IN THE MARYLAND HEALTH CARE COMMISSION

Matter No. 17-12-EX004

REQUEST FOR EXEMPTION
FROM CERTIFICATE OF NEED REVIEW

to
Convert UM Harford Memorial Hospital
to a Freestanding Medical Facility

Joint Applicants

UM Upper Chesapeake Medical Center, Inc. and
UM Harford Memorial Hospital, Inc.

October 21, 2019

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TABLE OF CONTENTS

Page

BACKGROUND **1**

I. COMPREHENSIVE PROJECT DESCRIPTION **8**

II. COMAR 10.24.19.04A(1)-(4) **8-9**

A. 10.24.19.04(A)(1). **8**

B. 10.24.19.04(A)(2) **8-9**

C. 10.24.19.04(A)(3) **9**

D. 10.24.19.04(A)(4) **9**

III. COMAR 10.24.19.04C(1)-(8). **9-67**

A. 10.24.19.04(C)(1) **9**

B. 10.24.19.04(C)(2) **9**

C. 10.24.19.04(C)(3) **10-13**

D. 10.24.19.04(C)(4) **13**

E. 10.24.19.04(C)(5) **13-21**

F. 10.24.19.04(C)(6) **21**

G. 10.24.19.04(C)(7) **21**

H. 10.24.19.04(C)(8) **21-67**

IV. **CONCLUSION** **68**

IN THE MATTER OF CONVERSION OF	*	BEFORE THE
UM HARFORD MEMORIAL HOSPITAL	*	MARYLAND HEALTH
HOSPITAL TO A FREESTANDING	*	CARE COMMISSION
FACILITY	*	

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MODIFIED REQUEST FOR EXEMPTION FROM CERTIFICATE OF NEED REVIEW FOR THE CONVERSION OF UM HARFORD MEMORIAL HOSPITAL TO A FREESTANDING MEDICAL FACILITY

University of Maryland Upper Chesapeake Medical Center, Inc. ("UCMC") and University of Maryland Harford Memorial Hospital, Inc. ("HMH") as joint applicants, by the undersigned counsel, seek approval from the Maryland Health Care Commission (the "Commission") to convert HMH to a freestanding medical facility. For the reasons set forth more fully below, UCMC and HMH respectfully request that the Commission grant an exemption from Certificate of Need ("CON") review for the conversion of HMH to a freestanding medical facility and for associated capital expenditures.

BACKGROUND

HMH is an acute care hospital with fifty-one (51) licensed MSGA beds and thirty-one (31) licensed psychiatric beds located in Havre de Grace. UCMC is a 161-bed licensed acute care hospital, with 149 MSGA beds, 10 obstetrics beds, and 2 pediatric beds located in Bel Air. HMH and UCMC are the sole acute general hospitals located in Harford County. Both HMH and UCMC are owned and operated by the University of Maryland Upper Chesapeake Health System ("UM UCH"), a community based, not-for-profit health system. UM UCH is dedicated to maintaining and improving the health of the people in the communities it serves through an integrated health delivery system that provides the highest quality of care to all. UM UCH has been affiliated with the University of Maryland Medical System ("UMMS") since 2009, and in late 2013, UM UCH formally merged into UMMS in order to continue its commitment to the growing northeast Maryland area with expanded clinical services, programs and facilities, and physician recruitment. In addition to HMH and UCMC, UM UCH consists of the: (1) Patricia D. and M. Scot Kaufman Cancer Center (an affiliate of the University of Maryland Marlene and Stewart Greenebaum Cancer Center) located on the campus of UCMC; (2) the Klein Ambulatory Care Center located on the campus of UCMC; (3) the Senator Bob Hooper House, a residential hospice facility in Forest Hill; and (4) Upper Chesapeake Medical Services, a physician practice group.

HMH was constructed in phases between 1943 and 1972. Although UM UCH has been committed to maintaining the facility and has undertaken capital expenditures to make infrastructure, clinical equipment, and information technology improvements, the existing physical plant has outlived its useful life. As discussed more fully herein, renovation of the facility

is not cost-effective and the nine (9) acre site in downtown Havre de Grace is surrounded by existing developed parcels, limiting a practical opportunity for renovation or expansion. Relocation of HMH as acute general hospital was considered but determined not to be cost effective and was viewed disfavorably by both staff of the Maryland Health Care Commission Staff and the Health Services Cost Review Commission ("HSCRC").

Consistent with local and national healthcare trends and to best promote access to convenient and quality care for the population it serves, UM UCH proposes to transition portions of HMH to a multi-service facility to be located on an approximate 35.63 acre property known as the Upper Chesapeake Health Medical Campus at Aberdeen ("UC Medical Campus at Aberdeen"), approximately four and four-fifths (4.8) miles from the existing HMH campus and conveniently located near Interstate 95. In accordance with recently enacted legislation and corresponding regulatory changes, UCMC and HMH, as joint applicants, seek to convert HMH to a freestanding medical facility ("FMF") to be developed at the UC Medical Campus at Aberdeen. As described in this request, the proposed project resulting from the conversion of HMH to an FMF is referred to as "UC FMF." Contemporaneous with this modified request for exemption from CON review, UM UCH has filed an application for a Certificate of Need to establish a thirty-three (33) bed special psychiatric hospital to be located on the UC Medical Campus at Aberdeen, which will be located above UC FMF. Additionally, HMH and UCMC, as joint applicants, have also filed a modified Request for Exemption from CON review to relocate MSGA beds from HMH to UCMC and to incur capital expenditures as part of a merger and consolidation of these two facilities.

DISCUSSION

For some time, several acute general hospitals in Maryland have been exploring options to reconfigure and modernize facilities in the face of aging physical plants, declining utilization for acute inpatient admissions, while recognizing the continued need to provide high quality and effective care to the communities they serve. Through legislation, Chapter 420, Acts of 2016 (Senate Bill 707), the General Assembly elected to use the FMF as the preferred facility type for the conversion of acute general hospitals by amending MARYLAND CODE HEALTH-GENERAL to: (1) authorize a CON exemption process for conversion of an existing hospital to an FMF along with associated capital expenditures; and (2) authorize the HSCRC to regulate rates for outpatient services in an FMF, including observation services and ancillary services needed to support emergency and observation services. As contemplated by this enactment, acute general hospitals converting to FMFs are authorized to provide a much broader array of services in order to treat patients with more complex and more acute health care needs than the three currently established Maryland FMFs, none of which converted from an acute general hospital. The existing FMFs in Maryland lack many of the capabilities that hospitals converting to FMFs will require to continue to serve the converting hospital's community. Otherwise, hospital conversions to FMFs or hospital closures will leave substantial gaps in health care services needed by communities formerly served by a hospital. This is particularly true with respect to HMH which has served the residents of Harford and Cecil Counties for more than one hundred years.

Pursuant to amended HEALTH-GENERAL § 19-120 and the State Health Plan Chapter for Freestanding Medical Facilities, COMAR 10.24.19 (the "State Health Plan"), an acute general hospital may convert to a freestanding medical facility if it follows certain procedures and demonstrates that: (1) the conversion is consistent with the State Health Plan; (2) the conversion

will result in the delivery of more efficient and effective health care services; and (3) the conversion is in the public interest. For the reasons set forth more fully below, the proposed conversion of HMH to UC FMF satisfies each of these criteria. Accordingly, UCMC and HMH request that the Commission grant an exemption from CON review to permit the conversion of HMH to a freestanding medical facility and for associated capital expenditures.

HMH's conversion to UC FMF is part of UM UCH's plan to create an optimal patient care delivery system for the future health care needs of Harford and Cecil County residents, which comprise a population of approximately 360,000. The applicants propose to locate UC FMF on the UC Medical Campus at Aberdeen, an approximate thirty-five (35) acre parcel. The services at UC Medical Campus at Aberdeen will be organized around two (2) main components: (1) UC FMF, an approximate 69,343 departmental gross square feet building located on the first floor; and (2) the Upper Chesapeake Health Behavioral Health Pavilion ("UC Behavioral Health"), an approximate 74,892 departmental gross square feet special psychiatric hospital located on the second floor. The combined total gross square footage of these components is approximately 144,235 departmental gross square feet.[1]

Table 1 below reflects the square footage of both UC FMF and UC Behavioral Health, with shared space allocated 49% to UC FMF and 51% to UC Behavioral Health.

Table 1
Department Gross Square Footage UC FMF and UC Behavioral Health

	UC Behavioral Health	UC FMF	Total
Dedicated Departmental Square Footage	61,417	56,395	116,336
Shared Space Allocation	13,475	12,948	26,423
Shared Space Allocation %	51%	49%	100%
Total Gross Departmental Square Feet Consistent with Table B	74,892	69,343	144,235

[1] The overall 69,343 gross square feet allocated to UC FMF includes 56,395 departmental square feet dedicated to UC FMF and a 49% allocation of 26,423 gross square feet of public and administrative space that will be shared between UC FMF and UC Behavioral Health. Accordingly, an additional 12,948 square feet of space to be shared between UC FMF and UC Behavioral Health (49% of 26,423) has been allocated to the proposed project. The allocation of shared space between the UC Behavioral Health and the UC FMF was calculated pro-rata based on the gross square foot size of each facility.

As mentioned above and in accordance with recent statutory changes allowing hospital conversions to FMFs, UM UCH's planned FMF will be much different than the three existing Maryland FMFs. UC FMF will be a fully functional, full service emergency department, open twenty-four (24) hours per day, seven (7) days per week with the capability of caring for patients categorized in EMS priority levels 2 through 4 as well as EMS priority level 1 patients who suffer from either an unsecured airway, who are in extremis, or who suffer from a stroke if an accredited Primary or Comprehensive Stroke Facility is greater than 15 additional minutes.[2] UC FMF will have the ability to rapidly transfer those who cannot be definitively cared for at the facility via a dedicated, onsite ambulance unit and ground helipad (located at UC FMF) with proximity to several hospitals and tertiary centers.

UC FMF will include the following features:

1. A main public/ambulatory entry and waiting area with two (2) public toilets;

2. An emergency department with twenty-five treatment spaces consisting of:
   a) 4 standard emergency treatment rooms;
   b) 6 standard flex/hold treatment rooms, which have the ability to convert to secure holding rooms for behavioral health patients by utilizing a rolling door to cover medical equipment and any ligature points to the extent the behavioral health crisis treatment spaces are occupied;
   c) 5 emergency treatments spaces specifically designed for geriatric patients, which include a quieter zone, enhanced lighting, a soft rubber backed flooring, and geriatric visitor chairs;
   d) 1 SAFE or S.A.N.E. room, which will be used for patients who have experienced a rape, assault, or criminal related injuries and who require appropriate treatment and testing equipment available within this specialty room;
   e) 2 resuscitation rooms and 2 isolation rooms; and
   f) A behavioral health crisis unit with four (4) standard exam rooms, as well as a seclusion room that will be used in for patients who have emotional responses

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[2] Until only recently, Maryland Institute for Emergency Medical Services Systems ("MIEMSS") jurisdictional protocols only permitted EMS providers to transport stable patients categorized as priority 3 or 4 who did not need time-critical intervention to the FMFs located at Bowie and Germantown with certain limited exceptions. *See* MIEMSS, The Maryland Medical Protocols for Emergency Medical Services Providers Protocols at 417 (July 1, 2016). Thus, until July 1, 2017, EMS providers were only permitted to transport patients who either did not require medical attention at all or who suffered from non-emergent conditions to two of the three existing FMFs in Maryland. *See* MIEMSS, The Maryland Medical Protocols for Emergency Medical Services Providers Protocols at 35 & 355 (July 1, 2017).

that are poorly modulated and who pose a threat to themselves or others in the unit (including staff) such that temporary seclusion provides an effective means to protect the patient and others while the patient receives medical attention, 2 patient toilets, and related staff and support spaces.

3. An observation suite with seventeen (17) patient rooms, each having its own private toilet, and related staff and support spaces;

4. A diagnostic imaging suite with x-ray, ultrasound, CT, MRI, and cardiac and vascular ultrasound modalities and related staff and support spaces;[3]

5. Non-treatment space, including three triage rooms, two blood draw rooms, a decontamination area, a room for law enforcement, a separate room for UC FMF's security team,

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[3] UC FMF will require an MRI in its imaging department for three main reasons. First, the EMS Acute Stroke Ready pilot program applicable to UC FMF and described more fully below will lead to UC FMF obtaining Acute Stroke Ready Joint Commission Accreditation, which will allow EMS providers to transport patients suspected of stroke to UC FMF. These patients must be within the 4.5-hour window from "last known normal." The AHA/ASA 2013 Guidelines for the Early Management of Patients With Acute Ischemic Stroke Regarding Endovascular Treatment published in coordination between the American Health Association and American Stroke Association ("AHA/ASA Guidelines") require that a facility must offer CT or MRI at all times. For the system to be high reliable, however, there must be a secondary mode of imaging a suspected stroke patient should the CT undergo repair or maintenance. Additionally, when evaluating a patient with a suspected stroke that may qualify for tPA, there are patients that may be a stroke mimic that can be ruled in or out by a diffusion weighted MRI (DW-MRI).

Second, there is a need for an MRI at UC FMF to treat any patient with Transient Ischemic Attack ("TIA") or suspected stroke. MRI is superior to CT to identify acute ischemic stroke as per the AHA/ASA Guidelines in 2010 and 2013. A very large patient population may show a focal neurologic deficit. When this occurs and is transient, it will require an MRI. The emergency department TIA pathway requires an MRI so that clinicians can safely discharge the patient from the emergency department with additional outpatient testing. If discharge from the emergency department is not possible, these patients can be admitted to the observation unit for evaluation that would include an MRI. Lack of an MRI would result in an increase in transfers that would result in observation stays less than 23 hours and would put the stroke patient "in the window" at risk with only one modality to evaluate stroke.

Lastly, back and cervical pain is a common chief complaint for emergency department patients. Some patients will have intractable pain that is resistant to analgesia. In such UC FMF cases, MRI imaging will be performed to determine the reason for the intractable pain and inability to ambulate. Once the anatomy is determined with an MRI, clinicians can focus on analgesia and anti-inflammatories. If a patient has a history of intravenous drug abuse, there is a high risk for an epidural abscess that can only be diagnosed with an MRI of the spine. Lack of an MRI would result in unnecessary transfers for patients that would only require an MRI and no other interventions, while having MRI capability at UC FMF would eliminate unnecessary inter-facility transfers.

rooms for family consultation, and offices for emergency department physicians and leadership, one of which will be used for telemedicine;

6. A laboratory and pharmacy; and

7. Administration and staff support spaces.

Submitted herewith as **Exhibit 2** are drawings of UC FMF's floor plan with the number of treatment spaces in the emergency department, the behavioral health crisis unit, and the observation unit sequentially numbered in each respective department.

Also as reflected on **Exhibit 2**, UC FMF's observation unit includes seventeen (17) observation rooms comprised of seventeen (16) standard patient rooms and one (1) isolation suite. The isolation suite includes three (3) sub-rooms including a patient isolation ante room, an isolation toilet, and the actual patient isolation room. The observation isolation suite will be utilized for patients suspected of having an active infection that requires isolation during continued testing and monitoring.

Dietary and dining services will be located on the ground floor, below UC FMF in space to be shared between UC FMF and UC Behavioral Health. Shared public toilets will also be included on the ground floor to serve patients and visitors to both UC FMF and UC Behavioral Health. Also included on the ground floor to be shared between UC FMF and UC Behavioral Health will be administration, information technology, support services, including materials management and a loading dock, mechanical, electrical, and plumbing spaces, environmental services, medical gas, and linen storage.

UC FMF's emergency department will be staffed by Board Certified Emergency Medicine physicians and nursing staff specializing in emergency medicine with up to forty (40) hours of emergency physician and twelve (12) hours of emergency Advanced Practice Clinicians per day. The observation unit at UC FMF will be staffed by hospitalists. Additionally, the five-bed behavioral health crisis center will be staffed by personnel specializing in the diagnosis and treatment of patients suffering from psychiatric conditions. Specialty services currently not on-site at HMH would remain at UCMC and would be accessible to UC FMF patients via telemedicine. UC FMF will utilize current established clinical protocols and order sets, electronic medical records, technology, and medication administration for the full range of clinical diagnoses.

UC FMF will maintain HMH's EMS Base Station designation to allow communication with EMS providers in transport and the ability to direct patients to the appropriate level of service; such communications are required for all EMS priority 1 and 2 patients before arrival at UC FMF. The EMS Board has also approved a pilot protocol for UC FMF under which UC FMF would obtain accreditation by the Joint Commission as "acute stroke ready." The pilot protocol and acute stroke ready accreditation will allow EMS providers to transport priority 1 stroke patients to UC FMF if a Primary Stroke or Comprehensive Stroke Center is greater than fifteen (15) additional minutes away. Stroke treatment is time sensitive and the applicants believe that the approved EMS pilot protocol and accreditation of UC FMF as "acute stroke ready" is vital to maintaining the level of service needed for the aging population of UC FMF's service area.

The applicants anticipate maintaining nearly the same level of emergency and observation services as currently provided at HMH, with the exception of limited non-stroke EMS priority 1 patients, inpatient acute care beds, and operating room capabilities. Patients requiring these acute levels of service will be transferred from UC FMF to UCMC or other acute facilities as needed. Patients requiring observation stays would be transferred only in the event that UC FMF was at full capacity or the patients' condition deteriorated and warranted an acute care admission or transfer to a tertiary facility. The goal for optimal patient management is to achieve an average two-hour transport time for emergent, high acuity patients requiring a higher level of care. This two-hour window will start from the time a decision to admit a patient has been made and continue until the patient arrives at the receiving facility. The two-hour transport window will be accelerated for patients experiencing life threatening conditions; for example, UC FMF will have accelerated transport protocols for stroke and cardiac patients. For non-emergent transports, a three to four-hour transport window will start from the time the receiving facility confirms bed availability. This transport time is consistent with existing patient boarding times at HMH and UCMC and will include transit time in an ambulance. UC FMF will require time to coordinate placement of most patients in an MSGA unit of the receiving facility before transporting the patient. This optimal transport time will be supported by a dedicated, onsite ambulance unit housed at UC FMF and helicopter ambulance via the on-site helipad if necessary.

Both UC FMF and UC Behavioral Health were 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, UC FMF was designed considering the FGI Guidelines Part 2 – Hospitals, Section 2.2-3 Diagnostic and Treatment Facilities, and Section 2.3 – Specific Requirements for Freestanding Care Facilities.

The FGI Guidelines do not prescribe minimum or maximum ranges of overall program area/square footage, but rather prescribe minimum requirements, including some minimum square footage/clear floor area requirements, based on the functional program for the project. For example, Section 2.2-3.1.3.6 provides requirements for treatment rooms and states, "Single-patient treatment room(s) shall have a minimum clear floor area of 100 square feet." The proposed project currently includes 111 to 141 square feet for the single-bed treatment room. This allows for the patient stretcher and other required furniture such as side chairs and storage for supplies to be accommodated in the room, leaving more than the 100 square feet of clear floor area as required by the FGI Guidelines. The proposed project meets the requirements of the FGI Guidelines while also taking advantage of FGI Guideline provisions allowing for dual-use of certain program spaces, including consultation, conference and charting room, staff space, and building support spaces which will be shared between UC FMF and UC Behavioral Health.

The behavioral health crisis treatment center at UC FMF was designed according to the FGI Guidelines Part 2 – Hospitals, Section 2.2-3 Diagnostic and Treatment Facilities, Section 2.2-3.1.3 Emergency Department; and specifically 2.2-3.1.4.3 Secure Holding Room which states, the secure holding room shall have a minimum clear floor area of 60 square feet with a minimum wall length of 7 feet and a maximum wall length of 11 feet. Accordingly, the proposed project includes treatment rooms in the range of 175 to 180 square feet. Taking into account the patient stretcher within this space, the remaining clear floor area complies with the requirements of FGI Guidelines.

The total project budget is $56,665,400. The proposed project and as well as the other capital projects for which UM UCH and its constituent hospitals have sought approval from the Commission will be funded through a combination of $214.3 million in tax exempt debt and $4.0 million of interest earned on bond proceeds. The bonds are anticipated to be issued in fiscal year 2020 through the University of Maryland Medical System.

Construction of the proposed project is projected to take place according to the same project schedule as set forth in UC Behavioral Health's CON Application, which the applicants incorporate by reference. Further the same site controls, required approvals, need for utilities as applicable to UC Behavioral Health apply to UC FMF, and the applicants incorporate by reference Sections 10 and 13(B) of UC Behavioral Health's CON Application.

The applicants have provided project drawings, including two copies of full scale drawings, at **Exhibit 2**. UCMC has also completed hospital CON **Tables** A, B, C, D, E, I, J, and K, which are related to UCMC's proposed project and relocation of MSGA beds from HMH to UCMC, as well as the projected utilization and financial performance of UCMC, inclusive of the UC FMF which becomes a department of UCMC beginning in fiscal year 2022. These tables are included with **Exhibit 1**. **Table I** includes utilization projections that reflect both the inpatient and outpatient utilization of UCMC and outpatient emergency department visits, observation cases, and related outpatient ancillary services at UC FMF. Also enclosed with **Exhibit 1**, are **Tables F**, **G**, and **H** that cover the entire utilization and financial performance of all UM UCH hospital facility components, including UCMC and HMH during the period from fiscal year 2015 to fiscal year 2021 and UCMC, UC FMF, and UC Behavioral Health between fiscal years 2022 and 2024. The financial projection assumptions related to revenue, expenses and financial performance underlying **Tables G, H, J and K** are also provided with **Exhibit 1**. Additionally, **Exhibit 1** includes a **Table L** that incorporates the workforce for HMH's emergency department in fiscal year 2017 and UC FMF in fiscal year 2024. Included in the figures are full-time equivalent employees ("FTEs") dedicated to the provision of services to patients when they are in the emergency department.

COMPREHENSIVE PROJECT DESCRIPTION

10.24.19.04 Standards

A. General Standards for Certificate of Need.

(1) The parent hospital shall be the applicant for a Certificate of Need to establish, relocate, or expand a freestanding medical facility.

Applicants' response: This standard is not applicable because UCMC and HMH are not seeking a CON and because 10.24.19.04(C)(3)(b) requires that an application to convert an acute general hospital to a freestanding medical facility "be filed with the converting hospital and its parent hospital as joint applicants."

(2) The applicant shall address and meet the applicable general standards in COMAR 10.24.10.04A in addition to the applicable standards in this chapter.

Applicants' response: This standard is not applicable because UCMC and HMH are not seeking a CON.

(3) The applicant shall document that it is consistent with the licensure standards established by DHMH.

Applicants' response: This standard is not applicable because UCMC and HMH are not seeking a CON.

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

Applicants' response: This standard is not applicable because UCMC and HMH are not seeking a CON.

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.

Applicants' response: Following the conversion of HMH to UC FMF, patients will only be retained overnight for observation stays and for treatment in UC FMF's emergency department.

(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.

Applicants' response: The Applicants have and will continue to provide simultaneously to the Commission and the Maryland Institute for Emergency Medical Services Systems ("MIEMSS") all notices, documentation, or other information regarding the proposed conversion that are required by Section C of COMAR 10.24.19 or by COMAR 30.08.15.03, including this Modified Request for Exemption from CON Review. *See also* **Exhibit 3** (August 4, 2017 Letter Providing Notice of Intent to Convert to a Freestanding Medical Facility and Enclosing Request for Exemption from CON Review); **Exhibit 4** (September 18, 2017 Cover Letter Responding to the Commission's Additional Information Requests); **Exhibit 5** (September 22, 2017 Cover Letter Transmitting Response to MIEMSS' Additional Information Requests); **Exhibit 6** (November 21, 2018 Cover Letter Transmitting Modified Request for Exemption from CON Review).

(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.

Applicants' response: The Applicants met with the Commission staff prior to filing its Notice of Intent to Seek Exemption from CON Review for the Conversion of UM Harford Memorial Hospital to a Freestanding Medical Facility ("Exemption Request") to discuss the proposed project, and filed the August 4, 2017 request ("Initial Request") and this Modified Exemption Requests in the form and manner specified by the Commission staff.

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

Applicants' response: UCMC and HMH have filed this Request for Exemption from CON Review as joint applicants. Following all regulatory approvals necessary to convert HMH to UC FMF, UCMC will become the parent of UC 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 transitioning acute care services previously provided on the hospital campus to residents of the hospital service area, and plans for the hospital's physical plant and site.

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

(iii) Within ten working days after the public informational hearing, the converting hospital provides a written summary of the hearing and all written feedback provided by the general public and from community stakeholders to the Governor, Secretary of DHMH, the governing body of the jurisdiction in which the hospital is located, the local health department and local board of health for the jurisdiction in which the hospital is located, the Commission,

and the Senate Finance Committee, House Health and Government Operations Committee, and members of the General Assembly who represent the district in which the hospital is located;

Applicants' response: The Applicants filed the Initial Request for exemption CON review to convert UM Harford Memorial Hospital to a freestanding medical facility on August 4, 2017. In consultation with the Commission staff, UM UCH held a public informational hearing on August 30, 2017, beginning at 6:00 p.m. at the Level Volunteer Fire Company, 3633 Level Village Road, Havre de Grace, Maryland. The Commission's Executive Director and Director for Center for Health Care Facilities Planning and Development attended the hearing.

Before holding the public informational hearing, UM UCH exceeded its regulatory obligations to ensure that the hearing was well attended. UM UCH published notice of the hearing date and location on its website's homepage and in the Maryland Daily Record print and electronic versions for no fewer than seventeen days. An example of UM UCH's print notices published in the Maryland Daily Record is attached as **Exhibit 7**. UM UCH also purchased quarter page advertisements in the Harford County Aegis and Cecil County Whig announcing the date and location of the public hearing. Examples of the advertisements published in the Harford County Aegis and Cecil County Whig are attached as **Exhibit 8**. Notice of the hearing was also posted on the webpage for the City of Havre de Grace and at the Level Volunteer Fire Company venue. UM UCH also published its transition plan on its website beginning on August 11, 2017, which addressed job retraining and placement of employees displaced by the conversion, plans for transitioning acute care services previously provided at UM Harford Memorial Hospital to residents of the service area, and plans for the hospital's physical plant and site. A written summary of the public informational hearing was distributed on September 14, 2017, and was provided to several members of the Commission staff on that date. A cover letter transmitting a summary of the initial public informational hearing is attached as **Exhibit 9**. The Applicants understand that Commission maintains on file a complete copy of summary of the public informational hearing in the Commission's file, 17-12-EX004, item #7.

On November 21, 2018, UM UCH filed the Modified Request, which changed the location of the proposed freestanding medical facility from Bulle Rock to Aberdeen, Maryland. In consultation with the Commission staff, UM UCH elected to hold a second public informational hearing to address the transition of UM Harford Memorial Hospital to a freestanding medical facility. The second public informational hearing was held on December 13, 2018, at the Aberdeen Fire Hall beginning at 6:00 p.m. The Commission's Director for Center for Health Care Facilities Planning and Development attended the second public informational hearing.

Before holding the second public informational hearing, UM UCH published notice of the hearing date and location on its website's homepage and in the Maryland Daily Record print and electronic versions for no fewer than seventeen days. An example of UM UCH's print notices from in the Maryland Daily Record is attached as **Exhibit 10**. UM UCH also purchased advertisements in the Harford County Aegis and Cecil County Whig announcing the date and location of the second public hearing. An example of the advertisements published in the Harford County Aegis and Cecil County Whig is attached as **Exhibit 11**. UM UCH also published its transition plan on its website no fewer than fourteen days before the public informational hearing,

which addressed job retraining and placement of employees displaced by the conversion, plans for transitioning acute care services previously provided at UM Harford Memorial Hospital to residents of the service area, and plans for the hospital's physical plant and site. A written summary of the second public informational hearing was distributed on December 27, 2018, and was provided to several members of the Commission staff on that date. A cover letter transmitting a summary of the December 27, 2018 public informational hearing is attached as **Exhibit 12**. The Applicants understand that Commission maintains on file a complete copy of summary of second public informational hearing in the Commission's file, 17-12-EX004, item #17.

(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;

Applicants' response: On October 10, 2017, the State Emergency Medical Services Board (the "EMS Board") reviewed and discussed the factors enumerated at COMAR 30.08.15.03 to determine whether the conversion of UM Harford Memorial Hospital to a freestanding medical facility would continue to maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system. On October 12, 2017, MIEMSS issued a cover letter, attached as **Exhibit 13**, explaining that the EMS Board unanimously voted that the conversion of UM Harford Memorial Hospital to a freestanding medical facility would continue to maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system. Also included with **Exhibit 13** is a MIEMSS Report and Recommendation to the EMS Board.

On August 14, 2018, the EMS Board considered whether the relocation of the freestanding medical facility to be created through the conversion of UM Harford Memorial Hospital to another site within five miles would have an impact on its October 10, 2017 determination. The EMS Board determined that relocation of the freestanding medical facility to another site within five miles would not impact the factors that the EMS Board is required to consider under COMAR 30.08.15.03, and therefore, the Board would not need to revisit its October 10, 2017 decision that the conversion of UM Harford Memorial Hospital to a freestanding medical facility would continue to maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system. Attached as **Exhibit 14** is a February 7, 2019 letter from Patricia Gainer, JD, MPA to Ben Steffen, explaining the EMS Board's August 14, 2018 decision.

(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.

Applicants' response: The Applicants are engaged in ongoing discussions with the HSCRC to discuss each rate-regulated service to be provided at UC FMF and hope to have a determination and approved rates from HSCRC in the near term. Notably, the HSCRC is required by regulation to issue rates for each of the outpatient services to be provided at UC FMF pursuant to COMAR 10.37.10.07-2.

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

Applicants' response: The Applicants will comply with this standard. The Applicants are engaged in ongoing discussions with the HSCRC to discuss each rate-regulated service to be provided at UC FMF and hope to have a determination and approved rates from HSCRC in the near term. Notably, the HSCRC is required by regulation to issue rates for each of the outpatient services to be provided at UC FMF pursuant to COMAR 10.37.10.07-2.

(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.

Applicants' response: The Applicants have and will continue to provide all information requested by the Commission staff.

(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.

Applicants' response: UCMC and HMH are both members of UM UCH, a merged asset system, and are the only two general acute hospitals in Harford County. The UC FMF project site, 635 McHenry Road, Aberdeen, Maryland, is within HMH's primary service area and is located approximately four and four-fifths (4.8) miles from HMH in a straight line and five and four-fifths (5.8) miles following public roadways. The proposed project complies with this standard.

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

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

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

Applicants' response: UM UCH's policy, implemented at both UCMC and HMH, relating to transparency in health care pricing complies with this standard and is attached as **Exhibit 15**. This policy will be extended to UC FMF when it opens.

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.

Applicants' response: UM UCH's Financial Assistance Policy, implemented at both UCMC and HMH, complies with this standard and is attached as **Exhibit 16**. UCH's Financial Assistance Policy complies with COMAR 10.24.10.04A(2). Section 4(d) on page 6 of UM Upper Chesapeake Health's Financial Assistance Policy (**Exhibit 16**) provides, "[w]ithin two (2) business days following a patient's request for Financial Assistance, application for Medical Assistance, or both, the hospital will make a determination of probable eligibility." This policy will be implemented at UC FMF when it opens.

Along with **Exhibit 16**, UM UCH is also enclosing its Financial Assistance Form, instructions to patients and financially responsible persons concerning completion of its Financial Assistance Application Form, a follow-up letter to patients regarding probable eligibility, and the current schedule of federal poverty levels used to make eligibility determinations.

Notices regarding UM UCH's financial assistance policy are currently posted in UM UCH's respective admissions offices, business offices, and emergency department areas. Additionally, UM UCH publishes notice annually in the Harford County Aegis in the form attached as **Exhibit 16**. Further, UM UCH's Financial Assistance Policy and related materials are available on UM UCH's website at the following URL:

https://www.umms.org/uch/patients-visitors/for-patients/financial-assistance

As set forth in UM UCH's Financial Assistance Policy, patients will be deemed presumptively eligible for financial assistance if they qualify pursuant to one or more of fourteen (14) enumerated criteria, including:

I. Active Medical Assistance pharmacy coverage
II. Special Low Income Medicare Beneficiary (SLMB) coverage (covers Medicare Part B premiums)
III. Homelessness
IV. Medical Assistance and Medicaid Managed Care patients for services provided in the ED beyond coverage of these programs
V. Maryland Public Health System Emergency Petition (EP) patients (balance after insurance)
VI. Participation in Women, Infants and Children Program (WIC)
VII. Supplemental Nutritional Assistance Program (SNAP)
VIII. Eligibility for other state or local assistance programs
IX. Deceased with no known estate
X. Determined to meet eligibility criteria established under former State Only Medical Assistance Program
XI. Households with children in the free or reduced lunch program
XII. Low-income household Energy Assistance Program
XIII. Self-Administered Drugs (in the outpatient environment only)
XIV. Medical Assistance Spenddown amounts

Even if a patient does not qualify for presumptive eligibility, a probable eligibility determination may be made based on verbal or documented income levels and number of family members. Following a determination of probable eligibility, the follow-up letter enclosed with **Exhibit 16** is mailed to patients within two business days. UM UCH also reserves the right to make eligibility determinations without a formal application from its patients.

(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.

Applicants' response: As shown in **Table 2** below, neither HMH nor UCMC are in the bottom quartile in terms of the percentage of charity care to total operating expenses for acute general hospitals in the State of Maryland. This standard is inapplicable.

Table 2
HSCRC Community Benefit Report, Data Excerpts
FY2017

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	%	
Holy Cross Hospital	$413,796,889	$31,396,990	7.59%	1st Quartile
Garrett County Hospital	$46,818,203	$2,792,419	5.96%	
St. Agnes	$433,986,000	$21,573,282	4.97%	
Doctors Community	$193,854,072	$6,756,740	3.49%	
Adventist Washington Adventist*	$219,120,045	$7,442,497	3.40%	
Western Maryland Health System	$322,835,314	$10,385,555	3.22%	
UM Prince Georges Hospital Center	$286,955,092	$9,166,191	3.19%	
Mercy Medical Center	$464,031,500	$14,411,600	3.11%	
Holy Cross Germantown	$97,124,985	$2,819,650	2.90%	
Johns Hopkins Bayview Medical Center	$613,834,000	$16,951,000	2.76%	
UM Laurel Regional Hospital	$93,884,647	$2,521,365	2.69%	
UM Midtown	$204,226,000	$5,174,000	2.53%	
Frederick Memorial	$350,118,000	$8,081,000	2.31%	2nd Quartile
UM Harford Memorial	$84,926,000	$1,927,000	2.27%	
Atlantic General	$117,342,233	$2,569,517	2.19%	
Ft. Washington	$42,883,433	$928,769	2.17%	
UM Baltimore Washington	$334,210,000	$6,703,000	2.01%	
Calvert Hospital	$135,047,535	$2,694,783	2.00%	
Peninsula Regional	$432,141,737	$8,301,400	1.92%	
McCready	$16,564,839	$307,205	1.85%	
UM St. Joseph	$341,335,000	$6,105,000	1.79%	
UM SMC at Dorchester	$42,909,000	$647,362	1.51%	
MedStar Harbor Hospital	$187,002,302	$2,816,043	1.51%	
Meritus Medical Center	$309,163,913	$4,596,841	1.49%	3rd Quartile
UM SMC at Easton	$190,646,000	$2,786,102	1.46%	
MedStar St. Mary's Hospital	$168,757,516	$2,458,649	1.46%	
MedStar Good Samaritan	$282,735,786	$4,078,427	1.44%	
UMMC	$1,470,095,000	$20,308,000	1.38%	
Howard County Hospital	$260,413,000	$3,368,222	1.29%	
UM Charles Regional Medical Center	$117,918,178	$1,474,409	1.25%	
MedStar Southern Maryland	$243,629,886	$3,014,042	1.24%	
Lifebridge Northwest Hospital	$240,547,439	$2,734,207	1.14%	

Shady Grove*	$323,661,835	$3,646,551	1.13%	
Suburban Hospital	$283,346,000	$3,168,000	1.12%	
UM Upper Chesapeake	$284,219,000	$3,014,000	1.06%	
MedStar Franklin Square	$508,539,888	$5,147,814	1.01%	4th Quartile
MedStar Union Memorial	$443,482,532	$4,426,976	1.00%	
Johns Hopkins Hospital	$2,307,202,000	$21,697,000	0.94%	
Union Hospital of Cecil County	$157,260,383	$1,411,673	0.90%	
LifeBridge Sinai	$727,868,000	$6,526,756	0.90%	
MedStar Montgomery General	$160,725,287	$1,322,823	0.82%	
UM SMC at Chestertown	$46,048,000	$373,000	0.81%	
Anne Arundel Medical Center	$561,392,000	$4,450,854	0.79%	
Bon Secours	$113,068,120	$675,245	0.60%	
GBMC	$419,396,862	$2,085,315	0.50%	
Carroll Hospital Center	$197,802,000	$790,716	0.40%	
All Hospitals	**$15,292,865,451**	**$276,027,989**	**1.80%**	
Excluded:				
Levindale	$73,760,005	$1,341,932	1.82%	
UM Rehabilitation and Ortho Institute	$107,006,000	$2,271,000	2.12%	
Adventist Rehab of Maryland*	$43,589,181	$502,712	1.15%	
Sheppard Pratt	$221,570,405	$5,473,873	2.47%	
Adventist Behavioral Health Rockville*	$40,204,927	$1,451,432	3.61%	
Mt. Washington Pediatrics	$55,412,291	$382,465	0.69%	

* 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.

Source: http://www.hscrc.state.md.us/Documents/HSCRC_Initiatives/CommunityBenefits/CBR-FY17/FiscalYear17HCBFinancialReport20180501.xlsx (Last visited September 19, 2019.)

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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.

Applicants' response: UCMC and HMH comply with requirements issued by Maryland Department of Health (formerly the Department of Health and Mental Hygiene) for licensure, are accredited by the Joint Commission, and comply and will continue to comply with all conditions

of participation in the Medicare and Medicaid programs. UCMC's and HMH's license from the Maryland Department of Health, Office of Health Care Quality, most recent Joint Commission accreditations, most recent verifications of CMS 855a Medicare enrollment forms Novitas Solutions, the Medicare Administrative Contractor for Maryland, and verifications from the Maryland Department of Health Medicaid website are submitted herewith as **Exhibit 18.**

(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.

Applicants' 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], which 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).

UC FMF will be a provider-based department of UCMC. UCMC ranked "better than average" or "average" on fifty (50) of the seventy-two (72) quality measures. For an additional eleven (11) quality measures, UCMC did not have sufficient data to report. UCMC ranked "below average" on only eleven (11) quality measures. **Table 3** below, identifies those quality measures for which UCMC was ranked "below average" along with UCMC's corrective action plan:

Table 3
Below-Average Quality Measures and Corrective Action

Quality Measure	Corrective Action Plan
COPD- Chronic Obstructive Pulmonary Disease	
Dying within 30-days after getting care in the hospital for chronic obstructive pulmonary disease (COPD).	As a part of UCMC's Patient and Family Centered Care Oversight Council, a multi-disciplinary COPD Workgroup has been created to focus on transitions of care. There are various scopes of work being implemented by the workgroup. The development of new pathway and order sets are in progress to reduce clinical variation in the COPD management. In addition, UCMC is working to increase patient education through video and pulmonary consults as needed.

Quality Measure	Corrective Action Plan
Communication	
How often did doctors always communicate well with patients?	UCMC's Patient Experience Plan includes several strategies to improve physician communication including: language of caring education, direct observations of physician interactions with patients, and structured bedside rounding with physicians and nurses to communicate each patient's plan of care and to answer patient questions.
Were patients always given information about what to do during their recovery at home?	UCMC's Patient Experience Committee as well as the Transition of Care Committee work plans include revision of patient discharge educational materials and the implementation of a new interactive patient engagement system to include patient specific education plans, patient portal registration, and an extensive library of education videos.
Environment	
How often was patients' pain always well-controlled?	UM UCH's Pain Management Steering Committee work plan includes several strategies for improving pain management including pain medication reassessment monitoring, RN education, designated pain management RN specialist and palliative care program. UCMC has also included pain assessment during hourly care rounds and shift hand-off communication.
How often was the area around patients' rooms always kept quiet at night?	UCMC is implementing several strategies to reduce noise including noise stoplights at nurses station to increase staff awareness of noise levels, reducing noise from delivery carts by changing cart wheels, reducing deliveries during night hours ,and implementing "quiet times" at designated times to promote uninterrupted rest.

Quality Measure	Corrective Action Plan
Wait Times	
How long patients spent in the emergency department before being sent home? How long patients spent in the emergency department before they were seen by a healthcare professional?	In furtherance of UM UCH's fiscal year 2019 strategic objective for efficient care, a process improvement team has been charged to review Emergency Department ("ED") throughput and efficiency. Specifically, the work group will utilize the organization's IMPRV methodology to improve the ED's average length of stay and the times from "door to doctor." Executive oversight for this initiative will be driven through the Patient & Family Centered Care Oversight Committee and performance improvements will be monitored through a system-wide scorecard.
Heart Attack and Chest Pain	
Patients with heart attack who received aspirin on arrival to the hospital.	UCMC is actively developing a plan to ensure that all patients with heart attack receive aspirin on arrival to the hospital.
Practice Patterns	
Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses.	During FY18, three new CT scanners were installed within UCH (2 at UCMC and one at HMH). All three new scanners have the newest software and X-ray tube technology assuring low dose CT scans. A dose monitoring software, Radimetrics, was also purchased to monitor patient exposures during the CT scans allowing UCH to benchmark and watch for any outliers or trends with dose. During calendar year 2018, January through October measuring period, zero patients underwent CT of the sinus when ordered for a CT of the brain.
Results of Care - Death	
How often patients die in the hospital after bleeding from stomach or intestines.	All-cause mortality is an area of focus on UCMC's fiscal year 2019 Operating Plan. It also constitutes 15% of its Quality Based Reimbursement. A multidisciplinary project team has been deployed to determine both clinical interventions and documentation optimization to better understand the root causes driving any below average performance In addition, under the Safety domain, potentially preventable complications are being tracked, evaluated, and preventive

Quality Measure	Corrective Action Plan
	efforts focused on opportunities for improvement.
How often patients die in the hospital after fractured hip.	UM UCH implemented a Geriatric Hip Fracture Program in April 2017. The primary focus of the program is to improve clinical care for acute hip fractures seen at UM UCMC and UM HMH. Following implementation of the program, there has been a decreases in average length of stay, time from admission to surgery, 30 day readmission rates, and 1 year all-cause mortality. In addition, the Geriatric Hip Fracture program has implemented a process to identify patients with an increased risk of a large bone fracture to provide preventative care coordination.

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

Applicants' response: UC FMF will meet or exceed licensure standards 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.

Applicants' response: Submitted as **Exhibit 16** is UM UCH's financial assistance policy currently in effect at both UCMC and HMH, which policy complies with COMAR 10.24.10. This same policy as may be updated prior to the proposed opening of UC FMF in 2020 will be established and maintained at the UC FMF.

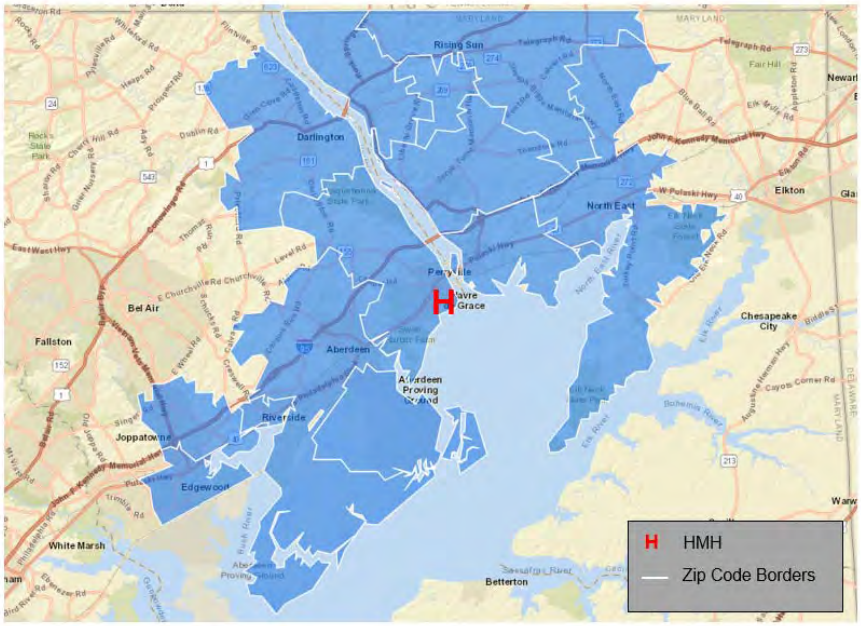
(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

(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;

Applicants' response: In fiscal year 2018, 85% of HMH's emergency department visits came from residents of thirteen (13) zip codes in Harford and Cecil Counties (i.e., HMH's ED Service Area and UC FMF's Service Area) as listed and depicted in **Table 4** below.

Table 4
UC FMF ED Service Area
FY2018

ZIP	City
21001	Aberdeen
21078	Havre De Grace
21904	Port Deposit
21903	Perryville
21040	Edgewood
21911	Rising Sun
21918	Conowingo
21901	North East
21009	Abingdon
21005	Aberdeen Proving Ground
21017	Belcamp
21034	Darlington
21917	Colora



In fiscal year 2018, there were 68,562 visits to Maryland hospital emergency departments by residents of this service area. A combined 70.5% of these emergency department visits were to UCMC (37.8%) and HMH (32.7%) with an additional 16.2% of visits going to Union Hospital of Cecil County and 3.1% going to MedStar Franklin Square Hospital (**Table 5**).

Table 5
UC FMF Service Area ED Visits
FY2014 – FY2018

	Historical						
Hospital	2014	2015	2016	2017	2018 [1]	2018 % of Total	2014 - 2018 % Change
UM Upper Chesapeake Medical Center	24,580	26,175	27,051	26,609	25,890	37.8%	5.3%
UM Harford Memorial Hospital	24,289	24,981	24,679	23,424	22,451	32.7%	-7.6%
Union Hospital of Cecil County	11,658	11,558	11,790	11,500	11,128	16.2%	-4.5%
MedStar Franklin Square Hospital	2,974	2,733	2,574	2,279	2,094	3.1%	-29.6%
Johns Hopkins Hospital	986	1,057	1,088	1,216	1,300	1.9%	31.8%
Other Hospitals with less than 1,000 visits	5,284	5,078	5,240	5,523	5,699	8.3%	7.9%
Total	69,771	71,582	72,422	70,551	68,562	100.0%	-1.7%

Note (1): Reflects six months outpatient ED actual experience annualized
Source: St. Paul Computer Center statewide non-confidential utilization data tapes

Utilization of all hospital emergency departments by residents of this service area declined 1.7% between fiscal years 2014 and 2018, yet utilization of the emergency department at UCMC increased by 5.3%. Service area utilization of HMH declined 7.6%.

The applicants also project that UC FMF's "primary service" area will be the same as HMH's primary service area. In fiscal year 2018, 65.5% of HMH's MSGA discharges (primary service area) came from residents of two (2) zip codes in Harford County and two (2) zip codes in Cecil County as listed below in **Table 6** below.

Table 6
HMH MSGA Primary Service Area Zip Codes and Discharges
FY2018

Zip Code	Community	County	Discharges	% of Discharges
21001	Aberdeen	Harford	856	26.3%
21078	Havre De Grace	Harford	825	25.4%
21903	Perryville	Cecil	228	7.0%
21904	Port Deposit	Cecil	222	6.8%
	Subtotal 2018 Service Area		2,131	65.5%
	Out of Service Area		1,121	34.5%
	Total MSGA Discharges		3,252	100.0%

In fiscal year 2018, 62.1% of HMH's inpatient psychiatric discharges (primary service area) came from residents of seven (7) zip codes in Harford County as listed in **Table 7** below.

Table 7
HMH Psychiatric Primary Service Area Zip Codes and Discharges
FY2018

Zip Codes	Community	County	Discharges	% of Discharges
21001	Aberdeen	Harford	172	15.0%
21040	Edgewood	Harford	129	11.3%
21078	Havre De Grace	Harford	105	9.2%
21014	Bel Air	Harford	85	7.4%
21015	Bel Air	Harford	83	7.3%
21009	Abingdon	Harford	79	6.9%
21017	Belcamp	Harford	57	5.0%
	Subtotal 2018 Service Area		710	62.1%
	Out of Service Area		434	37.9%
	Total Psychiatric Discharges		1,144	100.0%

The creation of UC FMF is critical to ensure that access to emergency services for the service area population continues. Other area hospitals, especially UCMC, would be overwhelmed if UC FMF were not developed to the size and with the capabilities to meet the needs of the service area population. Further, UCMC could not accommodate a significant increase in emergency visits upon conversion of HMH to UC FMF without UCMC's own major capital improvements to its emergency department.

(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.

Applicants' response: UC FMF has been designed to provide similar emergency and observation services as has been historically provided at HMH. Through community education and outreach, which UM UCH has been engaged in for some time, UM UCH will make the community aware of the significant capabilities of UC FMF. As noted above, the applicants anticipate that UC FMF will maintain nearly the same level of emergency care services as currently provided at HMH, with the exception of existing EMS protocols prohibiting the transfer of a limited number of non-stroke EMS priority 1 patients.[4] Accordingly, the applicants projected UC FMF's service area and number of emergency department visits based on historical utilization at HMH, excluding non-stroke EMS priority 1 patients. *See* **Table 3** above.

Within UC FMF's primary service area, there are no other acute general hospitals or FMFs. The nearest acute general hospitals to the proposed project site are UCMC, which is approximately 12.4 miles by public roadways. Union Hospital of Cecil County and MedStar Franklin Square Hospital are approximately 21.8 and 23.2 miles, respectively, from UC FMF by public roadways.

Within UC FMF's primary service area, the applicants have identified the following urgent care centers and their proximity to UC FMF by roadway travel as set forth in **Table 8**.

Table 8
Urgent Care Centers in UC FMF's Service Area

Urgent Care Center Name	Address	Proximity to UC FMF	Hours
Patient First	995 Hospitality Way, Aberdeen, MD 21001	0.8 miles	8am-10pm (M-Sunday)
Choice One Urgent Care	744 S Philadelphia Blvd, Aberdeen, MD 21001	2.7 miles	8am-8pm (M-Sunday)
Medstar Prompt Care	1321 Riverside Pkwy, Belcamp, MD 21017	6 miles	8am-8pm (M-Th) 8am-6pm (F) 8am-2pm (S-S)

[4] In fiscal year 2016, HMH had a total of 187 EMS transports classified as priority 1, of which approximately 151 would no longer qualify for treatment at UC FMF based on EMS protocols while 36 would qualify for transfer to UC FMF through the EMS pilot protocol. In this same period, HMH had a total of 61 EMS priority 1 transports from Cecil County. In fiscal year 2018, HMH had a total of 208 EMS transports by Harford County EMS units classified as priority 1, of which approximately 160 would no longer qualify for treatment at UC FMF based on EMS protocols while 48 would qualify for transfer to UC FMF through the EMS pilot protocol.

MD Immediate Care	504 Lewis St, Havre de Grace, MD 21078	6.1 miles	9am-5pm (M-F) 9am-3pm (S-S)
Total Urgent Care	2120 Emmorton Park Rd, Edgewood, MD 21040	10.4 miles	8am-6pm (M-F) 9am-5pm (S-S)
Infinite Medical Express	1010 Edgewood Road, Edgewood, MD 21040	10.6 miles	9am-10pm (M-Th) 3pm-10pm (F) 9am-5pm (S-S)
Principio Health Center	4863 Pulaski Highway Perryville, Suite 110, MD 21903	11.1 miles	9am-8pm (M-F) 9am-5pm (S-S)
MedStar Express Care Northeast	101 N. East Plaza, North East, MD 21901	14.9 miles	8am-8pm (M-Sunday)
Got A Doc North East	2327 Pulaski Hwy, North East, MD 21901	15.4 miles	8am-8pm (M-Sat.) 9am-5pm (Sunday)

UM UCH has not gathered market intelligence on the use rates of the eight independent urgent care centers identified in **Table 8** and does not have information regarding those use rates. UM UCH, however, is involved in a joint venture with ChoiceOne to operate the urgent care center located in Aberdeen. Despite efforts by UM UCH to direct patients with non-emergent medical conditions to urgent care centers as more fully below, the ChoiceOne/UM UCH urgent care center in Aberdeen has received less patient volume than the joint venture partners initially projected. UM UCH is not aware of the entry of new urgent care centers into the area.

UM UCH has implemented a comprehensive community educational campaign focusing on delivering "the right care at the right time and in the right setting" and has presented this patient education model in multiple community sessions and open door café sessions. UM UCH has developed an educational tool that provides specific clinical presentations that are more appropriate for the urgent care setting versus the emergency department setting. This educational information has been printed in brochures, marketing advertisements, placed on UM UCH's website and on UM UCH's electronic patient/community educational screens throughout both UCMC and HMH. Finally and as an additional educational strategy, UM UCH worked with ChoiceOne Urgent Care to develop and distribute a direct mailing to all patients who had sought care in the emergency departments of either UCMC or HMH whose low acuity care fell within the capabilities of an urgent care center. UM UCH has also been using the following graphic as part of its education efforts.

Despite the location of these urgent care centers in HMH's existing primary emergency department service area, which is also UC FMF's projected primary service area, and UM UCH's efforts to educate patients on seeking "the right care at the right time in the right setting," emergency visits at HMH and in UC FMF's projected service area have not declined appreciably. *See* **Table 4** above. UM UCH and its member hospitals attribute declining emergency department utilization to significant population health initiatives described in Section II.G below rather than a market shift of emergency department visit volume in the service area to urgent care centers. Indeed, HMH experienced an increase in emergency department visits between fiscal years 2014 and 2016, even with the presence of urgent care centers in the market. And, the number of emergency department visits from HMH's service area increased 5.3% at UCMC between fiscal years 2014 and 2018. As such, the applicants assume that the presence of urgent care centers will not have an impact on the projection of emergency department visits at the UC FMF.

Moreover, in fiscal year 2017, approximately 32% percent of HMH's emergency department visits occurred between 8 p.m. and 8 a.m. Between these hours, only two of the urgent care centers identified in **Table 9** of are open.

Table 9
HMH Emergency Department Visits Between 8 p.m. and 8 a.m.
FY2017

Timeframe	8 a.m. - 8 p.m.	8 p.m. - 8 a.m.	Total
Inpatient Visits	2,727	1,021	3,748
Outpatient Visits	16,666	8,062	24,728
Total Visits	19,393	9,083	28,476
% of Total	*68.1%*	*31.9%*	*100.0%*

Source: HMH FY2017 Internal Utilization

In addition to urgent care centers, UCH is aware of two (2) primary care practices that offer walk in services: (1) Bala Family Practice; and (2) Dr. Andrew Mrowiec's practice. To the applicants' knowledge, there are no additional primary care practices within UC FMF's proposed service area or in the Bel Air area that offer health care services to patients on an unscheduled, walk-in basis.

In sum, there are an ample number of urgent care centers in UC FMF's projected service area and only two primary care practices that offer walk-in services. Despite the presence of these services in HMH's service area, emergency department visits at area hospitals have not declined appreciably. Furthermore, the limited hours of operation of these urgent care centers does not provide an alternative for patients experiencing emergency medical conditions. The development of UC FMF with the proposed level of beds and ancillary equipment is critical to ensure continued access to emergency and observation services for the service area population.

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

Applicants' response: UM UCH in conjunction with the Harford County Health Department and Healthy Harford completed the most recent Community Health Needs Assessment in July 2018. A copy of the Community Health Needs Assessment is provided as **Exhibit 17**. The Community Health Needs Assessment identified behavioral health, prevention and wellness, and family stability and wellness as the priority health care concerns for Harford County in order of importance. Further, with respect to behavioral health, the Health Resources and Services Administration designated all of Harford County as a Health Professional Shortage Area, meaning "that the need for mental health services far outweighs their availability." (Id. at 37.) To this end, UC FMF's proposed five behavioral health treatment spaces, coupled with UM UCH's plan to develop a special psychiatric hospital above UC FMF, is consistent with the Community Health Needs Assessment. The scope of behavioral health services planned for the UC Medical Campus at Aberdeen is intended to strongly support and provide added services to meet the well-recognized need within the community for comprehensive mental health services. As it relates to community addiction needs also addressed in the Community Health Needs Assessment, UM UCH has maintained a strong collaboration with the Ashley Addiction program as well as with additional community-based providers throughout Harford and Cecil Counties.

UM UCH also promotes and supports optimal health prevention and wellness in the community through population health initiatives and programs which will be supported by UC

FMF. In addition to UM UCH's constituent hospitals' traditional medical and surgical capabilities, UM UCH developed community-based care teams in 2016 that conduct in-home interventions for patients with complex, chronic health conditions. The teams are part of the Wellness Action Teams of Cecil and Harford Counties ("WATCH") program. Each WATCH team is comprised of one registered nurse, one pharmacist, one social worker, and two community health workers that assess and address barriers to maintain health. The WATCH program was developed in partnership with the Health Department, Office on Aging, and a local Federally Qualified Health Center, among others. The program has the capacity to work with 2,000 clients annually with two teams in Harford County, one that spans the Susquehanna River, and one in Cecil County for a total of four teams. UC FMF will further the efforts of the Watch Program by making administrative and conference room space that is shared between UC FMF and UC Behavioral Health available for use by the Watch team both as a touchdown area between community interventions and for community outreach and education.

UM UCH has also entered into a regional partnership with Union Hospital of Cecil County ("UHCC") to address the medical and social needs of high utilizer patients and those with multiple chronic conditions. This regional partnership has deployed people, processes, and technology that identify and support patients in the pursuit of optimal health. The partnership leverages post-discharge clinics and community-based care teams while implementing telehealth programs and a shared, CRISP-hosted, care management documentation system. Patients are engaged at a post-discharge clinic at UHCC, UM UCH, and/or the WATCH Program. The regional partnership's interventions target Medicare and dual-eligible patients with multiple visits to the hospital and/or two or more chronic conditions. The regional partnership has discovered that patients are more likely to become engaged with the program following a hospital visit. Another benefit of the regional partnership has been the development of numerous community partnerships, including with the local Health Departments and Offices of Aging, Community Action Agency, the United Way, as well as faith-based organizations. This partnership works closely with the UM UCH HealthLink team to develop and deploy chronic disease self-management programs, diabetes prevention, and health screening programs for vulnerable populations in the market.

Beyond the WATCH and Healthlink programs, UM UCH developed a Comprehensive Care Center ("CCC") in 2015 to serve as a high intensity medical and social clinic for high risk patients. The CCC includes a physician and nurse practitioner, nurses, and social workers who work with patients by phone and in a clinic setting for up to 30 days before transitioning them back to primary care practices. This clinic is centrally located at UCMC in Bel Air where there is close proximity to the Diabetes Center, Wound Center, Ashley Addiction Services, and other vital specialty practices also needed to support chronic diseases experienced by Harford County residents. Additionally, a Congestive Heart Failure program and Infectious Disease practice is located within the CCC. The annual referrals to the CCC have doubled to nearly 3,000 annually. UM UCH is planning a satellite CCC location to be located in a medical office building on its proposed Aberdeen Campus.

Strategic deployment of technology is also critical to optimizing patients' health in Harford County. UM UCH has successfully implemented a telemedicine program with five of the six skilled nursing facilities in the county. This program allows for emergency department providers to remotely evaluate patients at skilled nursing facilities to potentially prevent unnecessary trips to the hospital. A pilot program conducted as part of the Commission's grant program showed a 34%

reduction in 30-day readmissions. UM UCH is working to deploy this system in all skilled nursing facilities in Harford County in the coming year. Telemedicine services will also be available at UC FMF for specialty services.

UM UCH also has an extensive partnership with CRISP to benefit the communities it serves. The WATCH Program and CCC utilize a CRISP-hosted care management documentation program allowing all providers with the appropriate patient relationship the ability to view patient interactions that occur between office visits. This system also helps different stakeholders understand what other providers are engaged with the patient to avoid duplication of services. Recently, the Harford County Health Department has begun using this system as well, and UM UCH believes that this will enable CRISP to become the closest version of a personal health record for patients since it is not confined to a hospital or ambulatory electronic medical record. UC FMF will continue with UM UCH's collaborative efforts with CRISP.

The previously outlined population health strategies represent a significant investment by UM UCH to not only meet the needs of individuals in the community with chronic conditions but also to improve access to care, seeing patients in their homes as one of many vital strategies. Additionally, UM UCH is planning to renovate the existing office building on the UC Medical Campus at Aberdeen Campus into a medical office building that will house both primary and specialty care physician practices in order to provide access to additional providers in this portion of Harford County.

(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.

Applicants' response: The Number and Size of UC FMF's Emergency Department Treatment Spaces is Consistent with the ACEP Low Range Guidance. **Table 9**, above, reflects emergency department visits to HMH from residents within UC FMF's defined service area. Total emergency department visits at HMH, including emergency department visits from residents outside the defined service area are set forth in **Table 9**. Total emergency department visits at HMH declined by 6.8% between fiscal years 2014 and 2018 (**Table 10**).

Table 10
HMH Historical Emergency Department Visits
FY2013 – FY2018

	Emergency Department Visits at HMH					FY14-FY18
	FY2014	FY2015	FY2016	FY2017	FY2018	% Change
Inpatient	3,388	3,472	3,179	3,626	3,583	*5.8%*
Outpatient	25,294	25,870	26,341	24,730	23,160	*-8.4%*
Total	28,682	29,342	29,520	28,356	26,743	*-6.8%*

Source: FY2014-FY2016 = Maryland non-confinential data sets;
FY2017-FY2018 = HSCRC Experience Report data sets

Beginning in fiscal year 2019, emergency department visits at HMH are expected to grow annually with the population. With the closure of HMH in fiscal year 2022 and shift of emergency department visits to UC FMF, the growth in population is offset by the redirection of non-stroke EMS priority level 1 patients from HMH to the nearest acute general hospital. Based on these assumptions, the applicant expects that UC FMF will see 27,348 emergency department visits by fiscal year 2024 (**Table 11**). Of these visits, 25,440 or approximately 93% will be non-psychiatric visits.

