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TO: Commissioners

FROM: Kevin R. McDonald
Chief, Certificate of Need

DATE: April 16, 2020

SUBJECT: University of Maryland Upper Chesapeake Health System Projects

- Upper Chesapeake Health Behavioral Health at Aberdeen, Docket No. 18-12-2436
- Conversion of University of Maryland Harford Memorial to a Freestanding Medical Facility, Docket No. 17-12-EX004
- The Consolidation of University of Maryland Upper Chesapeake Medical Center and University of Maryland Harford Memorial Hospital, Docket No. 17-12-EX003

Attached is a set of three related and interdependent projects which MHCC is reviewing together because of their close relationship.

The projects result from a plan developed by the University of Maryland Upper Chesapeake Health System (UCHS) to restructure its health care services to reconfigure and modernize the UCHS delivery system to consolidate services to realize cost savings and efficiencies.

The plan would replace University of Maryland Harford Memorial Hospital (HMH), which UCHS asserts is inefficient and at the end of its useful life, with a freestanding medical facility (FMF) to be constructed in Aberdeen; a special psychiatric hospital to be co-located with and constructed on the floor above the FMF; and the relocation of MSGA beds from HMH to University of Maryland Upper Chesapeake Medical Center (UCMC).

The conversion of HMH to a new FMF would move the emergency, imaging, laboratory, and observation services to Aberdeen, and the new, expanded inpatient psychiatric hospital would relocate and augment the 29 psychiatric beds currently operating at HMH. The proposed project at UCMC would add 30 MSGA beds, a dedicated observation unit, and shell space at UCMC in a three-story addition. Two of the floors would be finished, adding a total of 72 MSGA and observation beds. This additional bed capacity is a response to the reduction of bed capacity occurring with the conversion of HMH to an FMF.

The special psychiatric hospital requires Certificate of Need (CON) review; the two related projects involve requests for exemption from CON review.

A thumbnail sketch of the three-project package is shown in Figure 1.

Figure 1: Proposed Re-Configuration of Upper Chesapeake Health System Facilities

Upper Chesapeake Behavioral Health at Aberdeen (a special psychiatric hospital):

- approximately 75,000 SF of new construction
- 33 beds and shell space that could eventually accommodate 7 more beds
- Total project budget estimate is just under $63 million.

UC FMF:

- Approximately 69,000 SF of new construction (on the first floor of the building that would include the psychiatric hospital)
- 5 triage rooms
- 25 ED treatment spaces
- 17 observation rooms
- A diagnostic imaging suite with related staff and support spaces;
- Non-treatment spaces, including triage/blood draw rooms, consultation rooms, staff support spaces, and offices; and
- A laboratory and pharmacy
- Total project budget estimate is $56,665,400.

Expansion of UCMC to accommodate the conversion of HMH to an FMF:

- Addition of three floors above the current cancer center (approximately 98,000 SF)
- A shelled floor to accommodate actual and anticipated cancer center growth
- One floor with 42 observation beds
- One floor with 30 medical/surgical beds
- Total project budget estimate is $84.4 million.

Staff notes that UCHS's negotiations with HSCRC resulted in an agreement on a GBR that HSCRC staff estimates would save Maryland rate-payers almost $10 million in the first year of operation, and about $15 million annually in subsequent years.

Staff will recommend that the Commission **APPROVE** all three of these projects based on its review and conclusion that each is consistent with the applicable criteria and standards.

IN THE MATTER OF THE	*	**BEFORE THE**
CONVERSION OF	*	**MARYLAND**
UNIVERSITY OF MARYLAND	*	**HEALTH CARE**
HARFORD MEMORIAL HOSPITAL TO A	*	**COMMISSION**
FREESTANDING MEDICAL FACILITY	*	
Docket No. 17-12-EX004	*	

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STAFF REPORT & RECOMMENDATION

EXEMPTION FROM CERTIFICATE OF NEED REVIEW
CONVERSION OF THE UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL TO A FREESTANDING MEDICAL FACILITY

April 16, 2020

TABLE OF CONTENTS

I. INTRODUCTION

A. The Applicants

The joint applicants in this request for exemption from Certificate of Need (CON) review (exemption request) are two general hospitals owned and operated by University of Maryland Upper Chesapeake Health System (UCHS) – University of Maryland Upper Chesapeake Medical Center, Inc. (UCMC) and University of Maryland Harford Memorial Hospital, Inc. (HMH).

HMH is a general hospital in Havre de Grace. It was constructed in phases between 1943 and 1972. It is licensed to operate 82 beds. It allocates 51 licensed beds to medical/surgical/ gynecological/addictions (MSGA) beds and 31 licensed beds to adult psychiatric services.

UCMC is a general hospital located in Bel Air. It is currently licensed for 161 beds (149 MSGA, 10 obstetric, and two pediatric beds). UCHS became affiliated with the University of Maryland Medical System (UMMS) in 2009 and formally merged into UMMS in late 2013.

B. The Project

The applicants seek to convert HMH to a freestanding medical facility (FMF). The proposed facility will be constructed on a 36-acre property at 635 McHenry Road in Aberdeen, within five miles of the existing HMH campus. The FMF will be located on the first floor of a two-story building. The second floor will house a special psychiatric hospital, Upper Chesapeake Behavioral Health at Aberdeen (UC Behavioral Health), a thirty-three (33) bed special psychiatric hospital.

A freestanding medical facility is an outpatient health care facility that: (a) provides medical and health care services; (b) is an administrative part of an acute care general hospital; (c) is physically separated from the hospital or hospital grounds; (d) operates 24 hours a day, seven days a week; (e) complies with the provisions of the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Medicare Conditions of Participation; (f) has the ability to rapidly transfer complex cases to an acute care general hospital after the patient has been stabilized; (g) maintains adequate and appropriate delivery of emergency medical care within the statewide emergency medical services system as determined by the Maryland State Emergency Medical Services Board; and (h) may provide observation services. COMAR 10.24.19.05B(8). FMFs are commonly called "freestanding emergency centers."

The FMF is proposed to have a capacity of 25 emergency treatment spaces and 17 observation rooms. Five of the treatment spaces would be dedicated to behavioral health patients (one a seclusion room). Of the remaining 20 treatment spaces, two would be resuscitation rooms, two would be isolation rooms, and one a SAFE (Sexual Assault Forensic Examiner) room. The

FMF would also contain: a diagnostic imaging suite[1] with related support space, a laboratory and pharmacy. Space allocation for the FMF is shown in Table I-1. (DI #30, p. 4).

Space allocation for the proposed FMF is shown in Table I-1.

Table I-1: Space Allocation
Proposed UCHS FMF

Function	Departmental Gross Square Feet
Emergency Treatment – 25 Treatment Spaces	19,211
Observation Unit – 17 Rooms	11,666
Imaging	5,573
Laboratory	1,622
Pharmacy	1,602
Administration	7,574
Public, Maintenance, and Support Spaces	22,095
Total (includes space not specifically allocated as departmental space for specific functional areas)	69,343

Source: DI #30, Exh. 1, Table B.

The total estimated cost of the entire building, housing both the FMF and the psychiatric hospital is $119,656,520, with $56,665,400 of that total allocated to the project budget for the MF. (DI #30, Exh. 1, Table E). Project budget estimate details are provided at Appendix 2.

C. Background

This proposed project is one of three related projects with the other two having their origin in the conversion of HMH to an FMF. MHCC is reviewing the projects together because of their close relationship.

In addition to this exemption request to convert HMH to an FMF, UCHS has also filed a request to make changes to UCMC: relocate beds and add physical bed space (30 rooms); add a dedicated observation unit (42 rooms); and add shell space at UCMC. That project would add 98,000 square feet (SF) through construction of three floors vertically expanding an existing building. Two of the floors would be finished, adding a total of 72 MSGA and observation beds.

The third project is the subject of a CON application. As previously noted, UCHS proposes to establish a special psychiatric hospital in Aberdeen. It would occupy approximately 75,000 SF of a proposed building of approximately 144,000 SF that also includes the proposed FMF. This facility would replace the 31 psychiatric beds currently operated at HMH.

UCHS states that, despite its ongoing investment in the infrastructure of HMH, the existing physical plant has outlived its useful life and that it is cost prohibitive to invest in a replacement facility at the existing site, which is described as lacking adjacent property readily available or suitable for expansion of the HMH campus and too small. UCHS states that it also considered

[1] Will include x-ray, ultrasound, CT, MRI, and cardiac and vascular ultrasound modalities.

relocating and replacing HMH but determined that that alternative would not be cost-effective. (DI #30, pp. 1-3).

A thumbnail sketch of the three-project package is shown in Figure 1.

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The Proposed FMF (UC FMF)

D. Staff Recommendation

MHCC staff recommends that the Commission approve the applicants' request for an exemption from CON to convert HMH to an FMF, with a condition

The project under review was put forward in 2019. MHCC staff expressed concern that the 2018 CON request for 40 psychiatric beds was excessive. Staff also noted to the applicant that the proposed number of both FMF treatment spaces and observation beds exceeded the guidance in the FMF chapter of the State Health Plan. Finally, staff pointed out that the UCHS hospitals use of observation status was among the highest in the state, a characteristic underlying the large

number of observation beds proposed for the FMF and general hospital expansion projects and asked UCHS to reconsider the number of observation beds in the project plans.

In response, UCHS modified and resubmitted its proposals, with several changes. Among other changes, observation beds planned for the FMF were reduced from 25 to 17 and the number of psychiatric hospital beds was reduced from 40 to 33, without redesign of the actual Aberdeen building space. UCHS states that the FMF treatment space originally planned for eight treatment spaces will be finished and used for other purposes until expansion of FMF capacity is warranted. The seven-bed reduction in psychiatric hospital beds will result in unfinished space on the second floor of the new building in Aberdeen.

MHCC staff concerns that the proposed project may include excess space and, thus, cost were mitigated by the Health Services Cost Review Commission's (HSCRC) decision regarding the global budget revenue (GBR) it will approve for these projects. (See Appendix 5) HSCRC took into account the possibility that the project includes excess space in setting the GBR. HSCRC staff projects that the combined GBR for the UCHS projects would save Maryland consumers $9.9 million in the first year of operation, and about $15 million annually starting in the third year of operation.

Staff concludes that the exemption request complies with the applicable criteria and standards established for such conversions, as discussed in the body of this report and that the Commission should grant the request for an exemption for the conversion. One of those standards reviewed in this report, COMAR 10.24.19.04C(8)(h), is intended to serve as an automatic check on recognizing excessive building cost, identified through use of a published health care construction cost index. While very recent adoption of policies by HSCRC that narrow the size of hospital capital projects eligible for recognition of increased capital cost in the adjustment of global budgeted revenues will require review of this MHCC standard, the current standard in the State Health Plan indicates that the Commission should attach the following condition to an approval of this request for an exemption from CON:

> Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $865,036. This figure includes the estimated new construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

II. PROCEDURAL HISTORY

As explained above, this CON application is one of three proposals filed by UCHS to reconfigure and modernize the hospital facilities of UCHS. The system will operate only one general hospital in Harford County, UCMC, going forward and the hospital will be expanded. The second general hospital, HMH, is being replaced by an FMF and a special psychiatric hospital.

UCHS filed the initial package of proposed actions on July 1, 2017. It differed from the current package in that the FMF and special psychiatric hospital were to be built on land in the Bulle Rock section of Havre de Grace, just off the Level Road exit of Interstate-95. A 40-bed

psychiatric hospital was proposed at this site as a replacement for two general hospital psychiatric units: the unit at HMH; and the adult unit at Union Hospital, located at Elkton in adjacent Cecil County that is currently licensed for eight beds. Expansion of medical/surgical and observation bed space at UCMC was proposed along with shell space. However, during the local planning and permitting process, UCHS determined that the requirements that would be imposed by the City for infrastructure investments to develop the Havre de Grace site would be too costly.

After acquiring the Aberdeen site, UCHS filed modified proposals on November 21, 2018. The scope of this new version of the project was essentially the same but Union Hospital was no longer a partner in the project. The plan still involved a two-story facility to house both the FMF and 40-bed special psychiatric hospital, as well as a building addition to UCMC to accommodate additional observation beds.

MHCC staff expressed concern that the CON request for 40 psychiatric beds was excessive and, as previously noted, questioned the choice of maintaining a separate psychiatric hospital in Harford County. Staff noted to the applicant that the proposed number of both FMF treatment spaces and observation beds exceeded the guidance in the FMF chapter of the State Health Plan. Finally, staff pointed out that the UCHS hospitals use of observation status was among the highest in the state, a characteristic underlying the very large number of observation beds proposed for the FMF and general hospital expansion projects and asked UCHS to reconsider the number of observation beds in the project plans.

In response, UCHS modified and resubmitted its proposals, with several changes. Observation beds planned for the FMF were reduced from 25 to 17, and the number of psychiatric hospital beds was reduced from 40 to 33, without redesign of the actual Aberdeen building space. The FMF treatment space originally planned for eight treatment spaces will be finished and used for other purposes until expansion of FMF capacity is warranted. The reduction in hospital beds (seven beds) will remain unfinished. The number of observation beds proposed for UCMC was reduced from two floors in the new building addition, with 77 beds, to a single floor, with 42 observation beds. The second floor, formerly observation bed space, is now proposed to be finished as a 30-bed MSGA unit. The third level of the building addition is identified as unfinished space in both the original and modified set of proposals.

The evolution of the proposals is illustrated in the following table.

Table II-2: Bed Capacity Changes
Three UCHS Proposals

Facility	Space	July 2017 Application Havre de Grace	Nov 2018 Application Aberdeen	October 2019 Modifications Aberdeen
FMF	Emergency treatment spaces	25	25	25
	Observation beds	25	25	17
UCMC Expansion	MSGA beds	32	0	30
	Observation beds	41	77	42
UC BH	Acute psychiatric beds (adult)	40	40	33

The complete Record of the Review follows.

