IN THE MARYLAND HEALTH CARE COMMISSION

APPLICATION FOR CERTIFICATE OF NEED

to establish 20-bed
Regional Infection Containment Unit at Meritus Medical Center

Applicant:

Meritus Health, Inc.

June 2, 2023

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MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Meritus Medical Center

Address:

11116 Medical Campus Road	Hagerstown	21742	Washington
Street	City	Zip	County

Name of Owner (if differs from applicant):

2. OWNER

Name of owner: Meritus Medical Center, Inc.

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

Legal Name of Project Applicant
Meritus Medical Center, Inc.

Address:

11116 Medical Campus Road	Hagerstown	21742	MD	Washington
Street	City	Zip	State	County

Telephone: 301-790-8000

Name of Owner/Chief Executive: Maulik Joshi, President & Chief Executive Officer

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from applicant:

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

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

A. Governmental ☐

B. Corporation

(1) Non-profit ☒

(2) For-profit ☐

(3) Close ☐ State & date of incorporation

C. Partnership

General ☐

Limited ☐

Limited liability partnership ☐

Limited liability limited partnership ☐

Other (Specify):

D. Limited Liability Company ☐

E. Other (Specify):

To be formed: ☐

Existing: ☐

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

A. Lead or primary contact:

Name and Title: David White, Manager Reimbursement & Strategy

Mailing Address:

11116 Medical Campus Road	**Hagerstown**	**21742**	**MD**
Street	City	Zip	State

Telephone: **301-790-9138**

E-mail Address (required): **David.White@meritushealth.com**

Fax:

B. Additional or alternate contact:

Name and Title: Joshua Repac, Chief Financial Officer

Mailing Address:

11116 Medical Campus Road	**Hagerstown**	**21742**	**MD**
Street	City	Zip	State

Telephone: **301-790-9351**

E-mail Address (required): **Joshua.Repac@meritushealth.com**

Fax:

7. TYPE OF PROJECT

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

If approved, this CON would result in:

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

8. PROJECT DESCRIPTION

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

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

On March, 21, 2020, the Maryland Health Care Commission ("MHCC") issued Meritus Medical Center ("Meritus") an Emergency Certificate of Need authorizing the establishment of additional inpatient bed capacity in a 20-bed Regional Infectious Containment Unit ("RIC-Unit" or "RICU") located within a 12,650 square foot addition to the current hospital facility. The establishment of the RIC-Unit at Meritus was a direct response to the State's call to expand inpatient bed capacity with a negative pressure capable 20-bed unit to help prepare for the incoming wave of COVID-19 patients. Construction of the RIC-Unit was completed rapidly and in August, 2020 patients began being admitted to the RIC-Unit. Since the unit opened, over 1,500 patients have received care in the RIC-Unit of Meritus Medical Center. The total project cost is $13,511,770 of which $12,403,666 is the cost of constructing the building, $968,586 is for major medical equipment, $135,555 is for improvements needed to current facility, and $3,995 is for land development prior to construction. Currently, hospitals are no longer facing the severe inpatient capacity challenges wrought by COVID-19 and as such, the RIC-Unit will be converted to a 20-bed dedicated clinical observation unit due to its beneficial proximity to Meritus' Emergency Department. However, during a surge of an infectious respiratory disease, the RIC-Unit will become the primary point of treatment for patients.

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

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

COMPREHENSIVE PROJECT DESCRIPTION

I. Meritus Medical Center

Washington County Hospital Association was chartered by the Maryland Legislature as a voluntary nonprofit organization on April 7, 1904. In October of the following year, the hospital opened its doors to patients for the first time. It had 10 beds, six staff members, and 12 physicians and admitted 106 patients in the first year. In 1912, facility which housed the hospital, a former residence in Hagerstown, was no longer large enough to handle the patient load and the hospital moved to its long-time site on Antietam Street.

From its opening in 1905, Washington County Hospital has made patient care a priority, as evidenced by investments in nursing education, technological advancements, and population health improvement. Reflecting the organization's commitment to keep pace with the changing health needs of its community, the hospital transitioned to a replacement facility in 2010 which was constructed to be state of the art and was renamed Meritus Medical Center.

Today, Meritus Medical Center is western Maryland's largest health care provider and serves about 200,000 residents of the region, including southern Pennsylvania and the eastern panhandle of West Virginia. As the sole-community provider of hospital based acute care services in Washington county, and a regional hub for the tri-state region, Meritus offers a comprehensive array of services which include: specialty services for cancer care, stroke, general surgery, urology, gynecology, orthopedics and joint replacement, neurosurgery, wound healing, behavioral health & substance abuse, palliative care, and comprehensive inpatient rehabilitation. Additional service offerings include cardiovascular and pulmonary rehabilitation fitness, digestive health, sleep disorder treatment, and pain management. Surgical services include minimally invasive robotic assisted surgical procedures. Meritus is designated as a Level-III Trauma Center.

II. Regional Infection Containment Unit

In March of 2020, Maryland Governor Larry Hogan declared a State of Emergency due to the public health threat of the COVID-19 pandemic the impacts of which on the people of the state were projected to overwhelm the health care system. As part of this declaration, the Governor requested that the hospitals in Maryland expand capacity by 6,000 beds to prepare for the anticipated surge in the fall of 2020. As the sole community provider of acute hospital services in Washington county, the responsibility of expanding capacity in our region to prepare and respond to the pandemic impacts as best as possible was squarely on Meritus Medical Center's shoulders. In order to meet this responsibility and provide the best care possible for our community, Meritus rapidly conceptualized and constructed a 12,650 square foot twenty-bed Regional Infection Containment Unit (RIC-Unit). The RIC-Unit is specifically designed to provide acute healthcare services while minimizing the spread of infections disease. The RIC-Unit is a negative pressure unit with twenty private patient rooms sized as medical/surgical/gynecological rooms, each of which are ventilator capable. On March 21, 2020, Meritus was issued an Emergency Certificate of Need for the RIC-Unit project and construction began immediately following approval in order to complete construction within four months. A copy of the Emergency Certificate of Need issued for the RIC-Unit project is included as **Exhibit 16**. The construction of the RIC-Unit to create additional hospital capacity was one component in Meritus' multi-pronged response to COVID-19 which also included: (1) the establishment of a drive through testing site for the community where many of the 340K COVID tests done by the health system were performed; (2) largest provider in the state of monoclonal

antibody infusion therapy when indicated for COVID-19 patients; and (3) caring for at times over 100 patients a day who were admitted to Meritus Medical Center for acute care services due to COVID-19 infection.

1. Construction, renovation, and demolition plans

The RIC-Unit was constructed on the existing campus of Meritus Medical Center as an expansion to the facility, located adjacent to the hospital's emergency department. The schedule for the construction occurred on a 120-day timeline beginning March 21, 2020 in order to bring the facility online as quickly as possible for the community. The compressed timeframe necessitated that the planning, design, permitting, and construction of the facility had to happen concurrently. Eight days after the Meritus received E-CON approval, work began on the foundation for the building and the steel frame was erected after six weeks. Within two months, the facility was weather tight and after only four months of design and construction the RIC-Unit received its temporary certificate of occupancy.

In order to accomplish the construction of the unit within 120 days, the project team from Gilbane Building Company and Matthei & Colin Associates brought the Washington County Permit and Inspection Department into their daily meetings to provide as much transparency as possible and increase communication. Working collaboratively with the county government, areas for improvement were proactively identified through out the construction process to minimize delays in the permitting and life safety process.

The facility construction was completed July 31, 2020.

2. Changes in square footage of departments and units

The RIC-Unit, designated 2 South, was constructed as an independent unit of the Meritus hospital and is 12,500 square feet in size. Project drawings of the unit and its location on the Meritus campus have been submitted as **Exhibit 2**.

3. Physical plant or location changes

The project increases the physical plant of the Meritus Medical Center facility by 12,500 square feet. No location changes occurred.

4. Changes to affected services following completion of the project

The RIC-Unit project, once completed, provided needed additional capacity in response to the unprecedented scope of the COVID-19 pandemic and the danger to the public it poses.

5. Project phases

The project was construction in one phase over a four-month period from March 21, 2020 – July 31, 2020.

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

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

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

See **Exhibit 1,** Table A.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 1.95 acres

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

N/A

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

(1) Owned by: Meritus Medical Center, Inc.
Please provide a copy of the deed. A copy of the deed dated November 15, 2011, which is recorded at Plat folio 10022 among the Lands Records of Washington County, Maryland is attached as **Exhibit 3.**

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

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

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

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

11. PROJECT SCHEDULE

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

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date	Complete	months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	Complete	months
Completion of project from capital obligation or purchase order, as applicable	Complete	months
Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract		months
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.		months
Initiation of Construction within 4 months of the effective date of the binding construction contract.		months
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract		months
Fill out the following section for each phase. (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase		months
Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date		months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1		months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.		months
To Be Completed for each subsequent Phase of Construction		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase		months
Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase		months
Completion of each phase within 24 months of the effective date of binding construction contract for that phase		months

12. PROJECT DRAWINGS

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

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

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

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

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

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

Applicant Response

See **Exhibit 2**.

13. FEATURES OF PROJECT CONSTRUCTION

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

See **Exhibit 1**, Tables C and D.

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

The project is an expansion to the previously existing Meritus Medical Center building, and as such is integrated into the available utilities of the hospital. Adequate utilities such as water, electricity, sewage, natural gas, and others are provided to the RIC-Unit through the existing water lines, gas lines, sewage lines, and power plant of Meritus Medical Center. Other than connecting the lines of the RIC-Unit to existing sources, no additional capacity was needed to provide the unit with adequate utilities.

PART II - PROJECT BUDGET

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

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

Applicant Response

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

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

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

   Owner: Meritus Medical Center, Inc.
   Responsible Individual: Maulik S. Joshi, President & CEO, Meritus Health, Inc.
   Address: 11116 Medical Campus Road, Hagerstown, MD 21742

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

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

   Executive Vice President of Integrated Care Delivery & Chief Operating Officer
   Luminus Health (Previously Anne Arundel Health System)
   2001 Medical Pkwy, Annapolis, MD 21401
   2016 to 2019

   Senior Director of Quality
   University of Pennsylvania Health System
   3400 Spruce St, Philadelphia, PA 19104
   1997 to 1999

   Member, Board of Trustees Quality and Patient Safety Committee
   Mercy Health System
   345 St Paul Pl, Baltimore, MD 21202
   2004 to 2015

   Member, Board of Trustees
   Hospice of the Chesapeake
   Address
   2017 to 2019

   Member, Board of Trustees
   Luminus Health (Previously Anne Arundel Health System)
   2001 Medical Pkwy, Annapolis, MD 21401
   2010 to 2016

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

No

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

No

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

No

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

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

June 1, 2023
Date

Maulik Joshi
Signature of Owner or Board-designated Official

President & CEO
Position/Title

Maulik S. Joshi, Dr.P.H.
Printed Name

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

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

10.24.01.08G(3)(a). <u>The State Health Plan</u>.

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

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

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

Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here:
http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp

10.24. 07	**State Health Plan: an overview** ○ **Psychiatric services** ○ **EMS**
10.24. 09	**Specialized Health Care Services - Acute Inpatient Rehab Services**
10.24. 11	**General Surgical Services**
10.24. 12	**Inpatient Obstetrical Services**
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10.24. 17	**Cardiac Surgery and Percutaneous Coronary Artery Intervention Services**
10.24. 18	**Neonatal Intensive Care Services**
Capital Projects Exceeding the CON Threshold for Capital Expenditures	**Hospital Capital Projects Exceeding the CON Threshold for Capital Expenditures** Hospital projects that require CON review because the capital expenditure exceeds the CON threshold for capital expenditures but do not involve changes in bed capacity, the addition of new services, and otherwise have no elements that are categorically regulated should address all applicable standards in **COMAR 10.24.10: Acute Care Hospital Services** in their CON application. Applicants should consult with staff in a pre-application conference about any other SHP chapters containing standards that should be addressed, based on the nature of the project.

COMAR 10.24.10. Acute Care Chapter

.04A. GENERAL STANDARDS

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

Standard .04A (1) – Information Regarding Charges.

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

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

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

Applicant Response

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

The current list of representative services and charges for inpatient and outpatient services is readily available to the public, both in written form at Meritus Medical Center and on the hospital's website under the section "CMS Price Transparency". The address to the website is provided below:

https://www.meritushealth.com/patients-visitors/cms-price-transparency/

This list is also attached as **Exhibit 4**. The most recent representative list of services and charges available is from the third quarter of fiscal year 2023, and will be updated quarterly, as required, as soon as more recent charges are available.

Standard .04A (2) – Charity Care Policy.

Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.

(a) The policy shall provide:

(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical

assistance, or both, the hospital must make a determination of probable eligibility.

(ii) Minimum Required Notice of Charity Care Policy.

1. **Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and, in a format, understandable by the target population on an annual basis;**
2. **Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and**
3. **Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.**

Applicant Response

Meritus Medical Center provides inpatient and other care to all patients regardless of their ability to pay. A copy of the hospitals Financial Assistance Policy is attached as **Exhibit 5**. Notices regarding the availability of charity care at the hospital are posted at each patient registration area. A copy of that notice is attached as **Exhibit 6**. Each patient or representative is advised of Meritus Health's charity care policy at the time of admission or outpatient registration. The hospital's Financial Assistance Policy specifically states that it will make a determination of probable eligibility within thirty (30) days following a patient's request for charity services, application for medical assistance, or both. Financial counselors assist individuals to prepare and file all documents required to seek charity care at the hospital.

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

Applicant Response

The most recent published Community Benefit Report from the HSCRC is from fiscal year 2021. As shown in **Table 1** below, Meritus Medical Center fell within the third quartile in fiscal year 2021, with charity care comprising 1.5% of the hospital's total operating expenses.

Table 1
HSCRC Community Benefit Report, Data Excerpts
FY 2021

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	CB Reported Charity Care % of Total Hospital Operating Expense	Quartile
Holy Cross Hospital	$482,480,260	$28,661,872	5.9%	1st Quartile
Garrett Regional Hospital	$61,545,442	$2,721,400	4.4%	
UPMC Western Maryland Hospital	$331,929,405	$14,029,126	4.2%	
Mercy Medical Center, Inc.	$527,348,607	$22,257,214	4.2%	
Ascension Saint Agnes Hospital	$462,155,000	$17,929,501	3.9%	
Holy Cross Germantown Hospital	$123,537,343	$4,751,018	3.8%	
TidalHealth Peninsula Regional Medical Center	$423,885,800	$13,233,221	3.1%	
Johns Hopkins Bayview Med. Center	$714,247,000	$22,241,000	3.1%	
Doctors Community Hospital	$240,162,000	$6,776,100	2.8%	
Univ. of Maryland Capital Region Medical Center	$348,047,000	$9,544,000	2.7%	
CalvertHealth Medical Center	$143,031,020	$3,510,458	2.5%	
Sheppard & Enoch Pratt Hospital	$210,491,083	$4,629,793	2.2%	
Levindale Hebrew Geriatric Center & Hospital	$83,280,000	$1,768,778	2.1%	
MedStar Southern Maryland Hospital	$266,837,862	$5,579,397	2.1%	2nd Quartile
MedStar St. Marys Hospital	$176,289,631	$3,589,292	2.0%	
MedStar Good Samaritan Hospital	$292,805,277	$5,827,941	2.0%	
Univ. of Maryland St. Joseph Medical Center	$353,751,000	$6,890,000	1.9%	
TidalHealth McCready Pavilion	$9,152,200	$167,600	1.8%	
Howard County General Hospital	$280,849,000	$5,128,938	1.8%	
MedStar Montgomery General Hospital	$184,307,676	$3,346,776	1.8%	
Suburban Hospital	$335,865,000	$5,868,000	1.7%	
MedStar Harbor Hospital Center	$207,141,258	$3,598,223	1.7%	
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$111,255,000	$1,884,000	1.7%	
MedStar Franklin Square Hospital	$613,396,845	$9,875,732	1.6%	
Univ. of Maryland Medical Center Midtown Campus	$245,964,000	$3,929,000	1.6%	
Univ. of Maryland Baltimore Washington Medical Center	$434,108,000	$6,901,000	1.6%	
MedStar Union Memorial Hospital	$469,421,642	$7,263,945	1.5%	3rd Quartile
Univ. of Maryland Shore Medical Center at Easton	$219,817,000	$3,380,000	1.5%	
Adventist Shady Grove Medical Center	$408,846,144	$6,258,689	1.5%	
Meritus Medical Center	$417,623,284	$6,062,105	1.5%	
Univ. of Maryland Shore Medical Center at Dorchester	$34,558,000	$501,000	1.4%	
Univ. of Maryland Harford Memorial Hospital	$98,857,946	$1,430,047	1.4%	
Frederick Memorial Hospital	$383,617,000	$5,525,800	1.4%	
The Johns Hopkins Hospital	$2,809,105,000	$37,794,000	1.3%	
Univ. of Maryland Shore Medical Center at Chestertown	$46,947,000	$629,000	1.3%	
Univ. of Maryland Upper Chesapeake Medical Center	$294,765,774	$3,671,000	1.2%	
Univ. of Maryland Medical Center	$1,867,360,000	$20,877,000	1.1%	
Univ. of Maryland Charles Regional Medical Center	$138,614,740	$1,355,034	1.0%	
ChristianaCare, Union Hospital	$181,465,929	$1,763,814	1.0%	4th Quartile
Adventist White Oak Hospital	$297,894,224	$2,682,922	0.9%	
Greater Baltimore Medical Center	$557,120,000	$4,777,000	0.9%	
Atlantic General Hospital	$146,641,248	$1,217,677	0.8%	
Grace Medical Hospital	$66,425,000	$545,277	0.8%	
Anne Arundel General Hospital	$600,619,000	$3,806,489	0.6%	
Northwest Hospital	$276,365,800	$1,379,300	0.5%	
Adventist Rehabilitation	$52,271,127	$242,956	0.5%	
J. Kent McNew Family Medical Center	$8,462,000	$37,632	0.4%	
Carroll Hospital Center	$219,612,494	$856,982	0.4%	
Sinai Hospital of Baltimore	$852,535,000	$3,261,955	0.4%	
Mt. Washington Peds	$62,131,847	$33,673	0.1%	
Adventist Fort Washington Medical Center	$51,160,794	$0	0.0%	
All Hospitals	**$18,226,100,702**	**$329,992,677**	**1.8%**	

Notes:

[1]The Adventist Hospital System has requested and received permission to report their Community Benefit activities on a CY Basis. This allows them to more accurately reflect their true activities during the Community Benefit Cycle. The numbers listed in the 'FY 2020 Amount in Rates for Charity Care, DME, and NSPI' Column as well as the Medicaid Deficit Assessments from the Inventory spreadsheets reflect the Commission's activities for FY 2020 and therefore will be different from the numbers reported by the Adventist Hospitals.

[2]Source: Health Services Cost Review Commission Maryland Hospital Community Benefit Report FY 2021

While statewide data for fiscal year 2022 community benefit reported charity, care has not yet been published, Meritus Medical Center reported $10,003,851 of charity care for the fiscal year. This represents 2.1% of the hospital's total operating expenses. Additionally, Meritus Medical Center was identified in Becker's Hospital Review as a hospital whose community benefit, including charity

care, exceeds the tax benefit the organization receives from the IRS. In FY2022, Meritus is identified as hospital in the top 1% of all hospitals nationally for the level of community benefit the organization provides.

Standard .04A (3) – Quality of Care.

An acute care hospital shall provide high quality care.
(a) Each hospital shall document that it is:
- **(i) Licensed, in good standing by the Maryland Department of Health and Mental Hygiene**
- **(ii) Accredited by the Joint Commission; and**
- **(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.**

Applicant Response

Meritus Medical Center is licensed by the State of Maryland. Its license is attached as **Exhibit 8**. Additionally, Meritus Medical Center is in good standing with the State Department of Assessments and Taxation and its certification is attached as **Exhibit 17**.

Meritus Medical Center is accredited by the Joint Commission. Its accreditation certificated are attached as **Exhibit 9**.

Meritus Medical Center is in compliance with the Conditions of Participation of the Medicare and Medicaid programs.

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

Applicant Response

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

Meritus Medical Center scored (add # of scores we did better, average, or worse than average on). **Exhibit 10** identifies those quality measure for which Meritus Medical Center scored "below

average".

COMAR 10.24.10. Acute Care Chapter

.04B. PROJECT REVIEW STANDARDS

Standard .04B(1) – Geographic Accessibility

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

Applicant Response

This standard is not applicable. The project is an expansion to the current Meritus Medical Center facility on its existing campus, located at 1116 Medical Campus Road, Hagerstown, Maryland 21742.

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

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

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

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

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

- **(i) The proposed additional beds will not cause the total bed #765422 41 capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19- 307.2; or**
- **(ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter.**
- **(iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or**
- **(iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.**

Applicant Response

Not applicable. Outside periods where our service area experiences a sustained level of infectious disease spread and corresponding hospital patients, the RIC-Unit shall operate as a dedicated observation unit.

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

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

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

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

Applicant Response

Not applicable.

Standard .04B(4) – Adverse Impact

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

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

Applicant Response

Meritus is not requesting an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the project. However, Meritus reserves the right to do so in the future.

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

Applicant Response

This standard is not applicable. The project was completed to add capacity to the existing hospital facility.

Standard .04B(5) – Cost-Effectiveness

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

(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:

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

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

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

Applicant Response

Not applicable. See applicant response to Standard 0.4B(5)(b).

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

Applicant Response

The project involved two limited objectives:

1. Expand hospital capacity with construction of new unit designed to respond to the immediate and specific challenges of the COVID-19 pandemic as well as our community's future and changing health challenges
2. Complete project in 120 days of E-CON so patient care operations can begin in time to respond to anticipated COVID-19 surge in the fall of 2020.

In March, 2020 when it became clear that the Maryland health system needed to expand capacity to respond to COVID-19, no existing unused physical bed space at Meritus Medical Center was available to treat admitted patients. Meaning, in order to expand the capacity of Meritus to the levels demanded by Washington county, and the region, Meritus could either construct a temporary structure on the existing campus or construct a permanent expansion to the existing facility. Although temporary capacity could be stood up more rapidly, it was already evident at the time that the impacts of the pandemic would not be short term and Meritus would need ICU capacity specifically designed for the treatment of infectious disease over several months, and years. The decision was made to move forward with a permanent facility instead of temporary facilities after thorough evaluation of

each option including: the cost of construction, timeline for completion, impact on quality of patient care, safety for patients & care providers, project flexibility to respond to different care needs, among many other factors. Working closely with Gilbane Building Company and Matthei & Colin Associates to evaluate the feasibility of the 120-day project timeline for a project that would take six to nine months under normal conditions, it was determined that it could be accomplished and the decision was made to move forward with the RIC-Unit permanent facility.

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

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

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

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

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

Applicant Response

Not applicable. The project did not establish or relocate an existing hospital no a new site.

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

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

Applicant Response

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

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

The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic

locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

Applicant Response

Not applicable, Meritus is not seeking a rate increase related to the capital costs of the project. If Meritus does propose a rate increase at any point in the future for the capital costs of this project, the amount of the projected construction cost that exceeds the Marshall Valuation Service benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost shall not be included in the proposal.

The construction of the RIC-Unit by Meritus Medical Center was a response to the public health emergency caused by COVID-19 and required rapid design and construction. The compressed timeframe contributed to the unit having costs per square ft that exceed the Marshall Valuation Service benchmark. Additionally, the design of the unit to limit viral infection spread as mentioned in this document is a contributing factor to the cost per square ft above the benchmark.

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

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

Applicant Response

Not applicable.

Standard .04B(9) – Inpatient Nursing Unit Space

Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount

of the projected construction cost for the space that exceeds the per bed square footage limitation in this standard, or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

Applicant Response

The first part of this standard states that "for inpatient nursing units that exceed reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment". While the RIC unit exceeds the 500 square feet per bed average and the applicant is not seeking a rate adjustment for capital costs at this time, certain types of units that are required by code or circumstantial necessity to have additional spaces that result in a higher square feet per bed average. An inflexible 500 SF/bed ratio may not be a reasonable space standard for a nursing unit created in response to a declared public health emergency.

The inpatient nursing space of the RIC-Unit is specially designed for the treatment of patients during the outbreak and spread of highly infectious viral diseases in the community, particularly respiratory viruses. As such, each patient room is negative pressure and each patient bed is ventilator capable. In order to regulate the flow of the care team in and out of patient rooms and allow hospital staff to don and doff the required personal protective equipment to care for patients without contaminating themselves or others, the unit requires additional space to maneuver.

Standard .04B(10) –Rate Reduction Agreement

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

Applicant Response

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

However, Meritus Medical Center is not a high charge hospital and under the methodologies used by the HSCRC to evaluate the reasonableness of hospital rates, Meritus Medical Center is shown as an efficient provider of care. The results are provided in Table 2.

Table 2
HSCRC Integrated Efficiency Policy Results
RY2020 ICC

HOSP id	Hospital Name	Volume Adjused ICC Result	ICC Rank (50%)	2018 Medicare TCOC Relative to Benchmark	2018 Medicare TCOC Rank (25%)	2018 Commercial TCOC Relative to Benchmark	2017 Commercial TCOC Rank (25%)	Total Rank Points (Low Score is Better)
210048	Howard County General Hospital	-3.91%	6	-2.22%	5	-32.32%	3	10
210022	Suburban Hospital	-7.97%	11	-10.14%	1	-36.06%	1	12
990099	Holy Cross Hospitals	-2.36%	5	2.89%	11	-28.02%	8	15
210060	Fort Washington Medical Center	2.75%	2	-3.80%	4	-21.35%	23	16
210023	Anne Arundel Medical Center	-8.47%	14	-1.33%	7	-31.15%	5	20
210010	University of Maryland Shore Medical Center at Dorchester	-1.85%	4	11.60%	18	-23.21%	17	22
210016	Washington Adventist Hospital	-9.15%	15	2.03%	8	-26.22%	11	26
210043	University of Maryland Baltimore Washington Medical Center	-6.17%	10	10.19%	16	-24.27%	15	26
210057	Shady Grove Adventist Hospital	-12.85%	24	-2.05%	6	-31.64%	4	29
210017	Garrett County Memorial Hospital	6.49%	1	7.79%	15	3.01%	43	30
210028	MedStar St. Mary's Hospital	-4.94%	8	5.28%	12	-13.24%	37	33
210051	Doctors Community Hospital	-14.39%	30	-4.86%	3	-31.06%	6	35
210011	St. Agnes Hospital	-9.27%	16	14.13%	22	-23.55%	16	35
210001	Meritus Medical Center	-4.39%	7	14.45%	25	-16.75%	32	36
210009	Johns Hopkins Hospital	-8.03%	12	14.42%	24	-20.79%	25	37
210035	University of Maryland Charles Regional Medical Center	-9.79%	19	6.02%	14	-21.83%	22	37
210002	University of Maryland Medical Center	-9.60%	18	16.60%	29	-25.70%	12	39
210019	Peninsula Regional Medical Center	-5.49%	9	21.47%	38	-21.99%	21	39
210061	Atlantic General Hospital	-0.87%	3	29.41%	43	-17.29%	31	40
210034	MedStar Harbor Hospital Center	-8.41%	13	27.59%	42	-25.13%	13	41
210062	MedStar Southern Maryland Hospital Center	-10.31%	38	-6.70%	2	-28.54%	7	43
210005	Frederick Memorial Hospital	-14.45%	31	10.22%	17	-25.04%	14	47
210018	MedStar Montgomery Medical Center	-11.86%	41	2.69%	9	-32.46%	2	47
210044	Greater Baltimore Medical Center	-11.25%	22	14.37%	23	-20.28%	26	47
210008	Mercy Medical Center	-10.11%	20	17.56%	32	-19.96%	27	50
210039	Calvert Memorial Hospital	-11.45%	40	2.86%	10	-26.77%	9	50
210049	Upper Chesapeake Medical Center	-12.05%	23	19.30%	35	-22.89%	19	50
210015	MedStar Franklin Square Hospital Center	-9.50%	17	19.24%	34	-16.15%	34	51
210003	Prince Georges Hospital Center	-13.42%	36	5.39%	13	-22.23%	20	53
210063	University of Maryland St. Joseph Medical Center	-12.92%	25	16.58%	28	-18.03%	29	54
210058	University of Maryland Rehabilitation & Orthopaedic Institute	-14.06%	39	16.60%	29	-26.77%	9	58
210029	Johns Hopkins Bayview Medical Center	-14.15%	29	17.46%	31	-17.82%	30	60
210056	MedStar Good Samaritan Hospital	-10.43%	21	20.32%	36	-9.88%	41	60
210006	Harford Memorial Hospital	-13.47%	27	21.74%	39	-18.97%	28	[illegible]
210024	MedStar Union Memorial Hospital	-14.81%	32	13.87%	21	-13.68%	36	[illegible]
210037	University of Maryland Shore Medical Center at Easton	-16.03%	33	11.60%	18	-12.07%	38	[illegible]
210033	Carroll Hospital Center	-14.60%	37	15.88%	27	-21.25%	24	[illegible]
210040	Northwest Hospital Center	-13.65%	28	23.86%	40	-16.30%	33	[illegible]
210030	University of Maryland Shore Medical Center at Chestertown	-17.51%	35	13.29%	20	-12.02%	40	[illegible]
210027	Western Maryland Regional Medical Center	-13.01%	26	24.36%	41	-12.05%	39	[illegible]
210038	University of Maryland Medical Center Midtown Campus	-21.42%	42	19.01%	33	-23.21%	17	[illegible]
210032	Union Hospital of Cecil County	-17.34%	34	15.43%	26	-3.56%	42	[illegible]
210012	Sinai Hospital	-23.04%	43	20.99%	37	-14.56%	35	[illegible]

In the results of the most recent modelling for Rate Year 2022 published by the HSCRC, the price efficiency of Meritus Medical Center improved even further with an ICC result of 0.57%.

Standard .04B(11) – Efficiency

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

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

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

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

Applicant Response

Constructed as state of the art in 2010, Meritus Medical Center is already an efficient hospital based on national benchmarks. Under the current models of hospital reimbursement in Maryland, Meritus Medical Center has the incentive to reduce length of stay, ancillary testing, unnecessary admissions and readmissions, as well as improve efficiency in the provision of services while treating patients in a manner consistent with appropriate, high quality medical care. It is important to point out that Meritus Medical Center is a Global Budget Revenue ("GBR") hospital. Under its GBR agreement with the HSCRC, the HSCRC provides assurance of a certain amount of revenue each fiscal year, independent of the number of patients treated and the amount inpatient or outpatient services provided to these patients. To maintain GBR compliance and only charge for GBR revenue approved by the HSCRC, Meritus Medical Center is allowed to increase prices when patient volumes are below expectations and is allowed to lower prices when patient volumes are higher than expectations. Under the incentives of GBR, a hospital is punished for volume growth that is considered avoidable or unnecessary. Volume growth does not generate margin for Meritus Medical Center and the organization focuses on controlling expenses to improve efficiency. Meritus Medical Center has every incentive to become more efficient and continuously works to do so.

Infection Containment Unit. The 20-bed unit provides the hospital with the ability to rapidly expand capacity in response to a highly transmissible viral disease outbreak in the community. Allows Meritus to utilize a single space for infection containment. Utilization of a single unit allows for improved staff work flows and better management of personal protective equipment, ultimately reducing costs and improving patient care.

Observation Unit. A 20-bed dedicated observation unit located adjacent to the emergency department services to help optimize the emergency department by allowing the transfer of patient out of the critical emergency department workflow for observation, while also helping to prevent and reduce unnecessary admissions to inpatient bed units. The observation unit is a key element to improving the overall efficient use of the space, decanting patient volume from emergency services and nursing units. The location of the observation unit next to the emergency department will reduce internal patient transport time.

Standard .04B(12) – Patient Safety

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

Applicant Response

A core design element of the facility to house the 20-bed unit is patient and staff safety. In addition to design features meant to reduce the occurrence of common patient safety concerns such as falls and medication management, the unit is designed to protect patients and staff from highly transmittable infectious disease. As such, the unit is designed with the following:

- Air handling system that can switch between negative pressure and normal air handling

- All patient rooms are Airborne Infection Isolation Rooms and meet the necessary architectural design requirements
- Staff, patients, and visitors enter and exit the unit through separate doorways maintaining a one-way flow.
- Pneumatic tube system used to replenish patient care supplies and deliver samples to the clinal lab at Meritus for evaluation.

Standard .04B(13) – Financial Feasibility

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

(a) Financial projections filed as part of a hospital Certificate of Need application must be accompanied by a statement containing each assumption used to develop the projections.

(b) Each applicant must document that:

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

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and

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

Applicant Response

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

Included in **Exhibit 1** are Tables F, G, and H, which provide utilization and financial projections as well as a comprehensive statement of assumptions related to utilization, revenue, expenses, and financial performance for Meritus Medical Center.

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

1. Projected Meritus Medical Center Utilization

Table F includes utilization projections that reflect both the inpatient and outpatient utilization of Meritus Medical Center. Included with this application are clinical observation bed need assumptions.

2. Projected Meritus Medical Center Revenue

The presentations of projected revenue in Tables G and H reflect the utilization projections presented in Table F and the budgeted fiscal year 2024 regulated Global Budget Revenue ("GBR") assumptions related to update factors, demographic adjustments, and uncompensated care. A more detailed description of these assumptions, along with assumptions regarding unregulated revenue inflation, are included with the tables.

The projections do not include any rate increase from the HSCRC relating to the capital costs of this project.

3. Projected Meritus Medical Center Staffing and Operating Expenses

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

2. Projected Meritus Medical Center Financial Performance

As presented in Table H, Meritus is projected to maintain a positive operating margin for all historical and projected fiscal years. Given all assumptions listed above and listed in the tables, Meritus is projected to experience a 6.6% operating margin in the final projected year, fiscal year 2030.

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

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

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

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

(ii) **The number of uninsured, underinsured, indigent, and otherwise underserved patients in the applicant's primary service area and the impact of these patient groups on emergency department use;**
(iii) **Any demographic or health service utilization data and/or analyses that support the need for the proposed project;**
(iv) **The impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department to more appropriate primary care or urgent care settings; and**
(v) **Any other relevant information on the unmet need for emergency department or urgent care services in the service area.**

Applicant Response

Not applicable. The project does not create a new or expanded emergency department.

Standard .04B(15) – Emergency Department Expansion

A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it has made appropriate efforts, consistent with federal and state law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum:
(a) The applicant hospital must demonstrate that, in cooperation with its medical staff, it has attempted to reduce use of its emergency department for non-emergency medical care. This demonstration shall, at a minimum, address the feasibility of reducing or redirecting patients with non-emergent illnesses, injuries, and conditions, to lower cost alternative facilities or programs;
(b) The applicant hospital must demonstrate that it has effectively managed its existing emergency department treatment capacity to maximize use; and
(c) The applicant hospital must demonstrate that it has considered the need for bed and other facility and system capacity that will be affected by greater volumes of emergency department patients.

Applicant Response

Not applicable. The project does not create a new or expanded emergency department.

Standard .04B(16) – Shell Space

(a) Unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective.
(b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that:
(i) **Considers the most likely use identified by the hospital for the unfinished space;**
(ii) **Considers the time frame projected for finishing the space; and**
(iii) **Demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.**

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

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

Applicant Response

Not applicable. The Applicant does not propose the addition of any shell space in the new nursing unit.

10.24.01.08G(3)(b). NEED – Construction of Regional Infectious Containment Unit

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

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

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

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

Please assure that all sources of information used in the need analysis are identified. Fully explain all assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), the relevant population considered in the analysis, and the service capacity of buildings and equipment included in the project, with information that supports the validity of these assumptions.

Explain how the applicant considered the unmet needs of the population to be served in arriving at a determination that the proposed project is needed. Detail the applicant's consideration of the provision of services in non-hospital settings and/or through population-based health activities in determining the need for the project.

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

Applicant Response

Need for Additional Capacity in Response to COVID-19

The RIC-Unit at Meritus Medical Center was constructed as a direct response to the COVID-19 pandemic in order to expand hospital capacity rapidly in anticipation of the surge of patients that was expected to occur in our community, both during the first wave as the virus began to spread and subsequent waves. As it became evident that hospitals needed to prepare for the effects of COVID-19, the management of Meritus created and continuously updated projections to analyze hospital capacity and how many COVID-19 patients would require hospitalization using the best available data and information at the time. The Meritus team relied on the analysis predicting infection rates and hospitalizations for the state of Maryland completed by Johns Hopkins University completed in early March of 2020. The Johns Hopkins Model predicted the first case of COVID-19 in Washington county on April 1, 2020 with cases peaking in July of 2020. These predictions are shown in **Table 3** and **Table 4**.

Table 3
Johns Hopkins University Prediction of COVID-19 Infections in Washington County
March 2020

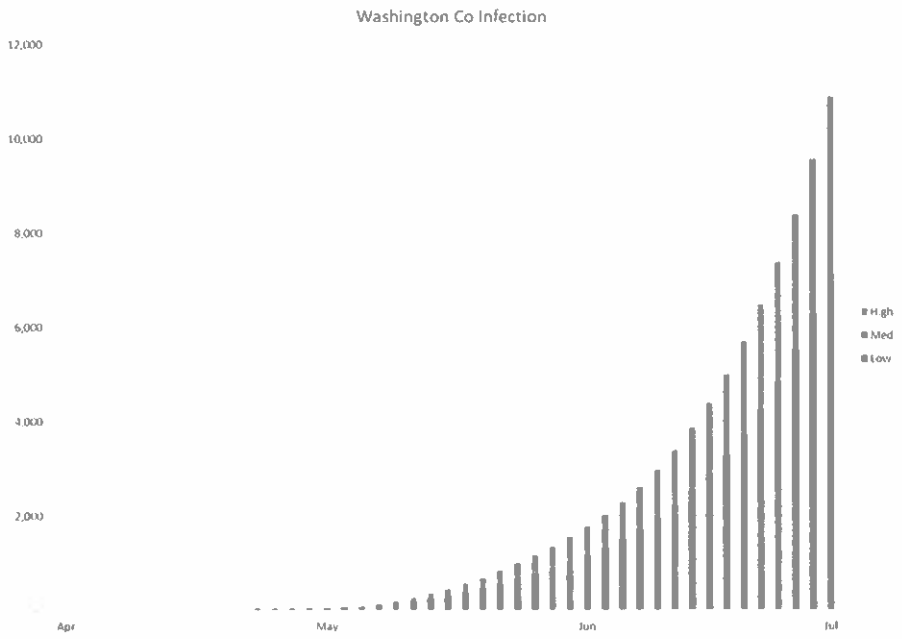


Table 4
Johns Hopkins University Prediction of COVID-19 Hospitalizations in Washington County March 2020

Table 5 shows predictive modeling completed by Meritus in March of 2020 around the time hospital leadership was planning how best to expand hospital capacity and approval to move forward with the construction of the RIC-Unit. Compared to the assumptions used by Johns Hopkins University in their predictive modelling around infection rates and viral spread acceleration (doubling of cases every 6 days), Meritus used a rate of acceleration that was faster based on real time data and the experience in areas of the nation being impacted in late March. This revision changed our anticipated peak from July to the week of May 27th in 2020. In all models (low, medium, and high) the expected impacts of COVID-19 would overwhelm existing hospital ICU capacity. Anticipated volumes would overwhelm existing hospital capacity in total in the medium and high models. In the worst-case scenario, a ventilator shortage could be expected with projected utilization of 125% of existing ventilators.

Table 5
Meritus Health Capacity & Projected COVID-19 Volumes
March 2020

	Medical / Surgical			Intensive Care			Total Hospital			Ventilators		
Hospital Capacity	**Low**	**Med**	**High**	**Low**	**Med**	**High**	**Low**	**Med**	**High**	**Low**	**Med**	**High**
Total Beds	221	221	221	24	24	24	245	245	245	44	44	44
Current Utilization	97	97	97	16	16	16	113	113	113	4	4	4
Available Capacity	124	124	124	8	8	8	132	132	132	40	40	40
Proj. COVID Cases												
30 Days	13	16	15	5	10	11	18	26	26	2	6	7
60 Days	53	89	89	20	56	69	73	145	158	10	31	45
Peak	55	94	97	22	60	77	77	154	174	10	33	51
Proj. Occupancy												
30 Days	50%	51%	51%	88%	108%	113%	53%	57%	57%	14%	23%	25%
60 Days	68%	84%	84%	150%	300%	354%	76%	105%	111%	32%	80%	111%
Peak	69%	86%	88%	158%	317%	388%	78%	109%	117%	32%	84%	125%

Notes:

[1]Based on Washington County Population of 151,000

[2]Assumptions for COVID19 transmission rate and effectiveness of social distancing from Penn Medicine

[3]Hospitalization, ICU, and Ventilator rates sourced from 3D Health, based on age of population

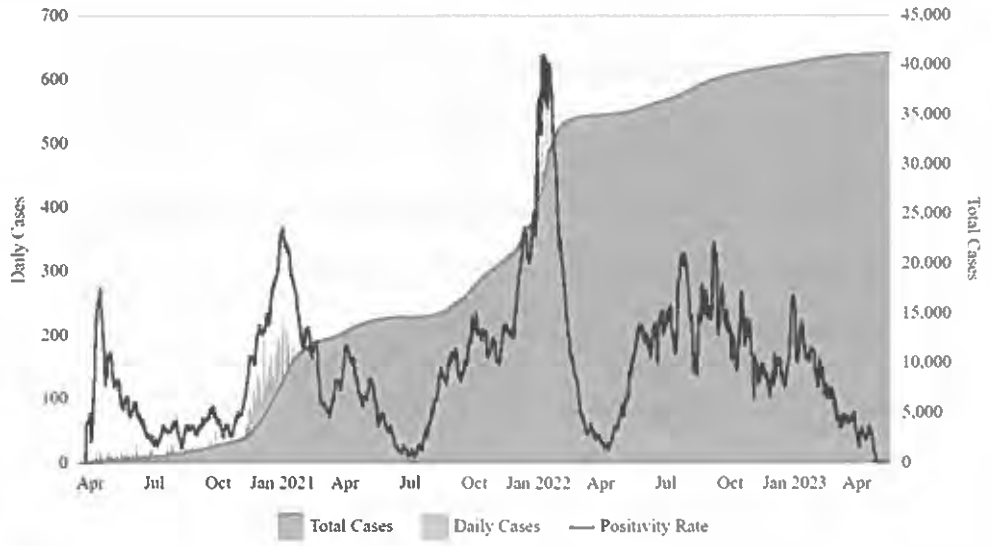
[4]Length of stay assumptions from Johns Hopkins Medicine

[5]Assumes peak of May 27, 2020 for all 3 models

[6]Med/Surg Available Beds includes Meritus' 20 IP Rehab beds and 5 beds granted through E-CON

The projections made it clear that Meritus needed to rapidly expand the hospital's capacity of ventilator capable beds in preparation for the anticipated volume surge. Our projections proved true as Meritus experienced several surges of COVID-19 patients requiring hospital care from 2020 through the end of 2021. The county, which has a population of an estimated 150,000, has had 41, 276 confirmed cases of COVID-19 since April of 2020 with the most severe surges occurring in spring of 2020, winter of 2021, and winter of 2022. Table 6 shows total cases of COVID-19 and the testing positivity rate in Washington County which in the winter of 2022 approached 32% due to uncontrolled viral spread.

