GALLAGHER
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November 27, 2019

Ms. Ruby Potter
Health Facilities Coordination Officer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Certificate of Need Application
Greater Baltimore Medical Center, Inc.
Modernization of Greater Baltimore Medical Center

Dear Ms. Potter:

On behalf of applicant Greater Baltimore Medical Center, Inc., enclosed are four copies of its "Response to Additional Information Questions Dated October 25, 2019" with respect to the CON Application for a proposed hospital addition at Greater Baltimore Medical Center.

I hereby certify that a copy of this submission has also been forwarded to the appropriate local health planning agencies as noted below. Thank you for your assistance.

Sincerely,

Thomas C. Dame

TCD:blr
Enclosures
cc: Kevin McDonald, Chief, Certificate of Need
Paul Parker, Director, Center for Health Care Facilities Planning & Development
Suellen Wideman, Esq., Assistant Attorney General, MHCC
Sarah Pendley, Esq., Assistant Attorney General, MHCC
Gregory Wm. Branch, Baltimore County Health Officer
John Chessare, MD, MPH, FACHE, President and CEO, GBMC
Keith Poisson, Executive VP and Chief Operating Officer, GBMC
Laurie R. Beyer, MBA, CPA, Executive Vice President and CFO, GBMC
Stacey McGreevy, VP of Support Services, GBMC
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#684642
010236-0002

GREATER BALTIMORE MEDICAL CENTER, INC.
HOSPITAL PROPOSED ADDITION
Matter No. 19-03-2439

Responses to Additional Information Questions
Dated October 25, 2019

Construction Cost of Hospital Space

1. **Your construction project estimates that the cost of the project will exceed the MVS benchmark by $61.24 per square foot. Please:**

   a. **Explain what factors are responsible for a project cost estimate that exceeds the calculated benchmark by about 17%.**

   b. **Justify the need for and merits of each factor.**

Applicant Response

The estimated project costs exceed the MVS benchmark for two reasons.

First, GBMC budgeted the project to protect against the need to seek a post-approval project change for cost modification. For the initial project design/cost estimating phase, GBMC requested and received three proposals from different cost estimating companies. In terms of cost per square foot, the proposals ranged from $487 per square foot to $526 square foot. During this phase, in order to assure that the project costs submitted in the CON application would not have to be increased, GBMC used the highest proposal for budgeting purposes. GBMC concluded this would be an appropriately conservative approach to take during the design/cost estimating phase. GBMC is currently in the process of choosing a construction manager and anticipates that the project cost estimate will be adjusted.

Second, GBMC designed Level 3 of the new construction to be of higher quality than the other three levels. Level 3 will serve as the new main entrance to the hospital and will provide many patients and visitors with the first impression of the hospital facility. This level is planned to have premium finishes and was designed to the "excellent" quality benchmark of the MVS, rather than the "good" quality characterization. MVS defines good and excellent quality as follows (excerpted from the MVS Complete Guide to Building Costs, Section 1, p. 10):

GOOD QUALITY

> Buildings designed for good appearance, comfort and convenience, as well as an element of prestige, constitute the Good Quality category. Ornamental treatment is usually of higher quality and interiors are designed for upper-class rentals. The amenities of better lighting and mechanical work are primary items in their costs.
>
> In dwellings, the good residence is generally built to cater to the young executive or move-up market. It will be much the same construction as the Average, with more detail and higher mechanical and electrical costs and may be the standard structure in the so-called move-up community.

EXCELLENT QUALITY

> Excellent buildings are normally prestige buildings. On an economic basis, part of the cost must be written off to pride of ownership and some of the income intangibly derived from advertising. Excellent dwellings are generally built for the established professional or those with higher incomes and will have some expensive finishes and fixtures.
>
> The High Value quality dwelling will normally have more ornamentation, special design, and top quality materials. However, the costs listed will not be high enough for the most luxurious types of dwellings, built without regard for cost, since each listed cost represents the center of the costs within that quality range.

Designing Level 3 to excellent quality standards increased the project costs. When the MVS benchmark is adjusted to reflect that Level 3 will be constructed to excellent quality (and building Levels 4 and 5 as good quality), reduces the amount that the project exceeds the MVS benchmark from $61.24 to $20.47 (5.33%).[1] For illustrative purposes, GBMC attaches an alternative MVS analysis as **Exhibit 24**. This alternative analysis, which is not strictly compliant with Standard .04B(7), applies the excellent quality benchmark to Level 3 only. As compared to a typical hospital replacement project, which includes many different types of finishes, this project has higher quality finishes in a larger portion of the project because it includes the replacement of the main entrance that will serve the entire hospital.

Availability of Cost Effective Alternatives

2. Our original completeness question was:

> **Note that the criterion requires that an *applicant compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities. The applicant's response compared the proposal to its existing facilities*; a proper interpretation of the criterion requires GBMC to provide an analysis of other existing facilities that provide the same services as GBMC (other acute care hospitals) and why they are or are not an appropriate alternative to this modernization project.**

Your response failed to address the question, which essentially asks you to justify the continuing need for these beds in the service area GBMC serves. One way to meet the expectations of this criterion would be to provide an analysis of supply and demand for inpatient hospital admissions in the service area. For example,

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[1] Since the submission of the MVS analysis as part of the first Completeness Responses was filed, the MVS Local Multiplier for Baltimore increased from 1 to 1.01 (MVS October 2019 Update). Also, in the MVS November 2019 Update, Section 15, (the section that includes General Hospitals) was updated with new base costs. The alternative MVS analysis submitted as part of this response reflects these changes. Also, GBMC attaches as **Exhibit 25** a revised version of the MVS analysis that is compliant with Standard .04B(7).

providing an analysis of the occupancy rates at other existing facilities in the service area to assess whether the service area's need could be met by those facilities, obviating the need for this project. Or, given the occupancy rates, might a more cost-effective alternative approach be for GBMC to renovate in place, increasing the size of existing rooms by building fewer but larger patient rooms without new construction. Another way of asking the question is, is the need in the service area great enough to require the retention of the current number of MSGA beds, or would the area be adequately served with fewer beds in a modernized space -- a modernization of existing units without construction of a new building?

Applicant Response

GBMC does not seek to expand operational bed capacity or services. The proposed project would modernize the hospital and update a substantial number of patient rooms to be consistent with FGI Guidelines. Many of the patient rooms are in portions of the hospital that were constructed decades ago, some in 1965. The proposed changes are necessary to enhance patient safety as well as patient experience.

As explained below, it is not possible to undertake the project by "renovating in place" without taking inpatient bed units out of service during construction and permanently reducing a substantial number of beds. Given the current and projected demand for inpatient care at GBMC, shutting down inpatient capacity would impair GBMC's ability to admit patients from its emergency department and would force patients, physicians, and payers to seek inpatient care in other facilities when they otherwise would choose GBMC for inpatient care. Reducing inpatient capacity at GBMC would also result in a reduction of Global Budget Revenue ("GBR") for GBMC and an increase in GBR for other hospitals that may be higher cost facilities. Thus, there is no reasonable alternative to the proposed project that would not involve significant reduction of needed capacity.

In questions related to the review criterion on cost-effective alternatives, COMAR § 10.24.01.08G(3)(c), Commission Staff suggests that GBMC should consider reducing its inpatient capacity and redirect patients to other area hospitals. GBMC respectfully disagrees with Staff's apparent interpretation of the review criterion in this review and the premise of Question No. 2. Regardless of the occupancy rates at other hospitals in GBMC's service area, patients, physicians, and payers intentionally choose GBMC for a variety of reasons, and these health care choices should not be disrupted when an applicant is not seeking to expand capacity or services.

A. The Premise of Question No. 2 Conflicts With Commission Precedent on the Application of the Cost-Effective Alternatives Review Criterion.

When applying the cost-effective alternatives review criterion to projects that do not seek to add capacity or new services, the Commission should not require an applicant to consider reducing existing capacity or services, especially, as here, when existing capacity is needed and the demand is expected to increase.[2] The Commission expressly acknowledged the

[2] In a CON review involving the establishment of a new facility or service, or the expansion of existing capacity, it is reasonable and appropriate for the Commission to require the applicant to evaluate whether the project is necessary by assessing the ability of existing or

correctness of GBMC's interpretation of COMAR § 10.24.01.08G(3)(c) in its 2018 decision in the CON review for the replacement and consolidation of operating rooms and cardiac care unit beds at University of Maryland St. Joseph's Medical Center ("UM SJMC"). Docket No. 18-03-2415. Like GBMC, UM SJMC needed CON approval only because the project cost exceeded the capital expenditure threshold. UM SJMC did not seek to expand its capacity or services. In considering UM SJMC's compliance with the cost effectiveness review criterion, the Commission concluded:

> In a project such as this, which seeks to renovate and replace existing operating rooms and facilities, it is not meaningful to compare the cost-effectiveness of the project with the provision of services in alternative existing facilities.

