GALLAGHER
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ATTORNEYS AT LAW

Thomas C. Dame
Direct Dial: 410.347.1331
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August 9, 2019

VIA HAND DELIVERY

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

Re: Certificate of Need Application
Greater Baltimore Medical Center, Inc.
Modernization of Greater Baltimore Medical Center

Dear Ms. Potter:

On behalf of applicant Greater Baltimore Medical Center, Inc., we are submitting four copies of its Certificate of Need Application and related exhibits, along with one set of full-size project drawings. Also enclosed is a CD containing searchable PDF files of the application and exhibits, a WORD version of the application, and native Excel spreadsheets of the MHCC tables.

I hereby certify that a copy of this submission has also been forwarded to the appropriate local health planning agencies as noted below.

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

Sincerely,

Thomas C. Dame

TCD:blr
Enclosures

671211
010236-0002

cc: Kevin McDonald, Chief, Certificate of Need
Paul Parker, Director, Center for Health Care Facilities Planning & Development
Suellen Wideman, Esq., Assistant Attorney General, MHCC
Sarah Pendley, Esq., Assistant Attorney General, MHCC
Gregory Wm. Branch, Baltimore County Health Officer
John Chessare, MD, MPH, FACHE, President and CEO, GBMC
Keith Poisson, Executive VP and Chief Operating Officer, GBMC
Laurie R. Beyer, MBA, CPA, Executive Vice President and CFO, GBMC
Stacey McGreevy, VP of Support Services, GBMC
Susan Martielli, Esq., VP for Legal Affairs and General Counsel, GBMC
Kimberly Jones, Assistant General Counsel, GBMC
Andrew Solberg, A.L.S. Healthcare Consultant Services
Hannah Perng, Esq.

IN THE MARYLAND HEALTH CARE COMMISSION

APPLICATION FOR CERTIFICATE OF NEED

to Modernize Greater Baltimore Medical Center

Applicant

Greater Baltimore Medical Center, Inc.

August 9, 2019

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For internal staff use

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Greater Baltimore Medical Center

Address:

6701 N. Charles Street	Towson	21204	Baltimore County
Street	City	Zip	County

Name of Owner (if differs from applicant):

2. OWNER

Name of owner:

3. APPLICANT. If the application has co-applicants, provide the detail regarding each co-applicant in sections 3, 4, and 5 as an attachment.

Legal Name of Project Applicant

Greater Baltimore Medical Center, Inc.

Address:

6701 N. Charles Street	Towson	21204	MD	Baltimore County
Street	City	Zip	State	County

Telephone: (410) 328-8667 (General Information)

Name of Owner/Chief Executive: John B. Chessare, MD, MPH, FACHE, President and CEO

4. Name of Licensee or Proposed Licensee, if different from applicant:

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5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☒	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation Maryland, 1960
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☒	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☒	

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Laurie R. Beyer, MBA, CPA
Name and Title: Executive Vice President and Chief Financial Officer
Mailing Address:

6701 N. Charles Street	Towson	21204	MD
Street	City	Zip	State

Telephone: 443-849-2519
E-mail Address (required): lbeyer@gbmc.org
Fax:

B. Additional or alternate contact:

Name and Title: Thomas C. Dame, Esquire
Mailing Address:
Gallagher Evelius & Jones LLP

218 N. Charles St. Suite 400	Baltimore	21201	MD
Street	City	Zip	State

Telephone: 410-347-1331
E-mail Address (required): tdame@gejlaw.com
Fax: 410-468-2786

Name and Title: Hannah L. Perng, Esquire
Mailing Address:
Gallagher Evelius & Jones LLP

218 N. Charles St. Suite 400	Baltimore	21201	MD
Street	City	Zip	State

Telephone: 410-347-1341
E-mail Address (required): hperng@gejlaw.com
Fax: 410-468-2786

7. TYPE OF PROJECT

The following list includes all project categories that require a CON under Maryland law. Please mark all that apply.

If approved, this CON would result in:

(1) A new health care facility built, developed, or established ☐
(2) An existing health care facility moved to another site ☐
(3) A change in the bed capacity of a health care facility ☐
(4) A change in the type or scope of any health care service offered by a health care facility ☐
(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_update_20180417.pdf ☒

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is; why you need/want to do it; and what it will cost. A one-page response will suffice. Please include:

(1) Brief description of the project – what the applicant proposes to do;
(2) Rationale for the project – the need and/or business case for the proposed project;
(3) Cost – the total cost of implementing the proposed project; and
(4) Master Facility Plans – how the proposed project fits in long term plans.

Applicant Response

(1) Greater Baltimore Medical Center ("GBMC") proposes to expand its facility to provide new, private, state-of-the-art inpatient rooms as well as expand patient, family, and staff support space. The proposed project will be a three (3) story expansion located in front of the existing main lobby and between two existing wings, to align with the existing third (on grade), fourth, and fifth floors of the hospital. The ground floor of the building (3rd floor) will house new patient, family, and staff support space. The upper two (2) floors will contain 30 inpatient beds each, with additional patient, family, and clinical support spaces.

The project will not increase the physical bed count. Sixty (60) beds will be relocated from existing undersized units on the third and fourth floor of the hospital, and those units will be vacated and no longer used to house inpatient beds. The vacated space may be renovated in other future projects as outlined below under the GBMC Master Facility Plan. Consistent with the Master Facility Plan, the availability of the vacated units will enable future projects which will modernize the existing patient units in succession.

(2) The existing hospital is predominantly comprised of private inpatient beds, which are sub-standard size, do not accommodate modern clinical and equipment needs, and cause significant patient, family, and staff dissatisfaction.

a. Approximately 100 of the smallest medical / surgical patient rooms, originally constructed in the 1960's, range from 100nsf – 115nsf, which is less than current FGI Guidelines recommend. These rooms also lack the FGI Guidelines-recommended 3'-0" clearance on each side of the bed. Moreover, they lack certain basic services, such as hand washing sinks in the patient toilet rooms.

b. Approximately 72 of the medical / surgical patient rooms that were built in the 1993 expansion are slightly larger at 130nsf clear, but they still lack the 3'-0" clearance around the bed and do not have staff handwashing sinks in the patient room.

c. To accommodate modern clinical requirements, GBMC plans to replace 60 of the smallest rooms with new medical / surgical inpatient rooms that comply with FGI Guidelines. Space vacated by this expansion will be utilized for future renovations as outlined below.

The hospital currently utilizes all of its existing space and has already moved many non-essential administrative functions outside of the hospital and, in many cases, off campus. To create much needed support space, and to provide future flexibility for other renovations outlined below, GBMC will provide new / replacement spaces inside the entry level of the new expansion, including:

a. appropriate reception / security desk;
b. public restrooms;
c. spiritual support services space, including a chapel, Kosher pantry, and inter-faith space;
d. food service amenity;
e. patient / family gift shop amenity;
f. medical staff library;
g. retail pharmacy amenity;
h. vertical circulation to support the building expansion; and
i. outdoor patient, family, and staff respite space.

(3) The estimated total cost of the project is $ 108,228,049.

(4) In 2013, GBMC developed a comprehensive Master Facility Plan, which was updated in 2018. The Master Facility Plan includes renovating all sub-standard bed units throughout the hospital over the next 10 years. Since most units cannot be expanded, the bed count in each unit will be reduced to meet current FGI Guidelines. Current 30-bed units are anticipated to be reduced to 15-bed units. To avoid reducing the overall bed count in the hospital, the first step in the Master Facility Plan is to do what this project proposes: create a new space for 60 beds, and move 60 existing patient beds into this new space, thus vacating the units where the 60 beds are currently located. When the timing is appropriate, and as separate future projects, GBMC plans to renovate the vacated units one at a time.

In addition, the Master Facility Plan identified that the emergency department ("ED") is undersized, particularly lacking in acute treatment rooms and behavioral health treatment rooms. Today, the ED is located on the ground (3rd) floor of the hospital. The ED is surrounded by the existing ambulance drop-off, the radiology department, an inpatient unit, and support space. The support space includes the reception desk, administrative suites, the chapel, the kosher pantry, the gift shop, and public restrooms. Through this proposed project, which contemplates the relocation of those support spaces, there will be additional space for future ED expansion as part of a separate, later project.

B. Comprehensive Project Description: The description must include details, as applicable, regarding:

(1) Construction, renovation, and demolition plans;
(2) Changes in square footage of departments and units;
(3) Physical plant or location changes;
(4) Changes to affected services following completion of the project; and
(5) If the project is a multi-phase project, describe the work that will be done in each phase. If the phases will be constructed under more than one construction contract, describe the phases and work that will be done under each contract.

Applicant Response

GBMC is proposing to modernize its existing complement of MSGA inpatient rooms to bring them in line with current FGI Guidelines and current patient care best practices. As part of this project, GBMC will also add much-needed patient and family support space to its campus.

(1) Construction, renovation, and demolition plans

A. GBMC's Existing Bed Capacity

A full summary of GBMC's existing bed capacity is set forth in Table A. All of the acute care beds are either original to the hospital or were constructed in additions more than 25 years ago. No significant renovations have been performed on any of the patient units, other than to refresh the materials within the patient rooms. Patient room layouts, sizes, and infrastructure have remained constant, sometimes for as long as 50+ years.

The typical patient rooms on the existing patient units do not satisfy current FGI Guidelines and make it difficult to satisfy the basic standard of patient care. Typical rooms in Units 34, 35, 36, 45, and 46 are between 105sf and 112sf, which is below the FGI Guidelines minimum of 120sf. Typical rooms in Units 38, 48, and 58 are 130sf, which do meet the FGI Guidelines, but do not comply with the clear space around the bed, and are below the 200sf industry standard (300sf including patient toilet room). All of the rooms also do not meet other FGI Guidelines, which are detailed elsewhere in this Application, see pp. 56-57, such as:

- Clear space around the bed;
- Sufficient handwashing for staff; and
- Sufficient space between the handwashing sink and the patient bed

The primary purpose of this project is to replace 60 of these too-small, substandard patient beds with 60 new beds that are modern and in line with FGI Guidelines. In addition, by vacating 60 existing beds from two current units in the hospital, those units ultimately will be able to be renovated and reconfigured to house fewer beds, each of which satisfies FGI Guidelines. Importantly, however, GBMC's total bed capacity will not be reduced through these later reconfigurations, as it will preserve its existing bed capacity through the expansion in this proposed project.

B. Existing Hospital Design

The existing hospital is designed with a central service core, with surgical, radiology, ED, and support services surrounded on all sides by inpatient bed units and outpatient services through a series of "fingers". In general, these existing units are too close together to build between them, except at the existing main entrance where the proposed project site is located.

The hospital is a five-story building that steps up along a hill side. At the existing main entrance, the third floor of the hospital is ground level, and it serves as the main entrance.

To provide utility services to the hospital core and "fingers," the existing hospital has a series of penthouses above level 5, some of which are connected by enclosed service walkways.

C. Proposed Building Design

The proposed building design is a three-story expansion in front of the main entrance of the existing building. The new building addition will align with the 3rd, 4th, and 5th floors of the existing hospital.

In addition to the three-story expansion project, there will be minor renovations to the existing hospital on the 3rd, 4th, and 5th floors where the proposed project will integrate the hospital, connecting utilities and existing finishes together between the new construction and the existing hospital. The proposed project also includes minor renovation work on the 2nd floor of the existing hospital where GBMC proposes to construct above the existing hospital below grade to tie the upper floors together. Finally, there will be a new penthouse on the building, which will connect back to two existing penthouses through new enclosed service walkways. The breakdown of the construction by floor is as follows:

(i) Second Floor

GBMC proposes to renovate 1,413sf of existing vacated space to provide new structure to support the addition above.

(ii) Third Floor

On the third floor, GBMC proposes to remove the existing entrance vestibule, drop off canopy, and exterior wall to make space for the new addition. The project will also remove approximately 3,220sf of existing single-story construction to make way for the three-story connection to the main hospital.

The new expansion of 35,593sf will provide for expanded patient and family amenity space, including:

- Reception
- Chapel and spiritual care support space
- Food Service
- Gift Shop
- Medical Library
- Retail Pharmacy
- Wellness and Patient Support Space

There will be approximately 5,326sf of renovation within the main lobby to allow the circulation and a new gift shop to connect through from the new building into the existing building.

By creating these new patient and family amenity spaces, the hospital will vacate approximately 5,970sf on the third floor which will enable a future ED expansion project. The ED expansion project is not part of this project, but will be included in the next phase of the hospital's Master Facility Plan. The ED currently is completely surrounded by either occupied space, or unbuildable exterior spaces, and it is operating beyond its physical capacity. Moving these adjacent functions is critical to the future success of that department.

In addition, a three-story public concourse along the north side of the addition will provide for public circulation into the hospital while allowing natural light into the new and existing patient rooms above.

(iii) Fourth Floor

The fourth floor will primarily consist of a 28,504sf expansion, with minor renovations to 2,755sf to connect through to the existing corridors.

The expansion will house 30 new, private inpatient rooms, and associated patient, family, and staff support spaces. The rooms will be designed as medical-surgical level of care. Two of the rooms will be designed for "patients of size" (300lbs or larger). Two of the rooms will also be designed for airborne infection isolation to serve potentially infectious patients.

The construction of this unit will allow the hospital to vacate 30 beds from the existing Unit 38, to allow for a future renovation of that unit.

(iv) Fifth Floor

The fifth floor will primarily consist of a 28,504sf expansion, with minor renovations to 2,093sf to connect through to the existing corridors.

The expansion will house 30 new, private inpatient rooms, and associated patient, family, and staff support spaces. The rooms will be designed for medical / surgical level of care. Two of the rooms will be designed for "Patients of size" (300lbs or larger). Two of the rooms will also be designed for airborne infection isolation to serve potentially infectious patients.

The construction of this unit will allow the hospital to vacate 30 beds from the existing Unit 45, to allow for a future renovation of that unit.

(v) Penthouse

Above the fifth floor of the building, the proposed project will include a 13,482sf penthouse, which will house equipment specifically to serve this expansion. It will include three new air handling units, a normal power electrical substation, and an emergency power distribution room.

The penthouse will be reached by one elevator and one stair in the new expansion. It will also be connected to the existing penthouse 2B and the existing penthouse 3 by enclosed service walkways to facilitate proper maintenance of the equipment.

(2) Changes in square footage of departments and units;

Changes to the overall building square footage, and the square footage of departments and units are detailed in the attached Table B, **Exhibit 1.**

(3) Physical plant or location changes;

There will be no changes to the physical plant or location other than those outlined above.

(4) Changes to affected services following completion of the project;

As outlined above, 60 existing inpatient beds will be vacated from Unit 38 and Unit 45 (30 beds each) and relocated to space created by the proposed project. Specifically, through the proposed project, 30 beds will be relocated to the 4th floor and 30 to the 5th floor.

(5) Phasing

The building will be constructed as a single-phase project, with all the minor renovations taking place within the time frame of the expansion. The project will be awarded as a single construction contract.

Complete the DEPARTMENTAL GROSS SQUARE FEET WORKSHEET (Table B) in the CON TABLE PACKAGE for the departments and functional areas to be affected.

See MHCC Form Tables, **Exhibit 1**, Table B.

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

Complete the Bed Capacity (Table A) worksheet in the CON Table Package if the proposed project impacts any nursing units.

Applicant Response

See MHCC Form Tables, **Exhibit 1**, Table A.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 57.933 acres

B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES_____ NO __X___ (If NO, describe below the current status and timetable for receiving necessary approvals.)

Applicant Response

The site is located in Towson, MD, and falls under the Baltimore County zoning requirements of a County Review Group ("CRG"). The CRG for GBMC has been revised several times in the past, most recently on 01/30/2004.

GBMC anticipates submitting an amendment to the CRG on or about September 1, 2019, and it is expected to take no more than 6 months to obtain approval for the modification. This process is consistent with two recent CRG amendment submissions that this team has made in Baltimore County within the past two years, which took three and half months and five months respectively to complete. Specific steps include:

Development Review Committee ("DRC") Process

Week 0	Submit the redlined CRG plan
Week 3-4	Attend DRC meeting - scheduled on a Tuesday at least 3 full weeks from the date of submission
Week 4-7	Receive DRC approval letter

Redlined CRG Process

Week 6-9	Submit Redlined CRG plans to County review departments PAI. At a minimum, DEPS, DPR, and Planning will review
Week 24-29	Address comments, revise and resubmit. Receive final CRG approval.

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: Greater Baltimore Medical Center, Inc.
Please provide a copy of the deed. GBMC's campus is comprised of more than one deed. Attached as **Exhibit 4** is the deed for the portion of the property impacted by the proposed project.