Table 11
HMH and UC FMF Historical and Projected Emergency Department Visits
FY2015 – FY2024

	Historical				Projection						% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Emergency Department Visits											
HMH											
Inpatient Visits	3,472	3,179	3,626	3,583	3,599	3,615	3,631	-	-	-	*-100.0%*
Outpatient Visits	25,870	26,341	24,730	23,160	23,263	23,366	23,470	-	-	-	*-100.0%*
Total	**29,342**	**29,520**	**28,356**	**26,743**	**26,862**	**26,981**	**27,101**	**-**	**-**	**-**	*-100.0%*
%Change	*2.3%*	*0.6%*	*-3.9%*	*-5.7%*	*0.4%*	*0.4%*	*0.4%*	*-100.0%*	*0.0%*	*0.0%*	
UC FMF											
IP Psych Visits (1)	-	-	-	-	-	-	-	653	656	659	
Outpatient Visits (2)	-	-	-	-	-	-	-	26,453	26,571	26,689	
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**27,106**	**27,227**	**27,348**	
%Change	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*100.0%*	*0.4%*	*0.4%*	
Total	29,342	29,520	28,356	26,743	26,862	26,981	27,101	27,106	27,227	27,348	*2.3%*
%Change	*2.3%*	*0.6%*	*-3.9%*	*-5.7%*	*0.4%*	*0.4%*	*0.4%*	*0.0%*	*0.4%*	*0.4%*	

Note (1): Reflects Behavioral Health patients that will be admitted to UC Behavioral Health on the UCH Medical Campus at Havre de Grace
Note (2): Includes approximately 3,000 patients that were previously admitted at HMH, but will enter UC FMF as outpatients and then be transferred to other hospitals for inpatient admission

Number of Standard ED Treatment Spaces

As described above in fiscal year 2024, the Applicants project that UC FMF will see 27,348 emergency visits. Under the current edition of the ACEP Guide, Figure 5.1 estimates treatment space need per emergency department visits in five thousand visit increments, starting at 10,000 visits per year. ACEP Guide at 116. Included in ACEP Guide, Figure 5.1 are also estimates for departmental gross square feet. Excluding psychiatric emergency visits at UC FMF which are

separately discussed, UC FMF emergency visits will range between the 25,000 and 30,000 annual visits tiers in the ACEP Guide. At 25,000 annual emergency department visits, the ACEP Guide projects a "low range" need for eighteen (18) treatment spaces in 14,850 departmental gross square feet and a "high range" need for twenty (20) treatment spaces in 17,500 departmental gross square feet. At 30,000 annual emergency department visits, the ACEP Guide "low range" projects a need for twenty-one (21) treatment spaces in 16,800 departmental gross square feet and a "high range" need for twenty-five (25) treatment spaces in 21,875 departmental gross square feet.[5]

Excluding triage spaces which will not be used as treatment spaces and the behavioral health crisis treatment unit which is separately addressed, the proposed project includes twenty (20) emergency department treatment spaces, including : (a) four standard emergency treatment rooms; (b) six standard flex/hold treatment rooms, which have the ability to convert to secure holding rooms for behavioral health patients by utilizing a rolling door to cover medical equipment and any ligature points to the extent the behavioral health crisis treatment spaces are occupied; (c) five emergency treatments spaces specifically designed for geriatric patients, which include a quieter zone, enhanced lighting, a soft rubber backed flooring, and geriatric visitor chairs; (d) one SAFE or S.A.N.E. room, which will be used for patients who have experienced a rape, assault, or criminal related injuries and who require appropriate treatment and testing equipment available within this specialty room; (e) two 2 resuscitation rooms and 2 isolation rooms. The proposed emergency department is all housed in 15,803 departmental gross square feet. Accordingly, the general emergency department treatment space is within the ACEP Guide's "low range" and "high range" guidelines for 27,000 visits per year.

Number of Behavioral Health ED Treatment Spaces

The UC FMF also proposes to have five (5) behavioral health crisis treatment spaces adjacent to the general emergency department in order to meet the needs of the population to be served. The Applicants have provided a separate analysis for the emergency department psychiatric visits because the ACEP low range states "under 3%" of emergency department visits are psychiatric patients and, therefore, "you would probably not define a specialized area in the

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[5] The Applicants note that the ACEP Guide itself is described by the author "as a starting point" for emergency department planning with "general guideline[s]" to be used for internal planning to set "preliminary benchmarks for sizing emergency departments," which can be adjusted for "each unique emergency department project" and that the size parameters are merely "estimates." *See* ACEP Guide at 106-109. Indeed, as the ACEP Guide states:

> there's no magic formula for a set number of examination rooms and square footage calculations for a certain number of patient visits. *There's no "if you see 'X' number of patients in a year, your department should be 'Y' square feet with 'Z' number of patient care spaces."* There are too many variables to consider. We can't reduce space programming to 'one size fits all. The key is for you to understand how your unique variables will affect your space need, and the biggest impact is your turnaround time for patients using examination spaces.

ACEP Guide at 106 (emphasis added).

emergency department for behavioral health patients." ACEP Guide at 111. At the mid-range, the ACEP Guide instructs: "4% to 6% behavioral health patients would be average and you might define a few rooms as safest possible healing environmental rooms." In contrast, the "high range" criterion states: "7% or over for behavioral health would be considered high, and you might develop special areas or suites for these specialty patients."

UC FMF projects to be in the "high range" because 7.3% of HMH's emergency department patients in fiscal year 2018 experienced behavioral health emergencies, and therefore, under the ACEP Guide recommends developing a special area or suite for these specialty patients. **Table 12** below, provides the percentages of emergency department visits involving behavioral health emergencies.

Table 12
HMH Historical Behavioral Health Emergencies
FY2015 - FY2017

	Historical		
	FY2016	FY2017	FY2018
HMH ED Visits	29,520	28,356	26,743
HMH Psych ED Visits	1,987	1,941	1,942
Psych Visits % of Total	*6.7%*	*6.8%*	*7.3%*
HMH Psych ED Visits ALOS (hrs)	9.1	8.9	11.3

Source: HMH internal ED patient level detail data sets

With respect to designing behavioral health service areas, the ACEP Guide further instructs:

> The first step in identifying your physical space needs for behavioral health care is to identify the intended services and corresponding length of stay. How long will you need to hold patients after initial diagnosis and stabilization? Will you transfer patients to psychiatric inpatient floors or outpatient services within your own hospital? Or, will you be at the mercy of the receiving facilities and transport services when referring patients to appropriate outplacement locations? Review all possible operational scenarios to determine the quantity of behavioral health patient cares paces.

See ACEP Guide at 218.

In accordance with this guidance, the Applicants projected the need for behavioral health treatment bays separately (or "carved" them out) from its non-behavioral health treatment bays. Both the need assessment and the separate placement are consistent with the ACEP Guide. As the ACEP Guide states:

> The behavioral health care unit should be designed in a location with direct access from both the ambulance entrance and the walk-in entrance. The intent is to place the behavioral health care zone in an accessible area while still limiting, or eliminating, all cross-circulation with other emergency department patients.

Id.

Overall, as a percentage of total ED visits, the number of patients experiencing behavioral health emergencies at HMH has been increasing. In fiscal year 2016, 6.7% of HMH's ED visits had psychiatric diagnoses. This percent grew to 6.8% in fiscal year 2017 and 7.3% in fiscal year 2018. *See* **Table 12** above. Patients experiencing behavioral health emergencies are also staying in the ED longer. From fiscal year 2016 to 2018, the average length of stay associated with psychiatric ED visits increased 24%; the length of stay increased from 9.1 hours in fiscal year 2016 to 11.3 hours in fiscal year 2018. This increased length of stay required the Applicants to plan a dedicated behavioral health unit at UC FMF that is sized for peak utilization. As is well documented, patients experiencing behavioral health emergencies in a general emergency department are often disruptive and bog down efficient department operations. And as a stand-alone emergency department, UC FMF will require treatment and holding space to house such patients.

As described by the ACEP Guide, UC FMF's proposed five (5) behavioral health crisis treatment spaces represent a small, specialized unit. As such, the Applicants determined it was necessary to size the behavioral health crisis treatment spaces around the peak period of utilization.

In fiscal year 2017, HMH experienced an annual peak utilization of 132 emergency psychiatric patients during the 5:00 pm hour (e.g., patient presented to the ED between 5:00 p.m. and 6:00 p.m.) *See* **Table 13** below.

Table 13
HMH Peak Hour Psychiatric Emergency Department Visits
FY2017

FY2017	
Hour of Visit	5:00 P.M.
Inpatient Visits	48
Outpatient Visits	84
Total Visits	**132**

Source: HMH FY2017 internal utilization report

These visits between the 5:00 p.m. and 6:00 p.m. hours represented 13.3% of HMH's total behavioral health ED visits. It is also important to note that 56.3% of HMH's behavioral health visits occurred between the hours of 12:00 p.m. and 8:00 p.m. Between these hours, UC FMF's behavioral health department projects to operate at 90% of peak utilization with an average of 4.5 patients. With a growth in psychiatric ED visits as a percentage of total ED visits and increase in the average length of stay, the Applicants strongly believe that it is important to have sufficient distinct behavioral health crisis treatment spaces to accommodate patients with psychiatric needs.

As such, the Applicants extrapolated the 5:00 pm peak utilization in fiscal year 2017 to calculate a peak period adjustment that was applied to the projected bed need to ensure a sufficient number of behavioral health treatment spaces are available to meet peak demand for patients experiencing behavioral health emergencies.

Extrapolating the peak period to all hours of the day yields 2,640 emergency psychiatric patients per year. The Applicants used an extrapolation at the 5:00 pm hour to ensure a sufficient number of behavioral health treatment spaces to meet peak demand for psychiatric patients who generally have longer lengths of stay. In fiscal year 2017, psychiatric patients had an average visit of 10.9 hours when seen during the 5:00 pm hour as compared to 3.3 hours for non-psychiatric patients over the course of fiscal year 2017. These considerations position the behavioral health crisis treatment spaces in the ACEP Guide mid-range for the volume of projected behavioral health visits and a need for five (5) behavioral health crisis treatment spaces.

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

Each of the exam rooms is designed to be 115 and 118 square feet and the overall department is 3,408 square feet. Moreover, the overall design of the behavioral health crisis treatment space is consistent with the ACEP Guide recommendations for design of a behavioral health services area within an emergency department. *See* ACEP Guide at 218 – 221.

Combining psychiatric and non-psychiatric visits results in a need for a total of 25 treatment spaces and 19,211 departmental gross square feet for the emergency department, which is still within the ACEP "high range" of 25 treatment spaces and below the ACEP "high range" for 30,000 ED visits per year and of the "high range" space of 21,875 departmental gross square feet.

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

Applicants' response: Excluding 25,408 departmental square feet of public and administrative space that will be shared between UC FMF and UC Behavioral, UC FMF is designed to be 56,395 departmental square feet. For purposes of financial projections an additional 12,948 square feet of 26,423 gross square feet that will be shared with UC Behavioral Health has been allocated to UC FMF. The proposed project has been allocated a total of 69,343 square feet, which includes the following patient and ancillary services with departmental gross square feet:

a) General Emergency Treatment – 15,803
b) Behavioral Health Crisis – 3,408

c) Observation – 11,666
d) Imaging – 5,573
e) Lab – 1,622
f) Pharmacy – 1,602
g) Public – 4,918
h) Administration – 7,574

See **Exhibit 1** at **Table B**.

In addressing the overall size of UC FMF and its consistency with ACEP low range guidance, it should be noted that the ACEP Guide indicates that the low, mid, and high ranges are "general guideline[s]" used to set "preliminary benchmarks for sizing emergency departments," which can be adjusted for "each unique emergency department project" and that the size parameters are merely "estimates." *Id*. at 109, 116-117. The low, mid, and high ranges are also not exacting tiers but represent a continuum based on projections. S*ee id.* at 109. Further the ACEP Guide's consideration of a freestanding emergency department does not contemplate such a facility as a replacement for an existing hospital's emergency and observation capacity. On the contrary, the ACEP Guide's discussion of freestanding emergency departments suggests that such facilities may be developed to "decant" or move certain emergency services from an existing crowded main hospital emergency department. *See* ACEP Guide at 260-61. In other words, the ACEP Guide was not written to address acute general hospital conversions to freestanding emergency departments.

The ACEP Guide categorizes emergency department designs into low, mid, and high range using sixteen factors. As reflected in **Table 14** below, UC FMF falls within the "high" range of the ACEP Guide for seven (7) of the ACEP range criteria, in the "mid" range for six (6) of the ACEP Guide criteria, and in the "low" range for only three (3) of the ACEP Guide criteria.[6] Overall, UC FMF projects to be in the mid-high range based on the ACEP Guide criteria, the

[6] It should be noted, however, that the State Health Plan Chapter for Freestanding Medical Facilities, COMAR 10.24.17.04(c)(8)(d)(ii), requires an applicant to "demonstrate that the building gross square footage is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for additional building gross square footage." The ACEP Guide does not contemplate an observation unit as part of the "architectural project" for an emergency department in the "low range," states that "imaging studies will not be performed within the department, so there is no need to add space for imaging rooms." Further, the ACEP Guide only provides for a 1.25 building gross square footage adjustment factor for a "freestanding facility," which factor appears only to account for wall thickness, mechanical penthouses, stair shafts, etc. ACEP Guide at 113. To the extent that UC FMF is classified in the low range for the "location of clinical decision unit (CDU) or observation space" and imaging modalities under Table 5.2 of the ACEP Guide, the observation and imaging departments should be excluded from the demonstration required by COMAR 10.24.17.04(c)(8)(d)(ii). As reflected in **Exhibit 1**, **Table B**, UC FMF's observation department is 11,666 gross departmental square feet and the imaging department is 5,573 gross departmental square feet. As a result, the overall size of UC FMF's "emergency department" should be reduced by this amount if the observation and imaging departments are excluded from the emergency department.

projected need for emergency and observation services for the community formerly served by HMH, and for the projected service line requirements. A detailed analysis of each ACEP factor follows **Table 14**.

Table 14
Evaluation of UC FMF ACEP Factors

UC FMF
Evaluation of Emergency Department Bed Range

Factor	Bed Range Low	Mid	High	Evaluation of UC FMF Bed Range	UC FMF Count of Low/Mid/High Low	Mid	High
Percentage of Admitted Patients	< 8%	12-20%	> 25%	Mid 12%-20%		1	
Length of Stay (LOS)	<2.25 Hours	2.5-3.75 Hours	>4 Hours	Mid (3.6 hours)		1	
Patient Care Spaces	Few	Majority	All	High (All Private)			1
Inner Waiting & Results Waiting Areas	Available	Limited	Pts. Stay in Bay	High (Stay in Bay)			1
Location of Observation Beds	Outside ED	Limited	Inside ED	High (Necessarily In)			1
Boarding of Admitted Pts	Outside ED	Stay 90-120 Min	Stay Over 150 Min.	High (315 minutes)			1
Turnaround Time Dx Tests	<46 Minutes	60 Minutes	> 90 Minutes	Mid (60-90 minutes)		1	
Percent of Behavioral Health Patients	< 3%	4-6%	>7	Mid (6.8%)		1	
Percent of Non-Urgent Patients	>45%	25-45%	<25%	Mid (29%)		1	
Age of Patient	<10% Age 65+	<10-20% Age 65+	>20% Age 65+	High (22%)			1
Imaging within ED	None	General and CT	Extensive	High (Necessarily In)			1
Family Amenities	None	Limited Consult	Multiple Consult, Grieving	High (multiple rooms)			1
Specialty Components: Geriatrics	None	Area	Module with Support	Low (none)	1		
Specialty Components: Pediatrics	None	Area	Module with Support	Low (none)	1		
Specialty Components: Detention	None	Area	Module with Support	Low (none)	1		
Admin/Teaching Space	Minimal	Moderate	Extensive	Mid (Flight CTRL / Conf.)		1	
Count					3	6	7
% of Total					19%	38%	44%

a) Projected Percentage of Admitted Patients at UC FMF

With respect to the percentage of patients admitted to a hospital, UC FMF projects to be in the mid-range of the ACEP guide based on historic emergency department visits at HMH and projected visits to UC FMF. Starting in fiscal year 2022, patients that were previously admitted at HMH will be treated at UC FMF as outpatients and then transferred to other hospitals for inpatient admissions. In fiscal year 2022, there is a projection of 653 emergency department visits that will result in admission to UC Behavioral Health. An additional 2,938 emergency department visits will be admitted to other hospitals in fiscal year 2022 growing to 2,964 by fiscal year 2024. Emergency department visits that are projected to be admitted as inpatients represent 13.2% of the total projected 27,348 emergency department visits to UC FMF in fiscal year 2024.

UC FMF's projected number of inpatient admissions is consistent with utilization trends at HMH, adjusted to eliminate 0.4% of inpatient emergency department visits related to non-stroke EMS Priority 1 patients that will not be transported to UC FMF. UC FMF's projection that in fiscal year 2024, 13.2% of emergency patients will be admitted to UC Behavioral Health, UCMC, and other hospitals is below the statewide hospital emergency department admission average of 14.8% inpatient admissions as reported by the Maryland Health Care Commission to the Maryland House Health and Government Operations Committee at a February 10, 2015 hearing.

While the percentage of patients projected for UC FMF exceeds that of existing Maryland FMFs, for the reasons discussed below, UC FMF will be a fundamentally different than the three

existing FMFs, Shore Emergency Center at Queenstown, Bowie Health Center, and Germantown Emergency Center. According to the Maryland Health Care Commission's presentation to the Maryland House Health and Government Operations Committee, an average of 5.1% of patients treated in fiscal year 2014 at Maryland's three existing FMFs were admitted as hospital inpatients. Importantly, however, none of the existing FMFs was planned, designed, equipped, or staffed to serve as a replacement for an existing hospital emergency department. Moreover, each of these existing FMFs is limited in its capacity and ability to serve the acuity of patients currently seen at HMH. No existing FMF in Maryland has observation beds, none is accredited by the Joint Commission as an Acute Stroke Ready Hospital and only one, UM Shore Emergency Center at Queenstown, has an EMS base station.

Perhaps more significant in relation to the admission rates at existing Maryland FMFs, until July 1, 2017, MIEMSS protocols prohibited EMS providers from transporting patients who were experiencing emergency medical conditions to two of the three existing Maryland FMFs. Under MIEMSS protocols, EMS providers could only transport patients who either did not require medical attention at all or who suffered from non-emergent conditions to Bowie Health Center and Germantown Emergency Center. Under a pilot protocol applicable only to UM Shore Emergency Center beginning on July 1, 2014, EMS providers could transport stable Priority 2 patients, defined as patients suffering from a "less serious condition yet potentially life-threatening injury or illness, requiring emergency medical attention but not immediately endangering the patient's life," following a consultation with clinical personnel staffing the base station at Shore Emergency Center at Queenstown. *See* MIEMSS, The Maryland Medical Protocols for Emergency Medical Services Providers Protocols at 268-18, 305 (July 1, 2014). As a result, the number of patients suffering from actual emergency medical conditions treated at existing FMFs in Maryland in fiscal year 2014 was largely limited to walk-in patients. The low acuity of patients seen at the existing Maryland FMFs in fiscal year 2014 certainly drove the low hospital admission rate for patients treated at these facilities as summarized by the Commission in its report.

Effective July 1, 2019 MIEMSS protocols have been updated to permit EMS providers to now transport stable Priority 2 patients to all Maryland FMFs. *See* MIEMSS, The Maryland Medical Protocols for Emergency Medical Services Providers Protocols at 355 (July 1, 2017). Assuming Maryland FMFs undertake measures to safely and effectively treat stable Priority 2 EMS patients, the expansion of the MIEMSS freestanding pilot protocol to all Maryland FMFs has likely increased the acuity of patients seen at FMFs and also correspondingly increased the percentage of patients admitted for inpatient care. UC FMF is designed and will be staffed to treat such patients. Indeed, as described above, UC FMF will maintain HMH's EMS base station designation in accordance with a pilot program approved by the EMS Board to allow EMS providers to transport priority 1 stroke patients to UC FMF if a Primary Stroke or Comprehensive Stroke Center is greater than fifteen (15) additional minutes away.

In sum, because UC FMF will have been planned, designed, equipped, and staffed to serve as a replacement for an existing hospital and to meet the emergency health care needs of its service area population, UC FMF will treat a greater percentage of high acuity patients who will require admission following emergency treatment than at existing Maryland FMFs. The projected number of patients who will be admitted is based on historic use rates in the service area population and falls within the mid-range of the ACEP Guidelines.

b) Projected ALOS for UC FMF Emergency Visits

The historic emergency department utilization at HMH and projected utilization at UC FMF also falls within the ACEP Guide "mid-range" criteria. An analysis of the average length of stay for emergency department visits at HMH in fiscal year 2017 presents an average of 3.6 hours. *See* **Table 15** below.

Table 15
HMH Historical Emergency Department Hours per Visit
FY2017

	FY2017
ED Visits	28,476
Average Minutes per Visit	238.48
Less: Average Minutes from Registration to ED Bay	(21.49)
Average Minutes per Visit in ED Bay	216.98
Average Hours per Visit in ED Bay	3.6

Source: UCHS Internal Utilization Report

UC FMF also projects that 7.0% of UC FMF emergency department visits will be patients suffering from emergency psychiatric conditions; such patients have a much longer visits the emergency department with the average being 10.9 hours at HMH during the 5:00 pm hour. Factoring in the psychiatric patients, the average visit time is expected to average approximately four (4) hours.

c) UC FMF Patient Care Services

In UC FMF's emergency department space programming, the applicants focused on patient and family experience, recognizing that negative patient satisfaction scores are generally associated with small, shared, less private care spaces. Such negative patient satisfaction scores are associated with patient confidentiality concerns as well as infection prevention considerations. The applicants expect that patient satisfaction will be a significant factor in ensuring that the community utilizes UC FMF to its full potential. As a result, UC FMF has been designed with private emergency department treatment spaces, which fall within the ACEP "high range," as opposed to using rapid medical evaluation areas and/or vertical areas, including patient recliners, three-walled patient areas, or cubicles as contemplated by the ACEP "low range."

d) Inner Waiting Areas and Results Waiting Areas

UC FMF has been designed such that patients will remain in private treatment spaces for their entire visit, which falls within the ACEP Guide "high range" criteria. The applicants do not agree with the author of the ACEP Guide that inner waiting or results waiting spaces in an emergency department are consistent with best practices or better outcomes. Rather, maintaining patients in triage provides benefits with respect to patient to flow. As acuity has risen within hospitals and emergency departments, the safety of inner waiting or results waiting spaces has also been questioned because such spaces do not provide for close patient monitoring.

e) Location of Clinical Decision Unit or Observation Space

As reflected on **Exhibit 2**, the observation unit at UC FMF will be adjacent to the emergency department and is part of the applicant's architectural project consistent with the ACEP Guide "high range" criteria. However, as patients are changed to observation status, they will leave the emergency department treatment space which consideration falls within the ACEP Guide "low range" criterion. To the extent the observation unit is deemed not to be part of the UC FMF emergency department, the overall size of the emergency department should be reduced by 11,666 square feet for purposes of COMAR 10.24.17.04(c)(8)(d)(ii).

f) Boarding Time of Admitted Patients

UC FMF projects to be with the ACEP Guide "high range" for this criteria with an average boarding time for admitted patients projected to be 315 minutes. The goal for optimal patient management is to achieve an average two-hour (120 minute) transport time for emergent, high acuity patients requiring a higher level of care. This two-hour window will start from the time a decision to admit a patient has been made and continue until the patient arrives at the receiving facility. The two-hour transport window will be accelerated for patients experiencing life threatening conditions; for example, UC FMF will have accelerated transport protocols for stroke and cardiac patients.

For non-emergent transports, a three to four-hour transport window will start from the time the receiving facility confirms bed availability. This transport time is consistent with existing patient boarding times at HMH and UCMC and will include transit time in an ambulance. UC FMF will require time to coordinate placement of most patients in an MSGA unit the receiving facility before transporting the patient. Moreover, UC FMF must still comply with the Emergency Medical Treatment and Labor Act ("EMTALA"), including the requirement to have a prepared room before transporting a patient and confirmation of acceptance from the receiving facility. *See* 42 C.F.R. §489.24(e)(2). UC FMF will not transfer patients to another emergency department unless the patient's condition requires surgery or the patient is suffering from time dependent diagnosis that requires immediate transport.

From a clinical perspective, UC FMF cannot accelerate the boarding time by routing patients awaiting transfer to an inpatient unit to UC FMF's observation unit. Such a practice would not be consistent with the standard of care. The applicants' intend to staff the observation unit at UC FMF with acute care nurse practitioners under the supervision of hospitalists. Patients requiring transfer from UC FMF's emergency department for an acute inpatient admission will necessarily require a higher level of care than will be provided in UC FMF's observation unit. Therefore, it would be clinically inappropriate to send emergency department patients awaiting an acute inpatient admission to UC FMF's observation unit.[7]

[7] In certain cases, patients already admitted to UC FMF's observation unit may require an inpatient admission. In such cases, UC FMF's observation unit staff will be supported by UC FMF emergency department physicians as needed to ensure the observation patient receives medically necessary treatment and intervention before the patient can be admitted.

Moreover, from compliance and billing perspectives, admitting patients from the emergency department to the observation unit while the patient is awaiting transfer to an inpatient facility would also be inappropriate. UC FMF's observation unit will not be merely a patient holding area but rather a unit dedicated to ongoing assessment and reassessment to determine whether an inpatient admission is necessary or whether the patient can be safely discharged. Medicare guidance, which is followed by Medicaid and most commercial insurers, defines observation care as:

> a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.

Centers for Medicare and Medicaid Services, *Medicare Claims Processing Manual*, Ch. 4 § 290.1 (Effective Date: 07-01-09) (emphasis added). Because a clinical decision to transfer emergency patients to a higher level of care will have already been made, it would not be appropriate to admit a patient awaiting such a transfer for observation services.

g) Turnaround Time for Diagnostic Tests

The applicants' projected average imaging study turnaround time is presumed to be consistent with historical trends at HMH. In the first through third calendar quarters of 2018, 95.7% of imaging studies during the day and evening shifts had a turnaround time within 60 minutes. For overnight imaging study interpretations, 85.1 % were completed within 60 minutes during the first through third calendar quarters of 2018. For laboratory testing, in fiscal year 2019, 91.6% of HMH's emergency department laboratory tests had a turnaround test result within 40 minutes. Based on these figures, HMH and UC FMF are projected to be within the ACEP Guide "mid-range" for this criterion as reflected on Table 5.2 of the ACEP Guide.

h) Percentage of Behavioral Health Patients

As reflected in the applicants' need analysis for behavioral health treatment spaces above, in fiscal year 2017, an average of 7.0% of HMH's emergency department visits were diagnosed with a behavioral health condition. This projects that UC FMF will be in the mid-to-high range as contemplated by the ACEP Guide.

i) Percentage of Non-Urgent Patients

Based on the historic emergency severity index ("ESI") levels of patients treated at HMH in fiscal year 2018, UC FMF projects to be the ACEP Guide mid-range with approximately 28% of non-urgent patients. **Table 16** below.[8]

Table 16
HMH FY 2018 ED Visits and Disposition

ESI Treatment Level	ED Discharges	Inpatient Admits	Observation Admits	Grand Total
1	113	139	49	301
2	2,798	2,031	1,232	6,061
3	10,376	1,559	1,460	13,395
4	6,961	84	55	7,100
5	399		1	400
Unclassified	108	2	1	111
	20,755	**3,815**	**2,798**	**27,368**

j) Age of Patients

In fiscal year 2018, patients 65 and older comprised 22.6% of the total number of emergency department visits to HMH, while in fiscal year 2017, patients 65 and older comprised 21.4% of emergency department visits. *See* **Table 17** below.

Table 17
HMH Percentage of Emergency Department Patients >= 65
FY 2018 and FY 2017

FY 2018	Patients >= 65	Total Visits	>= 65 % of Total
ED Visits	6,178	27,368	22.6%
FY 2017	**Patients >=65**	**Total Visits**	**>=65% of**
ED Visits	6,097	28,502	21.4%

[8] The percentage of ESI level 4 and 5 patients seen in HMH's emergency department in fiscal year 2018 includes 111 emergency department patients not assigned an ESI severity index classification.

Source: UCHS internal utilization report

Of the 65 and older patients, in fiscal year 2017, 48.0% arrived to HMH's emergency department by ambulance, **Table 18** below, and in fiscal year 2018, 48.8% arrived to HMH's emergency department by ambulance, **Table 19** below.

Table 18
HMH % of Emergency Department Patients >= 65 Arriving by Ambulance
FY 2017

Age Group	Patient Status	Arrived by Ambulance	Total Cases	% by Ambulance
>= 65	Inpatient	1,277	1,867	68.4%
	Outpatient	1,652	4,230	39.1%
>= 65 Total		**2,929**	**6,097**	**48%**
< 65	Inpatient	663	1,893	35.0%
	Outpatient	3,295	20,512	16.1%
< 65 Total		**3,958**	**22,405**	**17.7%**
Grand Total		**6,887**	**28,502**	**24.2%**

Source: UCHS Internal Utilization Report

Table 19
HMH % of Emergency Department Patients >= 65 Arriving by Ambulance
FY 2018

Age Grouping	Patient Status	Arrived by Ambulance	Total Cases	% by Ambulance
>= 65	Inpatient	1,232	1,849	66.6%
	Outpatient	1,783	4,329	41.2%
>= 65 Total		**3,015**	**6,178**	**48.8%**
< 65	Inpatient	719	1,966	36.6%
	Outpatient	3,387	19,224	17.6%
< 65 Total		**4,106**	**21,190**	**19.4%**

Ambulance transport for nearly fifty percent (50%) of the aged 65 and over population, particularly EMS transport, is expected to limit any patient self-selection of the emergency department to which these patients are transported. Moreover, it is also doubtful that any age patient, much less those aged 65 and over, would be inclined to drive past UC FMF, a full service emergency department, to another hospital further away such as UCMC (12.4 miles), Union Hospital (21.8 miles) or Franklin Square Medical Center (23.2 miles) in a medical emergency.

As noted by the Commission in its February 2, 2015 Report on the Operations, Utilization, and Financial Performance of Freestanding Medical Facilities, EMS transport protocols are likely contributing factors to low utilization of existing Maryland FMFs by the population aged 65 and older. As set forth above, UC FMF projects that only a limited number of non-stroke priority 1 patients that are currently treated at HMH could not be treated at UC FMF in accordance with revised MIEMSS protocols and the pilot stroke protocol approved for UC FMF. As a result, UC FMF is projected to be in the ACEP Guide "high range" with greater than twenty percent (20%) of emergency department patients aged sixty-five or older.

k) Imaging Facilities within the Emergency Department

With respect to imaging facilities, Table 5.2 of the ACEP Guide "low range" provides, "imaging studies will not be performed within the department, so there is no need to add space for imaging rooms." At UC FMF, an imaging department is a necessary component of the facility to safely and effectively treat emergency and observation patients and is necessarily a part of the construction project. To the extent the imaging unit is deemed not to be part of the UC FMF emergency department, the overall size of the emergency department should be reduced by 5,573 square feet for purposes of COMAR 10.24.17.04(c)(8)(d)(ii).

The imaging unit being developed at UC FMF will be used by both UC FMF patients arriving for urgent and emergent care on an unscheduled basis and for patients at the adjacent special psychiatric hospital requiring such services. UC FMF's imaging unit will not be used for scheduled outpatient use. In the first six (6) months of fiscal year 2018, HMH outpatient emergency department utilized imaging services as presented below in **Table 20**. The historical relationship of imaging services to emergency department visits will continue at UC FMF with the exception of nuclear medicine, which will not be offered at UC FMF.

Table 20
Imaging Services Utilized by Outpatient Emergency Department Visits
FY 2018 (1)

Service	Outpatient Utilization	% of ED Visits
Emergency Department Visits	23,368	100.0%
Radiology - Diagnostic	10,796	46.2%
CAT Scanner	5,744	24.6%
Electrocardiography	6,504	27.8%
Magnetic Resonance Imaging	542	2.3%
Nuclear Medicine	358	1.5%

Note (1): Reflects annualized 6 months (July 2017 – December 2017) of St. Paul's Non-Confidential Patient Level Data.

With respect to MRI, CT, and ultrasound, the applicants do not project that these imaging modalities will be used as efficiently at UC FMF as they are presently used at HMH, where they serve both emergency department patients and inpatients. However, MRI, CT, and ultrasound are necessary to provide clinically appropriate care to emergency and observation patients at UC FMF.

More specifically, MRI is necessary to treatment patients with Transient Ischemic Attack ("TIA") or suspected stroke. Indeed, as described in footnote 3 above, MRI has been shown as superior to CT to identify acute ischemic stroke as per the AHA/ASA Guidelines in 2010 and 2013. Further, as described in footnote 3, CT and MRI are necessary at UC FMF to maintain Acute Stroke Ready Joint Commission Accreditation under the EMS pilot protocol applicable to UC FMF.

l) Family Amenities

As reflected in **Exhibit 2**, UC FMF will have multiple provisions for family consultation and nourishment, which are necessarily a part of UF FMF's construction project and thus fall within the ACEP Guide "high range" for this criterion. The "Quiet Room" as show on **Exhibit 2** will be used for family consultation with the emergency department providers and/or chaplain. The "Rec Room" or reception room in the observation department will accommodate family consultations. Finally, UC FMF will share approximately 26,423 square feet the UC Behavioral Health, which will include family nourishment and waiting areas.

m) Specialty Components – Geriatrics, Pediatrics, and Detention

UC FMF will not have any specialty components for geriatrics, pediatrics, or detention, and therefore has classified each of these criterion within the ACEP "low range."

n) Need for Administrative Space

Because UC FMF is a freestanding facility, it will necessarily need administrative office space in its emergency department, including but not limited to telemedicine and flight control for the on-site helicopter pad. The applicants have therefore placed UC FMF within the ACEP Guide "mid-range" for this criterion.

* * *

In sum, UC FMF falls within the "high" range of the ACEP Guide for seven (7) of the ACEP range criteria, in the "mid" range for six (6) of the ACEP Guide criteria, and in the "low" range for only three (3) of the ACEP Guide criteria. Overall, UC FMF projects to be in the mid-high range based on the ACEP Guide criteria, the projected need for emergency and observation services for the community formerly served by HMH, and for the projected service line requirements. At the mid-range, projected 27,000 emergency department bed visits equates to a need for 17,404 departmental square feet.

Although the ACEP Guide provides for a 1.25 multiplier as a building square footage adjustment factor for a freestanding facility, this adjustment factor is inadequate given UC FMF's utilization projections, projected patient volumes and acuity levels, and needed specialty programs at UC FMF to serve a community that will lose its acute general hospital. Applying the 1.25 multiplier at the ACEP low range with 30,000 annual emergency visits would result in a facility of only 26,250 building gross square feet at the low range. Although the applicants have sought to demonstrate that the 1.25 multiplier is inapplicable to the proposed UC FMF, the ACEP Guide provides no rationale for the 1.25 multiplier for a freestanding facility nor a description of the services contemplated at such a freestanding facility. At bottom, the 1.25 adjustment factor referenced in the ACEP Guide is nothing more than an adjustment to account for wall thickness, mechanical penthouses, stair shafts, etc. *See* ACEP Guide at 113.

The ACEP Guide 1.25 adjustment factor for a freestanding facility fails to account for the need for an observation suite, imaging and laboratory services, a pharmacy, behavioral health crisis treatment spaces, or extensive administrative space within its square footage recommendations. Nor does the ACEP Guide contemplate the space required to obtain an EMS Base Station designation, to provide telemedicine services, or for a helicopter control room.

Contrary to the ACEP low range, the space programming at UC FMF will necessarily house observation, imaging, lab, and pharmacy, and other ancillary services which are intended to support the diagnostic and treatment needs of patients seen at UC FMF. Each of three distinct patient populations to be treated at UC FMF – general emergency, behavioral health crisis, and observation patients – require access to these ancillary services as a core aspect of their treatment. The ACEP Guide low range fails to allocate *any* space for existence of these services. Additionally, the imaging, lab, and pharmacy departments at UC FMF will also support UC Behavioral Health's patients needing these services. Therefore, each of these ancillary service departments have been sized in order to support each of the different patient populations to be treated at UC Medical Campus at Aberdeen, ultimately reducing the need for redundant services while seeking economies of scale.

As set forth above with respect to the emergency department treatment spaces and immediately below with respect to the size of the observation treatment spaces, UC FMF was designed in accordance with the 2018 FGI Guidelines to comply with licensing regulations and modern standards of care. Each of these departments either comply with the ACEP low range and any deviations are necessary to provide effective treatment for the population to be served.

Overall, the project design is, however, consistent with the ACEP Guide except where the ACEP Guide conflicts with the FGI Guidelines. For example, UC FMF's imaging department includes the following components and square footage:

a) MRI – 538 square feet, exclusive of the control room;
b) CT – 473 square feet, exclusive of the control room;
c) Diagnostic imaging suite with X-ray – 312 square feet;
d) Two cardio-vascular ultrasound modalities at 554 square feet combined.

The ACEP Guide recommends General Radiology room space at 250 to 325 square feet. ACEP Guide at 165. UC FMF's diagnostic imaging suite and two cardio-vascular ultrasound rooms are consistent with the ACEP Guide design recommendations. The ACEP Guide, however, recommends MRI and CT space at 300 to 325 square feet plus 120 to 150 square feet for the control room. *Id*. These room sizes are inadequate to meet the clear floor space requirements of the FGI Guidelines. For an MRI scan room, FGI Guidelines require a minimum of 4 feet clearance around all sides of the gantry and recommend the room size be per the equipment manufacturer's recommendations, in addition to making sure certain functions for the entry into the room and resuscitation fall outside of the 5 Gauss line, the limit beyond which ferromagnetic objects are strictly prohibited. Best practice provides space for the maneuvering of a patient stretcher on either side of the gantry, thereby exceeding the stated minimum in the guidelines. Therefore, a 325 square foot MRI room is too small, given the FGI Guideline standards. UC FMF's MRI room has been designed according to best practices and actual design and constructability experience. Similarly, for a CT room, the FGI Guidelines require a minimum of 4 feet clearance around all sides of the

gantry and recommend the room size be per the equipment manufacturer's recommendations. Best practice provides space for the maneuvering of a patient stretcher on either side of the gantry, thereby exceeding the stated minimum in the guidelines. Again, UC FMF's CT room has been designed according to best practices and actual design and constructability experience.

In sum, each component of UC FMF is designed according to FGI Guidelines requirements and is consistent with size recommendations found in the ACEP Guide unless such guidance conflicts with the FGI Guidelines required for licensure.

(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;

Applicants' response: Since filing its Modified Request for Exemption from CON Review on November 21, 2018 and based on discussions with Commission staff, UM UCH has revaluated the bed complement associated with the merger and consolidation of UCMC and HMH. UM UCH's clinical staff has considered implementation of clinical practices that could better align UM UCH's observation use rates with an identified peer group of hospitals. Through enhanced case management, utilization review, and triage evaluation processes, UM UCH estimates that it may be able to slightly reduce its observation utilization through either direct patient discharges or transitions of care to other outpatient departments or providers. UM UCH also estimates that through implementation of such clinical practices, approximately 34% of historic observation cases that lasted 24 or more hours will result in direct inpatient admissions from the emergency department at UCMC and from the proposed freestanding medical facility in Aberdeen. The planned changes to clinical protocols and process will be implemented beginning in January 2020 and require 18 months through the end of fiscal year 2021 to be fully implemented.

As described below, these changes in clinical observation practices and their impact on medical surgical admissions will move UCH's utilization of observation services in the direction of its hospital peer group and position UCH's utilization of inpatient medical surgical services to be comparable to that of its hospital peer group.

1. HMH / UC FMF Observation Cases

As presented in **Table 21** below, the changes outlined above are projected to achieve a 5.6% reduction in the number of projected observation cases in fiscal year 2020 followed by a 12.2% reduction in fiscal year 2021. Included in these changes are an assumed 0.25% annual reduction in observation PAUs offset partially by 0.6% annual growth in population.

Table 21
HMH and UC FMF Historical and Projection Observation Cases
FY2015 – FY2024

	Historical				Projection						% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Observation Cases											
HMH	**3,761**	**3,896**	**4,019**	**4,443**	**4,458**	**4,210.0**	**3,697**	**-**	**-**	**-**	
%Change	*2.3%*	*3.6%*	*3.2%*	*10.5%*	*0.3%*	*-5.6%*	*-12.2%*	*-100.0%*	*0.0%*	*0.0%*	
UC FMF								**3,718**	**3,740**	**3,763**	
%Change									*0.6%*	*0.6%*	
Total	**3,761**	**3,896**	**4,019**	**4,443**	**4,458**	**4,210**	**3,697**	**3,718**	**3,740**	**3,763**	
%Change		*3.6%*	*3.2%*	*10.5%*	*0.3%*	*-5.6%*	*-12.2%*	*0.6%*	*0.6%*	*0.6%*	*-15.3%*

Beginning in fiscal year 2022, the observation cases are projected to grow annually with population increases. While observation patients that are expected to stay greater than 48 hours will eventually be transferred to UCMC, they will continue to come to the UC FMF first and then be transferred after it is determined that they will stay greater than 48 hours. Overall, the applicant expects that there will be a 15.3% reduction in observation cases at UC FMF in fiscal year 2024 when compared with observation cases at HMH in fiscal year 2018. (**Table 21**).

In comparing HMH's actual utilization of observation cases per emergency department visit to that of its hospital peer group, UCH found that HMH has an observation utilization ratio that is greater than that of its peer group average **(Table 22**). Applying the projected reduction in observation cases in fiscal year 2020 to HMH's actual utilization of observation cases in fiscal year 2018 would reduce that ratio to be comparable to the hospitals in UCH's hospital peer group.

Table 22
Comparison of Observation Cases per Emergency Department Visit
FY2018

	Observation Cases	Emergency Department Vists	OBV Cases per ED Visit
UCHS			
UM Upper Chesapeake Medical Center	13,930	60,928	0.23
UM Harford Memorial Hospital	4,443	26,743	0.17
UCHS Combined	18,373	87,671	0.21
Peer Group			
UM St. Joseph Medical Center	6,832	45,512	0.15
UM Baltimore Washington Medical Center	10,015	84,775	0.12
Carroll Hospital Center	5,541	48,024	0.12
MedStar Franklin Square	9,245	85,810	0.11
Howard County General Hospital	8,286	78,049	0.11
Peer Group Weighted Average			**0.12**
Impact of UCHS Achieving Targeted Reductions in Observation Utilization			
UCHS Reduction			
UM Upper Chesapeake Medical Center	(2,496)		
% Reduction	*-17.9%*		
UM Harford Memorial Hospital	(808)		
% Reduction	*-18.2%*		
UCHS Combined	(3,304)		
% Reduction	*-18.0%*		
Pro Forma Observation Cases			
UM Upper Chesapeake Medical Center	11,434	60,928	0.19
UM Harford Memorial Hospital	3,635	26,743	0.14
UCHS Combined	15,069	87,671	0.17

Source: FY2018 Annual Filing

2. HMH / UC FMF Observation Average Length of Stay

Determining the average length of stay to apply to the observation patients at HMH through fiscal year 2021 and at the FMF beginning in fiscal year 2022 requires an understanding of the observation hours that can be billed and those hours that are not billed. Per the HSCRC Experience Report dataset, HMH reported 114,915 observation hours in fiscal year 2018 (**Table 23).** Included in these hours are 23,762 hours related to observation patients that were eventually admitted as an inpatient and 91,153 hours for patients that remained in outpatient status their entire stay.

Table 23
HMH's 2018 Observation ALOS

	2018		
	Inpatient	Outpatient	Total
FY2018 HSCRC Experience Report			
Cases	1,640	2,803	4,443
Hours	**23,762**	**91,153**	**114,915**
ALOS (Days)	0.60	1.35	1.08
HMH Internal Report on Observation Hours for 12 Months Ended August 2018			
Cases	1,624	2,843	4,467
Hours	**52,983**	**109,920**	**162,903**
ALOS (Days)	1.36	1.61	1.52
Unbilled Hours	**29,221**	**18,767**	**47,988**
Unbilled Hours % of HSCRC Reported Hours	123.0%	20.6%	41.8%

According to billing requirements for those patients that are eventually admitted, only those observation hours that occurred prior to 12:00 am of the day of admission can be billed. While at HMH, observation and medical patients will continue to overlap in the existing beds and the inpatient day will account for the time that a patient is in observation status. Beginning in fiscal year 2022, a distinct observation unit will be operated in the FMF. As a distinct observation unit, the full length of stay needs to be considered when determining the required number of observation beds.

During the 12 months ended August 2018, it was determined that HMH experienced 162,903 observation hours, a 41.8% increase over the hours billed during the twelve months ended June 2018 (fiscal year 2018). Rather than staying in a bed an average of 1.08 days as reported in fiscal year 2018 HSCRC Experience Report, observation patients actually stayed in beds for an equivalent of 1.52 days (**Table 23**). This 41.8% disparity in actual hours incurred over historical reported hours needs to be considered when determining the required number of observation beds.

Table 24 below demonstrates a continuation of the average length of stay of 1.08 days from fiscal year 2018 to fiscal year 2019. The average length of stay then increases 12.5% in fiscal year 2020 to reflect a net increase for outpatient observation hours greater than 48 hours, which is offset partially by the expected reduction in the number of observation cases greater than 24 hours. In fiscal year 2021, the average length of stay is projected to decline 8.3% as observation cases greater than 24 hours continue to be reduced. The average length of stay then increases 4.0% in fiscal year 2022 to reflect a combination of (1) the additional non-billable inpatient hours that observation patients will spend at UC FMF before being admitted to UCMC and (2) a reduction in the length of stay for those outpatient observation cases that have historically stayed greater than 48 hours but will be transported to UCMC before reaching 48 hours.

Table 24
HMH and UC FMF Historical and Projected ALOS
FY2015 – FY2024

	Historical				Projection					
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
HMH	**1.21**	**1.20**	**1.20**	**1.08**	**1.08**	**1.21**	**1.11**			
%Change		*-0.7%*	*-0.1%*	*-10.0%*	*0.0%*	*12.5%*	*-8.3%*			
UC FMF								**1.16**	**1.16**	**1.16**
%Change								*4.0%*	*0.0%*	*0.0%*

3. HMH / UC FMF Observation Patient Days

Multiplying the projection of observation cases by the projected average length of stay results in a projection of observation patient days (**Table 25**). In fiscal year 2020, the 6.2% increase in patient days reflects the reduction in projected observation cases offset by the increase in the average length of stay. In fiscal year 2022, the reduction in observation cases is compounded by a reduction in the average length of stay for a 19.4% reduction in patient days. In fiscal year 2022, the increase in observation cases related to population growth is combined with the increase in average length of stay for a 4.6% increase in patient days. Observation patient days are then projected to grow with population increases in fiscal year 2023 and 2024. Offset partially by the population growth, observation patient days are projected to decline 9.1% between fiscal year 2018 and 2024.

Table 25
HMH and UC FMF Historical and Projected Observation Patient Days
FY2015 – FY2024

	Historical				Projection						% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Observation Patient Days											
HMH	**4,541**	**4,670**	**4,813**	**4,788**	**4,802**	**5,101**	**4,109**	-	-	-	
%Change		*2.8%*	*3.1%*	*-0.5%*	*0.3%*	*6.2%*	*-19.4%*	*-100.0%*	*0.0%*	*0.0%*	
UC FMF								**4,298**	**4,324**	**4,350**	
%Change									*0.0%*	*0.0%*	
Total	**4,541**	**4,670**	**4,813**	**4,788**	**4,802**	**5,101**	**4,109**	**4,298**	**4,324**	**4,350**	
%Change		*2.8%*	*3.1%*	*-0.5%*	*0.3%*	*6.2%*	*-19.4%*	*4.6%*	*0.6%*	*0.6%*	*-9.1%*

4. HMH / UC FMF Observation Bed Need

Dividing the projected patient days by 365 days a year results in a projected average daily census (ADC) of 14 patients in fiscal years 2020 declining to 11 beds in fiscal year 2021 and 12 patients in fiscal years 2022 through 2024. The applicants then used the State Health Plan occupancy assumption of 80% for HMH's MSGA services with an ADC of 50-99 patients (State Health Plan for Acute Care Hospital Services, COMAR 10.24.07) to project the number of observation beds at HMH in fiscal years 2020 and 2021. Beginning in fiscal year 2022, the applicants used the State Health Plan occupancy assumption of 70% for MSGA services with an ADC of less than 50 patients (State Health Plan for Acute Care Hospital Services, COMAR 10.24.07) to project the number of observation beds at the UC FMF. Based on the assumptions

presented above, there is a projected need in fiscal year 2024 of 17 observation beds at UC FMF (**Table 26**).

Table 26
HMH and UC FMF Historical and Projected Observation Bed Need
FY2015 – FY2024

	Historical				Projection					
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Average Daily Census										
HMH	12	13	13	13	13	14	11			
UC FMF								12	12	12
Total	12	13	13	13	13	14	11	12	12	12
Occupancy										
HMH	80%	80%	80%	80%	80%	80%	80%			
UC FMF								70%	70%	70%
Bed Need										
HMH	16	16	16	16	16	17	14			
UC FMF								17	17	17
Total	16	16	16	16	16	17	14	17	17	17

(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.

Applicants' response: The ACEP Guide generally projects a square footage range of 135 to 150 for each observation room. ACEP Guide at 157. However, the ACEP Guide also instructs that, "if you decide to equip the [observation] rooms with standard inpatient hospital beds, you'll need larger rooms – 150 to 160 [square feet]." *Id*. at 271.

Because the projected average length of stay of patients in observation at UC FMF is 1.16 days or 27.8 hours, significantly longer than the ACEP Guide considers, which is between 8 and 12 hours, the observation unit has been planned to use standard inpatient hospital beds rather than gurneys. To comply with licensing regulations and modern standards of care, UC FMF has been designed to comply with the 2018 FGI Guidelines. Pursuant to 2014 FGI Guideline 2.2-3.2.2.2, observation beds require a minimum clear floor area of 120 square feet. Further, because the observation rooms may accommodate patients for up to forty-eight (48) hours and there will be no inpatient beds in which to house patients at UC FMF, the observation rooms have been designed to create a comfortable patient stay and to allow visitors. Twelve of UC FMF's observation rooms have been designed to be between 171 and 175 square feet, exclusive of in room toilet and bathing areas. This size allows for a standard hospital bed in each observation room and other required furniture such as side chairs and storage to be accommodated in the room while satisfying the minimum requirement of 120 square feet of clear floor area. Additionally, observation room one is designed as an isolation room and is 198 square feet, exclusive of in room toilet and bathing areas, and observation room 4 is designed as a "person of size room," being 233 square feet,

exclusive of in room toilet and bathing area. Observation rooms 2 and 3 are designed as 201 square feet and 202 square feet, exclusive of in room toilet and bathing areas. Observation rooms 1 through 4 are also larger simply because of their location within the floorplate of UC FMF.

This room sizing is consistent with the observation room sizes at FMFs recently approved by the Commission at UM Laurel Medical Center. In phase 1 of the of UM Laurel Medical Center, the Commission approved 10 observation rooms each being 260 square feet with 60 square foot toilets. In phase 2 of UM Laurel Medical Center, the Commission approved 8 observation rooms at 170 square feet, each with 60 square foot toilet and bathing areas, and two bariatric treatment rooms, each being 215 square feet. *See In re: Conversion of University of Maryland Laurel Regional Hospital to a Freestanding Medical Facility*, Docket No. 18-16-EX002, Staff Report and Recommendation at 4 (September 20, 2018).

The design of UC FMF's observation unit also took into consideration enhanced security, room design to support high quality clinical practice (i.e. medication administration delivery system), and enhanced the patient and family experience:

- Infection Prevention & Control:
  - Provision of individual toilets and showers reduces the incidence of infections
  - Physical separation within the semi-private rooms to enhance infection prevention

- Fall Prevention:
  - Due to the configuration of the rooms staff can see the entire patient room from entry
  - Space design supports area for family attendance providing added support to the patient who may be at risk for falls
  - Room design provides for a clear path of travel within the room reducing obstacles likely to cause falls
  - Bathrooms are configured in close proximity to the head wall decreasing distance patient needs to ambulate to the bathroom reducing likelihood of falls
  - Room design includes continuous handrails from the head of the bed to the toilet room reducing the likelihood of falls
  - Toilets and showers were designed to minimize fall risk

- Operational Efficiencies:
  - Clear path of travel within the room for efficient patient transfers and transports
  - Design allows for adequate space at each patient zone for mobile lift equipment when needed
  - Design allows staff visibility of the entire room

- Patient Care/Clinical practice enhancements:
  - Standardized head wall provides clear individual patient zone
  - Design provides a physical, visual, and auditory separation between patients enhancing clinical practice (medication zones)

- Patient & Family Experience:
  - Room design allows for a patient's significant other to stay in a recliner chair during their short stay providing additional support the patient may need thereby enhancing their short stay observation experience.

The observation rooms at UC FMF are designed around patient and family focused. The larger square footage takes into account the anticipated extended stay of the observation patients at UC FMF. When considering the ratio of nurse to patient care in the observation units the larger room provides for the collaboration of caregiver and family care for immediate patient needs. An inpatient room size in accordance with the FGI Guidelines facilitates the family zone and furniture for staying overnight with observation patients. At UC FMF, the observation room size provides for adjoining bathrooms (and shower units on the floor) as well as a family zone in anticipation of the patient stays up to 48 hours.

The floor plate of the building has also been designed to accommodate the space planning requirements of the specialty psychiatric hospital that will be located on the floor above.

In sum, the size of UC FMF's observation treatment spaces is needed to meet the needs of the population to be served and to comply with licensing standards.

(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:

Applicants' response: UCMC and HMH have completed **Tables A**, **B**, **C**, **D**, **E**, **I, J**, and **K**, which are related to UCMC's proposed project and relocation of MSGA beds from HMH to UCMC, as well as the projected utilization and financial performance of UCMC, inclusive of the UC FMF which becomes a department of UCMC beginning in fiscal year 2022. These tables are included with **Exhibit 1**. **Table I** includes utilization projections that reflect both the inpatient and outpatient utilization of UCMC and outpatient emergency department visits, observation cases, and related outpatient ancillary services at UC FMF. Also enclosed with **Exhibit 1**, are **Tables F**, **G**, and **H** that cover the entire utilization and financial performance of all UM UCH hospital facility components, including UCMC and HMH during the period from fiscal year 2015 to fiscal year 2021 and UCMC, UC FMF, and UC Behavioral Health between fiscal years 2022 and 2024. The financial projection assumptions related to revenue, expenses and financial performance underlying **Tables G, H, J** and **K** are also provided with **Exhibit 1**. Additionally, **Exhibit 1** includes a **Table L** that incorporates the workforce for HMH's emergency department in fiscal year 2017 and UC FMF in fiscal year 2024. Included in the figures are full-time equivalent employees ("FTEs") dedicated to the provision of services to patients when they are in the emergency department.

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

Applicants' response: The projection of emergency department visits at UC FMF assumes the continuation of emergency services at HMH adjusted for annual population growth

from actual experience in fiscal year 2018 through fiscal year 2024 with the following exception. In fiscal year 2022, there is an assumed 0.4% reduction in non-behavioral health inpatient projected visits to account for the redirection of non-stroke EMS priority level 1 patients arriving by ambulance who previously would be brought to HMH, but which patients will go to other hospitals with inpatient beds based on drive time and service line. The projected emergency visits are presented in **Table 27**.

Table 27
HMH and UC FMF Historical and Projected Emergency Department Visits
FY2015 – FY2024

	Historical				Projection						% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Emergency Department Visits											
HMH											
Inpatient Visits	3,472	3,179	3,626	3,583	3,599	3,615	3,631	-	-	-	*-100.0%*
Outpatient Visits	25,870	26,341	24,730	23,160	23,263	23,366	23,470	-	-	-	*-100.0%*
Total	**29,342**	**29,520**	**28,356**	**26,743**	**26,862**	**26,981**	**27,101**	**-**	**-**	**-**	*-100.0%*
%Change	*2.3%*	*0.6%*	*-3.9%*	*-5.7%*	*0.4%*	*0.4%*	*0.4%*	*-100.0%*	*0.0%*	*0.0%*	
UC FMF											
IP Psych Visits (1)	-	-	-	-	-	-	-	653	656	659	
Outpatient Visits (2)	-	-	-	-	-	-	-	26,453	26,571	26,689	
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**27,106**	**27,227**	**27,348**	
%Change	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*100.0%*	*0.4%*	*0.4%*	
Total	29,342	29,520	28,356	26,743	26,862	26,981	27,101	27,106	27,227	27,348	*2.3%*
%Change	*2.3%*	*0.6%*	*-3.9%*	*-5.7%*	*0.4%*	*0.4%*	*0.4%*	*0.0%*	*0.4%*	*0.4%*	

Note (1): Reflects Behavioral Health patients that will be admitted to UC Behavioral Health on the UCH Medical Campus at Havre de Grace
Note (2): Includes approximately 3,000 patients that were previously admitted at HMH, but will enter UC FMF as outpatients and then be transferred to other hospitals for inpatient admission

The Applicants have assumed that with the exception of 0.4% of historical EMS priority 1, non-stroke patients, the residents of HMH's service area will continue to come to UC FMF when experiencing emergency health conditions. These utilization projections are supported by UC FMF's plans to implement an Acute Stroke Ready Pilot and MIEMMS protocol changes allowing stable priority 2 and priority 1 stroke patients to be transported to UC FMF. The increase in accessibility to Interstate 95 rather than HMH's landlocked campus in downtown Havre de Grace is also likely to result in an increase in patient walk-ins particularly from surrounding areas, including Aberdeen, due to UC FMF being more readily accessible than HMH. Finally, UM UCH has been educating and will continue to educate the community consistently that approximately 90% of their care can be received on the UC Medical Campus at Aberdeen. The Applicants, therefore, anticipate the community will appropriately seek care at UC FMF when experiencing emergent medical conditions in the same manner as care is currently sought at HMH's emergency department. Moreover, patients experiencing emergency health conditions are unlikely to be able to self-diagnose conditions that may require an inpatient admission or to elect to bypass UC FMF in an emergency by traveling an additional 12.4 miles to UCMC, 21.8 miles to Union Hospital of Cecil county, or 23.2 miles to Franklin Square Medical Center.

The Applicants have engaged in extensive discussion with the service area community regarding the proposed capabilities of UC FMF. While UC UCH anticipates its patient education efforts will be successful, it is unlikely that patients will be able to self-diagnose all emergency

medical conditions such that they will be able to determine in an emergency whether to go to a hospital or UC FMF. For example, it is unlikely that an individual or the individual's family or friend believing that the individual is suffering from a heart attack will always drive to a hospital instead of UC FMF based on education of the service area population.

Finally, of the 65 and older patients, 48.0% arrived to HMH's emergency department by ambulance. *See* **Table 28** below.

Table 28
HMH % of Emergency Department Patients >= 65 Arriving by Ambulance
FY 2017

Age Group	Patient Status	Arrived by Ambulance	Total Cases	% by Ambulance
>= 65	Inpatient	1,277	1,867	68.4%
	Outpatient	1,652	4,230	39.1%
>= 65 Total		**2,929**	**6,097**	**48%**
< 65	Inpatient	663	1,893	35.0%
	Outpatient	3,295	20,512	16.1%
< 65 Total		**3,958**	**22,405**	**17.7%**
Grand Total		**6,887**	**28,502**	**24.2%**

Source: UCHS Internal Utilization Report

Ambulance transport for nearly fifty percent (50%) of the aged 65 and over population, particularly EMS transport, is expected to limit any patient self-selection of the emergency department to which these patients are transported. As noted by the Commission in its February 2, 2015 Report on the Operations, Utilization, and Financial Performance of Freestanding Medical Facilities, EMS transport protocols are likely contributing factors to low utilization of existing Maryland FMFs by the population aged 65 and older. As set forth above, UC FMF projects that only a limited number of non-stroke priority 1 patients that are currently treated at HMH could not be treated at UC FMF in accordance with revised MIEMSS protocols and the pilot stroke protocol approved for UC FMF.

(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.

Applicants' response: The Applicants project an increase in observation cases based on actual experience through fiscal year 2018. Between fiscal years 2019 and 2021, observation cases are projected to increase annually with population growth. In this same time period, the applicant projects a decrease in the number of observation cases at 0.25% annually associated with reductions in potentially avoidable utilization. As previously described, the applicants expect that changes in clinical observation practices will reduce observation utilization at HMH. As presented in **Table 29** below, the changes outlined above are projected to achieve a 5.6% reduction in the

number of projected observation cases in fiscal year 2020 followed by a 12.2% reduction in fiscal year 2021. Beginning in fiscal year 2022, the observation cases are projected to grow annually with population increases. Overall, the applicant expects that there will be a 15.3% reduction in observation cases at UC FMF in fiscal year 2024 when compared with observation cases at HMH in fiscal year 2018. (**Table 29**). This change is consistent with historical trends adjusted for the applicants' expected change in the utilization of observation services.

Table 29
HMH and UC FMF Historical and Projected Observation Cases
FY2015 – FY2024

	Historical				Projection						% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Observation Cases											
HMH	**3,761**	**3,896**	**4,019**	**4,443**	**4,458**	**4,474**	**4,491**	**-**	**-**	**-**	
%Change	*2.3%*	*3.6%*	*3.2%*	*10.5%*	*0.3%*	*0.4%*	*0.4%*	*-100.0%*	*0.0%*	*0.0%*	*-100.0%*
UC FMF								**4,516**	**4,543**	**4,571**	
%Change									*0.6%*	*0.6%*	
Total	**3,761**	**3,896**	**4,019**	**4,443**	**4,458**	**4,474**	**4,491**	**4,516**	**4,543**	**4,571**	
%Change		*3.6%*	*3.2%*	*10.5%*	*0.3%*	*0.4%*	*0.4%*	*0.6%*	*0.6%*	*0.6%*	*2.9%*

Laboratory and imaging services are projected to grow and decline in relation to the projection of emergency and observation patients that are presented above.

(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;

Applicants' response: Revenue projections in **Tables H** and **K** reflect the utilization projections presented above and the 2018 regulated Global Budget Revenue (GBR) assumptions related to update factors, demographic adjustments, revenue variability, and uncompensated care. These assumptions are included with the tables.

(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

Applicants' response: The presentation of projected staffing at UC FMF, as presented in **Table L**, reflects the changes in 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 HMH closes and UC FMF opens in fiscal year 2022.

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

Applicants' response: As reflected in **Table K**, UC FMF is projected to generate net operating losses of between $2.01 million and $1.68 million in net income between fiscal years 2022 and 2024. These earnings will contribute to the overall financial health of UM UCH which is projected in **Exhibit 1, Table H** to include UC Medical Campus at Aberdeen between fiscal years 2022 and 2024. In total, UM UCH will generate net operating income of $7.59 million and $11.57 million between fiscal years 2022 and 2024.

(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.

Applicants' response: This Standard is not applicable; no operating rooms are proposed at UC FMF.

(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.

