Luminis Health Doctors Community Medical Center
CON Application -- Obstetrics and Facility Modernization (Docket No. 23-16-2466)

Response to MHCC Request for Completeness Information Dated April 25, 2023

Proposed Project

1. Application page 25 asks about any required approvals and site control. The applicant states not all approvals have been obtained. Please provide an estimated timetable for all approvals and utilities.

Applicant Response:

Prince George's County passed CB-40-2021 allowing LHDCMC to forego the special exception requirement. The preliminary plan of subdivision has been approved by MNCPPC. Grading and utility permits are expected to be approved by July 2023. There are no additional approvals required.

2. Please include a description of the connection between the existing hospital and the new acute care pavilion and the plans to manage the renovations without disruption to the hospital.

Applicant Response:

In preparation for the Acute Care Pavilion construction, there is a preceding site development project underway that will address site circulation, utilities, parking, and loading dock functions. The Acute Care Pavilion will connect directly to the west side of the existing facility on Level 1 and Level 2. The site preparation work will allow us to maintain accessibility for material deliveries, staff, and visitors/patients throughout all phases of construction.

All new construction will be completed and ready for occupancy before renovation of the existing facility begins in order to minimize impact to hospital services.

At Level 1, the existing entrance will be maintained during all phases of construction. For the lobby and arrival circulation area, visitors and patients will access the hospital through a temporary circulation route that ensures safe and secure passage to their respective destinations. Planning and design related to interior and support services areas strongly considered the operational impact and maximized accessibility while minimizing the effect on patient safety, clinical operations, and staff wellbeing.

At Level 2, logistics planning and design strongly considered the impact on patient care, staff wellbeing, and safety while minimizing the impact to surgical services operations. The sequence of construction is set to construct new operating rooms in the Acute Care Pavilion in parallel with ongoing surgical operations, meaning that surgical operations will continue in the existing space until the new facility is ready. At that time, surgical services will move into the new space and renovation to existing hospital space will be phased in order to maximize uptime. All construction, renovation, and relocation activities will be performed to minimize impact to surgical operations. The connection on the second floor will ultimately be located in the pre- and post-operative service areas once all renovations are complete.

At Level 3, connecting to an existing corridor will have a minimal disruption to patient care.

Once complete, the connections between new and existing space will be generally through corridors connecting both sides. Attention was given to limit spaces that span both sides to allow for walls to provide natural barriers between the new and existing buildings to limit the impact during construction and renovation.

3. MHCC reports that the applicant had four outpatient general operating rooms, and nine mixed use general operating rooms in 2019[1]. For clarification, please confirm the proposed project will yield 10 mixed use ORs and 2 ORs used for C-sections.

Applicant Response:
The proposed project will yield 10 mixed use ORs and 2 ORs used for C-sections.

4. Please include at least one clear floor plan/drawing that is legible on an 8.5”x11” page.

Applicant Response:
Please see **Exhibit 3 (Corrected)**.

Project Schedule
Applicant History

5. Application page 32 question 2 asks if the applicant, owner, or responsible person listed in the application has been involved with other healthcare facilities and directs the reader to Exhibit 4. Exhibit 4 has no names, only facilities provided. Please supply information on facilities affiliated with Deneen Richmond and any other persons responsible for the project.

[1] https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/con_chartbook_md_gen_special_hospitals_20220930.pdf , Table 16.

Applicant Response:

Deneen Richmond is the President of Luminis Health Doctors Community Medical Center, Inc. and also serves as the Chief Quality and Population Health Officer for Luminis Health Inc. At this time, Ms. Richmond is not involved in the ownership, development, or management of another health care facility outside of LHDCMC. However, Ms. Richmond's prior involvement with other health care facilities is as follows: a) Vice President, Population Health & Clinical Improvement, Anne Arundel Medical Center (2018-2020); b) Vice President, Performance Improvement and Outcomes, Inova Health System (2011-2018); and c) Vice President, Quality and Care Management, Holy Cross Hospital (2007-2009).

6. Application page 32 question 4 asks if the applicant has had any possibility of penalties and directs the reader to Exhibit 5. Please provide more information on:
   (a) the basis of the Self Disclosure to the Office of Inspector General in January 2023;

Applicant Response:

Beginning in 2010 LHDCMC contracted with Diagnostic Imaging Associates, LLC, ("DIA") a radiology physician practice, to provide breast imaging services at LHDCMC. After LHDCMC joined Luminis Health, it was discovered that the breast imaging services were being billed under the wrong NPI number; the service was being billed under DIA's NPI number instead of LHDCMC. In April 2021, LHDCMC and DIA jointly reported to the U.S. Department of Health and Human Services Office of Counsel for the Inspector General (OIG-HHS) that it had used the wrong NPI number to bill for LHDCMC Breast Center imaging services. The United States Department of Justice Baltimore Office agreed to resolve the non-compliance in February 2022 for the amount proposed by LHDCMC in its self-disclosure. Following a lengthy period of government approvals, the parties executed the final settlement agreement in January 2023.

   (b) the applicant not receiving findings from the OHCQ survey conducted in February 2021. (If survey findings are received while the application is pending, please share them with MHCC staff).

Applicant Response:

There was an error in our response to Part III, Question 4 (p 32; Exhibit 5). While LHDCMC received findings from an OHCQ survey in Feb 2021, those findings were successfully addressed and the matter was closed on Feb. 10, 2021. In addition, there was a subsequent CMS survey related to these issues and the plan of correction was accepted on April 22, 2021.

Budget

7. In the applicant's budget (Table E) please provide the basis for:
   (a) the calculation of the applicant's contingency allowance and its inflation allowance;
   (b) the 3M in loan placement fees under financing cost, when there are no loans identified as a source of funding;
   (c) the terms for the authorized bonds (type, issued by, term, interest rate).

Applicant Response:

(a) Inflation contingency is calculated based on projected rates, compounded to December 2025, the midpoint of construction. Projected inflation rates are as follows; 8% for 2023, 6% for 2024 and 4.75% for 2025. The compounded resultant of these rates is 19.92%. This rate multiplied by the direct construction cost estimate results in the $29,100,650 allowance as noted in Table E.

Contingency allowance is based on a design contingency of 10% of the cost estimate and 3% for construction contingency. The resultant of the two considered contingency allowances is $22,575,000 as shown in Table E.

(b) The loan placement fees on Table E were incorrectly labeled. These fees represent Bond issue fees. The corrected Table E attached in **Exhibit 1 (Corrected)** correctly identifies these fees. In our review of the CON Tables we noticed a mistake in Table E. This increased the total cost by $628,629. The Source of Funds on Table E and depreciation on Tables G, H, J, and K are updated. A complete set of updated Tables is attached in **Exhibit 1 (Corrected)**.

(c) Luminis Health projects the use of a hybrid of taxable and tax-exempt bonds, with a term of 30 years at a rate of 5.50%. The bonds will be issued by the Maryland Health and Higher Education Facilities Authority.

<u>Acute Care and General</u>

Quality Care

8. Commission staff utilizes the Maryland Quality Reporting found on the Commission's website[2] which was accessed by staff on April 10, 2023. Staff found that not all the below average metrics were responded to. Please respond to the omitted metrics and provide the date data was accessed:
    (a) Nurse communication with patients;
    (b) Explanation about medication before giving to the patient;
    (c) How often patients received help quickly from staff;
    (d) Area around the patient's room quiet at night;
    (e) Patient rooms and bathrooms kept clean;
    (f) Wait time for cardiac patients needing to be transferred to another hospital for a procedure;
    (g) Deaths within 30 days after receiving hospital care for pneumonia.

Applicant Response:

Below are the action plans for the omitted metrics, which were accessed for this Response to Comments on 4/26/2023. For the original application, the data was accessed on 3/15/2023.

(a) Nurse Communication with patients
- New interdisciplinary rounding model and huddles were implemented
- Leadership rounds
- Developing teams with 1:1 coaching
- Living Our RISE Values Training in progress
- Patient Experience Committee meeting bi-weekly
- Team STEPPS Implementation

(b) Explanation about medication before giving to the patient;
- Implementing discharge folders which will help with medications.
- Patient Experience Committee meeting bi-weekly

(c) How often patients received help quickly from staff;
- Call bell data was pulled to determine average length of response time to identify target improvement
- Working with Hospital PFAC on call bell response time
- Patient Experience Committee meeting bi-weekly

(d) Area around the patient's room quiet at night;
- Senior Director of Nursing Optimization Operations is heading a Quietness of the hospital workgroup which meets weekly
- Patient Experience Specialist is sending noise comments to unit directors to identify and address areas of noise

[2] https://healthcarequality.mhcc.maryland.gov/

- Patient Experience Committee meeting bi-weekly

(e) Patient rooms and bathrooms kept clean;
- Patient Experience Committee meeting bi-weekly

(f) Wait time for cardiac patients needing to be transferred to another hospital for a procedure;
- Transitioned to High Sensitivity troponin in Oct 2022 for evaluation of chest pain.
- All providers completed education on the USACS Clinical Management Tool (CMT), modified HEART score.
- ED directors track the utilization of the CMT in patients discharged with chest pain.
- Developed a strong partnership with Washington Hospital Center for efficient transfer of STEMI and NSTEMI patients with active chest pain.
- Developed a transfer protocol and increased resources for transfer inside the Luminis Health System to Anne Arundel Medical Center for NSTEMI patients without active chest pain.

(g) Deaths within 30 days after receiving hospital care for pneumonia.
- Institution of early warning system across DCMC & AAMC.
- Institution of Sepsis navigator.
- Developed standardized mortality review process and tool to identify, track, and trend gaps in care uniformly.
- Early identification of potential hospice candidates on repeat readmissions.

Cost-Effectiveness

9. Although not selected for the project, what were the cost estimates of Option B Converting Existing Hospital Space and Option C Vertical Expansion of Existing Hospital?

Applicant Response:

LHDCMC evaluated several alternative approaches for implementing obstetric services and considered the following alternatives:

Option A: Do Nothing -$0

Option B: Convert Existing Hospital Space - $117,500,000

Option C: Vertical Expansion of Existing Hospital - $189,200,000

Option D: Change Model of Operations from LDR to LDRP - $291,120,000

Option E: Construct New Facility (Selected Option) -$286,582,858

Construction Cost of Hospital Space

10. Please provide the Excel spreadsheet used for the MVS calculation.

Applicant Response:

Please see **Exhibit 22**.

Efficiency

11. In the application p. 53, please elaborate on whether the project will maintain staffing efficiency with the impact of 107.6 new FTEs?

Applicant Response:

This project will allow us to provide new services leading to the creation of additional departments such as labor and delivery, post-partum and well-baby nursey. Creation of these departments necessitates the hiring of additional staff to provide care for these critical services to our community. Our units were designed to keep services either co-located or in close proximity to reduce excessive staff movement to promote efficiency. These design efficiencies that were developed for this project will allow us to keep our existing gross dollar per FTE ratio intact.

In addition, we anticipate following existing care models as well as best practices for staffing models for new services to LHDCMC, which will allow us to maintain our existing staffing efficiency. In many cases, design efficiencies will actually allow us to improve our staffing efficiencies through the implementation of improved physical and operational workflows.

Financial Feasibility

12. Provide assumptions used by the applicant in the Exhibit 1 financial tables A-L.

Applicant Response:

Please see **Exhibit 1 (Corrected).**

13. Please discuss the implications on the financial feasibility of the project if the requested rate relief from HSCRC is not granted.

Applicant Response:

Prior to submitting the original Certificate of Need Application in April 2023, Luminis Health met with the HSCRC to familiarize them with this project and our plan, including the proposed rate relief. If the requested rate relief from the HSCRC is not granted it would pose significant financial challenges for this project to be implemented as designed. We believe this application adheres to the HSCRC requirements to obtain rates to offset our capital investment per the current HSCRC Capital Funding Policy. Additionally, following

HSCRC methodologies for funding a new service, we believe the obstetrics program at LHDCMC will be funded.

Obstetrics

Need

14. Please provide the source for this statement on page 63 "The total number of licensed obstetrics beds in the local region has declined from over 100 obstetric beds in FY2015 to fewer than 50 today."

Applicant Response:

This statement comes from the annual publication of MHCC licensed bed tables. In FY2015, the Southern Maryland total licensed obstetric beds was 109. https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_con_acute_care_license_rpt_2015_revised_20150313.pdf

In FY23, the Southern Maryland total licensed obstetric beds was 63. The original response cited the number of obstetrics beds in only Prince George's County for FY23, which was an improper comparison to the original FY2015 number, by oversight. Despite the oversight, Southern Maryland has still lost 46 obstetric beds since FY15.

https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_Acute_Care_Beds_fy2023.pdf

The corrected statement should read, "The total number of licensed obstetrics beds in the Southern Maryland Region has declined from over 100 obstetric beds in FY2015 to fewer than 65 today (a 42% decline in Obstetrics Beds in the Region)."

15. Please provide the source of information for the initial two introductory paragraphs in the Obstetrics section under 1. Need.

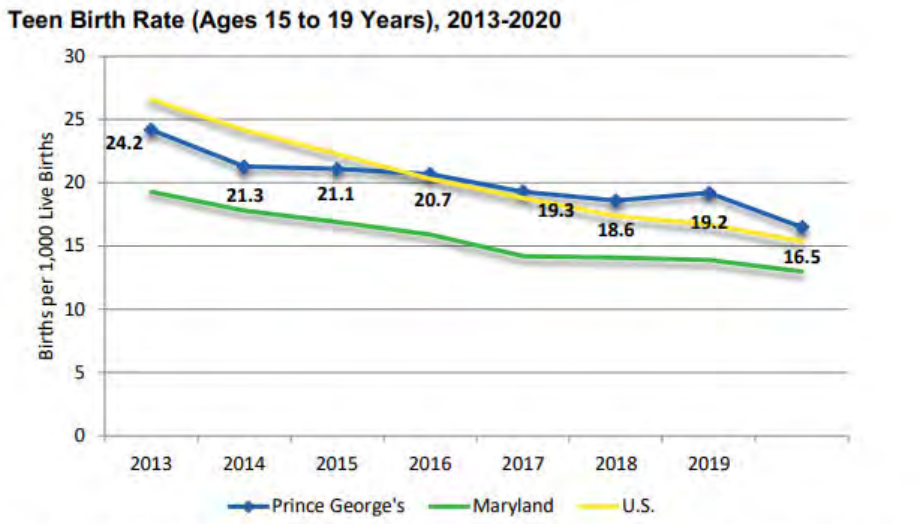
Applicant Response:

The introductory paragraph cited in the question did not include source references because they were detailed in the following complete Needs Analysis sections. The paragraph is re-stated, below, including the citations requested.

*Although Prince George's County has the second highest birth rate in the State of Maryland **(CON Table 3)**, the total number of licensed obstetric beds in the local region has declined from over 100 obstetric beds in FY2015 to fewer than 50 today (**See answer to completeness question #14)**. The limited number of obstetric beds in Prince George's*

*County forces over 7,000 women to leave the County each year to deliver their babies and to receive other related services (**CON Table 4**). Prince George's County has a low OB/GYN physician-to-population ratio **(CON Table 8)**. The dependence on out of county obstetric units and OB/GYNs creates inequities through transportation challenges, disjointed medical management of pregnancy and lack of perinatal continuity of care (**CON Figure 4**). Compared to the rest of the State, Prince George's County has high infant mortality rates **(CON Figure 8**), a high rate of low-birth-weight infants **(CON Figure 7**), and high teen birth rates **(CHNA, below)**.*

Figure 1
Teen Birth Rate
2013-2020



Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports; National Center for Health Statistics, National Vital Statistics Report

https://www.luminishealth.org/sites/default/files/2022-11/2022-Prince-Georges-County-CHA-Luminis.pdf

The Applicant recognizes the need for both community-based obstetrics care and inpatient obstetric beds in Prince George's County. Easy access to OB/GYNs and local delivery sites are critical for the improvement of maternal and infant outcomes. The women of Prince George's County deserve access to obstetrical care close to home, which this project will provide on the LHDCMC campus. LHDCMC's proposed obstetrics program will improve access to obstetrical care and related services in Prince George's County, including outpatient ambulatory women's care from preconception health to postpartum care, gynecology, and breast health.

16. Please provide Table 13 in the application in WORD format.

Applicant Response:

Table 13 is attached as **Exhibit 23** and will be provided in WORD format with the electronic filing of these responses.

Staffing

17. For Table 13 on application page 86:
    (a) Add a current staffing column to this table.
    (b) Add physicians to the table (note contracted or staff) and include salaries.
    (c) Please provide this table in WORD format.

Applicant Response:

(a) LHDCMC does not operate an obstetric program. There is no current staff to include in Table 13.

(b) Physicians for the obstetric program are added to Table 13 (**Exhibit 23)**. They were not originally included as they are contracted services and not LHDCMC staff. We provided a modified Table 13 that includes detail on these contractual services, such as the physician expense to LHDCMC, malpractice expense to LHDCMC, and other, non-physician contractual services that are not directly related to program staffing. The staffing section ties to the Table L and Table J *line 2a Salaries & Wages including benefits*. The contractual services ties to Table J *line 2b Contractual Services.*

(c) A word format of Table 13 (**Exhibit 23**) is being included in WORD format with the electronic version of this filing**..**

18. Please identify where the physician expenses are in the tables package. If no physician expenses are projected, please explain.

Applicant Response:

Physician expenses were included in Tables J and K on the line *b. Contractual Services*. Contractual services includes the physician expense, malpractice expense and non-physician contractual services that are not directly related to program staffing.

19. Provide a sample schedule for physician staffing.

Applicant Response:

A – D represent the 4 new physicians added to serve as laborists 24/7 on the unit. During weekday hours, the laborist will have a morning and an evening 12 hour shift. On weekends, the laborist will have 24 hour shifts. Laborists A – D will rotate on the schedule. Additional members of the clinical team will include a midwife and a resident physician.

FT Laborists	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Week1	A/B	→	→	→	→	C	D
Week2	C/D	→	→	→	→	A	B
Week3	A/B	→	→	→	→	C	D
Week4	C/D	→	→	→	→	A	B
Week5	A/B	→	→	→	→	C	D

20. On page 73 it states Luminis will be hiring four OB/GYNs. Please explain the assumptions that were relied on to project that 4 OB/GYNs will meet the need for 20 Obstetrics beds?

Applicant Response:

These OBGYNs represent a fraction of the total estimated deliveries at LHDCMC once the program is mature. On page 73, we are proposing to add four additional community providers to our existing community OBGYN practices. In addition to Luminis Health Clinical Enterprise ("LHCE") providers, we anticipate a number of area OBGYNs will choose to affiliate with LHDCMC's obstetric program. Therefore, the anticipated need for obstetrics beds is not intended to be generated solely by LHCE community OBGYN practices. There are also 8.4 employed provider/laborists in our staffing model who will be hospital-based, vs community based, and will focus their care on hospital obstetrics needs. This is the number of hospital-based providers required to staff a program of this size 24/7 for all deliveries.

21. In the application, it states that Luminis has the following recruiting strategies, please provide a timeframe in which these strategies will be implemented and include any other strategies that will be used.
    (a) strategic investment in salaries;
    (b) create a pipeline of clinicians by collaborating with medical schools (San Jorge, GWU, Hopkins and community colleges);
    (c) work with private practice physicians and physicians employed by other hospitals;
    (d) use of a "Laborist" model to work in conjunction with community physicians.

Applicant Response:

(a) Luminis Health has already invested in the salaries of 3 OBGYN providers who currently practice in Prince George's County and is projected to add 4 more OBGYN community providers leading up to the start of obstetric services at LHDCMC. In addition to the four community-based providers who will be hired

before the start of obstetric services at LHDCMC, Luminis Health intends to hire additional hospital-based laborists. These hires will occur over the coming years, with laborists being hired closer to the anticipated program start and community providers being added incrementally in the interim years.

The reference to a strategic investment in salaries, found on Page 119 of the Application, originally referred to Luminis Health's recent workforce investment in which staff salaries have been strategically increased in the past few years, including our improved corporate minimum wage of $17 per hour. Other compensation adjustments include incentives for high vacancy and high-demand positions, such as bedside nursing staff. The staffing investments are reflected in our CON tables.

(b) Luminis Health operates a large obstetric program at LHAAMC. In support of that program and medical education and strategic partnerships, it has already established strong relationships as a health system which will extend to LHDCMC, when appropriate. Below outlines the timeline of these collaborations with medical and nursing training programs:

Institution	**Educational Area**	**Initial Year of Collaboration**
San Jorge's	OB/Gyn	FY21
GWU	OB/Gyn/medicine/surgery	FY21
JHH	OB/Gyn	FY07
Anne Arundel County community College	Physician Assistant Program	FY07
Prince George's County Community College	Medical assistant and nursing programs	FY20

(c) We currently have formal collaborative relationships with physicians in private practice who are on the medical staff of LHDCMC and LHAAMC and we intend to maintain and grow these relationships. Several private practice physicians teach our OBGYN Residents and participate in the quality programs for our service line. Luminis Health has actively sought the input of OBGYN physicians who are on our medical staffs and practice in the region as this program has been developed. Many area physicians have expressed interest in joining our medical staff and/or having their pregnant mothers deliver at LHDCMC once this program is open.

(d) A laborist model will be implemented when the LHDCMC obstetric service opens. Currently, LHAAMC has a hybrid hospitalist-laborist model that supports

both LHCE-employed and community, private-practice physicians. Luminis Health has extensive experience operating blended medical models with both private and system-employed physicians and has a strong reputation for working with regional providers to enhance services available through blended employed/private models. The laborist model will support coverage of inpatient obstetrical clinical care and will allow private OBGYN providers to stay in their offices to maximize access to ambulatory women's healthcare while laborists deliver babies and other hospital-based services. https://pubmed.ncbi.nlm.nih.gov/30835985/

Community Benefit Plan

22. How will the Community Benefit Plan initiatives as described in response to the standard be staffed and funded?

Applicant Response:

The Community Benefit Plan initiatives are a continuation of the ongoing work of the Luminis Health Women's and Children's service line. These initiatives, including the ones below, are a part of ambulatory programming development.

Community Benefit Plan initiatives (listed on pg. 95):

- Access to physicians and healthcare providers;
- Create continuous pipeline of physicians, APP's and nurses through educational collaborations with San Jorges Medical School in Puerto Rico/George Washington University/John Hopkins Medical Center /and area community colleges;
- Programmatic initiatives to target reduction in preterm, low birth infants;
- Pre-conception Health program;
- Ambulatory models of care;
- Early prenatal visit campaign;
- Centering (https://www.centeringhealthcare.org/;)
- Post-partum Long-Acting Reversible Contraception (LARC);
- Increase education of the community (engagement of medical & nursing students and faculty) through Health Fairs/Civic organization presentations; and
- Engage community, industry, insurers and government partners in our health system efforts to decrease disparities in infant mortality and teen pregnancy. The engagement of multiple stakeholders across diverse disciplines positively impact outcomes for the medically underserved.

All of the cost of staffing medical providers in community practices will be borne by LHCE, which has direct professional billing. As discussed in Question 21, this work is already underway.

Ambulatory program development includes the programmatic initiatives to improve outcomes for women and babies, including reductions in preterm deliveries, low birth infants, expand pre-conception health programs, implement early prenatal visit campaign, expand use of centering programs, and offer post-partum, Long-Acting Reversible Contraception. Ambulatory practices run by LHCE include these initiatives and these practices collect revenue to cover the expenses of these initiatives.

The Community Health Improvement team will contribute to disseminating pregnancy tests and educating the community. These efforts are funded through donors. The staff includes existing a community health provider, community health RN, and community health educator.

Any additional funding needed for community benefit services would be borne by Luminis Health, if foundation support was not available.

Designated Bed Capacity

23. The standard states that "An applicant for a new obstetric service shall designate a number of the beds from within the hospital's licensed acute care beds that will comprise the proposed obstetric program." However, the CON application, page 100 states that the beds "will be new beds, not taking away from the hospital's existing licensed acute care beds." Please explain how this plan complies and why the applicant is not designating MSGA beds for the Obstetrics program.

    (a) Exhibit 1, Table A and Table F show 20 Obstetric beds. Please reconcile this number with the number under the Designated Bed Capacity standard on page 100 which states there will be 21 licensed beds.

    (b) Page 8 states there will be six LDRs and three Antepartum rooms, however the line diagram shows seven LDRs and two Antepartum. Please reconcile these numbers.

Applicant Response:

The Applicant has requested additional guidance from Staff on the requirements of this standard and will supplement this response based on this guidance.

(a) The correct number is 21, and Tables A and F have been corrected accordingly

(b) These rooms were mislabeled in the drawings filed with the Application. The correction has been made in Exhibit 3 (Corrected) and a corrected set of oversized drawings is being filed with MHCC.