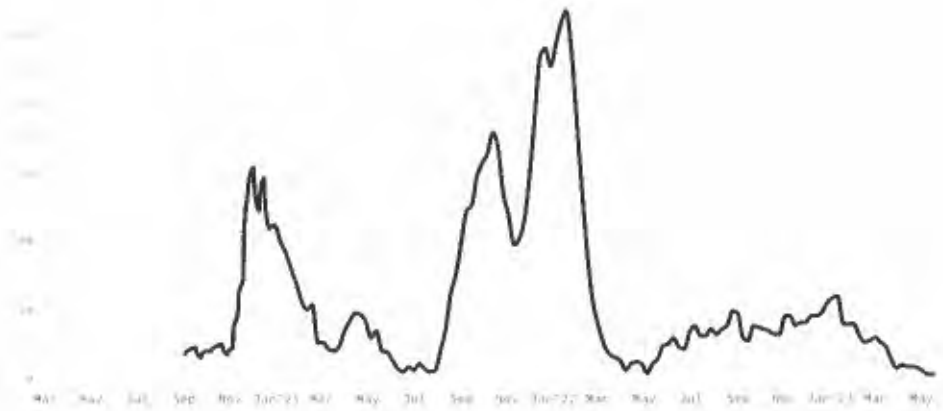
Table 6
Washington County COVID-19 Cases
April 2020 – April 2023



Source: https://www.washco-md.net/coronavirus-info/ using data provided by MDH PHPA

During these surges, Meritus Medical Center experienced periods where the hospital had a census of over 100 COVID-19 patients, amongst the most out of any hospital in Maryland. In the winter of 2022 during the most intense surge of COVID-19 patients, Meritus hit an ADC of 107 COVID-19 patients in the hospital (Table 7). Due to the high patient volumes, the ICUs of Meritus operated well above 85% capacity through COVID-19 surges reaching a maximum of 96.8% capacity being utilized (Table 8). COVID-19 patients accounted for nearly 38% of all hospital capacity utilized during the winter of 2022 COVID-19 surge (Table 9).

Table 7
Washington County Actual COVID-19 Hospitalizations
September 2020 – May 2023

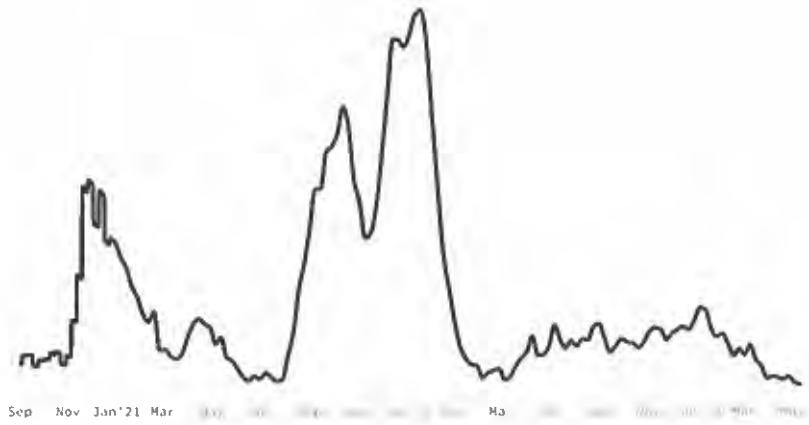


Source: https://covidactnow.org/us/maryland-md/county/washington_county/?s=46623411

Table 8
Washington County ICU Capacity Utilization
August 2020 – May 2023

Source: https://covidactnow.org/us/maryland-md/county/washington_county/?s=46623411

Table 9
Washington County % of Hospital Beds Utilized for COVID-19 Patients
September 2020 – May 2023



Source: https://covidactnow.org/us/maryland-md/county/washington_county/?s=46623411

Table 10 shows the calculation that HSCRC staff used to identify hospital COVID-19 patient volumes in their FY2022 Surge Funding Policy. Meritus ranks 4th in state with patients identified as COVID-19 accounting for $25.1 million of the hospital's $431.2 million Global Budget Revenue, approximately 5.8%. This compares to 2.3% statewide average of the share of hospital GBR accounted for to care for COVID-19 patients.

Table 10
HSCRC COVID-19 Surge Funding Calculation
Fiscal Year 2022

Hospital	GBR Revenue Associated with COVID-19 Patient Volumes	Rank	% of Total GBR	Rank	% of Total GBR Variance to Statewide Avg
Johns Hopkins	$30,970,802	1	1.1%	40	(1.2%)
Meritus	25,076,175	2	5.8%	5	3.5%
MedStar Franklin Square	25,066,918	3	4.1%	11	1.8%
Frederick	20,134,258	4	5.0%	7	2.7%
UMMC	19,940,324	5	1.0%	41	(1.3%)
Peninsula Regional	19,753,934	6	3.8%	13	1.5%
Western Maryland	19,071,636	7	5.3%	6	3.0%
Anne Arundel	16,925,799	8	2.3%	25	0.0%
Carroll	16,845,470	9	6.5%	2	4.2%
UM-Upper Chesapeake	13,426,050	10	3.7%	15	1.4%
Sinai	13,234,309	11	1.4%	38	(0.9%)
UM-BWMC	12,868,082	12	2.5%	24	0.2%
Holy Cross	12,752,009	13	2.2%	27	(0.1%)
JH Bayview	12,184,384	14	1.6%	34	(0.7%)
Northwest	11,138,673	15	3.7%	15	1.4%
ChristianaCare Union of Cecil	10,800,164	16	6.0%	3	3.7%
St. Agnes	10,446,652	17	2.1%	28	(0.2%)
GBMC	9,531,989	18	1.9%	31	(0.4%)
MedStar Good Samaritan	9,415,875	19	3.3%	19	1.0%
MedStar Southern Maryland	9,247,410	20	3.1%	21	0.8%
Doctors	9,230,918	21	3.1%	21	0.8%
MedStar Harbor	8,835,697	22	4.4%	10	2.1%
UM-Charles Regional	8,693,699	23	4.9%	8	2.6%
MedStar Union Memorial	8,490,618	24	1.9%	31	(0.4%)
MedStar St. Mary's	7,561,976	25	3.7%	15	1.4%
Howard County	7,370,496	26	2.1%	28	(0.2%)
UM-Harford	7,246,960	27	5.9%	4	3.6%
Adventist White Oak	6,750,410	28	2.0%	30	(0.3%)
UM-St. Joseph's	6,727,539	29	1.5%	37	(0.8%)
UM-Easton	6,401,210	30	2.3%	25	0.0%
Suburban	6,204,618	31	1.6%	34	(0.7%)
Shady Grove	6,154,553	32	1.2%	39	(1.1%)
UM-PGHC	6,085,257	33	1.6%	34	(0.7%)
Calvert	5,530,436	34	3.2%	20	0.9%
Holy Cross Germantown	5,343,665	35	3.8%	13	1.5%
MedStar Montgomery	5,258,395	36	2.7%	23	0.4%
UMMC Midtown	4,762,248	37	1.9%	31	(0.4%)
Atlantic General	4,294,133	38	3.4%	18	1.1%
Mercy	4,015,225	39	0.6%	42	(1.7%)
Garrett	3,285,511	40	4.5%	9	2.2%
Ft. Washington	2,590,631	41	3.9%	12	1.6%
UM-Chestertown	151,477	42	30.0%	1	27.7%
Levindale	87,510	43	0.1%	43	(2.2%)
Statewide	***$449,904,095***		***2.3%***		***0.0%***

Notes:
[1]Source: HSCRC Memo on FY22 COVID-19 Surge Funding Policy
[2]Removed eight hospitals that did not have any identified COVID-19 volume in FY2022

In total, since the onset of the pandemic through March of 2023, 3,642 COVID-19 patients have been admitted at Meritus with a COVID-19 diagnosis, representing 7.6% of all hospital admissions during the period. Of these 3,642 COVID-19 patients, 1,565 (43%) were cared for in the RIC-Unit during their hospital stay and in total the RIC-Unit has provided care to 2,451 patients since the units opening through March of 2023. Statistics showing RIC-Unit patient volumes and the unit's occupancy since its opening are presented in **Table 11**.

Table 11
Meritus RIC-Unit Occupancy
August 2020 – March 2023

	2020				2021				2022				2023			
Month	IP Discharges - Total	IP Discharges - COVID19	IP Discharges - RICU	IP Discharges - COVID19 RICU	IP Discharges - Total	IP Discharges - COVID19	IP Discharges - RICU	IP Discharges - COVID19 RICU	IP Discharges - Total	IP Discharges - COVID19	IP Discharges - RICU	IP Discharges - COVID19 RICU	IP Discharges - Total	IP Discharges - COVID19	IP Discharges - RICU	IP Discharges - COVID19 RICU
January	1,506	-	-	-	1,447	325	108	88	1,400	363	85	75	1,341	74	55	31
February	1,353	-	-	-	1,186	117	113	67	1,225	129	83	61	1,225	37	18	2
March	1,262	-	-	-	1,391	82	111	75	1,303	23	74	20	1,318	32	46	6
April	982	35	-	-	1,289	106	110	83	1,259	7	38	2	516	4	25	2
May	1,153	34	-	-	1,364	71	77	59	1,346	28	35	1	-	-	-	-
June	1,243	28	-	-	1,354	24	36	16	1,300	46	69	35	-	-	-	-
July	1,332	14	-	-	1,368	12	-	-	1,406	65	90	45	-	-	-	-
August	1,360	26	7	3	1,339	86	59	42	1,342	73	70	53	-	-	-	-
September	1,281	29	111	24	1,399	189	116	93	1,307	46	67	31	-	-	-	-
October	1,403	57	96	49	1,447	229	100	85	1,377	67	81	53	-	-	-	-
November	1,321	219	104	94	1,284	165	110	82	1,312	73	97	51	-	-	-	-
December	1,440	364	110	94	1,436	291	104	93	1,379	76	71	52	-	-	-	-
	15,636	806	428	264	16,304	1,697	1,044	783	15,956	996	860	479	4,400	147	144	41

Patient Days

	2020				2021				2022				2023			
Month	IP Days - Total	IP Days - COVID Total	IP Days - RICU Total	IP Days - RICU COVID	IP Days - Total	IP Days - COVID Total	IP Days - RICU Total	IP Days - RICU COVID	IP Days - Total	IP Days - COVID Total	IP Days - RICU Total	IP Days - RICU COVID	IP Days - Total	IP Days - COVID Total	IP Days - RICU Total	IP Days - RICU COVID
January	6,244	-	-	-	6,806	2,348	544	512	6,797	2,483	482	472	5,732	482	183	117
February	5,749	-	-	-	5,159	881	356	306	6,104	1,547	404	375	5,032	198	34	5
March	5,235	-	-	-	5,724	510	376	338	5,934	281	331	155	5,255	203	156	16
April	4,246	227	-	-	5,591	755	444	414	5,522	132	110	15	2,087	13	73	9
May	4,340	270	-	-	5,828	583	357	337	5,457	113	93	-	-	-	-	-
June	4,877	222	-	-	5,394	187	109	80	5,468	228	213	129	-	-	-	-
July	5,263	76	-	-	5,566	76	-	-	5,895	295	387	205	-	-	-	-
August	5,687	251	12	8	5,725	482	215	197	5,484	369	228	174	-	-	-	-
September	5,281	189	209	108	6,204	1,235	494	467	5,343	197	282	111	-	-	-	-
October	5,323	361	292	234	6,489	1,597	479	462	5,469	343	312	213	-	-	-	-
November	5,480	937	376	347	6,012	1,231	473	439	5,373	398	391	231	-	-	-	-
December	6,142	2,149	496	479	6,700	2,091	508	495	6,163	472	387	290	-	-	-	-
	63,867	4,682	1,385	1,176	71,198	11,976	4,355	4,047	69,009	6,858	3,620	2,370	18,106	896	446	147

Due to the direct impacts of COVID-19 (surges of COVID-19 patients requiring hospital care) and indirect impacts (patients delaying seeking care increasing the severity of their illness) on patient volumes at Meritus Medical Center, the hospital would have exceeded its capacity to admit patients in need of care at periods since the onset of the pandemic without the additional capacity of the RIC-Unit. Table 12, presents the occupancy rate of Meritus Medical Center since the onset of the pandemic in March 2020 through March 2023. Of the many reasons justifying the need for the construction of the 20-bed RIC-Unit at Meritus, the additional capacity it provided to keep the hospital from being overwhelmed by high patient census is foremost.

Table 12
Meritus Hospital Occupancy
August 2020 – March 2023

	2020				2021				2022				2023			
Month	IP Discharges - Total	IP Discharges - COVID19	IP Discharges - RICU	IP Discharges - COVID19 RICU	IP Discharges - Total	IP Discharges - COVID19	IP Discharges - RICU	IP Discharges - COVID19 RICU	IP Discharges - Total	IP Discharges - COVID19	IP Discharges - RICU	IP Discharges - COVID19 RICU	IP Discharges - Total	IP Discharges - COVID19	IP Discharges - RICU	IP Discharges - COVID19 RICU
January	1,506	-	-	-	1,447	325	108	88	1,400	363	85	75	1,341	74	55	31
February	1,353	-	-	-	1,186	117	113	67	1,225	129	83	61	1,225	37	18	2
March	1,262	-	-	-	1,391	82	111	75	1,303	23	74	20	1,318	32	46	6
April	982	35	-	-	1,289	106	110	83	1,259	7	38	2	516	4	25	2
May	1,153	34	-	-	1,364	71	77	59	1,346	28	35	1	-	-	-	-
June	1,243	28	-	-	1,354	24	36	16	1,300	46	69	35	-	-	-	-
July	1,332	14	-	-	1,368	12	-	-	1,406	65	90	45	-	-	-	-
August	1,360	26	7	3	1,339	86	59	42	1,342	73	70	53	-	-	-	-
September	1,281	29	111	24	1,399	189	116	93	1,307	46	67	31	-	-	-	-
October	1,403	57	96	49	1,447	229	100	85	1,377	67	81	53	-	-	-	-
November	1,321	219	104	94	1,284	165	110	82	1,312	73	97	51	-	-	-	-
December	1,440	364	110	94	1,436	291	104	93	1,379	76	71	52	-	-	-	-
	15,636	806	428	264	16,304	1,697	1,044	783	15,956	996	860	479	4,400	147	144	41

Patient Days

	2020				2021				2022				2023			
Month	IP Days - Total	IP Days - COVID Total	IP Days - RICU Total	IP Days - RICU COVID	IP Days - Total	IP Days - COVID Total	IP Days - RICU Total	IP Days - RICU COVID	IP Days - Total	IP Days - COVID Total	IP Days - RICU Total	IP Days - RICU COVID	IP Days - Total	IP Days - COVID Total	IP Days - RICU Total	IP Days - RICU COVID
January	6,244	-	-	-	6,806	2,348	544	512	6,797	2,483	482	472	5,732	482	183	117
February	5,749	-	-	-	5,159	881	356	306	6,104	1,547	404	375	5,032	198	34	5
March	5,235	-	-	-	5,724	510	376	338	5,934	281	331	155	5,255	203	156	16
April	4,246	227	-	-	5,591	755	444	414	5,522	132	110	15	2,087	13	73	9
May	4,340	270	-	-	5,828	583	357	337	5,457	113	93	-	-	-	-	-
June	4,877	222	-	-	5,394	187	109	80	5,468	228	213	129	-	-	-	-
July	5,263	76	-	-	5,566	76	-	-	5,895	295	387	205	-	-	-	-
August	5,687	251	12	8	5,725	482	215	197	5,484	369	228	174	-	-	-	-
September	5,281	189	209	108	6,204	1,235	494	467	5,343	197	282	111	-	-	-	-
October	5,323	361	292	234	6,489	1,597	479	462	5,469	343	312	213	-	-	-	-
November	5,480	937	376	347	6,012	1,231	473	439	5,373	398	391	231	-	-	-	-
December	6,142	2,149	496	479	6,700	2,091	508	495	6,163	472	387	290	-	-	-	-
	63,867	4,682	1,385	1,176	71,198	11,976	4,355	4,047	69,009	6,858	3,620	2,370	18,106	896	446	147

Need for Dedicated Observation Beds

Observation care services in the outpatient setting has increased significantly at Meritus Medical Center since FY2019, a trend seen throughout the majority of other Maryland acute care hospitals. This increase is driven by a number of factors including payor reimbursement rules and care redesign initiatives that shift inpatient services to the outpatient care setting. As shown in Table X below, observation cases at Meritus Medical Center increased by 3.4% between fiscal year 2019 and 2023. Meritus Medical Center's average hour per case also increased by 138% during this time period due to COVID-related throughput issues. In fiscal year 2022, observation patient stayed for an average of 33.9 hours or approximately 1.41 days. Meritus does not have a dedicated observation unit and observation patients are co-mingled throughout medical/surgical nursing units which makes caring for these patients less efficient, slows throughput, and increases ALOS. The hospital additionally has difficulties discharging patients to post-acute facilities currently due to the impacts of the COVID-19 pandemic. Using historical patient volumes, assuming an occupancy rate of 85%, Meritus projects a need for 32 dedicated observation beds in FY2023 and in subsequent years (Table 13).

Table 13
Observation Bed Need at Meritus Medical Center
FY2019 – FY2030 Proj

	Historical				Projected							
	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY2028	FY2029	FY2030
Observation Cases	8,013	4,958	6,088	7,609	8,286	8,286	8,286	8,286	8,286	8,286	8,286	8,286
Average Hours per Case	16.7	21.6	27.7	33.9	39.9	39.9	39.9	39.9	39.9	39.9	39.9	39.9
Total Observation Hours	133,670	107,014	168,418	258,202	330,957	330,957	330,957	330,957	330,957	330,957	330,957	330,957
Average Length of Stay (Days)	0.7	0.9	1.2	1.4	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7
Observation Days	5,570	4,459	7,017	10,758	13,790	13,790	13,790	13,790	13,790	13,790	13,790	13,790
Average Daily Census	15	12	19	29	38	38	38	38	38	38	38	38
Occupancy Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Bed Need	**13**	**10**	**16**	**25**	**32**	**32**	**32**	**32**	**32**	**32**	**32**	**32**

Notes:
(1)Source: FY2019 - FY2023 March YTD HSCRC Experience Data

Utilizing the RIC-Unit as a 20-bed dedicated observation unit during normal operations, combined with the bed space Meritus has available through comingling Med/Surg and Observation beds currently, will give Meritus the capacity to care for the projected number of patients requiring clinical observation services now and in the future. The creation of a dedicated observation unit at Meritus with dedicated physician, nursing, and ancillary staff will allow for the focus of providers in the unit to remain on one type of patient population and one type of medicine. The uniformity of patients who will be cared for in the dedicated observation unit increases the level to which protocols and treatment plans for patients can be standardized creating improvements in patient outcomes, generating operational efficiencies, and in turn helping Meritus contain cost growth. Dedicated observation units, compared to observation care that is provided co-mingled throughout the hospital, have shown superior metrics regarding patient length of stay and cost growth containment. As Meritus continues to experience patient volumes above historical trends and

manages the financial challenges currently facing hospitals in Maryland, establishing a dedicated unit for outpatient observation and working to ensure most if not all appropriate patients fall under the purview of the unit's dedicated care team offers Meritus a pathway to improving ED throughput, delivering a higher quality of care, improving clinical outcomes, in an efficient and affordable manner.

Table 14
Meritus Medical Center Rate Center Volume Change
FY2019 – FY2023 YTD March

	Hospital Rate Center Volume				Hospital Volume @ HSCRC Approved Rates			Variance			
Center	FY19 Rate Center Volume	FY22 Rate Center Volume	FY23 Rate Center Volume	FY23 Approved Rates	FY19 Volume @ FY23 Rates	FY22 Volume @ FY23 Rates	FY23 Volume @ FY23 Rates	Variance: FY22 vs FY19 ($)	Variance: FY23 vs FY22 ($)	Variance: FY23 vs FY19 ($)	Variance: FY23 vs FY19 (%)
OBV	133,670	258,202	330,783	$91.29	$12,202,575	$23,570,954	$30,196,756	$11,368,378	$6,625,803	$17,994,181	147.5%
LAB	11,929,697	14,511,564	14,096,600	3.02	36,011,294	43,804,985	42,552,364	7,793,691	(1,252,621)	6,541,070	18.2%
DEF	4,032	6,287	5,180	2,027.13	8,173,406	12,744,594	10,500,556	4,571,188	(2,244,038)	2,327,150	28.5%
OR	775,739	766,772	814,851	55.94	43,391,186	42,889,614	45,578,909	(501,572)	2,689,294	2,187,722	5.0%
DEL	61,736	74,284	77,480	128.04	7,904,723	9,511,378	9,920,596	1,606,655	409,218	2,015,873	25.5%
RAT	1,284,490	1,411,245	1,417,489	9.58	12,304,184	13,518,376	13,578,190	1,214,192	59,815	1,274,006	10.4%
CAT	1,465,198	1,817,190	1,933,612	2.57	3,765,289	4,669,843	4,969,026	904,555	299,183	1,203,738	32.0%
MRI	170,589	185,562	207,980	13.92	2,374,808	2,583,247	2,895,337	208,438	312,090	520,529	21.9%
ANS	839,270	918,841	924,012	5.06	4,246,010	4,648,574	4,674,735	402,563	26,161	428,724	10.1%
CL	443,507	433,778	454,879	35.98	15,957,315	15,607,268	16,366,483	(350,047)	759,215	409,168	2.6%
OTH	293,081	309,691	325,033	11.39	3,339,004	3,528,238	3,703,030	189,234	174,792	364,026	10.9%
EKG	578,881	709,919	715,657	2.55	1,476,038	1,810,160	1,824,792	334,122	14,632	348,754	23.6%
OBS	4,025	3,742	3,965	1,707.64	6,873,265	6,390,002	6,771,376	(483,263)	381,374	(101,889)	(1.5%)
SDS	5,687	6,318	5,577	1,196.15	6,802,504	7,557,274	6,671,326	754,770	(885,948)	(131,178)	(1.9%)
NUC	155,855	159,028	144,905	17.92	2,793,619	2,850,493	2,597,352	56,874	(253,141)	(196,267)	(7.0%)
STH	87,218	69,328	71,151	12.26	1,069,541	850,159	872,510	(219,382)	22,351	(197,031)	(18.4%)
RDL	1,593	1,718	1,468	1,590.65	2,533,913	2,732,745	2,335,081	198,832	(397,664)	(198,832)	(7.8%)
RES	4,491,891	5,450,703	4,379,197	1.92	8,602,713	10,438,996	8,386,886	1,836,283	(2,052,110)	(215,827)	(2.5%)
PED	600	194	408	1,764.62	1,058,771	342,336	719,964	(716,435)	377,628	(338,807)	(32.0%)
PUL	51,424	28,709	25,573	13.56	697,171	389,217	346,705	(307,954)	(42,511)	(350,465)	(50.3%)
ADM	15,481	14,241	13,979	289.79	4,486,191	4,126,856	4,050,835	(359,336)	(76,021)	(435,357)	(9.7%)
IRC	108,221	112,575	98,500	86.79	9,392,623	9,770,512	8,548,927	377,889	(1,221,585)	(843,697)	(9.0%)
RAD	564,096	549,479	533,215	29.88	16,852,676	16,415,985	15,930,079	(436,691)	(485,906)	(922,597)	(5.5%)
NUR	5,726	4,987	5,015	1,539.90	8,817,487	7,679,499	7,722,103	(1,137,989)	42,604	(1,095,385)	(12.4%)
PSY	5,096	3,917	3,759	1,573.96	8,020,902	6,165,203	5,915,992	(1,855,699)	(249,210)	(2,104,910)	(26.2%)
ORC	244,573	114,559	95,572	20.42	4,995,225	2,339,784	1,951,988	(2,655,441)	(387,796)	(3,043,237)	(60.9%)
MIS	5,942	6,425	4,893	3,042.13	18,076,352	19,545,702	14,886,169	1,469,350	(4,659,533)	(3,190,183)	(17.6%)
MSG	42,949	44,176	40,620	1,500.62	64,450,007	66,291,264	60,955,069	1,841,257	(5,336,195)	(3,494,937)	(5.4%)
EMG	372,351	254,083	261,813	109.70	40,847,908	27,873,620	28,721,660	(12,974,288)	848,039	(12,126,248)	(29.7%)
Other					13,271,477	11,620,263	12,411,070	(1,651,215)	790,807	(860,408)	(6.5%)
Subtotal Excluding Supplies & Drugs					***$370,788,177***	***$382,267,138***	***$376,555,865***	***$11,478,961***	***($5,711,273)***	***$5,767,687***	***1.6%***
OIO-340	11,517,212	15,540,261	17,637,713	1.18	13,601,926	18,353,182	20,830,291	4,751,255	2,477,109	7,228,365	53.1%
MSS	19,607,848	19,869,501	20,856,412	1.83	35,847,437	36,325,796	38,130,085	478,359	1,804,289	2,282,648	6.4%
CDS	11,892,483	13,319,152	10,889,412	3.10	36,832,750	41,251,351	33,726,093	4,418,601	(7,525,258)	(3,106,657)	(8.4%)
Subtotal Supplies & Drugs					***$86,282,113***	***$95,930,329***	***$92,686,470***	***$9,648,216***	***($3,243,860)***	***$6,404,356***	***7.4%***
Meritus Medical Center Total					***$457,070,291***	***$478,197,467***	***$469,242,334***	***$21,127,177***	***($8,955,133)***	***$12,172,044***	***2.7%***

Notes:

[1]Source: HSCRC Experience Report Data, FY2019-FY2023 March YTD

[2]FY2023 Volumes Annualized for 12 months experience

[3]Conversion factors applied to EMG and CL rate centers

[4]HYP Rate Center uses FY2022 Approved Rate

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

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

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

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

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

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

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

Applicant Response

Due to the time constraints and the state mandated expansion of inpatient bed capacity to respond to COVID-19, no alternate approaches were considered in order to achieve the goals and objectives of the RIC-Unit. The reasoning behind the RIC-Unit construction is addresses in the need section of this document.

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

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

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

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

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

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

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies.

Applicant Response

Financial Viability

As shown in **Exhibit 1**, Table E, the total cost of the project is $13,511,770, including $968,587 of major medical equipment. The project was funded in its entirety using Meritus Medical Center cash reserves. The annual increase in operating expense from the project depreciation of roughly $450K, does not result in Meritus Medical Center having operating losses in any of the projected years and does not have a significant impact on the hospital's total operating expenses.

Community Support

The project enjoys strong community support, both at the time of construction and currently, as demonstrated by the numerous and varied letter of support included in **Exhibit 12**. The crisis that the COVID-19 pandemic represented on the healthcare delivery system of our community, and communities across Maryland, resulted in heighted levels of fear and worry amongst members of the community. This was only heighted by the severe impact that the implementation of public health measures such mandatory quarantine periods, government mandated business closures, etc. had on the economy. Members of our community were not only worried about getting sick from the spread of the virus & the healthcare system not being able to provide care due to insufficient capacity, but on top of that there was the potential of losing their job and the uncertainty that brings. All of these factors tremendously heightened the interest that the public had in this project. The community demanded to know what actions Meritus was taking as the sole provider of acute hospital care in the county in order to prepare for surges in virus transmission and when updates were published by Meritus they were consumed widely. The local press frequently wrote about the actions Meritus was taking in response to the pandemic, including publishing several articles about this project.

Implementation of Project in Compliance with Performance Requirements

The Applicant is confident that it will be able to meet or has already met the applicable performance requirements. The construction of a major addition to an existing health care facility, (defined as greater than $5,000,000 project cost) is subject to the following performance requirements: up to 24 months to obligate 51 percent of the approved capital expenditure, and up to 24 months after the effective date of a binding construction contract to complete the project (COMAR 10.24.01.12C(3)(b)).

As indicated in the project Schedule in Part 1, Response 11, the Applicant has already completed the obligation and construction of the project in its entirety. From project initiation to completion, the project was completed in about a four-month time frame with construction being completed July 31, 2020.

Implementation of Project in Compliance with Performance Requirements

Audited Financial Statements are included in **Exhibit 14.**

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

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

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

Applicant Response

Since 2000, Meritus Medical Center has obtained 1 CON of which a copy is attached in Exhibit 15.

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

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

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

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project[1];

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[1] **Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, the relevant populations**

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

c) On costs to the health care delivery system.

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

Applicant Response

a. Impact on Service Area Access to Health Care Services

The project increases access to health care services in the area both as the only RIC-Unit in the region, and as dedicated observation beds.

b. Market Shift Impact on Other Regional Providers

Meritus believes that the RIC-Unit, since opening patient care operations in August 2020, has not had any significant impact on the volume of service provided by other existing health care providers in the region. The inpatient capacity of the unit is only made available for patients when it is necessary for them to be treated in the specialized unit to limit risk of viral spread to other patients and staff and other negative pressure beds are not available in other medical/surgical/gynecological acute units. The RIC-Unit is deactivated as an inpatient care unit when there is not a surge of infectious disease in the community and instead functions as a 20-bed observation unit. The marginal impact of the project on other providers is demonstrated when looking at the volumes of Frederick Memorial Hospital since the RIC-Unit began operating, shown in Table 15 below.

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considered in the analysis, and changes in market share, with information that supports the validity of these assumptions.

Table 15
Frederick Memorial Hospital Rate Center Volume
FY2021 – FY2023 YTD

	Hospital Rate Center Volume				Hospital Volume @ HSCRC Approved Rates			Variance			
Center	FY21 Rate Center Volume	FY22 Rate Center Volume	FY23 Rate Center Volume	FY23 Approved Rates	FY21 Volume @ FY23 Rates	FY22 Volume @ FY23 Rates	FY23 Volume @ FY23 Rates	Variance: FY22 vs FY21 ($)	Variance: FY23 vs FY22 ($)	Variance: FY23 vs FY21 ($)	Variance: FY23 vs FY21 (%)
EMG	133,572	295,494	308,836	$108.14	$14,444,538	$31,954,958	$33,397,772	$17,510,420	$1,442,815	$18,953,234	131.2%
OBV	178,094	222,640	269,961	89.16	15,878,095	19,849,625	24,068,592	3,971,530	4,218,967	8,190,496	51.6%
MSG	49,200	53,371	52,527	1,372.03	67,503,935	73,226,677	72,068,225	5,722,742	(1,158,452)	4,564,290	6.8%
LAB	19,031,026	20,453,447	20,878,008	1.81	34,427,126	37,000,286	37,768,316	2,573,160	768,031	3,341,190	9.7%
RAD	614,402	645,434	674,029	18.67	11,473,159	12,052,641	12,586,622	579,482	533,981	1,113,463	9.7%
PED	100	179	487	2,527.84	252,784	452,483	1,230,214	199,699	777,731	977,430	386.7%
RES	3,501,853	3,664,289	3,811,076	2.85	9,971,176	10,433,696	10,851,658	462,520	417,961	880,482	8.8%
PSY	4,633	4,886	5,200	1,521.33	7,048,300	7,433,195	7,910,892	384,895	477,696	862,591	12.2%
MRI	263,356	295,621	321,909	9.88	2,600,930	2,919,583	3,179,209	318,652	259,626	578,279	22.2%
CAT	1,365,501	1,512,340	1,476,263	4.01	5,473,884	6,062,517	5,917,894	588,633	(144,623)	444,010	8.1%
DEL	102,855	108,296	105,957	130.81	13,454,308	14,166,037	13,860,120	711,729	(305,917)	405,812	3.0%
PUL	23,309	28,515	38,851	22.08	514,614	629,551	857,741	114,938	228,190	343,127	66.7%
ROL	1,779	1,948	2,047	1,222.57	2,174,944	2,381,558	2,502,184	206,614	120,626	327,240	15.0%
EEG	176,095	208,434	195,489	14.36	2,529,517	2,994,050	2,808,107	464,534	(185,944)	278,590	11.0%
OTH	337,487	341,329	352,143	13.86	4,679,055	4,732,322	4,882,247	53,267	149,925	203,192	4.3%
NUR	4,627	4,999	4,807	990.11	4,581,242	4,949,563	4,759,132	368,321	(190,431)	177,890	3.9%
ORC	19,050	32,205	30,320	14.66	279,366	472,283	444,640	192,917	(27,643)	165,273	59.2%
EKG	832,359	870,159	882,087	2.86	2,383,959	2,492,222	2,526,384	108,263	34,162	142,425	6.0%
STH	67,973	93,566	77,903	13.14	893,322	1,229,672	1,023,820	336,351	(205,852)	130,499	14.6%
ADM	13,948	13,847	13,648	451.09	6,291,862	6,246,301	6,156,534	(45,561)	(89,768)	(135,328)	(2.2%)
HYP	1,071	883	832	647.04	692,983	571,339	538,340	(121,644)	(32,999)	(154,643)	(22.3%)
PDC	1,976	1,739	1,549	695.35	1,374,002	1,209,205	1,077,321	(164,797)	(131,884)	(296,681)	(21.6%)
IRC	147,833	132,070	143,851	86.36	12,766,754	11,405,473	12,422,843	(1,361,282)	1,017,370	(343,912)	(2.7%)
SDS	4,535	3,945	4,015	1,600.11	7,256,511	6,312,445	6,423,919	(944,066)	111,475	(832,592)	(11.5%)
MIS	4,483	4,324	4,129	2,497.49	11,196,247	10,799,146	10,312,968	(397,101)	(486,178)	(883,279)	(7.9%)
NEO	4,601	3,904	3,157	1,927.39	8,867,926	7,524,534	6,085,416	(1,343,391)	(1,439,119)	(2,782,510)	(31.4%)
OR	792,495	676,995	698,800	50.44	39,972,338	34,146,680	35,246,494	(5,825,658)	1,099,814	(4,725,845)	(11.8%)
Other					15,420,859	15,325,968	15,232,580	(94,891)	(93,388)	(188,278)	(1.2%)
Subtotal Excluding Supplies & Drugs					***$304,403,735***	***$328,974,011***	***$336,140,183***	***$24,570,276***	***$7,166,171***	***$31,736,447***	***10.4%***
CDS	11,435,035	13,412,043	11,701,476	3.04	34,741,922	40,748,470	35,551,424	6,006,548	(5,197,046)	809,502	2.3%
MSS	29,912,605	25,734,849	27,775,892	1.75	52,350,050	45,038,559	48,610,589	(7,311,490)	3,572,029	(3,739,461)	(7.1%)
Subtotal Supplies & Drugs					***$87,091,972***	***$85,787,030***	***$84,162,013***	***($1,304,942)***	***($1,625,017)***	***($2,929,959)***	***(3.4%)***
Meritus Medical Center Total					***$391,495,707***	***$414,761,041***	***$420,302,196***	***$23,265,334***	***$5,541,155***	***$28,806,488***	***7.4%***

Notes:
[1]Source: HSCRC Experience Report Data, FY2019-FY2023 March YTD
[2]FY2023 Volumes Annualized for 12 months experience
[3]Conversion factors applied to EMG and CL rate centers

Since FY2021, Frederick has experienced a 7.4% increase in hospital volumes, calculated using rate center unit volumes at FY2023 approved hospital rates. Excluding supplies and drugs, this increase is 10.4%, representing approximately $32 million of volume growth.

c. Costs to the Health Care Delivery System

The project will increase costs to the health care delivery system by approximately $12.5M over the new facilities useful life. Annually, this represents approximately $400K of additional cost to the health care delivery system. Meritus is not requesting that the project be funded through an increase

to the hospital's HSCRC approved rates at this time and currently is not being passed on to either patients directly nor to health insurance entities. With an annual total operating expense of around $400 Million, the impact this $400K in additional depreciation on the hospital's operating margin is minimal and does not result in the hospital having operating losses.

When not functioning as an inpatient unit, the dedicated observation capacity that the facility provides will improve the throughput of the Meritus emergency department allowing for patients not requiring inpatient admission to be treated in this outpatient setting. Additionally, the infection disease control of the RIC-Unit will result in less viral transmission and illness of viral diseases in the community, reducing necessary hospital admissions compared to a baseline of providing patient care in other Med/Surg/Gyn hospital space. Both of these will result in total cost of care savings in Meritus' community which are projected to more than offset the $400K of incremental annual depreciation cost.

INDEX OF EXHIBITS

Exhibit	Description
1	MHCC Tables
2	Project Drawings
3	Deed to Property
4	Meritus Policy for Provision of Information to the Public Concerning Charges
5	Financial Assistance Policy
6	Posted Notices Regarding the Availability of Charity Care
7	Newspaper Ads on Charity Care
8	State of Maryland License
9	Joint Commission Accreditation Certification
10	Quality Measures in MHCC Most Recent Hospital Guide and Corrective Action
11	FY 2023 Licensed Acute Care Beds
12	Letters of Support
13	Meritus Readmission Rates CY 2016 through CYTD 2023
14	Audited Financial Statements
15	Past CONs
16	Emergency CON for RIC-Unit
17	State of Maryland Department of Assessments and Taxation Certification of Good-standing

SIGNATURE PAGES

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for the Establish a 20-bed Regional Infection Containment Unit at Meritus Medical Center and its attachments are true and correct to the best of my knowledge, information, and belief.

June 1, 2023
Date

Maulik Joshi
Maulik S. Joshi, Dr. P.H
President & CEO
Meritus Health, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for the Establish a 20-bed Regional Infection Containment Unit at Meritus Medical Center and its attachments are true and correct to the best of my knowledge, information, and belief.

6/1/23
Date

Joshua Repac, CPA, M.B.A
Chief Financial Officer
Meritus Health, Inc.

EXHIBIT 1

See Excel File Submitted with the Following MHCC Tables:

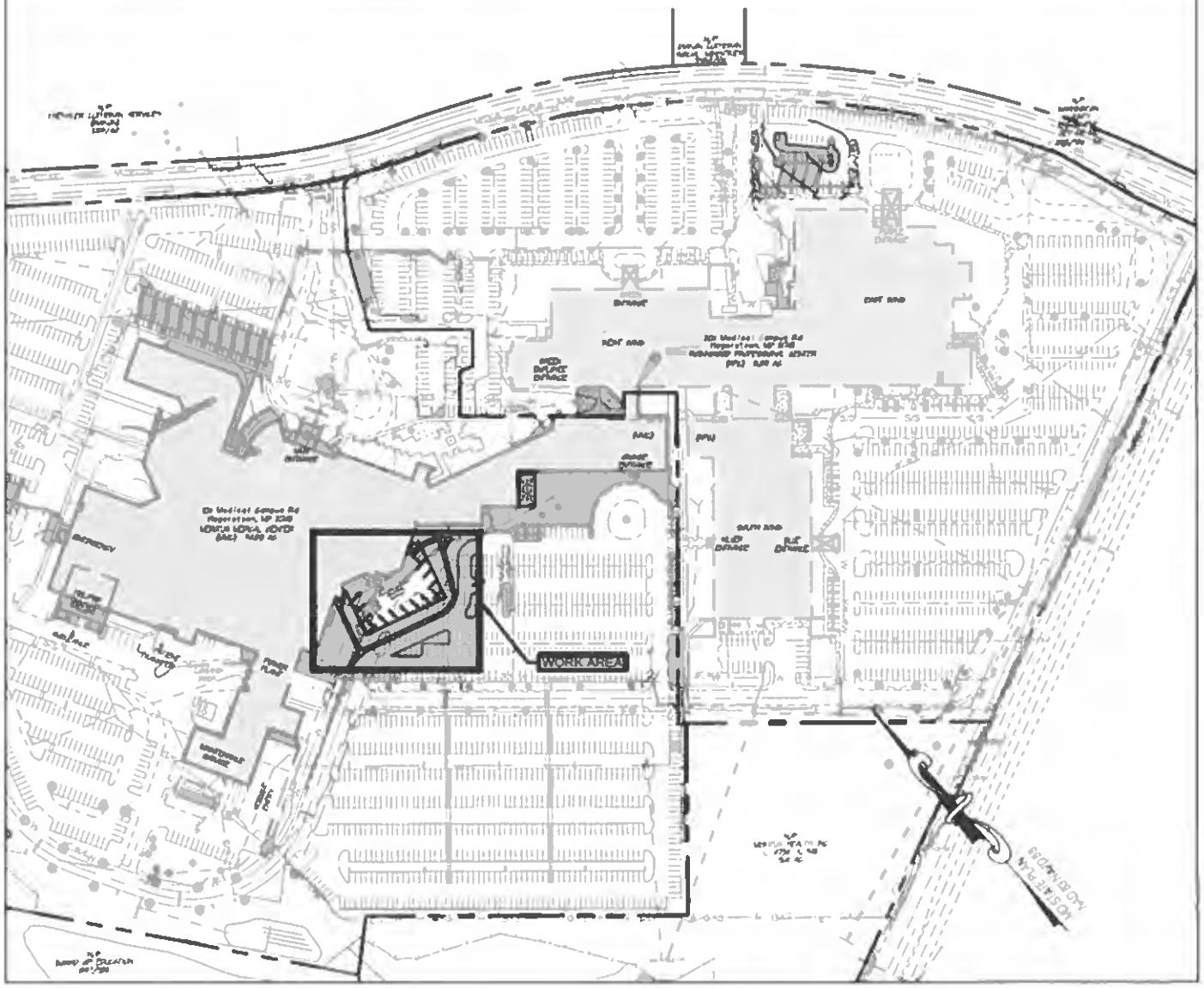
- A. Physical Bed Capacity
- B. Dept Gross Sq Ft
- C. Construction Characteristics
- D. Construction Costs
- E. Project Budget
- F. Entire Facility Stats
- G. Entire Facility Financials Uninflated
- H. Entire Facility Financials Inflated
- I. New Facility Stats
- J. New Facility Financials Uninflated
- K. New Facility Financials Inflated
- L. Work Force Information