Table I-2: Record of the Review

Docket Item #	Description	Date
1	Letter of Support from Maryland Senator Wayne Norman	8/2/17
2	Exemption Request	8/4/17
3	Request to publish notice of the Exemption Request in the Baltimore Sun	8/8/17
4	Request to publish notice of Exemption Request in the Maryland Register	8/10/17
5	Notice of Exemption Request as published in the Baltimore Sun	8/18/17
6	MHCC staff requests completeness information	9/1/17
7	Summary of Public Informational Hearing	9/14/17
8	Applicant submits response to completeness request of 9/1/17	9/18/17
9	Applicant submits response to questions raised by MIEMSS	9/22/17
10	MIEMSS comments and recommendation on proposed exemption	10/12/17
11	UCHS comments on proposed projects	1/9/18
12	City of Havre de Grace comments on proposed projects	2/6/18
13	Letter of Support from Harford County Councilman Curtis Beulah	5/30/18
14	Applicant submits FIRST MODIFIED Exemption Request	11/21/18
15	Request to publish notice of the Modified Exemption Request in the Baltimore Sun	11/26/18
16	Request to publish notice of Modified Exemption Request in the Maryland Register	11/26/18
17	Summary of Second Public Informational Hearing	12/27/18
18	MHCC staff requests completeness information regarding first modified exemption request	1/4/19
19	MHCC staff requests additional information regarding MIEMSS	1/9/19
20	MIEMSS confirms modifications to exemption request	2/7/19
21	Applicant submits response to completeness questions of 1/4/19 (email)	2/15/19
22	MHCC staff requests additional completeness information	3/22/19
23	MHCC staff sends out revised completeness questions of 3/22/19	3/27/19
24	Applicant submits response to revised completeness request of 3/22/19	4/5/19
25	Letter of Support from Director of Cecil County Department of Emergency Services, Richard Brooks	3/28/19
26	Letter of Concern from City Attorney for Havre de Grace, April Ishak	5/3/19
27	Email of Concern received by MHCC staff from a citizen	6/26/19
28	Email of Concern received by MHCC staff from a citizen	6/27/19
29	MHCC sends follow-up to 6/25/19 Meeting and a summary of issues	7/10/19
30	Applicant submits Second Modified Exemption Request	10/21/19
31	Havre de Grace Mayor sends letter to Governor Hogan	10/21/19
32	Petition emailed to MHCC Executive Director from medical staff of University of Maryland Upper Chesapeake Health	11/1/19
33	Havre de Grace Mayor submits comments on project to MHCC	11/1/19
34	Letter of Support from Maryland Delegate Teresa Reilly	11/5/19
35	MHCC staff requests completeness information regarding second modified exemption request	11/13/19
36	Letter of Support from Maryland Senators J.B. Jennings, Bob Cassilly, and Jason Gallion	11/19/19
37	MHCC staff requests additional completeness information	11/25/19
38	Letter of Support Harford County Health Officer, Russell Moy, MD	11/25/19
39	Letter of Support Harford County Director of Emergency Services, Edward Hopkins	11/25/19
40	MHCC staff requests information on MVS (email)	11/26/19
41	Email of Petition received by MHCC Executive Director from medical staff of University of Maryland Upper Chesapeake Health	11/26/19
42	Email of Petition received by MHCC Executive Director from medical staff of University of Maryland Upper Chesapeake Health	11/26/19
43	Applicant submits response to completeness request of 11/13/19	11/27/19
44	Applicant submits response to completeness request of 11/25/19	12/12/19

45	Email of Petition received by MHCC Executive Director from medical staff of University of Maryland Upper Chesapeake Health	1/3/20
46	MHCC staff requests HSCRC comments on proposed project	1/16/20
47	MHCC staff and applicant discuss rate regulated services (emails)	2/3/20 2/6/20
48	MHCC staff and applicant discuss UCMC Quality Measures corrective action plan (emails)	2/6/20 2/12/20
49	MHCC staff and applicant discuss and receive a modified Exhibit 15 (emails)	2/6/20 2/12/20
50	MHCC staff and applicant discuss Upper Chesapeake Health System Revenue Proposal (emails)	2/13/20
51	MHCC staff and applicant discuss and receive replacement Exhibit 4 and Exhibit 8 (emails)	2/19/20
51a	HSCRC Opinion re: Financial Feasibility	3/17/20
52	MHCC staff and applicant discuss and receive info related to standards involving HSCRC (emails)	3/25/20
53	Applicant provides list of rate regulated services to be provided at the proposed FMF	3/25/20
54	MHCC staff requests responses to questions from HSCRC	3/26/20
55	HSCRC Comments on proposed project	3/26/20

III. REQUIREMENTS FOR AN EXEMPTION

10.24.19.04C Exemption from Certificate of Need Review to Convert a General Hospital to a Freestanding Medical Facility.

(1) A freestanding medical facility created through conversion from a general hospital shall only retain patients overnight for observation stays.

Implementation of the proposed project will eliminate the provision of inpatient services on the HMH campus and convert this general hospital to a freestanding medical facility limited to providing outpatient care. Some patients may be observed overnight. Observation is defined as an outpatient service. (DI #30, p. 9).

(2) Each notice, documentation, or other information regarding a proposed conversion of a general hospital to a freestanding medical facility that is required by Section C of this regulation or by COMAR 30.08.15.03 shall be provided simultaneously to the Commission and to the Maryland Institute for Emergency Medical Services Systems.

The applicants state that they have and will continue to provide, to the Commission and MIEMSS, all notices, documentation, or other information regarding the proposed conversion that are required by COMAR 10.24.19.04C and/or by COMAR 30.08.15.03. (DI #30, p. 9).

(3) A notice of intent to seek an exemption from Certificate of Need review to convert a general hospital to an FMF shall:

(a) Be filed in the form and manner specified by the Commission, which may require a pre-filing meeting with Commission staff to discuss the proposed project, publication requirements, and plans for a public informational hearing.

(b) Be filed with the converting hospital and its parent hospital as joint applicant;

A notice to seek an exemption from CON review to convert HMH to a FMF was filed in the form and manner specified by the Commission and was filed by HMH, the converting hospital, and UCMC, the parent hospital.

Staff concludes that the applicants have satisfied the requirements of Paragraphs (3)(a) and (b) of the standard.

(c) Only be accepted by the Commission for filing after:

(i) The converting hospital publishes on its website and otherwise makes available to the general public and community stakeholders, at least 14 days before holding a public informational hearing, the hospital's proposed transition plan that addresses, at a minimum, job retraining and placement for employees displaced by the hospital conversion, plans for transitioning acute care services previously provided on the hospital campus to residents of the hospital service area, and plans for the hospital's physical plant and site.

The applicants held a public informational meeting on August 30, 2017. UCHS published notice of the hearing date and location on its website's homepage, and in both the print and electronic versions of the Maryland Daily Record 17 days prior to the public informational meeting. (DI #30, p. 11, Exh. 7, 8). UCHS published its transition plan on its website on August 11, 2017. This plan addressed job retraining and placement of employees displaced by the conversion, plans for transitioning acute care services previously provided at UM Harford Memorial Hospital to residents of the service area, and plans for the hospital's physical plant and site. (DI #30, p. 11).

On November 21, 2018, the applicants filed a Modified Request changing the location of the proposed freestanding medical facility to its current proposed location in Aberdeen. UCHS elected to hold a second public informational hearing to address the transition of HMH to a FMF. The second public informational hearing was held on December 13, 2018. UCHS published notice of the hearing date and location on its website's homepage, and in the *Maryland Daily Record* print and electronic versions 17 days prior to the public informational meeting. UCHS published its updated transition plan on its website 14 days prior to the second public informational meeting. (DI #30, p. 11, Exhs. 10 and 11).

Staff concludes that the applicants have met this requirement.

(ii) The converting hospital, in consultation with the Commission, and after providing at least 14 days' notice on the homepage of its website and in a newspaper of daily circulation in the jurisdiction where the hospital is located, holds a public

informational hearing that addresses the reasons for the conversion, plans for transitioning acute care services previously provided by the hospital to residents of the hospital service area, plans for addressing the health care needs of residents of the hospital service area, plans of the hospital or the merged asset system that owns or controls the hospital for retraining and placement of displaced employees, plans for the hospital's physical plant and site, and the proposed timeline for the conversion.

UCHS published notice of the hearing date and location on its website's homepage, and in the *Maryland Daily Record* print and electronic versions 17 days prior to both of its public informational meetings. (DI #30, p. 11, Exhs. 7-8).

Staff concludes that the applicants have met the requirement of Subparagraph (c)(iii).

(iii)Within ten working days after the public informational hearing, the converting hospital provides a written summary of the hearing and all written feedback provided by the general public and from community stakeholders to the Governor, Secretary of DHMH, the governing body of the jurisdiction in which the hospital is located, the local health department and local board of health for the jurisdiction in which the hospital is located, the Commission, and the Senate Finance Committee, House Health and Government Operations Committee, and members of the General Assembly who represent the district in which the hospital is located;

Staff concludes that the applicants satisfied this subparagraph by documenting their distribution of the required written summaries to the required bodies and individuals in a letter dated September 14, 2017. The summary of the second public meeting was distributed on December 27, 2018. It is attached as Appendix 3.

(iv) The State Emergency Medical Services Board has determined that the proposed conversion of the general hospital to an FMF will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system;

The applicants submitted a letter from MIEMSS, dated October 12, 2017, documenting that the State EMS Board "unanimously determined that the proposed conversion of the University of HMH to a freestanding medical facility will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system." (DI #30, Exh. 13). MIEMSS submitted a letter to MHCC on February 7, 2019, documenting that the State EMS Board discussed the new site proposed by the applicant and determined the relocation "was not a substantive change to the project and would not impact the factors that the Board is required to consider." (DI #20, p. 1). These letters are attached as Appendix 4.

Staff concludes that this action satisfies Subparagraph (c)(iv) of the standard.

(v) The applicants receive a determination from HSCRC, issued pursuant to COMAR 10.37.10.07-2D, regarding each outpatient service to be provided at the proposed FMF for which they seek rate regulation.

HSCRC communicated to MHCC staff confirming that it is "willing to approve rates for those services...included in the [exemption request) as follows: Emergency Department, Emergency Behavioral Health Crisis, Observation, Laboratory, Pharmacy, and Diagnostic Imaging (MRI, CT, Ultrasound, and X-ray)." (DI #55, p. 2).

(vi) The applicants receive approved rates from HSCRC for each rate-regulated outpatient service at the proposed FMF; and

HSCRC staff's communication to MHCC staff stated that it "will set rates for the FMF prior to its commencement of operations...[following] construction of the facility...[and that] [f]urther discussions need to occur to ensure that the then proposed rates are reasonable." (DI #55, p. 2).

(vii) The applicant provide any additional information determined by Commission staff as necessary for the notice of intent to seek an exemption to convert to an FMF to be complete.

The applicants complied with all staff requests for information and met this requirement.

(4) The Commission shall require that a freestanding medical facility created through the conversion of a general hospital remain on the site of, or on a site adjacent to, the converting general hospital unless:

(a) The converting general hospital is the only general hospital in the jurisdiction or is one of only two general hospitals in the jurisdiction and both belong to the same merged asset system; and

(b) The site is within a five-mile radius and in the primary service area of the converting general hospital.

UCMC and HMH are members of UCHS, a merged asset system, and are the only two general acute hospitals in Harford County. The UC FMF project site is located within a five-mile radius and in the primary service area of the converting general hospital, HMH. Staff concludes that the proposed FMF meets this requirement.

(5) The parent hospital shall demonstrate compliance with applicable general standards in COMAR 10.24.10.04A.

There are three applicable general standards in the Acute Hospital Services Chapter of the SHP, at COMAR 10.24.10.04A: (1) Information Regarding Charges; (2) Charity Care Policy; and (3) Quality of Care. They are addressed below.

COMAR 10.24.10.04A(1): Information Regarding Charges

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

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

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

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

This standard is intended to ensure that information regarding the average cost for common inpatient and outpatient procedures is readily available to the public and that policies are in place and employees are trained to address charge-related inquiries. The policy must include requirements to post a current list of charges for common inpatient and outpatient services, procedures for responding to requests and inquiries, and requirements for staff training.

The applicants submitted University of Maryland Upper Chesapeake Health System's Financial Policy on Estimation of Charges. The document provides for the provision of information on charges for hospital services to the public and on hospital internet sites; procedures for promptly responding to individual requests for current charges for specific services/procedures; and that the Patient Financial Services department "shall receive training and demonstrate the knowledge of accessing the estimator tools to ensure that inquiries regarding charges for services are appropriately handled." (DI #49).

Commission staff has verified that the applicants comply with this standard.

COMAR 10.24.10.04A(2): Charity Care Policy

Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. COMAR 10.24.10 10

(a) The policy shall provide:

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

The applicants provided a copy of the Financial Assistance policy of the University of Maryland Upper Chesapeake Health, which applies to HMH and will be implemented at UM FMF when it opens. The policy states that UCHS will make a determination of probable eligibility within two (2) business days following a patient's request for charity care services. There is no form used to determine a patient's eligibility; UCHS's representative asks the patient or family for family size and income to make a determination of probable eligibility. (DI #43, Exh. 8, p. 8).

Staff concludes that the proposed FMF meets this requirement.

(ii)Minimum Required Notice of Charity Care Policy.

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

The UCHS policy provides that its related entities will publish notice of the availability of financial assistance on a yearly basis in their local newspapers and post notices of its availability in admissions offices, business offices, and emergency department areas. (DI #30, pp. 14-15, DI #43, Exh. 8). UCHS's policy also states that "notice of financial assistance is provided at admission or preadmission to each person who seeks services in the hospital." (DI #43, Exh. 8, p. 9).

Staff concludes that the proposed FMF provides the notices required by this standard.

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

According to HSCRC's FY 2018 Community Benefit Report, HMH and UCMC are in the second and third quartiles, respectively. HMH reported provision of charity care valued at $1.9 million (equivalent to 2.2% of total operating expenses) and UCMC's reported provision of charity care was valued at $4.3 million (equivalent to 1.6% of total operating expenses). The average for all general hospitals in Maryland was 2.1%. HSCRC Community Benefit Report 2018). Staff concludes that the applicants have met this standard.

10.24.10.04A(3): Quality of Care

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

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

(ii) Accredited by the Joint Commission; and

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

The applicants provided documentation that UCMC and HMH are: (i) licensed in good standing with the Maryland Department of Health; (ii) accredited by the Joint Commission; and (iii) are in compliance with the conditions of participation of the Medicare and Medicaid programs. (DI #30, pp. 17-18 and Exhibit 18). Staff concludes that the applicants have met this standard

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

Staff notes that Paragraph (b) of this standard has become outdated in recent years, as currently written. There is still a Maryland Hospital Performance Evaluation Guide (HPEG), which is the hospital consumer guide component of the MHCC website. Quality measures are included as a component of that guide. However, since this standard was adopted, the HPEG has been substantially expanded to include many more measures of hospital quality and performance. Moreover, the specific format of the quality measure component of the HPEG no longer consists of a set of measure values that conform with the format of this standard in which each measure is scored as a compliance percentage that can be ranked by quartile. The performance for most of the expanded number of quality measures is now in a comparative context, expressed as "Below Average," "Average," or "Better than Average."

The applicants state that UC FMF will be a provider-based department of UCMC. Commission staff examined the latest results for UCMC as reported on the Commission's website and found that there are currently 68 quality measures for which comparisons among Maryland hospitals can be drawn. Staff found that UMCM rated above average on 16 measures, average on 28 measures, and below average on 13 measures. There were also 11 measures for which there was insufficient data to produce a meaningful value. Each measure for which UCMC was rated as less than average was addressed in a corrective action plan. (DI #30, pp. 18-21 and DI 49).

Staff concludes that the applicants have demonstrated compliance with Paragraph (b) of the quality standard by documenting actions it has or is taking to improve performance in those quality measures for which it scored below average compared to the other Maryland hospitals.

(6) The applicant shall document that the proposed FMF will meet licensure standards established by DHMH.

The applicant states that UC FMF will meet or exceed licensure standards established by the Department of Health. (DI #30, p.21). Staff notes that, in addition to their commitment, each of the UCHS hospitals currently meets the licensure standards established for hospitals. Staff concludes that the applicants have met this standard.

(7) The applicant shall establish and maintain financial assistance and charity care policies at the proposed freestanding medical facility that match the parent hospital's policies and that are in compliance with COMAR 10.24.10.

The applicant confirmed that it will implement the same financial assistance and charity care policies at the proposed freestanding medical facility that are in effect at UC FMF. The compliance of UCMC, the proposed parent hospital, with the charity care standard was discussed under compliance with COMAR 10.24.10.04A(2) of the Acute Hospital Services Chapter, *supra*, at pages 8-9.