Applicants' response:

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

I. Marshall Valuation Service

II. Valuation Benchmark

Type		Hospital
Construction Quality/Class		Good/A
Stories		2
Perimeter		813
Average Floor to Floor Height		14.8
Square Feet		69,343
f.1	Average floor Area	34,672
A. Base Costs		
	Basic Structure	$374.00
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$374.00

Adjustment for Departmental Differential Cost Factors		1.03
Adjusted Total Base Cost		$386.50
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$386.50
C. Multipliers		
Perimeter Multiplier		0.896362245
	Product	$346.44
Height Multiplier		1.07
	Product	$370.34
Multi-story Multiplier		1.000
	Product	$370.34
D. Sprinklers		
	Sprinkler Amount	$3.20
Subtotal		$373.55
E. Update/Location Multipliers		
Update Multiplier		1.08
	Product	$403.43
Location Multipier		1
	Product	$403.43
Calculated Square Foot Cost Standard		**$403.43**

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

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
Emergency Department (ED)	15,803	Emergency Suite	1.18	18,648
Imaging	5,573	Radiology	1.22	6,799
Observation	11,666	Inpatient Unit	1.06	12,366
Lab	1,622	Laboratories	1.15	1,865
Pharmacy	1,602	Pharmacy	1.33	2,131
Administration	7,574	Offices	0.96	7,271
Behavioral Health (BH) ED Crisis Unit	3,408	Emergency Suite	1.18	4,021
Public	4,918	Public Space	0.8	3,934
Engineering and Maintenance	1,475	Mechanical Equipment and Shops	0.7	1,033
Vertical Circulation	1,169	Internal Circulation	0.6	701
Dietary	1,148	Dietary	1.52	1,745
Engineering and Maintenance	1,660	Mechanical Equipment and Shops	0.7	1,162
Biomed	492	Laboratory	1.15	566
Shared Space	463	Offices	0.96	444
Provider Staff Lounge and Lockers	599	Employee Facilities	0.8	479
Housekeeping	632	Housekeeping	1.31	828
Storage	1,565	Storage and Refrigeration	1.6	2,504
Mechanical	1,434	Mechanical Equipment and Shops	0.7	1,004
Public Dining	724	Dining Room	0.95	688
Public Space	1,130	Public Space	0.8	904
Shared Vertical Circulation	527	Internal Circulation	0.6	316
Shared Exterior Walls	865	Unassigned	0.5	433
Shared Circulation	1,709	Internal Circulation	0.6	1,025
Exterior Walls	1,585	Unassigned	0.5	793
Total	69,343		1.03	71,660

Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
Building	$24,080,085	$347.26
Fixed Equipment		$0.00
Site Preparation	$1,628,964	$23.49

Architectual Fees	$2,430,586	$35.05
Permits	$946,453	$13.65
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$29,086,088	$404.20

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

B. Extraordinary Cost Adjustments

	Project Costs		**Associated Cap Interest & Financing**
Site Demolition Costs	$76,603	Site	
Storm Drains	$33,389	Site	
Rough Grading	$19,363	Site	
Paving	$242,202	Site	
Dewatering	$134,400	Site	
Exterior Signs on building	$11,059	Site	
Landscaping	$196,800	Site	
Walls	$91,920	Site	
Yard Lighting	$44,050	Site	
Dewatering	$69,266	Site	
Sediment Control & Stabilization	$16,070	Site	
Helipad	$33,926	Site	
Premium for Minority Business Enterprise Requirement	$65,159	Site	
Canopies	$386,080	Building	$85,062
Loading Dock Canopy	$89,856	Building	$19,797
Bullet Resistant Sheathing	$52,800	Building	$11,633
Bullet Resistant Glazing	$105,600	Building	$23,266
Fully Audible Fire Alarm System	$48,480	Building	$10,681
Fire Pump	$36,000	Building	$7,932
Pneumatic Tube System	$133,965	Building	$29,515
Premium for Minority Business Enterprise Requirement	$963,203	Building	$198,768
Jurisdictional Hook-up Fees	$600,000	Permits	
Total Cost Adjustments	$3,450,191		$386,654

Associated Capitalized Interest and Loan Placement Fees should be excluded from the comparison for those items which are also excluded from the comparison. Since only Capitalized

Interest and Loan Placement fees relating to the Building costs are included in the MVS analysis, we have only eliminated them for the Extraordinary Costs that are in the Building cost item. This was calculated as follows, using the Canopy as an example:

(Cost of the Canopy/Building Cost) X (Building related Capitalized Interest and Loan Placement Fees).

Explanation of Extraordinary Costs

Below are the explanations of the Extraordinary Costs that are not specifically mentioned as not being in contained in the MVS average costs in the MVS Guide (at Section 1, Page 3) but that are specific to this project and would not be in the average cost of a hospital project.

1. Bullet Resistant Sheathing, Bullet Resistant Glazing, and Fully Audible Fire Alarm System – Because the FMF is attached to the Behavioral Health Hospital, UMMS has determined that it should install these items throughout the building. These are not usually found in the average hospital.

2. Fire Pump - Fire pump is on an as needed basis. Because the water pressure is might be insufficient to meet the fire code, the fire pump is required. One would not normally expect one for a two-story building, but the demand required by the existing MOB diminishes performance. These are not usually found in the average hospital.

3. Premium for Minority Business Enterprise Requirement – UMMS projects include a premium for Minority Business Enterprises that would not be in the average cost of hospital construction. This premium was projected to be 4%. UMMS consulted with its cost estimators/construction managers on the impact on project budgets of targeting 25% inclusion of MBE subcontractors or suppliers as part of its projects, and their conservative estimate is that it adds 3-4% to the costs, compared to projects that do not include MBE subcontractors or suppliers. This estimate has been confirmed through UMMS' experience with past construction jobs. UMMS now uses this percentage in all of its construction cost estimates.

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

C. Adjusted Project Cost		**Per Square Foot**
Building	$22,264,100	$321.07
Fixed Equipment	$0	$0.00
Site Preparation	$594,758	$8.58
Architectual Fees	$2,430,586	$35.05
Permits	$346,453	$5.00
Subtotal	$25,635,897	$369.70
Capitalized Construction Interest	$4,005,601	$57.77

Total	$29,641,498	$427.46

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

Hospital	New	Renovation	Total		
Building Cost	$24,080,085				
Subtotal Cost (w/o Cap Interest)	$29,086,088		$29,086,088		
Subtotal/Total	100.0%	0.0%	Cap Interest	Financing	Total
Total Project Cap Interest &Financing [(Subtotal Cost/Total Cost) X Total Cap Interest]	$5,305,361	$0	$4,764,777	$540,584	$5,305,361
Building/Subtotal	82.8%	N/A			
Building Cap Interest & Financing	$4,392,256	N/A			
Associated with Extraordinary Costs	$386,654				
Applicable Cap Interest & Loan Place.	$4,005,601				

As noted below, the project's cost per square foot is slightly (approximately 6%) above the MVS benchmark.

MVS Benchmark	$403.43
The Project	$427.46
Difference	$24.03

(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.

Applicants' response: An assessment of the availability and accessibility of emergent and urgent care in UC FMF's projected service area is set forth in response to COMAR 10.24.19.04C(8)(b) above. In short, there will be no acute general hospitals with emergency departments or other FMFs in UC FMF's projected service area.

While there are nine (9) urgent care centers in UC FMF's service area (*see* **Table 8** above), in fiscal year 2018, seventy-one (72%) of HMH's emergency department visits fell within an ESI Treatment Level which could not be successfully transitioned to an urgent care center. This assumes that only patients at ESI Levels 4 and 5 who were discharged from HMH's emergency room could be transitioned to an urgent care center. The remaining 28% represent a patient population who self-selects care at a traditional emergency department rather than an urgent care center. Certainly, there are many factors that drive patient selection for site-of-service; however,

one key factor is a patient's inability to discern the lowest level of care for their presenting need(s). Another factor is the limited hours of operation of urgent care centers.

Moreover, it cannot be disputed that the emergency departments at acute general hospitals in nearest proximity to UC FMF could not absorb the approximate 27,000 emergency visits currently treated at HMH's emergency department and projected for UC FMF. In addition, UCMC would not be in a position to absorb even a significant fraction of this volume of emergency department visits without its own substantial emergency department expansion project and associated capital expenditures.

Table 30
HMH FY 2018 ED Visits and Disposition

ESI Treatment Level	ED Discharges	Inpatient Admits	Observation Admits	Grand Total
1	113	139	49	301
2	2,798	2,031	1,232	6,061
3	10,376	1,559	1,460	13,395
4	6,961	84	55	7,100
5	399		1	400
Unclassified	108	2	1	111
	20,755	**3,815**	**2,798**	**27,368**

Finally, UM UCH has engaged and continues to engage in a number of population health initiatives as described in response to COMAR 10.24.19.04C(8)(c) and the patient education programs described in response to COMAR 10.24.19.04C(8)(b). Despite these ongoing efforts, the number of emergency department visits from UC FMF's projected service area has not seen an appreciable decline in utilization. *See* **Table 30** above.

(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;

Applicants' response: **Table 31** reflects a 6.3% decline in HMH's hospital acute inpatient admissions between fiscal years 2013 and 2017. While less than the 10.8% decline in acute care hospital admissions across the State of Maryland, HMH's reduction in admissions has led to the discussion of merging beds with UCMC which is in the public interest.

Table 31
Comparison of HMH Historical Admissions to Statewide Trends
FY2013 – FY2017

	2013	2014	2015	2016	2017	2013-2017 % Change
HMH	4,727	4,693	4,174	4,384	4,429	*-6.3%*
% Change	*-7.9%*	*-0.7%*	*-11.1%*	*5.0%*	*1.0%*	
Statewide Trend	619,128	581,573	570,988	564,345	551,978	*-10.8%*
% Change	*-3.4%*	*-6.1%*	*-1.8%*	*-1.2%*	*-2.2%*	

Sources: FY2013 through FY2017 HSCRC Annual Filings

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

Applicants' response: As reflected on **Table 32** below, HMH generated operating margins ranging from 5.0% to 10.5% between fiscal years 2013 and 2017. These operating margins exceed those of the statewide average operating margins which ranged from 1.3% to 3.7% (**Table 32**). Notwithstanding HMH's operating margins, HMH has outlived the useful life of its physical plant. Continued operation of HMH for the long term would require significant capital improvements with estimated costs of $239.3 million to bring the entire facility to modern standards (updated to a midpoint of construction in 2020). Given the significant capital required to renovate HMH, it would not continue to generate operating margins following any such renovation project.

Table 32
Comparison of HMH Operating Margins to Statewide Financial Performance
FY2013 – FY2017

	Operating Margin (%)				
	2013	2014	2015	2016	2017
HMH	5.0%	10.5%	10.0%	8.3%	5.9%
Statewide Average	1.3%	3.1%	3.7%	3.3%	2.8%

Sources: FY2013 through FY2017 Annual Filings

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

Applicants' response: The average age of HMH's physical plant was 18.8 years in 2016. This compares to the statewide average of 10.8 years (**Table 33**). In a publication by Moody's

Investors Service, dated August 28, 2018, it presents the median average age of plant for hospitals that it rates as 11.5 years. The statewide average is consistent with that median while HMH is well above it.

Table 33
Comparison of HMH Average Age of Plant to Statewide Trends
FY2015 – FY2024

	Average Age of Plant (years)				
	2012	2013	2014	2015	2016
HMH	18.3	18.9	16.7	15.7	18.8
Statewide Average	12.0	11.2	12.7	12.0	10.8

Source: Annual Filings

For HMH to achieve the statewide average would require approximately $100 million in capital expenditures to modernize its physical plant. This estimate of capital expenditures reflects the level of investment in assets with a 25 year useful life that would be required to increase annual depreciation expense to achieve a 10.8 year average age of plant.

(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

Applicants' response: The conversion of HMH to UC FMF coupled with the other projects for which the applicants and UM UCH have sought the Commission's approval is in the public interest. As stated above, in conjunction with conversion of HMH to UC FMF, UM UCH has submitted a CON application to establish a bed special psychiatric hospital. The proposed project includes thirty-three (33) adult psychiatric beds to be organized into two units or neighborhoods. One neighborhood will have thirteen (13) beds to treat non-geriatric adult patients suffering from one or more psychiatric diagnoses. A second neighborhood will include twenty (20) rooms to treat both non-geriatric adult patients and geriatric patients suffering from one or more psychiatric diagnoses. In addition to inpatient behavioral health services, UC Behavioral will provide a broad array of outpatient services, including a partial hospitalization program, an intensive outpatient program, and a variety of outpatient, ambulatory behavioral health services, which will allow patients to transition through multiple stages of treatment at one centralized location.

UCMC and HMH have also applied for an exemption from CON review to construct a three-story, 78,070 square foot addition above the existing Kaufman Cancer Center at UCMC to accommodate thirty (30) MSGA beds to be relocated from HMH to UCMC and establish a 42-bed dedicated observation beds unit. Upon the conversion of HMH to UC FMF, the addition at UCMC

would open and existing inpatients at HMH would be transferred to UCMC or UC Behavioral Health as appropriate.

UM UCH also plans to renovate an existing medical office building at the UC Medical Campus at Aberdeen to house both primary and specialty care physician practices in order to provide access to additional providers in HMH's historical service area, including: (1) primary and specialty care physicians practices; (2) rehabilitation services (physical, occupational, and speech therapy); (3) outpatient infusion services (currently not offered at HMH); (4) imaging; and (5) laboratory services (draw station). The only existing outpatient services at HMH that will not be provided on the campus of UC Medical Campus at Aberdeen are: (1) outpatient pulmonary function testing; and (2) possibly a sleep study lab.

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

1. Plan for Job Retraining and Placement of HMH Employees.

2. Plan for Existing HMH's Physical Plant

Applicants' response: The conversion of HMH to UC FMF is in the public interest taking into consideration the adequacy and appropriateness of the Applicants' transition plan. The Applicants' transition planning focused around the overarching plan for transitioning emergency and observation services from HMH to UC FMF, the development of the special psychiatric hospital, needed outpatient behavioral health services, the relocation of acute inpatient MSGA beds from HMH to UCMC, and provision of other outpatient services at UC Medical Campus at Aberdeen. This transition plan supports the overarching vision that UM UCH has for its community, which includes creating an optimal patient care delivery system for the future health care needs of both Harford and Cecil County residents. This vision focused on the following:

- Quality and patient satisfaction with a focus on providing care in the right setting at the right time;
- Development of systems of care beyond the walls of a health care facility;
- A comprehensive network of specialty and primary care physicians; and
- Multi-faceted ambulatory services.

The projected timeline for transitioning acute care services will be dependent on the Commission's approval of the special psychiatric facility – UC Behavioral Health, however, the projected timeline for the opening of UC Behavioral Health is the end of calendar year 2020 or early-mid calendar year 2021.

An initial transition plan for job retraining and placement for HMH employees has been started with the early projections of the potential number of employees who will be impacted by the conversion recognizing that there will be retirements as well as traditional employee transitions over the course of the next three or more years. As a component of the applicants' early planning there has been a projection of the full time equivalent needs for UC FMF, UC Behavioral Health, and the expanded acute services at the UCMC. Future planning will include the identification of alternative locations for employment such as within the planned medical office building to be

developed at UC Medical Campus at Aberdeen where a wide array of outpatient ambulatory services will be provided in conjunction with primary and specialty care physician practices as well as the expansion of ambulatory surgical services within the community as a component of the overall UM UCH's Vision 2020 project. In addition, UM UCH plans to implement a Workforce Planning workgroup beginning in calendar year 2018. This workgroup will be comprised of multiple internal and external stakeholders including participation from the UM UCH Patient and Family Advisory Committee, the Susquehanna Workforce Network, the Harford County Government, and Harford Community College.

Cushman & Wakefield has concluded that the site would be attractive to investors and developers as a multi-phase, master-planned development that could provide a significant economic development benefits to the City of Havre de Grace and the surrounding community, and thus achieve the important shared goals for re-use of the property – maximizing financial returns and enhancing the second generation use of the property for the community's benefit.

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

Applicants' response: UCMC is projected to generate operating profits in each year of the projection period (**Table 34**). The assumed retention of HMH's GBR will enable UCMC to absorb the addition of depreciation and interest expenses associated with UC FMF.

Table 34
UCMC Historic and Projected Operating Income
FY2015 – FY2024

UCMC + UC FMF
Financial Performance
FY2017 - FY2024

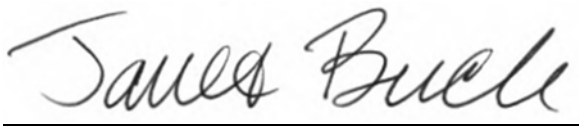
	Historical		Projection ($ in millions)					
	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Revenue	**$ 300.8**	**$ 306.9**	**$ 280.7**	**$ 282.7**	**$ 290.2**	**$ 368.6**	**$ 379.3**	**$ 390.3**
Expenses	**284.2**	**272.3**	**248.5**	**255.5**	**260.0**	**343.5**	**351.6**	**360.8**
Operating Income	**$ 16.6**	**$ 34.6**	**$ 32.1**	**$ 27.2**	**$ 30.2**	**$ 25.0**	**$ 27.6**	**$ 29.4**

For the reasons set forth above, the conversion of HMH to UC FMF is in the public interest.

CONCLUSION

For all of the reasons set forth above, HMH and UCMC respectfully request that the Commission authorize the conversion of HMH to a freestanding medical facility and associated capital expenditures.

Respectfully submitted,



James C. Buck
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218 N. Charles Street, Suite 400
Baltimore, Maryland 21201

Counsel for UM Upper Chesapeake Medical Center, Inc. and UM Harford Memorial Hospital, Inc.

Table of Exhibits

Exhibit	Description
1.	MHCC Tables
2.	Project drawings
3.	August 4, 2017 Letter Providing Notice of Intent to Convert to a Freestanding Medical Facility and Enclosing Request for Exemption from CON Review
4.	September 18, 2017 Cover Letter Responding to the Commission's Additional Information Requests
5.	September 22, 2017 Cover Letter Transmitting Response to MIEMSS' Additional Information Requests
6.	November 21, 2018 Cover Letter Transmitting Modified Request for Exemption from CON Review
7.	An example of UM UCH's print notices regarding the August 30, 2017public informational hearing published in the Maryland Daily Record
8.	Examples of the advertisements regarding the August 30, 2017 public informational hearing published in the Harford County Aegis and Cecil County Whig
9.	September 14, 2017 letter transmitting a summary of the August 30, 2017 public informational hearing
10.	An example of UM UCH's print notices published in the Maryland Daily Record UM UCH's print notices from in the Maryland Daily Record regarding the December 13, 2018 public informational hearing
11.	Examples of the advertisements published in the Harford County Aegis and Cecil County Whig regarding the December 13, 2018 public informational hearing
12.	December 27, 2018 letter transmitting a summary of the December 13, 2018 public informational hearing
13.	October 12, 2017 Letter from MIEMSS and Report and Recommendation to the EMS Board
14.	February 7, 2019 letter from Patricia Gainer, JD, MPA to Ben Steffen, explaining the EMS Board's August 14, 2018 decision
15.	UM UCH's Policy Regarding Charges
16.	UM UCH's Financial Assistance Policy and Financial Assistance Form
17.	Community Health Needs Assessment
18.	UCMC and HMH licensure, Joint Commission accreditation, and documentation of Medicare and Medicaid participation

Table of Tables

Table 1 Department Gross Square Footage UC FMF and UC Behavioral Health 3
Table 2 HSCRC Community Benefit Report, Data Excerpts FY2017 16
Table 3 Below-Average Quality Measures and Corrective Action 18
Table 4 UC FMF ED Service Area FY2018 22
Table 5 UC FMF Service Area ED Visits FY2014 – FY2018 22
Table 6 HMH MSGA Primary Service Area Zip Codes and Discharges FY2018 23
Table 7 HMH Psychiatric Primary Service Area Zip Codes and Discharges FY2018 23
Table 8 Urgent Care Centers in UC FMF's Service Area 24
Table 9 HMH Emergency Department Visits Between 8 p.m. and 8 a.m. FY2017 27
Table 10 HMH Historical Emergency Department Visits FY2013 – FY2018 30
Table 11 HMH and UC FMF Historical and Projected Emergency Department Visits FY2015 – FY2024 30
Table 12 HMH Historical Behavioral Health Emergencies FY2015 - FY2017 32
Table 13 HMH Peak Hour Psychiatric Emergency Department Visits FY2017 33
Table 14 Evaluation of UC FMF ACEP Factors 36
Table 15 HMH Historical Emergency Department Hours per Visit FY2017 38
Table 16 HMH FY 2018 ED Visits and Disposition 41
Table 17 HMH Percentage of Emergency Department Patients >= 65 FY 2018 and FY 2017 41
Table 18 HMH % of Emergency Department Patients >= 65 Arriving by Ambulance FY 2017 42
Table 19 HMH % of Emergency Department Patients >= 65 Arriving by Ambulance FY 2018 42
Table 20 Imaging Services Utilized by Outpatient Emergency Department Visits FY 2018 43
Table 21 HMH and UC FMF Historical and Projected Observation Cases FY2015 – FY2024 47
Table 22 Comparison of Observation Cases per Emergency Department Visit FY2018 48
Table 23 HMH's 2018 Observation ALOS 49
Table 24 HMH and UC FMF Historical and Projected ALOS FY2015 – FY2024 50
Table 25 HMH and UC FMF Historical and Projected Observation Patient Days FY2015 – FY2024 50
Table 26 HMH and UC FMF Historical and Projected Observation Bed Need FY2015 – FY2024 51
Table 27 HMH and UC FMF Historical and Projected Emergency Department Visits FY2015 – FY2024 54
Table 28 HMH % of Emergency Department Patients >= 65 Arriving by Ambulance FY 2017 55
Table 29 HMH and UC FMF Historical and Projected Observation Cases FY2015 – FY2024 56
Table 30 HMH FY 2018 ED Visits and Disposition 63
Table 31 Comparison of HMH Historical Admissions to Statewide Trends FY2013 – FY2017 64
Table 32 Comparison of HMH Operating Margins to Statewide Financial Performance FY2013 – FY2017 64
Table 33 Comparison of HMH Average Age of Plant to Statewide Trends FY2015 – FY2024 65
Table 34 UCMC Historic and Projected Operating Income FY2015 – FY2024 67

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

10.21.19
Date

Lyle E. Sheldon
President and Chief Executive Officer
University of Maryland Upper
Chesapeake Health System

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

October 18, 2019
Date

Stephen Witman

Stephen Witman
Senior Vice President, Chief Financial Officer
University of Maryland Upper Chesapeake Health System

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

10.21.19
Date

Robin Luxon
Senior Vice President, Corporate Planning, Marketing & Business Development
University of Maryland Upper Chesapeake Health System

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

10-18-19
Date

Amale Obeid
Director of Planning and Business Development
University of Maryland Upper Chesapeake Health System

#659186
011888-0023

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

10/18/19
Date

Phillip D. Crocker
Project Manager
University of Maryland Upper
Chesapeake Health System

#659189
011888-0023

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

10/18/19
Date

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

#659194
011888-0023

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

10/18/2019
Date

Jay Wall
Project Executive
ERDMAN

#659192
011888-0023

EXHIBIT 1

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

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

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

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/201_	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity				
			Room Count			Bed Count			Room Count			Bed Count	
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity	
ACUTE CARE							**ACUTE CARE**						
General Medical/ Surgical*					0	0	**General Medical/ Surgical***				0	0	
					0	0					0	0	
					0	0					0	0	
					0	0					0	0	
					0	0					0	0	
SUBTOTAL Gen. Med/Surg*							**SUBTOTAL Gen. Med/Surg***						
ICU/CCU					0	0	**ICU/CCU**				0	0	
Other *(Specify/add rows as needed)*					0	0					0	0	
TOTAL MSGA							**TOTAL MSGA**						
Obstetrics					0	0	**Obstetrics**				0	0	
Pediatrics					0	0	**Pediatrics**				0	0	
Psychiatric					0	0	**Psychiatric**				0	0	
TOTAL ACUTE		**0**	**0**	**0**	**0**	**0**	**TOTAL ACUTE**		**0**	**0**	**0**	**0**	
NON-ACUTE CARE							**NON-ACUTE CARE**						
Dedicated Observation**					0	0	**Dedicated Observation****		17		17	17	
Rehabilitation					0	0	**Rehabilitation**				0	0	
Comprehensive Care					0	0	**Comprehensive Care**				0	0	
Other *(Specify/add rows as needed)*					0	0	**Other** *(Specify/add rows as needed)*				0	0	
TOTAL NON-ACUTE							**TOTAL NON-ACUTE**		**17**		**17**	**17**	
HOSPITAL TOTAL		**0**	**0**	**0**	**0**	**0**	**HOSPITAL TOTAL**		**17**	**0**	**17**	**17**	

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

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

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

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

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Emergency Department (ED)		15,803			15,803
Imaging		5,573			5,573
Observation		11,666			11,666
Lab		1,622			1,622
Pharmacy		1,602			1,602
Administration		7,574			7,574
Behavioral Health (BH) ED Crisis Unit		3,408			3,408
Public		4,918			4,918
Engineering and Maintenance		1,475			1,475
Vertical Circulation		1,169			1,169
Dietary		1,148			1,148
Engineering and Maintenance		1,660			1,660
Biomed		492			492
Shared Space		463			463
Provider Staff Lounge and Lockers		599			599
Housekeeping		632			632
Storage		1,565			1,565
Mechanical		1,434			1,434
Public Dining		724			724
Public Space		1,130			1,130
Shared Vertical Circulation		527			527
Shared Exterior Walls		865			865
Shared Circulation		1,709			1,709
Exterior Walls		1,585			1,585
Total		69,343			69,343

TABLE C. CONSTRUCTION CHARACTERISTICS

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

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☑	☐
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☑	☐
Excellent	☐	☐
Number of Stories	2	

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Lower Level	12,948	
First Floor	56,395	
Second Floor	0	
Third Floor	0	
	0	
Average Square Feet	**34,672**	
Perimeter in Linear Feet	**Linear Feet**	
Lower Level	468	
First Floor	1,157	
Second Floor	0	
Third Floor	0	
	0	
Total Linear Feet	**1,625**	
Average Linear Feet	**813**	
Wall Height (floor to eaves)	**Feet**	
Lower Level	14	
First Floor	15	
Second Floor		
Third Floor		
Average Wall Height	**14.81**	
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	3	
Freight	1	
Sprinklers	**Square Feet Covered**	
Wet System	69,343	
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project	VAV, ducted return, AHUs with chilled and hot water	
Type of Exterior Walls for proposed project	Masonry	

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

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

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation	$594,758	
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs	**$594,758**	
Site Demolition Costs	$76,603	
Storm Drains	$33,389	
Rough Grading	$19,363	
Paving	$242,202	
Dewatering	$134,400	
Exterior Signs on building	$11,059	
Landscaping	$196,800	
Walls	$91,920	
Yard Lighting	$44,050	
Dewatering	$69,266	
Sediment Control & Stabilization	$16,070	
Helipad	$33,926	
Premium for Minority Business Enterprise Requirement	$65,159	
Subtotal On-Site excluded from Marshall Valuation Costs	**$1,034,206**	
OFFSITE COSTS		
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs	**$0**	
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$1,034,206**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$1,628,964**	**$0**
BUILDING COSTS		
Normal Building Costs	$22,264,100	
Subtotal included in Marshall Valuation Costs	$22,264,100	
Canopy (two)	$386,080	
Loading Dock Canopy	$89,856	
Bullet Resistant Sheathing	$52,800	
Bullet Resistant Glazing	$105,600	
Fully Audible Fire Alarm System	$48,480	
Fire Pump	$36,000	
Pneumatic Tube System	$133,965	
Premium for Minority Business Enterprise Requirement	$963,203	
Subtotal Building Costs excluded from Marshall Valuation Costs	**$1,815,985**	
TOTAL Building Costs included and excluded from Marshall Valuation Service*	**$24,080,085**	**#REF!**
A&E COSTS		
Normal A&E Costs	$2,430,586	
Subtotal included in Marshall Valuation Costs	**$2,430,586**	
Subtotal A&E Costs excluded from Marshall Valuation Costs	**$0**	
TOTAL A&E Costs included and excluded from Marshall Valuation Service*	**$2,430,586**	**$0**
PERMIT COSTS		
Normal Permit Costs	$346,453	
Subtotal included in Marshall Valuation Costs	**$346,453**	
Jurisdictional Hook-up Fees	$600,000	
Subtotal Permit Costs excluded from Marshall Valuation Costs	**$600,000**	
TOTAL Permit Costs included and excluded from Marshall Valuation Service*	**$946,453**	**$0**

TABLE E. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application.

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

	FMF	BHH	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building	$24,080,085	$23,264,685	$47,344,770
(2) Fixed Equipment			$0
(3) Site and Infrastructure	$1,628,964	$1,764,711	$3,393,675
(4) Architect/Engineering Fees	$2,430,586	$2,556,533	$4,987,119
(5) Permits (Building, Utilities, Etc.)	$946,453	$996,104	$1,942,557
SUBTOTAL	**$29,086,088**	**$28,582,033**	**$57,668,121**
b. Renovations			
(1) Building		$2,476,709	$2,476,709
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees		$157,921	$157,921
(4) Permits (Building, Utilities, Etc.)		$20,000	$20,000
SUBTOTAL	**$0**	**$2,654,630**	**$2,654,630**
c. Other Capital Costs			
(1) Movable Equipment	$8,450,287	$10,896,214	$19,346,501
(2) Contingency Allowance	$3,777,853	$4,200,332	$7,978,185
(3) Gross interest during construction period	$4,764,777	$5,266,774	$10,031,550
(4) Other (Specify/add rows if needed)			$0
SUBTOTAL	***$16,992,917***	***$20,363,319***	**$37,356,236**
TOTAL CURRENT CAPITAL COSTS	**$46,079,005**	**$51,599,983**	**$97,678,988**
d. *Land Purchase*	**$2,197,329**	**$2,299,294**	$4,496,623
e. Inflation Allowance	$1,533,141	$1,716,835	$3,249,975
TOTAL CAPITAL COSTS	**$49,809,475**	**$55,616,111**	**$105,425,586**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	**$540,584**	**$603,604**	$1,144,188
b. Bond Discount			$0
c CON Application Assistance			$0
c1. Legal Fees	**$110,322**	**$110,322**	$220,644
c2. Other (Specify/add rows if needed)	**$884,309**	**$884,309**	$1,768,618
d. Non-CON Consulting Fees			$0
d1. Legal Fees	**$227,508**	**$227,508**	$455,016
d2. Other (Specify/add rows if needed)	**$1,181,081**	**$1,181,081**	$2,362,163
e. Debt Service Reserve Fund	**$3,912,121**	**$4,368,184**	$8,280,305
f Other (Specify/add rows if needed)			$0
SUBTOTAL	***$6,855,926***	***$7,375,008***	**$14,230,934**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$56,665,400***	***$62,991,120***	***$119,656,520***
B. Sources of Funds			
1. Cash			$0
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds	**$55,517,385**	**$61,714,948**	$117,232,333
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other (Interest Earned on Trusteed Assets)	$1,148,015	$1,276,171	$2,424,186
TOTAL SOURCES OF FUNDS	***$56,665,400***	***$62,991,120***	**$119,656,520**
	Hospital Building	***Other Structure***	***Total***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

TABLE G. REVENUES & EXPENSES, UNINFLATED - UPPER CHESAPEAKE HEALTH SYSTI

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Gross patient services revenue	540,220	558,961	537,398	552,005	556,761	553,413	555,699	558,002
Gross Patient Service Revenues	***$ 540,220***	***$ 558,961***	***$ 537,398***	***$ 552,005***	***$ 556,761***	***$ 553,413***	***$ 555,699***	***$ 558,002***
c. Allowance For Bad Debt	14,027	14,080	14,227	14,663	14,701	14,130	14,199	14,268
d. Contractual Allowance	75,402	85,596	93,596	90,221	92,040	97,840	98,106	98,375
e. Charity Care	14,970	14,471	6,513	14,002	14,039	12,313	12,377	12,441
Net Patient Services Revenue	***$ 435,821***	***$ 444,814***	***$ 423,062***	***$ 433,119***	***$ 435,981***	***$ 429,129***	***$ 431,017***	***$ 432,918***
f. Other Operating Revenues (Specify/add row needed)	271	3,093	3,255	5,867	5,867	5,756	5,756	5,756
NET OPERATING REVENUE	***$ 436,092***	***$ 447,908***	***$ 426,317***	***$ 438,986***	***$ 441,848***	***$ 434,884***	***$ 436,772***	***$ 438,674***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 244,970	$ 234,694	$ 245,975	262,625	$ 257,893	$ 252,291	$ 252,155	$ 252,707
b. Contractual Services	13,253	10,071	10,029	11,839	11,987	11,013	11,155	11,295
c. Interest on Current Debt	8,150	9,808	9,523	9,271	8,963	9,282	8,940	8,645
d. Interest on Project Debt	-	-	-	-	-	8,961	8,794	8,619
e. Current Depreciation	22,137	22,922	23,591	22,755	23,518	23,042	23,979	24,980
f. Project Depreciation	-	-	-	-	-	8,127	8,127	8,127
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	83,351	84,045	64,830	65,492	67,218	66,250	67,149	68,074
j. Other Expenses (Purchased Services and Other Expenses)	58,623	65,064	55,238	62,328	59,666	51,981	51,611	51,065
TOTAL OPERATING EXPENSES	**$ 430,484**	**$ 426,605**	**$ 409,186**	**$ 434,309**	**$ 429,246**	**$ 430,948**	**$ 431,911**	**$ 433,512**
3. INCOME								
a. Income From Operation	**$ 5,608**	**$ 21,303**	**$ 17,132**	**$ 4,677**	**$ 12,602**	**$ 3,937**	**$ 4,861**	**$ 5,162**
b. Non-Operating Income	18,640	17,578	10,085	8,180	7,273	8,299	8,563	8,982
SUBTOTAL	***$ 24,248***	***$ 38,881***	***$ 27,217***	***$ 12,858***	***$ 19,875***	***$ 12,235***	***$ 13,424***	***$ 14,143***
c. Income Taxes	-	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ 24,248***	***$ 38,881***	***$ 27,217***	***$ 12,858***	***$ 19,875***	***$ 12,235***	***$ 13,424***	***$ 14,143***

TABLE G. REVENUES & EXPENSES, UNINFLATED - UPPER CHESAPEAKE HEALTH SYSTI

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%
2) Medicaid	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%
3) Blue Cross	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%
4) Commercial Insurance	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%
5) Self-pay	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
6) Other	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Day								
Total MSGA								
1) Medicare	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%
2) Medicaid	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
3) Blue Cross	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%
4) Commercial Insurance	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%
5) Self-pay	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
6) Other	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table G – Key Financial Projection Assumptions for UM Upper Chesapeake Health System (Excludes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Upper Chesapeake Health System FY2019 cost center level projections and high level FY2020 budget, including Upper Chesapeake Medical Center, Harford Memorial Hospital, Upper Chesapeake Medical Services, Upper Chesapeake Health System (Parent entity) and several other entities with assumptions identified below.	
Projection period reflects FY2021 – FY2024	
Volumes	- Refer to COE Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
• Gross Charges	
o Update Factor	- Based on each entity's FY2020 budget operating results.
o Demographic and Other Rate Adjustment	- Based on each entity's FY2020 budget operating results.
o Variable Cost Factor	- Based on each entity's FY2020 budget operating results.
• Revenue Deductions	
o Contractual Allowances	- Based on each entity's FY2020 budget operating results.
o Charity Care	- Based on each entity's FY2020 budget operating results.
o Allowance for Bad Debt	- Based on each entity's FY2020 budget operating results.
Other Revenue	- Based on each entity's FY2020 budget operating results.
Expenses • Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses	- 0.0% increase per year - 0.0% - 0.0% - 0.0% - 0.0% - 0.0%
• Expense Volume Driver	- For the hospital entities, identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes o Salaries and Benefits o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses	- Ranges from 10% for overhead departments to 100% for inpatient nursing units - 0% for all cost centers except inpatient nursing (50%) and Laboratory (100%) - Ranges from 0% for overhead departments to 100% for the Emergency Department - Ranges from 0% for overhead departments to 50% for certain ancillary departments - Ranges from 0% for overhead departments to 50% for certain ancillary departments
• Other Operating Expenses	- Beginning in FY2019 and F2020, UCHS includes 340B savings (at UCMC) offset by the increased cost of the implementation of the following systems: electronic medical records (EPIC), human resource module (Lawson), and time and attendance system (Kronos), which leads to a transition to UMMS Shared Services beginning in FY2020. - Beginning in FY2021 a $0.9M performance improvement plan is assumed at UCMC, growing to $7.2M in FY2022 ($5.9M at UCMC, $0.2M at UCMS and $1.1M at AMC Specialty Psych Hospital) when HMH closes and the Project opens. An incremental performance improvement of $1.5M per year is assumed throughout the projection period.
• Interest Expense – Existing Debt	- Continued amortization of existing debt and related interest expense: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Interest Expense – New Debt (Project Related)	- 4.5% interest on $214.4M bonds over 30 years
• Depreciation and Amortization	- Average life of 26 years on $196.3M (less land and debt service reserve fund) of construction project expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures	- $135.0M in routine capital over the projection period with another $47.4M of other strategic capital projects (none are related to this Project)

TABLE H. REVENUES & EXPENSES, INFLATED - UPPER CHESAPEAKE HEALTH SYSTEM

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. GROSS REVENUE								
a. Gross Patient Service Revenues	$ 540,220	$ 558,961	$ 537,398	$ 565,253	$ 583,806	$ 594,222	$ 610,997	$ 628,254
Gross Patient Service Revenues	***540,220***	***$ 558,961***	***$ 537,398***	***$ 565,253***	***$ 583,806***	***$ 594,222***	***$ 610,997***	***$ 628,254***
b. Allowance For Bad Debt	$ 14,027	$ 14,080	$ 14,227	$ 15,015	$ 15,415	$ 15,172	$ 15,612	$ 16,064
c. Contractual Allowance	75,402	85,596	93,596	92,386	96,511	105,055	107,869	110,760
d. Charity Care	14,970	14,471	6,513	14,338	14,721	13,221	13,609	14,008
Net Patient Services Revenue	***435,821***	***$ 444,814***	***$ 423,062***	***$ 443,514***	***$ 457,159***	***$ 460,773***	***$ 473,908***	***$ 487,422***
e. Other Operating Revenues (Specify/add rows if needed)	271	3,093	3,255	5,926	5,985	5,930	5,989	6,049
NET OPERATING REVENUE	***436,092***	***$ 447,908***	***$ 426,317***	***$ 449,440***	***$ 463,144***	***$ 466,703***	***$ 479,897***	***$ 493,472***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 244,970	$ 234,694	$ 245,975	$ 268,665	$ 269,892	$ 270,102	$ 276,166	$ 283,136
b. Contractual Services	13,253	10,071	10,029	12,194	12,717	12,034	12,555	13,094
c. Interest on Current Debt	8,150	9,808	9,523	9,271	8,963	9,282	8,940	8,645
d. Interest on Project Debt						8,961	8,794	8,619
e. Current Depreciation	22,137	22,922	23,591	22,755	23,518	23,042	23,979	24,980
f. Project Depreciation						8,127	8,127	8,127
g. Current Amortization								
h. Project Amortization								
i. Supplies	83,351	84,045	64,830	67,457	71,312	72,393	75,577	78,917
j. Other Expenses (Specify/add rows if needed)	58,623	65,064	55,238	63,575	62,077	55,163	55,866	56,380
TOTAL OPERATING EXPENSES	***$ 430,484***	***$ 426,605***	***$ 409,186***	***$ 443,916***	***$ 448,480***	***$ 459,105***	***$ 470,004***	***$ 481,898***
3. INCOME								
a. Income From Operation	**$ 5,608**	**$ 21,303**	**$ 17,132**	**$ 5,524**	**$ 14,664**	**$ 7,598**	**$ 9,893**	**$ 11,574**
b. Non-Operating Income	18,640	17,578	10,085	8,344	7,567	8,806	9,269	9,916
SUBTOTAL	***$ 24,248***	***$ 38,881***	***$ 27,217***	***$ 13,868***	***$ 22,231***	***$ 16,405***	***$ 19,162***	***$ 21,490***
c. Income Taxes	-	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ 24,248***	***$ 38,881***	***$ 27,217***	***$ 13,868***	***$ 22,231***	***$ 16,405***	***$ 19,162***	***$ 21,490***

TABLE H. REVENUES & EXPENSES, INFLATED - UPPER CHESAPEAKE HEALTH SYSTEM

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%
2) Medicaid	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%
3) Blue Cross	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%
4) Commercial Insurance	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%
5) Self-pay	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
6) Other	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days								
1) Medicare	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%
2) Medicaid	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
3) Blue Cross	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%
4) Commercial Insurance	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%
5) Self-pay	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
6) Other	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table H - Key Financial Projection Assumptions for UM Upper Chesapeake Health System (Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Upper Chesapeake Health System FY2019 cost center level projections and high level FY2020 budget, including Upper Chesapeake Medical Center, Harford Memorial Hospital, Upper Chesapeake Medical Services, Upper Chesapeake Health System (Parent entity) and several other entities with assumptions identified below.

Projection period reflects FY2021 – FY2024

Volumes	- Refer to CON Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
• Gross Charges	
o Update Factor	- Based on each entity's FY2020 budget operating results.
o Demographic and Other Rate Adjustment	- Based on each entity's FY2020 budget operating results.
o Variable Cost Factor	- Based on each entity's FY2020 budget operating results.
• Revenue Deductions	
o Contractual Allowances	- Based on each entity's FY2020 budget operating results.
o Charity Care	- Based on each entity's FY2020 budget operating results.
o Allowance for Bad Debt	- Based on each entity's FY2020 budget operating results.
Other Revenue	
Other Revenue	- Based on each entity's FY2020 budget operating results.
Expenses	
• Inflation	
o Salaries and Benefits	- 2.3%
o Professional Fees	- 3.0%
o Supplies	- 3.0%
o Purchased Services	- 3.0%
o Other Operating Expenses	- 2.0%
• Expense Volume Driver	- For the hospital entities, identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	
o Salaries and Benefits	- Ranges from 10% for overhead departments to 100% for inpatient nursing units
o Professional Fees	- 0% for all cost centers except inpatient nursing (50%) and Laboratory (100%)
o Supplies & Drugs	- Ranges from 0% for overhead departments to 100% for the Emergency Department
o Purchased Services	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
• Other Operating Expenses	- Beginning in FY2019 and F2020, UCHS includes 340B savings (at UCMC) offset by the increased cost of the implementation of the following systems: electronic medical records (EPIC), human resource module (Lawson), and time and attendance system (Kronos) which leads to a transition to UMMS Shared Services beginning in FY2020. - Beginning in FY2021 a $0.9M performance improvement plan is assumed at UCMC, growing to $7.2M in FY2022 ($5.9M at UCMC, $0.2M at UCMS and $1.1M at AMC Specialty Psych Hospital) when HMH closes and the Project opens. An incremental performance improvement of $1.5M per year is assumed throughout the projection period.
• Interest Expense – Existing Debt	- Continued amortization of existing debt and related interest expense: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Interest Expense – Project Debt	- 4.5% interest on $214.4M bonds over 30 years
• Depreciation and Amortization	- Average life of 26 years on $196.3M (less land and debt service reserve fund) of construction project expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures	- $135.0M in routine capital over the projection period with another $47.4M of other strategic capital projects (none are related to this Project)

TABLE J. REVENUES & EXPENSES, UNINFLATED - UC FMF

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE							
a. Inpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
b. Outpatient Services	-	-	-	-	33,800	34,090	34,383
Gross Patient Service Revenues	***$ -***	***$ -***	***$ -***	***$ -***	***$ 33,800***	***$ 34,090***	***$ 34,383***
c. Allowance For Bad Debt	-	-	-	-	2,450	2,472	2,493
d. Contractual Allowance	-	-	-	-	4,485	4,523	4,562
e. Charity Care	-	-	-	-	-	-	-
Net Patient Services Revenue	***$ -***	***$ -***	***$ -***	***$ -***	***$ 26,864***	***$ 27,095***	***$ 27,328***
f. Other Operating Revenues (Specify)	-	-	-	-	174	173	171
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ -***	***$ 27,039***	***$ 27,268***	***$ 27,499***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ -	$ -	$ -	$ -	$ 18,788	$ 18,708	$ 18,735
b. Contractual Services	-	-	-	-	-	-	-
c. Interest on Current Debt	-	-	-	-	422	406	392
d. Interest on Project Debt	-	-	-	-	2,877	2,824	2,767
e. Current Depreciation	-	-	-	-	-	-	-
f. Project Depreciation	-	-	-	-	2,380	2,416	2,523
g. Current Amortization	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-
i. Supplies	-	-	-	-	2,220	2,236	2,252
j. Other Expenses (Purchased Services, Professional Fees and Other Expense)	-	-	-	-	2,340	2,456	2,496
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ -***	***$ -***	***$ 29,028***	***$ 29,045***	***$ 29,166***
3. INCOME							
a. Income From Operation	**$ -**	**$ -**	**$ -**	**$ -**	**$ (1,989)**	**$ (1,777)**	**$ (1,666)**
b. Non-Operating Income	-	-	-	-	-	-	-
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ -***	***$ (1,989)***	***$ (1,777)***	***$ (1,666)***
c. Income Taxes	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ -***	***$ (1,989)***	***$ (1,777)***	***$ (1,666)***

TABLE J. REVENUES & EXPENSES, UNINFLATED - UC FMF

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare					32.4%	32.4%	32.4%
2) Medicaid					27.8%	27.8%	27.8%
3) Blue Cross					9.7%	9.7%	9.7%
4) Commercial Insurance					21.0%	21.0%	21.0%
5) Self-pay					2.4%	2.4%	2.4%
6) Other					6.7%	6.7%	6.7%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Emergency Department Visits							
Total MSGA							
1) Medicare					22.6%	22.6%	22.6%
2) Medicaid					35.3%	35.3%	35.3%
3) Blue Cross					9.6%	9.6%	9.6%
4) Commercial Insurance					19.9%	19.9%	19.9%
5) Self-pay					3.3%	3.3%	3.3%
6) Other					9.4%	9.4%	9.4%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***

Table J – Key Financial Projection Assumptions for the UM Upper Chesapeake Free Standing Medical Facility (Excludes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Harford Memorial Hospital (HMH) FY2019 cost center level projections and high level FY2020 budget results with assumptions identified below	
Projection period reflects FY2022 – FY2024	
Volumes	- Refer to COE Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue • Gross Charges o Update Factor	- 0.00% annual increase
o Demographic and Other Rate Adjustment	- Remains constant at 0.43% per year
o Variable Cost Factor	- UC HMH volume shifting at 100% VCF before the addition of retained revenue for capital
o Other	- Removed assessments and quality from HMH rates and changed the mark-up based on HMH FY2018 OP PDA payer mix and actual FY2018 UCC
• Revenue Deductions o Contractual Allowances	- Based on FY2018 HMH actual contractual allowances for HMH Behavioral Health, ED, and Observation Services and remains constant at 8.9% of gross revenue per year
o Charity Care	- Based on FY2018 actual charity care for HMH Behavioral Health, ED, and Observation Services and remains constant at 4.4% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	- Based on FY2018 actual bad debt for HMH Behavioral Health, ED, and Observation services and remains constant at 7.2% of gross revenue per year - No overfunding or underfunding of UCC
Other Revenue o Cafeteria Revenue and Other Operating Revenue	- 0.0% increase per year
Expenses • Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses	- 0.0% weighted average annual increase that reflects the following: - 0.0% - 0.0% - 0.0% - 0.0% - 0.0%
• Expense Volume Driver	- Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes o Salaries and Benefits o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses	- Ranges from 10% for overhead departments to 100% for inpatient nursing units - 0% for all cost centers except inpatient nursing (50%) and Laboratory (100%) - Ranges from 0% for overhead departments to 100% for the Emergency Department - Ranges from 0% for overhead departments to 50% for certain ancillary departments - Ranges from 0% for overhead departments to 50% for certain ancillary departments
• Other Operating Expenses	- Additional adjustments totaling approximately $3.0M were made to reduce other operating expenses and UCHS overhead allocations to reflect specific services at UC FMF and a smaller facility.
• Interest Expense – Existing Debt	- 4.9% allocation of the following UCHS debt: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Interest Expense – Project Debt	- 4.5% interest on $64.3M bonds over 30 years
• Depreciation and Amortization	- Average life of 26 years on $51.9M of construction project (less land and debt service reserve fund) expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures	- $0.3M in FY2022, growing to $1.1M in FY2023 and $1.8M in FY2024

TABLE K. REVENUES & EXPENSES, INFLATED - UC FMF

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE							
a. Inpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
b. Outpatient Services	-	-	-	-	35,868	36,900	37,962
Gross Patient Service Revenues	***$ -***	***$ -***	***$ -***	***$ -***	***$ 35,868***	***$ 36,900***	***$ 37,962***
c. Allowance For Bad Debt	-	-	-	-	2,600	2,675	2,752
d. Contractual Allowance	-	-	-	-	4,759	4,896	5,037
e. Charity Care	-	-	-	-	-	-	-
Net Patient Services Revenue	***$ -***	***$ -***	***$ -***	***$ -***	***$ 28,509***	***$ 29,329***	***$ 30,172***
f. Other Operating Revenues (Specify/add rows of needed)	-	-	-	-	185	187	189
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ -***	***$ 28,694***	***$ 29,516***	***$ 30,361***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ -	$ -	$ -	$ -	$ 20,114	$ 20,490	$ 20,991
b. Contractual Services	-	-	-	-	-	-	-
c. Interest on Current Debt	-	-	-	-	422	406	392
d. Interest on Project Debt	-	-	-	-	2,877	2,824	2,767
e. Current Depreciation	-	-	-	-	-	-	-
f. Project Depreciation	-	-	-	-	2,380	2,416	2,523
g. Current Amortization	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-
i. Supplies	-	-	-	-	2,426	2,516	2,611
j. Other Expenses (Purchased Services, Professional Fees and Other Expense)	-	-	-	-	2,483	2,658	2,756
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ -***	***$ -***	***$ 30,703***	***$ 31,309***	***$ 32,040***
3. INCOME							
a. Income From Operation	**$ -**	**$ -**	**$ -**	**$ -**	**$ (2,010)**	**$ (1,794)**	**$ (1,679)**
b. Non-Operating Income	-	-	-	-			
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ -***	***$ (2,010)***	***$ (1,794)***	***$ (1,679)***
c. Income Taxes	-	-	-	-			
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ -***	***$ (2,010)***	***$ (1,794)***	***$ (1,679)***

TABLE K. REVENUES & EXPENSES, INFLATED - UC FMF

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare					32.4%	32.4%	32.4%
2) Medicaid					27.8%	27.8%	27.8%
3) Blue Cross					9.7%	9.7%	9.7%
4) Commercial Insurance					21.0%	21.0%	21.0%
5) Self-pay					2.4%	2.4%	2.4%
6) Other					6.7%	6.7%	6.7%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Emergency Department Visits							
1) Medicare					22.6%	22.6%	22.6%
2) Medicaid					35.3%	35.3%	35.3%
3) Blue Cross					9.6%	9.6%	9.6%
4) Commercial Insurance					19.9%	19.9%	19.9%
5) Self-pay					3.3%	3.3%	3.3%
6) Other					9.4%	9.4%	9.4%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***

Table K – Key Financial Projection Assumptions for the UM Upper Chesapeake Free Standing Medical Facility (Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Harford Memorial Hospital (HMH) FY2019 cost center level projections and high level FY2020 budget results with assumptions identified below.	
Projection period reflects FY2022 – FY2024	
Volumes	- Refer to COE Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
• Gross Charges	
o Update Factor	- 2.1% annual increase in FY2021, 2.3% annual increase in FY2022 and 2.50% annual increase in FY2023 & FY2024
o Demographic and Other Rate Adjustment	- Remains constant at 0.43% per year
o Variable Cost Factor	- UC FMF volume shifting at 100% VCF before the addition of retained revenue for capital
o Other	- Removed assessments and quality from HMH rates and changed the mark-up based on HMH FY2018 OP PDA payer mix and actual FY2018 UCC
• Revenue Deductions	
o Contractual Allowances	- Based on FY2018 HMH actual contractual allowances for HMH Behavioral Health, ED, and Observation Service and remains constant at 8.9% of gross revenue per year
o Charity Care	- Based on FY2018 actual charity care for HMH Behavioral Health, ED, and Observation Services and remains constant at 4.4% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	- Based on FY2018 actual bad debt for HMH Behavioral Health, ED, and Observation services and remains constant at 7.2% of gross revenue per year - No overfunding or underfunding of UCC
Other Revenue	
o Cafeteria Revenue and Other Operating Revenue	- 1.0% increase per year
Expenses	
• Inflation	
o Salaries and Benefits	- 2.3%
o Professional Fees	- 3.0%
o Supplies	- 3.0%
o Purchased Services	- 3.0%
o Other Operating Expenses	- 2.0%
• Expense Volume Driver	- Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	
o Salaries and Benefits	- Ranges from 10% for overhead departments to 100% for inpatient nursing units
o Professional Fees	- 0% for all cost centers except inpatient nursing (50%) and Laboratory (100%)
o Supplies & Drugs	- Ranges from 0% for overhead departments to 100% for the Emergency Department
o Purchased Services	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
• Other Operating Expenses	- Additional adjustments totaling approximately $3.0M were made to reduce other operating expenses and UCHS overhead allocations to reflect specific services at UC FMF and a smaller facilit
• Interest Expense – Existing Debt	- 4.9% allocation of the following UCHS debt - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Interest Expense – Project Debt	- 4.5% interest on $64.3M bonds over 30 years
• Depreciation and Amortization	- Average life of 26 years on $51.9M of construction project (less land and debt service reserve fund) expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures	- $0.3M in FY2022, growing to $1.1M in FY2023 and $1.8M in FY2024

TABLE L. WORKFORCE INFORMATION - UC FMF

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted)*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table J)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Medical Staff Administration										0.5	$33.75
Quality & Health Information Management										3.3	$193.29
Fiscal Services										0.9	$62.34
Spirituality										0.1	$5.91
Patient Accounting										1.8	$90.02
Centralized Scheduling										1.4	$53.63
Admitting										7.2	$261.30
MIS										2.4	$215.00
Telecommunications										0.2	$16.58
Administration										0.4	$96.45
Safety										0.2	$15.55
Nursing Administration										1.6	$148.93
Hospital Education										1.0	$94.48
Quality Management										0.7	$53.63
Readmission										1.2	$94.59
Clinical Resource Management										1.0	$94.58
Distribution										1.2	$40.00
Volunteers										0.3	$16.03
Human Resources										0.7	$54.31
Healthlink										0.1	$4.72
Business Intelligence										0.4	$39.15
Population Health										3.7	$278.90
Performance Improvements										0.8	$85.39
HC Epidemiology & Infection Control										0.2	$13.80
Guest Services										0.3	$16.17
Purchasing										0.5	$29.70
Risk Management										0.3	$27.49
General Hospital										2.6	$261.45
Total Administration			$0			$0			$0	34.6	$2,397.13
Direct Care Staff *(List general categories, add rows if needed)*											
Observation			$0			$0			$0	22.1	$1,077.36
Emergency Department			$0			$0			$0	66.0	$5,236.33
IV Therapy			$0			$0			$0	0.7	$62.30
Pharmacy			$0			$0			$0	5.2	$487.81
Respiratory Therapy			$0			$0			$0	4.7	$360.75
Speech Therapy			$0			$0			$0	0.1	$9.98
Physical Therapy			$0			$0			$0	3.1	$224.11
Occupational Therapy			$0			$0			$0	1.0	$113.10
Radiology			$0			$0			$0	16.3	$1,133.20
General Ultrasound			$0			$0			$0	2.1	$197.16
Nuclear Medicine			$0			$0			$0	1.8	$179.10
Cat Scan			$0			$0			$0	5.9	$510.33
MRI			$0			$0			$0	1.9	$175.25
Imaging Support RN			$0			$0			$0	0.5	$55.95
Cardiovascular Institute			$0			$0			$0	2.2	$78.81
Cardiovascular Ultrasound			$0			$0			$0	6.9	$529.34
Electroencephalography			$0			$0			$0	0.3	$16.22
Laboratory			$0			$0			$0	16.2	$1,015.98
Total Direct Care			$0			$0			$0	157.0	$11,463.08
Support Staff *(List general categories, add rows if needed)*											
Nutritional Services			$0			$0			$0	15.5	$491.78
Plant Operations			$0			$0			$0	3.7	$230.76
Bio Med			$0			$0			$0	1.5	$80.40
Environmental Services			$0			$0			$0	10.0	$313.67
Security			$0			$0			$0	7.7	$284.82
Print Shop			$0			$0			$0	0.1	$7.26
Total Support			$0			$0			$0	38.6	$1,408.69
REGULAR EMPLOYEES TOTAL			$0			$0			$0	230.2	$15,268.89

TABLE L. WORKFORCE INFORMATION - UC FMF

2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below)* **:**											**$ 3,466**
22.7% of Salaries											
TOTAL COST	***0.0***		***$0***	***0.0***		***$0***	***0.0***		***$0***		***$18,735***

EXHIBIT 2

EROSION & SEDIMENT CONTROL PLANS

FOR

UCH MEDICAL CAMPUS

HARFORD COUNTY SEDIMENT CONTROL NOTES

CONTRACTOR SHALL CONTACT THE FOLLOWING 48 HOURS PRIOR TO ANY GROUND DISTURBING ACTIVITIES:
MISS UTILITY/ONE CALL: 1-800-257-7777
CITY OF ABERDEEN: 410-272-1600 EXT. 224
MORRIS & RITCHIE ASSOCIATES, INC: 410-515-9000

1. THE CONTRACTOR/OWNER IS RESPONSIBLE FOR OBTAINING ALL NECESSARY PERMITS. FURTHER, NO CONSTRUCTION ACTIVITY SHALL TAKE PLACE UNTIL ALL REQUIRED PERMITS HAVE BEEN OBTAINED.
2. THE LIMITS OF DISTURBANCE SHALL BE CLEARLY DELINEATED IN THE FIELD PRIOR TO GRADING OF THE SITE TO ENSURE COMPLIANCE WITH APPROVED PLANS. ALL FOREST RETENTION AREAS WILL BE DELINEATED WITH BLAZE ORANGE FENCE AS WELL AS ANY SWM INFILTRATION PRACTICE PRIOR TO ANY CLEARING. WORK BEYOND THE LIMITS OF DISTURBANCE AND IN ANY AREA INSIDE THE FOREST RETENTION AND SWM INFILTRATION AREA IS CONSIDERED TO BE A VIOLATION OF THIS PLAN.
3. ALL SEDIMENT CONTROL PRACTICES MUST BE INSTALLED PRIOR TO ANY CONSTRUCTION ACTIVITY. UPON COMPLETION OF INSTALLATION OF PERIMETER SEDIMENT CONTROL PRACTICES THE SITE MUST BE INSPECTED BY THE DEPARTMENT OF PUBLIC WORKS (DPW). NO ADDITIONAL CONSTRUCTION ACTIVITY WILL BE AUTHORIZED WITHOUT THE APPROVAL OF DPW.
4. ALL POINTS OF INGRESS AND EGRESS SHALL BE PROTECTED TO PREVENT TRACKING OF MUD INTO PUBLIC WAYS. DURING CONSTRUCTION, EVERY MEANS WILL BE TAKEN TO CONTROL SOIL EROSION AND SILTATION. IF NECESSARY, A WASH RACK MAY NEED TO BE ESTABLISHED.
5. EARTH DIKES, SEDIMENT TRAPS, ETC. WILL BE LOCATED AS SHOWN ON THESE DRAWINGS. FIELD CHANGES AND MINOR ADJUSTMENTS ARE PERMISSIBLE AS LONG AS THE INSTALLATION FUNCTIONS AND CONFORMS TO SPECIFICATIONS. THE SITE INSPECTOR PRIOR TO INSTALLATION MUST APPROVE ALL SUCH CHANGES. MAJOR CHANGES TO THE APPROVED PLAN WILL REQUIRE RE-APPROVAL BY THE HARFORD SOIL CONSERVATION DISTRICT.
6. FOLLOWING INITIAL SOIL DISTURBANCE OR RE-DISTURBANCE PERMANENT OR TEMPORARY STABILIZATION SHALL BE COMPLETED WITHIN:
   THREE CALENDAR DAYS ON SLOPES GREATER THAN 3:1, ALL WATERWAYS AND TO THE SURFACE OF ALL PERIMETER CONTROLS.
   SEVEN CALENDAR DAYS AS TO ALL OTHER DISTURBED OR GRADED AREAS OF THE PROJECT SITE.
7. DUST CONTROL MUST BE MANAGED AS PART OF ALL SEDIMENT CONTROL PLANS. FAILURE TO DO SO IS A VIOLATION OF THIS PLAN.
8. TEMPORARY FENCING SHALL BE PLACED AROUND ALL SEDIMENT BASINS, TRAPS, AND PONDS DURING CONSTRUCTION AND SITE GRADING.
9. AT THE END OF EACH WORKING DAY ALL SEDIMENT CONTROL PRACTICES WILL BE INSPECTED AND LEFT OPERATIONAL. A WEEKLY LOG WILL BE KEPT IN ACCORDANCE WITH NOI/NPDES REGULATIONS. A COPY OF THE APPROVED SEDIMENT CONTROL PLANS SHALL BE AVAILABLE AT THE SITE AT ALL TIMES.
10. ENSURE POSITIVE DRAINAGE TO ALL ROAD INLETS DURING ALL PHASES OF ROAD CONSTRUCTION TO ENSURE POSITIVE FLOW TO TRAPS AND OR BASINS.
11. CUT AND/OR FILL SHALL BE DONE IN CONFORMANCE WITH 2011 EROSION AND SEDIMENT CONTROL STANDARDS AND SPECIFICATIONS FOR LAND GRADING.
12. SURFACE FLOWS OVER CUT AND FILL SLOPES SHALL BE CONTROLLED BY EITHER REDIRECTING FLOWS FROM TRAVERSING THE SLOPES OR BY INSTALLING MECHANICAL DEVICES TO SAFELY CONVEY WATER DOWN SLOPES WITHOUT CAUSING EROSION.
13. OFF-SITE WASTE OR BORROW AREAS SHALL HAVE AN APPROVED EROSION AND SEDIMENT CONTROL PLAN PRIOR TO THE IMPORT OR EXPORT OF MATERIAL TO/FROM THE PROJECT SITE.
14. ALL MATERIAL ORIGINATING FROM THE DEVELOPMENT OF THE PROPERTY AND DEPOSITED ON THE PUBLIC RIGHT-OF-WAY SHALL BE IMMEDIATELY REMOVED.
15. STORM DRAIN INLETS AND OUTLETS SHALL BE PROTECTED PER 2011 EROSION AND SEDIMENT CONTROL STANDARDS AND SPECIFICATIONS.
16. TOPSOIL, LIMING, FERTILIZING, SEEDING, MULCHING, SOD, ETC. ARE ALL ESSENTIAL PARTS OF THE SEDIMENT CONTROL PLAN AND MUST BE COMPLETED ALONG WITH ALL OTHER PRACTICES.
17. TRAPS TO BE REMOVED SHALL BE DEWATERED AS PER THE 2011 EROSION AND SEDIMENT CONTROL STANDARDS AND SPECIFICATIONS.
18. PRIOR TO REMOVAL OF TRAPS OR CONVERSION OF SEDIMENT BASINS TO STORMWATER MANAGEMENT FACILITIES THE STORM DRAINS WILL BE FLUSHED.
19. SEDIMENT CONTROL PRACTICES WILL BE MAINTAINED UNTIL ALL DISTURBED AREAS FOR WHICH THE PRACTICES WERE INSTALLED HAVE BEEN STABILIZED. SEDIMENT CONTROL PRACTICES MAY BE REMOVED ONLY WITH THE AUTHORIZATION OF THE DPW INSPECTOR. ALL DISTURBED AREAS RESULTING FROM THE REMOVAL OF SEDIMENT CONTROL DEVICES SHALL BE STABILIZED IMMEDIATELY. REMOVAL PRIOR TO INSPECTOR'S APPROVAL CONSTITUTES A VIOLATION.