Staff Report and Recommendation for University of Maryland St. Joseph's Medical Center (Docket 18-03-2415), p. 24. Similarly, in granting a CON to Stella Maris in 2017 to modernize its patient rooms and facilities without expanding capacity or services, the Commission did not require Stella Maris to evaluate whether it should reduce its bed capacity and rely on other nursing homes to care for patients who otherwise would have chosen Stella Maris. Staff Report and Recommendation for Stella Maris (Docket No. 16-03-2376), pp. 13-16.

B. <u>The Need to Enlarge and Modernize Patient Rooms at GBMC</u>

1. <u>Expanding and modernizing patient rooms is a vitally important project to improve patient experience and safety.</u>

Through the proposed project, GBMC is executing a strategy much like other hospitals to expand its footprint to provide modern private patient rooms with the intent to subsequently renovate existing patient units and convert semi-private rooms into private rooms. The plan is intended to meet GBMC's need to provide a better patient experience and the standard of care that is the current practice in the industry. The CON application details the current functional deficiencies and the FGI Guideline requirements that will be satisfied through the implementation of the project.

2. <u>Renovating in Place Would Reduce MSGA Capacity by up to 26 Beds at the Beginning of the Project and up to 60 Beds Permanently</u>.

The impact of executing a phased "renovation in place" project would incrementally reduce GBMC's MSGA bed capacity by as many as 26 beds (the size of a typical existing inpatient unit) beginning at the outset of the renovation project. At the end of the multi-year, multi-phase renovation project, GBMC will realize a net permanent reduction of approximately 60 MSGA beds because, given space constraints, GBMC would lose one bed for every three rooms renovated (i.e., three rooms would be consolidated into two properly sized rooms). Such a reduction in GBMC's capacity would have a dramatic impact on the services which GBMC provides and the population it serves.

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proposed facilities to meet the need for the new or expanded services. This is especially important in a comparative review, where there is more than one proposal before the Commission to achieve the same objectives.

C. Inpatient Admissions

Closing inpatient units at GBMC likely would have a severe impact on admissions at the hospital.

Admissions to GBMC's MSGA bed units are generated from various sources and service lines, including the emergency department, Kaiser Permanente patients, surgical operations, geriatric referrals, among others. A "renovation in place" project would have the unintended consequence of, at times, a net reduction in beds, thereby reducing the number of patients GBMC is able to serve. The benefit of the proposed project is that it would create temporary replacement capacity that would enable future inpatient unit projects to be executed without adversely impacting inpatient capacity and the service lines.

1. The Demand for Inpatient Services at GBMC is Strong and Growing.

More than 70% of GBMC's inpatient admissions originate from GBMC's primary service area, designated by 52 zip codes surrounding the hospital. Within GBMC's primary service area, GBMC inpatient market share has grown over the last three years as shown in Table 26 below.

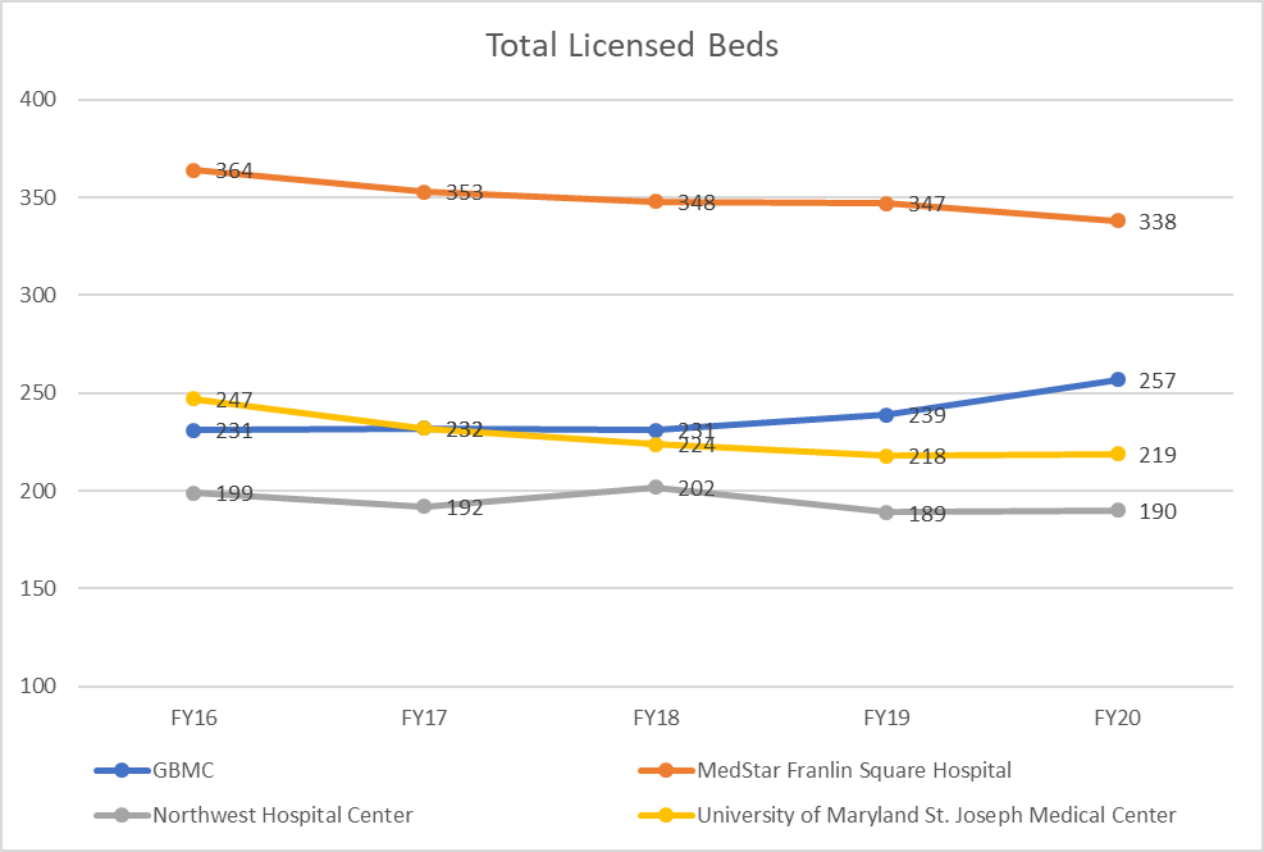
Table 26
Inpatient Market Share in GBMC Primary Service Area

Hospital	FY16	FY17	FY18	FY19 YTD Mar-19
GBMC	11.1%	10.8%	11.9%	12.5%
Medstar Franklin Square	14.0%	14.5%	14.8%	14.2%
Sinai	10.8%	10.0%	9.8%	9.6%
University of Maryland St. Joseph Medical Center	9.9%	9.7%	9.6%	9.6%
Northwest Hospital	6.1%	6.1%	5.6%	5.3%
Good Samaritan	5.5%	5.0%	4.7%	4.7%
Upper Chesapeake	5.1%	5.0%	4.8%	5.0%
Other	37.5%	38.8%	38.7%	39.1%
Total	100.0%	100.0%	100.0%	100.0%

Source: St. Paul's Data Group

As a result of GBMC's expanding market share and volume, GBMC's total bed license has increased over the past two years, while the bed license counts at other hospitals in the GBMC service area remained relatively flat, or declined. Table 27 below shows the relative increases and decreases of licensed bed count at the various hospitals.

Table 27
Total Licensed Beds at Hospitals in GBMC Primary Service Area



Source: MHCC Hospital Service Inventory

As shown in Table 28 below, GBMC experienced a positive change from CY 2017 to CY 2018 in Equivalent Case Mix Adjusted Discharges (ECMADs), a portion of which resulted from GBMC's increase in inpatient market share. The table below illustrates GBMC's growth in ECMADs, while some other local hospitals experienced a decline.

Table 28
Change in ECMAD for Select Hospitals (CY 2017 to CY 2018)

Hospital	ECMAD Change from CY17 to CY18
GBMC	908
MedStar Franlin Square Hospital	(762)
Northwest Hospital Center	(534)
University of Maryland St. Joseph Medical Center	(106)

Source: https://hscrc.state.md.us/Documents/Hospitals/gbr-tpr-update/FY-2020/MarketShift-CY18.pdf

2. Reducing MSGA Bed Capacity at GBMC Would Adversely Affect Emergency Department Services at GBMC and Other Area Hospitals.