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

(a) Provide the number of emergency department visits and FMF visits by residents in the converting hospital's service area for at least the most recent five years;

The applicant identified 13 zip code areas in Harford and Cecil Counties that contributed 85%, in order of descending frequency of the converting hospital's emergency department ("ED") visits in FY 2018, defining these areas as comprising the UC FMF's primary service area. The applicant stated that there were 68,562 visits to Maryland hospital emergency departments by residents of this ED service area in FY 2018. A combined 70.5% of these emergency department visits were to UCMC (37.8%) and HMH (32.7%). (DI #30, p. 22). There are currently no FMFs operating in Harford or Cecil Counties.

Table III-1: Emergency Department Visits by Residents of UCHS's Defined FMF Service Area FY2014 – FY2018

Hospital	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2018 Market Share	FY 2014-FY2018 Volume Change
UCMC	24,580	26,175	27,051	26,609	25,890	37.8%	5.3%
HMH	24,289	24,981	24,679	23,424	22,451	32.7%	(7.6%)
Union (Cecil Co.)	11,658	11,558	11,790	11,500	11,128	16.2%	(4.5%)
MedStar Franklin Square (Baltimore Co.)	2,974	2,733	2,574	2,279	2,094	3.1%	(29.6%)
Johns Hopkins (Baltimore City)	986	1,057	1,088	1,216	1,300	1.9%	31.8%
Other	5,284	5,078	5,240	5,523	5,699	8.3%	7.9%
Total Service Area ED Visits	69,771	71,582	72,422	70,551	68,562	100%	(1.7%)

Source: DI #30, p. 22.

Staff concludes that the applicants have met this requirement.

(b) Assess the availability and accessibility of emergent, urgent, and primary care services otherwise available to the population to be served, including information on the number and location of other hospital emergency departments, FMFs, and urgent care centers in the service area of the converting hospital or within five miles of any zip code area in the service area of the converting hospital.

There are no other acute general hospitals or FMFs within UCHS's defined FMF primary service area. The nearest acute general hospital to the proposed Aberdeen site is UCMC, the parent hospital of the FMF, approximately 12.4 miles by public roadways. Union Hospital in Elkhorn (Cecil) and MedStar Franklin Square Hospital (Baltimore County) are approximately 21.8 and 23.2 miles from the Aberdeen site, respectively, by public roadways. (DI #30, p. 24).

The applicants identified two primary care practices that offer walk-in service and nine urgent care centers in the defined FMF primary service area. (Table III-2). None of the urgent care centers operate 24 hours per day. Most are open between 8 a.m. and 8 p.m., with two remaining

open until 10 p.m. The applicant noted out that almost a third (32% in FY 2017) of HMH's emergency department visits occurred between 8 p.m. and 8 a.m. (DI #30, pp. 24-27).

Table III-2: Urgent Care Centers in UC FMF's Service Area

Urgent Care Center	Distance to Aberdeen FMF Site
Patient First	0.8
Choice One Urgent Care	2.7
MedStar Prompt Care	6.0
MD Immediate Care	6.1
Total Urgent Care	10.4
Infinite Medical Express	10.6
Principio Health Center	11.1
MedStar Express Care Northeast	14.9
Get A Doc North East	15.4

Source:DI#30, p.24

The applicants state that UC FMF is designed to provide emergency and observation services similar to those historically provided at HMH. The applicants state that it has been engaged in ongoing community education and outreach for some time in order to educate the community about the services to be provided by UC FMF and projects that UC FMF will maintain similar ED volumes to those of HMH. (DI #30, p. 24).

Staff concludes that the applicants have met this requirement.

(c) Demonstrate that the proposed conversion is consistent with the converting hospital's most recent community health needs assessment;

The applicants provided the 2018 community health assessment completed by UCHS in conjunction with the Harford County Health Department and Healthy Harford. The assessment identified the following priority community health needs: behavioral health, prevention and wellness, and family stability and wellness. The applicants note that UC FMF's dedicated behavioral health treatment spaces and the system's plan to develop a special psychiatric hospital at the same site are consistent with the Community Health Needs Assessment, stating that the scope of behavioral health services planned for the UC Medical Campus at Aberdeen is intended to meet the behavioral health needs described in the community health assessment. (DI #30, p. 27 and Exh.17).

Staff concludes that the proposed project is consistent with the community health needs assessment developed for Harford County, and recommends that the Commission find that the proposed project is consistent with and will contribute to addressing the needs identified in the Community Health Needs Assessment.

(d) Demonstrate that the number of treatment spaces and the size of the FMF proposed by the applicant are consistent with the applicable guidance included in the most current edition of Emergency Department Design: A Practical Guide to Planning

for the Future, published by the American College of Emergency Physicians, based on reasonably projected levels of visit volume.

> ***(i) Demonstrate that the proposed number of treatment spaces is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of treatment spaces.***
>
> ***(ii) Demonstrate that the building gross square footage is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for additional building gross square footage.***

Subparagraphs (d)(i) and (ii) of this standard require that the number of emergency treatment spaces and space proposed for an FMF be consistent with the guidance set forth in *Emergency Department Design: A Practical Guide to Planning for the Future,* published by the American College of Emergency Physicians (ACEP) and commonly referred to as the "ACEP Guidelines." Its two iterations have been incorporated by reference in chapters of the State Health Plan since 2009. The Commission incorporated these ED planning guidelines in the FMF Chapter in order to provide a basis for evaluating the appropriate space and service capacity needs for an FMF, even though the guidelines were specifically developed for hospital ED planning and not for freestanding emergency centers.

Essentially, the ACEP Guidelines prescribe the optimal amount of treatment spaces and square feet that an ED should have based on the number of annual visits and certain characteristics of the facility and the population to be served. The ACEP Guidelines set forth estimates of the number of treatment spaces and the departmental space appropriate for a range of projected annual ED visit volumes for EDs with low to high range operating characteristics. The position of an ED on the low to high range operational spectrum is determined on the basis of 16 factors such as percentage of admitted patients, length of stay in the ED, location of observation space, percentage of behavioral health patients, percentage of non-urgent patients, and age of patients, as well as the presence of specialty units within the ED. If an ED ranks high on more of the factors, space and treatment capacity should be planned for the number of treatment spaces and square footage called for in the high range estimate for a given volume. If an ED ranks on the low range for more factors, the low range guidance should apply. The ACEP Guidelines also identify medium measures for each factor but not space or guidance on the number of treatment spaces. If a facility ranks in the mid-range for more factors the number of treatment space and the amount of space should fall in between the low and high range. In this taxonomy, a facility whose characteristics and population served defined it as "high range" would require more treatment rooms and building space than a "mid range" or "low range" facility, as illustrated in Table III-3 below.

Table III-3: ACEP Guide Recommendations: Number of ED Treatment Spaces Needed at Various Visit Volume Levels

Annual Emergency Department Visits	Low Range ED			High Range ED		
	Total Treatment Spaces	Annual Visits per Treatment Space	Departmental Gross Square Feet	Total Treatment Spaces	Annual Visits per Treatment Space	Departmental Gross Square Feet
15,000	11	1,364	9,075	13	1,154	11,375
20,000	14	1,429	11,550	16	1,250	14,000
25,000	18	1,389	14,850	20	1,250	17,500
30,000	21	1,429	16,800	25	1,200	21,875

Source: Emergency Department Design – A Practical Guide to Planning for the Future (2nd edition) pp.116-117.

However, although this table shows both low range and high range values, staff notes that the FMF Chapter specifies that FMFs be outfitted according to the ACEP Guidelines at low range unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of treatment spaces or the need for additional building space. COMAR 10.24.19.04.C.(8)(d)(i) and (ii).

So, for example, as shown in Table III-3 above, a facility characterized as "low range" and experiencing 25,000 annual emergency department visits would need 18 treatment spaces in 14,850 departmental gross square feet; at 30,000 annual emergency department visits, the same facility would need 21 treatment spaces in 16,800 departmental gross square feet.

Need for ED Treatment Spaces

The applicants provided historic and projected ED visit volume for the existing hospital (HMH) as the basis for projecting ED visit volume for UC FMF. That data showed that HMH experienced a 9.4% decline in emergency department visits between FY 2016 and 2018, declining to 26,743. Despite that trend the applicants project emergency department visits to grow very modestly beginning in FY2019 (attributing the growth to population growth), and projects that UC FMF will see 27,106 emergency department visits in its first year of operation (FY2022) and 27,348 emergency department visits by FY 2024.

Table III-4: Actual and Projected ED Visits, Harford Memorial Hospital and UC FMF

	Actual HMH ED			Projected HMH ED			Projected UC FMF		
	2016	2017	2018	2019	2020	2021	2022	2023	2024
Total visits*	29,520	28,356	26,743	26,862	26,981	27,101	27,106	27,227	27,348

Source: (DI #30, p. 30 and Table F). * Patients with behavioral health diagnoses made up an average of 6.9% of annual visits at HMH; that patient population is projected to account for 7% (approximately 1,900 visits annually) in the projected years shown. .

Pointing out that its ED visit volume (excluding behavioral health patients) will range between the 25,000 and 30,000 annual visits, the applicant asserts that its proposed twenty (20) general ED treatment rooms is justified at that volume because "the general emergency department treatment space is within the ACEP Guide's 'low range' and 'high range' guidelines for 27,000 visits per year." (DI #30, pp.30, 31).

The applicants explained their rationale for a proposed five-bed behavioral health unit citing factors such as: an average length of stay of 9.8 hours (data from 2016, 2017, and 2018); a

clustering of behavioral health ED visits between 12 p.m. and 8 p.m. (56% of visits); and a need to plan for peak rather than average utilization. The applicants state that they:

> acknowledge that the five behavioral health treatment spaces will not be in peak demand all of the time. Because psychiatric patients are projected to be 7.0% of UC FMF's emergency department visits, to meet the peak demand, there is a need for five (5) behavioral health treatment spaces, including four (4) standard treatment rooms and one (1) isolation room, or twenty percent (20%) of the total twenty-five (25) treatment spaces in the UC FMF overall emergency department. (DI #30, p.34).

Further justifying its plans, the applicants also noted that the ACEP Guidelines state that "7% or over for behavioral health would be considered high, and you might develop special areas or suites for these specialty patients." (DI #30, p.32).

Emergency Department Square Footage

The applicants state that the space allotted for emergency services will be 19,211 DGSF, which includes the 3,408 DGSF allocated to the behavioral health emergency department crisis unit. Excluded from this calculation are administrative space, imaging, laboratory, and observation services. The general and behavioral health treatment rooms are between 115 and 142 square feet and special use treatment rooms are between 182 and 329 square feet. (DI #30, pp. 30-31 and Exh. 1, Table B).

The applicants note that ACEP calls its Guidelines a "starting point" for emergency department planning with "general guideline[s]" to be used for internal planning to set "preliminary benchmarks for sizing emergency departments," which can be adjusted for "each unique emergency department project" and that the size parameters are merely "estimates." The applicants further note that ACEP states that there is "no magic formula" to determine the correct number of emergency treatment rooms or square footage. The applicant also points to ACEP's statements that it "can't reduce space programming to 'one size fits all' " and "there are too many variables to consider." (ACEP Guidelines, pp. 106-109). (DI #30, p.31).

Staff Analysis

Staff concludes that the number of ED treatment rooms can be justified by the percentage of the applicants' patient population with a behavioral health diagnosis, which, according to ACEP, "would be considered high, and you might develop special areas or suites for these specialty patients." A facility plan that did not include a separate unit for these patients but instead simply built to the projected volume (27,000+ visits) would require about 20 treatment rooms at "low range" and 23 rooms at "high range. This is not far from what the applicants propose, and, considering their concern to meet the peak demand for behavioral health patients, seems to be reasonable. Similarly, the proposed amount of treatment space fits within the ACEP Guidelines.

Therefore staff recommends that the Commission find that the proposed FMF is consistent with each of these parts of the standard, based on a judgment that the applicants' number of

treatment spaces (25) and square footage (19,211 square feet) do not deviate significantly from the range guidance of ACEP.

(e) Demonstrate that the proposed number and size of observation spaces for the FMF are consistent with applicable guidance included in the most current edition of Emergency Department Design: A Practical Guide to Planning for the Future, published by the American College of Emergency Physicians, based on reasonably projected levels of visit volume and average patient time in observation spaces.

(i) Demonstrate that the FMF will achieve at least 1,100 visits per year per observation space, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of observation spaces;

(ii) Demonstrate that the size of each observation space does not exceed 140 square feet, exclusive of any toilet or bathing area incorporated into an individual observation space, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for larger observation spaces.

To provide context for the discussion under these subparts of the standard, the ACEP Guidelines make the following statements regarding the annual capacity, and appropriate sizing of, an observation space:

- [G]enerally program[s] [clinical decision unit or observation] spaces in the range of 900 to 1,100 patients per space annually. Use the lower number if your patients use the [clinical decision unit] for 12+ hours, and use the higher number if your patients use the space for 8 to 12 hours. (ACEP Guidelines, p. 272).

- The ACEP Guidelines generally recommend a square footage range of 135 to 150 SF for each observation room (ACEP Guide, p. 157), but also state that, "if you decide to equip the [observation] rooms with standard inpatient hospital beds, you'll need larger rooms – 150 to 160 [square feet]." (ACEP Guidelines, p. 271).

The applicants provided the historical and projected observation utilization data shown in Table III-5 below.

Observation Cases

The applicants project approximately 3,800 observation stays by the third year of FMF operation, somewhat fewer than HMH currently experiences. They attribute the decreased use of observation status, projected to begin in FY2020, to "implementation of clinical practices that could better align UM UCH's observation use rates with an identified peer group of hospitals." The slight increase (0.6%) beginning in 2022 is attributed to population growth. (DI #30, pp. 46-47).

Average Length of Stay (ALOS) and Observation Patient Days

The applicants maintain that the ALOS reported for HMH in Table III-5 below is systematically understated because billing requirements for patients that are eventually admitted, provide that "only those observation hours that occurred prior to 12:00 am of the day of admission can be billed." At the FMF (beginning in FY2022) a distinct observation unit will exist and thus the full length of stay will be captured. Observation patient days (Observation cases x ALOS) are projected to total approximately 4,300-4,400 in the third year of FMF operation. (DI #30, p. 49).

Average Daily Census (ADC) and Bed Need

Total observation patient days divided by 365 yields the average daily census (ADC), which the applicants project to be 12 patients in the third year of operation. From there the applicant applied a target occupancy rate of 70% to calculate a bed need of 17.[2]

Table III-6. Historical and Projected Observation Cases, HMH and UC FMF FY 2016 to FY 2024

	Actual at HMH			Projected at HMH			Projected at HMH		
	2016	2017	2018	2019	2020	2021	2022	2023	2024
Observation cases	3,896	4,019	4,443	4,458	4,210	3,697	3,718	3,740	3,763
Avg. length of stay (days)	1.20	1.20	1.08	1.08	1.21	1.11	1.16	1.16	1.16
Observation patient days	4,670	4,813	4,788	4,802	5,101	4,109	4,298	4,324	4,350
Average daily census	12.8	13	13	13	14	11	12	12	12
Bed occupancy target	80%	80%	80%	80%	80%	80%	70%	70%	70%
Bed need	16	16	16	16	17	14	17	17	17

Source: (DI #30, p. 46 - 51).