(2) Options to purchase held by: _____
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: _____
Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: _____
Please provide a copy of the option to lease as an attachment.

(5) Other: _____
Explain and provide legal documents as an attachment.

11. PROJECT SCHEDULE

In completing this section, please note applicable performance requirement time frames set forth at COMAR 10.24.01.12B & C. Ensure that the information presented in the following table reflects information presented in Application Item 7 (Project Description).

	Proposed Project Timeline
Single Phase Project	
Obligation of 51% of capital expenditure from CON approval date	9 months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	4 months
Completion of project from capital obligation or purchase order, as applicable	24 months

12. PROJECT DRAWINGS

A project involving new construction and/or renovations must include scalable schematic drawings of the facility at least a 1/16" scale. Drawings should be completely legible and include dates.

Project drawings must include the following before (existing) and after (proposed) components, as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, room sizes, number of beds, location of bathrooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space".

B. For a project involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. For a project involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after the proposed project.

D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

Applicant Response

Project drawings are attached as **Exhibit 2**.

13. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction Characteristics (Table C) and Onsite and Offsite Costs (Table D) worksheets in the CON Table Package.

Applicant Response

See **Exhibit 1** MHCC Form Tables, Table C, Table D.

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project, and the steps necessary to obtain utilities. Please either provide documentation that adequate utilities are available or explain the plan(s) and anticipated timeframe(s) to obtain them.

Applicant Response

There is adequate capacity in the public utilities that presently service the existing hospital to support the requirements of the proposed building addition.

Utilities (including normal and emergency power, chilled water, heating hot water, steam, domestic hot/cold water, and medical gases) for the proposed building addition will be extended from existing systems in the central plant and ED penthouse mechanical equipment room, with minor equipment and control modifications to accommodate added loads. Utilities will be routed to the new addition via existing penthouse spaces, as well as new rooftop heated piping chases, to the new addition penthouse, which will house air handling units and other mechanical, electrical, and plumbing equipment to support the addition.

A new site sanitary connection will be provided for the addition. Connecting to the existing sanitary sewer in the Charles Street Right of Way will require approval of a Public Utility Plan, a line item for sanitary drain security in the Right of Way Agreement, and an SHA Utility Permit. The storm water system will make use of new devices provided within the limits of the project and connect to the existing storm water management system provided on the campus.

PART II - PROJECT BUDGET

Complete the Project Budget (Table E) worksheet in the CON Table Package.

Note: Applicant must include a list of all assumptions and specify what is included in all costs, as well the source of cost estimates and the manner in which all cost estimates are derived.

Applicant Response

See **Exhibit 1**, MHCC Form Tables, Table E.

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. List names and addresses of all owners and individuals responsible for the proposed project.

   Owner: Greater Baltimore Medical Center, Inc.

   Responsible Individual: John B. Chessare, MD, MPH, FACHE, President and CEO,

   Address: 6701 N. Charles Street, Towson, Maryland 21204

2. Is any applicant, owner, or responsible person listed above now involved, or has any such person ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each such facility, including facility name, address, the relationship(s), and dates of involvement.

   Dr. Chessare has been involved in the following health care facilities and entities:

   Greater Baltimore Medical Center HealthCare System
   June 2010 – present: President and Chief Executive Officer

   Caritas Christi Health Care System
   July 2005 – October 2008

   President and Chief Executive Officer
   Caritas Norwood Hospital
   September 2005 – October 2008

   Senior Vice President for Quality and Patient Safety
   Caritas Christi Health Care System
   November 2005 – July 2008

   Interim President and CEO, Caritas Christi Health Care
   May 2006 – April 2008

   Chief Administrative Officer
   Caritas Norwood Hospital
   July 2005 – September 2005

   Boston Medical Center/Boston University School of Medicine
   August 1998 – June 2005

   Senior Vice President for Medical Affairs - Chief Medical Officer
   Boston Medical Center

   President
   BMC Management Services (Medical Services Organization)

Associate Dean for Clinical Affairs - Professor of Pediatrics
Boston University School of Medicine

Albany Medical Center/Albany Medical College
August 1994 – June 1998

Vice President for Clinical Process Improvement, Albany Medical Center
September 1997 - June 1998

Interim Chair, Department of Pediatrics, Albany Medical College
(Concomitant with other responsibilities as Associate Medical Director and Vice President for Clinical Process Improvement)
February 1997 - June 1998

Associate Medical Director, Albany Medical Center
August 1994 to September 1997

Medical College of Ohio
August 1983 – June 1994

Chief, Division of General Pediatrics, Department of Pediatrics

Vice-Chief of Staff, Medical College of Ohio Hospital

Director, Ambulatory Pediatrics

Associate Medical Director, Toledo Health Plan

Associate Professor of Pediatrics with Tenure

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3. In the last 5 years, has the Maryland license or certification of the applicant facility, or the license or certification from any state or the District of Columbia of any of the facilities listed in response to Question 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions)? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant(s), owners, or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

No.

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4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health

care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

On January 13, 2011, following an informal dispute resolution process, GBMC resolved deficiencies found by the Maryland Department of Health Office of Health Care Quality (OHCQ) by submitting a plan of correction and paying civil monetary penalty in the amount of $16,300.

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

No.

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

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.

August 9, 2019
Date

John B Chessare MD
Signature of Owner or Board-designated Official

President and CEO
Position/Title

John B. Chessare, MD, MPH, FACHE
Printed Name

PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

10.24.01.08G(3)(a). <u>The State Health Plan</u>.

To respond adequately to this criterion, the applicant must address each applicable standard from each chapter of the State Health Plan that governs the services being proposed or affected, and provide a direct, concise response explaining the project's consistency with each standard. <u>In cases where demonstrating compliance with a standard requires the provision of specific documentation, documentation must be included as a part of the application.</u>

Every acute care hospital applicant must address the standards in **COMAR 10.24.10: Acute Care Hospital Services**. A Microsoft Word version is available for the applicant's convenience on the Commission's website. Use of the *CON Project Review Checklist for Acute Care Hospitals General Standards* is encouraged. This document can be provided by staff.

Other State Health Plan chapters that may apply to a project proposed by an acute care hospital are listed in the table below. A pre-application conference will be scheduled by Commission Staff to cover this and other topics. It is highly advisable to discuss with Staff which State Health Plan chapters and standards will apply to a proposed project before application submission. Applicants are encouraged to contact Staff with any questions regarding an application.

<u>The State Health Plan</u>. Application for Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies and criteria.

The Applicable State Health Plan Chapter is COMAR 10.24.10, Acute Hospital Services.

COMAR 10.24.10. ACUTE CARE CHAPTER

.04A. GENERAL STANDARDS

The following general standards encompass Commission expectations for the delivery of acute care services by all hospitals in Maryland. Each hospital that seeks a Certificate of Need for a project covered by this Chapter of the State Health Plan must address and document its compliance with each of the following general standards as part of its Certificate of Need application. Each hospital that seeks a Certificate of Need exemption for a project covered by this Chapter of the State Health Plan must address and demonstrate consistency with each of the following general standards as part of its exemption request.

Standard .04A(1) – Information Regarding Charges.

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

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

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

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

Applicant Response:

GBMC complies with this standard. The GBMC policy on information regarding hospital charges is attached as **Exhibit 5**, and a Representative List of Services and Charges is available on its website at the following link: https://www.gbmc.org/hospital-charges.

Standard .04A(2) – Charity Care Policy.

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

(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; and

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

Applicant Response:

GBMC's financial assistance policy is attached as **Exhibit 6**. Public notice is provided through publication on GBMC's website at https://www.gbmc.org/workfiles/patients/2018-05-15-final-Financial-Assitance-Policy.pdf, and through print publication, attached as **Exhibit 7**. Notices of the financial assistance policy are posted at all hospital registration points (inpatient and outpatient), the business office, and the Emergency Department. *See, e.g.*, **Exhibit 8**, a photo of the notice of the financial assistance policy posted at the Emergency Department. Individual notice regarding the financial assistance policy is provided at the time of admission to each person who seeks services at GBMC.

(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.

Applicant Response:

When only Charity Care is considered as a percent of Total Operating Expenses, GBMC ranks in the bottom quartile. See **Exhibit 9**. GBMC is committed to the people it serves and the communities where they reside. Although GBMC's charity care is lower than other Maryland hospitals, GBMC is dedicated to serving the community and invests approximately $42,600,000, or 8.3% of operating expenses, in healthcare services and outreach programs, as shown in Exhibit 9.

Indeed, when total Community Benefits are considered, GBMC is ranked much higher. As the data in Exhibit 9 show:

1. Ranking the hospitals by "Total Community Benefit Expense" shows that GBMC has the 12th highest investment in Community Benefits, ranking at the top of the 2nd quartile.

2. Ranking the hospitals by "Total CB as % of Total Operating Expense," GBMC ranks in the 3rd quartile.

3. Ranking the hospitals by "Total Net CB minus Charity Care, DME, NSPI in Rates," GBMC is in the 1st quartile.

4. Ranking the hospitals by "Total Net CB (minus charity Care, DME, NSPI in Rates) as % of Operating Expense," GBMC is in the 3rd quartile.

GBMC's investments in the community are partially driven by a formalized Community Health Needs Assessment ("CHNA"), where input is received from community stakeholders. See https://www.gbmc.org/chna. The prioritized health issues in the CHNA includes: behavioral health/substance abuse, and access to care and obesity. GBMC is addressing these needs by implementing the following programs: behavioral health embedded in primary care offices, elder medical care at home, and expanding care coordination/care management outside the acute care setting. These programs have contributed to GBMC achieving a 9.46% readmission rate, one of the lowest in the State.

In addition, GBMC is increasing patient's access to care through the Patient-Centered Medical Home ("PCMH") model. GBMC's integrated, multi-specialty medical group manages patient's health across GBMC's system of care, with a focus on prevention and wellness, evidenced based care and active management of chronic diseases. Over a two-year period, covered lives in GBMC's program has increased 17%. Additional outreach efforts have included, but are not limited to: (1) providing clinical education and medical services (screenings, vaccinations, etc.) to eight Towson low-income senior living facilities, where the elderly are vulnerable to hospitalizations due to difficulties they face in traveling to see primary care providers; (2) maintaining 24/7 – 365 day coverage of a Forensic Nurse Examiner for adult domestic violence and sexual assault victims (more than 200 patients were served in 2018, and GBMC's services were recently expanded to include the pediatric population when a Baltimore-area hospital discontinued their pediatric services); and (3) maintaining a comprehensive obesity management program that has reached 100 individuals. GBMC will continue to partner with community leaders and groups in assessing the health and social needs of the community and how GBMC can services the needs.

Moreover, GBMC's charity care experience is a function of the insured and self-pay populations that GBMC serves. Furthermore, the Maryland Health Services Cost Review Commission ("HSCRC") provides for funding of charity care across all Maryland hospitals.

Standard .04A(3) – Quality of Care.

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

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

(ii) Accredited by the Joint Commission; and

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

Applicant Response:

GBMC complies with all mandated federal, state, and local health and safety regulations and applicable state certification requirements. GBMC is licensed by the Maryland Department of Health, is accredited by The Joint Commission, and is in compliance with all Medicare and Medicaid conditions of participation. Copies of GBMC's license and most recent accreditation letter are attached as **Exhibits 10** and **11**.

(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.

Applicant Response:

GBMC identifies, collects, monitors, and acts upon key quality performance indicators on a daily, weekly, and monthly basis. These quality performance indicators include: (1) outcome measures such as mortality, readmission, complication rate, length of stay; (2) serious safety events; (3) a review of Maryland Hospital Acquired Conditions, the AHRQ Patient Safety Indicators as well as through use of GBMC internal incident reporting systems; (4) core measures data; (5) HCAHPS results; and (6) Employee Injury Reports.

Review of the most recent Hospital Quality Measures available online illustrates that GBMC's performance was better than average for 15 of the Measures, average for 27 of the Measures, and below average for 20 of the Measures. As a continuously improving organization, some improvements have already been made on those Measures falling below average. Please see **Exhibit 12** for an explanation of GBMC's Quality Measure Action Steps.

COMAR 10.24.10 ACUTE CARE CHAPTER

.04B. PROJECT REVIEW STANDARDS

Standard .04B(1) – Geographic Accessibility

A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for its likely service area population. Optimal travel time for general medical/surgical, intensive/critical care and pediatric services shall be within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area.

Applicant Response:

Inapplicable.

Standard .04B(2) – Identification of Bed Need and Addition of Beds

Only medical/surgical/gynecological/addictions ("MSGA") beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.

(a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.

(b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection. (c) Additional MSGA or pediatric beds may be developed or put into operation only if:

(i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19-307.2; or

(ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter; or

(iii) 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 need 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; or

(iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.

Applicant Response:

Inapplicable. GBMC does not seek to add licensed MSGA or pediatric beds.

A discussion of the need for the total number of MSGA beds is provided in response to COMAR § 10.24.01.08G(3)(b), Need.

Standard .04B(3) – Minimum Average Daily Census for Establishment of a Pediatric Unit

An acute care general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:

(a) The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or

(b) The hospital is the sole provider of acute care general hospital services in its jurisdiction.

Applicant Response:

Inapplicable. GBMC does not seek to establish a pediatric unit.

Standard .04B(4) – Adverse Impact

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 Commission will grant a Certificate of Need only if the hospital documents the following:

(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise

demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

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Applicant Response:

GBMC plans to pursue an increase in rates with the HSCRC to fund the incremental depreciation and interest costs of the project, as well as other rate funding needs unrelated to this Certificate of Need ("CON") project. The anticipated impact of the capital related request will result in a projected 1.65% increase in Global Budget Revenue ("GBR"), as demonstrated in the calculation below:

Project Depreciation Expense	$	4,485,000
Project Interest Expense		2,833,859
Total Project Capital	$	7,318,859
GBMC FY19 Mark-Up		1.08878
Project Capital Expense	$	7,968,624
Less: MVS Adjustment		(173,297)
Less: SQFT Adjustment		(13,770)
Adjusted Capital Rate Request	$	7,781,558
FY2019 Approved GBR	$	471,379,273
% GBR Increase		1.65%

As with all but three hospitals in the state, GBMC has unfavorable performance under the most recently published Inter-hospital Cost Comparison ("ICC").The ICC methodology indicates GBMC's permanent revenue is 12.24% above the ICC standard. However, under the most recently published HSCRC Rate Efficiency Methodology ("REM"), GBMC's REM standard efficiency charge is -0.37% below ICC peer group and -7.34% below the statewide average. GBMC contends the ICC is not a rate setting methodology, but rather a relative comparison to an otherwise unattainable standard. The statewide average ICC adjustment is -13.91%, indicating GBMC has better than average efficiency relative to the state.

Further, based on FY2019 approved rates and actual volumes, GBMC's unit rates are approximately -4.8% below its ICC peer group average rates. After adjusting rates for the capital rate request above, GBMC's unit rates are projected to remain approximately -3.2% below the peer group average, as demonstrated in the table below:

Table 1
Comparison of Hospital Charges to ICC Peer Group
In $000s

GBMC FY19 Pro-forma Revenue			FY19 Approved Rates Variance to Peer Group		Capital Adjusted Rates Compared to Peer Group	
FY2019 Pro-Forma Revenue [1]	FY2019 Revenue at Capital Adjusted Rates [2]	FY19 Revenue at Peer Group Weighted Average Rates [3]	Over / (Under) Peer Group Rates	Percent Variance	Over / (Under) Peer Group Rates	Percent Variance
$ 471,086	$ 478,868	$ 494,631	$ (23,545)	-4.8%	$ (15,763)	-3.2%

Sources:
FY2019 HSCRC Approved Unit Rates
FY2019 Experience Report May YTD

(1) Calculated as FY2019 HSCRC approved unit rates x FY2019 actual volume May YTD annualized
(2) Capital-adjusted rates calculated be increasing FY2019 approved GBR by capital request of $7.8M then realigning revenue across rate realigned rate centers.
(3) Calculated as FY2019 weighted average ICC peer group unit rates x GBMC FY19 volume. ICC peer group hospitals include: MedStar Franklin Square Hospital, MedStar Good Samaritan Hospital, St. Agnes Hospital, Holy Cross Hospital, Suburban Hospital, University of Maryland Baltimore Washington Medical Center, and University of Maryland Rehabilitation and Orthopedic Institute.