Source of Patients

24. On page 99, the applicant states it is not currently providing OB services, however, data in the Medicaid table (p.68) shows OB cases. Please reconcile this contradiction.

Applicant Response:

LHDCMC treats patients who come in through the Emergency Room with obstetric concerns. LHDCMC does not provide inpatient obstetric services. The data in the Medicaid table on (p.68) includes other obstetric cases.

An internal review of LHDCMC's data found 48 other obstetric discharges and 24 of those discharges are Medicaid (corresponding to p.68). All of these cases arrived through the Emergency Room. Examples of the primary diagnoses and clinical classifications include postpartum diagnoses, other antepartum diagnoses, menstrual & other female reproductive system disorders, and infections of the female reproductive system. While women in labor occasionally present to the LHDCMC ED, these deliveries have been successfully transferred in recent years.

<u>General Surgical</u>

General Standards

25. Please refer to the State Health Plan General Standards at COMAR 10.24.11. Provide a response to Paragraph .05A (1) Information Regarding Charges and Network Participation, Paragraph .05A (2) Information Regarding Procedure Volume, and Paragraph .05A (5) Transfer Agreements.

.05 Standards
A. General Standards.
(1) Information Regarding Charges and Network Participation.

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

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

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

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

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

Applicant Response:

(a) All gross charges including operating room minute charges are listed on the Luminis Health website. Surgical services are also included in our Epic patient estimate toll that can be accessed both on the Luminis Health website and through My Chart. The link to the Luminis Health price transparency is Price/Cost Transparency | Luminis Health.
(b) Upon inquiry, Luminis Health will provide the names of networks in which we participate to the public.
(c) Upon inquiry, Luminis Health will provide the names of the networks in which each surgeon and other health care practitioner who provides surgical services at Luminis Health currently participates.
(d) From time to time, Luminis Health receives letters from the Maryland Office of the Attorney General/Consumer Protection Division/Health Education and Advocacy Unit ("HEAU"). These letters are sent by HEAU on behalf of individuals who have a question about the services received by Luminis Health providers. In each instance, Luminis Health has worked with HEAU representatives to provide all requested information in accordance with federal and state law. No inquiries from HEAU have led to the filing of a complaint by HEAU or the Maryland Attorney General.
(e) LHDCMC understands that providing a patient with an estimate of out-of-pocket charges prior to arrival for surgery is a condition of the CON.

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

Applicant Response:

Luminis Health will provide to the public upon request the volume of specific surgical procedures performed at LHDCMC for the most recent 12 months.

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

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

Applicant Response:

(a) LHDCMC operates under the LH-ADM1.1.79 *Emergency Medical Treatment and Active Labor Act-Evaluation, Treatment and/or Transfer of patient* and LHDCMC *transfer of Patients to Other Acute Facilities.* These policies comply with the requirements of Health-General Article §19-308.2. Please see **Exhibits 24 and 25, respectively.**
(b) This standard is not applicable as LHDCMC is not an ambulatory surgical facility.

Design Standards

26. Please include a narrative that demonstrates the project's compliance with section 2.2 of the FGI guidelines.

Applicant Response:

Please see **Exhibit 26** demonstrating compliance with section 2.2 of the FGI guidelines.

New Minimum Utilization for Establishment of a New or Replacement Facility

27. On p. 112-113, LHDCMC states that it currently only uses eight of the twelve licensed general purpose ORs. The applicant's proposed project seeks to construct a replacement facility for surgical services. Using Paragraph .06A Assumptions Regarding Operating Room Capacity, submit a response to Paragraph .05B (2) that supports the need for ten dedicated inpatient and/or mixed-use ORs at optimal capacity by providing the following:

    (a) Two years of historical and current utilization for the 8 ORs in the surgical services at LHDCMC;
    (b) Projected surgical utilization during the 66-month construction period for the new addition;

(c) Projected surgical utilization for the first three years after completion and the start of operations in the proposed new surgical services addition;
(d) Provide the assumptions and/or basis for any increases in projected surgical utilization that supports the need for ten ORs;
(e) Provide the Excel spreadsheet with the supporting calculations used to support the need for the ten operating rooms.

Applicant Response:

LHDCMC is renovating its existing surgical department, not establishing a new or replacement surgical facility. As discussed in the application, LHDCMC is licensed for twelve general purpose operating rooms but several of them are obsolete due to their size and cannot be utilized. The eight currently-in-use operating rooms are an average of 536 square feet each, which is too small to allow for specialty equipment or support staff who are needed for more complex surgeries. In addition, the existing LHDCMC operating rooms also lack advanced lighting and mechanical controls which leads to less efficient systems with higher energy use. Sterile processing and other support services are also undersized, and are not currently collocated, creating inefficiencies.

In addition to the overall facility deficiencies of LHDCMC's existing operating rooms and support services, there have been numerous downtimes for one or more operating room and sterile processing over the past few years. Ongoing repairs to maintain equipment and facilities have impacted OR utilization, including the need to address water leaks and replacement of sterile processing equipment. Given these challenges, LHDCMC has had operating room capacity reductions due to downtimes, which, if accounted for, demonstrate that LHDCMC is operating at a level at or above efficiency standards for hospital ORs.

(a) Table 27 shows two years of historical and current utilization for the 8 ORs in the surgical services at LHDCMC.

According to MHCC standard, the full capacity of an OR is 2,375 hours (142,500 minutes). Eight fully utilized ORs at 80% (the optimal capacity standard in COMAR 10.24.11) would translate to 912,000 surgical minutes with Turnaround Time. Even in FY22, when LHDCMC had reduced surgical demand due to the Dec-Jan COVID-19 surge, the surgical program exceeded optimal utilization rates. In each of the past two years, and for the current year projection, LHDCMC is operating above optimal utilization for 8 ORs. These utilization rates do not reflect actual OR downtimes which impacted surgical capacity over the past few years.

Table 27
LHDCMC Surgical Cases
FY 21 –FY 23 Projected

Year	DCMC Main OR Volume	DCMC Main OR Minutes and TAT	ORs Required at Optimal Utilization (COMAR 10.24.11)
FY21	6,486	938,525	8.23
FY22	6,261	915,343	8.03
FY23 Projected	6,541	968,119	8.49

(b) Table 28 shows projected surgical utilization during the 66-month construction period for the new addition.

Because we are operating close to surgical capacity, there is little surgical growth projected for the coming several years. However, there is ongoing programmatic recruitment to align with our strategic growth initiatives for the region. In addition to surgical specialists who have been recruited over the past 2 years, in FY24, LHCE has recruited a new Joint Surgeon who will be performing cases at both LHDCMC and LHAAMC. It would be preferable for these surgeons, who are based largely in the LHDCMC region, to focus their OR time at LHDCMC. However, the existing surgical infrastructure is not sufficient to support this projected growth. We expect these surgeons to continue to add volume at LHDCMC over several years, as we adjust OR utilization to align with programmatic needs.

Table 28 shows anticipated surgical volume at LHDCMC for the coming 5 years (Year 1 being FY23, which aligns to the volume shown above).

Table 28
LHDCMC Surgical Cases
66 month construction period

Year	DCMC Main OR Volume
Year 1	6,541
Year 2	6,581
Year 3	6,621
Year 4	6,661
Year 5	6,701

(c) Table 29 shows the projected surgical utilization for the first three years after completion and the start of operations in the proposed new surgical services addition. The increase in volume between Year 5 shown in Table 28 above, and Table 29 below, after construction is complete, is associated with the surgical volumes that align to the planned, ongoing recruitment of surgical specialists.

Table 29
LHDCMC Surgical Cases
First Three Years after Project Completion

Year	DCMC Main OR Volume
Year 1	7,101
Year 2	7,267
Year 3	7,427

(d) Luminis Health plans to recruit 11 surgical specialists into the LHDCMC market over the coming 5 years, as shown in Table 30 below. Four of these specialists are the community OB/GYNs discussed in the obstetric program descriptions, who will perform gynecologic surgery in addition to providing clinical office-based care. There are 3 projected orthopedic surgeons to be recruited to the market, including a joint surgeon who is joining LHCE in September 2023. The additional recruitments demonstrated below are slated to occur over the coming years in order to meet anticipated need in the LHDCMC community.

Table 30
LHDCMC-Region Planned Surgical Recruitment

Surgeon Specialty	Planned Recruitment
Bariatric Surgery	1
Breast Surgery	1
General Surgery	1
Gynecology	4
Orthopedics	3
Vascular Surgery	1
Grand Total	**11**

(e) **Exhibit 27** is an excel spreadsheet with the supporting calculations used to support the need for the ten operating rooms.

28. Please provide a list of the current number of surgeons (including specialties) that perform surgical services offered at LHDCMC. After project completion, please provide any expected changes in surgical staff.

Applicant Response:

LHDCMC plans to add 11 surgeons who will base their surgical practices largely at LHDCMC after project completion. The surgeons include 1 bariatric, 1 breast, 1 general, 4 gynecology (these are the 4 OB/GYNs recruited for the obstetric program), 3 orthopedics (hand, joint and spine) and 1 vascular surgeon.

Table 31
LHDCMC Current and Future Surgeons

Surgeon Specialty	**Current Count**	**Future Count**
Bariatric Surgery	1	2
Breast Surgery	2	3
Ear, Nose, And Throat	2	2
Gastroenterology	19	19
General Surgery	15	16
Gynecologic Oncology	4	4
Gynecology	6	10
Neurosurgery	2	2
Orthopedics	13	16
Plastic Surgery	5	5
Podiatry	6	6
Surgical Oncology	1	1
Urogynecology	2	2
Urology	15	15
Vascular Surgery	3	4
Grand Total	**96**	**107**

Service Area

29. Please identify the service area for General Surgical Services.

Applicant Response:

The service area for General Surgical Services is the same service area as is defined for LHDCMC's overall hospital and the proposed obstetric program. The service area is defined by our FY22 discharges, as shown below.

Table 32

Luminis Health Doctors Community Medical Center
Service Area Definition
FY22

Zip Code	Community	Discharges	% DCH Discharges	Cumulative %
20706	Lanham	1,104	12%	12%
20743	Capitol Heights	665	7%	20%
20785	Hyattsville	649	7%	27%
20784	Hyattsville	595	7%	34%
20774	Upper Marlboro	528	6%	39%
20770	Greenbelt	493	5%	45%
20737	Riverdale	372	4%	49%
20747	District Heights	340	4%	53%
20721	Bowie	312	3%	56%
20720	Bowie	240	3%	59%
PSA Subtotal		**5,298**	**59%**	**59%**
20715	Bowie	244	3%	62%
20716	Bowie	215	2%	64%
20740	College Park	213	2%	66%
20710	Bladensburg	199	2%	69%
20772	Upper Marlboro	186	2%	71%
20781	Hyattsville	153	2%	72%
20782	Hyattsville	153	2%	74%
20769	Glenn Dale	129	1%	75%
20748	Temple Hills	126	1%	77%
20746	Suitland	121	1%	78%
20708	Laurel	102	1%	79%
20744	Fort Washington	82	1%	80%
20735	Clinton	74	1%	81%
20705	Beltsville	71	1%	82%
20745	Oxon Hill	64	1%	83%
SSA Subtotal		**2,132**	**24%**	**83%**
All Other		1,564	17%	100%
Total		**8,994**	**100%**	**100%**

Source: HSCRC Discharge Abstract Database, FY 2022

Financial Feasibility

30. On page 111, under subpart (a) (ii) please elaborate the lack of projected increase in revenue associated with the expected increase in surgical cases.

Applicant Response:

We did not include additional revenue for surgical cases unrelated to OB to be conservative in our financial projections. LHDCMC's only source of additional revenue for these cases would be the HSCRC's market shift policy. This policy awards hospitals additional GBR in the event they capture market share from another hospital. However, another hospital would need to have year over year surgical volume declines in order for LHDCMC to receive additional revenue. In the event all hospitals in our service area experience surgical case growth, no hospital would receive a GBR adjustment. With the uncertainty surrounding this policy, and the potential revenue LHDCMC would receive, we felt it was appropriate to omit consideration of additional revenue in our financial forecast.

31. On p. 112, the applicant reports the following inpatient and outpatient surgical cases and surgical minutes for FY 2022:

	Reported Cases	**Reported Ave Min/ Case**	**MHCC Calculated Total Minutes**	**Reported Minutes**	**MHCC Minutes/ Case**	**% Difference**
Inpatient	2,224	136	302,464	380,857	171.2	25.9%
Outpatient	4,037	97	391,589	534,485	132.4	36.5%

There is a discrepancy in the average minutes per case between what LHDCMC reports, and what MHCC staff calculates, please clarify the discrepancy.

Applicant Response:

In the original table our reported total minutes included turnaround time, but turnaround time was not included in the average minutes per case. Average turnaround time at LHDCMC is 35 minutes.

Total surgical minutes was calculated by multiplying the number of surgical cases by the *sum* of the average minutes per case and the average turnaround time.

Please see Table 33 below which now includes the average turnaround time.

Table 33
LHDCMC Current Cases at Average Time per Case
Actual FY 2022

	Inpatient				Outpatient				Total		
Hospital	Cases	Avg time per Case	Avg. Turnaround Time	Total Minutes	Cases	Avg time per Case	Avg. Turnaround Time	Total Minutes	Total Cases	Total Minutes	# ORs
LHDCMC	2,224	136	35	380,857	4,037	97	35	534,485	6,261	915,343	8.03

General Review Criteria

Viability

32. Regarding the philanthropic portion of the applicant's funding plan, please provide applicant's historical success with similar fundraising campaigns.

Applicant Response:

Luminis Health has a long history of successful capital campaigns to support large capital projects. Our largest capital campaign to date was the $44M campaign to support the expansion of LHAAMC in 2010 when the 2nd Acute Care Hospital Tower was opened. In addition, in 2017 Luminis Health conducted a *Living the Way to Healthy Minds* campaign to support the construction of the J. Kent McNew Family Medical Center which raised $10M for our Behavioral Health campus on Riva Road. Another example involved Luminis Health's campaign to raise capital dollars for the LHAAMC Cardiac Surgery Program, which concluded in the spring of 2022 and raised over $2 million.

More recently at LHDCMC, the Foundation raised $800,000 in short order to supplement the $20 million grant from Prince George's County to renovate and open a new Behavioral Health Pavilion on the Lanham campus. Leveraging the expertise within Luminis Health and its history of successful capital campaigns, the LHDCMC Foundation plans to launch a more expansive campaign for the Obstetrics and Facility project, engaging our board, community leaders and corporate partners to reach our goals. In addition to the Foundation at LHDCMC, there are shared Luminis Health grants resources that will be allocated to support the fundraising goals for this project.

33. In the application page 118, the applicant states it has already received a commitment of 21M by the State. Please document what was received in the recent 2024 budget and explain how a 2025 capital budget request can be projected with certainty.

Applicant Response:

LHDCMC received an appropriation of $6 million in capital funding in FY24 under Chapter 102 of the Laws of Maryland of 2023 (the "Act") “for the acquisition, planning, design, construction, repair, renovation, reconstruction, site improvement, and capital equipping of infrastructure improvements to the Luminis Health Doctors Community Medical Center, including a new tower for obstetrical care." An additional $10 million is pre-authorized in the Act for the same project in FY25. Please refer to **Exhibit 28** for the relevant provisions of the Act. LHDCMC is also pursuing additional funding through the United States Congressionally Directed Spending program.

While the preauthorized amount of $10 million is not guaranteed, the fact that it was preauthorized is a strong indication of the State’s support of the project and intent to provide this funding in FY25. LHDCMC is working closely with elected officials and community organizations to educate them on the significant health care disparities within LHDCMC’s communities, LHDCMC’s strategy for addressing those disparities, and the critical need for community and government financial support to deliver obstetrical care to the community. Based on those discussions, LHDCMC is confident it will receive this and other significant financial support for the project.

34. Please discuss the applicant’s contingency plan for the total State award in the event it is not received.

Applicant Response

The project outlined in the CON application closely aligns with the priorities of Maryland, as outlined by Governor Moore’s Administration. The significant disparity in maternal and infant outcomes for people of color has been well documented in government reports, by non-governmental organizations, and in academic, trade and mass media. LHDCMC is in a unique position to partner with government agencies to launch initiatives to improve maternal and infant outcomes. Our existing partnerships with Prince George’s County and the State of Maryland have resulted in access to needed services, and we believe these partnerships will be continued, and expanded, due to the successful implementations of programs to address disparities. The $6M in FY24 funding and the preauthorization of another $10M in the FY25 budget highlight the State’s support of this project. With that said, should the projected $95M in anticipated funding from government sources, both State and Federal, not come to fruition, and no other grant source offsets that loss, Luminis Health could potentially back-fill this loss of funding with a combination of operating cash, investment redemption, and bond issuance, with bond issuance being the majority of the new funding. The increase of $79M in debt would result in an average annual increased interest expense over the first five years of $611,000. The annual increased depreciation expense due to capitalized interest for the roughly three-year construction period would be approximately $52,000.

35. For community support, (Exhibit 20) staff are unable to read all the signatures on the form letters from Luminis Health. If the applicant wants the individual names included

under the support section, please provide letters with legible signatures and/or typed names and titles.

Applicant Response

It is not necessary to include the individual names in the support section.

Impact

36. Please resubmit Table 24 with Obstetrics units for service area discharges in addition to Obstetric units for the whole State.

Applicant Response

Table 24 is resubmitted with all Obstetric units across the State impacted by the LHDCMC Obstetric Program. (Please note that the impact is 1% or less to the hospitals listed in the "Other" category.)

Table 24 (Revised)
Impact of LHDCMC Obstetric Programs on Existing Obstetric Units
In FY 2022 Volumes

Hospital	County	Total Shift of Discharges FY 2022 (Note 1)	Hospital's Total OB FY 2022 (Note 2 Note 3)	Shift as a % of Total Hospital OB, FY 2022
Anne Arundel Medical Center	Anne Arundel County	778	5,897	13.2%
Holy Cross Hospital	Montgomery County	613	9,142	6.7%
Adventist HealthCare White Oak Hospital	Montgomery County	103	1,528	6.8%
UM Capital Region Medical Center	Prince George's County	103	1,526	6.8%
MedStar Southern Maryland Hospital Center	Prince George's County	48	1,072	4.5%
Adventist HealthCare Shady Grove Medical Center	Montgomery County	45	1,528	2.9%
Howard County General Hospital	Howard County	44	2,876	1.5%
University of Maryland Medical Center	Baltimore City	43	2,159	2.0%
Holy Cross Germantown Hospital	Montgomery County	43	1,868	2.3%
UM Baltimore Washington Medical Center	Anne Arundel County	34	1,711	2.0%
Saint Agnes Hospital	Baltimore City	31	1,538	2.0%
Other Maryland Hospitals		48	36,739	0.1%
Total Maryland		**1,934**	67,584	

MedStar Washington Hospital Center	Washington, D.C.	240
George Washington University	Washington, D.C.	54
Sibley Memorial Hospital	Washington, D.C.	68
MedStar Georgetown University Hospital	Washington, D.C.	36
All Other Washington, D.C.		*30*
Total Washington, D.C.		**428**
Total FY22 Discharges to shift to DCMC		**2,362**

Note 1: Projected Discharges & Source of Volume, Fiscal Years 2027 through 2031
Note 2: HSCRC FY22 Abstract dataset for Maryland hospital discharges
Note 3: CY21 DCHA discharge database for DC hospital discharges Maryland discharges only

Tables

37. Exhibit 1, Table B, staff found multiple mathematical errors in this table, please review for accuracy, and revise accordingly.

Applicant Response

Please refer to Table B in **Exhibit 1 (Corrected)** for the corrected table.

38. Table D, please identify the total site and off-site costs included and excluded from the MVS analysis for the $127,369,727 in new construction.

Applicant Response

Please refer to Table D in **Exhibit 1 (Corrected)** for this information.

39. The applicant states on page 3 of the Project Description that the new acute care pavilion will span 167,000 square feet, but Table D states 186,949 square feet. Please reconcile these numbers.

Applicant Response

Table C showed the project as 182,949 square feet, which is the correct square footage. The square footage reference in the Project Description is incorrect and should say 182,949 square feet, to match Table D.

40. Table F is incomplete, please submit a completed table.

Applicant Response

Please refer to Table F in **Exhibit 1 (Corrected)** for a completed Table.

41. Table F for the Entire Facility shows that for the projected years after the new Obstetric program opens (2027-2031) the hospital occupancy is below minimum occupancy standards set forth in COMAR 10.24.10 State Health Plan Acute Care Hospital Services. Please comment on these projections.

Applicant Response

There was a calculation error for average length of stay in Table F that resulted in lower than projected occupancy (in patient days). Please refer to Table F in **Exhibit 1 (Corrected)** for a corrected Table F.

42. The coversheet for Exhibit 1 has the correct table listings. Table H Revenue and Expenses Inflated has never been received and was instead submitted as a workforce table which should be Table L. Please resubmit the correct tables.

Applicant Response

In responding to this question, the Applicant discovered that there is an inadvertent labelling variance between the paper copy of Tables H and L as filed with MHCC, and the electronic (PDF) version of these Tables that were transmitted to MHCC and are now posted on the MHCC website. The electronic version posted on the MHCC website includes the correct Table H (Revenues and Expenses Inflated), but the Workforce Information table (Table L) is mis-labelled as a second Table H. The paper version of the Application did not include Table H (Revenues and Expenses Inflated) but included the Workforce Information table mis-labelled as Table H. **Exhibit 1 (Corrected)** includes Table H (Revenues and Expenses Inflated) and Table L (Workforce Information) with the correct labels.

43. Please provide the assumptions used in your workforce table for calculating average salaries and note if there will be additional expenses related to contracted staff.

Applicant Response

Table L ties to the FY24 *2a Salaries & Wages (including benefits)* on Table G.

The FY24 LHDCMC budgeted salary and wages, including benefits, was used for both Tables G and L ($118,166,414).

For each employment category in the table (RN, Tech, Management), the average salary was determined by dividing the total salary, wage, and benefit expenses for each category by the number of FTEs within that category.

The staffing for the obstetrics program, including FTEs and wages by category were added to the second set of columns (PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) and the staffing related to other anticipated workforce growth to support the surgical program is included in the next set of columns (OTHER EXPECTED CHANGES

IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS). All of these numbers are added for the final columns of the table, which are presented in current dollars and ties to Table G.

44. Are benefits included in the workforce table in Exhibit 1?

Applicant Response

Yes benefits are included in Table L and are approximately 17% of the wages and salaries.

45. Please elaborate on the additional 8.7 FTEs needed under "other changes to operations."

Applicant Response

As discussed in 10.24.11 8(3) Financial Feasibility Table 23 to operate 10 operating rooms which is 2 more than LHDCMC currently operates we need to add 8.7 FTEs. These 8.7 FTEs include 4.16 staff nurse FTEs, 2.92 surgical technicians FTEs, and 1.62 operating room assistant FTEs. The estimated FTEs needed are based on the current FTEs needed to operate the existing 8 functioning ORs at LHDCMC and no additional support staff or staff beyond these specific functions will be needed to support the projected surgical operations.

