Application for Certificate of Need

Establishment of a Special Psychiatric Hospital
For Children and Adolescents

Hope Health Systems, Inc.

Hope Health Systems, Inc.

March 20, 2023

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LIST OF EXHIBITS

For internal staff use

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Hope Health Psychiatric Hospital

Address:

1726 Whitehead Rd.	Woodlawn	21207	Baltimore
Street	City	Zip	County

Name of Owner (if differs from applicant):

2. OWNER

Name of owner: Hope Health Systems, Inc.

3. APPLICANT. *If the application has co-applicants, provide the detail regarding each co-applicant in sections 3, 4, and 5 as an attachment.*

Legal Name of Project Applicant
Hope Health Systems, Inc.

Address:

1726 Whitehead Rd.	Woodlawn	21207	MD	Baltimore
Street	City	Zip	State	County

Telephone: 410-265-8737

Name of Owner/Chief Executive: Mr. Oladipo Fadiora

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from applicant:
Hope Health Systems, Inc.

5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☐	
	(2) For-profit	☒	Maryland - 09/16/1999
	(3) Close	☐	State & date of incorporation
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☐	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☐	

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: Mr. Yinka Fadiora

Mailing Address:

1726 Whitehead Rd.	**Woodlawn**	**21207**	**MD**
Street	City	Zip	State

Telephone: **410-265-8737**

E-mail Address (required): **yfadiora@hopehealthsystems.com**

Fax: **410-265-1258**

B. Additional or alternate contact:

Name and Title: Marta Harting

Mailing Address:

750 E. Pratt Street, Suite 900	**Baltimore**	**21202**	**MD**
Street	City	Zip	State

Telephone: **410-244-7542**

E-mail Address (required): **mdharting@venable.com**

Fax: **410-244-7742**

7. TYPE OF PROJECT

The following list includes all project categories that require a CON under Maryland law. Please mark all that apply.

If approved, this CON would result in:

(1)	A new health care facility built, developed, or established	☒
(2)	An existing health care facility moved to another site	☐
(3)	A change in the bed capacity of a health care facility	☐
(4)	A change in the type or scope of any health care service offered by a health care facility	☐
(5)	A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf	☐

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is; why you need/want to do it; and what it will cost. A one-page response will suffice. Please include:

(1) Brief description of the project – what the applicant proposes to do;
(2) Rationale for the project – the need and/or business case for the proposed project;
(3) Cost – the total cost of implementing the proposed project; and
(4) Master Facility Plans – how the proposed project fits in long term plans.

Applicant Response

(1) Brief Description of the Project

The Applicant, Hope Health Systems, Inc. ("HHS"), is proposing to establish Hope Health Psychiatric Hospital ("HHPH"), a 16-bed psychiatric hospital for children and adolescents, with four single patient rooms to treat the child patient population and twelve single patient rooms to treat the adolescent patient population. HHPH would be established in a renovated portion of a building in Woodlawn, Baltimore County in which HHS currently provides outpatient behavioral health services for adults, children, and adolescents.

(2) Rationale for the Project

HHPH will provide an integrated, comprehensive, and personalized care approach to children and adolescents in Baltimore County, Baltimore City, and the surrounding communities. The proposed hospital will address an urgent need for additional access to inpatient psychiatric services, as patients and their families all too often experience long wait times for bed placement, resulting in lengthy hospital emergency department (ED) boarding and detrimental outcomes. As an existing

provider of outpatient services within the community, HHS will bring additional inpatient capacity, diversity, culturally competent care, care coordination, and integrated care continuum options to the provider market for inpatient mental health care. HHS seeks to reduce wait times for inpatient bed placement, connect patients with the outpatient care continuum, and ultimately help reduce readmission rates. While offering services to all patients in need of its service offerings, HHS also anticipates publicly insured patients representing a large percentage of its inpatient population, and welcomes the opportunity to serve this historically disadvantaged population as it has for years in the outpatient context.

HHS currently provides a number of services to the community, including partial hospitalization, outpatient mental health, expanded school mental health, rehabilitation programs, substance abuse, and mobile treatment. As a result, HHS is uniquely positioned to provide its discharged inpatients with continued follow up to help reintegrate them into the community and reduce readmissions and discharge wait times.

At present, there are only seven hospitals in the State that provide child psychiatric services, and just five of these hospitals handle over 95% of admissions. Only eleven hospitals provide adolescent psychiatric services within the State, and just seven of these hospitals handle 95% of admissions. The current level and concentration of access is not sufficient to meet patient needs, as is further outlined in HHS's response to COMAR 10.24.21.05B(2) below.

In addition to the need for more access, health care providers and community stakeholders have identified lack of care after a patient is discharged from a psychiatric unit to be a major concern.[1] The transition from acute mental health inpatient to community care is a vulnerable period, where patients can experience a risk to their mental health.

As an existing provider in the community, HHS understands that many patients face additional burdens in the form of structural racism, cultural biases, and health disparities. HHS is a Minority Business Enterprise (MBE) that has made diversity and culturally competent care a guiding principle of the organization. HHS employs a diverse clinical and support staff workforce and trains all staff on the important principles of culturally competent care.

The goals and impact of this project align with the findings of the MHCC's Psychiatric Services Work Group (Work Group) and Psychiatric Services Clinical Advisory Group (CAG) regarding timely admission to acute psychiatric services, timely discharge following treatment, and the quality and safety of psychiatric hospital facilities and services, particularly with regard to children and adolescents within the market. HHS has analyzed public and non-public data, including data developed with HSCRC assistance to further confirm the need for the facility.

The project is responsive to all six State Health plan policies outlined by the Work Group and CAG and now contained in the State Health Plan for Facilities and Services: Acute Psychiatric Services (SHP Chapter):

1. Policy 1: People should be treated in the least restrictive setting appropriate to their medical conditions.

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[1] Tyler, N., Wright, N. & Waring, J. Interventions to improve discharge from acute adult mental health inpatient care to the community: systematic review and narrative synthesis. BMC Health Serv Res 19, 883 (2019).

2. Policy 2: Patients should be able to secure timely placement in a psychiatric bed when acute inpatient psychiatric services are required.

In accordance with Policies 1 and 2, HHPH will expand access to inpatient mental health beds to facilitate timely admissions from the Emergency Department or office setting to place patients in the most effective setting for their care.

3. Policy 3: Patients shall be timely discharged from hospitals once acute psychiatric services or other acute care services are no longer needed.

Responsive to Policy 3, HHS will not only operate HHPH, but maintain its outpatient services that will provide a ready outlet for patients and their family to step down from acute care as soon as clinically appropriate. By providing an outpatient care continuum that varies in severity, HHS will be able to directly meet the need for timely discharge for patients in need.

4. Policy 4: Acute psychiatric services shall be financially and geographically accessible to all who need them.

HHS's alignment with Policy 4 is demonstrated in its response to COMAR 10.24.21.05B(1) as well as COMAR 10.24.21.05B(12). Admission to the facility will provide more convenient care geographically to portions of the service area population, while the cost of care within the facility will be in keeping with existing facilities and systematically more cost effective than patient currently being held in emergency departments or observation units. HHPH will accept all payers, with an expectation of a high Medicaid population, delivering access to a key vulnerable population.

5. Policy 5: A hospital with acute psychiatric services will continuously and systematically work to improve the quality and safety of patient care.

HHS will build upon its existing high-quality clinical care to continuously improve upon the quality and safety of its patients. Already Joint Commission and CARF accredited for multiple behavioral health modalities, HHS is committed to Joint Commission accreditation for inpatient services and a culture of continuous improvement.

6. Policy 6: An increase in the funding and provision of mental health services by the private sector and federal and State government is necessary to meet the needs of Maryland's population adequately.

HHS will step in to provide additional private sector support for inpatient psychiatric care for the children and adolescent populations.

(3) Cost

As shown in the attached CON Application Table Package, Table E, the total cost of the project is $1,365,000.

(4) Master Facility Plans

The project will be completed in a single phase with two parts, with the first portion of the project to demolish the existing rooms and fixtures within the space that has been designated as the new hospital space. Following the demolition, the construction team will proceed with the renovation efforts to update the space within the existing facility to meet Facility Guidelines Institute (FGI) standards for an inpatient psychiatric hospital.

B. Comprehensive Project Description: The description must include details, as applicable, regarding:

(1) Construction, renovation, and demolition plans;
(2) Changes in square footage of departments and units;
(3) Physical plant or location changes;
(4) Changes to affected services following completion of the project; and
(5) If the project is a multi-phase project, describe the work that will be done in each phase. If the phases will be constructed under more than one construction contract, describe the phases and work that will be done under each contract.

Applicant Response

The project is the establishment of HHPH, a 16-bed psychiatric hospital for children and adolescents, with four single patient rooms to treat the child patient population and twelve single patient rooms to treat the adolescent patient population. HHPH would be established in a renovated portion of a building in Woodlawn, Baltimore County in which HHS has provided a broad continuum of outpatient behavioral health services for adults, children, and adolescents for more than two decades. The addition of HHPH will complete this continuum of care, enabling HHS to deliver a comprehensive, holistic and integrated mental health care program that will incorporate inpatient psychiatric care with its broad range of outpatient mental health programs. HHS will bring diversity, culturally competent care and care coordination to the market for inpatient mental health care.

Before turning to the specific information required in the Comprehensive Project Description, information about HHS, its experience and qualifications as a provider of culturally competent behavioral health care, and how HHPH will be integrated into the continuum of care provided by HHS is provided below. See also **Exhibits 2** and **9** for additional information regarding HHS and its leadership.

Additionally, HHS notes that it is currently finalizing an agreement with Scott Migdole, who is the Chief Operating Officer of Yale Behavioral Health and the Yale Program on Supervision, as an independent consultant. Mr. Migdole is also an Assistant Clinical Professor in the Department of Psychiatry at the Yale School of Medicine. He will provide consulting services in connection with HHS's establishment and operation of HHPH.[2]

[2] Mr. Migdole's responsibilities as Chief Operating Officer of Yale Behavioral Health and the Yale Program on Supervision and an Assistant Clinical Professor in the Department of Psychiatry at the Yale School of Medicine include outpatient mental health and substance abuse services, management of juvenile justice mental health services for pre-adjudicated youth and crisis services. Mr. Migdole also serves as the Chief Executive Officer of Crossroads, Inc., a 155-bed primary addiction residential treatment center in New Haven, Connecticut. He holds a Master's Degree in Social Work from Simmons College in Boston, MA and completed a Post-MSW Fellowship at the Yale Psychiatric Institute in co-occurring care. He has long

1. The Applicant

Founded in 1999, HHS is a private, for-profit organization with more than 20 years of experience in providing direct mental health, substance abuse, and community support services to adults, children, and adolescent clients in institutional and outpatient settings in Maryland. HHS is accredited through The Joint Commission (TJC), as well as Commission on Accreditation of Rehabilitation Facilities (CARF), and is a deemed status-certified Outpatient Mental Health Clinic by the Maryland Department of Health (MDH). HHS is a certified Minority Business Enterprise (MBE) by the Maryland Department of Transportation, and has received recognition as a Top 100 MBE organization.[3] Many of our staff and providers are minorities that reflect the communities we serve.

As further described below, HHS offers comprehensive outpatient mental health services to children, adolescents, young adults, adults, the geriatric population, and their families throughout the Baltimore Metropolitan region. HHS' wealth of programs include but are not limited to: onsite/offsite Outpatient Mental Health Programs, Substance Abuse Treatment Program, Psychiatric Rehabilitation Program (PRP), Case Management Services, Mental Health and Substance Abuse Services (Baltimore City and County), Department of Juvenile Service (BCJJC, Hickey, Waxter, Cheltenham), behavioral health assistance in Baltimore City and Baltimore County schools, one-on-one behavioral assistance in Baltimore City and Baltimore County schools, Mobile Treatment Services, and Expanded School Mental Health (ESMH) program.

In 2022, HHS delivered nearly 40,000 service encounters to patients through these programs.

HHS has offices in Baltimore City (Greenspring), Baltimore County (Woodlawn), and Carroll County (Eldersburg), and Prince George's County. Its award-winning staff of mental health professionals has decades of experience in the mental health field. HHS specializes in early interventions enhancing preventative and treatment services, including psychiatric evaluations, family counseling, individual counseling, group counseling, psychiatric rehabilitations, referral services, trainings, and consultations, in addition to many other mental health/substance abuse related services.

With its qualified and culturally competent staff of mental health professionals, substance abuse treatment professionals, and support staff, HHS has partnered with state, local and community organizations to provide an interdisciplinary and collaborative program of mental health, substance abuse, and support services to children, adolescents, young adults, adults, geriatrics, families, and at-risk populations.

HHS trains its staff in diversity and culturally competent care and incorporates this subject into treatment teams that are led by an HHS psychiatrist with clinicians and trainings. HHS also provides between 18 and 21 continuing education units (CEUs) per year to its therapists and clinicians. Training includes, among other subjects:

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focused on the development of the behavioral health workforce, including documentation, treatment planning, stages of change, standards of care, and compliance, including Medicaid and other third party payers.

[3] http://top100mbe.org/pdf/Top100_Winners_Flier_v1.pdf

- **Racism in Clinical Care:** Train employees in social determinants of health, and integrated behavioral health to help address the physical, social, and mental health needs of vulnerable urban and rural populations.
- **Welcoming Sexual and Gender Diversity into Practice for Clinicians:** Training to help reduce prejudices that include the cognitive, affective, and behavioral components. This training was aimed at educating providers about the sexual and gender diversity.
- **Cultural competence: The Unspoken Skill:** This training to increase the ability to understand, communicate with, and effectively interact with people across cultures. The training helps clinicians develop positive attitude towards cultural differences as well as increase knowledge of different cultural practices and world views.
- **Equitable Trauma informed Trainings:** The training to increase understanding of how to incorporate a racial justice lens in the development and implementation of a trauma awareness and resilience organization.

HHS's core values and mission as an organization is demonstrated in its Mission, Vision and Values Statement:

Mission

- HHS' mission has always required it to reach beyond the activities of a normal business day to see and understand the lives of its patients, the importance of targeting the emotional stability of the child, and the importance of extending our focus to the family as the basic unity of the community. This is to ensure the child maintains optimal levels of functioning.

Vision

- HHS' goal is to become a national leader of mental health services and to continue to provide services which will allow children, adolescents/youth, and adults become productive citizens in their communities and society.

Values

- Provide a great work environment and treat everyone with respect and dignity
- Embrace diversity as an essential component
- Apply the highest standards of excellence to providing quality health care services to children, adults, and their families.
- Contribute positively to the community.
- Recognize that profitability is essential to future success.

2. HHS's Existing Outpatient Programs

Outpatient Mental Health Clinic (OMHC)

Services provided through HHS's OMHC programs are designed to promote mental health and improve functioning in children, youth, adults and families. In addition, HHS's program uses tools to effectively decrease the prevalence and incidence of mental illness, emotional disturbance and social dysfunction. The responsibility for diagnostic and treatment services is vested in a multi-disciplinary team comprised of psychiatrists, licensed social workers, licensed professional

counsellors, marriage and family licensed therapists, public health educators and other mental health professionals. The services provided by HHS include but are not limited to:

- Diagnostic Evaluation
- Psychiatric Evaluation
- Family, Group and Individual Therapies
- Psychiatric Rehabilitation Program
- Medication Management Services
- Crisis or Emergency Interventions

Expanded School Mental Health

HHS's Expanded School Based Program strives every year to be the best clinical program serving public schools in Baltimore City and Baltimore County. HHS's goal, for each school serviced by them, is to strive for excellence in service, promote academic success, establish and develop students' personal assets and capabilities; and, provide high quality services that will incorporate evidence-based practices and practice-based evidence interventions, continuum of care, authentic parent/family engagement, meaningful youth involvement, culturally and linguistically competent service provisions, training, consultation services, and, data-driven planning, evaluation, and quality improvement. HHS's ESMH programs include:

- Mental health screening
- Psychiatric assessment and Diagnosis
- Individual treatment Plan (ITP)
- Continuing evaluation and Treatment
- Referral Services
- Medicaid services
- In school services
- Discharge Planning/ After Care Services

Mobile treatment Services

Mobile Treatment Services (MTS) are community-based, intensive, outpatient mental health services designed for individuals who have exhausted traditional forms of outpatient treatment interventions or who have had repeated psychiatric hospitalizations. HHS's MTS provides assertive outreach, treatment and support to children, adolescents and adults with mental illness who, according to medical necessity, are unable to utilize traditional outpatient mental health services because of the seriousness of their problems. HHS mobile treatment offers the following services:

- Therapy at home, school, street, shelter and in the community
- Psychiatric Evaluation and Treatment
- Clinical Assessment
- Medication Management/Monitoring
- Case Management
- One-on-one Counselling
- Training/Support with daily living skills

- Psychiatric Rehabilitation
- Crisis stabilization
- Referral Services (Continuity of Care)

Substance Abuse Treatment

HHS offers holistic and highly individualized substance abuse treatment program for adolescents and adults. At HHS, the goal is to treat the whole person, not just the addiction.
The services offered include:

- Alcohol and drugs of abuse evaluation, medication management
- Assessments for Juvenile Justice/JOINS with ongoing progress reports
- Coordination of twelve step self-help programs
- Case management services
- Randomized Urinalysis
- Specialized groups (including gender specific)
- Family, couple, and individual counselling sessions
- Individualized treatment planning & collaborative treatment approach
- DUI/Parole and Probation/Court Ordered Drug and Alcohol Counselling

Psychiatric Rehabilitation Program (PRP)

HHS's child and adolescent PRP program provides goal-directed, outcome-focused, and time-limited interventions designed to reduce maladaptive behaviors and to restore and strengthen specific age-appropriate skills so that the youth can function to their highest potential up to and including independence. PRP treatment is seen as a planned and integrated adjunct to outpatient mental health treatment, and the total plan of care or the youth. PRP includes a combination of psychoeducation, emotional and behavioral awareness competency, and social skills training in groups or individually, at the agency site, or in the youth's home or in the community. The focus of the PRP treatment model is directed towards the reduction of emotional or behavioral problems, and the restoration of age-appropriate skills, including:

- Facilitating the enhancement of an individual's independent living and social skills, including the individual's ability to make decisions about his or her life, while creating opportunities for choice regarding home, school or work, or community.
- Promoting community resources to integrate the individual into the community.

Targeted Case Management

HHS's child and adolescent Case Management Program provides help and hope to minor with psychiatric illnesses while providing their family with support and access to resources within the community. Families are assigned a care coordinator to help assess, prioritize, and advocate for their needs while developing a supportive team of people. Families' needs are addressed through referral to appropriate services, and through coordination of services with multiple providers and unpaid supporters. HHS provides wraparound services to support our client's growth, independence, and success in their future.

Partial Hospitalization Program (PHP)

The Partial Hospital Program is structured and patientcare oriented with a multidisciplinary team approach. HHS' PHP program acts as a step-down approach as well as a short-term program to treat patients with acute psychiatric symptoms who need significant support. Patients receive treatment for 6.5 hours a day, up to five days a week. Each patient's treatment needs are reviewed shortly after admission, and an individualized treatment plan is developed. Daily group-oriented programs focus on symptom management, stabilization, psychoeducation, and coping skills. The length of each patient's participation in the program varies based on the individual's response to treatment, with a maximum of 30 treatment days per admission. Discharge plans are made for each patient in conjunction with the referral source. This program will help move patients from the inpatient setting to partial hospitalization before the patient is discharged back to the community.

Intensive Outpatient Program (IOP)

The Intensive Outpatient Program offers more therapy than is available in a typical outpatient setting but involves less contact than the PHP. This program of HHS helps patients stabilize their symptoms and quickly return to work or their community. Patients receive four hours of treatment per day, three to five times per week. Patients with acute psychiatric symptoms will be discharged from HHS's inpatient setting to a partial hospital setting followed by an intensive outpatient setting, depending on their condition, which will help provide comprehensive care to the patient.

3. HHS's Partnerships

Through partnerships with physicians, therapists, schools, behavioral health care centers, and community-based organizations, HHS works to foster healthier and promising futures for patients and their families. HHS has partnered and collaborated with local and national child-serving and community-based organizations, public and charter schools, colleges and universities, hospitals, other mental health clinics and facilities, and federal and local government agencies which include but are not limited to the following:

- Behavioral Health Systems Baltimore
- KIPP Charter Schools
- Kennedy Krieger Institute and Universal Counseling
- Baltimore City and County Public Schools
- Family League of Baltimore
- Maryland Department of Labor (DOL)
- Maryland Department of Juvenile Services (DJS)
- My Sister's Place
- Our Daily Bread
- Hannah More Emergency Shelter
- Eastern Family Resource Center

HHS's longstanding partnership with the Maryland Department of Juvenile Services (DJS) is part of its long history of providing access to care for underserved populations. HHS has been providing mental health and substance abuse services to DJS-detained youth for over a decade. HHS provides a range of mental health and substance use treatment services to youth involved in the juvenile justice system. HHS's services at DJS's Juvenile Justice Center in Baltimore

Services resulted in the removal of all that facility's Civil Rights of Institutionalized Persons ACT (CRIPA) deficiencies. HHS provides services to DJS in a wide range of areas including: Protection from Harm, Suicide Prevention, Mental Health, and Quality Assurance. HHS helped DJS achieve the long-needed reform to ensure that every child has the services and support needed to succeed by:

- Implementation of mental health assessments: HHS administered Youth Admission Questionnaire and the Facility Initial Reception Referral Screening Tool (FIRRST) to help DJS determine if the young person has any medical, mental health or substance abuse conditions that would render admission unsafe.
- Development of Policies and Protocols: HHS helped DJS write policies and procedures to address the mental health issues.
- Creation of an Intensive Services Unit (ISU): HHS's services in the creation of an ISU helped monitor youths in danger of harming themselves or others as well as treating individuals who attempt suicide.
- Development of suicide protocols and suicide prevention training: HHS helped establish two-levels of suicide watch for supervision, intervention, and prevention for youth at risk of suicide. This included one to one supervision for observation and monitoring, followed by immediate consultation or intervention services. HHS established a training protocol that included identifying warning signs and symptoms of suicidal behaviour, responding to suicidal and depressed youth, and follow-up monitoring of youth who attempt suicide.
- Development of protocols for treatment planning: The comprehensive juvenile justice services provided by HHS include: psychiatric evaluation, psychological testing, medication management, counselling (individual, group and family), suicide assessments, crisis interventions and referral services, aggressive reduction therapy and training for direct care staff on de-escalation skills and peer relations. HHS services to DJS are based on an integrated treatment model with care providers who have extensive training in treating youth who have mental health and/or substance abuse disorders.
- Improved record keeping protocols: HHS implemented the documentation of all face to face crisis behavioural health assessments. This included date and time of the clinical interview, risk assessment record, the presence and severity of mental health issues as well as detailed description of the specific counselling or treatment intervention.

