IN THE MARYLAND HEALTH CARE COMMISSION

APPLICATION FOR CERTIFICATE OF NEED

for the
Replacement and Relocation of
University of Maryland Shore Medical Center at Easton

Applicant
Shore Health System, Inc.
January 6, 2023

#765422
012516-0003

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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: University of Maryland Shore Medical Center at Easton

Address:

10000 Longwoods Rd	Easton, Maryland	21601	Talbot
Street	City	ZIP	County

Name of Owner (if differs from applicant):

2. OWNER

Name of owner: Shore Health System, 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
Shore Health System, Inc.

Address:

219 S. Washington St.	Easton	21601	MD	Talbot
Street	City	ZIP	State	County

Telephone: 410-822-1000

Name of Owner/Chief Executive: Kenneth Kozel, President and CEO

4. NAME OF LICENSEE
or proposed licensee, if different from applicant

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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	☐	
	(3) Close	☐	State & date of incorporation Maryland - ___/___/____
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: Arvin Singh, Vice President, Strategic Planning and Communications

Mailing Address:

University of Maryland Shore Regional Health

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Street	City	ZIP	State

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Fax: 410-468-2786

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.

As explained more fully in the Comprehensive Project Description below, the proposed project involves the replacement and relocation of University of Maryland Shore Medical Center at Easton, following a significant build out of health care services and facilities across the entire Mid-Shore region. The proposed replacement regional medical center will be relocated about three miles to the north of the existing facility and it will have 110 acute care beds and 12 special hospital rehabilitation beds, for a total of 122 inpatient beds. It will also have 25 observation beds. The facility will have seven operating rooms and 27 emergency department treatment spaces. The total project cost is estimated to be $539,558,871. The replacement facility is needed to address the aging, inefficient, and obsolete existing hospital building, and will compliment health care infrastructure developed in the five-county region over the past decade. The proposed replacement regional medical center is anticipated to open July 1, 2028.

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.

COMPREHENSIVE PROJECT DESCRIPTION

I. UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT EASTON

A. University of Maryland Shore Medical Center at Easton

Emergency Hospital, a 32-bed predecessor of University of Maryland Shore Medical Center at Easton ("UM SMC at Easton"), officially opened its doors on January 28, 1907, on South Washington Street in Easton. One of the driving forces for opening a hospital in the Mid-Shore Region of Maryland was that physicians wanted to treat their patients close to home instead of referring them to Baltimore for care. From its beginnings, Emergency Hospital was a regional provider of medical care, serving people of Talbot, Caroline, and Queen Anne's Counties.

In 1915, following the largest fundraising effort the community had ever seen, a new hospital was built on South Washington Street. This structure is still a small part of the present hospital complex. In 1943, the name of the hospital was changed to The Memorial Hospital at Easton to honor local men and women who served in both world wars and the many volunteers whose service helped establish the Emergency Hospital. Over many years, the hospital building was expanded and today's building includes components dating from 1915, 1920, 1929, 1955, 1975, 1982, and 2006.

Today, as the regional hub for a vast array of health care services on the Mid-Shore, UM SMC at Easton offers specialty services for cancer care, stroke, general surgery, urology, obstetrics and gynecology, otolaryngology, orthopedics and joint replacement, neurosurgery, pain management, diabetes management, wound healing, medical rehabilitation, behavioral health, digestive health, sleep disorders, palliative care, and home health care. Cardiovascular and pulmonary services include testing and procedures, PCI, cardiac catheterization, and an accredited cardio-pulmonary fitness and wellness program. Surgical services include minimally invasive and robotic assisted surgical procedures. In partnership with the University of Maryland Medical System and its affiliates, UM SMC at Easton operates kidney transplant and dialysis vascular access clinics to help people who are candidates for these services prepare for treatments. Inpatient critical care services are supported by the University of Maryland ICU telemedicine program, which provides remote, after-hours, critical care physician and nursing expertise and monitoring of patients in the ICU at UM SMC at Easton.

B. Formation of University of Maryland Shore Regional Health

In 1996, UM SMC at Easton merged with Dorchester General Hospital in Cambridge, Maryland to form Shore Health System, Inc. ("SHS"), a unified network of medical services with the combined resources of community hospitals, physicians, and outpatient centers. Until October 27, 2021, Dorchester General Hospital was known as University of Maryland Shore Medical Center at Dorchester ("UM SMC at Dorchester"). On October 28, 2021, UM SMC at Dorchester converted to a freestanding medical facility ("FMF") and relocated to a new building approximately one mile away from its original campus, and is now known as University of Maryland Shore Medical Center at Cambridge ("UM SMC at Cambridge"). University of Maryland Shore Emergency Center at Queenstown ("UM Shore EC at Queenstown"), an FMF located in Queen Anne's County, opened in October 2010 and is also part of SHS.

In 2006, SHS affiliated with the University of Maryland Medical System ("UMMS"), and as of July 1, 2013, SHS joined with the University of Maryland Shore Medical Center at Chestertown

(formerly known as Chester River Health System) ("UM SMC at Chestertown"), to become University of Maryland Shore Regional Health, Inc. ("UM SRH"). UM SRH is the sole corporate member of SHS.

The UM SRH network serves the five counties of the Mid-Shore region: Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties. Team members, consisting of more than 2,000 employees, a medical staff of 674, board members, and approximately 200 volunteers, work with various community partners to fulfill the mission of UMMS: to purposefully advance the shared principles that are foundational to our work: Compassionate, High Quality-Care; Commitment to Community; Health Care Transformation; and Discovery-Based Medicine. In fulfilling this mission, the UM SRH network helps advance the vision of the UMMS system of building upon its tradition of excellence in patient care and innovation to be a national leader in the transformation of health care.

UM SRH is the primary provider of health care services in the five-county Mid-Shore region, offering a full range of primary and specialty care services to more than 170,000 people.

C. University of Maryland Shore Medical Center at Chestertown

UM SRH includes two hospitals — UM SMC at Chestertown and UM SMC at Easton. As of fiscal year 2023, these hospitals have a combined total of 103 licensed acute care beds, plus a 20-licensed bed acute rehabilitation unit at UM SMC at Easton.[1]

On July 1, 2021, UM SMC at Chestertown began its transition to Maryland's first "Rural Hospital," modeled after Critical Access Hospitals ("CAH") operating in rural areas across the United States. Maryland's first "Rural Hospital" model provides acute inpatient care services with an operating capacity of up to 25 beds and a targeted annual average acute care inpatient length of stay of 96 hours or less. The hospital also provides 24-hour emergency services, seven days a week and is supported by an Emergency Medical Stabilization and Transfer Team ("EMSTAT"). The team provides on-site or telemedicine support by a specially trained team of doctors and nurses for the most critical patients to stabilize or facilitate transfer to a higher level of care as needed. UM SMC at Chestertown continues to provide ambulatory surgical services, as well as a full array of diagnostic and therapeutic services to local communities. For services not provided on location in Chestertown, patients are often referred to UM SMC at Easton, which provides more comprehensive services and programs. UM SMC at Chestertown's electronic medical record ("EMR") is integrated with other UM SRH facilities, making scheduling and access to records convenient and further enhancing continuity of care.

As the "hub of health care" serving rural communities in Kent and Queen Anne's Counties, UM SMC at Chestertown has aligned its strategic priorities to address the unique needs of rural residents by providing services and programs including mobile wellness, population health, health education, expanded inpatient telemedicine, a Geriatric Emergency Department designation, and development of an Aging and Wellness Center. UM SMC at Chestertown is also currently designated as a Level 2 Age-Friendly Health System ("AFHS"), a designation bestowed by the

[1] UM SMC at Easton is licensed for a total of 20 acute rehabilitation beds. However, the size of UM SMC at Easton's rehabilitation unit was reduced to 15 physical beds as a result of the consolidation with UM SMC at Dorchester.

Institute for Healthcare Improvement for hospitals that reliably provide certain evidence-based, geriatric interventions. These programs employ an integrated approach to meet the challenging health care demands of rural communities with an overarching goal of improving quality of life and wellness. By addressing chronic disease through prevention efforts and a coordinated approach to care management, it is also expected that the overall cost of care will be reduced proportionally. Rural hospitals have struggled significantly over the years, which has resulted in many rural hospital closures nationwide. This results in rural communities without adequate access to health care services, which contributes to the increase in the population's chronic disease burden and a relative increase in the total cost of care.

UM SMC at Chestertown's decision to adopt a rural hospital model was made after years of strategic planning and discussions with community stakeholders, State policymakers and legislators, the Maryland Department of Health, the Maryland Health Care Commission ("MHCC"), and the Health Services Cost Review Commission ("HSCRC") regarding the future of health care delivery in Kent and northern Queen Anne's Counties. Senate Bill 1010, passed during the 2019 Maryland General Assembly's Legislative Session, directed the MHCC, in conjunction with the Office of Health Care Quality, to assess the levels of services provided at UM SMC at Chestertown. The MHCC contracted with the Walsh Center for Rural Health Analysis at NORC at the University of Chicago ("the Walsh Center") to leverage findings from the assessment of services in the upper Mid-Shore region to identify options for meeting the health care needs of residents in this region. The Walsh Center issued its Final Report on Options for Rural Health Care Delivery in Maryland on January 9, 2020.[2] UM SMC at Chestertown's care delivery plan, including the adoption of the rural hospital model and planned development of an Aging and Wellness Center, aligns with the recommendations made in the Walsh Center's Final Report. UM SMC at Chestertown has positioned itself well to continue serving the needs of the upper Mid-Shore community and to become Maryland's first rural hospital pilot.

D. Other UM SRH Facilities and Services

In addition to its two hospitals, UM SRH includes UM Shore EC at Queenstown and UM SMC at Cambridge — Maryland's only two rural FMFs— and a broad array of outpatient services in locations throughout the five-county region. The FMFs are operated as outpatient departments of UM SMC at Easton in accordance with Maryland Code, Health General § 19-3A-01.

UM SRH also includes a network of outpatient centers offering diagnostic imaging and laboratory testing, primary care and specialty treatment, and rehabilitation services in Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties. UM SRH also has ambulatory surgery centers in Easton, Queenstown, and Cambridge. Table 1 below lists the various UM SRH outpatient centers throughout the five-county region as well as the specialties and clinicians located at these sites.

[2] The Walsh Center, Final Report: Options for Rural Health Care Delivery in Maryland (Jan. 9, 2020), https://mhcc.maryland.gov/mhcc/pages/home/commissioners/documents/20200116/Ag5a_Models_Rural_Health_Delivery.pdf.

Table 1
UM SRH Outpatient Centers in
Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties

County	Name	Address	Type	MD Disciplines & Number Represented at Site
Caroline	UM Shore Regional Health Diagnostics at Denton	1140 Blades Farm Rd, Denton, MD 21629	Imaging Center, Laboratory	N/A
	UM Shore Regional Health Rehabilitation at Denton	1140 Blades Farm Rd, Suite 201 Denton, MD 21629	Rehab OP Physical Therapy	N/A
	University of Maryland Urgent Care	8 Denton Plaza Denton, MD 21629	Urgent Care	Primary Care (1 MD, 1 NP - employed by University of Maryland Urgent Care)
	UM Shore Medical Group – Primary Care	1140 Blades Farm Rd, Suite 101 Denton, MD 21629	Primary Care	Primary Care (2 MD, 2 NP)
	UM Shore Medical Group-Multispecialty Office	1140 Blades Farm Rd, Suite 103 Denton, MD 21629	Cardiology, Pulmonary, GYN, Urology, Nephrology	Rotating
	UM Shore Medical Group – Diabetes & Endo	1140 Blades Farm Rd, Suite 101 Denton, MD 21629	Diabetes & Endo	Tuesday, Wednesday, & Friday Endo – 1MD
Dorchester	UM Shore Medical Pavilion at Cambridge	713 Cambridge Marketplace Blvd Cambridge, MD 21613	Imaging Services, Community Education, Laboratory Services, Sleep Disorders Clinic, Rehabilitation & Balance Center, infusion center. Cardiology, Pediatrics, Surgery Diabetes & Endocrinology, Gastro-enterology, Nephrology, Neurology & Sleep Medicine, Pulmonology, Urology, Women's Health	Cardiology (*1MD, *1NP), Neurology & Sleep Medicine (*1NP), Pediatrics (2 MD); Urology (*1MD), Pulmonology (*1 MD), Endocrinology (*1MD), Nephrology (*1MD, *1NP), Women's Health (*1,NP), Diabetes/Endo (*1MD), Surgery (1MD, 1NP)
	UM SRH Surgery Center at Cambridge	713 Cambridge Marketplace Blvd, Second Floor Cambridge, MD 21613	Freestanding Multispecialty ASC	Various disciplines
	UM Shore Medical Pavilion at Cambridge	715 Cambridge Marketplace Blvd Cambridge, MD 21613	Behavioral Health	Behavioral Health (2MD, 1NP)

County	Name	Address	Type	MD Disciplines & Number Represented at Site
Kent	UM Shore Medical Pavilion at Chestertown	100 Brown Street Chestertown, MD 21620	Imaging Services, Community Education, Laboratory Services, Outpatient Surgical Services , Sleep Disorders Clinic, Pediatrics (Community Physician), Primary Care, Diabetes & Endocrinology, Nephrology	MDs and NPs Diabetes/Endo (*1MD, *1NP), Nephrology (*1MD, *1NP), Primary Care (*1MD)
	UM Shore Medical Pavilion at Chestertown	126 Philosophers Terrace, Chestertown, MD 21620	Pulmonology, Urology, Women's Health, General Surgery, Cardiology, Primary Care	Pulmonology (1MD), Urology (1MD), Women's Health (*1NP), Surgery (1MD), Cardiology (*1MD),
	UM Shore Regional Health Lab Services	6602 Church Hill Road Chestertown, MD 21620	Lab	N/A
	UM SMG Primary Care	119-C North Main Street Galena, MD 21620	Primary Care**,** Lab	Primary Care (2 NP)
Queen Anne's	UM Shore Emergency Center at Queenstown	115 Shoreway Drive Queenstown, MD 21658	Freestanding Emergency Center	Emergency MDs and APPs
	UM Shore Surgery Center at Queenstown	125 Shoreway Drive, Third Floor Queenstown, MD 21658	Freestanding Multispecialty ASC	Orthopedics, Urology, Pain
	UM Shore Medical Pavilion at Queenstown	125 Shoreway Drive Queenstown, MD 21658	Lab, Imaging, Rehabilitation, Sleep Lab, Cardiology, ENT, Sinus & Hearing, Neurology & Sleep Medicine, Surgical Care, Urology, Woman's Health, Orthopedics	Cardiology (*1MD), Urology (*1MD), Woman's Health (*1 NP), Pulmonology (*1MD), Nephrology (*2MD, *1NP), ENT (*1MD), FPI Cardiovascular Surgery (1MD), FPI Surgery (1MD),FPI Bariatric Surgery (1MD); FPI Pediatrics (1MD), Orthopedics (R), Primary Care
	UM Shore Medical Group–Primary Care	2540 Centreville Road Centreville, MD 21617	Primary Care, Lab	Primary Care (3NPs)
Talbot	UM Shore Surgery Center at Easton	6 Caulk Lane Easton, MD 21601	Freestanding Multispecialty ASC	Various disciplines (R)
	UM Shore Regional Health Diagnostic and Imaging Center	10 Martin Court Easton, MD 21601	Imaging Center, Lab, Breast Center	Radiology (1 MD), Breast Surgeons (2 MD)

County	Name	Address	Type	MD Disciplines & Number Represented at Site
	UM Shore Regional Rehabilitation Center	10B Martin Court Easton, MD 21601	Rehabilitation, Swallowing Center	N/A
	UM Shore Medical Pavilion at Easton	490 Cadmus Lane Easton, MD 21601	Continence & Pelvic Health, ENT, Sinus & Hearing, Neurology & Sleep Medicine, Neurosurgery, Urology	Continence & Pelvic Health (1 MD), ENT, Sinus & Hearing (2 MD), Neurology & Sleep Medicine (2 MD/4 NP), Neurosurgery (1 MD, 1 NP), Urology (4 MD, 1 NP)
	UM Shore Medical Pavilion at Easton	500 Cadmus Lane Easton, MD 21601	Cardiology, Pediatrics, Primary Care, Pulmonary, Surgical Care/ Wound Care, Palliative Care, Infectious Disease	Cardiology (6 MD, 3NP), Pediatrics (3 MD, 1 NP), Primary Care (2 MD, 3NP), Pulmonary (5 MD), Surgical Care/ Wound Care (3 MD, 1 NP, 2PA); Infectious Disease (1MD), FPI Pediatrics
	UM Shore Regional Health Cancer Center	509 Idlewild Avenue Easton, MD 21601	Chemotherapy, radiation	Medical Oncology (3 MD, 1 NP), Radiation Oncology (2 MD)
	University of Maryland Urgent Care	28522 Marlboro Avenue Easton, MD 21601	Urgent Care	Primary Care (1 MD, 1 NP - employed by University of Maryland Urgent Care)
	The Orthopedic Center	510 Idlewild Avenue Easton, MD 21601	Orthopedics, ASC, OP rehabilitation/physical therapy, diagnostic imaging	Orthopedics (7MDs, 2 PAs) PM&R (1 MD)
	Digestive Health Center	511 Idlewild Avenue Easton, MD 21601	Gastroenterology, procedure center	Gastroenterologists (4 MDs, 3NPs)
	UM Shore Medical Group Women's Health	522 Idlewild Avenue Easton, MD 21601	OB/GYN	OB/GYN (4 MDs, 4 NPs, 5 CNM)
	UM Shore Medical Clark Comprehensive Breast Center	10 Martin Court Easton, MD 21601	Breast Center	Breast Center (1 MD, 1 NP)
	UM Shore Medical Group Nephrology	5 Martin Court, Easton, MD 21601	Nephrology	Nephrology (3 MDs, 2 NPs)

In addition to the outpatient centers identified in Table 1 above, UM SRH has outpatient clinics at UM SMC at Easton and UM SMC at Chestertown that provide various outpatient services in the hospitals. Similar to the outpatient centers, the outpatient clinics at the hospitals include staffing rotations by many of the same practitioners in order to provide adequate access to specialty care to residents in the area.

E. Physician Practices

UM SMC at Chestertown and UM SMC at Easton have a unified medical staff called the UM SRH Medical Staff. It includes physicians, physicians' assistants, nurse anesthetists, nurse midwives, and nurse practitioners. Physicians who practice at UM SMC at Chestertown and/or UM SMC at Easton specialize in a full range of clinical specialties, including internal medicine,

emergency medicine, cardiology, gastroenterology, hematology/oncology, radiation oncology, pediatrics, pulmonology, radiology, orthopedics, obstetrics, gynecology, anesthesiology, surgery, neurology, infectious disease, physical medicine and rehabilitation, hospitalists' medicine, palliative care, wound care, and ophthalmology.

UM SRH includes University of Maryland Shore Medical Group ("UM SMG"), which employs more than 100 physicians and advanced practice providers in 20-plus specialties. UM SMG provides medical practice management for employed physicians and practices. UM SMG physicians provide primary care at offices in Easton, Chestertown, Centreville, Denton and Galena, as well as pediatric care at practices in Easton and Cambridge. Physicians also provide specialty care in otolaryngology, general surgery, endocrinology, psychiatry, obstetrics, gynecology, ENT, nephrology, urology, neurosurgery, neurology, physical medicine and rehabilitation, sleep medicine, and gastroenterology.

F. Honors and Accreditations

In addition to meeting all applicable Joint Commission standards, UM SMC at Easton maintains accreditation in many clinical areas, including diabetes education, stroke care, ultrasound and mammography, cardiovascular and pulmonary rehabilitation, clinical laboratory testing, blood bank, sleep medicine, and vascular and echocardiography testing.

The Requard Center for Acute Rehabilitation at UM Shore Medical Center at Easton (the "Requard Center") is also accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF"). The Requard Center was re-accredited as of 2021 in both comprehensive rehabilitation and stroke rehabilitation. CARF is an independent, non-profit accrediting body with a mission to promote the quality, value and optimal outcomes of rehabilitation services provided in hospitals and nursing homes. The Requard Center's CARF accreditation includes Comprehensive Integrated Inpatient Rehabilitation Program ("CIIRP") and Stroke Specialty Program ("SSP").

The Requard Center is part of a comprehensive network of rehabilitation services that include inpatient acute physical, occupational, and speech therapy, and outpatient centers for continued treatment in Easton, Denton, Cambridge, and Queenstown. Physical therapists at the Balance Center in Cambridge assist physicians in the diagnosis and treatment of patients with balance problems associated with dizziness/vertigo, musculoskeletal disorders, and neurologic conditions.

In 2019, UM SRH had the distinction of achieving Magnet® accreditation demonstrating nursing excellence across its multiple campuses. The significance of this achievement is that it is the first designation awarded regionally, including UM SMC at Chestertown, and the third consecutive designation for the UM SMC at Easton campus and former UM SMC at Dorchester campus. Magnet® status recognizes UM SRH's interprofessional contributions to quality patient outcomes, transformational leadership, structural empowerment, exemplary professional practice, and innovation.

Five UM SRH sites (UM SMC at Easton, UM SMC at Chestertown, UM SMC at Cambridge, UM Shore EC at Queenstown, and the UM Shore Medical Pavilion outpatient location in Easton) are accredited by the Intersocietal Accreditation Commission ("IAC") for Cardiology. The IAC is a non-profit, nationally recognized accrediting organization, founded by medical professionals to advance appropriate utilization, standardization, and quality of diagnostic imaging and intervention-based procedures. UM SMC at Easton is designated by the Maryland Institute for Emergency

Medical Services Systems ("MIEMSS") as a Certified Cardiac Interventional Center ("CIC") which recognizes its expertise and skillset in the hospital setting. UM SMC at Easton has also achieved the Get with the Guidelines® Gold Standard for STEMI and Bronze Standard for NSTEMI. This American Heart Association ("AHA") program recognizes hospitals for their outstanding performance in high quality systems care performance by meeting or exceeding guideline therapy recommendations in treating patients presenting with STEMI / NSTEMI heart attacks. In addition, UM SRH's Cardiopulmonary Rehabilitation Program, with locations in Easton, Chestertown and Cambridge, is certified by the American Association of Cardiovascular and Pulmonary Rehabilitation ("AACVPR"). AACVPR Program Certification is the only peer-reviewed accreditation process designed to review individual facilities for adherence to standards and guidelines developed and published by the AACVPR and other professional societies.

Since 1999, the University of Maryland Shore Regional Health Regional Sleep Disorders Center has been accredited through AASM (American Academy of Sleep Medicine). While not all sleep centers are AASM accredited, UM SRH is dedicated to assuring the highest quality sleep testing possible by meeting all AASM requirements. The UM SRH sleep program consists of both in-lab and home sleep testing. These services are strategically located to best serve UM SRH's patient population.

The Commission on Cancer of the American College of Surgeons granted a three-year reaccreditation to the Shore Regional Cancer Program in 2022. The Commission on Cancer accreditation program acknowledges cancer treatment facilities that deliver quality patient care with a focus on prevention, early diagnosis, pre-treatment evaluation, optimal treatment, rehabilitation, surveillance for recurrent disease, support services, and end-of-life care. The Shore Regional Cancer Program, which includes the Requard Radiation Oncology Center, the Lenny Satchell Chemotherapy Suite, and the Shore Regional Health Clark Comprehensive Breast Center, combines sophisticated technology, skilled clinical practitioners, and oncology social workers who guide patients through diagnosis and treatment while providing the social and financial resources patients need to transition to life as a cancer survivor. The Cancer Program is also accredited by the National Accreditation Program for Breast Centers (2021 – 2025), further signifying adherence to stringent quality and care requirements for cancer treatment.

UM SMC at Easton is designated as a Primary Stroke Center by MIEMSS. On February 3, 2022, UM SMC at Easton received notice from MIEMSS of re-designation as a Primary Stroke Center for five additional years. In 2022, the Primary Stroke Center earned the Gold Plus award from the AHA and American Stroke Association. This is the seventh year in a row that UM SMC at Easton has received this award. This award recognizes hospitals that demonstrate achievement of an aggressive goal of treating patients through compliance with 85% or greater adherence to all "Get With The Guidelines®" stroke achievement indicators. The award also acknowledges that UM SMC at Easton has met the guidelines for the highest standards of stroke care for two or more consecutive 12-month periods and attained 75% or greater compliance with at least four of six "Get with the Guidelines" stroke quality measures. In 2019, the Stroke Center received Target: Stroke Honor Roll Elite recognition and in 2020, Target: Stroke Honor Roll recognition from the AHA and ASA. Target: Stroke recognition is awarded based on a hospital's performance in door-to-treatment times with the treatment of alteplase. The Stroke Center also earned the Target: Type 2 Diabetes Honor Roll award from the AHA, which is a new initiative aimed at promoting evidenced based practices for patients with Type 2 Diabetes. This award is given to hospitals who have demonstrated 90% or greater compliance for 12 consecutive months for the "Overall Diabetes Cardiovascular Initiative Composite Score." This score is calculated based on compliance with key

metrics such as adhering to treatment times for patients upon arrival to the hospital, and promoting treatment plans and specialized prescriptions for diabetic patients upon discharge. In 2019, UM SMC at Easton also received the "Golden Brain Award" from the Maryland Stroke Center Consortium ("MSCC"). The MSCC is comprised of leaders from stroke centers in Maryland, including stroke coordinators and stroke center directors, who meet every other month to review stroke care in Maryland and receive updates in stroke care nationally. The "Golden Brain Award" was an initiative started by the MSCC and is presented to the hospital with the fastest median door-to-needle time for patients who received alteplase, in a quarter.

The Joint Replacement Center at UM SMC at Easton is a CareFirst BlueCross BlueShield Blue Distinction Center for Knee and Hip Replacement. The specialty center is also a UnitedHealth Premium® Specialty Center for Total Joint Replacement. In addition to positive patient outcomes, the selection criteria used in evaluating the Joint Replacement Center for these distinctions were the Center's orthopedic surgeons' experience, training, and number of cases; the use of proven best medical practices, such as surgical checklists and other standardized processes to streamline patient care; and the preoperative education available to patients.

UM SRH has also been awarded the following distinctions in recent years:

- SHS won the 2012 Minogue Award for Safety Innovation from the Maryland Patient Safety Council.

- In 2018, UM SMC at Easton was ranked by *US News and World Report* as one of the top 10 best hospitals in Maryland.

- UM SMC at Easton and UM SMC at Chestertown have earned "A" grades from The Leapfrog Group, the leading independent patient safety advocacy organization. When eligible and using their Hospital Safety Grade methodology, UM SMC at Chestertown earned an "A" grade for three consecutive reporting periods (fall 2020, spring 2021, and fall 2021), and UM SMC at Easton earned an "A" grade for five consecutive reporting periods (fall 2020, spring 2021, fall 2021, spring 2022, and fall 2022). For the most recent designation, UM SMC at Easton was the only hospital to earn an "A" grade on the Eastern Shore.

- In 2022, for the 2022-2023 rankings by *U.S. News and World Report*, UM SMC at Easton (along with four other Maryland hospitals) was amongst a national group of "high performing" hospitals for "Best Hospitals for Maternity Care."

G. Community Support

Volunteers, foundations and donors for UM SMC at Chestertown and UM SMC at Easton donate time, talent, and money that support programs and services made available to the community at the two UM SRH hospitals, two FMFs, and at its outpatient centers around the region.

II. THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM

UMMS is dedicated to providing quality health care through a market-responsive regional system composed of a world-class academic medical center and partnerships with the University of Maryland School of Medicine and premier community and specialty hospitals. The people who

work at UMMS are continually thinking about the health and well-being of Marylanders and are committed to delivering a Better State of Care for patients, families, and communities.

Over the last 28 years, UMMS has grown significantly to become an expansive, Maryland-based health care delivery system. The medical system includes 12 hospitals and 150+ ambulatory and physician practice sites that are located throughout Maryland. UMMS' impact on the health and well-being of Marylanders is significant by any measure. UMMS generates nearly $4.7 billion in economic activity in Maryland. It has more than 27,400 team members, 5,500 active medical staff, approximately 2,450+ licensed beds, 101,000 annual patient admissions and $4.86 billion in revenue. UMMS supports an estimated 13,400 additional jobs through the purchase of goods and services. It is the largest health system serving the State of Maryland, comprising 25% of hospital care in Maryland, and providing more than $460 million in community benefits each year. These community services include medical education, subsidized programs, community funding, civic involvement, community service programs, and charity care. In addition to UM SRH's two hospitals, UM SMC at Easton and UM SMC at Chestertown, the other hospitals comprising UMMS include:

- University of Maryland Medical Center Downtown Campus ("UMMC Downtown Campus"), one of Maryland's two large academic medical centers, was established in 1823 in close collaboration with the first public medical school in the nation. Located on the west side of downtown Baltimore, UMMC Downtown Campus provides highly specialized tertiary and quaternary care for the entire state and region. It is a 739-licensed bed facility that provides a broad range of inpatient and outpatient services and functions as a teaching hospital. The Downtown Campus is home to the Greenebaum Comprehensive Cancer Center, the R Adams Cowley Shock Trauma Center, the University of Maryland Children's Hospital as well as other noted clinical programs such as organ transplantation, neurosciences, heart, and vascular.

- University of Maryland Medical Center Midtown Campus is a not-for-profit hospital corporation operating a 121-licensed bed acute and chronic care hospital. A community teaching hospital serving residents of the west side of Baltimore, Maryland, this facility was originally organized in 1881 by a group of Baltimore physicians to serve as a teaching hospital for medical students. It became affiliated with UMMS in 1999. The Midtown Campus is the hub for numerous clinical programs such as diabetes and endocrinology, infectious diseases, wound care and psychiatry services.

- University of Maryland Rehabilitation and Orthopaedics Institute is a private not-for-profit corporation that operates a hospital specializing in medical/surgical acute care and rehabilitation. It has four medical/surgical beds and 134 special hospital beds which includes 82 rehabilitation beds, 36 chronic disease bed, and 16 dually licensed chronic/rehabilitation beds. The facility also operates an outpatient therapy facility and a variety of outpatient clinics.

- University of Maryland St. Joseph Medical Center is a 207-licensed bed acute care hospital located in Towson, Maryland. UM St. Joseph Medical Center became affiliated with UMMS in 2012. It provides general medical and complex surgical services, intensive care, obstetrics, emergency care, neonatal and pediatric services, behavioral health care, and rehabilitation services.

- University of Maryland Baltimore Washington Medical Center is a not-for-profit, 314-licensed bed acute care hospital in northern Anne Arundel County. UM BWMC became affiliated with UMMS in 2000. It provides general medical, surgical, and emergency services and a comprehensive array of specialty care services.

- University of Maryland Charles Regional Medical Center is a not-for-profit, 104-licensed bed hospital located in La Plata, Maryland. The hospital opened in 1939 and serves the residents of Southern Maryland. It joined UMMS in July 2011.

- University of Maryland Upper Chesapeake Medical Center is a 202-licensed bed hospital that serves residents of northeastern Maryland. As a member of UM Upper Chesapeake Health, the hospital affiliated with UMMS in July 2009 in order to continue delivering excellence in care.

- University of Maryland Harford Memorial Hospital is a not-for-profit acute care facility located in Havre de Grace, Maryland. It is an 88-licensed bed facility and member of Upper Chesapeake Health and became affiliated with UMMS in 2009. This hospital is scheduled to convert to an FMF in 2023 as modern outpatient services are brought on line.

- University of Maryland Capital Region Medical Center, formerly Prince George's Hospital Center, is a 217-licensed bed hospital that serves residents of Prince George's County and the Washington, D.C. suburbs. UM Capital Region Medical Center provides acute care and specialty hospital services, and includes a Level II trauma center, cardio-thoracic surgery services, a Level III neonatal intensive care unit, and a future comprehensive cancer program. UM Capital Region Health also includes the University of Maryland Laurel Health and Wellness Campus and the University of Maryland Bowie Health Center, FMFs, which provide 24/7 emergency services and a range of outpatient services to patients in these communities. UM Capital Region and its parent corporation, Dimensions Healthcare System, affiliated with UMMS in 2017.

In addition to the hospitals listed above, through a joint venture arrangement, Mt. Washington Pediatric Hospital ("MWPH") is affiliated with UMMS. It is a private not-for-profit hospital corporation which operates a 102-licensed bed children's specialty and rehabilitation facility in Baltimore, seven miles from UMMC Downtown Campus. MWPH operates 15 licensed special pediatric rehabilitation beds in leased space at UM Capital Region Medical Center. MWPH has been providing services since 1922. On July 1, 2006, UMMS entered into an affiliation agreement with the Johns Hopkins Health System Corporation ("JHHS") whereby UMMS and JHHS each own 50% of the equity interest in MWPH.

III. THE PROPOSED PROJECT

Today, UM SMC at Easton is a regional medical center. UM SMC at Easton's primary service area ("PSA") and secondary service areas ("SSA") include ZIP Codes in Talbot, Dorchester, Caroline, Queen Anne's, and Kent Counties, as shown in Table 2 below. In fact, the majority of acute admissions to UM SMC at Easton come from outside of Talbot County.

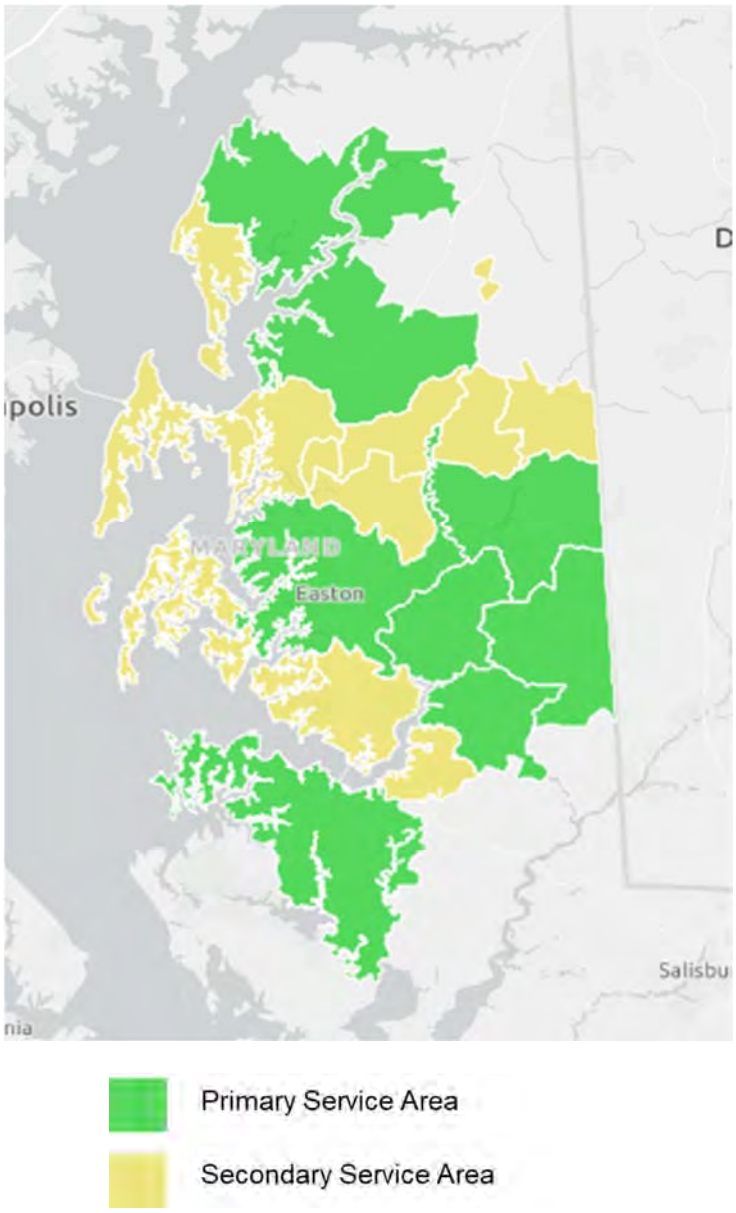
Table 2
UM SMC at Easton Primary and Secondary MSGA Service Areas
FY 2022

#	Zip Code	City	Service Area	County	Discharges	Cumulative % of Total
1	21601	Easton	Primary	Talbot County	862	22.0%
2	21613	Cambridge	Primary	Dorchester County	615	37.8%
3	21629	Denton	Primary	Caroline County	278	44.9%
4	21620	Chestertown	Primary	Kent County	154	48.8%
5	21643	Hurlock	Primary	Dorchester County	145	52.5%
6	21655	Preston	Primary	Caroline County	136	56.0%
7	21632	Federalsburg	Primary	Caroline County	134	59.4%
8	21617	Centreville	Primary	Queen Anne's County	132	62.8%
9	21663	Saint Michaels	Secondary	Talbot County	102	65.4%
10	21660	Ridgely	Secondary	Caroline County	97	67.9%
11	21639	Greensboro	Secondary	Caroline County	95	70.3%
12	21666	Stevensville	Secondary	Queen Anne's County	80	72.4%
13	21673	Trappe	Secondary	Talbot County	66	74.1%
14	21658	Queenstown	Secondary	Queen Anne's County	66	75.8%
15	21625	Cordova	Secondary	Talbot County	64	77.4%
16	21631	East New Market	Secondary	Dorchester County	64	79.0%
17	21638	Grasonville	Secondary	Queen Anne's County	55	80.4%
18	21654	Oxford	Secondary	Talbot County	45	81.6%
19	21619	Chester	Secondary	Queen Anne's County	43	82.7%
20	21661	Rock Hall	Secondary	Kent County	39	83.7%
21	21662	Royal Oak	Secondary	Talbot County	28	84.4%
22	21679	Wye Mills	Secondary	Talbot County	15	84.8%
23	21657	Queen Anne	Secondary	Queen Anne's County	11	85.1%

Source: hMetrix statewide non-confidential data tapes

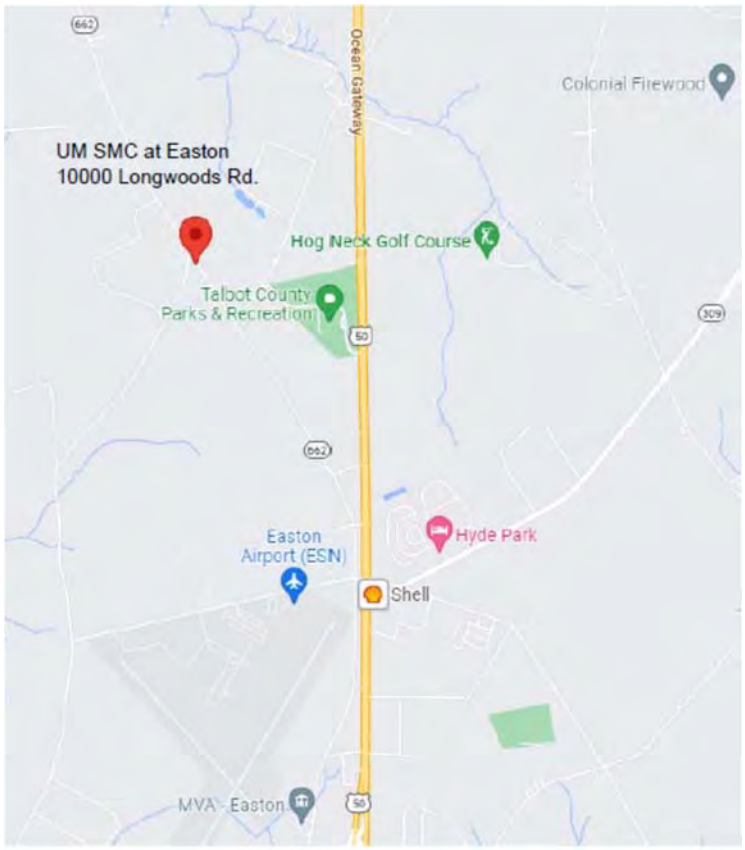
The service areas are shown in Figure 1.

Figure 1
Primary and Secondary Service Areas—UM SMC at Easton
FY 2022



The proposed project involves relocating UM SMC at Easton to a site approximately 3.5 miles north of the present location.[3] The proposed new location is 10000 Longwoods Road near the intersection of U.S. Route 50, as shown in Figure 2 below. The proposal follows the successful conversion of UM SMC at Dorchester to an FMF and consolidation of inpatient services from UM SMC at Dorchester to the existing UM SMC at Easton facility, located in downtown Easton. As part of this consolidation of inpatient services, UM SMC at Easton increased its licensed MSGA beds by 17 beds, and opened a new unit with 12 licensed psychiatric beds, as of October 2021.These beds and services are now part of the proposed replacement hospital that is the subject of this CON application.

Figure 2
Location of Proposed Replacement Hospital



[3] The Applicant filed a CON application in 2012 to seek approval of a similar project on the same site. That application was docketed, but was withdrawn on July 6, 2018, without prejudice, because the project had changed significantly following docketing. The Applicant filed a new CON application in September 2018 for a similar project on the same site, but MHCC's review of the application was deferred at SHS's request.

A. Summary of the Existing Hospital

The existing facility is comprised of four components from different eras. A small portion of the building was built in 1915. The majority of the building, including most of the inpatient units, was constructed in phases between 1955 and 1975. A four-story inpatient addition was made in 1982, with a fifth floor in 1990. Lastly, a one story ambulatory and emergency wing was constructed in 2006. With the majority of the building constructed between 1955 and 1982, with primarily semi-private patient rooms, this facility is functionally obsolete for inpatient care. (A diagram showing the existing building and the years when the different components were constructed is included in **Exhibit 3**.) As explained fully in the discussion of need in response to the need review criterion (COMAR 10.24.01.08G(3)(b)), the existing building is aged and obsolete.

B. Detailed Description of the Replacement Hospital

The new regional medical center will be located at 10000 Longwoods Road on approximately 200 acres, just north of the Easton Municipal Airport and adjacent to the Talbot County Community Center. The site is predominantly a greenfield site, not all of which will be used for the hospital campus.

The proposed replacement regional medical center will be relocated about three miles to the north of the existing facility and it will have 110 acute care beds and 12 special hospital rehabilitation beds, for a total of 122 inpatient beds. It will also have 25 observation beds. Attached to the hospital will be a two story multi-services building. The first floor of the building will include the hospital's regulated outpatient clinics, and the second floor of the building will include a full-service laboratory (which will also support other community based medical facilities) and administrative and education functions.

Overall, the new facility will include six floors.

The first floor will include:

- Registration
- Lobby
- Patient Advocacy/Guest Relations
- Imaging
- Cardiovascular Services
- Emergency Department (27 treatment spaces & 3 Behavioral Health Holding spaces)
- Observation Unit (25 beds)
- Support Services
- Kitchen
- Dining
- Gift Shop
- Security
- Clinical Information Management
- Outpatient Clinics

The second floor will include:

- Sterile Processing
- Pharmacy
- Catheterization & E.P. Labs
- PACU
- Surgery Suite (7 operating rooms)
- Prep/Stage II Recovery
- Nursing Administration
- Chapel
- Hospitalists
- Human Resources
- Lab Services
- Administration / Education

The third floor will include:

- MSGA Unit (27 beds), including one pediatric bed
- Obstetrics (11 beds), LDR, C-Section, and Nursery

The fourth floor will include:

- MSGA Unit (24 beds)
- ICU (12 beds)
- Inpatient Dialysis
- Respiratory Therapy

The fifth floor will include:

- MSGA Unit (24 beds)
- 12 Bed Requard Center (Acute Rehabilitation Unit)

The sixth floor will include:

- Behavioral Health (12 beds)
- On-Call

UM SRH has not yet determined the future use of the existing campus. The UM SRH Board has directed President and CEO Kenneth Kozel to convene a special study group to begin the process to analyze and direct the disposition of the existing hospital site. UM SRH plans to start the planning process while approval of the CON application is underway by the MHCC and has established the process by which that will occur.

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

See **Exhibit 1**, Table B.

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.

See **Exhibit 1**, Table A.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 199.123 acres. The total area conveyed under a deed from Talbot County to Shore Health System, Inc., dated October 23, 2015, is 223.3 acres in eleven parcels described in the deed. Four of the eleven parcels (199.123 acres) comprise the developable site. The remaining seven parcels (24.182 acres) will be transferred to an adjoining landowner or the State Highway Administration for storm water management or road right-of-way.

B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES _____ NO __X__ (If NO, describe below the current status and timetable for receiving necessary approvals.)

The 2010 Town Comprehensive Plan designates the project site for future development as a "regional-scale", "campus-style facility" containing a new hospital, medical offices and related services. Similarly, the 2005 County Comprehensive Plan, as amended by County Resolution No. 159, designates the property as a "primary growth area" or "Priority Development Area" appropriate for "a regional medical health care facility and related uses." The Talbot County Comprehensive Water and Sewer Plan designates the project site for immediate service by the Town of Easton's water and sewer systems. The project site was annexed by the Town of Easton on January 21, 2010. The Town adopted a new, specialized zoning district that is intended to facilitate the development of a regional medical campus, including a hospital. Concurrent with annexation, the Town amended its zoning map to apply the new Regional Healthcare (RH) zoning district to the entire project site. Pursuant to Article 23A, Section 9(c) of the Annotated Code of Maryland, the Talbot County Council expressly approved the RH rezoning of the project site.

The proposed hospital is a permitted use under the RH zoning district. As such, the Applicant must obtain site plan approval from the Town of Easton Planning Commission, but no variances, special exceptions, or legislative land use approvals are required for development of the project. The Applicant negotiated a Developers Rights and Responsibilities Agreement (DRRA) with both the Town and County. The DRRA became effective on October 14, 2014 and is recorded among the Land Records of Talbot County, Maryland in Liber MAS 2304, folio 266. It contractually vests the Applicant's rights in the existing RH zoning for a period of 30 years and memorializes the parties' responsibilities for infrastructure required for the project.

Compliance with Town and State forest conservation regulations and permitting for wetland impacts were addressed prior to the acquisition of the

site. Sketch site plan approval for the prior project design was granted by the Easton Planning Commission on November 15, 2012. The revised plans that are the subject of this application will be reviewed by the Planning Commission to update the prior site plan approval. The Town site plan review process will be initiated after submission of this CON application. The timeframe for completion of this process is dependent, in part, on the nature and extent of public participation and municipal comments and revisions, but is expected to require four to seven months. Following re-approval of the sketch site plan by the Planning Commission, review and approval of the "development site plan" or construction drawings are completed by Town staff. All other State and local approvals incidental to the development approval process, such as stormwater management, sediment and erosion control, and local and State Highway Administration access permitting, will be obtained or modified concurrent with the site plan review process.

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

(1) Owned by: Shore Health System, Inc.
Please provide a copy of the deed. A copy of the deed dated October 23, 2015, which is recorded among the Land Records of Talbot County, Maryland in Liber MAS 2304, folio 432, is attached as **Exhibit 4.**

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

(3) Land Lease held by: _____
Please provide a copy of the land lease as an attachment.

(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	15	months

Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	4	months
Completion of project from capital obligation or purchase order, as applicable	36	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 date of the binding construction contract.		Months
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

See **Exhibit 2.**

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.

See **Exhibit 1**, 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.

Utilities (water, electricity, sewage, etc.) must be brought to the property line. Costs are included in the project budget to do so. The Applicant will coordinate with the County, Town, and other utility providers to assure that this will be accomplished in time for construction of the new buildings.

A. Water: A new 12-inch water loop will be extended from the terminus of the existing water main at the Goldsborough Neck Road/Hailem School Road intersection along the easterly edge of Hailem School Road to the north end of the project site. The main will then follow the northerly property line to the proposed 400,000 gallon elevated water storage tank. A second new main will be extended up relocated Longwoods Road, following the northerly property line to the proposed water tank to complete the system loop. Two independent service laterals to the hospital, one from the water main along the northern property line and a second from Longwoods Road, will enter the building at the central plant, near the truck loading dock. The proposed water system is designed to deliver 1,600 gpm at 20 psi for fire suppression with a 90-minute duration, as mandated by the University of Maryland Medical System insurance provider. The average daily domestic water demand is estimated to be 225,000 gpd.

B. Sanitary Sewer: The first phase of the sanitary sewer will consist of a conventional gravity sewer with pumping station and force main. The gravity sewer will consist of PVC main and pre-cast concrete manholes set at intervals along the sewer main. Some manholes will be stubbed out for future use. The pump station will be constructed out of concrete and have two pumps for pumping wastewater through a 12" force main to the Town of Easton's existing sewer collection system. Phase II will consist of a conventional gravity sewer that will receive wastewater from future facility and development around the hospital and will connect into the Phase I sewer system.

C. Storm Drains: Catch basins will be located as required to intercept surface runoff from the drives and parking lots. Roof drain connections are anticipated along the perimeter of the hospital. Pipe for storm drains will typically be smooth interior HDPE. Reinforced concrete pipe may be used in public rights-of-way as required by the Town of Easton and/or State of Maryland. The increase in hard surface areas will require the design and installation of a stormwater management system to reduce discharge rates to those presently exiting the site into the receiving channels. Water quality treatment will be provided onsite by BMPs (Best Management Practices) such as bio-retention areas, landscape infiltration, grass swales, and stormwater planters. Quantitative management and channel protection will be provided in extended detention dry ponds in compliance with Maryland Department of the Environment (MDE) and Federal Aviation Administration (FAA) stormwater requirements.

D. Natural Gas: Natural gas is provided by Easton Utilities (EU). EU has indicated there is sufficient pressure and quantity of natural gas to serve this project.

E. Electric Power: EU is the electric utility. As mentioned above, overhead electric lines will be relocated underground and adequate electric service will be brought to the hospital site.

F. Telephone: Verizon is the principal telephone service provider in this area. Existing overhead lines on existing Route 662 will be relocated underground along the revised Route 662 alignment and adequate phone service will be provided for the hospital campus.

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 **Exhibit 1**, Table E and supporting assumptions.

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.

   Owner: Shore Health System, Inc.
   Responsible Individual: Kenneth D. Kozel, MBA, FACHE, President and CEO, University of Maryland Shore Regional Health and Shore Health System, Inc.

   Address: 219 South Washington St., Easton, Maryland 21601

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.

   The Responsible individual has been involved in the management of the following health care facilities:

President and CEO, University of Maryland Shore Regional Health ("UM SRH") and Shore Health System, Inc. ("SHS")	October 2011 – Present
President, UCH Hospitals and COO, Upper Chesapeake Health System ("UCH")	January 2011 – October 2011
Executive Vice President, Chief Operating Officer (UCH)	June 2009 – December 2010
Sr. Vice President and Chief Operating Officer (UCH) **Vice President, Operations (UCH)**	May 2005 – June 2009 January 2004 – May 2005
Assistant Vice President, Ambulatory Services and Business Development (UCH)	July 2003 – January 2004
Director, Ambulatory Services (UCH) & Director, Laboratory Services, Harford Memorial Hospital ("HMH")	March 2002 – July 2003
Director, Laboratory Services (HMH)	February 1997 – March 2002

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.

   The Applicant notes that this response is limited to information relevant to Shore Health System for compliance inquiries and investigations and to actions by regulatory bodies that resulted in penalties, admission bans, probationary status, or other sanctions at these facilities within the last five years.

   On October 18, 2022, Shore Health Systems, Inc. entered into a voluntary Settlement Agreement with the Maryland Department of the Environment to resolve alleged violations of the Maryland Department of the Environment's Radiation Management regulations. SHS agreed to pay $15,000, but did not admit liability.

   On May 6, 2022, UM Shore Regional Health entered into a voluntary Settlement Agreement with the Office of the Inspector General of the Department of Health and Human Services to resolve alleged violations of the False Claims Act based on claims that it improperly billed for unsupervised services. UM SRH agreed to pay $296,870 but did not admit liability.

   On June 8, 2021, UM Shore Regional Health and Shore Health Systems, Inc. entered into a voluntary Settlement Agreement with the Maryland Office of the Attorney General to resolve an alleged overpayment. UM SRH and SHS together agreed to pay $15,175, but did not admit liability. SHS also entered into a voluntary Settlement Agreement with the United States on June 29, 2019 related to the same allegations in which it agreed to pay $9,493,177, but did not admit liability.

   The Settlement Agreements described above are non-public documents.

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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.

11/28/2022
Date

Signature of Owner or Board-designated Official

President & CEO
Position/Title

Kenneth D. Kozel, MBA, FACHE
Printed Name

PART IV - CONSISTENCY WITH PROJECT REVIEW STANDARDS AND GENERAL REVIEW CRITERIA

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). <u>The State Health Plan</u>.

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. <u>In cases where demonstrating compliance with a standard requires the provision of specific documentation, documentation must be included as a part of the application.</u>

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.

COMAR 10.24.10. Acute Care Chapter

.04A. GENERAL STANDARDS

The following general standards encompass Commission expectations for the delivery of acute care services by all hospitals in Maryland. Each hospital that seeks a Certificate of Need for a project covered by this Chapter of the State Health Plan must address and document its compliance with each of the following general standards as part of its Certificate of Need application. Each hospital that seeks a Certificate of Need exemption for a project covered by this Chapter of the State Health Plan must address and demonstrate consistency with each of the following general standards as part of its exemption request.

Standard .04A (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.