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

Lucas Klock

Name: Luke Klock
Title: Director, Capital Projects
Date: 5/12/2023

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

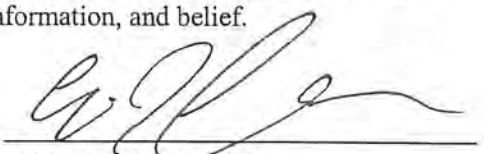
Jessica Farrar

Name: Jessica Farrar
Title: Vice President, Strategic Planning
Date: 5/12/2023

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

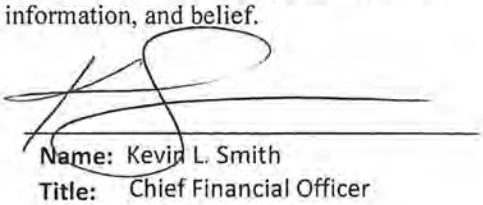
Name: Charlene E. Harrison, MHA
Title: Vice President, Women's & Children's
Date: 5/11/23

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



Name: Eric Crowder
Title: Associate General Counsel
Date: May 12, 2023

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



Name: Kevin L. Smith
Title: Chief Financial Officer
Date: May 12, 2023

Name: **Timothy Adelman**
Title: **Chief Legal Officer and General Counsel**
Date: **May 12, 2023**

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

Name: Zachary Pietsch
Title: Sr Manager, Hospital Reimbursement
Date: 5/12/23

Exhibits to Responses to 4/25/23 Completeness Questions

Replacement Exhibits:

Exhibit 1 (Corrected)	CON Application Tables and Assumptions
Exhibit 3 (Corrected)	Drawings

New Exhibits:

Exhibit 22	MVS Calculations
Exhibit 23	Table 13 (Obstetrics Staffing)
Exhibit 24	Emergency Medical Treatment and Active Labor Act – Evaluation, Treatment and/or Transfer of Patients
Exhibit 25	Transfer of Patients to Other Acute Facilities
Exhibit 26	FGI Narrative
Exhibit 27	Calculations for Ten Operating Rooms
Exhibit 28	Excerpt from State Capital Budget

EXHIBIT 1 (CORRECTED)

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*		178	169	17	186	186	General Medical/ Surgical*	178	169	17	186	186	
SUBTOTAL Gen. Med/Surg*		178	169	17	186	186	SUBTOTAL Gen. Med/Surg*		169	17	186	186	
ICU/CCU		22	24		24	24	ICU/CCU		24	0	24	24	
SICU					0	0	SICU				0	0	
MICU					0	0	MICU				0	0	
TOTAL MSGA		200	193	17	210	210	TOTAL MSGA		193	17	210	210	
Obstetrics					0	0	Obstetrics		21		21	21	
Pediatrics					0	0	Pediatrics				0	0	
Psychiatric					0	0	Psychiatric		16		16	16	
TOTAL ACUTE		200	193	17	210	210	TOTAL ACUTE		230	17	247	247	
NON-ACUTE CARE							NON-ACUTE CARE						
Dedicated Observation**					0	0	Dedicated Observation**				0	0	
Comprehensive Care					0	0	Comprehensive Care				0	0	
Other *(Specify/add rows as needed)*					0	0	Other *(Specify/add rows as needed)*				0	0	
TOTAL NON-ACUTE		0	0	0	0	0	TOTAL NON-ACUTE		0	0	0	0	
HOSPITAL TOTAL		200	193	17	210	210	HOSPITAL TOTAL		230	17	247	247	

* 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
LEVEL 1					
Public Space / Lobby	2,376	3,370	0	0	3,370
Community / Multipurpose Room	0	1,703	0	0	1,703
Café / Grab & Go	0	1,638	0	0	1,638
Care Management	1,332	2,610	0	0	2,610
Executive Administration	1,585	3,087	0	0	3,087
Medical Staff Services	1,010	2,239	0	0	2,239
Nursing Administration	767	2,271	0	0	2,271
Admin Space / Holding	0	1,465	0	0	1,465
Admissions / Check-in / HIMS (ROI)	1,436	1,619	0	0	1,619
Security	301	1,027	0	0	1,027
Sterile Processing Distribution (SPD)	5,942	9,006	0	0	9,006
Loading Dock/EVS (Linen,Red bag, Gas Cyl,)	347	3,695	0	0	3,695
Gift Shop / Retail	377	0	1,137	0	1,137
Imaging / Nuclear Medicine	7,072	883	14,907	0	15,570
Bio-Medical Engineering	1,155	0	2,074	0	2,074
EVS / Linen / Laundry	1,087	0	3,294	0	3,294
Food & Nutrition - Kitchen	4,015	0	2,600	2,600	5,200
Food & Nutriton - Dining & Servery	4,700	0	6,240	0	6,240
Laboratory	6,315	260	6,315	0	6,575
Morgue	344	0	844	0	844
Supply Chain Management / EPS	3,117	335	5,345	0	5,680
Staff Support Svc. - Staff Lng / Lockers	599	0	1,656	0	1,656
Mechanical / Electrical	4,207	8,705	989	4,207	13,901
Vertical Circulation	1,569	988	0	1,394	2,382
Circulation	9,206	6,173	9,222	0	15,395
Exterior Walls	0	2,376	0	0	2,376
Sub-Total Level 1	**59,837**	**53,233**	**84,623**	**8,201**	**116,056**
LEVEL 2					
Public Space / Lobby	0	2,665	281	0	2,946
Meditation	165	403	0	0	403
Surgery Services	27,295	26,420	21,589	0	48,009
Endoscopy	0	5,860	0	0	5,860
Imaging - CT / US	841	0	0	841	841
Information Technology (IT) & Information Systems	1,006	0	809	0	809
Cardiac Cath / Interventional Radiology	3,332	0	10,435	0	10,435
Non-Invasive Cardiology / PFT	592	0	2,358	0	2,358
Pharmacy - Inpatient	3,780	0	6,450	0	6,450
Respiratory Therapy	473	0	500	0	500
GME	0	0	746	0	746
Mechanical / Electrical	1,531	1,153	196	1,531	2,880
Vertical Circulation	2,001	988	0	2,001	2,988
Circulation (Horizontal)	6,576	4,801	7,554	0	12,355
Exterior Walls	0	1,740	0	0	1,740
Sub-Total Level 2	**47,592**	**44,030**	**50,918**	**4,373**	**99,321**
LEVEL 3					
Public Space	0	2,630	0	0	2,630
Labor & Delivery / Triage / C-Section	0	26,060	0	0	26,060
On-call	0	1,262	0	0	1,262
Mechanical / Electrical	0	5,187	0	0	5,187
Vertical Circulation	0	988	0	0	988
Circulation	0	2,420	0	0	2,420
Exterior Walls	0	1,712	0	0	1,712
Sub-Total Level 3	**0**	**40,259**	**0**	**0**	**40,259**
LEVEL 4					
Public Space	0	1,024	0	0	1,024
Postpartum / Antepartum	0	10,124	0	0	10,124
Level II Continuing Care Nursery and Well Baby Nursery / Resp. Therapy	0	2,905	0	0	2,905
Respiratory Therapy	0	264	0	0	264
Mechanical / Electrical	0	967	0	0	967
Vertical Circulation	0	988	0	0	988
Circulation	0	964	0	0	964
Exterior Walls	0	1,234	0	0	1,234
Sub-Total Level 4	**0**	**24,470**	**0**	**0**	**24,470**
PENTHOUSE					
Penthouse	0	20,958	0	0	20,958
Sub-Total Penthouse	**0**	**20,958**	**0**	**0**	**20,958**
Total	**108,429**	**182,949**	**135,541**	**12,574**	**301,064**

TABLE C. CONSTRUCTION CHARACTERISTICS

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

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☑	☐
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☑	☑
Excellent	☐	☐
Number of Stories	**5**	**2**

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement	NA	NA
First Floor	53,232	54,623
Second Floor	44,030	50,918
Third Floor	40,259	0
Fourth Floor	24,470	NA
Penthouse	20,958	NA
Total Square Footage	**182,949**	**105,541**
Average Square Feet	**36,590**	**52,771**
Perimeter in Linear Feet	**Linear Feet**	
Basement	NA	NA
First Floor	1,093	NA
Second Floor	814	NA
Third Floor	1,207	0
Fourth Floor	693	0
Penthouse	646	0
Total Linear Feet	**4,453**	NA
Average Linear Feet	**891**	NA
Wall Height (floor to eaves)	**Feet**	
Basement	NA	NA
First Floor	16	16
Second Floor	**16**	16
Third Floor	16	NA
Fourth Floor	16	NA
Penthouse	18	NA
Average Wall Height	**16.4**	**16.0**
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	**4**	NA
Freight	**2**	NA
Sprinklers	**Square Feet Covered**	
Wet System	182,949	105,541
Dry System	NA	NA
Other	**Describe Type**	
Type of HVAC System for proposed project	VAV Air Handling Systems	Replace entire systems with new VAV Air Handling Systems
Type of Exterior Walls for proposed project	Assembly of brick masonry, metal panels and glass.	

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	**$1,013,977**	**$0**
Utilities Connections	**$935,583**	**$0**
Subtotal included in Marshall Valuation Costs	**$1,949,560**	**$0**
Site Demolition Costs	**$0**	**$0**
Storm Drains	**$0**	**$0**
Rough Grading / Erosion Control	**$0**	**$0**
Site Utility Relocation	**$0**	**$0**
Paving / Site Roads / Hardscape	**$1,006,010**	**$0**
Site Signage	**$50,000**	**$0**
Landscaping	**$150,000**	**$0**
Walls	**$0**	**$0**
Site Lighting	**$200,000**	**$0**
Site Development (Railings, Bike Rack, Fixed Benches etc)	**$30,000**	**$0**
Subtotal On-Site excluded from Marshall Valuation Costs	**$1,436,010**	**$0**
OFFSITE COSTS		
Offsite Road Repairs	**$0**	**$0**
Extending Utilities to Site Line	**$0**	**$0**
Jurisdictional Hook-up and Impact Fees	**$850,000**	**$0**
Subtotal Off-Site excluded from Marshall Valuation Costs	**$850,000**	**$0**
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$2,286,010**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$4,235,570**	**$0**

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

TABLE E. PROJECT BUDGET

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

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

		New Construction	Other Structure	Total
A.	**USE OF FUNDS**			
	1. CAPITAL COSTS			
	a. New Construction			
	(1) Building	$ 125,033,933		$ 125,033,933
	(2) Fixed Equipment	in above		in above
	(3) Site and Infrastructure	$ 1,949,561		$ 1,949,560
	(4) Architect/Engineering Fees	$ 8,888,845		$ 8,888,845
	(5) Permits (Building, Utilities, Etc.)	$ 3,751,018		$ 3,751,018
	SUBTOTAL	**$ 139,623,357**	**$ -**	**$ 139,623,356**
	b. Renovations			
	(1) Building	$ 49,613,831		$ 49,613,831
	(2) Fixed Equipment (not included in construction)	$ 1,438,000		$ 1,438,000
	(3) Architect/Engineering Fees	$ 4,961,383		$ 4,961,383
	(4) Permits (Building, Utilities, Etc.)	$ 1,488,415		$ 1,488,415
	SUBTOTAL	**$ 57,501,629**		**$ 57,501,629**
	c. Other Capital Costs			
	(1a) County 3rd Party Inspections (Building, Utilities, Etc.)	$ 856,900		$ 856,900
	(1b) Regulatory & Enviromental Permitting	$ 1,466,813		$ 1,466,813
	(5a) Paving (Roadways, Parking, Etc.)	$ 1,006,000		$ 1,006,000
	(5b) Exterior Signs	$ 50,000		$ 50,000
	(5c) Landscaping	$ 150,000		$ 150,000
	(5d) Site Lighting	$ 200,000		$ 200,000
	(5e) Site Development (Railings, Bike Rack, Fixed Benches etc)	$ 30,000		$ 30,000
	(6a) Jurisdictional Hook up Fees	$ 850,000		$ 850,000
	(5-6) Arch / Eng. Fees for Non-MVS Cap Costs From Table D	$ 100,500		$ 100,500
	(7a) Additional Service Elevators (2)	$ 305,000		$ 305,000
	(7b) Atrium Premium	$ 322,000		$ 322,000
	(7c) Canopies	$ 475,000		$ 475,000
	(7d) Pneumatic Tube System	$ 1,010,600		$ 1,010,600
	(7e) Temporary Entrance During Construction Closure	$ 400,000		$ 400,000
	(7f) Constrained Site	$ 1,450,000		$ 1,450,000
	(7g) General Conditions - Schedule/Phasing Impact	$ 1,120,000		$ 1,120,000
	(7h) Arch / Engineering Fees for Other Capital Costs	$ 1,999,410		$ 1,999,410
	(7i) Movable Equipment (Inc. Furnishings)	$ 5,750,000		$ 5,750,000
	(7j) Minor Clinical Equipment Equipment	$ 2,730,000		$ 2,730,000
	(7k) Technology - Data/Communcation/AV	$ 2,550,000		$ 2,550,000
	(7l) Technology - Safety and Security Systems	$ 1,150,000		$ 1,150,000
	(7m) Technology - Clinical Systems (IoMT)	$ 3,125,000		$ 3,125,000
	(8a) Green Building / LEED Premium	$ 4,725,000		$ 4,725,000
	(8b) MBE Premium Premium	$ 2,900,000		$ 2,900,000
	(8c) Prevailing Wage	$ -		$ -
	(8d) Contingency Allowance	$ 22,575,000		$ 22,575,000
	SUBTOTAL	***$ 57,297,223***	***$ -***	***$ 57,297,223***
	TOTAL CURRENT CAPITAL COSTS	***$ 254,422,209***	***$ -***	***$ 254,422,208***
	d. Land Purchase	**$ -**	**$ -**	**$ -**
	e. Inflation Allowance	$ 29,100,650	$ -	$ 29,100,650
	TOTAL CAPITAL COSTS	***$ 283,522,859***	***$ -***	***$ 283,522,858***
	2. Financing Cost and Other Cash Requirements			
	a. Loan Placement Fees			$ -
	b. Bond Discount			$ -
	c CON Application Assistance			$ -
	c1. Legal Fees			$ -
	c2. Other (Specify/add rows if needed)			$ -
	d. Non-CON Consulting Fees			$ -
	d1. Legal Fees			$ -
	d2. Other (Specify/add rows if needed)			$ -
	e. Debt Service Reserve Fund			$ -
	f Bond Issue Fees	$3,060,000		$ 3,060,000
	SUBTOTAL	***$ 3,060,000***	***$ -***	***$ 3,060,000***
	3. Working Capital Startup Costs			
	TOTAL USES OF FUNDS	***$ 286,582,859***	***$ -***	***$ 286,582,858***
B.				
	1. Cash	$33,688,629		$ 33,688,629
	2. Philanthropy (to date and expected)	$5,000,000		$ 5,000,000
	3. Authorized Bonds	$152,894,229		$ 152,894,229
	4. Interest Income from bond proceeds listed in #3	$0		$ -
	5. Mortgage	$0		$ -
	6. Working Capital Loans	$0		$ -
	7.			
	a. Federal	$0		$ -
	b. State	$95,000,000		$ 95,000,000
	c. Local	$0		$ -
	8. Other *(Specify/add rows if needed)*	$0		$ -
	TOTAL SOURCES OF FUNDS	***$ 286,582,858***	***$ -***	***$ 286,582,858***
		Hospital Building	***Other Structure***	***Total***
	1. Land			$ -
	2. Building			$ -
	3. Major Movable Equipment			$ -
	4. Minor Movable Equipment			$ -
	5. Other *(Specify/add rows if needed)*			$ -

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

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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 sec 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 projection all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) include years, if needed in order to be consistent with Tables G and H.							
Indicate CY or FY	FY2021	FY2022	FY2023 Annu	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030
1. DISCHARGES										
a. General Medical/Surgical*	9,088	7,811	7,910	8,937	8,943	8,949	9,000	9,051	9,103	9,155
b. ICU/CCU	1,394	1,213	1,134	1,281	1,282	1,283	1,290	1,298	1,305	1,313
Total MSGA	10,482	9,024	9,044	10,218	10,225	10,232	10,291	10,349	10,408	10,467
c. Pediatric	0	0	0	0	0	0	0	0	0	0
d. Obstetric	0	0	0	0	0	0	556	1,460	1,754	2,090
e. Acute Psychiatric	0	0	182	695	700	705	710	710	710	710
Total Acute	10,482	9,024	9,226	10,913	10,925	10,937	11,557	12,519	12,872	13,267
f. Rehabilitation	0	0	0	0	0	0	0	0	0	0
g. Comprehensive Care	0	0	0	0	0	0	0	0	0	0
h. Other (Specify/add rows if needed)	0	0	0	0	0	0	0	0	0	0
TOTAL DISCHARGES	10,482	9,024	9,226	10,913	10,925	10,937	11,557	12,519	12,872	13,267
2. PATIENT DAYS										
a. General Medical/Surgical*	44,892	46,775	50,167	56,678	56,150	55,627	55,385	55,144	54,903	54,664
b. ICU/CCU	7,699	5,191	4,918	5,557	5,560	5,564	5,596	5,628	5,660	5,692
Total MSGA	52,591	51,966	55,085	62,235	61,711	61,192	60,981	60,771	60,563	60,356
c. Pediatric	0	0	0	0	0	0	0	0	0	0
d. Obstetric	0	0	0	0	0	0	1,363	3,596	4,301	5,123
e. Acute Psychiatric	0	0	1,274	4,865	4,900	4,935	4,970	4,970	4,970	4,970
Total Acute	52,591	51,966	56,359	67,100	66,611	66,127	67,314	69,337	69,834	70,449
f. Rehabilitation	0	0	0	0	0	0	0	0	0	0
g. Comprehensive Care	0	0	0	0	0	0	0	0	0	0
h. Other (Specify/add rows if needed)	0	0	0	0	0	0	0	0	0	0
TOTAL PATIENT DAYS	52,591	51,966	56,359	67,100	66,611	66,127	67,314	69,337	69,834	70,449
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	4.9	6.0	6.3	6.3	6.3	6.2	6.2	6.1	6.0	6.0
b. ICU/CCU	5.5	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3
Total MSGA	5.0	5.8	6.1	6.1	6.0	6.0	5.9	5.9	5.8	5.8
c. Pediatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
d. Obstetric	0.0	0.0	0.0	0.0	0.0	0.0	2.5	2.5	2.5	2.5
e. Acute Psychiatric	0.0	0.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0
Total Acute	5.0	5.8	6.1	6.1	6.1	6.0	5.8	5.5	5.4	5.3
f. Rehabilitation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL AVERAGE LENGTH OF STAY	5.0	5.8	6.1	6.1	6.1	6.0	5.8	5.5	5.4	5.3
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*	168	184	178	178	178	178	178	178	178	178
b. ICU/CCU	22	22	22	22	22	22	22	22	22	22
Total MSGA	190	206	200	200	200	200	200	200	200	200
c. Pediatric										
d. Obstetric							21	21	21	21
e. Acute Psychiatric			16	16	16	16	16	16	16	16
Total Acute	190	206	216	216	216	216	237	237	237	237
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Dedicated Observation)										
TOTAL LICENSED BEDS	190	206	216	216	216	216	237	237	237	237
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	73.2%	69.6%	77.2%	87.2%	86.4%	85.6%	85.2%	84.9%	84.5%	84.1%
b. ICU/CCU	95.9%	64.6%	61.2%	69.2%	69.2%	69.3%	69.7%	70.1%	70.5%	70.9%
Total MSGA	75.8%	69.1%	75.5%	85.3%	84.5%	83.9%	83.5%	83.2%	83.0%	82.7%
c. Pediatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
d. Obstetric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	17.8%	46.9%	56.1%	66.8%
e. Acute Psychiatric	0.0%	0.0%	21.8%	83.3%	83.9%	84.5%	85.1%	85.1%	85.1%	85.1%
Total Acute	75.8%	69.1%	71.5%	85.1%	84.5%	83.9%	77.8%	80.2%	80.7%	81.4%
f. Rehabilitation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL OCCUPANCY %	75.8%	69.1%	71.5%	85.1%	84.5%	83.9%	77.8%	80.2%	80.7%	81.4%
6. OUTPATIENT VISITS										
a. Emergency Department	32,970	36,149	36,222	33,039	33,062	33,085	33,273	33,463	33,654	33,845
b. Same-day Surgery	4,150	3,705	3,772	4,159	4,162	4,164	4,188	4,212	4,236	4,260
c. Laboratory	4,854	3,879	4,861	4,864	4,868	4,871	4,874	4,878	4,881	4,884
d. Imaging	520	763	521	521	521	522	522	523	523	523
e. Other (Clinic)	3,705	2,161	2,060	3,713	3,716	3,718	3,739	3,760	3,782	3,803
TOTAL OUTPATIENT VISITS	46,199	46,648	47,435	46,295	46,328	46,360	46,597	46,836	47,075	47,317
7. OBSERVATIONS**										
a. Number of Patients	3,927	3,823	3,684	3,935	3,938	3,941	3,963	3,986	4,008	4,031
b. Hours	95,745	101,760	126,760	95,945	96,011	96,078	96,626	97,176	97,730	98,287

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

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

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the I expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY2021	FY2022	FY2023 P	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030
1. REVENUE										
a. Inpatient Services	$ 166,407,973	$ 166,865,639	$ 195,069,043	$ 189,440,580	$ 189,650,628	$ 189,860,763	$ 190,959,713	$ 191,977,634	$ 193,001,356	$ 194,030,912
b. Outpatient Services	$ 91,753,629	$ 103,807,451	$ 114,364,819	$ 111,064,971	$ 111,142,147	$ 111,219,376	$ 111,782,766	$ 112,349,318	$ 112,919,049	$ 113,491,978
c. Obstetric Services							$ 9,624,128	$ 24,633,717	$ 29,536,897	$ 34,895,152
d. Capital funding							$ 4,161,451	$ 4,161,451	$ 4,161,451	$ 4,161,451
Gross Patient Service Revenues	***$ 258,161,602***	***$ 270,673,090***	***$ 309,433,862***	***$ 300,505,551***	***$ 300,792,775***	***$ 301,080,138***	***$ 316,528,058***	***$ 333,122,120***	***$ 339,618,753***	***$ 346,579,493***
c. Allowance For Bad Debt	$ 5,151,892	$ 8,511,088	$ 9,185,700	$ 9,449,145	$ 9,458,177	$ 9,467,213	$ 9,519,483	$ 9,569,306	$ 9,619,411	$ 9,669,799
d. Contractual Allowance	$ 35,434,170	$ 32,457,858	$ 38,979,515	$ 36,035,228	$ 36,069,670	$ 36,104,130	$ 36,303,470	$ 36,493,473	$ 36,684,552	$ 36,876,715
e. Charity Care	$ 6,776,112	$ 8,470,778	$ 17,076,760	$ 9,404,392	$ 9,413,380	$ 9,422,374	$ 9,474,397	$ 9,523,983	$ 9,573,851	$ 9,624,001
Net Patient Services Revenue	***$ 210,799,428***	***$ 221,233,366***	***$ 244,191,887***	***$ 245,616,787***	***$ 245,851,548***	***$ 246,086,423***	***$ 261,230,708***	***$ 277,535,358***	***$ 283,740,940***	***$ 290,408,979***
f. Other Operating Revenues (Specify/add rows if needed)	$ 18,562,531	$ 7,698,149	$ 7,302,559	$ 7,397,160	$ 2,597,160	$ 2,597,160	$ 2,597,160	$ 2,597,160	$ 2,597,160	$ 2,597,160
NET OPERATING REVENUE	***$ 229,361,960***	***$ 228,931,515***	***$ 251,494,446***	***$ 253,013,947***	***$ 248,448,708***	***$ 248,683,583***	***$ 263,827,868***	***$ 280,132,518***	***$ 286,338,100***	***$ 293,006,139***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 98,012,469	$ 101,584,949	$ 114,315,004	$ 118,166,414	$ 118,231,925	$ 118,297,426	$ 124,350,551	$ 127,600,282	$ 128,952,290	$ 130,769,652
b. Contractual Services	$ 40,848,292	$ 40,289,039	$ 41,541,754	$ 40,942,437	$ 40,962,004	$ 40,981,570	$ 44,440,432	$ 46,225,493	$ 46,157,021	$ 46,088,955
c. Interest on Current Debt	$ 4,512,479	$ 4,381,359	$ 4,290,651	$ 4,259,700	$ 4,260,718	$ 4,261,736	$ 4,267,618	$ 4,273,202	$ 4,278,796	$ 4,284,399
d. Interest on Project Debt	$ -	$ -	$ -				$ 4,170,900	$ 8,176,365	$ 8,001,597	$ 7,816,972
e. Current Depreciation	$ 11,193,187	$ 11,654,490	$ 11,948,147	$ 11,861,960	$ 11,864,794	$ 11,867,628	$ 11,884,009	$ 11,899,559	$ 11,915,135	$ 11,930,739
f. Project Depreciation	$ -	$ -	$ -				$ 3,952,722	$ 7,905,444	$ 7,905,444	$ 7,905,444
g. Current Amortization	$ 1,377,612	$ (60,919)	$ -							
h. Project Amortization	$ -	$ -	$ -							
i. Supplies	$ 37,762,429	$ 37,606,070	$ 34,900,852	$ 34,095,237	$ 34,121,308	$ 34,147,386	$ 35,068,557	$ 36,692,529	$ 37,283,244	$ 37,902,066
j. Other Expenses (Specify/add rows if needed)	$ 36,695,657	$ 47,980,503	$ 35,172,128	$ 34,258,767	$ 34,288,237	$ 34,317,719	$ 34,488,248	$ 34,650,700	$ 34,813,988	$ 34,978,115
TOTAL OPERATING EXPENSES	***$ 230,402,126***	***$ 243,435,492***	***$ 242,168,536***	***$ 243,584,515***	***$ 243,728,986***	***$ 243,873,464***	***$ 262,623,038***	***$ 277,423,574***	***$ 279,307,514***	***$ 281,676,342***
3. INCOME										
a. Income From Operation	***$ (1,040,166)***	***$ (14,503,977)***	***$ 9,325,910***	***$ 9,429,431***	***$ 4,719,722***	***$ 4,810,118***	***$ 1,204,830***	***$ 2,708,944***	***$ 7,030,586***	***$ 11,329,796***
b. Non-Operating Income										
SUBTOTAL	***$ (1,040,166)***	***$ (14,503,977)***	***$ 9,325,910***	***$ 9,429,431***	***$ 4,719,722***	***$ 4,810,118***	***$ 1,204,830***	***$ 2,708,944***	***$ 7,030,586***	***$ 11,329,796***
c. Income Taxes										
NET INCOME (LOSS)	***$ (1,040,166)***	***$ (14,503,977)***	***$ 9,325,910***	***$ 9,429,431***	***$ 4,719,722***	***$ 4,810,118***	***$ 1,204,830***	***$ 2,708,944***	***$ 7,030,586***	***$ 11,329,796***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	45.5%	44.7%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%
2) Medicaid	14.9%	20.1%	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%
3) Blue Cross	10.0%	8.6%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%
4) Commercial Insurance	22.9%	18.0%	24.1%	24.1%	24.1%	24.1%	24.1%	24.1%	24.1%	24.1%
5) Self-pay	3.5%	4.3%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%
6) Other	3.2%	4.4%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%
TOTAL	***100.0%***	***100.1%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare	45.5%	44.7%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%
2) Medicaid	14.9%	20.1%	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%
3) Blue Cross	10.0%	8.6%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%
4) Commercial Insurance	22.9%	18.0%	24.1%	24.1%	24.1%	24.1%	24.1%	24.1%	24.1%	24.1%
5) Self-pay	3.5%	4.3%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%
6) Other	3.2%	4.4%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%
TOTAL	***100.0%***	***100.1%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the (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 reasona

