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January 30, 2019

VIA EMAIL & REGULAR MAIL

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

Re: Application for Certificate of Need
Establishment of 16-Bed Inpatient Acute Psychiatric Unit at
University of Maryland Medical Center
Matter No. 18-24-2429

Dear Ms. Potter:

On behalf of applicant University of Maryland Medical Center, we are submitting four copies of its Response to Additional Information Questions dated January 8, 2019. WORD and EXCEL versions will be provided to Commission Staff by separate email.

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

Sincerely,

Thomas C. Dame

Ella R. Aiken

TCD/ERA:blr
Enclosures

#652835
006551-0237

cc: Kevin McDonald, Chief, Certificate of Need
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UNIVERSITY OF MARYLAND MEDICAL CENTER
Establishment of 16-Bed Inpatient Acute Psychiatric Services for Adolescents at UMMC
Matter No. 18-24-2429

Responses to Additional Information Questions Dated January 8, 2019

PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. **Please provide the following additional information and clarifications of the comprehensive project description:**

   a. **It is stated on page 17 of the application that the design will include barriers to keep the patient populations separate, and it's mentioned that the unit will be designed for up to eight children and eight adolescents. The floor plan shows seven beds (numbered 4-10) on one side of two sets of double doors. There are 9 beds (numbered 11-16, 1-3) on the other side of the two sets of double doors. Please explain in more detail of how is it possible to keep these distinct patient populations physically separate and safe as shown in the floor plan provided?**

Applicant Response

The proposed child and adolescent unit will serve youth ages 5 -17 years with clinical programming tailored to meet the individual needs of patients based on their developmental and functional level. The patients will be placed into three cohorts according to their adaptive function, symptom severity, and therapeutic need. Most of the time, UMMC anticipates similar age grouping in the cohorts; however, there may be times when it is clinically appropriate to mix ages. For example, a high-functioning 11-year-old may be grouped with teenagers because this child needs to work on social skills in a group setting instead of being clustered with younger children who would benefit from play-based activities. Similar programming occurs in other academic child and adolescent inpatient units (*e.g.*, Johns Hopkins Children's Hospital and Children's National in Washington DC). Cohorts will move from one activity and location to the next, accompanied by staff. There will only be six or fewer patients in any activity space at any time, but that space will be occupied for most of the day with the different cohorts. The children and adolescent populations have separate sleeping areas which will be closely monitored by staff.

As design progressed, UMMC added another set of cross-corridor doors on the northwest portion of the revised plan. A copy of the revised floor plan is attached as **Exhibit 15**. This will allow for better physical separation between latency age and adolescent populations, and will provide flexibility for using adolescent rooms N11W112, N11W111, and N11W110 as rooms for latency age kids for times when the volume for that age cohort is higher. Corridor doors adjacent to rooms N11W112 on the north side and the mechanical shaft next to N11W302 on the south side allow for the latency age zone on the west of the unit to be physically separated from space occupied by adolescent patients. All cross-corridor doors will have the ability to be left open during times when physical separation is not needed, and closed / locked when that separation is necessary.

b. The gym and a group therapy room is planned on the 12th floor, which will house the remaining 15 beds of the adult psychiatry unit. Define how the required separation of the patient populations will be maintained and provided when the children or adolescents access these proposed locations near the adult patients for necessary multidisciplinary care.

Applicant Response

The activity/gross motor movement room planned for the 12th floor includes a lockable barrier separating this space from the 12th floor adult inpatient psychiatric unit. Thus, children will be moved to the area on a protected path, not the same path as adult patients. Separation of the child and adult populations will occur through planned activity coordination and daily scheduled use of the activity/gross motor movement space. Patients, whether adult or child, will always be separate from each other, and will only utilized this activity space under the supervision of psychiatry staff.

c. In question 8.A2 on page 4 of the application, it's mentioned that HAs a safety precaution, UMMC often must assign one or more hospital security officers as "sitters" for disruptive and often violent adolescent patients ... " How will UMMC be able to "flexibly address" the different age groups in the overlapping areas of the floor plan and maintain patient safety for each psychiatric age group, child versus adolescent?

Applicant Response

Please see response to Question No. 2 below.

PART IV – CONSISTENCY WITH GENERAL REVIEW CRITERIA

a) THE STATE HEALTH PLAN

COMAR 10.24.07 – State Health Plan for Facilities and Services: Psychiatric Services

Standard AP 4b

2. Specifically describe the measures to be used that will provide separation of the child, adolescent and adult sections of the psychiatric units on floors eleven (N11W) and twelve (N12W). In your response please address the clinical and programmatic distinctions made for scheduling of services with regard to the floor plan design limitations, as it shows only one location for a gym, school services, group activity, OT/dining space and lounge areas. In addition, elementary schools have child sized desks and equipment compared to high schools. Please explain how one space as designed for these multidisciplinary care activities is able to meet the health care needs of these two distinct patient populations with unique physical requirements, and yet keep separate for the safety of all patients?

Applicant Response

Each hour of the day will be scheduled with structured therapeutic activities. A proposed schedule of activities is attached as **Exhibit 16**. The patients will be grouped by adaptive functional level and symptom severity into three cohorts that will move from one activity and location to the next, accompanied by staff. There will only be six or fewer patients in any activity space at any time, but that space will be occupied for the majority of the day with the different cohorts. No adult patients will be in contact with child or adolescent patients at any time. The children and adolescent populations have separate sleeping areas, which will be closely monitored by staff. UMMC planned a variety of seating (tables and chairs of different heights and sizes) and workspace options for the various needs of the patient population.

Standard AP 6

3. **Please provide copies of the written treatment protocols for child and adolescent psychiatric services, if any exist.**

Applicant Response

UMMC is in the process of developing written treatment protocols developed. An outline of the general approach to treatment modalities appears below.

Staff Needed	*Role in Unit*
Psychologist	-Provide individual and family therapy; psychological testing; develop behavior modification plans; manage milieu therapists -Use and teach Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT). Requires doctorate degree
Behavioral Milieu Therapist	-Provide direct patient care in a therapeutic environment focusing on areas of behavioral modification, improved social skills, more effective coping skills. Requires a bachelor's degree.
Occupational Therapist	-Provide direct patient treatment via individual and group sessions to improve emotional regulation skills, social skills, collaborative problem solving skills, and independent living skills. Requires a master's degree.
Recreational Therapist	-Provide individual, group programming to improve emotional expression, therapeutic leisure activities (Music, Art, Movement Therapy). Requires a bachelor's degree

Standard AP 12b

4. **How many qualified private therapists are available at UMMC? Do these therapists accept and treat Medicaid patients, and if so, what percentage? Will they accept patients for further outpatient treatment?**

Applicant Response

The Child and Adolescent Psychiatry Ambulatory Clinic, located at 701 W. Pratt Street, has six full-time staff therapists, 14 child and adolescent psychiatry fellows, and a psychology intern who provide therapy. The clinic has subspecialty programs: ADHD Clinic, Mood Clinic, and Trauma Clinic and uses only evidence-based treatments such as cognitive behavioral therapy, parent management, and trauma-focused cognitive behavioral therapy. This clinic accepts 100% Medical Assistance.

Standard AP 13

5. **Describe the key facilities, programs, and organizations ("inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs") in the service area that will comprise the referral network for discharged child and adolescent psychiatric patients.**

Applicant Response

With the addition of adolescent inpatient services, the Child and Adolescent Psychiatry Service Line will offer the complete continuum of care:

- *Partial Hospital Program* – UMMC currently has a partial hospital program ("PHP") serving ages 5-12 years, which provides weekday treatment from 8am – 3pm. Children receive psychiatric evaluations and treatment, medication management, psychosocial assessments, group and individual therapy, occupational therapy, nursing education groups and school supported by the Baltimore City School Home and Hospital Services; the average length of stay is 2 weeks.