In addition, GBMC's current and projected unit rates are favorable in comparison to statewide benchmarks. The table below demonstrates GBMC's capital adjusted rates are projected to remain -8.9% below the statewide median rates:

Table 2
Comparison of Hospital Charges to Statewide Median
In $000s

GBMC FY19 Pro-forma Revenue			FY19 Approved Rates Variance to SW Median		Capital Adjusted Rates Compared to SW Median	
FY2019 Pro-Forma Revenue [1]	FY2019 Revenue at Capital Adjusted Rates [2]	FY19 Revenue at SW Median Rates [3]	Over / (Under) SW Median Rates	Percent Variance	Over / (Under) SW Median Rates	Percent Variance
$ 471,086	$ 478,868	$ 525,425	$ (54,339)	-10.3%	$ (46,557)	-8.9%

Sources:
FY2019 HSCRC Approved Unit Rates
FY2019 Experience Report May YTD

(1) Calculated as FY2019 HSCRC approved unit rates x FY2019 actual volume May YTD annualized
(2) Capital-adjusted rates calculated be increasing FY2019 approved GBR by capital request of $7.8M then realigning revenue across rate realigned rate centers.
(3) Calculated as FY2019 statewide median unit rates x GBMC FY19 volume.

Given GBMC's relative unit rates and the funding mechanisms within the GBR system, GBMC expects to demonstrate it can maintain a reasonable charge structure including the requested funding for incremental capital expenditures, as demonstrated above.

Per the requirement, GBMC has a debt to capitalization ratio below the peer group average, as demonstrated in the table below:

Table 3
Comparison of FY2018 Debt to Capitalization Ratio to ICC Peer Group
In $000s

Hospital	Long-term Debt	Total Liabilities and Net Assets	Debt to Capitalization Ratio
Holy Cross Hospitals [1]	$ 394,650	$ 1,069,150	0.3691
MedStar Hospitals [2]	1,518,800	4,892,700	0.3104
St. Agnes Hospital	74,168	372,762	0.1990
Suburban Hospital	27,860	64,484	0.4320
UM Baltimore Washington Medical Center	161,116	517,789	0.3112
UM Rehab and Ortho Institute	20,486	155,639	0.1316
Peer Group Total	$ 3,715,880	$ 11,965,224	0.3106
GBMC	$ 140,713	$ 625,534	0.2249

Source: FY2018 Audited Financial Statements

(1) Includes Holy Cross Hospital and Holy Cross - Germantown Hospital
(2) MedStar Health Inc. is the sole member of the obligated group under the Master Trust Indenture agreement with the affiliates. Accordingly, long term debt is not reported at the affiliate level on the audited financial statements. Amounts included in this table are for the entire MedStar Health System

Further, GBMC's average age of plant is significantly older than its peers based on the most recent data available. Based on data from the FY2016 HSCRC Annual Filing reports, the last year for which average age of plant was required to be reported to the HSCRC, GBMC's average age of plant of 14.7 years is in the top decile in the state. GBMC also has the highest average age of plant in its ICC peer group, which has a median average age of plant of 11.8 years and a mean of 9.5 years. The Moody's Investor Services median average age of plant for AA rated stand-alone acute hospitals was 10.7 years in FY2017, the most recent data available.

(b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.

Applicant Response:

Inapplicable. The project will not reduce services.

Standard .04B(5) – Cost-Effectiveness

A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.

(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:

(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;

(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and

(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

Applicant Response:

As explained in response to part (b) below, the proposed project involves limited objectives. Therefore, GBMC did not complete the analysis in part (a).

(b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.

Applicant's Response

The proposed project principally involves the expansion of space for a single service without adding physical bed capacity, and once this proposed project is complete, it will allow the hospital to renovate additional portions of its campus for purposes of modernization. This limited objective—to expand space for a single service—is born out of GBMC's overall goals of improving patient safety, delivering quality care, and enhancing the patient experience. The only practical approach to implement GBMC's limited objective expansion project while still satisfying these goals is to build an addition to the main entrance of the hospital, as this project proposes to do.

GBMC seeks to expand its current hospital space in order to relocate 60 medical patient beds that are contemporary, patient-centered, and satisfy FGI Guidelines. The relocation and modernization of these 60 beds will enhance GBMC's move towards integrated care management teams that support a multi-disciplinary approach to patient care, which integrates physicians, advanced practitioners and case managers on every unit, thus reducing hospital re-admissions.

The modernization will also support new medication best practices through automated dispensing of nearly 100% of all medication.

The relocation of these 60 beds will create vacant space for future renovations under the Master Facility Plan—the ultimate goal of which is to modernize GBMC's hospital campus. Importantly, by first relocating these 60 beds, GBMC will then be able to pursue additional, future hospital renovations without reducing its overall bed capacity.

GBMC did consider alternative approaches to this proposed project and ultimately concluded that the proposed project is the only practical approach to achieving GBMC's limited objectives. Given that the objective of the project is to expand space for existing services with the goals of improving patient safety, delivering quality care, and enhancing the patient experience, the only potential alternative to constructing an addition to the existing hospital was to renovate existing space within the hospital. After reviewing its use of the existing inpatient units, however, GBMC concluded that renovation in place was not feasible. Renovation within the existing hospital would require the closure and complete renovation of three medical units through multiple phases, which would extend the duration of construction and impact hospital operations, including the quality of patient care in adjacent units. This renovation would result in a significant reduction of available beds during construction, resulting in GBMC being unable to meet its bed demand. Finally, renovation in place would ultimately result in fewer physical beds in the hospital – causing a reduction, not an expansion, of space-- because the number of beds would need to be reduced to provide for larger, FGI Guidelines-compliant patient rooms. Therefore, GBMC concluded that renovating within its existing hospital space was simply not feasible.

The only practical approach to meet its limited objections, therefore, is to construct an addition to the existing hospital space, as this project proposes to do. GBMC considered other locations for this expansion, including an addition at the end of Building Five. This location was quickly rejected, however, as it would require longer travel distances for patients and their families; longer travel distances for support services, given that the addition would be far removed from the hospital core; and significantly longer runs for the major utilities needed to serve the space. Existing clinical functions would also need to be permanently relocated, adding to the cost of the project. Finally, the topography in the area around Building Five would present significant challenges and result in additional cost.

GBMC ultimately concluded, therefore, that constructing the project in the proposed location – at the current main entrance to the hospital and in between Building One and Building Four – was the only practical location for the addition, because the expansion in this location will:

- provide the proper physical environment for modern medical inpatient rooms;
- provide new inpatient units in close proximity to the hospital core and enhance the patient, visitor and staff circulation within the building;
- maintain the existing hospital inpatient bed count through construction;
- support the operational concept of integrated care teams and provide sufficient support space for these multi-disciplinary teams;
- provide sufficient space for proper medication practices;
- use existing hospital utility infrastructure to support the expansion;
- provide vacated space for future renovation projects at the appropriate time; and
- fit within GBMC's budget.

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

(i) That it has considered, at a minimum, an alternative project site located within a Priority Funding Area that provides the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);

(ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;

(iii) That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and

(iv) That the proposed project site is superior, in terms of cost-effectiveness, to the alternative project site or sites located within a Priority Funding Area.

Applicant Response:

Inapplicable. GBMC is not proposing establishment of a new hospital or relocation of an existing hospital to a new site.

Standard .04B (6) – Burden of Proof Regarding Need

A hospital project shall be approved only if there is demonstrable need. The burden of demonstrating need for a service not covered by Regulation .05 of this Chapter or by another chapter of the State Health Plan, including a service for which need is not separately projected, rests with the applicant.

Applicant Response:

GBMC addresses the need for the project in response to COMAR 10.24.01.08G(3)(b), *infra*.

Standard .04B(7) – Construction Cost of Hospital Space

The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, 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 that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

Applicant Response:

The narrative attached as **Exhibit 13** compares the project costs to the Marshall Valuation Service ("MVS") benchmark.

Standard .04B(8) – Construction Cost of Non-Hospital Space

The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide for the appropriate structure. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the non-hospital space shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost. In general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.

Applicant Response:

Inapplicable. The proposed project does not include non-hospital space.

Standard .04B(9) – Inpatient Nursing Unit Space

Space built or renovated 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. 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 in this standard or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

Applicant Response:

GBMC will construct two new 30-bed inpatient units as part of the proposed project. The units will be located on the Fourth and Fifth Floors of the addition and the layouts of the units will be identical to each other, as shown in **Exhibit 14**. Once complete, the units will be 502 square feet per bed, slightly exceeding the standard. Both units will contain two Patient-of-Size rooms. Both units will also contain two Isolation Rooms, each with an accompanying vestibule and one of which is sized to accommodate a Patient-of-Size. The combination of Special Patient Care Rooms in each unit exceeds the minimum required by FGI Guidelines which, in the case of GBMC, requires only two Special Patient Care Rooms per unit. GBMC is designing this combination of Special Patient Care Rooms in order to best meet the isolation room requirement and the needs of its bariatric patient population.

Standard .04B(10) – Rate Reduction Agreement

A high-charge hospital will not be granted a Certificate of Need to establish a new acute care service, or to construct, renovate, upgrade, expand, or modernize acute care facilities, including support and ancillary facilities, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

Applicant Response:

This standard is obsolete. See MHCC Decision in *In re MedStar Franklin Square Medical Center,* Docket 16-03-2380, p. 17.

Standard .04B(11) – Efficiency

A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and

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Applicant Response:

Through the proposed project, GBMC expects to achieve several areas of improvement in operational efficiency on inpatient units:

A. Patient Room Size and Layout – the patient rooms will satisfy current FGI Guidelines regarding room size, enhance the patient and family care experience, and provide for better, quality patient care. These improvements will include:

1. Providing larger patient rooms will accommodate a variety of patients, equipment, and family needs, thus reducing the number of patient transfers required.

2. Providing sufficient in-room space for portable equipment will reduce the amount of nursing time spent looking for and transporting equipment from one room to another.

3. Providing additional resources in each patient room, such as a computer at every bedside, will reduce staff travel time to get portable computers and devices.

4. Standardized room designs, location of supplies and medical equipment will reduce staff time spent adjusting to various configurations.

B. Patient Unit Design Features – the patient units will be designed with a racetrack layout and a central core. The core is designed to bring support spaces closer to the bedside to make patient care easier and more efficient. These improvements will include:

1. Providing staff workstations immediately outside of each pair of rooms, and providing three distributed cluster nurse stations to sub-divide the unit into pods. This will reduce walking between the nurse station and the patient bedside.

2. Providing two medication, nourishment, clean supply, and equipment storage rooms on each unit will reduce the overall walking between patient rooms and key supplies.

3. Centralizing the staff lounge within the patient unit will provide easy access for staff without leaving the unit.

C. Integrated Care Team Support – GBMC is providing an integrated care team to better care for their inpatients. Providing workspace for all levels of staff integrated within the unit will foster collaboration, improve care, and reduce inefficiencies caused by time spent looking for the appropriate staff. The team members who will be integrated into each patient unit with dedicated work space include nurses, nurse leaders, technicians, case managers, social workers, physician assistants, nurse practitioners, and hospitalists.

In addition to dedicated workspace, collaboration space will be provided on each unit in the form of small-team huddle rooms dedicated to the unit and a conference room immediately outside of each unit that can be shared between units.

D. Additional Elevators – currently GBMC has several banks of elevators that are shared between visitors and inpatients. This project will provide dedicated patient and material transport elevators that will improve the efficiency of off-stage transport. GBMC will also provide additional dedicated visitor elevators that will reduce the load on existing elevators and improve patient transport times.

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or

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Applicant Response:

The proposed project will not increase bed capacity or add new services. Thus, volume increases are not expected as a result of the proposed project. The projected increases in the volume of inpatient medical discharges (Table F) are not driven by the proposed project. The projected increases stem from demographic shifts in age cohorts within GBMC's primary services.

(c) Demonstrate why improvements in operational efficiency cannot be achieved.

Applicant Response:

Not applicable.

Standard .04B(12) – Patient Safety

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety. A hospital proposing to replace or expand its physical plant shall 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.

Applicant Response:

The proposed project will dramatically improve patient safety for GBMC's inpatient population. Existing inpatient rooms at GBMC lack many modern safety features including:

- Sufficient clearance around the bed for equipment and access to patients on all sides;
- Easy access to handwashing sinks;
- Any handwashing sinks in patient bathrooms;
- Nurse workspace in the patient room; and
- Sufficient space to accommodate family members

The new rooms, while not excessively spacious, are designed with patient and staff safety as a core design element. The rooms will meet current FGI Guidelines and include the following safety features:

- Code minimum patient clearances on all sides of the bed for portable equipment access and larger team access to address the sensitivities associated with the interdependencies of care and space needed in an emergency situation.
- Handwashing sinks immediately accessible upon entering the room, and located on the opposite wall from the patient to minimize the risk of patient infection.
- A bedside computer in every room to minimize the risk of cross-contamination by moving portable computers from room to room and facilitate timely, accurate documentation and safe delivery of medications.
- Same-handed room design with identical features from room to room to standardize patient care.
- Ventilation and filtration systems to control and prevent the spread of infections and use of surfaces that can be easily decontaminated.
- Headwall design that provides easy staff access to critical infrastructure such as medical gasses and emergency power.
- Outboard patient toilets to maximize patient visibility by staff in the hallway.
- Staff work alcoves with direct line of sight to the patients for close monitoring of high-acuity patients.
- Patient toilet rooms that are sufficiently sized to allow for staff to assist patients with toilet and shower needs.
- Increased telemetry capability.
- Dedicated family space to encourage family members to remain at the bedside as much as possible, which has been shown to have a positive outcome on patient care.

In addition to the safety features in every patient room, several key safety features have been included in the overall unit design:

- Distributing the central nurse's station to provide better visibility to more patient rooms.
- Distributing key support spaces to locate nurses closer to the patient in case of an emergency.
- Providing two negative pressure airborne isolation rooms on each unit (four total) for increased infection prevention.
- Providing two "patient of size" rooms on each unit (four total) that feature special accommodations for patients who weigh more than 300 pounds. The extra clearances will help with patient access and transfers, and will reduce patient and staff injuries.
- Providing a patient / family staff lounge to encourage families to remain close to patients and encourage patients to move around as soon as possible.
- Providing two medication rooms on each unit (four total) that are sufficiently sized to accommodate automated medication dispensing units. Providing automated dispensing for almost all medication will greatly reduce the risk of medication errors. The current patient units cannot accommodate this equipment and rely on a tray delivery system for each patient room.
- Extending the pneumatic tube system to the new units to provide easy transport of critical medication and other supplies as well as safe transport and timely turnaround of lab results.

Incorporating evidenced-based care into the design and use of inpatient rooms is a key goal of the proposed project. Applicable literature confirms that hospital design can enhance patient safety and create healthier environments for patients, families, and staff by preventing injury from falls, infections, and medical errors; minimizing environmental stressors associated with noise and inefficient room and unit layout; and using nature, color, light and sound to control potential stressors. See Joseph, A. (2006) The role of the physical and social environment in promoting health, safety, and effectiveness in the healthcare workplace. Concord, CA: Center for Health Design. Accessed at www.healthdesi.gn.org/research/reports/workplace.php.

In addition to the patient safety features included in each room and on each unit, the expansion will allow space for future patient unit renovations throughout the hospital. Future renovations will enable GBMC to reduce the bed count on each unit, and increase the size and safety features for patient rooms in future projects.

Standard .04B(13) – Financial Feasibility

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

(a) (a) Financial projections filed as part of a hospital Certificate of Need application must be accompanied by a statement containing each assumption used to develop the projections.

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and

(iv) The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population.

Applicant Response:

The proposed project will be financially feasible. The financial feasibility of GBMC is based on the following assumptions:

(a) Utilization projections that are consistent with observed historic trends (Part III COMAR 10.24.01.08G(3)(b) – Table F)

(b) Revenue estimates that are consistent with utilization projections and are based on current Global Budget Revenue (GBR), rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by GBMC (Part III COMAR 10.24.01.08G(3)(b) – Tables G and H)

(c) Staffing and overall expense projections that are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by GBMC (Part III COMAR 10.24.01.08G(3)(f) – Table L)

(d) Depreciation, interest, and other operating costs associated with the renovated space (Part III COMAR 10.24.01.08G(3)(d) – Tables G and H)

(e) GBMC assumes increases in GBR of 3.2% from FY 2019 to FY 2020, and 2.5% annual increases beginning in FY 2020. In addition, GBMC assumes increases in GBR beginning in FY 2024 as a result of the capital cost of the proposed project. In FY 2023, GBMC assumes a $5,400,000 GBR increase for partial year depreciation, and a $7,800,000 increase in FY 2025 for full year depreciation.

As Table G shows, GBMC will generate excess revenues over total expenses (including debt expenses and depreciation).

Standard .04B(14) – Emergency Department Treatment Capacity and Space

(a) An applicant proposing a new or expanded emergency department shall classify service as low range or high range based on the parameters in the most recent edition of Emergency Department Design: A Practical Guide to Planning for the Future from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians Emergency Department Design: A Practical Guide to Planning for the Future, given the classification of the emergency department as low or high range and the projected emergency department visit volume.