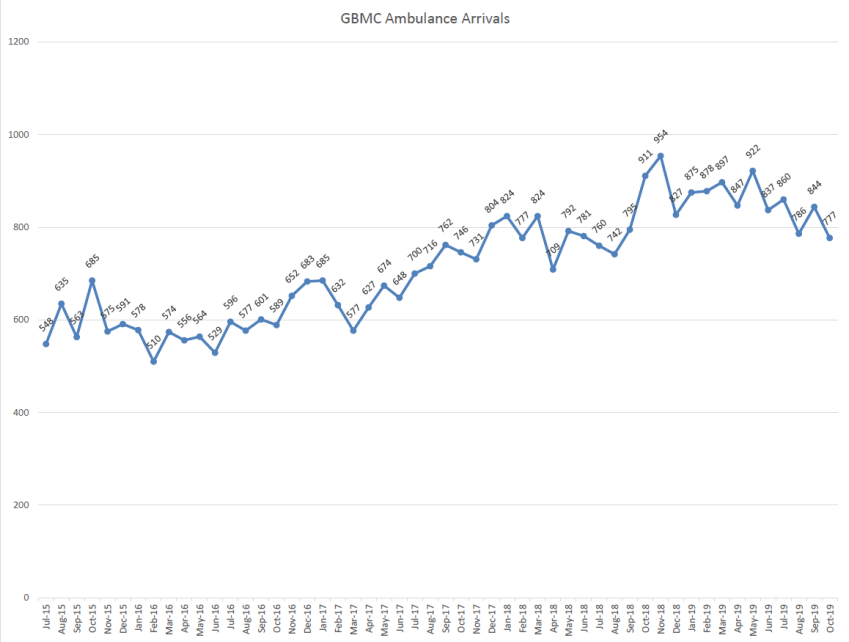
In FY 2019, GBMC experienced a substantial increase in inpatient medical admissions, a large portion of which entered the system through the emergency department ("ED"). GBMC's ED volume increased in FY 2018 and FY 2019, while ED volumes at other hospitals in close proximity declined or remained flat, as illustrated in Table 29 below.

Table 29
Emergency Department Volume Change at Select Hospitals (FY 2015 – FY 2019)

Emergency Department Volume Year over Year Change	% Change FY15 to FY16	% Change FY16 to FY17	% Change FY17 to FY18	% Change FY18 to FY19
42-Greater Baltimore Medical Center	0%	-5%	4%	6%
14-Franklin Square Hospital	-3%	-7%	-2%	-8%
12-Sinai Hospital	-2%	-7%	-2%	0%
07-Saint Joseph Hospital	1%	-1%	-4%	-1%
Source: Sinai Report				

In FY 2019 GBMC's ED admitted 13,630 patients out of 57,996 visits. Of the 13,630 patients admitted, 4,603 (33.8%) arrived by ambulance. Much of the increase in GBMC's ED utilization comes from ambulance arrivals as seen in the Table 30 below.

Table 30
GBMC Ambulance Arrivals to Emergency Department (2015 – 2019)



Source: GBMC internal data

GBMC continues to be able to serve these patients effectively, maintaining the lowest CY 2019 average for Yellow Alerts and Reroutes and the second lowest average for Red Alerts as summarized in Table 31 below.

Table 31
Emergency Department Alert Hours Summary

Yellow Alert	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	CY19 Average
GBMC	57.04	92.65	185.14	112.01	73.15	20.42	44.95	66.23	96.45	75.84	82.39
University of Maryland St. Joseph Medical Center	173.58	156.90	300.70	182.34	118.28	88.31	168.56	85.44	172.78	104.03	155.09
MedStar Franklin Square Hospital	184.06	263.75	314.64	193.99	230.65	217.14	171.80	155.44	154.48	224.17	211.01
Sinai	177.49	254.53	382.04	239.15	293.96	350.31	387.63	235.05	353.82	122.37	279.64
Red Alert	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**CY19 Averag**
GBMC	36.80	7.01	101.09	30.47	26.37	38.41	31.58	-	10.34	16.80	29.89
University of Maryland St. Joseph Medical Center	107.56	106.01	126.72	163.43	192.31	149.30	139.23	88.47	139.90	33.15	124.61
MedStar Franklin Square Hospital	-	-	-	-	5.26	-	-	0.02	-	-	0.53
Sinai	218.00	241.82	188.83	33.07	201.96	152.28	172.77	105.68	113.27	166.88	159.46

ReRoute	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	CY19 Averag
GBMC	-	3.30	4.77	4.42	1.15	-	5.89	0.67	5.54	5.65	3.14
University of Maryland St. Joseph Medical Center	5.03	18.38	13.88	6.04	1.09	1.18	1.24	2.42	4.63	6.04	5.99
MedStar Franklin Square Hospital	7.52	5.53	22.87	10.14	8.66	4.30	1.32	2.75	12.32	5.16	8.06
Sinai	3.97	11.30	8.22	4.79	9.17	1.73	7.83	7.26	11.27	8.06	7.36

Source: MIEMSS CHATS data reports, https://www.miemssalert.com/chats/

Closing current MSGA bed units would cause a backup in the GBMC ED and cause GBMC to go on Alert status far more frequently. Further, rerouting EMS transports would cause other hospitals in GBMC's service area to increase their Alert time as well. Since GBMC's walk-in ED patients are not affected by Alert status, that population would garner more MSGA beds than currently. Consequently, other area hospital EDs likely would experience higher acuity patients and the GBMC ED would experience lower acuity patients.

3. Reducing Inpatient Capacity at GBMC Would Restrict the Choices of Patients and Their Physicians.

In addition to the ED, GBMC serves patients who are referred by area physicians for acute care. GBMC's medical staff is comprised of employed physicians and independent physicians. Many of the independent physicians on GBMC's Medical Staff have privileges at other local hospitals. Referring physicians give patients a choice when an acute care setting is warranted. GBMC does not control where independent physicians refer their patients for acute care. If units were closed, GBMC would not be able to accommodate independent physician's offering patient choice for the acute care setting.

4. Reducing Inpatient Capacity at GBMC Would Compromise GBMC's Commitment to Serve a Growing Number of Kaiser Permanente Members.

Kaiser Permanente ("Kaiser") has a long-standing relationship with GBMC as the preferred provider of acute inpatient services for Baltimore County. Currently, Unit 35 at GBMC has 26 dedicated MSGA beds for Kaiser patients, which are fully utilized. In FY 2019, GBMC served more than 2,800 Kaiser patients. Kaiser recently announced a commitment to spend $13 billion by 2028 to substantially grow its Baltimore area membership from 64,000 to

200,000.[3] As Kaiser continues to grow its membership in the northern Baltimore area, GBMC expects Kaiser's medical/surgical volumes of acute inpatient services to increase. Closing current MSGA bed units would impair GBMC's ability to execute on its commitment to Kaiser to provide inpatient capacity for a growing population of Kaiser members.

Given that a "renovation in place" project would lead to a permanent reduction in MSGA beds, in order to maintain its commitment to Kaiser to provide inpatient capacity for Kaiser members, GBMC would have to reduce capacity with a disproportionate impact on non-Kaiser patients. Specifically, the reduction in MSGA beds at any point in time during the multi-year, multi-phased project would be borne by the non-Kaiser inpatient units making the adverse impact of a "renovation in place" project even greater.

D. Bed Capacity in Area Hospitals

Question No. 2 presumes there may be physical bed capacity available in other area hospitals and that patients could be admitted in those facilities. While most hospitals have more "physical bed capacity" than the operational beds reported in the MHCC's inventory, there is no available information on how many of these "beds" actually could be made operational or what the cost would be to restore bed capacity to accommodate patients who might be redirected from GBMC to other hospitals, as suggested by this question. Many non-operational physical beds in other facilities are located in rooms that have been converted to offices and other non-patient uses, a common practice throughout the hospital industry. Also, some patient rooms have been converted from semi-private to private rooms; converting them back to semi-private would adversely affect patient satisfaction and safety.

Furthermore, while other hospitals might appear to have the physical bed capacity to accept patients redirected from GBMC, they may not have staffing and other capacity in the needed service lines or the capability to increase service lines to support the additional MSGA beds. Simply put, redirecting patient beds to other hospitals would require a coordinated effort to have those facilities increase their service line capacity, which they may not be inclined to do because of physical or operational/financial barriers, such as required facility upgrades and increased staffing.

Finally, it is unlikely that other hospitals would open beds and increase staffing concurrently with GBMC's closing beds in order to execute a "renovation in place" project. The end result would be that once GBMC began a "renovation in place" project the bed capacity aggregated across all available hospitals would be reduced, adversely impacting to the community at large.

E. Renovating in Place Would Disrupt GBMC's Master Facility Plan.

While the proposed project provides new inpatient beds designed to current standards, the benefit of the project goes beyond the inpatient experience. As stated in the CON application, the proposed project will enable vacated spaces to be converted to support service lines in need of expansion, most notably the ED and behavioral health. The proposed project is

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[3] According to news reports, Kaiser plans to increase the number of Kaiser centers in the Baltimore area from five to fifteen, including a new $247 million medical center in Timonium. A November 20, 2019 Baltimore Sun article reporting Kaiser's plan is attached as **Exhibit 26**.

the cornerstone of GBMC's master facility plan, which addresses the service lines in need of modernization and physical plant expansion. If a "renovation in place" project is executed in lieu of the proposed project, then the subsequent projects identified in GBMC's master facility plan will not be executed and the service lines will be permanently impacted, bound by their existing, antiquated facilities.