- *Intensive Outpatient Program* – UMMC plans to establish an Adolescent Intensive Outpatient Program ("IOP") to serve ages 13-17 years. This program would run weekdays in the afternoon from 3-6 pm. Services will include psychiatric evaluation and treatment, medication management, psychosocial assessments, group and individual therapy, and occupational therapy. Therapeutic modalities utilized in the PHP and IOP programs include a trauma-informed framework (ARC- Attachment, Regulation and Competency), milieu therapy, skill building (emotional regulation, social skills, distress tolerance, resiliency, relaxation, anger management) and individual and family therapy (cognitive behavioral therapy and dialectical behavioral therapy components).

- *Ambulatory Clinics* – The Child and Adolescent Psychiatry Ambulatory Clinic has over 8,000 annual visits and is comprised of subspecialty clinics: ADHD Clinic, Mood Clinic, and Trauma Clinic. UMMC uses only evidence-based treatments such as cognitive

behavioral therapy, parent management, and trauma-focused cognitive behavioral therapy.

- *Community Programs* – UMMC also has an extensive School Mental Health Program, serving 27 Baltimore City Schools and a mobile treatment team for youth and families that are unable to make clinic-based appointments and require a higher level of treatment in the home and community.

- *Transition Programs* – Lastly, UMMC has a transition program from acute care services called "Bringing Families and Schools Together" ("BFAST"), which uses social work and peer specialists to facilitate the reintegration into the community and school and reduce readmissions.

For children who are not able to access the UMMC child and adolescent psychiatry services, UMMC has partnerships with Catholic Charities/Villa Maria and Hope Health Systems. Both programs offer a full range of outpatient mental health services including clinic, in-home and school-based mental health treatment. They also offer wrap-around services such as Psychiatric Rehabilitative Services, Therapeutic Behavioral Services, and Targeted Case Management.

COMAR 10.24.10 – State Health Plan for Facilities and Services: Acute Care Hospital Services

Standard .04B(4) Adverse Impact

6. **The proposed project appears to be reducing both inpatient adult and latency child psychiatric services in order to create adolescent psychiatric services. Please provide the following additional information and clarifications of the potential adverse impact of the project regarding volume, access and cost:**

   a. **Adult beds at UMMC are reduced by nearly 52% (from 31 beds down to 15, Table A). Please provide an explanation, including supporting data on demographics, volume, competitor expansion of service, etc. indicating that this reduction will not have an adverse impact on adult psychiatric care in the UMMC primary service area.**

Applicant Response

As explained below, the changes caused by the project and other changes on the UMMC campuses will result in the overall reduction of seven (7) adult psychiatric beds. The remaining beds will be sufficient to meet demand.

UMMC is comprised of two campuses – Downtown (the site of the proposed project) and Midtown (the former Maryland General Hospital). UMMC has a two campus strategy to meet the needs of adult psychiatric patients. In 2016, the University of Maryland School of Medicine ("UMSOM"), Department of Psychiatry assumed medical leadership of the UMMC Midtown Campus program, bringing a cohesive structure to both the Downtown and Midtown campuses.

In January 0f 2017, the UMMC Midtown Campus implemented a UMSOM faculty only staffing model on the inpatient psychiatric unit.

UMMC Midtown Campus is currently renovating and expanding the adult inpatient psychiatric unit. Currently, there is a 28 bed, all semi-private, unit that had an average daily census in FY2018 of 19.3 patients. The new unit will open in February 2019 with 37 private beds. The Midtown project was the subject of the Commission's Determination of Coverage dated July 19, 2016, copy attached as **Exhibit 17**.

As shown in Table 9 below, the combined average daily census for FY17 and FY18 at UMMC's Downtown and Midtown campuses was 42.9 and 40.1 respectively. The future capacity of the adult psychiatric inpatient program will be a combined 44.2 patients at 85% occupancy. This capacity exceeds the historical demand of the program.

Table 9
Demand and Capacity for Adult Psychiatry Capacity
at UMMC Downtown and Midtown Campuses

	UMMC Downtown	UMMC Midtown	Total UMMC
FY17 Adult Psychiatric Beds	31	28	**59**
FY17 ADC	19.8	23.1	**42.9**
FY17 Occupancy Rate	63.9%	82.5%	**72.7%**
FY18 Adult Psychiatric Beds	31	28	**59**
FY18 ADC	20.8	19.3	**40.1**
FY18 Occupancy Rate	67.1%	68.9%	**68.0%**
Future Adult Psychiatric Beds	15	37	**52**
Future ADC Capacity	12.8	31.5	**44.2**
Future Occupancy Rate	85%	85%	**85%**

ADC Source: HSCRC database

b. Latency aged children psychiatric beds are reduced from 12 beds to eight, a reduction of 1/3rd of the total capacity for this age group. Please provide an explanation, including supporting data on demographics, volume, competitor expansion of service, etc., indicating that this reduction will not have an adverse impact on child psychiatric care in the UMMC primary service area.

Applicant Response

The proposed project will cause no adverse impact on child psychiatric services in UMMC's service area. UMMC Downtown Campus is licensed for 12 child psychiatric beds. However, there are 10 current physical beds (5 semi-private rooms) on the unit. As shown in Table 10 below, in FY2017 and FY2018 UMMC experienced an average daily census of 5.5 and 5.9, respectively. The planned future bed complement will be eight private rooms. These rooms will accommodate an average daily census of 6.8 patients at 85% occupancy, ample capacity to meet historical demand.

Table 10
Historical Child Psychiatry Demand and
Future Capacity at UMMC Downtown Campus

	FY2017	FY2018	Future
Licensed Beds	12	12	8
Physical Beds	10	10	8
Average Daily Census	5.5	5.9	6.8*

ADC Source: HSCRC database
*6.8 is the capacity of the 8 beds at 85% occupancy

Standard .04B(5) Cost Effectiveness

7. Given your responses to a. and b. in question six above, why is it most cost effective to develop a new psychiatric hospital program that appears to be predicated on reducing availability of services for two of the three age categories?

Applicant Response

As explained above, the future configuration of the adult, child, and adolescent psychiatry beds will provide expanded services (inpatient adolescent psychiatry) and will still meet the inpatient demand for each age category (see response to Question No. 6 above).

Project Review Standard (11), Efficiency

8. The application mentions reduced security costs and better patient care in moving adolescents to an inpatient room more quickly as a result of this application.

a. Will adult psychiatric patients be expected to wait longer in the ED for a psychiatric bed due to the reduction in their bed count by over 50%? If not, explain the capacity that exists so this will be possible.

Applicant Response

Adult psychiatric patients are not expected to wait longer in the emergency department for a psychiatric bed as a result of the proposed project. As explained in response to Question No. 6 above, UMMC is using a two campus strategy to provide timely inpatient admission of adult psychiatric patients. The total capacity of adult psychiatric beds between both campuses will meet the historical need for admissions. In addition, UMMC uses a central Psychiatric Admission and Referral Center ("PARC") to monitor and coordinate requests for inpatient bed placement and admissions from the UMMC emergency department and requests from emergency departments from across the state. This centralized model of bed coordination, coupled with increase in single occupancy adult psychiatric beds at UMMC's Midtown Campus, will enhance the ability to take admissions in a more expeditious way.

b. Will latency children have to wait longer in the PED, as their bed count is reduced from 12 to eight? Does the existing experience at UMMC indicate that there is capacity so this is not a potential problem?

Applicant Response

The planned capacity will be adequate to continue meeting the demand of the latency children (see response to Question No. 6) and will not affect wait times in the PED for this age group.

The new 16-bed unit has the ability to flex beds based on demand. Typically, adolescents will be placed in the single rooms along the two hallways. However, due to seasonal variation (numbers of latency aged admissions decrease significantly during the summer when school is out of session), UMMC plans to flex the latency age beds to accommodate a need for more adolescent patients. Increased staffing with 24/7 security will ensure safety of all youth. There is adequate capacity to treat latency age children (see response to Question No. 6(b) above).

9. Why is putting the children and adolescent population on the same floor the most efficient? Does the efficiency as designed compromise other considerations in the certificate of need requirements?

Applicant Response

Cohorting the adolescent and latency aged children in the same pediatric behavioral health inpatient unit provides a much more efficient means to care for this population based on several factors.

