Exhibit 1

| Table Number | Table Title | Instructions |
|---|---|---|
| **Table A** | **Physical Bed Capacity Before and After Project** | All applicants whose project impacts any nursing unit, regardless of project type or scope, must complete Table A. |
| **Table B** | **Departmental Gross Square Feet** | All applicants, regardless of project type or scope, must complete Table B for all departments and functional areas affected by the proposed project. |
| **Table C** | **Construction Characteristics** | All applicants proposing new construction or renovation must complete Table C. |
| **Table D** | **Site and Offsite Costs Included and Excluded in Marshall Valuation Costs** | All applicants proposing new construction or renovation must complete Table D. |
| **Table E** | **Project Budget** | All applicants, regardless of project type or scope, must complete Table E. |
| **Table F** | **Statistical Projections - Entire Facility** | Existing facility applicants must complete Table F. All applicants who complete this table must also complete Tables G and H. |
| **Table G** | **Revenues & Expenses, Uninflated - Entire Facility** | Existing facility applicants must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table F. |
| **Table H** | **Revenues & Expenses, Inflated - Entire Facility** | Existing facility applicants must complete Table H. The projected revenues and expenses in H should be consistent with the projections in Tables F and G. |
| **Table L** | **Work Force Information** | All applicants, regardless of project type or scope, must complete Table L. |

**TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT**

Grace Medical Center Data

***INSTRUCTIONS: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.***

| Before the Project | | | | | | | After Project Completion | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hospital Service | Location (Floor/ Wing)* | Licensed Beds: 7/1/2019_ | Based on Physical Capacity | | | | Hospital Service | Location (Floor/ Wing)* | Based on Physical Capacity | | | |
| | | | Room Count | | | Bed Count | | | Room Count | | | Bed Count |
| | | | Private | Semi-Private | Total Rooms | Physical Capacity | | | Private | Semi-Private | Total Rooms | Physical Capacity |
| **ACUTE CARE** | | | | | | | **ACUTE CARE** | | | | | |
| **General Medical/ Surgical*** | 3rd floor | 25 | 0 | 0 | 0 | 25 | **General Medical/ Surgical*** | 3rd floor | 0 | 0 | 0 | 0 |
| *Emergency Department* | 1st floor | | 27 | 0 | 27 | 27 | *Emergency Department* | | 19 | 0 | 19 | 19 |
| | | | | | 0 | 0 | | | | 0 | 0 | 0 |
| | | | | | 0 | 0 | | | | 0 | 0 | 0 |
| | | | | | 0 | 0 | | | | 0 | 0 | 0 |
| **SUBTOTAL Gen. Med/Surg*** | | **25** | **27** | **0** | | **52** | **SUBTOTAL Gen. Med/Surg*** | | **19** | **0** | **0** | **19** |
| **ICU/CCU** | | **0** | 0 | 0 | 0 | 0 | **ICU/CCU** | | 0 | 0 | 0 | 0 |
| **Other** *(Specify/add rows as needed)* | | **0** | 0 | 0 | 0 | 0 | | | 0 | 0 | 0 | 0 |
| **TOTAL MSGA** | | **25** | **0** | **0** | **0** | **0** | **TOTAL MSGA** | | **19** | **0** | **19** | **19** |
| **Obstetrics** | | **0** | 0 | 0 | 0 | 0 | **Obstetrics** | | 0 | 0 | 0 | 0 |
| **Pediatrics** | | **0** | 0 | 0 | 0 | 0 | **Pediatrics** | | 0 | 0 | 0 | 0 |
| **Psychiatric** | | **36** | 0 | 0 | 0 | 36 | **Psychiatric** | | 0 | 0 | 0 | 0 |
| **TOTAL ACUTE** | | **61** | **0** | **0** | **0** | **88** | **TOTAL ACUTE** | | **19** | **0** | **19** | **19** |
| **NON-ACUTE CARE** | | | | | | | **NON-ACUTE CARE** | | | | | |
| **Dedicated Observation**** | | **8** | 0 | **0** | 0 | 8 | **Dedicated Observation**** | | 8 | **0** | 8 | 8 |
| **Rehabilitation** | | **0** | 0 | **0** | 0 | 0 | **Rehabilitation** | | 0 | **0** | 0 | 0 |
| **Comprehensive Care** | | **0** | 0 | **0** | 0 | 0 | **Comprehensive Care** | | 0 | **0** | 0 | 0 |
| **Other** *(Specify/add rows as needed)* | | **0** | 0 | **0** | 0 | 0 | **Other** *(Specify/add rows as needed)* | | 0 | **0** | 0 | 0 |
| **TOTAL NON-ACUTE** | | **8** | **0** | **0** | **27** | **8** | **TOTAL NON-ACUTE** | | **8** | **0** | **8** | **8** |
| **HOSPITAL TOTAL** | | **69** | **0** | **0** | **27** | **96** | **HOSPITAL TOTAL** | | **27** | **0** | **27** | **27** |

* Include beds dedicated to gynecology and addictions, if unit(s) is separate for acute psychiatric unit

** Include services included in the reporting of the “Observation Center”. Service furnished by the hospital on the hospital's promise, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient; Must be ordered and documented in writing, given by a medical practitioner.

**TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT**

*INSTRUCTION : Add or delete rows if necessary. See additional instruction in the column to the right of the table.*

| DEPARTMENT/FUNCTIONAL AREA | DEPARTMENTAL GROSS SQUARE FEET | | | | |
|---|---|---|---|---|---|
| | Current | To be Added Thru New Construction | To Be Renovated | To Remain As Is | Total After Project Completion |
| 1992 Building all five floors. Depts. to include; Emergency Dept, Surgery, Lab. Pharmacy, Physical Therapy, Dialysis, Imaging, Primary Care and Specilaty Exam Spaces, Admin Offices, Clinical Engineering, Information Systems, Infection Control and Support Staff Space. | 92,078 | | 92,078 | 0 | 92,078 |
| | | | | | 0 |
| New Outpatient Behavioral Health Building | 15,635 | 24,600 | 0 | 0 | 24,600 |
| | | | | | 0 |
| | | | | | 0 |
| | | | | | 0 |
| | | | | | 0 |
| | | | | | 0 |
| | | | | | 0 |
| | | | | | 0 |
| | | | | | 0 |
| | | | | | 0 |
| Total | | | | | 116,678 |

**TABLE C. CONSTRUCTION CHARACTERISTICS**

*INSTRUCTION : If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.*

| Grace 1992 Building Reno. and New Outpt. BHU | NEW CONSTRUCTION | RENOVATION |
|---|---|---|
| **BASE BUILDING CHARACTERISTICS** | **Check if applicable** | |
| **Class of Construction** (for renovations the class of the building being renovated)* | | |
| Class A | ☑ | ☑ |
| Class B | ☐ | ☐ |
| Class C | ☐ | ☐ |
| Class D | ☐ | ☐ |
| **Type of Construction/Renovation*** | | |
| Low | ☐ | ☐ |
| Average | ☐ | ☐ |
| Good | ☑ | ☑ |
| Excellent | ☐ | ☐ |
| **Number of Stories** | | |

*As defined by Marshall Valuation Service

| **PROJECT SPACE** | **List Number of Feet, if applicable** | |
|---|---|---|
| **Total Square Footage** | **Total Square Feet** | |
| First Floor | 12,300 | 20,669 |
| Second Floor | 12,300 | 22,775 |
| Third Floor | | 24,118 |
| Fourth Floor | | 12,258 |
| Fifth Floor | | 12,258 |
| **Average Square Feet** | **24,600** | **18,416** |
| **Perimeter in Linear Feet** | **Linear Feet** | |
| First Floor | 428 | 662 |
| Second Floor | 428 | 841 |
| Third Floor | | 707 |
| Fourth Floor | | 596 |
| Fifth Floor | | 596 |
| **Total Linear Feet** | **856** | **3,402** |
| **Average Linear Feet** | **428** | **680** |
| **Wall Height (floor to eaves)** | **Feet** | |
| First Floor | 12' | 11' 9" |
| Second Floor | 12' | 11' 4" |
| Third Floor | | 11' 4" |
| Fourth Floor | | 11' 4" |
| Fifth Floor | | 11' 4" |
| **Average Wall Height** | **12'** | **11' 4"** |
| **OTHER COMPONENTS** | | |
| **Elevators** | **List Number** | |
| Passenger | 2 | 4 |
| Freight | | 1 |
| **Sprinklers** | **Square Feet Covered** | |
| Wet System | 24,600 | 92,078 |
| Dry System | | |
| **Other** | **Describe Type** | |
| **Type of HVAC System for proposed project** | Ducted air distribution with chilled water/hot water coils. | |
| **Type of Exterior Walls for proposed project** | Brick | |

**TABLE C. CONSTRUCTION CHARACTERISTICS**

*INSTRUCTION : If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.*

| Grace Existing Hospital Demolition | NEW CONSTRUCTION | TO BE DEMOLISHED |
|---|---|---|
| **BASE BUILDING CHARACTERISTICS** | **Check if applicable** | |
| **Class of Construction** (for renovations the class of the building being renovated)* | | |
| Class A | ☐ | ☐ |
| Class B | ☐ | ☐ |
| Class C | ☐ | ☑ |
| Class D | ☐ | ☐ |
| **Type of Construction/Renovation*** | | |
| Low | ☐ | ☐ |
| Average | ☐ | ☑ |
| Good | ☐ | ☐ |
| Excellent | ☐ | ☐ |
| **Number of Stories** | | |

*As defined by Marshall Valuation Service

| **PROJECT SPACE** | **List Number of Feet, if applicable** | |
|---|---|---|
| **Total Square Footage** | **Total Square Feet** | |
| First Floor | | 63,162 |
| Second Floor | | 49,038 |
| Third Floor | | 50,100 |
| Fourth Floor | | 5,813 ; 19,806 |
| Fifth Floor | | 15,635 |
| **Average Square Feet** | | **203,554** |
| **Perimeter in Linear Feet** | **Linear Feet** | |
| First Floor | | 1500' 7" |
| Second Floor | | 1949' 5" |
| Third Floor | | 1421' |
| Fourth Floor | | 466' ; 891' 8" |
| Fifth Floor | | 712' 4" |
| **Total Linear Feet** | | **6,941** |
| **Average Linear Feet** | | **1,388** |
| **Wall Height (floor to eaves)** | **Feet** | |
| First Floor | | 11' 9" |
| Second Floor | | 11' 4" |
| Third Floor | | 11' 4" |
| Fourth Floor | | 11' 4" |
| Fifth Floor | | 11' 4" |
| **Average Wall Height** | | **11' 4"** |
| **OTHER COMPONENTS** | | |
| **Elevators** | **List Number** | |
| Passenger | | 7 |
| Freight | | |
| **Sprinklers** | **Square Feet Covered** | |
| Wet System | | 203,554 |
| Dry System | | |
| **Other** | **Describe Type** | |
| **Type of HVAC System for proposed project** | Ducted air distribution with chilled water/hot water coils. | |
| **Type of Exterior Walls for proposed project** | Brick | |

**TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS**

*INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table D for each structure.*

| | NEW CONSTRUCTION COSTS | RENOVATION COSTS |
|---|---|---|
| **SITE PREPARATION COSTS** | | |
| Normal Site Preparation | $350,000 | |
| Utilities from Structure to Lot Line | $125,000 | |
| **Subtotal included in Marshall Valuation Costs** | **$475,000** | |
| Site Demolition Costs | $5,900,000 | |
| Storm Drains | $180,000 | |
| Rough Grading | $235,000 | |
| Hillside Foundation | | |
| Paving | $320,000 | |
| Exterior Signs | $120,000 | |
| Landscaping | $190,000 | |
| Walls | | |
| Yard Lighting | $155,000 | |
| Other *(Specify/add rows if needed)* | | |
| **Subtotal On-Site excluded from Marshall Valuation Costs** | **$7,100,000** | |
| **OFFSITE COSTS** | | |
| Roads | | |
| Utilities | | |
| Jurisdictional Hook-up Fees | | |
| Other *(Specify/add rows if needed)* | | |
| **Subtotal Off-Site excluded from Marshall Valuation Costs** | | |
| **TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs** | **$7,100,000** | **$0** |
| **TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*** | **$7,575,000** | **$0** |

*The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

**TABLE E. PROJECT BUDGET** Grace Medical Center Data

*NOTE: Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.d as a use of funds and on line B.8 as a source of funds*

| | *Grace 1992 Building & New Outpatient Building* | *Hospital Building* | *Other Structure* | *Total* |
|---|---|---|---|---|
| **A.** | **USE OF FUNDS** | | | |
| **1.** | **CAPITAL COSTS** | | | |
| **a.** | **New Construction** | | | |
| (1) | Building | $10,750,000 | | $10,750,000 |
| (2) | Fixed Equipment | | | $0 |
| (3) | Site and Infrastructure | $790,000 | | $790,000 |
| (4) | Architect/Engineering Fees | $950,000 | | $950,000 |
| (5) | Permits (Building, Utilities, Etc.) | $150,000 | | $150,000 |
| | ***SUBTOTAL*** | **$12,640,000** | **$0** | **$12,640,000** |
| **b.** | **Renovations** | | | |
| (1) | Building | $23,175,000 | | $23,175,000 |
| (2) | Fixed Equipment (not included in construction) | | | $0 |
| (3) | Architect/Engineering Fees | $2,225,000 | | $2,225,000 |
| (4) | Permits (Building, Utilities, Etc.) | $100,000 | | $100,000 |
| | ***SUBTOTAL*** | **$25,500,000** | **$0** | **$25,500,000** |
| **c.** | **Other Capital Costs** | | | |
| (1) | Movable Equipment | $6,500,000 | | $6,500,000 |
| (2) | Contingency Allowance | $2,000,000 | | $2,000,000 |
| (3) | Gross interest during construction period | | | $0 |
| (4) | Other *(Specify/add rows if needed)* | | | |
| | I.T. Systems | $11,000,000 | | $11,000,000 |
| | Existing Buildings Demolition | $5,900,000 | | $5,900,000 |
| | Parking Lot | $1,200,000 | | $1,200,000 |
| | ***SUBTOTAL*** | ***$26,600,000*** | ***$0*** | **$26,600,000** |
| | ***TOTAL CURRENT CAPITAL COSTS*** | **$64,740,000** | **$0** | **$64,740,000** |
| **d.** | ***Land Purchase*** | | | |
| **e.** | **Inflation Allowance** | | | $0 |
| | ***TOTAL CAPITAL COSTS*** | **$64,740,000** | **$0** | **$64,740,000** |
| **2.** | **Financing Cost and Other Cash Requirements** | | | |
| a. | Loan Placement Fees | | | $0 |
| b. | Bond Discount | | | $0 |
| c | CON Application Assistance | | | |
| | *c1. Legal Fees* | | | $0 |
| | *c2. Other (Specify/add rows if needed)* | | | |
| d. | Non-CON Consulting Fees | | | |
| | *d1. Legal Fees* | | | $0 |
| | *d2. Other (Specify/add rows if needed)* | | | $0 |
| e. | Debt Service Reserve Fund | | | $0 |
| f | Other *(Specify/add rows if needed)* | | | $0 |
| | ***SUBTOTAL*** | ***$0*** | ***$0*** | **$0** |
| **3.** | **Working Capital Startup Costs** | | | $0 |
| | ***TOTAL USES OF FUNDS*** | ***$64,740,000*** | ***$0*** | ***$64,740,000*** |
| **B.** | **Sources of Funds** | | | |
| **1.** | **Cash** | | | $0 |
| **2.** | **Philanthropy (to date and expected)** | | | $0 |
| **3.** | **Authorized Bonds** | | | $0 |
| **4.** | **Interest Income from bond proceeds listed in #3** | | | $0 |
| **5.** | **Mortgage** | | | $0 |
| **6.** | **Working Capital Loans** | | | $0 |
| **7.** | **Grants or Appropriations** | | | |
| **a.** | **Federal** | | | $0 |
| **b.** | **State** | | | $0 |
| **c.** | **Local** | | | $0 |
| **8.** | **Other *(Specify/add rows if needed)*** | | | $0 |
| | ***TOTAL SOURCES OF FUNDS*** | | | **$0** |
| | | ***Hospital Building*** | ***Other Structure*** | ***Total*** |
| **Annual Lease Costs (if applicable)** | | | | |
| **1.** | **Land** | | | $0 |
| **2.** | **Building** | | | $0 |
| **3.** | **Major Movable Equipment** | | | $0 |
| **4.** | **Minor Movable Equipment** | | | $0 |
| **5.** | **Other *(Specify/add rows if needed)*** | | | $0 |

* Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

**TABLE F. STATISTICAL PROJECTIONS - SINAI HOSPITAL**

| | Two Most Recent Years (Actual) | | Current Year Projected | Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H. | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| *Indicate CY or FY* | FY 2019 (7/1/18 - 6/30/19) | FY 2020 (7/1/19 - 6/30/20) | FY 2021 (7/1/20 - 6/30/21) | Year 1 (7/1/21 - 6/30/22) | Year 2 (7/1/22 - 6/30/23) | Year 3 (7/1/23 - 6/30/24) | | | | |
| **1. DISCHARGES** | | | | | | | | | | |
| a. General Medical/Surgical* | 10,456 | 9,861 | 9,912 | 10,500 | 11,000 | 11,500 | | | | |
| b. ICU/CCU | 948 | 863 | 938 | 957 | 976 | 995 | | | | |
| ***Total MSGA*** | **11,404** | **10,724** | **10,850** | **11,457** | **11,976** | **12,495** | **0** | **0** | **0** | **0** |
| c. Pediatric | 625 | 773 | 566 | 608 | 654 | 703 | | | | |
| d. Obstetric | 1,908 | 1,844 | 1,816 | 1,850 | 1,850 | 1,850 | | | | |
| e. Acute Psychiatric | 1,209 | 806 | 918 | 1,311 | 1,409 | 1,515 | | | | |
| ***Total Acute*** | ***15,146*** | ***14,147*** | ***14,150*** | ***15,226*** | ***15,889*** | ***16,563*** | ***0*** | ***0*** | ***0*** | ***0*** |
| f. Rehabilitation | 1,068 | 1,057 | 1,036 | 1,050 | 1,050 | 1,050 | | | | |
| g. Comprehensive Care | | | | | | | | | | |
| h. Other (Specify/add rows of needed) | | | | | | | | | | |
| ***TOTAL DISCHARGES*** | ***16,214*** | ***15,204*** | ***15,186*** | ***16,276*** | ***16,939*** | ***17,613*** | ***0*** | ***0*** | ***0*** | ***0*** |
| **2. PATIENT DAYS** | | | | | | | | | | |
| a. General Medical/Surgical* | 65,236 | 69,205 | 73,354 | 72,500 | 73,700 | 74,750 | | | | |
| b. ICU/CCU | 9,384 | 10,819 | 11,528 | 10,950 | 10,950 | 10,950 | | | | |
| ***Total MSGA*** | **74,620** | **80,024** | **84,882** | **83,450** | **84,650** | **85,700** | **0** | **0** | **0** | **0** |
| c. Pediatric | 2,132 | 2,312 | 1,840 | 2,100 | 2,300 | 2,450 | | | | |
| d. Obstetric | 5,240 | 4,636 | 4,790 | 4,800 | 4,800 | 4,800 | | | | |
| e. Acute Psychiatric | 7,617 | 7,579 | 10,313 | 12,813 | 12,813 | 12,813 | | | | |
| ***Total Acute*** | ***89,609*** | ***94,551*** | ***101,825*** | ***103,163*** | ***104,563*** | ***105,763*** | ***0*** | ***0*** | ***0*** | ***0*** |
| f. Rehabilitation | 11,383 | 11,187 | 11,332 | 11,250 | 11,250 | 11,250 | | | | |
| g. Comprehensive Care | | | | | | | | | | |
| h. Other (Specify/add rows of needed) | | | | | | | | | | |
| ***TOTAL PATIENT DAYS*** | ***100,992*** | ***105,738*** | ***113,157*** | ***114,413*** | ***115,813*** | ***117,013*** | ***0*** | ***0*** | ***0*** | ***0*** |
| **3. AVERAGE LENGTH OF STAY (patient days divided by discharges)** | | | | | | | | | | |
| a. General Medical/Surgical* | 6.2 | 7.0 | 7.4 | 6.9 | 6.7 | 6.5 | | | | |
| b. ICU/CCU | 9.9 | 12.5 | 12.3 | 11.4 | 11.2 | 11.0 | | | | |
| ***Total MSGA*** | 6.5 | 7.5 | 7.8 | 7.3 | 7.1 | 6.9 | | | | |
| c. Pediatric | 3.4 | 3.0 | 3.3 | 3.5 | 3.5 | 3.5 | | | | |
| d. Obstetric | 2.7 | 2.5 | 2.6 | 2.6 | 2.6 | 2.6 | | | | |
| e. Acute Psychiatric | 6.3 | 9.4 | 11.2 | 9.8 | 9.1 | 8.5 | | | | |
| ***Total Acute*** | 5.9 | 6.7 | 7.2 | 6.8 | 6.6 | 6.4 | | | | |
| f. Rehabilitation | 10.7 | 10.6 | 10.9 | 10.7 | 10.7 | 10.7 | | | | |
| g. Comprehensive Care | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | | | | |
| h. Other (Specify/add rows of needed) | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | | | | |
| ***TOTAL AVERAGE LENGTH OF STAY*** | 6.2 | 7.0 | 7.5 | 7.0 | 6.8 | 6.6 | | | | |
| **4. NUMBER OF LICENSED BEDS** | | | | | | | | | | |
| a. General Medical/Surgical* | 258 | 258 | 258 | 258 | 258 | 258 | | | | |
| b. ICU/CCU | 41 | 41 | 41 | 41 | 41 | 41 | | | | |
| ***Total MSGA*** | **299** | **299** | **299** | **299** | **299** | **299** | **0** | **0** | **0** | **0** |
| c. Pediatric | 20 | 20 | 20 | 20 | 20 | 20 | | | | |
| d. Obstetric | 27 | 27 | 27 | 27 | 27 | 27 | | | | |
| e. Acute Psychiatric | 24 | 24 | 48 | 48 | 48 | 48 | | | | |
| ***Total Acute*** | ***370*** | ***370*** | ***394*** | ***394*** | ***394*** | ***394*** | ***0*** | ***0*** | ***0*** | ***0*** |
| f. Rehabilitation | 57 | 57 | 57 | 57 | 57 | 57 | | | | |
| g. Comprehensive Care | | | | | | | | | | |
| h. Other (Specify/add rows of needed) | | | | | | | | | | |
| ***TOTAL LICENSED BEDS*** | ***427*** | ***427*** | ***451*** | ***451*** | ***451*** | ***451*** | ***0*** | ***0*** | ***0*** | ***0*** |
| **5. OCCUPANCY PERCENTAGE** **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.* | | | | | | | | | | |
| a. General Medical/Surgical* | 69.3% | 73.3% | 77.9% | 77.0% | 78.3% | 79.2% | | | | |
| b. ICU/CCU | 62.7% | 72.1% | 77.0% | 73.2% | 73.2% | 73.0% | | | | |
| ***Total MSGA*** | **68.4%** | **73.1%** | **77.8%** | **76.5%** | **77.6%** | **78.3%** | | | | |
| c. Pediatric | 29.2% | 31.6% | 25.2% | 28.8% | 31.5% | 33.5% | | | | |
| d. Obstetric | 53.2% | 46.9% | 48.6% | 48.7% | 48.7% | 48.6% | | | | |
| e. Acute Psychiatric | 87.0% | 86.3% | 58.9% | 73.1% | 73.1% | 72.9% | | | | |
| ***Total Acute*** | **66.4%** | **69.8%** | **70.8%** | **71.7%** | **72.7%** | **73.3%** | | | | |
| f. Rehabilitation | 54.7% | 53.6% | 54.5% | 54.1% | 54.1% | 53.9% | | | | |
| g. Comprehensive Care | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | | | | |
| h. Other (Specify/add rows of needed) | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | | | | |
| ***TOTAL OCCUPANCY %*** | **64.8%** | **67.7%** | **68.7%** | **69.5%** | **70.4%** | **70.9%** | | | | |
| **6. OUTPATIENT VISITS** | | | | | | | | | | |
| a. Emergency Department | 68,096 | 60,390 | 54,452 | 57,175 | 60,033 | 63,035 | | | | |
| b. Same-day Surgery | 10,824 | 8,571 | 8,944 | 10,000 | 10,000 | 10,000 | | | | |
| c. Laboratory | | | | | | | | | | |
| d. Imaging | | | | | | | | | | |
| e. Other - Clinic Visits (Regulated) | 81,877 | 71,131 | 77,088 | 77,000 | 77,000 | 77,000 | | | | |
| e. Other | | | | | | | | | | |
| ***TOTAL OUTPATIENT VISITS*** | ***160,797*** | ***140,092*** | ***140,484*** | ***144,175*** | ***147,033*** | ***150,035*** | ***0*** | ***0*** | ***0*** | ***0*** |
| **7. OBSERVATIONS**** | | | | | | | | | | |
| a. Number of Patients | 8,632 | 6,902 | 4,624 | 5,086 | 5,595 | 6,155 | | | | |
| b. Hours | 153,052 | 110,618 | 108,144 | 113,551 | 119,229 | 125,190 | | | | |

**TABLE F. STATISTICAL PROJECTIONS - GRACE**

| | Two Most Recent Years (Actual) | | Current Year Projected | Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H. | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| *Indicate CY or FY* | FY 2019 (9/1/18 - 8/31/19) | FY 2020 (9/1/19 - 8/31/20) | FY 2021 (9/1/20 - 8/31/21) | Year 1 (9/1/21 - 8/31/22) | Year 2 (9/1/22 - 8/31/23) | Year 3 (9/1/23 - 8/31/24) | | | | |
| **1. DISCHARGES** | | | | | | | | | | |
| a. General Medical/Surgical* | 1,778 | 454 | 6 | 0 | 0 | 0 | | | | |
| b. ICU/CCU | 91 | 10 | 0 | 0 | 0 | 0 | | | | |
| ***Total MSGA*** | **1,869** | **464** | **6** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| c. Pediatric | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| d. Obstetric | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| e. Acute Psychiatric | 1,125 | 932 | 214 | 0 | 0 | 0 | | | | |
| ***Total Acute*** | ***2,994*** | ***1,396*** | ***220*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** |
| f. Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| g. Comprehensive Care | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| h. Other (Specify/add rows of needed) | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| ***TOTAL DISCHARGES*** | ***2,994*** | ***1,396*** | ***220*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** |
| **2. PATIENT DAYS** | | | | | | | | | | |
| a. General Medical/Surgical* | 7,968 | 1,999 | 63 | 0 | 0 | 0 | | | | |
| b. ICU/CCU | 1,142 | 132 | 0 | 0 | 0 | 0 | | | | |
| ***Total MSGA*** | **9,110** | **2,131** | **63** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| c. Pediatric | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| d. Obstetric | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| e. Acute Psychiatric | 9,916 | 8,545 | 1,718 | | | | | | | |
| ***Total Acute*** | ***19,026*** | ***10,676*** | ***1,781*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** |
| f. Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| g. Comprehensive Care | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| h. Other (Specify/add rows of needed) | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| ***TOTAL PATIENT DAYS*** | ***19,026*** | ***10,676*** | ***1,781*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** |
| **3. AVERAGE LENGTH OF STAY (patient days divided by discharges)** | | | | | | | | | | |
| a. General Medical/Surgical* | 4.5 | 4.4 | 10.5 | | | | | | | |
| b. ICU/CCU | 12.5 | 13.2 | #DIV/0! | | | | | | | |
| ***Total MSGA*** | 4.9 | 4.6 | 10.5 | | | | | | | |
| c. Pediatric | #DIV/0! | #DIV/0! | #DIV/0! | | | | | | | |
| d. Obstetric | #DIV/0! | #DIV/0! | #DIV/0! | | | | | | | |
| e. Acute Psychiatric | 8.8 | 9.2 | 8.0 | | | | | | | |
| ***Total Acute*** | 6.4 | 7.6 | 8.1 | | | | | | | |
| f. Rehabilitation | #DIV/0! | #DIV/0! | #DIV/0! | | | | | | | |
| g. Comprehensive Care | #DIV/0! | #DIV/0! | #DIV/0! | | | | | | | |
| h. Other (Specify/add rows of needed) | #DIV/0! | #DIV/0! | #DIV/0! | | | | | | | |
| ***TOTAL AVERAGE LENGTH OF STAY*** | 6.4 | 7.6 | 8.1 | | | | | | | |
| **4. NUMBER OF LICENSED BEDS** | | | | | | | | | | |
| a. General Medical/Surgical* | 36 | 34 | 34 | 0 | 0 | 0 | | | | |
| b. ICU/CCU | 8 | 8 | 8 | 0 | 0 | 0 | | | | |
| ***Total MSGA*** | **44** | **42** | **42** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| c. Pediatric | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| d. Obstetric | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| e. Acute Psychiatric | 27 | 27 | 27 | 0 | 0 | 0 | | | | |
| ***Total Acute*** | ***71*** | ***69*** | ***69*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** |
| f. Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| g. Comprehensive Care | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| h. Other (Specify/add rows of needed) | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| ***TOTAL LICENSED BEDS*** | ***71*** | ***69*** | ***69*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** |
| **5. OCCUPANCY PERCENTAGE** ***IMPORTANT NOTE:*** *Leap year formulas should be changed by applicant to reflect 366 days per year.* | | | | | | | | | | |
| a. General Medical/Surgical* | 60.6% | 16.1% | 0.5% | | | | | | | |
| b. ICU/CCU | 39.1% | 4.5% | 0.0% | | | | | | | |
| ***Total MSGA*** | **56.7%** | **13.9%** | **0.4%** | | | | | | | |
| c. Pediatric | #DIV/0! | #DIV/0! | #DIV/0! | | | | | | | |
| d. Obstetric | #DIV/0! | #DIV/0! | #DIV/0! | | | | | | | |
| e. Acute Psychiatric | 100.6% | 86.5% | 17.4% | | | | | | | |
| ***Total Acute*** | **73.4%** | **42.3%** | **7.1%** | | | | | | | |
| f. Rehabilitation | #DIV/0! | #DIV/0! | #DIV/0! | | | | | | | |
| g. Comprehensive Care | #DIV/0! | #DIV/0! | #DIV/0! | | | | | | | |
| h. Other (Specify/add rows of needed) | #DIV/0! | #DIV/0! | #DIV/0! | | | | | | | |
| ***TOTAL OCCUPANCY %*** | **73.4%** | **42.3%** | **7.1%** | | | | | | | |
| **6. OUTPATIENT VISITS** | | | | | | | | | | |
| a. Emergency Department | 18,579 | 15,864 | 17,062 | 18,250 | 21,500 | 23,500 | | | | |
| b. Same-day Surgery | 504 | 245 | 147 | 200 | 250 | 350 | | | | |
| c. Laboratory | | | | | | | | | | |
| d. Imaging | | | | | | | | | | |
| e. Other - Clinic Visits (Regulated) | 12,865 | 9,778 | 8,988 | 9,000 | 9,450 | 9,923 | | | | |
| e. Other - Renal Dialysis (Treatments) | | 15,863 | 16,000 | 16,500 | 17,000 | 17,500 | | | | |
| ***TOTAL OUTPATIENT VISITS*** | ***31,948*** | ***41,750*** | ***42,197*** | ***43,950*** | ***48,200*** | ***51,273*** | ***0*** | ***0*** | ***0*** | ***0*** |
| **7. OBSERVATIONS**** | | | | | | | | | | |
| a. Number of Patients | 1,192 | 960 | 775 | 829 | 976 | 1,067 | | | | |
| b. Hours | 32,745 | 33,756 | 27,231 | 29,127 | 34,314 | 37,506 | | | | |

**TABLE F. STATISTICAL PROJECTIONS - COMBINED (SINAI & GRACE)**

| | Two Most Recent Years (Actual) | | Current Year Projected | Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H. | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| *Indicate CY or FY* | FY 2019 (7/1/18 - 6/30/19) | FY 2020 (7/1/19 - 6/30/20) | FY 2021 (7/1/20 - 6/30/21) | Year 1 (7/1/21 - 6/30/22) | Year 2 (7/1/22 - 6/30/23) | Year 3 (7/1/23 - 6/30/24) | | | | |
| **1. DISCHARGES** | | | | | | | | | | |
| a. General Medical/Surgical* | 12,234 | 10,315 | 9,912 | 10,110 | 10,110 | 10,110 | | | | |
| b. ICU/CCU | 1,039 | 873 | 938 | 900 | 935 | 935 | | | | |
| ***Total MSGA*** | **13,273** | **11,188** | **10,850** | **11,010** | **11,045** | **11,045** | **0** | **0** | **0** | **0** |
| c. Pediatric | 625 | 773 | 566 | 600 | 600 | 600 | | | | |
| d. Obstetric | 1,908 | 1,844 | 1,816 | 1,850 | 1,850 | 1,850 | | | | |
| e. Acute Psychiatric | 2,334 | 1,738 | 1,132 | 1,541 | 1,656 | 1,781 | | | | |
| ***Total Acute*** | ***18,140*** | ***15,543*** | ***14,364*** | ***15,001*** | ***15,152*** | ***15,276*** | ***0*** | ***0*** | ***0*** | ***0*** |
| f. Rehabilitation | 1,068 | 1,057 | 1,036 | 1,050 | 1,050 | 1,050 | | | | |
| g. Comprehensive Care | | | | | | | | | | |
| h. Other (Specify/add rows of needed) | | | | | | | | | | |
| ***TOTAL DISCHARGES*** | ***19,208*** | ***16,600*** | ***15,400*** | ***16,051*** | ***16,202*** | ***16,326*** | ***0*** | ***0*** | ***0*** | ***0*** |
| **2. PATIENT DAYS** | | | | | | | | | | |
| a. General Medical/Surgical* | 73,204 | 71,204 | 73,354 | 67,250 | 66,250 | 66,250 | | | | |
| b. ICU/CCU | 10,526 | 10,951 | 11,528 | 10,950 | 10,650 | 10,250 | | | | |
| ***Total MSGA*** | **83,730** | **82,155** | **84,882** | **78,200** | **76,900** | **76,500** | **0** | **0** | **0** | **0** |
| c. Pediatric | 2,132 | 2,312 | 1,840 | 2,100 | 2,100 | 2,100 | | | | |
| d. Obstetric | 5,240 | 4,636 | 4,790 | 4,800 | 4,800 | 4,800 | | | | |
| e. Acute Psychiatric | 17,533 | 16,124 | 12,031 | 12,813 | 12,813 | 12,813 | | | | |
| ***Total Acute*** | ***108,635*** | ***105,227*** | ***103,543*** | ***97,913*** | ***96,613*** | ***96,213*** | ***0*** | ***0*** | ***0*** | ***0*** |
| f. Rehabilitation | 11,383 | 11,187 | 11,332 | 11,250 | 11,250 | 11,250 | | | | |
| g. Comprehensive Care | | | | | | | | | | |
| h. Other (Specify/add rows of needed) | | | | | | | | | | |
| ***TOTAL PATIENT DAYS*** | ***120,018*** | ***116,414*** | ***114,875*** | ***109,163*** | ***107,863*** | ***107,463*** | ***0*** | ***0*** | ***0*** | ***0*** |
| **3. AVERAGE LENGTH OF STAY (patient days divided by discharges)** | | | | | | | | | | |
| a. General Medical/Surgical* | 6.0 | 6.9 | 7.4 | 6.7 | 6.6 | 6.6 | | | | |
| b. ICU/CCU | 10.1 | 12.5 | 12.3 | 12.2 | 11.4 | 11.0 | | | | |
| ***Total MSGA*** | 6.3 | 7.3 | 7.8 | 7.1 | 7.0 | 6.9 | | | | |
| c. Pediatric | 3.4 | 3.0 | 3.3 | 3.5 | 3.5 | 3.5 | | | | |
| d. Obstetric | 2.7 | 2.5 | 2.6 | 2.6 | 2.6 | 2.6 | | | | |
| e. Acute Psychiatric | 7.5 | 9.3 | 10.6 | 8.3 | 7.7 | 7.2 | | | | |
| ***Total Acute*** | 6.0 | 6.8 | 7.2 | 6.5 | 6.4 | 6.3 | | | | |
| f. Rehabilitation | 10.7 | 10.6 | 10.9 | 10.7 | 10.7 | 10.7 | | | | |
| g. Comprehensive Care | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | | | | |
| h. Other (Specify/add rows of needed) | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | | | | |
| ***TOTAL AVERAGE LENGTH OF STAY*** | 6.2 | 7.0 | 7.5 | 6.8 | 6.7 | 6.6 | | | | |
| **4. NUMBER OF LICENSED BEDS** | | | | | | | | | | |
| a. General Medical/Surgical* | 294 | 292 | 292 | 258 | 258 | 258 | | | | |
| b. ICU/CCU | 49 | 49 | 49 | 41 | 41 | 41 | | | | |
| ***Total MSGA*** | **343** | **341** | **341** | **299** | **299** | **299** | **0** | **0** | **0** | **0** |
| c. Pediatric | 20 | 20 | 20 | 20 | 20 | 20 | | | | |
| d. Obstetric | 27 | 27 | 27 | 27 | 27 | 27 | | | | |
| e. Acute Psychiatric | 51 | 51 | 75 | 48 | 48 | 48 | | | | |
| ***Total Acute*** | ***441*** | ***439*** | ***463*** | ***394*** | ***394*** | ***394*** | ***0*** | ***0*** | ***0*** | ***0*** |
| f. Rehabilitation | 57 | 57 | 57 | 57 | 57 | 57 | | | | |
| g. Comprehensive Care | | | | | | | | | | |
| h. Other (Specify/add rows of needed) | | | | | | | | | | |
| ***TOTAL LICENSED BEDS*** | ***498*** | ***496*** | ***520*** | ***451*** | ***451*** | ***451*** | ***0*** | ***0*** | ***0*** | ***0*** |
| **5. OCCUPANCY PERCENTAGE** ***IMPORTANT NOTE:*** *Leap year formulas should be changed by applicant to reflect 366 days per year.* | | | | | | | | | | |
| a. General Medical/Surgical* | 68.2% | 66.6% | 68.8% | 71.4% | 70.4% | 70.2% | | | | |
| b. ICU/CCU | 58.9% | 61.1% | 64.5% | 73.2% | 71.2% | 68.3% | | | | |
| ***Total MSGA*** | **66.9%** | **65.8%** | **68.2%** | **71.7%** | **70.5%** | **69.9%** | | | | |
| c. Pediatric | 29.2% | 31.6% | 25.2% | 28.8% | 28.8% | 28.7% | | | | |
| d. Obstetric | 53.2% | 46.9% | 48.6% | 48.7% | 48.7% | 48.6% | | | | |
| e. Acute Psychiatric | 94.2% | 86.4% | 43.9% | 73.1% | 73.1% | 72.9% | | | | |
| ***Total Acute*** | **67.5%** | **65.5%** | **61.3%** | **68.1%** | **67.2%** | **66.7%** | | | | |
| f. Rehabilitation | 54.7% | 53.6% | 54.5% | 54.1% | 54.1% | 53.9% | | | | |
| g. Comprehensive Care | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | | | | |
| h. Other (Specify/add rows of needed) | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | | | | |
| ***TOTAL OCCUPANCY %*** | **66.0%** | **64.1%** | **60.5%** | **66.3%** | **65.5%** | **65.1%** | | | | |
| **6. OUTPATIENT VISITS** | | | | | | | | | | |
| a. Emergency Department | 86,675 | 76,254 | 71,514 | 93,340 | 119,507 | 148,982 | | | | |
| b. Same-day Surgery | 11,328 | 8,816 | 9,091 | 8,836 | 8,645 | 8,562 | | | | |
| c. Laboratory | | | | | | | | | | |
| d. Imaging | | | | | | | | | | |
| e. Other - Clinic Visits (Regulated) | 94,742 | 80,909 | 86,076 | 90,772 | 95,684 | 100,822 | | | | |
| e. Other - Renal Dialysis (Treatments) | | 15,863 | 16,000 | 16,500 | 17,000 | 17,500 | | | | |
| ***TOTAL OUTPATIENT VISITS*** | ***192,745*** | ***181,842*** | ***182,681*** | ***209,448*** | ***240,835*** | ***275,866*** | ***0*** | ***0*** | ***0*** | ***0*** |
| **7. OBSERVATIONS**** | | | | | | | | | | |
| a. Number of Patients | 9,824 | 7,862 | 5,399 | 6,767 | 8,420 | 10,329 | | | | |
| b. Hours | 185,797 | 144,374 | 135,375 | 171,271 | 214,148 | 262,362 | | | | |

**TABLE G. REVENUES & EXPENSES, UNINFLATED - SINAI HOSPITAL**

| | Two Most Recent Years (Actual) | | Current Year Projected | Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard. | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| *Indicate CY or FY* | FY 2019 (7/1/18 - 6/30/19) | FY 2020 (7/1/19 - 6/30/20) | FY 2021 (7/1/20 - 6/30/21) | Year 1 (7/1/21 - 6/30/22) | Year 2 (7/1/22 - 6/30/23) | Year 3 (7/1/23 - 6/30/24) | | | | |
| **1. REVENUE (in thousands)** | | | | | | | | | | |
| a. Inpatient Services | $414,140 | $431,943 | $526,622 | $536,622 | $536,622 | $536,622 | | | | |
| b. Outpatient Services | $593,509 | $586,605 | $582,392 | $582,392 | $582,392 | $582,392 | | | | |
| ***Gross Patient Service Revenues*** | ***$ 1,007,649*** | ***$ 1,018,548*** | ***$ 1,109,014*** | ***$ 1,119,014*** | ***$ 1,119,014*** | ***$ 1,119,014*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ -*** |
| c. Allowance For Bad Debt | $23,526 | $33,169 | $23,620 | $23,833 | $23,833 | $23,833 | | | | |
| d. Contractual Allowance | $212,620 | $205,942 | $233,914 | $236,023 | $236,023 | $236,023 | | | | |
| e. Charity Care | $5,247 | $6,346 | $4,519 | $4,560 | $4,560 | $4,560 | | | | |
| ***Net Patient Services Revenue*** | ***$ 766,257*** | ***$ 773,091*** | ***$ 846,961*** | ***$ 854,598*** | ***$ 854,598*** | ***$ 854,598*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ -*** |
| f. Other Operating Revenues (Specify/add rows if needed) | $37,594 | $53,923 | $46,233 | $37,500 | $37,500 | $37,500 | | | | |
| ***NET OPERATING REVENUE*** | ***$ 803,851*** | ***$ 827,014*** | ***$ 893,194*** | ***$ 892,098*** | ***$ 892,098*** | ***$ 892,098*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ -*** |
| **2. EXPENSES (in thousands)** | | | | | | | | | | |
| a. Salaries & Wages (including benefits) | $343,338 | $359,008 | $373,324 | $383,324 | $383,324 | $383,324 | | | | |
| b. Contractual Services | $95,084 | $90,227 | $99,656 | $99,656 | $99,656 | $99,656 | | | | |
| c. Interest on Current Debt | $996 | $1,028 | $902 | $791 | $694 | $609 | | | | |
| d. Interest on Project Debt | $0 | $0 | $0 | $0 | $0 | $0 | | | | |
| e. Current Depreciation | $33,216 | $31,574 | $31,877 | $33,183 | $36,043 | $41,149 | | | | |
| f. Project Depreciation | $0 | $0 | $0 | $0 | $0 | $0 | | | | |
| g. Current Amortization | ($969) | ($955) | ($938) | ($921) | ($904) | ($887) | | | | |
| h. Project Amortization | $0 | $0 | $0 | $0 | $0 | $0 | | | | |
| i. Supplies | $159,557 | $157,373 | $169,917 | $169,917 | $169,917 | $169,917 | | | | |
| j. Repairs and Maintenance | $9,215 | $8,415 | $9,968 | $9,968 | $9,968 | $9,968 | | | | |
| k. Other Expenses - Corporate Allocation | $144,444 | $144,898 | $147,489 | $147,489 | $147,489 | $147,489 | | | | |
| ***TOTAL OPERATING EXPENSES*** | **$784,881** | **$791,568** | **$832,195** | **$843,407** | **$846,187** | **$851,225** | **$0** | **$0** | **$0** | **$0** |
| **3. INCOME (in thousands)** | | | | | | | | | | |
| **a. Income From Operation** | **$18,970** | **$35,446** | **$60,999** | **$48,691** | **$45,911** | **$40,873** | **$0** | **$0** | **$0** | **$0** |
| b. Non-Operating Income | $22,186 | $19,817 | $71,041 | $20,000 | $20,000 | $20,000 | | | | |
| ***SUBTOTAL*** | ***$41,156*** | ***$55,263*** | ***$132,040*** | ***$68,691*** | ***$65,911*** | ***$60,873*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| c. Income Taxes | | | | | | | | | | |
| ***NET INCOME (LOSS)*** | ***$41,156*** | ***$55,263*** | ***$132,040*** | ***$68,691*** | ***$65,911*** | ***$60,873*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| **4. PATIENT MIX** | | | | | | | | | | |
| **a. Percent of Total Revenue** | | | | | | | | | | |
| 1) Medicare | 41.0% | 41.6% | 41.6% | 41.6% | 41.6% | 41.6% | | | | |
| 2) Medicaid | 3.9% | 4.4% | 4.4% | 4.4% | 4.4% | 4.4% | | | | |
| 3) Blue Cross | 11.9% | 12.6% | 12.6% | 12.6% | 12.6% | 12.6% | | | | |
| 4) MCO (Medicare & Medicaid) | 25.3% | 26.2% | 26.2% | 26.2% | 26.2% | 26.2% | | | | |
| 5) Commercial Insurance | | | | | | | | | | |
| 6) Self-pay | | | | | | | | | | |
| 7) Other | 17.9% | 15.2% | 15.2% | 15.2% | 15.2% | 15.2% | | | | |
| ***TOTAL*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** |
| **b. Percent of Equivalent Inpatient Days** | | | | | | | | | | |
| 1) Medicare | | | | | | | | | | |
| 2) Medicaid | | | | | | | | | | |
| 3) Blue Cross | | | | | | | | | | |
| 4) Commercial Insurance | | | | | | | | | | |
| 5) Self-pay | | | | | | | | | | |
| 6) Other | | | | | | | | | | |
| ***TOTAL*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** |

**TABLE G. REVENUES & EXPENSES, UNINFLATED - GRACE MEDICAL CENTER**

| | Two Most Recent Years (Actual) | | Current Year Projected | Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard. | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| *Indicate CY or FY* | FY 2019 (9/1/18 - 8/31/19) | FY 2020 (9/1/19 - 8/31/20) | FY 2021 (9/1/20 - 8/31/21) | Year 1 (9/1/21 - 8/31/22) | Year 2 (9/1/22 - 8/31/23) | Year 3 (9/1/23 - 8/31/24) | | | | |
| **1. REVENUE (in thousands)** | | | | | | | | | | |
| a. Inpatient Services | $63,817 | $23,047 | $2,812 | | | | | | | |
| b. Outpatient Services | $105,227 | $91,321 | $78,233 | $ 78,187 | $79,574 | $80,961 | | | | |
| ***Gross Patient Service Revenues*** | ***$ 169,044*** | ***$ 114,367*** | ***$ 81,045*** | ***$ 78,187*** | ***$ 79,574*** | ***$ 80,961*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ -*** |
| c. Allowance For Bad Debt | $3,110 | $5,175 | $1,257 | $1,249 | $1,253 | $1,257 | | | | |
| d. Contractual Allowance | $60,086 | $53,451 | $41,284 | $41,031 | $41,156 | $41,281 | | | | |
| e. Charity Care | $491 | $297 | $72 | $72 | $72 | $72 | | | | |
| ***Net Patient Services Revenue*** | ***$ 105,357*** | ***$ 55,445*** | ***$ 38,431*** | ***$ 35,835*** | ***$ 37,093*** | ***$ 38,351*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ -*** |
| f. Other Operating Revenues (Specify/add rows if needed) | $2,993 | $10,135 | $8,127 | $1,500 | $1,500 | $1,500 | | | | |
| ***NET OPERATING REVENUE*** | ***$ 108,350*** | ***$ 65,579*** | ***$ 46,558*** | ***$ 37,335*** | ***$ 38,593*** | ***$ 39,851*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ -*** |
| **2. EXPENSES (in thousands)** | | | | | | | | | | |
| a. Salaries & Wages (including benefits) | $63,076 | $44,246 | $33,754 | $28,489 | $23,330 | $18,275 | | | | |
| b. Contractual Services | $35,154 | $27,025 | $17,533 | $14,798 | $12,118 | $9,493 | | | | |
| c. Interest on Current Debt | $634 | $0 | $0 | $0 | $0 | $0 | | | | |
| d. Interest on Project Debt | $0 | $351 | $893 | $758 | $622 | $486 | | | | |
| e. Current Depreciation | $4,822 | $3,201 | $3,185 | $3,070 | $2,808 | $2,369 | | | | |
| f. Project Depreciation | $0 | $0 | $544 | $1,661 | $4,101 | $6,541 | | | | |
| g. Current Amortization | $0 | $0 | $5,600 | $0 | $0 | $0 | | | | |
| h. Project Amortization | $0 | $0 | $0 | $0 | $0 | $0 | | | | |
| i. Supplies | $8,639 | $6,022 | $5,664 | $5,664 | $5,664 | $5,664 | | | | |
| j. Repairs and Maintenance | $0 | $0 | $819 | $0 | $0 | $0 | | | | |
| k. Other Expenses - Corporate Allocation | $2,283 | $1,264 | $0 | $0 | $0 | $0 | | | | |
| ***TOTAL OPERATING EXPENSES*** | **$114,608** | **$82,109** | **$67,992** | **$54,440** | **$48,643** | **$42,829** | **$0** | **$0** | **$0** | **$0** |
| **3. INCOME (in thousands)** | | | | | | | | | | |
| **a. Income From Operation** | **($6,258)** | **($16,530)** | **($21,434)** | **($17,105)** | **($10,050)** | **($2,978)** | **$0** | **$0** | **$0** | **$0** |
| b. Non-Operating Income | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ***SUBTOTAL*** | ***($6,258)*** | ***($16,530)*** | ***($21,434)*** | ***($17,105)*** | ***($10,050)*** | ***($2,978)*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| c. Income Taxes | | | | | | | | | | |
| ***NET INCOME (LOSS)*** | ***($6,258)*** | ***($16,530)*** | ***($21,434)*** | ***($17,105)*** | ***($10,050)*** | ***($2,978)*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| **4. PATIENT MIX** | | | | | | | | | | |
| **a. Percent of Total Revenue** | | | | | | | | | | |
| 1) Medicare | 30.2% | 21.2% | 21.2% | 21.2% | 21.2% | 21.2% | | | | |
| 2) Medicaid | 17.0% | 6.3% | 6.3% | 6.3% | 6.3% | 6.3% | | | | |
| 3) Blue Cross | 1.9% | 2.7% | 2.7% | 2.7% | 2.7% | 2.7% | | | | |
| 4) MCO (Medicare & Medicaid) | 35.8% | 54.5% | 54.5% | 54.5% | 54.5% | 54.5% | | | | |
| 5) Commercial Insurance | | | | | | | | | | |
| 6) Self-pay | | | | | | | | | | |
| 7) Other | 15.2% | 15.2% | 15.2% | 15.2% | 15.2% | 15.2% | | | | |
| ***TOTAL*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** |
| **b. Percent of Equivalent Inpatient Days** | | | | | | | | | | |
| 1) Medicare | | | | | | | | | | |
| 2) Medicaid | | | | | | | | | | |
| 3) Blue Cross | | | | | | | | | | |
| 4) Commercial Insurance | | | | | | | | | | |
| 5) Self-pay | | | | | | | | | | |
| 6) Other | | | | | | | | | | |
| ***TOTAL*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** |

**TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY**

| | Two Most Recent Years (Actual) | | Current Year Projected | Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard. | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| *Indicate CY or FY* | FY 2019 (7/1/18 - 6/30/19) | FY 2020 (7/1/19 - 6/30/20) | FY 2021 (7/1/20 - 6/30/21) | Year 1 (7/1/21 - 6/30/22) | Year 2 (7/1/22 - 6/30/23) | Year 3 (7/1/23 - 6/30/24) | | | | |
| **1. REVENUE (in thousands)** | | | | | | | | | | |
| a. Inpatient Services | $477,957 | $454,990 | $529,434 | $536,622 | $536,622 | $536,622 | | | | |
| b. Outpatient Services | $698,736 | $677,926 | $660,625 | $660,579 | $661,966 | $663,353 | | | | |
| ***Gross Patient Service Revenues*** | ***$ 1,176,693*** | ***$ 1,132,915*** | ***$ 1,190,059*** | ***$ 1,197,201*** | ***$ 1,198,588*** | ***$ 1,199,975*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ -*** |
| c. Allowance For Bad Debt | $26,636 | $38,344 | $24,877 | $25,082 | $25,086 | $25,090 | | | | |
| d. Contractual Allowance | $272,706 | $259,393 | $275,198 | $277,054 | $277,179 | $277,304 | | | | |
| e. Charity Care | $5,738 | $6,643 | $4,591 | $4,631 | $4,632 | $4,632 | | | | |
| ***Net Patient Services Revenue*** | ***$ 871,614*** | ***$ 828,536*** | ***$ 885,392*** | ***$ 890,433*** | ***$ 891,691*** | ***$ 892,949*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ -*** |
| f. Other Operating Revenues (Specify/add rows if needed) | $40,587 | $64,058 | $54,360 | $39,000 | $39,000 | $39,000 | | | | |
| ***NET OPERATING REVENUE*** | ***$ 912,201*** | ***$ 892,593*** | ***$ 939,752*** | ***$ 929,433*** | ***$ 930,691*** | ***$ 931,949*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ -*** |
| **2. EXPENSES (in thousands)** | | | | | | | | | | |
| a. Salaries & Wages (including benefits) | $406,414 | $403,254 | $407,078 | $411,813 | $406,654 | $401,599 | $0 | $0 | $0 | $0 |
| b. Contractual Services | $130,238 | $117,252 | $117,189 | $114,454 | $111,774 | $109,149 | $0 | $0 | $0 | $0 |
| c. Interest on Current Debt | $1,630 | $1,028 | $902 | $791 | $694 | $609 | $0 | $0 | $0 | $0 |
| d. Interest on Project Debt | $0 | $351 | $893 | $758 | $622 | $486 | $0 | $0 | $0 | $0 |
| e. Current Depreciation | $38,038 | $34,775 | $35,062 | $36,253 | $38,851 | $43,518 | $0 | $0 | $0 | $0 |
| f. Project Depreciation | $0 | $0 | $544 | $1,661 | $4,101 | $6,541 | $0 | $0 | $0 | $0 |
| g. Current Amortization | ($969) | ($955) | $4,662 | ($921) | ($904) | ($887) | $0 | $0 | $0 | $0 |
| h. Project Amortization | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| i. Supplies | $168,196 | $163,395 | $175,581 | $175,581 | $175,581 | $175,581 | $0 | $0 | $0 | $0 |
| j. Repairs and Maintenance | $9,215 | $8,415 | $10,787 | $9,968 | $9,968 | $9,968 | $0 | $0 | $0 | $0 |
| k. Other Expenses - Corporate Allocation | $146,727 | $146,162 | $147,489 | $147,489 | $147,489 | $147,489 | $0 | $0 | $0 | $0 |
| ***TOTAL OPERATING EXPENSES*** | **$899,489** | **$873,677** | **$900,187** | **$897,847** | **$894,830** | **$894,054** | **$0** | **$0** | **$0** | **$0** |
| **3. INCOME (in thousands)** | | | | | | | | | | |
| **a. Income From Operation** | **$12,712** | **$18,916** | **$39,565** | **$31,586** | **$35,861** | **$37,895** | **$0** | **$0** | **$0** | **$0** |
| b. Non-Operating Income | $22,186 | $19,817 | $71,041 | $20,000 | $20,000 | $20,000 | $0 | $0 | $0 | $0 |
| ***SUBTOTAL*** | ***$34,898*** | ***$38,733*** | ***$110,606*** | ***$51,586*** | ***$55,861*** | ***$57,895*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| c. Income Taxes | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ***NET INCOME (LOSS)*** | ***$34,898*** | ***$38,733*** | ***$110,606*** | ***$51,586*** | ***$55,861*** | ***$57,895*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| **4. PATIENT MIX** | | | | | | | | | | |
| **a. Percent of Total Revenue** | | | | | | | | | | |
| 1) Medicare | 39.6% | 40.6% | 40.6% | 40.6% | 40.6% | 40.6% | | | | |
| 2) Medicaid | 5.5% | 4.5% | 4.5% | 4.5% | 4.5% | 4.5% | | | | |
| 3) Blue Cross | 10.7% | 12.1% | 12.1% | 12.1% | 12.1% | 12.1% | | | | |
| 4) MCO (Medicare & Medicaid) | 26.6% | 27.5% | 27.5% | 27.5% | 27.5% | 27.5% | | | | |
| 5) Commercial Insurance | | | | | | | | | | |
| 6) Self-pay | | | | | | | | | | |
| 7) Other | 17.5% | 15.2% | 15.2% | 15.2% | 15.2% | 15.2% | | | | |
| ***TOTAL*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** |
| **b. Percent of Equivalent Inpatient Days** | | | | | | | | | | |
| 1) Medicare | | | | | | | | | | |
| 2) Medicaid | | | | | | | | | | |
| 3) Blue Cross | | | | | | | | | | |
| 4) Commercial Insurance | | | | | | | | | | |
| 5) Self-pay | | | | | | | | | | |
| 6) Other | | | | | | | | | | |
| ***TOTAL*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** |