Viability of the Proposal

3. **Our original question (#19) asked you to explain why there was such a stark difference in operating results between the uninflated (-$2.2 million in Table G) and inflated ($11.17 million in '26 in Table H) revenue/expense projections for the hospital.**

   In the completeness response you stated that the difference was "due to a significant projected cumulative revenue growth through rate increase in GBMC Healthcare's unregulated subsidiaries…not related to the proposed project." Are you saying that the Table H projections included the results from these subsidiaries, while the Table G projections did not? If so, that is not an apples to apples comparison, and needs to be corrected. In fact, these projections should project the operations of GBMC, separate from its subsidiaries.

Applicant Response

Tables G and H include projections for GBMC Healthcare Inc. and Subsidiaries, including Gilchrist Hospice Care, Inc. and other unregulated activity. As previously noted, the difference between Income from Operations presented in Tables G & H, is primarily due to cumulative revenue growth in these unregulated subsidiaries. Effective October 2019, the Center for Medicare & Medicaid Services significantly increased reimbursement rates for hospice inpatient services. The $11 million increase is comprised primarily of Gilchrist Hospice Care's Medicare net reimbursement increase.

The original submission of Tables G & H included the entire GBMC healthcare system since the system is an integrated continuum of care and it is appropriate to view financial viability at this level within the meaning of the financial feasibility standard (Standard .04B(13)). However, to address the request, and for purposes of illustration, GBMC now provides Tables G & H for Greater Baltimore Medical Center, Inc. only, which includes physician activity. These alternative tables are attached as **Exhibit 25**. Please note that the variance between inflated and uninflated for the Income from Operations is not materially different. In addition, the net income including investment earnings, is sufficient to cover the additional debt and capital costs related to the Project.

Charity Care

4. **Subpart (a) (i) of this standard requires an applicant to have a policy and procedure which will ensure that a determination of probable eligibility within two business days occurs. MHCC's interpretation of this standard has been to ensure that said applicant's administration of this policy has been explained to applicants thusly:**

   Note that requiring a completed application with documentation does not comply with this standard, which is intended to ensure that a procedure is

in place to inform a potential charity/reduced fee care recipient of his/her probable eligibility within two business days of initial inquiry or application for Medicaid based on a simple and expeditious process.

A two-step process that allows for a probable determination to be communicated within two days based on an abridged set of information, followed by a final determination based on a completed application with the required documentation is permissible. But the policy must include the more easily navigated determination of probable eligibility.

GBMC's response to this standard (as found in the CON application and completeness response) is: *"Following a patient's request for financial assistance, application for medical assistance, or both, GBMC will render and communicate to the patient a probable eligibility determination within two (2) business days,"* with reference this wording in the policy:

> **<u>Probable Eligibility</u>: GBMC will provide the patient a probable eligibility determination within two (2) business days of request. To provide a probable eligibility determination, GBMC will utilize the patient's completed and submitted Maryland Uniform Financial Assistance Application (Exhibit B). Please note that supporting documentation with the application will assist in the probable determination, but is not required. However, supporting documentation will be required for the final determination.**
>
> **<u>Final eligibility determination</u> will be based on all criteria and requirements set forth in this policy.**

With regard to GBMC's administration of this policy as it relates to decision on probable eligibility, our questions are:

a. Must the Maryland Uniform Financial Assistance Application be completed in its entirety in order to obtain a determination of probable eligibility?

b. Are there procedures in place to assist those applying for financial assistance who may need help completing the Maryland Uniform Financial Assistance Application?

Applicant Response

GBMC requires patients to complete the Maryland Uniform Financial Assistance Application in order to seek financial assistance. However, GBMC provides assistance to those applying for financial assistance.

GBMC's Patient Financial Services representatives often assist patients over the telephone and in person with completing the Financial Assistance application. Also, GBMC contracts with a Medical Assistance advocacy vendor to provide patients with assistance in completing the Medical Assistance application. The telephone number and hours of operations for financial application assistance are posted on GBMC's website, Financial Assistance Application, Patient Financial Services Brochure, and in the Financial Assistance Plain Language Summary.

Table of Exhibits

Table of Tables

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions dated October 25, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

November 27, 2019
Date

Amber Olig
Director, Corporate Strategy
GBMC

#670660
010236-0002

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions dated October 25, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

November 27, 2019
Date

Stacey McGreevy, CPA
Vice President of Support Services
GBMC

#670659
010236-0002

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions dated October 25, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

November 27, 2019
Date

Laurie R. Beyer, MBA, CPA
Executive Vice President
and Chief Financial Officer
GBMC

#670658
010236-0002

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions dated October 25, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

November 27, 2019
Date

Matthew McGovern
Consultant
Hammes Co.

#670663
010236-0002

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions dated October 25, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

November 27, 2019
Date

Andrew L. Solberg
A.L.S. Healthcare Consultant Services

#670664
010236-0002

EXHIBIT 24

EXHIBIT 24: ALTERNATIVE MVS ANALYSIS

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.

The following compares the project costs to the Marshall Valuation Service ("MVS") benchmark.

I. Marshall Valuation Service
Valuation Benchmark – Level 3

A. Hospital Building

Type		Hospital
Construction Quality/Class		Excellent/A
Stories		1
Perimeter		1,012
Average Floor to Floor Height		13.0
Square Feet		35,593
f.1	Average floor Area	35,593
A. Base Costs		
	Basic Structure	$520.00
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$520.00
Adjustment for Departmental Differential Cost Factors		0.88
Adjusted Total Base Cost		$459.13

B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$459.13
C. Multipliers		
Perimeter Multiplier		0.918818368
	Product	$421.86
Height Multiplier		1.023
	Product	$431.56
Multi-story Multiplier		1.000
	Product	$431.56
D. Sprinklers		
	Sprinkler Amount	$4.18
Subtotal		$435.74
E. Update/Location Multipliers		
Update Multiplier		1.02
	Product	$444.46
Location Multipier		1.01
	Product	$448.90
Calculated Square Foot Cost Benchmark		**$448.90**

The MVS estimate for this project is impacted by the Adjustment for Departmental Differential Cost Factor. In Section 87 on page 8 of the Valuation Service, MVS provides the cost differential by department compared to the average cost for an entire hospital. The calculation of the average factor is shown below.

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
Level 3 - Circulation & Seating - Atrium	4,601	Public Space	0.8	3,681
Level 3 - Circulation & Seating - New Addition	12,967	Public Space	0.8	10,374
Level 3 - Support & Reception	3,080	Offices	0.96	2,957
Level 3 - Spiritual / Chapel	2,043	Public Space	0.8	1,634
Level 3 - Gift Shop	2,326	Public Space	0.8	1,861
Level 3 - Food Service	1,360	Dining Room	0.95	1,292
Level 3 - Medical Library	2,230	Offices	0.96	2,141
Level 3 - Pharmacy	2,110	Pharmacy	1.33	2,806
Level 3 - Wellness	3,465	Offices	0.96	3,326
Level 3 - Welcome Center	1,411	Offices	0.96	1,354.56
Total	35,593		0.88	31,426

II. Marshall Valuation Service
Valuation Benchmark – Levels 4 and 5

B. Hospital Building

Type		Hospital
Construction Quality/Class		Good/A
Stories		3
Perimeter		877
Average Floor to Floor Height		12.7
Square Feet		57,008
f.1	Average floor Area	28,504

A. Base Costs

	Basic Structure	$398.00
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$398.00

Adjustment for Departmental Differential Cost Factors	1.02
Adjusted Total Base Cost	$407.34

B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$407.34
C. Multipliers		
Perimeter Multiplier		0.925780176
	Product	$377.11
Height Multiplier		1.015
	Product	$382.92
Multi-story Multiplier		1.000
	Product	$382.92
D. Sprinklers		
	Sprinkler Amount	$3.24
Subtotal		$386.16
E. Update/Location Multipliers		
Update Multiplier		1.02
	Product	$393.88
Location Multiplier		1.01
	Product	$397.82
Calculated Square Foot Cost Benchmark		**$397.82**

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
Level 4 - Med/Surg	26,240	Inpatient Units	1.06	27,814
Level 4 - Public Circulation	2,264	Internal Circulation, Corridors	0.6	1,358
Level 5 - Med/Surg	26,240	Inpatient Units	1.06	27,814
Level 5 - Public Circulation	2,264	Internal Circulation, Corridors	0.6	1,358
Total	57,008		1.02	58,346

C. Mechanical Penthouse

Type			Mechanical Penthouse
Construction Quality/Class			Excellent/A-B
Stories			1
Perimeter			812
Average Floor to Floor Height			20.00
Square Feet			13,482
	Average floor Area		13,482
A. Base Costs			
	Basic Structure	$	97.00
	Elimination of HVAC cost for adjustment		0
	HVAC Add-on for Mild Climate		0
	HVAC Add-on for Extreme Climate		0
Total Base Cost			$97.00
B. Additions			
	Elevator (If not in base)		$28.48
	Other		$0.00
Subtotal			$28.48
Total			$125.48
C. Multipliers			
Perimeter Multiplier			1.00178824
	Product	$	125.71
Height Multiplier			1.184
	Product		$148.84
Multi-story Multiplier			1.005
	Product		$149.58

D. Sprinklers	
Sprinkler Amount	$0.00
Subtotal	$149.58
E. Update/Location Multipliers	
Update Multiplier	1.02
Product	$152.57
Location Multiplier	1.01
Product	$154.10
Calculated Square Foot Cost Standard	**$154.10**

D. <u>Consolidated Benchmark</u>

	MVS Benchmark	Sq. Ft.	Total Cost Based on MVS
Standard			
"Tower" Component Levels 4 and 5	$397.82	57,008	$22,679,073.40
"Tower" Component Level 3	$448.90	35,593	$15,977,750.53
Mechanical Penthouse	$154.10	13,482	$2,077,554.62
Consolidated	**$383.99**	106,083	$40,734,378.55

Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
Building	$55,214,606	$520.48
Fixed Equipment		$0.00
Site Preparation	$8,393,957	$79.13
Architectural Fees	$5,294,254	$49.91
Permits	$393,594	$3.71
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$69,296,412	$653.23

However, as related below, this project includes expenditures for items not included in the MVS average.