SPECIFICATION FOR LOT FILL

LOT FILL SHALL CONSIST OF WELL TO MODERATELY WELL-GRADED SOILS CONSISTING OF SANDS, SILTS, CLAYS AND GRAVEL, AND SHALL BE FREE FROM DETRIMENTAL QUANTITIES OF DEBRIS, MUCK, PEAT, ROOTS, GRASS, LEAVES, HUMUS, SEWAGE AND OTHER ORGANIC MATERIAL, CLODS, LUMPS, AND BALLS OF CLAY, AND FROZEN MATERIALS. ALL FILL MATERIAL SHALL TO THE FOLLOWING MATERIALS SPECIFICATIONS:

LIQUID LIMIT	40 MAXIMUM
PLASTICITY INDEX	10 MAXIMUM
LABORATORY MAXIMUM	
DRY DENSITY (AASHTO T-180)	100 POUNDS PER CUBIC FOOT (MIN.)
PERCENT PASSING 4-INCH SIEVE	100
PERCENT PASSING U.S. #200 SIEVE	50 MAXIMUM

PRIOR TO THE PLACEMENT OF LOT FILL, REMOVE ALL TOPSOIL, ROOT MATER, ORGANIC MATERIALS, LARGE STONES, DEBRIS, AND ANY UNSTABLE MATERIAL TO THE DEPTH AT WHICH A STABLE SUBGRADE IS ACHIEVED. PRIOR TO THE PLACEMENT OF FILL ON THE PREPARED SUBGRADE, THE AREA SHOULD BE UNDERCUT TO STABLE MATERIALS AND BACKFILLED WITH SUITABLE FILL AND PROPERLY COMPACTED.

LOT FILL SHALL BE PLACED IN HORIZONTAL LAYERS, WITH LIFT THICKNESS LIMITED TO A MAXIMUM OF 12 INCHES. EACH LIFT SHALL BE EVENLY SPREAD AND THOROUGHLY COMPACTED TO THE SPECIFIED PERCENTAGE OF MAXIMUM DRY DENSITY. MOISTURE CONTENT AT THE TIME OF COMPACTION SHALL BE MAINTAINED WITHIN THE LIMITS SPECIFIED FOR EACH AREA OF LOT FILL.

THE DEGREE OF COMPACTION TO BE ACHIEVED FOR LOT FILL WITHIN THE BUILDING ENVELOPE SHALL BE DETERMINED BY THE GEOTECHNICAL ENGINEER. MOISTURE CONTENT OF THE COMPACTED FILL SHALL BE MAINTAINED WITHIN A SPECIFIED RANGE OF THE OPTIMUM MOISTURE CONTENT FOR COMPACTION SPECIFIED.

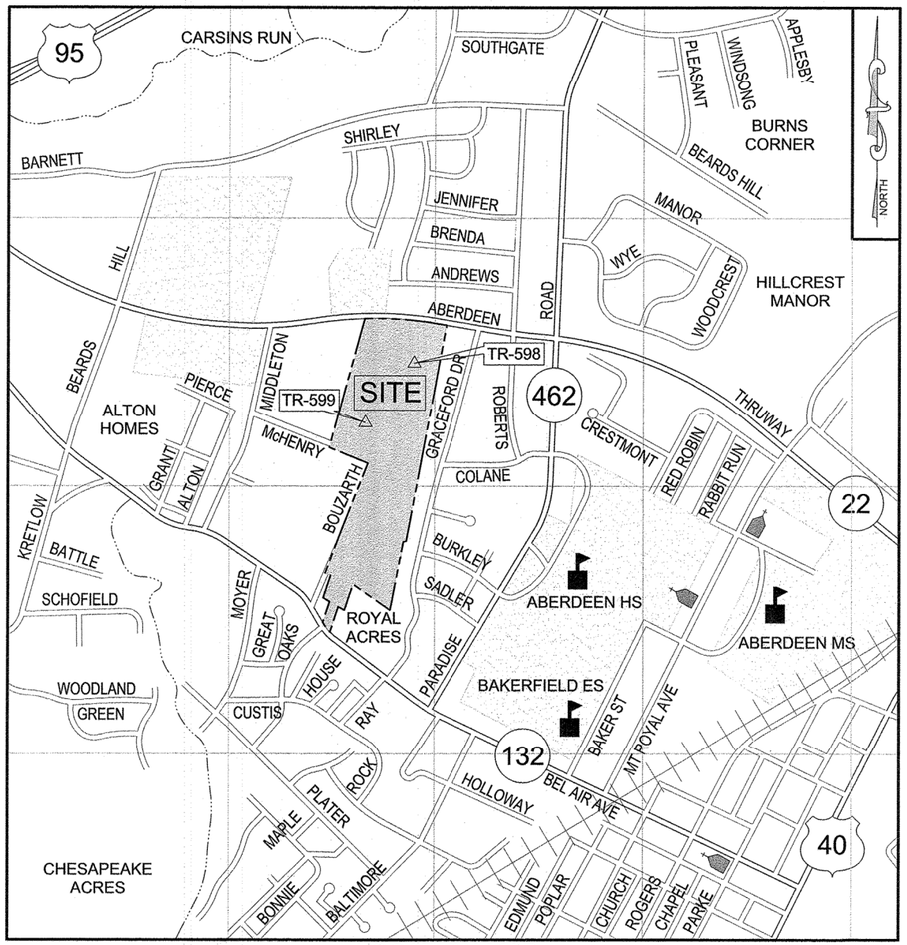
THE DEGREE OF COMPACTION TO BE ACHIEVED FOR LOT FILL OUTSIDE THE AREAS OF THE BUILDING ENVELOPE AND AREAS OF DRIVEWAY OR PARKING PADS SHALL BE DETERMINED BY THE GEOTECHNICAL ENGINEER. MOISTURE CONTENT SHALL BE MAINTAINED WITHIN A SPECIFIC RANGE OF THE OPTIMUM MOISTURE CONTENT FOR COMPACTION SPECIFIED. THE DEGREE OF COMPACTION ACHIEVED ON LOT FILL SHALL BE VERIFIED BY CONTINUOUS MONITORING AND TESTING BY AN APPROVED INDEPENDENT TESTING AGENCY. THE RESULTS SHALL BE SUBMITTED TO THE CLIENT WITHIN TWO WEEKS AFTER COMPLETION OF THE WORK FOR THEIR REVIEW.

FILL PLACEMENT NOTES

1. ALL FILL MATERIAL PLACED ON LOT SHALL BE COMPACTED AND TESTED TO CONTOURS SHOWN.
2. ALL FILL MATERIAL PLACED ON BUILDING PAD SHALL BE COMPACTED AND TESTED TO ELEVATIONS SHOWN.
3. ALL MATERIAL SHALL BE COMPACTED AND TESTED BY AN APPROVED SOILS ENGINEER WHERE NECESSARY.

LEGEND

EXISTING	PROPOSED	ESC (CONT'D)
PROPERTY LINE	PROPERTY LINE	STABILIZED CONSTRUCTION ENTRANCE
ADJOINING PROPERTY	LOT LINE	RIPRAP
RIGHT OF WAY	RIGHT OF WAY	MOUNTABLE BERM
EDGE OF PAVING	EDGE OF PAVING	I.P. INLET PROTECTION
1' CONTOURS	BUILDING SETBACK	A.G.I.P. ABOVE GROUND INLET PROTECTION
10' CONTOURS	EASEMENT	C.O.I.P. CURB OPENING INLET PROTECTION
WETLANDS	1' CONTOUR	S.I.P. STANDARD INLET PROTECTION
25' WETLANDS BUFFER	10' CONTOUR	
STREAM BUFFER	STORM DRAIN	
STREAM	SANITARY SEWER	
STORM DRAIN	WOODS	
WATER	ESC	
SANITARY SEWER	L.O.D.	
WOODS	SUPER SILT FENCE	
FENCE	SILT FENCE	



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PERMITTED USE No. 21006237

ADC MAP No. 4354 GRID No. B7

LOCATION MAP

SCALE: 1" = 600'

NOTE:

ALL DISTURBED AREAS PERTAINING TO AND INCLUSIVE OF THE SWM FACILITIES SHALL BE STABILIZED USING 4" TOPSOIL, SEED AND MULCH.

NOTE: OWNER & CONTRACTOR

THE ENGINEER SHALL BE NOTIFIED 2 WEEKS PRIOR TO THE COMMENCEMENT OF CONSTRUCTION.

Know what's below. Call before you dig.

PROTECT YOURSELF, GIVE THREE WORKING DAYS NOTICE

THIS DRAWING DOES NOT INCLUDE NECESSARY COMPONENTS FOR CONSTRUCTION SAFETY. ALL CONSTRUCTION MUST BE DONE IN COMPLIANCE WITH THE OCCUPATIONAL SAFETY AND HEALTH ACT OF 1970 AND ALL RULES AND REGULATIONS THERE TO APPURTENANT.

2nd ELECTION DISTRICT

CITY OF ABERDEEN, MARYLAND

INDEX OF DRAWINGS

1. TITLE SHEET
2. EXISTING CONDITIONS PLAN SHEET
3. PROPOSED CONDITIONS PLAN SHEET
4. ESC DETAILS SHEET
5. ESC NOTES SHEET
6. EX. & PROP. DRAINAGE AREA MAPS

ENGINEER'S CERTIFICATION

" I CERTIFY THAT THIS PLAN FOR EROSION AND SEDIMENT CONTROL REPRESENTS A PRACTICAL AND WORKABLE PLAN BASED ON MY PERSONAL KNOWLEDGE OF THE SITE CONDITIONS AND THAT IT WAS PREPARED IN ACCORDANCE WITH THE STANDARDS AND SPECIFICATIONS FCR SOIL EROSION AND SEDIMENT CONTROL, DATED 2011. "

SIGNATURE DANIEL SPIKER P.E. No. 32545 DATE 8/7/19

OWNER'S/APPLICANT'S CERTIFICATION

" I/WE CERTIFY THAT ALL DEVELOPMENT AND CONSTRUCTION WILL BE DONE ACCORDING TO THIS PLAN OF DEVELOPMENT AND PLAN FOR EROSION AND SEDIMENT CONTROL AND THAT ALL RESPONSIBLE PERSONNEL INVOLVED IN THE CONSTRUCTION PROJECT HAVE A CERTIFICATE OF ATTENDANCE AT A DEPARTMENT OF NATURAL RESOURCES APPROVED TRAINING PROGRAM FOR THE CONTROL OF SEDIMENT AND ERCSION BEFORE BEGINNING THE PROJECT. I/WE ALSO AUTHORIZE PERIODIC ON-SITE INSPECTION BY THE HARFORD SOIL CONSERVATION DISTRICT OR THEIR AUTHORIZED AGENTS, AS ARE DEEMED NECESSARY. "

SIGNATURE DATE 8/6/19

MR. LYLE SHELDON, PRESIDENT AND CEO, UCH / UMMS REAL ESTATE TRUST
NAME (PRINTED)

OWNER'S/DEVELOPER'S CERTIFICATION-AIR QUALITY

I ACKNOWLEDGE THAT I AM RESPONSIBLE UNDER THE CODE OF MARYLAND REGULATION'S (26.11.06.03d) TO PREVENT PARTICULATE MATTER FROM BECOMING AIRBORNE DUE TO GRADING, LAND CLEARING, EXCAVATION, CONSTRUCTION, OR OTHER RELATED ACTIVITIES. I HAVE RECEIVED A COPY OF "GUIDELINES TO THE AIR POLLUTION REGULATIONS FOR CONTROLLING EXCESSIVE ABP (DUST) ON ACTIVITY SITES" WHICH INCLUDES A COPY OF COMAR 26.11.06.03d.

SIGNATURE

MR. LYLE SHELDON, PRESIDENT AND CEO, UCH / UMMS REAL ESTATE TRUST
PRINTED NAME

SITE ANALYSIS

TOTAL AREA OF SITE:	1,552,043 S.F. / 35.63 AC.
AREA TO BE CLEARED / RAZED:	372,465 S.F. / 8.55 AC.
AREA TO BE VEGETATED:	103,982 S.F. / 2.39 AC.
AREA TO BE PAVED / ROOFTOP:	268,483 S.F. / 6.16 AC.
AREA TO BE DISTURBED:	372,465 S.F. / 8.55 AC.
TOTAL CUT:	12,100 CU. YD.
TOTAL FILL:	9,815 CU. YD.
TOPSOIL (6" DEPTH):	2,466 CU. YD.

"THE EARTHWORK QUANTITIES SHOWN HEREON ARE FOR INFORMATION PURPOSES ONLY. MRA MAKES NO GUARANTEE OF ACCURACY OF QUANTITIES OR BALANCE OF SITE. THE DEVELOPER AND CONTRACTOR SHALL TAKE FULL RESPONSIBILITY OF ACTUAL EARTHWORK QUANTITIES ENCOUNTERED DURING CONSTRUCTION."

NPDES COORDINATES N 675,953.19 E 1,544,466.99

E & S BMP LIST

ITEM	QUA.	UNIT
SUPER SILT FENCE	835	L.F.
SILT FENCE	1010	L.F.
STABILIZED CONSTRUCTION ENTRANCE	2	EA.
INLET PROTECTION	4	EA.
SEDIMENT BASIN	1	EA.

CITY OF ABERDEEN
DEPARTMENT OF PUBLIC WORKS - CITY ENGINEER
APPROVED:_____ DATE:_____

CITY OF ABERDEEN
DEPARTMENT OF PUBLIC WORKS - DIRECTOR
APPROVED:_____ DATE:_____

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

DATE	REVISIONS

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

PROFESSIONAL CERTIFICATION
"I (DAN SPIKER) HEREBY CERTIFY THAT THESE DOCUMENTS WERE PREPARED OR APPROVED BY ME, AND THAT I AM A DLLY LICENSED PROFESSIONAL ENGINEER UNDER THE LAWS OF THE STATE OF MARYLAND, LICENSE NO. 32545, EXPIRATION DATE: 01.19.2021."
8/7/19

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

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

JOB NO:	15402x4
SCALE:	AS SHOWN
DATE:	JULY 27, 2019
DRAWN BY:	JKC
DESIGN BY:	JKC/DRS
REVIEW BY:	DRS
SHEET:	ES-1 OF 6

SCALE: 1"=50'

NOTE:
SEE SHEET 6 OF 6 FOR SOILS MAP, DRAINAGE AREA MAPS AND SOILS DATA

SWM / SEDIMENT BASIN #1

EX. BASIN WAS CONSTRUCTED AND PARTIAL AS-BUILT, SEE CITY OF ABERDEEN GRADING PERMIT 09-02. THE DESIGN OF SEDIMENT BASIN #1 HAS NOT BEEN MODIFIED.

EX./PROP. DRAINAGE AREA TO POND/BASIN:	20.43 Ac
WET STORAGE REQUIRED:	36,774 Cu Ft
WET STORAGE PROVIDED:	41,815 Cu Ft
WET STORAGE ELEVATION:	146.00
DRY STORAGE REQUIRED:	36,774 Cu Ft
DRY STORAGE PROVIDED:	261,796 Cu Ft
DRY STORAGE ELEVATION:	147.28
WEIR CREST ELEVATION:	150.00
TOTAL STORAGE REQUIRED:	73,548 Cu Ft
TOTAL STORAGE PROVIDED:	303,610 Cu Ft
BOTTOM OF BASIN:	142.00
CLEANOUT ELEVATION:	144.92

EX. BUILDING
95,250± S.F.
3 STORY
FFE 173.5

PAVEMENT LEGEND

- EX. PAVEMENT TO BE REMOVED
- EX. LIGHT DUTY PAVEMENT TO REMAIN
- EX. HEAVY DUTY PAVEMENT TO REMAIN

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

DATE	REVISIONS

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

PROFESSIONAL CERTIFICATION
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6/7/19

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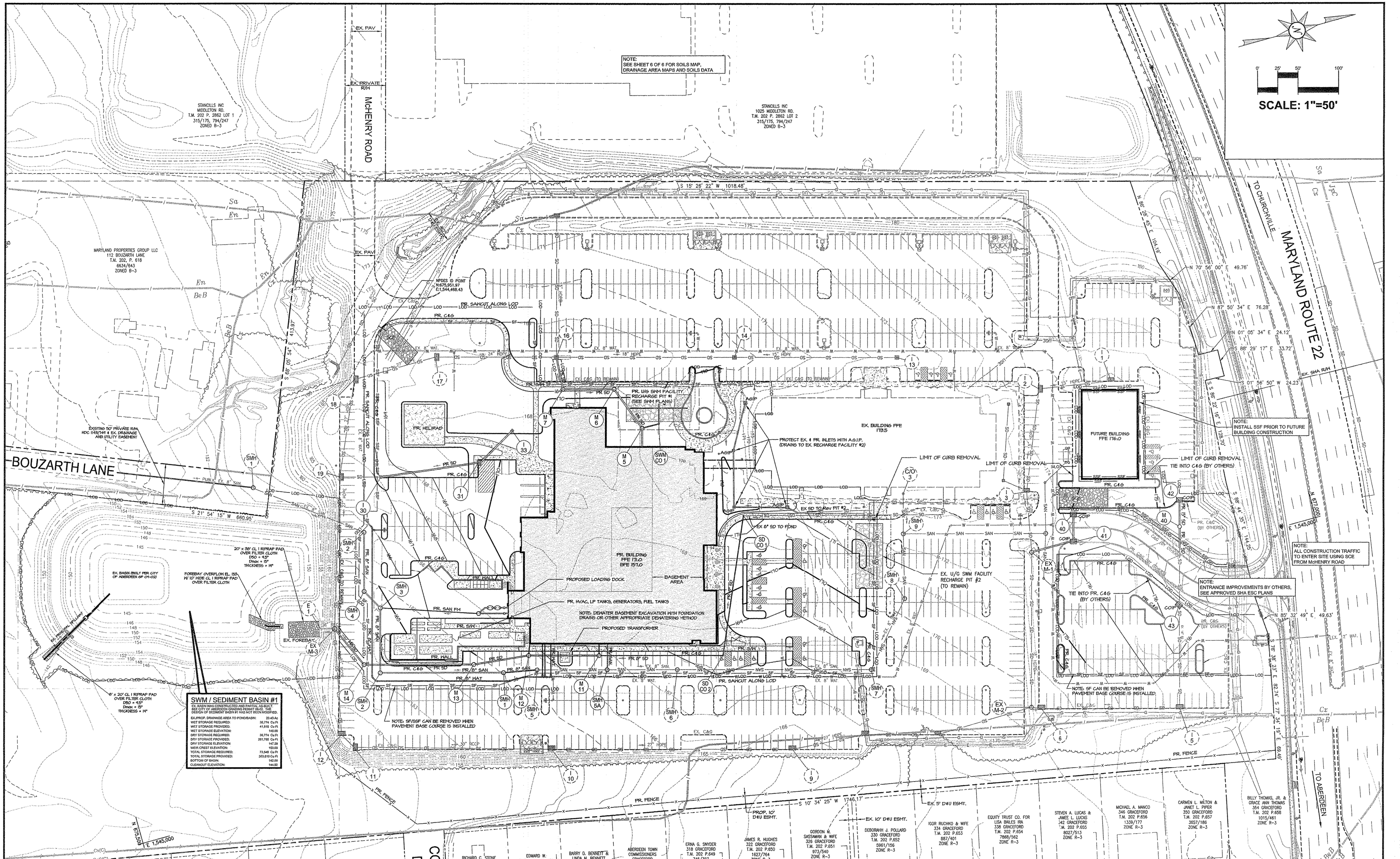
EROSION & SEDIMENT CONTROL PLAN
EXISTING CONDITIONS PLAN SHEET
FOR
UCH MEDICAL CAMPUS
CITY OF ABERDEEN
2ND ELECTION DISTRICT HARFORD COUNTY, MARYLAND

JOB NO:	15402x4
SCALE:	1" = 50'
DATE:	JULY 27, 2019
DRAWN BY:	JKC
DESIGN BY:	JKC/DRS
REVIEW BY:	DRS
SHEET:	ES-2 OF 6



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

DATE	REVISIONS

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

STATE OF MARYLAND DANIEL ROBERT SPIKER No. 32545 REGISTERED PROFESSIONAL ENGINEER 8/7/19

PROFESSIONAL CERTIFICATION
"I (DAN SPIKER) HEREBY CERTIFY THAT THESE DOCUMENTS WERE PREPARED OR APPROVED BY ME, AND THAT I AM A DULY LICENSED PROFESSIONAL ENGINEER UNDER THE LAWS OF THE STATE OF MARYLAND, LICENSE NO. 32545, EXPIRATION DATE: 01.19.2021."

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3445-A BOX HILL CORPORATE CENTER DRIVE
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EROSION & SEDIMENT CONTROL PLAN PROPOSED CONDITIONS PLAN SHEET

FOR

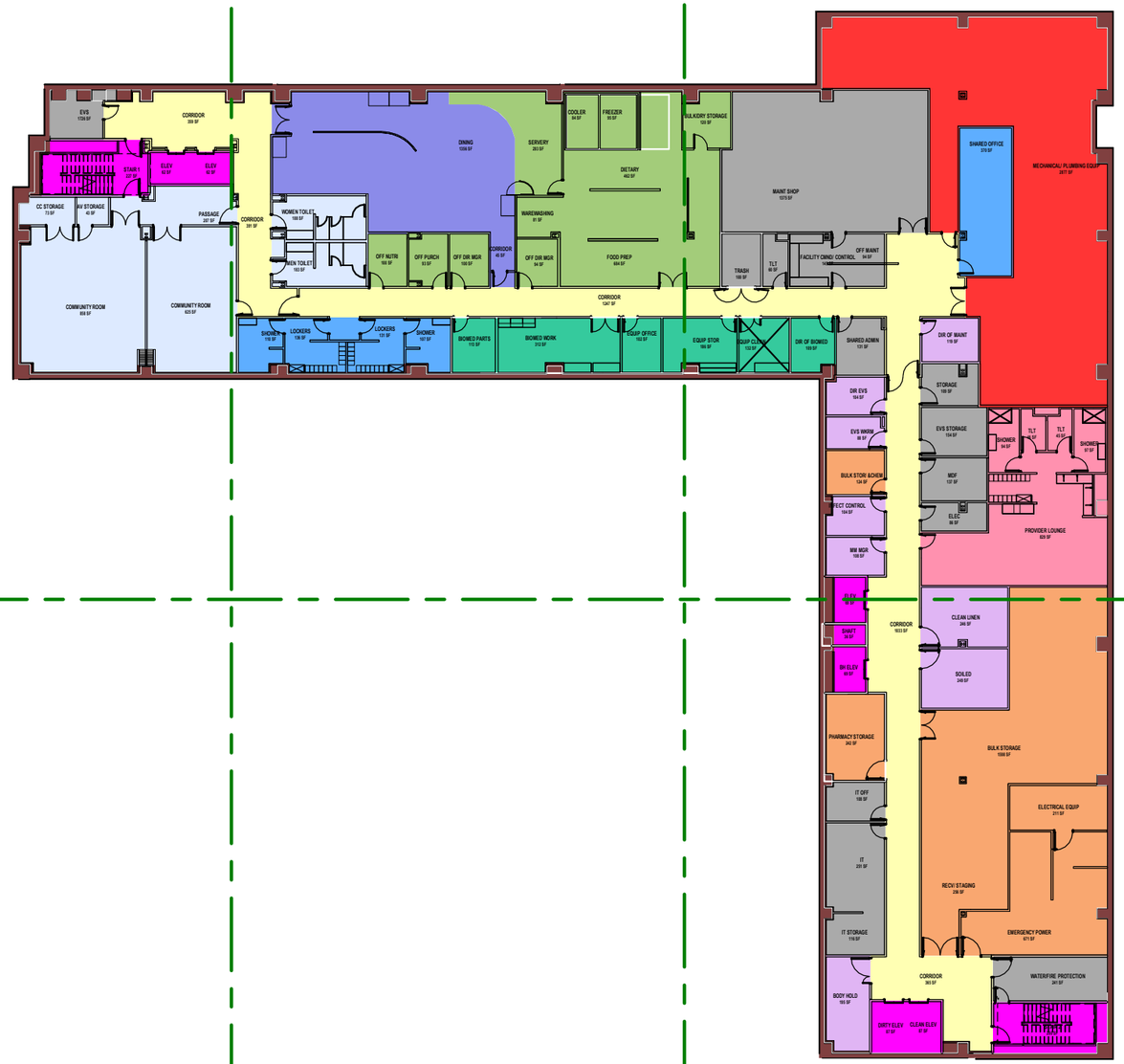
UCH MEDICAL CAMPUS

CITY OF ABERDEEN

2ND ELECTION DISTRICT — HARFORD COUNTY, MARYLAND

JOB NO:	15402x4
SCALE:	1" = 50'
DATE:	JULY 27, 2019
DRAWN BY:	JKC
DESIGN BY:	JKC/DRS
REVIEW BY:	DRS
SHEET:	ES-3 OF 6

F E D



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

C B A

ERDMAN

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

UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH

MEDICAL CAMPUS

ABERDEEN, MARYLAND, 21001

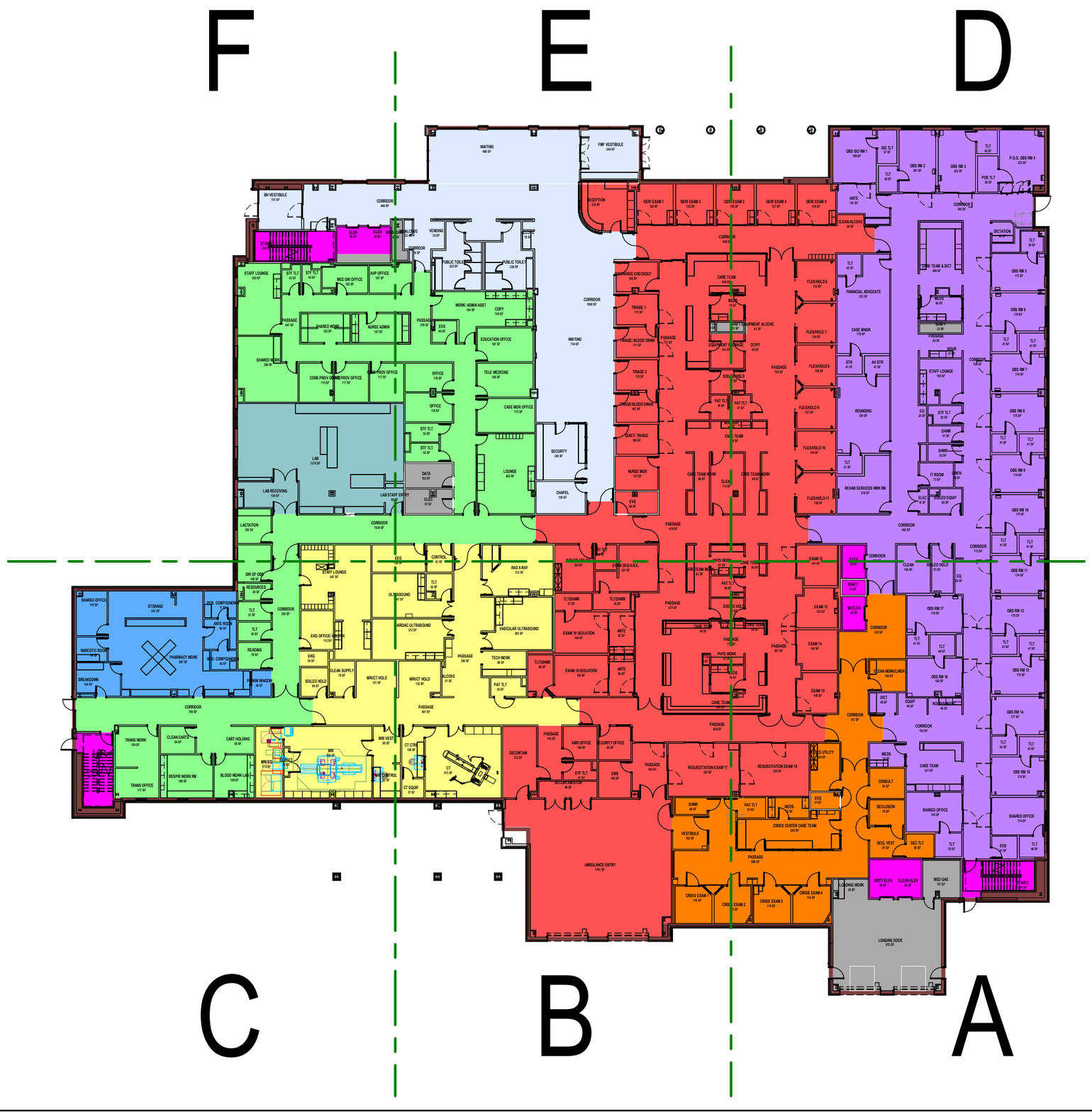
15°
N

LOWER LEVEL OVERALL

U100

Scale 1/32" = 1'-0"

JOB# 628620



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

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UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH

MEDICAL CAMPUS

ABERDEEN, MARYLAND, 21001

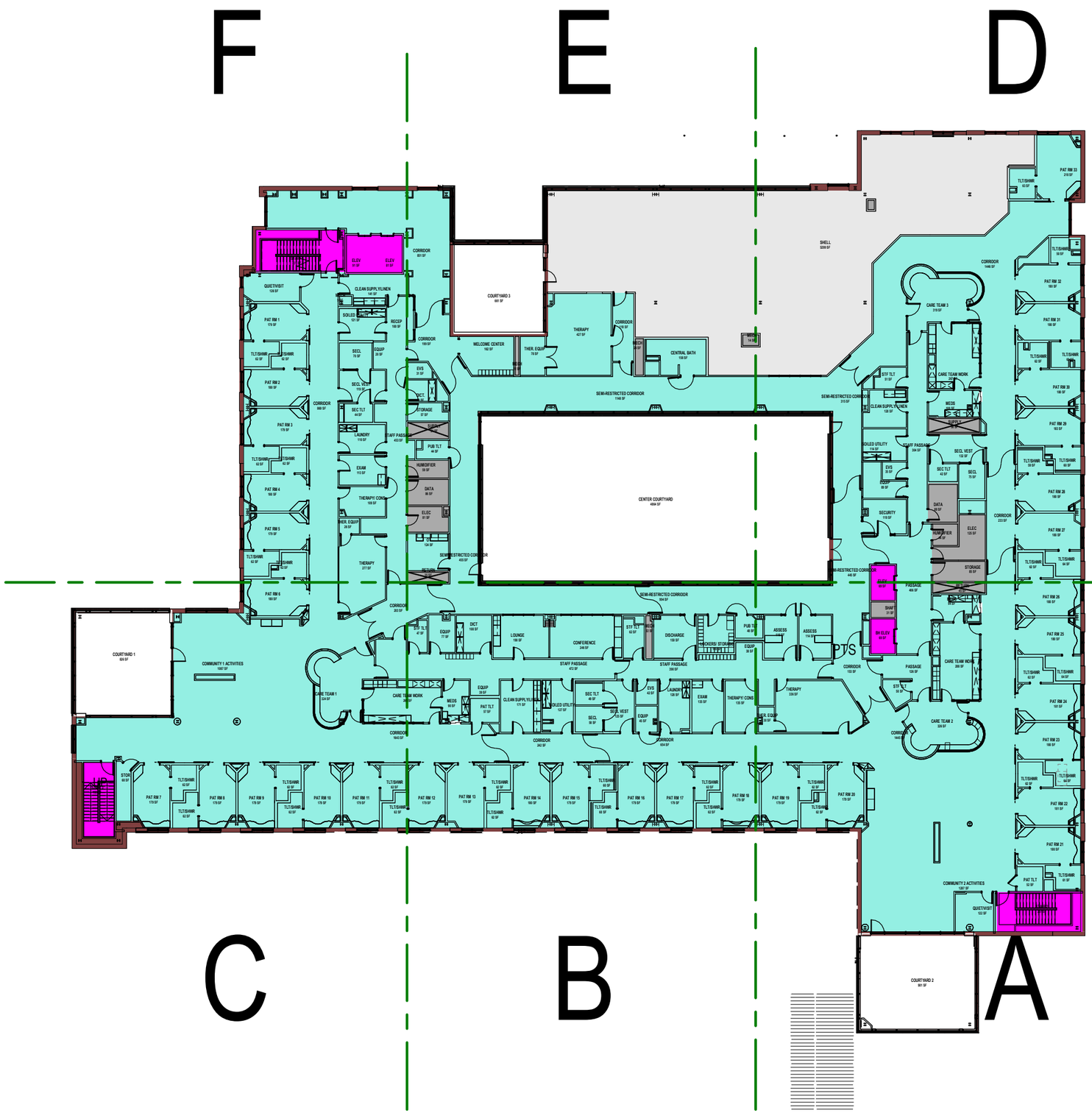
15°
N

FIRST FLOOR OVERALL

U101

Scale 1/32" = 1'-0"

JOB# 628620



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

ERDMAN

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UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH

MEDICAL CAMPUS

ABERDEEN, MARYLAND, 21001

15°
N

SECOND FLOOR OVERALL

U 102

Scale 1/32" = 1'-0"

JOB# 628620

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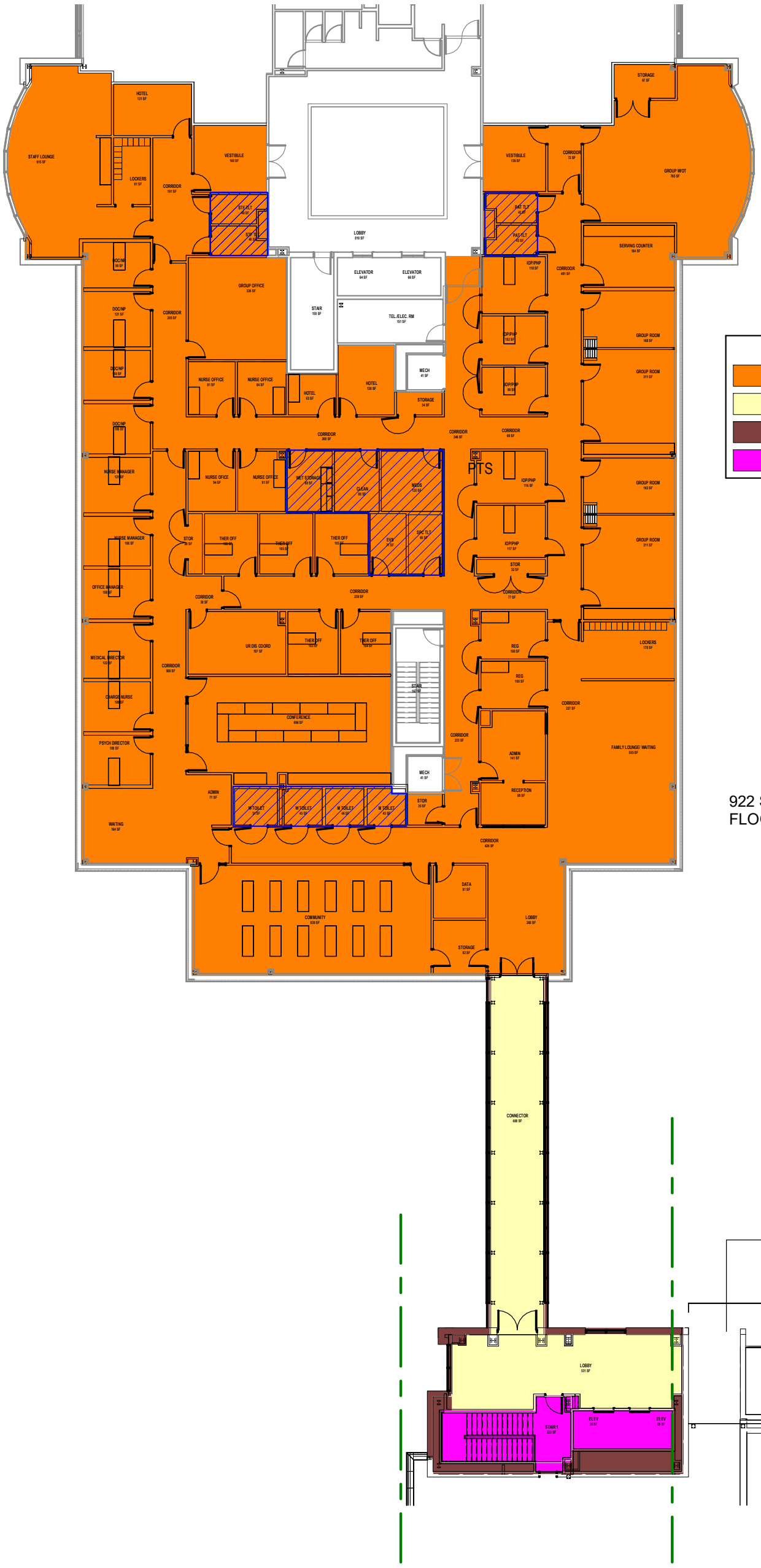


DEPARTMENTS	Area
BEH. HEALTH OUTPATIENT CARE SERVICES	15,090 SF
CIRCULATION	1,146 SF
EXTERIOR WALL	409 SF
VERTICAL CIRCULATION	387 SF

922 SF NEW RAISED FLOOR

ERDMAN

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

UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH

MEDICAL CAMPUS

ABERDEEN, MARYLAND, 21001

15° N

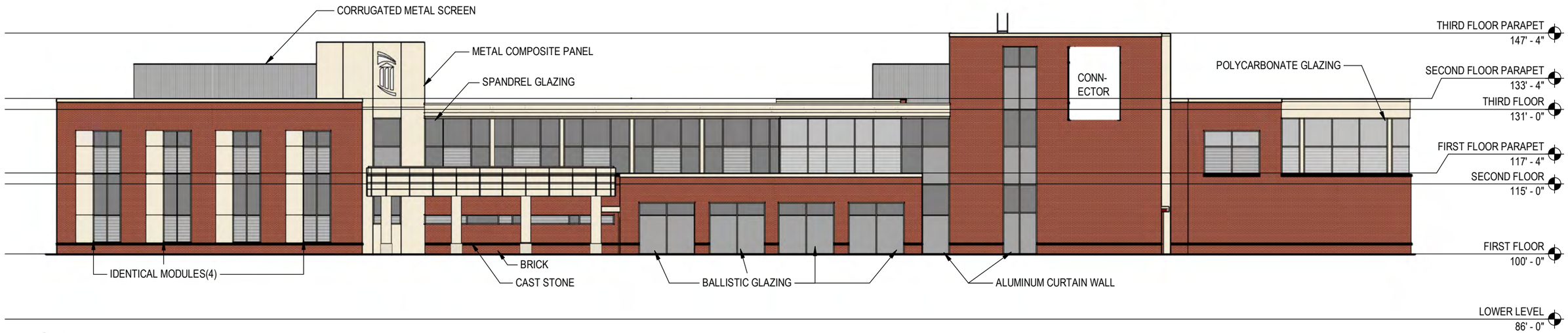
THIRD FLOOR INFILL AND FMF

U103.5

Scale 3/64" = 1'-0"

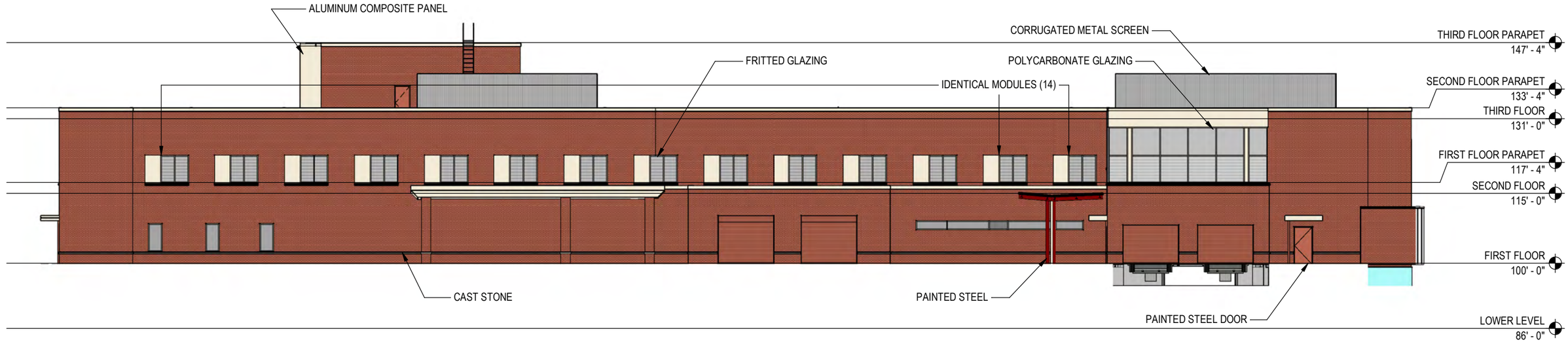
JOB# 628620

9/6/2019 7:29:31 AM



1 NORTH

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



2 SOUTH

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

ERDMAN

Madison Dallas Denver Jensen Beach
Los Angeles Nashville Seattle Washington DC

UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS

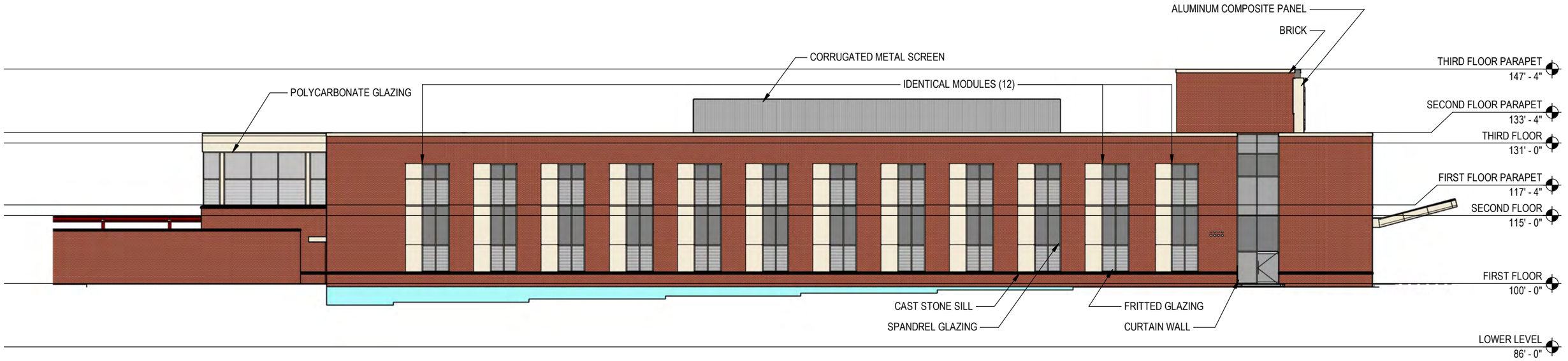
ABERDEEN, MARYLAND, 21001

EXTERIOR ELEVATIONS

Project number	628620
Issue Date:	8/23/2018

U201

Scale 3/64" = 1'-0"



1 EAST

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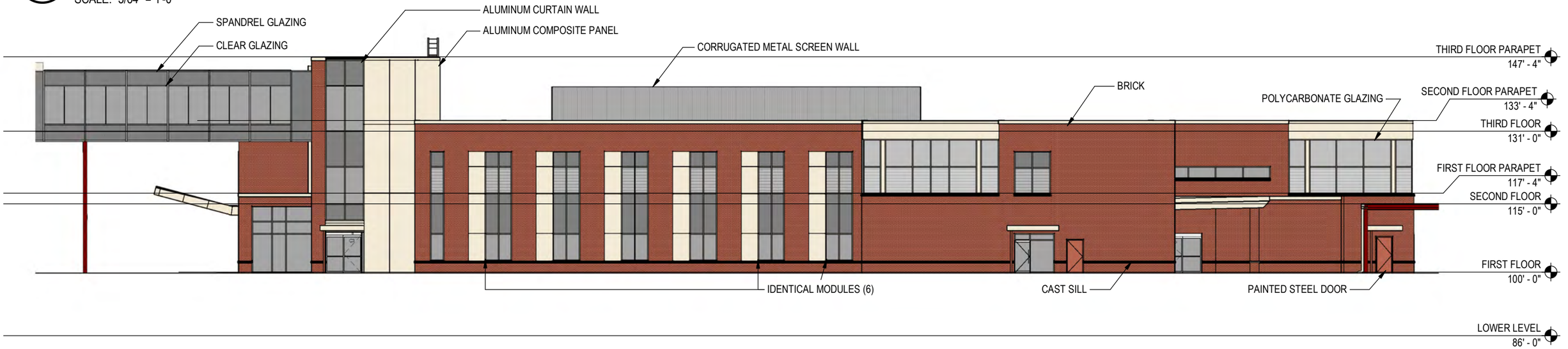

2 WEST

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

ERDMAN

Madison Dallas Denver Jensen Beach
Los Angeles Nashville Seattle Washington DC

UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS

ABERDEEN, MARYLAND, 21001

EXTERIOR ELEVATIONS

Project number	628620
Issue Date:	8/23/2018

U202

Scale 3/64" = 1'-0"

EXHIBIT 3

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Lyle E. Sheldon, FACHE
President and Chief Executive Officer

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

August 4, 2017

VIA EMAIL & HAND DELIVERY

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

Re: Notice of Intent to Convert University of Maryland Harford Memorial Hospital to a Freestanding Medical Facility and Request for Exemption from Certificate of Need Review

Dear Ms. Potter:

This letter serves as notice that University of Maryland Upper Chesapeake Medical Center and University of Maryland Harford Memorial Hospital, as joint applicants, intend to seek an exemption from Certificate of Need ("CON") review to convert HMH to a freestanding medical facility. Enclosed are six copies of the applicants' request for exemption from CON review, along with one set of full-size project drawings. Also enclosed is a CD containing electronic versions of the exemption application (WORD) and tables (EXCEL), and searchable PDF files of the application and exhibits.

If you have questions about the information provided above, please contact UM Upper Chesapeake Health System's legal counsel at your convenience:

James Buck
Gallagher, Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore, Maryland 21201
410-347-1353
jbuck@gejlaw.com

UM Upper Chesapeake Health System looks forward to working with the Maryland Health Care Commission, the Maryland Institute for Emergency Medical Services Systems, the Health Services Resources Cost Review Commission, and other interested stakeholders to

#600912
011888-0023

effectuate a new and innovative model of health care delivery for the residents of Harford and Cecil Counties.

Please sign and return to our waiting messenger the enclosed acknowledgment of receipt.

Sincerely,

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

Enclosures

CC:

Ben Steffen, Executive Director, Maryland Health Care Commission
Richard L. Alcorta, M.D., FACHE, MIEMSS Acting Co-Executive Director
Patricia S. Gainer, J.D., MIEMSS Acting Co-Executive Director
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Kevin McDonald, Chief, Certificate of Need Program
Suellen Wideman, Esq., Assitant Attorney General
Joseph E. Hoffman III, Executive Vice President and Chief Financial Officer, UM UCHS
Robin Luxon, Vice President, Corporate Planning, Marketing and Business Development, UM UCHS
Aaron Rabinowitz, Esq., Vice President and General Counsel, UM UCHS
Alison G. Brown, MPH, Senior Vice President and Chief Strategy Officer University of Maryland Medical System
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
James Buck, Gallagher, Evelius & Jones LLP

EXHIBIT 4

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Lyle E. Sheldon, FACHE
President and Chief Executive Officer

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

September 18, 2017

VIA EMAIL & FIRST CLASS MAIL

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

Re: Request for Exemption from Certificate of Need Review
for the Conversion of University of Maryland Harford Memorial Hospital to a Freestanding Medical Facility
Matter No. 17-12-2403

Dear Ms. Potter:

On behalf of UM Harford Memorial Hospital and UM Upper Chesapeake Medical Center, we are submitting four copies of the Applicants' Responses to Additional Information Questions Dated September 1, 2017 in the above-referenced matter. A Word version will be forwarded in a separate email.

Also enclosed as a supplement to Exhibit 7 to the Request for Exemption from Certificate of Need Review to convert UM Harford Memorial Hospital to a freestanding medical facility, please find a letter in support of UM Upper Chesapeake Health's proposed project from the Honorable Wayne Norman dated August 2, 2017.

Sincerely,

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

Enclosures

CC by email:

Ben Steffen, Executive Director, Maryland Health Care Commission

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011888-0023

Richard L. Alcorta, M.D., FACHE, MIEMSS Acting Co-Executive Director
Patricia S. Gainer, J.D., MIEMSS Acting Co-Executive Director
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Kevin McDonald, Chief, Certificate of Need Program
Suellen Wideman, Esq., Assistant Attorney General
Joseph E. Hoffman III, Executive Vice President and Chief Financial Officer, UM UCHS
Robin Luxon, Vice President, Corporate Planning, Marketing and Business Development, UM UCHS
Aaron Rabinowitz, Esq., Vice President and General Counsel, UM UCHS
Alison G. Brown, MPH, Senior Vice President and Chief Strategy Officer University of Maryland Medical System
Russell Moy, M.D., Acting Health Officer, Harford County
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
James Buck, Gallagher, Evelius & Jones LLP

EXHIBIT 5

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Lyle E. Sheldon, FACHE
President and Chief Executive Officer

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

September 22, 2017

VIA EMAIL

Patricia S. Gainer, JD, MPA
Maryland Institute for Emergency Medical Services Systems
Acting Co-Executive Director
653 West Pratt Street
Baltimore, MD 21201

Re: *Responses to September 12, 2017 Questions Regarding Request for Exemption from Certificate of Need Review for the Conversion of UM Harford Memorial Hospital to a Freestanding Medical Facility*

Dear Ms. Gainer:

This letter responds to questions raised and requests for additional information sought by the Maryland Institute for Emergency Medical Services Systems ("MIEMSS") dated September 12, 2017. Further, this letter provides additional information regarding UM Harford Memorial Hospital's adherence to MIEMSS regulations in connection with its proposed conversion to a freestanding medical facility.

Question 1: Please provide a description of the resources being contemplated for use in transferring patients from the planned FMF to Upper Chesapeake and from the FMF to other likely hospital destinations. Please also include any options being considered that would augment existing EMS resources that are available within the FMF's geographic coverage area.

As an initial matter, the conversion of UM Harford Memorial Hospital ("HMH") to a freestanding medical facility is one component of an overall strategy intended to transform the health delivery system for Harford and Cecil Counties, the primary service area of UM Upper Chesapeake Health System ("UM UCH"). Other components requiring regulatory approval include a three-level expansion at UM Upper Chesapeake Medical Center ("UCMC") and the development of a forty-bed (40) bed special psychiatric hospital to be connected with the proposed freestanding medical facility. Development of a medical office building and an ambulatory surgical facility are also contemplated. For those projects requiring regulatory approval, final approval of all project components is projected to be in or around the spring or summer of 2018. The ultimate conversion of HMH to a freestanding medical facility is not projected to occur until fiscal year 2022.

With that being said, UCH acknowledges the need to augment existing ambulance transport capabilities upon conversion of HMH to a freestanding medical facility. Recognizing that HMH will not

convert to a freestanding medical facility for approximately four years, UM UCH is currently in the early stages of evaluating an ambulance transport strategy. Possible strategies that are being considered include: (1) enhancing current commercial ambulance service contracts; (2) pursuing an ambulance service ownership model; and (3) a hybrid strategy with the overall focus on securing the appropriate number of ambulances to support the projected inter-facility transport needs. UM UCH will be exploring these three potential options taking in to account a number of factors such as optimal clinical care delivery and operational and financial parameters, and will have established a final plan for ensuring the ability to make timely ambulance transports in a safe and effective manner that will have minimal or no impact on the EMS system upon the conversion of HMH to a freestanding medical facility.

Question 2: Page 7 of the Request for Exemption provides information on expected physician staffing for the FMF, i.e., "...up to forty (40) hours of emergency physician and twelve (12) hours of emergency Advanced Practice Clinicians per day." Please provide information on expected nursing staffing.

HMH's current emergency department staffing, including nursing staff specializing in emergency medicine, were used to model the staffing at the proposed freestanding medical facility. HMH's current emergency department nurse and technician staffing matrix is provided below and broken down into four-hour time increments. This staffing matrix is expected to continue upon the conversion of HMH to a freestanding medical facility. The number of nurses and emergency department technicians currently serving HMH's emergency department are set forth below.

RN	**Sat/Sun**	**Mon-Fri**
Time	**Number**	**Number**
7 AM - 11 AM	6	6
11 AM - 3 PM	9	9
3 PM - 7 PM	10	11
7 PM - 11 PM	10	11
11 PM - 3 AM	7	7
3 AM - 7 AM	5	5
Total RN hours per day	**188**	**196**
ED Technicians	**Sat/Sun**	**Mon-Fri**
Time	**Number**	**Number**
7 AM - 11AM	1	1
11 AM - 3 PM	2	2
3 PM - 7 PM	2	2
7PM - 11PM	2	2
11 PM - 3 AM: Mon, Fri, Sat, Sun	2	2
11PM-3AM: Tues, Wed, Thu	1	1
3AM - 7AM	1	1
Total ED Technician hours per day	**44**	**44**

Question 3: Page 8 of the Request for Exemption states: "...It would be the goal for optimal patient management to achieve a two-hour transport expectation in order to support transitioning the patient to a higher level of care if needed. This optimal time will be supported by dedicated, onsite ambulance unit housed at UC FMF and helicopter ambulance via the on-site helipad if necessary." Please explain for both acute and observation patients, how the two-hour transport expectation would operate, what types of patient transfers would be subject to this or other time limitations, how the time limitations are defined (e.g., from onset of symptoms to arrival at receiving facility), and how the times will be monitored.

In response to additional information questions posed by the Maryland Health Care Commission dated September 1, 2017 and responded to on September 18, 2017, HMH and UCMC as joint applicants to convert HMH to a freestanding medical facility, provided the following additional clarification:

> [T]he goal for optimal patient management is to achieve an average two-hour transport time for emergent, high acuity patients requiring a higher level of care. This two-hour window will start from the time a decision to admit a patient has been made and continue until the patient arrives at the receiving facility. The two-hour transport window will be accelerated for patients experiencing life-threatening conditions; for example, UC FMF will have accelerated transport protocols for stroke and cardiac patients.
>
> For non-emergent transports, a three to four-hour transport window will start from the time the receiving facility confirms bed availability. This transport time is consistent with existing patient boarding times at HMH and UCMC and will include transit time in an ambulance. UC FMF will require time to coordinate placement of most patients in an MSGA unit [of] the receiving facility before transporting the patient.

UM UCH will monitor the transport times via a daily monitoring log in conjunction with ambulance transport services.

Question 4: Regarding the quality measures discussed in the Request for Exemption (pages 13-15), we are interested in understanding which specific measures comprise the Wait Time quality measures and would like to see the hospital's performance for those measurements over the past three (3) years. Additionally, we would appreciate if you would provide a copy of the hospital's Corrective Action Plan to address the below average rating for the Wait Time quality measures.

Following consultation with staff from the Maryland Health Care Commission, on pages 12 through 15 of the request for exemption from CON review to convert HMH to a freestanding medical facility (the "Exemption Application"), HMH and UCMC, as joint applicants, provided a response to "below average" quality metrics on behalf of UCMC because the proposed freestanding medical facility

will be a provider-based, administrative department of UCMC. With respect to UCMC's emergency department, it scored "better than average" on three of the six quality measures, including (1) how long patients spent in the emergency department before leaving for their hospital room; (2) how long patients spent in the emergency department after the doctor decided the patient would stay in the hospital room before leaving for their hospital room; and (3) how long patients who came to the emergency department with broken bones had to wait before receiving pain medication. UCMC's emergency department quality measures are set forth on the table below:

Emergency Department (ED)

Wait Times	Rating	Risk-Adjusted Rates
How long patients spent in the emergency department before leaving for their hospital room	Better than average	343 minutes
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	Better than average	118 minutes
How long patients spent in the emergency department before being sent home	Below average	207 minutes
How long patients spent in the emergency department before they were seen by a healthcare professional	Below average	63 minutes
How long patients who came to the emergency department with broken bones had to wait before receiving pain medication.	Better than average	59 minutes
Patients who left the emergency department without being seen	Below average	3%

Source: Maryland Health Care Commission, Maryland Health Care Quality Reports, UM Upper Chesapeake Medical Center.

Related to patient wait time quality measures, UCMC's emergency department was "below average" for "how long patients spent in the emergency department before they were seen by a health care professional."

UCMC's data for the how long patients spent in the emergency department before they were seen by a health care professional for the past three years is provided below:

UM UCMC Time in Minutes Before ED Patients Seen by a Health Care Professional	
Fiscal Year	**Time in Minutes**
7/1/2014-6/30/2015	85.77
7/1/2015-6/30/2016	86.45
7/1/2016-6/30/2017	89.99

Source: UM UCMC Midas Software for Emergency Department

As set forth on page 14 of the Exemption Application, UM UCH, as part of its strategic objectives for efficient care in fiscal year 2018, has charged a process improvement team to review emergency department throughput and efficiency at both HMH and UCMC. The process improvement team will utilize UM UCH's IMPRV methodology to improve average length of stay and wait times from "door to doctor." Executive oversight for this initiative will be led by the Patient and Family Centered Care Oversight Committee and performance improvements will be monitored through monthly reports on emergency department operations. These monthly reports will be reviewed with at monthly emergency department operations meetings, thereby improving accountability. Emergency department directors have held one-on-one meetings with individual charge nurses to discuss quality and data metrics and variability in individual practices, with a focus towards achieving consistency and accountability. To this end, monthly triage time results will also be shared directly with individual nurses to improve accountability and measure progress at the provider level.

Specifically related to reducing the time before patients presenting in UCMC's emergency department are seen by a health care professional, UCMC has assigned a nurse to provide rapid triage assessments and to expedite triage for patients suffering from more acute conditions. UCMC has also implemented a "pull to full" operational expectation, pursuant to which patients bypass triage when an exam room available thereby reducing the amount of time it takes for patients to be seen by a provider. Finally, UCMC has installed an electronic communication board in the emergency department that displays real time results related to metrics and objectives, including time before a patient is seen by a health care professional.

With respect to HMH's emergency department, it scored "better than average" on four of the six quality measures, including: (1) how long patients spent in the emergency department before leaving for their hospital room; (2) how long patients spent in the emergency department after the doctor decided the patient would stay in the hospital room before leaving for their hospital room; (3) how long patients spent in the emergency department before being sent home; and (4) how long patients spent in the emergency department before they were seen by a healthcare professional. HMH's emergency department quality measures are set forth on the table below:

Emergency Department (ED)

Wait Times	Rating	Risk-Adjusted Rates
How long patients spent in the emergency department before leaving for their hospital room	Better than average	334 minutes
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	Better than average	111 minutes
How long patients spent in the emergency department before being sent home	Better than average	168 minutes
How long patients spent in the emergency department before they were seen by a healthcare professional	Better than average	34 minutes
How long patients who came to the emergency department with broken bones had to wait before receiving pain medication.	Below average	74 minutes
Patients who left the emergency department without being seen	Below average	3%

Source: Maryland Health Care Commission, Maryland Health Care Quality Reports, UM Harford Memorial Hospital.

HMH's data for the how long patients who came to the emergency department with broken bones had to wait before receiving pain medication for the past three is provided in the table below:

HMH Time in Minutes Patients with Broken Bones Had to Wait Before Administration of Pain Medication	
Fiscal Year	**Time in Minutes**
7/1/2014-6/30/2015	92.12
7/1/2015-6/30/2016	83.80
7/1/2016-6/30/2017	66.05

Source: UM HMH Midas Software for Emergency Department

The UM UCH emergency department throughput and efficiency initiatives described above will also be implemented at HMH. Ongoing efforts specific to reducing the time before patients with broken bones are administered analgesia have included adding staff to increase the intake/provider triage model. HMH has also augmented nurse standing order protocols to permit nurses to order radiologic tests to more rapidly determine fractures and to more rapidly notify providers that analgesia is warranted.

* * *

As a final matter, in accordance with the correspondence provided to MIEMSS at our meeting on September 11, 2017, and in correspondence of September 14, 2017, HMH hosted a public informational regarding its proposed conversion to a freestanding medical facility on August 30, 2017, beginning at 6:00 p.m., at the Level Volunteer Fire Company, 3633 Level Village Road, Havre de Grace, Harford County, Maryland. In accordance with COMAR 30.08.05.03(B)(2), at least fourteen days before holding the public informational hearing, UM UCH published on its website physical and email addresses for EMS providers in jurisdictions affected by the proposed conversion of HMH to provide questions or comments. As of the date of this letter, UM UCH has received no written comments or questions from EMS providers.

Again, UM UCH and its constituent hospitals look forward to working with MIEMSS regarding the proposed conversion of HMH to a freestanding medical facility as part of the transformation of health care delivery in UM UCH's service area. Please let us know if you have any additional questions or information requests.

In Good Health,

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

CC by email:

Richard L. Alcorta, M.D., FACHE, MIEMSS Acting Co-Executive Director
Lisa Myers, RN, MS, Director, Cardiac and Special Programs
Sarah Sette, Esq., Assistant Attorney General
Ben Steffen, Executive Director, Maryland Health Care Commission
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Kevin McDonald, Chief, Certificate of Need Program
Suellen Wideman, Esq., Assistant Attorney General
Joseph E. Hoffman III, Executive Vice President and Chief Financial Officer, UM UCHS
Robin Luxon, Vice President, Corporate Planning, Marketing and Business Development, UM UCHS
Aaron Rabinowitz, Esq., Vice President and General Counsel, UM UCHS

Alison G. Brown, MPH, Senior Vice President and Chief Strategy Officer
University of Maryland Medical System
James Buck, Gallagher, Evelius & Jones LLP

Exhibit 6

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

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

November 21, 2018

VIA EMAIL & HAND DELIVERY

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

Re: Modified Request from Exemption from CON Review to Convert University of Maryland Harford Memorial Hospital to a Freestanding Medical Facility

Dear Ms. Potter:

This letter serves as notice that University of Maryland Upper Chesapeake Medical Center ("UCMC") and University of Maryland Harford Memorial Hospital ("HMH"), as joint applicants, are submitting a modified request for exemption from Certificate of Need ("CON") review to convert HMH to a freestanding medical facility. Six copies of the applicants' modified request for exemption from CON review, along with one set of full-size project drawings will be provided by courier. Also enclosed will be a CD containing electronic versions of the exemption application (WORD) and tables (EXCEL), and searchable PDF files of the application and exhibits.

If you have questions about the information provided above, please contact UM Upper Chesapeake Health System's legal counsel at your convenience:

James Buck
Gallagher, Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore, Maryland 21201
410-347-1353
jbuck@gejlaw.com

Please also note that on December 13, 2018, UCMC and HMH have reserved space at the Aberdeen Fire Hall, located at 21 North Rogers Street, Aberdeen, MD 21001, MD 21078, for a public informational hearing, which will begin at 6 pm. At the public informational hearing, UCMC and HMH will address HMH's proposed transition plan, including: (1) job retraining and placement for employees displaced by HMH's conversion to a freestanding medical facility;

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(2) plans for transitioning acute care services previously provided on HMH's campus to residents of the service area; and (3) tentative plans for reuse of HMH's physical plant.

