

# IN THE MARYLAND HEALTH CARE COMMISSION

## APPLICATION FOR CERTIFICATE OF NEED

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

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**Applicant**  
*Shore Health System, Inc.*  
September 7, 2018

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# MARYLAND HEALTH CARE COMMISSION

*For internal staff use*

\_\_\_\_\_  
MATTER/DOCKET NO.

\_\_\_\_\_  
DATE DOCKETED

## HOSPITAL APPLICATION FOR CERTIFICATE OF NEED

### PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

#### 1. FACILITY

Name of Facility: University of Maryland Shore Medical Center at Easton

**Address:**

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

Name of Owner (if differs from applicant):  
\_\_\_\_\_  
\_\_\_\_\_

#### 2. OWNER

Name of owner: Shore Health System, Inc.

#### 3. APPLICANT.

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

**Legal Name of Project Applicant**

Shore Health System, Inc.

**Address:**

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

Telephone: 410-822-1000

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

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

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

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

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

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

A. **Lead or primary contact:**

**Name and Title:** Patti K. Willis, Senior Vice President, Strategy and Communications

**Mailing Address:**

University of Maryland Shore Regional  
Health

219 South Washington St.

Easton

21601

MD

Street

City

ZIP

State

**Telephone:** 410-822-1000

**E-mail Address (required):** Patti.Willis@umm.edu

**Fax:** 410-822-7834

**B. Additional or alternate contact:**

**Name and Title:** Andrew L. Solberg

**Mailing Address:**

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Columbia

21044

MD

Street

City

ZIP

State

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**Name and Title:** Thomas C. Dame, Esq.

**Mailing Address:**

Gallagher Evelius & Jones LLP

218 N. Charles St. Ste. 400

Baltimore

21201

MD

Street

City

ZIP

State

**Telephone:** 410-347-1331

**E-mail Address (required):** tdame@gejlaw.com

**Fax:** 410-468-2786

**Name and Title:** Mallory M. Regenbogen, Esq.

**Mailing Address:**

Gallagher Evelius & Jones LLP

218 N. Charles St. Ste. 400

Street

**Telephone:** 410-951-1417

**E-mail Address (required):** mregenbogen@gejlaw.com

**Fax:** 410-468-2786

**7. TYPE OF PROJECT**

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

If approved, this CON would result in:

- |   |                                     |
|---|-------------------------------------|
| (1) A new health care facility built, developed, or established   | <input type="checkbox"/>            |
| (2) An existing health care facility moved to another site  | <input checked="" type="checkbox"/> |
| (3) A change in the bed capacity of a health care facility  | <input type="checkbox"/>            |
| (4) A change in the type or scope of any health care service offered by a health care facility                                | <input type="checkbox"/>            |
| (5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: | <input checked="" type="checkbox"/> |

## 8. PROJECT DESCRIPTION

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

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

As explained more fully in the Comprehensive Project Description below, the proposed project involves the replacement and relocation of University of Maryland Shore Medical Center at Easton. The proposed replacement hospital will be relocated about three miles to the north of the existing facility and it will have 121 acute care beds and 14 special hospital rehabilitation beds, for a total of 135 inpatient beds. It will also have 16 observation beds. The facility is proposed to have six operating rooms and 26 emergency department treatment spaces. The total project cost is estimated to be \$ 349,904,500. The replacement hospital is needed to address the aging, inefficient, and obsolete existing hospital building.

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

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

## **COMPREHENSIVE PROJECT DESCRIPTION**

### **I. UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT EASTON**

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

In 1915, following the largest fundraising effort the community had ever seen, a new hospital was built on South Washington Street, a structure that is still a small part of the Hospital complex. In 1943, the name of the hospital was changed to The Memorial Hospital at Easton to honor local men and women who served in both world wars and the many volunteers whose service helped establish the Emergency Hospital.

Over many years, the Hospital building was expanded and today’s building includes components dating from 1915, 1920, 1929, 1955, 1975, 1982, and 2006.

In 1996, the Hospital merged with Dorchester General Hospital in Cambridge, Maryland to form Shore Health System, Inc. (“SHS”), a unified network of medical services with the combined resources of community hospitals, physicians, and outpatient centers. Today, Dorchester General Hospital is known as University of Maryland Shore Medical Center at Dorchester (“UM SMC at Dorchester”). In 2006, SHS affiliated with the University of Maryland Medical System (“UMMS”), and, as of July 1, 2013, SHS joined with the University of Maryland Shore Medical Center at Chestertown (“UM SMC at Chestertown”) and other facilities to become University of Maryland Shore Regional Health, Inc. (“UM SRH”). UM SRH is the sole corporate member of SHS.

### **II. UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH**

The UM SRH network serves the five counties of the Mid-Shore region, which includes Caroline, Dorchester, Kent, Queen Anne’s, and Talbot counties. Team members, consisting of more than 2,500 employees, a medical staff of 485, board members, and some 400 volunteers, work with various community partners to fulfill the organization’s mission of Creating Healthier Communities Together.

#### **A. Facilities and Services**

UM SRH includes three hospitals — UM SMC at Chestertown, UM SMC at Dorchester, and UM SMC at Easton — with a combined total of 187 acute care beds, including a 20-bed acute rehabilitation unit at UM SMC at Easton and a 24-bed behavioral health unit at UM SMC at Dorchester. In addition to its three hospitals, UM SRH includes the University of Maryland Shore Emergency Center at Queenstown — Maryland’s only rural freestanding emergency center— and a broad array of inpatient and outpatient services in locations throughout the five-county region.

UM SRH offers specialty services for cancer care, stroke, general surgery, urology, obstetrics and gynecology, otolaryngology, orthopedics and joint replacement, neurosurgery, pain management, diabetes management, wound healing, medical rehabilitation, behavioral health, digestive health, sleep disorders, palliative care and home health care. Cardiovascular and pulmonary services include testing and procedures, PCI, cardiac catheterization and an accredited cardio-pulmonary fitness and wellness program. Surgical services include minimally invasive and robotic assisted surgical procedures and an ambulatory surgery center in Easton and Queenstown.

UM SRH also includes a network of outpatient centers offering diagnostic imaging and laboratory testing, primary care and specialty treatment, and rehabilitation services in Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties. In partnership with the University of Maryland Medical Center and the University of Maryland School of Medicine, UM SRH operates kidney transplant and dialysis vascular access clinics to help people who are candidates for these services prepare for treatments. Table 1 below lists the various UM SRH outpatient centers throughout the five-county mid-Shore region as well as the specialties and clinicians located at these sites.

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

County	Name	Address	Type	MD Disciplines & Number Represented at Site
Caroline	UM Shore Regional Health Diagnostics at Denton	838 S. 5th Avenue Denton, MD 21629	Imaging Center, Laboratory	N/A
	UM Shore Regional Health Rehabilitation at Denton	920B Market Street Denton, MD 21629	Rehab OP Physical Therapy	N/A
	ChoiceOne Urgent Care	8 Denton Plaza Denton, MD 21629	Urgent Care	Primary Care (1 MD, 1 NP - employed by ChoiceOne)
	UM Community Medical Group – Primary Care	836 S. 5th Avenue Denton, MD 21629	Primary Care	Primary Care (2 MD, 2 NP)
Dorchester	UM Shore Regional Health Outpatient Services	309 Sunburst Hwy. Suite 15, Cambridge, MD 21613	Rehabilitation, Lab	N/A
	UM Shore Medical Pavilions at Dorchester	400 Byrn Street Cambridge, MD 21613	MOB: Cardiology, Neurology & Sleep Medicine, Pediatrics, Women's Health	Cardiology (R), Neurology & Sleep Medicine (R), Pediatrics (2 MD)
		2 Aurora St Cambridge, MD 21613	MOB: Urology	
		100 Bramble Street Suite A Cambridge, MD 21613	MOB: General Surgery	
Kent	UM Shore Medical Pavilion at Chestertown	126 Philosophers Terrace, Chestertown, MD 21620	MOB: Continence & Pelvic Health, Primary Care, Urology, Pulmonology, ENT, Endocrine, Breast Surgery, cardiology, neurology	Continence & Pelvic Health (R), Primary Care (1 MD), Urology (R), Pulmonology (1 MD), ENT (R), Endocrinology (R), Breast Surgery (R) Cardiology (R), Neurology <sup>*</sup>



County	Name	Address	Type	MD Disciplines & Number Represented at Site
	UM Shore Regional Health Lab Services	6602 Church Hill Road Chestertown, MD 21620	Lab	N/A
	UM Community Medical Group – Primary Care	119-C North Main Street Galena, MD 21620	Primary Care, Lab	Primary Care (2 NP)
Queen Anne's	UM Shore Emergency Center at Queenstown	115 Shoreway Drive Queenstown, MD 21658	Freestanding Emergency Center	Emergency MDs and NPS
	UM Shore Medical Pavilion at Queenstown	125 Shoreway Drive Queenstown, MD 21658	Freestanding Multispecialty ASC	Cardiology (R), ENT, Sinus & Hearing (R), Neurology & Sleep Medicine (R), Surgical Care (R), Urology (R), Woman's Health (R NP), Orthopedics (R), Primary Care
			MOB: Lab, Imaging, Rehabilitation, Sleep Lab, Cardiology, ENT, Sinus & Hearing, Neurology & Sleep Medicine, Surgical Care, Urology, Woman's Health, Orthopedics	
	UM Community Medical Group – Primary Care	2540 Centreville Road Centreville, MD 21617	Primary Care, Lab	Primary Care (3 MD)
Talbot	UM Shore Regional Health Surgery Center	6 Caulk Lane Easton, MD 21601	Freestanding Multispecialty ASC	Various disciplines (R)
	UM Shore Regional Health Diagnostic and Imaging Center	10 Martin Court Easton, MD 21601	Imaging Center, Lab, Breast Center	Radiology (1 MD), Breast Surgeons (2 MD)
	UM Shore Regional Rehabilitation Center	10B Martin Court Easton, MD 21601	Rehabilitation, Swallowing Center	N/A
	UM Shore Medical Pavilion at Easton	490 Cadmus Lane Easton, MD 21601	MOB: Continence & Pelvic Health, ENT, Sinus & Hearing, Neurology & Sleep Medicine, Neurosurgery, Urology, Woman's Health, Lab	Continence & Pelvic Health (1 MD), ENT, Sinus & Hearing (2 MD), Neurology & Sleep Medicine (1 MD/1 NP), Neurosurgery (1 MD), Urology (4 MD), Woman's Health (2 NP)
		500 Cadmus Lane Easton, MD 21601	MOB: Cardiology, Pediatrics, Primary Care, Pulmonary, Surgical Care/ Wound Care	Cardiology (6 MD, 2 NP), Pediatrics (2 MD), Primary Care (2 MD), Pulmonary (5 MD, 1 NP), Surgical Care/ Wound Care (3 MD)
	UM Shore Regional Health Cancer Center	509 Idlewild Avenue Easton, MD 21601	Chemotherapy, radiation	Med Onc. (1 MD), Rad Onc (1 MD)
	ChoiceOne Urgent Care	28522 Marlboro Avenue Easton, MD 21601	Urgent Care	Primary Care (1 MD, 1 NP - employed by ChoiceOne)
	The Orthopedic Center	510 Idlewild Avenue Easton, MD 21601	Orthopedics, ASC, OP rehabilitation/physical therapy, diagnostic imaging	Orthopedics (7MDs, 2 PAs) PM&R (One MD)
	Digestive Health Center	511 Idlewild Avenue Easton, MD 21601	Gastroenterology, procedure center	Gastroenterologists (4), NPs (2)

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

UM SRH's inpatient critical care services are supported by the University of Maryland ICU telemedicine program, which provides remote critical care physician and nursing expertise and monitoring of patients in the ICUs at all three UM SRH hospitals.

## **B. Physician Practices**

UM SMC at Chestertown, UM SMC at Dorchester, and UM SMC at Easton have a unified medical staff called the UM SRH Medical Staff. It includes physicians, physicians' assistants, nurse midwives, and nurse practitioners. Physicians who practice at UM SMC at Chestertown, UM SMC at Dorchester, and UM SMC at Easton specialize in a full range of clinical specialties, including internal medicine, emergency medicine, cardiology, gastroenterology, oncology, pediatrics, pulmonology, radiology, orthopedics, obstetrics, gynecology, anesthesiology, surgery, neurology, infectious disease, physical medicine and rehabilitation, hospitalists' medicine, and ophthalmology.

University of Maryland Community Medical Group ("UMCMG") provides medical practice management for employed physicians and practices. UMCMG physicians provide primary care at offices in Easton, Chestertown, Centreville and Denton, as well as pediatric care at practices in Easton and Cambridge. Employed physicians also provide specialty care in orthopedics, otolaryngology, general surgery, endocrinology, psychiatry, obstetrics, gynecology, urology, neurosurgery, neurology, physical medicine and rehabilitation, and sleep medicine.

## **C. Honors and Accreditations**

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

The Requard inpatient rehabilitation unit is also accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF"). Requard was re-accredited as of 2018 in both comprehensive rehabilitation and stroke rehabilitation. CARF is an independent, nonprofit accrediting body with a mission to promote the quality, value and optimal outcomes of rehabilitation services provided in hospitals and nursing homes. The Requard Center is part of a comprehensive network of rehabilitation services that include inpatient acute physical, occupational and speech therapy, and outpatient centers for continued treatment in Easton, Denton, Cambridge, and Queenstown. Physical therapists at the Balance Center in Cambridge assist physicians in the diagnosis and treatment of patients with balance problems associated with dizziness/vertigo, musculoskeletal disorders, and neurologic conditions. The Requard Center's CARF accreditation includes CIIRP (Comprehensive Integrated Inpatient Rehabilitation Program) and SSP (Stroke Specialty Program).

In 2014, UM SMC at Easton achieved Magnet® reaccreditation for excellence in nursing services from the American Nurses Credentialing Center's Magnet Recognition Program. This

was UM SMC at Easton's second consecutive time earning this achievement, which followed intensive preparation and documentation to demonstrate that the hospital provides the best nursing care, the highest quality patient care, and the most supportive and innovative working environment for nursing professionals.

The Commission on Cancer of the American College of Surgeons granted a three-year reaccreditation to the Shore Regional Cancer Program in 2018. The Commission on Cancer accreditation program acknowledges cancer treatment facilities that deliver quality patient care with a focus on prevention, early diagnosis, pre-treatment evaluation, optimal treatment, rehabilitation, surveillance for recurrent disease, support services and end-of-life care. The Shore Regional Cancer Program, which includes the Requard Radiation Oncology Center, the Lenny Satchell Chemotherapy Suite, and the Shore Regional Health Clark Comprehensive Breast Center, combines sophisticated technology and skilled clinical practitioners and social workers who guide patients through diagnosis and treatment while providing the social and financial resources they need to transition to life as a cancer survivor. The Cancer Program is also accredited by the National Accreditation Program for Breast Centers (2017 – 2020), further signifying adherence to stringent quality and care requirements for cancer treatment.

UM SMC at Easton is designated as a Primary Stroke Center by the Maryland Institute for Emergency Medical Services Systems. In 2018, the Primary Stroke Center earned a Gold Plus Quality Achievement Award from the American Heart Association and American Stroke Association. The award recognizes hospitals that demonstrate achievement of an aggressive goal of treating patients through compliance with 85% or greater adherence to all "Get With The Guidelines®" stroke achievement indicators. The Award also acknowledges that UM SMC at Easton has met the guidelines for the highest standards of stroke care for two or more consecutive 12-month periods and attained a 75% or greater compliance with five of eight "Get with the Guidelines" stroke quality measures. The Stroke Center also earned the Target Stroke Honor Roll for meeting or exceeding the American Stroke Association's quality measures for timely treatment and outcomes.

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

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

In 2018, UM SMC at Easton was ranked by *US News and World Report* as one of the top 10 best hospitals in Maryland. (See <http://health.usnews.com/best-hospitals/area/md>).

#### **D. Community Support**

Volunteers, Foundations and Donors for UM SMC at Chestertown, UM SMC at Dorchester, and UM SMC at Easton donate time, talent, and money that support programs and

services made available to the community at the three UM SRH hospitals and at outpatient centers around the region.

### **III. THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM**

As part of the University of Maryland Medical System, UM SRH is a regional, nonprofit, medical delivery care network formed on July 1, 2013, through the consolidation of two University of Maryland partner entities, Shore Health System and the former Chester River Health. With more than 2,500 employees, 485 member medical staff, and hundreds of volunteers, UM SRH is the primary provider of health care services in the five-county Mid-Shore region, offering a full range of primary and specialty care services to more than 175,000 people.

- UM SMC at Easton (Easton) is a 124 licensed bed hospital, which includes the 20-bed Requard Center for Acute Rehabilitation. The hospital serves the residents of Caroline, Dorchester, Talbot, Queen Anne's, and Kent counties.
- UM SMC at Dorchester (Cambridge) is a 42 licensed bed hospital, which includes 24 inpatient acute adult behavioral health beds, principally serving the residents of Dorchester County.
- UM SMC at Chestertown (Chestertown) is a 21 licensed bed acute care hospital located in Kent County; it primarily serves residents of Kent and Queen Anne's counties.

### **IV. THE PROPOSED PROJECT**

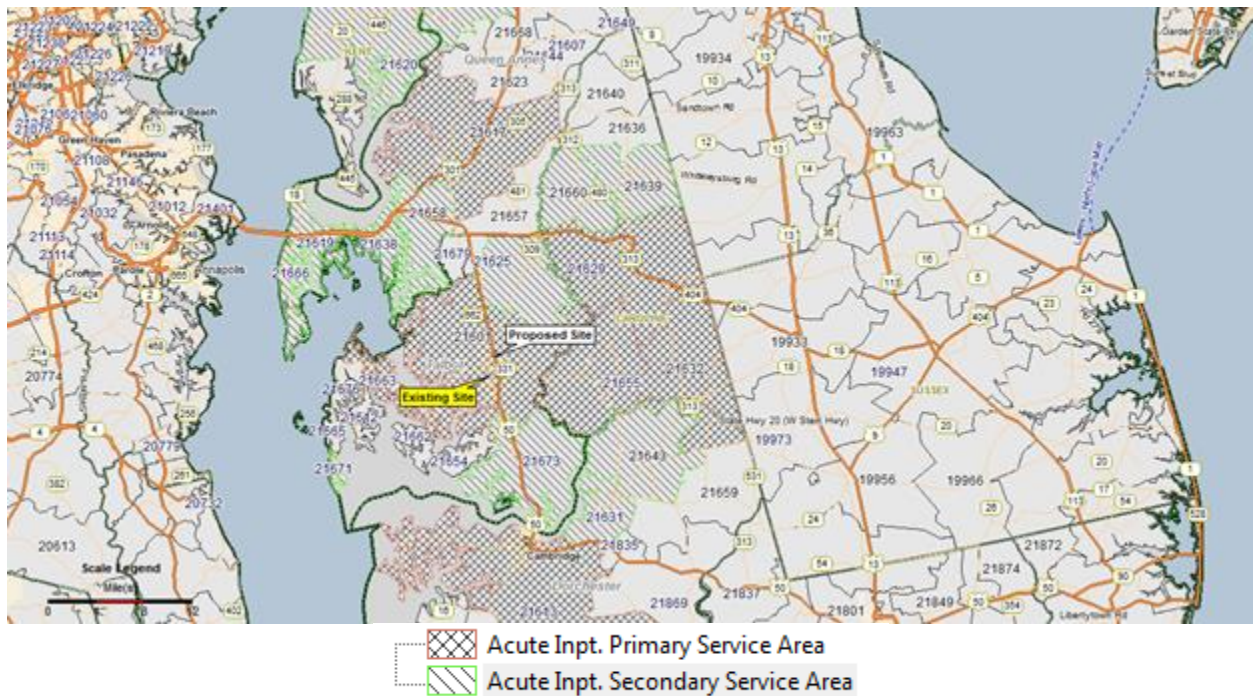
Today, UM SMC at Easton is a regional medical center. UM SMC at Easton's Primary Service Area ("PSA") includes ZIP Codes in Talbot, Dorchester, Caroline, and Queen Anne Counties, as does its Secondary Service Area ("SSA"). (See Figure 1) In fact, the majority of acute admissions to UM SMC at Easton come from outside of Talbot County.

The proposed project involves relocating the Hospital to a site approximately 3.5 miles north of the present location.<sup>1</sup> The proposed new location is on Longwoods Road near the intersection of U.S. Route 50, as shown in Figure 2 below. The proposal assumes that the Commission will approve the pending requests for CON exemption to convert UM SMC at Dorchester to a freestanding medical facility ("FMF") and consolidate certain inpatient services from UM SMC at Dorchester with the existing UM SMC at Easton located in downtown Easton. If those exemptions are granted, then 17 MSGA beds and 12 psychiatric beds will be relocated from UM SMC at Dorchester to UM SMC at Easton in FY 2022. Those beds and services will be part of the proposed replacement hospital that is the subject of this CON application.

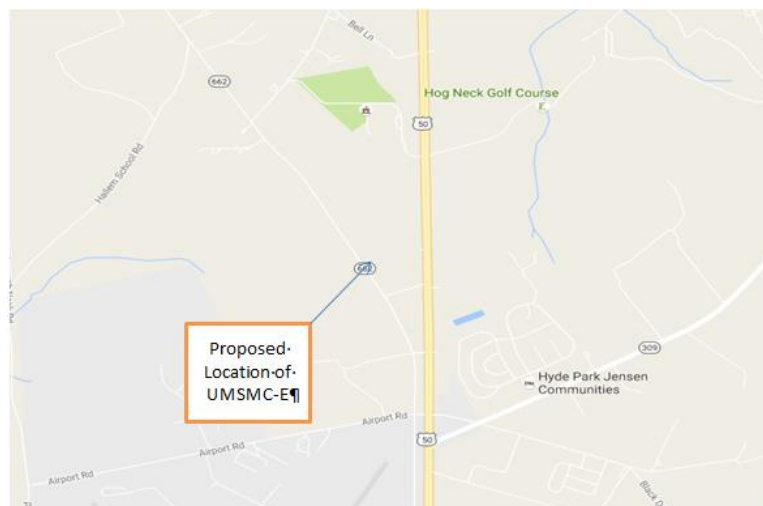
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<sup>1</sup> The Applicant filed a CON application in 2012 to seek approval of a similar project on the same site. That application was docketed, but was withdrawn on July 6, 2018, without prejudice, because the project had changed significantly following docketing.

**Figure 1**  
**Primary and Secondary Service Areas—UM SMC at Easton**  
**FY 2016**



**Figure 2**  
**Location of Proposed Replacement Hospital**



#### **A. Summary of the Existing Hospital**

The existing facility is comprised of four components from different eras. A small portion of the building was built in 1915. The majority of the building, including most of the inpatient

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

## **B. Detailed Description of the Replacement Hospital**

The new facility will be located on approximately 200 acres at the intersection of Longwoods Road and U.S. Route 50, just north of the Easton Municipal Airport and adjacent to the Talbot County Community Center. The site is predominantly a “green-fields” site, not all of which will be used for the Hospital. The remainder of the parcel will be used for future development.

The proposed replacement hospital will be relocated about three miles to the north of the existing facility and it will have 121 acute care beds and 14 special hospital rehabilitation beds, for a total of 135 inpatient beds. It will also have 16 observation beds. The new facility will include six floors.

The first floor will include:

- Registration
- Lobby
- Patient Advocacy/Guest Relations
- Imaging
- Cardiovascular Services
- Emergency Department (26 treatment spaces)
- Observation Unit (16 beds)
- Outpatient Clinics
- Infusion Center
- Support Services
- Human Resources
- Kitchen
- Dining
- Gift Shop
- Security

The second floor will include:

- Sterile Processing
- Information/Technology
- Pharmacy / Labs
- Catheterization & E.P. Labs
- PACU
- Surgery Suite (six operating rooms)

- Prep/Stage II Recovery
- Nursing Administration
- Chapel
- Hospitalists

The third floor will include:

- MSGA Unit, including one pediatric bed
- Labor and Delivery (13 beds), C-Section, and Nursery

The fourth floor will include:

- MSGA Unit
- 14 Bed Requard (Acute Rehabilitation) Unit

The fifth floor will include:

- ICU (16 beds)
- MSGA Unit
- Respiratory Therapy

The sixth floor will include:

- Behavioral Health (12 beds)
- Dialysis

UM SRH is also planning to build a Medical Office Building (“MOB”) adjacent to the replacement hospital on the same site as indicated on the Architectural Site Plan. The MOB is not part of this CON project. The MOB is planned to accommodate a full service lab, which will not only serve the replacement hospital but also other community based medical facilities located off campus. Space will also be allocated in the MOB for education and conference center functions. These flexible multi-purpose classrooms and conference rooms will support clinical staff needs as well as community services. The remaining area will accommodate a variety of professionals with medical office space.

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

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

**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.**

The “Before the Project” portion of Table A assumes that the pending request for exemption from CON review for the merger and consolidation of 17 MSGA and 12 behavioral health beds from UM SMC at Dorchester to UM SMC at Easton has been approved and reflects the physical bed capacity that will exist at UM SMC at Easton in FY 2022.

**10. REQUIRED APPROVALS AND SITE CONTROL**

- A. Site size: 199.123 acres. The total area conveyed under a deed from Talbot County to Shore Health System, Inc., dated October 23, 2015, is 223.3 acres in eleven parcels described in the deed. Four of the eleven parcels (199.123 acres) comprise the developable site. The remaining seven parcels (24.182 acres) will be transferred to an adjoining landowner or the State Highway Administration for storm water management or road right-of-way.
- B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES \_\_\_\_\_ NO  X  (If NO, describe below the current status and timetable for receiving necessary approvals.)

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

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



required for the project.

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

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

(1) Owned by: Shore Health System, Inc.

Please provide a copy of the deed. A copy of the deed dated October 23, 2015, which is recorded among the Land Records of Talbot County, Maryland in Liber MAS 2304, folio 432, is attached as **Exhibit 4**

(2) Options to purchase held by: \_\_\_\_\_

Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: \_\_\_\_\_

Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: \_\_\_\_\_

Please provide a copy of the option to lease as an attachment.

(5) Other: \_\_\_\_\_

Explain and provide legal documents as an attachment.

## 11. PROJECT SCHEDULE

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

	Proposed Project Timeline	
<b><u>Single Phase Project</u></b>		
Obligation of 51% of capital expenditure from CON approval date	36	months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	4	months
Completion of project from capital obligation or purchase order, as applicable	36	Months
<b><u>Multi-Phase Project</u></b> for an existing health care facility (Add rows as needed under this section)		
<b><u>One Construction Contract</u></b>		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 1 <sup>st</sup> Phase of Construction within 24 months of the effective date of the binding construction contract		Months
<b><u>Fill out the following section for each phase.</u></b> (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase		Months
<b><u>Multiple Construction Contracts</u></b> for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1 <sup>st</sup> 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
<b><u>To Be Completed for each subsequent Phase of Construction</u></b>		
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.
- B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project, and the steps necessary to obtain utilities. Please either provide documentation that adequate utilities are available or explain the plan(s) and anticipated timeframe(s) to obtain them.

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

A. Water: A new 12-inch water loop will be extended from the terminus of the existing water main at the Goldsborough Neck Road/Hailem School Road intersection along the easterly edge of Hailem School Road to the north end of the project site. The main will then follow the northerly property line to the proposed 400,000 gallon elevated water storage tank. A second new main will be extended up relocated Longwoods Road, following the northerly property line to the proposed water tank to complete the system

loop. Two (2) independent service laterals to the hospital, one from the water main along the northern property line and a second from Longwoods Road, will enter the building at the central plant, near the truck loading dock. The proposed water system is designed to deliver 1,600 gpm at 20 psi for fire suppression with a 90-minute duration, as mandated by the University of Maryland Medical System insurance provider. The average daily domestic water demand is estimated to be 225,000 gpd.

B. Sanitary Sewer: The first phase of the sanitary sewer will consist of a conventional gravity sewer with pumping station and force main. The gravity sewer will consist of PVC main and pre-cast concrete manholes set at intervals along the sewer main. Some manholes will be stubbed out for future use. The pump station will be constructed out of concrete and have two (2) pumps for pumping wastewater through a 12" force main to the Town of Easton's existing sewer collection system. Phase II will consist of a conventional gravity sewer that will receive wastewater from future facility and development around the hospital and will connect into the Phase I sewer system.

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

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

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

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

## **PART II - PROJECT BUDGET**

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

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

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

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

Owner: Shore Health System, Inc.

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

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

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

<b>President, UCH Hospitals and COO, Upper Chesapeake Health System ("UCH")</b>	January 2011 – October 2011
<b>Executive Vice President, Chief Operating Officer (UCH)</b>	June 2009 – December 2010
<b>Sr. Vice President and Chief Operating Officer (UCH)</b>	May 2005 – June 2009
<b>Vice President, Operations (UCH)</b>	January 2004 – May 2005
<b>Assistant Vice President, Ambulatory Services and Business Development (UCH)</b>	July 2003 – January 2004
<b>Director, Ambulatory Services (UCH) &amp; Director, Laboratory Services, Harford Memorial Hospital ("HMH")</b>	March 2002 – July 2003
<b>Director, Laboratory Services (HMH)</b>	February 1997 – March 2002

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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

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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

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

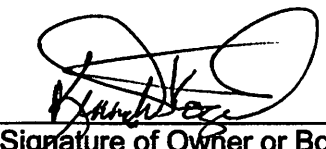
No

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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.

September 7, 2018  
Date

  
\_\_\_\_\_  
Signature of Owner or Board-designated Official

President & CEO  
Position/Title

Kenneth D. Kozel, MBA, FACHE  
Printed Name

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

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

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

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

### **10.24.01.08G(3)(a). The State Health Plan.**

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

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

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



## 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:*

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

The current list of representative services and charges is readily available to the public, both in written form at UM SMC at Easton and on the Hospital's website (<https://www.umms.org/shore/patients-visitors/for-patients/billing-insurance>). It is also attached as **Exhibit 6**. The current list of charges is effective as of June 1, 2018 and will be updated quarterly, as required.

#### **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.**

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#### **Applicant Response:**

UM SMC at Easton provides inpatient and other care to all patients regardless of the ability to pay. A copy of the hospital's Financial Assistance Policy is attached as **Exhibit 7**. Notices regarding the availability of charity care at the hospital are posted in the Emergency Department and in the Admission and Business Offices. A copy of that notice is attached as **Exhibit 8**. An annual notice is published in the following newspapers: *The Star Democrat*, *The Bay Times Record*, *Kent County News*, *Dorchester Star*, and *Record Observer*. See **Exhibit 9**. Each patient or patient representative is advised of UM SMC at Easton's charity care policy at the time of admission or outpatient registration. The hospital's Financial Assistance Policy specifically states that it will make a determination of probable eligibility within two (2) business days following a patient's request for charity care services, application for medical assistance, or both. Financial counselors assist individuals to prepare and file all documents required to seek charity care at the Hospital.

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

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Applicant Response:

At the time the proposed replacement hospital is open, and assuming pending requests for CON exemptions are approved, UM SMC at Easton will include existing inpatient services provided at UM SMC at Dorchester. As shown in Table 2 below, neither UM SMC at Easton nor UM SMC at Dorchester is in the bottom quartile in terms of percentage of Charity Care to Total Operating Expenses in the State of Maryland.

**Table 2**  
**HSCRC Community Benefit Report, Data Excerpts FY2017**

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	%	
Holy Cross Hospital	\$413,796,889	\$31,396,990	7.59%	1st Quartile
Garrett County Hospital	\$46,818,203	\$2,792,419	5.96%	
St. Agnes	\$433,986,000	\$21,573,282	4.97%	
Doctors Community	\$193,854,072	\$6,756,740	3.49%	
Adventist Washington Adventist*	\$219,120,045	\$7,442,497	3.40%	
Western Maryland Health System	\$322,835,314	\$10,385,555	3.22%	
UM Prince Georges Hospital Center	\$286,955,092	\$9,166,191	3.19%	
Mercy Medical Center	\$464,031,500	\$14,411,600	3.11%	
Holy Cross Germantown	\$97,124,985	\$2,819,650	2.90%	
Johns Hopkins Bayview Medical Center	\$613,834,000	\$16,951,000	2.76%	
UM Laurel Regional Hospital	\$93,884,647	\$2,521,365	2.69%	
UM Midtown	\$204,226,000	\$5,174,000	2.53%	
Frederick Memorial	\$350,118,000	\$8,081,000	2.31%	2nd Quartile
UM Harford Memorial	\$84,926,000	\$1,927,000	2.27%	
Atlantic General	\$117,342,233	\$2,569,517	2.19%	
Ft. Washington	\$42,883,433	\$928,769	2.17%	
UM Baltimore Washington	\$334,210,000	\$6,703,000	2.01%	
Calvert Hospital	\$135,047,535	\$2,694,783	2.00%	
Peninsula Regional	\$432,141,737	\$8,301,400	1.92%	
McCready	\$16,564,839	\$307,205	1.85%	
UM St. Joseph	\$341,335,000	\$6,105,000	1.79%	
UM Shore Medical Dorchester	\$42,909,000	\$647,362	1.51%	
MedStar Harbor Hospital	\$187,002,302	\$2,816,043	1.51%	
Meritus Medical Center	\$309,163,913	\$4,596,841	1.49%	3rd Quartile
UM Shore Medical Easton	\$190,646,000	\$2,786,102	1.46%	
MedStar St. Mary's Hospital	\$168,757,516	\$2,458,649	1.46%	

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	%	
MedStar Good Samaritan	\$282,735,786	\$4,078,427	1.44%	
UMMC	\$1,470,095,000	\$20,308,000	1.38%	
Howard County Hospital	\$260,413,000	\$3,368,222	1.29%	
UM Charles Regional Medical Center	\$117,918,178	\$1,474,409	1.25%	
MedStar Southern Maryland	\$243,629,886	\$3,014,042	1.24%	
Lifebridge Northwest Hospital	\$240,547,439	\$2,734,207	1.14%	
Shady Grove*	\$323,661,835	\$3,646,551	1.13%	
Suburban Hospital	\$283,346,000	\$3,168,000	1.12%	
UM Upper Chesapeake	\$284,219,000	\$3,014,000	1.06%	
MedStar Franklin Square	\$508,539,888	\$5,147,814	1.01%	4th Quartile
MedStar Union Memorial	\$443,482,532	\$4,426,976	1.00%	
Johns Hopkins Hospital	\$2,307,202,000	\$21,697,000	0.94%	
Union Hospital of Cecil County	\$157,260,383	\$1,411,673	0.90%	
LifeBridge Sinai	\$727,868,000	\$6,526,756	0.90%	
MedStar Montgomery General	\$160,725,287	\$1,322,823	0.82%	
UM Shore Medical Chestertown	\$46,048,000	\$373,000	0.81%	
Anne Arundel Medical Center	\$561,392,000	\$4,450,854	0.79%	
Bon Secours	\$113,068,120	\$675,245	0.60%	
GBMC	\$419,396,862	\$2,085,315	0.50%	
Carroll Hospital Center	\$197,802,000	\$790,716	0.40%	
All Hospitals	\$15,292,865,451	\$276,027,989	1.80%	

Source: HSCRC [http://www.hscrc.state.md.us/init\\_cb.cfm](http://www.hscrc.state.md.us/init_cb.cfm)

#### **Standard .04A(3) – Quality of Care.**

**An acute care hospital shall provide high quality care.**

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

**(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;**

**(ii) Accredited by the Joint Commission; and**

**(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.**

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Applicant Response:

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

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

UM SMC at Easton is in compliance with the Conditions of Participation of the Medicare and Medicaid programs.

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

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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, 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," and shows the hospital's risk-adjusted rate.

UM SMC at Easton scored "better than average" or "average" on 49 of the 72 quality measures. For an additional 13 quality measures, UM SMC at Easton did not have sufficient data to report. UM SMC at Easton scored "below average" on ten quality measures. **Exhibit 12** identifies those quality measures for which UM SMC at Easton scored "below average" along with the corrective action plans for these measures.

## COMAR 10.24.10 ACUTE CARE CHAPTER

### .04B. PROJECT REVIEW STANDARDS

#### Standard .04B(1) – Geographic Accessibility

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

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#### Applicant Response:

To address the requirement that travel time be addressed based on the hospital's "likely service area population," UM SMC at Easton performed a study using Google Maps to determine the travel time from each ZIP Code in its service area to each of the four sites it considered. For the proposed site, the Talbot County Community Center (located on the adjacent property) was used as a proxy, as an address does not yet exist for the proposed hospital.

UM SMC at Easton's PSA includes nine ZIP Codes, and its SSA includes eleven ZIP Codes. See Table 3 below.

**Table 3**  
**UM SMC at Easton Primary and Secondary MSGA Service Areas**  
**CY 2017**

ZIP	City	Service Area	Discharges	% Discharges	Cumulative Discharge %
21601	Easton	Primary	1,418	24.00%	24.00%
21629	Denton	Primary	562	9.50%	33.50%
21613	Cambridge	Primary	403	6.80%	40.30%
21655	Preston	Primary	292	4.90%	45.30%
21632	Federalsburg	Primary	282	4.80%	50.00%
21663	Saint Michaels	Primary	240	4.10%	54.10%
21617	Centreville	Primary	223	3.80%	57.90%
21639	Greensboro	Primary	206	3.50%	61.40%
21660	Ridgely	Primary	204	3.50%	64.80%
21643	Hurlock	Secondary	187	3.20%	68.00%
21620	Chestertown	Secondary	175	3.00%	70.90%
21673	Trappe	Secondary	154	2.60%	73.50%
21625	Cordova	Secondary	131	2.20%	75.80%
21638	Grasonville	Secondary	126	2.10%	77.90%
21666	Stevensville	Secondary	109	1.80%	79.70%

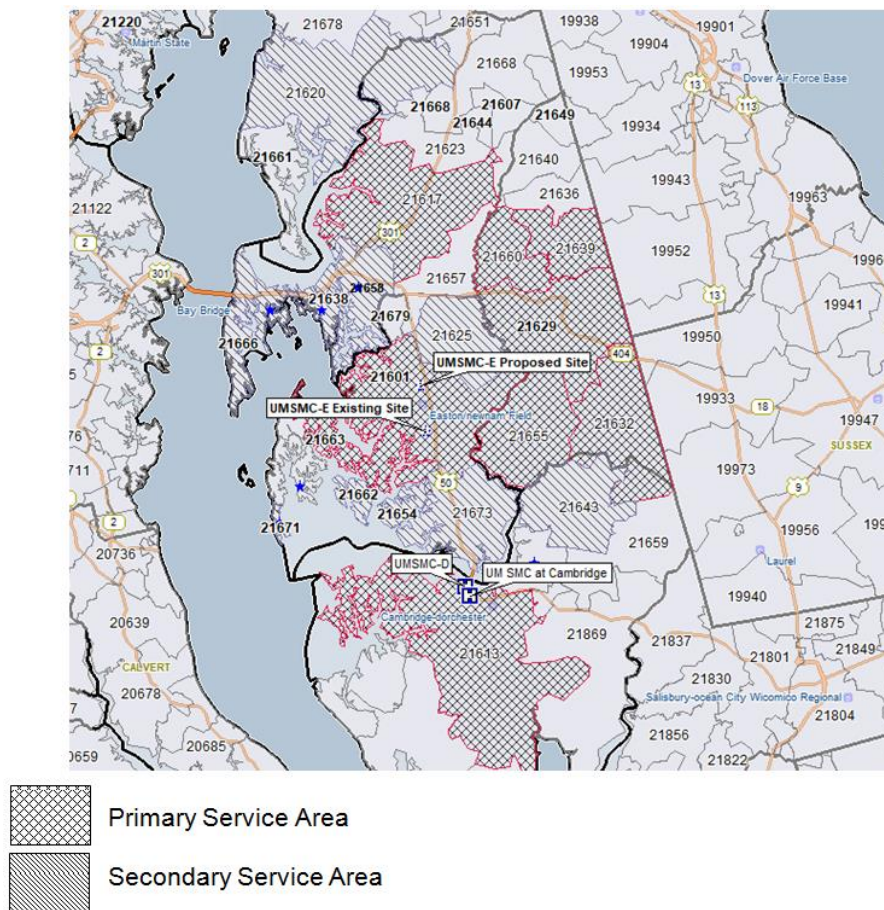


ZIP	City	Service Area	Discharges	% Discharges	Cumulative Discharge %
21658	Queenstown	Secondary	66	1.10%	80.90%
21619	Chester	Secondary	65	1.10%	82.00%
21654	Oxford	Secondary	62	1.00%	83.00%
21671	Tilghman	Secondary	52	0.90%	83.90%
21662	Royal Oak	Secondary	51	0.90%	84.80%

Source: St. Paul Statewide Non-Confidential Data

The Service Areas are shown in Figure 3.

**Figure 3**  
**Primary and Secondary Service Areas—UM SMC at Easton**  
**CY 2017**



To obtain the average drive time to each site in minutes, the Applicant first determined the drive time that Google Maps estimated from the Post Office in each ZIP Code listed above to each site. UM SMC at Easton then multiplied the drive times by the 2019 and 2024 population in each ZIP Code to obtain the weighted average drive time. The products of the drive times for the population for each ZIP Code were summed and divided by the total service area population to obtain the total weighted average drive time to each site.

The total weighted average drive time for the 2024 service area population to each site is summarized below. As this summary shows, the proposed site has a lower average drive time than the current site and the Bypass at Oxford Road site, and a slightly higher drive time (by 0.2 minutes) than the site in northern Talbot County.

**Table 4**  
**Weighted Drive Times for 2024**  
**Service Area Population**

	<b>219 South Washington St., Easton 21601 (Current Site)</b>	<b>Easton Bypass &amp; Oxford Rd., Easton 21601 (Bypass at Oxford Road)</b>	<b>10028 Ocean Gateway Easton 21601 (Proposed Site)</b>	<b>Route 50 and 404, Wye Mill 21679 (Site in Northern Talbot County)</b>
Average Drive Time in Minutes	27.3	28.5	25.9	25.7

When the travel times were multiplied by the 2024 service area population, the travel time savings associated with the proposed site were significant. For example, in total, the proposed site would save 205,156 minutes (or 3,419 hours) of drive time compared to the current site (3,996,182 minutes for the service area population to the current site minus 3,793,955 minutes to the proposed site = 205,156 person minutes; 205,156/60 minutes per hour = 3,419 hours).

When the Applicant performed this same analysis for the 2012 CON application based on 2012 and 2017 population data, the total weighted average drive time to the proposed site was slightly lower than to the other three sites based on the 2017 service population. Below are the results of the 2012 CON application drive time analysis based on the 2017 service area data.

**Table 5**  
**Weighted Drive Times for 2017**  
**Service Area Population**

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

In addition, the proposed site makes acute inpatient services available at UM SMC at Easton within 30 minutes for more people than is the case at the current location. The estimated population living within a 30 minute driving time of UM SMC at Easton's current site is 66,225 in 2019 and 66,709 in 2024. The population living with a 30 minute driving time of UM SMC at Easton's proposed site is 96,922 in 2019 and 98,622 in 2024. Of course, the Applicant recognizes that some portions of this population have access to other area hospitals, as well.



However, UM SMC at Easton is the only hospital in Talbot County, and there are no hospitals located in Caroline and Queen Anne's counties. UM SMC at Easton is the closest hospital for many residents living in Caroline and Queen Anne's counties. In addition, assuming the request for exemption to convert UM SMC at Dorchester to an FMF is approved, UM SMC at Easton will become the closest hospital for many residents of Dorchester County beginning in FY 2022.

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

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

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

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

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

**(i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19-307.2; or**

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

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

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

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**Applicant Response:**

The State Health Plan provides that MSGA beds may be developed or put into operation only if, among other things, the "proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted

by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection.” (COMAR 10.24.10.04(B)(2)).

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

On January 20, 2017, the MHCC published the most recent MSGA bed need projection by jurisdiction in the Maryland Register (Vol. 44, Issue 2, pp. 160-162). The replacement hospital for UM SMC at Easton will reflect MSGA beds currently at UM SMC at Easton and MSGA beds shifted from UM SMC at Dorchester (see *Notice of Intent to Seek Exemption from Certificate of Need Review for the Merger and Consolidation of Certain Beds and Services of University of Maryland Shore Medical Center at Dorchester and University of Maryland Shore Medical Center at Easton*). As such, the projections for both Dorchester and Talbot Counties are presented below in Table 6.

**Table 6**  
**MHCC’s MSGA Bed Need Projection by Jurisdiction**  
**2025**

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

UM SMC at Easton is currently licensed to operate 79 MSGA beds (Office of Health Care Quality and MHCC Acute General Hospitals FY 2019 Application for Annual Licensed Bed Designation). In addition, UM SMC at Dorchester is licensed to operate 18 MSGA beds (Office of Health Care Quality and MHCC Acute General Hospitals FY 2019 Application for Annual Licensed Bed Designation). Combined they are licensed to operate 97 MSGA beds. The current number of licensed beds at UM SMC at Easton and UM SMC at Dorchester falls below the range of projected bed need by the Commission. In addition, the Applicant expects to see continued declines in the utilization of inpatient services in the near and long term. Using the MSGA bed need methodology and assumptions described below, the Applicant projects a need for 95 MSGA beds to serve the residents of the service area in fiscal years 2025 through 2027.

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

## **MSGA Bed Need Calculation**

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

To project the need for MSGA beds at the replacement hospital for UM SMC at Easton, the Applicant began by defining the service area from which UM SMC at Easton currently draws its inpatient MSGA discharges. Using CY 2017 data, the Applicant accumulated its discharges by ZIP Code for ages 15 and above. The Applicant then ranked the ZIP Codes with the highest to lowest number of discharges to identify the ZIP Codes that comprise the top 85% of MSGA discharges and determined the ZIP codes to be included in the service area. As presented in Table 7 below, the MSGA Service Area is defined by 20 ZIP codes that span Talbot, Caroline, Dorchester, Queen Anne's and Kent counties.

**Table 7**  
**UM SMC at Easton MSGA Service Area ZIP Codes and Discharges**  
**CY 2017**

<b>#</b>	<b>Zip Code</b>	<b>City</b>	<b>County</b>	<b>Discharges</b>	<b>Cumulative % of Total</b>
1	21601	Easton	Talbot	1,418	24.0%
2	21629	Denton	Caroline	562	33.5%
3	21613	Cambridge	Dorchester	403	40.3%
4	21655	Preston	Caroline	292	45.3%
5	21632	Federalsburg	Caroline	282	50.0%
6	21663	Saint Michaels	Talbot	240	54.1%
7	21617	Centreville	Queen Anne's	223	57.9%
8	21639	Greensboro	Caroline	206	61.4%
9	21660	Ridgely	Caroline	204	64.8%
10	21643	Hurlock	Dorchester	187	68.0%
11	21620	Chestertown	Kent	175	70.9%
12	21673	Trappe	Talbot	154	73.5%
13	21625	Cordova	Talbot	131	75.8%
14	21638	Grasonville	Queen Anne's	126	77.9%
15	21666	Stevensville	Queen Anne's	109	79.7%
16	21658	Queenstown	Queen Anne's	66	80.9%
17	21619	Chester	Queen Anne's	65	82.0%
18	21654	Oxford	Talbot	62	83.0%
19	21671	Tilghman	Talbot	52	83.9%
20	21662	Royal Oak	Talbot	51	84.8%
Service Area Total				5,008	84.8%
Outside of Service Area				901	15.2%
Total				5,909	100.0%

Source: St. Paul statewide non-confidential data tapes

75% of discharges at UM SMC at Dorchester also originate from these ZIP Codes (see Notice of Intent to Seek Exemption from Certificate of Need Review for the Merger and Consolidation of Certain Beds and Services of University of Maryland Shore Medical Center at Dorchester and University of Maryland Shore Medical Center at Easton).

