The Maryland Health Care Commission

Request for Exemption from Certificate of Need Review to Convert Grace Medical Center to a Freestanding Medical Facility

Joint Applicants

Sinai Hospital of Baltimore, Inc. and Grace Medical Center, Inc.

June 29, 2021

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Grace Medical Center, Inc. ("Grace" or "Grace Medical Center") and Sinai Hospital of Baltimore, Inc. ("Sinai"), as joint applicants, seek approval from the Maryland Health Care Commission (the "Commission") to convert Grace Medical Center to a freestanding medical facility ("FMF") with Sinai as its parent hospital. For the reasons set forth more fully below, Grace Medical Center and Sinai respectfully request that the Commission grant an exemption from Certificate of Need ("CON") review for the conversion of Grace Medical Center to an FMF and for associated capital expenditures.

Background

Grace operates an acute care hospital located at 2000 West Baltimore Street, Baltimore, MD 21223. The hospital was founded in 1918 by the Sisters of Bon Secours and currently has 69 licensed beds. Grace Medical Center provides acute care, emergency care, ambulatory care, outpatient hospital behavioral health services and outpatient dialysis. In addition, Grace owns and operates substance abuse clinics on 2401 West Baltimore Street, Baltimore, MD 21223, a women's shelter, and a comprehensive behavioral health program at 6000 Metro Drive, Suite 110, Baltimore, MD 21215. Grace was formerly known as Bon Secours Hospital Baltimore, Inc. ("Bon Secours Hospital"), and was part of the Bon Secours Mercy Health system until being acquired on November 1, 2019 by LifeBridge Health, Inc. ("LifeBridge"), the parent company of an integrated health system which includes four other hospitals in central Maryland.

Sinai is a 460 licensed bed acute care facility with level two trauma designation, and the lead hospital of the LifeBridge system. Sinai is located at 2401 W. Belvedere Ave., Baltimore, MD 21215, approximately five miles away from Grace Medical Center. Sinai is the largest community teaching hospital in Maryland. While entrenched in care for the local community, it is also a destination hospital for patients from all 50 states and many countries who seek internationally renowned and highly specialized care. Sinai's dedication to community outreach and support spurred the launch of an 80-organization coalition to revitalize the Park Heights community, a Women and Minority Business Enterprise (WMBE) initiative, Health Equity Task Force, and Jewish Community Planning Initiative activities, as well as a program to co-manage certain outpatient services (pediatrics, obstetrics and adult medicine) with the local Federally Qualified Health Center and a board-level Community Mission Committee that prioritizes community health needs.

Changes in health care delivery and demand for inpatient acute services have resulted in a substantial decline in inpatient utilization at Grace. For example, prior to the acquisition of Grace by LifeBridge, the average daily census for the ten bed intensive care unit at Grace was two patients. With inpatient volumes declining, Grace has experienced significant financial difficulties, generating negative operating revenue each year since the 2015 fiscal year. This deteriorating economic situation has put the hospital's sustained financial viability in jeopardy; a concern which predates the acquisition of the hospital by LifeBridge. Shortly following the merger of the Bon Secours Health System with Mercy Health of Ohio, Bon Secours Mercy Health, Inc. ("BSMH"), the corporate parent of the newly merged system, revealed that Bon Secours Hospital was facing financial hardship and was at risk of being permanently closed.

However, due to the hospital's importance to the vulnerable and underserved population in West Baltimore, the Health Services Cost Review Commission ("HSCRC") worked with BSMH to find a potential transaction partner to acquire the hospital, with the goal of ensuring that the West Baltimore community would continue to have access to much-needed community-based healthcare services. LifeBridge was invited to participate in that transaction process and was ultimately selected as the winning bidder to acquire Bon Secours Hospital.

Prior to submitting a proposal to acquire Bon Secours Hospital, LifeBridge conducted an analysis of services provided at the hospital and the current needs of the community. Through meetings with community leaders, LifeBridge learned that the community placed a high priority on pediatric services, women's health services, and ophthalmology services. The 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 be crucial to serving the community's needs. It was ultimately determined that critical care (ICU), medical/surgical and inpatient behavioral health services were no longer cost-effective and/or the hospital was not the optimal site of care for patients from the community to receive such services. However, LifeBridge felt that integrating Bon Secours Hospital into the LifeBridge system could soften any negative impact of eliminating these services at the hospital, as care could be transitioned to other LifeBridge facilities where appropriate, including Sinai and Northwest Hospital Center, Inc. ("Northwest").

In addition to potential changes to the services offered by Bon Secours Hospital, LifeBridge inspected the hospital's existing facilities and determined that they were in significant need of renovation and/or replacement. The physical plant, which includes facilities built between 1918 and 1992, has significantly outlived its useful life. Over the past several years significant infrastructure issues such as aged water pipes and obsolescent HVAC systems have malfunctioned causing leaks and other environmental challenges. As part of its acquisition plans, LifeBridge proposed to construct a new, state-of-the-art facility to replace the existing physical plant. To minimize disruption to the community in desperate need of healthcare services, LifeBridge would continue to operate the emergency department and offer other streamlined services during the construction of the new site.

Throughout the transaction process, LifeBridge worked closely with the HSCRC and the Commission to ensure that the proposed service changes and construction project were aligned with the state's healthcare goals. Given the anticipated reductions to certain services, LifeBridge, the HSCRC and the Commission also discussed the possibility that, following the completion of the acquisition, the newly constructed facility might be converted into an FMF rather than continuing to maintain its license as an acute care hospital.

Following the consummation of the transaction on November 1, 2019, Grace, Sinai and LifeBridge have worked diligently to integrate the hospital into the LifeBridge system. During that time, the Applicants have gained a better understanding of Grace's operations and financial performance, as well as the needs of the community. The insights gained during this integration period have led the Applicants to conclude that the conversion of Grace to an FMF would provide for the most efficient delivery of health care services to the West Baltimore community

and help ensure that the community maintains access to high-quality health care by improving Grace's financial sustainability.

As a result, the Applicants request the Commission grant an exemption from CON review to permit conversion of Grace to an FMF.

Comprehensive Project Description

Grace and Sinai propose to convert Grace Medical Center from an acute care hospital to an FMF with Sinai as its parent hospital. This conversion is part of the plan created by Grace, Sinai and LifeBridge to develop an access point to high-quality, community-based healthcare for residents of West Baltimore. This plan creates optimal and high-quality care in West Baltimore by ensuring the continued financial viability of Grace Medical Center through the cessation of inefficient inpatient services, while maintaining access to much-needed emergency and observation services and outpatient clinics for the economically disadvantaged community served by Grace. Most importantly, following the conversion to an FMF, Grace will offer all of the services that were identified as critical to meeting the needs of the community during meetings between LifeBridge and community leaders prior to the acquisition.

As part of the proposed conversion, Grace has already initiated efforts to phase out the provision of inpatient services on-site. On November 21, 2019, Grace applied and received an exemption from the Commission to reallocate its inpatient psychiatric beds to Sinai and to Northwest. All inpatient psychiatric patients have been moved to the new unit at Sinai as of January 6, 2021. The floor at Northwest that had initially been reserved to accommodate the remainder of the psychiatric beds reallocated from Grace was converted into space to treat COVID patients at the onset of the pandemic. Once the pandemic has subsided, that space will be renovated to accommodate the psychiatric beds as originally planned. All other inpatient services, such as medical surgical and intensive care, have been moved to Sinai and Northwest, effective November 1, 2019.

Notwithstanding the elimination of inpatient services as part of the conversion, Grace will maintain the same level of emergency and observation services as are currently provided. Patients arriving at Grace who require an acute inpatient admission will be transferred to Sinai or, in some cases Northwest via the following process. When a patient arrives in the Grace emergency department and a provider has determined that a transfer is required, the provider will place a single phone call to the medical "quarterback" in the LifeBridge virtual hospital, 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, as well as the appropriate unit to receive the patient. The quarterback calls the hospitalist or admitting provider at the applicable hospital to alert them of the transfer. The admitting provider then calls Grace Medical Center for a physician to physician conversation. The patient is transferred as a direct admission to the appropriate unit via ambulance. Ambulance services are provided by Pulse, a commercial ambulance service which is stationed full-time at Grace and is equipped with advanced life support equipment and, when necessary, an advanced life support trained nurse.