UM Upper Chesapeake Health System looks forward to working with the Maryland Health Care Commission, the Maryland Institute for Emergency Medical Services Systems, the Health Services Resources Cost Review Commission, and other interested stakeholders to effectuate a new and innovative model of health care delivery for the residents of Harford and Cecil Counties.

Please sign and return to our waiting messenger the enclosed acknowledgment of receipt.

Sincerely,

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

Enclosures

CC by email without enclosures:

Ben Steffen, Executive Director, Maryland Health Care Commission
Richard L. Alcorta, M.D., FACHE, MIEMSS Acting Co-Executive Director
Patricia S. Gainer, J.D., MIEMSS Acting Co-Executive Director
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Kevin McDonald, Chief, Certificate of Need Program
Suellen Wideman, Esq., Assitant Attorney General
Steve Witman, Senior Vice President and Chief Financial Officer, UM UCHS
Robin Luxon, Vice President, Corporate Planning, Marketing and Business Development, UM UCHS
Aaron Rabinowitz, Esq., Vice President and General Counsel, UM UCHS
Alison G. Brown, MPH, Senior Vice President and Chief Strategy Officer University of Maryland Medical System

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011888-0023

Andrew L. Solberg, A.L.S. Healthcare Consultant Services
James Buck, Gallagher, Evelius & Jones LLP

Exhibit 7

The MBE goal is 13%
The WBE goal is 4%

SANITARY CONTRACT NO. 967

APPROVED:
Bernice H. Taylor
Clerk, Board of Estimates

APPROVED:
Rudolph S. Chow, P.E.
Director of Public Works

au18,21 11391296

City of Baltimore
Department of Finance
Bureau of Purchases

Sealed proposals addressed to the Board of Estimates of Baltimore will be received until, but not later than 11:00a.m. local time on the following date(s) for the stated requirements:

September 13, 2017

• METHANOL FOR WASTEWATER TREATMENT PLANTS **B50005115**

September 20, 2017

• LIQUID SODIUM BISULFITE FOR WASTEWATER TREATMENT PLANTS **B50005114**

THE ENTIRE SOLICITATION DOCUMENT CAN BE VIEWED AND DOWN LOADED BY VISITING THE CITY'S WEB SITE:
www.baltimorecitibuy.org

au18,25 11391335

City of Baltimore
Department of Finance
Bureau of Purchases

Sealed proposals addressed to the Board of Estimates of Baltimore will be received until, but not later than 11:00a.m. local time on the following date(s) for the stated requirements:

September 20, 2017

• PSYCHOLOGICAL SERVICES **B50005104**

September 27, 2017

• INTEGRATED PEST CONTROL AND MANAGEMENT SERVICES **B50005113**

THE ENTIRE SOLICITATION DOCUMENT CAN BE VIEWED AND DOWN LOADED BY VISITING THE CITY'S WEB SITE:
www.baltimorecitibuy.org

au11,18 11388090

SPECIAL MEETING NOTICE - KOPERNIK BANK

NOTICE IS HEREBY GIVEN, that a special meeting of the members of Kopernik Bank will be held at the main office of Kopernik Bank, located at 2101 Eastern Avenue, Baltimore, Maryland 21231, on August 29, 2017 at 1:00 p.m. (local time), to consider and vote upon St. Casimir's Savings Bank's merger with and into Kopernik Bank. You must have been a member of record as of the close of business on July 30, 2017, to vote at the Special Meeting.

au18,25 11391332

University of Maryland Upper Chesapeake Health will hold a Public Information Meeting to address the conversion of UM Harford Memorial Hospital to a freestanding medical facility on Wednesday, August 30, 2017, from 6-8 pm, at Level Fire Hall, 3633 Level Village Road, Havre de Grace, MD 21078. Additional information concerning the conversion of Harford Memorial Hospital and UM Upper Chesapeake Health's Vision 2020 can be found online at www.umuch.org/vision2020.

au11-30 11386853

Baltimore City

THE CITY OF BALTIMORE'S CIVIL SERVICE COMMISSION'S NOTICE OF PROPOSED RULES CHANGES

The Civil Service Commission has proposed amendments to Civil Service Rule 1 and Rules 10 through 39. The proposed amendments address rules that affect classes of positions, applying to work for the City, examinations, and employment lists.

The proposed Rules in their entirety are available for viewing at the Department of Human Resources, 201 E. Baltimore Street, Suite 300, Baltimore, MD, 21202. Interested persons are asked to consider the Commission's proposed Rules changes and forward any written comments to the Civil Service Commission, also located at the aforementioned address, by August 28, 2017.

au15-28 11369974

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presented or filed on or before that date, or any extension provided by law, is unenforceable thereafter. Claim forms may be obtained from the Register of Wills.

CHERYL BRANCH, Personal Representative(s).
True Test-Copy: BELINDA K. CONAWAY,
Register of Wills for Baltimore City,
111 N. Calvert Street, Maryland 21202.

au18,25,s1 11391762

Baltimore City

Tiffany M Blackwell, Proper Person
703 Sudbrook Road,
Pikesville, Maryland 21208,
Small Estate Notice of Appointment Notice to Creditors
Notice to Unknown Heirs to all Persons Interested in the

Estate of (139750) Warren Shaw Leath III

Notice is given that TIFFANY M BLACKWELL, 703 Sudbrook Road, Pikesville, Maryland 21208, was on August 15, 2017, appointed personal representative(s) of the small estate of Warren Shaw Leath III who died on August 2, 2017, without a will.

Further information can be obtained by reviewing the estate file in the office of the Register of Wills or by contacting the personal representative(s) or the attorney.

All persons having any objection to the appointment shall file their objections with the Register of Wills within 30 days after the date of publication of this Notice. All persons having an objection to the probate of the will shall file their objections with the Register of Wills within six months after the date of publication of this Notice.

All persons having claims against the decedent must serve their claims on the undersigned personal representative(s) or file them with the Register of Wills with a copy to the undersigned on or before the earlier of the following dates:

(1) Six months from the date of the decedent's death; except if the decedent died before October 1, 1992, nine months from the date of the decedent's death; or

(2) Thirty days after the personal representative mails or otherwise delivers to the creditor a copy of this published notice or other written notice, notifying the creditor that the claims will be barred unless the creditor presents the claim within thirty days from the mailing or other delivery of the notice. Any claim not served or filed within that time, or any extension provided by law, is unenforceable thereafter.

TIFFANY M BLACKWELL, Personal Representative(s).
True Test--Copy: BELINDA K. CONAWAY,
Register of Wills for Baltimore City,
111 N. Calvert Street, Baltimore, Maryland 21202

au18 11391759

Baltimore City

Thomas J. Kokolis, Attorney
Parker, Simon, & Kokolis, LLC
110 North Washington Street, Suite 500,
Rockville, Maryland 20850

IN THE ORPHANS' COURT FOR BALTIMORE CITY, MARYLAND - IN THE ESTATE OF:

Artis Shine; Estate No. 139737

Notice of Judicial Probate

To all Persons Interested in the above estate:

You are hereby notified that a petition has been filed by THOMAS J. KOKOLIS, Esquire for judicial probate and for the appointment of a personal representative. A hearing will be held at Orphan's Court for Baltimore City, 111 North Calvert Street, Room 303, Baltimore, Maryland 21202 on September 28, 2017 at 10:00 AM.

This hearing may be transferred or postponed to a subsequent time. Further information may be obtained by reviewing the estate file in the office of the Register of Wills.

BELINDA K. CONAWAY, Register of Wills.

au18,25 11391736

Morris L. Garten, Attorney
Fedder and Garten Professional Association
36 South Charles Street, Suite 2300
Baltimore, Maryland 21201
Notice of Appointment Notice to Creditors
Notice to Unknown Heirs to all Persons Interested in the

Estate of (139689) Alan E. Behrend

Notice is given that JANET BEHREND LIVINGSTON, 8808 Joshua Court, Baltimore, Maryland 21208 and MORRIS L. GARTEN, 36 South Charles Street, Suite 2300, Baltimore, Maryland 21201 were on August 9, 2017 appointed personal representative(s) of the estate of Alan E. Behrend who died on July 23, 2017 with a will.

Further information can be obtained by reviewing the estate file in the office of the Register of Wills or by contacting the personal representative(s) or the attorney.

All persons having any objection to the appointment or to the probate of the decedent's will shall file their objections with the Register of Wills on or before the 9th day of February, 2018.

Any person having a claim against the decedent must present the claim to the undersigned personal representative(s) or file it with the Register of Wills with a copy to the undersigned on or before the earlier of the following dates:

(1) Six months from the date of the decedent's death, except if the decedent died before October 1, 1992, nine months from the date of the decedent's death, or

(2) Two months after the personal representative mails or otherwise delivers to the creditor a copy of this published notice or other written notice, notifying the creditor that the claim will be barred unless the creditor presents the claims within two months from the mailing or other delivery of the notice. A claim not presented or filed on or before that date, or any extension provided by law, is unenforceable thereafter. Claim forms may be obtained from the Register of Wills.

JANET BEHREND LIVINGSTON and MORRIS L. GARTEN,
Personal Representative(s).
True Test-Copy: BELINDA K. CONAWAY,
Register of Wills for Baltimore City,
111 N. Calvert Street, Maryland 21202.

au11,18,25 11387936

Baltimore City

Charles Hall, Proper Person
2005 Wilhelm Avenue,
Baltimore, Maryland 21237
Notice of Appointment Notice to Creditors
Notice to Unknown Heirs to all Persons Interested in the

Estate of (139691) Daryl Broome aka: Daryl Bernard Broome

Notice is given that CHARLES HALL, 2005 Wilhelm Avenue, Baltimore, Maryland 21237 was on August 9, 2017 appointed personal representative(s) of the estate of Daryl Broome aka: Daryl Bernard Broome who died on July 28, 2017 without a will.

Further information can be obtained by reviewing the estate file in the office of the Register of Wills or by contacting the personal representative(s) or the attorney.

All persons having any objection to the appointment shall file their objections with the Register of Wills on or before the 9th day of February, 2018.

Any person having a claim against the decedent must present the claim to the undersigned personal representative(s) or file it with the Register of Wills with a copy to the undersigned on or before the earlier of the following dates:

(1) Six months from the date of the decedent's death, except if the decedent died before October 1, 1992, nine months from the date of the decedent's death, or

(2) Two months after the personal representative mails or otherwise delivers to the creditor a copy of this published notice or other written notice, notifying the creditor that the claim will be barred unless the creditor presents the claims within two months from the mailing or other delivery of the notice. A claim not presented or filed on or before that date, or any extension provided by law, is unenforceable thereafter. Claim forms may be obtained from the Register of Wills.

CHARLES HALL, Personal Representative(s).
True Test-Copy: BELINDA K. CONAWAY,
Register of Wills for Baltimore City,
111 N. Calvert Street, Maryland 21202.

au11,18,25 11387946

Exhibit 8

BUSINESS

Decor store opens near North East

Business Beat

Happening this week around the county ...

Bee's Nest Prims is becoming a popular stop for folks shopping for their own decor or for a gift for someone else.

Located at 463 W. Old Philadelphia Road near North East, Jeannie Slayman said her shop was the next step in her business dream.

"I started a year ago doing craft shows," she said. "I sell everything from small little blocks to shower curtains."

She describes her merchandise as everything from country decor to man cave items. She looks for items that are unique, but also affordable.

"Twenty years ago, I sold Home Interiors," she said, referring to the home party company that was sold and merged with another company in 2008.

Slayman is all about decorating.

"I love doing this. I've always liked putting things together," she said as she arranged a custom piece featuring dried flora and primitive Americana elements. "I wanted to open a business to help people and do what I like, which is decorate."

Whether you are starting fresh or need a do-over, Bee's Nest Prims has popular themes including red-white-and-blue and star decor, beach, cowboy, first responder and more. There's even a corner for pet parents.

"I have Tail Banger dog treats," she said, adding that to the decor for people with fur babies.

CECIL WHIG PHOTO BY JANE BELLMYER

Jeannie Slayman took her love of decorating and turned it into a business called Bee's Nest Prims, located at 463 W. Old Philadelphia Road near North East.

CECIL WHIG PHOTO BY JANE BELLMYER

Look for the sign and the flags along Route 7 in between North East and Charlestown to get to Bee's Nest Prims.

CECIL WHIG PHOTO BY JANE BELLMYER

Jude Grissom, 6, checks out the collection of toys awaiting children enrolled in Kid City, a child care center and pre-school operated by Way Of Life Community Church on Colonial Way in Rising Sun.

After moving into her Aberdeen home two years ago and completing restoration, Slayman converted what had been a garage on the property into her store. Her goal is to have it be successful enough that she can spend more time with her grandchildren.

Bee's Nest Prims is open from 5:30 to 8 p.m. Thursdays and Fridays, 9 a.m. to 5 p.m. Saturdays and 11 a.m. to 5 p.m. Sundays. Find them on Facebook for more information or to see some of the wares. Slayman also offers fundraising packages and donates a portion of each month's proceeds to a designated charity.

• • •

You may have watched as it was being built, but now there's a ribbon cutting planned for the new Elkton Ford Quick Lane Tire and Auto Center in Elkton. Everyone is welcome to attend the event Thursday from 4:30 to 6 p.m. at the shop, located at 601 E. Pulaski Highway. The ribbon will officially be cut at 5 p.m.

• • •

Proving Ground Federal Credit Union has named Christopher Mitchell, of Forest Hill, assistant vice president of branch operations. Mitchell was promoted from branch manager at the Edgewood office. A 2015 graduate of the Harford County Leadership Academy, Mitchell also earned his M.B.A. at Wilmington University.

• • •

Congratulations to Mount Harmon Plantation in Earleville for the huge turnout at its annual Lotus Blossom Art and Nature Festival. With acres of blooming flowers as well as numerous displays, demonstrations and performances plus great weather, more than 700 people visited the historic setting Aug. 5.

• • •

Kid City, a new child care center and preschool in Rising Sun, is holding an open house from 5 to 9 p.m. next Wednesday, Aug. 23, to welcome parents.

A ministry of Way Of Life Community Church, Kid City is offering before and after school day care and a pre school at the church located at 51 Colonial Way.

Sherilyn Grissom, director, said Kid City is licensed for 30 slots in its day care and 24 students each in classes for 3- and 4-year-olds. The facility will open the same day as Cecil County Public Schools on Tuesday, Sept. 5.

"We are taking registrations now," said Grissom, who has 10 years of experience teaching pre-school. "And I was director at a small private school for two years."

Grissom said Way Of Life, which has four locations, decided Rising Sun was the best for Kid City.

"We asked ourselves, 'Which area would be effective? Where was the greatest need?'" Grissom said of the discussion amongst church leadership.

Serving the Rising Sun elementary and middle school population, the cost is $90 per week, or $50 if only before or after care is needed. Preschool for 3-year-olds is Tuesday and Thursday from 9 a.m. until noon. Tuition is $120 per month. For the 4-year-olds, class is held Monday, Wednesday and Friday also from 9 a.m. until noon. Tuition for that program is $190 per month.

For more information contact Grissom at 443-371-3244 or go to kidcity.co.

• • •

With the pending retirement of Susan Bailey, the Cecil County Department of Social Services is in search of a new director. Paula Tolson, spokeswoman for the Maryland Department of Human Resources, said applications are being accepted through the end of August. Bailey's retirement is effective Aug. 31.

Business Beat is a weekly column on business happenings in Cecil County. If interested in having your business featured in this column, contact Jane Bellmyer at jbellmyer@cecilwhig.com

Cohen's Furniture opens at former Jodlbauer's location

By JESSICA IANNETTA
jiannetta@cecilwhig.com

ELKTON — Cohen's Furniture has set up shop in the former Jodlbauer's store on Route 40, marking the Delaware-based company's fourth location in the region.

The store, located at 901 E. Pulaski Highway, officially opened last month with a grand opening celebration planned for September, said Michael Hussein, the company's buying and marketing director. The store offers what Hussein refers to as "medium-priced" traditional, transitional furniture as well as a full line of bedding and mattresses, custom design options, a variety of financing options and speedy delivery.

The 75-year-old company, which also has two locations in New Castle, Del., and one in Wilmington, Del., already had many Elkton-area customers frequent its other stores, so opening a location in the county will allow Cohen's to better serve those customers as well as bring in new ones, he added.

"This building became available and we knew we had something to offer our customers as far as great service and good pricing," Hussein said.

CECIL WHIG PHOTO BY JESSICA IANNETTA

Cohen's Furniture has opened in the former Jodlbauer's location on U.S. Route 40.

Prior to Cohen's moving in, the building at the corner of Melbourne Boulevard and Route 40 had been unoccupied since Jodlbauer's quietly closed its flagship storefront in June 2015 after 69 years in business. In deciding to close, Jodlbauer's cited changing customer buying habits, increases in the state sales tax, increases in tolls into Cecil County and the near standstill of new home construction — which would likely necessitate the buying of new furniture, among other reasons.

Hussein acknowledged these economic realities, but said what sets Cohen's apart is the store's friendly customer service and reasonable prices. With many people still recovering from the economic downturn, Hussein said Cohen's makes sure its prices are the lowest around. If a customer finds the same piece at another store for lower, Cohen's will refund the customer the difference plus 10 percent, he added.

"We promise our customers that we will beat anyone," he said.

Since moving into the building, Hussein said Cohen's has made a lot of improvements, including repainting, replacing the carpet and putting on a new roof. As the company gets to know the area, Hussein said they hope to get involved with the community and give back by partnering with local nonprofits.

The store is open from 10 a.m. to 8 p.m. Monday through Saturday and from 11 a.m. to 6 p.m. on Sunday.

Join Lyle Sheldon, President/CEO of University of Maryland Upper Chesapeake Health to hear details on our Vision 2020 plans to improve and expand health care in northeastern Maryland.

PUBLIC INFORMATION MEETING
WEDNESDAY, AUGUST 30, 2017, 6-8 PM
LEVEL FIRE HALL, 3633 LEVEL VILLAGE ROAD
HAVRE DE GRACE, MD 21078

THE MEETING WILL INCLUDE INFORMATION ABOUT:

- Our plans for transitioning acute medical care services, job retraining and placement of team members
- Plans for repurposing the UM Harford Memorial Hospital property
- The expansion plans at UM Upper Chesapeake Medical Center in Bel Air
- Overall timeline for the project

REGISTER BY CALLING 1-800-515-0044 OR EMAIL MARKETING@UCHS.ORG

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

For more information visit **UMUCH.ORG/VISION2020**

EXHIBIT 9

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Lyle E. Sheldon, FACHE
President and Chief Executive Officer

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

September 14, 2017

VIA EMAIL & FEDEX

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

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

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

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

The Honorable Glen Glass
House Office Building, Room 325
6 Bladen Street
Annapolis, Maryland 21401
Glen.glass@house.state.md.us

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

#604616
011888-0023

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

The Honorable Richard C. Slutzky
President, Harford County Council
County Council
212 South Bond Street, 1st floor
Bel Air, MD 21014
rcslutzky@harfordcountymd.gov

The Honorable Dennis R. Schrader
Acting Secretary of Health
Office of Secretary
Maryland Department of Health
Herbert R. O'Conor State Office Building
201 West Preston Street
Baltimore, Maryland 21201
dennis.schrader@maryland.gov

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

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

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

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

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

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

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

Before holding the hearing, UM Upper Chesapeake Health System, the parent of both UM Harford Memorial Hospital and UM Upper Chesapeake Medical Center, exceeded its

regulatory obligations to ensure that the hearing was well attended. UM Upper Chesapeake Health published notice of the hearing date and location on its website's homepage and in the Maryland Daily Record print and electronic versions for no fewer than seventeen days. UM Upper Chespeake Health also purchased quarter page advertisements in the Harford County Aegis and Cecil County Whig announcing the date and location of the public hearing. Notice of the hearing was also posted on the webpage for the City of Havre de Grace and at the Level Volunteer Fire Company venue.

The public informational hearing lasted approximately two and one-half hours and no less than eighty-five members of the public attending in addition to the UM UCH Health Board members, executives, administrators, and staff of UM Upper Chesapeake Health System.

As President and Chief Executive Officer of UM Upper Chesapeake Health, I hosted the public informational hearing. With the assistance of Dr. Fermin Barrueto, UM Upper Chesapeake Health's Chief Medical Officer, and Sharon Lipford, Executive Director of Healthy Harford, I began the public informational hearing by reviewing an electronic slide presentation that addressed each of the issues required by Maryland Health Care Commission's regulations. Among other things, the slide presentation focused on UM Upper Chesapeake Health System's strategic plan to transform health care delivery in Harford and Cecil Counties, which it terms "Vision 2020." This plan includes conversion of UM Harford Memorial Hospital to a freestanding medical facility to be located on a ninety-seven acre parcel off of Interestate 95 in Havre de Grace, the development of a forty-bed special psychiatric hospital and medical office building on the same campus, and a three story addition to UM Upper Chesapaeake Medical Center in Bel Air. A copy of the electronic slide presentation is enclosed with this letter as Enclosure A and a transcript of the public informational hearing prepared by a court reporter retained by UM Upper Chesapeake Health is provided as Enclosure B.

Each person attending the public informational hearing was given an index card and encouraged to submit questions and/or comments. The index cards containing questions and comments were collected at the mid-point of the public hearing. Kathy Kraft, Uuniversity of Maryland Medical System Director, Organizational Development & Inclusion, then facilitated a panel of UM Upper Chesapeake Health System's team in responding to the public questions and comments. In addition to myself, Dr. Barrueto, and Ms. Lipford, the following persons participated on the panel responding to questions and comments at the public informational hearing:

1. Timothy Chizmar, M.D., Medical Director, UM Upper Chesapeake Health, EMS Base Station;

2. Richard Lewis, M.D., Chair, Department of Psychiatry, UM Upper Chesapeake Health;
3. Michael K. Abraham, M.D., Chair Department of Emergency Medicine, UM Upper Chesapeake Health;
4. Joseph E. Hoffman, III, Executive Vice President, Chief Financial Officer and Compliance Officer, UM Upper Chesapeake Health;
5. Robin Luxon, Vice President, Corporate Planning, Marketing & Business Development, UM Upper Chesapeake Health;
6. Angela Poppe Ries, M.D., President, Medical Staff, UM Upper Chespeake Health; and
7. Jeff Matthai, Morris Ritchie & Associates (civil engineering and planning).

In total, twenty-seven written questions and/or comments were received and answered at the public informational hearing. Submitted as Enclosure C is a list of the written questions and/or comments along with the corresponding citation to those portions of the hearing transcript where the question/comment was considered and answered. As reflected in the enclosed transcript, follow-up questions from the audience were also addressed.

In addition to the above summary of the public informational hearing, UM Upper Chespeake Health has not received any written feedback from the general public, EMS providers in Harford or Cecil County, or community stakeholders regarding the proposed conversion of UM Harford Memorial Hospital to a freestanding medical facility.

Please contact me if you have any questions regarding the public informational hearing, the enclosed materials, or UM Upper Chesapeake Health's Vision 2020.

In Good Health,

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

Enclosures

CC via email:

#604616
011888-0023

Senate Finance Committee

The Honorable John C. Astle, Vice Chair,
The Honorable Joanne C. Benson
The Honorable Brian J. Feldman
The Honorable Stephen S. Hershey, Jr.
The Honorable J. B. Jennings
The Honorable Katherine A. Klausmeier
The Honorable James N. Mathias, Jr.
The Honorable Nathaniel T. Oaks
The Honorable Edward R. Reilly
The Honorable James C. Rosapepe
David A. Smulski, Staff

House Health and Government Operations Committee

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

Harford County Council
The Honorable Mike Perrone, Jr.
The Honorable Joseph M. Woods,
The Honorable James V. McMahan, Jr.
The Honorable Chad R. Shrodes
The Honorable Patrick S. Vincenti
The Honorable Curtis L. Beulah

Richard L. Alcorta, M.D., FACHE, MIEMSS Acting Co-Executive Director
Patricia S. Gainer, J.D., MIEMSS Acting Co-Executive Director
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Kevin McDonald, Chief, Certificate of Need Program
Suellen Wideman, Esq., Assitant Attorney General
Joseph E. Hoffman III, Executive Vice President and Chief Financial Officer, UM UCHS
Robin Luxon, Vice President, Corporate Planning, Marketing and Business Development, UM UCHS
Aaron Rabinowitz, Esq., Vice President and General Counsel, UM UCHS
Alison G. Brown, MPH, Senior Vice President and Chief Strategy Officer University of Maryland Medical System
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
James Buck, Gallagher, Evelius & Jones LLP

EXHIBIT 10

The MBE goal is 13%
The WBE goal is 4%

SANITARY CONTRACT NO. 967

APPROVED:
Bernice H. Taylor
Clerk, Board of Estimates

APPROVED:
Rudolph S. Chow, P.E.
Director of Public Works

au18,21 11391296

City of Baltimore
Department of Finance
Bureau of Purchases

Sealed proposals addressed to the Board of Estimates of Baltimore will be received until, but not later than 11:00a.m. local time on the following date(s) for the stated requirements:

September 13, 2017

• METHANOL FOR WASTEWATER TREATMENT PLANTS **B50005115**

September 20, 2017

• LIQUID SODIUM BISULFITE FOR WASTEWATER TREATMENT PLANTS **B50005114**

THE ENTIRE SOLICITATION DOCUMENT CAN BE VIEWED AND DOWN LOADED BY VISITING THE CITY'S WEB SITE:
www.baltimorecitibuy.org

au18,25 11391335

City of Baltimore
Department of Finance
Bureau of Purchases

Sealed proposals addressed to the Board of Estimates of Baltimore will be received until, but not later than 11:00a.m. local time on the following date(s) for the stated requirements:

September 20, 2017

• PSYCHOLOGICAL SERVICES **B50005104**

September 27, 2017

• INTEGRATED PEST CONTROL AND MANAGEMENT SERVICES **B50005113**

THE ENTIRE SOLICITATION DOCUMENT CAN BE VIEWED AND DOWN LOADED BY VISITING THE CITY'S WEB SITE:
www.baltimorecitibuy.org

au11,18 11388090

SPECIAL MEETING NOTICE - KOPERNIK BANK

NOTICE IS HEREBY GIVEN, that a special meeting of the members of Kopernik Bank will be held at the main office of Kopernik Bank, located at 2101 Eastern Avenue, Baltimore, Maryland 21231, on August 29, 2017 at 1:00 p.m. (local time), to consider and vote upon St. Casimir's Savings Bank's merger with and into Kopernik Bank. You must have been a member of record as of the close of business on July 30, 2017, to vote at the Special Meeting.

au18,25 11391332

University of Maryland Upper Chesapeake Health will hold a Public Information Meeting to address the conversion of UM Harford Memorial Hospital to a freestanding medical facility on Wednesday, August 30, 2017, from 6-8 pm, at Level Fire Hall, 3633 Level Village Road, Havre de Grace, MD 21078. Additional information concerning the conversion of Harford Memorial Hospital and UM Upper Chesapeake Health's Vision 2020 can be found online at www.umuch.org/vision2020.

au11-30 11386853

Baltimore City

THE CITY OF BALTIMORE'S CIVIL SERVICE COMMISSION'S NOTICE OF PROPOSED RULES CHANGES

The Civil Service Commission has proposed amendments to Civil Service Rule 1 and Rules 10 through 39. The proposed amendments address rules that affect classes of positions, applying to work for the City, examinations, and employment lists.

The proposed Rules in their entirety are available for viewing at the Department of Human Resources, 201 E. Baltimore Street, Suite 300, Baltimore, MD, 21202. Interested persons are asked to consider the Commission's proposed Rules changes and forward any written comments to the Civil Service Commission, also located at the aforementioned address, by August 28, 2017.

au15-28 11369974

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presented or filed on or before that date, or any extension provided by law, is unenforceable thereafter. Claim forms may be obtained from the Register of Wills.

CHERYL BRANCH, Personal Representative(s).
True Test-Copy: BELINDA K. CONAWAY,
Register of Wills for Baltimore City,
111 N. Calvert Street, Maryland 21202.

au18,25,s1 11391762

Baltimore City

Tiffany M Blackwell, Proper Person
703 Sudbrook Road,
Pikesville, Maryland 21208,
Small Estate Notice of Appointment Notice to Creditors
Notice to Unknown Heirs to all Persons Interested in the

Estate of (139750) Warren Shaw Leath III

Notice is given that TIFFANY M BLACKWELL, 703 Sudbrook Road, Pikesville, Maryland 21208, was on August 15, 2017, appointed personal representative(s) of the small estate of Warren Shaw Leath III who died on August 2, 2017, without a will.

Further information can be obtained by reviewing the estate file in the office of the Register of Wills or by contacting the personal representative(s) or the attorney.

All persons having any objection to the appointment shall file their objections with the Register of Wills within 30 days after the date of publication of this Notice. All persons having an objection to the probate of the will shall file their objections with the Register of Wills within six months after the date of publication of this Notice.

All persons having claims against the decedent must serve their claims on the undersigned personal representative(s) or file them with the Register of Wills with a copy to the undersigned on or before the earlier of the following dates:

(1) Six months from the date of the decedent's death; except if the decedent died before October 1, 1992, nine months from the date of the decedent's death; or

(2) Thirty days after the personal representative mails or otherwise delivers to the creditor a copy of this published notice or other written notice, notifying the creditor that the claims will be barred unless the creditor presents the claim within thirty days from the mailing or other delivery of the notice. Any claim not served or filed within that time, or any extension provided by law, is unenforceable thereafter.

TIFFANY M BLACKWELL, Personal Representative(s).
True Test--Copy: BELINDA K. CONAWAY,
Register of Wills for Baltimore City,
111 N. Calvert Street, Baltimore, Maryland 21202

au18 11391759

Baltimore City

Thomas J. Kokolis, Attorney
Parker, Simon, & Kokolis, LLC
110 North Washington Street, Suite 500,
Rockville, Maryland 20850

IN THE ORPHANS' COURT FOR BALTIMORE CITY, MARYLAND - IN THE ESTATE OF:

Artis Shine; Estate No. 139737

Notice of Judicial Probate

To all Persons Interested in the above estate:

You are hereby notified that a petition has been filed by THOMAS J. KOKOLIS, Esquire for judicial probate and for the appointment of a personal representative. A hearing will be held at Orphan's Court for Baltimore City, 111 North Calvert Street, Room 303, Baltimore, Maryland 21202 on September 28, 2017 at 10:00 AM.

This hearing may be transferred or postponed to a subsequent time. Further information may be obtained by reviewing the estate file in the office of the Register of Wills.

BELINDA K. CONAWAY, Register of Wills.

au18,25 11391736

Morris L. Garten, Attorney
Fedder and Garten Professional Association
36 South Charles Street, Suite 2300
Baltimore, Maryland 21201
Notice of Appointment Notice to Creditors
Notice to Unknown Heirs to all Persons Interested in the

Estate of (139689) Alan E. Behrend

Notice is given that JANET BEHREND LIVINGSTON, 8808 Joshua Court, Baltimore, Maryland 21208 and MORRIS L. GARTEN, 36 South Charles Street, Suite 2300, Baltimore, Maryland 21201 were on August 9, 2017 appointed personal representative(s) of the estate of Alan E. Behrend who died on July 23, 2017 with a will.

Further information can be obtained by reviewing the estate file in the office of the Register of Wills or by contacting the personal representative(s) or the attorney.

All persons having any objection to the appointment or to the probate of the decedent's will shall file their objections with the Register of Wills on or before the 9th day of February, 2018.

Any person having a claim against the decedent must present the claim to the undersigned personal representative(s) or file it with the Register of Wills with a copy to the undersigned on or before the earlier of the following dates:

(1) Six months from the date of the decedent's death, except if the decedent died before October 1, 1992, nine months from the date of the decedent's death, or

(2) Two months after the personal representative mails or otherwise delivers to the creditor a copy of this published notice or other written notice, notifying the creditor that the claim will be barred unless the creditor presents the claims within two months from the mailing or other delivery of the notice. A claim not presented or filed on or before that date, or any extension provided by law, is unenforceable thereafter. Claim forms may be obtained from the Register of Wills.

JANET BEHREND LIVINGSTON and MORRIS L. GARTEN,
Personal Representative(s).
True Test-Copy: BELINDA K. CONAWAY,
Register of Wills for Baltimore City,
111 N. Calvert Street, Maryland 21202.

au11,18,25 11387936

Baltimore City

Charles Hall, Proper Person
2005 Wilhelm Avenue,
Baltimore, Maryland 21237
Notice of Appointment Notice to Creditors
Notice to Unknown Heirs to all Persons Interested in the

Estate of (139691) Daryl Broome aka: Daryl Bernard Broome

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Further information can be obtained by reviewing the estate file in the office of the Register of Wills or by contacting the personal representative(s) or the attorney.

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(2) Two months after the personal representative mails or otherwise delivers to the creditor a copy of this published notice or other written notice, notifying the creditor that the claim will be barred unless the creditor presents the claims within two months from the mailing or other delivery of the notice. A claim not presented or filed on or before that date, or any extension provided by law, is unenforceable thereafter. Claim forms may be obtained from the Register of Wills.

CHARLES HALL, Personal Representative(s).
True Test-Copy: BELINDA K. CONAWAY,
Register of Wills for Baltimore City,
111 N. Calvert Street, Maryland 21202.

au11,18,25 11387946

EXHIBIT 11

PUBLIC INFORMATION MEETING

Hear details on our "Your Health. Our Mission" plans to improve and expand health care in northeastern Maryland.

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

THURSDAY, DECEMBER 13, 2018 • FROM 6-8 PM

@ Aberdeen Fire Hall,
21 North Rogers Street, Aberdeen, MD 21001

THE MEETING WILL INCLUDE INFORMATION ABOUT:

- Our plans for transitioning acute medical care services, job retraining and placement of team members
- Plans for repurposing the UM Harford Memorial Hospital property
- The expansion plans at UM Upper Chesapeake Medical Center in Bel Air
- Overall time-line for the project

REGISTER BY CALLING 1-800-515-0044
OR EMAIL MARKETING@UCHS.ORG

For more information visit UMUCH.ORG/NewCampus

Rendering of the University of Maryland Upper Chesapeake Medical Campus - Aberdeen

EXHIBIT 12

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Executive Office
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Bel Air, MD 21014
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uchs.org

December 27, 2018

VIA EMAIL & FEDEX

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

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

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

The Honorable Robert G. Cassilly
James Senate Office Building, Room 321
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The Honorable Glen Glass
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The Honorable Mary Ann Lisanti
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The Honorable Barry Glassman
Harford County Executive
Office of County Executive
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The Honorable Patrick S. Vincenti
President, Harford County Council
County Council
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Bel Air, MD 21014
pvincenti@harfordcountycouncil.com

The Honorable Robert R. Neall
Secretary of Health
Office of Secretary
Maryland Department of Health
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201 West Preston Street
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Robert.neall@maryland.gov

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In Good Health,

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

Enclosures

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

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

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

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

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

EXHIBIT 13

State of Maryland

Maryland Institute for Emergency Medical Services Systems

653 West Pratt Street
Baltimore, Maryland
21201-1536

Larry Hogan
Governor

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

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

October 12, 2017

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

Dear Mr. Steffen,

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

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

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

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

Sincerely,

Patricia S. Gainer

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

Enclosure

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

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

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

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

EMS Board Meeting
October 10, 2017

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

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

Executive Summary

University of Maryland Upper Chesapeake Medical Center, Inc. (UCMC) and University of Maryland Harford Memorial Hospital, Inc. (HMH) (jointly, the Applicants) are seeking approval from the Maryland Health Care Commission (MHCC) to convert HMH to a freestanding medical facility (FMF), as well as for an exemption from Certificate of Need review for the proposed conversion. Under Health-General 19-120, the MHCC determines whether to approve the request for exemption from the CON requirement based on a number of factors, including whether the conversion "will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system as determined by the State Emergency Medical Services Board." Health-General 19-120 (o)(3)(i) 5 C. By regulation, the EMS Board is required to consider eleven (11) factors in making its decision as to whether the proposed conversion will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system COMAR 30.08.15.03.

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

Background

HMH is an acute care hospital in Havre de Grace. It is currently a MIEMSS-designated Base Station and Primary Stroke Center. As of June 1, 2017, HMH reported a total of 28 emergency department (ED) treatment spaces. UCMC is an acute care hospital located in Bel Air, with 54 ED treatment spaces[1], and is a MIEMSS-designated as Base Station, Primary Stroke Center and Cardiac Interventional Center. HMH and

[1] Maryland Health Care Commission. Annual Report on Selected Maryland Acute Care and Special Hospital Services – FY2017. Page 23.

UCMC are the sole acute general hospitals in Harford County and are owned and operated by the University of Maryland Upper Chesapeake Health System which is part of the University of Maryland Medical System.

The Applicants are seeking to convert HMH to an FMF (the new entity to be created is referred to herein as 'UC FMF") to be developed at the Upper Chesapeake Medical Campus at Havre de Grace, at 210 Barker Lane, Havre de Grace, Maryland, which is located 3.75 miles from the current HMH campus. The plan calls for the current HMH campus to be redeveloped for a different use. Additionally, HMH and UCMC, as joint applicants, are also seeking to relocate beds from HMH to UCMC as part of a merger and consolidation of these two. The conversion of HMH to a freestanding medical facility is not anticipated to be completed until fiscal year 2022.

Process

Under COMAR 30.08.15.03 (B), the Applicants notified MIEMSS and the MHCC of their intent to convert HMH to a freestanding medical facility on August 4, 2017. The Applicants held the required public hearing on August 30, 2017, and provided specified information to MIEMSS within the required timeframe. They solicited input from the EMS community by publishing a physical address and email address on their website for receipt of comments. Additionally, MIEMSS has sought information from the EMS community by soliciting comments on its website "Opportunity for Comment for Harford Memorial Conversion to a Freestanding Medical Facility." Prior to the August 4, 2017, notice of intent to convert, MIEMSS had also engaged in dialogue with EMS providers in the affected jurisdictions. Under COMAR 30.08.15.03 (B), the EMS Board is required to issue the determination concerning the proposed hospital conversion under §A of this regulation within 45 days of the required public informational hearing held by the hospital proposing the conversion, in consultation with the MHCC. Accordingly, the deadline for EMS Board to make its determination and to notify the MHCC of its determination is October 16, 2017.

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

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

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

Harford County and Cecil County have been identified as the jurisdictions affected by the proposed conversion. Emergency medical services in Cecil County are primarily provided by the nine (9) volunteer

fire companies. Additionally, the Cecil County Department of Emergency Services operates four (4) advanced life support (ALS) rapid response non-transport units staffed by paramedics. The four paramedic units operate out of three (3) stations, located in the western (Colora), central (Elkton), and southern (Chesapeake City) areas of the county. These four units supplement the response of the volunteer fire departments.

Emergency medical services in Harford County are primarily provided by 11 volunteer fire and EMS companies [2] augmented by paid personnel provided by the Harford County Volunteer Fire and EMS Foundation. The Foundation has also operated three (3) ALS non-transport units. Based on the recommendations in the *Harford County Emergency Medical Services Policy Analysis and Evaluation, February 2017*[3] , Harford County has recently initiated a transition to recognize the county government as the Jurisdictional EMS Operational Program through the Department of Emergency Services (DES). This responsibility is being transferred from the Harford County Volunteer Fire and EMS Association, and is being governed by an EMS Standards Advisory Board appointed by the County Executive. In the short-term, Harford County government is planning to increase capability in the county through the addition of two ALS ambulances, staffed by 8 ALS providers.

Harford County EMS has formally expressed support for this conversion through letters submitted to the MHCC by the Harford County Volunteer Fire and EMS Association, Inc., and by Timothy Chizmar, M.D., who serves as the EMS Medical Director for the county and is an emergency physician at UCMC.

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

Patients who will be transported to the new freestanding medical facility and are determined to require hospitalization will require transfer from the freestanding to an acute care facility. Between fiscal years 2015 and 2017, the Applicants report that there was an average of 1.3 transfers per day from HMH's ED to other hospitals. [4] Hart to Heart Transportation is the primary commercial ambulance service operating in the affected jurisdiction and serves as a contracted vendor providing interfacility transports for patients requiring a higher level of care, primarily from HMH to UCMC. Data available to MIEMSS indicates that over a two-

[2] One (1) fire company in Harford County, Susquehanna Hose, does not provide EMS.
[3] University of Maryland Center for Health & Homeland Security: Harford county emergency Medical Services policy Analysis and Evaluation. February 2017.
[4] *Responses to Additional Information Questions Dated September 1, 2017*, from UMUCH, September 18, 2017, page 14.

year period, Heart to Hart transferred 87 patients by ground from HMH, 63 of which were transported to UCMC. Of the 87 patients, 56 were transported from the HMH emergency department. AMR also provides interfacility transport services which includes the capability of helicopter transport. Over a 13-month period, AMR transferred 160 patients from HMH to the University of Maryland Hospital, 35 of which were transported by air.

Additionally, the Applicants predict that 3,037 patients seen at UC FMF will require hospital admission. As a result, the Applicants project that the UC FMF would have to transport 8.3 patients per day from UC FMF to another facility. [5]

MIEMSS believes that use of public safety resources for this purpose would place an unreasonable burden on the EMS resources in the affected jurisdictions. Accordingly, the Applicants anticipate that there will be a need to augment existing interfacility transport capabilities as a result of the conversion. The conversion plan specifically provides for a dedicated on-site ambulance unit. UM UCH is considering several possible strategies to ensure adequate interfacility transport capabilities including: "(1) enhancing current commercial ambulance service contracts; (2) pursuing an ambulance service ownership model; and (3) a hybrid strategy with the overall focus on securing the appropriate number of ambulances to support the projected inter-facility transport needs." [6] Additionally, the new FMF facility will have a helipad on site. Currently any patient requiring emergent transport via air must be transported by ground ambulance to a landing pad off-site.

[5] *Id. At page 15*

[6] Letter to Patricia Gainer from Lyle Sheldon, dated September 22, 2017, Re: *Responses to September 12, 2017 Questions Regarding Request for Exemption from Certificate of Need Review for the Conversion of UM Harford Memorial Hospital to a Freestanding Medical Facility, page 2.*

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

Cecil County - Transport Count			
	CY2014	**CY2015**	**CY2016**
Priority 1 - Patient Critically Ill or Injured (Immediate / Unstable)	**309**	**367**	**398**
Transport to Harford Memorial Hospital	*40*	*47*	*49*
Other Facility	*269*	*320*	*349*
Priority 2 - Patient Less Serious (Urgent / Potentially Life Threatening)	**3,365**	**3,590**	**3,865**
Transport to Harford Memorial Hospital	*643*	*660*	*687*
Other Facility	*2,722*	*2,930*	*3,178*
Priority 3 - Patient Non-Urgent	**4,070**	**4,112**	**4,062**
Transport to Harford Memorial Hospital	*896*	*952*	*962*
Other Facility	*3,174*	*3,160*	*3,100*
Priority 4 - Patient does not require medical attention	**8**	**10**	**6**
Transport to Harford Memorial Hospital	-	*4*	*1*
Other Facility	*8*	*6*	*5*
Priority Unknown	**521**	**487**	**506**
Transport to Harford Memorial Hospital	*42*	*67*	*75*
Other Facility	*479*	*420*	*431*
Total	**8,273**	**8,566**	**8,837**

Harford County - Transport Count			
	CY2014	**CY2015**	**CY2016**
Priority 1 - Patient Critically Ill or Injured (Immediate / Unstable)	**974**	**979**	**1,023**
Transport to Harford Memorial Hospital	*170*	*188*	*180*
Other Facility	*804*	*791*	*943*
Priority 2 - Patient Less Serious (Urgent / Potentially Life Threatening)	**6,378**	**6,503**	**6,506**
Transport to Harford Memorial Hospital	*1,541*	*1,521*	*1,570*
Other Facility	*4,837*	*4,982*	*4,936*
Priority 3 - Patient Non-Urgent	**11,300**	**11,262**	**11,958**
Transport to Harford Memorial Hospital	*2,798*	*2,955*	*3,210*
Other Facility	*8,502*	*8,307*	*8,748*
Priority 4 - Patient does not require medical attention	**17**	**26**	**40**
Transport to Harford Memorial Hospital	*7*	*9*	*14*
Other Facility	*10*	*17*	*26*
Priority Unknown	**98**	**46**	**49**
Transport to Harford Memorial Hospital	*7*	*1*	*2*
Other Facility	*91*	*45*	*47*
Total	**18,767**	**18,816**	**19,576**

Source: eMEDS® data. Note that the use of the term "Priority Unknown" indicates that in the eMEDS® data, the county SUV/Chase unit is the record that contains the vast majority of the patient care information. The volunteer transport unit will advise that the County is on location first with all patient care. There is no mechanism in which to combine these two reports into a single patient care report.

As can be seen in the transport data, overall call volumes for Cecil County increased by 6.8% and for Harford County by 4.3% from 2014 – 2016. Regarding Priority 1 calls, Cecil County saw an increase of 89 patients (+2.8%), with Priority 1 transports to HMH increasing by about the same percentage (+2.2%). Harford County Priority 1 transports overall and Priority 1 transports to HMH remained relatively stable

during the period (+5%). Under MIEMSS protocols, Priority 1 patients cannot be transported to a free-standing medical facility unless the patient is in extremis.

Regarding Priority 2 patients, Cecil County saw an increase of 500 patients over the (2) year period (+14.8%), and an increase of 44 of such patient transports to HMH (+6.8%). Harford County also saw increases in Priority 2 patient transports (+2%); Priority 2 transports to HMH were relatively stable (+1.8%). MIEMSS protocols permit stable Priority 2 patients to be transported to a free-standing medical facility. It is unclear from the available data which of the Priority 2 patients were stable or unstable. Therefore, no conclusions could be drawn on the projected number of Priority 2 patients that could be transported to the UC FMF.

Priority 3 and 4 patients may be transported by ambulance to a freestanding medical facility under MIEMSS protocols. In 2016, Cecil County transported 4,068 Priority 3 or 4 patients, 963 of which were transported to HMH. During the same period, Harford Country transported 11,998 Priority 3 or 4 patients, of which 3,224 were transported to HMH.

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

As discussed above, according to eMEDS® data, in calendar year 2016, Cecil County EMS transported 49 Priority 1 patients to HMH. Harford County EMS transported 180 Priority 1 patients to HMH, for a total of 229 Priority 1 patients transported by the two jurisdictions to HMH in 2016. Under current EMS protocols, these 229 Priority 1 patients would no longer qualify for treatment at the FMF. Additionally, there were 2, 245 Priority 2 patients transported to HMH by the two jurisdictions. While the current protocol allows EMS to transport stable Priority 2 patients to a freestanding emergency medical facility with a required medical consultation, unstable Priority 2 patients will require transport to a hospital.

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

Cecil County - Avg. Transport Time (Left Scene - Arrived Destination)			
	CY2014	**CY2015**	**CY2016**
Priority 1 - Patient Critically Ill or Injured (Immediate / Unstable)			
Transport to Harford Memorial Hospital	0:14:26	0:11:53	0:13:43
Other Facility	0:14:25	0:13:03	0:12:00
Priority 2 - Patient Less Serious (Urgent / Potentially Life Threatening)			
Transport to Harford Memorial Hospital	0:17:05	0:16:28	0:16:24
Other Facility	0:13:55	0:13:42	0:13:36
Priority 3 - Patient Non-Urgent			
Transport to Harford Memorial Hospital	0:16:22	0:15:40	0:16:05
Other Facility	0:12:12	0:12:47	0:12:02
Priority 4 - Patient does not require medical attention			
Transport to Harford Memorial Hospital	-	0:13:13	0:11:21
Other Facility	0:20:42	0:12:15	0:08:48
Priority Unknown			
Transport to Harford Memorial Hospital	0:20:19	0:20:50	0:22:58
Other Facility	0:12:12	0:14:05	0:15:42

Harford County - Avg. Transport Time (Left Scene - Arrived Destination)			
	CY2014	**CY2015**	**CY2016**
Priority 1 - Patient Critically Ill or Injured (Immediate / Unstable)			
Transport to Harford Memorial Hospital	0:08:27	0:08:17	0:08:39
Other Facility	0:11:45	0:11:08	0:11:27
Priority 2 - Patient Less Serious (Urgent / Potentially Life Threatening)			
Transport to Harford Memorial Hospital	0:10:19	0:10:42	0:10:57
Other Facility	0:13:39	0:13:48	0:14:46
Priority 3 - Patient Non-Urgent			
Transport to Harford Memorial Hospital	0:10:52	0:10:30	0:11:12
Other Facility	0:14:09	0:15:14	0:14:44
Priority 4 - Patient does not require medical attention			
Transport to Harford Memorial Hospital	0:09:11	0:09:28	0:12:11
Other Facility	0:16:25	0:13:01	0:11:01
Priority Unknown			
Transport to Harford Memorial Hospital	0:09:50	-	0:13:40
Other Facility	0:09:27	0:10:10	0:08:09

0:00:00 denotes hour(s):minutes:seconds

Source: eMEDS® Data

Cecil County EMS, primarily those companies located in the western portion of the county, initially raised concerns regarding the potential for extended transport times resulting from the conversion. Cecil County EMS transported 49 Priority 1 patients to HMH in 2016. By protocol most of the seriously injured or ill patients in the western third of Cecil County are currently transported by aviation to the University of Maryland Medical Center or Christiana or by ground units to UCMC.

In terms of additional travel time, however, MIEMSS estimates an additional 19-24 minutes in transport times for Cecil County EMS to transport a patient to Upper Chesapeake instead of to Harford Memorial and an additional 23-27 minutes travel time to get a Cecil County unit back in service, i.e., back to its home county.

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

Hart to Heart Transportation is the primary commercial ambulance service operating in the affected jurisdiction and serves as a contracted vendor providing interfacility transports from HMH to UCMC for patients requiring a higher level of care. From August 1, 2015 to August 31, 2017, Hart to Heart provided 87 interfacility transports from HMH to UCMC. The average time from the call for a transport to arrival at HMH was 1 hour for all patients. The average time from picking-up the patient to arriving at the destination was 52 minutes for all patients. For those patients requiring the most urgent care, including STEMI patients and Cardiac Arrest Patients, the times were significantly lower, with the average time from the call for a transport to arrival at HMH being under 30 minutes.

Additionally, ExpressCare/AMR maintains a unit at HMH for the sole purpose of transferring patients from either HMH or UCMC to UMMC. During a 13 month period, the average total time from dispatch to HMH to arrival at UMMC for patients transferred by helicopter was 177 minutes (2 hours and 57 minutes). The existing HMH helipad is not located on the facility campus and requires ambulance transport from the hospital to the landing zone. For ground-transported patients, the average total time from dispatch to HMH to arrival at UMMC was 147 minutes (2 hours and 27 minutes).

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

The other Maryland hospitals likely to be affected by the conversion are UCMC, Union Hospital of Cecil County, and Franklin Square Hospital. UCMC is approximately 14.5 miles from HMH. Union Hospital of Cecil County is approximately 24 miles, and Franklin Square Hospital is approximately 26 miles from HMH.

Christiana Hospital (Christiana Care Medical System) in Newark, Delaware, could also see increased patterns of usage depending on distance and existing road and highway conditions. MIEMSS has a Memorandum of Understanding with Christiana Hospital as an out-of-state trauma center and a Cardiac Interventional Center. Maryland ambulances may transport patients to that hospital. Christiana Hospital is a 913-bed teaching hospital and an American College of Surgeons verified Level I trauma center. Christiana Hospital is located 29.8 miles from Harford Memorial Hospital.

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

UM UCH provided a table of emergency department visits from 2013 to 2017 by residents of its service area, which it defines as thirteen (13) zip codes within Harford and Cecil Counties.

	Historical					2017	2013-2017
Hospital	2013	2014	2015	2016	2017 (1)	% of Total	% Change
Upper Chesapeake Medical Center	25,169	24,580	26,175	27,051	26,502	37.7%	5.3%
Harford Memorial Hospital	25,921	24,289	24,981	24,679	23,938	34.1%	-7.7%
Union Hospital of Cecil County	12,547	11,658	11,558	11,790	11,490	16.3%	-8.4%
Franklin Square Hospital	3,394	2,974	2,733	2,574	2,350	3.3%	-30.8%
Other hospitals with less than 1000 visits	6,389	6,270	6,135	6,328	6,000	8.5%	-6.1%
Total Service Area ED Visits	73,420	69,771	71,582	72,422	70,280	100.0%	-4.3%

Note (1): Reflects six months actual experience annualized
Source: St. Paul Computer Center statewide non-confiential utilization data tapes

ED use by residents of the service area has dropped by 4.3% in the past 4 years. However, HMH still provides approximately 34% of the total ED service within the service area (the 13 zip codes within Harford and Cecil counties defined by the Applicants). UCMC sees an even greater percentage, almost 38%, and its ED usage has increased by a little over 5%. The Maryland Health Care Commission calculated projections for HMH ED visits to continue to decline over the next ten years. Projections as to future ED usage and associated increases in admission and observation patient volumes for the general hospitals likely to be affected by the proposed hospital conversion were not available for this analysis.

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

The closest facilities that would routinely receive patients when Harford Memorial is on diversion are Upper Chesapeake Medical Center and Union of Hospital of Cecil County, but Franklin Square also may occasionally receive patients as well. This would not be expected to change after the new facility is constructed in Bulle Rock. In the table below, alerts hours are reported for CY 2014-CY 2016 and through quarter three, 2017.

Harford Memorial Hospital has utilized relatively small hours of any of the three categories of diversion, trending significantly lower from 2016 to 2017.

Upper Chesapeake showed increased yellow alert utilization each year and as of September 30, 2017 is close to surpassing the total hours for 2016. In addition EMS has placed Upper Chesapeake on ReRoute for a significant amount of hours each year as compared to the other three hospitals, and also continues to trend higher with the exception of one very slight decrease in CY 2015. Upper Chesapeake also utilized a moderate amount of red alert each year which also increased each year through 2016, however appears to be trending significantly lower for 2017.

Union Hospital of Cecil County utilizes minimal yellow alert hours which tend to fluctuate up and down from year to year and ReRoute is nearly never implemented by EMS. Red Alerts increased significantly in 2015 and then again slightly in 2016, but may be trending lower for 2017.

Franklin Square Medical Center in Baltimore County utilized extremely high yellow alert hours which increased each year from 2014-2016, however, utilization has dropped down very significantly in 2017. ReRoutes are implemented but fluctuate up and down from year to year. Red Alert is not utilized frequently and decreased each year from 2014-2016, however it is slightly increased in 2017.

Hospital	CY2014	CY2015	CY2016	2017*	CY2014	CY2015	CY2016	2017*	CY2014	CY2015	CY2016	2017*
	Yellow	Yellow	Yellow	Yellow	Red	Red	Red	Red	ReRoute	ReRoute	ReRoute	ReRoute
MedStar Franklin Square	2248	3088	3945	285	22	18	16	34	31	51	83	38
Harford Memorial	61	68	128	29	92	26	49	0	19	13	28	14
Upper Chesapeake	351	432	515	500	223	269	346	94	85	78	129	97
Union Hospital of Cecil Co	12	45	25	33	58	344	366	200	0	1	2	1
* 1/1/17-9/30/17												

Data Source: MIEMSS County Hospital Alert Tracking System ***(CHATS)***

Alert Definitions:

Yellow Alert

The emergency department temporarily requests that it receive absolutely no patients in need of urgent medical care. Yellow alert is initiated because the emergency department is experiencing a temporary overwhelming overload such that priority two and three patients may not be managed safely. Prior to diverting pediatric patient transports, medical consultation is advised for pediatric patient transports when emergency departments are on yellow alert.

Red Alert

The hospital has no ECG monitored beds available. These ECG monitored beds will include all in-patient critical care areas and telemetry beds.

ReRoute

An ALS/BLS unit is being held in the emergency department of a hospital due to lack of an available bed.

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

The proposed FMF will be a 50,800 departmental square feet emergency department, open 24/7 and include the following features:

1. A main public/ambulatory entry and waiting area with two (2) public toilets;
2. An emergency department (with six (6) triage rooms at 125 square feet each, 21 exam rooms at 138 square feet each, 6 patient toilets, and 2 staff toilets) as well as related staff and support spaces, including an ambulance entrance and decontamination facilities;
3. A behavioral health crisis center with four (4) exam rooms at 122 square feet each and 2 patient toilets and related staff and support spaces;

4. An observation suite with eleven (11) patient rooms at 183 square feet each having its own private toilet at 50 square feet, and related staff and support spaces;

5. A diagnostic imaging suite with x-ray, ultrasound, CT, MRI, and two (2) cardio-vascular ultrasound modalities at and related staff and support spaces;

6. A laboratory and pharmacy; and

7. Administration and staff support spaces. [7]

The FMF will be staffed by Board Certified Emergency Medicine physicians and nursing staff specializing in emergency medicine with up to forty (40) hours of emergency physician and twelve (12) hours of emergency Advanced Practice Clinicians per day, as well as 196 RN hours per day Monday through Friday and 188 RN hours per day on the weekend, and 44 ED technician hours per day. The FMF will obtain base station designation. Specialty services at UCMC would be accessible to FMF patients via telemedicine.

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

Effective July 1, 2017, the Maryland Medical Protocols for EMS Providers were revised to allow EMS providers to transport stable Priority 2 patients to an FMF with a required medical consultation via base station communication. Previously, EMS providers could only transport Priority 3 & 4 patients (or higher acuity patients in such extremis they required immediate life-saving interventions) to FMFs. Additionally, on January 4, 2017, the MIEMSS Protocol Review Committee approved a pilot protocol which will allow EMS providers to transport Priority 1 stroke patients to a facility which has been designated as an Acute Stroke Ready Hospital (ASRH) if a Primary Stroke or Comprehensive Stroke Center is greater than fifteen (15) additional minutes away. The UC FMF can potentially apply for the ASRH designation once the EMS Board has approved regulations for the designation of ASRHs. These protocol changes broadening the categories of patients that EMS can deliver to the FMF will decrease the numbers of patients EMS would have to divert from the FMF to another, potentially further, facility. MIEMSS does not anticipate that other changes will need to be made to the EMS system as a result of the conversion.

[7] REQUEST FOR EXEMPTION FROM CERTIFICATE OF NEED REVIEW FOR THE CONVERSION OF UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL TO A FREESTANDING MEDICAL FACILITY, August 4, 2017 pages 6-7

Summary and Discussion

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

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

The affected jurisdictions are Cecil and Harford County. MIEMSS received no information that would indicate the need for additional EMS resources in these jurisdictions (staffing, equipment, and units) because of the proposed conversion. As the project moves toward its anticipated completion date of 2022, however, the need for additional resources may become apparent. Harford County EMS formally supported the proposed conversion with a Letter of Support.

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

The Applicants recognize that timely transfer of patients from the FMF to UCMC or another acute care hospital without creating a burden for the affected EMS jurisdictions is a potential vulnerability. UM UCH has stated its intention to ensure the "ability to make timely ambulance transports in a safe and effective manner that will have minimal or no impact on the EMS system upon the conversion of HMH to a freestanding medical facility". [8] Additionally, the dedicated on-site ambulance should limit the number of transfers conducted by an EMS jurisdictional ambulance. However, this will need to be monitored during the transition and UM UCH will have to be prepared to commit additional resources.

[8] Letter to Patricia Gainer from Lyle Sheldon, dated September 22, 2017, page 2

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

The EMS call volume for the affected jurisdictions has been relatively stable over the past three years. There is no evidence to suggest that the EMS call volume, per se, will be affected by the proposed conversion in the affected jurisdictions.

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

EMS Priority 1 patients and unstable Priority 2, or those that would require admission for inpatient care patients will require transport to an acute general hospital, rather than UC FMF. The number of Priority 1 and Priority 2 patients has remained relatively stable in the two affected jurisdictions from 2014 – 2016, experiencing only modest increases. EMS Priority 1 patients from both of the affected jurisdictions totaled 229 in 2016; none of these patients could be treated at UC FMF, unless the patient was in extremis. EMS Priority 2 patients from both of the jurisdictions totaled 2,245 during 2016; it is unclear how many of this patient were "stable," and thus able to be transported to UC FMF.

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

As the UC FMF will be located 3.8 miles from HMH, MIEMSS does not project a significant change in the transport times for ambulance-transported patients by either jurisdiction to the new facility instead of HMH. In terms of travel time to UCMC for those patients who cannot be transported to UC FMF, however, MIEMSS estimates an additional 19-24 minutes in transport times for Cecil County EMS to transport a patient to Upper Chesapeake instead of to Harford Memorial and an additional 23-27 minutes travel time to get a Cecil County unit back in service, i.e., back to its home county.

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

On its face, it appears that UC FMF should be able to secure adequate support from commercial ambulance services to complete necessary patient transfers in a timely manner. Securing such support is key to ensuring there is not a burden placed on the jurisdictional EMS Operational Programs for such interfacility transfers. Additionally, the UC FMF will need to ensure that patients, particularly those requiring time critical interventions are transferred in a timely manner. In support of the application, the applicants have stated:

> [T]he goal for optimal patient management is to achieve an average two-hour transport time for emergent, high acuity patients requiring a higher level of care. This two-hour window will start from the time a decision to admit a patient has been made and continue until the patient arrives at the receiving facility. The two-hour transport window will be accelerated for patients experiencing life-threatening conditions; for example, UC FMF will have accelerated transport protocols for stroke and cardiac patients.
>
> For non-emergent transports, a three to four-hour transport window will start from the time the receiving facility confirms bed availability. This transport time is consistent with existing patient boarding times at HMH and UCMC and will include transit time in an ambulance. UC FMF will require time to coordinate placement of most patients in an MSGA unit [of] the receiving facility before transporting the patient.[9]

The applicants have further stated that these times will be monitored via a daily monitoring log in conjunction with ambulance transport services. Monitoring these times to ensure that benchmarks are being met is critical both to ensuring appropriate and timely patient care and to maintaining compliance with the standards for designation of specialty programs.

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

There are four (4) hospitals likely to be affected by the conversion: three (3) in Maryland (UCMC, Union Hospital of Cecil County, and Franklin Square Hospital) and one (1) in Delaware (Christiana). UCMC is the closest hospital and likely to be receive most of the patients that need hospital admission.

[9] Id at page 3

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

Information provided by Applicants indicates that ED usage dropped by 4% in the past 4 years. The Maryland Health Care Commission calculated projections for HMH ED visits to continue to decline over the next ten years. Projections as to future ED usage and associated increases in admission and observation patient volumes for the general hospitals likely to be affected by the proposed hospital conversion were not available for this analysis.

