

Notes to both tables:
Limited to 3M APR-DRGs 740-772 for mental health (excludes alcohol/drug dependency DRGs)
Excludes outpatient observation cases
Includes in and out of state cases - for any case in any county at the above hospital where the patient age < 18 years
Includes any hospital in the counties of Anne Arundel, Carroll, Harford, Howard, Baltimore, or Baltimore City with 10 or more cases
Excludes Psych Specialty Hospitals and Mt. Washington Pediatric Hospital data.

Hope Health also does not consider the alternative of addressing its goals "through population-health initiatives that would avoid or lessen hospital admissions." (*See* Application Instructions, 10.23.01.08.G(3)(c), Appl. p. 67). Instead, Hope Health proposes to establish a psychiatric facility that will charge significantly higher rates than Sheppard Pratt, while taking 12% of Sheppard Pratt's adolescent discharges and 10% of its child discharges. Moreover, due to its projected staffing, Hope Health cannot support these patients at staffing levels necessary to meet the standard of care. The Commission should deny Hope Health's application for its failure

[8] In "Figure 2" on page 25, Hope Health included acute inpatient stays lasting longer than 30 days in violation of Standard AP 11 and also erroneously included discharges from Mt. Washington Pediatric Hospital, which appear to have been infants treated for drug addiction and dependency, a population that Hope Health's programming and staffing demonstrate it will be unable to serve.

to demonstrate that the project is cost-effective and to explore lower cost alternatives, consistent with the CON application instructions.

III. HOPE HEALTH DOES NOT DEMONSTRATE THAT ITS PROPOSED PROGRAM COMPLIES WITH THE NEED STANDARD, COMAR § 10.24.01.08G(3)(b)

Sheppard Pratt is sensitive to the needs of Marylanders for additional mental health treatment options for children and adolescents. A CON applicant, however, always bears the burden of establishing need for its project. This is particularly true where the applicant seeks to establish its program by taking 85% of its market share from existing providers. (*See* App. at Figures 28-29.) Hope Health's need projection, however, relies upon undefined, misstated, and inaccurate data and assumptions. These fundamental flaws so undermine its need analysis that Hope Health wholly fails to demonstrate any need for the services it seeks to provide.

Applicants seeking a CON to establish a hospital must generally project need for their proposed services using assumptions founded in data and on sound mathematics and logic. Among the instructions for compliance with this review criterion are that an applicant:

- "quantify[] the need;"
- "apply[] utilization rates based on historic trends and expected future changes to those trends;"
- "demonstrate[] needs of the population served or to be served by the hospital;"
- "assure that all sources of information used in the need analysis are identified;"
- "fully explain all assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), the relevant population considered in the analysis…with information that supports the validity of these assumptions;"
- "Detail the applicant's consideration of the provision of services in non-hospital settings and/or through population-based health activities in determining the need for the project."

(COMAR § 10.24.01.08G(3)(b), Need, Instructions, CON Appl., p. 40, emphasis added.) These review criteria enable the Commission to carry out its important gate-keeping function to ensure that Marylanders continue to have access to affordable, appropriate care, by approving new

services only if they will serve an unmet need in an appropriate health care setting. Hope Health's need analysis fails to comply with these fundamental requirements.

Population Estimates. Hope Health claims its population projections are based on estimates from the Maryland Department of Health. Hope Health purports to have made certain adjustments in order to project the population for years 2021 and 2027, but Sheppard Pratt has been unable to replicate Hope Health's projections using its stated assumptions and the data cited. At a minimum, Hope Health should document in its Application its step-by-step application of any data adjustments in a manner sufficient to allow replication.

Utilization Rates. Hope Health does not apply a utilization rate for its proposed service area based on historic trends. Instead, it cherry-picks the population discharge rates for the entire State from from CY 2019, for both the child and adolescent age groups, and applies the discharge rate for that year to its projected population for 2022 to the entire State. This is troubling because Hope Health cites a declining use rate for its service area populations (Figure 11, App. p. 46), yet Hope Health does not quantify the decline or apply that decline to its 2022 projected population, instead assuming a static rate. (*Compare* CON Appl., Figure 11 with Figure 12.)[9]

Hope Health's projection is also concerning because it does not identify its data sources with clarity, and its extrapolation of its sources does not match other cited information. For example, in its Figure 11, Hope Health indicates that its psychiatric discharges per 100,000 population CY2017-2019 are based on "Maryland HSCSC [stet] custom data set." (Appl. p. 46;

[9] Sheppard Pratt questions the accuracy of the discharge rates Hope Health presents in Figure 11 and the decline it indicates. However, since Hope Health takes the position that the data reported in Figure 11 is correct, it should have adjusted its need projections for the declining use rate demonstrated.