Room Size

Regarding room size, the applicants cite: a length of stay that is "significantly longer than the ACEP Guide considers,"[3] up to 48 hours and, as a result, "the observation unit has been planned to use standard inpatient hospital beds rather than gurneys." As the FMF will have no inpatient beds in which to admit patients the observation rooms have been designed to facilitate "a comfortable patient stay and to allow visitors." For these reasons, it proposes 13 observation rooms sized between 173 and 182 SF, one isolation observation room at 198 SF, one bariatric observation room at 233 SF, and two slightly larger observation rooms, sized as a result of their location in the building at approximately 200 SF, exclusive of in-room toilet and bathing areas. (DI #30, p. 51, Exh. 2).

[2] The applicants stated that they used the State Health Plan target occupancy assumption of 80% for HMH's MSGA services with an ADC of 50-99 patients (State Health Plan for Acute Care Hospital Services, COMAR 10.24.07) to project the number of observation beds that would be needed in a distinct, dedicated unit at HMH. As the FMF comes on line in 2022, the applicants used a target occupancy assumption of 70% for MSGA services with an ADC of less than 50 patients (State Health Plan for Acute Care Hospital Services, COMAR 10.24.07) to project the number of observation beds needed at the UC FMF. (DI #30, p. 50).

[3] ACEP considers stays between 8 and 12 hours when creating its guidance. As stated in Table III-6 above, UC FMF projects an ALOS of 1.16 days

Staff Analysis

The 17 observation rooms proposed are significantly more than the guidance offered by Subparagraph (e)(i) of this standard would indicate, requiring that the FMF achieve at least 1,100 visits per year per space (i.e., three patients a day). In its initial set of reviews of proposed FMF conversions, MHCC staff noted that this standard is unrealistic for the patient population of observation patients now "observed" at hospitals. This population has grown substantially in the last ten years, because of changes in regulation of hospital charges, and, in most hospitals, admission of patients for short hospital stays as inpatients has correspondingly declined. It is staff's belief that the ACEP guidance presumes that the "typical" patient envisioned in the Guidelines is served in a hospital ED setting, has a much shorter observation stay, likely because they would be transferred to a hospital bed as either an inpatient or longer-term observation status. Thus a more reasonable method to project bed need is to project the percentage of patients who would require observation stays, identify the ALOS, and project an average daily census and bed need to accommodate it.

Thus, the applicants rely on the exception language in the standard which permits a larger number of observation spaces if the applicant demonstrates need "based on the particular characteristics of the population to be served ...." Accordingly, the applicants presented data for HMH's current observation patients that shows an actual ALOS for these patients that far exceeds what is implicit in the ACEP prescription of 1,100 visits per year per space. In projecting forward, UC FMF's ALOS remains stable. The target occupancy rate the applicants used to project the number of beds needed, at 70%, does not appear unreasonable. Staff concludes that deviation from the ACEP guidance in considering the need for observation beds at the proposed FMF is logical. Staff also notes that the applicants reduced their proposed capacity from 24 observation rooms to 17 after being questioned by staff on some of the underlying assumptions in their projection methodology.

While the size of the observation rooms is somewhat larger than that specified by the standard and the ACEP Guidelines on which it is based, staff concludes that the fact that the ALOS is obviously much longer than assumed in the ACEP Guidelines explains and justifies the additional space.

Staff recommends that the Commission find that UC FMF's proposed number and size of observation spaces is consistent with this standard, based on the applicants' explanation of the nature of the service and the characteristics of the population to be served.

(f) Provide utilization, revenue, and expense projections for the FMF, along with a comprehensive statement of the assumptions used to develop the projections, and demonstrate that:

(i) The utilization projections are consistent with observed historic trends in ED use by the population in the FMF's projected service area;

The applicants have projected future utilization based on the recent usage of the HMH emergency department, assuming that the residents of HMH's service area will continue to come to UC FMF when experiencing emergency health conditions, with the exception of the small

proportion of Emergency Severity Index (ESI) Treatment Level 1 patients. The projection also adjusted for annual population growth of 0.4%.

Table III-7: Historic and Projected ED Patient Visits for HMH and Projected Patient Visits for UC FMF

	Historic Visits – HMH ED			Projected Visits – HMH ED			Projected Visits - UC FMF		
	2016	2017	2018	2019	2020	2021	2022	2023	2024
Visits	29,520	28,356	26,743	26,862	26,981	27,101	27,106	27,227	27,348
Change	-	-3.9%	-5.7%	0.4%	0.4%	0.4%	0.0%	0.4%	0.4%

Source: (DI #30, p. 54).

To support the flattening out of visit volume and a return to growth in visit volume they projects, the applicants cite their assumption that a majority of the residents of the defined service area will come to the new UC FMF when experiencing emergency health conditions. The applicants support this assumption by noting the following factors: UCHS will implement an Acute Stroke Ready Pilot and MIEMMS protocol change allowing certain stroke patients to be transported to the UC FMF; the Aberdeen FMF will be more accessible than HMH to Interstate 95 and this will likely result in increased walk-in visits; and ongoing efforts to educate the community about how to use the UC FMF campus and its services.

Staff concludes that the applicants' utilization projections are not consistent with the trend in gradually declining ED use over the last ten years at HMH, the ED use most clearly reflective of the defined service area population of the FMF. The projections assume that a period of substantial decline at the HMH ED has ended and that modest growth in visit volume is now occurring and will continue as the FMF replaces the HMH ED. As noted in the preceding paragraph, the applicants have described why they believes this reversal of recent trends is taking place and will continue.be replaced with modest growth.

(ii) The utilization projections for rate-regulated outpatient services under Health-General Article §19-201(d)(ii) and (iv) and COMAR 10.37.10.07-2 are consistent with the observed historic trends by the population in the FMF's projected service area.

The utilization projections for observation stays at the FMF shown in Table III-8 below reflect a continuation of historic trends in the use of observation stays, modified to reflect a projected 5.6% reduction in the number of projected observation cases at HMH in fiscal year 2020 followed by another 12.2% reduction in fiscal year 2021. The applicants assume that changes to clinical protocols that the applicants are making will result in earlier decision-making regarding whether an ED patient should be discharged or admitted, resulting in fewer being put in observation status. Observation cases are projected to increase after the FMF goes into operation.

As a result, the applicants expect that there will be 15.3% fewer observation cases at UC FMF in fiscal year 2024 than occurred at HMH in fiscal year 2018. (DI #30, pp. 47, 56).

Table III-8: Historic and Projected Observation Cases for the HMH ED and Projected Observation Cases for the UC FMF

	Historic Visits – HMH ED			Projected Visits – HMH ED			Projected Visits - UC FMF		
	2016	2017	2018	2019	2020	2021	2022	2023	2024
Observation cases	3,896	4,019	4,443	4,458	4,210	3,697	3,718	3,740	3,763
Change	3.6%	3.2%	10.5%	0.3%	-5.6%	-12.2%	0.6%	0.6%	0.6%

Source: (DI #30, p. 47).

The applicants also projected use of laboratory and imaging services to change in proportion to the projections it has made for emergency visits and observation admission at the use rates per visit and admission for these ancillary services that are currently experienced. (DI #30, p. 56).

Staff concludes that the application meets this standard.

(iii) The revenue estimates for emergency services and other outpatient services specified by the HSCRC under Health-General Article §19-201(d)(iv) and COMAR 10.37.10.07-2 are consistent with utilization projections and the most recent HSCRC payment policies for FMFs;

HSCRC staff stated that it considers the projected revenue estimates to be reasonable and consistent with the HSCRC payment policies for FMFs. (DI #55, p. 2).

Staff concludes that the this standard has been met.

(iv) The staffing assumptions and expense projections for emergency services and any other rate-regulated outpatient services under Health-General Article §19-201(d)(ii) and (iv) and COMAR 10.37.10.07-2 are based on current expenditure levels, utilization projections, and staffing levels experienced by the applicant hospital's ED and with the recent experience of similar FMFs; and

The applicants state that the projected staffing of UC FMF reflects the small changes in volumes it projected, as well as assumptions related to expense inflation, expense variability with changes in volumes. (DI #30, p. 56, Exh. 1, Table L).

Staff concludes that the applicants meet the requirements of Subparagraph (f)(iv).

(v) Within three years of opening, the combined FMF and parent hospital will generate net positive operating income.

UC FMF and its parent hospital, UCMC, are projected to generate a net operating income of approximately $27.99 million in fiscal year 2024, which will be their third year of operation. (DI #56).

The proposed project meets Subparagraph (f)(v) of the standard.

(g) Demonstrate that each operating room at the FMF will be utilized at an optimal level within three years consistent with the standards in COMAR 10.24.11 for operating room capacity and needs assessment for dedicated outpatient operating rooms and that the design is consistent with requirements in COMAR 10.24.11 for health care facilities with surgical capacity.

This standard is not applicable since there are no operating rooms proposed in this request.

(h) Demonstrate that the proposed construction cost of the FMF is reasonable and consistent with current industry cost experience in Maryland, as provided in Regulation .04B(5) of this chapter.

This standard requires a comparison of the project's estimated construction cost, adjusted for specific construction characteristics of the proposed project, with an index cost (i.e., an expected cost) derived from the Marshall Valuation Service ("MVS"). The MVS methodology allows for a variety of adjustment factors related to the specific circumstances of the project, e.g., timing of the project, the locality, the number of stories, height per story, shape of the building (e.g., the relationship of floor size to perimeter), and departmental use of space.

The applicant's calculation yielded an adjusted project cost estimate of $427.46 per SF.

Staff calculated the MVS benchmark cost to be $416.90 as shown in Table III-9 below. Thus, the projected cost of the project is $10.56 (2.5%) per SF above the calculated MVS benchmark cost.

Table III-9: MHCC Staff Calculation of Marshall Valuation Service Benchmark, UC FMF

Construction Class/Quality	Class A/Good
Number of Stories	2
Square Feet	69,343
Perimeter	813
Average Floor to Floor Height	14.8
Base Cost per SF	$398.00
Elevator Add On	$0
Adjusted Cost per SF	$398.00
Adjustments for Dept. Cost Differences	1.03
Gross Base Cost per SF	$409.94
Multipliers	
Perimeter Multiplier	0.906
Height Multiplier	1.05
Multi-Story Multiplier	1.0
Refined Cost per SF	$389.98
Sprinklers	$3.33
Adjusted Refine SF Cost	$393.31
Update Location Multipliers	
Current Cost Multiplier	1.05
Location Multiplier	1.06
Final Benchmark MVS Cost per SF	$416.90

Source: DI #30 pp. 57-62

This standard requires that any rate increase proposed by the hospital related to the capital cost of the project "shall not include the amount of project construction costs that exceeds the MVS benchmark and those portions of the contingency allowance, inflation allowance and capital construction interest that are based on the excess construction cost." Since the MVS costs already include capital construction interest, the excess construction cost only needs to be adjusted for the contingency and inflation allowances. Staff has apportioned the costs shown in Table III-9, above, by the percentage that the applicant's estimates exceed the MVS benchmark (2.5%) calculated by staff. The resulting exclusion is shown in the following Table III-10. (DI #30, pp. 57-62).

Table III-10: Calculation of Excess Project Cost

Construction cost exceeding benchmark ($10.56 x 69,343 SF)	$732,262
The portion of future inflation that should be excluded ($1,533,141 x 2.5%)	$38,328
The portion of the contingencies that should be excluded ($3,777,853 x 2.5%)	$94,446
Total to be excluded from any rate increase proposed by the hospital related to the capital cost of the project	**$865,036**

Based on this analysis, staff recommends that, if the Commission approves the proposed conversion to an FMF, approval of the project should be accompanied by the following condition:

> Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $865,036. This figure includes the estimated new construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

(i) Demonstrate that the conversion to an FMF will result in the delivery of more efficient and effective health care services including an explanation of why the services proposed for the FMF cannot be provided at other area hospital EDs, FMFs, or other health care facilities, and demonstrate why other less expensive models of care delivery cannot meet the needs of the population to be served.

As discussed earlier in this staff report, the applicants point out that there are no acute general hospitals with emergency departments or other FMFs in UC FMF's projected service area. UCMC is the closest hospital emergency department, and the applicants state that UCMC "would not be in a position to absorb even a significant fraction of this volume of emergency department visits without its own substantial emergency department expansion project and associated capital expenditures." (DI #30, pp. 62-63). The other options would be Union Hospital of Cecil County and MedStar Franklin Square Medical Center, approximately 22 and 23 miles, respectively, from UC FMF. (DI #30, p. 24).

The area's urgent care centers are not set up to accommodate the emergency services currently provided by HMH. Most importantly, 72% of the patients visiting HMH's emergency

department in 2018 fell within an Emergency Severity Index (ESI) Treatment Level (1 - 3) which could not be successfully transitioned to an urgent care center. Secondarily, none of the urgent care centers operate 24 hours per day: seven of the nine close at 8 p.m.; and the other two at 10 p.m.

Staff concludes that the applicants have demonstrated that other hospitals are not in a position to absorb HMH's emergency patients, and that less expensive models of care delivery cannot meet the needs of the population to be served, and thus recommends that the Commission find that the applicants meet the requirements of Paragraph (i).

(j) Demonstrate that the conversion is in the public interest, based on an assessment of the converting hospital's long-term viability as a general hospital through addressing such matters as:

(i) Trends in the hospital's inpatient utilization for the previous five years in the context of statewide trends;

(ii) The financial performance of the hospital over the past five years and in the context of the statewide financial performance of Maryland hospitals;

The applicants submitted the information displayed in Table III-11 to illustrate HMH's utilization trends and financial performance trends.

Table III-11: HMH Admissions Compared to Statewide Average Admissions 2013-2017

		2013	2014	2015	2016	2017	2013-2017 Change
Admissions	HMH	4,727	4,693	4,174	4,384	4,429	(6.3%)
	Maryland Hospitals	619,128	518,573	570,988	564,345	551,978	(10.8%)
Operating Margin	HMH	5.0%	10.5%	10.0%	8.3%	5.9%	
	Statewide Avg.	1.3%	3.1%	3.7%	3.3%	2.8%	

Source: (DI #30, Tables 31 and 32, p. 64).

The applicants noted that HMH's performance in both utilization and operating margin outperformed the average of Maryland hospitals. However, the applicants maintained that, despite such performance, HMH has outlived the useful life of its physical plant, and that long-term operation of HMH would require significant capital improvements estimated at well over $2 million to bring the entire facility to modern standards. The applicants state that HMH would not continue to generate such operating margins after absorbing the cost of such a renovation project. (DI # 30, p. 64).

(iii) The age of the physical plant relative to other Maryland hospitals and the investment required to maintain and modernize the physical plant;

Table III-12 below reflects the average age of HMH's physical plant between 2012 and 2016 compared to the statewide average. HMH's average age of physical plant ranges from 15.7 years to 18.9 years over this period and the statewide average ranges from 10.8 years to 12.7 years over the same period.

The applicants state that HMH would require approximately $100 million in capital expenditures to modernize its physical plant in order for it to achieve the statewide average. (DI #30, pp. 64-65).

Table III-12: HMH Average Age of Plant Compared to Statewide Average 2012-2016

	2012	2013	2014	2015	2016
HMH	18.3	18.9	16.7	15.7	18.8
Statewide Average	12.0	11.2	12.7	12.0	10.8

Source: (DI #30, Table 33, p. 65).

(iv) The availability of alternative sources for acute care inpatient and outpatient services that will no longer be provided on the campus after conversion to a freestanding medical facility; and

As discussed at the beginning of this staff report, the applicants simultaneously submitted a CON application to establish a special psychiatric hospital which will provide the inpatient and outpatient behavioral health services that will no longer be provided by HMH. They also requested for exemption from CON review to relocate MSGA beds from HMH to UCMC and add a 30-bed MSGA unit and a dedicated 42-bed observation unit in space constructed at that hospital.