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

Applicant Response:

UM SMC at Easton has a written policy in place that meets the requirements of this standard. See **Exhibit 5.** This policy addresses all parts of this standard: procedures on maintenance of the Representative List of Services and Charges; procedures for responding to requests for information regarding current charges for specific services and procedures**;** and requirements for staff training on inquiries regarding charges for services.

The current list of representative services and charges for inpatient and outpatient services is readily available to the public, both in written form at UM SMC at Easton and on the hospital's website under the section titled "Average Charges by Type of Patient Group" (https://www.umms.org/shore/patients-visitors/for-patients/hospital-charges). It is also attached as **Exhibit 6.** The most recent representative list of services and charges available is from the first quarter of fiscal year 2023, and will be updated quarterly, as required, as soon as more recent charges are available.

Standard .04A(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.

Applicant Response:

UM SMC at Easton provides inpatient and other care to all patients regardless of the ability to pay. A copy of the hospital's Financial Assistance Policy is attached as **Exhibit 7.** Notices regarding the availability of charity care at the hospital are posted in the Emergency Department and in the Admission and Business Offices. A copy of that notice is attached as **Exhibit 8.** An annual notice is published in the following newspapers: *The Star Democrat, The Caroline County Times-Record, Kent County News, Dorchester Star, and The Bay Times and Record Observer*. See **Exhibit 9**. Each patient or patient representative is advised of UM SMC at Easton's charity care policy at the time of admission or outpatient registration. The hospital's Financial Assistance Policy specifically states that it will make a determination of probable eligibility within two business days following a patient's request for charity care services, application for medical assistance, or both. Financial counselors assist individuals to prepare and file all documents required to seek charity care at 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:

The most recent Community Benefit Report from the HSCRC is from fiscal year 2020. As shown in Table 3 below, UM SMC at Easton fell within the third quartile in fiscal year 2020, with charity care comprising 1.34% of its total operating expenses.

Table 3
HSCRC Community Benefit Report, Data Excerpts
FY 2020

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	%	
Garrett County Memorial Hospital	$49,847,123	$3,088,077	6.20%	1st Quartile
Holy Cross	$453,889,368	$25,216,478	5.56%	
Holy Cross German Town	$108,611,245	$4,804,910	4.42%	
Doctors Community Hospital	$215,413,138	$9,425,649	4.38%	
Western Maryland Health System	$333,791,774	$12,451,700	3.73%	
Mercy Medical Center, Inc.	$492,374,189	$17,767,062	3.61%	
Washington Adventist Hospital	$265,481,640	$9,248,445	3.48%	
Johns Hopkins Bayview Med. Center	$671,878,000	$21,680,000	3.23%	
UM Capital Region	$322,178,000	$10,373,355	3.22%	
MedStar Harbor Hospital Center	$191,182,619	$5,448,214	2.85%	
Shady Grove Adventist Hospital	$395,307,320	$11,221,259	2.84%	
St. Agnes Hospital	$460,174,000	$12,957,524	2.82%	2nd Quartile
MedStar St. Mary's Hospital	$162,834,942	$4,539,656	2.79%	
MedStar Good Samaritan Hospital	$263,976,142	$7,178,703	2.72%	
Peninsula Regional Medical Center	$493,289,357	$13,045,900	2.64%	
MedStar Union Memorial Hospital	$430,645,261	$9,977,661	2.32%	
MedStar Southern Maryland Hospital	$240,415,418	$5,442,147	2.26%	
MedStar Franklin Square Hospital	$549,838,800	$12,318,684	2.24%	
UM St. Joseph Medical Center	$340,304,000	$7,456,792	2.19%	
UM Harford Memorial	$88,580,314	$1,819,000	2.05%	
MedStar Montgomery General Hospital	$171,486,283	$3,193,638	1.86%	
Howard County General Hospital	$262,623,000	$4,679,000	1.78%	
Frederick Memorial Hospital	$356,515,000	$5,822,311	1.63%	3rd Quartile
UM Medical Center Midtown Campus	$232,223,000	$3,763,000	1.62%	
UM BWMC	$398,520,000	$6,375,000	1.60%	
Atlantic General Hospital	$134,967,041	$2,080,700	1.54%	
Suburban Hospital Association, Inc.	$311,199,000	$4,768,896	1.53%	
Calvert Memorial Hospital	$137,396,210	$2,092,026	1.52%	
UM Upper Chesapeake Medical Center	$272,962,267	$3,918,000	1.44%	
UM Shore Regional Health Chester River	$43,821,000	$624,742	1.43%	
UM Shore Regional Health Easton	$218,075,000	$2,913,105	1.34%	
Meritus Medical Center	$399,338,982	$5,280,200	1.32%	

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	%	
Johns Hopkins	$2,658,945,000	$35,066,500	1.32%	
Univ. of Maryland Medical Center	$1,692,179,000	$21,239,000	1.26%	
UM Shore Regional Health Dorchester	$34,558,000	$425,237	1.23%	4th Quartile
Union Hospital of Cecil County	$159,947,807	$1,429,900	0.89%	
Fort Washington Medical Center	$46,221,264	$400,374	0.87%	
UM Charles Regional Medical Center	$133,537,960	$1,088,000	0.81%	
Anne Arundel General Hospital	$585,311,000	$4,665,000	0.80%	
Northwest Hospital Center, Inc.	$249,673,000	$1,929,688	0.77%	
Sinai Hospital	$791,568,000	$5,349,000	0.68%	
Greater Baltimore Medical Center	$514,005,000	$2,193,000	0.43%	
Bon Secours Hospital	$66,479,100	$213,345	0.32%	
Carroll County General Hospital	$201,484,375	$503,782	0.25%	
McCready Foundation, Inc.	$10,283,006	$0	0.00%	
Total	**$17,148,098,364**	**$332,227,534**	**1.94%**	
* The Adventist Hospital System has requested and received permission to report their Community Benefit activities on a CY Basis. This allows them to more accurately reflect their true activities during the Community Benefit Cycle. The numbers listed in the 'FY 2020 Amount in Rates for Charity Care, DME, and NSPI' Column as well as the Medicaid Deficit Assessments from the Inventory spreadsheets reflect the Commission's activities for FY 2020 and therefore will be different from the numbers reported by the Adventist Hospitals.				

Source: HSCRC http://www.hscrc.state.md.us/init_cb.cfm

Standard .04A(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.

Applicant Response:

UM SMC at Easton is licensed by the State of Maryland. Its license is attached as **Exhibit 10**.

UM SMC at Easton is accredited by the Joint Commission. Its accreditation certificates are attached as **Exhibit 11.**

UM SMC at Easton is 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:

As noted in the Commission's recent decision in the CON review for the replacement and relocation of Washington Adventist Hospital, "subpart (b) of this standard is essentially obsolete in that it requires an improvement plan for any measure that falls within the bottom quartile of all hospitals' reported performance on that measure as reported in the most recent Maryland [Hospital Evaluation Performance Guide]." *In re Washington Adventist Hospital*, Docket No. 13-15-2349 (Nov. 18, 2015), Decision at 19-20. The Commission's new format for the Hospital Guide for Maryland Health Care Quality Reports does not report quality measures in a manner that shows hospitals' relative scores in quartiles, nor is it easy to determine the 90% level of compliance. Instead, the new Hospital Guide shows the hospital's rating as "below average," "average," or "better than average," in comparison to a Maryland hospitals' average score.

UM SMC at Easton scored "better than average" or "average" on 57 of the 76 quality measures. For an additional 15 quality measures, UM SMC at Easton did not have sufficient data to report. UM SMC at Easton scored "below average" on four quality measures. **Exhibit 12** identifies those quality measures for which UM SMC at Easton scored "below average" along with the corrective action plans for these measures.

COMAR 10.24.10 ACUTE CARE CHAPTER

.04B. PROJECT REVIEW STANDARDS

Standard .04B(1) – Geographic Accessibility

A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for its likely service area population. Optimal travel time for general medical/surgical, intensive/critical care and pediatric services shall be within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area.

Applicant Response:

In planning for the replacement regional medical center, UM SMC at Easton considered four different possible sites. UM SMC at Easton's considerations of each site are discussed in detail in the response to COMAR 10.24.10.04B(5) – Cost Effectiveness. The proposed site that UM SMC at Easton selected will optimize geographic accessibility to the service area population.

To address the requirement that travel time be considered based on the hospital's "likely service area population," UM SMC at Easton performed a study using Google Maps to determine the travel time from each ZIP Code in its service area to each of the four sites it considered. For the proposed site, the Talbot County Community Center (located on the adjacent property) was used as a proxy.

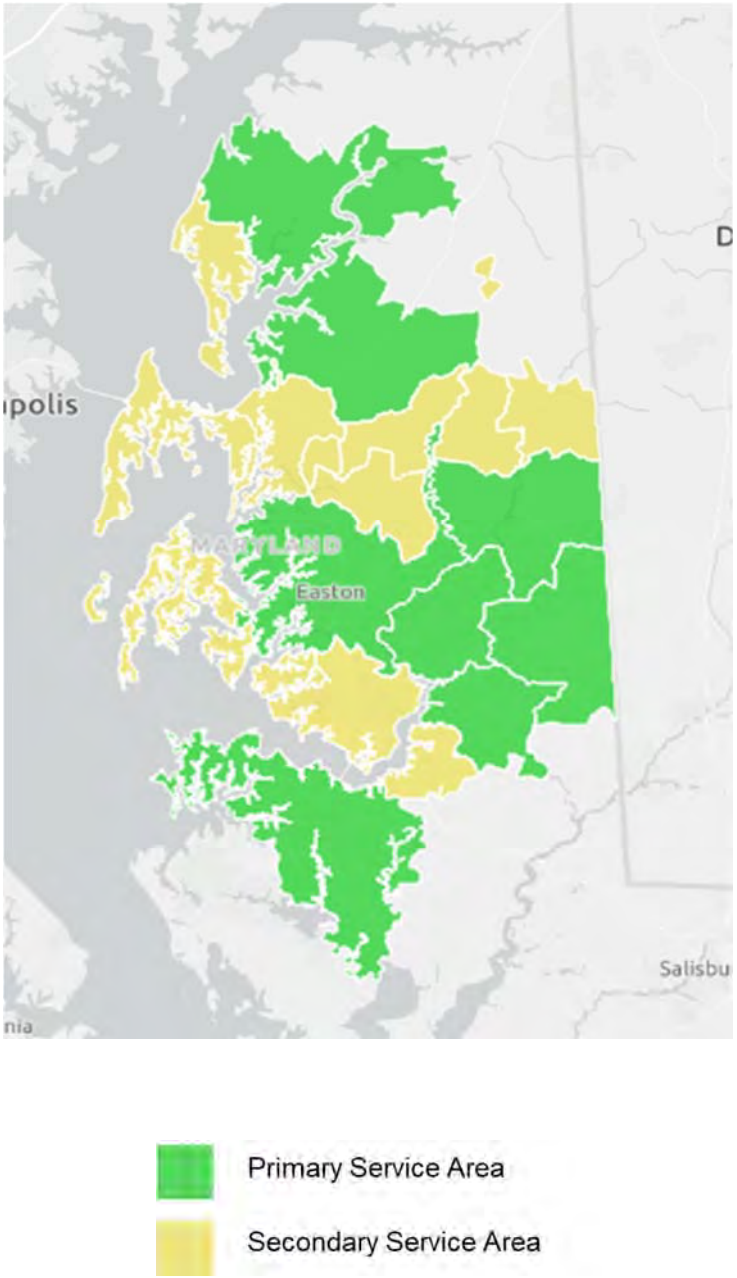
UM SMC at Easton's PSA includes eight ZIP Codes, and its SSA includes ten ZIP Codes. See Table 4 below.

Table 4
UM SMC at Easton Primary and Secondary MSGA Service Areas
FY 2022

ZIP	City	County	Discharges	Cumulative %
21601	Easton	Talbot County	855	22.0%
21613	Cambridge	Dorchester County	608	37.7%
21629	Denton	Caroline County	276	44.8%
21620	Chestertown	Kent County	153	48.7%
21643	Hurlock	Dorchester County	144	52.4%
21655	Preston	Caroline County	136	55.9%
21632	Federalsburg	Caroline County	134	59.4%
21617	Centreville	Queen Anne's County	132	62.8%
21663	Saint Michaels	Talbot County	102	65.4%
21660	Ridgely	Caroline County	96	67.9%
21639	Greensboro	Caroline County	95	70.3%
21666	Stevensville	Queen Anne's County	80	72.4%
21658	Queenstown	Queen Anne's County	66	74.1%
21673	Trappe	Talbot County	64	75.7%
21625	Cordova	Talbot County	63	77.3%
21631	East New Market	Dorchester County	63	78.9%
21638	Grasonville	Queen Anne's County	55	80.4%
21654	Oxford	Talbot County	45	81.5%
21619	Chester	Queen Anne's County	42	82.6%
21661	Rock Hall	Kent County	39	83.6%
21662	Royal Oak	Talbot County	28	84.3%
21679	Wye Mills	Talbot County	15	84.7%
21657	Queen Anne	Queen Anne's County	11	85.0%
Service Area Total			**3,302**	**85.0%**
Out of Service Area Total			583	15.0%
SHS Total			3,885	100.0%

The Service Areas are shown in Figure 3.

Figure 3
Primary and Secondary Service Areas—UM SMC at Easton
FY 2022



To obtain the average drive time to each site in minutes, the Applicant first determined the drive time that Google Maps estimated from the Post Office in each ZIP Code listed above to each site. UM SMC at Easton then multiplied the drive times by the 2029 population in each ZIP Code to obtain the weighted average drive time. The products of the drive times for the population for each ZIP Code were summed and divided by the total service area population to obtain the total weighted average drive time to each site.

The total weighted average drive time for the projected 2029 service area population to each site is summarized below. As this summary shows, the proposed site has a lower average drive time than the current site and the Bypass at Oxford Road site, and a slightly higher drive time (by 0.8 minutes) than the site in Northern Talbot County.

Table 5
Weighted Drive Times for 2029
Service Area Population

	219 South Washington St., Easton 21601 (Current Site)	Easton Bypass & Oxford Rd., Easton 21601 (Bypass at Oxford Road)	10028 Ocean Gateway Easton 21601 (Proposed Site)	Route 50 and 404, Wye Mill 21679 (Site in Northern Talbot County)
Average Drive Time in Minutes	26.1	25.1	23.5	22.7

When the travel times were multiplied by the projected 2029 service area population, the travel time savings associated with the proposed site were significant. For example, in total, the proposed site would save 421,808 minutes (or 7,030 hours) of drive time compared to the current site (4,235,817 minutes for the service area population to the current site minus 3,814,009 minutes to the proposed site = 421,808-person minutes; 421,808/60 minutes per hour = 7,030 hours).

The proposed site makes acute inpatient services available at UM SMC at Easton within 30 minutes for significantly more people than the current site. The projected population living within a 30-minute driving time of UM SMC at Easton's current site is 90,920 in 2029. The population living with a 30-minute driving time of UM SMC at Easton's proposed site is 135,802 in 2029. The Applicant recognizes that some portions of this population have access to other area hospitals as well. However, UM SMC at Easton is the only full-service hospital in Talbot County, and there are no full-service hospitals located in Caroline, Queen Anne's, or Dorchester counties. UM SMC at Easton is the closest hospital for many residents living in Caroline, Queen Anne's, and Dorchester counties. As a result, the replacement hospital is located optimally in terms of geographic access to the service area population.

Standard .04B(2) – Identification of Bed Need and Addition of Beds

Only medical/surgical/gynecological/addictions ("MSGA") beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.

(a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.

(b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection.

(c) Additional MSGA or pediatric beds may be developed or put into operation only if:

(i) The proposed additional beds will not cause the total bed

capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19-307.2; or

(ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter.

(iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or

(iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.

Applicant Response:

The State Health Plan provides that MSGA beds may be developed or put into operation only if, among other things, the "proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the Applicant can demonstrate need at the Applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection." (COMAR 10.24.10.04(B)(2)).

As an initial matter, COMAR 10.24.10.04(B)(2) is not applicable to the proposed project because the beds that the Applicant proposes to relocate are already developed and have been put into operation. Nevertheless, the Applicant demonstrates compliance with the standard as set forth below.

On January 20, 2017, the MHCC published the most recent MSGA bed need projection by jurisdiction in the Maryland Register (Vol. 44, Issue 2, pp. 160-162). At that time, UM SMC at Dorchester was still operating as a hospital with 22 licensed MSGA beds, and was approved in 2019 to move 17 licensed MSGA beds to UM SMC at Easton as part of the consolidation of these facilities. The replacement hospital for UM SMC at Easton will reflect MSGA beds currently at UM SMC at Easton and MSGA beds shifted from UM SMC at Dorchester as part of the consolidation of these facilities (see *Notice of Intent to Seek Exemption from Certificate of Need Review for the Merger and Consolidation of Certain Beds and Services of University of Maryland Shore Medical Center at Dorchester and University of Maryland Shore Medical Center at Easton,* Docket No. 18-20-EX007). As such, the projections for both Dorchester and Talbot Counties are presented below in Table 6.

Table 6
MHCC's MSGA Bed Need Projection by Jurisdiction
2025

Jurisdiction	Gross Bed Need		Licensed and Approved Beds	2025 Net Bed Need	
	Minimum	**Maximum**		**Minimum**	**Maximum**
Dorchester	25	32	22	3	10
Talbot	81	105	87	-6	18
Combined	**106**	**137**	**109**	**-3**	**28**

UM SMC at Easton is currently licensed to operate 72 MSGA beds (Acute General Licensed Bed Designation fiscal year 2023, Maryland Health Care Commission ("MHCC") and Office of Health Care Quality ("OHCQ"). See **Exhibit 13**. The current number of licensed beds at UM SMC at Easton falls below the range of projected bed need by the Commission for Dorchester and Talbot Counties in 2025. Using the MSGA bed need methodology and assumptions described below, the Applicant projects a need for 86 MSGA beds to serve the residents of the service area by fiscal year 2032.

Since the projected MSGA bed need at UM SMC at Easton will not exceed the MHCC's projection of MSGA bed need as presented above in Table 6, the proposed project is consistent with this standard.

MSGA Bed Need Calculation

1. Defining UM SMC at Easton's MSGA Service Area

To project the need for MSGA beds at the replacement hospital for UM SMC at Easton, the Applicant began by defining the service area from which UM SMC at Easton currently draws its inpatient MSGA discharges. Due to the conversion of UM SMC at Dorchester from a full-service hospital to an FMF in October 2021, the July 2021 through October 2021 admissions at UM SMC at Dorchester are considered when defining the service area for the replacement regional medical center. Following this conversion, UM SMC at Easton is the only provider of inpatient services within SHS.

Using fiscal year 2022 data, the Applicant accumulated the MSGA discharges from UM SMC at Easton and discharges from UM SMC at Dorchester through October 2021 by ZIP Code. The Applicant then ranked the ZIP Codes with the highest to lowest number of discharges to identify the ZIP Codes that comprise the top 85% of MSGA discharges and determined the ZIP Codes to be included in the service area. As presented in Table 7 below, the MSGA service area is defined by 23 ZIP Codes that span Talbot, Caroline, Dorchester, Queen Anne's, and Kent counties.

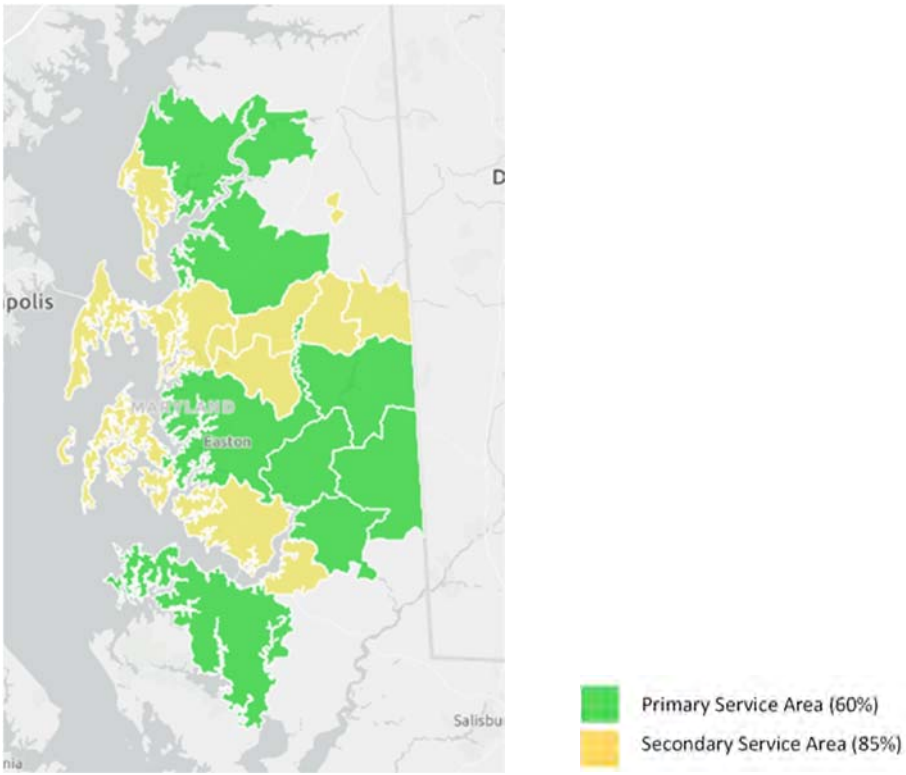
Table 7
UM SMC at Easton MSGA Service Area ZIP Codes and Discharges
FY 2022

ZIP	City	County	Discharges	Cumulative %
21601	Easton	Talbot County	855	22.0%
21613	Cambridge	Dorchester County	608	37.7%
21629	Denton	Caroline County	276	44.8%
21620	Chestertown	Kent County	153	48.7%
21643	Hurlock	Dorchester County	144	52.4%
21655	Preston	Caroline County	136	55.9%
21632	Federalsburg	Caroline County	134	59.4%
21617	Centreville	Queen Anne's County	132	62.8%
21663	Saint Michaels	Talbot County	102	65.4%
21660	Ridgely	Caroline County	96	67.9%
21639	Greensboro	Caroline County	95	70.3%
21666	Stevensville	Queen Anne's County	80	72.4%
21658	Queenstown	Queen Anne's County	66	74.1%
21673	Trappe	Talbot County	64	75.7%
21625	Cordova	Talbot County	63	77.3%
21631	East New Market	Dorchester County	63	78.9%
21638	Grasonville	Queen Anne's County	55	80.4%
21654	Oxford	Talbot County	45	81.5%
21619	Chester	Queen Anne's County	42	82.6%
21661	Rock Hall	Kent County	39	83.6%
21662	Royal Oak	Talbot County	28	84.3%
21679	Wye Mills	Talbot County	15	84.7%
21657	Queen Anne	Queen Anne's County	11	85.0%
Service Area Total			**3,302**	**85.0%**
Out of Service Area Total			583	15.0%
SHS Total			3,885	100.0%

Source: hMetrix statewide non-confidential data tapes
Note: Includes discharges from UM SMC at Dorchester through October 2021

Figure 4 below graphically shows UM SMC at Easton's primary and secondary service area.

Figure 4
UM SMC at Easton's MSGA Service Area
FY 2022



2. Projected MSGA Service Area Population Ages 15+

For the ZIP Codes included in the service area for UM SMC at Easton, population projections through 2027 were obtained from Environics Spotlight (formerly Nielsen Claritas) for the 15-64, 65-74 and 75+ age cohorts. These are presented below in Table 8. The 15-64 age cohort population is expected to increase 0.1% annually from 2022 to 2027. Additionally, the 65-74 and 75+ age cohort populations are expected to grow annually by 3.6% and 1.5%, respectively. In total, the projected population is expected to grow annually by 0.9% between 2022 and 2027.

Table 8
UM SMC at Easton's Historical and Projected
MSGA Service Area Population 2010 – 2027

	Service Area Population						% Change in Population	
	2010		2022		2027			
Age Cohort	Pop	% of Total	Pop	% of Total	Pop	% of Total	2010 - 2022	2022 - 2027
15-64	92,302	78.1%	89,853	71.8%	90,483	69.2%	-0.3%	0.1%
65-74	14,247	12.0%	19,953	15.9%	23,780	18.2%	3.8%	3.6%
75+	11,690	9.9%	15,347	12.3%	16,539	12.6%	3.1%	1.5%
Total	**118,239**	**100.0%**	**125,153**	**100.0%**	**130,802**	**100.0%**	**0.6%**	**0.9%**

Using the compounded annual growth rates from 2022 to 2027, population projections were extrapolated through fiscal year 2032. Table 9 below depicts the projected population for each age cohort by fiscal year. Led by the population over age 65, the total population is expected to grow annually by 0.9% to 1.0% from fiscal year 2022 to fiscal year 2032. Due to the higher annual growth rates of the 65-74 and 75+ age cohorts, these age cohorts make up a larger percentage of the population in fiscal year 2032 compared to fiscal year 2022.

Table 9
UM SMC at Easton's Historical and Projected MSGA Service Area Population
FY 2019 – FY 2032

MSGA	Historical				Projected										%Change
Age Cohort	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
15-64	90,459	90,257	90,055	89,853	89,979	90,104	90,230	90,357	90,483	90,610	90,736	90,863	90,990	91,117	1.4%
% Change		*-0.2%*	*-0.2%*	*-0.2%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	
65-74	18,342	18,864	19,401	19,953	20,666	21,404	22,168	22,960	23,780	24,629	25,509	26,420	27,364	28,341	42.0%
% Change		*2.8%*	*2.8%*	*2.8%*	*3.6%*	*3.6%*	*3.6%*	*3.6%*	*3.6%*	*3.6%*	*3.6%*	*3.6%*	*3.6%*	*3.6%*	
75+	14,337	14,666	15,003	15,347	15,578	15,813	16,051	16,293	16,539	16,788	17,041	17,298	17,559	17,824	16.1%
% Change		*2.3%*	*2.3%*	*2.3%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	
Total Service Area	**123,138**	**123,787**	**124,458**	**125,153**	**126,223**	**127,321**	**128,450**	**129,610**	**130,802**	**132,027**	**133,287**	**134,581**	**135,913**	**137,282**	9.7%
% Change		*0.5%*	*0.5%*	*0.6%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*1.0%*	*1.0%*	*1.0%*	*1.0%*	

3. MSGA Use Rates

Table 10 depicts the total use rate and use rate by age cohort for MSGA discharges per 1,000 population for ages 15 and older in UM SMC at Easton's defined service area in fiscal years 2019 through 2022. After a significant reduction in the MSGA use rate in fiscal year 2020 due to the COVID-19 pandemic, there was slight increase in fiscal year 2021 to a total MSGA use rate of 65.8 discharges per 1,000 population for ages 15 and over. In fiscal year 2022, total use rate declined again by 5.4%.

Table 10
UM SMC at Easton's Historical MSGA Service Area Use Rates
FY 2019 – FY 2022

	Historical			
MSGA Age Cohort	FY2019	FY2020	FY2021	FY2022
Age 15-64	46.5	37.7	39.5	36.6
% Change		-19.0%	4.7%	-7.3%
Age 65-74	121.9	101.7	100.5	97.7
% Change		-16.5%	-1.2%	-2.8%
Age 75+	233.4	180.3	178.8	166.4
% Change		-22.7%	-0.8%	-7.0%
Total Age 15+	**79.5**	**64.3**	**65.8**	**62.2**
% Change		-19.1%	2.2%	-5.4%

Prior to the pandemic, the Applicant was projecting an approximate 1% decline in MSGA use rate each year at each age cohort level based on an expected reduction in potentially avoidable utilization and on SHS's efforts to ensure care is being provided in less expensive care settings when appropriate in line with the Total Cost of Care Model. However, since there has been a substantial decline in the MSGA use rate due to COVID-19 in fiscal years 2020 to 2022, the Applicant now expects the MSGA use rate to remain stable through fiscal year 2032 at the age cohort level. The previously projected decline that was expected to occur steadily over time has been realized suddenly over the past three years. As the population ages into age cohorts with higher use rates, the overall MSGA use rate is projected to increase by 6.1% from fiscal year 2022 to 2032.

Table 11
UM SMC at Easton's Historical and Projected Service Area MSGA Use Rate
FY 2019 – FY 2032

MSGA	Historical				Projected										%Change
Age Cohort	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22 - FY32
Age 15-64	46.5	37.7	39.5	36.6	36.6	36.6	36.6	36.6	36.6	36.6	36.6	36.6	36.6	36.6	0.0%
% Change		-19.0%	4.7%	-7.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Age 65-74	121.9	101.7	100.5	97.7	97.7	97.7	97.7	97.7	97.7	97.7	97.7	97.7	97.7	97.7	0.0%
% Change		-16.5%	-1.2%	-2.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Age 75+	233.4	180.3	178.8	166.4	166.4	166.4	166.4	166.4	166.4	166.4	166.4	166.4	166.4	166.4	0.0%
% Change		-22.7%	-0.8%	-7.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Total	**79.5**	**64.3**	**65.8**	**62.2**	**62.6**	**63.0**	**63.4**	**63.7**	**64.1**	**64.5**	**64.9**	**65.3**	**65.7**	**66.1**	6.1%
% Change		*-19.1%*	*2.2%*	*-5.4%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	

4. MSGA Service Area Discharges

As shown in Table 12 below, based on the population growth and use rate assumptions described above, the 7,790 discharges in the MSGA service area in fiscal year 2022 are projected to increase 16.4% between fiscal years 2022 and 2032. The MSGA service area discharges will increase annually with a 0.9% to 1.0% annual increase in population and a 0.5% to 0.6% annual increase in the weighted average MSGA use rate.

Table 12
UM SMC at Easton's Historical and Projected MSGA Service Area Discharges
FY 2019 – FY 2032

	Historical				Projected										%Change
MSGA	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22 - FY32
Service Area Discharges	**9,789**	**7,964**	**8,186**	**7,790**	**7,903**	**8,019**	**8,137**	**8,260**	**8,385**	**8,514**	**8,647**	**8,784**	**8,924**	**9,068**	16.4%
% Change		*-18.6%*	*2.8%*	*-4.8%*	*1.4%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.6%*	*1.6%*	*1.6%*	*1.6%*	

5. UM SMC at Easton's MSGA Service Area Market Share

UM SMC at Easton's MSGA service area market share declined from 52.3% in fiscal year 2019 to 42.4% in fiscal year 2022. This decline is partially driven by the increased frequency of MIEMSS diversion status at UM SMC at Easton during the COVID-19 pandemic. *See* Applicant's response to the ED Treatment Capacity and Space Standard at COMAR 10.24.10.04B(14) for a detailed discussion of its recent MIEMSS Alerts. While UM SMC at Easton was on MIEMSS Yellow and Red Alerts, patients who may have otherwise arrived by emergency transport were routed to other facilities. As demonstrated in Table 13 below, the vast majority of patients admitted to UM SMC at Easton originate in the emergency department. During fiscal year 2022, 84.6% of UM SMC at Easton's MSGA admissions were admitted from the emergency department.

Table 13
UM SMC at Easton's Historical MSGA Discharges by Source of Admission
FY 2019 – FY 2022

Shore Health System MSGA Admissions	FY2019	FY2020	FY2021	FY2022	FY19 - FY22 % Variance
MSGA Admissions from ED	4,675	3,750	3,472	3,285	-29.7%
MSGA Total Admissions	6,003	4,766	4,245	3,885	-35.3%
MSGA Admissions from ED as a % of Total	**77.9%**	**78.7%**	**81.8%**	**84.6%**	**6.7%**

Table 14 below presents the number and total duration of MIEMSS Yellow and Red Alerts at UM SMC at Easton by fiscal year. From fiscal year 2019 to fiscal year 2022, the number of MIEMSS Alerts increased by 365.5% and the total hours with a Yellow or Red Alert in place increased by 3,754.2%. As a result of these alerts, a number of patients who would have otherwise been routed to the UM SMC at Easton emergency department (and subsequently may have been admitted to UM SMC at Easton as inpatients) were instead routed to the emergency departments at other facilities.

Table 14
UM SMC at Easton's Historical MIEMSS Red & Yellow Alerts
FY 2019 – FY 2022

Easton MIEMSS Alerts	FY2019	FY2020	FY2021	FY2022	FY19 - FY22 % Variance
Yellow Alert	49	27	95	178	263.3%
Red Alert	6	27	154	78	1,200.0%
Total Alerts	**55**	**54**	**249**	**256**	**365.5%**
Hours on Yellow Alert	151	81	600	2,084	1,282.2%
Hours on Red Alert	59	358	2,984	6,019	10,023.2%
Total Hours on Alert	**210**	**439**	**3,584**	**8,104**	**3,754.2%**

Source: CHATS Hospital MIEMSS Alert Tracker

Going forward, UM SMC at Easton's market share is expected to remain constant at the fiscal year 2022 level for each age cohort. Due to the aging of the population, the total MSGA market share for UM SMC at Easton will increase 0.7% from fiscal year 2022 to 2032, as shown in Table 15 below. The Applicant notes that this assumption is conservative, given the increase in MIEMSS alerts discussed above and the likelihood that the frequency of these alerts will normalize towards historical levels as pandemic related staffing issues improve.

Table 15
UM SMC at Easton's Historical and Projected MSGA Service Area Market Share
FY 2019 – FY 2032

MSGA	Historical				Projected										%Change
Age Cohort	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Age 15-64	46.2%	45.0%	40.6%	36.8%	36.8%	36.8%	36.8%	36.8%	36.8%	36.8%	36.8%	36.8%	36.8%	36.8%	0.0%
% Change		*-2.5%*	*-9.7%*	*-9.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
Age 65-74	50.1%	48.7%	44.6%	42.6%	42.6%	42.6%	42.6%	42.6%	42.6%	42.6%	42.6%	42.6%	42.6%	42.6%	0.0%
% Change		*-2.8%*	*-8.5%*	*-4.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
Age 75+	61.4%	58.8%	51.5%	49.4%	49.4%	49.4%	49.4%	49.4%	49.4%	49.4%	49.4%	49.4%	49.4%	49.4%	0.0%
% Change		*-4.3%*	*-12.4%*	*-4.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
Total	**52.3%**	**50.5%**	**45.1%**	**42.4%**	**42.4%**	**42.5%**	**42.5%**	**42.5%**	**42.5%**	**42.6%**	**42.6%**	**42.6%**	**42.7%**	**42.7%**	0.7%
% Change		*-3.5%*	*-10.6%*	*-6.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	

Note: Historical period includes discharges from UM SMC at Dorchester through October 2021

6. UM SMC at Easton's Out-of-Service Area MSGA Discharges

As shown in Table 16 below, UM SMC at Easton's out-of-service area MSGA discharges are projected to remain constant, as a percentage of service area discharges, at the age cohort level from fiscal year 2022 to 2032. Fluctuations from year to year in this percentage are due to aging of the population into older cohorts with fewer discharges from outside the service area.

Table 16
UM SMC at Easton's Historical and Projected Out-of-Service Area MSGA Discharges as % of Service Area Discharges
FY 2019 – FY 2032

	Historical				Projected									
MSGA	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032
Out-of-Service Area Discharge % of Service Area Discharges	**17.3%**	**18.6%**	**14.9%**	**17.7%**	**17.6%**	**17.6%**	**17.6%**	**17.6%**	**17.5%**	**17.5%**	**17.5%**	**17.5%**	**17.4%**	**17.4%**

Note: Historical period includes discharges from UM SMC at Dorchester through October 2021

7. UM SMC at Easton's Inpatient MSGA Discharges

Based on the population, use rate, market share and out-of-service area discharge assumptions described above, Table 17 below shows UM SMC at Easton's MSGA discharges, which are projected to increase from fiscal year 2022 to 2032 by 17.0%. Even with the population

growth and aging of the population described above, UM SMC at Easton's fiscal year 2032 projection of 4,547 MSGA discharges is 24.2% less than the 6,003 MSGA discharges that UM SMC at Easton and UM SMC at Dorchester experienced in fiscal year 2019 before the onset of the COVID-19 pandemic.

Table 17
UM SMC at Easton's Historical and Projected MSGA Discharges
FY 2019 – FY 2032

	Historical				Projected										%Change
MSGA	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Inpatient Discharges	**6,003**	**4,766**	**4,245**	**3,885**	**3,944**	**4,004**	**4,065**	**4,129**	**4,194**	**4,260**	**4,329**	**4,400**	**4,472**	**4,547**	**17.0%**
% Change		-20.6%	-10.9%	-8.5%	1.5%	1.5%	1.5%	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	1.7%	

Note: Historical period includes discharges from UM SMC at Dorchester through October 2021

8. MSGA Average Length of Stay

The average length of stay (ALOS) for MSGA patients at UM SMC at Easton increased from fiscal year 2019 to 2022, largely as a result of COVID-19 protocols, staffing shortages, and additional placement challenges to find post-acute care for patients following discharge. From fiscal year 2024 through fiscal year 2027, the ALOS is expected to decline by 0.025 days annually as staffing shortages improve. From fiscal year 2028 to fiscal year 2032, average length of stay is expected to remain constant by age cohort, as shown in Table 18 below.

Table 18
UM SMC at Easton's Historical and Projected ALOS
FY 2019 – FY 2032

	Historical				Projected										%Change
MSGA	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Average Length of Stay															
UM SMC at Easton	4.3	4.6	4.9	5.6	5.6	5.6	5.6	5.6	5.5	5.6	5.6	5.6	5.6	5.6	(0.1)
% Change		*5.4%*	*5.9%*	*16.9%*	*0.0%*	*-0.4%*	*-0.4%*	*-0.4%*	*-0.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*-1.5%*

Note: Historical period includes discharges from UM SMC at Dorchester through October 2021

9. MSGA Occupancy

The Applicant assumes an 80% occupancy of MSGA beds at UM SMC at Easton.

10. MSGA Bed Need

Based on the assumptions presented above, the Applicant has a calculated need for 75 MSGA beds in fiscal year 2022. This reflects an 80% occupancy assumption. The fiscal year 2023 licensed acute care bed designation of 72 reflects a lower occupancy assumption as a result of the 140% rule used to calculate licensed beds based on average daily census. The Applicant projects that the need for MSGA beds at UM SMC at Easton will increase to 86 MSGA beds by fiscal year 2032, as shown in Table 19 below.

Table 19
UM SMC at Easton's Historical and Projected MSGA Bed Need
FY 2019 – FY 2032

	Historical				Projected										%Change
MSGA	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Bed Need	**89**	**74**	**70**	**75**	**76**	**77**	**78**	**79**	**80**	**81**	**82**	**84**	**85**	**86**	**15.3%**
% Change		*-16.3%*	*-5.7%*	*7.0%*	*1.5%*	*1.1%*	*1.1%*	*1.1%*	*1.1%*	*1.6%*	*1.6%*	*1.7%*	*1.7%*	*1.7%*	

Note: Historical period includes discharges from UM SMC at Dorchester through October 2021

Pediatric Bed Need Calculation

UM SMC at Easton is currently licensed to operate three pediatric beds following the merger and consolidation with UM SMC at Dorchester in October 2021. Using the pediatric bed need methodology and assumptions described below, the Applicant projects a need for one pediatric bed to serve the residents of UM SMC at Easton's Service Area, ages 0-14, by fiscal year 2032.

1. Defining UM SMC at Easton's Pediatric Service Area

To project the need for pediatric beds at the replacement regional medical center for UM SMC at Easton, the Applicant defined its pediatric service area to be the same as the service area defined for MSGA discharges, as shown in Table 7 above.

2. Projected Pediatric Service Area Population

For the ZIP Codes included in the service area for UM SMC at Easton, population projections through 2027 were obtained from Environics Spotlight (formerly Nielsen Claritas) for the 0-14 age cohort. Using the compounded annual growth rates from 2022 to 2027, population projections were extrapolated through 2032 and applied to UM SMC at Easton's fiscal years.

As shown in Table 20 below, the population for the 0-14 age cohort is expected to remain at fiscal year 2022 levels from fiscal year 2022 to fiscal year 2032, with a total decline of 0.1% by fiscal year 2032.

Table 20
UM SMC at Easton's Historical and
Projected Pediatrics Service Area Population – Ages 0-14
FY 2019 – FY 2032

Pediatric	Historical				Projected										% Change
Age Cohort	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22 - FY32
0-14	**24,972**	**24,845**	**24,720**	**24,595**	**24,593**	**24,592**	**24,590**	**24,589**	**24,587**	**24,585**	**24,584**	**24,582**	**24,581**	**24,579**	**-0.1%**
% Change		*-0.5%*	*-0.5%*	*-0.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	

3. Pediatrics Service Area Use Rates

Table 21 presents the historical use rate per 1,000 population of pediatric discharges in the UM SMC at Easton Pediatrics Service Area for the 0-14 age cohort. While the service area use rate decreased from fiscal year 2019 to 2021, primarily due to the COVID-19 pandemic, the future use rate is projected to level off and remain constant from fiscal year 2022 to 2032.

Table 21
UM SMC at Easton's Historical and Projected Pediatrics Service Area Use Rate
FY 2019 – FY 2032

Pediatric Service	Historical				Projected										% Change
Area Use Rate	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Age 0-14	**12.0**	**10.5**	**8.6**	**10.4**	**10.4**	**10.4**	**10.4**	**10.4**	**10.4**	**10.4**	**10.4**	**10.4**	**10.4**	**10.4**	**0.0%**
% Change		*-11.9%*	*-18.7%*	*21.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	

4. UM SMC at Easton's Pediatrics Market Share & Out-of-Service Area Discharges

UM SMC at Easton's market share of the pediatric service area discharges declined from fiscal year 2019 to 2021. These fluctuations in market share, however, are due to the small sample size of pediatric admissions from the service area. UM SMC at Easton's market share of pediatric service area discharges is expected to level off at the fiscal year 2022 level and remain constant throughout the projection period. The fiscal year 2022 out-of-service area percentage of service area discharges is expected to remain constant throughout the projection period, as shown in Table 22 below.

Table 22
UM SMC at Easton's Historical and Projected Market Share and
Out-of-Service Area Pediatrics Discharges % of Service Area Discharges
FY 2019 – FY 2032

Pediatric Service Area	Historical				Projected										% Change
Market Share & OOS Area	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
UM SMC at Easton Market Share	**14.4%**	**17.6%**	**3.8%**	**9.4%**	**9.4%**	**9.4%**	**9.4%**	**9.4%**	**9.4%**	**9.4%**	**9.4%**	**9.4%**	**9.4%**	**9.4%**	**0.0%**
% Change		*22.1%*	*-78.5%*	*148.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
UM SMC at Easton Out of Service Area															
% of Service Area Discharges	**41.9%**	**15.2%**	**0.0%**	**12.5%**	**12.5%**	**12.5%**	**12.5%**	**12.5%**	**12.5%**	**12.5%**	**12.5%**	**12.5%**	**12.5%**	**12.5%**	**0.0%**
% Change		*-63.6%*	*-100.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	

5. UM SMC at Easton's Inpatient Pediatric Discharges

Based on the assumptions described above, UM SMC at Easton's pediatric discharges are projected to remain constant from fiscal year 2022 to fiscal year 2032, as shown in Table 23 below. The numbers shown below do not include pediatric observation patients who would also be treated in the proposed pediatric bed at the replacement regional medical center.

Table 23
UM SMC at Easton's Historical and Projected Pediatric Discharges
FY 2019 – FY 2032

Pediatric	Historical				Projected										% Change
Discharges	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Age 0-14	**61**	**53**	**8**	**27**	**27**	**27**	**27**	**27**	**27**	**27**	**27**	**27**	**27**	**27**	**0.0%**
% Change		*-13.1%*	*-84.9%*	*237.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	

Note: In FY 2021 and FY 2022 an additional 17 and 32 pediatric patients were treated in observation status, respectively.

6. Pediatrics Average Length of Stay

The average length of stay (ALOS) for pediatric patients at UM SMC at Easton increased slightly from fiscal year 2019 to 2022 but is projected to remain at the fiscal year 2022 ALOS through the projection period, as shown in Table 24 below.

Table 24
UM SMC at Easton's Historical and Projected Pediatric ALOS
FY 2019 – FY 2032

Pediatric	Historical				Projected										% Change
ALOS	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Age 0-14	**2.1**	**2.1**	**2.5**	**2.7**	**2.7**	**2.7**	**2.7**	**2.7**	**2.7**	**2.7**	**2.7**	**2.7**	**2.7**	**2.7**	**0.0%**
% Change		*1.4%*	*19.4%*	*6.7%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	

7. Pediatric Occupancy

The Applicant assumes a 50% occupancy for pediatric beds, which reflects the State Health Plan minimum occupancy standard (COMAR 10.24.10.05(D)(4)(b)) for pediatric inpatient services with an average daily census of 0-6 patients.

8. Pediatric Bed Need

Based on the assumptions presented above and the additional reasons presented below, the Applicant has a projected need for one pediatric bed at UM SMC at Easton by fiscal year 2032, as shown in Table 25 below.

Table 25
UM SMC at Easton and Projected Pediatric Bed Need
FY 2019 – FY 2032

Pediatric	Historical				Projected										% Change
Bed Need	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Age 0-14	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**0.0%**
% Change		*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	

UM SMC at Easton is the only facility within its five-county service area that has licensed pediatric beds. If there were no licensed pediatric beds at UM SMC at Easton, the absence would create a serious service gap within the Mid-Shore region. It is the reality that UM SMC at Easton will continue to experience pediatric admissions. In addition to preserving access to care for its pediatric population, it is necessary to maintain a pediatric bed at the replacement regional medical center for a number of reasons, including to ensure pediatric patients receive appropriate and tailored care, to promote seamless transitions across the continuum of care for pediatric patients, to minimize drive times in emergent situations, and to promote physician recruitment on the Mid-Shore. Moreover, as the pediatric population in the service area is projected to remain constant, UM SMC at Easton will experience steady demand for pediatric inpatient service capacity.

UM SMC at Easton proposes to have one pediatric bed at the replacement facility. UM SMC at Easton is not establishing an entire pediatric unit, so there are no additional costs or inefficiencies associated with operating a unit for one bed. As shown in **Exhibit 2**, page 9, this bed will be located on floor 3 adjacent to the Perinatal Labor and Delivery Unit and co-located with two medical-surgical beds that will provide flex capacity should the hospital have more than one pediatric patient at a time. The pediatric bed will enable pediatric patients and their families to be more comfortable during their high-stress inpatient stay. The hospital bed in the pediatric room will be shorter than adult beds, and the height and size of other room fixtures will be appropriate to pediatric patients. Pediatric nurses will care for the patients.

UM SMC at Easton is already well-positioned to offer high-quality care to its pediatric patients, and retaining a pediatric bed will enhance care delivery for this patient population throughout UM SMC at Easton's service area. UM SRH has a robust Women and Infants Service line. By maintaining one pediatric bed at UM SMC at Easton, pediatrician coverage will be available in the inpatient setting to care for newborns as well as other inpatient pediatric patients. SHS wishes to continue to provide safe, appropriate, and effective care to the newborn patients who either need admission or observation in an appropriate, pediatric patient-friendly environment.

Although many pediatric services are increasingly provided on an outpatient basis or in tertiary centers, there remains a need within the community to be able to serve the pediatric patient across the continuum of care. The continuum includes the inpatient, observation, and outpatient settings. UM SMC at Easton's proposed inpatient bed will facilitate a seamless transition of care as patients move from the emergency department, to the inpatient unit, to outpatient services. The one bed will also help retain patients and families in the local community, which otherwise requires patients to travel significant distances to other pediatric inpatient providers and for patients' parents, guardians, and other family members to travel significant distances to visit their children and loved ones admitted at distant providers.

It is important to SHS and its stakeholders to maintain a licensed inpatient pediatric service for the residents of the Mid-Shore region at UM SMC at Easton to preserve such residents' access to vital pediatric care. Indeed, the need to ensure timely access to pediatric inpatient care has been in the national spotlight this fall as the "tripledemic" of RSV, influenza, and coronavirus has caused a surge in pediatric hospital admissions and shortage of beds in many states.[4] UM SMC at Easton plans to maintain its pediatric service at the replacement regional medical center to meet the

[4] See, e.g., C. Rowland, D. Keating, and D. Gilbert, *Why Parents Are Struggling to Get Hospital Beds for Kids with Flu and RSV*, WASHINGTON POST, Dec. 17, 2022 (https://www.washingtonpost.com/business/2022/12/17/pediatric-bed-shortage-tripledemic-rsv-flu-covid/).

projected need for pediatric care in its community. Providing a local inpatient care option for patients of the service area is essential to help mitigate the pediatric bed shortage that has surfaced this fall.

Proximity to inpatient pediatric care is important, especially in emergent situations. Caring for pediatric patients in a close-to-home setting provides comfort and satisfaction to families and to the patient. Table 26 below shows the driving time between the five Mid-Shore counties in UM SMC at Easton's service area and the hospitals in Maryland with pediatric units. The table shows that, of all the hospitals, the proposed new location of UM SMC at Easton has the shortest travel time from each county.

Table 26
Driving Time (in Minutes) from the Five Mid-Shore Counties To Maryland Hospitals with Pediatric Units

	UM SMC at Easton (Proposed Site)	Univ. of MD (Baltimore, MD)	Johns Hopkins (Baltimore, MD)	Baltimore Wash. (Glen Burnie, MD)	Anne Arundel (Annapolis, MD)	ChristianaCare Union Hospital (Elkton)	Tidal Health Peninsula Regional (Salisbury, MD)
Pediatric Beds	1	59	140	4	8	2	8
Caroline	24	79	99	67	48	74	59
Dorchester	30	99	116	85	68	116	38
Kent	42	85	102	76	58	50	100
Queen Anne's	21	64	87	53	34	65	80
Talbot	11	80	103	69	49	84	56

Source of travel time is Google Maps, using the shortest travel time between each county and each hospital. Measurements were taken between 1:00 and 2:00 pm on Wednesday, October 12, 2022.

UM SMC at Easton recognizes that there are also hospitals in Delaware with pediatric units to which Mid-Shore residents have access. Table 27 shows the driving time between the five Mid-Shore counties in UM SMC at Easton's service area and the hospitals in Delaware. Once again, the table shows that, of all the hospitals, the proposed new location of UM SMC at Easton has the shortest travel time from each county. UM SMC at Easton is the only hospital with a pediatric inpatient service within a 30-minute drive time for the majority of its service area (Kent County is slightly above this at 42 minutes). All other Maryland and Delaware hospitals with pediatric units are significantly farther for residents of UM SMC at Easton's service area.

Table 27
Driving Time (in Minutes) from the Five Mid-Shore Counties to Delaware Hospitals with Pediatric Units

	UM SMC at Easton (Proposed Site)	Beebe Medical Center (Lewes, DE)	Bayhealth Hospital, Kent Campus (Dover, DE)	Christiana Hospital (Newark, DE)	Nemours Children's Hospital (Wilmington, DE)	Tidal Health Nanticoke (Seaford, DE)
Pediatric Beds	**1**	**9**	**6**	**19**	**260**	**8**
Caroline	24	66	44	75	83	34
Dorchester	30	99	103	98	128	40
Kent	42	96	58	52	66	79
Queen Anne's	21	86	52	59	73	59
Talbot	11	92	66	80	95	46

Source of travel time is Google Maps, using the shortest travel time between each county and each hospital. Measurements were taken between 1:00 and 2:00 pm on Wednesday, October 12, 2022.

Maintaining a pediatric service will be a benefit to UM SMC at Easton's family medicine program and will attract skilled providers to the area. Currently, the Mid-Shore has a shortage of medical practitioners to provide essential services in the community. The continuation of an inpatient pediatric service would provide an additional dimension of residency training and would enhance UM SMC at Easton's ability to attract and retain needed practitioners, which will further contribute to community wellness.

Finally, retaining an inpatient pediatric bed at UM SMC at Easton will ensure UM SMC at Easton is commensurate with other community regional hospitals across the state. While many hospitals are facing decreased pediatric inpatient census, families still expect to have basic pediatric services available in their community regional hospitals. Facilities across the state must consider how to develop a care model that meets the basic needs of pediatric patients. Of the 34 hospitals in Maryland with licensed pediatric beds, 18 are licensed for four beds or fewer for fiscal year 2023. Nine of these 34 hospitals have only one or two licensed beds. UM SMC at Easton is thus typical of many other Maryland hospitals. UM SMC at Easton is a regional hospital serving a five-county service area. Though specialized services are increasingly offered at larger hospital centers, families in UM SMC at Easton's service area should have continued access to pediatric care in the local setting that is within 30 minutes' drive time under normal driving conditions consistent with the Geographic Accessibility standard at COMAR 10.24.10.04B(1). UM SMC at Easton's proposed single pediatric bed would preserve this vital access.

Standard .04B(3) – Minimum Average Daily Census for Establishment of a Pediatric Unit

An acute care general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:

(a) The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or

(b) The hospital is the sole provider of acute care general hospital services in its jurisdiction.

Applicant Response:

Not applicable. The Applicant has an established pediatric service line.

Standard .04B(4) – Adverse Impact

A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:

(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

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Applicant Response:

The Applicant will request an increase in rates equal to approximately 50% of the increase in regulated capital costs (depreciation and interest) plus markup associated with the proposed project. Funding for the other 50% of capital costs will be covered by the hospital. The Applicant's request for a rate increase will be filed as a Full Rate Application with the HSCRC in the first quarter of fiscal year 2024.