Hope Health Jan 29, 2020 Compl. Resp., Resp. to Question 13.) But, Hope Health does not explain what parameters were applied to its "custom data set." Hope Health's assumptions, therefore, are impossible to test or evaluate. This is particularly troubling because Hope Health's reported extrapolation from the data in Figure 11 directly contradicts the Commission's April 2019 White Paper: Maryland Acute Psychiatric Hospital Services ("Commission April 2019 White Paper"), a source Hope Health relies upon heavily elsewhere in its Application. The April 2019 White Paper reports 183 psychiatric discharges per 100,000 Maryland residents ages 0-12, in CY 2017, and 1,273 per Maryland residents 13-17 in CY 2017. (*Id.* at 19.) In contrast, Hope Health reports discharges of 200 and 1,319 for the same respective age groups in the same calendar year. (Figure 11, Appl. p. 46.) Even minor errors at each step of Hope Health's undetailed analysis may have a significant impact on its overall projections.

Hope Health's application of discharge rates for the entire State is also concerning because it proposes to establish a facility in the Central Maryland region, and proposes to focus on patients within a 30 and 60 minute drive time of its location. (App. at p. 42.) Yet, Hope Health admits that its bed need analysis "focused on [S]tate-wide figures as the concentration of beds in the central planning region distorts a regional analysis." (*Id*. at p. 46.) In making this statement, Hope Health both concedes and in the same breath overlooks a fundamental flaw in its analysis. If Hope Health proposes to serve primarily residents of the Central Maryland region, it must demonstrate bed need for that population. If an analysis for that population would not result in sufficient bed need to support the project due to the "concentration of beds" in Central Maryland, then there is not sufficient need in this region for a new facility. Unlike facilities that may draw referrals from throughout Maryland, Hope Health does not purport that it will do so,

nor does it provide any basis for such a suggestion. If Hope Health cannot demonstrate need for its services in Central Maryland, then it fails to satisfy the need review criterion.[10]

Bed Estimates and Occupancy. Hope Health's estimate of State-wide demand also relies upon faulty assumptions regarding bed occupancy and staffing. Hope Health projects a need for 11.7 child and 102.5 adolescent beds in Maryland by assuming a 70% occupancy rate for all inpatient psychiatric beds in Maryland, based on a supposed finding that this is the "level at which the [S]tate should consider evaluation of additional beds *for facilities under 20 beds* to further increase access points." (App. at p. 46). But even if that finding supports applying a 70% occupancy assumption to Hope Health's bed request, it should not be used to artificially inflate bed need for the State as a whole. In applying this assumption to calculate need for the entire State, Hope Health's projection at best can demonstrate the number of beds Maryland *would* need *if all* facilities providing acute child and adolescent psychiatric services had fewer than 20 beds. They do not.

Hope Health also makes the unreasonable and unsupported assumption that all private double-occupancy adolescent and child psychiatric rooms in the State are used solely as private rooms. As support, Hope Health appears to rely on anecdotal reports that some facilities may occasionally deny admissions when a facility has a bed available in a semi-private room. In Sheppard Pratt's experience, however, the decision to deny an admission to a semi-private room is based on whether the standard of care would permit cohabitation of an existing patient and a referred patient needing admission. There is no support for Hope Health's sweeping assumption

[10] The reliance on State-wide need is particularly concerning for child beds, for which Hope Health projects a need of just 11.7 beds in the State. Given the thin margin for projected bed need, approval of Hope Health's CON could result in regulatory barriers for future applicants who propose to provide these services in planning regions where the beds are actually needed.

that *all* semi-private rooms are *always* used for single occupancy. Sheppard Pratt has a number of semi-private rooms, and expressly denies Hope Health's assumption as inconsistent with its actual experience.