Following the conversion, Grace Medical Center will be staffed in accordance with regulations issued by the Department of Health, Office of Health Care Quality, which ensures that staff will

include, at all times, at least one physician board certified in emergency medicine, as well as advance practitioners, registered nurses and other professionals to provide advanced life support, radiology and laboratory technicians and support. Grace will also have a full time Executive Director who will liaise with Sinai, as the parent hospital, for operational support and a Chief Medical Officer who will provide clinical oversight at Grace.

The conversion plan includes a complete overhaul of Grace's existing physical plant, which will occur in two phases. In the first phase of the capital project ("Phase One"), which is currently underway, Grace will renovate a portion of the existing hospital facility to construct a brand-new, state-of-the-art emergency department and clinic spaces, enhance two of the existing surgical suites, renovate the existing dialysis unit, and add additional outpatient dialysis chairs. The second phase of the project ("Phase Two") will consist of the demolition of the rest of the existing hospital structure, which was built in 1918, and the construction of a 24,600 square foot facility in its place to accommodate the outpatient behavioral health programs.

In connection with Phase One, Grace will renovate a wing of the existing hospital facility that was constructed in 1992 (the "1992 Wing"), in which inpatient registration was located. Following completion of such renovations, the 1992 Wing will house the new emergency department, observation unit, radiology, laboratory, and outpatient clinic space. During Phase One of construction, Grace's emergency department, observation units, radiology and laboratory service will continue to operate in their current locations in the portion of the hospital built in 1918. There will be no need to temporarily relocate any of these services during the construction. Outpatient behavioral health programs will temporarily be housed in the existing Family Wellness Center. As described in our letter to the Commission dated January 31, 2020, Phase One of construction began in February 2020 and is expected to be complete in July 2021.

Phase Two of the construction plan will take place in three stages: (i) the abatement process of the hospital structure built in 1918, which is anticipated to begin in June 2021, (ii) the demolition of the existing hospital (other than the 1992 Wing) which is expected to occur in August or September of 2021 and (iii) the construction a new 24,600 square foot building that will house all outpatient behavioral programs which is expected to occur from winter 2021 through spring 2023.

These new facilities have been 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 was designed in accordance with the FGI Guidelines Part 2 – Hospitals, Section 2.2-3 Diagnostic and Treatment Facilities, and Section 2.3 – Specific Requirements for Freestanding Care Facilities.

The total construction budget is $25,500,000 for Phase One and $12,600,000 for Phase Two. Grace Medical Center intends to have all construction completed by the end of 2023.

Upon completion of the proposed construction, the FMF will consist of the following:

1. An emergency department with twenty-seven rooms, observation beds and chairs for eight patients, and four rooms for psychiatric holding beds. The emergency department

will continue to operate 24/7, a base station with the capability of caring for patients categorized in EMS priority levels 2 through 4.

2. Radiology unit, including x-ray, computed tomography (CT), and ultrasound.

3. Laboratory services.

4. Peri-op, post-acute care unit, and two surgical suites for outpatient surgical procedures.

5. Waiting areas, morgue and viewing room.

In addition, the following unregulated services will be provided on-site, but will not be part of the FMF for licensure purposes and will, therefore, not be considered part of the provider-based location of Sinai (and will instead continue to be provided by Grace Medical Center, Inc.):

1. Upgraded outpatient dialysis unit which will include an additional six chairs and serve up to 41 patients at a time

2. Small outpatient physical therapy room;

3. Physician offices;

4. Clinic space that includes examination rooms for primary care and specialty care providers, as well as clinic space for Health Care for the Homeless; and

5. 24,600 square foot facility for outpatient behavioral health programs.

* * *

Described within this report are the proposed details of Phase One and Phase Two of the conversion, and in **Exhibit 3** are detailed project drawings. In addition, we have included the information required pursuant to COMAR 10.24.19.04.C.

Since acquiring Grace Medical Center in November 2019, the LifeBridge team has worked to build meaningful relationships within the West Baltimore community. 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.

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

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

Response:

Following the conversion of Grace, patients will only be retained overnight for observation stays and for treatment in the Grace emergency department. Grace will not admit patients for acute inpatient stays.

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

Reponses:

The Applicants will provide each notice, documentation, and other information regarding the proposed conversion of Grace simultaneously to the Commission and the Maryland Institute for Emergency Medical Services.

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

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

Response:

The Applicants conferred with the Commission staff prior to filing this request for exemption from certificate of need review, and have filed this request in the form and manner specified by the Commission staff.

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

Response:

Sinai and Grace have filed this request for exemption from certificate of need review as joint applicants. Following all regulatory approvals necessary to convert Grace, Sinai will become the parent hospital of the FMF.

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

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

Response:

The Applicants complied with this standard before holding public hearings regarding the conversion. A copy of the proposed transition plan is included in **Exhibit 2**. The transition plan was posted on Grace's website and a link to the appropriate webpage was included in all notices announcing the public hearings.

(ii) The converting hospital, in consultation with the Commission, and after providing at least 14 days' notice on the homepage of its website and in a local newspaper of daily circulation in the jurisdiction where the hospital is located, holds a public informational hearing that addresses the reasons for the conversion, plans for transition acute care services previously provided by the hospital to residents of the hospital service area, plans for addressing the health care needs of residents of the hospital service area, plans of the hospital or the merged asset system that owns or controls the hospital for retraining and placement of displaced employees, plans for the hospital's physical plant and site, and the proposed timeline for the conversion.

Response:

The Applicants complied with this standard by hosting two "electronic town hall" informational hearings on June 16 and June 18, 2020 to inform the general public and community stakeholders of the proposed conversion plan, as well as an additional electronic informational hearing on July 8, 2020 which focused primarily on the provision of emergency medical services following the conversion. Notices announcing the public hearings were published in the Baltimore Sun and on the "Community Calendar" page of the LifeBridge website beginning two weeks prior to the first hearing. Copies of these notices are included in **Exhibit 4**. The hearings were held remotely due to the COVID-19 pandemic. Grace and Sinai received approval of the remote format from MEIMSS and the Commission prior to hosting the public hearings. A written summary of each hearing is included in **Exhibit 5**.

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

Response:

The Applicants complied with this standard. **Exhibit 5** includes examples of the cover letters that were sent to the applicable stakeholders with summaries of the June 16 and June 18 public hearings, as well as the cover letters that accompanied a summary of the July 8 public hearing focusing on the provision of emergency medical services.

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

Response:

The Applicants have notified the EMS Board and received a Letter of Determination that the conversion of Grace to a freestanding medical facility will maintain adequate and appropriate delivery of emergency care within the statewide EMS system. A copy of the Letter of Determination is included in **Exhibit 6**.

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

Response:

The Applicants are currently working with the HSCRC on this standard, but have been informed that the HSCRC will not provide the requisite determination until after this Application is filed with the Commission. The Applicants will promptly notify the Commission when the HSCRC approves each outpatient service at Grace Medical Center for which the Applicants seek rate regulation.

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

Response:

The Applicants are currently working with the HSCRC on this standard, but have been informed that the HSCRC will not provide approved rates until after this Application is filed with the Commission. The Applicants will promptly notify the Commission when the HSCRC approves rates for each rate regulated service to be provided at Grace Medical Center following the conversion.

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

Response:

The Applicants will provide any additional information determined by the Commission staff as necessary for approval of the conversion of Grace Medical Center to a freestanding medical facility.

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

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

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

Response:

The proposed project complies with this standard, as the proposed location for the FMF is on the current site of the existing hospital operated by Grace Medical Center.

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

Information Regarding Charges

Information regarding hospital charges shall be available to the public.

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

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

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

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

Response:

Sinai's policy relating to transparency in healthcare pricing complies with this standard. A copy of this policy is included in **Exhibit 7**. A Presentative List of Services and Charges is available on the Sinai website at the following location: https://www.lifebridgehealth.org/Main/PriceTransparency.aspx.

This policy will be applied to the FMF following the proposed conversion.

Charity Care Policy

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

(a) The policy shall provide:

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

(ii) Minimum Required Notice of Charity Care Policy

1. **Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and, in a format, understandable by the target population on an annual basis;**

2. **Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital.**

3. **Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.**

Response:

Sinai has adopted a Financial Assistance Policy consistent with these standards. A copy of this policy is included in **Exhibit 8**. Sinai currently complies with the notice requirements described above and the FMF will continue to do so following the proposed conversion.

