GALLAGHER

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ATTORNEYS AT LAW

February 22, 2023

VIA EMAIL & HAND DELIVERY

Ms. Ruby Potter
ruby.potter@maryland.gov
Health Facilities Coordination Officer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Shore Health System, Inc. Responses to Additional Information Questions dated January 25, 2023 for Replacement and Relocation of University of Maryland Shore Medical Center at Easton

Dear Ms. Potter:

On behalf of the applicant Shore Health System, Inc., we are submitting an electronic version of the Responses to Additional Information Questions dated January 25, 2023 and related exhibits. By separate email, we will provide a WORD version of the application, an EXCEL file of the Revised MHCC Tables and Alternate MHCC Tables referenced as Exhibits 27 and 36, an EXCEL file of the MVS analysis referenced in response 14, and an EXCEL file of the surgical services need projection referenced in response 28.

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

If you have questions about the information provided above, please contact us at your convenience.

Very truly yours,

Thomas C. Dame Mallory Regenbogen Alison Lutich

cc: Ben Steffen, Executive Director, MHCC
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SHORE HEALTH SYSTEM, INC.
RELOCATION OF UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT EASTON
Matter No. 23-20-2463

Responses to Additional Information Questions Dated January 25, 2023

Revisions to MHCC Tables

Attached as **Exhibit 27** is a revised full set of MHCC Tables. The Applicant is providing revised versions of Tables G and H, with changes to actual revenue and expense reported in FY 2021 and FY 2022. While preparing its completeness responses, the Applicant determined that the amounts reported in these two years were not consistent with the audited financial statements and certain audit adjustments – namely the allocation of physician losses from Shore Medical Group to Shore Health System, Inc. ("SHS") entities, which are not included in the Tables, the inclusion of which will reconcile to the audited financial statements. In FY 2021 the physician loss allocation was $22.567 million and in FY 2022 the physician loss allocation was $19.924 million on the audited financial statements. In the original Table Set, the Shore Medical Group physician loss allocations were excluded from the financial presented in FY 2022 through FY 2032, but were inadvertently included in the FY 2021 financials. This has been corrected for in the Revised Tables and all periods presented are consistent and do not include this physician loss allocation, nor do they include revenue and expense for entities other than UM SMC at Easton, UM SMC at Dorchester / Cambridge, and UM SMC at Queenstown. The Tables do, however, include $36.28 million in FY 2021 and $44.99 million in FY 2022 in unregulated gross revenue that falls under the UM SMC at Easton, UM SMC at Dorchester / Cambridge, and UM SMC at Queenstown reporting structures. The accompanying unregulated expense is also included. No other Tables are impacted by this revision.

Modification to Add an LDR Room

As described in the CON Application response to the Obstetrics Need Standard at COMAR 10.24.12.04(1), the existing hospital building is based on a labor-delivery-recovery-postpartum ("LDRP") model, meaning all aspects of the patient's stay for vaginal delivery occurs in the same room. In contrast, the obstetric unit at the replacement hospital is planned to have a combination of labor-delivery-recovery ("LDR") rooms for laboring patients, and upon delivery the patient will transfer to the postpartum room for the remainder of her stay. Within the current model, because patients are not in a separate room during labor and delivery, UM SMC at Easton did not have readily available data on the peak number of patients in labor at the time it filed the CON Application. This is because many data measures in the current model are based on when the patient is moved to inpatient status at the time of delivery. Although the Applicant could quantify the peak number of patients requiring postpartum rooms, it was having difficulty quantifying the number of patients laboring at one time in order to quantify the peak number of patients requiring LDR or LDRP rooms.

Since filing of the CON Application, UM SMC at Easton's clinical team has manually collected data from patient charts on the number of patients in labor on the OB unit in a given day to provide another measure of how many LDR and LDRP rooms are needed at the replacement hospital to accommodate patients in labor. This data is presented in response to Question 35 below. Upon review of this additional data, SHS has determined to modify the current floor plan

to add one additional LDR room to the current OB unit at the replacement facility to ensure sufficient capacity to accommodate patients in labor. This brings the total available rooms on the unit appropriate for vaginal deliveries to five: four LDRs and one flex labor-delivery-recovery-postpartum room (LDRP). This is accomplished by reducing the footprint previously included in the well-baby nursery and shifting unit offices into the space. Moving the offices allows for contiguous LDR rooms along the south face of the wing. The DGSF and total building footprint does not change as a result of this minor modification.

Because there is no net new square footage being added to the footprint, the cost increase of adding an additional LDR to the plan is nominal. There would be minimal additional costs for a headwall and casework, medical gas piping and medical equipment. In a project of this size, its impact does not warrant a change to the budget.

Attached as **Exhibit 28** is a revised floor plan for Level 3, which includes the additional LDR room.

Part I – Project Identification and General Information

1. **While we recognize a study group will be convened to address the disposition of the existing hospital site on South Washington Street, please provide the projected time frame to complete the analysis and final decision. Please describe any potential options under consideration.**

Applicant Response

As UM SRH works with the MHCC and HSCRC to obtain approval for the UM SMC at Easton Regional Medical Center in CY 2023, there are three enabling steps that will be completed in preparation for community/stakeholder engagement concerning disposition of the existing hospital property located on South Washington Street. These enabling steps include: 1) identification of consulting support for this phase of the project; 2) development of the Easton Repurpose Committee, which will oversee this process on behalf of the UM SRH and UMMS Boards; and 3) obtaining an appraisal of the existing hospital property. With the completion of these steps in CY 2023, UM SRH will be well-positioned to begin the process of identifying viable options for the property in CY 2024.

UM SRH fully expects that options ultimately presented for Board approval will complement the redevelopment underway and planned for the Town of Easton, specifically the downtown section surrounding the hospital property. Similar to the solutions considered for the disposition of UM SMC at Dorchester's hospital property in Cambridge, the goal will be to identify options that are beneficial to the community and provide the best value for the nonprofit enterprise.

2. **What is the status of the Planning Commission's revised site plan approval?**

Applicant Response

Existing site plan approvals based on the previous submission have expired. The site plans will require updating the drawings and resubmission for approval. UM SMC at Easton anticipates beginning the site plan re-design process within the next one to three months. Upon receipt of the updated documents, it is anticipated that it will take four to six months to receive

Planning Commission and Sketch Site Plan approval, and six to 12 months to receive Development Site Plan approval.

Part IV - Consistency with Project Review Standards And General Review Criteria at COMAR 10.24.10

Charity Care Policy

3. **Please provide a copy of the application used to determine probably eligibility for charity care.**

Applicant Response

Attached as **Exhibit 29** is UMMS' financial assistance application that is used as part of its financial clearance process to make final eligibility determinations. The determination of probable eligibility for financial assistance is made within two business days of receipt of a patient's request. This occurs during the screening process for both state medical assistance and UMMS' Financial Assistance program. The financial assistance application, which is used to obtain information in writing or verbally, is used as part of the probable eligibility and financial clearance process.

4. **The charity care policy states that "within two business days of receipt of a patient's request for financial assistance or an application for medical assistance, UMMS *may* provide determination of probable eligibility" The charity care standard states that a determination of probable eligibility must be made within two business days. Please amend your policy to meet the standard and provide a copy of the amended policy.**

Applicant Response

UMMS has amended its Financial Assistance Policy to correct this issue. The policy now reads on page 4: "Within two business days of receipt of a patient's request for financial assistance or an application for medical assistance, UMMS must make a determination of probable eligibility." (emphasis added). The revised policy is posted to UM SRH's Financial Assistance website (see https://www.umms.org/shore/patients-visitors/for-patients/financial-assistance) and is attached as **Exhibit 30**.

Acute Hospital Services

Geographic Accessibility

5. **Please demonstrate that the new hospital site will be located to optimize accessibility in terms of travel time for its likely service area population. The standard indicates that such a demonstration can be shown by defining the likely service area for general medical/surgical, intensive/critical care, and pediatric services and providing a travel time analysis that shows that at least 90% of this service area population is within a 30-minute travel time of the new hospital site, under normal conditions. The defined "Service Area" should be a "contiguous area comprised of the postal zip code areas from which the first 85% of" the replacement hospital's discharged patients are likely to originate.**

Applicant Response

As shown in Table 102 below, UM SMC at Easton's Current Site is within a 30-minute drive for 60.1% of the FY 2029 projected MSGA service area population. The Proposed Site is within a 30-minute drive for 83.7% of the FY 2029 projected MSGA service area population. By relocating to the Proposed Site, an additional 23.7% of the MSGA service area population will be within a 30-minute drive. The zip codes that are not within a 30-minute drive of the Current Site, but are within a 30-minute drive of the Proposed Site are shown in green text in Table 102 below.

Table 102
Percent of FY 2029 Projected MSGA Service Population Within 30-Minute Drive Of Current and Proposed Sites

					Current Site		Proposed Site	
Zip Code	City	County	2029 Projected Population	% of Total SA Populaiton	Within 30 Min of Current Site?	% of SA Population w/in 30 Min	Within 30 Min of Proposed Site?	% of SA Population w/in 30 Min
21601	Easton	Talbot County	24,918	15.4%	Y	15.4%	Y	15.4%
21613	Cambridge	Dorchester County	19,039	11.7%	Y	11.7%	Y	11.7%
21629	Denton	Caroline County	10,481	6.5%	Y	6.5%	Y	6.5%
21617	Centreville	Queen Anne's County	11,688	7.2%	N	0.0%	Y	7.2%
21655	Preston	Caroline County	5,295	3.3%	Y	3.3%	Y	3.3%
21620	Chestertown	Kent County	13,779	8.5%	N	0.0%	N	0.0%
21632	Federalsburg	Caroline County	6,780	4.2%	N	0.0%	N	0.0%
21643	Hurlock	Dorchester County	6,517	4.0%	Y	4.0%	Y	4.0%
21639	Greensboro	Caroline County	5,888	3.6%	N	0.0%	Y	3.6%
21660	Ridgely	Caroline County	4,788	3.0%	Y	3.0%	Y	3.0%
21663	Saint Michaels	Talbot County	3,646	2.2%	Y	2.2%	Y	2.2%
21673	Trappe	Talbot County	3,482	2.1%	Y	2.1%	Y	2.1%
21625	Cordova	Talbot County	6,351	3.9%	Y	3.9%	Y	3.9%
21666	Stevensville	Queen Anne's County	14,194	8.8%	N	0.0%	Y	8.8%
21619	Chester	Queen Anne's County	6,595	4.1%	N	0.0%	Y	4.1%
21638	Grasonville	Queen Anne's County	5,673	3.5%	Y	3.5%	Y	3.5%
21658	Queenstown	Queen Anne's County	4,409	2.7%	Y	2.7%	Y	2.7%
21631	East New Market	Dorchester County	3,127	1.9%	N	0.0%	N	0.0%
21654	Oxford	Talbot County	1,061	0.7%	Y	0.7%	Y	0.7%
21661	Rock Hall	Kent County	2,696	1.7%	N	0.0%	N	0.0%
21662	Royal Oak	Talbot County	449	0.3%	Y	0.3%	Y	0.3%
21679	Wye Mills	Talbot County	311	0.2%	Y	0.2%	Y	0.2%
21657	Queen Anne	Queen Anne's County	1,016	0.6%	Y	0.6%	Y	0.6%
		Total MSGA SA Population:	**162,184**		**% Population within 30 min:**	**60.1%**		**83.7%**

Source: DataPop population projections; Drive times based on projected drive time from zip code Post Office to address of Current & Proposed Sites according to Google Maps

In addition to the fact that 23.7% more of UM SMC at Easton's MSGA service area would be within a 30-minute drive of the Proposed Site compared to the Current Site, the Applicant believes that its status as a rural hospital should be considered in evaluating this standard. Further, as shown in Table 103 below, if Chestertown (21620) is removed from UM SMC at Easton's MSGA service area population for the purposes of this analysis, 91.5% of UM SMC at Easton's projected FY 2029 MSGA service area population would be within a 30-minute drive of the Proposed Site. The Applicant believes that it is appropriate to exclude Chestertown from this analysis as the residents of Chestertown are served by UM SMC at Chestertown, a full-service hospital operated by UM SRH and located within Chestertown's city's limits.

Table 103
Percent of FY2029 Projected MSGA Service Population Within 30-Minute Drive Of Current and Proposed Sites – Adjusted

					Current Site		Proposed Site	
Zip Code	City	County	2029 Projected Population	% of Total SA Populaiton	Within 30 Min of Current Site?	% of SA Population w/in 30 Min	Within 30 Min of Proposed Site?	% of SA Population w/in 30 Min
21601	Easton	Talbot County	24,918	16.8%	Y	16.8%	Y	16.8%
21613	Cambridge	Dorchester County	19,039	12.8%	Y	12.8%	Y	12.8%
21629	Denton	Caroline County	10,481	7.1%	Y	7.1%	Y	7.1%
21617	Centreville	Queen Anne's County	11,688	7.9%	N	0.0%	Y	7.9%
21655	Preston	Caroline County	5,295	3.6%	Y	3.6%	Y	3.6%
21632	Federalsburg	Caroline County	6,780	4.6%	N	0.0%	N	0.0%
21643	Hurlock	Dorchester County	6,517	4.4%	Y	4.4%	Y	4.4%
21639	Greensboro	Caroline County	5,888	4.0%	N	0.0%	Y	4.0%
21660	Ridgely	Caroline County	4,788	3.2%	Y	3.2%	Y	3.2%
21663	Saint Michaels	Talbot County	3,646	2.5%	Y	2.5%	Y	2.5%
21673	Trappe	Talbot County	3,482	2.3%	Y	2.3%	Y	2.3%
21625	Cordova	Talbot County	6,351	4.3%	Y	4.3%	Y	4.3%
21666	Stevensville	Queen Anne's County	14,194	9.6%	N	0.0%	Y	9.6%
21619	Chester	Queen Anne's County	6,595	4.4%	N	0.0%	Y	4.4%
21638	Grasonville	Queen Anne's County	5,673	3.8%	Y	3.8%	Y	3.8%
21658	Queenstown	Queen Anne's County	4,409	3.0%	Y	3.0%	Y	3.0%
21631	East New Market	Dorchester County	3,127	2.1%	N	0.0%	N	0.0%
21654	Oxford	Talbot County	1,061	0.7%	Y	0.7%	Y	0.7%
21661	Rock Hall	Kent County	2,696	1.8%	N	0.0%	N	0.0%
21662	Royal Oak	Talbot County	449	0.3%	Y	0.3%	Y	0.3%
21679	Wye Mills	Talbot County	311	0.2%	Y	0.2%	Y	0.2%
21657	Queen Anne	Queen Anne's County	1,016	0.7%	Y	0.7%	Y	0.7%
		Total MSGA SA Population:	**148,405**		**% Population within 30 min:**	**65.7%**		**91.5%**

Source: DataPop population projections; Drive times based on projected drive time from zip code Post Office to address of Current & Proposed Sites according to Google Maps

Identification of Bed Needs and Addition of Beds

6. The application states that the MIEMSS red/yellow alert system has kept a significant number of patients out of the emergency room, leading to a decline in patient admissions. Provide more detail on the factors that triggered the MIEMSS alerts. How do the Easton hospital's hours on alert compare with the experience of other hospitals that have substantive market share in the service area of University of Maryland Shore Medical Center at Easton (Shore Easton)?

Applicant Response

UM SRH has experienced an increase in MIEMSS red and yellow alerts over the past few years. This is consistent with an increase in MIEMSS alerts at other facilities across the state. As noted in the CON application on page 104, footnote 9, a 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 are not be transported to their facility. UM SMC at Easton has a limited number of monitored beds available at the existing hospital – 38 monitored telemetry beds, 10 ICU beds, and 10 overflow monitored beds. In contrast, the replacement facility will have all monitored beds. Accordingly, when the existing hospital's monitored beds are occupied due to an increase in patient admissions, this results in utilization of red alert. In addition, it can result in already admitted patients being cared for in the ED as boarders until a

bed becomes available. These boarders occupy ED treatment bays, which result in less treatment bays being available to treat ED patients, and leads to longer ALOS and can overwhelm the ED's capacity. This inability to admit patients requiring monitoring and lack of capacity in the ED results in the ED at UM SMC at Easton needing to go on yellow alert.

The significant increase in patient boarding and increased length of stay at UM SMC at Easton, has impacted Shore's FMFs, UM SMC at Cambridge and UM Shore EC at Queenstown, with rerouting of ambulance traffic and patients self-selecting to go to the other facilities. UM Shore EC at Queenstown is further impacted by alert status in Region III. With AAMC and BWMC on yellow alert and/or reroute, the EMS units from Arundel County, Annapolis City, and Naval District Washington transport to UM Shore EC at Queenstown. Many of these patients require repatriation to facilities in Region III, which leads to holds and boarders.

UM SMC at Cambridge's MIEMSS yellow alerts have increased as it is also holding transfers and boarders in addition to EMS transporting directly to this facility.

UM SMC at Chestertown's MIEMSS alerts have primarily been impacted by the alert status of UM Shore EC at Queenstown and the inability to meet the higher level of care needed by certain patients and lack of alternative facilities to transfer patients due to those facilities' capacity.

Table 14 from the original CON Application, which is reproduced 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%.

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

Table 104 toTable 107 below present the number and total duration of MIEMSS Yellow and Red Alerts at other facilities with substantive market share within UM SMC at Easton's

primary service area. Other hospitals with substantive market share in the service area were identified as:

- UM SMC at Dorchester / Cambridge
- UM EC at Queenstown
- UM SMC at Chestertown
- TidalHealth Peninsula Regional Medical Center
- Luminis Health Anne Arundel Medical Center

TidalHealth does not declare Yellow or Red Alerts due to internal policies, and as such they are excluded from the analysis.

Besides TidalHealth Peninsula Regional Medical Center, each of these facilities experienced significant growth in the frequency and duration of MIEMSS Alerts from FY2019 to FY2022. Among these facilities, growth in the total number of Red or Yellow Alerts ranged from 122.8% to 1,640.0%, while growth in the total number of hours on Red or Yellow Alert ranged from 273.3% to 5,785.5%. The growth experienced at UM SMC at Easton over this time falls within these ranges for both the number (365.5% at UM SMC at Easton) and duration (3,754.2% at UM SMC at Easton) of Red and Yellow Alerts.

Table 104
UM SMC at Dorchester / Cambridge Historical MIEMSS Red & Yellow Alerts
FY 2019 – FY 2022

Dorchester / Cambridge MIEMSS Alerts	FY2019	FY2020	FY2021	FY2022 (1)	FY19 - FY22 % Variance
Yellow Alert	6	5	20	73	1,116.7%
Red Alert	3	22	81	31	933.3%
Total Alerts	**9**	**27**	**101**	**104**	**1,055.6%**
Hours on Yellow Alert	16	5	77	574	3,572.3%
Hours on Red Alert	36	282	1,668	1,746	4,801.1%
Total Hours on Alert	**51**	**287**	**1,745**	**2,321**	**4,426.2%**

Note (1): FY2022 includes Dorchester through October 2021 and Cambridge FMF for November 2021 through June 2022

Source: CHATS Hospital MIEMSS Alert Tracker

Table 105
UM SMC at Chestertown Historical MIEMSS Red & Yellow Alerts
FY 2019 – FY 2022

Chestertown MIEMSS Alerts	FY2019	FY2020	FY2021	FY2022	FY19 - FY22 % Variance
Yellow Alert	4	2	3	63	1,475.0%
Red Alert	1	1	15	23	2,200.0%
Total Alerts	**5**	**3**	**18**	**86**	**1,620.0%**
Hours on Yellow Alert	13	6	10	410	3,121.3%
Hours on Red Alert	8	21	213	491	6,364.9%
Total Hours on Alert	**20**	**27**	**223**	**901**	**4,333.8%**

Source: CHATS Hospital MIEMSS Alert Tracker

Table 106
UM EC at Queenstown Historical MIEMSS Red & Yellow Alerts
FY 2019 – FY 2022

Queenstown MIEMSS Alerts	FY2019	FY2020	FY2021	FY2022	FY19 - FY22 % Variance
Yellow Alert	5	3	6	87	1,640.0%
Red Alert	-	-	-	-	0.0%
Total Alerts	**5**	**3**	**6**	**87**	**1,640.0%**
Hours on Yellow Alert	12	13	22	696	5,785.5%
Hours on Red Alert	-	-	-	-	0.0%
Total Hours on Alert	**12**	**13**	**22**	**696**	**5,785.5%**

Source: CHATS Hospital MIEMSS Alert Tracker

Table 107
Luminis Health Anne Arundel Medical Center Historical MIEMSS Red & Yellow Alerts
FY 2019 – FY 2022

AAMC MIEMSS Alerts	FY2019	FY2020	FY2021	FY2022	FY19 - FY22 % Variance
Yellow Alert	94	79	109	204	117.0%
Red Alert	7	13	13	21	200.0%
Total Alerts	**101**	**92**	**122**	**225**	**122.8%**
Hours on Yellow Alert	972	855	1,148	2,974	205.9%
Hours on Red Alert	43	233	76	818	1,782.3%
Total Hours on Alert	**1,016**	**1,088**	**1,224**	**3,792**	**273.3%**

Source: CHATS Hospital MIEMSS Alert Tracker

7. **The application states that currently, observation patients are dispersed throughout the hospital because there is no specified observation unit. Is the use of licensed beds by observation patients included in bed occupancy rates reported in the application?**

Applicant Response

No, the use of licensed beds by observation patients is not included in bed occupancy rates reported in the application. Occupancy rates reported in the application in **Exhibit 1**, Table F are calculated using total patient days for inpatient admissions only, not for observation stays.

8. **How has the development of dedicated observation space, that should eliminate the practice of using licensed bed capacity to accommodate observation stays, influenced Shore Easton's need assessment for bed capacity in the replacement hospital?**

Applicant Response

As Question 7 recognizes, since there is no current dedicated observation unit in the existing hospital, patients are occupying beds throughout the hospital. Patients' use of those beds is not captured in the hospital's current occupancy rates presented in the CON Application given that occupancy formulas are based on inpatient patient days only. As such, the Applicant's actual occupancy rates and demand for those beds would be much greater if observation stays were factored into the licensed bed need assessment. As stated on page 61 of the CON Application, the existing hospital has significant excess physical bed capacity, which is used, in part, to serve observation patients. The dedicated observation unit planned for the replacement facility will allow the hospital to more efficiently serve observation patients in this unit, thereby decreasing the overall number of licensed beds needed for inpatients. As is shown in Table 32 of the CON Application, which is reproduced below, the existing hospital has 165 physical beds

but is licensed for 118 beds, whereas the replacement facility will be right-sized to a total of 122 licensed beds.

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**

9. The application references staffing shortages as a cause of the increased average length of stay (ALOS) (p. 49). Please provide more specific detail on how staffing shortages have affected ALOS for MSGA beds?

Applicant Response

Staffing shortages, reflected in increased patient to nurse ratios as well as increased patient to case manager ratios, resulted in less direct contact time with the patient from both disciplines. This contributed to longer care plan and discharge plan implementation and execution, resulting in a longer ALOS.

10. Table L shows 9.6 FTE reserved for the pediatric service. Provide more detail on the assumptions used for this staffing plan.

Applicant Response

The 9.6 FTEs are comprised of one registered nurse and one technician staffed 24 hours a day, 365 days per year.

11. How has the "triple-demic" (COVID-19, RSV and influenza) affected the pediatric need assessment?

Applicant Response

The tripledemic's main impact occurred in October 2022 through January 2023, and therefore is not factored into the pediatric bed need projection, which is based on FY 2022 data (July 2021-June 2022). UM SMC at Easton is planning to include one pediatric bed at the replacement hospital, which should provide sufficient capacity the majority of the time to care for its pediatric patients based on its projected bed need analysis. As noted on page 53 of the CON Application, the pediatric bed will be co-located on the Perinatal Labor and Delivery Unit with two medical-surgical beds that will provide flex capacity should the hospital have more than one pediatric patient at a time.

No additional assumptions have been applied to the pediatric bed need projection period related to the tripledemic. However, Table 108 below shows the number of pediatric admissions by week during the tripledemic. This additional data supports that the one pediatric bed plus two co-located MSGA beds should provide sufficient capacity most of the time during busy cold and flu seasons, such as the tripledemic, for pediatric patients in the service area.

Table 108
UM SMC at Easton
Pediatric Admissions by Week
October 2022 - January 2023

Week	# Of Admissions
Oct 2-8	2
Oct 9-15	4
Oct 16-22	4
Oct 23-29	10
Oct 30-Nov 5	4
Nov 6-12	4
Nov 13-19	5
Nov 20-26	3
Nov 27- Dec 3	2
Dec 4-10	2
Dec 11-17	0
Dec 18-24	1
Dec 25-31	2
Jan 1-7	1
Jan 8-14	2

Jan 15-21	2
Jan 22-28	3
Jan 29-31	0
TOTAL	**51**

Source: Shore internal data.

Construction Cost of Hospital Space

12. Please clarify whether the differential cost factor calculation in the MVS analysis includes the square footage (SF) for corridors, elevator shafts, and any unassigned areas. If not, please provide the SF for all these areas and revise the MVS analysis to include these areas. (pp. 81-82) Note: The total square footage reported on pp. 81-82 is 307,655 SF, whereas in Table 1, p. 79 you indicate the total square footage for the hospital is 382,977 SF, a difference of over 75,000 SF. Please clarify.

Applicant Response

UM SMC at Easton inadvertently excluded 75,322 square feet for the "Building Grossing Factor" which includes interdepartmental corridors, mech/elec/telecom rooms on the floors, vertical transportation, and the exterior walls. A revised MVS analysis is included below.

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

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.

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		1.05
Adjusted Total Base Cost		$511.62
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$511.62
C. Multipliers		
Perimeter Multiplier		0.902213343
	Product	$461.59
Height Multiplier		1.076
	Product	$496.54
Multi-story Multiplier		1.015
	Product	$503.99
D. Sprinklers		
	Sprinkler Amount	$3.09
Subtotal		$507.07
E. Update/Location Multipliers		
Update Multiplier		1.21
	Product	$613.56
Location Multiplier		0.97
	Product	$595.15
Calculated Square Foot Cost Benchmark		**$595.15**

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
Building Grossing Factor (interdepartmental corridors, mech/elec/telecom rooms on the floors, vertical transportation, and the exterior walls)	75,322	Internal Circulation and Corridors	0.6	45,193
Total	382,977		1.05	403,995

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		0.97
Product		$431.46
Calculated Square Foot Cost Standard		**$431.46**

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 Multipier			0.97
	Product		$162.36
Calculated Square Foot Cost Standard			**$162.36**

IV. Consolidated MVS Benchmark

Standard	MVS Benchmark	Sq. Ft.
"Tower" Component	$595.15	382,977
Mechanical Penthouse	$162.36	2,510
CUP	$431.46	22,385
Consolidated	**$583.51**	407,872

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 that are necessary for the construction of the hospital but 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. Outside the Loop is considered off-site. However, there are enabling infrastructure costs required for the hospital that are Outside the Loop. According to Section 1, Page 3 of the MVS book, "Off-site costs, including roads, utilities, park fees, jurisdictional hookup, tap-in, impact or entitlement fees and assessments, etc." are not included in the MVS benchmark. Consequently, the costs that would not be in the MVS benchmark 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 on 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.[1] UM SMC at Easton has searched for an average premium that it 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

[1] 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.

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 associated 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	
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		$583.51
The Project		$535.28
Difference		-$48.22
%		-8.26%

As shown above, the project's cost per square foot is below the MVS benchmark.[2]

13. The MVS analysis uses the base cost of $485 dollars for the CUP, while the schematics refer to the construction as only a modular plant, not of the same construction type as the general hospital. Please provide a justification for using this base cost.

Applicant Response

The MVS cost comparison includes the following rows in the CON Project Budget: Building, Fixed Equipment, Site Preparation, Architectural/Engineering Fees, and Permits. The Building construction cost/Square Foot of the CUP building is, indeed, lower than hospital costs. However, the cost/SF for Site, A/E Fees, and Permits (all of which are included in the MVS analysis) are all higher for the CUP than for the Hospital Building, as the costs from the Project Budget shown below demonstrate.

[2] 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.

	Hospital Building		CUP	
	Costs	Cost/SF	Costs	Cost/SF
Square Feet	385,487		22,385	
Building	$210,528,602	$546	$6,110,000	$273
Fixed Equipment	In Building		In Building	
Site and Infrastructure	$36,933,315	$96	$7,476,645	$334
Architect/Engineering Fees	$9,013,929	$23	$1,986,071	$89
Permits (Building, Utilities, Etc.)	$5,027,314	$13	$1,107,686	$49
Total	$261,503,160	$678	$16,680,402	$745

The total of these costs per square foot is actually higher for the CUP than it is for the hospital building.

While UM SMC at Easton started with the $485 base cost, it adjusted that figure down in the Departmental Cost Differential Factor, using a .7 factor (the factor for "Mechanical Equipment and Shops."). After all of the adjustments to the MVS base cost, the CUP's MVS benchmark is $443 compared with the hospital's $612.

On 9/27/13, UM SMC at Easton's consultant, Andrew Solberg telephoned Marshall and Swift to seek guidance on this issue (as well as the issue cited previously). The Marshall and Swift technical assistance person (John Thompson) confirmed to Mr. Solberg that the MVS book does not have a benchmark for CUPs and that the way Mr. Solberg typically approaches it (the same way he has approached it in this application) is appropriate.

14. Please provide the Excel spreadsheets with the formulas and calculations used to determine the MVS benchmark and departmental differential factors for the proposed project.

Applicant Response

The MVS Excel workbook is being submitted electronically under separate cover with this filing.

Rate Reduction Agreement

15. This standard as written is no longer applicable. However, please address the hospital's position in the work that HSCRC has done in developing its Integrated Efficiency Policy. Does this work indicate that the Shore Easton is efficient or inefficient?

Applicant Response

Historically most rural hospitals in Maryland, including UM SMC at Easton, have tended to perform poorly on the HSCRC's efficiency policy. As an example, of the 14 hospitals within legislatively designated rural counties in Maryland, almost half performed at or near the bottom quartile, with only two in the top quartile, in the most recent published policy results using FY 2020 revenue and FY 2019 volumes. UM SMC at Easton tends to rank at or just better than the 4th quartile, in line with the efficiency performance of many rural hospitals in the State. UM SRH is concerned about this overall reality in the HSCRC's current efficiency metric, as well as whether the HSCRC's policies adequately account for rural circumstances.

Patient Safety

16. **Please address safety improvements for disabled patients and severely obese patients.**

Applicant Response

The hospital design includes wide corridors with clear interdepartmental wayfinding to simplify movement throughout the building for patients. Floors within the hospital do not include level changes and handrails will be included throughout, easing transit for mobility-challenged patients. Consideration will be given to appropriate color contrast in key interior finish selections to assist the visually impaired. In inpatient spaces, each unit will have ADA-compliant patient rooms. Provisions for motorized wheelchairs, like additional space in waiting rooms and dressing areas, address the footprint these wheelchairs occupy without obstructing walkways.

Severely obese patients are considered throughout public, outpatient, and inpatient spaces. Waiting rooms will accommodate minimum 5% seating for patients 600 lbs or greater. The Emergency Department includes an exam room with attached toilet designed to individuals of size specifications, as outlined in the FGI Guidelines for Hospitals (2022) 2.2-3.1.3.6. Exam rooms for individuals of size are also included in clinics where deemed appropriate to the population, such as the Diabetes Clinic. Inpatient rooms sized to FGI individuals of size requirements are located within inpatient units as determined by clinical need by specialty. Provisions for individuals of size include patient lifts in every inpatient room.

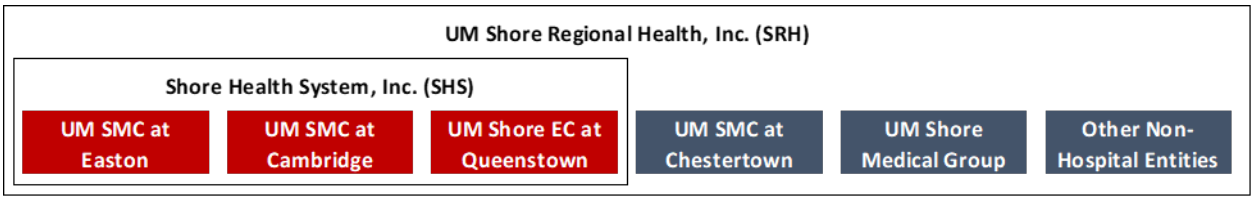
Financial Feasibility

17. **The financial feasibility response defines Shore Health System differently than the comprehensive project description. On page 99, Shore Health System includes Shore Easton and the freestanding medical facilities in Cambridge and Queenstown but does not include the University of Maryland Shore Medical Center at Chestertown (Shore Chestertown) in the financial discussion of Shore Health System. Please explain why Shore Chestertown is not included? What is the status of Shore Chestertown in Shore Health System?**

Applicant Response

Figure 8 below provides an illustration of the corporate structure of University of Maryland Shore Regional Health, Inc. ("UM SRH"), which is the parent corporation of Shore Health System, Inc. and Chester River Hospital Center, Inc.

Figure 8
UM Shore Regional Health, Inc. Corporate Structure



Each of Shore Health System, Inc. and Chester River Hospital Center, Inc. are separate legal entities under the UM SRH umbrella. UM SRH is also the parent corporation of other non-hospital entities, which primarily include the Shore Medical Group and other entities that employ physicians and other practitioners who provide services to the UM SRH facilities.