The total cost of the project is $539.6 million, of which $484.1 million are depreciable assets, $2.5 million is for the purchase of land, and $53.0 million represents gross interest and related financing

fees during construction. Proceeds from the issuance of tax-exempt bonds will be used to fund $333.3 million of the depreciable assets and gross interest.

Table 28
UM SMC at Easton Projected Capital Costs
($ in thousands)

	Total Project Costs
Land Acquisition	$ 2,464.7
New Construction & Infrastructure	399,054.3
Equipment, Furnishings, & IT	85,061.0
Gross Interest During Construction	52,978.0
Total Project Costs	**$ 539,558.0**

A full year of depreciation and interest expenses (i.e. capital costs) related to the project are projected to equal $43.7 million with the opening of the new hospital facility in fiscal year 2029. Of these capital costs, $21.8 million will be funded with an increase in UM SMC at Easton's regulated revenue. Applying UM SMC at Easton's approved fiscal year 2021 markup of 1.10136 results in a requested rate increase of $24.0 million in gross charges. This rate increase represents a 6.1% increase over SHS's projected fiscal year 2029 regulated gross charges of $396.1 million.

In the HSCRC Efficiency Methodology, the Peer Group for UM SMC at Easton is comprised of all non-AMC acute care hospitals in the State. This would include hospitals significantly larger than UM SMC at Easton in terms of licensed beds and revenue. It would also include hospitals serving urban populations that differ greatly from the largely suburban / rural population served by UM SMC at Easton. It is more appropriate to instead compare UM SMC at Easton to hospitals that are similar in terms of size and suburban / rural location, including Calvert Memorial Hospital, Carroll Hospital Center, UM SMC at Chestertown, Garrett County Memorial Hospital, Meritus Medical Center, UM SMC at Dorchester, ChristianaCare Union Hospital, and Western Maryland Regional Medical Center.

Comparing the pro forma gross regulated charges at UM SMC at Easton with its actual volumes and approved rates, by rate center, to the pro forma revenue at each of the other similarly sized hospitals calculated with UM SMC at Easton volumes at the fiscal year 2022 approved rates for each of the other hospitals results in a finding that UM SMC at Easton's gross regulated charges are 1.8% below the average of the other hospitals (Table 29).

Table 29
Comparison of UM SMC at Easton Charges to Those of Other Similarly Sized Hospitals
($ in thousands)

UM SMC at Easton FY2022 Pro-Forma Revenue			Approved Rates Compared to Peer Group		Capital-Adjusted Rates Compared to Peer Group	
FY2022 Pro-Forma Revenue [1]	FY2022 Revenue at Capital Adjusted Rates[2]	FY2022 Revenue at Peer Group Average Rates[3]	Over/(Under) Average Rates	Percent Variance	Over/(Under) Average Rates	Percent Variance
$ 261,507	$ 279,280	$ 266,191	(4,684)	-1.8%	$ 13,089	4.9%

Notes:

(1) Calculated as FY2022 HSCRC approved unit rates x FY2022 actual unit volume

(2) Capital-adjusted rates calculated by increasing FY2022 GBR by $24,039,922

(3) Calculated as average FY2022 peer group unit rates x UM SMC at Easton FY2022 actual unit volume. TPR Hospital peer group hospitals include: Meritus, UM SMC at Cambridge, Garrett Regional Medical Center, Western Maryland Regional Medical Center, ChristianaCare Union Hospital, Carroll Hospital Center, Calvert Memorial, and UM SMC at Chestertown

Source:

HSCRC FY2022 Statewide approved rates file

HSCRC FY2022 Final Experience Report

With a $24.0 million rate increase for capital, UM SMC at Easton's pro forma revenue is greater than that of the other similarly sized hospitals. Because the capital adjusted revenue for UM SMC at Easton is greater than the pro forma revenue of the other similarly sized hospitals, the Applicant calculated and compared the fiscal year 2021 Debt to Capitalization ratio and Average Age of Plant ratio for UM SMC at Easton to the average of the same ratios for the other hospitals.

For financial reporting purposes, debt and unrestricted net assets for UM SMC at Easton and UM SMC at Dorchester are considered a single entity, Shore Health System, Inc. ("SHS"). The information for these facilities are, therefore, combined and presented together. In fiscal year 2021, the Debt to Capitalization ratio of 38.1% for SHS was below the average of 40.5% for the other similarly sized hospitals (Table 30).

Table 30
Comparison of UM SMC at Easton Debt to Capitalization Ratio to Those of Other Similarly Sized Hospitals
($ in thousands)

Hospital	Total Debt	Unrestricted Net Assets	Debt to Capitalization
Calvert Memorial Hospital	$ 49,549	$ 54,708	90.6%
Carroll Hospital Center	130,916	193,625	67.6%
UM SMC at Chestertown	3,511	41,248	8.5%
Garrett Regional Medical Center	11,708	61,541	19.0%
Meritus	245,688	435,797	56.4%
ChristianaCare Union Hospital	51,404	105,231	48.8%
Western Maryland Regional Medical Center	782	326,825	0.2%
Peer Group Weighted Average	**$ 70,508**	**$ 174,139**	**40.5%**
UM Shore Health System As-Is	**$ 116,918**	**$ 306,834**	**38.1%**

Source: FY2021 Audited Financial Statements

Based on calculations performed using fiscal year 2021 audited financial statements, the Average Age of Plant of 13.3 years for SHS exceeded the average of 7.1 years for the other similarly sized hospitals / health systems (Table 31).

Table 31
Comparison of UM SMC at Easton Average Age of Plant Ratio to Those of Other Similarly Sized Hospitals
($ in thousands)

Hospital / Health System	Accumulated Depreciation	Current Depreciation	Average Age of Plant
Calvert Health System[(1)]	$ 126,761	$ 12,826	9.9
Carroll Hospital Center[(2)]	N/A	N/A	N/A
UM SMC at Chestertown	45,154	3,459	13.1
Garrett Regional Medical Center[(1)]	46,572	4,631	10.1
Meritus[(1)]	239,347	25,464	9.4
ChristianaCare Union Hospital[(2)]	N/A	N/A	N/A
Western Maryland Regional Medical Center	39,713	23,425	1.7
Peer Group Weighted Average	**$ 99,510**	**$ 13,961**	**7.1**
UM Shore Health System	**$ 225,730**	**$ 16,972**	**13.3**

Note (1): Includes entire health system as detail was not available for hospital entity only
Note (2): Detail was not available for Carroll Hospital Center or ChristianaCare Union Hospital at the entity level and inclusion of Lifebridge Health or ChristianaCare Health System would be innappropriate given their size

Source: FY2021 Audited Financial Statements - UM Shore entities based on UMMS internal data

(b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.

Applicant Response:

While the replacement regional medical center will have fewer physical beds than the existing facility and certain service lines will have fewer licensed beds, the project does not reduce the availability or accessibility of any service because the replacement facility has been sized based on the projected bed need of the service area population. All of the inpatient and outpatient services that are currently offered at UM SMC at Easton will continue to be offered at the replacement facility. None of the proposed changes of this project will impact access for indigent or uninsured patients. UM SMC at Easton will continue to care for patients regardless of their ability to pay.

The existing facility has significant excess physical capacity compared to its licensed bed capacity, which creates operational and cost inefficiencies.[5] The replacement facility has been planned to right-size the bed capacity based on the service area population's projected bed needs. See Table 32 below which compares the existing facility's physical and licensed bed capacity to the replacement facility's physical and licensed bed capacity. The size of the replacement facility has been planned to ensure continued access and availability of services for the indigent, uninsured, and the community.

Table 32
Physical and Licensed Bed Capacity of Current Facility Compared to Replacement Facility

Bed Type	Existing Facility – Physical Capacity	Existing Facility – Licensed Capacity	Replacement Facility – Licensed and Physical Capacity
MSGA	120	72	86
Obstetric	13	13	11
Pediatric	5	3	1
Psychiatric	12	10	12
Rehabilitation	15	20	12
Total	**165**	**118**	**122**

Standard .04B(5) – Cost-Effectiveness

A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.

(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two

[5] See **Exhibit 1**, Table A for a detailed breakdown of the existing facility's physical capacity. Physical capacity denotes the total number of beds that could physically be set up in a space with available headwalls and gasses and without significant renovations. UM SMC at Easton's excess physical capacity at the existing facility is generally used today to accommodate observation patients, whereas the replacement hospital will have a dedicated 25-bed observation unit. UM SMC at Easton's semi-private rooms also account for some of its excess physical capacity, as it endeavors to provide patients their own room when possible and is sometimes restricted or prohibited from cohorting two patients in its semi-private rooms due to COVID-19 or a patient's isolation status, gender, or acuity level, as discussed in response to COMAR 10.24.21.05B(2).

alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:

(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;

(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and

(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

Applicant Response:

I. Transformation of UM SRH Regional Service Delivery Model and Facilities

When SHS initially began planning this project, it was still refining its ambulatory care strategy and service delivery model in the Mid-Shore region and determining the long-term plans for UM SMC at Dorchester and UM SMC at Chestertown. For the past decade, UM SRH has embarked on a strategic journey to implement a service delivery plan that promotes access to needed services for local residents while creating a seamless, integrated, and coordinated rural health care delivery system across Maryland's Mid-Shore region.

Beginning in October 2010 with the opening of one of the state's first FMFs, Queen Anne's County saw the first phase of UM SRH's health care vision as it opened the doors to UM Shore EC at Queenstown, which is open 24/7. This emergency center helps address the immediate health care needs of a county with limited health care resources and significant access issues with beach traffic restricting egress to and from the county six months of the year. One year later, in October 2011, the UM Shore EC at Queenstown campus expanded to include an adjacent comprehensive medical office building, inclusive of primary care and specialist providers, diagnostic and rehabilitative services, and an ambulatory surgery center. With the addition of urgent care services in May 2022, UM SRH has implemented an innovative and comprehensive health care solution for one of three Maryland counties without a hospital.

Capitalizing on its successes in Queen Anne's County, UM SRH adopted a tailored health care delivery system for Caroline County in May 2019. UM SRH's solution for the health care needs of this eastern-most county, which also lacks a hospital facility, is to provide centralized health care services in Denton. These services are co-located in a new state of the art Medical Office Building (MOB) conveniently located on Maryland State Route 404. Complemented with an Urgent Care Center less than one mile from the MOB, that is open seven days per week, 14 hours per day, the MOB and Urgent Care Center ensure Caroline County residents have access to primary care, specialists, diagnostic testing, and urgent care services locally with nearby access to hospital-based services in adjacent Talbot County. Implementation of UM SRH's Denton campus has been effective in controlling the total cost of care, and this model has thrived in Caroline County as the second of three Maryland counties without hospital-based services.

Working closely with its MHCC and HSCRC partners, UM SRH has also addressed the health care service delivery needs of Kent County by developing and implementing the first Maryland Rural Hospital in Chestertown, Maryland on July 1, 2021. Modeled after highly effective critical access hospitals from across the nation, this unique acute care facility offers inpatient care

for mild to moderately complex patients with a four-day or less length of stay and is complemented with a full-service emergency department, observation beds, and surgical services. Providing access to hospital-based services close to home for residents of Kent County meets the needs of the local community while enhancing UM SRH's integrated care delivery model on the Mid-Shore. In an effort to ensure sustainability, UM SRH has complemented its hospital-based vision with a plan to address the needs of the aging population of Kent County by creating an Aging and Wellness Center of Excellence. Currently in development, this newly renovated center is located adjacent to the Chestertown hospital and provides comprehensive aging and wellness services in one easily accessible building on the campus in Chestertown.

Transforming health care in Cambridge, Dorchester County, Maryland was the next essential step in UM SRH's Mid-Shore health care service delivery plan. After years of planning, and with the support of city, county, and state elected officials, long-standing community health care providers, and the community at large, October 28, 2021 saw the closing of Dorchester General Hospital and the opening of UM SRH's new Cambridge FMF. This new state-of-the-art facility provides all essential community health care services with regional, hospital-based care accessible just 15 miles north in Easton, Maryland. Complementing community-based primary care with a full-service campus offering emergency and observation services on a 24/7 basis, specialists, diagnostic and rehabilitative services, ambulatory surgery, and behavioral health services, the community has embraced UM SRH's solution for health care in Dorchester County as a forward-thinking and sustainable solution for the county and as a critical part of its Mid-Shore service delivery plan.

As plans for four of the five Mid-Shore counties have taken hold with innovative, sustainable, and integrated plans, UM SRH is now ready to complete the transformation of its service delivery plan with submission of this application for the replacement hospital in Talbot County. The new state-of-the-art regional medical center located in Easton, Maryland will serve as the regional solution for hospital-based inpatient care on the Mid-Shore. With the relocation of the existing facility from a congested site without capability to expand in downtown Easton to a sprawling 200 plus acre parcel on U.S. Route 50 near the Easton airport, access to regional inpatient care will dramatically improve for the region. Replacing an aged conglomeration of buildings with a state-of-the-art medical facility on a larger, more accessible campus will ensure the community's needs will be met for decades to come. Focusing on key regional inpatient services most needed by its rural community, including cancer, cardiology, neurology, neurosurgery, orthopedics, obstetrics, vascular services, behavioral health, and acute rehabilitation will help ensure the community has access to outstanding hospital-based care close to home. Integrating care delivery models with UMMS affiliate hospitals will provide seamless access to tertiary and quaternary care by world-renowned experts when needed.

Over a decade in the making, UM SRH's transformation of its service delivery model is soon to be complete with the development of the new regional medical center in Easton. Please see **Exhibit 14** for a before and after overview of UM SRH's health care facilities and the changes that have occurred as part of this transformation. The replacement regional medical center will serve as the hub for inpatient care for Maryland's Mid-Shore and a cost-effective means of meeting the long-term needs of its regional service area. When complemented with county-based local solutions for access to pre- and post-acute care, UM SRH will have created the ideal solution for accessible, sustainable delivery of health care for the rural community it serves on the Mid-Shore. UM SRH's service delivery transformation aims to achieve a comprehensive solution for quality, cost-effective health care by way of Maryland's Global Budget Reimbursement model and may serve as an important model for the future of rural health care delivery for the rest of the nation.

II. Identification of Primary Objectives

Planning for this project has occurred in phases over many years. In 2005, the Applicant began evaluating alternatives for the proposed project as it explored its affiliation with UMMS. In doing so, it identified its primary objectives for the proposed project.

At the time of the early planning of the project, the population of the Eastern Shore of Maryland was growing rapidly. The Applicant wanted to make sure that the physical solutions to its facility constraints continued to adequately provide for the needs of these growing communities, including improvements that support exceptional patient experience with facilities and services.

The population of the five-county service area was also expected to continue to age over the planning horizon. This growing senior population was expected to have a significant impact on health service needs because seniors use health services at a much greater rate than the younger population. SHS wanted to make sure that its facilities solution continued to adequately provide services for the senior citizens in the service area.

SHS also determined that there was a need for more physicians in the five-county service area. There was a shortage of both primary care physicians and specialists serving the region. The shortage was expected to grow as the population grew and some of the existing physicians retired. The existing members of the medical staff at UM SMC at Easton indicated that it was difficult to recruit new physicians into their practices. The recruitment difficulties were partially due to physician reimbursement rates in the region, but also due to the physical environment of the hospital. Although physician recruitment for SHS would require various initiatives, SHS wanted to make sure that the physical solution for its facilities would enhance physician recruitment.

Based on surveys conducted at the time, it was clear that choosing a location that was accessible to residents was very important to the community. However, there was no general agreement on the most accessible location. After considering a number of options, SHS determined that the location near the Talbot County Community Center was the best option.

SHS concluded that the optimal facility solution for a replacement hospital would need to address several primary objectives:

1. Accommodate the growth of the population in the five-county service area.

The facility and campus solutions were evaluated based on the volume projections generated and their ability to accommodate the needs of the growing service area population.

2. Provide for the special needs of the growing senior citizens population.

Senior citizens use health care resources at a much greater rate than younger patients. The use rates of seniors were built into the volume projections for each site. Seniors also have a special need for simple wayfinding, i.e., navigating the physical layout of the hospital. The facility solutions and site configurations for each site were evaluated on their ability to support simple wayfinding.

3. Improve access to hospital services for all of the residents of the five-county region.

Patient access and site accessibility were two key considerations for the alternatives. Access to hospital services was measured by a drive time analysis. Site accessibility included a

centrally located site that was easy to access in terms of roadways, visibility, driving, and parking. The drive time from each community in the hospital's service area to each of the alternative sites was measured using online mapping software. The drive time was weighted for the population of each community, and then aggregated. The site with the lowest aggregate drive time was considered to have the best access for all residents of the service area.

4. Enhance physician recruitment to the Eastern Shore.

Recruiting new physicians to the Eastern Shore is difficult, due to both its rural nature and reimbursement challenges. In interviews with existing physicians and community leaders, participants believed that physician recruitment would be enhanced only with new hospital facilities. Renovation of existing facilities was not believed to provide any enhancement. Therefore, each site alternative was evaluated for this objective based on whether it provided a new or renovated hospital.

5. Enhance and sustain the hospital's long-term financial performance

SHS was focused on ensuring the proposed alternative meets all objectives above and will also enhance and sustain the hospital's long-term financial performance. With this goal in mind, SHS aimed to keep the capital costs modest but still meet the programmatic needs of the facility. It evaluated the likely philanthropic support for the proposed alternative and ability to obtain financing. Most significantly, it also evaluated the impact of the project's capital costs on the projected operating income of the hospital.

III. Final Project Alternatives

SHS's planning committee identified a number of project alternatives and narrowed it to the final alternatives described below:

1. Redevelopment of the Existing Hospital Campus

SHS has considered several redevelopment plans for the existing hospital campus. First, SHS considered a renovation plan in conjunction with planning the hospital's new ED and outpatient center as part of the hospital's approved CON in 2005. After completion of that project, the footprint of the hospital could not change significantly due to space limitations on the campus. In addition, it was determined to be unlikely SHS could achieve necessary local land use approvals to undertake a large-scale renovation and redevelopment of the facility on the existing site. Accordingly, this modest project alternative included 21,600 square feet of new construction and 19,500 square feet of renovation, without expanding the existing footprint of the hospital, aimed at improving a few design issues with the existing facility and making critical investments in its aged infrastructure. Other than the addition of eight ICU beds, all other inpatient units would remain the same under this alternative. There would be no change in the private to semi-private room mix in any of the inpatient units, a significant drawback to the plan.

More recently, SHS explored a renovation plan in 2015 and 2016. This plan, which never progressed beyond a conceptual level based on its limitations, involved renovation of approximately 288,000 SF (the hospitals East and West towers) to create all private patient rooms. It also involved key upgrades to the hospital's infrastructure, and the addition of a parking garage and new Central Utility Plant on the hospital's current surface parking lot. To minimize disruption to the existing hospital's operations and patient care, this alternative would have to be completed in

phases over a seven or more year time frame. This phased renovation plan was predicted to cause significant, lengthy disruptions to the daily operations of the hospital, eroding its market share and resulting in low consumer confidence. Although the renovations would have created all private patient rooms, it was projected that there would not be sufficient bed capacity, even after the renovations, to meet projected demand or to allow for any future growth or change due to the space constraints on the campus. The renovations would also not resolve the accessibility issues with the existing campus, of being located in a congested, residential area without access to major roadways. Finally, SHS's concerns remained over its ability to obtain necessary land use approvals for this renovation option.

2. Relocate to a New Site in Easton – "Bypass at Oxford Road Site"

UM SMC at Easton owned a 60-acre parcel of land in southwestern Easton, on the Easton Bypass (Route 322) at Oxford Road and considered relocating the hospital to this parcel. The hospital facility design in this alternative would be the same as the proposed project. There would be no land acquisition costs associated with this alternative, as the land had been donated to SHS. Because there were utility services available on Maryland Route 322, UM SMC at Easton would not be responsible for extending water and electrical services to the site, as is the case in the proposed project. Access to municipal services such as fire and police on this site would be the same as the existing site. All other project costs of this alternative would be the same as described in the proposed project.

3. Relocate to a Site in Northern Talbot County – "Northern Talbot County Site"

In this alternative, UM SMC at Easton planned to acquire a 90-acre parcel of land on the southeast corner of the intersection of Maryland Routes 50 and 404. The cost of land acquisition was estimated at $7.15 million at that time. The hospital facility design in this alternative would be the same as the proposed project. There were no utilities available to serve this site. UM SMC at Easton assumes that electric service would have to be extended from Wye Mills and that wells would have to be dug on the property to provide water. A sewage treatment plant to serve the new facility would also have to be developed on the property. There was no access to municipal services of fire and police at this site. All other project costs of this alternative would be the same as described in the proposed project.

4. Relocate to Talbot County Community Center Site – "Proposed Project Site"

When the Northern Talbot County Site was initially considered by SHS, it was not favored by Town of Easton, nor the Talbot County Commissioners. Following the affiliation between SHS and UMMS in 2006, the Talbot County Council offered to donate a significant portion of the proposed project site to SHS to ensure the hospital would be located close to Easton. Also, the Town of Easton proposed to annex the site to provide utilities to the site. These arrangements reduced the cost of the proposed project site and made it a very attractive alternative.

The proposed project site is a 235-acre parcel at the intersection of Longwoods Road and U.S. Route 50, just north of the Easton Municipal Airport. Talbot County conveyed the proposed project site to SHS in 2015 for $2.5 million. The site is predominantly a greenfield site, not all of which will be used for the hospital campus. The remainder of the parcel will be used for future development. As a greenfield site, utilities will have to be brought to the site lines, but the land has been annexed by the Town of Easton to provide utilities and services to the site. Access to municipal services of fire and police is the same as the existing site.

IV. SHS's Site Selection and Recent Developments

The costs and financial performance of the project alternatives were initially evaluated by SHS in the early planning stages of this project, and SHS scored each project alternative based on how well it met SHS's objectives. SHS determined that the proposed project site would be the most cost-effective alternative that would meet its objectives. It rejected its initial redevelopment alternative because it found the redevelopment of the existing campus would ultimately not meet its primary objectives, and rejected the other two relocation alternatives because they ranked lower in meeting its primary objectives. SHS's evaluation of each alternative and its rationale for selecting the proposed project site and rejecting the other project alternatives as described below in the section on "Ranking of the Final Alternatives."

SHS was conveyed the proposed project site in 2015 and has continued its planning based on its determination that this is the most cost-effective site for building the replacement regional medical center that will best meet its objectives. In the intervening years, SHS briefly considered another redevelopment alternative for the existing hospital campus, but rejected this option as it would also not meet its primary objectives. SHS also sold the Bypass at Oxford Road Site, so this site is no longer available. It has also completely transformed its service delivery model and facilities in the Mid-Shore region over the past decade with the aim of providing accessible, high-quality care in the most cost-effective health care environment. In doing so, SHS has tried to ensure that the size of the replacement hospital will meet the needs of the service area population but not be overbuilt, as described below in the section on "Design Alternatives for the Proposed Project."

V. Comparison of Project Costs and Projected Financial Performance for Each Alternative

Since its initial evaluation the project alternatives, some of SHS's assumptions regarding the project alternatives have changed. For purposes of responding to this standard and validating the cost-effectiveness determination SHS made years ago, SHS has re-assessed the capital costs and financial performance of each alternative and applied inflation factors where appropriate to account for the passage of time.

For alternative one, the infrastructure of the existing facility has continued to age during the planning of this project. As explained in the Applicant's response to the general need criterion at COMAR 10.24.01.08G(3)(b), the existing building now requires extensive infrastructure updates. These critical updates have become more difficult and expensive to perform because necessary parts are no longer being produced and are difficult to purchase. This will require full repairs or replacement of certain systems, such as elevators and air handler units. The operations costs of the hospital will increase significantly as the hospital is required to perform full replacements of systems as they continue to deteriorate.

For alternatives two through four, SHS has re-evaluated each relocation alternative to provide a more apples-to-apples financial comparison by using the same assumptions it has used for the proposed project when appropriate.

The assumptions UM SMC at Easton used to update its models are as follows:

Alternative One – Redevelopment of the Existing Hospital Campus

a. The cost of this alternative was last estimated in 2015 at of $188.1 million. To estimate the change in hospital construction costs between 2015 and 2022, UM SMC at Easton utilized the differences in the Marshall Valuation Service estimates, as shown in the following table.

Table 33
MVS Cost Comparison
2015 versus 2022

	2015	2022	Resultant Difference Factor
MVS Base Cost	$354.99	$485.00	
Update Multiplier	1.05	1.21	
Location Multiplier	0.98	0.99	
	$365.28	$580.98	1.59

b. UM SMC at Easton then multiplied the 2015 cost estimates in the categories that were used at the time by 1.59 to convert them to 2022 costs.

2015 Categories	2015 Cost Estimates	Adjusted to 2022 (x 1.59)
BUILDING CONSTRUCTION	$0	$0
BUILDING RENOVATION	$76,700,000	$121,990,546
SITE	$1,000,000	$1,590,490
BUILDING MAINTENANCE	$3,000,000	$4,771,469
EAST WING EXTERIOR	$5,000,000	$7,952,448
CAMPBELL BUILDING DEMOLITION	$2,000,000	$3,180,979
INFRASTRUCTURE	$30,000,000	$47,714,685
PARKING GARAGE (300 SPACES)	$6,000,000	$9,542,937
CENTRAL UTILITY PLANT	$5,000,000	$7,952,448
TOTAL CONSTRUCTION COST	$128,700,000	$204,696,000
PROJECT COST ALLOWANCE	$59,350,000	$94,395,553
TOTAL PROJECT COST	$188,050,000	$299,091,553

UM SMC at Easton did not apply an inflation rate to the midpoint of construction, Capitalized Interest, Financing Fees, Permits, or other costs because it is not clear whether they were included in the “Project Cost Allowance.”

c. Due to the aging of the current facility and community optics around not replacing it, the Applicant assumes a loss in market share in this scenario in which the hospital is renovated rather than replaced. The market share reduction is equal to 2% annual reduction in volume than projected in Table F for the replacement hospital. The

associated revenue impact is assumed to be 50% of the volume reduction, consistent with the HSCRC's Market Shift Policy.

d. The permanent rate increase of $24.0 million (full rate application or "FRA") assumption included in the proposed project and alternatives two through four is not included in alternative one.

Alternatives Two through Four – Relocation of the Hospital to a New Site

a. The implementation timetables and project schedule for each relocation alternative (alternatives two through four) are the same as the proposed project, so the project costs for each relocation alternative are inflated from the first quarter through the third quarter of 2026. For inflation, UM SMC at Easton applied the Building Cost Index in the IHS Markit Healthcare Cost Review that is found on the MHCC website, as follows:

Filing Date	2023.1				
Midpoint of Construction	2026.3				
Step 1	2024.1	%MOVAVG	1.5	1.015	*A*
Step 2	2025.1	%MOVAVG	1.6	1.016	*B*
Step 3	2026.1	%MOVAVG	1.8	1.018	*C*
	2026.1	CIS Proxy	1.291		*D*
	2026.3	CIS Proxy	1.298		*E*
	E/D			1.005778	*F*
	*A * B * C * F*			**1.055868**	

b. The data on the MHCC website only shows factors through the third quarter of 2023. UM SMC at Easton used the Compound Average Growth Rate for the first quarter of 2022 through the third quarter of 2023 to estimate the factors from the first quarter of 2024 through the third quarter of 2026, as follows:

		CMS 2006-based PPS Hospital Capital IPI, CAPB06 Line	**%MOVAVG Line**
	CAGR	0.002957	0.026025
Actual	2022.1	1.231	1.2
Actual	2022.2	1.234	1.2
Actual	2022.3	1.235	1.3
Actual	2022.4	1.241	1.3
Actual	2023.1	1.247	1.3
Actual	2023.2	1.251	1.3
Actual	2023.3	1.253	1.4
Estimated	2023.4	1.257	1.4

Estimated	2024.1	1.260	1.5
Estimated	2024.2	1.264	1.5
Estimated	2024.3	1.268	1.6
Estimated	2024.4	1.272	1.6
Estimated	2025.1	1.275	1.6
Estimated	2025.2	1.279	1.7
Estimated	2025.3	1.283	1.7
Estimated	2025.4	1.287	1.8
Estimated	2026.1	1.291	1.8
Estimated	2026.2	1.294	1.9
Estimated	2026.3	1.298	1.9

c. Square footage of the facilities in each of the relocation alternatives will be equivalent to the square footage of the proposed project.

d. New construction costs, per square foot, are the same across all relocation alternatives to be equal to the new construction costs of the proposed project.

e. Patient volumes are equivalent across all relocation alternatives, given the relative proximity of the sites and distance to other providers.

f. With the exception of land and site development costs, the project costs for each relocation alternative are assumed to be the same and are inflated for 56 months (5.59% to the midpoint of construction in the third quarter of 2026) using the MHCC inflation index. The original site development costs that were estimated for each alternative have been updated to account for inflation. Land acquisition costs were not inflated.

Using these assumptions, UM SMC at Easton updated the estimated project costs for each alternative, which are shown below:

Table 34
Project Cost Comparisons for Final Alternatives

	Remain at 219 S. Washington	Relocate to New Site in Easton (Bypass at Oxford Road)	Relocate to New Site in Northern Talbot County (Route 50 at 404)	Proposed Project
New Construction		$216,638,602	$216,638,602	$216,638,602
Fixed Equipment (not in building)				
Renovation				
Land			$7,150,000	$2,464,658

Site Development		$39,371,597	$50,452,050	$44,409,960
A/E Fees		$11,000,000	$11,000,000	$11,000,000
Permits		$6,135,000	$6,135,000	$6,135,000
Major Moveable Equipment		$125,060,730	$125,060,730	$125,060,730
Minor Moveable Equipment				
Contingencies		$19,452,735	$19,452,735	$19,452,735
IT etc.		$24,578,129	$24,578,129	$24,578,129
Subtotal		$442,236,792	$460,467,246	$449,739,814
Inflation cost		$27,427,990	$28,637,456	$28,740,058
Capitalized Construction Interest		$48,709,707	$52,128,048	$49,999,000
Total Project Capital Costs	$299,091,553	$518,374,490	$541,232,750	$528,478,871

Table 35 provides the key financial indicators for the Remain at 219 S. Washington alternative, which is lower than that of the projection for proposed project provided in **Exhibit 1,** Table H. The Beginning Operating Revenue in Table 35 assumes an adjustment in volume relative to the projections shown in **Exhibit 1,** Table F, and assumes the associated revenue loss to be 50% variable. Operating Expense reflects a change in depreciation and interest expense based on the change in the capital costs for the Remain at 219 S. Washington alternative. Supplies expense projected in **Exhibit 1**, Table H is assumed to be 80% variable with the 2% annual reduction in volume, while non-supply expenses are assumed to be fixed. All other financial statement assumptions are consistent with the proposed project site financial projection.

Table 35
Key Financial Indicators – Remain at 219 S. Washington
FY 2020 – FY 2032
(Dollars in Thousands)

	Actual			Budget	Projected								
	2020	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**
Alt Scenario 1 - Remain at 219 S. Washington													
Operating Revenue (Proposed Project)	$ 271,570	$ 279,462	$ 275,427	$ 283,523	$ 290,968	$ 299,104	$ 307,072	$ 315,243	$ 322,948	$ 350,421	$ 359,003	$ 367,796	$ 376,805
Plus													
Removal of Net Revenue from FRA										(19,572)	(20,053)	(20,546)	(21,052)
Market Shift Adjustment					(2,835)	(5,796)	(8,883)	(12,102)	(15,429)	(19,003)	(22,711)	(26,554)	(30,539)
Total Operating Revenue	$ 271,570	$ 279,462	$ 275,427	$ 283,523	$ 288,133	$ 293,308	$ 298,189	$ 303,141	$ 307,519	$ 311,846	$ 316,240	$ 320,696	$ 325,215
Operating Expenses (Proposed Project)	$ 255,035	$ 254,372	$ 244,639	$ 255,457	$ 253,610	$ 256,647	$ 261,024	$ 264,632	$ 272,348	$ 321,587	$ 330,177	$ 339,143	$ 348,401
Plus													
Incremental Depreciation	-	-	-	-	-	-	-	-	-	(12,137)	(12,137)	(12,137)	(12,137)
Incremental Interest	-	-	-	-	-	-	-	-	-	(6,812)	(6,668)	(6,517)	(6,358)
Variable Supplies					(512)	(522)	(533)	(544)	(568)	(594)	(619)	(645)	(672)
Total Operating Expense	$ 255,035	$ 254,372	$ 244,639	$ 255,457	$ 253,098	$ 256,125	$ 260,492	$ 264,088	$ 271,780	$ 302,045	$ 310,754	$ 319,845	$ 329,234
Operating Income	$ 16,535	$ 25,090	$ 30,787	$ 28,065	$ 35,035	$ 37,183	$ 37,697	$ 39,054	$ 35,739	$ 9,801	$ 5,486	$ 851	$ (4,019)

Table 36 provides the key financial indicators for the Bypass at Oxford Road Site alternative, which is comparable to the projection for proposed project provided in **Exhibit 1**, Table H. The Operating Revenue in Table 36 assumes an adjustment in revenue related to the changes in the capital project costs illustrated in Table 34 and consistent with the full rate application assumption of 50% funding of incremental depreciation and interest. Operating expense reflects a reduction to depreciation and interest expense based on the change in the capital costs for the Bypass at Oxford Road Site, compared to the proposed project site. All other financial statement assumptions are consistent with the proposed project site financial projection.

Table 36
Key Financial Indicators – Relocation to Bypass at Oxford Road Site in Easton
FY 2020 – FY 2032
(Dollars in Thousands)

	Actual			Budget	Projected								
	2020	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**
Alt Scenario 2 - Bypass at Oxford Rd													
Operating Revenue (Proposed Project)	$ 271,570	$ 279,462	$ 275,427	$ 283,523	$ 290,968	$ 299,104	$ 307,072	$ 315,243	$ 322,948	$ 350,421	$ 359,003	$ 367,796	$ 376,805
Full Rate Adjustment										(417)	(417)	(417)	(417)
Total Operating Revenue	$ 271,570	$ 279,462	$ 275,427	$ 283,523	$ 290,968	$ 299,104	$ 307,072	$ 315,243	$ 322,948	$ 350,003	$ 358,586	$ 367,379	$ 376,388
Operating Expenses (Proposed Project)	$ 255,035	$ 254,372	$ 244,639	$ 255,457	$ 253,610	$ 256,647	$ 261,024	$ 264,632	$ 272,348	$ 321,587	$ 330,177	$ 339,143	$ 348,401
Less													
Incremental Depreciation	-	-	-	-	-	-	-	-	-	(535)	(535)	(535)	(535)
Incremental Interest	-	-	-	-	-	-	-	-	-	(300)	(294)	(287)	(280)
Total Operating Expense	$ 255,035	$ 254,372	$ 244,639	$ 255,457	$ 253,610	$ 256,647	$ 261,024	$ 264,632	$ 272,348	$ 320,753	$ 329,349	$ 338,321	$ 347,586
Operating Income	$ 16,535	$ 25,090	$ 30,787	$ 28,065	$ 37,358	$ 42,457	$ 46,048	$ 50,611	$ 50,600	$ 29,251	$ 29,237	$ 29,058	$ 28,802

Table 37 provides the key financial indicators for the Northern Talbot County Site, which is comparable to the projection for proposed project provided in **Exhibit 1**, Table H. The operating revenue in Table 37 assumes an adjustment in revenue capital support in relationship to the changes in the capital project costs illustrated in Table 34. Operating expense reflects a change in depreciation and interest expense based on the change in the capital costs for the Northern Talbot County Site. All other financial statement assumptions are consistent with the proposed project financial projection.

Table 37
Key Financial Indicators – Relocation to Site in Northern Talbot County
FY 2020 – FY 2032
(Dollars in Thousands)

	Actual			Budget	Projected								
	2020	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**
Alt Scenario 3 - Site In Northern Talbot County													
Operating Revenue (Proposed Project)	$ 271,570	$ 279,462	$ 275,427	$ 283,523	$ 290,968	$ 299,104	$ 307,072	$ 315,243	$ 322,948	$ 350,421	$ 359,003	$ 367,796	$ 376,805
Full Rate Adjustment										527	527	527	527
Total Operating Revenue	$ 271,570	$ 279,462	$ 275,427	$ 283,523	$ 290,968	$ 299,104	$ 307,072	$ 315,243	$ 322,948	$ 350,948	$ 359,530	$ 368,323	$ 377,332
Operating Expenses (Proposed Project)	$ 255,035	$ 254,372	$ 244,639	$ 255,457	$ 253,610	$ 256,647	$ 261,024	$ 264,632	$ 272,348	$ 321,587	$ 330,177	$ 339,143	$ 348,401
Plus													
Incremental Depreciation	-	-	-	-	-	-	-	-	-	675	675	675	675
Incremental Interest	-	-	-	-	-	-	-	-	-	379	371	362	353
Total Operating Expense	$ 255,035	$ 254,372	$ 244,639	$ 255,457	$ 253,610	$ 256,647	$ 261,024	$ 264,632	$ 272,348	$ 322,641	$ 331,223	$ 340,180	$ 349,429
Operating Income	$ 16,535	$ 25,090	$ 30,787	$ 28,065	$ 37,358	$ 42,457	$ 46,048	$ 50,611	$ 50,600	$ 28,307	$ 28,307	$ 28,143	$ 27,903

Total margin financial indicators are not included in the revised Table 35 - Table 37 as the components for non-operating income, such as investment income, are carried at the health system level. The cash and investments that generate investment income are held by the UM SRH system and are not allocated at a hospital-level. Likewise, the balance sheet indicators are not reported in Table 35 through Table 37 because that information is only reported at the UM SRH system level and not allocated to UM SMC at Easton.

VI. Reassessing its Primary Project Objectives

SHS's objectives for the project largely remain the same today as they were in the early planning states except for minor changes to its first objective. In the early planning stages for the project, population growth was expected to be much greater for the service area population and utilization and volumes trends have changed since that time. In addition, UM SRH has transformed its service delivery model aimed at providing local, county-based pre- and post-acute care with the total cost of care model in mind. UM SMC at Easton's current demand projections are based on recent utilization and apply conservative assumptions about future utilization, use rates, market share, and population growth.

Accordingly, SHS's first objective is no longer focused on accommodating growth of the service area population, but rather it is focused on a facility and campus alternative that provides flexibility to meet the long-term health care needs of its regional service area population and provide for potential future growth and change. The existing hospital building and campus have been in use since 1915 and have adapted over time to account for changing needs of the service area and care delivery. SHS expects the replacement hospital and campus will similarly serve the regional service area for decades to come. UM SRH's long-term strategic vision is for the new site to be a medical campus, where various inpatient and outpatient medical services will be more accessible for residents of the service area. Accordingly, the facility and campus' ability to meet current demands but also adapt and expand, as needed, were important considerations for the project. Adaptability was considered especially important in light of the recent lessons learned from the COVID-19 pandemic about the need for hospitals to handle surge capacity and other unforeseen changes in volume. The need for private patient rooms for infection control and to improve patient experience was also a strong consideration. As such, SHS has evaluated the project site and design alternatives based on their ability to accommodate the long-term needs of the service area population and provide flexibility for future changes in utilization such as population growth and surge capacity.

After revising the project objectives and updating the project costs and financial projections for each alternative, SHS has assigned a ranking for each alternative and the proposed project, which are presented in the following table.

Table 38
Ranking of Final Project Alternatives

Objectives	Redevelopment of the Existing Hospital Campus	Relocate to New Site in Easton (Bypass at Oxford Road)	Relocate to New Site in Northern Talbot County (Route 50 and 404)	Relocate to Proposed Project Site
Accommodate Long-Term Needs of Service Area Population				
Modern Infection Prevention/Control	4	1	1	1
Private Beds	2	1	1	1

Objectives	Redevelopment of the Existing Hospital Campus	Relocate to New Site in Easton (Bypass at Oxford Road)	Relocate to New Site in Northern Talbot County (Route 50 and 404)	Relocate to Proposed Project Site
Building and campus capable of adaption/expansion	4	1	1	1
Needs of Senior Citizens				
Campus/Building Wayfinding	4	1	1	1
Improve Access				
Aggregate Drive Times	4	3	1	2
Ease of EMS Access	4	3	2	1
Access to Municipal Fire/Police	3	2	4	1
Enhance Physician and Staff Recruitment				
New v. Renovation Facility	4	1	1	1
Enhance and Sustain Financial Performance				
Lowest Capital Cost	1	2	4	3
Projected Operating Income	4	1	3	2
Philanthropic Support	4	2	3	1
Aggregate Score	38	18	22	15
Overall Ranking	**4**	**2**	**3**	**1**

Rankings: 1 = Best; 4 = Worst

[1]As noted above, the Bypass at Oxford Road site has been sold by SHS and is no longer available.

VII. Ranking of the Final Alternatives

a. Alternative One

Alternative one, redevelopment of the existing hospital campus, ranks lowest of all of the alternatives. SHS determined that this alternative would not meet the objective of providing a building and campus that would accommodate the long-term needs of the service area population. While this renovation project would have renovated the hospital's east and west towers and enabled upgrades to some key infrastructure needs in the facility, it would not resolve other significant deficiencies with the existing building as detailed in the response to COMAR 10.24.01.08G(3)(b), including, an inefficient design, remaining significant issues with the aged infrastructure in clinical and support service areas of the facility, poor layout for way-finding, and inadequate storage. Although the renovation would have created all private rooms, SHS projected that with consolidation of inpatient services from UM SMC at Dorchester and UM SMC at Chestertown, there would not be sufficient bed capacity, even after the renovations, to meet projected demand or to allow for any future growth, or change in bed capacity.

Due to site constraints, this modest redevelopment alternative would not replace all portions of the facility (some of which are older than 70 years) that have outlived their useful life, nor does it provide for adequate options for future expansion or change. This alternative would have been

extremely disruptive to the operations of the hospital, requiring numerous phases of construction that were estimated to last for at least seven years. SHS estimated that this would have eroded its market share and consumer confidence in the hospital, impacting its financial performance. Significantly, the existing site scored lowest on accessibility because it could not provide the same ease of access for patients, staff, or EMS as the other project alternatives since it is located in a densely populated residential neighborhood with lack of access to major roadways.

Should the proposed project not be implemented, the market share and operating income of the existing hospital is expected to erode over time, as evidenced by the projected operating loss beginning in FY2032. Finally, this alternative was least likely to enhance physician recruitment.

b. Alternatives Two through Four

Each of the relocation alternatives two through four ranked as equivalent on several of the objectives: accommodating the long-term needs of the service area population, meeting the needs of senior citizens in providing improved wayfinding, and enhancing physician recruitment. The ability of the building and campus to accommodate the long-term needs of the service area and improve wayfinding were identified as objectives, in part, because they are serious deficiencies with the existing facility. All of the relocation alternatives would provide a new site with fewer space limitations and a new facility with a more modern design that would easily meet these objectives. Similarly, a modern, state-of-the-art facility was estimated to enhance physician recruitment, and all of these alternatives would provide such a facility.

The relocation alternatives could be distinguished primarily by how they ranked on improving access and enhancing and sustaining financial performance of the hospital. For improving access, the proposed project site ranked first because, based on the original drive time analysis prepared as part of the 2012 CON application, it was estimated to have the lowest aggregate drive time of the relocation alternatives and was thought to provide the most ease of access for patients, employees, and EMS services. Below are the results of the 2012 CON application drive time analysis based on 2017 projected service area data.

Table 39
2012 Weighted Drive Times for 2017
Service Area Population

	219 South Washington St., Easton 21601 (Current Site)	Easton Bypass & Oxford Rd., Easton 21601 (Bypass at Oxford Road)	10028 Ocean Gateway Easton 21601 (Proposed Site)	Route 50 and 404, Wye Mill 21679 (Site in Northern Talbot County)
Average Drive Time in Minutes	24.0	25.6	23.3	24.4

Similarly, due to its location near the Town of Easton and accessibility to major roadways, the proposed project site was expected to obtain the greatest philanthropic support. The Northern Talbot County Site ranked second for overall accessibility, and the Bypass at Oxford Road Site ranked third (worst) for improving access. The Northern Talbot County Site was expected to have the lowest philanthropic support due to its location being the farthest from the Town of Easton. In addition, the Northern Talbot County Site did not have nearby access to municipal police and fire resources, which are important resources that SHS depends on today and which are accessible at

the proposed project site. Based on an updated drive time analysis presented in the Geographic Accessibility response, the Northern Talbot County Site is now estimated to have a very slightly lower drive time than the proposed project site. The total weighted average drive time to the proposed project site is now estimated to be 23.5 minutes while the Northern Talbot County Site is estimated to be 22.7 minutes.

As for capital costs, the Northern Talbot County Site was estimated to have higher capital costs than the proposed project site for several reasons. First, SHS would have to purchase all of the land for the Northern Talbot County Site and would have to pay the market value, which was estimated at $7.2 million. Talbot County conveyed the land for the proposed project site to UM SRH for $2.5 million in 2015, thereby donating a significant portion of the parcel. The Town of Easton and the County also promised to bring the major utilities to the site, which would also save costs. By comparison, the Northern Talbot County Site would be expensive to develop since utilities would have to be brought from long distances, and SHS would have to develop its own sewage treatment facility. With updated inflation, the capital costs of the Northern Talbot County Site are estimated to be approximately $14.2 million more than the capital costs at the proposed project site. Although the capital costs for the Bypass at Oxford Road Site were estimated to be lower than the Northern Talbot County Site and proposed project site since the land had been donated to SHS, this alternative was ultimately rejected by SHS because it ranked the poorest for accessibility for the service area population.

Based on all of the above considerations, SHS determined that the proposed project site was the most cost effective alternative that would best meet its objectives. For purposes of responding to this standard, SHS updated its original cost and financial projection models above by applying an inflation factor to account for the passage of time. In doing so, the proposed project site still results today in the same overall ranking of the project alternatives. The passage of time has only exacerbated the deficiencies of the existing hospital campus as seen through its rankings on the objectives. SHS is confident that the proposed project site continues to be the most cost-effective approach to meeting its objectives.

VIII. Design Alternatives for the Proposed Project

Although SHS determined years ago that the proposed project site was the most cost-effective site alternative, it has continued to refine the design of the proposed project to select the most cost-effective design capable of serving the long-term needs of its service area population. Since selecting the proposed project site, SHS has continued analyzing ways to reduce capital cost and operating cost of the proposed campus while meeting the changing needs of care delivery and respond to lessons learned during the COVID pandemic.

Multiple alternatives were explored within the proposed site to minimize land development impact and cost. The current iteration reflects a collaborative effort with community stakeholders to responsibly develop a health care campus that can adapt over time. To that end, UM SRH studied multiple campus building configurations to meet programmatic needs, but it was determined to consolidate into a single building footprint with three wings around a central elevator core to reduce site impact and building exterior skin cost. The consolidated building is sited within a new ring road with traffic circles to accommodate future traffic growth with any future development on the campus. Space has been left adjacent to the building to provide flexibility in case future expansion is needed. As the FGI Guidelines have changed over the past decade, targeted area shifts have been implemented to accommodate larger clinical spaces, such as operating rooms capable of supporting a robust robotics program. Optimal structural grid size was studied and grid reduction implemented in one wing to reduce overall building gross area. The proposed project chooses the

more straightforward and cost-effective solution where possible. The helipad is on the ground rather than on the hospital roof, to reduce structural and elevator cost. Exterior air handling units (AHUs) are included, rather than a full mechanical penthouse. The hospital was sited so that more expensive curtain wall is limited to high impact, highly visible areas and other exterior skin is more modest materials. Inpatient units have been standardized in design and bed quantity for ease of staffing but also with replicable components eligible for prefabricated construction. These standardized units also include standardized infrastructure, such as universal telemetry capability, to provide efficient bed units with the flexibility to adapt to changes in health care delivery and community health needs. This strategic analysis of high-cost decisions ensures that programmatic priorities and budget are met.

In response to lessons learned during the COVID pandemic, the replacement facility design responds to challenges faced by UM SRH care providers. As mentioned above, universal units with telemetry capability allows for more flexibility in determining a patient's room of admission. Within the units, dedicated staff lounge space provides an on-unit location for staff break without travel time burden. A garden at the cafeteria provides an outdoor eating and respite opportunity. An increase in airborne isolation rooms, within Emergency Department, perioperative, and inpatient units, acknowledges the increased need to provide care to infectious patients without shutting down service lines. The enlarged observation unit includes all private patient rooms with private toilets to reduce potential cross-contamination. A decontamination suite at the rear of the Emergency Department has nearby exterior-access emergency management storage as well as a staff parking lot that can be taken off-line and used as staging in an off-stage area. The Emergency Department parking lot has been arranged in a loop manner to allow for future mass vaccinations or drive-through testing. These decisions add relatively minor cost to the overall project but solve pain points experienced over the past years' pandemic care delivery and support future flexibility in providing care in this rural environment.

The proposed replacement hospital has been designed to meet the needs of this community in a cost-effective manner.

(b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.

Applicant's Response

Not applicable.

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

(i) That it has considered, at a minimum, an alternative project site located within a Priority Funding Area that provides the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);

(ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;

(iii) That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and

(iv) That the proposed project site is superior, in terms of cost-effectiveness, to the alternative project site or sites located within a Priority Funding Area.

Applicant Response:

The proposed site is within a Priority Funding Area. (See **Exhibit 15**.)

Standard .04B (6) – Burden of Proof Regarding Need

A hospital project shall be approved only if there is demonstrable need. The burden of demonstrating need for a service not covered by Regulation .05 of this Chapter or by another chapter of the State Health Plan, including a service for which need is not separately projected, rests with the applicant.

Applicant Response:

The Applicant acknowledges that it has the burden of proof regarding need.

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

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 given 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 rate increase proposed by the hospital related to the capital cost of the project 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.

Applicant Response:

As shown below, the cost per square foot of the new construction is lower than the Marshall Valuation Service ("MVS") benchmark.

I. Marshall Valuation Service
Valuation Benchmark – New Construction – Tower

Type		Hospital
Construction Quality/Class		Good/A
Stories		6
Perimeter		1,366
Average Floor to Floor Height		15.3
Square Feet		382,977
f.1	Average floor Area	63,830
A. Base Costs		
	Basic Structure	$485.00
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$485.00
Adjustment for Departmental Differential Cost Factors		1.17
Adjusted Total Base Cost		$565.63
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$565.63
C. Multipliers		

Perimeter Multiplier	0.902213343
Product	$510.32
Height Multiplier	1.076
Product	$548.96
Multi-story Multiplier	1.015
Product	$557.20
D. Sprinklers	
Sprinkler Amount	$3.09
Subtotal	$560.28
E. Update/Location Multipliers	
Update Multiplier	1.21
Product	$677.94
Location Multiplier	0.99
Product	$671.16
Calculated Square Foot Cost Benchmark	**$671.16**

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

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
Inpatient Nursing Units				
Intensive Care	12,413	Inpatient Units	1.06	13,158
Med / Surg (Telemetry / Neuro)	14,873	Inpatient Units	1.06	15,765
Rehab (Requard Center)	13,465	Inpatient Units	1.06	14,273
Med / Surg (General)	32,581	Inpatient Units	1.06	34,536
Pediatric Unit	incl in M/S Unit	Inpatient Units	1.06	0
Med / Surg (Joint, Med/Surg)	incl in M/S Unit	Inpatient Units	1.06	0
Obstetrics incl. nursery	21,063	Obstetrical Suite Only	1.44	30,331
Behavioral Health Unit	11,616	Inpatient Units	1.06	12,313
Diagnostic & Treatment				
Clinical Lab / Pathology	10,225	Laboratories	1.15	11,759
Emergency Department / Express Care	21,890	Emergency Suite	1.18	25,830
Inpatient Dialysis	2,332	Inpatient Units	1.06	2,472
Imaging Department	15,605	Radiology	1.22	19,038
Interventional Suite (incl O.R.'s, Cath, EP, PACU)	30,968	Operating Suite, Total	1.59	49,239
Prep / Stage 2 Recovery	16,128	Operating Suite, Total	1.59	25,644
Pre-Anesthesia Testing	710	Laboratories	1.15	817
Observation Unit	11,976	Inpatient Units	1.06	12,695
Respiratory Therapy	697	Adjunct Facilities	1.18	822
Administrative / Public Services				
Auxiliary	310	Offices	0.96	298
Admitting / Registration	1,784	Offices	0.96	1,713
Chapel	597	Public Space	0.8	478
Education Center / Med Library	4,956	Offices	0.96	4,758
Gift Shop	1,255	Public Space	0.8	1,004
Hospitalist Suite	-	Offices	0.96	0
On-Call	1,670	Offices	0.96	1,603
Executive Admin	4,631	Offices	0.96	4,446
Medical Records	2,060	Medical Records	0.98	2,019
Quality Team	incl in Admin	Offices	0.96	0
Human Resources / Employee Health	1,808	Offices	0.96	1,736
Nursing Administration / Staff offices	1,361	Offices	0.96	1,307
Information Technology	2,046	Offices	0.96	1,964
Lobby Services	1,192	Public Space	0.8	954

Support Services				
EVS / Linen / Facilities / Mat. Mgmt.	13,592	Laundry	1.68	22,835
Biomed	894	Offices	0.96	858
Maryland Express Care Suite	372	Offices	0.96	357
Sterile Processing	7,306	Central Sterile Supply	1.54	573
Pharmacy	4,843	Pharmacy	1.33	9,717
Security	989	Offices	0.96	4,649
Morgue	252	Storage and Refrigeration	1.6	1,503
Food & Nutrition	13,316	Dietary	1.52	1,503
Clinics				
Cardiopulmonary / Vascular	5,952	Outpatient Department	0.99	5,892
Education Center	incl in Education above			
Behavioral Health Outpatient Clinic	3,133	Outpatient Department	0.99	3,102
Cardio Rehab	3,758	Outpatient Department	0.99	3,720
Diabetes Clinic	2,935	Outpatient Department	0.99	2,906
Infusion Center	2,178	Physical Medicine	1.09	2,374
Pain Management Clinic	3,133	Outpatient Department	0.99	3,102
Sleep Lab	-	Outpatient Department	0.99	0
Multi-Specialty Clinic	4,039	Outpatient Department	0.99	3,999
Outpatient Lab Draw	751	Outpatient Department	0.99	743
Total	307,655		1.17	358,802

II. Marshall Valuation Service
Valuation Benchmark – New Construction – Central Utility Plant ("CUP")

The MVS does not have a separate benchmark for the CUP. UM SMC at Easton utilized the hospital benchmark but applied the Departmental Cost Differential Factor of 0.7 for Mechanical Equipment and Shops.