First, the staff (nursing, occupational therapy, recreational therapy, psychiatrists, psychologists, social workers, etc.) will be able to be utilized to manage the population as one team rather than split across two distinct geographic areas (reference program schedule for functional cohorts). Second, cohorting will allow UMMC to treat the population according to adaptive function and developmental level, rather than strictly based on the age of the patient, which is a more progressive and appropriate approach to therapeutic care for this population. This programming promotes individualized care (see response to Question 1(a) above) and the potential mixing of cohorts mirrors a naturalistic environment where youth interact with children of various ages and developmental stages.

Additional efficiencies are gained through the anticipated smoothing of average daily census ("ADC") that is projected for this unit. Currently, the latency age population experiences dramatic seasonal shifts in ADC that can be attributed to the elementary school schedule and resources available through school programs. The adolescent population does not experience the same dramatic seasonal shifts, since their referrals for treatment are much less dependent on the school system resources.

The age cohorting approach does not compromise any other certificate of need requirements in in any way.

Project Review Standard (12), Safety

10. **The application states the design is based on FGI Guidelines. Explain how the child, adolescent and adult psychiatric populations will be kept safe with services for all populations overlapping on either floors N11W or N12W.**

Applicant Response

The populations based on floor N11W (pediatric) will never be comingled with the patients on floor N12W (adult). This will be accomplished through physical space design and protocol for use of gross motor movement space located on the N12W. The gross motor movement room will be separated from the adult inpatient area by doors that can only be accessed by staff. Staff will only allow adult patients in the gross motor movement room at times that are not programmatically scheduled for the latency and adolescent child populations. In addition, whenever staff from either N11W or N12W intend to use the gross motor movement room, a visual inspection of the room must first be completed by a staff member to ensure that the room is safe for entry and no patients from the opposite inpatient area are occupying the space. The route taken by the child and adolescent populations to occupy the gross motor movement room avoids the need to enter N12W in any way. The gross motor movement room is the only space were programmatic overlap will occur between the child and adult populations.

As explained in response to several other questions above, UMMC will cohort the patients by adaptive and developmental function. Separation related to function and therapeutic need will occur through planned movement of patients and staff through the space to reach areas were treatment and therapy will occur. Please see Exhibit 16 (detailed programmatic plan).

11. **On page 32 of the application, it states that UMMC seeks to renovate existing facilities on the 11th floor, and that existing psychiatric patients do not have rooms meeting modern codes, such as private bedrooms and bathrooms. However, this appears to be a move backwards from the existing facilities on P4G rather than a modernization, as the floor plan provided shows only two toilets and one shower for the six patients in beds numbered 11-16. This potentially has different sexes sharing the shower at different times. All other rooms are private bed/private bath in design, which the application defines as the modernization standard. How does this better meet the needs for young psychiatric patients? Please provide a copy of the existing child psychiatric floor plan on P4G for comparison.**

    Also, please have your architect provide a letter supporting the FGI/JCAHO quality and safety standards that allow only two toilets and one shower for the six psychiatric patients in beds numbered 11-16.

Applicant Response

As the design progressed following submission of the application, UMMC added another set of cross-corridor doors on the northwest of the revised plan. Please see Exhibit 15. This will allow for better separation physical between latency age and adolescent populations; and provides flexibility for using adolescent rooms N11W112, N11W111, and N11W110 as rooms for latency age kids if that volume is higher at times. Corridor doors adjacent to rooms N11W112 on the north side and the mechanical shaft next to N11W302 on the south side allow for the latency

age zone on the west of the unit to be physically separated from space occupied by adolescent patients. All cross-corridor doors will have the ability to be left open during times when physical separation is not needed, and closed / locked when that separation is necessary.

The toilet and shower facilities for the younger patients are compliant with FGI/JCAHO standards. (please see certification letter from the project architect, attached as **Exhibit 18**). The decision to design central toileting and showering facilities was based on the clinical needs of the younger children and the desire to maximize space in the treatment area (where the children spend most of their day). UMMC's treatment approach involves a highly structured day with hourly therapeutic activities, limiting the time children will spend in their bedrooms. In UMMC's experience, younger children often prefer semi-private rooms given their age appropriate fear of sleeping alone in an unfamiliar setting. Additionally, many younger children require staff assistance with hygiene activities, therefore it is more efficient to have staff provide help and support in a common area. As such, UMMC chose to maximize treatment space instead of enlarging bedrooms to accommodate individual bathrooms for this age group.

12. Please verify staff's understanding of the following design items:

a. The design indicates there are only two seclusion rooms on the 11th floor, and two on the 12th floor. Is this sufficient for sixteen patients? As submitted, access to one seclusion room appears it is through another, and access to a toilet is only available from one. Is this correct (rooms N11W117 and 117A)?

Applicant Response

The design shows only one seclusion room on N11W (N11W117A) for the 16 bed child/adolescent inpatient space. Applicable guidelines require an anteroom separating the seclusion room from the general milieu area (N11W117). FGI Guidelines, §21-2.4.3.4. The same provisions require a bathroom space dedicated for the seclusion room that can only be accessed from the anteroom (N11W117). The purpose for this safety code and design feature is to prevent the need to move a dysregulated patient, who requires isolation, through the general milieu space to access a bathroom. The anteroom allows staff to provide a secure area to move such a patient from the seclusion room to a bathroom, if necessary. Placement of access to the bathroom directly from the seclusion room would be a violation of the building code for seclusion rooms.

Based on experience with latency aged children, the expertise of UMMC child/adolescent psychiatrists, and the infrequency of need to use isolation space, UMMC concludes that one seclusion room will be completely adequate for 16 patients. UMMC is not aware of a seclusion space to patient ratio requirement.

The N12W seclusion room is intended to only be used, if necessary, by the adult population. The design includes revision of the seclusion room on N12W because the creation of the gross motor movement space requires that the existing seclusion room be located on N12W (adult psychiatry inpatient).

b. There appear to be two seclusion rooms isolated on the 12th floor, (rooms N12W47 and 47A) and a patient sensory room (N12W49). Will there be adequate supervision for these rooms? Will it be a safe environment for children on the adult floor? How will this be provided?

Applicant Response

As explained in response to Question No. 12(a), similar to the seclusion room on the N11W, N12W47A is the seclusion room and N12W47 is the required seclusion room.

The rooms have been labeled for clarity in the revised attached floor plans (Exhibit 15).

The North 12th floor inpatient psychiatric unit is dedicated for adult psychiatric patients. The changes to the floor plan of the 12th floor provides a separation of the activity/gross motor movement room from the inpatient area, so that comingling of children/adolescents with adults will not occur. Latency age children and adolescents will not be permitted into the inpatient space. The seclusion room on the 12th floor will be exclusively used for the adult population.

c. The application states there are a variety of respite rooms, sensory rooms, seclusion rooms, and group areas. The group rooms are all on one side of the floor design. How is this design compatible with the safety needs of the child patient from the adolescent patient, and the ability to segregate patients by age?

Applicant Response

Please see response to Question No. 2 above.

COMAR 10.24.01.08G(3), State Health Plan

Project Review Standard (b), Need

13. The resulting change in bed distribution in each age category demands a need analysis for child and adult psychiatric hospital services, in addition to the adolescent information provided. What is the actual experience of UMMC in providing acute hospital services for children and adults with psychiatric disorders, and what are the projections? Provide a brief service-area level analysis of the demand for psychiatric services experienced by UMMC, for the two existing age categories, which identifies the primary service area market share and the proportion of demand coming from beyond the service area.

Applicant Response

UMMC has demonstrated that the new configuration of inpatient beds among its two campuses will meet the historical demand (please see response to Question No. 6 above) of the adult and child psychiatry programs. In addition to meeting this demand, UMMC will add a new adolescent service to meet the demand of this population as outlined in the CON application.

14. Please answer the following:

a. Whether preventive and outpatient services for behavioral health issues in the adolescent population are optimized in the UMMC service area. If not, how will the project assist UMMC in improving these services?

Applicant Response

Please see the response to Question No. 5 above. The comprehensive outpatient and school-based programs treat adolescents and UMMC is developing an adolescent IOP, which will provide daily treatment after school. Additionally, the existing school-based program provides adolescent prevention services such as classroom presentations and peer group activities on various topics including substance use, healthy relationships, and bullying prevention.

b. How do hospitalization rates in the UMMC service area compare with use seen in other regions of Maryland and what does this comparison indicate about the relative need for investment in additional hospital facilities versus alternative, non-inpatient programming to address the needs of persons in the 12 to 17 age range?