**TABLE H. ASSUMPTIONS**

| | Year 1 | Calculation Assumptions |
|---|---|---|
| Emergency Room | $ 14,538,953.75 | Visits * Avg. RVU/Visit * $171.25/RVU (FY21 Rate = $156.25/RVU) |
| Observation Hours | $ 2,190,350.40 | Observation Hrs.* $75.2/Hr (FY21 Rate = $69.88/Hr.) |
| Clinic Visits | $ 5,288,382.00 | Visits * Avg. RVU/Visit * $76.75/RVU (FY21 Rate = $71.16/RVU) |
| Same Day Surgery | $ 231,100.00 | Same Day Surgery Cases * $1,155.52/case (FY21 Rate = $1,069.67/Hr.) |
| OR & Anesthesia | $ 800,000.00 | 6-months YTD Dec had 82 SDS cases and 8,909 OR minutes; $499K of charges |
| Medical Supplies | $ 650,000.00 | 6-months YTD Dec outpatient charges = $432K |
| Laboratory | $ 2,500,000.00 | 6-months YTD Dec outpatient charges = $1.2M |
| Radiology | $ 2,200,000.00 | 6-months YTD Dec outpatient charges = $1.1M (EKG, EEG, Diag Radiology & CT Scan) |
| Drugs | $ 4,000,000.00 | 6-months YTD Dec outpatient charges = $3.5M |
| Total Regulated | $ 32,398,786.15 | |
| Total Unregulated | $ 45,787,500.00 | |
| Total Outpatient Services | $ 78,186,286.15 | = Grace Inflated Year 1 Gross Patient Service Projection (E8) |

| Additional Assumptions | |
|---|---|
| Annual Increase in gross patient services revenue | 2.5% |
| Annual increase in other operation revenue | 2.0% |
| Annual increase in salaries & wages (incl benefits), contractual services, and supplies | 2.0% |
| Rate assumptions based off HSCRC set rates. | |
| Inflation rate based on core inflation. | |
| Volume growth rate based on historical volume at facility and current affilation with LifeBridge Health. | |
| No changes in patient demographics / payor mix. | |

| FY '20 - Audited | | | | |
|---|---|---|---|---|
| | Bon | LBH | FY '20 | |
| Sal & Wage | $ 34,916 | $ 9,330 | $ 44,246 | |
| Supply | $ 4,782 | $ 1,240 | $ 6,022 | |
| Purch Serv | $ 19,460 | $ 7,565 | $ 27,025 | |
| Depr | $ 2,669 | $ 532 | $ 3,201 | |
| Repairs | $ 1,264 | $ - | $ 1,264 | |
| Interest | $ 351 | $ - | $ 351 | |
| | $ 63,442 | $ 18,667 | $ 82,109 | = Grace Inflated - Grace FY20 Total Operating Expenses (C27) |

| 19 MC C/R | | | |
|---|---|---|---|
| FY '19 | % of '20 Bon | Spread based on '20 | |
| Sal & Wage | 55.0% | $ 63,076 | |
| Supply | 7.5% | $ 8,639 | |
| Purch Serv | 30.7% | $ 35,154 | |
| Depr | 4.2% | $ 4,822 | |
| Repairs | 2.0% | $ 2,283 | |
| Interest | 0.6% | $ 634 | |
| | 100.0% | $ 114,608 | = Grace Inflated - Grace FY19 Total Operating Expenses (B27) |

**TABLE H. REVENUES & EXPENSES, INFLATED - SINAI HOSPITAL**

Grace Medical Center Data

*INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.*

| | Two Most Recent Years (Actual) | | Current Year Projected | Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard. | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Indicate CY or FY** | **FY 2019 (7/1/18 -** | **FY 2020 (7/1/19 -** | **FY 2021 (7/1/20 - 6/30/21)** | **Year 1 (7/1/21 - 6/30/22)** | **Year 2 (7/1/22 - 6/30/23)** | **Year 3 (7/1/23 - 6/30/24)** | | | | |
| **1. REVENUE (in thousands)** | | | | | | | | | | |
| a. Inpatient Services | $414,140 | $431,943 | $526,622 | $547,154 | $558,098 | $569,259 | | | | |
| b. Outpatient Services | $593,509 | $586,605 | $582,392 | $594,040 | $605,921 | $618,039 | | | | |
| ***Gross Patient Service Revenues*** | ***$1,007,649*** | ***$1,018,548*** | ***$1,109,014*** | ***$1,141,194*** | ***$1,164,018*** | ***$1,187,299*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| c. Allowance For Bad Debt | $23,526 | $33,169 | $23,620 | $24,305 | $24,791 | $25,287 | | | | |
| d. Contractual Allowance | $212,620 | $205,942 | $233,914 | $240,701 | $245,516 | $250,426 | | | | |
| e. Charity Care | $5,247 | $6,346 | $4,519 | $4,650 | $4,743 | $4,838 | | | | |
| ***Net Patient Services Revenue*** | ***$766,257*** | ***$773,091*** | ***$846,961*** | ***$871,537*** | ***$888,968*** | ***$906,747*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| f. Other Operating Revenues (Specify/add rows if needed) | $37,594 | $53,923 | $46,233 | $37,500 | $37,500 | $37,500 | | | | |
| ***NET OPERATING REVENUE*** | ***$803,851*** | ***$827,014*** | ***$893,194*** | ***$909,037*** | ***$926,468*** | ***$944,247*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| **2. EXPENSES (in thousands)** | | | | | | | | | | |
| a. Salaries & Wages (including benefits) | $343,338 | $359,008 | $373,324 | $394,524 | $406,360 | $418,551 | | | | |
| b. Contractual Services | $95,084 | $90,227 | $99,656 | $101,649 | $103,682 | $105,756 | | | | |
| c. Interest on Current Debt | $996 | $1,028 | $902 | $791 | $694 | $609 | | | | |
| d. Interest on Project Debt | $0 | $0 | $0 | $0 | $0 | $0 | | | | |
| e. Current Depreciation | $33,216 | $31,574 | $31,877 | $33,183 | $36,043 | $41,149 | | | | |
| f. Project Depreciation | $0 | $0 | $0 | $0 | $0 | $0 | | | | |
| g. Current Amortization | ($969) | ($955) | ($938) | ($921) | ($904) | ($887) | | | | |
| h. Project Amortization | $0 | $0 | $0 | $0 | $0 | $0 | | | | |
| i. Supplies | $159,557 | $157,373 | $169,917 | $175,015 | $180,265 | $185,673 | | | | |
| j. Repairs and Maintenance | $9,215 | $8,415 | $9,968 | $10,267 | $10,575 | $10,892 | | | | |
| k. Other Expenses - Corporate Allocation | $144,444 | $144,898 | $147,489 | $150,439 | $153,448 | $156,517 | | | | |
| ***TOTAL OPERATING EXPENSES*** | **$784,881** | **$791,568** | **$832,195** | **$864,947** | **$890,163** | **$918,260** | **$0** | **$0** | **$0** | **$0** |
| **3. INCOME (in thousands)** | | | | | | | | | | |
| **a. Income From Operation** | **$18,970** | **$35,446** | **$60,999** | **$44,090** | **$36,305** | **$25,987** | **$0** | **$0** | **$0** | **$0** |
| b. Non-Operating Income | $22,186 | $19,817 | $71,041 | $20,000 | $20,000 | $20,000 | | | | |
| ***SUBTOTAL*** | ***$41,156*** | ***$55,263*** | ***$132,040*** | ***$64,090*** | ***$56,305*** | ***$45,987*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| c. Income Taxes | | | | | | | | | | |
| ***NET INCOME (LOSS)*** | ***$41,156*** | ***$55,263*** | ***$132,040*** | ***$64,090*** | ***$56,305*** | ***$45,987*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| **4. PATIENT MIX** | | | | | | | | | | |
| **a. Percent of Total Revenue** | | | | | | | | | | |
| 1) Medicare | 41.0% | 41.6% | 41.6% | 41.6% | 41.6% | 41.6% | | | | |
| 2) Medicaid | 3.9% | 4.4% | 4.4% | 4.4% | 4.4% | 4.4% | | | | |
| 3) Blue Cross | 11.9% | 12.6% | 12.6% | 12.6% | 12.6% | 12.6% | | | | |
| 4) MCO (Medicare & Medicaid) | 25.3% | 26.2% | 26.2% | 26.2% | 26.2% | 26.2% | | | | |
| 5) Commercial Insurance | | | | | | | | | | |
| 6) Self-pay | | | | | | | | | | |
| 7) Other | 17.9% | 15.2% | 15.2% | 15.2% | 15.2% | 15.2% | | | | |
| ***TOTAL*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** |
| **b. Percent of Equivalent Inpatient Days** | | | | | | | | | | |
| ***Total MSGA*** | | | | | | | | | | |
| 1) Medicare | | | | | | | | | | |
| 2) Medicaid | | | | | | | | | | |
| 3) Blue Cross | | | | | | | | | | |
| 4) Commercial Insurance | | | | | | | | | | |
| 5) Self-pay | | | | | | | | | | |
| 6) Other | | | | | | | | | | |
| ***TOTAL*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** |

**TABLE H. REVENUES & EXPENSES, INFLATED - GRACE**

Grace Medical Center Data

*INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.*

| | Two Most Recent Years (Actual) | | Current Year Projected | Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard. | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Indicate CY or FY** | **FY 2019 (9/1/18 - 8/31/19)** | **FY 2020 (9/1/19 - 8/31/20)** | **FY 2021 (9/1/20 - 8/31/21)** | **Year 1 (9/1/21 - 8/31/22)** | **Year 2 (9/1/22 - 8/31/23)** | **Year 3 (9/1/23 - 8/31/24)** | | | | |
| **1. REVENUE (in thousands)** | | | | | | | | | | |
| a. Inpatient Services | $63,817 | $23,047 | $2,812 | $0 | $0 | $0 | | | | |
| b. Outpatient Services | $105,227 | $91,321 | $78,233 | $78,187 | $81,528 | $84,953 | | | | |
| ***Gross Patient Service Revenues*** | ***$169,044*** | ***$114,367*** | ***$81,045*** | ***$78,187*** | ***$81,528*** | ***$84,953*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| c. Allowance For Bad Debt | $3,110 | $5,175 | $1,257 | $1,249 | $1,258 | $1,268 | | | | |
| d. Contractual Allowance | $60,086 | $53,451 | $41,284 | $41,031 | $41,332 | $41,640 | | | | |
| e. Charity Care | $491 | $297 | $72 | $72 | $72 | $73 | | | | |
| ***Net Patient Services Revenue*** | ***$105,357*** | ***$55,445*** | ***$38,431*** | ***$35,835*** | ***$38,866*** | ***$41,972*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| f. Other Operating Revenues (Specify/add rows if needed) | $2,993 | $10,135 | $8,127 | $1,500 | $1,530 | $1,561 | | | | |
| ***NET OPERATING REVENUE*** | ***$108,350*** | ***$65,579*** | ***$46,558*** | ***$37,335*** | ***$40,396*** | ***$43,533*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| **2. EXPENSES (in thousands)** | | | | | | | | | | |
| a. Salaries & Wages (including benefits) | $63,076 | $44,246 | $33,754 | $29,164 | $24,588 | $20,025 | | | | |
| b. Contractual Services | $35,154 | $27,025 | $17,533 | $15,149 | $12,772 | $10,402 | | | | |
| c. Interest on Current Debt | $634 | $0 | $0 | $0 | $0 | $0 | | | | |
| d. Interest on Project Debt | $0 | $351 | $893 | $758 | $622 | $486 | | | | |
| e. Current Depreciation | $4,822 | $3,201 | $3,185 | $3,070 | $2,808 | $2,369 | | | | |
| f. Project Depreciation | $0 | $0 | $544 | $1,661 | $4,101 | $6,541 | | | | |
| g. Current Amortization | $0 | $0 | $5,600 | $0 | $0 | $0 | | | | |
| h. Project Amortization | $0 | $0 | $0 | $0 | $0 | $0 | | | | |
| i. Supplies | $8,639 | $6,022 | $5,664 | $5,777 | $5,893 | $6,011 | | | | |
| j. Repairs and Maintenance | $0 | $0 | $819 | $0 | $0 | $0 | | | | |
| k. Other Expenses - Corporate Allocation | $2,283 | $1,264 | $0 | $0 | $0 | $0 | | | | |
| ***TOTAL OPERATING EXPENSES*** | **$114,608** | **$82,109** | **$67,992** | **$55,579** | **$50,784** | **$45,835** | **$0** | **$0** | **$0** | **$0** |
| **3. INCOME (in thousands)** | | | | | | | | | | |
| **a. Income From Operation** | **($6,258)** | **($16,530)** | **($21,434)** | **($18,244)** | **($10,389)** | **($2,302)** | **$0** | **$0** | **$0** | **$0** |
| b. Non-Operating Income | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ***SUBTOTAL*** | ***($6,258)*** | ***($16,530)*** | ***($21,434)*** | ***($18,244)*** | ***($10,389)*** | ***($2,302)*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| c. Income Taxes | | | | | | | | | | |
| ***NET INCOME (LOSS)*** | ***($6,258)*** | ***($16,530)*** | ***($21,434)*** | ***($18,244)*** | ***($10,389)*** | ***($2,302)*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| **4. PATIENT MIX** | | | | | | | | | | |
| **a. Percent of Total Revenue** | | | | | | | | | | |
| 1) Medicare | 30.2% | 21.2% | 21.2% | 21.2% | 21.2% | 21.2% | | | | |
| 2) Medicaid | 17.0% | 6.3% | 6.3% | 6.3% | 6.3% | 6.3% | | | | |
| 3) Blue Cross | 1.9% | 2.7% | 2.7% | 2.7% | 2.7% | 2.7% | | | | |
| 4) MCO (Medicare & Medicaid) | 35.8% | 54.5% | 54.5% | 54.5% | 54.5% | 54.5% | | | | |
| 5) Commercial Insurance | | | | | | | | | | |
| 6) Self-pay | | | | | | | | | | |
| 7) Other | 15.2% | 15.2% | 15.2% | 15.2% | 15.2% | 15.2% | | | | |
| ***TOTAL*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** |
| **b. Percent of Equivalent Inpatient Days** | | | | | | | | | | |
| ***Total MSGA*** | | | | | | | | | | |
| 1) Medicare | | | | | | | | | | |
| 2) Medicaid | | | | | | | | | | |
| 3) Blue Cross | | | | | | | | | | |
| 4) MCO (Medicare & Medicaid) | | | | | | | | | | |
| 5) Commercial Insurance | | | | | | | | | | |
| 6) Self-pay | | | | | | | | | | |
| 7) Other | | | | | | | | | | |
| ***TOTAL*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** |

**TABLE H. REVENUES & EXPENSES, INFLATED - COMBINED (SINAI & GRACE)**

Grace Medical Center Data

*INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.*

| | Two Most Recent Years (Actual) | | Current Year Projected | Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard. | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Indicate CY or FY** | **FY 2019 (7/1/18 - 6/30/19)** | **FY 2020 (7/1/19 - 6/30/20)** | **FY 2021 (7/1/20 - 6/30/21)** | **Year 1 (7/1/21 - 6/30/22)** | **Year 2 (7/1/22 - 6/30/23)** | **Year 3 (7/1/23 - 6/30/24)** | | | | |
| **1. REVENUE (in thousands)** | | | | | | | | | | |
| a. Inpatient Services | $477,957 | $454,990 | $529,434 | $547,154 | $558,098 | $569,259 | | | | |
| b. Outpatient Services | $698,736 | $677,926 | $660,625 | $672,226 | $687,449 | $702,992 | | | | |
| ***Gross Patient Service Revenues*** | ***$1,176,693*** | ***$1,132,915*** | ***$1,190,059*** | ***$1,219,381*** | ***$1,245,546*** | ***$1,272,252*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| c. Allowance For Bad Debt | $26,636 | $38,344 | $24,877 | $25,555 | $26,050 | $26,555 | | | | |
| d. Contractual Allowance | $272,706 | $259,393 | $275,198 | $281,732 | $286,847 | $292,066 | | | | |
| e. Charity Care | $5,738 | $6,643 | $4,591 | $4,722 | $4,815 | $4,911 | | | | |
| ***Net Patient Services Revenue*** | ***$871,614*** | ***$828,536*** | ***$885,392*** | ***$907,372*** | ***$927,834*** | ***$948,720*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| f. Other Operating Revenues (Specify/add rows if needed) | $40,587 | $64,058 | $54,360 | $39,000 | $39,030 | $39,061 | | | | |
| ***NET OPERATING REVENUE*** | ***$912,201*** | ***$892,593*** | ***$939,752*** | ***$946,372*** | ***$966,864*** | ***$987,781*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| **2. EXPENSES (in thousands)** | | | | | | | | | | |
| a. Salaries & Wages (including benefits) | $406,414 | $403,254 | $407,078 | $423,688 | $430,948 | $438,576 | | | | |
| b. Contractual Services | $130,238 | $117,252 | $117,189 | $116,798 | $116,454 | $116,158 | | | | |
| c. Interest on Current Debt | $1,630 | $1,028 | $902 | $791 | $694 | $609 | | | | |
| d. Interest on Project Debt | $0 | $351 | $893 | $758 | $622 | $486 | | | | |
| e. Current Depreciation | $38,038 | $34,775 | $35,062 | $36,253 | $38,851 | $43,518 | | | | |
| f. Project Depreciation | $0 | $0 | $544 | $1,661 | $4,101 | $6,541 | | | | |
| g. Current Amortization | ($969) | ($955) | $4,662 | ($921) | ($904) | ($887) | | | | |
| h. Project Amortization | $0 | $0 | $0 | $0 | $0 | $0 | | | | |
| i. Supplies | $168,196 | $163,395 | $175,581 | $180,792 | $186,158 | $191,684 | | | | |
| j. Repairs and Maintenance | $9,215 | $8,415 | $10,787 | $10,267 | $10,575 | $10,892 | | | | |
| k. Other Expenses-Corporate Allocation | $146,727 | $146,162 | $147,489 | $150,439 | $153,448 | $156,517 | | | | |
| ***TOTAL OPERATING EXPENSES*** | **$899,489** | **$873,677** | **$900,187** | **$920,526** | **$940,947** | **$964,095** | **$0** | **$0** | **$0** | **$0** |
| **3. INCOME (in thousands)** | | | | | | | | | | |
| **a. Income From Operation** | **$12,712** | **$18,916** | **$39,565** | **$25,846** | **$25,916** | **$23,686** | **$0** | **$0** | **$0** | **$0** |
| b. Non-Operating Income | $22,186 | $19,817 | $71,041 | $20,000 | $20,000 | $20,000 | | | | |
| ***SUBTOTAL*** | ***$34,898*** | ***$38,733*** | ***$110,606*** | ***$45,846*** | ***$45,916*** | ***$43,686*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| c. Income Taxes | | | | | | | | | | |
| ***NET INCOME (LOSS)*** | ***$34,898*** | ***$38,733*** | ***$110,606*** | ***$45,846*** | ***$45,916*** | ***$43,686*** | ***$0*** | ***$0*** | ***$0*** | ***$0*** |
| **4. PATIENT MIX** | | | | | | | | | | |
| **a. Percent of Total Revenue** | | | | | | | | | | |
| 1) Medicare | 39.6% | 40.6% | 40.6% | 40.6% | 40.6% | 40.6% | | | | |
| 2) Medicaid | 5.5% | 4.5% | 4.5% | 4.5% | 4.5% | 4.5% | | | | |
| 3) Blue Cross | 10.7% | 12.1% | 12.1% | 12.1% | 12.1% | 12.1% | | | | |
| 4) MCO (Medicare & Medicaid) | 26.6% | 27.5% | 27.5% | 27.5% | 27.5% | 27.5% | | | | |
| 5) Commercial Insurance | | | | | | | | | | |
| 6) Self-pay | | | | | | | | | | |
| 7) Other | 17.5% | 15.2% | 15.2% | 15.2% | 15.2% | 15.2% | | | | |
| ***TOTAL*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***100.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** |
| **b. Percent of Equivalent Inpatient Days** | | | | | | | | | | |
| ***Total MSGA*** | | | | | | | | | | |
| 1) Medicare | | | | | | | | | | |
| 2) Medicaid | | | | | | | | | | |
| 3) Blue Cross | | | | | | | | | | |
| 4) Commercial Insurance | | | | | | | | | | |
| 5) Self-pay | | | | | | | | | | |
| 6) Other | | | | | | | | | | |
| ***TOTAL*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** | ***0.0%*** |

**TABLE L. WORKFORCE INFORMATION**

Grace Medical Center Data

| | *CURRENT ENTIRE FACILITY* | | | *PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)* | | | *OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)* | | | *PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) ** | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Job Category** | **Current Year FTEs** | **Average Salary per FTE** | **Current Year Total Cost** | **FTEs** | **Average Salary per FTE** | **Total Cost** *(should be consistent with projections in Table G, if submitted).* | **FTEs** | **Average Salary per FTE** | **Total Cost** | **FTEs** | **Total Cost** *(should be consistent with projections in Table G)* |
| **1. Regular Employees** | | | | | | | | | | | |
| Administration *(List general categories, add rows if needed)* | | | | | | | | | | | |
| Admin | 16.3 | $102,532 | $1,674,234 | | | | | | | 16.3 | $1,674,234 |
| Finance | 6.0 | $86,549 | $515,418 | | | | | | | 6.0 | $515,418 |
| HIM | 3.3 | $62,880 | $206,490 | | | | | | | 3.3 | $206,490 |
| Human Resources | 2.1 | $89,605 | $184,208 | | | | | | | 2.1 | $184,208 |
| Marketing | 1.9 | $83,737 | $161,422 | | | | | | | 1.9 | $161,422 |
| **Total Administration** | **29.6** | | **$2,741,772** | **0.0** | | **$0** | **0.0** | | **$0** | **29.6** | **$2,741,772** |
| Direct Care Staff *(List general categories, add rows if needed)* | | | | | | | | | | | |
| Cardiology | 6.0 | $77,617 | $464,251 | | | | | | | 6.0 | $464,251 |
| clinic | 41.9 | $88,842 | $3,724,875 | | | | | | | 41.9 | $3,724,875 |
| ED/OBS | 37.9 | $73,873 | $2,796,673 | 22.3 | $73,873 | $1,649,588 | | | | 60.2 | $4,446,261 |
| IP Nursing | 105.7 | $74,716 | $7,894,634 | -105.7 | $74,716 | -$7,897,436 | | | | 0.0 | -$2,802 |
| Lab | 12.6 | $72,183 | $910,663 | | | | | | | 12.6 | $910,663 |
| OP Renal | 29.4 | $64,586 | $1,900,295 | | | | | | | 29.4 | $1,900,295 |
| OR | 19.1 | $92,526 | $1,762,702 | | | | | | | 19.1 | $1,762,702 |
| Pharmacy | 7.1 | $54,539 | $387,456 | | | | | | | 7.1 | $387,456 |
| Physical Therapy | 4.7 | $84,131 | $394,464 | | | | | | | 4.7 | $394,464 |
| PT Transport | 3.3 | $28,780 | $96,191 | -3.3 | $28,780 | -$94,976 | | | | 0.0 | $1,216 |
| Quality Mgmt | 16.3 | $80,118 | $1,309,270 | -13.8 | $80,118 | -$1,105,628 | | | | 2.5 | $203,642 |
| Radiology | 17.4 | $76,826 | $1,337,834 | -7.7 | $76,826 | -$591,561 | | | | 9.7 | $746,273 |
| Respiratory Therapy | 10.8 | $72,997 | $786,227 | -3.3 | $72,997 | -$240,891 | | | | 7.5 | $545,336 |
| Vascular Lab | 3.8 | $75,813 | $290,408 | | | | | | | 3.8 | $290,408 |
| **Total Direct Care** | **316.0** | | **$24,055,943** | **-111.5** | | **-$8,280,902** | **0.0** | | **$0** | **204.6** | **$15,775,041** |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| Communications | 6.7 | $32,374 | $217,366 | | | | | | | 6.7 | $217,366 |
| IT | 3.5 | $98,476 | $348,083 | | | | | | | 3.5 | $348,083 |
| Materials Mgmt | 5.2 | $51,309 | $266,720 | | | | | | | 5.2 | $266,720 |
| Registration | 12.5 | $39,064 | $488,992 | | | | | | | 12.5 | $488,992 |
| Transporation | 5.6 | $34,194 | $191,178 | | | | | | | 5.6 | $191,178 |
| **Total Support Staff** | ***33.6*** | | **$1,512,338** | ***0.0*** | | **$0** | ***0.0*** | | **$0** | **33.6** | **$1,512,338** |
| **Total** | ***379.2*** | | **$28,310,054** | ***-111.5*** | | **-$8,280,902** | ***0.0*** | | **$0** | **267.8** | **$20,029,151** |
| | | | | | | | | | | | |
| ***CONTRACTUAL EMPLOYEES TOTAL*** | | | **$1,696,330** | | | **-$356,967** | | | | **0.0** | **$1,339,363** |
| **Benefits** *(State method of calculating benefits below)* **: @24% of Salaries** | | | **6,794,413** | | | **-1,987,417** | | | **0** | | **4,806,996** |
| | | | | | | | | | | | |
| ***TOTAL COST*** | ***379.2*** | | ***$36,800,797*** | ***-111.5*** | | ***-$10,625,286*** | ***0.0*** | | ***$0*** | ***267.7*** | ***$26,175,511*** |

Exhibit 2

# Transition Plan for Grace Medical Center

**History**

For over 100 years, the Congregation of the Sisters of Bon Secours have offered "Good Help to Those in Need" in the West Baltimore community. In 1919, the Sisters established a hospital in Baltimore to provide greater care for the local community. The services provided by the hospital expanded over the years and, by 2018, Bon Secours Hospital Baltimore had become a 69-bed hospital providing emergency care, intensive care, general surgery, primary care, and outpatient dialysis, as well as outpatient primary and secondary care clinics, including endocrinology, cardiology, neurology, orthopedics, podiatry and urology.

**Acquisition by LifeBridge Health**

In 2018, the Bon Secours Health System (the corporate parent of Bon Secours Hospital Baltimore) merged with Mercy Health of Ohio, creating a combined not-for-profit Catholic health system under the name Bon Secours Mercy Health, Inc. (BSMH). Shortly following the merger, BSMH indicated that it planned to sell Bon Secours Hospital Baltimore and LifeBridge Health was invited to participate in the transaction process. The hospital was facing significant financial hardship and if no transaction partner stepped forward, it would it would likely be forced to close, cutting off vital services to a community in need.

In considering whether to acquire the hospital, LifeBridge Health determined that certain programs would need to be modified, while clinical services and the physical infrastructure would need to be enhanced in order to assure sustainability of the organization and provision of high-quality services. LifeBridge analyzed the services being provided, the needs of the community and the integrity of the buildings. A comprehensive Community Health Needs Assessment was conducted, and LifeBridge Health executive leadership met with community members and asked what services they felt were needed on-site. Through these meetings, LifeBridge learned that the community placed a high priority on pediatric services, women's health services, and ophthalmology services. LifeBridge's analysis further showed that having an emergency department, outpatient clinics, outpatient surgical services, and the continuance of outpatient behavioral health services, substance abuse clinics and outpatient dialysis would best serve the current and future needs of the community. It was ultimately determined that critical care (ICU), medical/surgical and inpatient behavioral health services were not sustainable from a quality or cost perspective. However, integrating the hospital into the LifeBridge system could help ameliorate any negative impact of eliminating these services at the hospital, as care could be transitioned to other LifeBridge facilities where appropriate, including Sinai Hospital of Baltimore ("Sinai") and Northwest Hospital Center ("Northwest"), subsidiaries of LifeBridge located approximately five and twelve miles away from the hospital, respectively.

In addition to potential changes to the services offered by the hospital, LifeBridge inspected its existing facilities and determined that they were in significant need of renovation or

replacement. LifeBridge proposed to construct a new, state-of-the-art facility either on the existing hospital campus or in the immediately surrounding neighborhood. To minimize disruption to the community in desperate need of healthcare services, LifeBridge planned to continue operating the emergency department and offer other streamlined services during the construction of the new site.

On November 1, 2019, LifeBridge Health acquired Bon Secours Hospital. With the acquisition came a new name: Grace Medical Center. At Grace Medical Center, LifeBridge Health continues what Bon Secours started -- focusing efforts on the social determinants of health, and providing healthcare for all, regardless of patients' socio-economic status and ability to pay.

**Conversion to Freestanding Medical Facility**

In conjunction with the Community Heath Needs Assessment and following conversations with community members and local non-profit partners, the decision was made, that as inpatient programs and beds were scaled back, the hospital would be converted into a freestanding medical facility, commonly referred to as an "FMF". Under Maryland law, an FMF is a facility offering medical and health services similar in nature to a hospital. However, the services which may be provided by a freestanding medical facility are narrower in scope than those which may be provided by a hospital. For example, an FMF is only permitted to retain patients overnight for observation. Similarly, an FMF does not provide complex inpatient surgical procedures, labor and delivery, oncology services or critical care. However, unlike an urgent care center that is more limited in services and has defined hours of operation, a freestanding medical facility provides more advanced lifesaving, imaging, and laboratory capabilities, 24 hours a day 7 days a week. FMFs also have staff that include physicians and nurses specifically trained and certified in emergency care. In Maryland, an FMF must be part of an acute care general hospital and must be physically separated from the hospital or hospital grounds. The FMF must also comply with the Emergency Medical Treatment and Labor Act (EMTALA) and the Medicare Conditions of Participation.

<u>Changes to the Hospital's Physical Plant and Site</u>

As part of the transition to an FMF, Grace Medical Center will undergo a two-phase renovation process. In Phase I of the project, which is currently underway, the newest building on the existing hospital campus is currently being renovated to create a state-of-the-art emergency department, as well as new surgery and clinic space. The surgery space is expected to be completed by July 2020, while the emergency department and clinic space are expected to be completed by December 2020.

In Phase II of the project, the other buildings on the existing hospital campus will receive environmental remediation and demolition, allowing for the construction of a new 20,000 square foot outpatient behavioral health facility and green space for the community. The new on-site outpatient behavioral health facility will house programs which include a children's day

school (for children 6-10 years old) operated under the supervision psychologists, an adult day program, and an outpatient behavioral health counseling program. The demolition of the existing hospital is expected to be complete in September 2021, while the new outpatient behavioral health facility is expected to be constructed by June 2023.

Please refer to the enclosed slides for additional information and visuals regarding the renovation plans.

Provision of Acute Care Services

As a freestanding medical facility, Grace Medical Center will continue to provide a range of health and wellness services that are vital to the West Baltimore Community. These services include:

- 24/7 Emergency services
- 24/7 Observation services
- Outpatient dialysis
- Radiology
- Outpatient behavioral health and substance abuse clinics
- Primary care
- Outpatient surgery
- Outpatient Specialty care: pediatrics, OB/GYN, wound care, vascular surgery, orthopedics, ophthalmology, general outpatient surgery, endocrinology, cardiology, gastroenterology, podiatry, urology, neurology
- Diagnostic testing
- 3D Mammography
- Respiratory therapy
- Case management

These services may be modified over time, based on our ongoing evaluation of community health needs as well as feedback from the community.

*Emergency and Observation*
As an FMF, Grace will continue to provide 24/7 emergency services and observation services but will no longer have inpatient care for medical or surgical cases, intensive care or inpatient behavioral health.

We anticipate 22,000-23,000 visits to the Grace emergency department and observation unit this year. The emergency room will continue to provide comprehensive services, from stabilizing critically ill or injured patients to servicing patients with lower acuity needs. The facility will also provide diagnostic radiology, telemedicine, and social services.

An 8-bed observation unit will be part of the new state-of-the-art emergency department to assist patients who need less than 24 hours of care. Grace will also assist patients needing stabilization of chronic disease and medication management.

The FMF will continue to accept all priority levels from the city and local EMS providers. Grace Medical Center will communicate with LifeBridge Health's virtual hospital for all patients requiring inpatient medical, surgical, critical care or inpatient behavioral health services. Once a patient is stabilized at the FMF, the emergency physician working with the 'medical quarterback' at the virtual hospital will seamlessly transfer the patient to the appropriate level of care using the most appropriate means of medical transportation.

Due to the historical volumes of patients and the fact that certain clinical staff formerly stationed at Grace have been relocated to Sinai and Northwest, Sinai and Northwest are able to absorb patients from Grace. The LifeBridge virtual hospital is staffed by nurses, advance practice providers and physicians who will collaborate with the emergency provider at Grace and facilitate the appropriate transfer of the patient as a direct admission to the appropriate hospital and department for care. LBH has a long-standing partnership with Pulse Medical Transportation and has an ambulance stationed at Grace. The ambulance is equipped and staffed to provide advanced life support.

Beginning on November 1, 2020, patients arriving at Grace Medical Center in need of inpatient behavioral health services will be transferred to Sinai or Northwest's inpatient behavioral health units depending on the level of care needed and the preference of the patient. Patients in need of outpatient behavioral health services will continue to have access to a psychiatry case worker and psychiatry assessment through the Grace Medical Center Outpatient Behavioral health services programs. Currently Sinai and Northwest are working to expand their physical capacity for inpatient behavioral health patients. Sinai's construction will be completed and ready for inpatient behavioral health patients in November, and Northwest shortly thereafter. The current capacity at Grace Medical for inpatient behavioral health patients today is 20.

Grace currently uses the evidence based SBIRT (Screening, Brief Intervention, and Referral to Treatment) practice in the emergency department. These services are covered by grants that assist us in treating a large homeless and emergency population that come to the emergency department in crisis. A material number of patients struggle with substance abuse conditions. We are applying for grants to resume offering HIV testing in the emergency room.

Patients access Grace Medical Center's emergency department through city and private ambulance companies, walk-ins, private or public transportation. Grace Medical has agreements with private ambulance companies to transport patients to hospitals in the LifeBridge Health system for those patients who need to be admitted. Grace Medical has

proactively worked with MIEMSS (Maryland Institute for Emergency Medical Services Systems) to ensure that there are no disruptions and to make sure that communities in west Baltimore are served and patients are brought to Grace Medical Center via 911 calls.

We have had (and will continue) ongoing dialogue with the local EMS providers and state authorities to best serve the needs of our patients and the community. We follow EMTALA laws governing emergency departments.

*Outpatient Dialysis*

Other services continuing at Grace Medical Center include the 35-chair outpatient dialysis center that will continue to provide dialysis and nephrology care. Grace Medical currently takes all outpatient dialysis patients regardless of their ability to pay. We assist uninsured patients by helping them sign up for Medicaid. The nephrologists who oversee the program are currently completing over 1,300 treatments per month. The need for dialysis is so great in the community that we are expanding the program to add 6 additional chairs.

*Primary Care*

Along with our dialysis program, primary care and specialty care continue on-site and will both be expanded. The current primary care physicians will continue their services and provide those services regardless of a patient's ability to pay. The primary care physicians participate in the Community Health Needs Assessment and assist with the implementation plan as much of the focus has been on obesity, diabetes, chronic disease management and social needs coordination. The primary care clinic will also include certain pediatric services.

*Specialty Services*

In partnership with primary care, Grace Medical Center will continue endocrinology services to address diabetes and metabolic conditions and a licensed diabetes educator will provide services around diabetes education. Additional specialty services will be embedded with primary care. Other specialties we are planning include vascular surgery, as well as orthopedics, podiatry, urology, neurology, ophthalmology, wound care, general outpatient surgical services, gastroenterology, and cardiology. Those services are delivered in the clinic setting as well as emergency and outpatient settings.

*Outpatient Surgery*

Grace Medical Center will include two surgical suites for outpatient surgeries and procedures. Procedures such as wound debridement, abscess drainage and outpatient orthoscopic and endoscopic procedures will be offered.

<u>Plan for Job Retraining and Placement of Grace Medical Center Employees</u>

Since the acquisition of Grace Medical Center, LifeBridge Health has been proactively working with the employees in the areas of critical care and medical surgical care to find new jobs within the LifeBridge Health System. We believe that our alignment with Grace will be of great benefit to the community, as well as the employees of Grace. A benefit to joining the Lifebridge Health system is access to greater opportunity for employment, as well as opportunity for career growth. Prior to November 1, 2019, the legacy Bon Secours human resource department working alongside LifeBridge Health human resources and clinical leaders held career fairs for both Sinai and Northwest. Employees who worked in critical care areas and medical surgical areas were invited to the career fair and visited critical care and medical surgical areas in Sinai and Northwest. Employees were invited to shadow clinical peers in departments of their choosing. Since November 1, 2019, 44 clinical staff have successfully transferred to Sinai or Northwest.

In advance of the relocation of inpatient behavioral health services from Grace to Sinai and Northwest, we will undertake the same exercise with the Grace behavioral health staff. LifeBridge Health human resources and clinical leadership are proactively identifying open positions across the health system for employees impacted by the new scope of Grace Medical Center. The multi-disciplinary team made up of human resources and clinical leadership has worked hard to provide clear and regular communications via management councils, town halls and printed materials. On a bi-weekly basis the team meets to discuss openings in the broader system and provide cross training opportunities.

Over the past year, the LifeBridge Health team has also worked to build meaningful relationships within the west Baltimore community -- one area of focus in this community development has been potential job placement. The LifeBridge team has participated in several community meetings with Bon Secours Community Works, Fayette Street Outreach, Boyd-Booth neighborhood association, and Southwest Partnership, updating groups on the progress of the acquisition, the future of Grace Medical and opportunities for employees. It is a privilege to come together with Grace to meet the needs of the community and further the mission of providing exceptional health and wellness services to those in need.


# About Grace Medical Center

## LifeBridge Health Welcomes Grace Medical Center

Grace Medical Center (formerly Bon Secours Baltimore Hospital) is committed to the mission of caring for people in our communities. Grace Medical Center allows LifeBridge Health to advance healthcare services and community resources in West Baltimore, thereby creating more opportunities for our patients and neighbors. We are dedicated to enhancing the care LifeBridge Health provides to the residents of West Baltimore.

## Transition Plan for Grace Medical Center

For more than 100 years, the Congregation of the Sisters of Bon Secours has been offering "Good Help to Those in Need" in the West Baltimore community.

In 1919, the Sisters established a hospital in Baltimore to provide greater care for the local community. The services provided by the hospital expanded over the years and, by 2018, Bon Secours Hospital Baltimore (now Grace Medical Center) had become a 69-bed facility providing emergency care, intensive care, general surgery, primary care and outpatient dialysis, as well as outpatient primary and secondary care clinics including endocrinology, cardiology, neurology, orthopedics, podiatry and urology.

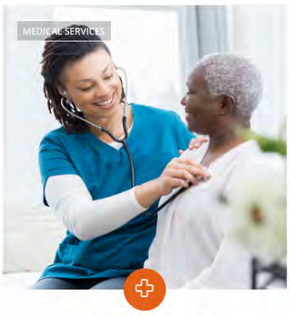
There will be two virtual town halls (via conference call) regarding proposed changes to Grace Medical Center on June 16 and June 18, 2020 at 7 p.m. (both nights).

Attendees may participate in the town halls by dialing the following numbers:
June 16, 2020 - 410-949-1362
June 18, 2020 - 410-949-1361

Read more about the Transition Plan | Read more about Campus Improvements


Grace Medical Center
→


MyChart gives you direct online access to portions of the electronic medical record (EMR) where your doctor stores your health information.
→




Explore our available medical services.
→

## LIFEBRIDGE HEALTH CENTERS OF EXCELLENCE

- Brain and Spine
- Cancer
- Cardiology
- Emergency Medicine
- Eye Care
- Minimally Invasive & Robotic Surgery
- Orthopedics
- Pain Management
- Pediatrics
- Primary Care
- Rehabilitation
- Women's Services

## UPCOMING EVENTS

VIEW ALL EVENTS

Notice of Public Informational Hearings - June 18, 2020 – 6/18/2020

## Additional Information

- Patient and Visitor Information +
- Important Information +
- Driving Directions +
- Need Help Paying Your Bill? +
- Have a Question? Ask Rebecca Altman of Grace Medical Center +

Exhibit 3

# Grace Medical Center

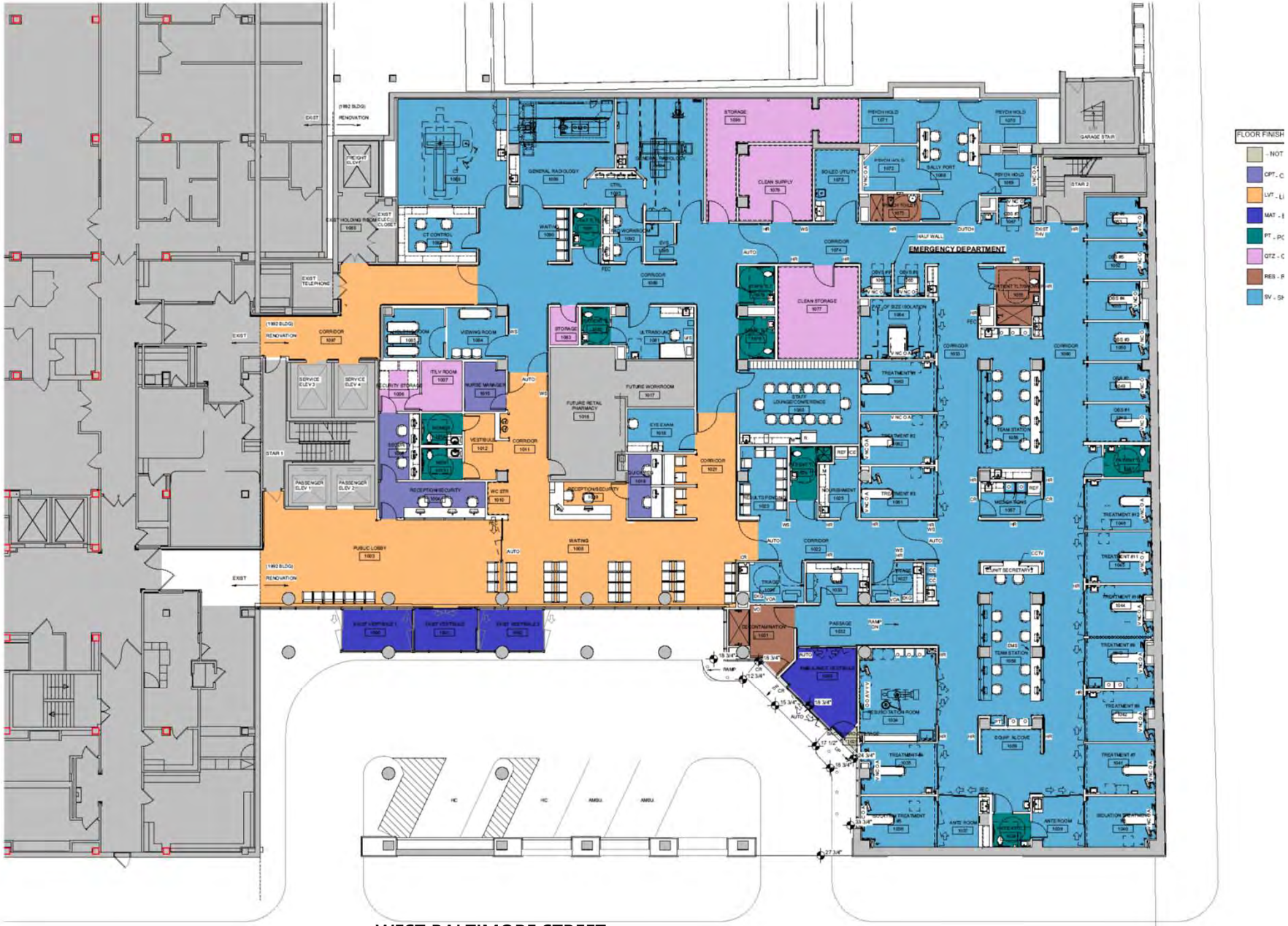
## Campus Improvements

GRACE MEDICAL CENTER
A LifeBridge Health Center
CARE BRAVELY

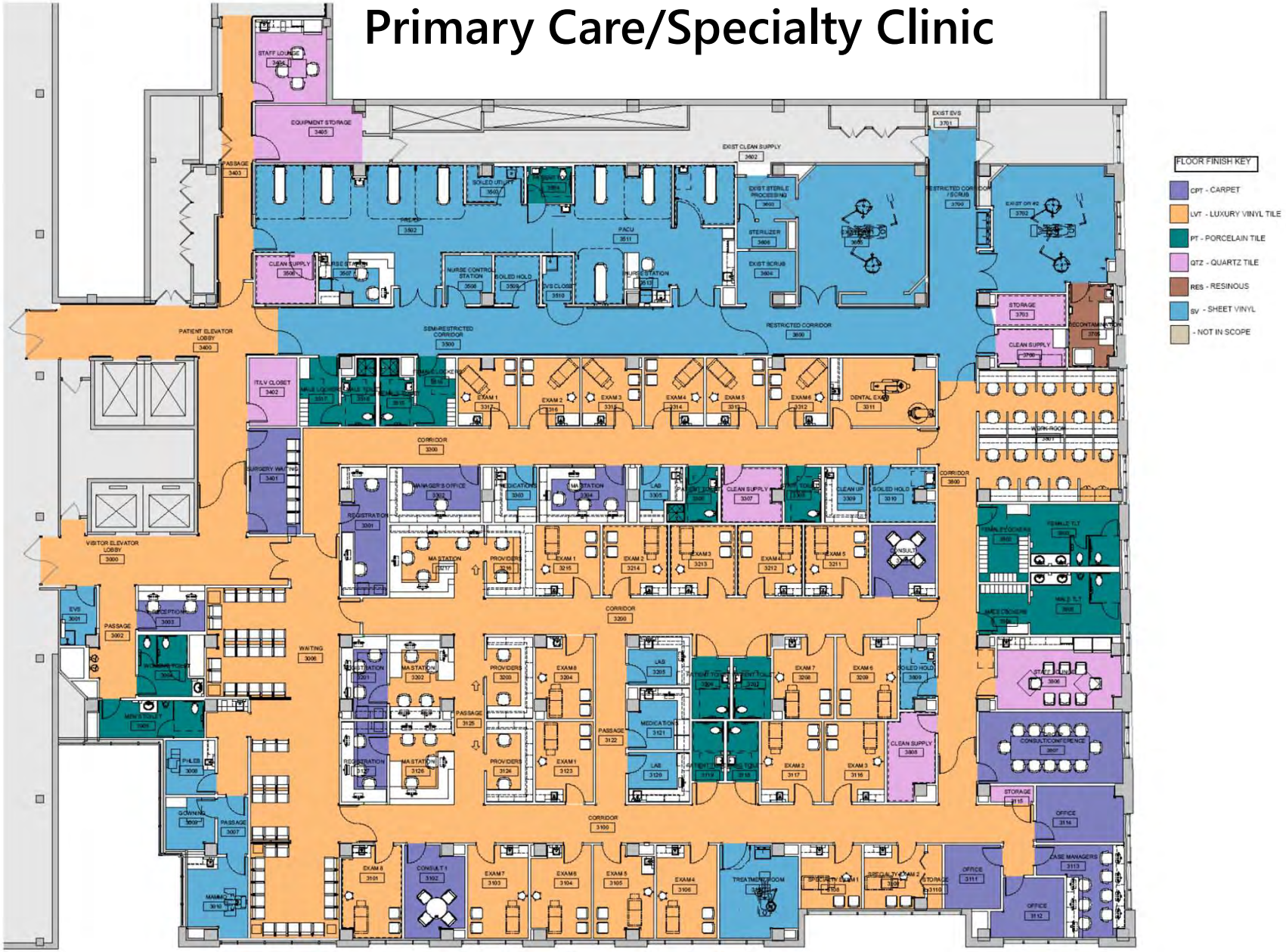
# Existing Grace Medical Campus


Phase Two
Demolish Existing
Hospital Buildings
Construct New
Outpatient Facility
Phase One
Renovate
Existing 1992
Building
Existing
Parking
Garage
W Fairmount Ave
2000 W Baltimore St

# New First Floor Emergency Department



# New Third Floor Surgery Space & Primary Care/Specialty Clinic



# EMERGENCY DEPARTMENT

(1992 BLDG)
EXIST
RENOVATION
FREIGHT ELEV 5
EXIST ELEVATOR LOBBY
EXIST ELEC CLOSET
CT
CT CONTROL
GENERAL RADIOLOGY
CONTROL
GENERAL RADIOLOGY
WAITING
PAT TLT
RAD WORKROOM
EVS
CLEAN SUPPLY
SOILED UTILITY
PSYCH HOLD
PSYCH HOLD
PSYCH HOLD
SALLY PORT
PSYCH HOLD
PSYCH TOILET
OBS #7
CORRIDOR
GARAGE EXTERIOR STAIR
STAIR 2
OBS #6
OBS #5
OBS #4
OBS #3
OBS #2
OBS #1
PATIENT TLT
EXIST TELEPHONE
(1992 BLDG)
EXIST
RENOVATION
HOLDING ROOM
VIEWING ROOM
SERVICE ELEV 3
SERVICE ELEV 4
SECURITY STORAGE
IT/LV ROOM
NURSE MANAGER
STAIR 1
WOMEN
SECURITY
03 MEN
PASSENGER ELEV 1
PASSENGER ELEV 2
RECEPTION/SECURITY
WC STR
STORAGE
PATIENT TLT
ULTRASOUND
U/S
PHARMACY WORKROOM
RETAIL PHARMACY
EYE EXAM
QUICK REG
RECEPTION/SECURITY
STAFF TLT
CLEAN STORAGE
STAFF TLT
OBVS #9
OBVS #8
PAT. OF SIZE ISOLATION
PATIENT TLT/SHOWER
STAFF LOUNGE/CONFERENCE
TREATMENT #1
TREATMENT #2
M
R
REF
ICE
M
NOURISHMENT
RESULTS PENDING
TREATMENT #3
TEAM STATION
MEDICATIONS
REF.
PUBLIC LOBBY
WAITING
(1992 BLDG)
EXIST
RENOVATION
EXIST VESTIBULE 1
EXIST VESTIBULE
EXIST VESTIBULE 2
TRIAGE
EKG
EMS
TRIAGE
CC
CC
EKG
UNIT SECRETARY
DECONTAMINATION
TEAM STATION
AMBULANCE VESTIBULE
AUTO
RESUSCITATION ROOM
PT.
EQUIP. ALCOVE
TREATMENT #4
TREATMENT #12
TREATMENT #11
TREATMENT #10
TREATMENT #9
TREATMENT #8
TREATMENT #7
HC
HC
AMBU.
AMBU.
ISOLATION TREATMENT #5
ANTE ROOM
PATIENT TLT
ANTE ROOM
ISOLATION TREATMENT #6
27 3/4"

Exhibit 4

# Notice of Public Informational Hearings

Grace Medical Center will be holding two virtual town halls regarding proposed changes to Grace Medical Center (formerly Bon Secours Hospital Baltimore), located at 2000 W. Baltimore St., Baltimore, MD 21223. Grace Medical Center, which is currently licensed as an acute care hospital, is applying to the Maryland Health Care Commission to be converted into a freestanding medical facility. Following the proposed conversion to a freestanding medical facility, Grace will maintain a new state-of-the-art emergency department, observation beds, primary care and specialty clinics, as well as operating rooms for outpatient surgical procedures. The full transition plan can be found at: www.lifebridgehealth.org/grace.

Topics to be discussed at the town halls will include: (i) reasons for the conversion; (ii) plans for transitioning acute care services; (iii) addressing the healthcare needs of the community; (iv) retraining and placement of employees; (v) plans for Grace's physical plant and site; and (vi) timeline of the conversion.

The town halls will be conducted via conference call on June 16 and June 18, 2020 at 7 p.m. Attendees may participate in the town halls by dialing the following numbers:

June 16, 2020 - 410-949-1362
June 18, 2020 - 410-949-1361

Attendees who call in will be given directions by the moderator enabling them to ask questions or give comments during the town hall. Questions and comments may also be submitted in advance to: GraceMedicalTownHall@lifebridgehealth.org.

GRACE MEDICAL CENTER

*A LifeBridge Health Center*

**CARE BRAVELY**

In This Section

Cancer Programs
Carroll Hospital Events
Childbirth and Parenting
Community Events
Computer Classes
Exercise and Fitness
Health Management
Health Screenings
Speakers Bureau
Support Groups
Webinars

# Community Calendar

**Title:** Notice of Public Informational Hearings - June 18, 2020

**Event Date:** Thursday, June 18, 2020

**Start Time:** 7:00 p.m.

**End Time:** 8:00 p.m.

**Description:** Grace Medical Center will be holding two virtual town halls regarding proposed changes to Grace Medical Center (formerly Bon Secours Hospital Baltimore), located at 2000 W. Baltimore St. Baltimore MD 21223. Grace Medical Center, which is currently licensed as an acute care hospital, is applying to the Maryland Health Care Commission to be converted into a freestanding medical facility. Following the proposed conversion to a freestanding medical facility, Grace will maintain a new state of the art emergency department, observation beds, primary care and specialty clinics, as well as operating rooms for outpatient surgical procedures. The full transition plan can be found at: www.lifebridgehealth.org/grace

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aceMedicalTownHall@lifebridgehealth.org.

