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August 4, 2017

VIA EMAIL & HAND DELIVERY

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

Re: Request for Certificate of Exemption from CON Review – Merger and Consolidation of UM Harford Memorial Hospital, Inc., and UM Upper Chesapeake Medical Center, Inc.

Dear Ms. Potter:

On behalf of University of Maryland Upper Chesapeake Medical Center and University of Maryland Harford Memorial Hospital, as joint applicants, we are submitting six copies of a request for exemption from Certificate of Need review and related exhibits, along with two sets of full-size project drawings. Also enclosed is a CD containing searchable PDF files of the application and exhibits, Word versions of the application and available exhibits, and native Excel spreadsheets of the MHCC tables and available exhibits.

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

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#600945
011888-0023

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

Sincerely,

A handwritten signature in black ink, appearing to read "Lyle E. Sheldon". The signature is fluid and cursive, with the first name "Lyle" being the most prominent.

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

Enclosures

cc: 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, 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

IN THE MATTER OF THE MERGER *
AND CONSOLIDATION OF * BEFORE THE
UNIVERSITY OF MARYLAND UPPER * MARYLAND HEALTH CARE
CHESAPEAKE MEDICAL CENTER * COMMISSION
AND HARFORD MEMORIAL HOSPITAL *
* * * * *

**REQUEST FOR EXEMPTION
FROM CERTIFICATE OF NEED REVIEW
MERGER AND CONSOLIDATION OF HARFORD MEMORIAL HOSPITAL
AND UPPER CHESAPEAKE MEDICAL CENTER**

University of Maryland Upper Chesapeake Medical Center, Inc. (“UCMC”) and Harford Memorial, Inc. (“HMH”), by their undersigned counsel, seek approval from the Maryland Health Care Commission (the “Commission”) to relocate MSGA beds from HMH to UCMC and to construct a three story addition to UCMC pursuant to a merger and consolidation of these two facilities in accordance with COMAR 10.24.01.02(A)(3)(c) and 10.24.01.04(A)(4)-(5). 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.

BACKGROUND

HMH is an acute care hospital with fifty-seven (57) licensed MSGA beds and twenty-nine (29) licensed psychiatric beds located in Havre de Grace. UCMC is a 171-bed licensed acute care hospital located in Bel Air, with 160 MSGA beds, 10 obstetrics beds, and 1 pediatric bed. 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 (“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 UCHS has been affiliated with the University of Maryland Medical System (“UMMS”) since 2009, and in late 2013, UM UCHS 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 UCHS 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; and (2) Senator Bob Hooper House, a residential hospice facility in Forest Hill.

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. 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. Consistent with local and national healthcare trends and to best promote access to convenient and quality care for the population it serves, UM UCHS proposes to transition portions of HMH to a multi-service facility to be located on an approximate ninety-seven (97) acre property known as the Upper Chesapeake Health Medical Campus at Havre de Grace (“UC Medical Campus at Havre de Grace”), approximately three miles from the existing HMH campus and conveniently located off of Interstate 95. Contemporaneous with this Request for Exemption from CON review, HMH and UCMC, as joint applicants, have sought a Request for Exemption to convert HMH to a freestanding medical facility to be located on the UC Medical Campus at Havre de Grace, and

UM UCH has filed a CON Application to establish a forty (40) bed special psychiatric hospital which will be connected to and located beneath the freestanding medical facility.

Upon conversion of HMH to a freestanding medical facility, there will be loss of medical/surgical/gynecological/addictions (“MSGA”) bed capacity in Harford County. The Commission projects a minimum need of 168 MSGA beds for Harford County in 2025 and a maximum MSGA bed need of 223. Maryland Register, v. 44, Issue 2 (Jan. 20, 2017). UCMC is presently licensed for only 160 MSGA beds – less than the Commission’s projected minimum need. Thus, upon conversion of HMH to a freestanding medical facility, Harford County will clearly have a need for additional MSGA beds. As discussed more fully herein, the applicants have projected a need to relocate all of HMH’s MSGA beds to UCMC.

To house the beds to be transferred from HMH to UCMC, UCMC proposes to construct a three-story, 78,070 square foot addition above the Kaufman Cancer Center to house forty-one (41) MSGA beds and thirty-two (32) observation beds. Because the Kaufman Cancer Center was designed to accommodate vertical expansion and is one of the final locations on the UCMC campus that is capable of being developed, UCMC also proposes to construct one floor of shell space to accommodate future growth of the Kaufman Cancer Center’s diagnostic and treatment services and/or additional future inpatient and observation needs. The proposed addition has been designed in accordance with applicable building codes and the Facilities Guidelines Institute, Guidelines for Design and Construction of Hospitals and Outpatient Facilities 2014 Edition (“FGI Guidelines”). A more detailed description of the project is provided below.

DISCUSSION

Maryland Code, Health-General §§ 19-120(j) permits a hospital to increase the volume of an existing health care service if the proposed change: (i) is pursuant to the merger of two or

more health care facilities, (ii) is not inconsistent with the State Health Plan; (iii) will result in the delivery of more effective and efficient service, and (iv) is in the public interest. Similarly, COMAR 10.24.01.02(A)(3)(c) provides that a CON is not required to change the bed capacity of a hospital if the change in bed capacity is “proposed pursuant to a merger or consolidation between health care facilities” and the Commission finds that the change is not inconsistent with the State Health Plan, will result in the delivery of more efficient and effective health care services, and is in the public interest. The Commission may also exempt the requirement of CON review and approval for capital expenditures and changes in the scope of health care services offered by a health care facility if done as part of a consolidation or merger of two hospitals. Health-General § 19-120(k)(6)(v); COMAR 10.24.01.04(A)(4)-(5).

Health-General § 19-120(a)(1)(2) defines “consolidation” or “merger” to include “increases or decreases in bed capacity or services among the components of an organization that: (i) operates more than one health care facility[.]” “Health care facility” is defined to include a “hospital.” COMAR 10.24.01.01(B)(12). “Health care service means any clinically related patient service,” including a “medical service.” Health-General § 19-120(a)(3)(i)-(ii). In turn, a “medical service” includes “medicine, surgery, gynecology, addictions.” *Id.* § 19-120(a)(5); COMAR 10.24.01.01(B)(27).

Because UCMC and HMH are both owned and operated by UM UCH, the relocation of MSGA bed capacity from HMH to UCMC constitutes a consolidation or merger in accordance with Health-General § 19-120(a)(1)(2) and COMAR 10.24.01.02(A)(3)(c). Further, the proposed MSGA bed relocation and associated capital expenditures are not inconsistent with the State Health Plan, will result in the delivery of more efficient and effective health care services, and are in the public interest.

I. COMPREHENSIVE PROJECT DESCRIPTION

The existing Kaufman Cancer Center was constructed in 2011. It occupies two stories above the garden level parking garage but was designed to accommodate an additional three floors of vertical expansion. The proposed expansion project will provide 26,290 square of additional space on each of three floors. Level 3, the first floor of new construction will be constructed as shell space, with a horizontal connection to UCMC's existing top floor (the existing hospital is a total of three stories above the garden level). Levels 4 and 5 of the new construction will house a new dedicated observation unit and new MSGA units. More specifically, the MSGA unit on Level 5 will house thirty (30) private rooms, including five (5) 310 square foot patient rooms to accommodate patients with disabilities and twenty-five (25) private rooms each constructed at 285 square feet. Level 4 will include both a dedicated observation unit and an MSGA unit. The observation unit on Level 4 will include four (4) private rooms each constructed at 285 square feet, and fourteen (14), 450 square foot semi-private patient rooms, with each room housing two bathrooms. Also planned for Level 4 are eleven (11) private MSGA rooms each constructed at 285 square feet.¹

To support of the additional inpatient beds, 1,164 square feet on the existing Garden Level will be renovated to expand the food services department (kitchen) by 453 square feet. Further, 256 square feet on existing Level 1 of the Kaufman Cancer Center will be renovated to accommodate the Fire Command Center required for a high-rise building.

¹ Before first use of the new eleven bed MSGA unit to be located on Level 4 of the Kaufman Cancer Center, UCMC will convert a total of ten (10) existing semi-private MSGA rooms to private rooms and remove headwalls and cap gas lines if required by the Commission. See Exhibit 1 at Table A. The exact semi-private rooms that will be converted to private rooms will be determined at a later date to taking into consideration the most efficient use of staff and resources.

To separate traffic flows to and from the inpatient units from traffic flows to and from the existing Kaufman Cancer Center at the existing public elevator bank, a new and separate public elevator and lobby will be established. Further, a 512 square foot addition on Level 1 will relocate toilets currently at the location of the proposed new lobby. An equal addition on Level 2 will provide additional toilets needed to support existing outpatient services on Level 2.