Applicant Response

As shown in Table 11 below, use rates in the four-county UMMC service area (Anne Arundel, Baltimore City, Baltimore, and Howard) for inpatient adolescent psychiatry appear to be higher than the State as a whole. However, there will be some discrepancy, especially for counties with large numbers of patients leaving the State for treatment and those discharges from hospitals in other states not being included in the numerator when calculating use rate while the denominator does include the population. For example, it is reasonable to assume a majority portion of Prince George's patients seek treatment in Washington DC, causing the use rate to be severely understated. Counties that have more access to inpatient treatment centers within Maryland have higher use rates. This further supports the need assumption in the CON application that there is unmet need in the State of Maryland.

Table 11
Adolescent Psychiatry Use Rates by Maryland County

County Name	Adolescent Population	2018 Annualized Discharges	Use Rate per 1,000 Population
Allegany	3,714	52	14.0
Anne Arundel	35,405	535	15.1
Baltimore City	33,271	531	15.9
Baltimore	50,030	836	16.7
Calvert	6,645	73	11.0
Caroline	2,251	3	1.2
Carroll	11,503	163	14.1
Cecil	7,099	5	0.8
Charles	11,521	64	5.6
Dorchester	1,855	20	10.8
Frederick	17,251	235	13.6
Garrett	1,689	-	-
Harford	16,844	237	14.1
Howard	23,215	297	12.8
Kent	1,007	1	1.3

County Name	Adolescent Population	2018 Annualized Discharges	Use Rate per 1,000 Population
Montgomery	68,395	844	12.3
Prince George's	55,458	217	3.9
Queen Anne's	3,218	4	1.2
St. Mary's	7,830	109	14.0
Somerset	1,272	1	1.0
Talbot	1,994	1	0.7
Washington	9,568	187	19.5
Wicomico	6,702	24	3.6
Worcester	2,659	8	3.0
TOTAL Maryland	**380,396**	**4,448**	**11.7**

Source: HSCRC database

c. Was the option of renovating the existing child space to more modern standards, and have the adolescent unit be all16 beds in the proposed space considered? The updated use rate in Table 4 of your need analysis increased substantially and discharges nearly doubled when all facility information was received, yet your volume projections did not change. Why wouldn't your discharge numbers increase with the increased adolescent psychiatric market volumes provided?

Applicant Response

UMMC did not consider opening a 16-bed adolescent unit because UMMC's analysis did not indicate there was a need for that many adolescent beds. Please see UMMC's CON Application, pages 42-48.

Project Review Standard (d), Viability

15. Please clarify the projections for total psychiatric services by providing a breakdown by the three categories, child, adolescent and adult for days, discharges and ALOS. Describe why the ALOS is shown as constant at 11.5 in Table F, with the changes being made in this proposal, which include an additional age group as one factor.

Applicant Response

Table F has been corrected and the four psychiatric services broken out to provide additional detail. A copy of the revised Table F is attached as **Exhibit 19**.

16. Please explain the difference in discharges, days and ALOS in Table 7 on page 48 for adolescents versus the volumes reported for the new service on page 15 of Table I, Exhibit 1.

Applicant Response

UMMC updated Table I with only adolescent volume. The original submission had other psychiatric discharges included in error. A copy of the revised Table I is attached as **Exhibit 20**.

17. **Total volume for adult and geriatric psychiatric patients in projection years (FY21-FY23), calculated by removing new service volumes, equal just over 500 discharges, 11,300 days and an ALOS of over 21. Please explain this variance, especially compared to FY2017, when total discharges were 1,129 and patient days 12,950 for an ALOS of 11.5 (Table F, pgs. 8-9).**

Applicant Response

Table F has been corrected and the four psychiatric services broken out to provide additional detail (please see Exhibit 19).

18. **Are there any physician staffing expenses for this project? (There do not appear to by any shown in the work force table). Explain the plan for providing medical direction for this program. How many child psychiatrists are on the staff of UMMC?**

Applicant Response

Under supervision and management of the child and adolescent psychiatry medical director, there will be two board-certified child and adolescent psychiatrists and a psychiatric nurse practitioner who will provide direct psychiatric care. There are also child and adolescent psychiatry fellows (physicians who have completed adult psychiatry residency and are receiving additional child and adolescent training in an accredited graduate medical education fellowship program) who provide care under direct supervision of the attending psychiatrists. In total, the UMMC Division of Child and Adolescent Psychiatry has seven full-time and three part-time board-certified child and adolescent psychiatrists. Each of these professionals will be contractors, not employees.

Project Review Standard (0, Impact on Existing Providers and the Health Care Delivery System

19. **The market data provided indicate the impact on other providers to the adolescent population does appear minimal. However, please identify the hospitals that will experience a projected impact as a result of implementing this proposed project and quantify that impact by projecting the shift in admissions that will occur with regard to the reduction in beds for adults and latency age children.**

Applicant Response

UMMC does not anticipate any impact on other hospitals regarding latency age children and adults. The capacity at UMMC will continue to meet demand (please see response to Question No. 6).

Table of Exhibits

Exhibit	Description
15	Revised Floor Plans
16	Summary of Programmatic Activities
17	Determination of Coverage dated July 19, 2016
18	Architect's Compliance Certification Letter
19	Revised Table F
20	Revised Table I

Table of Tables

Table	Description

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions Dated January 8, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

01/25/2019
Date

Leonard Taylor
Senior Vice President for Asset Planning
UMMS

#652407
006551-0237

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions Dated January 8, 2019 and its exhibits are true and correct to the best of my knowledge, information, and belief.

1/25/2019
Date

Greg D. Raymond, MS, MBA, RN
Vice President of Nursing and Patient Care Services, Clinical Practice & Professional Development, Neuroscience, Behavioral Health
UMMC

#630379
006551-0237

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions Dated January 8, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

1/22/19
Date

Marina Bogin
Senior Director, Finance Decision Support
UMMC

#651309
006551-0238

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions Dated January 8, 2019 and its exhibits are true and correct to the best of my knowledge, information, and belief.

01/22/19
Date

Scott Tinsley-Hall
Director, Strategy & System Market Intelligence
UMMC

#630367
006551-0237

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions Dated January 8, 2019 and its exhibits are true and correct to the best of my knowledge, information, and belief.

1/22/2019

Date

Sarah M. Edwards, DO
Assistant Professor of Psychiatry and
Medical Director, Child and
Adolescent Psychiatry Services
UMMC

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions Dated January 8, 2019 and its exhibits are true and correct to the best of my knowledge, information, and belief.

1/22/19
Date

Bret Elam
Project Manager
UMMS

#630375
006551-0237

EXHIBIT 15

Existing Child Psych Unit

- MECHANICAL
- PATIENT SERVICES
- STAFF SPACES
- BUILDING SERVICES
- INTAKE / EXAM
- PATIENT ACTIVITY
- BATHROOM
- PATIENT ROOM
- CIRCULATION