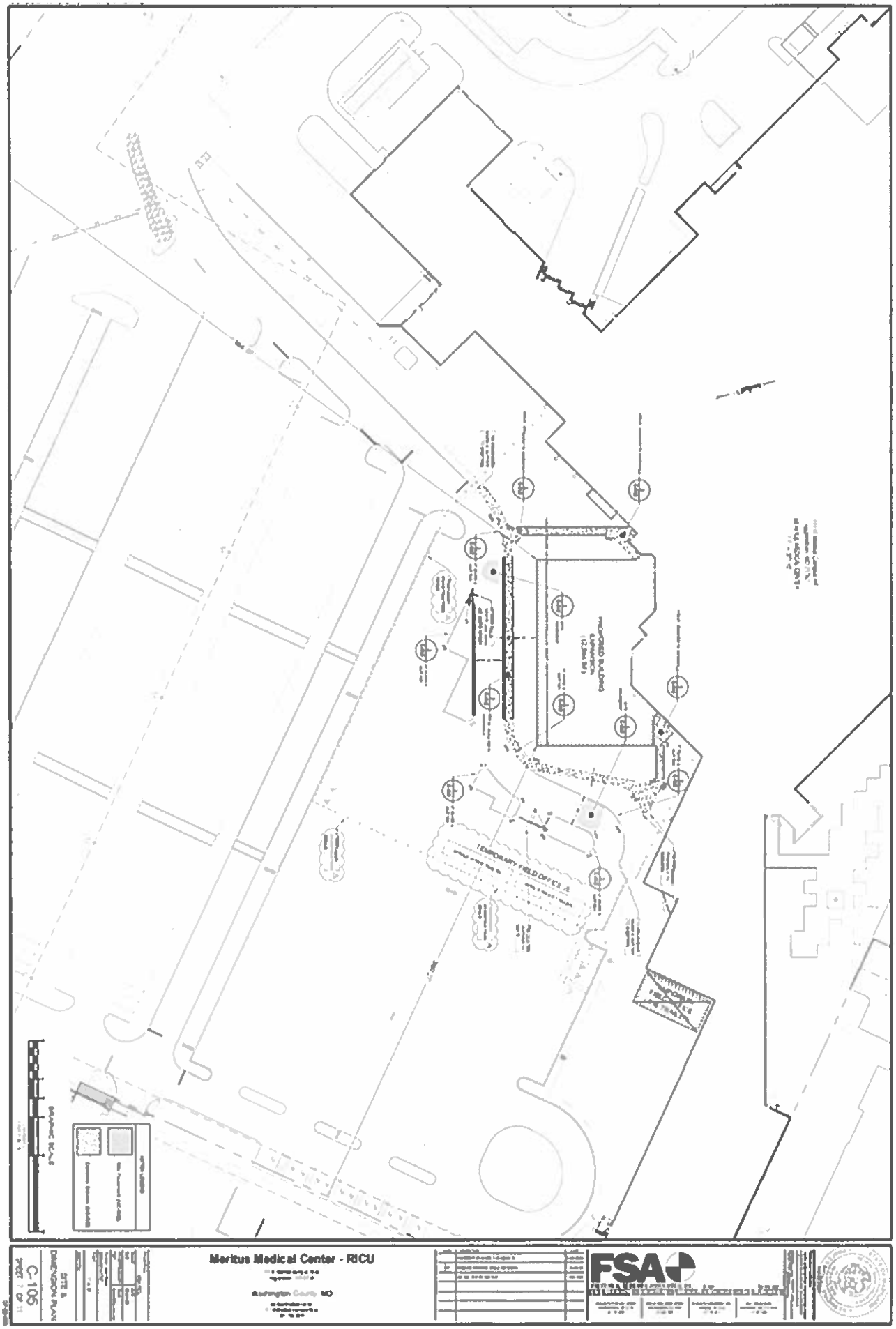
EXHIBIT 2

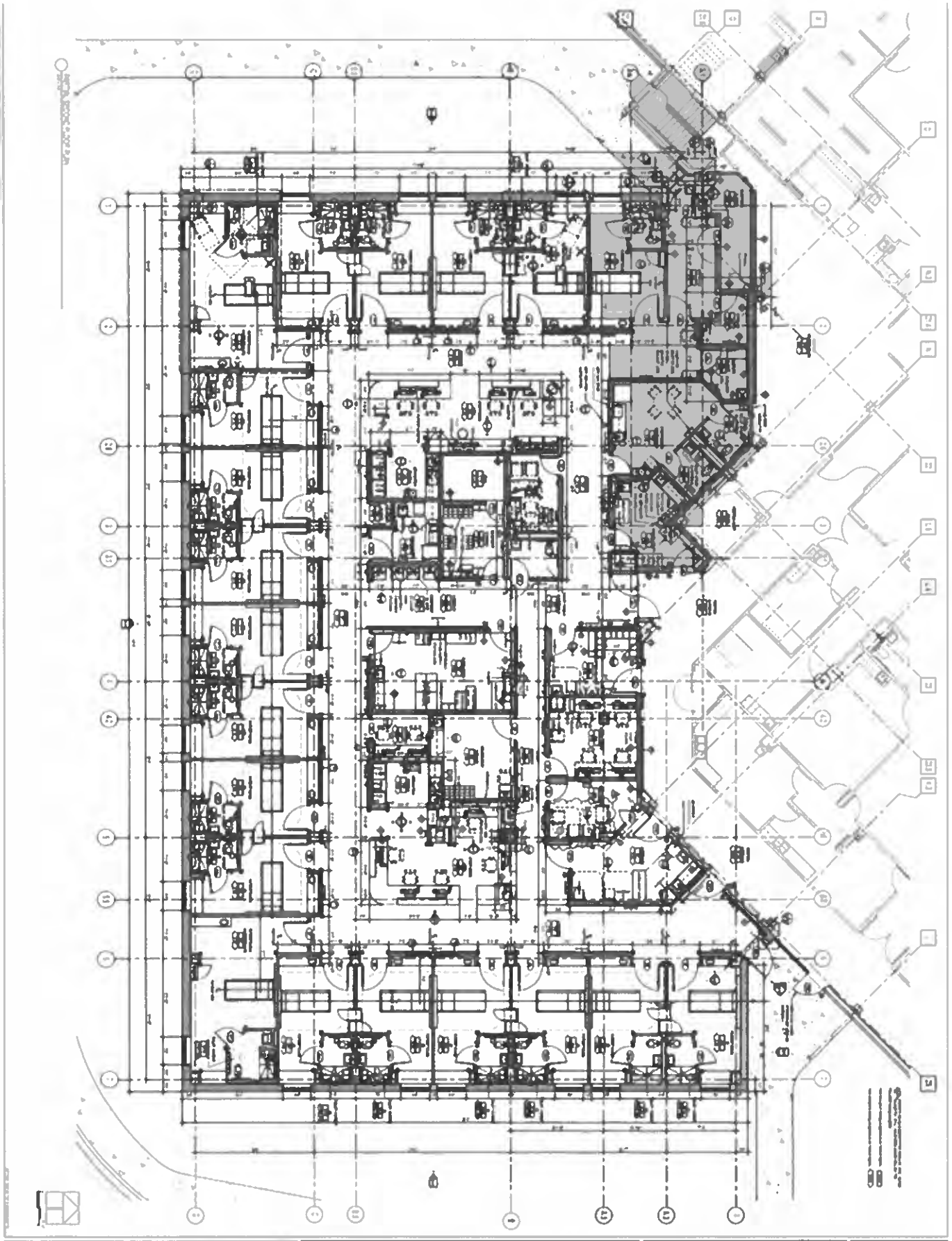
LOCATION PLAN

SCALE: 1" = 200'

TAX MAP 0050-0014-1747
ACCT # 059860



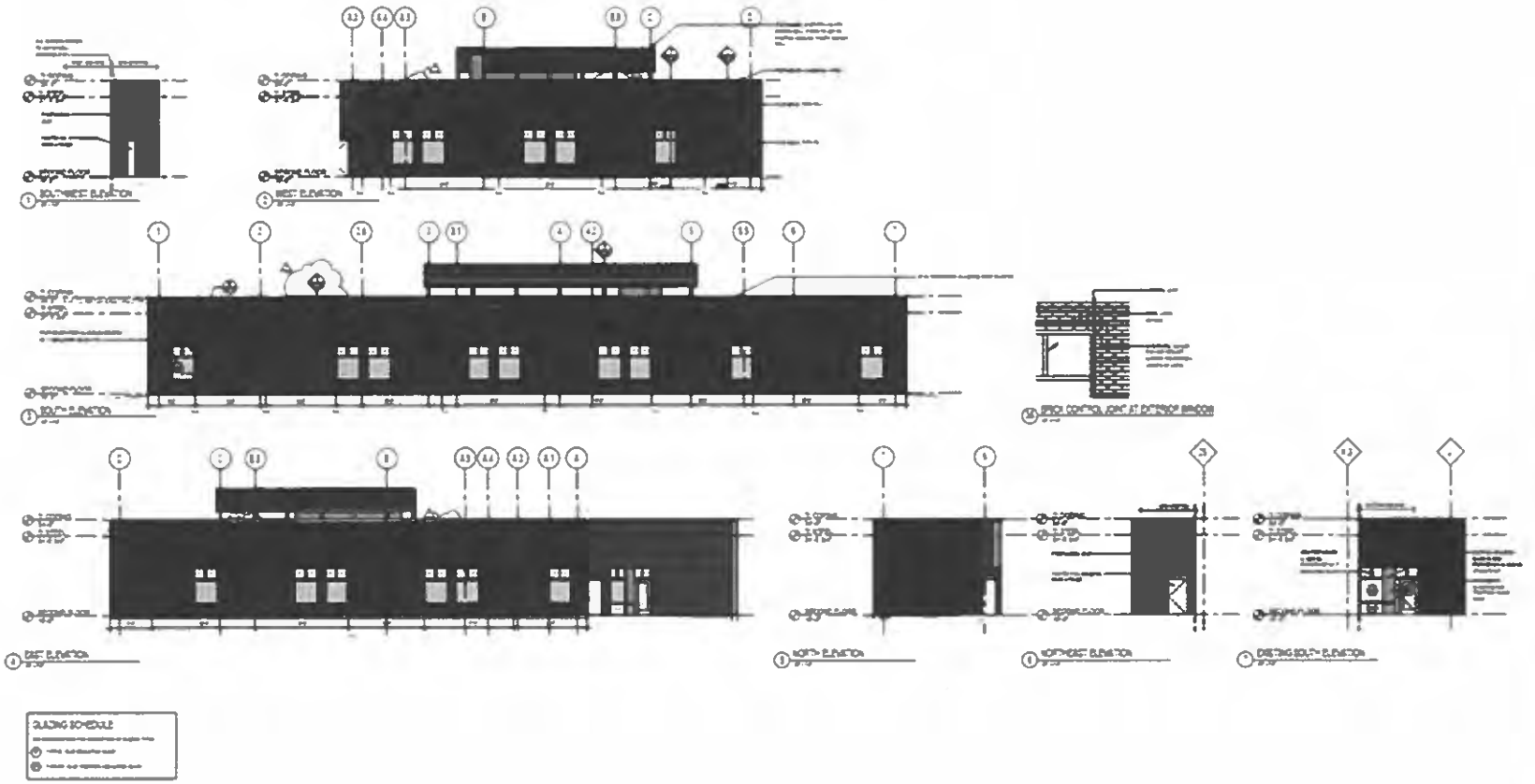

TEMPORARY FIELD OFFICE A
TEMPORARY FIELD OFFICE B
GRAPHIC SCALE
SITE LEGEND
C-105
SITE & DIMENSION PLAN
Meritus Medical Center - RICU
Washington County, MD
FSA



A1.20

Regional Infectious Containment Unit
at Meritus Medical Center

M&CA



M&CA

Regional Infectious Containment Unit
at Mmitus Medical Center

Mmitus

A2.10

Meritus Medical Center · RCU
GRADING & DRAINAGE PLAN
C-103
SHEET 9 OF 11
FSA

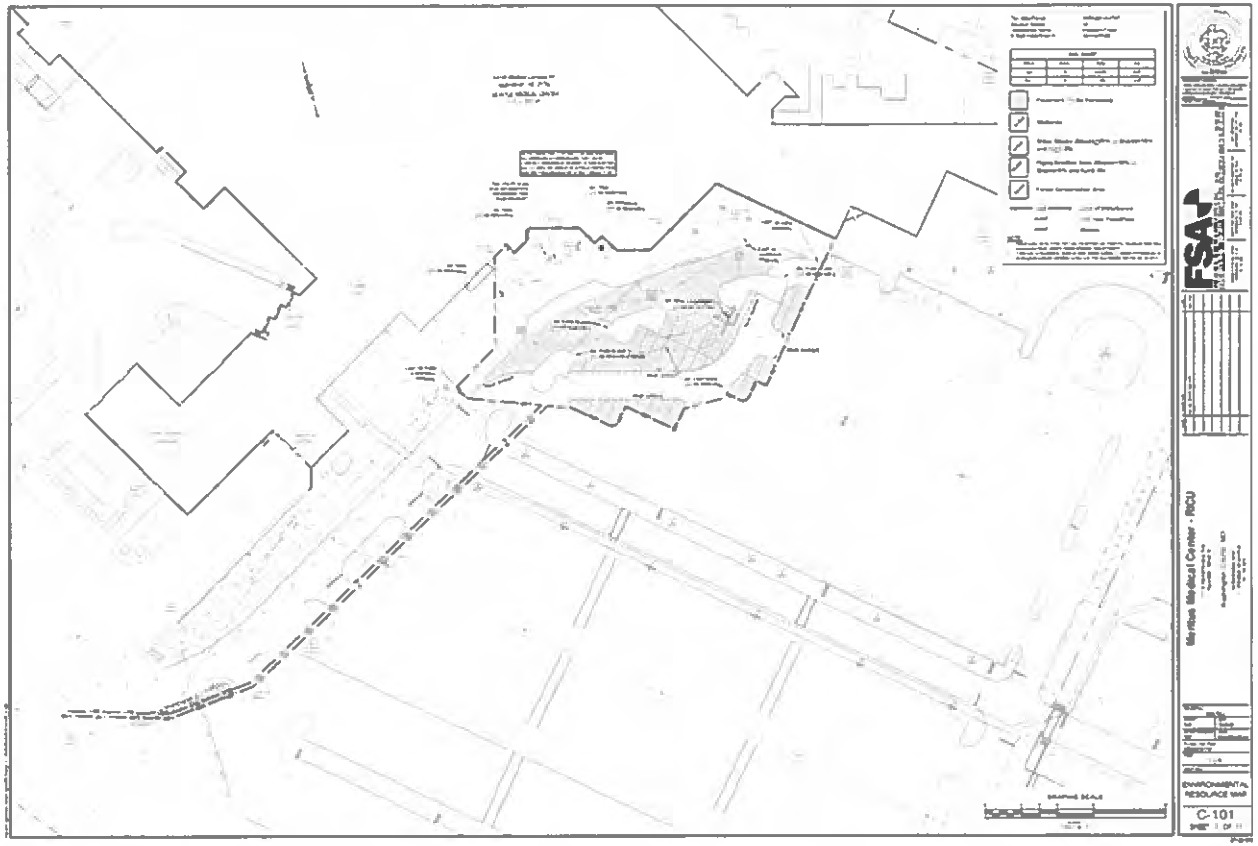

FSA
Meritus Medical Center - RCU
ENVIRONMENTAL RESOURCE MAP
C-101

EXHIBIT 3

CLERK OF CIRCUIT COURT
WASHINGTON COUNTY

THIS DEED, made this 15th day of November, 2011, by **MERITUS MEDICAL CENTER ENDOWMENT DEVELOPMENT COMPANY, INC., a Maryland Corporation formerly named WASINGTON COUNTY ENDOWMENT DEVELOPMENT COMPANY, INC.** (hereinafter sometimes referred to as "Grantor").

WITNESSETH: That for good and valuable consideration but for no monetary consideration, the receipt of which is hereby acknowledged, the said **MERITUS MEDICAL CENTER ENDOWMENT DEVELOPMENT COMPANY, INC.** does hereby grant and convey unto **MERITUS MEDICAL CENTER, INC.** all that parcel of land described as follows:

Situate southwest of Medical Campus Road and north of Robinwood Drive, in Election District Nos. 10 and 18 Washington County, Maryland, containing 1.95 acres of land, more or less, and being more particularly described as all of Parcel "C" on a subdivision plat entitled "Replat of Subdivision of Lot 4 of Robinwood Medical Campus" recorded at Plat folio 10022 among the Land Records of Washington County, Maryland.

Being a portion of the land conveyed to the Washington County Endowment Development Company, Inc. (now named Meritus Medical Center Endowment Development Company, Inc.) by Robert W. Lewis, Personal Representative of the Estate of Sarah A. Eyler by deed dated March 25, 1993 and recorded in Liber 1085, folio 273 among the aforesaid land records.

This conveyance is made subject to all recorded rights of way, easements, restrictions, conditions and reservations applicable thereto.

AND, the said Grantor does hereby covenant that it will Warrant Specially the property hereby conveyed and that it will execute such other and further assurances as may be requisite.

Pursuant to the provisions of the Real Estate Article, Section 14-133 of the Annotated Code of Maryland, Joseph P. Ross, President of the Meritus Medical Center Endowment Development Company, Inc. does hereby certify that this conveyance is not a part of a transaction in which there is a sale, lease, exchange or other transfer of all or substantially all of the property and assets of the Corporation.

IN WITNESS WHEREOF, the Grantor has caused its corporate name to be hereunto subscribed by Joseph P. Ross, its President, and its corporate seal to be affixed hereto and duly attested by its Secretary.

CLERK OF CIRCUIT COURT
WASHINGTON COUNTY

ATTEST:

MERITUS MEDICAL CENTER
ENDOWMENT DEVELOPMENT
COMPANY, INC.

By: _____ (SEAL)
Joseph P. Ross, President

_____
Carolyn Simonsen, Secretary

STATE OF MARYLAND, Washington County, to-wit:

I HEREBY CERTIFY that on this 15th day of November, 2011, before me, the subscriber, a Notary Public in and for the State and County aforesaid, personally appeared **JOSEPH P. ROSS, President of the Meritus Medical Center Endowment Development Company, Inc.**, a body corporate of the State of Maryland, and acknowledged the aforegoing Deed to be the act and deed of said Corporation and at the same time made oath in due form of law that he is the President of said Corporation and is duly authorized to make this acknowledgment.

WITNESS my hand and Official Notarial Seal.

_____
Notary Public

My Commission Expires: 9-15-14

THIS IS TO CERTIFY that the within instrument has been prepared by or under the supervision of the undersigned Maryland attorney, or by a party to this instrument.

_____
Michael J. Schaefer, Attorney at Law

Mail to:
McGrory and Schaefer
148 West Washington Street
Hagerstown, MD 21740

RECORDING FEE 46.00
SURCHARGE 40.00
TOTAL 86.00
Rec'd MWB
TLR
Nov 21, 2011
Rec'd # 64866
Bk: 4 1365
16:23 pm

TODD L. HERSHEY, TREASURER
TAXES PAID November 21, 2011

4187 0024

CLERK OF CIRCUIT COURT
WASHINGTON COUNTY

State of Maryland Land Instrument Intake Sheet

☐ Baltimore City ☑ County: Washington

Information provided is for the use of the Clerk's Office, State Department of Assessments and Taxation, and County Finance Office Only.

(Type or Print in Black Ink Only—All Copies Must Be Legible)

1 Type(s) of Instruments (☐ Check Box if addendum Intake Form is Attached)

X	Deed Deed of Trust	☐	Mortgage Lease	☐	Other _____	☐	Other _____

2 Conveyance Type Check Box

☐	Improved Sale Arms-Length (1)	☐	Unimproved Sale Arms-Length (2)	☐	Multiple Accounts Arms-Length (3)	☐	Not an Arms-Length Sale (9)

3 Tax Exemptions (if applicable) Cite or Explain Authority

Recordation	
State Transfer	
County Transfer	

4 Consideration and Tax Calculations

Consideration Amount		Finance Office Use Only Transfer and Recordation Tax Consideration	
Purchase Price/Consideration	$ 0.00	Transfer Tax Consideration	$
Any New Mortgage	$	X ( )% =	$
Balance of Existing Mortgage	$	Less Exemption Amount	$
Other	$	Total Transfer Tax =	$
Other	$	Recordation Tax Consideration	$
		X ( ) per $500 =	$
Full Cash Value	$	TOTAL DUE	$

5 Fees

Amount of Fees	Doc. 1	Doc. 2	
Recording Charge	$ 20.00	$	Agent
Surcharge	$ 40.00	$	Tax Bill
State Recordation Tax	$	$	CB Credit
State Transfer Tax	$	$	Ag. Tax/Other
County Transfer Tax	$	$	
Other	$	$	
Other	$	$	

6 Description of Property

SDAT requires submission of all applicable information. A maximum of 40 characters will be indexed in accordance with the priority cited in Real Property Article Section 3-104(g)(3)(i)

District	Property Tax ID No. (1)	Grantor Liber/Folio	Map	Parcel No.	Var. LOG
10	059800	3446/0426	50	1747	☐ (5)

Subdivision Name	Lot (3a)	Block (3b)	Sect/Alt (3c)	Plat Ref.	Sqft/Acreage (4)
	4			10022	1.95 acres

Location/Address of Property Being Conveyed (2)

Robinwood Medical Campus Road, Hagerstown, Maryland

Other Property Identifiers (if applicable)	Water Meter Account No.

Residential ☐ or Non-Residential ☑ | Fee Simple ☑ or Ground Rent ☐ Amount: |

Partial Conveyance? ☐ Yes ☑ No | Description/Amt. of SqFt/Acreage Transferred

If Partial Conveyance, List Improvements Conveyed

7 Transferred From

Doc. 1 – Grantor(s) Name(s)	Doc. 2 – Grantor(s) Name(s)
Meritus Medical Center Edmonment Development Co., Inc.	
(f/k/a Washington County Endowment Development Co., Inc.)	
Doc. 1 – Owner(s) of Record, if Different from Grantor(s)	Doc. 2 – Owner(s) of Record, if Different from Grantor(s)

8 Transferred To

Doc. 1 – Grantee(s) Name(s)	Doc. 2 – Grantee(s) Name(s)
Meritus Medical Center, Inc.	

New Owner's (Grantee) Mailing Address

9 Other Names to Be Indexed

Doc. 1 – Additional Names to be Indexed (Optional)	Doc. 2 – Additional Names to be Indexed (Optional)

10 Contact/Mail Information

Instrument Submitted By or Contact Person

Name: Michael J. Schaefer

Firm: McGrory & Schaefer

Address: 148 West Washington Street

Hagerstown, MD 21742 Phone: (301) 739-4141

☐ Return to Contact Person
☐ Hold for Pickup
☑ Return Address Provided

11 IMPORTANT: *BOTH* THE ORIGINAL DEED AND A PHOTOCOPY MUST ACCOMPANY EACH TRANSFER

Assessment Information

☐ Yes ☑ No Will the property being conveyed be the grantee's principal residence?

☐ Yes ☑ No Does transfer include personal property? If yes, identify _____

☐ Yes ☑ No Was property surveyed? If yes, attach copy of survey (if recorded, no copy required)

Space Reserved for County Validation

Assessment Use Only – Do Not Write Below This Line

Terminal Verification	Agricultural Verification	Whole / Part	Tran. Process Verification
Transfer Number	Date Received	Deed Reference	Assigned Property No.

Year	20	20	Geo.	Map	Sub	Block
Land			Zoning	Grid	Plat	Lot
Buildings			Use	Parcel	Section	Occ. Cd.
Total			Town Cd.	Ex. S1	Ex. Cd.	

REMARKS

Distribution: White – Clerk's Office Canary – SDAT ADC-EC-320 (8/2017)

WASHINGTON COUNTY CIRCUIT COURT Land Records, Liber 4187, p. 0024, MSA_CE18_4187. Date available 11/28/2023. Printed 03/24/2023.

EXHIBIT 4

Average Charge on Top 20 Inpatient Services		
DRG	Description	Ave. Charge
795	NORMAL NEWBORN	$ 2,196.32
807	VAGINAL DELIVERY W-O STERILIZATION-DANDC W-O CC-MCC	$ 7,349.16
885	PSYCHOSES	$ 8,092.23
871	SEPTICEMIA OR SEVERE SEPSIS W-O MV GREATER THAN 96 HOURS W MCC	$ 16,205.42
794	NEONATE W OTHER SIGNIFICANT PROBLEMS	$ 2,842.66
470	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W-O MCC	$ 18,544.17
806	VAGINAL DELIVERY W-O STERILIZATION-DANDC W CC	$ 7,935.35
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	$ 10,852.17
189	PULMONARY EDEMA AND RESPIRATORY FAILURE	$ 13,345.67
872	SEPTICEMIA OR SEVERE SEPSIS W-O MV GREATER THAN 96 HOURS W-O MCC	$ 9,497.81
194	SIMPLE PNEUMONIA AND PLEURISY W CC	$ 8,262.22
291	HEART FAILURE AND SHOCK W MCC OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	$ 12,211.19
392	ESOPHAGITIS GASTROENT AND MISC DIGEST DISORDERS W-O MCC	$ 7,321.18
788	CESAREAN SECTION W-O STERILIZATION W-O CC-MCC	$ 9,871.30
787	CESAREAN SECTION W-O STERILIZATION W CC	$ 10,839.45
065	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	$ 10,271.82
193	SIMPLE PNEUMONIA AND PLEURISY W MCC	$ 13,345.73
683	RENAL FAILURE W CC	$ 9,098.46
603	CELLULITIS W-O MCC	$ 7,951.39
191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	$ 8,540.99

Average Charge on Top 20 Outpatient Services		
ICD	Description	Ave. Charge
3E0T3TZ	Introduction of Destructive Agent into Peripheral Nerves and Plexi Percutaneous Approach	$ 1,816.64
3E0R3BZ	Introduction of Anesthetic Agent into Spinal Canal Percutaneous Approach	$ 873.39
0W9G3ZZ	Drainage of Peritoneal Cavity Percutaneous Approach	$ 722.81
0FT44ZZ	Resection of Gallbladder Percutaneous Endoscopic Approach	$ 6,686.60
4A023N7	Measurement of Cardiac Sampling and Pressure Left Heart Percutaneous Approach	$ 6,100.83
0DJD8ZZ	Inspection of Lower Intestinal Tract Via Natural or Artificial Opening Endoscopic	$ 1,574.36
0DBK8ZX	Excision of Ascending Colon Via Natural or Artificial Opening Endoscopic Diagnostic	$ 2,059.88
3E0T3BZ	Introduction of Anesthetic Agent into Peripheral Nerves and Plexi Percutaneous Approach	$ 2,110.07
057Y3ZZ	Dilation of Upper Vein Percutaneous Approach	$ 3,649.65
08B53ZZ	Excision of Left Vitreous Percutaneous Approach	$ 7,102.60
08B43ZZ	Excision of Right Vitreous Percutaneous Approach	$ 7,154.95
0UT94ZZ	Resection of Uterus Percutaneous Endoscopic Approach	$ 11,136.31
0DTJ4ZZ	Resection of Appendix Percutaneous Endoscopic Approach	$ 7,319.89
0DB68ZX	Excision of Stomach Via Natural or Artificial Opening Endoscopic Diagnostic	$ 2,384.32
0WUF4JZ	Supplement Abdominal Wall with Synthetic Substitute Percutaneous Endoscopic Approach	$ 8,785.45
0DB98ZX	Excision of Duodenum Via Natural or Artificial Opening Endoscopic Diagnostic	$ 2,512.38
0DJ08ZZ	Inspection of Upper Intestinal Tract Via Natural or Artificial Opening Endoscopic	$ 1,806.76
02PYX3Z	Removal of Infusion Device from Great Vessel External Approach	$ 467.52
0DBN8ZX	Excision of Sigmoid Colon Via Natural or Artificial Opening Endoscopic Diagnostic	$ 1,929.44
009U3ZX	Drainage of Spinal Canal Percutaneous Approach Diagnostic	$ 2,112.09

EXHIBIT 5

DEPARTMENT:	Patient Financial Services
POLICY NAME:	Financial Assistance
POLICY NUMBER:	0436
ORIGINATOR:	Patient Financial Services
EFFECTIVE DATE:	8/97
REVISION DATE(s):	03/99, 03/00, 03/03, 02/04, 03/04, 06/04, 10/04, 6/05, 3/06, 2/07, 3/07, 1/08, 3/09, 8/10, 2/11, 1/12, 1/14, 11/15, 1/18, 7/19, 2/20
REVIEWED DATE:	12/00, 2/03, 3/04

SCOPE

This policy applies to all patients seeking emergency or other medically necessary care at Meritus Medical Center. This policy also applies to patients seeking treatment at any Meritus owned physician practice. These entities are hereinafter collectively referred to as "Meritus."

The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under available Federal, State and Local Medical Assistance Programs, but whom outstanding "self-pay" balances exceed their own ability to pay. The underlying theory is that a person, over a reasonable period of time can be expected to pay only a maximum percentage of their disposable income towards charges incurred while in the hospital. Any "self-pay" amount in excess of this percentage would place an undue financial hardship on the patient or their family and may be adjusted off as financial assistance.

PURPOSE

Meritus is committed to providing quality health care for all patients regardless of their ability to pay and without discrimination on the grounds of race, sex, age, color, national origin, creed, marital status, sexual orientation, gender identity, or disability. The purpose of this document is to present a formal set of policies and procedures designed to assist hospital Patient Financial Services personnel in their day to day application of this commitment. The procedures describe how applications for financial assistance should be made, the criteria for eligibility, and the steps for processing applications.

This policy is intended to comply with Section 501(r) of the Internal Revenue Code and has been adopted by Meritus' Board of Directors.

POLICY

A. OVERVIEW

1. Financial assistance can be offered before, during, or after services are rendered. After applying, the hospital will send an acknowledgment letter to the patient within two (2) business days and an eligibility determination will be made within thirty (30) days.
    a. For purposes of this policy, "financial assistance" refers to healthcare services provided without charge or at a discount to qualifying patients.
    b. A list of our health care service providers is available at4Only providers employed by Meritus are covered under this policy and are indicated on the provider list.

c. If a provider is not covered under this policy, patients should contact the provider's office to determine if financial assistance is available.

2. Notice of the Availability of Financial Assistance:

   a. Meritus will make available brochures informing the public of its Financial Assistance Policy. Such brochures will be available throughout the community and within Meritus locations.

   b. Notices of the availability of financial assistance will be posted at appropriate admission areas, the Patient Financial Services department, and other key patient access areas.

   c. A statement on the availability of financial assistance will be included on patient billing statements.

   d. A Plain Language Summary of Meritus' Financial Assistance Policy will be provided to patients receiving inpatient services with their Summary Bill and will be made available to all patients upon request.

   e. Meritus' Financial Assistance Policy, a Plain Language Summary of the policy, and the Financial Assistance Application are available to patients upon request at Meritus, through mail (postal service), and on Meritus' website at www.meritushealth.com/financialassistance.

   f. Meritus' Financial Assistance Policy, Plain Language Summary, and Financial Assistance Application are available in Spanish.

      i. On an annual basis, Meritus shall assess the needs of our limited English proficiency community and determine whether additional translations are needed.

3. Availability of Financial Assistance: Meritus retains the right, in its sole discretion, to determine a patient's ability to pay, in accordance with Maryland and Federal law.

   a. Financial assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

   b. All patients presenting for emergency services will be treated regardless of their ability to pay.

      i. For emergent services, applications for financial assistance will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

4. Limitation of Charges: Individuals eligible for reduced-cost care under this policy will not be charged more than the hospital's standard charges, as set by Maryland's Health Services Cost Review Commission (HSCRC).

   a. Meritus' rate structure is governed by the HSCRC rate setting authority. As an "all-payer system", all patient care is charged according to the resources consumed in treating them regardless of the patient's ability to pay.

   b. Charges are developed based on a relative predetermined value set by the HSCRC at the approved unit rate developed by the HSCRC.

B. PROGRAM ELIGIBILITY

1. Meritus strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Meritus reserves the right to

grant financial assistance without formal application being made by patients. These patients may include the homeless or individuals with returned mailed and no forwarding address.

2. Patients who are uninsured, underinsured, ineligible for a government programs, such as Medicaid, or otherwise unable to pay for medically necessary care may be eligible for Meritus' Financial Assistance Program.

3. All residents of Meritus' service area will be considered for financial assistance regardless of United States immigration status. Financial assistance consideration is available to non-service area residents requiring emergency services at Meritus.

4. For non-emergent services for patients residing outside of Meritus' service area, including patients traveling to the United States to obtain health care services, Meritus reserves the right to screen patients for insurance coverage and ability to pay. Meritus may only offer financial assistance to non-service area residents for non-emergency services on a case-by-case basis.

5. Services Eligible under this Policy. Health care services that are eligible for financial assistance include:
    a. Emergency medical services provided in an emergency room setting;
    b. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of the individual;
    c. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
    d. Medically necessary services.
        i. A medically necessary service is one which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which: (i) endanger life; (ii) cause suffering or pain; (iii) result in illness or infirmity; (iv) threaten to cause or aggravate a handicap; or (v) cause physical deformity or malfunction.
        ii. A service or item is not medically necessary if there is another service or item that is equally safe and effective and substantially less costly, including, when appropriate, no treatment at all.
        iii. Experimental services or services which are generally regarded by the medical profession as unacceptable treatment are not medically necessary.
6. Exclusions from Financial Assistance: Specific exclusions to coverage under the Financial Assistance Program include the following:
    a. Patients whose insurance program or policy denies coverage for the services received (e.g., HMO, PPO, Workers Compensation, or Medicaid);
        i. Exceptions to this exclusion may be made, in Meritus' sole discretion, considering medical and programmatic implications.
    b. Unpaid balances resulting from cosmetic or other non-medically necessary services; and
    c. Patient convenience items.

7. Ineligibility: Patients may become ineligible for financial assistance, for a specific date of service, for the following reasons:
    a. After being notified by Meritus, for refusal to provide requested documentation or information required to complete a Financial Assistance Application within the 240 days after the patient receives the first post-discharge billing statement (approximately 8 months).
    b. Unless seeking emergency medical services, having insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance program that denies access to Meritus due to insurance plan restrictions/limitations.
    c. Failure to pay co-payments as required by the Financial Assistance Program.
    d. Failure to keep current on existing payment arrangements with Meritus.
    e. Failure to make appropriate arrangements on past payment obligations owed to Meritus (including those patients who were referred to an outside collection agency for a previous debt).
    f. Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program, unless Meritus can readily determine that the patient would fail to meet the eligibility requirements.
8. Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.
9. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance eligibility criteria (See Section C.2. below).
    a. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Meritus' Senior Finance Executive for approval.
    b. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.
10. Coverage amounts will be calculated using a sliding fee scale based on federal poverty guidelines. An example of the sliding scale is included in *Appendix 1.*

C. PRESUMPTIVE ELIGIBILITY FOR FINANCIAL ASSISTANCE

1. Patients may be eligible for financial assistance on a presumptive basis. There are instances when a patient may appear eligible for financial assistance, but there is no Financial Assistance Application and/or supporting documentation on file. Often there is adequate information, provided by the patient or other sources, that is sufficient for determining financial assistance eligibility.
    a. In the event there is no evidence to support a patient's eligibility for financial assistance, Meritus reserves the right to use outside agencies or propensity to pay modeling in determining financial assistance eligibility.
    b. Patients who are determined to satisfy presumptive eligibility will receive free care on that date of service. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service.

2. Presumptive eligibility will be determined on the basis of individual life circumstances that may include:
    a. Active Medical Assistance pharmacy coverage;
    b. Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums);
    c. Homelessness;
    d. Maryland Public Health System Emergency Petition patients;
    e. Participation in Women, Infants and Children Programs ("WIC");
    f. Food Stamp eligibility;
    g. Eligibility for other state or local assistance programs;
    h. Deceased patient with no known estate; and
    i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.
3. Patients deemed to be presumptively eligible for financial assistance based on participation in a social service program identified above must submit proof of enrollment within 30 days of such eligibility determination. A patient, or a patient's representative, may request an additional 30 days to submit required proof.
4. Exclusions from consideration for presumptive eligibility include:
    a. Purely elective procedures (e.g., cosmetic procedures).
    b. Uninsured patients seen in the Emergency Department under Emergency Petition unless and until the Maryland Behavioral Health Administration (BHA) has been billed.
5. All Amish and Mennonite patients will be extended a 25% reduction to charges. For religious reasons the Amish and Mennonite community are opposed to accepting Medicare, Medicaid, public assistance or any form of health coverage.

D. FINANCIAL MEDICAL HARDSHIP

1. Patients falling outside of conventional income or who are not presumptively eligible for financial assistance are potentially eligible for bill reduction through the Medical Hardship Program.
    a. Patients may qualify under the following circumstances:
        i. Combined household income less than 500% of the current federal poverty level; or
        ii. Having incurred collective family hospital medical debt at Meritus exceeding 25% of the combined household income during a 12-month period.
            (a) Medical debt excludes co-payments, co-insurance, and deductibles.
2. Meritus applies the criteria above to a patient's balance after any insurance payments have been received.
3. Coverage amounts will be calculated using a sliding fee scale based on federal poverty guidelines. An example of the sliding scale is included in *Appendix 1*.

4. If determined eligible, patients and their immediate family qualify for reduced-cost, medically necessary care for a 12-month period effective on the date the medically necessary care was initially received.
5. In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance Program, Meritus is to apply the greater of the two discounts.
6. The patient is required to notify Meritus of their potential eligibility for reduced cost-care due to financial medical hardship.

E. ASSISTANCE BASED ON INDIVIDUAL CIRCUMSTANCES: Meritus reserves the right to consider individual patient and family financial circumstances to grant reduced-cost care in excess of State established criteria.

1. The eligibility, duration, and discount shall be patient-situation specific.
2. Patient balance after insurance accounts may be eligible for consideration.
3. Cases falling into this category require management level review and approval.

F. ASSET CONSIDERATION

1. Assets are generally not considered as part of the financial assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient's responsibility without causing undue hardship. When assets are reviewed, individual financial circumstances, such as the ability to replenish the asset and future income potential, are taken into consideration.
2. The following assets are exempt from consideration:
    a. The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families.
    b. Up to $150,000 in primary residence equity.
    c. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account. Generally, this consists of plans that are tax exempt and/or have penalties for early withdrawal.

G. APPEALS

1. Patients whose Financial Assistance Applications are denied have the option to appeal the decision. Appeals should be made in writing and mailed to: Meritus Medical Center, 11116 Medical Campus Road, Hagerstown, Maryland 27142 Attn: Financial Counseling Team.
2. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
3. Appeals are documented and reviewed by the next level of management above the representative who denied the original application.
4. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
5. Appeals can be escalated up to the Chief Financial Officer, who will render the final decision.
6. Patients who have formally submitted an appeal will receive a letter of the final determination.

H. PATIENT REFUND

1. If, within a two (2) year period after the date of service, a patient is found to be eligible for free or reduced-cost care under Meritus' Financial Assistance Program, for that date of service, the patient shall be refunded payments in excess of their financial obligation where such refund is greater than $5.
    a. The two (2) year period may be reduced to 240 days (approximately 8 months) after receipt of the first post-discharge billing statement where Meritus' documentation demonstrates a lack of cooperation by the patient, or guarantor, in providing documentation or information necessary for determining patient's eligibility.
2. If a patient is found to be eligible for financial assistance after Meritus has initiated extraordinary collection actions (ECA), such as reporting to a credit agency, liens, or lawsuits, Meritus will not take any further ECA and will take all reasonable steps available to reverse any ECA already taken.

I. OPERATIONS

1. Meritus will designate a trained person or persons who will be responsible for taking Financial Assistance Applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, or other designated trained staff.
2. Every effort will be made to determine eligibility prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request financial assistance to determine if they meet preliminary criteria for assistance.
    a. Staff will complete an eligibility check with the applicable state Medicaid program to determine whether patients have current coverage or may be eligible for coverage.
        i. To facilitate this process, each applicant must provide information about family size and income (as defined by Medicaid regulations).
    b. Meritus will provide patients with the Maryland State Uniform Financial Assistance Application and a checklist of what paperwork is required for a final determination of eligibility.
        i. Patients may be required to submit the following documentation with their completed application:
            (a) A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income);
            (b) Proof of disability income (if applicable);
            (c) A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income or documentation of how they are paying for living expenses;
            (d) Proof of social security income (if applicable);
            (e) A Medical Assistance Notice of Determination (if applicable);
            (f) Reasonable proof of other declared expenses; and
            (g) If unemployed, reasonable proof of unemployment, such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.

3. If a patient has not submitted a completed Financial Assistance Application or any required supporting documentation within 30 days after a formal application request, a letter will be sent reminding the patient that financial assistance is available and informing the patient of the collection actions that may be taken if no documentation is received.
    a. A deadline for submission, prior to initiation of extraordinary collection actions, will be included in the letter. Such deadline may not be earlier than 30 days after the date on which the reminder letter is sent.
    b. No extraordinary collection actions, such as reporting to a credit agency, liens, or lawsuits, will be taken prior to 120 days after the first post-discharge billing statement (approximately 4 months).
    c. If documentation is received after collection actions have been initiated, but within 240 days after patient receipt of the first post discharge billing statement, Meritus shall cease all collection actions and determine whether the patient is eligible for financial assistance.
4. A Plain Language Summary of this policy shall be included with the letter and Meritus staff shall make a reasonable effort to orally notify the individual of Meritus' Financial Assistance Program.
5. Once a patient has submitted all the required information, appropriate personnel will review the application and forward it to the Patient Financial Services Department for final determination of eligibility based on Meritus guidelines.
    a. For complete applications, the patient will receive a letter notifying them of approval/denial within 30 days of submitting the completed applications.
    b. If an application is determined to be incomplete, the patient will be contacted regarding any additional required documentation or information.
    c. If a patient is determined to be ineligible prior to receiving services, all efforts to collect co-pays, deductibles, or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.
    d. If a patient is determined to be ineligible after receiving services, a payment arrangement may be obtained, subject to Meritus approval, on any balance due by the patient.
6. Except as noted below, once a patient is approved for financial assistance, such financial assistance shall be effective as of the date treatment is received and the following six (6) calendar months.
    a. For those who qualify for reduced-cost care due to medical hardship, such qualification will apply for a twelve (12) month period.
    b. If additional healthcare services are provided beyond the approval period, patients must reapply to continue to receive financial assistance.
7. The following may result in the reconsideration of financial assistance approval:
    a. Post approval discovery of an ability to pay; and
    b. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to Meritus.

8. Meritus will track patient qualification for financial assistance or medical hardship. However, it is ultimately the responsibility of the patient to inform Meritus of their eligibility status at the time of registration or upon receiving a statement.

J. CREDIT & COLLECTIONS POLICY

1. Meritus maintains a separate Credit & Collections Policy that outlines what actions Meritus may take in the event a patient fails to meet their financial responsibility.
2. A copy of this policy may be obtained by requesting a copy from Meritus staff or by visiting Meritus' website at www.meritushealth.com/financialassistance.

K. PROVIDER LIST

1. Meritus maintains a list of all Meritus and non-Meritus providers who may care for patients while at Meritus. This list indicates whether the provider is covered by this policy. Non- Meritus providers are not covered and bill separately for their services.
2. A copy of this list may be obtained by requesting a copy from Meritus staff or by visiting Meritus' website at www.meritushealth.com/financialassistance.

RESPONSIBILITY
Executive Director, Finance

REFERENCES
I.R.C. § 501(r) (2015).
26 C.F.R. § 1.501(r)-4
(2015). Md. Code Regs.

10.37.10.26.

RELATED POLICIES
Meritus Policy 0444, Credit & Collections

Appendix 1

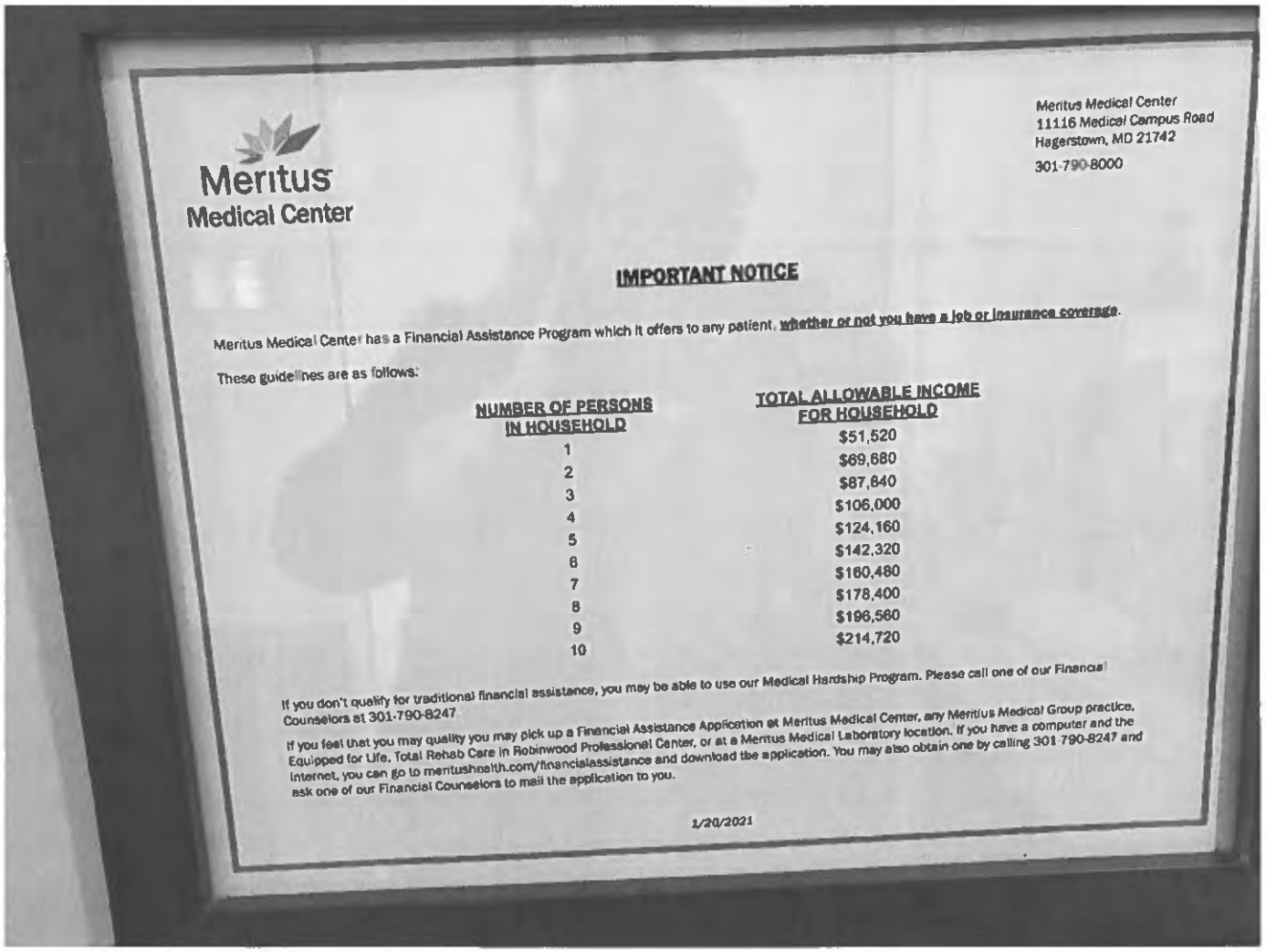
Sliding Scale

US Federal Poverty guidelines are updated annually by the Department of Health and Human Services. Below is an example of the sliding scale Meritus shall use to determine patient eligibility for financial assistance or medical hardship.
https://aspe.hhs.gov/poverty-guidelines

		% of Federal Poverty Level Income					
	2020	200%	250%	300%	350%	400%	500%
Size of Family Unit	FPL Income	Approved % of Financial Assistance					
		100%	80%	60%	40%	20%	0%
1	$12,140	$25,520	$31,900	$38,280	$44,660	$51,040	❸$63,800
2	$16,460	$34,480	$43,100	❷$51,720	$60,340	$68,960	$86,200
3	$20,780	$43,440	$54,300	$65,160	$76,020	$86,880	$108,600
4	$25,100	❶$52,400	$65,500	$78,600	$91,700	$104,800	$131,000
5	$29,420	$61,360	$76,700	$92,040	$107,380	$122,720	$153,400
6	$33,740	$70,320	$87,900	$105,480	$123,060	$140,640	$175,800
7	$38,060	$79,280	$99,100	$118,920	$138,740	$158,560	$198,200
8	$42,380	$88,240	$110,300	$132,360	$154,420	$176,480	$220,600

Example # 1	Example # 2	Example # 3
1. Patient earns $57,000 per year. 2. There are 4 people in the patient's family. 3. The % of potential Financial Assistance coverage would equal 80% (they earn more than $52,400 but less than $65,500)	1. Patient earns $54,000 per year. 2. There are 2 people in the patient's family. 3. The % of potential Financial Assistance coverage would equal 40% (they earn more than $51,720 but less than $60,340)	1. Patient earns $61,000 per year. 2. There is 1 person in the patient's family. 3. The balance owed is $20,000. 4. If the patient qualifies for Hardship coverage, they would owe $15,250 (25% of 61,000).