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order t revenues over total expenses consistent with the Financial Feasibility stand						
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023 P**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**
1. REVENUE										
a. Inpatient Services	$ 166,407,973	$ 166,865,639	$ 195,069,043	$ 194,744,916	$ 194,960,846	$ 195,176,864	$ 196,306,584	$ 197,353,008	$ 198,405,394	$ 199,463,777
b. Outpatient Services	$ 91,753,629	$ 103,807,451	$ 114,364,819	$ 114,174,791	$ 114,254,127	$ 114,333,518	$ 114,912,684	$ 115,495,099	$ 116,080,783	$ 116,669,754
c. Obstetric Services							$ 10,748,153	$ 28,281,049	$ 34,859,693	$ 42,336,690
d. Capital Policy							$ 4,647,477	$ 4,777,606	$ 4,911,379	$ 5,048,898
Gross Patient Service Revenues	***$ 258,161,602***	***$ 270,673,090***	***$ 309,433,862***	***$ 308,919,707***	***$ 309,214,973***	***$ 309,510,382***	***$ 326,614,899***	***$ 345,906,762***	***$ 354,257,249***	***$ 363,519,119***
c. Allowance For Bad Debt	$ 5,151,892	$ 8,511,088	$ 9,185,700	$ 9,713,721	$ 9,723,006	$ 9,732,294	$ 9,822,842	$ 9,936,559	$ 10,034,034	$ 10,142,426
d. Contractual Allowance	$ 35,434,170	$ 32,457,858	$ 38,979,515	$ 37,044,214	$ 37,079,621	$ 37,115,045	$ 37,460,357	$ 37,894,028	$ 38,265,756	$ 38,679,123
e. Charity Care	$ 6,776,112	$ 8,470,778	$ 17,076,760	$ 9,667,715	$ 9,676,955	$ 9,686,200	$ 9,776,319	$ 9,889,497	$ 9,986,510	$ 10,094,389
Net Patient Services Revenue	***$ 210,799,428***	***$ 221,233,366***	***$ 244,191,887***	***$ 252,494,057***	***$ 252,735,391***	***$ 252,976,843***	***$ 269,555,381***	***$ 288,186,678***	***$ 295,970,949***	***$ 304,603,181***
f. Other Operating Revenues (Specify/add rows if needed)	$ 18,562,531	$ 7,698,149	$ 7,302,559	$ 7,397,160	$ 2,597,160	$ 2,597,160	$ 2,597,160	$ 2,597,160	$ 2,597,160	$ 2,597,160
NET OPERATING REVENUE	***$ 229,361,960***	***$ 228,931,515***	***$ 251,494,446***	***$ 259,891,217***	***$ 255,332,551***	***$ 255,574,003***	***$ 272,152,541***	***$ 290,783,838***	***$ 298,568,109***	***$ 307,200,341***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 98,012,469	$ 101,584,949	$ 114,315,004	$ 121,711,407	$ 121,778,882	$ 121,846,348	$ 128,081,068	$ 131,428,291	$ 132,820,859	$ 134,692,742
b. Contractual Services	$ 40,848,292	$ 40,289,039	$ 41,541,754	$ 41,761,286	$ 41,781,244	$ 41,801,202	$ 45,329,241	$ 47,150,003	$ 47,080,161	$ 47,010,734
c. Interest on Current Debt	$ 4,512,479	$ 4,381,359	$ 4,290,651	$ 4,344,894	$ 4,345,933	$ 4,346,971	$ 4,352,971	$ 4,358,666	$ 4,364,372	$ 4,370,087
d. Interest on Project Debt	$ -	$ -	$ -				$ 4,514,716	$ 9,027,368	$ 9,011,098	$ 8,979,244
e. Current Depreciation	$ 11,193,187	$ 11,654,490	$ 11,948,147	$ 12,099,199	$ 12,102,090	$ 12,104,981	$ 12,121,689	$ 12,137,550	$ 12,153,438	$ 12,169,354
f. Project Depreciation	$ -	$ -	$ -				$ 3,952,722	$ 8,063,553	$ 8,224,824	$ 8,389,320
g. Current Amortization	$ 1,377,612	$ (60,919)	$ -							
h. Project Amortization	$ -	$ -	$ -							
i. Supplies	$ 37,762,429	$ 37,606,070	$ 34,900,852	$ 35,459,046	$ 35,486,160	$ 35,513,281	$ 36,471,299	$ 38,160,230	$ 38,774,574	$ 39,418,148
j. Other Expenses (Specify/add rows if needed)	$ 36,695,657	$ 47,980,503	$ 35,172,128	$ 34,943,942	$ 34,974,002	$ 35,004,073	$ 35,178,013	$ 35,343,714	$ 35,510,267	$ 35,677,677
TOTAL OPERATING EXPENSES	***$ 230,402,126***	***$ 243,435,492***	***$ 242,168,536***	***$ 250,319,775***	***$ 250,468,311***	***$ 250,616,856***	***$ 270,001,719***	***$ 285,669,375***	***$ 287,939,592***	***$ 290,707,306***
3. INCOME										
a. Income From Operation	**$ (1,040,166)**	**$ (14,503,977)**	**$ 9,325,910**	**$ 9,571,442**	**$ 4,864,240**	**$ 4,957,147**	**$ 2,150,822**	**$ 5,114,464**	**$ 10,628,517**	**$ 16,493,034**
b. Non-Operating Income										
SUBTOTAL	***$ (1,040,166)***	***$ (14,503,977)***	***$ 9,325,910***	***$ 9,571,442***	***$ 4,864,240***	***$ 4,957,147***	***$ 2,150,822***	***$ 5,114,464***	***$ 10,628,517***	***$ 16,493,034***
c. Income Taxes										
NET INCOME (LOSS)	***$ (1,040,166)***	***$ (14,503,977)***	***$ 9,325,910***	***$ 9,571,442***	***$ 4,864,240***	***$ 4,957,147***	***$ 2,150,822***	***$ 5,114,464***	***$ 10,628,517***	***$ 16,493,034***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	45.5%	44.7%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%
2) Medicaid	14.9%	20.1%	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%
3) Blue Cross	10.0%	8.6%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%
4) Commercial Insurance	22.9%	18.0%	24.1%	24.1%	24.1%	24.1%	24.1%	24.1%	24.1%	24.1%
5) Self-pay	3.5%	4.3%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%
6) Other	3.2%	4.4%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%
TOTAL	***100.0%***	***100.1%***	***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	45.5%	44.7%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%
2) Medicaid	14.9%	20.1%	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%
3) Blue Cross	10.0%	8.6%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%
4) Commercial Insurance	22.9%	18.0%	24.1%	24.1%	24.1%	24.1%	24.1%	24.1%	24.1%	24.1%
5) Self-pay	3.5%	4.3%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%
6) Other	3.2%	4.4%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%
TOTAL	***100.0%***	***100.1%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, 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 th are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables
Indicate CY or FY	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030
1. DISCHARGES							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric				556	1,460	1,754	2,090
e. Acute Psychiatric							
Total Acute				***556***	***1,460***	***1,754***	***2,090***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL DISCHARGES				***556***	***1,460***	***1,754***	***2,090***
2. PATIENT DAYS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric				1,363	3,596	4,301	5,123
e. Acute Psychiatric							
Total Acute				***1363***	***3596***	***4301***	***5123***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL PATIENT DAYS				***1,363***	***3,596***	***4,301***	***5,123***
3. AVERAGE LENGTH OF STAY							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric				2.5	2.5	2.5	2.5
e. Acute Psychiatric							
Total Acute							
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL AVERAGE LENGTH OF STAY				2.5	2.5	2.5	2.5
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric				21	21	21	21
Total Acute				***21***	***21***	***21***	***21***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL LICENSED BEDS				***21***	***21***	***21***	***21***
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric				17.8%	46.9%	56.1%	66.8%
e. Acute Psychiatric							
Total Acute				***17.8%***	***46.9%***	***56.1%***	***66.8%***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL OCCUPANCY %				***17.8%***	***46.9%***	***56.1%***	***66.8%***
6. OUTPATIENT VISITS							
a. Emergency Department							
b. Same-day Surgery							
c. Laboratory							
d. Imaging							
e. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS							
7. OBSERVATIONS**							
a. Number of Patients							
b. Hours							

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

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

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

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Pr should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fis 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 sour

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to doc generate excess revenues over total expenses consistent with the Financial Feasibility standard				
Indicate CY or FY	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**
1. REVENUE					
a. Inpatient Services	$ 9,624,128	$ 24,633,717	$ 29,536,897	$ 34,895,152	$ 39,456,249
b. Outpatient Services					
c. Capital Policy Reimbursement	$ 4,161,451	$ 4,161,451	$ 4,161,451	$ 4,161,451	$ 4,161,451
Gross Patient Service Revenues	***$ 13,785,579***	***$ 28,795,168***	***$ 33,698,348***	***$ 39,056,603***	***$ 43,617,700***
c. Allowance For Bad Debt	$ 409,601	$ 1,009,984	$ 1,206,112	$ 1,420,442	$ 1,602,886
d. Contractual Allowance	$ 1,331,203	$ 3,282,450	$ 3,919,863	$ 4,616,436	$ 5,209,379
e. Charity Care					
Net Patient Services Revenue	***$ 12,044,775***	***$ 24,502,734***	***$ 28,572,373***	***$ 33,019,725***	***$ 36,805,436***
f. Other Operating Revenues (Specify)					
NET OPERATING REVENUE	***$ 12,044,775***	***$ 24,502,734***	***$ 28,572,373***	***$ 33,019,725***	***$ 36,805,436***
2. EXPENSES					
a. Salaries & Wages (including benefits)	$ 5,710,762	$ 8,644,285	$ 9,679,126	$ 10,752,493	$ 11,880,580
b. Contractual Services	$ 3,345,727	$ 5,023,249	$ 4,846,909	$ 4,670,647	$ 4,528,446
c. Interest on Current Debt					
d. Interest on Project Debt	$ 4,170,900	$ 8,176,365	$ 8,001,597	$ 7,816,972	$ 7,621,932
e. Current Depreciation					
f. Project Depreciation	$ 3,952,722	$ 7,905,444	$ 7,905,444	$ 7,905,444	$ 7,905,444
g. Current Amortization					
h. Project Amortization					
i. Supplies	$ 770,342	$ 2,250,708	$ 2,697,153	$ 3,171,039	$ 3,479,941
j. Other Expenses (Specify)					
TOTAL OPERATING EXPENSES	**$ 17,950,453**	**$ 32,000,050**	**$ 33,130,229**	**$ 34,316,595**	**$ 35,416,343**
3. INCOME					
a. Income From Operation	**$ (5,905,677)**	**$ (7,497,316)**	**$ (4,557,855)**	**$ (1,296,870)**	**$ 1,389,093**
b. Non-Operating Income					
SUBTOTAL					
c. Income Taxes					
NET INCOME (LOSS)	***$ (5,905,677)***	***$ (7,497,316)***	***$ (4,557,855)***	***$ (1,296,870)***	***$ 1,389,093***
4. PATIENT MIX					
a. Percent of Total Revenue					
1) Medicare					
2) Medicaid	34.0%	34.0%	34.0%	34.0%	34.0%
3) Blue Cross	18.0%	18.0%	18.0%	18.0%	18.0%
4) Commercial Insurance	44.0%	44.0%	44.0%	44.0%	44.0%
5) Self-pay	1.0%	1.0%	1.0%	1.0%	1.0%
6) Other	3.0%	3.0%	3.0%	3.0%	3.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days					
Total MSGA					
1) Medicare					
2) Medicaid	34.0%	34.0%	34.0%	34.0%	34.0%
3) Blue Cross	18.0%	18.0%	18.0%	18.0%	18.0%
4) Commercial Insurance	44.0%	44.0%	44.0%	44.0%	44.0%
5) Self-pay	1.0%	1.0%	1.0%	1.0%	1.0%
6) Other	3.0%	3.0%	3.0%	3.0%	3.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

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

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

	Projected Years (ending at least two years after project completion and full occu order to document that the hospital will generate excess revenues over total e Financial Feasibility standard.				
Indicate CY or FY	**FY2027**	**FY2028**	**FY2029**	**FY2030**	**FY2031**
1. REVENUE					
a. Inpatient Services	$ 10,748,153	$ 28,281,049	$ 34,859,693	$ 42,336,690	$ 49,210,833
b. Outpatient Services					
c. Capital Policy Reimbursement	$ 4,647,477	$ 4,777,606	$ 4,911,379	$ 5,048,898	$ 5,190,267
Gross Patient Service Revenues	***$ 15,395,630***	***$ 33,058,656***	***$ 39,771,072***	***$ 47,385,588***	***$ 54,401,100***
c. Allowance For Bad Debt	$ 457,439	$ 1,159,525	$ 1,423,463	$ 1,723,357	$ 1,999,160
d. Contractual Allowance	$ 1,486,677	$ 3,768,458	$ 4,626,255	$ 5,600,911	$ 6,497,269
e. Charity Care					
Net Patient Services Revenue	***$ 13,451,514***	***$ 28,130,673***	***$ 33,721,354***	***$ 40,061,320***	***$ 45,904,671***
f. Other Operating Revenues (Specify/add rows of needed)					
NET OPERATING REVENUE	***$ 13,451,514***	***$ 28,130,673***	***$ 33,721,354***	***$ 40,061,320***	***$ 45,904,671***
2. EXPENSES					
a. Salaries & Wages (including benefits)	$ 6,427,513	$ 10,021,095	$ 11,557,382	$ 13,224,211	$ 15,049,963
b. Contractual Services	$ 3,621,523	$ 5,546,073	$ 5,458,407	$ 5,365,105	$ 5,305,796
c. Interest on Current Debt					
d. Interest on Project Debt	$ 4,514,716	$ 9,027,368	$ 9,011,098	$ 8,979,244	$ 8,930,308
e. Current Depreciation					
f. Project Depreciation	$ 3,952,722	$ 8,063,553	$ 8,224,824	$ 8,389,320	$ 8,557,107
g. Current Amortization					
h. Project Amortization					
i. Supplies	$ 901,191	$ 2,738,330	$ 3,412,759	$ 4,172,870	$ 4,762,540
j. Other Expenses (Specify/add rows of needed)					
TOTAL OPERATING EXPENSES	***$ 19,417,665***	***$ 35,396,418***	***$ 37,664,470***	***$ 40,130,750***	***$ 42,605,714***
3. INCOME					
a. Income From Operation	***$ (5,966,151)***	***$ (7,265,746)***	***$ (3,943,116)***	***$ (69,430)***	***$ 3,298,957***
b. Non-Operating Income					
SUBTOTAL	***$ (5,966,151)***	***$ (7,265,746)***	***$ (3,943,116)***	***$ (69,430)***	***$ 3,298,957***
c. Income Taxes					
NET INCOME (LOSS)	***$ (5,966,151)***	***$ (7,265,746)***	***$ (3,943,116)***	***$ (69,430)***	***$ 3,298,957***
4. PATIENT MIX					
a. Percent of Total Revenue					
1) Medicare					
2) Medicaid	34.0%	34.0%	34.0%	34.0%	34.0%
3) Blue Cross	18.0%	18.0%	18.0%	18.0%	18.0%
4) Commercial Insurance	44.0%	44.0%	44.0%	44.0%	44.0%
5) Self-pay	1.0%	1.0%	1.0%	1.0%	1.0%
6) Other	3.0%	3.0%	3.0%	3.0%	3.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days					
1) Medicare					
2) Medicaid	34.0%	34.0%	34.0%	34.0%	34.0%
3) Blue Cross	18.0%	18.0%	18.0%	18.0%	18.0%
4) Commercial Insurance	44.0%	44.0%	44.0%	44.0%	44.0%
5) Self-pay	1.0%	1.0%	1.0%	1.0%	1.0%
6) Other	3.0%	3.0%	3.0%	3.0%	3.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE L. WORKFORCE INFORMATION

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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT	
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)*											
Management	37.2	261,330	$ 9,721,494	2.8	$ 190,589	$533,648			$0	40.0	$10,255,142
						$0			$0	0.0	$0
Total Administration	**37.2**		**$9,721,494**	**2.8**		**$533,648**			**$0**	**40.0**	**$10,255,142**
Direct Care Staff *(List general categories, add rows if needed)*											
Registered nurses	280.6	196,941	$55,261,765	51.9	$ 142,138	$7,376,955	4.2	$123,432	$513,478	336.7	$63,152,198
Nursing assistive personnel	198.7	80,906	$16,076,065	4.2	$59,473	$249,788	1.6	$55,097	$89,257	204.5	$16,415,109
Licensed practical (vocational) nurses	13.9	89,984	$1,250,774						$0	13.9	$1,250,774
Total Direct Care	**493.2**		**$72,588,604**	**56.1**		**$7,626,743**	**5.8**		**$602,735**	**555.1**	**$80,818,081**
Support Staff *(List general categories, add rows if needed)*											
All Other Personnel	133.8	127,031	$16,996,740	8.4	$ 64,121	$538,612			$0	142.2	$17,535,353
Service	99.2	70,926	$7,035,827	13.3	$ 64,174	$853,518				112.5	$7,889,344
Techs	59.6	135,619	$8,082,919	6.3	$ 96,893	$610,424	2.9	$85,273	$248,998	68.8	$8,942,341
Professionals	16.8	222,668	$3,740,830	12.0	$ 143,135	$1,717,617				28.8	$5,458,447
Total Support	309.4		$35,856,316	40.0		$3,720,171	2.9		$248,998	352.3	$39,825,485
REGULAR EMPLOYEES TOTAL	***839.8***		**$118,166,414**	***98.9***		**$11,880,562**	***8.7***		**$851,733**	**947.4**	**$130,898,709**
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
Providers			$0	17.2	$94,677	$1,628,446			$0	17.2	$1,628,446
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0	17.2		$1,628,446			$0	17.2	$1,628,446
Direct Care Staff *(List general categories, add rows if needed)*											
Providers											
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)*:											
TOTAL COST	***839.8***		***$118,166,414***	***98.9***		***$11,880,562***	***8.7***		***$851,733***		***$130,898,709***

Table F – Key Financial Projection Assumptions for Doctors Community Medical Center Statistical Projections – Entire Facility	
Historical period reflects FY 2021 – 2022 Current period reflects YTD FY2023 annualized Projection period reflects FY 2024 – FY 2034 The projection includes: Doctors Community Medical Center	
Discharges	Maintains constant use rate at FY 2023 levels using Advisory Board population projections plus volumes associated with the project
Patient Days	Assumes a 1% annual improvement in average length of stay starting at FYTD 2023 levels.
Licensed Beds	Held at FY 2023 license plus beds associated with the project
Outpatient Visits	Maintains constant use rate at FY 2023 levels using Advisory Board population projections
Observation patients & hours	Maintains constant use rate at FY 2023 levels using Advisory Board population projections and constant average length of stay at FY 2023 levels

Tables G & H– Key Financial Projection Assumptions for Doctors Community Medical Center Revenues & Expenses, Uninflated – Entire Facility and Inflated – Entire Facility Projection is based on FY 2021 with additional assumptions outlined below.		
Historical period reflects FY 2021-2022 Current period reflects YTD FY2023 annualized Projection period reflects FY 2024 – FY 2033 The projection includes: Doctors Community Medical Center		
Revenue	Variability with volume & other assumptions	Inflation (Table H Only)
Gross Patient Revenue	At FY 2023 prices and 100% variable with volume changes	2.8%/year from FY 2023
Deductions from Revenue	At FY 2023 rate (as a % of Gross Patient Revenue)	2.8%/year from FY 2023
Non-Patient Revenue	Changes with Gross Patient Revenue at 50% variability	2.8%/year from FY 2023
Non-Operating Revenue	Based on historical experience, no non-operating revenue was assumed	2.8%/year from FY 2023
Expenses		
Salaries, Wages & Benefits	Assumed 50% variable from FY 2023 projection	3.0%/year from FY 2023
Contractual Services	Assumed 50% variable from FY 2023 projection	2.0%/year from FY 2023
Interest on Current Debt	Assumed 25% variable from FY 2023 projection	2.0%/year from FY 2023
Interest on Project Debt	Please refer to assumptions on Table J	
Current Depreciation & Amortization	Assumed depreciation is 25% variable from FY 2023 projection and amortization held constant at FY 2023 projection	2.0% year from FY 2023
Project Depreciation & Amortization	Please refer to assumptions on Table J	
Supplies	Assumed 80% variable from FY 2023 projection	4.0%/year from FY 2023
Other Expenses	Assumed 90% variable from FY 2021 projection	2.0%/year from FY 2023
Payer Mix	Held constant at FY23 YTD Jan	

Table I – Key Financial Projection Assumptions for Doctors Community Medical Center Statistical Projections – New Facility or Service	
Projection period reflects FY 2025 – FY 2028	
Discharges	**10.24.12.04 (9). Source of Patients** LHDCMC Projected Discharges: Key Metrics Table 18
Patient Days	Assumed an average length of stay of 2.40 which is LHAAMC's current obstetric average length of stay.