ACTIVITY AREAS

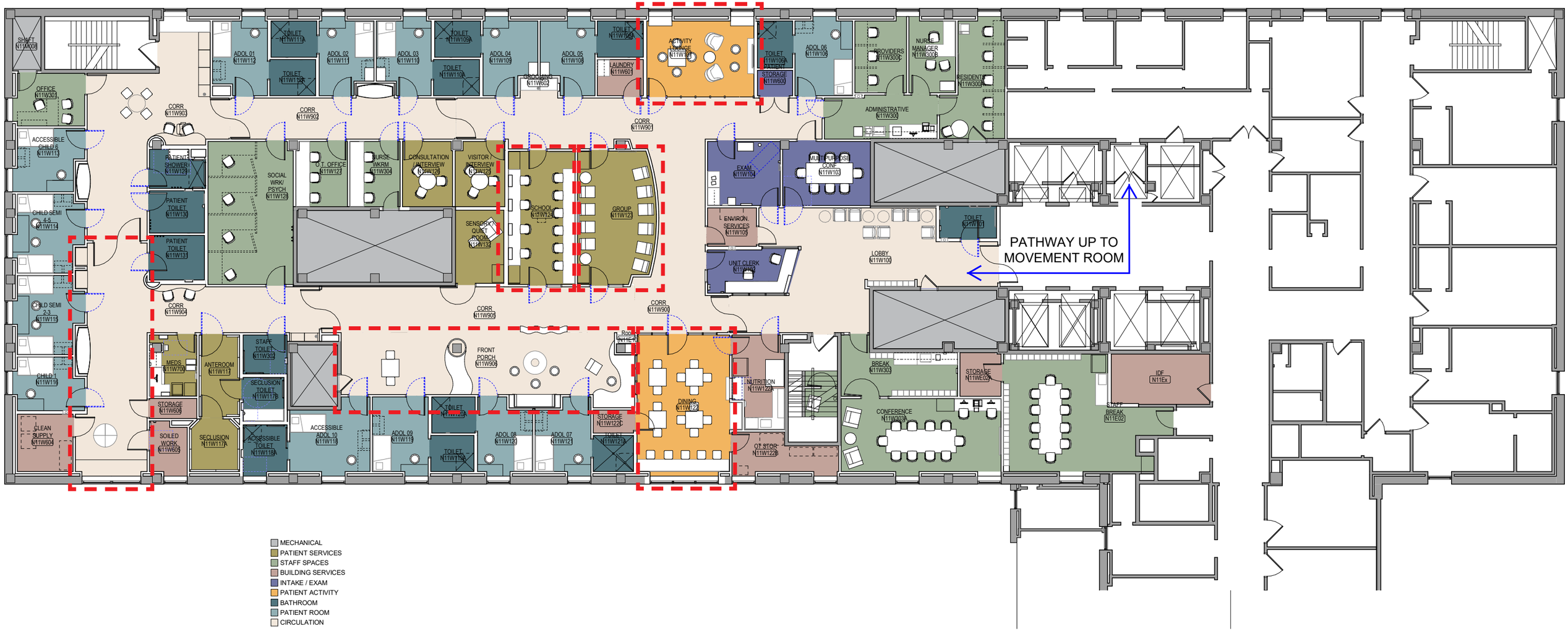
LIVING DESIGN LAB

0’ 2’ 4’ 8’ 16’ 32’

UMMC Child & Adolescent Psych

January 14, 2019

11th Floor



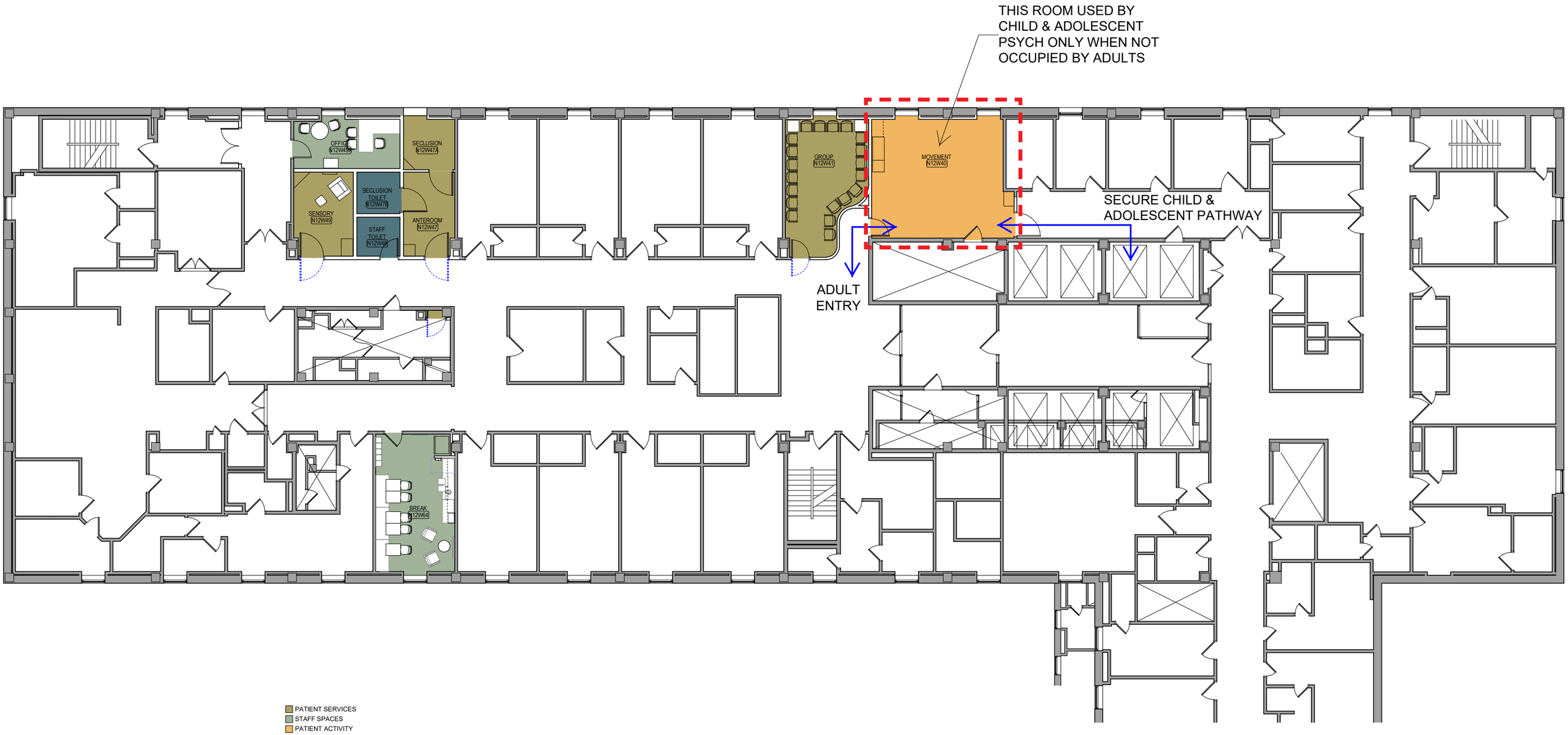
LIVING DESIGN LAB

0’ 2’ 4’ 8’ 16’ 32’

UMMC Child & Adolescent Psych

January 14, 2019

12th Floor



LIVING DESIGN LAB

UMMC Adult Psych Partial Renovation

January 14, 2019

EXHIBIT 16

TIME	High Functioning Group Topic	Room	People	Mid Functioning Group Topic	Room	People	Low Functioning Group Topic	Room	People	Staff Responsibilities
6:00	Meds	Bedrooms 1-6	**Total: 8** 6 kids RN E Tech F (1:1)	Meds	Bedrooms 7-10	**Total: 6** 4 kids RN F Tech G (1:1)	Meds	Bedrooms 11-16	**Total: 8** 6 kids RN G Tech H (1:1)	Charge RN night – pt assignments, admissions, staffing Overnight RNs – documentation time AM Charge RN: begin report at 6:45am
7:00	Meds, morning ADLs	Bedrooms 1-6	**Total: 8** 6 kids RN E Tech F (1:1)	Meds, morning ADLs	Bedrooms 7-10	**Total: 6** 4 kids RN F Tech G (1:1)	Meds, morning ADLs	Bedrooms 11-16, shared bathroom	**Total: 8** 6 kids RN G Tech H (1:1)	Charge RN –report with all day shift nursing staff (RN, BHA, Tech)
7:30										Daily Schedule Planning meeting: OT, RT, Edu, charge nurse
8:00	Morning ADL's, breakfast, meds, RN assessment (vitals, mental status exam)	Dining	**Total: 13** 8 kids RN A RN B Techs A (Q15) Tech B (1:1) BHA A	Morning ADL's, breakfast, meds, RN assessment (vitals, mental status exam)	Activity	**Total: 12** 8 kids RN C RN D Tech C (Q15) Tech D(1:1)				Charge RN - patient assignments, scheduling, huddle OT - evals
9:00	New pt orientation, daily goals, community meeting	Activity	**Total: 8** 5 Kids BHA A Tech A (1:1) RN A	Engine Check-in, goals	Group	**Total: 9** 6 Kids RN B BHA B Tech C (1:1)	Engine check-in, goals, exercise group	School	**Total: 9** 5 Kids RN C RN D (providing 1:1) Tech D BHA C (1:1)	Charge RN - rounds RN A -may also be helping with: documenting, PRNS, calls, labs OT - evals Tech B (Q15min check)
10:00	OT – Activity based	Dining	**Total: 9** 5 Kids Tech A (1:1) OT A OT B RN A	School	School	**Total: 10** 6 Kids Teacher 1 Tech C (1:1) BHA A (1:1, can also assist with other groups for dysregulated pts) RN B -may also be floating PRN in different areas)	SW – Family therapy/ transitions	Group	**Total: 11** 5 Kids SW 1 RN C RN D Tech B (1:1) Tech D BHA C	1 Charge - rounds RN A– may also be helping with: documenting, PRNS, calls, labs) BHA B (planning for 12pm group) Tech C (Q15min check)
11:00	School	School	**Total: 8** 5 Kids Teacher 1 Tech A (1:1) BHA A	OT – Psychosocial/Play	Group	**Total: 10** 6 kids Tech C (1:1) OT A OT B BHA B	Lunch/ phone calls	Dining	**Total: 9** 5 kids RN A RN B BHA C Tech E (1:1) (E starts at 11)	Charge RN A -discharges, covering lunch Tech B lunch RN C lunch RN D lunch Tech D Q15min