## 2. Projected MSGA Service Area Population Ages 15+

For the ZIP Codes included in the service area for UM SMC at Easton, population projections through 2023 were obtained from Environics Spotlight (formerly Nielsen Claritas) for the 15-64, 65-74 and 75+ age cohorts. These are presented below in Table 8. The 15-64 age cohort population is expected to decrease 1.7% from 2018 to 2023. Over the same period, the 65-74 and 75+ age cohort populations are expected to grow 16.8% and 5.3%, respectively. In total, the projected population is expected to grow by 1.9% between 2018 and 2023.

**Table 8**  
**UM SMC at Easton's Historical and**  
**Projected MSGA Service Area Population**  
**2010 – 2023**

Age Cohort	Service Area Population						% Change in Population	
	2010		2018		2023		2010-18	2018-23
	Pop	% of Total	Pop	% of Total	Pop	% of Total		
15-64	88,394	78.1%	84,553	73.6%	83,093	71.0%	-4.3%	-1.7%
65-74	13,598	12.0%	17,667	15.4%	20,635	17.6%	29.9%	16.8%
75+	11,157	9.9%	12,599	11.0%	13,266	11.3%	12.9%	5.3%
Total	113,149	100.0%	114,819	100.0%	116,994	100.0%	1.5%	1.9%

Source: Environics Spotlight Pop-Facts Demographics by Age Race Sex

Using the compounded annual growth rates from 2018 to 2023, population projections were extrapolated through 2027 and applied to UM SMC at Easton's fiscal years. Table 9 below depicts the projected population for each age cohort. Led by the population over age 65, the total population is expected to grow annually by 0.3% to 0.5% from fiscal year 2018 to fiscal year 2027.

**Table 9**  
**UM SMC at Easton's Historical and**  
**Projected MSGA Service Area Population**  
**FY 2016 – FY 2027**

Age Cohort	Historical			Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
15-64	85,497	85,024	84,553	84,259	83,966	83,674	83,383	83,093	82,804	82,516	82,229	81,943	-3.1%
%Change		-0.6%	-0.6%	-0.3%	-0.3%	-0.3%	-0.3%	-0.3%	-0.3%	-0.3%	-0.3%	-0.3%	
65-74	16,548	17,098	17,667	18,224	18,799	19,392	20,004	20,635	21,286	21,957	22,650	23,365	32.2%
%Change		3.3%	3.3%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	
75+	12,222	12,409	12,599	12,730	12,862	12,995	13,130	13,266	13,404	13,543	13,683	13,825	9.7%
%Change		1.5%	1.5%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	
Total Service Area	114,267	114,531	114,819	115,213	115,627	116,061	116,517	116,994	117,494	118,016	118,562	119,133	3.8%
%Change		0.2%	0.3%	0.3%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.5%	0.5%	

### 3. MSGA Use Rates

Table 10 depicts the total use rate of MSGA discharges per 1,000 population for ages 15 and older in UM SMC at Easton's defined service area in fiscal years 2016 through 2018 annualized. The total MSGA use rate of 95.8 discharges per 1,000 population for ages 15 and over in fiscal year 2018 represents a decrease from fiscal year 2017, although there was an increase in use rates from fiscal year 2016 to 2017.

**Table 10**  
**UM SMC at Easton's Historical MSGA Service Area Use Rates**  
**FY 2016 – FY 2018**

MSGA Age Cohorts	Actual	Actual	Annualized (1)
	FY2016	FY2017	FY2018
<b>Age 15-64</b>	<b>61.1</b>	<b>62.2</b>	<b>58.7</b>
%Change		1.8%	-5.7%
<b>Age 65-74</b>	<b>164.9</b>	<b>164.8</b>	<b>153.4</b>
%Change		-0.1%	-6.9%
<b>Age 75+</b>	<b>315.3</b>	<b>320.0</b>	<b>263.4</b>
%Change		1.5%	-17.7%
<b>Total Age 15+</b>	<b>103.3</b>	<b>105.5</b>	<b>95.8</b>
%Change		2.1%	-9.2%

Note (1): Reflects 6 months July - December 2017 annualized

Source: St. Paul statewide non-confidential data tapes

Due to an expected reduction in potentially avoidable utilization, MSGA use rates are projected to continue to decline. In fiscal year 2019, use rates are projected to decline by 4.7%

in each age cohort to achieve targeted reductions in unnecessary utilization. Beginning in fiscal year 2020, inpatient use rates are projected to decline by an additional 1% each year at each age cohort level. The total use rate decline will be muted due to the increase in population of the older age cohorts with higher use rates (Table 11). Taking into consideration the aging of the population, the total MSGA use rate will still decline by 7.2% from fiscal year 2018 to 2027.

**Table 11**  
**UM SMC at Easton's Historical and Projected MSGA Use Rate**  
**FY 2016 – FY 2027**

MSGA Age Cohorts	Actual	Actual	Annualized	Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
<b>Age 15-64</b>	<b>61.1</b>	<b>62.2</b>	<b>58.7</b>	<b>55.9</b>	<b>55.4</b>	<b>54.8</b>	<b>54.3</b>	<b>53.7</b>	<b>53.2</b>	<b>52.7</b>	<b>52.1</b>	<b>51.6</b>	
%Change	-2.9%	1.8%	-5.7%	-4.7%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-12.1%
<b>Age 65-74</b>	<b>164.9</b>	<b>164.8</b>	<b>153.4</b>	<b>146.1</b>	<b>144.7</b>	<b>143.2</b>	<b>141.8</b>	<b>140.4</b>	<b>139.0</b>	<b>137.6</b>	<b>136.2</b>	<b>134.8</b>	
%Change	-7.8%	-0.1%	-6.9%	-4.7%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-12.1%
<b>Age 75+</b>	<b>315.3</b>	<b>320.0</b>	<b>263.4</b>	<b>250.9</b>	<b>248.4</b>	<b>245.9</b>	<b>243.5</b>	<b>241.0</b>	<b>238.6</b>	<b>236.2</b>	<b>233.9</b>	<b>231.5</b>	
%Change	-8.0%	1.5%	-17.7%	-4.7%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-12.1%
<b>Total</b>	<b>103.3</b>	<b>105.5</b>	<b>95.8</b>	<b>91.7</b>	<b>91.4</b>	<b>91.0</b>	<b>90.6</b>	<b>90.2</b>	<b>89.9</b>	<b>89.5</b>	<b>89.2</b>	<b>88.8</b>	
	-5.0%	2.1%	-9.2%	-4.2%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-7.2%

#### 4. MSGA Service Area Discharges

Based on the population and use rate assumptions described above, the 10,994 discharges in the MSGA Service Area in fiscal year 2018 are projected to decline 3.8% between fiscal years 2018 and 2024 (Table 12). Much of this decline is expected in fiscal year 2019 as population growth is expected to offset use rate reductions in fiscal years 2020-2027.

**Table 12**  
**UM SMC at Easton's Historical and Projected MSGA Service Area Discharges**  
**FY 2016 – FY 2027**

MSGA	Actual	Actual	Annualized	Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
<b>Service Area Discharges</b>	<b>11,809</b>	<b>12,081</b>	<b>10,994</b>	<b>10,570</b>	<b>10,564</b>	<b>10,560</b>	<b>10,558</b>	<b>10,558</b>	<b>10,561</b>	<b>10,565</b>	<b>10,572</b>	<b>10,580</b>	-3.8%
%Change	-4.8%	2.3%	-9.0%	-3.9%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	

#### 5. UM SMC at Easton's MSGA Service Area Market Share (excluding shift of beds from UM SMC at Dorchester)

UM SMC at Easton's MSGA Service Area market share declined slightly from 44.5% in fiscal year 2016 to 43.5% in fiscal year 2018. Going forward, though, the market share is expected to remain constant at the fiscal year 2018 level for each age cohort, exclusive of the shift of MSGA beds from UM SMC at Dorchester. As a result, the total hospital market share will increase 0.8% from fiscal year 2018 to 2017 as the population shifts to older age cohorts with greater market share (Table 13).

**Table 13**  
**UM SMC at Easton's Historical and Projected MSGA Service Area Market Share**  
**FY 2016 – FY 2027**

MSGA Age Cohorts	Actual	Actual	Annualized	Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
<b>Age 15-64</b>	38.1%	37.1%	37.1%	37.1%	37.1%	37.1%	37.1%	37.1%	37.1%	37.1%	37.1%	37.1%	0.0%
%Change	3.1%	-2.7%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
<b>Age 65-74</b>	44.1%	41.2%	43.4%	43.4%	43.4%	43.4%	43.4%	43.4%	43.4%	43.4%	43.4%	43.4%	0.0%
%Change	6.3%	-6.5%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
<b>Age 75+</b>	53.4%	53.8%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	0.0%
%Change	1.6%	0.8%	-1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
<b>Total</b>	<b>44.5%</b>	<b>43.5%</b>	<b>43.5%</b>	<b>43.6%</b>	<b>43.6%</b>	<b>43.7%</b>	<b>43.7%</b>	<b>43.7%</b>	<b>43.8%</b>	<b>43.8%</b>	<b>43.8%</b>	<b>43.9%</b>	0.8%
	3.0%	-2.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	

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

UM SMC at Easton's out-of-service area MSGA discharges are projected to remain constant, as a percentage of service area discharges, at the age cohort level from fiscal year 2018 through the projection period. Fluctuations from year to year in this percentage are due to aging of the population into older cohorts with fewer discharges from outside the service area (Table 14).

**Table 14**  
**UM SMC at Easton's Historical and Projected**  
**Out-of-Service Area MSGA Discharges**  
**% of Service Area Discharges**  
**FY 2016 – FY 2027**

MSGA	Actual	Actual	Annualized	Projected								
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027
<b>Out-of-Service Area Discharges</b>												
% of Service Area Discharges	17.4%	17.1%	18.5%	18.5%	18.5%	18.4%	18.4%	18.4%	18.4%	18.4%	18.4%	18.4%

## 7. UM SMC at Easton's Inpatient MSGA Discharges

Based on the assumptions described above, UM SMC at Easton's MSGA discharges, exclusive of the shift of discharges from UM SMC at Dorchester, are projected to decline from fiscal year 2018 to fiscal year 2027 by 3.1%. Much of this decline is expected in fiscal year 2019 as population growth and minimal market share gains will offset use rate reductions in fiscal years 2020-2027 (Table 15)

**Table 15**  
**UM SMC at Easton's Historical and Projected MSGA Discharges**  
**FY 2016 – FY 2027**

MSGA	Actual	Actual	Annualized	Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
<b>Inpatient Discharges</b>	<b>6,165</b>	<b>6,157</b>	<b>5,672</b>	<b>5,458</b>	<b>5,459</b>	<b>5,462</b>	<b>5,465</b>	<b>5,470</b>	<b>5,475</b>	<b>5,482</b>	<b>5,490</b>	<b>5,498</b>	-3.1%
%Change		-0.1%	-7.9%	-3.8%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	

In fiscal year 2022, due to the proposed conversion of UM SMC at Dorchester to a freestanding medical facility (“FMF”) and transfer of an additional 17 medical/surgical beds to UM SMC at Easton, it is projected that UM SMC at Easton will have an additional 1,155 discharges related to patients who have historically been admitted to UM SMC at Dorchester (Table 16).

**Table 16**  
**Projected Shift of UM SMC at Dorchester Medical and Surgical Discharges, FY 2022**

UM SMC at Dorchester MSGA Discharges	Projected FY2022	% of Total
Medical Discharges	1,376	92.6%
Surgical Discharges	110	7.4%
Reduction in UM SMC at Dorchester MSGA Discharges	1,486	100.0%
Shift to UM SMC at Easton	(1,155)	-77.7%
Shift to Other Hospitals	(331)	-22.3%
Increase at Other Hospitals	(1,486)	-100.0%

It is expected that Peninsula Regional Medical Center and Atlantic General Hospital will pick up 22.3% of UM SMC at Dorchester’s MSGA cases, all of which will be comprised of medical cases. This shift is based on a drive time analysis that was conducted by service line. It reflects patients who live farther from the new location of MSGA services in Easton.

All of UM SMC at Dorchester’s surgical cases are projected to transfer to UM SMC at Easton. The Applicant anticipates that all of UM SMC at Dorchester’s surgical cases will be retained within SHS for the following reasons: (1) community medical staff referral patterns are not expected to change based upon change in facility location; (2) all surgical providers currently operating at UM SMC at Dorchester have privileges at UM SMC at Easton; and (3) surgical providers currently performing cases at UM SMC at Dorchester have expressed the intention to move such cases to UM SMC at Easton. A majority of the operating surgical providers at UM SMC at Dorchester are employed by UM SRH and, therefore, the shift of surgical practice locations to other hospitals is not anticipated.

As a result of the assumptions described above, discharges at UM SMC at Easton will increase by 21.2% in fiscal year 2022. From fiscal year 2018 to 2027, the discharges at UM SMC at Easton will increase by 18.1% (Table 17).



**Table 17**  
**UM SMC at Dorchester's Historical and Projected MSGA Discharges**  
**FY 2016 – FY 2027**

MSGA	Actual	Actual	Annualized	Projected									% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY18-FY27
Inpatient Discharges													
UM SMC at Easton	6,165	6,157	5,672	5,458	5,459	5,462	5,465	5,470	5,475	5,482	5,490	5,498	
UM SMC at Dorchester	-	-	-	-	-	-	1,155	1,163	1,172	1,181	1,190	1,200	
Total	6,165	6,157	5,672	5,458	5,459	5,462	6,620	6,633	6,647	6,663	6,680	6,698	
%Change	-1.1%	-0.1%	-7.9%	-3.8%	0.0%	0.0%	21.2%	0.2%	0.2%	0.2%	0.3%	0.3%	18.1%

## 8. MSGA Average Length of Stay

The average length of stay (ALOS) for MSGA patients at UM SMC at Easton declined in fiscal year 2018 and is expected to decline further in fiscal year 2019. With improved case management, the ALOS is then expected to decline by an additional 0.2% a year throughout the projection period. Reductions in the ALOS associated with discharges shifted from UM SMC at Dorchester are expected to occur prior to the closing of inpatient services at UM SMC at Dorchester. As such, the ALOS associated with discharges from UM SMC at Dorchester will continue at UM SMC at Easton. Combined, the weighted average ALOS for MSGA discharges at UM SMC at Easton will approximate 3.9 days from fiscal year 2019 to 2027 (Table 18).

**Table 18**  
**UM SMC at Easton's Historical and Projected ALOS**  
**FY 2016 – FY 2027**

MSGA	Actual	Actual	Annualized	Projected									% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY18-FY27
Average Length of Stay													
UM SMC at Easton	4.33	4.44	4.08	3.94	3.93	3.92	3.91	3.90	3.90	3.89	3.88	3.87	
UM SMC at Dorchester	-	-	-	-	-	-	4.13	4.13	4.13	4.14	4.14	4.14	
Average	4.33	4.44	4.08	3.94	3.93	3.92	3.95	3.94	3.94	3.93	3.93	3.92	-4.0%
%Change	3.8%	2.7%	-8.1%	-3.6%	-0.2%	-0.2%	0.8%	-0.2%	-0.2%	-0.1%	-0.1%		

## 9. MSGA Occupancy

The expected 75% occupancy of inpatient MSGA beds at UM SMC at Easton reflects the State Health Plan for hospitals with an average daily census of 50-99 patients.

## 10. MSGA Bed Need

Based on the assumptions presented above, the Applicant has a projected need for 85 MSGA beds in fiscal year 2018. This reflects a 75% occupancy assumption. The Maryland State estimate of 95 licensed beds reflect a lower occupancy assumption that is included in their 140% rule to calculate licensed beds based on average daily census.

The Applicant projects the need for MSGA beds will decline in fiscal year 2019 with the elimination of unnecessary inpatient utilization and then continue to decline minimally in each following year until 17 MSGA beds are shifted from UM SMC at Dorchester in fiscal year 2022. A combined need for 95 MSGA beds will continue through fiscal year 2027 at the replacement hospital for UM SMC at Easton (Table 19).

**Table 19**  
**UM SMC at Easton's Historical and Projected MSGA Bed Need**  
**FY 2016 – FY 2027**

	Actual	Actual	Annualized	Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
<b>MSGA Bed Need</b>													
UM SMC at Easton	98	100	85	79	79	79	79	79	78	78	78	78	
%Change		2.0%	-15.0%	-7.1%	0.0%	0.0%	0.0%	0.0%	-1.3%	0.0%	0.0%	0.0%	
UM SMC at Dorchester	-	-	-	-	-	-	16	16	17	17	17	17	
<b>Total</b>	<b>98</b>	<b>100</b>	<b>85</b>	<b>79</b>	<b>79</b>	<b>79</b>	<b>95</b>	<b>95</b>	<b>95</b>	<b>95</b>	<b>95</b>	<b>95</b>	<b>11.8%</b>
%Change		2.0%	-15.0%	-7.1%	0.0%	0.0%	20.3%	0.0%	0.0%	0.0%	0.0%	0.0%	

### **Pediatric Bed Need Calculation**

UM SMC at Easton is currently licensed to operate eight pediatric beds. Using the pediatric bed need methodology and assumptions described below, the Applicant projects a need for one (1) Pediatric bed to serve the residents of Dorchester and Talbot counties, ages 0-14, in fiscal years 2025 through 2027.

#### **11. Defining UM SMC at Easton's Pediatric Service Area**

To project the need for pediatric beds at the replacement hospital for UM SMC at Easton, the Applicant defined its Pediatric Service Area to be same as the service area defined for MSGA discharges (See Table 12).

#### **12. Projected Pediatric Service Area Population**

For the ZIP Codes included in the service area for UM SMC at Easton, population projections through 2023 were obtained from Environics Spotlight (formerly Nielsen Claritas) for the 0-14 age cohort. Using the compounded annual growth rates from 2018 to 2023, population projections were extrapolated through 2027 and applied to UM SMC at Easton's fiscal years. As the service area population ages, the population for the 0-14 age cohort is expected to decline annually by 0.7% from fiscal year 2018 to fiscal year 2027 (Table 20).

**Table 20**  
**UM SMC at Easton's Historical and**  
**Projected Pediatrics Service Area Population – Ages 0-14**  
**FY 2016 – FY 2027**

Age Cohort	Historical			Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
0-14	23,746	23,532	23,319	23,161	23,003	22,847	22,692	22,538	22,385	22,233	22,082	21,932	-5.9%
%Change		-0.9%	-0.9%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	

### 13. Pediatrics Service Area Use Rates

Table 21 presents the historical use rate per 1,000 population of pediatrics discharges in the UM SMC at Easton Pediatrics Service Area for the 0-14 age cohort. While the service area use rate decreased from fiscal year 2016 to 2018 as pediatric treatment shifted to outpatient and observation settings, utilization started to level off in fiscal year 2018 and is projected to remain constant from fiscal year 2018 to 2027.

**Table 21**  
**UM SMC at Easton's Historical and Projected Pediatrics Use Rate**  
**FY 2016 – FY 2027**

	Actual FY2016	Actual FY2017	Annualized FY2018	Projected									% Change FY18-FY27
Pediatric Service Area Use Rate				FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
Age 0-14	14.9	13.2	12.9	12.9	12.9	12.9	12.9	12.9	12.9	12.9	12.9	12.9	
%Change	-6.0%	-11.4%	-1.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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

UM SMC at Easton's market share of the pediatric service area discharges declined from fiscal year 2016 to 2018, but is expected to level off at the fiscal year 2018 level and remain constant throughout the projection period. There was also a decline in the out of service area discharges as a percent of service area discharges, but this percentage is expected to level off at the fiscal year 2018 level and remain constant throughout the projection period (Table 22).

**Table 22**  
**UM SMC at Easton's Historical and Projected Market Share and**  
**Out-of-Service Area Pediatrics Discharges % of Service Area Discharges**  
**FY 2016 – FY 2027**

	Actual FY2016	Actual FY2017	Annualized FY2018	Projected									% Change FY18-FY27
UM SMC at Easton Pediatrics Market Share				FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
Age 0-14	29.5%	30.0%	17.2%	17.2%	17.2%	17.2%	17.2%	17.2%	17.2%	17.2%	17.2%	17.2%	
%Change		1.8%	-42.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
UM SMC at Easton Out of Service Area				FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
% of Service Area Discharges	20.2%	14.0%	19.2%	19.2%	19.2%	19.2%	19.2%	19.2%	19.2%	19.2%	19.2%	19.2%	0.0%

### 15. UM SMC at Easton's Inpatient Pediatric Discharges

Based on the assumptions described above, UM SMC at Easton's pediatric discharges are projected to decline 5.9% from fiscal year 2018 to fiscal year 2027. This decline is due to the comparable decline in the 0-14 age cohort population (Table 23)

**Table 23**  
**UM SMC at Easton's Historical and Projected Pediatric Discharges**  
**FY 2016 – FY 2027**

	Actual FY2016	Actual FY2017	Annualized FY2018	Projected									% Change FY18-FY27
Pediatric Discharges	125	106	62	61	61	61	60	60	59	59	59	58	
%Change		-15.2%	-41.6%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	-5.9%

#### 16. Pediatrics Average Length of Stay

The average length of stay (ALOS) for pediatric patients at UM SMC at Easton increased from fiscal year 2016 to 2018, but is projected to remain at the fiscal year 2018 ALOS through the projection period (Table 24).

**Table 24**  
**UM SMC at Easton's Historical and Projected Pediatric ALOS**  
**FY 2016 – FY 2027**

	Actual FY2016	Actual FY2017	Annualized FY2018	Projected									% Change FY18-FY27
ALOS	2.34	2.31	2.46	2.46	2.46	2.46	2.46	2.46	2.46	2.46	2.46	2.46	
%Change		-1.1%	6.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

#### 17. Pediatric Occupancy

The Applicant assumes a 50% occupancy for pediatric beds which reflects the State Health Plan (COMAR 10.24.10) for Pediatric inpatient services with an average daily census of 0-6 patients.

#### 18. Pediatric Bed Need

Based on the assumptions presented above, the Applicant has a projected need for one pediatric bed at UM SMC at Easton in fiscal years 2018 through 2027 (Table 25).

**Table 25**  
**UM SMC at Easton's Historical and Projected Pediatric Bed Need**  
**FY2016 – FY2027**

	Actual FY2016	Actual FY2017	Annualized FY2018	Projected									% Change FY18-FY27
Pediatric Bed Need	2	1	1	1	1	1	1	1	1	1	1	1	
%Change	-3.0%	-16.1%	-37.9%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%	-5.9%

**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:**

The Applicant will request an increase in rates equal to approximately 75% of the increase in capital costs (depreciation and interest) plus markup associated with the proposed project. Funding for the other 25% of capital costs will be covered by the hospital. The Applicant's request for a rate increase will be filed as a full rate application with the Health Services Cost Review Commission ("HSCRC") in the third quarter of fiscal year 2019.

The total cost of the project is \$349.9 million, of which \$277.3 million are depreciable assets, \$2.5 million is for the purchase of land, \$39.6 million represents gross interest during construction, and \$30.5 million relates to a debt service reserve fund and financing costs.

\$311.0 million of the depreciable assets and gross interest will be funded with proceeds from the issuance of tax exempt bonds.

**Table 26**  
**UM SMC at Easton Projected Capital Costs**  
**(\$ in thousands)**

	<b>Total Project Costs</b>
Land Acquisition	\$ 2,464.7
New Construction	240,935.3
Medical Equipment	36,397.0
Gross Interest During Construction	39,658.0
Debt Service Reserve Fund	19,586.0
Finance Costs	10,863.5
<b>Total Project Costs</b>	<b>\$ 349,904.5</b>

A full year of depreciation and interest expenses (i.e. capital costs) related to the project are projected to equal \$30.5 million with the opening of the new hospital facility in fiscal year 2025. Of these capital costs, \$23.0 million will be funded with an increase in UM SMC at Easton's regulated revenue. Applying UM SMC at Easton's approved fiscal year 2019 markup of 1.0991 results in a requested rate increase of \$25.3 million in gross charges. This rate increase represents an 11.7% increase over UM SMC at Easton's approved fiscal year 2019 gross charges of \$215.5 million.

In the HSCRC Rate Efficiency Methodology, the Peer Group for UM SMC at Easton is comprised of twenty-eight hospitals. Several of these hospitals are more than twice the size of UM SMC at Easton in terms of revenue. It is more appropriate to compare UM SMC at Easton to hospitals that are similar in terms of size and suburban / rural location, including Calvert Memorial Hospital, Carroll Hospital Center, UM SMC at Chestertown, Garrett County Memorial Hospital, McCready Memorial Hospital, Meritus, UM SMC at Dorchester, Union Hospital of Cecil County and Western Maryland Regional Medical Center.

Comparing the pro forma gross regulated charges at UM SMC at Easton with its actual volumes and approved rates, by rate center, to the pro forma revenue at each of the other similarly sized hospitals calculated with UM SMC at Easton volumes at the FY2018 approved rates for each of the other hospitals results in a finding that UM SMC at Easton's gross regulated charges are 1.2% below the average of the other hospitals (Table 27).

**Table 27**  
**Comparison of UM SMC at Easton Charges to Those of Other Similarly Sized Hospitals**  
**(\$ in thousands)**

FY2018 Pro-Forma Gross Charges			UM SMC at Easton Pro Forma Gross Charges Compared to Other Similar Hospitals		UM SMC at Easton Capital- Adjusted Gross Charges Compared to Other Similar Hospitals	
UM SMC at Easton Pro Forma Gross Charges <sup>(1)</sup>	UM SMC at Easton Gross Charges with Capital Adjusted Rates <sup>(2)</sup>	Other Similar Hospitals FY2018 Pro Forma Gross Charges <sup>(3)</sup>	Over/(Under)	Percent Variance	Over/(Under)	Percent Variance
\$ 223,913	\$ 249,131	\$ 226,682	(2,769)	-1.2%	\$ 22,449	9.9%

Note (1): Calculated as UM SMC at Easton FY2018 actual unit volume x FY2018 HSCRC approved unit rates

Note (2): Calculated as UM SMC at Easton FY2018 actual unit volume x FY2018 HSCRC approved unit rates increased by \$25.5M for capital rate increase

Note (3): Calculated as UM SMC at Easton FY2018 actual unit volume x average of other similar peer group hospital's FY2018 approved unit rates. Other similar hospitals include: Calvert Memorial Hospital, Carroll Hospital Center, Chester River Hospital Center, Dorchester General Hospital, Edward W. McCready Hospital, Garrett County Memorial Hospital, Memorial Hospital at Easton, Meritus Medical Center, Union Hospital of Cecil County, and Western Maryland Regional Medical Center

Source: HSCRC FY2018 Statewide approved rates file

With a \$25.3 million rate increase for capital, though, UM SMC at Easton's pro forma revenue is greater than that of the other similarly sized hospitals. Because the capital adjusted revenue for UM SMC at Easton is greater than the pro forma revenue of the other similarly sized hospitals, the Applicant calculated and compared the FY2017 Debt to Capitalization ratio and Average Age of Plant ratio for UM SMC at Easton to the average of the same ratios for the other hospitals.

For financial reporting purposes, debt and unrestricted net assets for UM SMC at Easton and UM SMC at Dorchester are considered a single entity, SHS. The information for these facilities are, therefore, combined and presented for each of these facilities. In fiscal year 2017, the Debt to Capitalization ratio of 27% for SHS was below the average of 47% for the other similarly sized hospitals (Table 28)

**Table 28**  
**Comparison of UM SMC at Easton Debt to Capitalization Ratio**  
**to Those of Other Similarly Sized Hospitals**  
**(\$ in thousands)**

<b>Hospital</b>	<b>Total Debt</b>	<b>Unrestricted Net Assets</b>	<b>Debt to Capitalization</b>
Calvert Memorial Hospital	\$ 63,007	\$ 25,948	71%
Carroll Hospital Center	133,119	118,887	53%
Chester River Hospital Center	4,412	55,913	7%
Garrett County Memorial Hospital	14,970	43,993	25%
McCready Memorial Hospital	1,083	11,800	8%
Meritus	271,038	259,001	51%
UM SMC at Dorchester	83,786	222,367	27%
Union of Cecil	63,575	83,405	43%
Western Maryland Regional Medical Center	247,419	162,481	60%
Peer Group Weighted Average	<u>\$ 882,408</u>	<u>\$ 983,795</u>	<u>47%</u>
<b>UM SMC at Easton</b>	<b>\$ 83,786</b>	<b>\$ 222,367</b>	<b>27%</b>

Source: FY2017 Audited Financial Statements

For the Average Age of Plant, additional detail was obtained to be able to calculate the ratio for UM SMC at Easton separate from UM SMC at Dorchester. In fiscal year 2017, the Average Age of Plant of 12.0 years for UM SMC at Easton exceeded the average of 10.8 years for the other similarly sized hospitals (Table 29).

**Table 29**  
**Comparison of UM SMC at Easton Average Age of Plant Ratio**  
**to Those of Other Similarly Sized Hospitals**  
**(\$ in thousands)**

<b>Hospital</b>	<b>Accumulated Depreciation</b>	<b>Current Depreciation</b>	<b>Average Age of Plant</b>
Calvert Memorial Hospital (1)	\$ 50,945	\$ 9,941	5.1
Carroll Hospital Center (1)	206,408	14,908	13.8
Chester River Hospital Center (1)	48,152	4,338	11.1
Garrett County Memorial Hospital (1)	35,547	3,633	9.8
McCready Memorial Hospital	11,106	943	11.8
Meritus (1)	208,502	19,799	10.5
Shore Medical Dorchester (1)	43,246	3,192	13.5
Union of Cecil	124,327	11,378	10.9
Western Maryland Regional Medical Center	280,073	24,971	11.2
Peer Group Weighted Average	<u>\$ 1,008,304</u>	<u>\$ 93,103</u>	<u>10.8</u>
<b>UM SMC at Easton</b>	<b>\$ 170,046</b>	<b>\$ 14,137</b>	<b>12.0</b>

Note (1): FY2017 Accumulated Depreciation equals FY2016 Accumulated Depreciation + FY2017 Annual Depreciation due to lack of detail presented in audited financial statements

Source: FY2017 Audited Financial Statements, HSCRC Annual Filings Schedule H1



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

*Applicant Response:*

While reductions in MSGA inpatient use rates are expected to decline annually, by age cohort, the aging of the population will offset that decline and, therefore, results in no change in the number of beds when UM SMC at Easton moves from its current location to the new hospital location. All of the outpatient services that are currently offered at UM SMC at Easton will continue to be offered at the replacement facility. None of the proposed changes in this project will impact access for indigent and/or uninsured patients. UM SMC at Easton will continue to care for patients regardless of their ability to pay.

**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.

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*Applicant Response:*

Planning for this project occurred in several phases over a number of years.

**Identification of Primary Objectives**

In 2005, the Applicant began evaluating alternatives for the proposed project as it explored its affiliation with UMMS. In doing so, it identified its primary objectives for the proposed project.

At the time of the early planning of the project, the population of the Eastern Shore of Maryland was growing rapidly. The Applicant wanted to make sure that the physical solutions to its facility constraints continued to adequately provide for the needs of these growing

communities, including improvements that support exceptional patient experience with facilities and services.

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

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

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

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

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

The facility solutions were evaluated based on the volume projections generated by the growing population. SHS projected the volume of both inpatient admissions and clinical service workloads based on the population size and current use rates. Market shares for each facility were calculated for each community and applied to the volumes.

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

Senior citizens use health care resources at a much greater rate than their younger counterparts. The use rates of the senior citizens were built into the volume projections for each site. Seniors also have a special need for simple wayfinding. The facility solutions and site configurations for each site were evaluated on their ability to support simple wayfinding.

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

The access to hospital services was measured by a drive time analysis. The drive time from each community in the hospital's service area to each of the alternative sites was measured using online mapping software. The drive time was weighted for the population of each community, and then aggregated. The site with the lowest aggregate drive time was considered to have the best access for all residents of the service area.

4. Enhance physician recruitment to the Eastern Shore.

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

**Evaluation of the Final Project Alternatives**

Initially, SHS included the redevelopment of the existing hospital campus as an additional project alternative. However, after it filed its 2012 CON application, SHS withdrew that alternative because, upon further consideration, SHS determined that this alternative would not meet its primary objectives and it would not resolve many of the deficiencies in the existing building. Most significantly, the existing site cannot provide the same ease of access as the other project sites. Moreover, SHS concluded that it was highly unlikely it could achieve necessary local land use approvals to undertake a large-scale renovation and redevelopment of the facility on the existing site.

After withdrawing the existing campus alternative, the proposed project and two alternative projects remained, which are summarized below:

1. Relocate to a New Site in Easton – “Bypass at Oxford Road Site”

UM SMC at Easton owns a parcel of land in southwestern Easton, on the Easton Bypass (Route 322) at Oxford Road. The new hospital facility in this alternative would be sized exactly the same as the proposed project. There would be no land acquisition costs associated with this alternative. Because there are utility services available on Route 322, UM SMC at Easton would not be partially responsible for extending water and electrical services to the site, as is the case in the proposed project. Access to municipal services such as fire and police is the same as the current site. All other project costs of this alternative would be the same as described in the proposed project.

2. Relocate to a Site in Northern Talbot County – “Northern Talbot County Site”

In this alternative, UM SMC at Easton planned to acquire a 90-acre parcel of land on the southeast corner of the intersection of Maryland Routes 50 and 404. The cost of land acquisition – \$7.2 million – is included in the cost of this alternative. The hospital facility in this alternative would be the same as the proposed project. There are no utilities available currently to serve this site. UM SMC at Easton assumes that electric service would have to be extended from Wye Mills and that wells would have to be dug on the property to provide water. A sewage treatment plant to serve the new facility would also have to be developed on the property. There is no access to municipal services of fire and police. All other project costs of this alternative would be the same as described in the proposed project.

3. Relocate to Talbot County Community Center Site – “Proposed Project Site”

The proposed project site is a 235-acre parcel at the intersection of Longwoods Road and Route 50, just north of the Easton Municipal Airport (the “Proposed Project Site”).<sup>2</sup> Talbot County conveyed the Proposed Project Site to SHS in 2015 for \$2.5 million. The site is predominantly a “green-fields” site, not all of which will be used for the Hospital. The remainder of the parcel will be used for future development. As a green-fields site, utilities will have to be brought to the site lines, but the land has been annexed by the Town of Easton to provide utilities and services to the site. Access to municipal services of fire and police is the same as the current site.

SHS has re-evaluated each of these alternatives to provide a more apples-to-apples comparison by using the same assumptions it had used for the proposed project when appropriate. The assumptions UM SMC at Easton used to update its models were as follows:

- a. The implementation timetables and project schedule for each alternative are the same as the proposed project.
- b. Square footage of the facilities in each of the relocation alternatives will be equivalent to the square footage of the proposed project.
- c. New construction costs, per square foot, are the same across all relocation alternatives to be equal to the new construction costs of the proposed project.
- d. Patient volumes are equivalent across all relocation alternatives.
- e. With the exception of land and site development costs, the project costs for each alternative are assumed to be the same and are inflated for 61 months (8.37% to the midpoint of construction in July 2023) using the MHCC inflation index. The original site development costs that were estimated for each alternative have been updated to account for inflation. Land acquisition costs were not inflated.
- f. Each alternative assumes that UM SMC at Dorchester has received approval to convert to an FMF and merge and consolidate 17 MSGA and 12 behavioral health beds with UM SMC at Easton in FY 2022.

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

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<sup>2</sup> SHS did not consider the Proposed Project Site as part of its initial planning process because the site had not yet been offered by Talbot County. Following the affiliation between SHS and UMMS in 2006, the Talbot County Council offered to donate a significant portion of the Proposed Project Site to SHS in order to ensure the hospital would be located close to Easton. Also, the Town of Easton proposed to annex the site to provide utilities to the site. These arrangements reduced the cost of the Proposed Project Site and made it an attractive alternative.

**Table 30**  
**Project Cost Comparisons for Final Alternatives**

	Site in Easton (Bypass at Oxford Road)	Site in Northern Talbot County (Routes 50 and 404)	Proposed Project Site
Building and Fit Out			
Planning and Design	\$9,500,000	\$9,500,000	\$9,500,000
Land Acquisition	--	\$7,150,000	\$2,464,658
Site Development	\$32,678,878	\$41,875,782	\$37,000,000
Construction	\$132,511,795	\$132,511,795	\$132,511,795
Medical Equipment	\$36,397,000	\$36,397,000	\$36,397,000
Contingency	\$20,373,047	\$21,841,865	\$20,982,770
Inflation	\$24,555,872	\$26,326,255	\$25,290,777
Other	\$15,650,000	\$15,650,000	\$15,650,000
	<b>\$271,666,593</b>	<b>\$291,252,697</b>	<b>\$279,797,000</b>
Capitalized Interest	\$38,505,608	\$41,281,713	\$39,658,000
Debt Service Reserve Fund	\$19,016,865	\$20,387,907	\$19,586,000
Other Costs (Financing, consultants)	\$10,863,500	\$10,863,500	\$10,863,500
<b>Total Project Capital Costs</b>	<b>\$340,052,566</b>	<b>\$363,785,817</b>	<b>\$349,904,500</b>

Table 31 provides the key financial indicators for the Bypass at Oxford Road Site alternative, which is comparable to the projection for proposed project provided in **Exhibit 1**, Table K. The Operating Revenue in Table 31 assumes an adjustment in revenue capital support in relationship to the changes in the capital project costs illustrated in Table 30. Operating Expense reflects a change in depreciation and interest expense based on the change in the capital costs for the Bypass at Oxford Road Site. All other financial statement assumptions are consistent with the Proposed Project Site financial projection.

**Table 31**  
**Key Financial Indicators – Relocation to Bypass at Oxford Road Site in Easton**  
**FY 2019 – FY 2027**  
**(Dollars in Thousands)**

Alt Scenario 1 - Bypass at Oxford Rd	Budget				Projected				
	2019	2020	2021	2022	2023	2024	2025	2026	2027
Operating Revenue	\$ 210,761	\$ 215,863	\$ 221,088	\$ 251,184	\$ 257,267	\$ 263,498	\$ 291,510	\$ 298,571	\$ 305,804
Operating Expenses	209,143	211,286	213,993	242,860	247,616	252,512	284,987	290,243	295,827
Operating Income	1,618	4,576	7,095	8,324	9,651	10,986	6,523	8,328	9,977
Other Operating Expense	-	-	-	-	-	9,592	-	-	-
Excess of Revenue Over Expense	\$ 1,618	\$ 4,576	\$ 7,095	\$ 8,324	\$ 9,651	\$ 1,394	\$ 6,523	\$ 8,328	\$ 9,977
<i>Operating Margin</i>	0.8%	2.1%	3.2%	3.3%	3.8%	4.2%	2.2%	2.8%	3.3%
<i>Excess Margin</i>	0.8%	2.1%	3.2%	3.3%	3.8%	0.5%	2.2%	2.8%	3.3%

Table 32 provides the key financial indicators for the Northern Talbot County Site, which is comparable to the projection for proposed project provided in **Exhibit 1**, Table K. The Operating Revenue in Table 32 assumes an adjustment in revenue capital support in relationship to the changes in the capital project costs illustrated in Table 30. Operating Expense reflects a change in depreciation and interest expense based on the change in the capital costs for the Bypass at Oxford Road Site. All other financial statement assumptions are consistent with the Proposed Project financial projection.

**Table 32**  
**Key Financial Indicators – Relocation to Site in Northern Talbot County**  
**FY 2019 – FY 2027**  
**(Dollars in Thousands)**

Alt Scenario 2 - Site In Northern Talbot County	Budget				Projected				
	2019	2020	2021	2022	2023	2024	2025	2026	2027
Operating Revenue	\$ 210,761	\$ 215,863	\$ 221,088	\$ 251,184	\$ 257,267	\$ 263,498	\$ 291,510	\$ 298,571	\$ 305,804
Operating Expenses	209,143	211,286	213,993	242,860	247,616	252,512	286,732	291,970	297,535
Operating Income	1,618	4,576	7,095	8,324	9,651	10,986	4,778	6,601	8,269
Other Operating Expense	-	-	-	-	-	9,592	-	-	-
Excess of Revenue Over Expense	\$ 1,618	\$ 4,576	\$ 7,095	\$ 8,324	\$ 9,651	\$ 1,394	\$ 4,778	\$ 6,601	\$ 8,269
<i>Operating Margin</i>	0.8%	2.1%	3.2%	3.3%	3.8%	4.2%	1.6%	2.2%	2.7%
<i>Excess Margin</i>	0.8%	2.1%	3.2%	3.3%	3.8%	0.5%	1.6%	2.2%	2.7%

Total Margin financial indicators are not included in the revised Table 31 and Table 32 as the components for Non-Operating Income, like investment income, are carried at the health system level. The cash and investments which generate investment income are held by the UM SRH system and are not allocated at a hospital-level. Likewise, the balance sheet indicators are not reported in Table 31 and Table 32 because that information is only reported at the UM SRH system level and not allocated to UM SMC at Easton.

After updating the project costs and financial projections for each alternative, SHS revised its ranking of the final two alternatives and the proposed project, which are presented in the following table.

**Table 33**  
**Ranking of Final Two Alternatives**  
**and Proposed Project**

Objectives	Relocation to New Site in Easton (Bypass at Oxford Road)	Relocation to New Site in Northern Talbot County (Route 50 and 404)	Proposed Project
Needs of Growing Population			
BGSF as % of Required	1	1	1
% Private Beds	1	1	1
Inter-Department Layout	1	1	1
Intra-Department Layout	1	1	1
Needs of Senior Citizens			
Campus/Building Wayfinding	1	1	1
Improve Access			
Aggregate Drive Times	3	1	1
Ease of Access by Employees	1	3	1
Ease of EMS Access	3	2	1
Access to Municipal Fire/Police	1	3	1
Enhance Physician Recruitment			
New v. Renovation Facility	1	1	1
Financial Considerations			
Lowest Capital Cost	1	3	2
Projected Operating Margin	2	3	1
Philanthropic Support	2	3	1
Aggregate Score	19	24	14
<b>Overall Ranking</b>	<b>2</b>	<b>3</b>	<b>1</b>

Rankings: 1 = Best; 2 = 2<sup>nd</sup> Best; 3 = Worst

### **Ranking of the Final Alternatives**

All of the alternatives ranked as equivalent on several of the objectives: meeting the needs of a growing population, meeting the needs of senior citizens in providing improved wayfinding, and enhancing physician recruitment. Meeting the needs of a growing population and improving wayfinding were identified as objectives, in part, because they are serious deficiencies with the existing facility. All of the alternatives would provide a new site with fewer space limitations and a new facility with a more modern design that would easily meet these objectives. Similarly, a modern, state-of-the-art facility was estimated to enhance physician recruitment, and all of these alternatives would provide such a facility.

The final alternatives could be distinguished primarily by how they ranked on two objectives: improving access to citizens and the capital costs of the project. For improving access, the Proposed Project Site ranked first because, based on drive time analysis, it was estimated to have the lowest aggregate drive time and was thought to provide the most ease of

access for employees and EMS services. The Northern Talbot County Site ranked second, and the Bypass at Oxford Road Site ranked third (worst) for improving access for all citizens.

As for capital costs, the facility at the Northern Talbot County Site was estimated to have higher capital costs than the Proposed Project Site for several reasons. First, SHS would have to purchase all of the land for the Northern Talbot County Site and would have to pay the market value, which was estimated at \$7.2 million, but would likely be even greater today. Talbot County conveyed the Proposed Project Site to UM SRH for \$2.5 million in 2015, thereby donating a significant portion of the land. The Town of Easton and the County also promised to bring the major utilities to the site. By comparison, the Northern Talbot County Site would be expensive to develop since utilities would have to be brought from long distances, and SHS would have to develop its own sewage treatment facility. The capital costs of the Northern Talbot County Site would be approximately \$9.6 million more than the capital costs at the Proposed Project Site. In addition, the Northern Talbot County Site did not have nearby access to municipal police and fire resources, which are important resources that SHS depends on today and which are accessible at the Proposed Project Site.

Although the capital costs for the Bypass at Oxford Road Site were estimated to be lower than the Northern Talbot County Site and Proposed Project Site, this site ranked the poorest for accessibility for the service area population as presented above in response to COMAR 10.24.10.04(B)(1) – Geographic Accessibility. Based on the updated drive time analysis, the Northern Talbot County Site is now estimated to have a very slightly lower drive time than the Proposed Project Site by two-tenths of a minute. The total weighted average drive time to the Proposed Project Site is now estimated to be 25.9 minutes while the Northern Talbot County Site is estimated to be 25.7 minutes.

Based on all factors, the Proposed Project Site was found to be the most cost effective alternative that would best meet SHS's objectives. Since filing of the 2012 CON application, SHS's primary objectives have not changed, and the Proposed Project Site continues to be the most cost-effective approach to meeting all of SHS's objectives. Using the same assumptions and applying an inflation factor to account for the passage of time, the proposed alternative would still result in the same overall ranking of alternatives, as presented in Table 33.

### **Size Analysis of Proposed Project**

The Applicant is mindful of the importance of not "overbuilding" the replacement facility, and it does not wish to spend more resources than are necessary to meet the health care needs of the service area population. There is no single hospital sizing benchmark applicable to all hospital projects. Each project is distinctive. Some differences in hospital sizing can be explained by grouping hospitals into like categories, such as academic hospitals or rural hospitals. Other differences can only be understood by examining the particular needs of each hospital and the community it serves. The proposed replacement hospital has been designed to meet the needs of the community in a cost effective manner.

The area of the proposed replacement hospital is 358,868 BGSF, including the Central Utility Plant, as shown in Table C. With 135 acute care beds and 16 observation beds, the facility size equates to 2,377 sf/bed. The proposed size compares favorably to other recently approved facilities, even with the inclusion of significant outpatient clinic space (27,781 sf).



(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.

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[Applicant's Response](#)

Not applicable.

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

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

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

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

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

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[Applicant Response:](#)

The proposed site is within a Priority Funding Area. (See Exhibit 13.)