# The Baltimore Sun seeks nominations for the region's Top Workplaces

By Christopher Dinsmore

The coronavirus pandemic has changed the nature of how and even where we work, but for those of us who remain working our employers remain the same.

A fortunate few of us relish going to work, whether you're in an essential job requiring you to report for duty or sitting in your home office or your dining room and videoconferencing with co-workers and customers. These folks love their jobs and admire their employers. Their jobs may offer purpose, flexibility, collaboration, respect, challenge and, of course, rewards.

If you're one of the lucky who actually like going to work, Baltimore Sun Media wants to know about your workplace and what makes it so special.

The Sun is seeking nominations for the 10th edition of its annual Top Workplaces list.

For the past nine years, The Sun has showcased the region's Top Workplaces each December, based on surveys of their employees by our partner, Energage, which has conducted Top Workplace surveys for dozens of news organizations across the country.

Last year, 135 companies were recognized as Top Workplaces in the Baltimore region, encompassing the city and Anne Arundel, Baltimore, Carroll, Harford and Howard counties.

Winners included the Baltimore engineering firm RK&K in the large employers division, the Annapolis Junction software company Next Century Corp. in the midsize employer category and, among small employers, the Constellation Technologies consulting firm.

Many other employers are perennial contenders, but new companies emerge every year.

And there's real value in it. Research shows that being designated a Top Workplace helps those companies attract more highly qualified job applicants and retain employees longer.

Nominations are due by July 17, but don't delay. Nominate your workplace today and see whether it has what it takes to make the list or even top it this year.

Anyone can suggest a company — employees, customers, executives. It doesn't matter whether the workplace is privately owned or publicly held or even a nonprofit. Companies must employ at least 35 people to qualify.

Employees of nominated firms that choose to participate will be asked to respond to a short survey later this summer by Energage. The surveys will be used to rank the top companies. Winners will be announced at an event and featured in a special magazine in early December.

To nominate a company, go to baltimoresun.com/nominate or call 410-779-9337.

*Christopher Dinsmore is The Baltimore Sun's senior editor for business and health.*

## AROUND THE REGION

### Ruppersberger elected to chair Naval Academy Board of Visitors

Rep. C.A. "Dutch" Ruppersberger is the new chairman of the Naval Academy Board of Visitors. The board unanimously elected Ruppersberger, a Baltimore County Democrat, as chairman at its livestreamed meeting Monday. Ruppersberger, who serves on the Defense Appropriations Committee, has served as the board's vice chair since April 2019 and has been on the board since 2009. He replaces Christine Fox, a former acting deputy secretary of defense and four-year board member. "The Naval Academy trains men and women to be officers of competence, character and compassion – values our country needs in its leaders now more than ever," Ruppersberger said. Other new members of the board sworn in Monday were Tony Parker as vice chair, Rep. Anthony Brown, Admiral Joseph Walsh and Jonathan Hiler.

*— Selene San Felice*

### Millersville man charged with shooting 14-year-old

A Millersville man has been arrested for allegedly shooting a 14-year-old boy in Glen Burnie in mid-May, Anne Arundel County police said. Tyler Vincent Berry, of Minton Court, has been charged with felony and misdemeanor assault, a host of firearms offenses, reckless endangerment and disorderly conduct, according to online court records. Officers responded around 6:30 p.m. May 21 to the 100 block of Loyd Lane for reports of a shooting and found a 14-year-old inside the Heritage Overlook apartments suffering from one gunshot wound. The teen was transported to a hospital with injuries police described as non-life-threatening. Police said, with the help of Maryland State Police, they found and arrested Berry in the 4700 block of Belair Road in Baltimore.

*— Alex Mann*

### Police: Woman killed after jumping from pickup truck

Police say a Pennsylvania woman died on a highway after jumping out of a moving pickup truck in Carroll County in the midst of an argument. Maryland State Police said Sunday that Nicole Renae Whitcomb, 23, of Hanover, Pennsylvania, was pronounced dead at Carroll Hospital. Police said she was a passenger in a Ford F250 being driven by Justin T. Well, 32, of Hanover on Hanover Pike (Md. 30) in the area of Mt. Ventus Road in Manchester shortly after 4 a.m. Sunday. Police said the two were arguing when Whitcomb opened the front passenger door to exit the vehicle while it was moving and was run over by the truck, according to the release. No charges had been filed as of Monday morning.

*— Mary Grace Keller*

### 2 men found fatally shot in separate incidents after violent weekend

A 64-year-old man died after suffering multiple gunshot wounds to the chest and head Monday afternoon in Mid-Govans, Baltimore Police said in a news release. Officers were sent to the 600 block of Harwood Ave. around 2:15 p.m. to investigate a report of a shooting. The victim was taken to an area hospital, where he later died. Earlier in the day, police said a man died around 1 a.m. in the 4700 block of Park Heights Ave. in Northwest Baltimore after officers were dispatched there to investigate reports of a shooting. The unidentified victim was as pronounced dead at the scene. The shootings followed a violent weekend in Baltimore during which at least 14 people were shot, three fatally.

*— Baltimore Sun staff*

## LOTTERY YESTERDAY'S NUMBERS AND RECENT DRAWINGS

**MARYLAND**
Day Daily: 202
Pick 4: 9544
Night Daily: 975
Pick 4: 8761
5 Card Cash: 5S 8H 3D 7S 3S
Bonus
Match 5: 08 20 25 28 35/16
Multi-Match,
June 1: — — — — — —

**DELAWARE**
Day Daily: 131
Play 4: 8481
Night Daily: 126
Play 4: 6609
Multi-Win,
June 1: 07 20 22 30 32 34

**PENNSYLVANIA**
Day Pick 3: 908
Pick 4: 4691
Night Pick 3: 616
Pick 4: 2905
Treasure Hunt: 05 12 14 16 20
Match 6:
04 14 16 24 27 44
Cash 5: 05 16 18 31 41

**DISTRICT OF COLUMBIA**
Day D.C. 3: 874
D.C. 4: 7129
Night D.C. 3: 047
D.C. 4: 8958
Day D.C. 5: 2 6 2 6 6
Night D.C. 5: 3 7 0 5 6

**MULTISTATE GAMES**
Mega Millions,
May 29: 10 13 32 41 51/03
Powerball,
May 30: 13 32 41 58 60/14
Cash4Life,
May 31: 02 13 29 40 44/02
MegaMillions: There was no winner in Friday's drawing. Tuesday's jackpot is an estimated $356 million.
Powerball: There was no winner in Saturday's drawing. Wednesday's jackpot is an estimated $135 million.

## CORRECTIONS

The Baltimore Sun is committed to providing fair and accurate coverage.
Readers who have concerns or comments are encouraged to call us at 800-829-8000.

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Exhibit 5

LIFEBRIDGE HEALTH
CARE BRAVELY

**Grace Medical Center**
**Tele Town Hall**
**June 16, 2020 at 7 p.m.**

## *LifeBridge Health Presenters*

| | |
|---|---|
| Ms. Rebecca Altman | Vice President Sinai Hospital and Grace Medical Center, Chief Integration Officer, LifeBridge Health |
| Mr. Daniel Blum | President Sinai Hospital and Grace Medical Center, Senior Vice President LifeBridge Health |
| Mr. James Roberge | Vice President Capital Improvements and Support Services |
| Mr. Kurt Sommer | Director, Community Development, LifeBridge Health |
| Mr. Maurice Spielman | Corporate Director, Design and Construction, LifeBridge Health |
| Mr. Jason Weiner | Senior Vice President and General Counsel, LifeBridge Health |

## *Tele Town Hall Summary*

A public Tele Town Hall on the Grace Medical Center conversion to a Freestanding Medical Facility ("FMF") was held on Tuesday, June 16, 2020 via teleconference. Teleconference and recording services were provided by The Sexton Group. Data revealed that a total of 335 people joined the call (though they did not all remain for the entire call), 56 people called into the Town Hall. The rest of the attendees participated from outbound calls made by the Sexton Group to the residents in West Baltimore. Sixteen people opted to ask a question and have their question answered and recorded as part of the Town Hall. Those questions are included in this document.

Rebecca Altman, Vice President of Sinai Hospital and Grace Medical Center and Chief Integration Officer of LifeBridge Health, began the call at 7 p.m. and disclosed that the call would be recorded. Ms. Altman asked that any public officials please press 0 to be acknowledged. The public was informed that by pressing 0, they would be able to ask questions or comment during the call.

Ms. Altman reviewed the agenda for the call:
- Introduction of LifeBridge Health presenters
- Welcome from Daniel Blum, President of Sinai Hospital and Grace Medical Center
- A brief history of the acquisition of Grace Medical Center
- Future state of Grace Medical Center
- Grace's physical plant, the site and timelines
- Questions and comments from the public

## *Introduction of Presenters*

Mr. Daniel Blum, President of Sinai Hospital and Grace Medical Center and Senior Vice President of LifeBridge Health.

Mr. James Roberge, the Vice President of Capital Improvements and Support Services for LifeBridge Health.

Mr. Maurice Spielman, the Corporate Director of Design and Construction at LifeBridge Health.

Mr. Jason Weiner, Senior Vice President and General Counsel of LifeBridge Health.

Mr. Kurt Sommer, the Director of Community Development for LifeBridge Health.

## *Welcome from Mr. Daniel Blum*

Mr. Blum introduced himself as a recent transport from New York and Northwell Health and stated that the opportunity to work with Grace and the surrounding community was one of the things that drew him to LifeBridge Health. He added that tonight is the continuation of ongoing conversations with community members, regulators, elected officials and that the hope is for Grace to provide critically important care to the community and respond accordingly to changes in healthcare and the needs of the community.

## *Acquisition of Grace Medical Center, Ms. Rebecca Altman*

Ms. Altman presented an overview of the history of Grace Medical Center, previously Bon Secours Hospital. Over 100 years ago, the Sisters of Bon Secours opened the hospital in West Baltimore to provide "good help to those in need." The hospital was a subsidiary of the Bon Secours Health System, which merged with Mercy Health of Ohio in 2018, creating a combined not-for-profit Catholic health system under the name Bon Secours Mercy Health, Inc. (BSMH). Shortly following the merger, BSMH indicated that it planned to sell Bon Secours Hospital Baltimore due to significant financial hardships facing the hospital. LifeBridge Health was invited to participate in the transaction process and was ultimately selected as the winning bidder. The LifeBridge acquisition of Bon Secours Hospital Baltimore was officially completed on November 1, 2019 and, shortly thereafter, the hospital's name was changed to Grace Medical Center.

### *Services at Grace*

In considering whether to acquire the hospital, LifeBridge Health determined that certain programs would need to be modified, while clinical services and the physical infrastructure would need to be enhanced in order to assure sustainability of the organization and provision of high-quality services. LifeBridge conducted community listening tours and a comprehensive community health needs assessment and based on community feedback, determined that pediatric services, women's health services, ophthalmology services, outpatient clinics,

outpatient surgery, outpatient behavioral health, substance abuse clinics, outpatient dialysis, and an emergency room were all critical to the current and future needs of the community. Because LifeBridge is an integrated health system with existing resources in close proximity to Grace Medical Center, certain services, including inpatient medical/surgical, critical care and inpatient behavioral health, could be efficiently transitioned to other LifeBridge facilities and would no longer need to be provided at Grace. Inpatient medical/surgical and critical care services were successfully transitioned to Sinai and Northwest Hospitals shortly following the transaction, and renovations are underway at those facilities to accommodate additional inpatient behavioral health patients from Grace. The inpatient behavioral health department will transition to Sinai and Northwest Hospitals on November 1, 2020.

***Conversion to an FMF***

Ms. Altman continued that during conversations with community members and non-profit partners, the decision was made to convert the hospital to a freestanding medical facility. Under Maryland law, an FMF offers medical and health services similar in nature to a hospital, however the services are narrower in scope. An FMF does not provide complex inpatient surgical procedures, critical care, labor and delivery, or oncology. Unlike an urgent care center that has very limited services, patients may stay at an FMF overnight for observation, and an FMF has a 24/7 emergency room that provides lifesaving care, imaging, laboratory capabilities. In Maryland, an FMF must be part of an acute general hospital but be physically separate from that hospital. An FMF must also have nurses and doctors board certified in emergency medicine. Patients who arrive at the Grace Medical Center emergency room needing a higher level of care can be transferred to Sinai Hospital (5 miles from Grace) or Northwest Hospital (12 miles from Grace). LifeBridge will use Pulse Ambulance to transfer patients needing acute care.

Ms. Altman continued to explain that Grace will still accept patients of all priority levels from Baltimore city and local EMS providers. Grace Medical Center communicates with LifeBridge Health's virtual hospital to coordinate care for all patients requiring admission for inpatient medical/surgical, critical care or inpatient behavioral health services. The Grace emergency room physician works with the virtual hospital to ensure a seamless transition of patients to the most appropriate level of care. In the case of a transfer of a patient from Grace to Northwest or Sinai Hospitals, LifeBridge will offer free transportation services to the applicable facility for the patient's family.

***Employee Retention***

Ms. Altman explained that during the conversion to an FMF, Grace employees who will be impacted by the transition of services to Sinai or Northwest Hospitals, will be given every opportunity to stay within the LifeBridge Health system. These employees will have the chance to stay within the same type of unit or transition to a different type of job; training and cross-training will be provided. Ms. Altman paused and asked for questions.

***The Future State of Grace***

Ms. Altman stated that a new state of the art emergency department would be constructed at Grace. The new ED will have trauma bays and a new CT scanner. The ED will continue to provide pediatric telemedicine; tele-stroke services; social services and care management; and Screening, Brief Intervention and Referral to Treatment (SBIRT). Ms. Altman continued that primary care and specialty care will be provided in a new space on the third floor of an existing

building on the hospital campus, which is frequently referred to as the "92 Wing". There will also be 3-D mammography, pediatrics, OBGYN, orthopedics, endocrinology, pulmonology, vascular service and ophthalmology. Grace will also provide outpatient elective surgery. On the second floor of the 92 Wing will be an expanded and refreshed outpatient dialysis unit. The outpatient behavioral health programs will also be expanded, and they will eventually be relocated into a new building attached to the 92 Wing.

Mr. Blum added that one goal is to get consistent feedback from the community over time so LifeBridge can hear how they are meeting the community needs. Additionally, he noted the assets that LifeBridge has like the Center for Hope and the Baltimore Child Abuse Center that can provide support around family needs. Furthermore, LifeBridge aims to influence social determinants of health and influence health and wellness in the community.

**Q:** (Gwendolyn) ***– When Bon Secours first came to Baltimore it was to help low income people get medical care. Previously, Bon Secours was on the voting ballots to receive state funds. Now that it is part of LifeBridge, and won't have a connection to the State, how will it affect funding for low income residents?***

**A:** Ms. Altman responded that care will not change for those seeking medical attention regardless of ability to pay. LifeBridge Health is a nonprofit. Grace Medical has not changed its policy around payment or providing care for the community. Grace will continue to receive State dollars for Medicare and Medicaid. Mr. Weiner added that Grace will continue to be a regulated space and that all FMFs need to comply with the Emergency Medical Treatment and Labor Act (EMTALA), a federal law which requires Grace to stabilize any patient who arrives at the door regardless of ability to pay.

***Grace Medical Center Physical Plant and Timeline, Maurice Spielman and James Roberge***

Mr. Spielman described the location of the 92 Wing, explaining that it is the five-story building connected to the parking garage on the corner of West Baltimore Street and North Pulaski.

Mr. Spielman explained that during phase 1 of the renovation project, the new emergency department will be constructed on the first floor, and that the contractors are currently framing the walls and installing the new CT scanner. The project will be completed in December 2020 and will aim to see patients in January 2021.

The next phase is the renovation of the third-floor operating room, which will have two operating rooms and will be completed in July 2020. The new clinic space, also on the third floor, will have private exam rooms, mammography, a lab and will be completed in December 2020.

The dialysis center on the second floor will also be improved (by installing new flooring, lighting, etc.) and will be expanded by six chairs (for a total of 41 chairs). Support spaces for staff will be renovated on the fourth and fifth floors. By the end of this year, all renovations in the 92 Wing will be completed.

**Q:** (Archie) – ***Will you all be bringing back the help for pregnant women and children? The program was transferred to St. Agnes Hospital. What will you do for the children? Not everyone has transportation to St. Agnes***.

**A:** Ms. Altman answered that OBGYN services were started at Grace in January 2020. The chair of the Sinai OBGYN department comes to Grace to see patients. There will not be labor and delivery, but Sinai has superb women and baby services. The Chair of the Sinai Pediatric department will come to Grace. Grace also has pediatric telemedicine in the emergency department and the means to transport the patient to Sinai, if necessary. The relationship with St. Agnes will continue.

**Q:** (Theresa) – ***Will you help people who can't read and write?***

**A:** Ms. Altman responded that as part of the commitment to West Baltimore, LifeBridge has started a foundation (the "Foundation") that will have a Resource Center on N. Calhoun Street that will have tutoring for adults and children and meeting the needs of the community.

**Q:** (Benita) – ***When did this original project begin? Was the community involved from the beginning?***

**A:** Ms. Altman iterated that the acquisition started in 2019 and LifeBridge started transitioning patients and some services on November 1, 2019. The demolition of the first and third floors started two months ago. The original proposal to acquire the hospital began in early 2019, and the community was involved from the beginning, including the leadership of Bon Secours and neighborhood organizations.

**Q:** (Tony) – ***Will the entrance on Pulaski change?***

**A:** Mr. Spielman responded that the entrance will stay in the same place.

**Q**: (Josephine) – ***I work with Case Management at Grace Medical Center and you mentioned several services needed in the community, what about inpatient psychiatry?***

**A:** Ms. Altman explained that inpatient psychiatry is in an old part of the building and will be moved to Sinai Hospital on November 1, 2020. All staff members who have been working in inpatient psychiatry will be offered positions in inpatient psychiatry at Sinai or Northwest. During the mid-summer, there will be job fairs at Sinai and Northwest for these positions. Due to COVID, there will be adjustments to how these are conducted. There will also be the opportunity to join another department.

**Q:** (Gwendolyn) – ***All the properties that have Bon Secours' name, like the senior citizen complexes on Wilkens and Monroe, will those properties transfer to LifeBridge?***

**A**: Ms. Altman stated that those properties will remain under the management of Bon Secours Community Works, which remained part of the Bon Secours Mercy Health system and will not be part of Grace Medical Center. However, LifeBridge does work closely with Community Works and we have a long-standing relationship with Dr. Sam Ross who oversees Community Works.

Grace does provide care management to many of the residents.

**Q:** (Carolyn) ***– Bon Secours had a group called Silver Seniors. Will that relationship continue? The nurses haven't been coming out because of COVID.***

**A:** Ms. Altman stated that Grace Medical Center will continue the relationship with the senior groups in any way that we can help the senior citizens of West Baltimore. We will need to look at how we provide services during COVID and adjust to the needs of the community and LifeBridge has only just begun with that process.

Mr. Spielman continued that the 92 Wing will be finished by the end of the year. This will allow us to vacate the existing hospital and start taking those buildings down. By September 2021, all the existing buildings (except the parking garage) will be demolished so we can build the new 20,000 square foot outpatient behavioral health building. Design has not started on the new outpatient building, but it will be attached to the 92 Wing. New green space will also be created where the old hospital was located. That space has not yet been designed - it is still in a programming phase. The plan is for the new facility to be completed and ready for occupancy by June 2023.

Ms. Altman reminded callers to press 0 for questions and comments.

Ms. Altman added to a previous question by stating that Grace does provide transportation services to patients' families should they be transferred to Sinai or Northwest for a higher level of care. LifeBridge will pay for family transport to either facility.

**Q:** (Dorothy) – ***How do you propose you will get this information out to the community? Are you offering the community incentive or grants for purchasing or improving property? Will there by a truck for ear and eye check-ups for children? Will there be plenty of health fairs? Will you provide a medical adult day care?***

**A:** Ms. Altman explained that ideally LifeBridge likes to meet in-person at community events, but with COVID, that has changed. Fortunately, we have good relationships with community groups like Fayette Street Outreach, Bon Secours Community Works and Southwest Partnership, and they have invited us to attend their meetings. For information sharing, we have a website, Lifebridgehealth.org and you can click on Grace Medical for services and events. We are also located on Facebook. Ms. Altman added that LifeBridge has a Live Where You Work program. Mr. Sommer explained that LifeBridge works with community partners to engage in programs and strategies that can support community members with home improvement activities. There is a program called HUB that is active in West Baltimore administered through Civic Works that helps seniors with critical safety related improvements. The inward facing Live Where You Work Program helps LifeBridge employees purchase homes. Southwest Partnership is also working on home ownership strategies.

Ms. Altman continued that the LifeBridge Chair of Pediatrics is interested in creating a pediatric mobile health van and we are currently rolling out a mobile health unit for adults and seniors. The van for adults will be coming around within two weeks and the pediatric van will be running in two months. Ms. Altman added that LifeBridge plans to continue hosting health fairs.

Those events had to be put on hold due to COVID. Ms. Altman stated that there is currently not an adult day care, but that LifeBridge is working on implementing a PACE program for the system that would include in-home care and care in a place like a community center. This program was about to get started when COVID hit. The PACE program should be implemented within 12-18 months.

**Q:** (Archie) – ***With COVID, when will you accept people for testing without an RX? Also, some of the community want to go back to college. Do you have scholarship or grant programs for college?***

**A:** Ms. Altman responded that the college scholarships are a great idea and that she will take that suggestion back to the Foundation board.

Ms. Altman also stated that COVID testing is currently available. There is a walk-up tent at the parking garage area at Grace from M-F between 10 and 2 pm. When you get registered, there is a standing doctor's order so you will get free testing on the spot.

**Q:** (Carolyn) – ***Will you have hospice care?***

**A:** Ms. Altman answered that, as an FMF, there will not be any inpatient care at Grace Medical Center. Instead, there would be a consult for inpatient hospice care at Sinai or Northwest. LifeBridge has a robust palliative care and hospice program.

**Q: We received an email question asking how many operating rooms will be in the new OR.**

**A:** Mr. Spielman responded that we will have two operating rooms. Ms. Altman added that because of COVID, Grace is currently doing elective surgery only on Wednesday. There are plans to add three days of scheduled outpatient surgery.

**Q:** (Archie) – ***Will you have a picture posted outside of the new campus so people can see what the changes will look like?***

**A:** Mr. Spielman answered that there will be renderings posted outside so that the community can see the new design. The pictures will be posted in about 6-9 months, since they are still talking with the community about what the design will look like.

**Q:** (Dorothy) – ***With the Mother Mary Lange Catholic School being built, what relationship will you have?***

**A:** Ms. Altman stated that as part of the Foundation's outreach, LifeBridge is committed to mentoring partnerships, we will be welcome to partnering with any of the local public schools**.**

**Q:** (Kim) **– *When should we be planning the design of the outside around Grace?***

**A:** Mr. Spielman responded in the spring of 2021 LifeBridge will start working with community groups on how the space should look.

Ms. Altman shared that if callers have additional questions or comments, they can stay on the line and leave a message, and added that Thursday, June 18 at 7 pm there will be another Tele Town Hall.

Mr. Sommer shred his contact information and welcomed the community to call or email him with questions or concerns or to invite him to a community meeting.

**Q:** (Archie) – ***When you design the new campus will you be buying up property in the neighborhood? There was a rumor that Bon Secours was going to buy an entire block down to Monroe Street?***

**A:** Mr. Roberge responded that the existing campus already provides us with enough space for the FMF and any ancillary medical services and Grace has no need to acquire more space.

## *Adjournment*

With no more questions, at 8:50 p.m., Ms. Altman thanked the community for their questions, comments and participation in the virtual town hall.

LIFEBRIDGE HEALTH
CARE BRAVELY

**Grace Medical Center**
**Tele Town Hall**
**June 18, 2020 at 7 p.m.**

## *LifeBridge Health Presenters*

| | |
|---|---|
| Ms. Rebecca Altman | Vice President Sinai Hospital and Grace Medical Center, Chief Integration Officer, LifeBridge Health |
| Mr. Daniel Blum | President Sinai Hospital and Grace Medical Center, Senior Vice President LifeBridge Health |
| Ms. Regina Merritt | Manager of Community Partnerships, LifeBridge Health |
| Mr. James Roberge | Vice President Capital Improvements and Support Services |
| Mr. Kurt Sommer | Director, Community Development, LifeBridge Health |
| Mr. Maurice Spielman | Corporate Director, Design and Construction, LifeBridge Health |
| Mr. Jason Weiner | Senior Vice President and General Counsel, LifeBridge Health |

## *Tele Town Hall Summary*

A public Tele Town Hall on the Grace Medical Center conversion to a Freestanding Medical Facility ("FMF") was held on Thursday, June 18, 2020 via teleconference. Teleconference and recording services were provided by The Sexton Group. Data revealed that a total of 278 people joined the call (though they did not all remain for the entire call), 35 people called into the Town Hall. The rest of the attendees participated from outbound calls made by the Sexton Group to residents of West Baltimore. Ten people asked a question. Those questions are included in this document.

Rebecca Altman, Vice President of Sinai Hospital and Grace Medical Center and Chief Integration Officer of LifeBridge Health, began the call at 7 p.m. and disclosed that the call would be recorded. Ms. Altman asked that any public officials please press 0 to be acknowledged. The public was informed that by pressing 0, they would be able to ask questions or comment during the call.

Ms. Altman reviewed the agenda for the call:
- Introduction of LifeBridge Health presenters
- Welcome from Daniel Blum, President of Sinai Hospital and Grace Medical Center
- A brief history of the acquisition of Grace Medical Center
- Future state of Grace Medical Center
- Grace's physical plant, the site and timelines
- Questions and comments from the public

## *Introduction of Presenters*

Mr. Daniel Blum, President of Sinai Hospital and Grace Medical Center and Senior Vice President of LifeBridge Health.

Mr. James Roberge, the Vice President of Capital Improvements and Support Services for LifeBridge Health.

Mr. Maurice Spielman, the Corporate Director of Design and Construction at LifeBridge Health.

Mr. Jason Weiner, Senior Vice President and General Counsel of LifeBridge Health.

Mr. Kurt Sommer, the Director of Community Development for LifeBridge Health.

Ms. Regina Merritt, Manager of Community Partnerships for LifeBridge Health.

## *Welcome from Mr. Daniel Blum*

Mr. Blum introduced himself as a recent transport from Northwell Health in New York and stated that the opportunity to work with Grace and the surrounding community was one of the things that drew him to LifeBridge Health. He added that tonight is the continuation of ongoing conversations with community members, regulators, elected officials and that the hope is for Grace to provide critically important care to the community and respond accordingly to changes in healthcare and the needs of the community.

## *Acquisition of Grace Medical Center, Ms. Rebecca Altman*

Ms. Altman presented an overview of the history of Grace Medical Center, previously Bon Secours Hospital. Over 100 years ago, the Sisters of Bon Secours opened the hospital in West Baltimore to provide "good help to those in need." The hospital was a subsidiary of the Bon Secours Health System, which merged with Mercy Health of Ohio in 2018, creating a combined not-for-profit Catholic health system under the name Bon Secours Mercy Health, Inc. (BSMH). Shortly following the merger, BSMH indicated that it planned to sell Bon Secours Hospital Baltimore due to significant financial hardships facing the hospital. LifeBridge Health was invited to participate in the transaction process and was ultimately selected as the winning bidder. LifeBridge's acquisition of Bon Secours Hospital Baltimore was officially completed on November 1, 2019 and, shortly thereafter, the hospital's name was changed to Grace Medical Center.

### *Services at Grace*

In considering whether to acquire the hospital, LifeBridge Health determined that certain programs would need to be modified, while clinical services and the physical infrastructure would need to be enhanced in order to assure sustainability of the organization and provision of high quality services. LifeBridge conducted community listening tours and a comprehensive community health needs assessment and based on community feedback, determined that pediatric services, women's health services, ophthalmology services, outpatient clinics,

outpatient surgery, outpatient behavioral health, substance abuse clinics, outpatient dialysis, and an emergency room were all critical to the current and future needs of the community. Because LifeBridge is an integrated health system with existing resources in close proximity to Grace Medical Center, certain services, including inpatient medical/surgical, critical care and inpatient behavioral health, could be efficiently transitioned to other LifeBridge facilities and would no longer need to be provided at Grace. Inpatient medical/surgical and critical care services were successfully transitioned to Sinai and Northwest Hospitals shortly following the transaction, and renovations are underway at those facilities to accommodate inpatient behavioral health patients from Grace. The inpatient behavioral health department at Grace Medical Center will transition to Sinai and Northwest Hospitals on November 1, 2020.

***Employee Retention***

Ms. Altman explained that during the conversion to an FMF, Grace employees who will be impacted by the transition of services to Sinai or Northwest Hospitals, will be given every opportunity to stay within the LifeBridge Health system. These employees will have the chance to stay within the same type of unit or transition to a different type of job; training and cross-training will be provided.

***Conversion to an FMF***

Ms. Altman continued that during conversations with community members and non-profit partners, the decision was made to convert the hospital to a freestanding medical facility. Under Maryland law, an FMF offers medical and health services similar in nature to a hospital, however the services are narrower in scope. An FMF does not provide complex inpatient surgical procedures, critical care, labor and delivery, or oncology. Unlike an urgent care center that has very limited services, patients may stay at an FMF overnight for observation, and an FMF has a 24/7 emergency room that provides lifesaving care, imaging, laboratory capabilities. In Maryland, an FMF must be part of an acute general hospital but be physically separate from that hospital. An FMF must also have nurses and doctors board certified in emergency medicine. Patients who arrive at the Grace Medical Center emergency room needing a higher level of care can be transferred to Sinai Hospital (5 miles from Grace) or Northwest Hospital (12 miles from Grace). LifeBridge will use Pulse Ambulance to transfer patients needing acute care. As an FMF, Grace will continue to adhere to the Emergency Medical Treatment and Labor Act (EMTALA), a federal law which requires Grace to stabilize any patient who arrives at the door regardless of ability to pay.

At this point, Ms. Altman asked for questions and comments from the community.

With no questions coming in, Ms. Altman continued to explain that Grace will still accept patients of all priority levels from Baltimore city and local EMS providers. Grace Medical Center communicates with LifeBridge Health's virtual hospital to coordinate care for all patients requiring admission for inpatient medical/surgical, critical care or inpatient behavioral health services. The Grace emergency room physician works with the virtual hospital to ensure a seamless transition of patients to the most appropriate level of care. In the case of a transfer of a patient from Grace to Northwest or Sinai Hospitals, LifeBridge will offer free transportation services to the applicable facility for the patient's family.

***The Future State of Grace***

Ms. Altman stated that a new state of the art emergency department would be constructed at Grace. The new ED will have trauma bays and a new CT scanner. The ED will continue to provide pediatric telemedicine; tele-stroke services; social services and care management; and Screening, Brief Intervention and Referral to Treatment (SBIRT). Ms. Altman continued that primary care and specialty care will be provided in a new space on the third floor of an existing building on the hospital campus, which is frequently referred to as the "92 Wing". There will also be 3-D mammography, pediatrics, OBGYN, orthopedics, endocrinology, pulmonology, vascular service and ophthalmology. Grace will also provide outpatient elective surgery. On the second floor of the 92 Wing will be an expanded and refreshed outpatient dialysis unit. The outpatient behavioral health programs will also be expanded, and they will eventually be relocated into a new building attached to the 92 Wing.

**Q:** (Philip) – ***How will case management staff be impacted?***

***A:*** Ms. Altman responded that any employee in a service impacted by the move will be able to find a position within the LifeBridge Health system.

## *Grace Medical Center Physical Plant and Timeline, Mr. Maurice Spielman*

Mr. Spielman described the location of the 92 Wing, explaining that it is the five-story building connected to the parking garage on the corner of West Baltimore Street and North Pulaski. LifeBridge is currently doing construction on the first and third floors of this building. Demolition began in March 2020 and is complete; appropriate permits are in place.

Mr. Spielman explained that during phase 1 of the renovation project, the new emergency department will be constructed on the first floor, and that the contractors are currently framing the walls and installing the new CT scanner. The project will be completed in December 2020 and will aim to see patients in January 2021.

The next phase is the renovation of the third-floor operating room, which will have two operating rooms and will be completed in July 2020. There will be four new prep bays and four recovery areas. The new clinic space, also on the third floor, will have private exam rooms, mammography, a lab and will be completed in December 2020.

**Q:** (Kirsten) – ***I am an area investor with property on Vine Street. I am trying to find out what the plan is for the properties torn down on Vine.***

**A:** Ms. Altman responded that LifeBridge would love to talk with Kirsten about Vine Street. At this point, LifeBridge doesn't have any plans but would like to talk with her about her plans and how we can partner.

Mr. Spielman continued that the dialysis center on the second floor will also be improved (by installing new flooring, lighting, etc.) and will be expanded by six chairs (for a total of 41 chairs). Support spaces for staff will be renovated on the fourth and fifth floors. By the end of this year, all renovations in the 92 Wing will be completed.

Mr. Spielman went on to outline that the 92 Wing will be finished by the end of the year. This will allow us to vacate the existing hospital and start taking those buildings down. By September 2021, all the existing buildings (except the parking garage) will be demolished so we can build the new 20,000 square foot outpatient behavioral health building. Design has not started on the new outpatient building, but it will be attached to the 92 Wing. New green space will also be created where the old hospital was located. The design process for this space will begin in the spring of 2021. The plan is for the new facility to be completed and ready for occupancy by June 2023. Mr. Spielman noted that as LifeBridge moves into the design phase, they will be getting community feedback and making renderings available.

Ms. Altman reminded callers to press 0 for questions and comments.

**Q:** (via email) – ***What happens to current employees impacted by the change in services?***

**A:** Ms. Altman explained that LifeBridge will hold job fairs for current Grace employees. They will be invited to tour units at Sinai and Northwest. We are working with employees to cross train for the hospitals or urgent care centers. There is plenty of opportunity within LifeBridge. When we move inpatient behavioral health services off campus in early November, the staff who were providing such services at Grace will have the opportunity to tour Sinai and Northwest. In conjunction with LifeBridge human resources, we will also conduct tours of Sinai and Northwest for other Grace employees.

Ms. Altman took a moment to ask any elected officials or representatives to press 0 to announce themselves. She welcomed Baltimore City Councilman John Bullock, Chanan Lewis (on behalf of US Representative Kweisi Mfume), State Senator Charles Sydnor, and State Delegate Nick Mosby.

**Q:** (Philip) – ***Is the building that will be torn down where the ER is right now? Where will the offices that are located there be moved?***

**A:** Mr. Spielman answered, yes, the building where the ED is currently located is one of the buildings that will come down, and the offices will be re-distributed to the 2nd, 4th and 5th floors of the 92 Wing. The LifeBridge construction team is currently working to identify all the employees in these spaces so that the right number of offices are built.

**Q:** (Alice) –***I am a patient of Sinai and live near Grace. Will you be accepting Johns Hopkins Medicare Advantage Plan?***

**A:** Ms. Altman stated the we will need to collect Alice's contact information and then get back to her with an answer.

## *Adjournment*

Mr. Blum concluded by saying that hospitals have a history of addressing problem once they occur, but the goal is for Grace Medical Center to work with the community and address the social determinants of health, in order to head off those problems before they arrive.

Ms. Altman added a reminder that Grace Medical Center has a walk-up COVID testing tent up and running for the community. The tent is open for walk-up M-F from 10 am to 2 pm, and no prescription is required because patients will receive a doctor's order when they register at the tent. This is a free service.

Ms. Altman shared that if callers additional questions or comments, they can email gracemedicaltownhall@lifebridghealth.org

After allowing four minutes to call-in with questions, Ms. Altman thanked the community for their questions, comments and participation in the virtual town hall.

LIFEBRIDGE HEALTH
CARE BRAVELY

**Grace Medical Center**
**Tele Town Hall with EMS Providers**
**July 8, 2020 at 7 p.m.**

## *LifeBridge Health Presenters*

| | |
|---|---|
| Ms. Rebecca Altman | Vice President Sinai Hospital and Grace Medical Center, Chief Integration Officer, LifeBridge Health |
| Mr. Daniel Blum | President Sinai Hospital and Grace Medical Center, Senior Vice President LifeBridge Health |
| Dr. Reginald Brown | President, Medical Staff and Emergency Department Director, Grace Medical Center |
| Mr. Jonathan Moles | Assistant Vice President, Virtual Hospital and Access, LifeBridge Health |
| Dr. Arsalan Sheikh | Chief Medical Officer, Grace Medical Center |
| Dr. Esteban Schabelman | Chief Medical Officer, Sinai Hospital |
| Mr. Maurice Spielman | Corporate Director, Design and Construction, LifeBridge Health |

## *LifeBridge Health Attendees*

| | |
|---|---|
| Mr. Kevin Begley | Assistant General Counsel, LifeBridge Health |
| Mr. Chris Panagiotopoulos | Chief Technology Officer, LifeBridge Health |

## *Tele Town Hall Summary*

A public Tele Town Hall on the Grace Medical Center conversion to a Freestanding Medical Facility ("FMF") was held on Wednesday, July 8, 2020 via video teleconference. While this Tele Town Hall was open to all members of the public who wished to join, it was specifically focused on the potential impact of the proposed conversion on the provision of EMS services. There were 18 total attendees, including those representing LifeBridge Health.

Rebecca Altman, Vice President of Sinai Hospital and Grace Medical Center and Chief Integration Officer of LifeBridge Health, began the video teleconference at 7 p.m. and disclosed that the call would be recorded. Participants were informed that they would be able to ask questions or comment during the call, but Ms. Altman requested that all attendees mute their phones when not speaking.

Ms. Altman reviewed the agenda for the call:

- Introduction of LifeBridge Health presenters
- Welcome from Daniel Blum, President of Sinai Hospital and Grace Medical Center
- A brief history of the acquisition of Grace Medical Center
- Future state of Grace Medical Center and acute service needs of West Baltimore
- Grace's physical plant, the site and timelines

## *Introduction of Presenters*

Mr. Daniel Blum, President of Sinai Hospital and Grace Medical Center and Senior Vice President of LifeBridge Health

Mr. Kevin Begley, Assistant General Counsel of LifeBridge Health

Mr. Maurice Spielman, the Corporate Director of Design and Construction at LifeBridge Health

Dr. Reginald Brown, President, Medical Staff and Emergency Department Director for Grace Medical Center

Dr. Arsalan Sheikh, Chief Medical Officer of, Grace Medical Center

Dr. Esteban Schabelman, Chief Medical Officer of Sinai Hospital

Jonathan Moles, Assistant Vice President, Virtual Hospital and Access at LifeBridge Health

## *Welcome from Mr. Daniel Blum*

Mr. Blum introduced himself as a recent transport from Northwell Health in New York and stated that the opportunity to work with Grace and the surrounding community was one of the things that drew him to LifeBridge Health. He added that he is particularly interested in tonight's Town Hall because he is a former paramedic by trade. Mr. Blum explained that LifeBridge views Grace Medical Center as an essential asset to the West Baltimore community and is committed to providing high-quality services to the community, particularly emergency care. Mr. Blum concluded that he is confident that LifeBridge will deliver an exceptional quality of service. Grace will also offer primary care and specialty care, so the focus of care is not solely on consequence management, but preventive care. The services provided by Grace will be continuously refined through an ongoing conversation with our stakeholders, including the EMS community.

## *Acquisition of Grace Medical Center, Ms. Rebecca Altman*

Ms. Altman presented an overview of the history of Grace Medical Center, previously Bon Secours Hospital. Over 100 years ago, the Sisters of Bon Secours opened the hospital in West Baltimore to provide "good help to those in need." The hospital was a subsidiary of the Bon Secours Health System, which merged with Mercy Health of Ohio in 2018, creating a combined

not-for-profit Catholic health system under the name Bon Secours Mercy Health, Inc. (BSMH). Shortly following the merger, BSMH indicated that it planned to sell Bon Secours Hospital Baltimore due to significant financial hardships facing the hospital. LifeBridge Health was invited to participate in the transaction process and was ultimately selected as the winning bidder. LifeBridge Health's acquisition of Bon Secours Hospital Baltimore was officially completed on November 1, 2019 and, shortly thereafter, the hospital's name was changed to Grace Medical Center.

***Services at Grace***

In considering whether to acquire the hospital, LifeBridge Health determined that certain programs would need to be modified, while clinical services and the physical infrastructure would need to be enhanced in order to assure sustainability of the organization and provision of high-quality and efficient services. LifeBridge conducted community listening tours and a comprehensive community health needs assessment and based on community feedback, determined that pediatric services, women's health services, ophthalmology services, outpatient clinics, outpatient surgery, outpatient behavioral health, substance abuse clinics, outpatient dialysis, and an emergency room were all critical to the current and future needs of the community.

Because LifeBridge is an integrated health system with existing resources close to Grace Medical Center, certain services, including inpatient medical/surgical, critical care and inpatient behavioral health, could be efficiently transitioned to other LifeBridge facilities and would no longer need to be provided at Grace. Inpatient medical/surgical and critical care services were successfully transitioned to Sinai and Northwest Hospitals shortly following the transaction, and renovations are underway at those facilities to accommodate inpatient behavioral health patients from Grace. The inpatient behavioral health department at Grace Medical Center will transition to Sinai and Northwest Hospitals on November 1, 2020.

***Employee Retention***

Ms. Altman explained that during the conversion to an FMF, Grace employees who will be impacted by the transition of services to Sinai or Northwest Hospitals, will be given every opportunity to stay within the LifeBridge Health system. These employees will have the chance to stay within the same type of unit or transition to a different type of job; training and cross-training will be provided.

***Conversion to an FMF***

Ms. Altman continued that during conversations with community members and non-profit partners, the decision was made to scale back inpatient beds and convert the hospital to a freestanding medical facility. Under Maryland law, an FMF offers medical and health services similar in nature to a hospital, however the services are narrower in scope. An FMF does not provide complex inpatient surgical procedures, critical care, labor and delivery, or oncology. Unlike an urgent care center that has very limited services, patients may stay at an FMF overnight for observation, and an FMF has a 24/7 emergency room that provides lifesaving care, imaging, laboratory capabilities. In Maryland, an FMF must be part of an acute general hospital but be physically separate from that hospital. An FMF must also have nurses and doctors board certified in emergency medicine. Patients who arrive at the Grace Medical Center emergency room needing a higher level of care can be transferred to Sinai Hospital (5

miles from Grace) or Northwest Hospital (12 miles from Grace). LifeBridge will use Pulse Ambulance to transfer patients needing acute care. As an FMF, Grace will continue to adhere to the Medicare Conditions of Participation (CoP) and Emergency Medical Treatment and Labor Act (EMTALA), a federal law which requires Grace to stabilize any patient who arrives at the door regardless of ability to pay.

At this point, Ms. Altman asked for questions and comments from participants.

***Acute Care in West Baltimore***

With no questions coming in, Ms. Altman invited Dr. Reginald Brown to explain how Grace will handle the acute needs of patients in West Baltimore. Dr. Brown reiterated that as the Director of the Emergency Department at Grace Medical Center, he began his career in the same emergency department 10 years ago. Dr. Brown acknowledged that prior to the LifeBridge acquisition there was some anxiety about the facility becoming overwhelmed by transfer holds. Dr. Brown explained that prior to the acquisition, Bon Secours was transferring the most acute patients or those needing sub-specialty care to Johns Hopkins or University of Maryland Medical Center. Post-acquisition we now have a streamlined transfer process to our own LifeBridge Health facilities. Over the past three months, 70-75% of our patients have been seen, treated and stabilized in our own ED. Ten percent have been admitted to Grace and 10% have been transferred—of which more than 90% have remained in the LifeBridge Health system.

***Grace Medical Center's New Emergency Department***

Dr. Brown explained that Grace Medical Center has recently contracted with US Acute Care Solutions (USACS) to staff the emergency department. USACS is a physician group that also staffs Sinai and Northwest Hospitals' emergency departments, thus adding to the continuity of care for transferred patients. Furthermore, a new emergency department is currently being constructed at Grace which is expected to open in January 2021. The state-of-the art ED was designed for patient-centered care and will house 24 beds and 3 vertical patient areas. There will be a decontamination zone and resuscitation area at the front entrance. Grace has begun a pediatric telemedicine program and will be adding tele-neurology in the coming months. The new ED will have four negative pressure rooms and a 64-slice 3-D CT scanner will reduce radiation exposure and study times. Lastly, the new Grace ED will have an EMS workstation.

***Transfer Process from Grace***

Ms. Altman asked Dr. Esteban Schabelman to review the transfer process. Dr. Schabelman explained that, when a patient arrives in the Grace emergency department and requires transfer, there is a streamlined system already in place, pursuant to which the provider places a single phone call to a "quarterback" who handles both medical and surgical transfers. The "quarterback" is a physician and is therefore able to determine whether the patient's need will be best met at Sinai or Northwest Hospital, and which unit the patient should be sent to. Then, the "quarterback" calls the hospitalist or admitting provider to alert them of the transfer. The admitting provider calls Grace Medical Center for a physician to physician conversation, and then LifeLink dispatches Pulse Ambulance and Pulse transfers the patient to the appropriate location.

Mr. Jonathan Moles further explained that transfer patients would be categorized according to criticality level using a familiar nomenclature.

Category 1A: Most urgent and emergent transfers (stabilized to be moved to the closest and most appropriate location).
Category 1B: Patients have 60-minutes before they need to reach the appropriate hospital
Category 2: Patients have 4-hour timeline to arrive at the appropriate hospital
Category 3: Patients have an 8-hour timeline in which they need to arrive at a hospital (for example patients who are admitted for continuing cancer care)
Category 4: Patients who would need placement inside of 24 hours (this category has not been used yet)

***The Future State of Grace***

Ms. Altman invited Dr. Arsalan Sheikh to provide an update on the clinics and specialty care that will be offered at Grace. In addition to the brand-new emergency department, Grace Medical Center is currently building a new ambulatory space for specialty and primary care services on the third floor of an existing building on the hospital campus, which is frequently referred to as the "92 Wing." Grace has four primary care providers and recently added a pediatrician and an OB/GYN provider. Grace Medical Center provides care for endocrinology, cardiology, gastroenterology, infectious diseases, urology, pulmonology, vascular service, diabetes education, and ophthalmology. Grace also provides general surgery (elective outpatient procedures) and is expanding orthopedic surgery and vascular surgery. Dr. Sheikh concluded that, due to urgent needs in the local community, Grace will offer expanded outpatient behavioral health services in a new wing that will be constructed as part of the conversion plan. Grace will continue to provide outpatient drug treatment, social services and care management; and Screening, Brief Intervention and Referral to Treatment (SBIRT).

## *Grace Medical Center Physical Plant and Timeline, Mr. Maurice Spielman*

Mr. Maurice Spielman then explained the plans for the physical plant at Grace with the assistance of PowerPoint slides which were made available on the video conference feed. Mr. Spielman began by describing the location of the 1992 Wing, explaining that it is the five-story red brick building connected to the parking garage on the corner of West Baltimore Street and North Pulaski. LifeBridge is currently doing construction on the first and third floors of this building. Demolition began in March 2020 and is complete; appropriate permits are in place.

Mr. Spielman explained that during phase 1 of the renovation project, the new emergency department will be constructed on the first floor, and that the contractors are currently framing the walls and installing the new CT scanner. The project will be completed in December 2020 and will aim to see patients in January 2021.

The next phase is the renovation of the third-floor operating room, which will have two operating rooms and will be completed in July 2020. There will be four new prep bays and four recovery areas. The new clinic space, also on the third floor, will have private exam rooms, mammography, a lab and will be completed in December 2020.

Ms. Altman added that the new emergency department is being laid out in a "racetrack layout". The emergency rooms line the unit in an oval shape with all nursing stations and supplies in the

center of the space. At the back of the space will be four psychiatric holding rooms, and nine total observation spaces.

***Question:*** (Dr. Jennifer Guyther) ***What will be the capacity for psychiatric patients at Grace*****?**

***Answer:*** Ms. Altman responded that the inpatient psychiatric floor previously had 35 beds available, but, when COVID-19 arrived, the beds were capped at 20. With permission from the Maryland Healthcare Commission (MHCC), LifeBridge will be moving the inpatient beds to Sinai and Northwest Hospitals by November 1, 2020 and Grace will no longer offer inpatient psychiatric care after that time. Precautions are in-place to prevent the spread of COVID-19 and all patients are tested before being admitted to Sinai or Northwest. Dr. Brown added that the new ED will have four separate psychiatric bays that have adequate room and provide a good view for the staff. Dr. Brown added that LifeBridge will be streamlining the psychiatric transfer process so that it works as smoothly as the transfers for acute care patients.

***Question:*** *(Dr. Jennifer Guyther)* ***The police department views Grace as a center of excellence for emergency petitions, how has that been addressed?***

***Answer:*** Dr. Brown stated that Grace will continue to welcome first responders who bring emergency petition patients to the facility. Dr. Brown added that there may be a culture shift because some of those arrivals were related to the contract with the Maryland Department of Public Safety and Correctional Services (DPSCS) for patients who did not qualify to go directly into Central Booking. Dr. Brown stated that Grace will get communication out to the West Baltimore Police department as well as the physicians at the University of Maryland as they may see an uptick in emergency petition cases initially.

***Question:*** *(Dr. Jennifer Guyther)* ***What is Grace's newest protocol for cardiac and stroke patients? Will they be observed in the Grace ED or transferred?***

***Answer***: Dr. Brown stated that the initial plan was to roundtrip patients to Sinai Hospital for an MRI, but those plans have been delayed until Grace transitions its electronic medical records platform from Epic to Cerner. Grace will be on Cerner when the new emergency department opens in December 2020 or January 2021. Grace will have a new CT scanner and instantaneous neurological telemedicine consults from Sinai and Northwest Hospitals. Dr. Brown added, that if needed, Grace can push tPA and get the patient transferred ASAP. Dr. Schabelman added that the new CT scanner has perfusion imaging and Grace nurses are receiving the MIEMSS stroke-ready training, despite Grace not being a stroke center.

Chief James Matz, Deputy Chief of EMS for the Baltimore City Fire Department introduced paramedic Robert Patterson and invited him to ask questions from a provider perspective.

***Question*** *(Robert Patterson):* ***In reference to a command call, who do we contact for a patient who is borderline to go to Grace? We used to use University of Maryland or St. Agnes, but since Grace is now part of LifeBridge, should we use Sinai and Grace to get command orders?***

***Answer:*** Dr. Schabelman responded that Grace is not a base station. However, LifeBridge is discussing having Grace apply to become a base station. Dr. Schabelman stated that in the

meantime, it depends on current protocols and whether they call a parent facility or the closest one. Chief Matz added that MIEMSS has an existing protocol for FMFs.

Chief Matz stated that The Baltimore City Fire Department has been long-term friends with LifeBridge, Sinai and the former Bon Secours. He stated that, “From an EMS perspective, we bring in 1600 transports per month with the exception of April due to COVID-19.” Chief Matz said that he has met with his three medical directors and they will communicate clearly to all of their providers about which transports are appropriate for Grace, but that they are already following MIEMSS protocols for an FMF.

Mr. Jeffrey Huggins, Region III Administrator from MIEMSS stated that he supports Grace Medical Center becoming a base station and offered his support for the transition.

## *Adjournment*

Ms. Altman wrapped up the teleconference by thanking the participants for their time and stated that, since before the of acquisition, LifeBridge Health has worked directly with the community to solicit feedback for the future of Grace Medical Center. She also stated that this is the third Town Hall LifeBridge has conducted in reference to the FMF conversion and that the community participants were engaged and made some great suggestions during prior virtual Town Halls. She welcomed attendees to send any questions to Gracemedicaltownhall@lifebridghealth.org for the next two weeks.

Mr. Blum welcomed ongoing feedback and conversation from the EMS providers and thanked them for their ongoing support. Ms. Altman then adjourned the meeting.

June 30, 2020

**VIA ELECTRONIC MAIL**

Letitia Dzirasa, MD
Commissioner of Health
Baltimore City Health Department
1001 E. Fayette Street
Baltimore MD 21202
letitia.dzirasa@baltimorecity.gov

Re: Summary of Public Informational Hearings regarding Conversion to FMF

Dear Commissioner Dr. Dzirasa:

As you may be aware, Grace Medical Center, Inc. ("Grace"), which is currently licensed as an acute care hospital, intends to convert to a Freestanding Medical Facility and intends to seek an exemption from certificate of need review with respect to such conversion. In order to comply with the requirements of the Maryland Health Care Commission, Grace has hosted two "electronic town hall" informational hearings on June 16 and June 18 to inform the general public and community stakeholders of the proposed conversion plan, and will host an additional electronic informational hearing on July 8, which will be primarily focused on the provision of emergency medical services following the conversion.

Pursuant to COMAR 10.24.19.04.C.03(c)(iii), enclosed with this letter are summaries of the informational hearings held on June 16 and June 18. We will provide a written summary of the July 8 hearing within ten working days following such meeting. To date, we have not received any written feedback from the general public or community stakeholders regarding the proposed conversion.

Should you have any questions or need additional information, please let me know.

Very truly yours,

Rebecca A. Altman RN MBA

VP Sinai and Grace Medical Center

and Chief Integration Officer for LifeBridge Health

June 30, 2020

**VIA ELECTRONIC MAIL**

Honorable Robert R. Neall
Secretary of Health
Herbert R. O'Conor State Office Building
201 W. Preston Street
Baltimore MD 21201
robert.neall@maryland.gov

Re: Summary of Public Informational Hearings regarding Conversion to FMF

Dear Secretary Neall:

As you may be aware, Grace Medical Center, Inc. ("Grace"), which is currently licensed as an acute care hospital, intends to convert to a Freestanding Medical Facility and intends to seek an exemption from certificate of need review with respect to such conversion. In order to comply with the requirements of the Maryland Health Care Commission, Grace has hosted two "electronic town hall" informational hearings on June 16 and June 18 to inform the general public and community stakeholders of the proposed conversion plan, and will host an additional electronic informational hearing on July 8, which will be primarily focused on the provision of emergency medical services following the conversion.

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Should you have any questions or need additional information, please let me know.

Very truly yours,

Rebecca A. Altman RN MBA

VP Sinai and Grace Medical Center

and Chief Integration Officer for LifeBridge Health

June 30, 2020

**VIA ELECTRONIC MAIL**

Theodore Delbridge, M.D.
Executive Director
Maryland Institute for Emergency Medical Services Systems
653 West Pratt Street
Baltimore, MD 21201
tdelbridge@miemss.org

Re: Summary of Public Informational Hearings regarding Conversion to FMF

Dear Dr. Delbridge:

As you may be aware, Grace Medical Center, Inc. ("Grace"), which is currently licensed as an acute care hospital, intends to convert to a Freestanding Medical Facility and intends to seek an exemption from certificate of need review with respect to such conversion. In order to comply with the requirements of the Maryland Health Care Commission, Grace has hosted two "electronic town hall" informational hearings on June 16 and June 18 to inform the general public and community stakeholders of the proposed conversion plan, and will host an additional electronic informational hearing on July 8, which will be primarily focused on the provision of emergency medical services following the conversion.