B. Extraordinary Cost Adjustments

	Project Costs		Associated Cap Interest
Site Demolition Costs	$150,000	Site	
Storm Drains	$720,000	Site	
Rough Grading	$2,902,632	Site	
Site Fire Protection Systems	$78,000	Site	
Rock Removal	$420,000	Site	
Sanitary Sewer Premium for elevation and Charles Street	$828,000	Site	
Paving	$573,482	Site	
Exterior Signs	$120,000	Site	
Landscaping	$210,000	Site	
Walls	$168,000	Site	
Yard Lighting	$124,800	Site	
Constricted Site	$419,698	Site	
Sanitary Sewer Charles Street	$600,000	Site	
LEED Silver Green Building Premium	$335,758	Site	
MBE Participation Cost Premium	$335,758	Site	
Atrium Premium	$7,745,898	Building	$691,926
Canopy	$1,021,200	Building	$91,222
Premium for Concrete Frame Construction	$1,080,000	Building	$96,474
Terracotta Rain Screen	$465,791	Building	$41,608
Above-average glass percentage for updated exterior design	$240,000	Building	$21,439
Laboratory Gas Quality Piping and Connection to Existing System	$245,454	Building	$21,926
DX Remote Condenser w/fan coil & piping	$183,664	Building	$16,406
Electrical, Patient Ground Modules	$127,722	Building	$11,409
Electrical, Isolation Power Panels	$52,276	Building	$4,670
Conditioned Covered Utility Walkways on New Addition	$360,098	Building	$32,167
Required Atrium smoke evacuation system	$120,000	Building	$10,719
Pneumatic Tubes	$120,779	Building	$10,789
Concrete Mud Slab	$207,900	Building	$18,571
Misc. Roof Patching on Existing Building	$240,000	Building	$21,439
Constricted Site	$2,760,730	Building	$246,611
Connector Structures	$412,548	Building	$36,852
MPE Piping at Existing	$1,292,183	Building	$115,428
LEED Silver Green Building Premium	$2,208,584	Building	$197,288
MBE Participation Cost Premium	$2,208,584	Building	$197,288
Jurisdictional/Bldg Permit Review Fee	$320,594	Permits	
Storm Water Mgmt. Review Fee	$18,000	Permits	
Utility Connection Fees	$20,000	Permits	
Total Cost Adjustments	$29,438,134		$1,884,233

Explanation of Extraordinary Costs

1. **Site Demolition Costs:** Work involved with removal of existing exterior site appurtenances, such as sidewalks, curb & gutter, pavement, light pole bases, and retaining walls. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost per Section 1, page 3 of the Marshall Valuation Service.

2. **Storm Drains:** Installation of storm water drain catchment system. It is a series of at-grade and above grade retention areas/structures that contains storm water on-site. The system is comprised of a network of concrete piping, precast structures, and aggregate filter media. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost per Section 1, page 3 of the Marshall Valuation Service.

3. **Rough Grading & Structural Fill:** Work involved with mass excavation, cut and fill operations to bring building pad site and overall site to rough grade elevation to facilitate building foundation work and site work construction. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost per Section 1, page 3 of the Marshall Valuation Service.

4. **Site Fire Protection Systems:** Removal of existing site fire protection system and installation of new fire protection system. Includes modifications of existing system to create temporary system during construction to maintain require fire equipment access & use.

5. **Rock Removal:** GBMC anticipates that it will encounter significant rock excavation and has included a premium in the costs. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost per Section 1, page 3 of the Marshall Valuation Service.

6. **Sanitary Sewer Premium for Elevation Drop and Charles St.:** Premium cost for new sanitary service line running approximately 800 linear feet and dropping 90 – 100' in grade elevation. Sanitary line will traverse some terrain exceeding 45% in slope and will cross major artery, N. Charles Street to tie into the municipal sanitary main on the road's far side. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost per Section 1, page 3 of the Marshall Valuation Service.

7. **Paving:** Asphalt paving required for new hospital entry/drop-off lanes, short-term handicap parking, and re-surfacing the adjacent "Rose" surface parking lot. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost per Section 1, page 3 of the Marshall Valuation Service.

8. **Exterior Signs:** New exterior wayfinding and directory signage along access road, main entry lanes, main entrance and adjacent "Rose" parking lot. Also includes illuminated 3D ID signage affixed to new addition exterior. Traffic control, regulatory (ADA) parking signs, EXIT signage also included. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost per Section 1, page 3 of the Marshall Valuation Service.

9. **Landscaping:** Work involved with final grading, topsoil import/spreading, plantings and ground cover/sod, fertilizer, watering for all non-paved site areas including meditation garden and raised planter boxes/structures. These costs are specifically excluded from the

Marshall & Swift Valuation base square foot cost per Section 1, page 3 of the Marshall Valuation Service.

10. **Walls:** Exterior site retaining wall at new main entry elevation change and ADA "switch-back" ramp. Wall includes excavation footer, retaining wall, electrical rough-in, masonry veneer, handrails, and lighting. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost per Section 1, page 3 of the Marshall Valuation Service.

11. **Yard Lighting:** Includes new light fixtures attached to exterior of new addition, lighting for sidewalks, new drive lanes, and re-configured "Rose" parking lot. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost per Section 1, page 3 of the Marshall Valuation Service.

12. **Sanitary Sewer Charles Street:** Cost for installing new sanitary sewer service from new addition to the far side of N. Charles Street, approximately 800 linear feet.

13. **Atrium Premium:** Premium cost to build 3-story atrium the full-length of the addition including large skylights, re-cladding existing north elevation, lighting, and premium finishes.

14. **Canopy (Main Front Entrance):** Cost for canopy structure at new main medical center entrance, which extends from the building face to over the drop-off lanes. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost per Section 1, page 3 of the Marshall Valuation Service.

15. **Premium for Concrete Frame:** Premium cost to design and construct the new addition's structural frame out of reinforced cast-in-place concrete in lieu of conventional structural steel. Concrete frame construction is significantly more costly than steel frame. Only the premium is being considered an extraordinary cost.

16. **Terracotta Rain Screen:** Cost for secondary architectural exterior "skin".

17. **Above-Average Glass Percentage for updated exterior design:** Premium cost for greater than average glass exterior, i.e. windows, storefronts, and curtain-wall systems.

18. **Laboratory Gas Quality Piping and Connection to Existing System:** Medical gas piping system required for in-wall gases and vacuum in each patient room.

19. **DX Remote Condenser w/fan coil & piping:** Independent cooling system required for the IT-tel/com rooms, elevator machine room, and the west-side life-safety exit corridor.

20. **Electrical, Patient Ground Modules:** Required isolated grounding system in a healthcare setting.

21. **Electrical, Isolation Power Panels:** Required isolated power distribution panel system in a healthcare setting.

22. **Conditioned Covered Utility Walkways on New Addition:** Rooftop structure on new addition to house routing of MEP services sources from the existing medical center's central plant.

23. **Required Atrium smoke evacuation system:** An emergency smoke-purge/exhaust system in 3-story atrium required by NFPA code.

24. **Pneumatic Tube System:** An internal material handling conveyance system to transport samples between various departments.

25. **Concrete Mud Slab:** A temporary concrete slab-on-grade constructed to mitigate the building site from becoming muddy due to rain and thereby creating limited or no access. This measure is done to create a stable work surface until the overhead levels provide adequate cover. A mud slab is a means to maintain progress.

26. **Misc. Roof Patching on Existing Building:** Patching required on existing medical center roof where it was cut open to build the new MEP utilities covered walkways.

27. **Constricted Site:** Five percent premium cost as a result of a tight work area, which affects site logistics, i.e. sequencing building activities, handling of materials, access of construction vehicles and equipment. A constricted site results in additional cost for measures employed to maintain schedule. The potential for a 2%-5% premium is recognized by MVS in Section 99, Page 1.

28. **Connector Structures:** A series of narrow conditioned covered utility walkways to house MEP services routed across the existing medical center roof from point of roof or penthouse penetration to edge of medical center where it meets the new addition.