Shore Health System, Inc. operates three licensed health care facilities: the UM SMC at Easton hospital and two freestanding medical facilities: UM SMC at Cambridge and UM Shore EC at Queenstown. UM SMC at Cambridge and UM Shore EC at Queenstown are financially integrated with UM SMC at Easton and are considered an administrative part of the hospital, as required by Maryland law and CMS provider-based rules. Shore Health System, Inc. also includes financially integrated unregulated sites in Easton, Denton, Cambridge and Queen Anne's Counties.

UM SRH is the parent corporation of Chester River Hospital Center, Inc., which operates UM SMC at Chestertown. UM SMC at Chestertown is not part of Shore Health System, Inc. Chester River Hospital Center, Inc. also includes financially integrated unregulated sites in Chestertown.

Because Shore Health System, Inc., Chester River Hospital Center, Inc., and UM Shore Medical Group are separate legal entities, their financial structures are also separate. As a result, the financial feasibility response considers only Shore Health System facilities: UM SMC at Easton, UM SMC at Cambridge, and UM Shore EC at Queenstown. All revenue and expense incurred at UM SMC at Chestertown, UM Shore Medical Group, and other SRH entities are not included in any of the Tables reference in the CON Application, including Tables A-L as submitted. Further, all references made to financial performance in this document and in the CON Tables are exclusive of allocations of UM Shore Medical Group losses.

Emergency Department Treatment Capacity and Space

18. Please label the emergency department (ED) diagram, Exhibit 2, page 5, identifying the treatment spaces, including the psychiatric exam spaces, the behavioral health

holding spaces, and the observation spaces. Also provide the SF for all the ED spaces.

Applicant Response

As discussed with MHCC Staff during the completeness review meeting held February 7, 2023, the ED diagram found within Exhibit 2, page 5 contains labels, numbering, and square footage for each ED and observation space, which are viewable in the full size project drawings or by zooming in on the electronic copies. The psychiatric exam rooms 22 and 24 and are labeled with "BH" for behavioral health; exam room 13 is labeled with "PoS" for person of size; exam rooms 9, 11, and 12 are labeled with "AII" for airborne infection isolation; exam rooms 16 and 17 are labeled with "PEDS" as designated pediatric spaces; and exam room 23 is labeled as "SANE" for sexual assault nurse examiner. The behavioral health holding spaces are located in the top right corner of the ED and are labeled as "B.H. HOLD."

19. **The need for 25 observation beds is based, at least in part, on the increase in observation length of stay experienced between 2019 and 2022, an unusual time for hospital operations due to the COVID-19 emergency. Additionally, it is stated that staffing shortages and COVID-19 were the drivers of the increase in the length of observation stays. Please provide more detail about the basis of the assumption that the ALOS in the observation unit will remain high. What assumptions have been made related to staffing and staffing shortages and how has that affected the staffing plan for the new hospital?**

Applicant Response

As stated in the CON Application on page 206, as COVID-19 related staffing pressures ameliorate, ALOS is expected to decrease in the years leading up to the opening of the replacement hospital. However, criteria for observation continue to evolve and higher acuity patients are being required by payors to be placed in observation, which contributes to longer lengths of stay and/or the patient being transferred to inpatient status. The proposed replacement facility will have a dedicated observation unit that will help improve efficiency of staff workflow and patient throughput, which should in turn help reduce time spent in observation status. Given these factors, the Applicant assumes that observation ALOS will decrease by 1.0% annually throughout the projection period, as shown in Table 99 of the CON Application, which is reproduced below. ALOS in fiscal year 2032 is reduced to only 1.0 hours above that of historical levels in fiscal year 2020. This annual reduction is attributable to normalization of observation ALOS to near pre-COVID levels and increased throughput and efficiency relating to the dedicated observation unit at the proposed replacement facility.

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

20. Describe any current or future efforts to divert non-emergency patients from the ED to more appropriate levels of care. What is the projected impact that these diversions will have on utilization?

Applicant Response

As shown in Table 1 of the CON Application, UM SRH has established a network of primary care, urgent, and emergent care locations throughout the Mid-Shore region to ensure patients have access to the right care, at the right time, in the right place.

A study published in 2021 titled *The Impact of Urgent Care Centers on Nonemergent Emergency Department Visits*[3] found that the opening of an urgent care center in a ZIP code reduced the total number of ED visits by residents in that ZIP code by 17.2%, due largely to decreases in ED visits for less emergent conditions. This effect was concentrated among visits to EDs with the longest wait times, which had reductions in the total number of ED visits by uninsured and Medicaid patients by 21% and 29.1%, respectively.

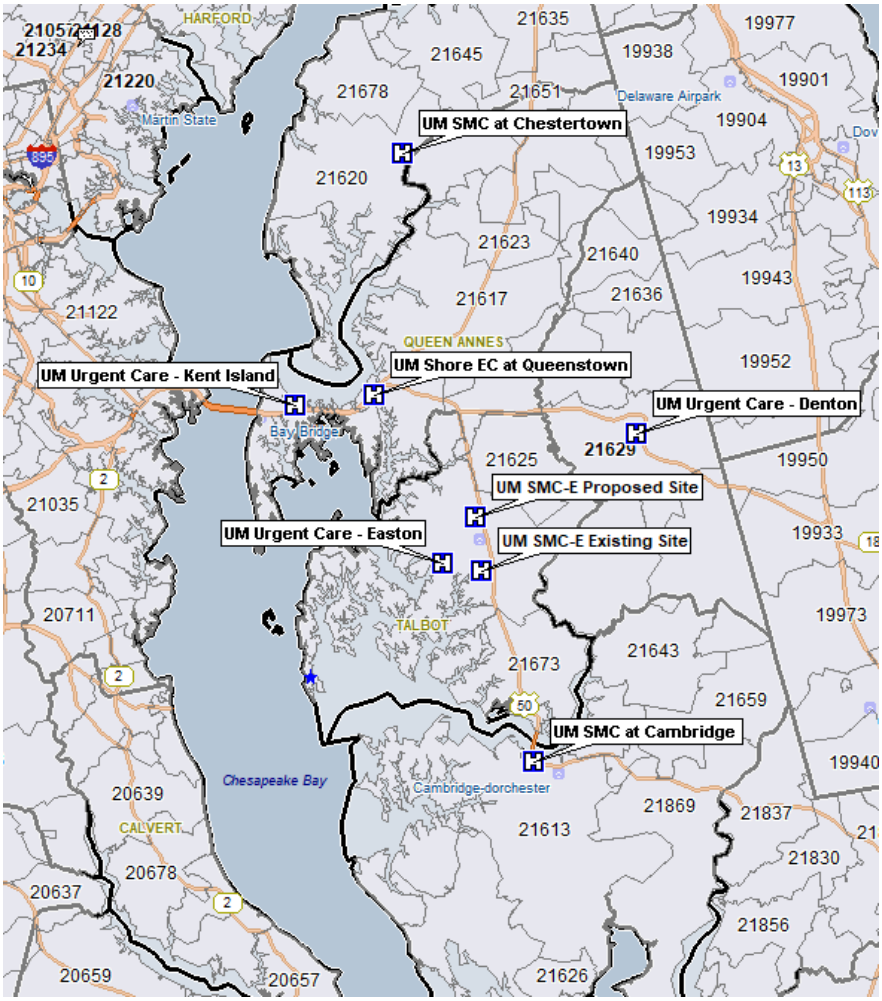
Since 2016, UM SRH has opened three urgent care centers in its service area:

Center Name	Address	County	Opening Date
UM Urgent Care - Denton	8 Denton Plaza Denton Plaza, Denton, MD 21629	Caroline	5/25/2016
UM Urgent Care - Easton	28522-C Marlboro Avenue Easton, Maryland 21601	Talbot	9/16/2016
UM Urgent Care - Kent Island	25 Kent Town Market, Chester MD 21619	Queen Anne's	5/9/2022

[3] Lindsay Allen PhD, MA, Janet R. Cummings PhD, Jason M. Hockenberry PhD, *The Impact of Urgent Care Centers on Nonemergent Emergency Department Visits*, HSR: Health Services Research, Vol. 56, Issue 4, (August 2021), Pages 721-730, available at: https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13631.

Figure 9 below shows the locations of UM SRH's urgent care centers in Denton, Easton, and Kent Island and their relative proximity to UM SRH's EDs and FMFs located in Easton, Chestertown, Cambridge, and Queenstown.

Figure 9
UM SRH Urgent Care Center, ED, and FMF Locations



UM SMC at Easton also partners with Caroline County EMS on a pilot program called the Alternative Destination Program, which diverts non-urgent 9-1-1 calls to UM SRH's Denton Urgent Care Center and its primary care offices located in Choptank rather than UM SRH's EDs.

The data presented below show the impact of the opening of UM SRH urgent care centers on ED volumes at the closest ED or FMF. In order to measure the impact, UM SMC at Easton measured the average monthly visits over a six month period ending six months before the closest Urgent Care Center opened and compared it to the six month period beginning six months after

the Center opened. Table 109 below shows that the average monthly volumes declined in each case.

Table 109
Average Emergency Department Monthly Visits per Day
Nearest Shore Health Emergency Rooms
2016-2022

Urgent Care Center	Opening Date	Closest ED or FMF	Pre Avg	Pre Period	Post Avg	Post Period	% Change
UM Urgent Care - Denton	5/25/2016	UM SMC at Easton	98.3	6/15-11/15	84.5	11/16-4/17	-14.1%
UM Urgent Care - Easton	9/16/2016	UM SMC at Easton	91.9	10/15-3/16	89.1	3/17-8/17	-3.0%
UM Urgent Care - Kent Island	5/9/2022	UM SMC at Queenstown	52.5	6/21-11/21	48.7	11/22-1/23	-7.2%

Source: Shore internal data.

UM SRH also looked at the impact that the recent opening of UM Urgent Care - Kent Island on May 9, 2022 had on the acuity level of ED cases at the UM SRH EDs. The Applicant compared the acuity levels of ED cases for the four-month period before the urgent care center opened with the four-month period following its opening.

UM SMC at Easton categorizes ED cases as being in one of five levels[4] based on the following definitions:

Level	Description
1	Stable, with no resources anticipated except oral or topical medications, or prescriptions
2	Stable, with only one type of resource anticipated (such as only an X-ray, or only sutures)
3	Stable, with multiple types of resources needed to investigate or treat (such as lab tests plus X-ray imaging)
4	High risk of deterioration, or signs of a time-critical problem
5	Immediate, life-saving intervention required without delay

Lower acuity cases that are suitable for the urgent care setting generally correspond to levels 1 and 2, while emergency (or higher) levels correspond to levels 3-5. Each of UM SRH's EDs showed that the lower level cases (levels 1 and 2) comprised a smaller percentage of ED cases after the Urgent Care Center opened on Kent Island in Queen Anne's County, while higher level cases (levels 3-5) comprised a higher percentage of ED cases.

[4] Note that, in Maryland, hospital data categories are based on resources used in each category and are the *inverse* of the industry Emergency Severity Index ("ESI") categories, in which 1 is the highest severity and 5 is the lowest.

Table 110
ED Case Severity Levels Impact
Six Months Prior to and following the Opening of UM Urgent Care - Kent Island

	UM SMC at Queenstown		UM SMC at Easton		UM SMC at Chestertown		UM SMC at Cambridge	
	Pre*	Post**	Pre*	Post**	Pre*	Post**	Pre*	Post**
Lower (Levels 1& 2)	7.7%	6.4%	21.1%	19.7%	11.7%	9.2%	15.1%	13.4%
Higher (Levels 3, 4, & 5)	92.3%	93.6%	78.9%	80.3%	88.3%	90.8%	84.9%	86.6%

*"Pre" dates – 01/01/2022 – 05/08/2022.
**"Post" dates – 05/09/2022 – 08/31/2022.
Source: Shore internal data.

Similar to the 2021 ED Study referenced above, Shore's data suggests that its opening of urgent care centers in its service area reduced ED visit volume and has diverted less emergent cases to its urgent care centers in the time period following the opening of these centers. The Applicant anticipates that the impact of opening its urgent care centers has stabilized and will increase as the population increases.

UM SRH also endeavors to expand its Mobile Integrated Care programs, a community-based program aimed at providing accessible health care to individuals in their homes. This program may help reduce visits from patients who are frequent utilizers of its ED services, but the impact of the program on overall ED utilization is not likely to be significant.

21. Identify and discuss the number of uninsured, underinsured, indigent and otherwise underserved patients in the primary service area and the impact of these groups on ED use.

Applicant Response

According to The Commonwealth Fund's Biennial Health Insurance Survey from 2022, 23% of adults ages 19-64 in the U.S. were considered underinsured.[5] The survey defines "underinsured" as "people who are insured all year [but] their coverage doesn't enable affordable access to health care."

[5] The Commonwealth Fund, *The State of U.S. Health Insurance in 2022* (Sept. 29, 2022), available at: https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey#:~:text=Who%20Is%20Underinsured%3F,-For%20our%20analysis%2C%20people.

Table 111 below provides the percentage of persons in poverty within UM SMC at Easton's five-county service area. The percentage of persons in poverty in Dorchester, Caroline, and Kent County is slightly above the Maryland average of 10.3%, and Queen Anne's and Talbot County are slightly below the Maryland average.

Table 111
Percentage of Persons in Poverty
Within UM SMC at Easton Five-County Service Area

County	Percentage of Persons in Poverty
Dorchester	15.0%
Caroline	13.5%
Kent	12.0%
Queen Anne's	8.0%
Talbot	9.4%
Maryland average	10.3%

Source: U.S. Census Bureau, available at: https://www.census.gov/quickfacts/fact/table/US.

Table 112Table 112 below provides the percentage of population in UM SMC at Easton's five-county service area with "Public" (Medicaid) and "No Insurance" status.

Table 112
Percent of Population who are Medicaid Recipients and Uninsured
UM SMC at Easton's Five-County Service Area and Maryland
2021

County	Public (Medicaid)	No Insurance
Caroline	32.40%	6.20%
Dorchester	32.10%	4.90%
Kent	21.90%	4.10%
Queen Anne's	14.70%	4.30%
Talbot	18.40%	4.10%
Maryland	18.10%	5.90%

Source: TownCharts, available at: https://www.towncharts.com/Maryland/Maryland-state-Healthcare-data.html, Data quoted from Figure 13 on the page for each county and Maryland.

Some studies have found that uninsured populations have not historically been higher users of EDs than insured patients. For example, a study published in 2017 titled *The Uninsured*

*Do Not Use The Emergency Department More—They Use Other Care Less,*6 found that uninsured populations used the ED at a lower rate than insured populations, and a much lower rate than Medicaid recipients in 2013. Data form this study on the per capita rates of ED utilization by uninsured, insured, and adults with Medicaid is presented in Table 113 below.

Table 113
Per capita Rates of ED Utilization in the U.S.
2013

	Uninsured adults	Insured adults	Adults on Medicaid
Average no. of visits per capita	0.177	0.202	0.523

Source: Ruohua Annetta Zhou, Katherine Baicker, Sarah Taubman, and Amy N. Finkelstein, *The Uninsured Do Not Use The Emergency Department More—They Use Other Care Less*, Health Affairs (Millwood). 2017 Dec; 36(12): 2115–2122, Exhibit 1, available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0218.

This study's findings are consistent with data on ED utilization in UM SMC at Easton's Five-County Service Area in FY 2022. As presented in Table 114 below, the payor mix shows that the percent of ED cases by "self-pay" patients is, in all counties, lower than the percent of residents identified as having "No Insurance" in Table 112 above; whereas, Statewide, percent of "self-pay" patients utilizing ED services (6.7%) is higher than the percent of State residents identified as having "No Insurance" (5.9%). In contrast, the percent of ED cases for patients with Medicaid is, in all counties, higher than the percent of residents identified as having "Public (Medicaid)" as shown in Table 112 above. Similarly, Statewide the percent of Medicaid patients utilizing ED services (33.4%) is higher than the percent of State residents identified as having Medicaid (18.1%).

Table 114
ED Payor Mix, Medicaid and Self-Pay
Residents of UM SMC at Easton's Five-County Service Area
At Any ED in Maryland
FY 2022

County	Medicaid	Self-Pay
Caroline	39.8%	4.3%
Dorchester	47.5%	4.1%
Kent	37.4%	3.4%
Queen Anne's	25.5%	3.8%
Talbot	28.2%	4.2%

[6] Ruohua Annetta Zhou, Katherine Baicker, Sarah Taubman, and Amy N. Finkelstein, *The Uninsured Do Not Use The Emergency Department More—They Use Other Care Less*, Health Affairs (Millwood). 2017 Dec; 36(12): 2115–2122, available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0218.

Maryland	33.4%	6.7%

Source: HSCRC Data.

Another study published in 2018 titled *Emergency Department Utilization Among the Uninsured During Insurance Expansion in Maryland*[7] found that "insurance expansion in Maryland was associated with a modest relative increase in ED visits among the uninsured, driven by increases in higher-acuity visits. It remains unclear whether insurance coverage helped the uninsured address their unmet medical needs."

As it has historically done, UM SRH will continue to offer resources for uninsured, underinsured, and indigent patients.

22. Is there dedicated ED space for the treatment of children and adolescents? Please describe any plans to accommodate that population. Did the hospital consider developing a combined ED/observation/inpatient space in the ED, given the very low demand for pediatric hospitalization, rather than the plan proposed for handling pediatric patients in a conventional nursing unit? Wouldn't such a configuration provide staffing efficiencies?

Applicant Response

Yes, the replacement hospital's ED exam rooms 16 and 17 are designated as "PEDS" to serve pediatric patients, but can also flex to serve adult patients as needed. These rooms are immediately adjacent to a nurse station, allowing for enhanced supervision and dedicated storage of pediatric-specific equipment, including resuscitation equipment. These ED exam rooms are also located adjacent to patient toilets to support patient and family needs.

The UM SMC at Easton team did consider a combined space in either the ED or observation area for pediatric patients. However, UM SMC at Easton's obstetric nursing staff are cross-trained to care for pediatric patients and techs are shared across Women's and Children's Services. The current planned nursing unit location, co-located with obstetric beds, offers both an efficient staffing solution and an optimal patient and family experience. As UM SMC at Easton will not have a dedicated pediatric ED, nursing staff in the ED and observation unit are not pediatric nurses. Shifting nursing staff with pediatric competency from adjacent to the obstetric unit to the ED limits the flexibility currently proposed.

23. The application references three psychiatric holding rooms outside of the ED. What services will be provided to patients in these rooms? What safety features will be

[7] Tim Xu, Eili Y Klein, Mo Zhou, Justin Lowenthal, Joshua M Sharfstein, and Susan M Peterson, *Emergency Department Utilization Among the Uninsured During Insurance Expansion in Maryland*, Annals of Emergency Medicine, 2018 Aug; 72(2):156-165, available at: https://pubmed.ncbi.nlm.nih.gov/29887191/.

incorporated into these rooms? What is the projected length of stay for patients in these rooms?

Applicant Response

The behavioral health holding rooms adjacent to the ED are not medical treatment spaces. They are not equipped with gases or sinks for medical treatment. The rooms are intended for medically-cleared patients awaiting placement in the UM SMC at Easton inpatient psychiatric unit or another inpatient psychiatric facility or pending discharge. The behavioral health holding rooms allow such patients to be monitored and cared for in a safe and comfortable space pending transfer, discharge, or admission to UM SMC at Easton's inpatient psychiatric unit. UM SMC at Easton may initiate some therapeutic interventions for patients (particularly with pediatric and adolescent patients) placed in the behavioral health holding spaces, but only medically-cleared patients will occupy these rooms. The therapeutic interventions may allow for discharge back to the community or at least earlier initiation of treatment pending transfer to a higher level of care.

The behavioral health holding spaces will be equipped with appropriate safety features. These rooms will be designed to ligature-resistant standards and Environmental Safety Risk Assessment Level IV, as defined in "Behavioral Health Design Guide" January 2022. The holding rooms are also located in a locked, secure unit.

UM SMC at Easton does not currently have a similar behavioral health holding area. Currently, patients are treated and generally remain in an ED treatment space until discharge, transfer, or admission. As noted in the CON Application on pages 107-108, in fiscal year 2022, the ALOS for behavioral health patients in the ED was 8.6 hours. Table 115 below presents the FY 2020 through FY 2022 actual behavioral health ED visits, ALOS, and patient hours broken out separately for adult and pediatric patients. During this time frame, the ALOS for adult behavioral health patients has exceeded that of pediatric patients.

Table 115
UM SMC at Easton Behavioral Health ED Visits – Pediatric and Adult
FY 2020 –FY 2022

	Historical		
	2020	**2021**	**2022**
Visits:			
Easton Adult BH ED Visits	1,777	1,770	1,478
Easton Pediatric BH ED Visits	259	206	229
Total Easton BH ED Visits	**2,036**	**1,976**	**1,707**
Average Length of Stay:			
Easton Adult BH ED ALOS	6.5	7.5	9.0
Easton Pediatric BH ED ALOS	5.2	6.6	6.6
Total BH ED ALOS	**6.3**	**7.4**	**8.6**
Patient Hours:			
Easton Adult BH ED Patient Hours	11,588	13,356	13,244
Easton Pediatric BH ED Patient Hours	1,334	1,364	1,517
Total BH ED Patient Hours	**12,922**	**14,720**	**14,761**

Source: Shore internal data

At the replacement hospital, the length of stay of patients placed in a behavioral health holding room may vary significantly depending on the availability of an alternative inpatient placement. As noted in the response to question 24 below, the expectation is that the behavioral health holding area will flex to hold the age cohort of behavioral health patients with the greatest volume at a given time. For example, if there are multiple pediatric behavioral health patients awaiting transfer, they will likely be held in the behavioral health holding area, while simultaneously an adult behavioral health patient may await transfer or discharge in a behavioral health ED treatment space. Pediatric and adult behavioral health patients will not be cohorted together in the behavioral health holding unit.

24. Will the psychiatric holding rooms be used for pediatric and adolescent patients? If so, how will these rooms be outfitted to meet the special needs of these populations?

Applicant Response

The behavioral health holding rooms are designed to accommodate both pediatric and adolescent patients and adult patients, allowing for maximum flexibility. UM SMC at Easton intends to use the holding rooms for both patient populations, but will not cohort pediatric patients with adults under any circumstances, given that the rooms are located in a locked unit. Depending on the age group (pediatric and adolescent versus adult) with the highest volume of behavioral health holds in the ED at that time, UM SMC at Easton will allocate the holding rooms to either pediatric and adolescent patients or adult patients.

The holding rooms have been placed along the exterior of the building to allow for daylight and views to nature, supporting reduced stress and anxiety as well as positive distraction in an appropriate way. Special attention to acoustic properties of psychiatric-appropriate finishes and placement of mechanical infrastructure will reduce reverberant spaces, a known agitator. Dimmable lighting supports patients' sense of control and can provide a sense of calm. Given that patients will occasionally experience an extended length of stay, a lounge outside the patient holding rooms provides a safe place for large muscle movement or beginning therapeutic intervention outside of the sleeping environment.

Shell Space

25. Please confirm that the project will not include the construction of any shell space.

Applicant Response

As noted in the Applicant's response to the Shell Space Standard at COMAR 10.24.10.04B(16), the project will not include any shell space.

COMAR 10.24.11.

General Surgical Services

26. Regarding the use of Metrix statewide data and HSCRC Experience Data (Tables 51-53 on pp. 123 - 125.), please clarify the source of the utilization data reported. Is it from the electronic health records for each of the surgeons who performed surgical cases at Shore Easton? Or is this data reported by the hospital to these vendors? Please clarify whether this data includes only surgery at Shore Easton or includes other surgical facilities in the Shore system.

Applicant Response

The source of the data presented in Tables 51-53 is the HSCRC statewide non-confidential data and HSCRC experience data. Hospitals are required to submit monthly experience data to the HSCRC. This data captures HSCRC regulated hospital volumes, by HSCRC rate center. Hospitals are also required to submit their non-confidential data to the HSCRC, which includes more detailed de-identified encounter level data for regulated hospital visits.

Both data sources only include data for services provided in the regulated space at the hospital. Table 51 only includes surgical cases performed at UM SMC at Easton, Table 52 only includes surgical cases performed at UM SMC at Dorchester, and Table 53 includes cases performed at both UM SMC at Easton and UM SMC at Dorchester. No data is included in Tables 51-53 for surgical cases performed outside of these facilities.

27. Given the improvements in the surgical suite design, the increased storage space for equipment and supplies, clean and soiled storage, etc., for the surgical services

department, please explain the rationale for assuming a constant 45-minute turnaround time (TAT) through FY 2032, as used in Table 53 on p. 125. Please discuss why the applicant did not use the 25-minute TAT assumption specified in the SHP.

Applicant Response

The State Health Plan Chapter for General Surgical Services section on Operating Room Capacity and Need Assumptions states that: "[w]hen reliable information on average room turnaround time is not available from an applicant, it is assumed that an average room turnaround time of 25 minutes can be achieved." COMAR 10.24.11.06A(2)(a). UM SMC at Easton tracks its surgical turnaround times through its E.H.R. System, and it has used an assumption based on its own experience. Adopting the 25-minute TAT assumption from the State Health Plan would greatly understate the amount of time needed at UM SMC at Easton for TAT.

While reviewing and responding to this question, UM SMC at Easton discovered that the 45-minute TAT assumed in its need projections in the CON Application is based on an estimated average TAT for FY 2021, rather than the actual average TAT for FY 2021, as measured by its E.H.R. system. Historical average TAT as measured by UM SMC at Easton's E.H.R. System are presented below in Table 116.

Table 116
UM SMC at Easton
Historical TAT Measures

Fiscal Year	Turnaround Time
2019	39 mins.
2020	38 mins.
2021	36 mins.
2022	37 mins.
2023 (YTD)	38 mins.

Source: Shore internal data.

Although it appears the TAT times improved in FY 2020 and FY 2021, this decrease in TAT was due to the impact of the COVID-19 pandemic. During this time, UM SMC at Easton experienced a decreased volume of surgical cases, and therefore had the ability to use other ORs to "flip" the next case into instead of having to do cases concurrently in the same OR. As a result, ORs that were not turned over within 60 minutes were automatically excluded from the TAT calculation produced by the E.H.R. system. This has resulted in the historical TATs presented in Table 116 above, as measured by the E.H.R. system, being artificially deflated. As surgical volumes have started to normalize in FY 2022 and the first half of FY 2023, TAT is beginning to increase to 38 minutes per case in the first half of FY 2023 since UM SMC at Easton can no longer "flip" cases to another OR and is required to do them concurrently in the same OR.

Table 117 below presents UM SMC at Easton's revised OR need projection applying a 37 minute TAT assumption, which is based on its FY 2022 actual OR TAT, as measured by its E.H.R. system. Even with the more conservative TAT assumption of 37 minutes per case, there is a

projected need for 6.5 ORs by the anticipated opening date of the replacement facility in FY 2029, and a projected need for 6.7 ORs by FY 2032.

Table 117
UM SMC at Easton's Current and Projected OR Bed Need with Updated TAT
FY 2019 – FY 2032

UM SMC at Easton
Historical and Projected Operating Room Need

		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)**	**39**	**38**	**36**	**37**	**37**	**37**	**37**	**37**	**37**	**37**	**37**	**37**	**37**	**37**
E = A * D	**Total TAT Minutes**	236,886	193,154	201,888	198,616	200,303	202,046	203,838	205,678	207,570	209,514	211,512	213,567	215,680	217,853
F = C + E	**Total OR & TAT Minutes**	743,902	658,901	742,866	696,233	702,147	708,259	714,538	720,991	727,621	734,436	741,442	748,645	756,051	763,668
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**	**6.5**	**5.8**	**6.5**	**6.1**	**6.2**	**6.2**	**6.3**	**6.3**	**6.4**	**6.4**	**6.5**	**6.6**	**6.6**	**6.7**

Source: hMetrix non-confidential statewide data & HSCRC Experience Data; Turnaround time based on Shore internal data

Applying a 37-minute average TAT also does not account for anticipated future increases in average TAT due to the increased number of robotics and complex cases at UM SMC at Easton, which typically have longer TAT. For example, average TATs for robotics general surgeries were 48 minutes and 47 minutes in FY 2021 and FY 2022, respectively. As the volume of robotics cases continues to grow, the turnaround times associated with these complex cases will increase as well. Neurosurgery is another specialty that has seen increased turnaround times from 42 minutes in FY 2019 to 49 minutes in the first half of FY 2023, due to the increased complexity of cases. As the volume of these more complex cases increases over time, UM SMC at Easton anticipates that average TAT will also increase. Thus, the 45-minute TAT presented in the CON Application may ultimately be a closer estimate of average TAT in the projection period.

28. Regarding Table 53 on p. 125. Please provide the Excel spreadsheet, assumptions and background methodology used to demonstrate the need for seven operating rooms (ORs). Please also include a more detailed discussion on block time and the impact of clock time on utilization and OR scheduling.

Applicant Response

Surgical Services Demand Projection Assumptions and Methodology

The Surgical Services Need Projection Excel workbook is being submitted electronically under separate cover with this filing.

UM SMC at Easton's projected need for 7 ORs is based on historical utilization and its TAT assumption (described more fully in response to Question 27 above), with assumptions for future growth based solely on anticipated population growth rates for UM SMC at Easton's OR primary service area.

Historical Period (FY 2019- FY 2022):

Volumes for the historical period are inclusive of actual OR cases and OR minutes for surgeries performed at UM SMC at Easton and UM SMC at Dorchester, prior to its decommissioning in October 2021. Turnaround times (TATs) for this period are based on the applicant's internal data.

Projection Period (FY 2023- FY 2032):

Beginning in FY 2023, UM SMC at Easton's IP and OP OR cases **(A)** are projected to grow based on the annual population growth assumption for UM SMC at Easton's OR primary service area. This growth rate is based on Claritas SPOTLIGHT population data and is assumed to be 0.9% to 1.0% annually between FY 2023 and FY 2032. Additionally, in FY 2023, the OR case volumes performed at UM SMC at Dorchester (prior to its conversion to an FMF) are expected to transition to UM SMC at Easton (in all, 33 OP and 1 IP case will transition from UM SMC at Dorchester).

OR minutes per case **(B)** for IP and OP surgical cases are assumed to remain constant at FY 2023 levels through FY 2032 at 123 minutes per IP surgical case and 86 minutes per OP surgical case. Projected surgical cases are multiplied by assumed minutes per surgical case, separately for IP and OP cases, to calculate projected OR minutes **(C)**.

TAT per case **(D)** is assumed to remain constant at the FY 2022 level of 37 minutes per case through FY 2032. TAT per case is multiplied by the number of total surgical cases to calculate total TAT minutes **(E)**. Total TAT minutes are then added to total OR minutes to calculate total OR & TAT minutes **(F)**, which represents the total time that the ORs are either in use or being turned around.

Optimal minutes per OR **(G)** assumes that at peak efficiency, an OR can operate for 1,900 hours (114,000 minutes) per year. Total OR & TAT minutes are divided by optimal minutes per OR to determine operating room need **(H)**. Based on the assumptions described herein, this

methodology demonstrates need for 6.5 ORs in FY 2029 and 6.7 ORs in FY 2032 at the proposed replacement facility.

Block Time Impact on Utilization and Scheduling

All UM SMC at Easton ORs utilize block scheduling to provide efficient scheduling of OR surgical cases. In block scheduling, a block of time is assigned to a specific surgeon or surgical group and no other surgeon can schedule cases in that particular OR during that particular time and day. Block scheduling has certain advantages that complement UM SRH. It allows for specific ORs to be dedicated to specialized equipment like the Da Vinci Robot. It also allows the surgeon to make the most efficient use of his/her time by being able to cluster cases at one time, allowing the surgeon to balance time in the operating room and time in the office without disruption. It provides a reliable time frame when the physician is available at either location. It also is a more efficient use of the OR since the same surgeon is present and ready to begin with the next patient as soon as the OR is turned around.

Allocation and utilization of surgical block time is a formal process documented in a policy and agreed upon by the Perioperative Oversight Committee to ensure surgeons are provided the appropriate amount of time needed to perform their elective case load, as well as urgent and semi urgent procedures. Since surgeons and their offices function around this designated time, it is a set day of the week or month. While there is some work done between offices to allow flexibility for surgeon's vacations, for the most part, there is very little movement of the block due to the impact movement can have on patients being seen in surgeons' offices.