Not only does Hope Health employ faulty and unsupported assumptions, it incorrectly extrapolates historical data. Figure 13 purports to demonstrate Bed Occupancy Rates for Sheppard Pratt and Brook Lane, and reports occupancy levels ranging up to well over 100% for both facilities over a three-year period. (App. p. 47.) Unlike acute general hospitals, specialty psychiatric hospitals may not exceed their licensed-bed capacity and, thus, cannot operate at in excess of 100% of licensed capacity. (*See, e.g.,* Commission April 2019 White Paper at 6.) Not unexpectedly, the occupancy data Hope Health projects for Sheppard Pratt is materially inaccurate when compared to Sheppard Pratt's actual patient days and discharges. (*See* Table 5 below.)[11]

Table 4
Sheppard Pratt Bed Occupancy Rates FY 2017-2019 Compared to Hope Health Application
Child and Adolescent Patients

Time Period		FY 2019	FY 2018	FY 2017
Total Patient Days	HHS CON	36,491	35,582	35,168
	Actual	30,828	30,441	29,695
	Variance	**5,663**	**5,141**	**5,473**
Total Patient Admissions	HHS CON	2,442	2,739	2,933
	Actual	2,357	2,698	2,867
	Variance	**85**	**41**	**66**
ALOS	HHS CON	14.94	12.99	11.99
	Actual	13.08	11.28	10.36
	Variance	**1.86**	**1.71**	**1.63**
Bed Count	HHS CON & Actual	96	96	96
Occupancy Rate	HHS CON	104.14%	101.55%	100.37%
	Actual	87.98%	86.88%	84.75%
	Variance	**16.16%**	**14.67%**	**15.62%**

Source: App. p. 47; Sheppard Pratt internal admissions data for child and adolescent patients, both campuses, FY 2017-2019

[11] Hope Health also implies poor patient outcomes due to high occupancy but provides no data to support this implication. CON Appl., p. 48.

Hope Health also suggests that Sheppard Pratt has a high turn-away rate based on its high occupancy rate, and states that Sheppard Pratt "may have to deny or delay admission anywhere from 20% to 50% or more of the time." (App. at p. 48.) This is unsupported, inconsistent with Sheppard Pratt's actual experience, and misleading. In any event, most admission denials and delays at Sheppard Pratt are due to lack of beds in Sheppard Pratt's 14-bed specialty neuropsychiatry unit, one of only a few in the country. Hope Health's CON staffing levels demonstrate that its program could not care for such patients.

Additionally, while Hope Health projects that it will capture market share from the Commission-approved but yet to-open 16-bed child and adolescent unit at the University of Maryland Medical Center ("UMMC"), Docket No. 18-24-2429, Hope Health's need projections and estimates do not consider the impact of the opening of that facility to its need projections. Given the other flaws in its need assessment and the concentration of beds in the Central Maryland region, the inclusion of UMMC's beds in a reliable, supportable bed assessment could further undermine the need for the proposed project.

All of these significant inaccuracies should be scrutinized by the Commission staff or an appointed Reviewer with great care. Hope Health cannot meet its burden of demonstrating need unless it puts forth a need analysis that relies upon accurate, verifiable data.

ED Boarding. Hope Health alleges that discharge delays and ED boarding in the State demonstrate bed need beyond that shown in its calculations. Hope Health contends ED boarding would result in an additional 508 child psychiatric discharges annually, of which it would serve 234, and 2,225 adolescent psychiatric admissions, of which it would serve 300. Rather than building its analysis from an independent review of data sets, Hope Health invents an ED Boarding need that is inaccurate, misleading, and unsupported by its own data.

Hope Health's starting point appears to be the Maryland Hospital Association paper titled Behavioral Health Patient Delays in Emergency Departments (the "MHA Report").[12] That paper is based on a narrow, 45-day period during which 442 child and adolescent patients who were seen in participating EDs for behavioral health reasons experienced a discharge delay. (*Id.*, p. 10). Hope Health jumps to the assumption that this sole data point supports a finding that 3,585 patients ages 0-17 experienced delays on an annualized basis in Maryland. But the MHA Report does not indicate that its 45-day study period is representative of hospitals' experiences on an annual basis. As Sheppard Pratt demonstrated in its CON application to relocate to Ellicott City, demand for behavioral health services for adolescents generally peaks in October, and March through April associated with school attendance and demands. (CON App., Docket No. 15-152367, pp. 40-41.) The MHA Report sampled a 45-day period from April 15 through May 31 – or the very peak of demand for adolescent services. (MHA Report, pp. 1-2.) This 45-day period is not a reasonable basis to extrapolate either a number or percentage of patients ages 0-17 who experience delay year round.