(b) In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:

(i) The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant hospital's primary service areas;

(ii) The number of uninsured, underinsured, indigent, and otherwise underserved patients in the applicant's primary service area and the impact of these patient groups on emergency department use;

(iii) Any demographic or health service utilization data and/or analyses that support the need for the proposed project;

(iv) The impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department to more appropriate primary care or urgent care settings; and

(v) Any other relevant information on the unmet need for emergency department or urgent care services in the service area.

Applicant Response:

Inapplicable. GBMC is not proposing a new or expanded emergency department.

Standard .04B(15) – Emergency Department Expansion

A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it has made appropriate efforts, consistent with federal and state law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum:

(a) The applicant hospital must demonstrate that, in cooperation with its medical staff, it has attempted to reduce use of its emergency department for non-emergency medical care. This demonstration shall, at a minimum, address the feasibility of reducing or redirecting patients with non-emergent illnesses, injuries, and conditions, to lower cost alternative facilities or programs;

(b) The applicant hospital must demonstrate that it has effectively managed its existing emergency department treatment capacity to maximize use; and

(c) The applicant hospital must demonstrate that it has considered the need for bed and other facility and system capacity that will be affected by greater volumes of emergency department patients.

Applicant Response:

Inapplicable. GBMC is not proposing expansion of emergency department treatment capacity.

Standard .04B(16) – Shell Space

(a) 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.

(b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that:

(i) Considers the most likely use identified by the hospital for the unfinished space;

(ii) Considers the time frame projected for finishing the space; and

(iii) Demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.

(c) 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 shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.

(d) 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 Health Service Cost Review Commission.

Applicant Response:

The proposed project will not create any new shell space. However, to implement the project, several areas within the existing building will be vacated, including:

- Inpatient Unit on the Third Floor of Building Four (9,100sf) – vacated for construction access.
- Inpatient Unit on the Fourth Floor of Building Six (9,270sf) – 30 private inpatient rooms will be vacated to move patient beds into the new addition.
- Inpatient Unit on the Third Floor of Building Eight (15,230sf) – 30 private inpatient rooms will be vacated to move patient beds into the new addition.
- Existing Main Lobby Support Space (1,910sf) – The existing gift shop will be vacated and service will be moved to the main floor (Third Floor) of the new addition.

The costs associated with vacating these spaces will be minimal, as no new work will be performed in these areas other than to make them safe and lock them off.

The purpose of vacating these areas is to provide flexibility for future renovations under separate projects. Possible future uses of the spaces include:

- Renovating the vacated units to house new, FGI Guidelines-compliant inpatient rooms.
- Renovating the existing main lobby support space to provide additional ED space, including appropriate behavioral health and pediatrics care.

These possible future renovations may occur within the next several years, after the completion and implementation of this proposed project.

10.24.01.08G(3)(b). NEED.

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

INSTRUCTIONS: Please identify the need that will be addressed by the proposed project, quantifying the need, to the extent possible, for each facility and service capacity proposed for development, relocation, or renovation in the project. The analysis of need for the project should be population-based, applying utilization rates based on historic trends and expected future changes to those trends. This need analysis should be aimed at demonstrating needs of the population served or to be served by the hospital. The existing and/or intended service area population of the applicant should be clearly defined.

Fully address the way in which the proposed project is consistent with each applicable need standard or need projection methodology in the State Health Plan.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population of the hospital. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified. Fully explain all assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), the relevant population considered in the analysis, and the service capacity of buildings and equipment included in the project, with information that supports the validity of these assumptions.

Explain how the applicant considered the unmet needs of the population to be served in arriving at a determination that the proposed project is needed. Detail the applicant's consideration of the provision of services in non-hospital settings and/or through population-based health activities in determining the need for the project.

Complete the Statistical Projections (Tables F and I, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package.

Applicant Response

A. 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 need 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).

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). The table below shows the MSGA projections for Baltimore County.

Table 4
MHCC's MSGA Bed Need Projection by Jurisdiction
2025

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

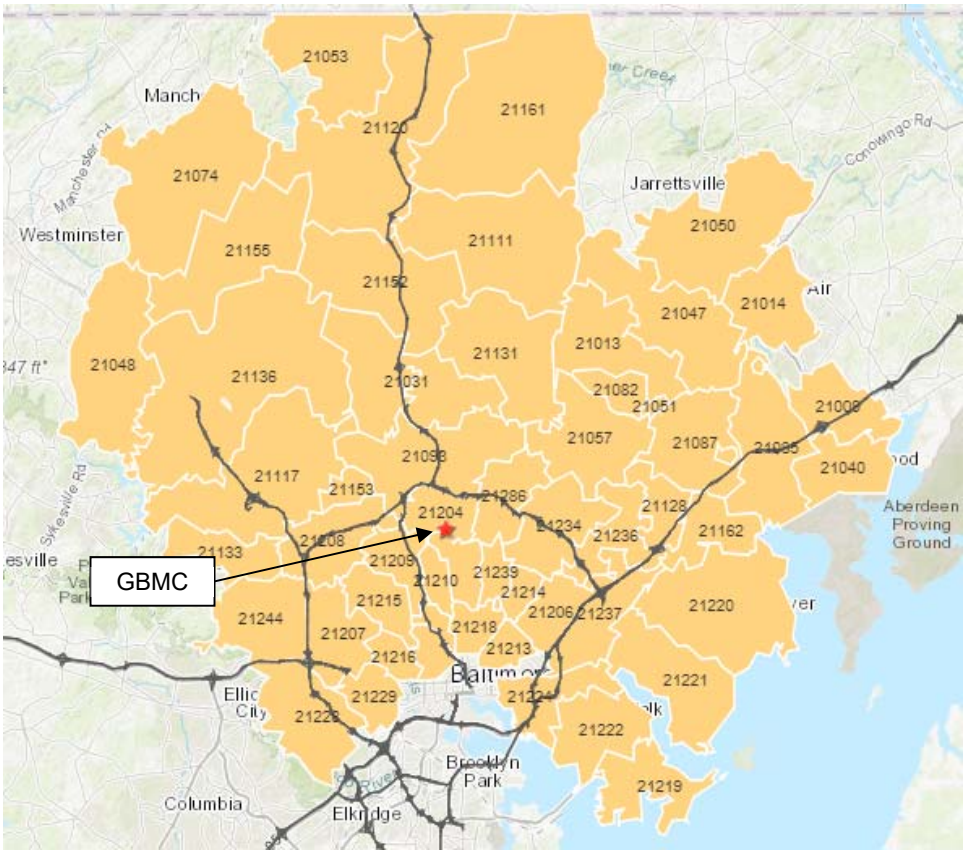
Jurisdiction	Gross Bed Need		Licensed and Approved Beds	2025 Net Bed Need	
	Minimum	Maximum		Minimum	Maximum
Baltimore County	530	700	782	-252	-82

The proposed project will not result in additional physical beds at GBMC. Based on the bed need projection calculated below, GBMC anticipates a need of 208 licensed MSGA beds, which includes 204 general MSGA beds and 4 pediatric beds. GBMC used the following methodology and assumptions to project the bed need.

1. Defining GBMC's MSGA Service Area

To identify the MSGA service area, GBMC's fiscal year 2018 discharges were accumulated by Zip code of patient residence for all ages. To determine the Zip codes to be included in the service area, the applicant identified the Zip codes that comprised the top 85% of GBMC's MSGA, which is inclusive of all age cohorts, discharges.

Figure 1
GBMC MSGA Service Area
FY2018



As presented in the Figure 1 above and the table below, the proposed service area for all MSGA discharges is defined by sixty-five (65) Zip codes that span Baltimore City, Baltimore, Carroll, and Harford Counties. Zip codes are ranked from those with the highest to lowest discharges from GBMC to identify the top 85% of total MSGA discharges.

Table 5
GBMC Projected MSGA Service Area (All Ages) Zip Codes and Discharges
FY2018

#	Zip Code	Community	County	Discharges[(1)]	% of Discharges
1	21093	Lutherville Timonium	Baltimore County	1,118	8.5%
2	21234	Parkville	Baltimore County	942	15.7%
3	21030	Cockeysville	Baltimore County	647	20.6%
4	21204	Towson	Baltimore County	566	24.9%
5	21286	Towson	Baltimore County	538	29.0%
6	21212	Baltimore	Baltimore City	406	32.1%
7	21117	Owings Mills	Baltimore County	394	35.1%
8	21208	Pikesville	Baltimore County	346	37.7%
9	21215	Baltimore	Baltimore City	334	40.3%
10	21236	Nottingham	Baltimore County	319	42.7%
11	21206	Baltimore	Baltimore City	286	44.9%
12	21222	Dundalk	Baltimore County	279	47.0%
13	21239	Baltimore	Baltimore City	266	49.0%
14	21136	Reisterstown	Baltimore County	264	51.1%
15	21207	Gwynn Oak	Baltimore County	252	53.0%
16	21221	Essex	Baltimore County	246	54.8%
17	21209	Baltimore	Baltimore County	236	56.6%
18	21220	Middle River	Baltimore County	229	58.4%
19	21218	Baltimore	Baltimore City	207	60.0%
20	21133	Randallstown	Baltimore County	179	61.3%
21	21131	Phoenix	Baltimore County	170	62.6%
22	21244	Windsor Mill	Baltimore County	168	63.9%
23	21214	Baltimore	Baltimore City	166	65.2%
24	21237	Rosedale	Baltimore County	163	66.4%
25	21120	Parkton	Baltimore County	144	67.5%
26	21057	Glen Arm	Baltimore County	131	68.5%
27	21111	Monkton	Baltimore County	127	69.5%
28	21210	Baltimore	Baltimore City	126	70.4%
29	21152	Sparks Glencoe	Baltimore County	124	71.4%
30	21211	Baltimore	Baltimore City	115	72.2%
31	21014	Bel Air	Harford County	114	73.1%
32	21228	Catonsville	Baltimore County	113	74.0%
33	21224	Baltimore	Baltimore City	103	74.8%
34	21128	Perry Hall	Baltimore County	100	75.5%
35	21040	Edgewood	Harford County	99	76.3%
36	21213	Baltimore	Baltimore City	96	77.0%
37	21217	Baltimore	Baltimore City	95	77.7%
38	21229	Baltimore	Baltimore City	95	78.4%
39	21161	White Hall	Harford County	87	79.1%
40	21009	Abingdon	Harford County	85	79.8%
41	21216	Baltimore	Baltimore City	84	80.4%
42	21085	Joppa	Harford County	75	81.0%
43	21074	Hampstead	Carroll County	71	81.5%
44	21050	Forest Hill	Harford County	68	82.0%
45	21053	Freeland	Baltimore County	65	82.5%
46	21047	Fallston	Harford County	62	83.0%
47	21013	Baldwin	Baltimore County	58	83.4%
48	21219	Sparrows Point	Baltimore County	55	83.9%
49	21087	Kingsville	Baltimore County	36	84.1%
50	21155	Upperco	Baltimore County	34	84.4%
51	21048	Finksburg	Carroll County	30	84.6%
52	21162	White Marsh	Baltimore County	28	84.8%
53	21082	Hydes	Baltimore County	19	85.0%
54	21153	Stevenson	Baltimore County	11	85.1%
55	21071	Glyndon	Baltimore County	6	85.1%
56	21051	Fork	Baltimore County	3	85.1%
57	21156	Upper Falls	Baltimore County	3	85.1%
58	21022	Brooklandville	Baltimore County	8	85.2%
59	21052	Fort Howard	Baltimore County	4	85.2%
60	21023	Butler	Baltimore County	3	85.3%
61	21139	Riderwood	Baltimore County	3	85.3%
62	21105	Maryland Line	Baltimore County	2	85.3%
63	21282	Baltimore	Baltimore City	2	85.3%
64	21284	Baltimore	Baltimore City	2	85.3%
65	21285	Baltimore	Baltimore City	1	85.3%
		Subtotal 2018 Service Area		**11,208**	
		Out of Service Area		1,926	14.7%
		Total MSGA Discharges		**13,134**	100.0%

Note (1): MSG-A definition includes Psych and Substance Abuse discharges
Source: St. Paul's Inpatient Abstract Data Tapes

2. Projected MSGA Service Area Population

For the Zip codes included in GBMC's projected service area, population projections through 2024 were obtained from Environics Spotlight (formerly Nielsen Claritas) for the 0-14, 15-64, 65-74 and 75+ age cohorts. These are presented in the table below. The 15-64 age cohort is expected to decrease from 2019 to 2024, while the 0-14 age cohort is expected to remain constant. Over the same period the 65-74 and 75+ age cohorts are expected to grow 20.0% and 9.3%, respectively. In total, the projected population is expected to grow by 1.4% between 2019 and 2024.

Table 6
GBMC's Historical and Projected MSGA Service Area Population
2010 – 2024

	Service Area Population						% Change in Population	
	2010		2019		2024			
Age Group	Pop	% of Total	Pop	% of Total	Pop	% of Total	2010-19	2019-24
75+	96,097	6.9%	99,258	7.0%	108,500	7.6%	3.3%	9.3%
65-74	96,326	6.9%	138,246	9.8%	165,919	11.6%	43.5%	20.0%
15-64	950,071	68.0%	924,923	65.4%	907,218	63.2%	-2.6%	-1.9%
0-14	255,515	18.3%	252,590	17.9%	252,742	17.6%	-1.1%	0.1%
Total	1,398,009	100.0%	1,415,017	100.0%	1,434,379	100.0%	1.2%	1.4%

Source: Environics Spotlight Pop-Facts Demographics by Age Race Sex

Using the compounded annual growth rates from 2019 to 2024, as set forth in Table 6, population projections were extrapolated through 2026 and applied to GBMC's fiscal years. Table 7 below depicts the projected population for each age cohort. Led by the population over age 65, the total population is expected to grow by 2.2% from fiscal year 2018 to fiscal year 2026.

Table 7
GBMC's Estimated and Projected MSGA Service Area Population
FY2016 – FY2026

	Historical			Projection								% Change
Age Cohort	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY18-FY26
0-14	253,561	253,237	252,913	252,590	252,620	252,651	252,681	252,712	252,742	252,772	252,803	*0.0%*
%Change	-	*-0.1%*	*-0.1%*	*-0.1%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
15-64	933,231	930,453	927,684	924,923	921,355	917,800	914,259	910,732	907,218	903,718	900,231	*-3.0%*
%Change	-	*-0.3%*	*-0.3%*	*-0.3%*	*-0.4%*	*-0.4%*	*-0.4%*	*-0.4%*	*-0.4%*	*-0.4%*	*-0.4%*	
65-74	122,560	127,580	132,806	138,246	143,384	148,713	154,241	159,973	165,919	172,086	178,482	*34.4%*
%Change	-	*4.1%*	*4.1%*	*4.1%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	
75+	98,193	98,547	98,902	99,258	101,041	102,856	104,704	106,585	108,500	110,449	112,433	*13.7%*
%Change	-	*0.4%*	*0.4%*	*0.4%*	*1.8%*	*1.8%*	*1.8%*	*1.8%*	*1.8%*	*1.8%*	*1.8%*	
Total Service Area	1,407,545	1,409,817	1,412,305	1,415,017	1,418,400	1,422,020	1,425,885	1,430,002	1,434,379	1,439,025	1,443,949	*2.2%*
%Change	-	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.3%*	*0.3%*	*0.3%*	*0.3%*	*0.3%*	*0.3%*	

3. MSGA Use Rates

Table 8 depicts the total use rate of MSGA discharges per 1,000 population in GBMC's defined service area in fiscal years 2016 through 2018. The total MSGA use rate of 105.1 discharges per 1,000 population in fiscal year 2018 represents a decline of 3.3% from fiscal year 2016. The decline in total use rates is a result of lower use rates among all age cohorts.

Table 8
GBMC's Historical MSGA Service Area Total Use Rate
FY2016 – FY2018

	Historical			% Change
	FY2016	FY2017	FY2018	FY16-18
MSGA Use Rates				
Age 0-14	**21.6**	**20.8**	**20.5**	
%Change	-	*-3.8%*	*-1.6%*	*-5.4%*
Age 15-64	**84.0**	**84.2**	**80.8**	
%Change	-	*0.2%*	*-4.0%*	*-3.9%*
Age 65-74	**224.3**	**218.9**	**208.7**	
%Change	-	*-2.4%*	*-4.7%*	*-7.0%*
Age 75+	**372.5**	**364.5**	**361.9**	
%Change	-	*-2.1%*	*-0.7%*	*-2.8%*
Total	**105.1**	**104.6**	**101.7**	
%Change	-	*-0.5%*	*-2.8%*	*-3.3%*

The total use rate declined by 3.3% from fiscal years 2016 and 2018, which is consistent with statewide trends and is attributable to the decline in potentially avoidable utilization ("PAU")

and shifts of inpatients to the lowest cost setting of care, including the outpatient observation setting.