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

Response:

As shown in **Table 1** below, Sinai is in the fourth quartile in terms of the percentage of charity care to total operating expenses for acute general hospitals in the State of Maryland. However, this seemingly low level of charity care is largely attributable to the severe economic challenges facing the community served by Sinai. Charity care is primarily intended to provide discounted (or no cost) care to uninsured or underinsured patients. Patients who meet the eligibility requirements typically lack sufficient insurance coverage because their income is too high to qualify for Medicaid but too low to afford commercial coverage. Compared to most other hospitals in the state, Sinai's service area population faces significant economic hardship and, as a result, a much higher percentage of the population served by Sinai qualifies for Medicaid. Counterintuitively, the elevated poverty levels in the community result in fewer patients who require, or qualify for, financial assistance.

Notwithstanding the lower need for charity care in the community, Sinai maintains a very generous financial assistance policy, which provides free care to uninsured or underinsured

individuals whose family income is less than or equal to 300% of federal poverty guidelines with a sliding scale offered to those between 300-500% of federal poverty guidelines. This policy became applicable to Grace following its acquisition by LifeBridge and represents a significant expansion in eligibility for charity care compared to the financial assistance policies maintained by Grace prior to the transaction.

Further, Sinai's mission to care for the community is expressed in other significant ways beyond the provision of charity care. Sinai and Grace take an active role in community development efforts, including by participating in and providing financial assistance to community organizations such as, Bon Secours Community Works and Fayette Street Outreach. In fiscal year 2019, Sinai Hospital provided $63.2 million in community benefit which represented 8.1% of its operating expenses. This amount included $22 million for mission driven health services such as housing initiatives and managing complex or high utilization patients. In coordination with LifeBridge, Sinai also participates with job training programs, including the VSP program, which provides training to members of vulnerable communities in areas such as printing, housekeeping and other life skills. Sinai also sponsors food insecurity programs by hosting local farmers markets and providing nutritional education in schools and faith-based organizations. Additionally, Sinai is active in population health programs to manage chronic disease through efforts like diabetes medical home extender programs, community health and wellness teams, and mobile community outreach. Supplementing the direct provision of charity care, these community-based initiatives are a critical element of Sinai's efforts to improve the health of the population it serves.

Table 1: HSCRC Community Benefit Report FY 2019

Hospital Name	**Total Hospital Operating Expense**	**CB Reported Charity Care**	**Percentage of Charity Care to Total Expense**	
Holy Cross	$ 437,129,013	$ 31,098,161	7.1%	1st Quartile
Garrett County Memorial Hospital	$ 49,273,773	$ 2,924,970	5.9%	
St. Agnes Hospital	$ 448,522,000	$ 23,179,252	5.2%	
Doctors Community Hospital	$ 200,232,626	$ 8,425,301	4.2%	
Holy Cross German Town	$ 108,725,994	$ 4,282,298	3.9%	
Mercy Medical Center, Inc.	$ 493,862,600	$ 18,604,182	3.8%	
Calvert Memorial Hospital	$ 135,516,353	$ 4,881,836	3.6%	
Western Maryland Hospital	$ 330,368,433	$ 10,860,972	3.3%	

UM Capital Region	$ 350,398,857	$ 11,417,000	3.3%	
Johns Hopkins Bayview Med. Center	$ 652,464,000	$ 19,238,000	2.9%	
MedStar St. Mary's Hospital	$ 160,019,685	$ 4,627,204	2.9%	
MedStar Harbor Hospital Center	$ 190,590,189	$ 5,016,378	2.6%	
Washington Adventist Hospital	$252,683,556	$6,114,949	2.40%	2nd Quartile
Univ. of Maryland St. Joseph's Medical Center	$335,424,000	$8,081,000	2.40%	
MedStar Southern Maryland Hospital	$247,304,491	$5,863,574	2.40%	
Fort Washington Medical Center	$44,440,761	$1,042,403	2.30%	
MedStar Good Samaritan Hospital	$261,186,698	$6,085,945	2.30%	
Peninsula Regional Medical Center	$451,254,859	$10,436,200	2.30%	
Sheppard Pratt	$239,576,824	$5,435,243	2.30%	
McCready Foundation, Inc.	$17,725,100	$378,616	2.10%	
Univ. of Maryland Harford Memorial Hospital	$89,425,000	$1,862,000	2.10%	
Frederick Memorial Hospital	$340,006,000	$7,002,000	2.10%	
Howard County General Hospital	$266,793,000	$5,237,664	2.00%	
MedStar Franklin Square Hospital	$538,458,852	$10,276,998	1.90%	
Atlantic General Hospital	$134,838,095	$2,388,460	1.80%	

MedStar Union Memorial Hospital	$447,659,408	$7,793,317	1.70%	
Univ. of Maryland Medical Center Midtown Campus	$228,130,000	$3,819,000	1.70%	
Univ. of Maryland Baltimore Washington Medical Center	$384,744,000	$6,285,000	1.60%	
Univ. of Maryland Upper Chesapeake Medical Center	$251,520,000	$4,041,000	1.60%	
UMROI	$109,077,000	$1,668,000	1.50%	3rd Quartile
MedStar Montgomery General Hospital	$164,980,014	$2,495,104	1.50%	
Suburban Hospital Association, Inc.	$300,567,000	$4,484,000	1.50%	
Shady Grove Adventist Hospital	$388,910,383	$5,786,233	1.50%	
Levindale	$77,338,000	$1,142,100	1.50%	
Univ. of Maryland Medical Center	$1,639,396,000	$23,193,000	1.40%	
Union Hospital of Cecil County	$162,448,177	$1,836,442	1.10%	
Univ. of Maryland Shore Medical Center at Dorchester	$40,190,863	$446,565	1.10%	
Univ. of Maryland Shore Medical Center at Easton	$210,627,325	$2,265,611	1.10%	
Meritus Medical Center	$402,886,829	$4,286,507	1.10%	
Johns Hopkins	$2,476,117,000	$25,938,000	1.00%	4th Quartile

Univ. of Maryland Shore Medical Center at Chestertown	$51,275,000	$464,000	0.90%	
Northwest Hospital Center, Inc.	$246,006,000	$1,936,100	0.80%	
Univ. of Maryland Charles Regional Medical Center	$124,218,000	$966,929	0.80%	
Anne Arundel General Hospital	$557,932,000	$4,024,300	0.70%	
Sinai Hospital	$784,881,000	$5,247,000	0.70%	
Adventist Rehabilitation	$48,735,998	$298,167	0.60%	
Bon Secours Hospital (Grace Medical Center)	$114,971,612	$491,056	0.40%	
Greater Baltimore Medical Center	$524,072,000	$1,264,000	0.20%	
Carroll County General Hospital	$203,344,125	$376,223	0.20%	
Mt. Washington Pediatric Hospital	$62,496,501	$101,000	0.20%	
All Hospitals	**$16,778,744,994**	**$325,409,261**		
	$335,574,900	**$6,508,185**		

* The Adventist Hospital System has requested and received permission to report their Community Benefit activities on a CY Basis. This allows them to more accurately reflect their true activities during the Community Benefit Cycle. The numbers listed in the FY 2017 Amount in Rates for Charity Care, DME, and NSPI' Column as well as the Medicaid Deficit Assessments from the Inventory spreadsheets reflect the Commission's activities for FY17 and therefore will be different from the numbers reported by the Adventist Hospitals.			

Quality of Care

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

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

(ii) Accredited by the Joint Commission; and

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

Response:

Sinai is licensed by the State of Maryland and accredited by the Joint Commission. Its license and accreditation are attached as **Exhibit 9**. Sinai is also in compliance with the Conditions of Participation of the Medicare and Medicaid programs.

As a provider-based department of Sinai under 42 C.F.R. 413.65 and HEALTH-GENERAL 19-3A-01(3), Grace will comply with requirements issued by the Maryland Department of Health and Office of Health Care Quality (formerly the Department of Health and Mental Hygiene) for licensure as a freestanding medical facility, will be accredited by the Joint Commission, and will comply with all conditions of participation in the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the

Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

Response:

The Commission has recognized that "subpart (b) of [COMAR 10.24.10.04 (A)(3)] is essentially obsolete in that it requires an improvement plan for any measure that falls within the bottom quartile of all hospitals' reported performance on that measure as reported in the most recent Maryland [Hospital Evaluation Performance Guide]," while noting that the Maryland Hospital Performance Evaluation Guide "has been reengineered with a different focus, and no longer compiles percentile standings." *In re Dimensions Health Corporation,* Docket No. 13-16-2351, Decision at 19 (Sept. 30, 2016).

The proposed FMF will be a provider-based department of Sinai. Quality is an important cornerstone of Sinai. Set forth in **Table 2** below are the quality measures for which Sinai was ranked below the state average and the associated corrective action plan.