29. **Mechanical/Electrical/Plumbing (MEP) Piping at Existing:** Extension of existing MEP utility services from medical center mechanical and electrical rooms across existing roof (in new covered walkway) to the new patient addition.

30. **LEED Silver Green Building Premium (Building):** Four percent premium cost for building new addition to USGBC LEED Silver Certification standards. The potential for a 0%-7% premium is recognized by MVS in Section 99, Page 1.

31. **MBE Participation Cost Premium:** Premium cost to meet minimum MBE subcontractor participation goal. GBMC established a goal of including approximately 25% Minority Business Enterprise ("MBE") participation in the construction of the project. A consultant on this project, Andrew L. Solberg, has also served as a consultant on other CON projects, including numerous projects for a hospital system that also includes in its project cost estimates the goal of including approximately 25% MBE participation. MBE participation would not be in the average cost of hospital construction. As explained in its CON submissions, the other CON applicant consulted with its cost estimators/construction managers on the impact on project budgets of targeting 25% inclusion of MBE subcontractors or suppliers as part of its projects, and their conservative estimate was that it adds 3-4% to the costs, compared to projects that do not include MBE subcontractors or suppliers. It costs more than the average cost because committing to the MBE inclusion means that the contractor manager will not simply seek the lowest cost suppliers of subcontracting or materials. The other CON applicant has used 4%, and this estimate has been confirmed through experience with past construction jobs, and the Commission has accepted this percentage in several CON reviews. GBMC relied upon this significant empirical experience regarding the impact of MBE participation.

32. **Jurisdictional/Building Permit Review Fee, $320,594:** Fees for county building department review fees to issue building permit. Includes cost for permit expediting consultant.

33. **Storm Water Management Review Fee:** County fee required to require and approve design of storm water retention system. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost per Section 1, page 3 of the Marshall Valuation Service.

34. Utility Connection Fees: Fees required by the various public utilities to connect new systems coming from the new hospital addition to the existing mains located off-site. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost per Section 1, page 3 of the Marshall Valuation Service.

Associated Capitalized Interest and Loan Placement Fees should be excluded from the comparison for those items which are also excluded from the comparison. Since only Capitalized Interest and Loan Placement fees relating to the Building costs are included in the MVS analysis, we have only eliminated them for the Extraordinary Costs that are in the Building cost item. This was calculated as follows, using the MBE Participation Cost Premium as an example:

(Cost of the MBE Participation Cost Premium/Building Cost) x
(Building related Capitalized Interest and Loan Placement Fees).

Eliminating all of the extraordinary costs reduces the project costs that should be compared to the MVS benchmark.

C. Adjusted Project Cost	Adjusted Project Costs	Per Square Foot
Building	$34,121,195	$321.65
Fixed Equipment	$0	$0.00
Site Preparation	$407,829	$3.84
Architectural Fees	$5,294,254	$49.91
Permits	$35,000	$0.33
Subtotal	$39,858,278	$375.73
Capitalized Construction Interest	$3,047,979	$28.73
Total	$42,906,257	$404.46

Building associated Capitalized Interest and Loan Placement Fees were calculated as follows:

Hospital	New	Renovation	Total		
Building Cost	$55,214,606	$3,432,929			
Subtotal Cost (w/o Cap Interest)	$69,296,412	$3,752,929	$73,049,341		
Subtotal/Total	94.9%	5.1%	Cap Interest	Loan Placement Fees	Total
Total Project Cap Interest &Financing [(Subtotal Cost/Total Cost) X Total Cap Interest]	$6,190,112	$335,242	$5,825,354	$700,000	$6,525,354
Building/Subtotal	79.7%	91.5%			
Building Cap Interest & Loan Place.	$4,932,212	$ 306,657			
Associated with Extraordinary Costs	$1,884,233				
Applicable Cap Interest & Loan Place.	$3,047,979				

As noted below, the project's cost per square foot exceeds the MVS benchmark.

MVS Benchmark	$383.99
The Project	$404.46
Difference	$20.47
%	5.33%

EXHIBIT 25

EXHIBIT 25: REVISED MVS ANALYSIS

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.

The following compares the project costs to the Marshall Valuation Service ("MVS") benchmark.

I. Marshall Valuation Service Valuation Benchmark

A. Hospital Building

Type		Hospital
Construction Quality/Class		Good/A
Stories		3
Perimeter		922
Average Floor to Floor Height		12.7
Square Feet		92,601
f.1	Average floor Area	30,867
A. Base Costs		
	Basic Structure	$398.00
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$398.00
Adjustment for Departmental Differential Cost Factors		0.97
Adjusted Total Base Cost		$385.84

B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$385.84
C. Multipliers		
Perimeter Multiplier		0.923251052
	Product	$356.23
Height Multiplier		1.016
	Product	$361.93
Multi-story Multiplier		1.000
	Product	$361.93
D. Sprinklers		
	Sprinkler Amount	$3.06
Subtotal		$364.98
E. Update/Location Multipliers		
Update Multiplier		1.02
	Product	$372.28
Location Multiplier		1.01
	Product	$376.01
Calculated Square Foot Cost Benchmark		**$376.01**

The MVS estimate for this project is impacted by the Adjustment for Departmental Differential Cost Factor. In Section 87 on page 8 of the Valuation Service, MVS provides the cost differential by department compared to the average cost for an entire hospital. The calculation of the average factor is shown below.

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
Level 3 - Circulation & Seating - Atrium	4,601	Public Space	0.8	3,681
Level 3 - Circulation & Seating - New Addition	12,967	Public Space	0.8	10,374
Level 3 - Support & Reception	3,078	Offices	0.96	2,955
Level 3 - Spiritual / Chapel	2,043	Public Space	0.8	1,634
Level 3 - Gift Shop	2,326	Public Space	0.8	1,861
Level 3 - Food Service	1,360	Dining Room	0.95	1,292
Level 3 - Medical Library	2,230	Offices	0.96	2,141
Level 3 - Pharmacy	2,110	Pharmacy	1.33	2,806
Level 3 - Wellness	3,465	Offices	0.96	3,326
Level 3 - Welcome Center	1,411	Offices	0.96	1354.56
Level 4 - Med/Surg	26,240	Inpatient Units	1.06	27,814
Level 4 - Public Circulation	2,265	Internal Circulation, Corridors	0.6	1,359
Level 5 - Med/Surg	26,240	Inpatient Units	1.06	27,814
Level 5 - Public Circulation	2,265	Internal Circulation, Corridors	0.6	1,359
Total	92,601		0.97	89,771

B. Mechanical Penthouse

Type	Mechanical Penthouse
Construction Quality/Class	Excellent/A-B
Stories	1
Perimeter	812
Average Floor to Floor Height	20.00
Square Feet	13,482
Average floor Area	13,482

A. Base Costs

Basic Structure	$	97.00
Elimination of HVAC cost for adjustment		0
HVAC Add-on for Mild Climate		0
HVAC Add-on for Extreme Climate		0
Total Base Cost		$97.00

B. Additions		
	Elevator (If not in base)	$28.48
	Other	$0.00
Subtotal		$28.48
Total		$125.48
C. Multipliers		
Perimeter Multiplier		1.00178824
	Product	$ 125.71
Height Multiplier		1.184
	Product	$148.84
Multi-story Multiplier		1.005
	Product	$149.58
D. Sprinklers		
	Sprinkler Amount	$0.00
Subtotal		$149.58
E. Update/Location Multipliers		
Update Multiplier		1.02
	Product	$152.57
Location Multiplier		1.01
	Product	$154.10
Calculated Square Foot Cost Standard		**$154.10**

C. Consolidated Benchmark

		MVS Benchmark	Sq. Ft.		Total Cost Based on MVS
Standard					
"Tower" Component		$376.01	92,601	$	34,818,532.49
Mechanical Penthouse		$154.10	13,482	$	2,077,554.62
Consolidated	**$**	**347.80**	106,083	$	36,896,087.11

Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
Building	$55,214,606	$520.48
Fixed Equipment		$0.00
Site Preparation	$8,393,957	$79.13
Architectual Fees	$5,294,254	$49.91
Permits	$393,594	$3.71
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$69,296,412	$653.23

However, as related below, this project includes expenditures for items not included in the MVS average.