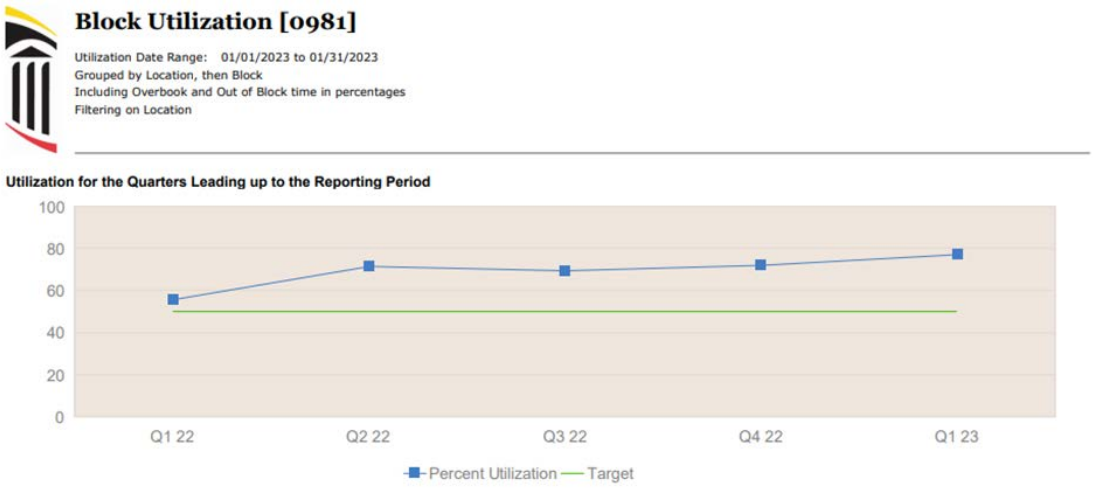
Block time for a surgeon or group of surgeons in a practice is allocated based on volume. Block time typically is scheduled in eight-hour time slots. In some situations, busier groups have been afforded the "late room" allowing for scheduling of elective procedures until 5:30 p.m. There are many factors that are considered during the approval process for requested block time to ensure conflicts are kept at a minimum. Some of those considerations are the amount of staff needed (OR and radiology), C- arm availability, robot availability, and other instrumentation. The use of block time allows providers to be spaced out to ensure not all cases requiring the same resources occur on the same day.

Block time scheduling works best with surgeries that can be scheduled in advance. Reserved block time that is unfilled by one week before it is to take effect will be offered on a first-call basis, except for time of the general surgery group. Because this group's case mix is higher for urgent/ emergent cases, their time does not release until the day before their assigned block to allow them to schedule more urgent/emergent cases within the regular work day. Providers are also encouraged to "release" their block time when they know they are going to be away, so others can use it, but historically the time is not able to be filled with elective cases. When this occurs, it allows urgent/emergent cases to be done earlier in the day when resources are more plentiful. This is a positive, in that these cases are typically more difficult and the patients are sicker.

A drawback of block time scheduling is that it can impact overall utilization if a surgeon does not use their block time due to vacation or not having enough surgical volume. At UM SMC at Easton this is generally not an issue. Due to the limited amount of open general time available

for surgeons without block time and add-on cases that need to be completed, open blocks are almost always utilized. Utilization is calculated quarterly with a 50% utilization target. Clean-up and set-up time are not included in the utilization calculation as it can lead to an underestimate the overall room utilization due to variations in set-up and clean-up times. Therefore, UM SMC at Easton uses in-room to out-of-room time for OR utilization calculations. Surgeons or specialty groups with underutilized time are evaluated quarterly and the block time is reallocated as necessary. Figure 10 below presents UM SMC at Easton's block utilization percentages in comparison to the target utilization for the four quarters leading up to January 2023. Figure 10 demonstrates that block utilization, which excludes any TAT time, was approximately 70% or above in the second, third, and fourth quarters of calendar year 2022.

Figure 10
Block Utilization In Comparison to Target Utilization
Four Quarters Preceding January 2023



At UM SMC at Easton, the six ORs are utilized Monday through Friday from 7:45 am to 3:30 pm. During these normal work hours, elective, urgent, semi-urgent, and emergent add-on cases can be performed. In addition, the hospital works to accommodate all add-on cases into the regular OR schedule whenever space is available, regardless of the case classification, provided the posting surgeon is available when the OR has the time and the case will be completed during normal operating hours. The hospital also offers extended operating hours from 3:30 pm to 7:00 pm in a reduced number of ORs. Urgent, semi-urgent, and emergent add-on cases are to be done during this time. These extended operating hours are often also utilized by surgeons whose cases did not finish at 3:30 pm as predicted. On-call hours are also available from 7:00 pm to 7:45 am on weekdays and 24-hour on-call coverage for weekends and holidays for emergent cases only.

When block time is completely full it impacts the ability to perform urgent/emergent cases during the regular work day. This is currently an issue at UM SMC at Easton. In January 2023, there were 13 cases performed between 7:30 pm and 7:30 am, comprising 15.36 hours of surgical time after the normal and extended work hours. Due to limited block time availability, surgeons

will also perform weekend cases because they know they will not be able to perform those cases during the regular hours of operation during the week. In January 2023, 16 cases were performed on the weekend, comprising 32 additional hours of surgical time.

UM SMC at Easton's block schedule for its six ORs is highly utilized today and the ORs are being operated during extended workdays and weekends to accommodate elective and urgent/emergent cases. In order to have sufficient surgical capacity to serve residents of its service area, UM SMC at Easton projects that a seventh OR will be needed at the replacement facility, even using a conservative TAT assumption of 37 minutes.

29. The applicant indicates that three Shore ambulatory surgical centers operate in Easton, Queenstown, and Cambridge. However, Table 1 on page 9 lists outpatient centers throughout the five counties. Please provide more detail on the types of surgical services provided by these facilities and their case volumes and OR minutes. Please identify all centers in the system that perform outpatient surgery. Explain why these ambulatory surgical centers cannot be used to handle the outpatient surgical cases projected for performance at Shore Easton.

Applicant Response

UM SRH has three ambulatory surgery centers ("ASCs") that operate in Easton, Queenstown, and Cambridge. Table 118 below presents the ASCs' case volumes by location and surgical specialty from FY 2019 to FY 2023, and Table 119 below presents the ASCs' surgical minutes by location and surgical specialty from FY 2019 to FY 2023. Table 119 includes only surgical minutes and does not include any turnaround time.

Table 118
UM SRH ASC Surgical Cases by Location and Specialty
FY 2019- FY 2023

UM SRH
ASC Cases by Location
FY2019 - FY2023

Specialty	FY2019 [1]	FY2020	FY2021	FY2022	FY2023[2]	FY19 - FY23 % Variance
Easton ASC:						
Pain Management	952	1,077	1,268	1,382	1,686	77.1%
Ophthalmology	1,048	792	969	1,101	1,014	-3.2%
Urology	526	452	543	532	522	-0.8%
Otolaryngology	318	114	124	190	220	-30.8%
General Surgery	152	143	160	177	132	-13.2%
Gynecology	46	29	25	24	24	-47.8%
Orthopedics	36	11	14	17	22	-38.9%
Plastic Surgery	6	12	11	2	2	-66.7%
Colorectal	-	-	-	9	-	0.0%
Podiatry	-	-	-	1	-	0.0%
Subtotal - Easton ASC	**3,084**	**2,630**	**3,114**	**3,435**	**3,622**	**17.4%**
Queenstown ASC:						
Pain Management	110	51	-	-	-	-100.0%
Vascular	-	2	-	-	-	0.0%
Urology	20	-	-	-	-	-100.0%
Gynecology	10	-	-	-	-	-100.0%
General Surgery	4	-	-	-	-	-100.0%
Subtotal - Queenstown ASC	**144**	**53**	**-**	**-**	**-**	**-100.0%**
Cambridge ASC:	**-**	**-**	**-**	**53**	**100**	
Colorectal	-	-	-	13	52	0.0%
General Surgery	-	-	-	29	48	0.0%
Pain Management	-	-	-	11	-	0.0%
Subtotal - Cambridge ASC	**-**	**-**	**-**	**53**	**100**	**0.0%**
Grand Total ASC Cases	**3,228**	**2,683**	**3,114**	**3,488**	**3,722**	**15.3%**

Note (1): FY2019 cases annualized based on January 2019 - June 2019 data
Note (2): FY2023 cases annualized based on July 2022 through December 2022 data

Source: Shore internal data

Table 119
UM SRH ASC Surgical Minutes by Location and Specialty
FY 2019- FY 2023

UM SRH

ASC Surgical Minutes by Location

FY2019 - FY2023

	FY2019 (1)	FY2020	FY2021	FY2022	FY2023(2)	FY19 - FY23 % Variance
Easton ASC:						
Pain Management	16,116	16,372	19,901	20,405	24,316	50.9%
Ophthalmology	21,882	16,297	19,186	21,564	18,582	-15.1%
Urology	12,438	10,137	12,243	12,309	12,328	-0.9%
Otolaryngology	14,682	5,555	8,330	10,573	8,964	-38.9%
General Surgery	10,156	8,885	11,470	11,922	8,276	-18.5%
Orthopedics	1,384	376	514	583	638	-53.9%
Gynecology	1,022	611	597	550	590	-42.3%
Plastic Surgery	1,488	2,125	2,097	546	372	-75.0%
Colorectal	-	-	-	518	-	0.0%
Podiatry	-	-	-	20	-	0.0%
Subtotal - Easton ASC	**79,168**	**60,358**	**74,338**	**78,990**	**74,066**	**-6.4%**
Queenstown ASC:						
Pain Management	1,372	784	-	-	-	-100.0%
Vascular	-	175	-	-	-	0.0%
Urology	680	-	-	-	-	-100.0%
General Surgery	166	-	-	-	-	-100.0%
Gynecology	118	-	-	-	-	-100.0%
Subtotal - Queenstown ASC	**2,336**	**959**	**-**	**-**	**-**	**-100.0%**
Cambridge ASC:	**-**	**-**	**-**	**3,622**	**7,464**	
Colorectal	-	-	-	1,225	3,812	0.0%
General Surgery	-	-	-	2,239	3,652	0.0%
Pain Management	-	-	-	158	-	0.0%
Subtotal - Cambridge ASC	**-**	**-**	**-**	**3,622**	**7,464**	**0.0%**
Grand Total	**81,504**	**61,317**	**74,338**	**82,612**	**81,530**	**0.0%**

Note (1): FY2019 cases annualized based on January 2019 - June 2019 data
Note (2): FY2023 cases annualized based on July 2022 through December 2022 data

Source: Shore internal data

Although some of UM SRH's ASCs have capacity for additional outpatient cases, the outpatient cases currently being performed at UM SMC at Easton are cases that are generally

not suitable for an ASC due to patient acuity and safety-related issues. At an ASC, there is only one anesthesiologist. ASA classification and patient BMI plays an important role in where a case can be performed. Patients with lots of comorbidities or a BMI over 40 cannot be safely performed in an ASC, and must be performed in a hospital.

The only other locations providing outpatient surgery that are identified in Table 1, on page 9 of the CON Application are: 1) University of Maryland Shore Medical Center at Chestertown ("UM SMC at Chestertown"), located at 100 Brown Street, Chestertown, MD 21620, which provides outpatient hospital-based surgery; and 2) The Orthopedic Center, located at 510 Idlewild Avenue, Easton, MD 21601, which is an independent ASC in which UM SRH holds no ownership interest. It was identified in Table 1 as an affiliated outpatient location only because it is operated by surgeons employed by UM SRH.

30. Please identify the surgeons, by specialty who performed surgical cases in the six ORs at Shore Easton in FY 2022. How many surgeons, by specialty, are assumed to be performing surgery at the hospital following project completion.

Applicant Response

Table 120 below identifies the surgeons, by specialty, who performed surgical cases at UM SMC at Easton in FY 2022. There were a total of 41 physicians performing surgery at UM SMC at Easton in FY 2022, including: five general surgeons, one neurosurgeon, 15 OB/GYNs, five orthopedic surgeons, two otolaryngologists, two plastic surgeons, one podiatrist, one transplant surgeon, four urologists, and five vascular surgeons.

Table 120
UM SMC at Easton Surgeons by Specialty
Performing Cases in FY 2022

Physician	Surgical Specialty	Total Surgeons by Specialty
BAIR, WILLIAM EDWIN	General Surgery	5
BANDYOPADHYAY, DABANJAN	General Surgery	
HAHN, AMANDA S	General Surgery	
MOON, JOHN TAE SUNG	General Surgery	
LILLY, ROBERTA JOLINE	General Surgery	
KURTOM, KHALID HELMY	Neurosurgery	1
ARUMALA, RUTH OKIEMUTE	Obstetrics & Gynecology	15
BODDU, ROHINI	Obstetrics & Gynecology	
CAJINA, JAVIER HUMBERTO	Obstetrics & Gynecology	
DIBARI, KARIN LOSCOCCO	Obstetrics & Gynecology	
DOSHI, PALAK K	Obstetrics & Gynecology	
DRUMMEY, AUDREY BOWES	Obstetrics & Gynecology	
FOROOGH-NASSIRAEE, MITRA	Obstetrics & Gynecology	
GARAVENTE, EILEEN MARIA	Obstetrics & Gynecology	
GORDON, SANLARE CEMELLE	Obstetrics & Gynecology	
GRAHAM, REIESHA DANA	Obstetrics & Gynecology	
KEIRNS, BARBARA ANNE	Obstetrics & Gynecology	
KHANJAR, SAMIR	Obstetrics & Gynecology	
NWADIKE, VALINDA RIGGINS	Obstetrics & Gynecology	
O'BRIEN, PATRICK MICHAEL	Obstetrics & Gynecology	
SAMUEL, JONELLE KHALILAH	Obstetrics & Gynecology	
JANCOSKO, JASON JOSEPH	Orthopedic Surgery	5
MASON, RICHARD JOSEPH	Orthopedic Surgery	
MCCOY, KEVIN	Orthopedic Surgery	
PALUMBO, JAMES WESSINGER	Orthopedic Surgery	
STAUCH, THOMAS EDWARD	Orthopedic Surgery	
ASLANIDIS, TASOS	Otolaryngology	2
PORTER, LAURIE BRIGANDI	Otolaryngology	
GOLDBERG, NELSON HOWARD	Plastic Surgery, Hand Surgery	2
ORSINI, ROGER AMADEUS	Plastic Surgery	
ALBRECHT, LARRY TODD	Podiatry	1
NIEDERHAUS, SILKE VERENA	Transplant Surgery - Kidney, Pancreas	1
CESPEDES, RICHARD DUANE	Urology	4
FOLEY, JOHN PATRICK	Urology	
RIGGIN, ANDREW JOHN	Urology	
RUNZ, CHRISTOPHER LOUIS	Urology	
AROSEMENA, MARIANO FABIO	Vascular Surgery	5
KARWOWSKI, JOHN KAZIMIERZ	Vascular Surgery	
LILLY, MICHAEL P.	Vascular Surgery	
NELMS, JUSTIN KRISTOFER	Vascular Surgery	
NEUZIL, DANIEL FLORIAN	Vascular Surgery	
Total Surgeons		**41**

UM SMC at Easton anticipates that an equivalent number of surgeons by specialty will be performing surgeries at the replacement hospital when it opens in 2028. For any surgeons who retire or depart in a particular specialty between now and when the replacement hospital opens, UM SMC at Easton expects to recruit and replace these surgeons.

31. Please respond to Standard .05B(6)(a) & .05B(6)(b) on Patient Safety. Address the way in which the design of the surgical facilities and services will enhance and improve patient safety.

Applicant Response

The surgical department has been designed with patient safety central to many design decisions, from perioperative through operating rooms ("ORs") into support spaces. Early decisions to locate surgical services adjacent to invasive cardiology and proximate to central sterile processing facilities creates optimal flow for patients, staff, and supplies.

A critical early decision was to create space to accommodate flexibility in equipment and technology to support safe patient movement and care. The ORs are appropriately sized to allow for safe movement of the care team and equipment around the patient. The ORs are designed to be standardized and oriented in the same way to reduce errors. Anesthesia support spaces are integrated within the surgical suite to enable quick response times and staff teaming areas near care delivery zones encourage communication, another tactic to reduce errors. Staff lounge and support spaces are proximate to ensure the care team is rested and focused on patients' care. ORs will have ASHRAE-compliant ventilation, filtration, and environmental control. Ceilings will be a pre-manufactured specialized OR air system. All ORs will have resinous floors to reduce damage to the flooring material and reduce infection risk. All ORs will have patient lifts for safe transfer of patients, unless ceiling mounted imaging equipment prohibits its functionality, which is not anticipated at this time. Additional airborne infection isolation rooms in perioperative areas provide safe accommodation for infectious patients. Updated technology and electrical infrastructure facilitates appropriate lighting, audio-visual integration, and power supply for equipment to deliver care in complex cases in an effective manner. Attention will be paid to finishes and acoustic design, to reduce noise-related stressors for patients and staff.

32. Please provide a response to Standard .05B(8)(a)(i)-(iv) with respect to Financial Feasibility that documents the information submitted and supports the financial feasibility for the project.

Applicant Response

Following the completeness review meeting held with the Applicant on February 7, 2023, MHCC Staff agreed to withdraw this question.

COMAR 10.24.12.

Inpatient Obstetric Services

33. On page 132 of the application, you discuss "a model commonly used in facilities with 900 or more births per year." Please identify the source of the referenced model and provide specifics on who or what organization developed this model and how it is used as an industry standard.

Applicant Response

The model in question refers to an obstetrical program model, as defined in the FGI Guidelines (2022) Sections 2.2-2.10.1 (A)(a): the labor / delivery / recovery model ("LDR"), as opposed to labor / delivery / recovery / postpartum model ("LDRP"). These two primary models of obstetrical unit design are widely recognized by facility design and care standards such as The FGI Guidelines; Guidelines for Perinatal Care, published by American Academy of Pediatrics ("AAP") and The American College of Obstetrics and Gynecologists ("ACOG"); and Department of Defense Space Planning Criteria. The reference to annual birth threshold guiding obstetrical program model and facility design is in reference to throughput per room. This is based on HKS' (the project architect's) benchmarking gathered through experience programming, designing, documenting, and analyzing obstetric units nationwide. There is no industry-wide fixed standard for adoption of the LDR versus LDRP model.

34. Are the two antepartum rooms intended to function as licensed beds for overnight hospitalization? If so, please elaborate on how they will be used and if it is intended that they be categorized as obstetric beds within the four planner-defined inpatient service categories used in licensing acute care hospital beds.

Applicant Response

The two antepartum rooms are intended to function as licensed beds, and are included in UM SMC at Easton's request for 11 licensed obstetric beds. Antepartum beds are used to provide services to pregnant women experiencing a variety of health issues. For example, pregnant patients experiencing pre-eclampsia or ruptured membranes in need of observation may occupy an antepartum bed. Antepartum beds will also be used to administer intravenous antibiotics to pregnant patients and for preterm labor observation.

Antepartum rooms will be sized the same as the licensed postpartum rooms, but will be outfitted with specialized equipment necessary to treat pregnant patients prior to delivery. In times of peak postpartum census, the antepartum rooms could accommodate postpartum patients, providing flexibility as needed for the capacity needs of the unit.

35. The application uses two different standards to calculate bed need ("Health Design Metrics" and SHP Acute Care Standard at 70% and later 80% to account for peak). Explain how MHCC should evaluate the use of these two different bed need methodologies.

Applicant Response

The Obstetrics State Health Plan does not dictate use of a particular need methodology or occupancy standard. Sections 1 through 9 of the Applicant's obstetric bed need analysis (pg. 132-138) is used to demonstrate that by applying the 70% occupancy standard from the Acute Care SHP and other assumptions described therein, the Applicant projects a need for eight postpartum beds by FY 2032. This was presented in Table 62 of the CON Application, which is reproduced below.

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

The Applicant presents this 70% occupancy methodology first to provide a baseline demonstration of its need for eight licensed postpartum beds, but also to show the limitations of applying just this methodology to evaluate its overall OB bed need. The Applicant states on page 138 that "using this need methodology based on HSCRC data alone [which only captures a patient's postpartum stay] 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." In other words, applying a 70% occupancy standard based only on postpartum stay data is deficient in demonstrating UM SMC at Easton's holistic need for licensed OB beds. Accordingly, the Applicant next presents additional data in section 10 on its antepartum and LDR/LDRP bed need, as well as peak census data in section 11 (where it presents the 80% of the ratio of peak daily census to average daily census), to provide a more holistic and realistic picture of its OB bed need, which is summarized in section 12. The MHCC should evaluate all data presented in the original need analysis as well as the additional data presented in this response to understand how the proposed unit will meet its needs.

Section 10 (pg. 138-140) describes how the postpartum bed need analysis does not adequately capture all obstetric patients, namely antepartum patients requiring pre-delivery testing, monitoring, and observation when the risk for complications is increased, and the time

that obstetric patients spend in the hospital prior to delivery during labor. Accounting for these patients, while still assuming 70% occupancy for postpartum patients, drives the need for 11 obstetric beds by FY 2032, as demonstrated in Table 63, which is reproduced below.

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

Section 10 also discusses the health design metrics UM SMC at Easton used in determining the number of LDR/LDRP rooms to include on the unit. These design metrics are explained more fully in the Applicant's response to Question 36, which explains that there is no firm guidance in design models for determining the ideal ratio of LDRs to annual births. Using HKS' benchmark of one LDR for approximately every 250 vaginal and unplanned cesarean section deliveries, UM SMC at Easton had projected a need for 3.4 LDRs based on its 853 vaginal deliveries projected for FY 2032. This projection does not account for unplanned c-section cases, which will also begin in those rooms. Based on this projection, UM SMC at Easton had considered whether to have three or four LDR rooms, but initially decided to include three LDRs, given that an LDRP will also be available on the unit.

Because UM SMC at Easton is currently in an LDRP model where the patient's labor-delivery-recovery-postpartum stay all occurs in the same room, UM SMC at Easton did not have readily available data on the average or peak number of patients in labor on the OB unit each day. Since filing the CON Application, UM SMC at Easton has manually collected additional data through a chart review on the number of patients in labor on the OB unit in a given day to ensure sufficient LDR and LDRP capacity is available at the replacement hospital. The OB unit clinical team reviewed three months of data in FY 2022 for two busy months with a high number of deliveries and one average delivery census month. Table 121 below presents this additional data, which shows the number of patients in labor per day for July 2021 (high census), August 2021 (high census), and January 2022 (average census).

Table 121
Birthing Unit Labor Census – Patients in Labor Per Day
FY 2022

Shore Health System

Obstetrics Unit Daily Census

FY2022

Birthing Unit Labor Census - # of patients in labor per day	Days with Census: July 2021	August 2021	January 2022
Less than 3	13	14	21
3	12	9	4
4	5	5	6
5	1	2	-
6	-	1	-
Total	**31**	**31**	**31**
Days with Census of 4	**5**	**5**	**6**
Days with Census of 5+	**1**	**3**	**-**

Source: Shore internal data

This data review shows that in each month, even January 2022, an average census month, the UM SMC at Easton OB unit had at least five days per month with four patients in labor, and in its busiest months, it had several days with five or more patients in labor. After review of this additional data and discussions with its OB clinical team, the Applicant has determined to add another LDR room within the OB unit for a total of four LDR rooms and one LDRP to ensure sufficient capacity for laboring mothers on the unit. Although antepartum testing rooms and triage rooms could serve in an absolute emergency as overflow rooms for laboring mothers, this would not be ideal for patient safety in that only LDR/LDRP rooms are equipped with the monitoring, space, and other equipment needed for safe labor and delivery. Adding a fourth LDR will ensure the replacement hospital is better equipped to handle higher labor census peaks. The LDRP room will serve as a fifth laboring room when needed, but will also provide flexibility for use as a postpartum room depending on the needs of the patient census.

Section 11 of the obstetric need section (pg. 140-141) was included to provide additional justification and support for the total request for 11 obstetric beds by better demonstrating the number of beds needed to accommodate peak census fluctuations. The demand for obstetric beds is not uniform, and instead fluctuates throughout the month and year. To address this

fluctuation, the Applicant identified the day in each month of FY 2022 where the UM SMC at Easton obstetric unit experienced the highest volume of patients (peak daily census) and identified the average daily census by month. To be conservative, and in recognition that the need projection should not account for extraordinary surges in volume, the Applicant adjusted its peak daily census by multiplying it by 80%. After applying this adjustment, the ratio of average daily census to 80% of peak daily census was 190% for FY 2022, as presented in Table 66, which is reproduced below.

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

In Table 67, reproduced below, the Applicant demonstrates that applying this 190% adjustment for 80% of the peak to ADC ratio results in the need for 11 obstetric beds, the same number of beds derived through the approach used in Table 63.

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

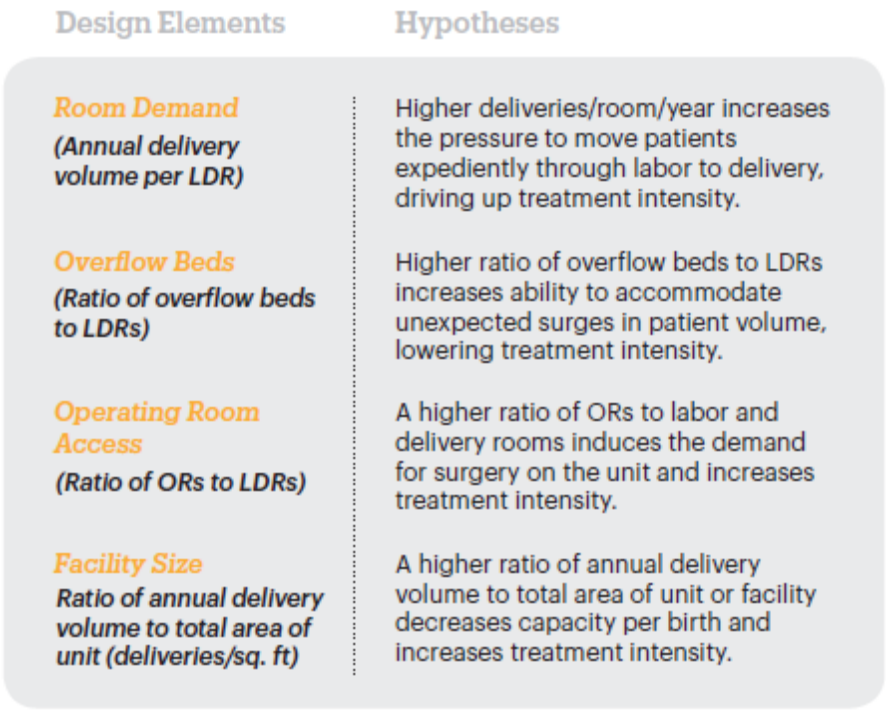
The Applicant requests that in the MHCC's review of the need for OB beds, the MHCC consider the approach outlined in Table 63 (with the 70% occupancy standard) as one component demonstrating need for postpartum beds at the replacement regional medical center, and consider the remainder of the data presented holistically (including the 80% of peak daily census) as support for UM SMC at Easton's request for 11 total licensed obstetric beds.

36. On page 132, the application discusses "health design benchmarks." What are the benchmarks and who established these benchmarks?

Applicant Response

The health design benchmarks referenced on page 132 of the CON Application refer to planning for the number of LDR or LDRP rooms in a health care facility. An evidence-based design research study from Ariadne Labs and MASS Design Group that evaluated capacity within several OB facilities identified four primary design elements that are central to supporting patient care functions in OB units, as demonstrated in Figure 11 below.

Figure 11
OB Unit Capacity Design Elements



Design Elements	Hypotheses
Room Demand (Annual delivery volume per LDR)	Higher deliveries/room/year increases the pressure to move patients expediently through labor to delivery, driving up treatment intensity.
Overflow Beds (Ratio of overflow beds to LDRs)	Higher ratio of overflow beds to LDRs increases ability to accommodate unexpected surges in patient volume, lowering treatment intensity.
Operating Room Access (Ratio of ORs to LDRs)	A higher ratio of ORs to labor and delivery rooms induces the demand for surgery on the unit and increases treatment intensity.
Facility Size Ratio of annual delivery volume to total area of unit (deliveries/sq. ft)	A higher ratio of annual delivery volume to total area of unit or facility decreases capacity per birth and increases treatment intensity.

Source: Ariadne Labs & Mass Design Group, "The Impact of Design on Clinical Care in Childbirth," (available at: https://www.mhtf.org/document/designing-capacity-for-high-value-healthcare-the-impact-of-design-on-clinical-care-in-childbirth/), p. 13.

The study notes that "currently, little guidance exists for facilities when budgeting number of LDRs." *Id.* at p. 13. The study evaluates several design models, concluding that one of the primary challenges for hospital obstetric units is identifying the ideal ratio of LDRs to annual births to ensure that capacity exists to accommodate surges in patient volumes. In fact, the study concludes that "even facilities with recent renovations or entirely new unit designs frequently lacked sufficient LDRs to accommodate surges in patient volume." *Id.* at p. 14. To ensure appropriate capacity for surges in deliveries, facilities must consider fluctuations in daily unit census, the rate at which patients move through LDRs, turnaround times in LDRs, and the capacity for overflow beds on the unit to accommodate peaks in deliveries. These elements are factored into unit design by design firms.

The benchmark that UM SMC at Easton referenced in its planning for the replacement regional medical center's obstetric unit is based on data HKS gathered through experience programming, designing, documenting, and analyzing obstetric units nationwide. These benchmarks inform the unit design to optimize patient throughput, in recognition of the strains that surges in deliveries can place on units without sufficient capacity.

37. Please provide the data for fiscal years 2019-2021 for Table 60 on page 137.

Applicant Response

A revised version of Table 60 is shown below with FY 2019 – FY 2032 data.

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

	Allocation of Discharges	Historical				Projected									
	FY22 - FY32	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030	FY2031	FY2032
Number of OB Discharges															
Vaginal	79%	819	849	825	791	795	801	807	814	820	827	833	840	846	853
C-Section	21%	263	210	205	208	209	211	212	214	216	217	219	221	223	224
Total	100%	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

Source: hMetrix statewide non-confidential utilization data tapes

38. Please provide data for fiscal year 2019 for Table 65 on page 140.

Applicant Response

A revised version of Table 65 is shown below. The data used for this table was obtained from EPIC (UM SRH's electronic health records system), to which UM SRH converted in November 2018. The same data is not readily available prior to this time. In revised Table 65 below, FY 2019 includes the seven-month period of December 2018 through June 2019. Although the number of days with 11 or more patients is lower in FY 2019 given that it is a partial year of data, the unit had an even higher percentage of days (19%) with 11 or more patients during this time frame.

REVISED Table 65
Number of Days Per Year with 11 or More Patients Occupying the UM SMC at Easton Obstetric Unit
FY 2019 – FY 2022

	FY19[(1)]	FY20	FY21	FY22
Days with 11 or more Obstetric Patients	40	61	43	48
Days per Year	213	365	365	365
% of Year with 11+ Patients	19%	17%	12%	13%

Source: Shore Internal Data

Note (1): FY19 Data includes 11/30/2018 - 06/30/2019

39. Table 66 on page 141 is titled "UM SMC at Easton's Average and Peak Daily Census FY 2022." Please clarify the beds included in this table; does it account for both antepartum and postpartum beds, or postpartum only?

Applicant Response

The census data reflected in Table 66 on page 141 of the CON Application includes only postpartum patients on the UM SMC at Easton obstetric unit.

40. On page 149, the application states that "Some, but not all of these laborists have offices in the primary service area." Please identify how many laborists participate in the Shore Easton program. How many have offices within the primary service area of the hospital?

Applicant Response

UM SRH contracts with Ob Hospitalist Group ("OBHG"), a laborist company that supplies approximately eight FTE board-certified obstetrician gynecologists who staff UM SMC at Easton's birthing center and do not have offices in the primary service area of the hospital. UM SRH employs three full-time obstetrician gynecologists and five nurse midwives to provide robust prenatal care to the region. OBHG's contracted laborists staff UM SMC at Easton's birthing center but do not provide ongoing, prenatal care to the service area. UM SRH's employed obstetricians and employed midwifery team provide care both in the hospital's birthing center and through its outpatient clinics to meet patients' prenatal care needs.

41. Please provide more detail on outreach programs that address low birth weight and infant mortality.

Applicant Response

UM SMC at Easton works with many partners in the community and entry of women into the health care system occurs through may referral sources, including county health departments, community centers, local physicians, schools, social service agencies, and other organizations in the service area that identify women in need of prenatal care, especially those who may be uninsured, underinsured, or indigent.

As part of its community health education initiatives and outreach, UM SMC at Easton offers a wide range of free classes and support groups to the community, including: Successful Breastfeeding, Labor and Delivery, New Mom, New Baby & Infant Safety, Pregnancy and Infant Loss (in partnership with Talbot Hospice), and Infant CPR. These classes help educate pregnant women in the service area about key areas of pregnancy and infant health and wellness, with the aim of achieving healthier outcomes and reducing the likelihood of infant mortality. The Pregnancy and Infant Loss class is a support group offering resources, support, and community to those experiencing pregnancy or infant loss.

UM SMC at Easton's program accommodates referrals for obstetric and gynecologic care for underserved women in all five counties of its service area from the many referral sources

identified above. In addition, when UM SRH Staff identify pregnant women at UM SRH community education outreach programs who are at risk of the conditions that could lead to low birth weight or infant mortality, the women are referred to one of University of Maryland Shore Medical Group's locations at Easton, Cambridge, Chestertown, or Queenstown. When a need is identified in the hospital setting, a referral is made to case management and from there the patient is directed to applicable resources that could include WIC and Healthy Families.

Acute Inpatient Rehabilitation Services

42. The hospital is an existing provider establishing a new hospital in a new location. 10.24.09.04A(2)(b) states *"An applicant that currently provides acute inpatient rehabilitation services that is seeking to establish a new location… 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."* Please respond to this standard.

Applicant Response

Please see the response to COMAR 10.24.10.04A(3)(b), which discusses UM SMC at Easton's performance on all Hospital Guide for Maryland Health Care Quality Reports measures, and to **Exhibit 12**, which identifies those quality measures for which UM SMC at Easton scored "below average" along with the corrective action plans for those measures. None of the quality measures requiring corrective action plans relate specifically to acute inpatient rehabilitation services.