**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.

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Applicant Response:

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

**Standard .04B(7) – Construction Cost 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.

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Applicant Response:

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

**I. Marshall Valuation Service  
Valuation Benchmark – New Construction – Tower 1**

Type	Hospital
Construction Quality/Class	Good/A
Stories	6
Perimeter	1,276
Average Floor to Floor Height	15.2
Square Feet	334,016
f.1 Average floor Area	55,669
<b>A. Base Costs</b>	
Basic Structure	\$374.00
Elimination of HVAC cost for adjustment	0
HVAC Add-on for Mild Climate	0
HVAC Add-on for Extreme Climate	0
<b>Total Base Cost</b>	<b>\$374.00</b>

<b>Adjustment for Departmental Differential Cost Factors</b>		1.15
<b>Adjusted Total Base Cost</b>		<b>\$429.80</b>
<b>B. Additions</b>		
	Elevator (If not in base)	\$0.00
	Other	\$0.00
<b>Subtotal</b>		<b>\$0.00</b>
<b>Total</b>		<b>\$429.80</b>
<b>C. Multipliers</b>		
Perimeter Multiplier		0.906333458
	Product	\$389.54
Height Multiplier		1.074
	Product	\$418.27
Multi-story Multiplier		1.015
	Product	\$424.55
<b>D. Sprinklers</b>		
	Sprinkler Amount	\$2.46
<b>Subtotal</b>		<b>\$427.01</b>
<b>E. Update/Location Multipliers</b>		
Update Multiplier		1.04
	Product	\$444.09
Location Multiplier		0.99
	Product	\$439.65
<b>Calculated Square Foot Cost Benchmark</b>		<b>\$439.65</b>

The MVS estimate for this project is impacted by the Adjustment for Departmental Differential Cost Factor. In Section 87 on page 8 of the Valuation Service, MVS provides the

cost differential by department compared to the average cost for an entire hospital. The calculation of the average factor is shown below.

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
<b>ACUTE PATIENT CARE</b>				
Inpatient Nursing Units				
Intensive Care	13,131	Inpatient Units	1.06	13,919
Med / Surg - Telemetry	13,874	Inpatient Units	1.06	14,706
Rehab (Requard Center)	13,889	Inpatient Units	1.06	14,722
Med / Surg - General	33,007	Inpatient Units	1.06	34,987
Pediatric Unit	incl in M/S Unit	Inpatient Units	1.06	0
Med / Surg - Joint, Neuro, Med/ Surg	incl in M/S Unit	Inpatient Units	1.06	0
Obstetrics incl. nursery	18,863	Obstetrical Suite Only	1.44	27,163
Behavioral Health Clinic	11,915	Outpatient Department	0.99	11,796
Diagnostic & Treatment				
Clinical Lab / Pathology	3,923	Laboratories	1.15	4,511
Emergency Department	20,761	Emergency Suite	1.18	24,498
Inpatient Dialysis	1,777	Inpatient Units	1.06	1,884
Imaging Department	15,004	Radiology	1.22	18,305
Interventional Suite (incl ORs, Cath, EP)	26,802	Operating Suite, Total	1.59	42,615
Prep / Stage 2 Recovery	14,983	Operating Suite, Total	1.59	23,823
Pre-Anesthesia Testing	1,300	Laboratories	1.15	1,495
Observation Unit	5,142	Inpatient Units	1.06	5,451
Respiratory Therapy	870	Adjunct Facilities	1.18	1,027
Administrative / Public Services				
Auxiliary	354	Offices	0.96	340
Admitting / Registration	2,599	Offices	0.96	2,495
Chapel	487	Public Space	0.8	390
Education Center / Med Library	-	Offices	0.96	0
Gift Shop	1,248	Public Space	0.8	998
Hospitalist Suite	600	Offices	0.96	576
On-Call	768	Offices	0.96	737
Executive Admin	-	Offices	0.96	0

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
CIM / Physician Lounge	2,977	Employee Facilities	0.8	2,382
Quality Team	-	Offices	0.96	0
Human Resources / Employee Health	1,831	Offices	0.96	1,758
Nursing Administration / Staff offices	3,461	Offices	0.96	3,323
Information Technology	2,576	Offices	0.96	2,473
Lobby Services	-	Public Space	0.8	0
Support Services				
EVS/Linen/Facilities/Mat. Mgmt	13,028	Laundry	1.68	21,887
Maryland Express Care	733	Offices	0.96	704
Sterile Processing	6,336	Central Sterile Supply	1.54	9,757
Pharmacy	4,032	Pharmacy	1.33	5,363
Security	930	Offices	0.96	893
Food & Nutrition	12,104	Dietary	1.52	18,398
Clinics				
Cardiopulmonary / Vascular	5,763	Outpatient Department	0.99	5,705
Allied Health / School of Nursing	-			
Behavioral Health Outpatient Clinic	3,839	Outpatient Department	0.99	3,801
Breast Center	-			
Cardio Rehab	3,484	Outpatient Department	0.99	3,449
Child Advocacy Center	-			
Diabetes Clinic	3,685	Outpatient Department	0.99	3,648
Infusion Center	2,090	Outpatient Department	0.99	2,069
Coumadin (anti-Thromb) Clinic	-			
Pain Management Clinic	2,771	Outpatient Department	0.99	2,743
Sleep Lab	-			
Multi-Specialty Clinic	3,813	Outpatient Department	0.99	3,775
Wound Healing Center	-			

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
Outpatient Lab Draw	742	Outpatient Department	0.99	735
Building Grossing Factor	58,524	Mechanical Equipment and Shops	0.7	44,552
Total	334,016		1.15	383,852

## II. Marshall Valuation Service Valuation Benchmark – New Construction – Central Utility Plant (“CUP”)

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

Type	Hospital
Construction Quality/Class	Good/A
Stories	1
Perimeter	610
Average Floor to Floor Height	20.00
Square Feet	22,385
Average floor Area	22,385
<b>A. Base Costs</b>	
Basic Structure	\$ 374.00
Elimination of HVAC cost for adjustment	0
HVAC Add-on for Mild Climate	0
HVAC Add-on for Extreme Climate	0
<b>Total Base Cost</b>	<b>\$374.00</b>
<b>Adjustment for Departmental Differential Cost Factors</b>	
	0.70
<b>Adjusted Total Base Cost</b>	<b>\$261.80</b>
<b>B. Additions</b>	
Elevator (If not in base)	(\$8.70)
Other	\$0.00
<b>Subtotal</b>	<b>(\$8.70)</b>

<b>Total</b>	<b>\$253.10</b>
<b>C. Multipliers</b>	
Perimeter Multiplier	0.9197208
Product	\$ 232.78
Height Multiplier	1.184
Product	\$275.61
Multi-story Multiplier	1.000
Product	\$275.61
<b>D. Sprinklers</b>	
Sprinkler Amount	\$3.90
<b>Subtotal</b>	<b>\$279.51</b>
<b>E. Update/Location Multipliers</b>	
Update Multiplier	1.04
Product	\$290.69
Location Multiplier	0.99
Product	\$287.78
<b>Calculated Square Foot Cost Standard</b>	<b>\$287.78</b>

### III. Marshall Valuation Service Valuation Benchmark– Mechanical Penthouse

Type	Mechanical Penthouse
Construction Quality/Class	Good/A-B
Stories	7
Perimeter	205
Average Floor to Floor Height	21.83
Square Feet	2,534
Average floor Area	2,534
<b>A. Base Costs</b>	
Basic Structure	\$ 83.00
Elimination of HVAC cost for adjustment	0

HVAC Add-on for Mild Climate	0
HVAC Add-on for Extreme Climate	0
<b>Total Base Cost</b>	<b>\$83.00</b>
<b>B. Additions</b>	
Elevator (If not in base)	\$0.00
Other	\$0.00
<b>Subtotal</b>	<b>\$0.00</b>
<b>Total</b>	<b>\$83.00</b>
<b>C. Multipliers</b>	
Perimeter Multiplier	1.052304
Product	\$ 87.34
Height Multiplier	1.22609
Product	\$107.09
Multi-story Multiplier	1.020
Product	\$109.23
<b>D. Sprinklers</b>	
Sprinkler Amount	\$5.64
<b>Subtotal</b>	<b>\$114.87</b>
<b>E. Update/Location Multipliers</b>	
Update Multiplier	1.04
Product	\$119.46
Location Multiplier	0.99
Product	\$118.27
<b>Calculated Square Foot Cost Standard</b>	<b>\$118.27</b>



#### IV. Consolidated MVS Benchmark

	MVS Benchmark	Sq. Ft.	Total Cost Based on MVS
<b>Standard</b>			
"Tower" Component	\$439.65	334,016	\$146,850,174.75
Mechanical Penthouse	\$118.27	2,534	\$299,687.11
CUP	\$287.78	22,385	\$6,442,003.71
<b>Consolidated</b>	<b>\$427.91</b>	<b>358,935</b>	<b>\$153,591,865.57</b>

#### V. Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
Building	\$132,511,795	\$369.18
Fixed Equipment	In Building	\$0.00
Site Preparation	\$37,000,000	\$103.08
Architectural Fees	\$9,500,000	\$26.47
Permits	\$8,003,000	\$22.30
Capitalized Construction Interest	Calculated Below	Calculated Below
<b>Subtotal</b>	<b>\$187,014,795</b>	<b>\$521.03</b>

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

#### B. Extraordinary Cost Adjustments

	Project Costs	Associated Architectura l Fees	Associated Cap Interest	
<b>Inside the Loop</b>				
Canopy	\$1,032,052	\$57,840	\$222,288	Building
Premium for Labor Shortages on Eastern Shore Projects	\$7,950,708	\$445,584	\$1,712,455	Building
LEED Silver Premium	\$5,300,472	\$297,056	\$1,141,637	Building
Seismic Costs	\$2,650,236	\$148,528	\$570,818	Building
Pneumatic Tube System	\$750,000	\$42,032	\$161,538	Building
TransVac System	\$2,700,000	\$151,317	\$581,537	Building

Signs	\$1,040,000	\$58,285	\$223,999	Building
Premium for Minority Business Enterprise Requirement	\$4,443,533	\$249,030	\$957,066	Building
Jurisdictional Hook-up Fees	\$1,852,215			Permits
Impact Fees	\$1,539,819			Permits
Paving and Roads	\$6,240,000	\$349,710		Site
Demolition	\$26,000	\$1,457		Site
Storm Drains	\$2,472,660	\$138,576		Site
Rough Grading	\$1,476,214	\$82,732		Site
Landscaping	\$2,222,382	\$124,550		Site
Sediment Control & Stabilization	\$209,130	\$11,720		Site
Helipad	\$622,594	\$34,892		Site
Water	\$60,900	\$3,413		Site
Sewer	\$97,440	\$5,461		Site
Premium for Labor Shortages on Eastern Shore Projects	\$2,220,000	\$124,416		Site
Seismic Costs	\$740,000	\$41,472		Site
Premium for Minority Business Enterprise Requirement	\$942,907	\$52,844		Site
<b>Outside the Loop</b>				
Roads	\$6,240,000	\$349,710		Site
Pump Station	\$745,680	\$41,790		Site
8" to 12" Force Main	\$1,040,000	\$58,285		Site
Misc.	\$520,000	\$29,143		Site
EASTON ELECTRICAL SERVICE	\$704,369	\$39,475		Site
EASTON GAS SERVICE TO PROPERTY	\$254,196	\$14,246		Site
Verizon	\$1,170,497	\$65,599		Site
MD Broad Band (Fiber)	\$1,592,448	\$89,246		Site
Chop Tank (Electric)	\$2,826,004	\$158,379		Site
Cable TV	\$3,532,880	\$197,994		Site
Amount Spent on the 2012 CON Project that is not now Usable				
Architect/Engineering Fees		\$2,022,908		
Permits	\$52,849			
<b>Total Cost Adjustments</b>	<b>\$65,268,185</b>	<b>\$5,487,690</b>	<b>\$5,571,339</b>	<b>\$76,327,213</b>

### **Explanation of Extraordinary Costs**

- Demolition - The project requires a small amount of demolition. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A - Good General Hospital per Section 1, page 3 of the Marshall Valuation Service.
- Premium for Labor Shortages/Remote Location on Eastern Shore Projects – Whiting Turner, the cost estimator on this project, has included a premium (based on Building Costs) due to labor shortages and costs of transporting equipment and construction materials that they have experienced on the Eastern Shore. In Section 99, Page 1, MVS recognizes the potential for a 2%-10% premium for Abnormal Shortages and for a 5%-15% for Remote Areas.
- LEED Silver Premium - Whiting Turner has included a 4% premium (based on Building Costs only) due to constructing this building to LEED Silver standards. The potential for a 0%-7% premium is recognized by MVS in Section 99, Page 1.
- Seismic Costs - Whiting Turner has included a premium (based on Building Costs only) due to constructing this building to the necessity of building in seismic protection factors. The potential for a 2%-5% premium is recognized by MVS in Section 99, Page 1.
- Signs, Canopy, Jurisdictional Hook-up Fees, Impact Fees, Paving and Roads, Storm Drains, Rough Grading, Landscaping, and Sediment Control & Stabilization – These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the Marshall Valuation Service.
- Helipad - Land improvement costs, such as helipads, are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A -Good General Hospital per Section 1, page 3 of the Marshall Valuation Service. (While helipads are not specifically mentioned, UM SMC at Easton considers it a land improvement cost.)
- Water and Sewer– This project requires the extension of utilities to the perimeter of the hospital related portion of the site (i.e., to the outer boundary of the “Inner Loop”). These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the Marshall Valuation Service.
- Premium for Minority Business Enterprise Requirement – This construction will be subject to the Minority Business Enterprise Requirement (“MBE”). UM SMC at Easton estimates that the premium will be 4%, based on input from contractors.

- All Outer Loop Costs – These are considered off-site costs, as they relate to a portion of the parcel that is not hospital related. Off-site costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the Marshall Valuation Service.
- Capitalized Construction Interest and Loan Placement Fees on Extraordinary Costs - Capital interest and Loan Placement Fees shown on the project budget sheet is for the entire costs of the hospital building. The costs associated with this line item also apply to the extraordinary costs. Because the Capitalized Construction Interest and Loan Placement Fees only associate with the costs in the “Building” budget line are considered in the MVS analysis, it is appropriate to adjust the cost of each of the above items that are in the Building costs to include the associated capitalized construction interest.

Capitalized Construction Interest and Loan Placement Fees were calculated as follows:

Hospital	New	Renovation	Total		
Building Cost	\$132,511,795	\$0			
Subtotal Cost (w/o Cap Interest)	\$187,014,795	\$0	\$187,014,795		
Subtotal/Total	100.0%	0.0%	Cap Interest	Loan Placement Fees	Total
Total Project Cap Interest & Financing [ (Subtotal Cost/Total Cost) X Total Cap Interest]	\$40,280,000	\$0	\$39,658,000	\$622,000	\$40,280,000
Building/Subtotal	70.9%	N/A			
Building Cap Interest & Loan Place.	\$28,540,924	N/A			
Associated with Extraordinary Costs	\$5,571,339				
Applicable Cap Interest & Loan Place.	\$22,969,586				

The percent that each of the Extraordinary Costs in the Building line comprised of the Building Costs was then multiplied by the Building Cap Interest and Loan Fees (\$28,443,752) to obtain the applicable associated cost that should be removed from the comparison.

- Architectural and Engineering Fees Related to Extraordinary Costs – A&E Fees are typically a percentage of the total cost of Building and Site Preparation, including extraordinary costs. Consequently, like Capitalized Interest, if the extraordinary costs are removed from the comparison, their related A&E Fees should also be removed. This was accomplished by calculating the percent that the original A&E Fees comprised of the Building and Site Prep costs (5.7%),

multiplying that percentage times the sum of the extraordinary costs, and subtracting that number from the original A&E fees.

- Amount Spent on the 2012 CON Project that is not now Usable – Within the costs are the costs spent on the 2012 CON project, which total nearly \$9M. Only A&E Fees and Permits are relevant to the MVS Analysis. Some of what was spent on A&E fees for the 2102 CON application is still usable, but almost half of it was not. UM SMC at Easton has only counted what is not usable as Extraordinary Costs. These costs would not be in the average benchmark for current projects.

Row Labels	Usable	Not Usable	Grand Total
A&E	\$2,224,553	\$2,022,908	\$4,247,461
Consultant	\$273,997	\$1,051,679	\$1,325,677
Legal		\$2,000	\$2,000
Other		\$3,282,548	\$3,282,548
Permits		\$52,849	\$52,849
<b>Grand Total</b>	<b>\$2,498,551</b>	<b>\$6,411,984</b>	<b>\$8,910,534</b>

Eliminating all of the extraordinary costs reduces the project costs that should be compared to the MVS estimate to \$392.72. As noted below, the project's cost per square foot is below the MVS benchmark.

<b>C. Adjusted Project Cost</b>	<b>Adjusted Project Costs</b>	<b>Per Square Foot</b>
Building	\$106,644,795	\$297.11
Fixed Equipment	\$0	\$0.00
Site Preparation	\$1,043,699	\$2.91
Architectural Fees	\$4,012,310	\$11.18
Permits	\$4,558,117	\$12.70
Subtotal	\$116,258,921	\$323.90
Capitalized Construction Interest	\$22,969,586	\$63.99
<b>Total</b>	<b>\$139,228,506</b>	<b>\$387.89</b>

## ***VI. Comparison to the MVS Benchmark***

MVS Benchmark	\$427.91
The Project	\$387.89
Difference	-\$40.02
%	-9.35%

#### **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.

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#### **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.

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#### **Applicant Response:**

The average square feet/bed of the inpatient nursing units in the proposed facility is 467 sf/bed, using the definition in the Acute Care Chapter of the State Health Plan. The average sf/bed varies by the type of nursing unit. The 16-bed ICU unit exceeds the standard because it has very few beds. The perinatal (OB) unit also exceeds the standard because the beds in that unit will be LDRP (labor, delivery, recovery, postpartum) beds, which require more space than a typical patient bed. The behavioral health unit exceeds the standard due to the inclusion of code required functions to support unique needs for proper care of behavioral health patients not found in a typical nursing unit. In fact, the patient rooms (approximately 210 NSF) and core nursing functions are identical to the appropriately sized medical/surgical units. This additional

2,500 NSF of required space includes spaces such as the day room/dining, group therapy, quiet room, therapist workroom, treatment planning room, and seclusion room. All of these spaces are not found in a typical medical/surgical unit and are unique requirements for this specialty of care. However, the overall average square feet for bed for the facility is reduced to below the benchmark because the medical/surgical units have fewer square feet per bed than the standard. A summary of the calculations is shown below. The detailed analysis is included in **Exhibit 14**.

**Table 34**  
**Average Square Feet Per Bed of Inpatient Nursing Units**

INPATIENT UNIT	LEVEL	NSF	# BEDS	SF/BED
<b>GENERAL MED/SURG UNITS</b>				
MED/SURG (MED/SURG & PEDS)	3	11,022	27	408
MED/SURG (ADULT & PALLIATIVE)	4	10,384	28	371
MED/SURG (TELEMETRY BEDS)	5	9,530	25	422
<b>SPECIALTY UNITS</b>				
PERINATAL / LDRP*	3	8,725	13	671
ICU	5	8,518	16	532
BEHAVIORAL HEALTH	6	8,353	12	696
<b>TOTAL AREA &amp; BEDS**</b>		56,530	121	
<b>AVERAGE SF/BED</b>				467

\* EXCLUDES NURSERY, 'C' SECTION & TRIAGE / ANTEPARTUM

\*\* EXCLUDES REHAB UNIT SINCE IT IS A SEPARATELY LICENSED FACILITY.

#### **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:**

Inapplicable. The Commission recently 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 this case, Total Patient Revenue model). *In re Washington Adventist Hospital*, Docket 13-15-2349, Decision at 51.

**Standard .04B(11) – Efficiency**

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

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

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

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

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**Applicant Response:**

UM SMC at Easton is already an efficient hospital, in spite of some of its existing facility limitations. It is important to note that UM SMC at Easton is a GBR hospital. Under its GBR agreement with HSCRC, the HSCRC provides assurance of a certain amount of revenue each year, independent of the number of patients treated and the amount of services, either inpatient or outpatient, provided to these patients. If volumes go down, UM SMC at Easton has to increase prices, and if volumes go up, UM SMC at Easton has to decrease prices. Volume will not drive earnings from operations, only expenses will do so. Consequently, UM SMC at Easton has every incentive to become more efficient and where UM SMC at Easton has been able to become more efficient, it has attempted to do so.

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

Since the IMA engagement, UM SMC at Easton has maintained its benchmarking construct and continues to efficiently staff its departments according to the established productivity standards. As a result, a new facility will not make the departments more efficient from a staffing/FTE perspective, as they are already high performers, but instead efficiencies will be generated through: (i) plant design in reduction of utilities; (ii) the TransVac System which will reduce inter-facility transporters; (iii) reduction in repairs and maintenance expenses



being incurred at the existing hospital site due to the age of the facility; and (iv) operational efficiencies gained through improved design elements

These include:

**Bed Units.** The new hospital design will have all private rooms, which will be a major improvement over the existing facility in which more than one-quarter of the rooms are semi-private. The bed units are designed to improve staff efficiency, reduce transfers, increase patient safety, reduce patient falls, reduce medication errors and help prevent hospital communicated diseases and infections.

The rooms have been mocked up to simulate room work flow for staff, patients and family, which will help optimize care giver time with the patient. All of these are improvements over the aged nursing units, and non-standardized care areas of the existing hospital. Additionally, the sweeping triangular form minimizes unit-wide circulation to key rooms and reduced footsteps for the caregiver by as much as 30% over their current race-track configuration in most units while improving visibility and security. The location of the ADA designed rooms near the patient elevators, as well as the location of the elevators between the units, further improves work flow and efficiency processes for patient transport and critical time to key services. Other things that foster improved efficiency are the location of the gym/rehab space on the unit for Ortho/Rehab and the location of ICU with Step Down Unit and Respiratory Therapy. All of these are critical improvements over the limitations of the existing hospital.

**Imaging.** Imaging efficiency is achieved by both locating it convenient to the primary public space, as well as its direct adjacency to emergency services and close relationship to the patient/service elevators for inpatient imaging which optimizes patient treatment times. Internally, the department is designed to operate at optimum efficiency by separating inpatient and outpatient flows, and building in synergies between imaging service modalities, such as a dedicated cardiac imaging center.

**Surgery.** Surgery offers the biggest improvement over the existing facility where departments are fragmented by other departments, prep/recovery is fragmented and central sterile is more remote than desired resulting in a significant amount of time wasted with travel in the delivery of care and increases safety risk factors. In the new facility, the prep and recovery area is designed to flex between prep and stage II recovery in standardized rooms that can flex with patient flow—which optimizes the use of space. The outpatient access is less than 90 feet from the front door to check-in. Prep and Recovery is closely located to both the minor procedure suite as well as the major ORs, Cath Rooms, and lab. The PACU is located to minimize transport from the OR suite, as well as to the patient elevators for inpatients. Central Sterile is located directly adjacent to the OR suite for more timely and efficient processing of sterile supplies, further improving quality and safety. Furthermore, all invasive procedure suites are co-located in one new department to take advantage of a shared prep/recovery/PACU platform that improves nurse efficiency. Within the OR suite, the standardized OR's allow for maximum utilization and the central core allows for staging of case carts for optimum throughput.

**Observation Unit.** A 16-bed observation unit is located directly adjacent to the emergency department. This serves to help optimize the size of the emergency department, allowing patients to be transferred out of the critical flow of the emergency department for

observation, while helping to prevent and reduce unnecessary admissions to inpatient bed units. The observation unit is a key element to improving the overall efficient use of space, allowing the other departments to be optimized for their core uses. The location of the observation unit next to the emergency department will reduce internal transport time.

**Emergency.** The emergency department has been greatly optimized to improve efficiency, including standardization of the emergency department exam rooms to improve census flexibility and surge capacity, creation of Behavioral Health holding areas to promote better safety and security and proximity of emergency to key support areas such as imaging and observation. Improved quick assessment areas are also included to help keep the lighter acuity patients from slowing the flow of the main emergency department, further helping to reduce treatment times and space needed in the overall emergency department.

**Support Services.** This same mind toward efficiency holds true for materials management, lab and pharmacy. All located to shorten the distance for delivery of supplies or specimens and medications. As noted above, the inclusion of the TransVac system will greatly help the efficiency, as well as safety, in the handling of dirty linen and supplies, eliminating as much as 30% of the corridor usage and elevator usage. This in turn will help with infection control and further optimizes use of space.

All in, the project was designed with efficiency as one of the top priorities. The proposed new facility, which is designed to the latest codes and standards for an all private room hospital, will accommodate all needed beds and services, and still reduce the overall size by approximately 35,000 BGSF over the existing 396,000 BGSF hospital. This in turn will help lower utility expenses by up to 30%, and maintenance and upkeep expenses.

#### **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.**

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#### **Applicant Response:**

The new facility is designed with patient and staff safety as a core design element. This begins with the organization of the facility with clear separation of public and staff/service corridors to improve patient privacy, patient experience, and staff efficiency. The facility will include 100% private rooms, which will help reduce medication errors and infections. The facility will also feature standardized patient care areas in both the patient units as well as in the surgical suite. The units themselves are designed to be as efficient as possible, locating key supplies near patient units to minimize staff travel distances by as much as 30% at the new facility. Placing computers in rooms and charting between the rooms will facilitate safe delivery of medications allowing for bedside barcode checking of medications, as well as greater visibility of the staff to the patients. The investment in patient care units with fewer beds/unit than in the

existing hospital further helps with both localizing resources, minimizing staff travel distances, and opening up visibility of patients, while controlling noise in the units.

Patient handling and movement is also a key aspect of patient and staff safety. The elevators at the replacement facility will be centralized to minimize patient transport distances. On the patient units, ADA designed rooms are located close to the patient elevators to minimize staff handling, and all the rooms are planned to accommodate patient lifts.

In the diagnostic areas, the invasive procedure rooms are all located together and in close proximity to patient prep and recovery. The ORs, Cath Room, Prep and PACU are all standardized, with daylight in both patient care and staff areas to help with recovery and fatigue. To help with stress, the facility will feature embedded way finding for patients and family. This means that all public areas, both circulation and waiting, are oriented to the exterior with views of where patients parked. This minimizes the distances patients have to travel, and helps alleviate congestion and confusion within staff/service only areas. Another example of efficient design in diagnostic areas is the proximity of departments to streamline services. Central Sterile Processing is located adjacent to Surgery. Lab and Pharmacy are located adjacent to surgery and immediately next to the service elevators. The gym for Rehab is located on the patient unit, with corridors designed to promote ambulating in the units.

In all areas, patient privacy is a key factor in safety. As part of the planning process, acoustical design is an increased consideration and now required by the 2014 guidelines. As such, materials and finishes are being selected that not only soften footfalls for wear and tear of staff, but also help absorb noise. This is in addition to three-walled rooms in prep for privacy and the private rooms in the patient care units.

As a Greenfield replacement facility, UM SMC at Easton is afforded the opportunity to design both to the current guidelines for acoustics, patient safety and patient handling, as well as to design a facility that is readily adaptable to new services and ever changing technologies. The infrastructure is being planned accordingly. The floor to floor height accommodates larger technologies, the first two floor plates feature a regular grid that allows for adaptability over time to new modalities and services. For future flexibility, the hospital departments are carefully planned to allow for horizontal expansion without disruption to existing services. As an added measure, a mobile technology dock is being planned to further allow for any unanticipated technology needs until more permanent solutions can be incorporated.

One of the other features of the proposed facility is that given its location along U.S. Route 50, the building is sited and the emergency department is planned to allow for scalability in the event of contingency events. This includes both provisions for mass decontamination, flow of the department and flexible use of spaces in such demanding situations.

Some of the other features that improve patient safety over the existing facility include:

- Co-location of related support functions to maximize efficiency
- Universal patient room design
- Dedicated trauma/patient elevator

- Continuing Care Nursery with accommodations for opioid addicted neonates or other special care needs
- Directed traffic flow into building (main entrance) past security
- Automation of technology and patient records
- Upgrade to ADA/ANSI standards
- Reduced patient transfer distances (surgery to short stay recovery, ED to ICU, ED to helipad, nursery/LDRP to helipad, etc.)
- Appropriate number of prep/recovery bays
- Increased telemetry capability
- Direct access from C-section to nursery
- Charting/observation at each patient room
- Increased number of airborne infection isolation rooms

#### **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.**

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*Applicant Response:*

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

Included in **Exhibit 1** are Tables F, G, and H, which provide utilization and financial projections, and a comprehensive statement of assumptions related to utilization, revenue, expenses, and financial performance for SHS, which includes UM SMC at Easton and UM Shore Emergency Center at Queenstown ("UM Shore EC Queenstown") through fiscal year 2027, UM SMC at Dorchester through fiscal year 2021 and UM SMC at Cambridge in fiscal years 2022 through 2027. Also included in **Exhibit 1** are Tables I, J, and K, which provide utilization and financial projections that include a comprehensive statement of assumptions related to utilization, revenue, expenses, and financial performance of the incremental impact of UM SMC at Easton and UM Shore EC Queenstown including 1) shifting MSGA and Psychiatric beds from UM SMC at Dorchester to UM SMC at Easton in fiscal year 2022 and 2) the replacement of UM SMC at Easton beginning in fiscal year 2025.

As presented in Tables G and H, SHS is projected to be financially viable in the long-term. As presented in Tables J and K, the replacement of UM SMC at Easton will continue to generate excess revenues over total expenses and will not pose a threat to SHS's long-term financial viability.

**1. Projected SHS Utilization**

Table F includes utilization projections that reflect both the inpatient and outpatient utilization of UM SMC at Dorchester, UM SMC at Easton, UM Shore EC Queenstown, as well as outpatient emergency department visits, observation cases, and related outpatient ancillary services at the proposed FMF, UM SMC at Cambridge. Table I presents the inpatient utilization and outpatient utilization associated with UM SMC at Easton and outpatient utilization at UM Shore EC Queenstown.

Included within sections II and III of this application are bed need assumptions at UM SMC at Easton which include the projected shift of inpatient MSGA and Psychiatric beds from UM SMC at Dorchester to UM SMC at Easton in fiscal year 2022. The projections of outpatient services assume the continuation of existing emergency, observation, surgery, and other ancillary services with annual population growth through fiscal year 2027.

## **2. Projected SHS Revenue**

The presentations of projected revenue in Tables H and K reflect the utilization projections presented in Tables F and I and the 2019 regulated Global Budget Revenue (“GBR”) assumptions related to update factors, demographic adjustments, revenue variability, and uncompensated care. These assumptions are included with the tables.

Also incorporated into the revenue projections and described in the list of assumptions are assumptions related to the redistribution of the GBR with the transformation of UM SMC at Dorchester to an FMF in fiscal year 2022. SHS will request that the HSCRC allow SHS to retain in its GBR cap 50% of the revenue at UM SMC at Dorchester related to patients that will seek care at other providers after the closing of UM SMC at Dorchester. Keeping this revenue will allow SHS to fund the capital costs and other population health, ambulatory and physician network investment associated with the transformation of SHS.

In fiscal year 2025 SHS is requesting an increase in rates of \$25.2M (including markup) which equals approximately 75% of the increase in capital costs (depreciation and interest) net of mark-up associated with the proposed project. Funding for the other 25% of capital costs will be funded by the Hospital. Using this retained revenue to partially fund the capital costs reduces the need to request an increase in rates equal to 100% of the capital costs. The request for a rate increase will be filed as a full rate application with the HSCRC in the third quarter of fiscal year 2019.

## **3. Projected SHS Staffing and Operating Expenses**

The projection of staffing of SHS is presented in **Exhibit 1**, Table L, which reflects the utilization presented in Table F, as well as assumptions related to expense inflation, expense variability with changes in volumes, one-time adjustments and benchmarking of UM SMC at Easton inpatient units over the projection period through FY2027. Included in the one-time adjustments to staffing and related expenses is the reduction of staff and salaries and benefits in fiscal year 2022 as the staff at UM SMC at Dorchester are transitioned to UM SMC at Cambridge and UM SMC at Easton. The projection does not assume any additional savings or incremental expense in salaries or other operating expenses (besides depreciation and interest) that will occur in FY2025 as part of the project. A one-time non-operating depreciation expense of \$9.6M is assumed due to physical plant assets that will be written off and not transferred to the new replacement facility.

Beginning in fiscal year 2022, the retention of 50% of revenue associated with patients that will seek care at other providers following the transformation of UM SMC at Dorchester to an FMF, will enable SHS to fund initiatives related to ambulatory and physician network development, population health initiatives, and its regional vision.

## **4. Projected UM SMC at Easton Financial Performance**

As presented in Table K, beginning in FY2025 the first full year post new hospital occupancy, UM SMC at Easton is projected to provide positive financial contributions to SHS for fiscal years 2025-2027. This positive contribution is included in the operating profits of SHS which are presented in Table H. As shown in Table H, SHS which includes UM SMC at Easton, UM Shore EC Queenstown, UM SMC at Dorchester through fiscal year 2021, and UM SMC at

Cambridge in fiscal years 2022 through 2027 will generate positive operating income throughout the projection period.

**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 *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.

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**Applicant Response:**

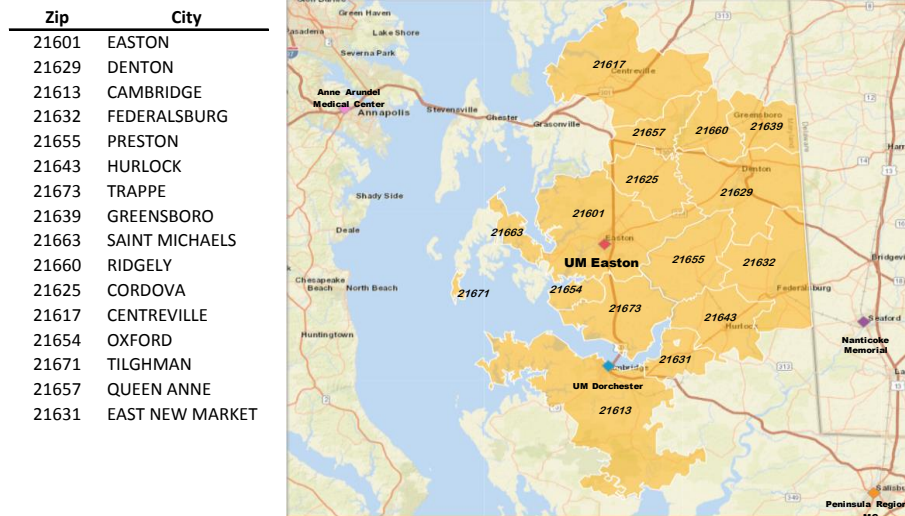
**Emergency Department Visits in UM SMC at Easton Service Area for the Last Five Years – COMAR 10.24.10(4)(B)(14)(b)**

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

## A. Definition of UM SMC at Easton Service Area

In fiscal year 2018, 85% of UM SMC at Easton's emergency department visits came from residents of sixteen (16) ZIP codes in Talbot County, Caroline County, Dorchester County, and Queen Anne's County, (*i.e.*, UM SMC at Easton's Service Area) as listed and depicted in Table 35 below.

**Table 35**  
**UM SMC at Easton ED Service Area**  
**FY2018**



## B. Historical Emergency Department Utilization in Service Area

In fiscal year 2018, there were 52,582 annualized visits to Maryland hospital emergency departments by residents of the UM SMC at Easton ED Service Area (see Table 36). This utilization represents a 7% reduction from the utilization of hospital emergency departments by residents of this service area since fiscal year 2014. UM SMC at Easton's emergency department utilization by residents of its service area declined by 6% from 30,514 visits in fiscal year 2014 to an annualized 28,676 visits in fiscal year 2018. With declining volumes, it is important to right size the facility in the new hospital to enable it to continue to provide access to emergency services for the service area population.



**Table 36**  
**UM SMC at Easton Service Area Emergency Department Visits**  
**FY2014 – FY2018**

Hospital	Historical ED Service Area Visits					2018	2014-2018
	2014	2015	2016	2017	2018**	% of Total	% Change
UM SMC at Easton	30,514	30,872	30,111	27,999	28,676	54.5%	-6.0%
UM SMC at Dorchester	15,524	17,834	17,274	16,509	14,532	27.6%	-6.4%
University of Maryland Medical Center	4,634	5,143	5,268	4,776	5,018	9.5%	8.3%
Anne Arundel Medical Center	1,470	1,623	1,716	1,750	1,472	2.8%	0.1%
Peninsula Regional Medical Center	1,271	1,376	1,350	1,303	972	1.8%	-23.5%
Hospitals with <1000 visits	3,136	2,951	2,749	2,751	1,912	3.6%	-39.0%
<b>Total Service Area ED Visits</b>	<b>56,549</b>	<b>59,799</b>	<b>58,468</b>	<b>55,088</b>	<b>52,582</b>	<b>100.0%</b>	<b>-7.0%</b>

Source: St. Paul statewide non-confidential utilization data tapes

\*\* Annualized based on six month data from July-December 2017.

UM SMC at Easton's 28,676 annualized emergency department service area visits in fiscal year 2018 represented 54.5% of the total service area emergency department visits. Other hospitals with smaller market share of emergency department visits in the service area include UM SMC at Dorchester (27.6%), University of Maryland Medical Center (9.5%), Anne Arundel Medical Center (2.8%), and Peninsula Regional Medical Center (1.8%).

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

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

As presented in Table 37, the emergency department visits to UM SMC at Easton from its service area ZIP Codes declined by 6.0% between fiscal years 2014 and 2018. This decline in service area visits was accompanied by a 3.5% decline in visits from outside of the service area. Combined, UM SMC at Easton's total emergency department visits declined by 5.6% from 35,995 visits in fiscal year 2014 to 33,966 annualized visits in fiscal year 2018.

**Table 37**  
**UM SMC at Easton Historical Emergency Department Visits**  
**FY2014 – FY2018**

	ED Visits to UM Shore Easton					2014-2018 % Change
	2014	2015	2016	2017	2018**	
<b>Service Area</b>						
Inpatient	4,937	4,926	4,486	4,091	3,722	-24.6%
Outpatient	25,577	25,946	25,625	23,908	24,954	-2.4%
Subtotal	30,514	30,872	30,111	27,999	28,676	-6.0%
<b>Outside Service Area</b>						
Inpatient	1,176	1,229	1,093	1,087	910	-22.6%
Outpatient	4,305	4,314	4,392	4,331	4,380	1.7%
Subtotal	5,481	5,543	5,485	5,418	5,290	-3.5%
<b>Total</b>	<b>35,995</b>	<b>36,415</b>	<b>35,596</b>	<b>33,417</b>	<b>33,966</b>	<b>-5.6%</b>

**Source:** St. Paul statewide non-confidential utilization data tapes

\*\* Annualized based on six month data from July-December 2017.

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

It is anticipated that the emergency department at UM SMC at Easton will operate similar to the existing emergency department and will not be impacted by the closure of inpatient services at UM SMC at Dorchester. The planned Dorchester FMF will continue the operational role of an emergency department and the type of patients and services provided at UM SMC at Dorchester will be the same at the Dorchester FMF. As such, an analysis of the emergency department utilization at UM SMC at Easton is used to compare the future emergency department utilization to the ACEP guidelines.

As presented in Table 38, eight factors fall in the “high - range” including (a) the average length of stay of a patient over 4 hours; (b) there will be all private rooms; (c) the inner waiting and result waiting takes place in the patient bay; (d) the location of observation beds are adjacent to the ED; (e) the boarding of admitted patients is over 150 minutes; (f) 28% of patients are age 65 and over; (g) imaging within the ED is extensive; and (h) there will be multiple spaces for family amenities.

Four factors fall in the “medium range” including: (a) 17% of patients are admitted; (b) approximately 25% - 45% are non-urgent patients; (c) there are designated areas for detention; and (d) the new facility will include moderate administrative and teaching space.

**Table 38**  
**UM SMC at Easton Comparison to ACEP Guide**

Factor	Current Hospital (Red)			Future Hospital
	Low	Medium	High	
% Admitted Patients	< 8%	<b>12-20%</b>	> 25%	Medium (17%)
ALOS	<2.25 Hours	2.5-3.75 Hours	<b>&gt;4 Hours</b>	High (4.7 Hrs)
Private Rooms	<b>Few</b>	Majority	All	High
Inner Waiting and Result Waiting Areas	Available	Limited	<b>Pts. Stay in Bay</b>	High
Location of Observation Beds	<b>Outside ED</b>	Limited	Inside ED	High
Boarding of Admitted Pts.	Stay < 60 Min	Stay 90-120 Min	<b>Stay Over 150 Min.</b>	High
Turnaround Time Dx Tests	<b>&lt; 45 Minutes</b>	60 Minutes	> 90 Minutes	Low
% Behavioral Health Patients	<b>&lt; 3%</b>	4-6%	>7	Low (2%)
% Nonurgent Pts.	>45%	<b>25-45%</b>	<25%	Medium
Age of Patient	<10% Age 65+	10-20% Age 65+	<b>&gt;20% Age 65+</b>	High (28%)
Imaging w/n ED	No	General and CT	<b>Extensive</b>	High
Family Amenities	None	<b>Limited Consult</b>	Multiple Consult, Grieving	High
Specialty Components: Geriatrics	<b>None</b>	Designated Area	Module with Support	Low
Specialty Components: Pediatrics	<b>None</b>	Designated Area	Module with Support	Low
Specialty Components: Detention	<b>None</b>	Designated Area	Module with Support	Medium
Admin/Teaching Space	<b>Minimal</b>	Moderate	Extensive	Medium

Source: *Factors = Emergency Department Design: A Practical Guide to Planning for the Future*, published by the American College of Emergency Physicians  
Proposed FMF = LRH management reports and input by LRH Department of Emergency Medicine Medical Director

Only four of the sixteen factors fall in the “low - range”. These low range factors include: (a) turnaround time for diagnostic testing is less than 45 minutes; (b) 2% of the patients have behavioral health diagnoses; (c) there are no specialty areas for geriatric patients; and (d) there are no specialty areas for pediatric patients.

The applicable edition of the ACEP Guide (2d. ed. 2014), Figure 5.1 estimates treatment space need per emergency department visits in five thousand visit increments, starting at 10,000 visits per year. (ACEP Guide, p. 116). The emergency department visits at UM SMC at Easton are projected to grow with 0.2% annual population growth from 33,966 visits in fiscal year 2018 to 34,611 visits in fiscal year 2027 (Table 39). This projection of emergency department visits falls between the ACEP groupings of 30,000 and 35,000 annual visits.

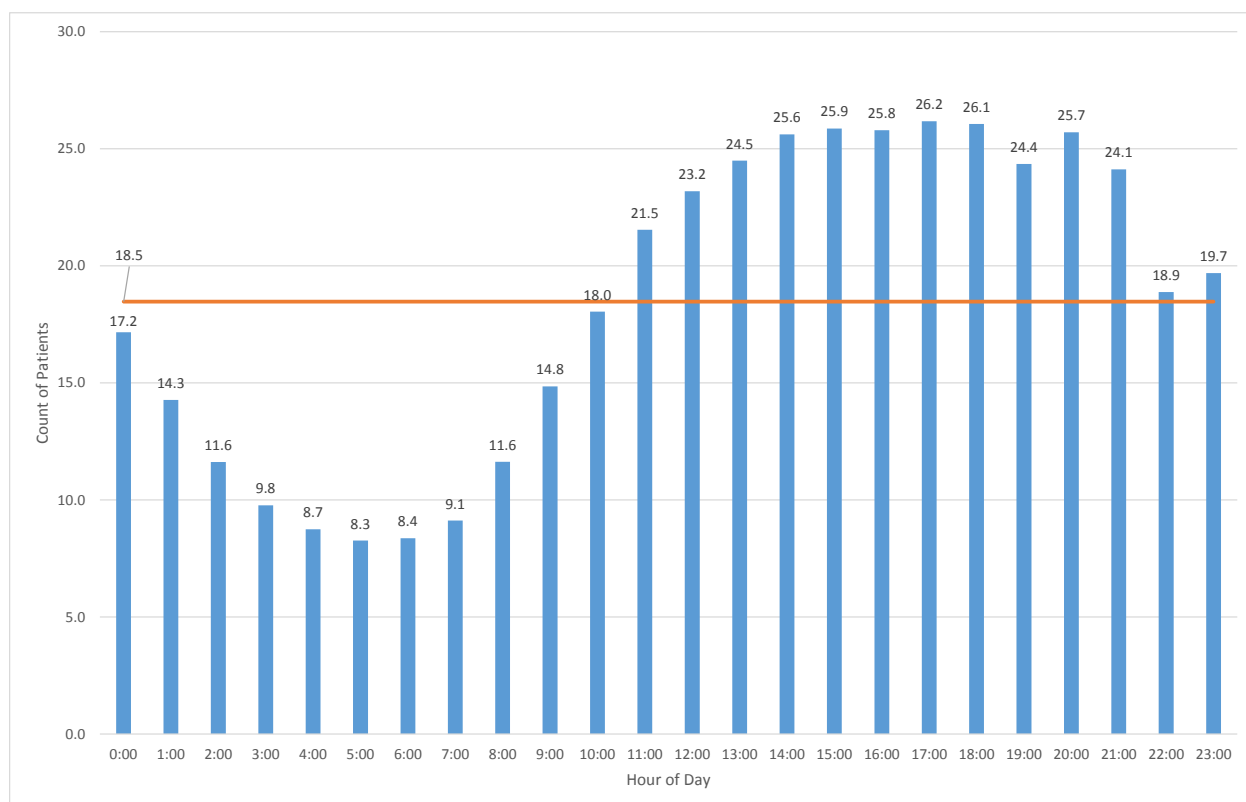
**Table 39**  
**UM SMC at Easton Projected Emergency Department Visits**

	Historical			Projected								
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Easton ED Visits	35,596	33,417	33,966	34,037	34,108	34,180	34,251	34,323	34,394	34,466	34,538	34,611
% Change		-6.1%	1.6%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%

Using the ACEP Guide is problematic because it addresses only the *average* number of patients in the emergency department in a year to determine the number of emergency department treatment spaces. The ACEP Guide does not address surge issues or account for the peak number of patients in an emergency department, each of which will require a treatment

space. In fiscal year 2018, there was an average hourly census of 18.5 patients in the UM SMC at Easton emergency department. However, UM SMC at Easton experienced a peak census of 26.2 patients in the emergency department in the same year (Table 40).

**Table 40**  
**UM SMC at Easton**  
**Average Number of ED Patients by Hour of Day**  
**FY 2018**



The ACEP “low range” guide for 30,000 to 35,000 visits identifies a need for 21 to 23 treatment spaces. The “high range” identifies a need for 25 to 28 treatment spaces. As presented in Table 41, UM SMC at Easton is in the “mid-range” of the ACEP Guide criteria. Taking the average of the “low range” and “high range” treatment spaces in fiscal year 2018 results in a calculated need for 25 treatment spaces (Table 41). The peak utilization of 26.2 patients represents a 5% increase over the ACEP calculation. Sizing to address UM SMC at Easton’s peak volume, therefore, requires a 5% add-on to the calculated number of emergency department beds using the ACEP guidelines. Applying the 5% adjustment factor for peak utilization results in a projected need for 26 emergency department treatment spaces in the new hospital.