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Very truly yours,

Rebecca A. Altman RN MBA

VP Sinai and Grace Medical Center

and Chief Integration Officer for LifeBridge Health

July15, 2020

**VIA ELECTRONIC MAIL**

Theodore Delbridge, M.D.
Executive Director
Maryland Institute for Emergency Medical Services Systems
653 West Pratt Street
Baltimore, MD 21201
tdelbridge@miemss.org

Re: Summary of Public Informational Hearings regarding Conversion to FMF

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Should you have any questions or need additional information, please let me know.

Very truly yours,

Rebecca A. Altman RN MBA

VP Sinai and Grace Medical Center

and Chief Integration Officer for LifeBridge Health

July 15, 2020

**VIA ELECTRONIC MAIL**

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

Re: Summary of Public Informational Hearings regarding Conversion to FMF

Dear Mr. Steffen:

As you may be aware, Grace Medical Center, Inc. ("Grace"), which is currently licensed as an acute care hospital, intends to convert to a Freestanding Medical Facility and intends to seek an exemption from certificate of need review with respect to such conversion. As described in my previous letter dated 6/30, to comply with the requirements of the MHCC, Grace hosted two "electronic town halls" on June 16 and 18 to inform the public of its plan to convert to an FMF. As I also indicated in the letter, Grace held an additional "electronic town hall" on July 8 which was focused primarily on the provision of EMS following the conversion.

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Should you have any questions or need additional information, please let me know.

Very truly yours,

Rebecca A. Altman RN MBA

VP Sinai and Grace Medical Center

and Chief Integration Officer for LifeBridge Health

July15, 2020

**VIA ELECTRONIC MAIL**

Theodore Delbridge, M.D.
Executive Director
Maryland Institute for Emergency Medical Services Systems
653 West Pratt Street
Baltimore, MD 21201
tdelbridge@miemss.org

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Should you have any questions or need additional information, please let me know.

Very truly yours,

Rebecca A. Altman RN MBA

VP Sinai and Grace Medical Center

and Chief Integration Officer for LifeBridge Health

July 15, 2020

**VIA ELECTRONIC MAIL**

Honorable Lawrence J. Hogan, Jr.
Governor
State House
100 State Circle
Annapolis MD 21401
governor.mail@maryland.gov

Re: Summary of Public Informational Hearings regarding Conversion to FMF

Dear Governor Hogan:

As you may be aware, Grace Medical Center, Inc. ("Grace"), which is currently licensed as an acute care hospital, intends to convert to a Freestanding Medical Facility and intends to seek an exemption from certificate of need review with respect to such conversion. As described in my previous letter dated 6/30, to comply with the requirements of the MHCC, Grace hosted two "electronic town halls" on June 16 and 18 to inform the public of its plan to convert to an FMF. As I also indicated in the letter, Grace held an additional "electronic town hall" on July 8 which was focused primarily on the provision of EMS following the conversion.

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Should you have any questions or need additional information, please let me know.

Very truly yours,

Rebecca A. Altman RN MBA

VP Sinai and Grace Medical Center

and Chief Integration Officer for LifeBridge Health

July 15, 2020

**VIA ELECTRONIC MAIL**

Honorable Bernard C. "Jack" Young
Mayor
City of Baltimore
City Hall—Room 250
100 N. Holliday Street
Baltimore MD 21202
mayor@baltimorecity.gov

Baltimore City Council
Honorable Brandon M. Scott, President
City Hall – Room 400
100 N. Holliday Street
Baltimore Md 21202
CouncilPresident@baltimorecity.gov

Re: Summary of Public Informational Hearings regarding Conversion to FMF

Dear Mayor Young and President Scott:

As you may be aware, Grace Medical Center, Inc. ("Grace"), which is currently licensed as an acute care hospital, intends to convert to a Freestanding Medical Facility and intends to seek an exemption from certificate of need review with respect to such conversion. As described in my previous letter dated 6/30, to comply with the requirements of the MHCC, Grace hosted two "electronic town halls" on June 16 and 18 to inform the public of its plan to convert to an FMF. As I also indicated in the letter, Grace held an additional "electronic town hall" on July 8 which was focused primarily on the provision of EMS following the conversion.

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Very truly yours,

Rebecca A. Altman RN MBA

VP Sinai and Grace Medical Center

and Chief Integration Officer for LifeBridge Health

July 15, 2020

**VIA ELECTRONIC MAIL**

House Health and Government Operations Committee
Room 241
House Office Building
Annapolis, Maryland 21401
AA_HGO@mlis.state.md.us

Re: Summary of Public Informational Hearings regarding Conversion to FMF

Dear Committee Members:

As you may be aware, Grace Medical Center, Inc. ("Grace"), which is currently licensed as an acute care hospital, intends to convert to a Freestanding Medical Facility and intends to seek an exemption from certificate of need review with respect to such conversion. As described in my previous letter dated 6/30, to comply with the requirements of the MHCC, Grace hosted two "electronic town halls" on June 16 and 18 to inform the public of its plan to convert to an FMF. As I also indicated in the letter, Grace held an additional "electronic town hall" on July 8 which was focused primarily on the provision of EMS following the conversion.

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Very truly yours,

Rebecca A. Altman RN MBA

VP Sinai and Grace Medical Center

and Chief Integration Officer for LifeBridge Health

July15, 2020

**VIA ELECTRONIC MAIL**

Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401
AA_FIN@mlis.state.md.us

Re: Summary of Public Informational Hearings regarding Conversion to FMF

Dear Committee Members:

As you may be aware, Grace Medical Center, Inc. ("Grace"), which is currently licensed as an acute care hospital, intends to convert to a Freestanding Medical Facility and intends to seek an exemption from certificate of need review with respect to such conversion. As described in my previous letter dated 6/30, to comply with the requirements of the MHCC, Grace hosted two "electronic town halls" on June 16 and 18 to inform the public of its plan to convert to an FMF. As I also indicated in the letter, Grace held an additional "electronic town hall" on July 8 which was focused primarily on the provision of EMS following the conversion.

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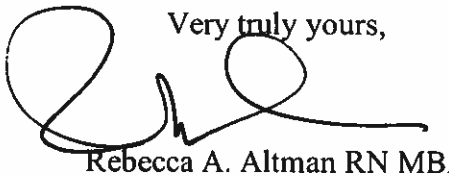
Should you have any questions or need additional information, please let me know.

Very truly yours,



Rebecca A. Altman RN MBA

VP Sinai and Grace Medical Center

and Chief Integration Officer for LifeBridge Health

July 15, 2020

**VIA ELECTRONIC MAIL**

Honorable Charles E. Sydnor, III
Senator, District 44
216 James Senate Office Building
11 Bladen Street
Annapolis, MD 21401
charles.sydnor@senate.state.md.us

Honorable Keith Haynes
Delegate, District 44A
362 House Office Building
6 Bladen Street
Annapolis, MD 21401
keith.haynes@house.state.md.us

Re: Summary of Public Informational Hearings regarding Conversion to FMF

Dear Senator Sydnor and Delegate Haynes:

As you may be aware, Grace Medical Center, Inc. ("Grace"), which is currently licensed as an acute care hospital, intends to convert to a Freestanding Medical Facility and intends to seek an exemption from certificate of need review with respect to such conversion. As described in my previous letter dated 6/30, to comply with the requirements of the MHCC, Grace hosted two "electronic town halls" on June 16 and 18 to inform the public of its plan to convert to an FMF. As I also indicated in the letter, Grace held an additional "electronic town hall" on July 8 which was focused primarily on the provision of EMS following the conversion.

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Very truly yours,

Rebecca A. Altman RN MBA

VP Sinai and Grace Medical Center

and Chief Integration Officer for LifeBridge Health

Exhibit 6

State of Maryland

**Maryland Institute for Emergency Medical Services Systems**

653 West Pratt Street
Baltimore, Maryland
21201-1536

*Larry Hogan*
*Governor*

*Clay B. Stamp, NRP*
*Chairman*
*Emergency Medical Services Board*

*Theodore R. Delbridge, MD, MPH*
*Executive Director*

*410-706-5074*
*FAX 410-706-4768*

September 14, 2020

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

Dear Mr. Steffen,

As you know, Grace Medical Center, Inc., and Sinai Hospital of Baltimore, Inc., are seeking approval from the Maryland Health Care Commission to convert Grace Medical Center 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 determines 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 September 8, 2020, the State EMS Board reviewed the proposed conversion and considered an analysis of the COMAR-enumerated factors. After consideration of these factors, the State EMS Board determined that the proposed conversion of Grace Medical Center 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.

At the same time, however, the EMS Board also asked me to convey to the Commission its concern that any reduction in hospital capacity or change in patient transfer patterns, by their very nature, can impact EMS in ways unanticipated at the outset and may ultimately affect the ability of our system to maintain adequate capacity for emergency care.

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

Sincerely,

Theodore R. Delbridge, MD, MPH, FACEP
Executive Director

Enclosure

# MIEMSS Report and Recommendation to the State Emergency Medical Services Board Regarding the Proposed Conversion of Grace Medical Center to a Freestanding Medical Facility without a Certificate of Need (CON):

# Whether the Proposed Conversion Will Maintain Adequate and Appropriate Delivery of Emergency Care within the Statewide Emergency Medical Services System

**MIEMSS Report and Recommendation to the State Emergency Medical Services Board Regarding the Proposed Conversion of Grace Medical Center to a Freestanding Medical Facility without a Certificate of Need (CON):**

**Whether the Proposed Conversion will Maintain Adequate and Appropriate Delivery of Emergency Care Within The Statewide Emergency Medical Services System**

## Executive Summary

Grace Medical Center, Inc. (formerly Bon Secours Hospital of Baltimore, Inc.) and Sinai Hospital of Baltimore, Inc. ("Sinai"), both members of LifeBridge Health, Inc., (jointly, "the Applicants") are seeking approval from the Maryland Health Care Commission (MHCC) to convert Grace Medical Center to a freestanding medical facility (FMF), as well as for an exemption from a Certificate of Need (CON) review for the proposed conversion. Under Health-General 19-120, the MHCC determines 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 Board." Health-General 19-120 (o)(3)(i) 5 C. By regulation, the EMS Board is required to consider eleven (11) factors in making its determination whether the proposed conversion will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system (COMAR 30.08.15.03).

MIEMSS has completed an analysis of each of the required factors. Based on its review, MIEMSS recommends that the EMS Board make a determination that the conversion of Grace Medical Center to a freestanding medical facility will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system.

## Background

Grace Medical Center is an acute care hospital in Baltimore, Maryland, with 34 licensed MSGA (medical/surgical/gynecological/addictions) beds and 35 licensed psychiatric beds, and an average daily census of 20 inpatients. However, Grace stopped admitting inpatients on November 1, 2019. Currently, it is not a MIEMSS-designated Base Station. The Applicants are seeking to convert Grace Medical Center to an FMF in two phases. In Phase One, currently underway, a new emergency department and clinic spaces will be constructed; and in Phase Two, the existing hospital (in an adjacent building) will be demolished and replaced with a 20,000 square foot facility to accommodate outpatient behavioral health programs.

## Process

Under COMAR 30.08.15.03 (B), the Applicants notified MIEMSS and the MHCC on July 15, 2020 of their intent to convert Grace Medical Center to a FMF. The Applicants held the required public hearing three times virtually on June 16, June 18, and July 8 (the third meeting included EMS representatives) and provided the required information to MIEMSS within the required timeframe. The Applicants solicited input from the EMS community by publishing a physical address and email address on their website for receipt of comments. Additionally, MIEMSS sought information from the EMS community by soliciting comments on its website as "Opportunity for Comment for Grace Medical Center Conversion to a Freestanding Medical Facility" from June 26 – July 22, 2020. Neither Grace Medical Center, nor MIEMSS, received any comments. Under COMAR 30.08.15.03 (D), the EMS Board is required to issue the determination concerning the proposed hospital conversion under §A of this regulation within 45 days of the required public informational hearing held by the hospital proposing the conversion, in consultation with the MHCC. MIEMSS and the Applicants agreed to extend the deadline for EMS Board to make its determination and to notify the MHCC of its determination which was August 24, 2020.

## Required Factors for EMS Board Consideration under COMAR 30.08.15.03(A)

Each of the eleven (11) factors specified for consideration by the EMS Board is discussed below.

*(1) The EMS resources in the jurisdictions affected by the proposed hospital conversion, including staffing, equipment, and units.*

The primary jurisdiction that will be affected by the conversion is Baltimore City. Baltimore County would be expected to be impacted to a lesser extent because transports to Grace Medical Center from Baltimore County are typically only a very small portion of their total transports (see infra).

Baltimore City Fire Department (BCFD) provides emergency services through 38 stations within the city's response area. Battalion Three provides services in and around the area of Grace Medical Center and includes seven stations. The Hollins Street and Frederick Avenue stations are closest to Grace Medical Center. All locations are staffed 24/7 with career providers. The responding crew generally consists of a paramedic and EMT based upon the severity of the call. Medics 1, 8, 12, 15 and 21 serve Grace while ambulance units 22, 23, 27, 34 and 36 serve Grace's area.

*(2) Any additional resources which will be provided by the hospital seeking to convert to augment the resources available in the affected jurisdiction.*

Patients transported to the new FMF who require hospitalization will have to be transferred from the FMF to an acute care facility. The applicants reported that Grace Medical Center had 17,544 ED visits in FY 2019, a 17.3% decrease from FY 2016. Since November 1, 2019, Grace has averaged 101 patients per month or ~3.34 patients per day that required transport to an acute care hospital for inpatient admission.[1] Pulse Ambulance is the primary commercial service providing transports from Grace Medical Center to other facilities, primarily Sinai and Northwest. Since November 1, 2019, Pulse has transported 914 patients from Grace Medical Center to Sinai and other acute care facilities. Pulse Ambulance is on-site at Grace Medical Center 24/7, fully staffed and equipped with advanced life support equipment and personnel.

As a result of the conversion, the Applicants project the need to transfer approximately 3.3 patients per day to an acute care hospital. Annualizing the Applicants' projections indicates that the number of interfacility transfers would total approximately 1,219 a year.

Use of public safety resources for these transfers would place an unreasonable burden on the EMS resources in the affected jurisdiction. The Applicants intend to use a commercial ambulance service for interfacility transport of patients, consistent with current practice. Pulse has one dedicated ambulance on-site at Grace Medical Center 24/7, fully staffed and equipped with advanced life support equipment and personnel. A second unit is available onsite if needed.

[1] November 1, 2019 is when Bon Secours officially became Grace Medical Center and stopped admitting patients.

(3) *The EMS call volume of affected jurisdictions by priority.*

| EMS Transports from Baltimore City and Baltimore County (selected destinations) | | | | | |
|---|---|---|---|---|---|
| **EMSOPS by Patient Priority and Destination Category** | | | | | |
| **Calendar Years 2017, 2018, and 2019** | | | | | |
| **Source: eMEDS®** | | | | | |
| | | | | | |
| **Maryland EMSOP** | **CY 2017** | **CY 2018** | **CY 2019** | **Grand Total** | **EMSOP Priority Percent** |
| **Batimore City** | | | | | |
| Priority 1 - Patient Critically Ill or Injured (Immediate / Unstable) | 2,295 | 2,441 | 2,708 | 7,444 | 6.0% |
| Grace Medical Center (Bon Secours Hospital – 208) | 154 | 129 | 152 | 435 | |
| Midtown (UM) – 206 | 171 | 142 | 202 | 515 | |
| Sinai Hospital – 210 | 815 | 882 | 913 | 2,610 | |
| St. Agnes Hospital – 212 | 474 | 523 | 636 | 1,633 | |
| University of Maryland Medical Center – 215 | 681 | 765 | 805 | 2,251 | |
| | | | | | |
| Priority 2 - Patient Less Serious (Urgent / Potentially Life Threatening) | 12,630 | 11,555 | 10,568 | 34,753 | 28.2% |
| Grace Medical Center (Bon Secours Hospital – 208) | 1,346 | 1,198 | 886 | 3,430 | |
| Midtown (UM) – 206 | 1,628 | 1,504 | 996 | 4,128 | |
| Sinai Hospital – 210 | 4,245 | 3,767 | 3,397 | 11,409 | |
| St. Agnes Hospital – 212 | 2,258 | 2,243 | 2,703 | 7,204 | |
| University of Maryland Medical Center – 215 | 3,153 | 2,843 | 2,586 | 8,582 | |
| | | | | | |
| Priority 3 - Patient Non-Urgent | 28,715 | 26,792 | 25,228 | 80,735 | 65.5% |
| Grace Medical Center (Bon Secours Hospital – 208) | 5,601 | 5,407 | 4,749 | 15,757 | |
| Midtown (UM) – 206 | 4,828 | 4,695 | 4,139 | 13,662 | |
| Sinai Hospital – 210 | 7,264 | 6,594 | 5,594 | 19,452 | |
| St. Agnes Hospital – 212 | 4,930 | 4,731 | 5,302 | 14,963 | |
| University of Maryland Medical Center – 215 | 6,092 | 5,365 | 5,444 | 16,901 | |
| | | | | | |
| Priority 4 - Patient does not require medical attention | 99 | 76 | 64 | 239 | 0.2% |
| Grace Medical Center (Bon Secours Hospital – 208) | 15 | 10 | 11 | 36 | |
| Midtown (UM) – 206 | 28 | 22 | 18 | 68 | |
| Sinai Hospital – 210 | 16 | 23 | 6 | 45 | |
| St. Agnes Hospital – 212 | 16 | 9 | 13 | 38 | |
| University of Maryland Medical Center – 215 | 24 | 12 | 16 | 52 | |
| | | | | | |
| **Baltimore City Total** | **43,739** | **40,864** | **38,568** | **123,171** | 100% |
| | | | | | |

| Maryland EMSOP | CY 2017 | CY 2018 | CY 2019 | Grand Total | EMSOP Priority Percent |
|---|---|---|---|---|---|
| **Baltimore County** | | | | | |
| Priority 1 - Patient Critically Ill or Injured (Immediate / Unstable) | 892 | 970 | 1,178 | 3,040 | 6.8% |
| Grace Medical Center (Bon Secours Hospital – 208) | | 2 | 3 | 5 | |
| Sinai Hospital – 210 | 367 | 433 | 555 | 1,355 | |
| St. Agnes Hospital – 212 | 501 | 504 | 580 | 1,585 | |
| University of Maryland Medical Center – 215 | 24 | 31 | 40 | 95 | |
| | | | | | |
| Priority 2 - Patient Less Serious (Urgent / Potentially Life Threatening) | 5,473 | 5,056 | 5,704 | 16,233 | 36.1% |
| Grace Medical Center (Bon Secours Hospital – 208) | 33 | 42 | 31 | 106 | |
| Midtown (UM) – 206 | 4 | 3 | 1 | 8 | |
| Sinai Hospital – 210 | 2,227 | 2,188 | 2,239 | 6,654 | |
| St. Agnes Hospital – 212 | 2,963 | 2,639 | 3,267 | 8,869 | |
| University of Maryland Medical Center – 215 | 246 | 184 | 166 | 596 | |
| | | | | | |
| Priority 3 - Patient Non-Urgent | 8,272 | 8,370 | 9,028 | 25,670 | 57.0% |
| Grace Medical Center (Bon Secours Hospital – 208) | 217 | 234 | 174 | 625 | |
| Midtown (UM) – 206 | 7 | 3 | 7 | 17 | |
| Sinai Hospital – 210 | 2,736 | 2,900 | 3,305 | 8,941 | |
| St. Agnes Hospital – 212 | 5,127 | 5,010 | 5,363 | 15,500 | |
| University of Maryland Medical Center – 215 | 185 | 223 | 179 | 587 | |
| | | | | | |
| Priority 4 - Patient does not require medical attention | 36 | 18 | 12 | 66 | 0.1% |
| Grace Medical Center (Bon Secours Hospital – 208) | 1 | 0 | 0 | 1 | |
| Midtown (UM)-206 | 0 | 0 | 0 | 0 | |
| Sinai Hospital – 210 | 9 | 7 | 3 | 19 | |
| St. Agnes Hospital – 212 | 25 | 10 | 9 | 44 | |
| University of Maryland Medical Center – 215 | 1 | 1 | 0 | 2 | |
| | | | | | |
| **Baltimore County Total** | **14,673** | **14,414** | **15,922** | **45,009** | 100% |
| | | | | | |
| **Grand Total** | **58,412** | **55,278** | **54,490** | **168,180** | |

As would be expected, Baltimore City EMS transports the greatest number of priority 1 and 2 patients to Grace Medical Center, totaling 3,865 during the three-year period from CY17-CY19, with an additional 15,793 priority 3 and 4 patient transports to Grace Medical Center during the same period. Baltimore County transports to Grace Medical Center were minimal during the same period.

*(4) The projected number of patients who could require transport to a general acute hospital rather than the proposed freestanding medical facility for appropriate medical care.*

After the conversion, all EMS Priority 1 patients and unstable Priority 2 patients will require transport to an acute general hospital, rather than Grace Medical Center, unless the patient requires immediate intervention which Grace Medical Center would provide. As noted above, recent historic data indicates that Baltimore City EMS transported approximately 1,288 patients per year to Grace Medical Center who were priority 1 and 2; data was not available to indicate which of the transported priority 2 patients were unstable. The Applicants project interfacility transfers will be required for approximately 3.3 patients a day, which annualizes to approximately 1,219 patients a year.

*(5) EMS transport times in the jurisdictions affected by the proposed hospital conversion and the potential for extended transport and out-of-service times resulting from the proposed conversion to a freestanding medical facility, relative to the current pattern of transport times.*

| **EMS Average Transport *Times from Baltimore City and Baltimore County (for selected destinations)** | | | |
|---|---|---|---|
| **EMSOPS by Destination Category** | | | |
| **Calendar Years 2017, 2018, and 2019** | | | |
| **Source: eMEDS®** | | | |
| **Maryland EMSOP** | **CY 2017** | **CY 2018** | **CY 2019** |
| **Baltimore City** | **0:08:24** | **0:09:05** | **0:09:26** |
| Bon Secours Hospital – 208 | 0:07:31 | 0:08:14 | 0:08:44 |
| Midtown (UM) – 206 | 0:08:11 | 0:08:51 | 0:09:11 |
| Sinai Hospital – 210 | 0:09:03 | 0:09:46 | 0:09:59 |
| St. Agnes Hospital – 212 | 0:08:34 | 0:09:12 | 0:09:32 |
| University of Maryland Medical Center – 215 | 0:08:16 | 0:08:55 | 0:09:18 |
| | | | |
| **Baltimore County** | **0:14:33** | **0:14:39** | **0:14:34** |
| Bon Secours Hospital – 208 | 0:17:39 | 0:16:07 | 0:17:19 |
| Midtown (UM) – 206 | 0:24:16 | 0:26:06 | 0:22:41 |
| Sinai Hospital – 210 | 0:17:25 | 0:17:41 | 0:17:26 |
| St. Agnes Hospital – 212 | 0:12:25 | 0:12:16 | 0:12:21 |
| University of Maryland Medical Center – 215 | 0:19:42 | 0:19:42 | 0:20:41 |
| | | | |
| **Grand Total** | **0:09:57** | **0:10:33** | **0:10:57** |

Average times are reported in hh/mm/ss format.

Baltimore City EMS is within less than a ten minute transport time to Grace Medical Center and the surrounding hospitals. Average transport time is defined as the time the unit left the scene to patient arrival at destination.

*(6) Commercial ambulance services availability and response times in the jurisdictions affected by the proposed hospital conversion.*

Pulse Ambulance is the primary commercial service providing transport from Grace Medical Center to other facilities, primarily Sinai and Northwest hospitals. Pulse has one dedicated ambulance on-site at Grace Medical Center 24/7, fully staffed and equipped with advanced life support equipment and personnel. A second unit is available onsite if needed. Between November 1, 2019 and July 31, 2020, 914 patients were transferred from Grace Medical Center with all but 11.8% being transferred to either Sinai or Northwest. The average transport time from Grace to Sinai is 18 minutes and from Grace to Northwest is 24 minutes.

(7) *The number of general hospitals likely to be affected by the proposed hospital conversion and the distance to the closest general hospital ED for appropriate patients if the hospital converts to a freestanding medical facility relative to current patterns of hospital use.*

The Applicants provided the following list of the hospitals that may be affected by the conversion of Grace Medical Center and the distance from Grace Medical Center to these hospitals:

- Sinai Hospital-5 miles
- Northwest Hospital-10 miles
- University of Maryland Medical Center-2.2 miles
- University of Maryland Midtown-2.2 miles
- St. Agnes Hospital-2.4 miles

It should be noted, however, that the Centers for Medicare & Medicaid Services require freestanding medical facilities to transfer patients to the "parent hospital" in order to maintain provider based status and receive reimbursement, in this case, another Lifebridge Health Facility.
As a result, the hospitals that will be most affected by the conversion will be Sinai and Northwest.

*(8) The expected additional ED visit volume and associated increases in admission and observation patient volumes for the general hospitals likely to be affected by the proposed hospital conversion.*

Grace Medical Center stopped inpatient admissions in November 2019. Between fiscal years 2015 and 2019, Grace Medical Center reports an inpatient decline of 36.3% compared to a statewide decline of 3.8%. The Maryland Health Care Commission Maryland Hospital Emergency Department and Freestanding Medical Facility data show 2,287 (11.5%) ED patients at Grace Medical Center were admitted to that facility in CY 2019, a decline from 4,595 in CY2012. In the future, these patients will be required to be transported directly to another area hospital or transferred for admission primarily to either Sinai or Northwest Hospitals. In CY 2019, Sinai had 66,979 ED visits, 9,019 (13.5%) of which resulted in inpatient admissions. Northwest had 50,444 ED visits, 7,108 (14%) of which resulted in inpatient admission.

(9) *Recent diversion utilization at the converting hospital and other general hospitals likely to be affected by the proposed hospital conversion and the potential impact of the proposed conversion on diversion utilization.*

| Hospital | CY18 | CY19 | CY20* | CY2018 | CY2019 | 2020* | CY2018 | CY2019 | 2020* | CY17 | CY18 | CY19* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Yellow | Yellow | Yellow | Red | Red | Red | ReRoute | ReRoute | ReRoute | Bypass | Bypass | Bypass |
| Grace | 426 | 512 | 74 | 365 | 1512 | 0 | 161 | 78 | 21 | N/A | N/A | N/A |
| Northwest | 719 | 2117 | 773 | 517 | 4 | 12 | 78 | 134 | 16 | N/A | N/A | N/A |
| Sinai | 2316 | 3283 | 634 | 2256 | 1856 | 225 | 79 | 83 | 51 | 70 | 166 | 18 |
| Midtown | 2087 | 2685 | 1051 | 2178 | 2679 | 515 | 78 | 34 | 21 | N/A | N/A | N/A |
| UMMC | 3389 | 3062 | 1060 | 777 | 1233 | 801 | 272 | 170 | 83 | N/A | N/A | N/A |
| St. Agnes | 2176 | 1261 | 463 | 1598 | 432 | 127 | 223 | 305 | 122 | N/A | N/A | N/A |

***1/1/20-7/30/20** *Data Source: MIEMSS County Hospital Alert Tracking System (**CHATS**)*

Alert Utilization has declined significantly in 2020 at Grace Medical Center, though utilization of yellow alert was never very high. The applicant noted surrounding hospitals have not seen a dramatic increase in yellow or red alert hours as a result of the recent changes at Grace Medical center and stated that they believe two factors may be impacting the alert hours for 2020: (1) the utilization of a commercial ambulance service (Pulse) which has facilitated throughput at Grace, and (2) the decline in ED visits across the city due to the COVID-19 pandemic. Alerts have decreased to date in 2020 for all of the hospitals that may be affected. Prior to COVID-19 however, alert utilization at most hospitals was relatively frequent and it is likely to go back up when COVID-19 eventually goes away. To get better idea of the amount of time EMS spends in the ED, MIEMSS analyzed 2019 data and found that Baltimore City EMS spends between 33 and 44 minutes, an

average of 40 minutes, in the ED at Grace Medical Center and the surrounding hospitals. The goal for EMS is to be no longer than 30 minutes in the ED. It will be important for the hospitals to closely monitor their utilization of alerts.

*(10) The size, scope, configuration, services, and staffing of the proposed project.*

The project will be developed in two phases. In Phase One of construction which is currently underway, plans include converting the first floor of the existing building into a brand-new state of the art emergency department. The observation unit which is currently on the third floor will be relocated to the ED. The new ED will contain a total of 27 rooms, 9 of those being observation rooms and 4 being psychiatric holding rooms. Also included in Phase One is the construction of a new clinic space for primary care, specialty care, and Federally Qualified Health Center services on the third floor, a refresh of the second floor surgical suite and a refresh with expansion of six chairs of the outpatient dialysis unit. Other updates include administrative space, additional staff space and a micro market on floors four and five. Phase One's anticipated completion date is December 2020.

In sum, in Phase One, Grace Medical Center ED will consist of:

1. An emergency department for up 27 patients, including four airborne infection isolation rooms, two trauma/resuscitation rooms, a bariatric room, a human decontamination room, four psych rooms and nine observation rooms;

2. Diagnostic imaging with radiography, computed tomography or CT with a new CT scanner, and ultrasound.

3. Pharmaceutical Services.

4. Laboratory Services.

5. Pediatric Telemedicine for pediatric patients transported to Grace.

The emergency department is staffed 24/7 with one fully boarded emergency room doctor and an Advanced Practice Provider, with sufficient nursing staff, laboratory and radiology technicians, and other professionals who are trained to provide advanced life support to patients. All services are provided in accordance with the Department of Health, Office of Health Care Quality Freestanding Medical Facilities regulations and are consistent with guidance from the American College of Emergency Physicians as well as the current guidance published by the Emergency Department Design: A Practical Guide to Planning for the Future. The

emergency department also has a full time Administrative Director for emergency services, as well as a Medical Director for emergency services. The entire Grace Medical Center campus is overseen by an Administrative Executive Director and a Chief Medical Officer.

In Phase Two of the project, the other buildings on the existing hospital campus will receive environmental remediation and demolition, allowing for the construction of a new 20,000 square foot outpatient behavioral health facility and green space for the community. The new on-site outpatient behavioral health facility will house programs which include a children's day school (for children 6-10 years old) operated under the supervision of psychologists, an adult day program, and an outpatient behavioral health counseling program. The demolition of the existing hospital is expected to be complete in September 2021, while the new outpatient behavioral health facility is expected to be constructed by June 2023.

Provision of Acute Care Services

As a freestanding medical facility, Grace Medical Center will continue to provide a range of health and wellness services that are vital to the West Baltimore Community. These services include:

• 24/7 Emergency services

• 24/7 Observation services

• Outpatient dialysis

• Radiology

• Outpatient behavioral health and substance abuse clinics

• Primary care

• Outpatient surgery

• Outpatient Specialty care: pediatrics, OB/GYN, wound care, vascular surgery, orthopedics, ophthalmology, general outpatient surgery, endocrinology, cardiology, gastroenterology, podiatry, urology, neurology

• Diagnostic testing

• 3D Mammography

• Respiratory therapy

• Case management

The applicants indicate that services may be modified over time, based on their ongoing evaluation of community health needs as well as feedback from the community.

*(11) Reasonable changes in the EMS system that are planned or can be made to maintain adequate and appropriate delivery of emergency care within the Statewide emergency medical services system if the hospital converts to a freestanding medical facility.*

No changes the EMS system are planned as a result of the conversion.

## Summary and Discussion

The EMS Board is charged with determining whether the proposed conversion will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system. This determination is to be made on 11 specified factors. Each factor and MIEMSS findings are briefly summarized below:

*(1) The EMS resources in the jurisdictions affected by the proposed hospital conversion, including staffing, equipment, and units.*

The primarily affected EMS jurisdiction is Baltimore City. Baltimore County will be minimally impacted. MIEMSS received no information that would indicate the need for additional EMS resources in these jurisdictions (staffing, equipment, and units) because of the proposed conversion.

*(2) Any additional resources which will be provided by the hospital seeking to convert to augment the resources available in the affected jurisdiction.*

Timely transfer of patients from the Grace FMF to an acute care hospital without creating a burden for the affected EMS jurisdiction is critical to ensure that conversion does not negatively impact the adequate and appropriate delivery of emergency care. Consistent with current practice, the Applicants intend to use a commercial ambulance service for interfacility transport of patients. To that end, Grace Medical Center has

an agreement with Pulse Ambulance Service for an ambulance to reside onsite and provide interfacility transfers when needed.

*(3) The EMS call volume of affected jurisdictions by priority.*

There is no evidence to suggest that the EMS call volume, per se, will be affected by the proposed conversion in the affected jurisdictions.

*(4) The projected number of patients who could require transport to a general acute hospital rather than the proposed freestanding medical facility for appropriate medical care.*

EMS Priority 1 patients and unstable Priority 2 patients, or those that would require admission for inpatient care, will require direct transport to an acute general hospital, rather than the Grace Medical Center FMF. The Applicants project approximately 3.3 patients per day or about 1,219 patients annually will require transfer to an acute care hospital, namely Sinai and Northwest hospitals.

*(5) EMS transport times in the jurisdictions affected by the proposed hospital conversion and the potential for extended transport and out-of-service times resulting from the proposed conversion to a freestanding medical facility, relative to the current pattern of transport times*

As Grace Medical Center will remain at Grace Medical Center's current location MIEMSS does not project a significant change in the transport times for ambulance-transported patients. Additionally, the surrounding hospitals EMS may transport to are all within 2-5 miles.

*(6) Commercial ambulance services availability and response times in the jurisdictions affected by the proposed hospital conversion.*

Securing timely transfer of patients from Grace Medical Center to other facilities (namely Sinai and Northwest hospitals) is key to ensuring high quality patient care; however, such transfers must not place a burden on the jurisdictional EMS Operational Programs for such interfacility transfers. The Applicants have an agreement with a commercial ambulance company (Pulse) which resides onsite at Grace 24/7 in order to provide these interfacility transports.

*(7) The number of general hospitals likely to be affected by the proposed hospital conversion and the distance to the closest general hospital ED for appropriate patients if the hospital converts to a freestanding medical facility relative to current patterns of hospital use.*

Although there are five (5) hospitals that could potentially be somewhat affected by the conversion, because of CMS payment constraints, in reality, the primary hospitals to be affected are Sinai Hospital and Northwest Hospital.

*(8) The expected additional ED visit volume and associated increases in admission and observation patient volumes for the general hospitals likely to be affected by the proposed hospital conversion.*

Based on information provided by MHCC for inpatient ED visits at Grace in 2019, an additional ED volume of patients requiring admission would be approximately 2,287 per year. However, based on current trends in patients requiring transfer from Grace since November 1, 2019, the applicants project approximately 1,219 patients per year.

*(9) Recent diversion utilization at the converting hospital and other general hospitals likely to be affected by the proposed hospital conversion and the potential impact of the proposed conversion on diversion utilization.*

The ability of receiving hospitals to accept and timely treat direct transport or transferred patients from Grace Medical Center is critical. Sinai and Northwest hospitals will receive most of the transferred patients, while UMMC, UMMS Midtown, and St. Agnes receive the majority of direct transports that cannot go to Grace Medical Center. Sinai and Northwest Hospitals utilization of diversion declined in 2020. Additionally alerts have decreased to date in 2020 for all of the hospitals that may be affected, possibly because of COVID-19. Prior to COVID-19 however, alert utilization at most hospitals was relatively frequent and it is likely to go back up when COVID-19 eventually goes away. It will be important for the hospitals to closely monitor their utilization of alerts.

*(10) The size, scope, configuration, services and staffing of the proposed project.*

The size, scope, configuration, services and staffing planned for the Grace FMF are consistent with applicable guidance included in the most current edition of the *Emergency Department Design: A Practical Guide to Planning for the Future,* published by the American College of Emergency Physicians.

Grace Medical Center will be designed in accordance with the Facilities Guidelines Institute, Guidelines for Design and Construction of Hospitals 2018 Edition ("FGI Guidelines"), the 2015 National Fire and Protection Association 101 Life Safety Code, and the 2018 International Building Code. More specifically, Grace Medical Center will be designed considering the FGI Guidelines Part 2 – Hospitals, Section 2.2-3 Diagnostic and Treatment Facilities, and Section 2.3 – Specific Requirements for Freestanding Care Facilities.

*(11) Reasonable changes in the EMS system that are planned or can be made to maintain adequate and appropriate delivery of emergency care within the Statewide emergency medical services system if the hospital converts to a freestanding medical facility.*

MIEMSS does not anticipate that changes will need to be made to the EMS system as a result of the conversion.

## Recommendation

MIEMSS recommends that the EMS Board make a determination that the conversion of Grace Medical Center to a freestanding medical facility will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system.

Exhibit 7

| **TITLE**<br>Price Transparency | | |
|---|---|---|
| **SITE(S)**<br>☒ Sinai Hospital<br>☒ Northwest Hospital<br>☒ Carroll Hospital<br>☒ Levindale Hebrew Geriatric Center and Hospital<br>☒ Grace Medical Center<br>☐ Community Physician Enterprise<br>☐ Carroll Health Group<br>☐ Carroll Hospice<br>☐ LifeBridge Health & Fitness<br>☐ Practice Dynamics, Inc.<br>☐ Baltimore Child Abuse Center | **CATEGORY**<br>Human Resources<br>☐ Human Resources<br><br>Clinical<br>☐ Patient Care Services<br>☐ Medical Staff<br>☐ Research<br>☐ Laboratory<br>☐ Pharmacy<br>☐ Infection Control<br>☐ Radiology<br>☐ Respiratory Services<br>☐ Care Management<br>☐ Rehabilitation<br>☐ Psychiatry<br><br>Administrative<br>☐ Administration<br>☐ Emergency Preparedness<br>☐ Environmental Services<br>☐ Information Systems<br>☐ Health Information Management<br>☐ Legal<br>☐ Compliance<br>☒ Finance<br>☐ Security<br>☐ Quality, Risk and Patient Safety<br>☐ Environment of Care<br>☐ Patient Experience<br><br>**DEPARTMENT:** Revenue Cycle Division<br><br>**DOCUMENT OWNER:** Senior Vice President and Chief Revenue Officer | |
| **EFFECTIVE DATE:** 01/28/2021 | **LAST REVIEW DATE:** 01/28/2021<br>**REVIEW CYCLE**<br>☐ 1 year ☒ 2 years ☐ 3 years | **REPLACES TITLE:** N/A |

I. POLICY

A. Purpose. The purposes of this Policy are to (a) set forth an online comprehensive machine-readable file of standard charges for all medically necessary items and services, (b) make readily available online a consumer-friendly file or equivalent electronic price estimation tool with a minimum of 300 shoppable services and items, of which 70 mandated by Center for Medicare Medicaid Services (CMS), and within limitation of services offered at the Hospital, (c) establish means by which a list of standard charges for all medical necessary items and services is readily available in written form at each hospital location upon request, (d) state the measures to promptly respond to requests for standard pricing and price estimation for medically necessary items and services and, (e) establish employee training on how to handle requests for standard pricing, answer questions appropriately and issue price estimates from information provided. LifeBridge Health recognizes the importance of price transparency and price estimates in an effort to inform patients of the cost of services and items as part of a complex decision process. Price estimates are a calculation based on best available information at the time of the estimate and may not reflect additional services ordered by a physician for unforeseen clinical reasons.

B. Scope. This policy applies to State of Maryland regulated hospital affiliates specifically Sinai Hospital, Northwest Hospital, Carroll Hospital, Levindale Hebrew Geriatric Center and Hospital, and Grace Medical Center.

C. Policy. It is the policy of LifeBridge Health to make readily available standard of charges for medical necessary services and items and provide price estimation upon request and free of charge. LifeBridge Health provides medically necessary health care services to all patient's without regard to the patient's ability of pay or Protected Class as defined in MD Code, Health-General §19-214.1, at each applicable hospital location (as defined below). Each hospital also provides, without discrimination, care for Emergency Medical Conditions (as defined below) to individuals without regard to such individual's eligibility for Financial Assistance, as more specifically set forth in LifeBridge Health's separate Emergency Medical Treatment & Labor Act (EMTALA) Policy, a copy of which can be obtained free of charge from any one of the sources or locations listed in this Policy.

D. Adoption of Policy. This policy is approved by the Senior Vice President and Chief Revenue Officer.

E. Frequency of Review. This policy is to be reviewed and approved every two years.

II. DEFINITIONS

For purposes of this Policy, the terms below shall be defined as follows:

A. **"Chargemaster"** is a database of all billable items and services also known as the Charge Description Master (CDM) at the hospital location including Employed Providers, which also contain descriptions, revenue codes, department associations, CPT/HCPCS codes if applicable and other information related to billing and revenue capture.

B. **"Employed Provider"** means a licensed physician or non physician practitioner in the State Maryland directly employed by the hospital location as a faculty provider and having completed the credentialing process to treat patients in accordance with their respective scope of license.

C. **"Emergency Medical Conditions"** has the same meaning as such term is defined in section 1867 of the Social Security Act, as amended (42 U.S.C. 1395dd) and as stated:

> "A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions: (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child."

D. **"Financial Assistance"** means any financial assistance in the form of free or discounted care granted to an eligible individual pursuant to this Policy.

E. **"Hospital Cost Review Commission (HSCRC)"** means an independent agency of the State of Maryland with broad regulatory authority to establish rates to promote cost containment,

access to care, financial stability and accountability; including guidelines that govern hospital financial assistance.

F. **"Hospital"** means a facility (whether operated directly or through a joint venture arrangement) that is required by the State of Maryland to be licensed, registered, or similarly recognized as a hospital. "Hospital" means collectively, more than one Hospital Facility. As it relates to this Policy, applicable locations include:

- Carroll Hospital,
- Grace Medical Center
- Levindale Hebrew Geriatric Center and Hospital
- Northwest Hospital,
- Sinai Hospital

G. **"Medically Necessary"** shall have the same meaning as such term is defined for Medicare (services or its reasonable and necessary for the diagnosis or treatment of illness or injury).

H. **"Policy"** means this "Price Transparency" of a Hospital, as amended from time to time.

I. **"Price Estimation"** means a calculation of Standard Charges from an average of items and services, or for a specific item or service derived from the Chargemaster and based on information made available at the time of the estimate. Additional services ordered by a physician as medically indicated are not included in the original estimate.

J. **"Protected Class"** shall comply with the Code of Maryland Regulation specifically representing race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, disability, citizenship status, or any other class, ethnicity or designation not otherwise specified.

K. **"Standard Charges"** means the amounts generally billed as defined by IRS Section 501(r)(5) for hospital emergency and other Medically Necessary care to individuals who have insurance covering that care, and calculated in accordance to the State of Maryland Health Services Cost Review Commission (HSCRC).

## III. GUIDELINES

A. Availability of Standard Charges. Each Hospital Chargemaster with a list of Standard Charges as established by the HSCRC will be posted online in a machine-readable format. An identical list of Standard Charges for each Hospital's Chargemaster including charges for Employed Physician services is available in written format upon request at any one of the locations listed in Section G. below of this Policy. Recognizing that price changes as established by HSCRC or other government agencies occur frequently, and to the extent possible, Hospital Chargemasters with lists of Standard Charges are to be updated monthly with current information and pricing.

At a minimum, the list of Standard Charges includes consumer friendly description, pricing as set by the HSCRC which represents gross and negotiated charges, applicable Current Procedural Terminology (CPT) code and/or the Healthcare Common Procedure Coding System (HCPCS) code.

B. Availability of Shoppable Services. Shoppable services as defined by CMS as those items or services scheduled in advance and frequently ordered of which 70 are predefined by CMS leaving the remainder 230 selected by the Hospital. Each Hospital will post Shoppable services in a machine-readable format online and free of charge. An identical list of Shoppable services will be made available in written format upon request at any one of the locations listed in Section G. below of this policy. When available, listing of Shoppable services in a machine-readable format will be replaced by an internet-based price estimation tool that consumers can obtain out-of-pocket estimates, again free of charge and readily available. Those individuals without internet access or experience difficulty using the price estimation tool, may obtain assistance from Customer Service at (800)788-6995 or from a representative at any one of the locations listed in Section G. below of this Policy.

   At a minimum, the list of Shoppable Services includes consumer friendly description, average pricing for CMS defined and Hospital selected items and services as set by the HSCRC which represents gross and negotiated charges, applicable Current Procedural Terminology (CPT) code and/or the Healthcare Common Procedure Coding System (HCPCS) code, Category location of services and whether the service is provided in an inpatient, outpatient or both setting.

C. Price Estimation. Price Estimates for items and services in advance of scheduled services or for unsolicited requests are available to consumers and prospective patients free of charge online, by calling Customer Service at (800)788-6995 or from a representative at any one of the locations listed in Section G. below of this policy. Such Price Estimates do not include services from physicians or non-physician practitioners. Furthermore, Price Estimates are calculated using best information available at the time of the estimate and may not contain other services ordered by the physician or non-physician practitioner as clinically indicated. Price Estimates are prohibited in the Emergency Department or when patients may be experiencing Emergency Medical Conditions. When possible or appropriate, employee representatives will provide written estimates at the time of the request or by US Mail.

D. Training and Education. Employee representatives expected to provide Price Estimates to consumers or patients will be required to complete education modules and training on how to calculate Price Estimation and use of the Price Estimation Tool. Training includes communication scripting for consistency, insurance plan basics and familiarization, calculation of insurance out-of-pocket balances (copay, coinsurance, deductible, etc…), basic CPT and HCPCS code selection and Price Estimation Tool navigation. Each employee representative is required to complete and successfully pass learning validation assessment before issuing price estimates and also complete annual re-education training annually thereafter.

E. Consumer Complaints. Patients or Guarantors who have complaints about their price estimates may file a complaint by calling Customer Service. Each complaint is documented as to the reason for the complaint and any extenuating circumstance surrounding the occurrence for investigation by the Manager of Customer Service. A written response to the complaint will be mailed to the individual who filed the complaint within fourteen (14) calendar days.

F. Document Retention Procedures. The Hospital will maintain documentation in accordance with retention policies sufficient to identify each Price Estimate issued and, when applicable, patient complaint filed for future reference and management review. Documentation is retained electronically in the documentation management system.

G. Sources of and Locations for Information. Copies of this Policy, Price Estimation, Shoppable services, and the EMTALA Policy, may be obtained from or at any one or more of the following sources or locations:

1. Any Customer Service, Patient Access, or Patient Registration areas, except the Emergency Department;
2. Admission areas or billing department;
3. By calling Customer Service at (800)788-6995; and
4. LifeBridge Health's website at www.lifebridgehealth.org.

Exhibit 8

**Header Information**

**Participating Organizations:** Sinai Hospital, Northwest Hospital, Carroll Hospital, Levindale Hebrew Geriatric Center and Hospital, Grace Medical Center
**Policy Category:** Finance
**Subject:** Hospital Financial Assistance
**Department Responsible for Review:** Revenue Cycle Division
**Policy Owner:** Senior Vice President and Chief Revenue Officer

I. POLICY

A. Purpose. The purposes of this Policy are to (a) set forth eligibility criteria for receiving Financial Assistance; (b) outline circumstances and criteria under which each hospital will provide free or discounted care for Eligible Services to eligible patients who are Uninsured, Underinsured, patients ineligible for public or government assistance or who are otherwise unable to pay for Eligible Services, (c) set forth the basis and methods of calculation for charging any discounted amounts to such patients, and (d) state the measures to widely publicize this Policy within the communities to be served by the hospital. LifeBridge Health expects that patients will comply fully with the terms of this Policy in the determination of their eligibility for, and any receipt of, Financial Assistance and discounts. LifeBridge Health further expects its patients to apply for Medicaid and other governmental program assistance when appropriate, and to pursue any payments from third parties who may be liable to pay for the patient's care as the result of personal injury or similar claims. LifeBridge Health also encourage individuals to obtain health insurance to the extent such individuals are financially able to do so.

B. Scope. This policy applies to LifeBridge Health State of Maryland regulated hospital affiliates specifically Carroll Hospital, Grace Medical Center, Levindale Hebrew Geriatric Center and Hospital, Northwest Hospital and Sinai Hospital (collectively known for this policy as "LifeBridge Health")

C. Policy. It is the policy of LifeBridge Health to provide medically necessary health care services to all patient's without regard to the patient's ability of pay or Protected Class as defined in MD Code, Health-General §19-214.1, at each applicable hospital location (as defined below). Each hospital also provides, without discrimination, care for Emergency Medical Conditions (as defined below) to individuals without regard to such individual's eligibility for Financial Assistance, as more specifically set forth in LifeBridge Health's separate Emergency Medical Treatment & Labor Act (EMTALA) Policy, a copy of which can be obtained free of charge from any one of the sources or locations listed in Section III. K. of this Policy.

D. Adoption of Policy. The Board of Directors of LifeBridge Health and each of its applicable tax-exempt affiliates that provides medically necessary hospital services, has adopted the following policies and procedures for the provision of Financial Assistance.

E. Frequency of Review. This policy is to be reviewed and approved every two years.

II. DEFINITIONS

For purposes of this Policy, the terms below shall be defined as follows:

A. **"AGB"** means the amounts generally billed as defined by IRS Section 501(r)(5) for hospital emergency and other Medically Necessary care to individuals who have insurance covering that care, and calculated in accordance to the State of Maryland Health Services Cost Review Commission (HSCRC).

B. **"Application"** has the meaning set forth in Section III. B. below which shall comply with the HSCRC uniform financial assistance application requirements.

C. **"Assets"** means assets and resources (and the values thereof) of an individual, that would be taken into account and valued in accordance with the Code of Maryland Regulations in determining eligibility specifically excluding such individual's (a) primary personal residence not to exceed an assessed value of $150,000, (b) retirement assets or plans as qualified or nonqualified by the Internal Revenue Service including one or more retirement plans which shall include, without limitation, an individual retirement account (traditional or Roth), profit-sharing plan, defined benefit pension plan, 401(k) plan, 403(b) plan, nonqualified deferred compensation plan, money purchase pension plan, or other retirement plan equivalent to any of the foregoing, (c) one motor vehicle owned by the patient or any family member used for necessary transportation needed, (d) prepaid education assets or plans as defined by the State of Maryland or Internal Revenue Service which include, without limitation, Education Savings Account or 529 plans, (e) any assets expressly excluded in determining eligibility for a Federal or State financial or medical assistance program or plan which include, but not limited to, the Federal Supplemental Nutrition Assistance Program (SNAP), the Maryland Medical Assistance Program, State Energy Assistance Program, or Supplemental Food Program for Women, Infants, and Children, (f) burial space or plot, funds or prepaid burial contracts, and (g) household goods and personal effects.

D. **"CMO"** means Chief Medical Officer at a LifeBridge Health hospital or Chief Physician Executive.

E. **"Eligible Services"** means the services (and any related products) provided by a LifeBridge Health hospital that are eligible for Financial Assistance under this Policy, which shall include: (1) emergency medical services provided in an emergency room setting, (2) non-elective medical services provided in response to life-threatening circumstances that are other than emergency medical services in an emergency room setting, and (3) Medically Necessary Services as defined in this policy.

F. **"Emergency Medical Conditions"** has the same meaning as such term is defined in section 1867 of the Social Security Act, as amended (42 U.S.C. 1395dd) and as stated:

> "A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions: (i) that there is inadequate time to effect a safe transfer to another hospital before

delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child."

G. **"Family Member"** means a member of a group of two (2) or more individuals who reside together and who are related by birth, marriage, or adoption, including, without limitation, any individual claimed as a dependent by any such individual on his or her federal income tax return.

H. **"Family Income"** means the gross income of an individual and all of his or her Family Members, including, without limitation, compensation for services (wages, salaries, commissions, etc.), interest, dividends, royalties, capital gains, annuities, pension, retirement income, Social Security, public or government assistance, rents, alimony, child support, business income, income from estates or trusts, survivor benefits, scholarships or other educational assistance, annuity payments, payments under or from a reverse mortgage, fees, income from life insurance or endowment contracts, and any other gross income or remuneration, from whatever source derived, all on a pre-tax basis.

I. **"Federal Poverty Guidelines"** means poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services in effect at the time of such determination.

J. **"Financial Assistance"** means any financial assistance in the form of free or discounted care granted to an eligible individual pursuant to this Policy.

K. **"Financial Hardship"** means an Uninsured or Underinsured patient of a LifeBridge Health hospital who (1) after payment by all third-party payers, is financially obligated to a LifeBridge Health hospital for an amount in excess of twenty-five percent (25%) of such patient's gross annual income and (2) has Assets that total value of which is less than the amount of "Assets", as amended from time to time.

L. **"Hospital Cost Review Commission (HSCRC)"** means an independent agency of the State of Maryland with broad regulatory authority to establish rates to promote cost containment, access to care, financial stability and accountability; including guidelines that govern hospital financial assistance.

M. **"Hospital"** means a facility (whether operated directly or through a joint venture arrangement) that is required by the State of Maryland to be licensed, registered, or similarly recognized as a hospital. "Hospital" means collectively, more than one Hospital Facility. As it relates to this Policy, applicable locations include:

- Carroll Hospital,
- Grace Medical Center
- Levindale Hebrew Geriatric Center and Hospital

- Northwest Hospital,
- Sinai Hospital

N. **"Medically Necessary"** shall have the same meaning as such term is defined for Medicare (services or its reasonable and necessary for the diagnosis or treatment of illness or injury), or for disputed or less clear cases referred to the CMO or designee to render a decision.

O. **"Policy"** means this "Financial Assistance Policy" of a LifeBridge Health hospital, as amended from time to time.

P. **"Protected Class"** shall comply with the Code of Maryland Regulation specifically representing race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, disability, citizenship status, or any other class, ethnicity or designation not otherwise specified.

Q. **"Provider"** means a LifeBridge Health hospital employed physician, advanced clinical practitioner or licensed professional recognized and granted authority by the State of Maryland to provide health care services.

R. **"Uninsured"** means a patient of a LifeBridge Health hospital who has no level of insurance, third party assistance, medical savings account, or claims against one or more third parties covered by insurance, to pay or assist with such individual's payment obligations for the provision of Eligible Services.

S. **"Underinsured"** means a patient of LifeBridge Health hospital who has some level of insurance, third party assistance, medical savings account, or claims against one or more third parties covered by insurance, to pay or assist with such individual's payment obligations for provision of Eligible Services, but who nevertheless remains obligated to pay out-of-pocket expenses for the provision of Eligible Services that exceed such individual's financial abilities.

III. GUIDELINES

A. Eligibility. Upon a determination of financial need and eligibility in accordance with this Policy, a LifeBridge Health hospital will provide Financial Assistance for Eligible Services to or for Uninsured patients, Underinsured patients, patients who are ineligible for public or government assistance, or who are otherwise unable to pay for Eligible Services. Financial Assistance pursuant to this Policy shall be based on a determination of financial need for each individual, regardless of race, sex, age, disability, national origin or religion, or other Protected Class.