12:00	Lunch/ phone calls	Activity	**Total: 8** 5 Kids Tech B (1:1) RN C BHA A	Lunch/ phone calls	Dining	**Total: 10** 6 Kids Tech D RN D BHA B RN B	BHA / Psych Group	Group	**Total: 9** 5 Kids BHA C 1 psych intern 1 psychologist (responsible for documentation) Tech E (1:1)	Charge RN A- discharges, covering for discharges, family education/visiting 12:00 – 12:15 : RT and Charge RN – report RT - evals BHA A lunch Tech A lunch RN A lunch Tech C Q15
13:00	Gross Motor	5th Floor Gym	**Total: 12** 6 Kids RT Tech A (1:1) Tech B (Q 15min) BHA A RN A Security	Gross Motor	Studio 12W	**Total: 10** 5 Kids RT BHA B RN D (1:1) RN C Tech D (Q15min)	OT – Activity based	Dining	**Total: 8** 5 Kids OT B OT C Tech E (Q 15min) RN B (1:1)	Charge RN – discharges/cover for discharges/ admission' available for dysregulated kids Tech C lunch BHA C lunch
14:00	OT - DBT group	Group	**Total: 9** 5 Kids OT A OT B RN A BHA A (1:1)	SW - Transitions Group	Dining	**Total: 12** 6 Kids SW psych intern psychologist RN B Tech B (1:1) BHA C	School	School	**Total: 8** 5 Kids Tech C (1:1) Tech E teacher	RN D as charge admissions, discharges/coverage discharges Charge RN lunch RN B lunch Tech D lunch BHA B lunch RT documentation time RN C Documentation *note- 4 off during this hour) Tech A Q15
15:00	SW - Transitions Group	Group	**Total: 11** 5 Kids SW psych intern psychologist BHA A Tech A (1:1)	OT – Activity based/ DBT	Dining	**Total: 10** 6 Kids OT A OT B Tech B (1:1) BHA B	Refueling time	Bedroom Hallway	**Total: 10** 5 kids RT BHA C (responsible for documentation) Tech C (1:1) RN C BHA	Charge RN – admissions, discharges/coverage for discharges, documentation, Tech E lunch RN B document RN A Documentation Tech D Q15
16:00	BHA - DBT group	Group	**Total: 8** 5 Kids BHA A Psychologist (responsible for documentation) Psych intern Tech A RN A	Refueling time More Structure provided by BHA and/or RT	Activity	**Total: 9** 6 kids RT BHA B (responsible for documentation) Tech B Tech C RN B	Dinner/phone calls	Dining	**Total: 8** 5 Kids Tech D RN C BHA C	Charge RN – admissions, documentation, parent education RN D documentation Tech E Q15

17:00	Chores/ Life skills building	Bedrooms/ Group	**Total: 8** 5 Kids BHA A RN A Tech A (1:1) Tech E (Q15)	Dinner/phone calls	Dining	**Total: 10** 6 Kids Tech B (1:1) Tech C (Q15) RN B	Gross Motor	11W or 12W	**Total: 9** 5 Kids RT BHA C RNC RN D Tech D (Q15)	Charge RN -Parent education, visiting, discharges/coverage for discharges BHA B documentation
18:00 Only 2 BHA	Dinner/ phone calls	Dining	**Total: 8** 5 Kids Tech A (Q15) RN A RN D	Evening ADL's, meds	Bedrooms	**Total: 10** 6 Kids BHA B Tech B (Q15) Tech C RN B	Evening ADL's, meds	Bedrooms/ Hallway	**Total: 9** 5 Kids BHA C/A (flip flop documentation) Tech D (Q15) Tech E RN C	Charge RN - Parent education, visiting, discharges/coverage for discharges BHA A and C documentation for 30 min RT documentation time
19:00 REPORT	Quiet Activities/ homework	Activity	**Total: 8** 5 Kids Tech A (Q15) RN A RN	Quiet Activities/ homework, relaxation	Group Room	**Total: 10** 6 Kids Tech B (Q15) Tech C RN B BHA B (until end of report)	Quiet Activities/ homework story time	Bedrooms	**Total: 9** 5 Kids Tech D (Q15) Tech E RN C BHA C (until end of report)	Charge RN – Report All nurses rotate to give their report RTs float for milieu support
20:00	Evening ADL's, meds	Bedrooms/ Hallways	**Total: 7** 5 Kids RN E Tech F (Q15)	Bedtime	Bedrooms	**Total: 8** 6 Kids RN F Tech G (Q15)	Bedtime	Bedrooms	**Total: 8** 5 Kids RN G Tech E (Q15) Tech H	Charge RN night – pt assignments, admissions, staffing RT finish documentation, leave at 20:30
21:00	Bed Time	Bedrooms 1-6	**Total: 8** 6 kids RN E Tech F (1:1)	Asleep	Bedrooms 7-10	**Total:6** 4 kids RN F Tech G (1:1)	Asleep	Bedrooms 11-16	**Total:8** 6 kids RN G Tech E (Q15) Tech H (1:1)	Charge RN night – pt assignments, admissions, staffing
22:00	Asleep	Bedrooms 1-6	**Total: 8** 6 kids RN E Tech F (1:1)	Asleep	Bedrooms 7-10	**Total:6** 4 kids RN F Tech G (1:1)	Asleep	Bedrooms 11-16	**Total:8** 6 kids RN G Tech E (Q15) Tech H (1:1)	Charge RN night – pt assignments, admissions, staffing
23:00	Asleep	Bedrooms 1-6	**Total: 8** 6 kids RN E Tech F (1:1)	Asleep	Bedrooms 7-10	**Total:6** 4 kids RN F Tech G (1:1)	Asleep	Bedrooms 11-16	**Total:8** 6 kids RN G Tech H (1:1)	Charge RN night – pt assignments, admissions, staffing