The Requard Center for Acute Rehabilitation (the "Requard Center"), UM SMC at Easton's acute inpatient rehabilitation unit, is accredited by CARF. A copy of the most recent CARF accreditation certificate was attached to the CON Application as **Exhibit 20**. Re-accreditation with CARF requires a site survey. Based on the site survey, CARF issues an Accreditation Decision report that identifies "Recommendations," which relate to any standard for which CARF determined that the organization did not meet the minimum requirements to demonstrate full conformance, requiring a quality improvement plan to be submitted to CARF. The reports also identify "Consultation" points, which do not indicate nonconformance to the standards, but are rather intended to offer ideas to the organization to consider in ongoing quality improvement efforts, and which organizations are not required to address. The Requard Center most recently underwent re-accreditation with CARF in February 2021. The Accreditation Decision report is attached hereto as **Exhibit** Error! Reference source not found.. The Requard Center received only one Recommendation and was offered five "Consultations." Notably, CARF determined that the "Requard Center of Acute Rehabilitation is recognized for providing quality services" and that it "demonstrates a commitment to ongoing quality improvement." *See* **Exhibit 31,** p. 4.

43. Will the proposed acute rehabilitation unit comply with FGI Guidelines? How did design of the unit incorporate patient safety features?

Applicant Response

Yes, the proposed acute rehabilitation unit will comply with FGI Guidelines.

The unit was designed to incorporate patient safety features throughout. All rooms are private, with attached private toilet and showers. The private room and bathroom design reduces noise and chance of infection. One room on the unit is tailored to meet standards for individuals of size to provide an appropriate and safe environment of care for that patient population. The unit includes decentralized nursing stations to increase patient visibility. Rooms are also equipped for bedside documentation to increase nursing staffs' time with patients. Rooms include provisions for family space, to encourage and support both patient and family involvement in care.

Compared with the existing facility, patient transfer distances will be reduced at the replacement regional medical center by incorporating on-unit spaces like an activities of daily living ("ADL") lab and gym. This minimizes the chance of injury to patients as they move about the unit for treatment. Therapists' work area is located off the gym, to increase team communication. There will also be an on-unit staff lounge with exterior glazing to provide convenient respite.

COMAR 10.24.21

Acute Psychiatric Services

44. Please provide separate written quality assurance programs, evaluations, and treatment protocols for geriatric patients as the standard requests.

Applicant Response

It is UM SMC at Easton's policy to consider admission based on a patient's ability to participate in and benefit from treatment. Patients that are 65 and older are routinely admitted to the hospital's inpatient behavioral health unit with depressive disorders, bipolar mania, and schizophrenia. Patients with neurocognitive deficits are typically not considered for admission, and are referred to an appropriate provider. UM SMC at Easton also determines admission of patients 65 and older by their acuity and safety on the unit, as they are a vulnerable population.

UM SMC at Easton is also in the process of implementing the policy and procedures outlined in **Exhibit 32.** This policy titled "Special Behavioral Health Population Treatment Protocols" was in place at UM SMC at Dorchester prior to the unit's relocation to UM SMC at Easton in fall 2021, and addresses special protocols for geriatric patients.

Other Criteria

Viability

45. Project funding includes $50 million in philanthropy. How much of the $50 million fundraising goal has been collected? What are the contingency plans if the applicant does not meet its fundraising goal?

Applicant Response

UM Memorial Hospital Foundation has restricted funds, designated for the UM SMC at Easton Regional Medical Center, which are reserved for this project. With investment returns impacting the total amount of this contribution, the current estimated range of these funds is $7 million to $10 million.

In addition to the UM Memorial Hospital Foundation contribution, UM SRH is pursuing funding from the Federal Government in the form of grants and Congressional Directed Spending, as well as State Grants (in addition to the Governor's capital budget allocation), Mid-Shore County/City/Town Governmental contributions, community foundation support (unaffiliated with UM SRH), and a community-focused capital campaign. UM SRH is confident that this multifaceted fundraising campaign will ensure its success.

The contingency plan, should UM SRH not meet the $50 million fundraising goal, is to use UM Memorial Hospital Foundation unrestricted funds and/or increase borrowings to cover the variance.

46. Project funding includes $100 million of proposed funding from state government. It does not appear that this funding is included in the current administration's proposed budget. Please discuss any implications of this absence. Specifically, what is the impact of having to borrow an additional $100 million to fund the project?

Applicant Response

While the prior Administration recommended the inclusion of $100 million in Capital funds in the State CIP for the UM SMC at Easton Regional Medical Center, the incoming Administration indicated that the funding was not included in the budget as submitted as it lacked the time necessary to independently vet the project. With the new Administration and relevant cabinet members in place, UMMS and UM SRH executives are meeting regularly with the Moore Administration to facilitate their analysis of the project and consideration of the funding request. The State of Maryland has a long history of partnering with the UMMS to address health disparities and market failures that have led to insufficient health care infrastructure in vulnerable communities, with recent examples including significant investments in Baltimore City and Prince George's County. We believe that this partnership should and will naturally extend to address disparities related to the provision of health care in rural areas on the Eastern Shore.

A $100 million increase to the debt issuance for this project would drive an incremental $4.7 million in annual interest expense and an incremental $0.6 million in annual depreciation expense (due to the increase in capitalized interest during the construction period).

Impact

47. Please provide a map of the Shore Easton service area that identifies the following:

- **The current location of the hospital;**
- **The proposed location for the replacement facility;**

- **The jurisdictional lines in the service area;**
- **The major highways and roads in the service area; and**
- **The existing or future public transportation routes in the service area.**

Applicant Response

Exhibit 33 provides a map of the current location of the hospital, the proposed location of the replacement facility, the county lines in the service area, and the major highways and roads in the service area. In order for the map to be clearly legible, the Applicant separately provides a map of existing public transit routes in the service area as **Exhibit 34.** It may appear from these first two maps as if the current location and replacement facility site are located about the same distance to major roadways and public transportation routes. However, they do not capture the disparity between the congested location of the current hospital, and, in comparison, the unhindered location of the replacement facility. **Exhibit 35** provides a more detailed roadway map that better demonstrates the current hospital's location in congested downtown Easton, nestled in a residential area many city blocks away from U.S. Route 50. As seen in this map, the replacement facility location is more easily accessible to U.S. Route 50, the major throughway in Easton.

Tables

48. Provide alternative versions of Tables F, G, and H that do not include revenues or expenses for the FMF operations in Queenstown or Cambridge, i.e, alternative tables that are limited to revenues obtained and expenses incurred at the existing Shore Easton hospital and the proposed replacement hospital.

Applicant Response

Attached as **Exhibit 36** are the alternate versions of Tables F, G, and H requested. Alternative Table F includes actual and projected utilization data at UM SMC at Easton only for FY 2021 through FY 2032.

Alternative Tables G and H include actual, budgeted, and projected revenue and expense incurred by UM SMC at Easton, adjusted for SHS overhead allocations due to the interconnected nature of the operations at UM SMC at Easton, UM SMC at Dorchester / Cambridge, and UM Shore EC at Queenstown. The relevant overhead components were allocated from UM SMC at Easton to the other SHS facilities based on net patient service revenue. Alternative Tables G and H also include revenue and expense associated with unregulated services provided at all SHS facilities. Specifically, the Tables include $36.28 million in FY 2021 and $44.99 million in FY 2022 in unregulated gross revenue that falls under the UM SMC at Easton, UM SMC at Dorchester / Cambridge, and UM SMC at Queenstown reporting structures. The accompanying unregulated expense is also included. However, neither the SHS Revised CON Tables (**Exhibit 27**) nor Alternative Tables G and H (**Exhibit 36**) include allocations of physician losses from Shore Medical Group, the inclusion of which will reconcile to the audited financial statements. Allocations of Shore Medical Group losses to SHS entities totaled $22.567 million in FY 2021 and $19.924 million in FY 2022 on the audited financial statements. Such physician losses are also not included in the FY 2023 budget and the FY 2023 – FY 2032 projection period presented in the two Table sets.

49. Budget Table E - Please explain the methodology used or the basis for the $19.5 million in estimated Contingency Allowance and the $28.7 million in estimated Inflation Allowance.

Applicant Response

Contingency

The $19.5 million Contingency Allowance is calculated at 7% of total construction costs. As indicated in the CON Application in the budget assumptions supporting Exhibit 1, Table E, SHS compared this amount to actual contingency carried at UM Capital Region Medical Center and other UMMS projects and adjusted the total for scope differences and the extensive site work. Additionally this value was cross-checked against industry standards. The typical rule of thumb for a project of this size, developed to a CON conceptual level, would be to carry approximately 10-12% contingency, or more. However, in 2013 HKS completed a 100% Design Development set of drawings, and SHS will be retaining most of the elements of that design including the exterior skin and infrastructure. By utilizing that document set in conjunction with the adjusted plans, SHS was able to receive updated pricing to achieve more cost assurance. Accordingly, SHS feels confident that a 7% contingency is appropriate.

Inflation

In the application, the Inflation rate is 5.75% percent. ($28,740,058 (Inflation)/ $499,738,814 (Total Current Capital Costs) = 0.0575. The inflation rate was calculated using the MHCC's index, the Building Cost Index in Healthcare Cost Review from the MHCC's website. The Budget was developed in the last quarter of 2022 (2022.4), and the midpoint of construction is the third quarter of 2026 (2026.3).

Budget Date	2022.4				
Midpoint of Construction	2026.3				
Step 1	2023.4	%MOVAVG	1.4	1.014	*A*
Step 2	2024.4	%MOVAVG	1.6	1.016	*B*
Step 3	2025.4	%MOVAVG	1.8	1.018	*C*
Step 4	2025.4	CIS Proxy	1.287		*D*
	2026.3	CIS Proxy	1.298		*E*
	E/D			1.00854701	*F*
	*A * B * C * F*			**1.05773186**	

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

UM SMC at Easton rounded down the inflation rate from 5.77% to 5.75%.

50. With respect to the Workforce Table L, please discuss the projected FTE staffing reductions: MedSurg/Acute Direct Care (4.4); Med/Surg/Acute (11.6); Obstetrics (3.7); OR (9.1); ER (8.6); Lab (5.2); Pharmacy (2.1); Radiology (4.8); and Other Ancillary (14.2). Explain the extent to which these reductions in work force are attributable to the design of the new hospital or other factors.

Applicant Response

The projected reductions in workforce presented in the "Other Expected Changes" columns of Table L are based on analysis performed by the Applicant on reductions in agency spend and better aligning staffing levels with patient utilization patterns. These reductions are assumed to be phased in between FY 2024 and FY 2027 and are unrelated to the opening of the

new facility. Table 122 and Table 123 below present the projected FTE reductions and salary savings by year in these two categories.

Table 122
Detail of Other Expected Changes from Table L – FTE Reductions
FY2024 – FY2027

	Cumulative FTE Reductions					
Savings Category	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**
Agency Reductions	(18.5)	(37.0)	(55.5)	(74.0)	(74.0)	(74.0)
Staffing to Demand	(6.2)	(12.3)	(18.5)	(24.7)	(24.7)	(24.7)
Total Workforce Savings	**(24.7)**	**(49.3)**	**(74.0)**	**(98.7)**	**(98.7)**	**(98.7)**

Table 123
Detail of Other Expected Changes from Table L – Salary Savings
FY2024 – FY2027

	Cumulative Salary Savings					
Savings Category	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**
Agency Reductions	$ (1,500,000)	$ (3,000,000)	$ (4,500,000)	$ (6,000,000)	$ (6,000,000)	$ (6,000,000)
Staffing to Demand	$ (500,000)	$ (1,000,000)	$ (1,500,000)	$ (2,000,000)	$ (2,000,000)	$ (2,000,000)
Total Workforce Savings	**$ (2,000,000)**	**$ (4,000,000)**	**$ (6,000,000)**	**$ (8,000,000)**	**$ (8,000,000)**	**$ (8,000,000)**

The reduction of 4.4 FTEs in the MSGA units is the only work force reduction attributable to the project. Additional detail on this anticipated reduction was provided in the Efficiency section on page 94 of the CON Application and is provided below for reference.

> 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.

51. Will any equipment currently in operation be moved to the replacement facility? Please explain the use of the term "in building" in Exhibit 1, Table E-Project Budget for Fixed Equipment?

Applicant Response

Yes, UM SMC at Easton plans to move existing equipment that is usable, has the latest technology, and will not be at its "end of life" to the new facility from the existing hospital building.

These include laboratory equipment, imaging equipment, infusion pumps, defibrillators and others. UM SMC at Easton must also carefully manage the equipment selected for relocation to ensure it does not create service disruptions at the existing facility prior to the move. **Exhibit 37** provides the list of the equipment currently slated as potential equipment to be moved to the new facility. This list will be further evaluated once detailed architectural drawings have been completed. Based on current costs of purchasing replacement equipment, it is expected that moving this equipment to the new facility will save approximately $18,769,000.

Definition of "In Building"

Typically, the MHCC has recognized that Fixed Equipment costs may be included in the Building line costs in the project budget, as Fixed Equipment is generally installed by the contractor building the building. That is the case in UM SMC at Easton's Project Budget.

Table of Exhibits

Table of Tables

Table of Figures

Table	Description

I hereby declare and affirm under the penalties of perjury that the facts stated in the Responses to Completeness Questions dated January 25, 2023 and its attachments are true and correct to the best of my knowledge, information, and belief.

2/15/2023

Date

DocuSigned by:
ken kozel
D6A3A2E51ED74B4...

Ken Kozel, MBA FACHE
President and Chief Executive Officer
University of Maryland Shore Regional Health

I hereby declare and affirm under the penalties of perjury that the facts stated in the Responses to Completeness Questions dated January 25, 2023 and its attachments are true and correct to the best of my knowledge, information, and belief.

2/15/2023

Date

DocuSigned by:
JoAnne Haney
DFC8B488258E42A...

JoAnne Haney, 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 the Responses to Completeness Questions dated January 25, 2023 and its attachments are true and correct to the best of my knowledge, information, and belief.

2/15/2023
Date

Arvin Singh, EdD, MBA, MPH, MS,
FACHE,VP, Strategic Planning &
Communications
University of Maryland Shore
Regional Health

I hereby declare and affirm under the penalties of perjury that the facts stated in the Responses to Completeness Questions dated January 25, 2023 and its attachments are true and correct to the best of my knowledge, information, and belief.

Feb 16 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 the Responses to Completeness Questions dated January 25, 2023 and its attachments are true and correct to the best of my knowledge, information, and belief.

2-16-2023
Date

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 the Responses to Completeness Questions dated January 25, 2023 and its attachments are true and correct to the best of my knowledge, information, and belief.

2/15/2023

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 the Responses to Completeness Questions dated January 25, 2023 and its attachments are true and correct to the best of my knowledge, information, and belief.

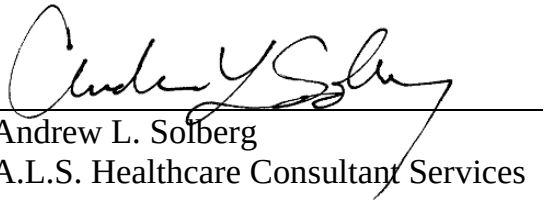
2/17/2023

Date

Lucas Sater
Senior Director, Reimbursement and Revenue Advisory Services
University of Maryland Medical Systems

I hereby declare and affirm under the penalties of perjury that the facts stated in the Responses to Completeness Questions dated January 25, 2023 and its attachments are true and correct to the best of my knowledge, information, and belief.

2/17/2023
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 the Responses to Completeness Questions dated January 25, 2023 and its attachments are true and correct to the best of my knowledge, information, and belief.

2/15/2023
Date

Emily Dickinson
Vice President
HKS, Inc.

EXHIBIT 27

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

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTIONS: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/2022	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
ACUTE CARE							**ACUTE CARE**					
General Medical/ Surgical*		62					**General Medical/ Surgical***		74			
MedSurg	2 East		19	6	25	31	MedSurg	3	26	0	26	26
Surgical/Medical	3 East		10	10	20	30	MedSurg	4	24	0	24	24
Neuro	4 East		6	2	8	10	MedSurg	5	24	0	24	24
Joint	4 East		5	3	8	11					0	0
Telemetry	4 South		20	4	24	28					0	0
SUBTOTAL Gen. Med/Surg*		**62**	**60**	**25**	**85**	**110**	**SUBTOTAL Gen. Med/Surg***		**74**	**0**	**74**	**74**
ICU/CCU		**10**	10	0	10	10	**ICU/CCU**	4	12	0	12	12
Other *(Specify/add rows as needed)*					0	0					0	0
TOTAL MSGA		**72**	**70**	**25**	**95**	**120**	**TOTAL MSGA**		**86**	**0**	**86**	**86**
Obstetrics Total		**13**			0	**13**	**Obstetrics Total**		11		11	11
5 East (LDRP)	Birthing Center 5E		10	0	10	10	LDRP	3	1	0	1	1
Antepartum	Birthing Center 5E		3	0	3	3	Postpartum	3	8	0	8	8
OR 5 East	Birthing Center 5E		1	0	1	1	Antepartum	3	2	0	2	2
PACU 5 East	Birthing Center 5E		1	0	1	1					0	0
Triage 5 East	Birthing Center 5E		3	0	3	3					0	0
Pediatrics		**3**	1	2	3	5	**Pediatrics**	3	1	0	1	1
Psychiatric	3 South	**10**	4	4	8	12	**Psychiatric**	6	12	0	12	12
TOTAL ACUTE		**98**	**75**	**31**	**106**	**150**	**TOTAL ACUTE**		**110**	**0**	**110**	**110**
NON-ACUTE CARE							**NON-ACUTE CARE**					
Dedicated Observation**					0	0	**Dedicated Observation****	1	25	0	25	25
Rehabilitation	5 South	**20**	3	6	9	15	**Rehabilitation**	5	12	0	12	12
Comprehensive Care					0	0	**Comprehensive Care**				0	0
Other *(Specify/add rows as needed)*					0	0	**Other** *(Specify/add rows as needed)*				0	0
TOTAL NON-ACUTE		**20**	**3**	**6**	**9**	**15**	**TOTAL NON-ACUTE**		**37**	**0**	**37**	**37**
HOSPITAL TOTAL		**118**	**78**	**37**	**115**	**165**	**HOSPITAL TOTAL**		**147**	**0**	**147**	**147**

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

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

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

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

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Inpatient Nursing Units					
Intensive Care	6,090	12,413	0	0	12,413
Med / Surg (Telemetry / Neuro)	16,317	14,873	0	0	14,873
Rehab (Requard Center)	8,700	13,480	0	0	13,480
Med / Surg (General)	29,738	32,788	0	0	32,788
Pediatric Unit	2,300	incl in M/S Unit	0	0	0
Med / Surg (Joint, Med/Surg)	6,810	incl in M/S Unit	0	0	0
Obstetrics incl. nursery	15,623	20,607	0	0	20,607
Behavioral Health Unit	9,775	11,616			11,616
Subtotal	**95,353**	**105,777**	0	0	**105,777**
Diagnostic & Treatment					
Clinical Lab / Pathology	7,451	10,225	0	0	10,225
Emergency Department	17,570	21,890	0	0	21,890
Inpatient Dialysis	2,298	2,332	0	0	2,332
Imaging Department	16,680	15,605	0	0	15,605
Interventional Suite (incl O.R.'s, Cath, EP, PACU)	23,040	30,968	0	0	30,968
Prep / Stage 2 Recovery	3,889	16,128	0	0	16,128
Pre-Anesthesia Testing	400	710	0	0	710
Observation Unit	0	11,976	0	0	11,976
Respiratory Therapy	1,927	697	0	0	697
Subtotal	**73,255**	**110,531**	0	0	**110,531**
Administrative / Public Services					
Auxiliary	126	310	0	0	310
Admitting / Registration	3,845	1,784	0	0	1,784
Chapel	170	597	0	0	597
Education Center / Med Library	6,289	4,956	0	0	4,956
Gift Shop	1,106	1,255	0	0	1,255
Hospitalist Suite	1,259	0	0	0	0
On-Call	1,034	1,670	0	0	1,670
Executive Admin	6,252	4,631	0	0	4,631
Medical Records	7,933	2,060	0	0	2,060

Quality Team	1,055	incl in Admin	0	0	0
Human Resources / Employee Health	1,900	1,808	0	0	1,808
Nursing Administration / Staff offices	1,835	1,361	0	0	1,361
Information Technology	1,900	2,046	0	0	2,046
Lobby Services	1,255	1,192	0	0	1,192
Subtotal	**35,959**	**23,670**	0	0	**23,670**
Support Services					
EVS / Linen / Facilities / Mat. Mgmt	9,389	13,592	0	0	13,592
Biomed	600	894			894
Maryland Express Care Suite	795	372	0	0	372
Sterile Processing	4,658	7,306	0	0	7,306
Pharmacy	4,181	4,843	0	0	4,843
Security	420	989	0	0	989
Morgue	500	252			252
Food & Nutrition	9,176	13,316	0	0	13,316
Subtotal	**29,719**	**41,564**	0	0	**41,564**
Clinics					
Cardiopulmonary / Vascular	2,502	5,952	0	0	5,952
Education Center	983	incl in Education above			
Behavioral Health Outpatient Clinic	1,077	3,133	0	0	3,133
Cardio Rehab	2,700	3,758	0	0	3,758
Diabetes Clinic	3,487	2,935	0	0	2,935
Infusion Center	1,760	2,178	0	0	2,178
Pain Management Clinic	2,402	3,133	0	0	3,133
Sleep Lab	1,078	0	0	0	0
Multi-Specialty Clinic	1,645	4,039	0	0	4,039
Outpatient Lab Draw	556	751	0	0	751
Subtotal	**18,190**	**25,879**	0	0	**25,879**
Total Department Gross SF	**252,476**	**307,421**			**307,421**
Building Grossing Factor	113,590	75,556	0	0	**75,556**
Penthouse	5,550	2,510	0	0	**2,510**
Central Plant	16,917	22,385	0	0	**22,385**
Total Building Gross SF	**366,066**	**407,872**			**407,872**

TABLE C. CONSTRUCTION CHARACTERISTICS

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

	NEW CONSTRUCTION		RENOVATION
	Hospital	**Central Utility Plant**	
BASE BUILDING CHARACTERISTICS	**Check if applicable**		
Class of Construction (for renovations the class of the building being renovated)*			
Class A	☑	☑	☐
Class B	☐	☐	☐
Class C	☐	☐	☐
Class D	☐	☐	☐
Type of Construction/Renovation*			
Low	☐	☐	☐
Average	☐	☐	☐
Good	☑	☑	☐
Excellent	☐	☐	☐
Number of Stories	6 plus penthouse	1	

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**		
Total Square Footage	**385,487**	**22,385**	
Basement	n/a		
First Floor	135,968	22,385	
Second Floor	111,505		
Third Floor	45,044		
Fourth Floor	36,652		
Fifth Floor	35,228		
Sixth Floor	18,580		
Penthouse	2,510		
Average Square Feet	**55,070**	**22,385**	
Perimeter in Linear Feet	**Linear Feet**		
Basement	n\a		
First Floor	2,135	610	
Second Floor	2,076		
Third Floor	1,194		
Fourth Floor	1,079		
Fifth Floor	1,066		
Sixth Floor	648		
Penthouse	204		
Total Linear Feet	**8,402**	**610**	
Average Linear Feet	**1,200**	**610**	
Wall Height (floor to eaves)	**Feet**		
Basement	n/a		
First Floor	16	20	
Second Floor	16		
Third Floor	14		
Fourth Floor	14		
Fifth Floor	14		
Sixth Floor	14		
Penthouse	21.83		
Average Wall Height	**15.69**		
OTHER COMPONENTS			
Elevators	**List Number**		
Passenger	3	0	
Freight	3	0	
Trauma	1	0	
Sprinklers	**Square Feet Covered**		
Wet System	385,487	22,385	
Dry System			
Other	**Describe Type**		
Type of HVAC System for proposed project	Excellent Grade - Forced Air: VAV / Constant Volume, Digitally Controlled		
Type of Exterior Walls for proposed project	Glass Curtain Wall, Brick Veneer, Metal Panels, Cultured Stone		

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS		
INSTRUCTION : If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table D for each structure.		
	NEW CONSTRUCTION COSTS	**RENOVATION COSTS**
SITE PREPARATION COSTS		
Normal Site Preparation	$649,215	
Utilities from Structure to Lot Line	In Offsite Costs	
Subtotal included in Marshall Valuation Costs	**$649,215**	
Paving and Roads	$6,091,611	
Demolition	$412,500	
Storm Drains	$3,282,000	
Rough Grading	$2,455,794	
Landscaping	$4,239,791	
Sediment Control & Stabilization	$375,000	
Helipad	$55,000	
Water	$91,350	
Sewer	$146,160	
Premium for Labor Shortages on Eastern Shore Projects	$2,664,598	
Premium for Prevailing Wage	$2,664,598	
Premium for Minority Business Enterprise Requirement	$1,090,430	
Subtotal On-Site excluded from Marshall Valuation Costs	**$23,568,831**	
OFFSITE COSTS		
Roads	$6,653,000	
Pump Station	$1,118,520	
8" to 12" Force Main	$1,560,000	
Misc.	$780,000	
EASTON ELECTRICAL SERVICE	$704,369	
EASTON GAS SERVICE TO PROPERTY	$254,196	
Verizon	$1,170,497	
MD Broad Band (Fiber)	$1,592,448	
Chop Tank (Electric)	$2,826,004	
Cable TV	$3,532,880	
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs	**$20,191,914**	
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$43,760,745**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$44,409,960**	**$0**
BUILDING COSTS		
Normal Building Costs	$170,264,261	
Subtotal included in Marshall Valuation Costs	$170,264,261	
Canopy	$1,881,250	
Premium for Labor Shortages on Eastern Shore Projects	$12,998,316	
LEED Silver Premium	$8,665,544	
Pneumatic Tube System	$1,125,000	
Signs	$135,000	
Premium for Prevailing Wage	$12,998,316	
Premium for Minority Business Enterprise Requirement	$8,570,914	
Subtotal Building Costs excluded from Marshall Valuation Costs	**$46,374,341**	
TOTAL Building Costs included and excluded from Marshall Valuation Service*	**$216,638,602**	**$0**
A&E COSTS		
Normal A&E Costs	$11,000,000	
Subtotal included in Marshall Valuation Costs	**$11,000,000**	
Subtotal A&E Costs excluded from Marshall Valuation Costs	**$0**	
TOTAL A&E Costs included and excluded from Marshall Valuation Service*	**$11,000,000**	**$0**
PERMIT COSTS		
Normal Permit Costs	$6,135,000	
Subtotal included in Marshall Valuation Costs	**$6,135,000**	
Subtotal Permit Costs excluded from Marshall Valuation Costs	**$0**	
TOTAL Permit Costs included and excluded from Marshall Valuation Service*	**$6,135,000**	**$0**

TABLE E. PROJECT BUDGET

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

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

	Hospital Building	CUP	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. Land Purchase	**$2,464,658**		**$2,464,658**
b. New Construction			
(1) Building	$210,528,602	$6,110,000	$216,638,602
(2) Fixed Equipment	In Building	In Building	In Building
(3) Site and Infrastructure	$36,933,315	$7,476,645	$44,409,960
(4) Architect/Engineering Fees	$9,013,929	$1,986,071	$11,000,000
(5) Permits (Building, Utilities, Etc.)	$5,027,314	$1,107,686	$6,135,000
SUBTOTAL	**$261,503,160**	**$16,680,402**	**$278,183,562**
c. Renovations			
(1) Building			$0
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees			$0
(4) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$0**	**$0**
d. Other Capital Costs			
(1) Movable Equipment	$85,060,730	$40,000,000	$125,060,730
(2) Contingency Allowance	$16,974,712	$2,478,023	$19,452,735
(3) Gross interest during construction period	$44,210,733	$5,788,267	$49,999,000
(4) Other (Specify/add rows if needed)			
Easton Utility Fees	$9,000,000		$9,000,000
EDU'S			$0
Impact Fee (Town) / County	$1,500,000		$1,500,000
Forest Conservation			$0
Builder's Risk Insurance	$500,000		$500,000
HOSPITAL MOVE	$2,000,000		$2,000,000
UMMS/OVHO	$1,500,000		$1,500,000
Previous Expenditures (Design/Planning/etc)	$10,078,129		$10,078,129
SUBTOTAL	***$170,824,304***	***$48,266,290***	**$219,090,594**
TOTAL CURRENT CAPITAL COSTS	**$434,792,122**	**$64,946,691**	**$499,738,814**
e. Inflation Allowance	$25,435,020	$3,305,038	$28,740,058
TOTAL CAPITAL COSTS	**$460,227,142**	**$68,251,729**	**$528,478,871**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	$2,635,012	$344,988	$2,980,000
b. Bond Discount	$0		$0
c CON Application Assistance			$0
c1. Legal Fees	$150,000		$150,000
c2. Other (Specify/add rows if needed)			$0
Accounting, Architectural, Planning	$850,000		$850,000
d. Non-CON Consulting Fees			
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			
IT Design	$75,000		$75,000
SHA Study	$300,000		$300,000
Geo-tech consult (if needed)	$75,000		$75,000
Project Development Consultant	$4,500,000		$4,500,000
CM Preconstruction Fees	$200,000		$200,000
Exterior Wall Mock Up & Testing	$500,000		$500,000
Scheduling	$200,000		$200,000
Third Party Inspections	$750,000		$750,000
Third Party Building Permit Review	$400,000		$400,000
Curtainwall Testing	$100,000		$100,000
e. Debt Service Reserve Fund	$0		$0
f Other (Specify/add rows if needed)			$0
			$0
			$0
e. Liquidation of Existing Debt			$0
f. Debt Service Reserve Fund	$0		$0
g. Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$10,735,012***	***$344,988***	**$11,080,000**
3. Working Capital Startup Costs			$0
##### ***TOTAL USES OF FUNDS***	***$470,962,155***	***$68,596,717***	***$539,558,871***
B. Sources of Funds			
1. Cash	$38,588,871	$0	$38,588,871
2. Philanthropy (to date and expected)	$50,000,000	$0	$50,000,000
3. Authorized Bonds	$264,727,283	$68,596,717	$333,324,000
4. Interest Income from bond proceeds listed in #3	$17,646,000		$17,646,000
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State	$100,000,000		$100,000,000
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$470,962,154***	***$68,596,717***	**$539,558,871**
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

Budget Assumptions for the UM Shore Health Regional Medical Center

1. **Building:** The construction cost of the RMC is a Rough Order of Magnitude ("ROM") provided Clark Construction, the Construction Manager who completed the construction of UM Capital Region Medical Center in Largo, MD in June 2021. This ROM was developed from a combination of Schematic Design Documents from 2022, and previous iterations of this project which were at a Design Development level of completion.

2. **Fixed Equipment:** The cost of fixed equipment was developed internally by UMMS Facilities' Design and Construction Department, utilizing actual costs from UM Capital Region Medical Center as a benchmark for pricing, while adjusting for differences in scope and current day pricing.

3. **Architect/Engineering Fees:** The cost of design and engineering was provided in a proposal from HKS, the architectural firm designing the Regional Medical Center. HKS is an interdisciplinary global design firm with extensive experience in the Healthcare sector. They are the designers of the UM Upper Chesapeake Bed Tower Expansion in Bel Air, MD, which is currently under construction.

4. **Permit Fees:** The cost of the permit fees for this project was developed by Clark Construction based on their experience working in Talbot County, adjusted for a project of this size and complexity.

5. **Movable Equipment:** The cost of movable equipment was developed internally by UMMS Clinical Engineering department, a group which includes in-house medical equipment planners. This cost was established in a room-by-room format using Attania pricing models, and cross-checked using UM Capital Region actual purchase prices adjusted for current day pricing.

6. **Contingency:** The contingency for this project was developed using UM Capital Region Medical Center and other UMMS projects as a guideline. The amount of contingency was adjusted for scope differences, drawing completion levels, and the extensive site infrastructure and development requirements for this location.

7. **Information Technology (IT):** Information Technology budgets were developed internally by UMMS IT project development group based on the actual costs of UM Capital Region Medical Center's IT infrastructure and implementation. The costs were adjusted for differences in scope and current pricing.

8. **Legal Fees:** The legal fee estimate was provided by Gallagher Evelius & Jones, LLP, a firm currently advising the organization on the CON application process. The estimate is based on working on other projects of this magnitude.

9. **Non-legal Consultant Fees:** The estimate for non-legal consultant fees for this project was developed by UMMS Facilities' Design and Construction department, based on actual consultant fees paid throughout the course of the UM Capital Region Medical Center Project.