EXHIBIT 6



Meritus
Medical Center

Meritus Medical Center
11116 Medical Campus Road
Hagerstown, MD 21742
301-790-8000

IMPORTANT NOTICE

Meritus Medical Center has a Financial Assistance Program which it offers to any patient, **whether or not you have a job or insurance coverage**.

These guidelines are as follows:

NUMBER OF PERSONS IN HOUSEHOLD	TOTAL ALLOWABLE INCOME FOR HOUSEHOLD
1	$51,520
2	$69,680
3	$87,840
4	$106,000
5	$124,160
6	$142,320
7	$160,480
8	$178,400
9	$196,560
10	$214,720

If you don't qualify for traditional financial assistance, you may be able to use our Medical Hardship Program. Please call one of our Financial Counselors at 301-790-8247.

If you feel that you may qualify you may pick up a Financial Assistance Application at Meritus Medical Center, any Meritus Medical Group practice, Equipped for Life, Total Rehab Care in Robinwood Professional Center, or at a Meritus Medical Laboratory location. If you have a computer and the internet, you can go to meritushealth.com/financialassistance and download the application. You may also obtain one by calling 301-790-8247 and ask one of our Financial Counselors to mail the application to you.

1/20/2021

EXHIBIT 7

EXHIBIT 8

MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY
7120 SAMUEL MORSE DRIVE, SECOND FLOOR
COLUMBIA, MARYLAND 21046-3422

License No. 21-012

Issued to:

Meritus Medical Center
11116 Medical Campus Road
Hagerstown, MD 21742

Type of Facility: **Acute General Hospital**
Special Hospital - Rehabilitation with 20 beds

Ownership: **Meritus Medical Center**

Date Issued: 07/01/2019
Expiration Date: Non-Expiring License

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Section 318 Annotated Code of Maryland, 1982 Edition, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Patricia Tomasko May MD

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

EXHIBIT 9

Meritus Medical Center Inc.

Hagerstown, MD

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

April 27, 2019

Accreditation is customarily valid for up to 36 months.

David H. Perrott

David Perrott, MD, DDS, MBA, FACS
Chair, Board of Commissioners

ID #6283
Print Report Date: 10/09/2019

Mark R. Chassin

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

EXHIBIT 10

Topic	Sub Category	Description	Rating	Score	#
COPD	Results of Care	Dying within 30-days after getting care in the hospital for COPD	Average	7.8 (6.4 - 9.5)	1
COPD	Results of Care	Returing to the hospital after getting care for COPD	Average	19.3 (17.5 - 21.3)	2
Childbirth	Practice Patterns	Percentage of births that are C-sections	Better than Average	26.4706	3
Childbirth	Practice Patterns	How often babies in the hospital are delivered vaginally when the mother previously delivered by C-section	Below Average	12.6168	4
Childbirth	Practice Patterns	How often babies in the hospital are delivered using C-sections when this is the mothers first birth	Better than Average	13.9847	5
Childbirth	Practice Patterns	How often babies are born vaginally when the mother has had a C-section in the past (includes complications)	Below Average	11.7647	6
Childbirth	Practice Patterns	Newborn deliveries scheduled 1-3 weeks earlier than medically necessary	Better than Average	0%	7
Combined Quality and Safety Ratings	Combined Quality and Safety Ratings	Patients who died in the hospital after having one of six common conditions	Average	0.9315 (0.7392, 1.1237)	8
Combined Quality and Safety Ratings	Combined Quality and Safety Ratings	How well this hospital keeps patients safe based on eleven patient safety problems	Below Average	2.8628 (2.5537, 3.1719)	9
Consumer Ratings	Communication	How often did nurses always communicate well with patients?	Better than Average	78%	10
Consumer Ratings	Communication	How often did doctors always communicate well with patients?	Below Average	75%	11
Consumer Ratings	Communication	How often did staff always explain about medicines before giving them to patients?	Below Average	58%	12
Consumer Ratings	Communication	Were patients always given information about what to do during their recovery at home?	Better than Average	88%	13
Consumer Ratings	Communication	How well do patients understand their care when they leave the hospital?	Below Average	45%	14
Consumer Ratings	Environment	How often were the patients rooms and bathrooms always kept clean?	Better than Average	71%	15
Consumer Ratings	Environment	How often did patients always receive help quickly from hospital staff?	Better than Average	63%	16
Consumer Ratings	Environment	How often was the area around patients' rooms always kept quiet at night?	Below Average	54%	17
Consumer Ratings	Satisfaction Overall	How do patients rate the hospital overall?	Below Average	62%	18
Consumer Ratings	Satisfaction Overall	Would patients recommend the hospital to friends and family?	Below Average	58%	19
Emergency Department	Wait Times	How long patients spent in the emergency department before leaving for their hospital room?	Better than Average	390 minutes	20
Emergency Department	Wait Times	How long patients spent in the emergency department after the doctor decided the patient would stay in the hospital before leaving for their hospital room	Below Average	192 minutes	21
Emergency Department	Wait Times	How long patients spent in the emergency department before being sent home	Below Average	206 minutes	22
Emergency Department	Wait Times	Patient who left the emergency department without being seen	Below Average	5%	23
Flu Prevention	Protecting Patients	Patients in the hospital who got the ful vaccine if they were likely to get flu	Better than Average	100%	24
Heart Attack and Chest Pain	Recommended Care - Outpatient	How long patients with chest pain or possible heart attack waited to be transferred to another hospital for a procedure	Not Enough Data to Report	N/A	25
Heart Attack and Chest Pain	Recommended Care - Outpatient	How long patients who come to the hospital with chest pain or possible heart attack waited to get a test that detects heart damage after a heart attack	Average	10 minutes	26
Heart Attack and Chest Pain	Results of Care	How often patients die in the hospital after a heart attack	Average	4.5291 (1.7539, 7.3042)	27
Heart Attack and Chest Pain	Results of Care	Dying within 30-days after getting care in the hospital for a heart attack	Average	14.2 (11.7 - 17.0)	28
Heart Attack and Chest Pain	Results of Care	Returing to the hospital after getting care for a heart attack	Average	17.4 (14.8 - 20.3)	29
Heart Failure	Results of Care	How often patients die in the hospital after heart failure	Average	1.9322 (0.1537, 3.7107)	30
Heart Failure	Results of Care	Dying within 30-days after getting care in the hospital for heart failure	Not Enough Data to Report	N/A	31
Heart Failure	Results of Care	Returing to the hospital after getting care for heart failure	Average	21.8 (19.3 - 24.4)	32
Heart Surgeries and Procedures	Results of Care	Death rate for CABG	Not Enough Data to Report	N/A	33
Heart Surgeries and Procedures	Results of Care	Rate of unplanned readmission for CABG	Not Enough Data to Report	N/A	34
Hip or Knee Replacement Surgery	Results of Care	Returning to the hospital after getting hip or knee replacement surgery	Average	3.8 (2.9 - 5.0)	35
Hip or Knee Replacement Surgery	Results of Care	Complications after hip or knee replacement surgery	Not Enough Data to Report	N/A	36
Imaging	Practice Patterns	Patients who come to the hospital with low back pain who had an MRI without trying recommended treatments first, such as physical therapy	Not Enough Data to Report	N/A	37
Imaging	Practice Patterns	Contrast material (dye) used during abdominal CT scan	Better than Average	0.20%	38
Imaging	Practice Patterns	Contrast material (dye) used during thorax CT scan	Better than Average	0%	39
Imaging	Practice Patterns	Patients who had a low-risk surgery and received a heart related test, such as an MRI, at least 30 days prior to their surgery though they do not have a heart condition	Not Enough Data to Report	N/A	40

Topic	Sub Category	Description	Rating	Score	#
Imaging	Practice Patterns	Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses	Average	1.40%	41
Patient Safety	Results of Care - Complications	How often the hospital accidentally makes a hole in a patient's lung	Average	0.2719 (0.0000, 0.6054)	42
Patient Safety	Results of Care - Complications	Returning to the hospital for any unplanned reason within 30 days after being discharged	Average	14.6 (13.9 - 15.3)	43
Patient Safety	Results of Care - Complications	Patients who developed a blood clot while in the hospital and did not get treatment that could have prevented it	Better than Average	0%	44
Patient Safety	Results of Care - Complications	Percentage of patients who received appropriate care for severe sepsis and septic shock	Below Average	39	45
Patient Safety	Results of Care - Deaths	How often patients die in the hospital after bleeding from stomach or intestines	Average	1.8278 (0.0008, 3.6548)	46
Patient Safety	Results of Care - Deaths	How often patients die in the hospital after fractured hip	Average	1.3769 (0.0000, 3.4238)	47
Patient Safety	Results of Care - Deaths	How often patients die in the hospital while getting care for a condition that rarely results in death	Below Average	17.8189 (17.1458, 18.4921)	48
Pneumonia	Results of Care	How often patients die in the hospital while getting care for pneumonia	Below Average	4.0444 (2.5926, 5.4962)	49
Pneumonia	Results of Care	Dying within 30-days after getting care in the hospital for pneumonia	Average	15.9 (13.8 - 18.2)	50
Pneumonia	Results of Care	Returning to the hospital after getting care for pneumonia	Average	18.1 (16.3 - 20.1)	51
Stroke	Results of Care	How often patients who came in after having stroke subsequently died in the hospital	Average	4.0498 (1.2037, 6.8960)	52
Stroke	Results of Care	Death rate for stroke patients	Average	11.8 (9.4, 14.7)	53
Surgeries for Specific Health Conditions	Results of Care - Deaths	How often patients die in the hospital during or after surgery on the esophagus	Not Enough Data to Report	N/A	54
Surgeries for Specific Health Conditions	Results of Care - Deaths	How often patients die in the hospital during or after pancreas surgery	Average	0.0000 (0.0000, 30.1169)	55
Surgeries for Specific Health Conditions	Results of Care - Deaths	How often patients die in the hospital during or after a surgery to fix the artery that carries blood to the lower body when it gets too large	Average	0.0000 (0.0000, 9.7667)	56
Surgical Patient Safety	Results of Care	How often patients die in the hospital because a serious condition was not identified and treated	Average	133.6090 (70.6204, 196.5976)	57
Surgical Patient Safety	Results of Care	How often patients in the hospital had to use a breathing machine after surgery because they could not breath on their own	Below Average	9.4255 (4.4752, 14.3759)	58
Surgical Patient Safety	Results of Care	How often patients in the hospital get a blood clot in the lung or leg vein after surgery	Average	4.2589 (1.7640, 6.7537)	59
Surgical Patient Safety	Results of Care	How often patients accidentally get cut or have a hole poked in an organ that was not part of the surgery or procedure	Below Average	3.9347 (2.3064, 5.5629)	60
Surgical Patient Safety	Results of Care	Number of times a medical tool was accidentally left in a patient's body during surgery or procedure	Not Enough Data to Report	N/A	61

EXHIBIT 11

Acute General Hospital Licensed Bed Designation: FY 2023

Office of Health Care Quality and Maryland Health Care Commission

Hospital Name: Meritus Medical Center

License Number: 21012

A. LICENSED ACUTE CARE BEDS SUBJECT TO DESIGNATION PROCEDURES

Service Category:	Designation of Beds
MEDICAL/SURGICAL/GYNECOLOGICAL/ADDICTIONS (MSGA)	185
Medical-Surgical Acute	0
Gynecologic	0
Addictions	0
Definitive Observation/Stepdown	24
Medical Surgical Intensive Care	0
Medical Cardiac Critical Care	0
Burn Critical Care (HSCRC-designated service only)	0
Shock Trauma (HSCRC-designated service only)	0
Oncology (HSCRC-designated service only)	209
Total Medical/Surgical/Gynecological/Addictions (MSGA)	17
OBSTETRIC	
PEDIATRIC	4
Pediatric Acute	0
Pediatric Intensive Care	4
Total Pediatric	
PSYCHIATRIC	18
Acute Psychiatric-Adult	0
Acute Psychiatric-Child (MHCC-designated service only)	0
Acute Psychiatric-Adolescent (MHCC-designated service only)	0
Acute Psychiatric-Geriatric (MHCC-designated service only)	0
Acute Psychiatric-Intensive Care	18
Total Acute Psychiatric	248
TOTAL: CURRENT LICENSED ACUTE CARE BED CAPACITY	

B. INVENTORY OF OTHER BEDS

BASSINETS	41
Newborn Nursery	0
Premature Nursery (HSCRC-designated service only)	0
Neonatal Intensive Care Unit (NICU)	41
Total Newborn Services (Bassinets)	
SPECIAL HOSPITAL SERVICES	20
Acute Rehabilitation-Comprehensive Inpatient	0
Acute Rehabilitation-Brain Injury	0
Acute Rehabilitation-Spinal Cord Injury	0
Acute Rehabilitation-Stroke Specialty Programs	0
Acute Rehabilitation-Pediatrics	0
Chronic Care	20
Total Special Hospital Services	
NON ACUTE SERVICES	0
Comprehensive Care	0
Intermediate Care Facility (ICF)	0
Residential Treatment Center (RTC)	0
Total Non Acute Care Services	

Approved: _____ (MDH)

Date Issued: July 1, 2022 Expiration Date: June 30, 2023

cc: Health Services Cost Review Commission

EXHIBIT 12

Item #	Name	Title	Organization / Affiliation	Address
1	Paul Kifer	Chief of Police	Hagerstown City Police Department	50 N Burhans Blvd. Hagerstown, Maryland 21740
2	Suzi Ford	Strategic Partnerships Manager	American Cancer Society	250 Williams St. Atlanta, Georgia 30303
3	Dr. Boyd J. Michael, III	Superintendent	Washington County Public Schools	10435 Downsville Pike. Hagerstown, Maryland 21740
4	Addie Nardi	Chief Executive Officer	Boys and Girls Club of Washington County	805 Pennsylvania Avenue, Hagerstown Maryland 21742
5	R. Lynn Rushing	Chief Executive Officer	Brook Lane	13121 Brook Lane, Hagerstown Maryland 21742
6	Kevin Simmers	Founder	Brooke's House	17670 Technology Blvd. Hagerstown, Maryland 21740
7	Paul Frey, IOM	President & Chief Executive Officer	Washington County Chamber of Commerce	1 South Potomac St. Hagerstown, Maryland 21740
8	Nicole R. Houser	Executive Director	Community Free Clinic	249 Mill Street, Hagerstown Maryland 21740
9	Paul D. Corderman	Delegate, Legislative District 28	The Maryland House of Delegates	6 Bladen Street, Room 213. Annapolis, Maryland 21401
10	Stephen Coetzee, LNHA	President & Chief Executive Officer	Fahrney Keedy	8507 Mapleville Road, Boonsboro Maryland 21713
11	Kimberly Z. Murdaugh, MPH	Executive Director	Family Healthcare of Hagerstown	201 S. Cleveland Avenue, Hagerstown Maryland 21740
12	Tara L. Sargent, D.Ed.	Executive Director	Leadership, Washington County	11 Public Square, Suite 4008. Hagerstown, Maryland 21740
13	Cynthia M. Demarest	Chief Executive Officer	Maryland Physicians Care	1201 Winterson Road 4th floor. Linthicum Heights, Maryland 21090
14	John A. Latimer, III	Chair, Board of Directors	Meritus Healthcare Foundation	11116 Medical Campus Rd, Suite 3977. Hagerstown, Maryland 21742
15	Dana Jenkins, MBA	Executive Director	Reach of Washington County	140 W. Franklin St, Suite 300. Hagerstown, Maryland 21740
16	Andrew D McCarthy, MD	Neurology and Rehabilitation	Meritus Health	11116 Medical Campus Rd, Suite 3977. Hagerstown, Maryland 21742
17	Andrew A. Serafini	State Senator, Legislative District 2	The Senate of Maryland	11 Bladen Street, Room 321. Annapolis, Maryland 21401
18	George C. Edwards	State Senator, Legislative District 1	The Senate of Maryland	11 Bladen Street, Room 323. Annapolis, Maryland 21401
19	Mary J.C. Hendrix, Ph.D.	President	Shepherd University	P.O. Box 5000. Shepherdstown, West Virginia. 25443
20	Troy Van Scoyoc	Executive Director	The Arc of Washington County	820 Florida Ave, Hagerstown, Maryland 21740
21	Heather H. Guessford	President & Chief Executive Officer	United Way	1800 Washington Blvd #340. Baltimore, Maryland 21230
22	Mark C. Halsey	Executive Director	University System of Maryland, Hagerstown	32 W. Washington Street. Hagerstown, Maryland 21740
23	Cort F. Meinelschmidt	County Commissioner	Board of County Commissioners of Washington County, Maryland	100 West Washington Street, Suite 1101. Hagerstown, Maryland 21740
24	Doug Mullendore	Sheriff	Washington County Sheriff's Office	500 Western Maryland Parkway. Hagerstown, Maryland 21740
25	Wendy Zimmerman, BSN, RN-BC	Parish Nursing Program Manager	Meritus Health Parish Nursing Program	1799 Howell Road. Hagerstown, Maryland 21740

CITY OF HAGERSTOWN
MARYLAND

DEPARTMENT OF POLICE
50 N Burhans Blvd

Non-Emergency 301-790-3700
Emergency 240-313-4345
Fax 301-733-5513

May 25, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

Meritus Medical Center continues to demonstrate its commitment to protecting and promoting the health and wellness of our community by engaging in the current effort to build a negative pressure and ventilator capable, 20-bed RIC-Unit on its campus. Crews are working day and night to complete the structure with the goal of accepting patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the western Maryland region. The RIC-Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons. Meritus Medical Center is not merely responding to the current pandemic through resiliency, but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society.

I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Chief Paul Kifer
Hagerstown City Police Department

May 26, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

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I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Suzi Ford
American Cancer Society
Cancer Control Strategic Partnerships
Suzi.Ford@cancer.org
410.933.5252

WCPS | Washington County Public Schools

10435 Downsville Pike
Hagerstown, MD 21740
301-766-2800

Boyd J. Michael, Ed.D.
Superintendent of Schools

May 20, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen and Dr. Pollak:

On behalf of Washington County Public Schools (WCPS), I would like to give full support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is a vital community partner in promoting a healthy, educated, and thriving community in Washington County.

The recent COVID-19 pandemic has challenged our nation, our state, and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

Through the pandemic, Meritus Medical Center continues to provide high quality health care services to residents of our community and others throughout the western Maryland region. The health system's current effort to build a negative pressure and ventilator capable, 20 bed RIC Unit on its campus further demonstrates its commitment to protecting and promoting the health and wellness of our community. This coordinated and strategic plan will position Meritus to accept patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the western Maryland region. The RIC-Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons. Meritus Medical Center is not merely responding to the current pandemic through resiliency but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society.

I fully support this project for the health of my community and for the residents of the western Maryland region, and I ask that the commission approve this emergency Certificate of Need specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Dr. Boyd J. Michael, III
Superintendent

BOYS & GIRLS CLUB
OF WASHINGTON COUNTY

May 19, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

Meritus Medical Center continues to demonstrate its commitment to protecting and promoting the health and wellness of our community by engaging in the current effort to build a negative pressure and ventilator capable, 20-bed RIC-Unit on its campus. Crews are working day and night to complete the structure with the goal of accepting patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the western Maryland region. The RIC-Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons. Meritus Medical Center is not merely responding to the current pandemic through resiliency, but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society.

I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

A.J. Nardi

Addie Nardi
CEO

Celebrating 70 Years

1949 2019

Brook Lane

A Continuum of Mental Health Services

May 19, 2020

Mr. Ben Steffen, Executive Director
Dr Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

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I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please do not hesitate to contact me.

Sincerely,

R. Lynn Rushing
Chief Executive Officer

May 22, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

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I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Kevin Simmers
Brookes House

WASHINGTON COUNTY CHAMBER of Commerce
hagerstown.org

1 SOUTH POTOMAC STREET, HAGERSTOWN, MD 21740

May 27, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

On behalf of the Washington County Chamber of Commerce, representing 575 businesses with over 40,000 employees, please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

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I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me at 301-54-5738.

Sincerely,

Paul Frey

Paul Frey, IOM
President & CEO

CITY OF HAGERSTOWN
MARYLAND

DEPARTMENT OF POLICE
50 N Burhans Blvd.

Non Emergency 301-790-3700
Emergency 240-313-4345
Fax 301-733-5513

May 25, 2020

Mr. Ben Steffen, Executive Director
Dr Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

Meritus Medical Center continues to demonstrate its commitment to protecting and promoting the health and wellness of our community by engaging in the current effort to build a negative pressure and ventilator capable, 20-bed RIC-Unit on its campus. Crews are working day and night to complete the structure with the goal of accepting patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the western Maryland region. The RIC-Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons. Meritus Medical Center is not merely responding to the current pandemic through resiliency, but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society.

I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Chief Paul Kifer
Hagerstown City Police Department

A Nationally Accredited Law Enforcement Agency

Community Free Clinic
A Beacon for Medical & Mental Health in Washington County, Maryland

249 Mill Street
Hagerstown, MD 21740
Phone: 301-733-9234
Fax: 301-733-9205
www.mycommunityfreeclinic.org

May 19, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MIICC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

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I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Nicole R. Houser
Executive Director

PAUL D. CORDERMAN
Legislative District 2B
Washington County

Appropriations Committee

Public Safety and
Administration Subcommittee

Annapolis Office
The Maryland House of Delegates
6 Bladen Street, Room 213
Annapolis, Maryland 21401
410-841-3425 · 301-858-3425
800-492-7122 *Ext.* 3425
Fax 410-841-3414 · 301-858-3414
Paul.Corderman@house.state.md.us

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

District Office
5 Public Square, Suite 210
Hagerstown, Maryland 21740
240-313-3929

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Tuesday, May 26, 2020

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

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I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me

Sincerely,

Delegate Paul D. Corderman

Fahrney Keedy
ENRICHING THE LIVES OF SENIORS

8507 Maplaville Road
Boonsboro, MD 21713
301-733-6284
www.fkhv.org

5/19/2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

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The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

Meritus Medical Center continues to demonstrate its commitment to protecting and promoting the health and wellness of our community by engaging in the current effort to build a negative pressure and ventilator capable, 20-bed RIC-Unit on its campus. Crews are working day and night to complete the structure with the goal of accepting patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the western Maryland region. The RIC Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons. Meritus Medical Center is not merely responding to the current pandemic through resiliency, but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society.

As a healthcare entity that is engaged daily in our local partnership with Meritus Medical, Fahrney-Keedy Senior Living fully supports this project for our community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Stephen Coetzee, LNHA
President/CEO

FAMILY
HEALTHCARE
OF HAGERSTOWN

PRIMARY CARE | MENTAL HEALTH | DENTAL

May 19, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit).

Family Healthcare of Hagerstown is a Federally Qualified Health Center that provides primary care, integrated behavioral health services and dental care to medically underserved, low-income residents of Washington County. To ensure comprehensive care is provided, we rely on collaborative partners and Meritus Medical Center is one that is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

Meritus Medical Center continues to demonstrate its commitment to protecting and promoting the health and wellness of our community by engaging in the current effort to build a negative pressure and ventilator capable, 20-bed RIC-Unit on its campus. Crews are working day and night to complete the structure with the goal of accepting patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the western Maryland region. The RIC-Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons. Meritus Medical Center is not merely responding to the current pandemic through resiliency but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society.

I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please do not hesitate to contact me.

Sincerely,

Kimberly Z. Murdaugh, MPH
Executive Director

201 S. Cleveland Avenue, Hagerstown, MD 21740 familyhch.org 301.745.3777

LEADERSHIP
WASHINGTON COUNTY

May 19, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

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I fully support this project for my community and for the residents of the western Maryland region, and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Tara L. Sargent, D.Ed.
Executive Director
301.393.5323

MARYLAND
physicians care
MANAGED CARE ORGANIZATION

May 18, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

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I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Cynthia M. Demarest

Cynthia M. Demarest
Chief Executive Officer
Maryland Physicians Care

Meritus Healthcare Foundation

11116 Medical Campus Rd. Suite 3977
Hagerstown, MD 21742
Phone 301-790-8631
Fax 301-790-9233
www.meritushealth.com/foundation

May 27, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

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In representing the Meritus Healthcare Foundation's Board of Directors, and the unanimous support expressed therefrom, I speak in favor of this project, without reservation or exception. Accordingly, I highly encourage the Commission to approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

John A. Latimer, III
Chair, Board of Directors
Meritus Healthcare Foundation

Reach
OF WASHINGTON COUNTY

140 W. Franklin St. • Suite 300 • Hagerstown MD 21740
Phone: 301-733-2371 • Fax: 1-301-250-7308 • Email: info@reachofwc.org

May 19, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

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I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Dana Jenkins, MBA
Executive Director
301-733-2371 x 101

Christie Phillips

To: Maulik S. Joshi
Subject: RE: In Support of the Regional Infectious Containment Unit

From: Andrew D. McCarthy <Andrew.McCarthy@meritushealth.com>
Sent: Tuesday, June 2, 2020 2:57 PM
To: Maulik S. Joshi <Maulik.Joshi@meritushealth.com>
Subject: In Support of the Regional Infectious Containment Unit

Dear Dr Joshi,

I recently read about the new unit being built here on the Meritus Campus. I found the following clip in the Herald Media news concerning the unit:

"Meritus Health has started work on its previously announced $12.5 million, four-month project to create a regional treatment unit in response to the COVID-19 pandemic.

The addition will establish a 20-bed, negative pressure and ventilator-capable unit adjacent to the current wound center. The addition will cover about 12,650 square feet, Meritus announced in a news release Tuesday afternoon.

The new unit will provide surge capacity for immediate needs and serve as a future resource for the region.

'The unprecedented scope of the COVID-19 pandemic and danger to the public if additional capacity is not created within the Maryland health care system puts this project in the public's interest for ... much needed, high-acuity, inpatient capacity', Maulik Joshi, Meritus Health president and CEO, said in the release."

[Mike Lewis Herald Mail writer]

I want to give my enthusiastic support to this fantastic new regional infectious containment unit, currently being built on the Meritus Campus. I think it is a wonderful idea for reasons far greater than just for use during this Covid Pandemic. Yes it will, right now. It will help immensely in regards to giving the best care with minimal risks to health care workers and fellow patients during this COVID 19 crisis. But we should not think of this as a one time event

Infectious diseases, especially from respiratory illnesses, are one of the leading causes of death in the United States, AND are on the upswing. They affect people from the age of one day old to a hundred years old. Infectious illnesses are also the 3rd most preventable illness again when linked to respiratory diseases. Such a unit would help treat both. Better treatment for the respiratory disease and reduced spread to others!

What was so tragic in the Covid Pandemic was the initial reaction around the world to the respiratory illness. Every patient who became ill came to the hospital first and then infected countless others. We obviously have corrected much of this. Still, both patients and health care workers remain at risk without such RIC units that can create a negative pressure healing environment as well as a way to effectively reduce the risk of spread.

I have worked at several University level positions in health care over the last 33 years in medical practice. This may be the best idea to happen in that time. It is definitely needed. Lives will be saved! And so will dollars be saved, ones that would have gone to those people infected needlessly by not having such a unit in Hagerstown!

Sincerely

Andrew D McCarthy MD

Neurology and Rehabilitation

ANDREW A. SERAFINI
Legislative District 2
Washington County

Budget and Taxation Committee

Annapolis Office
James Senate Office Building
11 Bladen Street, Room 121
Annapolis, Maryland 21401
410-841-3903 301-858-3903
800-492-7122 *Ext* 3903
Fax 410-841-3940 301-858-3940
Andrew.Serafini@senate.state.md.us

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

District Office
P.O. Box 454
Williamsport, Maryland 21795
301-223-4188

May 29, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

Meritus Medical Center continues to demonstrate its commitment to protecting and promoting the health and wellness of our community by engaging in the current effort to build a negative pressure and ventilator capable, 20-bed RIC-Unit on its campus. Crews are working day and night to complete the structure with the goal of accepting patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the western Maryland region. The RIC-Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons. Meritus Medical Center is not merely responding to the current pandemic through resiliency, but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society.

I fully support this project for my community and for the residents of the western Maryland region. Therefore, I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Andrew A. Serafini

George C. Edwards
1st Legislative District
Garrett, Allegany and Washington Counties

Budget and Taxation Committee

Annapolis Office
James Senate Office Building
11 Bladen Street, Room 323
Annapolis, Maryland 21401
410-841-3565 · 301-858-3565
800-492-7122 *Ext.* 3565
Fax 410-841-3552 · 301-858-3552
George.Edwards@senate.state.md.us

District Office
Western Maryland Railway Station
13 Canal Street, Room 304
Cumberland, Maryland 21502
301-722-4780 · 866-430-9553
Fax 301-722-4790

The Senate of Maryland
ANNAPOLIS, MARYLAND 21401

May 19, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

Meritus Medical Center continues to demonstrate its commitment to protecting and promoting the health and wellness of our community by engaging in the current effort to build a negative pressure and ventilator capable, 20-bed RIC-Unit on its campus. Crews are working day and night to complete the structure with the goal of accepting patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the western Maryland region. The RIC-Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons. Meritus Medical Center is not merely responding to the current pandemic through resiliency, but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society.

I fully support this project for my community and for the residents of the Western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please do not hesitate to contact me.

Sincerely,

George C. Edwards

Shepherd
UNIVERSITY

Office of the President

PO Box 5000
Shepherdstown
West Virginia 25443-5000
t 304-876-5107
f 304-876-6007

May 18, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak:

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

Meritus Medical Center continues to demonstrate its commitment to protecting and promoting the health and wellness of our community by engaging in the current effort to build a negative pressure and ventilator capable, 20-bed RIC-Unit on its campus. Crews are working day and night to complete the structure with the goal of accepting patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the western Maryland region. The RIC-Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons. Meritus Medical Center is not merely responding to the current pandemic through resiliency, but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society.

I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me at 304-876-5107.

With best wishes,

Mary J.C. Hendrix

Mary J.C. Hendrix, Ph.D.
President

The Arc.
Washington County

Achieve with us®

19-May-2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

Meritus Medical Center continues to demonstrate its commitment to protecting and promoting the health and wellness of our community by engaging in the current effort to build a negative pressure and ventilator capable, 20-bed RIC-Unit on its campus. Crews are working day and night to complete the structure with the goal of accepting patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the western Maryland region. The RIC-Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons. Meritus Medical Center is not merely responding to the current pandemic through resiliency but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society.

As the Executive Director for a large Developmental Disabilities provider in Washington County this project is particularly important to us as we provide supports in hundreds of vulnerable Marylanders. I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Troy Van Scoyoc
Executive Director

The Arc of Washington County
820 Florida Ave, Hagerstown, MD 21740
Phone 301-733-3550
Fax 301-745-5573
arcwc-md.org

May 28, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

Meritus Medical Center continues to demonstrate its commitment to protecting and promoting the health and wellness of our community by engaging in the current effort to build a negative pressure and ventilator capable, 20-bed RIC-Unit on its campus. Crews are working day and night to complete the structure with the goal of accepting patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the western Maryland region. The RIC-Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons. Meritus Medical Center is not merely responding to the current pandemic through resiliency, but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society.

I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me. I may be reached at hguessford@unitedwaywashcounty.org or by phone 301.739.8200 x 102.

Sincerely,

Heather H. Guessford
President and CEO

USMH
UNIVERSITY SYSTEM of MARYLAND | HAGERSTOWN

May 22, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

It is my privilege as Executive Director of the University System of Maryland at Hagerstown (USMH) to support the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems.

Meritus Medical Center continues to demonstrate its commitment to protecting and promoting the health and wellness of our community by engaging in the current effort to build a negative pressure and ventilator capable, 20-bed RIC-Unit on its campus. Crews are working day and night to complete the structure with the goal of accepting patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the western Maryland region. The RIC-Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons.

Meritus Medical Center is not merely responding to the current pandemic through resiliency, but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society. As USMH develops contingency plans for the future in addressing the safety of our students, faculty and staff, we look to Meritus as our chief local healthcare resource.

I fully support this project for our Washington County community and the residents of the western Maryland region. I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Mark C. Halsey

Executive Director
Email: mchalsey@hagerstown.usmd.edu

32 W. Washington Street • Hagerstown, MD 21740 • Phone: 240.527.2060 • Fax: 240.527.2742

Washington County
MARYLAND

BOARD OF COUNTY COMMISSIONERS OF
WASHINGTON COUNTY, MARYLAND

June 4, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the western Maryland region.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

Meritus Medical Center continues to demonstrate its commitment to protecting and promoting the health and wellness of our community by engaging in the current effort to build a negative pressure and ventilator capable, 20-bed RIC-Unit on its campus. Crews are working day and night to complete the structure with the goal of accepting patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the western Maryland region. The RIC-Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons. Meritus Medical Center is not merely responding to the current pandemic through resiliency, but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society.

I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Cort F. Meinelschmidt
County Commissioner

100 West Washington Street, Suite 1101 | Hagerstown, MD 21740 | P: 240.313 2200 | F: 240.313.2201 | TDD: 711

WWW.WASHCO-MD.NET

Office of the Sheriff:
Washington County
500 Western Maryland Parkway
Hagerstown, MD 21740-5199
Sheriff Douglas W. Mullendore

OFFICE: 240-313-2101
FAX: 240-313-2105
Email: dmullendore@washco-md.net

May 19, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

Please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Meritus Medical Center is vitally important to providing high-quality health care services to the citizens of Washington County and throughout the Western Maryland region. The Washington County Sheriff's Office provides a level of security at Meritus Medical Center and we certainly see the need for this Certificate of Need, not only during the COVID-19 pandemic but well into the future.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

Meritus Medical Center continues to demonstrate its commitment to protecting and promoting the health and wellness of our community by engaging in the current effort to build a negative pressure and ventilator capable, 20-bed RIC-Unit on its campus. Crews are working day and night to complete the structure with the goal of accepting patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the Western Maryland region. The RIC-Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons. Meritus Medical Center is not merely responding to the current pandemic through resiliency, but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society.

I fully support this project for my community and for the residents of the Western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Doug Mullendore

Sheriff Doug Mullendore
Washington County, Maryland

Meritus Health

PARISH NURSING PROGRAM

A Journey Toward Wholeness

June 2, 2020

Mr. Ben Steffen, Executive Director
Dr. Andrew Pollak, MHCC Chairman
Maryland Health Care Commission (MHCC)
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Steffen and Dr. Pollak,

I manage the Parish Nursing Program for our Washington County/Tri-State area and on behalf of the 28,198 faith community members that are reached by this program, please accept this letter of support for the Certificate of Need (CON) application submitted by Meritus Medical Center (MMC) to establish a Regional Infectious Containment Unit (RIC-Unit). Our parish nurses volunteer to serve in over 50 faith communities located in Western Maryland, Pennsylvania and West Virginia. Many parishioners travel across state lines to benefit from the high-quality health care services at Meritus Medical Center. In addition, Meritus Medical Center ranks in the top quartile for delivering cost effective services and is setting the course to be the lowest total cost of care provider in the state of Maryland.

The recent COVID-19 pandemic has challenged our nation, our state and our community in ways never before experienced in our lifetime. COVID-19 has shown how a single point of infection can infiltrate and proliferate throughout communities and compromise entire health care systems as well as global economies.

Meritus Medical Center continues to demonstrate its commitment to protecting and promoting the health and wellness of our community by engaging in the current effort to build a negative pressure and ventilator capable, 20-bed RIC-Unit on its campus. Crews are working day and night to complete the structure with the goal of accepting patients by August 2020, which coincides with the estimated timeframe that the COVID-19 virus will reach its peak in the western Maryland region. The RIC-Unit will be a permanent addition to Meritus Medical Center and will prepare the region for the second and future surges and peaks during the approaching autumn and winter seasons. Meritus Medical Center is not merely responding to the current pandemic through resiliency, but is adapting to the changes that this and future contagious diseases and pandemics will bring to our community and our society.

I fully support this project for my community and for the residents of the western Maryland region and I ask that the commission approve this emergency certificate of need (CON) specific to Meritus Medical Center's application for the construction of the RIC-Unit.

Should you have any questions, please don't hesitate to contact me.

Sincerely,

Wendy Zimmerman, BSN, RN-BC

Wendy Zimmerman, BSN, RN-BC
Parish Nursing Program Manager

1799 Howell Road Hagerstown, MD 21740 (301) 766-7840 (301) 766-7830 Fax
wendy.zimmerman@meritushealth.com
an affiliate of Meritus Health

EXHIBIT 13

EXHIBIT 14

Schedule 2

MERITUS MEDICAL CENTER, INC.

Consolidating Statement of Operations and Change in Net Assets

Year ended June 30, 2019

(Dollars in thousands)

Fiscal period ending June 30, 2019	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total	Consolidating entries	Consolidated total
Unrestricted revenue, gains and other support:						
Net patient revenue	$ 321,342	—	67,445	388,787	(11,938)	376,849
Other revenue	10,944	79	1,095	12,118	(2,506)	9,612
Equity earnings in affiliates	3,826	—	746	4,572	—	4,572
Net assets released from restriction used for operations	832	790	—	1,622	(577)	1,045
	336,944	869	69,286	407,099	(15,021)	392,078
Operating expenses:						
Salaries and wages	123,429	287	36,824	160,540	—	160,540
Benefits	29,607	78	6,756	36,441	(330)	36,111
Professional fees	15,570	—	334	15,904	—	15,904
Supplies and other	128,048	150	39,824	168,022	(14,114)	153,908
Interest	11,443	—	6	11,449	—	11,449
Depreciation and amortization	23,659	—	1,316	24,975	—	24,975
	331,756	515	85,060	417,331	(14,444)	402,887
Operating income (loss)	5,188	354	(15,774)	(10,232)	(577)	(10,809)
Nonoperating gains (losses), net:						
Investment returns, net	7,283	337	1,016	8,636	—	8,636
Other, net	(65)	(660)	—	(725)	577	(148)
Income tax expense	(5)	—	(54)	(59)	—	(59)
Excess (deficit) of revenue over expenses	$ 12,401	31	(14,812)	(2,380)	—	(2,380)

Schedule 2

MERITUS MEDICAL CENTER, INC.

Consolidating Statement of Operations and Change in Net Assets

Year ended June 30, 2020

(Dollars in thousands)

Fiscal period ending June 30, 2020	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total	Consolidating entries	Consolidated total
Unrestricted revenue, gains and other support:						
Net patient revenue	$ 314,201	—	66,189	380,390	(12,419)	367,971
Other revenue	23,018	260	2,049	25,327	(3,496)	21,831
Equity earnings in affiliates	3,517	—	931	4,448	—	4,448
Net assets released from restriction used for operations	1,051	712	—	1,763	(630)	1,133
	341,787	972	69,169	411,928	(16,545)	395,383
Operating expenses:						
Salaries and wages	129,925	297	36,706	166,928	—	166,928
Benefits	30,676	81	6,936	37,693	(277)	37,416
Professional fees	16,170	—	351	16,521	—	16,521
Supplies and other	113,760	132	42,760	156,652	(15,388)	141,264
Interest	11,197	—	6	11,203	—	11,203
Depreciation and amortization	24,664	—	1,343	26,007	—	26,007
	326,392	510	88,102	415,004	(15,665)	399,339
Operating income (loss)	15,395	462	(18,933)	(3,076)	(880)	(3,956)
Nonoperating gains (losses), net:						
Investment returns, net	3,385	117	1,375	4,877	—	4,877
Other, net	(64)	(892)	1	(955)	880	(75)
Income tax expense	(46)	—	(287)	(333)	—	(333)
Excess (deficit) of revenue over expenses	$ 18,670	(313)	(17,844)	513	—	513

Schedule 2

MERITUS MEDICAL CENTER, INC.

Consolidating Statement of Operations and Changes in Net Assets

Year ended June 30, 2021

(Dollars in thousands)

Fiscal period ending June 30, 2021	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total	Consolidating entries	Consolidated total
Unrestricted revenue, gains and other support:						
Net patient revenue	$ 381,605	—	82,116	463,721	(14,815)	448,906
Other revenue	17,254	376	3,753	21,383	(3,258)	18,125
Equity earnings in affiliates	11,760	—	902	12,662	—	12,662
Net assets released from restriction used for operations	795	551	—	1,346	(513)	833
	411,414	927	86,771	499,112	(18,586)	480,526
Operating expenses:						
Salaries and wages	151,313	—	45,976	197,289	—	197,289
Benefits	33,976	—	7,479	41,455	(464)	40,991
Professional fees	17,587	—	390	17,977	—	17,977
Supplies and other	102,049	185	40,354	142,588	(17,609)	124,979
Interest	10,919	—	4	10,923	—	10,923
Depreciation and amortization	24,184	—	1,280	25,464	—	25,464
	340,028	185	95,483	435,696	(18,073)	417,623
Operating income (loss)	71,386	742	(8,712)	63,416	(513)	62,903
Nonoperating gains (losses), net:						
Investment returns, net	42,298	1,643	2,043	45,984	—	45,984
Other, net	(27)	(1,019)	—	(1,046)	513	(533)
Income tax expense	(1)	—	(246)	(247)	—	(247)
Excess (deficit) of revenue over expenses	$ 113,656	1,366	(6,915)	108,107	—	108,107

Schedule 2

MERITUS MEDICAL CENTER, INC. AND SUBSIDIARIES

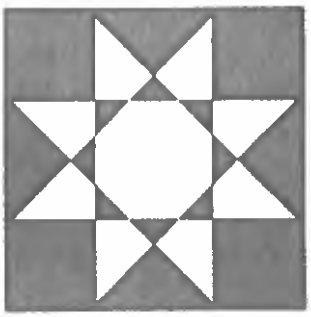
Consolidating Statement of Operations and Changes in Net Assets

Year ended June 30, 2022

(Dollars in thousands)

Fiscal period ending June 30, 2022	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total	Consolidating entries	Consolidated total
Unrestricted revenue, gains and other support:						
Net patient revenue	$ 381,142	—	105,617	486,759	(15,065)	471,694
Other revenue	16,132	308	(681)	15,759	(1,371)	14,388
Equity earnings in affiliates	3,024	—	1,203	4,227	—	4,227
Net assets released from restriction used for operations	951	938	—	1,889	(890)	999
	401,249	1,246	106,139	508,634	(17,326)	491,308
Operating expenses:						
Salaries and wages	183,614	2	52,691	236,307	—	236,307
Benefits	36,426	1	8,880	45,307	(487)	44,820
Professional fees	19,978	—	10,271	30,249	—	30,249
Supplies and other	108,860	105	38,234	147,199	(15,949)	131,250
Interest	11,170	—	2	11,172	—	11,172
Depreciation and amortization	24,951	—	1,565	26,516	—	26,516
	384,999	108	111,643	496,750	(16,436)	480,314
Operating income (loss)	16,250	1,138	(5,504)	11,884	(890)	10,994
Nonoperating (losses), net:						
Investment returns, net	(38,928)	(1,342)	(2,043)	(42,313)	—	(42,313)
Other, net	(697)	(1,522)	—	(2,219)	890	(1,329)
Income tax expense	(34)	—	(304)	(338)	—	(338)
(Deficit) of revenue over expenses	$ (23,409)	(1,726)	(7,851)	(32,986)	—	(32,986)

EXHIBIT 15



WASHINGTON COUNTY
HEALTH SYSTEM

CERTIFICATE OF NEED APPLICATION

WASHINGTON COUNTY HOSPITAL REPLACEMENT PROJECT

September 10, 2004

MARYLAND HEALTH CARE COMMISSION

03-21-2116
DOCKET NO.