The applicants plan to renovate an existing medical office building at the UC FMF campus to house primary and specialty care physician practices. This will provide the public with access to medical providers that are currently in HMH's service area, including: (1) primary and specialty care physician practices; (2) rehabilitation services (physical, occupational, and speech therapy); (3) outpatient infusion services (currently not offered at HMH); (4) imaging; and (5) laboratory services. (DI #30, pp. 65-66).

(iv) The adequacy and appropriateness of the hospital's transition plan.

The applicants state that their transition planning flowed from the key elements in the initiative to reconfigure and modernize the UCHS delivery system – i.e., transitioning emergency and observation services from HMH to UC FMF; establishing the special psychiatric hospital and needed outpatient behavioral health services; relocating acute inpatient MSGA beds from HMH to UCMC; and developing other outpatient services at UC Medical Campus at Aberdeen. The applicants noted that their transition plan had two essential elements: (1) plan for job retraining and placement of HMH employees; and (2) plan for the existing HMH physical plant.

The applicants state that they began transition planning with a projection of the workforce needs of UC FMF, UC Behavioral Health, and the acute services at the UCMC. That projection will inform the plan for job retraining and placement of HMH employees. The plan will include

identification of alternative employment opportunities associated with the medical office building that will be developed at UC Medical Campus at Aberdeen where a wide array of outpatient ambulatory services will be provided in conjunction with primary and specialty care physician practices. UCHS also plans to implement a Workforce Planning workgroup comprised of internal and external stakeholders including the Susquehanna Workforce Network, the Harford County Government, and Harford Community College.

Regarding the existing HMH physical plant, the applicants state that UCHS has consulted with a commercial real estate firm, which "has concluded that the site would be attractive to investors and developers as a multi-phase, master-planned development that could provide a significant economic development benefits to the City of Havre de Grace and the surrounding community, and thus achieve the important shared goals for re-use of the property – maximizing financial returns and enhancing the second generation use of the property for the community's benefit." (DI #30, pp. 66-67).

Summary regarding requirements in Paragraph J(i) - (v)

Staff concludes that the applicants have demonstrated that the conversion of Harford Memorial Hospital to an FMF is in the public interest. Despite reasonably successful recent operations, the HMH physical plant has outlived its useful life and does not meet current standards. Efforts to modernize it on site would be expensive and challenging, given its current site. The applicants have developed a plan to replace the services provided by HMH and has developed an appropriate transition plan. Staff recommends that the Commission find that the applicants have met this standard.

(k) Demonstrate that the conversion is in the public interest, based on an assessment of the parent hospital's projected financial performance or the projected financial performance of the parent hospital and other health care facilities that share a global budget with the parent hospital.

Although the proposed FMF is projected to incur operating losses totaling of approximately $1.7 to $2 million annually in fiscal years 2022 to 2024, its parent hospital, UCMC, has shown a healthy margin in recent years and projects to continue that going forward. The applicants state that "[t]he assumed retention of HMH's GBR will enable UCMC to absorb the addition of depreciation and interest expenses associated with UC FMF." (DI #30, p. 67).

UCHS's negotiations with HSCRC resulted in an agreement on a GBR that would save rate-payers approximately $10 million in the first year of operation, and about $15 million annually after that. (DI#51a).

(9) The Commission shall grant a requested exemption from Certificate of Need within 60 days of receipt of a complete notice of intent from a general hospital to convert to a freestanding medical facility if the Commission, in its sole discretion, finds that the action proposed:

(a) Is consistent with the State Health Plan;

Based on the information contained in this staff report, staff recommends that the Commission find that the proposed conversion is consistent with the State Health Plan.

(b) Will result in more efficient and effective delivery of health care services;

Please see the discussion above, at Subparagraph 8(i), *supra*, at pages 26-27, which staff concluded demonstrates conformance with this part of the standard.

(c) Will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system as determined by the State Emergency Medical Services Board; and

A positive determination on this criterion was made by the State EMS Board. *See* Appendix 4.

(d) Is in the public interest.

Please see the discussion at 8(j)(i-v), *supra*, at pages 26-27, and (k) *supra*, at page 29, in which staff concluded demonstrates that the proposed conversion is in the public interest.

(10) If a general hospital decides that it will close because the Commission denied its request for exemption from Certificate of Need to convert to a freestanding medical facility or because its conversion request was not considered by the Commission as the result of a determination by the State Emergency Medical Services Board that conversion to an FMF would not maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system, the hospital must provide the notice of closure and hold the public informational hearing required by Health-General §19-120 and Commission regulations adopted pursuant to the statute.

This requirement is not applicable in this review unless the request for an exemption from CON is denied.

IV. SUMMARY AND STAFF RECOMMENDATION

MHCC staff concludes that the request complies with the applicable standards established for such conversions. As required by Maryland law, both the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and the Health Services Cost Review Commission have provided input to MHCC that is supportive of the proposed hospital transition to an FMF. According to MIEMMS, the transition of HMH to an FMF is not anticipated to cause a disruption in the availability and accessibility of emergency medical services that poses a threat to public safety or health care delivery. In addition, HSCRC has agreed to provide rate regulation to the FMF emergency and observation services and has determined that the proposal would be financially feasible as a component of UCHS.

Finally, MHCC staff concludes that this reconfiguration of services will help establish a more efficient and effective health care delivery system in Harford County. Access to emergency

and urgent care will be retained in the HMH service area. The proposed consolidation of medical/surgical inpatient care into a single general hospital should produce economies of scale in producing these services. HSCRC estimates that the suite of projects proposed by UCHS will save rate-payers almost $10 million in the first year of implementation, and about $15 million annually beginning in year three.

MHCC staff recommends that the Maryland Health Care Commission **APPROVE** the proposed conversion of University of Maryland Harford Memorial Hospital to a freestanding medical facility, with the following condition:

> Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $865,036. This figure includes the estimated new construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

IN THE MATTER OF	*	**BEFORE THE**
CONVERSION OF	*	**MARYLAND**
UNIVERSITY OF MARYLAND	*	**HEALTH CARE**
HARFORD MEMORIAL HOSPITAL TO A	*	**COMMISSION**
FREESTANDING MEDICAL FACILITY	*	
Docket No. 17-12-EX004	*	

* *

FINAL ORDER

Based on the Commission staff's analysis and recommendation, it is this 16th day of April, 2020, **ORDERED**:

That the request for an exemption from Certificate of Need to convert the University of Maryland Harford Memorial Hospital to a freestanding medical facility, at an approved expenditure of $56,665,400, involving initiation of freestanding medical facility operations in the new building, which will include 25 emergency treatment spaces and 17 observation beds in single occupancy rooms, and will include rate regulation of emergency services, observation services, related ancillary services, and other services as ordered by the Health Services Cost Review Commission, is **APPROVED,** subject to the following condition:

> Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $865,036. This figure includes the estimated new construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

MARYLAND HEALTH CARE COMMISSION

Appendix 1: FMF Background

A freestanding medical facility, or FMF, is a type of health care facility that was first established in Maryland by a legislatively approved pilot project in 2005. For the next ten years FMFs operated only as pilot projects, subject to study by MHCC and subsequent legislative action. Legislative changes that became effective in 2015 required Certificate of Need (CON) review to establish an FMF, followed by 2016 legislation that granted the Commission authority to issue an exemption from CON for the conversion of an acute general hospital to an FMF.[4]

As defined in regulation at COMAR 10.24.19.05B(8), a freestanding medical facility (FMF) is an outpatient health care facility that provides medical and health care services, and is:

- An administrative part of an associated acute care general hospital;
- Is physically separated from the hospital or hospital grounds;
- Operates 24 hours a day, seven days a week;
- Complies with the provisions of the Emergency Medical Treatment and Active Labor Act[5] and the Medicare Conditions of Participation;
- Has the ability to rapidly transfer complex cases to an acute care general hospital after the patient has been stabilized;
- Maintains adequate and appropriate delivery of emergency medical care within the statewide emergency medical services system as determined by the Maryland State Emergency Medical Services Board; and
- May provide observation services.

In other states this type of facility is commonly called a "freestanding emergency center."

The Commission has granted three exemptions from CON to create an FMF as a rate-regulated facility within a hospital system to replace a general hospital; this proposal from UCHS is the fourth. The others were in Laurel, Cambridge, and Crisfield.

[4] In 2016, Maryland law was amended to permit an acute general hospital that is part of a multi-hospital system to transition from a general hospital to a FMF through an exemption from CON review, a review process that requires approval by the Commission but, unlike CON review, does not permit interested parties, thereby limiting the possibility for judicial appeal. COMAR 10.24.19: State Health Plan for Facilities and Services: Freestanding Medical Facilities (FMF Chapter) governs (a) the establishment of an FMF through Certificate of Need (CON) review or, (b) the conversion of an acute general hospital to a FMF, through an exemption from CON review.

[5] Known as EMTALA, 42 U.S.C. §1395.

Appendix 2: Project Budget

Estimated Project Budget

USES OF FUNDS	
New Construction	
Building	$24,080,085
Fixed Equipment	
Site and Infrastructure	$1,628,964
Architect/Engineering Fees	$2,430,586
Permits (Building, Utilities, Etc.)	$946,453
SUBTOTAL – NEW CONSTRUCTION	**$29,086,088**
Other Capital Costs	
Movable Equipment	$8,450,287
Contingency Allowance	$3,777,853
Gross interest during construction period	$4,764,777
Other	
SUBTOTAL – OTHER CAPITAL	**$16,992,917**
TOTAL CURRENT CAPITAL COSTS	**$46,079,005**
Land Purchase	$2,197,329
Inflation Allowance	$1,533,141
TOTAL CAPITAL COSTS	**$49,809,475**
Financing Cost and Other Cash Requirements	
Loan Placement Fees	$540,584
CON Application Assistance	
c1. Legal Fees	$110,322
c2. Other	$884,309
Non-CON Consulting Fees	
d1. Legal Fees	$227,508
d2. Other (Specify/add rows if needed)	$1,181,081
Debt Service Reserve Fund	$3,912,121
SUBTOTAL	**$6,855,926**
TOTAL USES OF FUNDS	**$56,665,400**
SOURCES OF FUNDS	
Authorized Bonds	$55,517,385
Earned Interest on Trusteed Assets	$1,148,015
TOTAL SOURCES OF FUNDS	**$56,665,400**

Appendix 3: Summary of Second Public Meeting

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Executive Office
520 Upper Chesapeake Drive, Suite 405
Bel Air, MD 21014
443-643-3302 | 443-643-3334 FAX
uchs.org

December 27, 2018

VIA EMAIL & FEDEX

The Honorable Lawrence J. Hogan, Jr.
100 State Circle
Annapolis, Maryland 21401
Governor.mail@maryland.gov

The Honorable Thomas McLain Middleton
Chair, Senate Finance Committee
Miller Senate Office Building
3 East Wing
11 Bladen Street,
Annapolis, Maryland 21401
Thomas.mclain.middleton@senate.state.md.us

The Honorable Shane E. Pendergrass
Chair, House Health and Government Operations Committee
House Office Building, Room 241
6 Bladen Street
Annapolis, Maryland 21401
Shane.pendergrass@house.state.md.us

The Honorable Robert G. Cassilly
James Senate Office Building, Room 321
11 Bladen Street
Annapolis, Maryland 21401
Bob.cassilly@senate.state.md.us

The Honorable Glen Glass
House Office Building, Room 325
6 Bladen Street
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Glen.glass@house.state.md.us

The Honorable Mary Ann Lisanti
House Office Building, Room 415
6 Bladen Street
Annapolis, Maryland 21401
Maryann.lisanti@house.state.md.us

#649492v2
011888-0023

The Honorable Barry Glassman
Harford County Executive
Office of County Executive
County Office Building
220 South Main Street
Bel Air, Maryland 21014
countyexecutive@harfordcountymd.gov

The Honorable Patrick S. Vincenti
President, Harford County Council
County Council
212 South Bond Street, 1st floor
Bel Air, MD 21014
pvincenti@harfordcountycouncil.com

The Honorable Robert R. Neall
Secretary of Health
Office of Secretary
Maryland Department of Health
Herbert R. O'Conor State Office Building
201 West Preston Street
Baltimore, Maryland 21201
Robert.neall@maryland.gov

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
ben.steffen@maryland.gov

Russell W. Moy, M.D.
Acting Harford County Health Officer
P. O. Box 797
120 South Hays Street
Bel Air, Maryland 21014
russell.moy@maryland.gov

Re: Summary of Second Public Informational Hearing Regarding Conversion of University of Maryland Harford Memorial Hospital to a Freestanding Medical Facility

Dear Governor Hogan, Senators Middleton and Cassilly, Delegates Pendergrass, Glass, and Lisanti, County Executive Glassman, Councilman Slutzky, Mssrs. Shrader and Steffen, and Dr. Moy:

Pursuant to MARYLAND CODE, HEALTH-GENERAL § 19-120(l)(6) and Code of Maryland Regulations § 10.24.17.04(C)(3)(c)(iii), this letter and the accompanying enclosures provide a summary of the public informational hearing held by the University of Maryland Harford Memorial Hospital in connection with its notice of intent filed with the Maryland Health Care Commission to convert UM Harford Memorial Hospital to a freestanding medical facility.

As background, UM Harford Memorial Hospital and UM Upper Chesapeake Medical Center, as joint applicants (together "UM UCH"), filed a notice of intent and request for an exemption from certificate of need review to convert UM Harford Memorial Hospital to a freestanding medical facility with the Maryland Health Care Commission on August 4, 2017. These filings followed years of planning to develop a new and innovative model for efficient and effective health care delivery for the communities served by UM Upper Chesapeake Health System to address Harford Memorial Hospital's aging physical plant that has outlived its useful life, declining inpatient utilization, and recognized community health care needs. On November 21, 2018, UM UCH filed a modified request for exemption from Certificate of Need review to change the location of the proposed freestanding medical facility from Bulle Rock to Aberdeen, Maryland.

MARYLAND CODE, HEALTH-GENERAL § 19-120(l)(2) and Code of Maryland Regulations § 10.24.17.04(C)(3)(c)(ii) require that a hospital, within thirty days of filing a notice of intent to convert to a freestanding medical facility, hold a public informational hearing in the jurisdiction where the hospital is located. The public informational hearing must address: (1) the reasons for the proposed conversion; (2) plans for transitioning acute care services previously provided by the hospital to residents of the the hospital's service area; (3) plans for addressing the health care needs of residents of the hospital's service area; (4) plans of the hospital or the merged asset system that owns or controls the hospital for retraining and placement of displaced employees; (5) plans for the hospital's physical plant and site; and (6) the proposed timeline for the conversion. UM Harford Memorial Hospital held an initial public informational on August 30, 2017, beginning at 6:00 p.m., at the Level Volunteer Fire Company, 3633 Level Village Road, Havre de Grace, Harford County, Maryland. Within ten working days of holding the public

informational hearing, UM Harford Memorial Hospital provided a summary of the public hearing as required by statute and regulation.