TABLE F. STATISTICAL PROJECTIONS - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.								
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
1. DISCHARGES												
a. MSGA	4,245	3,885	3,944	4,004	4,065	4,129	4,194	4,260	4,329	4,400	4,472	4,547
Total MSGA	**4,245**	**3,885**	**3,944**	**4,004**	**4,065**	**4,129**	**4,194**	**4,260**	**4,329**	**4,400**	**4,472**	**4,547**
b. Pediatrics	8	27	27	27	27	27	27	27	27	27	27	27
c. Obstetrics	1,030	999	1,004	1,012	1,020	1,028	1,036	1,044	1,052	1,060	1,069	1,077
e. Psych	432	349	350	351	352	353	355	356	478	480	481	483
f. Rehabilitation	312	191	198	206	214	222	231	239	249	259	269	279
Total Acute	**6,027**	**5,451**	**5,523**	**5,599**	**5,678**	**5,759**	**5,842**	**5,927**	**6,135**	**6,225**	**6,318**	**6,413**
g. Other (Specify/add rows of needed)												
TOTAL DISCHARGES	**6,027**	**5,451**	**5,523**	**5,599**	**5,678**	**5,759**	**5,842**	**5,927**	**6,135**	**6,225**	**6,318**	**6,413**
2. PATIENT DAYS												
a. MSGA	20,454	21,888	22,224	22,469	22,720	22,978	23,242	23,619	24,006	24,403	24,812	25,231
Total MSGA	**20,454**	**21,888**	**22,224**	**22,469**	**22,720**	**22,978**	**23,242**	**23,619**	**24,006**	**24,403**	**24,812**	**25,231**
b. Pediatrics	20	72	72	72	72	72	72	72	72	72	72	72
c. Obstetrics	1,865	1,892	1,901	1,916	1,931	1,946	1,962	1,977	1,993	2,008	2,024	2,040
e. Psych	3,648	1,996	2,014	2,033	2,052	2,071	2,091	2,111	2,854	2,882	2,910	2,938
f. Rehabilitation	3,040	2,197	2,280	2,367	2,457	2,550	2,648	2,750	2,857	2,967	3,083	3,203
Total Acute	**29,027**	**28,045**	**28,492**	**28,857**	**29,232**	**29,618**	**30,015**	**30,529**	**31,781**	**32,333**	**32,900**	**33,485**
g. Other (Specify/add rows of needed)												
TOTAL PATIENT DAYS	**29,027**	**28,045**	**28,492**	**28,857**	**29,232**	**29,618**	**30,015**	**30,529**	**31,781**	**32,333**	**32,900**	**33,485**

TABLE F. STATISTICAL PROJECTIONS - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.								
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)												
a. MSGA	4.8	5.6	5.6	5.6	5.6	5.6	5.5	5.5	5.5	5.5	5.5	5.5
Total MSGA	**4.8**	**5.6**	**5.6**	**5.6**	**5.6**	**5.6**	**5.5**	**5.5**	**5.5**	**5.5**	**5.5**	**5.5**
b. Pediatrics	2.5	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7
c. Obstetrics	1.8	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9
e. Psych	8.4	5.7	5.8	5.8	5.8	5.9	5.9	5.9	6.0	6.0	6.0	6.1
f. Rehabilitation	9.7	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5
Total Acute	**4.8**	**5.1**	**5.2**	**5.2**	**5.1**	**5.1**	**5.1**	**5.2**	**5.2**	**5.2**	**5.2**	**5.2**
g. Other (Specify/add rows of needed)												
TOTAL AVERAGE LENGTH OF STAY	**4.8**	**5.1**	**5.2**	**5.2**	**5.1**	**5.1**	**5.1**	**5.2**	**5.2**	**5.2**	**5.2**	**5.2**
4. NUMBER OF LICENSED BEDS												
a. MSGA	70	75	76	77	78	79	80	81	82	84	85	86
Total MSGA	**70**	**75**	**76**	**77**	**78**	**79**	**80**	**81**	**82**	**84**	**85**	**86**
b. Pediatrics	1	1	1	1	1	1	1	1	1	1	1	1
c. Obstetrics	11	10	10	11	11	11	11	11	11	11	11	11
e. Psych	14	8	8	8	8	8	8	8	11	11	11	12
f. Rehabilitation	11	8	8	9	9	9	10	10	10	11	11	12
Total Acute	**107**	**102**	**103**	**106**	**107**	**108**	**110**	**111**	**115**	**118**	**119**	**122**
g. Other (Specify/add rows of needed)												
TOTAL LICENSED BEDS	**107**	**102**	**103**	**106**	**107**	**108**	**110**	**111**	**115**	**118**	**119**	**122**

TABLE F. STATISTICAL PROJECTIONS - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.								
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*												
a. MSGA	80.0%	80.0%	80.0%	79.8%	80.0%	80.0%	80.0%	79.8%	80.0%	80.0%	80.0%	79.8%
Total MSGA	**80.0%**	**80.0%**	**80.0%**	**79.8%**	**80.0%**	**80.0%**	**80.0%**	**79.8%**	**80.0%**	**80.0%**	**80.0%**	**79.8%**
b. Pediatrics	5.5%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%
c. Obstetrics	46.5%	51.8%	52.1%	47.6%	48.1%	48.5%	48.9%	49.1%	49.6%	50.0%	50.4%	50.7%
e. Psych	71.4%	68.4%	69.0%	69.4%	70.3%	70.9%	71.6%	72.1%	71.1%	71.8%	72.5%	66.9%
f. Rehabilitation	75.7%	75.2%	78.1%	71.8%	74.8%	77.6%	72.6%	75.1%	78.3%	73.9%	76.8%	72.9%
Total Acute	**74.3%**	**75.4%**	**75.7%**	**74.4%**	**75.0%**	**75.4%**	**75.0%**	**75.2%**	**75.6%**	**75.3%**	**75.8%**	**74.7%**
i. Other (Specify/add rows of needed)												
TOTAL OCCUPANCY %	**74.3%**	**75.4%**	**75.7%**	**74.4%**	**75.0%**	**75.4%**	**75.0%**	**75.2%**	**75.6%**	**75.3%**	**75.8%**	**74.7%**
6. OUTPATIENT VISITS (RVU's)												
a. Emergency Department - Easton	25,546	25,393	25,610	25,833	26,062	26,297	26,539	26,788	27,043	27,306	27,576	27,854
b. Emergency Department - Dorchester/Cambridge	12,027	14,539	14,663	14,791	14,922	15,057	15,195	15,338	15,484	15,634	15,789	15,948
c. Emergency Department - Queen Anne's	13,716	18,035	18,189	18,347	18,510	18,677	18,849	19,026	19,207	19,394	19,586	19,783
d. Same Day Surgery	4,609	4,500	4,538	4,578	4,619	4,660	4,703	4,747	4,792	4,839	4,887	4,936
e. Laboratory RVU's	4,988,179	5,941,602	5,992,382	6,044,543	6,098,133	6,153,198	6,209,787	6,267,950	6,327,740	6,389,212	6,452,420	6,517,424
f. Imaging RVU's	1,163,618	1,224,633	1,235,099	1,245,850	1,256,896	1,268,245	1,279,909	1,291,897	1,304,221	1,316,891	1,329,919	1,343,317
g. MRI RVU's	4,988,179	5,941,602	5,992,382	6,044,543	6,098,133	6,153,198	6,209,787	6,267,950	6,327,740	6,389,212	6,452,420	6,517,424
TOTAL OUTPATIENT VISITS (RVU's)	**11,195,874**	**13,170,304**	**13,282,863**	**13,398,486**	**13,517,274**	**13,639,333**	**13,764,769**	**13,893,695**	**14,026,228**	**14,162,487**	**14,302,597**	**14,446,685**

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TABLE G. REVENUES & EXPENSES, UNINFLATED - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.								
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
1. REVENUE												
a. Inpatient Services	$124,234	$129,265	$122,858	$122,675	$123,276	$123,732	$124,173	$124,090	$131,531	$131,439	$131,363	$131,287
b. Outpatient Services	$204,536	$233,541	$216,296	$ 217,014	$ 217,346	$ 217,441	$ 217,527	$ 217,382	$ 230,417	$ 230,256	$ 230,123	$ 229,989
Gross Patient Service Revenues	***$ 328,770***	***$ 362,806***	***$ 339,154***	***$ 339,689***	***$ 340,622***	***$ 341,172***	***$ 341,699***	***$ 341,472***	***$ 361,948***	***$ 361,694***	***$ 361,485***	***$ 361,276***
c. Deductions	$61,770	$70,527	$63,036	$ 63,136	$ 63,309	$ 63,412	$ 63,509	$ 63,467	$ 67,273	$ 67,226	$ 67,187	$ 67,148
Net Patient Services Revenue	***$ 267,000***	***$ 292,279***	***$ 276,117***	***$ 276,553***	***$ 277,312***	***$ 277,761***	***$ 278,190***	***$ 278,005***	***$ 294,675***	***$ 294,469***	***$ 294,298***	***$ 294,128***
d. Grants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
e. Other Operating Revenue	$ 12,462	$ 11,145	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405
NET OPERATING REVENUE	***$ 279,462***	***$ 303,424***	***$ 283,523***	***$ 283,959***	***$ 284,718***	***$ 285,166***	***$ 285,595***	***$ 285,410***	***$ 302,080***	***$ 301,874***	***$ 301,704***	***$ 301,533***
2. EXPENSES												
a. Salaries & Wages (including benefits)	$ 109,453	$ 116,928	$ 115,870	$ 113,988	$ 112,179	$ 110,509	$ 108,902	$ 109,362	$ 110,013	$ 110,622	$ 111,235	$ 111,854
b. Contractual Services	$ 47,970	$ 55,769	$ 56,418	$ 56,418	$ 56,322	$ 56,229	$ 56,141	$ 56,141	$ 55,856	$ 55,856	$ 55,856	$ 55,856
c. Interest on Current Debt	$ 2,346	$ 3,044	$ 4,993	$ 4,893	$ 4,795	$ 4,699	$ 4,605	$ 4,513	$ 4,423	$ 4,335	$ 4,248	$ 4,163
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,694	$ 15,362	$ 15,014	$ 14,647
e. Current Depreciation and Amortization	$ 16,972	$ 17,243	$ 20,336	$ 17,914	$ 17,028	$ 17,231	$ 16,483	$ 16,566	$ 14,232	$ 14,791	$ 15,446	$ 16,102
f. Project Depreciation and Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 27,961	$ 27,961	$ 27,961	$ 27,961
g. Supplies	$ 36,197	$ 35,922	$ 34,741	$ 30,878	$ 30,380	$ 29,931	$ 29,530	$ 29,737	$ 30,005	$ 30,189	$ 30,375	$ 30,563
h. Professional Fees	$ 15,530	$ 15,147	$ 18,382	$ 18,491	$ 18,570	$ 18,649	$ 18,729	$ 18,810	$ 18,928	$ 19,049	$ 19,171	$ 19,293
i. Insurance & Other	$ 3,337	$ 4,214	$ 4,718	$ 4,718	$ 4,718	$ 4,718	$ 4,718	$ 4,718	$ 4,718	$ 4,718	$ 4,718	$ 4,718
j. Fixed Cost Additions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL OPERATING EXPENSES	**$231,805**	**$248,267**	**$255,457**	**$247,301**	**$243,992**	**$241,967**	**$239,109**	**$239,847**	**$281,831**	**$282,883**	**$284,023**	**$285,158**
3. INCOME												
a. Income From Operation	**$ 47,657**	**$ 55,157**	**$ 28,065**	**$ 36,658**	**$ 40,726**	**$ 43,199**	**$ 46,486**	**$ 45,563**	**$ 20,250**	**$ 18,991**	**$ 17,681**	**$ 16,375**
b. Non-Operating Income	$ 28,052	$ (20,369)	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187
SUBTOTAL	***$ 75,709***	***$ 34,788***	***$ 43,253***	***$ 51,845***	***$ 55,913***	***$ 58,386***	***$ 61,674***	***$ 60,751***	***$ 35,437***	***$ 34,179***	***$ 32,868***	***$ 31,563***
c. Income Taxes												
NET INCOME (LOSS)	***$ 75,709***	***$ 34,788***	***$ 43,253***	***$ 51,845***	***$ 55,913***	***$ 58,386***	***$ 61,674***	***$ 60,751***	***$ 35,437***	***$ 34,179***	***$ 32,868***	***$ 31,563***

TABLE G. REVENUES & EXPENSES, UNINFLATED - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.								
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
4. PATIENT MIX												
a. Percent of Total Revenue												
1) Medicare	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%
2) Medicaid	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%
3) Blue Cross	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
4) Commercial Insurance	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%
5) Self-pay	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
6) Other	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days												
1) Medicare	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%
2) Medicaid	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%
3) Blue Cross	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%
4) Commercial Insurance	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%
5) Self-pay	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
6) Other	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Note: Values presented do not include SHS allocations of Shore Medical Group losses, which totaled $22.57M in FY2021 and $19.92M in FY2022. These amounts will need to be added back in order to reconcile to the audited financial statements

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Table G – Key Financial Projection Assumptions for Shore Health System (Uninflated)	
Projection is based on the UM Shore Health System FY2023 budgeted revenues and expenses with assumptions identified below	
Projection period reflects FY2024 – FY2032	
Volumes	— See Table F of the application for volume projections
Patient Revenue	
• FY2024	
○ HSCRC Inflation Factor	— 0.00%
○ Quality Adjustments	— -0.12%
○ Other Rates	— 0.40%
○ Volume	— 0.05%
— Total	0.33%
• FY2025	
○ HSCRC Inflation Factor	— 0.00%
○ Quality Adjustments	— 0.00%
○ Other Rates	— 0.03%
○ Volume	— 0.05%
— Total	0.08%
• FY2026+	
○ HSCRC Inflation Factor	— 0.00%
○ Quality Adjustments	— 0.00%
○ Other Rates	— -0.10%
○ Volume	— 0.05%
— Total	-0.05%
• Deductions from Gross Revenue	— 18.6%
• Revenue Enhancements	— In FY2029, Shore Health System will request a full rate adjustment of $24.0M, equal to 50% of depreciation and interest related to the project — Includes an HSCRC Markup factor of 1.1
Other Revenue	
• Other Operating Revenue Inflation	— 2.0%
Expenses	
• Inflation	
○ Salaries & Benefits	— 0.0%
○ Professional Fees	— 0.0%
○ Supplies	— 0.0%
○ Purchased Services	— 0.0%
○ Insurance & Other	— 0.0%
• Volume Variability	
○ Salaries & Benefits	— 45.0%
○ Professional Fees	— 80.0%
○ Supplies	— 50.0%
○ Purchased Services	— 50.0%
○ Insurance & Other	— 0.0%
• Interest Expense	
○ Project Debt	— Interest expense on $333.3M proceeds from a 30-year issuance of debt at an interest rate of 5%
• Depreciation and Amortization	— Reflects depreciation on a $539.6M project with a weighted average useful life of 19.2 years
• Shore Medical Group Physician Loss Allocations	— SHS allocations of Shore Medical Group physician losses, totaling $22.57M in FY2021 and $19.92M in FY2022 are not included in this projection. This will need to be added back in order to reconcile to the audited financial statements
• Performance Improvements	
○ Indentified PI:	
— Agency Reductions	— $6.0M by FY2027
— FTE Savings	— $2.5M by FY2027
— 340B Savings	— $4.0M in drug savings & $1.0M in other savings by FY2027
— Inventory Management	— $2.0M by FY2027
— Other PI	— $0.5M by FY2027
○ Total Identified PI:	— $15.0M by FY2027 (cumulative)
○ Unindentified PI:	— No unidentified PI included in the projection

REVISED

TABLE H. REVENUES & EXPENSES, INFLATED - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.								
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
1. REVENUE												
a. Inpatient Services	$ 124,234	$ 129,265	$ 122,858	$ 125,719	$ 129,538	$ 133,288	$ 137,134	$ 140,501	$ 152,691	$ 156,448	$ 160,297	$ 164,240
b. Outpatient Services	$ 204,536	$ 233,541	$ 216,296	$ 222,398	$ 228,386	$ 234,235	$ 240,232	$ 246,132	$ 267,486	$ 274,066	$ 280,809	$ 287,717
Gross Patient Service Revenues	***$ 328,770***	***$ 362,806***	***$ 339,154***	***$ 348,117***	***$ 357,924***	***$ 367,523***	***$ 377,366***	***$ 386,633***	***$ 420,177***	***$ 430,514***	***$ 441,105***	***$ 451,958***
c. Deductions	$ 61,770	$ 70,527	$ 63,036	$ 64,702	$ 66,525	$ 68,309	$ 70,139	$ 71,861	$ 78,096	$ 80,017	$ 81,985	$ 84,002
Net Patient Services Revenue	***$ 267,000***	***$ 292,279***	***$ 276,117***	***$ 283,415***	***$ 291,399***	***$ 299,214***	***$ 307,227***	***$ 314,772***	***$ 342,081***	***$ 350,497***	***$ 359,120***	***$ 367,955***
d. Grants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
e. Other Operating Revenue	$ 12,462	$ 11,145	$ 7,405	$ 7,553	$ 7,704	$ 7,859	$ 8,016	$ 8,176	$ 8,340	$ 8,506	$ 8,676	$ 8,850
NET OPERATING REVENUE	***$ 279,462***	***$ 303,424***	***$ 283,523***	***$ 290,968***	***$ 299,104***	***$ 307,072***	***$ 315,243***	***$ 322,948***	***$ 350,421***	***$ 359,003***	***$ 367,796***	***$ 376,805***
2. EXPENSES												
a. Salaries & Wages (including benefits)	$ 109,453	$ 116,928	$ 115,870	$ 117,408	$ 119,011	$ 120,757	$ 122,571	$ 126,781	$ 131,361	$ 136,051	$ 140,910	$ 145,944
b. Contractual Services	$ 47,970	$ 55,769	$ 56,418	$ 57,546	$ 58,597	$ 59,671	$ 60,769	$ 61,984	$ 62,903	$ 64,161	$ 65,444	$ 66,753
c. Interest on Current Debt	$ 2,346	$ 3,044	$ 4,993	$ 4,893	$ 4,795	$ 4,699	$ 4,605	$ 4,513	$ 4,423	$ 4,335	$ 4,248	$ 4,163
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,694	$ 15,362	$ 15,014	$ 14,647
e. Current Depreciation and Amortization	$ 16,972	$ 17,243	$ 20,336	$ 17,914	$ 17,028	$ 17,231	$ 16,483	$ 16,566	$ 14,232	$ 14,791	$ 15,446	$ 16,102
f. Project Depreciation and Amortization	$ -	$ -	$ -	$ -	$ -	$ -			$ 27,961	$ 27,961	$ 27,961	$ 27,961
g. Supplies	$ 36,197	$ 35,922	$ 34,741	$ 31,990	$ 32,606	$ 33,281	$ 34,018	$ 35,489	$ 37,099	$ 38,669	$ 40,308	$ 42,018
h. Professional Fees	$ 15,530	$ 15,147	$ 18,382	$ 19,046	$ 19,700	$ 20,378	$ 21,080	$ 21,806	$ 22,601	$ 23,428	$ 24,285	$ 25,173
i. Insurance and Other	$ 3,337	$ 4,214	$ 4,718	$ 4,812	$ 4,908	$ 5,007	$ 5,107	$ 5,209	$ 5,313	$ 5,419	$ 5,528	$ 5,638
TOTAL OPERATING EXPENSES	**$231,805**	**$248,267**	**$255,457**	**$253,610**	**$256,647**	**$261,024**	**$264,632**	**$272,348**	**$321,587**	**$330,177**	**$339,143**	**$348,401**
3. INCOME												
a. Income From Operation	**$ 47,657**	**$ 55,157**	**$ 28,065**	**$ 37,358**	**$ 42,457**	**$ 46,048**	**$ 50,611**	**$ 50,600**	**$ 28,834**	**$ 28,826**	**$ 28,654**	**$ 28,405**
b. Non-Operating Income	$ 28,052	$ (20,369)	$ 15,187	$ 15,491	$ 15,801	$ 16,117	$ 16,439	$ 16,768	$ 14,303	$ 17,445	$ 17,794	$ 18,150
SUBTOTAL	***$ 75,709***	***$ 34,788***	***$ 43,253***	***$ 52,849***	***$ 58,258***	***$ 62,165***	***$ 67,050***	***$ 67,368***	***$ 43,137***	***$ 46,272***	***$ 46,448***	***$ 46,555***
c. Income Taxes	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NET INCOME (LOSS)	***$ 75,709***	***$ 34,788***	***$ 43,253***	***$ 52,849***	***$ 58,258***	***$ 62,165***	***$ 67,050***	***$ 67,368***	***$ 43,137***	***$ 46,272***	***$ 46,448***	***$ 46,555***

TABLE H. REVENUES & EXPENSES, INFLATED - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.								
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
4. PATIENT MIX												
a. Percent of Total Revenue												
1) Medicare	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%
2) Medicaid	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%
3) Blue Cross	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
4) Commercial Insurance	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%
5) Self-pay	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
6) Other	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days												
Total MSGA												
1) Medicare	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%
2) Medicaid	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%
3) Blue Cross	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%
4) Commercial Insurance	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%
5) Self-pay	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
6) Other	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Note: Values presented do not include SHS allocations of Shore Medical Group losses, which totaled $22.57M in FY2021 and $19.92M in FY2022. These amounts will need to be added back in order to reconcile to the audited financial statements

REVISED

Table H – Key Financial Projection Assumptions for Shore Health System (Includes HSCRC Annual Update Factors & Expense Inflation)	
Projection is based on the UM Shore Health System FY2023 budgeted revenues and expenses with assumptions identified below	
Projection period reflects FY2024 – FY2032	
Volumes	— See Table F of the application for volume projections
Patient Revenue • FY2024 ○ HSCRC Inflation Factor ○ Quality Adjustments ○ Other Rates ○ Volume — Total	 — 2.48% — -0.12% — 0.40% — 0.05% 2.81%
• FY2025 ○ HSCRC Inflation Factor ○ Quality Adjustments ○ Other Rates ○ Volume — Total	 — 2.50% — 0.00% — 0.03% — 0.05% 2.58%
• FY2026+ ○ HSCRC Inflation Factor ○ Quality Adjustments ○ Other Rates ○ Volume — Total	 — 2.50% — 0.00% — -0.10% — 0.05% 2.45%
• Deductions from Gross Revenue	— 18.6%
• Revenue Enhancements	— In FY2029, Shore Health System will request a full rate adjustment of $24.0M, equal to 50% of depreciation and interest related to the project — Includes an HSCRC Markup factor of 1.1
Other Revenue • Other Operating Revenue Inflation	 — 2%
Expenses • Inflation ○ Salaries & Benefits ○ Professional Fees ○ Supplies ○ Purchased Services ○ Insurance & Other	 — 3.0% — 3.6% — 3.0% — 2.0% — 2.0%
• Volume Variability ○ Salaries & Benefits ○ Professional Fees ○ Supplies ○ Purchased Services ○ Insurance & Other	 — 45% — 80% — 50% — 50% — 0%
• Interest Expense ○ Project Debt	 — Interest expense on $333.3M proceeds from a 30-year issuance of debt at an interest rate of 5%
• Depreciation and Amortization	— Reflects depreciation on a $539.6M project with a weighted average useful life of 19.2 years
• Shore Medical Group Physician Loss Allocations	— SHS allocations of Shore Medical Group physician losses, totaling $22.57M in FY2021 and $19.92M in FY2022 are not included in this projection. This will need to be added back in order to reconcile to the audited financial statements
• Performance Improvements ○ Indentified PI: — Agency Reductions — FTE Savings — 340B Savings — Inventory Management — Other PI ○ Total Identified PI:	 — $6.0M by FY2027 — $2.5M by FY2027 — $4.0M in drug savings & $1.0M in other savings by FY2027 — $2.0M by FY2027 — $0.5M by FY2027 — $15.0M by FY2027 (cumulative)
○ Unindentified PI:	— No unidentified PI included in the projection

TABLE L. WORKFORCE INFORMATION - SHS

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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Total Administration	218.5	$ 66,260	$ 14,477,936			$ -			$ 4,411,660	218.5	$ 18,889,596
Direct Care Staff *(List general categories, add rows if needed)*											
Med/Surg Acute	195.1	$ 77,437	$ 15,110,442	(4.4)	$ 77,437	$ (343,515)	(11.6)	$ (309,787)	$ 3,606,835	179.1	$ 18,373,762
Pediatrics	9.6	74,226	712,577				-	-	216,930	9.6	929,507
Obstetrics	43.1	98,711	4,252,496				(3.7)	(241,815)	900,247	39.4	5,152,743
Operating Room	87.2	83,993	7,325,329				(9.1)	(146,895)	1,341,606	78.1	8,666,935
Psych	23.8	77,541	1,845,478				1.5	543,275	791,307	25.3	2,636,785
Rehab	42.0	82,923	3,482,791				7.0	258,857	1,815,100	49.0	5,297,891
Emergency Department	122.6	98,200	12,038,972				(8.6)	(328,762)	2,822,469	114.0	14,861,442
Lab	79.7	69,125	5,512,095				(5.2)	(257,920)	1,335,058	74.6	6,847,153
Pharmacy	32.7	91,911	3,005,495				(2.1)	(342,940)	727,946	30.6	3,733,441
Radiology	74.3	90,200	6,706,249				(4.8)	(336,558)	1,624,288	69.5	8,330,537
Other Ancillary Services	187.4	68,273	12,797,255				(14.2)	(218,178)	3,100,666	173.2	15,897,921
Total Direct Care	897.7	$ 81,088	$ 72,789,180	(4.4)	$ 77,437	$ (343,515)	(51.0)	$ (358,815)	$ 18,282,452	842.3	$ 90,728,116
Support Staff *(List general categories, add rows if needed)*											
Security	25.6	$ 45,896	$ 1,174,938				-	-	358,090	25.6	1,533,028
Environmental Services	51.6	34,251	1,767,347				-	-	538,640	51.6	2,305,988
Other Support Staff	52.7	74,400	3,921,675				0.3	3,828,440	1,216,971	53.0	5,138,646
Total Support	*129.9*	$ 52,836	*$ 6,863,961*				*0.3*	$ 6,649,439	*$ 2,113,701*	*130.2*	*$ 8,977,662*
REGULAR EMPLOYEES TOTAL	*1,246.1*	$ 75,542	*$ 94,131,076*	*-4.4*	$ 77,437	*$ (343,515)*	*(50.6)*	$ (489,940)	*$ 24,807,813*	*1,191.0*	*$ 118,595,374*
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
Total Administration											
Direct Care Staff *(List general categories, add rows if needed)*											
Total Direct Care Staff											
Support Staff *(List general categories, add rows if needed)*											
Total Support Staff											
CONTRACTUAL EMPLOYEES TOTAL											
Benefits *(State method of calculating benefits below)***:**			$ 21,738,646						$ 5,610,297		$ 27,348,944
23.1% of Salaries											
TOTAL COST	***1,246.1***		***115,869,723***	***(4.4)***		***$ (343,515)***	***(50.6)***		***$ 30,418,111***		***$ 145,944,318***

EXHIBIT 28

01 **2022_LEVEL 03 - DEPARTMENT AREA PLAN ALT**
1/16" = 1'-0"

PLOT DATE:
2/15/2023 4:15:25 PM

HKS

ARCHITECT
HKS, Inc.
2100 E. Cary Street, Suite 100
Richmond, VA 23223

1250 Eye Street NW, Suite 600
Washington, D.C. 20005

INTERIORS
HKS, Inc.
2100 E. Cary Street, Suite 100
Richmond, VA 23223

CIVIL
Daft McCune Walker Inc.
200 East Pennsylvania Avenue
Towson, MD 21286

MEP
Highland Associates
102 Highland Avenue
Clarks Summit, PA 18411

STRUCTURAL
O'Donnell & Naccarato
111 South Independence Mall East
Suite 950
Philadelphia, PA 19106-2524

LANDSCAPE
Mahan Rykiel Associates
The Stueff Silver Building
800 Wyman Park Drive, Suite 100
Baltimore, MD 21211

INFORMATION TECHNOLOGY
Smith Seckman Reid, Inc.
2995 Sidco Drive
Nashville, TN 37204

FOOD SERVICE
L2M FOOD SERVICE DESIGN GROUP
811 Cromwell Park Drive, Suite 113
Glen Burnie, MD 21061

MEDICAL EQUIPMENT
Mitchell Planning Associates
2794 Oakbrook Drive
Weston, FL 33332

SHORE HEALTH
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

Shore Health
Easton Replacement Hospital

OWNER
University of Maryland Health System
250 W. Pratt Street
Suite 2400
Baltimore, MD 21201

Shore Health System
219 S. Washington Street
Easton, MD 21601

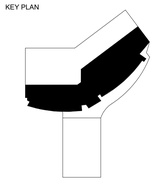
OWNER'S CONSULTANT
FM Global
2100 Reston Parkway, Suite 600
Reston, VA 20191

INTERIM REVIEW ONLY

These documents are incomplete, and are released for interim review only and are not intended for regulatory approval, permit, or construction purposes.

Architect: Shannon B. Kraus
Arch. Reg. No.: 16103
Date: 10/25/2022

KEY PLAN



PLAN NORTH TRUE NORTH

REVISION

NO.	DESCRIPTION	DATE

HKS PROJECT NUMBER
19782.010

DATE
FEBRUARY 22, 2023

ISSUE
CON COMPLETENESS

SHEET TITLE
LEVEL 03 - DEPARTMENTAL AREA PLAN

SHEET NO.
CON 10A

EXHIBIT 29

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Financial Assistance Program Application

Please complete, sign, and return this application with the following required documentation:

- **Income (Including all of the following documents you currently receive):**
  - ☐ Copy of last 2 pay stubs or copy of W-2 form from current tax year filed including patient, patient spouse and/or patient guarantor (parents/legal guardians of children under 18 yrs old) living in the household.
  - ☐ If self-employed, a copy of your current Federal Tax form 1040.
  - ☐ Documentation of Social Security/Social Security Disability or any other additional household income.
- **Copy of Mortgage/Rent Bill, or copy of Property Tax statement if home is no longer mortgaged**
- **If you applied for Medical Assistance, a copy of your approval or denial letter.**

If you are unable to supply any of the required documents above, please complete form FAF 116, page 3 below.

Patient Information		
Last Name:	First:	M.I.:
Social Security #:	Date of Birth:	

Guarantor (Legal Parent, Guardian, or Power of Attorney) If same as Patient skip to Part II; complete all fields.			
Last Name:	First:		M.I.:
Social Security #:	Date of Birth:	Relationship to Patient:	

Part II (Patient/Guarantor Information)			
Street Address:			Apt:
City:	State:	ZIP:	
Home Phone: ( )	Cell Phone: ( )	Marital Status:	
Employers Name and Address:			
Monthly Gross Income: $	Monthly Net Income: $		
Position/Title:	Length of Current Employment:		
Are you a Legal Resident of the United States: Yes ☐	No ☐		

Spouse		
Last Name:	First:	M.I.:
Employer Name/Address:	Phone #:	
Position/Title:	Length of Employment:	
Monthly Gross Income: $	Monthly Net Income: $	

Household Information (Name and Date Of Birth of all persons in household, excluding self or spouse)		
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:

Additional Household income	
Checking Account Balance:	Monthly Unemployment Amount:
Savings Account Balance:	Monthly Social Security Amount:
Public Assistance/ Food Stamps:	Monthly Workers Compensation Amount:
Monthly/Annual Pension Amount:	Any Other:

Mortgage/Rent (Copy of Mortgage/Rent payment required)	
Mortgage/Rent Payment:	

Health Insurance Information (Copy of Medical Assistance Approval or Denial letter you received is required)		
Name Of Company:		Effective Date:
Have you applied for Medical Assistance: Yes ☐ No ☐		When:
Where:	Name of Caseworker & phone #:	
Outcome/Reason for Denial:		

Disability Information		
Is the Patient Disabled: Yes ☐ No ☐		Length Of Disability:
Name of Physician:		Physician Phone Number:

Third Party Liabilities (Auto Accident, Workers Compensation, Bodily Injury, or other legal claim)			
Injuries/Illness result of an Auto Accident	Yes ☐	No ☐	Date of Incident:
Injuries/Illness occuring at your workplace?	Yes ☐	No ☐	Date of Incident:
Injuries/Illness result of a Crime?	Yes ☐	No ☐	Date of Incident:
Injuries/Ilness resulting in legal action?	Yes ☐	No ☐	Date of Incident:

Third Party Liability Claims are ineligible for Financial Assistance until all means of payment are exhausted. Failure to disclose information pertaining to any third party liability claim will deem patient ineligible for Financial Assistance.

I declare that I have examined this application and to the best of my knowledge all information in it or otherwise provided to UMMS and it's practices is true, correct, and complete. I understand that misrepresentation of this information may cancel any financial assistance I may be provided and that I will then be liable for all medical charges. By signing and submitting this request, I give UMMS, and it's facility practices permission to determine my need for financial assistance; including review of my credit file. I also give permission to UMMS to release or disclose this information to University Physicians Inc. for the purpose of evaluating my financial status in response for assistance with my physician bills. I understand that it is my responsibility to advise UMMS of any changes in status in regards to my income or assets while this application is in process.

Patient/Guarantor Signature (required) _____ Date _____

Spouse's Signature (required) _____ Date _____

If you have any questions or need assistance completing this application, please call the Financial Assistance Dept. (410) 821-4140, Extension 2003, Monday through Friday, 8:00am - 4:30pm.

You may mail, email or fax this application along with required documents to:

Mail: UMMS
11311 McCormick Road, Suite 230
Hunt Valley, MD 21031

Email: CBOService@umm.edu

Fax: 410-630-5341

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Verification of Living, Financial, and Income Statement

This form will need to be completed by a Financial Assistance applicant who:

- Receives assistance with food and/or shelter
- Currently unemployed
- Hospital bills due to injuries from an auto accident, workers compensation, personal injury, or any other third party liability claim

Patient Information:

Name: _____ Date: _____
Phone Number: _____ Cell Phone Number: _____
Date of Birth: _____ Patient Signature: _____

If receiving assistance with food and shelter, complete the following**:**

I have been receiving assistance from _____, who has been assisting me with food and shelter. Relationship to patient: _____.