Tables J & K– Key Financial Projection Assumptions for Doctors Community Medical Center Revenues & Expenses, Uninflated – New Facility/Service and Inflated – New Facility/Service Projection is based on FY 2023 with additional assumptions outlined below.		
Projection period reflects FY 2027 – FY 2033		
Revenue	Variability with volume & other assumptions	Inflation (Table K Only)
Gross Patient Revenue	At FY 2023 prices and 100% variable	2.8%/year from FY 2023
Deductions from Revenue	At FY 2023 rate (as a % of Gross Patient Revenue)	2.8%/year from FY 2023
Expenses		
Salaries, Wages & Benefits	Used staffing based on AAMC L&D and MBU nursing care model with continuous hospitalists coverage	3.0% year from FY 2023
Contractual Services	Hospitalists, Midwives, MFM providers, Neonatologists and Pediatrician coverage including malpractice	2.0% year from FY 2023
Project Depreciation & Amortization	Depreciated the Building over 40 years, Equipment over 15	2.0% year from FY 2023
Supplies	Used cost per case based on AAMC FY22 actuals for W&C IP and W&C Gyn surg	4.0%/year from FY 2023
Other Expenses		
Payer Mix	Weighted average of FY22 AAMC Payer Mix of LHDCMC Service Area deliveries and LHDCMC Service Area Obstetric Payer Mix	

Tables L– Key Assumptions for Doctors Community Medical Center
Current period reflects FY 2024 Rolling Forecast Benefits are assumed 17%

EXHIBIT 3 (Corrected)

Luminis Health

DOCTORS COMMUNITY MEDICAL CENTER

8118 Good Luck Road,
Lanham, MD 20706

006663.00
[Acute Care Pavilion & Capital Improvements CON]
13 Mar 2023

CANNONDESIGN

250 West Pratt Street Suite 2100
Baltimore, MD 21201
P: 410.234.1155
F: 410.234.1160

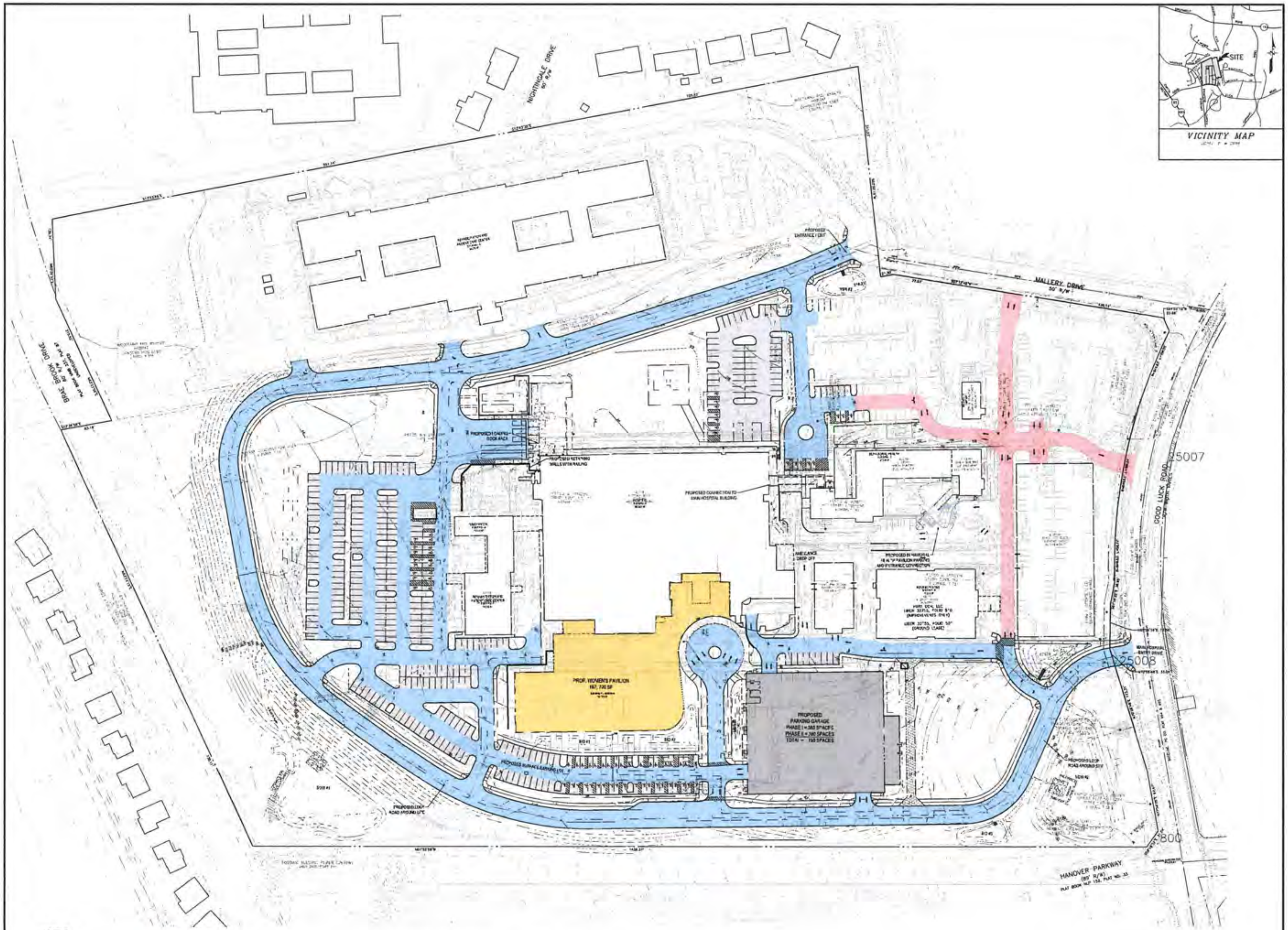
BOSTON NEW YORK BALTIMORE WASHINGTON DC BUFFALO TORONTO COLUMBUS PITTSBURGH DALLAS
CHICAGO ST. LOUIS IRVINE SAN FRANCISCO DENVER HOUSTON LOS ANGELES PHOENIX PASADENA MUMBAI

Consultants:

ATWELL, LLC
Civil Engineering
11721 Woodmore Rd. Suite 200
Mitchellville, MD 20721
P 301.430.2000

Sheet List

Sheet Number	Sheet Name
[illegible]	COVER SHEET
[illegible]	SITE IMPROVEMENT PLAN
CON101	LEVEL 01 SCOPE PLAN
CON102	LEVEL 02 SCOPE PLAN
CON103	LEVEL 03 SCOPE PLAN
CON104	LEVEL 04 SCOPE PLAN
CON105	LEVEL 05 SCOPE PLAN
CON201	LEVEL 01 CON DEPARTMENT PLANS
CON202	LEVEL 02 CON DEPARTMENT PLANS
CON203	LEVEL 03 CON DEPARTMENT PLANS
CON204	LEVEL 04 CON DEPARTMENT PLANS
CON205	LEVEL 05 CON DEPARTMENT PLANS
CON301	STACKING DIAGRAMS
CON401	EXTERIOR ELEVATIONS



GENERAL NOTES:

1. THE TOPOGRAPHY SHOWN ON THIS PLAN IS FROM GIS SOURCES, AND IS NOT REFLECTIVE OF FIELD RUN SURVEYS.
2. THIS PROPERTY IS SUBJECT TO A FOREST CONSERVATION (TCPI) PRESERVATION REQUIREMENT. ADJUSTMENTS, WHICH MAY ALSO ENTAIL THE REMOVAL OF AREAS FROM FOREST CONSERVATION, WILL REQUIRE COMPLIANCE WITH THE LATEST COUNTY REGULATIONS PERTAINING TO THE RE-ESTABLISHMENT AND/OR OFFSITE MITIGATION FOR FOREST PRESERVATION.
3. SPECIMEN TREES REFLECTED HEREON ARE FROM BEST AVAILABLE DATA AND MAY NOT REFLECT ALL SPECIMEN TREES LOCATED ON THE PROPERTY.
4. TO THE EXTENT THEY COULD BE IDENTIFIED BY PUBLIC RECORD AT THIS TIME, EASEMENTS FOR EXISTING UTILITIES ARE SHOWN ON THIS BASE. THERE ARE KNOWN TO EXIST ON AND THROUGHOUT THE PROPERTY MULTIPLE OTHER UTILITIES THAT ARE NOT ENCLOSED WITHIN EASEMENTS. BEFORE ANY FINAL DEVELOPMENT, THESE UTILITIES SHOULD BE INVESTIGATED FOR THEIR LOCATION AND IF SO NEEDED, THEIR ABILITY TO BE RELOCATED.
5. DEVELOPMENT/REDEVELOPMENT OF THE PROPERTY WILL REQUIRE COMPLIANCE WITH, AT A MINIMUM:
   a. CONFORMANCE WITH THE LATEST COUNTY STORMWATER MANAGEMENT REGULATIONS.
   b. CONFORMANCE TO THE COUNTY LANDSCAPE MANUAL, INCLUDING THE ADDITION OF SUPPLEMENTAL LANDSCAPE THAT THE COUNTY DEEMS NECESSARY DURING THE REVIEW AND APPROVAL PROCESS.
   c. REVISED FOREST CONSERVATION (TCPI PLANS).

	AREA:
DOCTORS' HOSPITAL, INC.	1,301,226 SQUARE FEET or 29.8720 ACRES
MAGNOLIA GARDENS REAL ESTATE LLC	443,131 SQUARE FEET or 10.1729 ACRES
TOTAL	1,744,357 SQUARE FEET or 40.0449 ACRES

OWNERS
DOCTOR'S HOSPITAL, INC.
8118 GOOD LUCK ROAD
LANHAM, MD 20706

MAGNOLIA GARDENS REAL ESTATE, LLC
101 EAST STATE STREET
KENNETT SQUARE, PA 19320

ATTN: LUCAS KLOCK
PHONE: (301) 343-5518

APPLICANT
LUMINIS HEALTH
ANNE ARUNDEL MEDICAL CENTER
2001 MEDICAL PARKWAY
ANNAPOLIS, MD 21401
ATTN: LUCAS KLOCK
PHONE: (301) 343-5518

CERTIFICATE OF NEED - EXHIBIT A
LANDS OF
DOCTORS' HOSPITAL, INC
DISTRICT No. 21
PRINCE GEORGE'S COUNTY, MARYLAND

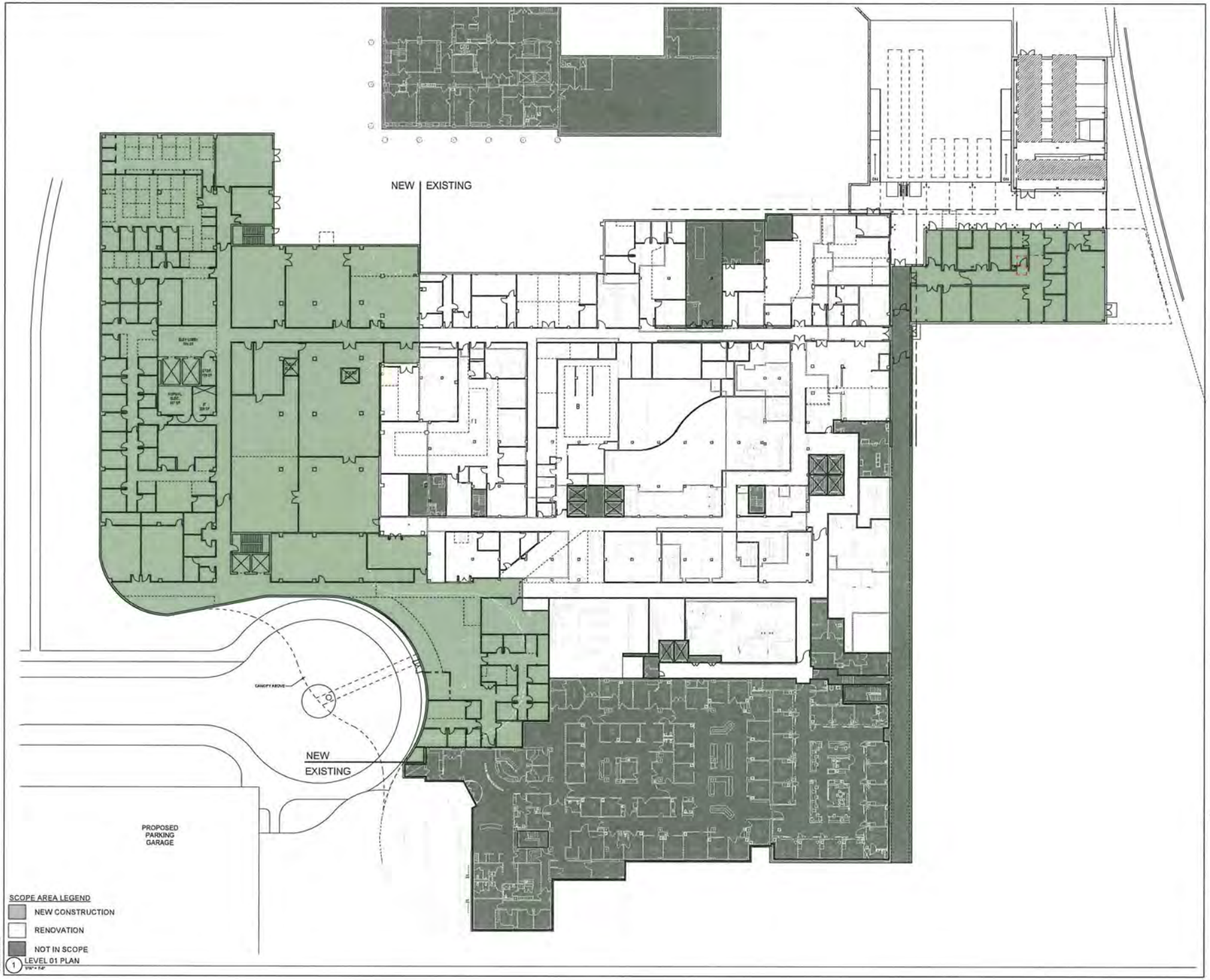
A100
SITE IMPROVEMENT PLAN

35

BEN DYER ASSOCIATES, INC.
Engineers / Surveyors / Planners

DATE	DESCRIPTION	BY
	REVISIONS	

DECEMBER 2022
3-A73023



1 LEVEL 01 PLAN
1/16" = 1'-0"

Luminis Health

DOCTORS COMMUNITY MEDICAL CENTER

8118 GOOD LUCK ROAD,
LANHAM, MD 20706

CANNONDESIGN
200 West Pratt Street Suite 2100
Baltimore, MD 21201
P: 410.234.1100
F: 410.234.1102
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Rev.	Description	Date
RELEASE 1		22 FEB 2022

KEY PLAN

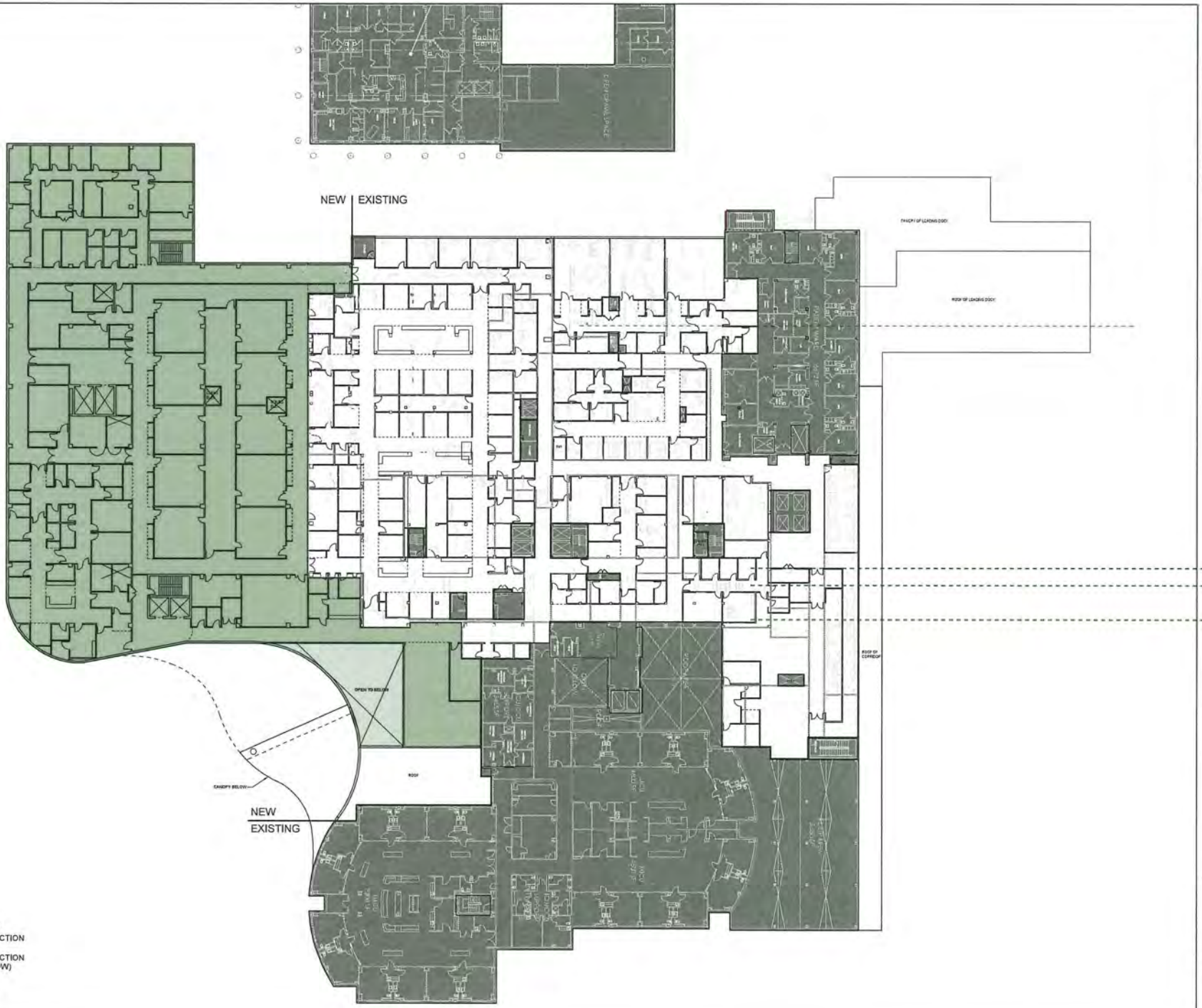
Drawing Title:

LEVEL 01 SCOPE PLAN

Project No.: 084224.07 Checked by: Checker

CON101

3/1/2022 8:16:14 PM



SCOPE AREA LEGEND

- NEW CONSTRUCTION
- NEW CONSTRUCTION (OPEN TO BELOW)
- RENOVATION
- NOT IN SCOPE

1 LEVEL 02 PLAN
1/16" = 1'-0"

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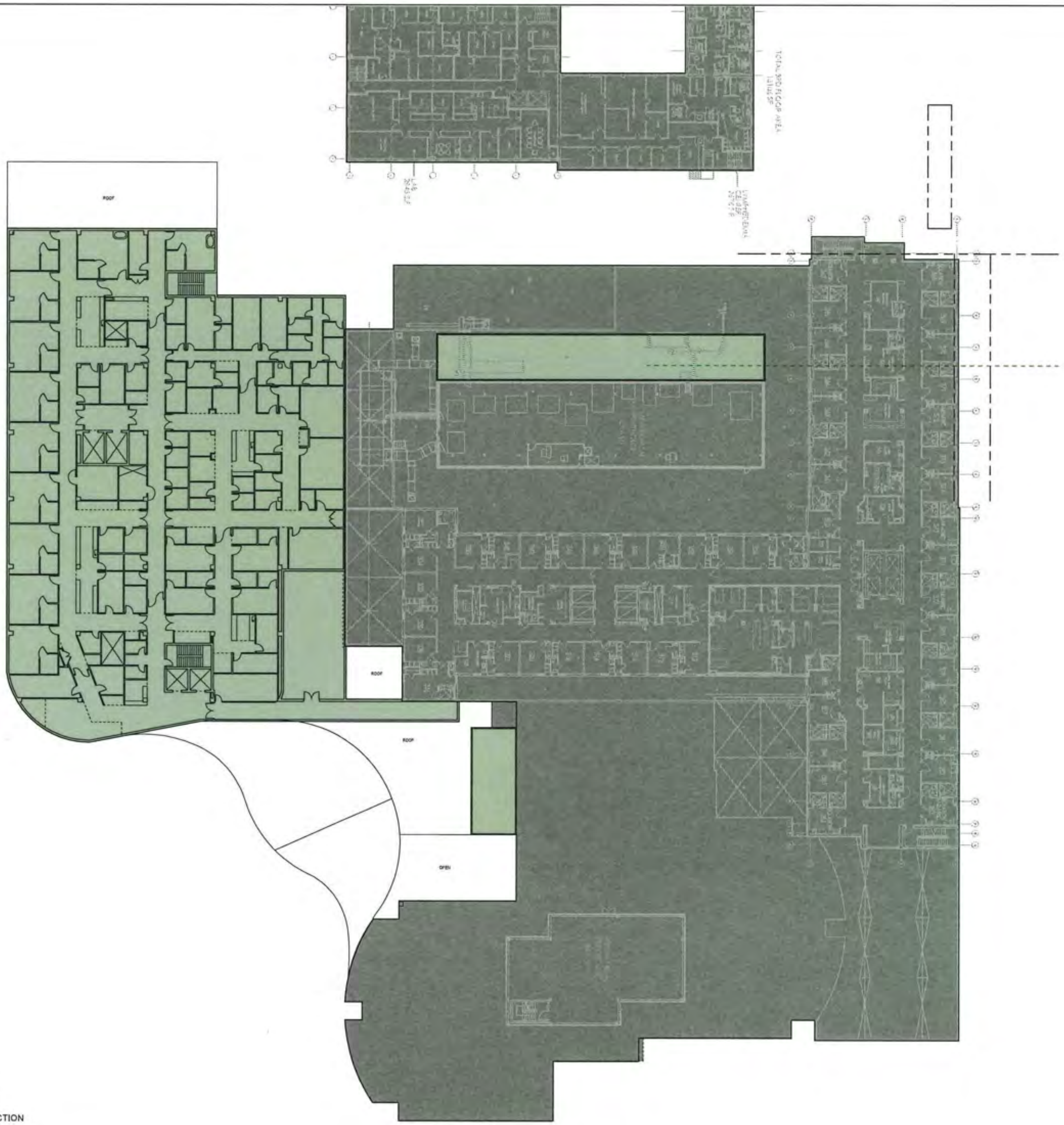
Rev.	Description	Date
	RELEASE 1	22 FEB 2021

KEY PLAN

LEVEL 02 SCOPE PLAN

Project No.: 046226.01 Checked by: Checker

CON102



SCOPE AREA LEGEND

- NEW CONSTRUCTION
- NOT IN SCOPE

(1) LEVEL 03 PLAN

1/16" = 1'-0"

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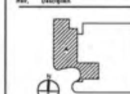

KEY PLAN

Drawing Title:

LEVEL 03 SCOPE PLAN

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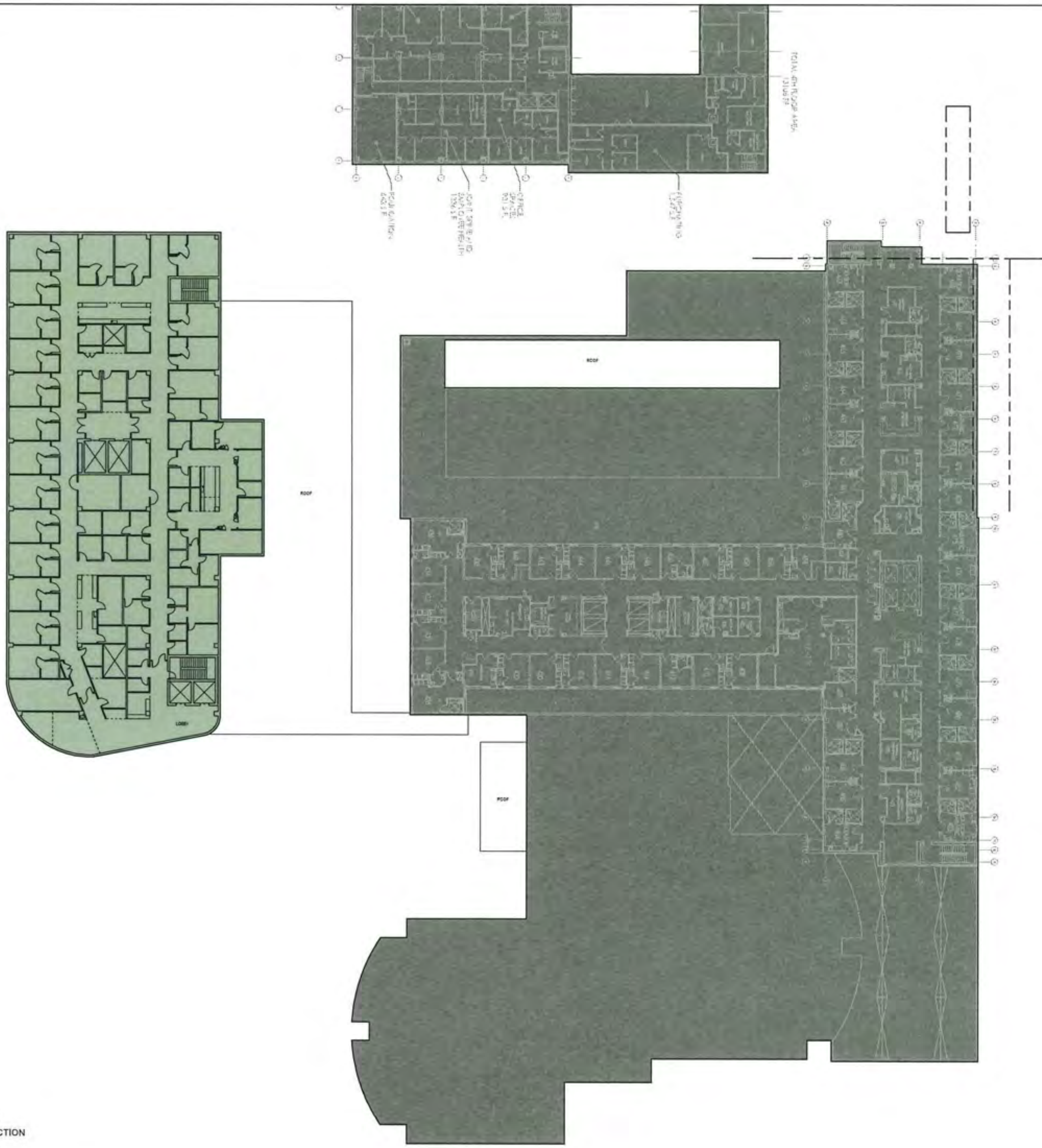