While not required to do so pursuant to statute or regulation, UM UCH held a second public informational hearing on December 13, 2018, at the Aberdeen Fire Hall beginning at 6:00 p.m. in order to educate and inform the public concerning the changes in its plan to convert UM Harford Memorial Hospital to a freestanding medical facility, including the relocation of the proposed freestanding medical facility to Aberdeen, Maryland. At the hearing, UM UCH addressed each of the factors set forth in HEALTH GENERAL § 19-120(l)(2) and COMAR § 10.24.17.04(C)(3)(c)(ii).

Before holding the second public informational hearing, UM UCH, exceeded its regulatory obligations to ensure that the hearing was well attended. UM UCH published notice of the hearing date and location on its website's homepage and in the Maryland Daily Record print and electronic versions for no fewer than seventeen days. UM Upper Chespeake Health also purchased advertisements in the Harford County Aegis and Cecil County Whig announcing the date and location of the second public hearing.

The second public informational hearing lasted approximately two hours and was well attended. As President and Chief Executive Officer of UM UCH, I hosted the second public informational hearing. I began the public informational hearing by reviewing an electronic slide presentation that addressed each of the issues required by Maryland Health Care Commission's regulations. Among other things, the slide presentation focused on UM UCH's strategic plan to transform health care delivery in Harford and Cecil Counties. This plan includes conversion of UM Harford Memorial Hospital to a freestanding medical facility to be located on an approximate 35 acre parcel off of Maryland Route 22 in Aberdeen the development of a forty-bed special psychiatric hospital and medical office building on the same campus, and a three story addition to UM Upper Chesapaeake Medical Center in Bel Air. A copy of the electronic slide presentation is enclosed with this letter as Enclosure A and a transcript of the public informational hearing prepared by a court reporter retained by UM UCH is provided as Enclosure B.

Each person attending the public informational hearing was given an index card and encouraged to submit questions and/or comments. The index cards containing questions and comments were collected at the mid-point of the public hearing. Martha Mallonee, UM UCH's Director of Marketing and Communications, then facilitated a panel of UM UCH's team in responding to the public questions and comments. In addition to myself and Ms. Mallonee, the following persons participated on the panel responding to questions and comments at the public informational hearing:

1. Richard Lewis, M.D., Chair, Department of Psychiatry, UM Upper Chesapeake Health;
2. Robin Luxon, Senior Vice President, Corporate Planning, Marketing & Business Development, UM Upper Chesapeake Health;
3. Jason Brinbaum, M.D., Chair of the Department of Medicine, UM Upper Chespeake Health; and
4. Lisa Thomas, M.D., an Emergency Department physician at UM Harford Memorial Hospital.

In total, sixteen written questions and/or comments were received and answered at the public informational hearing.

Please contact me if you have any questions regarding the public informational hearing, the enclosed materials, or UM UCH's intent to convert UM Harford Memorial Hospital to a freestanding medical facility.

In Good Health,

Lyle E. Sheldon FACHE,
President and Chief Executive Officer
UM Upper Chesapeake Health System, Inc.

Enclosures

cc via email: **Senate Finance Committee**
The Honorable John C. Astle, Vice Chair,
The Honorable Joanne C. Benson
The Honorable Brian J. Feldman
The Honorable Stephen S. Hershey, Jr.
The Honorable J. B. Jennings
The Honorable Katherine A. Klausmeier
The Honorable James N. Mathias, Jr.
The Honorable Edward R. Reilly
The Honorable James C. Rosapepe
David A. Smulski, Staff

House Health and Government Operations Committee
The Honorable Eric M. Bromwell, Vice Chair
The Honorable Angela M. Angel
The Honorable Erek L. Barron
The Honorable Bonnie L. Cullison
The Honorable Antonio L. Hayes
The Honorable Terri L. Hill
The Honorable Ariana B. Kelly
The Honorable Nicholaus R. Kipke
The Honorable Susan W. Krebs
The Honorable Patrick L. McDonough
The Honorable Richard W. Metzgar
The Honorable Christian J. Miele
The Honorable Marice I. Morales
The Honorable Matt Morgan
The Honorable Joseline A. Pena-Melnyk
The Honorable Andrew Platt
The Honorable Samuel I. Rosenberg
The Honorable Sid A. Saab
The Honorable Sheree L. Sample-Hughes
The Honorable Kathy Szeliga
The Honorable Christopher R. West
The Honorable Karen Lewis Young
Erin R. Hopwood, Staff

Harford County Council
The Honorable Patrick S. Vincenti
The Honorable Joseph M. Woods,
The Honorable Andre V. Johnson
The Honorable Chad R. Shrodes
The Honorable Tony Giangiordano
The Honorable Curtis L. Beulah
The Honorable Robert S. Wagner

Richard L. Alcorta, M.D., FACHE, MIEMSS Acting Co-Executive Director
Patricia S. Gainer, J.D., MIEMSS Acting Co-Executive Director
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Kevin McDonald, Chief, Certificate of Need Program

Suellen Wideman, Esq., Assistant Attorney General
Joseph E. Hoffman III, Executive Vice President and Chief Financial Officer, UM UCHS
Robin Luxon, Senior Vice President, Corporate Planning, Marketing and Business Development, UM UCHS
Aaron Rabinowitz, Esq., Vice President and General Counsel, UM UCHS
Alison G. Brown, MPH, Senior Vice President and Chief Strategy Officer University of Maryland Medical System
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
James Buck, Gallagher, Evelius & Jones LLP

Appendix 4: MIEMSS Letters

State of Maryland

Maryland Institute for Emergency Medical Services Systems

653 West Pratt Street
Baltimore, Maryland
21201-1536

Larry Hogan
Governor

Donald L. DeVries, Jr., Esq.
Chairman
Emergency Medical Services Board

410-706-5074
FAX: 410-706-4768

October 12, 2017

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Steffen,

As you are aware, the University of Maryland Upper Chesapeake Medical Center, Inc. (UCMC) and University of Maryland Harford Memorial Hospital, Inc. (HMH) are seeking approval from the Maryland Health Care Commission to convert HMH to a freestanding medical facility, as well as for an exemption from Certificate of Need (CON) review for the proposed conversion.

The Maryland Health Care Commission will determine whether to approve the request for exemption from the CON requirement based on a number of factors, including whether the conversion "will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system as determined by the State Emergency Medical Services (EMS) Board." Health General 19-120 (o)(3)(i)5C. In making this determination, the State EMS Board is required to consider eleven (11) factors specified in regulation. COMAR 30.08.15.03.

Please be advised that at its meeting on October 10, 2017, the State EMS Board reviewed and discussed an analysis of the COMAR-enumerated factors. After consideration of these factors, the State EMS Board unanimously determined that the proposed conversion of HMH to a freestanding medical facility will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system. Attached is a copy of the analysis that provided the basis for the Board's determination.

Please let me know if you have any questions or if I may provide any further information.

Sincerely,

Patricia S. Gainer

Patricia S. Gainer, JD, MPA
Acting Co-Executive Director

Enclosure

Cc: Donald L. DeVries, Jr., Esq.
Chairman, State EMS Board

Lyle Sheldon, FACHE
President and Chief Executive Officer
University of Maryland Upper Chesapeake Health

20

State of Maryland

Maryland Institute for Emergency Medical Services Systems

653 West Pratt Street
Baltimore, Maryland
21201-1536

Larry Hogan
Governor

Donald L. DeVries, Jr., Esq.
Chairman
Emergency Medical Services Board

410-706-5074
FAX: 410-706-4768

February 7, 2019

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Steffen,

On October 10, 2017, the Emergency Medical Services Board made a determination that the conversion of Harford Memorial Hospital to a freestanding medical facility will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system as required by Health-General 19-120 (o)(3)(i) 5 C.

Subsequently, UM Harford Memorial Hospital and UM Upper Chesapeake Medical Center filed a modified request for exemption from CON review with the Maryland Health Care Commission after determining that the original site for the freestanding medical facility was no longer viable.

This letter is to confirm that the EMS Board discussed the new site at its meeting of August 14, 2018, and determined that the relocation to the new site five (5) miles from the original site was not a substantive change to the project and would not impact the factors that the Board is required to consider under COMAR 30.08.15.03. The Board, therefore, determined that there was no need to conduct another analysis of the project under COMAR 30.08.15.03.

Please let me know if you need additional information.

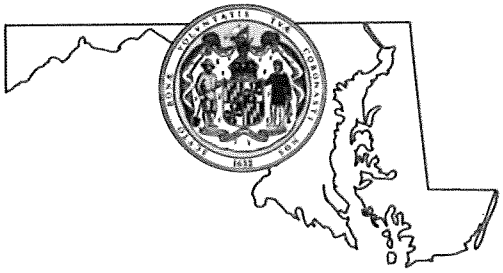
Sincerely,

Patricia A Gainer

Patricia Gainer, JD, MPA
Acting Executive Director

Appendix 5: HSCRC Opinion

State of Maryland
Department of Health



Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

MEMORANDUM

TO: Kevin McDonald, Chief - CON, MHCC

FROM: Katie Wunderlich, Executive Director, HSCRC
Jerry Schmith, Deputy Director, Hospital Rate Setting, HSCRC

DATE: March 17, 2020

RE: **University of Maryland Upper Chesapeake Health Projects:**
Modified Request for Merge/Consolidation UM UCMC and UM HMH, Matter No. 17-12-EX003
Modified Request to Convert UM HMH to an FMF in Aberdeen, Matter No. 17-12-EX004
Modified Certificate of Need for Special Psychiatric Hospital at Aberdeen Medical Center, Docket No. 18-12-2436

****

On March 5, 2020, MHCC sent a memo requesting HSCRC staff to review and comment on the financial feasibility of University of Maryland Upper Chesapeake Health System's (UCHS) three intertwined proposals. Because of their interdependence, HSCRC staff reviewed them as concurrent projects and understand that MHCC will act on them simultaneously.

As per the description in the March 5 memo, two projects involve requests for exemption from Certificate of Need (CON), while one is a CON application. One exemption request is to convert University of Maryland Harford Memorial Hospital (HMH) to a freestanding medical facility (FMF) to be built in Aberdeen, while the other is to merge and consolidate certain inpatient services from HMH with University of Maryland Upper Chesapeake Medical Center (UCMC). The third element of this package is a CON application to establish a Special Psychiatric Hospital in Aberdeen, which would occupy the second floor of a building, constructed above the first floor FMF. This facility would be the centerpiece of what Upper Chesapeake Health System is calling the "Aberdeen Medical Campus" (AMC).

According to the memo, the primary objectives of the project package are to reconfigure and modernize the UCHS's delivery system to enable the continuation of quality of care and to consolidate services for cost savings and efficiency. A brief description of each project follows:

Upper Chesapeake Behavioral Health at Aberdeen:

- approximately 75,000 square feet ("SF") of new construction;
- 33 beds and shell space that could eventually accommodate 7 more beds;
- Total project budget is just below $63 million.

FMF:

- 25 ED treatment spaces
- 17 observation rooms
- approximately 69,000SF of new construction (on the first floor of the building that would include the psychiatric hospital)
- a diagnostic imaging suite with related staff and support spaces;
- non-treatment spaces, including triage/blood draw rooms, consultation rooms, staff support spaces, and offices; and
- a laboratory and pharmacy;
- Total project budget is $56,665,400.

Addition at UCMC to accommodate merging of HMH services:

- addition of three floors above the current cancer center (approximately 98,000SF);
- a shelled floor to accommodate actual and anticipated cancer center growth;
- one floor with 42 observation beds;
- one floor with 30 medical/surgical beds;;
- Total project budget of $84.4 million.

UM UCHS will fund the total project as well as the other capital projects for which UM UCHS and its constituent hospitals have sought approval from MHCC through a combination of $214.3 million in tax exempt debt and $4.0 million of interest earned on bond proceeds. The bonds are anticipated to be issued in fiscal year 2020 through the University of Maryland Medical System.

In commenting on the revenue and expense projections and financial feasibility of the proposed project, MHCC staff advised HSCRC staff to assume that UM UCH will achieve the projected volumes for the FMF and psychiatric hospital, but that there is not sufficient need shown for the 30 additional inpatient beds in the merger.

HSCRC Staff Comments:

We have reviewed the financial projections presented by UCHS and numerous schedules and narratives in support of such projections. These projections were reviewed in the context of the individual projects and the collective UCHS system, with a focus on the regulated service entities while maintaining awareness of the unregulated service components. The main purpose of our review was to determine what level of revenue should be retained by the regulated entities of UCHS and to determine the financial feasibility of the resulting UCHS as a whole.

The proposed construction is to be complete, and the related services are to commence by fiscal 2023. At that time, the projected GBR equivalent of HMH is to be approximately $119,400,000. Based upon the data provided by UCHS, the volume of business previously conducted at HMH would be redirected as follows: approximately $43.8M to UCMC; $17.0M to the Special Psychiatric Hospital; $36.0M to the FMF; and $22.6M to other third party regulated hospitals or to unregulated components.

Of the $22.6M volume directed to other third party/unregulated, UCHS would be allowed to retain $11.3M in revenue. Of the remaining $96.8M volume directed to regulated UCHS entities, UCHS would

be allowed to retain $86.9M in revenue to be distributed among those entities, respectively. Therefore in total, UCHS would be allowed to retain $98.2M in GBR revenue.

The state-wide public health care system would save approximately $9.9M (gross reduction in retained GBR of $21.2M less $11.3M retained by UCHS). This would be coupled with approximately $4.7M of savings resulting from reduced Medicare reimbursement on billings from a standalone psychiatric hospital. Such reimbursement would not be based upon HSCRC rates as was approved at HMH, and which rates were paid by Medicare, but rather based upon the national Medicare fee schedule.