The reliance on this small sample size is also concerning because it is from 2018 – five years before when Hope Health projects reaching full occupancy. The 45-day sample period is too small to make any projection of future trends, and does not account for any potential changes in utilization or other factors, such as the expansion of child and adolescent bed capacity at UMMC and the opening of Sheppard Pratt's new facility at Elkridge with 75 private and 5 semi-private rooms (versus only all semi-private rooms at its prior location).

[12] Available at: https://www.wilder.org/sites/default/files/imports/MarylandHospitalAssociation_EmergencyDept_Report_9-19.pdf

Hope Health makes a further serious error when it estimates that expanded inpatient psychiatric bed capacity could address 45% of its annualized assumption of 3,585 ED Boarding patients, based on the MHA Report's finding that 45% of ED Boarding hours were due to patients waiting on bed capacity. (App. p. 53.) That 45% figure is not limited to patients waiting for capacity to open *at an inpatient psychiatric unit*. (*See* Sept. 2019 MHA Report, p. Reasons for discharge or transfer delays, and pp. 5-6, Staff recommended placement settings.)

The Sept. 2019 MHA Report does not identify what the portion of the 45% of patients whose delay was attributable to lack of bed capacity (a total of 538 patients) were child and adolescent patients, or distribute those patients across the recommended placement facility types. (*Id.*) However, the Report does demonstrate that not all patients who experienced a delay were referred to an inpatient psychiatric unit. (*Id.*)

Even if MHA report did identify the lower portion of patients whose delay was attributable to bed capacity *and who were waiting on an inpatient psychiatric unit bed*, we still would not be able to extrapolate from this data what role Hope Health could serve in alleviating that delay. As addressed more fully in Section I, Hope Health's proposed staffing is significantly less than that of an inpatient general psychiatric unit or a specialty psychiatric unit such as those Sheppard Pratt staffs. Furthermore, based on Sheppard Pratt's experience, patients waiting for beds are generally psychiatric patients with specialty needs over and above those of the median psychiatric patient, such as those with autism or neuropsychiatry needs. Hope Health's staffing is far below what would be required to service these patients. As a few examples, Sheppard Pratt staffs its specialty unit with twice the FTEs Hope Health plans, has higher nursing and social work ratios, and has behavioral specialists, expressive therapy, occupational therapy, and speech language pathologist available for its specialty unit. As its staffing plan, expenses, and ALOS

assumptions demonstrate, Hope Health does not plan to serve these patients, and will not be equipped to do so. Its proposed project will do nothing to alleviate their ED boarding times.

Readmissions. Hope Health suggests there is a link between bed need and readmissions but provides no concrete data to support this link. It appears to suggest that it will perform better than current providers on discharge planning and outpatient care. Sheppard Pratt, the largest provider of the services Hope Health seeks to offer, has low readmission rates – 5.3% for CY 2019 and 6.6% for CY 2020, [13] and a much larger outpatient network than Hope Health. Hope Health has provided no credible evidence to support its conclusion it will be able to improve readmission rates in Maryland. Indeed, every provider of acute psychiatric services in the proposed service area provides all of the services provided by Hope Health, except MedStar Franklin Square, which does not provide partial hospitalization or intensive outpatient programs to children and adolescents.

Other Unmet Need and Access Barriers. Hope Health identifies many factors that it claims demonstrate additional unmet need in the Baltimore area (App. 54-57), but does connect these issues to a need for inpatient care. Systemic racism, violence, and increasing suicide rates may very well be important issues to address in the proposed service area, but Hope Health offers no credible plan to address them through its proposed inpatient unit.