Type	Hospital
Construction Quality/Class	Good/A
Stories	1
Perimeter	610
Average Floor to Floor Height	20.00
Square Feet	22,385

	Average floor Area		22,385
A. Base Costs			
	Basic Structure	$	485.00
	Elimination of HVAC cost for adjustment		0
	HVAC Add-on for Mild Climate		0
	HVAC Add-on for Extreme Climate		0
Total Base Cost			$485.00
Adjustment for Departmental Differential Cost Factors			0.70
Adjusted Total Base Cost			$339.50
B. Additions			
	Elevator (If not in base)		($8.70)
	Other		$0.00
Subtotal			($8.70)
Total			$330.80
C. Multipliers			
Perimeter Multiplier			0.9197208
	Product	$	304.24
Height Multiplier			1.184
	Product		$360.22
Multi-story Multiplier			1.000
	Product		$360.22
D. Sprinklers			
	Sprinkler Amount		$7.38
Subtotal			$367.60
E. Update/Location Multipliers			
Update Multiplier			1.21
	Product		$444.80
Location Multiplier			0.99
	Product		$440.35

Calculated Square Foot Cost Standard	**$440.35**

III. Marshall Valuation Service
Valuation Benchmark– Mechanical Penthouse

Type			Mechanical Penthouse
Construction Quality/Class			Good/A-B
Stories			7
Perimeter			204
Average Floor to Floor Height			21.83
Square Feet			2,510
	Average floor Area		2,510
A. Base Costs			
	Basic Structure	$	105.00
	Elimination of HVAC cost for adjustment		0
	HVAC Add-on for Mild Climate		0
	HVAC Add-on for Extreme Climate		0
Total Base Cost			$105.00
B. Additions			
	Elevator (If not in base)		$0.00
	Other		$0.00
Subtotal			$0.00
Total			$105.00
C. Multipliers			
Perimeter Multiplier			1.053432
	Product	$	110.61
Height Multiplier			1.22609
	Product		$135.62
Multi-story Multiplier			1.020
	Product		$138.33
D. Sprinklers			
	Sprinkler Amount		$0.00
Subtotal			$138.33

E. Update/Location Multipliers	
Update Multiplier	1.21
Product	$167.38
Location Multiplier	0.99
Product	$165.71
Calculated Square Foot Cost Standard	**$165.71**

IV. Consolidated MVS Benchmark

Standard	MVS Benchmark	Sq. Ft.	Total Cost Based on MVS
"Tower" Component	$671.16	382,977	$257,039,670
Penthouse	$165.71	2,510	$415,923
CUP	$440.35	22,385	$9,857,267
Consolidated	**$655.38**	407,872	$267,312,859

V. Cost of New Construction

Unadjusted Costs

A. Base Calculations	Actual	Per Sq. Foot
Building	$216,638,602	$531.14
Fixed Equipment	In Building	$0.00
Site Preparation	$44,409,960	$108.88
Architectural Fees	$11,000,000	$26.97
Permits	$6,135,000	$15.04
Loan Placement Fees	$2,980,000	$7.31
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$281,163,562	$689.34

However, as related below, this project includes expenditures for items not included in the MVS average. As shown below, there are costs both in areas called “Inside the Loop” and “Outside the Loop.” The entire real estate parcel is not allocated to the hospital. Only the portion of the site called “Inside the Loop” is hospital related, and the remainder of the site will be used for future, non-hospital related development. However, the project costs include all of the costs related to the entire site. Consequently, the costs related to the portion of the parcel that is not related to the hospital (“Outside the Loop”) are being subtracted from the comparison, as off-site costs.

	Project Costs	Associated Cap Interest		Loan Placement Fees
Inside the Loop				
Canopy	$1,881,250	$334,541	Building	$19,939
Premium for Labor Shortages on Eastern Shore Projects	$12,998,316	$2,311,476	Building	$137,767
LEED Silver Premium	$8,665,544	$1,540,984	Building	$91,844
Pneumatic Tube System	$1,125,000	$200,057	Building	$11,924
Signs	$135,000	$24,007	Building	$1,431
Premium for Prevailing Wage	$12,998,316	$2,311,476	Building	$137,767
Premium for Minority Business Enterprise Requirement	$8,570,914	$1,524,156	Building	$90,842
Paving and Roads	$6,091,611		Site	$64,564
Demolition	$412,500		Site	$4,372
Storm Drains	$3,282,000		Site	$34,785
Rough Grading	$2,455,794		Site	$26,029
Landscaping	$4,239,791		Site	$44,937
Sediment Control & Stabilization	$375,000		Site	$3,975
Helipad	$55,000		Site	$583
Water	$91,350		Site	$968
Sewer	$146,160		Site	$1,549
Premium for Labor Shortages on Eastern Shore Projects	$2,664,598		Site	$28,242
Premium for Prevailing Wage	$2,664,598		Site	$28,242
Premium for Minority Business Enterprise Requirement	$1,090,430		Site	$11,557
Outside the Loop				
Roads	$6,653,000		Site	$70,514
Pump Station	$1,118,520		Site	$11,855
8" to 12" Force Main	$1,560,000		Site	$16,534
Misc.	$780,000		Site	$8,267
EASTON ELECTRICAL SERVICE	$704,369		Site	$7,465
EASTON GAS SERVICE TO PROPERTY	$254,196		Site	$2,694
Verizon	$1,170,497		Site	$12,406
MD Broad Band (Fiber)	$1,592,448		Site	$16,878
Chop Tank (Electric)	$2,826,004		Site	$29,952
Cable TV	$3,532,880		Site	$37,444
Total Cost Adjustments	$90,135,086	$8,246,697		$955,325

Explanation of Extraordinary Costs

- Demolition - The project requires a small amount of demolition. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A - Good General Hospital per Section 1, page 3 of the MVS.

- Premium for Labor Shortages/Remote Location on Eastern Shore Projects – UM SMC at Easton has included a premium (based on Building Costs) due to labor shortages and costs of transporting equipment and construction materials based advice of cost estimators and previous experience that they have had on the Eastern Shore. In Section 99, Page 1, MVS recognizes the potential for a 2%-10% premium for Abnormal Shortages and for a 5%-15% for Remote Areas.

- LEED Silver Premium – UM SMC at Easton has included a 4% premium (based on Building Costs only) due to constructing this building to LEED Silver standards. The potential for a 0%-7% premium is recognized by MVS in Section 99, Page 1.

- Signs, Canopy, Jurisdictional Hook-up Fees, Impact Fees, Paving and Roads, Storm Drains, Rough Grading, Landscaping, and Sediment Control & Stabilization – These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the MVS.

- Helipad - Land improvement costs, such as helipads, are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the MVS. (While helipads are not specifically mentioned, UM SMC at Easton considers it a land improvement cost.)

- Water and Sewer– This project requires the extension of utilities to the perimeter of the hospital related portion of the site (i.e., to the outer boundary of the "Inner Loop"). These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the MVS.

- Premium for Minority Business Enterprise Requirement – This construction will be subject to the Minority Business Enterprise Requirement ("MBE"). UM SMC at Easton estimates that the premium will be 4%, based on input from contractors.

- Premium for Paying Prevailing Wage – Because State funds may be used to construct the replacement hospital, UM SMC at Easton's contractors will have to pay "prevailing" wages, rather than "scale." UM SMC at Easton's consultant, Andrew Solberg, telephoned Marshall and Swift's Technical Assistance staff on 9/27/13 and asked John Thompson whether this would constitute a premium over the average cost per square foot presented in the MVS, even when adjusted for update and local multipliers. Mr. Thompson stated that paying prevailing wage would definitely be a premium over the average. He stated that he had previously been an electrician and, on buildings on which he was paid scale, the pay was approximately $11/hour. However, on projects on which he was paid prevailing wage, he was paid

approximately $32/hour.[6] UM SMC at Easton has searched for an average premium that is should use as the basis for its assumption. The Associated Builders and Contractors cited a study by the Minnesota Taxpayers Association (MTA) that found that the prevailing wage rates on public construction increased project costs between 7 and 10 percent. (http://www.abc.org/EducationTraining/AcademyPages/tabid/340/entryid/820/Default.aspx) UM SMC at Easton has assumed that the premium will be 6%, below the lower end of the range. Because prevailing wage will have to be paid for both site preparation and construction, UM SMC at Easton has applied it to both.

- All Outer Loop Costs – These are considered off-site costs, as they relate to a portion of the parcel that is not hospital related. Off-site costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the MVS.

- Loan Placement Fees on Extraordinary Costs – The Loan Placement Fees shown on the project budget table are for the entire costs of the hospital building. The costs associated with this line item also apply to the extraordinary costs. The Fees associated with Extraordinary Costs should not be included in the comparison, since the item they pertain to is not included. They were calculated by dividing each Extraordinary Cost by the $282,013,562 shown as the subtotal in the unadjusted project costs shown above to obtain the percent that that Extraordinary Cost comprised of the total costs. This was then multiplied by the Loan Placement Fees to obtain that Extraordinary Cost's related amount that should not be included.

- Capitalized Construction Interest on Extraordinary Costs - Capital Interest shown on the project budget sheet is for the entire costs of the hospital building. The costs associated with this line item also apply to the extraordinary costs. Because the Capitalized Construction Interest only associate with the costs in the "Building" budget line are considered in the MVS analysis, it is appropriate to adjust the cost of each of the above items that are in the Building costs to include the associated capitalized construction interest.

  Capitalized Construction Interest was calculated as follows:

Hospital	New	Renovation
Building Cost	$216,638,602	$0
Subtotal Cost (w/o Cap Interest)	$281,163,562	$0
Subtotal/Total	100.0%	0.0%
Total Project Cap Interest	$49,999,000	$0
Building/Subtotal	77.1%	
Building Cap Interest	$38,524,599	
Associated with Extraordinary Costs	$8,246,697	

[6] Mr. Solberg asked Mr. Thompson if he would send Mr. Solberg an email confirming his opinion, but Mr. Thompson stated that he was not allowed to do so.

Applicable Cap Interest	$30,277,902

To obtain the Cap Interest for each Extraordinary Cost associated with the Building line, the cost of that Extraordinary Cost was divided by the Building Cost ($216,638,602) and then multiplied by the Building Cap Interest ($38,524,599).

Costs – Less Extraordinary Cost Adjustments

	Adjusted Project Costs	**Per Square Foot**
Building	$170,264,261	$417.45
Fixed Equipment	$0	$0.00
Site Preparation	$649,215	$1.59
Architectural Fees	$11,000,000	$26.97
Permits	$6,135,000	$15.04
Subtotal	$188,048,476	$461.05
Loan Placement Fees	$2,024,675	$4.96
Capitalized Construction Interest	$30,277,902	$74.23
Total	$218,326,378	$535.28

MVS Benchmark		$655.38
The Project		$535.28
Difference		-$120.10
%		-18.33%

As shown above, the project's cost per square foot is below the MVS benchmark.[7]

[7] In recent reviews, MHCC Staff have been adding Contingency and Inflation to the costs being compared to the MVS benchmark. Historically, Contingency and Inflation costs have never been included in the comparison. It is only in the last few years that MHCC Staff have included it. UM SMC at Easton believes that Contingency costs should not be included because they may not be spent. If the inclusion of Contingency in the comparison causes an applicant to exceed the MVS benchmark, a condition is imposed on the CON approval that the HSCRC should take a related amount out of the rates that the HSCRC approves for the project. However, if, in building the project, an applicant subsequently does not need to spend the Contingency, the condition is not revised or removed. Because of the contingent nature of this budget item, it should not be included in the comparison. Like Contingency costs, the MHCC has only begun including Inflation in the MVS comparison in the last few years. It should not be added. Inflation is calculated through the midpoint of construction (reflecting future costs per square foot), while the MVS benchmark reflects current costs. This is an unfair comparison. However, if MHCC Staff persist in including Contingency and/or Inflation, certainly the percentage of Contingency and/or Inflation associated with Extraordinary Costs (which are, themselves, excluded from the comparison) should not be included.

Standard .04B(8) – Construction Cost of Non-Hospital Space

The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide for the appropriate structure. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the non-hospital space 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. In general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.

Applicant Response:

Not applicable.

Standard .04B(9) – 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 rate increase proposed by the hospital related to the capital cost of the project 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:

Importantly, the first part of this standard states that "for inpatient nursing units that exceed *reasonable* space standards per bed for the *type of unit being developed* shall not be recognized in a rate adjustment." (*emphasis added*). As described above, for certain types of units such as ICU and inpatient behavioral health that are required by code to have additional family and support spaces, an inflexible 500 SF/bed ratio may not be a reasonable space standard for hospitals like UM SMC at Easton with smaller specialty units.

The average square feet/bed of the inpatient nursing units in the replacement facility is slightly under the 500 SF/bed standard at an average of 498, using the definition in the Acute Care

Chapter of the State Health Plan. The average SF/bed varies by the type of nursing unit. The medical / surgical units are well within the 500 SF/bed standard at an average of 459 SF/bed. A summary of the calculations is shown below in Table 40. The detailed analysis is included in **Exhibit 16.**

The 12-bed ICU unit exceeds the standard because it has very few beds in relation to the required family and support space to support an ICU. Unlike a general medical / surgical unit, an ICU is required to provide 20 SF equipment storage per bed, provisions for staff on-call room(s), and additional space for family / visitors both within the room and in the family and visitor lounge, all of which requires more space. In larger hospitals, this additional space gets more evenly distributed when there is a larger denominator of ICU beds. However, for smaller ICUs like that planned for UM SMC at Easton, the unit must still accommodate the larger support space but with a smaller denominator of beds which creates a much larger SF/bed ratio. As described in Cost-Effectiveness response (COMAR 10.24.10.04B(5)), the building design seeks to simplify massing in the inpatient wings. As such, the south patient wing is sized to accommodate three standardized medical / surgical inpatient units all stacked vertically, which creates staffing and space efficiencies. The north wing houses the specialty units, which have differing space needs by service line but must also fit within a stackable footprint. ICU has been located on Level 4, in order to be located on the closest level to surgery within the smaller tower footprint.

The behavioral health unit also exceeds the standard due to the inclusion of code-required functions to support unique needs for proper care of behavioral health patients not found in a typical nursing unit. This additional required space for a behavioral health includes spaces such as the day room / dining (at minimum 25 – 35 SF/patient), group therapy, staff-controlled patient storage, dedicated conference and treatment planning room, visitor room (at minimum 100 SF), locked visitor storage, patient laundry, consultation room (at minimum 100 SF), quiet room (at minimum 80 SF), and seclusion room (at minimum 60 SF plus vestibule and toilet room). All these spaces are not found in a typical medical / surgical unit and are unique requirements for this type of specialty care. Similar to the ICU, UM SMC at Easton's behavioral health unit is a smaller unit with only 12 beds, which drives a higher SF/bed ratio due to the smaller denominator.

Table 40
Average Square Feet Per Bed of Inpatient Nursing Units

INPATIENT UNIT	LEVEL	NSF	# BEDS	SF/BED
GENERAL MED/SURG UNITS				
MED/SURG (MED/SURG, PALLIATIVE & PEDS)	3	12,646	27	468
MED/SURG (TELEMETRY BEDS)	4	11,061	24	461
MED/SURG (ADULT)	5	10,761	24	448
SPECIALTY UNITS				
ICU	4	7,559	12	630
BEHAVIORAL HEALTH	6	7,293	12	608
TOTAL AREA & BEDS		49,318	99	
AVERAGE SF/BED				498

Standard .04B(10) – Rate Reduction Agreement

A high-charge hospital will not be granted a Certificate of Need to establish a new acute care service, or to construct, renovate, upgrade, expand, or modernize acute care facilities, including support and ancillary facilities, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

Applicant Response:

Not applicable. The Commission determined in the CON review for the replacement and relocation of Washington Adventist Hospital that this standard is inapplicable because the rate reduction agreements referenced in the standard have been replaced by the Global Budget revenue model. *In re Washington Adventist Hospital*, Docket 13-15-2349, Decision at 51.

Standard .04B(11) – Efficiency

A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or

(c) Demonstrate why improvements in operational efficiency cannot be achieved.

Applicant Response:

UM SMC at Easton is already an efficient hospital based on national benchmarks, in spite of some of its existing facility limitations. Under the current models of hospital reimbursement in Maryland, UM SMC at Easton has the incentive to reduce length of stay, ancillary testing, unnecessary admissions and readmissions, as well as improve efficiency in the provision of services while treating patients in a manner consistent with appropriate, high quality medical care. It is important to note that UM SMC at Easton is a GBR hospital. Under its GBR agreement with HSCRC, the HSCRC provides assurance of a certain amount of revenue each year, independent of the number of patients treated and the amount of services, either inpatient or outpatient, provided to these patients. If volumes go down, UM SMC at Easton has to increase prices, and if volumes go up, UM SMC at Easton has to decrease prices. A GBR hospital essentially is penalized for higher volumes and specifically volumes considered to be avoidable, or unnecessary. Volume will not drive earnings from operations, only expenses will do so. Consequently, UM SMC at Easton has every incentive to become more efficient and where UM SMC at Easton has been able to become more efficient, it has attempted to do so.

In the spring of 2015, UM SRH engaged IMA Consulting, a national health care advisory firm, to evaluate staffing throughout the UM SRH System. IMA Consulting utilizes interviews with key stakeholders and direct observations of operations, supplemented by comparative data analyses and cost per unit of service, to identify viable opportunities for improvement. By establishing worked hours per unit of service targets, it guides the organization's leaders to assure that productivity remains on track. IMA compared UM SMC at Easton's worked hours per unit of service to national standards and proposed adjustments in processes and procedures in order to staff its departments at the 25-50th percentile benchmark for the "most efficient departments" throughout the nation. Since the IMA engagement, UM SMC at Easton has implemented Vizient's Operational Data Base tool for its benchmarking construct and continues to efficiently staff its departments according to the established productivity standards.

In addition to achieving staffing efficiencies through the benchmarks and productivity standards that UM SMC at Easton implemented in accordance with its productivity management process, SHS generated significant staffing efficiencies as a result of the consolidation of UM SMC at Dorchester and UM SMC at Easton which occurred in fiscal year 2022. As outlined in the Applicant's Request for Exemption filed with the MHCC on July 13, 2018, the consolidation of UM SMC at Dorchester's inpatient services at UM SMC at Easton resulted in an estimated reduction of 113 FTEs and savings of $8 million in associated salaries and benefits.[8] Given that SHS has already implemented these staffing efficiencies, there are not additional significant staffing

[8] *See* Applicant's Request for Certificate of Exemption for Merger and Consolidation of UM SMC at Dorchester and UM SMC at Easton, Docket No. 18-20-EX007, pp.46-47.

efficiencies to be realized through this project. UM SMC at Easton will implement the same standards for staffing efficiency at the replacement hospital that have been successful thus far at the existing facility.

Specific to the new facility, efficiencies will be generated through: (i) operational efficiencies gained through improved design elements; (ii) reduction in repairs and maintenance expenses being incurred at the existing hospital site due to the age of the facility; and (iii) plant design in reduction of utilities. These include:

Bed Units. The new hospital design will have all private rooms, which will be a major improvement over the existing facility in which more than one-quarter of the rooms are semi-private. The bed units are designed to improve staff efficiency, reduce transfers, increase patient safety, reduce patient falls, reduce medication errors, and help prevent hospital communicated diseases and infections. Standardized unit sizes and universal telemetry capability will provide a flexible framework to accommodate varying patient populations and acuity with an agile clinical staff.

The room design plans were developed to optimize room workflow for staff, patients, and family, which will help optimize caregiver time with the patient. Central support cores are similar on all med/surg units, with centralized equipment and clean supply to streamline stocking. All of these are improvements over the aged nursing units and non-standardized care areas of the existing hospital. Additionally, the sweeping arced form minimizes unit-wide circulation to key rooms and reduces footsteps for the caregiver by as much as 30% compared to the current race-track configuration in most units. The triangular circulation design also improves visibility and security. The location of the ADA designed rooms near the patient elevators, as well as the location of the elevators between the units, further improves workflow and efficiency processes for patient transport and reduces critical time to reach key services. Other elements that foster improved efficiency include the location of the gym/rehab space on the unit for ortho/rehabilitation and the location of ICU and respiratory therapy. Dialysis is located nearest the highest acuity patients and infrastructure provisions will be made for bedside dialysis care where appropriate, to further minimize transfers. All of these are critical improvements over the limitations of the existing hospital.

Other sizing improvements to bed units include the combination of the existing Joint Center and the nursing multispecialty unit “3 East.” In the existing facility, these units are on different floors and require patients to be transported via elevator. As shown in **Exhibit 1**, Table L, the replacement regional medical center is expected to generate savings of 4.4 FTEs, or approximately $344,000 in fiscal year 2029 dollars through the merging of these two units.

Imaging. Imaging efficiency is achieved by locating the department conveniently close to the primary public space and directly adjacent to emergency services. The department is also close to the patient/service elevators, streamlining patient treatment times for inpatient imaging. Internally, the department is designed to operate at optimal efficiency by separating inpatient and outpatient flows, creating a central shared tech work area, and building in synergies between imaging service modalities, such as a dedicated cardiac imaging center.

Surgery. Surgery offers the biggest improvement over the existing facility, where departments are fragmented by other departments, prep/recovery spaces are disjointed and severely undersized, and central sterile is more remote than desired. These layout challenges result in wasted time due to required travel time and increase safety risk factors. In the new facility, the prep and recovery areas will have the ability to flex between prep and stage II recovery in standardized rooms depending on patient flow, which will optimize the use of space. The outpatient access is less than 90 feet from the front door to check-in. Prep and Recovery space is located

close to both the minor procedure suite and the major ORs, Cath Rooms, and EP lab. The PACU is located to minimize transport from the OR suite and the patient elevators for inpatients. Central Sterile is located directly adjacent to the OR suite for more timely and efficient processing of sterile supplies, further improving quality and safety. Materials will move up from the loading dock in a timely manner due to proximity to the central elevator bank. Additionally, all invasive procedure suites are co-located in one new department to take advantage of a shared prep/recovery/PACU platform that improves nursing efficiency. Within the OR suite, the standardized ORs allow for maximum utilization and the central core allows for staging of case carts for improved throughput.

Observation Unit. A 25-bed observation unit is located directly adjacent to the emergency department. This serves to help optimize the size of the emergency department, allowing patients to be transferred out of the critical flow of the emergency department for observation, while helping to prevent and reduce unnecessary admissions to inpatient bed units. The observation unit is a key element to improving the overall efficient use of space, decanting patient volume from emergency services and nursing units. The location of the observation unit next to the emergency department will reduce internal transport time.

Emergency. The emergency department has been greatly optimized to improve efficiency, including standardization of the emergency department exam rooms to improve census flexibility and surge capacity, creation of Behavioral Health holding areas to promote better safety and security for a specific patient population, and proximity of emergency to key support areas such as imaging and observation. Improved quick assessment areas are also included to segregate lower acuity patients from the main emergency department pods, creating space-efficient bays for ambulatory patients and freeing up rooms for higher acuity patients.

Support Services. Materials management, lab, and pharmacy have also been located and designed with efficiency in mind. All are located to shorten the distance for delivery of supplies or specimens and medications. Pneumatic tube stations are located in each department, including a dedicated route between the lab and emergency department. This in turn will help with infection control and efficient use of staff and clinician time.

Altogether, the project was designed with efficiency as one of the top priorities. The proposed new facility, which is designed to the latest codes and standards for an all-private room hospital, will accommodate all needed beds and services in an improved layout to maximize efficient, quality patient care. This in turn is expected to lower utility expenses by 20% per square foot and lower maintenance and repair expenses by 40% per square foot, compared to the current costs incurred by UM SMC at Easton. These savings are partially offset by the larger footprint of the proposed replacement facility, resulting in a net savings of approximately $321,000 in fiscal year 2029 dollars.

Standard .04B(12) – Patient Safety

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety. A hospital proposing to replace or expand its physical plant shall provide an analysis of patient safety features included for each facility or service being replaced or expanded, and document the manner in which the planning and design of the project took patient safety into account.

Applicant Response:

The new facility is designed with patient and staff safety as a core design element. This begins with the organization of the facility, with clear separation of public and staff/service corridors to improve patient privacy, patient experience, and staff efficiency. To avoid staffing difficulties associated with the current hospital's semi-private rooms, the replacement facility will have 100% private rooms. This will also help reduce medication errors and infections. The facility will also feature standardized patient care areas in both the patient units and the surgical suite. The units themselves are designed to be as efficient as possible, locating key supplies near patient units to minimize staff travel distances by as much as 30%. At the replacement facility, computers will be placed in rooms and additional charting alcoves will be placed between patient rooms. These strategic locations will facilitate the safe delivery of medications by allowing better bedside barcode checking of medications and greater visibility of patients at all times. The investment in patient care units with fewer beds per unit than in the existing hospital will further promote patient safety by localizing resources, minimizing staff travel distances, and opening up visibility of patients while controlling noise in the units.

Patient handling and movement is also a key aspect of patient and staff safety. The replacement facility is designed with centralized elevators to minimize patient transport distances. ADA designed rooms on the patient units will be located close to the patient elevators to minimize staff handling, and all medical / surgical rooms will accommodate patient lifts. The Emergency Department includes a designated patient of size exam room with dedicated toilet appropriate for the patient population, which will decrease the risk of staff injury and promote safety and dignity for patients.

In the diagnostic areas of the replacement facility, the invasive procedure rooms will be co-located and immediately adjacent to patient prep and recovery. The ORs, Cath Labs, EP Lab, Prep and PACU are all standardized, with daylight in both patient care and staff areas to help with recovery and fatigue. Direct routes from Interventional Radiology and the Emergency Department to the Cath Labs via the trauma elevator will support the hospital's STEMI program. To prevent and relieve stress, the facility features embedded way finding for patients and family. This intuitive wayfinding starts with hospital campus entry and continues with public and visitor-facing amenities, organized along the exterior of the facility, to maximize views and orient visitors. These design features help minimize the distances that patients have to travel and will alleviate congestion and confusion within staff/service-only areas. Support functions, like Pharmacy and Lab, are located near the diagnostic departments and connected to diagnostic and inpatient units with a pneumatic tube system to provide quick and accurate service.

UM SMC at Easton recognizes that patient privacy is a key factor in safety. As part of the planning process for the replacement facility, the design team has increasingly focused on acoustical design in accordance with the 2022 guidelines. The replacement facility will be constructed with materials and finishes that help absorb noise and thereby reduce staff fatigue and improve patient rest and satisfaction. Patient spaces are inherently designed to maximize acoustic privacy and family inclusion. In particular, the replacement hospital will have fully private rooms with doors in the Emergency Department, Surgery Prep, and Observation areas, rather than bays or cubicles.

As a greenfield replacement facility, UM SMC at Easton has the opportunity to design a facility that both satisfies the current guidelines and is readily adaptable to new services and ever-changing technologies. For example, the floor-to-floor height will accommodate larger technologies. The first two floor plates also feature a regular grid that allows for adaptability over

time to new modalities and services. For future flexibility, the hospital departments are carefully planned to allow for horizontal expansion without disruption to existing services. As an added measure, the replacement facility will be outfitted with a mobile technology dock to address unanticipated technology needs in departments such as Imaging until more permanent solutions can be incorporated.

Given the proposed facility's location along US Route 50 and its important role as a regional medical center serving the Eastern Shore community, the campus is designed to adapt and scale for a variety of contingency events. This includes provisions for mass decontamination, mass vaccination, flow of the Emergency Department and flexibility of spaces to adapt in emergency situations. The design of the replacement regional medical center has taken into account the quantity and location of isolation rooms in every department within both diagnostic and inpatient units, based on lessons learned during the COVID-19 pandemic. All MSGA rooms will include point-of-use storage provisions for personal protection equipment (PPE) as well. The replacement facility design further reflects pandemic preparedness through its inclusion of appropriate decontamination spaces that enable one-way flow, increased air changes in interventional rooms, and design flexibility allowing for the segregation of units or portions of units if patient populations require different air exhaust or isolation procedures.

Additional features that improve patient safety as compared with the existing facility include:

- Co-location of related support functions to maximize efficiency
- Universal patient room design
- Dedicated trauma/patient elevator
- Continuing Care Nursery with accommodations for opioid addicted neonates or other special care needs
- Directed traffic flow into building (main entrance) past security further supported by limited building entrances
- Automation of technology and patient records
- Upgrade to ADA/ANSI standards
- Reduced patient transfer distances (surgery to short stay recovery, ED to ICU, ED to helipad, nursery/LDR to helipad, ED to Cath Lab, etc.)
- Appropriate number of prep/recovery bays
- Increased telemetry capability
- Direct access from C-section to nursery
- Charting/observation at each patient room
- Appropriate medication safety zones located out of circulation paths to support staff concentration and reduce errors

- Increased number of airborne infection isolation rooms with dedicated toilets
- Dedicated behavioral health holding suite within Emergency Department
- Specific provisions for patients of size, following current standards of care and guidelines
- Staff break and respite spaces convenient to all diagnostic and inpatient units

Standard .04B(13) – 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 must be accompanied by a statement containing each assumption used to develop the projections.

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

(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), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations, with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population.

Applicant Response:

The State Health Plan requires that a hospital capital project be financially feasible and not jeopardize the long-term financial viability of the hospital.

Included in **Exhibit 1** are Tables F, G, and H, which provide utilization and financial projections, and a comprehensive statement of assumptions related to utilization, revenue, expenses, and financial performance for Shore Health System, Inc., which includes UM SMC at Easton, UM SMC at Dorchester / Cambridge and UM Shore EC at Queenstown.

In accordance with Maryland Code, Health-General § 19-3A-01 governing freestanding medical facilities, UM SMC at Cambridge and UM Shore EC at Queenstown are recognized as outpatient departments and administrative parts of UM SMC at Easton, and subject to CMS's provider-based status requirements set forth at 42 C.F.R. § 413.65. CMS's provider-based requirements include that a provider-based outpatient department must be financially integrated with the main hospital provider, as evidenced by shared income and expenses. 42 C.F.R. § 413.65(d)(3). For these reasons, UM SMC at Easton cannot be considered independent of UM SMC at Cambridge and UM Shore EC at Queenstown in the financial projections due to the facilities' interdependence and the integrated nature of the SHS health care delivery system. Because the proposed project is a replacement facility with no addition/removal of any service lines, the Applicant has provided Tables F, G, and H for its statistical and revenue and expense projections.

As presented in Tables G and H, SHS is projected to be financially viable in the long-term.

1. Projected Shore Health System Utilization

Table F includes utilization projections that reflect both the inpatient and outpatient utilization of UM SMC at Easton, UM SMC at Dorchester / Cambridge, and UM Shore EC at Queenstown. Included within this application are bed need assumptions at UM SMC at Easton which include the historical shift of inpatient MSGA and psychiatric beds from UM SMC at Dorchester to UM SMC at Easton in fiscal year 2022 (October 2021).

2. Projected Shore Health System Revenue

The presentations of projected revenue in Tables G and H reflect the utilization projections presented in Tables F and the budgeted 2023 regulated Global Budget Revenue ("GBR") assumptions related to update factors, demographic adjustments, and uncompensated care. These assumptions, along with assumptions regarding unregulated revenue inflation, are included with the tables.

The projections include a rate increase of $24.0 million (including markup) from the HSCRC beginning in fiscal year 2029, which equals approximately 50% of the project-related capital costs (depreciation and interest) net of mark-up. The other 50% of capital costs will be funded by the Applicant's retained earnings and future operating income. The request for a rate increase will be filed as a Full Rate Application with the HSCRC in the first quarter of fiscal year 2024.

3. Projected Shore Health System Staffing and Operating Expenses

The projection of staffing of SHS is presented in **Exhibit 1**, Table L, which reflects the utilization presented in Table F, as well as assumptions related to expense inflation, expense variability with changes in volumes, and other performance improvements over the projection period through fiscal year 2032.

The applicant assumes additional savings of 20% per square foot for utilities and 40% per square foot for repairs and maintenance, described further in the response to the Efficiency

standard (see COMAR 10.24.10.04B(11)). The projection assumes no other incremental expense in salaries or other operating expenses (besides depreciation and interest) that will occur in fiscal year 2029 as part of the project. A one-time non-operating depreciation expense of $2.8 million is assumed due to physical plant assets that will be written off and not transferred to the new replacement facility.

4. Projected UM SMC at Easton Financial Performance

As presented in Table H, SHS is projected to maintain a positive operating margin for all historical and projected fiscal years. Given all the assumptions listed above, SHS is projected to experience a 7.5% operating margin in the final projected year, fiscal year 2032.

Standard .04B(14) – Emergency Department Treatment Capacity and Space

(a) An applicant proposing a new or expanded emergency department shall classify service as low range or high range based on the parameters in the most recent edition of *Emergency Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians *Emergency Department Design: A Practical Guide to Planning for the Future*, given the classification of the emergency department as low or high range and the projected emergency department visit volume.

(b) In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:

(i) The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant hospital's primary service areas;

(ii) The number of uninsured, underinsured, indigent, and otherwise underserved patients in the applicant's primary service area and the impact of these patient groups on emergency department use;

(iii) Any demographic or health service utilization data and/or analyses that support the need for the proposed project;

(iv) The impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department to more appropriate primary care or urgent care settings; and

(v) Any other relevant information on the unmet need for emergency department or urgent care services in the service area.

Applicant Response:

Emergency Department Visits in UM SMC at Easton Service Area for the Last Five Years – COMAR 10.24.10(4)(B)(14)(b)

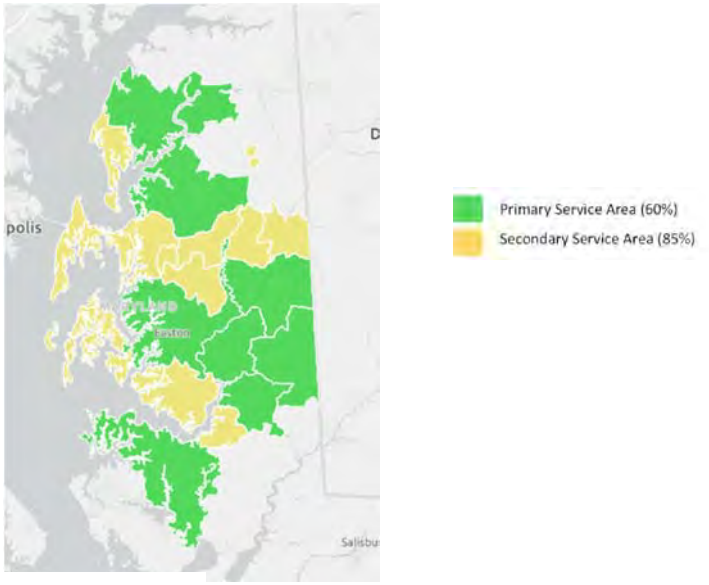
The State Health Plan requires that applicants seeking a new or expanded emergency department provide the number of emergency department visits by residents in the hospital's service area for at least the most recent five years.

A. Definition of UM SMC at Easton Service Area

In fiscal year 2022, 85% of UM SMC at Easton's Emergency Department ("ED") visits came from the residents of 23 ZIP codes in Talbot County, Caroline County, Dorchester County, Kent County, and Queen Anne's County (*i.e.*, UM SMC at Easton's ED service area) as listed and depicted in Table 41 below.

Table 41
UM SMC at Easton ED Service Area

ZIP	City	County	Discharges	Cumulative %
21601	Easton	Talbot County	7,395	29.1%
21613	Cambridge	Dorchester County	2,380	38.5%
21629	Denton	Caroline County	2,041	46.5%
21632	Federalsburg	Caroline County	1,324	51.7%
21655	Preston	Caroline County	1,238	56.6%
21643	Hurlock	Dorchester County	1,090	60.9%
21663	Saint Michaels	Talbot County	880	64.4%
21639	Greensboro	Caroline County	866	67.8%
21673	Trappe	Talbot County	802	70.9%
21660	Ridgely	Caroline County	693	73.7%
21617	Centreville	Queen Anne's County	621	76.1%
21625	Cordova	Talbot County	537	78.2%
21666	Stevensville	Queen Anne's County	286	79.4%
21620	Chestertown	Kent County	279	80.5%
21654	Oxford	Talbot County	248	81.4%
21631	East New Market	Dorchester County	238	82.4%
21658	Queenstown	Queen Anne's County	233	83.3%
21671	Tilghman	Talbot County	222	84.2%
21638	Grasonville	Queen Anne's County	205	85.0%
		Service Area Total	**21,577**	**85.0%**
		Out of Service Area Total	3,816	15.0%
		SHS Total	25,393	100.0%



Source: hMetrix FY2022 statewide non-confidential utilization data tapes

B. Historical Emergency Department Utilization in Service Area

In fiscal year 2022, there were 49,485 visits to Maryland hospital emergency departments by residents of the UM SMC at Easton ED service area (see Table 42). UM SMC at Easton's emergency department utilization by residents of its service area declined by 30.3% from 30,954 visits in fiscal year 2017 to 21,577 visits in fiscal year 2022. This decline is slightly greater than the 20.5% reduction in Maryland hospital emergency department visits to all Maryland hospitals by residents of the UM SMC at Easton ED service area. With these declines in volume, it is important to right-size the emergency department in the replacement hospital to enable it to continue to provide access to emergency services for the service area population, especially in a growing and aging rural market.

Table 42
UM SMC at Easton Service Area Emergency Department Visits
FY 2017 – FY 2022

Hospital	Historical ED Service Area Visits						2022	2017-2022
	2017	2018	2019	2020	2021	2022	% of Total	% Change
UM SMC at Easton	30,954	31,419	29,607	25,006	23,066	21,577	43.6%	-30.3%
UM SMC at Dorchester (Cambridge FMF)	17,884	17,675	16,952	14,134	11,435	12,865	26.0%	-28.1%
UM Queen Anne's ED	10,813	11,059	11,721	10,912	10,078	13,219	26.7%	22.2%
UM SMC at Chestertown	821	634	376	320	257	127	0.3%	-84.5%
Anne Arundel Medical Center	949	922	925	776	837	798	1.6%	-15.9%
Peninsula Regional Medical Center	244	227	250	262	277	306	0.6%	25.2%
Hospitals with <200 Visits	611	614	597	526	539	593	1.2%	-3.0%
Total Service Area ED Visits	**62,276**	**62,550**	**60,429**	**51,937**	**46,489**	**49,485**	**100.0%**	**-20.5%**

Source: hMetrix statewide non-confidential utilization data tapes

UM SMC at Easton's 21,577 emergency department service area visits in fiscal year 2022 represented 43.6% of the total service area emergency department visits to Maryland hospitals within the service area (not including potential visits at Delaware hospitals). Other hospitals with smaller market share of emergency department visits in the service area in fiscal year 2022 included UM SMC at Dorchester (which converted to the Cambridge FMF in fiscal year 2022) (26.0%), UM Shore EC at Queenstown (26.7%), UM SMC at Chestertown (0.3%), Anne Arundel Medical Center (1.6%), and Peninsula Regional Medical Center (0.6%). The remaining 1.2% of emergency department visits by the service area population were seen at other Maryland hospitals, with no other individual hospital accounting for more than 200 visits annually.

C. Number and Size of Emergency Treatment Spaces – COMAR 10.24.10(4)(B)(14)(a)

The State Health Plan requires that applicants seeking a new or expanded emergency department demonstrate that the proposed number and size of emergency treatment spaces proposed by the Applicant are consistent with applicable guidance included in the most current edition of the *Emergency Department Design: A Practical Guide to Planning for the Future*, published by the American College of Emergency Physicians (the "ACEP Guide"), based on reasonably projected visit volume.

As presented in Table 43 below, the emergency department visits to UM SMC at Easton from its service area ZIP Codes declined by 25.5% between fiscal years 2017 and 2022. Emergency department visits at UM SMC at Easton from individuals outside of the service area also declined by 25.0% over the same period. Combined, UM SMC at Easton's total emergency department visits declined by 29.2% from 35,883 visits in fiscal year 2017 to 25,393 visits in fiscal year 2022.

Table 43
UM SMC at Easton Historical Emergency Department Visits
FY 2017 – FY 2022

	ED Visits to UM Easton						2017-2022
	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	% Change
Service Area							
Inpatient	4,740	4,314	3,587	3,024	2,976	3,252	-31.4%
Outpatient	26,215	27,104	26,020	21,982	20,091	18,325	-30.1%
Subtotal	30,954	31,419	29,607	25,006	23,066	21,577	-25.5%
Outside Service Area							
Inpatient	780	664	608	558	471	594	-23.8%
Outpatient	4,149	4,143	4,195	3,668	3,227	3,222	-22.4%
Subtotal	4,929	4,807	4,802	4,226	3,698	3,816	-25.0%
Total	**35,883**	**36,225**	**34,409**	**29,232**	**26,764**	**25,393**	**-29.2%**

Source: hMetrix statewide non-confidential utilization data tapes and Easton internal data

The recent opening of UM SRH-owned urgent care facilities is one of the primary drivers of the decrease in emergency department volumes within UM SMC at Easton's ED service area. Since 2019, UM SRH established three new urgent care facilities within the ED service area: UM Urgent Care – Kent Island (Chester, MD; 2022), UM Urgent Care – Easton (formerly ChoiceOne Urgent Care) (Easton, MD; 2016), and UM Urgent Care – Denton (Denton, MD; 2016). Increasing the availability of urgent care sites is part of an ongoing UM SRH initiative to ensure that patients are seen in the appropriate setting in line with the goals of the Total Cost of Care model. UM SRH also has an extended network of primary care locations in the Mid-Shore area as shown in Table 1 of the Project Description, and is focused on delivering care in the right location in accordance with patients' needs and the Total Cost of Care model.

COVID-19 related staffing shortages, particularly on its inpatient units, have required UM SMC at Easton to increase frequency of its MIEMSS Alerts significantly from fiscal year 2019 to fiscal year 2022, which has also contributed to decreased emergency department utilization. Table 44 below presents the number and total duration of MIEMSS Yellow and Red Alerts[9] at UM SMC at Easton by fiscal year. From fiscal year 2019 to fiscal year 2022, the number of MIEMSS Alerts increased by 365.5% and the total hours with a Yellow or Red Alert in place increased by 3,754.2%. As a result of these alerts, a number of patients who would have otherwise been routed to UM SMC at Easton's emergency department or inpatient units were instead routed to the emergency departments at other facilities.

[9] Red Alert means the hospital has no ECG monitored beds available, which includes critical care and telemetry beds, and requests that patients who are likely to require this type of care not be transported to their facility. Yellow Alert means the ED temporarily requests that it receive absolutely no patients in need of urgent medical care. When these alerts are active, regional hospitals will still receive unstable (Priority I) monitored patients from within its catchment area for initial stabilization, and subsequent transfer to another facility for admission may be necessary.

Table 44
UM SMC at Easton's Historical MIEMSS Red & Yellow Alerts
FY 2019 – FY 2022

Easton MIEMSS Alerts	FY2019	FY2020	FY2021	FY2022	FY19 - FY22 % Variance
Yellow Alert	49	27	95	178	263.3%
Red Alert	6	27	154	78	1,200.0%
Total Alerts	**55**	**54**	**249**	**256**	**365.5%**
Hours on Yellow Alert	151	81	600	2,084	1,282.2%
Hours on Red Alert	59	358	2,984	6,019	10,023.2%
Total Hours on Alert	**210**	**439**	**3,584**	**8,104**	**3,754.2%**

Source: CHATS Hospital MIEMSS Alert Tracker

In addressing the number of treatment spaces needed to care for the emergency department patients seen at UM SMC at Easton and consistency with ACEP guidance, it should be noted that the ACEP Guide categorizes emergency department designs into low, mid, and high-range using 16 factors. The Guide indicates, though, that these low, mid, and high ranges are "general guideline[s]" used to set "preliminary benchmarks for sizing emergency departments," which can be adjusted for "each unique emergency department project" and that the size parameters are mere "estimates." (ACEP Guide at 109, 116-117).

As presented in Table 45 below, 10 of the 16 factors for the replacement hospital fall in the "high - range" as shown in the "Future Hospital" column, including (a) the average length of stay of a patient over 4 hours; (b) there will be all private rooms; (c) the inner waiting and result waiting takes place in the patient bay; (d) the location of observation beds are adjacent to the ED; (e) the boarding of admitted patients is over 150 minutes; (f) less than 25% of patients are nonurgent; (g) 34% of patients are age 65 and over; (h) imaging within the ED is extensive; (i) there will be multiple spaces for family amenities; and (j) there will be a module with support for geriatric patients. The Applicant has also highlighted in red in Table 45 how the existing hospital scores on the various ACEP factors.

Six factors fall in the "medium - range," including (a) 18.4% of patients are admitted; (b) turnaround time for diagnostic tests is 60 minutes; (c) 4-6% of patients have behavioral health diagnoses; (d) there are designated areas for pediatrics; (e) there are designated areas for detention; and (f) the new facility will include moderate administrative and teaching space. None of the sixteen factors fall in the "low - range."

Table 45
UM SMC at Easton Comparison to ACEP Guide

Factor	Current Hospital (Red) Low	Medium	High	Future Hospital
% Admitted Patients	< 8%	12-20%	> 25%	Medium (18.4%)
ALOS	<2.25 Hours	2.5-3.75 Hours	>4 Hours	High (6.4 Hrs)
Private Rooms	Few	Majority	All	High
Inner Waiting and Result Waiting Areas	Available	Limited	Pts. Stay in Bay	High
Location of Observation Beds	Outside ED	Limited	Inside ED	High
Boarding of Admitted Pts.	Stay < 60 Min	Stay 90-120 Min	Stay Over 150 Min.	High
Turnaround Time Dx Tests	< 45 Minutes	60 Minutes	> 90 Minutes	Medium
% Behavioral Health Patients*	< 3%	4-6%	>7%	Medium (6.7%)
% Nonurgent Pts.	>45%	25-45%	<25%	High (19%)
Age of Patient	<10% Age 65+	10-20% Age 65+	>20% Age 65+	High (34%)
Imaging w/n ED	No	General and CT	Extensive	High
Family Amenities	None	Limited Consult	Multiple Consult. Grieving	High
Specialty Components: Geriatrics	None	Designated Area	Module with Support	High
Specialty Components: Pediatrics	None	Designated Area	Module with Support	Medium
Specialty Components: Detention	None	Designated Area	Module with Support	Medium
Admin/Teaching Space	Minimal	Moderate	Extensive	Medium

** - Future hospital is expected to experience an increase in number of Behavioral Health ED patients due to the location of inpatient Psych beds*

Source: Factors = Emergency Department Design: A Practical Guide to Planning for the Future, published by the American College of Emergency Physicians
Future Hospital = SRH management reports and input by SRH Department of Emergency Medicine Medical Director
Data based on SRH internal data & HSCRC non-confidential statewide data

The applicable edition of the ACEP Guide (2d. ed. 2014), Figure 5.1 estimates treatment space need per emergency department visit in five thousand visit increments, starting at 10,000 visits per year. (ACEP Guide, p. 116). It also provides an estimated visits per space measure. The emergency department visits at UM SMC at Easton are projected to grow with 0.9% annual population growth from 25,393 visits in fiscal year 2022 to 27,854 visits in fiscal year 2032 (Table 46).[10]

[10] Throughout the projection period, older age cohorts with higher use rates have greater growth than younger age cohorts, like the MSGA service area population. This is not accounted for in the aggregate for emergency department visits.

Table 46
UM SMC at Easton Projected Emergency Department Visits

	Historical				Projected									
	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Easton ED Visits	**32,401**	**27,597**	**25,546**	**25,393**	**25,610**	**25,833**	**26,062**	**26,297**	**26,539**	**26,788**	**27,043**	**27,306**	**27,576**	**27,854**
% Change		*-14.8%*	*-7.4%*	*-0.6%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*1.0%*	*1.0%*	*1.0%*	*1.0%*

The Applicant believes that to best account for the clinical and operational differences in the treatment of the patients seen in the emergency department at UM SMC at Easton, it is most appropriate to separately project the need for behavioral health and general emergency department treatment spaces.

Replacement Hospital ED Design

The replacement hospital ED design includes a total of 27 ED treatment spaces, two of which will be psychiatric exam spaces. The replacement hospital ED is also planned to include three behavioral health holding spaces that will not be treatment spaces. By comparison, the existing hospital has a total of 32 ED treatment spaces, plus an additional four non-monitored non-treatment spaces.

The replacement hospital ED is designed around a pod concept to provide critical visibility and accommodate fluctuating patient census, with an observation unit located directly adjacent to the ED. The pods integrate isolation exam rooms as well as exam rooms appropriate for pediatric patients, patients of size, behavioral health patients, and SAFE examinations. Behavioral health patients will be triaged at a dedicated intake space and then taken to a psych-appropriate exam room for medical treatment, if necessary. After medical clearance, these patients will move to a three-room behavioral health holding suite, as needed, for longer stays while awaiting transfer. The new department incorporates lessons learned thus far from the COVID-19 pandemic and provides three airborne infection isolation rooms with dedicated toilets. A clear path of travel from the ambulance drop off area to resuscitation and the primary exam pod creates straightforward workflows. Appropriate clinical support space is integrated into the center of the ED exam pods and staff support is located within the department, providing convenient opportunities for respite.

The ED is located between a 25-bed observation unit and comprehensive imaging department, with immediate access to a trauma elevator connecting to surgery services above. A helipad is located at grade directly outside the department. Please see **Exhibit 2,** page 5 for a diagram of the ED and these adjacent spaces.

Request for 2 Dedicated Behavioral Health and Isolation / Detention Treatment Spaces

Patients with behavioral health issues are included in the historical and projected emergency department visits shown in Table 42, Table 43 and Table 46 above. In fiscal year 2022, 1,707 of UM SMC at Easton's emergency department visits were diagnosed with a behavioral health condition. Behavioral health emergency department visits are anticipated to grow to 1,872 in fiscal year 2032 based on 0.9% to 1.0% annual population growth (Table 47).

Table 47
UM SMC at Easton
Historical and Projected Behavioral Health ED Visits

	Historical			Projected									
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Easton BH ED Visits	**2,036**	**1,976**	**1,707**	**1,722**	**1,737**	**1,752**	**1,768**	**1,784**	**1,801**	**1,818**	**1,836**	**1,854**	**1,872**
% Change		*-2.9%*	*-13.6%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*1.0%*	*1.0%*	*1.0%*	*1.0%*

The ACEP guidelines, as shown in Table 48 “ALOS” row, define the following parameters for ED average length of stay (ALOS): “low - range” is less than 2.25 hours, “medium – range” is between 2.5 and 3.75 hours, and “high – range” is greater than 4 hours (Table 48). Comparing UM SMC at Easton’s ALOS to the ACEP Guide, the hospital is well above the “high – range” assumption of 4 hours at 8.6 hours per behavioral health visit for fiscal year 2022. The longer ALOS for behavioral health emergency department visits is appropriate due to the complications related to treating these patients, as well as finding an inpatient placement for patients requiring admission. The ACEP Guide provides general sizing recommendations intended for typical ED visits and does not factor in considerations related to the treatment of behavioral health patients.

Because 10 out of the 16 ACEP future hospital measures for UM SMC at Easton fall within the “high – range,” ED volumes for behavioral health patients are projected using the high space need recommendation of 909 visits per treatment space for annual ED volume of less than 10,000 visits. Applying the recommendation of 909 visits per treatment space to the projected 1,872 behavioral health emergency department visits in fiscal year 2032 results in a need for two behavioral health emergency department treatment spaces.

This recommendation does not, however, account for the longer ALOS for behavioral health emergency department visits experienced at UM SMC at Easton. As shown in Table 48 below, UM SMC at Easton’s behavioral health emergency department visit ALOS of 8.6 hours in fiscal year 2022 is 216% of the 4.0 hour length of stay assumed in the “high – range” of the ACEP Guide. The Applicant assumes that as staffing shortages and COVID-related pressures are relieved, the ALOS for these patients will decline by 3.0% annually through fiscal year 2032. By the end of the projection period, the Applicant assumes that behavioral health ALOS will return to historical levels equal to that of fiscal year 2020. The fiscal year 2032 projected ALOS for behavioral health emergency department visits is 6.3 hours, which is 156% of the ACEP assumed 4.0 hour ALOS.