HHS also successfully implemented standards for providing youth in the DJS system access to adequate mental health treatment within a reasonable time frame. Specifically, HHS helped reduce the average length of stay for youth by 30% by providing evidence-based programs such as multi-systemic therapy and functional family therapy.

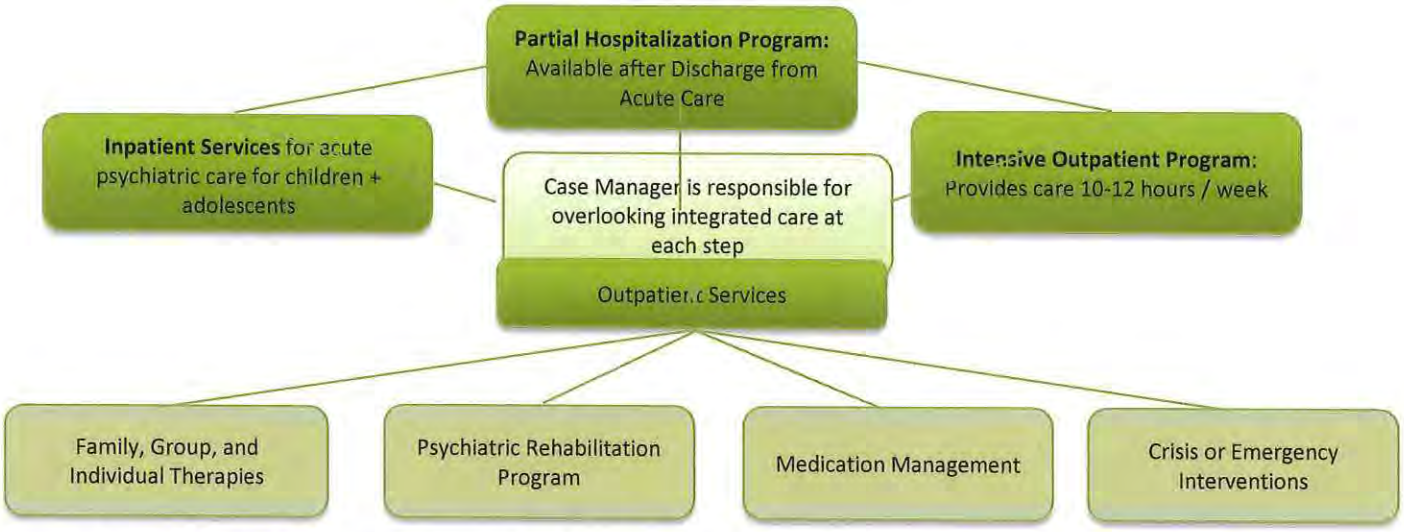
Additionally, at DJS's request, HHS's work regarding suicide prevention practices within the Juvenile Justice Center in Baltimore City was evaluated by the Project Director of the National Center on Institutions and Alternatives. The evaluation report commended the in-service training of mental health clinicians provided by HHS. HHS's mental health clinicians screened and assessed each newly admitted youth within 72 hours of arrival. The Project Director evaluated the screening methods implemented by HHS and concluded, "The screening and assessment forms utilized by Hope Health Systems regarding suicide risk inquiry are excellent." **Exhibit 1**.

4. Addressing the "Revolving Door"

The term "revolving door" is widely used to describe the circumstance where mental health service recipients (in particular, children, adolescents, as well as forensic patients) repeatedly transition between inpatient care back to the community, and then back to hospital within a very short period of time[4]. It stems not only from patient's health condition but also from the lack of adequate continuous care after inpatient discharge, and causes increased readmission rates, resulting in increased cost of care for patients. The MHCC recognized the importance of pois concept in its White Paper: Maryland Acute Psychiatric Hospital Services that "Patient care will be optimized if the continuum of facilities and services can by systemized for timely and coordinated transfer of patients and delivery of services along the continuum."

Through HHPH, HHS will help to address the "revolving door" problem through a care transition program and its broad integrated care continuum of outpatient programs

Figure 1: HHS's Integrated Care Continuum



HHS's PHP (which can serve up to 30 patients at any one time) offers lower-cost community-based alternative to the inpatient setting. HHS will use PHP as a step-down level of care for patients who are admitted to the inpatient facilities to make the transition to the community smoother. HHS's mobile treatment services (MTS) are community-based, intensive, outpatient mental health services designed for individuals who have exhausted traditional forms of outpatient treatment interventions or who have had repeated psychiatric hospitalizations. Once a patient is discharged from the inpatient setting, HHS will transfer the patients based on severity of the condition to its PHP or MTS, and a case manager will be responsible for ensuring that a timely personalized care is provided to the patient.

HHS's intensive outpatient program (IOP) allows patients to continue their therapies on a part-time yet intensive schedule designed to accommodate work and family balance. This program will help in discharging a patient sooner from the PHP to the next step in the step-down protocol. The IOP provides 10-12 hours of group as well as individual therapy each week before the patient is moved to the next stage of outpatient care.

4 https://www2.census.gov/programs-surveys/popest/datasets/2020-2021/counties/asrh/

The final stage in the HHS' care continuum is community-based outpatient care. HHS works in collaboration with schools, child welfare/foster system, and other child/family caring agencies as appropriate to provide community-based comprehensive outpatient care to the patient. HHS's programs include:

- Family, Group and Individual Therapies: This therapy generally occurs weekly until sufficient progress has occurred to decrease the frequency of sessions. The case manager works with a multi-disciplinary team to assess the duration and the frequency of the sessions as well as goals that need to be accomplished before a complete transition into the community takes place.
- Psychiatric Rehabilitation Program (PRP): HHS's child and adolescent PRP is goal directed, outcome focused, and provides time-limited interventions designed to reduce maladaptive behaviours and to restore and strengthen specific age appropriate skills so that the youth can function to their highest potential up to and including independence. PRP treatment is seen as a planned and integrated adjunct to outpatient mental health treatment.
- Medication Management Services: Medication services are provided as needed. These services include providing prescriptions, monitoring and patient education.
- Crisis or Emergency Interventions: This service offers 24/7 mobile crisis intervention as well emergency care to patients who contact the facility.

5. Project Details

(1) Construction, renovation, and demolition plans;

HHPH will be established in renovated space consisting of 15,329 square feet within an existing building owned by Hope Health Properties, LLC ("HHP"). HHP and HHS share common ownership and management, as detailed in Part IV below. HHS currently leases another part of the same building in which it operates its outpatient programs. HHP will undertake a gut renovation of the space in which HHPH will be located for use as a psychiatric hospital as proposed in this Application. HHS will enter into a lease with HHP of the finished space the form of which is attached as **Exhibit 3**. The space is currently vacant but was previously used as offices, classrooms, and conference rooms.

The newly renovated space in which HHPH will be located will be separate and distinct from the space within which HHS operates its outpatient programs. As shown in the floor plans (**Exhibit 4**), HHPH will have a separate entrance for patients and visitors. The space will feature private sleeping rooms and the variety of rooms and environments required by the FGI guidelines and recommended by evidence-based best practices. The experience of the Applicant's architect that prepared the floor plans is described in **Exhibit 5**.

The present mechanical, electrical, and plumbing (MEP) infrastructure within the building is adequate to serve the area identified for renovation. The project includes all new MEP services within the project area and modifications to the controls systems as necessitated by the design. Utility services to HHPH will be supplied from the existing infrastructure in the building.

As shown in the floor plans (**Exhibit 4**), the space for the adolescent and children age groups will

be distinct, each having nursing stations and protocols to allow for a specialized treatment based upon the age group. The facility will include features that are friendly to families, children, and adolescents, enabling the family, as appropriate, to participate in care.

(2) Changes in square footage of departments and units;

Not applicable HHPH will be a new special hospital.

(3) Physical plant or location changes;

Not applicable. HHPH will be a new special hospital.

(4) Changes to affected services following completion of the project; and

Not applicable. HHPH will be a new special hospital. HHPH will share a building with outpatient clinical services, which will experience minimal impacts from the inpatient construction. The inpatient care will be constructed in an area that is currently vacant.

(5) If the project is a multi-phase project, describe the work that will be done in each phase. If the phases will be constructed under more than one construction contract, describe the phases and work that will be done under each contract.

The project is planned as a single phase of construction.

Complete the DEPARTMENTAL GROSS SQUARE FEET WORKSHEET (Table B) in the CON TABLE PACKAGE for the departments and functional areas to be affected.

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

Complete the Bed Capacity (Table A) worksheet in the CON Table Package if the proposed project impacts any nursing units.

Applicant Response

See attached CON Table Package, Table A.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size:

Applicant Response

The project will affect a total of 15,329 gross departmental square feet. See attached CON Application Table Package, Table B, for additional information. See also **Exhibit 4** for a floor plan of the proposed hospital.

B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES__X___ NO _____ (If NO, describe

below the current status and timetable for receiving necessary approvals.)

Applicant Response

Please see **Exhibit 6** for evidence of zoning approval for the facility.

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: _____
Please provide a copy of the deed.

(2) Options to purchase held by: _____
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: Hope Health Systems, Inc.
Please provide a copy of the land lease as an attachment. Please refer to **Exhibit 3**.

(4) Option to lease held by: _____
Please provide a copy of the option to lease as an attachment.

(5) Other: _____
Explain and provide legal documents as an attachment.

11. PROJECT SCHEDULE

In completing this section, please note applicable performance requirement time frames set forth at COMAR 10.24.01.12B & C. Ensure that the information presented in the following table reflects information presented in Application Item 7 (Project Description).

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date	2	months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	1	months
Completion of project from capital obligation or purchase order, as applicable	6	months
Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract		months
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.		months
Initiation of Construction within 4 months of the effective		months

date of the binding construction contract.		
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract		months
Fill out the following section for each phase. (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase		months
Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date		months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1		months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.		months
To Be Completed for each subsequent Phase of Construction		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase		months
Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase		months
Completion of each phase within 24 months of the effective date of binding construction contract for that phase		months

12. PROJECT DRAWINGS

A project involving new construction and/or renovations must include scalable schematic drawings of the facility at least a 1/16" scale. Drawings should be completely legible and include dates.

Project drawings must include the following before (existing) and after (proposed) components, as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, room sizes, number of beds, location of bathrooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space".

B. For a project involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. For a project involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after the proposed project.

D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

Applicant Response

The project drawings are attached as **Exhibit 4**.

13. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction Characteristics (Table C) and Onsite and Offsite Costs (Table D) worksheets in the CON Table Package.

Applicant Response

See attached CON Table Package, Tables C and D.

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project, and the steps necessary to obtain utilities. Please either provide documentation that adequate utilities are available or explain the plan(s) and anticipated timeframe(s) to obtain them.

Applicant Response

The present water, sewer, electrical power, emergency power, heating ventilation and air conditioning, fire suppression, detection and alarm, and electronic security systems (the utilities) that service the facility are adequate to serve the new hospital use of the space. Updates will be made to serve all the new rooms in keeping with state and federal guidelines.

PART II - PROJECT BUDGET

Complete the Project Budget (Table E) worksheet in the CON Table Package.

Note: Applicant must include a list of all assumptions and specify what is included in all costs, as well the source of cost estimates and the manner in which all cost estimates are derived.

Applicant Response

See attached CON Table Package, Table E.

The Applicant has provided two versions of Table E. The first version ""E. Project Budget (HHS)" is the required table for the Applicant's budget. The second version "E. Project Budget (HHP)" provides the budget for HHP's renovation of the space to be leased to HHS as finished hospital space. Although the Applicant is not responsible for the renovation costs, in light of the common control of HHS and HHP, the Applicant is providing a project budget for the renovation costs to be borne by HHP in the interest of transparency.

A summary of the assumptions/cost estimates is as follows:

- Table E, Project Budget for Hope Health Systems, Inc.
  - IT Equipment / Software
    - This line includes an estimate for the IT systems and software necessary for the operation of the proposed facility. HHS estimated the costs based on recent projects of a similar size and/or type, both in Maryland and other jurisdictions.
  - CON Application Assistance
    - This line items includes the estimated costs of the filing preparation costs incurred by HHS in developing the CON filing. This is based on costs incurred to date and estimated remaining expenses.
  - Working Capital Startup Costs
    - This line items includes the estimated operating costs for the proposed facility prior to the facility generating positive cash flow. The applicant estimated these costs based on monthly forecasting of pre-opening costs for personnel, supplies, and facility expenses necessary to prepare for opening and patient care services, along with the projected monthly costs prior to the facility generating positive cash flow during year 1 of operations. Cash flow projections excluded depreciation and considered accounts receivables delays. Revenue estimates accounted for delayed Medicare/Medicaid effective date for initial certification and contractual allowances.
  - Working capital loan
    - Please see the letter from MMG regarding a working capital credit line attached as **Exhibit 7**.
  - Annual Lease Costs
    - Please see the attached lease at **Exhibit 3** with the terms and conditions for the property lease costs.
- Table E, Project Budget for Hope Health Properties, LLC.
  - Building Renovations

        - The cost estimates were prepared by CostCon Construction Services and benchmarked to the Marshall Valuation Services by Treffer Appraisal Group. See **Exhibit 8**.
    - Architect/Engineering Fees
        - HDS Architecture and Design provided the cost estimate after preparing the Floor Plan and working with CostCon Construction Services to procure the cost estimates on the buildout. A description of HDS's experience is provided in **Exhibit 5**.
    - Contingency Allowances
        - The cost estimates were prepared by CostCon Construction Services and benchmarked to the Marshall Valuation Services by Treffer Appraisal Group. See **Exhibit 8**.
    - Mortgage
        - The project will be financed by HHP through a refinancing of an existing mortgage on the building.

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. List names and addresses of all owners and individuals responsible for the proposed project.

Applicant Response

Mr. Yinka Fadiora
Address: 26 Bellchase court, Pikesville, MD- 21208

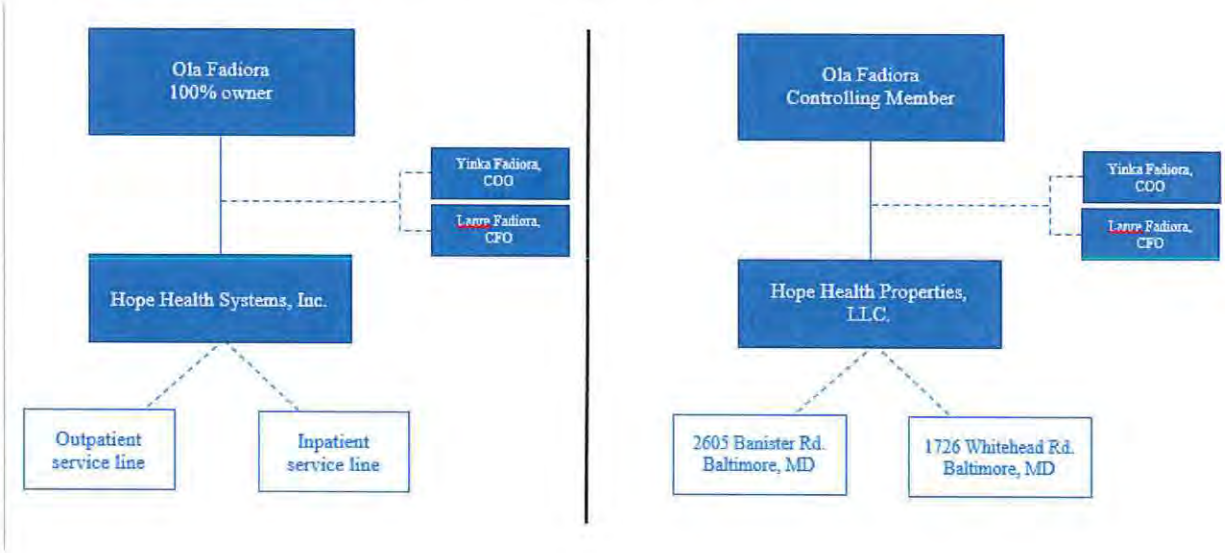
Mr. Oladipo Fadiora
Address: 8616 Glen Hannah, Windsor Mill, MD- 21244

Mr. Lanre Fadiora
Address: 4252 Pinefield, Baltimore, MD 21133

HHS will operate and be the licensee of the hospital. HHP owns the building where the proposed hospital will be located. HHS has entered into a lease for a portion of the HHP owned property located at 1726 Whitehead Rd. Baltimore, MD to operate HHPH. See **Exhibit 3**.

HHP and HHS share common ownership and management. The sole shareholder, board chair and president of HHS and the controlling member of HHP is Ola Fadiora. Yinka Fadiora, serves as the chief operating officer/general manager of HHS and HHP and is responsible for day-to-day management of both. Lanre Fadiora, is an accountant and serves as the chief financial officer of both HHS and HHP.

Please see the organizational chart below. Please refer to **Exhibit 9** for additional information regarding the owner and leadership team of the Applicant.



2. Is any applicant, owner, or responsible person listed above now involved, or has any such person ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each such facility, including facility name, address, the relationship(s), and dates of involvement.

Applicant Response

The following are the locations of the existing outpatient programs operated by HHS which are not "health care facilities" as defined by the MHCC, but provided for informational purposes.

1. Woodlawn, MD
6707 Whitestone Rd
Suite 106
Baltimore, MD 21207
Phone 1: 410.944.HOPE
Phone 2: 410.265.8737
Fax: 410.265.1258
Email: info@hopehealthsystems.com
Programs include: Outpatient mental health clinic, Behavioral health coordination, Expanded School based Mental health, Mobile Treatment Services Unit, Health homes, Psychiatric Rehabilitation Program (PRP), Correctional and aftercare mental health services, Case management, Adult services, Intensive outpatient program, Partial hospitalization Programs, Substance abuse Treatment and consulting services.

2. Greenspring, MD
2605 Banister Rd
Baltimore, MD 21215
Phone: 410.878.0236
Fax: 410.567.0399
Programs include: Outpatient mental health clinic, Behavioral health coordination, Expanded School based Mental health, Mobile Treatment Services Unit, Health homes, Psychiatric Rehabilitation Program (PRP), Correctional and aftercare mental health services, Case management, Adult services, Intensive outpatient program, Partial hospitalization Programs, Substance abuse Treatment and consulting services.

3. Carroll County No PHP AND IOP
6210 Georgetown Blvd
Suites A, B & C
Eldersburg, MD 21784
Phone: 410.216.5500
Fax: 410.567.0401
Programs include: Outpatient mental health clinic, Behavioral health coordination, Expanded School based Mental health, Mobile Treatment Services Unit, Health homes, Psychiatric Rehabilitation Program (PRP), Correctional and aftercare mental health services, Case management, Adult services, Substance abuse Treatment and consulting services.

4. Prince George's County, 7300 Van Dusen Road, Laurel Md, 20707; (410) 265-8737, ext. 500. HHS has been providing behavioral health services including outpatient services, partial hospitalization services, psychiatric evaluations and follow ups, family therapy, individual therapy as well as tele-psychiatric services at the Laurel Medical center location since 2021. HHS' office was located next to the emergency department of Laurel Medical Center and is currently in the process of being relocated to the new building.

3. In the last 5 years, has the Maryland license or certification of the applicant facility, or the license or certification from any state or the District of Columbia of any of the facilities listed in response to Question 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions)? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant(s), owners, or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

No.

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

No.

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

No.

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

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

Date

Signature of Owner or Board-designated Official

Owner and CEO
Position/Title

Oladipo Fadiora
Printed Name

PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.
An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.
If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

10.24.01.08G(3)(a). The State Health Plan.
To respond adequately to this criterion, the applicant must address each applicable standard from each chapter of the State Health Plan that governs the services being proposed or affected, and provide a direct, concise response explaining the project's consistency with each standard. In cases where demonstrating compliance with a standard requires the provision of specific documentation, documentation must be included as a part of the application.

Every acute care hospital applicant must address the standards in **COMAR 10.24.10: Acute Care Hospital Services**. A Microsoft Word version is available for the applicant's convenience on the Commission's website. Use of the *CON Project Review Checklist for Acute Care Hospitals General Standards* is encouraged. This document can be provided by staff.

Other State Health Plan chapters that may apply to a project proposed by an acute care hospital are listed in the table below. A pre-application conference will be scheduled by Commission Staff to cover this and other topics. It is highly advisable to discuss with Staff which State Health Plan chapters and standards will apply to a proposed project before application submission. Applicants are encouraged to contact Staff with any questions regarding an application.

Applicant Response
The State Health Plan for Facilities and Services: Acute Psychiatric Services Chapter states (COMAR 10.24.21.05(A)) that:

> *An applicant for a Certificate of Need to establish acute psychiatric services shall address and meet the applicable general standards in COMAR 10.24.10.04A, in addition to the applicable standards in this Chapter.*

COMAR 10.24.10,04A Acute Care – General Standards

(1) Information Regarding Charges.
Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

a) **Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;**
b) **Procedures for promptly responding to individual requests for current charges for specific services/procedures; and**
c) **Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.**

Applicant Response

HHS will make information regarding its hospital charges available to the public. Please refer to **Exhibit 10** for HHS's written policy in accordance with this standard.