1:00	Asleep	Bedrooms 1-6	**Total: 8** 6 kids RN E Tech F (1:1)	Asleep	Bedrooms 7-10	**Total:6** 4 kids RN F Tech G (1:1)	Asleep	Bedrooms 11-16	**Total:8** 6 kids RN G Tech H (1:1)	Charge RN night – pt assignments, admissions, staffing
2:00	Asleep	Bedrooms 1-6	**Total: 8** 6 kids RN E Tech F (1:1)	Asleep	Bedrooms 7-10	**Total:6** 4 kids RN F Tech G (1:1)	Asleep	Bedrooms 11-16	**Total:8** 6 kids RN G Tech H (1:1)	Charge RN night – pt assignments, admissions, staffing
3:00	Asleep	Bedrooms 1-6	**Total: 8** 6 kids RN E Tech F (1:1)	Asleep	Bedrooms 7-10	**Total:6** 4 kids RN F Tech G (1:1)	Asleep	Bedrooms 11-16	**Total:8** 6 kids RN G Tech H (1:1)	Charge RN night – pt assignments, admissions, staffing
4:00	Asleep	Bedrooms 1-6	**Total: 8** 6 kids RN E Tech F (1:1)	Asleep	Bedrooms 7-10	**Total:6** 4 kids RN F Tech G (1:1)	Asleep	Bedrooms 11-16	**Total:8** 6 kids RN G Tech H (1:1)	Charge RN night – pt assignments, admissions, staffing RNs: documentation time
5:00	Asleep	Bedrooms 1-6	**Total: 8** 6 kids RN E Tech F (1:1)	Asleep	Bedrooms 7-10	**Total:6** 4 kids RN F Tech G (1:1)	Asleep	Bedrooms 11-16	**Total:8** 6 kids RN G Tech H (1:1)	Charge RN night – pt assignments, admissions, staffing RNs: documentation time

EXHIBIT 17

Craig P. Tanio, M.D.
CHAIR

STATE OF MARYLAND

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

July 19, 2016

Thomas C. Dame, Esquire
Gallagher, Evelius & Jones, LLP
218 North Charles Street, Suite 400
Baltimore, Maryland 21201

Re: University of Maryland Medical Center – Midtown Campus
Determination of Coverage Request

Dear Mr. Dame:

I write in response to your letter of June 30, 2016 to Suellen Wideman, on behalf of University of Maryland Medical Center-Midtown Campus (UMMC-Midtown). Additional pertinent information on this determination of coverage request was provided through a e-mail communication on July 19, 2016.

The letter provides more specific detail concerning a project previously described in a way which indicated an increase in the physical bed capacity at UMMC-Midtown. The project, with an estimated cost of $8 to $9 million, was determined to require Certificate of Need ("CON") review and approval on the basis that it would add bed capacity at UMMC-Midtown.

UMMC-Midtown has now described a project with two phases that involve the hospital's acute and special hospital bed capacity. First, a special hospital-chronic unit (6th Floor), housed in a unit with a physical bed capacity for 57 beds (even though UMMC-Midtown reports that the licensed bed capacity is 80), will be moved to another unit of the hospital (5 North) that has a physical bed capacity of 30 beds and is used for general medical/surgical/gynecological/ addictions ("MSGA") services. This MSGA unit will be renovated to house a special hospital-chronic unit with a physical bed capacity of 25 beds and the licensed special hospital-chronic bed capacity of UMMC-Midtown will be changed from 80 to 25 beds. Next, the 57-bed unit that housed chronic care (6th Floor) will be renovated to create a unit with 37 private patient rooms. This will serve as the new acute psychiatric unit. The current 28-bed psychiatric unit, located on 5 West/5 South, will, after relocation of acute psychiatric services, "no longer normally be used to accommodate patients." UMMC-Midtown states that "it has no current plans for this space," which consists of 14 semi-private rooms and "it would not be feasible to use these rooms (on 5 West/5 South, to accommodate patient beds because the rooms lack private bathrooms." Additionally, the hospital notes that "only two or three rooms in this space are equipped with headwalls and gas lines."

The room and bed schedule provided by UMMC-Midtown, when viewed in the context of the narrative description of the project contained in your letter, indicates the following "before and after" patient room and physical bed capacity at the hospital.

BEFORE PROJECT				
Service/Units	General Hospital		Special Hospital	
	Rooms	Beds	Rooms	Beds
MSGA				
3 South	25	25		
3 North	18	21		
4 South	10	12		
4 North	9	9		
5 Central	18	18		
5 North	27	30		
Acute Psychiatric				
5 West/5 South	14	28		
GENERAL HOSPITAL TOTAL	121	143		
Chronic Care				
6TH Floor			49	57
SPECIAL HOSPITAL TOTAL			49	57
TOTAL PHYSICAL BED CAPACITY	121	143	49	57

AFTER PROJECT				
Service/Units	General Hospital		Special Hospital	
	Rooms	Beds	Rooms	Beds
MSGA				
3 South	25	25		
3 North	18	21		
4 South	10	12		
4 North	9	9		
5 Central	18	18		
Acute Psychiatric				
6th Floor	37	37		
GENERAL HOSPITAL TOTAL	117	122		
Chronic Care				
5 North			25	25
SPECIAL HOSPITAL TOTAL			25	25
Unused				
5 West/5 South	14	28		
TOTAL PHYSICAL BED CAPACITY	131	150	25	25

While the plan that UMMC-Midtown has now described calls for abandonment of the 5 West/5 South unit, the description indicates that it will be left in place at this time and, as such, it will represent physical bed capacity. If viewed as potential general hospital bed capacity, consistent with its current use, the project will increase the room capacity, from 121 to 131 rooms, and will increase the bed capacity, from 143 beds to 150 beds, of this health care facility, i.e., the general hospital.

However, as noted, the hospital stated that it does not believe this unit, as currently configured, is suitable for reuse as patient room and bed space. For this reason, I am willing to determine that this project does not expand the physical bed capacity of the general hospital at UMMC-Midtown if the hospital agrees that it will not use the 5 West/5 South unit, currently in operation as an acute psychiatric unit, to house any patients after the psychiatric service moves to the 6th Floor without notifying and obtaining approval from the Maryland Health Care Commission. Your e-mail of July 19, 2016 states, "UMMC-Midtown agrees to this condition" that "after completion of the project, UMMC-Midtown (will) not use units on 5 South and 5 West for any patient beds without prior Commission approval." On that basis, I am willing to determine that the project, as described, does not require CON approval. If you have any questions concerning this matter, please call Kevin McDonald at 410-764-5982.

Sincerely,

Ben Steffen

Ben Steffen
Executive Director

cc: Brian G. Bailey, Senior Vice President, UMMMC-Midtown
Jerry Schmith, HSCRC
Jennifer Whitten, MHA
Patricia Nay, M.D., Office of Health Care Quality, DHMH
Leana Wen, M.D., Health Officer, Baltimore City
Kevin McDonald
Suellen Wideman

EXHIBIT 18

LIVING DESIGN LAB

January 16, 2019

Mr. Bret Elam
University of Maryland Medical Center
Facilities Project Development
110 S. Paca Street, Suite 107
Baltimore, MD 21201

RE: Architect's qualifying statement regarding Responses to Additional Information Questions Dated January 8, 2019 (Matter No. 18-24-2429)

Dear Bret:

The Patient Bedrooms at the west end of the unit (N11W113, N11W114, N11W115, and N11W115) are intended for latency aged patients. These rooms all share common toilet and bathing facilities directly across the hall (N11W129, N11W130, and N11W131). The decision to provide common facilities in lieu of private ones is related to clinical needs for this patient population cited by the clinicians during the predesign phase. The use of shared facilities for this population is not uncommon and is also included in designs of other similar hospitals with similar patient populations.

The use of common bathing and toilet facilities is allowable by governing regulations. Please refer to sheet 111-RE submitted with the Schematic Design submission, dated 10/29/2018, and the key notes within N11W129, N11W130, and N11W131 (attached hereto). These refer to applicable FGI 2014 provisions which expressly allow for shared bathing and toilet facilities; the specific sections include:

2.5-2.2.2.6 Patient toilet room

(1) Each patient shall have access to a toilet room without having to enter a corridor. Omission of this direct access requirement shall be permitted at child or adolescent patient bedrooms or in specific patient bedrooms where the use of corridor access is part of the hospital's written clinical risk assessment and management program.

(2) One toilet room shall serve no more than two patient bedrooms and no more than four patients.

(3) The toilet room shall contain a toilet and a hand- washing station.

(4) Toilet room doors

(a) Where indicated by the safety risk assessment, toilet room doors shall be equipped with keyed locks that allow staff to control access to the toilet room.

(b) If a swinging door is used, the door to the toilet room shall swing outward or be double- acting.

(5) Where a toilet room is required to be ADA- or ANSI-compliant:

(a) Thresholds shall be designed to facilitate use and to prevent tipping of wheelchairs and other portable wheeled equipment by patients and staff.