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

The ability of the three Maryland hospitals to receive patients who would otherwise have been transported to HMH is critical. As many of these admissions would come into the hospital through the emergency departments, the use of alerts by the affected hospitals are noteworthy. UCMC has had increased yellow alert utilization each year and as of September 30, 2017 is close to surpassing the total hours for 2016 and EMS has placed UCMC on Re-Route for a significant amount of hours each year as compared to the other three hospitals. UCMC will need to ensure that it is able to accept additional admissions, as well as transfers from UC FMF in a timely manner. Also a designated specialty center, UCMC serves as a resource for the community for receiving and treating time-critical illness. Maintaining this ability to timely receive and treat patients is key to the hospital maintaining its specialty center designation status.

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

MIEMSS reviewed the size, scope, configuration, services and staffing planned for the UC FMF. The Applicants described how these components were consistent with applicable guidance included in the most current edition of the *Emergency Department Design: A Practical Guide to Planning for the Future,* published by the American College of Emergency Physicians.

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

Changes recently instituted by MIEMSS are applicable to the proposed project. First, EMS providers are now permitted to transport stable Priority 2 patients to a freestanding medical facility. Additionally, the MIEMSS Protocol Review Committee approved a pilot protocol which will allow EMS providers to transport Priority 1 stroke patients to a facility which has been designated as an Acute Stroke Ready Hospital (ASRH) if a Primary Stroke or Comprehensive Stroke Center is greater than fifteen (15) additional minutes away. These protocol changes broaden the categories of EMS patients that be transported to an FMF which, in turn, should decrease the numbers of patients EMS would have to divert to an acute care facility. MIEMSS does not anticipate that other changes will need to be made to the EMS system as a result of the conversion.

Recommendation

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

EXHIBIT 14

State of Maryland

Maryland Institute for Emergency Medical Services Systems

653 West Pratt Street
Baltimore, Maryland
21201-1536

Larry Hogan
Governor

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

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

February 7, 2019

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

Dear Mr. Steffen,

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

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

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

Please let me know if you need additional information.

Sincerely,

Patricia S Gainer

Patricia Gainer, JD, MPA
Acting Executive Director

EXHIBIT 15

Upper Chesapeake Health

Subject: Estimate of Charges

Origin Date: 1/7/11

Approved by: _____

Craig Willig, Vice President of Finance

To provide for transparency in health care pricing

Policy

Upper Chesapeake Health (UCH) shall publicly disclose, on a continuous basis, price estimates for such items, products, services, or procedures in accordance with current Legislation.

Manner of Disclosure

- Shall be made in an open and conspicuous manner;
- Shall be made available at the point of service, in print, and on the Internet; and
- UCH provides estimated charges for the most commonly used inpatient, outpatient, and ancillary services. The information is reviewed semi-annually by the Director of Reimbursement and updated when appropriate.

The amounts are estimates of charges for hospital procedures and services only.

Procedures

UCH promptly responds to individual requests for current charges for specific services/procedures.

- Patients seeking estimates of procedures/services that are not listed on the UCH Common Procedure chart will be encouraged to call the Cashier (443-643-1663).
- The UM Upper Chesapeake Health website will include a listing of current rates for common services; to be updated semi-annually
- If the Cashier is unable to provide the estimate, the Director of Reimbursement will be consulted.
- An estimate will be provided within three business days of receiving the request.

All Patient Accounting, Patient Access, Guest Services, and Administrative Personnel are knowledgeable of the process for providing estimates of charges.

DEVELOPER:

Patient Access, UCH

Reviewed / Revised: 7/1/17

ORIGIN DATE: 1/2011

NEXT REVIEW DATE: 7/2018

EXHIBIT 16

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Upper Chesapeake Health

Subject: Financial Assistance Policy

Effective Date: 10/2018

Approved by: _____

Steve Witman, Sr. VP CFO

_____

Board of Directors

To provide financial relief to patients unable to meet their financial obligation to University of Maryland Upper Chesapeake Health.

1. **Policy**
   a. This policy applies to the University of Maryland Upper Chesapeake Health (UM UCH) facilities to include:
      i. University of Maryland Upper Chesapeake Medical Center
      ii. University of Maryland Harford Memorial Hospital.

   UM UCH is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for all medically necessary care will be covered based on their individual financial situation.

   b. It is the policy of UM UCH to provide Financial Assistance (FA) based on indigence or high medical expenses (Medical Financial Hardship program) for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for FA should be made, the criteria for eligibility, and the steps for processing applications.

   c. UM UCH will post notices of availability at appropriate intake locations as well as the Patient Accounting Office. Notice of availability will also be sent to patients on patient bills. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge and will be available to all patients upon request and without charge, both by mail and in the emergency room and admission areas. A written estimate of total charges, excluding the emergency department, will be available to all

patients upon request. This policy, the Patient Billing and Financial Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UM UCH website (https://www.umms.org/uch/patients-visitors/for-patients/financial-assistance).

d. FA may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include a review of the patient's existing medical expenses and obligations, including any accounts having gone to bad debt.
e. Payments made for care received during the financial assistance eligibility window that exceed the patients determined responsibility will be refunded if that amount exceeds $5.00
    i. Collector notes, and any other relevant information, are deliberated as part of the final refund decision; in general refunds are issued based on when the patient was determined unable to pay compared to when the payments were made
    ii. Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for a refund
f. UM UCH retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services or diagnosed-cancer care will be treated regardless of their ability to pay, except as noted under 2. d. iv. below.

2. Program Eligibility

a. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UM UCH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further the UM UCH commitment to our mission to provide healthcare to the surrounding community, UM UCH reserves the right to grant financial assistance without formal application being made by our patients.
b. Specific exclusions to coverage under the Financial Assistance Program:
    i. Physician charges are excluded from UM UCH's FA policy. Patients who wish to pursue FA for physician related bills must contact the physician directly. For a list of physicians providing emergency and other medically necessary care in the hospital facility, whose services are not covered under this policy, please contact our Financial Assistance Department at (443) 843-5092.

ii. Generally, the FA program is not available to cover services that are 100% denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications
iii. Cosmetic or other non-medically necessary services

c. Patients may become ineligible for FA for the following reasons:
   i. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, Motor Vehicle or other insurance programs that deny access to UM UCH due to insurance plan restrictions/limits
   ii. Refusal to be screened for other assistance programs prior to submitting an application to the FA program

d. Determination for Financial Assistance eligibility will be based on assets, income, and family size. Please note the following:
   i. Liquid assets greater than $15,000 for individuals, and $25,000 for families will disqualify the patient for 100% assistance.
   ii. Equity of $150,000 in a primary residence will be excluded from the calculation for determination of financial assistance; and
   iii. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans will not be used for determination of financial assistance.
   iv. Non-citizens/non-residents of the United States may only qualify for Financial Assistance under these circumstances: 1. an initial visit for emergency care or 2. if qualified for presumptive Medical Assistance upon inpatient admission or prior to outpatient treatments for cancer care, and only after a determination by the Financial Counselor/Director of Patient Accounting and/or V.P. of Finance. See the Upper Chesapeake Health Self Pay Billing policy for criteria for beginning outpatient cancer care for these patients.

e. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a FA application unless they meet Presumptive FA (see section 3 below) eligibility criteria. If a patient qualifies for COBRA coverage, the patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

f. Free medically necessary care will be awarded to patients with family income at or below 200 percent of the Federal Poverty Level (FPL).
g. Reduced-cost, medically necessary care will be awarded to low-income patients with family income between 200 and 300 percent of the FPL
h. If a patient requests the application be reconsidered after a denial determination made by the Financial Counselor, the Director of Patient Accounting will review the application for final determination.
i. Payment plans can be offered for all self-pay balances by our Self Pay Vendor.

3. Presumptive Financial Assistance

a. Patients may also be considered for Presumptive Financial Assistance eligibility with proof of enrollment in one of the programs listed below. There are instances when a patient may appear eligible for FA, but there is no FA form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patent with FA. In the event there is no evidence to support a patient's eligibility for FA, UM UCH reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100-percent write-off of the account balance. Presumptive FA eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
    i. Active Medical Assistance pharmacy coverage
    ii. Special Low Income Medicare Beneficiary (SLMB) coverage (covers Medicare Part B premiums)
    iii. Homelessness
    iv. Medical Assistance and Medicaid Managed Care patients for services provided in the ED beyond coverage of these programs
    v. Maryland Public Health System Emergency Petition (EP) patients (balance after insurance)
    vi. Participation in Women, Infants and Children Program (WIC)
    vii. Supplemental Nutritional Assistance Program (SNAP)
    viii. Eligibility for other state or local assistance programs
    ix. Deceased with no known estate
    x. Determined to meet eligibility criteria established under former State Only Medical Assistance Program

xi. Households with children in the free or reduced lunch program
xii. Low-income household Energy Assistance Program
xiii. Self-Administered Drugs (in the outpatient environment only)
xiv. Medical Assistance Spenddown amounts

b. Specific services or criteria that are ineligible for Presumptive FA include:
   i. Uninsured patients seen in the ED under EP will not be considered under the presumptive FA program until the Maryland Medicaid Psych program has been billed

4. Procedures

a. The Financial Counselor will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage
b. The Financial Counselor will consult via phone or meet with patients who request FA to determine if they meet preliminary criteria for assistance.
   i. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility
   ii. All applications will be tracked and after eligibility is determined, a letter of final determination will be submitted to the patient
   iii. Patients will have fifteen days to submit required documentation to be considered for eligibility. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to. For any episode of care, the financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent.
c. There will be one application process for UM UCH. The patient is required to provide a completed FA application. In addition, the following may be required:
   i. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return)
   ii. Proof of disability income (if applicable)
   iii. A copy of their three most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income
   iv. A Medical Assistance Notice of Determination (if applicable)
   v. Proof of U.S. citizenship or lawful permanent residence status (green card)
   vi. Reasonable proof of other declared expenses may be taken in to consideration

vii. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
viii. A Verification of No Income Letter (if there is no evidence of income)
ix. Three most recent bank statements

Written request for missing information will be sent to the patient. Where appropriate, oral submission of needed information will be accepted.

d. In addition to qualifying for Financial Assistance based on income, a patient can qualify for FA either through lack of sufficient income, insurance or catastrophic medical expenses based on the Financial Hardship criteria discussed below. Within two (2) business days following a patient's request for Financial Assistance, application for Medical Assistance, or both, the hospital will make a determination of probable eligibility. Completed applications will be forwarded to the Manager of Patient Accounting who will determine approval for adjustments up to $10,000. Adjustments of $10,000 or greater will be forwarded to the Director of Patient Financial Services and the V.P. of Finance for an additional approval.
e. Once a patient is approved for FA, FA coverage is effective for:
    i. All accounts in an AR (Accounts Receivable) status
    ii. All accounts in a BD (Bad Debt) status that were transferred within one year of the service date of the oldest AR account being adjusted using the current application
    iii. All future visits within 6 months of the application date
    iv. In addition, coverage will also extend to any account for which a written notice described in paragraph h (below) has not been sent or for which the deadline stated therein has not elapsed. However, UM UCH may decide to extend the FA eligibility period further into the past or the future.
f. Social Security beneficiaries with lifelong disabilities may become eligible for FA indefinitely and may not need to reapply
g. UM UCH does not report debts owed to credit reporting agencies.
h. In rare cases, accounts may warrant Extraordinary Collection Actions (ECAs). Once an account has met the following criteria, the account is closed by the collection agency as "uncollectible" and forwarded back to Patient Accounting for review to establish grounds for legal action. UM UCH reserves the right to place a lien on a patient's income, residence and/or automobile. This only occurs after all efforts to resolve the debt have been exhausted.

Criteria:

i. The debt is valid
ii. The account is equal to or greater than 120 days old
iii. Patient refuses to acknowledge the debt
iv. Upon review and investigation, we have determined liquid assets are available (checking, savings, stocks, bonds or money market accounts)
v. The VP of Finance must authorize legal action

Action will be preceded by notice 30 days prior to commencement. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any ECA action being taken. This written notice will indicate that Financial Assistance is available for eligible individuals, identify the ECAs that the hospital (or its collection agency, attorney or other authorized party) intends to initiate to obtain payment for the care, and state a deadline after which such ECAs may be initiated. It will also include a Patient Billing and Financial Assistance Information Sheet. In addition, the hospital will make reasonable efforts to orally communicate the availability of Financial Assistance to the patient and tell the patient how he or she may obtain assistance with the application process.

5. Financial Hardship

a. The following guidelines are outlined as a separate, supplemental determination of Financial Assistance, known as Financial Hardship. Financial Hardship will be offered to all patients who apply for FA and are determined to be eligible. Medical Financial Hardship is available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy.
b. Financial Hardship Assistance is defined as facility charges incurred at UM UCH owned hospitals or physician practices for medically necessary treatment by a family household that exceeds 25% of the family's annual income. The Financial Assistance reduction will be the balance that exceeds the 25% of the family's annual income. Family annual income must be less than 500% of the Federal Poverty Limit
c. Once a patient is approved for Financial Hardship Assistance, coverage may be effective starting with the first qualifying date of service and the following twelve (12) months
d. Financial Hardship Assistance may cover the patient and the immediate family members living in the same household. Each family member may

be approved for the reduced cost and eligibility period for medically necessary treatment.

e. Coverage will not apply to elective or cosmetic procedures.
f. In order to continue in the program after the expiration of an eligibility period, each patient (family member) must reapply to be considered.
g. Patients who have been approved for the program should inform UM UCH of any changes in income, assets, expenses or family (household) status within 30 days of such changes. Patients determined to be eligible for Financial Hardship Assistance and granted an eligibility period extending into the future will be notified about how to apply for more generous assistance during such eligibility period.
h. All other eligibility, ineligibility and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance, unless otherwise stated
i. See Attachment A for the sliding scale reduced cost of care.

6. Amounts Generally Billed

a. An individual who is eligible for assistance under this policy for emergency or other medically necessary care will never be charged more than the amounts generally billed (AGB) to an individual who is not eligible for assistance. The charges to which a discount will apply are set by the State of Maryland's rate regulation agency (HSCRC) and are the same for all payers (i.e. commercial insurers, Medicare, Medicaid or self-pay).

Reviewed / Revised: 10/2018

ORIGIN DATE: 10/2010

NEXT REVIEW DATE: 10/2019

2/1/2019

% discount	MAX/MIN	Family 1	Family 2	Family 3	Family 4	Family 5	Family 6	Family 7	Family 8
Fed Pov Guideline		$12,490.00	$16,910.00	$21,330.00	$25,750.00	$30,170.00	$34,590.00	$39,010.00	$43,430.00
MHA Guidelines now at 200% of FPL									
100%	up to	$ 24,980.00	$ 33,820.00	$ 42,660.00	$ 51,500.00	$ 60,340.00	$ 69,180.00	$ 78,020.00	$ 86,860.00
90%	Min	$ 24,981.00	$ 33,821.00	$ 42,661.00	$ 51,501.00	$ 60,341.00	$ 69,181.00	$ 78,021.00	$ 86,861.00
	Max	$ 27,478.00	$ 37,202.00	$ 46,926.00	$ 56,650.00	$ 66,374.00	$ 76,098.00	$ 85,822.00	$ 95,546.00
80%	Min	$ 27,479.00	$ 37,203.00	$ 46,927.00	$ 56,651.00	$ 66,375.00	$ 76,099.00	$ 85,823.00	$ 95,547.00
	Max	$ 28,727.00	$ 38,893.00	$ 49,059.00	$ 59,225.00	$ 69,391.00	$ 79,557.00	$ 89,723.00	$ 99,889.00
70%	Min	$ 28,728.00	$ 38,894.00	$ 49,060.00	$ 59,226.00	$ 69,392.00	$ 79,558.00	$ 89,724.00	$ 99,890.00
	Max	$ 29,976.00	$ 40,584.00	$ 51,192.00	$ 61,800.00	$ 72,408.00	$ 83,016.00	$ 93,624.00	$ 104,232.00
60%	Min	$ 29,977.00	$ 40,585.00	$ 51,193.00	$ 61,801.00	$ 72,409.00	$ 83,017.00	$ 93,625.00	$ 104,233.00
	Max	$ 31,225.00	$ 42,275.00	$ 53,325.00	$ 64,375.00	$ 75,425.00	$ 86,475.00	$ 97,525.00	$ 108,575.00
50%	Min	$ 31,226.00	$ 42,276.00	$ 53,326.00	$ 64,376.00	$ 75,426.00	$ 86,476.00	$ 97,526.00	$ 108,576.00
	Max	$ 32,474.00	$ 43,966.00	$ 55,458.00	$ 66,950.00	$ 78,442.00	$ 89,934.00	$ 101,426.00	$ 112,918.00
40%	Min	$ 32,475.00	$ 43,967.00	$ 55,459.00	$ 66,951.00	$ 78,443.00	$ 89,935.00	$ 101,427.00	$ 112,919.00
	Max	$ 33,723.00	$ 45,657.00	$ 57,591.00	$ 69,525.00	$ 81,459.00	$ 93,393.00	$ 105,327.00	$ 117,261.00
30%	Min	$ 33,724.00	$ 45,658.00	$ 57,592.00	$ 69,526.00	$ 81,460.00	$ 93,394.00	$ 105,328.00	$ 117,262.00
	Max	$ 34,972.00	$ 47,348.00	$ 59,724.00	$ 72,100.00	$ 84,476.00	$ 96,852.00	$ 109,228.00	$ 121,604.00
20%	Min	$ 34,973.00	$ 47,349.00	$ 59,725.00	$ 72,101.00	$ 84,477.00	$ 96,853.00	$ 109,229.00	$ 121,605.00
	Max	$ 36,221.00	$ 49,039.00	$ 61,857.00	$ 74,675.00	$ 87,493.00	$ 100,311.00	$ 113,129.00	$ 125,947.00
10%	Min	$ 36,222.00	$ 49,040.00	$ 61,858.00	$ 74,676.00	$ 87,494.00	$ 100,312.00	$ 113,130.00	$ 125,948.00
	Max	$ 37,470.00	$ 50,730.00	$ 63,990.00	$ 77,250.00	$ 90,510.00	$ 103,770.00	$ 117,030.00	$ 130,290.00

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

UM Upper Chesapeake Health has a Financial Assistance Program based on financial need.

Please complete and return the attached form and required documents within 15 days.

This information will be held in the strictest confidence and is necessary to determine eligibility.

Within two (2) business days of receipt of the Financial Assistance Request, the hospital will make a determination of probable eligibility.

Thank you for choosing **UM Upper Chesapeake Health**

We would like to assist you with the **Financial Assistance** process. Please complete the attached form and return it to us **within 15 days** with the requested information from the list below. This information will be held in the strictest confidence and is necessary to determine eligibility. Within two (2) business days of receipt of the Financial Assistance Request, the hospital will make a determination of probable eligibility. If you are unable to provide this information within that time frame, please contact:

Financial Counselor
(443) 843-5092

In order for you to qualify for **Financial Assistance**, we are required to obtain the completed and signed application along with the following:

- **Copies of all pages of your last three (3) bank statements**
  - Must be copies of original bank statements showing bank's name and all account holders' names
  - Need copies for applicant and spouse
  - If there are deposits other than payroll, please provide an explanation
- **Copies of your last three (3) pay stubs**
  - Need copies for applicant and spouse
- **Copies of all pages of your current income tax return and W-2's**
- **Copies of any benefits you are receiving**
  - Social Security benefit letter
  - Unemployment notifications
  - Disability benefit letters
  - Proof of any public assistance
    - Food Stamps
    - WIC program
    - Primary Adult Care Program
    - Energy Assistance
    - Free or reduced lunch plans
- **If there is no income**, you will need to call me to obtain a copy of our Verification of No Income form

Please be assured that this information is necessary to determine your eligibility.

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Maryland State Uniform Financial Assistance Application

Information About You

Name: _____
First *Middle Initial* *Last*

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐ Marital Status: ☐ Single ☐ Married ☐ Separated

US Citizen: ☐ Yes ☐ No Permanent Resident: ☐ Yes ☐ No

Home Address: _____
Street Address
_____
City *State* *Zip code* *Country*

Home Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐
(Area Code) ### - ####

Employer Name & Address: _____
Employer Name
_____
Street Address
_____
City *State* *Zip code*

Work Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐
(Area Code) ### - ####

Household Members:

Name	*Age*	*Relationship*

Have you applied for Medical Assistance ☐ Yes ☐ No

If yes, what was the date you applied? ☐☐/☐☐/☐☐☐☐ *(MM/DD/YYYY)*

If yes, what was the determination?

Do you receive any type of state or county assistance? ☐ Yes ☐ No

If Yes, please attach a copy of your benefit letter as proof of this assistance.

Please return application to:
UM Upper Chesapeake Health
Patient Accounting Department
2027 Pulaski Highway, Suite 215
Havre de Grace, MD 21078

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals. Within two (2) business days following a patient's request for Financial Assistance the hospital will make a determination of probable eligibility.

	Monthly Amount
Employment	
Retirement/pension benefits	
Social security benefits	
Public assistance benefits	
Disability benefits	
Unemployment benefits	
Veterans benefits	
Alimony	
Rental property income	
Strike benefits	
Military allotment	
Farm or self employment	
Other income source:	
Total	

II. Liquid Assets

	Current Balance
Checking account	
Savings account	
Stocks, bonds, CD, or money market	
Other accounts	
Total	

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home :	Loan Balance:			Approximate value:	
Automobile:	Make:		Year:	Approximate value:	
Additional vehicle:	Make :		Year:	Approximate value:	
Additional vehicle:	Make:		Year:	Approximate value:	
Other property:				Approximate value:	
				Total	

IV. Monthly Expenses

	Amount
Rent or Mortgage	
Utilities	
Car payment(s)	
Credit card(s)	
Car insurance	
Health insurance	
Other medical expenses	
Other expenses	
Total	

Do you have any other unpaid medical bills? ☐ Yes ☐ No

For what service? _____

If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____

Applicant signature *Date* *Relationship to Patient*

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

UM Harford Memorial Hospital
443-843-5000
UM Upper Chesapeake Medical Center
443-643-1000

Help for Patients to Pay Hospital Care Costs

If you cannot pay for all or part of your care from our hospital, you may be able to get **free** or **lower cost** services.

PLEASE NOTE:

1. We treat all patients needing emergency care, no matter what they are able to pay.
2. There may be services provided by physicians or other providers that are not covered by the **hospital's** Financial Assistance Policy. For a **list of physicians** providing emergency and other medically necessary care in the hospital facility, whose services are not covered under this policy, please visit our website or contact our Financial Assistance Department at (443) 843-5092.
3. You will never be charged for emergency and other medically necessary care more than **amounts generally billed** to patients who are not eligible for financial assistance under the financial assistance policy. Rates are set by the State of Maryland.

HOW THE PROCESS WORKS:

When you become a patient, we ask if you have any health insurance. We will not charge you more for hospital services than we charge people with health insurance. The hospital will:

1. Give you information about our financial assistance policy or
2. Offer you help with a counselor who will help you with the application.

HOW WE REVIEW YOUR APPLICATION:

The hospital will look at your ability to pay for care. We look at your income and family size. You may receive free or lower costs of care if:

1. Your income or your family's total income is at 300% or less of the federal poverty level.
2. Your income or your family's income is at 500% or less of the federal poverty level **and** your medical debt incurred at an UMMS hospital facility exceeds 25% of your family's annual household income.

PLEASE NOTE: If you are able to get financial help, we will tell you how much you can get. If you are not able to get financial help, we will tell you why not.

HOW TO APPLY FOR FINANCIAL HELP:

1. Fill out a **Financial Assistance Application Form**. (see below for website address of application form)
2. Give us all of your information to help us understand your financial situation.
3. Turn the Application Form into us.

PLEASE NOTE: The hospital must screen patients for Medicaid before giving financial help. Cosmetic and other non-medically necessary services may not be covered.

OTHER HELPFUL INFORMATION:

1. You can get a **free copy** of our Financial Assistance Policy and Application Form:
- *Online* at www.umuch.org/patients/financial-assistance
- *In person* at UM Upper Chesapeake Health, 2027 Pulaski Highway Ste 215, Havre De Grace MD 21078
- *By mail* by calling (443) 843-5092 to request a copy.

2. You can call the Financial Assistance Department at (443) 843-5092 if you have questions or need help applying.
3. The FAP, FAP application or Plain Language Summary are also available in Spanish. If you need information translated in another language, please call (443) 843-5092.

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

UM Harford Memorial Hospital
443-843-5000
UM Upper Chesapeake Medical Center
443-643-1000

[f_Mis Current Date]

[f_Reg Guar Name Full]
[f_Reg Guarantor Address1]
[f_Reg Guarantor City], [f_Reg Guarantor State] [f_Reg Guarantor Zip]

Dear [f_Reg Guar Name Full]:

Thank you for returning your Financial Assistance application.

At this time, we have completed a preliminary review of your application and have determined that you did not return sufficient information with your application to allow us to complete the assessment of your eligibility. However, based on information we have received your eligibility for Financial Assistance is probable.

Therefore, if you would like for us to reconsider your application at this time, please return the requested information to us within **5 business days** to **University of Maryland Upper Chesapeake Health, Patient Accounting Department, 2027 Pulaski Highway, Suite 215, Havre de Grace, MD 21078.**

Missing or incomplete information: Account #: [f_Reg Account Number]

___ Three (3) most recent pay stubs
___ Three (3) most current bank statements (must be copies of original statements)
___ Explanation for deposits on bank statements
(explanations must be submitted in writing)
___ Proof of Retirement/Pension benefits
___ Proof of Social Security Income
___ Proof of Public Assistance benefits (WIC, PAC, Food Stamps, Energy Assistance)
___ Proof of Disability benefits
___ Proof of Unemployment benefits
___ Proof of Veteran's benefits
___ Proof of Alimony/Child Support
___ Most current Tax Return including W-2's
___ Verification of No Income form
___ Applicant's signature on form
___ Proof of insurance (copy of insurance card)
___ Other _____

Please feel free to contact me directly Monday through Friday at (443) 843-5092 with any questions.

If the requested information is not available, please contact our **Billing Office at 855-748-0680 within 5 business days** on Monday through Thursday from 8am to 8pm or Friday from 8am to 4:30pm to set up an acceptable payment plan. We would like to continue to work with you to clear this account as soon as possible.

Thank you for your continued cooperation.

Sincerely,

Financial Counselor

NOTICE

University of Maryland Upper Chesapeake Health maintains accessibility to all emergency and other medically-necessary services regardless of an individual's ability to pay. The hospital's financial assistance policy will consider free or discounted care for those patients who cannot pay the total cost of hospitalization due to lack of insurance coverage and/or inability to pay. For more information on our financial assistance policy for patients who qualify for help with their hospital bills, or if you require translation services to understand this policy, please call 443-843-5092 or visit us at umuch.org.

AGF 3-2600 March 1 6163214

EXHIBIT 17

COMMUNITY HEALTH NEEDS ASSESSMENT

JULY 2018

Public Health
Prevent. Promote. Protect.
Harford County Health Department

University of Maryland Upper Chesapeake Health

Healthy Harford
LIVE WELL. BE WELL.

Index

I.	Executive Summary	2
II.	Acknowledgments and Overview	5
III.	Methodology	7
IV.	Local Planning Initiatives	8
V.	Harford County Fast Facts	9
VI.	Demographic Profile	10
VII.	Social and Physical Environment	13
VIII.	Health Behaviors	21
IX.	Health Outcomes	25
X.	Access to Healthcare	35
XI.	Online Community Health Survey	40
XII.	References	60

"Your zip code is a better predictor of your health than your genetic code..."

Melody Goodman, Assistant Professor, Washington University

Executive Summary

The Harford County Community Health Needs Assessment is a reflective assessment of the health status of Harford County. Assessments are an important component of meeting local community health needs and are used to inform decisions about public health strategies to improve the health, safety, and environment for Harford County residents. This assessment builds on previous efforts to identify and quantify public health concerns. It is a collaborative process that reports health indicator statistics and community stakeholder input in order to identify and prioritize our community health needs, areas for health improvement, and resources that can be mobilized to improve community health.

The Community Health Needs Assessment describes the health status of Harford County residents, as individuals and as population groups, and provides population comparisons to residents of Maryland and to the nation as a whole. It also examines trends in health indicators of County residents over time, highlights racial and geographic disparities, and identifies areas of poverty and at-risk populations which will provide a basis for public health planning. Data in this assessment comes from a variety of National and State sources, including, but not limited to, the United States Census Bureau, Maryland State Health Improvement Plan, Maryland Vital Statistics, the Maryland Behavioral Risk Factor Surveillance Survey, the Injuries in Maryland report, and national County Health Rankings.

The Harford County Community Health Needs Assessment (CHNA) is a compilation of secondary statistical data, key informant feedback, an online community survey, and focus group input.
This assessment reflects the current status of the medical and social determinants of health for Harford County residents, and provides qualitative feedback on key health issues. Based on information provided in this report, the Harford County Local Health Improvement Coalition (LHIC) and the University of Maryland Upper Chesapeake Health (UMUCH) have prioritized the following health concerns in order of importance: **Behavioral Health, Prevention and Wellness, and Family Stability and Wellness**.

Harford County Profile: Harford County is a relatively well educated affluent community located northwest of the city of Baltimore. With a population of close to a quarter million people, Harford County has grown from a primarily agricultural community to a more suburban environment whose main employers include: the Department of Defense Aberdeen Proving Ground and supporting contractors, the University of Maryland Upper Chesapeake Health, and local government/schools. The typical profile of a Harford County resident is a white (79.8%), employed (64.1%), high school graduate

(92.8%), who drives themselves to work (83.4%). Overall, while indicators of education and employment depict a prosperous community, persistent pockets of poverty exist both geographically, and along racial and gender lines. In Harford County, black households have a lower median income when compared to white; blacks are more than twice as likely to be poor; and women earn disproportionately lower incomes than men, presenting a particular poverty issue for female-headed households. Given the high rate of people who own cars, public transportation for those without access to vehicles remains a persistent problem.

Key Findings Regarding the Prioritization of Behavioral Health, Prevention and Wellness, and Family Stability and Wellness

Behavioral Health (Mental Health/Addictions): The suicide rate of a community is considered to be a key indicator of its mental health status. Harford County's rate of 12.3 per 100,000 population far exceeds the 9.2 rate for the state of Maryland. According to the Maryland Behavioral Risk Factor Surveillance System (BRFSS) for 2013-2015, 21% of Harford County residents have been diagnosed with depressive disorder, compared to 16.1% for the state. In addition, 18.2% of high school students reported that they have seriously considered attempting suicide. While approximately 96% of Harford County residents are insured, there is a notable lack of mental health care providers to meet community
needs. As such the Health Resources and Service Administration has designated all of Harford County as a Health Professional Shortage Area (HPSA) for mental health services.

Since 2007 the number of drug and alcohol-related intoxication deaths has more than doubled in both Maryland and Harford County. The numbers of drug-related law enforcement incidents and overdose calls have also increased dramatically since 2011, by 57% and 95% respectively. Another indicator of the severity of the addiction problem in Harford County is the number of substance-exposed newborns (SEN) born in the community. Between 2000 and 2016, Harford County has experienced an eightfold increase in the rate of hospital encounters for newborns with maternal drug/alcohol exposure. This not only indicates an increase in substance abuse but also a lack of treatment access.

Prevention and Wellness: As a whole, Harford County residents have access to a better food environment and greater access to exercise opportunities when compared to the state and the nation, however despite greater opportunities to engage in healthy behaviors regarding nutrition and exercise, Harford County adults are just as likely or more likely to be obese or overweight (72.4%) and physically inactive (26.3%) as the rest of the State. In addition, tobacco use is high among both adults (20.7%) and youth (16.9%) which correlates with high rates of chronic obstructive pulmonary disease (COPD) and lung cancer. Even more concerning is the high rate of students reporting they currently use electronic vapor products (24.6%), and the total percentage of students (32.1%) using any type of tobacco product (burned, smokeless, or electronic). Obesity, insufficient physical exercise, and tobacco use are some of the biggest drivers of preventable chronic diseases and increased risk for many health conditions. Obesity, often a symptom of diet and exercise, can have a tremendous impact on health and wellbeing.

Black adults were almost twice as likely to be obese than white adults, and adults without a high school diploma were almost twice as likely to be obese than their college graduate counterparts. As such minority and low-income families are disproportionately negatively affected.

The top five causes of death in Harford County are cancer, heart disease, chronic obstructive pulmonary disease, stroke, and accidents which are consistent with the state and the nation. The role of accidents as the fifth leading cause of death is a relatively new phenomenon that could likely be attributed to the growing opioid epidemic and accidental overdoses, as well as an aging population.

Family Stability and Wellness: While the majority of babies in Harford County are born into married families (69.4%) to mothers over the age of 20 (96.5%), there are significant ethnic and racial disparities. Most concerning is the significantly higher number of low birth weight babies born to black women (12.1%) as compared to white (7.6%), and the 2.5 times higher rate of infant mortality for black babies (14.4 per 1,000 births) as compared to white (4.8 per 1,000 births).

The percentage of mothers receiving prenatal care in the first trimester in Harford County is 71.%, however when broken down along racial and ethnic lines the percentage of non-white mothers receiving prenatal care in the first trimester is significantly lower. According to 2016 Maryland Vital Statistics, 74.8% of white women received prenatal care in the first trimester, while only 59.7% of black women and 60.3% of Hispanic women did. The lack of prenatal care and the potentially negative health outcomes for newborns can have long-lasting detrimental developmental effects, including school readiness and long-term health complications.

While Harford County's violent crime and property crime rate are much lower than the state rate, crime and the resulting incarceration disproportionally affect low-income areas. In Harford County, the city of Aberdeen, one of the community's lowest income areas, has a significantly higher rate of overall and violent crime rate than the surrounding municipalities.

This community assessment is a result of the shared goal of the partnership and the dedication of University of Maryland Upper Chesapeake Health, Harford County Health Department, and Healthy Harford to create a healthier Harford County.

Acknowledgments and Overview

University of Maryland Upper Chesapeake Health

Mission
University of Maryland Upper Chesapeake Health is dedicated to maintaining and improving the health of the people in its communities through an integrated health delivery system that provides high-quality care to all. University of Maryland Upper Chesapeake Health is committed to service excellence as it offers a broad range of healthcare services, technology and facilities. It will work collaboratively with its communities and other health organizations to serve as a resource for health promotion and education.

Vision
The Vision of University of Maryland Upper Chesapeake Health is to become the preferred, integrated healthcare system creating the healthiest community in Maryland.

The University of Maryland Upper Chesapeake Health (UMUCH) is a community based, integrated, non-profit health system. The vision of UMUCH is to become the preferred, integrated healthcare system creating the healthiest community in Maryland. UMUCH is dedicated to maintaining and improving the health of the people in northeastern Maryland through an integrated health delivery system that provides high-quality care to all. Their commitment to service excellence is evident through a broad range of healthcare services, technologies, and facilities. They work collaboratively with the community and other health organizations to serve as a resource for health promotion and education.

Presently, UMUCH is the leading healthcare system and second largest private employer in Harford County, employing 3,500 team members and over 650 medical staff physicians.

Major centers and services include two acute care hospitals – UM Upper Chesapeake Medical Center in Bel Air and UM Harford Memorial Hospital in Havre de Grace. As part of the Bel Air campus, UMUCH also operates the Klein Ambulatory Care Center, two medical offices, and the Patricia D. and M. Scot Kaufman Cancer Center. UMUCH also owns and operates the Senator Bob Hooper House Hospice Center, provides community outreach, health screenings and educational programs through the HealthLink Community Outreach.

A combined facility to treat mental health and opioid addiction issues is expected to open Summer 2018 in Bel Air. The Behavioral Health Crisis Center will offer walk-in crisis services, a 24/7 call/triage center and, eventually, residential crisis beds.

As part of Vision 2020, UMUCH is moving towards replacing the downtown Havre de Grace UM Harford Memorial Hospital with a new modern freestanding medical facility, an expanded Behavioral Health Pavilion and psychiatric specialty hospital on their 97-acre property off of I95 and Rt 155. Included in this vision is the expansion of medical/surgical beds above the Kaufman Cancer Center as well as additional parking on the Bel Air campus.

Harford County Health Department

The Harford County Health Department (HCHD) is the local operating arm of the Maryland Department of Health (MDH). As such, it is governed by State rules but reports locally to the Harford County Council, which functions as the Harford County Board of Health. The health department's mission is to protect and promote the health, safety, and environment of the citizens of Harford County through community assessment, education, collaboration and assurance of services. Employing over 170 employees, the health department provides services in Havre de Grace, Aberdeen, Bel Air, and Edgewood. The health department is responsible for the delivery of a wide range of preventive health care, clinical services, and environmental health services to citizens living in Harford County. Its six major bureaus include:

Public Health
Prevent. Promote. Protect.
Harford County Health Department

1. Administration
2. Behavioral Health
3. Care Coordination
4. Clinical Health
5. Environmental Health
6. Family Health

Healthy Harford

Healthy Harford is the healthy communities initiative of Harford County, dedicated to the health and wellness of the northern Chesapeake community. Founded in 1993 as a non-profit 501c3 by leaders from University of Maryland Upper Chesapeake Health, the Harford County Health Department, and Harford County Government, Healthy Harford is a coalition of local government agencies, businesses, non-profits, and citizens dedicated to improving the health of Harford County residents through education, policy changes, improvements in the built environment, increased access to care, and improved care coordination for people with chronic illness.

Healthy Harford
LIVE WELL. BE WELL.

Healthy Harford's mission is to inspire and empower healthy people, healthy families, and healthy communities in mind, body, and spirit, with a focus of improving health and wellness in the Harford County region by promoting healthy lifestyles, building community partnerships, and proving care coordination.

Methodology

The CHNA was comprised of both quantitative and qualitative research components. A brief synopsis of the research components is included below with further details provided throughout the document.

Quantitative Data: Existing Secondary Data

A Statistical Secondary Data Profile depicting population and household statistics, education, and economic measures, morbidity rates, incident rates, and other health statistics for the Harford County community was compiled from publicly available sources. It should be noted that the availability of and lag time of secondary data may present some research limitations.

Harford County Community Health Survey

An online Community Survey of Harford County residents was conducted between October 2017 and February 2018. The survey was designed to assess health status, health risk and behaviors, preventative health practices, and health care access primarily related to chronic disease and injury. A total of 1,741 resident surveys were completed, representing the geographical, gender, and ethnic diversity of the community.

Qualitative Data: Community Forum and Focus Groups

In order to gain a better understanding of the Harford County community, qualitative data was collected via the Local Health Improvement Coalition (LHIC) Community Forum meeting, as well as through a series of targeted focus groups.

At the October 2017 LHIC Community Forum meeting twenty-eight stakeholder organizations representing diverse community interests discussed health and social determinants. These stakeholders provided particular insight into the challenges facing the medically under-served, low income, marginalized, and minority populations.

In addition, four focus groups were convened to gather the input of targeted groups. These focus groups included members of faith-based organizations; Emergency Medical System (EMS) personnel; participants from the EpiCenter (a community center in a predominantly low-income minority community); and residents living with chronic disease.

Local Planning Initiatives

Local Health Improvement Coalition (LHIC)

In an effort to improve the health of all Marylanders, the Maryland Department of Health (MDH), through the office of Population Health Improvement, launched the State Health Improvement Process (SHIP). This initiative focuses on health priorities, both statewide and in each jurisdiction, and provides a framework for accountability, local action, and public engagement. SHIP measures are aligned with the national Healthy People 2020 objectives established by the Department of Health and Human Services, and target state goals set by the MDH.

Using the SHIP framework, each of the 24 Maryland jurisdictions is responsible for convening a Local Health Improvement Coalition (LHIC) comprised of community stakeholders to determine local health priorities. The Harford County Health Department is the local LHIC lead entity for Harford County.

In October of 2017, 28 stakeholder organizations from the Harford County community met at Harford Community College to evaluate community health goals for the next 3 to 5 years. In a half day Community Forum focusing on current health statistics, social determinants of health and their community impact, and current community challenges, three health priorities emerged: Behavioral Health, Chronic Disease Prevention/Wellness, and Family Health/Resiliency. LHIC Workgroups addressing these priorities were formed, and these groups will develop and implement the new Harford County Local Health Action Plan for addressing these priorities.

Harford County Fast Facts

Measure	Harford	Maryland
Median Age	40.3	38.3
Only English spoken at home	93.1%	82.4%
Married and living together	56.4%	47.7%
Average family size	3.17	3.26
Median household income	$81,052	$76,067
Mean household income	$96,509	$100,071
Female householder no husband	11.3%	14.3%
People in poverty	7.7%	9.9%
Female headed households with children under 5 in poverty	44.3%	29.9%
Unemployment rate	6.0%	6.7%
Drive alone to work	83.4%	73.7%
Mean travel time to work	31.6 minutes	32.4 minutes
Have health insurance	95.4%	91.9%
Top causes of mortality	Cancer Heart Disease COPD	Heart Disease Cancer Stroke
Low birth weight babies for white mothers	6.4%	6.6%
Low birth weight babies for African American mothers	12.1%	12.1%
Lyme Disease rate per 100,000	69.4	21.2
Suicide rate per 100,000	12.3	9.2
Age-adjusted death rate for all causes per 100,000	732.0	706.7
Adult that currently smoke	20.7%	15.1%
Percentage of high school graduates	92.8%	89.6%
Percentage of college graduates	34.5%	38.4%

Demographic Profile

The demographic composition of Harford County's population is critical to understanding the health of the community because characteristics such as age, gender, race, and ethnicity all have an impact on people's health. The distribution of these characteristics across the county is helpful in determining the number and types of resources that are needed to ensure the optimum health and well-being of the population.

Population

In 2016, the total population of Harford County was estimated to be 249,776, which was an increase of 2.0% from 2010 (244,826). The county is located in the northeastern part of the state, with the towns and cities of varying sizes, wealth, and diversity. Bel Air is Harford's county seat, home to roughly 10,109 residents, or 4% of the county's population. The cities of Aberdeen and Havre de Grace each make up 6% and 5%, respectively. The remaining 75% of the county's population is mostly distributed along the Route 40 corridor and in rural parts of the county. The table below illustrates the change in population size for Maryland, Harford County, and selected zip codes.

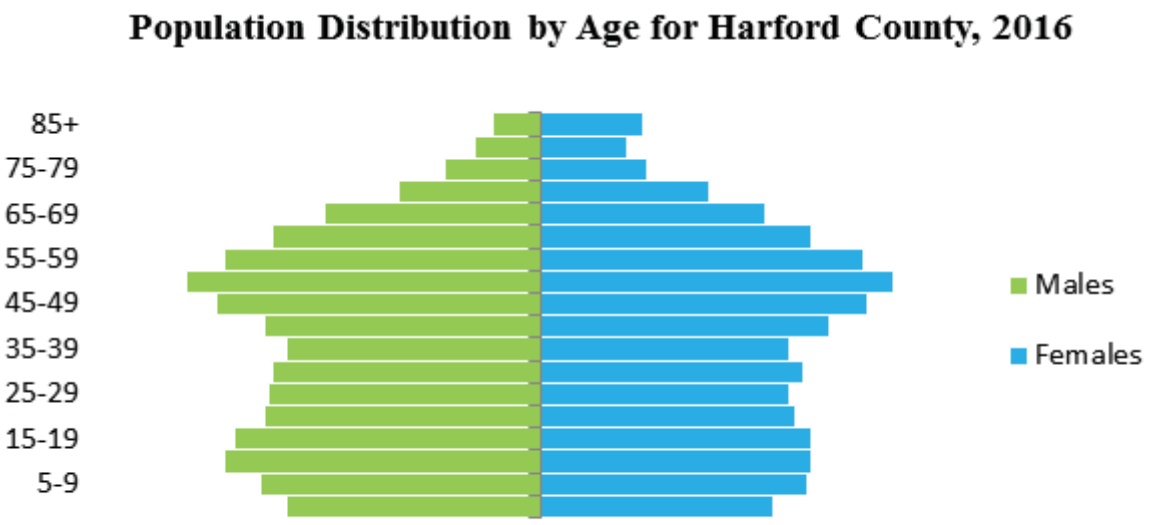
Change in Population Size 2012-2016, Maryland and Harford County

	2010 Population	2016 Population	Change in Population
Maryland	5,773,552	5,959,902	↑ 3.2%
Harford County	244,826	249,776	↑ 2.0%
Edgewood (21040)	24,420	24,590	↑ 0.7%
Aberdeen (21001)	21,487	24,470	↑ 13.9%
Havre de Grace (21078)	17,603	17,844	↑ 1.4%

Source: US Census Bureau, American Community Survey 5-Year Estimates

Age Distribution

Data on age can be used to determine the distribution of age-appropriate services throughout the county, such as those specifically designed for children or seniors. The population pyramid below provides a breakdown of Harford County residents by age and sex. The median age in Harford County is 38.6 for males and 41.3 for females, with the age category containing the largest percentage of the population being adults ages 50-54. The distribution of the population pyramid is close to the distribution of age and sex in the United States, although the county has a slightly lower percentage of younger people and a higher percentage of middle-aged adults.



Source: US Census Bureau, American Community Survey 5-Year Estimates

Racial and Ethnic Diversity

Data on the racial and ethnic diversity of a population can help healthcare organizations create culturally competent health care services and deliverables. For example, 6.9% of Harford County residents reported speaking a language other than English at home. Race is also a social determinant of health and is a contributing factor to health inequities.

The table below illustrates the substantial variation in the levels of racial and ethnic diversity across Harford County. While whites make up the majority of Harford County's population, the percentages of African Americans and Hispanic/Latino residents are increasing in both Edgewood and Aberdeen. Since 2010, the populations of these two zip codes have started to more closely reflect the demographics found across the state of Maryland, while the racial composition of Havre de Grace has remained relatively stable over time.

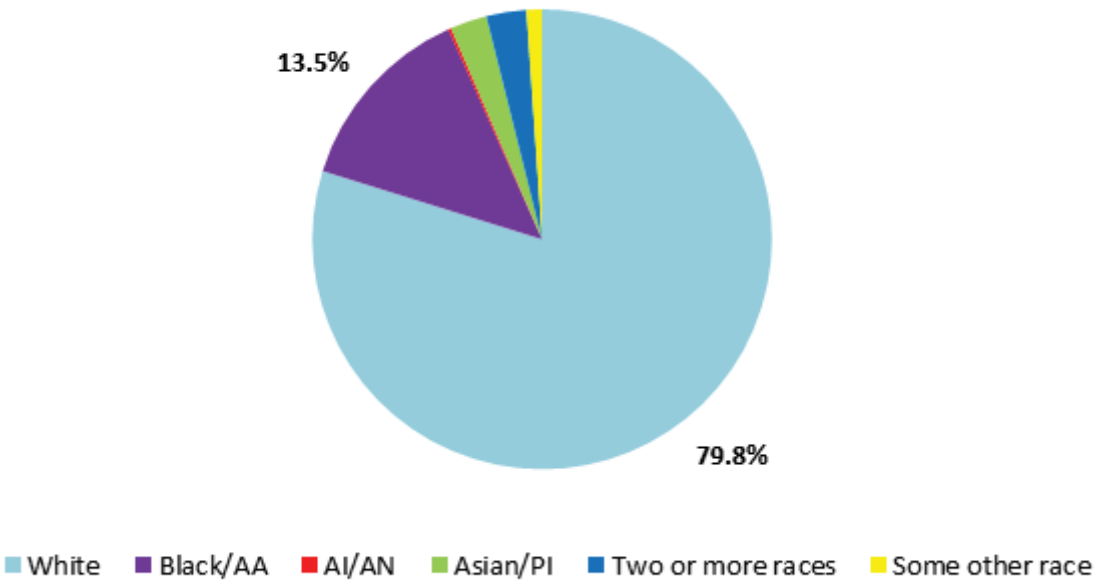
Race/Ethnicity Distribution for Maryland, Harford County, and Selected Zip Codes

Race/Ethnicity	Maryland	Harford	Edgewood	Aberdeen	HdG
White	57.2%	79.8%	48.3%	60.3%	77.0%
Black/African American	29.6%	13.5%	40.6%	30.6%	15.3%
American Indian/ Alaska Native	0.3%	0.2%	0.1%	0.3%	0.4%
Asian/Pacific Islander	6.1%	2.6%	1.0%	3.6%	4.2%
Two or More Races	3.1%	2.8%	5.8%	3.8%	2.8%
Hispanic/Latino	9.2%	10.0%	7.4%	5.8%	3.3%

**Hispanic/Latino respondents can be of any race*

Source: US Census Bureau 2012-2016 ACS Demographic and Housing Estimates

2016 Racial/Ethnic Distribution in Harford County

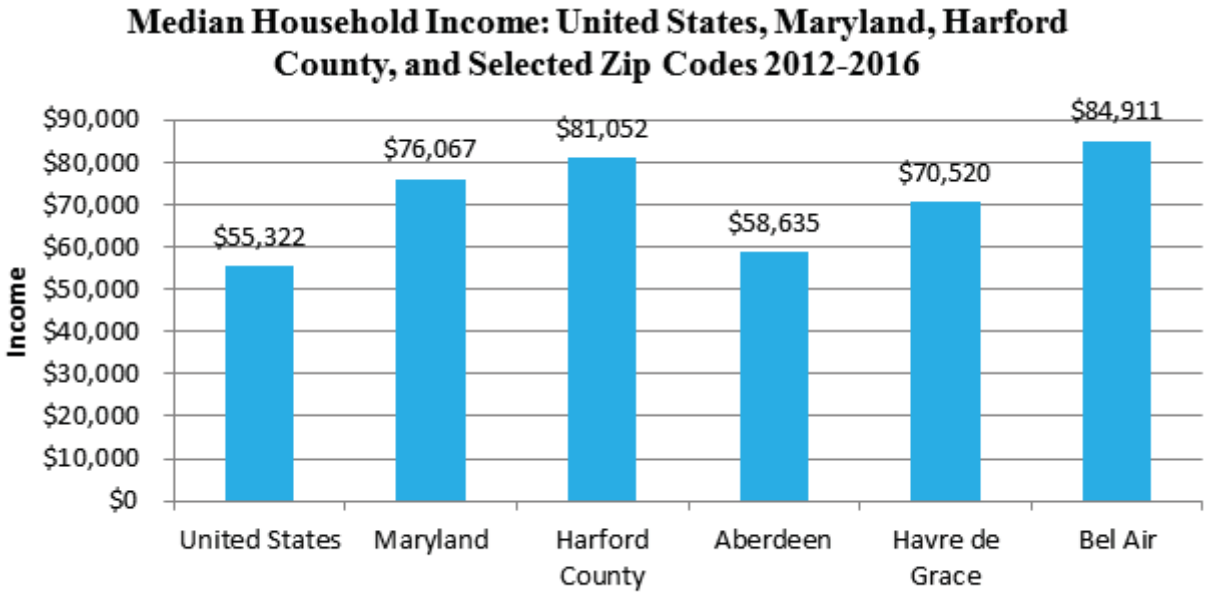


Source: US Census Bureau 2012-2016 ACS Demographic and Housing Estimates

Social & Physical Environment

Income and Poverty

When compared to the United States, Maryland is a wealthy state, with a median household income ($76,067), well above the nation's ($53,889). Harford County is one of Maryland's wealthier jurisdictions, with a median household income of $81,052. However, the county's higher income is not distributed equally across the county: the three municipalities in Harford County have vastly different median incomes, with the city of Aberdeen having the lowest ($58,635), followed by Havre de Grace ($70,520) and Bel Air ($84,911) (U.S. Census Bureau, 2016 American Community Survey 5-year estimates).



Source: U.S. Census Bureau, 2012-2016 American Community Survey

Percentages provided in the 2008-2010 American Community Survey, 3-year estimates (U.S. Census Bureau) indicate that the poverty rate in Harford County families has increased, climbing from 4% to 6%, in line with an increase in Maryland's poverty rate (5.7% to the recent estimate of 7%) (U.S. Census Bureau, 2016 American Community Survey 5-year estimates).

Harford County poverty rates for White and Black families are starkly different: the percentage of families with a householder who is White has an estimated poverty level of 5.1% while families with a Black or African American householder has a poverty level of 14.3% (U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates).

Percentage of families whose income in the past 12 months is below the poverty level for Maryland, Harford, and Selected Zip Codes 2012-2016

Jurisdiction	Percent
Maryland	6.8%
Harford County	5.8%
Aberdeen	10.2%
Bel Air	2.8%
Havre de Grace	5.9%

Source: U.S. Census Bureau, 2012-2016 American Community Survey

The disparity in household incomes in Harford County and the cities of Aberdeen and Havre de Grace is consistent with the percentage of families whose income is below the poverty level. Both in Maryland and in Harford County, poverty rates are highest in families headed by a female and for families with related children under 18 years of age. Harford County has a slightly higher poverty rate among families with a female head when compared to Maryland, and a slightly lower rate for people age 65 and over. Poverty rates for families are distributed unequally across the county, with almost a third of families with a female head and close to one-quarter of related children below the poverty level in Aberdeen. The poverty rates in Harford County are reflected in the percentage of families receiving food stamps, with Aberdeen having the highest percentage of families and the town of Bel Air having the lowest.

Households with Food Stamp/SNAP Benefits in Past 12 Months for Maryland, Harford and Selected Zip Codes, 2012-2016

Jurisdiction	Percentage
Maryland	11.1%
Harford County	8.7%
Aberdeen	17.5%
Bel Air	4.2%
Havre de Grace	11.7%

Source: U.S. Census Bureau, 2016 American Community Survey

The percentage of households in Harford County receiving food stamps has increased by 3% since the 2008-2010 American Community Survey; 3-year estimates (U.S. Census Bureau) reported that 5% of Harford County households were food stamp recipients, consistent with the increase in the poverty level in the County.

Education and Employment

Harford County Public School District has 54 schools, including 7 Title I elementary schools, with the mission to ensure academic achievement for at-risk students attending schools in high poverty areas. All 7 are located in the southern portion of the County: three in Aberdeen, and one each in Edgewood, Havre de Grace, Joppa, and Abingdon (http://www.hcps.org/schools/).

Harford County Public Schools had a total of 37,448 students in the 2016-2017 school year. The high school graduation rate was 89.09%, slightly higher than Maryland's rate of 87.61% (http://reportcard.msde.maryland.gov/). According to Schooldigger, an organization that calculates school rankings based on test scores released by the Maryland Department of Education, Harford County Public Schools ranked 7th best out of the 24 public school systems in Maryland in 2016. This was a drop from 5th best in 2015 (https://www.schooldigger.com/go/MD/districtrank.aspx).

In 2016, 92.8 % of people 25 years and over in Harford County had at least graduated from high school and 34.5% had a bachelor's degree or higher. An estimated 7.2% did not complete high school. In comparison, in the town with the highest level of poverty, Aberdeen, an estimated 12.4% did not complete high school, and only 21.3% had college degrees.

2016 Percent Educational Attainment of Population 25 Years and Over, Harford County and Selected Zip Codes

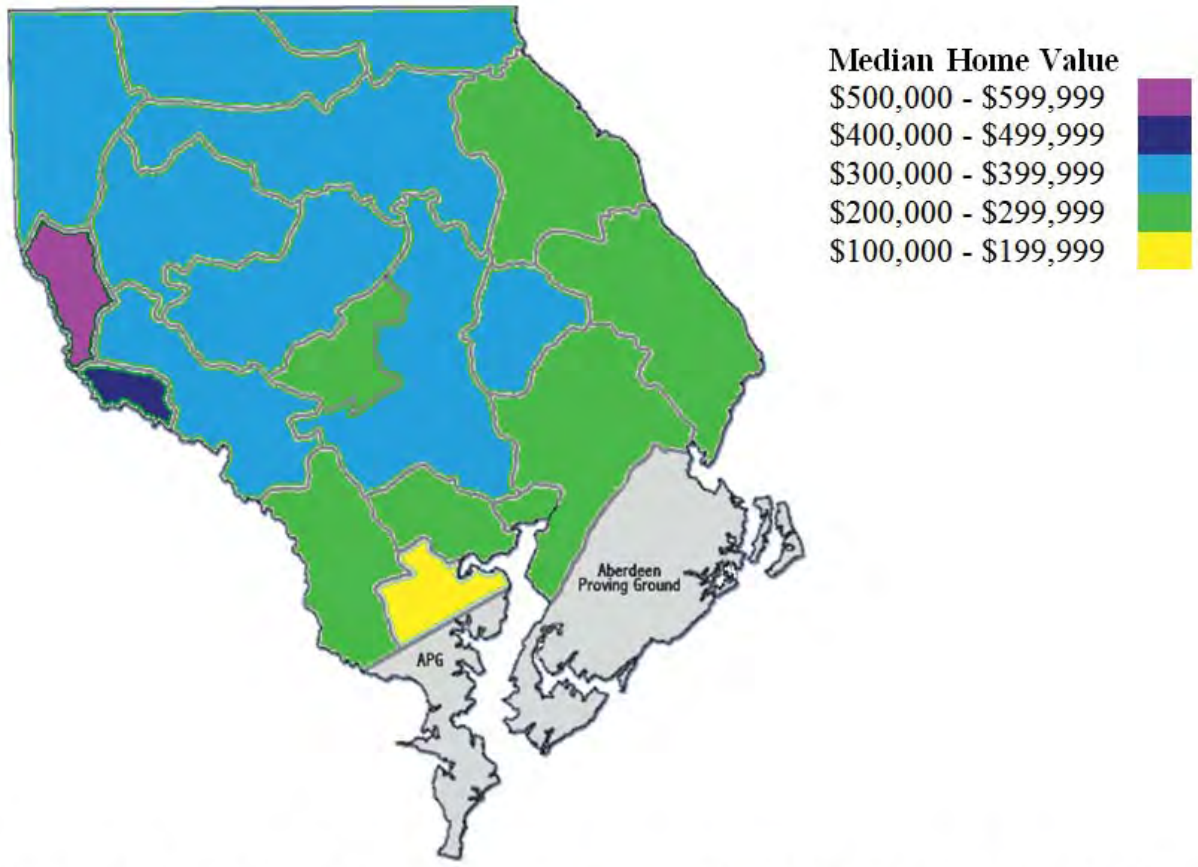
Educational Attainment	Harford	Aberdeen	Edgewood	HdG
Less than High school diploma	7.2	12.4	11.0	9.8
High school diploma or equivalency	27.8	32.7	34.7	27.4
Some college, no degree	22.4	26.6	28.5	20.5
Associate's degree	8.1	7.0	9.0	6.6
Bachelor's degree	20.7	13.9	10.4	20.6
Graduate or Professional degree	13.8	7.4	6.3	15.1

Source: U.S. Census Bureau, 2012-2016 American Community Survey

In Harford County, 64.1% of the population age 16 and over was employed; 31.0% were not currently in the labor force. An estimated 74.6% of the people employed were private wage and salary workers; 21% were federal, state, or local government workers; and 4.3% were self-employed in their own (not incorporated) business (U.S. Census Bureau, 2012-2016 American Community Survey).

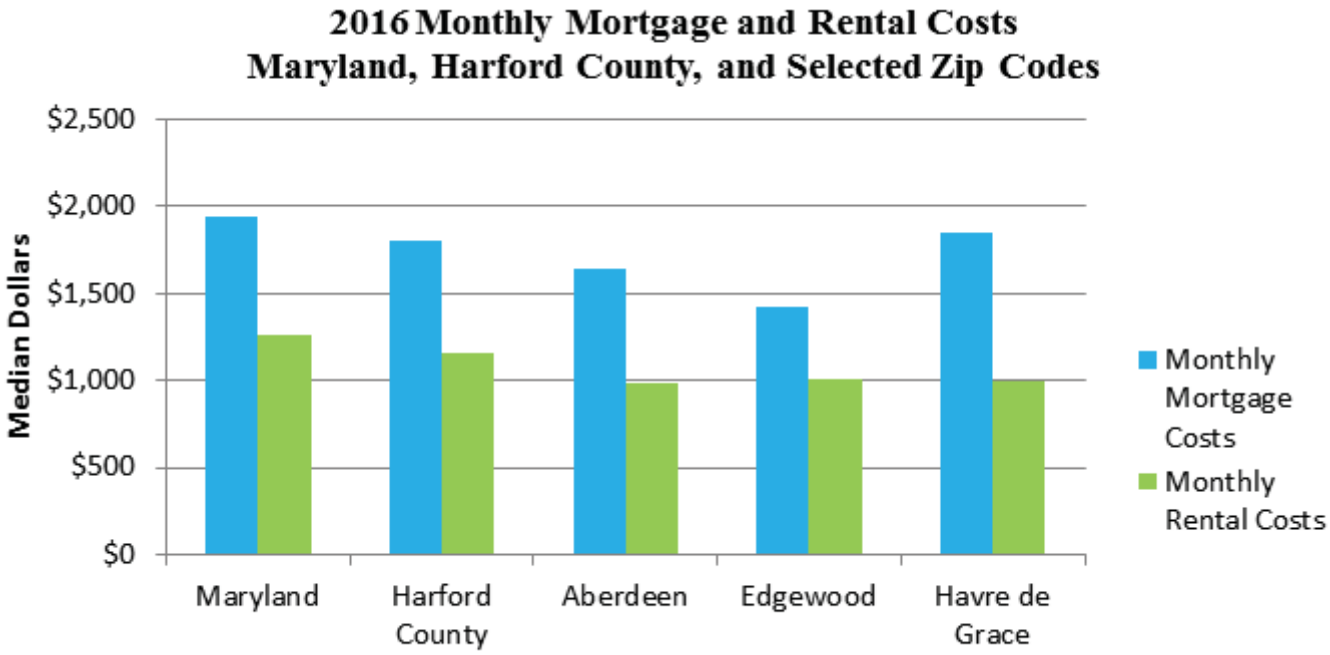
Housing and Transportation

While the median value of homes in Harford County ($278,500) is only slightly less than Maryland's ($286,900), the difference when considering housing prices by zip code is dramatic. Prices range from below the state value in the Edgewood area, where the median home value is $162,900, to well above the state in the Monkton area, where the median home costs $563,300. The following map shows median home values by zip code.



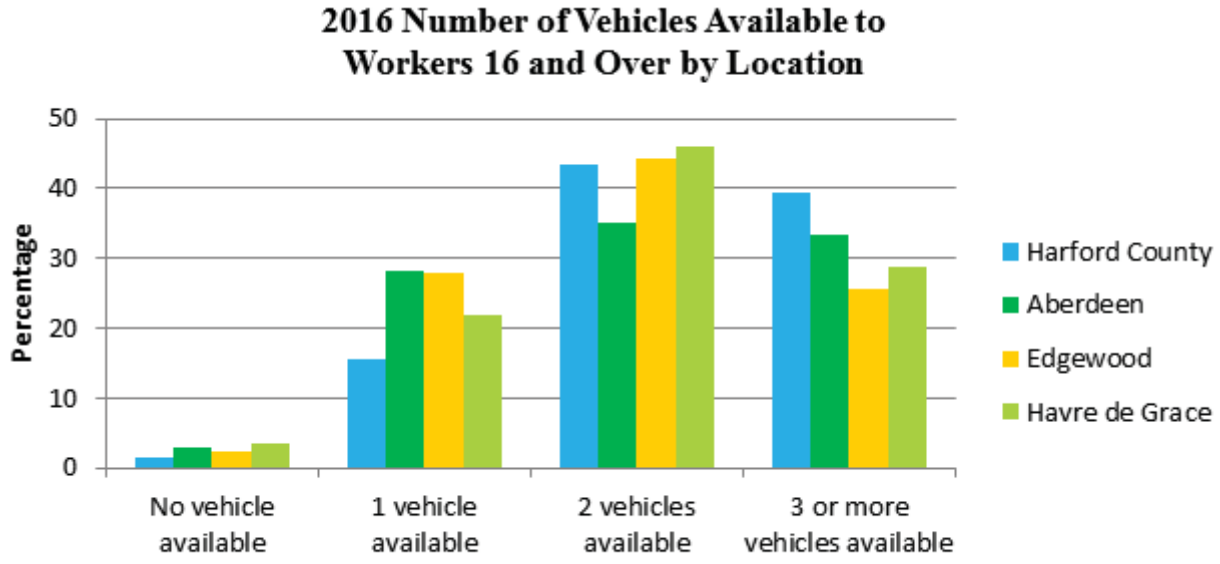
Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates, Median Value

Rental costs must also be taken into account when assessing the housing landscape of a community. The following table shows monthly mortgage and rental costs for Maryland, Harford County, and selected zip codes from the U.S. Census Bureau.