(2) 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.**
   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;**
      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; and**
      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.**
b) **A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.**

Applicant Response

HHS will have a written charity care policy for indigent patients to ensure access to services regardless of an individual's ability to pay. Please refer to **Exhibit 10** for HHS's written policy in accordance with this standard. Paragraph (b) of this standard does not apply because HHS is not an existing hospital.

(3) Quality of Care.
An acute care hospital shall provide high quality care.

a) **Each hospital shall document that it is:**

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;
(ii) Accredited by the Joint Commission; and
(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

Applicant Response

HHPH will be licensed by the Maryland Department of Health, accredited by the Joint Commission, and operate in compliance with the conditions of participation for Medicare and Medicaid programs. HHS currently holds all required licenses and approvals to operate its existing outpatient programs, and is accredited for those programs by the Joint Commission and CARF. Please see **Exhibit 12** for copies of the current Joint Commission and CARF accreditations for the Applicant's outpatient services.

COMAR 10.24.21 – Psychiatric Services – Standards

10.24.21.05(B) Project Review Standards
(1) Geographic Accessibility
A site proposed for a new psychiatric hospital or relocation of a psychiatric hospital shall optimize accessibility through minimizing travel time for the likely population to be served.

(a) Optimal travel time for adult acute psychiatric services is within 30 minutes under normal driving conditions. The geographic accessibility standard is met if 90 percent of the population in the health planning region where the facility is located or will be located, has or will have as a result of the proposed project, optimal travel time to acute psychiatric services or if the Commission determines that access will be substantially improved for the population I the applicant's likely service area through a reduction in travel time.

(b) Optimal travel time for adolescent and child acute psychiatric services is within 45 minutes under normal driving conditions. The geographic accessibility standard is met if 90 percent of the population in the health planning region where the facility is located, or will be located, has or will have as a result of the proposed project, optimal travel time to acute psychiatric services or if the Commission determines that access will be substantially improved for the population in the applicant's likely service area through a reduction in travel time.

Applicant Response

Paragraph (a) of this standard is not applicable because HHPH will serve only children and adolescents.

The location of the project in southwest Baltimore County, and adjacent to Baltimore City's western boundary, has an estimated population of more than eight-hundred thousand children and adolescents aged 17 and under within a 45-minute drive time radius, though this radius includes residents in Washington District of Columbia and Pennsylvania, our analysis will focus

on Maryland residents. This area spans 172 populated zip codes and 9 counties in Maryland.

Figure 2 - 30- & 45-Minute Drive Time Map

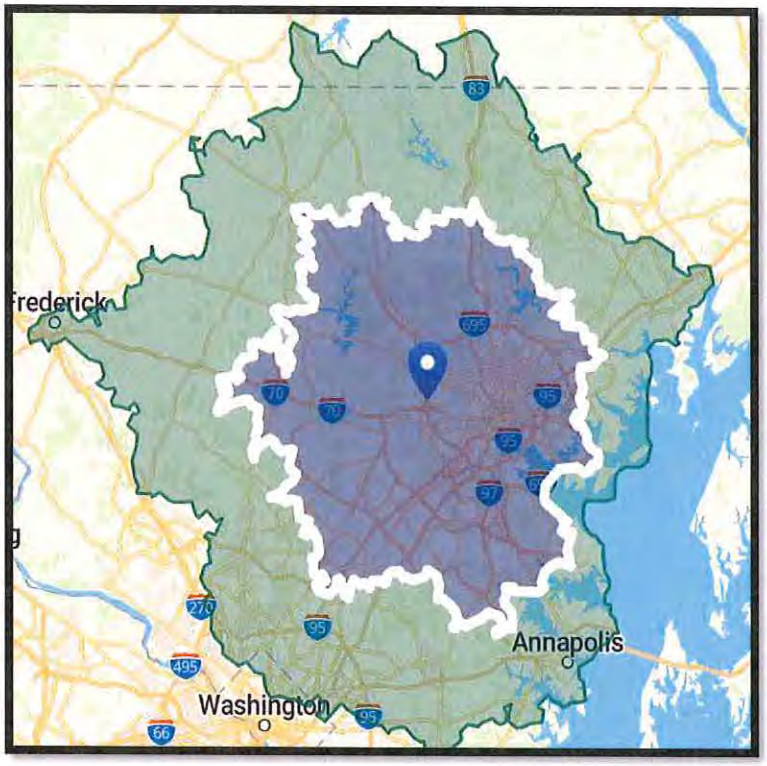


Table 1

	Population <18	# of Zips
Primary Service Area (30-min drive time)	454,246	81
Secondary Service Area (45-min drive time)	370,314	91
Total	**824,560**	**172**

Drive Time Source: https://www.smappen.com/app/

Population Source: 2020 American Community Survey

Six of the nine counties within the optimal drive time radius are indicated in the Baltimore Upper Shore health planning region. This region has a child and adolescent population of 659,815[5] and more than 93% of this population resides within the 45-minute drive time radius, exceeding the standard. Approximately 50% of the residents with the 45-minute radius, live in Baltimore City or Baltimore County.

5 https://www2.census.gov/programs-surveys/popest/datasets/2020-2021/counties/asrh/

Table 2

Baltimore Upper Shore Planning Region; Under 18 Population	
Maryland County	**2020 Pop. Est.**
Anne Arundel County	132,327
Baltimore City	118,698
Baltimore County	187,211
Carroll County	37,894
Cecil County	23,364
Harford County	58,565
Howard County	81,209
Kent County	2,969
Queen Anne's County	10,722
Talbot County	6,856
Total	**659,815**

Baltimore Upper Shore Planning Region Pop. 2020	Planning Region Pop. within Optimal Travel Time 2020	% of Total Population
659,815	615,904	93.34%

(2) Need for Acute Psychiatric Services.

(a) The Commission shall publish, at least every two years, regional projections for adults, children, adolescents, and the geriatric population using the methodology in Regulation .06 of this Chapter.
(b) The Commission shall publish at least every two years a needs determination for historically underserved populations for acute psychiatric services by region.
(i) The needs determination for historically underserved populations will be developed based on consideration of factors that include trends in acute psychiatric discharges, trends in hospital emergency department boarding, and needs assessments developed by local behavioral health authorities and State agencies that identify gaps in the mental health system.
(ii) Commission staff shall publish on its website a draft needs determination for historically underserved populations that includes the sources and assumptions used to develop the determination and request public comment regarding the draft determination. Staff shall also send the notice to each acute general hospital and special psychiatric hospital in Maryland. The Commission shall consider the comments and Commission's staff's recommendations at a public meeting before establishing a needs determination for historically underserved populations that shall apply to a Certificate of Need review and to a request for exemption from Certificate of Need review for a project that involves acute psychiatric services.
(c) The Commission shall use the regional acute psychiatric hospital utilization projections and the needs determination for historically underserved populations to evaluate the need for a proposed new psychiatric hospital, the proposed introduction of

psychiatric services by a general hospital, the relocation of a special psychiatric hospital or a general hospital providing psychiatric inpatient services, and other projects that involve acute psychiatric services. An applicant shall address the need for its proposed project within the context of the regional acute psychiatric hospital utilization projections and the needs determination for historically underserved populations in effect when a Certificate of Need application or request for an exemption from Certificate of Need review is filed and shall explain the basis for any inconsistency between the needs determination for historically underserved populations and the bed capacity and patient populations it proposes to serve.

(i) When the needs determination for historically underserved populations indicates a level of regional utilization for a patient population with specialized needs that is sufficient to support four or more beds for one or more historically underserved populations, an applicant shall address how its proposed project will meet the needs of at least one of the historically underserved patient populations; or

(ii) If the applicant does not currently serve or propose to serve any of the historically underserved populations in need, as identified in the needs determination for historically underserved populations, the applicant shall demonstrate that developing bed capacity or programming to serve any of these patient populations would jeopardize the financial viability of the hospital or would jeopardize the ability of the hospital to meet the needs of the broader patient population it serves, or that the Commission, after considering evidence provided by the applicant, finds that the applicant will be unable to effectively meet the needs of any of the historically underserved populations.

Applicant Response

The Commission has not published the regional utilization projections or needs determination for historically underserved populations under subsections (a), (b) and (c) of this Standard at this time. Accordingly, HHS demonstrates the need for this project in accordance with subsection (d) of this Standard below.

(d) In addition to addressing the current needs determination for historically underserved populations, an applicant shall demonstrate in a service-area level needs assessment that the acute psychiatric hospital bed capacity proposed is needed. The applicant's service-area level needs assessment shall include a forecast of demand for acute psychiatric hospital beds by the population in its projected service area and a zip-code area level analysis of the market share that the applicant expects to capture within the projected service area. The applicant shall demonstrate the reasonableness of its assumptions in:

(i) Defining the service area of the proposed project;
(ii) Projecting acute psychiatric discharge rates for its service area population;
(iii) Projecting the market share of applicable acute psychiatric discharges within the project's service area; and
(iv) Projecting the average length of stay in proposed psychiatric beds.

Applicant Response

Research has shown that half of all lifetime cases of mental illness begin by age 18, with the peak year of onset between the ages of 14 and 15 years old[6]. Further, the benefits are of intervention maximal when young people are targeted at around the time of onset of mental disorders.

HHPH will be a vital lifeline to expand access for children and adolescents in need of inpatient psychiatric care, while connecting them and discharging them to intensive and supportive wraparound services. The inpatient facility will integrate community health providers and ensure smooth transitions, appropriate placements, and a reduction in acute care readmissions. The goal is to heal those suffering from mental health disorders and provide the support necessary so they can continue to lead productive lives.

The project will address the mental health needs of the children and adolescent patient population by expanding regional capacity and increasing access to appropriate psychiatric inpatient services. Specifically, the project is to establish a 16-bed inpatient psychiatric facility to increase the availability of beds for children (ages 0-12) and adolescents (ages 13-17). Higher level or acute psychiatric care for youth is intended to be short-term with treatment focusing on crisis stabilization, assessment, safety monitoring, and longer-term treatment planning.

The need analysis below considers the population, historical use rates, future trends, and incorporates unmet needs to quantify the need for HHPH. HHS considered both the defined primary service area and state-wide needs given the limited options available to these patient populations in need of acute psychiatric services.

To quantify the need for this project, HHS examined the methodology in the State Health Plan, HSCRC data on utilization, research regarding inpatient bed need for children and adolescent psychiatric patients, and feedback from experts and the community to understand the need for the project.

Based on these factors, and as described in more detail below, the service area defined by HHS has an identifiable need for additional inpatient psychiatric bed capacity for children and adolescents. Further, the project is responsive to the overall coordinated and comprehensive care plan for Maryland's response to the mental health crisis.

HHS has organized its response to this Standard as follows:

I. **Service Area Definition**
II. **Population Estimates**
III. **Projected Psychiatric Discharge Rates & Historical Analysis**
IV. **Bed Shortages Based on Expert's Bed per Population Standards**
V. **Need Based on Historical Bed Occupancy Rates**
VI. **Need Based on Discharge Delays & ED Boarding**
VII. **Access for Low Income Children/Adolescents**
VIII. **Additional Factors Indicative of Growing / Unmet Need**
IX. **Cumulative Project Need / Discharge Assumptions**

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[6] Solmi, M., Radua, J., Olivola, M. *et al.* Age at onset of mental disorders worldwide: large-scale meta-analysis of 192 epidemiological studies. *Mol Psychiatry* **27**, 281–295 (2022). https://doi.org/10.1038/s41380-021-01161-7

I. Service Area Definition

HHS's primary service area for HHPH is within the Baltimore Upper Shore Planning region and includes Anne Arundel, Baltimore City, Baltimore County, Carroll, Hartford, and Howard. As outlined below, HHS identifies a need for beds across the State of Maryland, but also a concentration of population and need in the Baltimore Upper Shore Planning Region focused around the Baltimore metropolitan area. HHS expects to draw patients from across the State given the limited access option for children and adolescents. For example, the applicant is aware of children and adolescents with delays waiting for inpatient services in surrounding areas such as Prince George's and Montgomery Counties that may seek services at the proposed facility. Please see **Exhibit 14** for a list of zip codes included within the service area.

Figure 3
Map of Proposed Service Area

II. Population Estimates

The estimated patient population of Baltimore County and Baltimore City are expected to experience some growth through 2027, based upon the state of Maryland population estimates published by the Maryland Department of Planning[7] and US Census Bureau[8] growth trends.

To estimate the patient population, HHS reviewed the Maryland Department of Planning's estimated trends for population between 2020 -2030, and amended the data to reflect 2021 – 2027, which mirror the tables and analysis provided in Exhibit 1. HHS identified that the change in estimated population was in keeping with the Census Bureau trends in population, and therefore utilized the state-based data projections.

However, since the state-based data project age categories did not align with the child and adolescent patient population age ranges, HHS assumed the ages were equally distributed throughout each age range. The state age ranges were 0-4, 5-9, 10-14, 15-19. HHS removed 40% of the 15-19 total to reflect the adolescent cut off at age 17. HHS also shifted 60% of the 10-

[7] https://planning.maryland.gov/MSDC/Pages/s3_projection.aspx
[8] https://data.census.gov/cedsci/

14 age range to the children analysis to reflect the state child age range of 0-12[9]. The total for each column reflects this analysis.

The patient population was then equally distributed on a year over year basis to equal the estimated population changes indicated in the state data. The following tables summarize the anticipated patient population for the service area over the next five years.

Table 3

State of Maryland Population 2021-2027				
Year	Total (Ages 0-12)	Percent Change	Total (Ages 13-17)	Percent Change
Total 2021	969,571		393,733	
Total 2022	974,944		393,993	
Total 2023	980,316		394,250	
Total 2024	985,691		394,508	
Total 2025	991,065		394,766	
Total 2026	996,440		395,022	
Total 2027	1,001,816	3.33%	395,278	0.39%

Table 4

Maryland Baltimore Upper Shore Planning Region Children (Ages 0-12) Population 2021-2027			
County	**Year**	**Total (Ages 0-12)**	**Percent Change**
Anne Arundel Co.	2021	94,991	
Anne Arundel Co.	2027	96,320	1.40%
Baltimore Co.	2021	131,163	
Baltimore Co.	2027	129,458	-1.30%
Carroll Co.	2021	26,158	
Carroll Co.	2027	27,309	4.40%
Harford	2021	41,414	
Harford	2027	43,692	5.50%
Howard	2021	57,414	
Howard	2027	60,227	4.90%
Baltimore City	2021	84,051	
Baltimore City	2027	83,714	-0.40%
Total All 2021		**435,190**	
Total All 2027		**440,721**	**1.27%**

[9] HHS notes that the 40%/60% assumptions led to results in line with the State-wide population figures reported by age from the US Census for 2019.

Table 5

Maryland Baltimore Upper Shore Planning Region Adolescents (Ages 13-17) Population 2021-2027			
County	**Year**	**Total (Ages 13-17)**	**Percent Change**
Anne Arundel Co.	2021	36,566	
Anne Arundel Co.	2027	36,932	1%
Baltimore Co.	2021	54,291	
Baltimore Co.	2027	54,834	1%
Carroll Co.	2021	11,857	
Carroll Co.	2027	10,671	-10%
Harford	2021	17,182	
Harford	2027	16,323	-5%
Howard	2021	23,061	
Howard	2027	23,753	3%
Baltimore City	2021	32,979	
Baltimore City	2027	32,650	-1%
Total All 2021		**175,937**	
Total All 2027		**175,163**	**-0.44%**

Please see **Exhibit 14** for a list of population by zip codes included within the service area.

III. Projected Psychiatric Discharge Rates & Historical Analysis

In assessing the historical discharge rates and projecting its discharge rates, HHS built upon its research and data from its prior CON filing initially submitted at the end of CY 2020. This included reviewing the prior data collected and discussing with HSCRC the options/suitability of utilizing updated data from the intervening years.10 However, given the COVID-19 pandemic's impact during the CY 2020-CY 2022 timeline, the HSCRC related its concerns about the reliability and forecasting use of this data, including anticipated issues with small cell size limitations (whereby HSCRC must mask data).

Given this feedback, HHS collected data for the entire <18 age group (vs. adolescent and children separately) to ensure larger groupings, and focused the data on the primary service area to analyze total inpatient admissions, emergency department visits, observation stays, and admission sources to estimate the projected admissions, market shifts, and service area volume from CY 2019 – CY 2022.[11]

In addition to this recent analysis, the prior research through CY 2019 is included below to document the need present within the market outside of the COVID-19 pandemic period. HHS notes that recent signs of returning volumes to pre-COVID levels is also documented within the

[10] HHS retained the services of the Durant Bailey Group (DBG), which assisted in the gathering/analysis/presentation of the HSCRC data.
[11] CY 2022 was annualized based on data through September 2022.

most recent HSCRC Experience Reports, as discussed below and reflected in Table 9 and Table 15 below.

Analysis of HSCRC Data

Based upon an updated set of HSCRC data for the under 18 aged population, HHS estimated the following utilization and calculated use rates based upon census population counts from FY 2019 through an annualized CY 2022. Please note the annualized CY 2022 estimates (data through September 2022) are likely depressed from experience, as the October-December period typically experiences increased children and adolescent admissions (as seen in the HSCRC experience reports for Sheppard Pratt and Brook Lane for the PCD cost center volume).

Table 6

Acute Psychiatric Utilization (<18 Years Old)[12] Baltimore Upper Shore Planning Region				
	CY 2019	**CY 2020**	**CY 2021**	**CY 2022***
IP (ADM visits)	4,053	3,391	3,425	3,733
ED (EMG visits)	22,889	14,751	15,549	17,547
OBS (OBV visits)	634	636	809	729

Table 7

Population[13] Baltimore Upper Shore Planning Region				
	CY 2019	**CY 2020**	**CY 2021**	**CY 2022***
Pop <18 (Baltimore Upper Shore Population)	601,688	606,371	611,127	615,883

Table 8

Use Rates per 100,000 Baltimore Upper Shore Planning Region				
	CY 2019	**CY 2020**	**CY 2021**	**CY 2022***
IP	674	559	560	606
ED	3,804	2,433	2,544	2,849
OBS	105	105	132	118

[12] Data from HSCRC through September 2022; Patient origin = 45 min dive time zip codes; Principal and Secondary codes = F01-F099.

[13] 2019, 2020 and 2021 figures calculated using 2020 estimate as base period and using 2021-2027 annual growth rate. https://www2.census.gov/programs-surveys/popest/datasets/2020-2021/counties/asrh/

As seen above, the use rates within the under 18 population dropped precipitously during the COVID-19 pandemic within the inpatient and emergency department populations in CY 2020, but have steadily grown back towards pre-pandemic rates in CY 2022. Although the HSCRC data was only available through September 2022, the HSCRC experience report data for the PCD cost center for Sheppard Pratt and Brook Lane document a continued rebound and expansion in <18 inpatient volume to end CY 2022.

Table 9
HSCRC Experience Report FY 2023[14]

Hospital Name	REPORT_DATE	CODE	VOL_IN
Sheppard Pratt	7/1/2022	PCD	2358
Sheppard Pratt	8/1/2022	PCD	2335
Sheppard Pratt	9/1/2022	PCD	2615
Sheppard Pratt	10/1/2022	PCD	3068
Sheppard Pratt	11/1/2022	PCD	3031
Sheppard Pratt	12/1/2022	PCD	3034
Brook Lane	7/1/2022	PCD	630
Brook Lane	8/1/2022	PCD	605
Brook Lane	9/1/2022	PCD	786
Brook Lane	10/1/2022	PCD	1047
Brook Lane	11/1/2022	PCD	1003

Despite the pandemic period drop in inpatient and emergency department volumes, observation rates and time spent in observation status per patient in fact increased during the pandemic period. Factors may vary for these experiences and research is not definitive, with influences including pandemic period staffing challenges, lockdown effects, school closures, and the pandemic's impact on mental health. The following chart further breaks downs the CY 2019 – CY 2022 (annualized) period from the HSCRC data to document the year over year changes and growth in observation rates.

[14] https://hscrc.maryland.gov/Pages/hsp_Data2.aspx

Table 10

Service Area Volume	CY2019	CY2020	CY2021	CY2022*
Inpatient Admissions (Psych age <18)	4,053	3,391	3,425	3,733
% YOY change		*-16.3%*	*1.0%*	*9.0%*
Emergency Department Visits (Psych age <18)	22,889	14,751	15,549	17,547
% YOY change		*-35.6%*	*5.4%*	*12.8%*
% of IP Admissions from the ED	*55.07%*	*53.11%*	*57.64%*	*57.18%*
Observation Stays	634	636	809	729
Avg # of Hours in Observation per Patient	*24.98*	*33.82*	*33.87*	*47.09*
% of Patients Admitted from Observation	*39.75%*	*42.30%*	*49.69%*	*56.49%*
Observation Stays > Than 24 Hours	211	227	351	307
% of total observation stays	*33.28%*	*35.69%*	*43.39%*	*42.05%*

Given the clear pandemic specific impacts on the HSCRC data from CY 2020 – CY 2022, HHS also includes an analysis of the historical discharge factors from the pre-pandemic data.

Pre-Pandemic Data Analysis

HHS first references the reported per-population discharge rates for the applicable age groups from an MHCC's pre-pandemic publication. The following table from the Maryland Health Care Commission's "White Paper: Maryland Acute Psychiatric Hospital Services". April 2019 showcases the use rates per 100,000 in population from 2008-2017. The MHCC analysis documented a rise in use rates from 2008 to 2017, with a sharp increase in the adolescent population.