To accommodate the increased mechanical and electrical loads required by the proposed building expansion, modifications to the existing free-standing central utility plant will be necessary. Two 550-ton electric centrifugal chillers and associated pumps will be installed to meet the increased loads and provide redundancy in case of a chiller failure. The existing cooling towers, currently located within an enclosure on grade, will be replaced with four 625-ton units to serve the expanded chiller plant.

The existing high pressure steam boilers in the central plant will remain, with heating for the new vertical addition to be provided by the existing steam converters in the existing Kaufman Cancer Center mechanical equipment room, and new, gas-fired condensing hot water boilers, that will be located in the existing mechanical equipment room, to back-feed the existing Kaufman Cancer Center.

The existing fire pump and controller will be replaced with a higher-pressure pump, to meet the higher pressure demands at the tops of the standpipes. Existing site electrical utilities (normal power from BGE) are adequate for the proposed expansion. The natural gas service to the central plant will require an upgrade to accommodate the increased load for the new hot water boilers and gas fired humidifiers in the building. As part of this project, UM UCH will be extending a second source of domestic water to the Central Utility Plant from the existing main in MacPhail Road. All other utilities are currently sufficient to service this addition.

The total project budget is \$74,379,294. 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 \$6,000,000 in operating cash, interest earned on bond proceeds of \$2,908,675, and \$184,750,000 in tax exempt bonds. The bonds are anticipated to be issued in fiscal year 2019 through the University of Maryland Medical System.

Construction of the proposed project is projected to take approximately 18 months but will not open until HMH is converted to a freestanding medical facility which is projected to take place in 2022. UCMC has provided project drawings at **Exhibit 2**. UCMC has also completed hospital CON **Tables A-H** and **Tables J** and **K**, which are provided at **Exhibit 1**.

II. THE RELOCATION OF MSGA BEDS FROM HMH TO UCMC IS NOT INCONSISTENT WITH THE STATE HEALTH PLAN CHAPTER FOR ACUTE HOSPITAL SERVICES.

The relocation of MSGA beds from HMH to UCMC is not inconsistent with the State Health Plan Chapter for Acute Hospital Services, COMAR § 10.24.10.04 (the “State Health Plan”). Because the proposed project only involves the relocation of MSGA beds, the applicants have not addressed State Health Plan Chapters applicable to pediatric and obstetrics beds, emergency department expansion, and other inapplicable sections of the State Health Plan.

A. *Information Regarding Charges*

UM UCH’s policy relating to transparency in health care pricing complies with this COMAR 10.24.10.04(A)(1), and attached as **Exhibit 3**. This policy is currently implemented at both UCMC and HMH.

B. Charity Care Policy

UM UCH's financial assistance policy, implemented at both UCMC and HMH, complies with COMAR 10.24.10.04(A)(2) and is attached as **Exhibit 4**.

C. Quality of Care

UCMC complies with requirements issued by Maryland Department of Health (formerly the Department of Health and Mental Hygiene) for licensure, is accredited by the Joint Commission, and complies and will continue to comply with all conditions of participation in the Medicare and Medicaid programs.

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).

UCMC ranked "better than average" or "average" on forty-seven (47) of the seventy (70) quality measures. For an additional twelve (12) quality measures, UCMC did not have sufficient data to report. UCMC ranked "below average" on only eleven (11) quality measures. Table 1 below, identifies those quality measures for which UCMC was ranked "below average" along with UCMC's corrective action plan:

Table 1
Below-Average Quality Measures and Corrective Action

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 did patients always receive help quickly from hospital staff?	UCMC's Patient Experience Plan includes several strategies to improve responsiveness to patient needs including hourly care rounds and change of shift report at the patient's bedside. New reports have been developed to monitor and improve response time to patient call bells.
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
Satisfaction Overall	
<p>Would patients recommend the hospital to friends and family?</p>	<p>UCMC is currently expanding its Patient and Family Advisory Council to facilitate active participation on hospital committees to ensure that patient input is included in the development of hospital policies and procedures. UCMC is also increasing community awareness of hospital services through ongoing community education forums and enhanced social media strategies.</p>
Wait Times	
<p>How long patients spent in the emergency department before being sent home?</p> <p>How long patients spent in the emergency department before they were seen by a healthcare professional?</p>	<p>In furtherance of UM UCH’s fiscal year 2018 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 an system-wide scorecard.</p>
Results of Care	
<p>Dying within 30-days after getting care in the hospital for a heart attack.</p>	<p>An HSCRC-funded grant program was implemented during FY2017. The Wellness Action Teams of Cecil & Harford (WATCH) program provides home visits with a team consisting of an RN, pharmacist, and case manager to monitor and improve medication compliance and disease management for patients with congestive heart failure and other comorbid conditions associated with heart attack, e.g., hypertension and diabetes mellitus. This initiative will help to ensure that proper care is provided to patients who received care for a heart attack at UCMC.</p>

Quality Measure	Corrective Action Plan
Practice Patterns	
Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses.	During fiscal year 2017, Choosing Wisely recommendations regarding CT were implemented to reduce unnecessary radiation exposure. During the most recent three month measuring period ending June 30, 2017, 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 2018 Operating Plan. In addition, under the Safety domain, potentially preventable complications are being evaluated and tracked and preventive efforts focused for any with identified opportunities for improvement. In fiscal year 2018, a project team will be deployed to better understand the root causes driving any below average performance.
How often patients die in the hospital after fractured hip.	A formal UM UCH Hip Fracture Program is currently underway with a dedicated Hip Fracture Coordinator to focus on issues specific to this population. In addition, a Fragility Fracture Program is being implemented which will enhance UM UCH's hip fracture prevention program.

D. Identification of Bed Need and Addition of Beds

The State Health Plan provides that MSGA beds may be developed or put into operation only if, among other things, the “proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed n eed projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection.” COMAR 10.24.10.04(B)(2).

As an initial matter, COMAR 10.24.10.04(B)(2) is not applicable to the proposed project because the beds that the applicants proposed to relocate are already developed and have been put into operation. Nevertheless, the applicants demonstrate compliance with standard as set forth below.

On January 20, 2017, the MHCC published the most recent MSGA bed need projection by jurisdiction in the Maryland Register (Vol. 44, Issue 2, pp. 160-162). Table 2 shows the MSGA projections for Harford County.

Table 2
MHCC’s MSGA Bed Need Projection by Jurisdiction
2025

Gross and Current Bed Need Projections for MSGA Beds - Maryland, 2025

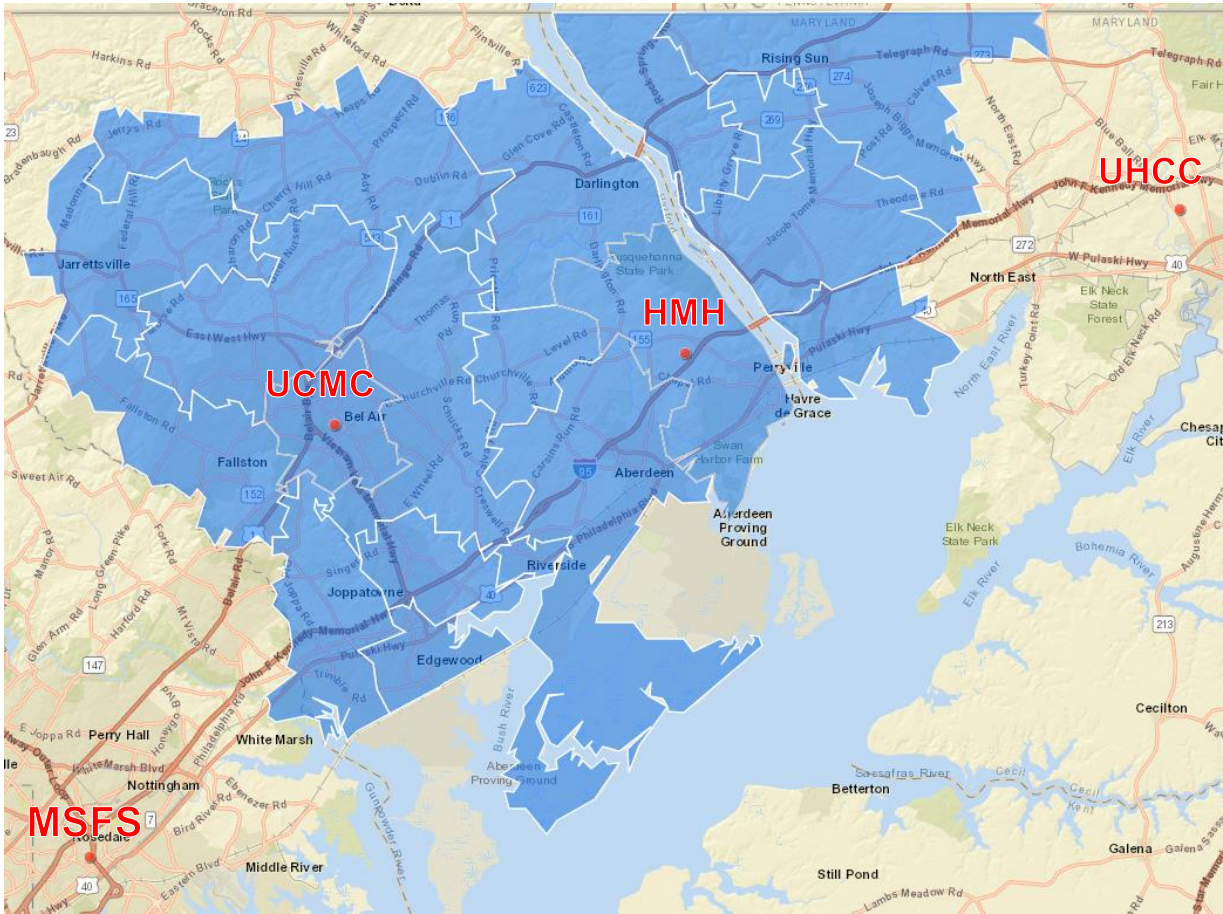
Jurisdiction	Gross Bed Need		Licensed and Approved Beds	2025 Net Bed Need	
	Minimum	Maximum		Minimum	Maximum
Harford	168	223	218	-50	5