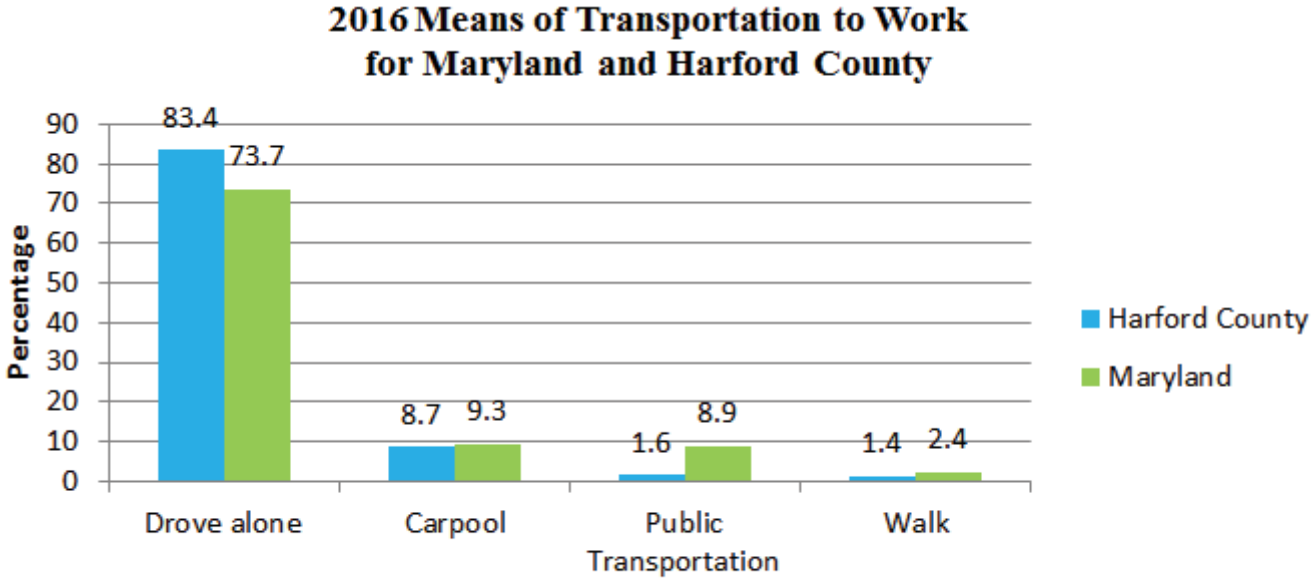
Source: U.S. Census Bureau, 2016 American Community Survey 5-Year Estimates

Transportation is also a concern in many parts of the county, especially for seniors, youth, and low-income individuals in the rural areas of northern Harford County. Amenities such as shopping, entertainment, and health services are often far away, and there are few public transportation options. The bus service has limited hours and routes making it difficult for those without cars to access them. Data show that 1.6% of residents in the county have no access to a vehicle, with that number reaching 3.4% in Havre de Grace. The table below shows vehicle availability for households in select zip codes for the county.



Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

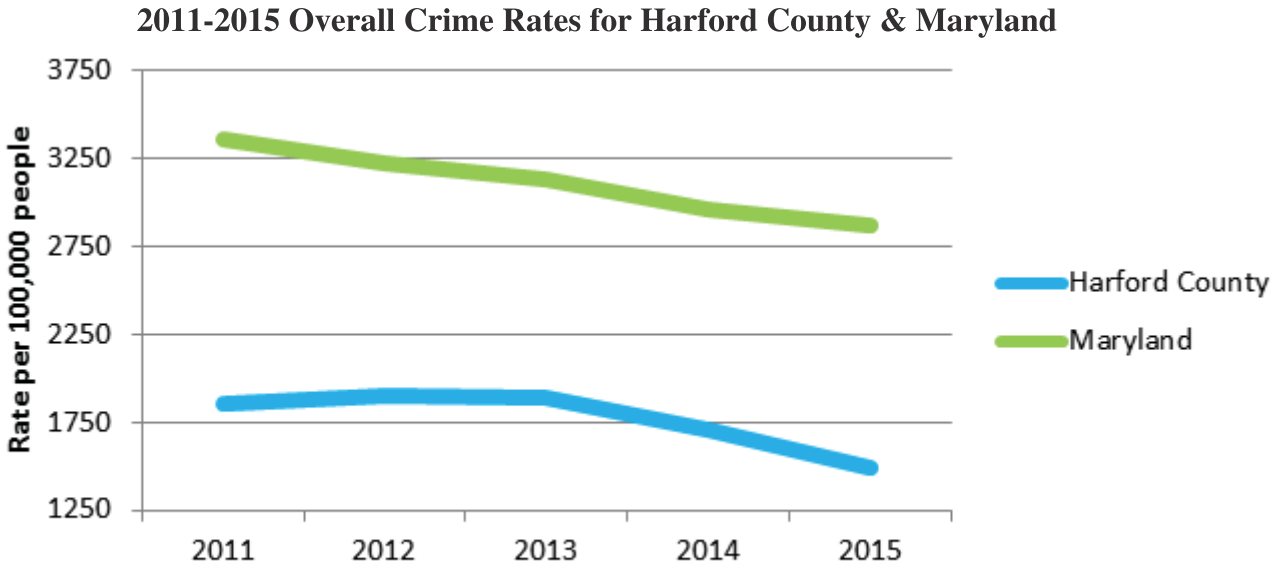
In addition, 45% of county residents work outside of Harford County, either in a different Maryland county or another state. The following table shows means of transportation to work for Maryland and Harford County. Notice that 83.8% of residents drove alone to work and only 9.1% carpooled. With limited availability of public transport throughout the county, only 1.7% of residents use public transportation when compared to 9% of Maryland residents.



Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

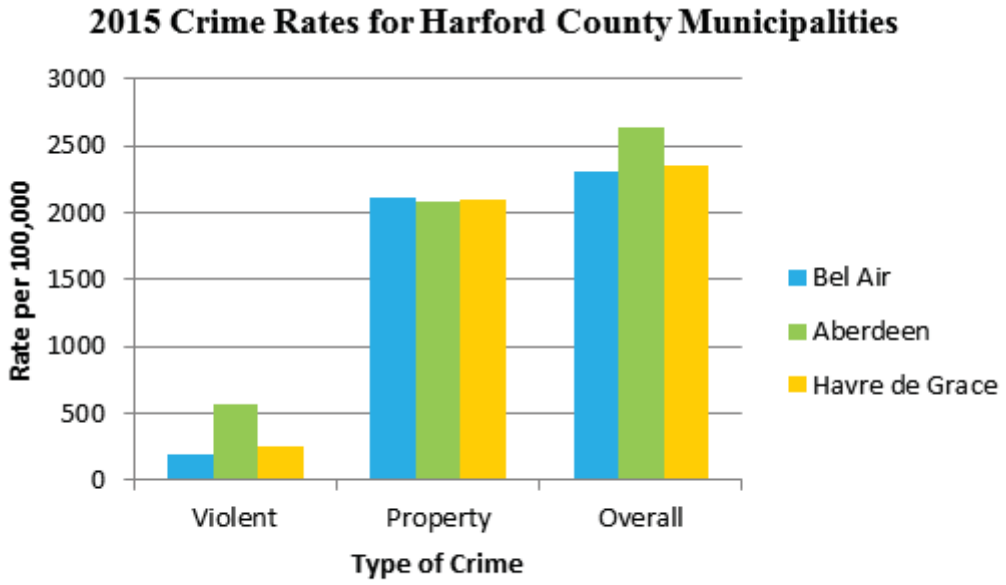
Crime

In 2015, Harford County had an annual violent crime rate of 239 per 100,000 people, which is much lower than Maryland's rate of 471. Similarly, the rate of property crime in Harford County was lower than the state's at 1,257 per 100,000 when compared to 2,395. The chart below shows the overall crime rates in both Harford County and Maryland; both have been decreasing since 2011.



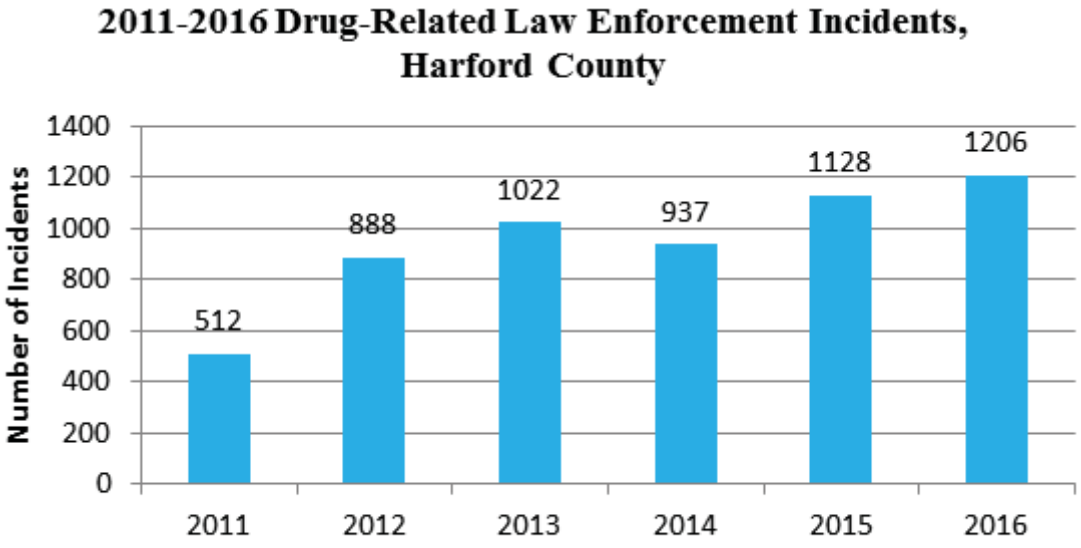
Source: Maryland Crime Data from the Governor's Office of Crime Control & Prevention

The chart below shows the violent, property, and overall crime rates for the towns of Bel Air, Aberdeen, and Havre de Grace. The violent and overall crime rates in Aberdeen are significantly higher than the county's as a whole (565), illustrating the inequity in living conditions for families residing in this area.



Source: Maryland Crime Data from the Governor's Office of Crime Control & Prevention

Despite the dramatic decreases in both violent crime and property crime in Harford County and throughout the state, the number of drug-related incidents reported by the Harford County Sheriff's Office has increased by 136% from 2011 to 2016. This growing trend has shifted the focus of law enforcement to combat the drug crisis in Harford County.



Source: Harford County Sheriff's Office Incident Dataset (Socrata)

Access to Healthy Foods and Recreational Opportunities

In Harford County, most residents have access to grocery stores where healthy foods are available. According to the 2017 County Health Rankings, which provides a measure of "Limited Access to Healthy Foods," 97% of residents live close to a grocery store, with only 3% or an estimated 8,400 people having limited access to healthy food. This measure is based on the percentage of the population that is low income and does not live close to a grocery store. While access to grocery stores is not a problem for most Harford County residents, many families require assistance in purchasing foods: 8.2 % or 91,727 of households in Harford County received food stamps from the Supplemental Nutrition Assistance Program in 2015 (U.S. Census, Fact Finder). Of these, 31,422 were families with children under 18 and 33,941 were families with one or more people in the household 60 years or older.

A more pressing issue for a small percentage of Harford County residents is having an inadequate amount of food or "food insecurity" at some time during each year. Food insecurity is the USDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Per the USDA Food Environment Atlas, households experiencing food insecurity experience this condition, on average, in seven months of the year. It is estimated that in 2015 the food insecurity rate for the Harford County population was 8.4% or 20,990 people. This is less than Maryland's rate of 11.4%. In Harford County, the weekly food budget shortfall for food insecure people was $17.38 per person, per week in 2015. In summary, most Harford County residents have access to grocery stores to purchase healthy foods. However, a number of these residents face food insecurity at some time during the year, with healthy foods out of reach.

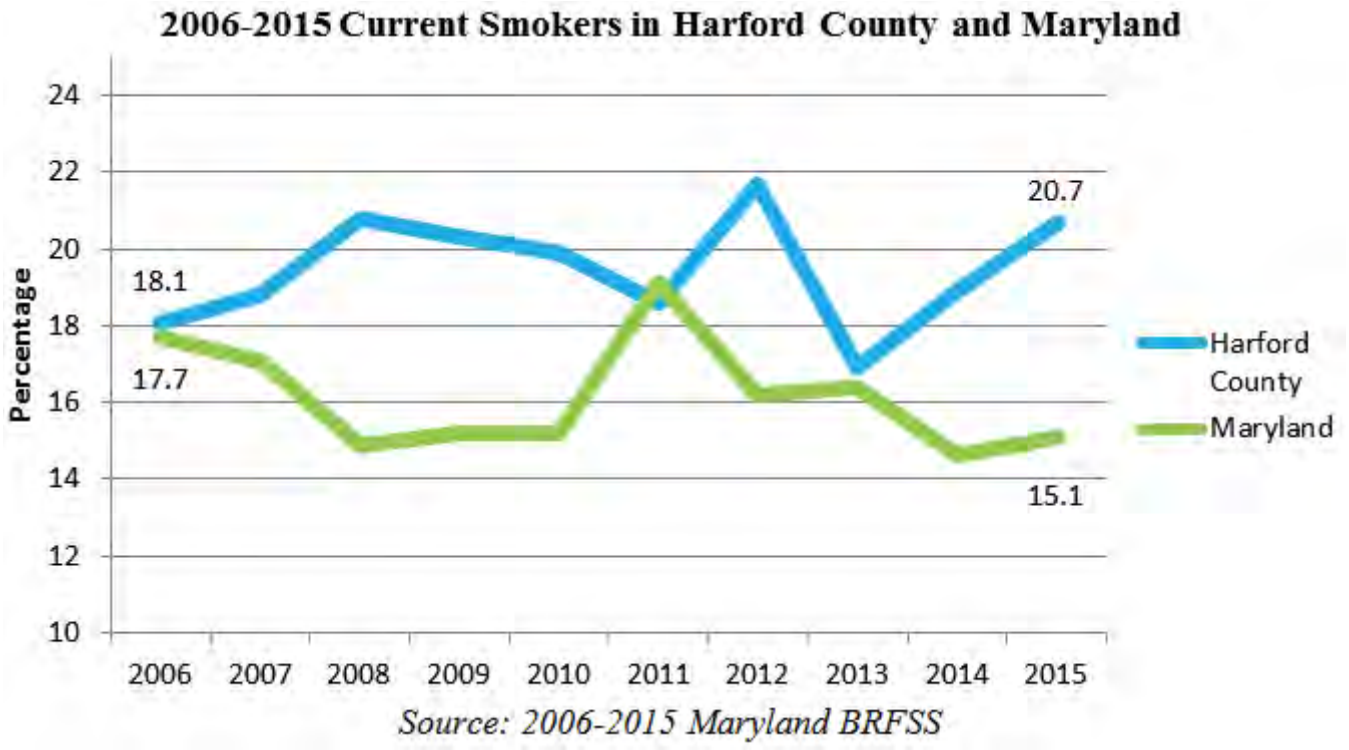
To help Harford County residents keep active, the County's Department of Parks and Recreation maintains 12 community centers, 7 senior activity centers, and over 25 parks and open spaces. The department sponsors a number of programs for adults, preschoolers, youth and families and also works with members of the general community through 20 Recreation Councils in the development of programs. Healthy Harford, a non-profit organization, was established a number of years ago to promote health and wellness in the county, providing opportunities for the public to participate in physical activities by sponsoring and advertising various events. Most recently, Healthy Harford worked with county partners to promote the Harford County parks; the program was based on a Healthy Parks/Healthy People program designed by the National Parks Department to reframe the role of parks and public lands as an emerging, powerful health prevention strategy.

Healthy behaviors can help to prevent and protect people from getting diseases and also to maintain or improve overall health and wellbeing. Healthy behaviors are estimated to affect 40% of health outcomes and make up the most significant factor influencing the health of individuals. Practicing good behaviors enhances health, while harmful behaviors may lead to disease, injury or death.

Health Behaviors

Tobacco Use

According to the 2015 Behavioral Risk Factor Surveillance Survey (BRFSS), 20.7% of Harford County adults reported that they currently smoked cigarettes every day or some days. Adults with annual incomes less than $15,000 were 5.7 times more likely to smoke than those with income at or above $75,000 in 2014. Educational attainment also contributed to smoking rates: adults without a high school diploma were 9.7 times more likely to smoke than college graduates according to the 2014 BRFSS. The graph below outlines smoking rates over the past ten years for Harford County and Maryland.

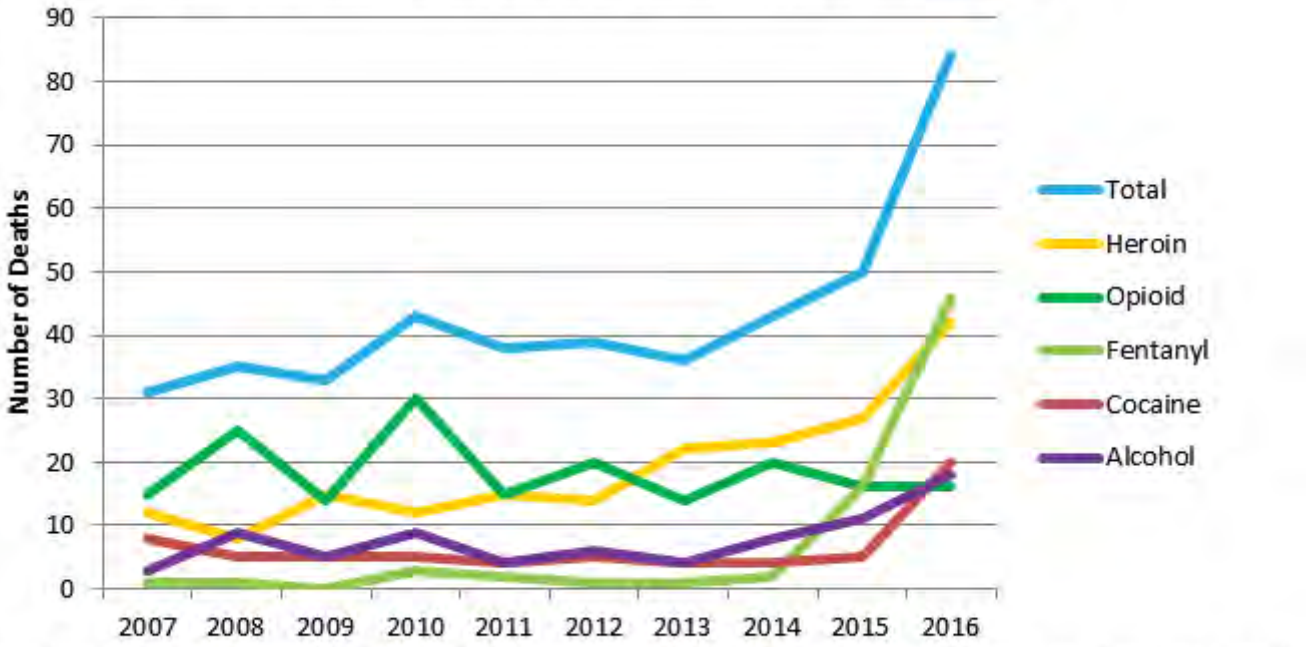


School-aged students were considered smokers if they smoked at least 1 cigarette or cigar in the past 30 days. The 2016 Youth Risk Behavior Surveillance System Survey (YRBS) found that the percentage of current smokers in Harford County high schools was 9.3% when compared to 16.9% in 2014. While this rate has decreased over time, the percentage of students reporting that they currently use electronic vapor products exceeded the number of current smokers at 14.3% according to the 2016 YRBS. The percentage of students using any type of tobacco products (cigarette, smokeless tobacco, cigar, or electronic vapor products) was 21.9% (2016 YRBS).

Alcohol and Substance Abuse

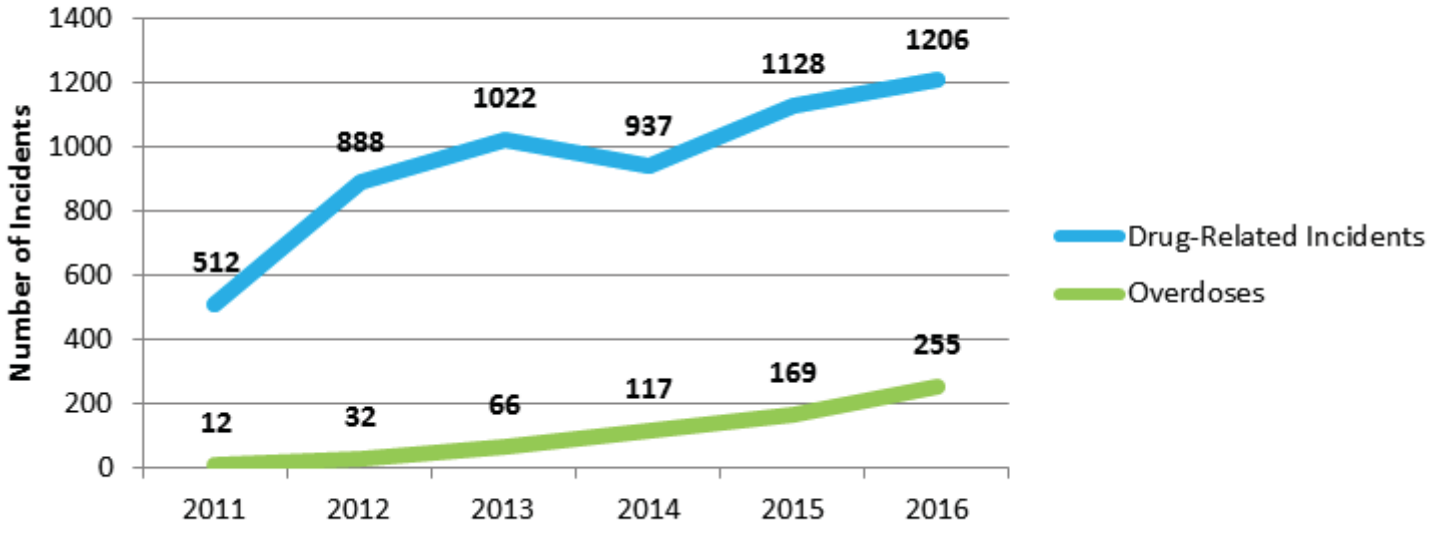
Since 2007 the number of drug and alcohol-related intoxication deaths has more than doubled in both Maryland and Harford County. The graph below shows the number of intoxication deaths by substance for Harford County, including heroin, opioids, fentanyl, cocaine, alcohol, and all deaths. Notably, heroin and fentanyl have caused the largest increase in intoxication deaths due to the increasingly volatile nature of the chemicals being mixed into the local drug supply. The numbers of drug-related law enforcement incidents and overdose calls have also increased dramatically since 2011 by 57% and 95%, respectively, which can be seen in the 2011-2016 data in the graph below.

2007-2016 Intoxication Deaths by Substance, Harford County



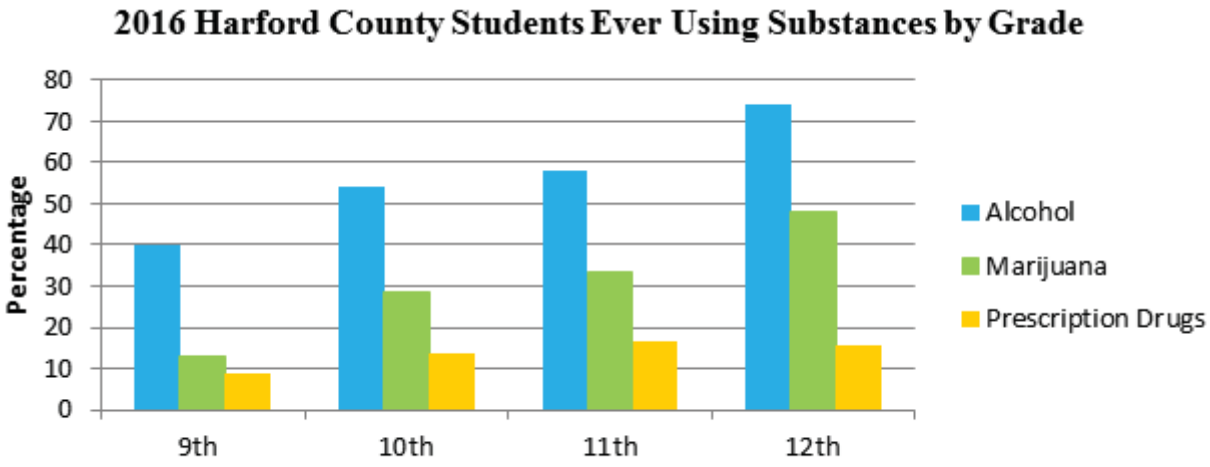
Source: Maryland Department of Health, Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2016

2011-2016 Drug-Related Law-Enforcement Incidents and Overdoses Harford County, 2011 - 2016



Source: Harford County Sheriff's Office Crime Reports, 2011-2016

In BRFSS data for 2013-2015, 14.6% of Harford County adults reported binge drinking in the past month and 5.5% reported being chronic drinkers (1-2 or more drinks per day), both of which are close to the state percentages. The percentage of high school students reporting binge drinking was higher than the adult's: 15.6% of Harford County high school students reported being binge drinkers in 2016. The graph below shows alcohol and substance use by grade for high school students.



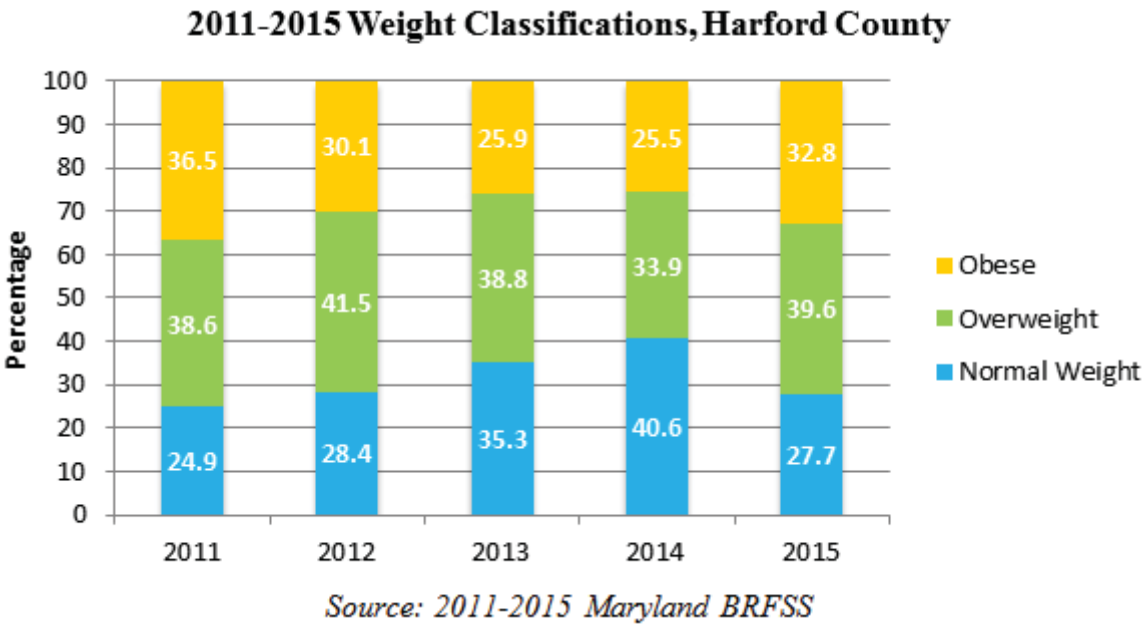
Source: 2016 Maryland Youth Risk Behavior Survey (YRBS)

Healthy Eating, Active Living, and Obesity

Diet and exercise habits have a tremendous impact on health and wellbeing. Data from the 2013-2015 BRFSS indicate that only 65.9% of Harford County adults consume one or more servings of fruits per day and only 76.8% consume one or more servings of vegetables daily. Both percentages mirrored the state as a whole for fruit and vegetable consumption.

Physical activity was also recorded during the same years and showed that 73.7% of adults reported engaging in some form of leisure time physical activity throughout the week. While this percentage does not indicate whether the respondents got the recommended 150 minutes of exercise each week, it is encouraging to see such a high percentage of adults participating in physical exercise. The state's percentage was slightly higher at 76.5%.

According to the 2015 BRFSS, Harford County's obesity rate was 32.8%, which was higher than the state's (28.9%). Several factors were shown to increase a person's chance of obesity including income, race, and educational attainment. Black adults were almost twice as likely to be obese when compared to white adults, a disparity that is much more evident in Harford County than the state as a whole (2015 BRFSS). Adults without a high school diploma were also almost twice as likely to be obese than their college graduate counterparts. Adults making over $75,000 annually were slightly less likely to be obese than adults making less than $15,000. The graph below shows obesity, overweight, and normal weight trends between 2011 and 2015.



Source: 2011-2015 Maryland BRFSS

Health Outcomes

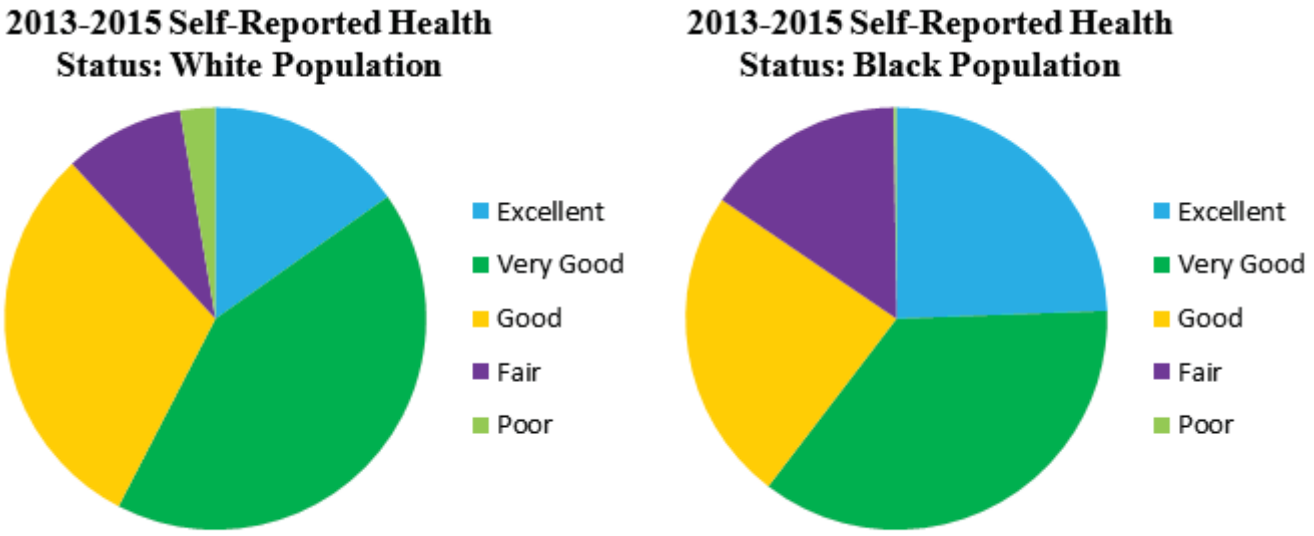
The Health Outcomes section of this report provides an overview of the health conditions of Harford County residents by exploring perceived health status, the leading causes of death and hospitalization, chronic and communicable disease, injury, mental health, and maternal and child health. The combination of these outcomes paints the picture of how the health behaviors outlined in the previous section manifest in a community.

Perceived Health Status

In the 2013-2015 BRFSS, respondents were asked to rank their overall health from poor to excellent. The survey indicated that the 40.8% of Harford County residents consider their health to be very good, which is above the state average (34.3%). However, Maryland respondents as a whole were more likely to identify as being in excellent health (21.4%) than Harford County respondents (16.9%). The graph below shows the percentage of perceived health status for each ranking.

Source: 2013-2015 Maryland BRFSS

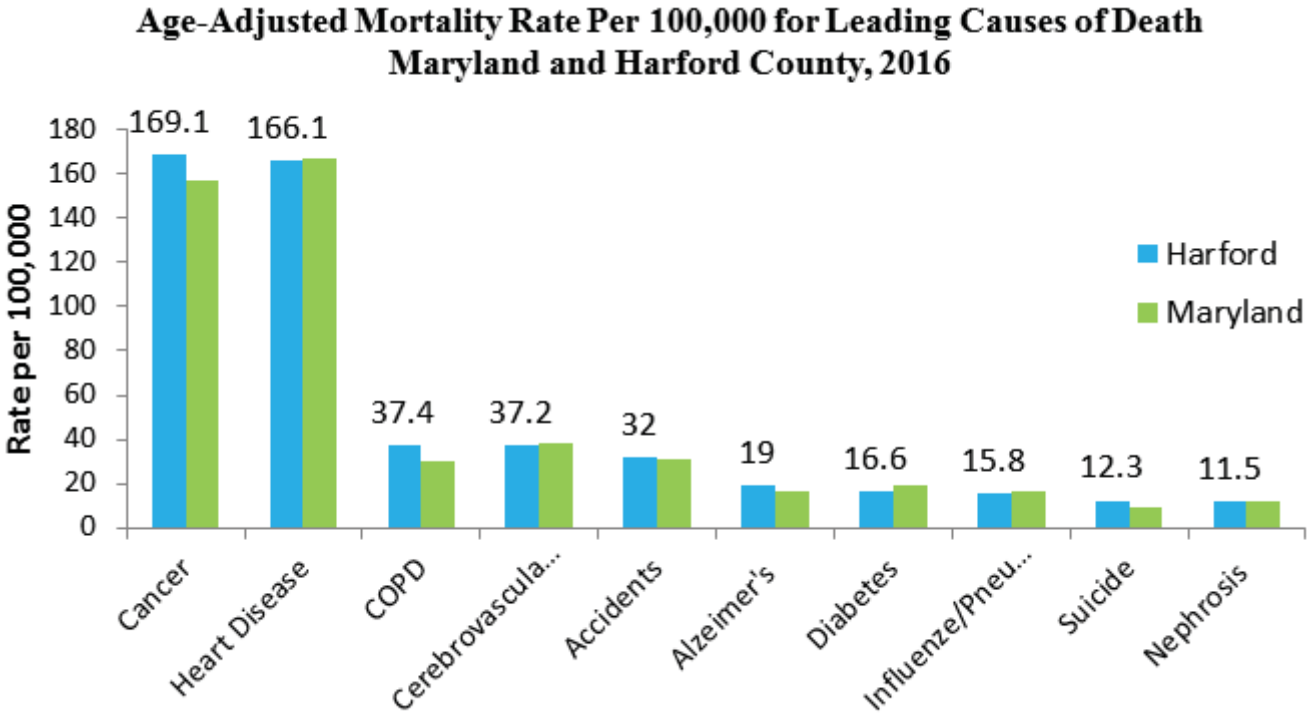
The same data indicated that Harford County's white non-Hispanic and black non-Hispanic populations have differences in perceived health status, with 56.6% of whites reporting very good or excellent health status as compared 60.4% of blacks. The white population had a higher percentage reporting good health (30.5%) than the black population (24.1%), and a lower percentage reporting fair health (9.2%) compared to the black responses (15.3%).



Source: 2013-2015 Maryland BRFSS

Leading Causes of Death and Hospitalization

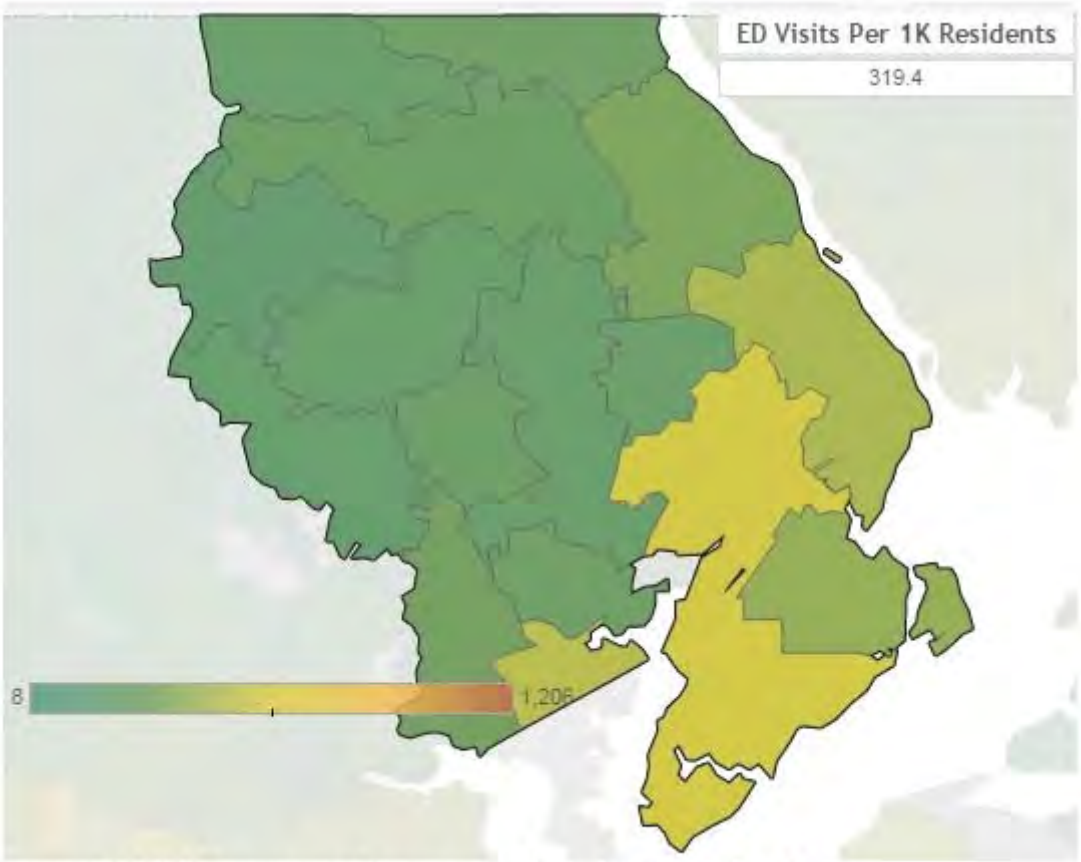
Data from the Maryland Vital Statistics Administration indicate that the top three leading causes of death in Maryland include heart disease, cancer, and cerebrovascular disease (stroke). The role of accidents as the fourth leading cause of death is a relatively new phenomenon that could likely be attributed to the growing opioid epidemic and accidental overdoses. Harford County's leading causes of death do not mirror the state's. The county's three leading causes of death include cancer, heart disease, and chronic obstructive pulmonary disease (COPD). The graph below includes age-adjusted mortality rates per 100,000 for the leading causes of death in both Maryland and Harford County. In addition, between 2014 and 2016 the number of years of potential life lost in Harford County was 5,800 per 100,000 population when compared to 6,500 for the state of Maryland. For African Americans in Harford County, that number increased to 7,600 years of life lost.



Source: 2016 Maryland Vital Statistics Annual Report

The image below shows rates of emergency department (ED) visits per 1,000 residents in Harford County by zip code. Lighter colors on the image indicate higher ED visit rates, while darker colors indicate lower rates. The rate for Maryland was 353.2 per 1,000 residents in 2016. Harford County's rate was slightly lower at 316.1. When each zip code was examined individually, it was found that the zip codes with the highest ED visit rates were Aberdeen (580), Edgewood (502), and Havre de Grace (460), all of which were well above the state and county averages.

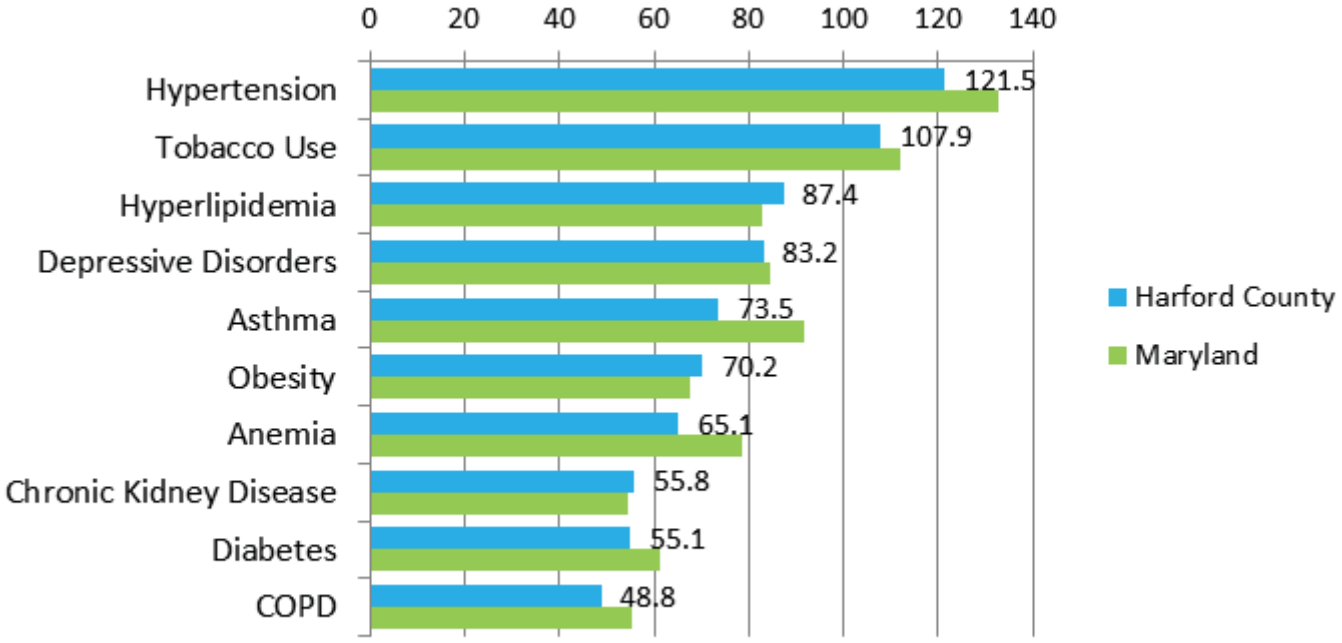
2016 Harford County Emergency Department Visits Per 1,000 Residents



Source: CRISP Emergency Department Visits by Zip Code (2016)

Using the Centers for Medicare and Medicaid Service's definition of chronic conditions, 2016 data for Harford County indicated that the three most common conditions associated with ED visits were hypertension, tobacco use, and hyperlipidemia (high concentration of fats or lipids in a patient's blood). Havre de Grace's top three chronic disease indicators were the same as those recorded for the county. However, while Aberdeen and Edgewood had tobacco use and hypertension as their leading indicators, the third and fourth highest indicators were depressive disorders and asthma, respectively, which suggest that these conditions were not being successfully treated on an outpatient basis. The top ten indicators for the entire county are listed in the table below.

Leading Chronic Conditions for Emergency Department Visits
Harford County and Maryland, 2016

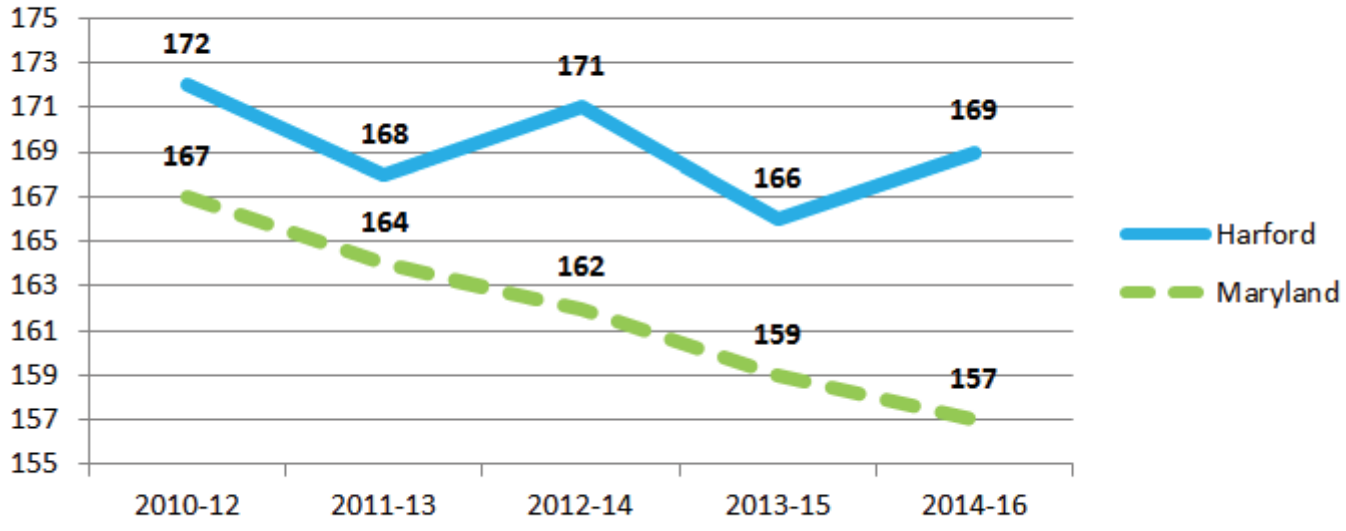


Source: CRISP Emergency Department CCW Conditions (2016)

Chronic and Communicable Disease

According to the Vital Statistics Administration, the leading cause of death in Harford County was cancer in 2016. Cancer mortality rates are also worse in Harford County than for the State of Maryland. While the state's mortality rates have steadily declined over time, Harford County's rate has remained relatively stable. Cancer mortality rates for Harford County and Maryland are shown below.

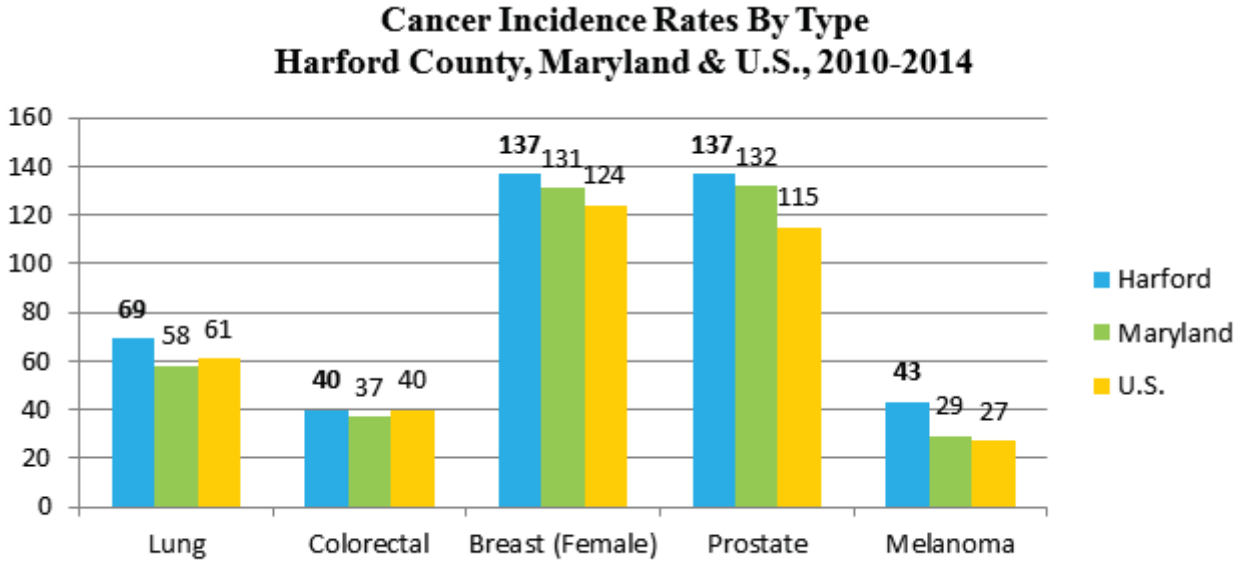
Cancer Mortality Rates
Harford County & Maryland, 2012-2016



**Age-Adjusted Rates*

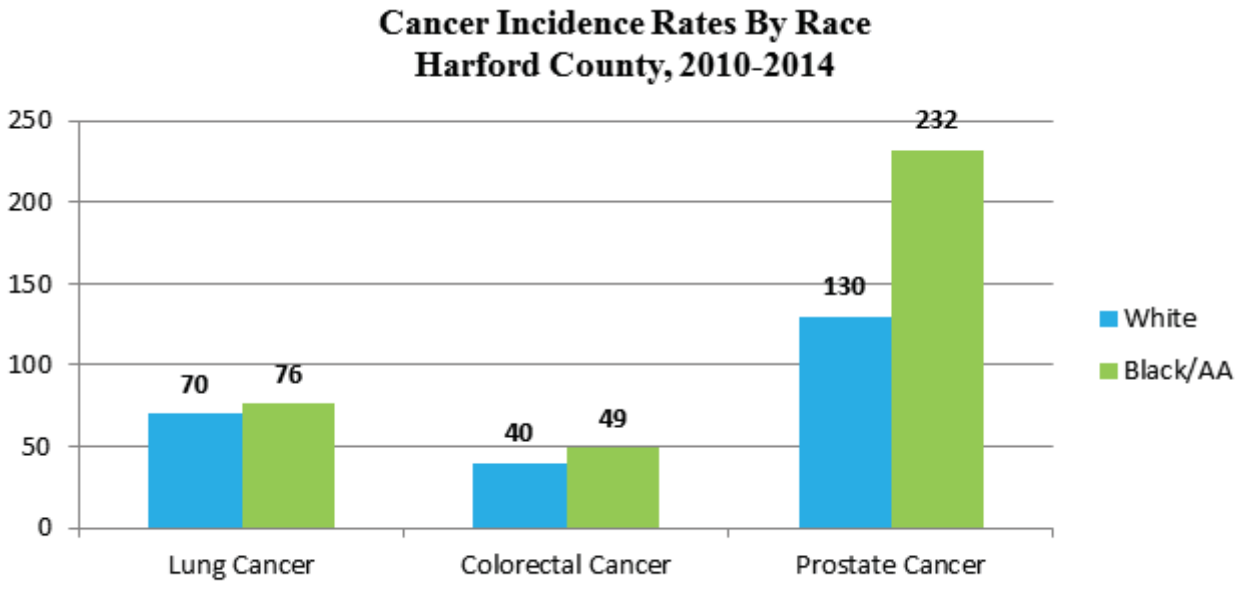
Source: Maryland Vital Statistics Reports

Cancer incidence rates by type are shown in the figure below for Harford County, Maryland, and the United States. Notice that Harford County rates are the same or worse for every cancer type when compared both locally and nationally.



Source: CDC and NCI at https://www.statecancerprofiles.cancer.gov/incidencerates/

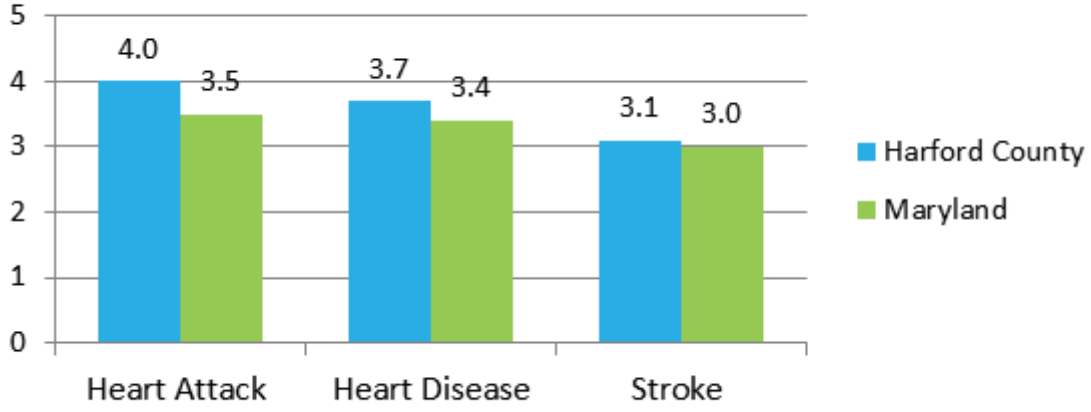
In addition to higher rates of cancer in the county, racial disparities exist for three types of cancers that have positive outcomes when screening occurs regularly. The figure below depicts incidence rates for lung cancer, colorectal cancer, and prostate cancer among white and black residents from 2010 to 2014.



Source: CDC and NCI at https://www.statecancerprofiles.cancer.gov/incidencerates/

Harford County adults have been shown to have a higher percentage of several vascular diseases when compared to Maryland adults. The chart below shows the percentage of adults that have been told that they have experienced a heart attack, been diagnosed with heart disease, or had a stroke. In each case, the percentage of Harford County adults is slightly higher than the state percentages.

2013-2015 Pergentage of Adults Diagnosed with Heart-Related Conditions



Source: 2013-2015 Maryland BRFSS

For other chronic conditions such as diabetes, asthma, Chronic Obstructive Pulmonary Disease (COPD), hypertension, and high cholesterol, the prevalence of each of these conditions is higher in Harford County than in the state, with the exception of diabetes. The following chart summarizes prevalence rates for each condition and compares them to the state prevalence.

Table: Percentage of Adults Ever Told They Have the Chronic Condition, 2013-2015

Chronic Condition	Harford County	Maryland
Asthma	14.3%	13.8%
COPD	8.1%	5.8%
Diabetes	9.7%	10.2%
High Cholesterol	37.0%	30.9%
Hypertension	36.6%	33.3%

Source: 2013-2015 Maryland BRFSS

A notifiable disease is any condition that, when identified in a patient, is required to be reported to the government so that its incidence can be monitored for potential outbreaks and clustering. In Maryland, there are 86 notifiable diseases that are reported to the Centers for Disease Control (CDC). Of those diseases, the highest case rates in Harford County were observed for chlamydia, Lyme disease, gonorrhea, salmonellosis (salmonella), and aseptic meningitis. The following chart provides rates for Harford County and Maryland per 100,000 residents. Notice that Harford County's Lyme disease rate is much higher than the state rate. In addition, 23 Harford County residents were diagnosed with HIV in 2016.

2016 Notifiable Disease Incidence Rates per 100,000 in Harford County and Maryland

Notifiable Disease	Harford County	Maryland
Chlamydia	320.5	509.6
Lyme Disease	69.4	21.2
Gonorrhea	62.3	158.5
Salmonellosis	11.6	16.1
Meningitis, Aseptic	10.4	8.7
Syphilis	6.8	8.5

Source: Maryland Department of Health

Maternal and Child Health

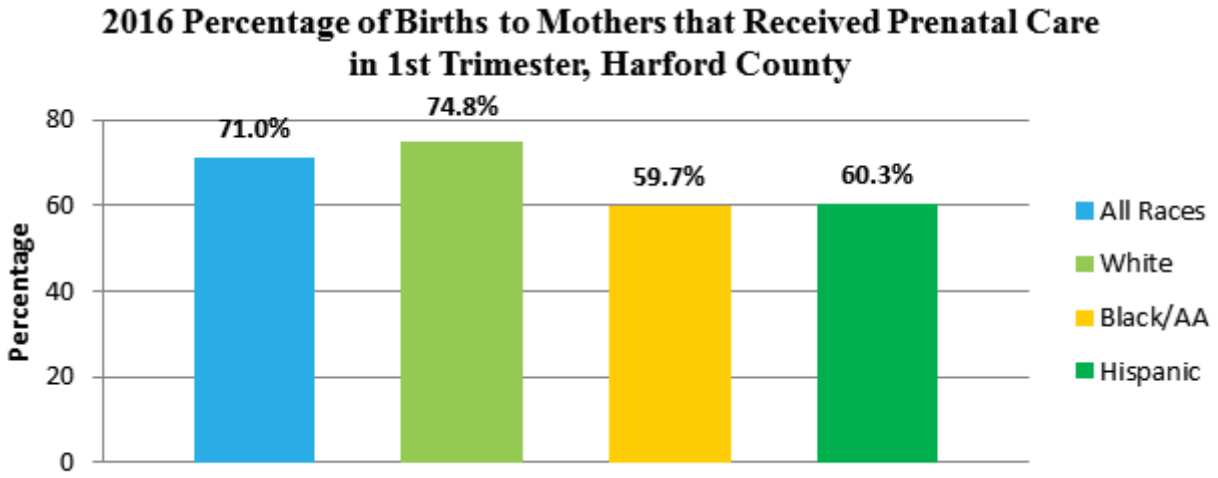
In 2016 there were 2,701 live births in Harford County. The chart below outlines maternal and child health data for the county. Maternal characteristics and birth outcomes in Harford County vary by race, indicating health disparities exist for mothers and babies for racial and ethnic minorities. Maternal characteristics and birth outcomes are provided by race in the chart below. Notice that the infant mortality rate for blacks in the county is more than three times higher than the rate for all races combined.

2016 Maternal and Child Health Data, Harford County and Maryland

Maternal Characteristics	Harford County	White	Black/AA	Hispanic
Under 20 years of age	3.5%	2.6%	6.6%	6.0%
Unmarried	30.6%	24.7%	56.4%	38.4%
Birth Outcomes				
Low birth weight (<2500 grams)	7.6%	6.4%	12.1%	7.5%
Infant Mortality (per 1,000 live births)	4.8	3.1	14.4	N/A

Source: 2016 Maryland Vital Statistics

A mother's well-being before, during, and after pregnancy can affect the health of a child from infancy to adulthood. The percentage of births to mothers receiving prenatal care in the first trimester of pregnancy was 71.0%, which was high when compared to Maryland's (67.8%). Births to mothers under the age of 20 made up only 3.5% of births in the county, while births to unmarried mothers made up 30.6% of births. The chart below highlights disparities in prenatal care by race in Harford County.



Source: 2016 Maryland Vital Statistics

Injury

According to County Health Rankings data between 2011 and 2015, the overall death rate from injuries in Harford County per 100,000 population was 61, which was slightly higher than the rate for Maryland (58). The rate of motor vehicle crash deaths was 11 per 100,000 in Harford County and 9 in Maryland. In addition, the percentage of motor vehicle deaths in which alcohol-impairment was the primary factor was higher in Maryland at 33%, than the 24% for Harford County deaths.

The table below shows causes of death and their corresponding death rates in both Harford County and Maryland from the 2016 Maryland Vital Statistics Annual Report. Intentional injuries from suicide and homicide accounted for 2.1% of deaths in Harford County in 2016 and unintentional injury deaths accounted for around 5.8%. While injury deaths from motor vehicle accidents have decreased over the past ten years, deaths from intentional self-harm (suicide), poisoning, and falls have continued to increase throughout the state.

2014-2016 External Causes of Death Rate per 100,000

Cause of Death	Harford	Maryland
Accident	32.0	30.5
Intentional Self-Harm (Suicide)	12.3	9.2
Assault (Homicide)	*	9.0

Source: Maryland Vital Statistics 2016 Annual Report

*Rates based on <20 events in the numerator are not presented since such rates are subject to instability.

Mental Health

A combination of qualitative data collected in hospitals, schools, and community surveys paints a startling picture of mental health for both children and adults in some of Harford County's most vulnerable communities. The Maryland BRFSS data for 2013-2015 indicates that 21% of Harford County residents have been diagnosed with depressive disorder, compared to 16.1% for the state. In addition, hospital data made available by the Chesapeake Regional Information System for our Patients (CRISP) reporting system, which serves as a regional health information exchange for Maryland, Virginia, West Virginia, and the District of Columbia, indicates that the rates of hospitalizations and emergency department visits for mental health-related conditions are similar in Harford County and the state of Maryland, but geographic disparities appear in the three zip codes with the highest need index for the county. The need index is based on the Community Need Index developed by Dignity Health in 2004. The following tables summarize hospitalization and Emergency Department (ED) visit rates per 1,000 residents for the state, county, and three selected jurisdictions.

Hospitalizations per 1,000 Residents for Mental Health Indicators, CRISP 2016

Population	Depression	Alzheimer's	Bipolar	Schizophrenia
Maryland	43.86	13.05	12.50	8.17
Harford County	45.14	13.46	11.94	5.64
Aberdeen	70.9	19.3	22.2	10.3
Edgewood	58.03	12.12	19.57	8.52
Havre de Grace	62.1	20.9	17.7	8.2

Source: 2016 CRISP Hospitalization Data

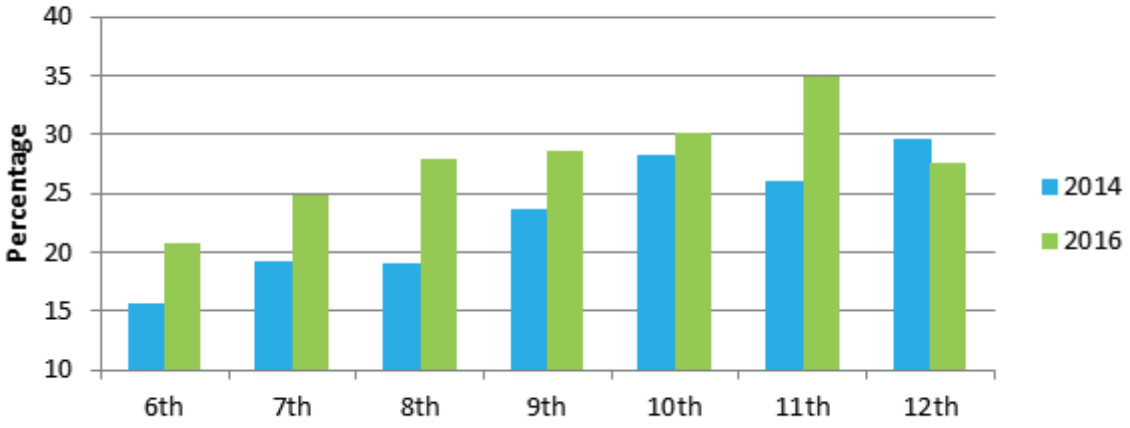
ED Visits per 1,000 Residents for Mental Health Indicators, CRISP 2016

Population	Depression	Alzheimer's	Bipolar	Schizophrenia
Maryland	84.7	12.6	40.9	21.6
Harford County	83.2	11.4	34.3	11.9
Aberdeen	164.5	18.6	77.7	27.3
Edgewood	128.9	11.4	61.4	22.2
Havre de Grace	128.8	20.2	50.2	18.3

Source: 2016 CRISP ED Visit Data

According to the 2014 and 2016 Maryland Youth Risk Behavior Survey, the percentage of students who reported feeling sad or hopeless for more than two weeks in a row climbed 33.3% between the first year of middle school and the senior year of high school. The percentage of high school students who seriously considered committing suicide was 18.2 % while 14.4% made a plan for how they would commit suicide.