Table 11
Psychiatric Discharge Rates per 100,000 Population, CY 2008-CY 2017[15]

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Use Rate Change
Child (0-12)	179	189	204	209	217	201	192	170	175	183	2.30%
Adolescent (13-17)	1,008	1,199	1,190	1,291	1,294	1,328	1,329	1,318	1,273	1,273	26.40%
Adult (>18)	853	896	896	905	887	869	850	804	802	772	-9.60%
All Ages	752	799	801	816	804	790	775	734	731	709	-5.60%

[15] Maryland Health Care Commission: "White Paper: Maryland Acute Psychiatric Hospital Services". April 2019

In addition, HHS obtained separate data from HSCRC for CY 2017-2019, which documented the following acute psychiatric discharges rates for the children and adolescent populations.

Table 12
Psychiatric Discharge Rates per 100,000 Population, CY 2017-CY 2019

	2017	2018	2019
Child (0-12)	200	198	188
Adolescent (13-17)	1,319	1,280	1,133

HHS used the CY 2019 pre-pandemic data to produce a basic analysis for forecasting bed need within the patient population.

Based on the HSCRC data, HHS has outlined the following bed need/demand analysis. HHS focused on state-wide figures as the concentration of beds in the Baltimore Upper Shore planning region distorts a purely regional analysis (for example Sheppard Pratt beds located in the Baltimore Upper Shore Region are often filled with patients from other planning regions).

Table 13
State of Maryland Bed Demand / Need Calculation

Children	Ages (0-12)	Adolescent	(Ages 13-17)
Population in 2023[1]	980,216	Population	394,250
Projected Discharges (188 per 100,000)[2]	1,842.8	Projected Discharges (1,133 per 100,000)	4,466.9
Projected Patient Days (10.5 ALOS)[3]	19,349.5	Projected Patient Days (11.4 ALOS)	50,922.12
Bed Demand at 100% Occupancy	53.01	Bed Demand at 100% Occupancy	139.51
Bed Demand at 80% Occupancy	66.27	Bed Demand at 80% Occupancy	174.39
Bed Demand at 70% Occupancy	75.73	Bed Demand at 70% Occupancy	199.30
Staff Beds per MHCC[4]	71	Staff Beds per MHCC	150
Bed Need @ 70% Occupancy	**4.73**	Bed Need @ 70% Occupancy	**49.3**
Staff Beds per MHCC[4] (Single Occupancy)	63	Staff Beds per MHCC (Single Occupancy)	95
Bed Need @ 70% Occupancy	**12.73**	Bed Need @ 70% Occupancy	**104.3**

1: Population based on estimates from Section (II) in this response.
2: Discharge Rate based on 2019 discharge rates reported for age group from HSCRC data
3: ALOS based on CY 2019 ALOS reported for age group from HSCRC data
4. Staffed bed totals based on MHCC Psychiatric Services work group survey & "single occupancy" equates to all private rooms. There is no more recent public reporting on staffed beds.

The State-wide assessment at pre-pandemic CY 2019 rates documents the need for additional inpatient psychiatric beds. The above table displays bed need at an occupancy level of 70%, the level considered by the MHCC Staff and Psychiatric Services Work Group to be the level at which the state should consider evaluation of additional beds for facilities under 20 beds to further increase access points, or 80% for facilities with >39 beds.

The 70% occupancy rate for target bed counts is supported by research discussed under "Bed Occupancy Rates" section below. As further outlined below, HHS in fact expects a higher need and occupancy rate for HHPH, as unmet need is evident in the planning region and likely not identifiable solely by looking at historical use rates.

While a formulaic approach may not be a definitive analysis of bed need, the results of the analysis do lend further credence to the conclusion that the state requires additional bed capacity, particularly for adolescents, capacity that HHPH would provide.

IV. Bed Shortages Based on Expert's Bed per Population Standards

One metric for determining bed need is the consensus from experts within the field on how many beds are required to service a given population. The Treatment Advocacy Center (TAC) has been the most-cited source of a per-population bed need assessment in recent decades. Although not focused on child and adolescent age groups, their research in 2008 and 2016 has reported an estimate of 40-60 inpatient beds per 100,000 in population, with a consensus of about 50 beds per 100,000 for inpatient psychiatric care. For comparison, the ratio in England in 2008 was 63.2 beds per 100,000.

While the population grew and awareness of mental health increased in America over the last decades, there was a concurrent long-term trend of inpatient psychiatric bed reductions. In fact, ninety-five percent of public psychiatry beds available in 1955 were no longer available as of 2005. Maryland's state beds decreased from 4,390 in 1982 to 950 in 2016. In Maryland today there is only one state run inpatient mental health unit that serves adolescents, and there are no inpatient beds for children. As reported by the Maryland Hospital Association[16], the closing of state-operated psychiatric beds has not been offset by greater access to community-based services.

As reported by the MHCC in 2019, Maryland ranks near the average of States in inpatient psychiatric bed counts, with a reported 34.3 beds per 100,000 in population[17]. This places Maryland at 26th of 52 reporting States. MHCC's Psychiatric Services Work Group published a preliminary analysis of psychiatric bed counts by age group as part of its March 17, 2020 meeting materials. This is the most specific breakdown of staffed beds by age group currently available publicly.

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[16] https://www.mhaonline.org/docs/default-source/publications/roadmap-to-an-essential-comprehensive-system-of-behavioral-health-care-for-maryland.pdf?sfvrsn=f7c0da0d_4

[17] Maryland Health Care Commission: "White Paper: Maryland Acute Psychiatric Hospital Services". April 2019

Per "Agenda Item 3 (Part 1) – Current Health Planning regions for Acute Psychiatric Services in Hospital", the following were estimates on the current bed counts[18]. HHS added in population estimates from the US Census to calculate beds per 100,000 in population.

Table 14
Bed Estimates Per 100,000 in Population

	Population*	Staffed Bed Count	Bed Per 100,000 in Population	Staffed Bed Count at "Single Occupancy"**	Beds Per 100,000
Maryland (Age 13-17)	393,733	150	38.10	95	24.12
Maryland (Age 0-12)	969,571	71	7.32	63	6.50

*Per US Census for 2021
**Staffed beds identified by MHCC as "Semi-Private" were reduced to single occupancy to provide additional context on available beds. "Semi-Private" rooms often only bed (1) psychiatric patient.

As seen in the above table, the availability of beds for children is far below the 40-60 bed estimates reported by TAC. Likewise, the bed availability for adolescents is near or below the TAC figures. This is especially true when treating semi-private rooms with 2 or more beds as a single bed, which is an important consideration because semi-private rooms often function as private rooms due to a variety of patient safety and staffing challenges that prevent patients from sharing a semi-private room.

The new unit serving adolescents at Sheppard Pratt's Towson campus converted some of the semi-private rooms to private, and UMMC opened a new 16-bed psychiatric unit for children and adolescents that included 8 newly licensed adolescent beds after the Work Group data was published. However, these additions have not closed the gap compared to the TAC standards.

V. Need Based on Historical Bed Occupancy Rates

HHS also analyzed the occupancy rates at Sheppard Pratt and Brook Lane, the two largest psychiatric hospitals in the State of Maryland serving children and adolescents, which also have publicly reported figures for their beds dedicated to under age 18 patients. HHS notes occupancy rates at the age group level are notoriously difficult to track, as some facilities flex their staffed beds and beds dedicated to certain age groups as demand dictates. However, the data does help to demonstrate the need for additional private psychiatric bed capacity to service this patient population.

For the most age-specific analysis from public data, HHS reviewed the HSCRC financial data reports for psychiatric specialty hospitals in Maryland. Included in these reports are volume figures and bed count for the "PCD PSYCHIATRIC - CHILD/ADOLESCENT" rate center. Included in this rate center are all patient days for care provided to patients under the age of 18. The same reports for general acute care providers do not provide the same age-specific breakdowns for psychiatric care by cost center.

[18] https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/Psych%20work%20group/Agenda%20Item%203_part1.docx.pdf

Table 15
Bed Occupancy Rates FY2019 - FY2023*

Provider	Time Period	Total Patient Days	Total Patient Admissions	ALOS	Bed Count	Occupancy Rate
Sheppard Pratt	FY 2023*	32,882	2,424	13.56	96	93.84%
	FY 2022	31,442	2,247	13.99	96	89.73%
	FY 2021	27,968	1,956	14.30	96	79.82%
	FY 2020	30,090	2,204	13.65	96	85.87%
	FY 2019	31,871	2,480	12.85	96	90.96%
Brook Lane	FY 2023*	9,770	907	10.77	28	95.60%
	FY 2022	9,682	870	11.12	28	94.73%
	FY 2021	10,120	931	10.87	28	99.02%
	FY 2020	8,978	837	10.73	28	87.85%
	FY 2019	10,142	1,041	9.7	28	99.24%

*Annualized from the available FY 2023 Final Experience Report Data as of February 08, 2023.

As seen above, both Brook Lane and Sheppard Pratt show occupancy rates between ~80% and 99.24% from FY 2019 through the first half of FY 2023. The data documents the dip in inpatient volume due to the COVID-19 pandemic, as well as the recent and ongoing rebound to pre-COVID levels.

The State Health plan sets a minimum average occupancy rate by facility bed size as follows:

Table 16

Bed Capacity Minimum Average Annual Psychiatric Bed Occupancy Rate

Less than 20 beds	70%
Between 20 and 39 beds	75%
Over 39 beds	80%

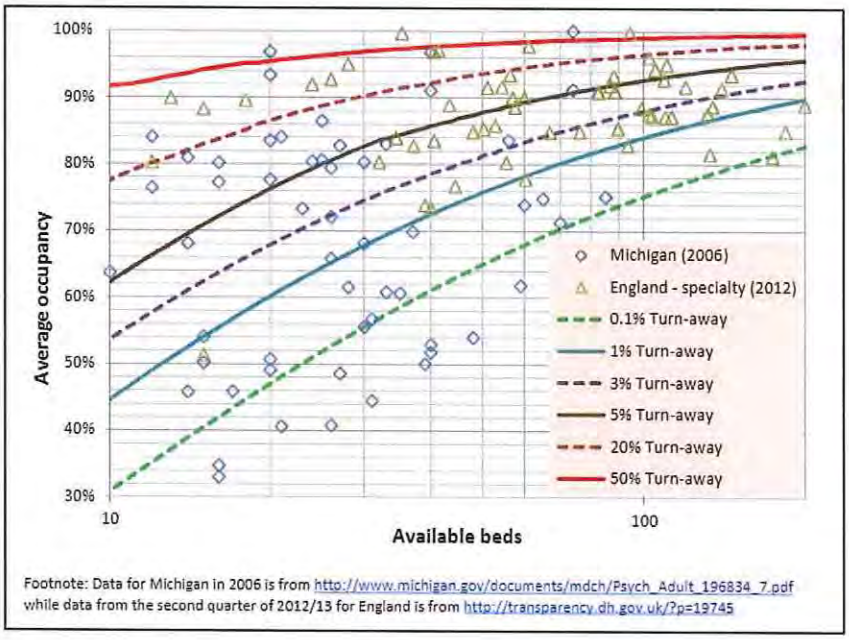
These standards for minimum occupancy are lower than the levels under the prior State Health Plan chapter. The Acute Psychiatric Services Workgroup charged with updating the standards remarked during its work that under the prior standards:

> The threshold standard for a facility with 40 beds is an occupancy rate of at least 90%. For a facility with between 20 and 39 beds, the threshold occupancy rate is 85%. For a

facility with less than 20 psychiatric beds, the threshold occupancy rate is 80%. MHCC staff considers these occupancy thresholds too high.[19]

By lowering the minimum occupancy levels, the current State Health Plan recognized this concern, which is also supported by research. For example, a 2013 statistical study identified increasing rates of patient turn-away when bed occupancy increases[20]. Turn-away is the percentage of time that a bed will be unavailable for the next arriving patient who must either wait for admission or go elsewhere (if immediate admission is a priority). Occupancy rates above 90% can cause around a 50% rate of patient turn-away, as seen in the following figure:

Figure 4
Average Occupancy Rates & Patient Turn-Away



Footnote: Data for Michigan in 2006 is from http://www.michigan.gov/documents/mdch/Psych_Adult_196834_7.pdf while data from the second quarter of 2012/13 for England is from http://transparency.dh.gov.uk/?p=19745

After the COVID-related dip in volume, Sheppard Pratt and Brook Lane are both operating at a high average occupancy rate for patients under 18 years of age. Using the projections from the above study, we can see that the two freestanding psychiatric facilities providing the majority of the inpatient psychiatric capacity for children and adolescents in Maryland may have to deny or delay an admission anywhere from 20% to 50% or more of the time as staffed bed availability and patient demand fluctuates.

As further stated in the same study:

> If immediate access is considered to be a desirable feature such as in [...] psychiatric care; then optimum occupancy could be said to lie somewhere near to the 0.1% turn-away line, which as [Figure 4 above] demonstrates, relies upon an average occupancy well below 85% in all but the very largest bed pools.

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[19] https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/Psych%20work%20group/Final%20MHCC%20psych%20workgroup%20June%202019%20meeting%20summary_20190617.pdf

[20] Jones, Rodney. (2013). Optimum bed occupancy in psychiatric hospitals.

> [...] A recent review of average occupancy in English and US acute hospitals has concluded that the 'optimum' whole hospital occupancy, i.e. across multiple constituent specialty bed pools, is around 72% for a 200 bed hospital, 78% for 500 and 83% at 1,000 beds.

Other experts agree, and recognize the challenges with operating at high capacity. As quoted by the Baltimore Sun in 2021 in discussing Maryland psychiatric bed occupancy, Elizabeth Sinclair Hanc, director of research for the Treatment Advocacy Center, stated that "It's hard to operate a facility at 99%" and she noted "Without enough beds and community supports, the incentive structure of society is shifting people towards the criminal justice system."[21]

Finally, HHS notes that based on its cost report and experience report data reported by HSCRC, Sheppard Pratt represents approximately 96 of the 158 staffed beds for children and adolescents in the Baltimore Upper Shore Region. With the majority of planning region beds above a 90% occupancy rate, the private psychiatric hospital bed availability is under enormous strain and there is insufficient capacity for additional patient demand. As further discussed below, this strain on access is showing up in observable patient outcomes in the region.

VI. Need Based on Discharge Delays & ED Boarding

Recent research has begun to focus on observable outcomes in patient populations as a key indicator of bed need shortages for inpatient psychiatric care[22]. The idea is that necessary levels of psychiatric beds can be connected to observable outcomes in the population. A key focus of this approach has been upon research showing that extended wait times in Emergency Departments by psychiatric patients (i.e. "ED Boarding") is a sign of inadequate inpatient psychiatric bed supply.

While there is no standard definition of psychiatric ED boarding, the American College of Emergency Physicians has defined it as the practice of holding patients in the emergency department after they have been evaluated due to a lack of inpatient beds or delays in transfer to another facility. These factors often result in lengthy wait times, increased suffering among patients and contributed to the strain hospital emergency departments are already experiencing. The Joint Commission recommends that boarding not exceed 4 hours. Since 2010 the number of psychiatric child and adolescent ER visits lasting longer than **24 hours** in Maryland has risen more than 600% and more than 300% respectively.[23]

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[21] https://www.baltimoresun.com/health/bs-md-psychiatric-bed-capacity-maryland-coronavirus-pandemic-20210610-dizdjld265d35ouvmu4ggoxdl4-story.html

[22] O'Reilly, R., Allison, S. & Bastiampiallai, T. Observed Outcomes: An Approach to Calculate the Optimum Number of Psychiatric Beds. *Adm Policy Ment Health* **46,** 507–517 (2019). https://doi.org/10.1007/s10488-018-00917-8

[23] https://www.marylandmatters.org/2019/12/28/youth-needing-psychiatric-care-find-long-waits-drives/

Table 17

	2010	2018	% Change
Child Psychiatric ED visit >24 hours	43	325	656%
Adolescent Psychiatric ED visit >24 hours	189	838	343%

Data obtained from the HSCRC shows that total psychiatric ED visits for children under 18, within HHS' service area increased 13% from calendar year 2021 to calendar year 2022. Additionally, psychiatric patients admitted from hospital ED's increased more than 8% over this same period. The addition of HHS pediatric psychiatric beds would aid in relieving pressure on hospital emergency departments while also providing comprehensive continuity of appropriate level treatment through its outpatient services which would have a positive impact on Maryland's ability to reduce healthcare costs and improve outcomes."

Table 18

	CY 2020	CY 2021	CY 2022*
ED Visits	14,751	15,549	17,547
YOY % change		*5.41%*	*12.85%*
Admitted from ED	1,801	1,974	2,135
YOY % change		*9.61%*	*8.14%*

Source: HSCRC Casemix data; Psych Dx codes; Age= <18; HHS service area zips
*2022 ytd Q3 annualized

There are various problems associated with boarding including delayed care, negative outcomes for patients, families and the hospital system, along with financial losses. It is not difficult to understand how the ED environment can overwhelm a child already in crisis, or how the same child would be a difficult patient for ED staff to care for appropriately when designated mental health professionals are scarce in most EDs.

ED boarding of adolescents is a well-documented problem, as research has been reported through the news, research studies and clinical papers, including, but not limited to:

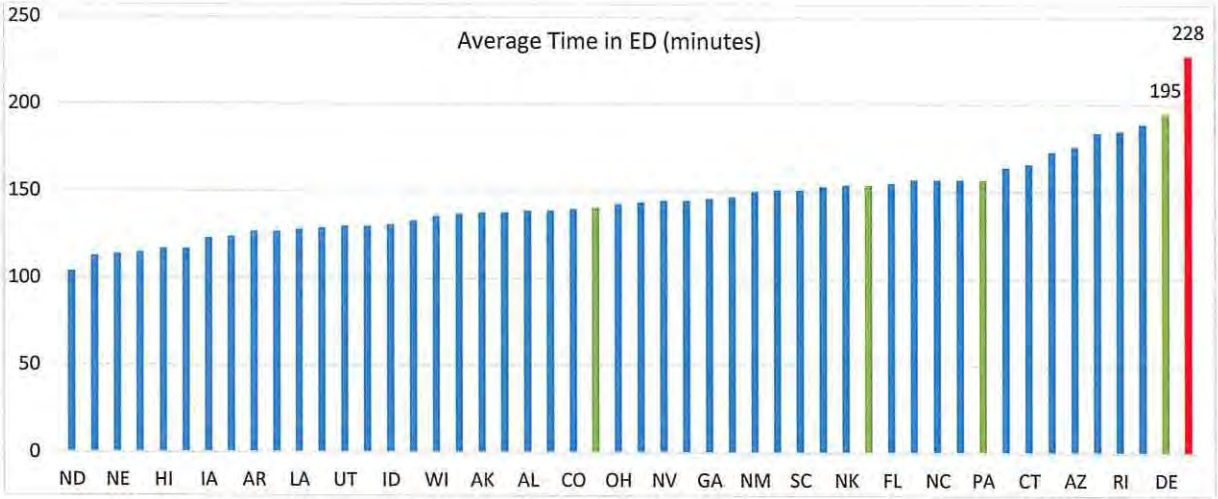
- Hlavinka, E. (2020, January 7). Teenager in Psych Crisis Waits 25 Days in ED for Admission. *MedPage Today*. https://www.medpagetoday.com/special-reports/exclusives/84236
- Jones, R. (2016, October 2). Kids with mental illness forced to wait for care. Exclusive: In Crisis, Out of Room. *ABC WXYZ Detroit*. https://www.wxyz.com/longform/in-crisis-out-of-room
- Appleby, J. (2008, June 17). Mentally Ill Face Extra-Long ER Waits. *ABC News.* https://abcnews.go.com/Health/MindMoodNews/story?id=5183940&page=1
- Kutcher, B. (2013, November 16). Bedding, not Boarding – Psychiatric patients boarded in hospital Eds create crisis for patient care and hospital finances. *Modern Healthcare.*: https://www.modernhealthcare.com/article/20131116/MAGAZINE/311169992/bedding-not-boarding
- Greene, J. (Emergency rooms fill up with psych patients – and then they wait. Modern Healthcare.

https://www.modernhealthcare.com/article/20190128/NEWS/190129944/emergency-rooms-fill-up-with-psych-patients-and-then-they-wait

- Claudius I, Donofrio JJ, Lam CN, Santillanes G. Impact of boarding pediatric psychiatric patients on a medical ward. Hosp Pediatr. 2014;4:125-132.
- Hazen EP, Prager LM. A quiet crisis: pediatric patients waiting for inpatient psychiatric care. J Am Child Adolesc Psychiatry. 2017;56(8):631-3

Maryland has the longest average ED wait times in the nation, almost 16% longer than the next closest state according to data from MEIMSS. In fact, it is the only state in the nation with wait times exceeding 200 minutes.

Figure 5



In addition, following resources represent some of the most targeted, recent, and relevant reports on the issue of ED Boarding for children and adolescents in Maryland.

- Maryland Health Care Commission: "White Paper: Maryland Acute Psychiatric Hospital Services". April 2019.
- Maryland Hospital Association: "Behavioral Health Patient Delays in Emergency Departments". September 2019.
- Maryland Hospital Association: "Delays in Hospital Discharges of Behavioral Health Patients". January 2019.
- Maryland Report / Capital News Service: "MD. Youths Needing Psychiatric Care Find Long Waits, Drives". December 2019
- Maryland Hospital Association: "A Roadmap to an Essential, Comprehensive System of Behavioral Health Care for Maryland". 2018

MHCC recognized ED Boarding in April 2019 in its publication "White Paper: Maryland Acute Psychiatric Hospital Services", covering the topic under "Evidence of Access Barriers". As noted therein: "Wait times in Maryland hospital emergency departments (EDs) have been identified, in recent years, as among the longest in the nation". While MHCC also noted they do not have access to data that allows a broad and detailed analysis of this problem, the available data and widely reported issues in Maryland (akin to much of the United States) demonstrates that the number of providers and available beds for children and adolescents falls far short of the need.