(b) Grab bars shall be designed to facilitate use (i.e., be graspable) and to be ligature-resistant.

(c) Each entry door into a patient toilet room required to be ADA- or ANSI-compliant shall provide space for health care providers to transfer patients to the toilet using portable mechanical lifting equipment.

2.5-2.2.2.7 Patient bathing facilities. A bathtub or shower shall be provided for each six beds not otherwise served by bathing facilities at patient bedrooms.

Similarly, the decision to include two semi-private patient bedrooms (N11W114 and N11W115) was dictated by clinical requirements identified during predesign. Here again, the design abides by FGI 2014 which expressly allows for two occupants per room:

2.5-2.2.2.1 Capacity. Maximum room capacity shall be two patients.

The design for this child & adolescent unit abides by the provisions allowed in the FGI 2014 references above.

Sincerely,

Kevin Day
Principal

EXHIBIT 19

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year 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.						
Indicate CY or FY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**			
1. DISCHARGES										
a. General Medical/Surgical*	21,903	20,637	20,297	20,483	20,144	20,251	20,359			
b. ICU/CCU	2,804	2,846	2,826	2,834	2,849	2,864	2,878			
Total MSGA	**24,707**	**23,483**	**23,123**	**23,317**	**22,993**	**23,115**	**23,237**	**0**	**0**	**0**
c. Pediatric	1,585	1,768	1,782	1,796	1,810	1,825	1,839			
d. Obstetric	1,997	2,110	2,118	2,120	2,125	2,135	2,140			
e. Acute Psychiatric	1,129	1,173	1,149	1,321	1,322	1,325	1,327			
Adult	537	565	496	322	322	322	322			
Gero	220	192	266	266	266	266	266			
Child	372	416	387	462	462	462	462			
Adolescent	-	-	-	271	272	275	277			
Total Acute	***29,418***	***28,534***	***28,172***	***28,554***	***28,250***	***28,400***	***28,543***	***0***	***0***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL DISCHARGES	***29,418***	***28,534***	***28,172***	***28,554***	***28,250***	***28,400***	***28,543***	***0***	***0***	***0***
2. PATIENT DAYS										
a. General Medical/Surgical*	121,983	121,104	121,992	121,390	120,952	120,480	120,057			
b. ICU/CCU	70,332	70,453	70,085	70,283	70,655	71,027	71,374			
Total MSGA	**192,315**	**191,557**	**192,077**	**191,673**	**191,607**	**191,507**	**191,431**	**0**	**0**	**0**

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year 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.						
Indicate CY or FY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**			
c. Pediatric	5,396	5,151	5,346	5,388	5,431	5,474	5,517			
d. Obstetric	6,031	6,562	6,587	6,593	6,609	6,640	6,655			
e. Acute Psychiatric	13,011	13,483	12,743	13,099	13,107	13,133	13,150			
Adult	6,961	7,499	6,744	4,380	4,380	4,380	4,380			
Gero	4,088	3,791	4,015	4,015	4,015	4,015	4,015			
Child	1,962	2,193	1,984	2,373	2,373	2,373	2,373			
Adolescent	-	-	-	2,331	2,339	2,365	2,382			
Total Acute	***216,753***	***216,753***	***216,753***	***216,753***	***216,753***	***216,753***	***216,753***	***0***	***0***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	***216,753***	***216,753***	***216,753***	***216,753***	***216,753***	***216,753***	***216,753***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
Total MSGA	7.8	8.2	8.3	8.2	8.3	8.3	8.2			
c. Pediatric	3.4	2.9	3.0	3.0	3.0	3.0	3.0			
d. Obstetric	3.0	3.1	3.1	3.1	3.1	3.1	3.1			
e. Acute Psychiatric	11.5	11.5	11.1	9.9	9.9	9.9	9.9			
Adult	13.0	13.3	13.6	13.6	13.6	13.6	13.6			
Gero	18.6	19.7	15.1	15.1	15.1	15.1	15.1			
Child	5.3	5.3	5.1	5.1	5.1	5.1	5.1			
Adolescent	-	-	-	8.6	8.6	8.6	8.6			
Total Acute	7.4	7.6	7.7	7.6	7.7	7.6	7.6			

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year 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.						
Indicate CY or FY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**			
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL AVERAGE LENGTH OF STAY	7.4	7.6	7.7	7.6	7.7	7.6	7.6			
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*	416	433	450	450	450	450	450			
b. ICU/CCU	241	241	241	241	241	241	241			
Total MSGA	**657**	**674**	**691**	**691**	**691**	**691**	**691**	**0**	**0**	**0**
c. Pediatric	59	59	59	59	59	59	59			
d. Obstetric	30	30	35	35	35	35	35			
e. Acute Psychiatric	56	56	56	56	56	56	56			
Total Acute	***802***	***819***	***841***	***841***	***841***	***841***	***841***	***0***	***0***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL LICENSED BEDS	***802***	***819***	***841***	***841***	***841***	***841***	***841***	***0***	***0***	***0***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year 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.						
Indicate CY or FY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**			
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	80.3%	76.6%	74.3%	73.9%	73.6%	73.4%	73.1%			
b. ICU/CCU	80.0%	80.1%	79.7%	79.9%	80.3%	80.7%	81.1%			
Total MSGA	**80.2%**	**77.9%**	**76.2%**	**76.0%**	**76.0%**	**75.9%**	**75.9%**			
c. Pediatric	25.1%	23.9%	24.8%	25.0%	25.2%	25.4%	25.6%			
d. Obstetric	55.1%	59.9%	51.6%	51.6%	51.7%	52.0%	52.1%			
e. Acute Psychiatric	63.7%	66.0%	62.3%	64.1%	64.1%	64.2%	64.3%			
Total Acute	**74.0%**	**72.5%**	**70.6%**	**70.6%**	**70.6%**	**70.6%**	**70.6%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL OCCUPANCY %	**74.0%**	**72.5%**	**70.6%**	**70.6%**	**70.6%**	**70.6%**	**70.6%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS										
a. Emergency Department	54,868	67,311	68,811	68,811	69,004	69,383	69,751			
b. Same-day Surgery	18,025	11,638	11,638	11,638	11,671	11,735	11,797			
c. Laboratory										
d. Imaging										
e. Other (Specify/add rows of needed)	227,600	257,684	261,821	261,821	262,554	263,998	265,397			
TOTAL OUTPATIENT VISITS	***300,493***	***336,633***	***342,270***	***342,270***	***343,229***	***345,116***	***346,945***	***0***	***0***	***0***
7. OBSERVATIONS**										
a. Number of Patients										
b. Hours										

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

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

EXHIBIT 20

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	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 J and K.						
Indicate CY or FY	**FY21**	**FY22**	**FY23**				
1. DISCHARGES							
a. General Medical/Surgical*	0	0	0				
b. ICU/CCU	0	0	0				
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0				
d. Obstetric	0	0	0				
e. Acute Psychiatric	272	275	277				
Total Acute	***272***	***275***	***277***	***0***	***0***	***0***	***0***
f. Rehabilitation	0	0	0				
g. Comprehensive Care	0	0	0				
h. Other (Specify/add rows of needed)	0	0	0				
TOTAL DISCHARGES	***272***	***275***	***277***	***0***	***0***	***0***	***0***
2. PATIENT DAYS							
a. General Medical/Surgical*	0	0	0				
b. ICU/CCU	0	0	0				
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0				
d. Obstetric	0	0	0				
e. Acute Psychiatric	2,339	2,365	2,382				
Total Acute	***2339***	***2365***	***2382***	***0***	***0***	***0***	***0***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL PATIENT DAYS	***2,339***	***2,365***	***2,382***	***0***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY							
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	8.6	8.6	8.6	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	8.6	8.6	8.6	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	8.6	8.6	8.6	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	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 J and K.						
Indicate CY or FY	**FY21**	**FY22**	**FY23**				
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL LICENSED BEDS							
5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE: *Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS							
a. Emergency Department							
b. Same-day Surgery							
c. Laboratory							
d. Imaging							
e. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***
7. OBSERVATIONS**							
a. Number of Patients							
b. Hours							

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

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