Hope Health also asserts that access barriers indicate unmet need, but it does not prove that these barriers in fact exist, and if they do, Hope Health puts forth no credible plan as to how

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[13] While there is no readily available benchmark data for child and adolescent readmissions, Sheppard Pratt performs well against the benchmark for readmissions when are available. (*See* The Centers for Medicare and Medicaid Services, Psychiatric Unit Services, Unplanned Readmissions, available at: https://data.cms.gov/provider-data/topics/hospitals/psychiatric-unit-services/#unplanned-readmissions.) Sheppard Pratt further notes that these national data points are not adjusted for acuity so do not perfectly reflect the specialty nature of much of Sheppard Pratt's admissions.

it will address these barriers. Hope Health merely recognizes a problem without presenting an evidenced-based solution. For example, despite Hope Health's focus throughout its application on the needs of Baltimore City residents, Hope Health proposes a location in Baltimore County, and does not provide sufficient support for its theory that it is uniquely positioned to attract and serve city residents as compared to other providers. Hope Health similarly claims that it is uniquely positioned to serve the Medicaid population. But Hope Health makes no actual comparison to other providers. As an example, Medicaid patients represented 61-63% of Sheppard Pratt's total discharges in the past three calendar years.

Cumulative Projected Need. For all of the reasons addressed above, Hope Health's need projections, Figures 23 and 24 (App. p. 58), are not reasonably supported by competent data. In addition to the issues identified, Hope Health's cumulative need projections assume an ALOS that is inconsistent with its projection of state need and with the experience of other providers. In its stated need projection, Hope Health projects need based on a 10.5 day ALOS for children and an 11.4 ALOS for adolescents. (App. p. 46.) Hope Health asserts this is based on "CY 2019 data for age group from HSCRC data," without identifying the data set or what filters were applied to the data. The Commission's recent April 2019 White Paper demonstrates that the ALOS for psychiatric discharges from Maryland hospitals has risen year over year between 2013 and 2017, the most recent year included. (Commission April 2019 White Paper, p. 22.) This increasing trend is consistent with the experience of Maryland's two private inpatient psychiatric hospitals. (App. p. 47.) Yet, Hope Health assumes an ALOS of 9.2 days in CY 2022 for both child and adolescent beds. This is lower than the 2019 state average, and Hope Health decreases it year over year to 8.7. Hope Health includes no discussion of the method is used to create its

ALOS assumptions. Based on the limited data it does provide, its ALOS assumptions are unreasonable.

* * *

The significant errors and unsupported data and assumptions in Hope Health's need projections render its projected need incapable of verification or replication and unsupportable. Sheppard Pratt recognizes that expanding capacity for behavioral health services may be appropriate in Maryland, but Hope Health simply has not met its burden of demonstrating that the need for the particular services Hope Health seeks to establish, in the Central Maryland region or elsewhere.

IV. HOPE HEALTH FAILS TO EVALUATE THE IMPACT OF ITS PROPOSED PROGRAM ON EXISTING PROVIDERS OR THE HEALTH CARE DELIVERY SYSTEM, COMAR § 10.24. 01.08G(3)(f).

Hope Health fails to comply with the requirements of the impact standard, projecting its impact only in terms of volume shift from other providers, and not the impact it will have on the costs and charges of other providers, or on costs to the health care delivery system. COMAR § 10.24.01.08G(3)(f), provides that a CON applicant must "provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system." As discussed elsewhere in these comments, Sheppard Pratt does not believe Hope Health's projections on need are supportable based on the Application's unsupported or unreasonable assumptions. However, if the Commission were to credit Hope Health's assumptions and projections regarding need and cost effectiveness, it would have to conclude that Hope Health fails to satisfy the impact standard.

Significantly, Hope Health anticipates shifting a total of 169 cases from Sheppard Pratt in its first year of operation. (App. at p. 71-72.)[14] Hope Health fails to demonstrate the financial impact of that volume shift. Due to increasing costs of treating this patient population, especially those with higher severity needs, such as those with neuropsychiatric or autism spectrum disorders, Sheppard Pratt operates at an annual loss. (Table 1, *supra*). If Hope Health succeeded in shifting 10% of Sheppard Pratt's child and adolescent volume, as it projects, Sheppard Pratt estimates a minimum loss of at least $4.1 million in revenue and $770,000 in profit in the first year of Hope Health's operation, based on a 10% reduction of Sheppard Pratt's patient revenue and profit margin for this patient population.[15] However, the true loss is likely to be even more significant. Hope Health's staffing plan, costs, and estimated ALOS all indicate that it will not be able to support higher severity patients requiring admission to a specialty unit. Sheppard Pratt's neuropsych patients had an ALOS of 66 days in FY 2019, compared with an average ALOS of 13.1. Sheppard Pratt treats these patients at a significant loss per patient, while lower severity patients average positive net revenue for Sheppard Pratt. In the first three quarters of FY 2020, Sheppard Pratt's average cost per for patients in its neuropsych unit was $1,371, compared to a range of $732 to $876 for its general adolescent patients. If Hope Health, as Sheppard Pratt suspects, were to shift only lower severity patients, the financial impact on Sheppard Pratt will be far more significant.