The proposed project will result in 210 MSGA beds in Harford County, 194 general MSGA beds and 16 intensive care (“ICU”) beds. The applicants used the following methodology and assumptions to project the need for these beds at UCMC.

1. Defining UCMC’s MSGA Service Area

To identify the MSGA service area for UCMC that also serves MSGA patients currently treated at HMH, the applicants combined fiscal year 2016 UCMC and HMH discharges by zip code for all ages. To determine the zip codes to be included in the service area, the applicants identified the zip codes that comprised the top 85% of UCMC’s and HMH’s combined MSGA discharges.

Figure 1
UCMC and HMH Combined MSGA Service Area
FY2017



As presented in the Figure 1 above and Table 3 below, the proposed service area for all MSGA discharges is defined by eighteen (18) zip codes that span Harford and Cecil Counties. Zip codes are ranked from those with the highest to lowest combined discharges between UCMC and HMH to identify the top 85% of total discharges.

Table 3
UCMC Projected MSGA Service Area (All Ages) Zip Codes and Discharges
FY2016

#	Zip Code	Community	County	2016 Discharges (1)			% of Discharges
				UCMC	HMH	Total	
1	21014	Bel Air	Harford County	1,616	52	1,668	12.6%
2	21001	Aberdeen	Harford County	611	912	1,523	24.2%
3	21078	Havre De Grace	Harford County	359	816	1,175	33.1%
4	21040	Edgewood	Harford County	1,013	55	1,068	41.2%
5	21009	Abingdon	Harford County	961	53	1,014	48.9%
6	21015	Bel Air	Harford County	950	41	991	56.4%
7	21050	Forest Hill	Harford County	680	21	701	61.7%
8	21085	Joppa	Harford County	642	13	655	66.7%
9	21047	Fallston	Harford County	384	7	391	69.6%
10	21154	Street	Harford County	305	17	322	72.1%
11	21904	Port Deposit	Cecil County	91	220	311	74.4%
12	21903	Perryville	Cecil County	66	199	265	76.4%
13	21084	Jarrettsville	Harford County	219	2	221	78.1%
14	21017	Belcamp	Harford County	191	29	220	79.8%
15	21034	Darlington	Harford County	183	32	215	81.4%
16	21911	Rising Sun	Cecil County	82	119	201	82.9%
17	21918	Conowingo	Cecil County	101	69	170	84.2%
18	21028	Churchville	Harford County	114	31	145	85.3%
Subtotal 2016 Service Area				8,568	2,688	11,256	
Out of Service Area				1,516	421	1,937	14.7%
Total MSGA Discharges				10,084	3,109	13,193	100.0%

Notes (1): Excludes Substance Abuse discharges
Source: St. Paul's Inpatient Abstract Data Tapes

2. Projected MSGA Service Area Population

For the zip codes included in UCMC's projected future service area, population projections through 2021 were obtained from Nielsen Claritas for the 0-14, 15-64, 65-74 and 75+ age cohorts. These are presented below in Table 4. The 0-14 age cohort is expected to decrease from 2016 to 2021, while the 15-64 age cohort is expected to remain constant. Over the same period only the 65-74 and 75+ age cohorts are expected to grow 24.2% and 15.1%, respectively. In total, the projected population is expected to grow by 2.4% between 2016 and 2021.

Table 4
UCMC’s Historical and Projected MSGA Service Area Population
2010 – 2021

Age Cohort	Service Area Population						% Change in Population	
	2010		2016		2021		2010-16	2016-21
	Pop	% of Total	Pop	% of Total	Pop	% of Total		
75+	14,064	5.4%	16,600	6.2%	19,106	7.0%	18.0%	15.1%
65-74	18,302	7.0%	25,306	9.5%	31,437	11.5%	38.3%	24.2%
15-64	175,504	67.4%	177,315	66.4%	177,380	64.8%	1.0%	0.0%
0-14	52,689	20.2%	47,910	17.9%	45,679	16.7%	-9.1%	-4.7%
Total	260,559	100.0%	267,131	100.0%	273,601	100.0%	2.5%	2.4%

Source: Nielsen Claritas Pop-Facts Demographics by Age Race Sex

Using the compounded annual growth rates from 2016 to 2021, as set forth in Table 3, population projections were extrapolated through 2024 and applied to UCMC’s fiscal years. Table 5 below depicts the projected population for each age cohort. Led by the population over age 65, the total population is expected to grow by 4.2% from fiscal year 2016 to fiscal year 2024.

Table 5
UCMC’s Estimated and Projected MSGA Service Area Population
FY2015 – FY
2024

Age Cohort	Historical		Projection								% Change FY16-FY24
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	
0-14	48,675	47,910	47,455	47,005	46,559	46,116	45,679	45,245	44,815	44,390	-7.3%
%Change	-1.6%	-1.6%	-0.9%	-0.9%	-0.9%	-0.9%	-0.9%	-0.9%	-0.9%	-0.9%	
15-64	177,012	177,315	177,328	177,341	177,354	177,367	177,380	177,392	177,405	177,418	0.1%
%Change	0.2%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
65-74	23,975	25,306	26,428	27,600	28,824	30,102	31,437	32,831	34,287	35,807	41.5%
%Change	5.5%	5.5%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	
75+	16,148	16,600	17,073	17,560	18,061	18,576	19,106	19,651	20,211	20,787	25.2%
%Change	2.8%	2.8%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	
Total Service Area	265,810	267,131	268,285	269,506	270,797	272,161	273,601	275,119	276,719	278,403	4.2%
%Change	0.5%	0.5%	0.4%	0.5%	0.5%	0.5%	0.5%	0.6%	0.6%	0.6%	

3. **MSGA Use Rates**

Table 6 depicts the total use rate of MSGA discharges per 1,000 population in UCMC’s defined service area in fiscal years 2015 and 2016. The total MSGA use rate of 74.0 discharges per 1,000 population in fiscal year 2016 represents a 0.1% increase over fiscal year 2015 which is driven by the increase in the Age 15-64 use rate (Table 6). As this age cohort represents 65% of the population, it offsets the decline in use rates in each of the other age cohorts.

Table 6
UCMC’s Historical MSGA Service Area Total Use Rate
FY2015 – FY2016

MSGA Use Rates	<u>Historical</u>	
	<u>FY2015</u>	<u>FY2016</u>
Age 0-14	13.7	13.2
<i>%Change</i>	-17.1%	-3.4%
Age 15-64	51.1	51.3
<i>%Change</i>	-10.3%	0.4%
Age 65-74	180.9	174.5
<i>%Change</i>	-6.4%	-3.6%
Age 75+	347.2	338.2
<i>%Change</i>	-3.6%	-2.6%
Total	73.9	74.0
<i>%Change</i>	-6.5%	0.1%

While fiscal year 2016 showed an increase in the total MSGA use rate, it was preceded by a 6.5% reduction in the total use rate in fiscal year 2015. Consistent with the decline in the fiscal year 2015, total future MSGA use rates are expected to reflect reductions in potentially avoidable utilization (“PAU”) and shifts of inpatients to the lowest cost setting of care. This reduction, though, is expected to be partially offset in fiscal years 2018 and 2019 with a shift of observation patients with stays greater than 48 hours to the inpatient setting. This offset is the

result of an analysis conducted by UM UCH that found that UCMC’s observation cases as a percentage of total inpatient and observation cases is significantly higher than industry benchmarks.

a) PAU Reductions

As of December 2016, UCMC’s PAUs were at the statewide average of 19.7%. An assumed 2% annual reduction in PAU’s between fiscal years 2017 and 2021 will drive UCMC’s pro forma PAU% below the statewide average to 18.3% (Table 7).