**Table 41**  
**UM SMC at Easton**  
**Projected Need for Emergency Department Treatment Spaces**

	Historical			Projected								
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Easton ED Visits	35,596	33,417	33,966	34,037	34,108	34,180	34,251	34,323	34,394	34,466	34,538	34,611
% Change		-6.1%	1.6%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
ACEP Calculation of ED Bed Need Between 30,000 and 35,000 Visits												
Low Range	23.2	22.4	22.6	22.6	22.6	22.7	22.7	22.7	22.8	22.8	22.8	22.8
High Range	28.4	27.1	27.4	27.4	27.5	27.5	27.6	27.6	27.6	27.7	27.7	27.8
Average	25.8	24.7	25.0	25.0	25.1	25.1	25.1	25.2	25.2	25.2	25.3	25.3
Peak ED Patients in Beds in 2018			26.2									
Adjustment Factor for Peak Utilization			105%	105%	105%	105%	105%	105%	105%	105%	105%	105%
ED Bed Need (1)	27.1	25.9	26.2	26.2	26.3	26.3	26.3	26.4	26.4	26.5	26.5	26.5
Requested Beds										26	26	26

Note (1): Reflects ACEP calculation of ED beds multiplied by the Peak ED Adjustment Factor in 2018

As shown in the emergency department floor plan provided as **Exhibit 2**, p.7, the proposed replacement hospital's emergency department has 26 treatment spaces, including two behavioral health spaces and two resuscitation rooms. In addition, the emergency department includes several triage/rapid evaluation rooms which are non-treatment spaces.

#### **Standard .04B(15) – Emergency Department Expansion**

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

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

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

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

*Applicant Response:*

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

**Standard .04B(16) – Shell Space**

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

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

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

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

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

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

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

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*Applicant Response:*

Inapplicable. The Applicant does not propose to add any shell space in the relocated hospital.

**COMAR 10.24.11. General Surgical Services**

**.05A. GENERAL STANDARDS**

**Standard .05(A)(1) – Information Regarding Charges**

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

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

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

(c) Making this information available shall be a condition of any CON issued by the Commission.

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**[Applicant Response:](#)**

Please see the response to COMAR 10.24.10.04A-Standard .04A (1) – Information Regarding Charges.

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

A hospital, physician outpatient surgery center, or ASF shall provide to the public upon inquiry information concerning the volume of specific surgical procedures performed at the location where an individual has inquired. A hospital, POSC, or ASF shall provide the requested information on surgical procedure volume for the most recent 12 months available, updated at least annually.

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**[Applicant Response:](#)**

Upon inquiry, the Applicant will provide information to members of the public concerning the volume of specific surgical procedures performed at the location where the individual made inquiry.

**Standard .05(A)(3) – Charity Care Policy.**

**(a) Each hospital and ambulatory surgical facility shall have a written policy**

**for the provision of charity care that ensures access to services regardless of an individual's ability**

**to pay and shall provide ambulatory surgical services on a charitable basis to qualified indigent**

**persons consistent with this policy. The policy shall have the following provisions:**

**(i) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility shall make a determination of probable eligibility.**

**(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's arrival for surgery, the facility shall address any financial concerns of the patient, and individual notice regarding the facility's charity care policy shall be provided.**

**(iii) Criteria for Eligibility. A hospital shall comply with applicable State statutes and Health Services Cost Review Commission ("HSCRC") regulations regarding financial assistance policies and charity care eligibility. An ASF, at a minimum, shall include the following eligibility criteria in its charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of ASFs described in these regulations.**

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

**(c) A proposal to establish or expand an ASF for which third party reimbursement is available, shall commit to provide charitable surgical**



services to indigent patients that are equivalent to at least the average amount of charity care provided by ASFs in the most recent year reported, measured as a percentage of total operating expenses. The applicant shall demonstrate that:

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

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

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

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a Certificate of Need for a surgical facility project, shall make a commitment to provide charitable services to indigent patients. Charitable services may be surgical or non-surgical and may include charitable programs that subsidize health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by ASFs, measured as a percentage of total ASF expenses, in the most recent year reported. The applicant shall demonstrate that:

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

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

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

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[Applicant Response:](#)

Please see the response to COMAR 10.24.10.04A – Standard .04A(2) – Charity Care Policy.

**Standard .05(A)(4) – Quality of Care**

**A facility providing surgical services shall provide high quality care.**

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

**(b) A hospital shall document that it is accredited by the Joint Commission.**

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

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

**(ii) Accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, or another accreditation agency recognized by the Centers for Medicare and Medicaid as acceptable for obtaining Medicare certification; and**

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

**(d) A person proposing the development of an ambulatory surgical facility shall demonstrate that the proposed facility will:**

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

**(ii) Obtain accreditation by the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the American Association for Accreditation of Ambulatory Surgery Facilities within two years of initiating service at the facility or voluntarily suspend operation of the facility.**

**(e) An applicant or a related entity that currently or previously has operated or owned a POSC or ambulatory surgical facility, in Maryland or outside of Maryland, in the five years prior to the applicant's filing of a request for exemption request to establish an ASF, shall address the quality of care provided at each location through the provision of information on licensure, accreditation, performance metrics, and other relevant information.**

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*Applicant Response:*

Please see the response to COMAR 10.24.10.04A – Standard .04A (3) – Quality of Care.

**Standard .05A(4) – Transfer Agreements**

**(a) Each ASF shall have written transfer and referral agreements with hospitals capable of managing cases that exceed the capabilities of the ASF.**

**(b) Written transfer agreements between hospitals shall comply with Department of Health regulations implementing the requirements of Health-General Article §19-308.2.**

**(c) Each ASF shall have procedures for emergency transfer to a hospital that meet or exceed the minimum requirements in COMAR 10.05.05.09.**

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*Applicant Response:*

Please see **Exhibit 15**, which includes copies of UM SMC at Easton's transfer agreements with other hospitals.

## **.05B. PROJECT REVIEW STANDARDS**

### **Standard .05B(1) – Service Area**

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

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#### **Applicant Response:**

Inapplicable. The Applicant does not propose to establish a new service or expand its existing service.

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

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

(a) Demonstrate the need for the number of operating rooms proposed for the facility, consistent with the operating room capacity assumptions and other guidance included in Regulation .07 of this chapter.

(b) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility, consistent with Regulation .07 of this chapter.

(c) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following:

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

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

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

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

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

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

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

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*Applicant Response:*

Even if the hospital were not being replaced, UM SMC at Easton would need to replace its surgical suite. Most of the operating rooms are not sufficient in size to house the equipment necessary for contemporary complex surgery. Even some of the otolaryngology cases now use brain laboratory equipment, which take up a significant footprint. Another larger piece of equipment is the robot which consists of three very large pieces of equipment. As a result, the OR setting at UM SMC at Easton has no space flexibility. Although UM SMC at Easton staff have tried to utilize the rooms as "universal," it is logistically impractical due to the size. Two of the operating rooms are larger (operating rooms 1 and 6) and therefore many of the cases require UM SMC at Easton to use them in order to allow appropriate clearances (examples are neuro, laparoscopic cholecystectomy, larger vascular cases, major otolaryngology, and all orthopedic cases). When the robot was acquired, in order to keep from damaging the equipment, an alcove was constructed in two of the operating rooms (operating rooms 1 and 5) so it is within these two rooms that UM SMC at Easton focuses its current robotic surgery volume.

UM SMC at Easton currently has six operating rooms and is proposing to maintain six operating rooms at the new facility.

UM SMC at Easton anticipates that the inpatient surgical cases currently performed at UM SMC at Dorchester will transfer to UM SMC at Easton in fiscal year 2022, assuming that the separately filed conversion application to convert UM SMC at Dorchester to an FMF is approved. All of the surgeons at UM SMC at Dorchester have privileges at UM SMC at Easton and have expressed to UM SRH that they intend to move their inpatient cases to UM SMC at Easton.

The surgical service area for UM SMC at Easton will be comprised of the top ZIP Codes from which 85% of the surgical cases from both hospitals derived. Table 42 shows the list of these ZIP Codes. UM SMC at Easton does not anticipate that the relocation of the hospital to the new site will result in a change of its surgical service area. UM SMC at Easton is a regional surgical service, and that will not change.

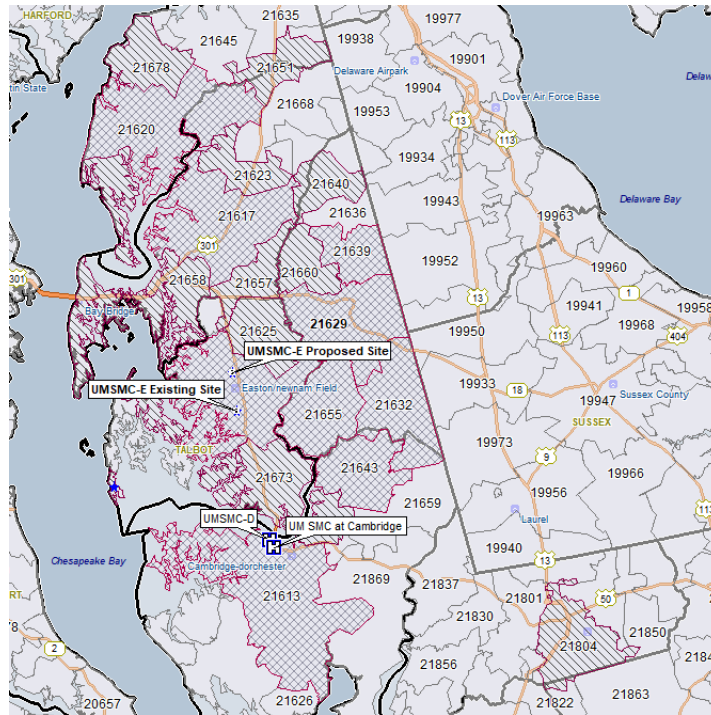
**Table 42**  
**UM SMC at Easton's Surgical Service Area**  
**2018**

<u>ZIP Code</u>	<u>Inpatient Cases</u>	<u>Outpatient Cases</u>	<u>Total Cases</u>	<u>%</u>	<u>Cumulative %</u>
	<u>UM SMC at Easton &amp; Dorchester</u>	<u>UM SMC at Easton</u>			
21601	285	554	839	19.5%	19.5%
21613	179	361	540	12.5%	32.0%
21629	94	208	302	7.0%	39.0%
21643	58	137	195	4.5%	43.5%
21655	55	127	182	4.2%	47.8%
21617	47	117	164	3.8%	51.6%
21632	46	116	162	3.8%	55.3%
21620	47	102	149	3.5%	58.8%
21639	43	89	132	3.1%	61.9%
21663	38	75	113	2.6%	64.5%
21660	36	76	112	2.6%	67.1%
21673	30	71	101	2.3%	69.4%
21631	25	59	84	1.9%	71.4%
21625	25	55	80	1.9%	73.2%
21638	23	40	63	1.5%	74.7%
21666	19	38	57	1.3%	76.0%
21658	15	40	55	1.3%	77.3%
21804	13	36	49	1.1%	78.4%
21654	19	29	48	1.1%	79.5%
21661	9	31	40	0.9%	80.5%
21640	8	30	38	0.9%	81.4%
21671	12	22	34	0.8%	82.1%
21619	6	27	33	0.8%	82.9%
21678	7	22	29	0.7%	83.6%
21623	4	24	28	0.6%	84.2%
21657	11	17	28	0.6%	84.9%
21651	5	21	26	0.6%	85.5%
117 additional ZIP Codes	205	420	625	14.5%	100.0%
<b>TOTAL</b>	<b>1,364</b>	<b>2,944</b>	<b>4,308</b>		

Source: UM SMC at Easton

Figure 4 below graphically shows UM SMC at Easton's Primary and Secondary Surgical Service Areas.

**Figure 4**  
**Primary and Secondary Surgical Service Areas**  
**UM SMC at Easton**





 Primary Service Area  
 Secondary Service Area

Table 43 and Table 44 below shows the historical surgical volumes at both UM SMC at Easton and UM SMC at Dorchester.

**Table 43**  
**Historical OR Volumes**  
**UM SMC at Easton**  
**2016-2018**

Year	Cases			Minutes		
	Inpt.	Outpt.	Total	Inpt.	Outpt.	Total
2016	1,647	3,112	4,759	181,861	261,477	443,338
2017	1,726	3,264	4,990	207,535	267,708	475,243
2018	1,291	2,944	4,235	181,976	272,705	454,681

Source: UM SMC at Dorchester, volumes include only OR Cases, and exclude endoscopies, cystoscopies, and other procedure room cases.

**Table 44**  
**Historical OR Volumes**  
**UM SMC at Dorchester**  
**2016-2018**

Year	Cases			Minutes		
	Inpt.	Outpt.	Total	Inpt.	Outpt.	Total
2016	128	468	596	10,772	30,804	41,576
2017	119	512	631	9,469	33,356	42,825
2018	73	374	447	8,411	29,895	38,306

Source: UM SMC at Dorchester, volumes include only OR Cases, and exclude endoscopies, cystoscopies, and other procedure room cases.

In calculating the need for operating rooms, the Applicant used a 35 minute turnaround time ("TAT") per case. The Director of Surgical and Ambulatory Services for UM SMC at Easton has tracked the TAT on 90 percent of UM SMC at Easton's inpatient and outpatient surgical cases in FY 2018. Cleanup time varies by specialty. Unlike urban hospitals, which may have many nurses, residents, and other staff who help "turn over" an operating room, UM SMC at Easton has a limited number of staff members who are available to do this. On average, the turnover time at UM SMC at Easton was 35 minutes in FY 2018.

UM SMC at Easton has been very conservative in its projections of need. It has projected future need based on the 2018 surgical use rate by ZIP Code in the hospital's acute care Primary and Secondary Service Areas. This is despite the fact that there were surgeons at UM SMC at Easton who were not performing surgery during part of the year due to leaving the system and relocating outside of the service area. Ongoing recruitment efforts have been successful in that a physician leader has been recruited to oversee the surgical service line. One surgeon and an Advanced Practice Provider ("APP") have been hired to replace three of UM SMC at Easton's surgeons, who recently departed. In addition, two local surgeons have been added to the general surgical practice. An additional surgeon and APP are still being recruited.

As shown in Table 45, projections show that UM SMC at Easton will need six operating rooms in 2027. As at other hospitals, surgeons desire to have "blocked" time so that they can better plan and make use of their time. Due to the wide geographic area that UM SMC at Easton's physicians cover, they have offices in most of the five counties in the mid-shore region. Using block scheduling is essential to maintaining a reliable schedule for the physicians to prevent them from having to reschedule an entire office of patients. For some UM SMC at Easton surgeons, patients have to wait four to six weeks to obtain their surgery. Thus, the maintenance of six operating rooms is crucial to UM SMC at Easton's ability to adequately serve the community.



**Table 45**  
**OR Need**  
**UM SMC at Easton**  
**Through 2027**

	Inpatient					Outpatient			Total
ZIP Code	2018 Cases	2018 Population	2018 Use Rate	2027 Projected Population	2027 Projected Cases	2018 Cases	2018 Use Rate	2027 Projected Cases	2027
21601	285	23,684	0.0120	24,025	289	554	0.0234	562	851
21613	179	17,425	0.0103	17,622	181	361	0.0207	365	546
21629	94	9,799	0.0096	10,337	99	208	0.0212	219	319
21643	58	5,744	0.0101	5,768	58	137	0.0238	138	196
21655	55	5,054	0.0109	5,206	57	127	0.0251	131	187
21617	47	11,017	0.0043	12,086	52	117	0.0106	128	180
21632	46	6,374	0.0072	6,416	46	116	0.0182	117	163
21620	47	12,365	0.0038	12,130	46	102	0.0082	100	146
21639	43	4,678	0.0092	5,027	46	89	0.0190	96	142
21663	38	3,108	0.0122	2,975	36	75	0.0241	72	108
21660	36	3,968	0.0091	4,191	38	76	0.0192	80	118
21673	30	2,914	0.0103	2,789	29	71	0.0244	68	97
21631	25	3,146	0.0079	3,128	25	59	0.0188	59	84
21625	25	2,402	0.0104	2,369	25	55	0.0229	54	79
21638	23	5,118	0.0045	5,456	25	40	0.0078	43	67
21666	19	12,328	0.0015	12,885	20	38	0.0031	40	60
21658	15	3,833	0.0039	3,887	15	40	0.0104	41	56
21804	13	40,432	0.0003	42,910	14	36	0.0009	38	52
21654	19	1,194	0.0159	1,139	18	29	0.0243	28	46
21661	9	7,521	0.0012	7,657	9	31	0.0041	32	41
21640	8	1,847	0.0043	1,874	8	30	0.0162	30	39
21671	12	704	0.0170	677	12	22	0.0312	21	33
21619	6	6,522	0.0009	7,049	6	27	0.0041	29	36
21678	7	9,704	0.0007	9,854	7	22	0.0023	22	29
21623	4	2,003	0.0020	2,122	4	24	0.0120	25	30
21657	11	1,146	0.0096	1,210	12	17	0.0148	18	30
21651	5	5,077	0.0010	5,302	5	21	0.0041	22	27
Service Area Subtotal	1,159				1,455	2,524		2,577	3,759
Out of SA Cases	205				257	420		429	686
SA %	84.97%				84.97%	85.73%		85.73%	0.796702
Total Cases	1,364				1,712	2,944		3,006	4,719
Min/Case	139.6				139.6	92.6		92.6	
OR Minutes	190,387				239,010			278,467	517,478

ZIP Code	Inpatient					Outpatient			Total
	2018 Cases	2018 Population	2018 Use Rate	2027 Projected Population	2027 Projected Cases	2018 Cases	2018 Use Rate	2027 Projected Cases	2027
TAT Min/Case									35
TAT Min									165,150
Total Min									682,627
Capacity Minutes/OR									114,000
<b>NEEDED ORS</b>									<b>6.0</b>

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

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

(a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .07 of this chapter;

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

(c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity, consistent with Regulation .07 of this chapter. The needs assessment shall include the following:

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

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

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

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**Applicant Response:**

Inapplicable. The Applicant does not propose to expand surgical capacity in the replacement hospital.

#### **Standard .05B(4) – Design Requirements**

Floor plans submitted by an applicant must be consistent with the current Facility Guidelines Institute's Guidelines for Design and Construction of Health Care Facilities (FGI Guidelines):

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

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

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

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#### **Applicant Response:**

Please see **Exhibit 16**, which is a letter from the architectural firm HKS attesting that the surgical suite meets FGI Guidelines.

#### **Standard .05B(5) – Support Services**

Each applicant shall agree to provide laboratory, radiology, and pathology services as needed, either directly or through contractual agreements.

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#### **Applicant Response:**

UM SMC at Easton provides laboratory, radiology, and pathology services on-site and will continue to do so in the replacement facility.

#### **Standard .05B(6) – Patient Safety**

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

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

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

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Applicant Response:

Please see the response to COMAR 10.24.10, Standard .04B(12) – Patient Safety.

**Standard .05B(7) – Construction Costs**

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

**(a) Hospital projects.**

(i) The projected cost per square foot of a hospital construction or renovation project that includes surgical facilities shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include:

1. The amount of the projected construction cost and associated capitalized construction cost that exceeds the Marshall Valuation Service® benchmark; and
2. Those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

**(b) Ambulatory Surgical Facilities.**

(i) The projected cost per square foot of new construction shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. This standard does not apply to the costs of renovation or the fitting out of shell space.

(ii) If the projected cost per square foot of new construction exceeds the Marshall Valuation Service® benchmark cost by 15% or more, then the applicant's project shall not be approved unless the applicant demonstrates the reasonableness of the construction costs. Additional independent construction cost estimates or information on the actual cost of recently constructed surgical facilities similar to the proposed facility may be provided to support an applicant's analysis of the reasonableness of the construction costs.

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[Applicant Response:](#)

Please see the response to COMAR 10.24.10.04B-Standard .04B(7) – Construction Cost of Hospital Space.

**Standard .05B(8) – Financial Feasibility**

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

**(a) An applicant shall document that:**

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

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

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

**(iv) The facility 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 of initiating operations.**

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

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[Applicant Response:](#)

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

**Standard .05B(9) – Impact**

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

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

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

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

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

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

(ii) The operating room capacity assumptions in Regulation .07A of this chapter and the operating room inventory rules in Regulation .07C of this chapter shall be used in the impact assessment.

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*Applicant Response:*

Not applicable.

**Standard .05B(10) – Preference in Comparative Reviews**

In a comparative review of CON applications to establish an ambulatory surgical facility or provide surgical services, preference will be given to a project that commits to serve a larger proportion of charity care and Medicaid patients. An applicant's commitment to provide charity care will be evaluated based on its past record of providing such care and its proposed outreach strategies for meeting its projected level of charity care.

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*Applicant Response:*

Not applicable.

## **COMAR 10.24.12. OB Services Chapter**

### **.04 REVIEW STANDARDS**

#### **Standard .04(1) – Need.**

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

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#### **Applicant Response:**

UM SMC at Easton is currently licensed to operate 17 acute obstetrical beds, but only has 13 physical obstetrics beds available at the existing facility. Using the obstetrics bed need methodology and assumptions described below, the Applicant projects a need for 13 obstetric beds at the replacement hospital.

#### **Obstetrics Bed Need Calculation**

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

To project the need for obstetric beds at the replacement hospital for UM SMC at Easton, the Applicant began by defining the service area from which UM SMC at Easton currently draws its inpatient obstetric discharges. Using CY 2017 data, the Applicant accumulated its obstetrics discharges by ZIP Code. The Applicant then ranked the ZIP Codes with the highest to lowest number of discharges to identify the ZIP Codes that comprise the top 85% of its obstetric discharges and determined the ZIP Codes to be included in the service area. As presented in Table 46 below, UM SMC at Easton's Obstetric Service Area is defined by 21 ZIP Codes that span Talbot, Dorchester, Caroline, Queen Anne's, Kent and Wicomico counties.

**Table 46**  
**UM SMC at Easton Obstetrics Service Area Zip Codes and Discharges**  
**CY 2017**

#	Zip Code	City	County	Discharges	Cumulative % of Total
1	21601	Easton	Talbot	220	20.3%
2	21613	Cambridge	Dorchester	185	37.4%
3	21629	Denton	Caroline	71	44.0%
4	21632	Federalsburg	Caroline	60	49.5%
5	21639	Greensboro	Caroline	45	53.7%
6	21643	Hurlock	Dorchester	41	57.5%
7	21617	Centreville	Queen Anne's	37	60.9%
8	21673	Trappe	Talbot	31	63.8%
9	21655	Preston	Caroline	30	66.5%
10	21649	Marydel	Caroline	29	69.2%
11	21660	Ridgely	Caroline	26	71.6%
12	21631	East New Market	Dorchester	22	73.7%
13	21640	Henderson	Caroline	19	75.4%
14	21620	Chestertown	Kent	18	77.1%
15	21804	Salisbury	Wicomico	18	78.7%
16	21663	Saint Michaels	Talbot	16	80.2%
17	21625	Cordova	Talbot	12	81.3%
18	21869	Vienna	Dorchester	12	82.4%
19	21636	Goldsboro	Caroline	9	83.3%
20	21801	Salisbury	Wicomico	9	84.1%
21	21619	Chester	Queen Anne's	8	84.8%
Service Area Total				918	84.8%
Outside of Service Area				164	15.2%
Total				1,082	100.0%

Source: St. Paul statewide non-confidential data tapes

## 2. Projected Obstetric Service Area Population

For the ZIP Codes included in the service area for UM SMC at Easton, population projections through 2023 were obtained from Environics Spotlight (formerly Nielsen Claritas) for the 15-64 age cohort. Using the compounded annual growth rates from 2018 to 2023, population projections were extrapolated through 2027 and applied to UM SMC at Easton's fiscal years. As the service area population ages, the population for the 15-64 age cohort is expected to decline annually by 0.1% from fiscal year 2018 to fiscal year 2027 (Table 47).



**Table 47**  
**UM SMC at Easton's Historical and**  
**Projected Obstetrics Service Area Population – Ages 15-64**  
**FY 2016 – FY 2027**

Age Cohort	Historical			Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
15-64	123,759	123,430	123,102	122,953	122,804	122,655	122,506	122,358	122,210	122,062	121,914	121,766	-1.1%
%Change		-0.3%	-0.3%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	

### 3. Obstetrics Service Area Use Rates

Table 48 presents the historical use rate per 1,000 population of obstetrics discharges in the UM SMC at Easton Obstetrics service area for the 15-64 age cohort. While the service area use rate increased from fiscal year 2016 to 2018, it is projected to remain constant from fiscal year 2018 to 2027.

**Table 48**  
**UM SMC at Easton's Historical and Projected Obstetrics Use Rate**  
**FY 2016 – FY 2027**

	Actual	Actual	Annualized	Projected									% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY18-FY27
OB Service Area Use Rate													
Age 15-64	17.9	17.6	20.0	20.0	20.0	20.0	20.0	20.0	20.0	20.0	20.0	20.0	
%Change	1.8%	-1.7%	13.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

### 4. UM SMC at Easton Obstetrics Market Share & Out-of-Service Area Discharges

UM SMC at Easton's market share of the service area discharges remained relatively constant from fiscal year 2016 to 2018. While there was an increase in fiscal year 2017, the out-of-service area obstetric discharges for UM SMC at Easton remained relatively constant as a percent of service area discharges from fiscal year 2016 to 2018. Both the market share and out of service area percent of service area discharges for UM SMC at Easton are projected to remain constant from fiscal year 2018 through the projection period (Table 49).

**Table 49**  
**UM SMC at Easton's Historical and Projected Market Share &**  
**Out-of-Service Area Obstetrics Discharges % of Service Area Discharges**  
**FY 2016 – FY 2027**

	Actual	Actual	Annualized	Projected									% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY18-FY27
UM SMC at Easton Obstetrics Market Share													
Age 15-64	40.2%	40.2%	40.4%	40.4%	40.4%	40.4%	40.4%	40.4%	40.4%	40.4%	40.4%	40.4%	
%Change	-6.2%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
UM SMC at Easton Out of Service Area													
% of Service Area Discharges	17.7%	21.1%	17.4%	17.4%	17.4%	17.4%	17.4%	17.4%	17.4%	17.4%	17.4%	17.4%	0.0%

## 5. UM SMC at Easton Inpatient Obstetric Discharges

Based on the assumptions described above, UM SMC at Easton's obstetric discharges are projected to decline 1.1% from fiscal year 2018 to fiscal year 2027. This decline is due to the comparable decline in the 15-64 age cohort population (Table 50)

**Table 50**  
**UM SMC at Easton's Historical and Projected Obstetric Discharges**  
**FY 2016 – FY 2027**

	Actual FY2016	Actual FY2017	Annualized FY2018	Projected									% Change FY18-FY27
				FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
Obstetric Discharges	1,050	1,057	1,171	1,170	1,169	1,167	1,166	1,164	1,163	1,162	1,160	1,159	
%Change		0.7%	10.8%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-1.1%

## 6. Obstetrics Average Length of Stay

The average length of stay (ALOS) for obstetric patients at UM SMC at Easton increased from fiscal year 2016 to 2018, but is projected to remain at the fiscal year 2018 ALOS through the projection period (Table 51). The ALOS for obstetric discharges at UM SMC at Easton includes an average of eight hours associated with the delivery of the baby in the same room that the mother will reside for the extent of her stay at the hospital. While the bed is in use during this time, the ALOS that is actually reported to the State does not begin until the actual time of delivery.

**Table 51**  
**UM SMC at Easton's Historical and Projected Obstetric ALOS**  
**FY2016 – FY2027**

	Actual FY2016	Actual FY2017	Annualized FY2018	Projected									% Change FY18-FY27
				FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
ALOS (1)	2.73	2.76	2.79	2.79	2.79	2.79	2.79	2.79	2.79	2.79	2.79	2.79	
%Change		1.4%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Note (1): Includes an average of 8 hours per delivery for time spent in the bed prior to admission

## 7. Obstetric Occupancy

The Applicant assumes a 70% occupancy of obstetric beds similar to the State Health Plan for acute care services (COMAR 10.24.10), which provides a 70% occupancy standard for services with an average daily census of 0-49 patients.

## 8. Obstetric Bed Need

Based on the assumptions presented above, the Applicant has a projected need for 13 obstetric beds at UM SMC at Easton in fiscal years 2018 through 2027 (Table 52).

**Table 52**  
**UM SMC at Easton's Historical and Projected Obstetric Bed Need**  
**FY 2016 – FY 2027**

	Actual FY2016	Actual FY2017	Annualized FY2018	Projected										% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027		
Obstetric Bed Need	11	11	13	13	13	13	13	13	13	13	13	13		
%Change	-3.9%	0.0%	18.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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

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

#### **Applicant Response:**

UM SMC at Easton currently has a Level I nursery, as will the proposed replacement facility. **Exhibit 17** includes a self-assessment conducted in August 2018 in preparation for the CON utilizing the 2014 Standards from the Maryland Department of Health and Mental Hygiene. The self-assessment shows that UM SMC at Easton meets all of the essential perinatal standards for Level I.

#### **Standard .04(3) – Charity Care Policy**

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

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

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

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

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

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

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

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*Applicant Response:*

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

**Standard .04(4) – Medicaid Access**

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

- (a) an estimate of the number of Medical Assistance enrollees in its primary service area, and**
  - (b) the number of physicians that have or will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.**
- 

*Applicant Response:*

UM SMC at Easton provides care to all individuals, regardless of ability to pay or source of payment. According to the Maryland Department of Health and Mental Hygiene's Maryland Medicaid eHealth Statistics there were 8,444 Medicaid enrollees in Talbot County, 11,921 in Caroline County, 12,972 in Dorchester County, 8,533 in Queen Anne's County, and 5,106 in Kent County in May 2018 (<https://md-medicaid.org/eligibility/index.cfm>).

Each of the obstetricians and pediatricians with privileges at UM SMC at Easton participates in the Medical Assistance Program. There are nine obstetricians, four pediatricians, and eight nurse-midwives privileged to provide care at UM SMC at Easton, and all are participating in Medicaid. UM SMC at Easton is recruiting another obstetrician and another pediatrician. Each is expected to obtain privileges in 2019.

UM SMC at Easton works with many local partners to identify underserved, uninsured, under insured, and indigent women, including Medicaid enrollees, and to connect them with prenatal care. UM SMC at Easton's community partners include county health departments, community centers, local physicians, schools, social service agencies, and other UM SRH affiliates. UM SMC at Easton also partners with Choptank Community Health System, which operates several federally qualified health centers on the Eastern Shore. These organizations help identify women in need of prenatal services and refer them to UM SMC at Easton for services. Once a woman is identified as in need of prenatal care, she is referred to the Local Health Department, which evaluates her situation and assures that she has all the resources she needs. UM SMC at Easton also works with the Health Department to assign the woman to a UM SMC at Easton obstetrician. No women are turned away, and every woman who needs

an obstetrician becomes a private patient of an UM SMC at Easton obstetrician. UM SMC at Easton also provides a number of outreach programs and free educational classes in the community geared towards pregnant women, as described below in response to COMAR 10.24.12.04(15) – Outreach Program.

As shown in Table 53 below, UM SMC at Easton's efforts to ensure access to prenatal care to underserved and indigent women in the community, including Medicaid enrollees, have been successful to date, as UM SMC at Easton's service area has a lower percentage of births with "Late or No Prenatal Care" compared to the State as a whole and a higher percentage of births that had "First Trimester Prenatal Care" than the State as a whole.

#### **Standard .04(5) – Staffing**

**Each applicant shall provide information on the proposed staffing, associated number and type of FTEs, projected expenses per FTE category and total expenses, for labor and delivery, post partum, nursery services, and other related services, including nurse staffing, non-nurse staffing and physician coverage, at year three and at maximum projected volumes; if applicable, current staffing and expenses should also be included.**

#### **Applicant Response:**

Staffing at third-year projected volumes is estimated to be:

**Table 53**  
**Staffing at Third-Year Projected Volumes**

<b>Employee Category</b>	<b>FTE</b>	<b>FTE Replacement Factor</b>	<b>Total Expense</b>	<b>Comments</b>
Staff Nurse (RN)	25.64	7.27%	\$2,716,511	All RNs are cross-trained to L&D, Nursery, Post-partum, and outpatient testing/triage. This is an LDRP unit.
Per diem RN	2.01			These are the replacement factor FTEs.
Clinical Coordinators	2.4			
Surgical Technician (ST)	7.0		\$338,932	All core surgical technicians are cross-trained to unit secretary functions.
Per Diem ST	0.2	2.86%		These are the replacement factor FTEs.
Nurse Manager	1.0		\$106,496	Includes benefits. Responsible for OB and Pediatrics.
Relief Unit Secretary (US)	0		\$4,266	These are relief unit secretaries that fill in for the unit secretary role as needed.
Lactation Consultant	1.0		\$81,661	

Employee Category	FTE	FTE Replacement Factor	Total Expense	Comments
Midwife*	8			*Not a part of the nursing staff. Credentialed through the Medical staff office. Five employed by Chesapeake Women's Health and three with Community Medical Group Women's Health.
Overtime			\$12,320	All employee categories.
On-Call			\$17,615	All employee categories.
Call-Back			\$36,183	
<b>TOTAL</b>	39.25		\$3,313,984	Midwives not included in total.

#### **Standard .04(6) – Physical Plant Design and New Technology**

**All applicants must describe the features of new construction or renovation that are expected to contribute to improvements in patient safety and/or quality of care, and describe expected benefits.**

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#### **Applicant Response:**

As is the case with the entire proposed facility, the Birthing Center at the proposed replacement hospital is designed with patient and staff safety as a core design element. This commitment to safety begins with the organization of the facility with clear separation of public and staff/service corridors to improve patient privacy and staff efficiency. Also, the proposed facility will feature standardized patient care areas in both the patient units as well as in the surgical suite. The units themselves are designed to be as efficient as possible, with key supplies located to minimize staff travel distances by as much as 30% over their existing facilities. Locating computers in patient rooms, as well as charting between the rooms, will facilitate safe delivery of medications allowing for bedside barcode checking of medications, as well as great visibility of the patients by staff. The proposed facility will be configured to consolidate and centralize resources, minimize staff travel distances, and open up visibility of patients, while controlling noise in the units.

Patient handling and movement is also a key aspect of patient and staff safety, as the elevators are centralized to minimize patient transport distances. The elevators for the Birthing Center allow direct access from the operating room and emergency department.

In the diagnostic areas, the invasive procedure rooms are all located together and convenient to patient prep and recovery. The Birthing Center's cesarean section rooms are all standardized, designs with input from the Director of Surgical Services and Anesthesia. To help relieve patient and family stress, the facility will feature embedded way finding for patients and family. Public areas, both circulation and waiting, will be oriented to the exterior with views of

parking areas. This minimizes the distances patients have to travel, and helps alleviate congestion and confusion within staff/service only areas.

In the Birthing Center (as in the rest of the proposed hospital), patient privacy is a key factor in safety. As part of the planning process, acoustical design is an increased consideration and is now required by the 2014 guidelines. As such, materials and finishes are being selected that not only soften footfalls to reduce strain on staff, but also to help absorb noise. Also, all rooms in the Birthing Center, and throughout the facility, will be private.

The greater floor to floor height in the proposed facility will accommodate larger technologies. The first two floor plates feature a regular grid that allows for adaptability over time to new modalities and services.

Some of the other features that improve patient safety in the Birthing Center include:

- Co-location of related support functions to maximize efficiency
- Universal patient room design
- Charting/observation at each patient room
- Automation of technology and patient records
- Separate lactation room
- Appropriate number of triage bays
- Dedicated bathrooms in triage
- Dedicated trauma and Birthing Center elevator for patient transfers in emergencies
- Reduced patient transfer time (surgery to short stay recovery, emergency department to ICU, emergency department to helipad, nursery/LDRP to helipad, etc.)
- Appropriate number of prep/recovery bays
- Special operating room lights in all triage rooms
- Direct access from C-section to nursery
- Continuing Care Nursery with accommodations for opioid addicted neonates or other special care needs
- Newborn / Baby Holding Nursery separated from Continuing Care Nursery to minimize noise and disruption
- Increased telemetry capability

- Storage alcoves on the Birthing Center for wheel chairs and stretchers
- Upgrade to ADA/ANSI standards
- Directed traffic flow into building (main entrance) past security
- Locked unit with an infant security system
- Dedicated medication/clean supply room

#### **Standard .04(7) – Nursery**

**An applicant for a new perinatal service shall demonstrate that the level of perinatal care, including newborn nursery services, will be consistent with the needs of the applicant's proposed service area.**

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#### **Applicant Response:**

Inapplicable.

#### **Standard .04(8) – Community Benefit Plan**

**Each applicant proposing to establish a new perinatal service will develop and submit a Community Benefit Plan addressing and quantifying the unmet community needs in obstetric and perinatal care within the applicant's anticipated service area population, This Plan should include an outreach program component, and should provide a detailed description of the manner in which the proposed perinatal service will meet these needs, and the resources required, At a minimum, the Community Benefit Plan must include:**

- (a) a needs assessment related to obstetric and nursery services for the proposed program's service area population, including a description of the manner in which the proposed perinatal service will satisfy unmet needs identified in the needs assessment,**
- (b) measurable and time-limited goals and objectives for health status improvements pursuant to which the Plan can be evaluated; and**
- (c) information on the structure, staffing and funding of the Plan;**
- (d) documentation of community support and involvement in program planning for the Plan by other agencies, organizations or institutions which will be involved, directly or indirectly, with the Plan;**
- (e) an implementation scheme for the Community Benefit Plan.**
- (f) Applicants must commit to implementation of the Community Benefit Plan and continuing commitment to the Plan as a condition of**



Commission approval, and as an ongoing condition of providing obstetric services.

(g) Applicants must agree to submit an Annual Report to the Commission which will include:

(i) an evaluation of the achievement of the goals and objectives of the Community Benefit Plan; and

(ii) information on staffing levels and the total costs of any programs implemented as part of the Community Benefit Plan.

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*Applicant Response:*

Inapplicable.

**Standard .04(9) – Source of Patients**

An applicant for a new obstetric service shall demonstrate that the majority of its patients will come from its primary service area.

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*Applicant Response:*

Inapplicable.

**Standard .04(10) – Non-metropolitan Jurisdictions**

A proposed obstetrics program in non-metropolitan jurisdictions, as defined in the chapter, shall demonstrate that physicians with admitting privileges to provide obstetric services have offices for patient visits within the primary service area of the hospital.

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*Applicant Response:*

The Applicant is not proposing to create a new obstetrics program, it is simply relocating the existing program. In any event, all of the obstetricians practicing at UM SMC at Easton have offices in Easton, which is within the primary service area.

**Standard .04(11) – Designated Bed Capacity**

An applicant for a new obstetric service shall designate a number of the beds from within the hospital's licensed acute care beds that will comprise the proposed obstetric program.

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Applicant Response:

Inapplicable.

**Standard .04(12) – Minimum Volume**

(a) An applicant for a new obstetrics program must be able to demonstrate to the Commission's satisfaction that the proposed program can achieve a minimum volume of 1,000 admissions annually in metropolitan jurisdictions, or 500 cases annually in non-metropolitan jurisdictions, within 36 months of initiation of the program.

(b) As a condition of approval; the applicant shall accept a requirement that it will lose 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.

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Applicant Response:

Inapplicable.

**Standard .04(13) – Impact on the Health Care System**

(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 § 19-120(k) not to increase rates for that project, so long as the pledge was based, at least in part, on assumptions about obstetric volumes.

(d) The Commission may consider evidence:

(i) from an applicant as to why rules (a) through (e) should not apply to the applicant, or;

(ii) from a very low volume program (fewer than 500 annual obstetric discharges) as to why a lower volume impact should apply.

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[Applicant Response:](#)

Inapplicable.

**Standard .04(14) – Financial Feasibility**

Hospitals applying for a Level I or II perinatal program must clearly demonstrate that the hospital has the financial and non-financial resources necessary to implement the project, and that the average charge per admission for new perinatal programs will be less than the current statewide average charge for Level I and Level II perinatal programs. When determining whether to approve an application for an obstetric program, the Commission will consider the following:

- (a) the applicant's projected sources of funds to meet the program's total expenses for the first three years of operation,
  - (b) the proposed unit rates and/or average charge per case for the perinatal services;
  - (c) evidence that the perinatal service will be financially feasible at the projected volumes and at the minimum volume standards in this Plan, and
  - (d) the written opinions or recommendations of the HSCRC.
- 

[Applicant Response:](#)

Inapplicable.

**Standard .04(15) – Outreach Program**

Each applicant with an existing perinatal service shall document an outreach program for obstetric patients in its service area who may not have adequate prenatal care, and provide hospital services to treat those patients. The program shall address adequate prenatal care, prevention of low birth weight and infant mortality, and shall target the uninsured, under-insured, and indigent patients in the hospital's primary service area, as defined in COMAR 10.24.01.01.B.

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Applicant Response:

UM SMC at Easton works closely with many partners. Entry into the health care system occurs through many referral sources. UM SMC at Easton along with UM SMC at Dorchester, UM SMC at Chestertown, county health departments, community centers, local physicians, schools, social services agencies, and other organizations in the five counties identify women who need prenatal care, especially those who may be uninsured, under-insured, or indigent. Of course, families may also refer women who think that they may be pregnant and some women refer themselves for services.

UM SMC at Easton's program accommodates referrals for obstetric and gynecologic care for underserved women in all five counties from any of these sources.

In addition, UM SMC at Easton offers dozens of classes in the community, including:

- Planning for baby's arrival - Take A Childbirth Education Class
- Successful Breastfeeding
- Health & Wellness Classes
- Labor & Delivery Class
- Childbirth Class
- Stroke Awareness
- Alzheimer's Support
- Psychosocial Support
- Palliative Care Education
- Prostate Cancer and Urological Conditions
- Classes and Support Groups Focus on Managing Diabetes
- Pneumonia - Antibiotic and Antiviral Drug Classes
- Mindfulness-Based Stress Reduction
- Blood Pressure Screenings
- Breast Cancer Screenings
- Cancer Support Groups
- Pregnancy and Infant Loss
- New Mom, New Baby & Infant Safety
- Big Brother & Big Sister
- Infant CPR
- Labor & Delivery I, II, III
- Stroke Survivor Support Group
- Us Too Prostate Support Group
- Look Good...Feel Better
- Shore Kids Camp
- Safe Sitter Class
- Breast Cancer – Chemotherapy

There is no financial barrier to attend these classes, as there is no charge for any participant.

In terms of prenatal care, whenever a woman in need of medical care is identified, either by a Health Department, social service agency, school, at an UM SMC at Easton class, or other

source, the woman is referred to the Local Health Department, which evaluates the situation to assure that the family has all the resources it needs (not only regarding the pregnancy). Working with the Health Department, UM SMC at Easton assigns the woman to a UM SMC at Easton obstetrician. No women are turned away. Every woman who needs an obstetrician becomes a private patient of an UM SMC at Easton obstetrician.

As Table 54 below shows, UM SMC at Easton's OB service area has a lower percentage of births that had "Late or No Prenatal Care" compared to the State of Maryland as a whole. Also, the UM SMC at Easton OB service area had a significantly higher percent of births that had "First Trimester Prenatal Care" than did the State as a whole.

**Table 54**  
**Births with "Late or No Prenatal Care" and "1st Trimester Prenatal Care"**  
**Queen Anne's, Kent, Caroline, Talbot, and Dorchester Counties**  
**CY 2016**

	Total Births	Late or No Prenatal Care		1st Trimester Prenatal Care	
		#	%	#	%
Kent	148	11		105	
Queen Anne's	499	23		360	
Caroline	387	32		276	
Talbot	331	21		244	
Dorchester	381	26		290	
Total	1,746	113	6.5%	1,275	73.0%
Maryland	73,073	5,805	7.9%	46,068	63.0%

Source: Maryland Vital Statistics Annual Report 2016\*

[https://health.maryland.gov/vsa/Documents/2016\\_AnnualReport.WebVersion.pdf](https://health.maryland.gov/vsa/Documents/2016_AnnualReport.WebVersion.pdf)

\*CY 2016 is the most recent report available on the Maryland Department of Health, Vital Statistics and Reports website.

**COMAR 10.24.09. Specialized Health Care Services—**  
**Acute Inpatient Rehabilitation Services**

**Standard .04A. – General Review Standards.**

**(1) Charity Care Policy.**

**(a) Each hospital and freestanding acute inpatient rehabilitation provider shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide acute inpatient rehabilitation services on a charitable basis to qualified persons consistent with this policy. The policy shall have the following provisions:**

**(i) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility shall make a determination of probable eligibility.**

**(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's admission, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.**

**(iii) Criteria for Eligibility. A hospital shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. A hospital that is not subject to HSCRC regulations regarding financial assistance policies shall at a minimum include the following eligibility criteria in its charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of hospitals that are not subject to HSCRC regulations regarding financial assistance policies.**

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Applicant Response:

See response to COMAR 10.24.10.04A(2). UM SMC at Easton's Charity Care policy applies to both acute care and rehabilitation services.

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

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Applicant Response:

See response to COMAR 10.24.10.04A(2).

**(c) A proposal to establish or expand an acute inpatient rehabilitation hospital or subunit, for which third party reimbursement is available, and which is not subject to HSCRC regulations regarding financial assistance policies, shall commit to provide charitable rehabilitation services to eligible patients, based on its charity care policy, which shall meet the minimum requirements in .04A(1)(a) of this Chapter. The applicant shall demonstrate that:**

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

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

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Applicant Response:

Inapplicable. UM SMC at Easton is subject to HSCRC regulations.

**(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a CON for a project that involves acute inpatient rehabilitation services, shall commit to provide charitable services to indigent patients. Charitable services may be rehabilitative or non-rehabilitative and may include a charitable program that subsidizes health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by acute general hospitals, measured as a percentage of total expenses, in the most recent year reported. The applicant shall demonstrate that:**

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

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

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

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Applicant Response:

Inapplicable.

**(2) Quality of Care.**

A provider of acute inpatient rehabilitation services shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

(ii) Accredited by the Commission for Accreditation of Rehabilitation Facilities.

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) An applicant that currently provides acute inpatient rehabilitation services that is seeking to establish a new location or expand services shall report on all quality measures required by federal regulations or State agencies, including information on how the applicant compares to other Maryland acute inpatient rehabilitation providers. An applicant shall be required to meet quality of care standards or demonstrate progress towards reaching these standards that is acceptable to the Commission, before receiving a CON.

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Applicant Response:

The Requard Center is in compliance with all applicable accreditation standards, certification standards, and with the conditions of participation for Medicare and Medicaid programs. A copy of the most recent CARF accreditation certificate is attached as **Exhibit 18**, and a copy of UM SMC at Easton's license is attached as **Exhibit 10**.

For UM SMC at Easton's performance under the quality measures, see response to COMAR 10.24.10.04A(3).



(c) An applicant that does not currently provide inpatient rehabilitation services that is seeking to establish an inpatient rehabilitation unit within an acute care hospital or an inpatient rehabilitation specialty hospital shall demonstrate through reporting on quality measures that it provides high quality health care compared to other Maryland providers that provide similar services or, if applicable, nationally.

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[Applicant Response:](#)

Inapplicable. The Requard Center is an existing provider of inpatient rehabilitation services.

**Standard .04B. – Project Review Standards.**

In addition to these standards, an acute general hospital applicant shall address all applicable standards in COMAR 10.24.10 that are not duplicated in this Chapter. These standards apply to applicants seeking to provide comprehensive acute rehabilitation services or both comprehensive acute rehabilitation services and specialized acute rehabilitation services to adult or pediatric patients.