B. Application for Financial Assistance. Except as otherwise provided in this Policy, a LifeBridge Health authorized representative will review all information requested and set forth in an application for Financial Assistance (a copy of which can be obtained free of charge from any one of the sources or locations listed in Section III. K. below of this Policy), an in any and all

documentation therein requested and provided (the application and such documentation, collectively, an "Application"), as well as any one or more items of the following information, in determining whether an individual will be eligible for and receive Financial Assistance:

1. Publicly available data that provides information about an individual's ability to pay (e.g. credit reports, scores, or ratings; Federal Poverty Guidelines, relevant published federal or state guidelines, bankruptcy filings or orders);
2. Insurance eligibility for public or private health insurance including qualification for other public programs that may cover health care costs;
3. Information relating to such individual's participation or enrollment in, or receipt of benefits from or as part of, (a) any state or federal assistance program enrollment (e.g., Supplementary Security Income, Medicaid, Food Stamps/SNAP, Women, Infants, and Children (WIC) programs, AFDC, Children's Health Insurance Program (CHIP), low-income housing, disability benefits, unemployment compensation, subsidized school lunch, or (b) any free clinic, indigent health access programs, or Federally Qualified Health Center (FQHC).
4. Information substantiating the total gross Family Income and assets owned or held by the individual and liabilities or other obligations of the individual;
5. Information substantiating that such individual is or has been homeless, disabled, declared mentally incompetent or otherwise incapacitated, so as to adversely affect such individual's financial ability to pay; and/or
6. Information substantiating that such individual has sought or is seeking benefits from all other available funding sources for which the individual is eligible, including insurance, Medicaid or other state or federal programs.

It is preferred, but not required, that an individual request Financial Assistance prior to Eligible Services being provided. Any Application may be submitted prior to, upon receipt of Eligible Services, or during the billing and collection process. The information that an individual requesting Financial Assistance has provided will be re-evaluated, verified, and required to be updated at each subsequent time Eligible Services are provided that is more than twelve (12) months after the time such information was previously provided. If such information does change or additional information is discovered relevant to the patient's eligibility for Financial Assistance, it is the patient's responsibility to notify Customer Service at (800)788-6995. Applications will be made available, free of charge, at any hospital Patient Access or Customer Service. Requests for Financial Assistance will be processed promptly, and the hospital will determine eligibility within two (2) business days for probable determination or 14 (fourteen) days for final determination after receipt of a completed Application, submission of all required information, and make all reasonable efforts to provide written notification to the patient or applicant of its determination within thirty (30) days. Such notification may be in the form of a billing statement which shows the amount of Financial Assistance applied to the patient's account(s), and if the patient is granted 100% Financial Assistance or denied, written notice will be sent in the form of a letter delivered to the patient's or guarantor's mailing address on file.

A LifeBridge Health hospital may deny or reject any Application and/or may reverse any previously provided discounts or Financial Assistance, if it determines in good faith, that information previously provided was intentionally false, incomplete or misleading. Moreover, a

LifeBridge Health hospital may, at its sole discretion, pursue any and all legal remedies or actions, including criminal charges, against any person who knowingly misrepresented their financial condition including, without limitation, the amount or value of Family Income and/or Assets.

C. Appeals and Complaints. Patients or Guarantors with applications denied for Financial Assistance covered under this Policy may appeal such decisions or file a complaint.
   1. Appeals must be in writing and describe the basis of reconsideration, including any supporting documentation. Appeals must be submitted to Customer Service within fourteen (14) calendar days of the application decision or otherwise the decision shall be upheld and considered final. Customer Service will make every effort to notify Patients or Guarantors of the appeal decision within thirty (30) calendar days.
   2. Complaints regarding this Policy can be received by mail, email or phone. All complaints are to be reported to LifeBridge Health Compliance Department for monitoring and reporting. Customer Service will respond to each complaint, contact the individual who filed the complaint and notify the LifeBridge Health Compliance Department of the complaint's outcome.

      Patients or Guarantors may also file a complaint with Maryland Health Education and Advocacy Unit using the following contact information:

      Office of the Attorney General
      Health Education and Advocacy Unit
      200 St. Paul Place, 16th Floor
      Baltimore, MD 21202
      Phone: (410)528-1840
      Fax: (410)576-6571
      Email: HEAU@oag.state.md.us

D. Presumptive Financial Assistance. In some cases or circumstances a patient or applicant may appear eligible for Financial Assistance, but either has not provided all requested information or otherwise non-responsive to the application process. In such cases or circumstances, an authorized representative of a LifeBridge Health hospital may complete the Application on the patient's behalf and research evidence of eligibility for Financial Assistance from available outside sources to determine the patient's estimated income and potential discount amounts or may utilize other sources of information to make an assessment of financial need. As a result of such information, the patient may be eligible for discounts up to 100% of the amounts owed for Eligible Services. In such circumstances, a patient is presumed eligible to receive Financial Assistance for Eligible Services if the patient meets one or more of the following criteria:
   1. Eligible for the Maryland Medical Assistance program or Maryland Children's Health Program and:
      i. Lives in a household with children enrolled in the free and reduced-cost meal program;
      ii. Receives benefits through the federal Supplemental Nutrition Assistance Program;

iii. Receives benefits through the State's Energy Assistance Program;
iv. Receives benefits through the federal Special Supplemental Food Program for Women, Infants, and Children; or
v. Receives benefits from any other social service program as determined by the Maryland Department of Health and Mental Hygiene (MD DHMH) and the State of Maryland HSCRC.

2. Residence in low income or subsidized housing;
3. Unfavorable credit history, based on the patient's credit report (high risk, low medical score, delinquent accounts);
4. Utilization of third-party predictive modeling based on public record databases and calibrated historical approvals statistically matched to this Policy. Such technology will be deployed prior to bad debt assignment in an effort to screen all patients for financial assistance prior to collection agency placement or pursuing any extraordinary collection actions.
5. Homeless or received care from a homeless shelter, free clinic;
6. Mentally incompetent as declared by a court or licensed professional; or
7. Deceased with no known estate.

E. Eligibility Criteria and Amounts Charged to Patients. Patients who are determined to be eligible, shall receive Financial Assistance in accordance with such individual's financial need, as determined by referring to the Federal Poverty Guidelines as published annually in the Federal Register.

1. Notwithstanding anything in this Policy to the contrary, no patient who is eligible to receive Financial Assistance for Eligible Services will be charged more than allowed by the State of Maryland HSCRC pricing or AGB for emergency or other Medically Necessary care.
2. The basis for determining and calculating the amounts billed an Uninsured or Underinsured patient who is eligible for Financial Assistance is as follows:
    i. Any Uninsured or Underinsured patient eligible for Financial Assistance will first receive the Financial Assistance discount for either 100% of billed charges or a reduced billed amount for those with Family income above 300% of the Federal Poverty Guidelines.
    ii. Uninsured or Underinsured patients eligible for Financial Assistance whose yearly Family Income is equal to or less than 300% of the Federal Poverty Guidelines and whose total Assets do not exceed amounts allowed will receive a discount of 100% of their remaining account balance.
    iii. Any Uninsured with Family Income above 300%, but less than 500% of the Federal Poverty Guidelines may qualify for a Financial Hardship discount. To qualify total Assets must be less than allowed provided total outstanding medical expenses minus co-payments, coinsurance and deductibles exceed 25% of annual Family Income. The amount of the Financial Hardship discount is any amount that exceeds 25% of annual Family Income. Thus, remaining balance owed excluding co-payments, coinsurance and deductibles if applicable after discount does not exceed 25% of Family Income.

F. Excluded Services. The following healthcare services are not eligible for Financial Assistance under this Policy:

1. Purchases from retail operations, including gift shops, retail pharmacy, durable medical equipment, cafeteria purchases;
2. Services provided by non-LifeBridge Health entities or professional services from physicians or advanced practice providers during hospital visits;
3. Elective procedures or treatments that are not Medically Necessary including cosmetic surgery, bariatric surgery, venous ablation.
4. Services provided at Levindale Nursing, Rehabilitation and Adult Day Care locations and any amounts deemed by Medicaid as patient liability.
5. Existing or pre-established programs to assist patients with defined coverage of services similar to Best Beginnings for undocumented women needing prenatal care or Access Carroll for free clinic care to uninsured and underinsured patient populations in Carroll County.

G. Communication of Information about the Policy to Patients and the Public. LifeBridge Health hospitals will take measures to inform and notify patients and visitors and the residents of the community at large served by the hospital, of this Policy in a manner that, at a minimum, will notify the listener and reader that the hospital offers Financial Assistance and informs individuals about how and where to obtain more information about this Policy. Such measures will include the following:

1. Clearly and conspicuously post signage to advise patients and visitors of Financial Assistance availability including Emergency Department, admission areas and billing departments
2. Make this Policy, the Application, and a plain language summary of this Policy widely available on its website www.lifebrigehealth.org.
3. Make paper copies of this Policy, the Application, and a plain language summary of this Policy available upon request, without charge, in public locations in each hospital including Emergency Department, admission areas, billing department and by mail or e-mail. Furthermore, Patient Access and Customer Service representatives will notify and inform individuals upon admission or discharge of Financial Assistance and offer a paper copy of a plain language summary of the Financial Assistance Policy.
4. List all Providers, as referenced as Addendum I, whether employed or not employed by the hospital, covered by this Policy and will make widely available on its website www.lifebridgehealth.org.
5. Referral of patients for Financial Assistance may be made by any member of LifeBridge Health staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors.
6. A request for Financial Assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws and limitations.
7. Any and all written or printed information concerning this Policy, including the Application, will be made available in each of the languages spoken by the lesser of 1,000 individuals or 5% of the community served by the hospital or the population likely

to be encountered or affected by the hospital. The hospital will take reasonable efforts to ensure that information about this Policy and its availability is clearly communicated to patients who are not proficient in reading and writing and/or who speak languages other than those for which information about this Policy are printed or published.

H. Document Retention Procedures. The hospital will maintain documentation in accordance with retention policies sufficient to identify each patient determined to be eligible for Financial Assistance including the patient's Application, any information obtained or considered in determining such patient's eligibility for Financial Assistance (including information about such patient's income and assets), the method used to verify patient's income, the amount owed by the patient, the method and calculation of any Financial Assistance for which such patient was eligible and in fact received, and the person who approved the determination of such patient's eligibility for Financial Assistance.

I. Relationship to Billing and Collections Policy. For any patient who fails to timely pay all or any portion of amount(s) owed, the hospital will follow guidelines set forth in its separate Billing and Collections Policy; provided that, the hospital will not commence or institute any extraordinary collection actions (including garnishments, liens, foreclosures, levies, attachments or seizures of assets, commencing civil or criminal actions, sales of debts to third parties, reporting adverse information to credit reporting agencies or credit bureaus) against any patient for failure to timely pay all of any portion of patient's account, without first, making reasonable efforts to determine whether the patient is eligible for Financial Assistance. Reasonable efforts are set forth in the separate Billing and Collections Policy, including those relating to patient communications and required actions, time periods, and notices of complete or incomplete Application for Financial Assistance. A copy of the Billing and Collection Policy may be obtained free of charge from any one of the sources or locations listed in Section III.K. below.

J. No Effect on Other Policies; Policy Subject to Applicable Law. This Policy shall not alter or modify other policies regarding efforts to obtain payment from third party payers, transfers or emergency care. This Policy and the provision of any Financial Assistance will be subject to all applicable federal, state, and local law.

K. Sources of and Locations for Information. Copies of this Policy, the Application, the Billing and Collections Policy, and the EMTALA Policy, may be obtained from or at any one or more of the following sources or locations:
    1. Any Customer Service, Patient Access, or Patient Registration areas;
    2. Emergency Department, admission areas or billing department;
    3. By calling Customer Service at (800)788-6995; and
    4. LifeBridge Health's website at www.lifebridgehealth.org.

Exhibit 9

# Sinai Hospital of Baltimore

## Baltimore, MD

has been Accredited by

## The Joint Commission

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

Hospital Accreditation Program

November 14, 2017

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #6260
Print/Reprint Date: 01/18/2018

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

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

The Joint Commission

Joint Commission accredited organizations that have a full accreditation survey that has been postponed due to the COVID-19 pandemic will continue to be considered accredited beyond their current certificate expiration date.

The Joint Commission has resumed survey/review activity and as soon as The Joint Commission has determined it is safe to resume onsite survey activity in your county, scheduling of past due surveys will be prioritized.

Organizations that have an approaching accreditation due date that may be impacted as The Joint Commission begins to survey past due organizations will also continue to be considered accredited. Once the full survey has been conducted and a final accreditation decision of Accredited has been rendered, the accreditation will be renewed without any lapse in the existing accreditation.

www.jointcommission.org

**Headquarters**
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

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

**License No. 30-062**

Issued to:

**Sinai Hospital Of Baltimore, Inc.**
**2401 West Belvedere Avenue**
**Baltimore, MD 21215**

Type of Facility: **Acute General Hospital**
**Special Hospital - Rehabilitation with 57 beds**

Ownership: **Sinai Hospital of Baltimore**

Date Issued: July 1, 2018
Expiration Date: Non-Expiring License

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

Patricia Tomako May, MD

Director

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

Exhibit 10

# Community Health Needs Assessment

Bon Secours Baltimore Health System

Bon Secours Hospital

July 2019


Good Help to Those In Need®

respect | compassion | justice | integrity | quality | innovation | stewardship | growth

## Executive Summary

Bon Secours Baltimore Hospital (Bon Secours) is a 69-bed facility licensed in the state of Maryland providing acute, primary and specialty care services to residents in various communities in and near West Baltimore. Bon Secours includes a community-based primary care site, behavioral medicine program with multiple substance abuse treatment sites, renal dialysis services, and preventive health and education programs. Bon Secours is part of the Bon Secours Baltimore Health System which also includes Unity Properties Housing, Bon Secours Community Works, and the Bon Secours Baltimore Health System Foundation. Bon Secours is a member of Bon Secours Mercy Health. On February 26, 2019 Bon Secours Mercy Health and LifeBridge Health signed a letter of intent for LifeBridge Health to acquire Bon Secours Hospital.

The Patient Protection and Affordable Care Act [§ 9007, 26 U.S.C. 501(c) (2010], requires non-profit hospitals to conduct a community health needs assessment ("CHNA") and adopt an implementation strategy every 3 years to be considered a non-profit by the Internal Revenue Service (IRS). A CHNA defines the community a hospital serves, surveys the health of their community, and listens to their community members' opinions and consults with public health and health condition experts in order to decide what the greatest needs of their community are and what resources are available. An implementation strategy then describes how the hospital plans to address the greatest needs in their community. This Executive Summary provides an overview of the CHNA initiative and the findings.

### 2016 Community Health Needs Assessment

A Community Health Needs Assessment and corresponding Implementation Plan were prepared for the Bon Secours Baltimore Hospital service area in 2016. The documents were made available to the public and posted online in August of 2016. In concurrence with the 2019 CHNA Bon Secours solicited public comments on the 2016 documents. Solicitation was made through the media outlets listed in the table below. Two comments were received regarding the Implementation Plan.

| Venue | Date |
|---|---|
| Radio One, Magic 95.9 Radio Spotlight -Talib Horne (CHNA only) | February 4, 2019 |
| Bon Secours Baltimore Social Media Platforms | March 29, 2019 |
| Baltimore Sun | April 13 - 19, 2019 |

**Approach and Methodology:** Similarly to the CHNAs conducted in 2013 and 2016, Bon Secours used an inclusive approach to complete the CHNA to ensure that the CHNA was conducted in a way that best identifies west Baltimore's health needs and meets the IRS CHNA requirements for not-for-profit hospitals. In fiscal year 2019, Bon Secours leadership recognized the importance of continuity with previous CHNAs and the corresponding Implementation Plans (IP).

For 2013 and 2016, the goals and actions of the IP responded to identified needs that could be categorized as *Healthy People, Healthy Economy, and Healthy Environment*. The 2019 IP is expected to be consistent with the thematic categories of previous IPs and, where appropriate, continue with actions previously established to successfully address identified needs.

Bon Secours utilized its established Bon Secours Community Works CHNA Advisory Board (Advisory Board) as well as representation from community leaders, community anchor institutions, faith-based organizations, and the Baltimore public health department to serve in an advisory capacity for the CHNA initiative. Bon Secours staff met with partner healthcare organizations, St. Agnes Hospital and Kaiser Permanente, as well as the local primary schools to provide input and establish identified health and social needs of west Baltimore. Along with input from the Bon Secours Hospital Board and Community Works Board, leadership prioritized the identified community health needs for the 2019 CHNA.

As part of the CHNA methodology, Bon Secours collected and analyzed both primary and secondary data for ten Community Statistical Areas (CSAs) that more accurately comprise the Bon Secours service area than the zip code population of the 2016 CHNA. The following CSAs make up Bon Secours CHNA Service Area: Edmondson Village, Forest Park/Walbrook, Greater Mondawmin, Greater Rosemont, Penn North/Reservoir Hill, Poppleton/The Terraces/Hollins Market, Sandtown-Winchester/Harlem Park, Southwest Baltimore, Upton/Druid Heights, and Washington Village/Pigtown.

**Key Findings from Secondary Data Analysis:** Key findings from the secondary data analysis are summarized below.

The 2010 US Census indicates the population of the ten CSAs (primary service area) to be 105,816 or approximately 17.1% of the total population of the City of Baltimore. Demographically, Bon Secours' service area is similar to Baltimore City in regards to age and gender, but is different in terms of race/ethnicity and income.

According to the American Community Survey (2013 – 2017), Bon Secours' service area has a larger percentage of household income below $25,000 (42%) than the City as a whole (29.5%) and a larger proportion of African Americans (88%) than Baltimore City (62%) and the state of Maryland (29.4%). The CSAs also experiences a higher rate of public insurance coverage (57.6%) than across the entire City (29.6%).

West Baltimore health outcomes and socio-economic factors were less favorable to those of Baltimore City across all categories. In particular,

- The Bon Secours Service Area has worse health outcomes, particularly life expectancy and mortality compared to Baltimore City and Maryland.
- Bon Secours' CSAs ranks worse amongst families living below the poverty level, children in poverty and number of vacant properties.
- The Bon Secours Service Area has seen increases in all-cause mortality, cancer, and homicide rates since the last CHNA process which are related to health behavior and socioeconomic factors.

**Community and Stakeholder Involvement:** The CHNA team used a multi-pronged approach to solicit input from the west Baltimore community regarding their health needs. Data collection methodologies included surveys, stakeholder interviews, and focus groups.

The team engaged with representatives of the community with knowledge of public health (e.g., Maryland Department of Health and Mental Hygiene and the Baltimore City Health Department), the broad interests of the community served, and individuals with special knowledge of the medically underserved, as well as low-income and vulnerable populations and people with chronic diseases. The CHNA work group met with seniors, re-entry residents, faith-based stakeholders, community leaders, health care providers, neighborhood associations, representatives from community-based organizations and other key community stakeholders with an intimate knowledge of the west Baltimore community and its health needs. Two hundred seventy-three (273) surveys were

collected within the defined service area. Eleven (11) stakeholder interviews and three (3) focus groups were conducted between January and March 2019. All methods focused on community health needs, community assets and resources available to respond to the community health needs, barriers and challenges to accessing the community assets and resources, and ways in which Bon Secours could help address the health needs.

**West Baltimore Priority Health Needs**

In 2016, Bon Secours Hospital identified the following health needs in the community:

- Crime and Related Trauma
- Behavioral Health/Substance Abuse
- Access to Primary Care Physicians
- Health Education
- Children's Health
- Access to Healthy Foods
- Expanded Housing
- Employment and Workforce Development
- Community Engagement
- Coordination of services across Bon Secours
- Advocacy, Policy, and Public Agency Dialogue, and
- Hospital Quality and Public Health

The hospital and the local health system chose to prioritize all these needs and developed an Implementation Plan accordingly.

In 2019, the first ten needs (above) remained as Identified Needs of the community, and five additional needs (in green boxes) as well as modifications (in black text) were added. See Figure 1 below.

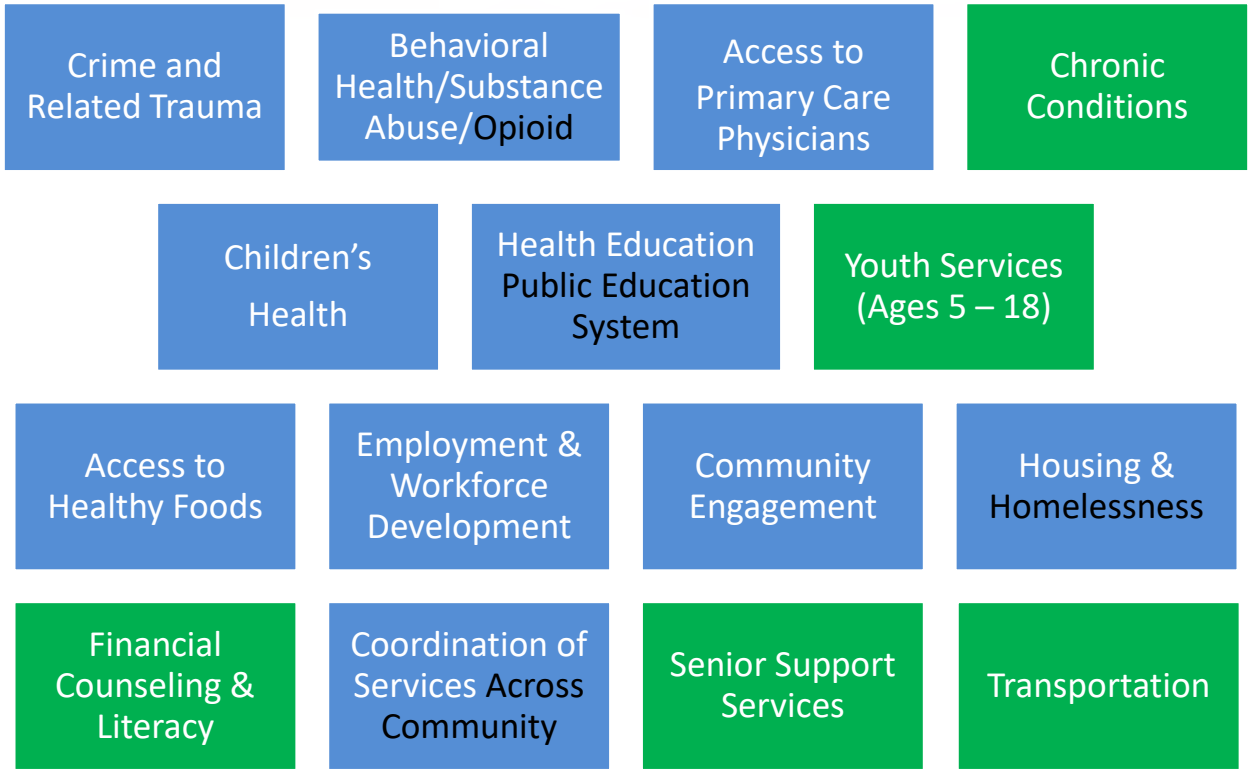



**Figure 1 – Identified Needs of Community Served**

The Bon Secours Baltimore CHNA work group met with members of the Bon Secours Hospital board on May 22, 2019 and the Community Works board on May 23, 2019. Utilizing the criteria below, board members were asked to select those identified needs for which there was **"High Need and High Feasibility"** (ability to impact). Board members expressed particular concern for Employment and Workforce Development, Behavioral Health, Substance Abuse and Opioids, as well as Crime and Safety in the community.

The following criteria were used to prioritize the community needs:

- Supported by Community Service Area data;
- Consistent with Public Health and health expert input, including the Baltimore City wide CHNA;
- In support of the Bon Secours Mercy Health strategic pillars and Key Performance Indicators;
- In support of benefitting a significant population of the community;
- In support of continuity and progress made by 2013 and 2016 Implementation Plans; and
- In consideration of 2019 community survey results.

The following Identified Needs were selected as Priorities by Bon Secours and will be included in the 2019 – 2021 Implementation Plan:

1) **Crime and Related Trauma**
2) **Employment and Workforce Development**
3) **Housing and Homelessness**
4) **Access to Healthy Foods**
5) **Health Education, and collaboration with the Public Education System**
6) **Services for Youth (ages 5 to 18)**
7) **Senior Support Services**

Bon Secours leadership anticipates the 2019 – 2021 Implementation Plan will address these needs within the *Healthy People, Healthy Economy, and Healthy Environment* framework in conjunction with the new ownership and management of the hospital. Unity Properties is the developer for affordable housing within the Bon Secours service area.

In addition, all parties recognize the significant need to address Behavioral Health / Substance Abuse and Opioid crisis. Bon Secours Community Works envisions supportive coordination with new hospital management for **Behavioral Health/Substance Abuse/Opioid** screening and interventions, **Children's Health** services as well as appropriate referrals and support to improve **Access to Primary Care Physicians** and to address **Chronic Conditions**. Bon Secours Community Works will also work with City agencies and collaborative organizations to advocate for and support improved **Transportation**.

Bon Secours Community Works will continue to offer **Financial Counseling and Literacy** services and to provide all its programs and services through processes that include **Community Engagement** and **Coordination of Services across the Community**.

# 1 Purpose of the CHNA Report

A community health needs assessment (CHNA) provides the foundation for improving and promoting the health of a community. Through the assessment process, Bon Secours Baltimore Health System ("Bon Secours") identifies and describes the health status of the community that it serves; any factors in the community that contribute to health challenges; and, existing community assets and resources that can be mobilized to improve the health status of the community. The community health needs assessment, therefore, ensures that Bon Secours and partner resources are directed toward activities and interventions that address critical and timely community health needs. This Report documents the results of Bon Secours' CHNA for fiscal year 2019. This Report will inform Bon Secours' CHNA Implementation Strategy that will describe how Bon Secours plans to address identified health needs.

## 1.1 Federal CHNA Requirement

The Patient Protection and Affordable Care Act [§ 9007, 26 U.S.C. 501(c) (2010], (commonly referred to as "Obamacare") requires non-profit hospitals to conduct a community health needs assessment (CHNA) and adopt an implementation strategy (i.e., community health improvement plan (CHIP)) every 3 years to be considered a non-profit by the Internal Revenue Service (IRS). A CHNA defines the community a hospital serves, surveys the health of their community, and listens to their community members' opinions in order to decide what the greatest needs of their community are and what resources are available. An implementation strategy then describes how the hospital plans to address the greatest needs in their community.

The IRS describes a CHNA as:

> "The collection of information required for hospital organizations to receive the benefits of being described in section 501(c)(3) of the Internal Revenue Code (Code) and flows from section 501(r)(3), which requires a hospital organization to conduct a community health needs assessment (CHNA) and adopt an implementation strategy to meet the community health needs identified through the CHNA at least once every three years…The Affordable Care Act also added section 4959, which imposes a $50,000 excise tax on a hospital organization that fails to meet the CHNA requirements for any taxable year."

A CHNA will only meet the requirements of the law if it:

(i) Defines the community it serves.
(ii) Assesses the health needs of that community.

(iii) Reviews input from their community and local public health officials.
(iv) Documents the CHNA in a written report (CHNA Report) that is adopted for the hospital by an authorized body of the hospital facility.
(v) Makes the CHNA report widely available to the public.

## 1.2 Comments on FY2016 CHNA Report and Implementation Plan

Bon Secours prepared a CHNA and corresponding Implementation Plan in 2016. Both documents were made available to the public and posted online. Bon Secours received two comments indicating satisfaction with the FY2016 CHNA report and Implementation Plan.

# 2 Impact of Current Implementation Plan (2016 – 2019)

The current CHNA Implementation Plan has three categories – Healthy People, Healthy Economy, and Healthy Environment. Within each category are several goal areas. The progress of each goal, including Actions and Outcomes are as follows:

**Healthy People**

Goal 1 – Improve residents' access to healthy food and nutrition, and increase health education.

*Actions to increase access to healthy foods in west Baltimore included successful completion of Hoop House with fresh produce, expansion of community gardens across four locations, and launch of mobile food truck, as well as provision of healthy foods market at hospital. Several partnerships formed with local non-profits and area churches.*

*Outcome: In addition to purchasers of fresh produce and fruits, bi-weekly delivery of fresh food to 26 families and pursuit of partnership with Maryland Food Bank for service to 75 more families.*

*Actions to increase youth and family education in nutrition, food selection and preparation resulted in:*

- *Annual registration of 57 children in Early Head Start;*
- *15 Teen Parent educated (FY17) and 22 Teen Parent educated (FY18) within Family Support Program;*
- *30 youth educated on nutrition (FY17) and 58 youth educated on nutrition (FY18) through Summer Youth Works program;*

- *Education provided to 108 pre-kindergarten and kindergarten students at Frederick Elementary school.*

*Actions to expand outreach education to up to six elementary schools.*

*Outcome: Annual education of 30 high school youth and 57 children on beneficial nutrition, food selection, and preparation.*

*Contract food service provider has held twice monthly produce market for past two years. Efforts to establish a virtual supermarket for residents have had limited success The Wayland Village housing location does operate the Virtual Supermarket for its residents.*

*Actions to support and advocate in conjunction with Baltimore Development Corporation for development of a grocery store in west Baltimore continue. This effort has a timeframe beyond the current CHNA and will require additional partners to accomplish.*

Goal 2 – Improve the health status of southwest Baltimore residents by increasing awareness and treatment options surrounding mental illness and addiction, and empowering residents that suffer from mental illness and addiction through health promotion and education.

*Actions to investigate and implement Behavioral Health screening services for both children and adults at Bon Secours Community Works resulted in creation of Behavioral Health screening tool by Bon Secours Department of Behavioral Medicine in FY17 that included component on adverse childhood events to identify childhood trauma. The tool was administered in FY18 across clients of Bon Secours Community Works.*

*Outcome: 742 assessments were completed through February 2019 with 24 referrals to the department of Behavioral Medicine.*

*Actions were directed to partner with the City of Baltimore Police Department (Western District) to provide annual training sessions for police officers' interactions with residents who have mental health issues or are in a mental health emergency / crisis.*

*Outcomes: In FY17 seventy-seven (77) were provided training and education. In FY18, Bon Secours participated in the Mayor's "Violence Reduction Initiative" and provided training and education to 56 officers. Through February 2019, 59 officers have been provided with training and education.*

*Actions were made to develop a more trauma-informed workforce through in-services and education regarding trauma-informed principles and corresponding protocols. Outcomes: In FY17, 217 workforce members, representing 25% of the total workforce*

*received training. In FY18, another 15 training sessions were conducted reaching a total of 776 workforce members.*

Goal 3 – Improve the health status of southwest Baltimore residents by engaging the community in screening and educational events that promote healthier lifestyles and better self-management of health and chronic illness.

*Actions include a partnership with Kaiser Permanente, area schools, and community organizations to improve health outcomes through health education and health screenings.*

*Outcomes: In FY17, community school partnerships established with Frederick Elementary and Mary Ann Winterling Elementary (Kaiser). In FY18, 2,056 individuals received health screenings across thirteen senior housing sites, five health clinics, and seven faith based organizations. In addition, the Community Health and Housing Program was launched at Bon Secours housing residences to include smoking cessation classes, AED training, Narcan training, and HIV/AIDS education. In FY19, six local area school principals were funded to attend REACH Whole School Conference and 22 health screening events were conducted at faith-based communities.*

*Actions to inform the community of hospital quality and patient safety performance led to quarterly data reporting to community advisory board as well as link on hospital internet page.*

*Actions to maintain and expand capacity for emergency services resulted in continuation of contract with University of Maryland Medical Center.*

Goal 4 – Improve the health status of southwest Baltimore youth by increasing awareness efforts and preventive measures related to children's health to promote healthy lifestyles for the entire family.

*Actions to improve education and preventive measures included expanded engagement of the Family Health and Wellness Center, educational classes at the Women's Resource Center (WRC), and greater outreach and communication to community members.*

*Outcomes: In FY17, 248 women participated in monthly screenings and workshops at the WRC and 187 families attended Back to School Open House. The In FY18, the Family Health and Wellness Center participated in 8 community health fairs and provided child safety education. WRC education classes were held twice a month, and the quarterly newsletter was distributed to 1200 households.*

*Actions to address infant mortality included in-home parenting skills training and education for 30 families annually through the Home Visiting Program with intent to increase babies born at full term by 5 percent annually.*

*Outcomes: In FY17, through a grant Bon Secours hired a Teen Parent Program coordinator. Twenty families were enrolled in the Home Visiting Program and of 17 babies born, 16 were full-term, an increase of 13% from FY16. Forty-one (41) young mothers received ongoing in-home parenting skills training for children under the age of three. In FY18, 15 teen parents participated in Program before funding ended. Home Visiting Program continued through FY18 and in FY19, thirty-two (32) families are presently being served through the Family League of Baltimore partnership.*

*Actions to expand behavioral health and substance abuse programs for children and youth included up to six annual presentations at the Bon Secours Family Support Center and establishment of new programs for Addiction Services for Adolescents and Child Psychiatric Rehabilitation Services.*

*Outcomes: In FY17, behavioral health and substance abuse staff made 26 presentations. In FY18, staff completed 452 assessments for Bon Secours Community Works clients and made 226 client referrals. In addition, staff screened 141 high risk/high utilizers for emergency services and with screening tools determined 32% of participants were at risk for anxiety, and 39% at risk for moderate or severe depression. In FY19, eight presentations have been made to date. Resources insufficient to continue development for intended new programs.*

**Healthy Economy**

Goal 1 – Improve Baltimore residents' economic status by providing job readiness programs, ongoing adult education, and specific youth outreach, and participating in the creation of jobs in areas in which we have the most expertise and influence, namely, the health care field.

*Actions to workforce development and economic status per above goal included job coaching assistance to community residents, increased enrollment in a CNA/GNA health care positions, and participation in Kaiser Future Baltimore Initiative.*

*Outcomes: In FY17, 73 residents were enrolled in CNA/GNA training and certification program, 63 completed the training, 60 obtained certification, and 56 were hired. Through workforce development coaching, 167 residents were placed in jobs averaging $13.17 per hour wage. In FY18, 90 clients gained paid employment with job search and*

*placement support; nine received paid urban landscaping training. Nine Patient Care Tech trainees were placed with jobs at the University of Maryland Medical Center. The Kaiser Future Baltimore Initiative enrolled 50 residents, 42 of whom completed training, and 35 participants received CNA certification and 18 participants obtained their GNA certifications. Through February in FY19, 62 residents have received employment support, and Kaiser Future Baltimore has enrolled 25 trainees in their most recent cohort.*

*Actions to increase pipeline of qualified candidates for health care jobs include CNA/GNA training programs funded by grants from the Workforce Innovation Opportunity Act (WOIA), and Ann E. Casey Foundation.*

*Outcomes: Across all funders, in FY17, there were 31 enrolled, 25 of whom completed training, 25 achieved certification, and 24 were placed in jobs. Seasonal job fairs were held for healthcare employers with average participation of 27 employers represented. In FY18, 35 individuals were enrolled, 28 of whom completed training, 26 of whom achieved certification, and 24 were placed in jobs. Through February of FY19, 52 participants were or are enrolled, 12 have completed training, 12 have achieved certification, and four individuals have obtained jobs with an average wage of $13/hour.*

*Actions to provide jobs and skills training for formerly incarcerated individuals include the Bon Secours Re-Entry Program, TYRO, with funding by the Department of Labor, and Kaiser Permanente.*

*Outcomes: In FY17, there were 117 enrolled participants and 60 completed TYRO programs. In FY18, a case manager was hired and 154 clients were enrolled in TYRO programs with 110 participants completing Individual Career Plans, 29 of whom received a degree or certificate, and 14 were employed. Two expungement workshops were conducted with 379 expunged offenses for 78 individuals.*

*Actions to incorporate job readiness into the Youth Works development program included enrollment of 16 – 24 year old CNA/GNA trainees in forty hour Pathway to Success training as well as occupational training and certificate preparation for up to eight annual trainees of the Clean and Green initiative.*

*Outcomes: In FY17, of the 24 WOIA students enrolled, 20 completed training, and 18 received CNA/GNA certifications. Of the eight Clean and Green trainees, five graduated and completed certification training. In FY18, 21 of the 24 CNA/GNA youth trainees graduated and all received CNA certification. In addition five received GNA certification, and 9 obtained jobs in health care. In FY19, there are currently 30 recent high school graduated youth enrolled in CNA/GNA Baltimore Promise program.*

*Actions to enroll 50 participants in GED program with at least 5 percent obtaining their GED included efforts to partner with Baltimore City Community College and the South Baltimore Learning Center for referral of enrollees.*

*Outcomes: In FY17, nine enrolled participants. In FY18, twenty-seven (27) enrolled participants. In FY19, fourteen (14) adult students currently enrolled in GED program.*

Goal 2 – Support the creation and preservation of affordable housing opportunities for families, seniors and special populations through the development of additional housing units.

*Actions to expand the availability of affordable housing included construction and completion of the New Shiloh Family Apartments and development of an additional 200 units of rental apartments for families, seniors, and disabled persons.*

*Outcomes: In FY17 Bon Secours Gibbons Apartments opened and all 80 unites were leased in FY18. In FY18, New Shiloh Apartments opened and in FY19 all 73 units were leased. In FY17, feasibility studies were completed for Wayland II, Bon Secours Apartments V, and Southwest Partnership Lease-Purchase projects. In FY18 and FY19 tax credit applications to state were submitted. Awaiting approval.*

**Healthy Environment**

Goal 1 – Increase the number of public green spaces that are safe and well-maintained by supporting the transformation of vacant lots to develop safe, public spaces for use by the community.

*Actions to expand the conversion of vacant lots into clean and usable spaces included partnerships with community associations and targeting of 52 vacant lots.*

*Outcomes: In FY17, grant obtained to continue Clean & Green initiative. In FY18, vacant lots were prioritized with cooperation from Anchor Community Group. Fifty-seven lots were cleaned and maintained. In FY19, a new Workforce Development director was hired with plans to expand Clean & Green initiative.*

*Actions to raise environmental awareness across community included coordination of up to six workshops/projects with residents and community groups.*

*Outcomes: In FY17, team conducted six clean up and service day projects in partnership with various community groups and organizations. In FY18, team conducted two clean up and service day projects in partnership with community groups.*

*In FY19, team initiated student engagement in advocacy with legislators and Future Baltimore initiatives. Fifty-five (55) students and 117 individuals participated in meetings and workshops.*

*Actions to develop safe and well maintained spaces included Clean & Green program participants providing landscaping services at Unity Properties housing developments.*

*Outcomes: In FY17, trainees expanded landscaping services to include snow removal and urban agriculture. In FY18 and FY19, had and have six trainees enrolled in Clean & Green program with annual spring graduation.*

*Actions to address community concerns and needs included convening quarterly community forums in all segments of the service area.*

*Outcomes: In FY17, four Community Forums were held. In FY18, four Community Forums were held. Through February of FY19, two Community Forums have been held.*

Goal 2— Address ongoing community resident concerns related to crime and sanitation.

*Actions to address community concerns related to crime and sanitation included convening a minimum of ten (10) meetings per year with participation from at least three City agencies (non-police).*

*Outcomes: In FY17, staff convened 12 Crime and Grime meetings with between 3 to 5 City agencies representatives in attendance. In FY18 and FY19, monthly meetings have continued with average of 4+ City agencies in attendance across community associations.*

*Actions to convene and develop leadership across community associations included a leadership training program and establishment of Anchor Group Committee.*

*Outcomes: In FY17, increased participation by Celebration Church, Central Baptist Church, Fayette Street Outreach, Boyd Booth and Franklin Square association leaders. Anchor Group Committee began monthly meetings. In FY18, Leadership Training in partnership with Kaiser Permanente was initiated. Curriculum was provided to Anchor Group Committee leaders. Ten training sessions occurred in fiscal year. In FY19, Anchor Group conducts and leads monthly meeting and gives guidance to Bon Secours work and engagement.*

*Actions to strengthen relationships with police districts in Bon Secours service area included participation of police in Crime and Grime meetings as well as annual updates to community relations committees of each police district.*

*Outcomes: In FY17, Southwestern and Western District police departments were active participants in Crime and Grime meetings. In FY18, meetings continue and representatives of City Department of Justice and Violence Reduction Initiative attend as well. In FY19, meetings have continued.*

*Actions to continue Crime and Grime committee include twelve meetings per year and continued staff support by Bon Secours.*

*Outcomes: In FY17, twelve (12) meetings were held. In FY18, nine meetings were held. Meetings are monthly in FY19.*

# 3 Overview of Bon Secours Hospital and the Bon Secours Baltimore Health System

Bon Secours Baltimore Hospital (Bon Secours) is a 69-bed facility licensed in the state of Maryland providing acute, primary and specialty care services to residents in various communities in and near west Baltimore. Bon Secours includes a community-based primary care site, behavioral medicine program with multiple substance abuse treatment sites, renal dialysis services, and preventive health and education programs. Bon Secours is part of the Bon Secours Baltimore Health System which also includes Unity Properties Housing, Bon Secours Community Works, and the Bon Secours Baltimore Health System Foundation. Bon Secours is a member of Bon Secours Mercy Health. On February 26, 2019 Bon Secours Mercy Health and LifeBridge Health signed a letter of intent for LifeBridge Health to acquire Bon Secours Hospital.

## Mission

As a member of Bon Secours Mercy Health, the mission of the Bon Secours Baltimore Health System, including Bon Secours Hospital, is to extend the compassionate ministry of Jesus by improving the health and wellbeing of our communities and bring good help to those in need, especially those who are poor, dying and underserved.

With this mission in mind, Bon Secours stands proudly as an anchor institution in an area of west Baltimore that has suffered from disinvestment for many years. Its delivery of quality healthcare and community services is critical to the health and wellbeing of people in the area. In fulfilling its mission, Bon Secours also generates critical economic impact in the surrounding community and across Baltimore City.

Our team cares for west Baltimore residents through nonprofit subsidiaries comprising the Bon Secours Baltimore Health System, each with a separate Board of Directors responsible for fiscal and operational oversight.

- **Bon Secours Baltimore Hospital** focuses on acute, primary and specialty care. It includes a 69-bed acute care hospital, a community-based primary care site, behavioral medicine program with multiple substance abuse treatment sites, HIV/AIDS counseling and treatment, renal dialysis services, and preventive health and education programs.

- **Bon Secours Baltimore Health System Foundation** was established in 2012 as the fundraising arm for all Bon Secours Baltimore Health system entities, managing public and private grants, individual and corporate gifts, special events, and

marketing. It serves as the fiscal agent for many grants.

- **Bon Secours Community Works** was launched in 1991 to provide programs that address the social determinants of health impacting West Baltimore residents. Although a client may come in requesting help with one issue, one of our strengths is our wide array of wraparound services: job readiness training, assistance with job placement and occupational training enrollment, tutoring in reading and math, GED preparation, financial education and counseling with help to enroll in public benefits, eviction prevention assistance, family strengthening programming including Early Head Start child development and parenting classes, a women's day shelter, and other services.

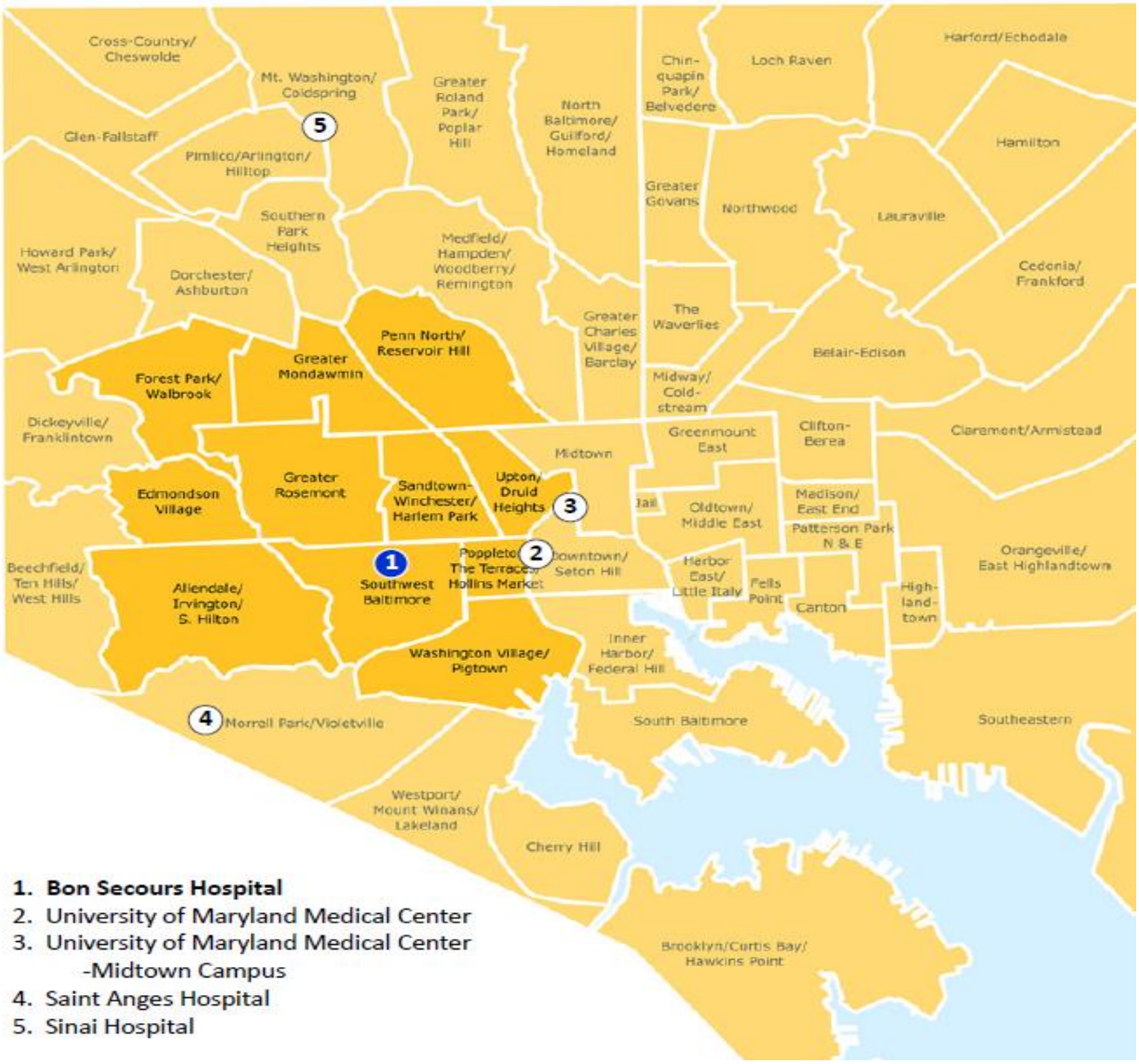
- **Unity Properties** is the housing and community development subsidiary, providing safe and affordable housing to low-income families, seniors and people with disabilities. Together, their supportive programs integrate with Bon Secours' health care services to make positive changes in individuals' physical and mental health.

## 3.1 Description of the Community Served

Baltimore City collects data across fifty-five (55) Community Statistical Areas ("CSAs"). These CSAs reflect neighborhood groupings. Bon Secours has determined that its primary service area is comprised of ten CSAs, depicted in Figure 2 (darker shaded area).

Bon Secours is the only hospital provider located within these ten CSAs though other hospitals and health systems are adjacent to the CSA population and provide corresponding and complementary services.

## Figure 2 - Bon Secours Primary Service Area



## Service Area Demographics

### *Population*

As of 2017 the population of Bon Secours' CSAs ("service area") is 105,816 residents, or 17.1% of Baltimore City's population. The CSAs have lost 3.5% of its population since the 2010 US Census.

Three CSAs - Greater Rosemont, Southwest Baltimore, and Sandtown-Winchester/ Harlem Park - comprise 44.8% of the service area population.

**Table 1 – Service Area Population**

| Community Statistical Area (CSA) | Total Population |
|---|---|
| Edmondson Village | 8,160 |
| Forest Park/Walbrook | 10,156 |
| Greater Mondawmin | 9,089 |
| Greater Rosemont | 17,348 |
| Penn North/Reservoir Hill | 10,569 |
| Poppleton/The Terraces/Hollins Market | 4,834 |
| Sandtown-Winchester/Harlem Park | 13,204 |
| Southwest Baltimore | 16,843 |
| Upton/Druid Heights | 10,210 |
| Washington Village/Pigtown | 5,403 |
| Bon Secours Service Area | 105,816 |
| Baltimore City | 619,796 |

**Source: Baltimore Neighborhood Indicators Alliance – Jacob France Institute, Vital 17**

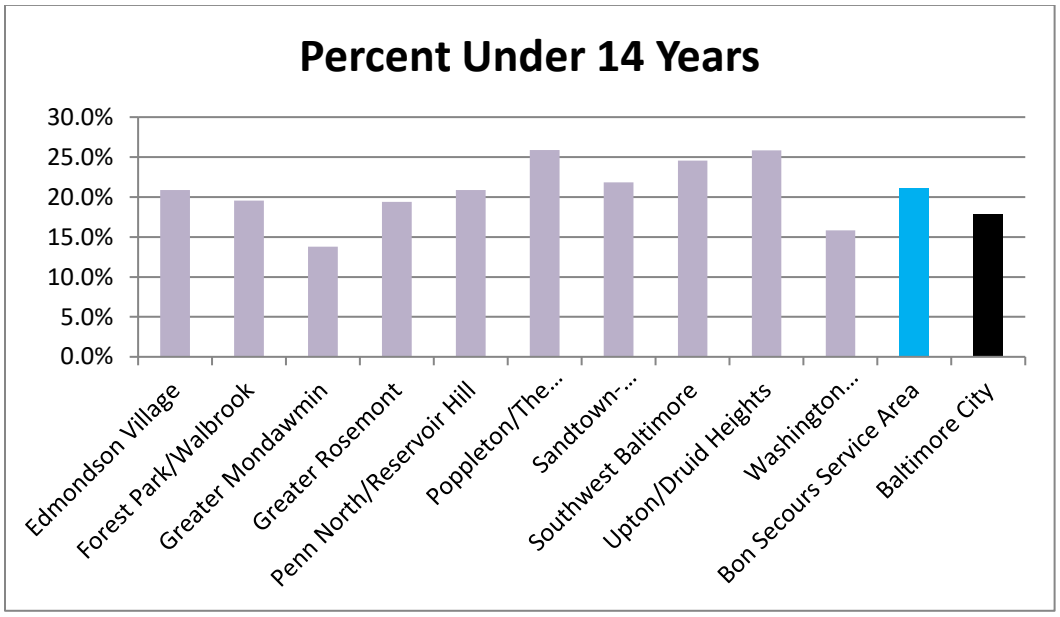
The service area is similar to Baltimore City in regards to gender with females constituting 53.5% and males 46.5% of the population. City-wide, males are 47% of the population.

### *Age*

Across the service area the population is younger than Baltimore City as a whole.

- 21.1% of the population is under 14, versus 17.8% city-wide; Upton/Druid Heights and Poppleton/The Terraces/Hollins Market each have 25.9% population under 14 years of age. Greater Mondawmin has significantly less population (13.8%) under 14 years. (See Figure 3 below)
- The 60+ population (18%) is comparable (less than 1 percent variation) to all of Baltimore City, though Poppleton/The Terraces/Hollins Market has significantly fewer seniors (11.7%).

Figure 3 – Population Under Age 14




Source: Baltimore Neighborhood Indicators Alliance – Jacob France Institute

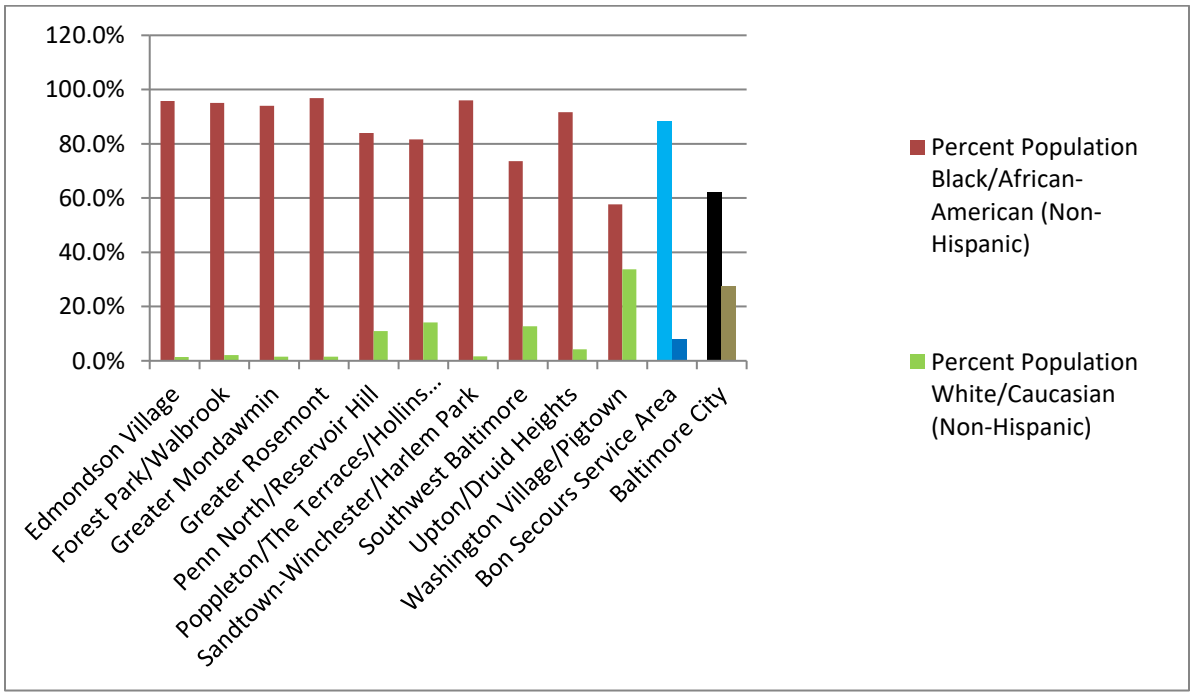
In addition, there are significant differences with regard to race/ethnicity, income, and access to insurance (Income will be discussed within the Socio-Economic section). Overall, the service area is a substantially African American, of lower income, and either uninsured or publicly insured.

### *Race/Ethnicity*

The service area's race/ethnicity is substantially African American, with six CSAs exceeding 90 percent.

- 88.4% of the total service area is African American, which is greater than Baltimore City and the state of Maryland (62.3% and 29.4%, respectively). White/Caucasians constitute another 7.8% across the service area.
- Only Washington Village/Pigtown has a White/Caucasian population percentage greater than the City as a whole (33.7% vs. 27.6%).
- All other race and ethnic groups combined represent less than 4 percent of the service area's population.