Table 7
UCMC’s Historical PAUs
CY2016

	<u>UCMC</u>
CY2016 Total PAU%	19.7%
CY2016 Statewide Average	19.7%
CY2016 Pro Forma PAU% ⁽¹⁾	18.3%

Note (1): Reflects 2% annual reduction in UCMC PAUs for five years

Sources:

- December 2016 UMMS Potentially Avoidable Utilization Analytical Report
- November 2016 CRISP PAU Summary

A 2% reduction in PAUs over a 5-year period will result in an approximately 0.25% annual reduction in the MSGA inpatient use rate for five years (Table 8).

Table 8
Impact of UCMC's 2% Annual PAU Reduction on MSGA Use Rates
FY2016

<u>FY2016 Total PAUs</u>	<u>UCMC</u>	<u>% of Total</u>
Inpatient	2,426	72.0%
Observation	946	28.0%
Total PAUs	<u>3,372</u>	<u>100.0%</u>
2% Reduction in Inpatient PAUs	49	
FY2016 MedSurg Service Area Discharges	19,013	
2% Reduction in Inpatient PAUs as % of MedSurg Service Area Discharges	<u>0.26%</u>	
Projected Annual Reduction in MedSurg Service Area Use Rates 2017-2021	<u>0.25%</u>	

Sources:

- December 2016 UMMS Potentially Avoidable Utilization Analytical Report
- November 2016 CRISP PAU Summary

A similar 0.25% annual reduction in observation cases over five years in fiscal year 2017 through fiscal year 2021 is also projected to reduce observation related PAUs.

b) Shift from Observation to Inpatient

UM UCH assessed its observation cases as a percent of total inpatient and observation cases at its constituent hospitals and concluded that it is higher than industry benchmarks and that many of the patients met medical criteria for inpatient admission. To reduce the number of observation patients, UCMC will shift 60% of patients with an observation stay greater than 48 hours to the inpatient setting in fiscal years 2018 and 2019. The resulting shift in observation cases from the outpatient setting to an inpatient setting will drive an increase in in the MSGA use rate by 2.9 discharges per 1,000 population or 3.8% (Table 9).

Table 9
Impact of Shift in Observation Cases to Inpatient Cases on MSGA Use Rate
FY2018 – FY2019

	UCMC
FY2016 Observation Cases >48 Hrs	1,438
60% Reduction in Observation Cases >48 Hrs	863
FY2019 Service Area in Population	257,224
Increase in MedSurg Use Rate in FY2018-FY2019	2.9
<i>% Increase</i>	3.8%

c) *Other Reductions in Inpatient MSGA Use Rates*

The increase in MSGA use rates due to the shift of observation patients to the inpatient setting will offset the projected reduction in use rates due to the elimination of PAUs. To address expected reductions in MSGA use rates due to improvements in population health initiatives, UM UCH and the applicants expect that MSGA use rates will decline by an additional 1% a year between fiscal years 2017 and 2021. Combined with the reduction in use rates driven by reductions in UCMC’s PAUs and an increase in use rates driven by UCMC’s shift of observation patients to the inpatient setting, use rates will decline by 1.7%, by age cohort, between fiscal years 2016 and 2024 (Table 10).

Table 10
UCMC’s Historical and Projected MSGA Use Rate
FY2015 - FY2024

	Historical		Projection							% Change FY16-FY24	
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023		FY2024
MSGA Use Rates											
Age 0-14	13.7	13.2	13.1	13.2	13.4	13.2	13.0	13.0	13.0	13.0	
<i>%Change</i>	-17.1%	-3.4%	-1.37%	1.22%	1.22%	-1.37%	-1.37%	0.00%	0.0%	0.0%	-1.7%
Age 15-64	51.1	51.3	50.6	51.2	51.8	51.1	50.4	50.4	50.4	50.4	
<i>%Change</i>	-10.3%	0.4%	-1.37%	1.22%	1.22%	-1.37%	-1.37%	0.00%	0.0%	0.0%	-1.7%
Age 65-74	180.9	174.5	172.1	174.2	176.3	173.9	171.5	171.5	171.5	171.5	
<i>%Change</i>	-6.4%	-3.6%	-1.37%	1.22%	1.22%	-1.37%	-1.37%	0.00%	0.0%	0.0%	-1.7%
Age 75+	347.2	338.2	333.6	337.6	341.7	337.0	332.4	332.4	332.4	332.4	
<i>%Change</i>	-3.6%	-2.6%	-1.37%	1.22%	1.22%	-1.37%	-1.37%	0.00%	0.0%	0.0%	-1.7%

4. MSGA Service Area Discharges

Based on the assumptions described above, the total projected MSGA service area discharges are projected to increase 14.2% between fiscal year 2016 and fiscal year 2024 as presented below (Table 11).

**Table 11
UCMC’s Historical and Projected MSGA Service Area Discharges
FY2015 - FY2024**

	Historical		Projection								% Change FY16-FY24
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	
Service Area Discharges	19,650	19,758	19,833	20,437	21,067	21,169	21,279	21,695	22,126	22,573	14.2%
<i>%Change</i>	-6.1%	0.5%	0.4%	3.0%	3.1%	0.5%	0.5%	2.0%	2.0%	2.0%	

5. UCMC MSGA Market Share

When HMH is projected to convert to a freestanding medical facility and cease inpatient services in fiscal year 2022, its acute inpatient services will necessarily shift to other local providers based on a drive time analysis that was conducted by service line. The applicants anticipate, though, that all of HMH’s surgical cases will be retained within UM UCH for the following reasons: (1) community medical staff referral patterns are not anticipated to change based upon change in facility location; (2) all surgical providers currently operating at HMH have privileges at UCMC; and (3) surgical providers currently performing cases at HMH have expressed the intent to move such cases to UCMC. A majority of the operating surgical providers at HMH are employed by UM UCH and, therefore, the shift of surgical practice locations to other hospitals is not anticipated. In addition, UM UCH and the applicants are not anticipating a change in the primary care provider base other than the primary care recruitment that UM UCH is leading in conjunction with community and employed primary care providers.

As a result of the foregoing, the applicants project a combined 77.3% of HMH’s acute medical and surgical cases will shift to UCMC and 22.7% will shift to other facilities (Table 12).

Table 12
Shift of HMH MSGA Discharges
FY2022

HMH MSGA Discharges	Projected FY2022	HMH Discharge Shift %
Medical Discharges	3,367	86.2%
Surgical Discharges	539	13.8%
Transfer to UCMC	(3,021)	-77.3%
Transfer to UHCC	(754)	-19.3%
Transfer to Other Hospitals	(131)	-3.4%
HMH Total Discharges - MSGA	-	-

UCMC’s MSGA market share decreased in fiscal year 2016 but then increased in fiscal year 2017 based on actual utilization through the first six months of the fiscal year. Market share at UCMC is projected to increase in fiscal years 2018 and 2019 as the hospital shifts greater than forty-eight hour observation cases to the inpatient setting. UCMC projects that it will capture 100% of those cases from HMH, thus increasing its market share. In fiscal year 2022, UCMC’s market share is projected to increase with the shift of 3,021 cases from HMH and then remain constant through fiscal year 2024 (Table 13).

Table 13
UCMC’s Historical and Projected MSGA Market Share
FY2015 - FY2024

	Historical		Projection							% Change FY16-FY24	
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023		FY2024
UCMC Market Share	44.8%	45.4%	44.7%	46.1%	47.3%	47.5%	47.6%	60.3%	60.3%	60.3%	
<i>%Change</i>	-2.1%	1.5%	-1.7%	3.1%	2.8%	0.3%	0.3%	26.7%	0.0%	0.0%	32.7%

a) *UCMC Out-of-Service Area MSGA Discharges*

UCMC’s out-of-service area MSGA discharges are projected to equal 16.7% of its in-service area discharges as experienced in fiscal year 2016 (Table 14).