As shown in Table 48 below, the Applicant calculates ACEP equivalent ALOS adjusted emergency department visits by determining the projected behavioral health emergency department ALOS as a percentage of the 4.0 hour ALOS assumed by the ACEP Guide and multiplying this percentage by the ACEP Guide’s projected behavioral health emergency department visits, by year.

For example, the projected 6.3 hour ALOS in fiscal year 2032 is 156% of the 4.0 hour ALOS for the ACEP “high – range.” Multiplying 156% by 1,872 projected visits results in the ACEP equivalent ALOS adjusted visits of 2,954. This ACEP equivalent ALOS adjusted visits number is then divided by the ACEP Guide recommendation for visits per emergency department treatment space (909 for the “high – range,” as discussed above) to determine the number of justified behavioral health treatment spaces. In fiscal year 2032, this calculation justifies the need for three behavioral health emergency department treatment spaces.

Table 48
UM SMC at Easton
Projected Need for Behavioral Health & Detention / Isolation Treatment Spaces

	Historical			Projected									
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Easton BH ED Visits	**2,036**	**1,976**	**1,707**	**1,722**	**1,737**	**1,752**	**1,768**	**1,784**	**1,801**	**1,818**	**1,836**	**1,854**	**1,872**
% Change		*-2.9%*	*-13.6%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*1.0%*	*1.0%*	*1.0%*	*1.0%*
ACEP ALOS - High Space Need	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
Easton BH ED ALOS	6.3	7.4	8.6	8.4	8.1	7.9	7.6	7.4	7.2	7.0	6.7	6.5	6.3
% Change		*17.4%*	*16.1%*	*-3.0%*	*-3.0%*	*-3.0%*	*-3.0%*	*-3.0%*	*-3.0%*	*-3.0%*	*-3.0%*	*-3.0%*	*-3.0%*
ALOS Adjustment	**159%**	**186%**	**216%**	**210%**	**203%**	**197%**	**191%**	**185%**	**180%**	**174%**	**169%**	**164%**	**159%**
ACEP Equivalent ALOS Adjusted Visits [(1)]	**3,230**	**3,680**	**3,690**	**3,608**	**3,529**	**3,451**	**3,376**	**3,304**	**3,233**	**3,164**	**3,098**	**3,033**	**2,970**
ACEP Visits per Treatment Space													
High Space Need (<10,000 Visits)	909	909	909	909	909	909	909	909	909	909	909	909	909
Easton BH ED Treatment Space Need	**3.6**	**4.0**	**4.1**	**4.0**	**3.9**	**3.8**	**3.7**	**3.6**	**3.6**	**3.5**	**3.4**	**3.3**	**3.3**
Projected Need for BH ED Treatment Spaces									**4**	**3**	**3**	**3**	**3**
Requested BH ED Treatment Spaces									**2**	**2**	**2**	**2**	**2**

Note (1): Reflects projection of ED visits adjusted for the variance of Easton ALOS from ACEP High-Space threshold

Source for Historical ED Visits and ALOS data: UM SMC Internal ED Data Set
Source for ACEP Visits per Treatment Space: American College of Emergency Physicians - Emergency Department Design, A Practical Guide Planning for the Future

The potential need to accommodate more than one behavioral health patient in the emergency department is essential given the fact that behavioral health patients stay longer in the emergency department than non-behavioral health patients. In fiscal year 2022, the ALOS of 8.6 hours for behavioral health patients at UM SMC at Easton is 39% higher than ALOS for general visits of 6.2 hours.

The Applicant is projecting need for 3.3 behavioral health treatment spaces in 2032. The replacement hospital has been designed to meet this need by having two dedicated behavioral health treatment spaces and an adjacent behavioral health suite with three behavioral health holding spaces. The treatment spaces are within the emergency department and will meet appropriate environment of care requirements, as outlined in FGI 2022 2.2-3.1.4.3(4). The holding spaces will not be outfitted for treatment of patients. At the replacement hospital, UM SMC at Easton intends to triage patients at intake and send them to a behavioral health treatment space if medically necessary; other behavioral health patients may be transferred directly to a behavioral health holding space as they await transfer to another facility. These three holding rooms are in a secured suite with integral patient and staff support spaces.

Request for 25 General Treatment Spaces (Non-Behavioral Health)

The remaining ED visits not classified as behavioral health are projected using a similar methodology. General emergency department volumes are projected using the high space need recommendation of 1,233 visits per treatment space based on the fact that a majority of the replacement hospital ACEP factors fall into the high range. Applying the ACEP's recommendation of 1,233 visits per treatment space to the projected 25,981 general emergency department visits in fiscal year 2032 results in a need for 22 general emergency department treatment spaces.

However, the ACEP guide's treatment space recommendations do not account for UM SMC at Easton's longer ALOS for emergency department visits, which has increased in part due to COVID-related patient throughput and staffing issues. As shown in Table 49 below, UM SMC at Easton's general emergency department visit ALOS of 6.2 hours in fiscal year 2022 is 156% of the 4.0 hour length of stay assumed in the "high – range" of the ACEP Guide. The Applicant assumes that as staffing shortages and COVID-related pressures are relieved, the ALOS for these patients will decline by 2.0% annually through fiscal year 2032. By the end of the projection period, general ALOS returns to historical levels equal to that of fiscal year 2021. The fiscal year 2032 projected ALOS for general emergency department visits is 5.1 hours; 127% of the ACEP assumed 4.0 hour ALOS.

As shown in Table 49 below, the Applicant calculates ACEP equivalent ALOS adjusted visits by determining the projected general emergency department ALOS as a percentage of the 4.0 hour ALOS assumed by the ACEP Guide and multiplying this percentage by the projected general emergency department visits, by year. For example, the projected 5.1 hour ALOS in fiscal year 2032 is 127% of the 4.0 hour ALOS for the ACEP "high – range," which is then multiplied by 25,981 projected visits to calculate the ACEP equivalent ALOS adjusted visits of 33,120. This ACEP equivalent ALOS adjusted visits number is then divided by the average ACEP Guide recommendation for visits per emergency department treatment space (1,216 for the "high – range" in the case of 30,000 visits annually, 1,250 for the "high – range" in the case of 35,000 visits annually, averaging 1,233 visits per treatment space) to determine the number of justified general treatment spaces. In fiscal year 2032, the applicant projects a need for 27 general emergency department treatment spaces.

Table 49
UM SMC at Easton
Projected Need for General (Non-Behavioral Health)
Emergency Department Treatment Spaces

	Historical			Projected									
	2020	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**
Easton ED Visits													
Total Visits	27,597	25,546	25,393	25,610	25,833	26,062	26,297	26,539	26,788	27,043	27,306	27,576	27,854
Less: BH Visits	(2,036)	(1,976)	(1,707)	(1,722)	(1,737)	(1,752)	(1,768)	(1,784)	(1,801)	(1,818)	(1,836)	(1,854)	(1,872)
Non-BH ED Visits	**25,561**	**23,570**	**23,686**	**23,888**	**24,096**	**24,310**	**24,530**	**24,755**	**24,987**	**25,225**	**25,470**	**25,722**	**25,981**
% Change		-7.8%	0.5%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	1.0%	1.0%	1.0%	1.0%
ACEP ALOS - High Space Need	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
Easton Non-BH ED ALOS	**4.3**	**5.1**	**6.2**	6.1	6.0	5.9	5.8	5.6	5.5	5.4	5.3	5.2	5.1
% Change		17.6%	23.5%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%
ALOS Adjustment	**107%**	**126%**	**156%**	**153%**	**150%**	**147%**	**144%**	**141%**	**138%**	**135%**	**133%**	**130%**	**127%**
ACEP Equivalent ALOS Adjusted Visits [1]	**27,439**	**29,764**	**36,954**	**36,524**	**36,105**	**35,697**	**35,299**	**34,911**	**34,533**	**34,165**	**33,807**	**33,459**	**33,120**
ACEP Visits per Treatment Space													
High Space Need													
35,000 Visits	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250
30,000 Visits	1,216	1,216	1,216	1,216	1,216	1,216	1,216	1,216	1,216	1,216	1,216	1,216	1,216
Average	1,233	1,233	1,233	1,233	1,233	1,233	1,233	1,233	1,233	1,233	1,233	1,233	1,233
ED Treatment Space Need													
Based on ALOS Adjusted ED Visits	**22.3**	**24.1**	**30.0**	**29.6**	**29.3**	**29.0**	**28.6**	**28.3**	**28.0**	**27.7**	**27.4**	**27.1**	**26.9**
Projected Need for Gen. ED Treatment Spaces									**29**	**28**	**28**	**28**	**27**
Requested Gen. ED Treatment Spaces									**25**	**25**	**25**	**25**	**25**

Note (1): Reflects projection of ED visits adjusted for the variance of Easton ALOS from ACEP High-Space threshold

Source for Historical ED Visits: UM SMC Internal ED Data Set
Source for ALOS data: UM SMC Internal ED Data Set
Source for ACEP Visits per Treatment Space: American College of Emergency Physicians - Emergency Department Design, A Practical Guide Planning for the Future

The sizing recommendations in the ACEP Guide were most recently published in 2016, years before the COVID-19 pandemic. Average length of stay for emergency department visits increased in fiscal years 2021 and 2022, indicative of COVID-19 induced struggles experienced by UM SMC at Easton. Complications from the pandemic impacted staffing at all levels, from the emergency department to observation and inpatient units, significantly inhibiting throughput ability. Further, necessity for a higher degree of cleaning standards and protocols increased the turnaround time between patients in emergency department treatment spaces. Given these changes to hospital experience since the ACEP Guide was published, the Applicant believes it is reasonable to project future need based on their actual ALOS with assumptions for some degree of normalization to historical levels.

The Applicant is projecting need for 26.9 treatment spaces in 2032 for general emergency department patients. The replacement regional medical center is current designed to have 25 general emergency department treatment spaces plus two behavioral health spaces for a total of 27 treatment spaces. Within the general treatment spaces, there are provisions for airborne isolation rooms, sexual assault forensic exam, patient of size exam, and pediatric exam. The replacement regional medical center emergency department will meet the service area's projected needs because it is designed to achieve greater throughput efficiency and overflow flexibility than the current emergency department at UM SMC at Easton. The replacement regional medical center will include a dedicated observation unit with 25 observation beds located directly adjacent to the emergency department, which could provide overflow capacity for patients in the event of a surge in patient census, as well as transfer patients with longer anticipated lengths of stay out of the primary emergency department pods' treatment spaces, as clinically appropriate. In comparison, the existing facility does not have a dedicated observation unit currently and there is no adjacent space for overflow emergency department patients in the existing facility. As stated in the response to the Efficiency standard, construction of treatment spaces was designed with consideration for staff workflow, patients and family, and optimization of caregiver time with the patient. Improved efficiency of staff workflow and patient throughput should in turn reduce unnecessary time spent in patient care treatment spaces.

Standard .04B(15) – Emergency Department Expansion

A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it has made appropriate efforts, consistent with federal and state law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum:

(a) The applicant hospital must demonstrate that, in cooperation with its medical staff, it has attempted to reduce use of its emergency department for non-emergency medical care. This demonstration shall, at a minimum, address the feasibility of reducing or redirecting patients with non-emergent illnesses, injuries, and conditions, to lower cost alternative facilities or programs;

(b) The applicant hospital must demonstrate that it has effectively managed its existing emergency department treatment capacity to maximize use; and

(c) The applicant hospital must demonstrate that it has considered the need for bed and other facility and system capacity that will be affected by greater volumes of emergency department patients.

Applicant Response:

Not applicable. The Applicant is not proposing to expand its emergency department treatment capacity.

Standard .04B(16) – Shell Space

(a) Unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective.

(b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that:

(i) Considers the most likely use identified by the hospital for the unfinished space;

(ii) Considers the time frame projected for finishing the space; and

(iii) Demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.

(c) Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.

(d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Services Cost Review Commission.

Applicant Response:

Not applicable. The Applicant does not propose to add any shell space in the replacement facility.

COMAR 10.24.11. General Surgical Services

.05A. GENERAL STANDARDS

Standard .05(A)(1) – Information Regarding Charges and Network Participation

Information regarding charges for surgical services shall be available to the public.

(a) Each ambulatory surgery center, ambulatory surgical facility, and hospital shall provide to the public, upon inquiry or as required by applicable regulations or law, information concerning charges for the full range of surgical services provided.

Applicant Response:

Please see the response to COMAR 10.24.10.04A(1) – Information Regarding Charges. As noted in Section 2.2 of the Applicant's Public Disclosure of Charges policy, attached as **Exhibit 5**, individuals may request an estimate of charges for any scheduled or non-scheduled service.

(b) Each ambulatory surgery center, ambulatory surgical facility, and general hospital shall provide to the public, upon inquiry or as required by applicable regulations, the names of the health carrier networks in which it currently participates.

Applicant Response:

UM SMC at Easton provides to the public, upon inquiry or as required by applicable law, the names of the health carrier networks in which it currently participates.

(c) Each ambulatory surgery center, ambulatory surgical facility, and general hospital shall provide to the public, upon inquiry, the names of the health carrier networks in which each surgeon and other health care practitioner that provides services at the facility currently participates.

Applicant Response:

UM SMC at Easton provides to the public, upon inquiry, the names of the health carrier networks in which its employed surgeons and other health care practitioners that provide services at the facility currently participate. The hospital directs inquiries involving network participation of non-employed surgeons directly to the surgeon's office.

(d) The Commission shall consider complaints to the Consumer Protection Division in the Office of the Attorney General of Maryland or to the Maryland Insurance Administration when evaluating an applicant's compliance with this standard in addition to evaluating other sources of information.

Applicant Response:

As of its last inquiry on September 30, 2022, UM SMC at Easton is unaware of any complaints to the Consumer Protection Division in the Office of the Maryland Attorney General of

Maryland or to the Maryland Insurance Administration alleging that it failed to provide information, either upon request or as required by law, to the public concerning its charges for the full range of surgical services.

(e) Providing a patient with an estimate of out-of-pocket charges prior to arrival for surgery shall be a condition of any CON issued by the Commission.

Applicant Response:

The Applicant acknowledges that this is a condition of any CON issued by the Commission.

Standard .05(A)(2) – Information Regarding Procedure Volume

Each hospital, ambulatory surgical facility, and ambulatory surgery center shall provide to the public upon inquiry information concerning the volume of specific surgical procedures performed at the location. A hospital, ambulatory surgical facility, or ASC shall provide the requested information on surgical procedure volume for the most recent 12 months available, updated at least annually.

Applicant Response:

The Applicant acknowledges and agrees that, upon request, it will provide information to members of the public concerning the volume of specific surgical procedures performed at UM SMC at Easton for the most recent 12 months available, and will update this information at least annually.

Standard .05(A)(3) – Charity Care and Financial Assistance Policy.

Each hospital and ambulatory surgical facility shall have a written policy for the provision of charity care and financial assistance regarding free and reduced-cost care to uninsured, underinsured, or indigent patients and shall provide ambulatory surgical services on a charitable basis to qualified persons consistent with the policy. The policy shall include, as applicable below, at a minimum:

(a) Determination of Eligibility for Charity Care or Financial Assistance. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital or ambulatory surgical facility shall make a determination of probable eligibility and notify the patient of that determination.

Applicant Response:

Please see the response to COMAR 10.24.10.04A(2) – Charity Care Policy. The hospital notifies patients of probable eligibility determinations within two business days of the patient's request.

(b) Notice of Charity Care and Financial Assistance Policy. Public notice and information regarding the hospital or ambulatory surgical

facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population in a format understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. This notice shall include general information about who qualifies and how to obtain a copy of the policy or may include a posted copy of the policy. Prior to a patient's arrival for surgery, the facility shall address any financial concerns of the patient, and individual notice regarding the facility's charity care policy shall be provided.

Applicant Response:

Please see the response to COMAR 10.24.10.04A(2) – Charity Care Policy. UM SMC at Easton's financial assistance policy applies to acute care and surgical services.

(c) Criteria for Eligibility. A hospital shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of ambulatory surgical facilities described in these regulations. An ambulatory surgical facility, at a minimum, shall include the following eligibility criteria in its charity care policies:

(i) Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge; and

(ii) Persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands.

Applicant Response:

Please see the response to COMAR 10.24.10.04A(2) – Charity Care Policy. UM SMC at Easton's Financial Assistance Policy applies to acute care and surgical services and complies with applicable state statutes and HSCRC regulations regarding charity care and financial assistance policies.

(d) 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 HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

Applicant Response:

Please see the response to COMAR 10.24.10.04A(2)(b) – Charity Care Policy.

(e) A hospital shall be able to demonstrate that its historic level of charity care or its projected level of charity care is appropriate to the needs of its actual or projected service area population. This demonstration shall include an analysis of the socio-economic conditions of the hospital's actual or projected service area population, a comparison of those conditions with those of Maryland's overall socio-economic indicators, and a comparative analysis of charity care provision by the applicant hospital and other hospitals in Maryland. The socio-economic indicators evaluated shall include median income and type of insurance by zip code area, when available. The analysis provided may also include an analysis of the social determinants of care affecting use of health care facilities and services and the health status of the actual or projected hospital service area population.

Applicant Response:

UM SMC at Easton's historical and projected level of charity care is appropriate to the needs of its service area population as demonstrated in its response to COMAR 10.24.01.04A(2)(b) – Charity Care Policy.

(f) An applicant submitting a proposal to establish or expand an ambulatory surgical facility for which third party reimbursement is available, shall commit to provide charitable surgical services to indigent patients that are equivalent to at least the average amount of charity care provided by ambulatory surgical facilities in the most recent year reported, measured as a percentage of total operating expenses. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment;

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed; and

(iii) If an existing ambulatory surgical facility has not met the expected level of charity care for the two most recent years reported to the Commission, the applicant shall demonstrate that its historic level of charity care was appropriate to the needs of its service area population.

Applicant Response:

Not applicable.

(g) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a Certificate of Need for a surgical facility project, shall make a commitment to provide charitable services to indigent patients. Charitable services may

be surgical or non-surgical and may include charitable programs that subsidize health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by ambulatory surgical facilities, measured as a percentage of total ambulatory surgical facility expenses, in the most recent year reported. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that its historic level of charity care was appropriate to the needs of the population in the proposed service area.

Applicant Response:

Not applicable.

Standard .05(A)(4) – Quality of Care

A facility providing surgical services shall provide high quality care.

(a) An existing hospital or ambulatory surgical facility shall document that it is licensed, in good standing, by the Maryland Department of Health.

Applicant Response:

Please see the response to COMAR 10.24.10.04A(3)(a) – Quality of Care.

(b) A hospital shall document that it is accredited by the Joint Commission or other accreditation organization recognized by the Centers for Medicare and Medicaid and the Maryland Department of Health as acceptable for obtaining Medicare certification and Maryland licensure.

Applicant Response:

Please see the response to COMAR 10.24.10.04A(3)(a) – Quality of Care.

(c) An existing ambulatory surgical facility or ASC shall document that it is:

(i) In compliance with the conditions of participation of the Medicare and Medicaid programs;

(ii) Accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, the American Association

for Accreditation of Ambulatory Surgery Facilities, or another accreditation organization recognized by the Centers for Medicare and Medicaid Services as acceptable for obtaining Medicare certification; and

(iii) A provider of quality services, as demonstrated by its performance on publicly reported performance measures, including quality measures adopted by the Centers for Medicare and Medicaid Services. The applicant shall explain how its ambulatory surgical facility or each ASC, as applicable, compares on these quality measures to other facilities that provide the same type of specialized services in Maryland.

Applicant Response:

Not applicable.

(d) An applicant seeking to establish an ambulatory surgical facility shall:

(i) Demonstrate that the proposed facility will meet or exceed the minimum requirements for licensure in Maryland in the areas of administration, personnel, surgical services provision, anesthesia services provision, emergency services, hospitalization, pharmaceutical services, laboratory and radiologic services, medical records, and physical environment;

(ii) Agree that, within two years of initiating service at the facility, it will obtain accreditation by the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the American Association for Accreditation of Ambulatory Surgery Facilities or another accreditation organization recognized by the Centers for Medicare and Medicaid Services as acceptable for obtaining Medicare certification and approved by the State of Maryland; and

(iii) Acknowledge in writing that, if the facility fails to obtain the accreditation in subparagraph (ii) on a timely basis, it shall voluntarily suspend operation of the facility.

Applicant Response:

Not applicable.

(e) An applicant or a related entity that currently or previously has operated or owned one or more ASCs or ambulatory surgical facilities in or outside of Maryland in the five years prior to the applicant's filing of an application to establish an ambulatory surgical facility, shall provide details regarding the quality of care provided at each such ASC or ambulatory surgical facility including information on licensure, accreditation, performance metrics, and other relevant information.

Applicant Response:

Not applicable.

Standard .05A(5) – Transfer Agreements

(a) Each hospital shall have arrangements for transfer of surgical patients to another hospital that comply with the requirements of Health-General Article §19-308.2.

Applicant Response:

Please see **Exhibit 17**, which includes copies of UM SMC at Easton's transfer agreements with other hospitals.

(b) Each ambulatory surgical facility shall have a process for assuring the emergency transfer of surgical patients to a hospital that complies with the requirements of COMAR 10.05.05.09.

Applicant Response:

Not applicable.

.05B. PROJECT REVIEW STANDARDS

Standard .05B(1) – Service Area

An applicant proposing to establish a hospital providing surgical services or an ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

Applicant Response:

Please see the response to Standard .05B(2) below.

Standard .05B(2) – Need- Minimum Utilization for Establishment of a New or Replacement Facility

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for the number of operating rooms proposed for the facility, consistent with the operating room capacity assumptions and other guidance included in Regulation .06 of this Chapter.

(b) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility, consistent with Regulation .06 of this Chapter.

(c) An applicant proposing to establish or replace a hospital shall submit a needs assessment that includes:

(i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospital's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and

(iii) In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of the relocation.

(d) An applicant proposing the establishment of a new ambulatory surgical facility shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for outpatient surgical procedures by the proposed facility's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed facility by surgical specialty or, if approved by Commission staff, another set of categories; and

(iii) Documentation of the current surgical caseload of each physician likely to perform surgery at the proposed facility.

Applicant Response:

Need to Replace the Existing Surgical Suite

Even if the hospital were not being replaced, UM SMC at Easton would need to replace its surgical suite. The current operating rooms ("ORs") do not meet the minimum standards required for today's complex surgery. Current FGI standard for minimum OR size is 400 SF, with a focus on appropriate clearances for safety and circulation. The existing ORs at Easton are sized at the minimum 400 SF and are approximately 20'-0"clear in either dimension. However, two of the existing ORs are not square in shape. Although they meet the minimum in terms of square footage, the actual usable space is far less. The current footprint recommended to provide general anesthesia is six feet by eight feet, which further reduces the available space for equipment and staff in the existing rooms.

Beginning in 2019, urological robotics cases at UM SMC at Easton have increased and this trend has since expanded into general surgery and gynecology. Most surgery previously performed laparoscopically now is performed with the use of the robot. Surgical robots require a significant amount of space within the OR. While two of the six ORs (Rooms 1 and 5) at the current facility were previously renovated to accommodate this large robotic equipment, the increased robotic surgical volume now creates scheduling problems and limits flexibility for all ORs. Traditionally, the ORs could be used universally for any type of case. With the addition of the robot, however, UM SMC at Easton is limited in the spaces where it may perform certain surgeries. Other service lines, such as neurosurgery and orthopedics, now also have equipment requirements that necessitate the use of the larger rooms.

Each OR at the replacement hospital will be sized appropriately to accommodate the needs of modern surgical delivery and current industry standards. Minimum clear floor area, per FGI guidance for surgical procedures that require additional personnel and large equipment, is 600 SF. Each of the proposed ORs will meet this minimum size standard, which will provide enhanced flexibility for the future of UM SMC at Easton's surgical program.

Surgical Services Need Projection for Replacement Hospital

UM SMC at Easton currently has six mixed-use, general purpose operating rooms and is proposing to build seven mixed-use, general purpose operating rooms at the new facility based on its need projection presented below.

UM SMC at Dorchester had four mixed-use, general purpose operating rooms. In October 2021, UM SMC at Dorchester converted to an FMF. Since then, inpatient surgical cases performed at UM SMC at Dorchester have transitioned to UM SMC at Easton. All the surgeons previously operating at UM SMC at Dorchester have privileges at UM SMC at Easton.

The surgical service area for UM SMC at Easton is defined based on the ZIP Codes from

which the top 85% of the surgical cases performed at UM SMC at Easton and UM SMC at Dorchester originated in fiscal year 2022. Table 50 shows the list of these ZIP Codes. UM SMC at Easton does not anticipate that the relocation of the hospital to the new site will result in a change of its surgical service area.

Table 50
UM SMC at Easton's Surgical Service Area
FY 2022

ZIP Code	City Name	County	Inpatient Cases at UM SMC at Easton & Dorchester	Outpatient Cases at UM SMC at Easton & Dorchester	Total Cases	% of Total	Cumulative %
21601	Easton	Talbot County	183	852	1,035	19.3%	19.3%
21613	Cambridge	Dorchester County	146	613	759	14.1%	33.4%
21629	Denton	Caroline County	74	246	320	6.0%	39.4%
21620	Chestertown	Kent County	58	216	274	5.1%	44.5%
21643	Hurlock	Dorchester County	33	197	230	4.3%	48.8%
21632	Federalsburg	Caroline County	40	166	206	3.8%	52.6%
21655	Preston	Caroline County	30	174	204	3.8%	56.4%
21617	Centreville	Queen Anne's County	34	137	171	3.2%	59.6%
21639	Greensboro	Caroline County	17	118	135	2.5%	62.1%
21673	Trappe	Talbot County	19	115	134	2.5%	64.6%
21660	Ridgely	Caroline County	20	113	133	2.5%	67.1%
21663	Saint Michaels	Talbot County	24	101	125	2.3%	69.4%
21625	Cordova	Talbot County	14	79	93	1.7%	71.1%
21666	Stevensville	Queen Anne's County	21	71	92	1.7%	72.9%
21631	East New Market	Dorchester County	11	70	81	1.5%	74.4%
21658	Queenstown	Queen Anne's County	15	51	66	1.2%	75.6%
21661	Rock Hall	Kent County	12	47	59	1.1%	76.7%
21638	Grasonville	Queen Anne's County	15	44	59	1.1%	77.8%
21619	Chester	Queen Anne's County	8	46	54	1.0%	78.8%
21654	Oxford	Talbot County	14	34	48	0.9%	79.7%
21678	Worton	Kent County	7	37	44	0.8%	80.5%
21623	Church Hill	Queen Anne's County	3	40	43	0.8%	81.3%
21671	Tilghman	Talbot County	6	36	42	0.8%	82.1%
21651	Millington	Kent County	7	34	41	0.8%	82.9%
21657	Queen Anne	Queen Anne's County	4	31	35	0.7%	83.5%
21668	Sudlersville	Queen Anne's County	8	26	34	0.6%	84.1%
21662	Royal Oak	Talbot County	8	20	28	0.5%	84.7%
21679	Wye Mills	Talbot County	4	11	15	0.3%	84.9%
21647	Mcdaniel	Talbot County	4	10	14	0.3%	85.2%
	Service Area Subtotal		**839**	**3,735**	**4,574**	**85.2%**	
	Outside of Service Area		118	676	794	14.8%	100.0%
Total Easton & Dorchester Surgical Cases			**957**	**4,411**	**5,368**	**85.2%**	**100.0%**

Source: hMetrix non-confidential statewide data & HSCRC Experience Data

Figure 5 below graphically shows UM SMC at Easton's primary and secondary surgical service area.

Figure 5
UM SMC at Easton's Primary & Secondary Surgical Service Areas
FY 2022

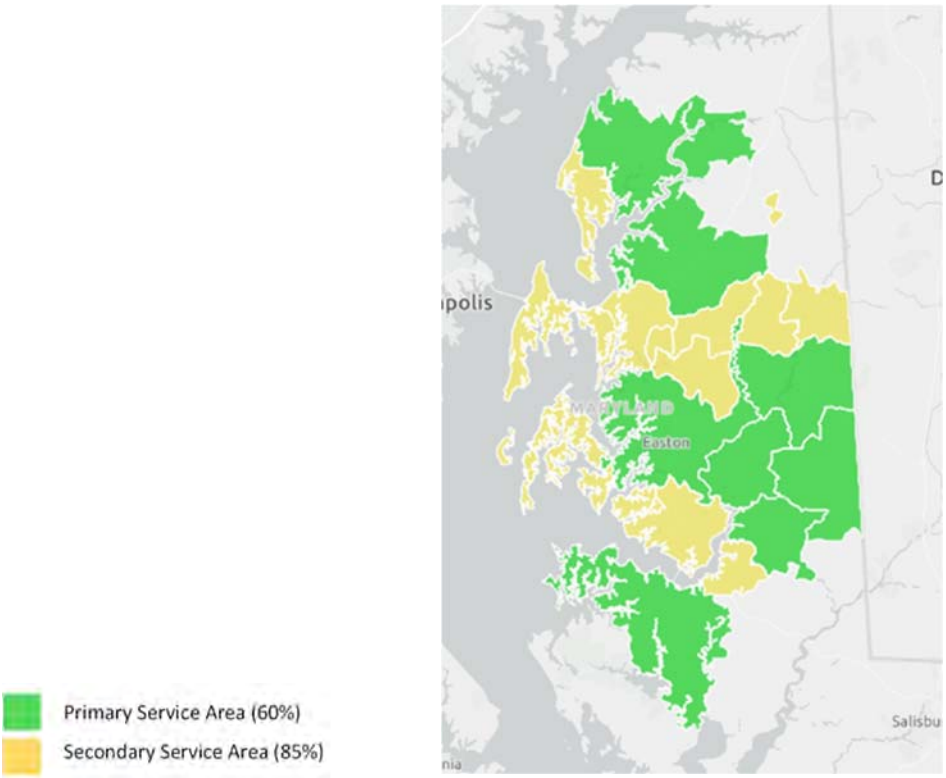


Table 51 and Table 52 below show the historical surgical volumes at both UM SMC at Easton and UM SMC at Dorchester.

Table 51
Historical OR Volumes
UM SMC at Easton
FY 2019 – FY 2022

	Cases			Minutes			Average Minutes per Case		
Year	Inpt.	Outpt.	Total	Inpt.	Outpt.	Total	Inpt.	Outpt.	Total
2019	1,450	4,188	5,638	176,480	296,669	473,149	122	71	84
2020	1,178	3,635	4,813	138,803	299,103	437,906	118	82	91
2021	1,062	4,243	5,305	137,685	374,833	512,518	130	88	97
2022	956	4,378	5,334	117,013	377,760	494,773	122	86	93

Source: hMetrix non-confidential statewide data & HSCRC Experience Data

Note: Volumes from both the hMetrix statewide data and HSCRC Experience Data include OR cases only and exclude endoscopies, cystoscopies, and other procedure room cases.

Table 52
Historical OR Volumes
UM SMC at Dorchester
FY 2019 – FY 2022

	Cases			Minutes			Average Minutes per Case		
Year	Inpt.	Outpt.	Total	Inpt.	Outpt.	Total	Inpt.	Outpt.	Total
2019	44	392	436	4,963	28,904	33,867	113	74	78
2020	26	244	270	3,472	22,451	25,923	134	92	96
2021	23	280	303	3,805	24,655	28,460	165	88	94
2022	1	33	34	225	2,619	2,844	225	79	84

Source: hMetrix non-confidential statewide data & HSCRC Experience Data

In calculating the need for ORs, the Applicant used a 45-minute turnaround time ("TAT") per case, as shown in Table 53 below. UM SMC at Easton tracks its TAT internally, and on average, the turnover time at UM SMC at Easton was 45 minutes per case in fiscal year 2021.

UM SMC at Easton's average TAT has increased in recent years due to the increased volume of complex surgical cases and the increased processing demands associated with those cases. For example, robotic surgery is increasingly utilized in urology, general surgery, and gynecological surgery at UM SMC at Easton. Most, if not all, small routine procedures for ambulatory patients are performed in the ambulatory setting of either the surgeon's office or freestanding ambulatory surgical centers (ASCs). As a result, the vast majority of surgical cases performed at UM SMC at Easton are complex cases with considerable instrumentation demands. Complex orthopedics and neurosurgery cases also require a significant number of instruments, set up, and processing time. In comparison to larger, urban hospitals, UM SMC at Easton also has a smaller number of staff available to help "turn over" an OR, which contributes in small part to its TAT.

UM SMC at Easton has projected future need based on actual utilization in fiscal year 2022 at UM SMC at Easton and UM SMC at Dorchester prior to its conversion. To determine the number of operating rooms that will be needed at the replacement hospital the Applicant used the formula in red shown in the left column of Table 53 below. Population growth was applied to fiscal year 2022 cases to determine projected cases through fiscal year 2032. Average inpatient and outpatient minutes per case are assumed to remain constant at fiscal year 2022 levels through fiscal year 2032. Total projected OR cases for inpatient and outpatient cases, respectively, were multiplied by the projected average minutes per case for inpatient and outpatient cases, respectively, to determine total projected OR minutes. The Applicant then multiplied the projected number of OR cases by the average TAT per case to arrive at the total projected TAT minutes. Total OR minutes and total TAT minutes were summed and divided by the optimal minutes per case of 114,000 (as provided in COMAR 10.24.11.06A(1)(a)(ii)) to arrive at the projected number of ORs that will be needed when the replacement regional medical center opens in fiscal year 2029. As shown in Table 53 below, UM SMC at Easton projects that its proposed seven operating rooms will be operating at optimal capacity within three years of initiating surgical services at the replacement regional medical center.

Table 53
UM SMC at Easton's Current and Projected OR Bed Need
FY 2019 – FY 2032

		Historical				Projected									
		2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
	Population Growth					0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	1.0%	1.0%	1.0%	1.0%
A	**OR Cases**														
	Easton + Dorchester														
	Inpatient	1,494	1,204	1,085	957	965	974	982	991	1,000	1,010	1,019	1,029	1,039	1,050
	Outpatient	4,580	3,879	4,523	4,411	4,448	4,487	4,527	4,568	4,610	4,653	4,697	4,743	4,790	4,838
	Total	6,074	5,083	5,608	5,368	5,414	5,461	5,509	5,559	5,610	5,663	5,717	5,772	5,829	5,888
B	**OR Minutes per Case**														
	Easton + Dorchester														
	Inpatient	121	118	130	123	123	123	123	123	123	123	123	123	123	123
	Outpatient	71	83	88	86	86	86	86	86	86	86	86	86	86	86
	Total	83	92	96	93	93	93	93	93	93	93	93	93	93	93
C = A * B	**OR Minutes**														
	Easton + Dorchester														
	Inpatient	181,443	142,570	141,490	117,238	118,239	119,268	120,326	121,412	122,529	123,676	124,856	126,069	127,316	128,599
	Outpatient	325,573	323,177	399,488	380,379	383,606	386,945	390,375	393,900	397,523	401,246	405,074	409,009	413,055	417,216
	Total	507,016	465,747	540,978	497,617	501,844	506,213	510,701	515,312	520,052	524,923	529,930	535,078	540,371	545,815
D	**Turnaround Time (TAT) per Case (minutes)**	35	45	45	45	45	45	45	45	45	45	45	45	45	45
E = A * D	**Total TAT Minutes**	212,590	228,735	252,360	241,560	243,611	245,732	247,911	250,149	252,450	254,814	257,245	259,744	262,314	264,956
F = C + E	**Total OR & TAT Minutes**	719,606	694,482	793,338	739,177	745,456	751,945	758,611	765,462	772,501	779,737	787,175	794,822	802,685	810,771
G	**Optimal Minutes per OR (1900 hours)**	114,000	114,000	114,000	114,000	114,000	114,000	114,000	114,000	114,000	114,000	114,000	114,000	114,000	114,000
H = F / G	**Operating Room Need**	**6.3**	**6.1**	**7.0**	**6.5**	**6.5**	**6.6**	**6.7**	**6.7**	**6.8**	**6.8**	**6.9**	**7.0**	**7.0**	**7.1**

Source: hMetrix non-confidential statewide data & HSCRC Experience Data

SHS has not assumed that any additional volumes will move to the ASC setting during the projection period because cases that are capable of being performed in an ambulatory setting have already been moved to that setting. UM SRH has many years' experience in operating ASCs. It operates three ASCs located in Easton, Queenstown, and Cambridge. Whether a particular surgery is appropriate for the ASC setting is largely driven by the type of procedure, patient acuity level, and type of anesthesia required for the procedure. Payers have also increasingly required certain types of outpatient cases to be performed in a lower-cost setting when medically appropriate. For example, many orthopedic procedures are now performed in the ASC setting due to a change in Medicare coverage that occurred in 2020. Although robotic surgery is expanding at UM SMC at Easton, these cases cannot be moved to ASCs because robotics is only cost efficient in the hospital setting.

Operational Need for Seven ORs

As at other hospitals, surgeons desire to have "blocked" schedules so that they can better plan and make use of their time. Due to the very wide geographic area that UM SMC at Easton's physicians cover due to the broad service area and rural nature of the hospital, they have offices in most of the five counties in the Mid-Shore region. Therefore, using block OR scheduling is essential to maintaining a reliable schedule for physicians and patients and preventing physicians from

having to reschedule an entire office of patients due to an emergent or urgent case arising.

Due to the current limitations of the surgical suite described in detail above, UM SMC at Easton experiences patient scheduling challenges as well. For certain surgeries, patients often wait in excess of three months to obtain their surgery due to scheduling backlogs, though wait times vary by surgical specialty. UM SMC at Easton estimates that neurosurgeries are currently scheduling out approximately eight weeks, robotics surgeries several months, and orthopedic surgeries three to four months. Adding a seventh OR at the replacement facility will help alleviate the scheduling constraints that UM SMC at Easton experiences in its existing facility.

Standard .05B(3) – Need - Minimum Utilization for Expansion of An Existing Facility

An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .06 of this Chapter;

(b) Demonstrate that its existing operating rooms were utilized at optimal capacity in the most recent 12-month period for which data has been reported to the Health Services Cost Review Commission or to the Maryland Health Care Commission; and

(c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity, consistent with Regulation .06 of this Chapter. The needs assessment shall include the following:

(i) Historic and projected trends in the demand for specific types of surgery among the population in the proposed service area;

(ii) Operating room time required for surgical cases historically provided at the facility by surgical specialty or operating room category; and

(iii) Projected cases to be performed in each proposed additional operating room.

Applicant Response:

Not applicable. The Applicant is not proposing to expand the number of operating rooms at an existing facility.

Standard .05B(4) – Design Requirements

Floor plans submitted by an applicant must be consistent with the current FGI Guidelines:

(a) A hospital shall meet the requirements in current Section 2.2 of the FGI Guidelines.

(b) An ambulatory surgical facility shall meet the requirements in current Section 3.7 of the FGI Guidelines.

(c) Design features of a hospital or ambulatory surgical facility that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.

Applicant Response:

Please see **Exhibit 18**, which is a letter from the architectural firm HKS attesting that the surgical suite meets FGI Guidelines.

Standard .05B(5) – Support Services

Each applicant seeking to establish or expand an ambulatory surgical facility shall provide or agree to provide laboratory, radiology, and pathology services as needed, either directly or through contractual agreements, in compliance with COMAR 10.05.05.

Applicant Response:

Not applicable.

Standard .05B(6) – Patient Safety

The design of proposed surgical facilities or changes to existing surgical facilities shall include features that enhance and improve patient safety. An applicant shall:

(a) Document the manner in which the planning of the project took patient safety into account; and

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities.

Applicant Response:

Please see the response to COMAR 10.24.10.04B(12) – Patient Safety.

Standard .05B(7) – Construction Costs

The cost of constructing surgical facilities shall be reasonable and consistent with current industry cost experience.

(a) Hospital projects.

(i) The projected cost per square foot of a hospital construction or renovation project that includes surgical facilities shall be compared to the benchmark cost of good quality Class A hospital construction given 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.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any adjustment of the hospital's global budget revenue authorized for the hospital related to the capital cost of the project shall not include:

1. The amount of the projected construction cost and associated capitalized construction cost that exceeds the Marshall Valuation Service® benchmark; and

2. Those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

Applicant Response:

Please see the response to COMAR 10.24.10.04B(7) – Construction Cost of Hospital Space.

(b) Ambulatory Surgical Facilities.

(i) The projected cost per square foot of new construction shall be compared to the benchmark cost of good quality Class A construction given 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. This standard does not apply to the costs of renovation or the fitting out of shell space.

(ii) If the projected cost per square foot of new construction exceeds the Marshall Valuation Service® benchmark cost by 25% or more, then the applicant's project shall not be approved unless the applicant demonstrates the reasonableness of the construction costs. Additional independent construction cost estimates or information on the actual cost of recently constructed surgical facilities similar to the proposed facility may be provided to support an applicant's analysis of the reasonableness of the construction costs.

Applicant Response:

Not applicable.

Standard .05B(8) – Financial Feasibility

A surgical facility project shall be financially feasible. Financial projections filed as part of an application that includes the establishment or expansion of surgical facilities and services shall be accompanied by a statement containing each assumption used to develop the projections.

(a) An applicant shall document that:

(i) Utilization projections are consistent with observed historic trends in use of each applicable service by the likely service area population of the facility;

(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 facility or, if a new facility, the recent experience of similar facilities;

(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 facility, or, if a new facility, the recent experience of similar facilities; and

(iv) The hospital or ambulatory surgical facility will generate excess revenues over total expenses for the specific services affected by the project (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years of initiating operations.

(b) A project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project may be approved upon demonstration that overall facility financial performance will be positive and that the services will benefit the facility's primary service area population.

Applicant Response:

Please see the response to COMAR 10.24.10.04B(13) - Financial Feasibility.

Standard .05B(9) – Impact

(a) An application to establish a new ambulatory surgical facility shall present the following data as part of its impact assessment, in addition to addressing COMAR 10.24.01.08G(3)(f):

(i) The number of surgical cases projected for the facility and for each physician and other practitioner;

(ii) A minimum of two years of historic surgical case volume data for each physician or other practitioner, identifying each facility at which cases were performed and the average operating room time per case. Calendar year or fiscal year data may be provided as long as the time period is identified and is consistent for all physicians and other practitioners; and

(iii) The proportion of case volume expected to shift from each existing facility to the proposed facility.

(b) An application shall assess the impact of the proposed project on surgical case volume at hospitals:

(i) If the applicant's needs assessment includes surgical cases performed by one or more physicians who currently perform cases at a hospital within the defined service area of the proposed ambulatory surgical facility that, in the aggregate, account for 18 percent or more of the operating room time in use at that hospital, the applicant shall include, as part of its impact assessment, a projection of the levels of use at the affected hospital for at least three years following the anticipated opening of the proposed ambulatory surgical facility.

(ii) The operating room capacity assumptions in Regulation .06A of this Chapter and the operating room inventory rules in Regulation .06C of this Chapter shall be used in the impact assessment.

Applicant Response:

Not applicable.

COMAR 10.24.12. OB Services Chapter

.04 REVIEW STANDARDS

Standard .04(1) – Need.

All applicants must quantify the need for the number of beds to be assigned to the obstetric service, consistent with the approach outlined in Policy 4.1. Applicants for a new perinatal service must address Policy 4.1.

Policy 4.1 The burden of demonstrating need for additional obstetric program capacity rests with the applicant. In determining whether a new obstetric service should be established, the Commission shall consider, at a minimum,

(a) the historical and projected service area of the applicant hospital, obstetric service utilization forecasts, the number of providers of hospital obstetric services in the applicant hospital's service area, the anticipated medical staff which will utilize the proposed obstetric service and the proportion of their patients expected to use the proposed service;

(b) information on the number of uninsured, underinsured, indigent and otherwise underserved obstetric patients in the applicant's primary service area, and an estimate of the number of women not receiving adequate prenatal care;

(c) any data and/or analyses provided by the applicant outlining improvements in the delivery of obstetric services to the defined service area population anticipated to result from implementation of the proposed project, such as improvements in patient care outcomes, lower costs than that currently available in the service area, improvements in geographic or financial access to care, improvements in continuity of care, or improvements in the acceptability or cultural competency of obstetric care for the defined service area population or specific segments of that population;

(d) any demographic or health service utilization data and/or analyses providing a perspective on the need for the proposed project which is significantly different from that found in the Commission's forecast of obstetric service utilization; and

(e) any other relevant information on the unmet needs for obstetric services in the service area.

Applicant Response:

UM SMC at Easton is currently licensed to operate 13 acute obstetrical beds. Of these beds, three are used to accommodate antepartum patients and the remaining ten are labor-delivery-recovery-postpartum (LDRP) beds. Under this existing model, a patient's labor, delivery, recovery, and postpartum stay all occurs in the same room.

The obstetric unit at the replacement facility will have a combination of labor-delivery-recovery (LDR), antepartum, and postpartum rooms to provide an optimal patient experience in line with industry standards. Under this design model, a patient's birthing process from labor through delivery and recovery of mother and baby occurs in an LDR room, and then the patient transfers to a postpartum room for the remainder of her stay. This model is commonly used in facilities with 900 or more births per year, as the design provides for higher throughput, better accommodates seasonal volume swings, and improves patient experience. Using the obstetrics bed need methodology and assumptions described below, the Applicant projects a need for 11 licensed obstetric beds at the replacement regional medical center. The 11 licensed obstetric beds will include eight postpartum beds to accommodate patients after delivery, two antepartum beds, and one LDRP bed to provide flexibility to handle surges in deliveries.

Vaginal and unplanned cesarean section deliveries typically start in an LDR or LDRP room. Health design benchmark metrics assume approximately 250 deliveries annually per LDR room, which takes into account factors such as room turnover times. Based on these metrics, UM SMC at Easton plans to include three LDR rooms at the replacement regional medical center. The replacement facility's obstetric wing will also have appropriate provisions for antepartum care including two testing rooms, three triage rooms, and two medical-surgical inpatient rooms contiguous to the unit. The combination of LDR, postpartum, LDRP, and antepartum rooms at the replacement regional medical center is expected to provide an optimal patient experience while improving overall throughput.

Compared with the current model at the existing facility that primarily uses LDRP beds and thus means patients remain in the same bed throughout their stay, the replacement hospital model will allow for enhanced flexibility to accommodate the care needs of mothers through each stage of the birthing process. In particular, the replacement facility model will provide flexibility in care based on staffing, current census, and volume trends. LDR/LDRP rooms are significantly larger (approximately 340-360 SF) than antepartum and postpartum rooms (approximately 200 SF). The square footage saved in using a LDR-postpartum model also allows for appropriately sized family amenities and co-located triage and testing on the unit. Separate corridors for LDR and postpartum rooms also create a quieter experience for postpartum families. However, the proximity of the LDR and postpartum corridors to one another (immediately adjacent) limits patient transfer distance and does not require transfers to be routed outside the locked unit, which promotes patient safety.

Like the current hospital, the replacement regional medical center will have two cesarean section rooms to optimize patient safety and appropriately support patients requiring emergency cesarean delivery. Availability of personnel and an operating theater for emergency cesarean delivery aligns with the standard of care. The obstetric unit is also connected directly to the emergency department and surgical platform via a trauma elevator for quick connection for emergent births and in the rare circumstance that an additional operating room is needed.

Obstetrics Bed Need Calculation

1. Defining UM SMC at Easton's Obstetrics Service Area

To project the need for obstetric beds at the replacement facility, the Applicant began by defining the service area from which UM SMC at Easton currently draws its inpatient obstetric discharges. Using fiscal year 2022 data, the Applicant ranked obstetrics discharges for the top 85% of resident ZIP Codes to determine its obstetrics service area. As presented in Table 54 below, UM

SMC at Easton's obstetrics service area is defined by 30 ZIP Codes that span Talbot, Dorchester, Caroline, Queen Anne's, and Kent counties.

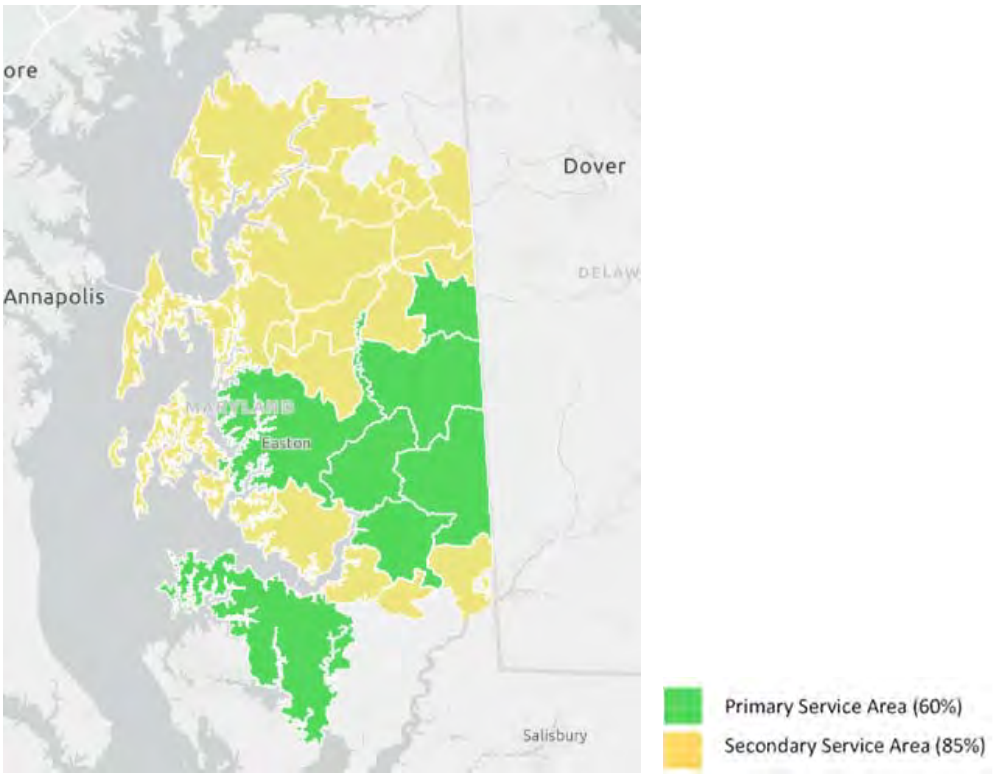
Table 54
UM SMC at Easton Obstetrics Service Area Zip Codes and Discharges
FY2022

ZIP	City	County	Discharges	Cumulative %
21613	Cambridge	Dorchester County	182	18.2%
21601	Easton	Talbot County	164	34.6%
21629	Denton	Caroline County	72	41.8%
21632	Federalsburg	Caroline County	61	47.9%
21643	Hurlock	Dorchester County	49	52.9%
21655	Preston	Caroline County	41	57.0%
21639	Greensboro	Caroline County	36	60.6%
21649	Marydel	Caroline County	33	63.9%
21673	Trappe	Talbot County	24	66.3%
21660	Ridgely	Caroline County	24	68.7%
21620	Chestertown	Kent County	23	71.0%
21640	Henderson	Caroline County	17	72.7%
21663	Saint Michaels	Talbot County	16	74.3%
21658	Queenstown	Queen Anne's County	14	75.7%
21636	Goldsboro	Caroline County	13	77.0%
21625	Cordova	Talbot County	12	78.2%
21623	Church Hill	Queen Anne's County	12	79.4%
21617	Centreville	Queen Anne's County	10	80.4%
21666	Stevensville	Queen Anne's County	9	81.3%
21631	East New Market	Dorchester County	8	82.1%
21659	Rhodesdale	Dorchester County	7	82.8%
21638	Grasonville	Queen Anne's County	5	83.3%
21619	Chester	Queen Anne's County	5	83.8%
21661	Rock Hall	Kent County	4	84.2%
21679	Wye Mills	Talbot County	3	84.5%
21657	Queen Anne	Queen Anne's County	2	84.7%
21612	Bozman	Talbot County	2	84.9%
21654	Oxford	Talbot County	1	85.0%
21607	Barclay	Queen Anne's County	1	85.1%
21644	Ingleside	Queen Anne's County	1	85.2%
	Service Area Total		**851**	**85.2%**
	Out of Service Area Total		148	14.8%
	SHS Total		999	100.0%

Source: hMetrix statewide non-confidential data tapes

Figure 6 below graphically shows UM SMC at Easton's primary and secondary OB service area.

Figure 6
UM SMC at Easton's OB Service Area
FY 2022



2. Projected Obstetric Service Area Population

For the ZIP Codes included in the service area for UM SMC at Easton, population projections through 2027 were obtained from Environics Spotlight (formerly Nielsen Claritas) for females in the 15-44 age cohort. Using the compounded annual growth rates from 2022 to 2027, population projections were extrapolated through 2032. Through the projection period, the population of females in the 15-44 age cohort is expected to increase annually by 0.8% from fiscal year 2022 to fiscal year 2032, as shown in Table 55 below.