A key citation in MHCC's publication about the ED Boarding issue are the reports compiled by the Maryland Hospital Association. The Maryland Hospital Association published a report in January of 2019 specifically focused on behavioral health discharge delays in Maryland hospital. Based on their survey work, they estimated behavioral health patients experiencing a discharge delay wait an average of 13 days per patient. Per the MHA report:

- What was the most common discharge destination for those experiencing a delay?
  - **An inpatient acute psychiatric unit.**

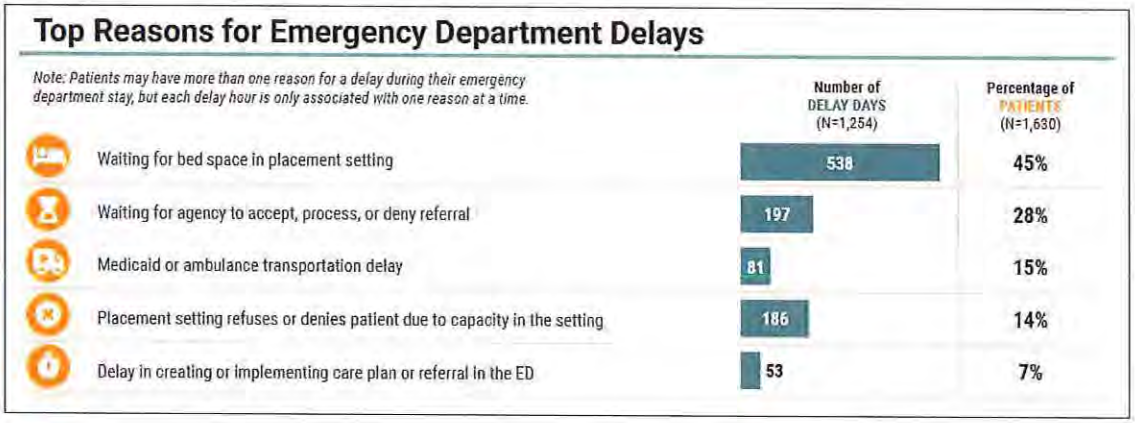
- What was the most common reason for a delay?
  - **A lack of bed space.**

A subsequent report by the Maryland Hospital Association in September of 2019 focus even more acutely on the issue. The results were both informative and alarming. Key findings included:

- 42% of behavioral health ED patients experienced a delay being discharged or transferred
- These patients were delayed for 1,676 days — an average of 20 hours per patient
- Delays account for 48% of the time those patients spend in EDs
- **Patients under age 18 tended to have delays 2x as long** (median=18 hours) as those age 18 and over (median=9 hours). This difference is statistically significant.
- Over the 45-day study, 22% or 442 of the patients with a discharge delay were under the age of 18.

Three of the top four most common reasons for discharge delays were associated with placement setting barriers, including denying admission (14%), taking too long to process referrals (28%), or **lacking bed space (45%)**. These reasons alone accounted for well over half of the delay days in the study.

Figure 6
MHA Report Chart on Reasons for Emergency Department Delays



As reported in the MHCC white paper, ED visits with a psychiatric diagnosis not resulting in inpatient admission increased by ~19% from 2008 to 2017 across all age groups. As noted by MHCC, "The growth in ED visits with a primary psychiatric diagnosis that did not result in an admission could be related, to some extent, to the boarding of patients in general hospital EDs". Additional research further indicates this issue is growing and acute for children in Maryland.

A December 2019 report by Capitol News Services posted by the Maryland Reporter further detailed the issue with an emphasis on children and adolescents in an article titled "MD. Youths Needing Psychiatric Care Find Long Waits, Drives". As they reported, at the heart of the issue is that there were only five (5) inpatient psychiatric units for children and seven (7) for adolescents in the entire State.[24]

Per the Capital News Service report and based on MHCC data, in 2018 there were 4,106 child visits and 8,198 adolescent visits to emergency departments across the state for psychiatric issues, according to a report from the Maryland Health Care Commission and data from the Maryland Health Services Cost Review Commission. Of those 12,304 juvenile visits, 1,163 of them lasted anywhere from over 24 hours to 20 or more days in the emergency department, waiting for a bed elsewhere. However, the Maryland Hospital Association studies (as referenced above) indicate nearly 9,000 of these 12,304 visits may extend beyond 4 hours, which is a common benchmark for ED Boarding.

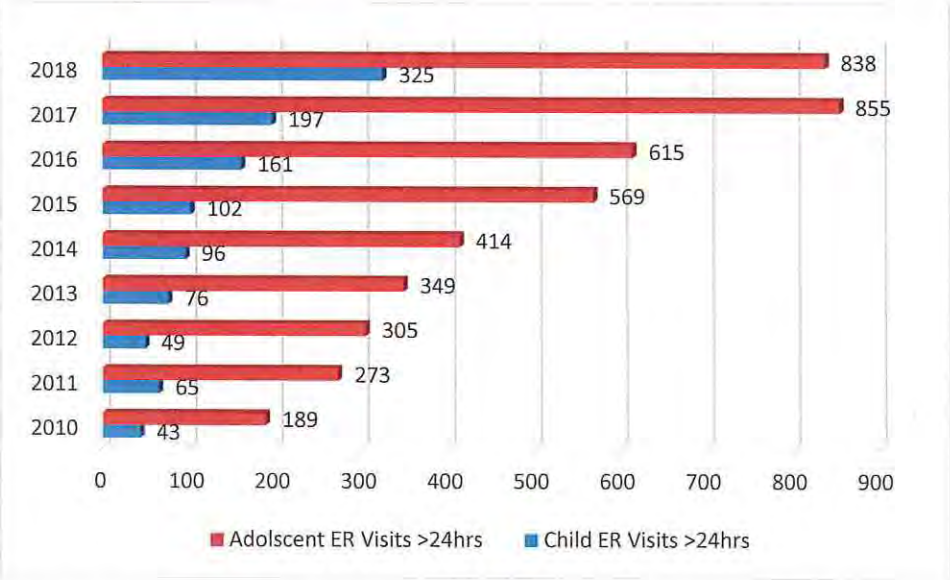
Table 19
ED Visits for Children + Adolescents by Estimated Time – CY 2010 - 2018

Estimated Time in ED	2010	2011	2012	2013	2014	2015	2016	2017	2018
< than 24 hours	9,728	10,331	11,179	11,385	11,786	11,920	10,773	10,931	11,141
Between 24 and 48 hours	173	241	248	275	345	427	433	526	568
2-3 days	33	51	51	65	91	110	145	208	263
4-8 days	20	43	46	69	69	127	178	269	282
9-20 days	5	3	6	14	3	5	20	41	45
20+ days	1	0	3	2	2	2	0	8	5
Total	9,960	10,669	11,533	11,810	12,296	12,591	11,549	11,983	12,304

The following figure depicts how many children and adolescents were reported to experience ED visits lasting a day or more waiting for a psychiatric bed.

[24] Capital News Service: "MD. Youths Needing Psychiatric Care Find Long Waits, Drives". December 2019. https://cnsmaryland.org/2019/12/11/md-youths-needing-psychiatric-care-find-long-waits-drives/

Figure 7
ED Visits for Children / Adolescents - >24 Hours



In its document "A Roadmap to an Essential, Comprehensive System of Behavioral Health Care for Maryland", the Maryland Hospital Association had this to say about the crisis:

> Heightening the hospital crisis is a lack of placement options for children. One hospital leader recently attributed "an alarming increase" in the lengths of stay for young behavioral health patients to an inability to transfer them to more appropriate settings of care, in turn causing longer wait times in the emergency department. Some hospitals report children being hospitalized more than 100 days beyond what is medically necessary; others have experienced their entire pediatric unit being filled with behavioral health patients. Many hospitals report that when transfers of pediatric and adolescent patients do take place, they are increasingly being sent to an out-of-state facility.[25]

The ED boarding and discharge delays of youths with mental illness are also costly, particularly for the State through the Medicaid population. In its 2020 report on 2019 utilization, the Local Behavioral Health Authority in Baltimore City stated the following regarding discharge delays:

> Such delays, even in a small percent of the population, can drive up costs. The largest proportion of discharge delay cases in the state occurred in Baltimore City (29%), and 83% of the cases across the state occurred among the publicly insured or uninsured. Often the reason for delayed discharges across the state involved consumers being unable to transfer to another facility, indicating that though the capacity and utilization in Baltimore City and the state are increasing, the needs of the consumers may not always be met in a timely manner.[26]

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[25] https://www.mhaonline.org/docs/default-source/publications/roadmap-to-an-essential-comprehensive-system-of-behavioral-health-care-for-maryland.pdf?sfvrsn=2

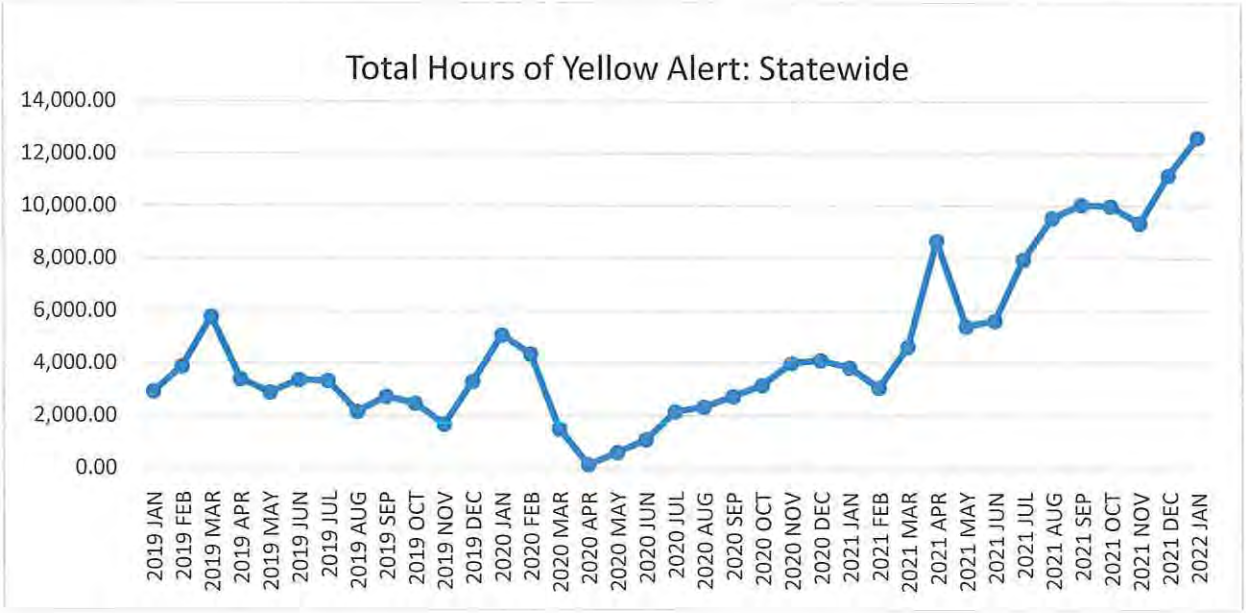
[26] https://www.bhsbaltimore.org/wp-content/uploads/2019/06/BHSB-Behavioral-Health-Crisis-System-Plan-Final.pdf

In addition, the recent CON application by UMMC for additional adolescent bed capacity (Docket #18-24-2429) highlighted the issue of ED Boarding within its hospital alone (see p.12 of 11/21/18 Supplement):

> The 70 patients transferred to an inpatient facility waited from one to nine days with an average wait time of 33 hours to be transferred. Of the patients who were not discharged to an inpatient psychiatric facility, 45 patients had a length of stay between two and 11 days in the PED and would have benefited from an inpatient psychiatric bed if one could have been secured. Instead, these patients were stabilized in the PED until it was medically safe to discharge them with outpatient psychiatric support services. Thus, a total of at least 115 patients (70 + 45) were eligible for inpatient care in FY18.

Delays and overcrowding in hospital emergency departments stemming from a lack of available beds has a downstream impact on the entire emergency medicine system throughout the state. MIEMSS noted in response to a 2017 Joint Chairmens Report on Emergency Department Overcrowding, that delays in ambulance off-load effectively keeps the ambulance out-of-service, delaying EMS responses to other emergency calls. This results in decreased advanced life support coverage that responds to situations that are best treated in acute care emergency settings such as traumas, cardiac arrests and other critical cases.[27] In this same report, the Baltimore City Fire Department noted that problems of ED overcrowding, particularly in areas within close proximity to Baltimore City with ambulance offload times exceeding 3 or more hours. Events such as these often lead to hospitals diverting emergency medical transports to other hospital EDs due to overcrowding. This practice of diversion or going on "Yellow Alert" has risen significantly over the past several years as displayed in the figure below.

Figure 8



[27] https://www.miemss.org/home/Portals/0/Docs/LegislativeReports/JCR-Emergency-Department-Overcrowding-201712.pdf?ver=2022-01-27-091531-623

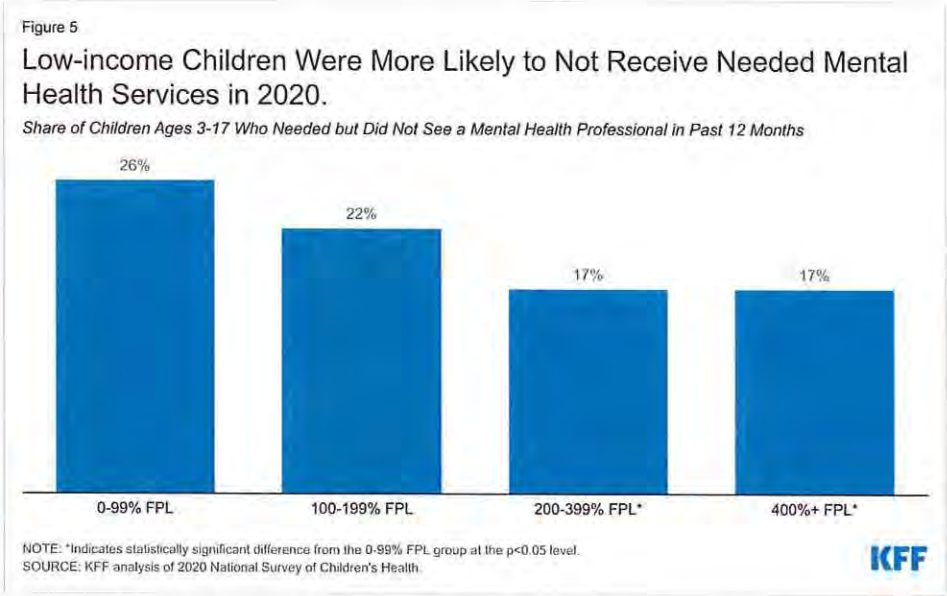
Accordingly, the prevalence and severity of ED boarding in Maryland further demonstrates the need for the additional psychiatric bed capacity for children and adolescents that HHPH would provide.

VII. Access for Low Income Children/Adolescents

Children in poverty have been shown to endure more stress as a result of environmental factors. Although not all children in poverty face these stresses, the cumulation of environmental stressors they face increases the likelihood of mental health issues. Some of the correlating indicators include school absenteeism and drop-out. Mental illness and emotional disturbance account for a significant percentage of dropouts [28] School dropout is a direct predictor of future employability and long-term physical health.

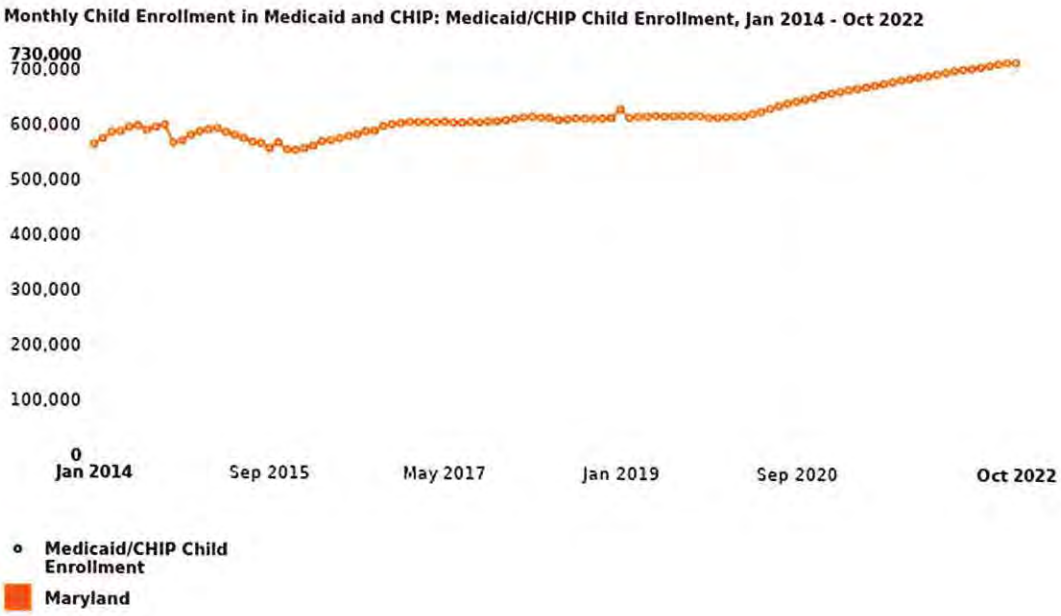
The need for care is continuing to grow but the capacity, as shown above, is limited. The 2020 National Survey of Children's Health shows that low-income children were more likely not to receive needed mental health services. During this same period, Maryland saw an increase in children enrollment in Medicaid/CHIP but the percentage of Medicaid utilization in the service area for HHPH has steadily declined since 2019.

Figure 9



[28] Haynes NM. Addressing students' social and emotional needs: the role of mental health teams in schools. J Health Soc Policy. 2002;16(1-2):109–123

Figure 10



From 2019 through 2022, the percentage of Medicaid-enrolled pediatric psychiatric inpatient admissions dropped from 56.5% of total cases to 44.3%. Outpatient visits also declined but at an even greater rate. It is expected that based on pre-COVID utilization, the increase in Medicaid enrollment, national trends in increased need for children/adolescent psychiatric care, the Medicaid utilization rates, at minimum would reflect those rates of 2019.

Table 20
COVID-19 Pandemic Variance in Medicaid Utilization

	CY2019		CY2020		CY2021		CY2022*	
Payer Group	IP Cases	OP Visits	IP Cases	OP Visits	IP Cases	OP Visits	IP Cases	OP Visits
Commercial	1,532	26,871	1,361	22,527	1,605	29,172	1,419	26,842
Medicaid	2,312	52,843	1,884	40,653	1,656	37,701	1,255	21,902
All Other	245	4,461	170	3,675	192	3,585	156	2,744
TOTAL	4,089	84,175	3,415	66,855	3,453	70,458	2,830	51,488

% of Total	IP Cases	OP Visits	IP Cases	OP Visits	IP Cases	OP Visits	IP Cases	OP Visits
Commercial	37.5%	31.9%	39.9%	33.7%	46.5%	41.4%	50.1%	52.1%
Medicaid	56.5%	62.8%	55.2%	60.8%	48.0%	53.5%	44.3%	42.5%
All Other	6.0%	5.3%	5.0%	5.5%	5.6%	5.1%	5.5%	5.3%

Source: HSCRC hospital submission data for children & adolescents in service area.
* Annualized on 9 months of data

(e) A hospital shall obtain a Certificate of Need to establish acute psychiatric services for adults, adolescents, or children.

Applicant Response

HHS is seeking a Certificate of Need for the establishment of HHPH to serve adolescents and children in this Application.

(f) In addition to the annual reallocation of hospital bed capacity permitted under COMAR 10.24.01.03A(3)(b)(iii) and COMAR 10.07.01.06-1.C, upon notice to the Commission and the Maryland Department of Health, a hospital that does not increase its total psychiatric hospital bed capacity, may:

(i)Reallocate acute psychiatric hospital beds from one age group of patients that it is authorized to serve to another age group that it is authorized to serve, or

(ii)Reallocate acute psychiatric hospital beds to establish designated beds for geriatric patients.

Applicant Response

This standard is not applicable because HHPH would be a new special psychiatric hospital so no reallocation of existing beds is involved.

(g) The need for long-term psychiatric hospital beds, in which the average length of stay exceeds 30 days, will be evaluated on a case-by-case basis, considering the needs assessment provided by the applicant. The needs determination for historically underserved populations referenced in Paragraphs(a) through (d) of this standard will only be applicable in the review of a project by an existing special psychiatric hospital or general hospital with a psychiatric unit or by an applicant that proposes to establish a special psychiatric hospital or psychiatric unit in a general hospital in which the average length of stay is less than 30 days for psychiatric patients

Applicant Response

This standard is not applicable to HHPH because it will not include long-term psychiatric hospital beds.

(3) Patient Rooms.

(a) All new patient rooms in a special psychiatric hospital or in a psychiatric unit of a general hospital will be private rooms designed for single-occupancy. Semi-private patient rooms, which are designed for double-occupancy, shall only be permitted if the applicant provides evidence demonstrating that, under the specified circumstances presented by the proposed project, semi-private patient rooms are appropriate.

Applicant Response

All of the patient rooms within HHPH will be private rooms for single occupancy. Please see **Exhibit 4** for the floor plan.

(4) Other Program Requirements.

An applicant proposing to provide acute psychiatric services for two or more age groups shall provide physical separation and programmatic distinctions between the patient groups consistent with Maryland Department of Health requirements.

Applicant Response

HHPH will provide physical separation and programmatic distinctions between children and adolescents in accordance with current best practices and FGI Guideline requirements. As seen in the floor plans attached as **Exhibit 4**, the entire child unit sleeping quarters will be separated by locked doors from the rest of the hospital with its own designated nursing station.

The dining, social, and therapy space will be used by both age groups. However, the plans of care and timing of use will differ between each age cohort to ensure clinically appropriate separation between children and adolescents, consistent with existing clinical operations of like facilities within the State. See University of Maryland CON Application (Psych) - Docket No. 18-24-2429.

(5) Support for the Project.