DATE DOCKETED

HOSPITALS
APPLICATION FOR CERTIFICATE OF NEED

ALL PAGES THROUGHOUT THE APPLICATION SHOULD BE NUMBERED CONSECUTIVELY.

PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION

1.a. Washington County Hospital Association
Legal Name of Project Applicant
(i.e. Licensee or Proposed Licensee)

b. 251 East Antietam Street
Street

c. Hagerstown 21740 Washington
City Zip County

d. 301 790 8000
Telephone

e. James P. Hamill
Name of Owner/Chief Executive

2.a. _____
Legal Name of Project Co-Applicant
(i.e. if more than one applicant)

b. _____
Street

c. _____
City Zip County

d _____
Telephone

e. _____
Name of Owner/Chief Executive

3.a. Washington County Hospital
Name of Facility

b. 251 East Antietam Street
Street (Project Site)

c. Hagerstown 21740 Washington
City Zip County

4. _____
Name of Owner (if different than applicant)

5.a. _____
Representative of Co-Applicant

b. _____
Street

c. _____
City Zip County

4. _____
Telephone

6. Person(s) to whom questions regarding this application should be directed: (Attach sheets if additional persons are to be contacted)

a. James P. Hamill, President
Name and Title

b. 251 East Antietam Street
Street

c. Hagerstown 21740 Washington
City Zip County

a. Raymond Grahe, CFO
Name and Title

b. 251 East Antietam Street
Street

c. Hagerstown 21740 Washington
City Zip County

a. Jack C. Tranter, Esq.
Name and Title

b. Gallagher Evelius & Jones LLP
218 N. Charles Street
Street

c. Baltimore 21201 Baltimore City
City Zip County

a. Richard S. Coughlan
Name and Title

b. Cohen, Rutherford, Blum & Schott, PC
6903 Rockledge Drive, Suite 1330
Street

c. Bethesda 20817
City Zip County

7. Brief Project Description (for identification only; see also item #14):

Washington County Hospital Association ("WCHA") proposes to replace Washington County Hospital. The new hospital will be located adjacent to Robinwood Medical Center.

8. Legal Structure of Licensee (check one from each column):

a. Governmental _____
Proprietary _____
Nonprofit √

b. Sole Proprietorship _____
Partnership _____
Corporation √
Subchapter "S" _____

c. To be Formed _____
Existing √

9. Current Licensed Capacity and Proposed Changes:

Service	Current Licensed Beds (as of July 1, 2004)	Beds to be Added or Reduced	Total Beds if Project is Approved
M/S/G/A	181	-4	177
Pediatrics	9	-1	8
Obstetrics	15	+5	20
ICU/CCU Care	20	+4	24
Psychiatry	18	0	18
Rehabilitation	28	-8	20
Chronic			
Other (Specify			
TOTAL BEDS	271	-4	267

10. Project Location and Site Control:

A. Site Size 34.64 acres

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

WCHA is working with Washington County representatives to obtain all necessary land-use approvals so that the new hospital can be constructed at Robinwood. WCHA anticipates that all approvals will be obtained by December 31, 2004.

C. Site Control:

(1) Title held by: Washington County Endowment Development Company, Inc.

(2) Options to purchase held by: _____
(i) Expiration Date of Option _____
(ii) Is Option Renewable? _____ If yes, Please explain
_____
_____
(iii) Cost of Option _____

(3) Land Lease held by: _____
(i) Expiration Date of Lease _____
(ii) Is Lease Renewable? _____ If yes, please explain
_____
_____
(iii) Cost of Lease _____

(4) Option to lease held by: _____
(i) Expiration date of Option _____
(ii) Is Option Renewable? _____ If yes, please explain
_____
_____

(iii) Cost of Option _____

(5) If site is not controlled by ownership, lease, or option, please explain how site control will be obtained.

The site will be conveyed to WCHA by the current owner, Washington County Endowment Development Company, Inc.

(INSTRUCTION: IN COMPLETING ITEMS 11, 12 & 13, PLEASE NOTE APPLICABLE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

11. Project Implementation Target Dates (for construction or renovation projects):

A. Obligation of Capital Expenditure 3 months from approval date.
B. Beginning Construction 1 months from capital obligation.
C. Pre-Licensure/First Use 30 months from capital obligation.
D. Full Utilization 12 months from first use.

12. Project Implementation Target Dates (for projects not involving construction or renovations):

A. Obligation of Capital Expenditure _____ months from approval date.
B. Pre-Licensure/First Use _____ months from capital obligation.
C. Full Utilization _____ months from first use.

13. Project Implementation Target Dates (for new service projects not involving a capital expenditure):

A. Obligation of Capital Expenditure _____ months from approval date.
B. Pre-Licensure/First Use _____ months from capital obligation.
C. Full Utilization _____ months from first use.

14. Project Description:

Describe the project's construction and renovation plan, and all services to be provided following completion of the project.

See Exhibit 1.

15. Project Drawings:

Projects involving renovations or new construction should include architectural drawings outlining the current facility (if applicable), the new facility (if applicable) and the proposed new configuration. These drawings should include, as applicable:

1) the number and location of nursing stations,
2) approximate room sizes,
3) number of beds to a room,
4) number and location of bath rooms,
5) any proposed space for future expansion, and
6) the "footprint" and location of the facility on the proposed or existing site.

See Exhibit 2.

16. Features of Project Construction:

A. Please Complete **"CHART 1. PROJECT CONSTRUCTION CHARACTERISTICS"** describing the applicable characteristics of the project, if the project involves new construction.

B. Explain any plans for bed expansion subsequent to approval which are incorporated in the project's construction plan.

The new hospital will not include space for bed expansion.

C. Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.

Discussions with the City of Hagerstown regarding water and sewer service are underway. Representatives of the Hospital have developed in conjunction with the staff of the City of Hagerstown's engineering Department, solutions for the water and sewer issues. The Hospital has been in active negotiations with the City staff for nearly five months defining the issues associated with the relocation. The hospital has also been in discussion with Alleghany Energy for the connection of the electrical service. The hospital has been working closely with the County Government for a developer's agreement for the road improvements to the Robinwood corridor. All of the identified costs of the water and sewer utility connections, and road improvements have been included in the Project Budget in the budget line item of $7,580,760 entitled APFO, Water , Sewer, Connection fees. We believe these costs to be an accurate assessment of the costs to be incurred for the Project

Chart 1: Project Construction Characteristics

Base Building Characteristics			Complete if Applicable
Class of Construction			
Class A			X
Class B			
Class C			
Class D			
Type of Construction/Renovation			
Low			
Average			
Good			X
Excellent			
Number of Stories			5
Total Square Footage			
First Floor			163,435
Second Floor			171,792
Third Floor			74,634
Fourth Floor			53,616
Fifth Floor (includes Penthouse of 2,249 DGSF)			39,031
Perimeter in Linear Feet			
First Floor			2,178
Second Floor			3,937
Third Floor			2,317
Fourth Floor			1,785
Fifth Floor			1,205
Wall Height (floor to eaves)			
First Floor			16'
Second Floor			16'
Third Floor			14'
Fourth Floor			14'
Fifth Floor			16' 6"
Elevators			
Type	*Passenger*	*Freight*	
Number	10	3	
Sprinklers (Wet or Dry System)			Wet
Type of HVAC System			Central Plant
Type of Exterior Walls			Masonry and Pre-Cast
Costs			
Site Preparation			
Normal Site Preparation*			X
Demolition			X
Storm Drains			X
Rough Grading			X
Hillside Foundation			
Terracing			
Pilings			X
Offsite Costs			
Roads			X
Utilities			X
Jurisdictional Hook-up Fees			X
Signs			X
Landscaping			X

*As defined by Marshall Valuation Service. Copies of the definitions may be obtained by contacting staff of the Commission.

PART II – PROJECT BUDGET

(INSTRUCTION: All estimates for 1.a.-e., 2.a.-h., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken)

A. Use of Funds

1. Capital Costs:

a.	New Construction	
(1)	Building	$ 89,537,000[1]
(2)	Fixed Equipment (not included in construction)	10,728,000
(3)	Land Purchase	
(4)	Site Preparation	7,670,800
(5)	Architect/Engineering Fees	7,760,000
(6)	Permits, (Building, Utilities, Etc)	230,000
SUBTOTAL		$ 115,925,800
b.	Renovations	
(1)	Building Demolition	$ 3,140,000
(2)	Fixed Equipment (not included in construction)	
(3)	Architect/Engineering Fees	
(4)	Permits, (Building, Utilities, Etc.)	
SUBTOTAL		$ 3,140,000
c.	Other Capital Costs	
(1)	Major Movable Equipment	26,899,000
(2)	Minor Movable Equipment	3,249,000
(3)	Contingencies	9,750,131
(4)	Other (See Below)	
	MIS/Signage/Security	5,227,000
	IT/Telephone Fit-Out	240,000
	Consulting Services	2,798,846
	Connection Fees, APFO, Roads, Water, Sewer	7,580,760
SUBTOTAL		$ 55,744,743
TOTAL CURRENT CAPITAL COSTS (a – c)		$ 174,810,543
d.	Inflation Allowance (@7.2% Per Year from Application Submission Date to Midpoint Of Construction)	$ (included above)
e.	Capitalized Construction Interest (gross)	$ 34,050,859

[1] Represents the GMP estimate effective through October, 2004, and includes an inflation allowance to midpoint of construction.

TOTAL PROPOSED CAPITAL COSTS (a – e)		$ 208,801,402

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	$ 2,740,703
b.	Bond Discount	
c.	Legal Fees, Printing, etc.	50,000
d.	Consultant Fees	
	CON Application Assistance	150,000
	Other (Specify)	
e.	Liquidation of Existing Debt	2,739,434
f.	Debt Service Reserve Fund	16,235,091
g.	Principal Amortization Reserve Fund	
h.	Other (Specify)	
	TOTAL (a - h)	$ 21,915,228
3.	Working Capital Startup/Transition Costs	$ 2,500,000
	TOTAL USES OF FUNDS (1 -3)	$ 233,276,630

B. Sources of Funds for Project:

1.	Cash	5,283,266
2.	Pledges: Gross $10,000,000 less allowance for uncollectible $ 0 = Net	10,000,000
3.	Gifts, bequests	
4.	Interest Income (gross)	7,248,364
5.	Authorized Bonds	210,745,000
6.	Mortgage	
7.	Working capital loans	
8.	Grants or Appropriation	
	(a) Federal	
	(b) State	
	(c) Local	
9.	Other	
TOTAL SOURCES OF FUNDS (1-9)		$ 233,276,630

Lease Costs:

a. Land	$_____	x _____	=	$_____
b. Building	$_____	x _____	=	$_____
c. Major Movable Equipment	$_____	x _____	=	$_____
d. Minor Movable Equipment	$_____	x _____	=	$_____
e. Other (Specify)	$_____	x _____	=	$_____

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

(INSTRUCTION: Each applicant must respond to all criteria included in COMAR 10.24.01.08G(3), listed below.)

10.24.01.08G(3)(a). <u>The State Health Plan</u>.

List each applicable standard from the appropriate chapter of the State Health Plan and provide a direct, concise response explaining the project's consistency with that standard. In cases where standards require specific documentation, please include the documentation as a part of the application. (Copies of the State Health Plan are available from the Commission. Contact the Staff of the Commission to determine which standards are applicable to the Project being proposed.)

COMAR 10.24.10, the Acute Inpatient Services Chapter (the "Acute Care Chapter"), COMAR 10.24.12, the Obstetrics Services Chapter (the "OB Chapter"), and COMAR 10.24.09.04, the Acute Inpatient Rehabilitation Services Chapter (the "Rehab Chapter"), are discussed below.

THE ACUTE CARE CHAPTER
COMAR 10.24.10.06A

Section .06A(1) Identification of Bed Need:

(a) Minimum and maximum need for acute inpatient medical/ surgical/gynecological/ addictions, obstetrical, and pediatric beds are identified using the need projection methodologies in Regulation .07 of this Chapter.

(b) Projected need for trauma, critical care, and progressive care beds, and care for AIDS patients, is included in the calculated medical/surgical/gynecological/addictions need projection.

(c) Additional MSGA or pediatric beds shall be constructed or put into operation such that the total bed capacity increases only if:

(i) The total number of beds added does not cause the total bed capacity of the hospital to exceed the most recent calculation of licensed bed capacity for the hospital pursuant to §19.307.2 of Health General Article; or,

(ii) Such addition is consistent with the jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .07 of this Chapter.

(iii) If consistent with Regulation .5C3, the total number of MSGA and pediatric beds proposed for addition may be derived through application of the projection method, assumptions and targets contained in the most recent iteration of the applicable bed need projection methodology in Regulation .07 of this Chapter, as applied to the service area of the hospital.

The proposed replacement hospital includes 201 MSGA and eight pediatric beds. As of July 1, 2004, WCHA is licensed to operate 201 MSGA and nine pediatrics beds. As explained below, inclusion of 201 MSGA and eight pediatric beds in the replacement hospital is consistent with the bed need methodologies in the Acute Care Chapter.

The Acute Care Chapter estimates a need for no fewer than eight and no more than nine pediatric beds in Washington County in 2010. See Table 2, Appendix at A-2. Inclusion of an eight-bed pediatrics unit in the replacement hospital is consistent with these projections.

In terms of MSGA beds, Table 1 of the Acute Care Chapter includes two bed need projections; i.e., a "low forecast" of 182 beds and a "high forecast" of 201 beds. These estimates are based on a forecast of MSGA discharges in 2010 and two different ALOS assumptions.

The Acute Care Chapter projects that MSGA discharges at WCHA, the only acute care hospital in Washington County, will increase at an annual average rate of 2.1%, i.e., from 10,799 in 2002 to 12,708 in 2010. WCHA projects that admissions will increase from 11,448 in FY '04 to 12,660 in FY '10, an average annual increase of 1.3%. Clearly, the MSGA discharges projected by the Acute Care Chapter for 2010 (12,708) and the admissions projected by WCHA for that year (12,660) are consistent.

The Acute Care Chapter's "high forecast" projection of 201 MSGA beds is based on an average length of stay ("ALOS") assumption of 4.6 days (12,708 admissions x 4.6 ALOS = 58,457 patient days ÷ 365 days = 160.2 average daily census ("ADC") ÷ .80 occupancy = 201 beds). The "low forecast" results from an ALOS assumption of 4.2 days (12,708 admissions x 4.2 ALOS = 53,374 patient days ÷ 365 = 146.23 ADC ÷ .80 = 182.8. Since the discharge projection in the methodology and the admissions estimate

made by WCHA are consistent, the question then becomes: What ALOS assumption should be used to forecast bed need at WCHA in FY 2010?

The "low forecast" of ALOS assumption of 4.2 days assumes that length of stay will continue to decline at the annual average rate of decline for the period CY 1997 to CY 2002. WCHA does not believe that this is the appropriate benchmark in this case. First, over the last several years the case mix adjusted ALOS at WCHA has increased (i.e., from 4.43 in CY 2001 to 4.55 in CY 2002 to 4.66 in Cy 2003), not declined as the Acute Care Chapter "low forecast" projects. For CY 2003, WCHA's MSGA case-mix adjusted ALOS, at 4.66, increased from 4.55 days calculated for the year before. During this same period, not surprisingly, the actual ALOS at WCHA increased from 4.61 days in CY 2002 to 4.80 days in CY 2003. In light of this recent experience and a case mix adjusted ALOS in CY 2003 that is consistent with the 4.6 ALOS assumption in the methodology for CY 2010, WCHA believes that the high forecast of 201 MSGA beds in 2010 is the appropriate estimate to use in this case. [2]

Moreover, WCHA anticipates that its actual ALOS will decline somewhat over the next few years and be more consistent with the statewide average, as WCHA's experience has been in the past. One step already taken to achieve this objective is initiation of a hospitalist program.

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[2] However, MSGA admissions at WCHA increased by 8.1% from FY '00 to FY '04. If this rate of growth continues, MSGA admissions will increase to 13,908 in 2010. As noted above, WCHA does not believe that the Acute Care Chapter's "low forecast" ALOS assumption of 4.2 is the appropriate standard to project MSGA bed need in Washington County in 2010. However, if this benchmark is used and admissions continue to grow at the same rate to 2010, WCHA will need 201 beds (13,908 x 4.2 = 58,414 day/365 = 160 ADC ÷ .8 = 200.04 = 201 MSGA beds).

The hospital completed an extensive bid process with several companies who provide hospitalist programs. The bid process, which included active participation of members of the medical staff, as well as hospital administration. The program has been approved by all parties, both Board and Medical Staff, and the hospital is now under active contract negotiations with the firm selected from the bid process.

WCHA's actual ALOS in FY '02 and FY '03 was also affected by establishment of a Rapid Diagnostic Center ("RDC"). Five hundred and two patients who would have previously been admitted with an average ALOS of one day were diagnosed and treated on an outpatient basis in the RDC. In FY '03, the number of admissions that were averted in this manner increased to 1,024. In FY '04, the number of admissions that were averted increased again to 1,306. As a result of diverting "short stay" admissions, WCHA's actual and CMA ALOS increased. The impact of treating patients previously admitted on an outpatient basis in the RDC is related below. As shown there, if these cases had been admitted, WCHA's actual ALOS would have been substantially lower (4.21 rather than 4.61 in CY 2002 and 4.44 rather than 4.80 in CY 2003). Equally important, WCHA's actual ALOS would have been below the case-mix adjusted ALOS standard.

	CY 2002	CY 2003
Total MSGA Discharges	10,768	11,336
Total Patient Days	49,658	54,424
Actual ALOS	4.61	4.80
Case-Mix Adjusted ALOS	4.55	4.66
RDC Cases	629	932
Adjusted Admissions	11,957	12,268
Adjusted Patient Days	50,287	54,412
Adjusted ALOS	4.21	4.44
Adjusted ALOS/Case-Mix Adjusted ALOS	.93	.95

Source: Washington County Hospital, MHCC, Actual and Case-Mix Adjusted (CMA) Average Length of Stay (ALOS) Selected Maryland Hospitals ,April, 2004.

Section .06A(2). Utilization Review and Control Programs. Each hospital shall participate in or have utilization review and control programs and treatment protocols, including written policies governing admission, length of stay, and discharge planning and referral, which conform to the requirements of Health-General Article, ' 19-131(d), and enforcing regulations.

Existing utilization review programs and protocols (including written policies governing admission, length of stay, discharge planning and referral) will be used at the new hospital. These programs and policies conform to the requirements of Health-General Article §19-319(d) and applicable regulations, as required by this standard. The Utilization Management Plan is included as Exhibit 3.

Section .06A(3). Travel Time. Medical/surgical/gynecological/addictions, critical and progressive care, obstetrical, and pediatric services shall be available within 30 minutes one-way average automobile travel time under normal driving conditions for at least 90 percent of each health service area's population.

Relocation to Robinwood will have no impact on the availability of the identified services. As is the case now, all of the identified services will be within 30 minutes drive time for 90% of Washington County's population.

Section .06A(4). Information Regarding Charges. Each hospital shall provide to the public, upon inquiry, information concerning charges for and the range and types of services provided.

WCHA's practice of providing the identified information to the public upon request will continue at the new hospital. A copy of the Patient Pamphlet that is in use now and will be used at the new hospital is included as Exhibit 4.

Section .06A(5). Charity Care Policy.

(a) Each hospital shall develop a written policy for the provision of complete and partial charity care for indigent and Medicaid patients to promote access to all services regardless of an individual's ability to pay.

(b) Public notice and information regarding a hospital's charity care policy shall include, at a minimum, the following:

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

(ii) Posted notices in the admission, business office, and, if existing, emergency room areas within the hospital; and

(iii) Individual notice provided to each person who seeks services in the hospital at the time of preadmission or admission.

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

WCHA will continue to provide inpatient and other care to all patients regardless of ability to pay. WCHA's current charity care policy will be used at the new hospital and is included as Exhibit 5. Notices regarding the availability of charity care will be posted in the emergency department and other locations. Annual notices will be published in The Herald-Mail, a Washington County newspaper, as is done now. Each patient or patient representative will be advised of WCHA's charity care policy at the time of admission or outpatient registration. WCHA's charity care policy specifically states that if charity care is requested, the patient is given a determination regarding his or her eligibility within two business days. As noted above, this policy will be used at the new hospital.

Section .06A(6). Compliance with Quality Standards. Each hospital shall be able to demonstrate upon request by the Commission, compliance with all-mandated federal, state, and local health and safety regulations, applicable Joint Commission on Accreditation of Healthcare Organizations and other appropriate national accrediting organization standards, applicable state certification standards, unless otherwise exempted by an appropriate waiver.

WCHA currently complies with all applicable federal, state and local health and safety regulations. This will continue at the new hospital. Following a May, 2004 survey, the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") accredited WCHA for three years, subject to WCHA correcting a few deficiencies by September, 2004 (See Exhibit 6). WCHA filed a Plan of Correction addressing the few deficiencies identified by JCAHO. In June of 2004, the Office of Health Care Quality ("OHCQ") of the Maryland Department of Health and Mental Hygiene, as agent for the federal Centers for Medicare and Medicaid Services ("CMS"), surveyed WCHA to validate the JCAHO survey. WCHA filed a Plan of Correction addressing the few deficiencies identified by OHCQ.

Section .06A(7). Transfer and Referral Agreements.

(a) Each hospital shall have written transfer and referral agreements with:

(i) Facilities capable of managing cases which exceed its own capabilities; and

(ii) Facilities that provide inpatient, outpatient, long term, home health, aftercare, follow-up, and other alternative treatment programs appropriate to the types of services the hospital offers.

(b) Written transfer agreements shall meet the requirements of Department of Health and Mental Hygiene regulations implementing Health-General Article 19-308.2 and shall include, at a minimum, the following:

(i) A mechanism for notifying the receiving facility of the patient's health status and services needed by the patient prior to transfer;

(ii) That the transferring hospital will provide appropriate life-support measures, including personnel and equipment, to stabilize the patient before transfer and to sustain the patient during transfer;

(iii) That the transferring hospital will provide all-necessary patient records to the receiving facility to ensure continuity of care for the patient; and

(iv) A mechanism for the receiving facility to confirm that the patient meets its admission criteria relating to appropriate bed, physician, and other services necessary to treat the patient.

Existing transfer agreements will be used at the new hospital. WCHA has numerous transfer and referral agreements, including ten with local nursing homes, and six with neighboring hospitals. All transfer agreements meet applicable state requirements. For tertiary care, WCHA will continue the current practice of following established state guidelines, including MIEMSS protocols and internal policies and procedures. WCHA's transfer and referral agreements are found at Exhibit 7.

Section .06A(8). Outpatient Services. Each hospital shall offer outpatient diagnostic and treatment services to support its inpatient services, either directly or through referral.

The new hospital will offer a full array of outpatient diagnostic and treatment services, including emergency care, diagnostic imaging, clinic services and same-day surgery. As is done now, referrals will be made for services not offered at the hospital.

Section .06A(9). Interpreters. Each hospital shall have staff or volunteer interpreters available or on call to translate for deaf and non-English speaking patients and families who do not otherwise have interpreters available to them.

Effective communication between caregiver and patient is critically important. Patients need to understand their conditions and make informed decisions regarding care. WCHA provides interpreter services for deaf and non-English speaking patients, their families, or caregivers. A list of interpreters is found at Exhibit 8. These resources will be used when service begins at the new hospital.

Section .06A(10). <u>In-Service Education</u>. Each hospital shall institute or maintain, or both, and be able to document standardized in-service orientation and continuing education programs for all categories of direct service personnel, whether paid or volunteer.

WCHA helps employees enhance their skills and education by offering a comprehensive array of in-service orientation and continuing education programs. Copies of educational policies and a calendar of events are included as Exhibit 9. These policies and practices will continue at the new hospital.

Section .06A(11). <u>Overnight Accommodations</u>. Each hospital shall make available information concerning nearby overnight accommodations to the family of each patient during that patient's stay in the facility.

A list of nearby hotels is provided to family members and out-of-town visitors. See Exhibit 10. This practice will continue at the new hospital.

Section .06A(12). Required Social Services. Each hospital shall have social services available to patients and families, and written guidelines and procedures for referrals to appropriate social services following patient discharge.

WCHA provides social services to patients and their families. Social workers address long-term illnesses, post-hospital planning, and referrals to community agencies. Discharge planners/social workers work with the patient, family, physician, and other healthcare team members to determine the appropriate level of care. These practices will continue at the new hospital. Copies of Discharge Planning Policies are appended as Exhibit 11. WCHA provided over 32,750 hours of social service in FY 2004, serving 10,000 patients and their families.

Section .06A(13)-(18). Obstetrics.

These provisions were repealed when a separate Acute Hospital Inpatient Obstetrics Services Chapter (the "OB Chapter") was adopted by the Commission and became effective on April 15, 2002.

Section .06A(19). Minimum Size for Pediatric Unit. There shall be a minimum of ten designated pediatric beds in a unit, unless:

(a) Travel time from the unit to another pediatric unit exceeds 30 minutes; or

(b) The hospital is the sole provider of pediatric services in its jurisdiction.

Inclusion of an 8-bed pediatric unit in the new hospital is consistent with this standard because WCHA is the sole provider of pediatric services in Washington County and the nearest pediatric unit is more than 30 minutes away.

Section .06A(20). Admission to Non-Pediatric Beds. Stable non-emergency pediatric patients may be admitted to licensed medical/surgical beds, which are separated from other adult beds, only when the quality and the level of care is equal to that of a designated pediatric unit.

WCHA's current practice of admitting all stable, non-emergency pediatric patients to the pediatric unit will continue at the new hospital.

Section .06A(21). <u>Required Services When Providing Critical Care</u>. Each hospital providing critical care services shall make available, either directly or through referral, health education, mental health consultation, and physical rehabilitation services for patients and, where appropriate, their families.

WCHA offers physical and occupational therapy services, social services, spiritual support, care management and discharge planning, psychiatric consultation, patient education and specific disease-related education programs and information (e.g., diabetes education and cardiac rehabilitation). When appropriate, patients are referred to home care or community-based services. These activities will continue at the new hospital.

Section .06A(22). Average Length of Stay for Critical Care Units. A hospital that has, or proposes to establish, a definitive observation cost center must achieve lower case-mix adjusted average lengths of stay in its critical care unit or units than hospitals which do not have this cost center and are otherwise comparable with respect to size and type of critical care service. The hospital has a reasonable period of time (up to six months) after opening its definitive observation unit to achieve the reduced length of stay.

The new hospital will have a definitive observation cost center. WCHA anticipates that ALOS in the critical care units at the new hospital will be lower than at hospitals that do not have a definitive observation cost center.

Section .06A(23). Waiver of Standards for Proposals Responding to the Needs of AIDS Patients. The Commission may waive any of the standards in the State Health Plan which would prevent the approval of an application proposing to respond to the inpatient needs of AIDS patients if:

(a) An applicant can demonstrate that the waiver is in the public interest; and

(b) The Commission, in consultation with the Secretary of Health and Mental Hygiene, determines that a public health emergency exists.

This standard is inapplicable because WCHA does not seek a waiver.

COMAR 10.24.10.06B

Section .06B. Certificate of Need—New Construction or Expansion of Beds or Services. The Commission will review proposals involving new construction or expansion of beds or services, including replacement of existing beds or services if new outside walls are proposed, using the following standards:

Section .06B(1). Compliance with Systems Standards. Each Certificate of Need applicant shall submit, as part of its application, written documentation of compliance with all applicable standards in Regulation .06A of this Chapter.

As demonstrated above, this project complies with all applicable system standards.

Section .06B(2). Duplication of Services and Adverse Impact. The Commission will only grant a Certificate of Need if a hospital seeking to establish or expand a service, or to construct a new facility, documents that none of the following will occur as a result of the project:

(a) Duplication of existing services beyond that allowed by this Chapter;

WCHA's proposal to construct a new hospital with 201 MSGA and eight pediatric beds is consistent with the 2010 bed need forecasts in the Acute Care Chapter.

(b) If the hospital's costs are above the mean, any necessary rate increase will not change the hospital's cost ranking on adjusted Screen A, prepared by the Health Services Cost Review Commission;

WCHA is 5.78% below its peer group under the HSCRC's current screening methodology, i.e., reasonableness of charges ("ROC"). WCHA has been one of the lowest-cost hospitals in Maryland for many years, as shown below.

Financial Overview – Hospital Position

Screening Release Date	% Below State
September '96	(3.92%)
September '97	(5.10%)
September '98	(5.13%)
September '99	(8.85%)
September '00	(6.57%)

Date of ROC	% Below Peer Group
December '01	(3.71%)
October '02	(3.50%)
April '03	(3.69%)
October '03	(5.47%)
April '04	(5.78%)

(c) If the hospital's costs are below the mean, any necessary rate increase will not raise the hospital's cost ranking above the mean on adjusted Screen A, prepared by the Health Services Cost Review Commission; or

WCHA seeks a rate increase in conjunction with this project. The proposed increase, however, will not cause WCHA to be above the mean of its peer group. See Exhibit 12.

(d) Inappropriately diminishing the quality of care, access to care, or the provision of uncompensated care.

Relocating and building a replacement hospital at Robinwood will not impact quality of care. If anything, construction of a modern state-of-the-art hospital will enhance WCHA's ability to provide high quality care. Constructing a replacement hospital at Robinwood, ten minutes by car and 3.2 miles from the current location, will also not "inappropriately diminish access or the provision of uncompensated care." More detail is provided below.

Standard .06B(2)(d) provides that a "new facility" should not be constructed if it "[i]nappropriately diminish[es] ... access to care." The operative word in this standard is "inappropriately," which requires the Commission to balance the benefits associated with construction of a new facility with the need to maintain <u>appropriate</u> access to care.

The Acute Care Chapter itself provides an objective measure of appropriate access. Standard .06A(3) states that all applicants must demonstrate that a proposed project is consistent with the following "travel time" standard.

> Medical/surgical/gynecological/addictions, critical and progressive care, obstetric and pediatric services shall be available within 30 minutes one-way average automobile time under normal driving condition for at least 90 percent of each health service area's population.

Ninety percent (90%) of the health service area's population will still be within 30 minutes of hospital care if WCHA is relocated to Robinwood.

Commission precedent also demonstrates that a relocation that makes hospital services less convenient for some county residents does not violate Standard .06B(2)(d). In the Upper Chesapeake Medical Center ("UCMC") case, the Commission approved the replacement of an antiquated facility, Fallston General Hospital ("Fallston General"), located in Fallston, Maryland, with a modern hospital to be constructed in Bel Air. The distance between Fallston and Bel Air (3.2 miles) is the same as the distance between the existing hospital and the Robinwood site (3.2 miles). Neither Commission Staff nor the interested parties in the UCMC case (Helix Health/Franklin Square Hospital Center, GBMC and the City of Havre de Grace) claimed that the new hospital project was unapprovable because relocation from Fallston to Bel Air "inappropriately" diminished access to care for residents of Fallston and nearby areas. More importantly, the Commission made no such finding. The UCMC case demonstrates that relocating a hospital to a site 3.2 miles away does not "inappropriately" diminish access to care.

In addition to replacing Fallston General, the UCMC project also involved the relocation of the obstetrics and pediatrics services from Harford Memorial Hospital in Havre de Grace to the new hospital in Bel Air. The distance from Harford Memorial in Havre de Grace to Bel Air is 20 miles, much greater than the distance from WCHA's existing site to Robinwood. However, in the UCMC case, the Commission did not find that access would be "inappropriately" diminished because lower income residents and Medicaid recipients in some parts of Harford County would have to travel a greater distance to obtain obstetrics care.

In finding that the 20-mile relocation of obstetrics from Havre de Grade to Bel Air did not inappropriately impact low income residents, the Commission also noted that

local and federal transportation programs were available to meet these patients needs and that UCHS would make other arrangements if these programs did not do so. While the distance involved here is significantly shorter than the distances considered by the Commission in the UCMC case, WCHA has agreed to address the transportation needs of low income residents if the public resources described below are inadequate. WCHA will provide a free van service between the existing site and the Robinwood campus. Upon request, van service is also available to take patients from their homes to the current hospital. These services are intended to continue for the replacement hospital.

These services are intended to continue for the Replacement facility. In addition, Washington County Health Systems, in conjunction with Frederick Memorial Hospital and Valley Health Services operates a transportation service (Mid Maryland Medical Transport "MMMT") which provides ambulance and taxi cab transport in Washington and Frederick Counties as well as the surrounding region. MMMT currently is contracted with the Washington County Health Department to provide these services to the Medicaid population.

Opponents to the proposed project may argue that the UCMC case is distinguishable because the new hospital was constructed in Bel Air, an area where a significant percentage of Harford County's residents reside. While this is so, moving the hospital from Fallston to Bel Air, and the obstetrics service from Havre de Grace to Bel Air, resulted in some Harford County residents, including Medicaid recipients, traveling greater distances for care. As was determined by the Commission in the UCMC case,

the distances in question were not material and did not inappropriately diminish access to care.

The City of Hagerstown (the "City") previously argued that access will be diminished "inappropriately" because "32% of the annual admissions," the "majority of the patients who rely upon Medicaid or who self-pay for medical services" and one-third of the seniors admitted to WCHA are City residents. These statistics, however, do not demonstrate that a replacement hospital located at Robinwood will be inaccessible to City residents, including seniors and those with low incomes.

The vast majority of admissions to the hospital, 68% according to the City's analysis; 75% according to WCHA's), and two out of every three seniors admitted to WCHA, are not City residents. Access for this much larger group of patients served by WCHA may actually be better at a replacement hospital constructed at Robinwood.[3]

To determine how patients currently reach the hospital, WCHA surveyed all who arrived from August 25 through November 23, 2003. The results of this three-month survey are set forth below:

[3] Information regarding Medicaid and self-pay patients currently served by physicians with offices at Robinwood is appended as Exhibit 13. As noted there, 471 Medicaid recipients whose physician's office is located at Robinwood gave birth at WCHA.

INPATIENT AND OUTPATIENT ARRIVALS[4]

8/25/03 - 6/30/04

Mode of Transportation	# Patients	Percentage
Car	88,167	86.96%
EMS - In State	9623	9.49%
Walk	1120	1.10%
Taxi	851	0.84%
Nursing Home/Hospital Shuttle	378	0.37%
Law Enforcement	596	0.59%
EMS - Out of State	464	0.46%
Helicopter	160	0.16%
Bus	24	0.02%
Bike/Motorcycle	10	0.01%
TOTAL	101,393	100%

During the survey, almost 90% of all patients arriving at WCHA came by car. However, many patients do not choose how they arrive (i.e., those brought by helicopter, ambulance, law enforcement officers, and patients transferred between the hospital and the on-site extended care facility, i.e., a total of 11,221 patients). Excluding those patients, reveals that more than 97% of all patients who choose how they travel to the hospital come by car (88,167/(101,393-11,221)=97.8%). During the survey period, only 24 patients (.02%) arrived by bus; 851 patients (.84%) came by taxi; and 1120 patients (1.1%) walked. The distance between the hospital and the Robinwood site is only 3.2 miles and ten minutes by car. Relocation to Robinwood will have no material effect whatsoever on the vast majority of WCHA's patients.

Moreover, the County Commuter bus service already operates a route from the City to the Robinwood Medical Center, located adjacent to the replacement hospital's site. The County most certainly will assess the needs for expanded service when the

[4] Information used in the study was obtained when patients registered as an inpatient or outpatient upon arrival at WCHA. The survey was performed under the overall supervision of Raymond Grahe, Vice President and Chief Financial Officer at WCHA. See Exhibit 14.

new hospital begins operation several years from now. The map and schedule of the County Commuter Bus Route—Robinwood, effective July, 2003, is attached as Exhibit 15.[5]

The City previously claimed that relocating the hospital to Robinwood will "inappropriately" diminish access to care for City residents because, at present, nine of the existing eleven bus routes have stops within three blocks of the hospital and only one bus route serves the Robinwood campus.

While the existing bus routes may make it more convenient for City residents to reach the hospital at its present site, that does not mean that relocating the hospital to Robinwood will "inappropriately" diminish access to care,[6] particularly since so few patients travel to the hospital by bus (.02%). As explained below, public transportation services will undoubtedly change after the hospital relocates to Robinwood.

The "Washington County Transportation Development Plan—Final Report" (July 16, 2003) (the "2003 County Transportation Plan"), included as Exhibit 16, also demonstrates that access to care will not be "inappropriately" diminished if the hospital is relocated to Robinwood. As is noted there:

> Since the last TDP, County Commuter [the name for the regional bus service] has continued to modify services to keep up with changing demographics and uses in the County. In addition, County Commuter has expanded its services to meet the employment transportation needs of lower income families.

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[5] As the Schedule notes, a one-way fare for adults is $1.25. The rate for seniors (60 years +), disabled persons and Medicare recipients is only $0.95.

[6] Moreover, the existing service includes a transfer station where bus passengers who board any of the other ten bus routes in Washington County can transfer to the Robinwood "line."

As the 2003 Transportation Development Plan further notes, "current and projected growth and resulting changes in travel patterns suggest that transit services will need to be restructured and improved." Exhibit 16 at 1-2. Indeed, one of the 2003 Transportation Development Plan's goals is to "[r]estructure existing routes to more accurately reflect changing demand and land use" and "[t]o continue to serve major concentrations of medical offices, health facilities, nursing homes and similar destinations." Id. at 1-3. (Emphasis added) WCHA and Washington County representatives have already discussed altering the existing bus routes to ensure that the replacement hospital at Robinwood is accessible via public transportation.

The 2003 Transportation Development Plan also relates that the County Commuter is required to provide complementary transit, as specified by the Americans With Disabilities Act ("ADA"). This service is a specialized curb-to-curb service for ADA-eligible individuals who are unable to reach or access the fixed-route services, and will be available to bring eligible persons to the replacement hospital at Robinwood.

Another transportation service available in Washington County is the State Specialized Transportation Assistance Program, a voucher program that assists the elderly and persons with disabilities. See 2003 Transportation Development Plan at 2-25, included as Exhibit 16. Significantly, the 2003 Transportation Development Plan notes that the "greatest unmet needs are the smaller communities in the County where there are currently no daytime general public transportation services. . . ." Id. at 3-29. In that regard, a WCHA affiliate, in a joint venture with Frederick and Valley Medical, provides taxi and ambulance transportation to WCHA. This will continue after the hospital relocates to Robinwood.

In sum, construction of a replacement hospital at Robinwood, 3.2 miles and ten minutes by car from the existing hospital, will not "unreasonably" diminish access to care. Relocating the hospital to this site is consistent with the Acute Care Chapter travel time standard and the distance involved is not material. Since the vast majority of patients come to the hospital by car, at most, they will need to drive another ten minutes to reach the new hospital at Robinwood. Moreover, similar and greater distances were found not to "unreasonably" diminish access in the UCMC case, which involved relocation of an existing hospital. In fact, the new site may actually improve access for the majority of WCHA's patients who do not reside in the City. As explained above, public transportation already serves the Robinwood campus and the 2003 County Transportation Plan proposes to "[r]estructure existing routes" to continue to serve major concentration of "medical offices [and] health facilities." Finally, WCHA will provide van service to take patients from their homes to the hospital following the relocation to Robinwood, if necessary.

Section .06B(3). Optimal Alternative. An applicant proposing new construction or expansion of beds or services, including ancillary services, shall demonstrate that it has considered the costs and effectiveness of the following alternatives: not carrying out the project, renovation, merger, consolidation, closure of the service, and delivery of the service in another setting, and that the proposed project is the optimal alternative.

WCHA pursued a vigorous and participatory planning process before selecting the proposed project as the optimal alternative. That process and the criteria that were used are described in detail below in the response to COMAR 10.24.01.08G(3)(c). Infra at p. 115-133. The costs and effectiveness of the alternatives identified in this standard are also discussed here. More detail is provided in the discussion of program and cost effectiveness below. Infra at p. 115-133.

Not Carrying out the Project: Delivering efficient and effective services to the public in the existing hospital is problematic. For example, the current Emergency Department/Level III Trauma Center does not have enough space to accommodate even the current demand. During periods of peak demand, hall beds are used to accommodate patients. In addition, patient flow in many departments "mixes" inpatients, outpatients and visiting families.

Pre-admission testing is performed in a facility located two miles from the hospital. Only phone screens can be performed on site. This arrangement, dictated by the lack of space, creates inefficiencies and inconveniences for patients and physicians. The existing operating rooms are too small and do not easily accommodate modern equipment and staff. Moreover, the recovery area for the ORs and procedure rooms are not all located in the same area of the hospital. Two locations are used for inpatient

and outpatient surgical recovery, resulting in inefficiencies. The step-down/progressive care unit is also used as a corridor.

Put simply, doing nothing is at odds with the growth and aging of the population WCHA serves, WCHA's role as a sole community provider, and the age and configuration of the existing physical plant. The existing hospital is also inadequate to meet patient care needs in the future.

Renovation of the Existing Hospital: WCHA considered and rejected the option of extensively renovating the existing facility because this approach would not provide sufficient space and the appropriate configuration to provide care efficiently. The renovation approach was also rejected because it would not: (i) facilitate public access and utilization; (ii) promote the efficient use of technology; (iii) provide flexibility for future growth; (iv) result in cost-effective life cycle operations, and (v) promote a positive image to the community.

Moreover, certain characteristics of the existing facility cannot be corrected by renovation. For example: (i) the hospital's very long corridors lead to inefficiencies in staffing and patient care; (ii) the hospital's inefficient configuration is problematic, particularly in terms of outpatient care; and (iii) the aging buildings present a poor public image. Also, the hospital's layout reflects an era when inpatients stayed much longer than today. Furthermore, the functional relationships between hospital departments and

resources have been compromised over the years, as a result of having to adapt to an out-of-date facility. The renovation approach would not address these problems.

Today, patients and caregivers expect hospital-based care to respect their privacy. As a result of safety and privacy concerns, new hospital projects include mostly single rooms. WCHA's goal of having all single patient rooms cannot be achieved by renovating the existing facility. Certain basic patient amenities, like in-room showers, are not possible if WCHA were to renovate the existing hospital. For these and other reasons, including the inability to address the future demand for diagnostic and therapeutic services, including the ED, and to be flexible in developing new programs and services, WCHA decided to pursue the new hospital option.

Merger or Consolidation with another Hospital: As the sole provider of hospital services in Washington County, WCHA cannot consolidate to improve access or the availability of care.

Closure of Service/Hospital: Closure is not an appropriate option because WCHA is the only hospital in Washington County.

Delivery of the Services in Another Setting: The services provided by WCHA cannot be provided in another setting, as WCHA is the only hospital in Washington County.

Section .06B(4). Burden of Proof Regarding Need. The burden of demonstrating need for services not covered by Regulation .07 of this Chapter or by other parts of the State Health Plan, including sub services for which need is not separately projected, rests on the applicants.

WCHA acknowledges that it must demonstrate need for services "not covered by the Acute Care Chapter or by other parts of the State Health Plan." The need for surgical, imaging, emergency room, Level II nursery, and laboratory services to be provided at the new hospital are discussed below. Outpatient services already available at Robinwood Medical Center are included in this analysis.

I. Surgery

WCHA has 11 operating rooms and three procedure rooms. The new hospital will have 14 operating rooms, i.e., 10 general purpose operating rooms to be used for inpatient and outpatient surgery, two dedicated C-Section rooms, one dedicated trauma room, and a cystoscopy room.

WCHA used two methods to project how many operating rooms should be included in the new hospital. Both approaches use historical growth to estimate future utilization. To assure that surgical capacity at the new hospital does not replace existing outpatient surgical capacity at the ASF at Robinwood Medical Center ("RMC"), future utilization based on historical experience at that facility was projected as well.