**(1) Access.**

A new or relocated acute rehabilitation hospital or subunit shall be located to optimize accessibility for its likely service area population. An applicant that seeks to justify the need for a project on the basis of barriers to access shall present evidence to demonstrate that barriers to access exist for the population in the service area of the proposed project, based on studies or other validated sources of information. In addition, an applicant must demonstrate that it has developed a credible plan to address those barriers. The credibility of the applicant's plan will be evaluated based on whether research studies or empirical evidence from comparable projects support the proposed plan as a mechanism for addressing the barrier(s) identified, whether the plan is financially feasible and whether members of the communities affected by the project support the plan.

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[Applicant Response:](#)

See response to Acute Hospital Services Standard COMAR 10.24.10.04B(1).

**(2) Need.**

A project shall be approved only if a net need for adult acute rehabilitation beds is identified by the need methodology in Section .05 in the applicable health planning region (HPR) or if the applicant meets the applicable

standards below. The burden of demonstrating need rests with the applicant.

(a) An application proposing to establish or expand adult acute inpatient rehabilitation services in a jurisdiction that is directly contiguous to another health planning region may be evaluated based on the need in contiguous regions or states based on patterns of cross-regional or cross-state migration.

(b) For all proposed projects, an applicant shall explicitly address how its assumptions regarding future in-migration and out-migration patterns among Maryland health planning regions and bordering states affect its need projection.

(c) If the maximum projected bed need range for an HPR includes an adjustment to account for out-migration of patients that exceeds 50 percent of acute rehabilitation discharges for residents of the HPR, an applicant proposing to meet the need for additional bed capacity above the minimum projected need, shall identify reasons why the existing out-migration pattern is attributable to access barriers and demonstrate a credible plan for addressing the access barriers identified.

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[Applicant Response:](#)

UM SMC at Easton was licensed to operate 20 special hospital rehabilitation beds in FY 2018. UM SMC at Easton proposes to reduce the number of rehabilitation beds at the replacement hospital to 14 beds. The current rehabilitation licensed bed capacity on the Eastern Shore is 79 beds (Table 55). The projected 2021 gross acute rehabilitation bed need range is 49 to 89 beds and the net need is -30 to 10 (See *Maryland Register* dated April 13, 2018). The projected need for 14 rehabilitation beds at UM SMC at Easton, combined with 59 beds at HealthSouth Chesapeake will result in 73 licensed rehabilitation beds on the Eastern Shore. Since UM SMC at Easton's "total bed capacity" will not cause the number of beds on the Eastern Shore to exceed "the most recent annual calculation of bed capacity," the proposed project is within the most current need projections in the State Health Plan.

**Table 55**  
**MHCC Gross and Net 2021 Bed Need Projections for Acute Rehabilitation Beds**  
**Eastern Shore**

Hospital	Current License Bed Capacity	Gross Bed Need		2021 Net Bed Need	
		Minimum	Maximum	Minimum	Maximum
UM SMC at Easton	20	-	-	-	-
HealthSouth Chesapeake	59	-	-	-	-
<b>TOTAL</b>	<b>79</b>	<b>49</b>	<b>89</b>	<b>-30</b>	<b>10</b>

Using the acute rehabilitation bed need methodology and assumptions described below, the Applicant projects a need for 14 rehabilitation beds at the replacement hospital.

## 1. Defining UM SMC at Easton's Rehabilitation Service Area

To project the need for rehabilitation beds at the replacement hospital for UM SMC at Easton, the Applicant began by defining the service area from which UM SMC at Easton currently draws its inpatient rehabilitation discharges. Using CY 2017 data, the Applicant accumulated its rehabilitation discharges by ZIP Code. The Applicant then ranked the ZIP Codes with the highest to lowest number of discharges to identify the ZIP Codes that comprise the top 85% of its rehabilitation discharges and determined the ZIP Codes to be included in the service area. The Primary (ZIP Codes contributing the top 65% of discharges) and the Secondary (ZIP Codes contributing the next 20% of discharges) Rehabilitation Service Areas are shown in Table 56. The aggregate of both the Primary and Secondary Rehabilitation Service Areas will be referred to as UM SMC at Easton's Rehabilitation Service Area. As presented in Table 56 below, the total Rehabilitation Service Area is defined by 18 ZIP codes that span Talbot, Dorchester, Caroline, Queen Anne's and Kent counties.

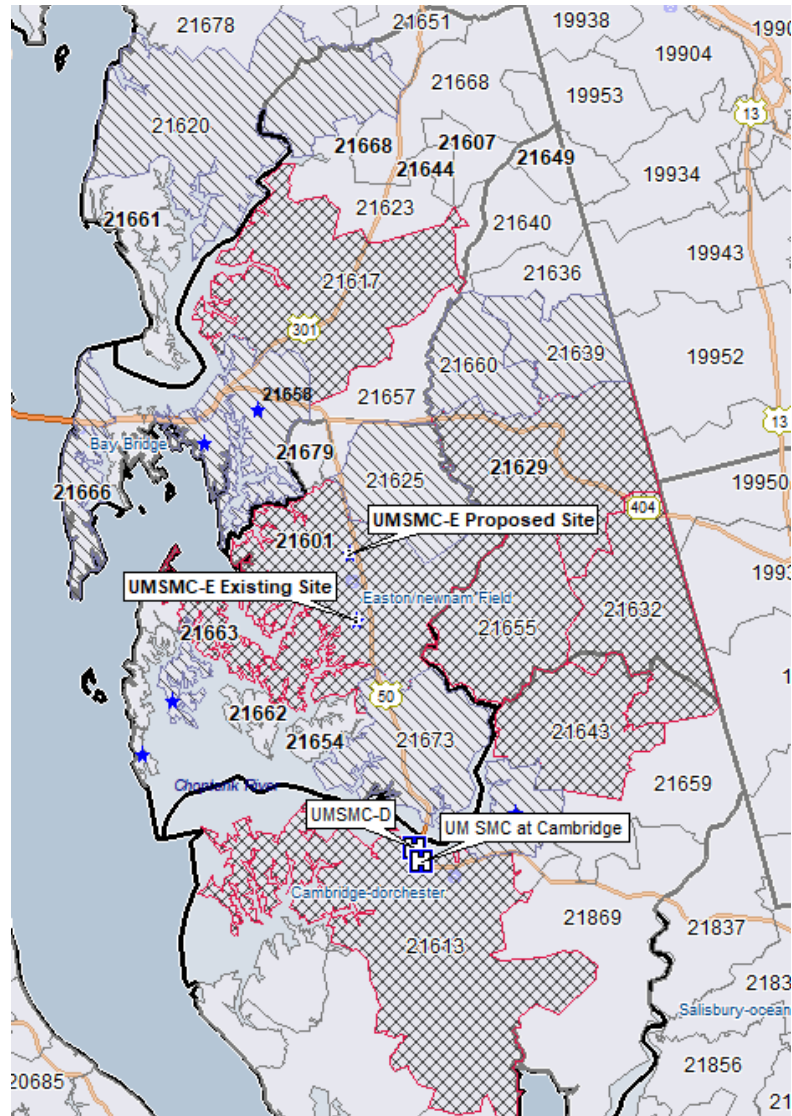
**Table 56**  
**UM SMC at Easton Rehabilitation Service Area ZIP Codes and Discharges**  
**CY 2017**

#	Zip Code	City	County	Discharges	Cumulative % of Total
1	21601	Easton	Talbot	107	30.1%
2	21613	Cambridge	Dorchester	45	42.7%
3	21629	Denton	Caroline	20	48.3%
4	21663	Saint Michaels	Talbot	13	52.0%
5	21632	Federalsburg	Caroline	12	55.3%
6	21643	Hurlock	Dorchester	12	58.7%
7	21655	Preston	Caroline	11	61.8%
8	21617	Centreville	Queen Anne's	10	64.6%
9	21639	Greensboro	Caroline	10	67.4%
10	21620	Chestertown	Kent	10	70.2%
11	21625	Cordova	Talbot	9	72.8%
12	21631	East New Market	Dorchester	9	75.3%
13	21660	Ridgely	Caroline	7	77.2%
14	21666	Stevensville	Queen Anne's	7	79.2%
15	21638	Grasonville	Queen Anne's	6	80.9%
16	21652	Neavitt	Talbot	6	82.6%
17	21658	Queenstown	Queen Anne's	6	84.3%
18	21673	Trappe	Talbot	6	86.0%
Service Area Total				306	86.0%
Outside of Service Area				50	14.0%
Total				356	100.0%

Rehabilitation definition: Inpatient discharges assigned Rehab as the Nature of Admission code

Source: St. Paul statewide non-confidential data tapes

**Figure 5**  
**UM SMC at Easton**  
**Primary and Secondary Rehabilitation Service Areas**  
**FY 2017**



There are only two other rehabilitation facilities serving the Eastern Shore:

HealthSouth Chesapeake Rehabilitation Hospital  
 220 Tilghman Road  
 Salisbury, MD 21804

HealthSouth Rehabilitation Hospital of Middletown  
 250 East Hampden Road  
 Middletown, DE 19709

## 2. Projected Rehabilitation Service Area Population

For the ZIP Codes included in the Rehabilitation Service Area for UM SMC at Easton, population projections for 2018 and 2023 were obtained from Environics Spotlight (formerly Nielsen Claritas) for the 15-64, 65-74 and 75+ age cohorts. Using the compounded annual growth rates from 2018 to 2023, population projections were extrapolated through 2027 and applied to UM SMC at Easton's fiscal years. As the service area population ages, the population for the 15-64 age cohort is expected to decline by 3.0% from fiscal year 2018 to fiscal year 2027. Over the same period, the 65-74 and 75+ age cohorts are projected to increase 32.2% and 9.8%, respectively. In total, the population is expected to grow 3.7% from fiscal year 2018 to 2027 (Table 57).

**Table 57**  
**UM SMC at Easton's Historical and**  
**Projected Rehabilitation Service Area Population – Ages 15+**  
**FY 2016 – FY 2027**

Age Cohort	Historical			Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
15-64	82,123	81,678	81,236	80,959	80,683	80,408	80,134	79,861	79,589	79,318	79,047	78,778	-3.0%
%Change		-0.5%	-0.5%	-0.3%	-0.3%	-0.3%	-0.3%	-0.3%	-0.3%	-0.3%	-0.3%	-0.3%	
65-74	15,671	16,197	16,740	17,267	17,811	18,371	18,949	19,546	20,161	20,796	21,451	22,126	32.2%
%Change		3.4%	3.4%	3.1%	3.1%	3.1%	3.1%	3.1%	3.1%	3.1%	3.1%	3.1%	
75+	11,715	11,891	12,069	12,195	12,321	12,450	12,579	12,710	12,842	12,976	13,111	13,247	9.8%
%Change		1.5%	1.5%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	
Total Service Area	109,510	109,766	110,045	110,421	110,815	111,229	111,663	112,117	112,592	113,089	113,609	114,151	3.7%
%Change		0.2%	0.3%	0.3%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.5%	0.5%	

Source: 2018 and 2023 = Environics Spotlight Pop-Facts Demographics by Age Race Sex

## 3. Rehabilitation Service Area Use Rates

Table 58 presents the historical use rate per 1,000 population of rehabilitation discharges in the UM SMC at Easton Rehabilitation Service Area for the 15+ age cohorts. The service area use rates decreased from fiscal year 2016 to 2018 and are expected to decline further in fiscal year 2019 to achieve targeted reductions. Beginning in fiscal year 2020, the use rates are projected to remain constant, at the age cohort level. With the aging of the service area population, the total service area use rate will increase annually by 1.0% from fiscal year 2019 to 2027 as the population shifts to older age cohorts with higher use rates.

**Table 58**  
**UM SMC at Easton's Historical and Projected Rehabilitation Use Rates**  
**FY 2016 – FY 2027**

Age Cohort	Actual	Actual	Annualized	Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
Age 15-64	1.4	1.4	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	-2.7%
%Change	-17.1%	-1.2%	-11.9%	-2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Age 65-74	7.1	7.8	7.0	6.9	6.9	6.9	6.9	6.9	6.9	6.9	6.9	6.9	-2.7%
%Change	7.4%	10.7%	-10.1%	-2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Age 75+	18.1	18.2	17.7	17.2	17.2	17.2	17.2	17.2	17.2	17.2	17.2	17.2	-2.7%
%Change	-10.0%	0.4%	-2.8%	-2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
<b>Total</b>	<b>4.0</b>	<b>4.1</b>	<b>3.9</b>	<b>3.8</b>	<b>3.9</b>	<b>3.9</b>	<b>3.9</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>4.1</b>	<b>4.1</b>	<b>6.0%</b>
	-7.2%	3.9%	-5.9%	-1.8%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	

#### 4. UM SMC at Easton's Rehabilitation Market Share

UM SMC at Easton's Rehabilitation Service Area market share increased from 67.9% in fiscal year 2016 to 74.9% in fiscal year 2018. Going forward, the market share is expected to remain constant at the fiscal year 2018 level at each age cohort. With the aging of the service area population, UM SMC at Easton's total hospital market share will increase 0.35% from fiscal year 2018 to 2027 as the population shifts to older age cohorts with greater market share (Table 59).

**Table 59**  
**UM SMC at Easton's Historical and Projected Rehabilitation Service Area Market Share**  
**FY 2016 – FY 2027**

Age Cohort	Actual	Actual	Annualized	Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
Age 15-64	50.4%	39.6%	66.0%	66.0%	66.0%	66.0%	66.0%	66.0%	66.0%	66.0%	66.0%	66.0%	0.0%
%Change	44.0%	-21.4%	66.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Age 65-74	77.5%	65.4%	75.4%	75.4%	75.4%	75.4%	75.4%	75.4%	75.4%	75.4%	75.4%	75.4%	0.0%
%Change	17.4%	-15.6%	15.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Age 75+	72.2%	79.2%	78.6%	78.6%	78.6%	78.6%	78.6%	78.6%	78.6%	78.6%	78.6%	78.6%	0.0%
%Change	-3.8%	9.7%	-0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
<b>Total</b>	<b>67.9%</b>	<b>65.6%</b>	<b>74.9%</b>	<b>74.9%</b>	<b>74.9%</b>	<b>75.0%</b>	<b>75.0%</b>	<b>75.0%</b>	<b>75.1%</b>	<b>75.1%</b>	<b>75.1%</b>	<b>75.1%</b>	<b>0.35%</b>
	10.56%	-3.32%	14.08%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	

#### 5. UM SMC at Easton Out-of-Service Area Rehabilitation Discharges

UM SMC at Easton's out-of-service area rehabilitation discharges declined as a percent of service area discharges from fiscal year 2016 to 2018, although there was an increase in fiscal year 2017. The out-of-service area discharges are projected to remain constant, as a percentage of service area discharges, at the age cohort level, from fiscal year 2018 through the projection period. Fluctuations from year to year in the total percentage of discharges from out-of-service area are due to the aging of the population into older cohorts with greater discharges from outside the service area (Table 60).

**Table 60**  
**UM SMC at Easton's Historical and Projected Out-of-Service Area Rehabilitation**  
**Discharges % of Service Area Discharges**  
**FY 2016 – FY 2027**

Rehabilitation	Actual	Actual	Annualized	Projected								
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027
Out-of-Service Area Discharges % of Service Area Discharges	16.2%	19.8%	11.6%	11.6%	11.7%	11.7%	11.7%	11.8%	11.8%	11.8%	11.9%	11.9%

## 6. UM SMC at Easton Inpatient Rehabilitation Discharges

Based on the assumptions described above, UM SMC at Easton's rehabilitation discharges are projected to increase 10.6% from fiscal year 2018 to fiscal year 2027 (Table 61). This increase is driven by the increases in population and age adjusted use rates, market share, and out-of-service area discharges.

**Table 61**  
**UM SMC at Easton's Historical and Projected Rehabilitation Discharges**  
**FY 2016 – FY 2027**

	Actual	Actual	Annualized	Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
Rehabilitation Discharges	344	357	358	353	358	363	368	373	379	384	390	396	
%Change		3.8%	0.3%	-1.4%	1.4%	1.4%	1.4%	1.4%	1.5%	1.5%	1.5%	1.5%	10.6%

## 7. Rehabilitation Average Length of Stay

The average length of stay (ALOS) for rehabilitation patients at UM SMC at Easton declined from fiscal year 2016 to 2018, but is expected to increase in fiscal year 2019. With improvements in case management, the ALOS is projected to return to the fiscal year 2018 ALOS and then remain constant through the projection period by age cohort (Table 62).

**Table 62**  
**UM SMC at Easton's Historical and Projected Rehabilitation ALOS**  
**FY2016 – FY2027**

	Actual	Actual	Annualized	Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
ALOS	10.37	9.51	9.80	10.34	9.80	9.81	9.81	9.81	9.81	9.81	9.81	9.81	
%Change		-8.3%	3.1%	5.5%	-5.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%

## 8. Rehabilitation Occupancy

The Applicant assumes a 75% occupancy for rehabilitation beds which reflects the State Health Plan (COMAR 10.24.09) for acute rehabilitation inpatient services with an average daily census of 0-49 patients.



## 9. Rehabilitation Bed Need

Based on the assumptions presented above, the Applicant has a projected need for 14 rehabilitation beds at the replacement hospital for UM SMC at Easton in fiscal years 2025 through 2027 (Table 63).

**Table 63**  
**UM SMC at Easton's Historical and Projected Rehabilitation Bed Need**  
**FY 2016 – FY 2027**

	Actual	Actual	Annualized	Projected									% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	FY18-FY27
Rehabilitation Bed Need	13	12	13	13	13	13	13	13	14	14	14	14	
%Change	0.0%	-7.7%	8.3%	0.0%	0.0%	0.0%	0.0%	0.0%	7.7%	0.0%	0.0%	0.0%	7.7%

**(d) An applicant proposing to establish or expand adult acute rehabilitation beds that is not consistent with the projected net need in .05 in the applicable health planning region shall demonstrate the following:**

**(i) The project credibly addresses identified barriers to access; and**

**(ii) The applicant's projection of need for adult acute rehabilitation beds explicitly accounts for patients who are likely to seek specialized acute rehabilitation services at other facilities due to their age or their special rehabilitative and medical needs. At a minimum, an applicant shall specifically account for patients with a spine or brain injury and pediatric patients; and**

**(iii) The applicant's projection of need for adult acute rehabilitation beds accounts for in-migration and out-migration patterns among Maryland health planning regions and bordering states.**

### Applicant Response:

Inapplicable. The Applicant does not propose to expand the number of beds, and as described above, the Applicant's proposal to build 14 beds at the replacement hospital combined with the 59 beds at HealthSouth Chesapeake is consistent with the Commission's projection of need for rehabilitation beds on the Eastern Shore in 2021 (published in the *Maryland Register* on April 13, 2018).

**(e) An applicant that proposes a specialized program for pediatric patients, patients with brain injuries, or patients with spinal cord injuries shall submit explanations of all assumptions used to justify its projection of need.**



Applicant Response:

Inapplicable. UM SMC at Easton is not proposing a specialized program for pediatric patients.

**(f) An applicant that proposes to add additional acute rehabilitation beds or establish a new health care facility that provides acute inpatient rehabilitation services cannot propose that the beds will be dually licensed for another service, such as chronic care.**

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Applicant Response:

Inapplicable. UM SMC at Easton is not proposing to add additional rehabilitation beds.

**(3) Impact.**

**A project shall not have an unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services. A project also shall not have an unwarranted adverse impact on the availability of services, access to services, or the quality of services. Each applicant must provide documentation and analysis that supports:**

**(a) Its estimate of the impact of the proposed project on patient volume, average length of stay, and case mix, at other acute inpatient rehabilitation providers;**

**(b) Its estimate of any reduction in the availability or accessibility of a facility or service that will likely result from the project, including access for patients who are indigent or uninsured or who are eligible for charity care, based on the affected acute rehabilitation provider's charity care policies that meet the minimum requirements in .04A(1)(a) of this Chapter;**

**(c) Its estimate of any reduction in the quality of care at other providers that will likely be affected by the project; and**

**(d) Its estimate of any reduction in the ability of affected providers to maintain the specialized staff necessary to provide acute inpatient rehabilitation services.**

---

Applicant Response:

UM SMC at Easton is not proposing to add additional rehabilitation beds. In addition, patient volume is assumed to increase consistent with population growth and UM SMC at Easton will maintain its current market share. This project will not result in the reduction in the availability or accessibility of rehabilitation services, as the bed need projections are based on actual utilization and the location will improve geographic access. See response to Acute Hospital Services Standard COMAR 10.24.10.04B(4).

**(4) Construction Costs.**

**(a) The proposed construction costs for the project shall be reasonable and consistent with current industry and cost experience in Maryland.**

**(b) For a hospital that is rate-regulated by the Health Services Cost Review Commission, the projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.**

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*Applicant Response:*

Please see the response to COMAR 10.24.10.04B-Standard .04B(7) – Construction Cost of Hospital Space.

**(5) Safety.**

**The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety.**

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*Applicant Response:*

The acute rehabilitation unit design meets all safety related standards of The Joint Commission and CARF. It is also consistent with requirements of ADA design. Environment of Care/Safety self-inspection rounds are currently performed semi-annually, and will continue per CARF requirements. Annual inspections by external authorities are also completed and will be continued.

The replacement facility will also implement the design and safety features discussed in response to Acute Care Services Standard 10.24.10.04B(12) (Patient Safety), which is incorporated herein by reference.

**(6) Financial Feasibility.**

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

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

(b) Each applicant must document that:

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

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

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

(iv) The hospital will generate excess revenues over total expense (including debt service expenses and plant and equipment depreciation), if the applicant's utilization forecast is achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital proposing an acute inpatient rehabilitation unit that does not generate excess revenues over total expenses, even if utilization forecasts are achieved for the services affected by the project, may demonstrate that the hospital's overall financial performance will be positive.

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[Applicant Response:](#)

Please see the response to COMAR 10.24.10.04B-Standard .04B(13) – Financial Feasibility.

**(7) Minimum Size Requirements.**

(a) A proposed acute inpatient rehabilitation unit in a hospital shall contain a minimum of 10 beds and shall be projected to maintain an average daily census consistent with the minimal occupancy standard in this Chapter within three years.

(b) A proposed acute inpatient rehabilitation specialty hospital shall contain a minimum of 30 beds and shall be projected to maintain within

**three years an average daily census consistent with the minimum occupancy standard in this Chapter.**

---

*Applicant Response:*

Inapplicable. The Requard Center is and will be part of an acute inpatient rehabilitation unit in an acute general hospital, not a specialty hospital.

**(8) Transfer and Referral Agreements.**

**Each applicant shall provide documentation prior to licensure that the facility will have written transfer and referral agreements with facilities, agencies, and organizations that:**

**(a) Are capable of managing cases that exceed its own capabilities;**  
**and**

**(b) Provide alternative treatment programs appropriate to the needs of the persons it serves.**

---

*Applicant Response:*

UM SMC at Easton has established written transfer agreements with other health care facilities to ensure the continuum of care for patients requiring transfer to another facility or entity. Examples of patient transfer agreements with other facilities can be found in **Exhibit 19**.

Transfers that exceed the Requard unit's capabilities fall into two categories: (1) patients whose acute care needs exceed the rehabilitation unit's capabilities and so must be transferred to an acute care service; and (2) patients whose rehabilitation needs exceed the Requard unit's capabilities and so must be transferred to another rehabilitation facility (such as new acute traumatic brain injury, new quadriplegics, new paraplegics, and multiple traumas with multiple weight bearing limitations). The acute care hospitals to which such cases are transferred include: UM SMC at Easton, UM SMC at Dorchester, University of Maryland Medical Center, and Johns Hopkins Hospital. The Acute Rehabilitation Hospital to which patients are transferred for rehabilitation is University of Maryland Rehabilitation & Orthopaedic Institute (the former Kernan Hospital). The number of transfers for Fiscal Years 2014 – 2018 are shown below in Table 64.

**Table 64**  
**Patients Transferred Due to Exceeding the Reguard Unit's Capabilities**  
**2014 – 2016**

<b>Types of Cases</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>FY 2016</b>	<b>FY 2017</b>	<b>FY 2018</b>
Acute Care Transfers (discharged from Rehab)	31	21	38	31	24
Specialized Rehab/Care (admitted to Rehab then transferred)	0	0	0	1	0

Source of Data: UDS Pro I IRF PAI Data base

Some cases could have been provided at UM SMC at Easton (*i.e.*, evidenced medical necessity for acute rehab) but were referred elsewhere because of bed availability issues, patient/caregiver choice, and/or health plan/payer barriers. These patients were transferred to the following Acute Rehab Hospitals: HealthSouth Chesapeake Rehabilitation Hospital (Salisbury, MD) and University of Maryland Rehabilitation & Orthopaedic Institute (Baltimore, MD). Other patients were transferred to skilled nursing facilities, including: Genesis (Easton, Cambridge, Centreville, MD), Bayleigh Chase (Easton, MD), Mallard Bay (Cambridge, MD), Envoy Nursing and Rehab (Denton, MD), Caroline Nursing and Rehabilitation (Denton, MD), and Resorts at Chester River Manor (Chestertown, MD).

**(9) Preference in Comparative Reviews.**

**In the case of a comparative review of applications in which all standards have been met by all applicants, the Commission will give preference to the applicant that COMAR 10.24.09 Supplement 1 13 offers the best balance between program effectiveness and costs to the health care system as a whole.**

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[Applicant Response:](#)

Inapplicable.

## COMAR 10.24.07 – Psychiatric Services Chapter

### Approval Policies

#### Availability

**AP 1a.** The projected maximum bed need for child, adolescent, and adult acute psychiatric beds is calculated using the Commission's statewide child, adolescent, and adult acute psychiatric bed need projection methodologies specified in this section of the State Health Plan. Applicants for Certificates of Need must state how many child, adolescent, and adult acute psychiatric beds they are applying for in each of the following categories: net acute psychiatric bed need, and/or state hospital conversion bed need.

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#### Applicant Response:

There is no current or recent Commission statewide child, adolescent, or adult bed need projection. Moreover, the bed need projection methodologies set forth in the State Health Plan for Psychiatric Services are outdated and obsolete. The Applicant has projected need for the relocated psychiatric beds in response to Standard 10.24.01.08G(3)(b), pp. 58-67.

**AP 1b.** A Certificate of Need applicant must document that it has complied with any delicensing requirements in the State Health Plan or in the Hospital Capacity Plan before its application will be considered.

---

#### Applicant Response:

This standard is inapplicable; there are no delicensing requirements applicable to the proposed project.

**AP 1c.** The Commission will not docket a Certificate of Need application for the "state hospital conversion bed need" as defined, unless the applicant documents written agreements with the Mental Hygiene Administration. The written agreements between the applicant and the Mental Hygiene Administration will specify:

- (i) the applicant's agreement to screen, evaluate, diagnose and treat patients who would otherwise be admitted to state psychiatric hospitals. These patients will include: the uninsured and underinsured, involuntary, Medicaid and Medicare recipients;
- (ii) that an equal or greater number of operating beds in state facilities which would have served acute psychiatric patients residing in the jurisdiction of the applicant hospital will be closed and delicensed, when the beds for the former state patients become operational;

(iii) that all patients seeking admission to the applicant's facility will be admitted to the applicant's facility and not be transferred to the state psychiatric hospital unless the applicant documents that the patient cannot be treated in its facility; and

(iv) that the applicant and the Mental Hygiene (MHA) Administration will be responsible for assuring financial viability of the services, including the payment of bad debt by DHMH as specified in the written agreement between MHA and the applicant.

---

*Applicant Response:*

This standard is inapplicable; the proposed project does not involve state hospital conversion beds.

**AP 1d. Preference will be given to Certificate of Need applicants applying for the "net adjusted acute psychiatric bed need," as defined, who sign a written agreement with the Mental Hygiene Administration as described in part (i) and (iii) of Standard AP 1 c.**

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*Applicant Response:*

This standard is inapplicable.

**AP 2a. All acute general hospitals with psychiatric units must have written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 days a week with no special limitation for weekends or late night shifts.**

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*Applicant Response:*

UM SMC at Easton is a 24/7 acute general hospital. The psychiatric services that will be provided at UM SMC at Easton will follow written procedures already implemented within UM SRH for providing psychiatric emergency inpatient services 24/7 with no special limitation for weekend or late night shifts. These policies are specific to psychiatric services that will be provided at UM SMC at Easton and include:

- Behavioral Health Response Team Inquiry Calls Policy (See **Exhibit 20**)
- Admission Criteria Adult Psychiatric Inpatient (See **Exhibit 21**)
- Assessment for Admission of Patients to Inpatient Behavioral Health Unit (See **Exhibit 22**)

Each of the psychiatric protocols, policies, and procedures referenced in this section will be updated as appropriate to reflect their application to UM SMC at Easton prior to the transfer of psychiatric beds from UM SMC at Dorchester to UM SMC at Easton.

**AP 2b. Any acute general hospital containing an identifiable psychiatric unit must be an emergency facility, designated by the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition.**

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[Applicant Response:](#)

The proposed replacement Hospital will be an acute general hospital with a 26-bay emergency department, including two rooms that are designated as psychiatric holding areas for psychiatric patients awaiting disposition. The facility is designated by the Maryland Department of Health to perform evaluations of persons believed to have a mental disorder and brought to the hospital on an emergency petition.

**AP 2c. Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.**

---

[Applicant Response:](#)

The replacement hospital will include two designated psychiatric emergency holding treatment rooms in the emergency department (Level 1) as well as a seclusion room in the behavioral health unit (Level 6).

**AP 3a. Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.**

---

[Applicant Response:](#)

The inpatient acute psychiatric program provides an array of services. The services include psychotropic medication therapy, individual therapy, group therapy, family therapy, social services, and co-occurring addictions treatment. All services are provided by dedicated staff assigned to the unit. Recreational therapy activities are provided by psychiatric technicians and by community-based providers. Social services are provided by the social worker and case management team dedicated to the behavioral health unit. Occupational and physical therapy services are provided on a consultative basis through the UM SRH Rehabilitation Department. If an inpatient behavioral health patient requires chemotherapy, UM SMC at Easton intends to transfer the patient to the MSGA inpatient unit within the facility or to the UM SRH Cancer Center in Easton to receive outpatient services.



**AP 3b. In addition to the services mandated in Standard 3a., inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills, psychoeducational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.**

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*Applicant Response:*

This standard is inapplicable because UM SMC at Easton does not provide inpatient child or adolescent acute psychiatric services.

**AP 3c. All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.**

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*Applicant Response:*

Psychiatric consultation services will be provided by UM SRH's Psychiatry Department. The department will be staffed by 4.0 FTE psychiatric providers comprised of psychiatrists and mental health nurse practitioners. Services are provided 7 days per week. Additional consultation and referral services will be provided by the hospital's Behavioral Health Response Team, a group of licensed social workers and counselors who provide evaluation services and referral to patients.

**AP 4a. A Certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.**

---

*Applicant Response:*

The Applicant is not proposing to add child or adolescent psychiatric beds as part of this application.

**AP 4b. Certificate of Need applicants proposing to provide two or more age specific acute psychiatric services must provide that physical separations and clinical/programmatic distinctions are made between the patient groups.**

---

*Applicant Response:*

This standard is inapplicable because the proposed project does not involve two or more age-specific psychiatric service lines.

**Accessibility**

**AP 5. Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:**

- (i) intake screening and admission;**
  - (ii) arrangements for transfer to a more appropriate facility for care if medically indicated; or**
  - (iii) necessary evaluation to define the patient's psychiatric problem and/or**
  - (iv) emergency treatment.**
- 

*Applicant Response:*

Once a patient has requested admission to UM SMC at Easton's behavioral health unit, the hospital will provide the following services: intake screening and admission or arrangements for transfer when a more appropriate treatment facility is indicated, and evaluation to better define the patient's psychiatric problem and to initiate emergency treatment. These functions will be provided through the Hospital's emergency department and psychiatry department. See **Exhibit 21** for UM SRH's Admission Criteria Adult Psychiatric Treatment Policy and **Exhibit 22** for UM SRH's Assessment for Admission of Patients to Inpatient Behavioral Health Unit, which provide more details on how these services will be provided at UM SMC at Easton.

**AP 6. All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special populations including: children, adolescents, patients with secondary diagnosis of substance use, and geriatric patients, either through direct treatment or referral.**

---

*Applicant Response:*

Within the general adult unit at UM SMC at Easton, geriatric and patients with a co-morbidity of substance use disorder will be treated. The treatment team will consist of

psychiatrists, nurses, and therapists with training and expertise in geriatrics, substance use disorder, and general psychiatry.

UM SMC at Dorchester's present behavioral health quality assurance program and program evaluation process will be implemented at UM SMC at Easton after the unit is transferred to the existing UM SMC at Easton facility pursuant to its pending CON exemption request. UM SMC at Dorchester's Behavioral Health Quality Assurance policy is attached as **Exhibit 23**. UM SMC at Dorchester's treatment protocols for special behavioral health populations, including for geriatric patients and patients with a secondary diagnosis of substance use disorder, will also be implemented at the existing and replacement UM SMC at Easton facilities. These treatment protocols are attached as **Exhibit 24**.

**AP 7. An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.**

---

*Applicant Response:*

The Applicant does not seek a CON for new or expanded acute psychiatric services. Nevertheless, patients will be admitted to the Behavioral Health unit regardless of their legal status. Patients are accepted for admission based on their clinical presentation and the availability of beds in the inpatient psychiatric unit. See UM SRH's Assessments for Admission of Patients to Inpatient Behavioral Health Unit provided as **Exhibit 22**.

**AP 8. All acute general hospitals and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the Health Services Cost Review Commission for the most recent 12 month period.**

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*Applicant Response:*

UM SMC at Easton intends to provide a level of uncompensated care that equals or exceeds the average uncompensated care for acute psychiatric patients in the service area.

As explained in response to COMAR 10.24.01.08G(3)(b) below, UM SMC at Easton's projected adult psychiatric service area includes Dorchester, Talbot, Caroline, Kent, Queen Anne's, and Anne Arundel Counties. The current providers of acute psychiatric services in this service area include UM SMC at Easton, UM SMC at Dorchester, Peninsula Regional Medical Center, and Atlantic General Hospital. UM SMC at Dorchester and UM SMC at Easton's percentages of uncompensated care are based on their fiscal year 2017 actual percentages of uncompensated care of 5.11% and 3.43%, respectively. This level of uncompensated care was published in the fiscal year 2017 HSCRC Annual Report of Revenue and Expenses and Volumes and reflects the level of uncompensated care for the entire hospital.

Combined with patients from UM SMC at Dorchester, UM SMC at Easton's percentage of uncompensated care is greater than the average 3.94% of uncompensated care provided by UM SMC at Easton, UM SMC at Dorchester, Peninsula Regional Medical Center, and Atlantic General, the four acute general hospitals providing psychiatric services in the health service area. (Table 65).

**Table 65**  
**Health Service Area Uncompensated Care Percent of Revenue**

<u>Hospital</u>	<u>FY2017 Percent UCC</u>
UM SMC at Easton	3.43%
UM SMC at Dorchester	5.11%
<b>SHS Average</b>	<b>4.27%</b>
Peninsula Regional Medical Center	3.88%
Atlantic General	4.58%
<b>Health Service Area Average</b>	<b>3.94%</b>

Source: FY2017 HSCRC Annual Report of Revenue and Expenses and Volumes

**AP 9. If there are no child acute psychiatric beds available within a 45 minute travel time under normal road conditions, then an acute child psychiatric patient may be admitted, if appropriate, to a general pediatric bed. These hospitals must develop appropriate treatment protocols to ensure a therapeutically safe environment for those child psychiatric patients treated in general pediatric beds.**

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*Applicant Response:*

The pediatricians and the psychiatrists at UM SRH have developed treatment protocols for caring for pediatric psychiatric patients while they await transfer to another facility with pediatric inpatient bed capacity, which sometimes involves admission to a general pediatric bed. Attached as **Exhibit 25** is a decision chart and a Pediatric Behavioral Policy, which describes UM SMC at Easton's treatment protocol for pediatric psychiatric patients.

**AP 10. Expansion of existing adult acute psychiatric bed capacity will not be approved in any hospital that has a psychiatric unit that does not meet the following occupancy standards for two consecutive years prior to formal submission of the application.**

<u>Psychiatric Bed Range (PBR)</u>	<u>Occupancy Standards</u>
PBR <20	80%
20 ≤PBR <40	85%
PBR ≥40	90%

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*Applicant Response:*

This standard is inapplicable because the proposed project does not involve expansion of existing adult care psychiatric beds.

**AP 11. Private psychiatric hospitals applying for a Certificate of Need for acute psychiatric beds must document that the age-adjusted average total cost for an acute (≤ 30 days) psychiatric admission is no more than the age-adjusted average total cost per acute psychiatric admission in acute general psychiatric units in the local health planning area.**

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*Applicant Response:*

The standard is inapplicable because UM SMC at Easton is applying for an exemption to transfer existing adult psychiatric beds to another general acute care hospital.

**Quality**

**AP 12a. Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.**

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*Applicant Response:*

The acute inpatient psychiatric services provided at UM SMC at Easton will be under the clinical supervision of a qualified psychiatrist, Dr. Eric Anderson. Dr. Anderson is the current Medical Director for the behavioral health inpatient unit of UM SMC at Dorchester as well as the Department of Psychiatry Chairperson and will continue in these roles when the behavioral health inpatient unit transfers to the existing and replacement UM SMC at Easton facilities. He will continue to oversee 4.0 FTE psychiatric providers comprised of psychiatrists and mental health nurse practitioners and provide clinical supervision to the nursing staff and therapists within the department. Dr. Anderson also leads training, quality improvement, and program development efforts for the Department of Psychiatry and its acute, inpatient unit.

Dr. Anderson has served as Medical Director for Shore Behavioral Health since July of 2013 and the Chairman of the Department of Psychiatry since 2017. Dr. Anderson is Board Certified in Psychiatry. He received his undergraduate degree from Iowa State University. He received his medical degree from the University of Iowa, his internship training in Family Practice at Pensacola Naval Hospital, and completed his psychiatric training at the Johns

Hopkins Hospital in Baltimore. During his psychiatric residency, Dr. Anderson served as Chief Resident in Psychiatry. While in the U.S. Navy and prior to his psychiatric residency, he completed the Naval Aerospace Medicine Institute's Naval Flight Surgeon School.

Prior to coming to UM SRH, Dr. Anderson was in private practice in the Annapolis area and served as Chief Psychiatrist for Anne Arundel Medical Center. In 2011 he was named a "Top Doc." He is also an Assistant Professor for the University of Maryland's School of Medicine and a Clinical Instructor for Drexel University. He is a reviewer for a number of medical periodicals and has a lengthy list of published articles, book chapters, and interviews to his own credit. He also serves as an independent reviewer for the Maryland Board of Physicians.

Dr. Anderson directs the psychiatric care provided through UM SRH including the current 24-bed inpatient acute psychiatric unit at UM SMC at Dorchester, mental health intensive outpatient program, addictions intensive outpatient program, consultation-liaison service, and outpatient clinic. In addition to the above duties, he is a flight surgeon for the U.S. Air Force, having completed the Air Force's Flight Surgeon School. He serves as the chief flight surgeon for the 104th Fighter Squadron in Maryland's Air National Guard.

**AP 12b. Staffing of acute psychiatric programs should include therapies for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven day per week treatment program.**

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*Applicant Response:*

A psychiatrist or mental health nurse practitioner is provided for each patient in the unit. Each patient is assigned to a therapist and a case manager who helps with coordination of services and referrals. See **Exhibit 26** for UM SRH's Behavioral Health Discharge Planning and Referral Policy, which provides additional information on UM SRH's Patient Care Services team, which provides referral and coordination services for patients being discharged from its behavioral health unit. The treatment program covers a seven day period. Staffing for this unit is also provided seven days per week.

**AP 12c. Child and/or adolescent acute psychiatric units must include staff who have experience and training in child and/or adolescent acute psychiatric care, respectively.**

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*Applicant Response:*

This standard is inapplicable because the proposed project does not involve child or adolescent psychiatric units.

**AP 13. Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term**

care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

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*Applicant Response:*

Attached as **Exhibit 26** is UM SRH's Behavioral Health Discharge Planning and Referral Policy, which governs discharge planning and referrals for patients being discharged from the behavioral health unit. This policy includes providing patients referrals and coordinating other services as needed, including: outpatient psychiatric treatment, community based programming, long term care, and other specialized inpatient care or referrals.

**Acceptability**

**AP 14. Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:**

- (i) the local and state mental health advisory council(s);**
- (ii) the local community mental health center(s);**
- (iii) the Department of Health and Mental Hygiene; and**
- (iv) the city/county mental health department(s).**

**Letters from other consumer organizations are encouraged.**

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*Applicant Response:*

This standard is inapplicable because UM SRH is not proposing a new or expanded program.

**COMAR 10.24.01.08G(3)(b). NEED—Building Replacement, Psychiatric Beds, and Observation Beds**

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

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

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

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

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

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

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

**Applicant Response:**

Please see discussion of bed and capacity need in response to COMAR 10.24.10.04B(2) (acute care bed need); COMAR 10.24.10.04B(14) (emergency department space); COMAR 10.24.12.04(1) (obstetric bed need); COMAR 10.24.11.05B(2) (operating rooms); and COMAR 10.24.09.04B(2) (acute rehabilitation bed need). The discussion below addresses: (1) the need to replace the aging and obsolete existing building; (2) the need for inpatient psychiatric beds; and (3) the need for observation beds, which is not subject to any need standard under the State Health Plan.



## **1. The Need to Replace the Existing Hospital Building.**

The existing building is deficient in many ways. It is not designed for modern, family oriented medicine. It is undersized in various critical areas (such as the size of the operating rooms). It does not have adequate parking. The footprint of the Hospital building cannot be expanded (being surrounded by residential areas) and is inconvenient for the many patients from outside Easton who have to drive into downtown Easton to access the Hospital. Although the outpatient component is newer, it was designed to be an addition to the older building components and, therefore, suffers from considerable limitations.

Prior to submitting its CON application in 2012, the Applicant engaged The Schachinger Group ("TSG") to conduct departmental interviews, meeting with representatives from many clinical and service-oriented departments. The numerous findings as to existing physical space deficiencies and limitations affected nearly every department in the hospital. A summary is presented below, followed by issues specific to departments identified in the TSG's interviews.

Not surprising, given the age and limited space of the existing hospital facility, there are many concerns about the existing physical plant, which are summarized below.

- Location and accessibility of supplies are not optimal. Hoarding of supplies is common. Night and weekend supply searches occur often by nursing staff.
- An inordinate amount of staff time is taken with supply and inventory ordering, tracking, and maintenance. Much of the work is manual. Par levels may be higher than necessary to mitigate supply chain problems.
- General lack of storage throughout the hospital has resulted in inefficient use of staff time and cluttered hallways. Patient rooms have been closed and used for storage as no central storage area for beds and other necessary equipment exists. A semi-private bed area on almost every floor has been closed for storing beds, computer carts, blood pressure cuffs, and other equipment.
- The elevators are too small for larger patient transports and are inconveniently located, both in terms of physical location and difficulty getting there through the corridors. Elevator protocol leaves some departments with very long wait times. Patients in transport are always exposed to public spaces.
- The rooftop helipad is too small to accommodate Maryland State police helicopter transports, so the helicopter must land at the airport and the patient must be transferred by vehicle.
- Concerns were voiced regarding cleaning certain equipment or transporting equipment to be cleaned. Locations for equipment storage rooms have been debated; centralized versus a more common call for decentralized storage on patient floors. The request to have Environmental Services ("EVS") clean equipment was heard and responded to positively.
- Clean and especially soiled utility rooms must be sized appropriately for the units. The existing soiled utility rooms are considerably under sized.

- Par levels need better management. There is no way to electronically reconcile supplies to inventory, so a lot of time is spent doing it manually. A better system is needed for tracking, billing, and reordering supplies. Some form of automation, bar-codes or similar, was mentioned as desirable.
- The structure and configuration of the facility makes wayfinding difficult.

### **The Emergency Department**

- There is no elevator near the emergency department. It is a long trip to the main hospital elevators, and even further to the helipad elevator. The trip to an elevator includes maneuvering many corners. In addition, there are no oversized elevators for patient transport. It is difficult for a critical care team to squeeze into the elevator. The helipad elevator, which typically handles larger teams, is smaller than the other elevators in the hospital. This elevator is also used extensively by materials management for supply transport.
- While the emergency department does not have many extra beds and stretchers, there is no storage space for storing the extras.
- The Pneumatic Tube System station is located in the middle of the nurses' station, which is not ideal because a column blocks lines of sight within the area.
- Location and accessibility of supplies is an issue; the supply room is down a hallway (about 200 feet away) and is not convenient or near the nurses' station. Centralized supplies in emergency department (Pyxis stations preferred) would reduce staff steps required. Because there is no central supply, the nurses tend to hoard high-demand items as they do not know when they will get more. Reducing the amount of steps to get supplies to make things more accessible in general would be welcomed.
- Patient care equipment is stored in numerous locations due to space limitations, making the equipment difficult to locate, charge, and track.
- There are two soiled utility rooms. Neither is large enough for trash and dirty supplies (particularly bedside commodes). There is a need for three utility rooms: soiled, clean, and storage.
- Environmental Services has a small storage space in the emergency department, however additional room is needed to store cubicle curtains.
- There is no practical storage space for dietary carts. Special delivery trays are often left on top of the nurse station counters. There is no collection area for dirty trays; a pick up / drop off location is needed.

### **Dietary**

- There are long waits for elevators, especially when one is down.

## **Imaging**

- Elevator sizes are an issue. One can barely access the control panel when transporting a patient by bed, as the bed barely fits in the elevator. When the patient is transported with additional equipment and a multiple person team, the elevator is cramped.

## **Infection Control**

- Clean and soiled utility rooms are inadequately sized for current usage.
- Need for private rooms in order to accommodate the number of isolation patients.
- Isolation supplies are kept on a cart outside the patient's room. This creates hallway clutter. Nurse servers are difficult to keep clean.
- Separate rooms for clean and soiled are preferred by the Joint Commission. Custom ultrasonic equipment travels in and out of soiled rooms, even after cleaning.
- Placement of sinks is not ideal. Sinks should be placed closer to room exit.
- Negative pressure isolation room(s) are inadequate.
- Bed storage is an issue.
- Deliveries from vendors / suppliers to Materials Management must be unpacked for storage and not stored on the units in shipping containers.
- Sinks aren't deep enough. Design and depth of sinks needs to be considered.

## **Inpatient Care Services/Nursing**

- The warehouse where most supplies are stored is too far away from the clinical areas, which is critical during the hours when Materials Management is not staffed and nursing supervisors are required to find necessary items.
- An area is needed for storing supplies and equipment that has been cleaned and is ready for use. Storage for soiled equipment is lacking. When needed, equipment has to be located and the status (clean/soiled) is often unknown. Much time is wasted looking for items needed for patient care.
- Storage is a major concern. Having no central storage area for beds and other necessary equipment, a semi-private bed area on inpatient units have been closed for storing beds, computer carts, blood pressure cuffs, and other equipment. Many items are stored in the hallways. The existing utility rooms have electric panels on the inside walls, reducing the ability for optimum storage.
- Because of the transition to electronic records, there should be a computer located at every bed side.