Certificate of Need applications and requests for exemption from Certificate of Need review involving acute psychiatric services shall document support for the project from entities that serve the population in the applicant's service area, including:

(a) Local health departments;
(b) Local community mental health centers;
(c) Each local mental health advisory council or agency; and
(d) Behavioral health service providers.

Applicant Response

Please refer to **Exhibit 13** for letters of support as required by this Standard.

(6) Emergency Services.

General hospitals with acute psychiatric services shall have the ability to provide services on an emergency basis at all times, including the capability to perform evaluations of persons believed to have a mental disorder and brought to the hospital on emergency petition, unless otherwise exempted by the Maryland Department of Health as provided in Health-General §10- 620(d)(2). Each such hospital shall also have emergency holding bed capabilities and at least one seclusion room.

Applicant Response

This standard is inapplicable to the HHPH because it will not be a general hospital.

(7) Involuntary Admissions.

(a) Each special psychiatric hospital and psychiatric unit operated by a general hospital shall admit involuntary patients, unless otherwise exempted by the Commission. The factors the Commission will consider in determining whether to exempt a hospital from the requirement to admit involuntary patients include the following:
(i) Number of psychiatric beds;
(ii) Access to hospitals that admit involuntary patients for the population to be served; and
(iii) Comments from interested parties or other stakeholders.
(b) A special psychiatric hospital or hospital with a psychiatric unit may not discontinue admissions of involuntary patients without written approval from the Commission.

Applicant Response

HHS will admit involuntary patients and does not intend to seek an exemption from the Commission.

(8) Access to Acute Psychiatric Services.

(a) A special psychiatric hospital or a psychiatric unit in a general hospital shall only deny admission if it is unable to provide the appropriate level of care for a patient and shall not deny admission due to:
(i) A patient's full or partial inability to pay for services; or
(ii) A patient's status as an involuntary patient unless the hospital has been issued an exemption by the Commission that permits it to serve only voluntary patients.

(b) A special psychiatric hospital and a general hospital with a psychiatric unit shall participate in the Medicare and Medicaid programs.

Applicant Response

HHS will only deny admission to patients it is unable to provide with the appropriate level of care. HHS affirms it will not deny admission due to a patient's full or partial inability to pay for services or a patient's status as an involuntary patient. HHS does not intend to seek an exemption from the Commission to only serve voluntary patients.

HHPH will participate in the Medicare and Medicaid programs.

(9) Adverse Impact.

(a) A project requiring action by the Commission involving acute psychiatric services shall not have an unwarranted adverse impact on the total cost of care, availability of acute psychiatric services, or access to acute psychiatric services. If the applicant is a Maryland general hospital seeking a capital-related adjustment in its global budget revenue, it shall demonstrate that:
(i) It is an efficient hospital both in terms of hospital cost per case and total cost of care, consistent with the Health Services Cost Review Commission's most recent efficiency policies;
(ii) It does not have excess capital costs in comparison to statewide peers, and does not have demonstrated excess capacity relative to its prior bed capacity, as reflected in the most recent Capital Policy Recommendation published by Health Services Cost Review Commission;
(iii) If the project involves replacement of a physical plant asset, the age of the physical plant asset being replaced exceeds the average age of plant for its peer group or the hospital shall otherwise demonstrate why replacement of the physical plant asset is required to achieve the primary objectives of the project; and
(iv) If the project will likely reduce the availability or accessibility of acute psychiatric services by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish the availability of or access to acute psychiatric services: for the population within an optimal drive time, as defined in Regulation .05B(1) of this Chapter; for the population in the hospital's health planning region; or for the indigent, underinsured, and uninsured.

Applicant Response

As the applicant is not a Maryland general hospital, subsections (i)-(iv) above are not applicable to the proposed project. As discussed below, in accordance with part (a) of this Standard, the proposed project will not have an unwarranted adverse impact on the total cost of care, availability of acute psychiatric services, or access to acute psychiatric services, as described below.

Availability and Access to Care

HHPH would increase availability and access by increasing capacity in a service area lacking the beds to meet the current and projected demand. Additional benefits to the population from an access perspective include:

- Reducing drive time for patients in south Baltimore County and Baltimore City who are currently being admitted to Sheppard Pratt and inpatient hospitals outside of the service area. The new facility would also reduce the number of transfers currently required for a patient to reach admission to a psychiatric unit.
- The new facility would increase the speed at which patients in need of inpatient care can be admitted.

As described above and recently highlighted,[29] as a consequence of the lack of sufficient psychiatric bed capacity to serve the under-18 population, at-risk youth in need of an inpatient admission for psychiatric care end up being housed in juvenile justice detention facilities which are not equipped or appropriate to care for them while they await a bed becoming available. The additional inpatient bed capacity at HHPH will improve access to inpatient psychiatric care, including for these vulnerable youth. The volume shifts associated with the proposed project are not expected to affect existing inpatient children and adolescent psychiatric units in such measure as to compromise the financial viability, thereby threatening access/availability, of any existing programs. This is based on the following assumptions:

- The majority of existing inpatient pediatric psychiatric volume is handled by Sheppard Pratt and Brook Lane – the only two facilities in the state with dedicated child and adolescent units – which have recently operated at occupancy rates reaching 99% in recent years (see Table 15). Other facilities throughout the state with dedicated pediatric psychiatric units are often simply a last resort for those seeking care.
- Sheppard Pratt remains as the only psychiatric hospital within the HHS service area with both a dedicated child and adolescent unit, which serves as regional provider of care for this population. HHS would serve a less severe patient population than what Sheppard Pratt can accommodate, thus a projected rise in uses rate and severity would sufficiently backfill an already significantly burdened facility.
- Roughly 19% of HHPH's year one volume would be direct admits shifting from Sheppard Pratt and Brook Lane (73 cases total) – generally aligning with the Brook Lane and Sheppard Pratt statewide market share of pediatric psych volume.
- Most of the year one volume (80%) would be patients who ultimately get admitted from acute care hospital emergency departments, observation units (60%) and those who have extended observation stays (18%).
- These estimates are highly conservative as, it is unknown how many patients are currently on waitlists for inpatient care which would result in undercounting the demand in the service area, limiting any impact even further.

Total Costs of Care

HHPH would provide a lower cost per care than the acute care general hospitals where the children and adolescents are currently being admitted when a bed is available. Additionally, cost improvements to the system would stem from reduced length of stay in hospital emergency rooms and observation units. By providing additional and appropriate capacity to serve children and adolescents, this would ease pressures on the system currently unable to meet the need for

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[29] *(Shortage of inpatient beds in Maryland Psychiatric Hospitals is putting children at risk, officials worry.* Baltimore Sun. (n.d.). Retrieved March 14, 2023, from https://www.baltimoresun.com/health/bs-md-cr-juvenile-detention-psychiatric-care-20211103-wcidebu7unhzpaf2fg7ix5hrri-story.html)

inpatient psychiatric care within the under-18 population. By easing volume in overburdened hospital emergency departments and costly acute care rates, savings to the system would be realized through increased efficiency in throughput, discharging and providing inpatient care for those who need it.

Conservatively, HHPH would be expected to produce roughly $709,000 in savings to the health system through a reduction of emergency department length of stay, elimination of observation hours for certain cases, including observations greater than 24 hours, as shown in the following Table.

Table 21

Service Area Cases Shifted to HHS from Existing CY 2022 Volume				
Source of Admission	**Year 1 Volume**	**LOS Reduction (hours)**	**LOS (hours) * Statewide Unit Rate**	**Assumptions**
Direct admissions	73			
Admissions from ED	203	142	$18,084	On average, patients admitted from the ED have almost 1 hour longer LOS than patients not admitted. This hour is assumed as potential savings. Actual reduction in LOS is expected to be much more significant.
Admissions from observation	41	1,468	$135,292	Assumes patients historically admitted from observation, would have hours of observation eliminated from total costs and would be admitted directly or through ED. Does not assume all observation for pediatric psych cases would be eliminated.
Admissions from observation >24 hours	70	6,023	$ 555,252	Assumes, patients in observation greater than 24 hours are in need of inpatient care. Increased service area capacity allows navigation of these patients to appropriate care.
Population growth	2			
Total	**389**		**$708,628**	

(10) Construction Cost.
(a) The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any capital-related adjustment of global budget revenue shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.
(b) An applicant shall provide the information necessary for Commission staff to calculate the construction cost per square foot based on the Marshall Valuation Service® guide.
(c) An applicant is permitted but not required to submit calculation of the construction cost per square foot based on the Marshall Valuation Service® guide, independent of Commission staff's analysis.

Applicant Response

HHS has provided the Marshall Valuation Services benchmark analysis as **Exhibit 8**. As noted in the analysis, the project costs are below the required threshold, and are reasonable and consistent with current industry cost experience in Maryland.

(11) Inpatient Nursing Unit Space.
Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If the inpatient unit program space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any capital-related adjustment in global budget revenue shall not include the amount of the projected construction cost for the space that exceeds the per bed square footage limitation in this standard or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

Applicant Response

Please see **Exhibit 4** for the floor plans documenting nursing units do not exceed 500 sq. ft. per bed.

(12) Financial Feasibility.

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.
(a) Financial projections filed as part of a hospital Certificate of Need application or a request for an exemption from Certificate of Need review must be accompanied by a statement containing each assumption used to develop the projections;
(b) An applicant must document that:

(i) Utilization projections are consistent with observed historic trends in use of the acute psychiatric services, unless the applicant demonstrates why future utilization should not be expected to be consistent with observed historic trends for the likely population to be served by the applicant;
(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;
(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and(iv) The hospital will generate excess revenues over total 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. An exception to this requirement is permitted if the hospital demonstrates or the Commission finds that overall the hospital's financial performance will be positive; the hospital can support operating losses for the proposed services over the long-term; and the proposed services will benefit the hospital's service area population.

Applicant Response

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

(b)(i) Utilization projections are consistent with observed historic trends of like hospitals and conservative assumptions on growth, as demonstrated in the section 10.24.21.05(B)(2)(d) and Table I of the Exhibits.

(b)(ii) Revenue estimates are consistent with utilization projections and are based on historic rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by like providers. (see attached CON Table Package, Tables J & K).

(b)(iii) Staffing and overall expense projections that are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by similar projects (see attached CON Table Package, Table L).

(b)(iv) As Table J shows, HHS will generate excess revenues over total expenses by year 1 of operations.

Please see below for additional details regarding our assumptions and reasonableness.

Inpatient Revenue:

HHS evaluated the current FY23 rates for Sheppard Pratt and Brook Lane to develop its rate assumptions based on the rates of currently operational providers. Details on the rate centers, volume, and assumption of rate values are set forth in the table below.

Table 22

Measurement Unit	# of Units Per Day	Description	Rate	Per Diem Rate	Notes
patient days	1	Child Psych	$1,380.90	$1,380.90	Rate is Average of Sheppard Pratt & Brook Lane
	N/A - Per Admission	Admission Services	$462.17	$43.03	Rate is Average of Sheppard Pratt & Brook Lane
Maryland RVUs	1.28	Laboratory Services	$36.10	$46.20	Brook Lane Rate
hours	1.65	Group Therapies	$28.86	$47.62	Brook Lane Rate
hours	0.7	Individual Therapy	$199.73	$139.81	Brook Lane Rate
EIPA	53.10	Drugs	$2.00	$106.21	(CDS missing for FY23, so this is approximate from FY20 rate)
Rate Per Patient Day				$1,763.78	FY23 Basis
FY 24 Rate Increase Assumption at 3.25%				**$1,821.11**	2024 (Year 1 of Operation)

Based upon the FY 2023 rate assumptions, HHS then added inflationary assumptions for rate increases. HHS looked at the recent rate increase trajectory and the current inflationary climate to further adjust the rate for projected years of operation. HHS projects a lower inflationary rate increase in FY24 than FY23, although still higher than the rate of increase prior to FY23. This reflects the continued inflationary environment driving up costs of goods and services, although at a more conservative level than the FY23 update. For FY25 onwards, HHS is projecting a 3% rate increase to reflect a flattening of recent inflationary pressures.

Table 23

FY20	FY21	FY22	FY23	FY24 (projected)	FY25 (projected)	FY26 (projected)	FY27 (projected)
2.46%	2.77%	2.57%	4.06%	3.25%	3.00%	3.00%	3.00%

HHS also projected charity care at 2%, bad debt at 2%, and contractual adjustments at 10% to be in line with the recent operational experiences of Sheppard Pratt and Brook Lane and the projections contained in the UMMC CON application (Docket #18-24-2429) for an adolescent/child psychiatric unit.

Table 24

SOURCE	GROSS PATIENT REVENUE	BAD DEBT	CHARITY	CONTRACT
SP FY21 CR "RE"	$152,435,000	$976,000	$4,630,000	14,883,000
BL FY21 CR "RE"	$26,587,000	$563,000	$225,000	3,161,000
SP % of Gross Revenue		0.64%	3.04%	9.76%
BL % of Gross Revenue		2.12%	0.85%	11.89%

Patient Mix:

1) Medicare	0.0%
2) Medicaid	80.0%
3) Blue Cross	2.5%
4) Commercial Insurance	8.5%
5) Self-pay	5.0%
6) Other	4.0%

HHS has been a provider of outpatient mental health services and worked with inpatient facilities for many years in Maryland. Working heavily with the Medicaid patient population (~70% of HHS's existing patient population) and the underserved, HHS has actively encountered the access barriers for inpatient care and disconnected inpatient to outpatient treatment for this patient population. In addition to these operational experiences, HHS reviewed a number of data sources regarding the Medicaid patient population in the service area.

Based on HHS's research described below, HHS estimates its Medicaid patient percentage at 80%. HHS believes this figure is a conservative assumption given the facility location, evidence of like providers, and importantly the fact that HHS's existing patient base and common referral networks are heavily weighted to servicing the Medicaid population. Although this is our working assumption for a payer percentage, the proposed facility will accept all patients regardless of payer source.

HSCRC Data

HHS looked at its pre-COVID data for perspective on Medicaid patient expectations. The pandemic's effect on volumes and distortion of Medicaid enrollments due to a pause in eligibility reviews favors the pre-pandemic period for forecasting figures in 2024 and beyond.

The HSCRC data obtained by HHS documented that Medicaid patients make up around 70% of the patient population for children inpatient psychiatric services looking at 2017-2019. Further, some providers, such as the University of Maryland were often above the State average.

Table 25

Medicaid Patient Days as % of Total Patient Days – Children (0-12)			
	2017	2018	2019
State Total	71%	72%	68%
University of Maryland	84%	90%	81%

The HSCRC data obtained by HHS documented that Medicaid patients make up around 50% of the patient population for adolescent inpatient psychiatric services looking at 2017-2019. Further, some providers, such as the University of Maryland and MedStar were often above the State average.

Table 26

Medicaid Patient Days as % of Total Patient Days – Adolescent (13-17)			
	2017	2018	2019
State Total	51%	49%	51%
University of Maryland	62%	79%	80%
MedStar Franklin Square	61%	65%	64%

The HSCRC data confirms that Medicaid patients comprise a significant portion - and often a majority - of inpatient children and adolescent psychiatric patients within the State and at providers in the Baltimore area.

UMMC CON Filing

HHS also referenced the payer statistics in the University of Maryland's recent CON application (Docket #18-24-2429) to establish an adolescent unit at UMMC. UMMC's filing also empathized admission/transfer access issues for ED patients – a core component of the need identified in our filing. UMMC projected Medicaid patients would account for approximately 85% of their volume. This is in line with HHS's estimates as well.

Expenses:

To evaluate the reasonableness of its expense assumptions, HHS looked at the recent experience of Sheppard Pratt and Brook Lane as one data point for cost reasonableness.

Salaries and Wages (including Benefits): based upon final amount in Table L

Contractual services: HHS calculated the total amount paid by similarly situated hospitals (Brook Lane, Shepherd Pratt) based upon their most recently filed cost report. HHS identified the amount on a per patient day basis and adjusted it upward by 120% to adjust for inflation to the first year of operations and possible inefficiencies in size and scale for the smaller proposed location.

The per bed day amount was then applied to the anticipated patient days at the proposed hospital.

Table 27

		Per Patient Day Cost	Year 1	Year 2	`Year 3	Year 4	Year 5
Contracted Services	Laundry Linen, Uniforms:	$2.85	$3.43	$14,307.57	$15,002.91	$15,708.53	$16,188.07
	Agency Nurses:	$7.72	$9.26	$38,690.90	$40,571.25	$42,479.40	$43,776.20
	Food:	$28.31	$33.98	$141,923.97	$148,821.40	$155,820.76	$160,577.61
	Other Contracted Services:	$57.48	$68.98	$288,134.70	$302,137.89	$316,348.03	$326,005.40
	Total		$115.65	$483,057.13	$506,533.45	$530,356.71	$546,547.28
Other Expenses	Insurance:	$19.87	$23.85	$99,606.02	$104,446.82	$109,359.16	$112,697.65
	Telephone:	$5.87	$7.04	$29,421.20	$30,851.06	$32,302.04	$33,288.15
	Utilities and Water:	$14.31	$17.17	$71,710.58	$75,195.68	$78,732.28	$81,135.79
	Office Supplies:	$4.39	$5.27	$21,993.93	$23,062.82	$24,147.51	$24,884.68
	Total		$53.32	$222,731.74	$233,556.38	$244,541.00	$252,006.27
Medical Supplies	Medical Supplies:	$92.39	$110.86	$463,081.65	$485,587.18	$508,425.29	$523,946.34

Inflation: HHS projects the following inflation assumptions for its expenses:

Table 28

Year	2025	2026	2027	2028
Inflation percent	3.00%	3.00%	3.00%	3.00%
a. Salaries & Wages (including benefits)	3.00%	3.00%	3.00%	3.00%
b. Contractual Services	2.00%	2.00%	2.00%	2.00%
i. Medical Supplies	3.00%	3.00%	3.00%	3.00%
j. Other Expenses:	2.00%	2.00%	2.00%	2.00%

Outpatient Revenue / Expenses:

While the proposed hospital project does not include new outpatient services, HHS has included its existing outpatient services within the applicant tables for transparency. HHS utilized its existing operational history along with the following assumptions to project current and future year figures for volume related growth.

Table 29

Outpatient Program Volume Growth					
2023	**2024**	**2025**	**2026**	**2027**	**2028**
105.00%	106.00%	103.00%	103.00%	103.00%	103.00%
Rebound from CV19 / organic growth	Boost from year one of hospital operations, building increased exposure and use of outpatient programs	Stable Growth assumption from expanding inpatient volumes / organic growth			

Table 30

Outpatient Program Expense (Volume Growth Related)						
2. EXPENSES	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**
Salaries & Wages (including benefits)	104.80%	104.80%	102.40%	102.40%	102.40%	102.40%
Contractual Services	104.80%	104.80%	102.40%	102.40%	102.40%	102.40%
Supplies	103.00%	103.00%	101.50%	101.50%	101.50%	101.50%
Other Expenses	103.00%	103.00%	101.50%	101.50%	101.50%	101.50%

For inflationary rates, HHS applied the following factors to the outpatient program.

Table 31

Inflation - Reimbursement				
2024	2025	2026	2027	2028
102.75%	105.50%	108.25%	111.00%	113.75%
2.75%	2.75%	2.75%	2.75%	2.75%

Inflation - Expenses						
2023	2024	2025	2026	2027	2028	2029
Salaries & Wages (including benefits)	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
Contractual Services	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Medical Supplies	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
Other Expenses:	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%

10.24.01.08G(3)(b). Need.

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

INSTRUCTIONS: Please identify the need that will be addressed by the proposed project, quantifying the need, to the extent possible, for each facility and service capacity proposed for development, relocation, or renovation in the project. The analysis of need for the project should be population-based, applying utilization rates based on historic trends and expected future changes to those trends. This need analysis should be aimed at demonstrating needs of the population served or to be served by the hospital. The existing and/or intended service area population of the applicant should be clearly defined.

Fully address the way in which the proposed project is consistent with each applicable need standard or need projection methodology in the State Health Plan.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population of the hospital. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please 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, and the service capacity of buildings and equipment included in the project, with information that supports the validity of these assumptions.

Explain how the applicant considered the unmet needs of the population to be served in arriving at a determination that the proposed project is needed. 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.

Complete the Statistical Projections (Tables F and I, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package.

Applicant Response

See response to COMAR 10.24.21.05B(2) (Need for Acute Psychiatric Services) above.

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the proposed project. The applicant should identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including:

a) the alternative of the services being provided through existing facilities;

b) or through population-health initiatives that would avoid or lessen hospital admissions.

Describe the hospital's population health initiatives and explain how the projections and proposed capacities take these initiatives into account.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development costs to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective method to reach stated goal(s) and objective(s) or the most effective solution to the identified problem(s) for the level of costs required to implement the project, when compared to the effectiveness and costs of alternatives, including the alternative of providing the service through existing facilities, including outpatient facilities or population-based planning activities or resources that may lessen hospital admissions, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Applicant Response:

As described above, there is a demonstrated need for additional bed capacity to serve children and adolescents in Maryland. HHS has two primary objectives in establishing HHPH to meet this demonstrated need. First, HHS seeks to expand inpatient psychiatric bed capacity to serve this population in order to address the lengthy delays and barriers to timely, culturally competent inpatient psychiatric care this population experiences, in particular minority and underserved populations that HHS has primarily served for over two decades. Second, HHS seeks to address the disconnect between inpatient and outpatient care experienced by this population by integrating HHPH into HHS's comprehensive continuum of care through its step-down approach to care, as described above. Achieving these goals will allow HHS to provide quality, culturally competent, integrated and personalized care to the underserved population in the region, and help reduce ED Boarding, readmission rates, and the length of stay in the inpatient setting.

HHS has been a provider of outpatient mental health services and worked with inpatient facilities for over two decades in Maryland. Working heavily with the Medicaid patient population and the

underserved, HHS has actively encountered the access barriers for inpatient care and disconnected inpatient to outpatient treatment. HHS can address these barriers to access and disjointed care only if it has the full range of services – including inpatient care – within the continuum of care it provides.