**Figure 4 – Race/Ethnicity by CSA and Baltimore City**

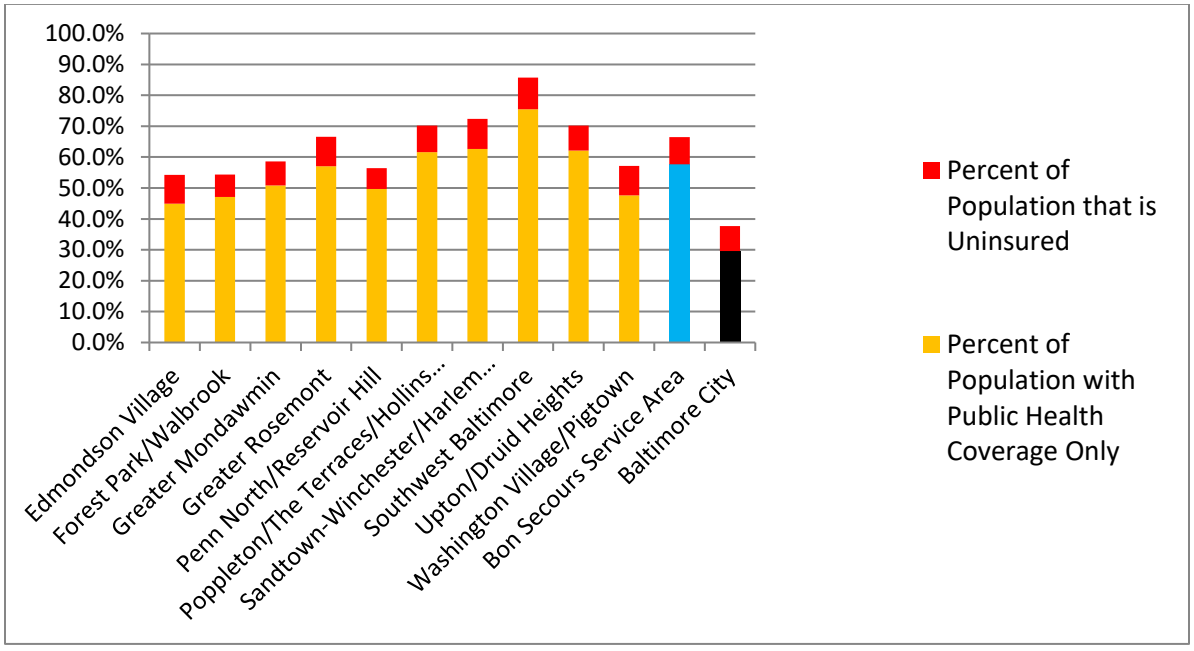



**Source: Baltimore Neighborhood Indicators Alliance – Jacob France Institute**

### *Access to Insurance*

The service area has a much higher percent of individuals that have public insurance compared to Baltimore as a whole (57.6% vs. 29.6%). All CSAs have more than 40% of their population enrolled in public insurance, the vast majority being enrolled in Medicaid. The service area has a higher proportion of uninsured persons (8.8%) compared to Baltimore (8.0%).

**Figure 5 – Percentage of Individuals with Public or No Insurance by CSA and Baltimore**




**Source: Baltimore Neighborhood Indicators Alliance – Jacob France Institute**

# 4 CHNA Approach and Methodology

Bon Secours used a work group ("team") to complete the CHNA to ensure that the CHNA was conducted in a way that best identifies west Baltimore's health needs and meets the IRS CHNA requirements for not-for-profit hospitals. (Refer to Appendix 1 for the list of Bon Secours team members). The CHNA Advisory Board, which had representation from community leaders, community anchor institutions, faith-based organizations, as well as representatives of The Mayor's Office participated in discussion of community health needs and supported the prioritization of identified health needs. (Refer to Appendix 2 for the list of Community Advisory Board membership).

As part of the CHNA methodology to identify community health needs, the team collected and analyzed both qualitative and quantitative data via community input and review of secondary data sources. Quantitative data was provided by the Baltimore City Health Department as well as Baltimore Neighborhood Indicators Alliance – Jacob Francis Institute (BNIA).

The CHNA team used a multi-pronged approach to solicit input from the community across the service area regarding their health needs. Qualitative data collection methodologies included stakeholder interviews, focus groups, and a survey.

Methods were based on the intended target audience and information needs. Figure 6 below shows the data collection method used to meet CHNA requirements.

Figure 6 - CHNA Requirement and Data Collection Methodology

| CHNA Requirement | Data Collection Methodology |
|---|---|
| Secondary Data sources reflecting health and social conditions of the community served. | • Baltimore City Health Dept; BNIA |
| At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health with knowledge, information, or expertise relevant to the health needs of that community; | • Stakeholder Interviews |
| Members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; | • Stakeholder Interviews<br>• Survey<br>• Focus Groups |

| | |
|---|---|
| Input received from a broad range of persons located in or serving its community including but not limited to health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers, and community health centers, health insurance and managed care organizations, private businesses and labor and workforce representatives. | • Survey<br>• Focus Groups |

# 5 Qualitative Findings

### *Stakeholder Interviews*

Qualitative in-depth interviews were conducted with key stakeholders to include city and state health department representatives, community leaders, and health care providers. The stakeholders were selected because they had special knowledge of or expertise in public health or represented the broad interest of the community served by Bon Secours, including the interests of medically underserved, low-income and minority populations with chronic disease needs.

The stakeholder interviews were conducted between January 2019 and March 2019.

Bon Secours obtained input from eleven (11) key Community Stakeholders regarding the health needs of the community. Interviewees were asked to identify available health resources in the community, gaps in resources, barriers to obtaining services, existing collaborations and expected changes or trends in the community. Interviews were conducted in-person (with the exception of two) and lasted approximately 45 minutes to 1 hour. A designee employed by Bon Secours Community Works conducted the interviews and provided each participant with the Bon Secours 2016 CHNA Report & Implementation Plan.

Overall, Bon Secours received positive feedback about the community health resources and investments made within Southwest Baltimore and surrounding community service areas. Despite, Bon Secours' strong commitment to address the health concerns of the community, stakeholders highlighted the following themes as top health concerns:

- **Behavioral Health, Substance Abuse, Mental Health and related Trauma** with a special emphasis on the opioid crisis, drug overdose, and violence reduction;
- **Addressing Social Determinants of Health** (stable housing, workforce development, increase access to healthy foods and physical activity);

- **Chronic Health Conditions** (childhood and adult obesity, cardiovascular disease, cancer, diabetes, hypertension, asthma).

A number of health resources in the community were highlighted in collaboration with the health department: direct medical and dental services, mobile clinics, urgent care/acute management, outreach workers/community health workers, homeless services, access to care, legal clinic services, EMS department, mental health, treatment programs, family planning and care coordination. Bon Secours was highlighted as a great partner and anchor institution to bring resources to the community. “Hospitals are available to serve the community” but there must be a coordinated effort to keep asset maps up-to date. **A recommendation was given to encourage community member to use “2-1-1 Maryland” as a centralized resource to received access to health and human services information.**

Although, key stakeholders were able to mention a variety of available health resources in the community there are still gaps that impact the health status of residents. Additionally, it was highlighted that there is a lack of connection between access to care and awareness of resources. The development of creative approaches to engage various partners and best utilize strategies for care coordination could assist with needs. The following were major themes:

- **The need for case management services** not only in the hospital but in community based programs to help persons navigate their health challenges; helping persons to access resources when they are ready for change; and providing safe spaces to address mental health, behavioral health treatment and trauma on-demand;
- **Building stronger youth programming** - childcare support should be affordable and high quality; provide access to “judgement free” health services for young people; provide recreational facilities and out-of-school-time program to play an important role in young people’s development;
- There is a **critical need for addressing the chronic homelessness** experienced due to a lack of stable and affordable housing options. When individuals and families are displaced it greatly impacts overall health status.
- There continues to be a **lack of available resources around food** (lack of fresh food and grocery stores), **and employment** (job training resources).

Stakeholders also gave recommendations for resources in the community that are not being used to their full capacity, including:

- Mental health and trauma related resources are underutilized possibly due to stigma and trust must be built;
- Treatment (substance abuse) for outpatient medication assistance programs need to be evidence-based and increase community members awareness/training around naloxone;
- Chronic disease management programs and community-based programs for cardiovascular disease and diabetes (traditional vs. non-traditional settings can impact success of reach and delivery);
- Services for returning citizens population to get connected to society, family and employment;
- Police department not used to full capacity because of communities perceptions (fear, lack of trust).

Bon Secours understands that in an effort to address the central health needs of the community, barriers to obtaining health services in the community must be highlighted and addressed. **Community stakeholders highlighted the following barriers:** transportation; communication/messaging; related trauma; stigma, trust and awareness of resources; gaps in funding to support community; ability to navigate services; legal backgrounds; neighborhood barriers to seek services from other communities; services provided only during traditional hours; income and insurance prevents persons to seek services; and lack of knowledge/low literacy.

Despite barriers all stakeholders remain hopeful for the future of southwest Baltimore. Stakeholders expected changes and trends will lead to revitalization around housing, blight elimination and increase in homeownership amongst minority populations. There is hope for the opioid epidemic to plateau and shifts in reduction of stigma/increase in access to treatment which impacts crime. Positive feedback was given about the Kaiser Permanente, Bon Secours, and Community relationship/partnership to strengthen the mission of making a better Baltimore. Lastly, “the community has strong advocates and capable people to help anchor institutions help the community with existing needs. There is a need for more partnership building between the community and its members. Focus should be placed on the community as a force that can truly help institutions move forward.”

The interview questions can be found in Appendix 3. The list of stakeholders interviewed is provided in Appendix 4.

### *Focus Groups*

The Bon Secours CHNA team held three focus group conversations on March 13, 2019, April 5, 2019 and April 10, 2019. The first conversation was with Behavioral Health and Substance Abuse professionals. The second conversation was with leadership of the "Anchor" organizations – community associations and church groups – of west Baltimore. The third focus group conversation was with CHNA Advisory Board members who have provided input over the past two CHNAs conducted by Bon Secours Baltimore.

For the Behavioral Health focus group the conversation was structured to elicit current views of the Opioid crisis, perspective on trends over the past three to five years, identification of barriers to treatment or disinclination to choose treatment, as well as open-ended opportunity to propose impactful actions at the clinical, regulatory, and macro/holistic level.

For both the "Anchor" as well as Advisory Board conversations, the participants reviewed the 2016 CHNA Implementation Plan goals and actions under *Healthy People*, *Healthy Economy*, and *Healthy Environment*. Participants were asked to provide feedback on the 29 actions, identify additional unmet needs, and in the last segment of the focus group to give input to the Prioritization process by selecting the one or two most significant actions or unmet needs.

The following issues/needs were recommended as significant Priorities:

- **Children's Health / Trauma** (specifically mental health/substance abuse), including youth;
- **Development and Advocacy for a neighborhood Grocery Store**/supermarket
    - Develop a food access strategy
    - Provide greater nutritional education, especially for children
    - Obesity prevention and reduction;
- **Crime and Related Trauma;**
- Increase financial resources for programs and services.

A record of the three focus group conversations can be found in Appendix 5.

### *Survey*

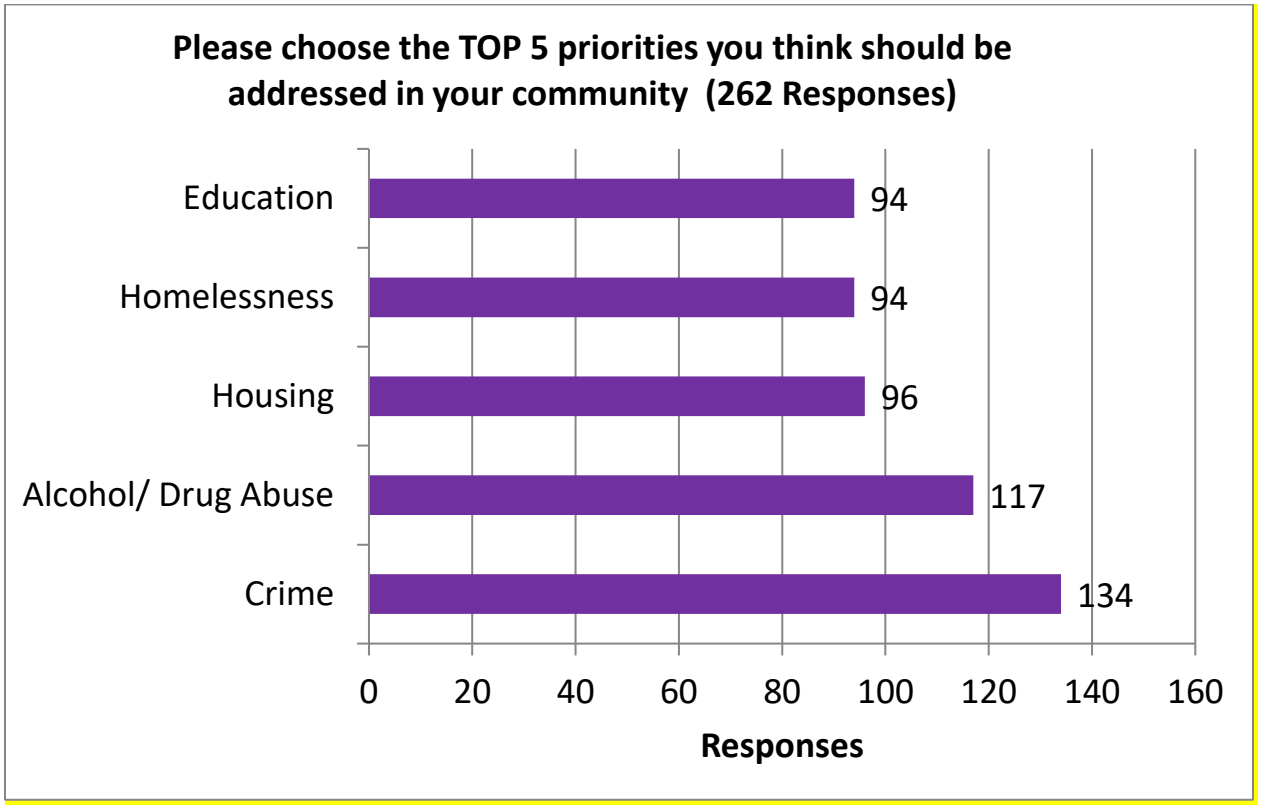
A web-based and hardcopy survey instrument used in 2016 to collect information from West Baltimore residents regarding their health and social needs was distributed again in 2019. The survey consisted of twenty-seven questions (both open and closed ended) covering the following categories: My Community, Community Support and Services,

Health Literacy, Community Safety, Community Priorities, Technology and Health and Demographics. Hardcopies of the survey were made available across the ten CSAs at various community partner and public entities, e.g. library.

A total of 273 surveys were collected between December 2018 and March 2019. Females represented 69% of the respondents, while 25% were older adults (between the ages of 65 – 79). Eighty-eight percent (88%) described themselves as Black, African-American, or African-Caribbean. Only 29% indicated they were working full-time, and 49% said they were renting their residence. Forty-one percent (41%) had obtained their high school diploma or GED. Aside from the skewed gender participants, the demographics of survey respondents are similar to the population of the service area.

Crime and Alcohol/Drug Abuse were the most significant concerns of respondents, listed 51% and 45% respectively. Housing, Homelessness, and Education were listed by more than one-third of all respondents (36-37%). See Figure 7. Four of the five concerns were among the TOP 5 concerns in 2016. Alcohol/Drug Abuse replaced Jobs with Fair Wages in 2019.

Figure 7 – Survey of Top 5 Priorities to be Addressed in Community



Responses to all Survey questions can be found in Appendix 6.

# 6 Secondary Data Analysis

## *Data Source*

City and service area CSA data were gathered from publically available datasets, using the most recently available year(s). The Baltimore City Health Department, Neighborhood Health Profile Online Data, January 2019 (Baltimore City Health Department) served as source for all health data below.

The organizing entity for socio-economic data was Baltimore Neighborhood Indicators Alliance-Jacob Francis Institute (BNIA) (www.bniajfi.org). Their *Vital Signs 16* indicators come from sources that can be grouped into the following categories:

- City sources - CitiStat/Baltimore 311, Department of Public Works, Department of Parks and Recreation-TreeBaltimore, Board of Elections
- State sources - Maryland Department of Housing and Community Development, 2011-2015
- Federal sources - American Community Survey, 2012-2016

Unless noted otherwise, BNIA is cited for data across the social and economic tables and charts.

## 6.1 Health Outcomes

**Life Expectancy:** Overall life expectancy in Baltimore City is 73.6 years compared to 70.3 years in the Bon Secours Service area.

Table 2 – Life expectancy at birth by CSAs, Bon Secours Service Area and Baltimore City

| Community Statistical Area (CSA) | Life expectancy at birth, in years |
|---|---|
| Edmondson Village | 71.8 |
| Forest Park/Walbrook | 74.0 |
| Greater Mondawmin | 70.4 |
| Greater Rosemont | 70.6 |
| Penn North/Reservoir Hill | 71.6 |
| Poppleton/The Terraces/Hollins Market | 68.4 |
| Sandtown-Winchester/Harlem Park | 70.0 |
| Southwest Baltimore | 68.0 |
| Upton/Druid Heights | 68.2 |
| Washington Village/Pigtown | 70.1 |
| ***Bon Secours Service Area*** | ***70.3*** |
| **Baltimore City** | **73.6** |

**Mortality Rate:** The all-cause age-adjusted mortality rate in Baltimore City is 100 per 10,000 residents vs. 118 in the Bon Secours Service Area. The tops causes of death in Baltimore City are due to heart disease, cancer, and drug-and/or alcohol-related. The number of homicides that occurred per 10,000 residents (all ages) per year in Baltimore City is 3.9. Homicide mortality rate is also a large health disparity in the Bon Secours Service Area with age-adjusted mortality rates as high as 7.7 (Poppleton/The Terraces/Hollins Market). Youth homicide mortality rate in Baltimore City is 31.3 per 100,000 youth under 25 years old.

Table 3 – All-cause mortality, homicide, and Drug/Alcohol Rate by CSAs, Bon Secours Service Area and Baltimore City

| Community Statistical Area (CSA) | All-Causes Mortality Rate | Homicide Mortality Rate | Drug/Alcohol Mortality Rate |
|---|---|---|---|
| Edmondson Village | 113.0 | 5.6 | 2.8 |
| Forest Park/Walbrook | 94.4 | 4.6 | 4.3 |
| Greater Mondawmin | 116.2 | 5.9 | 7.4 |
| Greater Rosemont | 115.5 | 6.8 | 8.1 |
| Penn North/Reservoir Hill | 109.7 | 5.8 | 3.9 |
| Poppleton/The Terraces/Hollins Market | 131.4 | 7.7 | 8.8 |
| Sandtown-Winchester/Harlem Park | 116.0 | 7.3 | 10.3 |
| Southwest Baltimore | 128.7 | 5.5 | 8.5 |
| Upton/Druid Heights | 131.6 | 6.5 | 6.8 |
| Washington Village/Pigtown | 121.6 | 3.2 | 7.6 |
| ***Bon Secours Service Area*** | ***117.8*** | ***5.9*** | ***6.9*** |
| **Baltimore City** | **99.5** | **3.9** | **4.4** |

**Heart Disease, Cancer, HIV/AIDS:** The percentage of deaths due to HIV/AIDS in the Bon Secours Service Area (3.2%) is almost twice the percentage in Baltimore City (1.8).

**Table 4 – Percentage of Deaths due to Heart Disease, Cancer, and HIV/AIDS by CSAs, Bon Secours Service Area and Baltimore City**

| Community Statistical Area (CSA) | % of Deaths due to Heart Disease | % of Deaths due to Cancer | % of Deaths due to HIV/AIDS |
|---|---|---|---|
| Edmondson Village | 23.9 | 21.9 | 2.2 |
| Forest Park/Walbrook | 26.7 | 14.9 | 1.8 |
| Greater Mondawmin | 23.0 | 20.1 | 3.9 |
| Greater Rosemont | 23.6 | 20.7 | 2.7 |
| Penn North/Reservoir Hill | 26.4 | 21.5 | 2.9 |
| Poppleton/The Terraces/Hollins Market | 23.3 | 19.4 | 3.1 |
| Sandtown-Winchester/Harlem Park | 22.4 | 18.7 | 4.8 |
| Southwest Baltimore | 21.2 | 19.8 | 2.9 |
| Upton/Druid Heights | 28.1 | 18.9 | 2.8 |
| Washington Village/Pigtown | 25.6 | 15.3 | 4.6 |
| *Bon Secours Service Area* | *24.4* | *19.1* | *3.2* |
| Baltimore City | 24.4 | 21.3 | 1.8 |

**Infant Mortality Rate:** Infant mortality before the age of one continues to be an alarming concern for addressing the health needs of Women and their babies in Baltimore. The Infant Mortality rate in the Bon Secours Service Area is comparable to Baltimore City rates. However, there are two CSAs in the Bon Secours Service Area with alarming rates, Poppleton/The Terraces/Hollins Market and Southwest Baltimore, 15.4 and 13.9 respectively.

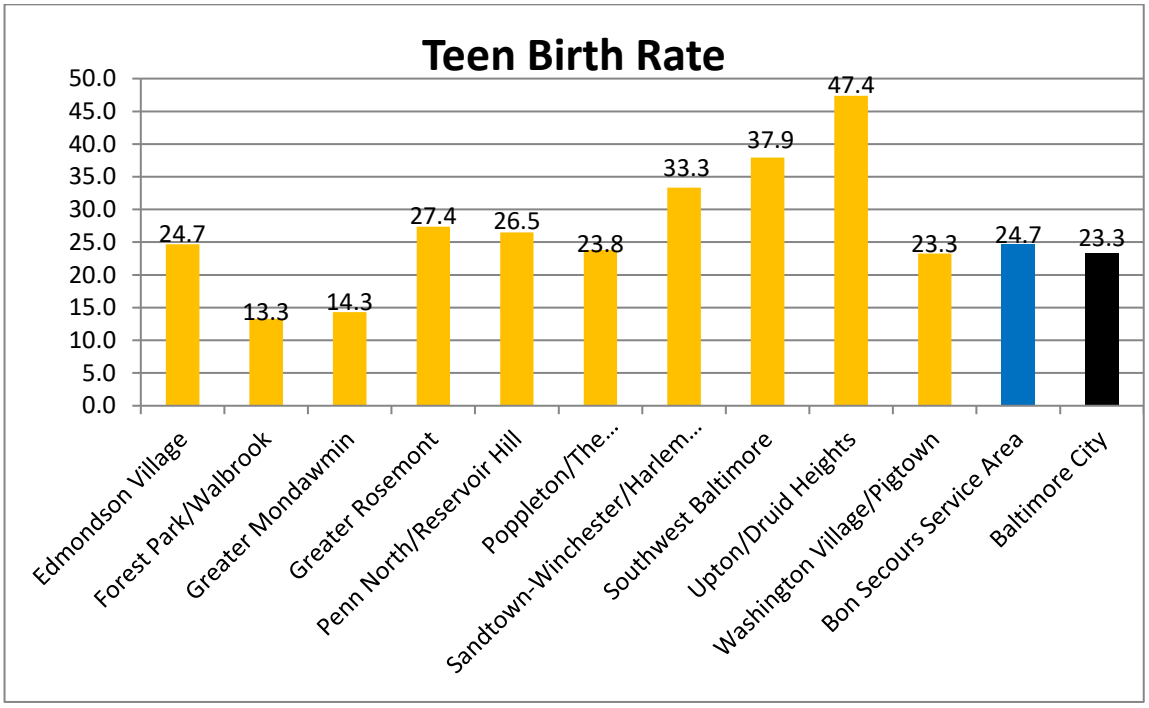
Table 5 – Infant Mortality Rate per 1,000 Live Births by CSA, Bon Secours Service Area and Baltimore City

| Community Statistical Area (CSA) | Infant Mortality Rate, 1,000 live births |
|---|---|
| Edmondson Village | 9.8 |
| Forest Park/Walbrook | 10.6 |
| Greater Mondawmin | 5.2 |
| Greater Rosemont | 11.3 |
| Penn North/Reservoir Hill | 9.9 |
| Poppleton/The Terraces/Hollins Market | 15.4 |
| Sandtown-Winchester/Harlem Park | 10.1 |
| Southwest Baltimore | 13.9 |
| Upton/Druid Heights | 10.0 |
| Washington Village/Pigtown | 4.6 |
| ***Bon Secours Service Area*** | ***10.1*** |
| **Baltimore City** | **10.4** |

### *Morbidity*

**Teen Birth Rate:** Despite teen birth rates declining in the state of Maryland, the rate of female teens aged 15-19 that gave birth is 23.3 per 1,000 in Baltimore City. In the Bon Secours Service Area (24.7) there are some of the highest rates observed across Baltimore City. Upton/Druid Heights has a teen birth rate of 47.4 per 1,000 and Southwest Baltimore a teen birth rate of 37.9 per 1,000.

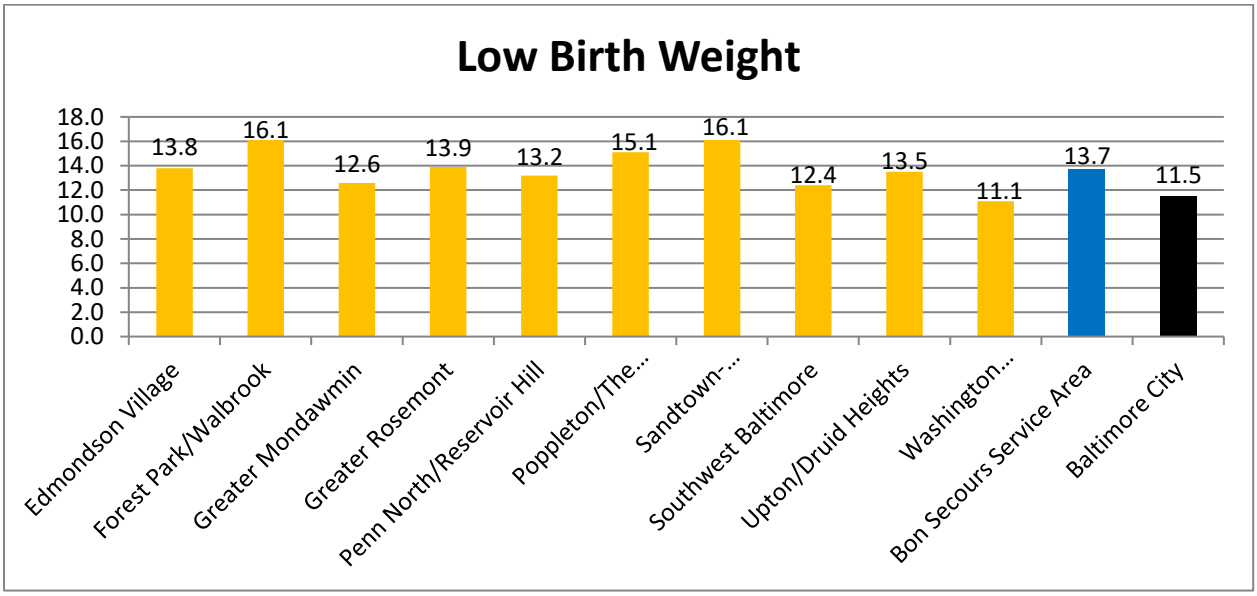
Figure 8 – Teen Births per 1,000 by CSA, Bon Secours Service Area, and Baltimore City




Source – Baltimore City Health Department

**Low Birth Weight:** Low birth weights (<5 lb., 8 oz) greatly impact the health status of children and within the Bon Secours Service Area the percentage of children with low birth weight is greater compared to Baltimore City. Three of the CSAs have the highest observed low birth weights across the entire City of Baltimore, Forest Park/Walbrook (16.1%), Sandtown-Winchester/Harlem Park (16.1%) and Poppleton/The Terraces/Hollins Market (15.1%).

Figure 9 – Percentage of Low Birth Weights by CSA, Bon Secours Service Area, and Baltimore City



## 6.2 Social and Economic Factors

Social and economic inequality, and its causes, are and have been a key focus of Bon Secours. The Bon Secours Service Area has been affected by decades of disinvestment and systemic racism that has contributed to significant health disparities for its population.

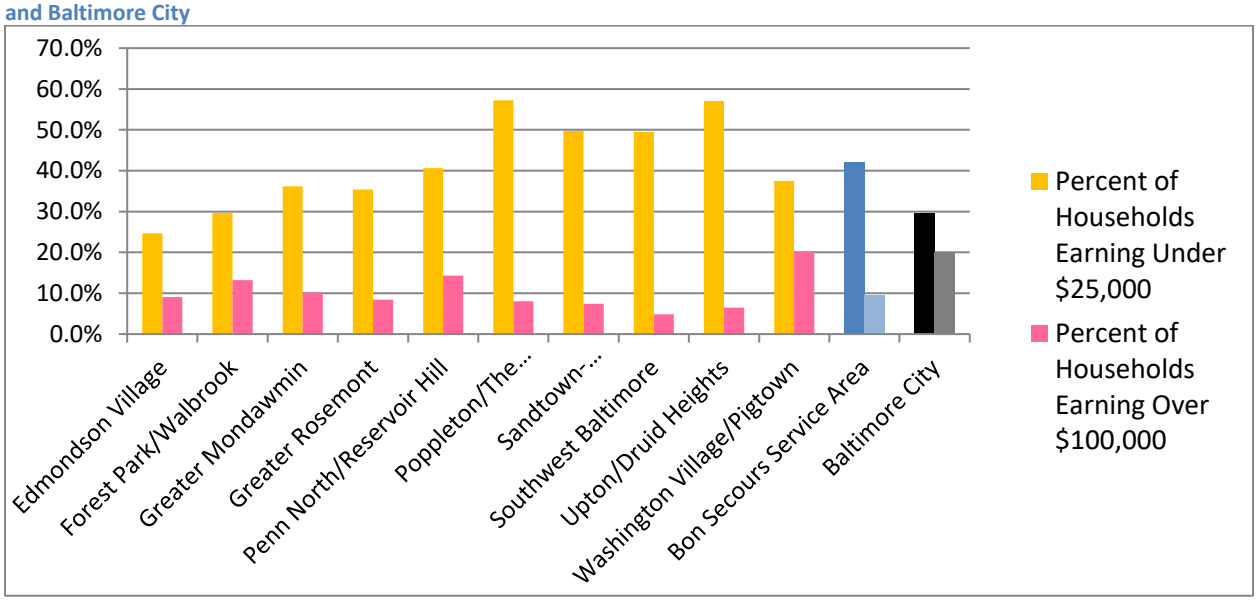
Inequalities exist among income, employment, education, and wealth gaps. The service area experiences more frequent crime and violence, and fewer affordable housing options than the City of Baltimore experiences as a whole. The deep poverty experienced by these residents has created conditions that undermine the health, economic, and educational success of families in the Bon Secours Service Area. While social and economic progress is being made much of it is incremental and will take additional decades to remedy.

### *Household Income/Poverty/Unemployment*

**Income, employment, and education**, are key social determinants of health that impact the livelihood of Baltimore City residents.

In Bon Secours Service Area 42.1% of Households earn under $25,000 and 9.5% of households earn over $100,000 in comparison to 29.5% and 20% in Baltimore City, respectively. Consequently, for the Bon Secours Service Area more than 48% of children live below the poverty line compared to 33% for all of Baltimore City.

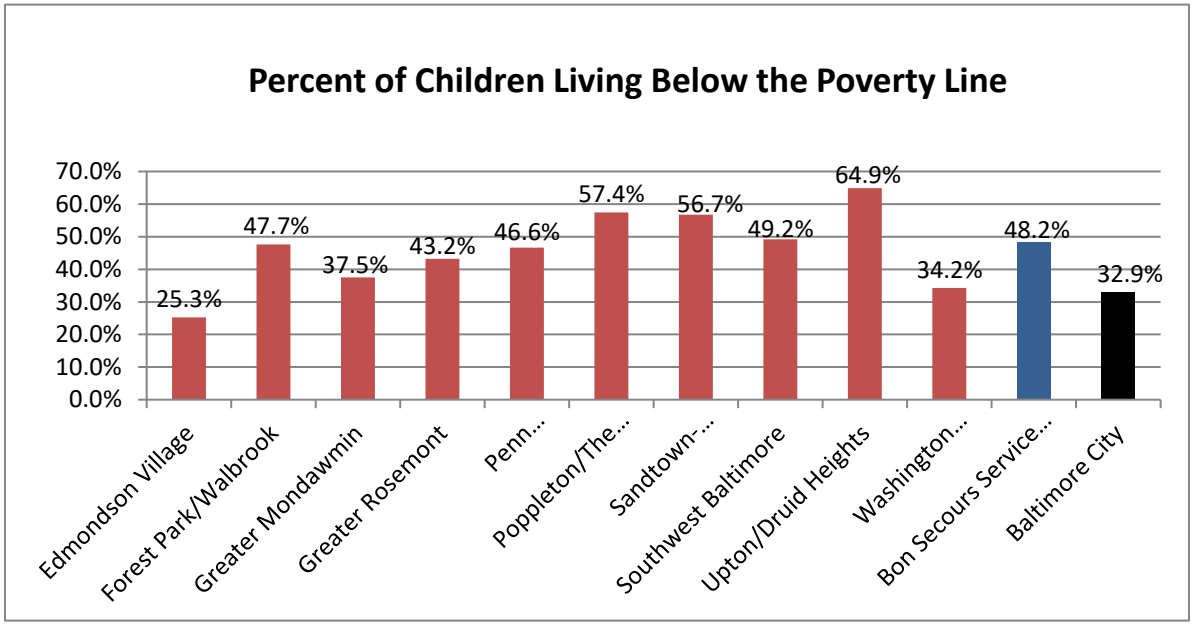
Figure 10 – Percentage of Households Earning less than $25,000 or greater than $100,000 by CSA, Bon Secours Service Area, and Baltimore City



Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

**Children Living Below Poverty**: In certain neighborhoods, including Upton/Druid Heights, Poppleton/Hollins Market, Sandtown-Winchester/Harlem Park and Southwest Baltimore, more than half of all children live below the poverty line.

Figure 11 – Percentage of Children Living in Poverty by CSA, Bon Secours Service Area, and Baltimore City




Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

The **Unemployment Rate** is 10% in Baltimore City compared to 13.7% in the Bon Secours Service Area.

Table 6 – Percentage of Unemployed adults by CSAs, Bon Secours Service Area and Baltimore City

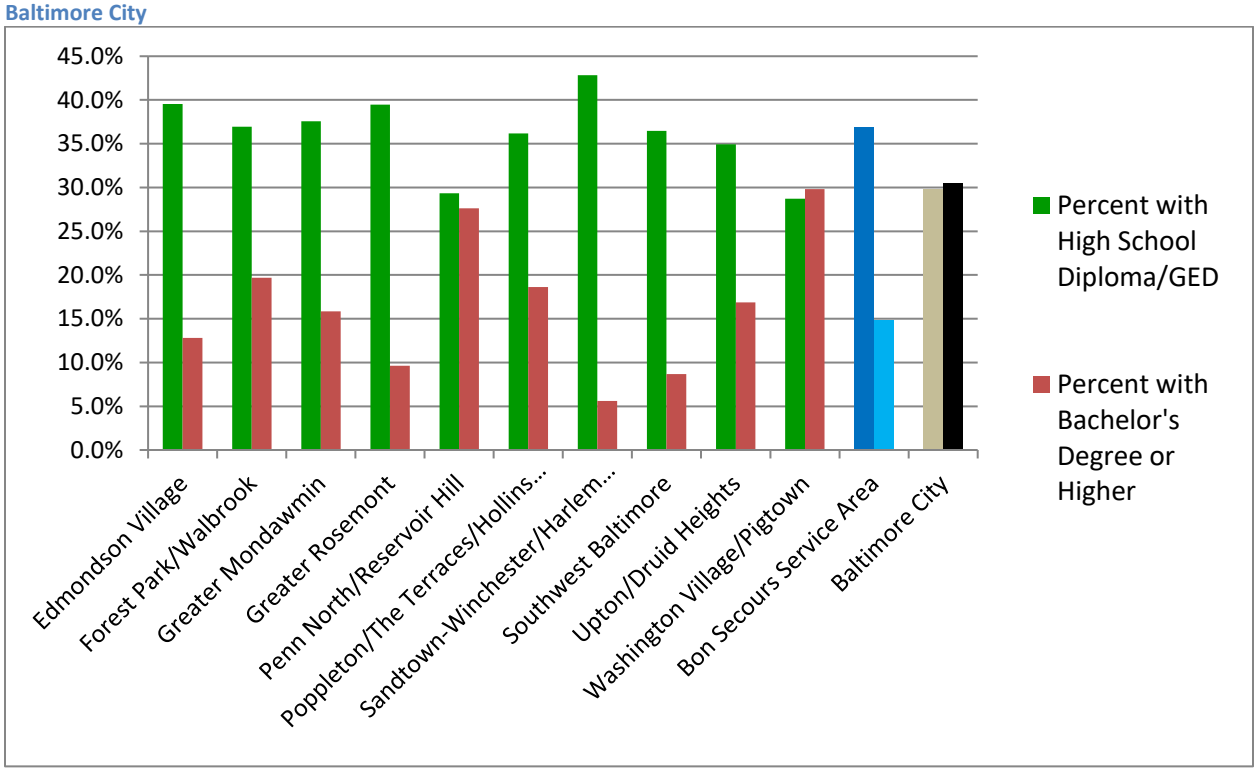
| Community Statistical Area (CSA) | Unemployment rate, % |
|---|---|
| Edmondson Village | 12.5% |
| Forest Park/Walbrook | 11.4% |
| Greater Mondawmin | 12.6% |
| Greater Rosemont | 15.6% |
| Penn North/Reservoir Hill | 12.0% |
| Poppleton/The Terraces/Hollins Market | 16.1% |
| Sandtown-Winchester/Harlem Park | 14.9% |
| Southwest Baltimore | 15.1% |
| Upton/Druid Heights | 12.0% |
| Washington Village/Pigtown | 13.0% |
| ***Bon Secours Service Area*** | ***13.7%*** |
| **Baltimore City** | **10.0%** |

Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

### *Education Attainment*

In terms of education, in the Bon Secours Service Area 36.8% of adults have obtained a **high school diploma or GED** and only 14.8% have obtained a **bachelor's degree or higher** compared to 29.7% and 30.4% in Baltimore City, respectively.

**Figure 12 – Percentage of High School Graduates, Bachelor's Degree or Higher by CSA, Bon Secours Service Area, and Baltimore City**

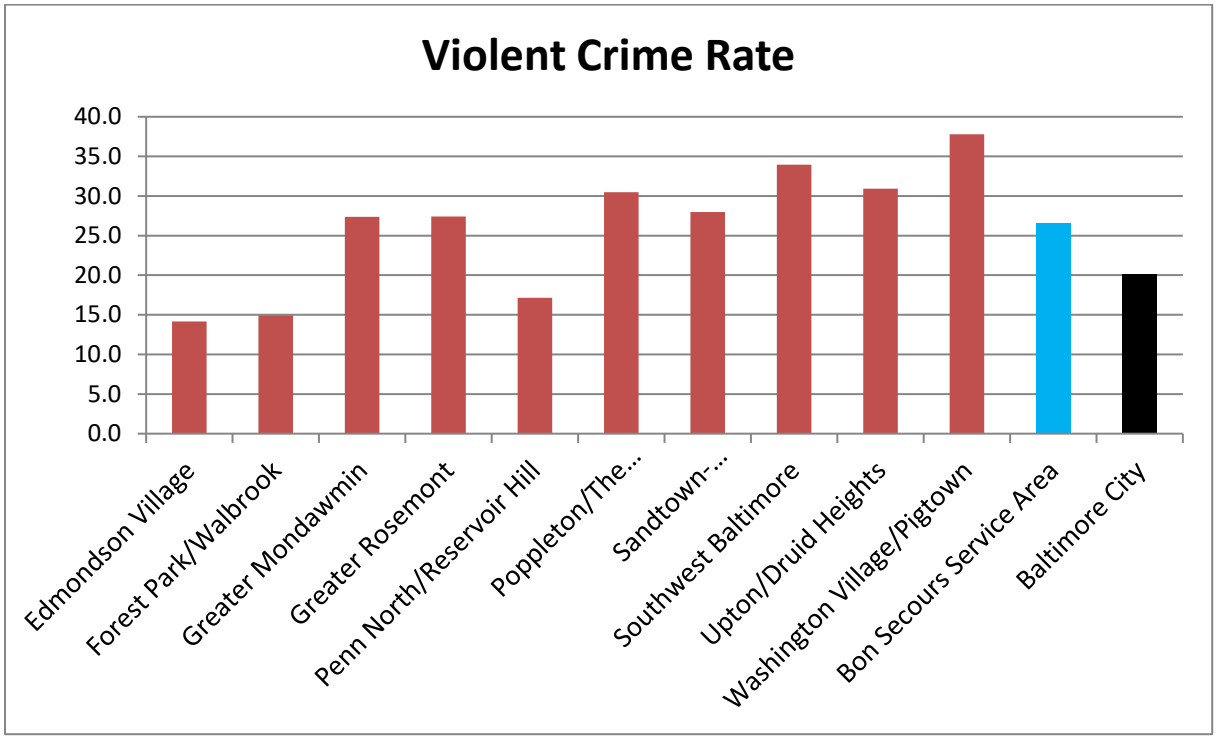



**Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute**

### *Violent Crime*

**Violent Crimes:** The Bon Secours Service Area violent crime rate is 26.6 per 1,000 residents compared to 20.1 per 1,000 residents in Baltimore City. Violent crimes involve homicide, rape, aggravated assault, and robbery reported to the police department. Seven of the ten CSAs have violent crime rates higher than the rate for Baltimore City.

Figure 13 – Violent Crimes per 1,000 residents by CSAs, Bon Secours Service Area, and Baltimore City

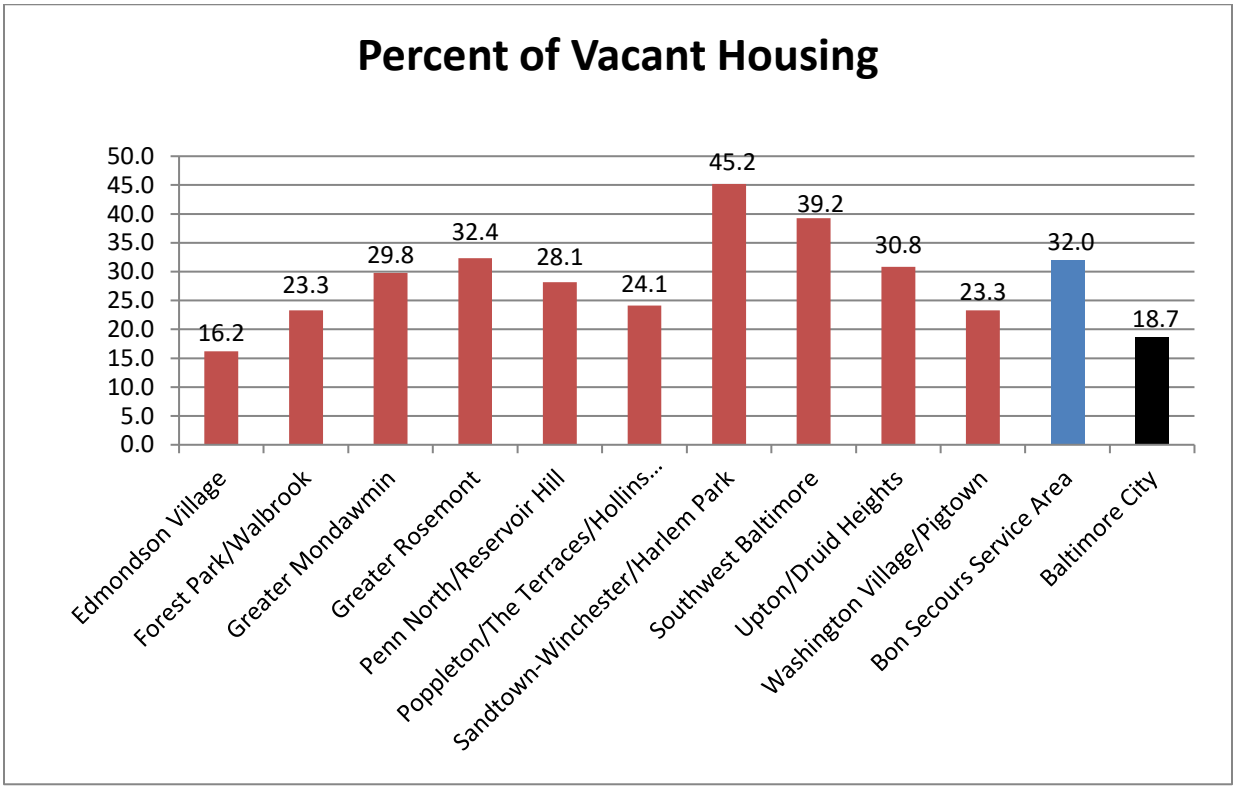



Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

## Housing Vacancy

**Housing Vacancy:** The Bon Secours Service Area (32.0%) has almost double the percent of housing vacancy in comparison to Baltimore City (18.7%). Within the service area there is wide variation in the percentage of vacant properties, though all but one CSA (Edmondson Village) has a vacant housing rate greater than Baltimore City.

Figure 14 – Percent of Housing Properties that are Vacant by CSAs, Bon Secours Service Area, and Baltimore City




Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

## 2-1-1 Calls

Of the 41,144 calls for assistance placed to United Way's 2-1-1 social services hot line between July 1,2018 and April 30,2019 (10 months), thirty-five percent (35%) of the calls (14,434) came from Bon Secours' neighbors in west Baltimore (zip code basis), a disproportionate share for all Baltimore City. The vast majority of calls throughout the city and in Bon Secours' service area were placed by women, and the top four requests were for assistance with Utilities, Housing, Taxes, and Food.

### *Hardship Index*

**Hardship Index:** The Hardship Index is a measure of combined socioeconomic factors that include income, education, unemployment, poverty, crowded housing, and dependency (persons aged less than 18 years and 65+ years). As a multi-factor measurement, the Hardship Index more substantially reflects the wider context and varied dimensions of a community's overall health.

The Index has a range from 0 to 100, where a higher score reflects greater hardship across the community. In Baltimore City, the Hardship Index is 51. The Hardship Index for Bon Secours Service Area is 65 with the CSAs in the area ranging from 44-82.

Table 7 – Hardship Index by CSAs, Bon Secours Service Area and Baltimore City

| Community Statistical Area (CSA) | Hardship Index, N |
|---|---|
| Edmondson Village | 54 |
| Forest Park/Walbrook | 44 |
| Greater Mondawmin | 62 |
| Greater Rosemont | 65 |
| Penn North/Reservoir Hill | 65 |
| Poppleton/The Terraces/Hollins Market | 75 |
| Sandtown-Winchester/Harlem Park | 80 |
| Southwest Baltimore | 76 |
| Upton/Druid Heights | 82 |
| Washington Village/Pigtown | 56 |
| ***Bon Secours Service Area*** | ***65*** |
| **Baltimore City** | **51** |

# 7 West Baltimore Priority Health Needs

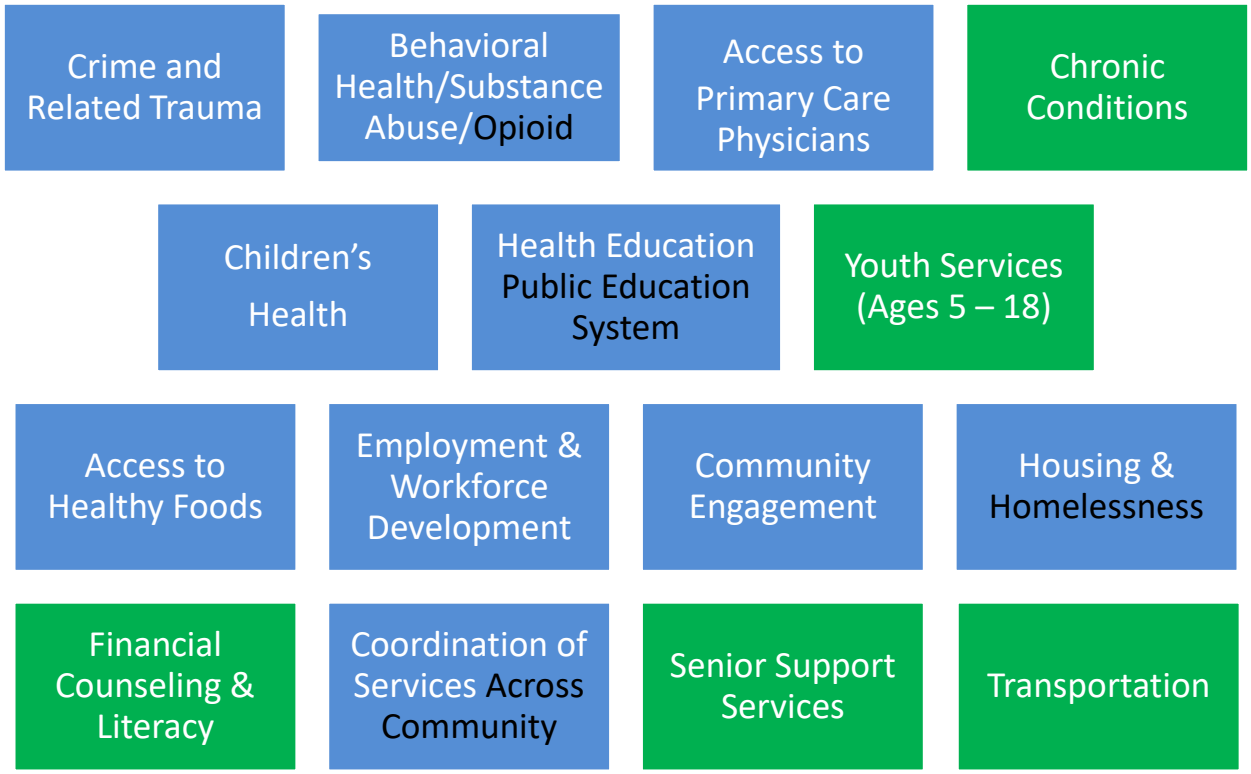
In 2016, Bon Secours Hospital identified the following health needs in the community:

- Crime and Related Trauma
- Behavioral Health/Substance Abuse
- Access to Primary Care Physicians
- Health Education
- Children's Health
- Access to Healthy Foods
- Expanded Housing
- Employment and Workforce Development
- Community Engagement
- Coordination of services across Bon Secours
- Advocacy, Policy, and Public Agency Dialogue, and
- Hospital Quality and Public Health

At that time the hospital and the local health system chose to prioritize all these needs and developed an Implementation Plan accordingly.

In 2019, the first ten needs (above) remained as **Identified Needs** of the community, and five additional needs (in green boxes below) as well as modifications (in black text) were added. See Figure 15 below.

Figure 15 – Identified Needs of Community Served




## 7.1 Prioritization Process and Criteria Used to Prioritize Needs

The Bon Secours Baltimore CHNA work group met with members of the Bon Secours Hospital board on May 22, 2019 and the Community Works board on May 23, 2019. Utilizing the criteria below, board members were asked to select those identified needs for which there was **"High Need and High Feasibility"** (ability to impact). Board members expressed particular concern for Employment and Workforce Development, Behavioral Health, Substance Abuse and Opioids, as well as Crime and Safety in the community.

The following **Criteria** were used to prioritize the community needs:

- Supported by Community Service Area data;
- Consistent with Public Health and health expert input, including the Baltimore City wide CHNA;

- In support of the Bon Secours Mercy Health strategic pillars and Key Performance Indicators (see Appendix 7);
- In support of benefitting a significant population of the community;
- In support of continuity and progress made by 2013 and 2016 Implementation Plans; and
- In consideration of 2019 community survey results.

## 7.2 Priorities for 2019 - 2021

The following **Identified Needs were selected as Priorities** by Bon Secours and will be included in the 2019 – 2021 Implementation Plan:

1. **Crime and Related Trauma**
2. **Employment and Workforce Development**
3. **Housing and Homelessness**
4. **Access to Healthy Foods**
5. **Health Education, and collaboration with the Public Education System**
6. **Program/Services for Youth (ages 5 to 18)**
7. **Senior Support Services**

Current management anticipates the 2019 – 2021 Implementation Plan will address these needs within the *Healthy People, Healthy Economy, and Healthy Environment* framework in conjunction with new ownership and management of the hospital. Unity Properties is the developer for affordable housing within the Bon Secours service area.

In addition, all parties recognize the significant need to address Behavioral Health / Substance Abuse and Opioid crisis. Bon Secours Community Works envisions supportive coordination with new hospital management for **Behavioral Health/Substance Abuse/Opioid** screening and interventions, **Children's Health** services as well as appropriate referrals and support to improve **Access to Primary Care Physicians** as well as to address **Chronic Conditions**. Bon Secours Community Works will also work with City agencies and collaborative organizations to advocate for and support improved **Transportation**.

Bon Secours Community Works will continue to offer **Financial Counseling and Literacy** services and to provide all its programs and services through processes that include **Community Engagement** and **Coordination of Services across the Community**.

# 8 Resources Available Within the Community Served to Meet Identified Needs

There are numerous programs and services available within the Bon Secours Baltimore Health System to address many of the identified community health needs. Additionally, there are a number of organizations and resources within the service area community with programs, services and or resources to address the needs identified via the CHNA. Bon Secours is prepared to partner with these organizations as needed to address the prioritized health needs of the community.

**Bon Secours New Hope Treatment Center**

Bon Secours New Hope Treatment Center has been rooted in west Baltimore for several decades and was one of the first Substance Abuse Treatment Programs funded by Behavioral Health Systems Baltimore to provide Methadone as a form of pharmacotherapy treatment to adult men and women diagnosed with a substance use disorder. Treatment & Medical Services include:

- Comprehensive Screening and Assessments
- Individual Counseling
- Standard & Intensive Group Counseling
- Gender-Specific group counseling
- Self-Help Support Groups-Methadone Anonymous
- Patient Advisory Board
- Overdose Prevention
- Smoking Cessation
- Relapse Prevention Family
- Education & Counseling
- Primary Care
- HIV education, counseling and testing

**Bon Secours Family Support Center**

Bon Secours Community Works' Family Support Center serves pregnant mothers and families with children up to age three. The Center offers Early Head Start services. At the Center, families receive support, encouragement and resources, such as GED preparation, developmental child care, parenting classes, employment readiness, counseling, tutoring, life skills training and money management. The Center's staff helps families make smart choices and become more self-sufficient by working with parents on child development and showing them best practices for raising children.

**Bon Secours Housing (Unity Properties)**

Bon Secours Apartments, Bon Secours Gibbons Apartments, and New Shiloh Village Apartments provide high-quality, low-cost rental housing to 272 low-and moderate-income families. This housing program began in 1997 when Bon Secours started acquiring and renovating large abandoned and severely dilapidated row houses near the hospital. The purpose is two-fold: to provide safe, decent and affordable housing and to improve a blighted neighborhood.

Bon Secours Baltimore Health System also offers several affordable independent living options for seniors and people with disabilities. Bon Secours has six properties in west Baltimore with over 530 apartment units. Each property is designed for people who want to enjoy a lifestyle filled with recreational, educational and social activities. These communities are for those who can live on their own, but who desire the security and conveniences of community living. Buildings are fully accessible and are close to shopping, recreation, educational opportunities, and many places of worship.

**Other community resources include:**

**PUBLIC HEALTH DEPARTMENTS**

**The Maryland Department of Health and Mental Hygiene** promotes and improves the health and safety of all Marylanders through disease prevention, access to care, quality management, and community engagement. The Public Health Services Division oversees vital public services to Maryland residents including infectious disease and environmental health concerns, family health services and emergency preparedness and response activities. The Behavioral Health Division promotes recovery, resiliency, health, and wellness for individuals who have emotional, substance use, addictive and/or psychiatric disorders. The Developmental Disabilities Administration provides a coordinated service delivery system to ensure appropriate services for individuals with developmental and intellectual disabilities. The Health Care Financing Division implements the Medicaid program, which features the department's HealthChoice and

Children's Health Program along with other initiatives, including those that help people with the cost of prescription medications.

**The Baltimore City Health Department** has a wide-ranging area of responsibility, including acute communicable diseases, animal control, chronic disease prevention, emergency preparedness, HIV/STD, maternal-child health, restaurant inspections, school health, senior services and youth violence issues. In collaboration with other city agencies, health care providers, community organizations and funders, the Health Department aims to empower all Baltimoreans with the knowledge, access, and environment that will enable healthy living.