- Nurses must often locate, clean, and store the equipment necessary for their functions. This takes valuable time away from patient care. With no central supply, items cannot be requisitioned and delivered on an on-call basis. There should be adequate space and EVS staff to pick up soiled items, clean, return, and place in storage.
- The elevators are too small to transport a patient with patient care equipment and the necessary transport team. There are a large number of bariatric patients at SHS and transportation of those patients requires additional equipment and staff, as well as wider doorways.

### **Laboratory**

- The lab is currently in a space that was not originally designed to be a lab. The layout for the new hospital needs to be reconfigured with blood bank in front; supervisor offices segregated; a more open layout (not compartmentalized); better access to phone, printers, and computers; and adequate space for automation.

### **Linen Services**

- On the floors, linens are stored in a variety of areas, depending on space and department. Storage areas include linen closets, clean utility rooms, and hallways.

### **Materials Management**

- Multi-levels of receiving and supply storage are not efficient. Traffic patterns and busy intersections within the hospital are not optimal. The ideal dock area at the new facility would be well lit with a recessed overhang that is high enough to not be damaged by large trucks. The docks should be 48" high with a generous ramp and a large staging area.
- The delivery of supplies and storage of waste is inadequate due to the physical configuration of the current space.
- Emergency supplies are located in trailers on the campus and in off-site, rented, climate controlled storage. These should all be stored on site.
- IT storage room is needed as well. Placement will depend on where the IT department is eventually located.
- Cylinder storage is also inadequate at the existing facility but will be improved at the proposed facility.
- Bulk gas is automatically refilled by the vendor when the meter reaches a certain level, so deliveries are unscheduled. While the delivery truck is refilling the tanks, the truck must park across the loading dock bay, blocking the loading dock.

### **Outpatient Services and Surgery**

- There is no Central Supply to store and supply what is used by multiple departments, so multiples of the same supplies are spread throughout the building. Multiples are common and unnecessary, and there are a lot of special orders. Materials Management does not have the necessary space for this storage.
- The elevators are not large enough to support the equipment and large teams. The gap between the door and the floor is large and catches the wheels of beds, carts, and gurneys. The location of the service elevators is inconvenient to the OR and travel involves multiple turns, corners, and intersections. Easy access between the OR and ICU is planned for the new facility, whether by adjacency or by elevator.

### **Pharmacy**

- The hospital has a 6" Translogic (Swisslog) Pneumatic Tube System. Most stations are not located within the secure nursing area, making it inconvenient. It is also loud; having been installed after the hospital was built. It has been changed at least once.

### **Plant Operations (Engineering/Maintenance)**

- The maintenance area is located in a bay beside the receiving dock. They are short on equipment storage space for items such as televisions, wheelchairs, and beds. They need expanded organized storage with standard wire shelving and sufficient space to navigate around them. Drawers, pipe racks, and lumber racks are necessary.
- Storage is the major issue with Bio-Med, which has 2,500 pieces of equipment. There is no central storage; their equipment is located throughout the hospital.

### **Respiratory Services**

- The outpatient services performed by the department are on the third and fourth floors, which is not convenient. Patients often have problems with wayfinding.
- There is no Pneumatic Tube Station in respiratory care or the cardiac catheterization lab.
- Elevators are an issue at the existing facility when moving equipment. The size of the elevators and usage by other departments makes it difficult to transport respiratory equipment. Wait times at the elevators are long due to multiple use causing delays in transporting equipment for patient care.
- The department has limited space for storage of soiled equipment.

### **Sterile Processing and Surgery**

- The cart washer can only handle one cart at a time, with a cycle of 20-30 minutes. A backup of 2 to 4 carts is common and very limited storage for the cleaned carts

waiting to be filled; the staff must work around these extra carts. There is also no storage for prepared case carts, which line up in the operating room area.

- There are storage issues with portable equipment. This equipment should be stored at point of use, but there is not enough space or enough staff; it is stored where ever space can be found.
- Two double-well sinks are in Sterile Processing, but only one is utilized due to storage issues.

Thus, the proposed project is needed to replace an aged facility that has deficiencies in nearly every department.

## **2. The Need for Inpatient Psychiatric Beds.**

The Commission has recognized that many of the standards in the State Health Plan Chapter for psychiatric Services are “out of date due to dramatic changes in use of hospital psychiatric beds (especially with respect to average length of stay) and changes in the role and scope of State psychiatric hospital facilities that have occurred since its development” and that the State Health Plan “does not have an applicable need analysis.” (*In re Sheppard Pratt at Elkridge*, Docket No. 15-152367, Staff Report and Recommendation pp. 5, 13 (Sept. 20, 2016)).

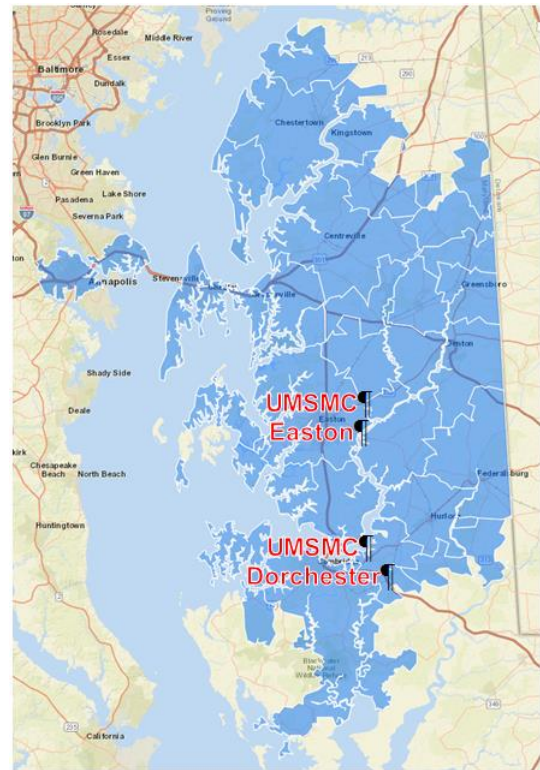
To project psychiatric bed need at UM SMC at Dorchester through fiscal year 2021, at the existing UM SMC at Easton facility beginning in fiscal year 2022, and at the replacement hospital for UM SMC at Easton beginning in fiscal year 2025, the Applicant utilized a modified MSGA need analysis. The projected need for inpatient psychiatric beds reflect the methodology and assumptions described below.

### **a. Defining UM SMC at Dorchester and UM SMC at Easton’s Psychiatric Service Area**

To determine the proposed psychiatric service area for UM SMC at Dorchester in the near term and at UM SMC at Easton in the long term, the Applicant considered the fiscal year 2017 discharges by ZIP code for the adult psychiatric cohort at UM SMC at Dorchester. Child and adolescent psychiatric discharges were excluded from this analysis because UM SMC at Dorchester does not currently provide psychiatric inpatient treatment to children and adolescent patients and will not provide these services at the replacement hospital for UM SMC at Easton. The Applicant identified the adult psychiatric service area as the ZIP codes that comprise the top 85% of adult psychiatric discharges in FY 2017 at UM SMC at Dorchester.

**Figure 6**  
**UM SMC at Dorchester's Adult Psychiatric Service Area**  
**FY2017**

<u>ZipCode</u>	<u>City</u>	<u>ZipCode</u>	<u>City</u>
21613	Cambridge	21658	Queenstown
21601	Easton	21662	Royal Oak
21629	Denton	21663	Saint Michaels
21620	Chestertown	21671	Tilghman
21643	Hurlock	21623	Church Hill
21632	Federalsburg	21631	East New Market
21655	Preston	21625	Cordova
21638	Grasonville	21679	Wye Mills
21617	Centreville	21657	Queen Anne
21619	Chester	21659	Rhodesdale
21639	Greensboro	21835	Linkwood
21666	Stevensville	21626	Crapo
21660	Ridgely	21409	Annapolis
21673	Trappe	21636	Goldsboro
21661	Rock Hall	21677	Woolford
21678	Worton	21644	Ingleside
21401	Annapolis	21654	Oxford
21640	Henderson	21647	Mcdaniel
21649	Marydel	21676	Wittman



As presented in Figure 6 above and Table 66 below, UM SMC at Dorchester's service area for the adult (aged 18 and over) psychiatric cohort is defined by ZIP codes that span Dorchester, Talbot, Caroline, Kent, Queen Anne's, and Anne Arundel Counties in Maryland. As shown in Table 66, the ZIP Codes for adult psychiatric discharges from UM SMC at Dorchester are ranked from highest to lowest to identify the top 85% of total discharges.

**Table 66**  
**UM SMC at Dorchester's Adult Psychiatric Service Area**  
**FY 2017**

#	Zip Code	Community	Total Discharges	Cumulative % of Discharges
1	21613	Cambridge	112	20.6%
2	21601	Easton	66	32.7%
3	21629	Denton	41	40.3%
4	21620	Chestertown	37	47.1%
5	21643	Hurlock	29	52.4%
6	21632	Federalsburg	24	56.8%
7	21655	Preston	19	60.3%
8	21638	Grasonville	14	62.9%
9	21617	Centreville	13	65.3%
10	21619	Chester	12	67.5%
11	21639	Greensboro	10	69.3%
12	21666	Stevensville	9	71.0%
13	21660	Ridgely	8	72.4%
14	21673	Trappe	8	73.9%
15	21661	Rock Hall	5	74.8%
16	21678	Worton	5	75.7%
17	21401	Annapolis	5	76.7%
18	21640	Henderson	4	77.4%
19	21649	Marydel	4	78.1%
20	21658	Queenstown	4	78.9%
21	21662	Royal Oak	4	79.6%
22	21663	Saint Michaels	4	80.3%
23	21671	Tilghman	4	81.1%
24	21623	Church Hill	3	81.6%
25	21631	East New Market	3	82.2%
26	21625	Cordova	2	82.5%
27	21679	Wye Mills	2	82.9%
28	21657	Queen Anne	2	83.3%
29	21659	Rhodesdale	2	83.6%
30	21835	Linkwood	2	84.0%
31	21626	Crapo	2	84.4%
32	21409	Annapolis	2	84.7%
33	21636	Goldsboro	1	84.9%
34	21677	Woolford	1	85.1%
35	21644	Ingleside	1	85.3%
Other Service Area			80	85.3%
Service Area Total			464	85.3%
Outside of Service Area			80	100.0%
Total			544	100.0%

Source: St. Paul statewide non-confidential data tapes

#### **b. Projected Adult Psychiatric Service Area Population**

Based on UM SMC at Dorchester's adult psychiatric service area, population projections through 2023 were obtained from Environics Spotlight (formerly Nielsen Claritas) for the 15-64 age cohort, the 65-74 age cohort and the 75+ age cohort, which are reflected below in Table 67. The 15-64 age cohort is expected to decline by 1.0% from 2018 to 2023, while the 65-74 age



cohort is expected to grow by 17.1%, and the 75+ age cohort is expected to grow by 7.7%. Combined, the total service area population is projected to grow by 2.6% from 2018 to 2023.

**Table 67**  
**UM SMC at Dorchester's Historical and**  
**Projected Adult Psychiatric Service Area Population**  
**2010 – 2023**

Age Group	Service Area Population						% Change in Population	
	2010		2018		2023		2010-18	2018-23
	Pop	% of Total	Pop	% of Total	Pop	% of Total		
15-64	138,490	78.7%	134,705	74.3%	133,348	71.7%	-2.7%	-1.0%
65-74	20,469	11.6%	26,864	14.8%	31,470	16.9%	31.2%	17.1%
75+	17,078	9.7%	19,676	10.9%	21,189	11.4%	15.2%	7.7%
<b>Total</b>	<b>176,037</b>	<b>100.0%</b>	<b>181,245</b>	<b>100.0%</b>	<b>186,007</b>	<b>100.0%</b>	<b>3.0%</b>	<b>2.6%</b>

Source: Environics Spotlight Pop-Facts Demographics by Age Race Sex

Using the compounded annual growth rate from 2018 to 2023, as set forth above in Table 67, population projections were extrapolated through 2027 and applied to the projected fiscal years for UM SMC at Dorchester and UM SMC at Easton. Table 68 below depicts the projected service area population for the 15-64, 65-74, and 75+ age cohorts through 2027. Combined, the total population is expected to grow by 0.5% to 0.6% per year for a total growth of 5.1% from fiscal years 2018 to 2027.

**Table 68**  
**UM SMC at Dorchester's Historical and**  
**Projected Adult Psychiatric Service Area Population**  
**FY2016 - FY2027**

	Historical			Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
Service Area Population													
18-64	135,641	135,172	134,705	134,432	134,161	133,889	133,618	133,348	133,078	132,809	132,540	132,272	-1.8%
65-74	25,099	25,966	26,864	27,728	28,619	29,540	30,490	31,470	32,482	33,526	34,604	35,717	33.0%
75+	18,992	19,331	19,676	19,970	20,268	20,570	20,877	21,189	21,505	21,826	22,152	22,483	14.3%
Total	179,732	180,470	181,245	182,130	183,048	183,999	184,985	186,007	187,065	188,162	189,297	190,472	5.1%
%Change		0.4%	0.4%	0.5%	0.5%	0.5%	0.5%	0.6%	0.6%	0.6%	0.6%	0.6%	

### c. UM SMC at Dorchester Adult Psychiatric Use Rates

Use rates for the patient population cohorts were established based on historical trends in use rates that were calculated and projected per 1,000 population. Use rates in UM SMC at Dorchester's adult psychiatric service area declined in fiscal year 2017 and have declined year-to-date (quarters one and two) in fiscal year 2018. After experiencing these declines, future use rates are assumed to level off and remain constant, at each age cohort, with the use rates

experienced in fiscal year 2018 year to date, while aging of the population will drive a lower overall use rate by fiscal year 2027, as the older two age cohorts have lower projected use rates than the younger age cohort (Table 69).

**Table 69**  
**UM SMC at Dorchester's Historical and**  
**Projected Adult Psychiatric Use Rates**  
**FY2016 - FY2027**

	Actual FY2016	Actual FY2017	Annualized FY2018	Projected									% Change FY18-FY27
Use Rate				FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
15-64	5.6	5.1	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2	
%Change		-8.8%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
65-74	2.7	2.7	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	
%Change		0.9%	-42.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
75+	2.6	3.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	
%Change		50.4%	-24.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Total</b>	<b>4.9</b>	<b>4.6</b>	<b>4.4</b>	<b>4.4</b>	<b>4.4</b>	<b>4.4</b>	<b>4.4</b>	<b>4.3</b>	<b>4.3</b>	<b>4.3</b>	<b>4.3</b>	<b>4.3</b>	
% Change		-5.0%	-4.1%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-0.5%	-3.7%

#### d. Adult Psychiatric Service Area Discharges

With the growth in population and shift to older patients with lower use rates, total adult psychiatric discharges are projected to increase by 1.2% from fiscal year 2018 to 2027 (Table 70), a rate slower than that of total population growth of 5.1% shown above in Table 68.

**Table 70**  
**UM SMC at Dorchester's Historical and**  
**Projected Adult Psychiatric Service Area Discharges**  
**FY2016 – FY2027**

	Actual FY2016	Actual FY2017	Annualized FY2018	Projected									% Change FY18-FY27
Service Area Discharges				FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
15-64	756	687	702	701	699	698	696	695	694	692	691	689	-1.8%
%Change		-9.1%	2.2%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	
65-74	68	71	42	43	45	46	48	49	51	52	54	56	33.0%
%Change		4.4%	-40.8%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	
75+	49	75	58	59	60	61	62	62	63	64	65	66	14.3%
%Change		53.1%	-22.7%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	
<b>Total</b>	<b>873</b>	<b>833</b>	<b>802</b>	<b>803</b>	<b>804</b>	<b>805</b>	<b>806</b>	<b>807</b>	<b>808</b>	<b>809</b>	<b>810</b>	<b>811</b>	<b>1.2%</b>
%Change		-4.6%	-3.7%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.2%	

#### e. Adult Psychiatric Market Share

The expected market share at UM SMC at Dorchester was calculated within the planned service area based on the number of fiscal year 2017 psychiatric discharges for the 15-64,

65-74, and 75+ age cohorts at UM SMC at Dorchester as a percentage of total adult psychiatric discharges within the service area.

UM SMC at Dorchester's adult psychiatric market share decreased from fiscal year 2016 to fiscal year 2018 year to date in the 15-64 age cohort, but increased in the 65-74 and 75+ age cohorts. Going forward, UM SMC at Easton's market share is projected to remain constant, at each age cohort, from fiscal year 2018 at UM SMC at Dorchester until the end of the projection period in fiscal year 2027 at UM SMC at Easton (Table 71).

**Table 71**  
**UM SMC at Dorchester's Historical and**  
**Projected Adult Psychiatric Market Share**  
**FY2016 - FY2027**

	Actual FY2016	Actual FY2017	Annualized FY2018	Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
<b>Market Share</b>													
<b>15-64</b>	<b>62.7%</b>	<b>59.8%</b>	<b>57.5%</b>	<b>57.5%</b>	<b>57.5%</b>	<b>57.5%</b>	<b>57.5%</b>	<b>57.5%</b>	<b>57.5%</b>	<b>57.5%</b>	<b>57.5%</b>	<b>57.5%</b>	
%Change		-4.6%	-3.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>65-74</b>	<b>54.4%</b>	<b>52.1%</b>	<b>71.4%</b>	<b>71.4%</b>	<b>71.4%</b>	<b>71.4%</b>	<b>71.4%</b>	<b>71.4%</b>	<b>71.4%</b>	<b>71.4%</b>	<b>71.4%</b>	<b>71.4%</b>	
%Change		-4.2%	37.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>75+</b>	<b>18.4%</b>	<b>21.3%</b>	<b>31.0%</b>	<b>31.0%</b>	<b>31.0%</b>	<b>31.0%</b>	<b>31.0%</b>	<b>31.0%</b>	<b>31.0%</b>	<b>31.0%</b>	<b>31.0%</b>	<b>31.0%</b>	
%Change		16.1%	45.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Total</b>	<b>59.6%</b>	<b>55.7%</b>	<b>56.4%</b>	<b>56.4%</b>	<b>56.4%</b>	<b>56.3%</b>	<b>56.3%</b>	<b>56.3%</b>	<b>56.3%</b>	<b>56.3%</b>	<b>56.3%</b>	<b>56.3%</b>	
%Change		-6.5%	1.3%	0.0%	0.0%	-0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-0.2%

#### f. Out-of-Service Area Adult Psychiatric Discharges

UM SMC at Dorchester's out-of-service area adult psychiatric discharges declined in fiscal year 2017 as a percentage of total discharges, but then increased in fiscal year 2018 year to date. Out-of-service area discharges are expected to remain constant, at each age cohort, at the 2018 level through fiscal year 2027 (Table 72).

**Table 72**  
**UM SMC at Dorchester's Out-of-Service Area Adult Psychiatric Discharges**  
**% of Service Area Discharges**  
**FY2016 - FY2027**

	Actual FY2016	Actual FY2017	Annualized FY2018	Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
<b>Out-of-Service Area Discharges % of Service Area Discharges</b>													
<b>15-64</b>	<b>26.2%</b>	<b>18.7%</b>	<b>24.3%</b>	<b>24.3%</b>	<b>24.3%</b>	<b>24.3%</b>	<b>24.3%</b>	<b>24.3%</b>	<b>24.3%</b>	<b>24.3%</b>	<b>24.3%</b>	<b>24.3%</b>	
%Change		-28.4%	29.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>65-74</b>	<b>10.8%</b>	<b>5.4%</b>	<b>20.0%</b>	<b>20.0%</b>	<b>20.0%</b>	<b>20.0%</b>	<b>20.0%</b>	<b>20.0%</b>	<b>20.0%</b>	<b>20.0%</b>	<b>20.0%</b>	<b>20.0%</b>	
%Change		-50.0%	270.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>75+</b>	<b>0.0%</b>	<b>6.3%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>	
%Change		0.0%	-100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Total</b>	<b>24.6%</b>	<b>17.2%</b>	<b>23.0%</b>	<b>23.0%</b>	<b>23.0%</b>	<b>22.9%</b>	<b>22.9%</b>	<b>22.9%</b>	<b>22.9%</b>	<b>22.8%</b>	<b>22.8%</b>	<b>22.8%</b>	
%Change		-30.0%	33.5%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.2%

#### g. Inpatient Adult Psychiatric Discharges

In fiscal year 2017, the adult psychiatric discharges at UM SMC at Dorchester declined by 16.0%, but then increased by 2.2% in fiscal year 2018 year to date. Based on the assumptions presented above, adult psychiatric discharges are projected to grow by 0.1% per year between fiscal years 2018 and 2027, due primarily to population growth. Total adult psychiatric discharges are projected to increase by 1.0% between fiscal years 2018 and 2027 (Table 73).

**Table 73**  
**UM SMC at Dorchester's Historical and**  
**Projected Adult Psychiatric Inpatient Discharges**  
**FY2016 – FY2027**

	Actual FY2016	Actual FY2017	Annualized FY2018	Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
Psychiatric Discharges	648	544	556	556	557	557	558	558	559	560	561	561	1.0%
% Change		-16.0%	2.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	

#### h. UM SMC at Dorchester Adult Psychiatric Average Length of Stay

While the average length of stay ("ALOS") of adult psychiatric patients at UM SMC at Dorchester increased to 7.2 days in fiscal year 2017, it is expected to return to the fiscal year 2016 level through additional case management initiatives. This fiscal year 2018 ALOS is projected to continue at UM SMC at Easton when UM SMC at Dorchester's inpatient adult psychiatric services move to UM SMC at Easton and when they relocate to the replacement hospital. The ALOS will remain constant, at the age cohort level, through the end of the projection period (Table 74).

**Table 74**  
**UM SMC at Dorchester's Historical and Projected Adult Psychiatric ALOS**  
**FY2016 – FY2027**

	Actual FY2016	Actual FY2017	Projected FY2018	Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
ALOS (days)	6.82	7.20	6.82	6.82	6.82	6.82	6.82	6.82	6.82	6.82	6.82	6.82	0.0%
% Change		5.6%	-5.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	

#### i. UM SMC at Easton Psychiatric Occupancy

The adult psychiatric inpatient bed occupancy is projected at 85% which is consistent with the outdated State Health Plan for Psychiatric Services, COMAR 10.24.07 (Need Projection Methodology (B)(7)).

#### j. UM SMC at Easton Psychiatric Bed Need

Based on the assumptions presented above, the Applicant has projected a need to relocate 12 adult psychiatric inpatient beds from UM SMC at Dorchester to UM SMC at Easton,

beginning in fiscal year 2022, and to build a 12-bed adult psychiatric unit at the replacement hospital, as demonstrated in Table 75.

**Table 75**  
**UM SMC at Dorchester's Historical and Projected Adult Psychiatric Bed Need**  
**FY2016 – FY2027**

	Actual FY2016	Actual FY2017	Projected FY2018					Projected FY2023	FY2024	FY2025	FY2026	FY2027	% Change FY18-FY27
Psychiatric Bed Need	14	13	12	12	12	12	12	12	12	12	12	12	1.0%
% Change		-11.3%	-3.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	

### 3. The Need for Observation Beds.

As presented in Table 76 below, observation cases at UM SMC at Easton increased by 68.0% between fiscal years 2016 and 2018. In fiscal year 2018, these patients stayed for an average of 30.0 hours or approximately 1.2 days.

**Table 76**  
**UM SMC at Easton**  
**Historical Observation Cases and Hours**  
**FY2016 – FY2018**

	Historical			% Change
	FY2016	FY2017	FY2018	FY16-FY18
Observation Cases	1,474	1,739	2,477	68.0%
Observation Hours	58,111	75,966	74,242	27.8%
Hours per Case	39.4	43.7	30.0	-24.0%
Days per Case	1.6	1.8	1.2	-24.0%

Source: FY2016-FY2017 HSCRC Annual Filings; FY2018 UM SMC at Easton Internal Report & HSCRC Experience Report.

The Applicant projects the need for observation treatment spaces at UM SMC at Easton will grow with the projected increase in emergency department visits, which are expected to increase 0.2% a year with population growth, as well as a 1% annual increase in the utilization of observation cases per 1,000 population as inpatient cases that were previously admitted receive care in the future in the outpatient setting in the observation unit. This 1% annual growth reflects the projected 1% annual reduction in the utilization of inpatient MSGA discharges, by age cohort, per 1,000 population as presented in Table 77. The cumulative growth in observation cases between fiscal year 2018 and fiscal year 2027 is projected to equal 11.4% (Table 77).

**Table 77**  
**UM SMC at Easton**  
**Historical and Projected Observation Cases**  
**FY2016 – FY2027**

	Historical			Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
<b>Observation Cases</b>	<b>1,474</b>	<b>1,739</b>	<b>2,477</b>	<b>2,507</b>	<b>2,537</b>	<b>2,568</b>	<b>2,599</b>	<b>2,631</b>	<b>2,663</b>	<b>2,695</b>	<b>2,727</b>	<b>2,760</b>	<b>11.4%</b>
Population % Change		0.0%	0.0%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	
Use Rate % Change		18.0%	42.4%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	
Total % Change		18.0%	42.4%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	

As inpatient cases shift to the observation setting, the average length of stay for observation cases at UM SMC at Easton is projected to increase 2% a year to reflect an increase in the acuity of patients that are shifting from the inpatient setting. By fiscal year 2017, observation patients are projected to stay approximately 36 hours (Table 78) or 1.5 days on average.

**Table 78**  
**UM SMC at Easton**  
**Historical and Projected Average Length of Stay**  
**FY2016 – FY2027**

	Historical			Projected									% Change FY18-FY27
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027	
<b>Observation ALOS (Hours)</b>	<b>39.4</b>	<b>43.7</b>	<b>30.0</b>	<b>30.6</b>	<b>31.2</b>	<b>31.8</b>	<b>32.4</b>	<b>33.1</b>	<b>33.8</b>	<b>34.4</b>	<b>35.1</b>	<b>35.8</b>	<b>19.5%</b>
% Change		10.8%	-31.4%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	

For observation patients projected to stay an average of 36 hours at UM SMC at Easton, it is unreasonable to apply the ACEP Guide recommendation of 1,100 visits per observation space – which equals three visits per observation bed per day or approximately eight hours per visit – to project the need for observation spaces, particularly when historical data and observation use rates are known and projections of observation use at UM SMC at Easton can be reasonably projected.<sup>3</sup>

To this end, the projected average length of stay of 36 hours for observation cases at UM SMC at Easton is 4.5 times longer than the eight hour stays contemplated by the ACEP Guide recommendation for programming at 1,100 visits per observation space per year.

<sup>3</sup> The Applicant addresses the ACEP Guide because the State Health Plan chapter on freestanding medical facilities incorporates portions of the ACEP Guide for purposes of demonstrating need for observation beds. Of course, the project proposed here is a hospital, not an FMF. Thus, the standards for demonstrating need for observation beds in an FMF do not apply in this review. Also, it should also be noted that the ACEP Guide is based on the experience of a single architect, the author of the ACEP Guide, and not a broader data analysis of trends in observation utilization, average observation lengths of stay, or use rate demographics.

Applying the ACEP Guide's recommendation of 1,100 observation visits per observation space to the projection of 2,760 observation cases in fiscal year 2027 would result in only 2.5 observation spaces at UM SMC at Easton. 2.5 observation spaces would be grossly inadequate to serve the needs of the service area population.

Rather than using the ACEP Guide to project observation bed need, it is more appropriate to project observation bed need at UM SMC at Easton similar to the projection of MSGA bed need which considers length of stay and occupancy. Because of the small number of observation cases at UM SMC at Easton and because any overflow of observation cases would necessitate potentially unnecessary inter-facility transports, the Applicant assumes a 70% occupancy for observation beds at the UM SMC at Easton replacement hospital. This occupancy assumption is based on the State Health Plan for Acute Care Hospital Services (COMAR 10.24.10) that provides the minimum occupancy standard for MSGA services with average daily census of 0-49 patients.

Based on the assumptions presented above, there is a projected need in fiscal year 2027 for sixteen (16) observation beds at UM SMC at Easton (Table 79).

**Table 79**  
**Projected Need for Observation Beds**  
**FY2016 – FY2027**

	Actual			Projected								
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Observation Cases	1,474	1,739	2,477	2,507	2,537	2,568	2,599	2,631	2,663	2,695	2,727	2,760
Average Hours Per Case	39.4	43.7	30.0	30.6	31.2	31.8	32.4	33.1	33.8	34.4	35.1	35.8
Total Observation Hours	58,111	75,966	74,242	76,644	79,124	81,684	84,327	87,055	89,872	92,779	95,781	98,880
Average Length of Stay (days)	1.6	1.8	1.2	1.3	1.3	1.3	1.4	1.4	1.4	1.4	1.5	1.5
Observation Days	2,421	3,165	3,093	3,194	3,297	3,403	3,514	3,627	3,745	3,866	3,991	4,120
Average Daily Census	6.6	8.7	8.5	8.7	9.0	9.3	9.6	9.9	10.3	10.6	10.9	11.3
Occupancy Target	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
<b>Bed Need</b>	<b>9.5</b>	<b>12.4</b>	<b>12.1</b>	<b>12.5</b>	<b>12.9</b>	<b>13.3</b>	<b>13.8</b>	<b>14.2</b>	<b>14.7</b>	<b>15.1</b>	<b>15.6</b>	<b>16.1</b>
<b>Requested Beds</b>										<b>16.0</b>	<b>16.0</b>	<b>16.0</b>

The proposed number of observation treatment spaces at UM SMC at Easton, a total of sixteen, is consistent with the needs and characteristics of the population to be served.

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

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

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

- a) the alternative of the services being provided through existing facilities;
- b) or through population-health initiatives that would avoid or lessen hospital admissions.

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

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

**Applicant Response:**

See response to COMAR 10.24.10.04B(3) above.



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

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

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

- Complete applicable Revenues & Expenses (Tables G, H, J and K as applicable), and the Work Force information (Table L) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable.
- Describe and document relevant community support for the proposed project.
- Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.
- Audited financial statements for the past two years should be provided by all applicant entities and parent companies.

**Applicant Response:**

Audited Financial Statements are included in **Exhibit 27**.

Under the current models of hospital reimbursement in Maryland, UM SMC at Easton has the incentive to reduce length of stay, ancillary testing, unnecessary admissions and readmissions, as well as improve efficiency in the provision of services while treating patients in a manner consistent with appropriate, high quality medical care. UM SMC at Easton operates under the GBR system pursuant to an agreement with the HSCRC. A GBR hospital essentially is penalized for higher volumes. UM SMC at Easton will seek a rate increase from HSCRC in the third quarter of fiscal year 2019 in the form of a full rate application, to raise its revenue, to enable it to have adequate revenue to cover the additional debt service.

As shown in Table E, the total cost of the project is \$349.9 million. The sources of funding for the project are cash (\$13.9 million), philanthropic gifts (\$25 million), and debt (\$311 million). A full year of depreciation and interest expense (*i.e.*, capital costs) related to the

project are projected to equal \$31.3 million in FY 2025 with the opening of the new hospital facility.

The proposed project enjoys strong community support, as shown by the numerous and varied letters of support included in **Exhibit 28**.

Community interest in and support for a replacement hospital has been at a high level region-wide since initial considerations for a replacement hospital were first developed in 2011. Since 2011, there have been a number of changes in UM SRH, health care, and hospital reimbursement. Despite these changes, public interest in the project has not waned, but it has quietly waited for the right time for expansion into community advocacy, philanthropy, and communications. Whenever UM SRH updates are given in the region or gatherings are held with community physicians/providers, partner agencies and with donors, participants consistently inquire about when UM SRH anticipates moving forward with a new hospital to replace the aged facility in Easton. Donor interest remains strong and capital campaign planning, under the leadership of the Memorial Hospital Foundation Board, is top of the mind. The Memorial Hospital Auxiliary, a volunteer organization of more than 200 members, has indicated its intention to be an early and significant donor to the capital campaign once launched.

UM SRH commissioned two fundraising feasibility studies since 2012 for the purpose of assessing potential donor support for a new hospital in Easton. The studies, conducted by respected philanthropy consultants Ghiorso & Sorrenti, Inc., included interviews with potential donors and community leaders and identified multiple committed and potential gifts in support of the new hospital, ranging from several individual gifts of more than \$1 million each to multiple gifts of \$500,000 and greater. Board, executive, staff, volunteer, and physician potential support alone was assessed to be almost \$2 million. In all, based upon the two feasibility studies, fundraising success of between \$20 million and \$29 million is highly likely over the course of the campaign. The Capital Campaign Plan is ready for implementation – from campaign leadership and cabinet, community and team structure, and collateral materials to actual gifts received—as soon as the project receives final approval.

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

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

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

**Applicant Response:**

UM SMC at Easton has obtained two CONs and one Certificate of Conformance since 2000. Copies are attached at **Exhibit 29**.

- In July 2003, UM SMC at Easton received a CON for the “Capital Renovation and Expansion to Memorial Hospital at Easton.” 03-20-2112
- In September 2004, UM SMC at Easton received a CON for the “Establishment of a Twenty-Bed Acute Inpatient Rehabilitation Unit at The Memorial Hospital at Easton.” 03-20-2128
- In April 2016, UM SMC at Easton received a Certificate of Conformance to provide primary and secondary percutaneous coronary intervention (PCI) services. CC-15-20-0001.

There were no specific conditions placed on the CON projects. Both CON projects were completed as approved. UM SMC at Easton implemented the Certificate of Conformance for PCI services in 2017.

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

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

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

- a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project<sup>4</sup>;
- 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:**

The project will improve geographic access, as discussed previously. (See Standard .04B(1) – Geographic Accessibility). The project will also address and resolve considerable deficiencies in the current site.

UM SMC at Easton will continue to provide the same broad array of inpatient and outpatient health care services to the residents of its service area in the new hospital. It does not expect any changes in its market share of inpatient and outpatient services as a result of moving to the new hospital. As such, there will not be any adverse impacts to other hospitals and the residents of UM SMC at Easton's service area will continue to have the same access to health care services.

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<sup>4</sup> Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, the relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions.

## **INDEX OF EXHIBITS**

<b><u>Exhibit</u></b>	<b><u>Description</u></b>
1	MHCC Tables
2	Project Drawings
3	Drawing Showing Age of Buildings
4	Deed dated October 23, 2015
5	UM SRH Policy for Provision of Information to the Public Concerning Charges
6	List of Representative Services and Charges from UM SMC at Easton's Web Site
7	Financial Assistance Policy
8	Posted Notices Regarding the Availability of Charity Care
9	Newspaper Ads on Charity Care
10	State of Maryland License
11	Joint Commission Accreditation Certificates
12	Quality Measures in MHCC Most Recent Hospital Guide and Corrective Action Plan
13	Priority Funding Area Letters
14	Inpatient Nursing Unit Sizes - detailed description
15	Surgical Services Transfer Agreements
16	Architectural firm HKS Certification Letter re Design Requirements
17	Maryland Perinatal System Standards Self-Assessment
18	CARF Accreditation Certificate
19	Inpatient Rehabilitation Transfer and Referral Agreements
20	UM SRH Behavioral Health Response Team Inquiry Calls Policy
21	UM SRH Admission Criteria Adult Psychiatric Inpatient
22	UM SRH Assessment for Admission of Patients to Inpatient Behavioral Health Unit
23	UM SRH Behavioral Health Quality Assurance Policy
24	UM SRH Special Behavioral Health Population Treatment Protocols
25	Decision chart and Pediatric Behavioral Policy
26	UM SRH Behavioral Health Discharge Planning and Referral Policy
27	Audited Financial Statements
28	Letters of support
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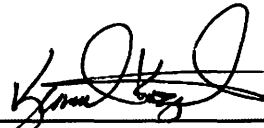
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I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Sept. 7, 2018

Date



Kenneth D. Kozel  
President & CEO

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.

Sept. 7, 2018

Date



Robert Frank, MBA  
Senior Regional Vice President,  
Operations  
UM Shore Regional Health

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.

Sept. 7, 2018

Date



William Ruffner, M.D.

MBAFACEP, FACHE

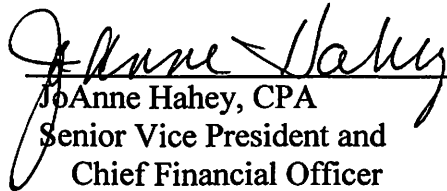
Senior Vice President, Medical Affairs  
and Chief Medical Officer

UM Shore Regional Health

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.

Sept. 7, 2018

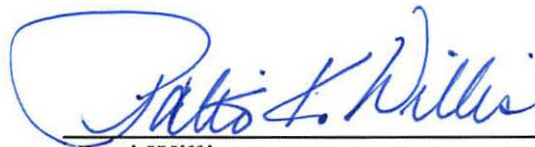
Date

  
JoAnne Hahey, CPA  
Senior Vice President and  
Chief Financial Officer  
UM Shore Regional Health

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.

Sept. 7, 2018

Date



Patti Willis

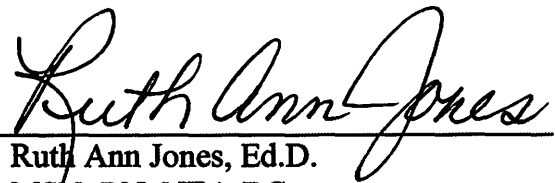
Senior Vice President, Strategy &  
Communications

UM Shore Regional Health

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.

Sept. 7, 2018

Date

A handwritten signature in black ink, reading "Ruth Ann Jones", written over a horizontal line.

Ruth Ann Jones, Ed.D.

MSN, RN, NEA-BC

Senior Vice President, Patient Care

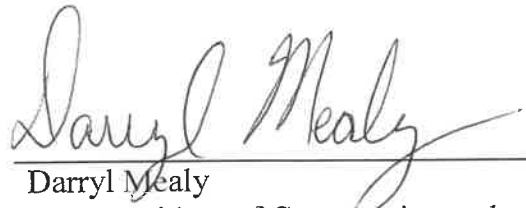
Services and Chief Nursing Officer

UM Shore Regional Health

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.

Sept. 7, 2018

Date

A handwritten signature in black ink, reading "Darryl Mealy", written over a horizontal line.

Darryl Mealy  
Vice President of Construction and  
Facilities Planning  
University of Maryland Medical  
System

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.

Sept. 7, 2018

Date



David Klahn  
Associate  
HKS



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.

Sept. 7, 2018

Date

A handwritten signature in blue ink, appearing to read "Andrew L. Solberg", written over a horizontal line.

Andrew L. Solberg

A.L.S. Healthcare Consultant Services

# **EXHIBIT 1**

Name of Applicant: Shore Health System, Inc.

Date of Submission: 7-Sep-18

*Applicants should follow additional instructions included at the top of each of the following worksheets. Please ensure all green fields (see above) are filled.*

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

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTIONS: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.												
Before the Project							After Project Completion					
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/2018	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
ACUTE CARE							ACUTE CARE					
General Medical/ Surgical*		69					General Medical/ Surgical*				0	0
MedSurg	2 East		24	6	30	36	MedSurg	3	2	0	2	2
Surgical/Medical	3 East		17	10	27	37	Neuro	3	12	0	12	12
Neuro	4 East		5	3	8	11	Joint	3	12	0	12	12
MedSurg	4 East		5	0	5	5	MedSurg	4	28	0	28	28
Joint	2 East/South		6	2	8	10	MedSurg	5	25	0	25	25
Telemetry	4 South		20	4	24	28		.				
Resp/Cardio	3 Center		3	4	7	11						
Pediatrics	5 South		3	0	3	3						
Renal	2 South		5	0	5	5						
SUBTOTAL Gen. Med/Surg*		69	88	29	117	146	SUBTOTAL Gen. Med/Surg*		79	0	79	79
ICU/CCU		10	10	0	10	10	ICU/CCU	5	16	0	16	16
Other (Specify/add rows as needed)					0	0					0	0
TOTAL MSGA		79	98	29	127	156	TOTAL MSGA		95	0	95	95
Obstetrics		17					Obstetrics					
5 East (LDRP)	Birthing Center 5E		10	0	10	10	LDRP	3	11	0	11	11
Antepartum	Birthing Center 5E		3	0	3	3	Antepartum	3	2	0	2	2
OR 5 East	Birthing Center 5E		1	0	1	1						
PACU 5 East	Birthing Center 5E		1	0	1	1						
Triage 5 East	Birthing Center 5E		3	0	3	3						
Pediatrics	3rd Floor South	8	0	0	0	0	Pediatrics	3	1	0	1	1
Psychiatric	3rd Floor South		4	4	8	12	Psychiatric	6	12	0	12	12
TOTAL ACUTE		104	120	33	153	186	TOTAL ACUTE		121	0	121	121
NON-ACUTE CARE							NON-ACUTE CARE					
Dedicated Observation**					0	0	Dedicated Observation**	1	16	0	16	16
Rehabilitation	5 South	20	5	5	10	15	Rehabilitation	4	14	0	14	14
Comprehensive Care					0	0	Comprehensive Care				0	0
Other (Specify/add rows as needed)					0	0	Other (Specify/add rows as needed)			0	0	0
				0	0	0						
									0	0	0	
TOTAL NON-ACUTE		20	5	5	10	15	TOTAL NON-ACUTE		30	0	30	30
HOSPITAL TOTAL		124	125	38	163	201	HOSPITAL TOTAL		151	0	151	151

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

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

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

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

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
<b>Inpatient Nursing Units</b>					
Intensive Care	6,505	13,131	0	0	13,131
Med / Surg - Telemetry	12,665	13,874	0	0	13,874
Rehab (Requard Center)	12,740	13,889	0	0	13,889
Med / Surg - General	25,370	33,007	0	0	33,007
Pediatric Unit	6,025	incl in M/S Unit	0	0	0
Med / Surg - Joint, Neuro, Med/Surg	14,705	incl in M/S Unit	0	0	0
Obstetrics incl. nursery	16,070	18,863	0	0	18,863
Behavioral Health Clinic	0	11,915			11,915
<b>Subtotal</b>	<b>94,080</b>	<b>104,679</b>	<b>0</b>	<b>0</b>	<b>104,679</b>
<b>Diagnostic &amp; Treatment</b>					
Clinical Lab / Pathology	9,885	3,923	0	0	3,923
Emergency Department	21,220	20,761	0	0	20,761
Inpatient Dialysis	2,410	1,777	0	0	1,777
Imaging Department	16,465	15,004	0	0	15,004
Interventional Suite (incl O.R.'s, Cath, EP)	20,265	26,802	0	0	26,802
Prep / Stage 2 Recovery	14,425	14,983	0	0	14,983
Pre-Anesthesia Testing	1,010	1,300	0	0	1,300
Observation Unit	0	5,142	0	0	5,142
Respiratory Therapy	0	870	0	0	870
<b>Subtotal</b>	<b>85,680</b>	<b>90,562</b>	<b>0</b>	<b>0</b>	<b>90,562</b>
<b>Administrative / Public Services</b>					
Auxiliary	805	354	0	0	354
Admitting / Registration	3,410	2,599	0	0	2,599
Chapel	160	487	0	0	487
Education Center / Med Library	5,405	0	0	0	0
Gift Shop	1,185	1,248	0	0	1,248
Hospitalist Suite	0	600	0	0	600
On-Call	0	768	0	0	768
Executive Admin	5,250	0	0	0	0
CIM / Physician Lounge	incl. in Quality Team	2,977	0	0	2,977
Quality Team	8,695	0	0	0	0
Human Resources / Employee Health	795	1,831	0	0	1,831
Nursing Administration / Staff offices	1,835	3,461	0	0	3,461
Information Technology	3,005	2,576	0	0	2,576
Lobby Services	1,400	0	0	0	0
<b>Subtotal</b>	<b>31,945</b>	<b>16,901</b>	<b>0</b>	<b>0</b>	<b>16,901</b>
<b>Support Services</b>					
EVS/Linen/Facilities/Mat. Mgmt	15,825	13,028	0	0	13,028
Maryland Express Care	0	733	0	0	733
Sterile Processing	4,600	6,336	0	0	6,336
Pharmacy	4,570	4,032	0	0	4,032
Security	0	930	0	0	930
Food & Nutrition	10,320	12,104	0	0	12,104
<b>Subtotal</b>	<b>35,315</b>	<b>37,163</b>	<b>0</b>	<b>0</b>	<b>37,163</b>
<b>Clinics</b>					
Cardiopulmonary / Vascular	6,065	5,763	0	0	5,763
Allied Health / School of Nursing	9,920	0	0	0	0
Behavioral Health Outpatient Clinic	1,110	3,839	0	0	3,839
Breast Center	1,725	0	0	0	0
Cardio Rehab	2,685	3,484	0	0	3,484
Child Advocacy Center	1,310	0	0	0	0
Diabetes Clinic	4,225	3,685	0	0	3,685
Infusion Center	0	2,090	0	0	2,090
Coumadin (anti-Thromb) Clinic	925	0	0	0	0
Pain Management Clinic	0	2,771	0	0	2,771
Sleep Lab	2,230	0	0	0	0
Multi Specialty Clinic	1,570	3,813	0	0	3,813
Wound Healing Center	3,160	0	0	0	0
Outpatient Lab Draw	0	742	0	0	742
<b>Subtotal</b>	<b>28,860</b>	<b>26,187</b>	<b>0</b>	<b>0</b>	<b>26,187</b>
<b>Total Department Gross SF</b>	<b>275,880</b>	<b>275,492</b>			<b>275,492</b>
Building Grossing Factor	96,968	58,524	0	0	58,524
Penthouse		2,534			2,534
Central Plant	16,917	22,385	0	0	22,385
<b>Total Building Gross SF</b>	<b>389,765</b>	<b>358,935</b>			<b>358,935</b>

**TABLE C. CONSTRUCTION CHARACTERISTICS**

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

	Hospital	Central Utility Plant
<b>BASE BUILDING CHARACTERISTICS</b>	<b>Check if applicable</b>	
<b>Class of Construction</b> (for renovations the class of the building being renovated)*		
Class A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Class B	<input type="checkbox"/>	<input type="checkbox"/>
Class C	<input type="checkbox"/>	<input type="checkbox"/>
Class D	<input type="checkbox"/>	<input type="checkbox"/>
<b>Type of Construction/Renovation*</b>		
Low	<input type="checkbox"/>	<input type="checkbox"/>
Average	<input type="checkbox"/>	<input type="checkbox"/>
Good	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Excellent	<input type="checkbox"/>	<input type="checkbox"/>
<b>Number of Stories</b>	6 plus mechanical penthouse	1