Due to declines in PAUs, shifts to outpatient observation, and improvements in population health initiatives, GBMC anticipates a service area use rate reduction of 0.5% in fiscal years 2019 and 2020. After the initiatives to reduce discharges in fiscal years 2019 and 2020, GBMC expects that use rates will level off at the age cohort level. Due to the aging of the population, though, to age cohorts with higher use rates, the aggregate use rate is expected to increase 5.1% from fiscal year 2018 to 2026 as presented in Table 9.

Table 9
GBMC's Historical and Projected MSGA Use Rate
FY2016 - FY2026

	Historical			Projection								% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY18-26
MSGA Use Rates												
Age 0-14	**21.6**	**20.8**	**20.5**	**20.4**	**20.3**	**20.3**	**20.3**	**20.3**	**20.3**	**20.3**	**20.3**	
%Change	-	*-3.8%*	*-1.6%*	*-0.5%*	*-0.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*-1.0%*
Age 15-64	**84.0**	**84.2**	**80.8**	**80.4**	**80.0**	**80.0**	**80.0**	**80.0**	**80.0**	**80.0**	**80.0**	
%Change	-	*0.2%*	*-4.0%*	*-0.5%*	*-0.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*-1.0%*
Age 65-74	**224.3**	**218.9**	**208.7**	**207.6**	**206.6**	**206.6**	**206.6**	**206.6**	**206.6**	**206.6**	**206.6**	
%Change	-	*-2.4%*	*-4.7%*	*-0.5%*	*-0.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*-1.0%*
Age 75+	**372.5**	**364.5**	**361.9**	**360.1**	**358.3**	**358.3**	**358.3**	**358.3**	**358.3**	**358.3**	**358.3**	
%Change	-	*-2.1%*	*-0.7%*	*-0.5%*	*-0.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*-1.0%*
Total	**105.1**	**104.6**	**101.7**	**101.7**	**102.0**	**102.7**	**103.5**	**104.3**	**105.1**	**106.0**	**106.8**	
%Change	-	*-0.5%*	*-2.8%*	*0.0%*	*0.2%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*5.1%*

4. MSGA Service Area Discharges

Based on the assumptions described above, the total projected MSGA service area discharges are projected to increase 7.4% between fiscal year 2018 and fiscal year 2026 as presented below (Table 10). The increase is attributable to the aging of the population with higher use rates.

Table 10
GBMC's Historical and Projected MSGA Service Area Discharges
FY2016 - FY2026

	Historical			Projection								% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY18-FY26
Service Area Discharges	**147,981**	**147,442**	**143,616**	**143,927**	**144,623**	**146,091**	**147,612**	**149,189**	**150,823**	**152,516**	**154,271**	
%Change	-	*-0.4%*	*-2.6%*	*0.2%*	*0.5%*	*1.0%*	*1.0%*	*1.1%*	*1.1%*	*1.1%*	*1.2%*	*7.4%*

5. GBMC MSGA Market Share

GBMC's MSGA market share increased by 9.4% in fiscal year 2018 as a result of market shifts in the orthopedic and general surgery service lines and the closure of MedStar Franklin Square Medical Center's pediatric department. MSGA market share is projected to increase by

another 2.4% in fiscal year 2019.[1] GBMC assumes that market share will increase by 2.2% in fiscal year 2020 and then remain constant at the age cohort level, but will increase slightly each year, in aggregate, through fiscal year 2026 with the aging of the population in age cohorts with greater market share (Table 11).

Table 11
GBMC's Historical and Projected MSGA Market Share
FY2016 - FY2026

	Historical			Projection								% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY18-FY26
GBMC Market Share												
Age 0-14	**4.0%**	**4.4%**	**4.7%**	**4.8%**	**4.9%**	**4.9%**	**4.9%**	**4.9%**	**4.9%**	**4.9%**	**4.8%**	
%Change	-	*9.7%*	*5.3%*	*2.3%*	*2.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*-2.0%*	*2.3%*
Age 15-64	**5.8%**	**6.2%**	**6.6%**	**6.8%**	**6.9%**	**6.9%**	**6.9%**	**6.9%**	**6.9%**	**6.9%**	**6.9%**	
%Change	-	*6.9%*	*6.5%*	*2.3%*	*2.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*4.4%*
Age 65-74	**7.4%**	**7.4%**	**7.8%**	**8.0%**	**8.2%**	**8.2%**	**8.2%**	**8.2%**	**8.2%**	**8.2%**	**8.2%**	
%Change	-	*-0.3%*	*5.6%*	*2.3%*	*2.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*4.4%*
Age 75+	**10.0%**	**9.3%**	**10.7%**	**10.9%**	**11.1%**	**11.1%**	**11.1%**	**11.1%**	**11.1%**	**11.1%**	**11.1%**	
%Change	-	*-7.3%*	*15.0%*	*2.3%*	*2.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*4.4%*
Total	**7.1%**	**7.1%**	**7.8%**	**8.0%**	**8.2%**	**8.2%**	**8.2%**	**8.2%**	**8.2%**	**8.2%**	**8.3%**	
%Change	-	*0.5%*	*9.4%*	*2.4%*	*2.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.1%*	*5.8%*

6. GBMC Out-of-Service Area MSGA Discharges

GBMC's out-of-service area MSGA discharges are held constant as a percentage of service area discharges at the age cohort level from fiscal year 2018 through the projection. Fluctuations from year to year in this percentage are due to aging of the population into older cohorts (Table 12).

Table 12
GBMC's Historical and Projected Out-of-Service Area MSGA Discharges
% of Service Area Discharges
FY2016 – FY2026

	Historical			Projection							
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026
Out-of-Service Area Discharges											
% of Service Area Discharges	17.2%	18.0%	17.2%	17.2%	17.1%	17.1%	17.0%	17.0%	16.9%	16.9%	16.8%

7. GBMC Inpatient MSGA Discharges

Based on the assumptions listed above and the aging population for which GBMC has a higher market share, GBMC's MSGA discharges are projected to increase from fiscal year 2018 to fiscal year 2026 by 13.3% (Table 13).

[1] Fiscal year 2019 is based on annualized data from July 2018 through March 2019.

Table 13
GBMC's Historical and Projected Inpatient MSGA Discharges
FY2016 – FY2026

	Historical			Projection								% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY18-FY26
Inpatient Discharges												
GBMC	**12,308**	**12,411**	**13,134**	**13,471**	**13,831**	**13,992**	**14,159**	**14,331**	**14,509**	**14,693**	**14,878**	
%Change	*-*	*0.8%*	*5.8%*	*2.6%*	*2.7%*	*1.2%*	*1.2%*	*1.2%*	*1.2%*	*1.3%*	*1.3%*	*13.3%*

8. MSGA Average Length of Stay (ALOS)

The average length of stay for MSGA patients at GBMC increased in fiscal years 2016-2018 and is projected to increase through fiscal year 2020. GBMC currently has initiatives underway to reduce length of stay. The initiatives are projected to result in a length of stay decrease of 4.2% and 3.6% in fiscal years 2021 and 2022, respectively. GBMC then assumes that the length of stay will then remain constant at the age cohort level, but will increase slightly each year, in aggregate, through fiscal year 2026 with the aging of the population into age cohorts which have a longer length of stay (Table 14).

Table 14
GBMC's Historical and Projected ALOS
FY2016 – FY2026

	Historical			Projection								% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY18-FY26
ALOS - MSGA	**4.10**	**4.19**	**4.20**	**4.28**	**4.33**	**4.15**	**4.00**	**4.01**	**4.01**	**4.02**	**4.03**	
%Change	*-*	*2.1%*	*0.2%*	*2.0%*	*1.2%*	*-4.2%*	*-3.6%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*-4.0%*

9. MSGA Occupancy

The expected occupancy of inpatient MSGA and pediatric beds at GBMC reflects the State Health Plan for acute care hospitals with an average daily census of 100-299 (for adult) and 0-6 (for pediatric) patients, respectively, as follows (Table 15)

Table 15
GBMC MSGA Projected Bed Occupancy

	Projected Occupancy
GBMC – MSGA	80%
GBMC – Pediatric	50%

10. MSGA Bed Need

Based on the assumptions presented above, GBMC projected a need for 208 inpatient MSGA and Pediatric beds at GBMC in fiscal year 2026 (Table 16).

Table 16
GBMC's Historical and Projected MSGA Bed Need
FY2016 – FY2026

	Historical			Projection								% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY18-FY26
MSGA Bed Need	**175**	**180**	**191**	**200**	**207**	**201**	**196**	**199**	**202**	**205**	**208**	
%Change	*-*	*2.9%*	*6.1%*	*4.7%*	*3.5%*	*-2.9%*	*-2.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*8.9%*

The fiscal year 2026 projected MSGA beds at GBMC are split between 204 general MSGA and 4 pediatric beds as presented in Table 17.

Table 17
GBMC's Historical and Projected MSGA Bed Need
FY2016 – FY2026

	Historical			Projection								% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY18-FY26
MSGA Bed Need												
General MSGA	171	176	187	196	203	197	192	195	198	201	204	*9.1%*
Pediatric	4	4	4	4	4	4	4	4	4	4	4	*0.0%*
Total	**175**	**180**	**191**	**200**	**207**	**201**	**196**	**199**	**202**	**205**	**208**	*8.9%*

B. Observation Cases.

In addition to the need for MSGA beds, GBMC also evaluated the demand for observation beds. The number of observation cases at GBMC decreased by 6.6% between fiscal years 2016 to 2018 (Table 18).

Table 18
GBMC Historical Observation Cases
FY2016 – FY2018

	Historical			% Change
	FY2016	FY2017	FY2018	FY16-FY18
Observation Cases	**6,069**	**5,860**	**5,670**	*-6.6%*

There was a noted decrease in observation cases from fiscal year 2016 to 2018. However, in fiscal year 2019, GBMC projects observation cases to increase by 5.8%, which is based on fiscal year 2019, March year-to-date, annualized volumes. The increase in fiscal year 2019 observation cases is attributable to the increase in emergency department visits, as a majority of GBMC's observation cases originate from the emergency department. GBMC assumes that observations cases will grow at the MSGA service area population growth through fiscal year 2026. With the growth in cases in fiscal year 2019, the resulting number of observation cases will increase by 8.0% between fiscal years 2018 and 2026 (Table 19).

Table 19
GBMC's Historical and Projected Observation Cases
FY2016 – FY2026

	Historical			Projection								% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY18-FY26
Observation Cases	**6,069**	**5,860**	**5,670**	**5,999**	**6,013**	**6,028**	**6,045**	**6,062**	**6,081**	**6,100**	**6,121**	
%Change	*-*	*-3.4%*	*-3.2%*	*5.8%*	*0.2%*	*0.3%*	*0.3%*	*0.3%*	*0.3%*	*0.3%*	*0.3%*	*8.0%*

1. Observation Average Length of Stay

The average length of stay for observation patients at GBMC decreased by 13.1% from fiscal year 2016 to 2018 due to a number of operational initiatives. GBMC projects the average length of stay to decrease by 1.1% in fiscal year 2019. The average length of stay is projected to remain constant from fiscal years 2020 to 2026 as GBMC has already undertaken initiatives to lower the observation average length of stay by 15.2% from fiscal year 2016 through 2019 (Table 20).

Table 20
GBMC's Historical and Projected ALOS – Observation
FY2016 – FY2026

	Historical			Projection								% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY18-FY26
ALOS - Observation	**1.0**	**1.0**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	
%Change	*-*	*-1.0%*	*-13.1%*	*-1.1%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*-1.1%*

The resulting ALOS that is projected for observation patients at the GBMC is 0.8 days.

2. Observation Bed Need

GBMC used the State Health Plan occupancy rate of 80% to project the number of observation beds at the GBMC 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 18 observation beds at GBMC in fiscal year 2026 (Table 21).

Table 21
GBMC's Historical and Projected Observation Bed Need
FY2016 – FY2026

	Historical			Projection								% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY18-FY26
Observation Bed Need	**21**	**20**	**17**	**18**	**18**	**18**	**18**	**18**	**18**	**18**	**18**	*5.9%*
%Change	*-*	*-4.8%*	*-15.0%*	*5.9%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	

3. Total Inpatient Discharges and Observation Cases

GBMC does not have a dedicated Observation Unit. Rather, observation patients stay in MSGA beds. Combining MSGA discharges with observation cases, the total number of patients occupying beds at GBMC is expected to increase 11.7% between fiscal years 2018 and 2026, with 20,999 patients occupying beds in fiscal year 2026 (Table 22).

Table 22
GBMC Historical and Projected MSGA Discharges and Observation Cases
FY2016 – FY2026

	Historical			Projection								% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY18-FY26
IP Discharges + Observation Cases												
Inpatient MSGA	**12,308**	**12,411**	**13,134**	**13,471**	**13,831**	**13,992**	**14,159**	**14,331**	**14,509**	**14,693**	**14,878**	*13.3%*
%Change	-	*0.8%*	*5.8%*	*2.6%*	*2.7%*	*1.2%*	*1.2%*	*1.2%*	*1.2%*	*1.3%*	*1.3%*	
Observation	**6,069**	**5,860**	**5,670**	**5,999**	**6,013**	**6,028**	**6,045**	**6,062**	**6,081**	**6,100**	**6,121**	*8.0%*
%Change	-	*-3.4%*	*-3.2%*	*5.8%*	*0.2%*	*0.3%*	*0.3%*	*0.3%*	*0.3%*	*0.3%*	*0.3%*	
Total	**18,377**	**18,271**	**18,804**	**19,470**	**19,844**	**20,020**	**20,203**	**20,393**	**20,590**	**20,793**	**20,999**	*11.7%*
%Change		*-0.6%*	*2.9%*	*3.5%*	*1.9%*	*0.9%*	*0.9%*	*0.9%*	*1.0%*	*1.0%*	*1.0%*	

These patients are projected to need a total of 208 MSGA beds and 18 observation beds for a total of 226 beds in fiscal year 2026 (Table 23).

Table 23
GBMC's Historical and Projected Bed Need
FY2016 – FY2026

	Historical			Projection								% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	FY18-FY26
Bed Need												
MSGA Bed Need	**175**	**180**	**191**	**200**	**207**	**201**	**196**	**199**	**202**	**205**	**208**	*8.9%*
%Change	-	*2.9%*	*6.1%*	*4.7%*	*3.5%*	*-2.9%*	*-2.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	
Observation Bed Need	**21**	**20**	**17**	**18**	**18**	**18**	**18**	**18**	**18**	**18**	**18**	*5.9%*
%Change	-	*-4.8%*	*-15.0%*	*5.9%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
Total	**196**	**200**	**208**	**218**	**225**	**219**	**214**	**217**	**220**	**223**	**226**	*8.7%*
%Change		*2.0%*	*4.0%*	*4.8%*	*3.2%*	*-2.7%*	*-2.3%*	*1.4%*	*1.4%*	*1.4%*	*1.3%*	

C. Need to Modernize the Facility.

The vast majority of the patient rooms to be replaced through this proposed project are original to the hospital and were constructed in 1965. These patient rooms do not meet current FGI 2018 standards in numerous ways. Addressing these features will dramatically enhance square foot limitations, functional deficiencies, and inefficiencies leading to greater patient safety and provision of patient-centered care.

FGI 2018 Guideline Reference	Guideline Requirement	Current State
2.2-2.2.2.2 (1) (a)	Single patient rooms shall have a minimum clear area of 120sf.	Typical patient rooms are 107sf – 111sf. The clear floor area does not facilitate the number of clinicians necessary for patient-centered care.
2.1-2.2.5.1 (1)	A hand-washing station shall be located in each patient room, at or adjacent to the door to provide unobstructed access to staff entering and leaving the room.	The sink in the patient room is not near the door, is blocked by the bed, and has very limited access by staff.
2.1-2.2.6.3 (2)	Every patient toilet room requires a hand-washing station.	There are no sinks in the patient toilet rooms.
2.1-2.3	Hospitals must provide rooms designed to accommodate patients of size (300lbs or heavier), with additional clearances and safety features.	There are no rooms in the hospital today that meet these increased size requirements for patients of size. This project will add four patients of size rooms.
2.1-2.8.8	Medication safety zones require that medication be prepared in controlled rooms or from automated dispensing units.	Due to the small size of the medication room, most drugs are dispensed from patient trays located in manually locked cabinets in alcoves immediately outside of pods of patient rooms. In addition, these alcoves are multi-purpose and are not dedicated to medication dispensing.
2.1-2.8.13.2	At least 10 sf / bed of clean supply and equipment storage is required on the unit.	Due to the size of the unit, only approximately 160sf of storage is provided on the typical 30 bed unit (*i.e.*, approximately 5 sf / bed).
2.1-7.2.2.3 (2)(a)(1)	Minimum patient room door opening shall be 45.5” clear width.	Actual patient room door opening is approximately 44” clear width.