Even aside from the impact Hope Health will have on Sheppard Pratt if it meets its projections, and the indirect impact that will have on the health care delivery system, Hope

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[14] Sheppard Pratt notes that this projected shift directly contradicts Hope Health's assertion that there is significant unmet need in the service area.

[15] Hope Health's suggestion that the impact of its project may be mitigated by significant unmet need is not supportable.

Health will have a direct negative impact on Maryland's total cost of care because it anticipates treating patients at a higher rate than Maryland's existing specialty psychiatric hospitals, as demonstrated in the following table.

Table 5
Financial Impact of Sheppard Pratt and Brook Lane Volume Shift on Total Cost of Care

	Patient Per-Day Rate	HHS Projected Shift	Patient Days @ ALOS 9.2	Total Charges at Source Hosp.	Total Charges at HHS	Increased Cost to Healthcare System
Hope Health	$1,658		9.2			
Sheppard Pratt	$1,288	136	1251.2	$ 1,611,492	$ 2,074,940	$ 463,448
Brook Lane	$1,163	33	303.6	$ 353,133	$ 503,478	$ 150,345
Total		169	1554.8	$ 1,964,624	$ 2,578,418	$ 613,794

Notes:
ALOS: HHS projects an ALOS of 9.2. This table assumes these patients will require the same ALOS regardless of treatment location.
Charges: HHS rate based on HHS projection. Sheppard Pratt and Brook Lane rate based on 2021 rate with 2.3% update factor. (*See* Table 1 and discussion of annual update factor, page 5, *supra*.)
Volume shift Based on HHS projections (App. pp. 71-72).

V. HOPE HEALTH DOES NOT DEMONSTRATE IT HAS PLANNED APPROPRIATELY FOR PATIENT SAFETY AND OTHER QUALITY ISSUES.

The applicable State Health Plan chapter is significantly outdated and does not directly address consideration of or compliance with modern standards for inpatient psychiatric units. The Commission should nevertheless evaluate Hope Health's facility for such issues because the failure to address safety and quality issues jeopardizes the viability of the project and the costs its failure would impose on the healthcare delivery system.

Hope Health plans to renovate existing commercial office space to create an inpatient until within a portion of a commercial office building. Hope Health provides little depth in its description of direct renovation costs to account for the significant modifications needed to address the needs of its proposed patient population. Its architect, Health Design Group, does not appear to have hospital design experience. Rather, the Health Design Group's website

indicates that, like Hope Health, its prior experience is outpatient focused. Hope Health's floor plan also raises serious concerns. While it contains the features one would expect to see in an inpatient unit, the facility is not organized in a meaningful way to assure patient safety, security, and separation of patient populations.

Sheppard Pratt urges the Commission to consider whether Hope Health has planned or budgeted for a safe, durable environment, including the following considerations:

- **Psychiatric patient safety.** Design and construction of all patient accessible areas with anti-ligature, tamper-resistant, and vandal resistant features, including hardware, fasteners, fixtures, and furnishings based on the level of supervision in each area. Appropriately reinforced walls and shatter proof glass. These and more features are necessary to account for significant safety-risk psychiatric patients pose to themselves and others, and their destructive tendencies that can yield frequent and high replacement costs if inferior materials are used.

- **Security**. Hope Health references security but includes no space in the floor plan for a security office or monitoring. Hope Health similarly includes a brief notation on "upgraded security doors," but these appear to be just the doors themselves, there is no sally port or way of preventing elopement. Hope Health does not indicate it has considered child abduction policies, or how to safely treat patients with a history of aggression or sexual acting out. Its location in a commercial space also raises serious questions about the safety of others and the risk to patients if a patient elopes from the unit.

- **Code and TJC Compliance.** Compliance with life safety codes and Joint Commission manual, include fire rated doors, separation walls, an appropriate ventilations system, ceiling free of penetration, measures to protect tempering with water supply, and all other requirements of hospital units.

- **Separation of patient population.** Hope Health states that its child population will be separated from its adolescent population, but its floor plan raises serious concerns that this is not possible. The child bedrooms are at the end of a floor, and require passage through a hallway with adolescent rooms for all activities – the dining room, social spaces, entrance and admission space, and multipurpose space all share a common hallway with adolescent patient rooms.