Financial Feasibility:

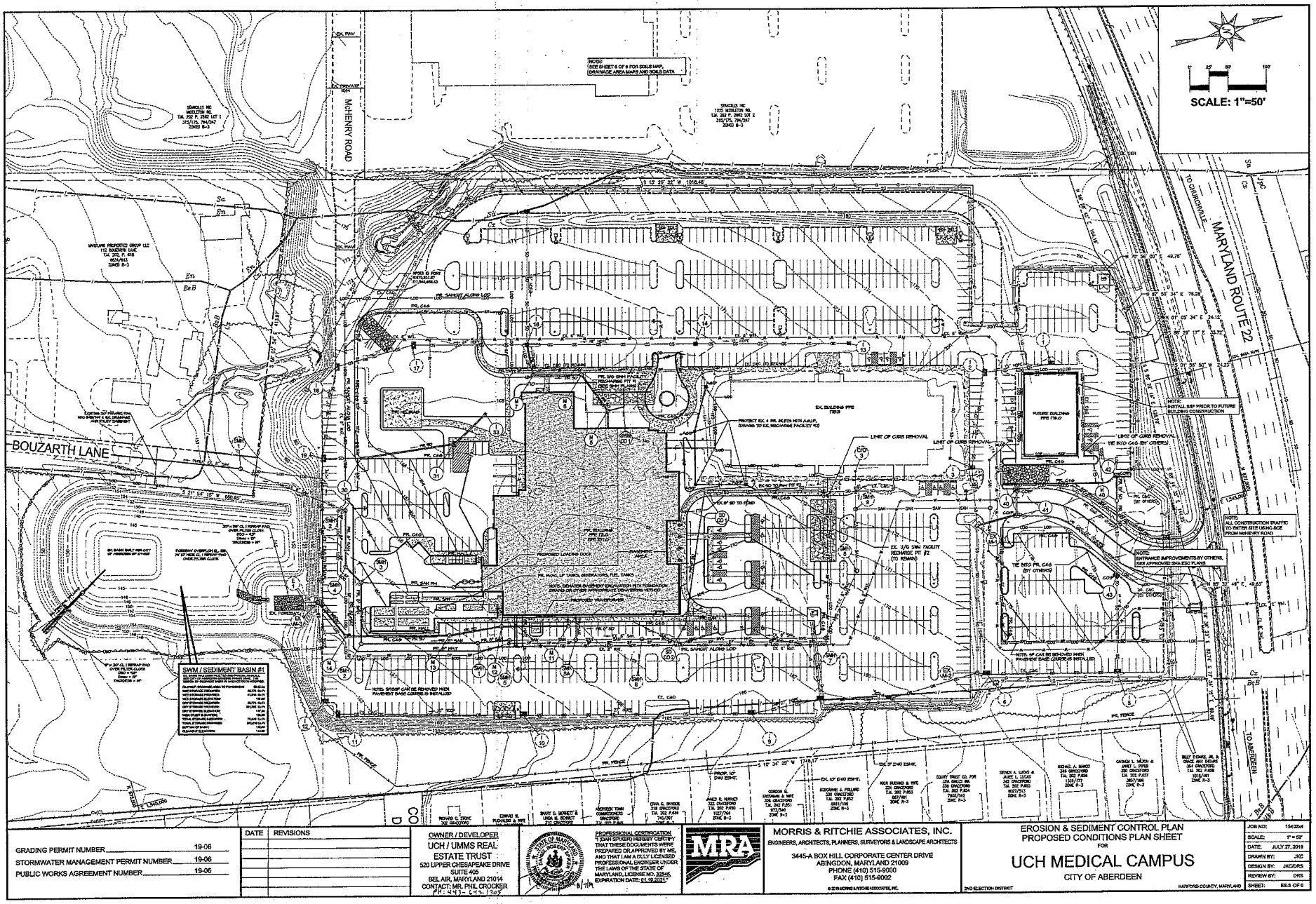
When the aforementioned $21.2M reduction in GBR revenue is applied to the 5-year projections (FY 2023 through FY 2027) the results imply the need to ramp up the reduction as follows: $15.2M in the first year of operations; $18.2M in the second year; and the full $21.2M in the third year of operations and forward. Focusing on the projected fifth year of operation (FY 2027) for the regulated entities (UCMC and AMC), gross patient revenues approximate $503M; net operating revenues approximate $425M; total operating expenses approximate $412M yielding an approximate $13M positive operating margin or 3%.

Although the HSCRC is focused upon regulated volumes, revenues and profitability, we noted the impact upon UCHS as a whole inclusive of UCHS owned physicians' practices and other UCHS owned but unregulated components. Again focusing on the fifth year of operation (FY 2027), the profit/loss was measured at a net loss of approximately $4M before non-operating income, which has averaged a positive $11M per year over the past three fiscal years, and averaged a positive $5M per year over the past five fiscal years. This implies that the UCHS system as a whole has the ability to absorb the planned reduction in GBR and remain profitable. We anticipate that UCHS will take full advantage of the current historically low interest rates on its financing needs, and that UCHS will continue to monitor and manage its operating costs. In addition, UCHS has the prerogative to amend its plans of financing this project should it wish to reduce the interest expense included in the projections. Further, UCHS has the prerogative to increase the shell space and defer certain of the fit-out should it wish to defer the depreciation expense included in the projections.

HSCRC staff believes that this project can be feasible. However, as is often the case, feasibility will depend on UCHS's ability to manage the project and the resulting operating expenses after the completion of the project. As pointed out, decisions on how to finance this project now will have an impact upon future operating margins. HSCRC staff believes that UCHS will make the decisions that they believe are appropriate in the future and that allow them to operate most efficiently.

cc: Ben Steffen, MHCC
Paul Parker, MHCC
Eric Baker, MHCC
Laura Hare, MHCC
Bob Gallion, HSCRC

Appendix 6: Floor Plan and Plot Plan



GRADING PERMIT NUMBER	19-06
STORMWATER MANAGEMENT PERMIT NUMBER	19-06
PUBLIC WORKS AGREEMENT NUMBER	19-06

DATE	REVISIONS

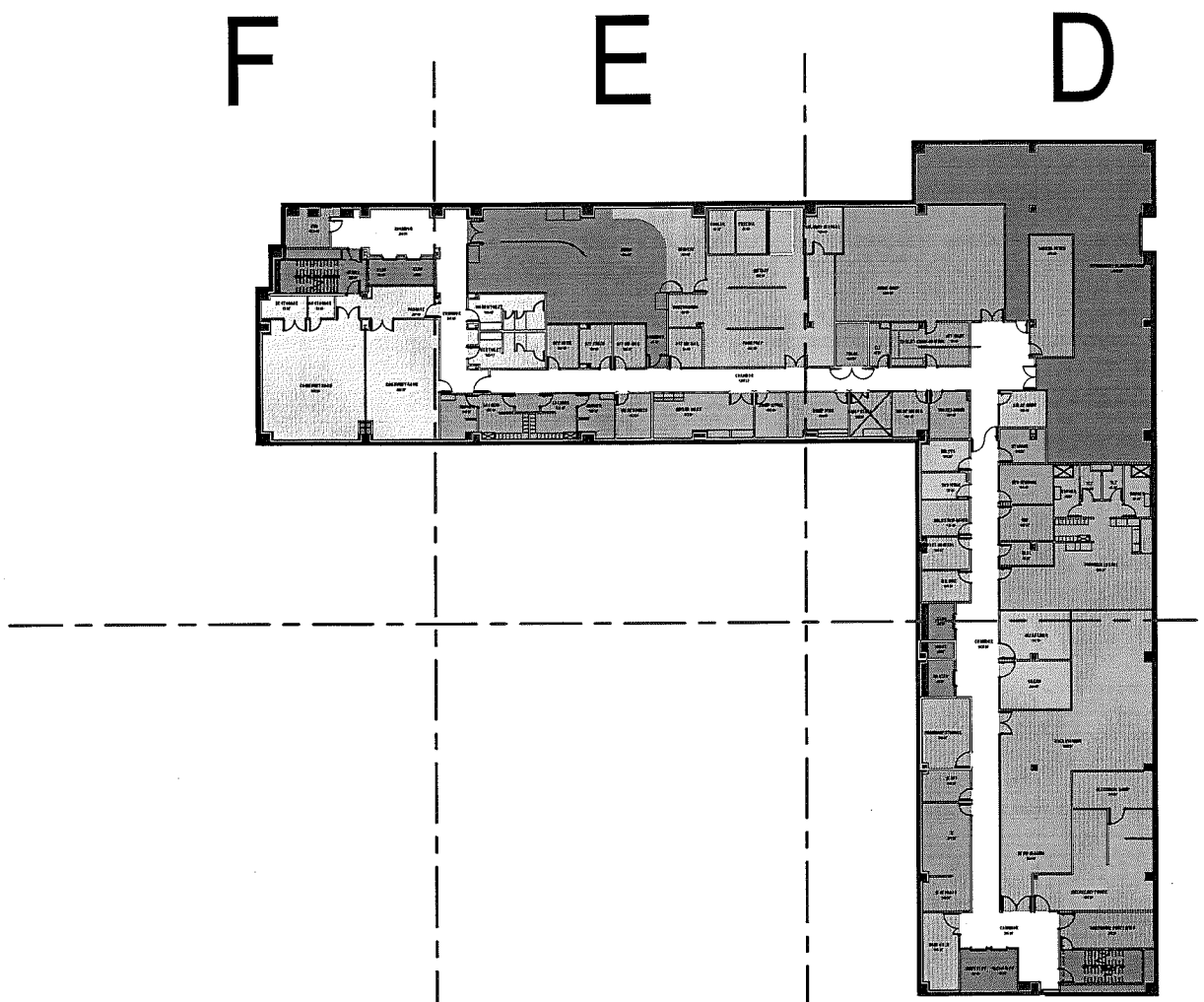
OWNER / DEVELOPER
UCH / UMMS REAL ESTATE TRUST
520 UPPER CHESAPEAKE DRIVE
SUITE 405
BEL AIR, MARYLAND 21014
CONTACT: MR. PHIL CROCKER
PH: 443-643-1305

PROFESSIONAL CERTIFICATION
I, DAN SPIKER, HEREBY CERTIFY THAT THESE DOCUMENTS WERE PREPARED OR APPROVED BY ME, AND THAT I AM A DULY LICENSED PROFESSIONAL ENGINEER UNDER THE LAWS OF THE STATE OF MARYLAND, LICENSE NO. 32245, EXPIRATION DATE: 01.19.2021.
8/7/19

MORRIS & RITCHIE ASSOCIATES, INC.
ENGINEERS, ARCHITECTS, PLANNERS, SURVEYORS & LANDSCAPE ARCHITECTS
3445-A BOX HILL CORPORATE CENTER DRIVE
ABINGDON, MARYLAND 21009
PHONE (410) 515-9000
FAX (410) 515-9002

EROSION & SEDIMENT CONTROL PLAN
PROPOSED CONDITIONS PLAN SHEET
FOR
UCH MEDICAL CAMPUS
CITY OF ABERDEEN
2ND ELECTION DISTRICT
HARFORD COUNTY, MARYLAND

JOB NO:	1542s4
SCALE:	1" = 50'
DATE:	JULY 27, 2019
DRAWN BY:	JKC
DESIGN BY:	JKC/DRS
REVIEW BY:	DRS
SHEET:	ES-3 OF 6



DEPARTMENTS	Area
BIOMED	1,005 SF
CIRCULATION	3,488 SF
DIETARY	2,344 SF
ENGINEERING AND MAINTENANCE	3,388 SF
EXTERIOR WALL	1,766 SF
HOUSEKEEPING	1,290 SF
MECH	2,926 SF
PROVIDER LOUNGE/LKR	1,222 SF
PUBLIC DINING	1,478 SF
PUBLIC SPACE	2,306 SF
SHARED SPACE	944 SF
STORAGE	3,193 SF
VERTICAL CIRCULATION	1,076 SF

ERDMAN

One Erdman Place
P.O. Box 44975
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53717
Phone: (608) 410-8000
FAX: (608) 410-8500

UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH

MEDICAL CAMPUS

ABERDEEN, MARYLAND, 21001

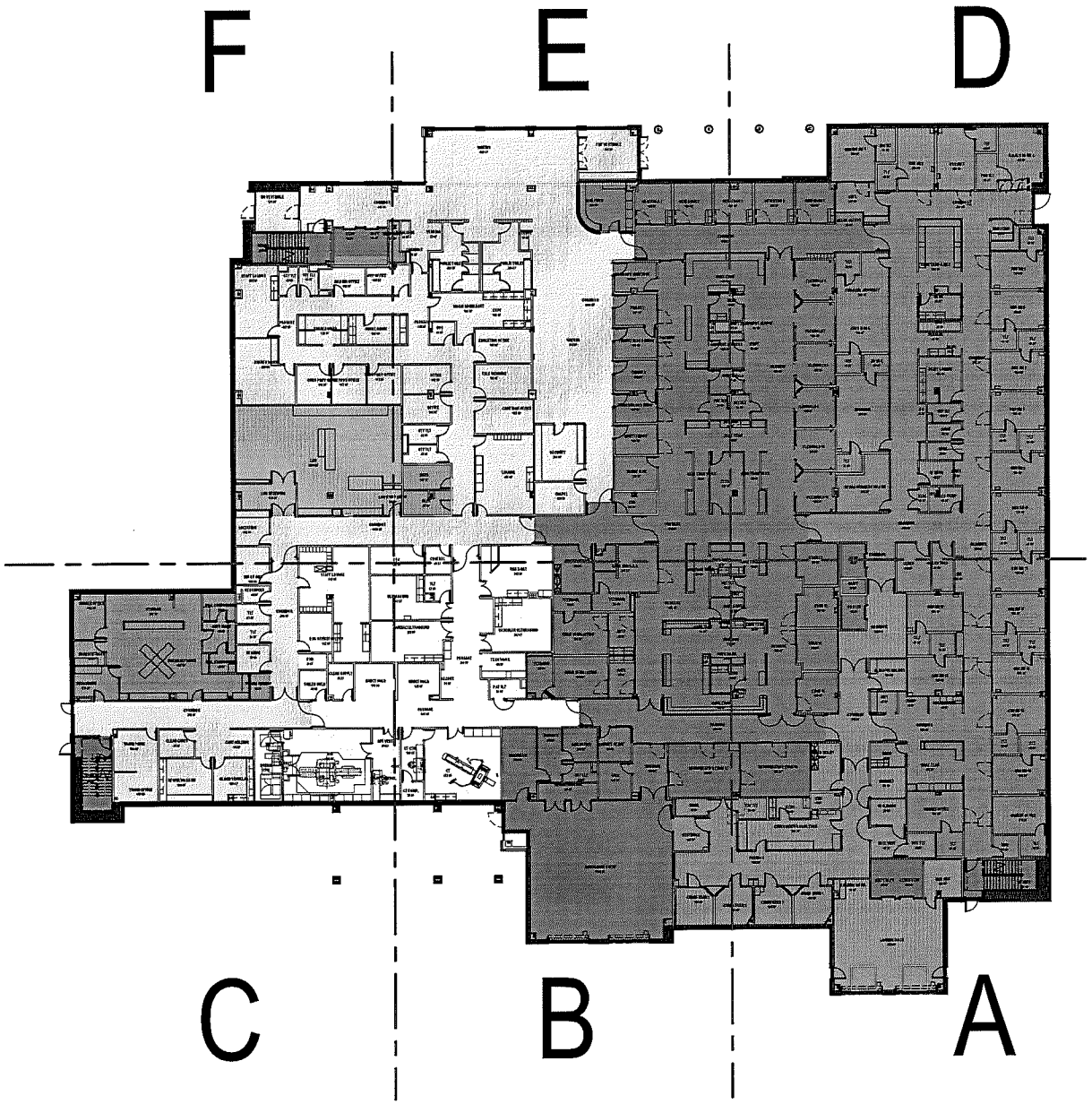
15°
N

LOWER LEVEL OVERALL

U100

Scale 1/32" = 1'-0"

JOB# 628620



DEPARTMENTS	Area
ADMIN	7,574 SF
BEHAVIORAL HEALTH CRISIS CENTER	3,408 SF
EMERGENCY SERVICES	15,803 SF
ENGINEERING AND MAINTENANCE	1,475 SF
EXTERIOR WALL	1,585 SF
IMAGING	5,573 SF
LABORATORY	1,622 SF
OBSERVATION	11,666 SF
PHARMACY	1,602 SF
PUBLIC SPACE	4,918 SF
VERTICAL CIRCULATION	1,169 SF

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UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH

MEDICAL CAMPUS

ABERDEEN, MARYLAND, 21001

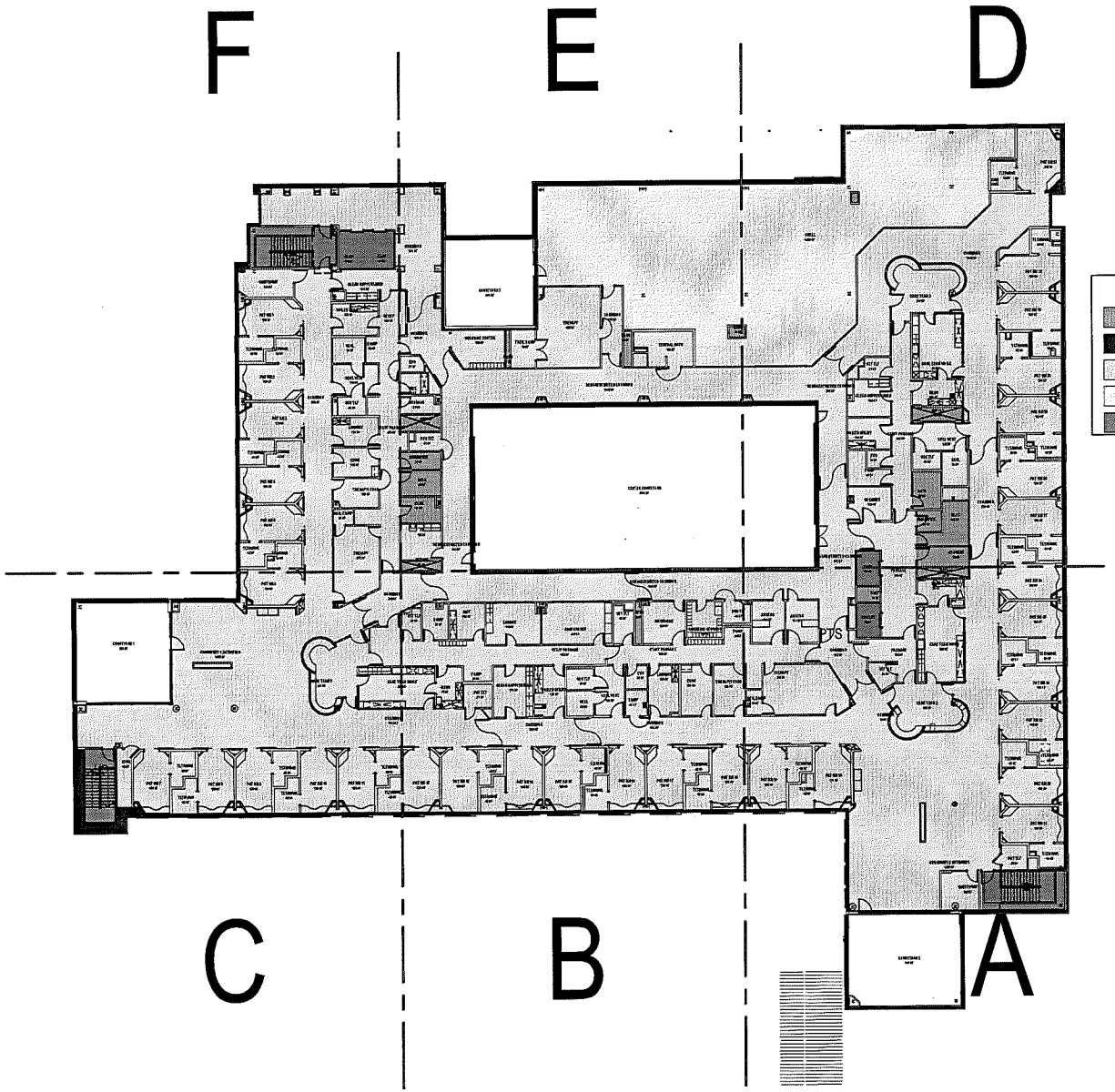
15°
N

FIRST FLOOR OVERALL

U101

Scale 1/32" = 1'-0"

JOB# 628620



DEPARTMENTS	Area
ENGINEERING AND MAINTENANCE	1,001 SF
EXTERIOR WALL	2,018 SF
INPATIENT CARE SERVICES	34,977 SF
SHELL	5,269 SF
VERTICAL CIRCULATION	1,123 SF

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UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH

MEDICAL CAMPUS

ABERDEEN, MARYLAND, 21001

15°
N

SECOND FLOOR OVERALL

U 102

Scale 1/32" = 1'-0"

JOB# 628620

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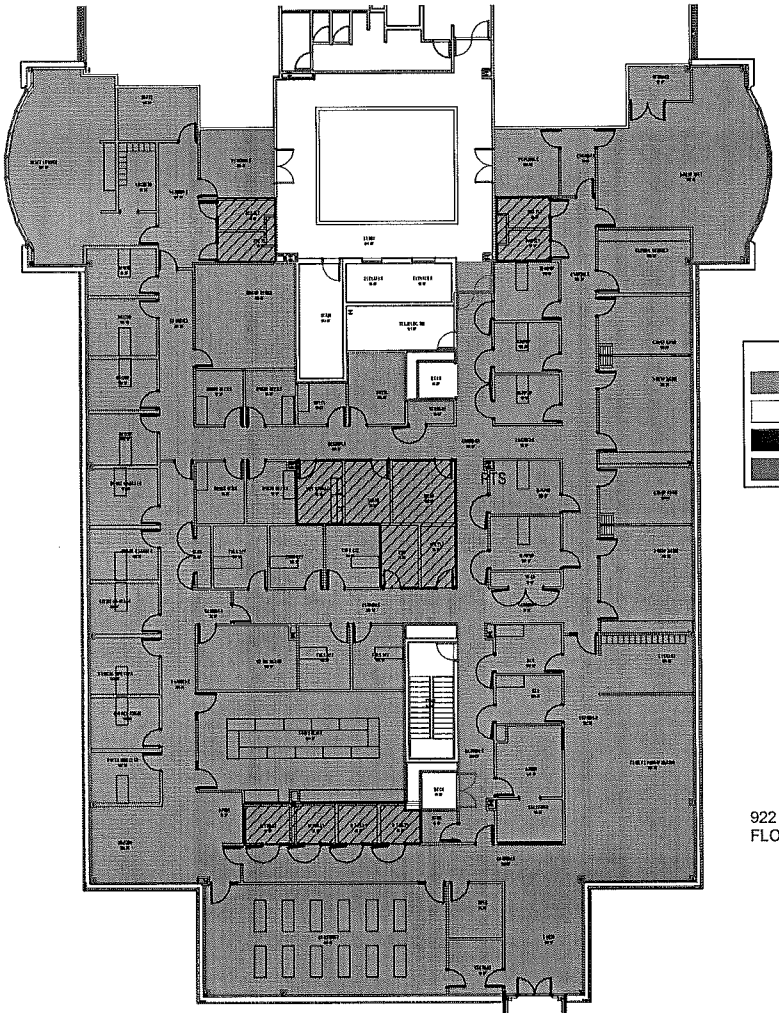
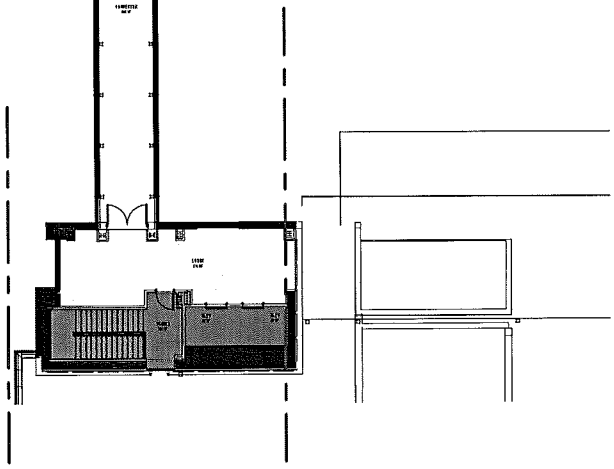


DEPARTMENTS	Area
BEH. HEALTH OUTPATIENT CARE SERVICES	15,090 SF
CIRCULATION	1,146 SF
EXTERIOR WALL	409 SF
VERTICAL CIRCULATION	387 SF

922 SF NEW RAISED FLOOR



ERDMAN
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Madison, Wisconsin 53717
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FAX: (608) 410-8600

UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH

MEDICAL CAMPUS

ABERDEEN, MARYLAND, 21001

15° N

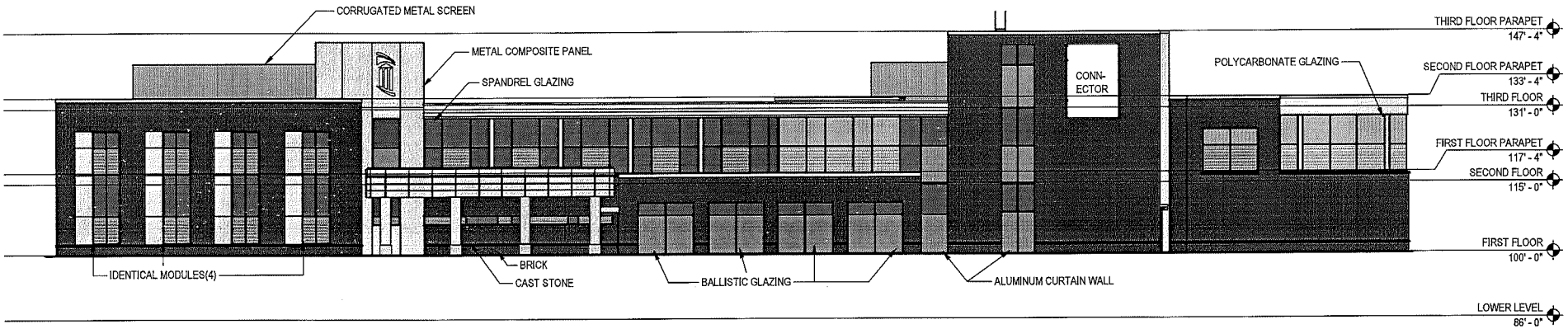
THIRD FLOOR INFILL AND FMF

U103.5

Scale 3/64" = 1'-0"

JOB# 628620

9/6/2019 7:29:31 AM



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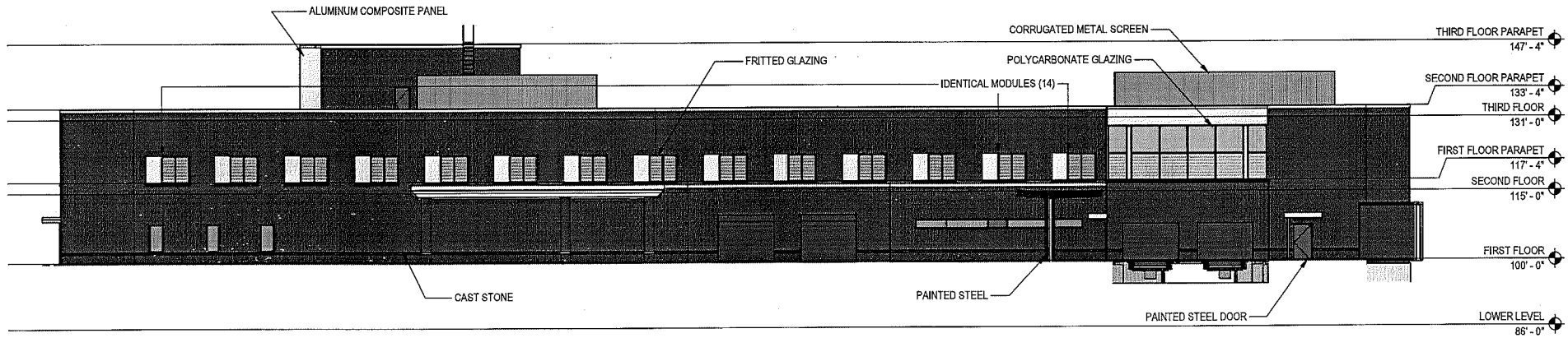

2 SOUTH

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Los Angeles Nashville Seattle Washington DC

UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS

ABERDEEN, MARYLAND, 21001

EXTERIOR ELEVATIONS

Project number	628620
Issue Date:	8/23/2018

U201

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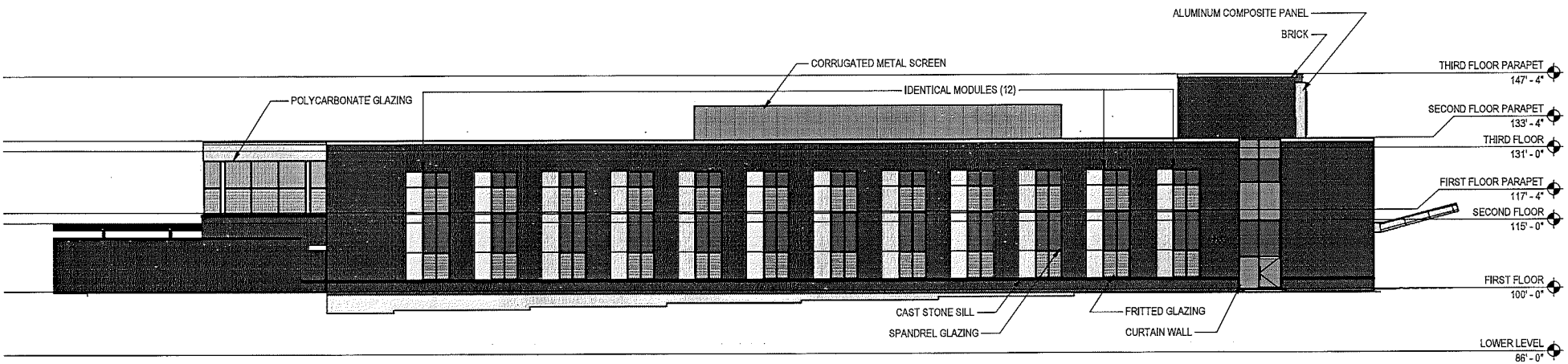

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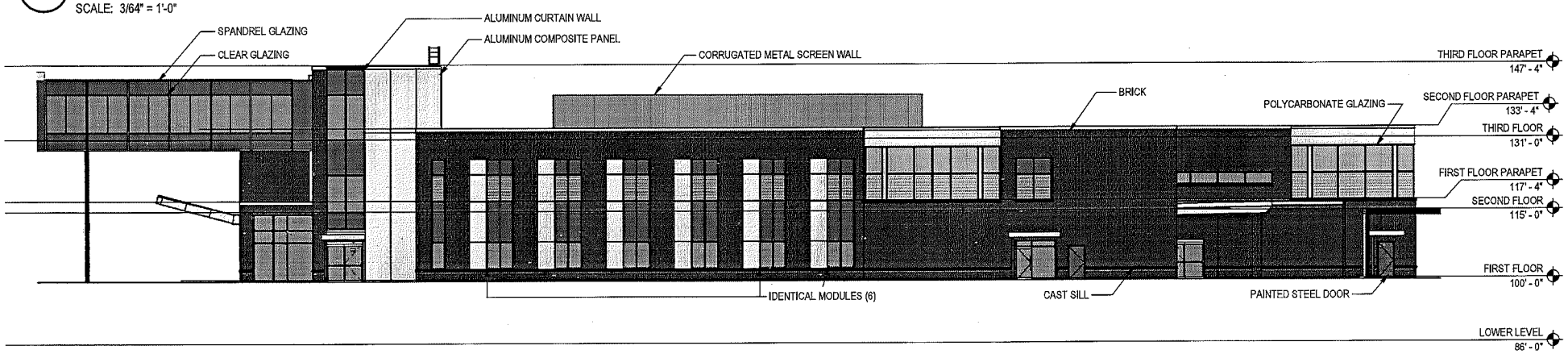

2 WEST

SCALE: 3/64" = 1'-0"

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Los Angeles Nashville Seattle Washington DC

UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS

ABERDEEN, MARYLAND, 21001

EXTERIOR ELEVATIONS

Project number	628620
Issue Date:	8/23/2018

U202

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