Table 55
UM SMC at Easton's Historical and Projected Obstetrics Service Area Population
FY 2019 – FY 2032

	Historical				Projected										% Change
Age Cohort	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
15-44	**26,703**	**26,685**	**26,668**	**26,650**	**26,859**	**27,071**	**27,283**	**27,498**	**27,714**	**27,932**	**28,151**	**28,373**	**28,596**	**28,820**	**8.1%**
% Change		*-0.1%*	*-0.1%*	*-0.1%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	

3. Obstetrics Service Area Use Rates

Table 56 presents the historical use rate per 1,000 population of obstetrics discharges in the UM SMC at Easton Obstetrics service area for the female 15-44 age cohort. While the service area use rate decreased from fiscal year 2019 to 2021, it returned to pre-pandemic levels in fiscal year 2022. UM SMC at Easton's use rate is expected to remain constant at fiscal year 2022 levels throughout the projection period.

Table 56
UM SMC at Easton's Historical and Projected Obstetrics Use Rate
FY 2019 – FY 2032

OB Service Area Use	Historical				Projected										%Change
Rate	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Age 15-44	**62.4**	**60.1**	**59.6**	**63.9**	**63.9**	**63.9**	**63.9**	**63.9**	**63.9**	**63.9**	**63.9**	**63.9**	**63.9**	**63.9**	**0.0%**
% Change		*-3.7%*	*-0.8%*	*7.2%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	

Source: hMetrix statewide non-confidential utilization data tapes

4. UM SMC at Easton Service Area Discharges

Obstetric discharges originating from UM SMC at Easton's service area declined from fiscal year 2019 to 2022. Driven by the projected increase in population in the female 15-44 age cohort, service area discharges are projected to increase slightly by 0.8% annually, as they are assumed to normalize to pre-pandemic levels by 2032 (Table 57).

Table 57
UM SMC at Easton's Historical and Projected Service Area Obstetric Discharges
FY 2019 – FY 2032

	Historical				Projected										%Change
	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Service Area Obstetric Discharges	**921**	**908**	**880**	**851**	**858**	**864**	**871**	**878**	**885**	**892**	**899**	**906**	**913**	**920**	**8.1%**
% Change		*-1.4%*	*-3.1%*	*-3.3%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	

Source: hMetrix statewide non-confidential utilization data tapes

5. UM SMC at Easton Obstetrics Market Share & Out-of-Service Area Discharges % of Service Area Discharges

UM SMC at Easton's market share of the service area discharges decreased from fiscal year 2020 to 2022. The out-of-service area obstetric discharges for UM SMC at Easton also decreased from fiscal year 2019 to 2020 but normalized by fiscal year 2022. UM SMC at Easton's market share and out-of-service area percentage of service area discharges are projected to remain constant from fiscal year 2022 through the projection period (Table 58).

Table 58
UM SMC at Easton's Historical and Projected Market Share & Out-of-Service Area Obstetrics Discharges % of Service Area Discharges
FY 2019 – FY 2032

	Historical				Projected										%Change
	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Easton Service Area Market Share	**55.2%**	**56.6%**	**55.3%**	**49.9%**	**49.9%**	**49.9%**	**49.9%**	**49.9%**	**49.9%**	**49.9%**	**49.9%**	**49.9%**	**49.9%**	**49.9%**	**0.0%**
% Change		*2.5%*	*-2.2%*	*-9.8%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
UM SMC at Easton Out of Service Area															
% of Service Area Discharges	**17.5%**	**16.6%**	**17.0%**	**17.0%**	**17.0%**	**17.0%**	**17.0%**	**17.0%**	**17.0%**	**17.0%**	**17.0%**	**17.0%**	**17.0%**	**17.0%**	**0.0%**

Source: hMetrix statewide non-confidential utilization data tapes

6. UM SMC at Easton Inpatient Obstetric Discharges

Given the anticipated growth of the female 15-44 age cohort population, UM SMC at Easton's obstetric discharges are projected to increase slightly from 999 discharges in fiscal year 2022 to 1,077 discharges in fiscal year 2032 (Table 59).

Table 59
UM SMC at Easton's Historical and Projected Obstetric Discharges
FY 2019 – FY 2032

	Historical				Projected										%Change
	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
UM SMC at Easton Obstetric Discharges	**1,082**	**1,059**	**1,030**	**999**	**1,004**	**1,012**	**1,020**	**1,028**	**1,036**	**1,044**	**1,052**	**1,060**	**1,069**	**1,077**	**7.8%**
% Change		*-2.1%*	*-2.7%*	*-3.0%*	*0.5%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	

Source: hMetrix statewide non-confidential utilization data tapes

7. Allocation of UM SMC at Easton Historical and Projected Obstetrics Discharges

The projected obstetric discharges are expected to be split between vaginal deliveries and cesarean sections based on historical experience at UM SMC at Easton. Vaginal deliveries are projected to account for 79% of obstetric discharges while cesarean sections are projected to account for 21% of obstetric discharges (Table 60).

Table 60
UM SMC at Easton's Historical and Projected Obstetric Discharges
FY 2019 – FY 2032

	Allocation of Discharges	Historical FY2022	Projected FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032
Number of OB Discharges												
Vaginal	79%	791	795	801	807	814	820	827	833	840	846	853
C-Section	21%	208	209	211	212	214	216	217	219	221	223	224
Total	100%	999	1,004	1,012	1,020	1,028	1,036	1,044	1,052	1,060	1,069	1,077

Source: hMetrix statewide non-confidential utilization data tapes

8. Average Length of Stay of UM SMC at Easton Projected Obstetrics Discharges

UM SMC at Easton projects the average length of stay (ALOS) associated with vaginal and cesarean section deliveries based on historical obstetric utilization at UM SMC at Easton. The ALOS for obstetric deliveries is projected to remain constant at fiscal year 2022 levels through fiscal year 2032 (Table 61).

Table 61
UM SMC at Easton's Historical and Projected Obstetric ALOS
FY 2019 – FY 2032

	Historical FY2019	FY2020	FY2021	FY2022	Projected FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032
ALOS														
Vaginal	2.1	1.8	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7
% Change		*-13%*	*-7%*	*4%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*
C-Section	3.0	2.7	2.4	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6
% Change		*-9%*	*-11%*	*6%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*

9. Projected Bed Need with Standard Occupancy Assumptions

Similar to the State Health Plan for acute care services, which provides a 70% occupancy standard for services with an average daily census (ADC) of 0 to 49 patients, the Applicant projected demand using a 70% occupancy of its OB beds for vaginal deliveries and cesarean sections. As shown in Table 62 below, dividing the ADC by this occupancy standard shows a need for 8.0 postpartum beds at the replacement hospital in 2032.

Table 62
UM SMC at Easton's Historical and Projected Baseline Postpartum Bed Need
FY2019 – FY2032

	Actual				Projected									
	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032
Postpartum Average Daily Census														
Vaginal	4.6	4.2	3.8	3.7	3.7	3.8	3.8	3.8	3.9	3.9	3.9	4.0	4.0	4.0
C-Section	2.2	1.6	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.6	1.6	1.6
Total	6.8	5.7	5.1	5.2	5.2	5.2	5.3	5.3	5.4	5.4	5.5	5.5	5.5	5.6
Occupancy Standard	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
Bed Need														
Vaginal	6.6	6.0	5.4	5.3	5.3	5.4	5.4	5.5	5.5	5.6	5.6	5.6	5.7	5.7
C-Section	3.1	2.2	1.9	2.1	2.1	2.1	2.1	2.1	2.2	2.2	2.2	2.2	2.2	2.2
Postpartum Bed Need	**9.7**	**8.2**	**7.3**	**7.4**	**7.4**	**7.5**	**7.6**	**7.6**	**7.7**	**7.7**	**7.8**	**7.9**	**7.9**	**8.0**

Source: hMetrix statewide non-confidential utilization data tapes

As discussed in Sections 10 and 11 below, using this need methodology based on HSCRC data alone and a 70% occupancy assumption does not fully account for UM SMC at Easton's OB bed need because it does not capture patients' time spent in beds on the OB unit prior to delivery, nor beds needed at the replacement regional medical center to accommodate peak census on the unit. Additional data is provided below in order to support the need for a total of 11 licensed OB beds at the replacement hospital.

10. Need for Antepartum and LDRP Beds to Accommodate Full OB Unit Census

To ensure sufficient capacity in the obstetric unit for all patients across each stage of the birthing process, the unit at the replacement hospital must be able to accommodate patients in need of antepartum services, patients in labor, and postpartum patients, and be designed to accommodate surges in patient deliveries. As shown in the obstetric bed need Table 63 below, the Applicant projects a need for 11 total licensed beds, including eight postpartum rooms, two antepartum rooms, and one LDRP room.

Health design benchmarks assume a need for antepartum rooms equivalent to 20% of the unit's postpartum rooms. To account for patients in need of antepartum services, such as certain pre-delivery testing, monitoring, and observation when the risk for complications is increased, the Applicant plans to include two antepartum beds at the replacement facility. Ensuring sufficient antepartum capacity to monitor high-risk patients is important given the distance to the next closest OB providers, as shown in Section 13 below. As part of the baseline need projection, the applicant assumes a need for one LDRP room to account for peak census in either deliveries or postpartum patients. Table 63 below shows the breakout of the additional projected need for each type of bed.

Table 63
UM SMC at Easton's Historical and Projected Baseline Obstetric Bed Need
FY2019 – FY2032

	Actual				Projected									
	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032
Postpartum Bed Need	9.7	8.2	7.3	7.4	7.4	7.5	7.6	7.6	7.7	7.7	7.8	7.9	7.9	8.0
Antepartum % of Postpartum Length of Stay	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
Antepartum Bed Need	1.9	1.6	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.6	1.6	1.6	1.6
Need for 1 LDRP	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total Bed Need	12.6	10.8	9.8	9.9	9.9	10.0	10.1	10.1	10.2	10.3	10.4	10.4	10.5	10.6
Total Requested Beds	**13.0**	**11.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**	**11.0**	**11.0**

Source: hMetrix statewide non-confidential utilization data tapes, HKS health design standards

The ALOS shown in Table 63 above for obstetric deliveries is derived from HSCRC's statewide data tapes and begins when a patient is admitted, which occurs at the time of delivery. Obstetric patients also spend time in beds prior to delivery during labor or an extended antepartum observation stay. This period, when a patient occupies a bed in the obstetric unit prior to delivery, is not captured in the HSCRC ALOS data above because the patient has not yet been admitted. As shown in Table 64 below, UM SMC at Easton's internal data demonstrates that, on average, 22% of an obstetric patient's total stay is spent in a bed prior to delivery. The Applicant projects that this pre-delivery ALOS will remain constant throughout the projection period.

Table 64
UM SMC at Easton's Historical and Projected
Pre-Delivery ALOS as % of Postpartum ALOS
FY 2019 – FY 2032

	Historical				Projected									
	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032
ALOS (Hours)														
Postpartum	64.7	60.3	62.5	62.5	62.5	62.5	62.5	62.5	62.5	62.5	62.5	62.5	62.5	62.5
Pre-delivery	12.1	12.6	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0
Total ALOS	76.8	72.9	76.5	76.5	76.5	76.5	76.5	76.5	76.5	76.5	76.5	76.5	76.5	76.5
Pre-delivery LOS % of Postpartum LOS	*19%*	*21%*	*22%*	*22%*	*22%*	*22%*	*22%*	*22%*	*22%*	*22%*	*22%*	*22%*	*22%*	*22%*

Source: Shore internal data

It is essential to take into consideration the total time patients occupy beds on the obstetric unit in order to adequately plan for sufficient bed capacity on the unit. UM SMC at Easton has internal data on the occupied beds by hour for the obstetric unit. UM SMC at Easton has frequently experienced surges of 11 or more obstetric patients on a given day. Table 65 shows the number of

days per year that *11 or more* patients occupied a bed on the UM SMC at Easton obstetric unit at once in recent years.

Table 65
Number of Days Per Year with 11 or More
Patients Occupying the UM SMC at Easton Obstetric Unit
FY 2020 –FY 2022

	FY20	FY21	FY22
Days with 11 or more Obstetric Patients	61	43	48
Days per Year	365	365	365
% of Year with 11+ Patients	17%	12%	13%

Source: Shore Internal Data

During periods of peak census, like those reflected above, the replacement regional medical center's obstetric unit will be able to accommodate 11 postpartum patients in its eight postpartum, two antepartum, and one LDRP bed, plus additional overflow capacity that will be available in the two MSGA beds located adjacent to this unit. As shown in the table above, UM SMC at Easton had an obstetrics patient census of 11 or more for 13% of days in fiscal year 2022. The replacement regional medical center's unit is thus sized appropriately to handle delivery surges at the levels historically seen at UM SMC at Easton.

As described above, UM SMC at Easton will transition to a more flexible LDR and postpartum bed model at the replacement facility. In this model, patients will primarily deliver in one of the three LDR rooms or the LDRP room, after which they will be moved to a postpartum bed.

Health design metrics assume one LDR bed for every 250 vaginal and unplanned cesarean section deliveries for a community hospital like UM SMC at Easton. Higher deliveries per LDR room, per year can increase pressure to move patients expediently through labor to delivery, which may increase treatment intensity. As shown in Table 60 above, UM SMC at Easton projects that it will have 853 vaginal deliveries alone in 2032, which drives a need for 3.4 LDR rooms, without taking into account volumes for unplanned c-sections that also begin in a LDR room. Accordingly, UM SMC at Easton is planning to include one LDRP bed on the unit alongside the three LDR beds. The LDRP bed will provide flexibility to accommodate an additional laboring mother or provide additional postpartum capacity during times of peak census, as described more fully below. During extreme surges in deliveries, the triage rooms and antepartum testing rooms on the unit could also be used for delivery if needed.

11. Adjustment for Peak Daily Census

The Applicant requests 11 licensed obstetric beds at the replacement hospital to account for surges in patient census based on its historical data on peak census. To calculate bed need, the Applicant takes actual fiscal year 2022 average daily census and applies the ratio of 80% of peak

daily census to average daily census. Given UM SMC at Easton's recent peak daily census experience, this calculation is more appropriate to adequately plan for needed beds at the replacement hospital. Applying a 70% occupancy standard to average daily census, as shown in Section 8, would result in an undersized unit not capable of managing UM SMC at Easton's common census peaks. This would be particularly problematic given the rural nature of this facility and distance to other OB providers, as described in Section 13 below. Due to differences in staffing competencies and equipment needs, overflow obstetric patients are difficult to place in other medical/surgical inpatient units. Accordingly, UM SMC at Easton's OB unit must be properly sized to accommodate all patients during periods of peak census. Table 66 shown below reflects the ratios of peak census to average daily census that are utilized in the bed need calculation.

Table 66
UM SMC at Easton's Average and Peak Daily Census
FY 2022

	Average Daily Census	Peak Daily Census	80% of Peak Daily Census
July	6.2	12.0	9.6
August	6.0	14.0	11.2
September	6.2	15.0	12.0
October	5.8	13.0	10.4
November	5.7	12.0	9.6
December	5.2	12.0	9.6
January	4.7	13.0	10.4
February	5.0	12.0	9.6
March	5.0	11.0	8.8
April	4.5	12.0	9.6
May	3.7	11.0	8.8
June	4.5	11.0	8.8
Average	5.2	12.3	9.9
Peak % of ADC		**237%**	**190%**

Source: Shore Internal Data

12. Overall Obstetric Bed Need

Based on the assumptions presented above, the Applicant has projected a need for 11 total licensed obstetric beds at UM SMC at Easton by fiscal year 2032 (Table 67), which includes eight postpartum beds, two antepartum beds, and one LDRP.

The request for 11 licensed beds does not include capacity for 100% of peak daily census since this would create inefficiency in periods of average or below average utilization. The obstetric unit will also include three unlicensed LDR rooms, two cesarean section rooms, triage and antepartum testing spaces, which will also provide flexibility to accommodate surges in capacity.

The Applicant also plans to have postpartum overflow capability in the adjacent MSGA beds mentioned above.

Bed need in Table 67 below is calculated based on the assumptions described above, projected separately for vaginal and c-section births. The bed need for each type of birth is ultimately determined by multiplying ADC by 80% of the ratio of peak daily census to average daily census. This peak adjustment is equivalent to 190% of the postpartum ADC in fiscal year 2022. Utilizing only 80% of the ratio of peak census to ADC allows for capacity to accommodate the frequent surges experienced at UM SMC at Easton while also maintaining a conservative assumption that optimizes the use of beds requested by the Applicant.

Table 67
UM SMC at Easton's Historical and Projected Peak-Adjusted Obstetric Bed Need
FY 2020 – FY 2032

	Actual			Projected									
	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032
Postpartum Average Daily Census													
Vaginal	4.2	3.8	3.7	3.7	3.8	3.8	3.8	3.9	3.9	3.9	4.0	4.0	4.0
C-Section	1.6	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.6	1.6	1.6
Total	5.7	5.1	5.2	5.2	5.2	5.3	5.3	5.4	5.4	5.5	5.5	5.5	5.6
80% Peak Ratio to Average Daily Census [(1)]	192%	196%	190%	190%	190%	190%	190%	190%	190%	190%	190%	190%	190%
Bed Need													
Vaginal	8.0	7.3	7.1	7.1	7.2	7.2	7.3	7.3	7.4	7.4	7.5	7.6	7.6
C-Section	3.0	2.7	2.8	2.8	2.8	2.8	2.9	2.9	2.9	2.9	2.9	3.0	3.0
Total Bed Need	11.0	10.0	9.8	9.9	10.0	10.0	10.1	10.2	10.3	10.4	10.4	10.5	10.6
Total Requested Beds	**11.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**	**11.0**	**11.0**

Note (1): 80% Peak represents the average of maximum daily census for a given year times 80%

Source: hMetrix statewide non-confidential utilization data tapes , Shore internal data

13. Preserving Access to Obstetric Services in the Mid-Shore Region

UM SMC at Easton is the only facility within its service area that offers a labor and delivery service line where expecting mothers can deliver babies. It is critical that the replacement regional medical center obstetric unit be sized appropriately with sufficient surge capacity to ensure patients have timely access to labor and delivery services when needed due to the emergent nature of this service line and the distance to the next closest OB providers.

The State Health Plan chapter for inpatient obstetrics services states that "[h]ospital obstetrics services should be no more than a 30 minute one-way average automobile travel time under normal driving conditions for at least 90 percent of the population." COMAR 10.24.12B(5), p. 14. Table 68 below shows the driving time between the five Mid-Shore counties of Easton's service area and the next closest labor and delivery units in Maryland and Delaware. The table shows that the proposed site for the replacement regional medical center is the only hospital providing access within a 30-minute drive time for residents of the service area.

Table 68
Driving Time (in Minutes) from the Five Mid-Shore Counties
To the Nearest Maryland and Delaware OB Units

	UM Shore Regional Health - Easton (Proposed Site)	Anne Arundel (Annapolis, MD)	Tidal Health Peninsula Regional (Salisbury, MD)	Beebe Medical Center (Lewes, DE)	Bayhealth Sussex Campus (Milford, DE)	Bayhealth Hospital, Kent Campus (Dover, DE)	Christiana Hospital (Newark, DE)	ChristianaCare Wilmington (Wilmington, DE)	Saint Francis Hospital (Wilmington, DE)	Tidal Health Nanticoke (Seaford, DE)	The Birth Center (Newark, DE)
Caroline	24	48	59	66	40	44	75	78	78	34	69
Dorchester	30	68	38	99	70	103	98	127	125	40	114
Kent	42	58	100	96	68	58	52	61	61	79	51
Queen Anne's	21	34	80	86	62	52	59	69	70	59	59
Talbot	11	49	56	92	63	66	80	88	88	46	79

Source of travel time is Google Maps, using the shortest travel time between each county and each hospital. Measurements were taken between 1:00 and 2:00 pm on Wednesday, October 12, 2022.

Standard .04(2) – The Maryland Perinatal System Standards

Each applicant shall demonstrate the ability of the proposed obstetric program and nursery to comply with all essential requirements of the most current version of Maryland's Perinatal System Standards, as defined in the perinatal standards, for either a Level I or Level II perinatal center.

Applicant Response:

UM SMC at Easton currently has a Level I nursery, as will the proposed replacement facility. **Exhibit 19** includes a self-assessment conducted in October 2022 utilizing the 2019 Maryland Perinatal System Standards from the Maryland Department of Health, Perinatal Clinical Advisory Committee. The self-assessment shows that UM SMC at Easton meets all of the essential perinatal standards for Level I.

Standard .04(3) – Charity Care Policy

Each hospital shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to obstetric services regardless of an individual's ability to pay.

(a) The policy shall include provisions for, at a minimum, the following:

(i) annual notice by a method of dissemination appropriate to the hospital's patient population (for example, radio, television, newspaper);

(ii) posted notices in the. admissions office, business office and emergency areas within the hospital;

(iii) individual notice provided to each person who seeks services in the hospital at the time of community outreach efforts, prenatal services, preadmission, or admission, and

(iv) within two business days following a patient's initial request for charity care services, application for medical assistance, or both, the facility must make a determination of probable eligibility.

(b) Public notice and information regarding a hospital's charity care policy shall be in a format understandable by the target population.

Applicant Response:

Please see response to COMAR 10.24.10.04A(2) – Charity Care Policy. UM SMC at Easton's Financial Assistance policy applies to acute care and obstetric services.

Standard .04(4) – Medicaid Access

Each applicant shall provide a plan describing how the applicant will assure access to hospital obstetric services for Medical Assistance enrollees, including:

(a) an estimate of the number of Medical Assistance enrollees in its primary service area, and

Applicant Response:

UM SMC at Easton provides care to all individuals, regardless of ability to pay or source of payment. According to the Maryland Department of Health's Maryland Medicaid eHealth Statistics, there were 9,602 Medicaid- eligible individuals in Talbot County, 13,605 in Caroline County, 14,635 in Dorchester County, 9,661 in Queen Anne's County, and 5,533 in Kent County in December 2021(https://md-medicaid.org/eligibility/index.cfm).

(b) the number of physicians that have or will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.

Applicant Response:

Each of the obstetricians and pediatricians with privileges at UM SMC at Easton participate in the Medical Assistance Program. There are 16 obstetricians, seven pediatricians, and seven nurse-midwives privileged to provide care at UM SMC at Easton, and all are participating in Medicaid. UM SMC at Easton is currently recruiting one additional OB/GYN.

UM SMC at Easton works with many local partners to identify underserved, uninsured, under insured, and indigent women, including Medicaid enrollees, and to connect them with prenatal care. UM SMC at Easton's community partners include county health departments, community centers, local physicians, schools, social service agencies, and other UM SRH affiliates. UM SMC at Easton also partners with Choptank Community Health System, which operates several federally qualified health centers on the Eastern Shore. These organizations help identify women in need of prenatal services and refer them to UM SMC at Easton for services. Once a woman is identified as in need of prenatal care, she is referred to the local health department, which evaluates her situation and assures that she has all the resources she needs. UM SMC at Easton also works with the health department to assign the woman to a UM SMC at Easton obstetrician. No women are turned away, and every woman who needs an obstetrician becomes a private patient of a UM SMC at Easton obstetrician. UM SMC at Easton also provides a number of

outreach programs and free educational classes in the community geared towards pregnant women, as described below in response to COMAR 10.24.12.04(15) – Outreach Program.

As shown in Table 70 below, UM SMC at Easton's efforts to ensure access to prenatal care to underserved and indigent women in the community, including Medicaid enrollees, have been successful to date, as UM SMC at Easton's service area has a lower percentage of births with "Late or No Prenatal Care" compared to the State as a whole and a higher percentage of births that had "First Trimester Prenatal Care" than the State as a whole.

Standard .04(5) – Staffing

Each applicant shall provide information on the proposed staffing, associated number and type of FTEs, projected expenses per FTE category and total expenses, for labor and delivery, post partum, nursery services, and other related services, including nurse staffing, non-nurse staffing and physician coverage, at year three and at maximum projected volumes; if applicable, current staffing and expenses should also be included.

Applicant Response:

Staffing at third-year projected volumes is estimated to be:

Table 69
Staffing at Third-Year Projected Volumes

Employee Category	FTE	FTE Replacement Factor	Total Expense	Comments
Staff Nurse (RN)	31.48	13%	$3,497,490	All RNs are cross-trained to L&D, Nursery, Postpartum, operating room, and outpatient testing/triage.
Per diem RN				
Clinical Coordinators	2.4			
Surgical Technician (CNA/sec/tech)	7.2	12.5%	$438,970	All surgical technicians are cross-trained to unit secretary functions.
Per Diem ST (CAN/sec/tech)				
Nurse Manager	1.0		$115,606	Responsible for OB and Women & Children's (former Pediatrics).
Relief Unit Secretary (US)	0			These are relief unit secretaries that fill in for the unit secretary role as needed.
Lactation Consultant	1.0		$93,891	

Employee Category	FTE	FTE Replacement Factor	Total Expense	Comments
Midwife*	5			*Not a part of the nursing staff. Credentialed through the Medical staff office and hired through UM SMG-Women's Health
Physicians	3+			3 physicians with UM SMG-Women's Health Several physicians with OB Hospitalist program providing 24/7 in-hospital coverage
Overtime			$49,377	OT FTEs incl. in EE Category. All employee categories.
On-Call				All employee categories.
Call-Back				
TOTAL	43.08	13%	$4,195,334	Midwives not included in total.

Standard .04(6) – Physical Plant Design and New Technology

All applicants must describe the features of new construction or renovation that are expected to contribute to improvements in patient safety and/or quality of care, and describe expected benefits.

Applicant Response:

As is the case with the entire proposed facility, the obstetric unit at the proposed replacement regional medical center is designed with patient and staff safety as a core design element. This commitment to safety begins with the organization of the facility with clear separation of public and staff/service corridors to improve patient privacy and staff efficiency. The proposed facility will also feature standardized patient care areas in both the patient units as well as in the surgical suite. The units themselves are designed to be as efficient as possible, with key supplies located to minimize staff travel distances by as much as 30% compared with the existing facility. The replacement facility will be configured to consolidate and centralize resources, minimize staff travel distances, and improve continuous visibility of patients, while controlling noise in the units.

Patient handling and movement is also a key aspect of patient and staff safety. Taking these elements into consideration, the new facility will have centralized elevators to minimize patient transport distances. The trauma-sized elevator for the obstetric unit further allows direct access from the operating room and emergency department.

In the diagnostic areas, the invasive procedure rooms are all located together and convenient to patient prep and recovery. The obstetric unit's two cesarean section rooms are standardized designs that were prepared with input from the Director of Surgical Services and Anesthesia.

In the obstetric unit (as in the rest of the replacement hospital), patient privacy is a key factor in safety. The facility design team took patient privacy into special consideration when planning the acoustical design features of the replacement hospital. Additionally, all rooms in the obstetric unit (like the rest of the facility) will be private. The new facility will have a mix of private labor-delivery rooms (LDR), a flexible labor-delivery-postpartum room (LDRP), and private postpartum rooms. This flexible chassis provides modern standards of care and safe and appropriate spaces for patients to deliver, even when the unit experiences a surge of deliveries. The arrangement of rooms also allows for a safe walking loop for laboring mothers.

Some of the other features that improve patient safety and quality of care in the obstetric unit include:

- Co-location of related support functions to maximize efficiency
- Universal patient room design
- Charting/observation at each patient room
- Automation of technology and patient records
- Inclusion of lactation services and support spaces
- Appropriate number of triage rooms with dedicated bathrooms
- Dedicated trauma and obstetric unit elevator for patient transfers in emergency situations
- Reduced patient transfer time (surgery to short stay recovery, emergency department to ICU, emergency department to helipad, nursery/LDRP to helipad, etc.)
- Appropriate number of prep/recovery bays
- Special operating room lights in all triage rooms
- Direct access from C-section to nursery
- Continuing Care Nursery with accommodations for opioid addicted neonates or other special care needs
- Newborn / Baby Holding Nursery separated from Continuing Care Nursery to minimize noise and disruption
- Increased telemetry capability
- Storage alcoves on the obstetric unit for wheelchairs and stretchers
- Upgrade to ADA/ANSI standards
- Directed traffic flow into building (main entrance) past security

- Locked unit with an infant security system
- Increased family amenities located centrally with daylight access
- Dedicated medication/clean supply room

Standard .04(7) – Nursery

An applicant for a new perinatal service shall demonstrate that the level of perinatal care, including newborn nursery services, will be consistent with the needs of the applicant's proposed service area.

Applicant Response:

Not applicable. The Applicant has an established perinatal service.

Standard .04(8) – Community Benefit Plan

Each applicant proposing to establish a new perinatal service will develop and submit a Community Benefit Plan addressing and quantifying the unmet community needs in obstetric and perinatal care within the applicant's anticipated service area population, This Plan should include an outreach program component, and should provide a detailed description of the manner in which the proposed perinatal service will meet these needs, and the resources required, At a minimum, the Community Benefit Plan must include:

(a) a needs assessment related to obstetric and nursery services for the proposed program's service area population, including a description of the manner in which the proposed perinatal service will satisfy unmet needs identified in the needs assessment,

(b) measurable and time-limited goals and objectives for health status improvements pursuant to which the Plan can be evaluated; and

(c) information on the structure, staffing and funding of the Plan;

(d) documentation of community support and involvement in program planning for the Plan by other agencies, organizations or institutions which win be involved, directly or indirectly, with the Plan;

(e) an implementation scheme for the Community Benefit Plan.

(f) Applicants must commit to implementation of the Community Benefit Plan and continuing commitment to the Plan as a condition of Commission approval, and as an ongoing condition of providing obstetric services.

(g) Applicants must agree to submit an Annual Report to the Commission which will include:

(i) an evaluation of the achievement of the goals and objectives of the Community Benefit Plan; and

(ii) information on staffing levels and the total costs of any programs implemented as part of the Community Benefit Plan.

Applicant Response:

Not applicable. The Applicant has an established perinatal service.

Standard .04(9) – Source of Patients

An applicant for a new obstetric service shall demonstrate that the majority of its patients will come from its primary service area.

Applicant Response:

Not applicable. The Applicant has an established perinatal service.

Standard .04(10) – Non-metropolitan Jurisdictions

A proposed obstetrics program in non-metropolitan jurisdictions, as defined in the chapter, shall demonstrate that physicians with admitting privileges to provide obstetric services have offices for patient visits within the primary service area of the hospital.

Applicant Response:

The Applicant is not proposing to create a new obstetrics program, it is simply relocating the existing program. In any event, all of the primary care obstetricians practicing at UM SMC at Easton have offices in Easton, which is within the primary service area. Beginning January 2022, UM SMC at Easton established a new in-house, 24/7 laborist program that provides immediate access to obstetrical care. Some, but not all of these laborists have offices in the primary service area.

Standard .04(11) – Designated Bed Capacity

An applicant for a new obstetric service shall designate a number of the beds from within the hospital's licensed acute care beds that will comprise the proposed obstetric program.

Applicant Response:

Not applicable. The Applicant has an established perinatal service.

Standard .04(12) – Minimum Volume

(a) An applicant for a new obstetrics program must be able to demonstrate to the Commission's satisfaction that the proposed program can achieve a minimum volume of 1,000 admissions annually in metropolitan jurisdictions, or 500 cases annually in non-metropolitan jurisdictions, within 36 months of initiation of the program.

(b) As a condition of approval; the applicant shall accept a requirement that it will close the obstetric program, and its authority to operate will be revoked, if:

(i) it fails to meet the minimum annual volume for any 24 consecutive month period, and

(ii) it fails to provide good cause for its failure to attain the minimum volume, and a feasible corrective action plan for how it will achieve the minimum volume within a two year period.

Applicant Response:

Not applicable. The Applicant has an established perinatal service.

Standard .04(13) – Impact on the Health Care System

(a) An application for a new perinatal program will he approved only if its likely impact on the volumes of obstetric discharges at any existing obstetric program, after the three year start-up period, will not exceed 20 percent of an existing program's current or projected volume.

(b) When determining whether to approve an application for an obstetrics program, the Commission will consider whether an existing program's payer mix of obstetrics patients will significantly change as a. result of the proposed program, and the existing program will have to care for a disproportionate share of the indigent obstetrics patients in its service area; and

(c) When determining whether to approve an application for an obstetrics program the Commission will also consider the impact on a hospital with an existing program that has undertaken a capital expenditure project for which it has pledged pursuant to H-G Article § 19·120(k) not to increase rates for that project, so long as the pledge was based, at least in part, on assumptions about obstetric volumes.

(d) The Commission may consider evidence:

(i) from an applicant as to why rules (a) through (e) should not apply to the applicant, or;

(ii) from a very low volume program (fewer than 500 annual obstetric discharges) as to why a lower volume impact should apply.

Applicant Response:

Not applicable. The Applicant has an established perinatal service.

Standard .04(14) – Financial Feasibility

Hospitals applying for a Level I or II perinatal program must clearly demonstrate that the hospital has the financial and non-financial resources necessary to implement the project, and that the average charge per

admission for new perinatal programs will be less than the current statewide average charge for Level I and Level II perinatal programs. When determining whether to approve an application for an obstetric program, the Commission will consider the following:

(a) the applicant's projected sources of funds to meet the program s total expenses for the first three years of operation,

(b) the proposed unit rates and/or average charge per case for the perinatal services;

(c) evidence that the perinatal service will be financially feasible at the projected volumes and at the minimum volume standards in this Plan, and

(d) the written opinions or recommendations of the HSCRC.

Applicant Response:

Not applicable. The Applicant has an established perinatal service.

Standard .04(15) – Outreach Program

Each applicant with an existing perinatal service shall document an outreach program for obstetric patients in its service area who may not have adequate prenatal care, and provide hospital services to treat those patients. The program shall address adequate prenatal care, prevention of low birth weight and infant mortality, and shall target the uninsured, under-insured, and indigent patients in the hospital's primary service area, as defined in COMAR 10.24.01.01.B.

Applicant Response:

UM SMC at Easton works closely with many partners. Entry into the health care system occurs through many referral sources. UM SMC at Easton, UM SMC at Chestertown, UM Shore EC at Queenstown, UM SMC at Cambridge, county health departments, community centers, local physicians, schools, social services agencies, and other organizations in the five counties identify women who need prenatal care, especially those who may be uninsured, under-insured, or indigent. Of course, families may also refer women who think that they may be pregnant and some women refer themselves for services.

UM SMC at Easton's program accommodates referrals for obstetric and gynecologic care for underserved women in all five counties from any of these sources.

In addition, UM SMC at Easton offers dozens of classes in the community, including:

- Planning for baby's arrival - Take A Childbirth Education Class
- Successful Breastfeeding
- Health & Wellness Classes
- Labor & Delivery Class
- Stroke Awareness
- Diabetes Support Group

- Palliative Care Education
- Prostate Cancer and Urological Conditions
- Classes and Support Groups Focus on Managing Diabetes
- Blood Pressure Screenings
- Breast Cancer Screenings
- Cancer Support Groups
- Pregnancy and Infant Loss (this program is offered via partnership with Talbot Hospice)
- New Mom, New Baby & Infant Safety
- Big Brother & Big Sister (this program is temporarily on hold due to COVID-19 restrictions)
- Infant CPR
- Labor & Delivery
- Stroke Survivor Support Group
- Look Good…Feel Better
- Shore Kids Camp (this program is temporarily on hold due to COVID-19 restrictions)
- Safe Sitter Class

There is no financial barrier to attend these classes, as there is no charge for any participant.

In terms of prenatal care, whenever a woman in need of medical care is identified, either by a Health Department, social service agency, school, at a UM SMC at Easton class, or other source, the woman is referred to the University of Maryland Shore Medical Group ("UM SMG) – Women's Health to initiate prenatal care. If needs (pregnancy-related or otherwise) are identified, the woman is referred to the appropriate local agency for assistance obtaining necessary resources. If a woman presents for care at UM SMC at Easton and does not have a prenatal provider, UM SMC at Easton assigns the woman to a laborist and refers the woman to UM SMG- Women's Health for follow-up. No women are turned away.

As Table 70 below shows, UM SMC at Easton's obstetric service area has a lower percentage of births that had "Late or No Prenatal Care" compared to the State of Maryland as a whole. Also, the UM SMC at Easton obstetric service area had a significantly higher percent of births that had "First Trimester Prenatal Care" than did the State as a whole.

Table 70
Births with "Late or No Prenatal Care" and "1st Trimester Prenatal Care"
Queen Anne's, Kent, Caroline, Talbot, and Dorchester Counties
CY 2020

	Total Births	Late or No Prenatal Care		1st Trimester Prenatal Care	
		#	%	#	%
Kent	148	17		115	
Queen Anne's	478	26		350	

Caroline	398	28		283	
Talbot	377	11		318	
Dorchester	377	14		297	
Total	1778	96	5.4%	1336	76.7%
Maryland	68,546	4,303	6.3%	46,259	67.5%

Source: Maryland Vital Statistics Annual Report 2020*
https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2020Annual.pdf

*CY 2020 is the most recent report available on the Maryland Department of Health, Vital Statistics Administration website.

COMAR 10.24.09. Specialized Health Care Services—
Acute Inpatient Rehabilitation Services

Standard .04A. – General Review Standards.

(1) Charity Care Policy.

(a) Each hospital and freestanding acute inpatient rehabilitation provider shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide acute inpatient rehabilitation services on a charitable basis to qualified persons consistent with this policy. The policy shall have the following provisions:

(i) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility shall make a determination of probable eligibility.

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's admission, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) Criteria for Eligibility. A hospital shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. A hospital that is not subject to HSCRC regulations regarding financial assistance policies shall at a minimum include the following eligibility criteria in its charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of hospitals that are not subject to HSCRC regulations regarding financial assistance policies.

Applicant Response:

See response to COMAR 10.24.10.04A(2) – Charity Care Policy. UM SMC at Easton's Financial Assistance policy applies to both acute care and rehabilitation services.

(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 HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

Applicant Response:

See response to COMAR 10.24.10.04A(2)(b) – Charity Care.

(c) A proposal to establish or expand an acute inpatient rehabilitation hospital or subunit, for which third party reimbursement is available, and which is not subject to HSCRC regulations regarding financial assistance policies, shall commit to provide charitable rehabilitation services to eligible patients, based on its charity care policy, which shall meet the minimum requirements in .04A(1)(a) of this Chapter. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

Applicant Response:

Not applicable. UM SMC at Easton is subject to HSCRC regulations.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a CON for a project that involves acute inpatient rehabilitation services, shall commit to provide charitable services to indigent patients. Charitable services may be rehabilitative or non-rehabilitative and may include a charitable program that subsidizes health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by acute general hospitals, measured as a percentage of total expenses, in the most recent year reported. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the population in the proposed service area.

Applicant Response:

Not applicable.

(2) Quality of Care.

A provider of acute inpatient rehabilitation services 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 Commission for Accreditation of Rehabilitation Facilities.

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

Applicant Response:

The Requard Center is in compliance with all applicable accreditation standards, certification standards, and with the conditions of participation for Medicare and Medicaid programs. A copy of the most recent CARF accreditation certificate is attached as **Exhibit 20,** and a copy of UM SMC at Easton's license is attached as **Exhibit 10**.

For UM SMC at Easton's performance under the quality measures, see response to COMAR 10.24.10.04A(3) – Quality of Care.

(b) An applicant that currently provides acute inpatient rehabilitation services that is seeking to establish a new location or expand services shall report on all quality measures required by federal regulations or State agencies, including information on how the applicant compares to other Maryland acute inpatient rehabilitation providers. An applicant shall be required to meet quality of care standards or demonstrate progress towards reaching these standards that is acceptable to the Commission, before receiving a CON.

Applicant Response:

Not applicable. The Applicant is not seeking to establish a new location or expand services.

(c) An applicant that does not currently provide inpatient rehabilitation services that is seeking to establish an inpatient rehabilitation unit within an acute care hospital or an inpatient rehabilitation specialty hospital shall demonstrate through reporting on quality measures that it provides high quality health care compared to other Maryland providers that provide similar services or, if applicable, nationally.

Applicant Response:

Not applicable. The Requard Center at UM SMC at Easton is an existing provider of inpatient rehabilitation services.

Standard .04B. – Project Review Standards.

In addition to these standards, an acute general hospital applicant shall address all applicable standards in COMAR 10.24.10 that are not duplicated in this Chapter. These standards apply to applicants seeking to provide comprehensive acute rehabilitation services or both comprehensive acute rehabilitation services and specialized acute rehabilitation services to adult or pediatric patients.

(1) Access.

A new or relocated acute rehabilitation hospital or subunit shall be located to optimize accessibility for its likely service area population. An applicant that seeks to justify the need for a project on the basis of barriers to access shall present evidence to demonstrate that barriers to access exist for the population in the service area of the proposed project, based on studies or other validated sources of information. In addition, an applicant must demonstrate that it has developed a credible plan to address those barriers. The credibility of the applicant's plan will be evaluated based on whether research studies or empirical evidence from comparable projects support the proposed plan as a mechanism for addressing the barrier(s) identified, whether the plan is financially feasible and whether members of the communities affected by the project support the plan.

Applicant Response:

See response to Acute Hospital Services Standard COMAR 10.24.10.04B(1) – Geographic Accessibility.

(2) Need.

A project shall be approved only if a net need for adult acute rehabilitation beds is identified by the need methodology in Section .05 in the applicable health planning region (HPR) or if the applicant meets the applicable standards below. The burden of demonstrating need rests with the applicant.

(a) An application proposing to establish or expand adult acute inpatient rehabilitation services in a jurisdiction that is directly contiguous to another health planning region may be evaluated based on the need in contiguous regions or states based on patterns of cross-regional or cross-state migration.

(b) For all proposed projects, an applicant shall explicitly address how its assumptions regarding future in-migration and out-migration patterns among Maryland health planning regions and bordering states affect its need projection.

(c) If the maximum projected bed need range for an HPR includes an adjustment to account for out-migration of patients that exceeds 50 percent of acute rehabilitation discharges for residents of the HPR, an applicant proposing to meet the need for additional bed capacity above the minimum projected need, shall identify reasons why the existing out-migration pattern is attributable to access barriers and demonstrate a credible plan for addressing the access barriers identified.

Applicant Response:

UM SMC at Easton is licensed to operate 20 special hospital rehabilitation beds in fiscal year 2023. However, the size of UM SMC at Easton's rehabilitation unit was reduced to 15 physical beds as a result of the consolidation with UM SMC at Dorchester. UM SMC at Easton proposes to reduce the number of rehabilitation beds at the replacement hospital to 12 beds. The current rehabilitation licensed bed capacity on the Eastern Shore is 84 beds (Table 71). The projected 2026 gross acute rehabilitation bed need range for the Eastern Shore is 35 to 76 beds and the net need is -49 to -8 (See *Maryland Register* Volume 49, Issue 14, dated July 1, 2022). The 12 rehabilitation beds planned for inclusion at the UM SMC at Easton replacement hospital, combined with 64 beds at Encompass Health Rehabilitation Hospital of Salisbury ("Encompass Salisbury") will result in 76 licensed rehabilitation beds on the Eastern Shore. The 12 beds included in the proposed project will provide necessary access to inpatient rehabilitation services for Eastern Shore residents, while reducing the total number of licensed beds in the region by eight beds. The result of the project will be a net decrease of eight licensed beds in the Eastern Shore planning region, which falls within the current regional need projection. Since UM SMC at Easton's "total bed capacity" will not cause the number of beds on the Eastern Shore to exceed "the most recent annual calculation of bed capacity," the proposed project is within the most current need projections in the State Health Plan.

Table 71
MHCC Gross and Net 2026 Bed Need Projections for Acute Rehabilitation Beds Eastern Shore

Hospital	Current License Bed Capacity	Gross Bed Need		2026 Net Bed Need	
		Minimum	Maximum	Minimum	Maximum
UM SMC at Easton	20	-	-	-	-
Encompass Salisbury	64	-	-	-	-
TOTAL	**84**	**35**	**76**	**-49**	**-8**

Source: Maryland Register, Volume 49, Issue 14, July 1, 2022

Using the acute rehabilitation bed need methodology and assumptions described below, the Applicant projects a need for 12 rehabilitation beds at the proposed replacement facility.

1. Defining UM SMC at Easton's Rehabilitation Service Area

To project the need for rehabilitation beds at the replacement facility for UM SMC at Easton, the Applicant began by defining the service area from which UM SMC at Easton currently draws its inpatient rehabilitation discharges.

Using fiscal year 2022 data, the Applicant accumulated its rehabilitation discharges by ZIP Code. The Applicant then ranked the ZIP Codes from highest to lowest number of discharges to identify the ZIP Codes that comprise the top 85% of its rehabilitation discharges. These Zip Codes are considered UM SMC at Easton's rehabilitation service area. The rehabilitation service area is shown in Table 72. As presented in Table 72 below, the total rehabilitation service area is defined by 21 ZIP codes that span Talbot, Dorchester, Caroline, Queen Anne's and Kent counties.

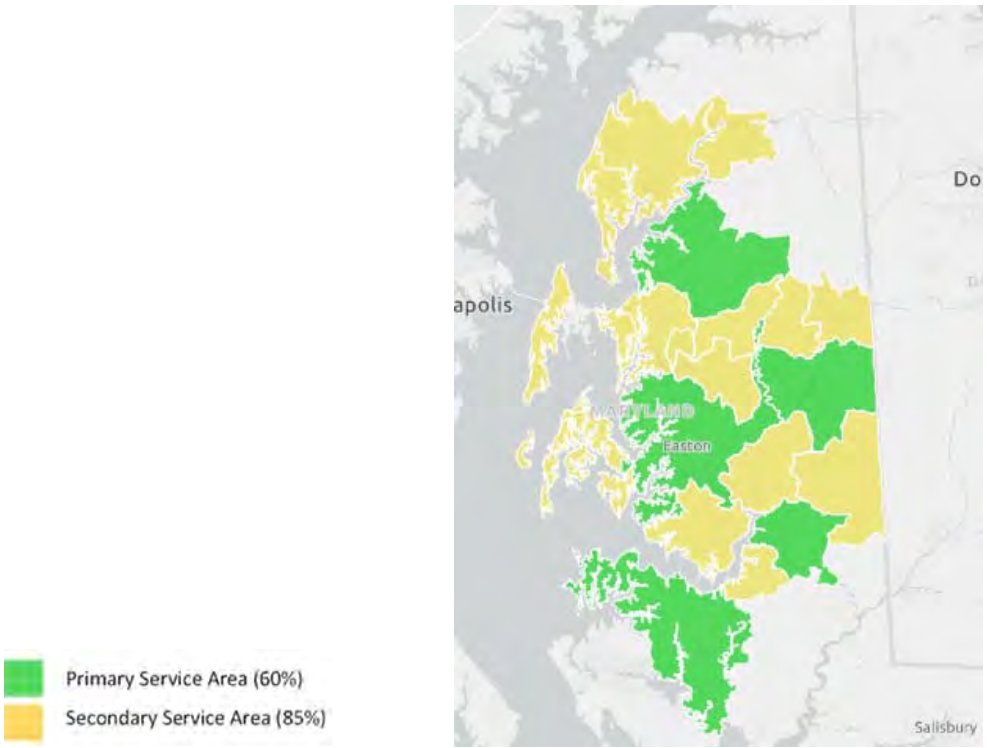
Table 72
UM SMC at Easton's Rehabilitation Service Area ZIP Codes and Discharges FY 2022

ZIP	City	County	Discharges	Cumulative %
21601	Easton	Talbot County	52	27.2%
21613	Cambridge	Dorchester County	27	41.4%
21654	Oxford	Talbot County	10	46.6%
21629	Denton	Caroline County	9	51.3%
21617	Centreville	Queen Anne's County	8	55.5%
21643	Hurlock	Dorchester County	7	59.2%
21639	Greensboro	Caroline County	5	61.8%
21660	Ridgely	Caroline County	5	64.4%
21620	Chestertown	Kent County	5	67.0%
21666	Stevensville	Queen Anne's County	5	69.6%
21625	Cordova	Talbot County	4	71.7%
21632	Federalsburg	Caroline County	4	73.8%
21673	Trappe	Talbot County	4	75.9%
21638	Grasonville	Queen Anne's County	4	78.0%
21662	Royal Oak	Talbot County	3	79.6%
21658	Queenstown	Queen Anne's County	3	81.2%
21663	Saint Michaels	Talbot County	2	82.2%
21631	East New Market	Dorchester County	2	83.2%
21655	Preston	Caroline County	2	84.3%
21679	Wye Mills	Talbot County	1	84.8%
21657	Queen Anne	Queen Anne's County	1	85.3%
	Service Area Total		**163**	**85.3%**
	Out of Service Area Total		28	14.7%
	SHS Total		191	100.0%

Source: hMetrix statewide non-confidential data tapes

Figure 7 below graphically shows UM SMC at Easton's primary and secondary rehabilitation service area.

Figure 7
UM SMC at Easton's Rehabilitation Service Area
FY 2022



UM SMC at Easton is the only acute hospital providing inpatient rehabilitation services to the residents of the five counties comprising UM SMC at Easton's rehabilitation service area. Neither of the other two acute care hospitals that serve residents in the UM SMC at Easton rehabilitation service area, Luminis Health Anne Arundel Medical Center and Tidal Health Peninsula Regional, provide inpatient rehabilitation services.

There are only two other non-acute hospital rehabilitation facilities serving the Eastern Shore:

Encompass Health Rehabilitation Hospital of Salisbury
220 Tilghman Road
Salisbury, MD 21804

Encompass Health Rehabilitation
Hospital of Middletown 250 East
Hampden Road
Middletown, DE 19709

2. Projected Rehabilitation Service Area Population

For the ZIP Codes included in the rehabilitation service area for UM SMC at Easton, population projections for 2022 and 2027 were obtained from Environics Spotlight (formerly Nielsen Claritas) for the 15-64, 65-74 and 75+ age cohorts. Using the compounded annual growth rates from 2022 to 2027, population projections were extrapolated through 2032. As the service area population ages, the population for the 15-64 age cohort is expected to increase by 1.3% from fiscal year 2022 to fiscal year 2032. Over the same period, the 65-74 and 75+ age cohorts are projected to increase by 41.6% and 15.9%, respectively. In total, the population is expected to grow 9.5% from fiscal year 2022 to 2032 (Table 73).

Table 73
UM SMC at Easton's Historical and
Projected Rehabilitation Service Area Population – Ages 15+
FY 2019 – FY 2032

	Historical				Projected										% Change
Age Cohort	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Age 15-64	84,777	84,570	84,364	84,158	84,267	84,376	84,485	84,595	84,704	84,814	84,923	85,033	85,143	85,254	1.3%
% Change		*-0.2%*	*-0.2%*	*-0.2%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	
Age 65-74	17,123	17,610	18,110	18,625	19,284	19,967	20,674	21,406	22,164	22,949	23,761	24,603	25,474	26,375	41.6%
% Change		*2.8%*	*2.8%*	*2.8%*	*3.5%*	*3.5%*	*3.5%*	*3.5%*	*3.5%*	*3.5%*	*3.5%*	*3.5%*	*3.5%*	*3.5%*	
Age 75+	13,428	13,734	14,046	14,366	14,580	14,797	15,018	15,242	15,469	15,700	15,934	16,171	16,412	16,657	15.9%
% Change		*2.3%*	*2.3%*	*2.3%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	
Total	**115,328**	**115,914**	**116,520**	**117,149**	**118,131**	**119,141**	**120,177**	**121,242**	**122,337**	**123,462**	**124,618**	**125,807**	**127,029**	**128,286**	**9.5%**
% Change		*0.5%*	*0.5%*	*0.5%*	*0.8%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*1.0%*	*1.0%*	*1.0%*	

Source: 2022 and 2027 Environics Spotlight Pop-Facts Demographics by Age Race Sex
Note: UM SMC at Easton only admits patients ages 18 and older to its inpatient rehabilitation unit.

3. Rehabilitation Service Area Use Rates

Table 73 presents the historical use rate per 1,000 population of rehabilitation discharges in the UM SMC at Easton rehabilitation service area by age cohort. The service area use rate for the age group 15-64 largely held constant from fiscal year 2017 to fiscal year 2019. The use rate for that age group then decreased from fiscal year 2019 to fiscal year 2020 but increased slightly in

fiscal year 2021 before declining again in fiscal year 2022. The use rate for the age group 65-74 increased in fiscal year 2020 compared to fiscal year 2019, but then declined in fiscal years 2021 and 2022. The use rate for age group 75+ has also decreased from 2019 to 2022.

These decreases in age cohort use rates are largely due to the impacts of the COVID-19 pandemic and COVID-19-related staffing shortages, which limited the number of patients that could be admitted to the rehabilitation unit. These pandemic effects are described in more detail in Section 10 below. The Applicant expects that use rates will increase towards historical levels as staffing pressures are resolved. Beginning in fiscal year 2023, the use rates are projected to increase at the age cohort level. These anticipated increases, along with the aging of the service area population into age cohorts with higher use rates, results in the projected total service area use rate increasing by 32.8% from fiscal year 2022 to 2032. While use rates are projected to increase by 2.0% annually for all age cohorts, fiscal year 2022 use rates were an outlier. As such, the overall projected use rates by each age cohort in fiscal year 2032 remain in-line with UM SMC at Easton's historical use rates, as demonstrated by the Table 74 below.