As a longstanding existing provider of a broad continuum of outpatient mental health services, HHS is keenly aware of the important role that outpatient programs and population health measures play. However, a child or adolescent in crisis being boarded in an ED waiting for an admission needs a bed, not an outpatient program or population health initiative. These programs and measures are important, but they cannot address the demonstrated need for additional inpatient capacity.

Likewise, existing facilities are not meeting the demonstrated need, and cannot meet the demonstrated need because there are not enough available beds in these facilities, as shown by the lengthy ED boarding and barriers to inpatient care being experienced in the State, particularly among minority and underserved populations that HHS primarily serves.

The project is also a cost effective alternative because it involves the renovation of an existing building rather than new construction.

10.24.01.08G(3)(d). Viability of the Proposal.

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.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- Complete applicable Revenues & Expenses (Tables G, H, J and K as applicable), and the Work Force information (Table L) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable.

- Describe and document relevant community support for the proposed project.

- Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.

- Audited financial statements for the past two years should be provided by all applicant

entities and parent companies.

Applicant Response:

The proposed project is financially feasible, as shown in the attached CON Table Package, Tables G, H, J, K, and L. The facility reaches net income of $179,075 in year 1 for the proposed inpatient services (Table J) and $543,652 in net income in year 1 for the entire operations (Table G). As further explained and documented in response to COMAR 10.24.21.05(B)(12) herein, the applicant benchmarked its projections based on like providers, while also adapting projections for its own circumstances for the proposed project. The applicant took conservative positions on its assumptions to build in the ability for variances that will not jeopardize the financial viability of the project.

Please see **Exhibit 13** for letters of support documenting strong community support for the project.

The applicant engaged HD2 Design for its project planning, and obtained cost estimates from CostCon Construction Services to ensure the project can be developed within the proposed timeframe and costs. HHS has documented its project budget in Table E, but also provided a project budget for its landlord (Hope Health Properties, LLC) in a separate Table E for transparency given the common ownership between the two entities. The facility buildout will be financed through a mortgage on the property by HHP. HHS will lease the finished space from HHP under a Triple Net Lease (see **Exhibit 3**) for the premises. The applicant already leases a portion of the property for existing operations, and has allocated the incremental costs of the revised lease to HHPH under Tables J and K.

For working capital, HHS is working with MMG to secure a Line of Credit of up to $1.5M (which is in excess of the $1.3M in working capital requirements assumed in the project budget) for starting the hospital operations. Please refer to the letter from MMG attached as **Exhibit 7**.

Pursuant to COMAR § 10.24.01.12.C, if this application is approved, HHS will have 36 months to obligate not less than 51% of the approved capital expenditure, and 36 months after the effective date of the binding construction contract to complete the project. HHP will enter into the construction contract within 4 months of CON approval, and the renovations are projected to take 16 weeks from the contract date to complete.

HHS has attached its two most recent audited financial statements that have been completed (for calendar years 2019 and 2020) as **Exhibit 15**. HHS retained a new CPA firm (CliftonLarsenAllen LLP) ("CLA"), which is in the process of preparing HHS's audited financial statements for 2021 and 2022. As documented in the letter from CLA attached as **Exhibit 16**, HHS's 2021 financial statements are expected to be delivered by management by April 7, 2023, and the 2022 financial statement by the end of June, 2023. HHS will provide the statements to the MHCC promptly upon receipt.

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

INSTRUCTIONS: List all of the Certificates of Need that have been issued to the applicant or related entities, affiliates, or subsidiaries since 2000, including their terms and conditions, and any changes to approved CONs that were approved. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Applicant Response:

Not applicable. HHS has not previously been issued any certificates of need.

10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

An applicant shall 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.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project[30];
b) On access to health care services for the service area population that will be served by the project. (state and support the assumptions used in this analysis of the impact on access);
c) On costs to the health care delivery system.

If the applicant is an existing hospital, provide a summary description of the impact of the proposed project on costs and charges of the applicant hospital, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

Applicant Response:

On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project ;

[30] **Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, the relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions.**

The volume shifts associated with the proposed project are not expected to affect existing inpatient children and adolescent psychiatric units in such measure as to compromise the financial viability of any existing programs. The assumptions on which this is based are listed in response to COMAR 10.24.21.05B(9) (Adverse Impact standard) above.

On access to health care services for the service area population that will be served by the project (state and support the assumptions used in this analysis of the impact on access);

HHPH would increase access by increasing capacity in a service area lacking the beds to meet the current and projected demand. Additional benefits to the population from an access perspective include:

- Reducing drive time for patients in south Baltimore County and Baltimore City who are currently being admitted to Sheppard Pratt and hospitals outside of the service area. The new facility would also reduce the number of transfers currently required for a patient to reach admission to a psychiatric unit.
- The new facility would increase the speed at which patients in need of inpatient care can be admitted.

As recently highlighted,[31] as a consequence of the lack of sufficient psychiatric bed capacity to serve the under-18 population, at-risk youth in need of an inpatient admission for psychiatric care end up being housed in juvenile justice detention facilities which are not equipped or appropriate to care for them while they await a bed becoming available. The additional inpatient bed capacity at HHPH will improve access to inpatient psychiatric care, including for these vulnerable youth.

On costs to the health care delivery system.

The new facility would provide a lower cost per care than the acute care hospitals many of the existing patients are in. Additionally, cost improvements to the system would stem from reduced length of stay in hospital emergency rooms and observation units. By providing additional and appropriate capacity the population in need, this would ease pressures on the system currently challenged with meting the current need for the under 18 population in need of inpatient psychiatric care. By easing volume in overburdened hospital emergency departments and costly acute care rates, savings to the system would be realized through increased efficiency in throughput, discharging and providing care for those requiring necessary inpatient acute care.

As explained in response to COMAR 10.24.21.05B(9) (Adverse Impact standard) above, conservatively, the new facility would be expected to produce roughly $709,000 in savings to the health system through a reduction of emergency department length of stay, elimination of observation hours for certain cases, including observations greater than 24 hours.

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[31] *(Shortage of inpatient beds in Maryland Psychiatric Hospitals is putting children at risk, officials worry.* Baltimore Sun. (n.d.). Retrieved March 14, 2023, from https://www.baltimoresun.com/health/bs-md-cr-juvenile-detention-psychiatric-care-20211103-wcidebu7unhzpaf2fg7ix5hrri-story.html)

AFFIRMATIONS

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Application by Hope Health Systems, Inc. for a Certificate of Need for the Establishment of a Freestanding Inpatient Psychiatric Hospital for Children and Associates, and in its attachments, are true and correct to the best of my knowledge, information and belief.

Date: March 20, 2023

Printed Name: Vinka Fadiora

Title: Executive Program Director

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Application by Hope Health Systems, Inc. for a Certificate of Need for the Establishment of a Freestanding Inpatient Psychiatric Hospital for Children and Associates, and in its attachments, are true and correct to the best of my knowledge, information and belief.

Date: March 20, 2023

Printed Name: LANRE FADIORA

Title: CFO

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Application by Hope Health Systems, Inc. for a Certificate of Need for the Establishment of a Freestanding Inpatient Psychiatric Hospital for Children and Associates, and in its attachments, are true and correct to the best of my knowledge, information and belief.

Date: March 20, 2023

Bryan Niehaus

Printed Name: Bryan Niehaus

Title: Vice President - Advis, Inc.

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Application by Hope Health Systems, Inc. for a Certificate of Need for the Establishment of a Freestanding Inpatient Psychiatric Hospital for Children and Associates, and in its attachments, are true and correct to the best of my knowledge, information and belief.

Date: March 20, 2023

Printed Name: Angela Wells-Sims

Title: Principal

CON APP TABLES PACKAGE

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

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

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: 7/1/201_	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
ACUTE CARE							ACUTE CARE					
General Medical/ Surgical*					0	0	General Medical/ Surgical*				0	0
					0	0					0	0
					0	0					0	0
					0	0					0	0
					0	0					0	0
SUBTOTAL Gen. Med/Surg*							SUBTOTAL Gen. Med/Surg*					
ICU/CCU					0	0	ICU/CCU				0	0
Other *(Specify/add rows as needed)*					0	0					0	0
TOTAL MSGA							TOTAL MSGA					
Obstetrics					0	0	Obstetrics				0	0
Pediatrics					0	0	Pediatrics				0	0
Psychiatric			0		0	0	Psychiatric		16		16	16
TOTAL ACUTE		0	0	0	0	0	TOTAL ACUTE		16	0	16	16
NON-ACUTE CARE							NON-ACUTE CARE					
Dedicated Observation**					0	0	Dedicated Observation**				0	0
Rehabilitation					0	0	Rehabilitation				0	0
Comprehensive Care					0	0	Comprehensive Care				0	0
Other *(Specify/add rows as needed)*					0	0	Other *(Specify/add rows as needed)*				0	0
TOTAL NON-ACUTE							TOTAL NON-ACUTE					
HOSPITAL TOTAL		0	0	0	0	0	HOSPITAL TOTAL		16	0	16	16

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

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

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

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

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Adolescent Patient Rooms (12 Total)			1,950		1,950
Children Patient Rooms (4 Total)			666		666
Special Patient Care Rooms			309		309
Patient Support Areas			5,867		5,867
Staff Support Areas			513		513
Patient & Visitor Support Areas			1,644		1,644
Multipurpose Room / Gymnasium			4,380		4,380
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total			15,329		15329.00

TABLE C. CONSTRUCTION CHARACTERISTICS

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

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

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		
First Floor		15,329
Second Floor		
Third Floor		
Fourth Floor		
Average Square Feet		**15,329**
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		978
Second Floor		
Third Floor		
Fourth Floor		
Total Linear Feet		**978**
Average Linear Feet		**978**
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor		12'-8"
Second Floor		
Third Floor		
Fourth Floor		
Average Wall Height		**12'-8"**
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		N/A
Freight		N/A
Sprinklers	**Square Feet Covered**	
Wet System		15,329
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project	VAV INDEPENDENT SYSTEM	
Type of Exterior Walls for proposed project	Existing Brick Masonry on Cold Formed Metal Framing	

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		
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs		
Site Demolition Costs		
Storm Drains		
Rough Grading		
Hillside Foundation		
Paving		
Exterior Signs		
Landscaping		
Walls		
Yard Lighting		
Other *(Specify/add rows if needed)*		
Subtotal On-Site excluded from Marshall Valuation Costs		
OFFSITE COSTS		
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs		
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$0**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$0**	**$0**

*The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

TABLE E. PROJECT BUDGET

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

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

	Hospital Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building			$0
(2) Fixed Equipment			$0
(3) Site and Infrastructure			$0
(4) Architect/Engineering Fees			$0
(5) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$0**	**$0**
b. Renovations			
(1) Building			$0
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees			$0
(4) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL		**$0**	**$0**
c. Other Capital Costs			
(1) Movable Equipment (Medical Equipment, Furnishings, Fixtures & Instruments, not included in contruction contract)			$0
(2) IT Equipment / Software			
(3) Contingency Allowance			$0
(4) Gross interest during construction period			$0
(5) Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$0***	***$0***	**$0**
TOTAL CURRENT CAPITAL COSTS	$0	$0	$0
d. *Land Purchase*			
e. Inflation Allowance			$0
TOTAL CAPITAL COSTS	**$0**	**$0**	**$0**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c CON Application Assistance	**$65,000**		$65,000
c1. Legal Fees			$0
c2. Other (Specify/add rows if needed)			$0
d. Non-CON Consulting Fees			$0
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund			$0
f Other *(Miscellaneous start up and funding)*			$0
SUBTOTAL	***$65,000***	***$0***	**$65,000**
3. Working Capital Startup Costs	**$1,300,000**		$1,300,000
TOTAL USES OF FUNDS	***$1,365,000***	***$0***	***$1,365,000***
B. Sources of Funds			
1. Cash			
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans	**$1,365,000**		$1,365,000
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*		**$0**	$0
TOTAL SOURCES OF FUNDS	***$1,365,000***	***$0***	***$1,365,000***
	Hospital Building	***Other Structure***	***Total***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building	$ 259,800.00		$259,800
3. Movable Equipment (Medical Equipment, Furnishings, Fixture	$ 215,000.00		$215,000
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 E. PROJECT BUDGET

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

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

	Hospital Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building			$0
(2) Fixed Equipment			$0
(3) Site and Infrastructure			$0
(4) Architect/Engineering Fees			$0
(5) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	$0	$0	$0
b. Renovations			
(1) Building	$3,874,673		$3,874,673
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees	$350,000		$350,000
(4) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	$4,224,673	$0	$4,224,673
c. Other Capital Costs			
(1) Movable Equipment			$0
(2) Contingency Allowance	$387,467		$387,467
(3) Gross interest during construction period			$0
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL	$387,467	$0	$387,467
TOTAL CURRENT CAPITAL COSTS	$4,612,140	$0	$4,612,140
d. *Land Purchase*			
e. Inflation Allowance			$0
TOTAL CAPITAL COSTS	$4,612,140	$0	$4,612,140
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c CON Application Assistance			$0
c1. Legal Fees			$0
c2. Other (Specify/add rows if needed)			$0
d. Non-CON Consulting Fees			$0
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund			$0
f Other *(Miscellaneous start up and funding)*			$0
SUBTOTAL	$0	$0	$0
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	$4,612,140	$0	$4,612,140
B. Sources of Funds			
1. Cash			
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage	$4,612,140		$4,612,140
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	$0
TOTAL SOURCES OF FUNDS	$4,612,140	$0	$4,612,140
	Hospital Building	Other Structure	Total
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

Item 10. Moveable Equipment not in construction contracts - $850,000

The total amount for equipment and furnishings is $850,000, of which $642,068 is associated with clinical services.

Clinical area furnishings include patient room beds and wardrobes, seclusion room beds, tables, chairs and sofas, loveseats and side tables for therapy spaces, consult rooms and day rooms. Equipment for patient areas include TV sets with protective enclosures, and washers and dryers for patient clothing.

Furnishings include tables and chairs for waiting areas, conference rooms, and administrative and staff areas, desks and work stations.

Item 14. Other Costs to be Capitalized - $790,000

Information technology includes computers, switches, cabling	$750,000
Artwork for lobby and public areas, waiting, exam rooms	$25,000
Directional signage and signs for functional areas	$15,000

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**		
1. DISCHARGES										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric				389	408	427	440	453		
Total Acute	***0***	***0***	***0***	***389***	***408***	***427***	***440***	***453***	***0***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL DISCHARGES	***0***	***0***	***0***	***389***	***408***	***427***	***440***	***453***	***0***	***0***
2. PATIENT DAYS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric				4,177	4,380	4,586	4,726	4,865		
Total Acute	***0***	***0***	***0***	***4,177***	***4,380***	***4,586***	***4,726***	***4,865***	***0***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	***0***	***0***	***0***	***4,177***	***4,380***	***4,586***	***4,726***	***4,865***	***0***	***0***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**		
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA										
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric				10.74	10.74	10.74	10.74	10.74		
Total Acute										
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL AVERAGE LENGTH OF STAY										
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL LICENSED BEDS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**		
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA										
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric				71.5%	75.0%	78.5%	80.9%	83.3%		
Total Acute				**71.5%**	**75.0%**	**78.5%**	**80.9%**	**83.3%**		
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL OCCUPANCY %				**71.5%**	**75.0%**	**78.5%**	**80.9%**	**83.3%**		
6. OUTPATIENT VISITS										
a. Emergency Department										
b. Same-day Surgery										
c. Laboratory										
d. Imaging										
e. Other (Specify/add rows of needed)	40,019	40,765	43,211	45,804	47,178	48,593	50,051	51,552		
TOTAL OUTPATIENT VISITS	***40,019***	***40,765***	***43,211***	***45,804***	***47,178***	***48,593***	***50,051***	***51,552***	***0***	***0***
7. OBSERVATIONS**										
a. Number of Patients										
b. Hours										

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

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

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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 consistent with the Financial Feasibility standard.						
Indicate CY or FY	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**		
1. REVENUE										
a. Inpatient Services	$ -	$ -	$ -	$ 7,606,771	$ 7,976,456	$ 8,351,604	$ 8,606,559	$ 8,859,693		
b. Outpatient Services	$ 12,130,246	$ 12,495,864	$ 13,378,072	$ 14,180,756	$ 14,606,178	$ 15,044,364	$ 15,495,695	$ 15,960,566		
c. Professional Services	$ -	$ -	$ -	$ 229,735	$ 240,900	$ 252,230	$ 259,930	$ 267,575		
Gross Patient Service Revenues	***$ 12,130,246***	***$ 12,495,864***	***$ 13,378,072***	***$ 22,017,262***	***$ 22,823,534***	***$ 23,648,198***	***$ 24,362,184***	***$ 25,087,834***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ -	$ -	$ -	$ 156,730	$ 164,347	$ 172,077	$ 177,330	$ 182,545		
d. Contractual Allowance	$ -	$ -	$ -	$ 783,651	$ 821,736	$ 860,383	$ 886,649	$ 912,727		
e. Charity Care	$ -	$ -	$ -	$ 156,730	$ 164,347	$ 172,077	$ 177,330	$ 182,545		
Net Patient Services Revenue	***$ 12,130,246***	***$ 12,495,864***	***$ 13,378,072***	***$ 20,920,151***	***$ 21,673,104***	***$ 22,443,661***	***$ 23,120,875***	***$ 23,810,017***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)										
NET OPERATING REVENUE	***$ 12,130,246***	***$ 12,495,864***	***$ 13,378,072***	***$ 20,920,151***	***$ 21,673,104***	***$ 22,443,661***	***$ 23,120,875***	***$ 23,810,017***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 9,848,702	$ 8,796,218	$ 9,218,437	$ 14,507,931	$ 14,785,531	$ 15,269,556	$ 15,512,681	$ 15,761,641		
b. Contractual Services	$ 1,948,148	$ 1,775,130	$ 1,860,336	$ 2,432,689	$ 2,502,957	$ 2,574,694	$ 2,639,949	$ 2,706,265		
c. Interest on Current Debt	$ 134,361	$ 170,964	$ 176,093	$ 176,093	$ 176,093	$ 176,093	$ 176,093	$ 176,093		
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ 190,186	$ 190,186	$ 190,186	$ 190,186		
e. Current Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
f. Project Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
g. Current Amortization	$ 6,528	$ 4,206	$ 4,332	$ 4,332	$ 4,332	$ 4,332	$ 4,332	$ 4,332		
h. Project Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
i. Supplies	$ 49,447	$ 90,417	$ 93,130	$ 559,005	$ 582,949	$ 607,248	$ 624,251	$ 641,166		
j. Other Expenses:	$ 1,264,619	$ 1,063,481	$ 1,095,385	$ 1,350,979	$ 1,378,727	$ 1,406,889	$ 1,431,790	$ 1,456,898		
j. Other Expenses: Property Lease	$ 539,389	$ 525,665	$ 525,665	$ 914,465	$ 914,465	$ 914,465	$ 914,465	$ 914,465		
j. Other Expenses: Moveable Equipment / IT Lease Costs				$ 215,000	$ 215,000	$ 215,000	$ 215,000	$ 215,000		
TOTAL OPERATING EXPENSES	***$ 13,791,195***	***$ 12,426,081***	***$ 12,973,378***	***$ 20,160,494***	***$ 20,750,240***	***$ 21,358,463***	***$ 21,708,746***	***$ 22,066,046***	***$ -***	***$ -***
3. INCOME										
a. Income From Operation	***$ (1,660,948)***	***$ 69,783***	***$ 404,694***	***$ 759,657***	***$ 922,865***	***$ 1,085,198***	***$ 1,412,128***	***$ 1,743,970***	***$ -***	***$ -***
b. Non-Operating Income	$ 1,759,192	$ (4,584)	$ (4,584)	$ (4,584)	$ (4,584)	$ (4,584)	$ (4,584)	$ (4,584)		
SUBTOTAL	***$ 98,243***	***$ 65,198***	***$ 400,110***	***$ 755,073***	***$ 918,280***	***$ 1,080,614***	***$ 1,407,544***	***$ 1,739,386***	***$ -***	***$ -***
c. Income Taxes	$ 132,579	$ 3,373	$ 112,031	$ 211,420	$ 257,119	$ 302,572	$ 394,112	$ 487,028		
NET INCOME (LOSS)	***$ (34,335)***	***$ 61,825***	***$ 288,079***	***$ 543,652***	***$ 661,162***	***$ 778,042***	***$ 1,013,432***	***$ 1,252,358***	***$ -***	***$ -***