Table 14
UCMC's Historical and Projected Out-of-Service Area MSGA Discharges
% of Service Area Discharges
FY2015 – FY2024

	Historical		Projection							
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Out-of-Service Area Discharges										
% of Service Area Discharges	16.0%	16.7%	16.7%	16.7%	16.7%	16.7%	16.7%	16.7%	16.7%	16.7%

6. UCMC Inpatient MSGA Discharges

Based on the assumptions listed above, UCMC's MSGA discharges are projected to increase from fiscal year 2016 to fiscal year 2024 by 49% (Table 15).

Table 15
UCMC's Historical and Projected Inpatient MSGA Discharges
FY2015 – FY2024

	Historical		Projection							% Change FY16-FY24	
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023		FY2024
Inpatient Discharges											
UCMC	9,651	9,990	9,891	10,403	10,916	11,013	11,114	14,374	14,662	14,961	
%Change		3.5%	-1.0%	5.2%	4.9%	0.9%	0.9%	29.3%	2.0%	2.0%	49.8%

7. MSGA Average Length of Stay (ALOS)

The average length of stay for MSGA patients at UCMC is expected to remain constant from UCMC's actual 2016 actual experience even with the shift of observation cases with stays greater than 48 hours to the inpatient setting (Table 16).

Table 16
UCMC's Historical and Projected ALOS
FY2015 – FY2024

	Historical		Projection							% Change FY16-FY24	
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023		FY2024
ALOS - MSGA	4.84	4.09	4.09	4.09	4.09	4.09	4.09	4.09	4.09	4.09	
%Change		-15.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

8. MSGA Occupancy

The expected occupancy of inpatient MSGA beds at UCMC reflects the State Health Plan for hospitals with an average daily census of 100-299 patients as follows (Table 17).

**Table 17
UCMC MSGA Projected Bed Occupancy**

	<u>Projected Occupancy</u>
UCMC - MSGA	80%

9. MSGA Bed Need

Based on the assumptions presented above, the applicants projected a need for 210 inpatient MSGA beds at UCMC in fiscal year 2024 (Table 18).

**Table 18
UCMC’s Historical and Projected MSGA Bed Need
FY2015 – FY2024**

	Historical		Projection							% Change FY16-FY24	
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023		FY2024
MSGA Bed Need	140	140	139	146	153	154	156	202	206	210	50.0%
<i>%Change</i>		<i>0.0%</i>	<i>-0.7%</i>	<i>5.0%</i>	<i>4.8%</i>	<i>0.7%</i>	<i>1.3%</i>	<i>29.5%</i>	<i>2.0%</i>	<i>1.9%</i>	

Based on UCMC’s allocation of MSGA patient days in fiscal year 2016, the fiscal year 2024 projected MSGA beds at UCMC are split between 194 general MSGA and 16 ICU beds as presented in Table 19.

**Table 19
UCMC’s Historical and Projected MSGA Bed Need
FY2015 – FY2024**

	Historical		Projection							% Change FY16-FY24	
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023		FY2024
MSGA Bed Need											
General MSGA	149	128	127	135	141	142	144	186	190	194	51.6%
ICU/CCU	12	12	12	11	12	12	12	16	16	16	33.3%
Total	161	140	139	146	153	154	156	202	206	210	50.0%

10. Observation Cases

In addition to the need for MSGA beds, UCH also evaluated the demand for observation beds. The number of observation cases at UCMC increased 1.3% between fiscal years 2015 to 2017 (Table 20).

**Table 20
UCMC and HMH Historical Observation Cases
FY2015 – FY2017**

	Historical			% Change FY15-FY17
	FY2015	FY2016	FY2017	
Observation Cases - UCMC	7,562	7,460	7,661	1.3%

As stated previously, UCMC will shift 60% of its patients with an observation stay longer than 48 hours to the inpatient setting in fiscal years 2018 and 2019. This reduction in observation cases at UCMC, however, will be partially offset in fiscal year 2022 when a projected 277 or approximately 12% of HMH’s cases with stays longer than 48 hours will shift to UCMC. Even with the shift of cases from HMH, though, the resulting number of observation cases on the UCMC campus will decline by 4.6% between fiscal years 2016 and 2024 (Table 21).

**Table 21
UCMC’s Historical and Projected Observation Cases
FY2015 – FY2024**

	Historical		Projection							% Change FY16-FY24	
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023		FY2024
Observation Cases - UCMC	7,562	7,460	7,479	7,070	6,662	6,683	6,707	7,026	7,071	7,119	
<i>%Change</i>		-1.3%	0.3%	-5.5%	-5.8%	0.3%	0.3%	4.8%	0.6%	0.7%	-4.6%

11. Observation Average Length of Stay

The average length of stay for observation patients at UCMC will decline in fiscal years 2018 and 2019 with the shift of 60% of cases with stays greater than 48 hours to the inpatient

setting. It will then increase in fiscal year 2022 with the shift of HMH’s remaining cases with stays longer than 48 hours. The combined impact of these assumptions is an 8.2% reduction in the length of stay for observation patients at UCMC from fiscal year 2016 to fiscal year 2024 (Table 22).

Table 22
UCMC’s Historical and Projected ALOS – Observation
FY2015 – FY2024

	Historical		Projection							% Change FY16-FY24	
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023		FY2024
ALOS - Observation	1.55	1.53	1.53	1.44	1.34	1.34	1.34	1.40	1.40	1.40	
<i>%Change</i>		-1.6%	0.0%	-5.7%	-7.2%	0.0%	0.0%	5.0%	0.0%	0.0%	-8.2%

The resulting ALOS that is projected for observation patients at the UCMC is 1.4 days.

12. Observation Bed Need

The applicants used the State Health Plan occupancy rate of 80% to project the number of observation beds at the UCMC where other MSGA beds may be available for the potential overflow of observation patients as described below. Based on the assumptions presented above, there is a projected need for 34 observation beds at UCMC in fiscal year 2024 (Table 23).

Table 23
UCMC’s Historical and Projected Observation Bed Need
FY2015 – FY2024

	Historical		Projection							% Change FY16-FY24	
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023		FY2024
Observation Bed Need	40	39	39	35	31	31	31	34	34	34	-12.8%
<i>%Change</i>		-2.5%	0.0%	-10.3%	-11.4%	0.0%	0.0%	9.7%	0.0%	0.0%	

13. Total Inpatient Discharges and Observation Cases

Combining MSGA discharges with observation cases, the total number of patients occupying beds at UCMC is expected to increase 26.5% between fiscal years 2016 and 2024, with 22,080 patients occupying observation beds in fiscal year 2024 (Table 24).

Table 24
UCMC Historical and Projected MSGA Discharges and Observation Cases
FY2015 – FY2024

	Historical		Projection							% Change FY16-FY24	
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023		FY2024
IP Discharges + Observation Cases											
UCMC - Inpatient MSGA	9,651	9,990	9,891	10,403	10,916	11,013	11,114	14,374	14,662	14,961	49.8%
<i>%Change</i>		3.5%	-1.0%	5.2%	4.9%	0.9%	0.9%	29.3%	2.0%	2.0%	
UCMC - Observation	7,562	7,460	7,479	7,070	6,662	6,683	6,707	7,026	7,071	7,119	-4.6%
<i>%Change</i>		-1.3%	0.3%	-5.5%	-5.8%	0.3%	0.4%	4.8%	0.6%	0.7%	
Total	17,213	17,450	17,370	17,473	17,578	17,696	17,821	21,400	21,733	22,080	26.5%
<i>%Change</i>		1.4%	-0.5%	0.6%	0.6%	0.7%	0.7%	20.1%	1.6%	1.6%	

These patients are projected to need a total of 210 MSGA beds and 34 observation beds for a total of 244 beds in fiscal year 2024 (Table 25).

Table 25
UCMC’s Historical and Projected Bed Need
FY2015 – FY2024

	Historical		Projection							% Change FY16-FY24	
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023		FY2024
Bed Need - MSGA + Observation											
UCMC - MSGA	161	140	139	146	153	154	156	202	206	210	50.0%
<i>%Change</i>		-13.0%	-0.7%	5.0%	4.8%	0.7%	1.3%	29.5%	2.0%	1.9%	
UCMC - Observation	40	39	39	35	31	31	31	34	34	34	-12.8%
<i>%Change</i>		-2.5%	0.0%	-10.3%	-11.4%	0.0%	0.0%	9.7%	0.0%	0.0%	
Total	201	179	178	181	184	185	187	236	240	244	36.3%

The applicants have, therefore, demonstrated need for the relocation of beds from HMH to UCMC.

E. The Proposed Project Will Not Have an Unwarranted Adverse Impact on Hospital Charges, Availability of Services, or Access to Services – COMAR 10.24.10.04(B)(4).