(Check one)
_____ Providing room and board free
_____ I have been paying $ _____ per month for room and board
_____ Other, please explain below:

_____
_____
_____

If unemployed and receiving no income, complete the following**:**

(Check one) __ I have been unemployed since ___/___/___ and receiving assistance with food and shelter per above. Expected date to return to work? _____
___ I have been unemployed since ___/___/___ and living off of savings or other monetary assets.
Please explain in detail: _____
_____
Expected date to return to work? _____

Why are you not receiving unemployment income?
(Check one) ___ Eligibility Expired - Patient has exhausted all eligible unemployment benefits.
___ Not Eligible, reason: _____

If you have a third party liability claim (Auto accident, workers compensation, personal injury) complete the following:

Attorney: : Name: _____
Address
Phone Number: _____

Insurance Company: Name: _____
Address: _____
Phone Number:_____

Expected Settlement Date: _____/_____/_____

(Form FAF 116)

EXHIBIT 30

UNIVERSITY of MARYLAND MEDICAL SYSTEM **Revenue Cycle Services**	**PAGE:** **1 OF 14**	**POLICY NO:** **RCS - 01**
	EFFECTIVE DATE: 09/18/19	**REVISION DATE(S):** 07/01/22
SUBJECT: UMMS Financial Assistance Policy		

KEY WORDS:
Financial Assistance, Financial Hardship, Financial Clearance, Medical Assistance

OBJECTIVE/BACKGROUND:
The purpose of the following policy statement is to describe the financial assistance application process, how applications are reviewed and determinations of eligibility are made, eligibility criteria for financial assistance programs (including presumptive eligibility and financial hardship assistance), financial clearance of patients with medically unique or humanitarian needs, how UMMS notifies patients of the availability financial assistance availability, the appeal process, and extraordinary collection actions.

APPLICABILITY:
This policy applies to all team members, vendors, and agents [volunteers, medical team members] of any of the following University of Maryland Medical System member organizations:

University of Maryland Medical Center (UMMC)
UM Midtown Campus (MTC)
UM Rehabilitation & Orthopaedic Institute (UMROI)
UM St. Joseph Medical Center (UMSJMC)
UM Baltimore Washington Medical Center (UMBWMC)
UM Shore Regional Health (UMSRH)
UM Shore Medical Center at Dorchester (UMSMCD)
UM Shore Medical Center at Easton (UMSME)
UM Charles Regional Medical Center (UMCRMC)
UM Upper Chesapeake Health (UCHS)
UM Capital Region Health (UMCRH)
UM Physician Networks (UMPN)
UMMS Outpatient Rx Weinberg
UMMC Pharmacy at Redwood
UMMS Pharmacy Services
UMMC Mid-Town Campus Pharmacy
UMMC Pharmacy at Capital Region
UMMC Pharmacy at Baltimore Washington

DEFINITIONS:

Federal Poverty Level	A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits.
Financial Hardship	Instances in which member organization charges incurred at UMMS member organizations for medically necessary treatment by a family household over a twelve (12) month period that exceeds 25% of that family's annual income.
MDH Limits	Refers to the income eligibility limits for reduced cost care, set by Maryland Department of Health (MDH) office of Medical Assistance Planning. The State of Maryland accepted the Federal Medicaid expansion on January 1, 2014 vs the Federal Poverty Levels, under the Affordable Care Act, which expanded the eligible income limits for Maryland Medicaid. UMMS adopted these new limits for the reduced cost care sliding scale, as set forth in Attachment A.
Medical Debt	Out-of-pocket expenses, including co-payments, coinsurance, and deductibles, incurred at UMMS member organizations for medically necessary treatment.
Presumptive Eligibility	Instances in which information provided by the patient or through other sources provides sufficient evidence that the patient is eligible for financial assistance, but there is no financial assistance form on file.

POLICY:

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

It is the policy of the University of Maryland Medical System ("UMMS") member organizations to provide financial assistance which meets or exceeds the requirements set forth by the State of Maryland for patients who meet specified financial criteria and request such assistance.

I. **Free Care -** Those with income up to 200% of the income eligibility limits established by the Maryland Department of Health are eligible for free care.

II. **Reduced Cost Care -** Those between 200% and 300% of the income eligibility limits established by the Maryland Department of Health are eligible for discounts on a sliding scale, as set forth in Attachment A.

III. **Financial Hardship -** Those who otherwise do not qualify for financial assistance under the primary guidelines of this policy, but for whom their medical debt incurred at all UMMS member organizations exceeds 25% of the Family Annual Household Income, are eligible for financial hardship assistance.

Payment plans are also available to all patients. Plan terms may be modified at the request of the patient. Additional information on payment plans is available in the UMMS Payment Plan Policy. UMMS retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent/urgent services, financial assistance applications will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

PROCEDURE:

I. How To Apply for Financial Assistance

For any episode of care, the financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent. Patients may voluntarily apply for financial assistance before or after receiving healthcare services, or they may be identified as potential candidates for financial assistance during the financial clearance process or a presumptive financial assistance eligibility screening.

Financial clearance is a process that determines a patient's ability and likelihood to pay. When possible effort will be made to provide financial clearance prior to date of service. During the financial clearance process, patients who indicate they are unemployed and have no insurance coverage will be required to submit a financial assistance application before receiving non-emergency medical care (unless they meet presumptive financial assistance eligibility criteria).

There will be one application process for all UMMS member organizations. UMMS will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications (and application requirements) in determining eligibility for the UMMS Financial Assistance program. Patients are required to provide a completed financial assistance application (with all required information and documentation), unless they meet the criteria for presumptive eligibility. To facilitate this process, each applicant must provide information about

family size and income. Oral submission of needed information will be accepted, where appropriate. UMMS will provide the financial assistance application to all patients regardless of health insurance status to all patients, including uninsured patients, and the application will be readily available on the UMMS website and by request.

Supporting Documentation for Financial Assistance Applications

To help applicants complete the process, required and suggested documentation will be clearly listed on the financial assistance application, including:

- A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable).
- If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
- A copy of their most recent pay stubs (if employed) or other evidence of income.
- A Medical Assistance Notice of Determination (if applicable).
- Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.
- If a patient submits both a copy of their most recent Federal Income Tax Return and a copy of their most recent pay stubs (or other evidence of income), and only one of the two documents indicates eligibility for financial assistance, the most recent document will dictate eligibility.

Financial assistance may not be denied based on the omission of information or documentation that is not specifically required in this policy or on the financial assistance application, and UMMS reserves the right to offer financial assistance to patients that have not provided all supporting documentation.

- If a patient submits a financial assistance application without the information or documentation required for a final determination of eligibility, a written request for the missing information or documentation will be sent to the patient.
- This written request will also contain the contact information (including telephone number and physical location) of the office or department that can provide information about financial assistance and assistance with the application process.
- The patient will have thirty (30) days from the date this written request is provided to submit the required information or documentation to be considered for eligibility. If no the information is not received within the 30 days, a letter will be sent notifying the patient that the case is now closed for lack of the required documentation.
- The patient may re-apply for financial assistance and initiate a new case by submitting the missing information or documentation

II. Reviewing and Determining Eligibility of Financial Assistance Applications

There are designated team members who will be responsible for taking financial assistance applications. These team members can be financial counselors, patient financial receivable coordinators, customer service representatives, or third party agencies working as an extension of the central business office. To help applicants complete the process, UMMS will provide the financial assistance application that will let them know what paperwork is required for a final determination of eligibility. Where possible, designated team

members will consult via phone or meet with patients who request financial assistance to determine if they meet preliminary criteria for assistance.

Preliminary data will be entered into a third party data exchange system which will allow the designated team member to track the application and determine eligibility for financial assistance. Designated team members will:

- Determine whether the patient has health insurance. Patients who have access to other medical coverage (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for financial assistance.
- If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the designated team member and recommendations shall be made to Senior Leadership.
- Complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage. To facilitate this process each applicant must provide information about family size and income.
- Determine whether the patient is presumptively eligible for free or reduced-cost care.
- Determine whether uninsured patients are eligible for public or private health insurance. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

To the extent practicable, the designated team members will offer assistance to uninsured patients if the patient chooses to apply for public or private health insurance, determine whether the patient is eligible for other public programs that may assist with health care costs, and use information available to UMMS to determine whether the patient is qualified for free or reduced-cost care under the UMMS Financial Assistance policy.

Within two business days of receipt of a patient's request for financial assistance or an application for medical assistance, UMMS must make a determination of probable eligibility. The determination of probable eligibility is subject to change, based on the receipt of supporting documentation.

If the patient's financial assistance application is determined to be complete and appropriate, the designated team member will recommend the patient's level of eligibility and forward for a second and final approval. UMMS will provide final determination the patient's eligibility within 14 days after the patient submits a completed application for financial assistance and suspend any billing or collections actions while eligibility is being determined.

If a Financial Assistance Application is Approved

Once a patient is approved for financial assistance, financial assistance coverage is effective for the month of determination and a year prior to the determination.

- A letter of final determination will be submitted to each patient who has formally requested financial assistance, which includes (if applicable): the assistance for which the individual is eligible and the basis for the determination.
- UMMS may decide to extend the financial assistance eligibility period further into the past or the future on a case-by-case basis.

- Financial assistance is generally applicable to all emergency and other medically necessary care provided by each UMMS member organization (See Exclusions for more information).
- If additional healthcare services are provided beyond the eligibility period, patients must reapply for financial assistance.
- If the patient is determined to be eligible for reduced-cost care, and has already received a statement for eligible healthcare services rendered during the financial assistance coverage period, the patient will also be provided with a billing statement that indicates the amount the patient owes for the care after financial assistance is applied.
- If a patient made payments for healthcare services prior to receiving approval for financial assistance, they may be eligible for a refund. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. If the amount that the patient is determined able to pay is less than the amount of the patient payment, the resulting credit balance will be issued to the patient as a refund if the amount exceeds the patient's determined responsibility by $5.00 or more. This includes determinations of eligibility for financial assistance within 240 days after the initial bill was provided.

If there are changes to the patient's income, assets, expenses or family status, the patient is expected to notify the Financial Assistance Department at 410-821-4140. To facilitate this process, and ensure that patients have the opportunity to be re-evaluated for eligibility for financial assistance within 240 days of the initial statement, UMMS will notify patients that if their income has changed, they should contact the Financial Assistance Program Department on each statement.

If a Financial Assistance Application is Not Approved

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

- If the patient is determined to be ineligible for financial assistance, and they applied in order to obtain financial clearance for non-emergent or non-urgent hospital based services, the designated team member will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
- A clinician may appeal this decision and request reconsideration by the Financial Clearance Executive Committee on a case-by case basis.
- For emergent or urgent services, financial assistance applications will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.
- Patients who are ineligible for financial assistance will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.
- The patient may appeal the decision, please see the Appeals section for more information.
- For any episode of care, the financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent.

III. Eligibility Criteria

UMMS will offer financial assistance when a review of a patient's individual financial circumstances has been conducted and documented. UMMS will not use a patient's citizenship or immigration status as an eligibility

requirement for financial assistance; or withhold financial assistance or deny a patient's application for financial assistance on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or on the basis of disability.

The following criteria will be applied in assessing a patient's eligibility for financial assistance, presumptive eligibility for financial assistance, and eligibility for financial hardship assistance.

Financial Assistance Eligibility

UMMS will refer to the MDH household income thresholds to determine eligibility for financial assistance and the level of free or reduced cost care to award to eligible patients. UMMS will calculate a patient's family (household) income at time of service. To account for any changes in financial circumstance, UMMS will recalculate family (household) income within 240 days after the initial hospital bill is provided.

UMMS may consider household monetary assets in determining eligibility for free and reduced-cost care under the financial assistance policy in addition to income-based criteria. Monetary assets shall be adjusted annually for inflation in accordance with the Consumer Price Index. The following monetary assets that are convertible to cash shall be excluded:

- At a minimum, the first $10,000 of monetary assets.
- A safe harbor equity of $150,000 in a primary residence.
- Retirement assets that the Internal Revenue Service has granted preferential tax treatment as a retirement account, including deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans.
- One motor vehicle used for the transportation needs of the patient or any family member of the patient;
- Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act.
- Prepaid higher education funds in a Maryland 529 Program account.

In determining the family income of a patient, UMMS shall apply a definition of household size that consists of the patient and, at a minimum, a spouse (regardless of whether the patient and spouse expect to file a joint federal or State tax return), biological children, adopted children, or stepchildren, and anyone for whom the patient claims a personal exemption in a federal or State tax return. For a patient who is a child, the household size shall consist of the child and biological parents, adopted parents, or stepparents or guardians, biological siblings, adopted siblings, or stepsiblings, and anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

Patients may be deemed ineligible for financial assistance:

- If they have insurance coverage (e.g., HMO, PPO, or Workers Compensation, Medicaid, or other insurance programs), that denies access to UMMS due to insurance plan restrictions/limits.
- If they refuse to be screened for other assistance programs prior to submitting an application for financial assistance.
- If they refuse to divulge information pertaining to a pending legal liability claim.

Financial assistance generally applies to all emergency and other medically necessary care provided by each UMMS member organization; however, the following exclusions may apply:

- Services provided by healthcare providers not affiliated with UMMS member organizations (e.g., durable medical equipment, home health services).
- Services denied by a patient's insurance program or policy (e.g., HMO, PPO, or Workers Compensation). Exceptions may be made on a case by case basis considering medical and programmatic implications.
- Cosmetic or other non-medically necessary services.
- Patient convenience items, meals, and lodging.
- Supervised Living accommodations and meals while a patient is in the Day Program.
- Third Party Liability claims (Auto Accident, Workers Compensation, Bodily Injury, or other legal claim) until all means of payment are exhausted.

Financial assistance for professional charges awarded under this policy applies to the UM Physician Network (UMPN). Patients who wish to pursue financial assistance for non-UM Physician Network charges must contact the physician or provider group directly. A list of providers delivering medically necessary care in each UMMS hospital can be obtained on the website of each UMMS entity. This list specifies which such as providers do not participate in the UMMS Financial Assistance Policy.

Presumptive Financial Assistance Eligibility

In the event there is no evidence to support a patient's eligibility for financial assistance, UMMS reserves the right to determine presumptive financial assistance eligibility for all hospital accounts. To determine presumptive eligibility for financial assistance, UMMS may use outside agencies or information to estimate income which can be used to assess the patient's eligibility for financial assistance eligibility. Due to the inherent nature of presumptive circumstances, UMMS will award free care to patients deemed presumptively eligible for financial assistance. Presumptive eligibility for financial assistance shall only cover the patient's specific date of service. UM Physician Network provider groups will offer financial assistance on a physician balance based on a determination of eligibility on a hospital balance.

Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

a. Active Medical Assistance pharmacy coverage
b. Specified Low Income Medicare (SLMB) coverage
c. Primary Adult Care (PAC) coverage
d. Homelessness
e. Patient currently has Medical Assistance coverage
f. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
g. Medical Assistance spend down amounts
h. Eligibility for other state or local assistance programs, such as:
    i) Supplemental Nutrition Assistance Program
    ii) State Energy Assistance Program
    iii) Special Supplemental Food Program for Women, Infants, and Children
    iv) Any other social service program as determined by MD DHMH and Health Services Cost Review Commission (HSCRC).

i. Patient is deceased with no known estate
j. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
k. Non-US Citizens deemed non-compliant
l. Non-Eligible Medical Assistance services for Medical Assistance eligible patients
m. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID)
n. Bankruptcy, by law, as mandated by the federal courts
o. Eligibility in certain UMMS clinical programs (including: St. Clare Outreach Program, UMMS Maternity Program, UMSJMC Hernia Program).

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

Financial Hardship Assistance Eligibility

Financial hardship assistance is available for patients who otherwise do not qualify for financial assistance under the primary guidelines of this policy, but for whom medical debt for medically necessary treatment over a twelve (12) month period exceeds 25% of that family's annual income.

- The amount of uninsured medical costs incurred at all UMMS member organizations will be considered in determining a patient's eligibility (including any accounts having gone to bad debt, except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses.
- For the patients who are eligible for reduced-cost care under the financial assistance criteria and also meet the criteria for financial hardship assistance criteria, UMMS will grant the total eligible reduction in charges.
- To calculate household income, UMMS will use the same criteria outlined in the Financial Assistance Eligibility section of this policy to calculate assets, household income, and family size.
- Once a patient is approved for financial hardship assistance, coverage will be effective for the month of the first qualifying date of service and a year prior to the determination. UMMS may decide to extend the financial hardship eligibility period further into the past or the future on a case-by-case basis.
- Financial hardship assistance will cover the patient and the eligible family members living in the household for the approved reduced cost and eligibility period for medically necessary care and will remain eligible for reduced-cost medically necessary care when seeking subsequent care at the same member organization during the 12–month period beginning on the date on which the reduced-cost medically necessary care was initially received. To avoid an unnecessary duplication of UMMS' determination of eligibility for free and reduced-cost care, the patient or eligible family members shall inform UMMS of the patient's or family member's eligibility for the reduced-cost medically necessary care.

All other eligibility, ineligibility, and procedures for primary financial assistance criteria apply to financial hardship assistance criteria, unless otherwise stated above.

IV. Appealing a Determination of Eligibility for Financial Assistance

Patients whose financial assistance applications are denied have the option to appeal the decision. Appeals can be initiated verbally or written. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

If a patient wishes to make an appeal, UMMS will:

- Notify the patient that the Health Education and Advocacy Unit is available to assist them or their authorized representative in filing and mediating a reconsideration request.
- Provide the address, phone number, facsimile number, e-mail address, mailing address, and website of the Health Education and Advocacy Unit: Office of the Attorney General, Health Education and Advocacy Unit | 200 St. Paul Place, 16th Floor, Baltimore, MD 21202 | Phone: (410) 528-1840 | Toll-free in Maryland 1-877-261-8807 | Fax: (410) 576-6571 | Email: heau@oag.state.md.us
- Document appeals within the third party data and workflow tool for review by the next level of management above the representative who denied the original application.
- Submit a letter of final determination to each patient who has formally submitted an appeal.

Provider Driven Financial Clearance and Reconsideration

Where there is a compelling educational, medical, and/or humanitarian benefit, UMMS clinical team members may request financial clearance of patients that are not otherwise able or likely to pay for their healthcare services. Clinical team members must submit appropriate justification in advance of the patient receiving services. UMMS Revenue Cycle central billing office will evaluate the patient's eligibility for Medical Assistance and financial assistance. A Financial Clearance Executive Committee at the member organization level, comprised of clinical and financial leadership, will request the information submitted by the requesting clinical and the central billing office and make the final determination on whether to grant financial clearance on a case-by-case basis.

If financially cleared, patients are still responsible to complete the financial assistance application process, and may be subject to presumptive eligibility screening, as outlined in this policy.

V. Notice of Availability of Financial Assistance

UMMS will advise patients, patient's families, and authorized representatives of the availability of financial assistance using posted notices and the Patient Billing and Financial Assistance Information Sheet. The Patient Billing and Financial Assistance Information Sheet notifies the patient of the availability of financial assistance and payment plans, includes a description of UMMS Financial Assistance Policy, explains how to apply for financial assistance, and includes a description of the patient's rights and obligations with regard to hospital billing and collection under the law.

- UMMS will post notices of financial assistance availability in each UMMS hospital's emergency room (if any), admissions areas, key patient access areas, and the hospital billing office. Notice of availability will also be sent to the patient with patient statements.
- The Patient Billing and Financial Assistance Information Sheet will be provided at preadmission and before discharge for each hospital encounter, with each hospital statement, and it will be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas.

- The Financial Assistance Policy and the Financial Assistance Application will also be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas.
- The Financial Assistance Policy, the Patient Billing and Financial Assistance Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UMMS website (www.umms.org).

Patient Billing and Financial Assistance Information Sheet Content

In addition to the content referenced above, the Patient Billing and Financial Assistance Information Sheet will include:

- The website and physical location(s) where patients can obtain copies of the financial assistance policy and financial assistance application form
- Instructions on how to obtain a free copy of the financial assistance policy and financial assistance application form by mail.
- A statement of the availability of translations of the financial assistance documents.
- Contact information for UMMS Hospital Billing Customer Service Department, which is available to assist the patient, the patient's family, or the patient's authorized representative understand their statement, understand the patient's rights and obligations regarding the statement, learn how to apply for free or reduced cost care, or learn how to apply for Maryland Medical Assistance, or any other programs that may help pay their medical bills.
- Contact information for the Maryland Medical Assistance Program.
- A notification that physician charges are not included in the hospital statement and are billed separately.
- A notification informing patients of the right to request and receive a written estimate of the total charges for hospital nonemergency services, procedures, and supplies that reasonably are expected to be provided for professional services by the hospital.
- A notification that a patients who are eligible for free or reduced care may not be charged more than AGB for emergency or other medically necessary care.
- A section that informs the patient of their ability to make a formal complaint with the HSCRC and the Office of the Attorney General of Maryland.
- A section for the patient to initial to indicate that they have been made aware of UMMS Financial Assistance Policy

The Patient Billing and Financial Assistance Information Sheet will be written in plain language, as specified by the Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r), and will be made available in the patient's preferred language. It will also include a section that allows for patients to initial that they have been made aware of the financial assistance policy.

VI. Extraordinary Collection Actions

Account balances that have not been paid may be transferred to Bad Debt (deemed uncompensated care) and referred to an outside collection agency or to UMMS's attorney for legal and/or collection activity. Third party agencies and/or attorneys are jointly and severally responsible for meeting the debt collection requirements listed in this policy, and in the UMMS Credits and Collections Policy. Collection activities taken on behalf of

UMMS by a collection agency or UMMS' attorney may include the following Extraordinary Collection Actions (ECAs):

- Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus. UMMS will not report adverse information to a consumer reporting agency regarding a patient who was uninsured or eligible for free or reduced-cost care at the time of service. UMMS will not report to a consumer reporting agency until at least 180 days after the initial statement was provided. Prior to reporting to a consumer reporting agency, UMMS will determines whether the patient is eligible for free or reduced-cost care. UMMS will not report adverse information about a patient to a consumer reporting agency if UMMS was notified in accordance with federal law by the patient or an insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days, or if UMMS has completed a requested reconsideration of the denial of free or reduced-cost care that was appropriately completed by the patient within the immediately preceding 60 days.
- Commencing a civil action against the individual. UMMS will not hold a spouse or another individual liable for the debt owed on a hospital bill of an individual who is at least 18 years old. UMMS will not file a civil action to collect debt until at least 180 days of after the initial bill was provided. Prior to filing the civil action, UMMS will determines whether the patient is eligible for free or reduced-cost care. UMMS will not file a civil action to collect debt if UMMS was notified in accordance with federal law by the patient or an insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days. UMMS will not file a civil action to collect debt if UMMS has completed a requested reconsideration of the denial of free or reduced-cost care that was appropriately completed by the patient within the immediately preceding 60 days.
- Attaching or seizing an individual's bank account or any other personal property.
- Garnishing an individual's wage. UMMS will not request a garnishment of wages or file an action that would result in an attachment of wages against a patient if the patient is eligible for free or reduced-cost care.

ECAs may be taken on accounts that have not been disputed or are not on a payment arrangement. ECAs will occur no earlier than 180 days from submission of first post-discharge bill to the patient and will be preceded by a written notice 45 days prior to commencement of the ECA. This written notice will be accompanied by an application for financial assistance (and instructions for completing the application) and a notice of availability of a payment plan to satisfy the medical debt, and the Patient Billing and Financial Assistance Information Sheet. The written notice will include the following information:

- Specified contact and procedural information.
    - The name and telephone number for UMMS,
    - The name and telephone number for the debt collector (if applicable)
    - The contact information for the UMMS Financial Assistance Department (or third party agency acting on behalf of UMMS), authorized to modify the terms of a payment plan (if applicable)
    - Telephone number and internet address of the Health Education Advocacy Unit in the Office of the Attorney General, available to assist patients experiencing medical debt.
- The amount required to satisfy the debt (including any past due payments, penalties, or fees, if applicable)

- Identification of ECAs that UMMS (or its collection agency, attorney, or other authorized party) intends to utilize in order to obtain payment for the care, and state a deadline after which such ECAs may be initiated.
- A deadline after which such ECA(s) may be initiated that is no earlier than 45 days after the date that the written notice is provided.
- A statement recommending that the patient seek debt counseling services,
- An explanation of the UMMS Financial Assistance Policy, and a notification of availability of financial assistance for eligible individuals
- And any other information as prescribed by the HSCRC

Written notice and accompanying documentation will be sent to the patient by certified mail and first class mail, in the patient's preferred language, or another language, as specified. The written notice will be in simplified language of at least 10 point type.

In addition to the written notification, UMMS (and/or its collection agency or attorney) will make reasonable efforts to orally communicate the availability of financial assistance to the patient and tell the patient how he or she may obtain assistance with the application process. A presumptive eligibility review will occur prior to any ECA being taken. Finally, no ECA will be initiated until approval has been obtained from the UMMS Revenue Cycle Services leadership.

If a patient is determined to be eligible for financial assistance, UMMS (and/or its collection agency or attorney) will take all reasonably available measures to reverse any ECAs taken against the patient to obtain payment for care rendered during the financial assistance eligibility window. Such reasonably available measures will include measures to vacate any judgment against the patient, lift levies or liens on the patient's property, and remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau. All ECAs will cease once the patient is approved for financial assistance and all the patient responsible balances are paid.

UMMS will not engage in the following ECAs:

- Selling debt to another party.
- Charge interest on bills incurred by patients before a court judgement is obtained
- Requesting a lien against a patient's primary residence. In some cases, Local, State, or Federal judicial protocols may mandate that a lien is placed, but UMMS will not force the sale or foreclosure of a patient's primary residence.
- Request the issuance of or take action causing a court to issue a body attachment or an arrest warrant against a patient.
- Make a claim against the estate of a deceased patient if the deceased patient was known by UMMS to be eligible for free care or if the value of the estate after tax obligations are fulfilled is less than half of the debt owned. However, UMMS may offer the family of the deceased patient the ability to apply for financial assistance.
- Require payment of medical debt prior to providing medically necessary care.

ATTACHMENTS:

ATTACHMENT A: Sliding Scale – Reduced Cost of Care

2022 Federal Poverty Limits (FPL) Annual Income Eligibility Limit Guidelines							
House-hold (HH) Size	1	2	3	4	5	6	See UMMS Charity Thresholds below
Income Limit (up to Max)	$13,590	$18,310	$23,030	$27,750	$32,470	$37,190	

2022 Maryland Dept of Health (MDH) Annual Income Eligibility Limit Guidelines							
House-hold (HH) Size	1	2	3	4	5	6	See UMMS Charity Thresholds below
Income Limit (up to Max)	$18,768	$25,272	$31,800	$38,304	$44,808	$51,336	

UMMS Financial Assistance Charity Income Thresholds							
If your total annual household (HH) income level is at or below:							You are eligible for the following level of charity at UMMS:
House-hold (HH) Size	1	2	3	4	5	6	
Income Limit (up to Max)	$37,536	$50,544	$63,600	$76,608	$89,616	$102,672	**100% Charity** (Equals Up to 200% of MDH Annual Income limits)
Income Limit (up to Max)	$39,413	$53,071	$66,780	$80,438	$94,097	$107,806	**90% Charity** (Equals Up to 210% of MDH Annual Income limits)
Income Limit (up to Max)	$41,290	$55,598	$69,960	$84,269	$98,578	$112,939	80% Charity (Equals Up to 220% of MDH Annual Income limits)
Income Limit (up to Max)	$43,166	$58,126	$73,140	$88,099	$103,058	$118,073	**70% Charity** (Equals Up to 230% of MDH Annual Income limits)
Income Limit (up to Max)	$45,043	$60,653	$76,320	$91,930	$107,539	$123,206	60% Charity (Equals Up to 240% of MDH Annual Income limits)
Income Limit (up to Max)	$46,920	$63,180	$79,500	$95,760	$112,020	$128,340	**50% Charity** (Equals Up to 250% of MDH Annual Income limits)
Income Limit (up to Max)	$48,797	$65,707	$82,680	$99,590	$116,501	$133,474	40% Charity (Equals Up to 260% of MDH Annual Income limits)
Income Limit (up to Max)	$50,674	$68,234	$85,860	$103,421	$120,982	$138,607	**30% Charity** (Equals Up to 270% of MDH Annual Income limits)
Income Limit (up to Max)	$52,550	$70,762	$89,040	$107,251	$125,462	$143,741	**20% Charity** (Equals Up to 280% of MDH Annual Income limits)
Income Limit (up to Max)	$56,303	$75,815	$95,399	$114,911	$134,423	$154,007	**10% Charity** (Equals Up to 290% of MDH Annual Income limits)

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

Effective 7/1/22

RELATED POLICIES:
UMMS Credit & Collections Policy
UMMS Payment Plan Policy

POLICY OWNER:
UMMS Revenue Cycle Services

APPROVED:
Executive Compliance Committee Approved Initial Policy: 09/18/19
Executive Compliance Committee Approved Revisions: 10/19/2020, 11/07/22

This policy was approved by the UMMS Executive Compliance Committee (ECC) Board on October 19, 2020.
This policy was adopted for:

- UM St. Joseph Medical Center (UMSJMC) effective June 1, 2013.
- UM Midtown Campus (MTC) effective September 22, 2014.
- UM Baltimore Washington Medical Center (UMBWMC) effective July 1, 2016.
- UM Shore Regional Health (UMSRH) effective September 1, 2017.
- UM Charles Regional Medical Center (UMCRMC) effective December 2, 2018.
- UM Upper Chesapeake Health (UCHS) effective July 1, 2019
- UM Capital Region Health (UMCRH) effective September 18, 2019

EXHIBIT 31

carf INTERNATIONAL

CARF Accreditation Report

for

University of Maryland Shore Regional Health/Requard Center for Acute Rehabilitation

Three-Year Accreditation

CARF International Headquarters
6951 E. Southpoint Road
Tucson, AZ 85756-9407, USA

www.carf.org

Contents

About CARF

CARF is an independent, nonprofit accreditor of health and human services, enhancing the lives of persons served worldwide.

The accreditation process applies CARF's internationally recognized standards during a site survey conducted by peer surveyors. Accreditation, however, is an ongoing process that distinguishes a provider's service delivery and signals to the public that the provider is committed to continuous performance improvement, responsive to feedback, and accountable to the community and its other stakeholders.

CARF accreditation promotes providers' demonstration of value and Quality Across the Lifespan® of millions of persons served through application of rigorous organizational and program standards organized around the ASPIRE to Excellence® continuous quality improvement framework. CARF accreditation has been the recognized benchmark of quality health and human services for more than 50 years.

For more information or to contact CARF, please visit www.carf.org/contact-us.

Organization

University of Maryland Shore Regional Health/Requard Center for Acute Rehabilitation
219 South Washington Street
Easton, MD 21601

Organizational Leadership

Stephen Wills, MD, Medical Director

Survey Number

140775

Survey Date(s)

February 4, 2021–February 5, 2021

Surveyor(s)

Pamela Tamulevicius, DESS Administrative
Melissa Bourgeois, SLP, DESS Program

Program(s)/Service(s) Surveyed

Inpatient Rehabilitation Programs - Hospital (Adults)
Inpatient Rehabilitation Programs - Hospital: Stroke Specialty Program (Adults)

Previous Survey

February 5, 2018–February 6, 2018
Three-Year Accreditation

Accreditation Decision

Three-Year Accreditation
Expiration: April 30, 2024

Executive Summary

This report contains the findings of CARF's site survey of University of Maryland Shore Regional Health/Requard Center for Acute Rehabilitation conducted February 4, 2021–February 5, 2021. This report includes the following information:

- Documentation of the accreditation decision and the basis for the decision as determined by CARF's consideration of the survey findings.
- Identification of the specific program(s)/service(s) and location(s) to which this accreditation decision applies.
- Identification of the CARF surveyor(s) who conducted the survey and an overview of the CARF survey process and how conformance to the standards was determined.
- Feedback on the organization's strengths and recognition of any areas where the organization demonstrated exemplary conformance to the standards.
- Documentation of the specific sections of the CARF standards that were applied on the survey.
- Recommendations for improvement in any areas where the organization did not meet the minimum requirements to demonstrate full conformance to the standards.
- Any consultative suggestions documented by the surveyor(s) to help the organization improve its program(s)/service(s) and business operations.

Accreditation Decision

On balance, University of Maryland Shore Regional Health/Requard Center for Acute Rehabilitation demonstrated substantial conformance to the standards. Requard Center of Acute Rehabilitation's leadership and personnel demonstrate a dedication to providing quality rehabilitation services and embrace a core philosophy of continuous program improvement. The program demonstrates a high level of leadership and commitment to the person-centered approach to rehabilitation. An opportunity for improvement exists in facilitating infection control within the rehabilitation gyms. Requard Center of Acute Rehabilitation is recognized for providing quality services and is encouraged to continue to remain current with the CARF standards during its next period of accreditation.

University of Maryland Shore Regional Health/Requard Center for Acute Rehabilitation appears likely to maintain and/or improve its current method of operation and demonstrates a commitment to ongoing quality improvement. University of Maryland Shore Regional Health/Requard Center for Acute Rehabilitation is required to submit a post-survey Quality Improvement Plan (QIP) to CARF that addresses all recommendations identified in this report.