- **Entrance and Admissions.** Hope Health includes only a small seating area at the entrance. Patients require evaluation in a separate space at the time of admission and completion of a history and physical soon after. Most patients are transferred via ambulance from an ED or hospital unit. Hope Health plans no space to complete such a process prior to entry to the patient unit. The $50,000 budget for civil design and

modification to the parking lot does not appear to contemplate adding an ambulance bay or an ambulance parking area to the parking lot.

- **Access to Unit.** The plans do not include a secure area where patients in the admission process, visitors, and contractors can be searched and provided a safe space to secure any and all belongings that could be weaponized or cause any patient safety issues. There is no planned space for family visitation. There is also no separate entrance and access point for contractors to make deliveries without accessing the unit (for example, the only way to access the kitchen/dining space is through the patient hallway). Yet, Hope Health's lack of staffing for several necessary departments suggests a significant presence by parties contracted to provide services. Will all contractors be screened? Will they be accompanied by staff at all times? How will Hope Health address patient privacy issues with frequent access to the patient unit by contractors?

- **Other ingress and egress.** It is not clear from the plans how many exits there are from the unit. The plans demonstrate a central entrance in the middle of the unit. It appears there may be another exit near the Multipurpose room. It is unclear if the plan includes sufficient safety features for this exit, if it exists, and if the exit is on a shared hallway with other commercial space, as it appears to be – which would raise serious patient privacy issues as well as safety issues for the patients and other office tenants. The hallway by the child rooms is similarly unclear – if there is no exit here, that raises serious fire safety concerns. If there is an exit, it seems likely that it is shared space with other building tenants.

- **Food safety.** Hope Heath's plans do not demonstrate sufficient space for a commercial kitchen. If all food services will be contracted, the facility will require sufficient space to maintain any hot meals at required temperatures until time of service. Given the required separation of child and adolescents, including when dining, and the lack of temperature regulated commercial storage space, this will require six meal deliveries a day, with appropriate space and temporary temperature storage, plus space for storing used dishes and uneaten meals in a compliant manner. Storage is not permitted in patient hallways.

- **Nursing Stations, Crash Carts**. There are three nursing stations, only two of which have a line of sight to patient rooms. Staffing plans call for only two nurses a shift, raising questions as to whether any nurse will be able to be present at a nursing station for any considerable period of time. Crash carts appear to be stored in alcove areas rather than in a secure area.

- **Seclusion rooms**. The space includes only one seclusion room, which is inadequate for the proposed 16-bed facility and patient population.

- **Outdoor space**. Hope Health does not appear to plan for any outdoor space, and it is questionable that it could do so securely in the location it has selected.

Conclusion

As the Commission staff has recently recognized, the Commission maintains a "gatekeeper" function "assuring that those persons entering Maryland to provide health care facilities services . . . have the requisite competence." (Commission April 2019 White Paper at 3.) Based upon its Application, Hope Health has demonstrated that it lacks the competence necessary to operate a special psychiatric hospital serving children and adolescents. For the reasons set forth above, the Commission should use its "gatekeeping" function wisely and deny Hope Health's Application.

Respectfully submitted,

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(410) 727-7702

Attorneys for Sheppard Pratt Health System, Inc.

March 1, 2021

Table of Exhibits

Exhibit	Description
1	**REVISED** Table L

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CERTIFICATE OF SERVICE

I hereby certify that on the 1st day of March, 2021, a copy of Sheppard Pratt Health System, Inc.'s Interested Party Comments on Hope Health System, Inc.'s CON Application Proposing the Establishment of a Freestanding Inpatient Psychiatric Hospital for Children and Adolescents sent via email and first-class mail to:

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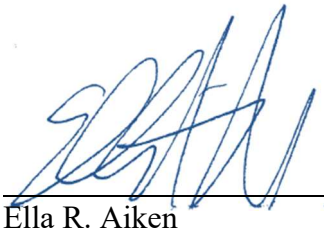


Ella R. Aiken

I hereby declare and affirm under the penalties of perjury that the facts stated in Sheppard Pratt Health System's Comments on Hope Health System's CON Application, dated March 1, 2021, and its attachments are true and correct to the best of my knowledge, information, and belief.