The State Health plan provides that a capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services.

The proposed project will not have an adverse impact on hospital charges, availability of services, or access to services. On the contrary, if the proposed project is not approved and HMH converts to a freestanding medical facility, there will be a lack of MSGA beds in Harford County to meet the projected needs of UCMC's projected service area, thereby erecting an access barrier to acute inpatient services. Instead, pursuant to the merger and consolidation of UCMC and HMH, UM UCH has requested that the HSCRC approve a proposed Global Budget Revenue ("GBR") Plan that will provide for a revenue base to support UCH's plans for the proposed expansion at UCMC as well as the construction of a special psychiatric hospital and freestanding medical facility at UC Medical Campus at Havre de Grace. UM UCH is requesting that the HSCRC work with UCH to develop and implement a new GBR Plan that redistributes and redeploys revenue among UM UCH's rate-regulated components, including UCMC, the freestanding medical facility, and the special psychiatric hospital. The redeployment of UM UCH's GBR revenue can largely pay for the financing costs of the proposed expansion at UCMC as well as the new special psychiatric hospital and freestanding medical facility. By taking this approach, the HSCRC and associated parties can avoid adding additional revenue to UM UCH and by extension to the State's health care system.

F. The Proposed Project is the Most Cost-Effective Alternative to Continue to Provide Needed Acute Inpatient Services to the Residents of Harford County – COMAR 10.24.10.04(B)(5).

Before deciding on the proposed project, UCMC evaluated and studied various options to expand inpatient capacity on its campus. Ultimately, the proposed project was determined to be the most cost-effective alternative.

1. *Option One – A Two Floor Vertical Expansion of the Cancer Center*

The Kaufman Cancer Center (2011) was designed for 3 stories of vertical expansion. The floorplate (26,000 BGSF) is capable of supporting up to 30 single-patient rooms with private en-suite toilet/shower rooms or 15 private and 14 semi-private rooms. A 2-story expansion would provide up to 60 private patient rooms or 30 private and 28 semi-private rooms.

Essential components of this option include replacing 2 existing chillers, 3 existing cooling towers and 2 existing boilers with larger units, replacing the existing fire pump, and a new emergency power feeder from the central plant as well as renovations to include a fire command center to accommodate the new designation as a high-rise building.

However, the Kaufman Cancer Center is the most recent addition to the UCMC campus and is most likely to meet current seismic codes. It was also planned to become a high-rise and, therefore, the conversion accommodations are already in place. Structural stub-ups exist and rooftop mechanical equipment is disposable and was planned to be replaced.

1A. *The Proposed Project - Option One-A – A Three Floor Vertical Expansion of the Cancer Center*

Option 1.A., the proposed project, included a 3-story expansion above the Kaufman Cancer Center, with one floor constructed as shell space in addition to the patient rooms described in Option 1 above.

2. *Option Two - Renovation of Levels 3 and 4 of the Ambulatory Care Center (ACC)*

The Ambulatory Care Center (“ACC”) was built in 1998 and was not designed for vertical expansion, but is connected to the main hospital and has a floorplate (24,000 BGSF) capable of supporting up to 30 single-patient rooms with private en-suite toilet/shower rooms (approximately 300 square feet each). A two-level renovation project would provide up to 60

private patient rooms. Additional floors could be renovated in the future if additional beds are needed.

Essential components of this alternative include construction of a new medical office building (“MOB”) to accommodate the existing tenants on the 3rd and 4th floors of the ACC, conversion of plenum air return system to ducted system, new sanitary risers, new medical gas risers, and new emergency power feeder from the central plant.

Additional potential (recommended) components of this option include renovations to the existing structure to provide a second patient/service elevator and relocation of an electrical/data room to maximize the number of inpatient rooms.

3. *Option Three - One floor vertical expansion of the Main Hospital towers and the ED/bed tower addition to the east*

UCMC’s main hospital bed towers were constructed in 1998 and the emergency department/bed tower addition, constructed in 2005, were each designed for one story of vertical expansion and the floorplate of the two combined, 47,000 building gross square feet, is capable of supporting up to 60 single-patient rooms with private en-suite toilet/shower rooms (approximately 250 square feet each).

Essential components of this option include relocation of 3 penthouses, structural re-analysis for seismic compliance with current building codes, phased construction (including temporary air handling units with resulting increases in construction duration), replacing 1 chiller and 2 cooling towers with larger units, replacing the existing fire pump to meet the high-rise code, a new emergency power feeder from the central plant, and replacement of all rooftop fans, lightning protection, etc.

4. *Option Four - One floor vertical expansion of main hospital bed towers*

The main hospital bed towers constructed in 1998 were designed for one story of vertical expansion and have a 38,000 building gross square foot floorplate capable of supporting up to 44 single-patient rooms with private en-suite toilet/shower rooms (approximately 250 square feet each).

Essential components of this alternative include relocation of 3 penthouses, structural re-analysis for seismic compliance with current building codes, phased construction (including temporary air handling units with resulting increases in construction duration), replacing 1 chiller and 2 cooling towers with larger units, replacing the existing fire pump to meet the high-rise code, new emergency power feeder from the central plant, and replacement of all rooftop fans, lightning protection, etc.

5. *Option Five - One floor vertical expansion of the main hospital diagnostic and treatment core.*

UCMC's main hospital diagnostic and treatment core was built in 1998 and designed for one story of vertical expansion. It has a floorplate for expansion of 24,600 building gross square feet and is capable of supporting up to 30 single-patient rooms with private en-suite toilet/shower rooms (approximately 300 square feet each).

Essential components of this alternative include renovation of existing Level 1 space to provide two new stairs, relocation of surgical air handler and MRI chillers, structural re-analysis for seismic compliance with current building codes, new sanitary piping in ceilings of surgery suite, removal and relocation of three existing air handling units, phased construction (including temporary air handling units with resulting increases in construction duration), replacing one

chiller and two cooling towers with larger units, new emergency power feeder from the central plant, and replacement of all rooftop fans, lightning protection, etc.

6. Analysis of Options

Upon review of the costs and benefits of the available options, Option 1A provides the most viable and cost-effective solution. Option 1A provides the optimal number of beds to meet the projected need – forty-one total MSGA beds and thirty-two observation beds – at the optimal patient room size and at the lowest cost per bed. Option 1A also provides efficient and effective flexibility for future expansion of either inpatient needs or oncology diagnostic and treatment services. In addition to the benefits listed above, Option 1A provides adequate space to expand a number of the semi-private rooms to serve as semi-private observation rooms in a manner that is cost effective, space efficient, and focused on patient and staff safety.

G. The Applicants Have Satisfied Their Burden of Proof Regarding Need – COMAR 10.24.10.04(B)(6).

The State Health provides that a hospital project shall be approved only if there is a demonstrable need. UCMC and HMH have established need for the relocation of MSGA beds from HMH to UCMC and creation of a dedicated observation unit at UCMC. *See* Section II.D above.

H. The Proposed Construction Cost of Hospital Space is Reasonable and Consistent with Industry Cost Experience in Maryland – COMAR 10.24.10.04(B)(7).

The State Health Plan requires that the proposed cost of a hospital construction project shall be reasonable and consistent with current industry guidance in Maryland. As set forth below, the projected construction cost per square foot for the proposed project is reasonable.

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

**I. Marshall Valuation Service
Valuation Benchmark**

Type		Hospital
Construction Quality/Class		Good/A
Stories		5
Perimeter		501
Average Floor to Floor Height		16.7
Square Feet		79,894
f.1	Average floor Area	15,979
A. Base Costs		
	Basic Structure	\$365.78
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
	Total Base Cost	\$365.78
	Adjustment for Departmental Differential Cost Factors	0.87
	Adjusted Total Base Cost	\$319.85
B. Additions		
	Elevator (If not in base)	\$0.00
	Other	\$0.00
	Subtotal	\$0.00
	Total	\$319.85
C. Multipliers		
	Perimeter Multiplier	0.92625537
	Product	\$296.27

Height Multiplier		1.11
Product		\$328.11
Multi-story Multiplier		1.010
Product		\$331.39
D. Sprinklers		
Sprinkler Amount		\$3.04
Subtotal		\$334.44
E. Update/Location Multipliers		
Update Multiplier		1.03
Product		\$344.47
Location Multiplier		1.01
Product		\$347.91
Calculated Square Foot Cost Standard		\$347.91

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				
Med / Surg Patient Unit Level 5	26,290	Inpatient Unit	1.06	27,867
Observation Unit Level 4	26,290	Inpatient Unit	1.06	27,867
Shell Space Level 3	26,290	Unassigned Space	0.5	13,145
Existing Cancer Center	1,024	Outpatient Department	0.96	983
TOTAL	79,894		0.8744	69,863

Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
Building	\$30,498,145	\$341.60
Fixed Equipment	\$0	\$0.00
Site Preparation	\$171,303	\$1.92
Architectural Fees	\$3,966,675	\$44.43
Permits	\$1,385,969	\$15.52
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	\$36,022,092	\$403.47

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 and Loan Placement
Complexity Premium	\$3,049,815	Building	\$714,203.22
2/5 HVAC System	\$3,013,365	Building	\$705,667.55
OVHD Bridges	\$2,500,000	Building	\$585,448.08
Pneumatic tube	\$460,000	Building	\$107,722.45
Signage	\$130,625	Building	\$130,625.00
Elevator Premium	\$864,546	Building	\$130,625.00
Premium for Minority Business Enterprise Requirement	\$457,472	Building	\$107,130.48
Total Cost Adjustments	\$10,475,823	32.7%	2,481,421.79

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).