2014-2016 Percentage of Students Who Felt Sad or Hopeless by Grade, Harford County



Source: 2014 & 2016 Maryland Youth Risk Behavior Survey

Access to Health Care

Health Insurance Coverage

Without health insurance, most people cannot afford quality healthcare. Lack of coverage may lead to disparities in overall health. Access to health insurance coverage has remained strong in Harford County with the expansion of Medicaid eligibility and implementation of the Maryland Health Exchange for Qualified Health Plans under the Affordable Care Act. In 2016, the percentage of uninsured adults was just 4.6% compared to Maryland (8.1%) according to the U.S. Census Bureau. However, the following disparities arise by zip code, age, sex, race, and educational attainment. Notice that the following characteristics make adults less likely to have health insurance coverage: 18 to 24 years of age, male, Hispanic, and less than a high school degree. Populations with the highest uninsured rates live in Aberdeen (21001) and Edgewood (21040).

2016 Percentage Uninsured by Category by Zip Code, Harford County

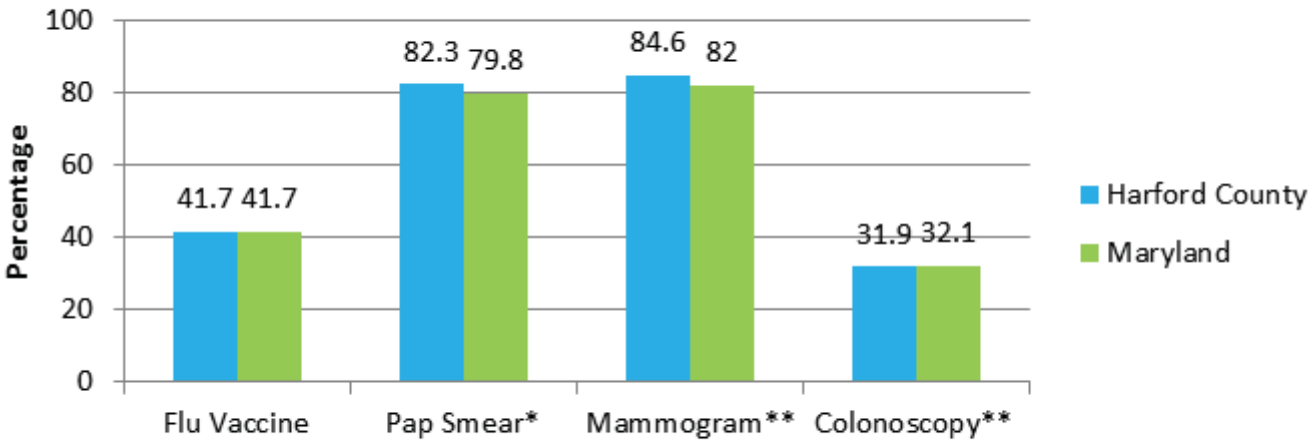
Age	Harford	Aberdeen	Edgewood	Havre de Grace
Under 18 years	2.1	1.8	1.4	2.0
18 to 24 years	8.7	16.6	19.2	11.8
25 to 34 years	9.1	15.0	13.4	6.9
35 to 44 years	5.9	10.3	10.4	7.2
45 to 54 years	5.4	11.4	8.6	5.9
55 to 64 years	4.6	9.5	9.0	6.2
Sex				
Female	3.7	6.7	5.9	4.3
Male	5.5	10.1	10.0	5.5
Race/Ethnicity				
White	3.7	7.1	9.8	4.0
Black/AA	7.4	9.3	6.6	8.4
Hispanic	12.8	18.8	17.6	8.9
Educational Attainment				
Less than high school	12.5	16.3	12.7	6.1
High school graduate	6.6	11.9	9.6	9.9
Some college	4.5	6.9	8.1	3.5
Bachelor's or higher	2.3	5.2	6.9	2.2

Source: U.S. Census 2012-2016 American Community Survey, 5-year Estimates

Access to Primary Care and Preventive Health Services

Preventive health services are essential for early detection of diseases and to avoid serious complications when diseases are not caught in their early stage. Most health insurance plans are required to cover a set of preventive services – such as vaccines and screenings – at no cost to the patient. The chart below shows the percentage of Harford County adults that took advantage of such opportunities in 2014. Notice that the use of each type of preventive health service is similar in Harford County and Maryland.

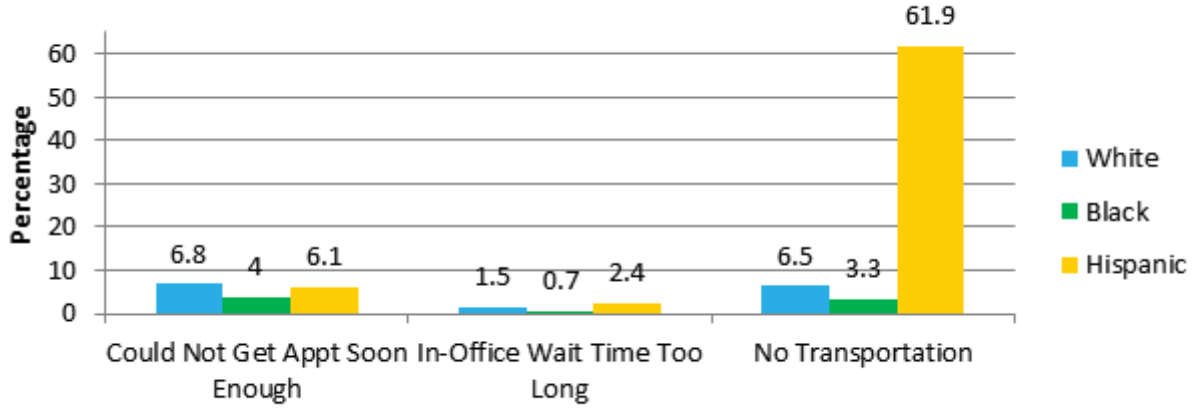
2014 Percentage of Harford County Residents Receiving Preventive Health Services



Source: 2014 Maryland BRFSS
**Screening in past 3 years for women 18 years and older*
***Screening in past 2 years for adults 50 years and older*

In the 2013-2015 BRFSS, 87.6% of Harford County residents reported having a person that they think of as their personal doctor or health care provider, higher than the state percentage of 82.4%. Responses to the 2015 BRFSS indicate that more Harford County residents have had routine health checkups in the last year (79.9%) than Maryland residents (76.2%). However, in the 2013-2015 BRFSS, 11.5% of Harford County residents reported needing to see a doctor but not being able to because of a cost barrier. In 2014 the two most reported reasons for delaying medical care included not being able to get an appointment soon enough (6.1%) and not having transportation to reach an appointment (8.3%), according to the Maryland BRFSS. The graph below shows that Hispanics were almost 10 times more likely than whites to report transportation as a barrier to receiving care.

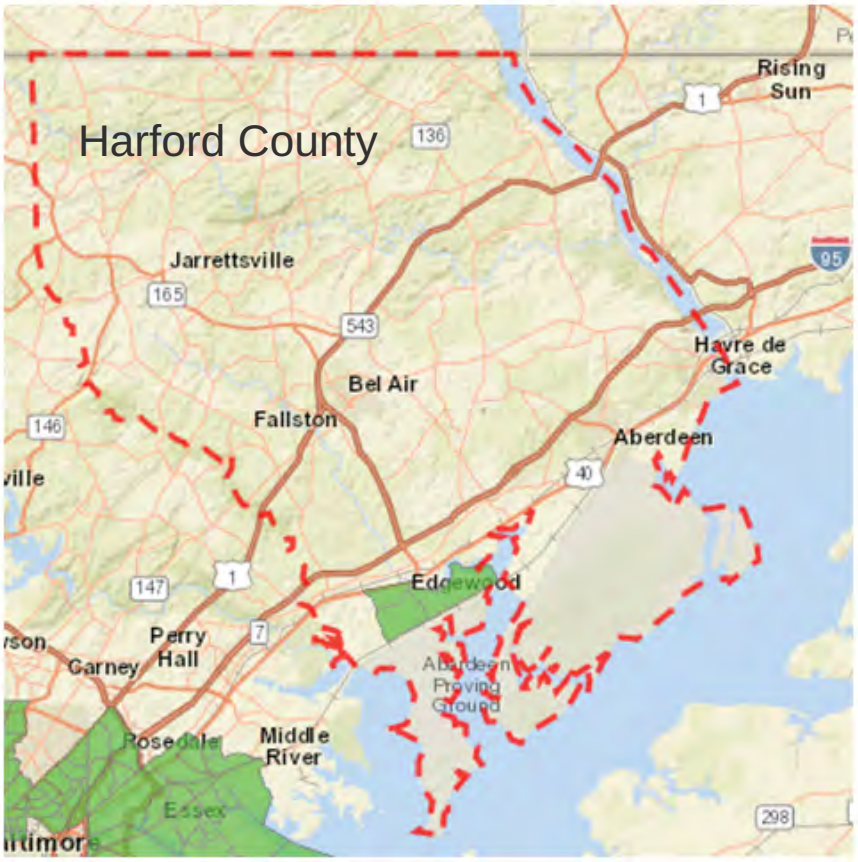
2014 Reasons for Delaying Needed Medical Care, by Race



Source: 2014 Maryland BRFSS

According to the Maryland Department of Health's Health Resources and Services Administration, a portion of Harford County is considered a Health Professional Shortage Areas (HPSA) for primary care. The following image shows in green the area of Harford County that has been designated as HPSA for primary care.

Primary Care Health Professional Shortage Areas



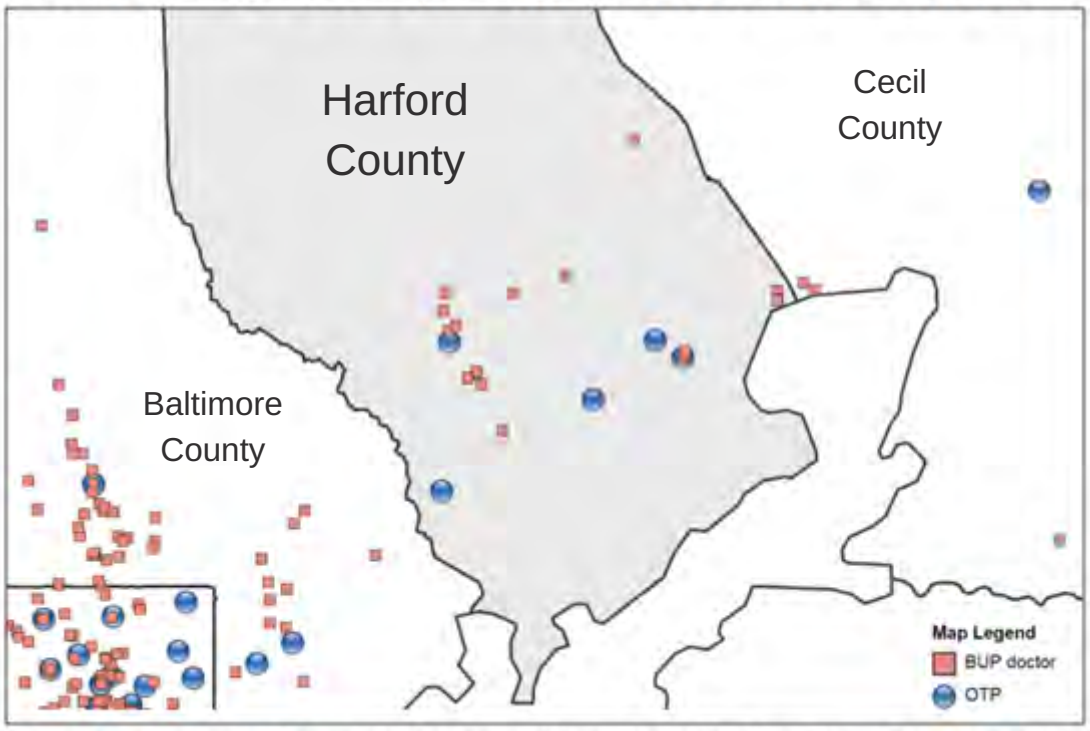
Source: Health Resources and Services Administration, County and County Equivalent Listing – Primary Care

Access to Mental Health and Substance Abuse Care

While most mental health and substance use disorders can be treated successfully, many who suffer from these diseases do not receive the care they need. The Health Resources and Services Administration designated all of Harford County as a Health Professional Shortage Area (HPSA) for mental health services. This designation means that the need for mental health services far outweighs their availability.

The Maryland Department of Health's Behavioral Health Administration compares each Maryland County's Opioid Treatment Program (OTP) capacity to the estimated need in that county. In 2015 Harford County's estimated need was 2,570 patients. In comparison, existing capacity could only serve 1,687 patients, leaving about 883 persons in need. The figure below maps Buprenorphine Treatment Providers and OTP facilities throughout the county. In addition, data from County Health Rankings show that in 2016, Harford County's mental health provider ratio was 740:1. This is much higher than Maryland's ratio of 490:1. United States counties in the 90th percentile for this measure report ratios closer to 360:1 for mental health providers.

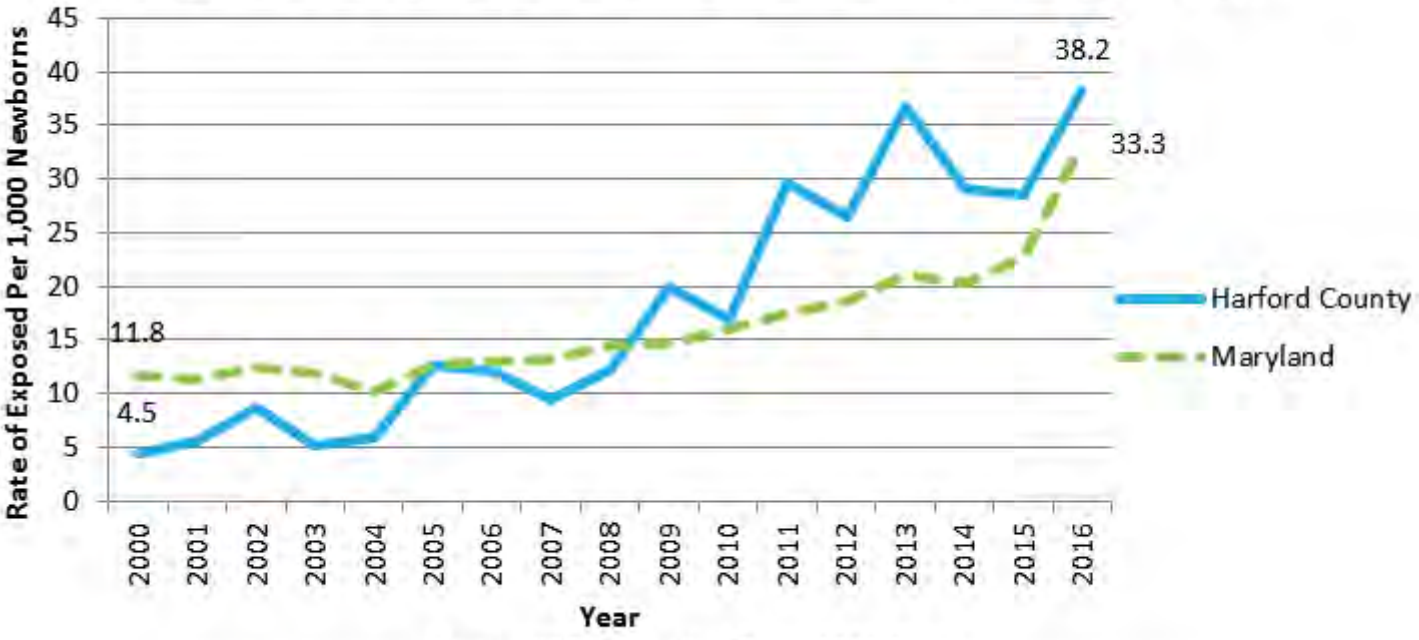
Harford County Buprenorphine Treatment Providers and OTP Facilities



Source: 2015 Maryland Behavioral Health Administration Opioid Treatment Programs in Maryland

Another indicator that suggests limited access to substance abuse treatment is the rate of substance-exposed newborns. The following graph shows the 8-fold increase in the rate of hospital encounters for newborns with maternal drug/alcohol exposure for Harford County and Maryland between 2000 and 2016.

Rate of Hospital Encounters for Newborns Born with Maternal Drug/Alcohol Exposure in Harford County and Maryland, 2000-2015



Source: HSCRC Hospital Data, 2000-2016

NOTE: ICD-10 Codes Used 760.70, 760.71, 760.72, 760.73, 760.75, 760.77, 779.5

The Harford County Health Department provides community-based behavioral health treatment and support services, as well as outreach, education, and specialized substance use disorder programs. The University of Maryland Upper Chesapeake Health provides behavioral health services through its Harford Memorial Hospital, including acute inpatient treatment, emergency room evaluations, medical consultations, and intensive outpatient programs. However, data indicates that the county needs additional capacity for treating those with mental illness and with addiction disorders.

Access to Oral Health Care

Oral health is an important part of overall health. Poor oral health has been associated with heart disease and has recently been linked to cancer in women (1). Dental problems are often painful, causing difficulty in eating and, consequently, to poor nutrition. On occasion, periodontal disease can require hospitalization and may lead to death. Access to affordable dental care is critical to ensuring good oral health. The ratio of dentists to population is lower in Harford County than for the state as a whole: 1 dentist for every 1,630 people in the county as compared to 1 to 1,350 in the state. Harford County has a lack of dentists in the southern area, which has been designated as a Health Professional Shortage Area (HPSA) for dental health. In the map below, the county's dental HPSA is shaded purple.

Health Professional Shortage Areas - Dental Health

Source: Health Resources and Services Administration, County and County Equivalent Listing – Oral Health Care

Data for 2015 from the Maryland BRFSS showed that just 67% of adults in Harford County reported visiting the dentist in the past year, a figure that was lower than for the state (72%). In addition, 6.8% reported that their last dental visit was over 5 years ago.

(1) Ngozi N. Nwizu, et. al., Periodontal Disease and Incident Cancer Risk among Postmenopausal Women: Results from the Women's Health Initiative Observational Cohort, Cancer Epidemiology, Biomarkers and Prevention, August 2017.

Online Community Health Survey

Background

The customized survey tool consisted of approximately 46 questions to assess access to health care, health status and behaviors, and health-related community strengths and opportunities. The online survey took respondents approximately 15 minutes to complete. In total, 1,741 respondents completed the survey.

The following section provides an overview of the findings from the Online Community Survey, including highlights of important health indicators and health disparities.

Demographic Information

The demographic profile of the respondents who completed the online survey is depicted in Tables 1 and 2. Approximately 55% of all respondents reside in zip codes 21014, 21015, 21009, 21078, and 21050. An additional 13.8% of respondents live in an "Other" zip code, the most common of which are 21901, 21918, and 21921. As depicted in Table 2, of the total 1,741 respondents, 80.29% were female and 19.71% were male. Whites comprised 83.77% of study participants and Blacks/African-Americans represented 11.55%. Approximately 3% of all respondents identified as Latino/Hispanic. Approximately 49% of all respondents were between the ages of 45 and 64 years. An additional 34.8% of all respondents were between the ages of 25 and 44 years.

Table 1. Zip Code Representation

Zip Code	%	Zip Code	%	Zip Code	%	Zip Code	%
21014	17.18	21040	7.15	21084	1.61	21005	0.52
Other	13.83	21001	6.80	21028	1.21	21111	0.29
21015	11.87	21047	3.75	21034	1.15	21010	0.23
21009	9.91	21085	2.54	21013	0.75	21060	0.12
21078	8.24	21154	2.42	21087	0.69	21018	0.06
21050	7.32	21017	1.61	21132	0.69	21082	0.06

Table 2. Demographic Information

Demographics	%
Gender	
Male	19.71
Female	80.29
Age	
18-24	4.97
25 – 34	16.94
35 – 44	17.86
45 – 54	24.10
55 – 64	24.97
65 – 80	10.69
81+	0.46
Race/Ethnicity	
White	83.77
Black/African American	11.55
American Indian/Alaska Native	0.40
Asian/Pacific Islander	1.68
One or more races	2.60
Hispanic/Latino*	3.06

* Hispanic/Latino respondents can be of any race, for example, White Hispanic or Black/African American Hispanic

The marital status, education level, employment status, and income level were also assessed for each respondent. The majority of respondents (63.09%) were married. Approximately 15% of respondents were single (never married) and 11.71% were divorced. 2.07% of respondents attained less than a high school diploma or GED. Approximately one-third (29.76%) of respondents attained some college, technical school or nursing school and 51.69% of respondents have an undergraduate degree or higher.

The majority (72.29%) of respondents were currently employed and working full-time. In addition, half of the respondents had an annual household income of $75,000 or more. Less than 14% of respondents had an income less than $25,000.

Table 2. Demographic Information Cont'd

Demographics	%
Marital Status	
Married	63.09
Divorced	11.71
Widowed	4.15
Separated	2.08
Never married	15.11
Member of an unmarried couple	3.86
Level of Education	
Never attended school or only attended kindergarten	0.0
Grades 1-8 (Elementary School)	0.52
Grades 9-11 (High school, no diploma)	1.55
High school diploma or GED	11.97
Some college or Technical school	32.30
College degree	29.76
Graduate degree	21.93
Other	1.96
Employment Status	**%**
Full-time employee	72.29
Part-time employee	12.99
Unemployed, looking for work	2.08
Unemployed, not looking for work	.064
Retired	6.93
Disabled, Not able to work	3.29
Student	0.75
Homemaker	1.04
Annual household income from all sources	
Less than $10,000	5.21
$10,000-$14,999	2.87
$15,000-$19,999	1.99
$20,000-$24,999	3.10
$25,000-$34,999	6.91
$35,000-$49,999	9.02
$50,000-$74,999	16.29
$75,000 and more	54.60

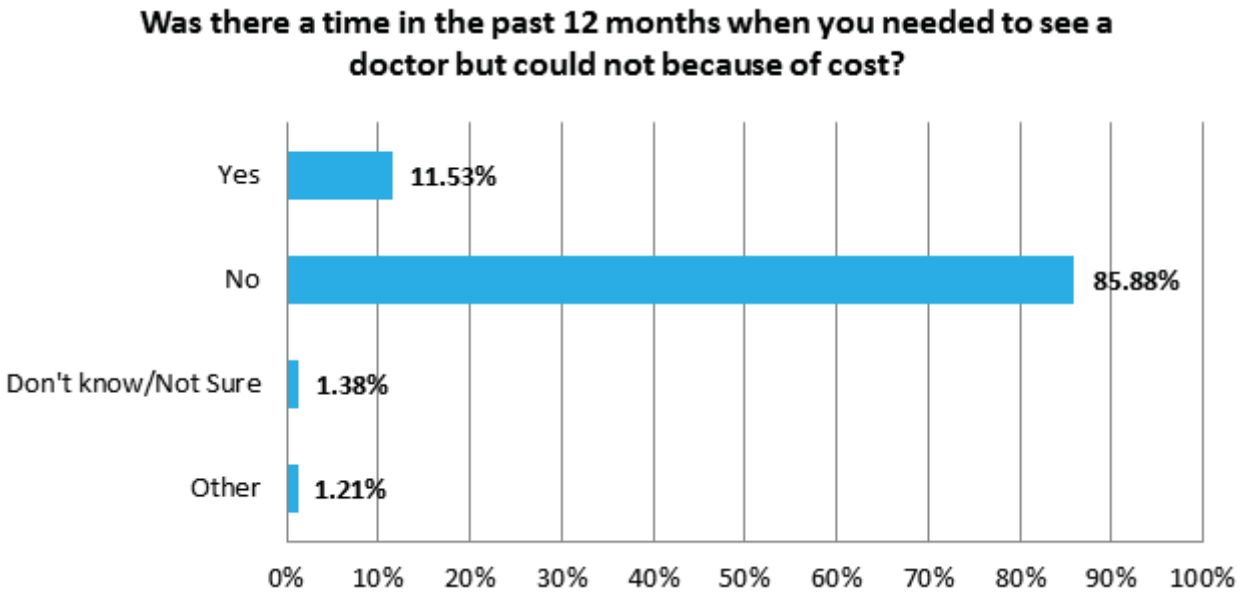
Access to Health Care

A high proportion of respondents had health care coverage (97.92%) and at least one person who they think of as their personal doctor or health care provider (88.44%). In addition, 76.33% of respondents had a routine checkup within the past year and 13.95% had one within the past two years. The source of respondent's health insurance coverage is detailed in Table 3.

Table 3. Source of Health Insurance Coverage

Health Insurance Source	%
Your employer	61.09
Someone else's employer	21.59
Medicaid or Medical Assistance, MCHiP	8.49
The military, CHAMPUS, or the VA	2.60
Some other source	5.60
A plan that you or someone else buys on your own	3.35
None/No Health Insurance	2.08

Despite primarily positive findings regarding health insurance and access to primary care, respondents in Harford County still cite the cost of care as a barrier. Nearly 12% of respondents said that there was a time in the past 12 months when they needed to see a doctor but could not because of cost. This finding may be an indicator that out-of-pocket expenses not covered by insurance (e.g. copays) are preventing respondents from seeking care when they need it. In addition, 21 respondents cited an "Other" reason for not being able to see a doctor due to cost. Of these 21 respondents, seven stated they were not able to afford dental care or they had transportation issues.



Next, respondents were asked if they had delayed needed medical care in the past 12 months. Nearly 71% of respondents did not delay or need medical care in the past 12 months. Of those who did delay medical care, 13.04% stated they could not get an appointment soon enough. Approximately 146 respondents (8.50%) cited an "Other" reason for delaying care. The most frequently mentioned themes are summarized below. The majority of respondents mentioned the inability to pay out-of-pocket costs as their main reason for delaying needed medical care. Others indicated being unable to take time off work.

Reason: Cost	Reason: Work
"No money."	"Time off work means no pay."
"No money for co-pays and couldn't get an appointment quick enough."	"Work gets in the way."
"High co-pay/deductible."	"Too busy at work to go."
"Not being able to afford the tests I knew they would order."	"Put job before my health and the care of an elderly parent."
"Had to pay out of pocket as the doctor was out of network and the deductible was too high, and there was not a similar doctor I could go to instead of the one I went to."	"Stressors at work make it difficult to make time for personal calls during regular business hours."
"Can't afford it."	"Too hard to take off work to go."
"I couldn't afford the co-pay."	"Appointment times inconvenient because I work during business hours too."
"Co-pay too expensive; cannot afford."	"Work prevents me from follow up with care after diagnosis."
"Dentist cost a lot of money."	"I cannot take time off to go to my doctor's appointments because my job has a policy that two people cannot be off at the same time."

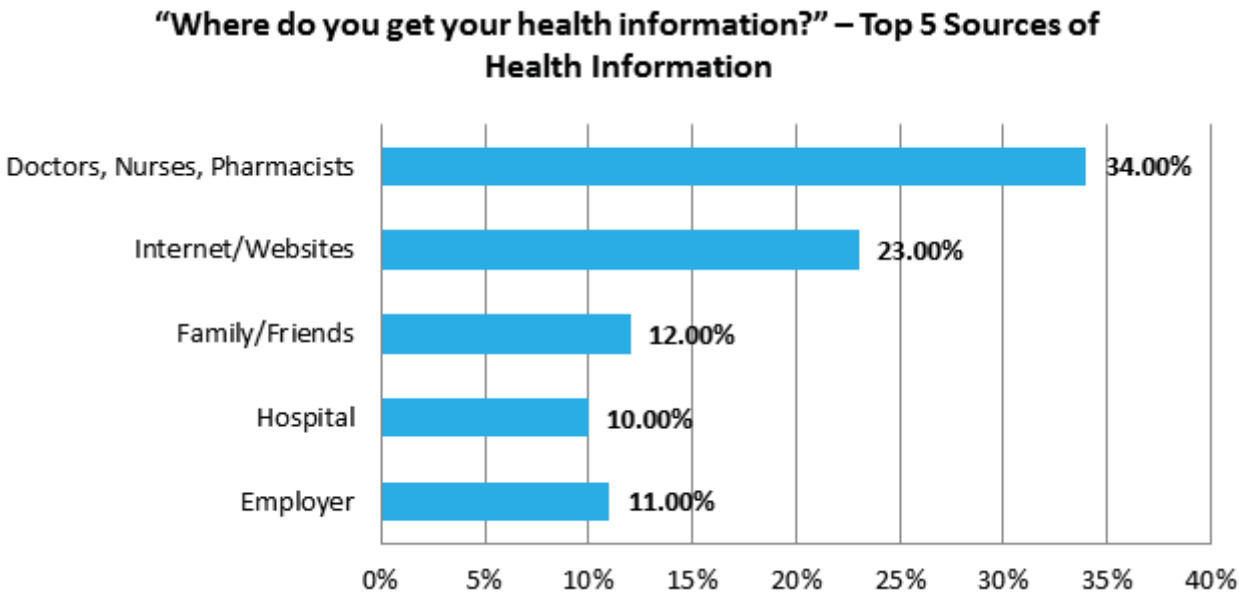
Next, respondents were asked if they travel outside of Harford County to get medical help. More than one-third of respondents (35.66%) travel outside of the County for medical help. Respondents travel outside of the county for primary care, obstetrics/gynecology, and specialty care. The following is a summary of the approximate number of times the most prominent types of care/providers were mentioned.

Table 4. "Other" Types of Care/Providers Respondents Travel Outside of the County to Visit

Type of Care/Provider	Number of Mentions
Primary care/Routine care	122
Obstetrics/Gynecology	81
Specialist	49
Dentist	18
Rheumatologist	16
Oncology	13
Surgery	12
Dermatology	10
Eye Doctor	9
Neurology	8
Mental Health	8
Orthopedics	8
Endocrinology	7
Pediatric	7
Gastrointestinal	6

Health Information

Respondents were asked to indicate where they get their health information. Approximately 90% of respondents get their information from one of the five sources shown in the graph below. More than one-third of participants (34%) reported that they get health-related information from health professionals (doctors, nurses, pharmacists). Respondents also indicated that they get health information from a variety of sources that were listed, not just one source.



Health Status & Chronic Health Issues

Overall Physical & Mental Health

Respondents were asked to rate their general health status. Approximately 56% of respondents stated their general health is very good or excellent. Approximately 11% of respondents stated their general health is fair or poor. Respondents were also asked to rate their overall physical and mental health. In general, self-reported measures of poor physical and mental health days were favorable among Harford County respondents. Nearly 50% of respondents reported having no poor physical health (including physical illness and injury) or mental health (including stress, depression, and problems with emotions) during the past 30 days. Thirty percent of respondents reported having poor physical health and 26% reported having poor mental health for a maximum of one to two days during the past 30 days.

Respondents were also asked how many hours of sleep they get in a 24 hour period on average. The vast majority of respondents (87.27%) reported getting 5 to 8 hours of sleep and 7.93% reported getting 9 to 12 hours of sleep. An average of 7 to 9 hours of sleep is recommended for adults by the National Sleep Foundation.

Physical Activity

It is widely supported that physical activity can inhibit health concerns such as obesity and overweight, heart disease, joint and muscle pain, and many others. It is recommended that individuals regularly engage in at least 30 minutes of moderate physical activity, preferably daily, and at least 20 minutes of vigorous physical activity several days a week. Approximately 72% of respondents reported that they have participated in physical activities or exercises such as running, calisthenics, golf, gardening or walking during the past month. Among respondents who participated in physical activity, the majority (51.50%) reported participating in exercise 1 to 5 times per week, and nearly 10% were physically active 6 to 10 times per week. The majority of respondents (59.29%) engaged in exercise for 30 minutes to 1 hour. These findings may indicate that the majority of respondents for Harford County engage in physical activity on a regular basis.

Dietary Behaviors

Respondents were asked about their consumption of fruits and vegetables. Only 10% of respondents reported eating fruits and/or vegetables three or more times a day. Approximately one-third of respondents eat fruits and/or vegetables one to two times per day.

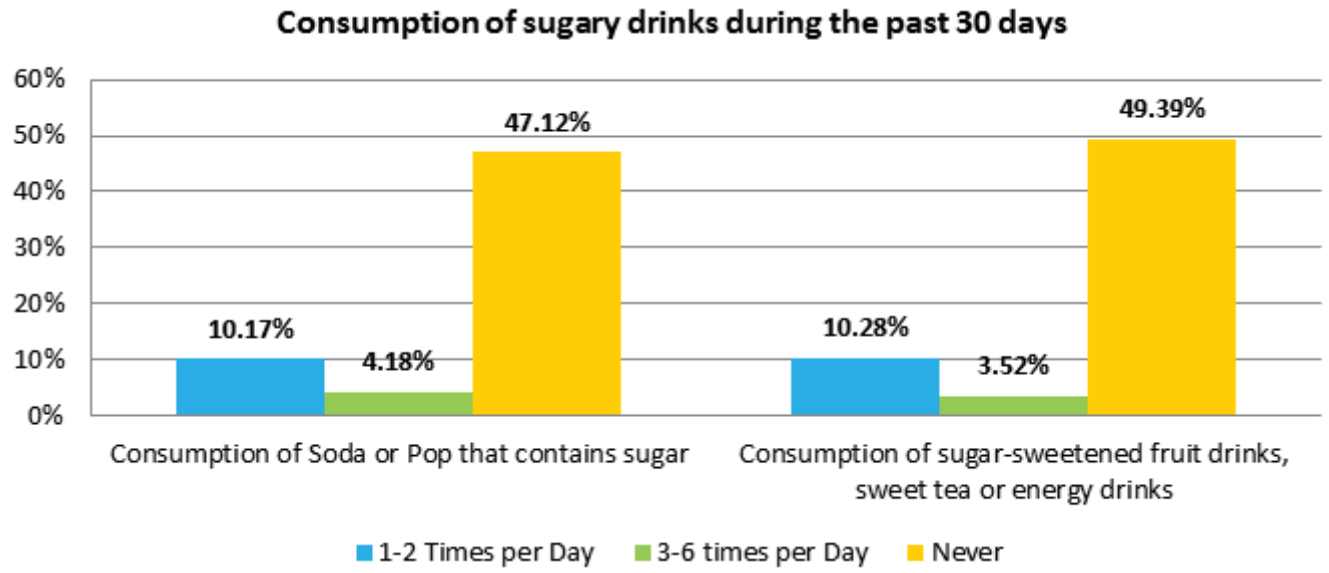
Table 6. Fruit and Vegetable Consumption

	Consumption of Fruits	Consumption of Vegetables
1 to 2 Times per Day	37.67%	31.31%
3 to 6 Times per Day	9.34%	9.78%
1 to 2 Times per Week	16.19%	18.23%
3 to 6 Times per Week	21.24%	29.92%
1 to 3 Times per Month	10.27%	8.04%
Never	3.89%	1.68%

The majority of respondents reported that they never drink soda or sugar-sweetened drinks (47.12% and 49.39% respectively). Nearly one quarter of respondents reported drinking soda and/or sugar-sweetened drinks one to nine times a month (25.28% and 22.70% respectively). In contrast, approximately 14% of respondents reported drinking soda and sugar-sweetened drinks respectively, one to six times per day. Strong evidence indicates that consumption of sugary drinks on a regular basis contributes to the development of type 2 diabetes, heart disease, and other chronic conditions.

Table 7. Regular Soda and Sugar-Sweetened Drink Consumption

	Consumption of Soda or Pop that contains sugar	Consumption of sugar-sweetened fruit drinks, sweet tea or energy drinks
1 - 2 Times per Day	10.17%	10.28%
3 - 6 Times per Day	4.18%	3.52%
1 - 6 Times per Week	8.31%	6.82%
7 - 15 Times per Week	1.28%	2.02%
More than 15 Times per Week	0.52%	0.64%
1 - 9 Times per Month	25.28%	22.70%
10 - 25 Times per Month	1.05%	2.08%
More than 25 Times per Month	0.52%	0.81%
Never	47.12%	49.39%



Next, respondents were asked if they are currently watching or reducing their sodium or salt intake. More than half of the respondents (51.59%) reported that they are not watching or reducing their salt or sodium intake currently and another 46.78% reported that they are currently watching or reducing their sodium or salt intake.

Chronic Conditions

Some chronic conditions are of concern in Harford County, including high cholesterol, high blood pressure, anxiety disorder and depressive disorder. Approximately 30% of respondents have been told they have high cholesterol and/or high blood pressure and 25% have been told they have an anxiety and/or depressive disorder. In addition, 22.8% of respondents have been told they have arthritis and 17.82% of respondents have been told they have asthma. Respondents also mentioned other chronic conditions that they have been diagnosed with but were not included in the survey list. Hyper/Hypothyroidism was the most frequently mentioned condition. A summary of chronic condition diagnoses among respondents is reported in Table 8.

Table 8. Chronic Condition Diagnoses

Chronic Condition	%
High blood pressure	30.30
High cholesterol	29.85
Anxiety disorder	25.18
Depressive disorder	24.63
Arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia	22.78
Asthma	17.82
Diabetes	9.35
Cancer	7.77
Angina or coronary disease	2.94
Chronic Obstructive Pulmonary Disease	2.24
Heart attack	1.82
Stroke	1.76

Respondents who reported having cancer were asked to specify the type of cancer with which they were diagnosed. The most common types of cancer reported by respondents included skin cancer (other than melanoma), breast cancer, and melanoma. Table 9 highlights the top 12 cancer types reported by respondents.

Table 9. Most Common Cancer Types Reported

Cancer Types	%
Other skin cancer	38.89
Breast cancer	20.56
Melanoma	12.78
Cervical cancer	8.89
Lung cancer	4.44
Thyroid cancer	4.44
Prostate cancer	3.33
Ovarian cancer	3.33
Endometrial (uterus) cancer	2.22
Bladder cancer	2.22
Head and neck cancer	1.11
Stomach	1.11

Health Risk Factors

Health Behaviors

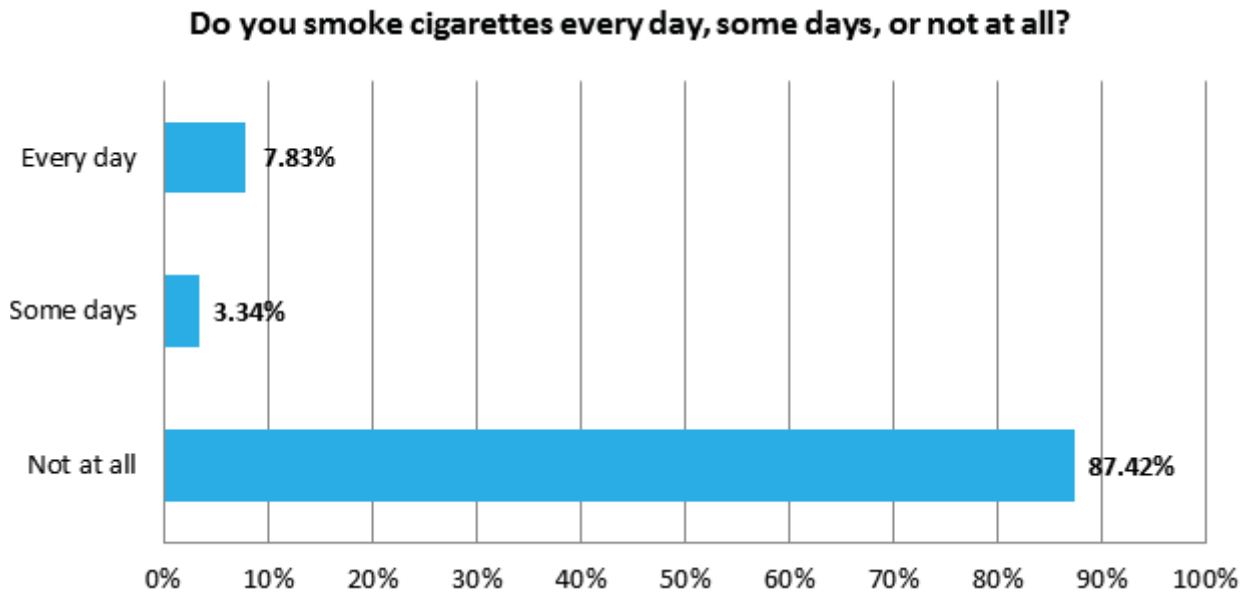
The survey respondents were asked to rate their level of health and safety practices on a scale of "1 – Always" to "5 - Never." As detailed in the table below, respondents were highly likely to use safety measures including wearing a seatbelt, practicing safe sex, using sunscreen regularly, and driving responsibly. In addition, respondents were less likely to eat fast foods more than once a week, use electronic cigarettes, get exposed to second-hand smoke, use marijuana, or misuse prescription drugs. However, 24.20% of respondents reported feeling stressed out or overwhelmed "Always" or "Most of the time."

Table 10. Respondent Health and Safety Practices

Factor	Frequency of "Always" and "Most of the Time" Responses
Wear a seatbelt	97.7%
Wear a helmet while riding a bicycle, scooter, roller blading, etc.	33.81%
Eat fast food more than once a week	12.37%
Use electronic cigarettes	1.74%
Get exposed to second hand smoke or vaping mist at home or work	6.61%
Use marijuana	1.33%
Misuse prescription drugs, opioids, heroin, or other illegal drugs	0.41%
Exercise 30 minutes a day, 3 times a week	34.27%
Use sunscreen regularly	47.75%
Practice safe sex i.e. use a condom, monogamous, get tested	67.11%
Feel stressed out or overwhelmed	24.20%
Drive responsibly, follow safe rules of the road, drive within the speed limit	89.00%

Tobacco & Alcohol Use

Risky behaviors related to tobacco and alcohol use were measured as part of the survey. Approximately 34% of respondents reported smoking at least 100 cigarettes in their lifetime. Among this group, 87.42% reported they currently do not smoke at all, whereas 7.832% smoke every day and 3.34% smoke some days.



In regards to alcohol use, almost two-thirds of respondents (65.66%) did not have an alcoholic beverage during the past 30 days. Among respondents who did drink an alcoholic beverage, 22.16% participated in binge drinking one to two times during the past month. Only a very small percentage of respondents (approximately 11%) participated in binge drinking three or more times during the past month. Binge drinking is defined as four drinks or more on one occasion for women and five drinks or more on one occasion for men.

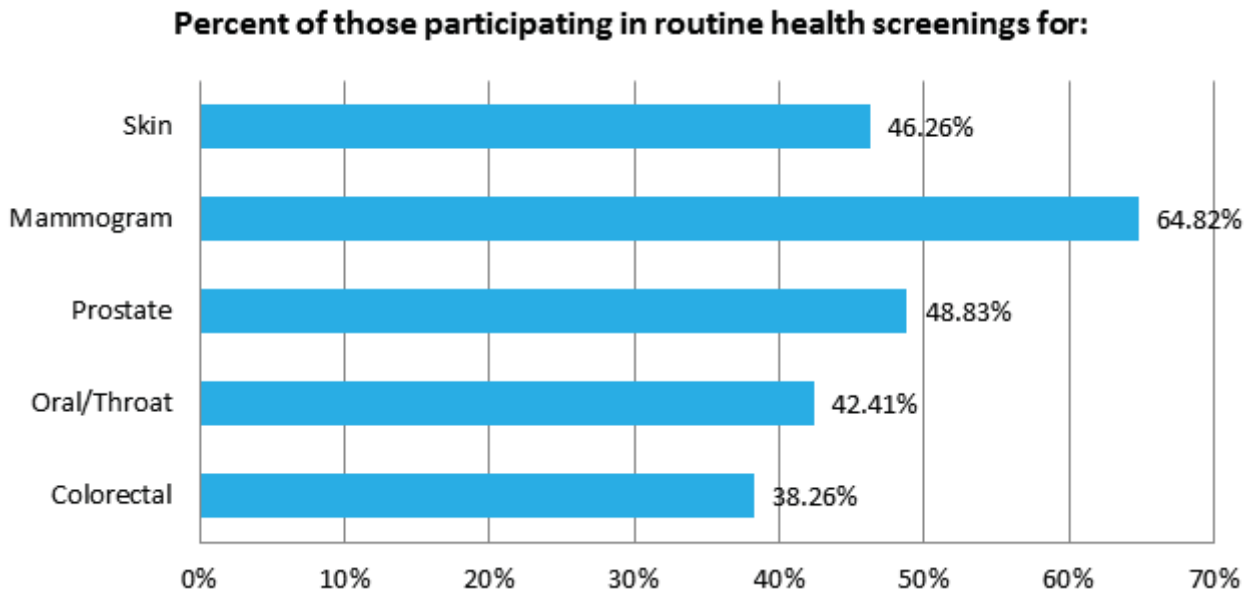
Preventive Health Practices

Immunizations

A positive finding among Harford County respondents was the prevalence of immunizations. In the past 12 months, 78.98% of respondents received a flu vaccine either as a shot or a nasal spray.

Screenings

The prevalence of routine health screenings among Harford County respondents varies based on the type of screening. In general, Harford County respondents are less likely to receive skin screenings. Only 46.26% of respondents have routine health screenings for skin-related conditions. Oral/throat health screenings and prostate screenings are also less prevalent among Harford County respondents (42.41% and 48.83% respectively). A low percentage of respondents also participate in routine health screenings for colorectal cancer (38.26%). In contrast, a larger proportion of respondents participate in routine mammogram screening (64.82%).



Key Health Issues

Respondents were asked to rank the three most significant health issues facing Harford County. The respondents could choose from a list of 13 health issues as well as suggest their own that were not on the list. Drug/Alcohol abuse was the primary area of shared concern among Harford County respondents. Nearly 83% of respondents selected this issue as one of the top three most pressing health issues facing the county. Mental Health/Suicide was also a concern shared by 44.80% of respondents. The third most pressing health issue, as viewed by the respondents was overweight/obesity with a 41.36% rating. The following table shows the breakdown of the percent of respondents who selected each health issue.

Table 11. Ranking of the Top Three Most Pressing Health Issues

Rank	Key Health Issues	Count	Percent of Respondents Who Selected The Issue
1	Drug Abuse/Alcohol Abuse	1,442	82.83%
2	Mental Health/Suicide	780	44.80%
3	Overweight/Obesity	720	41.36%
4	Cancer	442	25.39%
5	Access to Care/Uninsured	438	25.16%
6	Diabetes	324	18.61%
7	Heart Disease	302	17.35%
8	Tobacco Use/Smoking	254	14.59%
9	Alzheimer's Disease/Aging Issues	210	12.06%
10	Dental Health	150	8.62%
11	Sexually Transmitted Diseases	43	2.47%
12	Other	42	2.41%
13	Stroke	38	2.18%
14	Maternal/Infant Health (Pregnancy)	38	2.18%

In addition, respondents were asked through an open-ended response to specify other pressing issues they think are facing Harford County. The most frequently voiced issues included drug abuse, transportation, homelessness, and non-compliance. A complete listing of answers given by respondents shown below.

Most Pressing Health Issues Facing Harford County:

- "Homeless people/we need Homes!"
- "Opioid use/overdose"
- "Transportation"
- "Dental health for adults on fixed income with Medical Assistance."
- "Doctor, not Urgent Care facilities, where you can get an appointment in under 2 weeks"
- "Medication costs"
- "Healthcare costs"
- "Noncompliance with care recommendations/medication"
- "Additional Treatment"
- "Kidney stones"
- "Opioids and liberal Rx writing by Practitioners"
- "Having to wait weeks or months for an appointment"
- "Lyme disease"
- "Counseling"
- "Glasses to wear"
- "Too much sugar"

Barriers to Services

Respondents were asked to consider the most significant barriers that keep people in the community from accessing health services. The five most significant barriers included cost of out of pocket expenses (81.40%), lack of health insurance coverage (57.62%), lack of transportation (42.03%), difficult to understand/navigate health care system (37.15%), and inability find a doctor/get an appointment (35.58%). Responses are summarized in the table below.

Table 12. Barriers to Accessing Health Care

Rank	Key Health Issues	Count	Percent of Respondents Who Selected The Barrier
1	Cost/Paying Out of Pocket Expenses (Co-pays, Prescriptions, etc.)	1400	81.40%
2	Lack of Health Insurance Coverage	991	57.62%
3	Lack of Transportation	723	42.03%
4	Difficult to Understand/Navigate Health Care System	639	37.15%
5	Can't Find Doctor/Can't Get Appointment	612	35.58%
6	Basic Needs Not Met (Food/Shelter)	574	33.37%
7	Not Enough Time	333	19.36%
8	Lack of Child Care	252	14.65%
9	Lack of Trust	245	14.24%
10	Language/Cultural Issues	171	9.94%
11	Other	73	4.24%
12	None/No Barriers	58	3.37%

Respondents also identified through an open-ended response other significant barriers that they perceived were keeping people in the community from accessing health care. The vast majority pointed out lack of education and awareness as the most significant barrier. Responses such as "people lack education on how to maintain general health" and "they lack understanding of common health issues such as stroke, heart attack and diabetes" were very common. Other barriers that were mentioned frequently included conflicting work schedules, laziness, and the stigma or fear of addressing issues.

Resources Needed to Improve Access

Respondents were asked what resources or services are missing in the community. More than half of respondents (51.93%) indicated that free/ low-cost dental care services are missing in the community. A few other resources identified as missing included mental health services (42.46%), substance abuse services (42.22%), free/ low-cost vision/eye care (38.13%), and free/ low-cost Medicare services (37.95%). In addition, respondents indicated through an open-ended question that they want to have more access to affordable senior living facilities, health insurance, and substance abuse programs. Table 12 includes a listing of missing resources in rank order.

Table 13: Listing of Resources Needed in the Community

Rank	Resources Needed	Count	Percent of Respondents Who Selected The Resource
1	Free/Low Cost Dental Care	888	51.93%
2	Mental Health Services	726	42.46%
3	Substance Abuse Services	722	42.22%
4	Free/Low Cost Vision/Eye Care	652	38.13%
5	Free/Low Cost Medicare Care	649	37.95%
6	Transportation	597	34.91%
7	Prescription Assistance	560	32.75%
8	Access to Affordable Fresh Fruits & Vegetables	529	30.94%
9	Health Education/Information/Outreach	428	25.03%
10	Elder Care/Senior Services	395	23.10%
11	Health Screenings	373	21.81%
12	Primary Care Providers (Family Doctors	315	18.42%
13	Immunization/Vaccination Programs	197	11.52%
14	Bilingual Services	186	10.88%
15	Medical Specialists (Ex. Cardiologist)	152	8.89%
16	Availability of Parks & Recreation Areas	149	8.71%
17	Prenatal Care Services	85	4.97%
18	Other	58	3.39%
19	None	53	3.10%

Risky Behaviors in our Community

Respondents were asked to rank the three most important "risky behaviors" in Harford County. The respondents could choose from a list of 12 risky behaviors as well as suggest their own that were not on the list. Drug abuse was the most frequently identified risky behavior. Nearly 90% of respondents selected this issue as one of the top three most important risky behaviors in the county. Alcohol abuse was also a concern shared by 47.90% of respondents. The third most identified risky behavior, as viewed by the respondents, was being overweight with a 41.99% rating. In addition, respondents indicated through an open-ended question that texting while driving was an identified risky behavior. Table 13 includes a listing of risky behaviors in rank order.

Table 14. Ranking of the Top Three Most Important "Risky Behaviors"

Rank	Key Health Issues	Count	Percent of Respondents Who Selected The Issue
1	Drug Abuse	1555	89.32%
2	Alcohol Abuse	834	47.90%
3	Being overweight	731	41.99%
4	Poor eating habits	553	31.76%
5	Tobacco use	353	20.28%
6	Lack of exercise	303	17.40%
7	Unsafe sex	201	11.55%
8	Racism	194	11.14%
9	Not using birth control	141	8.10%
10	Dropping out of school	132	7.58%
11	Not getting "shots" to prevent disease	119	6.84%
12	Not using seat belts/child safety seats	57	3.27%
13	Other	50	2.87%

Needs for a Healthy Community/Quality of Life

Respondents were asked to rank the three most important needs for a "Healthy Community". The respondents could choose from a list of 16 things that most improve the quality of life in a community as well as suggest their own that were not on the list. Low crime/safe neighborhoods was the most identified need. More than half of respondents (54.51%) selected this issue as one of the top three needs for a healthy community. Access to health care was also a need shared by 37.51% of respondents. The third most identified need, as viewed by the respondents, was healthy behaviors and lifestyles with a 34.81% rating. Table 14 includes a listing of important needs for a "Healthy Community" in rank order.

Table 15. Ranking of the Top Three Most Important Needs for a "Healthy Community"

Rank	Key Health Issues	Count	Percent of Respondents Who Selected The Issue
1	Low crime/safe neighborhoods	949	54.51%
2	Access to health care (e.g., family doctor)	653	37.51%
3	Healthy behaviors and lifestyles	606	34.81%
4	Good jobs and healthy economy	560	32.17%
5	Good schools	503	28.89%
6	Strong family life	442	25.39%
7	Affordable housing	382	21.94%
8	Good place to raise children	337	19.36%
9	Religious or spiritual values	227	13.04%
10	Clean environment	197	11.32%
11	Parks and recreation	111	6.38%
12	Excellent race relations	95	5.46%
13	Low level of child abuse	74	4.25%
14	Low adult death and disease rates	36	2.07%
15	Arts and cultural events	25	1.44%
16	Other	23	1.32%
17	Low infant deaths	3	0.17%

Community Feedback

What Prevents You From Being Healthy In Harford County?

Respondents were asked to comment on what prevents them from being healthy in Harford County. The most common responses referenced lack of time, affordable health care, transportation, the high cost of healthy foods, and work-related issues.

Select Responses:

- "Healthy food is too expensive, needs to be low cost healthy food."
- "Money, even with insurance, I am unable to afford the co-pays for the services my insurance covers, so I don't go."
- "Can't afford housing, no train, no buses that work."
- "Transportation challenges for those without a car."
- "Cost of fresh fruits and vegetables."
- "Lack of easy access to outdoor recreation."
- "Demanding full-time job, raising busy family."
- "No drug awareness education program in elementary school. The county and state must step up and make it a top priority to help our youth."
- "Out of pocket costs for healthcare."
- "Healthcare hours aren't convenient."
- "No doctor will see a new patient in a reasonable time."
- "Lack of resources, cost of healthcare, lack of mental health support."
- "Affordable exercise programs and flexible doctor hours."
- "Work too many hours for too little pay which leaves me stressed for time."
- "Getting doctor's appointments in a reasonable amount of time."
- "Exhausted, single parent, short staffed at work – no lunch, no breaks."
- "My job – they talk the talk, but don't walk the walk."
- "Cost of groceries."
- "I am living from paycheck to paycheck. I cannot afford to buy the healthier foods to eat due to their cost is higher than the cost of processed and pre-packaged foods. Time is another issue. Not enough community activities that young, single and older single adults can go to mingle and develop friendships."
- "Cost of living and lack of good paying jobs."
- "Too many fast food options."
- "Horrible public transportation access."
- "Time to cook healthy and get outside to exercise."
- "Harford County needs engaging affordable activities for child, teens and elderly citizens."
- "Cost of living too high, pay is too low, co-pays just continue to increase."
- "Lack of adult dental care and good paying jobs."

General/Additional Comments:

- "Local transportation needs to be more readily available."
- "More mental health facilities/providers are desperately needed."
- "More community programs for Route 40 corridor."
- "Harford County and the State of MD need to address the heroin issue. Drug awareness education needs to be implemented in all elementary Social Studies curriculum. This is a serious issue and children must be educated by using a new high tech drug awareness program. The VHS tape program of the 1990's is completely obsolete."
- Harford County needs to up the pay rates for hard working employees and provide better more affordable housing."
- "WE NEED TO FIND PEDIATRIC PSYCH CARE!!!! How in the world can we raise children to be strong productive members of our community if we are not helping children in need of mental illness help!!! It's out of control."
- "Make health care affordable for everyone."
- "To help the people with no insurance to get the care and help the need."
- "Health education needs to have congruency starting in elementary schools all the way through high school. We cannot preach good eating habits and have vending machines in school or serve hot dogs and pizza in school cafeterias."
- "PCP involvement to stop the Opioid crisis."
- "Harford County also needs user friendly assistance for adults with prescription medication...and assistance with substance abuse treatments. Cost is a big issue."
- "Nutrition counseling services are grossly unattainable."
- "We desperately need drug abuse assistance as well as mental health assistance in this county."
- "Our county is in need of practical and affordable transportation options for community members, especially the senior community members."
- "There is a significant need for affordable access to healthy food and for affordable coverage for individuals who are on medical assistance."
- "Navigating a system while managing a family and full time job is difficult."
- "Need more specialists that you can see quickly."

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"When 'I' is replaced by 'We', illness becomes wellness."

- Shannon L. Adler

EXHIBIT 18

MARYLAND
DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY
SPRING GROVE CENTER
BLAND-BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 12-006

Issued to:

University Of M D Upper Chesapeake Medical Center
500 Upper Chesapeake Drive
Bel Air, MD 21014

Type of Facility: Acute General Hospital

Date Issued: July 1, 2018

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

Patricia Tomasko May, MD

Director

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

MARYLAND
DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 12-004

Issued to:

University Of Maryland Harford Memorial Hospital
501 South Union Avenue
Havre De Grace, MD 21078

Type of Facility: Acute General Hospital

Date Issued: July 1, 2018

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University of Maryland Upper Chesapeake Medical Center

Bel Air, MD

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

December 8, 2018

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #6279
Print/Reprint Date: 02/19/2019

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

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University of Maryland Harford Memorial Hospital

Havre De Grace, MD

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

November 17, 2018

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #502615
Print/Reprint Date: 02/06/2019

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

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Search Again

Return to Multiple Results Page

You entered Legal Business Name: Upper Chesapeake Medical Center

DCN/CCN	640795002
NPI	1598761355
Tracking Id	
Application Type	855A
Name	
Legal Business Name	UPPER CHESAPEAKE MEDICAL CENTER
Received Date	2014-03-20

The status of this application is: Approved

Novitas Solutions has processed and approved this CMS-855, CMS-20134, EFT application, or Opt Out request.

Please refer to the notification letter for complete details and additional required action.

Status History	
Date	**Status**
March 27, 2014	Approved
March 24, 2014	In Process

Search Again

Return to Multiple Results Page

You entered Legal Business Name: Harford Memorial Hospital

DCN/CCN	761500900004-001
NPI	1770589533
Tracking Id	
Application Type	855A
Name	
Legal Business Name	HARFORD MEMORIAL HOSPITAL
Received Date	2016-05-20

The status of this application is: Approved

Novitas Solutions has processed and approved this CMS-855 or EFT application.

Please refer to the notification letter for complete details and additional required action.

Status History	
Date	**Status**
June 15, 2016	Approved
June 15, 2016	In Process
June 15, 2016	In Process
June 13, 2016	Payment Hold
June 6, 2016	In Process
May 31, 2016	Payment Hold
May 31, 2016	In Process
May 17, 2016	Payment Hold
March 28, 2016	In Development
March 28, 2016	In Development
May 21, 2015	Activated/Received
May 21, 2015	In Process
April 14, 2015	Revalidation Requested
January 9, 2015	Revalidation Requested

HEALTHCHOICE

MARYLAND CHILDREN'S HEALTH PROGRAM

MARYLAND PHARMACY ASSISTANCE PROGRAM

LONG TERM CARE

SPECIALTY MENTAL HEALTH SERVICES

WAIVER PROGRAMS

LISTING OF LOCAL DEPARTMENTS OF SOCIAL SERVICES

MEDICAL PROGRAMS HOME

FOR PROVIDERS: WHAT SHOULD I DO IF MY INFORMATION IS INCORRECT?

Search Criteria

MCO: Not Specified **Provider Type:** HOSPITAL - ACUTE
Last Name: Harford Memorial **Provider Location:** State of **MD**
Show only PCP? No

Time taken to search:94 ms <Previous **1** Next> **[Showing 1 - 1 of 1]**

Print this page Search

HARFORD MEMORIAL HOSPITAL
501 S UNION AVE
HAVRE DE GRACE , MD 21078
(443) 643-3721

Provider Number:**0002551 61**
NPI:**1770589533**
HOSPITAL, ACUTE

Handicap Accessible: Y TTY: Y EPSDT Certified:N

Managed Care Organization(s):

AMERIGROUP COMMUNITY CARE	Primary Care Physician: N	
MARYLAND PHYSICIANS CARE	Primary Care Physician: N	Accepting New Patients:N
PRIORITY PARTNERS	Primary Care Physician: N	
U M HEALTH PARTNERS	Primary Care Physician: N	Accepting New Patients:N
UNITEDHEALTHCARE	Primary Care Physician: N	

<Previous **1** Next> **[Showing 1 - 1 of 1]**

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HEALTHCHOICE

MARYLAND CHILDREN'S HEALTH PROGRAM

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SPECIALTY MENTAL HEALTH SERVICES

WAIVER PROGRAMS

LISTING OF LOCAL DEPARTMENTS OF SOCIAL SERVICES

MEDICAL PROGRAMS HOME

FOR PROVIDERS: WHAT SHOULD I DO IF MY INFORMATION IS INCORRECT?

Search Criteria

MCO: Not Specified **Provider Type:** HOSPITAL - ACUTE
Last Name: Upper Chesapeake **Provider Location:** State of **MD**
Show only PCP? No

Time taken to search:390 ms <Previous **1** Next> **[Showing 1 - 3 of 3]**

Print this page Search

UPPER CHESAPEAKE MEDICAL CENTE
500 UPPER CHESAPEAKE DR
BEL AIR , MD 21014
(443) 643-1000

Provider Number:**1413017 60**
NPI:**1598761355**
HOSPITAL, ACUTE

Handicap Accessible: Y TTY: N EPSDT Certified:N

Managed Care Organization(s):

MARYLAND PHYSICIANS CARE Primary Care Physician: N Accepting New Patients:N

UPPER CHESAPEAKE MEDICAL CENTE
500 UPPER CHESAPEAKE DR
BEL AIR , MD 21014
(443) 643-1000

Provider Number:**0004758 61**
NPI:**1598761355**
HOSPITAL, ACUTE

Handicap Accessible: Y TTY: Y EPSDT Certified:N

Managed Care Organization(s):

AMERIGROUP COMMUNITY CARE Primary Care Physician: N
MARYLAND PHYSICIANS CARE Primary Care Physician: N Accepting New Patients:N
U M HEALTH PARTNERS Primary Care Physician: N Accepting New Patients:N

UPPER CHESAPEAKE MEDICAL SERVI
500 UPPER CHESAPEAKE DR
BEL AIR , MD 21014
(443) 643-1500

Provider Number:**0218227 60**
NPI:**1497801419**
HOSPITAL, ACUTE

Handicap Accessible: Y TTY: Y EPSDT Certified:N

Managed Care Organization(s):

U M HEALTH PARTNERS Primary Care Physician: N Accepting New Patients:N

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