Table 2: Sinai Hospital of Baltimore Quality Plan

Quality Measure	Corrective Action Plan
How long patients spent in the emergency department before leaving for their hospital room	• ED monitors from time of arrival to time seen by provider, to decision to admit, to transfer to inpatient and identifies opportunities to improve throughput. • Accountable Care Rounds are held daily on the inpatient units to help facilitate and expedite discharges of inpatients. • Bedboard rounds with charge nurse and ED provider are held regularly to identify opportunities to expedite placement. • Mon – Fri, twice a day, there are multidisciplinary huddles to identify concerns for expedited care and barriers to placing patients. • The multidisciplinary group includes a broad scope of disciplines, including, but not limited to, case management, social work, physical therapy, Lab and Radiology. • As issues/concerns are identified, a multidisciplinary approach is taken to find a resolution. • Goals of the rounds and huddles include identifying any outstanding labs, diagnostics, and any other barriers to

	discharge or transfer from the ED to an inpatient unit.
How long patients spent in the emergency department after the doctor decided the patient would stay in the hospital before leaving for their hospital room	• Emergency Dept monitors Ready Bed to Transfer and Patient Care Services has an established goal for transfer to a ready bed. • A partnership has been established with EVS to ensure quick turnaround of empty patient rooms and with Transportation for timely transporting of patients to rooms. • ED monitors from time of arrival to time seen by provider, to decision to admit, to transfer to inpatient. • Accountable Care Rounds are held on the inpatient units to help facilitate and expedite discharges of inpatients. • Bedboard rounds with charge nurse and ED provider are held regularly to identify opportunities to expedite placement. • Mon – Fri, twice a day, there are multidisciplinary huddles to identify concerns for expedited care and barriers to placing patients. • The multidisciplinary group includes a broad scope of disciplines, including, but not limited to, case management, social work, physical therapy, Lab and Radiology. • As issues/concerns are identified, a multidisciplinary approach is taken to find a resolution. • Goals of the rounds and huddles include identifying any outstanding labs, diagnostics, and any other barriers to discharge or transfer from the ED to an inpatient unit.
Patients who left the emergency department without being seen	• Multiple efforts are in place to help expedite the care provided to patients in a timely manner and mitigate the number of patients who leave the ED without being seen. • Strategies that have been initiated include staffing provider and mid-levels in triage when needed and having teletriage abilities.

	• Bedboard rounds with charge nurse and ED provider are held regularly to identify opportunities to expedite triaging and evaluation of patients. • Mon – Fri, twice a day, there are multidisciplinary huddles to identify concerns for expedited care and barriers to placing patients to reduce the number of boarding hours in the ED. • The multidisciplinary group includes a broad scope of disciplines, including, but not limited to, case management, social work, physical therapy, Lab and Radiology. • As issues/concerns are identified, a multidisciplinary approach is taken to find a resolution. • Goals of the rounds and huddles include identifying any outstanding labs, diagnostics, and any other barriers to discharge or transfer from the ED to an inpatient unit.
Contrast material (dye) used during abdominal CT scan a (OP-10) [Numerator Criteria] - To meet the numerator criteria, beneficiaries from the initial patient population have an abdomen CT without and with contrast material or an abdomen and pelvis CT without and with contrast material counted in the measure's denominator. Doing so (for beneficiaries not excluded from the measure) may be a reflection of poor quality of care and overuse of diagnostic imaging.	• Implemented quality improvement efforts to understand and improve our performance in performing CT scans, both with and without contrast - conducted analysis to identify commonalities and trends. • Medical records examined in collaboration with our radiology and quality teams to identify scenarios where a single CT scan could replace multiple scans. • Education was provided to radiologists and referring physicians. Instituted steps to ensure timely and transparent data sharing with vested stakeholders.
Patients who had a low-risk surgery and received a heart-related test, such as an MRI, at least 30 days prior to their surgery though they do not have a heart condition (OP-13)	• Conduct analysis of the data for photon emission computed tomography myocardial perfusion imaging, stress magnetic resonance imaging, and cardiac computed tomography angiography studies performed at hospital outpatient facilities within 30 days prior to an ambulatory non-cardiac, low-risk surgery to identify process and systematic barriers

	or breakdowns, opportunities for improvement, and trends. • Feedback and education provided to invested stakeholders including providers. • Providers are to consider risk factors used to stratify patients planned for noncardiac surgeries to help estimate the cardiac risk which include but are not limited to the following: clinical predictors, functional capacity predictors, surgical risk predictors, and disease predictors. • Instituted steps to ensure timely and transparent data sharing with vested stakeholders.
Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses (OP-14) ***This measure calculates the percentage of brain CT studies performed with a simultaneous sinus CT (i.e., brain CT and sinus CT studies conducted on the same day at the same facility).***	• Conduct analysis of the data for those patients who received both brain CT and sinus CT studies performed on the same day at the same location. • Identify opportunities for improvement during the assessment of patients' conditions, related to the ordering and capturing of tests, systematic barriers, and trends. • Instituted steps to ensure timely and transparent data sharing with vested stakeholders.
How often the hospital accidentally makes a hole in a patient's lung (PSI-6 Iatrogenic Pneumothorax)	• These complications are reviewed to ensure the standard of care was met and to identify any opportunities for improvement by our quality and patient safety teams. • If deemed necessary, cases are forwarded along for peer review.
How often patients die in the hospital during or after a surgery to fix the artery that carries blood to the lower body when it gets too large (Abdominal Aortic Aneurysm)	• All mortalities are reviewed to ensure standard of care was met and to identify any opportunities for improvement. • There is a Cardiovascular Quality Program during which any complication is abstracted and pulled into a complication list and referred to Quality for review. • If deemed necessary, forwarded along for peer review.

How often patients in the hospital get a blood clot in the lung or leg vein after surgery	• Actions put into place to ensure the safety of our patients as they transition through various levels of care, including clearer protocols and standardized DVT prophylaxis order sets; staff and provider education provided regarding best practice and protocol requirements. • Opportunities for improvement included consistent documentation of and administration of prophylactic measures, including mechanical and pharmacological prophylaxis.
Abdominal Hysterectomy	• Actions put in place to reduce the incidence of abdominal hysterectomy surgical site infections included the standardization of the following: o Skin preparation process o Hair removal technique o Antibiotic prophylaxis o Closure technique o Vaginal preparation
HCAHPS	
Consumer Ratings	
How often did doctors always communicate well with patients?	• Implemented Care Team Communication Coaching for all hospitalists and physician leaders at Sinai Hospital. Cohort results to track and trend identified areas for improvement with key strategic tactics. • Key outcomes from improvement strategies include targeted communications trainings for courtesy and respect (#1 Key Impact Driver from Press Ganey). • Established the Family Communication Center as a direct dial centralized location for loved ones to receive information from a clinician regarding their patient care.
How often did staff always explain about medicines before giving them to patients?	• CAHPS 101 training for all staff regarding impact and value of each domain. • Best practice training for all nursing leaders for Nurse Leader Rounding,

	Hourly Rounding, and Bedside Shift Report.
Were patients always given information about what to do during their recovery at home?	• CAHPS 101 training for all staff regarding impact and value of each domain. Best practice training for all nursing leaders for Nurse Leader Rounding, Hourly Rounding, and Bedside Shift Report. • Post-Discharge phone calls initiated for all discharged patients to review discharge instructions and follow-up regarding concerns. • Discharge rounds conducted in tandem with care management and nursing team, often including physicians, to address discharge process, instructions and transitions of care with the patient. • These are completed on 100% of discharged patients.
How often were the patients' rooms and bathrooms always kept clean?	• Developed frontline, interdepartmental chartered workgroups tasked to address shared accountability and No Pass Zone for cleanliness and responsiveness. • Best practice training for all nursing leaders for Nurse Leader Rounding, Hourly Rounding, and Bedside Shift Report. Monthly leadership calls with EVS leadership and Patient Experience to highlight key drivers and areas of impact for cleanliness. • Weekly environmental rounds conducted by key executive leadership team to identify and address cleanliness in common areas, patient rooms, and other key clinical areas.
How often did patients always receive help quickly from hospital staff?	• Developed frontline, interdepartmental chartered workgroups tasked to address shared accountability and No Pass Zone for cleanliness and responsiveness. • Best practice training for all nursing leaders for Nurse Leader Rounding, Hourly Rounding, and Bedside Shift Report. • Established pro-active rounding on patients on all units led by the Patient Experience Team focused on addressing

	needs of patient and responsiveness to call bells, and service recovery.

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

Response:

Grace Medical Center will meet or exceed licensure standards for FMFs established by the Department of Health.