B. Extraordinary Cost Adjustments

	Project Costs		Associated Cap Interest
Site Demolition Costs	$150,000	Site	
Storm Drains	$720,000	Site	
Rough Grading	$2,902,632	Site	
Site Fire Protection Systems	$78,000	Site	
Rock Removal	$420,000	Site	
Sanitary Sewer Premium for Elevation and Charles St..	$828,000	Site	
Paving	$573,482	Site	
Exterior Signs	$120,000	Site	
Landscaping	$210,000	Site	
Walls	$168,000	Site	
Yard Lighting	$124,800	Site	
Constricted Site	$419,698	Site	
Sanitary Sewer Charles Street	$600,000	Site	
LEED Silver Green Building Premium	$335,758	Site	
MBE Participation Cost Premium	$335,758	Site	
Atrium Premium	$7,745,898	Building	$691,926
Canopy	$1,021,200	Building	$91,222
Premium for Concrete Frame Construction	$1,080,000	Building	$96,474
Terracotta Rain Screen	$465,791	Building	$41,608
Above-average glass percentage for updated exterior design	$240,000	Building	$21,439
Laboratory Gas Quality Piping and Connection to Existing System	$245,454	Building	$21,926
DX Remote Condenser w/fan coil & piping	$183,664	Building	$16,406
Electrical, Patient Ground Modules	$127,722	Building	$11,409
Electrical, Isolation Power Panels	$52,276	Building	$4,670
Unconditioned Covered Utility Walkways on New Addition	$360,098	Building	$32,167

	Project Costs		Associated Cap Interest
Required Atrium smoke evacuation system	$120,000	Building	$10,719
Pneumatic Tubes	$120,779	Building	$10,789
Concrete Mud Slab	$207,900	Building	$18,571
Misc. Roof Patching on Existing Building	$240,000	Building	$21,439
Constricted Site	$2,760,730	Building	$246,611
Connector Structures	$412,548	Building	$36,852
MPE Piping at Existing	$1,292,183	Building	$115,428
LEED Silver Green Building Premium	$2,208,584	Building	$197,288
MBE Participation Cost Premium	$2,208,584	Building	$197,288
Jurisdictional/Bldg Permit Review Fee	$320,594	Permits	
Storm Water Mgmt. Review Fee	$18,000	Permits	
Utility Connection Fees	$20,000	Permits	
Total Cost Adjustments	$29,438,134		$1,884,233

Associated Capitalized Interest and Loan Placement Fees should be excluded from the comparison for those items which are also excluded from the comparison. Since only Capitalized Interest and Loan Placement fees relating to the Building costs are included in the MVS analysis, we have only eliminated them for the Extraordinary Costs that are in the Building cost item. This was calculated as follows, using the MBE Participation Cost Premium as an example:

(Cost of the MBE Participation Cost Premium/Building Cost) x
(Building related Capitalized Interest and Loan Placement Fees).

Eliminating all of the extraordinary costs reduces the project costs that should be compared to the MVS benchmark.

C. Adjusted Project Cost	Adjusted Project Costs	Per Square Foot
Building	$34,121,195	$321.65
Fixed Equipment	$0	$0.00
Site Preparation	$407,829	$3.84
Architectural Fees	$5,294,254	$49.91
Permits	$35,000	$0.33
Subtotal	$39,858,278	$375.73
Capitalized Construction Interest	$3,047,979	$28.73
Total	$42,906,257	$404.46

Building associated Capitalized Interest and Loan Placement Fees were calculated as follows:

Hospital	New	Renovation	Total		
Building Cost	$55,214,606	$3,432,929			
Subtotal Cost (w/o Cap Interest)	$69,296,412	$3,752,929	$73,049,341		
Subtotal/Total	94.9%	5.1%	Cap Interest	Loan Placement Fees	Total
Total Project Cap Interest &Financing [(Subtotal Cost/Total Cost) X Total Cap Interest]	$6,190,112	$335,242	$5,825,354	$700,000	$6,525,354
Building/Subtotal	79.7%	91.5%			
Building Cap Interest & Loan Place.	$4,932,212	$ 306,657			
Associated with Extraordinary Costs	$1,884,233				
Applicable Cap Interest & Loan Place.	$3,047,979				

As noted below, the project's cost per square foot exceeds the MVS benchmark.

MVS Benchmark	$347.80
The Project	$404.46
Difference	$56.66

EXHIBIT 26

Kaiser Permanente announces huge expansion in Baltimore area

Plans include 10 new centers, widespread jobs

BY MEREDITH COHN AND LILLIAN REED

Kaiser Permanente announced plans Tuesday for a big expansion in the Baltimore market as the health insurer triples the number of health care centers in the area and adds tens of thousands of new patients in the next decade.

Kaiser said it would invest and spend a combined $13 billion by 2028 to increase the number of Kaiser centers in the Baltimore region to 15 from 5 in an effort to expand coverage to an estimated 200,000 people from about 64,000 today.

“Kaiser Permenante is a health system, not just an insurer,” said Gracelyn McDermott, executive director of account management for Kaiser. “Our strength is in our integrated model, our coordinated care. Our physicians and providers work together to treat members. … It’s really about providing easier access to care not only where people live and work, and that access is what is going to drive member growth.”

The insurer operates differently than other carriers in that it runs its own medical centers, employing hundreds of medical and other staff at each center, and providing primary and specialty services directly to patients in an effort to coordinate care and control costs.

Already a dominant carrier in the Washington suburbs, Kaiser has been growing aggressively nationwide and aims to expand its share of the Baltimore market, which is served predominantly by insurer CareFirst Blue Cross BlueShield.

Kaiser first came to the region in 1980 and has been growing steadily. For example, it announced in April it would open a new $247 million medical center in Timonium in the next two years with primary care, urgent care, pharmacy services, surgery and specialty care such as audiology, optometry and pain management.

Other centers opened in Anne Arundel and Harford counties and Baltimore City in recent years. Kaiser expects to open new centers Columbia, Odenton, Owings Mills, White Marsh and Baltimore, among other locations, though sites have not yet been chosen.

Jonathan Weiner, professor of health policy and management at the Johns Hopkins Bloomberg School of Public Health, said taken together the Baltimore-Washington area is

Kaiser's third-biggest market, though it's a distant third. The expansion could have a big impact.

"I believe the Mid-Atlantic region, and especially Metro Baltimore, is being robustly targeted for further growth," he said.

"After studying them for over 30 years, I can say unequivocally, this is a good thing for local patients, the economy and the health care system at-large," Weiner said. "Given how successful [Kaiser] has been in terms of achieving great care for modest costs, perhaps they will also shake things up a bit when it comes to other local health plans or delivery systems."

An issue, he said, is that Kaiser hasn't been so successful in attracting patients outside of California. That could be because new patients don't like the more limited choice of providers offered at Kaiser centers or contractors, compared with a wide network of providers allowed by popular preferred provider organization, or PPO, insurance plans.

Kaiser patients, for example, can't always tap services from the region's renowned specialists at Johns Hopkins or University of Maryland Medical Center.

Anthony T. Lo Sasso, an economics professor at DePaul University in Chicago, agreed that the limits on doctors can put off consumers who value choice, but just having a bigger footprint could induce enrollment.

Mostly, he sees the move as a "full frontal assault on CareFirst," with the local economy benefiting from the investment in new facilities.

"For consumers, it might mean lower prices, but often in healthcare markets you see providers competing on quality, or perceived quality," he said. "Under this 'medical arms race' hypothesis, cost, and prices, grow in the effort to woo new customers. So the bottom line is that I would think of this primarily as an effort to grab customers from CareFirst."

CareFirst officials said they were reviewing Kaiser's announcement.

Kaiser officials say, however, more all-in-one centers can increase the availability of services for the region and could improve health and reduce hospitalizations by increasing preventive care and ensuring maintenance of care for chronic conditions.

In addition to the 13 new medical centers, Kaiser also will maintain two multi-specialty medical hubs. One is open in Halthorpe and the second will be included in the center in Timonium.

Kaiser operates far more centers in the Washington area. The nonprofit California-based insurer already covers more than 430,000 people in Maryland. Kaiser serves about 12.3 million people in eight states and Washington, D.C.

A report conducted by the Sage Policy Group for Kaiser that also was released Tuesday found that Kaiser's expansion could more than triple its annual operating expenditures to $1.8 billion by 2028.

It also could add 19,000 jobs in the region's economy, bringing its overall employment impact to 26,000 jobs, Sage found. Those jobs include those Kaiser employs, those who work at its partners and suppliers, and other jobs created by its and its employees' spending.

"Kaiser Permanente's unique model of health care delivery outperforms the majority of the marketplace, and when you apply that high level of care to the new members it will be able to reach, residents, businesses and the community have much to gain in terms of economic growth and overall health," said Anirban Basu, Sage's chairman and CEO, in a statement.

Al Redmer Jr., Maryland insurance commissioner, said the expansion would be good for individuals and businesses in the state because they would have more choices of plans. It's possible that more people would buy insurance if they found more plans they liked and were affordable.

The state's uninsured rate dropped in half to about 6% in the years since the federal Affordable Care Act was enacted. Kaiser and CareFirst are the only two carriers to offer their plans on the state health exchange, which is where those without workplace insurance can buy coverage. There are more than a half dozen insurers offering plans to companies in Maryland, though CareFirst is the state's dominant carrier.

The Maryland Insurance Administration approves insurance plans and their premiums, and officials have been in discussions with other insurers to enter, or reenter, the exchange-based insurance market in Maryland. Kaiser's expansion could help generate more interest from those carriers and others, Redmer said, which would continue to improve the market.

"Any time you have more access instead of less, that in and of itself is a good thing," Redmer said. "Having more competition than less, that's a good thing."