SCOPE AREA LEGEND

- NEW CONSTRUCTION
- NOT IN SCOPE

(1) LEVEL 04 PLAN

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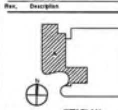


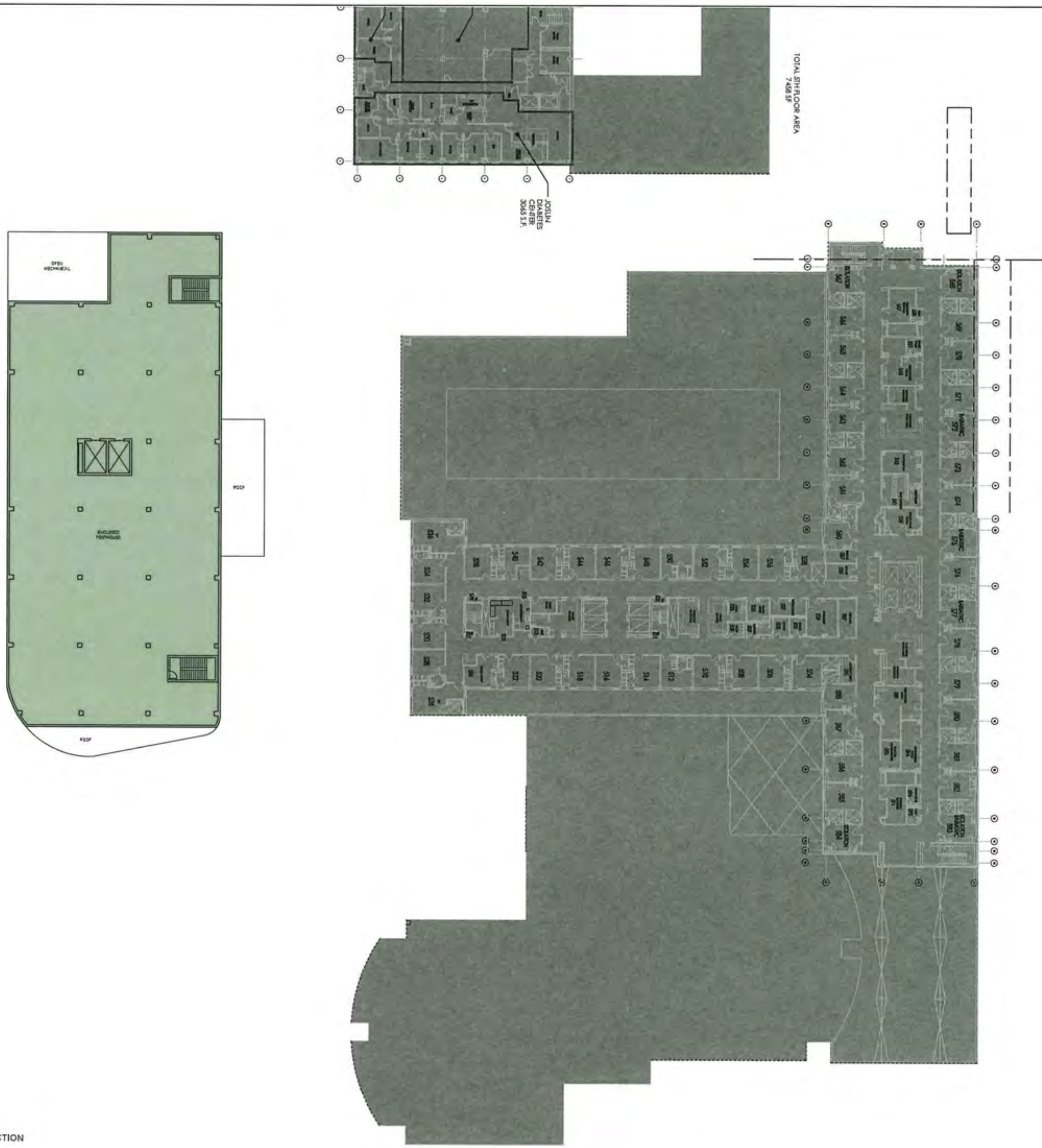
KEY PLAN

Drawing Title:

LEVEL 04 SCOPE PLAN

Checked by: Checker

CON104



SCOPE AREA LEGEND

- NEW CONSTRUCTION
- NOT IN SCOPE

(1) PENTHOUSE PLAN

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DOCTORS COMMUNITY MEDICAL CENTER

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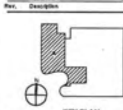
	RELEASE 1	22 FEB 2023



KEY PLAN

Drawing Title:

LEVEL 05 SCOPE PLAN

Project No.: 006226.07 Checked by: Checker

CON105

Luminis Health.

DOCTORS COMMUNITY MEDICAL CENTER

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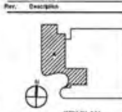
CANNONDESIGN

RELEASE 1

Rev. Description Date

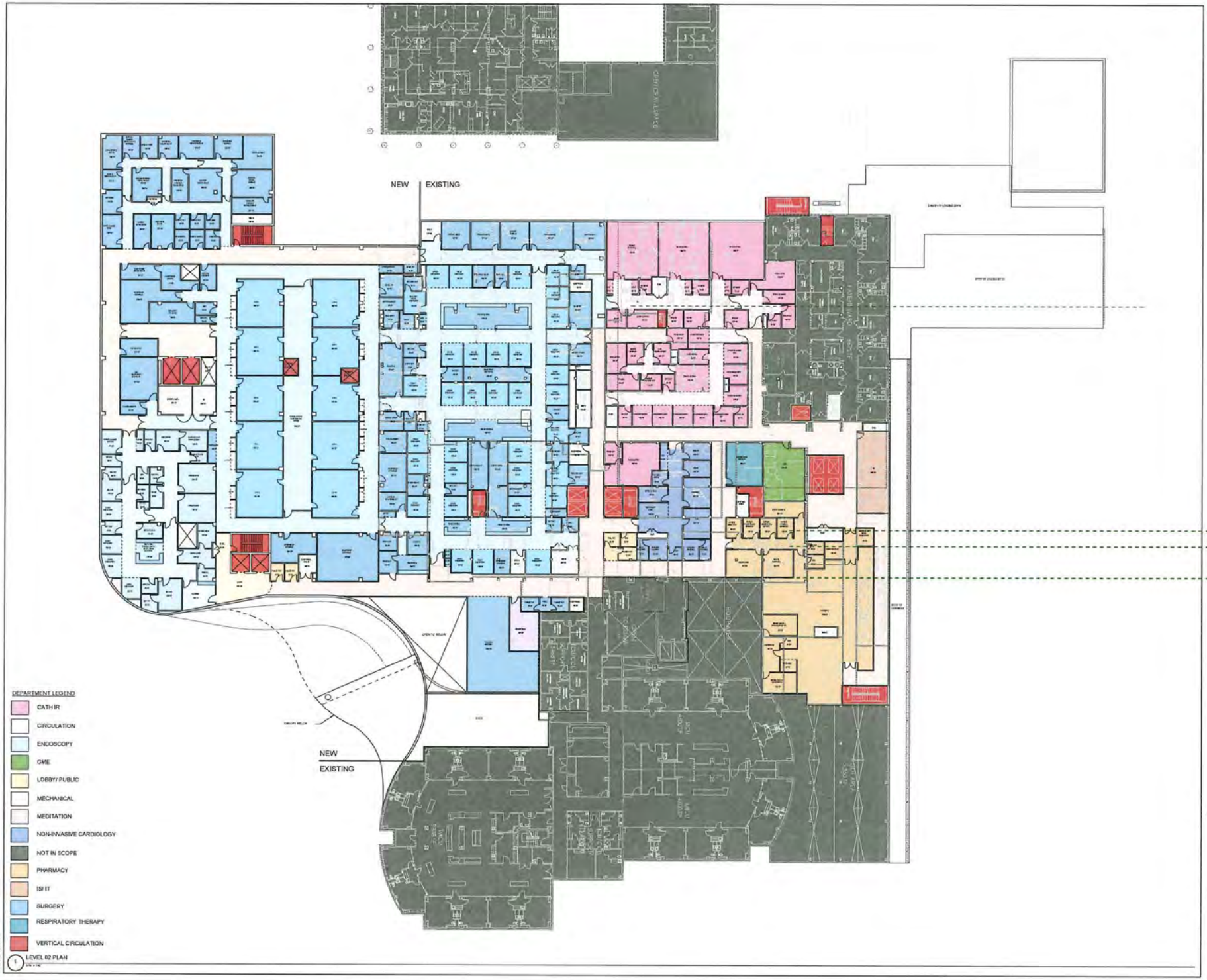


Drawing Title:

LEVEL 01 CON DEPARTMENT PLANS

Project No.: Checked by: Checker

CON201



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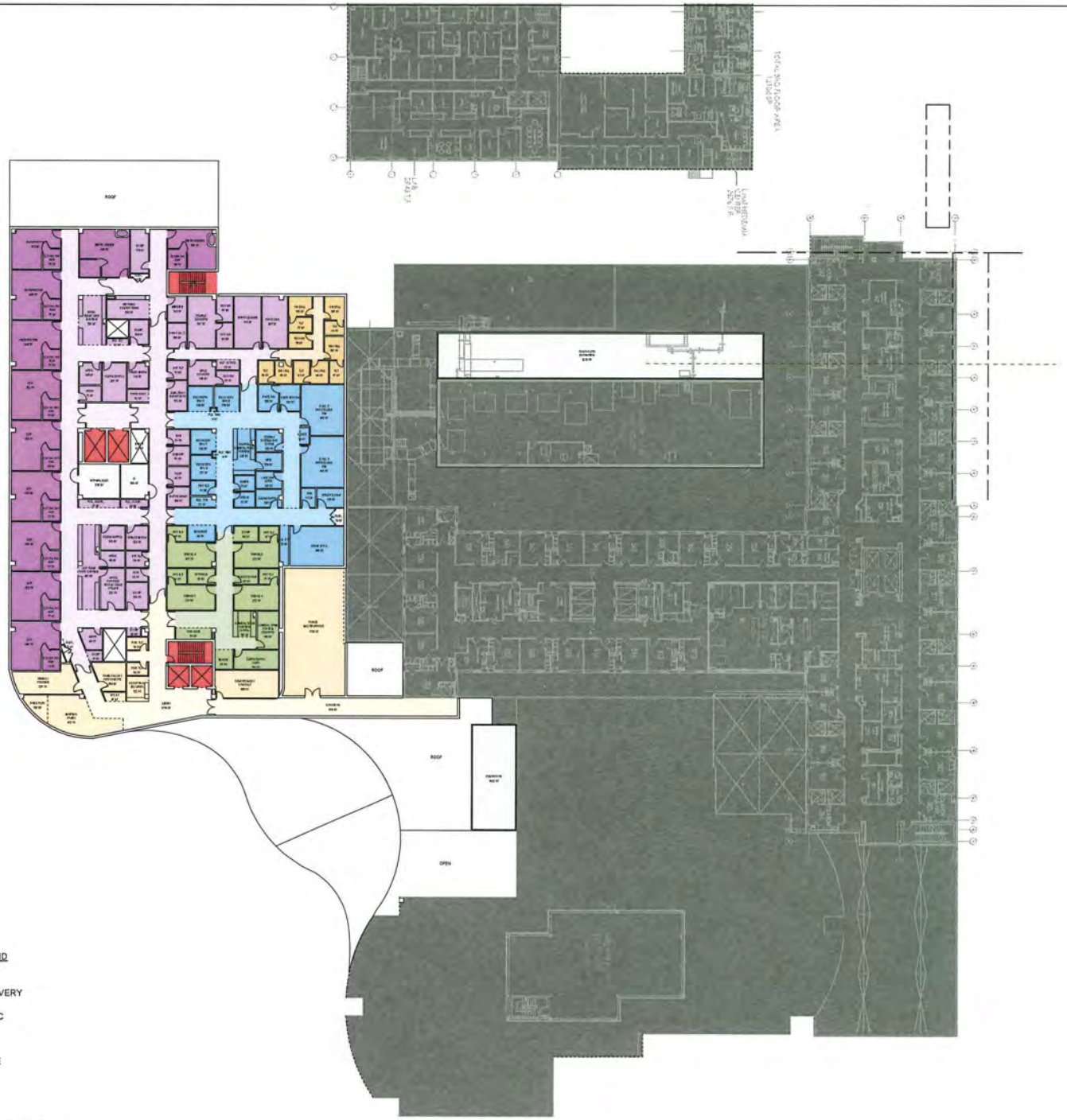
KEY PLAN

LEVEL 02 CON DEPARTMENT PLANS

CON202



DEPARTMENT LEGEND

- C-SECTION
- LABOR & DELIVERY (LDR)
- LOBBY/ PUBLIC
- MECHANICAL
- NOT IN SCOPE
- ON-CALL
- TRIAGE
- VERTICAL CIRCULATION

1 LEVEL 03 PLAN
1/16" = 1'-0"

Luminis Health.

DOCTORS COMMUNITY MEDICAL CENTER

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Rev.	Description	Date
	RELEASE 1	22 FEB 2021

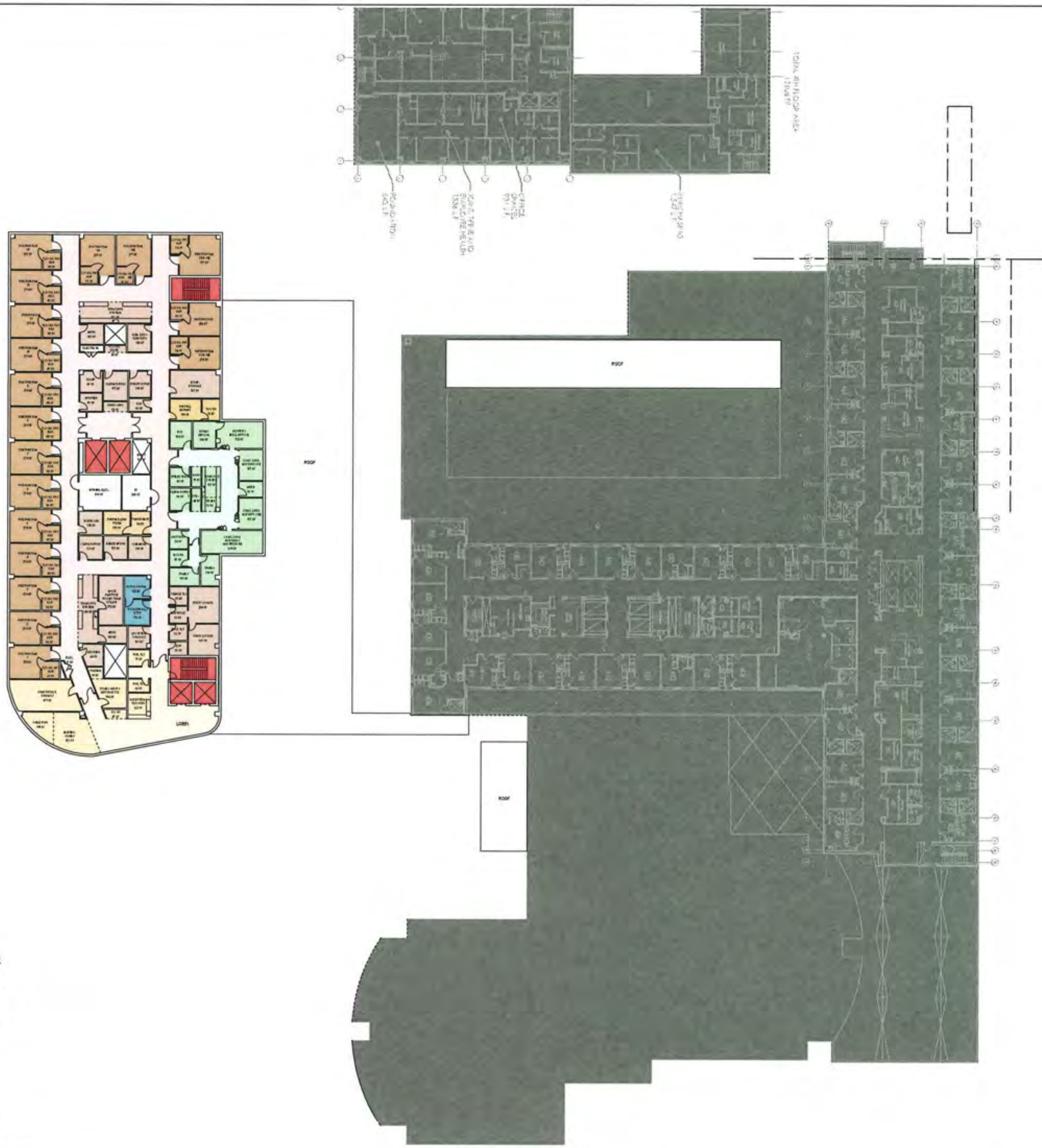
KEY PLAN

Drawing Title:

LEVEL 03 CON DEPARTMENT PLANS

Project No.: 060220.07 Checked by: Checker

CON203



DEPARTMENT LEGEND

- LOBBY/ PUBLIC
- MECHANICAL
- NOT IN SCOPE
- NURSERY
- ON-CALL
- PHARMACY
- POSTPARTUM
- RESPIRATORY THERAPY
- VERTICAL CIRCULATION

(1) LEVEL 04 PLAN

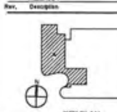
Luminis Health.

DOCTORS COMMUNITY MEDICAL CENTER

8118 GOOD LUCK ROAD, LANHAM, MD 20706

CANNONDESIGN

	RELEASE 1	22 FEB 2023
Rev.	Description	Date



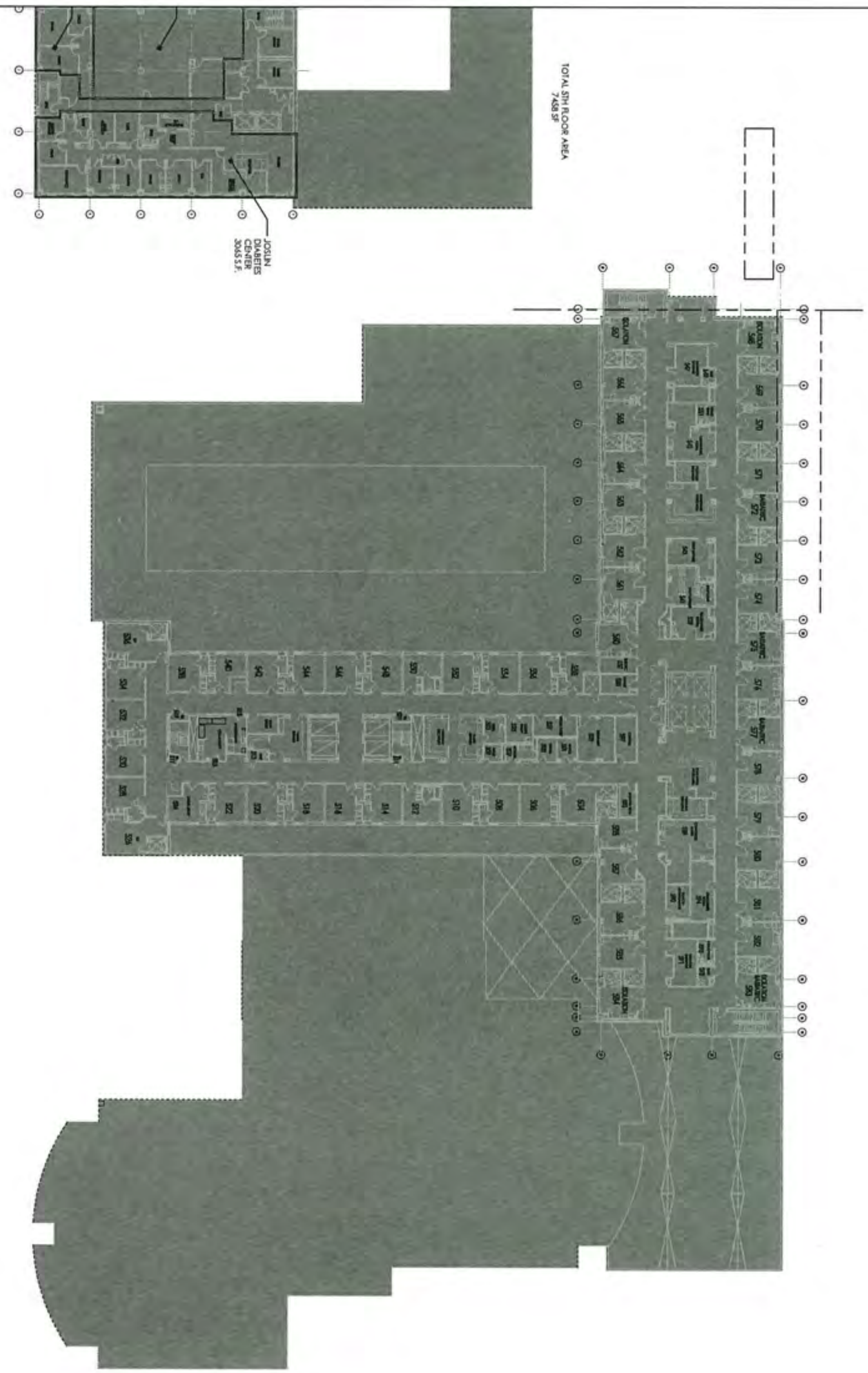
KEY PLAN

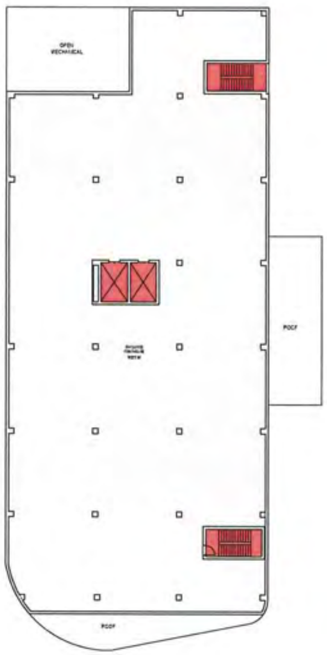
Drawing Title:

LEVEL 04 CON DEPARTMENT PLANS

Checked by: Checker

CON204





DEPARTMENT LEGEND

- MECHANICAL
- MECHANICAL (EXTERIOR)
- NOT IN SCOPE
- VERTICAL CIRCULATION

1 PENTHOUSE PLAN

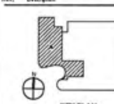
Luminis Health.