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

Response:

Grace is currently subject to the same Financial Assistance Policy as Sinai, which complies with the requirements of COMAR 10.24.10. The policy will remain in effect following the conversion. A copy of this policy is included in **Exhibit 8**.

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

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

Response:

Please see the requested information set forth in **Table 3** below.

Table 3

Grace Medical Center's Service Area Emergency Department Visits
FY2016 - FY2020

Hospital	FY2016	FY2017	FY2018	FY2019	FY2020	FY2020 Market Share	FY2016 - FY2020 Volume Change	FY2016 - FY2020 Volume % Change
St. Agnes Hospital	58,496	58,756	54,573	51,782	46,668	16.6%	-11,828	-20.2%
Sinai Hospital	45,815	42,982	41,611	40,953	36,463	12.9%	-9,352	-20.4%
University of Maryland Medical Center	46,189	47,131	45,916	43,771	33,636	11.9%	-12,553	-27.2%
Mercy	36,439	34,249	31,957	31,471	26,159	9.3%	-10,280	-28.2%
The Johns Hopkins Hospital	35,685	36,938	35,427	33,330	29,403	10.4%	-6,282	-17.6%
MedStar Union Memorial Hospital	33,804	32,819	31,616	29,563	24,579	8.7%	-9,225	-27.3%
UMMC Midtown Campus	23,525	21,461	20,686	20,403	15,941	5.7%	-7,584	-32.2%
Grace Medical Center	21,213	20,398	18,506	17,544	14,191	5.0%	-7,022	-33.1%
Others	67,478	63,951	63,585	62,587	54,854	19.5%	-12,624	-18.7%
All	368,644	358,685	343,877	331,404	281,894	100.0%	-86,750	-23.5%

Notes: Includes ED Discharges and ED Visits

Excludes normal newborns

Source: HSCRC

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

Response:

Table 3 above shows the number of visits to each of the nearby emergency departments from residents of the primary Grace service area from fiscal year 2016 through fiscal year 2020. **Tables 4 and 5a-5d** below identify the urgent care centers, primary care centers, and emergency care centers located near Grace. There are no FMFs located near Grace.

The construction plan has been designed to allow Grace to provide similar emergency and observation services following conversion to an FMF as it historically provided as an acute care hospital. While the total number of emergency room visits for the residents of Grace's service area has declined slightly over the past several years, the proportion of those visits received by Grace has remained relatively stable during this period. The consistency in Grace's market share is due, in part, to fundamental transportation barriers which limit the ability of West Baltimore residents to seek care elsewhere in the city. Many patients who visit the Grace emergency department do not have vehicles and must either walk or rely on public transportation which is notoriously unreliable and inefficient. **Tables 6a-6e** show emergency room visits to Grace for fiscal years 2016-2020 broken out by patient zip code and the manner in which the patient arrived (i.e., arrival by ambulance versus walk-in). Note that the number of the walk-in patients from the zip codes immediately surrounding Grace (particularly 21223, the zip code in which Grace is located) significantly surpasses the number of patients arriving by ambulance. Grace serves as a critical access point for these residents of the immediately surrounding neighborhoods who cannot easily travel several miles for emergency treatment at an urgent care center or another emergency department.

Table 4 - Map of Baltimore City and Surrounding Area with Driving Distance from Grace Medical Center

Table 5a – Urgent Care Centers in the Service Area

Urgent Care Center	Address	Hours of Operation	Distance to Grace Medical Center
Urgent Care University of Maryland Downtown Campus	105 Penn St. Baltimore MD 21201	Mon-Friday: 8am-8pm Sat. and Sun: Closed	1.5 miles
Express Care Urgent Care Center	3815 Wilkens Ave. Baltimore MD 21229	Mon-Sunday: 10am-8pm	2.7 miles
Concentra Urgent Care Center	1419 Knecht Ave. Baltimore MD 21227	Mon-Sunday: Open 24 hours	3.3 miles
Express Care (Sinai)	2400 Cylburn Ave. Baltimore MD 21215	Mon-Sunday: 10am-8pm	5.0 miles

Table 5b – Primary Care in the Service Area

Primary Care	Address	Hours of Operation	Distance to Grace Medical Center
Grace Medical Center Family Health and Wellness	1940 W. Baltimore St. Baltimore MD 21223	Mon-Tuesday: 8am-5pm Wed: 10am-7pm Thurs-Friday: 8am-5pm Sat.-Sunday: Closed	On the campus
University of Maryland Medical Center: Midtown Health	822 Linden Ave. Baltimore MD 21201	Mon-Wed: 7:30-5:30pm Tues-Thurs: 8am-5pm Fri-Sunday: Closed	2.2 miles

Table 5c – Federally Qualified Health Centers in the Service Area

FQHC	Address	Hours of Operation	Distance to Grace Medical Center
Total Health Care	1501 W. Saratoga St. Baltimore MD 21223 2449 Frederick Ave Baltimore MD 21223	Mon-Wed: 8:30-5pm Thursday: 8:30-12pm Friday: 8:30-5pm Mon-Friday: 8:30-5pm	0.6 miles 0.8 miles
St. Agnes Baltimore Medical System	900 S. Caton Ave Baltimore MD 21229	Mon: 9-7:30pm Tues-Friday: 8-5:30pm Sat: 9-1pm	2.2 miles
Healthcare for the Homeless	2000 W. Baltimore St. Baltimore MD 21223	Temp. closed due to Covid	On the campus
Chase Brexton Health Services	1111N. Charles St. Baltimore MD 2120	Mon-Friday: 8-5pm Sat. and Sunday: Closed	2.7 miles

Table 5d – Emergency Care Centers in the Service Area

Emergency Care	Address	Hours of Operation	Distance to Grace Medical Center
St. Agnes Hospital	900 S. Caton Ave Baltimore MD 21229	24/7	2.2 miles
University of Maryland Medical Center	22 S. Greene St. Baltimore MD 21201	24/7	2.2 miles
UMMC Midtown Campus	822 Linden Ave Baltimore MD 21201	24/7	2.2. miles
Sinai Hospital	2401 W. Belvedere Ave Baltimore MD 21215	24/7	5.0 miles

Table 6a – Emergency Room Visits July 2015 – June 2016

Zip	Walk	Ambulance
21223	3783	2182
21201	137	137
21215	305	420
21216	823	1248
21217	956	1269
21229	670	754
21230	135	276

Table 6b -Emergency Room Visits July 2016-June 2017

Zip	Walk	Ambulance
21223	3738	2125
21201	109	145
21215	331	406
21216	842	1126
21217	885	1150
21229	550	818
21230	115	224

Table 6c- Emergency Room Visits July 20 July 2017- June 2018

Zip	Walk	Ambulance
21223	3355	1774
21201	69	133
21215	294	384
21216	705	941
21217	778	1085
21229	511	708
21230	120	175

Table 6d- Emergency Room Visits July 2018-June 2019

Zip	Walk	Ambulance
21223	3328	1550
21201	79	197
21215	219	412
21216	651	934
21217	861	1135
21229	384	657
21230	82	156

Table 6e- Emergency Room Visits July 2019-June 2020

Zip	Walk	Ambulance
21223	2684	1409
21201	67	181
21215	138	306
21216	526	712
21217	565	893
21229	326	570
21230	78	126

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

Response:

As noted above, LifeBridge acquired Grace (then Bon Secours Hospital) from the Bon Secours Mercy Health System on November 1, 2019. Prior to the acquisition Bon Secours conducted a Community Health Needs Assessment (CHNA) in the spring and summer of 2019 (the "2019 CHNA"). A copy of the 2019 CHNA is included in **Exhibit 10**. Following the acquisition and the integration of Grace into the LifeBridge system, LifeBridge and Grace conducted a review of the 2019 CHNA, including the prioritization of identified needs. This review was finalized in March 2020 and an implementation plan was completed and adopted by the Board of Grace Medical Center in June 2020. The 2020 implementation plan is included as **Exhibit 11**.

Upon review of the Bon Secours CHNA and identified needs in the spring of 2020, the following identified needs were selected as priorities:

1) Behavioral Health/Substance Abuse/Opioids
2) Access to Care Providers
3) Chronic Conditions
4) Community Engagement and Development
5) Crime and Related Trauma
6) Transportation

Grace Medical Center anticipates the 2020/2021 – 2024 implementation plan will continue to address these needs. Leadership also recognizes the significant need to continue to address longstanding social determinants of health such as economic and workforce development as well as homelessness and the shortage of affordable housing within the community. Grace Medical Center envisions ongoing and supportive coordination with Bon Secours Community Works and Unity Properties to improve these conditions. Grace will also support the work of city agencies and collaborative organizations to advocate for and address additional identified needs not prioritized for its implementation plan.