EXHIBIT 27

TABLE G. REVENUES & EXPENSES, UNINFLATED - GREATER BALTIMORE MEDICAL CENTER, INC.

UNINFLATED	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**
1. REVENUE										
a. Inpatient Services	$ 245,997	$ 249,570	$ 255,299	$ 267,112	$ 267,112	$ 267,112	$ 267,112	$ 271,500	$ 273,685	273,632
b. Outpatient Services	230,261	228,503	238,835	250,966	250,966	250,966	250,966	250,966	250,966	250,966
Gross Patient Service Revenues	***$ 476,258***	***$ 478,072***	***$ 494,134***	***$ 518,078***	***$ 518,078***	***$ 518,078***	***$ 518,078***	***$ 522,466***	***$ 524,650***	***$ 524,598***
c. Allowance For Bad Debt	13,607	8,787	11,170	10,402	10,402	10,402	10,402	10,402	10,402	10,402
d. Contractual Allowance	56,832	58,254	56,411	65,366	65,368	65,368	65,368	65,368	65,368	65,368
e. Charity Care	1,670	1,640	1,171	1,489	1,487	1,487	1,487	1,487	1,487	1,487
Net Patient Services Revenue	***$ 404,149***	***$ 409,391***	***$ 425,382***	***$ 440,821***	***$ 440,821***	***$ 440,821***	***$ 440,821***	***$ 445,209***	***$ 447,394***	***$ 447,341***
% of Gross Revenue	***85%***	***86%***	***86%***	***85%***	***85%***	***85%***	***85%***	***85%***	***85%***	***85%***
Net Part B Revenue	59,637	67,516	73,758	74,925	76,555	77,048	77,482	78,228	78,846	79,514
Non-Patient Care Revenue	21,279	18,328	19,325	17,240	15,240	15,240	17,240	17,240	17,240	17,240
NET OPERATING REVENUE	***$ 485,065***	***$ 495,235***	***$ 518,465***	***$ 532,986***	***$ 532,616***	***$ 533,109***	***$ 535,543***	***$ 540,677***	***$ 543,480***	***$ 544,095***
2. EXPENSES										
a. Salaries & Wages (incl benefits)	$ 277,335	286,501	299,671	308,288	308,659	309,036	309,417	309,805	310,198	310,598
b. Contractual Srvs	29,876	21,791	19,804	20,026	20,026	20,026	20,026	20,026	20,026	20,026
c. Interest on Current Debt	6,903	6,560	6,484	5,951	5,338	5,123	4,937	4,647	4,343	4,006
d. Interest on Project Debt				-	-	-	-	2,331	2,280	2,227
e. Current Depreciation & Amortization	30,747	36,283	37,275	36,459	38,740	37,154	35,920	34,888	35,448	35,709
f. Project Depreciation & Amortization	-	-	-	-	-	-	-	2,242	4,485	4,485
g. Supplies	82,716	88,159	94,789	98,307	98,557	98,807	99,057	99,307	99,557	99,807
h. Purchased Services	65,156	66,906	67,957	71,337	73,367	73,431	74,639	75,860	76,973	78,044
i. Project related Operating Costs	-	-	-	-	-	-	-	632	647	662
j. Other Expenses (Operational Improvements)	(1,710)	(1,852)	(1,900)	(2,244)	(7,799)	(5,764)	(3,521)	(3,911)	(5,197)	(6,162)
TOTAL OPERATING EXPENSES	***$ 491,023***	***$ 504,347***	***$ 524,079***	***$ 538,125***	***$ 536,888***	***$ 537,812***	***$ 540,475***	***$ 545,827***	***$ 548,759***	***$ 549,401***
Exp/Rev	***101%***	***102%***	***101%***	***101%***	***101%***	***101%***	***101%***	***101%***	***101%***	***101%***
3. INCOME										
a. Income From Operation	**$ (5,958)**	**$ (9,112)**	**$ (5,614)**	**$ (5,139)**	**$ (4,272)**	**$ (4,703)**	**$ (4,932)**	**$ (5,151)**	**$ (5,279)**	**$ (5,306)**
Operating Margin	***-1.2%***	***-1.8%***	***-1.1%***	***-1.0%***	***-0.8%***	***-0.9%***	***-0.9%***	***-1.0%***	***-1.0%***	***-1.0%***
b. Non-Operating Inc - Investmnt Earnings 4% and Net Contributions	$ 14,355	18,237	16,891	10,374	10,124	10,689	11,070	11,663	12,278	12,917
NET INCOME (LOSS) EXCESS REV	***$ 8,397***	***$ 9,125***	***$ 11,277***	***$ 5,235***	***$ 5,852***	***$ 5,987***	***$ 6,138***	***$ 6,513***	***$ 6,999***	***$ 7,611***

TABLE H. REVENUES & EXPENSES, INFLATED - GREATER BALTIMORE MEDICAL CENTER, INC.

INFLATED	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**
1. REVENUE										
a. Inpatient Services	$ 245,997	$ 249,570	$ 255,299	$ 267,112	$ 273,790	$ 280,635	$ 287,651	$ 299,634	$ 309,392	$ 316,889
b. Outpatient Services	230,261	228,503	238,835	250,966	257,240	263,671	270,262	277,019	283,944	291,043
Gross Patient Service Revenues	***$ 476,258***	***$ 478,072***	***$ 494,134***	***$ 518,078***	***$ 531,030***	***$ 544,305***	***$ 557,913***	***$ 576,653***	***$ 593,336***	***$ 607,932***
c. Allowance For Bad Debt	13,607	8,787	11,170	10,402	10,662	10,928	11,202	11,482	11,769	12,063
d. Contractual Allowance	56,832	58,254	56,411	65,366	66,752	68,134	69,550	71,406	73,096	74,616
e. Charity Care	1,670	1,640	1,171	1,489	1,487	1,524	1,563	1,602	1,642	1,683
Net Patient Services Revenue	***$ 404,149***	***$ 409,391***	***$ 425,382***	***$ 440,821***	***$ 452,129***	***$ 463,719***	***$ 475,599***	***$ 492,164***	***$ 506,830***	***$ 519,571***
% of Gross Revenue	*85%*	*86%*	*86%*	*85%*	*85%*	*85%*	*85%*	*85%*	*85%*	85%
Part B and Non-Patient Care Revenue	80,916	85,844	93,084	92,165	93,337	95,436	99,518	101,952	104,308	106,762
NET OPERATING REVENUE	***$ 485,065***	***$ 495,235***	***$ 518,465***	***$ 532,986***	***$ 545,466***	***$ 559,155***	***$ 575,117***	***$ 594,116***	***$ 611,138***	***$ 626,333***
2. EXPENSES										
a. Salaries & Wages (incl benefits)	$ 277,335	286,501	299,671	308,288	315,883	323,636	331,554	339,638	347,893	$ 356,322
b. Contractual Srvs, incl in Salaries	29,876	21,791	19,804	20,026	20,426	20,835	21,252	21,677	22,110	22,552
c. Interest on Current Debt	6,903	6,560	6,484	5,951	5,338	5,123	4,937	4,647	4,343	4,006
d. Interest on Project Debt	-	-		-	-	-	-	2,331	2,280	2,227
e. Current Depreciation & Amortization	30,747	36,283	37,275	36,459	38,740	37,154	35,920	34,888	35,448	35,709
f. Project Depreciation & Amortization	-	-	-		-	-	-	2,242	4,485	4,485
g. Supplies	82,716	88,159	94,789	98,307	103,059	108,042	113,270	118,755	124,511	130,551
h. Purchased Services	65,156	66,906	67,957	71,337	74,101	74,906	76,875	78,877	80,790	82,680
i. Project related Operating Costs								632	647	662
j. Other Expenses (Operational Improvements) and Overhead Allocation	(1,710)	(1,852)	(1,900)	(2,244)	(7,799)	(5,764)	(3,521)	(3,911)	(5,197)	(6,162)
TOTAL OPERATING EXPENSES	***$ 491,023***	***$ 504,347***	***$ 524,079***	***$ 538,125***	***$ 549,747***	***$ 563,932***	***$ 580,286***	***$ 599,776***	***$ 617,309***	***$ 633,033***
3. INCOME										
a. Income From Operation	**$ (5,958)**	**$ (9,112)**	**$ (5,614)**	**$ (5,139)**	**$ (4,281)**	**$ (4,777)**	**$ (5,170)**	**$ (5,660)**	**$ (6,170)**	**$ (6,700)**
Operating Margin	*-1.2%*	*-1.8%*	*-1.1%*	*-1.0%*	*-0.8%*	*-0.9%*	*-0.9%*	*-1.0%*	*-1.0%*	-1.1%
b. Non-Operating Inc - Investmnt Earnings 4% and Net Contributions	14,356	18,237	16,891	10,374	10,124	10,689	11,070	11,663	12,278	12,917
NET INCOME (LOSS)	***$ 8,398***	***$ 9,125***	***$ 11,277***	***$ 5,235***	***$ 5,843***	***$ 5,912***	***$ 5,900***	***$ 6,003***	***$ 6,108***	***$ 6,217***