DOCTORS COMMUNITY MEDICAL CENTER

8118 GOOD LUCK ROAD,
LANHAM, MD 20706

CANNONDESIGN

Rev.	Description	Date
	RELEASE 1	22 FEB 2023



KEY PLAN

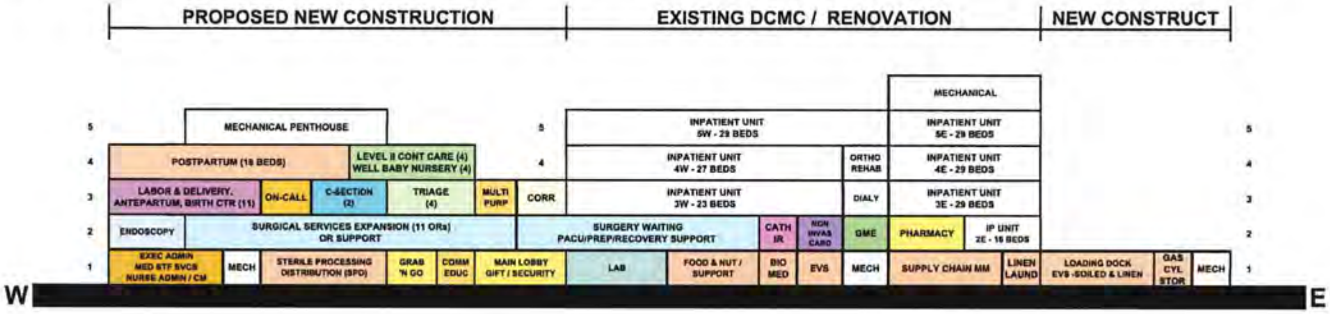
Drawing Title:

LEVEL 05 CON DEPARTMENT PLANS

Project No.: 006226.07 Checked by: Checker

CON205

STACKING DIAGRAM
EAST - WEST VIEW



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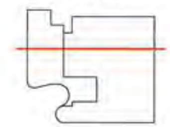
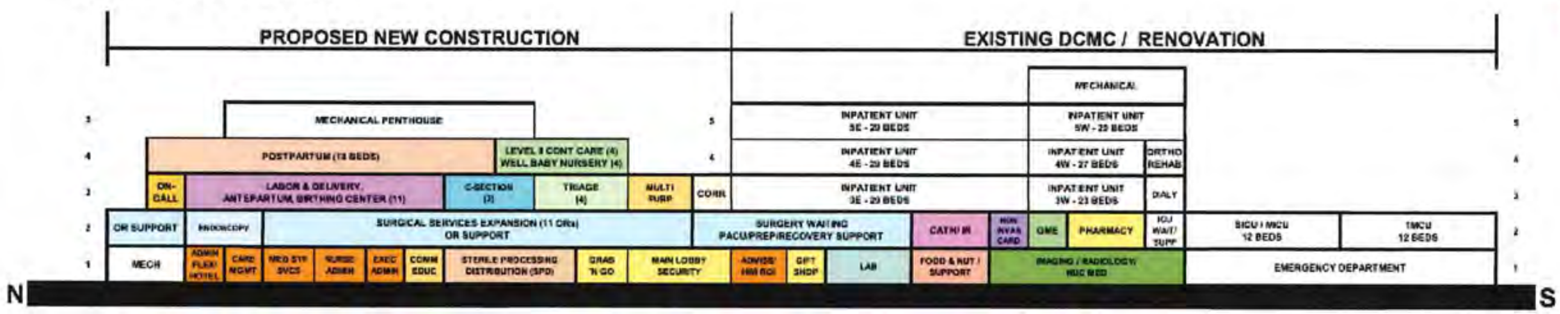


STACKING DIAGRAM
NORTH - SOUTH VIEW



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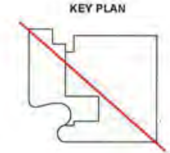


Luminis Health

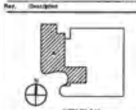
DOCTORS COMMUNITY MEDICAL CENTER

8118 GOOD LUCK ROAD, LANHAM, MD 20706

CANNONDESIGN

RELEASE 1

Rev. Description Date



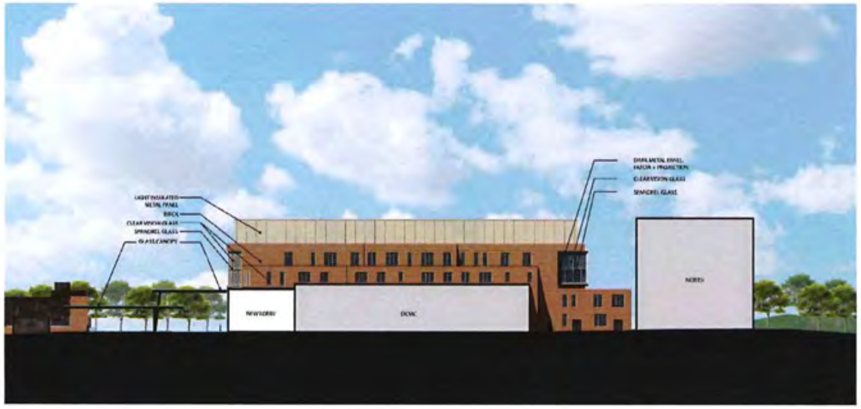
KEY PLAN

Drawing Title

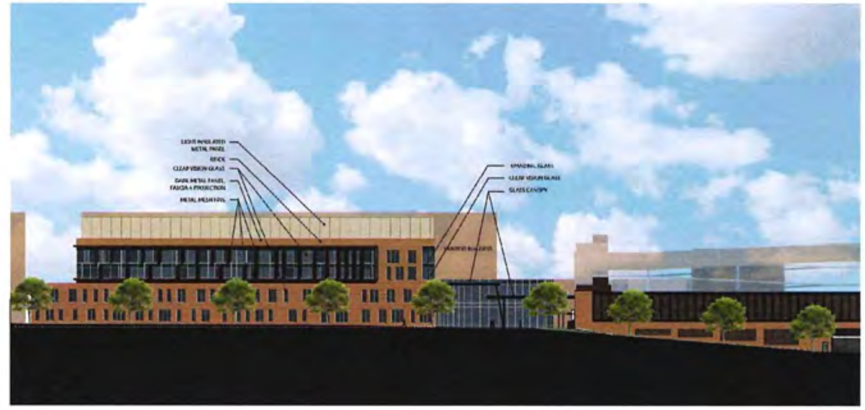
STACKING DIAGRAMS

Project No. | Checked by

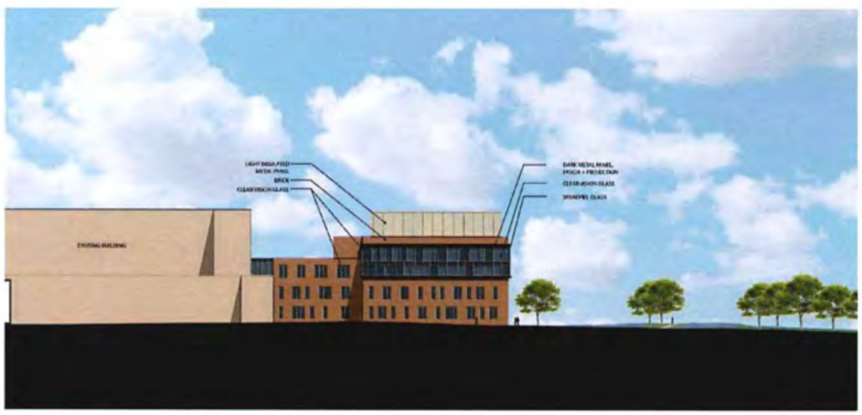
CON401



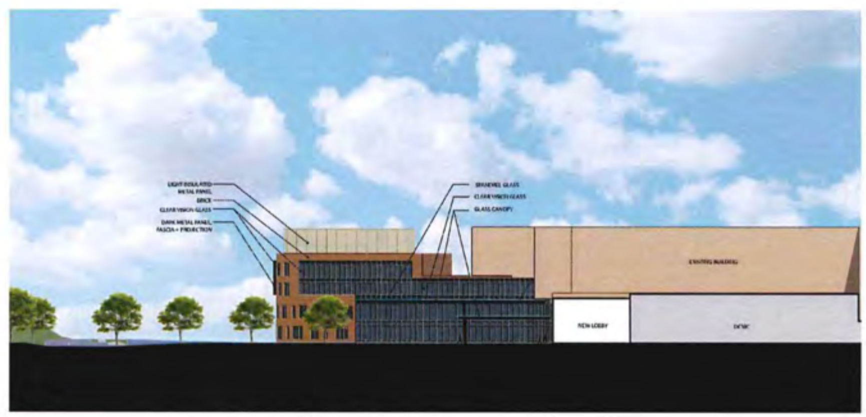
ELEVATION - EAST FACADE



ELEVATION - WEST FACADE



ELEVATION - NORTH FACADE



ELEVATION - SOUTH FACADE

Luminis Health.

DOCTORS COMMUNITY MEDICAL CENTER

8118 GOOD LUCK ROAD,
LANHAM, MD 20706

CANNONDESIGN

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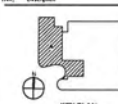
Rev.	Description	Date
	RELEASE 1	12 JAN 2023



KEY PLAN

Drawing Title:

EXTERIOR ELEVATIONS

Checked by: Checker

CON501

EXHIBIT 22

Doctors Community Medical Center - Acute Care Pavilion
Marshall Valuation Service Budget Analysis - Cost SF Calculation

New Construction for Class A, Type Good for General Hospital Project

	NEW Construction (Level 1-5)	NEW Construction (Penthouse)	Renovation		
Allowable Cost/GSF	**$ 485.00**		**$ 485.00**	Section 15 Page 24	NC: Class A, Good
Adjustment for Departmental Differential Cost Factors	1.09988		1.24202		
Subtotal	**$ 533.44**		**$ 602.38**		
Elevator	$ -		$ -	Section 15 Page 24	NC: In base costs PH: 2, excellent
Subtotal	**$ 533.44**		**$ 602.38**		
Floor Area-Perimeter Multiplier	0.90828		1.000	Section 15 Page 38	
Subtotal	**$ 484.52**		**$ 602.38**		
Story Height Multiplier	1.1012		1.092	Section 15 Page 38	ACP: 16.8' PH: 18' Avg. Wall Height
Subtotal	**$ 533.55**		**$ 657.80**		
Multi-story Multiplier	$ 5.33		$ -	Section 15 Page 25	
Subtotal	**$ 538.88**		**$ 657.80**		
Sprinklers - Add for Wet	$ 3.49		$ 3.83	Section 15 Page 37	Good
Subtotal	**$ 542.38**		**$ 661.63**		
Current Cost Multiplier	1.21		1.21	Section 99 Page 3	Eastern U.S., Class A, 11/21
	$ 656.28		**$ 800.58**		
Local Market Multiplier	1.03		1.03	Section 99 Page 8	Maryland, Class A
Total Allowable	**$ 675.96**		**$ 824.59**		Includes A/E fee, Construction, normal site prep for building only, permits/testing, attached equipment

Floor Area Perimeter Multipliers	**Perimeter**	**Area**	**Perimeter**	**Area**	**Perimeter**	Area
First	1,093	53,232	0	0	0	54,623
Second	814	44,030	0	0	0	50,918
Third	1,207	40,259	0	0	0	
Fourth	693	24,470	0	0	0	
Penthouse	646	20,958	0	0	0	
Total	**4,453**	**182,949**	-	-	-	**105,541**
Average	**891**	**36,590**	-	-	-	**52,771**

Floor	Exterior Skin			
First	50,856	53,232	2,376	
Second	42,290	44,030	1,740	Updated 2/19
Third	38,547	40,259	1,712	updated 2/19 based on B2.
Fourth	23,236	24,470	1,234	
Penthouse	20,958	20,958	-	
Total	**175,887**	**182,949**	**7,062**	

Luminis Health Doctors Community Medical Center - Acute Care Pavilion
Marshall Valuation Service Budget Analysis - Area Perimeter Calculations

New Construct

	Area (GSF)	Perimeter (LF) Low	Actual	High
		800	891	1000
Low	35,000	0.904	0.911	0.919
Actual	36,590	0.902	**0.90828**	0.916
High	40,000	0.897	0.903	0.910

Section 15 Page 38

	Sprinkler Area (GSF)	$
Low	150,000	3.62
Actual	182,949	**3.49**
High	200,000	3.43

RENOVATION

	Area (GSF)	Perimeter (LF) Low	Actual	High
		1000	0	1200
Low	50,000	0.897	0.842	0.908
Actual	52,771	0.895	**0.84278**	0.905
High	75,000	0.879	0.849	0.885

Section 15 Page 38

Renovation	Area (GSF)	Sprinkler $
Low	100,000	3.87
Actual	105,541	**3.83**
High	125,000	3.70

Department / Function	EXISTING	New Construct DGSF	Renovation DGSF	MVS Department Name	MVS Differential Cost Factor	New Construction MVS Differential Factor x DGSF	Renovation MVS Differential Factor x DGSF
Level 1							
Public Space / Lobby	2,375	3,370	0	Public Spaces	0.80	2,696	-
Community / Multipurpose Room	0	1,703	0	Public Spaces	0.80	1,362	-
Café / Grab & Go	0	1,638	0	Public Spaces	0.80	1,310	-
Care Management	1,332	2,610	0	Offices	0.96	2,506	-
Executive Administration	1,585	3,087	0	Offices	0.96	2,964	-
Medical Staff Services	1,010	2,239	0	Offices	0.96	2,149	-
Nursing Administration	767	2,271	0	Offices	0.96	2,180	-
Admin Space / Hoteling	0	1,465	0	Offices	0.96	1,406	-
Admissions / Check-in / HIMS (ROI)	1,436	1,619	0	Offices	0.96	1,554	-
Security	301	1,027	0	Offices	0.96	986	-
Sterile Processing Distribution (SPD)	5,942	9,008	0	Central Sterile Supply	1.54	13,872	-
EVS/Loading Dock (Linen,Red Bag, Gas Cyl.	347	3,695	0	Housekeeping	1.31	4,840	-
Gift Shop / Retail	377	0	1,137	Public Spaces	0.80	-	910
Imaging / Nuclear Medicine	7,072	663	14,907	Radiology	1.22	809	18,187
Bio-Medical Engineering	1,155	0	2,074	Service Dept	1.20	-	2,489
EVS / Linen / Laundry	1,067	0	3,294	Laundry	1.68	-	5,534
Food & Nutrition - Kitchen	4,015	0	2,600	Dietary	1.52	-	3,952
Food & Nutrition - Dining & Servery	4,700	0	6,240	Dining Room	0.95	-	5,928
Laboratory	6,315	260	6,315	Laboratories	1.15	299	7,262
Morgue	344	0	844	Storage and Refrigeration	1.60	-	1,350
Supply Chain / Materials Management/EPS	3,117	335	5,345	Storage and Refrigeration	1.60	536	8,552
Support Staff Lounge / Lockers	599	0	1,656	Employee Facilities	0.80	-	1,325
Mechanical / Electrical	4,207	8,705	989	Mechanical Equipment Shop	0.70	6,094	692
Vertical Circulation	1,569	988		Internal Circulation, Shafts	0.60	593	
Circulation	9,205	6,173	9,222	Internal Circulation, Corridors	0.60	3,704	5,533
Exterior Walls		2,376			1.00	2,376	
Subtotal - Level 1	**58,837**	**53,232**	**54,623**			**52,237**	**61,714**
LEVEL 2							
Public Space / Lobby	0	2,665	281	Public Spaces	0.80	2,132	225
Meditation	165	403	0	Public Spaces	0.80	322	-
Surgery Services	27,295	26,420	21,589	Operating Suite	1.59	42,008	34,327
Endoscopy	0	5,860	0	Operating Suite	1.59	9,317	-
Imaging - CT / US	841	0	0	Radiology	1.22	-	-
Information Technology (IT) & Information Sy	1,006	0	809	Offices	0.96	-	777
Cardiac Cath / Interventional Radiology	3,332	0	10,435	Operating Suite	1.59	-	16,592
Non-Invasive Cardiology / PFT	592	0	2,358	Radiology	1.22	-	2,877
Pharmacy - Inpatient	3,780	0	6,450	Pharmacy	1.33	-	8,579
Respiratory Therapy	473	0	500	Radiology	1.22	-	610
GME	0	0	746	Offices	0.96	-	716
Mechanical / Electrical	1,531	1,153	196	Mechanical Equipment Shop	0.70	807	137
Vertcal Circulation	2,001	988	0	Internal Circulation, Shafts	0.60	593	-
Circulation	6,576	4,801	7,554	Internal Circulation, Corridors	0.60	2,881	4,532
Exterior Walls		1,740			1.00	1,740	
Sub-Total Level 2	**47,592**	**44,030**	**50,918**			**59,800**	**69,371**
LEVEL 3							
Public Space	0	2,630	0	Public Spaces	0.80	2,104	-
Labor & Delivery / Triage	0	20,426	0	Obstetric Suite	1.44	29,413	-
C-Section	0	5,634	0	Operating Suite	1.59	8,958	-
On-call	0	1,262	0	Offices	0.96	1,212	-
Mechanical / Electrical	0	5,187	0	Mechanical Equipment Shop	0.70	3,631	-
Vertical Circulation	0	988		Internal Circulation, Shafts	0.60	593	
Circulation	0	2,420	0	Internal Circulation, Corridors	0.60	1,452	-
Exterior Walls		1,712			1.00	1,712	
Subtotal - Level 3	**0**	**40,259**	**0**			**49,075**	**0**
LEVEL 4							
Public Space	0	1,024	0	Public Spaces	0.80	819	-
Postpartum / Antepartum	0	16,124	0	Inpatient Unit	1.06	17,091	-
Level II Continuing Care Nursery and Well Baby Nursery	0	2,905	0	Inpatient Unit	1.42	4,125	-
Respiratory Therapy	0	264	0	Radiology	1.22	322	-
Mechanical / Electrical	0	967	0	Mechanical Equipment Shop	0.70	677	-
Vertical Circulation	0	988		Internal Circulation, Shafts	0.60	593	
Circulation	0	964	0	Internal Circulation, Corridors	0.60	578	-
Exterior Walls		1,234			1.00	1,234	
Subtotal - Level 4	**0**	**24,470**				**25,440**	
PENTHOUSE							
Penthouse	0	19,221	0	Mechanical Equipment Shop	0.70	13,455	0
Shafts/Exterior Wall Thickness		1,737	0	Shafts/Exterior Wall	0.70	1,216	0
Subtotal - Penthouse	**0**	**20,958**	**0**			**14,671**	**0**
Total	**106,429**	**182,949**	**105,541**			**201,222**	**131,084**

EXHIBIT 23

Employee Category	Year 1 FTE	Average Salary per FTE	Year 1 Total Expense	Year 3 FTE	Average Salary per FTE	Year 3 Total Expense	Year 5 FTE	Average Salary per FTE (1)	Year 5 Total Expense
Labor and Delivery									
Nursing Director	0.5	$ 152,214	$ 76,107	1.0	$ 159,920	$ 159,920	1.0	$ 168,016	$ 168,016
L&D Clin Supe - Night	0.5	$ 159,619	$ 71,829	0.9	$ 167,700	$ 150,930	0.9	$ 176,190	$ 158,571
Clinical Educator	0.3	$ 108,909	$ 32,673	0.6	$ 114,422	$ 68,653	0.6	$ 120,215	$ 72,129
Charge/Resource Nurse	2.8	$ 109,158	$ 300,186	3.3	$ 114,685	$ 378,459	3.3	$ 120,490	$ 397,618
Triage Nurse	1.8	$ 109,158	$ 191,027	2.1	$ 114,685	$ 240,838	2.1	$ 120,490	$ 253,030
OR/Recovery Nurse	1.8	$ 109,158	$ 200,124	2.2	$ 114,685	$ 252,306	3.2	$ 120,490	$ 385,569
RN - Laboring and Non-Laboring	10.5	$ 109,158	$ 1,146,163	16.8	$ 114,685	$ 1,926,700	20.4	$ 120,490	$ 2,458,005
OB Surg Tech	4.2	$ 80,309	$ 337,297	4.2	$ 84,374	$ 354,373	4.2	$ 88,646	$ 372,313
Clerical/ Reg. Staff	4.2	$ 49,650	$ 208,528	4.2	$ 52,163	$ 219,085	4.2	$ 54,804	$ 230,176
Anesthesia/Equipment PCT	1.1	$ 69,742	$ 73,230	2.1	$ 73,273	$ 153,874	2.1	$ 76,983	$ 161,663
Perinatal Loss Coordinator	0.2	$ 130,021	$ 19,503	0.3	$ 136,603	$ 40,981	0.6	$ 143,519	$ 86,111
Subtotal	***27.7***		***$ 2,656,666***	***37.7***		***$ 3,946,119***	***42.6***		**$ 4,743,202**
Post Partum									
Community Educator/Navigator	0.45	$108,222.40	$48,700	0.9	$113,701	$102,331	0.9	$119,457	$107,512
Lactation	0.8	$111,550.40	$89,240	2.8	$117,198	$328,153	3.6	$123,131	$443,271
Charge Nurse	2.5	$111,862.40	$276,859	3.3	$117,525	$387,834	3.3	$123,475	$407,468
RN/Special Care Nursery	9.45	$111,862.40	$1,057,100	15	$117,525	$1,762,882	19.6	$123,475	$2,420,113
MBU Clin Supe - Nights	0.45	$130,894.40	$58,902	0.9	$137,521	$123,769	0.9	$144,483	$130,035
MBU Educator	0.3	$116,875.20	$35,063	0.6	$122,792	$73,675	0.6	$129,008	$77,405
PCT Techs	2.1	$46,051.20	$96,708	4.2	$48,383	$203,207	4.2	$50,832	$213,494
Clerical Staff and Vital Statistics	2.1	$49,649.60	$104,264	4.2	$52,163	$219,085	4.2	$54,804	$230,176
Subtotal	***18.1***		***$ 1,766,836***	***31.9***		***$ 3,200,936***	***37.3***		**$ 4,029,473**
Support Staff									
Social Work/Case Management	1.4	$ 80,059	$ 112,083	2.8	$ 84,112	$ 235,514	2.8	$ 88,370	$247,437
EVS	3.0	$ 43,597	$ 128,611	7.1	$ 45,804	$ 325,208	8.3	$ 48,123	$399,418
Respiratory Therapy	0.2	$ 111,176	$ 16,676	0.3	$ 116,804	$ 35,041	0.3	$ 122,718	$36,815
BioMed	0.2	$ 81,869	$ 12,280	0.3	$ 86,013	$ 25,804	0.5	$ 90,367.84	$45,184
Security Officer	1.5	$ 55,786	$ 83,678	3.0	$ 58,610	$ 175,829	5	$ 61,576.86	$307,884
Pharmacist	0.7	$ 148,803	$ 104,162	2.1	$ 156,336	$ 328,306	2.1	$ 164,250.89	$344,927
Subtotal	***6.9***		***$ 457,491***	***15.6***		***$ 1,125,703***	***19.0***		**$ 1,381,666**
Total Salaries									**$ 10,154,342**
Benefits @ 17%									$ 1,726,238
Total Salaries and Benefits									**$ 11,880,580**
Contracted Physicians									
OB Laborist	2.1		$ 1,492,508	4.2		$ 1,698,472	4.2		$1,380,009
Certified Nurse Midwife	2.1		$ 738,281	4.2		$ 1,476,563	4.2		$1,476,563
Maternal Fetal Medicine	0.1		$ 60,156	0.2		$ 120,313	0.2		$120,313
Anesthesiology			$ 259,000	0.0			0.0		
Neonatologist	0.1		$ 62,656	0.2		$ 85,313	0.2		$85,313
Pediatrician/NP	2.0		$ 733,125	4.0		$ 1,466,250	4.0		$1,466,250
Total Contractual Services	***6.4***		***$ 3,345,727***	***12.8***		***$ 4,846,909***	***12.8***		***$ 4,528,446***

EXHIBIT 24

Luminis Health

Dates Previously Reviewed/Revised: 6/2021 **Reviewed By:** LHSSPRC 4/2022 **Approver:** Chief Compliance Officer **Approval Date:** 5/2022 **Effective Date:** 5/2022	**Owner:** Senior Director, Corporate Compliance

LH-ADM1.1.79 - Emergency Medical Treatment and Active Labor Act (EMTALA) - Evaluation, Treatment and/or Transfer of Patients

Scope

Luminis Health, Inc. (LH)

Purpose

To establish guidelines for the evaluation, treatment and/or transfer of patients seeking emergency medical treatment at LH and to assure that patients are appropriately evaluated and treated within the capabilities of LH, stabilized prior to transfer to the extent appropriate, and adequately informed of the risks and benefits of treatment and transfer or of alternative means of treatment available.

Definitions

"Hospital" will include Luminis Health Anne Arundel Medical Center ("LHAAMC") and Luminis Health Doctor's Community Medical Center ("LHDCMC").

"Capacity": The ability of the Hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified medical staff, beds, and equipment, and the Hospital's best practices of accommodating additional patients in excess of its occupancy limits.

"Emergency Medical Condition" (EMC):

a. A medical condition manifesting itself by acute symptoms (including severe pain or discomfort, psychiatric disturbances and symptoms of substance abuse) of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

   i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child or born alive infant) in serious jeopardy,
   ii) Serious impairment of bodily functions, or
   iii) Serious dysfunction of any bodily organ or part.

b. With respect to a pregnant woman who is having contractions or is in the latent or early stages of labor (unless a physician or other qualified medical personnel determines the woman is in false labor after a reasonable period of observation) and

   i) there is inadequate time to affect a safe transfer to another hospital before delivery, or
   ii) transfer may pose a threat to the health or safety of the woman, unborn child or born alive infant.

"Hospital property": The entire main Hospital campus as defined by 42 CFR 413.65(b), including the parking lots, sidewalks and driveways and any hospital owned property within 250 yards of the main Hospital.

"Medical Screening Examination" (MSE): A medical examination performed in the Emergency Department / Labor & Delivery by Qualified Medical Personnel to determine if an EMC exists. A MSE is not the equivalent of a triage assessment.

"Qualified Medical Personnel" Includes Physicians, Nurse Practitioners, and Physician Assistants as defined by 42 CFR 489.24(a) and 42 CFR 482.55 as well as those defined within the Hospital Medical Staff Bylaws who have been granted appropriate clinical privileges.

"Stabilize": Treatment of a patient with respect to an EMC that:

a. Within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or

b. With respect to a pregnant woman who is in labor, to deliver the child and placenta.

"Transfer": The movement of an individual outside LH's facilities at the direction of any person employed by (or affiliated or associated), directly or indirectly, with LH, but does not include such a movement of an individual who (a) has been declared dead, (b) is admitted as a patient or (c) leaves the facility without the permission of any LH affiliated person.