2.2-2.2.2.2 (2) (b)	Require 3’ between the side and foot of the bed and any fixed obstruction.	Typical patient room width ranges from 8’-0” to 9’-0”, with a 3’-6” bed that leaves 2’-3” to 2’-9” clear on each side. Typical patient room length is 10’-5”, assuming 7’-10” bed that leaves 2’-7” clear.
2.2-2.2.3.1 (1) (a)	Family Support - Space shall be provided in the patient room for moveable seating with a minimum of one seat for a family member or visitor and one seat for the patient.	There is insufficient space for multiple chairs in the room.

In addition to the specific FGI Guideline issues noted above, the current patient units do not provide sufficient space for the integrated care team model that GBMC utilizes to maximize patient outcomes. Specifically, there is not sufficient space for hospitalists, residents, case managers, and social workers to regularly reside on the unit, in proximity to patients and one another.

10.24.01.08G(3)(c). AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the proposed project. The applicant should identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including:

a) the alternative of the services being provided through existing facilities;

b) or through population-health initiatives that would avoid or lessen hospital admissions.

Describe the hospital's population health initiatives and explain how the projections and proposed capacities take these initiatives into account.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development costs to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective method to reach stated goal(s) and objective(s) or the most effective solution to the identified problem(s) for the level of costs required to implement the project, when compared to the effectiveness and costs of alternatives, including the alternative of providing the service through existing facilities, including outpatient facilities or population-based planning activities or resources that may lessen hospital admissions, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Applicant Response

During GBMC's annual strategic planning process, which identifies strategic challenges and critical success factors and incorporates stakeholder feedback from patients and the broader community, GBMC gathered quantitative and qualitative data on its inpatient facility. The data illustrated the following:

1. The private inpatient beds are sub-standard in size;
2. The private inpatient beds do not accommodate modern clinical and equipment needs; and
3. The private inpatient beds cause patient and family dissatisfaction.

Upon thorough analysis of the data, GBMC developed the following two strategic objectives that apply to the proposed project:

1. Better Health: Redesign care to provide value to patients and the community GBMC serves.

2. Better Care: Continuously improve the patient experience across the care continuum.

To accomplish these strategic objectives, GBMC defined three project-specific objectives. These objectives goals were used as criteria to guide the development of the ideal solution to the inpatient master facility challenges and are as follows:

1. Create adequately-sized inpatient units to accommodate current operational models;

2. Maximize opportunities for improved operational efficiency and patient experience; and

3. Optimize materials flow and distribution.

A. The alternatives of the services being provided through existing facilities

Please see the response to Standard 04.B(5) Cost Effectiveness. As explained in that response, the proposed project involves limited objectives and there is only one practical approach to achieving the project's objectives. Again, as explained in that response, the only potential alternative to constructing an addition to the existing hospital, as this project proposes to do, would be to renovate existing space within the hospital. For all the reasons described in the response to Standard 04.B(5), this type of renovation is not feasible.

B. Population health initiatives that would avoid or lessen hospital admissions.

GBMC's population health initiatives aim to avoid or reduce unnecessary hospital admissions. GBMC offers its patients a PCMH (patient-centered medical home) in 12 locations. Each of the locations provides care management, behavioral health services, and rotating multi-specialty practices on site. In addition, GBMC has a Complex Care Clinic and Elder Medical Care providing PCMH in the outpatient clinical setting, home, or residential facility to most complex patients. PCMHs address care access, care delivery, and care transition to maximize clinical outcomes and patient satisfactions.

When patients need a community hospital setting for inpatient care, GBMC aims to be their hospital of choice, again maximizing care access, care delivery, and care transition in the inpatient setting. The proposed project will modernize and upgrade outdated facilities to enhance clinical outcomes and patient experience.

C. GBMC's population health initiatives and how the projections and proposed capacities take these initiatives into account.

GBMC's response to the Need Review Criterion, COMAR § 10.24.01.08G(3)(b), discusses the projection methodology used to create the projections included in Table F. The projections use rates that reflect adjustments for efforts to shift services from inpatient to outpatient settings, readmission avoidance, and population health initiatives. GBMC Healthcare Inc., comprised of

GBMC Hospital, GBMC Health Partners, and Gilchrist, offers numerous population health initiatives to ensure patients have appropriate access to care, care delivery, and care transition.

GBMC's population health initiatives include the following:

- GBMC has 12 PCMHs with extended weekday and weekend hours, integrated electronic health records and a focus on preventative medicine and chronic disease management for nearly 80,000 covered lives. PCMH offers a team approach of care delivery including providers, nurse care managers, and care coordinators. In addition, PCMH has behavioral specialists, psychiatrists, and addiction specialists.
- GBMC is an active participant in the Maryland Primary Care Program in the PCMH offices. The Maryland Primary Care Program addresses the management of diabetes, hypertension, substance abuse, and reduction of unnecessary utilization through inpatient and outpatient centralized care teams of providers and care management.
- GBMC is an active participant in the Episode of Care Improvement Program, designed to enhance the management of scheduled and traumatic joint replacements post-surgery.
- GBMC's Complex Care Clinic works with patients who have multiple ER visits or inpatient admissions due to complex medical disease.
- GBMC is an active participant in the Hospital Care Improvement Program, designed to improve inpatient medical and surgical care delivery, provide effective transitions of care, ensure effective discharge planning, encourage the effective management of inpatient resources, and reduce potentially avoidable utilization.
- GBMC's integrated Palliative Care team across the GBMC system enhances the patient's quality of life and can reduce unnecessary utilization for patients with serious illness.
- Gilchrist Elder Medical Care is a coordinated team that offers medical care and support at every stage of serious illness to help older adults. This includes integrated medical care and guidance and assistance in connecting patients to community resources. Often times, the care is delivered at a site convenient to the patient, be it their home, or elsewhere.

10.24.01.08G(3)(d). VIABILITY OF THE PROPOSAL

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- Complete applicable Revenues & Expenses (Tables G, H, J and K as applicable), and the Work Force information (Table L) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable.

- Describe and document relevant community support for the proposed project.

- Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies.

Applicant Response

Project Funding:

GBMC plans to fund the proposed project with a combination of financing, fundraising and through the hospital's operating budget. The financing will be a tax-exempt bond issued through the Maryland Health and Higher Facility Authority. The financing will be timed to coincide payoff of the 2015 taxable debt. The new debt will be styled to lower GBMC's current overall annual debt services without extending the term of its existing debt. The sizing of the loan would require, based upon current information, a debt issue of $70,000,000 inclusive of bond discount/premium, interest proceeds, issuance and underwriting expenses. It is anticipated that GBMC will maintain its "A/A2" rating throughout this process, based on strength of its balance sheet. It is anticipated that GBMC will go to market with a bond issue shortly after the formal approval of this CON application.

In addition, the proposed projected will also be funded by a fundraising campaign, called the "Promise Project." GBMC HealthCare has a rich heritage of philanthropic support from the local community. Over the last three years, GBMC has raised more $46,000,000 in contributions. This consistent stream of sizable realized gifts provides assurance that the $30,000,000 goal for this project is attainable. In addition, GBMC's last formal campaigns (40th and 50th Anniversary Campaigns in 2005 and 2015) raised $35,000,000 and $55,000,000, respectively. To date, GBMC has raised 10% of its $30,000,000 goal for the Promise Project.

The balance of the project's budget, $8,000,000, will be funded by GBMC's operating funds or unrestricted investment reserves and interest on the proceeds of the $70,000,000 in debt. As of June 30, 2019, GBMC's strong unrestricted cash and investment reserves yielded days cash on hand of 278, exceeding the median for "A/A2" rated hospitals. Based on GBMC's strong liquidity, GBMC will be able to fund the balance of the project through operating funds or investment reserves.

See **Exhibit 1** for GBMC Healthcare's Table Package, which includes projected Revenue & Expenses (Tables G and H), financial assumptions, and Work Force Information (Table L).

Community Support

The proposed project enjoys strong community support, as demonstrated by the Letters of Support, **Exhibit 3.**

Project Implementation and Performance Requirements

This will be a single-phase project contracted as a single construction contract, thereby minimizing the complexity of the project and its associated risk. The performance requirements applicable to the project require GBMC to obligate at least 51% of the approved capital expenditure within 24 months and complete the project within 24 months after the effective date of a binding construction contract. COMAR § 10.24.01.12C(3)(b).

GBMC does not anticipate any issues with meeting its performance requirements. During the design development, GBMC will select the construction manager, which will enable the team to ensure that it maintains the program budget and is able to commence work without delay upon CON approval and subsequent completion of the design.

Audited Financial Statements

Audited financial statements for GBMC Healthcare, Inc. and Subsidiaries are included in **Exhibit 15.**

10.24.01.08G(3)(e). COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED.

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

INSTRUCTIONS: List all of the Certificates of Need that have been issued to the applicant or related entities, affiliates, or subsidiaries since 2000, including their terms and conditions, and any changes to approved CONs that were approved. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Applicant Response

Since 2000, GBMC obtained one CON for an expansion and renovation project (Docket No. 01-03-2082). A copy of the CON Order is attached as **Exhibit 16**. The CON project was fully implemented pursuant to the terms of the Order, and the Order did not include any conditions.

10.24.01.08G(3)(f). IMPACT ON EXISTING PROVIDERS AND THE HEALTH CARE DELIVERY SYSTEM

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;[1]

b) On access to health care services for the service area population that will be served by the project. (state and support the assumptions used in this analysis of the impact on access);

c) On costs to the health care delivery system.

If the applicant is an existing hospital, provide a summary description of the impact of the proposed project on costs and charges of the applicant hospital, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

Applicant Response

(a) GBMC does not anticipate the project will have an impact on the volume of service provided by other existing health care providers. The proposed project modernizes existing medical/surgical rooms due to their current age, size, and configuration, but does not result in any additional beds.

(b) There will be no impact on the access of health care services for the service area population.

(c) GBMC plans to pursue a full rate application with the HSCRC to fund 100% of the incremental depreciation and interest costs of the project. The anticipated impact of the capital rate funding request will result in a projected 1.65% increase in Global Budget Revenue (GBR), as demonstrated in the calculation below:

[1] Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, the relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions.

Project Depreciation Expense	$	4,485,000
Project Interest Expense		2,833,859
Total Project Capital	$	7,318,859
GBMC FY19 Mark-Up		1.08878
Project Capital Expense	$	7,968,624
Less: MVS Adjustment		(173,297)
Less: SQFT Adjustment		(13,770)
Adjusted Capital Rate Request	$	7,781,558
FY2019 Approved GBR	$	471,379,273
% GBR Increase		1.65%

Based on FY2018 approved rates and actual volumes, GBMC's unit rates are approximately -4.8% below its ICC peer group average rates. After adjusting rates to reflect the capital rate request above, GBMC's unit rates are projected to remain approximately -3.2% below the peer group average, as demonstrated in the table below:

Table 24
Comparison of Hospital Charges to ICC Peer Group
In $000s

GBMC FY19 Proforma Revenue			FY19 Approved Rates Variance to Peer Group		Capital Adjusted Rates Compared to Peer Group	
FY2019 Pro-Forma Revenue [1]	FY2019 Revenue at Capital Adjusted Rates [2]	FY19 Revenue at Peer Group Weighted Average Rates [3]	Over / (Under) Peer Group Rates	Percent Variance	Over / (Under) Peer Group Rates	Percent Variance
$ 471,086	$ 478,868	$ 494,631	$ (23,545)	-4.8%	$ (15,763)	-3.2%

In addition, GBMC's current and projected unit rates are favorable in comparison to statewide benchmarks. The table below demonstrates GBMC's capital adjusted rates are projected to remain -8.9% below statewide median rates:

Table 25
Comparison of Hospital Charges to Statewide Median
In $000s

GBMC FY19 Pro-forma Revenue			FY19 Approved Rates Variance to SW Median		Capital Adjusted Rates Compared to SW Median	
FY2019 Pro-Forma Revenue [1]	FY2019 Revenue at Capital Adjusted Rates [2]	FY19 Revenue at SW Median Rates [3]	Over / (Under) SW Median Rates	Percent Variance	Over / (Under) SW Median Rates	Percent Variance
$ 471,086	$ 478,868	$ 525,425	$ (54,339)	-10.3%	$ (46,557)	-8.9%

Sources:
FY2019 HSCRC Approved Unit Rates
FY2019 Experience Report May YTD

(1) Calculated as FY2019 HSCRC approved unit rates x FY2019 actual volume May YTD annualized
(2) Capital-adjusted rates calculated be increasing FY2019 approved GBR by capital request of $7.8M then realigning revenue across rate realigned rate centers.
(3) Calculated as FY2019 statewide median unit rates x GBMC FY19 volume.

Given GBMC's relative unit rates and the funding mechanisms within the GBR system, GBMC expects to demonstrate it can maintain a reasonable charge structure including the requested funding for incremental capital expenditures.

Table of Exhibits

Table of Tables

Table of Figures

Figure	Description

GBMC

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.

August 9, 2019
Date

Keith R. Poisson
Executive Vice President
and Chief Operating Officer
GBMC

#670653
010236-0002

GBMC

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.

August 9, 2019
Date

Laurie R. Beyer, MBA, CPA
Executive Vice President
and Chief Financial Officer
GBMC

#670658
010236-0002

GBMC

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.

August 9, 2019
Date

Jenny Coldiron
Vice President of Development,
GBMC
President, GBMC Foundation

#670661
010236-0002

GBMC

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.

August 9, 2019
Date

Stacey McGreevy, CPA
Vice President of Support Services
GBMC

#670659
010236-0002

GBMC

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.

August 9, 2019
Date

Amber Olig
Director, Corporate Strategy
GBMC

#670660
010236-0002

GBMC

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.

August 9, 2019
Date

James F. Albert
Principal
Hord Coplan Macht

#670665
010236-0002

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.

August 9, 2019
Date

Mike Sheehan
Architect
Hord Coplan Macht

#671611
010236-0002

GBMC

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.

August 9, 2019
Date

Brett Kass
Consultant
Hammes Co.

#670662
010236-0002

GBMC

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.

August 6, 2019
Date

Matthew M. McGovern
Consultant
Hammes Co.

#670663
010236-0002

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.

August 9, 2019
Date

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

#670664
010236-0002

EXHIBIT 1

Name of Applicant: Greater Baltimore Medical Center, Inc.

Date of Submission: 9-Aug-19

Applicants should follow additional instructions included at the top of each of the following worksheets. Please ensure all green fields (see above) are filled.

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: 7/1/2020	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*							**General Medical/ Surgical***				0	0
Unit 58	5		25	4	29	33	Unit 58	5	25	4	29	33
Unit 48	4		24	5	29	34	Unit 48	4	24	5	29	34
Unit 45B	4		30	0	30	30	Unit 45B	4	0	0	0	0
Unit 45A	4		24	0	24	24	Unit 45A	4	24	0	24	24
Unit 38	3		29	4	33	37	Unit 38	3	7	0	7	7
Unit 36	3		42	0	42	42	Unit 36	3	42	0	42	42
Unit 35	3		26	0	26	26	Unit 35	3	26	0	26	26
Unit 34	3		25	0	25	25	Unit 34	3	25	0	25	25
New Building Floor 4	4		0	0	0	0	New Building Floor 4	4	30	0	30	30
New Building Floor 5	5		0	0	0	0	New Building Floor 5	5	30	0	30	30
SUBTOTAL Gen. Med/Surg*		**165**	**225**	**13**	**238**	**251**	**SUBTOTAL Gen. Med/Surg***		**233**	**9**	**242**	**251**
ICU/CCU		**24**	24	0	24	24	**ICU/CCU**		24	0	24	24
Unit 59 SICU		**12**	12	0	12	12	Unit 59 SICU		12	0	12	12
Unit 57 MICU		**12**	12	0	12	12	Unit 57 MICU		12	0	12	12
Other *(Specify/add rows as needed)*		**0**	0	0	0	0	**Other** *(Specify/add rows as needed)*		0	0	0	0
TOTAL MSGA		**189**	**249**	**13**	**262**	**275**	**TOTAL MSGA**		**257**	**9**	**266**	**275**
Obstetrics		**60**	60	0	60	60	**Obstetrics**		60	0	60	60
Pediatrics		**8**	7	1	8	9	**Pediatrics**		7	1	8	9
Psychiatric		**0**	0	0	0	0	**Psychiatric**		0	0	0	0
TOTAL ACUTE		**257**	**316**	**14**	**330**	**344**	**TOTAL ACUTE**		**324**	**10**	**334**	**344**
NON-ACUTE CARE							**NON-ACUTE CARE**					
Dedicated Observation**		**0**	0	0	0	0	**Dedicated Observation****		0	**0**	0	0
Rehabilitation		**0**	0	0	0	0	**Rehabilitation**		0	**0**	0	0
Comprehensive Care		**27**	15	12	27	39	**Comprehensive Care**		15	**12**	27	39
Other *(Specify/add rows as needed)*		**0**	0	0	0	0	**Other** *(Specify/add rows as needed)*		0	**0**	0	0

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: 7/1/2020	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
TOTAL NON-ACUTE		27	15	12	27	39	TOTAL NON-ACUTE		15	12	27	39
HOSPITAL TOTAL		284	331	26	357	383	HOSPITAL TOTAL		339	22	361	383

* 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.