## COMMUNITY HOSPITALS AND ACADEMIC MEDICAL CENTERS

Baltimore has world-class hospitals and academic medical centers that provide the full range of emergency, inpatient and outpatient services as well as associated training, academic research, and community-oriented programs. There are 5 hospitals located in our West Baltimore CBSA. These hospitals are: University of Maryland Medical Center, University of Maryland Mid-Town, Bon Secours Hospital, Sinai Hospital of Baltimore, and Saint Agnes Hospital. In addition to these 5 hospitals, there are 6 other hospitals located in Baltimore that also serve Baltimore residents. These are: Mercy Medical Center, Harbor Hospital, The Johns Hopkins Hospital, Union Memorial Hospital, Good Samaritan Hospital, and Johns Hopkins Bayview Medical Center.

## SAFETY NET PROVIDERS

Despite this wide dispersion and fragmentation, there is a group of 10-15 core safety net providers, dominated by Federally Qualified Health Centers (FQHC) and practices affiliated with the University of Maryland that are the heart of West Baltimore's safety net. The FQHCs and many of the hospital-based practices that serve the largest portion of West Baltimore residents, on the other hand, typically provide a broad range of enabling and supportive services such as outreach, health education, case management, interpreter services, and transportation. A number of the FQHCs also offer integrated behavioral health, dental and medical specialty care services.

## STRONG NETWORK OF SOCIAL SERVICE, FAITH-BASED, AND OTHER COMMUNITY-BASED ORGANIZATIONS

Community dialogues reflected on the richness of West Baltimore's social service network and the long history of grassroots involvement in community development activities on behalf of West Baltimore's residents and neighborhoods. Faith-based organizations, community centers, Boys and Girls clubs, and schools are just some of the organizations that are at the core of this network. These organizations are and will continue to be a major asset for the community as safety net providers working to reach out and engage communities in primary care and other needed health care services.

## ACADEMIC AND WORKFORCE TRAINING RESOURCES

There are numerous universities, colleges, and community colleges throughout Baltimore that provide a broad range of academic opportunities including degrees and training in health related professions. Many of these academic institutions are within the West Baltimore area. These academic programs provide a rich resource for the community in a variety of ways. Foremost are their contributions to educate and train residents of West Baltimore and beyond. They play a critical role in workforce development. They are also an invaluable resource and provide guidance, expertise, and support (financial and in-kind) to community endeavors. These institutions also provide student interns and volunteers that are a great service to the community. This helps to feed newly trained workers into the local force.

# APPENDICES

## Appendix 1 – Bon Secours CHNA Team

| Organization | Staff Member/Title |
|---|---|
| **Bon Secours Baltimore Health System** | • Curtis Clark, Vice President, Mission (through December 2018)<br>• George Kleb, Executive Director, Housing and Community Development |
| **Bon Secours Community Works** | • Talib Horne, Executive Director (through March 2019)<br>• Maha Sampath, Executive Director (April 2019 forward)<br>• Tatiana Warren, PhD, Business Intelligence Specialist<br>• Hiwote Solomon, Graduate Resident |
| **Bon Secours Health System** | • Edward Gerardo, Facilitator<br>• Amber Sain, Graduate Resident |

## Appendix 2 – Community Advisory Board Members

| Name | Title | Organization |
|---|---|---|
| Tanya Terrell | GED provider | South Baltimore Learning Center |
| Carrie A. Williams | Employment Specialist | Project PLASE |
| Pastor Rodney Morton and Gail Edmonds | Pastor and Community Leader | Central Baptist Church |
| Reverend Bob Washington | Pastor and Community Leader | Celebration Baptist Church |
| Reverend Dr. Derrick Dewitt | Pastor and Community Leader | First Mount Calvary Baptist Church |
| Reverend Dr. Franklin Lance | Pastor and Community Leader | Mt. Lebanon Baptist Church |
| Joyce Smith | Chair, Community Leader | Operation ReachOut Southwest |
| Edith Gillard | President | Franklin Square Comm Assoc |
| Edna Manns | President | Fayette Street Outreach |
| Bertha Nixon | President | Boyd Booth Concerned Citizens |
| Celeste James | Director, Community Health | Kaiser Permanente |
| Camille Burke | Office of Chronic Disease | Baltimore City Health Department |
| Dr. Tyler Gray | Medical Director | Healthcare for the Homeless |
| Marianne Navarro | Anchor Institution Liaison & Coordinator | Mayor's Office of Economic & Neighborhood Development |
| John T. Bullock, PhD | District 9 Councilperson | Baltimore City Council |
| Dr. Ronald Williams | Interim Dean | Coppin State University, School of Business |
| Ashley Valis | Executive Director, Community Initiatives | University of Maryland |
| Roger Hartley | Dean of Public Affairs | University of Baltimore |
| Kimberly Hill | Principal | Lockerman Bundy Elementary School |

| Name | Title | Organization |
|---|---|---|
| George Kleb | Executive Director, Housing and Community Development | Bon Secours |
| Talib Horne, Maha Sampath | Executive Director, Community Works | Bon Secours |
| Tatiana Warren, PhD | Business Intelligence Specialist, Community Works | Bon Secours |

## Appendix 3 – Stakeholder Interview Questions

1) What is your current or past role in the Community?
2) What are the top three health concerns of the community?
3) What are the health resources available in the community?
4) What are the health resources that the community lacks?
5) What resources in the community are not being used to their full capacity?
6) What are the barriers to obtaining health services in the community?
7) What is the single most important thing that could be done to improve the health in the community?
8) What changes or trends in the community do you expect over the next three to five years?
9) What other information can be provided about the community that has not already been discussed?

## Appendix 4 – Stakeholders Interview List

| Name /Date of Interview | Organization / Affiliation | Special Knowledge / Expertise |
|---|---|---|
| Noel Brathwaite, PhD, MSPH<br>1/14/2019 | Director, Maryland Office of Minority Health and Health Disparities | Maryland Department of Health |
| Darcy Phelan-Emrick, DrPH<br>1/30/2019 | Chief Epidemiologist, Baltimore City Health Department | Baltimore City Health Department |
| Shelly Choo, MD, MPH<br>1/30/2019 | Senior Medical Advisor, Baltimore City Health Department | Baltimore City Health Department |
| Marianne Navarro<br>2/06/2019 | Anchor Institution Coordinator, Mayor's Office of Strategic Alliance | City's Anchor Institution Coordination/Special Assistant to Chief |
| Councilman John Bullock, PhD<br>2/06/2019 | 9th District Councilman, Baltimore City Council | Community Stakeholder |
| William Kellibrew IV<br>2/07/2019 | Director, Office of Youth Violence Prevention | Baltimore City Health Department |
| Camille Burke<br>2/14/2019 | Director, Office of Chronic Disease Prevention | Baltimore City Health Department – Division of Youth Wellness & Community Health |

| | | |
|---|---|---|
| Brandi Welsh<br><br>2/14/2019 | Community Liaison, Baltimore City Department of Public Works | Communications & Community Affairs |
| Reginald Williams<br><br>2/21/2019 | Western District Liaison, Office of the State's Attorney for Baltimore City | Criminal Strategy Unit |
| Olivia Farrow, Esq<br><br>3/06/2019 | Director of Community Engagement, St. Agnes Healthcare Baltimore | Healthcare |
| Maya Nadison, PhD, MHS<br><br>3/14/2019 | Community Health Evaluation Research, Kaiser Permanente | Healthcare |

## Appendix 5 - Focus Group Notes

**Substance Abuse & Mental Health Stakeholders - March 13, 2019**

**Organizations represented included** Bon Secours Behavioral Health services staff, and Maryland Department of Behavioral Health representative

(Facilitator) Opioid Crisis – What is the current state of the crisis? What issues are underlying the crisis?

- Medicaid burden
- Fatal overdose increase
- Make sure patients have Naloxone
    - How will uninsured get it?
    - Reallocate BHS funds, if leftover, to purchase
- Education for patients and families
    - Involve the family in the treatment
    - Fentanyl added to screening- the addition of Fentanyl to drugs should be scary but the addicts don't think it'll kill them (competition of how much of the drug they can handle)
- Funding issues
    - Naloxone used to be free (multiple doses are sometimes needed, raising cost)
- Stigma is still there, resulting in the hiding of usage

(Facilitator) Has there been a decline over the past 3-5 years?

- Increase in OTP's (opioid treatment programs)
- Hard to gauge if it's working
    - Medicaid expansion getting more people care
- Deaths not decreasing
- They think the kit is a lifesaver so doesn't decrease drug usage, but fuels it (justifies their use)

(Facilitator) Barriers to treatment/ why addicted persons don't choose treatment

- Individual not ready for treatment
    - Help them understand disease and services
    - Come in for wrong reasons (addict is still an addict)
        - Methadone prescription or money from selling prescription

- Make them comfortable in group sessions to make them more inclined to stay
    - Incentives currently comes out of pocket (part of need for funding)
- Most without jobs
    - How do they have money for drugs?
    - Can be clever- how do we change the way they think
- They don't want to work the process, they want immediate results
- Diversion - not all bad
    - Still addicts (not ready)
    - At least they take methadone instead
- Some get treatment and still use substances
- Education is working
    - Peer recovery support specialist (good to use as an example)
    - Get families involved - team approach
        - Mend relationships
- Guidelines different than conditions
    - Clinical different than peer (harm reduction)
- Personal cheerleader
    - Patient Advocacy Program acts as a voice for the patients, they come in to speak to beginners

(Facilitator) "Magic Wand" Wish-list

- Clinicians who care (personnel as a whole who care)
- Stricter guidelines and quality measures for programs
    - People open programs for the wrong reasons- just to get bodies in the door, not to make a difference
    - Gas and Go programs - just get the medications and go
    - Don't need more programs. Just better ones
- Team approach
    - Clinicians, state funders, medical providers, etc.
- Funding (budget for incentives)
    - It is now harder to ask for it
- Stopping provider harm
    - Just writes prescriptions (check on CRISP)
- Regulators walk in addicts shoes
    - Help them understand what is going on
- Retain clients that come in for treatment
    - Not hop from program to program
- Opt out system

    - Only allow opting out of a program once
- Workforce development
    - Encourage staff (counselor pool)
    - Make field more attractive - it currently is not

(Facilitator) What needs to happen at the Macro Level

- State level - Governor wants to reduce deaths, so focus is not on stopping program
- Police - drugs keep police employed, will respond for guns but not for drugs, overworked and have a lot of rules to follow, all don't carry kit or are trained to use kit (why?)
- Schools- state funds education prevention, fine line of over exposure
- Treat whole issue, not just drugs
- Regulation out, accreditation in
- Social media - influencing kids
- Include spirituality

**Community Focus Groups – April 5 and April 10, 2019**

**Anchor organizations** represented include: Franklin Square Community Association, Fayette Street Outreach Organization, Inc., Celebration Church, Tabernacle of the Lord Church and Ministries, Bon Secours CommunityWorks Clean and Green Committee, Bon Secours Housing.

**CHNA Advisory Group organizations** represented include: Central Baptist Church, St. Agnes Hospital, University of Maryland Baltimore Medical Center, the Mayor's office of the City of Baltimore, and Bon Secours CommunityWorks.

***Healthy People***

Feedback:

- Goal 1 – Nutrition education and access
    - Continue emphasis on nutrition education for children
    - Greater focus on Prevention services and programs needed
    - Recognize and collaborate with several churches and schools with existing programs to access to healthy foods and nutrition classes
    - Consider partnering urban farm efforts with churches
    - Clarify difference between produce market at hospital & mobile market

    - Community Engagement Center- run by UMB, is within our service area
        - Be better at promoting it within Community Works
    - Continue advocacy for Grocery store
- Goal 2 – Behavioral and Mental Health / Substance Abuse services
    - What is the outcome we're looking at → establish measures and SMART goals
    - Increase efforts to address opioid use, substance abuse
    - Increase communication of services; recognize impact of the history of segregation
    - Need for outpatient detox programs

- Goal 3 – Chronic diseases, healthy lifestyle education and services
    - Expand school services
    - Health outcomes, but also prevention
    - More emphasis on diabetes education and prevention
- Goal 4 – Prevention, screening and services for children's health
    - Not enough attention given to Pediatrics and children's services
    - BMORE for Healthy Babies (Brawnwine)
        - What work are partners doing regarding infant mortality within the service area?

<u>Questions raised:</u>

- How are the police being held responsible with trauma informed care → BHSB can provide update, have them come in and present to C&G or Anchor Group
- How would we move forward with the family practice physician goal since Family Health and Wellness will be part of the acquisition?

<u>What Else (Unmet Needs):</u>

- Obesity & diabetes
- Children's mental health
- Pediatric services
- Increase partnership with schools, system approach
- Institute a "Health Committee" for trauma, chronic conditions, substance abuse, Alzheimer's

***Healthy Economy***

Feedback:

- Goal 1 – Workforce Development and Job Readiness, Financial literacy, Youth outreach
    - More workforce development programs to reach more people within the area
        - Other programs within the city to refer or direct people to
    - Small business development
- Goal 2 – Affordable Housing
    - Unity Properties as employer/job creator through apprenticeships
    - Consider funding program for residents who have difficulty paying rent (combine with literacy and behavior education)
    - Address vacant community buildings surrounding hospital

What Else (Unmet Needs):

- Include advance financial education regarding Promise Program – free tuition for community college
- Consider home improvement initiative for seniors

***Healthy Environment***

- Goal 1 – Public green spaces and transformation of vacant lots
  No feedback given
- Goal 2 – Crime and Sanitation
    - Need further career development (pathway) for Clean and Green participants

What Else (Unmet Needs):

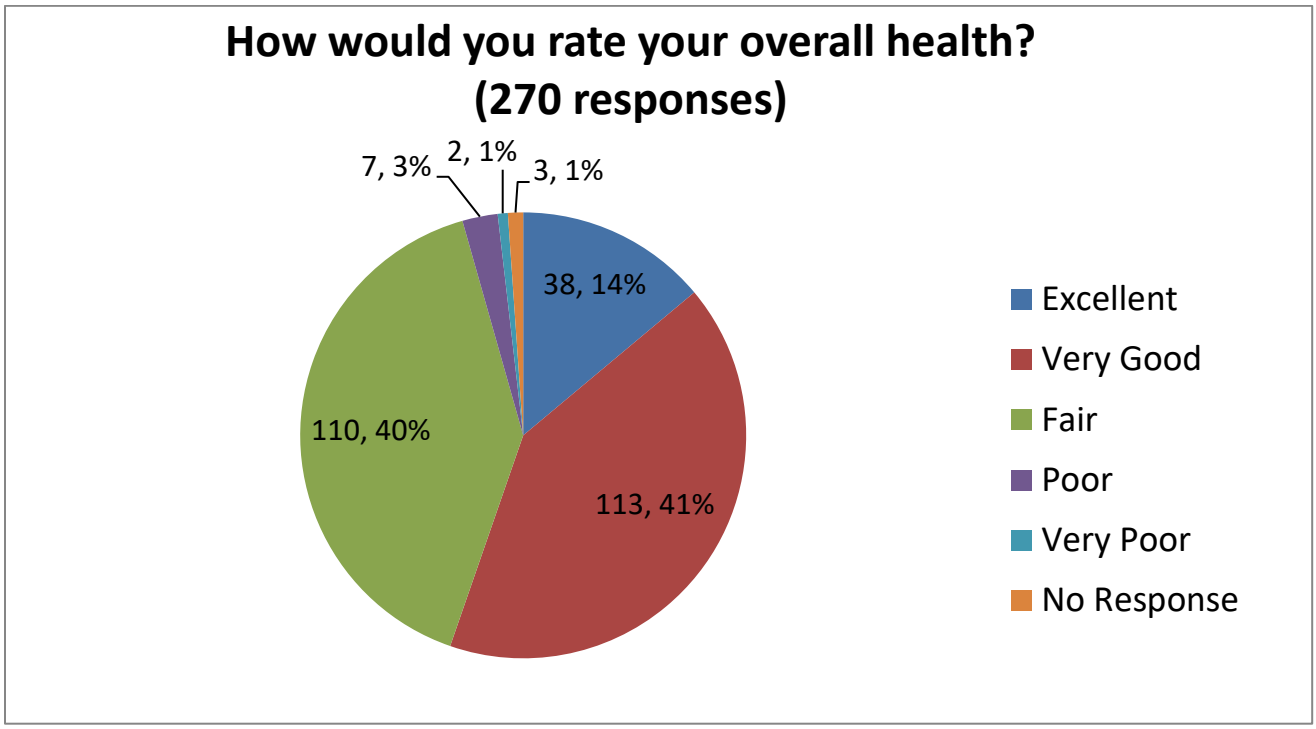
- Help to address Community cleanliness, work to end “dumping” on lots
- Expand environmental awareness
    - Climate change, storm water issues
- Work through Partnerships across community
- How to get kids to get involved in parks, both the clean-up and opportunities to play

Participants were asked to give input to the Prioritization process. The following issues/needs were recommended as significant Priorities:

- Children's Health / Trauma (specifically mental health/substance abuse), including Youth
- Development and Advocacy for a neighborhood Grocery Store/supermarket
    - Develop a food access strategy
    - Provide greater nutritional education, especially for children
    - Obesity prevention and reduction
- Crime and Related Trauma
- Increase financial resources for programs and services

## Appendix 6 – CHNA Survey Results

1.

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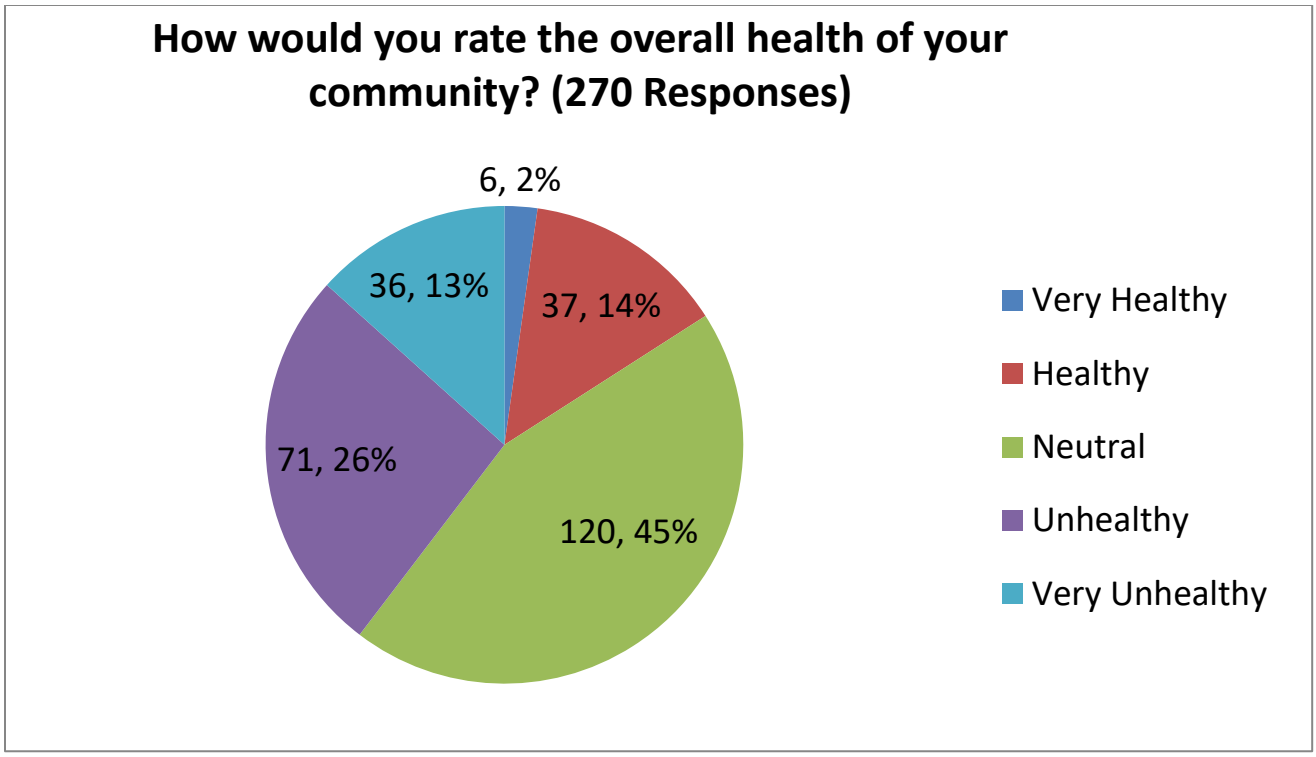
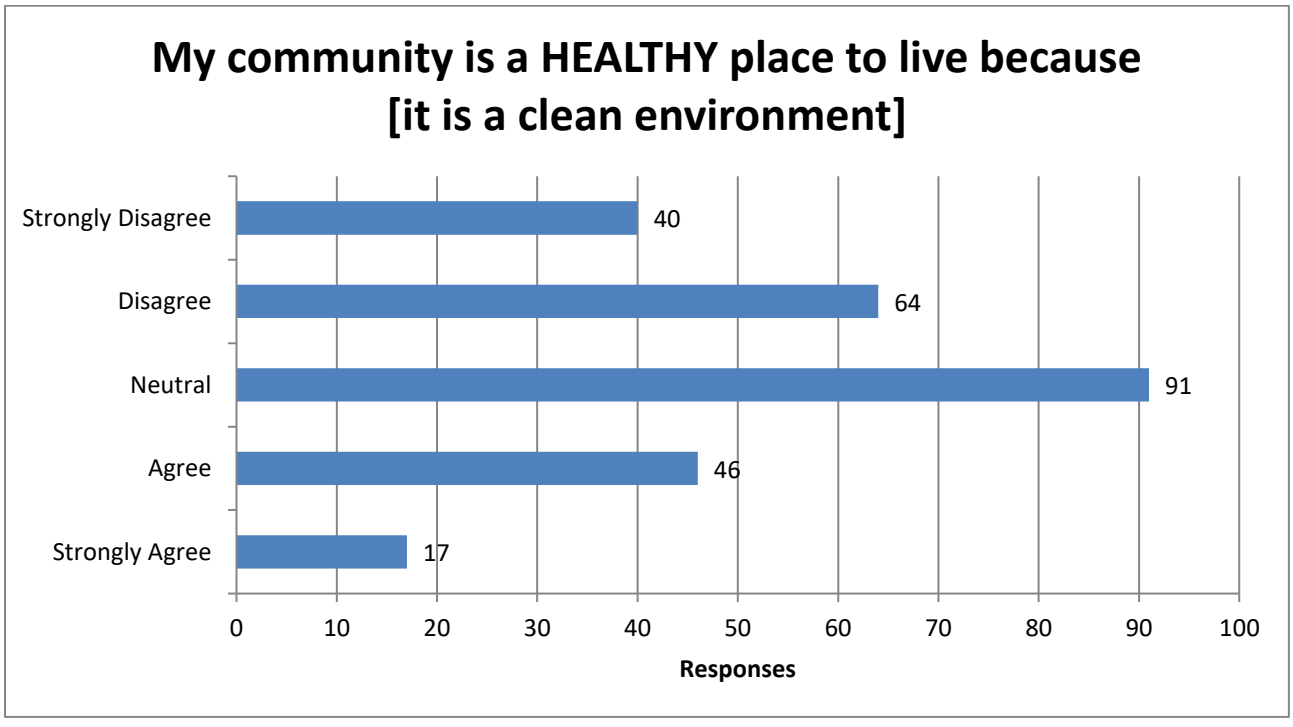
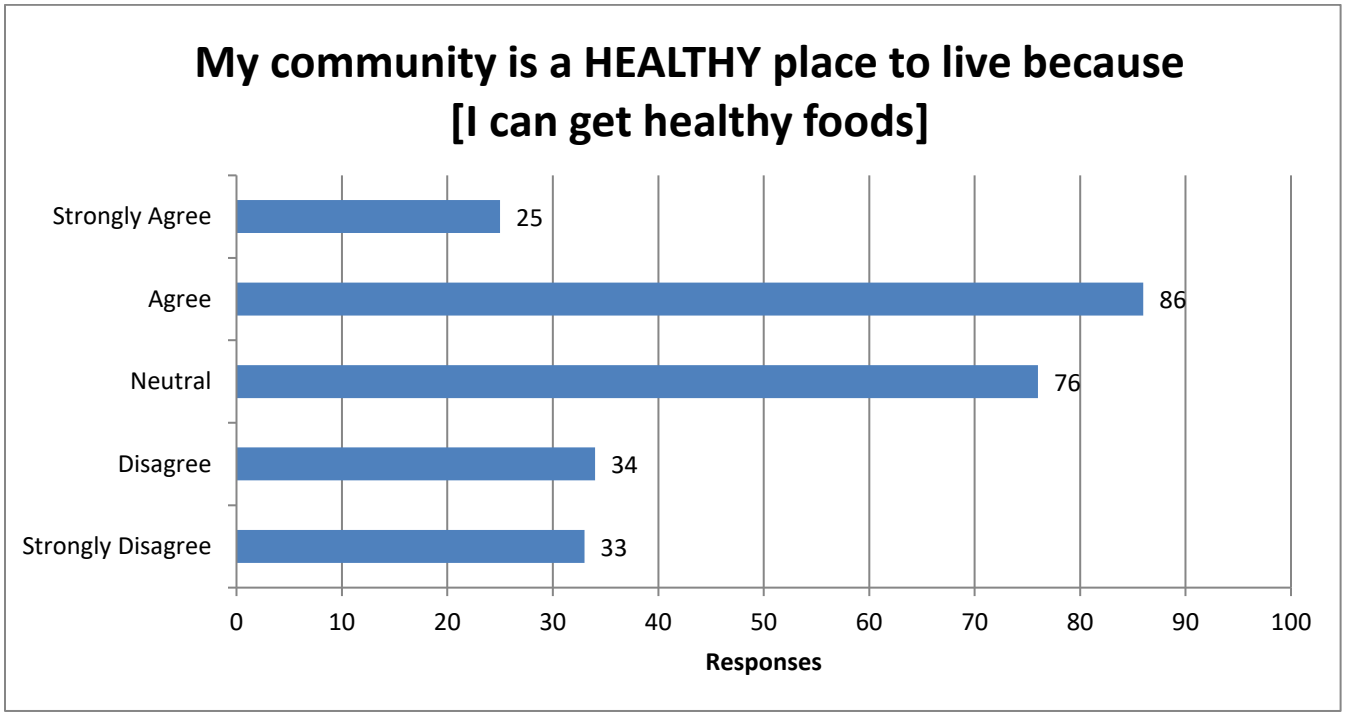
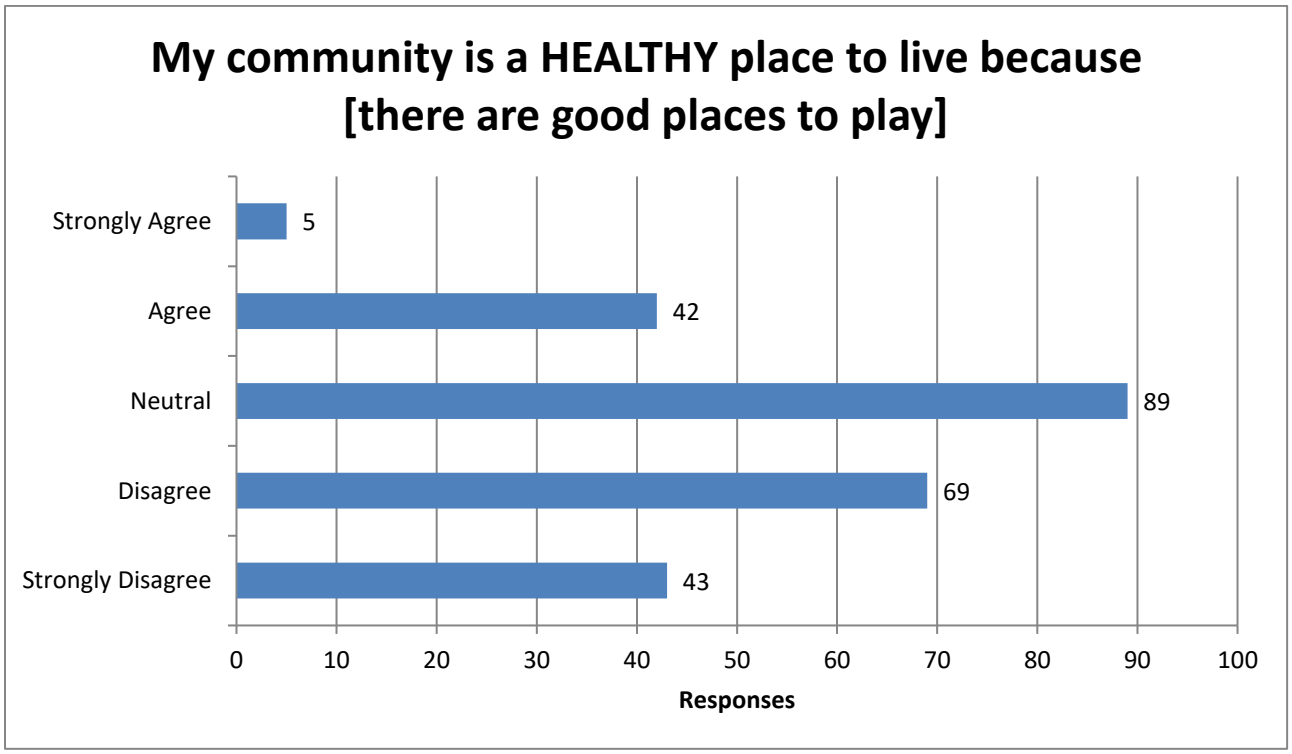
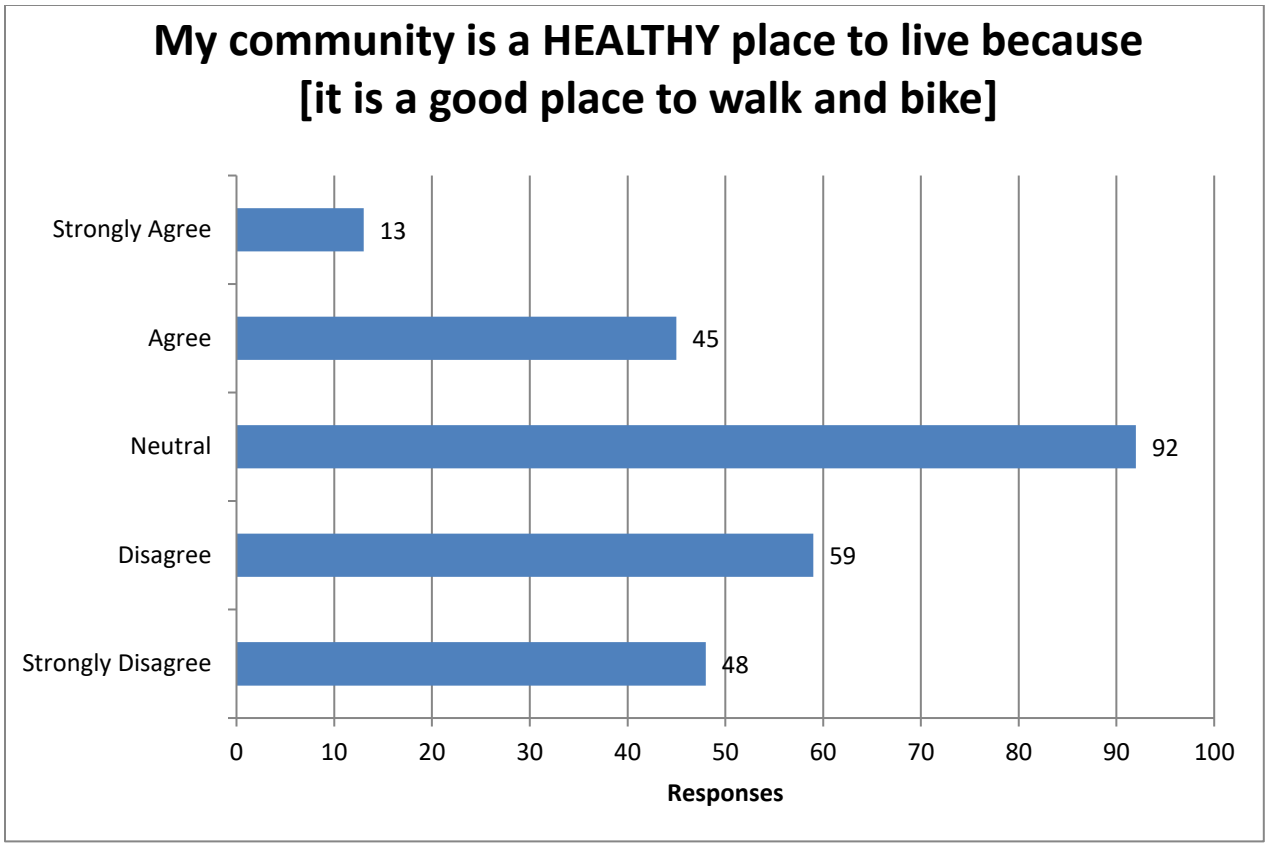

How would you rate the overall health of your community? (270 Responses)
6, 2%
37, 14%
120, 45%
71, 26%
36, 13%
Very Healthy
Healthy
Neutral
Unhealthy
Very Unhealthy

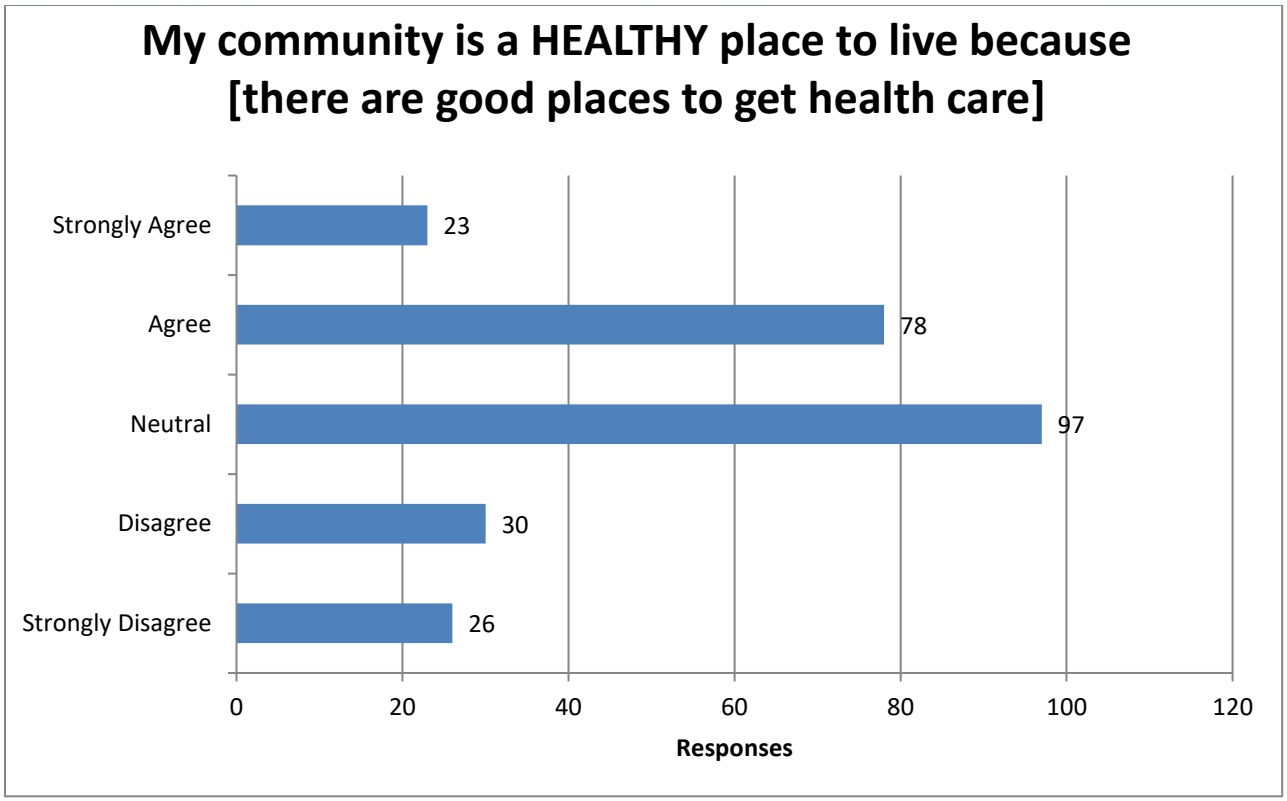
5.

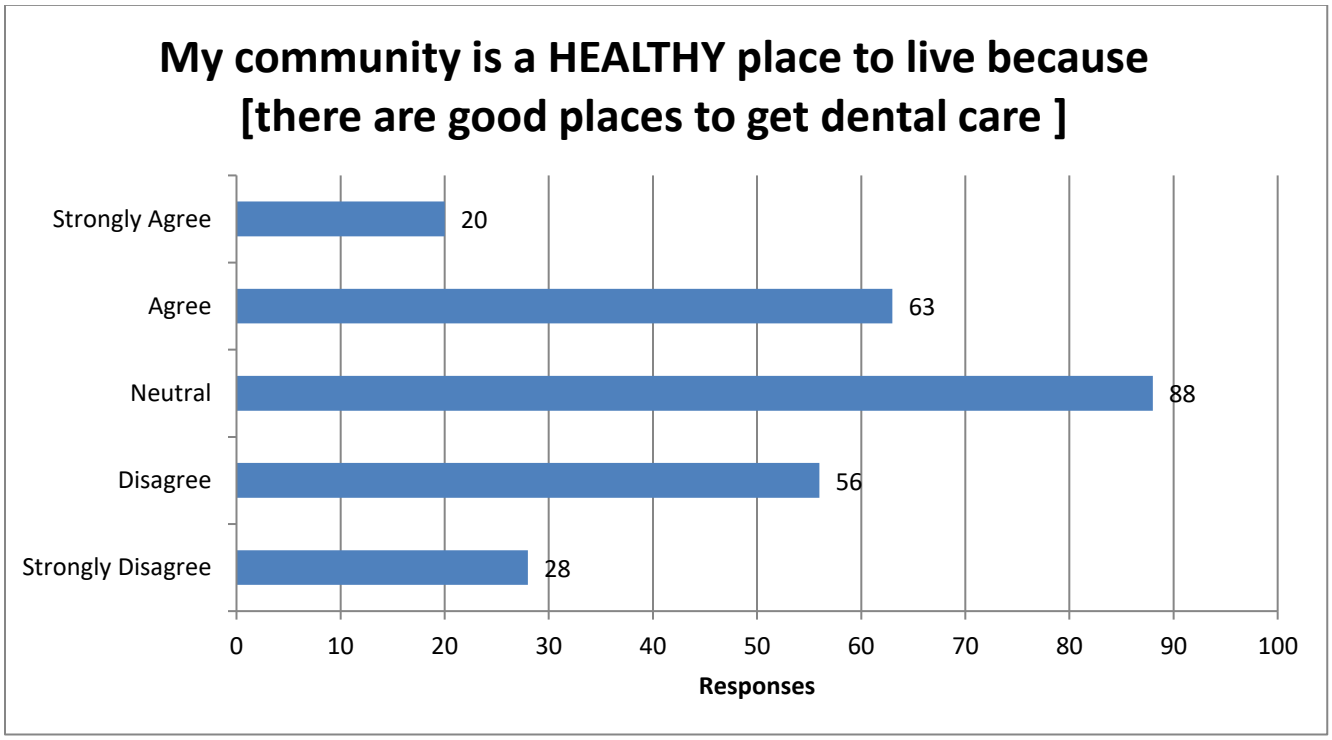

My community is a HEALTHY place to live because [it is a clean environment]
Strongly Disagree
Disagree
Neutral
Agree
Strongly Agree
40
64
91
46
17
0
10
20
30
40
50
60
70
80
90
100
Responses

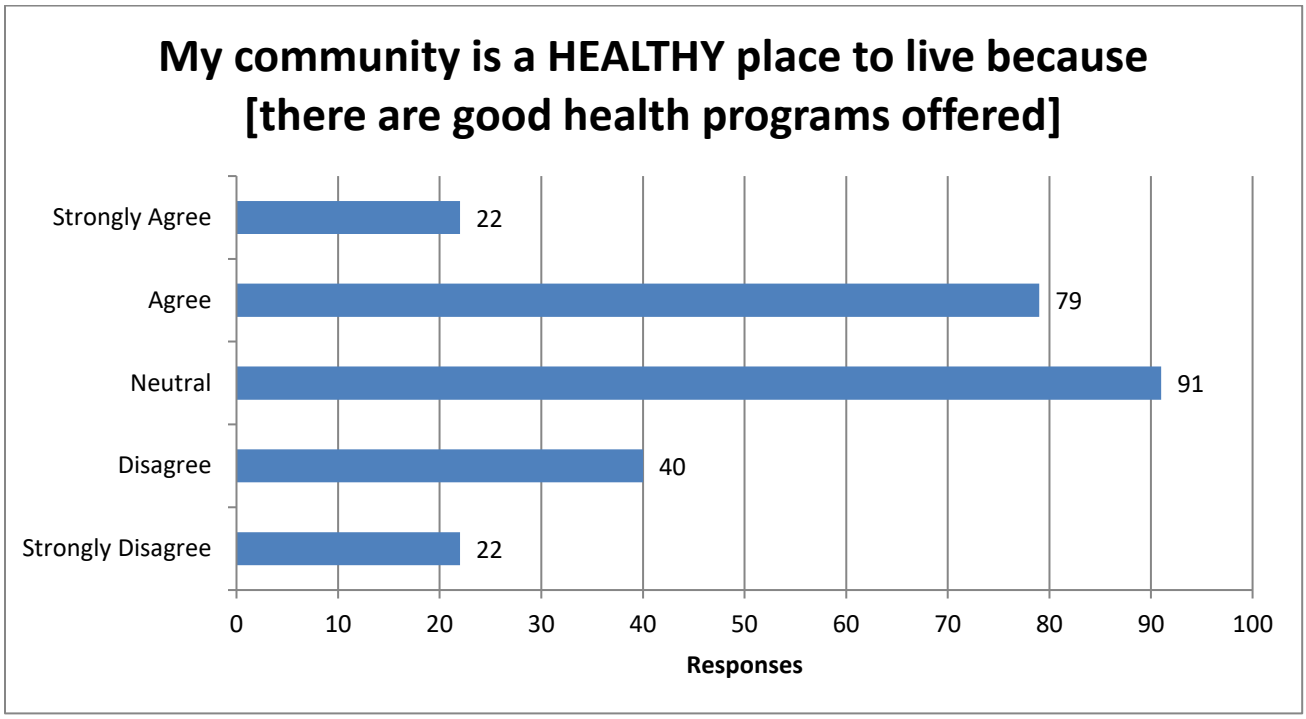

My community is a HEALTHY place to live because [I can get healthy foods]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
25
86
76
34
33
0
10
20
30
40
50
60
70
80
90
100
Responses

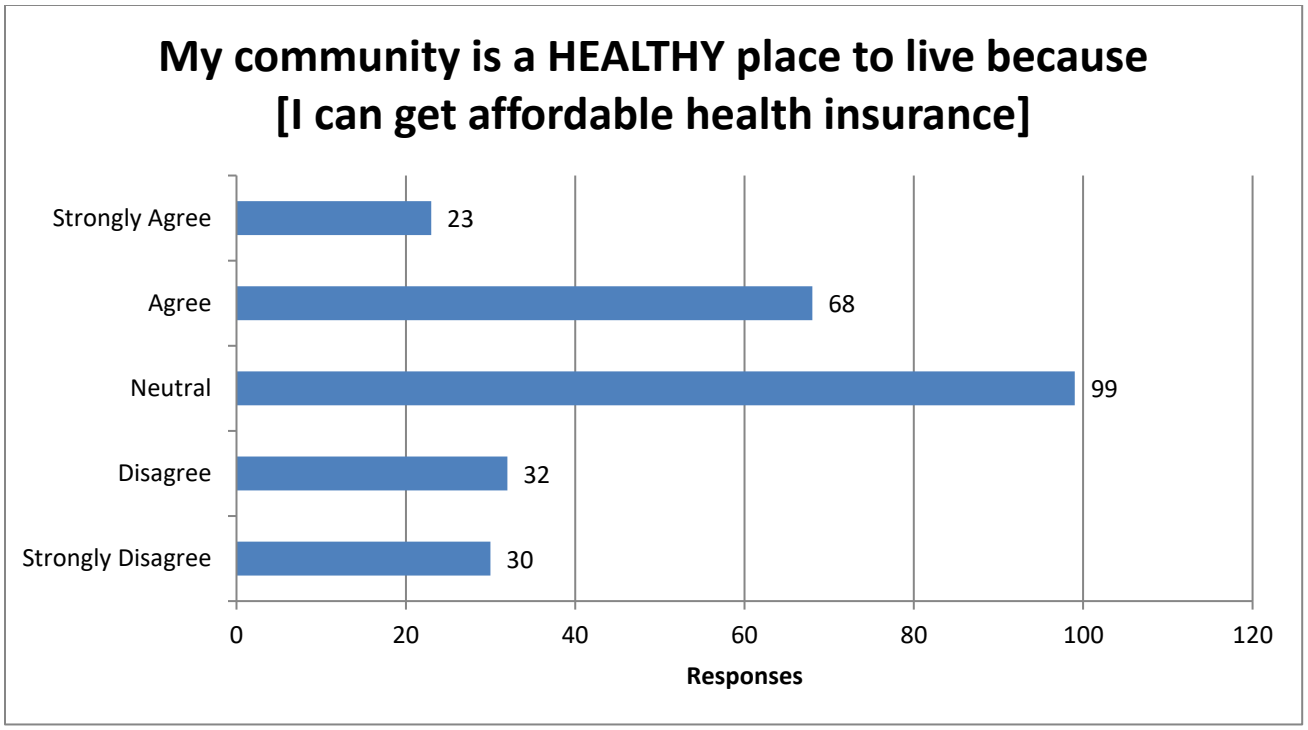

My community is a HEALTHY place to live because [there are good places to play]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
5
42
89
69
43
0
10
20
30
40
50
60
70
80
90
100
Responses


My community is a HEALTHY place to live because [it is a good place to walk and bike]
Strongly Agree
13
Agree
45
Neutral
92
Disagree
59
Strongly Disagree
48
0
10
20
30
40
50
60
70
80
90
100
Responses

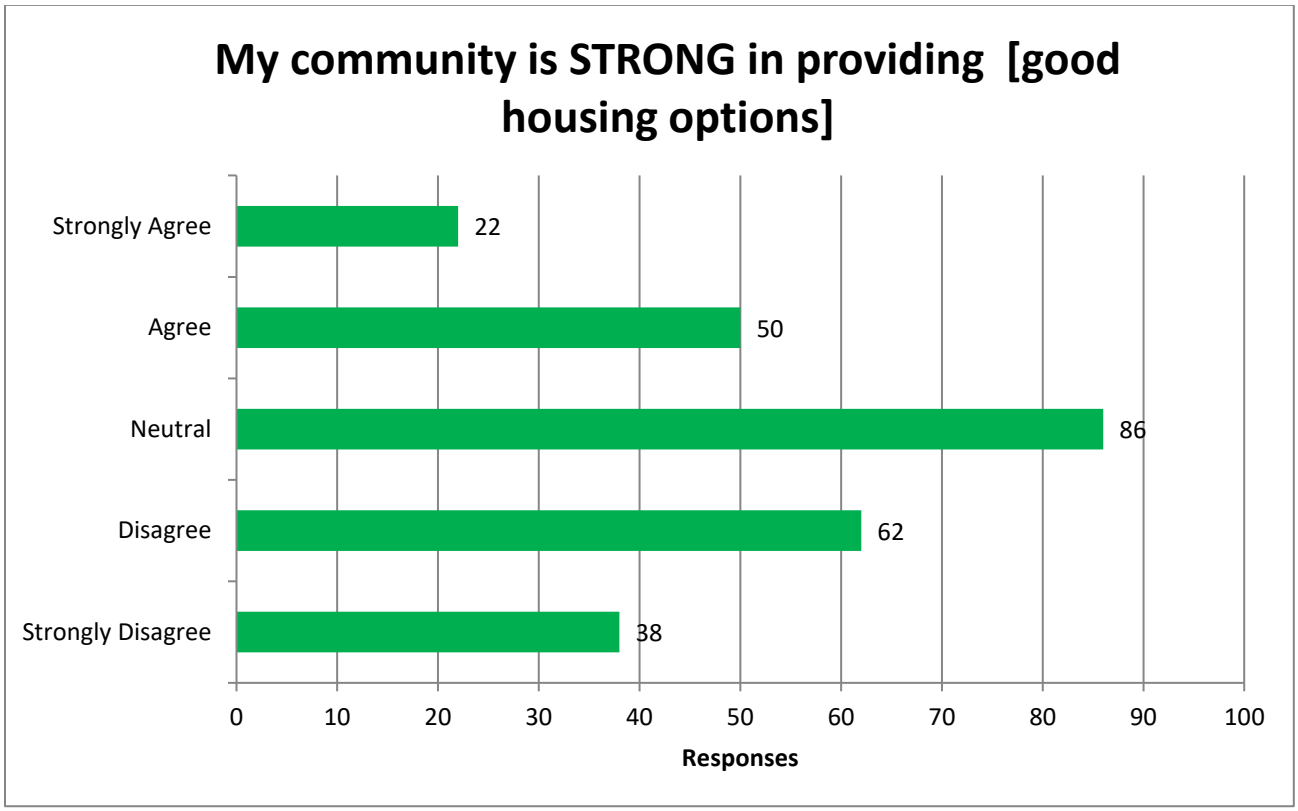

My community is a HEALTHY place to live because [there are good places to get health care]
Strongly Agree
23
Agree
78
Neutral
97
Disagree
30
Strongly Disagree
26
0
20
40
60
80
100
120
Responses

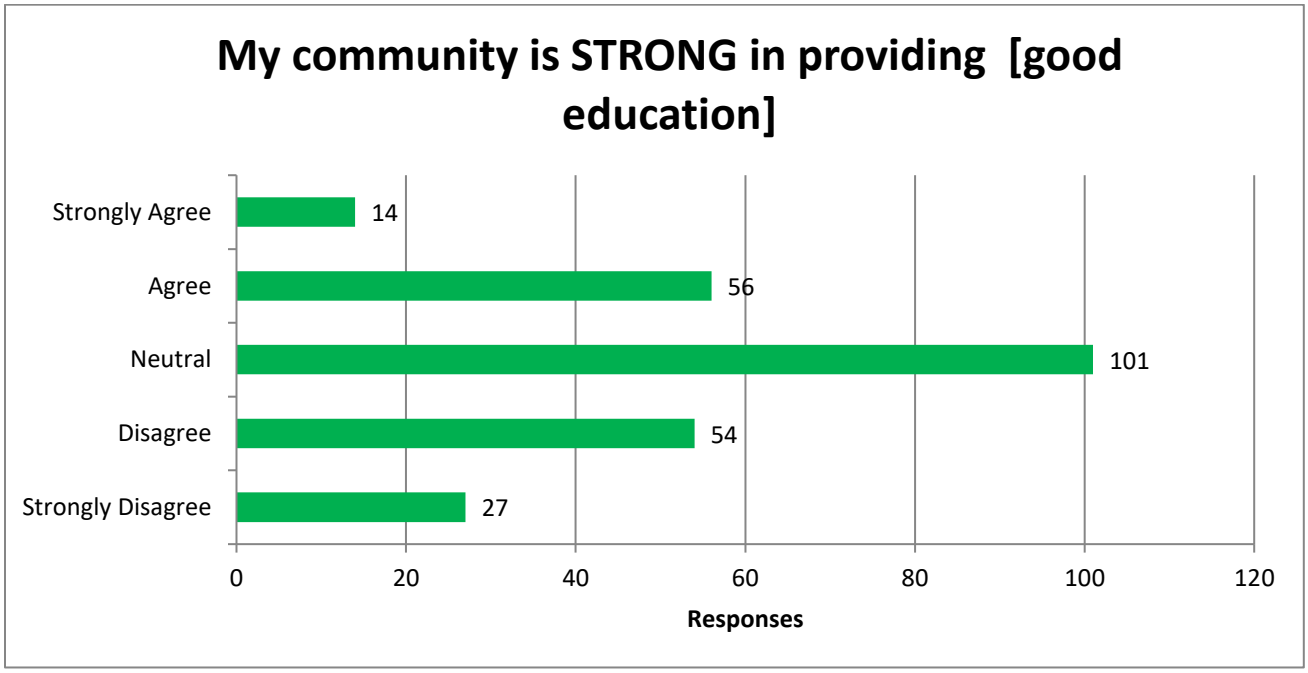

My community is a HEALTHY place to live because [there are good places to get dental care ]
Strongly Agree
20
Agree
63
Neutral
88
Disagree
56
Strongly Disagree
28
0
10
20
30
40
50
60
70
80
90
100
Responses

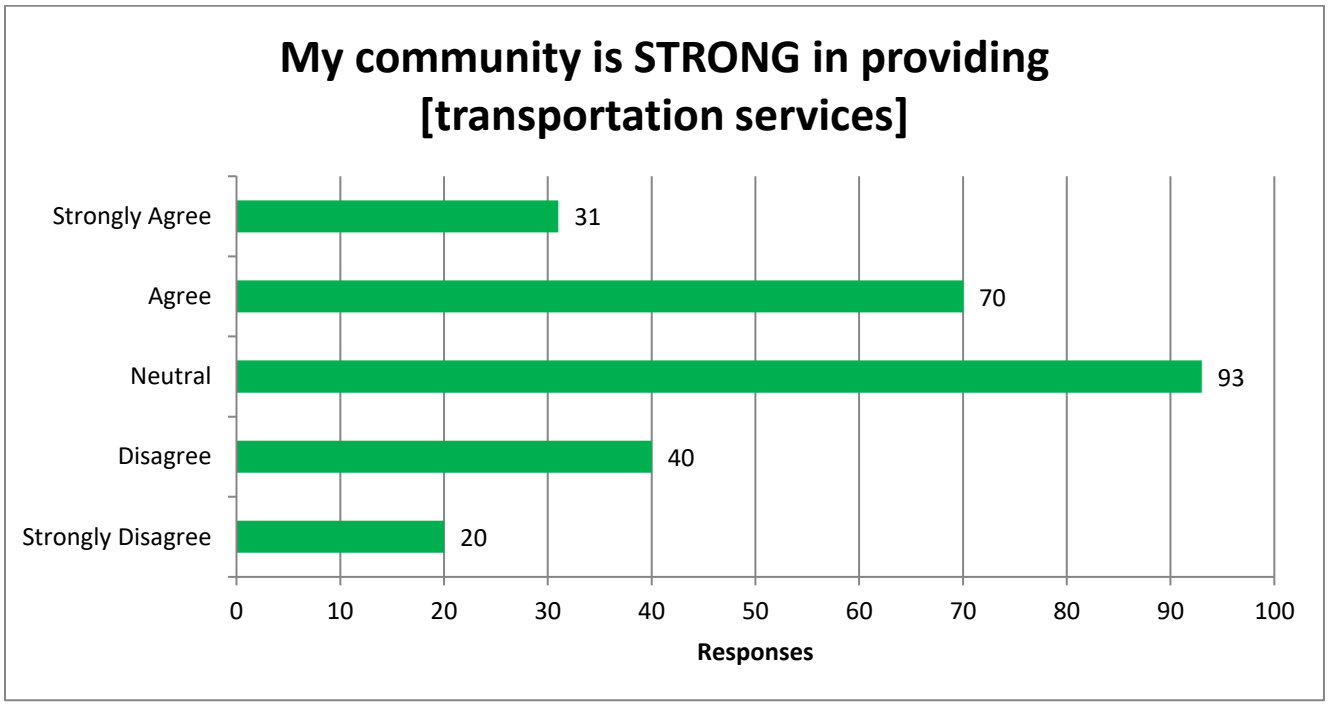

My community is a HEALTHY place to live because [there are good health programs offered]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
22
79
91
40
22
0
10
20
30
40
50
60
70
80
90
100
Responses

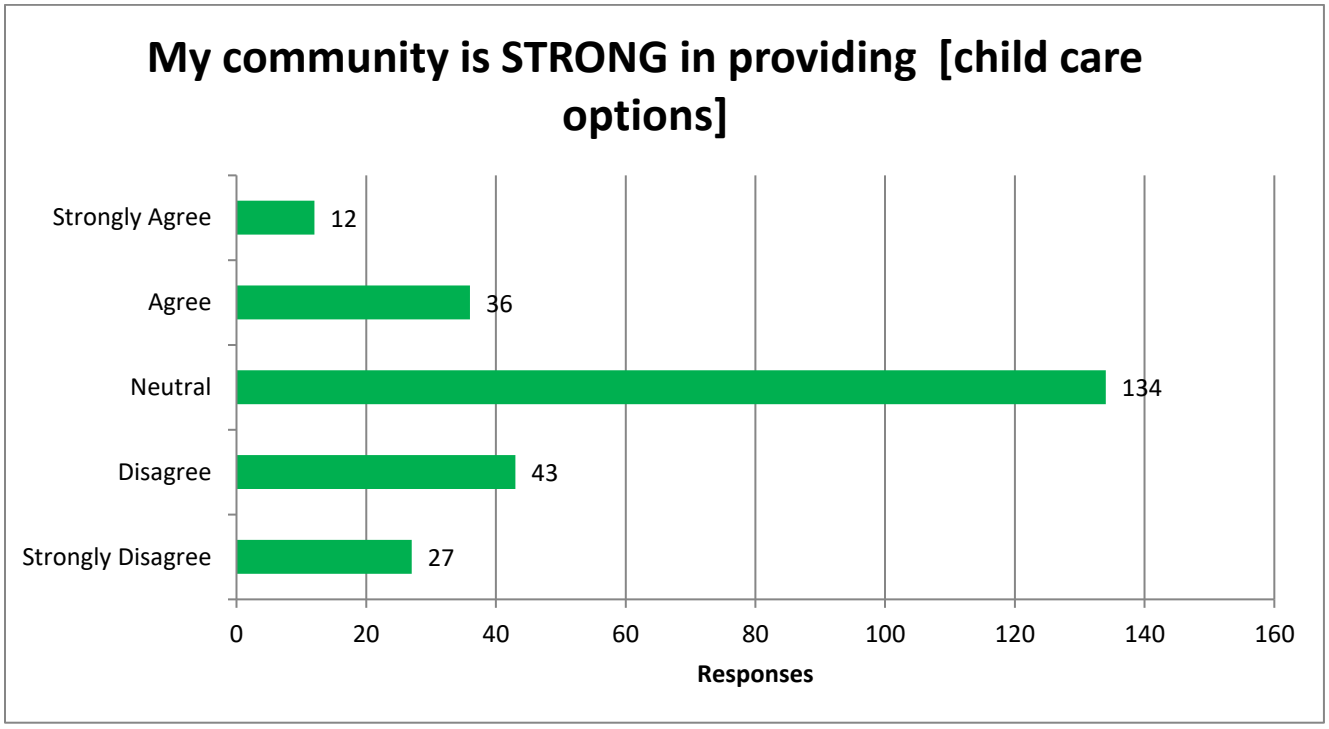

My community is a HEALTHY place to live because [I can get affordable health insurance]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
23
68
99
32
30
0
20
40
60
80
100
120
Responses

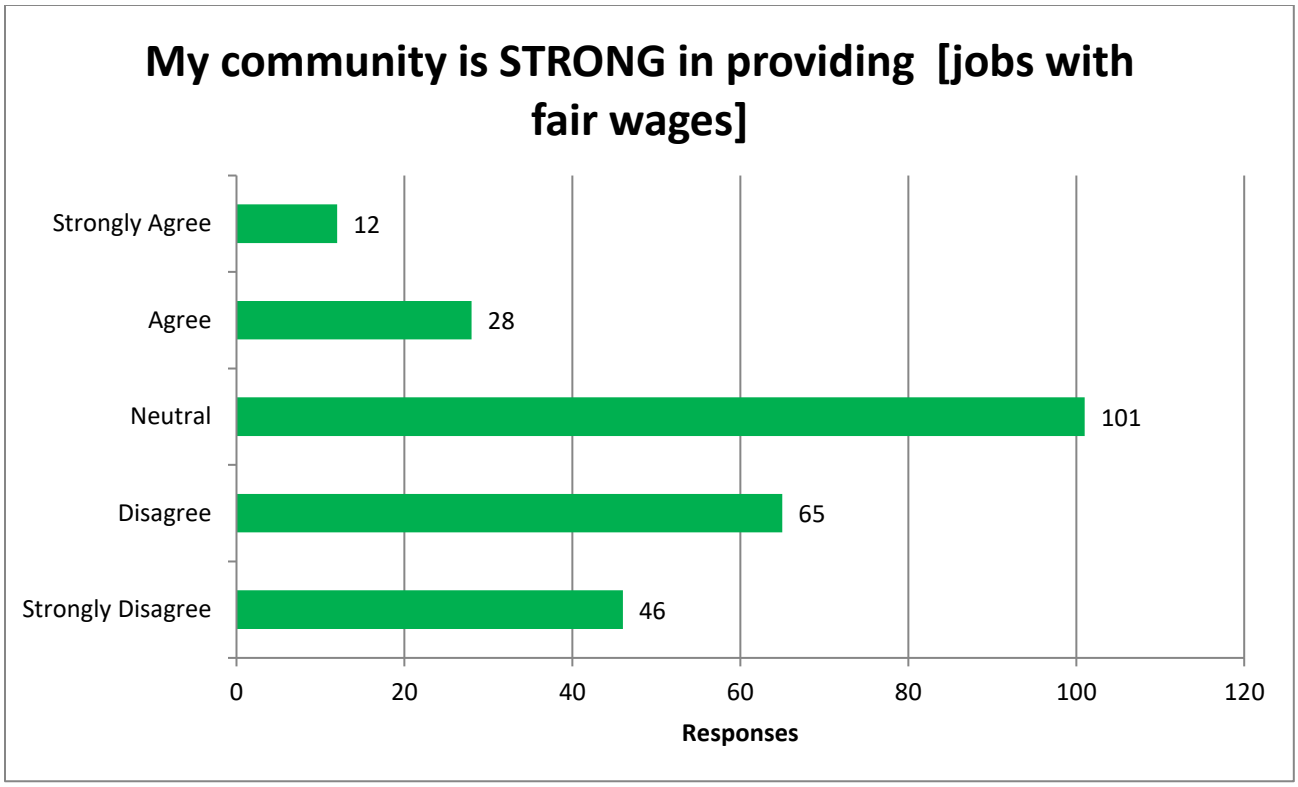
6.