The conversion of Grace Medical Center to an FMF is consistent with the community health needs assessment and the identified needs. The transition will increase access to physicians locally onsite at Grace and at Sinai. Physicians specializing in pediatric care and women's health will be onsite at Grace, as will numerous other specialty services that the community has not had

access to for many years. The FMF will provide numerous other services to meet the identified needs of the community, including the following:

- Emergency medicine services 24 hours a day, seven days a week
- Imaging and other diagnostic services support the emergency department
- Observation to treat and monitor patients to determine the need for inpatient care
- Outpatient behavioral health services
- Clinical and social services as wrap around services are onsite and embedded in the emergency department and the outpatient clinics
- Outpatient surgical suites to provide low acuity surgical procedures to the community

As noted by the latest CHNA, access to care is critical to the West Baltimore community, specifically access to primary care and specialty care necessary to address chronic conditions. Following conversion to an FMF, Grace will continue many programs designed to ensure that members of the community maintain this crucial access to care. For example, programs in the emergency department such as SBIRT and the substance abuse clinics that are located two blocks from the hospital will continue to address the substance abuse issues identified by the community. Grace will also continue to provide transportation to clinic and outpatient dialysis treatments due to the significant transportation issues facing the community.

The conversion will also allow Sinai to continue community health programs and improve community health and services within the communities that Sinai serves. These also include from Sinai "Care Happens Here" mobile unit which is part of Sinai's community efforts to go directly into communities to care for pediatric patients and patients who are homebound with multiple chronic conditions. Sinai will continue to support the clinics at Grace with telehealth support for patients needing specialty consults and behavioral health care at Grace.

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

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

Response:

As noted earlier, following the conversion, Grace will maintain the same level of emergency department services that are currently being provided. Between July 2015 and June 2020, Grace had a total of 121,402 visits which averages to 24,280 visits per year. See, **Tables 6a-6e** above. It is estimated that, following completion of the construction project, the new emergency department will receive approximately 23,500 visits per year.

The American College of Emergency Physicians, Emergency Department Design: A Practical Guide to Planning for the Future ("ACEP Guide") estimates the number of treatment spaces needed at a facility based on its anticipated number of emergency department visits. For an emergency department with 20,000 to 25,000 visits per year, the low range of the ACEP Guide recommends 14 to 18 treatment spaces total.

The existing emergency department at Grace has 25 treatment rooms, as well as 9 observation spaces which are located outside the emergency department on the third floor of the existing structure. As part of the planned renovation, the observation unit will be relocated and integrated into the new emergency department. The new combined emergency department and observation unit will contain a total of 27 treatment spaces. While this exceeds the low range guidance from the ACEP Guide, we believe the number of treatment spaces is appropriate given the incorporation of the observation unit into the emergency department, particularly considering the unique needs of the patient population served by Grace. Grace's patient population has historically required a high number of psychiatric visits and comprehensive discharge wrap around services such as care management and social work. In addition, observation or extended stay patients often have delayed discharges due to significant psychosocial needs. This level of care is critical to serving the needs of the West Baltimore community but frequently results in lengthier visits, which further supports the need for a greater number of treatment spaces in the Grace emergency department than the minimum recommendation.

(ii) Demonstrate that the building gross square footage is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrated the need for additional building gross square footage.

Response:

The gross square footage of the emergency department including the observation and psychiatric holding areas is 15,300 square feet. The ACEP Guide low range estimates of required square footage for a newly constructed or freestanding emergency department with 20,000 to 25,000 visits per year is 14,438 to 18,563 square feet, so the proposed square footage of the new Grace emergency department is consistent with ACEP guidance. Given the fact that the new emergency department is being constructed in a new location (as opposed to renovating the existing emergency department in its current space) and the existing emergency department will be completely demolished following completion of the project, we felt that the ACEP guidance for new construction and freestanding emergency departments was the appropriate benchmark to use in this case, rather than the estimates for renovation of internal space.

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

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

Response:

The ACEP Guide does not provide a projection regarding need for the number of treatment space. Instead the ACEP Guide instructs that its author "generally program(s) (clinical decision or observation) spaces in the range of 900 to 1,100 visits per space annually. Use the lower number if your patients use the space for 12+ hours and use the higher number if your patients use the space for 8 to 12 hours." The average observation case at Grace is 39.8 hours or 1.66 days. The expected length of stay of 1.66 days or 40 hours for observation cases at Grace is five times longer than the roughly 8 hour average stay necessary to achieve the ACEP recommendation of 1,100 visits per observation space per year. Therefore, the ACEP recommendation is not a practicable guideline for the FMF given the needs of Grace's patient population.

As indicated in **Table 7** below, for fiscal year 2020 Grace had 962 observation cases with a total of 39.8 hours per case and a total of 1,596.79 observation days. While the projected need for observation beds for the unit is 6.25 (based on a 70% occupancy rate), the level of need is not constant and additional spaces are necessary to ensure that Grace can accommodate times of peak demand. In addition, Grace Medical Center's population often requires wrap around services prior to discharge from observation, including counseling, drug addiction therapies and socioeconomic support services, which leads to significant variability in the length of stay for observation cases, further exacerbating the unpredictability of need for spaces. Of the nine total observation areas in the new emergency department, three will be observation lounges instead of beds. These lounge areas are more efficient and cost effective than the observation beds, and the additional spaces will provide flexibility to mitigate the need to potentially transfer patients who require observation care at times of high demand.

Table 7: Grace Medical Center Observation Cases and Hours

FY19 Grace Medical Center Observation Cases and Hours
Patient Origin: ALL

Bed Need Calc	Grace Medical Center
FY2019 Observation Cases	962
FY2019 Observation Hours	38,323
Average Hours Per Case	39.84
Observations Days	1,596.79
Observation Average Daily Census	4.37
Occupancy Target	70%
Projected Observation Bed Need	6.25

Source: LBH Finance

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

Response:

Each of the nine observation spaces measure 100 square feet or less.

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

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

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

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

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

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

Response:
Enclosed as **Exhibit 1**, Applicants have completed Tables A-H and L, which show the projected shift of inpatient admissions from Grace Medical Center to Sinai, as well as the projected utilization and financial performance of Sinai inclusive of the FMF, which will become a department of Sinai following the conversion.

- Tables F, G and H show the utilization and financial performance of Sinai and Grace, individually and on a combined basis, for fiscal years 2019 and 2020, as well as the projected utilization and financial performance (inflated and uninflated) for fiscal years 2021 through 2024. In Table F, the Grace projections for emergency department visits are consistent with historical trends in emergency department visits for the FMF's service area. In prior years Grace Medical Center saw on average 22,000 visits; the projections in Table F assume a fairly conservative increase in the utilization of the emergency department to 23,500 visits per year by the end of the projected timeframe. These projections are supported by the increase in visits that Grace has experienced since opening the new emergency department in January 2021. On average, the emergency department has received over fifty visits per day during such time, with some days exceeding sixty visits. Projections for rate-regulated outpatient services assume a decline due to the Department of Corrections contract termination in January 2021. However, it is also anticipated that over time, with a renovated facility providing appropriate community-based services, that there will be expansion of utilization by commercial payers. Under guidance by the HSCRC, the Health-General Article 19-201(d)(iv) and COMAR 10.37.10.07-2, the revenue estimates are consistent with the utilization projections for both Sinai and Grace. According to these projections, the combined operations of Sinai and Grace will generate positive net income by fiscal year FY22, while Grace, individually, would generate a net loss during the same timeframe.
- The projected revenue in Table H reflects the utilization projections presented above and the 2019 regulated Global Budget Revenue (GBR) assumptions related to update factors, demographic adjustments, revenue variability, and uncompensated care. With Grace Medical Center converting to a free standing medical facility, the assumptions for the projections are focused on emergency room visits, outpatient surgery, observation and other ancillary services associated with supporting an emergency department. Each assumption is based upon payment policies related to GBR and reimbursement policies by payers. Further explanation of the assumptions is included in Table H.
- Table L incorporates the workforce for Grace Medical Center emergency department, surgical suites and other ancillary services. Included are full-time equivalent employees

(FTE's) dedicated to the provision of services to patients in the emergency department and patients receiving outpatient surgical services. The presentation of projected staffing at Grace Medical Center in Table L, reflects the changing volumes presented above and assumptions related to expense inflation, expense variability with changes in volumes and one-time adjustments to the projection of staffing and expense when Grace Medical Center converts from an acute hospital to a free standing medical facility, which is assumed to occur in fiscal year 2022. The staffing assumptions, projections and workforce redevelopment in Table L are based upon current and projected utilization of Grace Medical Center.