Policy Statements

All patients to whom this Policy applies shall receive a medical screening evaluation (MSE) by Qualified Medical Personnel and appropriate treatment within the capabilities of LH without regard to age, race, color, religion, national origin, sex, sexual orientation, ability to pay, insurance, physical or mental condition or handicap. Any patient who cannot be appropriately treated at LH shall be stabilized to the extent it is medically appropriate, shall be informed of the risks and benefits of transfer or refusal of treatment to the extent practical and transferred in accordance with the provisions of this policy.

Procedures

1. Medical Screening Examinations (MSE) (42CFR 489.24)

1.1. All patients to whom this Policy applies shall be offered an appropriate MSE by Qualified Medical Personnel, within the capability of LH and its Emergency Department/ Labor & Delivery, including clinically indicated ancillary services routinely available to the Emergency Department, to determine whether or not an EMC exists.

1.2. All patients coming to the Emergency Department/ Labor & Delivery shall be triaged as soon as possible after arrival to determine treatment priorities; however, evaluating a patient only for triage purposes shall not constitute as a MSE.

1.3. An initial triage inquiry, MSE, and any further examination and treatment required, shall not be delayed in order to inquire about the individual's method of payment, ability to pay, or insurance status. However, a reasonable and customary registration process will be followed, including asking whether an individual is insured and, if so, what that insurance is, while awaiting a screening examination or further evaluation or treatment, if doing so will not result in delay in providing the screening examination or treatment or would not unduly discourage the individual from remaining for a screening examination or evaluation. No one may seek or direct an individual to seek, authorization from the individual's insurance company for screening or stabilization services to be furnished by the Hospital, until after the Hospital has provided the appropriate MSE and initiated any further medical examination and treatment that may be required to stabilize an EMC.

1.4. After triage, all patients shall be offered a screening examination by Qualified Medical Personnel to determine whether the patient has an Emergency Medical Condition. Qualified Medical Personnel shall include a physician, physician assistant, or nurse practitioner.

1.5. If, after initial screening examination, it is determined that the patient does not have an Emergency Medical Condition, the patient may (in the judgment of a physician) be:

1.5.1. discharged from the Emergency Department/ Labor & Delivery with appropriate discharge instructions and referral for any necessary non-emergency treatment,

1.5.2. provided further non-emergency examination and treatment, including admission, or
1.5.3. transferred to another facility for non-emergency evaluation and treatment.

1.6. If the patient is determined to have an Emergency Medical Condition, the patient shall be provided with either:

1.6.1. further medical examination and treatment within the available capabilities of LH as required to stabilize the patient (and admit if necessary), or
1.6.2. subject to the provisions of section 8 below, transfer the patient to another medical facility in accordance with this Policy and in accordance with LH-ADM1.1.46 - Transfer of patients to other acute care facilities policy.

1.7. If the Qualified Medical Personnel determines that a specialist is needed for consultation or treatment, or that the patient may require admission to a hospital, arrangements shall be made for the patient to be seen by the patient's private physician or a physician on call, unless an appropriate specialist is not reasonably available.

2. Transfers

2.1. No patient suffering from an EMC shall be transferred to another facility unless

2.1.1. the patient, or a legally authorized representative of the patient, requests the transfer after being advised of Hospital's obligations under this policy and the risks and expected benefits of transfer. This shall include situations where the patient does not have a physician with privileges the Hospital and the patient refuses treatment at LH by a physician with privileges, or
2.1.2. a physician has certified on the Inter-facility Transfer Record, also documented in the medical record, that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risk to the patient or, in the case of a woman in labor, to the woman or the unborn child, from being transferred.

2.2. Any patient to be transferred must be stabilized prior to transfer unless:

2.2.1. the patient, or a legally authorized representative of the patient, requests the transfer prior to stabilization after being advised of LH obligations under this policy and the risks and expected benefits of transfer without stabilization, or
2.2.2. a Qualified Medical Personnel has certified on the appropriate form that the medical benefits reasonably expected from being transferred prior to stabilization outweigh the increased risk to the patient or, in the case of a woman in labor, to the woman or the unborn child, from delaying the transfer to stabilize the patient.

2.3. Under no conditions shall a patient be transferred because of the patient's inability to pay or the source of payment.

2.4. In all cases where a transfer to another facility is to be made, LH shall, prior to transfer:

2.4.1. provide medical treatment within LH's capacity that minimizes the risks to the patient's health and, in the case of a woman in labor, the health of the unborn child or born alive infant;
2.4.2. determine that the receiving facility has available space and qualified personnel to provide appropriate treatment of the patient;
2.4.3. determine that the receiving hospital, including physicians, if appropriate, has agreed to accept transfer and provide appropriate treatment;
2.4.4. to the extent practical, explain to the patient or patient's representative the reasons for the proposed transfer, the alternatives to the transfer and the reasonably foreseeable risks and benefits of the transfer;
2.4.5. except in cases of involuntary psychiatric admission, obtain the written consent of the patient or the patient's representative to the transfer, when possible; and,
2.4.6. determine that a physician has signed the appropriate certifications when required by this Policy.

2.5. In effecting a transfer to another medical facility, the LH shall, to the extent possible, provide that:

2.5.1. medically appropriate life-support measures, as determined by a physician, are used to stabilize the patient before and during transfer;

2.5.2. appropriate personnel and equipment, as determined by a physician, are provided for use in the transfer;

2.5.3. copies of all medical records available shall be sent to the receiving facility at the time of transfer or as soon thereafter as possible, including but not limited to based on medical information pertinent to the current Emergency Medical Condition:

- o the patient's history
- o physicians or nurses notes, or other observations of the patient's condition
- o preliminary diagnosis
- o results of diagnostic studies or tests
- o medications given or other treatment provided
- o written consent to transfer signed by the patient or the patient's legal representative, if consent is obtained
- o any physician's certification regarding the necessity for transfer

2.5.4. If the transfer is necessary because a physician on-call did not respond on a timely basis, the receiving hospital shall be given the on-call physician's name and address. The Chief Medical Officer at LHAAMC and LHDCMC shall receive a written report outlining the delay and a notification shall be submit to the event reporting system.

2.6. Whenever a patient is transferred it shall be the responsibility of the medical staff/house staff to complete the appropriate forms and records to document compliance with this policy. This documentation should include the name of the accepting individual and transferring facility in the event a patient or representative of a patient refuses to sign any required document, such refusal shall be documented by the nursing staff. (Use Inter-facility Transfer Record Form #20280).

2.7. If the patient refuses any examination, treatment or transfer recommended by a treating physician, the medical staff shall take reasonable steps to obtain the written acknowledgment of the patient/responsible person, documenting the examination, treatment and/or services offered to the patient, the information given to the patient concerning the benefits of the offered services and the risks of refusal, and the patient's refusal to accept the examination, treatment or transfer recommended. (Use Inter-facility Transfer Record Form #20280).

3. Documentation

3.1. The legal medical record must contain a description of the MSE, treatment and/or transfer that was refused by or on behalf of the patient.

3.2. The Emergency Department and Labor & Delivery shall maintain a list of physicians who are available on call to stabilize and/or treat an individual with an EMC after the initial examination.

3.3 All data identifying each individual who came to the Emergency Department and to Labor & Delivery seeking treatment and indications of whether the individual refused treatment, or was refused treatment, or was transferred, admitted and treated, stabilized and transferred, or discharged is kept in the electronic medical record. Reports are available upon request.

3.4. Involuntary psychiatric commitments shall be handled in accordance with the Hospital's policy relating to psychiatric evaluations and commitments and determined under 42 CFR 489.24 (b), (f).

3.5. If a patient to whom this policy applies is going to be transferred, but is unstable, the Inter-facility Transfer Record Form shall be used as appropriate.

3.6. This policy and the Inter-facility Transfer Record form shall be utilized, to the extent practical, whenever there is a transfer of a patient from anywhere in LH to another acute care hospital, except discharges to

nursing homes or long-term care facility. Accordingly, the Inter-facility Transfer Record Form will be used for all transfers, including transfers of inpatients.

3.7. Hospital will post conspicuously in the Emergency Department or in a place likely to be noticed by all individuals entering the Emergency Department, as well as by all individuals waiting for examination and treatment in areas other than the Emergency Department, such as LH admitting areas, a sign specifying the rights of individuals to receive examination and treatment for emergency medical conditions and women in labor as indicated in 42 CFR 489.20 (q)1.

3.8. The obligation to perform a MSE and provide appropriate treatment or transfer applies to all hospitals with an emergency department pursuant to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). If a physician, physician assistant, or nurse practitioner believes that a patient has been transferred to LH from another hospital in an unstable medical condition, this is in violation of EMTALA and the practitioner should report the matter immediately to the senior physician on duty in the Emergency Department. The senior physician in the ED shall confer with the Chief Medical Officer as soon as possible. The Chief Medical Officer at the Hospital shall consult with Risk Management Department and the Corporate Compliance Department to determine whether an EMTALA violation has occurred which is required to be reported within 72 hours.

3.9. It is recognized that circumstances may arise which are not covered by this policy. In such situations, the Qualified Medical Personnel and Emergency Department/ Labor & Delivery staff shall take all appropriate steps to act in the best interests of the patient and, to the extent practical, document in the patient's record the action taken, the reasons for the action and the patient's wishes. The patient's wishes shall be ascertained and complied with whenever possible.

References

1. State Operations Manual, Appendix V- Interpretive Guidelines - Responsibilities of Medicare Participating Hospital in Emergency Cases, Rev. 191, July 9, 2019. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf
2. CMS - Inpatient Prospective Payment System (IPPS) 2009 Final Rule Revisions to Emergency Medical Treatment and Labor Act (EMTALA) Regulations, March 6, 2009. [Landmark] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter09-26.pdf
3. §1867 42 U.S.C. 1399ddExamination and treatment for emergency medical conditions and women in labor https://www.ssa.gov/OP_Home/ssact/title18/1867.htm
4. 42 CFR §413.65(b) - Requirements for a determination that a facility or an organization has provider-based status; Provider based determinations https://www.govregs.com/regulations/title42_chapterIV_part413_subpartE_section413.65
5. 42 CFR §489.20 - Essentials of Provider Agreements; Basic commitments https://www.govregs.com/regulations/title42_chapterIV_part489_subpartB_section489.20
6. 42 CFR §489.24 - Special responsibilities of Medicare hospitals in emergency cases https://www.govregs.com/regulations/title42_chapterIV_part489_subpartB_section489.24
7. 42 CFR §482.55 - Condition of Participation: Emergency Services https://www.govregs.com/regulations/title42_chapterIV_part482_subpartD_section482.55
8. *CMS* QSO-19-15 EMTALA 07/02/2019 - Frequently Asked Questions on the Emergency Medical Treatment and Labor Act (EMTALA) and Psychiatric Hospitals. QSO-19-15-EMTALA.pdf
9. CMS QSO-05-26 Rev. 06/27/2019 - Interaction of the Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infants Protection Act of 2002. *QSO-05-26.pdf*

Cross References

ADM1.1.46 - Ambulance - Air Transfer of Patients to Other Facilities
Departmental Policy - Emergency Department Registration
LH-Inter-facility Transfer Form
Hospital Medical Staff Bylaws
SNP15.2.155 - Maternal Transport Process

EXHIBIT 25

Luminis Health

DOCTORS COMMUNITY MEDICAL CENTER

Subject: TRANSFER OF PATIENTS TO OTHER ACUTE FACILITIES	Reference # PCS1030
Department: Patient Care Services	Page 1 of 3
	Created: September 2009 Next Review Date: February 2024

POLICY

I. **Luminis Health** Doctors Community Medical Center (LHDCMC) will transfer its patients based upon guidelines outlined in federal, state and Emergency Medical Treatment and Active Labor Act (EMTALA) laws. Patients will not be transferred to another acute care facility unless care required cannot be provided by this institution, or for a higher level of care or as requested by and/or consented to by the patient or legally authorized patient representative.

No patient will be transferred from LHDCMC until his/her medical condition is stabilized to a degree that allows for safety during transport. All transfers to other facilities require a written order by a physician. Contact with and acceptance by the receiving facility will be made prior to transfer. Patient safety and stability are the primary considerations of LHDCMC.

II. Per EMTALA, "appropriate transfer" meets the following criteria:

A. Unless extenuating circumstances are documented in the patient's record, no patient shall be arbitrarily transferred to another facility if LHDCMC has the means to provide appropriate care.

B. The receiving hospital has available space and qualified personnel for the treatment of the patient, and has agreed to accept the patient and provide necessary medical treatment.

C. The transferring hospital provides the receiving facility with appropriate medical records (or copies) of the examination and treatment provided at the transferring hospital.

D. A staff member (Case Management, Nursing) should be designated to oversee the transfer process. This person should notify the physician transferring their patient to make any advance preparations necessary and to prepare a transfer note to facilitate the transfer.

E. A checklist of items should be utilized by the staff member designated to oversee the transfer process including any issues that must be addressed prior to beginning the transfer process. This should include, but is not limited to, patient preparation, completion and compilation of all pertinent patient paperwork (including completed MOLST form), imaging, administration of medications, IV lines and Foley catheter placement, as necessary.

F. The designated staff member should also notify the patient's family of the process of the transfer and answer any questions the family members may have, or be prepared to direct them to the proper resource to have any concerns addressed.

G. The transfer is effected utilizing qualified personnel and transportation with appropriate equipment, including necessary life-support measures as indicated.

H. The transfer will meet any other requirements that are determined by federal, EMTALA, state or local regulations to be in the interest of the health and safety of the patient.

I. The transferring physician must contact a physician at the receiving facility who, after discussion of the case, agrees to accept responsibility for the care of the patient when transferred.

J. The transferring nurse will call report to the receiving nurse prior to transfer and document the receiving nurse's full name and contact number on the transfer form.

K. Memoranda of understanding or similar documents may be sought by hospital administration for those services designated as appropriate, to facilitate transfers of patients to other facilities.

L. The physician who is responsible for the care of the patient must complete the Physician Statement on the Emergency Transfer Form which addresses the following:

1. Based on the information available at the time of transfer, the medical benefits expected from treatment at another facility outweigh the risks of the transfer.

2. The transfer or delay caused by the transfer will not create a medical hazard for the patient. ("Medical hazard" is defined as deterioration or jeopardy to a patient's medical condition or expected chances for recovery).

3. Signature of a physician and completion of this statement on the Transfer Form constitutes a legal physician order to proceed with the process, including mode of transfer and whether a nurse is needed to accompany the patient. Additional physician documentation should be included on the patient's medical record as indicated.

4. Additional considerations for transfer of a stable patient to another healthcare facility may include:

    a. Patient preference;

    b. Patient physician preference;

    c. HMO/PPO and/or other insurance requirements;

    d. Active duty military personnel;

    e. LHDCMC must ensure safe transfer of the patient.

M. The physician, PA, or NP must ensure the Maryland Medical orders for Life-Sustaining Treatment (MOLST) form is completed prior to transfer.

N. The Patient Transfer Form will be completed by the nursing staff with the original copy sent with the patient. A copy of the MOLST form will also accompany the patient.

O. The medical record will be released as stated in hospital policies HIS1007 Disclosure of Information - Authorization Required and HIS1008 Disclosure of Information - Authorization Not Required.

1. The patient or legally responsible party or guardian must agree to the transfer by signing the Transfer Release on the Emergency Transfer Form after satisfactory explanation of the reason for the transfer. This signature is to be witnessed by a member of the nursing staff. As with other consents, telephone and fax consent are acceptable.

2. If the patient or legally responsible party or guardian refuses transfer to another healthcare facility after explanation of the risks and benefits related to such decision, the Transfer Refusal on the Emergency Transfer Form must be signed. This signature is to be witnessed by a member of the nursing staff.

APPROVAL PROCESS

1. **Departmental Review**
2. **Hospital Policy Review Committee** on 3/18/2021
3. **Vice President, Patient Care Services/Chief Nursing Officer- Final Approval**

REVIEWED/REVISED:

September 2011
December 2014
October 2017
February 2021

EXHIBIT 26

CANNONDESIGN

May 1, 2023

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Luminis Health Doctors Community Medical Center
CON Application for Acute Care Pavilion:

To whom it may concern:

CannonDesign is the architectural design firm that is designing the proposed Luminis Health Doctors Community Medical Center Acute Care Pavilion in Lanham, Maryland. I am confirming that the architectural design of the proposed Acute Care Pavilion project will comply with The Facility Guidelines Institute (FGI) Section 2.2 guidelines for General Hospitals.

If you have any questions, please contact me.

Sincerely,

Scott R. Thomas
Principal
CannonDesign

EXHIBIT 27

27(e) Provide the Excel spreadsheet with the supporting calculations used to support the need for the ten operating rooms.

file here: Surgical Model for DCMC_AH Edits_v2.xlsx

Luminis Health Doctors Community Medical Center

Current Cases at current average time per case with estimated OR Needs

Actual Fiscal Year 2022

	Inpatient						Outpatient			
Hospital	Cases	Avg time per Case	Avg. Turnaround Time	Shift to DCMC	Total DCMC Cases	Total DCMC Minutes	Cases	Avg time per Case	Avg. Turnaround Time	Shift to DCMC
Luminis Health Doctors Community Medical Center	2,224	136	35	100%	2,224	380,857	4,037	97	35	100%
Luminis Health Anne Arundel Medical Center	761	164	35	6%	46	9,107	1,576	98	35	6%
Other Maryland Hospitals	4,994	163	35	3%	150	29,596	6,062	94	35	3%
Washinton, DC Hospitals**	5,637	91	35	5%	282	35,531	8,248	56	35	5%
Total	13,616	133	35	20%	2,701	455,092	19,923	94	35	24%

Source: Inpatient and outpatient HSCRC data for FY 2022 within the DCMC Service Area. DCMC volume reflects total surgical volume.
Note: Surgical cases defined as any inpatient or outpatient case with a surgical DRG or procedure code, excluding Transplants and Cardiac Surgery.

**Estimated 41.1% surgical outmigration to DC from the DCMC Service Area based on outmigration report prepared by BRG in August 2019

Other MD includes 31 hospitals with no other hospitals contributing no more than 48.
3% of the service area from all other MD hospitals.

Total DCMC Cases	Total DCMC Minutes	Total DCMC Cases	# ORs
4,037	534,485	6,261	8.03
95	12,590	140	0.19
182	23,470	332	0.47
412	37,577	694	0.64
4,726	608,123	7,427	9.33

EXHIBIT 28

Chapter 102

(House Bill 201)

AN ACT concerning

Creation of a State Debt – Maryland Consolidated Capital Bond Loan of 2023, and the Maryland Consolidated Capital Bond Loans of 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, and 2022

FOR the purpose of authorizing the creation of a State Debt in the amount of ~~One Billion, Two Hundred Six Million, Six Hundred Thirty–Nine Thousand Dollars ($1,206,639,000)~~ ~~One Billion, Two Hundred and Sixteen Million, Six Hundred and Thirty–Nine Thousand Dollars ($1,216,639,000)~~ ~~*One Billion, Two Hundred and Seventeen Million, Five Hundred and Eighty–Six Thousand and Five Hundred Dollars ($1,217,586,500)*~~ *One Billion, Two Hundred and Eighteen Million, Six Hundred and Thirty–Nine Thousand Dollars ($1,218,639,000)*, the proceeds to be used for certain necessary building, construction, demolition, planning, renovation, conversion, replacement, and capital equipment purchases of the State, for acquiring certain real estate in connection therewith, and for grants to certain subdivisions and other organizations for certain development and improvement purposes, subject to certain requirements that certain matching funds be provided and expended by certain dates; providing generally for the issuance and sale of bonds evidencing the loan; imposing a certain tax on all assessable property in the State; requiring that certain grantees convey certain easements under certain circumstances to the Maryland Historical Trust; providing that the proceeds of certain loans must be expended or encumbered by a certain date; authorizing the Board of Public Works, under certain circumstances, to approve certain appropriations, notwithstanding certain technical differences; authorizing certain unexpended appropriations in certain prior capital budgets and bond loans to be expended for other public projects; altering certain requirements for certain programs in certain prior capital budgets and bond loans; reducing prior authorizations of State Debt; requiring that certain projects be constructed at certain locations; adding, altering, and repealing certain requirements for certain appropriations; specifying the use of certain project funds; altering and expanding the authorized purpose of certain grants; providing that certain grants may not terminate before certain dates; authorizing premiums from the sale of State bonds in certain fiscal years to be used for certain purposes; requiring the Comptroller to make certain transfers, adjustments, and reconciliations; authorizing, in a certain fiscal year, the fund balance of a certain fund to exceed a certain limit; repealing certain Maryland Consolidated Capital Bond Loan Preauthorization acts; specifying the use of certain project funds; authorizing the creation of State Debt in certain years to be used for certain purposes; clarifying the use of certain bond proceeds; making certain provisions of this Act subject to certain contingencies; altering certain reporting requirements for the Construction Contingency Fund; and generally relating to the financing of certain capital projects.

BY repealing and reenacting, with amendments,

and Town Council of Chesapeake Beach for the acquisition, planning, design, construction, repair, renovation, reconstruction, site improvement, and capital equipping of Chesapeake Beach Water Park (Calvert County) 600,000

(DM) Luminis Health Doctors Community Medical Center. Provide a grant to the Luminis Health Doctors Community Medical Center, Inc. for the acquisition, planning, design, construction, repair, renovation, reconstruction, site improvement, and capital equipping of infrastructure improvements to the Luminis Health Doctors Community Medical Center, including a new tower for obstetrical care (Prince George's County) ..... ~~5,000,000~~ *6,000,000*

(DN) Incubator Spaces – Cannabis. Provide funds to the Maryland Economic Development Corporation for the acquisition, planning, design, construction, repair, renovation, reconstruction, site improvement, and capital equipping of facilities to be used as incubator spaces in accordance with § 36–406 of the Alcoholic Beverages and Cannabis Article, contingent on enactment of HB 556 or SB 516 (Statewide) 2,000,000

(DO) Cal Ripken Sr. Foundation. Provide a grant to the Board of Directors of the Cal Ripken Sr. Foundation for the acquisition, planning, design, construction, repair, renovation, reconstruction, site improvement, and capital equipping of science, technology, engineering, and math centers built by the Cal Ripken Sr. Foundation (Statewide) ..... ~~300,000~~ *600,000*

(DP) ~~Community Preservation Trust~~ Community Park City–University Partnership – City of College Park. Provide a grant to the Board of Directors of the College Park City–University Partnership for the acquisition, planning, design, construction, repair, renovation, reconstruction, site improvement, and capital equipping of the Hiker Biker Trail project along ~~College~~ Campus Drive in the City of College Park (Prince George's County) 2,500,000

(DQ) Pride of Baltimore II. Provide a grant to the Board of Directors of the Pride of Baltimore, Inc. for the acquisition, planning, design, construction, repair, renovation, reconstruction, site improvement, and capital equipping of the Pride of Baltimore II (Baltimore City) 100,000

(DR) Woodlawn High School. Provide a grant to the County

acquisition, planning, design, construction, repair, renovation, reconstruction, site improvement, and capital equipping of Riverdale Park (Prince George's County) 1,500,000

(C) North Bethesda Metro Station. Provide a grant to the Washington Metropolitan Area Transit Authority for the acquisition, planning, design, construction, repair, renovation, reconstruction, site improvement, and capital equipping of the North Bethesda Metro Station (Montgomery County) 10,000,000

(D) City of Salisbury Infrastructure Improvements. Provide a grant to the Mayor and City Council of the City of Salisbury for the acquisition, planning, design, construction, repair, renovation, reconstruction, site improvement, and capital equipping of infrastructure improvements in the City of Salisbury (Wicomico County) 2,000,000

(E) Extended North Tunnel. Provide a grant to the County Executive and County Council of Howard County for the acquisition, planning, design, construction, repair, renovation, reconstruction, site improvement, and capital equipping for the Extended North Tunnel project for stormwater management (Howard County) .... ~~2,000,000~~ *10,000,000*

(F) City of Laurel Historical Dam Ruins at Riverfront Park Restoration. Provide a grant to the Mayor and Council of the City of Laurel for the acquisition, planning, design, construction, repair, renovation, reconstruction, site improvement, and capital equipping of the City of Laurel Historical Dam Ruins at Riverfront Park (Prince George's County) 1,200,000

(G) Luminis Health Doctors Community Medical Center. Provide a grant to the Luminis Health Doctors Community Medical Center, Inc. for the acquisition, planning, design, construction, repair, renovation, reconstruction, site improvement, and capital equipping of infrastructure improvements to the Luminis Health Doctors Community Medical Center, including a new tower for obstetrical care (Prince George's County) 10,000,000

(H) Cheverly Hospital Demolition. Provide a grant to the County Executive and County Council of Prince George's County for the acquisition, planning, design, construction, repair, renovation, reconstruction, site improvement, and capital equipping of the demolition of Cheverly Hospital (Prince George's County) 5,000,000

(I) Everyman Theatre. Provide a grant to the Board of Directors of