1. 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.

a) Complexity Premium.

The complexity and necessary logistics of the project has a profound impact on the cost of construction. The project is bordered by a major road artery within 30 feet of the building footprint on the west, a road artery within 50 feet of the south elevation which is also the sole access point to the building's parking garage. On the north elevation, there is a direct attachment to the hospital and no setback from the main and sole loading dock and Central Utility Plant on the east elevation. These constraints require extraordinary methods of construction, safety, access for patients, guests and employees that will ultimately reduce construction productivity. The limited access requires a specialized tower crane that will be interior to the existing building, extreme measures to provide safe access of patients, guests and employee in to and around the building site. The limited area around the building requires off-site staging and material storage which add logistic costs from the remote staging area and scheduling demands for delivery of materials to the construction site. The tower crane as the sole source of delivery of materials into the project along with an exterior elevator system for construction staff to reach the upper floors limit material and manpower into and out of the construction floors 3, 4 and 5.

The construction activity will occur immediately above the Cancer Center and immediately adjacent to the Main Hospital, specifically three (3) floors of in-patient rooms to the east and two floors of outpatient Cancer patients directly below the construction site. These constraints require additional consideration for noise, safety and the general need to maintain ongoing operations and respect our patient experience.

b) 2/5 HVAC System

With the elimination of the existing rooftop units new services must now be provided by the Central Utility Plant (CUP) and on the roof of the new expansion for the existing two floors plus the additional three floors. The combined total demand required for this five (5) story building requires relocation of existing chillers to accommodate the installation of new two (2) chillers, replacement of the existing Cooling Tower which is not expandable to meet the current demand, replacement of one (1) boiler of our existing three (3) boilers to provide the required redundancy, the replacement of the existing fire pump and an increase in the sprinkler supply lines for the additional water flow requirements and finally the addition of a Fire Command Center because the addition of the three floors classifies the building as “High Rise”. In essence, we are providing new mechanical systems for 2/5 of the ultimate build-out of the five story building and additional support services required by the NFPA.

c) OVHD Bridges.

This expansion requires the construction of two enclosed access bridges to the main hospital that will connect on existing Main Hospital patient floors two and three. These connections require modifications to the main hospital at the connection points. For efficiency, the design contemplates shared structural components gained with a stacked design. Adding to

the complex logistics of this project, this connector bridge construction will occur adjacent to occupied patient units and above the busy hospital loading dock.

d) Pneumatic tube

The hospitals existing pneumatic tube system will be extended to the new facility and will utilize the bridge connection to connect to the new floors.

e) Elevator Premium

The construction of new elevator systems and the extension of the existing elevator shafts to the new floors will impact patient access and will require overnight construction activity so as not to impact the Cancer Center outpatient experience during normal business hours. Only the premium over the anticipated MVS cost is included as an Extraordinary Cost. This was calculated as follows:

Elevator Cost in Budget		\$1,217,000	
MVS Costs			
\$103,000	per Elevator	2 Elevators	\$206,000
\$8,300	per Stop	16 Stops	\$132,800
	Subtotal:		\$338,800
	Location Multiplier		1.01
			\$342,188
	Update Multiplier		1.03
	Final MVS Cost		\$352,454
Premium			\$864,546

f) Premium for Minority Business Enterprise Requirement

UM UCH projects include a premium for Minority Business Enterprises that would not be in the average cost of hospital construction. This premium was conservatively projected to be 1.5%.

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	\$20,022,322	\$224.26
Fixed Equipment	\$0	\$0.00
Site Preparation	\$171,303	\$1.92
Architectural Fees	\$3,966,675	\$44.43
Permits	\$1,385,969	\$15.52
Subtotal	\$25,546,269	\$286.14
Capitalized Construction Interest	\$4,660,610	\$52.20
Total	\$30,206,879	\$338.34

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

Hospital	New	Renovation	Total			
Building Cost	\$30,498,145	\$1,204,994				
Subtotal Cost (w/o Cap Interest)	\$36,022,092	\$1,204,994	\$37,227,086			
Subtotal/Total	96.8%	3.2%		Interest	Loan Place.	Total
Total Project Cap Interest & Financing [(Subtotal Cost/Total Cost) X Total Cap Interest & Loan Place.]	\$8,435,626	\$282,185	\$8,381,215	\$336,595		\$8,717,810
Building/Subtotal	84.7%	100.0%				
Building Cap Interest & Financing	\$7,142,032	\$282,185				
Associated with Extraordinary Costs	\$2,481,422					
Applicable Cap Interest & Loan Place.	\$4,660,610					

As noted below, the project's cost per square foot is only \$3.52 (0.92%) above the MVS benchmark.

MVS Benchmark	\$347.91
The Project	\$338.34
Difference	-\$9.58
	-2.75%

Accordingly, the proposed construction costs are reasonable and comply with this standard.

I. The Size of the Proposed Project's Inpatient Nursing Unit Space is Reasonable and Does not Exceed 500 Square Feet Per Bed – COMAR 10.24.10.04(B)(9).

The State Health Plan requires that space built for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. Additionally, the State Health Plan provides that if the inpatient unit program space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost for the space that exceeds the per bed square footage limitation or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

The proposed patient bed floors on Levels 4 and 5 of the proposed project are 26,290 square foot per floor for a total of 52,580 square feet. For 73 new patient beds (41 MSGA and 32 observation), this equates to 720 square feet per bed. The space per bed is higher than a traditional bed unit given its location above an existing Kaufman Cancer Center with a set footprint and includes larger semi-private observation rooms. The larger support core space is also required given the remote location of these units from the support service chassis of UCMC.

All nurse station and support spaces meet the current edition of the FGI Guidelines. Additional mechanical shaft space is also required in the building core to allow for mechanical services to be delivered from the roof through our new units to the Kaufman Cancer Center below. The floor area has also been designed to include a connector to the existing hospital units requiring more circulation space. In any event, UCMC will not seek a rate increase associated with the proposed project for construction costs for the space that exceeds the 500 per bed square foot limitation.

J. The Proposed Project is Designed to Allow UCMC to Operate Efficiently – COMAR 10.24.10.04(B)(11).

The relocation of MSGA beds from HMH to UCMC does not require replacement or expansion of any diagnostic or treatment facilities on its campus. However, there is a need to expand non-clinical support services such as with dietary, environmental, and security services.

Additionally, as described above, a key component of the proposed project is the establishment of a dedicated observation unit at UCMC. The relocation of MSGA beds from HMH to UCMC will allow UCMC to more effectively distribute patients who are in an observation status to a dedicated observation unit. Currently, UCMC has its observation patient population scattered throughout all of its medical surgical units. This geographic dispersion of observation patients does not support optimum patient management as it relates to focused attention on timely diagnostic treatment. However, a clinical practice model that incorporates a dedicated observation unit provides a setting for focused attention to lower acuity patients from admission to the observation unit through discharge, thereby minimizing unnecessary testing and ultimately reducing lengths of stay. By establishing a dedicated observation unit clinical model, with the appropriate staffing matrix to support short lengths of stay and therefore rapid turnover

of patients on the unit, UCMC expects that the enhanced efficiencies will ultimately support enhanced clinical outcomes as well as positively impact overall patient experience.

The following summary provides an overview of the clinical, safety, and efficiency factors supporting UCMC's plans for a dedicated observation unit, including enhanced security benefits, enhanced 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:
 - The design of the zoned semi-private rooms provides a physical, visual and auditory separation between patients enhancing the individual 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.
- K. The Design of the Project Took Patient Safety into Consideration and Includes Design Features that Enhance and Improve Patient Safety – COMAR 10.24.10.04(B)(12).***

The State Health requires that the design of a hospital project take patient safety into consideration and include design features that enhance and improve patient safety. Furthermore, a hospital proposing to replace or expand its physical plant must provide an analysis of patient safety features included for each facility or service being replaced or expanded, and document the manner in which the planning and design of the project took patient safety into account.