University of Maryland Shore Regional Health/Requard Center for Acute Rehabilitation has earned a Three-Year Accreditation. The leadership team and staff are complimented and congratulated for this achievement. In order to maintain this accreditation, throughout the term of accreditation, the organization is required to:

- Submit annual reporting documents and other required information to CARF, as detailed in the Accreditation Policies and Procedures section in the standards manual.
- Maintain ongoing conformance to CARF's standards, satisfy all accreditation conditions, and comply with all accreditation policies and procedures, as they are published and made effective by CARF.

Survey Details

Survey Participants

The survey of University of Maryland Shore Regional Health/Requard Center for Acute Rehabilitation was conducted by the following CARF surveyor(s):

- Pamela Tamulevicius, DESS Administrative
- Melissa Bourgeois, SLP, DESS Program

CARF considers the involvement of persons served to be vital to the survey process. As part of the accreditation survey for all organizations, CARF surveyors interact with and conduct direct, confidential interviews with consenting current and former persons served in the program(s)/service(s) for which the organization is seeking accreditation. In addition, as applicable and available, interviews may be conducted with family members and/or representatives of the persons served such as guardians, advocates, or members of their support system.

Interviews are also conducted with individuals associated with the organization, as applicable, which may include:

- The organization's leadership, such as board members, executives, owners, and managers.
- Business unit resources, such as finance and human resources.
- Personnel who serve and directly interact with persons served in the program(s)/service(s) for which the organization is seeking accreditation.
- Other stakeholders, such as referral sources, payers, insurers, and fiscal intermediaries.
- Community constituents and governmental representatives.

Survey Activities

Achieving CARF accreditation involves demonstrating conformance to the applicable CARF standards, evidenced through observable practices, verifiable results over time, and comprehensive supporting documentation. The survey of University of Maryland Shore Regional Health/Requard Center for Acute Rehabilitation and its program(s)/service(s) consisted of the following activities:

- Confidential interviews and direct interactions, as outlined in the previous section.
- Direct observation of the organization's operations and service delivery practices.
- Observation of the organization's location(s) where services are delivered.
- Review of organizational documents, which may include policies; plans; written procedures; promotional materials; governing documents, such as articles of incorporation and bylaws; financial statements; and other documents necessary to determine conformance to standards.
- Review of documents related to program/service design, delivery, outcomes, and improvement, such as program descriptions, records of services provided, documentation of reviews of program resources and services conducted, and program evaluations.
- Review of records of current and former persons served.

Program(s)/Service(s) Surveyed

The survey addressed by this report is specific to the following program(s)/service(s):

- Inpatient Rehabilitation Programs - Hospital (Adults)
- Inpatient Rehabilitation Programs - Hospital: Stroke Specialty Program (Adults)

A list of the organization's accredited program(s)/service(s) by location is included at the end of this report.

Representations and Constraints

The accreditation decision and survey findings contained in this report are based on an on-balance consideration of the information obtained by the surveyor(s) during the site survey. Any information that was unavailable, not presented, or outside the scope of the survey was not considered and, had it been considered, may have affected the contents of this report. If at any time CARF subsequently learns or has reason to believe that the organization did not participate in the accreditation process in good faith or that any information presented was not accurate, truthful, or complete, CARF may modify the accreditation decision, up to and including revocation of accreditation.

Survey Findings

This report provides a summary of the organization's strengths and identifies the sections of the CARF standards that were applied on the survey and the findings in each area. In conjunction with its evaluation of conformance to the specific program/service standards, CARF assessed conformance to its business practice standards, referred to as Section 1. ASPIRE to Excellence, which are designed to support the delivery of the program(s)/service(s) within a sound business operating framework to promote long-term success.

The specific standards applied from each section vary based on a variety of factors, including, but not limited to, the scope(s) of the program(s)/service(s), population(s) served, location(s), methods of service delivery, and survey type. Information about the specific standards applied on each survey is included in the standards manual and other instructions that may be provided by CARF.

Areas of Strength

CARF found that University of Maryland Shore Regional Health/Requard Center for Acute Rehabilitation demonstrated the following strengths:

- Requard Center of Acute Rehabilitation is supported by the dedicated Shore Hospital leadership team that strives to live the vision of being a leading center of excellence in providing regional services with a national impact. This is evidenced by the roles Shore Regional Health and Requard Center of Acute Rehabilitation have taken to support and address the community needs and disparities identified in its five-county region.
- Requard Center of Acute Rehabilitation is supported by a knowledgeable rehabilitation leadership team that is committed to person-centered care and enhancing the lives of the persons served, as demonstrated in the outcomes of discharge to community and readmission rates.
- The safety and well-being of the persons served are the highest priority as evidenced by leadership and team members providing oversight, feedback, and training. The team has demonstrated significant adaptability during the COVID-19 pandemic, ensuring that the highest level of safety is maintained for staff and persons served.

- Requard Center of Acute Rehabilitation demonstrates the commitment to communication and teamwork through the use of daily safety huddles, comprehensive communication boards in the rooms pf persons served for updated status from all team members, and use of the goal passport to communicate goals to all team members and persons served.
- The human resources team provides support for an environment dedicated to the professional growth of employees through detailed performance evaluations, benefits packages, and recognition programs. There is an effort to recognize the recruitment and retention needs of the rehabilitation unit and share that with the larger organization.
- Requard Center of Acute Rehabilitation is commended for the use of a town hall model in the communities served to identify the ongoing needs, opportunities for growth, and concerns of the persons served throughout the continuum of the healthcare system.
- The leadership is recognized for the use of leadership rounding, stand-up meetings, and town halls as consistent ways to gather feedback from the staff and as a method of continued employee engagement and ongoing performance improvement.
- The stroke specialty rehabilitation team has an innovative idea of creating a celebration program, inviting graduates of its program back for a social and information gathering session, allowing the stroke survivors to share their continued success and give feedback for program improvements.
- Using feedback from past persons served, the stroke specialty team recognized the need for early identification of depression within its stroke population and worked with management to implement a depression screening protocol to be used with persons served.
- The medical director is enthusiastic about rehabilitation and has a holistic team approach. Persons served report that the medical director is approachable, responsive, and eager to provide education. Additionally, the medical director's expertise in pain management is of significant added value to the team.
- Referral sources are consistently impressed with the speed of response to inquiries.

Opportunities for Quality Improvement

The CARF survey process identifies opportunities for continuous improvement, a core concept of "aspiring to excellence." This section of the report lists the sections of the CARF standards that were applied on the survey, including a description of the business practice area and/or the specific program(s)/service(s) surveyed and a summary of the key areas addressed in that section of the standards.

In this section of the report, a recommendation identifies any standard for which CARF determined that the organization did not meet the minimum requirements to demonstrate full conformance. All recommendations must be addressed in a QIP submitted to CARF.

In addition, consultation may be provided for areas of or specific standards where the surveyor(s) documented suggestions that the organization may consider to improve its business or service delivery practices. Note that consultation may be offered for areas of specific standards that do not have any recommendations. Such consultation does not indicate nonconformance to the standards; it is intended to offer ideas that the organization might find helpful in its ongoing quality improvement efforts. The organization is not required to address consultation.

When CARF surveyors visit an organization, their role is that of independent peer reviewers, and their goal is not only to gather and assess information to determine conformance to the standards, but also to engage in relevant and meaningful consultative dialogue. Not all consultation or suggestions discussed during the survey are noted in this report. The organization is encouraged to review any notes made during the survey and consider the consultation or suggestions that were discussed.

During the process of preparing for a CARF accreditation survey, an organization may conduct a detailed self-assessment and engage in deliberations and discussions within the organization as well as with external stakeholders as it considers ways to implement and use the standards to guide its quality improvement efforts. The organization is encouraged to review these discussions and deliberations as it considers ways to implement innovative changes and further advance its business and service delivery practices.

Section 1. ASPIRE to Excellence®

1.A. Leadership

Description

CARF-accredited organizations identify leadership that embraces the values of accountability and responsibility to the individual organization's stated mission. The leadership demonstrates corporate social responsibility.

Key Areas Addressed

- Leadership structure and responsibilities
- Person-centered philosophy
- Organizational guidance
- Leadership accessibility
- Cultural competency and diversity
- Corporate responsibility
- Organizational fundraising, if applicable

Recommendations

There are no recommendations in this area.

1.C. Strategic Planning

Description

CARF-accredited organizations establish a foundation for success through strategic planning focused on taking advantage of strengths and opportunities and addressing weaknesses and threats.

Key Areas Addressed

- Environmental considerations
- Strategic plan development, implementation, and periodic review

Recommendations

There are no recommendations in this area.

1.D. Input from Persons Served and Other Stakeholders

Description

CARF-accredited organizations continually focus on the expectations of the persons served and other stakeholders. The standards in this subsection direct the organization's focus to soliciting, collecting, analyzing, and using input from all stakeholders to create services that meet or exceed the expectations of the persons served, the community, and other stakeholders.

Key Areas Addressed

- Collection of input
- Integration of input into business practices and planning

Recommendations

There are no recommendations in this area.

1.E. Legal Requirements

Description

CARF-accredited organizations comply with all legal and regulatory requirements.

Key Areas Addressed

- Compliance with obligations
- Response to legal action
- Confidentiality and security of records

Recommendations

There are no recommendations in this area.

1.F. Financial Planning and Management

Description

CARF-accredited organizations strive to be financially responsible and solvent, conducting fiscal management in a manner that supports their mission, values, and performance objectives. Fiscal practices adhere to established accounting principles and business practices. Fiscal management covers daily operational cost management and incorporates plans for long-term solvency.

Key Areas Addressed

- Budgets
- Review of financial results and relevant factors
- Fiscal policies and procedures
- Reviews of bills for services and fee structures, if applicable
- Safeguarding funds of persons served, if applicable
- Review/audit of financial statements

Recommendations

There are no recommendations in this area.

1.G. Risk Management

Description

CARF-accredited organizations engage in a coordinated set of activities designed to control threats to their people, property, income, goodwill, and ability to accomplish goals.

Key Areas Addressed

- Risk management plan implementation and periodic review
- Adequate insurance coverage
- Media relations and social media procedures
- Reviews of contract services

Recommendations

There are no recommendations in this area.

1.H. Health and Safety

Description

CARF-accredited organizations maintain healthy, safe, and clean environments that support quality services and minimize risk of harm to persons served, personnel, and other stakeholders.

Key Areas Addressed

- Competency-based training on safety procedures and practices
- Emergency procedures
- Access to first aid and emergency information
- Critical incidents
- Infection control
- Health and safety inspections

Recommendations

There are no recommendations in this area.

Consultation

- The organization has identified fall prevention as an area of focus for the current year. It is suggested that the organization consider a greater visual presence of fall tracking. An example of this could be a wall calendar that identifies fall-free days as green blocks, falls without injury as yellow blocks, and falls with injury as red blocks.

1.I. Workforce Development and Management

Description

CARF-accredited organizations demonstrate that they value their human resources and focus on aligning and linking human resources processes, procedures, and initiatives with the strategic objectives of the organization. Organizational effectiveness depends on the organization's ability to develop and manage the knowledge, skills, abilities, and behavioral expectations of its workforce. The organization describes its workforce, which is often composed of a diverse blend of human resources. Effective workforce development and management promote engagement and organizational sustainability and foster an environment that promotes the provision of services that center on enhancing the lives of persons served.

Key Areas Addressed

- Composition of workforce
- Ongoing workforce planning
- Verification of background/credentials/fitness for duty

- Workforce engagement and development
- Performance appraisals
- Succession planning

Recommendations

There are no recommendations in this area.

1.J. Technology

Description

Guided by leadership and a shared vision, CARF-accredited organizations are committed to exploring and, within their resources, acquiring and implementing technology systems and solutions that will support and enhance:

- Business processes and practices.
- Privacy and security of protected information.
- Service delivery.
- Performance management and improvement.
- Satisfaction of persons served, personnel, and other stakeholders.

Key Areas Addressed

- Ongoing assessment of technology and data use
- Technology and system plan implementation and periodic review
- Technology policies and procedures
- Written procedures for the use of information and communication technologies (ICT) in service delivery, if applicable
- ICT instruction and training, if applicable
- Access to ICT information and assistance, if applicable
- Maintenance of ICT equipment, if applicable
- Emergency procedures that address unique aspects of service delivery via ICT, if applicable

Recommendations

There are no recommendations in this area.

1.K. Rights of Persons Served

Description

CARF-accredited organizations protect and promote the rights of all persons served. This commitment guides the delivery of services and ongoing interactions with the persons served.

Key Areas Addressed

- Policies that promote rights of persons served
- Communication of rights to persons served
- Formal complaints by persons served

Recommendations

There are no recommendations in this area.

1.L. Accessibility

Description

CARF-accredited organizations promote accessibility and the removal of barriers for the persons served and other stakeholders.

Key Areas Addressed

- Assessment of accessibility needs and identification of barriers
- Accessibility plan implementation and periodic review
- Requests for reasonable accommodations

Recommendations

There are no recommendations in this area.

1.M. Performance Measurement and Management

Description

CARF-accredited organizations demonstrate a culture of accountability by developing and implementing performance measurement and management plans that produce information an organization can act on to improve results for the persons served, other stakeholders, and the organization itself.

The foundation for successful performance measurement and management includes:

- Leadership accountability and support.
- Mission-driven measurement.
- A focus on results achieved for the persons served.
- Meaningful engagement of stakeholders.
- An understanding of extenuating and influencing factors that may impact performance.
- A workforce that is knowledgeable about and engaged in performance measurement and management.
- An investment in resources to implement performance measurement and management.
- Measurement and management of business functions to sustain and enhance the organization.

Key Areas Addressed

- Leadership accountability for performance measurement and management
- Identification of gaps and opportunities related to performance measurement and management
- Input from stakeholders
- Performance measurement and management plan
- Identification of objectives and performance indicators for service delivery
- Identification of objectives and performance indicators for priority business functions
- Personnel training on performance measurement and management

Recommendations

There are no recommendations in this area.

Consultation

- The organization has chosen to use a length of stay and change score from the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) as a measure of efficiency. A focus area for the organization is improving the accuracy of scoring to capture the greatest burden of care upon admission and ensuring that the scores are obtained over the indicated timeframes for compliance to most accurately represent the skills level of the person served. The organization might consider the use of a peer auditor for therapy and nursing scoring who could observe interactions, review the medical record, and discuss opportunities to capture the greatest burden of care.

1.N. Performance Improvement

Description

CARF-accredited organizations demonstrate a culture of performance improvement through their commitment to proactive and ongoing review, analysis, reflection on their results in both service delivery and business functions, and transparency. The results of performance analysis are used to identify and implement data-driven actions to improve the quality of programs and services and to inform decision making. Performance information that is accurate and understandable to the target audience is shared with persons served, personnel, and other stakeholders in accordance with their interests and needs.

Key Areas Addressed

- Analysis of service delivery performance
- Analysis of business function performance
- Identification of areas needing performance improvement
- Implementation of action plans
- Use of performance information to improve program/service quality and make decisions
- Communication of performance information

Recommendations

There are no recommendations in this area.

Consultation

- The organization might consider the addition of its outcomes measures to its website or the Shore Medical Center social media page as a way to achieve greater reach in informing stakeholders and the persons served of the quality outcomes of its programs. Additionally, the organization might consider creating documents that could be emailed to referral sources or potential persons served that could provide an opportunity to share outcomes and highlights of the rehabilitation program. It might also consider the value in providing targeted success stories of persons served to case managers or referral sources as an opportunity to share the benefit and outcome of an individual person served in the rehabilitation program. This could also serve as an opportunity to further communicate admission criteria and appropriate acute rehabilitation referrals.

Section 2. The Rehabilitation and Service Process for the Persons Served

Description

The fundamental responsibilities of the organization are to effect positive change in functional ability and independence and self-reliance across environments, while protecting and promoting the rights of the persons served. The persons served should be treated with dignity and respect at all times. All personnel are able to demonstrate their awareness of the rights of the persons served as well as their own rights. The rehabilitation and

service process is delivered by an integrated team that includes the person served. The process focuses on clarity of information, efficient use of resources, reduction of redundancy in service delivery, achievement of predicted outcomes, and reintegration of the person served into his or her community of choice.

2.A. Program/Service Structure for all Medical Rehabilitation Programs

Key Areas Addressed

- Scope of the program and services
- Admission and transition/exit criteria
- Team communication
- Provision of services to any persons who require ventilatory assistance
- Provision of services related to skin integrity and wound care, when applicable

Recommendations

There are no recommendations in this area.

Consultation

- The organization is in the process of implementing standardization of job titles to support a clinical ladder program for nurses and clinicians. Using this as an incentive, leadership may consider also encouraging nursing and therapy staff to pursue specialty certifications.
- Staff members have identified adequately assessing and monitoring skin integrity as an area for growth following trends toward increased occurrences. The organization's leadership may consider utilizing specialists in its acute care setting for more advanced staff training and wound staging observation on persons in the acute care setting as a way to increase staff competency and confidence.

2.B. The Rehabilitation and Service Process for the Persons Served

Key Areas Addressed

- Scope of the program services
- Appropriate placement in and movement through the continuum of services
- Admission and ongoing assessments
- Information provided to persons served for decision making
- Team composition
- Team responsibilities and communication
- Medical director/physician providing medical input qualifications and responsibilities
- Discharge/transition planning and recommendations
- Family/support system involvement
- Education and training of persons served and families/support systems
- Sharing of outcomes information with the persons served
- Physical plant
- Behavior management
- Records of the persons served

Recommendations

2.B.41.d.

There is not currently a system in place for marking therapy surfaces as clean/dirty, creating a low but potential risk for two persons who utilize a surface without cleaning occurring between use. It is recommended that the physical plant of the program facilitate infection control. The program could adopt a means of clearly identifying clean/dirty surfaces in the gym via use of a laminated clean/dirty sign placed on the equipment. It is noted the organization has already begun to implement this idea.

Consultation

- Personnel, including occupational therapy and nursing, actively engage persons served in leisure activities. The program could consider including a list of leisure activities on the goal passport for the person served, which may serve to increase utilization as a diversional activity during non-therapy times.
- Given the COVID-19 pandemic-related restrictions on visitation, clergy have not been allowed to visit their parishioners who are in rehab. It is suggested that the program utilize local streaming services from community places of worship as a way to assist persons served in attending worship virtually.

2.D. The Rehabilitation and Service Process for Specific Diagnostic Categories

Key Areas Addressed

- Provision of services to any persons with limb loss, acquired brain injury, or spinal cord dysfunction
- Personnel demonstrate competency in limb loss, acquired brain injury, or spinal cord injury
- Provision or linkages with other entities for specialty services

Recommendations

There are no recommendations in this area.

Section 3. Program Standards

3.A. Comprehensive Integrated Inpatient Rehabilitation Program

Description

A Comprehensive Integrated Inpatient Rehabilitation Program is a program of coordinated and integrated medical and rehabilitation services that is provided 24 hours a day and endorses the active participation and preferences of the person served throughout the entire program. The preadmission assessment of the person served determines the program and setting that will best meet the needs of the person served. The person served, in collaboration with the interdisciplinary team members, identifies and addresses his or her medical and rehabilitation needs. The individual resource needs and predicted outcomes of the person served drive the appropriate use of the rehabilitation continuum of services, the provision of care, the composition of the interdisciplinary team, and discharge to the community of choice.

The scope and intensity of care provided are based on a medical and rehabilitation preadmission assessment of the person served. An integrated interdisciplinary team approach is reflected throughout all activities. To ensure the transparency of information the program provides a disclosure statement to each person served that addresses the scope and intensity of care that will be provided.

A Comprehensive Integrated Inpatient Rehabilitation Program clearly identifies the scope and value of the medical and rehabilitation services provided. Dependent on the medical stability and acuity of the person served, a Comprehensive Integrated Inpatient Rehabilitation Program may be provided in a hospital, skilled nursing facility, long-term care hospital, acute hospital (Canada), or hospital with transitional rehabilitation beds (Canada). Through a written scope of services, each program defines the services provided, intensity of services, frequency of services, variety of services, availability of services, and personnel skills and competencies. Information about the scope of services and outcomes achieved is shared by the program with stakeholders.

Key Areas Addressed

- Preadmission assessment
- Privileging process
- Appropriate placement in the continuum of services
- Secondary prevention
- Rehabilitation nursing services
- Rehabilitation physician/medical services and management
- Program-specific information-gathering requirements
- Information gathering regarding durability of outcomes

Recommendations

There are no recommendations in this area.

Section 4. Specialty Program Designation Standards

4.F. Stroke Specialty Program

Description

A stroke specialty program, through application of the research available to clinical practice, delivers services that focus on the unique needs of persons who have sustained a stroke, including:

- Minimizing impairments and secondary complications.
- Reducing activity limitations.
- Maximizing participation and quality of life.
- Decreasing environmental barriers.
- Preventing recurrent stroke.

The program recognizes the individuality, preferences, strengths, and needs of the persons served and their families/support systems. A stroke specialty program assists the persons served and their families/support systems to manage their own health, encourages their appropriate use of healthcare systems and services, and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span. The program provides ongoing access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles.

A stroke specialty program partners with the persons served, families/support systems, and providers within and outside of rehabilitation throughout phases of care from emergency through community-based services. A stroke specialty program fosters an integrated system of care that optimizes prevention, recovery, adaptation, and participation.

A stroke specialty program contributes to the development of stroke systems of care by partnering with providers within and outside of rehabilitation to increase access to services by advocating for persons who have sustained a stroke to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large. A stroke specialty program utilizes current research and evidence to provide effective rehabilitation and supports future improvements in care by advocating for or participating in stroke research.

Key Areas Addressed

- Intervention services provided for persons served and their families/support systems
- Prevention of recurrent stroke and the complications of stroke
- Reducing activity limitations and decreasing environmental barriers
- Continuum of services
- Health assessments and promotion of wellness
- Education for persons served and their families/support systems
- Maximizing participation and quality of life
- Discharge/transition recommendations
- Data collection and analysis regarding the effectiveness of the program
- Evidence of long-term positive outcomes

Recommendations

There are no recommendations in this area.

Consultation

- The staff currently conducts a post-stroke support and education group that is now open to persons served via video conferencing. Once the COVID-19 pandemic restrictions are lifted, the program may consider developing a peer mentor program for persons served with members of the outpatient support group. It might also consider rebranding the brochures for the education group to further promote the availability of a rehabilitation service program within the community.
- Requard Center for Acute Rehabilitation may consider expanding its community-based education programs to include periodic presentations on topics related to stroke prevention for the general population within its community.
- Participation in research projects is available through the University of Maryland Hospital system and nursing staff members have participated in projects. It is suggested that the leadership consider also encouraging therapy staff members to participate in existing research or develop their own projects.
- The use of an ultra-high fall classification could be a proactive means of identifying those persons served who may be at higher risk for falls. The use of the daily safety huddle could also help to ensure that all staff members are aware of those persons who are at higher risk.

Program(s)/Service(s) by Location

University of Maryland Shore Regional Health/Requard Center for Acute Rehabilitation

219 South Washington Street
Easton, MD 21601

Inpatient Rehabilitation Programs - Hospital (Adults)
Inpatient Rehabilitation Programs - Hospital: Stroke Specialty Program (Adults)

EXHIBIT 32

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES	POLICY NO:	
		REVIEWED:	
UM SMC at Dorchester	Special Behavioral Health Population Treatment Protocols	PAGE #:	
		SUPERSEDES	

PURPOSE: To establish any special procedure necessary for the safe management and treatment of special behavioral health populations.

SCOPE: All Shore Behavioral Health Personnel

POLICY:

1.0 Definitions:

Special Behavioral Health Population: Patients with characteristics and or diagnoses that place them outside of the typical patient group admitted and treated on the Shore Behavioral Health Inpatient Psychiatric Unit.

Medically Compromised Patients: Patients whose ability to engage in activities of daily living may be impaired because of medical condition.

Geriatric: Patients above the age of 65.

Intellectual Disability: Patients whose registration, retention, and or processing of sensory inputs has been undeveloped, disrupted, deteriorated, or damaged.

2.0 Background:

Shore Behavioral Health (SBH) Inpatient Psychiatric Unit is focused on the treatment of the general, adult psychiatric population. Typical diagnosis include affective disorders, psychosis, bipolar illness, and suicidality. Patient ages range from 18 years and greater. Patients are able to effectively participate in group, individual, and milieu therapy. Patients may have some minor medical conditions. They may have a secondary co-occurring, substance misuse conditions

3.0 Policy

3.1 SBH makes adjustments in its care and treatment to meet the special population needs of its patients so long as the efficacy of treatment and the safety of care is not unduly compromised.

4.0 Guidance for Specialty Populations

4.1 Patients with Medical Complications

4.1.1 Admissions Considerations

4.1.1.1 No IV pumps

4.1.1.2 No room isolation cases

4.1.1.3 No bed bound patient

4.1.2 Room Assignment
- **4.1.2.1** Patients will be placed in one of two medical rooms within close proximity of nurse's station.

4.1.3 Alternative treatment
- **4.1.3.1** Patients will be transferred to medical service
- **4.1.3.2** Follow-up to be provided by consulting psychiatrist with assistance from Behavioral Health Response Team (BHRT).

4.1.4 Related Policies

4.2 Geriatric Patients

4.2.1 Admissions Considerations
- **4.2.1.1** No limitation on admission if patient can participate and benefit from milieu setting and treatment.
- **4.2.1.2** Hospitalist consult is recommended
- **4.2.1.3** Fall risk assessment and precautions to be implemented

4.2.2 Room Assignment
- **4.2.2.1** Consider placement close to nurse's station.
- **4.2.2.2** Consider single room as appropriate

4.3 Intellectual Disability

4.3.1 Admissions considerations
- **4.3.1.1** No limitation if patient is able to participate and benefit from milieu setting and treatment.
- **4.3.1.2** Physical acting out behavior will need to be closely evaluated for impact on milieu and safety of other patients.

4.3.2 Room Assignment
- **4.3.2.1** Consider single room to decrease stimulation
- **4.3.2.2** Proximity to nursing station should also be considered depending on patient's presentation.

4.4 Child and Adolescent Patients

4.4.1 Admission Considerations
- **4.4.1.1** Patients under 18 years of age will not be admitted
- **4.4.1.2** Patients may be evaluated for admission to the Pediatric Unit with follow-up by psychiatry and Behavioral Health Response Team.
- **4.4.1.3** Patients not appropriate for the above option will be transferred to an available bed in a child/adolescent psychiatric unit at another hospital.

4.5 Co-occurring Substance Use Disorder

4.5.1 Admission Considerations
- **4.5.1.1** Patients with a psychiatric diagnosis as well as a co-occurring substance use disorder are appropriate for admission.
- **4.5.1.2** Medical detox is not provided on the inpatient psychiatric unit.

4.5.2 Treatment Considerations
- **4.5.2.1** The unit provides a daily, specialized Substance Use Disorder related group.

4.5.2.2 Patients are assigned to a therapist with experience working with this population

4.6 Pregnant Patients

4.6.1 Admission Considerations

4.6.1.1 Refer to Behavioral Health Admissions Policy

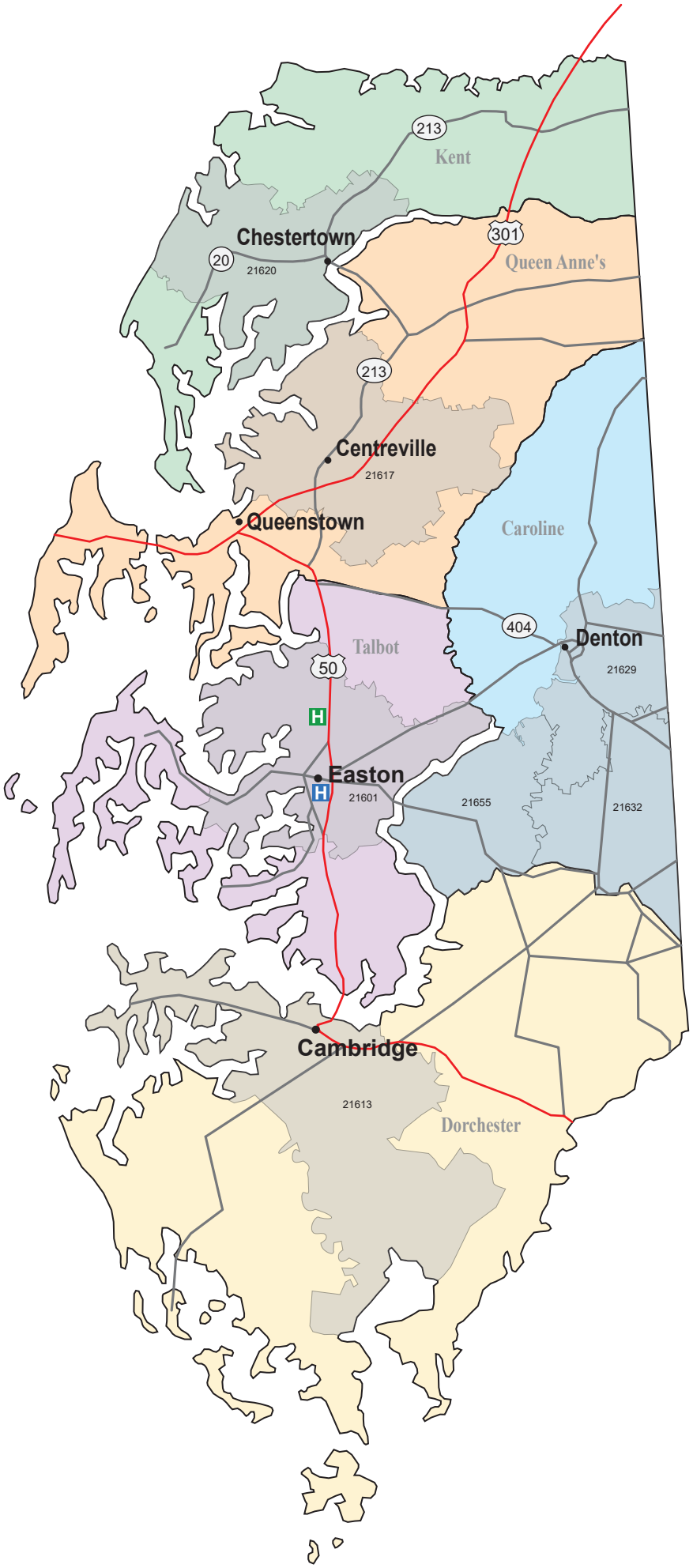
4.6.1.2 Certain limitations apply as specified in the Admissions Policy.

4.6.1.3 Commitment from Obstetrics to consult on case during treatment is a requirement for admission.

Policy	
Effective	
Revised/ Reviewed	
Policy Owner	Shore Behavioral Health Leadership Team
Approved by:	Shore Behavioral Health Leadership Team

REFERENCE: Behavioral Health Admissions Policy

EXHIBIT 33



- H Current Hospital Location
- H Proposed New Hospital Location
- Primary Service Areas
- Kent County
- Queen Anne's County
- Caroline County
- Talbot County
- Dorchester County

EXHIBIT 34

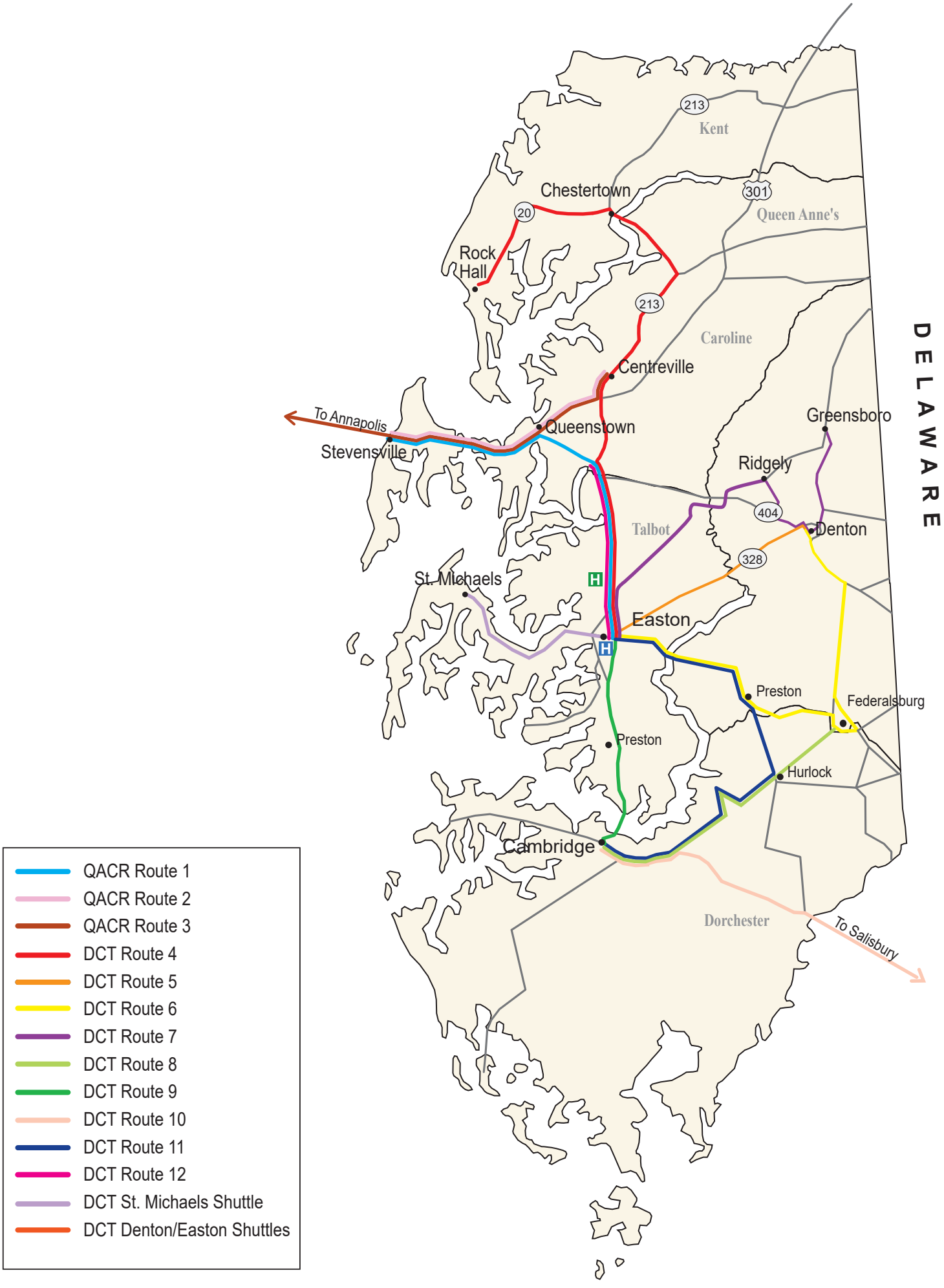

Kent
Queen Anne's
Caroline
Talbot
Dorchester
DELAWARE
213
301
20
404
328
Chestertown
Rock Hall
Centreville
Queenstown
To Annapolis
Stevensville
Greensboro
Ridgely
Denton
St. Michaels
Easton
Preston
Federalsburg
Hurlock
Cambridge
To Salisbury
QACR Route 1
QACR Route 2
QACR Route 3
DCT Route 4
DCT Route 5
DCT Route 6
DCT Route 7
DCT Route 8
DCT Route 9
DCT Route 10
DCT Route 11
DCT Route 12
DCT St. Michaels Shuttle
DCT Denton/Easton Shuttles

EXHIBIT 35

EASTON

AIRPORT

NORTH EASTON

IDLEWILD PARK

SPRING HILL CEM.