Notes: Of the total hospital bed count of 383 beds, 30 of these headwalls are currently used as office space, not patient care. Unit 45B has 3 offices. Unit 45A has 1 office. Unit 36 has 14 offices. Obstetrics has 12 offices.

Table A illustrates a discrepancy in GBMC’s reported physical bed count of 342 beds to the MHCC versus the actual physical bed count of 383 beds. During the CON process, three separate counts GBMC’s physical bed capacity were performed. Each count resulted in a physical bed capacity of 383 beds. GBMC will update the physical capacity data to the MHCC in its next scheduled data submission.

Table A illustrates that GBMC’s total hospital physical bed capacity does not change with this project.

- With the completion of the proposed project, 30 beds are removed from Unit 45B and placed in the project 4th floor space and 30 beds are removed from Unit 38 and placed in the project 5th floor space.
- The primary purpose of this project is to relocate 60 existing beds to the two new units, thereby enabling the subsequent renovation of the existing units under future projects. By moving 60 beds to the proposed project through the vacating of 60 existing beds from Units 45B and 38, those units ultimately will be able to be reconfigured with fewer beds, each of which will be code compliant.
- GBMC’s total bed capacity meets projected demand utilization of both IP and Observation patients found in Table F.

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
Level 2 - Cytogenetics - Vacated	3,621	0	1,413	2,208	3,621
Level 3 - Circulation & Seating - Atrium	0	4,601	0	0	4,601
Level 3 - Circulation & Seating - New Addition	0	12,967	4,335	0	17,302
Level 3 - Support & Reception	2,640	3,078	0	0	3,078
Level 3 - Spiritual / Chapel	1,020	2,043	0	0	2,043
Level 3 - Gift Shop	1,500	2,326	991	0	3,317
Level 3 - Food Service	640	1,360	0	0	1,360
Level 3 - Medical Library	2,950	2,230	0	0	2,230
Level 3 - Pharmacy	1,300	2,110	0	0	2,110
Level 3 - Wellness	0	3,465	0	0	3,465
Level 3 - Welcome Center	0	1,411	0	0	1,411
Level 4 - Med/Surg	0	26,240	0	0	26,240
Level 4 - Public Circulation	0	2,265	2,755	0	5,020
Level 5 - Med/Surg	0	26,240	0	0	26,240
Level 5 - Public Circulation	0	2,265	2,093	0	4,358
Level Penthouse - Facilities	0	13,482	0	0	13,482
Total		106,083			119,878

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		

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Second Floor	0	1,413
Third Floor	35,593	5,326
Fourth Floor	28,504	2,755
Fifth Floor	28,504	2,093
Penthouse	13,482	0
Average Square Feet	**21,217**	**2,317**
Perimeter in Linear Feet	**Linear Feet**	
Second Floor	0	163
Third Floor	1,012	652
Fourth Floor	877	688
Fifth Floor	877	450
Penthouse	812	0
Total Linear Feet	**3,578**	**1,953**
Average Linear Feet	**716**	**597**
Wall Height (floor to eaves)	**Feet**	
Second Floor	13	13
Third Floor	13	13
Fourth Floor	13	13
Fifth Floor	13	13
Penthouse	20	20
Average Wall Height	**14**	**14**
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	2	
Freight	2	
Sprinklers	**Square Feet Covered**	
Wet System	30,867	2,897
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project		
Type of Exterior Walls for proposed project		

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	$407,829	
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs	**$407,829**	
Site Demolition Costs	**$150,000**	
Storm Drains	**$720,000**	
Rough Grading	**$2,902,632**	
Site Fire Protection Systems	**$78,000**	
Rock Removal	**$420,000**	
Sanitary Sewer Premium for elevation and Charles Streeet.	**$828,000**	
Paving	**$573,482**	
Exterior Signs	**$120,000**	
Landscaping	**$210,000**	
Walls	**$168,000**	
Yard Lighting	**$124,800**	
Constricted Site	**$419,698**	
Sanitary Sewer Charles Street	**$600,000**	
LEED Silver Green Building Premium	**$335,758**	
MBE Participation Cost Premium	$335,758	
Subtotal On-Site excluded from Marshall Valuation Costs	**$7,986,129**	
OFFSITE COSTS		
Roads		
Extending Utilities to Site Line		
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	**$7,986,129**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$8,393,957**	**$0**
BUILDING COSTS		
Normal Building Costs	$34,121,195	
Subtotal included in Marshall Valuation Costs	$34,121,195	
Atrium Premium	$7,745,898	
Canopy	$1,021,200	
Premium for Concrete Frame Construction	$1,080,000	
Terracotta Rain Screen	$465,791	
Above-average glass percentage for updated exterior design	$240,000	
Laboratory Gas Quality Piping and Connection to Existing System	$245,454	
DX Remote Condenser w/fan coil & piping	$183,664	
Electrical, Patient Ground Modules	$127,722	
Electrical, Isolation Power Panels	$52,276	
Unconditioned Covered Utility Walkways on New Addition	$360,098	
Required Atrium smoke evacuation system	$120,000	

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
Pneumatic Tubes	$120,779	
Concrete Mud Slab	$207,900	
Misc. Roof Patching on Existing Building	$240,000	
Constricted Site	$2,760,730	
Connector Structures	$412,548	
MPE Piping at Existing	$1,292,183	
LEED Silver Green Building Premium	$2,208,584	
MBE Participation Cost Premium	$2,208,584	
Subtotal Building Costs excluded from Marshall Valuation Costs	**$21,093,411**	
TOTAL Building Costs included and excluded from Marshall Valuation Service*	**$55,214,606**	**$0**
A&E COSTS		
Normal A&E Costs	$5,294,254	
Subtotal included in Marshall Valuation Costs	**$5,294,254**	
Subtotal A&E Costs excluded from Marshall Valuation Costs	**$0**	
TOTAL A&E Costs included and excluded from Marshall Valuation Service*	**$5,294,254**	**$0**
PERMIT COSTS		
Normal Permit Costs	$35,000	
Subtotal included in Marshall Valuation Costs	**$35,000**	
Jurisdictional/Bldg Permit Review Fee	**$320,594**	
Storm Water Mgmt. Review Fee	**$18,000**	
Utility Connection Fees	$20,000	
Subtotal Permit Costs excluded from Marshall Valuation Costs	**$358,594**	
TOTAL Permit Costs included and excluded from Marshall Valuation Service*	**$393,594**	**$0**

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

TABLE E. PROJECT BUDGET

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

	Hospital Building	*Other Structure*	*Total*
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building	$55,214,606		$55,214,606
(2) Fixed Equipment			$0
(3) Site and Infrastructure	$8,393,957		$8,393,957
(4) Architect/Engineering Fees	$5,294,254		$5,294,254
(5) Permits (Building, Utilities, Etc.)	$393,594		$393,594
SUBTOTAL	**$69,296,412**	**$0**	**$69,296,412**
b. Renovations			
(1) Building	$3,432,929		$3,432,929
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees	$260,000		$260,000
(4) Permits (Building, Utilities, Etc.)	$60,000		$60,000
SUBTOTAL	**$3,752,929**	**$0**	**$3,752,929**
c. Other Capital Costs			
(1) Movable Equipment	$11,259,362		$11,259,362
(2) Contingency Allowance	$8,330,798		$8,330,798
(3) Gross interest during construction period	$5,825,354		$5,825,354
(4) Other *(Specify/add rows if needed)*	$895,000		$895,000
SUBTOTAL	***$26,310,514***	***$0***	**$26,310,514**
TOTAL CURRENT CAPITAL COSTS	**$99,359,855**	**$0**	**$99,359,855**
d. *Land Purchase*			
e. Inflation Allowance	$5,190,194		$5,190,194
TOTAL CAPITAL COSTS	**$104,550,049**	**$0**	**$104,550,049**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	**$700,000**		$700,000
b. Bond Discount			$0
c CON Application Assistance			
c1. Legal Fees	**$50,000**		$50,000
c2. Other (Specify/add rows if needed)	**$435,000**		$435,000
d. Non-CON Consulting Fees			
d1. Legal Fees	**$55,000**		$55,000
d2. Other (Specify/add rows if needed)	**$2,438,000**		$2,438,000
e. Debt Service Reserve Fund			$0
f Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$3,678,000***	***$0***	**$3,678,000**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$108,228,049***	***$0***	***$108,228,049***
B. Sources of Funds			
1. Cash	**$6,582,643**		$6,582,643
2. Philanthropy (to date and expected)	**$30,000,000**		$30,000,000
3. Authorized Bonds	**$70,000,000**		$70,000,000
4. Interest Income from bond proceeds listed in #3	**$1,645,406**		$1,645,406
5. Mortgage			$0
6. Working Capital Loans			$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

	Hospital Building	*Other Structure*	*Total*
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$108,228,049***		**$108,228,049**
	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.

Avg Proceeds balance net of construction pymts	36,564,576
Annual Interest	3%
# of Yrs	1.5
	$1,645,406

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. 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) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**
1. DISCHARGES										
a. General Medical/Surgical*	11,220	11,112	11,531	11,842	11,983	12,129	12,279	12,435	12,596	12,763
b. ICU/CCU	934	1,762	1,676	1,721	1,741	1,762	1,783	1,805	1,828	1,851
c. Observation Cases	5,860	5,670	5,999	6,013	6,028	6,045	6,062	6,081	6,100	6,121
Total MSGA& Observation	**18,014**	**18,544**	**19,205**	**19,576**	**19,752**	**19,935**	**20,125**	**20,321**	**20,525**	**20,736**
d. Pediatric	257	260	264	268	268	268	268	268	268	263
e. Obstetric	3,894	4,071	4,104	4,093	4,078	4,063	4,048	4,033	4,018	4,003
f. Acute Psychiatric										
Total Acute	***22,165***	***22,875***	***23,574***	***23,937***	***24,098***	***24,266***	***24,441***	***24,622***	***24,811***	***25,002***
g. Rehabilitation										
h. Comprehensive Care	554	558	556	557	559	560	562	564	565	567
TOTAL DISCHARGES	***22,719***	***23,433***	***24,130***	***24,494***	***24,657***	***24,826***	***25,003***	***25,186***	***25,376***	***25,569***
2. PATIENT DAYS										
a. General Medical/Surgical*	45,705	48,531	51,391	53,390	51,775	50,506	51,216	51,948	52,703	53,485
b. ICU/CCU	5,666	5,943	5,595	5,811	5,635	5,496	5,572	5,650	5,732	5,814
c. Observation Cases	5,649	4,747	4,969	4,981	4,994	5,007	5,022	5,037	5,053	5,071
Total MSGA& Observation	**57,020**	**59,221**	**61,955**	**64,182**	**62,403**	**61,009**	**61,809**	**62,635**	**63,488**	**64,370**
d. Pediatric	625	647	670	687	657	633	633	633	633	620
e. Obstetric	11,571	11,985	12,082	10,724	10,684	10,644	10,605	10,565	10,526	11,784
f. Acute Psychiatric										
Total Acute	***69,216***	***71,853***	***74,707***	***75,593***	***73,745***	***72,286***	***73,047***	***73,833***	***74,647***	***76,774***
g. Rehabilitation										
h. Comprehensive Care	8,907	8,781	8,707	8,727	8,750	8,774	8,799	8,826	8,854	8,885
TOTAL PATIENT DAYS	***78,123***	***80,634***	***83,414***	***84,320***	***82,495***	***81,060***	***81,845***	***82,659***	***83,502***	***85,659***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. 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) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	4.1	4.4	4.5	4.5	4.3	4.2	4.2	4.2	4.2	4.2
b. ICU/CCU	6.1	3.4	3.3	3.4	3.2	3.1	3.1	3.1	3.1	3.1
c. Observation Cases	0.6	0.5	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6
Total MSGA& Observation	**3.2**	**3.2**	**3.2**	**3.3**	**3.2**	**3.1**	**3.1**	**3.1**	**3.1**	**3.1**
d. Pediatric	2.4	2.5	2.5	2.6	2.4	2.4	2.4	2.4	2.4	2.4
e. Obstetric	3.0	2.9	2.9	2.6	2.6	2.6	2.6	2.6	2.6	2.9
f. Acute Psychiatric										
Total Acute	3.1	3.1	3.2	3.2	3.1	3.0	3.0	3.0	3.0	3.1
g. Rehabilitation										
h. Comprehensive Care	16.1	15.7	15.7	15.7	15.7	15.7	15.7	15.7	15.7	15.7
TOTAL AVERAGE LENGTH OF STAY	**3.4**	**3.4**	**3.5**	**3.4**	**3.3**	**3.3**	**3.3**	**3.3**	**3.3**	**3.4**
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*	140	139	147	165	177	173	175	178	181	184
b. ICU/CCU[(2)]	24	24	24	24	20	19	20	20	20	20
c. MSGA Beds used for Observation Patients[(2)]	21	20	17	18	18	18	18	18	18	18
Total MSGA	**185**	**183**	**188**	**207**	**215**	**210**	**213**	**216**	**219**	**222**
d. Pediatric	8	8	8	8	4	4	4	4	4	4
e. Obstetric	60	60	60	60	37	37	37	37	37	36
f. Acute Psychiatric										
Total Acute	***253***	***251***	***256***	***275***	***256***	***251***	***254***	***257***	***260***	***262***
g. Rehabilitation										
h. Comprehensive Care[(3)]	25	27	27	27	27	27	27	27	27	27
TOTAL LICENSED BEDS	***278***	***278***	***283***	***302***	***283***	***278***	***281***	***284***	***287***	***289***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. 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) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:*** *Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	89.4%	95.7%	95.8%	88.4%	80.1%	80.0%	80.2%	79.7%	79.8%	79.6%
b. ICU/CCU										
c. Observation Cases	73.7%	65.0%	80.1%	75.6%	76.0%	76.2%	76.4%	76.5%	76.9%	77.2%
Total MSGA& Observation	**84.4%**	**88.7%**	**90.3%**	**84.7%**	**79.5%**	**79.6%**	**79.5%**	**79.2%**	**79.4%**	**79.4%**
d. Pediatric	21.4%	22.2%	22.9%	23.5%	45.0%	43.3%	43.3%	43.2%	43.4%	42.5%
e. Obstetric	52.8%	54.7%	55.2%	48.8%	79.1%	78.8%	78.5%	78.0%	77.9%	89.7%
f. Acute Psychiatric										
Total Acute	**75.0%**	**78.4%**	**80.0%**	**75.1%**	**78.9%**	**78.9%**	**78.8%**	**78.5%**	**78.7%**	**80.3%**
g. Rehabilitation										
h. Comprehensive Care	97.6%	89.1%	88.3%	88.3%	88.8%	89.0%	89.3%	89.3%	89.8%	90.2%
TOTAL OCCUPANCY %	**77.0%**	**79.5%**	**80.8%**	**76.3%**	**79.9%**	**79.9%**	**79.8%**	**79.5%**	**79.7%**	**81.2%**
6. OUTPATIENT VISITS										
a. Emergency Department	51,073	53,156	55,868	56,002	56,145	56,297	56,460	56,632	56,816	57,010
b. Same-day Surgery	14,993	14,784	15,204	15,240	15,279	15,321	15,365	15,412	15,462	15,515
c. Laboratory	16,289,589	16,946,390	17,733,683	17,776,084	17,821,453	17,869,885	17,921,479	17,976,337	18,034,565	18,096,274
d. Imaging	1,529,417	2,489,183	2,707,302	2,713,775	2,720,701	2,728,095	2,735,972	2,744,347	2,753,236	2,762,657
e. Other (Specify/add rows of needed)										
TOTAL OUTPATIENT VISITS	***17,885,072***	***19,503,513***	***20,512,057***	***20,561,101***	***20,613,578***	***20,669,598***	***20,729,275***	***20,792,728***	***20,860,079***	***20,931,456***
7. OBSERVATIONS**										
a. Number of Patients	5,860	5,670	5,999	6,013	6,028	6,045	6,062	6,081	6,100	6,121
b. Hours	135,579	113,938	119,257	119,542	119,848	120,173	120,520	120,889	121,281	121,696