The design of the proposed project took patient safety into consideration and includes design features, including a dedicate observation unit, that will enhance and improve patient safety. See the applicants' response to COMAR 10.24.10.04(B)(11) above.

L. The Proposed Project is Financially Feasible and Will Not Jeopardize the Long-Term Financial Viability of UCMC – COMAR 10.24.10.04(B)(13).

The State Health Plan requires that a hospital capital project be financially feasible and not jeopardize the long-term financial viability of the hospital.

As presented in Table 26, UCMC is projected to generate positive operating income in each year of the projection period. With limited additional overhead costs added to UCMC with the expansion of its facilities, the addition of beds will have a positive financial contribution to the hospital beginning in fiscal year 2022.

Table 26
UCMC Historic and Projected Operating Income
FY2015 – FY2024

	Historical		Projection (\$ in millions)							
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Revenue	\$ 275.6	\$ 290.4	\$ 300.9	\$ 308.7	\$ 314.8	\$ 325.1	\$ 335.6	\$ 389.1	\$ 401.8	\$ 414.9
Expenses	241.6	261.1	269.7	275.6	284.1	292.7	301.7	352.2	364.2	376.9
Operating Income	\$ 34.0	\$ 29.3	\$ 31.2	\$ 33.1	\$ 30.7	\$ 32.4	\$ 33.9	\$ 37.0	\$ 37.6	\$ 37.9

M. The Proposed Construction of Shell Space is Cost Effective – COMAR 10.24.10.04(B)(16).

The State Health Plan requires that unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective. Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants must provide information on the cost, the most likely uses, and the likely time frame for using such shell space. Finally, the State Health Plan provides that the cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the HSCRC.

The proposed project includes construction of 26,290 square feet of shell space on the third floor of the proposed addition above the Kaufman Cancer Center. The shell space on this floor will support finished building space on upper floors. The estimated cost of constructing the shell space as part of this proposed project is \$ 3,170,406 and will accommodate growth for the Kaufman Cancer Center’s diagnostic and treatment services and/or additional future inpatient needs within the next three years.

Providing this shell floor directly above the Kaufman Cancer Center will allow for future expansion with limited impact to the daily operations of the Kaufman Cancer Center including mitigation of construction noise, leaks, and HVAC outages. If the shell space was not constructed during this planned expansion and UCMC required to construct an additional floor in the near future, the following impacts would be anticipated:

- Relocation of mechanical equipment would be needed;
- Replacement of roof screens would be needed;
- A new crane location would be needed due to inability to use the existing shaft; As an alternative, the loading dock would need to be used for a new crane location which would require a temporary location of hospital's loading dock;
- Another replacement roof would be needed;
- Disruption of occupied space would impact end users in inpatient units;
- There would be an extended schedule for fit out for the developed space that would be subject to existing patient census;
- New air handling units would be needed as UCMC could not shut down existing air handling units to add another floor; and
- A detrimental impact on everyday hospital operations and patient/visitor experience.

The addition of shell space now is reasonable to limit disruption of the Kaufman Cancer Center's operations, to allow for future expansion, and is cost effective.

III. THE RELOCATION OF MSGA BEDS FROM HMH TO UCMC WILL RESULT IN THE DELIVERY OF MORE EFFICIENT AND EFFECTIVE HEALTH CARE SERVICES.

Finally, UM UCH and the applicants have determined that the relocation of HMH's MSGA beds to UCMC will result in more efficient and effective services. The establishment of a dedicated observation unit will not only improve the efficiency of the care for patients with short stays, it will improve operational efficiencies overall within the system. As previously noted, observation stay patients are dispersed across all medical surgical units and are frequently transferred between beds and between different nursing units, in order to accommodate the needs of the acute, inpatient medical surgical patient population. It is anticipated that the level of

patient transfers between units and patient rooms would be significantly reduced with the implementation of a dedicated observation unit. Reducing patient transfer activity will directly impact operational and staffing efficiencies within the nursing, ancillary, and support services teams. Centralizing observation patients on one dedicated unit will also allow for the centralization of the inpatient acute care patient population appropriately on the medical surgical units. This model of care will support optimal staffing patterns, allowing for all staff to function at their highest, appropriate level.

Moreover, the project will achieve cost efficiencies over the long term. As is the case with many aging hospitals that were built over the span of several decades, HMH is not constructed to current best practices and energy codes. The cost, timing, and disruption to ongoing healthcare operation, compounded by numerous physical constraints make the replacement of the facility a more cost effective alternative. The following is a partial list of mechanical, electrical, and plumbing infrastructure inefficiencies at HMH that will be remediated by the relocation of acute MSGA inpatient services from HMH to UCMC under the proposed project:

- a) HMH's building envelope was not constructed to meet current R-values required by code. (Roof insulation, wall insulation, below grade foundation insulation, single pane windows). The proposed project will allow for required insulation R-values in the roof, walls and ceiling, with exterior glazing to be low E with double pane glazing.
- b) HMH has inefficient hospital boilers, while the proposed project will have higher efficiency units.
- c) HMH currently uses water cooled cooling towers whereas the proposed project will use air cooled chillers.
- d) HMH uses two-pipe heating and cooling systems while the proposed project will include a system that more accurately provides desired patient care temperatures.
- e) HMH has a dedicated split system cooling and other condensing units that provide cool air without monitoring, whereas the proposed project will utilize centralized

cooling systems that can be more accurately programmed and monitored for usage.

- f) HMM's plumbing fixtures are outdated and the proposed project will have lower flow heads and fixtures that require less consumption of water.
- g) HMM has inefficient lighting fixtures and ballasts while the proposed project will use higher efficiency fluorescent fixtures and/or LED fixtures.
- h) HMM's light fixtures are currently on timers or manual switches but the proposed project will have modern occupancy sensors that turn lights off when spaces sit idle.

For all of the reasons above, the proposed project satisfies this standard.

IV. THE RELOCATION OF MSGA BEDS FROM HMM TO UCMC IS IN THE PUBLIC INTEREST.

The proposed project is part of UM UCH's vision to create an optimal integrated health delivery system for the residents it services by providing care for patients in the right setting at the right time, at the lowest cost. The geographic proximity of Harford and Cecil Counties provide opportunities for a regionally integrated care network which facilitates coordination of healthcare throughout the services areas of the combined health systems. Ultimately, it is the goal of UCH to enhance the care delivery model by building contemporary state-of-the-art facilities which not only addresses the recognized needs for acute inpatient and behavioral health needs within its community, but which also offer services that continue to deliver consistent high quality patient outcomes and maximizes financial, operational and provider efficiencies.

The major goals of a regionally integrated care network include:

- Clinical and program development and Population Health collaboration;
- Facilitated coordination of healthcare throughout the services areas of the combined health systems;
- When appropriate shared, physician recruitment activities; and
- Programs to improve administrative efficiency, including, but not limited to, cost efficiency and cost savings.

Key aspects to the regionally integrated care network plan include the transition of HMH from an acute care general hospital to a freestanding medical facility. Following this conversion, there will be additional MSGA beds in Harford County, which will require the proposed expansion of UCMC. As noted above, the Commission projects a minimum need for 168 MSGA beds in Harford County in 2025 and a maximum bed need of 223. *Maryland Register v. 44, Issue 2* (Jan. 20, 2017). UCMC is presently licensed for only 160 MSGA beds. Accordingly, upon conversion of HMH to a freestanding medical facility, Harford County will have fewer MSGA beds than the Commission's projected need. The proposed project ensures that the residents of UCH's service area will have continued access to acute hospital services which is clearly in the public interest.

In addition to HMH's inpatient medical surgical beds, its inpatient psychiatric beds will also be transitioned to a new special psychiatric hospital located at UC Medical Campus at Havre de Grace. In addition, Union Hospital, located in Cecil County will also transition its inpatient psychiatric beds to the special psychiatric hospital. These inpatient psychiatric services will be aligned with a robust array of outpatient behavioral health services. This regional approach to the delivery of health care services provides greater access to health care services with improved geographic distribution across the two counties.

The proposed project is, therefore, in the public interest.

CONCLUSION

For all of the reasons set forth above, HMH and UCMC respectfully request that the Commission authorize the relocation of MSGA beds from HMH to UCMC and associated capital expenditures pursuant to a merger and consolidation of these two acute general hospitals.

Respectfully submitted,



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