- Table H shows an increase in salaries and wages for Sinai during the projected timeframe, which reflects the anticipated reallocation of staff from Grace to Sinai as a result of the conversion. As further described in the transition plan, the Applicants are highly focused on providing job retraining for Grace employees who would be displaced by the conversion, which will allow such employees an opportunity to find positions elsewhere within the LifeBridge Health system.

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

Response:

Grace Medical Center has two outpatient operating rooms that are utilized for limited outpatient surgical procedures. Due, in part, to the impact of COVID-19 and the ongoing construction at Grace, the operating rooms are currently running two days a week ten hours each day. However, it is projected that additional hours and days will be added to the schedule in order to meet increasing demand as the pandemic comes to an end and construction at the facility is completed. We also anticipate that the expansion of ambulatory care services primary and specialty care at the facility following the renovations will further increase demand for operating room capacity.

As an acute care hospital, Grace Medical Center had historically maintained seven operating rooms for inpatient and outpatient surgical treatments. While the conversion to an FMF necessitates a reduction in the number of operating rooms at the facility, access to outpatient surgical treatment remains a critical need for the underserved community in West Baltimore. In meetings with Grace and LifeBridge leadership, community leaders frequently expressed concerns about the negative impact that the elimination of such services would have on the health outcomes of local residents. Maintaining these outpatient operating rooms will allow Grace to continue to support the community by providing essential services such as AV fistulas for dialysis wound debridement and simple orthopedic surgeries and colonoscopies.

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

Response: The proposed construction cost of Grace Medical Center is reasonable and consistent with industry cost experience in Maryland as reflected by the Marshall Valuation Service (MVS) benchmark calculation presented below. The actual cost per square foot to renovate the 92 Wing is well below the MVS estimate for such renovation, as demonstrated below:

Marshall Valuation Service Calculation
GRACE MEDICAL
Renovation

I. The Marshall Valuation Service Estimate

Type			Hosp
Construction Quality / Class			Good / A
Stories			5
Perimeter			680
Height			11.40
Square Feet			92,078
Average Floor Area			18,416
A. Base Costs			
	Basic Structure		$374.00
	Elimination of HVAC Cost for Adjustment		$0.00
	HVAC Add-on for Mild Climates		$0.00
	HVAC Add-on for Extreme Climates		$0.00
Total Base			$374.00
B. Additions			
	Elevators (if not in base)		0
	Sprinkler Amount		$3.15
	Subtotal		$3.15
Total			$377.15
C. Multipliers			
Perimeter Multiplier			0.932
	Product		$351.50
Height Multiplier			1.000
	Product		$351.50
Multi-story Multiplier (0.5% / story above 3)			1.00
	Product		$351.50
D. Update / Location Multipliers			
Update Multiplier			1.03
	Product		$362.04
Location Multiplier			1.02
	Product		$369.28
Final MVS Square Foot Cost Estimate			**$369.28**

II. The Project

A. Base Calculations	**Actual**	**Per Sq. Ft.**
Renovation	$23,175,000	$251.69

Site Preparation		$0.00
Architectural Fees	$2,225,000	$24.16
Permits	$100,000	$1.09
	$25,500,000	$276.94

The proposed construction cost for the new outpatient behavioral health facility in Phase Two is also reasonable and consistent with industry standards for Maryland. As set forth in the table below, the MVS estimate for such new construction is $454.79 per square foot, while the actual costs for the new construction will be $436.99 per square foot. After taking into account expenses relating to site preparation, architectural fees and permits, the total cost will be $513.82 per square foot, but the MVS estimate does not take those expenses into account, so the appropriate comparison is between the MVS estimate and the "New Construction" row in Part II of the table.

Marshall Valuation Service Calculation
GRACE MEDICAL
New Construction

I. The Marshall Valuation Service Estimate

Type		Hosp
Construction Quality / Class		Good / A
Stories		2
Perimeter		428
Height		12'
Square Feet		24,600
Average Floor Area		12,300
A. Base Costs		
	Basic Structure	$374.00
	Elimination of HVAC Cost for Adjustment	$0.00
	HVAC Add-on for Mild Climates	$0.00
	HVAC Add-on for Extreme Climates	$0.00
Total Base		$374.00
B. Additions		
	Elevators (if not in base)	$0.00
	Sprinkler Amount	$3.96
	Subtotal	$3.96
Total		$377.96
C. Multipliers		
Perimeter Multiplier		1.146
	Product	$433.14
Height Multiplier		1.000
	Product	$433.14
Multi-story Multiplier (0.5% / story above 3)		NA
	Product	
D. Update / Location Multipliers		

Update Multiplier	1.03	
Product	$446.13	
Location Multiplier	1.02	
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	$32.11
Architectural Fees	$950,000	$38.62
Permits	$150,000	$6.10
	$12,640,000	$513.82

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

Response:

As shown in **Tables 5a-5d**, there are several urgent care centers, primary care offices, FQHC's and emergency departments located within five miles of Grace. However, with local hospitals already strained by heavy demand, their emergency departments could not effectively absorb the more than 22,000 visits currently seen at Grace without significant degradation of their service levels. In addition, the closest emergency departments are over two miles from Grace. Given the distance to these other emergency departments, Grace fills a critical need as a local destination for high-priority trauma patients with life-threatening conditions to be stabilized, even if they are ultimately transferred for admission to an acute care hospital. Further, due to the number of walk-ins to the Grace emergency department (as demonstrated in **Table 6**) and the lack of consistent public transportation in the service area, it is essential for this population to have access to emergency care in the neighborhood.

The provision of emergency services twenty-four hours per day, seven days a week is critical to the residents of West Baltimore. Due to their limited hours of operation and lack of lifesaving expertise and equipment, local urgent care and primary care simply cannot provide an alternative for patients experiencing a medical crisis, particularly after customary business hours. Additionally, in fiscal year 2018, patients with Medicaid, Medicaid HMO, Medicare, dual eligible, self-pay or charity care accounted for over 93% of emergency department visits at Grace. As unregulated facilities, the urgent care and primary care centers would not have the financial means to absorb such a high volume of patients without commercial payors.

The conversion will allow Grace to serve as a local access point for care in an underserved community, which will increase efficiency, better address the needs of West Baltimore residents and reduce disparities in health outcomes. The population served by Grace faces high levels of chronic disease which can significantly increase health care costs if such conditions are not

properly managed. The on-site outpatient clinics at Grace will provide a convenient location for community members suffering from chronic conditions to receive preventative care, leading to better outcomes for those patients and ultimately reducing the need for expensive hospital stays in the future.

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

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

Response:

As shown in **Table 9** below, between fiscal years 2016 and 2020, Grace saw a decline in its inpatients of 52.1% while the state of Maryland only declined by 9.4%. As previously noted, prior to the acquisition of Grace by LifeBridge, this severe decline in inpatient utilization created such a financial hardship that BSMH (Grace's former corporate parent) considered permanently closing the hospital. The closure of the hospital would have created a larger gap in the disparities in health outcomes by further reducing access to health care services for the community of West Baltimore. However, while continuing to operate as a 69 licensed bed hospital is no longer a viable financial option, converting to an FMF that is appropriately sized to meet the needs of the community would result in a more efficient delivery of care and allow Grace to maintain crucial access to health services in West Baltimore.