A. Historical Case Volume Approach

1. Ten General Purpose Mixed-Use ORs

WCHA first determined the trend in inpatient and outpatient surgical volumes (excluding endoscopy) from 2000-2004. Cystoscopies, C-Sections and trauma cases were not included in this analysis, as they are addressed separately.

WCHA determined that inpatient volumes excluding Cystoscopy, C-Sections, and Trauma increased an average of .5% per year from 2000-2004, and that outpatient surgical procedures increased by 3.1% per year during this same period. Trauma cases increased by 14.4%, C-Sections increased 10..8%, which Cystoscopy declined by fifty procedures. To be conservative, WCHA projected outpatient surgical volumes at the replacement hospital in 2010 based on an annual increase of just 2% per year, which is lower than the average annual rate of growth for the last four years, i.e., 3.1%. Inpatient surgical volumes increased from 2000-2004 by .5% per year. WCHA assumed that same rate of growth from 2004 to 2010.[7] WCHA also projected Cystoscopy volumes to be constant, and that both C-Sections and Trauma volumes would continue to increase through 2010 at the same annual average rates as during the 2000-2004 periods.

Assuming annual growth of 2% in outpatient surgery volumes and no growth in inpatient cases, WCHA projects a total surgical volume of 11,093 cases in 2010, i.e., 4,822 inpatient and 6,271 outpatient cases.

[7] During FY 2004, WCHA completely changed its surgical service line, replacing essentially all of the supervision. With input from the medical staff, WCHA revised the block scheduling system and began using disposable supplies. These changes are designed to improve the overall level and quality of service in the operating suites. A competing outpatient surgery center opened in FY 2003, and reached capacity in FY 2004.

	Inpatient		Outpatient		Total	
Period	# of Cases	# of Minutes	# of Cases	# of Minutes	# of Cases	# of Minutes
FY 2010	4,822	533,469	6,271	505,440	11,093	1,038,909
FY 2004	4,362	496,855	5,602	450,771	9,964	947,626
FY 2003	4,177	478,383	6,380	480,255	10,557	958,638
FY 2002	4,091	478,383	6,140	472,697	10,231	950,839
FY 2001	4,157	493,449	5,486	423,703	9,643	917,152
FY 2000	4,053	471,491	5,057	381,384	9,110	852,875

Source: WCHA.

In the Greater Baltimore Medical Center case, the Commission accepted 994 cases as an appropriate way to measure capacity of a mixed-use/general purpose operating room. See In the Matter of Greater Baltimore Medical Center, Docket No. 1-03-2082 at 28, n. 13. Applying that standard to the 2010 surgical volumes projected by WCHA demonstrates need for 11 mixed-use/general purpose operating rooms (11,342 ÷ 994 = 11.4 operating rooms).

2. Two C-Section ORs

The proportion of deliveries by C-section at WCHA has increased from 23% in 2000 to 26% in 2004. WCHA expects the C-section rate to increase to 30% by 2010. WCHA estimates that there will be 2,215 births at the replacement hospital in 2010.

Assuming a C-section rate of 30% and 2,215 births in FY 2010 yields 665 C-sections. Assuming 576 C-sections per OR per year, WCHA needs two ORs dedicated to C-section cases (665 ÷ 576 = 1.2 rounded to 2 C-section rooms).

3. Trauma OR

The replacement hospital also includes one operating room that will be used only for trauma cases because WCHA is a Level III Trauma Center.

4. ASF at RMC

In determining that the replacement hospital should have 14 operating rooms, WCHA also assessed the existing outpatient surgical capacity of the ASF at RMC. Although the average annual rate of growth at this facility was 7.3% from 2000 to 2004, WCHA used an annual growth rate of only 2% from 2004 to 2010 to forecast future volumes. This approach projects 6,750 outpatient surgical cases in 2010. The Ambulatory Surgery Services Chapter of the State Health Plan (the "ASF Chapter") identifies the optimal capacity of a dedicated outpatient operating room as 1,152 cases per year. Using this benchmark, all six outpatient ORs at the Robinwood ASF are needed and will be fully utilized in 2010 (6,750 ÷ 1,152 = 5.86 or 6 ORs).[8]

5. Cystoscopy OR

[8] Total surgical volume at WCH and at the ASF at RMC are found in Exhibit 17.

The replacement hospital includes an operating room dedicated to cystoscopy. In 2004, WCHA performed 213 inpatient and 303 outpatient cystoscopies. The ASF Chapter defines that the "optimal capacity" of a dedicated outpatient special purpose OR as 576 cases per year. See COMAR 10.24.01.O5A(3)(c). Even assuming no growth in cystoscopies from 2004 to 2010, the existing volume justifies inclusion of a cystoscopy OR in the replacement hospital (516/576 = .9 or 1 OR).

B. Historical OR Minutes Approach

1) General - purpose mixed-use ORs

The first step in this approach was to determine the trend in operating room minutes for the period FY 2000 to 2004. Average clean-up and preparation time between cases is assumed to be 30 minutes, the standard for outpatient surgical cases set forth in the ASF Chapter. See COMAR 10.24.11.05A(2)(b)(ii).

(a) Inpatient Minutes

Inpatient minutes increased by 25,000 minutes between 2000-2004, i.e., the average annual increase was 1% during this period. For this reason, WCHA assumed that the rate of increase in inpatient minutes would be the same through 2010. To determine OR utilization in 2010, the total inpatient minutes and 30 minutes per case clean-up were added. That total was divided by 96,000 minutes per OR, the annual capacity of an OR assuming eight hours of service per day, 250 days per year. This calculation is noted below:

$$\frac{533{,}461 + 4{,}822 \text{ cases} \times 30 \text{ minutes}}{96{,}000 \text{ minutes/OR/year}} = 7.06 \text{ ORs}$$

(b) Outpatient Minutes

Minutes associated with outpatient surgical cases increased from 2000-2004 at an average annual rate of 3.62% per year.

To be conservative, WCHA assumed a 2% average annual rate of growth from 2004 to 2010. This methodology projects 505,440 outpatient surgical minutes in 2010. Clean-up and prep time of thirty minutes per case were added to determine total OR minuts in 2010. The projected outpatient utilization of ORs in 2010 is noted below.

$$\frac{505{,}440 + 30 \text{ minutes} \times 6{,}271 \text{ cases}}{96{,}000} = \frac{693{,}570}{96{,}000} = 7.22 \text{ ORs}$$

(c) Conclusion

WCHA calculates a need for 7.06 ORs for inpatient cases and 7.22 ORs for outpatient cases in 2010, which totals 14.28. These projections support WCHA's decision to include ten general-purpose mixed-use operating rooms in the new hospital, plus one Cystoscopy room, one Trauma room, and two C-Section rooms.

2. Cystoscopy and Trauma

The surgical and clean-up minutes projected for 2010 support WCHA's decision to include a dedicated cystoscopy OR. As related above, a dedicated trauma OR was included in the replacement hospital because WCHA is a Level III Trauma Center. The trauma surgical and clean-up minutes projected for 2010 support this decision.

3. C-Section ORs

C-sections are both scheduled and unplanned. In the last year, there were 44 separate instances when two C-sections were performed, and two instances when three

C-sections were performed, requiring that more than one operating room in the hospital be utilized simultaneously. The minutes projected for 2010 demonstrate that a single OR might suffice if all C-sections were scheduled procedures (83,800 minutes/96,0000 minutes/year = .86 or 1 OR).[9] However, roughly half of the C-sections performed at WCHA are unscheduled. For this reason, a single dedicated C-section room with the annual capacity of 96,000 minutes per year cannot accommodate the minutes projected for 2010 (91,289), and provide sufficient capacity when more than one C-Section must be performed at the same time.

4. ASF at RMC

To assess expected utilization at the Robinwood ASF in 2010, a similar minutes-based analysis was used. Volume at the facility increased at the average annual rate of 6.7% from 2000 to 2004. However, WCHA used a growth rate of only 2% per year to project the growth in outpatient surgical volumes from 2004 to 2010. Addition of clean-up time demonstrates that the Robinwood ASF will be fully utilized in 2010 and that including 14 ORs in the replacement hospital is not duplicative.

$$\frac{337{,}559 + 6{,}750 \text{ cases} \times 30 \text{ minutes}}{96{,}000 \text{ minutes/OR/year}} = 5.6 \text{ or } 6 \text{ ORs}$$

D. Conclusion

Both the surgical minute-based and case-based methodologies demonstrate that the new hospital should have 10 mixed-use general purpose ORs, two ORs reserved for C-sections, one OR dedicated to trauma cases, and a cystoscopy OR. As also shown above, including 14 ORs in the new hospital does not duplicate the existing capacity at the Robinwood ASF.

[9] WCHA projects 2,215 births in FY 2010, of which approximately 30% will be by C-Section. Each C-section to be performed will require 136.5 minutes, including prep and clean up time.

II. Emergency Department

The Level III Trauma Center/Emergency Department (the "ED") in the replacement hospital is designed to accommodate 82,989 visits in 2010 based on historical growth. As noted below, ED utilization at WCHA increased by more than 38% from 1999 to 2004 (75,715 – 54,750 + 54,750 = 38.3%). While the annual rate of increase has varied somewhat, the average annual increase over this five-year period has been 7.7%.

ED Visits						
	Emergent Care	Express Care	RDC	Urgent Care*	Total	Change
1999	37,744	17,006	–	–	54,750	–
2000	39,876	18,275	–	–	58,151	6.2%
2001	42,067	19,872	–	–	61,939	6.5%
2002	43,173	19,968	560	–	63,701	2.8%
2003	42,131	18,676	1,024	4,207	66,038	3.7%
2004	44,517	21,009	1,306	8,883	75,715	14.7%
2010	53,805	27,002	2,182	10,765	93,754	4.0%

*Not included in Emergency Room Visits to the Hospital (See TABLE 1.)

WCHA believes that volumes in the ED will continue to grow and reach 82,989 visits in 2010. However, WCHA expects the rate of growth to moderate somewhat over the next six years. Based on historical volumes, WCHA projects an annual increase of

3.3% in emergent care cases, 4.4% annual growth in express care volumes, 4.0% annual increase in urgent care ED, and 9% annual growth in RDC volume. The calculation of 2010 ED volume based on these rates of growth is included as Exhibit 18.

The Commission has used the statewide average OF 1,428 visits per emergency room or bay in assessing CON applications proposing to expand existing emergency rooms. WCHA's proposal to have 45 bays in the replacement hospital's ED for emergent, express and urgent care patients and eight RDC rooms is consistent with this standard (82,989 ÷ 1,428 = 58).

II Imaging Services

WCHA identified several types of imaging procedures, i.e. diagnostic (including mammography), invasive, ultrasound, CT, nuclear medicine, and MRI. Future utilization was forecast based on the growth in volume from 2000 to 2004. A utilization standard was then used to project the number of imaging rooms to include in the new hospital. A brief description of the methodology is provided below for selected imaging procedures, and the forecasts are found at Exhibit 20

A. Diagnostic Imaging Procedures

From 2000 to 2004, diagnostic imaging procedures at WCHA declined by an average of 3% per year. However, because diagnostic imaging volumes increased by 2.7% from 2003 to 2004, WCHA used an annual growth rate of 1.5% to project growth from 2005 to 2010. As shown on Exhibit 20, this methodology projects 72,692 diagnostic imaging procedures at the new hospital in 2010. Peak procedures were

computed based on a 50% inpatient and a 75% outpatient standard provide by Lawrence Lammers, a WCHA consultant. The number of peak procedures (14,941 inpatient and 32,107 outpatient) were multiplied by the average time per imaging cases provided by Mr. Lammers (25 minutes for inpatients and 15 minutes for outpatients). Total minutes were divided by an imaging room capacity standard provided by Mr. Lammers; i.e., 123,750 minutes per imaging room. That calculation is set forth below.

$$\frac{(14{,}941 \times 25 \text{ minutes}) + (32{,}107 \times 15 \text{ minutes})}{123{,}750} = 6.9$$

Although the foregoing methodology suggests that seven imaging rooms should be sufficient, WCHA decided to include eight rooms to ensure that adequate capacity is available.

B. Invasive Imaging Procedures

Invasive imaging procedures at WCHA declined an average of 0.1% per year from 2000 to 2004. However, because the year-to-year change fluctuated significantly, WCHA decided that it would be prudent to assume that invasive imaging procedure volumes would grow by 0.5% per year from 2004 to 2010, resulting in a projection of 3,940 procedures in 2010. See Exhibit 21 for details regarding this calculation. Using the methdology provided by Mr. Lawrence Lammers for "peak" procedures–65% for inpatients and 75% for outpatients–WCHA calculated the number of procedures on peak.

The 2,818 peak procedures computed in this manner (892 inpatient and 1,926 outpatient) were then multiplied by the industry standard of 90 minutes per case, provided by Mr. Lammers. The result, the total procedure time per year in minutes, was

divided by 123,750, the capacity benchmark provided by Mr. Lammers. This calculation is set forth below and supports WCHA decision to include two invasive imaging rooms in the new hospital.

$$\frac{2{,}818 \times 90 \text{ minutes}}{123{,}750} = 2.1$$

C. Ultrasound Procedures

A similar methodology was used to identify need for ultrasound rooms. Due to the abnormal year-to-year fluctuations in ultrasound volumes, WCHA projected that volumes would grow by a conservative 2.5% per year from 2004 to 2010, as noted on Exhibit 21. This methodology projects that 6,634 ultrasounds will be performed at the new hospital in 2010. A "peak" procedure projection of 85%, provided by Mr. Lammers, was used to forecast 5,639 peak procedures in 2010, i.e. (2,826 inpatient; 2,813 outpatient). The number of peak procedures was then multiplied by sixty minutes for inpatient and 45 minutes for outpatient cases, the per case estimates provided by Mr. Lammers. Total minutes were then divided by the capacity measure provided by Mr. Lammers to determine the number of ultrasound rooms in 2010. This calculation is set forth below and supports WCHA's decision to include three ultrasound rooms in the new hospital.

$$\frac{(2{,}826 \times 60 \text{ minutes}) + (2{,}813 \times 45 \text{ minutes})}{123{,}750} = 2.4$$

The methodology used to project need for one CT, two nuclear medicine, and four MRI procedure rooms is the same as was used for diagnostic, invasive and ultrasound cases. The projections which supports the number of rooms WCHA included in the new hospital.

III. Laboratory Services

Laboratory services were relocated form the existing hospital to Robinwood Medical Center several years ago. The laboratory at Robinwood also services physician practices and nursing homes. A "stat" lab is maintained at the existing hospital to perform tests where the results must be provided in four hours or less. Because the new hospital will be adjacent to Robinwood Medical Center, neither a "full" laboratory nor "stat" lab is needed in the replacement hospital. Space for collecting and processing specimens, however, has been included. Information about laboratory procedures for the period 1999-2004 is attached as Exhibit 22. Many of the Hospital's laboratory processing tests are performed today at the Robinwood Medical Center. The Hospital currently only maintains a "stat-lab" capability to provide turnaround for tests that require less than four hour response. The rest of the laboratory processing is currently performed at the Robinwood Medical Center laboratory which provides testing for many physician's offices and nursing homes in the region. Placing the replacement hospital next to Robinwood Medical Center provides the opportunity to reduce the square footage needed. Space has been programmed in the replacement hospital for the collection and processing of specimens. The square footage reduction in the laboratory in the Hospital equates to 6,852 fewer square feet, and construction cost savings of approximately $1.6 Million, at $235/sq.ft. This savings will be accomplished despite the continued 10.1% annual increase in laboratory procedures experience at WCHA, which are expected to continue through 2010.

IV. Special Care Nursery

WCHA is currently in the process of upgrading it newborn services. This involves a number of changes to the manner in which care to newborns will be provided at the Hospital, including changes in the medical coverage to the newborn nursery. WCHA has received a number of proposals from neonatology groups to provide 24/7/365 coverage of its current nursery. The intention of the Hospital is to enhance the quality of care that is provided, to make available the necessary medical and nursing personnel and expertise to future newborns, and to obtain and make available additional medical equipment and supplies as is necessary to provide the best care possible. The goal of this upgrade is for the nursery at WCH to fully meet the necessary requirements to be designated as a Level II, or "Special Care Nursery." It is the intent of the Hospital that this upgrade to the Nursery be accomplished before the end of FY 2005.

In order to accommodate the future needs of newborns at WCHA in the replacement hospital, the Nursery has been designed to the architectural specifications consistent with those associated with a Level II Nursery for the number of newborns projected to be cared for in the future. The considerations in the design of the Nursery include providing sufficient space to accommodate the number of newborns who will be cared for by the neonatologists and specially trained neonatology nurses, particularly those newborns $\leq$ 32 weeks gestational age, or $\leq$ 1,500 grams. The Special Care Nursery designed for the replacement hospital will be 3,860 DGSF, and will have space for 10 special care stations, including one isolation room. The final architectural design of the unit will have input from the neonatologists selected to staff the special care nursery in the current hospital.

According to the Hospital's architect, Mr. William Heun, the Guidelines for Design and Construction of Hospitals and Healthcare Facilities makes no distinction between a Level II Nursery and a Neonatal Intensive Care Unit with respect to space planning. The space program for the proposed Special Care Nursery to be located in the replacement hospital will satisfy these Guidelines, and the current recommendations of the American Academy of Pediatrics.

The need for the number of patient care stations proposed for the Special Care Nursery is supported by the total volume of newborns anticipated in the Hospital, as well as the clinical needs of those newborns whose care will be provided by the neonatologists. In FY 2010, the Hospital projects 2,215 births, based on current trends in obstetrics utilization. This is a conservative forecast, as it does not include any additional deliveries which may result as a result of the initiation and operation of the Level II Nursery with neonatology coverage, and the ability of the Hospital to care for a larger number of women at-risk for premature delivery. According to neonatologists who have proposed to provide coverage to WCHA, an average daily census of six newborn in the special care nursery can be anticipated within five years, as the proportion of special needs newborns to total newborns increases over time. For purposes of demonstrating the need for the ten special care stations to be located in the special care nursery, a more conservative need methodology has been utilized which does not increase the number of births at the Hospital beyond those projected, and does not assume that the proportion of special needs newborns to total newborns will increase

over time, or that the Hospital will care for special care newborns "back transferred" from a Neonatal Intensive Care Unit located in a distant hospital for convalescent services. In all likelihood, the volume of newborns cared for in the special care nursery will exceed these forecasts, assuming the successful operation of Level II Nursery services in the current hospital in the years prior to the opening of the replacement Hospital.

This methodology assumes that 11% of newborns at WCHA will need special care, and that among those newborns, approximately 25% will require the acute intervention and care of the neonatologists; the remaining 75% will require convalescent care in the special care nursery.[10] Based on the range of need, the uses of the special care nursery for both acute and convalescent care, and the ALOS estimates provided, we forecast that the special care nursery will have a average daily census of between four and seven newborns in FY 2010, based on 2,215 births. The calculations of the methodology are shown below:

[10] The actual percentage of total newborns at WCHA which the neonatologists' estimated would require special care varied between 11% and 17%, and the average length of stay for acute care varied between 6.8 days and 8.6 days, and for convalescent care, ALOS varied between 5.7 days and 11.3 days.

Need Analysis for Special Care Nursery Stations in the Replacement Hospital				
	Low ALOS Forecast		High ALOS Forecast	
Newborns	2,215		2,215	
% Needing Special Care	11%		11%	
SCN Admissions	244		244	
% Acute/% Convalescent	25%	75%	25%	75%
Adjusted Admissions	60.91	182.74	60.91	182.74
ALOS: Acute/Convalescent	6.8	5.7	8.6	11.3
Patient Days	414	1,042	524	2,065
Total Patient Days		1,456		2,589
ADC		4		7

Section .06B(5). Discussion with Other Providers. In multiple-hospital jurisdictions with excess capacity, the Commission will only grant a Certificate of Need to a hospital not part of a merged or consolidated organization seeking to establish or expand a service, or to construct a new facility, if the applicant demonstrates in the proposal that merged, consolidated, and shared services, programs, or facilities have been discussed with other health care providers.

This standard is inapplicable because the proposed new hospital will not be located in a "multiple-hospital jurisdiction[ ] with excess capacity."

Section .06B(6). Cost Per Square Foot of Hospital Space.

(a) The cost per square foot of hospital construction projects shall be no greater than the cost of good quality Class A hospital construction given in the Marshall and Swift Valuation Quarterly, updated to the nearest quarter using the Marshall and Swift update multipliers, and adjusted as shown in the Marshall and Swift guide as necessary for terrain of the site, number of levels, geographic locality, and other listed factors.

(b) Each Certificate of Need applicant proposing costs per square foot above the limitations set forth in the Marshall and Swift Guide must demonstrate that the higher costs are reasonable.

The replacement hospital is consistent with the Marshall & Swift Valuation Service standard (the "M&S Standard") for good quality, Class A construction. As shown below, the comparable cost per square foot of the new hospital ($235.07) is consistent with the M&S Standard ($250.48).

I. Marshall Valuation Service
Valuation Standard

Base Cost	$237.85
Perimeter Multiplier	x.9253
	220.08
Height Multiplier	x1.08
	237.69
Multi-story Multiplier	x1.01
	240.06
Sprinklers	+1.53
	241.59
Location Multiplier	x .96
	231.93
Update Multiplier	x1.08
Cost Per Square Foot Standard	$250.48

II. Comparable Project Costs

Project Costs	
Category	**Costs**
Construction[11]	$89.537,000.
Fixed Equipment	10,728,000.
Site Preparation	7,670,800.
Architectural Fees	7,760,000.
Capitalized Construction Interest	34,050,859.
Permits	230,000.
Gross Total[12]	$149,976,659.
Adjustments	
Non-Normal Site Preparations	6,359,600
Cap. Interest Not Applicable to Interest on Actual Building Funds	25,490,980
Minus Cost Adjustments (see discussion below)	32,850,580
Net Total	$118,126,079
Square Footage	502.508
Comparable Cost/Sq. Ft.	235.07

A. Construction Costs

The building ($85,437,000) and fixed equipment ($10,728,000) cost estimates were prepared by Gilbane Building Company ("Gilbane"), based on plans developed by the Matthei & Colin Associates architectural firm. An estimate was also provided by Hanscomb, an independent cost estimating firm. Fixed equipment includes the following:

[11] GMP estimate as of May, 2004, as shown on Project Budget, Line A.1.a.

[12] Gross Total does not include building demolition costs, major or minor movable equipment costs, contingencies, other capital costs, or inflation. These costs are not included in the definition of "What the Costs Contain," MVS, Section I, page 3, March, 2001.

Electrical Power & Distribution	$1,425,000.
Emergency Generators	1,100,000.
Nurse Call System	1,358,000.
HVAC Major Equipment	5,750,000.
Fire Pump	67,000.
UPS Equipment	278,000.
Plumbing Equipment	750,000.
TOTAL	$10,728,000.

B. Site Preparation

The site preparation costs are based on line item estimates prepared by Gilbane. The M&S Standard only includes normal site preparation costs. Hence, "non-normal" site preparation costs ($6,359,600) were subtracted from the total ($7,670,800) to determine the appropriate cost to use in the comparative analysis. Both normal and non-normal site preparation costs are itemized below.

Normal Site Preparation Costs

Building, Final Gradings & Backfill[13]	$ 252,720.
Excavation for Foundation[14]	620,880.
Utilities from Structure to lot line[15]	317,200.
Other normal site preparation[16]	120,440.
TOTAL	$752,448.

Non-normal Site Preparation Costs

Drilled piers[17]	$ 1,330,160.
Site Concrete[18]	585,520.
Clearing Site Demo[19]	98,200.
Paving[20]	1,037,920.
Site Grading[21]	1,192,516.
Storm Drainage[22]	612,560.
Landscaping	440,960.
Site Electricity[23]	448,800.
Other non-normal site costs[24]	572,963.
TOTAL	$6,319,599.

C. Other Costs

Architect and engineering fees ($7,760,000) and permits ($230,000) are included in the M&S Standard. Costs in the Project Budget that are not included in an M&S Standard evaluation are itemized below:

[13] Includes 58,000 cubic yards of cut, 11,800 cubic yards of backfill, and 24,000 square feet of slope protection.
[14] Includes 45,000 cubic feet of cut to fill and 30,000 cubic yards of cut to waste.
[15] Includes 3,000 linear feet of 12" sanitary sewer and 2,190 linear feet of 10" water line.
[16] Includes general condition costs and fees associated with normal site preparation, i.e., on-site facilities, temporary barriers, washdown stations, etc.
[17] Approximately 2,500 linear feet of drilled piers ranging in diameter from 30" to 48"
[18] Includes 16,000 linear feet of curb and 75,000 square feet of concrete paving sidewalk
[19] Miscellaneous clear and demolition of existing paved surface
[20] Includes all on-site parking and roads (approx. 67,000 sq. yards)
[21] Balance of site grading including all paved areas–approx. 1,527,000 square feet
[22] Approximately 5,900 linear feet of piping ranging in diameter from 6 to 48 inches
[23] Mostly site lighting but this also includes a small amount of security and telecom work–panic station, emergency phones, etc.
[24] General conditions and fees associated with costs not above.

Demolition[25]	$ 3,140,000.
IT Tel fit-out	240,000.
Equipment & Furnishings[26]	30,146,660.
Connection fees (excluded from M&S)[27]	4,797,500.
Other consultant fees (equipment planning, CON/HSCRC, legal, program management, geo-tech and secure)	2,998,846.
Miscellaneous	
MIS/Telecom.	3,597,500.
Signage	250,000.
Security	200,000.
Audio visual	300,000.
Artwork	400,000.
Moving	480,000.
Contingency (6% of costs)	9,748,714.
TOTAL	$56,300,220.

In sum, as demonstrated above, the cost per square foot of the replacement hospital ($235.07) is consistent with the M&S Standard ($250.48).

[25] Estimate prepared by Gilbane based on existing site conditions and information provided by a demolition contractor.

[26] Equipment list and pricing provided by Equipment Planners, Inc.

[27] Based on 6/10/02 letter from the City of Hagerstown, WCHA understands that this is negotiable but the entire amount has been included.

Section .06B(7). Cost Per Square Foot of Non-Hospital Space.

(a) For construction of non-hospital projects sponsored by hospitals, cost per square foot of construction must be within the limitations of the appropriate good quality Class A construction costs given in the Marshall and Swift guide for the appropriate structure.

(b) Each Certificate of Need applicant proposing costs per square foot above the limitations set forth in the Marshall and Swift guide must demonstrate that the higher costs are reasonable.

This standard is inapplicable because this project does not include "non-hospital" space.

Section .06B(8). Maximum Square Footage.

(a) For all new construction projects, the following maximum standards for departmental gross square feet per bed apply:

(i) Medical/surgical nursing units - 325
(ii) Intensive care and coronary care - 365
(iii) Pediatric - 300; and

(b) Square footage needed for compliance with the federal Americans with Disabilities Act may be added to the maximums in (a).

(c) When the following areas are necessary, the square footage allotted must be shown to be needed when their inclusion results in exceeding the standard; solariums, patient and visitor lounges, special purpose treatment rooms (ear, nose and throat rooms; cast rooms; psychiatric group therapy and occupational therapy rooms; and others), and unit manager=s office.

(d) Each Certificate of Need applicant proposing to construct a nursing unit larger than that allowed in (a) shall provide evidence that the service cannot be provided safely and effectively within the limits of (a).

I. OVERVIEW

The proposed replacement hospital was designed by William Heun, A.I.A., Matthei & Colin Associates, recognized nationally as experts in hospital design. Standard .06B(9) identifies four "maximum" DGSF standards: (i) 325 DGSF/MSGA bed; (ii) 300 DGSF/pediatrics bed; (iii) 365 DGSF/intensive and coronary care bed; and (iv) 405 DGSF/psychiatric bed. In other reviews, the Commission has not applied these standards because they are woefully out-of-date, having been adopted fifteen years ago. Instead, the starting point for the DGSF/bed analysis required by this standard has been the revisions to the standard proposed by Commission Staff; i.e., 500 DGSF/MSGA bed, 550 DGSF/ICU bed, 500 DGSF/pediatrics bed, and 450 DGSF/psychiatric bed.

In other reviews, the Commission has approved projects that exceed the standards proposed by Staff if additional square footage is included for compliance with

the Americans with Disabilities Act ("ADA") and for other legitimate reasons. To assess consistency with the standards proposed by Staff, Mr. Heun prepared the chart set forth below.

Type - Location of Unit	Number of Beds	Proposed DGSF/Bed	Draft SHP Standard
Med/Surg - 5S	28	468	500
Med/Surg - 5E	28	470	500
Med/Surg - 4S	27	487	500
ICU/CCU - 4W	24	525	550
Med/Surg - PCU – 4E	28	492	500
Rehab Unit - 3W	20	575	N/A
Med/Surg - 3W	8	485	500
Med/Surg – Neuro/Ortho - 3E	28	498	500
Obstetrics LDRP – 2W	20	904	N/A
Med/Surg - Women's - 2E	30	474	500
Pediatrics Unit – 2E	8	660	500
Behavioral Health (Psych.) - 1W	18	556	450

II. MSGA/ICU

The new hospital includes seven MSGA units. As noted above, the size of these units ranges from 468 to 498 DGSF per bed. All of these units are consistent with the 500 DGSF standard proposed by Staff. Similarly, the ICU/CCU (525 DSGF per bed) is consistent with Staff's 550 DGSF per bed standard.

III. PEDIATRICS

At 660 DGSF per bed, the eight-bed pediatrics unit is larger than the 500 DGSF standard used by Staff. This unit is larger than Staff's proposed standard for several reasons. First, the small unit size (8 beds) means that square footage for support areas and other required services must be "spread" over fewer beds. In addition, a pediatrics unit must have all of the accoutrements of a MSGA unit and include separate procedure and play therapy rooms. Equipment and supplies for patients from infancy to 17 years of age must also be available. For these reasons, the supply and support areas can be as large or larger than in a 30-bed adult unit. For security and infection control issues, no areas are shared with other patient units. These matters are discussed in the AIA "Guidelines for Design and Construction of Hospital and Healthcare Facilities" (the "Guidelines"). The Guidelines require that treatment rooms, consultation rooms, formula storage, play rooms, and space for specialty beds, cribs and equipment be included in a pediatric unit. These features added 234 GSF per bed to the proposed eight-bed unit. Because of the unique clinical needs of pediatric patients, this unit is designed to be larger than Staff's proposed DGSF standard.

IV. BEHAVIORAL HEALTH

At 556 DGSF per bed, the 20-bed behavioral health (psychiatric) unit is larger than the 450 DGSF standard proposed by Staff. The Guidelines require a psychiatric unit have the same support areas as a MSGA unit. Space for medical examinations, consultations, group therapy, day rooms, dining, seclusion and laundry facilities is also required. These features add approximately 148 GSF/bed to the proposed unit.

Last year the Commission approved construction of a new psychiatric hospital proposed by Sheppard Pratt, even though the new facility included a 16-bed unit with 702 DGSF/bed. In the Matter of Sheppard & Enoch Pratt Hospital, Docket No. 02-03-2108 (March 18, 2003). The behavioral health unit proposed by WCHA in this review is substantially smaller than what the Commission approved in the Sheppard Pratt case.

Section .06B(9). <u>Approval of Project Beyond Construction Cost and Square Footage Standards</u>. A Certificate of Need applicant proposing construction costs or square footage above those allowed in Standards .06B(7)(a), (8)(a), or (9)(a), as adjusted by findings under Standards .06B(7)(a), (8)(b), or (9)(b) - (d), must demonstrate that all additional costs will be financed by the applicant without increases in rates.

This project does not involve construction costs above those allowed in Standard .06B7(a). The 20-bed behavior health and 8-bed pediatrics units are larger than the DGSF standards proposed by Staff. However, as explained above, the additional square footage is justified based on the types of services be included in these units. After the adjustments permitted by Standard .06B(8)(b)(c) and (d), the proposed project is consistent with this standard.

Because WCHA is not proposing hospital construction that exceeds contemporary standards for hospital square footage per bed or cost per square foot, this standard does not apply. The additional square footage is largely related to having the new inpatient units of the replacement hospital feature only private patient rooms, with each room having a large bed, a private bath, space for family support, effective support functions, and appropriate clean and soiled utility requirements and adequate technological equipment storage. The acuity level of the patient population makes these support services essential to the creation of a high-quality nursing unit.

In addition, the rate increase proposed will not cover the total costs of the project. The Hospital intends to contribute over $15 M to the costs of the project.

Section .06B(10). Rate Reduction Agreement. A high cost hospital will not be approved for Certificate of Need for the establishment of a new acute care service, or for the construction, renovation, upgrading, expansion, or modernization of acute care services, including support and ancillary services, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

This standard is inapplicable because WCHA has not been identified by the HSCRC as a "high cost hospital." In fact, as noted above, WCHA is one of the lowest-cost hospitals in Maryland. Supra at p. 33.

Section .06B(11). Efficiency. For Certificate of Need applications that involve improved facility or service efficiency, applicants must identify the specific portion of the project for which efficiency claims are made and demonstrate that efficiencies will be realized as a result of the project.

Construction of a new facility will address the operational problems in the existing hospital. For example, space will be used more efficiently. Unlike the existing hospital, major outpatient services will be in one place, i.e., on the first floor. For this reason, only a single waiting area for outpatient diagnostic services is required.

In addition, operating rooms in the existing hospital are too small for the technology and equipment necessary for major inpatient procedures. By constructing a replacement facility, WCHA can build appropriately sized operating rooms and configure the surgical suite and support space to promote efficiency. This would not be possible if WCHA renovated the existing hospital. Also, as noted above, laboratory space in the existing hospital need not be replaced. All laboratory services necessary for the new hospital will be provided by the existing laboratory at Robinwood Medical Center.

The current number of FTEs per Adjusted Occupied Bed ("AOB") utilized at the existing facility today is 4.87. The FY2005-2010 projections submitted in this CON reflect a gradual improvement in productivity as follows:

FTEs per Adjusted Occupied Bed	
FY2005	4.87
FY2006	4.87
FY2007	4.87
FY2008	4.65
FY2009	4.52
FY2010	4.52

Productivity improvements are being targeted throughout the facility using the productivity targets established by MacLeod Associates, a contracted consulting firm specializing in hospital productivity. MacLeod sets productivity targets using comparative data from hospitals across the state and applies these targets to our statistical volumes. Our targeted FTEs per AOB at our current facility are 4.65 – this is a reduction of 75.8 FTEs based on our current AOB of 348.198.

If the current facility were renovated adding an additional 100,000 square feet of space, our FTE requirements would increase as follows:

Maintenance	6.39 FTEs
Security	3.45 FTEs
Housekeeping	13.13 FTEs
Patient Transport	1.56 FTEs
Nursing	7.00 FTEs
Total	31.53 FTEs

These additional FTE requirements were calculated using the actual FTEs per existing square foot used today and multiplying this ratio by an additional 100,000 square feet of space. This would result in an increase in FTEs per AOB to 4.74 from our current target of 4.65.

This CON assumes additional productivity improvements at a facility built at the Robinwood campus. FTEs per AOB are targeted at 4.52 in FYs 2009-2010 after the opening and transition to the new facility. These productivity improvements will be

achieved through the synergy of services resulting from the new facility's improved lay-out and design. At an AOB of 380.37, approximately 11.80 less Direct Care FTEs will be needed at the new facility. The nursing units will be designed in a triangle shape instead of the long "bowling alley" design of the current hospital. This design will allow caregivers to spend more time with the patient instead of walking to and from dirty utility rooms, supply stations, etc. This efficiency will provide more opportunity for bedside patient care while reducing caregiver fatigue resulting from having to take fewer steps. All inpatient nursing units in the replacement hospital will utilize the same design which will improve the efficiency of the flex nursing staff because supplies will be in the same location on each unit. Productivity improvements will be gain by eliminating minimal staffing patterns in the Emergency Department, Rapid Diagnostic Center, Outpatient Recovery, ICU and CCU by the new design of the units and co-location of the Behavioral Health unit and the Emergency Department. Additionally, there will be savings by locating support personnel directly on the nursing units such as Respiratory Care, Medical Records, and Utilization Review personnel. We also expect improvements in pharmacy personnel associated with the implementation of the tube delivery system in the replacement hospital, which will reduce manual delivery of pharmaceuticals.

Ancillary and outpatient services will benefit from the improved lay-out and design of the new facility as well. The replacement facility will be designed such that similar services now located in different locations can be co-located. For example, the outpatient treatment centers, for which the recovery areas are currently separated, are found in several different locations in the existing hospital; these outpatient treatment

centers will be located in one area in the replacement hospital. Also, ancillary staff will have dedicated space on each nursing unit. This design will promote team interaction, communication and a continuity of care that improves productivity and patient satisfaction.

The replacement facility will also facilitate productivity improvements in support services to be realized. At an AOB of 380.37, approximately 1.85 total less support FTEs in Maintenance, Security, Housekeeping and Linen will be needed to achieve a targeted FTE per AOB of 4.52. For example, fewer FTEs will be needed in Maintenance since less upkeep will be necessary at a new facility than the current older facility. Elevator usage will be physically separated between the public and patient transport which will improve the ease of transport for patients for various ancillary services while also facilitating improved security and privacy. Fewer FTEs will be needed in Dietary and Housekeeping/Linen since the use of separate service elevators will facilitate quicker delivery of food, linen and supplies. Also, the single room design of the replacement facility will enable patients to remain in one room experiencing fewer transfers to accommodate current issues of same sex placement of patients in semi-private rooms. This single room concept will reduce the number of bed turnovers required which will also reduce laundry and housekeeping FTE requirements. Consolidating inpatient nursing support in one area as well as in the outpatient setting for nursing services, reception and clerical positions will yield efficiencies (approximately .88 FTEs) as well.

Improved Information systems in the replacement hospital will enhance productivity in the areas of Medical Records and I.S. Support services – approximately .88 FTEs at an AOB of 380.37. The achievement of an essentially digital or paperless medical record for improved record keeping and cost-efficiency will facilitate these productivity improvements.

Lastly, the physical design and layout of the replacement hospital will contribute to achieving Administrative efficiencies as well - approximately 7.65 FTEs at an AOB of 380.37. In the current facility there is a redundancy in the number of managers, secretarial and office support personnel resulting from the many different locations of similar services. The co-location of these similar services planned for in the replacement facility will facilitate the reduction of these redundancies and promote overhead productivity improvements.

Section .06B(12). Expedited Review for Conversions.

(a) The Commission will grant an expedited review of a Certificate of Need application for conversions of excess acute care capacity to a non-acute health care service under the expedited review provisions of COMAR 10.24.01.07B(3), if the proposed service does not exceed a need identified in the State Health Plan and no other applicant proposes the same service to meet the same need.

(b) The Commission will approve the Certificate of this expedited review if the:

(i) Applicant demonstrates that appropriate quality of care will be assured, including meeting applicable standards established in the State Health Plan and by Federal, State, local and private accrediting bodies;

(ii) Proposed service will provide financial access to care consistent with standards for the service, or similar services, found in the State Health Plan;

(iii) Proposed service will be offered at a reasonable cost, and the hospital con document that its charges will be acceptable to payors, that is, public payors, private insurance, or private pay patients; and

(iv) Proposed service is in the public interest.

This project does not involve conversion of "excess acute care capacity to non-acute care health care service[s]."

Section .06B(13). Preference for Conversion to Non-Acute Care. When a Hospital proposes a conversion of excess acute care capacity to a non-acute care service subject to Certificate of Need review, the Commission may give preference to such a hospital project over a non-hospital applicant in a comparative review for that non-acute care service.

This project does not involve conversion of "excess acute care capacity to non-acute care health care service[s]."

Section .06B(14). Preference for Conversion to Acute Psychiatric Care. When two or more hospitals are in a comparative review for acute psychiatric services, the Commission will give preference to a proposal for conversion of excess acute care capacity over a proposal for new construction to provide the same services, and will give preference to applicants who sign a written agreement with the Mental Hygiene Administration as part of an application for state hospital conversion bed need, as described in the Acute Psychiatric Services section of the State Health Plan, COMAR 10.24.07.02B.

This standard is inapplicable because this project is not a comparative review involving acute psychiatric services.

Section .06B(15). Emergency Certificate of Need. In granting an emergency Certificate of Need requiring new construction or expansion of beds or services under COMAR 10.24.01.20, the Commission does not apply the standards in Regulation .06B of this Chapter.

This standard is inapplicable because WCHA does not seek an emergency certificate of need.

COMAR 10.24.09

State Health Plan for Facilities and Services: Acute Inpatient Rehabilitation Services

WCHA currently operates a 28-bed acute inpatient rehabilitation unit. A 20-bed inpatient rehabilitation unit is included in the new hospital. See Exhibit 2. Docketing and approval rules in the Rehab Chapter only apply to proposals for "new or expanded services." See COMAR 10.24.09.04(C)(1)(b) and (2)(b). The CON review standards in the Rehab Chapter applicable to the proposed project are addressed below.

Section .04D(1) – Licensure, Certification, and Accreditation. Unless otherwise exempted by an appropriate waiver, each applicant shall be able to demonstrate ongoing compliance with all federal, state, and local health and safety regulations.

WCHA complies with all applicable legal requirements and is accredited by the JCAHO.

Section .04D(2) – Transfer and Referral Agreements. Each applicant shall provide documentation prior to licensure that the facility will have written transfer and referral agreements with facilities, agencies, and organizations that:

(a) Are capable of managing cases which exceed its own capabilities; and

(b) Provide alternative treatment programs appropriate to the needs of the persons it serves.

See the response to Acute Care Chapter Standard .06A(7), supra at p. 20.

Section .04D(3) – Research. Each applicant shall demonstrate in what ways, if any, it intends to address research projects.

WCHA does not propose to conduct research in the 20-bed acute rehabilitation unit in the new hospital.

COMAR 10.24.12

State Health Plan for Facilities and Services: Acute Hospital Inpatient Obstetric Services

Section .04 Review Standards – The standards in this section are intended to guide Certificate of Need and CON exemption reviews involving acute hospital inpatient obstetric services.

Section .04(1) The Maryland Perinatal System Standards. Each applicant shall demonstrate the ability of the proposed obstetric program and nursery to comply with all essential requirements of Maryland's Perinatal System Standards, as defined in the perinatal standards, for either a Level I or Level II perinatal center.

This standard is inapplicable because the Hospital is not proposing to establish a new obstetrics program and nursery as part of this project. The proposed nursery in the replacement hospital will be designed to enable the Hospital to continue to provide special care newborn services, currently under development.

Section .04(2) Nursery. An applicant shall demonstrate that the level of perinatal care, including newborn nursery services, will be consistent with the needs of the applicant's proposed service area.

WCHA is the only acute care general hospital in Washington County, and currently operates a Level I Nursery. As described in the response to **Section .06B(4). Burden of Proof Regarding Need.**, above, WCHA is in the process of upgrading its newborn nursery services consistent with the needs of families residing it its service area. The goal of this upgrade is to operate a Level II Nursery, and thus be better able to address the needs of newborns by providing on-site neonatology services not currently available at the Hospital.

Section .04(3) Charity Care Policy. Each hospital shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to obstetric services regardless of an individual's ability to pay. Public notice and information regarding a hospital's charity care policy shall be in a format understandable by the target population, and shall include, at a minimum, the following:

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

(b) posted notices in the admissions office, business office and emergency areas within the hospital, and

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

See, Section .06A(5), supra at p. 18.

Section .04(4) Medicaid Access. The applicant shall provide, in its community needs assessment for obstetric services, a plan describing how the applicant will assure access to hospital obstetric services for Medical Assistance enrollees, including:

(a) an estimate of the number of Medical Assistance enrollees in its primary service area, and

(b) the number of physicians that will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.

The primary service area of WCHA is Washington County. Data on the number of Medical Assistance enrollees is found in a publication entitled, DHR Fact Pack. The most recent publication is found at Exhibit 23, which states that the average Medicaid enrollment among Washington County residents, SFY 1996 through SFY 2003, increased from 11,496 to 17,497. Currently, the Hospital has 10 obstetricians and 23 pediatricians who participate in the Medical Assistance program and have admitting

privileges at WCHA. A listing of these physicians can be found at http://dhmh3.dhmh.state.md.us.