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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 consistent with the Financial Feasibility standard.						
Indicate CY or FY	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**		
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	11.0%	9.0%	10.0%	6.4%	6.4%	6.4%	6.4%	6.4%		
2) Medicaid	72.0%	78.0%	70.0%	73.6%	73.6%	73.6%	73.6%	73.6%		
3) Blue Cross	1.0%	1.0%	5.0%	4.1%	4.1%	4.1%	4.1%	4.1%		
4) Commercial Insurance	5.0%	3.0%	5.0%	6.2%	6.3%	6.3%	6.3%	6.3%		
5) Self-pay	1.0%	1.0%	1.0%	2.4%	2.4%	2.5%	2.5%	2.5%		
6) Other	10.0%	8.0%	9.0%	7.2%	7.2%	7.2%	7.2%	7.2%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare	11.0%	9.0%	10.0%	6.5%	6.5%	6.4%	6.4%	6.4%		
2) Medicaid	72.0%	78.0%	70.0%	73.5%	73.5%	73.6%	73.6%	73.6%		
3) Blue Cross	1.0%	1.0%	5.0%	4.1%	4.1%	4.1%	4.1%	4.1%		
4) Commercial Insurance	5.0%	3.0%	5.0%	6.2%	6.2%	6.2%	6.2%	6.2%		
5) Self-pay	1.0%	1.0%	1.0%	2.4%	2.4%	2.4%	2.4%	2.4%		
6) Other	10.0%	8.0%	9.0%	7.3%	7.2%	7.2%	7.2%	7.2%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**		
1. REVENUE										
a. Inpatient Services	$ -	$ -	$ -	$ 7,606,771	$8,235,691.00	$8,873,579.00	$9,402,666.00	$9,945,005.00		
b. Outpatient Services	$ 12,130,246	$ 12,495,864	$ 13,378,072	$ 14,570,727	$ 15,420,564	$ 16,319,969	$ 17,271,831	$ 18,279,210		
c. Professional Services	$ -	$ -	$ -	$ 229,735	$248,729.00	$267,994.00	$283,974.00	$300,353.00		
Gross Patient Service Revenues	***$ 12,130,246***	***$ 12,495,864***	***$ 13,378,072***	***$ 22,407,233***	***$ 23,904,984***	***$ 25,461,542***	***$ 26,958,471***	***$ 28,524,568***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ -	$ -	$ -	$ 156,730	$ 169,688	$ 182,831	$ 193,733	$ 204,907		
d. Contractual Allowance	$ -	$ -	$ -	$ 783,651	$ 848,442	$ 914,157	$ 968,664	$ 1,024,536		
e. Charity Care	$ -	$ -	$ -	$ 156,730	$ 169,688	$ 182,831	$ 193,733	$ 204,907		
Net Patient Services Revenue	***$ 12,130,246***	***$ 12,495,864***	***$ 13,378,072***	***$ 21,310,122***	***$ 22,717,165***	***$ 24,181,721***	***$ 25,602,341***	***$ 27,090,218***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
NET OPERATING REVENUE	***$ 12,130,246***	***$ 12,495,864***	***$ 13,378,072***	***$ 21,310,122***	***$ 22,717,165***	***$ 24,181,721***	***$ 25,602,341***	***$ 27,090,218***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 9,848,702	$ 8,796,218	$ 9,218,437	$ 14,797,758	$ 15,534,783	$ 16,517,261	$ 17,277,167	$ 18,070,218		
b. Contractual Services	$ 1,948,148	$ 1,775,130	$ 1,860,336	$ 2,471,682	$ 2,593,743	$ 2,721,038	$ 2,845,305	$ 2,974,387		
c. Interest on Current Debt	$ 134,361	$ 170,964	$ 176,093	$ 176,093	$ 176,093	$ 176,093	$ 176,093	$ 176,093		
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ 190,186	$ 190,186	$ 190,186	$ 190,186		
e. Current Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
f. Project Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
g. Current Amortization	$ 6,528	$ 4,206	$ 4,332	$ 4,332	$ 4,332	$ 4,332	$ 4,332	$ 4,332		
h. Project Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
i. Supplies	$ 49,447	$ 90,417	$ 93,130	$ 561,882	$ 603,447	$ 646,917	$ 683,996	$ 722,104		
j. Other Expenses:	$ 1,264,619	$ 1,063,481	$ 1,095,385	$ 1,373,544	$ 1,429,664	$ 1,487,816	$ 1,544,163	$ 1,602,287		
j. Other Expenses: Property Lease	$ 539,389	$ 525,665	$ 525,665	$ 785,465	$ 785,465	$ 785,465	$ 785,465	$ 785,465		
j. Other Expenses: Moveable Equipment / IT Lease Costs				$ 215,000	$ 215,000	$ 215,000	$ 215,000	$ 215,000		
TOTAL OPERATING EXPENSES	***$ 13,791,195***	***$ 12,426,081***	***$ 12,973,378***	***$ 20,385,756***	***$ 21,532,712***	***$ 22,744,108***	***$ 23,721,706***	***$ 24,740,072***	***$ -***	***$ -***
3. INCOME										
a. Income From Operation	***$ (1,660,948)***	***$ 69,783***	***$ 404,694***	***$ 924,366***	***$ 1,184,453***	***$ 1,437,613***	***$ 1,880,635***	***$ 2,350,146***	***$ -***	***$ -***
b. Non-Operating Income	$ 1,759,192	$ (4,584)	$ (4,584)	$ (4,584)	$ (4,584)	$ (4,584)	$ (4,584)	$ (4,584)		
SUBTOTAL	***$ 98,243***	***$ 65,198***	***$ 400,110***	***$ 919,781***	***$ 1,179,869***	***$ 1,433,029***	***$ 1,876,051***	***$ 2,345,562***	***$ -***	***$ -***
c. Income Taxes	$ 132,579	$ 3,373	$ 112,031	$ 257,539	$ 330,363	$ 401,248	$ 525,294	$ 656,757		
NET INCOME (LOSS)	***$ (34,335)***	***$ 61,825***	***$ 288,079***	***$ 662,243***	***$ 849,506***	***$ 1,031,781***	***$ 1,350,757***	***$ 1,688,804***	***$ -***	***$ -***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	11.0%	9.0%	10.0%	6.5%	6.5%	6.4%	6.4%	6.4%		
2) Medicaid	72.0%	78.0%	70.0%	73.5%	73.5%	73.6%	73.6%	73.6%		
3) Blue Cross	1.0%	1.0%	5.0%	4.1%	4.1%	4.1%	4.1%	4.1%		
4) Commercial Insurance	5.0%	3.0%	5.0%	6.2%	6.2%	6.3%	6.3%	6.3%		
5) Self-pay	1.0%	1.0%	1.0%	2.4%	2.4%	2.4%	2.4%	2.4%		
6) Other	10.0%	8.0%	9.0%	7.3%	7.2%	7.2%	7.2%	7.2%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**		
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	11.0%	9.0%	10.0%	#REF!	#REF!	#REF!	#REF!	#REF!		
2) Medicaid	72.0%	78.0%	70.0%	#REF!	#REF!	#REF!	#REF!	#REF!		
3) Blue Cross	1.0%	1.0%	5.0%	#REF!	#REF!	#REF!	#REF!	#REF!		
4) Commercial Insurance	5.0%	3.0%	5.0%	#REF!	#REF!	#REF!	#REF!	#REF!		
5) Self-pay	1.0%	1.0%	1.0%	#REF!	#REF!	#REF!	#REF!	#REF!		
6) Other	10.0%	8.0%	9.0%	#REF!	#REF!	#REF!	#REF!	#REF!		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***#REF!***	***#REF!***	***#REF!***	***#REF!***	***#REF!***	***0.0%***	***0.0%***

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	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 J and K.						
Indicate CY or FY	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
1. DISCHARGES							
a. General Medical/Surgical*	0						
b. ICU/CCU	0						
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0						
d. Obstetric	0						
e. Acute Psychiatric	389	408	427	440	453	453	453
Total Acute	**389**	**408**	**427**	**440**	**453**	**453**	**453**
f. Rehabilitation	0						
g. Comprehensive Care	0						
h. Other (Specify/add rows of needed)	0						
TOTAL DISCHARGES	**389**	**408**	**427**	**440**	**453**	**453**	**453**
2. PATIENT DAYS							
a. General Medical/Surgical*	0						
b. ICU/CCU	0						
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0						
d. Obstetric	0						
e. Acute Psychiatric	4177	4380	4586	4726	4865	4865	4865
Total Acute	**4177**	**4380**	**4586**	**4726**	**4865**	**4865**	**4865**
f. Rehabilitation	0						
g. Comprehensive Care	0						
h. Other (Specify/add rows of needed)	0						
TOTAL PATIENT DAYS	**4,177**	**4,380**	**4,586**	**4,726**	**4,865**	**4,865**	**4,865**
3. AVERAGE LENGTH OF STAY							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	10.74	10.74	10.74	10.74	10.74	10.74	10.74
Total Acute	10.74	10.74	10.74	10.74	10.74	10.74	10.74
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL AVERAGE LENGTH OF STAY	10.74	10.74	10.74	10.74	10.74	10.74	10.74

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	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 J and K.						
Indicate CY or FY	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	16	16	16	16	16	16	16
Total Acute	***16***	***16***	***16***	***16***	***16***	***16***	***16***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL LICENSED BEDS							
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	71.5%	75.0%	78.5%	80.9%	83.3%	83.3%	83.3%
Total Acute	**71.5%**	**75.0%**	**78.5%**	**80.9%**	**83.3%**	**83.3%**	**83.3%**
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL OCCUPANCY %	**71.5%**	**75.0%**	**78.5%**	**80.9%**	**83.3%**	**83.3%**	**83.3%**
6. OUTPATIENT VISITS							
a. Emergency Department							
b. Same-day Surgery							
c. Laboratory							
d. Imaging							
e. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***
7. OBSERVATIONS**							
a. Number of Patients							
b. Hours							

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

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

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
1. REVENUE							
a. Inpatient Services	$7,606,771.0	$7,976,456.0	$8,351,604.0	$8,606,559.0	$8,859,693.0		
b. Outpatient Services							
c. Professional Fees	$229,735.0	$240,900.0	$252,230.0	$259,930.0	$267,575.0		
Gross Patient Service Revenues	***$7,836,506.0***	***$8,217,356.0***	***$8,603,834.0***	***$8,866,489.0***	***$9,127,268.0***		
c. Allowance For Bad Debt	$156,730.0	$164,347.0	$172,077.0	$177,330.0	$182,545.0		
d. Contractual Allowance	$783,651.0	$821,736.0	$860,383.0	$886,649.0	$912,727.0		
e. Charity Care	$156,730.0	$164,347.0	$172,077.0	$177,330.0	$182,545.0		
Net Patient Services Revenue	***$6,739,395.0***	***$7,066,926.0***	***$7,399,297.0***	***$7,625,180.0***	***$7,849,451.0***		
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$6,739,395.0***	***$7,066,926.0***	***$7,399,297.0***	***$7,625,180.0***	***$7,849,451.0***		
2. EXPENSES							
a. Salaries & Wages (including benefits)	$4,847,009	$ 4,892,747	$ 5,139,345	$ 5,139,345	$ 5,139,345		
b. Contractual Services	$ 483,057	$ 506,533	$ 530,357	$ 546,547	$ 562,622		
c. Interest on Current Debt							
d. Interest on Project Debt		$ 190,186	$ 190,186	$ 190,186	$ 190,186		
e. Current Depreciation							
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Medical Supplies	$ 463,082	$ 485,587	$ 508,425	$ 523,946	$ 539,357		
j. Other Expenses:	$ 222,732	$ 233,556	$ 244,541	$ 252,006	$ 259,418		
j. Other Expenses: Property Lease	$ 259,800	$ 259,800	$ 259,800	$ 259,800	$ 259,800		
j. Other Expenses: Moveable Equipment / IT Lease Costs	$ 215,000	$ 215,000	$ 215,000	$ 215,000	$ 215,000		
TOTAL OPERATING EXPENSES	**$6,490,680**	**$6,783,410**	**$7,087,654**	**$7,126,831**	**$7,165,728**		
3. INCOME							
a. Income From Operation	**$ 248,715**	**$ 283,516**	**$ 311,643**	**$ 498,349**	**$ 683,723**	**$ -**	**$ -**
b. Non-Operating Income	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SUBTOTAL	***$ 248,715***	***$ 283,516***	***$ 311,643***	***$ 498,349***	***$ 683,723***	***$ -***	***$ -***
c. Income Taxes	$ 69,640	$ 79,385	$ 87,260	$ 139,538	$ 191,443	$ -	$ -
NET INCOME (LOSS)	***$ 179,075***	***$ 204,132***	***$ 224,383***	***$ 358,812***	***$ 492,281***	***$ -***	***$ -***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
a. Percent of Total Revenue							
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%		
2) Medicaid	80.0%	80.0%	80.0%	80.0%	80.0%		
3) Blue Cross	2.5%	2.5%	2.5%	2.5%	2.5%		
4) Commercial Insurance	8.5%	8.5%	8.5%	8.5%	8.5%		
5) Self-pay	5.0%	5.0%	5.0%	5.0%	5.0%		
6) Other	4.0%	4.0%	4.0%	4.0%	4.0%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***		
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%		
2) Medicaid	80.0%	80.0%	80.0%	80.0%	80.0%		
3) Blue Cross	2.5%	2.5%	2.5%	2.5%	2.5%		
4) Commercial Insurance	8.5%	8.5%	8.5%	8.5%	8.5%		
5) Self-pay	5.0%	5.0%	5.0%	5.0%	5.0%		
6) Other	4.0%	4.0%	4.0%	4.0%	4.0%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***		

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
1. REVENUE							
a. Inpatient Services	$7,606,771.00	$8,235,691.00	$8,873,579.00	$9,402,666.00	$9,945,005.00		
b. Outpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
c. Professional Fees	$ 229,735	$ 248,729	$ 267,994	$ 283,974	$ 300,353		
Gross Patient Service Revenues	***$ 7,836,506***	***$ 8,484,420***	***$ 9,141,573***	***$ 9,686,640***	***$ 10,245,358***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 156,730	$ 169,688	$ 182,831	$ 193,733	$ 204,907	$ -	$ -
d. Contractual Allowance	$ 783,651	$ 848,442	$ 914,157	$ 968,664	$ 1,024,536	$ -	$ -
e. Charity Care	$ 156,730	$ 169,688	$ 182,831	$ 193,733	$ 204,907	$ -	$ -
Net Patient Services Revenue	***$ 6,739,395***	***$ 7,296,601***	***$ 7,861,753***	***$ 8,330,511***	***$ 8,811,008***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)						$ -	$ -
NET OPERATING REVENUE	***$ 6,739,395***	***$ 7,296,601***	***$ 7,861,753***	***$ 8,330,511***	***$ 8,811,008***	***$ -***	***$ -***
2. EXPENSES	$ -	$ -	$ -	$ -	$ -	$ -	$ -
a. Salaries & Wages (including benefits)	$ 4,847,009	$ 5,039,529	$ 5,447,706	$ 5,601,886	$ 5,756,066	$ -	$ -
b. Contractual Services	$ 483,057	$ 516,664	$ 551,571	$ 579,340	$ 607,632	$ -	$ -
c. Interest on Current Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -
d. Interest on Project Debt	$ -	$ 190,186	$ 190,186	$ 190,186	$ 190,186	$ -	$ -
e. Current Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -
f. Project Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -
g. Current Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -
h. Project Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -
i. Supplies	$ 463,081	$ 500,155	$ 538,931	$ 571,102	$ 604,079	$ -	$ -
j. Other Expenses:	$ 222,732	$ 238,228	$ 254,323	$ 267,127	$ 280,172	$ -	$ -
j. Other Expenses: Property Lease	$ 259,800	$ 259,800	$ 259,800	$ 259,800	$ 259,800		
j. Other Expenses: Moveable Equipment / IT Lease Costs	$ 215,000	$ 215,000	$ 215,000	$ 215,000	$ 215,000		
TOTAL OPERATING EXPENSES	***$ 6,490,679***	***$ 6,959,562***	***$ 7,457,517***	***$ 7,684,441***	***$ 7,912,935***		
3. INCOME							
a. Income From Operation	**$ 248,716**	**$ 337,039**	**$ 404,236**	**$ 646,070**	**$ 898,073**		
b. Non-Operating Income							
SUBTOTAL	***$ 248,716***	***$ 337,039***	***$ 404,236***	***$ 646,070***	***$ 898,073***		
c. Income Taxes	$ 69,641	$ 94,371	$ 113,186	$ 180,900	$ 251,460		
NET INCOME (LOSS)	***$ 248,716***	***$ 242,668***	***$ 291,050***	***$ 465,170***	***$ 646,613***		
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%		
2) Medicaid	80.0%	80.0%	80.0%	80.0%	80.0%		
3) Blue Cross	2.5%	2.5%	2.5%	2.5%	2.5%		
4) Commercial Insurance	8.5%	8.5%	8.5%	8.5%	8.5%		
5) Self-pay	5.0%	5.0%	5.0%	5.0%	5.0%		
6) Other	4.0%	4.0%	4.0%	4.0%	4.0%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***		
b. Percent of Equivalent Inpatient Days							
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%		
2) Medicaid	80.0%	80.0%	80.0%	80.0%	80.0%		
3) Blue Cross	2.5%	2.5%	2.5%	2.5%	2.5%		
4) Commercial Insurance	8.5%	8.5%	8.5%	8.5%	8.5%		
5) Self-pay	5.0%	5.0%	5.0%	5.0%	5.0%		
6) Other	4.0%	4.0%	4.0%	4.0%	4.0%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***		

TABLE H. WORKFORCE INFORMATION

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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Administrator	1.00	$83,200	$83,200	1.00	$140,000	$140,000			$0	2.00	$223,200
Managers	5.00	$71,401	$71,401			$0	1.0	$71,401	$71,401	6.00	$142,802
			$0			$0			$0	0.00	$0
Total Administration	6.00		$154,601	1.00		$140,000			$71,401	7.00	$366,002
Direct Care Staff *(List general categories, add rows if needed)*											
Recreation Therapist			$0	1.00	$45,000	$45,000			$0	1.00	$45,000
Social Worker / Therapist	48.42	$61,909	$2,997,612	2.50	$63,600	$159,000	9.0	$61,909	$557,177	59.92	$3,713,789
RN	1.00	$51,812	$51,812	11.00	$83,000	$913,000			$0	12.00	$964,812
Occ. Therapist			$0	1.00	$87,000	$87,000			$0	1.00	$87,000
Psych Tech			$0	10.00	$37,800	$378,000			$0	10.00	$378,000
Nurse Manager			$0	1.00	$110,500	$110,500			$0	1.00	$110,500
Psychiatrist / Doctors	2.00	$188,452	$376,904				1.0	$188,452	$188,452	3.00	$565,356
Care Coordination	12.00	$43,555	$522,654				1.0	$43,555	$43,555	13.00	$566,209
PHP	1.00	$46,010	$46,010				2.0	$46,010	$92,019	3.00	$138,029
MA Assistant	1.00	$20,280	$20,280						$0	1.00	$20,280
Intern	2.00	$32,240	$64,480						$0	2.00	$64,480
Family Service Coordinator	9.00	$43,530	$391,768				2.0	$43,530	$87,060	11.00	$478,828
Therapist - DJS	2.40	$54,614	$131,074				1.0	$54,614	$54,614	3.40	$185,689
Total Direct Care	78.82		$4,602,594	26.50		$1,692,500			$1,022,877	105.32	$7,317,971
Support Staff *(List general categories, add rows if needed)*											
Discharge Coordinator			$0	1.50	$60,000	$90,000			$0	1.50	$90,000
Finance Staff	2.50	$41,877	$104,693	2.00	$55,000	$110,000			$0	4.50	$214,693
Reception/Assistant/Clerical	22.10	$31,597	$698,283	3.50	$35,000	$122,500	2.0	$31,597	$63,193	27.60	$883,976

TABLE H. WORKFORCE INFORMATION

UR/Billing	2.00	$42,813	$85,627	2.00	$55,000	$110,000			$0	4.00	$195,627
HIM/Medical Records			$0	1.00	$47,000	$47,000			$0	1.00	$47,000
Patient Services/Accounts			$0	2.00	$40,000	$80,000			$0	2.00	$80,000
Purchasing /Materials Management			$0	0.50	$25,000	$12,500			$0	0.50	$12,500
LAB	3.50	$73,989	$258,960						$0	3.50	$258,960
Drivers	1.00	$45,760	$45,760						$0	1.00	$45,760
IT	2.25	$51,280	$115,380						$0	2.25	$115,380
Maintenance	1.00	$37,440	$37,440						$0	1.00	$37,440
Total Support	34.35		$1,346,143	12.50		$572,000			$63,193	46.85	$1,981,336
REGULAR EMPLOYEES TOTAL	***119.17***		$6,103,338	***40.00***		$2,404,500			$1,157,471	***159.17***	$9,665,309
2. Contractual Employees											

TABLE H. WORKFORCE INFORMATION

Administration *(List general categories, add rows if needed)*											
Medical Director			$0	1.00	$115,000	$115,000			$0	1.00	$115,000
			$0			$0			$0	0.00	$0
			$0			$0			$0	0.00	$0
			$0			$0			$0	0.00	$0
			$0			$0			$0	0.00	$0
Total Administration			$0	1.00		$115,000			$0	1.00	$115,000
Direct Care Staff *(List general categories, add rows if needed)*											
Psychologist			$0	1.50	$85,000	$127,500			$0	1.50	$127,500
Psychiatrist	3.00	$378,352	$1,135,056	4.00	$380,000	$1,520,000			$0	7.00	$2,655,056
Infection Control / Health & Safety			$0	0.50	$63,000	$31,500			$0	0.50	$31,500
Clinical Psychiatrist Director	1.00	$346,885	$346,885			$0			$0	1.00	$346,885
Physicians	1.15	$205,860	$236,739			$0			$0	1.15	$236,739
			$0			$0			$0	0.00	$0
			$0			$0			$0	0.00	$0
Total Direct Care Staff	5.15		$1,718,679	6.00		$1,679,000			$0	11.15	$3,397,679
Support Staff *(List general categories, add rows if needed)*											
Security Officer			$0	7.20	$39,500	$284,400			$0	7.20	$284,400
Physical Plant Management / Maintenance			$0	1.00	$39,000	$39,000			$0	1.00	$39,000
Dietary/Food Service			$0	2.50	$45,000	$112,500			$0	2.50	$112,500
Professional Services	0.93	$124,020	$114,719			$0	0.03	$124,020	$3,319	0.95	$118,037
			$0			$0			$0	0.00	$0
			$0			$0			$0	0.00	$0
Total Support Staff	0.93		$114,719	10.70		$435,900			$3,319	11.63	$553,937
CONTRACTUAL EMPLOYEES TO	***6.08***		$1,833,398	***17.70***		$2,229,900			$3,319	***23.78***	$4,066,617
Benefits *(State method of calculating benefits below)* **:**			**1,281,701.0**			**504,945.0**					**2,029,714.8**
TOTAL COST	***125.25***		***$9,218,437***	***57.70***		***$5,139,345***	***0.0***		***$1,160,790***	***182.95***	***$15,761,640***