3/1/2021
Date

Jennifer Wilkerson
VP and Chief Strategy Officer

I hereby declare and affirm under the penalties of perjury that the facts stated in Sheppard Pratt Health System's Comments on Hope Health System's CON Application, dated March 1, 2021, and its attachments are true and correct to the best of my knowledge, information, and belief.

3/1/2021
Date

Kelley Savoca
VP and CFO

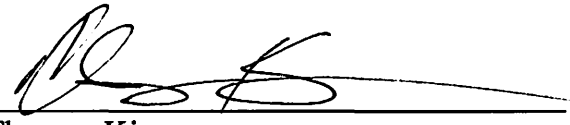
I hereby declare and affirm under the penalties of perjury that the facts stated in Sheppard Pratt Health System's Comments on Hope Health System's CON Application, dated March 1, 2021, and its attachments are true and correct to the best of my knowledge, information, and belief.

3/1/2021
Date

Sean Pumphrey,
Sr. Director of Integrated Operations

I hereby declare and affirm under the penalties of perjury that the facts stated in Sheppard Pratt Health System's Comments on Hope Health System's CON Application, dated March 1, 2021, and its attachments are true and correct to the best of my knowledge, information, and belief.

3/1/2021
Date



Thomas King
Director of Safety, Security &
Emergency Preparedness

I hereby declare and affirm under the penalties of perjury that the facts stated in Sheppard Pratt Health System's Comments on Hope Health System's CON Application, dated March 1, 2021, and its attachments are true and correct to the best of my knowledge, information, and belief.

3/1/2021
Date

Erin Thompson, Director of Quality Management

EXHIBIT 1

INSTRUCTION : List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
			$0	1.0	$158,400	$158,400			$0	1.0	$158,400
			$0	1.0	$109,300	$109,300			$0	1.0	$109,300
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0	2.0		$267,700			$0	2.0	$267,700
Direct Care Staff *(List general categories, add rows if needed)*											
Recreation Therapist			$0	1.0	$46,410	$46,410			$0	1.0	$46,410
Psychologist			$0	2.0	$70,600	$141,200			$0	2.0	$141,200
Psychiatrist			$0	4.0	$250,000	$1,000,000			$0	4.0	$1,000,000
Social Worker			$0	3.0	$52,710	$158,130			$0	3.0	$158,130
RN			$0	9.5	$77,910	$740,145			$0	9.5	$740,145
Occ. Therapist			$0	1.0	$87,610	$87,610			$0	1.0	$87,610
Psych Tech			$0	16.0	$35,910	$574,560			$0	16.0	$574,560
Nurse Manager			$0	1.0	$100,000	$100,000			$0	1.0	$100,000
Infection Control / Health & Safety			$0	0.5	$30,000	$30,000			$0	0.5	$30,000
Total Direct Care			$0	38		$2,878,055			$0	38	$2,878,055
Support Staff *(List general categories, add rows if needed)*											
Discharge Coordinator			$0	1.5	$60,700	$91,050			$0	1.5	$91,050
Finance Staff			$0	3.0	$75,900	$227,700			$0	3.0	$227,700
Food and Nutrition			$0	2.5	$41,925	$104,813			$0	2.5	$104,813
Reception/Assistant			$0	3.5	$32,600	$114,100			$0	3.5	$114,100
Security Officer			$0	7.2	$36,920	$265,824			$0	7.2	$265,824

TABLE L. WORKFORCE INFORMATION

UR/Billing			$0	2.5	$53,000	$132,500			$0	2.5	$132,500
HIM / Medical Records			$0	1.0	$45,760	$45,760			$0	0.0	$0
Patient Services / Accounts			$0	2.0	$37,440	$74,880				1.0	$45,760
Purchasing / Materials Management			$0	0.5	$16,640	$16,640				2.0	$74,880
Physical Plant Management / Maintenance			$0	1.4	$37,143	$52,000				0.5	$16,640
General Services (Housekeeping / Environmental Services, Laundry)			$0	2.4	$29,167	$70,000				1.4	$52,000
			$0			$0			$0	2.4	$70,000
Total Support			$0	27.5		$1,195,267			$0	27.5	$1,195,267
REGULAR EMPLOYEES TOTAL			$0	***65.5***		$4,073,322			$0	65.5	$4,073,322
2. Contractual Employees											