Section .04(5) Outreach. Each applicant shall document an outreach program for obstetric patients in its service area who may not have adequate prenatal care, and provide hospital services to treat those patients. The program shall address adequate prenatal care, prevention of low birth weight and infant mortality, and shall target the uninsured, under-insured, and indigent patients in the hospital's primary service area, as defined in COMAR 10.24.01.B.

The principal means of outreach for obstetrics patients in the area who may not have adequate prenatal care is through Maryland Physicians Care, a Medical Assistance-approved Managed Care Organization. This Managed Care Organization is affiliated with Washington County Hospital, and has been established, in part, to address the medical needs of Medical Assistance patients, including providing adequate prenatal care, preventing of low birth weight and infant mortality.

Consistent with State regulation, Maryland Physician's Care schedules an appointment for the first prenatal visit and for a postpartum visit within 10 days of request and complete a prenatal risk assessment, using an instrument approved by the Department of Health and Mental Hygiene, and forwards this form to Local Health Departments. Maryland Physician's Care must also refer a woman identified as high risk to the Healthy Start Case Management program in the Local Health Department.

Maryland Physician's Care follows the American College of Obstetricians and Gynecologists (ACOG) guidelines and provides to providers who are capable of addressing complex maternal and infant health issues, including obstetricians,

gynecologists, perinatologists, neonatologists, anesthesiologists, and advanced practice nurses.

Maryland Physician's Care provides substance abuse treatment for pregnant and postpartum substance abusers within 24 hours of request. In addition, offers nutrition counseling, smoking cessation education, and voluntary HIV counseling and testing, refers pregnant and postpartum women, infants, and children under five years of age to the WIC Program. In addition, Maryland Physician's Care links a pregnant woman with a pediatric provider prior to delivery, and arranges for the appropriate emergency transfer of pregnant women, newborns, and infants to tertiary care centers.

Section .04(6) Community Benefit Analysis. Each applicant proposing to establish a new obstetric program will develop and submit a Community Benefit Program Plan addressing and quantifying the unmet community needs in obstetric and perinatal care within the applicant's anticipated service area population, and providing a detailed description of the manner in which the proposed perinatal program will meet these needs, and the resources required. At a minimum, the Community Benefit Program must include:

(a) a needs assessment related to obstetric and nursery services for the proposed program's service area population;

(b) a description of the manner in which the proposed perinatal program will satisfy unmet needs identified in the needs assessment and/or a description of programs related to and developed in conjunction with the proposed perinatal program to meet needs identified in the needs assessment, including information on the structure, staffing and funding of such programs;

(c) documentation of involvement in program planning and support for the Plan by other agencies, organizations or institutions which will be involved with the applicant in implementing the Plan;

(d) measurable and time-limited goals and objectives for the unmet needs addressed by the Plan which allow for evaluation of Plan implementation; and

(e) a description of and a time-line for the process of evaluating successful implementation of the Community Benefit Program Plan.

(f) Applicants must commit to implementation of the Community Benefit Program Plan and continuing commitment to the Plan as a condition of CON approval, and as an ongoing condition of providing obstetric services.

(g) Applicants must agree to submit an Annual Report to the Commission which will include:

(i) an evaluation of the achievement of the goals and objectives of the Community Benefit Program Plan; and

(ii) information on staffing levels and the total costs of any programs implemented as part of the Community Benefit Program Plan.

This standard is inapplicable. WCHA is not proposing a new obstetric program.

Section .04(7) Source of Patients. An applicant for an obstetric service shall demonstrate that the majority of its patients will come from its primary service area.

This standard is inapplicable, WCHA already has an OB service.

Section .04(8) Staffing. Each applicant shall provide information on the proposed staffing, associated number and type of FTEs, projected expenses per FTE category and total expenses for labor and delivery, post-partum and nursery services, including nurse staffing, non-nurse staffing and physician coverage, at year three and at maximum projected volumes.

This standard is inapplicable because WCHA is not proposing to establish a new obstetrics and newborn program. As related above, following completion of this project, WCHA will designate 20 OB beds among the total number of acute care hospital beds eligible for licensure.

Section .04(11) Minimum Volume.

(a) An applicant for an obstetrics program must be able to demonstrate to the Commission's satisfaction that the proposed program can achieve a minimum volume of 1,000 admissions annually in metropolitan

jurisdictions, or 500 cases annually in non-metropolitan jurisdictions, within 36 months of initiation of the program.

(b) As a condition of approval, the applicant shall accept a requirement that it will close the obstetric program, and its authority to operate will be revoked, if:

(i) it fails to meet the minimum annual volume for any 24 consecutive month period, and

(ii) it fails to provide good cause for its failure to attain the minimum volume, and a feasible corrective action plan for how it will achieve the minimum volume within a two-year period.

This standard is inapplicable, WCHA already has an OB service.

Section .04(12) <u>Impact on the Health Care System.</u>

(a) An application for a new perinatal program will be approved only if its likely impact on the volumes of obstetric discharges at any existing obstetric program, after the three year start-up period, will not exceed 20 percent of an existing program's current or projected volume.

(b) When determining whether to approve an application for an obstetrics program the Commission will consider whether an existing program's payer mix of obstetrics patients will significantly change as a result of the proposed program, and the existing program will have to care for a disproportionate share of the indigent obstetrics patients in its service area; and

(c) When determining whether to approve an application for an obstetrics program the Commission will also consider the impact on a hospital with an existing program that has undertaken a capital expenditure project for which it has pledged pursuant to H-G Article §19-123(k) not to increase rates for that project, so long as the pledge was based, at least in part, on assumptions about obstetric volumes.

This standard is inapplicable, WCHA already has an OB service.

Section .04(13) Financial Feasibility. Hospitals applying for a Level I or II perinatal program must clearly demonstrate that the hospital has the financial and non-financial resources necessary to implement the project, and that the average charge per admission for new perinatal programs will be less than the current statewide average charge for Level I and Level II perinatal programs. When determining whether to approve an application for an obstetric program, the Commission will consider the following:

(a) the applicant's projected sources of funds to meet the program's total expenses for the first three years of operation,
(b) the proposed unit rates and/or average charge per case for the perinatal services,
(c) evidence that the perinatal service will be financially feasible at the projected volumes and at the minimum volume standards in the Plan, and
(d) the written opinions or recommendations of the HSCRC.

This standard is inapplicable, WCHA already has an OB service.

10.24.01 .08G(3)(b). Need.

For purposes of evaluating an application under this subsection, the Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Please discuss the need of the population served or to be served by the Project.

For applications involving projects in which need has not been defined in the State Health Plan, responses should include a quantitative methodology that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. For applications proposing to address the need of special population groups identified in this criterion, please specifically identify those populations that are underserved and describe how this Project will address their needs.

WCHA is the only acute care hospital in Washington County, Maryland. As a full-service general hospital with a Level III Trauma Center and acute inpatient rehabilitation beds, WCHA serves residents of Washington and Frederick Counties in Maryland, Franklin and Fulton Counties in Pennsylvania, and Morgan, Jefferson, and Berkeley Counties in West Virginia.

Inpatient Services

WCHA's service area and discharge data are shown on Chart 1 below. As shown there, WCHA's service area has been fairly constant from CY 2000 to CY 2003, with most patients residing in the greater Hagerstown area. WCHA anticipates that its service area in 2010 will be substantially the same as it is today. A zip code map depicting the areas served by WCHA is attached as Exhibit 24.

WCHA's Inpatient Service Area

Chart 1. Service Area of Washington County Hospital					
Zip Code	Place Name	2001 Discharges	2002 Discharges	2003 Discharges	Cumulative % 2003 Discharges
21740	Hagerstown	7,158	6,786	6,561	38.53%
21742	Hagerstown	2,314	2,292	2,602	53.81%
21713	Boonsboro	860	826	992	59.63%
21795	Williamsport	954	821	858	64.67%
21783	Smithsburg	592	531	512	67.68%
21722	Clear Spring	452	439	450	70.32%
17225	Greencastle, Pa.	318	336	360	72.44%
17268	Waynesboro, Pa.	285	321	351	74.50%
21750	Hancock	381	390	343	76.51%
25419	Falling Waters, W. Va.	332	272	322	78.40%
25401	Martinsburg, W. Va.	248	290	318	80.27%
21782	Sharpsburg	271	306	304	82.05%
21756	Keedysville	185	141	177	83.09%
21767	Maugansville	140	146	166	84.07%
All Other Zips		2,674	2,534	2,713	15.93%
TOTAL		17,164	16,431	17,029	100.00%

Source: Maryland Discharge Abstract.

WCHA'S discharges by jurisdiction and its share of all Maryland hospital discharges are shown below in Chart 2. These data indicate that Washington County residents depend on the inpatient services provided by WCHA. More than 86% of Washington County residents discharged from a Maryland hospital in 2003 were discharged from WCHA. Not surprisingly, close to 80% of the patients hospitalized at WCHA in 2003 were Washington County residents. Fifteen percent (15%) of WCHA's discharges originated in Pennsylvania and West Virginia; the remaining 5% were residents of other Maryland jurisdictions and other states. Nearly one in five Pennsylvania residents and one in seven West Virginia residents who were discharged from a Maryland hospital in 2003 were discharged from WCHA.

Chart 2. Market Share of Washington County Hospital				
	CY 2003 Discharges (includes Newborns)			
	Washington County Hospital		Maryland Hospitals	
Jurisdiction	Total Discharges	% Total	Total Discharges	Market Share
Washington County	13,563	79.65%	15,764	86%
Frederick County	543	3.19%	18,874	3%
Pennsylvania	1,475	8.66%	8,316	18%
West Virginia	1,112	6.53%	6,617	17%
All Other Jurisdictions	336	1.97%		
TOTAL	17,029	100.01%		

Source: Maryland Discharge Abstract.

Characteristics of the Population Served by WCHA

As shown above, Washington County Hospital is a regional medical center, serving residents of Washington County and neighboring counties in Maryland, West Virginia and Pennsylvania. As shown on Chart 3 below, the population of WCHA's service area is projected to grow by nearly 7% between 2000 and 2010.

Chart 3. Service Area Population, Washington County Hospital			
Jurisdiction	2000 Estimate	2010 Forecast	% Increase
Maryland	5,296,486	5,747,051	8.51%
Washington County	131,923	139,005	5.37%
Pennsylvania	12,241,488	12,407,523	1.36%
Bedford County	50,143	52,327	4.36%
Franklin County	128,644	131,561	2.27%
Fulton County	15,092	15,996	5.99%
West Virginia	1,808,344	1,779,017	-1.62%
Berkeley County	75,905	90,005	18.58%
Total Service Area Population	401,707	428,894	6.77%

Source: Maryland Department of Planning; Pennsylvania State Data Center; West Virginia University Regional Research Institute.

In addition to serving more people in 2010, the population served will be older, as shown in Chapter 4 below. Of note, the number of Washington County residents over 75 years of age will increase by 13.23% between 2000 and 2010.

Chart 4. Aging of the Service Area Population, Washington County, Maryland Residents

Age Cohort	2000 Estimate	2010 Forecast	% Increase
0-14	25,745	24,962	-3.04%
15-44	57,137	55,268	-3.27%
45-64	30,351	38,487	26.81%
65-74	9,803	10,238	4.44%
75+	8,887	10,061	13.21%
TOTAL	**131,923**	**139,016**	**5.38%**

Source: Maryland Department of Planning, 2002 Total Population Projections (9/27/02).

Approximately 90% of Washington County's population is white. The all-causes mortality rate (per 1,000 population) of 969.5 in 2000 exceeds the state average for all races. The infant mortality rate was 5.6 per 1,000 live births, less than the statewide average. The median household income in 1999 was estimated to be $40,708. Of the 39,000 families in the County, approximately 7% were below the Federal poverty level in 2000.

The first step in WCHA's need methodology is to compute WCHA's market share by comparing the Washington County residents discharged from WCHA by type of service with the Washington County residents discharged from all Maryland hospitals. That information is provided below in Chart 5.

Chart 5. Washington County Resident Discharges – Maryland Hospitals[28]									
	Total Discharges			Discharged from WCHA			WCHA Market Share		
Service/Year	2001	2002*	2003	2001	2002	2003	2001	2002	2003
Obstetrics	1,686	1,710	1,715	1,474	1,493	1,493	87.4%	87.3%	87.1%
Psychiatry	645	628	488	597	591	457	92.6%	94.1%	93.6%
Rehabilitation	231	320	329	219	296	314	94.8%	92.5%	95.4%
Pediatrics	885	775	684	692	550	463	78.2%	71.0%	67.7%
M/S/G/A									
15-44	2,060	2,014	1,934	1,685	1,536	1,565	81.8%	76.3%	80.9%
45-64	3,241	3,132	3,338	2,648	2,491	2,718	81.7%	79.5%	81.4%
65+	5,699	5,294	5,671	5,212	4,831	5,161	91.5%	91.3%	91.0%
TOTAL	14,447	13,873	14,159	12,527	11,788	12,171	86.7%	85.0%	86.0%

**CY 2002 excludes discharges not comparable to Washington County Hospital for HSCRC Case-Mix calculations, e.g, organ transplants.*

WCHA also compared the discharges of Washington County residents by type of service with the discharges from other Maryland counties and other states. Those data are set forth below.

CHART 6. WCHA Discharges									
	Washington County Residents			Non-Washington County Resident Discharges			Total – WCHA		
Service/ Year	2001	2002	2003	2001	2002	2003	2001	2002	2003
Obstetrics	1,474	1,493	1,493	389	475	508	1,863	1,968	2,001
Psychiatry	597	591	457	158	187	124	755	778	581
Rehabilitation	219	296	314	95	90	120	314	386	434
Pediatrics	692	550	463	131	113	111	823	663	574
M/S/G/A									
15-44	1,685	1,536	1,565	649	495	568	2,334	2,031	2,133
45-64	2,648	2,491	2,718	716	720	715	3,364	3,211	3,433
65+	5,212	4,831	5,161	743	715	828	5,955	5,546	5,989
TOTAL	**12,527**	**11,788**	**12,171**	**2,881**	**2,795**	**2,974**	**15,408**	**14,583**	**15,145**

[28] In compiling these data, WCHA defined the various services as follows: 1) Obstetrics (DRGs 370-379; 380-384); 2) Psychiatry (DRGs 424-428 and 430-432); 3) Rehabilitation (DRG 462); 4) Pediatrics, all discharges age <15, not Newborn, Psychiatry or Obstetrics; 5) Newborn (DRGs 385-391); and 6) Adult Medical/Surgical, all other discharges not Newborn, Psychiatry, Obstetrics, Rehabilitation or Pediatrics. These classifications approximate the utilization of inpatient beds at Washington County Hospital.

WCHA's methodology assumes that inpatient utilization by residents of Maryland jurisdictions other than Washington County and by residents of other states will be the same in 2010 as in 2003, i.e., approximately 20% of the total discharges. As shown on Chart 7 below, the inpatient services for which there is a lower proportion of discharges among Washington County residents are the regional services which attract out-of-state residents, e.g., rehabilitation and psychiatric and, to some extent, obstetric care.

CHART 7. Market Share and Proportion of Discharges, WCHA (2003)

Service	WCHA Market Share	WCHA Discharges Attributable to Washington County Residents
Obstetrics	87.1%	74.6%
Psychiatry	93.6%	78.7%
Rehabilitation	95.4%	72.4%
Pediatrics	67.7%	80.7%
M/S/G/A		
15-44	80.9%	73.4%
45-64	81.4%	79.2%
65+	91.0%	86.2%
AVERAGE	**86.0%**	**80.4%**

The next step in WCHA's methodology was to calculate the Maryland hospital use rates for inpatient services, except obstetrics, by Washington County residents. Because there are significant variations in the inpatient utilization of MSGA services, use rates are calculated for three age cohorts: 15-44, 45-64 and 65+. The 2003 use rates shown on 8 below:

CHART 8. Washington County Resident Use Rates, CY 2003			
Service	**CY 2003 Discharges**	**2003 Population**	**Use-Rate/1,000**
Psychiatry*	488	109,132	4.50
Rehabilitation*	329	109,132	3.01
Pediatrics	684	25,451	26.88
M/S/G/A			
15-44	1,934	56,436	34.30
45-64	3,338	33,402	101.02
65+	5,671	19,293	293.94

**Adults age 15+.*
Source: Interpolated population projections, Maryland Department of Planning.

To forecast the number of discharges in CY 2010, WCHA assumed that the 2003 age specific use rates will remain constant. To estimate discharges of Washington County residents from all Maryland hospitals in 2010, WCHA applied the use rate in Chart 8 to the population estimate for 2010. See Chart 9, below.

CHART 9. Forecasted Discharges/1000 Washington County Residents, CY 2010			
Service	**2010 Population**	**Use-Rate/ 1,000**	**Discharges**
Psychiatry	114,054	4.50	513
Rehabilitation	114,054	3.01	343
Pediatrics	24,962	26.88	671
M/S/G/A*			
15-44	55,268	34.30	1,896
45-64	38,487	101.02	3,888
65+	20,299	293.94	5,967
TOTAL			**13,278**

To estimate discharges in CY 2010, WCHA assumed that its market share and proportion of total discharges attributable to Washington County residents would remain the same. The discharges projected by WCHA for 2010 are noted in 10 below.

CHART 10. Forecasted Discharges at WCHA, CY 2010

Service	(a) Washington County Discharges	(b) Market Share Adjustment	(c) Allocation for Other Discharges	(a)*(b)/(c) WCHA TOTAL
Psychiatry	513	93.6%	78.7%	610
Rehabilitation	343	95.4%	72.4%	452
Pediatrics	671	67.7%	80.7%	563
M/S/G/A*				
15-44	1,896	80.9%	73.4%	2,090
45-64	3,888	81.4%	79.2%	3,996
65+	5,967	91.0%	86.2%	6,299
SUBTOTAL	**13,278**			**14,010**
Obstetrics				2,266
TOTAL				**16,276**

In sum, excluding obstetrics, WCHA projects that its discharges will increase from 13,144 in CY 2003 to 14,010 in CY 2010, i.e., 1% per year, assuming no change in patient migration and market share between CY 2003 and 2010.

Obstetrics discharges involving Washington County residents have been steady, as shown on Chart 5 above. In Maryland Hospital Obstetrics Services: Trends and 2006 Utilization Forecast, the Commission relates that Washington County had the highest fertility rate in Maryland in 1999, i.e., 66 births per 1,000 females age 15-44. WCHA is clearly the obstetrics provider of choice for residents of Washington County and the surrounding areas.

Almost nine out of every ten Washington County residents who give birth have their babies at WCHA. Out-of-county and out-of-state residents also choose WCHA for obstetrics care, since the proportion of the Hospital's total OB discharges in 2003 attributable to Washington County residents (74.6%) is below WCHA's market share (87.1%). For this reason, WCHA agrees with the Commission's forecast that obstetrics discharges will increase from 1,816 in CY 2000 to 2,094 in CY 2006.[29] WCHA extended this forecast to CY 2010, producing a 2% annual average increase in obstetrics discharges per year, or approximately 2,266 obstetrics discharges in CY 2010. It should be noted that the proportion of non-Washington County residents discharged from Washington County Hospital for Obstetrics services has increased from 20% to 25% from CY 2001 to CY 2003 (See Chart 6 above). The Hospital believes that most of this growth in Obstetrics admissions between FY 2004 and FY 2010 will be as a result of continuing increasing use of the Hospital by non-Washington County residents.

[29] The Commission subsequently released 2007 and 2008 forecasts for Washington County indicating 1,860 and 1,914 expected obstetric discharges at WCHA respectively, a decrease from the previously published 2006 forecast. These subsequent forecasts do not account for the 30% increase in non-Washington County Obstetrics discharges at the Hospital since CY 2001 (See Chart 6. above)

WCHA projects that inpatient admissions will increase between FY 2005 and FY 2010, as related on Table 1. These estimates reflect the fiscal year periods, not calendar years. Projected annual increases in admissions by service vary between 2.9% for Obstetrics and Rehabilitation admissions, 1.9% for Psychiatric admissions, 1.3% for MSGA and ICU admissions, and no growth in Pediatric admissions, following completion of the Project. Both sets of discharge projections and admission forecasts are summarized below.

CHART 11. Comparison Between Forecasted Discharges and Projected Admissions, WCHA				
Service	**CY 2003 Discharges***	**FY 2004 Admissions****	**CY 2010 Discharges***	**FY 2010 Admissions****
Obstetrics	2,001	2,037	2,266	2,398
Psychiatry	581	986	610	1,093
Rehabilitation	434	475	452	573
Pediatrics	574	603	563	685
M/S/G/A				
15-44	2,133		2,090	
45-64	3,433		3,996	
65+	5,989		6,299	
MSAGA Subtotal	11,555	11,148	12,385	12,660
TOTAL	15,145	15,549	16,276	17,409

**by MHCC DRG classifications by service.*
***by Inpatient Units.*

WCHA forecasts ALOS based on past patterns of utilization, and, for medical/surgical cases, continuing changes in case-mix adjusted ALOS already taking place.

Outpatient Services

Four types of outpatient services provided by WCHA are rate-regulated: emergency department visits, clinic visits, psychiatric day visits, and ambulatory

surgery. Consistent with the projected increases in admissions, WCHA estimates a 3.75% annual increase in emergency room visits and a 2% annual increase in all other outpatient services from FY 2005 through FY 2010. These projections are also shown on Table 1. The following discussion supplements the information submitted in response to Section .06B(4), Burden of Proof Regarding Need, and addresses need issues of interest to the Commission staff.

Emergency Department

At present, the Level III Trauma Center/Emergency Department ("ED") experiences 67,000 visits per year. As noted above, WCHA forecasts that ED visits will increase to 93,754 in FY 2010.

The existing ED has 28 treatment beds but only 27 are operational. The ED in the new hospital will have 45 treatment rooms for emergent, express and urgent care, i.e., four trauma/cardiac rooms, which can "flex" to six rooms in response to a disaster, 27 rooms for emergent care, 3 rooms for specialty care or isolation, two rooms for behavioral health patients, nine rooms for express care, eight rooms will be included for rapid diagnosis/observation patients.

Four million, seven hundred thousand dollars ($4,700,000) of new construction cost is allocable to the ED. Approximately $2,780,000 of new equipment will be purchased. Existing equipment valued at $272,000 will be relocated from the existing hospital. See Exhibit 25.

The current and proposed square footage of the current and proposed Emergency Department treatment rooms, operating rooms and procedures rooms are shown below:

	Current		Proposed	
	Number of Rooms	Square Footage	Number of Rooms	Square Footage
ED Treatment Rooms	28	15,133	53	31,206

There will be no patient bays dedicated only to the care of pediatric patients in the Emergency Department of the replacement Hospital. All forecasts of future Emergency Department outpatient visits are for patients of all ages. Volumes of visits to the Hospital Emergency Department by patients age 0-16 are shown below:

ED Visits, Age 0-16	
FY 2003	14,271
FY 2002	14,618
FY 2001	13,618

The Hospital does not currently designate a particular number of "holding beds" or "observation beds" in the ED. Specific plans for "holding beds" are not included in the replacement hospital. Emergency Department consists of Emergency Department Visits, visits to the Rapid Diagnostic Center and visits to Express Care. Patients who require extended observation are recorded as Rapid Diagnostic Center visits. The number of visits for each of these services is shown below for the past three years.

Total Visits to the Washington County Hospital Emergency Department				
	ED	Rapid Diagnostics	Express Care	TOTAL
FY 2004	44,517	1,306	21,009	66,832
FY 2003	42,131	1,024	18,676	61,831
FY 2002	43,173	560	19,968	63,701
FY 2001	42,067	0	19,872	61,939

*Projected demand exceeds current capacity due to space limitations.

The ED is designated by the Mental Hygiene Administration for evaluation of Emergency Petitions for Psychiatric Evaluation (See Exhibit 26).

In the replacement hospital, the management of psychiatric emergencies will be much more efficient and effective due to the adjacency of the 18-bed inpatient behavioral health unit and its clinical staff to the future Emergency Department. It is anticipated that the proximity of the inpatient unit will improve the care of patients in acute crises who present in the Emergency Department. In the Emergency Department itself, there will be two psychiatric holding rooms.

The most significant factor contributing to the emergency department overcrowding at WCHA has been the combination of overwhelming demand and insufficient space. WCHA responded to the growing demand by developing "urgent care" services at the Robinwood Medical Center in FY 2003.

The existing ED was designed to serve 35,000 patients. The current volume is

closer to 63,000. In addition, the ED was designed and constructed 20 years ago and did not take into account patient privacy issues or patient centered care. The replacement Hospital will both expand and enlarge the Emergency Room treatment areas. Currently, the 25 rooms support only 35,000 visits without a Rapid Diagnostic Service, and the planned 53 exam spaces will support 78,800 visits plus 8 rapid diagnostic spaces as projected for FY 2010.

Existing ED DGSF	15,850 square feet	566 DGSF/room
New ED DGSF	28,150 square feet	531 DGSF/room
Existing Trauma Bay	220 square feet	
New Trauma Bay	270 square feet	
Existing OR	8 Rooms @ 360 +/- square feet 1 Room @ 500 square feet 2 Rooms @ 600 +/- square feet	
New OR	5 Rooms @ 420 square feet 6 Rooms @ 640 square feet	
Existing Endoscopy	265 square feet	
New Endoscopy	335 square feet	

Outpatient Surgery

The existing hospital has eleven mixed-use/general purpose operating rooms, one OR dedicated to cystoscopies, and three procedure rooms. Endoscopies are performed in two procedure rooms outside the operating suite. The new hospital will have thirteen operating rooms and two dedicated C-section ORs in the OB unit, an OR reserved for trauma cases and an OR used only for Cystoscopies. Three procedure

rooms will be used only for endoscopies. No ORs are dedicated to C-sections or trauma cases.

The chart below indicates the number and location of operating rooms and procedure rooms in the current and proposed replacement hospital:

	Current		Proposed	
Room Type	Inside Sterile Area	Outside Sterile Area	Inside Sterile Area	Outside Sterile Area
General Inpatient OR				
General Outpatient OR				
General Mixed-use OR	11		11	
Special Inpatient				
Special Outpatient				
Special Mixed				
Other OR				
Dedicated C-Section OR			2	
Dedicated Cysto	1		1**	
Dedicated Endoscopy		2		3
Other: Special Procedure Rooms		5		2
Other: Cath & EP		1		3
TOTAL	12	8	14	8
***Doubles as an OR*				

Patient Safety

With respect to the design features of the project that incorporate patient safety infrastructure and technology design, the replacement hospital features multiple levels of security from having the building perimeter electronically monitored at all

times, to controlled access systems for individual departments to protect against unwarranted public intrusion or infant abduction. Second, the design of the building will prevent public access to patient care areas such as surgery or radiology. The Public will be denied access to patient service elevators. Third, state-of-the-art telecommunications technologies will be built in, such as a fibre optic backbone, and distributed information services closets to permit to flexibility in introducing known and anticipated technologies. Fourth, the Radiology Department will be entirely digital. This will improve accuracy, access and retrieval, and permit viewing where needed: at the OR table, trauma bed, or in the nursing unit. Fifth, all HVAC systems will exceed current standards, and permit all patient care sites to be optimized for environmental conditions specific to patient needs. Sixth, return air from the Emergency Department and one nursing unit can be diverted to direct exhaust and thereby create large scale isolation conditions for environmental protection in the event of a bio terror event.

WCHA's strategic initiatives contain initiatives to develop an electronic medical record, and CPOE. WCHA has Meditech Information systems and had purchased the Meditech version of Physician Order entry. This is a relatively new software package and has evidenced some problems in installation at other facilities. WCHA is planning to install this package after intense review and with participation of the Medical Staff to ensure successful installation. This initiative is currently underway, and will continue prior to the construction of the replacement Hospital. Medication dispensing is planned to be automated and bar-coded in the replacement Hospital.

WCHA has made progress to move to a paperless medical record, which also involves significant involvement of the Medical staff in implementation. WCHA has a largely digital medical record currently and a paperless medical record will be introduced within the next several years. This is a long-term project and will be continued in the replacement Hospital.

WCHA has investigated several options regarding use of intensivists, and evidence-based medicine. These initiatives involve significant cost outlays in some cases and changes in the product distribution and delivery systems. WCHA is committed to improving patient safety in the hospital and will incorporate those initiatives that are successful and that are "tried and true" within the context of the resources available to the hospital.

WCHA has planned this project to ensure project sustainability, patient safety, efficiency to better serve patients and physicians, enhance patient access to services, flexibility to accommodate future needs and technology, and to anticipate increasing demand for service. WCHA will take advantage of opportunities to advance these goals throughout the design and development of the replacement Hospital.

Over 20 site visits by staff, managers and physicians and over three years of preparation/research led to the safety initiatives incorporated into design. Guiding principles were incorporated into design at each step, providing prioritization in

decision-making. User involvement has been incorporated from the beginning, and at all design phases. [30]

They include:

•Separate elevators for the public, patients and equipment. Patient access limited through restricted corridors, badging requirement, and elevator access. Additional elevators decrease wait time, promoting patient privacy.[31]

•All elevators serve all floors

•Increased points of entry on services. Designated discharge areas for car, courtesy van, routine ambulance, transport – increasing efficiency and flow. [32]

•Additional protection for vulnerable populations: newborns, pediatrics, behavior health, geriatrics and brain injury patients.[33]

•Adjacencies of Emergency Department and Behavior Health where trained personnel immediately available to serve needs of behavioral health patients.[34]

•Ability to segregate one unit from the rest of the hospital in the event of biohazard outbreak

•Many doors automatic or delayed close timing devices to facilitate safe transport of patients and supplies

•Inpatient and outpatient areas segregated

[30] "Enhancing the Traditional Hospital Design Process, A Focus on Patient Safety," Joint Commission Journal on Quality and Safety, March, 2004.
[31] Sako & Associates, Inc: Washington County Hospital Security Recommendations Report, April 2003.
[32] Dill, RN, Sue: "Reducing Medical Errors and Improving Patient Safety Update," April 2004.
[33] Thrall, Terese: "The Patient," Hospitals & Health Networks, 34-51, May, 2004.
[34] "Enhancing the Traditional Hospital Design Process, A Focus on Patient Safety," Joint Commission Journal on Quality and Safety, March, 2004.

•Room mockups provided during design phase, utilizing caregiver feedback in placement of equipment.[35]

•Dedicated family space, acknowledging family's role in healing, including the family as an advocate for safety, and including family in plans of care and discharge.[36]

•Standardization: ED and OR rooms identical.[37]

•Operating rooms size consistent, adequate size to accommodate technology, equipment.

•Patient room design, standardization of gases and equipment.

•Rapid Diagnostic Unit. [38]

•Single rooms reduce infection rates.[39],[40]

•Reduce patient identification errors or return to wrong bed.[41]

•Allows for ease of patient access, transfer, manipulation of beds and equipment in room, promotes patient and staff safety.

•Private toilet and hand washing facilities.

•Close proximity between bed and bathroom reduce potential for patient falls.

•Promote ability of team to discuss patient issues without fear of violating privacy.[42]

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[35] Thrall, Terese: "The Patient," Hospitals & Health Networks, 34-51, May, 2004.
[36] "Family-Centered Care," Institute for Family-Centered Care, 246, 247, 469-480.
[37] Larson, Laurie: "Putting Patient Safety in the Blueprint," Hospitals & Health Networks, 46-53, February, 2003.
[38] "Redesign Helps ED Staff Deliver State-of-the-Art Patient Care," ENA, March, 2002.
[39] "Remaking of the Acute Care Infrastructure," The Advisory Board Company, 61-67, 2004.
[40] Based on the experience of WCHA, infection rates were reduced by 8% following the conversion of the Obstetrics Unit to an "all single room" configuration.
[41] "A Healthy Kind of Supersizing: New Hospital Rooms are Bigger, Nicer and Far More Cost-Effective," Healthcare Leadership Report, April, 2004.

•Patients visible to caregivers.

•HEPA air filters throughout hospital; Isolation rooms on each unit

•Provide large windows, natural light, pastoral views.

•Exam room in Behavioral Health provides for a physical exam space without removing patient from the secure environment.

•Standardization between units, common equipment, spaces triangular shape provides "core" for support services.

•Closer observation of patients.[43]

•Decentralized, multiple workstations promote MD/staff collaboration while keeping caregivers close to patients.[44]

•Ancillary staff have dedicated space on unit; promoting team interaction, communication, continuity of care and increases availability of staff to address patient needs.

•Fewer steps reduces caregiver fatigue, a factor in errors. Design promotes quicker staff response to patient needs – emergency care and increase in satisfaction.[45],[46]

•Locations and numbers of medication preparation and supply rooms promote reduction of medication errors and minimize distractions.[47]

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[42] Kaldenberg, PhD, Dennis: "The Influence of Having a Roommate on Patient Satisfaction," July, 2000, Available online: http://www.pressganey.com/research/resources/pubarticles/bin/15.shtm
[43] Ferrie, Brian: "Dreams Come True After All," Advance for Nurses, 12-17, December 10, 2001.
[44] Greene, Jan: "A Happy Workplace," Hospitals & Health Networks, 24-26, April, 2002.
[45] Goe, FACHE, Steven and Coye, MD, Molly: "Designing the Healthcare Facility of the Future," 2004 Congress on Healthcare Management: Best Practices for Healthcare Leaders, March 2003.
[46] Dowler, RN, Rhonda: "Nurses will benefit from new hospital," The Herald Mail, October 26, 2003
[47] Center for the Study of Healthcare Management: "Designing a Safe Hospital," Carlson School of Management, University of Minnesota.

•Tube system provides supplies without taking care givers away from patients.[48]

•Automated Systems:

- Immediate access to patient information electronic record, PACS
- Nurse Call, communication systems

•Selected Individual rooms for Rehab are larger to accommodate severely handicapped clients.

•Patients, staff and physician input incorporated into each phase of design.

•Surgery/special procedures/recovery provides for one location for recovering patient maximizing utilization of staff for this critical function.

.•Anesthesia and recovery staff not spread throughout separate recovery areas.

•Units which typically utilize certain service lines are planned to be adjacent to one another increasing efficiency, staffing effectiveness, and limiting distance transports.

•LDRP, Women's & Children together.

•ICU and CCU merged next to step down and med/surg telemetry

•Outpatient areas on same floor, segregated from inpatient with dedicated admission and discharge areas

•Configuration and number of patient units/beds promotes reduction of patient transfers, a key factor in reducing communication related errors.[49]

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[48] Beach, MD, Christopher and Seiling, MBA, MHA, John: "Designing Patient-Centered .....to Enhance the Culture of Safety," 6th Annual NPSF Patient Safety Congress, May, 2004.

•Workflow analyses incorporated into designs.

- •Inpatient/outpatient flow
- •nurse call
- •surgery
- •communication devices
- •medication administration
- • alarm system
- • team interaction

•Patient/family centered care expressed in design of departments, rooms, private family areas.

•Wherever possible, care brought to the patient. [50]

•Vulnerable populations addressed through design choice and utilizing available technology.

•Use of automated bar-code based technology to eliminate dispensing errors and to provide the necessary architecture for point of care bar-code verification at the time of medication administration.[51]

•Institute dispensing technology to reduce pharmacy labor requirements and redeploy pharmacists into patient focused clinical roles.[52]

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[49] "Twenty-Five Lessons for Managing the Inpatient Enterprise for Profitable Growth," The Advisory Board Company, 168-169, 2001.

[50] Runy, Lee Ann: "HealthSouth, Oracle lay plans for digital 'hospital of the future'," AHA News, April, 2001.

[51] Larrabee, S.: "Recognizing the Institutional Benefits of Bar-Code Point of CareTechnology," Joint Commission Journal on Quality and Safety, 29:345-353, 2003.

[52] Bates DW et al: "The costs of adverse drug events in hospitalized patients," JAMA, 277:307-311, 1997; Leape LL, et al: "Pharmacist Participation On Physician Rounds and Adverse Drug Events in the Intensive Care Unit," JAMA, 282:267-270, 1999.

Incorporate a state of the art sterile preparation area for pharmaceutical compounding that meets or exceeds the 2004 standards of the United States Pharmacopoeia.[53]

[53] United States Pharmacopeia/National Formulary. USP General Chapter 797. Pharmaceutical Compounding - Sterile Preparations. 2004.

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization				
Fiscal Year	2003	2004	2005	2006	2007	2008	2009	2010
1. Admissions								
a. M/S/G/A	9,506	10,181	10,332	10,580	10,718	10,857	10,998	11,141
b. Pediatric	625	603	685	685	685	685	685	685
c. Obstetric	1,943	2,037	2,083	2,142	2,203	2,266	2,331	2,398
d. Intensive Care	1,348	1,267	1,407	1,442	1,462	1,481	1,500	1,519
e. Psychiatric	923	986	996	1,015	1,034	1,053	1,073	1,093
f. Rehabilitation	395	475	494	509	525	540	556	573
g. ECF	492	416	0	0	0	0	0	0
h. TOTAL	**15,232**	**15,985**	**15,997**	**16,373**	**16,627**	**16,882**	**17,143**	**17,409**

Table 1 cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization				
Fiscal Year	2003	2004	2005	2006	2007	2008	2009	2010
2. Patient Days								
a. M/S/G/A	47,893	48,884	48,189	48,816	49,450	50,093	50,774	51,404
b. Pediatric	1,372	1,194	1,370	1,370	1,370	1,370	1,370	1,370
c. Obstetric	3,917	4,119	4,234	4,363	4,497	4,634	4,775	4,921
d. Intensive Care	5,041	5,097	6,571	6,657	6,743	6,831	6,920	7,010
e. Psychiatric	4,862	4,502	4,610	4,779	4,954	5,135	5,323	5,517
f. Rehabilitation	3,862	4,161	4,401	4,658	4,929	5,216	5,521	5,842
g. ECF	8,034	6,283	0	0	0	0	0	0
h. TOTAL	**74,981**	**74,240**	**69,375**	**70,643**	**71,943**	**73,279**	**74,683**	**76,064**
3. Average Length of Stay								
a. M/S/G/A	5.04	4.80	4.66	4.61	4.61	4.61	4.62	4.61
b. Pediatric	2.20	1.98	2.00	2.00	2.00	2.00	2.00	2.00
c. Obstetric	2.02	2.02	2.03	2.04	2.04	2.05	2.05	2.05
d. Intensive Care	3.74	4.02	4.67	4.62	4.61	4.61	4.61	4.61
e. Psychiatric	5.27	4.57	4.63	4.71	4.79	4.88	4.96	5.05
f. Rehabilitation	9.78	8.66	8.91	9.15	9.39	9.66	9.93	10.20
g. ECF	16.33	15.10	0	0	0	0	0	0
h. TOTAL	4.92	4.65	4.33	4.31	4.33	4.34	4.36	4.37

Table 1 cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization				
Fiscal Year	2003	2004	2005	2006	2007	2008	2009	2010
4. Occupancy Percentage *								
a. M/S/G/A	79%	76%	73%	72%	72%	77%	79%	80%
b. Pediatric	42%	37%	42%	42%	42%	46%	48%	48%
c. Obstetric	76%	81%	77%	80%	82%	64%	66%	68%
d. Intensive Care	69%	70%	90%	91%	91%	78%	79%	80%
e. Psychiatric	78%	72%	70%	73%	76%	78%	81%	84%
f. Rehabilitation	38%	41%	43%	46%	48%	72%	76%	80%
g. ECF	47%	48%	0	0	0	0	0	0
h. TOTAL	8%	72%	70%	70%	71%	75%	77%	78%
5. Number of Licensed Beds								
a. M/S/G/A	166	176	181	185	189	177	177	177
b. Pediatric	9	9	9	9	9	8	8	8
c. Obstetric	14	14	15	15	15	20	20	20
d. Intensive Care	20	20	20	20	20	24	24	24
e. Psychiatric	17	17	18	18	18	18	18	18
f. Rehabilitation	28	28	28	28	28	20	20	20
g. ECF	47	17	0	0	0	0	0	0
h. TOTAL	**301**	**281**	**271**	**275**	**279**	**267**	**267**	**267**

Table 1 cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization				
CY or FY (Circle)	2003	2004	2005	2006	2007	2008	2009	2010
6. Outpatient Visits								
a. Emergency	61,831	66,458	68,951	71,543	74,238	77,041	79,956	82,989
b. Clinic Services	14,549	12,709	12,963	13,222	13,486	13,756	14,031	14,312
c. Other (Psych Day)	0	1,000	1,020	1,040	1,061	1,082	1,104	1,126
d. Outpatient Surgery	6,380	5,602	5,708	5,816	5,927	6,040	6,154	6,271
e. TOTAL	**82,760**	**85,769**	**88,642**	**91,621**	**94,712**	**97,919**	**101,245**	**104,698**

* Number of beds and occupancy percentage should be reported on the basis of licensed beds.

Assumptions: Following completion of the project, MSGA admissions projected to increase at an annual rate of 1.3%/year; OB admissions, 2.9%/year; Pediatric admissions, 0% increase/year; Behavioral Health, 1.85%/year; Rehab, 3%/year. MSGA ALOS is anticipated to decline to State Health Plan "high forecast" target of 4.62 days; Pediatric ALOS is anticipated to remain unchanged at 2 days; Obstetrics ALOS is anticipated to increase with growth in deliveries by C-Section; ICU ALOS is anticipated to decrease consistent with decrease in MSGA ALOS; Psychiatric ALOS is anticipated to increase to approach statewide CMA ALOS standard; Rehabilitation ALOS is anticipated to increase to approach statewide CMA ALOS standard. Following completion of the project, Emergency Department visits are projected to increase 3.8%/year; Clinic Services, Psychiatric Day Services, and Outpatient Surgery Services are projected to increase 2%/year.

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

For purposes of evaluating an application under this subsection, the Commission shall compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly or a more effective alternative for meeting the needs identified.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project which will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics that the Commission should take into account.

Three alternatives were evaluated for cost-effectiveness, i.e.: (i) extensive expansion and renovation of the existing facility (the "E & R"), (ii) construction of a new hospital on a site adjacent to the existing facility (the "Adjacent Replacement"), and (iii) construction of a new hospital adjacent to Robinwood Medical Center (the "Robinwood Replacement").

Each alternative was assessed based on eight criteria: (i) patient safety and outcomes; (ii) accessibility; (iii) efficiency and productivity; (iv) synergy with existing health care and related resources; (v) ability to accommodate technological changes; (vi) ability to receive future grown; (vii) timely completion; and (viii) community perception.

Each program objective is briefly summarized below. Examples of relevant design features or project characteristics are discussed. Each alternative's ability to

meet the identified objectives is assessed and, where possible, measured. A summary of the relative ranking of each alternative is also provided.

Goal One: Patient Safety and Outcomes

WCHA identified several ways to maximize patient safety and quality care. First, a facility with all single-patient rooms was identified as a primary objective. As discussed elsewhere in greater detail, WCHA, through practical experience and by reviewing the experience of other hospitals, identified the availability of single-patient rooms for the largest possible number of inpatients as a way to impact patient safety and quality care. Several measures of effectiveness were identified, including lowered rates of preventable infection and medication errors that can be achieved in a facility with all single rooms. Also, fewer patient transfers are needed when all patient rooms are single. The Adjacent Replacement and the Robinwood Replacement options provided an equal opportunity to construct a facility with all single-patient rooms. The E & R alternative did not, due to the existing nursing care units which include semi-private rooms. In the E & R alternative, approximately 15% of the 201 MSGA beds needed in 2010 would be licensed as semi-private rooms.[54]

A second program objective relating to patient safety and quality outcomes was patient visibility to caregivers. A safer and more effective healing environment exists when patients and caregivers are able to see one another. In the existing hospital, the view of patients in many areas is obscured. The E & R alternative could not correct this problem in two inpatient units and in the Emergency Department, as they would not be

[54] Washington County Hospital, Facility Planning Analysis, Meeting 5, Lammers+Associates, May 7, 2001. See Exhibit 19.

renovated or expanded.[55] Both the Adjacent Replacement and the Robinwood Replacement provided an opportunity to design a facility where caregivers can see their patients.

A third way to maximize patient safety and quality outcomes is to standardize patient care technology. Examples include a single location for oxygen and suction in each patient room, a unified paging system in all areas, and design features that minimize noise and other distractions. These features could not be achieved in the E & R option, but could be accomplished in both replacement hospital alternatives.