Table 9

Grace Medical Center vs. Statewide Trends
FY 2016 - FY 2020

Grace Medical Center

Discharge Service Line	FY16	FY17	FY18	FY19	FY20	FY2016 - FY2020 Change	FY2016 - FY2020 % Change
Medical/Surgical	3,383	3,325	2,829	2,634	1,372	-2,011	-59.4%
Womens Health and Newborns	12	7	9	9	4	-8	-66.7%
Psychiatry	1,815	1,473	1,381	1,265	1,106	-709	-39.1%
Others	7	13	16	8	21	14	200.0%
Rehabiliatation	7	0	0	0	0	-7	-100.0%
Total	5,224	4,818	4,235	3,916	2,503	-2,721	-52.1%
Year-over-Year % Change	-14.96%	-7.77%	-12.10%	-7.53%	-36.08%		-52.1%

Statewide Acute Care Hospitals

Discharge Service Line	FY16	FY17	FY18	FY19	FY20	FY2016 - FY2020 Change	FY2016 - FY2020 % Change
Medical/Surgical	579,991	582,357	574,731	566,636	519,698	-60,293	-10.4%
Womens Health and Newborns	113,259	113,179	114,863	112,659	109,549	-3,710	-3.3%
Psychiatry	45,019	44,692	42,980	44,284	40,432	-4,587	-10.2%
Others	1,881	1,962	1,981	2,222	2,347	466	24.8%
Rehabiliatation	2,951	1,936	2,056	1,571	1,515	-1,436	-48.7%
Total	743,101	744,126	736,611	727,372	673,541	-69,560	-9.4%
	-1.69%	0.14%	-1.01%	-1.25%	-7.40%		-9.4%
Grace Medical Center vs Statewide % Change	-13.27%	-7.91%	-11.09%	-6.28%	-28.68%		-42.73%

Notes: Exlcudes Normal Newborns

Includes discharges and observation cases

Discharge service line defined by DRG

Source: HSCRC

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

Response:

Table 10

Comparison of Grace Medical Center Operating Margin to Statewide Financial Performance
FY2015 – FY2019

	Total Operating Margin					
Total Operating Margin Trend	FY2015	FY2016	FY2017	FY2018	FY2019	FY2015-FY2018 Change
Grace Medical Center	7.41%	-1.36%	-1.65%	-0.35%	NA*	-7.76%
Statewide Acute Care Hospitals	3.54%	3.29%	2.86%	3.35%	2.10%	-0.19%
Variance	3.87%	-4.65%	-4.51%	-3.70%		-7.57%

Notes:
Legacy Bon Secours has not filed FY 2019 information
FY 2015-FY2019 Acute Care Facilities Only
From HSCRC Annual Filings and Governor's Report

Between fiscal years 2015 and 2018, Grace's operating margin has ranged from 7.4% to -1.65% and Grace has not had a positive operating margin since fiscal year 2015. The statewide hospital performance ranged from 3.54% to 2.86% over the same period. The continued decline in operating margin at Grace is not in the public's interest as it threatens the financial viability of Grace as a general hospital and will greatly impact the quality of clinical care in the West Baltimore community.

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

Response:

While there are several buildings on the hospital campus that were constructed more recently, the original Bon Secours Hospital was built in 1919, which means that a portion of the physical plant is over 101 years old. Prior to the acquisition of Grace, LifeBridge Health engaged the engineering firm JMT to study the hospital facilities. The engineers determined that the physical plant is generally beyond its useful life and must be demolished, except for the portion of the main hospital contained in the 1992 Wing. In addition to any structural concerns, the age of the physical plant has a significant impact on the functionality of the facility. The existing emergency department does not have an observation unit as part of the floor plan so patients must be sent to another floor for observation. The existing hospital patient care spaces do not meet the FGI Guidelines. Except for the 92 Wing, all other buildings on the campus would need to be demolished and rebuilt to satisfy these standards. Based upon the current hospital project costs the estimated cost for new construction would range from $600-$750 per square feet. This estimate includes site work and infrastructure.

In order to reduce construction costs, Grace has elected to relocate the emergency department to the 92 Wing, which also has sufficient square footage to allow for the observation unit to be integrated into the emergency department. The estimated cost for the renovations required to build out the emergency department and observation unit in the 92 Wing is $294 per square foot. The existing emergency department measures 12,616 sq. ft. and the new emergency department (including the observation unit) measures 18,154 sq. ft. The renovations will alleviate many of the functional issues with the existing physical plant, as the new emergency department was designed in accordance with FGI Guidelines and incorporates the most current edition of the ACEP Guide. Further, the redesigned emergency department will include features that the existing facilities lack, such as all private treatment rooms with walls and doors, which will dramatically improve patient experience.

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

Response:

All current outpatient services currently provided by Grace will continue following the conversion, though any unregulated outpatient services will not be part of the FMF for licensure purposes. These unregulated outpatient services include primary care, specialty care, outpatient dialysis, outpatient behavioral health programs, and substance abuse clinics. Acute care inpatient services, such as stroke, or intensive care services, are no longer provided by Grace and are currently being provided by other acute care hospitals in the area. Patients arriving at Grace in need of such services are generally transported to Sinai, but have also been transported to Northwest Hospital, University of Maryland Medical Center, Johns Hopkins Hospital or Mercy Medical Center.

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

Response:

The conversion of Grace to an FMF is in the public interest taking into consideration the adequacy and appropriateness of the transition plan. Prior to the acquisition of Grace, senior leadership of LifeBridge and Sinai met with community leaders and regulators with a goal of rethinking the delivery of care in West Baltimore. Based on these discussions, the LifeBridge team determined that the best way for Grace to meet the needs of the community was to shift from a model that prioritized expensive inpatient services to one that sought to expand access to health care through the delivery of high-quality outpatient services. The transition plan was developed with this overarching goal in mind.

Due to the inherent challenges of providing inpatient services in a facility that had long surpassed its useful life, Grace had historically suffered from quality and efficiency issues that ultimately jeopardized the economic viability of the hospital. As laid out in the transition plan, Grace will narrow its focus going forward, concentrating on services that are desperately needed within the community, including primary care, specialty care, and an emergency department that

operates 24/7. Prioritizing ambulatory care over costly inpatient care in this manner will reduce inefficiencies, improving Grace's financial condition and allowing it to offer essential services that the community has historically lacked, such as pediatric and women's health services. By improving access to these community-based services, the FMF will support proactive care for residents of the service area and allow greater opportunities for providers to identify cases where a higher level of care is needed. When such a need arises, members of the West Baltimore community have access to a number of high-quality inpatient facilities in the areas immediately surrounding Grace.

In addition to the prioritization of outpatient services over inpatient care, the transition plan focused on the development of modern, state-of-the-art facilities to replace the obsolete hospital physical plant and allow for more effective and efficient delivery of health care services. The plan also included a job placement strategy to ensure that employees whose positions would no longer be required at Grace following the realignment of services would have the opportunity to find a job elsewhere in the LifeBridge system.

Below is a high-level summary of the transition plan, including a detailed listing of the services to be provided by Grace following the conversion. The full transition plan is included in **Exhibit 2**.

Provision of Acute Care Services

As a freestanding medical facility, Grace will 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
- SBIRT 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.

Outpatient Dialysis
Other services continuing at Grace include the 35-chair outpatient dialysis center that will continue to provide dialysis and nephrology care. Grace currently takes all outpatient dialysis patients regardless of their ability to pay and assists those uninsured patients with applying 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 Grace is expanding the program to add 6 additional hemodialysis 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 plan which focuses 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 will continue endocrinology services to address diabetes and metabolic conditions and a licensed diabetes educator will provide diabetes education services. Other specialties Grace is planning include vascular surgery, orthopedics, podiatry, urology, neurology, ophthalmology, wound care, general outpatient surgical services, gastroenterology, and cardiology. These services can be delivered in the clinic setting as well as emergency and outpatient settings.

Plan for Job Retraining and Placement of Grace Medical Center Employees

Since the acquisition of Grace, 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 health system. The LifeBridge Health alignment with Grace will be of great benefit to the community, as well as the employees of Grace. A benefit to joining LifeBridge Health is access to greater opportunity for employment, as well as opportunity for career growth. Prior to the acquisition of Grace by LifeBridge on 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 hospitals. Employees who worked at Grace in critical care and medical surgical areas were invited to the career fair and invited to shadow clinical peers in the departments of their choosing. In advance of the relocation of inpatient behavioral health services to Sinai and Northwest, Grace provided similar opportunities for the behavioral health staff.

LifeBridge Health human resources and clinical leadership are proactively identifying open positions across the 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. The team has met frequently to discuss openings in the broader system and provide cross training opportunities.

Please see **Exhibit 2** for the full transition plan.

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

Response:

Based on the projections set forth in **Exhibit 1**, **Tables F and H**, Sinai and Grace will combine to generate positive net income within the first three years following the conversion of Grace Medical Center to an FMF, while Grace would continue to post operating losses on its own. As an acute care hospital, Grace faced significant economic hardship and was in danger of being forced to permanently close its doors. The conversion to an FMF will ensure Grace's financial viability and allow it to remain a critical access point for health care services in the West Baltimore community.

Conclusion

For all of the reasons set forth above, Grace Medical Center, Inc. and Sinai Hospital of Baltimore, Inc. respectfully request that the Commission authorize and approve the conversion of Grace Medical Center to a freestanding medical facility and associated capital expenditures.