My community is STRONG in providing [good housing options]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
22
50
86
62
38
0
10
20
30
40
50
60
70
80
90
100
Responses

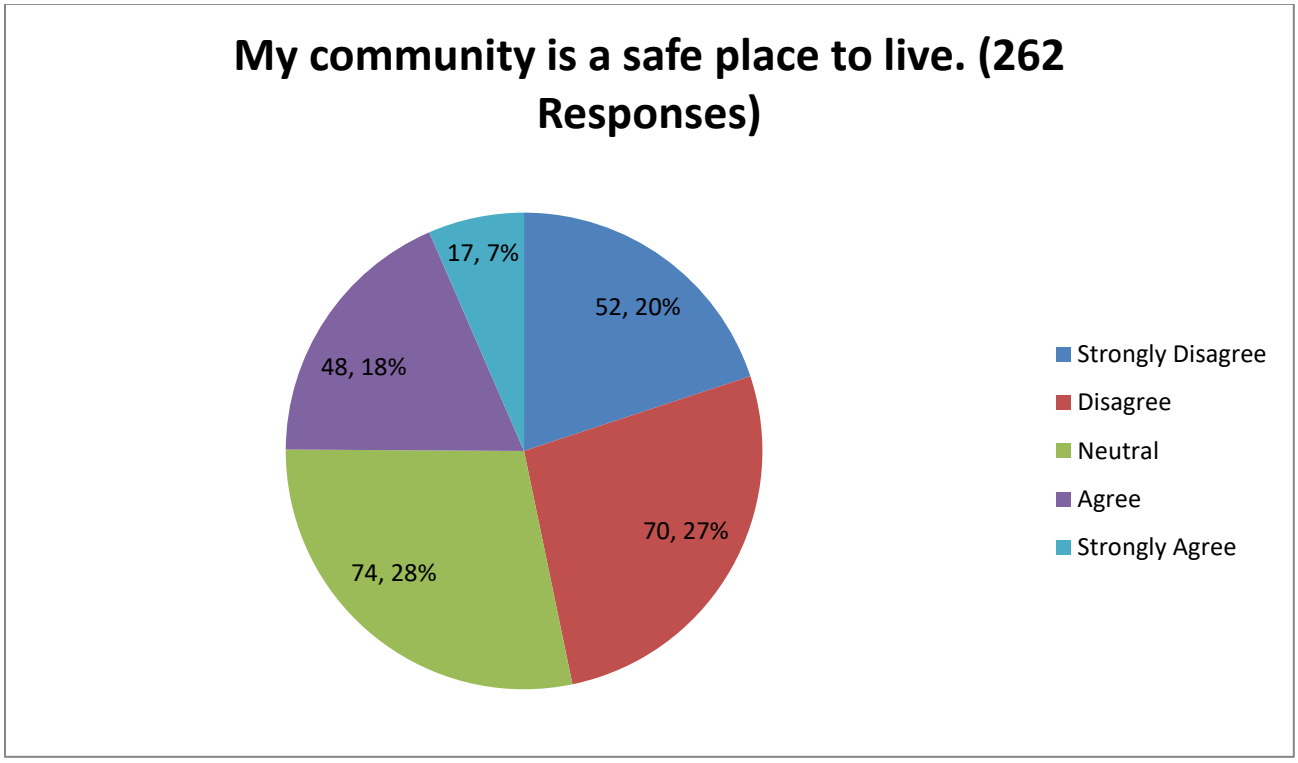

My community is STRONG in providing [good education]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
14
56
101
54
27
0
20
40
60
80
100
120
Responses


My community is STRONG in providing [transportation services]
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
31
70
93
40
20
0
10
20
30
40
50
60
70
80
90
100
Responses

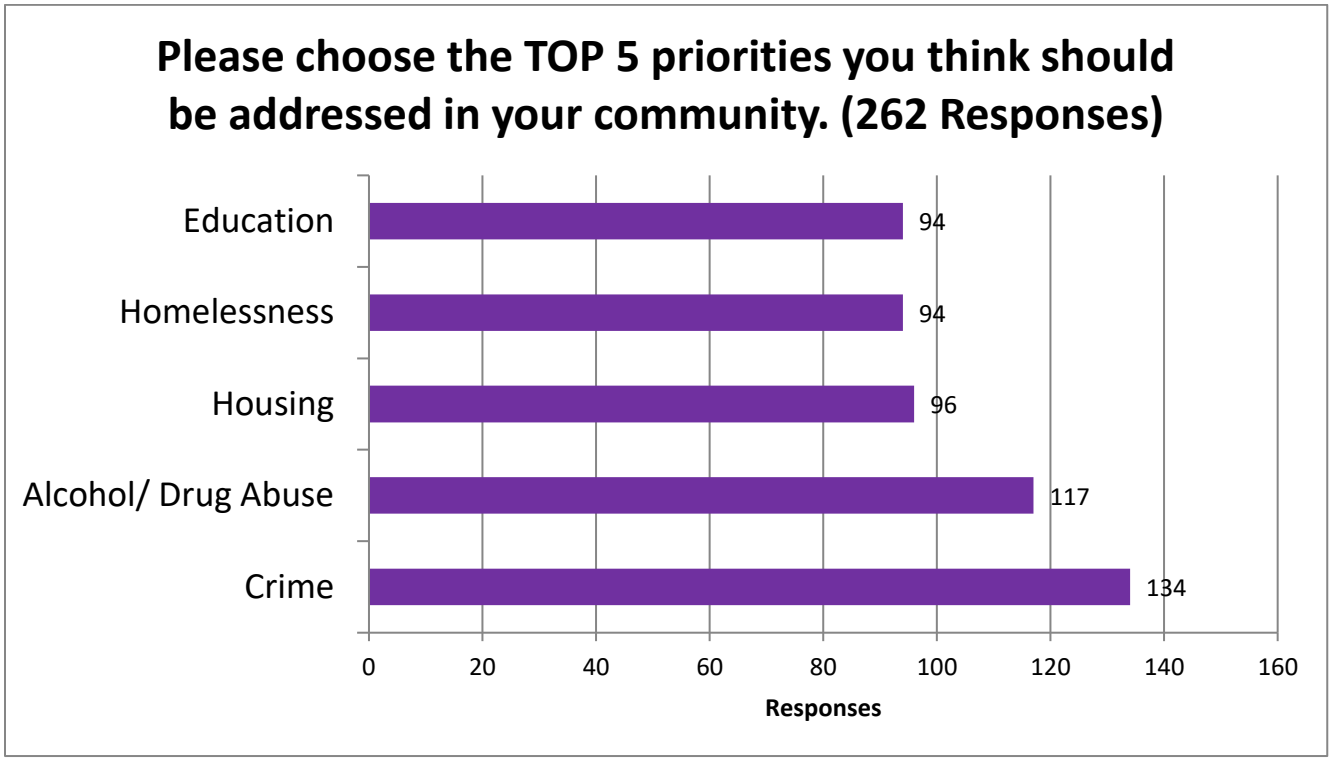

My community is STRONG in providing [child care options]
Strongly Agree
12
Agree
36
Neutral
134
Disagree
43
Strongly Disagree
27
0
20
40
60
80
100
120
140
160
Responses


My community is STRONG in providing [jobs with fair wages]
Strongly Agree
12
Agree
28
Neutral
101
Disagree
65
Strongly Disagree
46
0
20
40
60
80
100
120
Responses

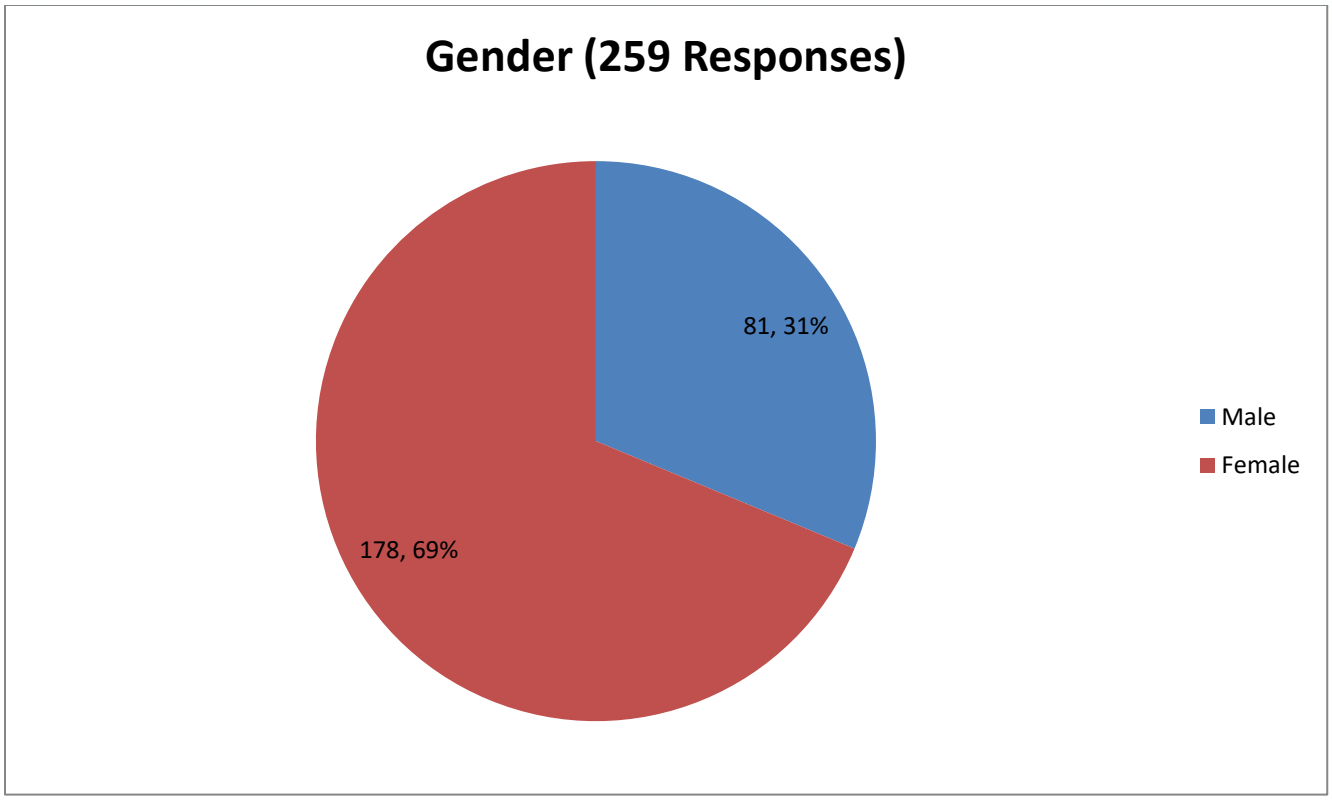
10.


My community is a safe place to live. (262 Responses)
17, 7%
52, 20%
48, 18%
70, 27%
74, 28%
Strongly Disagree
Disagree
Neutral
Agree
Strongly Agree

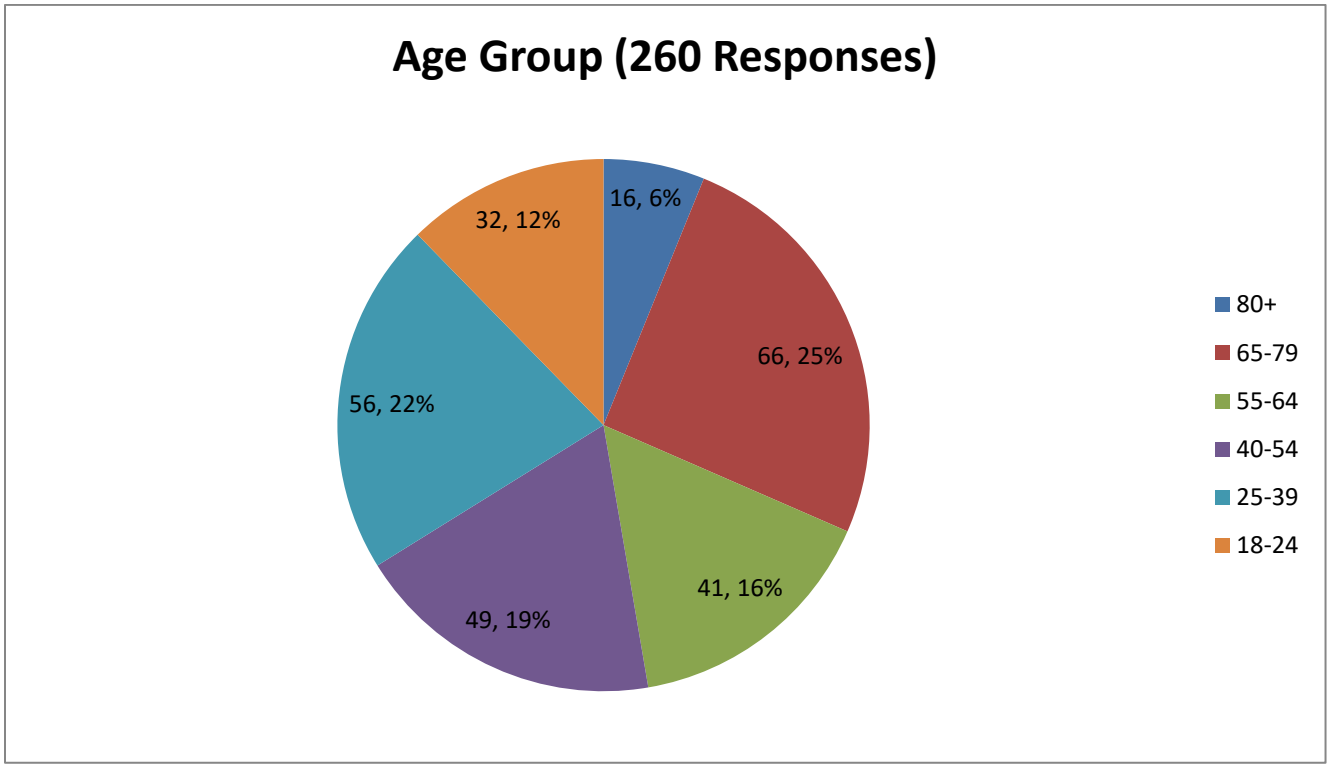
12.


Please choose the TOP 5 priorities you think should be addressed in your community. (262 Responses)
Education
Homelessness
Housing
Alcohol/ Drug Abuse
Crime
94
94
96
117
134
0
20
40
60
80
100
120
140
160
Responses

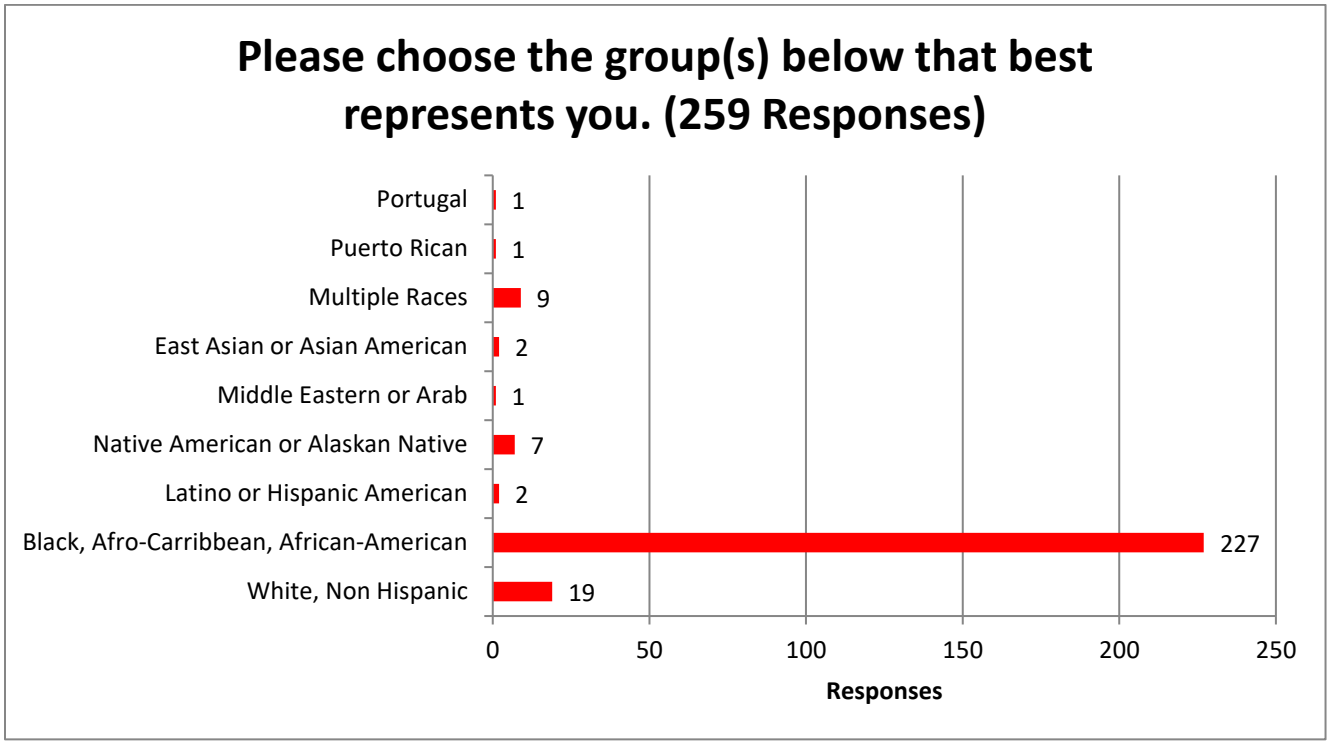
15.


Gender (259 Responses)
81, 31%
178, 69%
Male
Female

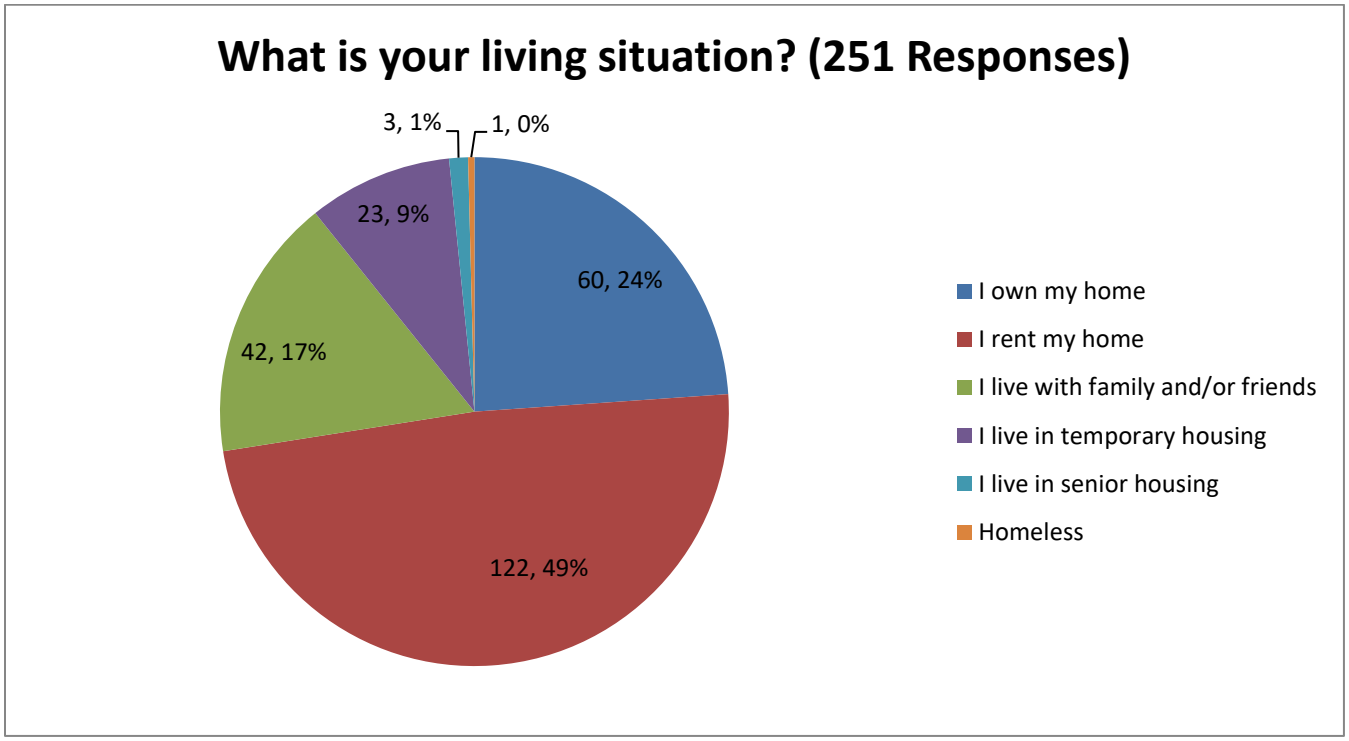
16.


Age Group (260 Responses)
16, 6%
66, 25%
41, 16%
49, 19%
56, 22%
32, 12%
80+
65-79
55-64
40-54
25-39
18-24

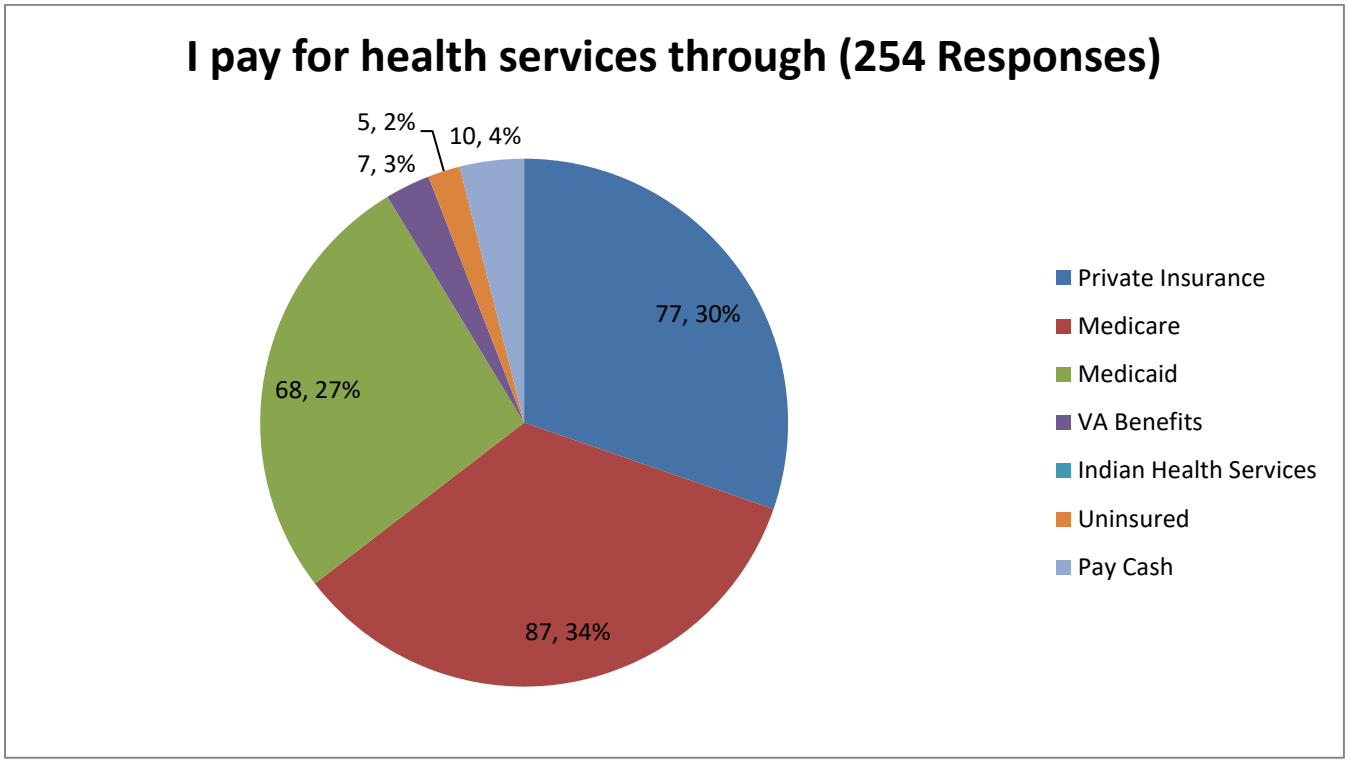
17.


Please choose the group(s) below that best represents you. (259 Responses)
Portugal
Puerto Rican
Multiple Races
East Asian or Asian American
Middle Eastern or Arab
Native American or Alaskan Native
Latino or Hispanic American
Black, Afro-Carribbean, African-American
White, Non Hispanic
1
1
9
2
1
7
2
227
19
0
50
100
150
200
250
Responses

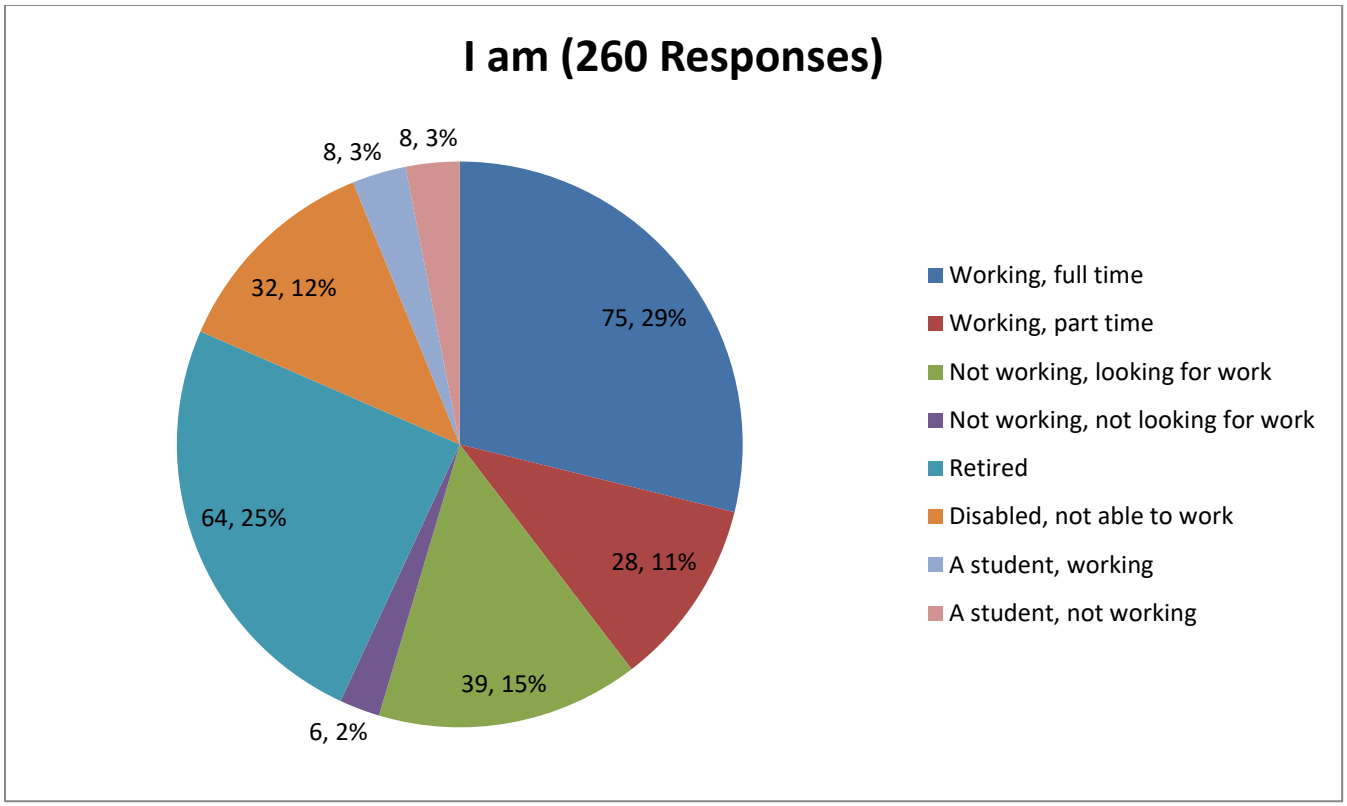
18.


What is your living situation? (251 Responses)
3, 1%
1, 0%
23, 9%
60, 24%
42, 17%
122, 49%
I own my home
I rent my home
I live with family and/or friends
I live in temporary housing
I live in senior housing
Homeless

21.


I pay for health services through (254 Responses)
5, 2%
10, 4%
7, 3%
77, 30%
68, 27%
87, 34%
Private Insurance
Medicare
Medicaid
VA Benefits
Indian Health Services
Uninsured
Pay Cash

22.


I am (260 Responses)
75, 29%
28, 11%
39, 15%
6, 2%
64, 25%
32, 12%
8, 3%
8, 3%
Working, full time
Working, part time
Not working, looking for work
Not working, not looking for work
Retired
Disabled, not able to work
A student, working
A student, not working

23.

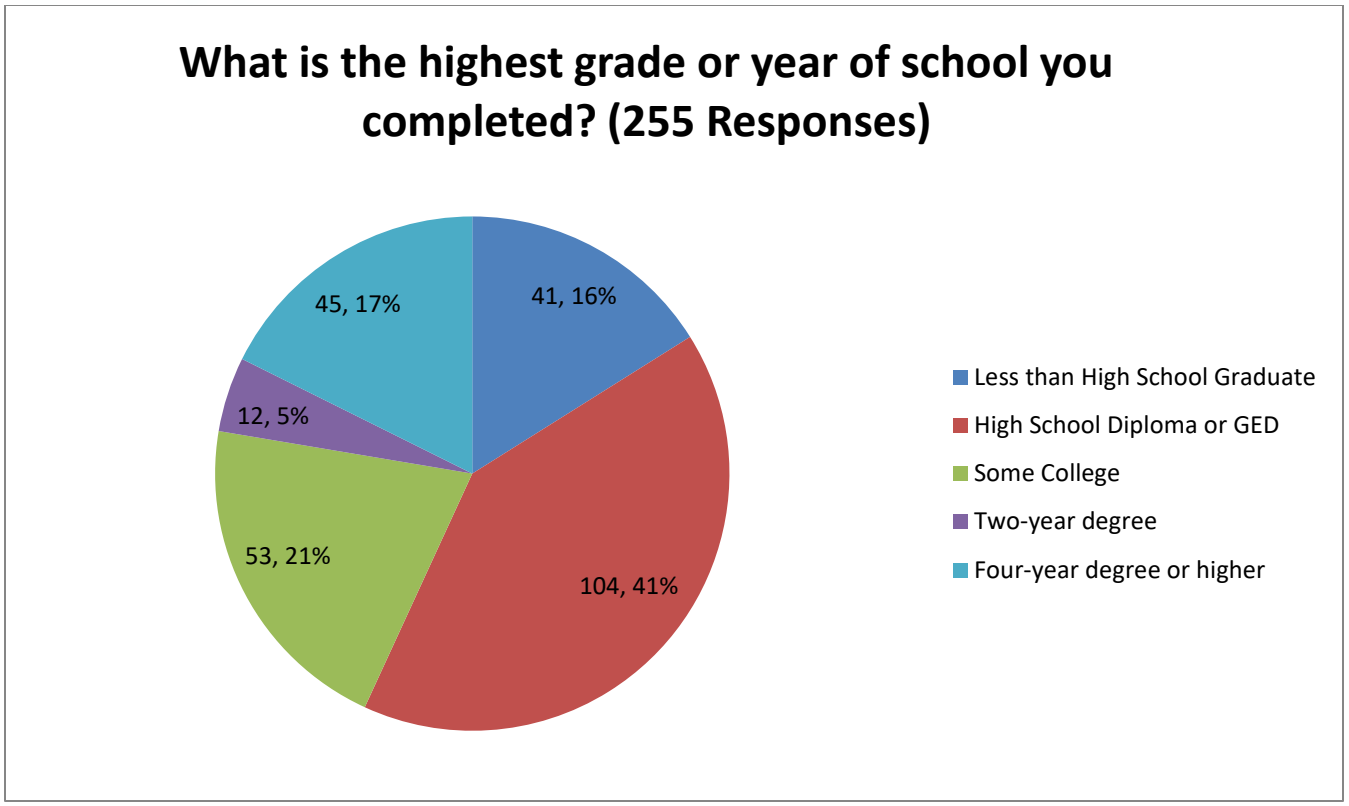

What is the highest grade or year of school you completed? (255 Responses)
41, 16%
104, 41%
53, 21%
12, 5%
45, 17%
Less than High School Graduate
High School Diploma or GED
Some College
Two-year degree
Four-year degree or higher

Exhibit 11

## Background Regarding

## Grace Medical Center CHNA Implementation Plan

In the winter and spring of 2019 Bon Secours Hospital in southwest Baltimore conducted its tri-annual Community Health Needs Assessment ("CHNA"). The CHNA included community meetings, surveys and interviews with those who have a knowledge of public health, the broad interests of the community served, as well as special knowledge of the medically underserved, low-income and vulnerable populations and people with chronic conditions. The CHNA was completed and approved by the Hospital Board of Directors in July 2019. The following health and social conditions were identified as significant needs of the community being served:

| | |
|---|---|
| Behavioral Health/Substance Abuse/Opioids | Crime and Related Trauma |
| Chronic Conditions | Housing and Homelessness |
| Access to Primary Physicians | Community Engagement |
| Children's Health | Employment; Workforce Development |
| Health Education within the Public Education System | Transportation |
| Access to Healthy Foods | Support for Senior Services |
| Youth Services (Ages 5 – 18) | Financial Counseling and Literacy |
| Coordination of Services Across Community | |

Prior to development of an associated CHNA Implementation Plan, Bon Secours Hospital was sold to LifeBridge Health, a multi-hospital and health system within Maryland. Bon Secours Hospital was renamed Grace Medical Center.

In the spring of 2020, the leadership of Grace Medical Center reviewed the completed CHNA and prioritized the following identified needs for development of a CHNA Implementation Plan for approval and adoption by its Board:

- Behavioral Health/Substance Abuse/Opioids
- Access to Primary and Specialty Care providers
- Chronic Conditions
- Crime and Trauma
- Community Engagement & Development
- Transportation

For its hospitals' 2018 CHNA Implementation Plans LifeBridge Health organized its prioritized needs into three major categories – Health, Social and Environmental, and Access – and developed specific Goals and Actions. Similarly, Grace Medical Center has developed the attached Implementation Plan for the prioritized needs above consistent with the LifeBridge Health model.

# Grace Medical Center CHNA Implementation Plan

## Health

| Prioritized Need - Behavioral Health/Substance Abuse/Opioids | |
|---|---|
| Goal – Reduce fatalities among residents of West Baltimore who accidentally overdose. | |
| Actions: | 1. Provide Overdose Prevention Education and Training to 100% of all patients enrolled in Grace Medical Center operated OTP's.<br>2. Provide naloxone kits to enrollees within two business days after completing an overdose prevention training document. |
| Anticipated Impact: | Prevention of overdose fatalities among enrollees in OTP programs as well as the southwest Baltimore community in general. |
| Metrics Used to determine Progress: | # Naloxone Kits distributed<br>#Total Enrollment in all OTP's. |
| Resources (Staff and/or Budget): | Existing OTP staff to provide overdose prevention education and training to all OTP enrollees.<br>Naloxone kits procured with grant funds |
| Leader(s): | Tara Buchanan, RN<br>Heather Young, FNP |

| Prioritized Need – Behavioral Health/Substance Abuse/Opioids | |
|---|---|
| Goal – Improve the health status of residents of southwest Baltimore by increasing the number of SBIRT Interventions and Overdose Survivor's Outreach Program (OSOP) referrals by 10% over FY 19 totals for individuals who screen positive during their ED visits. | |
| Actions: | 1. Provide SBIRT Interventions and OSOP referrals in the Emergency Department and on the Observation unit at Grace Medical Center for individuals with a positive SBIRT screening.<br>2. Conduct follow-up telephone surveys to validate treatment referrals |
| Anticipated Impact: | Reduce ED visits for individuals diagnosed with identified Substance Use Disorders.<br>Increase the number of Individuals who accept referrals to Substance Abuse Treatment. |
| Metrics Used to determine Progress: | # SBIRT/ OSOP referrals who kept referral appointments<br># SBIRT/ OSOP referrals |
| Resources (Staff and/or Budget): | Existing SBIRT Peer Recovery staff/ budget |
| Leader: | Dr. Nicole Wagner |

## Health

| Prioritized Need – Access to Care Providers (Primary, Pediatric, Specialty) | |
|---|---|
| Goals: 1) Improve and expand access to Primary Care, Preventive Services, and Specialty Care<br>2) Improve the health of the community by increasing the number of people connected to a primary care medical home and increasing annual primary care visits | |
| Actions: | 1. Increase capacity of services by reconstructing a new area to house Primary Care, and expanded Specialty Services including Ophthalmology, OB/GYN, and Pediatrics<br>2. Establish a Pediatric Clinic within our current Family Practice and protocols for referral<br>3. Establish OB/GYN Clinic<br>4. Establish Eye Clinic<br>5. Develop communications to the community in which we increase awareness of services and how to access<br>6. Ongoing referral coordination provided by Referral Coordinator in collaboration with Providers, and ED/Observation and Ambulatory Care Management teams.<br>7. Provide patient outreach by use of patient portal, letters, or phone calls to patients not seen in the practice within six months to schedule appointments<br>8. Referrals made from Community Programs and activities which identify patients without a medical home and/or patients at risk for chronic conditions<br>9. Conduct focused events (men's health, and women's health) and refer community members for utilization of services as needed<br>10. Community awareness and education provided to promote the importance of establishing a medical home, receiving preventive screenings and routine well visits<br>11. Transitions of Care activities from both ED/Observation Care - Transitions team and Ambulatory Care Management team to connect patients with Primary Care and Specialty Services to include appointment assistance, referrals, care coordination, and follow up with patients<br>12. Continue to assist patients with obtaining medical insurance via onsite vendor. Care Management teams identify and refer patients without insurance to the onsite vendor for assistance. |
| Anticipated Impact: | Overall improved access to Primary Care, Preventive Services, and Specialty Care. |
| Metrics Used to determine Progress: | 1. Increased Primary Care and Specialty Care volumes<br>2. Decreased inappropriate ED utilization<br>3. Improved preventive screening rates i.e. CRC, Breast Cancer<br>4. % of patients with post discharge appointment within 7 days<br>5. Number of people referred to care from Community Programs |

| | |
|---|---|
| Resources (Staff and/or Budget): | 1. Ambulatory Department<br>2. CHW Department<br>3. Care Management Team |
| Leader: | Dr. Sheikh and Michelle Berkley-Brown |

**Health**

| Prioritized Need – Chronic Conditions | |
|---|---|
| Goal – Improve the health status of southwest Baltimore residents by engaging the community in screenings and educational events that promote healthier lifestyles and better self-management of health and chronic conditions<br>Goal – Improve management of Chronic Conditions by early identification of patients at risk, provision of care, and management of those with chronic conditions | |
| Actions: | 1. Health Education programs, Community Screenings, and Chronic Disease Management programs will be conducted in the community, independent senior buildings, and faith-based organizations to promote healthier lifestyle and self-management of chronic illness. These programs include: Healthy Living Series, Chronic Disease Self-Management Program, Freedom from Smoking, Health and Housing Program, and Faith Community Partnership<br>2. Provision of blood pressure devices and education for patients to monitor blood pressure at home and communicate readings with provider.<br>3. Diabetic education provided by DM educator to diabetic patients in both ambulatory and observation care setting.<br>4. Provide educational programs to youth in public schools about proper nutrition, diet and exercise and the interplay with health and wellness.<br>5. Care Transitions team completes high risk assessment on all admissions to ED and Observation level of care; and team ensures a primary care appointment is obtained prior to discharge. This effort includes connecting to Community Care Management<br>6. Enrollment into Community Care Management programs for specific disease state education and management<br>7. Care Transitions team will complete home visits to high risk community members with chronic conditions to ensure medication reconciliation, medication compliance, and follow up appointment compliance.<br>8. Care Transitions will assist with nutritional support through Meals on Wheels |
| Anticipated Impact: | Decreased morbidity and mortality from chronic conditions such as Diabetes, HTN, heart disease, and COPD. |

| | |
|---|---|
| Metrics Used to determine Progress: | 1. Decreased readmission rate.<br>2. Decreased primary care no show rates.<br>3. Increased number of patients connected to primary care.<br>4. Decreased inappropriate ED utilization<br>5. Increased number of people reached through health fairs, educational workshops and events |
| Resources (Staff and/or Budget): | 1. Community Health & Wellness team<br>2. Care Transitions Team<br>3. Ambulatory Care Management team<br>4. Ambulatory Providers |
| Leader: | Karen Jarrell, Michelle Berkley-Brown, and Rhonda Williams |

## Social and Environmental

| Prioritized Need – Community Engagement [and Development] | |
|---|---|
| Goal - To address key health and socio-economic challenges in West Baltimore through community-based initiatives. | |
| Actions: | • In partnership with Population Health and Baltimore Child Abuse Center (BCAC); offer two health education-based workshops and/or events each year to the West Baltimore community.<br>• Build partnerships with two workforce development organizations and conduct two outreach events per year to connect area residents to employment opportunities.<br>• Test two new non-technological strategies to reduce information gaps and improve communication to both community members and medical personnel on hospital services, programs, and initiatives as well as community-based resources.<br>• Promote quality, healthy food access in West Baltimore through an initiative, e.g. food education, food market or organizational partnership.<br>• Expand LifeBridge Health *Live Near Your Work* program in the West Baltimore service area. |
| Anticipated Impact: | • Increase access to health education, child abuse prevention, violence prevention, and other outreach opportunities to West Baltimore residents.<br>• Increase opportunities for skills training, workforce development and employment for West Baltimore residents.<br>• Decrease communication barriers while increasing access to health resources within the community.<br>• Enhance community and hospital stability, through neighborhood revitalization efforts.<br>• Expand access to healthy food options and resources to west Baltimore residents |
| Metrics Used to determine Progress: | Reach:<br>• # of people attending events<br>• # of classes/workshops/events offered<br>• # of communication strategies initiated<br>• # of partnerships initiated<br>Outcomes:<br>• # of people completing post event surveys<br>• % of participants completing classes/workshops<br>• # of communication strategies implemented<br>• # of partnerships cultivated and maintained |
| Resources (Staff and/or Budget): | • Dedicated HSCRC/Community Benefit funding<br>• Foundation Board Members<br>• Additional Partnerships as Needed |

| | |
|---|---|
| Leader: | Sommer/Merritt |

**Social and Environmental**

| Prioritized Need – Crime and Trauma | |
|---|---|
| Goal - To address existing trauma and to prevent future trauma caused by violence within the west Baltimore community (zip codes 21223, 21217, 21216 – in descending order) | |
| Actions: | 1. Provide Violence Intervention & Prevention Awareness training for all GMC staff on all forms of violence & abuse<br>2. Assess need for onsite violence responders & community violence interrupters (i.e. establish a Safe Streets site) to ensure that patients who have been victims of gun violence, stabbings, domestic violence, elder abuse, and other forms of violence have the support needed while at Grace Medical and within the community<br>3. Provide Case Management, including individualized needs assessments, tailored case planning, and community-based client advocacy, for survivors of violence related trauma<br>4. Provide trauma-responsive mental health services for survivors of violence related trauma<br>5. Provide school-based violence prevention services, including academic enrichment opportunities, life skills training, and student support groups through an evidence-based violence prevention curriculum |
| Anticipated Impact: | 1. 100% of staff trained in violence-related risk and protective factors and other challenging dynamics within 12 months<br>2. Increase safety planning and continuity of community care with survivors of violence by 50% within 12 months<br>3. Increase school attendance rates for program participants by 40% within 24 months<br>4. Decrease arrests of program participants by 30% within 24 months<br>5. Decrease CPS referrals of program participants by 30% within 24 months<br>6. Increase community resource connections of program participants by 80% within 12 months<br>7. Increase access to mental health services for survivors of violence by 25% within 18 months |
| Metrics Used to determine Progress: | 1. Number of staff trained in Violence Intervention and Prevention dynamics compared to total number of staff<br>2. Number of patients connected to hospital and community-based violence response compared to number of patients presenting with violence-related injuries |

<table>
<tr><td></td><td>3. Client-reported school attendance rates; verified by school records<br>4. Client-reported arrests; verified by arrest records<br>5. Client-reported CPS referrals; verified by CPS records<br>6. Client-reported community resource connections made<br>7. Number of mental health clients compared to need assessed within community</td></tr>
<tr><td>Resources (Staff and/or Budget):</td><td><table>
<tr><td>Manager of Case Management Team (35%)</td><td></td></tr>
<tr><td>School-based Coordinator (100%)</td><td></td></tr>
<tr><td>Case Manager (100%)</td><td></td></tr>
<tr><td>Hospital-based Violence Responder (100%)</td><td></td></tr>
<tr><td>Trauma Therapist (100%)</td><td></td></tr>
<tr><td>Fringe (22%)</td><td></td></tr>
<tr><td>Total Cost</td><td>$ 295,240</td></tr>
</table></td></tr>
<tr><td>Leader:</td><td>Adam Rosenberg</td></tr>
</table>

**Access**

| Prioritized Need – Transportation | |
|---|---|
| Goal – Provide transportation to community residents for clinic appointments and dialysis treatments | |
| Actions: | 1) Further develop request system for rides to Primary Care and Specialty Care clinic appointments<br>2) Continue to provide transportation to dialysis patients to facilitate treatments<br>3) Assess fleet needs to accommodate additional riders who need transportation to physician appointments or outpatient dialysis<br>4) Assess community needs for transportation of family members to visit loved ones at Sinai, Northwest and Levindale hospitals. |
| Anticipated Impact: | Improved access by community for medical services at Grace Medical Center; Increased availability for hemodialysis services to the community; increased efficiency and effective use of Grace clinics |
| Metrics Used to determine Progress: | Patient ride volumes and reduced missed appointments |
| Resources (Staff and/or Budget): | 4 drivers, 3 fourteen passenger buses |
| Leader: | Stephen Winstead/John Knapp |

Exhibit 12

**Marshall Valuation Service Calculation**
**GRACE MEDICAL**
**New Construction**

**I. The Marshall Valuation Service Estimate**

| | | | MVS Page # |
|---|---|---|---|
| a | Type | Hosp | Section 15-17 |
| b | Construction Quality / Class | Good / A | |
| c | Stories | 2 | |
| d | Perimeter | 428 | |
| e | Height | 12' | |
| f | Square Feet | 24,600 | |
| f.1 | Average Floor Area | 12,300 | |
| | **A. Base Costs** | | |
| g | Basic Structure | $374.00 | Section 15-24 |
| h | Elimination of HVAC Cost for Adjustment | $0.00 | Section 15-24 |
| i | HVAC Add-on for Mild Climates | $0.00 | Section 15-24 |
| j | HVAC Add-on for Extreme Climates | $0.00 | Section 15-24 |
| k | **Total Base** | $374.00 | |
| | **B. Additions** | | |
| l | Elevators (if not in base) | $0.00 | Section 15-17 |
| m | Sprinkler Amount | $3.96 | Section 15-37 |
| n | **Subtotal** | $3.96 | |
| o | **Total** | $377.96 | |
| | **C. Multipliers** | | |
| p | Perimeter Multiplier | 1.146 | Section 15-38 |
| q | Product | $433.14 | |
| r | Height Multiplier | 1.000 | Section 15-38 |
| s | Product | $433.14 | |
| t | Multi-story Multiplier (0.5% / story above 3) | NA | Section 15-26 |
| u | Product | | |
| | **D. Update / Location Multipliers** | | |
| v | Update Multiplier | 1.03 | Section 99-3 |
| w | Product | $446.13 | |
| x | Location Multiplier | 1.02 | Section 99-8 |
| y | Product | $454.79 | |
| | **Final MVS Square Foot Cost Estimate** | **$454.79** | |

**II. The Project**

| **A. Base Calculations** | **Actual** | **Per Sq. Ft.** |
|---|---|---|
| New Construction | $10,750,000 | $436.99 |
| Site Preparation | $790,000 | $36.57 |
| Architectural Fees | $950,000 | $43.98 |
| Permits | $150,000 | $6.94 |
| | $12,640,000 | $524.48 |