A fourth goal is to increase patient involvement in the healing process. Most hospitals consider access to information a crucial contributor to patient safety and quality outcomes. High speed and reliable data access is not possible in the E & R option since there is no electronic infrastructure in the existing hospital, due to the age of the buildings, the construction materials used, and the technical difficulties in accommodating the necessary hardware. In both replacement hospital options, specifications for computer hardware and related technology can be planned from the ground up. This is a distinct and measurable advantage over the E & R alternative.

A fifth program objective is to maximize safety and quality patient outcomes for psychiatric patients. For these vulnerable patients, the problems in the existing hospital cannot be fully corrected by the E & R alternative. For example, the inpatient behavioral health unit is not adjacent to the ED. Most psychiatric patients are admitted to hospitals through the ED. The ability to transfer a patient from the ED to an inpatient psychiatric

[55] For example, in the same Meeting 5 Analysis, the Emergency Department, the Psychiatric Unit, and two M/S units would not have been affected by the expansion and renovation plan under consideration. This represents approximately 15% of the current hospital's treatment capacity as measured by treatment or patient rooms.

unit with minimal disruption is a benefit to patients and caregivers. The Adjacent Replacement and Robinwood Replacement options provide departmental adjacencies that cannot be achieved through the renovation and expansion approach. In addition, the Robinwood Replacement option includes a ground level "greenspace area" accessible only to behavioral patients on the behavioral health unit and their caregivers. This goal cannot be achieved in either the E & R or the Adjacent Replacement alternatives.

A sixth way to affect patient safety and quality outcomes is to improve caregiver efficiency. If a resource can be located in the nursing unit, caregivers can remain in the unit and at the bedside doing what they do best. Reconfiguration of space in the existing hospital facility to achieve this objective is not possible. Deficiencies in the existing hospital can be addressed and corrected in the replacement alternatives because larger treatment areas can be designed. Documentation of patient care will be more accurate if it is accomplished at the bedside.

Another way to impact patient safety and quality outcomes is for the hospital to function as normally as possible during construction. In this regard, the E & R alternative is inferior to either replacement alternative. Without question, the E & R approach will be disruptive to patients and caregivers. Constructing a new hospital, however, would have no impact on the delivery of care. The extensive renovations and new construction associated with the E & R option would also take much longer than building a new facility.

The two replacement alternatives offer significant advantages and opportunities to improve patient safety and quality outcomes that cannot be achieved by the E & R

option. The Robinwood Replacement approach, however, is considered the more effective approach due to the "dedicated green space" that can be designed to serve the behavioral health unit.

Goal Two: Accessibility

Access to the existing hospital is problematic for many patients. The overwhelming majority of patients arrive by car. However, parking and way finding in the City of Hagerstown ("City") is a barrier to access. WCHA is a regional medical center, and geographic access to all patients is important. WCHA considers the Robinwood Replacement alternative superior to the two City-based options, because ground level parking is available at Robinwood.

Access to patients with physical disabilities is also an important criterion. The existing hospital is not a handicapped-accessible. Renovating and expanding this facility will not solve this problem. Either replacement alternative will be accessible to handicapped persons.

WCHA also considered access to patients in the future. Washington County's population is growing, as is the population in WCHA's entire service area.[56] Robinwood Medical Center is one of the most successful medical malls in Maryland, if not in the country. The success of the outpatient care services available at RMC demonstrates that this location is accessible to patients. Developing a new hospital at Robinwood is consistent with this experience.

Goal Three: Efficiency And Productivity

WCHA used several criteria to assess each alternative in terms of efficiency and productivity. First, the E & R approach results in approximately 100,000 additional

[56] Although Washington County's population is growing, the City of Hagerstown's is not.

square feet of hospital space that must be maintained, cleaned, heated and protected. Both of the replacement options are much smaller facilities and would have lower operational costs. However, more space can be included on the ground floor in the Robinwood Replacement option. Because there is more land available at Robinwood, the new hospital can be constructed with more horizontal space and more space on the first level at grade. In addition, only five floors are required. The Adjacent Replacement approach requires more than five floors and there will be less space at grade.

Having more space on each floor and fewer floors at Robinwood permits WCHA to locate related and complementary services near each other. For example, imaging and the behavioral health unit are located on the same floor as the ED. The ability to improve adjacencies at the Robinwood site by constructing five floors and more square footage at grade is a benefit not available in the E & R or Adjacent Replacement options.

In addition, constructing a more horizontal hospital with fewer floors at Robinwood is less expensive than the Adjacent Replacement, which requires a more "vertical" approach.

The new hospital approach is also more beneficial in terms of efficiency and productivity because a new hospital can be correctly configured and sized. For instance, in the existing hospital, all of the procedure rooms are located with the ORs in the sterile area. If a new hospital is constructed, procedure rooms will be located where they ought to be, outside the "sterile core."

Centralized and fewer waiting areas also improve efficiency and productivity. In the existing hospital, there are numerous waiting areas, each associated with a particular function, e.g. ambulatory surgery and radiology. If a new hospital is

constructed, WCHA can consolidate waiting area space and patient registration areas, something that is impossible with the E & R approach.

Nursing units in a replacement hospital can also be designed to improve efficiency and productivity. Rather than the long "bowling alley" nursing units in the existing hospital, units in a new hospital would be triangular in shape, enabling nurses to spend more time with patients rather than walking to and from soiled and cleaned utility rooms, supply stations and other areas that would be farther away. Consistent design of nursing units in a new hospital also improves efficiency and productivity particularly by the flex nursing staff, because supplies will be located in the same place on each unit.

Transportation of patients will also be more efficient in a new hospital because separate elevators will be used by patients and the public. This will improve security and enhance patient privacy. Having separate service elevators, as can be done in a new hospital, will also result in the more efficient delivery of food, linen and supplies. Patient transfers will also be reduced in a new hospital with all single patient rooms. For example, patients will not need to move so that patients of the same sex are in a semi-private room, as now occurs. Having more monitored beds, as is possible with a new hospital would also reduce the transfer of patients needing those services.

Efficiency and productivity would also be improved in a new hospital which can incorporate a digital or paperless medical record, physician order entry and bar coding systems for pharmaceuticals, something that is not possible by renovating and expanding the existing facility.

Goal Four: Synergy And Site Advantages

WCHA developed the Robinwood Medical Center and already owns a large parcel of adjacent land. The Adjacent Replacement approach requires that many existing properties be acquired, presumably via condemnation, at significant expense. Of course, like constructing a new hospital at Robinwood, expanding and renovating the existing structure does not involve costs associated with site acquisition.

In addition, the existing hospital does not have a single "point of entry" or "exit" for scheduled outpatient procedures. Unlike the E & R approach, outpatient services and inpatient care can be separated and clearly delineated in a new hospital whether constructed at Robinwood or adjacent to the existing facility.

However, WCHA believe that the Robinwood site is a better location for a new hospital than adjacent to the existing facility. Complementary outpatient services already exist at Robinwood, creating a single "point of entry" for all healthcare needs.

Another benefit of the Robinwood site is the proximity of Hagerstown Community College. Being closer to the college will benefit students interested in healthcare careers. Relocating to Robinwood is also beneficial in terms of continuity of care and convenience for both providers and patients. For example, a surgical patient who needs physical therapy following discharge can receive care at RMC. If physical therapy is provided at RMC, the patient's medical history will be available and interaction with the WCHA staff that provided care during the inpatient stay will be easier. Similarly, with an integrated patient management system, hospital staff will be able to obtain information if an oncology patient who received outpatient care at the J.R. Marsh Cancer Center at Robinwood is admitted to the hospital.

Goal Five: New Technology & Growth

The existing structure cannot accommodate current technology, let alone changes that will occur in the future. Renovating and expanding an antiquated facility will not solve this problem. For example, specialized procedures involving sophisticated imaging technology and minimally invasive surgical techniques must be performed in an operating room within the sterile core.

Both replacement options can be designed to integrate existing technological changes and to anticipate changes that will occur in the future. WCHA cannot replace the existing surgical suites or develop on-site alternatives. Put simply, the existing structure's useful life as a hospital is over, and it cannot adapt and respond to new technology for this reason.

In addition, the existing hospital is "land-locked." There is no adjacent space on WCHA's campus that can be used for future growth or expansion. Moreover, residents and businesses will be displaced if adjacent property was assembled via condemnation. To grow, both the E & R and Adjacent Replacement approaches would require acquisition of adjacent properties. The renovation option eliminates the use of the existing helipad because the helicopter landing area would be compromised by two walls, making that site unacceptable to the EMS pilots. Moreover, the need to expand in this manner will occur over and over again. This problem, of course, does not exist if a new hospital is constructed at Robinwood.

Goal Six: Timely Completion

WCHA's transition to an improved facility must be accomplished in a reasonable period of time. The Adjacent Replacement approach is problematic in this regard.

Many, many properties must be condemned and acquired. This will be neither easy nor fast. Indeed, proceeding in this manner could result in significant delay.

Of course, this uncertainty and potential for delay does not exist if a new hospital is constructed at Robinwood. A WCHA affiliate already owns the land and will transfer it to WCHA. No additional land need be obtained.

As previously related, the Robinwood site was selected after an extensive review process when several other sites were considered. More information about that process, who was involved and how decisions were made is related in Exhibit 27.

Conclusion

In sum, as explained above, constructing a new hospital at Robinwood met more of WCHA's objectives than the other two alternatives. For this reason and based on the cost analysis set forth below, WCHA decided to proceed in this manner.

COST ANALYSIS

At the time of the original analysis, the project was in the "pre-design stage" and the information available at that time was incomplete. As a result, assumptions were made regarding operating/utility costs, maintenance costs, and costs of renovations. Capital costs were not included in the 2001 life cycle cost analysis, as they were defined and compiled separately. Now that significant design work has been done, the capital costs have been added in this analysis to better compare the total financial implication of each option. Additional research has also been performed and more accurate data are now available for all costs, including utilities, operation and maintenance, and capital construction costs. The original analysis used a 4% escalation factor, as that was more accurate in 2001. However, due to the more recent increase in construction,

utility, and maintenance costs, a 5% escalation factor is used in this analysis. The differences between the two analyses and the evolution of the current quantitative (cost) matrix are discussed below.

Proximate Hospital

The 2001 life cycle cost analysis estimated the present worth of annual operating and maintenance cost for the proximate hospital to be $62,063,800, not including capital costs. This estimate was based on projected utility consumption for the new facility and utility rates applicable at that time. Maintenance costs were calculated using the existing hospital maintenance budget ($1,408,000) for 2001, pro-rating it for the expanded square foot area, and then reducing that number by a factor of 0.90 to account for newer equipment and mechanical systems.

The current analysis used the same basic approach, but the data were updated due to inflation, new utility rates, and a further increase in project square foot area. The proximate solution was found to have added operational and maintenance costs due to the need for a parking garage in lieu of surface parking, an operating expense of about $636,000 per year (based on data available from The International Parking Institute). However, further research indicated that the overall maintenance costs could be reduced by using a 0.70 factor for all new systems (compared to the existing hospital maintenance costs) in lieu of the 0.90 factor used in 2001. The biggest impact on the updated analysis was the insertion of a "Cost of Operational Inefficiency". Due to site limitations, the proximate hospital must be taller than a new facility at Robinwood, so additional FTE's (48 for the proximate hospital) are expected. This additional labor requirement resulted in a "Cost of Operational Inefficiency of $2,944,884 per year.

Based on all of the new data, the present worth of the annual operating and maintenance cost was revised to $165,871,775.

Robinwood Campus

The analysis for the Robinwood option is similar to the Proximate solution with a few modifications. The 2001 analysis identified an increased cost for electricity, water, and sewer, due to the higher utility rates outside the city of Hagerstown. Maintenance costs were assumed to be the same as the Proximate. The total present worth of O&M costs was calculated at $70,922,000.

More current utility rate data are available now and have been incorporated into the life cycle cost analysis. Since the Robinwood replacement approach would require only surface parking, much lower operating and maintenance expense of $39,920 was added. As the "base" case for hospital staffing requirements, there was no "Cost of Operational Inefficiency" included for constructing a new hospital at Robinwood.

Expansion and Renovation

The expansion (113,960 square feet of new construction) and renovation (127,940 square feet) project outlined in the 2001 life cycle cost analysis was separated into two O&M cost groups: "As is" areas, which were not renovated, and "new and renovated" areas. The "As is" area had an associated operating and maintenance cost based on the existing conditions of the hospital. The "new and renovated" portion had a lower O&M cost, due to newer and more efficient systems. The total of these costs resulted in a present worth value of $80,658,700 for operating and maintenance, with no capital costs included. However, this is not comparable with the new hospital option as

the majority of the existing hospital would not be upgraded and thus the program goals would not be fully met.

As a result, the cost to renovate the existing hospital ("as is" areas) over a period of time was added to the annual O&M cost to create a fully renovated hospital over a given period of time (10 years for program renovations, 30 years for mechanical/electrical upgrades). This resulted in additional annual costs of $22,675,500 (program renovations) and $18,968,000 (mechanical/electrical upgrades) for a total of $41,643,500. Adding the O&M costs to the renovation allowances, the total present worth of annual utility, maintenance, and renovation costs was calculated at $122,302,200.

The current analysis for the E & R project used similar parameters in developing the O&M costs. Escalated for inflation since 2001, the renovations required to create a comparable program over ten years were calculated at $46,411,480 (versus $41,643,500 in 2001). The O&M costs were updated using current utility rates and included the cost of one new parking structure to be built on the existing campus. As in the case of the Proximate hospital option, the biggest added cost came in the form of a "Cost of Operational Inefficiency". The expansion and renovation project would result in a higher square foot area than either of the two new building solutions, which in turn requires an additional 80 FTE's over the base case (Robinwood). This annual labor cost of $4,414,285, coupled with the new O&M costs, resulted in a total present worth of $209,073,320.

Capital Costs

The first page of the quantitative analysis spreadsheet outlines the anticipated capital costs associated with all three construction options. The data included in this spreadsheet was compiled to compare the options on a first cost basis.

The most recent estimates from the Construction Manager have been inserted for Building Construction Costs. The Expansion/Renovation solution would be the least expensive, due to the minimum square footage of new construction. The Proximate hospital will be slightly more expensive than the Robinwood option due to the taller building required by the site limitations. In all cases, the Building Construction Cost includes the new building and site costs only, excluding the outside utilities which must be extended to the site.

The Equipment and Furnishing costs are listed in a separate line item, and are assumed the same for the proximate and Robinwood projects, as they will be programmed identically. However, the Expansion/Renovation project would require less new equipment due to the smaller scope of work.

Forest Conservation/Vegetation and Hazardous Waste Removal costs are listed separately, varying with the site. Since the Proximate hospital alternative requires the demolition of over 50 separate parcels of land, an allowance of $250,000 was added for removal of hazardous materials such as fuel tanks, lead paint, asbestos, etc.

The estimated cost for parking facilities is based on structured parking garages for the Proximate (two garages) and Expansion/Renovation (one new garage, one existing) options, and on-grade parking at Robinwood. In all cases, the total parking capacity will be 1500 cars.

The demolition costs include a complete demo of the existing hospital for both Robinwood and Proximate, select demo for the Expansion/Renovation project, and additional demo required for Proximate due to the razing of the structures which occupy the current site.

Due to the urban settings of the Proximate and Expansion/Renovation sites, a Construction Staging Premium has been included for both. This includes the added cost associated with storage of materials off site, difficulties involved with access to the site, and sequencing new construction within city streets.

The impact of the Adequate Public Facilities Ordinance ("APFO") is translated into costs primarily in the form of road construction and traffic improvements. These costs have been developed by a civil engineer with input from the City of Hagerstown and Washington County.

Permit costs vary based on the approach. The City has indicated that permit costs for the Proximate or Expansion/Renovation projects may be waived if approved by the City Council; however, no agreement has been reached.

Connection Fees include the cost due to the hospital for upgrades to the City water and sewer system to provide adequate service to the new facility. The City has indicated that connection fees for the Proximate or Expansion/Renovation projects may be waived if approved by the City Council; however, no agreement has been reached.

The costs of acquiring land for the Proximate solution is separated into several categories. The land cost itself was identified by the City. The time it takes to acquire the more than 59 parcels was estimated by the SmartGrowth panel as 36 months. Based on a 36-month acquisition period, there will be costs associated escalation in

building construction, equipment costs, parking facility construction, and finance charges.

The final component of the Capital Cost is the "Lost Business During Construction." Since the Robinwood approach will involve construction in a "green field", there is no impact on the current hospital. The Proximate hospital and Expansion/Renovation project will have a negative impact due to increased vacancy, staff turnover, and increased expenses (e.g. shuttle services, additional housekeeping costs) while constructing a new facility on or adjacent to the existing site. Based on internal estimates, as well as historical data from hospitals involved in similar projects, a cost of 1-1/2% of total gross revenues has been included for the Proximate hospital, and 3% for the Expansion and Renovation project.

Based on the above data, the Capital Costs associated with the three options are summarized as follows:

Proximate Hospital	$210,548,315
Robinwood Campus	$152,555,692
Expansion & Renovation	$117,139,300

Total Present Worth of Capital, O&M, and Renovation Costs

Summarizing the present worth of all costs, the life cycle project cost for each option is as follows:

Proximate Hospital	$376,420,090
Robinwood Campus	$235,663,320
Expansion & Renovation	$326,212,620

Alternative Project	Robinwood Medical Center	Proximate (Adjacent to Existing Hospital North)	Renovation and Additions at Existing
Capital Cost Summary:			
Building Construction Cost	$106,902,000	$110,800,000	$76,000,000
Equipment & Furnishings	$30,148,660	$30,148,660	$14,403,300
Site Utilities			
Gas	$400,000	$50,000	$0
Electric (Dual Feed)	$1,600,000	$400,000	$0
Water	$772,532	$0	$0
Sewer	$500,000	$0	$0
Telephone & Fiber Optic	$20,000	$20,000	$20,000
Vegetation - FCO Impacts	$50,000	$7,730	$0
Hazardous Waste Removal	$0	$250,000	$0
Parking (1500 cars total)	$998,000	$15,900,000	$6,400,000
Demolition Costs	$3,140,000	$6,500,000	$1,500,000
Construction Staging Premium	$0	$1,500,000	$3,000,000
APFO Impact $	$1,247,000	$475,000	$250,000
Permit Costs	$250,000	$376,000	$266,000
Connection Fees	$4,777,500	$2,400,000	$0
Land Acquisition Cost	$1,750,000	$9,100,000	$0
Land Acquisition Time	0	36 months	0
Land Acquisition Time Cost: Building Construction Costs	$0	$16,620,000	$0
Land Acquisition Time Cost: Equipment Costs	$0	$4,522,299	$0
Land Acquisition Time Cost: Parking Facilities	$0	$3,339,000	$0
Land Acquisition Time Cost: Finance Charges	$0	$489,626	$0
Lost Business During Construction	$0	$7,650,000	$15,300,000
Total Capital Costs:	**$152,555,692**	**$210,548,315**	**$117,139,300**
Location	Robinwood Medical Center	Proximate (Adjacent to Existing Hospital North)	Renovation and Additions at Existing
Annual Operating Cost Summary:			
Annual Operating Costs Water & Sewer	$641,700	$398,700	$305,400
Annual Operating Costs Gas	$463,900	$463,900	$740,800

Alternative Project	Robinwood Medical Center	Proximate (Adjacent to Existing Hospital North)	Renovation and Additions at Existing
Annual Operating Costs Electric	$988,280	$874,900	$777,800
Annual Building Maintenance Costs	$1,064,000	$1,064,000	$1,550,400
Annual Parking Structure O&M Costs	$39,920	$636,000	$256,000
Cost of Operational Inefficiency	$0	$2,944,884	$4,414,285
Total Annual O&M Costs	$3,197,800	$6,382,384	$8,044,685
Present Worth of O&M Costs	$83,107,628	$165,871,775	$209,073,320

Scoring the Alternatives			
Program Objectives	Expansion and Renovation Project	Adjacent Site Replacement Project	Robinwood Replacement Project
Patient Safety			
Single Patient Rooms	85%	100%	100%
Patient Visibility	<100%	100%	100%
Standardization	85%	100%	100%
Reliable Electronic Data Access	<100%	100%	100%
Special Needs of Psychiatric Patients	<100%	<100%	100%
Efficiency of Caregivers (Access to Patient Units)	85%	100%	100%
Ease of Project Implementation	<100%	100%	100%
Maximizing Access			
Ease of Access: Parking	<100%	<100%	100%
Access by Physically Disabled	<100%	<100%	100%
Access to the Growing Regional Population	<100%	<100%	100%
Maximizing Efficiency and Productivity			
Reductions in FTE/Adjusted Pt. Day			

Scoring the Alternatives			
Program Objectives	Expansion and Renovation Project	Adjacent Site Replacement Project	Robinwood Replacement Project
Correctly Designed and Sized Facilities	85%	100%	100%
Centralized Patient Waiting Areas	<100%	100%	100%
Maximizing Effectiveness			
Land Ownership	100%	0%	100%
Single "point of entry"	<100%	<100%	100%
Flexibility for Growth and Technological Change			
Adapting to Technology	0%	100%	100%
Physical Space to Grow	0%	0%	100%
Timely Completion of the Project			
Assuring a Reasonable Timetable	0%	0%	100%
TOTAL SCORE		9 OUT OF 17 = 100% 3 OUT OF 17 = 0% 5 OUT OF 17 = <100%	17 OUT OF 17: 100%

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

For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and non-financial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

WCHA will seek a rate increase in conjunction with the project. The schedule of construction is reasonable for a project of this magnitude and scope. The project will be implemented with the time frames set forth in the Commission performance standards. WCHA is seeking approximately $10 Million in charitable donations. To date, $4 Million in pledges has already been raised. Letters of support are attached as Exhibit 28.

Please include in your response:

a. **Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented.**

The most recent audited financial statements for FY 2003 and Unaudited statements for FY 2004 are attached as Exhibit 29 and 30. WCHA's financial performance has significantly improved in FY 2004. Several factors have contributed to the improvement, including, i.e., improved productivity, a modification of the benefit costs ($0.6M), revenue enhancement from the HSCRC for annual updated increased case mix index/case mix lag ($4.3M), transfer of the behavioral health services allowing revenues to become rate-regulated ($0.7M), transfer of physician practice from the Murphy Center to a

Federally Qualified Health Center ($0.6M), transition of the hospital-based Extended Care Facility ($1.0M), additional funding for Trauma Center ($0.4M), divestiture of an investment interest in The Village at Robinwood ($1.8M), change in pension interest credit ($0.6M), and growth in investment income ($3.0M).

b. Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility.

Costs and charges at Washington County Hospital will increase as a result of this project. Debt service expenses and operational expenses will increase. WCHA will seek a permanent increase in hospital rates. The CON projection utilizes the Health Services Cost Review Commission's (HSCRC) Partial Rate Application process in calculating the rate increase associated with the replacement facility project. This calculation uses the Spring 2004 ROC data as reported to the HSCRC on the FY 2003 annual filings to determine regulated capital costs, i.e., as total capital costs for WCHA's peer group (Suburban & Rural I).

The relaxed ICC calculations result in a positive amount, therefore no reduction to the allowed capital increase is required.

The following summary outlines the steps involved in this Capital rate increase calculation:

1) Capital costs (Depreciation and Interest) are calculated as a percentage of Regulated Total Operating Expense for the FY 2003 peer group, FY 2003 WCHA and projected FY 2008 WCHA.
2) A blended percentage (50% WCH and 50% Suburban & Rural I) is calculated using the FY 2003 peer group % as the 50% blend for both WCH FY 2003 and FY 2008.

3) The unadjusted rate increase is calculated by subtracting the blended percentage (2) from the actual capital cost percentage (1).
4) An offset of 1% related to inpatient services is made. This offset is calculated using the most current "final" Order NISI and Charge per Case (CPC) agreement from the HSCRC. (Note: For purposes of this projection, the 1/1/2004 Order NISI and Rate Year 2004 (CPC) agreements were used. Rate year 2005's "FINAL" Order NISI and CPC agreement will not be available until late September – early October 2005). The I/P Revenue base per the CPC agreement is taken as a percentage of the total revenue base including Med/Surg Supplies and Drugs per the Order NISI. The resulting percentage is used to calculate the 1% offset.
5) The net overall rate increase is calculated by taking the unadjusted rate increase (3) less the 1% offset (4).
6) The net overall rate increase percentage is converted to actual dollars. This is done by applying the net overall rate increase percentage to the total revenue base per the most recent Order NISI. This dollar rate increase is then split between I/P and O/P based on the revenue split per the most recent rate orders.

The resulting dollar rate increase for Washington County Hospital is using this calculation $8,466.9 M. This is split $5,432.7 M I/P and $3,034.2 M O/P.

c. A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.

Because Washington County Hospital is a "sole community hospital," and no new services are being proposed, there will be no impact on the costs and charges for similar services at other facilities in the area.

d. All applicants shall provide a detailed list of proposed patient charges for affected services.

All patient charges proposed for the WCHA replacement project will be consistent with the rates of the Hospital regulated by the HSCRC.

(INSTRUCTIONS: Table 3, "Revenue and Expenses - Entire Facility (including the proposed project)" is to be completed by existing facility applicants only. Applicants for new facilities should not complete Table 3. Table 4, "Revenues and Expenses - Proposed Project," is to be completed by each applicant for the proposed project only. Table 5, "Revenues and Expenses (for the first full year of utilization", is to be completed by each applicant for each proposed service in the space provided. Specify whether data are for calendar year or fiscal year. All projected revenue and expense figures should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application. Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses.)

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (Ending with first full year at full utilization)				
Fiscal Year	2003	2004	2005	2006	2007	2008	2009	2010
Revenues								
a. Inpatient Services	97,823	113,178	117,550	120,313	122,179	129,192	131,512	133,578
b. Outpatient Services	88,708	93,294	94,805	96,701	98,635	104,079	106,590	108,723
c. Gross Patient Services Revenues[57]	186,531	206,472	212,355	217,014	220,814	233,271	238,102	242,301
d. Allowance for Bad Debt	7,191	9,878	10,193	10,417	10,599	11,197	11,429	11,630
e. Contractual Allowance	21,791	22,042	22,828	23,329	23,738	25,077	25,596	26,047
f. Charity Care	4,114	5,325	5,521	5,642	5,741	6,065	6,191	6,300
g. Net Patient Services Revenue	153,435	169,227	173,813	177,626	180,736	190,932	194,886	198,324
h. Other Operating Revenues Investment Earnings	1,871	1,993	1,993	1,993	1,993	1,993	1,993	1,993
i. Interest Income – Project			2,952	4,111	1,647	487	487	487
j. Net Operating Revenue	155,306	171,220	178,758	183,730	184,376	193,412	197,366	200,804

[57] Includes HSCRC rate regulated revenue and non rate-regulated revenue

Table 3 cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (Ending with first full year at full utilization)				
Fiscal Year	2003	2004	2005	2006	2007	2008	2009	2010
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	104,065	107,566	106,603	108,149	110,139	108,501	108,231	110,175
b. Contractual Services	13,602	13,930	14,209	14,493	14,783	15,129	15,534	15,949
c. Interest on Current Debt	301	241	22	11	7	5	4	4
d. Interest on Project Debt (See Note 5.)						12,713	12,613	12,453
e. Current Depreciation (See Note 9.)	7,551	7,602	12,837	12,834	12,825	4,966	2,795	2,477
f. Project Depreciation						7,488	7,488	7,488
g. Current Amortization	36	33	2					
h. Project Amortization						1,226	1,226	1,226
i. Supplies	32,472	35,899	36,933	37,801	38,388	38,911	39,634	40,249
j. Other Expenses (Specify)	2,854	3,338	3,405	3,473	4,168	4,238	4,316	4,395
k. Total Operating Expenses	160,881	168,609	174,011	176,761	180,310	193,177	191,841	194,416
3. Income								
a. Income from Operation	(5,575)	2,611	4,747	6,969	4,066	235	5,525	6,388
b. Non-Operating Income	(597)	4,590	300	300	450	450	450	450
c. Subtotal	(6,172)	7,201	5,047	7,269	4,516	685	5,975	6,838
d. Income Taxes								
e. Net Income (Loss)	(6,172)	7,201	5,047	7,269	4,516	685	5,975	6,838

Table 3 cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (Ending with first full year at full utilization)				
Fiscal Year	2003	2004	2005	2006	2007	2008	2009	2010
4. Patient Mix: A. Percent of Total Revenue								
1) Medicare	43.1%	42.5%	41.6%	41.6%	41.6%	41.6%	41.6%	41.6%
2) Medicaid	7.6%	7.9%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%
3) Blue Cross	13.3%	13.5%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%
4) Commercial Insurance	12.7%	12.6%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%
5) Self-Pay	8.3%	9.1%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%
6) Other (Specify)	15.1%	14.3%	14.4%	14.4%	14.4%	14.4%	14.4%	14.4%
7) TOTAL	100%	100%	100%	100%	100%	100%	100%	100%
B. Percent of Patient Days (as applicable)								
1) Medicare	58.4%	57.6%	57.6%	57.6%	57.6%	57.6%	57.6%	57.6%
2) Medicaid	8.7%	9.2%	9.2%	9.2%	9.2%	9.2%	9.2%	9.2%
3) Blue Cross	9.0%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%
4) Commercial Insurance	9.5%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%
5) Self-Pay	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%
6) Other (Specify)	10.1%	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%
7) TOTAL	100%	100%	100%	100%	100%	100%	100%	100%

(INSTRUCTION: ALL APPLICANTS OPERATING EXISTING FACILITIES MUST SUBMIT THEIR MOST RECENT AUDITED FINANCIAL STATEMENTS)

Assumptions Used in Projecting All Revenues and Expenses:

1. The Hospital projections of volumes, revenues and expenses for FY 2005 were based on the current year budget.

2. The Hospital assumes a permanent increase in rates as follows: 5.26% effective upon the opening of the replacement hospital on July 1, 2008.

3. Patient Service Revenue includes both HSCRC-regulated revenue and non-regulated revenue.

4. The ECF unit closed on June 15, 2004.

5. Interest on project debt includes refinancing of 1994 Bond.

6. Other Expenses includes repairs and maintenance.

7. Transition Costs include moving expenses to the new hospital.

8. The case mix index is in the Rate Year 2004 target of 0.965963.

9. Write-off of PPE is included in Current Depreciation.

10. Expenses and Revenues include the addition of an Urgent Care Center in downtown Hagerstown to serve the residents after the move of the Hospital to the Robinwood Medical Center site, in accordance with discussions with the City of Hagerstown.

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

To meet this subsection, an applicant shall demonstrate compliance with all conditions applied to previous Certificates of Need granted to the applicant.

List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1983, and their status.

Since 1983 WCHA has obtained the following CONS:
Docket No: 82-21-1026 - Replacement of Telephone System. Project Implemented
Docket No: 82-21-1079 - Replacement of CT Scanner. Project Implemented
Docket No: 86-21-1360 - Creation of 17 bed psychiatric unit. Project Implemented
Docket No: 86-21-1356 - Creation of a 23 bed ECF unit. Project Implemented
Docket No: 87-21-1428 - Obstetrics relocation and renovation. Conditions met. Project Implemented.
Docket No: 90-21-1576 - Creation of a 51-bed CIR program at WCHA and at Cumberland
Memorial Hospital. Conditions met. Project Modified.
Docket No: 90-21-1576 - Creation of a 28 bed CIR unit at WCHA. Project Implemented
Docket No: 91-21-1649 - Renovation of nursing unit to add 22 ECF beds. Conditions met.
Project Implemented.

10.24.01.08G(3)(f). Impact on Existing Providers.

For evaluation under this subsection, an applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.

Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.

This project will have a positive impact on the existing health care providers. This project is designed to replace the existing hospital, and enhance WCHA's ability to address the future hospital and health care needs of its service area residents. Because the service area population is both growing and aging, the volume of care to be provided in the future will be significant. The existing facility is not adequate to meet these needs. As a sole-community provider and regional resource, WCHA must offer comprehensive services in a modern state-of-the-art facility.

The impact of the project on the existing health care providers will be positive. Many of the health care providers in the area rely on WCHA, including the 280 physicians on its staff. Letters of support are attached as Exhibit 28.

WCHA is the only acute general hospital services in Washington County. WCHA also services residents of West Virginia and Pennsylvania. The true measure of WCHA's importance is its growing volumes, which are expected to continue in most of the inpatient and all of the outpatient services WCHA offers. As WCHA is the only

hospital in Washington County, this does not duplicate the capabilities of any other provider in this area.

There is no untoward impact on the health care system if this project is approved, because WCHA is the only hospital in Washington County and hospitals outside Washington County will not be affected by this project. Those hospitals' occupancy and costs will not be affected by this project.

1. **an assessment of the sources available for recruiting additional personnel;**

Recruitment efforts to address the additional clinical openings projected in this application will be handled by the Washington County Hospital Clinical Directors in collaboration with the Hospital Department of Human Resources. Sources available for recruiting additional personnel include, but are not limited to:

Use of a job line;
Newspaper and magazine advertising;
Attendance at job fairs and career days;
Open houses;
Direct mailings
Sign-on bonuses;
Educational affiliations;
Internship programs;
Transfers from other Washington County Health system subsidiaries.

2. recruitment and retention plans for those personnel believed to be in short supply;

The recruitment and retention plans for those personnel believed to be in short supply include, but are not limited to :

Free educational offerings;
Tuition reimbursement;
Scholarships;
Employee benefits.

3. for existing facilities, a report on average vacancy rate and turnover rates for affected positions,

The average monthly vacancy rate at Washington County Hospital in FY2004 has been 2.00%. For RN positions, the monthly average vacancy rate has been 2.89%. The average monthly turnover rate in FY 2003 was less than 1%. For RN positions, the average monthly turnover rate was slightly over 1%.

(INSTRUCTION: FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours.

TABLE 5. MANPOWER INFORMATION

(INSTRUCTION: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project.)

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Secretarial	62.85	-.86	$ 28,946	E	$ 1,794,323
Office Clerks	8.36	-.11	$ 25,466	E	$ 210,070
Billing/Collect. Clerk	26.34	-.36	$ 28,538	E	$ 741,478
Accounting	12.95	-.18	$ 35,499	E	$ 453,439
Other Positions	446.06	-6.14	$ 44,642	E	$19,639,135
Total Administration	556.58	-7.65			
Direct Care					
Contractual Nursing	9.42	-.13	$ 112,216	C	$ 1,042,124
Nursing	624.28	-8.60	$ 51,692	E	$31,825,788
Technicians	81.58	-1.12	$ 51,198	E	$ 4,119,251
Phys. Asst.	0.69	-.01	$ 76,930	E	$ 52,684
Social Worker	38.36	-.53	$ 50,097	E	$ 1,895,255
Pharmacy	24.83	-.34	$ 51,891	E	$ 1,270,691
Therapists	78.00	-1.07	$ 50,115	E	$ 3,855,294
Total Direct Care	857.16	-11.80			
Support					
Maintenance	43.99	-.61	$ 38,163	E	$ 1,655,634
Dietary	59.87	-.83	$ 27,970	E	$ 1,651,356
Housekeeping	70.86	-.98	$ 24,684	E	$ 1,725,044
Security	18.79	-.26	$ 29,728	E	$ 550,915
Medical Records	55.50	-.77	$ 33,617	E	$ 1,840,013
Computer	7.79	-.11	$ 37,559	E	$ 288,396
Unit Clerks	63.32	-.88	$ 31,557	E	$ 1,970,550
QA Specialists	9.15	-.12	$ 41,750	E	$ 376,894

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Total Support	329.26	-4.56			
Total	1,743.00	-24.01			$76,958,334
Physician Practices					$ 3,435,967
Professional Fees					$ 8,538,765
Downtown UCC					$ 539,710
Sub-Total					$89,472,776
				Benefits	$ 20,701,794
				TOTAL	$110,174,570

(INSTRUCTION: Indicate method of calculating benefits percentage):
Benefits are calculated at 26.9% of total employee/contractual costs.

Notes: The projected change in employed manpower at WCHA is entirely a function of projected increases in volume and projected increases in productivity and efficiency. WCHA is a community hospital, and its medical staff is comprised of private practice physicians in the community, not employed physicians. WCHA has a contractual arrangement with an emergency medicine group to assure 24/7 coverage of the Emergency Department.

In addition to improving the quality of care and expanding the capacity to meet the anticipated growth project will also improve efficiency and increase productivity. These improvements will have a positive impact on the quality of care to be provided by permitting our clinical staff to spend more time "at the bedside" in the future than is currently possible now.

One measure of improvement in productivity is a reduction in the number of FTEs that

would otherwise be required in FY 2010, reduction is approximately 24 FTEs. The chart below shows the current labor cost/EIPA in FY 2004 and FY 2010 (in current dollars) by hospital employment category. WHCA projects that EIPAs will increase from 23,179 in FY 2004 to 25,221 in FY 2010, but that total compensation, excluding professional fees, physician practices, and the downtown urgent care center will increase from $96,016,000 to $97,660,000 (in current dollars). This will reduce the total labor cost per equivalent admissions from $4,142.43 to $3,872.18, a 6.5% savings.

	S&W plus Benefits/Equivalent Inpatient Admission (FY 2004)	S&W plus Benefits/Equivalent Inpatient Admission (FY 2010)
Secretarial	$ 85.65	$ 90.28
Office Clerks	$ 11.34	$ 10.57
Billing/Collec. Clerk	$ 40.01	$ 37.31
Accounting	$ 24.47	$ 22.81
Non-Specifics	$ 1,059.70	$ 988.15
Contractual	$ 56.23	$ 52.43
Nursing	$ 1,718.30	$ 1,601.32
Technicians	$ 222.27	$ 207.26
Phys. Asst.	$ 2.84	$ 2.65
Social Worker	$ 102.27	$ 95.36
Pharmacy	$ 68.56	$ 63.94
Therapists	$ 208.03	$ 193.98
Maintenance	$ 89.34	$ 83.30
Dietary	$ 89.11	$ 83.09
Housekeeping	$ 93.08	$ 86.80
Security	$ 29.73	$ 27.72
Medical Records	$ 99.28	$ 92.58
Computer	$ 15.56	$ 14.51
Unit Clerks	$ 106.33	$ 99.15
QA Specialists	$ 20.34	$ 18.96
Total	$ 4,142.43	$ 3,872.18

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

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

James. P. Hamill
President
Washington County Health System
251 Antietam Street, Hagerstown, Maryland 21740

2. Are the applicant, owners, or the responsible persons listed above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

Mr. Hamill was President of Holy Cross Hospital, Silver Spring, Maryland From 1988 to 1997, CEO of Columbus-Cuneo-Cabrini Medical Center, Chicago, from 1985 to 1987, and Vice President, and later President of Mercy Hospital and Misericordia Health System, Davenport, Iowa, from 1973 to 1985.

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

No.

4. Are any facilities with which the applicant is involved, or have any facilities with which the applicant has in the past been involved (listed in response to Question 2, above) ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to actions to suspend the licensure or certification at the applicant's facility or facilities listed in response to Question 2? If yes, provide copies of the findings of noncompliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable governmental authority.

No

5. Have the applicant, owners or responsible individuals listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

No

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

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

Date

Signature of Owner or
Board-designated Official

EXHIBIT 16

MARYLAND HEALTH CARE COMMISSION

Revised Emergency Certificate of Need

TO: Maulik S. Joshi, Dr. P.H.
Meritus Medical Center
1116 Medical Campus Road
Hagerstown, Maryland

April 2, 2020
Revision Date

RE: Establishment of 20-Bed Unit of
Negative Pressure Ventilator-Capable Rooms
Near the Endoscopy Center

EM-H20-21-002
Docket No.

DESCRIPTION OF EMERGENCY PROJECT

This Emergency Certificate of Need authorizes Meritus Medical Center to establish additional inpatient bed capacity in a 20-bed unit "Regional Infectious Containment Unit" consisting of 20 inpatient rooms that will be sized as medical/surgical/gynecological rooms, each of which will be negative pressure and ventilator capable, and will be located in a 15,000 square foot addition to be constructed near the endoscopy center at Meritus Medical Center, 1116 Medical Campus Road, Hagerstown (Washington County), Maryland (the Site). The estimated cost of the project is $12.5 million, for which the hospital plans to seek donor funding. Meritus Medical Center projects that the addition can be patient-ready in four months after the issuance of this Emergency Certificate of Need.

ORDER

Upon consideration of the request of Meritus Medical Center, suitably detailed information provided by the Office of Health Care Quality (OHCQ) and others, and consultation with the Chairman of the Maryland Health Care Commission (MHCC), Ben Steffen, MHCC Executive Director, determined that the lack of sufficient inpatient bed capacity at Maryland general hospitals resulting from COVID-19 presents a hazard to patients and/or employees, as provided in COMAR 10.24.01.20A.

Therefore, it is, on March 21 , 2020, ordered by the Executive Director that an Emergency Certificate of Need issue for the project. It is further ordered that the requirement in COMAR 10.24.01.20C that Meritus Medical Center file an application for Certificate of Need for the inpatient beds established in this Emergency Certificate of Need is suspended by the Executive Director pursuant to COMAR 10.24.01.10A(2) until 30 days after the termination of the state of emergency declared by Governor Lawrence J. Hogan, Jr. on March 5, 2020. This application filing date may be extended by the Executive Director.

Approvals by Maryland Department of Health

This Emergency Certificate of Need does not constitute a license or replace any approvals for other aspects of the project that are required by the OHCQ or other divisions of the Maryland Department of Health to operate inpatient bed capacity at the Site.

Further Action

This Emergency Certificate of Need will be considered for confirmation by the Maryland Health Care Commission at its next scheduled meeting on April 3. 2020. This Emergency Certificate of Need initially remains valid for a maximum of 165 days. as provided in COMAR 10.24.01.20C, or until 30 days after the termination of the state of emergency declared by Governor Lawrence J. Hogan. Jr. on March 5. 2020. The Emergency CON may be extended beyond that date for good cause shown.

MARYLAND HEALTH CARE COMMISSION

Ben Steffen
Executive Director

cc: Robert R. Neall, Secretary of Health
Patricia T. Nay, M.D., Executive Director, Office of Health Care Quality
Katie Wunderlich, Executive Director, HSCRC
Earl E. Stoner, MPH, Health Officer, Washington County

EXHIBIT 17

STATE OF MARYLAND
Department of Assessments and Taxation

I, PAUL B. ANDERSON OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF THE STATE OF MARYLAND, DO HEREBY CERTIFY THAT THE DEPARTMENT, BY LAWS OF THE STATE, IS THE CUSTODIAN OF THE RECORDS OF THIS STATE RELATING TO THE FORFEITURE OR SUSPENSION OF CORPORATIONS, OR THE RIGHTS OF CORPORATIONS TO TRANSACT BUSINESS IN THIS STATE, AND THAT I AM THE PROPER OFFICER TO EXECUTE THIS CERTIFICATE.

I FURTHER CERTIFY THAT MERITUS MEDICAL CENTER, INC., INCORPORATED APRIL 07, 1904, IS A CORPORATION DULY INCORPORATED AND EXISTING UNDER AND BY VIRTUE OF THE LAWS OF MARYLAND AND THE CORPORATION HAS FILED ALL ANNUAL REPORTS REQUIRED, HAS NO OUTSTANDING LATE FILING PENALTIES ON THOSE REPORTS, AND HAS A RESIDENT AGENT. THEREFORE, THE CORPORATION IS AT THE TIME OF THIS CERTIFICATE IN GOOD STANDING WITH THIS DEPARTMENT AND DULY AUTHORIZED TO EXERCISE ALL THE POWERS RECITED IN ITS CHARTER OR CERTIFICATE OF INCORPORATION, AND TO TRANSACT BUSINESS IN MARYLAND.

IN WITNESS WHEREOF, I HAVE HEREUNTO SUBSCRIBED MY SIGNATURE AND AFFIXED THE SEAL OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF MARYLAND AT BALTIMORE ON THIS MARCH 26, 2015.

Paul B. Anderson
Charter Division

301 West Preston Street, Baltimore, Maryland 21201
Telephone Balto. Metro (410) 767-1340 / Outside Balto. Metro (888) 246-5941
MRS (Maryland Relay Service) (800) 735-2258 TT/Voice
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