\*As defined by Marshall Valuation Service

<b>PROJECT SPACE</b>	<b>List Number of Feet, if applicable</b>	
<b>Total Square Footage</b>	<b>336,550</b>	<b>22,385</b>
Basement	n/a	
First Floor	125,941	22,385
Second Floor	75,592	
Third Floor	43,263	
Fourth Floor	37,203	
Fifth Floor	33,437	
Sixth Floor	18,580	
Penthouse	2,534	
<b>Average Square Feet</b>		
<b>Perimeter in Linear Feet</b>	<b>Linear Feet</b>	
Basement	n/a	
First Floor	1,977	610
Second Floor	1,472	
Third Floor	1,263	
Fourth Floor	1,245	
Fifth Floor	1,050	
Sixth Floor	650	
Penthouse	205	
<b>Total Linear Feet</b>	<b>7,862</b>	<b>610</b>
<b>Average Linear Feet</b>	<b>1,123</b>	
<b>Wall Height (floor to eaves)</b>	<b>Feet</b>	
Basement	n/a	
First Floor	16	20
Second Floor	16	
Third Floor	14	
Fourth Floor	14	
Fifth Floor	14	
Sixth Floor	14	
Penthouse	21.83	
<b>Average Wall Height</b>	<b>15.69</b>	
<b>OTHER COMPONENTS</b>		
<b>Elevators</b>	<b>List Number</b>	
Public	4	0
Patient / Service	3	0
Trauma	1	0
<b>Sprinklers</b>	<b>Square Feet Covered</b>	
Wet System	336,550	22,385
Dry System		
<b>Other</b>	<b>Describe Type</b>	
<b>Type of HVAC System for proposed project</b>	Excellent Grade - Forced Air: VAV / Constant Volume, Digitally Controlled	
<b>Type of Exterior Walls for proposed project</b>	Glass Curtain Wall, Brick Veneer, Metal Panels, Cultured Stone	

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS		
<i>plants), complete an additional Table D for each structure.</i>		
	NEW CONSTRUCTION COSTS	RENOVATION COSTS
<b>SITE PREPARATION COSTS</b>		
Normal Site Preparation	\$1,043,699	
Utilities from Structure to Lot Line		
<b>Subtotal included in Marshall Valuation Costs</b>		
Paving and Roads	\$6,240,000	
Demolition	\$26,000	
Storm Drains	\$2,472,660	
Rough Grading	\$1,476,214	
Landscaping	\$2,222,382	
Sediment Control & Stabilization	\$209,130	
Helipad	\$622,594	
Water	\$60,900	
Sewer	\$97,440	
Premium for Labor Shortages on Eastern Shore Projects	\$2,220,000	
Siesmic Costs	\$740,000	
Premium for Minority Business Enterprise Requirement	\$942,907	
<b>Subtotal On-Site excluded from Marshall Valuation Costs</b>	<b>\$17,330,227</b>	
<b>OFFSITE COSTS</b>		
Roads	\$6,240,000	
Pump Station	\$745,680	
8" to 12" Force Main	\$1,040,000	
Misc.	\$520,000	
EASTON ELECTRICAL SERVICE	\$704,369	
EASTON GAS SERVICE TO PROPERTY	\$254,196	
Verzion	\$1,170,497	
MD Broad Band (Fiber)	\$1,592,448	
Chop Tank (Electric)	\$2,826,004	
Cable TV	\$3,532,880	
Other (Specify/add rows if needed)		
<b>Subtotal Off-Site excluded from Marshall Valuation Costs</b>	<b>\$18,626,074</b>	
<b>TOTAL Estimated On-Site and Off-Site Costs <u>not</u> included in Marshall Valuation Costs</b>	<b>\$35,956,301</b>	<b>\$0</b>
<b>TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*</b>	<b>\$37,000,000</b>	<b>\$0</b>
<b>BUILDING COSTS</b>		
Normal Building Costs	\$106,644,795	
<b>Subtotal included in Marshall Valuation Costs</b>	<b>\$106,644,795</b>	
Canopy	\$1,032,052	
Premium for Labor Shortages on Eastern Shore Projects	\$7,950,708	
LEED Silver Premium	\$5,300,472	
Siesmic Costs	\$2,650,236	
Pneumatic Tube System	\$750,000	
Transvac System	\$2,700,000	
Signs	\$1,040,000	
Premium for Minority Business Enterprise Requirement	\$4,443,533	
<b>Subtotal Building Costs excluded from Marshall Valuation Costs</b>	<b>\$25,867,001</b>	
<b>TOTAL Building Costs included and excluded from Marshall Valuation Service*</b>	<b>\$132,511,795</b>	<b>\$0</b>
<b>A&amp;E COSTS</b>		
Normal A&E Costs	\$4,012,310	
<b>Subtotal included in Marshall Valuation Costs</b>	<b>\$4,012,310</b>	
Amount Spent on the 2012 Project that is not now Usable:	\$2,022,908	
Amount Associated with other Extraordinary Costs	\$3,464,782	
<b>Subtotal A&amp;E Costs excluded from Marshall Valuation Costs</b>	<b>\$5,487,690</b>	
<b>TOTAL A&amp;E Costs included and excluded from Marshall Valuation Service*</b>	<b>\$9,500,000</b>	<b>\$0</b>
<b>PERMIT COSTS</b>		
Normal Permit Costs	\$4,558,117	
<b>Subtotal included in Marshall Valuation Costs</b>	<b>\$4,558,117</b>	
Jurisdictional Hook-up Fees	\$1,852,215	
Impact Fees	\$1,539,819	
Amount Spent on the 2012 Project that is not now Usable	\$52,849	
<b>Subtotal Permit Costs excluded from Marshall Valuation Costs</b>	<b>\$3,444,883</b>	
<b>TOTAL Permit Costs included and excluded from Marshall Valuation Service*</b>	<b>\$8,003,000</b>	<b>\$0</b>

**TABLE E. PROJECT BUDGET**

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

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

	Hospital Building	Other Structure	Total
<b>A. USE OF FUNDS</b>			
<b>1. CAPITAL COSTS</b>			
<b>a. Land Purchase</b>	\$2,464,658		\$2,464,658
<b>b. New Construction</b>			
(1) Building	\$132,511,795		\$132,511,795
(2) Fixed Equipment	In Building		\$0
(3) Site and Infrastructure	\$37,000,000		\$37,000,000
(4) Architect/Engineering Fees	\$9,500,000		\$9,500,000
(5) Permits (Building, Utilities, Etc.)	\$8,003,000		\$8,003,000
<b>SUBTOTAL</b>	<b>\$187,014,795</b>	<b>\$0</b>	<b>\$187,014,795</b>
<b>c. Renovations</b>			
(1) Building			\$0
(2) Fixed Equipment (not included in construction)			\$0
(3) Architect/Engineering Fees			\$0
(4) Permits (Building, Utilities, Etc.)			\$0
<b>SUBTOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>d. Other Capital Costs</b>			
(1) Movable Equipment	\$36,397,000		\$36,397,000
(2) Contingency Allowance	\$20,982,770		\$20,982,770
(3) Gross interest during construction period	\$39,658,000		\$39,658,000
(4) Other (Specify/add rows if needed)			
EDU'S	\$1,300,000		\$1,300,000
Impact Fee (Town) / County	\$1,300,000		\$1,300,000
Forest Conservation	\$50,000		\$50,000
HOSPITAL MOVE	\$1,000,000		\$1,000,000
UMMS/OVHO	\$1,000,000		\$1,000,000
COST SPENT TO DATE	\$11,000,000		\$11,000,000
<b>SUBTOTAL</b>	<b>\$112,687,770</b>		<b>\$112,687,770</b>
<b>TOTAL CURRENT CAPITAL COSTS</b>	<b>\$302,167,223</b>	<b>\$0</b>	<b>\$302,167,223</b>
<b>e. Inflation Allowance</b>	<b>\$25,290,777</b>		<b>\$25,290,777</b>
<b>TOTAL CAPITAL COSTS</b>	<b>\$327,458,000</b>	<b>\$0</b>	<b>\$327,458,000</b>
<b>2. Financing Cost and Other Cash Requirements</b>			
<b>a. Loan Placement Fees</b>	\$622,000		\$622,000
<b>b. Bond Discount</b>	\$1,088,500		\$1,088,500
<b>c. Legal Fees</b>	\$700,000		\$700,000
<b>d. Non-Legal Consultant Fees</b>	\$450,000		\$450,000
<b>e. Liquidation of Existing Debt</b>			\$0
<b>f. Debt Service Reserve Fund</b>	\$19,586,000		\$19,586,000
<b>g. Other (Specify/add rows if needed)</b>			\$0
<b>SUBTOTAL</b>	<b>\$22,446,500</b>		<b>\$22,446,500</b>
<b>3. Working Capital Startup Costs</b>			\$0
<b>##### TOTAL USES OF FUNDS</b>	<b>\$349,904,500</b>	<b>\$0</b>	<b>\$349,904,500</b>
<b>B. Sources of Funds</b>			
<b>1. Cash</b>	\$13,860,500		\$13,860,500
<b>2. Philanthropy (to date and expected)</b>	\$25,000,000		\$25,000,000
<b>3. Authorized Bonds</b>	\$311,044,000		\$311,044,000
<b>4. Interest Income from bond proceeds listed in #3</b>			\$0
<b>5. Mortgage</b>			\$0
<b>6. Working Capital Loans</b>			\$0
<b>7. Grants or Appropriations</b>			
<b>a. Federal</b>			\$0
<b>b. State</b>			\$0
<b>c. Local</b>			\$0
<b>8. Other (Specify/add rows if needed)</b>			\$0
<b>TOTAL SOURCES OF FUNDS</b>	<b>\$349,904,500</b>		<b>\$349,904,500</b>
<b>Annual Lease Costs (if applicable)</b>			
<b>1. Land</b>			\$0
<b>2. Building</b>			\$0
<b>3. Major Movable Equipment</b>			\$0
<b>4. Minor Movable Equipment</b>			\$0
<b>5. Other (Specify/add rows if needed)</b>			\$0
Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.			



**TABLE F. STATISTICAL PROJECTIONS - UM Shore Health System**

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

	Current Year (Actual/ Projected)	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.								
	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027
<b>1. DISCHARGES</b>										
a. General Medical/Surgical*	6,916	6,704	6,715	6,728	6,419	6,432	6,446	6,461	6,478	6,496
b. ICU/CCU	215	209	209	209	200	201	201	201	202	203
<b>Total MSGA</b>	<b>7,132</b>	<b>6,913</b>	<b>6,924</b>	<b>6,937</b>	<b>6,620</b>	<b>6,633</b>	<b>6,647</b>	<b>6,663</b>	<b>6,680</b>	<b>6,698</b>
c. Pediatric	62	61	61	61	60	60	59	59	59	58
d. Obstetric	1,171	1,170	1,169	1,167	1,166	1,164	1,163	1,162	1,160	1,159
e. Acute Psychiatric	556	556	557	557	558	558	559	560	561	561
<b>Total Acute</b>	<b>8,921</b>	<b>8,700</b>	<b>8,711</b>	<b>8,722</b>	<b>8,404</b>	<b>8,415</b>	<b>8,429</b>	<b>8,443</b>	<b>8,459</b>	<b>8,477</b>
f. Rehabilitation	358	353	358	363	368	373	379	384	390	396
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
<b>TOTAL DISCHARGES</b>	<b>9,279</b>	<b>9,053</b>	<b>9,068</b>	<b>9,085</b>	<b>8,772</b>	<b>8,789</b>	<b>8,807</b>	<b>8,828</b>	<b>8,849</b>	<b>8,873</b>
<b>2. PATIENT DAYS</b>										
a. General Medical/Surgical*	27,964	26,366	26,373	26,385	24,747	24,759	24,776	24,802	24,830	24,864
b. ICU/CCU	1,549	1,448	1,447	1,446	1,402	1,401	1,401	1,401	1,401	1,402
<b>Total MSGA</b>	<b>29,513</b>	<b>27,814</b>	<b>27,820</b>	<b>27,831</b>	<b>26,149</b>	<b>26,160</b>	<b>26,177</b>	<b>26,203</b>	<b>26,231</b>	<b>26,266</b>
c. Pediatric	152	151	150	149	148	147	146	145	144	143
d. Obstetric	3,272	3,268	3,264	3,260	3,256	3,252	3,248	3,244	3,240	3,237
e. Acute Psychiatric	3,790	3,793	3,796	3,799	3,803	3,807	3,811	3,816	3,821	3,826
<b>Total Acute</b>	<b>36,727</b>	<b>35,026</b>	<b>35,030</b>	<b>35,039</b>	<b>33,356</b>	<b>33,366</b>	<b>33,382</b>	<b>33,408</b>	<b>33,436</b>	<b>33,473</b>
f. Rehabilitation	3,510	3,650	3,509	3,559	3,610	3,663	3,715	3,771	3,828	3,885
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
<b>TOTAL PATIENT DAYS</b>	<b>40,237</b>	<b>38,676</b>	<b>38,539</b>	<b>38,598</b>	<b>36,966</b>	<b>37,029</b>	<b>37,097</b>	<b>37,179</b>	<b>37,264</b>	<b>37,358</b>
<b>3. AVERAGE LENGTH OF STAY (patient days divided by discharges)</b>										
a. General Medical/Surgical*	4.0	3.9	3.9	3.9	3.9	3.8	3.8	3.8	3.8	3.8
b. ICU/CCU	7.2	6.9	6.9	6.9	7.0	7.0	7.0	7.0	6.9	6.9
<b>Total MSGA</b>	<b>4.1</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>3.9</b>	<b>3.9</b>	<b>3.9</b>	<b>3.9</b>	<b>3.9</b>
c. Pediatric	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5
d. Obstetric	2.8	2.8	2.8	2.8	2.8	2.8	2.8	2.8	2.8	2.8
e. Acute Psychiatric	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8
<b>Total Acute</b>	<b>4.1</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>3.9</b>
f. Rehabilitation	9.8	10.3	9.8	9.8	9.8	9.8	9.8	9.8	9.8	9.8
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>TOTAL AVERAGE LENGTH OF STAY</b>	<b>4.3</b>	<b>4.3</b>	<b>4.2</b>	<b>4.2</b>	<b>4.2</b>	<b>4.2</b>	<b>4.2</b>	<b>4.2</b>	<b>4.2</b>	<b>4.2</b>

TABLE F. STATISTICAL PROJECTIONS - UM Shore Health System

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

	Current Year (Actual/ Projected)	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.								
	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027
<b>4. NUMBER OF LICENSED BEDS</b>										
a. General Medical/Surgical*	94	98	96	94	79	79	79	79	79	79
b. ICU/CCU	16	16	16	16	16	16	16	16	16	16
<b>Total MSGA</b>	<b>110</b>	<b>114</b>	<b>112</b>	<b>110</b>	<b>95</b>	<b>95</b>	<b>95</b>	<b>95</b>	<b>95</b>	<b>95</b>
c. Pediatric	8	1	1	1	1	1	1	1	1	1
d. Obstetric	17	13	13	13	13	13	13	13	13	13
e. Acute Psychiatric	24	12	12	12	12	12	12	12	12	12
<b>Total Acute</b>	<b>159</b>	<b>140</b>	<b>138</b>	<b>135</b>	<b>121</b>	<b>121</b>	<b>121</b>	<b>121</b>	<b>121</b>	<b>121</b>
f. Rehabilitation	20	13	14	13	14	14	14	14	14	14
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
<b>TOTAL LICENSED BEDS</b>	<b>179</b>	<b>153</b>	<b>152</b>	<b>148</b>	<b>135</b>	<b>135</b>	<b>135</b>	<b>135</b>	<b>135</b>	<b>135</b>
<b>5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.</b>										
a. General Medical/Surgical*	81.5%	73.5%	75.3%	77.2%	85.8%	85.9%	85.9%	86.0%	86.1%	86.2%
b. ICU/CCU	26.5%	24.8%	24.8%	24.8%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%
<b>Total MSGA</b>	<b>73.5%</b>	<b>66.7%</b>	<b>68.1%</b>	<b>69.5%</b>	<b>75.4%</b>	<b>75.4%</b>	<b>75.5%</b>	<b>75.6%</b>	<b>75.6%</b>	<b>75.7%</b>
c. Pediatric	5.2%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
d. Obstetric	52.7%	70.0%	69.9%	69.8%	69.7%	69.7%	69.6%	69.5%	69.4%	69.3%
e. Acute Psychiatric	43.3%	86.6%	86.7%	86.7%	86.8%	86.9%	87.0%	87.1%	87.2%	87.4%
<b>Total Acute</b>	<b>63.3%</b>	<b>68.6%</b>	<b>69.8%</b>	<b>71.0%</b>	<b>75.8%</b>	<b>75.8%</b>	<b>75.8%</b>	<b>75.9%</b>	<b>76.0%</b>	<b>76.1%</b>
f. Rehabilitation	48.1%	76.9%	68.7%	75.0%	70.6%	71.7%	72.7%	73.8%	74.9%	76.0%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>TOTAL OCCUPANCY %</b>	<b>61.6%</b>	<b>69.3%</b>	<b>69.7%</b>	<b>71.3%</b>	<b>75.2%</b>	<b>75.4%</b>	<b>75.5%</b>	<b>75.7%</b>	<b>75.9%</b>	<b>76.1%</b>
<b>6. OUTPATIENT VISITS</b>										
a. Emergency Department (IP and OP)	81,850	81,333	81,504	81,680	81,862	82,048	82,241	82,439	82,643	82,853
b. Same-day Surgery	3,426	3,436	3,447	3,459	2,995	3,007	3,020	3,033	3,047	3,062
c. Laboratory	4,261,411	4,271,897	4,283,060	4,294,919	4,275,977	4,289,260	4,303,293	4,318,724	4,334,761	4,351,425
d. Imaging	1,089,322	1,092,276	1,095,407	1,098,720	1,096,249	1,099,937	1,103,822	1,108,029	1,112,408	1,116,966
e. MRI	72,398	72,604	72,821	73,051	59,547	59,791	60,046	60,313	60,592	60,884
<b>TOTAL OUTPATIENT VISITS</b>	<b>5,508,408</b>	<b>5,521,545</b>	<b>5,536,239</b>	<b>5,551,830</b>	<b>5,516,629</b>	<b>5,534,043</b>	<b>5,552,422</b>	<b>5,572,537</b>	<b>5,593,452</b>	<b>5,615,188</b>
<b>7. OBSERVATIONS**</b>										
a. Number of Patients	3,176	3,246	3,278	3,310	3,342	3,375	3,408	3,441	3,475	3,509
b. Hours	104,187	108,426	110,956	113,566	116,260	119,039	121,906	124,865	127,918	131,068

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

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

**TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM**

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

	Most Recent Years (Actual/ Projected)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.							
Indicate CY or FY	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
<b>1. REVENUE</b>										
a. Inpatient Services	\$ 129,172	\$ 128,991	131,415	131,405	133,931	133,918	133,905	143,722	143,708	143,694
b. Outpatient Services	185,931	192,271	187,237	187,221	182,396	182,380	182,364	194,340	194,323	194,306
<b>Gross Patient Service Revenues</b>	<b>315,103</b>	<b>321,262</b>	<b>318,652</b>	<b>318,626</b>	<b>316,327</b>	<b>316,298</b>	<b>316,269</b>	<b>338,062</b>	<b>338,031</b>	<b>338,000</b>
c. Allowance For Bad Debt	7,126	10,086	10,549	10,548	9,975	9,974	9,973	10,404	10,403	10,402
d. Contractual Allowance	58,378	58,308	56,176	56,171	58,948	58,942	58,937	61,345	61,339	61,334
e. Charity Care	2,770	2,787	2,861	2,861	2,698	2,698	2,698	2,957	2,957	2,956
<b>Net Patient Services Revenue</b>	<b>246,829</b>	<b>250,081</b>	<b>249,066</b>	<b>249,046</b>	<b>244,706</b>	<b>244,683</b>	<b>244,661</b>	<b>263,356</b>	<b>263,332</b>	<b>263,308</b>
f. Other Operating Revenues (Specify/add rows if needed)	4,305	4,709	4,882	4,876	4,554	4,554	4,554	4,554	4,554	4,554
<b>NET OPERATING REVENUE</b>	<b>\$ 251,134</b>	<b>\$ 254,790</b>	<b>\$ 253,948</b>	<b>\$ 253,922</b>	<b>\$ 249,260</b>	<b>\$ 249,237</b>	<b>\$ 249,215</b>	<b>\$ 267,910</b>	<b>\$ 267,886</b>	<b>\$ 267,862</b>
<b>2. EXPENSES</b>										
a. Salaries & Wages (including benefits)	\$ 112,640	\$ 116,748	\$ 113,303	\$ 112,924	\$ 105,524	\$ 105,784	\$ 106,051	\$ 106,331	\$ 106,626	\$ 106,935
b. Professional Fees	11,707	12,360	12,363	12,367	12,287	12,283	12,278	12,274	12,269	12,265
c. Interest on Current Debt	3,602	3,433	3,955	3,907	6,373	6,283	6,190	5,897	5,804	5,708
d. Interest on Project Debt	-	-	-	-	-	-	-	15,488	15,221	14,941
e. Current Depreciation	18,269	18,897	19,571	17,370	15,426	13,618	11,783	9,350	9,543	9,940
f. Project Depreciation	-	-	-	-	-	-	-	14,967	14,967	14,967
g. Supplies	38,533	37,580	37,183	37,153	35,829	35,797	35,772	35,310	35,061	34,718
h. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)	44,163	50,216	50,720	51,433	59,820	60,433	61,006	60,436	59,858	59,277
i. Population Health / Ambulatory & Phy. Network Investment	-	-	-	-	8,209	8,209	8,209	8,209	8,209	8,209
<b>TOTAL OPERATING EXPENSES</b>	<b>\$ 228,914</b>	<b>\$ 239,234</b>	<b>\$ 237,097</b>	<b>\$ 235,154</b>	<b>\$ 243,469</b>	<b>\$ 242,406</b>	<b>\$ 241,289</b>	<b>\$ 268,262</b>	<b>\$ 267,557</b>	<b>\$ 266,960</b>
<b>3. INCOME</b>										
a. Income From Operation	\$ 22,220	\$ 15,556	\$ 16,852	\$ 18,768	\$ 5,790	\$ 6,831	\$ 7,926	\$ (352)	\$ 329	\$ 902
b. Non-Operating Expense							\$ 9,592			
<b>SUBTOTAL</b>	<b>\$ 22,220</b>	<b>\$ 15,556</b>	<b>\$ 16,852</b>	<b>\$ 18,768</b>	<b>\$ 5,790</b>	<b>\$ 6,831</b>	<b>\$ (1,665)</b>	<b>\$ (352)</b>	<b>\$ 329</b>	<b>\$ 902</b>
c. Income Taxes										
<b>NET INCOME (LOSS)</b>	<b>\$ 22,220</b>	<b>\$ 15,556</b>	<b>\$ 16,852</b>	<b>\$ 18,768</b>	<b>\$ 5,790</b>	<b>\$ 6,831</b>	<b>\$ (1,665)</b>	<b>\$ (352)</b>	<b>\$ 329</b>	<b>\$ 902</b>

**TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM**

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

	Most Recent Years (Actual/ Projected)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.							
Indicate CY or FY	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
<b>4. PATIENT MIX</b>										
<b>a. Percent of Total Revenue</b>										
1) Medicare	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%
2) Medicaid	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%
3) Blue Cross	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
4) Commercial Insurance	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%
5) Self-pay	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
6) Other	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
<b>TOTAL</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>
<b>b. Percent of Patient Days</b>										
1) Medicare	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%
2) Medicaid	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%
3) Blue Cross	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%
4) Commercial Insurance	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
5) Self-pay	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
6) Other	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%
<b>TOTAL</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

**Table G – Key Financial Projection Assumptions for UM Shore Health System (Does not include HSCRC Annual Update Factors & Expense Inflation)**

<p>Projection is based on UM Shore Health System (SHS) FY2019 budgeted financial performance with assumptions identified below. SHS includes UM SMC at Easton, UM SMC at Dorchester through the conclusion of FY2021, UM SMC at Cambridge (FMF) beginning in FY2022 and Queen Anne's Emergency Center.</p>	
<p>Projection period reflects FY2019 – FY2027</p>	
Volumes	<ul style="list-style-type: none"> <li>- Refer to historical and projected utilization in Table F</li> </ul>
<p>Patient Revenue</p> <ul style="list-style-type: none"> <li>• Gross Charges <ul style="list-style-type: none"> <li>◦ Update Factor</li> <li>◦ Demographic and Other Rate Adjustment</li> <li>◦ Variable Cost Factor</li> <li>◦ Redistribution of Dorchester General Hospital Revenue Beginning in FY2022</li> <li>◦ Capital Costs in Rates beginning in FY2025</li> </ul> </li> <li>• Revenue Deductions</li> </ul>	<ul style="list-style-type: none"> <li>- 0.00% annual increase in FY2019 – FY2027</li> <li>- 0.00% annual increase in FY2019 – FY2027</li> <li>- 100% variable cost factor associated with regulated inpatient services shifted from Dorchester General Hospital to the SMC at Easton in FY2022</li> <li>- Shore Health System (SHS) will retain 50% of revenue related to volumes that will be lost to other providers in FY2022 (Retained Revenue)</li> <li>- \$4.3M of SHS's Retained Revenue will be apportioned to the FMF to cover its depreciation and interest expense</li> <li>- \$0.83M of SHS's Retained Revenue will be apportioned to the SMC at Easton to cover its depreciation and interest expense related to the transfer of IP beds.</li> <li>- An additional \$9.7M of SHS's Retained Revenue will be apportioned to UM SMC at Easton to fund ambulatory and physician network development and population health initiatives</li> <li>- Request for \$25.2M of capital costs in rate at UM SMC at Easton. After factoring in mark up equals \$23.0M or 75.3% of the project's total depreciation and interest expense of \$30.5M.</li> <li>- Continuation of 2019 deductions from revenue (contractual allowances, denials, charity, bad debts, assessments) as percentages of gross revenue</li> <li>- For the FY2025 capital rate request at UM SMC at Easton, deductions from regulated gross revenue were applied to the \$25.2M in gross revenue.</li> </ul>
Other Operating Revenue	<ul style="list-style-type: none"> <li>- Includes Rental Income, Cafeteria Revenue, Contributions and Other Miscellaneous Revenue with a 0.0% increase per year.</li> </ul>
<p>Expenses</p> <ul style="list-style-type: none"> <li>• Inflation <ul style="list-style-type: none"> <li>◦ Salaries and Benefits</li> <li>◦ Professional Fees</li> <li>◦ Supplies</li> <li>◦ Purchased Services</li> <li>◦ Other Operating Expenses</li> </ul> </li> <li>• Expense Variability with Volume Changes <ul style="list-style-type: none"> <li>◦ Salaries and Benefits</li> <li>◦ Professional Fees</li> <li>◦ Supplies &amp; Drugs</li> <li>◦ Purchased Services</li> <li>◦ Other Operating Expenses</li> </ul> </li> <li>• Interest Expense – Existing Debt</li> <li>• Interest Expense – Project Debt</li> <li>• Depreciation and Amortization</li> <li>• Population Health, Ambulatory &amp; Physician Network Improvement</li> <li>• Other Operating Expense</li> </ul>	<ul style="list-style-type: none"> <li>- 0.0% weighted average annual increase that reflects the following: <ul style="list-style-type: none"> <li>- 0.0%</li> <li>- 0.0%</li> <li>- 0.0%</li> <li>- 0.0%</li> <li>- 0.0%</li> </ul> </li> <li>- 80%</li> <li>- 0%</li> <li>- 80%</li> <li>- 50%</li> <li>- 0%</li> <li>- Continued amortization of existing debt and related interest expense, plus the amortization of the following debt issuance over 30 years for projects completed in FY22: <ul style="list-style-type: none"> <li>• \$42.0M for construction of the FMF</li> <li>• \$8.4M for renovations at Easton</li> <li>• \$33.1M for construction of a new MOB</li> </ul> </li> <li>- Amortization of \$311.1M for the project over 30 years at 5.0% interest.</li> <li>- 30 year useful life for new construction and renovations</li> <li>- 7 year useful life for new equipment</li> <li>- Beginning in FY2022, the retention of 50% of revenue associated with patients that will seek care at other providers following the merger and consolidation of Dorchester General Hospital, will enable SHS to fund \$8.2M of initiatives related to ambulatory and physician network development and population health initiatives</li> <li>- A \$9.5M one time write of existing MHE physical plant capital improvements that will not transfer over to the replacement facility.</li> </ul>

**TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM**

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

	Most Recent Years (Actual/ Projected)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.							
Indicate CY or FY	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
<b>1. REVENUE</b>										
a. Inpatient Services	\$ 129,172	\$ 128,991	\$ 134,621	\$ 137,896	\$ 143,976	\$ 147,475	\$ 151,058	\$ 166,089	\$ 170,125	\$ 174,259
b. Outpatient Services	185,931	192,271	191,806	196,469	196,076	200,843	205,725	224,585	230,044	235,637
<b>Gross Patient Service Revenues</b>	<b>315,103</b>	<b>321,262</b>	<b>326,427</b>	<b>334,365</b>	<b>340,052</b>	<b>348,317</b>	<b>356,783</b>	<b>\$ 390,674</b>	<b>400,169</b>	<b>\$ 409,896</b>
c. Allowance For Bad Debt	7,126	10,086	10,807	11,069	10,723	10,984	11,251	12,023	12,315	12,615
d. Contractual Allowance	58,378	58,308	57,546	58,945	63,369	64,909	66,486	70,892	72,615	74,380
e. Charity Care	2,770	2,787	2,931	3,002	2,901	2,971	3,044	3,417	3,500	3,585
<b>Net Patient Services Revenue</b>	<b>246,829</b>	<b>250,081</b>	<b>255,143</b>	<b>261,348</b>	<b>263,059</b>	<b>269,453</b>	<b>276,002</b>	<b>\$ 304,341</b>	<b>311,739</b>	<b>\$ 319,316</b>
f. Other Operating Revenues (Specify/add rows if needed)	4,305	4,709	4,980	5,073	4,833	4,929	5,028	5,129	5,231	5,336
<b>NET OPERATING REVENUE</b>	<b>\$ 251,134</b>	<b>\$ 254,790</b>	<b>\$ 260,123</b>	<b>\$ 266,421</b>	<b>\$ 267,892</b>	<b>\$ 274,382</b>	<b>\$ 281,030</b>	<b>\$ 309,470</b>	<b>\$ 316,970</b>	<b>\$ 324,652</b>
<b>2. EXPENSES</b>										
a. Salaries & Wages (including benefits)	\$ 112,640	\$ 116,748	\$ 115,852	\$ 118,062	\$ 112,808	\$ 115,631	\$ 118,530	\$ 121,518	\$ 124,596	\$ 127,769
b. Professional Fees	11,707	12,360	12,673	12,993	13,232	13,558	13,892	14,234	14,584	14,943
c. Interest on Current Debt	3,602	3,433	3,955	3,907	6,373	6,283	6,190	5,897	5,804	5,708
d. Interest on Project Debt	-	-	-	-	-	-	-	15,488	15,221	14,941
e. Current Depreciation	18,269	18,897	19,571	17,370	15,426	13,618	11,783	9,350	9,543	9,940
f. Project Depreciation	-	-	-	-	-	-	-	14,967	14,967	14,967
g. Current Amortization	-	-	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-	-	-
g. Supplies	38,533	37,580	38,299	39,416	39,152	40,290	41,469	42,285	43,120	43,980
h. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)	44,163	50,216	52,115	54,301	64,893	67,360	69,869	71,119	72,376	73,645
i. Population Health / Ambulatory & Phy. Network Investment	-	-	-	-	8,209	8,409	8,615	8,824	9,038	9,258
<b>TOTAL OPERATING EXPENSES</b>	<b>\$ 228,914</b>	<b>\$ 239,234</b>	<b>\$ 242,465</b>	<b>\$ 246,049</b>	<b>\$ 260,093</b>	<b>\$ 265,148</b>	<b>\$ 270,348</b>	<b>\$ 303,682</b>	<b>\$ 309,250</b>	<b>\$ 315,151</b>
<b>3. INCOME</b>										
a. Income From Operation	\$ 22,220	\$ 15,556	\$ 17,658	\$ 20,372	\$ 7,799	\$ 9,234	\$ 10,683	\$ 5,788	\$ 7,720	\$ 9,500
b. Non-Operating Expense							\$ 9,592			
<b>SUBTOTAL</b>	<b>\$ 22,220</b>	<b>\$ 15,556</b>	<b>\$ 17,658</b>	<b>\$ 20,372</b>	<b>\$ 7,799</b>	<b>\$ 9,234</b>	<b>\$ 1,091</b>	<b>\$ 5,788</b>	<b>\$ 7,720</b>	<b>\$ 9,500</b>
c. Income Taxes										
<b>NET INCOME (LOSS)</b>	<b>\$ 22,220</b>	<b>\$ 15,556</b>	<b>\$ 17,658</b>	<b>\$ 20,372</b>	<b>\$ 7,799</b>	<b>\$ 9,234</b>	<b>\$ 1,091</b>	<b>\$ 5,788</b>	<b>\$ 7,720</b>	<b>\$ 9,500</b>

**TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM**

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

	Most Recent Years (Actual/ Projected)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.							
Indicate CY or FY	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
<b>4. PATIENT MIX</b>										
<b>a. Percent of Total Revenue</b>										
1) Medicare	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%
2) Medicaid	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%
3) Blue Cross	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
4) Commercial Insurance	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%
5) Self-pay	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
6) Other	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
<b>TOTAL</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>
<b>b. Percent of Patient Days</b>										
<b>Total MSGA</b>										
1) Medicare	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%
2) Medicaid	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%
3) Blue Cross	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%
4) Commercial Insurance	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
5) Self-pay	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
6) Other	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%
<b>TOTAL</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

**Table H – Key Financial Projection Assumptions for UM Shore Health System (Includes HSCRC Annual Update Factors & Expense Inflation)**

<p>Projection is based on UM Shore Health System (SHS) FY2019 budgeted financial performance with assumptions identified below. SHS includes UM SMC at Easton, UM SMC at Dorchester through the conclusion of FY2021, UM SMC at Cambridge (FMF) beginning in FY2022 and Queen Anne's Emergency Center.</p>	
<p>Projection period reflects FY2019 – FY2027</p>	
Volumes	<ul style="list-style-type: none"> <li>- Refer to historical and projected utilization in Table F</li> </ul>
<p>Patient Revenue</p> <ul style="list-style-type: none"> <li>• Gross Charges <ul style="list-style-type: none"> <li>◦ Update Factor</li> <li>◦ Demographic and Other Rate Adjustment</li> <li>◦ Variable Cost Factor</li> <li>◦ Redistribution of Dorchester General Hospital Revenue Beginning in FY2022</li> <li>◦ Capital Costs in Rates beginning in FY2025</li> </ul> </li> <li>• Revenue Deductions</li> </ul>	<ul style="list-style-type: none"> <li>- 2.00% annual increase in FY2019 – FY2027</li> <li>- Totalling 0.43% annual increase in FY2019 – FY2027</li> <li>- 100% variable cost factor associated with regulated inpatient services shifted from Dorchester General Hospital to the SMC at Easton in FY2022</li> <li>- Shore Health System (SHS) will retain 50% of revenue related to volumes that will be lost to other providers in FY2022 (Retained Revenue) <ul style="list-style-type: none"> <li>- \$0.83M of SHS's Retained Revenue will be apportioned to the SMC at Easton to cover its depreciation and interest expense related to the transfer of IP beds.</li> <li>- An additional \$9.7M of SHS's Retained Revenue will be apportioned to UM SMC at Easton to fund ambulatory and physician network development and population health initiatives</li> </ul> </li> <li>- Request for \$25.2M of capital costs in rate at UM SMC at Easton. After factoring in mark up equals \$23.0M or 75.3% of the project's total depreciation and interest expense of \$30.5M.</li> <li>- Continuation of 2019 deductions from revenue (contractual allowances, denials, charity, bad debts, assessments) as percentages of gross revenue <ul style="list-style-type: none"> <li>- For the FY2025 capital rate request at UM SMC at Easton, deductions from regulated gross revenue were applied to the \$25.2M in gross revenue.</li> </ul> </li> </ul>
Other Operating Revenue	<ul style="list-style-type: none"> <li>- Includes Rental Income, Cafeteria Revenue, Contributions and Other Miscellaneous Revenue with a 2.0% increase per year.</li> </ul>
<p>Expenses</p> <ul style="list-style-type: none"> <li>• Inflation <ul style="list-style-type: none"> <li>◦ Salaries and Benefits</li> <li>◦ Professional Fees</li> <li>◦ Supplies</li> <li>◦ Purchased Services</li> <li>◦ Other Operating Expenses</li> </ul> </li> <li>• Expense Variability with Volume Changes <ul style="list-style-type: none"> <li>◦ Salaries and Benefits</li> <li>◦ Professional Fees</li> <li>◦ Supplies &amp; Drugs</li> <li>◦ Purchased Services</li> <li>◦ Other Operating Expenses</li> </ul> </li> <li>• Building Related Operating Expense</li> <li>• Interest Expense – Existing Debt</li> <li>• Interest Expense – Project Debt</li> <li>• Depreciation and Amortization</li> <li>• Population Health, Ambulatory &amp; Physician Network Improvement</li> <li>• Other Operating Expense</li> </ul>	<ul style="list-style-type: none"> <li>- 2.4% weighted average annual increase that reflects the following: <ul style="list-style-type: none"> <li>- 2.25%</li> <li>- 2.5%</li> <li>- 3.0%</li> <li>- 2.75%</li> <li>- 2.0%</li> </ul> </li> <li>- 80%</li> <li>- 0%</li> <li>- 80%</li> <li>- 50%</li> <li>- 0%</li> <li>- No incremental building operating costs or savings (utilities, housekeeping, maintenance, security) are included.</li> <li>- Continued amortization of existing debt and related interest expense, plus the amortization of the following debt issuance over 30 years for projects completed in FY22: <ul style="list-style-type: none"> <li>• \$42.0M for construction of the FMF</li> <li>• \$8.4M for renovations at Easton</li> <li>• \$33.1M for construction of a new MOB</li> </ul> </li> <li>- Amortization of \$311.1M for the project over 30 years at 5.0% interest.</li> <li>- 30 year useful life for new construction and renovations</li> <li>- 7 year useful life for new equipment</li> <li>- Beginning in FY2022, the retention of 50% of revenue associated with patients that will seek care at other providers following the merger and consolidation of Dorchester General Hospital, will enable SHS to fund \$8.2M of initiatives related to ambulatory and physician network development and population health initiatives, growing at a 2.4% inflation rate.</li> <li>- A \$9.5M one time write of existing MHE physical plant capital improvements that will not transfer over to the replacement facility.</li> </ul>



**TABLE I. STATISTICAL PROJECTIONS - UM SMC at Easton**

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

	Current Year (Actual/ Projected)	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.								
	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027
<b>1. DISCHARGES</b>										
a. General Medical/Surgical*	5,498	5,291	5,292	5,295	6,419	6,432	6,446	6,461	6,478	6,496
b. ICU/CCU	173	167	167	167	200	201	201	201	202	203
<b>Total MSGA</b>	<b>5,672</b>	<b>5,458</b>	<b>5,459</b>	<b>5,462</b>	<b>6,620</b>	<b>6,633</b>	<b>6,647</b>	<b>6,663</b>	<b>6,680</b>	<b>6,698</b>
c. Pediatric	62	61	61	61	60	60	59	59	59	58
d. Obstetric	1,171	1,170	1,169	1,167	1,166	1,164	1,163	1,162	1,160	1,159
e. Acute Psychiatric	-	-	-	-	558	558	559	560	561	561
<b>Total Acute</b>	<b>6,905</b>	<b>6,689</b>	<b>6,689</b>	<b>6,689</b>	<b>8,404</b>	<b>8,415</b>	<b>8,429</b>	<b>8,443</b>	<b>8,459</b>	<b>8,477</b>
f. Rehabilitation	358	353	358	363	368	373	379	384	390	396
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
<b>TOTAL DISCHARGES</b>	<b>7,263</b>	<b>7,042</b>	<b>7,047</b>	<b>7,052</b>	<b>8,772</b>	<b>8,789</b>	<b>8,807</b>	<b>8,828</b>	<b>8,849</b>	<b>8,873</b>
<b>2. PATIENT DAYS</b>										
a. General Medical/Surgical*	21,772	20,195	20,160	20,128	24,747	24,759	24,776	24,802	24,830	24,864
b. ICU/CCU	1,386	1,285	1,283	1,281	1,402	1,401	1,401	1,401	1,401	1,402
<b>Total MSGA</b>	<b>23,158</b>	<b>21,480</b>	<b>21,443</b>	<b>21,409</b>	<b>26,149</b>	<b>26,160</b>	<b>26,177</b>	<b>26,203</b>	<b>26,231</b>	<b>26,266</b>
c. Pediatric	152	151	150	149	148	147	146	145	144	143
d. Obstetric	3,272	3,268	3,264	3,260	3,256	3,252	3,248	3,244	3,240	3,237
e. Acute Psychiatric	-	-	-	-	3,803	3,807	3,811	3,816	3,821	3,826
<b>Total Acute</b>	<b>26,582</b>	<b>24,899</b>	<b>24,857</b>	<b>24,818</b>	<b>33,356</b>	<b>33,366</b>	<b>33,382</b>	<b>33,408</b>	<b>33,436</b>	<b>33,473</b>
f. Rehabilitation	3,510	3,650	3,509	3,559	3,610	3,663	3,715	3,771	3,828	3,885
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
<b>TOTAL PATIENT DAYS</b>	<b>30,092</b>	<b>28,549</b>	<b>28,366</b>	<b>28,377</b>	<b>36,966</b>	<b>37,029</b>	<b>37,097</b>	<b>37,179</b>	<b>37,264</b>	<b>37,358</b>
<b>3. AVERAGE LENGTH OF STAY (patient days divided by discharges)</b>										
a. General Medical/Surgical*	4.0	3.8	3.8	3.8	3.9	3.8	3.8	3.8	3.8	3.8
b. ICU/CCU	8.0	7.7	7.7	7.7	7.0	7.0	7.0	7.0	6.9	6.9
<b>Total MSGA</b>	<b>4.1</b>	<b>3.9</b>	<b>3.9</b>	<b>3.9</b>	<b>4.0</b>	<b>3.9</b>	<b>3.9</b>	<b>3.9</b>	<b>3.9</b>	<b>3.9</b>
c. Pediatric	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5
d. Obstetric	2.8	2.8	2.8	2.8	2.8	2.8	2.8	2.8	2.8	2.8
e. Acute Psychiatric	0.0	0.0	0.0	0.0	6.8	6.8	6.8	6.8	6.8	6.8
<b>Total Acute</b>	<b>3.8</b>	<b>3.7</b>	<b>3.7</b>	<b>3.7</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>3.9</b>
f. Rehabilitation	9.8	10.3	9.8	9.8	9.8	9.8	9.8	9.8	9.8	9.8
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>TOTAL AVERAGE LENGTH OF STAY</b>	<b>4.1</b>	<b>4.1</b>	<b>4.0</b>	<b>4.0</b>	<b>4.2</b>	<b>4.2</b>	<b>4.2</b>	<b>4.2</b>	<b>4.2</b>	<b>4.2</b>

TABLE I. STATISTICAL PROJECTIONS - UM SMC at Easton

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

	Current Year (Actual/ Projected)	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.								
	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY2027
<b>4. NUMBER OF LICENSED BEDS</b>										
a. General Medical/Surgical*	77	79	77	75	79	79	79	79	79	79
b. ICU/CCU	10	10	10	10	16	16	16	16	16	16
<b>Total MSGA</b>	<b>87</b>	<b>89</b>	<b>87</b>	<b>85</b>	<b>95</b>	<b>95</b>	<b>95</b>	<b>95</b>	<b>95</b>	<b>95</b>
c. Pediatric	8	1	1	1	1	1	1	1	1	1
d. Obstetric	17	13	13	13	13	13	13	13	13	13
e. Acute Psychiatric	0	0	0	0	12	12	12	12	12	12
<b>Total Acute</b>	<b>112</b>	<b>103</b>	<b>101</b>	<b>98</b>	<b>121</b>	<b>121</b>	<b>121</b>	<b>121</b>	<b>121</b>	<b>121</b>
f. Rehabilitation	20	13	14	13	14	14	14	14	14	14
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
<b>TOTAL LICENSED BEDS</b>	<b>132</b>	<b>116</b>	<b>115</b>	<b>111</b>	<b>135</b>	<b>135</b>	<b>135</b>	<b>135</b>	<b>135</b>	<b>135</b>
<b>5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.</b>										
a. General Medical/Surgical*	77.5%	69.8%	71.8%	73.9%	85.8%	85.9%	85.9%	86.0%	86.1%	86.2%
b. ICU/CCU	38.0%	35.2%	35.2%	35.1%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%
<b>Total MSGA</b>	<b>72.9%</b>	<b>65.9%</b>	<b>67.6%</b>	<b>69.3%</b>	<b>75.4%</b>	<b>75.4%</b>	<b>75.5%</b>	<b>75.6%</b>	<b>75.6%</b>	<b>75.7%</b>
c. Pediatric	5.2%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
d. Obstetric	52.7%	70.0%	69.9%	69.8%	69.7%	69.7%	69.6%	69.5%	69.4%	69.3%
e. Acute Psychiatric	0.0%	0.0%	0.0%	0.0%	86.8%	86.9%	87.0%	87.1%	87.2%	87.4%
<b>Total Acute</b>	<b>65.0%</b>	<b>66.3%</b>	<b>67.7%</b>	<b>69.2%</b>	<b>75.8%</b>	<b>75.8%</b>	<b>75.8%</b>	<b>75.9%</b>	<b>76.0%</b>	<b>76.1%</b>
f. Rehabilitation	48.1%	76.9%	68.7%	75.0%	70.6%	71.7%	72.7%	73.8%	74.9%	76.0%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>TOTAL OCCUPANCY %</b>	<b>62.5%</b>	<b>67.5%</b>	<b>67.9%</b>	<b>69.9%</b>	<b>75.2%</b>	<b>75.4%</b>	<b>75.5%</b>	<b>75.7%</b>	<b>75.9%</b>	<b>76.1%</b>
<b>6. OUTPATIENT VISITS</b>										
a. Emergency Department (IP and OP)	62,307	61,848	62,019	62,195	62,377	62,564	62,756	62,954	63,158	63,368
b. Same-day Surgery	2,951	2,961	2,972	2,983	2,995	3,007	3,020	3,033	3,047	3,062
c. Laboratory	2,937,672	2,947,751	2,958,341	2,969,455	2,981,110	2,993,320	3,006,101	3,019,470	3,033,443	3,048,039
d. Imaging	838,470	841,347	844,369	847,542	850,868	854,353	858,001	861,817	865,805	869,971
e. MRI	58,679	58,880	59,092	59,314	59,547	59,791	60,046	60,313	60,592	60,884
<b>TOTAL OUTPATIENT VISITS</b>	<b>3,900,079</b>	<b>3,912,787</b>	<b>3,926,793</b>	<b>3,941,489</b>	<b>3,956,896</b>	<b>3,973,034</b>	<b>3,989,924</b>	<b>4,007,587</b>	<b>4,026,046</b>	<b>4,045,323</b>
<b>7. OBSERVATIONS**</b>										
a. Number of Patients	2,477	2,507	2,537	2,568	2,599	2,631	2,663	2,695	2,727	2,760
b. Hours	72,456	76,644	79,124	81,684	84,327	87,055	89,872	92,779	95,781	98,880