Table 74
UM SMC at Easton's Historical and Projected Rehabilitation Service Area Use Rates
FY 2017 – FY 2032

	Historical						Projected										% Change
Age Cohort	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Age 15-64	1.4	1.4	1.3	1.1	1.3	1.1	1.1	1.1	1.1	1.2	1.2	1.2	1.2	1.3	1.3	1.3	21.9%
% Change		*-2.3%*	*-8.3%*	*-10.9%*	*17.0%*	*-18.6%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	
Age 65-74	7.6	7.2	5.8	7.0	6.4	5.4	5.5	5.6	5.8	5.9	6.0	6.1	6.2	6.4	6.5	6.6	21.9%
% Change		*-5.2%*	*-19.0%*	*20.6%*	*-9.0%*	*-15.3%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	
Age 75+	17.8	17.0	19.1	19.0	16.5	12.8	13.1	13.3	13.6	13.9	14.1	14.4	14.7	15.0	15.3	15.6	21.9%
% Change		*-4.7%*	*12.7%*	*-0.7%*	*-13.1%*	*-22.5%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	
Total	**4.1**	**4.0**	**4.0**	**4.1**	**3.9**	**3.2**	**3.3**	**3.4**	**3.5**	**3.6**	**3.7**	**3.8**	**3.9**	**4.0**	**4.1**	**4.3**	**32.8%**
% Change		*-3.0%*	*0.4%*	*2.9%*	*-4.9%*	*-18.7%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	

4. UM SMC at Easton's Rehabilitation Market Share

UM SMC at Easton's rehabilitation service area market share decreased from 67.3% in fiscal year 2019 to 43.4% in fiscal year 2022. Going forward, market share is expected to stay constant at fiscal year 2022 levels by age cohort. As a result of the population aging into age cohorts with higher market share, UM SMC at Easton's total hospital market share will increase by 0.3% in aggregate from fiscal year 2022 to 2032 (Table 75).

Table 75
UM SMC at Easton's Historical and Projected Rehabilitation Service Area Market Share
FY 2019 – FY 2032

	Historical				Projected										% Change
Age Cohort	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Age 15-64	46.3%	45.8%	33.0%	35.2%	35.2%	35.2%	35.2%	35.2%	35.2%	35.2%	35.2%	35.2%	35.2%	35.2%	0.0%
% Change		*-1.0%*	*-27.9%*	*6.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
Age 65-74	68.0%	67.7%	57.8%	41.6%	41.6%	41.6%	41.6%	41.6%	41.6%	41.6%	41.6%	41.6%	41.6%	41.6%	0.0%
% Change		*-0.4%*	*-14.7%*	*-28.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
Age 75+	75.9%	67.8%	69.0%	48.4%	48.4%	48.4%	48.4%	48.4%	48.4%	48.4%	48.4%	48.4%	48.4%	48.4%	0.0%
% Change		*-10.6%*	*1.7%*	*-29.9%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
Total	**67.3%**	**63.4%**	**57.4%**	**43.4%**	**43.4%**	**43.4%**	**43.4%**	**43.4%**	**43.4%**	**43.4%**	**43.5%**	**43.5%**	**43.5%**	**43.5%**	**0.3%**
% Change		*-5.8%*	*-9.5%*	*-24.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	

5. UM SMC at Easton System Out-of-Service Area Rehabilitation Discharges

UM SMC at Easton's out-of-service area rehabilitation discharges declined as a percent of service area discharges from fiscal year 2019 to 2020, although there was an increase from fiscal year 2020 to fiscal year 2021. One of the drivers of these fluctuations in the historical period is the low sample size of out-of-service area rehabilitation discharges. The out-of-service area discharges are projected to remain constant, as a percentage of service area discharges, at the age cohort level, from fiscal year 2022 through the projection period. The slight increase over the projection period in the total percentage of discharges from out-of-service area are due to the aging of the population into older cohorts with higher discharges from outside the service area (Table 76).

Table 76
UM SMC at Easton's Historical and Projected Out-of-Service Area Rehabilitation Discharges % of Service Area Discharges
FY 2019 – FY 2032

	Historical				Projected									
Rehabilitation	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032
Out-of-Service Area Discharges % of Service Area Discharges	**25.2%**	**15.7%**	**18.2%**	**17.2%**	**17.2%**	**17.2%**	**17.3%**	**17.3%**	**17.3%**	**17.3%**	**17.3%**	**17.4%**	**17.4%**	**17.4%**

6. UM SMC at Easton's Inpatient Rehabilitation Discharges

Based on the assumptions described above and additional explanation provided in Section 10 below on the Impact of COVID-19 on Projected Bed Need, UM SMC at Easton's rehabilitation discharges are projected to increase 46.2% from fiscal year 2022 to fiscal year 2032 (Table 77). Although this percentage increase seems significant, this only reflects an additional 88 discharges per year. This increase is driven by the increases in population and age-adjusted use rates that are driven by the normalization of utilization to pre-pandemic levels. UM SMC at Easton notes that this increase remains conservative in comparison to UM SMC at Easton's historical rehabilitation discharges prior to the COVID-19 pandemic.

Table 77
UM SMC at Easton's Historical and Projected Rehabilitation Discharges
FY 2019 – FY 2032

	Historical				Projected										% Change
Rehabilitation	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Discharges	**392**	**353**	**312**	**191**	**198**	**206**	**214**	**222**	**231**	**239**	**249**	**259**	**269**	**279**	**46.2%**
% Change		*-9.9%*	*-11.6%*	*-38.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	

7. Rehabilitation Average Length of Stay

There has been steady increase in the average length of stay (ALOS) for rehabilitation patients at UM SMC at Easton from fiscal year 2019 to fiscal year 2022. Despite this increase, UM SMC at Easton's fiscal year 2022 ALOS of 11.5 remains below the statewide average of 11.7 and the nationwide average of 12.4. The Applicant believes that the fiscal year 2022 ALOS of 11.5 days is appropriate, given the patients that are typically seen in the rehabilitation unit and the fact that rehabilitation services are focused on achieving certain goals and providing maximum benefit to the patient to optimize patient outcomes. The ALOS is projected to remain constant at the age cohort level from fiscal year 2022 to fiscal year 2032 (Table 78).

Table 78
UM SMC at Easton's Historical and Projected Rehabilitation ALOS
FY 2019 – FY 2032

	Historical				Projected										% Change
Rehabilitation	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
ALOS	**9.2**	**9.3**	**9.7**	**11.5**	**11.5**	**11.5**	**11.5**	**11.5**	**11.5**	**11.5**	**11.5**	**11.5**	**11.5**	**11.5**	**0.0%**
% Change		*1.2%*	*5.2%*	*18.1%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	

8. Rehabilitation Occupancy

The Applicant assumes a 75% occupancy for rehabilitation beds which reflects the State Health Plan (COMAR 10.24.09) for acute rehabilitation inpatient services with an average daily census of 0-49 patients.

9. Rehabilitation Bed Need

As UM SMC at Easton is the only acute hospital providing inpatient rehabilitation services to the residents of its rehabilitation service area, the Applicant projects need for 12 rehabilitation beds at the replacement regional medical center by fiscal year 2032 (Table 79). These 12 rehabilitation beds will provide necessary access to acute hospital rehabilitation services for the residents of UM SMC at Easton's rehabilitation service area and meet the minimum bed requirement as outlined in the State Health Plan for Facilities and Services: Specialized Health Care Services – Acute Inpatient Rehabilitation Services COMAR 10.24.09.04.B(7)(a).

Table 79
UM SMC at Easton's Current and Projected Rehabilitation Bed Need
FY 2032

	Historical				Projected										%Change
Rehabilitation	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Bed Need	**13**	**12**	**11**	**8**	**8**	**9**	**9**	**9**	**10**	**10**	**10**	**11**	**11**	**12**	**50.0%**
% Change		*-7.7%*	*-8.3%*	*-27.3%*	*0.0%*	*12.5%*	*0.0%*	*0.0%*	*11.1%*	*0.0%*	*0.0%*	*10.0%*	*0.0%*	*9.1%*	

10. Impact of COVID-19 on Projected Bed Need

While UM SMC at Easton can demonstrate the need for its proposed 12-bed acute inpatient rehabilitation unit as presented herein, UM SMC at Easton notes that the COVID-19 pandemic has impacted its projections in important ways. Utilization of UM SMC at Easton's inpatient rehabilitation beds declined during the pandemic due to unprecedented staffing challenges, which were particularly acute in fiscal year 2021 and fiscal year 2022, but have since improved. During the period beginning April 2021 through August 2022, UM SMC at Easton had to limit its inpatient rehabilitation admissions because it did not have sufficient staffing to cover all of its beds. During this period, UM SMC at Easton generally had only one nurse and one tech available to staff its rehabilitation unit, which required it to cap its patient census at six patients. Occasionally, with additional staff coverage, it could flex to a patient census of seven. Due to these limitations, the average daily census and total number of admissions to the inpatient rehabilitation unit declined significantly during this period.

The need for inpatient rehabilitation care, however, remained steady. Over the course of calendar years 2021 and 2022, UM SMC at Easton declined a total of 147 patient referrals for inpatient rehabilitation care due to the lack of available, fully-staffed beds. These 147 patient referrals were patients who were referred for inpatient rehabilitation care at UM SMC at Easton, but who were not admitted to the unit and instead were referred/transferred and admitted to other inpatient rehabilitation providers due to lack of available beds at UM SMC at Easton. These declined referrals do not include patients who were referred to UM SMC at Easton but who elected to receive post-acute care at a skilled nursing facility instead of an inpatient rehabilitation facility. As a result, UM SMC at Easton believes the total patients it declined due to COVID-19 capacity and staffing-related challenges that it could have treated under normal circumstances is likely even higher.

Beginning in August 2022, UM SMC at Easton's staffing levels in the rehabilitation unit began to improve. These staffing level improvements were primarily driven by an increased focus at the unit level on staff recruitment and retention. Additionally, as staffing challenges in other units of the hospital have improved, UM SMC at Easton's inpatient rehabilitation unit staff have been diverted to other units less frequently, resulting in a steady supply of dedicated inpatient rehabilitation personnel. As a result, UM SMC at Easton can accept additional patients, and its average daily census has begun to trend back towards pre-pandemic levels, as demonstrated in Table 80 below.

Table 80
UM SMC at Easton Average Daily Census
FY 2019 to Q1 FY 2023

Year	Average Daily Census
FY 2019	9.7
FY 2020	9.0
FY 2021	8.3
FY 2022	6.0
Quarter 1 FY 2023	8.0

Source: UM SMC at Easton Internal Data

UM SMC at Easton's rehabilitation average daily census has continued to normalize in recent months as demonstrated in Table 81 below.

Table 81
UM SMC at Easton Average Daily Census
FY 2023 Year-to-Date by Month

Month	Average Daily Census
July 2022	6.9
August 2022	9.0
September 2022	7.9
October 2022	9.2
November 2022	7.6*

Source: UM SMC at Easton Internal Data

*Note: UM SMC at Easton experienced a COVID-19 outbreak on the rehabilitation unit in November 2022 and had to temporarily close the unit per infection control requirements.

11. Access to Inpatient Rehabilitation Care and Impact on Patient Outcomes

Although UM SMC at Easton does not need to justify the need for its proposed 12 acute inpatient rehabilitation beds by identifying barriers to accessing care in the region, UM SMC at Easton notes that without its 12 beds, patients of the planning region would lack sufficient access to necessary post-acute care. UM SMC at Easton is the only acute care hospital in the Eastern Shore health planning region that offers acute inpatient rehabilitation services. The next closest inpatient rehabilitation facilities are Encompass Health Rehabilitation Hospital of Middletown, located approximately 54 miles from the proposed project, and Encompass Health Rehabilitation of

Salisbury, located approximately 58 miles from the proposed project. The State Health Plan chapter on acute inpatient rehabilitation recognizes that "the distance to providers, relative to a patient's residence may be a more powerful predictor of the use of acute inpatient rehabilitation services than the clinical characteristics of patients." COMAR 10.24.09.03. Without the proposed 12-bed unit at the UM SMC at Easton replacement regional medical center, patients of the service area would need to travel long distances for their rehabilitation care. As a result, many patients in need of this level of post-acute care may not receive it due to barriers to accessing the care in a location close to the patient's home.

Many patients who lack access to inpatient rehabilitation care receive their post-acute care treatment at a skilled nursing facility or through home health, instead. These care delivery settings are not equivalent to the acute inpatient rehabilitation setting. Patients in the acute inpatient rehabilitation setting receive more hours of therapy and a higher degree of multi-disciplinary care team oversight than patients in other settings. For example, Medicare conditions of payment for inpatient rehabilitation services require that a patient receive at least three hours of therapy per day at least five days per week, whereas SNFs have no minimum hour threshold. 42 C.F.R. 412.622(a)((3)(ii). Similarly, Medicare's regulations require active and ongoing therapeutic intervention by multiple therapy disciplines for patients receiving inpatient rehabilitation services. *Id.* at (a)(3)(i). These high standards for focused, integrative, and intensive care do not apply to other post-acute care settings. To ensure that patients in UM SMC at Easton's service area who qualify for inpatient rehabilitation care receive the most appropriate level of care, UM SMC at Easton must preserve a portion of its current inpatient rehabilitation bed capacity at the replacement facility.

Moreover, research indicates that patients who qualify for an inpatient rehabilitation level of care but who receive such care in a less intensive setting experience worse outcomes. For example, one 2014 study found that patients who receive post-acute inpatient rehabilitation care as opposed to care in a skilled nursing facility have lower readmission rates, fewer ED visits, and lower mortality. As a result, the study concluded that "different post acute care settings affect patient outcomes," and that care delivered through inpatient rehabilitation is not the same as the care delivered at a skilled nursing facility.[11]

Outcomes for stroke patients, in particular, improve when patients receive post-acute care in an inpatient rehabilitation setting. The American Heart Association/American Stroke Association's 2016 Guidelines for Adult Stroke Rehabilitation and Recovery recognize that stroke patients have the best chances for optimal recovery if the patient receives coordinated and sustained rehabilitation care following the stroke. These guidelines are endorsed by the American Academy of Physical Medicine and Rehabilitation and the American Society of Neurorehabilitation.[12] One study that compared the outcomes for patients who received treatment in a SNF with patients treated in an inpatient rehabilitation facility found that the inpatient rehabilitation care "was associated with greater improvement in mobility and self-care compared with care in a skilled nursing facility, and a significant difference in functional improvement remained after accounting for patient, clinical, and

[11] *See* Joan E. DaVanzo, Ph.D., M.S.W., Al Dobson, Ph.D., Audrey El-Gamil, Justin W. Li, and Nikolay Manolov, Ph.D.; Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities and After Discharge; 2014.

[12] *See* Guidelines for Adult Stroke Rehabilitation and Recovery. Stroke. Volume 47, Issue 6, June 2016.

facility characteristics at admission."[13] UM SMC at Easton's inpatient rehabilitation unit is accredited by CARF in stroke rehabilitation as a Specialty Stroke Program. UM SMC at Easton requests to retain 12 beds at the replacement facility, where it may continue to apply its recognized expertise in serving stroke patients and offer such patients the best chance for positive outcomes.

If UM SMC at Easton's 12-bed rehabilitation unit is not approved, patients in the service area may be less likely to seek inpatient rehabilitation care due to the long distance they will be required to travel to access such care. As demonstrated here, this reduced access to care may result in poorer clinical outcomes for patients of the UM SMC at Easton service area. To ensure UM SMC at Easton's patients continue to receive the appropriate level of post-acute care and thus experience the best possible outcomes, UM SMC at Easton must retain a 12-bed inpatient rehabilitation unit at the replacement hospital.

(a) An applicant proposing to establish or expand adult acute rehabilitation beds that is not consistent with the projected net need in .05 in the applicable health planning region shall demonstrate the following:

(i) The project credibly addresses identified barriers to access; and

(ii) The applicant's projection of need for adult acute rehabilitation beds explicitly accounts for patients who are likely to seek specialized acute rehabilitation services at other facilities due to their age or their special rehabilitative and medical needs. At a minimum, an applicant shall specifically account for patients with a spine or brain injury and pediatric patients; and

(iii) The applicant's projection of need for adult acute rehabilitation beds accounts for in-migration and out-migration patterns among Maryland health planning regions and bordering states.

Applicant Response:

Inapplicable. The Applicant does not propose to expand the number of beds, and is in fact reducing the number of beds by eight from its current licensed bed count. As described above, the Applicant's proposal to retain 12 rehabilitation beds at the replacement hospital combined with the 64 beds at Encompass Salisbury is consistent with the Commission's projection of need for

[13] *See* Hong I, Goodwin, et al, *Comparison of Functional Status Improvements Among Patients with Stroke Receiving Postacute Care in Inpatient Rehabilitation vs. Skilled Nursing Facilities*, JAMA Network Open. 2019;2(12):e1916646. doi:10.1001/jamanetworkopen.2019.16646.

rehabilitation beds on the Eastern Shore in 2026 (published in the *Maryland Register* on July 1, 2022).

(e) An applicant that proposes a specialized program for pediatric patients, patients with brain injuries, or patients with spinal cord injuries shall submit explanations of all assumptions used to justify its projection of need.

Applicant Response:

Not applicable. UM SMC at Easton is not proposing a specialized program for any of these patient populations.

(f) **An applicant that proposes to add additional acute rehabilitation beds or establish a new health care facility that provides acute inpatient rehabilitation services cannot propose that the beds will be dually licensed for another service, such as chronic care.**

Applicant Response:

Not applicable. UM SMC at Easton is not proposing to add additional rehabilitation beds, nor is it proposing to dually license its rehabilitation beds for another service.

(3) Impact.

A project shall not have an unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services. A project also shall not have an unwarranted adverse impact on the availability of services, access to services, or the quality of services. Each applicant must provide documentation and analysis that supports:

(a) Its estimate of the impact of the proposed project on patient volume, average length of stay, and case mix, at other acute inpatient rehabilitation providers;

(b) Its estimate of any reduction in the availability or accessibility of a facility or service that will likely result from the project, including access for patients who are indigent or uninsured or who are eligible for charity care, based on the affected acute rehabilitation provider's charity care policies that meet the minimum requirements in .04A(1)(a) of this Chapter;

(c) Its estimate of any reduction in the quality of care at other providers that will likely be affected by the project; and

(d) Its estimate of any reduction in the ability of affected providers to maintain the specialized staff necessary to provide

acute inpatient rehabilitation services

Applicant Response:

UM SMC at Easton is not proposing to add additional rehabilitation beds. UM SMC at Easton's projections above assume that patient volume will increase consistent with population growth and that UM SMC at Easton will maintain its current market share (with a slight increase due to the aging of the population into age cohorts with higher use rates for rehabilitation services). As a result, UM SMC at Easton does not estimate any impact on patient volume, average length of stay, or case mix at other acute inpatient rehabilitation providers. This project will not result in the reduction of the availability or accessibility of rehabilitation services. While UM SMC at Easton is reducing its licensed beds at the replacement hospital, its bed need projections are based on actual utilization of rehabilitation services in the service area. The replacement hospital's rehabilitation unit, therefore, will be right-sized to serve the identified need in the service area. Moreover, the location of the replacement hospital will improve geographic access for patients overall. See response to Acute Hospital Services Standard COMAR 10.24.10.04B(4). UM SMC at Easton is an existing provider of rehabilitation services that proposes to reduce its rehabilitation bed capacity to appropriately meet the need for rehabilitation services in the service area, as demonstrated by the need projections above and the Commission's own regional need projections. As a result, UM SMC at Easton does not estimate any reduction in the quality of care at other providers or any reduction in the ability of other providers to maintain their staffing levels.

(4) Construction Costs.

(a) The proposed construction costs for the project shall be reasonable and consistent with current industry and cost experience in Maryland.

(b) For a hospital that is rate-regulated by the Health Services Cost Review Commission, 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 given 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 rate increase proposed by the hospital related to the capital cost of the project 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.

Applicant Response:

Please see the response to COMAR 10.24.10.04B(7) – Construction Cost of Hospital Space.

(5) Safety.

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety.

Applicant Response:

The acute rehabilitation unit design meets all safety-related standards of The Joint Commission and CARF. It is also consistent with requirements of ADA design. Environment of Care/Safety self-inspection rounds are currently performed semi-annually, and will continue, per CARF requirements. Annual inspections by external authorities are also completed and will be continued.

The replacement facility will also implement the design and safety features discussed in response to COMAR 10.24.10.04B(12) – Patient Safety, which is incorporated herein by reference.

(6) 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 CON application must be accompanied by a statement containing each assumption used to develop the projections.

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in the use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

(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 expense (including debt service expenses and plant and equipment depreciation), if the applicant's utilization forecast is achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital proposing an acute inpatient rehabilitation unit that does not generate excess revenues over total expenses, even if utilization forecasts are achieved for the services affected by the project, may demonstrate that the hospital's overall financial performance will be positive.

Applicant Response:

Please see the response to COMAR 10.24.10.04B (13) – Financial Feasibility.

(7) Minimum Size Requirements.

(a) A proposed acute inpatient rehabilitation unit in a hospital shall contain a minimum of 10 beds and shall be projected to maintain an average daily census consistent with the minimal occupancy standard in this Chapter within three years.

Applicant Response:

The replacement hospital's rehabilitation unit will have 12 beds, and thus meets the minimum size requirement for an inpatient rehabilitation unit in an acute general hospital. The State Health Plan for Acute Inpatient Rehabilitation Services provides for a minimum occupancy of 75% for facilities with an ADC of 0-49 patients. COMAR 10.24.09.05D(5)(a). As shown in **Exhibit 1**, Table F in the Occupancy Percentage row for Rehabilitation services, UM SMC at Easton projects that it will maintain an average daily census consistent with the minimum occupancy percentage of 75% in fiscal year 2029 when the replacement hospital opens and in the years following the opening of the replacement facility.

(b) A proposed acute inpatient rehabilitation specialty hospital shall contain a minimum of 30 beds and shall be projected to maintain within three years an average daily census consistent with the minimum occupancy standard in this Chapter.

Applicant Response:

Not applicable. The Requard Center is and will be part of an acute inpatient rehabilitation unit in an acute general hospital, not a specialty hospital.

(8) Transfer and Referral Agreements.

Each applicant shall provide documentation prior to licensure that the facility will have written transfer and referral agreements with facilities, agencies, and organizations that:

(a) Are capable of managing cases that exceed its own capabilities; and

(b) Provide alternative treatment programs appropriate to the needs of the persons it serves.

Applicant Response:

UM SMC at Easton has established written transfer agreements with other health care facilities to ensure the continuum of care for patients requiring transfer to another facility or entity due to the level of care required. Examples of patient transfer agreements with other facilities can be found in **Exhibit 21.**

Transfers of patients who are admitted to the inpatient rehabilitation unit but who exceed the Requard Center's level of care capabilities fall into two categories: (1) patients whose acute care needs necessitate transfer to an acute care service; and (2) patients whose rehabilitation needs exceed the Requard unit's level of care capabilities and so must be transferred to another rehabilitation facility (such as new acute traumatic brain injury, new quadriplegics, new paraplegics, and multiple traumas with multiple weight bearing limitations). The acute care hospitals to which such cases are transferred include: UM SMC at Easton, University of Maryland Medical Center, and Johns Hopkins Hospital. The acute rehabilitation hospital to which patients are transferred for rehabilitation is University of Maryland Rehabilitation & Orthopaedic Institute (the former Kernan Hospital). The number of transfers based on level of care required for fiscal years 2017– 2022 are shown below in Table 82.

Table 82
Patients Transferred Due to Exceeding the Requard Unit's Level of Care Capabilities
FY 2017 – 2022

Types of Cases	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Acute Care Transfers (discharged from Rehab)	31	24	33	24	20	17
Specialized Rehab/Care (admitted to Rehab then transferred)	0	0	2	0	1	1

Source of Data: UDS Pro I IRF PAI Data base

In addition to patients admitted to the Requard Center who are transferred as a result of the level of care required in their treatment, there are occasions when care could have been provided at UM SMC at Easton (i.e., evidence demonstrated medical necessity for acute inpatient rehabilitation services), but these cases were referred elsewhere prior to admission due to patient/caregiver choice or bed availability issues. These referrals are not captured in Table 82 above. Such patients are referred to the following acute rehabilitation hospitals after hospital discharge from UM SMC at Easton: Encompass Health Rehabilitation Hospital of Salisbury (Salisbury, MD) and University of Maryland Rehabilitation & Orthopaedic Institute (Baltimore, MD). Patients not requiring acute rehabilitation level of care, and/or who require referral to a different post-acute setting due to payer restrictions are referred to skilled nursing facilities, including: Signature Health Care at Mallard Bay (Cambridge, MD), Autumn Lake at Chesapeake Woods (Cambridge, MD), Peak Healthcare at the Pines (Easton, MD), ACTs at Bayleigh Chase (Easton, MD), Autumn Lake Healthcare at Denton (Denton, MD), and Caroline Center for Rehabilitation and Healthcare (Denton, MD).

(9) Preference in Comparative Reviews.

In the case of a comparative review of applications in which all standards have been met by all applicants, the Commission will give preference to the applicant that COMAR 10.24.09 Supplement 1 13 offers the best balance between program effectiveness and costs to the health care system as a whole.

Applicant Response:

Not applicable.

COMAR 10.24.21 – Acute Psychiatric Services Standards

.04A. PROCEDUREAL RULES: ACUTE PSYCHIATRIC SERVICES

A. Acute Psychiatric Services Docketing Rules.

(1) The Commission shall not docket an application involving establishment of a special psychiatric hospital or changes to an existing special psychiatric hospital or psychiatric unit of a general hospital unless the applicant provides an affirmation, under penalties of perjury, that, within the last ten years:

(a) No current or former owner or senior manager of the hospital or of the hospital operator, or of any related or affiliated entity:

(i) Has been convicted of a felony or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony; or

(ii) Has received a determination of exclusion from participation in Medicare or State health care programs, with respect to a criminal conviction or civil finding of Medicare or Medicaid fraud or abuse; and

(b) Neither the hospital, its operator, nor a current or former related or affiliated entity:

(i) Has been convicted of a felony or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony;

(ii) Has received a determination of exclusion from participation in Medicare or State health care programs, with respect to a criminal conviction or civil finding of Medicare or Medicaid fraud or abuse; or

(iii) Has paid fines, penalties, or entered a monetary settlement that exceeds$10,000,000 with or without an admission or finding of guilt with respect to any criminal or civil charges or investigation relating to allegations of Medicare or Medicaid fraud or abuse.

(c) The applicant may show evidence as to why this rule should not be applied if each individual involved in the allegations of fraud or abuse that resulted in the monetary settlement, fines, or penalties is no longer associated with the entity, or any of the related or affiliated entities, and each entity has fully complied with each applicable plan of correction and, if applicable, with each condition of the imposition of a civil penalty, monetary settlement, or agreed disposition.

Applicant Response:

See **Exhibit 22**, Affirmation of Kenneth Kozel, MBA, FACHE.

B. Acquisition of a Special Psychiatric Hospital.

Commission staff shall apply the following rules to a person or legal entity seeking to acquire a special psychiatric hospital pursuant to Health-General §19-120. If Commission staff finds non-compliance with these rules, it shall not approve the acquisition.

(1) Notice of Acquisition. A person or legal entity seeking to acquire a special psychiatric hospital shall provide the Commission with the notice required by COMAR 10.24.01.03A. The notice shall include:

(a) The identity of each person with an ownership interest in the acquiring entity or a related or affiliated entity;

(b) The percentage of ownership interest of each such person; and

(c) The history of each such person's experience in ownership or operation of health care facilities.

(2) Information and Disclosures Required. A person or entity seeking to acquire a special psychiatric hospital shall:

(a) Affirm that the services provided will not change as a result of the proposed acquisition;

(b) Affirm that the commitment to Medicaid participation will not change as a result of the proposed acquisition and shall provide information on corporate structure and affiliations of the purchaser, purchase price, source of funds, and other relevant data as requested;

(c) Affirm, consistent with Regulation .04A(1) of this Chapter, under penalties of perjury, that within the last ten years neither the acquiring entity, a related or affiliated entity, nor an owner or former owner, or member of senior management or management organization, or a current or former owner or senior manager of any related or affiliated entity has been convicted of felony or crime, or pleaded guilty, nolo contendere, entered a best interest plea of guilty, received a diversionary disposition regarding a felony or crime, and that neither the acquiring entity or a related or affiliated entity has paid a civil penalty or monetary settlement in excess of $10,000,000 that relates to an investigation regarding the ownership or management of a health care facility.

(3) Disqualification for Acquisition. Commission staff may deny an acquisition of a special psychiatric hospital if the acquiring entity, a related or affiliated entity, or an owner or former owner, or member of senior management or management organization, an owner or member of senior management of a related or affiliated entity has, within the preceding ten years, been convicted of a felony or crime or pleaded guilty, nolo contendere, entered a best interest plea of guilty, received a diversionary disposition regarding a felony or crime, or paid fines, penalties, or entered a monetary settlement that exceeds $10,000,000 with or without an admission or finding of guilt with respect to any criminal or civil charge or investigation relating to allegations of Medicare or Medicaid fraud or abuse, if staff concludes that that the proposed acquiring entity has not shown sufficient evidence why the acquisition should go

forward, consistent with Regulation .04A(1)(c) of this Chapter and the public interest.

Applicant Response:

Not applicable.

.05A. GENERAL STANDARDS

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.

Applicant Response:

Please see the Applicant's responses to COMAR 10.24.10.04(A).

.05B. PROJECT REVIEW STANDARDS

The standards in this section shall apply to Certificate of Need applications and exemption requests involving acute psychiatric services. An applicant for a Certificate of Need must address, and its proposed project shall be evaluated for compliance with, all applicable review standards. An applicant for an exemption from Certificate of Need review must address, and its proposed project shall be evaluated for consistency with, all applicable review standards.

Standard .05B (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 in 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:

Please see the Applicant's response to COMAR 10.24.10.04(B)(1) – Geographic Accessibility.

Standard .05B (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.

(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:

The Commission has not yet published regional need projections, so the Applicant's response addresses its service-level needs assessment only.

UM SMC at Dorchester was licensed to operate 16 inpatient adult psychiatric beds through the date of its conversion to a freestanding medical facility (FMF), which occurred on October 28, 2021. As part of its approved merger and consolidation with UM SMC at Easton, UM SMC at Dorchester relocated 12 inpatient psychiatric beds to UM SMC at Easton on September 23, 2021. Prior to this time, UM SMC at Easton did not have an inpatient psychiatric unit. The Applicant projects the need for 12 inpatient psychiatric beds for the replacement hospital in fiscal year 2032 utilizing the methodology and assumptions described below.

a. Defining UM SMC at Easton's Psychiatric Service Area

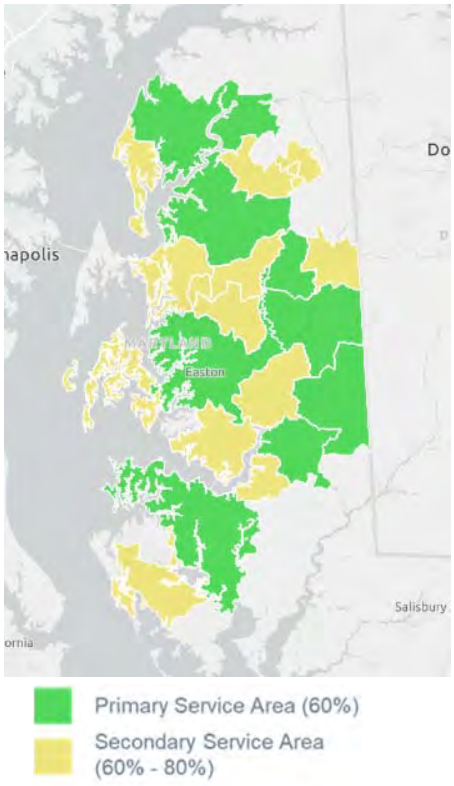
To determine the psychiatric service area for UM SMC at Easton, the Applicant considered the fiscal year 2022 discharges by ZIP code for the adult psychiatric cohort served by SHS, which encompasses UM SMC at Easton and UM SMC at Dorchester. Due to the conversion of UM SMC

at Dorchester from a full-service hospital to an FMF in October 2021 and transfer of the inpatient psychiatric unit to UM SMC at Easton as part of the merger and consolidation of these facilities, the July 2021 through October 2021 inpatient psychiatric admissions at UM SMC at Dorchester are considered when defining the service area for the replacement hospital as they will shift to UM SMC at Easton. Child and adolescent psychiatric discharges were excluded from this analysis because neither UM SMC at Dorchester nor UM SMC at Easton provide psychiatric inpatient treatment to children and adolescent patients, and the replacement facility will not serve this population. The Applicant identified the adult psychiatric service area as the ZIP codes that comprised the top 80% of adult psychiatric discharges in fiscal year 2022 at both UM SMC at Easton and UM SMC at Dorchester.

As presented in Table 83 below, UM SMC at Easton's service area for the adult (aged 15 and over) psychiatric cohort is defined by ZIP codes that account for 80% of total discharges. These ZIP Codes span Dorchester, Talbot, Caroline, Kent, and Queen Anne's Counties in Maryland.

Table 83
UM SM at Easton's Adult Psychiatric Service Area FY 2022

ZIP	City	County	Discharges	Cumulative %
21601	Easton	Talbot County	61	17.5%
21613	Cambridge	Dorchester County	58	34.1%
21629	Denton	Caroline County	21	40.1%
21620	Chestertown	Kent County	20	45.8%
21617	Centreville	Queen Anne's County	15	50.1%
21643	Hurlock	Dorchester County	15	54.4%
21660	Ridgely	Caroline County	14	58.5%
21632	Federalsburg	Caroline County	13	62.2%
21639	Greensboro	Caroline County	11	65.3%
21663	Saint Michaels	Talbot County	8	67.6%
21655	Preston	Caroline County	7	69.6%
21673	Trappe	Talbot County	7	71.6%
21625	Cordova	Talbot County	5	73.1%
21638	Grasonville	Queen Anne's County	5	74.5%
21662	Royal Oak	Talbot County	4	75.6%
21631	East New Market	Dorchester County	4	76.8%
21622	Church Creek	Dorchester County	4	77.9%
21665	Sherwood	Talbot County	3	78.8%
21657	Queen Anne	Queen Anne's County	2	79.4%
21658	Queenstown	Queen Anne's County	1	79.7%
21623	Church Hill	Queen Anne's County	1	79.9%
21679	Wye Mills	Talbot County	1	80.2%
	Service Area Total		**280**	**80.2%**
	Out of Service Area Total		69	19.8%
	SHS Total		349	100.0%



Source: hMetrix statewide non-confidential data tapes

b. Projected Adult Psychiatric Service Area Population

Based on UM SMC at Easton's adult psychiatric service area, population projections through 2027 were obtained from Environics Spotlight (formerly Nielsen Claritas) for the 15-64 age cohort, the 65-74 age cohort, and the 75+ age cohort, which are reflected below in Table 84**.** Annual population growth from 2022 to 2027 is projected at 0.2% for ages 15-64, 3.4% for ages 65-74, 1.4% for ages 75+, and 0.9% in aggregate.

Table 84
UM SMC at Easton's Historical and
Projected Adult Psychiatric Service Area Population
2010 – 2027

	Service Area Population						CAGR % Change in Population
	2010		2022		2027		
Age Cohort	Pop	% of Total	Pop	% of Total	Pop	% of Total	2022-27
15-64	79,301	77.8%	76,766	71.6%	77,358	69.1%	0.2%
65-74	12,309	12.1%	17,001	15.9%	20,143	18.0%	3.4%
75+	10,332	10.1%	13,396	12.5%	14,382	12.9%	1.4%
Total	**101,942**	**100.0%**	**107,163**	**100.0%**	**111,883**	**100.0%**	**0.9%**

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

Using the compounded annual growth rate by age cohort from 2022 to 2027, as shown in Table 84, population projections were extrapolated through 2032 and applied to the projected fiscal years for UM SMC at Easton. Table 85 below depicts the projected service area population for the 15-64, 65-74, and 75+ age cohorts through 2032.[14] The total service area population is expected to grow by 0.8% to 1.0% per year for an aggregate growth of 9.4% from fiscal years 2022 to 2032.

[14] Although the 15-17 age group is included as part of Environics standard age cohorts for purposes of calculating population growth, no discharges from this age group are included in the need projection given that UM SMC at Easton does not have an adolescent psych program.

Table 85
UM SMC at Easton's Historical and Projected Adult Psychiatric Service Area Population
FY 2019 – FY 2032

	Historical				Projected										%Change
Age Cohort	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
15-64	77,392	77,183	76,974	76,766	76,884	77,002	77,121	77,239	77,358	77,477	77,596	77,715	77,835	77,955	1.5%
% Change		*-0.3%*	*-0.3%*	*-0.3%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	
65-74	15,682	16,110	16,550	17,001	17,588	18,194	18,822	19,471	20,143	20,838	21,557	22,300	23,070	23,866	40.4%
% Change		*2.7%*	*2.7%*	*2.7%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	
75+	12,554	12,829	13,109	13,396	13,588	13,782	13,979	14,179	14,382	14,588	14,796	15,008	15,223	15,441	15.3%
% Change		*2.2%*	*2.2%*	*2.2%*	*1.4%*	*1.4%*	*1.4%*	*1.4%*	*1.4%*	*1.4%*	*1.4%*	*1.4%*	*1.4%*	*1.4%*	
Total Service Area	**105,628**	**106,121**	**106,633**	**107,163**	**108,059**	**108,979**	**109,922**	**110,890**	**111,883**	**112,903**	**113,949**	**115,024**	**116,127**	**117,261**	**9.4%**
% Change		*0.5%*	*0.5%*	*0.5%*	*0.8%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*1.0%*	*1.0%*	

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

c. Capacity Constraints and Referral of Patients to Delaware Hospitals

The inpatient psychiatric unit relocated to UM SMC at Easton on September 23, 2021 (early fiscal year 2022) as part of the merger and consolidation with UM SMC at Dorchester. Physical capacity and staffing constraints have required UM SMC at Easton to limit its patient census since the relocation.

When the unit was located at UM SMC at Dorchester, it consisted of all private rooms. Upon relocation to UM SMC at Easton, the unit consists of four private rooms and four semi-private, double occupancy rooms. The seclusion room at UM SMC at Easton was not large enough for the restraint bed, so UM SMC at Easton was required to convert one of the private rooms to house the restraint bed, leaving only three private rooms available for patients. The COVID-19 pandemic and other restrictions have limited or delayed UM SMC at Easton's ability to cohort two patients in the semi-private rooms. When the unit initially moved to UM SMC at Easton, only one patient could be admitted per semi-private room due to COVID-19 restrictions; now, UM SMC at Easton may admit two patients to a semi-private room, but only after both patients receive two negative COVID-19 tests. Furthermore, patient gender and acuity level restrict UM SMC at Easton's ability to cohort certain patients, so often only a single patient may be admitted to a semi-private room.

In addition to its physical capacity constraints, UM SMC at Easton experienced COVID-related staffing shortages during fiscal year 2022 that often required it to cap inpatient psychiatric census to ensure adequate staffing and provider coverage. At any point during a shift, if there are insufficient staff or providers to cover patients needing admission, patients are either held in the ED awaiting admission to Easton's unit once additional staff/providers are available, or transferred to another inpatient provider. UM SMC at Easton has had to reduce the number of involuntary psychiatric patients it admits due to these constraints. Based on these physical and staffing-related census restrictions in fiscal year 2022, UM SMC at Easton's utilization has declined because it has been required to refer patients to the next closest psychiatric provider with available beds and staff. In the last three months, UM SMC at Easton's staffing for its inpatient psych unit has begun to improve because it has closed its staffing pool so its staff are no longer being diverted to other units, and it has seen a corresponding increase in its average daily census as shown in Table 86 below.

Table 86
UM SMC at Easton
Inpatient Psychiatric Unit Average Daily Census
FY 2023 Year-to-Date

Month/Year	Average Daily Census
July 2022	4.74
August 2022	5.48
September 2022	5.16
October 2022	6.42
November 2022	6.93

Source: UM SRH internal data.

During fiscal year 2022, there were 121 adult psychiatric patients that UM SRH referred to hospitals in Delaware, given these hospitals' bed availability and relative proximity in comparison to the next closest referral options in Maryland (Table 87). These patients all came to a UM SRH emergency department or FMF in need of inpatient psychiatric services, but UM SRH referred these patients elsewhere by emergency transport largely due to its capacity constraints at UM SMC at Easton (e.g., room availability, staffing or provider coverage, COVID-19 positive patients and only semi-private room availability) and occasionally due to patient needs. These patients are accounted for in the population projections as residents of UM SMC at Easton's psychiatric service area, but not in the calculation of service area, psychiatric use rate, or market share calculations because the HSCRC statewide data tapes only capture admissions to Maryland hospitals. The Maryland statewide data tapes also only capture admissions to Maryland acute care hospitals, meaning specialty psychiatric facilities such as Sheppard Pratt and Brook Lane are excluded from the dataset.

Because the 121 patients in fiscal year 2022 originally came to UM SRH facilities for care, the Applicant's need projections assume that UM SMC at Easton's service area discharges will include this referral volume beginning in fiscal year 2029 when the replacement facility opens (Table 89). UM SMC at Easton assumes it will recapture this volume, as capacity and staffing issues improve, instead of referring patients to Delaware hospitals much farther away from their community.

Table 87
Psychiatric Referrals from
UM SRH to Delaware Hospitals
FY 2022

Hospital	FY2022 Easton Referrals
SUN Behavioral Delaware	76
Dover Behavioral Health System	40
Other Delaware Hospitals	5
Total	**121**

Source: UM SMC at Easton Internal Data

d. Adult Psychiatric Use Rates

Use rates for the patient population cohorts were established based on historical trends that were calculated and projected per 1,000 population. The total Maryland acute care hospital use rate for UM SMC at Easton's adult psychiatric service area declined from fiscal years 2021 to 2022. Until fiscal year 2029, use rates are held constant by age cohort. In aggregate, use rates are projected to decrease slightly by 0.5% to 0.6% annually due to the shift of age mix to those with lower use rates. In fiscal year 2029, when the replacement hospital opens, 121 service area discharges are added to UM SMC at Easton across the three age cohorts to account for recapture of referral volumes previously sent to Delaware hospitals, as described above. Use rates are held constant for the remainder of the projection period. Given these assumptions, use rates are projected to increase in total by 26.2% from fiscal years 2022 to 2032 (Table 88).

Table 88
UM SMC at Easton and UM SMC at Dorchester's
Historical and Projected Adult Psychiatric Use Rates
at Maryland Acute Care Hospitals
FY 2019 – FY 2032

	Historical				Projected										%Change
Age Cohort	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
15-64	5.9	4.6	4.9	4.3	4.3	4.3	4.3	4.3	4.3	4.3	5.8	5.8	5.8	5.8	33.6%
% Change		*-22.2%*	*7.4%*	*-11.9%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*33.6%*	*0.0%*	*0.0%*	*0.0%*	
65-74	1.7	2.0	2.0	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.6	1.6	1.6	1.6	26.3%
% Change		*15.4%*	*0.4%*	*-38.1%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*26.3%*	*0.0%*	*0.0%*	*0.0%*	
75+	2.6	1.1	1.0	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4	22.6%
% Change		*-58.5%*	*-9.1%*	*-69.9%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*22.6%*	*0.0%*	*0.0%*	*0.0%*	
Total Service Area	**4.9**	**3.8**	**4.0**	**3.3**	**3.3**	**3.3**	**3.3**	**3.3**	**3.3**	**3.2**	**4.3**	**4.3**	**4.2**	**4.2**	**26.2%**
% Change		*-22.8%*	*5.7%*	*-16.2%*	*-0.5%*	*-0.5%*	*-0.5%*	*-0.5%*	*-0.5%*	*-0.5%*	*32.2%*	*-0.5%*	*-0.6%*	*-0.6%*	

Source: FY2019-FY2022 hMetrix statewide non-confidential data tapes; UM SMC at Easton internal data

e. Adult Psychiatric Service Area Discharges

Besides the impact of the reduction in referrals to Delaware hospitals in fiscal year 2029, population growth drives a 0.4% annual increase in service area psychiatric discharges from Maryland acute hospitals. The total adult psychiatric discharges are projected to increase by 38.1% from fiscal years 2022 to 2032 as shown in Table 89 below.

Table 89
UM SMC at Easton and UM SMC at Dorchester's Adult Psychiatric Service Area
Total Discharges from Maryland Acute Care Hospitals
FY 2019 – FY 2032

	Historical				Projected										%Change
Age Cohort	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
15-64	456	354	379	333	334	334	335	335	336	336	450	450	451	452	35.6%
% Change		*-22.4%*	*7.1%*	*-12.1%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*33.8%*	*0.2%*	*0.2%*	*0.2%*	
65-74	27	32	33	21	22	22	23	24	25	26	34	35	36	37	77.3%
% Change		*18.5%*	*3.1%*	*-36.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*30.6%*	*3.4%*	*3.4%*	*3.4%*	
75+	33	14	13	4	4	4	4	4	4	4	5	5	6	6	41.4%
% Change		-57.6%	-7.1%	-69.2%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	24.4%	1.4%	1.4%	1.4%	
Total Service Area	**516**	**400**	**425**	**358**	**359**	**361**	**362**	**363**	**365**	**366**	**489**	**491**	**493**	**495**	**38.1%**
% Change		*-22.5%*	*6.3%*	*-15.8%*	*0.4%*	*0.4%*	*0.4%*	*0.4%*	*0.4%*	*0.4%*	*33.4%*	*0.4%*	*0.4%*	*0.4%*	

Source: FY2019-FY2022 hMetrix statewide non-confidential data tapes; UM SMC at Easton internal data

f. Adult Psychiatric Market Share

The market share at UM SMC at Easton and UM SMC at Dorchester was calculated within the planned service area based on the number of fiscal year 2022 psychiatric discharges for the 15-64, 65-74, and 75+ age cohorts as a percentage of total adult psychiatric discharges within the service area.

UM SMC at Easton's total adult psychiatric market share decreased by 2.0% from fiscal year 2019 to fiscal year 2022, partially due to the need to begin referring patients to other facilities because of space and staffing constraints. For all projection years, UM SMC at Easton's market share is projected to remain constant by age cohort. In fiscal year 2029 when the replacement hospital opens, the replacement hospital will be able to admit patients previously referred to Delaware hospitals, which are reflected in both total psychiatric service area discharges and UM SMC at Easton service area discharges. The increase of 6.9% to UM SMC at Easton's market share in fiscal year 2029 is due only to the ability to admit the patients previously referred to Delaware hospitals, and does not contemplate capture of market share from other Maryland hospitals. As presented in Table 90, the overall psychiatric market share for UM SMC at Easton will increase by 6.6% from fiscal year 2022 to 2032.

Table 90
UM SMC at Easton and UM SMC at Dorchester's
Historical and Projected Adult Psychiatric Market Share of
Maryland Acute Care Hospitals
FY 2019 – FY 2032

	Historical				Projected										%Change
Age Cohort	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
15-64	80.5%	82.2%	77.8%	79.0%	79.0%	79.0%	79.0%	79.0%	79.0%	79.0%	84.3%	84.3%	84.3%	84.3%	6.7%
% Change		*2.1%*	*-5.3%*	*1.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*6.7%*	*0.0%*	*0.0%*	*0.0%*	
65-74	85.2%	87.5%	72.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	73.6%	73.6%	73.6%	73.6%	10.4%
% Change		*2.7%*	*-16.9%*	*-8.3%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*10.4%*	*0.0%*	*0.0%*	*0.0%*	
75+	72.7%	57.1%	61.5%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	79.6%	79.6%	79.6%	79.6%	6.2%
% Change		*-21.4%*	*7.7%*	*21.9%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*6.2%*	*0.0%*	*0.0%*	*0.0%*	
Total Service Area	**80.2%**	**81.8%**	**76.9%**	**78.2%**	**78.2%**	**78.2%**	**78.1%**	**78.1%**	**78.1%**	**78.1%**	**83.5%**	**83.5%**	**83.4%**	**83.4%**	**6.6%**
% Change		*1.9%*	*-5.9%*	*1.7%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*6.9%*	*0.0%*	*0.0%*	*0.0%*	

Source: FY2019-FY2022 hMetrix statewide non-confidential data tapes; UM SMC at Easton internal data

g. Out-of-Service Area Adult Psychiatric Discharges

Both service area and out-of-service area adult psychiatric discharges at UM SMC at Easton and UM SMC at Dorchester decreased annually from fiscal year 2019 to fiscal year 2022. Out-of-service area discharges are expected to change with population growth for each respective age cohort through fiscal year 2032. Upon the opening of the replacement facility in fiscal year 2029, the Applicant assumes that the transition to a private-room only inpatient unit will decrease the number of psychiatric referrals to Delaware hospitals. The Applicant assumes that these patients, who would otherwise be referred to a Delaware hospital, all reside within UM SMC at Easton's service area. As such, the number of UM SMC at Easton service area discharges is expected to increase across all age cohorts starting in fiscal year 2029. In order to maintain the appropriate number of out-of-service area discharges, the out-of-service area percent of service area declines.

Table 91
UM SMC at Easton and UM SMC at Dorchester's
Historical and Projected Out-of-Service Area Adult Psychiatric Discharges
% of Total Service Area Discharges
FY 2019 – FY 2032

	Historical				Projected										%Change
Age Cohort	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
15-64 Discharges															
Service Area	367	291	295	263	263	264	264	265	265	265	379	379	380	381	
Out-of Service Area	115	113	98	68	68	68	68	68	69	69	69	69	69	69	
Out-of-Service Area as % of Service Area	31.3%	38.8%	33.2%	25.9%	25.9%	25.9%	25.9%	25.9%	25.9%	25.9%	18.1%	18.1%	18.1%	18.1%	-29.8%
65-74 Discharges															
Service Area	23	28	24	14	14	15	15	16	17	17	25	26	26	27	
Out-of Service Area	9	5	5	1	1	1	1	1	1	1	1	1	1	1	
Out-of-Service Area as % of Service Area	39.1%	17.9%	20.8%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%	5.1%	5.1%	5.1%	5.1%	-28.3%
75+ Discharges															
Service Area	24	8	8	3	3	3	3	3	3	3	4	4	4	5	
Out-of Service Area	1	2	2	-	-	-	-	-	-	-	-	-	-	-	
Out-of-Service Area as % of Service Area	4.2%	25.0%	25.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Source: FY2019-FY2022 hMetrix statewide non-confidential data tapes; UM SMC at Easton internal data

h. Inpatient Adult Psychiatric Discharges

Adult psychiatric discharges at UM SMC at Easton and UM SMC at Dorchester declined from fiscal year 2019 to fiscal year 2022 due to COVID-related staffing issues, census caps, and physical space limitations at the current facility. Based on the assumptions presented above, adult psychiatric discharges at UM SMC at Easton are projected to grow by 0.3% per year between fiscal years 2022 and 2032 due to population growth. In fiscal year 2029, the replacement facility is assumed to recapture 121 psychiatric discharges that came to UM SMC at Easton for inpatient psychiatric care but had to be referred to Delaware hospitals due to staffing and facility constraints. Adult psychiatric discharges are projected to increase by 38.4% between fiscal years 2022 and 2032, as presented in Table 92 below.

Table 92
UM SMC at Easton and UM SMC at Dorchester's
Historical and Projected Adult Psychiatric Inpatient Discharges
FY 2019 – FY 2032

	Historical				Projected										%Change
	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Psychiatric Discharges	**539**	**448**	**433**	**349**	**350**	**351**	**352**	**353**	**355**	**356**	**478**	**480**	**481**	**483**	**38.4%**
% Change		*-16.9%*	*-3.3%*	*-19.4%*	*0.3%*	*0.3%*	*0.3%*	*0.3%*	*0.3%*	*0.3%*	*34.4%*	*0.3%*	*0.4%*	*0.4%*	

Source: FY2019-FY2022 hMetrix statewide non-confidential data tapes; UM SMC at Easton internal data

i. Adult Psychiatric Average Length of Stay

The average length of stay ("ALOS") of adult psychiatric patients at UM SMC at Easton and UM SMC at Dorchester increased from 7.2 days in fiscal year 2017 to 8.4 days in fiscal year 2021 largely due to certain shelters and residential programs shutting down and additional patient

placement restrictions due to COVID-19. The ALOS then decreased significantly from 8.4 days in fiscal year 2021 to 5.7 days in fiscal year 2022.

Although UM SMC at Easton believes the reduction in ALOS in fiscal year 2022 is due in part to its efforts to improve collaboration with community partners in care coordination and outreach efforts for its psychiatric patients, it also believes the ALOS in fiscal year 2022 is an outlier and the ALOS will increase slightly back to more normal historical levels during the projection period. Accordingly, ALOS for adult psychiatric discharges is assumed to increase by 0.6% annually for all projected years in order to normalize and trend toward historical levels. Overall, ALOS is projected to increase by 6.4% from fiscal years 2022 to 2032, as shown in Table 93 below.