SPRING HILL CEM.

NEW REGIONAL MEDICAL CTR

UM SHORE MEDICAL CTR

GOLDSBOROUGH CREEK

GLEBE CREEK

TRED AVON RIVER

JACKS COVE

Hosewells Branch

Galloway Run

Wootenaux

Tred Avon

GOLDSBOROUGH NECK RD

HALLEM SCHOOL RD

COSS SCHOOL RD

LONGWOODS RD

HINERS LA

OCEAN GATEWAY

CORDOVA RD

OLD CORDOVA RD

KLONDIKE RD

COLDSBOROUGH NECK RD

AIRPORT RD

C036

BLACK DOG ALLEY

CHAPEL RD

C0272

GLEBE RD

MARLBORO AVE

ST. MICHAELS RD

EASTON PKWY

WASHINGTON ST

EASTON RAIL TRAIL

AURORA ST

BAY ST

FEDERAL ST

WEST ST

S WASHINGTON ST

PORT ST

N WASHINGTON ST TO EASTON RAIL TRAIL

GOLDSBORO RD

IDLEWILD AVE

CAULK LA

MARTIN CT

MARVEL CT

PURDY ST

CYNWOOD DR

DUTCHMANS PINTAIL DR

CANVASBACK TEAL DR

PEACH BLOSSOM RD

DOVER RD

MATTHEWSTOWN RD

50

309

322

328

331

334

662

EXHIBIT 36

TABLE F. STATISTICAL PROJECTIONS - UM SMC at Easton

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

	Two Most Recent Years (Actual)		Current Year Budgeted	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.								
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
1. DISCHARGES												
a. MSGA	3,822	3,862	3,944	4,004	4,065	4,129	4,194	4,260	4,329	4,400	4,472	4,547
Total MSGA	**3,822**	**3,862**	**3,944**	**4,004**	**4,065**	**4,129**	**4,194**	**4,260**	**4,329**	**4,400**	**4,472**	**4,547**
b. Pediatrics	8	27	27	27	27	27	27	27	27	27	27	27
c. Obstetrics	1,030	999	1,004	1,012	1,020	1,028	1,036	1,044	1,052	1,060	1,069	1,077
e. Psych	-	266	350	351	352	353	355	356	478	480	481	483
f. Rehabilitation	312	191	198	206	214	222	231	239	249	259	269	279
Total Acute	**5,172**	**5,345**	**5,523**	**5,599**	**5,678**	**5,759**	**5,842**	**5,927**	**6,135**	**6,225**	**6,318**	**6,413**
g. Other (Specify/add rows of needed)												
TOTAL DISCHARGES	**5,172**	**5,345**	**5,523**	**5,599**	**5,678**	**5,759**	**5,842**	**5,927**	**6,135**	**6,225**	**6,318**	**6,413**
2. PATIENT DAYS												
a. MSGA	18,810	21,786	22,224	22,469	22,720	22,978	23,242	23,619	24,006	24,403	24,812	25,231
Total MSGA	**18,810**	**21,786**	**22,224**	**22,469**	**22,720**	**22,978**	**23,242**	**23,619**	**24,006**	**24,403**	**24,812**	**25,231**
b. Pediatrics	20	72	72	72	72	72	72	72	72	72	72	72
c. Obstetrics	1,865	1,892	1,901	1,916	1,931	1,946	1,962	1,977	1,993	2,008	2,024	2,040
e. Psych	-	1,469	2,014	2,033	2,052	2,071	2,091	2,111	2,854	2,882	2,910	2,938
f. Rehabilitation	3,040	2,197	2,280	2,367	2,457	2,550	2,648	2,750	2,857	2,967	3,083	3,203
Total Acute	**23,735**	**27,416**	**28,492**	**28,857**	**29,232**	**29,618**	**30,015**	**30,529**	**31,781**	**32,333**	**32,900**	**33,485**
g. Other (Specify/add rows of needed)												
TOTAL PATIENT DAYS	**23,735**	**27,416**	**28,492**	**28,857**	**29,232**	**29,618**	**30,015**	**30,529**	**31,781**	**32,333**	**32,900**	**33,485**

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Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)												
a. MSGA	4.9	5.6	5.6	5.6	5.6	5.6	5.5	5.5	5.5	5.5	5.5	5.5
Total MSGA	**4.9**	**5.6**	**5.6**	**5.6**	**5.6**	**5.6**	**5.5**	**5.5**	**5.5**	**5.5**	**5.5**	**5.5**
b. Pediatrics	2.5	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7
c. Obstetrics	1.8	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9
e. Psych	-	5.5	5.8	5.8	5.8	5.9	5.9	5.9	6.0	6.0	6.0	6.1
f. Rehabilitation	9.7	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5
Total Acute	**4.6**	**5.1**	**5.2**	**5.2**	**5.1**	**5.1**	**5.1**	**5.2**	**5.2**	**5.2**	**5.2**	**5.2**
g. Other (Specify/add rows of needed)												
TOTAL AVERAGE LENGTH OF STAY	**4.6**	**5.1**	**5.2**	**5.2**	**5.1**	**5.1**	**5.1**	**5.2**	**5.2**	**5.2**	**5.2**	**5.2**
4. NUMBER OF LICENSED BEDS												
a. MSGA	70	75	76	77	78	79	80	81	82	84	85	86
Total MSGA	**70**	**75**	**76**	**77**	**78**	**79**	**80**	**81**	**82**	**84**	**85**	**86**
b. Pediatrics	1	1	1	1	1	1	1	1	1	1	1	1
c. Obstetrics	11	10	10	11	11	11	11	11	11	11	11	11
e. Psych	-	8	8	8	8	8	8	8	11	11	11	12
f. Rehabilitation	11	8	8	9	9	9	10	10	10	11	11	12
Total Acute	**93**	**102**	**103**	**106**	**107**	**108**	**110**	**111**	**115**	**118**	**119**	**122**
g. Other (Specify/add rows of needed)												
TOTAL LICENSED BEDS	**93**	**102**	**103**	**106**	**107**	**108**	**110**	**111**	**115**	**118**	**119**	**122**

TABLE F. STATISTICAL PROJECTIONS - UM SMC at Easton

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Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*												
a. MSGA	73.6%	79.6%	80.0%	79.8%	80.0%	80.0%	80.0%	79.8%	80.0%	80.0%	80.0%	79.8%
Total MSGA	**73.6%**	**79.6%**	**80.0%**	**79.8%**	**80.0%**	**80.0%**	**80.0%**	**79.8%**	**80.0%**	**80.0%**	**80.0%**	**79.8%**
b. Pediatrics	5.5%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%
c. Obstetrics	46.5%	51.8%	52.1%	47.6%	48.1%	48.5%	48.9%	49.1%	49.6%	50.0%	50.4%	50.7%
e. Psych	0.0%	50.3%	69.0%	69.4%	70.3%	70.9%	71.6%	72.1%	71.1%	71.8%	72.5%	66.9%
f. Rehabilitation	75.7%	75.2%	78.1%	71.8%	74.8%	77.6%	72.6%	75.1%	78.3%	73.9%	76.8%	72.9%
Total Acute	**69.9%**	**73.7%**	**75.7%**	**74.4%**	**75.0%**	**75.4%**	**75.0%**	**75.2%**	**75.6%**	**75.3%**	**75.8%**	**74.7%**
i. Other (Specify/add rows of needed)												
TOTAL OCCUPANCY %	**69.9%**	**73.7%**	**75.7%**	**74.4%**	**75.0%**	**75.4%**	**75.0%**	**75.2%**	**75.6%**	**75.3%**	**75.8%**	**74.7%**
6. OUTPATIENT VISITS (RVU's)												
a. Emergency Department - Easton	25,546	25,393	25,610	25,833	26,062	26,297	26,539	26,788	27,043	27,306	27,576	27,854
d. Same Day Surgery	4,328	4,467	4,538	4,538	4,538	4,538	4,538	4,538	4,538	4,538	4,538	4,538
e. Laboratory RVU's	3,053,290	3,492,427	3,522,275	3,552,935	3,584,435	3,616,801	3,650,064	3,684,252	3,719,396	3,755,529	3,792,682	3,830,890
f. Imaging RVU's	659,226	735,797	742,085	748,545	755,182	762,001	769,008	776,211	783,616	791,228	799,056	807,106
g. MRI RVU's	3,053,290	3,492,427	3,522,275	3,552,935	3,584,435	3,616,801	3,650,064	3,684,252	3,719,396	3,755,529	3,792,682	3,830,890
TOTAL OUTPATIENT VISITS (RVU's)	**6,795,680**	**7,750,511**	**7,816,784**	**7,884,787**	**7,954,651**	**8,026,439**	**8,100,214**	**8,176,041**	**8,253,990**	**8,334,130**	**8,416,534**	**8,501,279**

TABLE F. STATISTICAL PROJECTIONS - UM SMC at Easton

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

	Two Most Recent Years (Actual)		Current Year Budgeted	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.								
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
7. OBSERVATIONS**												
a. Number of Patients - Easton	3,581	3,602	3,633	3,664	3,697	3,730	3,765	3,800	3,836	3,873	3,912	3,951
b. Hours - Easton	93,658	150,523	150,291	150,084	149,900	149,741	149,607	149,498	149,415	149,358	149,327	149,323

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

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

TABLE G. REVENUES & EXPENSES, UNINFLATED - UM SMC at Easton & SHS Unregulated

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

	Two Most Recent Years (Actual)		Current Year Budgeted	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.								
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
1. REVENUE												
a. Inpatient Services	$111,566	$126,543	$122,858	$122,675	$123,276	$123,732	$124,173	$124,090	$131,531	$131,439	$131,363	$131,287
b. Outpatient Services	$172,055	$204,244	$186,661	$ 188,048	$ 188,341	$ 188,391	$ 188,433	$ 188,245	$ 201,238	$ 201,036	$ 200,859	$ 200,681
Gross Patient Service Revenues	***$ 283,621***	***$ 330,787***	***$ 309,519***	***$ 310,724***	***$ 311,617***	***$ 312,123***	***$ 312,605***	***$ 312,336***	***$ 332,769***	***$ 332,475***	***$ 332,221***	***$ 331,968***
c. Deductions	$57,479	$60,086	$57,528	$ 57,752	$ 57,918	$ 58,012	$ 58,102	$ 58,052	$ 61,850	$ 61,795	$ 61,748	$ 61,701
Net Patient Services Revenue	***$ 226,142***	***$ 270,701***	***$ 251,991***	***$ 252,971***	***$ 253,699***	***$ 254,110***	***$ 254,503***	***$ 254,284***	***$ 270,919***	***$ 270,680***	***$ 270,474***	***$ 270,267***
d. Grants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
e. Other Operating Revenue	$ 12,462	$ 11,145	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405
NET OPERATING REVENUE	***$ 238,604***	***$ 281,846***	***$ 259,396***	***$ 260,377***	***$ 261,104***	***$ 261,516***	***$ 261,909***	***$ 261,689***	***$ 278,325***	***$ 278,085***	***$ 277,879***	***$ 277,672***
2. EXPENSES												
a. Salaries & Wages (including benefits)	$ 90,231	$ 101,632	$ 102,118	$ 100,163	$ 98,284	$ 96,544	$ 94,864	$ 95,251	$ 95,782	$ 96,305	$ 96,833	$ 97,366
b. Contractual Services	$ 35,553	$ 50,470	$ 50,580	$ 50,580	$ 50,484	$ 50,391	$ 50,303	$ 50,303	$ 50,018	$ 50,018	$ 50,018	$ 50,018
c. Interest on Current Debt	$ 1,810	$ 2,532	$ 4,557	$ 4,476	$ 4,387	$ 4,299	$ 4,213	$ 4,128	$ 4,045	$ 3,963	$ 3,883	$ 3,805
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,694	$ 15,362	$ 15,014	$ 14,647
e. Current Depreciation and Amortization	$ 14,224	$ 13,334	$ 18,559	$ 16,387	$ 15,578	$ 15,764	$ 15,080	$ 15,152	$ 12,809	$ 13,358	$ 14,002	$ 14,648
f. Project Depreciation and Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 27,961	$ 27,961	$ 27,961	$ 27,961
g. Supplies	$ 30,386	$ 32,660	$ 32,911	$ 29,036	$ 28,526	$ 28,066	$ 27,654	$ 27,848	$ 28,101	$ 28,276	$ 28,453	$ 28,632
h. Professional Fees	$ 12,664	$ 11,797	$ 15,089	$ 15,177	$ 15,240	$ 15,302	$ 15,366	$ 15,430	$ 15,526	$ 15,624	$ 15,723	$ 15,823
i. Insurance & Other	$ 2,887	$ 3,715	$ 4,181	$ 4,181	$ 4,181	$ 4,181	$ 4,181	$ 4,181	$ 4,181	$ 4,181	$ 4,181	$ 4,181
j. Fixed Cost Additions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL OPERATING EXPENSES	**$187,755**	**$216,140**	**$227,994**	**$220,000**	**$216,681**	**$214,549**	**$211,661**	**$212,293**	**$254,116**	**$255,048**	**$256,068**	**$257,080**
3. INCOME												
a. Income From Operation	**$ 50,849**	**$ 65,706**	**$ 31,402**	**$ 40,377**	**$ 44,423**	**$ 46,967**	**$ 50,248**	**$ 49,396**	**$ 24,208**	**$ 23,037**	**$ 21,811**	**$ 20,592**
b. Non-Operating Income	$ 28,052	$ (20,369)	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187
SUBTOTAL	***$ 78,901***	***$ 45,337***	***$ 46,589***	***$ 55,564***	***$ 59,611***	***$ 62,154***	***$ 65,435***	***$ 64,583***	***$ 39,396***	***$ 38,224***	***$ 36,998***	***$ 35,779***
c. Income Taxes												
NET INCOME (LOSS)	***$ 78,901***	***$ 45,337***	***$ 46,589***	***$ 55,564***	***$ 59,611***	***$ 62,154***	***$ 65,435***	***$ 64,583***	***$ 39,396***	***$ 38,224***	***$ 36,998***	***$ 35,779***

TABLE G. REVENUES & EXPENSES, UNINFLATED - UM SMC at Easton & SHS Unregulated

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

	Two Most Recent Years (Actual)		Current Year Budgeted	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.								
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
4. PATIENT MIX												
a. Percent of Total Revenue												
1) Medicare	55.7%	55.7%	55.7%	55.7%	55.7%	55.7%	55.7%	55.7%	55.7%	55.7%	55.7%	55.7%
2) Medicaid	18.5%	18.5%	18.5%	18.5%	18.5%	18.5%	18.5%	18.5%	18.5%	18.5%	18.5%	18.5%
3) Blue Cross	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
4) Commercial Insurance	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%
5) Self-pay	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
6) Other	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days												
1) Medicare	59.2%	59.2%	59.2%	59.2%	59.2%	59.2%	59.2%	59.2%	59.2%	59.2%	59.2%	59.2%
2) Medicaid	22.9%	22.9%	22.9%	22.9%	22.9%	22.9%	22.9%	22.9%	22.9%	22.9%	22.9%	22.9%
3) Blue Cross	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%
4) Commercial Insurance	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
5) Self-pay	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
6) Other	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Note: Values presented do not include Easton allocations of Shore Medical Group losses, which totaled $19.48M in FY2021 and $18.49M in FY2022. These will need to be added back in order to reconcile to the audited financial statements

Table G – Key Financial Projection Assumptions for UM SMC at Easton & SHS Unregulated (Uninflated)

Projection is based on the UM SMC at Easton & SHS Unregulated FY2023 budgeted revenues and expenses with assumptions identified below. These amounts do not include allocations of physician losses from Shore Medical Group

Projection period reflects FY2024 – FY2032

Volumes	— See Table F of the application for volume projections
Patient Revenue	
• FY2024	
○ HSCRC Inflation Factor	— 0.00%
○ Quality Adjustments	— -0.12%
○ Other Rates	— 0.40%
○ Volume	— 0.05%
— Total	0.33%
• FY2025	
○ HSCRC Inflation Factor	— 0.00%
○ Quality Adjustments	— 0.00%
○ Other Rates	— 0.03%
○ Volume	— 0.05%
— Total	0.08%
• FY2026+	
○ HSCRC Inflation Factor	— 0.00%
○ Quality Adjustments	— 0.00%
○ Other Rates	— -0.10%
○ Volume	— 0.05%
— Total	-0.05%
• Deductions from Gross Revenue	— 18.6%
• Revenue Enhancements	— In FY2029, Shore Health System will request a full rate adjustment of $24.0M, equal to 50% of depreciation and interest related to the project — Includes an HSCRC Markup factor of 1.1
Other Revenue	
• Other Operating Revenue Inflation	— 2.0%
Expenses	
• Inflation	
○ Salaries & Benefits	— 0.0%
○ Professional Fees	— 0.0%
○ Supplies	— 0.0%
○ Purchased Services	— 0.0%
○ Insurance & Other	— 0.0%
• Volume Variability	
○ Salaries & Benefits	— 45.0%
○ Professional Fees	— 80.0%
○ Supplies	— 50.0%
○ Purchased Services	— 50.0%
○ Insurance & Other	— 0.0%
• Interest Expense	
○ Project Debt	— Interest expense on $333.3M proceeds from a 30-year issuance of debt at an interest rate of 5%
• Depreciation and Amortization	— Reflects depreciation on a $539.6M project with a weighted average useful life of 19.2 years
• Shore Medical Group Physician Loss Allocations	— Easton allocations of Shore Medical Group physician losses, totaling $19.48M in FY2021 and $18.49M in FY2022 are not included in this projection. This will need to be added back in order to reconcile to the audited financial statements
• Performance Improvements	
○ Indentified PI:	
— Agency Reductions	— $6.0M by FY2027
— FTE Savings	— $2.5M by FY2027
— 340B Savings	— $4.0M in drug savings & $1.0M in other savings by FY2027
— Inventory Management	— $2.0M by FY2027
— Other PI	— $0.5M by FY2027
○ Total Identified PI:	— $15.0M by FY2027 (cumulative)
○ Unindentified PI:	— No unidentified PI included in the projection

TABLE H. REVENUES & EXPENSES, INFLATED - UM SMC at Easton & SHS Unregulated

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

	Two Most Recent Years (Actual)		Current Year Budgeted	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.								
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
1. REVENUE												
a. Inpatient Services	$ 111,566	$ 126,543	$ 122,858	$ 125,719	$ 129,538	$ 133,288	$ 137,134	$ 140,501	$ 152,691	$ 156,448	$ 160,297	$ 164,240
b. Outpatient Services	$ 172,055	$ 204,244	$ 186,661	$ 192,714	$ 197,908	$ 202,941	$ 208,101	$ 213,142	$ 233,613	$ 239,287	$ 245,100	$ 251,053
Gross Patient Service Revenues	***$ 283,621***	***$ 330,787***	***$ 309,519***	***$ 318,433***	***$ 327,446***	***$ 336,230***	***$ 345,235***	***$ 353,643***	***$ 386,304***	***$ 395,735***	***$ 405,396***	***$ 415,293***
c. Deductions	$ 57,479	$ 60,086	$ 57,528	$ 59,185	$ 60,860	$ 62,493	$ 64,167	$ 65,729	$ 71,800	$ 73,553	$ 75,348	$ 77,188
Net Patient Services Revenue	***$ 226,142***	***$ 270,701***	***$ 251,991***	***$ 259,248***	***$ 266,586***	***$ 273,737***	***$ 281,068***	***$ 287,914***	***$ 314,504***	***$ 322,182***	***$ 330,048***	***$ 338,105***
d. Grants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
e. Other Operating Revenue	$ 12,462	$ 11,145	$ 7,405	$ 7,553	$ 7,704	$ 7,859	$ 8,016	$ 8,176	$ 8,340	$ 8,506	$ 8,676	$ 8,850
NET OPERATING REVENUE	***$ 238,604***	***$ 281,846***	***$ 259,396***	***$ 266,801***	***$ 274,290***	***$ 281,595***	***$ 289,084***	***$ 296,090***	***$ 322,844***	***$ 330,689***	***$ 338,724***	***$ 346,955***
2. EXPENSES												
a. Salaries & Wages (including benefits)	$ 90,231	$ 101,632	$ 102,118	$ 103,167	$ 104,270	$ 105,496	$ 106,771	$ 110,422	$ 114,368	$ 118,443	$ 122,666	$ 127,040
b. Contractual Services	$ 35,553	$ 50,470	$ 50,580	$ 51,591	$ 52,523	$ 53,476	$ 54,449	$ 55,538	$ 56,328	$ 57,455	$ 58,604	$ 59,776
c. Interest on Current Debt	$ 1,810	$ 2,532	$ 4,557	$ 4,476	$ 4,387	$ 4,299	$ 4,213	$ 4,128	$ 4,045	$ 3,963	$ 3,883	$ 3,805
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,694	$ 15,362	$ 15,014	$ 14,647
e. Current Depreciation and Amortization	$ 14,224	$ 13,334	$ 18,559	$ 16,387	$ 15,578	$ 15,764	$ 15,080	$ 15,152	$ 12,809	$ 13,358	$ 14,002	$ 14,648
f. Project Depreciation and Amortization	$ -	$ -	$ -	$ -	$ -	$ -			$ 27,961	$ 27,961	$ 27,961	$ 27,961
g. Supplies	$ 30,386	$ 32,660	$ 32,911	$ 30,082	$ 30,617	$ 31,208	$ 31,856	$ 33,235	$ 34,744	$ 36,219	$ 37,757	$ 39,363
h. Professional Fees	$ 12,664	$ 11,797	$ 15,089	$ 15,633	$ 16,168	$ 16,721	$ 17,294	$ 17,887	$ 18,539	$ 19,216	$ 19,918	$ 20,645
i. Insurance and Other	$ 2,887	$ 3,715	$ 4,181	$ 4,265	$ 4,350	$ 4,437	$ 4,526	$ 4,616	$ 4,709	$ 4,803	$ 4,899	$ 4,997
TOTAL OPERATING EXPENSES	**$187,755**	**$216,140**	**$227,994**	**$225,601**	**$227,893**	**$231,402**	**$234,190**	**$240,979**	**$289,197**	**$296,780**	**$304,703**	**$312,882**
3. INCOME												
a. Income From Operation	**$ 50,849**	**$ 65,706**	**$ 31,402**	**$ 41,200**	**$ 46,397**	**$ 50,194**	**$ 54,894**	**$ 55,110**	**$ 33,647**	**$ 33,909**	**$ 34,021**	**$ 34,073**
b. Non-Operating Income	$ 28,052	$ (20,369)	$ 15,187	$ 15,491	$ 15,801	$ 16,117	$ 16,439	$ 16,768	$ 14,303	$ 17,445	$ 17,794	$ 18,150
SUBTOTAL	***$ 78,901***	***$ 45,337***	***$ 46,589***	***$ 56,691***	***$ 62,198***	***$ 66,311***	***$ 71,334***	***$ 71,879***	***$ 47,950***	***$ 51,354***	***$ 51,816***	***$ 52,223***
c. Income Taxes	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NET INCOME (LOSS)	***$ 78,901***	***$ 45,337***	***$ 46,589***	***$ 56,691***	***$ 62,198***	***$ 66,311***	***$ 71,334***	***$ 71,879***	***$ 47,950***	***$ 51,354***	***$ 51,816***	***$ 52,223***

TABLE H. REVENUES & EXPENSES, INFLATED - UM SMC at Easton & SHS Unregulated

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

	Two Most Recent Years (Actual)		Current Year Budgeted	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.								
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
4. PATIENT MIX												
a. Percent of Total Revenue												
1) Medicare	55.7%	55.7%	55.7%	55.7%	55.7%	55.7%	55.7%	55.7%	55.7%	55.7%	55.7%	55.7%
2) Medicaid	18.5%	18.5%	18.5%	18.5%	18.5%	18.5%	18.5%	18.5%	18.5%	18.5%	18.5%	18.5%
3) Blue Cross	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
4) Commercial Insurance	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%
5) Self-pay	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
6) Other	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days												
Total MSGA												
1) Medicare	59.2%	59.2%	59.2%	59.2%	59.2%	59.2%	59.2%	59.2%	59.2%	59.2%	59.2%	59.2%
2) Medicaid	22.9%	22.9%	22.9%	22.9%	22.9%	22.9%	22.9%	22.9%	22.9%	22.9%	22.9%	22.9%
3) Blue Cross	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%
4) Commercial Insurance	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
5) Self-pay	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
6) Other	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Note: Values presented do not include Easton allocations of Shore Medical Group losses, which totaled $19.48M in FY2021 and $18.49M in FY2022. These will need to be added back in order to reconcile to the audited financial statements

Table H – Key Financial Projection Assumptions for UM SMC at Easton & SHS Unregulated (Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the UM SMC at Easton & SHS Unregulated FY2023 budgeted revenues and expenses with assumptions identified below. These amounts do not include allocations of physician losses from Shore Medical Group

Projection period reflects FY2024 – FY2032

Volumes	— See Table F of the application for volume projections
Patient Revenue	
• FY2024	
○ HSCRC Inflation Factor	— 2.48%
○ Quality Adjustments	— -0.12%
○ Other Rates	— 0.40%
○ Volume	— 0.05%
— Total	2.81%
• FY2025	
○ HSCRC Inflation Factor	— 2.50%
○ Quality Adjustments	— 0.00%
○ Other Rates	— 0.03%
○ Volume	— 0.05%
— Total	2.58%
• FY2026+	
○ HSCRC Inflation Factor	— 2.50%
○ Quality Adjustments	— 0.00%
○ Other Rates	— -0.10%
○ Volume	— 0.05%
— Total	2.45%
• Deductions from Gross Revenue	— 18.6%
• Revenue Enhancements	— In FY2029, Shore Health System will request a full rate adjustment of $24.0M, equal to 50% of depreciation and interest related to the project — Includes an HSCRC Markup factor of 1.1
Other Revenue	
• Other Operating Revenue Inflation	— 2%
Expenses	
• Inflation	
○ Salaries & Benefits	— 3.0%
○ Professional Fees	— 3.6%
○ Supplies	— 3.0%
○ Purchased Services	— 2.0%
○ Insurance & Other	— 2.0%
• Volume Variability	
○ Salaries & Benefits	— 45%
○ Professional Fees	— 80%
○ Supplies	— 50%
○ Purchased Services	— 50%
○ Insurance & Other	— 0%
• Interest Expense	
○ Project Debt	— Interest expense on $333.3M proceeds from a 30-year issuance of debt at an interest rate of 5%
• Depreciation and Amortization	— Reflects depreciation on a $539.6M project with a weighted average useful life of 19.2 years
• Shore Medical Group Physician Loss Allocations	— Easton allocations of Shore Medical Group physician losses, totaling $19.48M in FY2021 and $18.49M in FY2022 are not included in this projection. This will need to be added back in order to reconcile to the audited financial statements
• Performance Improvements	
○ Indentified PI:	
— Agency Reductions	— $6.0M by FY2027
— FTE Savings	— $2.5M by FY2027
— 340B Savings	— $4.0M in drug savings & $1.0M in other savings by FY2027
— Inventory Management	— $2.0M by FY2027
— Other PI	— $0.5M by FY2027
○ Total Identified PI:	— $15.0M by FY2027 (cumulative)
○ Unindentified PI:	— No unidentified PI included in the projection

EXHIBIT 37

UM SMC at Easton
Equipment List for Re-Use at Replacement Hospital

Department	Equipment Description	Ext Qty
Level 1 - Emergency Department	**Description**	
	Defibrillator, Monitor, w/Pacing	2
	Pump, Infusion, Single	2
Level 1 - Imaging	**Description**	
	Defibrillator, Monitor, w/Pacing	1
	Pump, Infusion, Controller, Modular	1
	Pump, Infusion, Single	2
	Pump, Infusion, Single, MRI	1
	X-Ray Unit, General Radiography, Digital	2
	X-Ray Unit, Interventional, Angio / Cardiac (Bi-Plane)	1
Level 2 - Prep & Recovery Area	**Description**	
	Pump, Infusion, Controller, Modular	35
	Pump, Infusion, Single	35
Level 2 - Stat Lab	**Description**	
	Analyzer, Allowance	1
	Analyzer, Lab, Blood Culture	3
	Analyzer, Lab, Blood Typing	1
	Analyzer, Lab, Coagulation, Plasma, Benchtop	1
	Analyzer, Lab, Coagulation, Plasma, Floor	1
	Analyzer, Lab, Coagulation, Portable	2
	Analyzer, Lab, DNA Amplification	1
	Analyzer, Lab, Hematology, Benchtop	1
	Analyzer, Lab, Immunoassay, Countertop	1
	Analyzer, Lab, Immunoassay, Fetal Fibronectin fFN	1
	Analyzer, Lab, Molecular Testing Real Time PCR	1
	Analyzer, Lab, Urinalysis, Automated	1
	Processor, Cell	2
	Workstation, Grossing, Floor	2
Level 2 - Surgery Suite	**Description**	
	Anesthesia Machine, General, 3 Vap	10
	Compression Unit, Extremity Pump, Intermittent	7
	Computer Workstation, Cardiac Cath-Lab, Hemodynamic	3
	Defibrillator, Monitor, w/Pacing	3
	Navigation System, Surgical, Robotic	2
	Pump, Infusion, Controller, Modular	10
	Pump, Infusion, Rapid	2

	Pump, Infusion, Single	26
	Pump, Infusion, Syringe	6
	X-Ray Unit, Interventional, Angio / Cardiac (Single Plane)	3
Level 3 - Med/Surg (LDRP)	**Description**	
	Compression Unit, Extremity Pump, Intermittent	2
	Pump, Infusion, Controller, Modular	2
	Pump, Infusion, Single	2
Level 3 - C-Section	**Description**	
	Compression Unit, Extremity Pump, Intermittent	2
	Defibrillator, Monitor, w/Pacing	1
	Pump, Infusion, Controller, Modular	2
	Pump, Infusion, Dual	1
	Pump, Infusion, PCA	2
	Pump, Infusion, Single	8
	Pump, Infusion, Syringe	1
Level 3 - Labor & Delivery/Perinatal	**Description**	
	Compression Unit, Extremity Pump, Intermittent	13
	Pump, Infusion, Controller, Modular	15
	Pump, Infusion, Epidural	15
	Pump, Infusion, Single	17
Level 3 - Medical/Surgical Unit	**Description**	
	Compression Unit, Extremity Pump, Intermittent	24
	Defibrillator, Monitor, w/Pacing	1
	Pump, Infusion, Controller, Modular	24
	Pump, Infusion, Single	25
	Pump, Infusion, Triple	1
Level 3 - Nursery	**Description**	
	Pump, Infusion, Single	2
	Pump, Infusion, Syringe	5
Level 4 - Medical Unit	**Description**	
	Compression Unit, Extremity Pump, Intermittent	28
	Defibrillator, Monitor, w/Pacing	1
	Pump, Infusion, Controller, Modular	28
	Pump, Infusion, Single	29
	Pump, Infusion, Triple	1
Level 4 - Rehab Therapy	**Description**	
	Defibrillator, Monitor, Manual	1
Level 5 - Medical/Surgical Unit	**Description**	
	Compression Unit, Extremity Pump, Intermittent	25
	Defibrillator, Monitor, w/Pacing	1

	Pump, Infusion, Controller, Modular	25
	Pump, Infusion, Single	51
	Pump, Infusion, Triple	1
Level 6 - Dialysis Unit	**Description**	
	Defibrillator, Monitor, w/Pacing	1