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

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

**TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - Replacement of UM Shore Medical Center at Easton**

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

	Most Recent Years (Actual/ Projected)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.							
Indicate CY or FY	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
<b>1. REVENUE</b>										
a. Inpatient Services	\$ 104,211	\$ 104,099	\$ 104,089	\$ 104,079	\$ 133,931	\$ 133,918	\$ 133,905	\$ 143,722	\$ 143,708	\$ 143,694
b. Outpatient Services	158,270	163,431	163,415	163,399	163,383	163,367	163,351	175,327	175,310	175,293
<b>Gross Patient Service Revenues</b>	<b>262,481</b>	<b>267,530</b>	<b>267,504</b>	<b>267,478</b>	<b>297,314</b>	<b>297,285</b>	<b>297,256</b>	<b>319,050</b>	<b>319,018</b>	<b>318,987</b>
c. Allowance For Bad Debt	5,417	8,005	8,004	8,003	8,896	8,895	8,894	9,325	9,324	9,323
d. Contractual Allowance	51,145	51,034	51,029	51,024	56,716	56,710	56,705	59,113	59,107	59,102
e. Charity Care	2,280	2,284	2,284	2,284	2,538	2,538	2,538	2,797	2,797	2,796
<b>Net Patient Services Revenue</b>	<b>203,639</b>	<b>206,207</b>	<b>206,187</b>	<b>206,167</b>	<b>229,164</b>	<b>229,142</b>	<b>229,119</b>	<b>247,815</b>	<b>247,790</b>	<b>247,766</b>
f. Other Operating Revenues (Specify/add rows of needed)	4,032	4,554	4,554	4,645	4,645	4,645	4,645	4,645	4,645	4,645
<b>NET OPERATING REVENUE</b>	<b>\$ 207,671</b>	<b>\$ 210,761</b>	<b>\$ 210,741</b>	<b>\$ 210,812</b>	<b>\$ 233,809</b>	<b>\$ 233,787</b>	<b>\$ 233,764</b>	<b>\$ 252,460</b>	<b>\$ 252,435</b>	<b>\$ 252,411</b>
<b>2. EXPENSES</b>										
a. Salaries & Wages (including benefits)	92,675	97,321	95,057	94,725	100,613	100,868	101,129	101,405	101,694	101,999
b. Professional Fees	8,620	9,215	9,215	9,215	10,433	10,433	10,433	10,433	10,433	10,433
c. Interest on Current Debt	3,264	3,095	3,743	3,697	4,076	4,024	3,972	3,921	3,869	3,818
d. Interest on Project Debt	-	-	-	-	-	-	-	15,488	15,221	14,941
e. Current Depreciation	17,663	18,897	17,532	15,127	13,646	11,802	9,930	7,461	7,615	7,974
f. Project Depreciation	-	-	-	-	-	-	-	14,967	14,967	14,967
g. Supplies	35,211	34,177	34,213	34,253	35,334	35,392	35,457	35,184	34,917	34,657
h. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)	33,674	46,438	46,931	47,642	55,147	55,789	56,392	55,849	55,299	54,745
i. Population Health / Ambulatory & Phy. Network Investment	-	-	-	-	8,209	8,209	8,209	8,209	8,209	8,209
<b>TOTAL OPERATING EXPENSES</b>	<b>\$ 191,107</b>	<b>\$ 209,143</b>	<b>\$ 206,691</b>	<b>\$ 204,660</b>	<b>\$ 227,458</b>	<b>\$ 226,517</b>	<b>\$ 225,523</b>	<b>\$ 252,917</b>	<b>\$ 252,225</b>	<b>\$ 251,742</b>
<b>3. INCOME</b>										
a. Income From Operation	\$ 16,564	\$ 1,618	\$ 4,050	\$ 6,152	\$ 6,351	\$ 7,270	\$ 8,241	\$ (457)	\$ 211	\$ 669
b. Non-Operating Expense							9,592			
<b>SUBTOTAL</b>	<b>\$ 16,564</b>	<b>\$ 1,618</b>	<b>\$ 4,050</b>	<b>\$ 6,152</b>	<b>\$ 6,351</b>	<b>\$ 7,270</b>	<b>\$ 17,833</b>	<b>\$ (457)</b>	<b>\$ 211</b>	<b>\$ 669</b>
c. Income Taxes										
<b>NET INCOME (LOSS)</b>	<b>\$ 16,564</b>	<b>\$ 1,618</b>	<b>\$ 4,050</b>	<b>\$ 6,152</b>	<b>\$ 6,351</b>	<b>\$ 7,270</b>	<b>\$ 17,833</b>	<b>\$ (457)</b>	<b>\$ 211</b>	<b>\$ 669</b>

**TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - Replacement of UM Shore Medical Center at Easton**

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

	Most Recent Years (Actual/Projected)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.							
Indicate CY or FY	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027

**4. PATIENT MIX**

**a. Percent of Total Revenue**

1) Medicare	54.6%	54.6%	54.6%	54.6%	54.6%	54.6%	54.6%	54.6%	54.6%	54.6%
2) Medicaid	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%
3) Blue Cross	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%
4) Commercial Insurance	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%
5) Self-pay	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
6) Other	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%
<b>TOTAL</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

**b. Percent of Patient Days**

1) Medicare	63.3%	63.3%	63.3%	63.3%	63.3%	63.3%	63.3%	63.3%	63.3%	63.3%
2) Medicaid	18.8%	18.8%	18.8%	18.8%	18.8%	18.8%	18.8%	18.8%	18.8%	18.8%
3) Blue Cross	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%
4) Commercial Insurance	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%
5) Self-pay	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
6) Other	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
<b>TOTAL</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

**Table J – Key Financial Projection Assumptions for Replacement of UM SMC at Easton (Does not include HSCRC Annual Update Factors & Expense Inflation)**

Projection is based on UM Shore Medical Center at Easton's FY2019 budgeted financial performance of its inpatient and outpatient services with assumptions identified below.	
Projection period reflects FY2019 – FY2027	
Volumes	Refer to historical and projected utilization in Table I and pages 31 - 42, 77 - 83, 91 - 96, and 148 - 157 of the CON Application related to the methodology, assumptions and projections of UM SMC at Easton's anticipated utilization.
<b>Patient Revenue</b> <ul style="list-style-type: none"> <li>• Gross Charges <ul style="list-style-type: none"> <li>○ Update Factor</li> <li>○ Demographic and Other Rate Adjustment</li> <li>○ Variable Cost Factor</li> <li>○ Redistribution of Dorchester General Hospital Revenue Beginning in FY2022</li> <li>○ Capital Costs in Rates beginning in FY2025</li> </ul> </li> <li>• Revenue Deductions</li> </ul>	<ul style="list-style-type: none"> <li>- 0.00% annual increase in FY2019 – FY2027</li> <li>- 0.00% annual increase in FY2019 – FY2027</li> <li>- 100% variable cost factor associated with regulated inpatient services shifted from Dorchester General Hospital to the SMC at Easton in FY2022</li> <li>- Shore Health System (SHS) will retain 50% of revenue related to volumes that will be lost to other providers in FY2022 (Retained Revenue)</li> <li>- \$0.83M of SHS's Retained Revenue will be apportioned to the SMC at Easton to cover its depreciation and interest expense related to the transfer of IP beds.</li> <li>- An additional \$9.7M of SHS's Retained Revenue will be apportioned to UM SMC at Easton to fund ambulatory and physician network development and population health initiatives</li> <li>- Request for \$25.2M of capital costs in rate. After factoring in mark up equals \$23.0M or 75.3% of the project's total depreciation and interest expense of \$30.5M.</li> <li>- Continuation of 2019 deductions from revenue (contractual allowances, denials, charity, bad debts, assessments) as percentages of gross revenue</li> <li>- For the FY2025 rate request, deductions from regulated gross revenue were applied to the \$25.2M in gross revenue.</li> </ul>
Other Operating Revenue	<ul style="list-style-type: none"> <li>- Includes Rental Income, Cafeteria Revenue, Contributions and Other Miscellaneous Revenue with a 0.0% increase per year.</li> </ul>
<b>Expenses</b> <ul style="list-style-type: none"> <li>• Inflation <ul style="list-style-type: none"> <li>○ Salaries and Benefits</li> <li>○ Professional Fees</li> <li>○ Supplies</li> <li>○ Purchased Services</li> <li>○ Other Operating Expenses</li> </ul> </li> <li>• Expense Variability with Volume Changes <ul style="list-style-type: none"> <li>○ Salaries and Benefits</li> <li>○ Professional Fees</li> <li>○ Supplies &amp; Drugs</li> <li>○ Purchased Services</li> <li>○ Other Operating Expenses</li> </ul> </li> <li>• Building Related Operating Expense</li> <li>• Interest Expense – Existing Debt</li> <li>• Interest Expense – Project Debt</li> <li>• Depreciation and Amortization</li> <li>• Population Health, Ambulatory &amp; Physician Network Improvement</li> <li>• Other Operating Expense</li> </ul>	<ul style="list-style-type: none"> <li>- 0.0% weighted average annual increase that reflects the following: <ul style="list-style-type: none"> <li>- 0.0%</li> <li>- 0.0%</li> <li>- 0.0%</li> <li>- 0.0%</li> <li>- 0.0%</li> </ul> </li> <li>- 80%</li> <li>- 0%</li> <li>- 80%</li> <li>- 50%</li> <li>- 0%</li> <li>- No incremental building operating costs or savings (utilities, housekeeping, maintenance, and security) are included.</li> <li>- Existing MHE debt plus the amortization of \$8.5M for renovations to accommodate the IP beds over 30 years at 5.0% which occurred in FY22.</li> <li>- Amortization of \$311.1M for the project over 30 years at 5.0% interest.</li> <li>- 30 year useful life for new construction and renovations</li> <li>- 7 year useful life for new equipment</li> <li>- Beginning in FY2022, the retention of 50% of revenue associated with patients that will seek care at other providers following the merger and consolidation of Dorchester General Hospital, will enable SHS to fund \$8.2M of initiatives related to ambulatory and physician network development and population health initiatives</li> <li>- A \$9.5M one time write of existing MHE physical plant capital improvements that will not transfer over to the replacement facility.</li> </ul>

**TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - Replacement of UM Shore Medical Center at Easton**

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

	Most Recent Years (Actual/ Projected)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.							
Indicate CY or FY	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
<b>1. REVENUE</b>										
a. Inpatient Services	\$ 104,211	\$ 104,099	\$ 106,629	\$ 109,220	\$ 143,976	\$ 147,475	\$ 151,058	\$ 166,089	\$ 170,125	\$ 174,259
b. Outpatient Services	158,270	163,431	167,402	171,470	175,637	179,905	184,277	202,613	207,536	212,580
<b>Gross Patient Service Revenues</b>	<b>262,481</b>	<b>267,530</b>	<b>274,031</b>	<b>280,690</b>	<b>319,613</b>	<b>327,379</b>	<b>335,335</b>	<b>368,702</b>	<b>377,661</b>	<b>386,839</b>
c. Allowance For Bad Debt	5,417	8,005	8,200	8,399	9,563	9,796	10,034	10,776	11,038	11,306
d. Contractual Allowance	51,145	51,034	52,274	53,544	60,969	62,451	63,968	68,313	69,973	71,673
e. Charity Care	2,280	2,284	2,340	2,396	2,729	2,795	2,863	3,232	3,311	3,391
<b>Net Patient Services Revenue</b>	<b>203,639</b>	<b>206,207</b>	<b>211,218</b>	<b>216,350</b>	<b>246,352</b>	<b>252,338</b>	<b>258,470</b>	<b>286,381</b>	<b>293,340</b>	<b>300,468</b>
f. Other Operating Revenues (Specify/add rows of needed)	4,032	4,554	4,645	4,738	4,833	4,929	5,028	5,129	5,231	5,336
<b>NET OPERATING REVENUE</b>	<b>\$ 207,671</b>	<b>\$ 210,761</b>	<b>\$ 215,863</b>	<b>\$ 221,088</b>	<b>\$ 251,184</b>	<b>\$ 257,267</b>	<b>\$ 263,498</b>	<b>\$ 291,510</b>	<b>\$ 298,571</b>	<b>\$ 305,804</b>
<b>2. EXPENSES</b>										
a. Salaries & Wages (including benefits)	92,675	97,321	97,195	99,036	107,558	110,257	113,029	115,888	118,834	121,871
b. Professional Fees	8,620	9,215	9,446	9,682	11,235	11,516	11,804	12,099	12,401	12,712
c. Interest on Current Debt	3,264	3,095	3,743	3,697	4,076	4,024	3,972	3,921	3,869	3,818
d. Interest on Project Debt	-	-	-	-	-	-	-	15,488	15,221	14,941
e. Current Depreciation	17,663	18,897	17,532	15,127	13,646	11,802	9,930	7,461	7,615	7,974
f. Project Depreciation	-	-	-	-	-	-	-	14,967	14,967	14,967
g. Supplies	35,211	34,177	35,154	36,162	38,330	39,448	40,608	41,404	42,219	43,057
h. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)	33,674	46,438	48,217	50,288	59,805	62,160	64,553	65,683	66,818	67,962
i. Population Health / Ambulatory & Phy. Network Investment	-	-	-	-	8,209	8,409	8,615	8,824	9,038	9,258
<b>TOTAL OPERATING EXPENSES</b>	<b>\$ 191,107</b>	<b>\$ 209,143</b>	<b>\$ 211,286</b>	<b>\$ 213,993</b>	<b>\$ 242,860</b>	<b>\$ 247,616</b>	<b>\$ 252,512</b>	<b>\$ 285,734</b>	<b>\$ 290,983</b>	<b>\$ 296,559</b>
<b>3. INCOME</b>										
a. Income From Operation	\$ 16,564	\$ 1,618	\$ 4,576	\$ 7,095	\$ 8,324	\$ 9,651	\$ 10,986	\$ 5,775	\$ 7,588	\$ 9,245
b. Non-Operating Expense							9,592			
<b>SUBTOTAL</b>	<b>\$ 16,564</b>	<b>\$ 1,618</b>	<b>\$ 4,576</b>	<b>\$ 7,095</b>	<b>\$ 8,324</b>	<b>\$ 9,651</b>	<b>\$ 1,394</b>	<b>\$ 5,775</b>	<b>\$ 7,588</b>	<b>\$ 9,245</b>
c. Income Taxes										
<b>NET INCOME (LOSS)</b>	<b>\$ 16,564</b>	<b>\$ 1,618</b>	<b>\$ 4,576</b>	<b>\$ 7,095</b>	<b>\$ 8,324</b>	<b>\$ 9,651</b>	<b>\$ 1,394</b>	<b>\$ 5,775</b>	<b>\$ 7,588</b>	<b>\$ 9,245</b>

**TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - Replacement of UM Shore Medical Center at Easton**

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

	Most Recent Years (Actual/ Projected)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.							
Indicate CY or FY	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
<b>4. PATIENT MIX</b>										
<b>a. Percent of Total Revenue</b>										
1) Medicare	54.6%	54.6%	54.6%	54.6%	54.6%	54.6%	54.6%	54.6%	54.6%	54.6%
2) Medicaid	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%
3) Blue Cross	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%
4) Commercial Insurance	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%
5) Self-pay	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
6) Other	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%
<b>TOTAL</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>
<b>b. Percent of Patient Days</b>										
1) Medicare	63.3%	63.3%	63.3%	63.3%	63.3%	63.3%	63.3%	63.3%	63.3%	63.3%
2) Medicaid	18.8%	18.8%	18.8%	18.8%	18.8%	18.8%	18.8%	18.8%	18.8%	18.8%
3) Blue Cross	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%
4) Commercial Insurance	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%
5) Self-pay	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
6) Other	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
<b>TOTAL</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

**Table K – Key Financial Projection Assumptions for Replacement of UM SMC at Easton (Includes HSCRC Annual Update Factors & Expense Inflation)**

Projection is based on UM Shore Medical Center at Easton's FY2019 budgeted financial performance of its inpatient and outpatient services with assumptions identified below.	
Projection period reflects FY2019 – FY2027	
Volumes	Refer to historical and projected utilization in Table I and pages 31 - 42, 77 - 83, 91 - 96, and 148 - 157 of the CON Application related to the methodology, assumptions and projections of UM SMC at Easton's anticipated utilization.
<b>Patient Revenue</b> <ul style="list-style-type: none"> <li>• Gross Charges <ul style="list-style-type: none"> <li>○ Update Factor</li> <li>○ Demographic and Other Rate Adjustment</li> <li>○ Variable Cost Factor</li> <li>○ Redistribution of Dorchester General Hospital Revenue Beginning in FY2022</li> <li>○ Capital Costs in Rates beginning in FY2025</li> </ul> </li> <li>• Revenue Deductions</li> </ul>	<ul style="list-style-type: none"> <li>- 2.00% annual increase in FY2019 – FY2027</li> <li>- Totalling 0.43% annual increase in FY2019 – FY2027</li> <li>- 100% variable cost factor associated with regulated inpatient services shifted from Dorchester General Hospital to the SMC at Easton in FY2022</li> <li>- Shore Health System (SHS) will retain 50% of revenue related to volumes that will be lost to other providers in FY2022 (Retained Revenue) <ul style="list-style-type: none"> <li>- \$0.83M of SHS's Retained Revenue will be apportioned to the SMC at Easton to cover its depreciation and interest expense related to the transfer of IP beds.</li> <li>- An additional \$9.7M of SHS's Retained Revenue will be apportioned to UM SMC at Easton to fund ambulatory and physician network development and population health initiatives</li> </ul> </li> <li>- Request for \$25.2M of capital costs in rate. After factoring in mark up equals \$23.0M or 75.3% of the project's total depreciation and interest expense of \$30.5M.</li> <li>- Continuation of 2019 deductions from revenue (contractual allowances, denials, charity, bad debts, assessments) as percentages of gross revenue <ul style="list-style-type: none"> <li>- For the FY2025 rate request, deductions from regulated gross revenue were applied to the \$25.2M in gross revenue.</li> </ul> </li> </ul>
Other Operating Revenue	<ul style="list-style-type: none"> <li>- Includes Rental Income, Cafeteria Revenue, Contributions and Other Miscellaneous Revenue with a 2.0% increase per year.</li> </ul>
<b>Expenses</b> <ul style="list-style-type: none"> <li>• Inflation <ul style="list-style-type: none"> <li>○ Salaries and Benefits</li> <li>○ Professional Fees</li> <li>○ Supplies</li> <li>○ Purchased Services</li> <li>○ Other Operating Expenses</li> </ul> </li> <li>• Expense Variability with Volume Changes <ul style="list-style-type: none"> <li>○ Salaries and Benefits</li> <li>○ Professional Fees</li> <li>○ Supplies &amp; Drugs</li> <li>○ Purchased Services</li> <li>○ Other Operating Expenses</li> </ul> </li> <li>• Building Related Operating Expense</li> <li>• Interest Expense – Existing Debt</li> <li>• Interest Expense – Project Debt</li> <li>• Depreciation and Amortization</li> <li>• Population Health, Ambulatory &amp; Physician Network Improvement</li> <li>• Other Operating Expense</li> </ul>	<ul style="list-style-type: none"> <li>- 2.4% weighted average annual increase that reflects the following: <ul style="list-style-type: none"> <li>- 2.25%</li> <li>- 2.5%</li> <li>- 3.0%</li> <li>- 2.75%</li> <li>- 2.0%</li> </ul> </li> <li>- 80%</li> <li>- 0%</li> <li>- 80%</li> <li>- 50%</li> <li>- 0%</li> <li>- No incremental building operating costs or savings (utilities, housekeeping, maintenance, security) are included.</li> <li>- Existing MHE debt plus the amortization of \$8.5M for renovations to accommodate the IP beds over 30 years at 5.0% which occurred in FY22.</li> <li>- Amortization of \$311.1M for the project over 30 years at 5.0% interest.</li> <li>- 30 year useful life for new construction and renovations</li> <li>- 7 year useful life for new equipment</li> <li>- Beginning in FY2022, the retention of 50% of revenue associated with patients that will seek care at other providers following the merger and consolidation of Dorchester General Hospital, will enable SHS to fund \$8.2M of initiatives related to ambulatory and physician network development and population health initiatives growing at a 2.4% inflation rate.</li> <li>- A \$9.5M one time write of existing MHE physical plant capital improvements that will not transfer over to the replacement facility.</li> </ul>



TABLE L. WORKFORCE INFORMATION - SHS

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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	Current Year FTEs	Average Salary per FTE	Current Year Total Cost	FTEs	Average Salary per FTE	Total Cost (should be consistent with projections in Table G, if submitted).	FTEs	Average Salary per FTE	Total Cost	FTEs	Total Cost (should be consistent with projections in Table G)
<b>1. Regular Employees</b>											
Administration (List general categories, add rows if needed)											
<b>Total Administration</b>	191	\$68,145	\$ 13,002,595			\$ -	-		\$ -	191	\$ 13,002,595
Direct Care Staff (List general categories, add rows if needed)											
Inpatient Units	342	\$67,095	22,977,882			\$ -	-28	\$ 67,095	\$ (1,880,670)	314	21,097,212
OP units and other Ancillary Services	217	\$73,538	15,932,815			-	-14	\$ 73,538	\$ (1,029,536)	203	14,903,278
Rehab Services	26	\$66,291	1,741,184			-	-1	\$ 66,291	\$ (71,483)	25	1,669,700
Emergency Department	93	\$69,867	6,517,486			-	-2	\$ 69,867	\$ (139,734)	95	6,377,752
Laboratory	95	\$57,208	5,453,612			-	-2	\$ 57,208	\$ (114,415)	102	5,339,197
Surgical Services	70	\$72,722	5,062,459			-	-3	\$ 72,722	\$ (218,167)	74	4,844,292
Pharmacy	29	\$83,259	2,389,531			-	1	\$ 83,259	\$ 62,587	29	2,452,118
Radiology	77	\$69,801	5,374,665			-	-1	\$ 69,801	\$ (43,139)	76	5,331,526
<b>Total Direct Care</b>	949	68,944	65,449,634			\$ -	-50	68,726	-3,434,558	918	62,015,076
Support Staff (List general categories, add rows if needed)											
<b>Security</b>	30	\$45,629	1,360,657				-5	\$45,629	\$ (213,383)	25	1,147,274
<b>Enviornmental Services</b>	64	\$30,395	1,930,681				-16	\$30,395	\$ (477,905)	48	1,452,776
<b>Other Support Staff</b>	132	\$59,929	7,924,497				-33	\$59,929	\$ (1,999,146)	99	5,925,351
<b>Total Support</b>	226	\$49,722	11,215,835				-54	\$50,047	-2,690,435	172	8,525,400
<b>REGULAR EMPLOYEES TOTAL</b>	1,366	65,657	89,668,063			-	-104	59,046	-6,124,993	1,281	83,543,071
<b>2. Contractual Employees</b>											
Administration (List general categories, add rows if needed)											
<b>Total Administration</b>											
Direct Care Staff (List general categories, add rows if needed)											
<b>Total Direct Care Staff</b>											
Support Staff (List general categories, add rows if needed)											
<b>Total Support Staff</b>											
<b>CONTRACTUAL EMPLOYEES TOTAL</b>											
<b>Benefits</b> (State method of calculating benefits below) :			27,079,755						-3,687,695		23,392,060
<b>FY19 = 30.2% of Salaries</b>											
<b>FY27 = 28.0% of Salaries</b>											
<b>TOTAL COST</b>	1,366		\$ 116,747,819	-		\$ -	(104)		\$ (9,812,688)		\$ 106,935,130

# **EXHIBIT 2**



# SHORE HEALTH EASTON REPLACEMENT HOSPITAL

## EASTON, MD

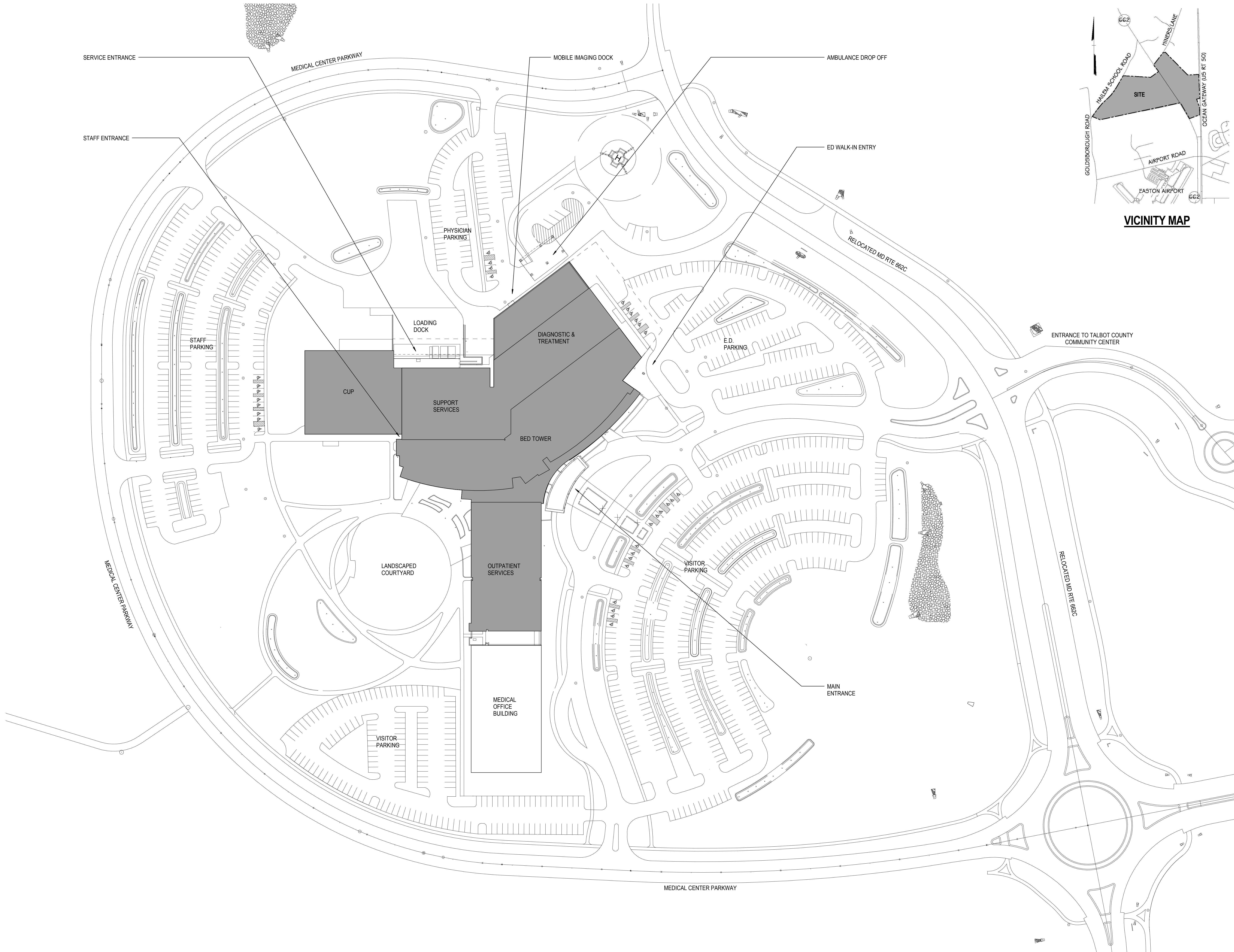


<b>OWNER</b>
UNIVERSITY OF MARYLAND HEALTH SYSTEM 250 W. PRATT STREET SUITE 2400 BALTIMORE, MD 21201 <b>SHORE HEALTH SYSTEM</b> 219 S. WASHINGTON STREET EASTON, MD 21601 BALTIMORE, MD 21201
<b>ARCHITECT</b>
HKS INC. 2100 E. GARY ST. SUITE 100 RICHMOND, VA 23223
<b>INTERIORS</b>
HKS INC. 2100 E. GARY ST. SUITE 100 RICHMOND, VA 23223
<b>CIVIL</b>
DAFT MCCUNE WALKER INC. BERLIN OFFICE, THE PAVILIONS 11200 RACETRACK ROAD, SUITE 202 BERLIN, MD 21811
<b>MEP</b>
HIGHLAND ASSOCIATES 102 HIGHLAND AVENUE CLARKS SUMMIT, PA 18411
<b>STRUCTURAL</b>
O'DONNELL & NACCARATO 111 SOUTH INDEPENDENCE MALL EAST SUITE 950 PHILADELPHIA, PA 19106-2545
<b>LANDSCAPE</b>
MAHAN RYKIEL ASSOCIATES THE STUEFF SILVER BUILDING 800 WYMAN PARK DRIVE, SUITE 100 BALTIMORE, MD 21211
<b>INFORMATION TECHNOLOGY</b>
SMITH SECKMAN REID, INC. 2985 SIDCO DRIVE NASHVILLE, TN 37204
<b>FOOD SERVICE</b>
L2M FOOD SERVICE DESIGN GROUP 811 CROMWELL PARK DRIVE, SUITE 113 GLEN BURNIE, MD 21061
<b>MEDICAL EQUIPMENT</b>
MITCHELL PLANNING ASSOCIATES 2704 OAKBROOK DRIVE WESTON, FL 33332
<b>OWNER'S CONSULTANTS</b>
FM GLOBAL 2100 RESTON PARKWAY, SUITE 600 RESTON, VA 20191

CON SUBMISSION

SEPTEMBER 7, 2018





**01** ARCHITECTURAL SITE PLAN -CON  
1" = 60'-0"

**HKS**

**ARCHITECT**  
HKS, Inc.  
2100 E. Cary Street, Suite 100  
Richmond, VA 23223  
1250 Eye Street NW, Suite 600  
Washington, D.C. 20005

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

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

**MEP**  
Highland Associates  
102 Highland Avenue  
Clark Summit, PA 18411

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

**LANDSCAPE**  
Mahan Rykiel Associates  
The Stuart Silver Building  
600 Wyman Park Drive, Suite 100  
Baltimore, MD 21211

**INFORMATION TECHNOLOGY**  
Smith Seidman Field, Inc.  
2995 Sidco Drive  
Nashville, TN 37204

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

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

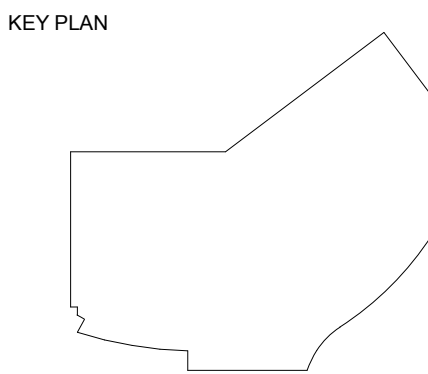
 **SHORE HEALTH**  
UNIVERSITY OF MARYLAND  
MEDICAL SYSTEM  
  
Shore Health  
Easton Replacement Hospital

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

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

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

**INTERIM REVIEW ONLY**  
These documents are incomplete, and  
are released for interim review only and  
are not intended for regulatory approval,  
permit, or construction purposes.  
Architect: Leslie Hanson  
Arch. Reg. No.: 15795  
Date: 01/23/2013



REVISION NO.	DESCRIPTION	DATE

HKS PROJECT NUMBER  
**19782.008**  
DATE  
**SEPTEMBER 7, 2018**  
ISSUE  
**CON SUBMISSION**

SHEET TITLE  
**ARCHITECTURAL  
SITE PLAN**

SHEET NO.  
**A1.010**

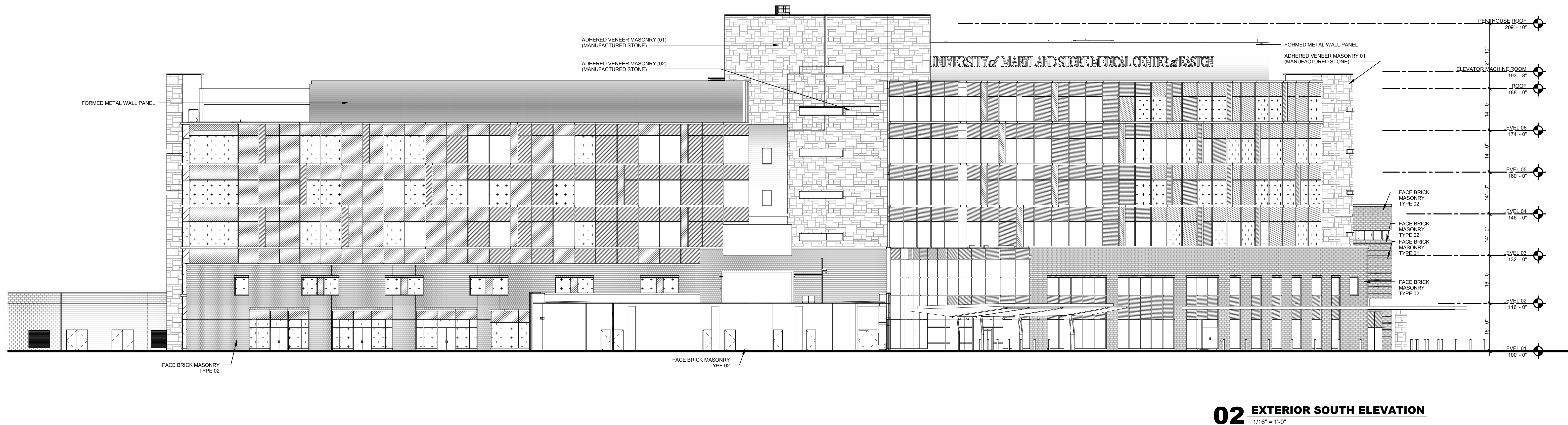
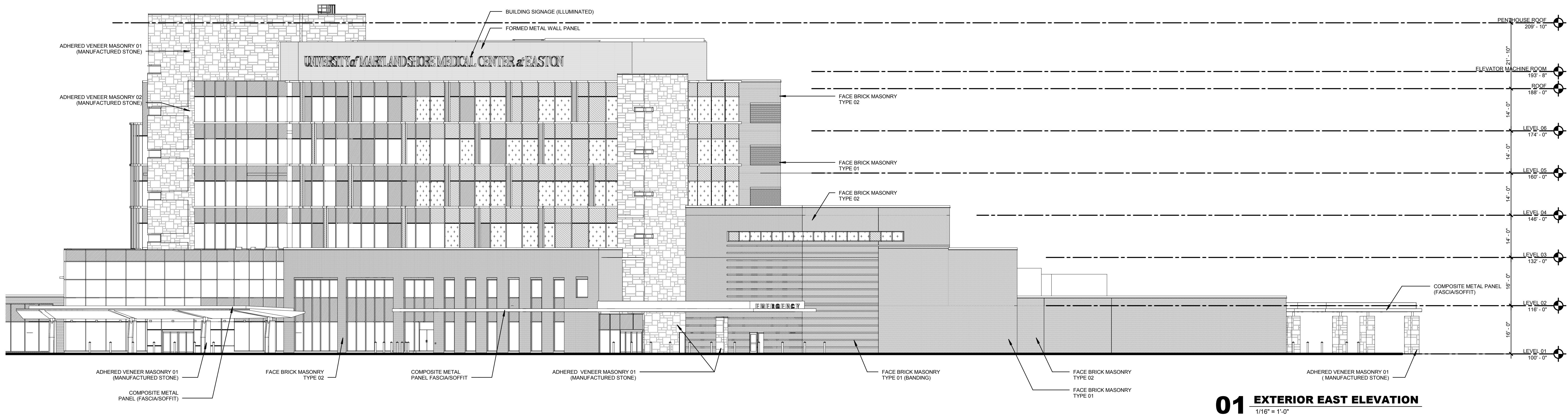










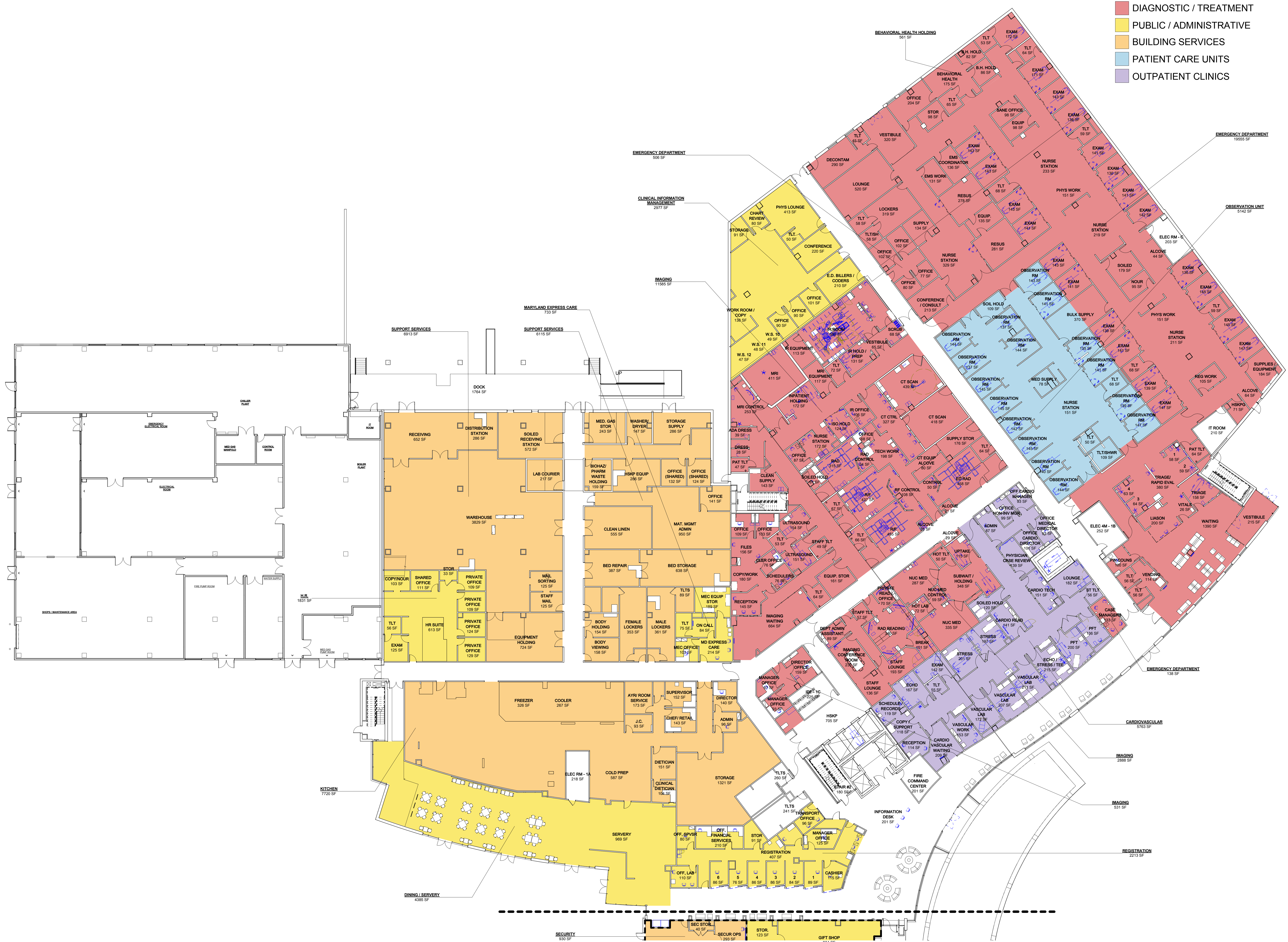






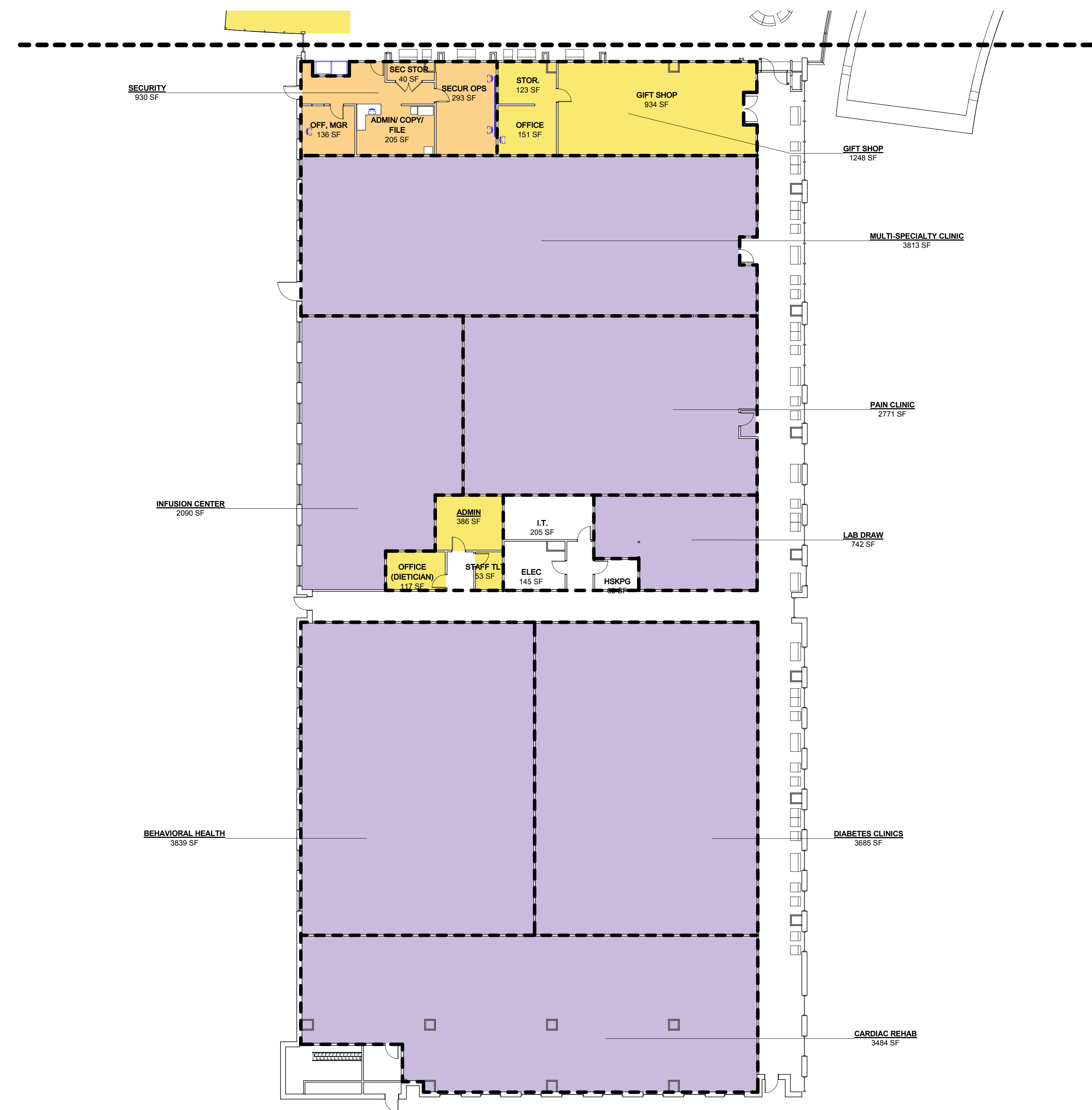


- DIAGNOSTIC / TREATMENT
- PUBLIC / ADMINISTRATIVE
- BUILDING SERVICES
- PATIENT CARE UNITS
- OUTPATIENT CLINICS



**01 LEVEL 01 - DEPARTMENT AREA PLAN - SECTOR 01**  
1/16" = 1'-0"

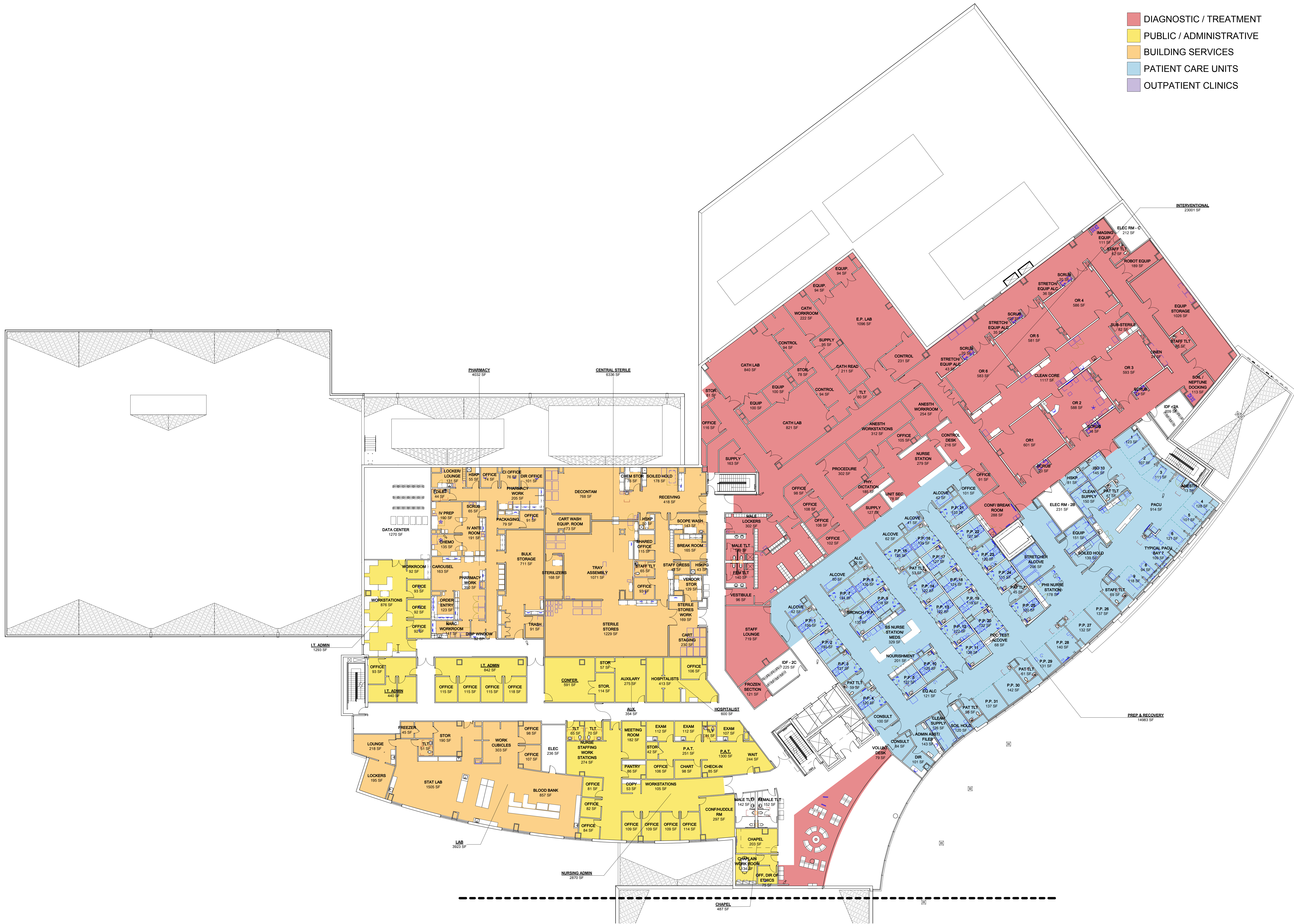




**01** **LEVEL 01 - DEPARTMENT AREA PLAN - SECTOR 02**  
1/16" = 1'-0"



- DIAGNOSTIC / TREATMENT
- PUBLIC / ADMINISTRATIVE
- BUILDING SERVICES
- PATIENT CARE UNITS
- OUTPATIENT CLINICS



01 LEVEL 02 - DEPARTMENT AREA PLAN - SECTOR 01  
1/16" = 1'-0"