Table 93
UM SMC at Easton and UM SMC at Dorchester's
Historical and Projected Adult Psychiatric ALOS
FY 2017 – FY 2032

	Historical						Projected										%Change
	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
ALOS (Days)	**7.2**	**6.9**	**7.4**	**7.3**	**8.4**	**5.7**	**5.8**	**5.8**	**5.8**	**5.9**	**5.9**	**5.9**	**6.0**	**6.0**	**6.0**	**6.1**	**6.4%**
% Change		*-4.2%*	*6.8%*	*-0.4%*	*14.8%*	*-32.1%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	

Source: FY2019-FY2022 hMetrix statewide non-confidential data tapes

It is assumed that the 121 psychiatric discharges that were previously referred to Delaware hospitals from UM SMC at Easton will have an average length of stay equal to the average length of stay of all acute psychiatric discharges from UM SMC at Easton in fiscal year 2029.

The significant decrease in ALOS for psychiatric discharges in fiscal year 2022 was due in part to the hospital's efforts to reduce ALOS and in part due to compressed utilization resulting from the capacity and staffing constraints discussed above. To determine a more appropriate estimate of its long-term ALOS in the projection period and reduce the impact of outliers and variability in DRGs during fiscal year 2022, geometric mean is used to compare LOS for MS DRG 885, Psychoses, to the CMS benchmark (Table 94). In fiscal year 2022, MS DRG 885 accounted for 92% of UM SMC at Easton's psychiatric discharges and had a geometric mean LOS of 4.9, which is 1.0 days less than the CMS benchmark.

By removing confounding factors, it is reasonable to assume that ALOS at UM SMC at Easton and at the replacement hospital will normalize towards historical levels over time. As such, the Applicant assumes a 0.6% annual increase in ALOS for inpatient psychiatric discharges. As the hospital is able to support a higher average daily census, it is likely that the mix of patients admitted will have a higher ALOS than UM SMC at Easton's experience in fiscal year 2022.

Table 94
UM SMC at Easton vs CMS Psychoses Geometric Mean LOS
FY 2022

MS DRG	Description	FY2022 Discharges	% of Total	FY2022 Geometric Mean LOS: Easton	CMS	Variance
885	Psychoses	320	92%	4.9	5.9	(1.0)
Other Psych Discharges		29	8%			
Total Psych Discharges		349	100%			

j. UM SMC at Easton Psychiatric Occupancy

The adult psychiatric inpatient bed occupancy is projected at 70%, which is consistent with the State Health Plan for Psychiatric Services, COMAR 10.24.21.06(G) (Need Projection Methodology (B)(7)).

k. UM SMC at Easton Psychiatric Bed Need

Based on the assumptions presented above, the Applicant has projected a need for 12 adult psychiatric beds at the replacement hospital by fiscal year 2032, as demonstrated in Table 95 below.

Table 95
UM SMC at Easton and UM SMC at Dorchester's Historical and Projected Adult Psychiatric Bed Need
FY 2019 – FY 2032

	Historical				Projected										%Change
	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	FY22-FY32
Psychiatric Bed Need	**16**	**13**	**14**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**11**	**11**	**11**	**12**	**50.0%**
% Change		*-18.8%*	*7.7%*	*-42.9%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*37.5%*	*0.0%*	*0.0%*	*9.1%*	

l. Preserving Access to Psychiatric Services in the Mid-Shore Region

The State Health Plan for Acute Psychiatric Services, newly revised in August 2021, acknowledges that geographic access to behavioral health services is a barrier to care for rural counties in Maryland:

> In 2017, the Maryland Rural Health Administration's assessment reported that access to behavioral health services was a priority need identified by 13 of the 18 rural counties in Maryland. In 2016, the Maryland Department of Health convened focus groups and the Commission established a Rural Health Care Delivery Work Group that identified a lack of behavioral health services as one of the largest barriers to health care in rural Maryland, citing a lack of providers and infrastructure, especially for children and adolescents. While community

mental health resources are limited across the board, individuals from rural areas may need to travel farther to obtain necessary services and options may be more limited than for patients in more urban areas. Additionally, referrals to rural areas may be more challenging, as more patients are treated in inpatient settings farther from where they reside.

COMAR 10.24.21.03A. – Geographic Access, p.6. Policy 4 of the Psychiatric State Health Plan states that acute psychiatric services shall be "financially and geographically accessible to all who need them." Similarly, the Geographic Accessibility Standard at COMAR 10.24.21.05B(1) states that optimal travel time for adult psychiatric services is within 30 minutes under normal driving conditions for 90 percent of the population.

UM SMC at Easton is the only facility within its service area that offers adult inpatient psychiatric services. In order to preserve necessary and timely access to these services for residents of its service area, it is essential that the replacement regional medical center's inpatient psychiatric unit be sized appropriately to provide sufficient capacity for residents of its service area. Without sufficient capacity, UM SMC at Easton will continue to have to refer patients to more distant providers outside of the patient's community to receive care. Table 96 below shows the driving time between the five Mid-Shore Counties of Easton's service area and the next closest inpatient psychiatric units in Maryland and Delaware. The table shows that the proposed site for the replacement hospital is the shortest travel time from each county.

Table 96
Driving Time (in Minutes) from the Five Mid-Shore Counties
To Psychiatric Inpatient Units in Maryland and Delaware

	UM SMC at Easton (Proposed Site)	Anne Arundel (Annapolis, MD)	ChristianaCare Union Hospital (Elkton)	Tidal Health Peninsula Regional (Salisbury, MD)	ChristianaCare Wilmington (Wilmington, DE)	Delaware Psychiatric Cntr (New Castle, DE)	MeadowWood Behavioral Health (New Castle, DE)	Rockford Center (Newark, DE)	Dover Behavioral Health System (Dover, DE)	SUN Behavioral (Georgetown, DE)
Caroline	24	48	74	59	78	69	60	71	44	44
Dorchester	30	68	116	38	127	112	103	100	103	70
Kent	42	58	50	100	61	53	49	54	58	88
Queen Anne's	21	34	65	80	69	63	55	61	52	66
Talbot	11	49	84	56	88	84	74	84	66	64

Source of travel time is Google Maps, using the shortest travel time between each county and each hospital. Measurements were taken between 2:00 and 3:00 pm on Wednesday, October 12, 2022.

Standard .05B (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 psychiatric inpatient rooms in the replacement hospital will be private rooms.

(b) Projects in a special psychiatric hospital or in a psychiatric unit of a general hospital that involve renovation or replacement of patient rooms will, to the maximum extent possible, replace semi-private rooms with private rooms. Renovation or replacement of patient rooms that retain semi-private rooms 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:

Not applicable.

Standard .05B (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:

Not applicable. The replacement hospital will not provide psychiatric services for two or more age-specific psychiatric service lines.

Standard .05B (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 see **Exhibit 23** for the Applicant's letters of support. This exhibit contains letters from local health departments, and from local community mental health centers, local mental health advisory council/agencies, and local behavioral health service providers, including from Marshy Hope Family Services, LLC, Community Behavioral Health, Affiliated Sante's Eastern Shore Crisis Response, Channel Marker, Inc., Mid-Shore Behavioral Health, Corsica River Behavioral Health, and For All Seasons.

Standard .05B (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:

UM SMC at Easton is a 24/7 acute general hospital. The psychiatric services that will be provided at UM SMC at Easton will follow written procedures already implemented within SHS for providing psychiatric emergency inpatient services 24/7 with no special limitation for weekend or late night shifts.

The replacement regional medical center will be an acute general hospital with a 27-bay emergency department, including two psychiatric-appropriate exam rooms as well as three rooms designated as psychiatric holding areas for psychiatric patients awaiting disposition. The facility is designated by the Maryland Department of Health to perform evaluations of persons believed to have a mental disorder and brought to the hospital on an emergency petition. There will also be a seclusion room in the behavioral health unit.

Standard .05B (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.

Applicant Response:

The proposed replacement regional medical center will admit involuntary patients. The facility is designated by the Maryland Department of Health to perform evaluations of persons believed to have a mental disorder and brought to the hospital on an emergency petition.

(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:

Not applicable; UM SMC at Easton does not intend to discontinue admissions of involuntary patients.

Standard .05B (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.

Applicant Response:

UM SMC at Easton 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.

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

Applicant Response:

UM SMC at Easton participates in the Medicare and Medicaid programs.

Standard .05B (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:

UM SMC at Easton is not planning to eliminate or downsize the number of beds in its behavioral health unit at the replacement regional medical center, and instead proposes to retain the same 12 beds that exist at the current facility. UM SMC at Easton's bed need projections are based on actual utilization of acute psychiatric services in the service area. The unit is thus right-sized to serve the identified need in the service area. UM SMC at Easton's replacement regional medical center will improve availability and accessibility of acute psychiatric services because it will be located optimally in terms of geographic access. The unit at the replacement hospital will also have all private rooms, which will allow the facility to accommodate more patients as described above, which further improves access to acute psychiatric services. See response to Acute Hospital Services Standard COMAR 10.24.10.04B(4). Please also see the response to COMAR 10.24.10.04B(4) – Adverse Impact, generally.

Standard .05B (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:

Please see the response to COMAR 10.24.10.04B(7) – Construction Cost of Hospital Space.

Standard .05B (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 the response to COMAR 10.24.10.04B(9) – Inpatient Nursing unit Space.

Standard .05B (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:

Please see the response to COMAR 10.24.10.04B(13) – Financial Feasibility.

COMAR 10.24.01.08G(3)(b). NEED—Building Replacement and Observation Beds

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:

Please see discussion of bed and capacity need in response to COMAR 10.24.10.04B(2) (acute care bed need); COMAR 10.24.10.04B(14) (emergency department space); COMAR 10.24.12.04(1) (obstetric bed need); COMAR 10.24.11.05B(2) (operating rooms); COMAR 10.24.09.04B(2) (acute rehabilitation bed need); and COMAR 10.24.21.05B(2) (psychiatric bed need). The discussion below addresses: (1) the need to replace the aging and obsolete existing building; and (2) the need for observation beds, which is not subject to any need standard under the State Health Plan.

1. The Need to Replace the Existing Hospital Building.

The existing hospital building is deficient in many ways. The majority of the existing facility was built between 1955 and 1975, but certain portions of it date back to 1915. Due to its age, the existing facility is functionally obsolete for modern, family oriented medicine. The facility is undersized in various critical areas (such as the size of the operating rooms) and it does not have adequate parking. Due to the location of the existing facility in a residential area, the footprint of the hospital building cannot be expanded as it is surrounded by existing neighborhoods. The location is also inconvenient for the many patients who live outside of Easton and who have to drive into downtown Easton to access the hospital. Although the outpatient component is newer, it was designed to be an addition to the older building components and, therefore, suffers from considerable limitations.

Prior to submitting its CON application in 2012, the Applicant engaged The Schachinger Group ("TSG") to conduct departmental interviews by meeting with representatives from many clinical and service-oriented departments. The numerous findings as to existing physical space deficiencies and limitations affected nearly every department in the hospital.

Since 10 years have lapsed since TSG external assessment, Shore's mechanical engineer provided a risk assessment of the existing hospital facility's mechanical, electrical, and plumbing infrastructure in 2021. A summary is presented below, followed by issues specific to departments identified in the TSG's interviews and the internal risk assessment.

Given the age and limited space of the existing hospital facility, there are many concerns about the existing physical plant and associated operational issues, which are summarized below.

- Location and accessibility of supplies are not optimal. Hoarding of supplies is common. Night and weekend supply searches occur often by nursing staff. Due to the inconvenient location of supplies, an inordinate amount of staff time is taken with supply and inventory ordering, tracking, and maintenance. Much of the work is manual. Par levels may be higher than necessary to mitigate supply chain problems.

- General lack of storage throughout the hospital has resulted in inefficient use of staff time and cluttered hallways. Patient rooms have been closed and used for storage as no central storage area for beds and other necessary equipment exists. A semi-private bed area on almost every floor has been closed for storing beds, computer carts, blood pressure cuffs, and other equipment.

- The elevators are too small for larger patient transports and are inconveniently located, both in terms of physical location and difficulty getting there through the corridors. Elevator protocol leaves some departments with very long wait times. Patients in transport are exposed to public spaces.

- The rooftop helipad is too small to accommodate Maryland State Police helicopter transports, so the helicopter must land at the airport and the patient must be transferred by vehicle.

- The elevator providing both rooftop helipad access and supply storage access has progressively increasing failures. Due to the age of the elevator, certain necessary replacement parts are not compatible with the older elevator providing this access.

- Concerns were voiced regarding cleaning certain equipment or transporting equipment to be cleaned. Locations for equipment storage rooms have been debated; centralized versus a more common call for decentralized storage on patient floors. The request to have Environmental Services ("EVS") clean equipment was heard and responded to positively.

- Clean and soiled utility rooms must be sized appropriately for the units. The existing soiled utility rooms are considerably under sized.

- The structure and configuration of the facility makes wayfinding difficult.

- The existing building design and features, including lack of all private rooms and airflow, are not ideal for patient safety and infection control.

The Emergency Department

- There is no elevator near the emergency department. It is a long trip to the main hospital elevators, and even further to the helipad elevator. The trip to an elevator includes maneuvering many corners. In addition, there are no oversized elevators for patient transport. It is difficult for a critical care team to squeeze into the elevator.

- The helipad elevator, which typically handles larger teams, is smaller than the other elevators in the hospital. This elevator is also used extensively by materials management for supply transport.

- While the emergency department does not have many extra beds and stretchers, there is no storage space for storing the extras.

- The Pneumatic Tube System station is located in the middle of the nurses' station, which is not ideal because a column blocks lines of sight within the area.

- Location and accessibility of supplies is an issue; the supply room is down a hallway (about 200 feet away) and is not convenient or near the nurses' station. Centralized supplies in emergency department (Pyxis stations preferred) would reduce staff steps required. Because there is no central supply, the nurses tend to hoard high-demand

items as they do not know when they will get more. Reducing the amount of steps to get supplies to make things more accessible in general would be welcomed.

- Patient care equipment is stored in numerous locations due to space limitations, making the equipment difficult to locate, charge, and track.

- There are two soiled utility rooms. Neither is large enough for trash and dirty supplies (particularly bedside commodes). There is a need for three utility rooms: soiled, clean, and storage.

- Environmental Services has a small storage space in the emergency department, however additional room is needed to store cubicle curtains.

- There is no practical storage space for dietary carts. Special delivery trays are often left on top of the nurse station counters. There is no collection area for dirty trays; a pick up / drop off location is needed.

Dietary

- Due to physical constraints, food services cannot be expanded in the existing building. In addition, there are long waits for elevators.

Imaging

- Elevator sizes are an issue. It is difficult to access the control panel when transporting a patient by bed, as the bed barely fits in the elevator. When the patient is transported with additional equipment and a multiple person team, the elevator is cramped.

Infection Control

- Clean and soiled utility rooms are inadequately sized for current usage.

- Need for private rooms in order to accommodate the number of isolation patients.

- Separate rooms for clean and soiled are preferred by the Joint Commission. While there are separate rooms, the clean room doubles as storage. Due to the rooms' configuration, custom ultrasonic equipment travels in and out of soiled rooms, even after cleaning.

- Placement of sinks is not ideal. Sinks should be placed closer to room exit.

- Negative pressure isolation room(s) are inadequate.

- Bed storage is an issue.

- Deliveries from vendors / suppliers to Materials Management should be unpacked for storage and not stored on the units in shipping containers. With a centralized storage location, this issue could be remedied, but this is not feasible in the existing building.

- Sinks aren't deep enough. Due to structural capabilities and concerns with disturbing the existing infrastructure, upgrades are impracticable.

Inpatient Care Services / Nursing

- The warehouse where most supplies are stored is too far away from the clinical areas, which is critical during the hours when Materials Management is not staffed and nursing supervisors are required to find necessary items.

- An area is needed for storing supplies and equipment that has been cleaned and is ready for use. Storage for soiled equipment is lacking. When needed, equipment has to be located and the status (clean/soiled) is often unknown. Much time is wasted looking for items needed for patient care.

- Storage is a major concern. Having no central storage area for beds and other necessary equipment, a semi-private bed area on inpatient units have been closed for storing beds, computer carts, blood pressure cuffs, and other equipment. Many items are stored in the hallways. The existing utility rooms have electric panels on the inside walls, reducing the ability for optimum storage.

- Additional IT equipment is needed to accommodate modern care delivery needs. Physical constraints pose limitations to integrating this technology within current spaces. For example, a computer station located at every bedside for electronic medical records entry would be ideal, but is not feasible in the existing building due to space constraints.

- Nurses must often locate, clean, and store the equipment necessary for their functions. This takes valuable time away from patient care. With no central supply, items cannot be requisitioned and delivered on an on-call basis. There should be adequate space and EVS staff to pick up soiled items, clean, return, and place in storage.

- The elevators are too small to transport a patient with patient care equipment and the necessary transport team. There are a large number of bariatric patients at SHS and transportation of those patients requires additional equipment and staff, as well as wider doorways.

Laboratory

- The lab is currently in a space that was not originally designed to be a lab. A new configuration is needed but space constraints prevent this in the current building.

Linen Services

- On the floors, linens are stored in a variety of areas, depending on space and department. Storage areas include linen closets, clean utility rooms, and hallways.

Materials Management

- Multi-levels of receiving and supply storage are not efficient. Traffic patterns and busy intersections within the hospital are not optimal. The ideal dock area at the new facility

would be well lit with a receded overhang that is high enough to not be damaged by large trucks. The docks should be 48” high with a generous ramp and a large staging area.

- The delivery of supplies and storage of waste is inadequate due to the physical configuration of the current space.

- Emergency supplies are located in trailers on the campus and in off-site, rented, climate controlled storage. Ideally, these would be stored in a central location within the building, but space constraints prevent this.

- IT storage room is lacking.

- Cylinder storage is also inadequate at the existing facility but will be improved at the proposed facility.

- Bulk gas delivery must occur in an inconvenient location. While the delivery truck is refilling the tanks, the truck must park across the loading dock bay, blocking access for staff and other vendors.

Outpatient Services and Surgery

- There is no Central Supply to store and supply what is used by multiple departments, so multiples of the same supplies are spread throughout the building. Multiples are common and insufficient, and there are a lot of special orders. Materials Management does not have a centralized space for this storage.

- The elevators are not large enough to support the equipment and large teams. The gap between the door and the floor is large and catches the wheels of beds, carts, and gurneys. The location of the service elevators is inconvenient to the OR and travel involves multiple turns, corners, and intersections. Easy access between the OR and ICU is planned for the new facility, whether by adjacency or by elevator.

- During the COVID 19 pandemic, it was noted that the endoscopy suite air exchanges were inadequate for patient and team member safety. Endoscopic procedures are now done in one of the OR suites. Upgrading the air handling system in current facility to meet the required air exchanges is cost prohibitive as major infrastructure changes are needed to make the necessary upgrades.

Pharmacy

- The hospital has a 6” Translogic (Swisslog) Pneumatic Tube System that is dated and beyond its life expectancy. Most stations are not located within the secure nursing area, making it inconvenient. It is also loud and breaks frequently.

Plant Operations (Engineering/Maintenance)

- The maintenance area is located in a bay beside the receiving dock. There is no space for equipment or stock items such as televisions, wheelchairs, and beds. Storage is lacking and physical constraints prevent adding such storage.

- Storage is the major issue with Bio-Med, which has 2,500 pieces of equipment. There is no central storage; their equipment is located throughout the hospital.

- The plumbing infrastructure for management of waste is deteriorating. Iron pipes are corroding and fragile, increasing the amount of work needed to repair the systems to a functional state. The work needed to repair the systems to a fully functional state will be time-consuming and costly.

- The domestic water supply and sanitary sewage infrastructure are deteriorating. There are increasing amounts of corrosion noted on these pipes and many efforts have already been made to repair the hospital main line connecting to the pharmacy and dietary.

- Many of the hospital air handling units are, at minimum, 10 years beyond normal life expectancy. Replacement of the units will require extensive amounts of money and time as well as put patient safety at risk.

- Air handler units that are currently used within the hospital are outdated and being pushed beyond their means. They are difficult to replace due to the existing infrastructure and repairs and replacements are cost prohibitive.

- There are known roofing issues within the South building that result in large leaks requiring frequent repairs following weather fronts. These repairs are known to be both time consuming and costly.

- Within the crawl space of the current hospital there are many pipe lines that run directly through the access area making repairs time consuming, difficult, and inefficient.

- The pneumatic tube system that services the entire hospital is commonly known to fail. With the age of the system all parts have been deemed obsolete, making repairs difficult.

- Within plant operations boilers, there is a Fire Hawk system that should alarm to let the engineers know that the boiler system is malfunctioning and/ or completely down. This function does not consistently work and the facility staff must instead rely on monthly maintenance and engineer monitoring to identify issues with the boilers.

- Valves within the entire steam system are well over 20 years old and commonly fail. With extensive corrosion of valves within the system, leaks occur resulting in shutdowns that leave the facility without heat and hot water for periods of time.

Respiratory Services

- The outpatient services performed by the department are on the third and fourth floors, which is not convenient. Patients often have problems with wayfinding.

- There is no Pneumatic Tube Station in respiratory care or the cardiac catheterization lab.

- Elevators are an issue at the existing facility when moving equipment. The size of the elevators and usage by other departments makes it difficult to transport respiratory equipment. Wait times at the elevators are long due to multiple users, which causes delays in transporting equipment for patient care.

- The department has limited space for storage of soiled equipment.

Sterile Processing and Surgery

- The cart washer can only handle one cart at a time, with a cycle of 20-30 minutes. A backup of 2 to 4 carts is common and very limited storage exists for the cleaned carts waiting to be filled; the staff must work around these extra carts. There is also no storage for prepared case carts, which line up in the operating room area.

- There are storage issues with portable equipment. This equipment should be stored at point of use, but there is not enough space or enough staff; it is stored where ever space can be found.

- Two double-well sinks are in Sterile Processing, but only one is utilized due to storage issues.

Thus, the proposed project is needed to replace an aged facility that has deficiencies in nearly every department. Moreover, the older the facility becomes, the more difficult it will be to make necessary repairs to keep each department operational. As outlined above, UM SMC at Easton has identified a number of outdated infrastructure components that will need repairs in the near term. Due to the age of these systems, repairs may not be possible because the necessary parts are no longer being produced and are difficult to purchase. This will necessitate full repairs of certain systems, such as the elevators and air handler units. The costs associated with full repairs of systems as they continue to deteriorate will be significant.

In addition to identifying issues with the physical facility through its updated risk assessment, UM SMC at Easton has also considered the existing facility's limitations in addressing unmet needs of UM SMC at Easton's patient population. In its most recent Community Health Needs Assessment, UM SMC at Easton identified access to care as a top-three challenge for its service-area population. It also identified a number of specific clinical needs of its population that will be better addressed through improved community space and updated technological capabilities as outlined below.

Community Space and Technology

Educational and community-based programs and strategies contribute to the improvement of health outcomes. Health education programs help empower individuals and communities to live healthier lives by improving their physical, mental, emotional and social health by increasing their

knowledge and influencing their attitudes about caring for their well-being. In fact, UM SMC at Easton's most recent Community Health Needs Assessment identified a need for several educational and community-based programs to improve the health of the patient population, including programs focused on diabetes prevention, high blood pressure, smoking cessation, healthy pregnancy and healthy baby, healthy eating featuring food demonstrations, chronic disease self-management programs, mental illness and behavioral health, substance abuse, and nutrition. To address these needs, UM SMC at Easton has been developing and implementing targeted community education programs.

UM SMC at Easton's current facilities, however, lack capacity for state-of-the-art technology and space to share expertise and knowledge about community health promotion. A more sophisticated electronic venue with the most recent and cutting-edge information about community health improvement is needed for the interactive exchange of information between communities and practitioners.

In addition, a new facility with community space would lead to more accessible transportation options and parking. The current facility is located in a residential area of Easton. It is inconvenient for many patients originating from outside of Easton, who must drive into downtown to access the hospital. The replacement regional medical center will be located about three miles north of the existing facility, at 10000 Longwoods Road. The new location is just north of the Easton Municipal Airport and adjacent to the Talbot County Community Center. This central location will be much more easily accessed by patients than the existing facility. Many patients will have a shorter drive-time to the replacement regional medical center, as well. The replacement facility will also be constructed on a 200 acre greenfield site, with substantially more space for parking and potential future expansion, if needed. Locating the replacement regional medical center in a more convenient, accessible, and visible location will improve patients' access to care, thereby addressing a known need of the service-area population.

Physician recruitment

UM SMC at Easton also anticipates that a replacement regional medical center will aid in physician recruitment efforts. As the Commission has previously recognized in discussions regarding the future of health care delivery on the Eastern Shore, recruiting new physicians to the Eastern Shore is difficult, due to both its rural nature and reimbursement challenges. In interviews with existing physicians and community leaders, the majority of participants believed that physician recruitment would be enhanced with new hospital facilities, and that renovation of the existing facilities would be insufficient to attract new physicians. A facility constructed with the newest, cutting edge technology will facilitate better subspecialty care for inpatients, thereby attracting more clinicians in these practice areas. Moreover, the replacement regional medical center will be constructed in accordance with all modern building codes, FGI Guidelines, and will take into consideration best practices for clinical care. It will include updated technology, larger treatment spaces, better storage capacity, and more efficient layouts. Altogether, this will improve efficiency and allow staff to dedicate more time to patient care. These efficiencies that facilitate the highest quality of care will help attract new physicians to UM SMC at Easton.

2. The Need for Observation Beds.

As presented in Table 97 below, observation cases at UM SMC at Easton increased by 7% between fiscal years 2019 and 2022. UM SMC at Easton's average hours per case also increased

by 84% during this time period due to COVID-related throughput issues. In fiscal year 2022, observation patients stayed for an average of 41.8 hours or approximately 1.74 days. The hospital opened a dedicated observation unit in 2018 prior to the pandemic, which it was required to repurpose as a COVID-19 unit in 2020 once the pandemic began. Observation patients are now dispersed throughout the facility, which makes caring for these patients less efficient, slows throughput, and increases ALOS. In addition, the hospital had difficulties discharging patients to post-acute facilities during the pandemic, which resulted in longer patient observation stays.

Table 97
UM SMC at Easton
Historical Observation Cases and Hours
FY 2019 – FY 2022

	Historical				% Change
	FY2019	FY2020	FY2021	FY2022	2019-2022
Observation Cases	3,370	2,684	3,581	3,602	7%
Observation Hours	76,342	98,715	93,658	150,523	97%
Hours per Case	22.7	36.8	26.2	41.8	84%
Days per Case	0.94	1.53	1.09	1.74	84%

Source: HSCRC Annual Filing and HSCRC Experience Reports

The Applicant assumes that the need for observation treatment spaces at UM SMC at Easton will grow with the projected increase in emergency department visits. The projection is based on 3,602 observation cases in fiscal year 2022 and will increase approximately 0.9% to 1.0% annually with population growth through fiscal year 2032. The cumulative growth in observation cases at UM SMC at Easton between fiscal years 2022 and 2032 is projected to equal 9.7%, as shown in Table 98 below.

Table 98
UM SMC at Easton
Historical and Projected Observation Cases
FY 2019 – FY 2032

	Historical				Projected										% Change
	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	2022-2032
Observation Cases	3,370	2,684	3,581	3,602	3,633	3,664	3,697	3,730	3,765	3,800	3,836	3,873	3,912	3,951	9.7%
% Change		-20.4%	33.4%	0.6%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	1.0%	1.0%	1.0%	1.0%	

Source: HSCRC Annual Filing and HSCRC Experience Reports

As additional inpatient cases shift to the observation setting, the average length of stay for observation cases at UM SMC at Easton in fiscal year 2022 is 41.8 hours or 1.74 days on average, as shown in Table 97 above. In fiscal year 2022, although certain COVID-19 related challenges have improved, cohorting of observation patients has not occurred due to high census and staffing challenges that increases observation ALOS. Staffing shortages in many areas of the facility (e.g., nursing, case management, hospitalists, radiology techs, lab) have contributed to slower throughput

for observation patients, such as by causing longer wait times for diagnostic testing. In addition, during various periods of fiscal year 2022, inpatient censuses were capped in certain service lines due to staffing issues. With limited ability to admit patients, average length of stay for observation patients increased above that of prior years.

As COVID-related staffing pressures ameliorate, ALOS for observation patients is anticipated to decrease in the years leading up to the opening of the replacement hospital. It is also anticipated that observation cases will continue to grow as more patients are managed in observation status. The replacement hospital will have a dedicated observation unit that will help improve efficiency of staff workflow and patient throughput in the replacement hospital, which should in turn reduce unnecessary time spent in patient care treatment spaces. This is true of inpatient beds as well, which should further remedy the elevated average length of stay that UM SMC at Easton experienced in fiscal year 2022. Given the opportunities to reduce observation ALOS before and after the opening of the replacement hospital, the Applicant assumes that ALOS will decrease by 1.0% annually throughout the projection period, as shown in Table 99 below. ALOS in fiscal year 2032 is reduced to only 1.0 hours above that of historical levels in fiscal year 2020.

Table 99
UM SMC at Easton
Historical and Projected Average Length of Stay
FY 2019 – FY 2032

	Historical				Projected										% Change
	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032	2019-2032
Observation ALOS (Hours)	22.7	36.8	26.2	41.8	41.4	41.0	40.5	40.1	39.7	39.3	38.9	38.6	38.2	37.8	66.8%
% Change		62.4%	-28.9%	59.8%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	

Source: HSCRC Annual Filing and HSCRC Experience Reports

To project observation bed need at the replacement hospital, the ACEP Guide recommendation of 1,100 visits per observation treatment space – which equals three visits per observation bed per day or approximately eight hours per visit – is not comparable to that of UM SMC at Easton. Even in fiscal year 2019, prior to any COVID-19 throughput related challenges, the average length of stay at UM SMC at Easton was 22.7 hours, which is 283% of the ACEP assumed eight hour length of stay. Since the ACEP guidelines predate the COVID-19 pandemic and do not match UM SMC at Easton's historical experience, the recommended visits per observation treatment space cannot reasonably be used to project utilization.[15]

[15] The Applicant addresses the ACEP Guide because the State Health Plan chapter on freestanding medical facilities incorporates portions of the ACEP Guide for purposes of demonstrating need for observation beds. Of course, the project proposed here is a hospital, not an FMF. Thus, the standards for demonstrating need for observation beds in an FMF do not apply in this review. Also, it should also be noted that the ACEP Guide is based on the experience of a single architect, the author of the ACEP Guide, and not a broader data analysis of trends in observation utilization, average observation lengths of stay, or use rate demographics.

To this end, the projected average length of stay of 41.8 hours for observation cases at UM SMC at Easton is 5.2 times longer than the eight-hour stays implied by the ACEP Guide recommendation for programming at 1,100 visits per observation treatment space per year.

Applying the ACEP Guide's recommendation of 1,100 observation visits per observation treatment space to the projection of 3,951 observation cases in fiscal year 2032 would result in only 3.9 observation treatment spaces at UM SMC at Easton, which would be grossly inadequate to serve the needs of the service area population.

Rather than using the ACEP Guide to project observation bed need, it is more appropriate to project observation bed need at UM SMC at Easton similar to the projection of MSGA bed need which considers length of stay and occupancy. Because of the small number of observation cases at UM SMC at Easton, the Applicant assumes a 70% occupancy for observation beds at the UM SMC at Easton replacement hospital. This occupancy assumption is based on the State Health Plan for Acute Care Hospital Services (COMAR 10.24.10) that provides the minimum occupancy standard for MSGA services with average daily census of 0-49 patients.

Based on the assumptions presented above, there is a projected need in fiscal year 2032 for 25 observation beds at UM SMC at Easton as shown in Table 100 below.

Table 100
Projected Need for Observation Beds
FY 2019 – FY 2032

	Historical				Projected									
	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032
Observation Cases	3,370	2,684	3,581	3,602	3,633	3,664	3,697	3,730	3,765	3,800	3,836	3,873	3,912	3,951
Average Hours per Case	22.7	36.8	26.2	41.8	41.4	41.0	40.5	40.1	39.7	39.3	38.9	38.6	38.2	37.8
Total Observation Hours	76,342	98,715	93,658	150,523	150,291	150,084	149,900	149,741	149,607	149,498	149,415	149,358	149,327	149,323
Average LOS (Days)	0.9	1.5	1.1	1.7	1.7	1.7	1.7	1.7	1.7	1.6	1.6	1.6	1.6	1.6
Observation Days	3,181	4,113	3,902	6,272	6,262	6,253	6,246	6,239	6,234	6,229	6,226	6,223	6,222	6,222
Average Daily Census	9	11	11	17	17	17	17	17	17	17	17	17	17	17
Occupancy Target	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
Bed Need	**13**	**17**	**16**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**

COMAR 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:

The Applicant has addressed the alternative of the services being provided through existing facilities in its response to COMAR 10.24.10.04B(5) – Cost Effectiveness above. In addition to that response, which outlines the objectives of the project and the process UM SMC at Easton underwent to ensure it has selected the most cost effective alternative for its project, UM SMC at Easton has considered how population health initiatives impact the project.

The primary role of population health departments is to help patients maintain their best quality of life in the community. By effectively managing transitions among care settings, promoting and improving health in the community, and offering innovative programs to address social determinants of health, UM SRH has designed and implemented multiple programs to achieve its population health goals. A healthier population leads to lower rates of hospital admissions and more cost-effective delivery of health care. Through its planning process, UM SRH determined that coupling population health initiatives with a more efficient and modernized replacement regional medical center will result in the most cost-effective care.

UM SRH has implemented several systems to effectively manage transitions between care settings. Since 2017, UM SMC at Easton has paired nurse navigators with patients who are at high risk for readmission for 30 days after hospital discharge. These partnerships provide patients with needed support and reduce the rate of readmission. In 2020, UM SMC at Easton also implemented a call back system for inpatients and ED patients. Through this system, a patient is contacted within 48 hours of discharge to address issues related to medications, discharge instructions, and access to follow-up care. ED case managers and social workers identify potential readmissions and avoidable admissions and redirect them to alternate care sites. All of these measures have served to reduce preventable readmissions at UM SMC at Easton, thereby reducing health care costs overall. As shown in **Exhibit 24**, UM SMC at Easton's risk-adjusted readmission rates ("RARR") have been below the statewide average from calendar year 2016 through calendar year 2022 to date. In calendar year 2022 to date, UM SMC at Easton's RARR is 9.39% while the statewide average is 11.16%.

In addition to addressing patient needs immediately after discharge, UM SMC at Easton also has a robust community outreach program designed to address common causes of readmissions. Issues related to medications are the leading reason for readmissions and avoidable hospital admissions. UM SRH has a Transitions Pharmacist who regularly provides medication consults for primary care offices and community agencies in the service area. Each month, the Transitions Pharmacist also visits the senior centers of the five counties in the service area to provide education on medications-related issues and meet individually with seniors who have medication questions. Proactive outreach helps address common health care needs of the community that could result in hospitalizations. In addition to medications programs, UM SMC at Easton has chronic care management programs in place for heart failure and COPD and plans to add a new program dedicated to diabetes soon. UM SRH also has a remote patient monitoring ("RPM") program, which was initiated in 2019 and is currently being modernized. Using scales, blood pressure cuffs and pulse oximeter devices at home, patients may call and report their data to a UM SMC at Easton nurse who monitors the patient and takes appropriate action when needed. UM SMC at Easton plans to launch an automated system to replace the current manual process in its RPM program, leading to increased patient volume and improved data collection, in the near future.

To further address the needs of its rural patient population, UM SRH created a pilot mobile wellness team ("MWT") in Kent County to address Social Determinants of Health as well as clinical issues. The MWT is comprised of a nurse coordinator, social worker, and two community health advocates, who travel between community locations to provide education, perform screenings, and oversee wellness activities. The MWT accepts referrals from community agencies and health care providers for inclusion in the community case management program. In addition, the team makes home visits to assess living situations, facilitate telehealth consults, conduct home safety inspections, and link people with needed services. By providing these services to patients in the community, patients may receive routine, preventative services in an appropriate non-hospital setting, while reducing the likelihood that medical conditions will worsen and require inpatient or emergency department care.

Finally, multiple studies have shown hospital utilization at end of life decreases the patient experience and significantly inflates the total cost of care. UM SRH has had a palliative care program, both outpatient and inpatient, for several years. To further decrease end of life hospital utilization, the population health department has set a goal that 70% of the community will have a

signed advance directive. UM SMC at Easton is partnering with post-acute facilities, home care, physician practices, and community groups to realize this goal.

As evidenced by the numerous programs that UM SRH has in place, improving population health is a major focus of the health system. Population health initiatives factored into the decision process in planning for the replacement UM SMC at Easton regional medical center and ensuring that the project, as proposed in this application, is the most cost-effective alternative. For example, the reduction in hospital admissions that will be achieved by the success of UM SMC at Easton's population health programs factored into the sizing of the replacement hospital facility. The improved efficiency that will be gained by the replacement facility, along with the focus on increasing the overall wellness of the community, will allow UM SMC at Easton to effectively deliver care in an optimally-sized hospital facility. Moreover, the coordination of care between the inpatient and outpatient setting that is achieved through the population health initiatives detailed above will reduce the total cost of care for patients by avoiding unnecessary and expensive hospital admissions.

COMAR 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:

Financial Viability of the Project

See the response to COMAR 10.24.10.04B(13) – Financial Feasibility for the Applicant's discussion of Tables G, H, and L and the project's financial feasibility.

As shown in **Exhibit 1**, Table E, the total cost of the project is $539.6 million. The sources of funding for the project include cash flow from operations ($38.6 million), philanthropic gifts ($50.0 million), proceeds from debt financing ($333.3 million), investment earnings on bond proceeds during construction ($17.6 million), and State support ($100.0 million).

The cash flow from operations of $38.6 million was used to fund $20.0 million of prior period expenses including design, CON preparation costs, and the purchase of land. The remainder of the cash flow from operations ($18.6 million) is temporarily restricted on the UM SRH balance sheet. The sources are from consecutive years of operating cash flows generated to support capital

investment and a disciplined approach to reserving cash flows for the future regional medical center project.

The philanthropic target of raising $50.0 million from the Mid-Shore communities has been established at this phase of the regional medical center process. Efforts to achieve this target will include private philanthropy and community funding support for what will be the largest construction project in Mid-Shore history. As the CON application is being reviewed by State agencies, SHS will initiate the silent phase of its capital campaign, meeting with potential donors and identifying lead gifts for the project. When formal approval for the project has been obtained, SHS intends to launch a feasibility study and a formal capital campaign to raise funds from the community. The feasibility study and capital campaign will be supported by a national fund-raising firm with experience raising similar campaign targets. Likewise, key board and foundation board members will be joined by philanthropic community members and the selected national campaign firm to establish and run the capital campaign.

The largest source of funding for the project are the proceeds from debt financing. While the current market conditions may be a factor, UMMS anticipates that it is capable of financing the $333.3 million of bond proceeds at its current credit ratings. UMMS was most recently rated in February 2022 and both Standard's and Poor's and Moody's reaffirmed their previous A / A2 rating with a stable outlook. An A/ A2 rating signifies a strong capacity to meet its financial obligations but is somewhat susceptible to economic conditions and changes in circumstances. The rating agencies noted the strengths of UMMS' credit rating on its strong, state-wide brand, consistent positive operating margins, and a unique relationship with the State of Maryland in supporting operating and capital commitments. Furthermore, the credit agencies noted other strengths, including a disciplined decision-making concerning capital projects and maintaining and improving its debt structure risk.

The investment earnings from bond proceeds during construction total $17.6 million. Earnings are based on a 2.5% reinvestment rate of the bond proceeds over the assumed draw schedule, also taking into account the sources from cash flows, State grants, and cash collections on philanthropic gifts.

The State support of $100.0 million for the project was announced on December 15, 2022 by Governor Larry Hogan as part of his fiscal year 2024 budget plan.[16]

Other alternative financing methods were not explored. The current proposed mix of cash flows, debt, philanthropy, and State support are consistent with UMMS' historical approach to funding large, system-wide strategic initiatives.

Community Support for the Project

The proposed project enjoys strong community support, as demonstrated by the numerous and varied letters of support included in **Exhibit 23.** Community interest in and support for a

[16] *See Governor Hogan Announces Preliminary FY24 Budget Plan, Transformative Health Care Investments For Rural and Vulnerable Communities*, THE OFFICE OF GOVERNOR LARRY HOGAN, (Dec. 21, 2022), https://governor.maryland.gov/2022/12/15/governor-hogan-announces-preliminary-fy24-budget-plan-transformative-health-care-investments-for-rural-and-vulnerable-communities/.

replacement hospital has been at a high level region-wide since initial considerations for a replacement regional medical center were first developed more than a decade ago. Since then, UM SRH has undertaken an innovative and long-term approach towards developing an integrated health care delivery system within the five counties of the Mid-Shore. Because of the advancements in access to care and quality care delivery that UM SRH has made in the region, public interest in this project has strengthened. Whenever UM SRH updates are given in the region or gatherings are held with community physicians/providers, partner agencies and with donors, participants consistently inquire about when UM SRH anticipates moving forward with a new hospital to replace the aged facility in Easton. Donor interest remains strong and capital campaign planning, under the leadership of the UM SRH board and the UM Memorial Hospital Foundation Board, is top of mind. With this new hospital serving as the regional medical center for the entire Mid-Shore, philanthropic donation requests will extend to all five counties for support of regional acute care services.

Implementation of Project in Compliance with Performance Requirements

The Applicant is confident that it will be able to meet the applicable performance requirements. The building of a replacement hospital is subject to the following performance requirements: up to 36 months from the date of the CON project's approval to obligate 51% of the approved capital expenditure (COMAR 10.24.01.12C(3)(a)); up to four months from the effective date of a binding construction contract to initiate construction (COMAR 10.24.01.12B(2)); and up to 36 months after the effective date of a binding construction contract to complete the project (COMAR 10.24.01.12C(3)(a)).

As indicated in the Project Schedule in Part 1, Response 11, the Applicant estimates it will obligate at least 51% of the approved capital budget within 15 months of the CON application's approval, will begin construction within 4 months of capital obligation for the building, and will complete construction, and first use within 36 months from capital obligation, which is within the performance requirement time frames. The project site will require significant regrading, roadwork, and utilities to be brought to the area. The site work is expected to commence prior to award of the building construction contract in order to timely complete this. The building permitting process is expected to take six months.

Audited Financial Statements

Audited Financial Statements are included in **Exhibit 25.**

COMAR 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:

Since 2000, UM SMC at Easton has obtained two CONs and one Certificate of Conformance. Copies are attached at **Exhibit 26.**

- In July 2003, UM SMC at Easton received a CON for the "Capital Renovation and Expansion to Memorial Hospital at Easton." (Docket No. 03-20-2112).

- In September 2004, UM SMC at Easton received a CON for the "Establishment of a Twenty-Bed Acute Inpatient Rehabilitation Unit at The Memorial Hospital at Easton." (Docket No. 03-20-2128).

- In April 2016, UM SMC at Easton received a Certificate of Conformance to provide primary and secondary percutaneous coronary intervention (PCI) services. (Docket No. CC-15-20-0001).

There were no specific conditions placed on the CON projects. Both CON projects were completed as approved. UM SMC at Easton implemented the Certificate of Conformance for PCI services in 2017.

COMAR 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[17];

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:

a. Impact on Service Area Access to Health Care Services

The new location of the replacement facility will improve geographic access, as discussed previously and measured by the Applicant's drive time analysis, see response to COMAR 10.24.10.04B(1) – Geographic Accessibility. The proposed site for the replacement regional medical center will make inpatient services available within a 30-minute drive time for a much greater portion of the projected service area population. The proposed site will also significantly improve access for EMS services, patients, and staff due to its proximity to major roadways and expanded parking options, compared with the current site's location in a congested area with limited parking availability, as discussed in the Applicant's response to the Cost-Effectiveness Standard (see COMAR 10.24.10.04B(5)). Additionally, the proposed site will be equipped with a helipad to accommodate Maryland State Police helicopter transports to the facility, whereas currently, Maryland State Policy helicopters must land at the Easton Municipal Airport and patients must be transported by vehicle to the hospital.

[17] 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.

Furthermore, the project will improve the service area's access to health care services by addressing and resolving considerable deficiencies in the current site, which are discussed in the General Need Criterion (See COMAR 10.24.01.08G(3)(b)) – "The Need to Replace the Existing Hospital Building." Finally, UM SMC at Easton is working to improve its recruiting and retention of physicians and staff and believes this project will assist in these efforts, which have been a challenge for all health care providers since the COVID-19 pandemic but are even more pronounced in a rural area like the Mid-Shore region.

The Applicant's planned design and size of each unit have been carefully selected to meet the projected future demand for services in the service area and preserve necessary access to care. The Applicant's demand analyses and its design for the replacement hospital account for peak demand and surge capacity, which is particularly important in preserving timely access to care for residents, given the rural nature of this facility and distance to the next closest providers. In addition, as more fully discussed in the response to the Cost-Effectiveness Standard, the Applicant's design and plans for the replacement facility and campus take into account important lessons learned during the COVID-19 pandemic to provide adequate infection control, surge capability, and adaptability to allow the new building and campus to continue to serve the needs of the community for many decades to come.

b. Market Shift Impact on Other Regional Providers

For all inpatient services to be provided at the replacement hospital, market share among Maryland acute care facilities is assumed to remain constant for each age cohort through all projection years, ending in fiscal year 2032. With the exception of inpatient psychiatric services, net changes in market share throughout the projection period for each service line are only due to the aging of the population into age cohorts with a higher or lower market share.

The only anticipated project-related market shift impact is to inpatient psychiatric admissions that were referred from UM SMC at Easton to Delaware hospitals in fiscal years 2021 and 2022. These referrals are assumed to be recaptured in fiscal year 2029 as the replacement regional medical center begins operation (see Table 87). As stated in Section 0.5B(2), Need for Acute Psychiatric Services, inpatient psychiatric census at UM SMC at Easton was limited by physical and staffing related capacity constraints in fiscal years 2021 and 2022. The Applicant assumes that in fiscal year 2029, the staffing-related constraints will have improved and the new unit with all private rooms at the replacement hospital will mitigate these constraints and it will be able to admit all psychiatric patients previously referred to Delaware hospitals.

As shown in Table 101 below, recaptured Delaware referrals are added to both UM SMC at Easton's service area discharges and total service area discharges. The increase in market share does not reflect a shift in volume from other Maryland hospitals but rather a decline in psychiatric referrals to Delaware hospitals.

Table 101
Market Share Impact of Recaptured Referrals
to Delaware Hospitals from UM SMC at Easton

	FY2029 Baseline			FY2029 Adjusted				
	A	B	C = B / A	D	E = A + D	F = B + D	G = F / E	H = G - C
Age Cohort	Total Maryland Hospital Service Area Discharges	Easton Service Area Discharges	Market Share	Recapture of Delaware Referrals	Total Maryland Hospital Service Area Discharges	Easton Service Area Discharges	Market Share	% Recapture
15 - 64	337	266	79.0%	113	450	379	84.3%	5.3%
65 - 74	27	18	66.7%	7	34	25	73.6%	6.9%
75+	4	3	75.0%	1	5	4	79.6%	4.6%
Total	**368**	**287**	**78.0%**	**121**	**489**	**408**	**83.5%**	**5.4%**

Source: UM SMC at Easton Internal Data; hMetrix statewide non-confidential data tapes

Due to the nature of the Maryland Total Cost of Care Model, UM SMC at Easton's approved revenue would not increase as a result of the repatriation of these referrals. The Market Shift calculation performed annually by the HSCRC only accounts for the shift of volumes between Maryland regulated entities and does not consider volumes shifted to or from out of state providers.

c. Costs to the Health Care Delivery System

The proposed project will not result in any significant reduction of volumes from facilities offering similar services in the area. The Applicant expects there will not be an impact on costs or charges at the other facilities in the area.

This project will not have an impact on the margin of other hospitals. As the inpatient utilization of Maryland hospitals declines, the inpatient revenue at these hospitals will be proportionately reduced. This reduction in revenue is limited to a 50% reduction in each hospital's GBR revenue in relation to the specific service line affected. This reduction occurs in the year following the change in volume through the HSCRC market shift adjustment methodology.

Any reduction in volumes and related revenue is expected to be partially offset by a reduction in variable expenses. Applying an assumption of 50% variability of expenses with changes in volumes suggests that for every 1% reduction in volumes, the 0.5% reduction in revenue will be offset by a 0.5% reduction in variable expenses.

As described in the financial feasibility section, 0.4B(13), the Applicant intends to request a rate increase of $24.0 million to cover 50% of project-related depreciation and interest (including markup) in fiscal year 2029. HSCRC's fulfillment of this rate increase would only impact the replacement hospital. This rate increase would result in a slight increase to Easton's charges and costs to patients. Under HSCRC's discretion, it is possible to implement this rate increase while maintaining the CMS guardrails and fair distribution of revenue among Maryland providers.

The proposed project will have positive effects on the health care system as a whole:

- The project will address and resolve considerable deficiencies with the current site (See Project Description).

- The project will assist UM SMC at Easton in recruiting and retaining physicians, which is a challenge in the current service area.
- The existing facility has 37 semi-private rooms. (See **Exhibit 2**, Table A). The new regional medical center will have all private rooms, which will produce higher occupancy rates than are achievable with semi-private rooms. Private rooms also enhance patient satisfaction and family involvement, reduce the risk of infection, and reduce the need for transfers due to patient incompatibility.
- In tandem with the opening of UM Shore Medical Pavilion at Cambridge, UM Urgent Care facilities, and transformation of UM SMC at Chestertown, the replacement regional medical center will be the health care hub for residents of the service area needing higher-level care. The facility will continue to enable SHS to ensure that the residents of its service area are being treated at the right place, right time, and right cost given their needs. Doing so allows for the health system to tailor its health care delivery model to appropriately address the unique population health needs of the Mid-Shore region.

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I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for the Replacement and Relocation of the University of Maryland Shore Medical Center at Easton and its attachments are true and correct to the best of my knowledge, information, and belief.

January 6, 2023
Date

Ken Kozel, MBA FACHE
President and Chief Executive Officer
University of Maryland Shore
Regional Health

#813833

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for the Replacement and Relocation of the University of Maryland Shore Medical Center at Easton and its attachments are true and correct to the best of my knowledge, information, and belief.

January 6, 2023
Date

DocuSigned by:
JoAnne Hahey
DFC8B488258E42A...

JoAnne Hahey, CPA
Senior Vice President and Chief Financial Officer
University of Maryland Shore Regional Health

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for the Replacement and Relocation of the University of Maryland Shore Medical Center at Easton and its attachments are true and correct to the best of my knowledge, information, and belief.

January 6, 2023
Date

William Huffner, MD, MBA, FACEP, FACHE, CMO and Senior Vice President of Medical Affairs
University of Maryland Shore Regional Health

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for the Replacement and Relocation of the University of Maryland Shore Medical Center at Easton and its attachments are true and correct to the best of my knowledge, information, and belief.

January 6, 2023
Date

Arvin Singh, EdD, MBA, MPH, MS, FACHE, VP, Strategic Planning & Communications
University of Maryland Shore Regional Health

#813859

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for the Replacement and Relocation of the University of Maryland Shore Medical Center at Easton and its attachments are true and correct to the best of my knowledge, information, and belief.

January 6, 2023
Date

DocuSigned by:
Jennifer Bowie
C3403384AEE4497...

Jennifer Bowie, MBA, BSN, RN
Senior VP Patient Care Services, CNO
University of Maryland Shore Regional Health

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for the Replacement and Relocation of the University of Maryland Shore Medical Center at Easton and its attachments are true and correct to the best of my knowledge, information, and belief.

January 6, 2023
Date

DocuSigned by:
Diane Murphy
E0C03AB3CAEC4FB...

Diane Murphy, DHA, MSEd, BSN,
VP Support Services
University of Maryland Shore
Regional Health

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for the Replacement and Relocation of the University of Maryland Shore Medical Center at Easton and its attachments are true and correct to the best of my knowledge, information, and belief.

January 6, 2023
Date

Sherri Hobbs, MSM, MSN, RN,
CPHQ, VP, Chief Quality, Safety, &
Experience Officer
University of Maryland Shore
Regional Health

#813863

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for the Replacement and Relocation of the University of Maryland Shore Medical Center at Easton and its attachments are true and correct to the best of my knowledge, information, and belief.

January 6, 2023
Date

DocuSigned by:
Richie Stever
97A8762E51904F5...

Richie Stever, CHFM, CLSS-HC,
LEED AP, VP, Real Estate and
Property Management
University of Maryland Medical
Systems

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for the Replacement and Relocation of the University of Maryland Shore Medical Center at Easton and its attachments are true and correct to the best of my knowledge, information, and belief.

December 31, 2022
Date

DocuSigned by:
Mike Wood
8F4C03144AA548F...

Michael Wood
Vice President, Reimbursement
University of Maryland Medical Systems

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for the Replacement and Relocation of the University of Maryland Shore Medical Center at Easton and its attachments are true and correct to the best of my knowledge, information, and belief.

January 6, 2023
Date

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

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for the Replacement and Relocation of the University of Maryland Shore Medical Center at Easton and its attachments are true and correct to the best of my knowledge, information, and belief.

January 6, 2023
Date

DocuSigned by:
CFEA1156B00B49C...

Emily Dickinson
Vice President
HKS, Inc.