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

UNINFLATED	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	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**
1. REVENUE										
a. Inpatient Services	$ 259,647	$ 263,693	$ 269,616	$ 281,164	$ 281,164	$ 281,164	$ 281,164	$ 286,503	$ 288,885	$ 288,822
b. Outpatient Services	312,771	319,227	337,880	354,310	354,310	354,310	354,310	354,310	354,310	354,310
Gross Patient Service Revenues	***$ 572,418***	***$ 582,920***	***$ 607,496***	***$ 635,473***	***$ 635,473***	***$ 635,473***	***$ 635,473***	***$ 640,813***	***$ 643,194***	***$ 643,131***
c. Allowance For Bad Debt	15,679	10,546	12,293	11,731	11,731	11,731	11,731	11,731	11,731	11,731
d. Contractual Allowance	89,713	89,145	90,161	102,084	102,084	102,084	102,084	102,535	102,736	102,731
e. Charity Care	2,121	3,339	3,391	1,605	1,605	1,605	1,605	1,605	1,605	1,605
Net Patient Services Revenue	***$ 464,906***	***$ 479,890***	***$ 501,650***	***$ 520,053***	***$ 520,053***	***$ 520,053***	***$ 520,053***	***$ 524,942***	***$ 527,123***	***$ 527,065***
% of Gross Revenue	*81%*	*82%*	*83%*	*82%*	*82%*	*82%*	*82%*	*82%*	*82%*	*82%*
Net Part B Revenue	59,637	67,516	73,758	79,967	81,597	82,090	82,524	83,270	83,888	84,556
Non-Patient Care Revenue	26,575	26,074	27,314	28,246	26,372	26,501	28,633	28,767	28,904	29,043
NET OPERATING REVENUE	***$ 551,118***	***$ 573,480***	***$ 602,722***	***$ 628,266***	***$ 628,022***	***$ 628,645***	***$ 631,210***	***$ 636,979***	***$ 639,914***	***$ 640,665***
2. EXPENSES										
a. Salaries & Wages (incl benefits)	$ 314,292	327,525	344,201	363,940	366,102	368,356	370,704	373,153	375,706	378,369
b. Contractual Srvs	31,057	22,846	21,117	21,085	21,085	21,085	21,085	21,085	21,085	21,085
c. Interest on Current Debt	6,915	6,566	6,484	5,951	5,265	5,051	4,865	4,575	4,271	4,006
d. Interest on Project Debt				-	-	-	-	**2,834**	**2,778**	**2,720**
e. Current Depreciation & Amortization	35,402	40,795	41,618	41,194	43,475	41,889	40,655	**37,381**	**35,697**	**35,959**
f. Project Depreciation & Amortization	-	-	-	-	-	-	-	**2,242**	**4,485**	**4,485**
g. Supplies	86,885	92,789	100,296	103,875	104,125	104,375	104,625	104,875	105,125	105,375
h. Purchased Services	75,366	78,833	80,993	85,871	87,956	88,073	89,332	90,603	91,765	92,884
i. Project related Operating Costs	-	-	-	-	-	-	-	**632**	**632**	**632**
j. Other Expenses (Operational Improvements)	-	-	-	-	(7,470)	(5,652)	(3,637)	(2,026)	(1,319)	(2,616)
TOTAL OPERATING EXPENSES	**$ 549,917**	**$ 569,354**	**$ 594,709**	**$ 621,916**	**$ 620,538**	**$ 623,176**	**$ 627,628**	**$ 635,353**	**$ 640,226**	**$ 642,899**

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

UNINFLATED	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	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**
3. INCOME										
a. Income From Operation	**$ 1,200**	**$ 4,126**	**$ 8,013**	**$ 6,350**	**$ 7,484**	**$ 5,468**	**$ 3,582**	**$ 1,625**	**$ (312)**	**$ (2,234)**
Operating Margin	***0.2%***	***0.7%***	***1.3%***	***1.0%***	***1.2%***	***0.9%***	***0.6%***	***0.3%***	***0.0%***	**-0.3%**
b. Non-Operating Inc - Investmnt Earnings 3% and Net Contributions	$ 25,797	26,505	35,522	8,701	8,518	8,766	7,821	8,049	8,283	8,524
NET INCOME (LOSS) EXCESS REV	***$ 26,997***	***$ 30,631***	***$ 43,535***	***$ 15,051***	***$ 16,002***	***$ 14,234***	***$ 11,403***	***$ 9,674***	***$ 7,971***	***$ 6,290***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	42.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%
2) Medicaid	3.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
3) Blue Cross	14.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%
4) HMO	23.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%
5) Other	17.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%
6) Self-Pay	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	42.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%
2) Medicaid	3.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
3) Blue Cross	14.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%
4) Commercial Insurance	23.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%
5) Self-pay	17.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%
6) Other	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table G - Key Financial Projection Assumptions for Greater Baltimore Medical Center, Inc. (Excludes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the entities FY20 budget with assumptions identified below.

Projection period reflects FY2020 – FY2026

The projection includes entities owned by GBMC HealthCare, Inc. as follows: Greater Baltimore Medical Center, Inc., Greater Baltimore Health Alliance, Health Partners, LLC, Gilchrist Hospice Care, Inc., GBMC Land, Inc., and GBMC Agency, Inc.

The Assumptions below relate **solely to** Greater Baltimore Medical Center, the regulated hospital.

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 Global Budget Revenue	- 0% increase per year
o Global Budget Revenue • Depreciation • Interest	- Beginning in FY2024 (includes mark-up and excludes Marshall Value overage; 1/2 year convention for 1st year depreciation). FY24 (1st Yr. - 1/2 Yr Deprec): $2.4M + $3.0M = $5.4M FY25 (Full Yr. Deprec): $4.8M + $3.0M = $7.8M
• Revenue Deductions	- Based on FY20 budget, 12.7% of gross revenue for total revenue deductions; variable contractual increasing with revenue
Other Revenue o Includes Rental Income, Net Assets Released from Restrictions, Parking Revenue, Grant Revenue, and Other Miscellaneous Revenue	- Based on FY2020 budget plus 0% increase per year
Non Patient Revenue o Includes Contributions, Investment Income & related fees	- 3.0% investment income per year
Expenses • Inflation	
o Salaries and Benefits	- 0.0% increase per year
o Supplies - Drugs	- 0.0% increase per year
o Supplies - Other	- 0.0% increase per year
o Purchased Services	- 0.0% increase per year
• Expense Variability with Volume Changes	- 52% variable with changes in volumes
• Interest Expense – Existing Debt	MHHEFA project and refunding revenue bonds, 26% of which mature by 2024
• Interest Expense – Project Debt	$70M tax exempt debt issued 7/1/21 at 4.23% over 30 years. Operating cash will provide additional funding.
• Project Related Facility Operating Expenses	Incremental building operating costs (utilities, environmental services, & maintenance)
• Depreciation and Amortization	Average life of 35 years on $108M of construction project expenditures and 14 years on routine capital equipment and construction expenditures
• Performance Improvement Plan	- Consolidation of Other Nursing Units - Further Maturation of Supply Chain - Systematic Reduction in Total Cost of Care - Other Value Based Reimbursement opportunities
Routine Capital Expenditures	$24M per year from FY21 through FY26 funded through GBMC operating cash

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INFLATED	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	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**
1. REVENUE										
a. Inpatient Services	$ 259,647	$ 263,693	$ 269,616	$ 281,164	$ 288,614	$ 296,275	$ 304,151	$ 317,589	$ 328,299	$ 336,801
b. Outpatient Services	312,771	319,227	337,880	354,310	364,939	375,951	387,362	399,190	411,452	424,168
Gross Patient Service Revenues	***$ 572,418***	***$ 582,920***	***$ 607,496***	***$ 635,473***	***$ 653,553***	***$ 672,226***	***$ 691,513***	***$ 716,779***	***$ 739,751***	***$ 760,969***
c. Allowance For Bad Debt	15,679	10,546	12,293	11,731	12,032	12,342	12,661	12,990	13,328	13,676
d. Contractual Allowance	89,713	89,145	90,161	102,091	104,556	107,115	109,775	112,988	116,061	119,040
e. Charity Care	2,121	3,339	3,391	1,598	1,641	1,686	1,732	1,779	1,827	1,877
Net Patient Services Revenue	***$ 464,906***	***$ 479,890***	***$ 501,650***	***$ 520,053***	***$ 535,324***	***$ 551,082***	***$ 567,345***	***$ 589,022***	***$ 608,535***	***$ 626,375***
% of Gross Revenue	*81%*	*82%*	*83%*	*82%*	*82%*	*82%*	*82%*	*82%*	*82%*	82%
Part B an Non-Patient Care Revenue	86,212	93,590	101,072	108,213	109,780	112,290	116,799	119,678	122,497	125,432
NET OPERATING REVENUE	***$ 551,118***	***$ 573,480***	***$ 602,722***	***$ 628,266***	***$ 645,104***	***$ 663,372***	***$ 684,144***	***$ 708,700***	***$ 731,032***	***$ 751,807***
2. EXPENSES										
a. Salaries & Wages (incl benefits)	$ 314,292	327,525	344,201	363,940	374,485	385,374	396,623	408,250	420,272	$ 432,709
b. Contractual Srvs, incl in Salaries	31,057	22,846	21,117	21,085	21,506	21,936	22,375	22,823	23,279	23,745
c. Interest on Current Debt	6,915	6,566	6,484	5,951	5,265	5,051	4,865	**4,575**	**4,271**	**4,006**
d. Interest on Project Debt	-	-		-	-	-	-	**2,834**	**2,778**	**2,720**
e. Current Depreciation & Amortization	35,402	40,795	41,618	41,194	43,475	41,889	40,655	**37,381**	**35,697**	**35,959**
f. Project Depreciation & Amortization	-	-	-		-	-	-	**2,242**	**4,485**	4,485
g. Supplies	86,885	92,789	100,296	103,875	108,831	114,027	119,474	125,188	131,180	137,466
h. Purchased Services	75,366	78,833	80,993	85,870	89,334	90,796	93,526	96,245	98,881	101,500
i. Project related Operating Costs								632	647	662
j. Other Expenses (Operational Improvements)	-	-		-	(7,470)	(5,652)	(3,637)	(2,026)	(1,319)	(2,616)
TOTAL OPERATING EXPENSES	***$ 549,917***	***$ 569,354***	***$ 594,709***	***$ 621,915***	***$ 635,427***	***$ 653,421***	***$ 673,881***	***$ 698,143***	***$ 720,172***	***$ 740,635***
3. INCOME										
a. Income From Operation	**$ 1,200**	**$ 4,126**	**$ 8,013**	**$ 6,351**	**$ 9,677**	**$ 9,951**	**$ 10,263**	**$ 10,557**	**$ 10,860**	**$ 11,172**
Operating Margin	*0.2%*	*0.7%*	*1.3%*	*1.0%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	1.5%
b. Non-Operating Inc - Investmnt Earnings 3% and Net Contributions	$ 25,798	26,505	35,522	8,701	8,818	9,075	8,890	9,149	9,416	9,691
NET INCOME (LOSS)	***$ 26,998***	***$ 30,631***	***$ 43,535***	***$ 15,052***	***$ 18,494***	***$ 19,026***	***$ 19,152***	***$ 19,706***	***$ 20,276***	***$ 20,864***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INFLATED	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	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	42.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%
2) Medicaid	3.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
3) Blue Cross	14.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%
4) HMO	23.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%
5) Other	17.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%
6) Self-Pay	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	42.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%
2) Medicaid	3.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
3) Blue Cross	14.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%
4) Commercial Insurance	23.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%
5) Self-pay	17.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%	19.0%
6) Other	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table H - Key Financial Projection Assumptions for Greater Baltimore Medical Center, Inc. (Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the entities FY20 budget with assumptions identified below.

Projection period reflects FY2020 – FY2026

The projection includes entities owned by GBMC HealthCare, Inc. as follows: Greater Baltimore Medical Center, Inc., Greater Baltimore Health Alliance, Health Partners, LLC, Gilchrist Hospice Care, Inc., GBMC Land, Inc., and GBMC Agency, Inc.

The Assumptions below relate **solely to** Greater Baltimore Medical Center, the regulated hospital.

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 Global Budget Revenue	- 3.2% increase from FY19 to FY20 and 2.5% increase per year, thereafter. Rate includes update factor, drug inflation, demographic adjustment, and market shift adjustment.
o Capital Costs in Rates	- Beginning in FY2024 (includes mark-up and excludes Marshall Value overage; 1/2 year convention for 1st year depreciation).
• Depreciation • Interest	FY24 (1st Yr. - 1/2 Yr Deprec): $2.4M + $3.0M = $5.4M FY25 (Full Yr. Deprec): $4.8M + $3.0M = $7.8M
• Revenue Deductions	- Based on FY20 budget, 12.7% of gross revenue for total revenue deductions; variable contractual increasing with revenue
Other Revenue o Includes Rental Income, Net Assets Released from Restrictions, Parking Revenue, Grant Revenue, and Other Miscellaneous Revenue	- Based on FY2020 budget plus 1.5% increase per year
Non Patient Revenue o Includes Contributions, Investment Income & related fees	- 3.0% investment income per year
Expenses • Inflation	
o Salaries and Benefits	- 2.9% increase per year
o Supplies - Drugs	- 5.0% increase per year
o Supplies - Other	- 3.5% increase per year
o Purchased Services	- 1.0% increase per year
• Expense Variability with Volume Changes	- 52% variable with changes in volumes
• Interest Expense – Existing Debt	MHHEFA project and refunding revenue bonds, 26% of which mature by 2024
• Interest Expense – Project Debt	$70M tax exempt debt issued 7/1/21 at 4.23% over 30 years. Operating cash will provide additional funding.
• Project Related Facility Operating Expenses	Incremental building operating costs (utilities, environmental services, & maintenance)
• Depreciation and Amortization	Average life of 35 years on $108M of construction project expenditures and 14 years on routine capital equipment and construction expenditures
• Performance Improvement Plan	- Consolidation of Other Nursing Units - Further Maturation of Supply Chain - Systematic Reduction in Total Cost of Care - Other Value Based Reimbursement opportunities
Routine Capital Expenditures	$24M per year from FY21 through FY26 funded through GBMC operating cash

TABLE L. WORKFORCE INFORMATION

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 G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Management	295.1	$130,998	$38,653,530			$0			$0	295.1	$38,653,530
Administrative	1,074.8	$55,408	$59,553,146			$0			$0	1,074.8	$59,553,146
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration	1,369.9	$186,405	$98,206,676	0.0	$0	$0	0.0	$0	$0	1,369.9	$98,206,676
Direct Care Staff *(List general categories, add rows if needed)*											
Nursing	871.2	$85,648	$74,612,086			$0	0.0	#DIV/0!	$0	871.2	$74,612,086
Patient Care - Other	627.5	$42,986	$26,973,045			$0	0.0	#DIV/0!	$0	627.5	$26,973,045
Provider	292.3	$237,377	$69,373,545			$0	0.0	#DIV/0!	$0	292.3	$69,373,545
Patient Care - Ancillary Services	227.4	$74,815	$17,013,683			$0				227.4	$17,013,683
Total Direct Care	2,018.3	$440,826	$187,972,360	0.0	$0	$0	0.0	#DIV/0!	$0	2,018.3	$187,972,360
Support Staff *(List general categories, add rows if needed)*											
Support Services	253.7	$36,730	$9,317,422	1.0	$50,000	$50,000			$0	254.7	$9,367,422
						$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support	253.7	$36,730	$9,317,422	1.0	$50,000	$50,000	0.0	$0	$0	254.7	$9,367,422
REGULAR EMPLOYEES TOTAL	***3,641.9***	***663,961.7***	***295,496,458.0***	***1.0***	***50,000.0***	***50,000.0***	***0.0***	***#DIV/0!***	***0.0***	3,642.9	$295,546,458
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
Contract Labor	0.0	$85,648	$21,117,260			$0			$0	0.0	$21,117,260
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration	0.0	85,647.8	21,117,260.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	$21,117,260
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***	***85,647.8***	***21,117,260.0***	***0.0***	***0.0***	***0.0***	***0.0***	***0.0***	***0.0***	0.0	$21,117,260
Benefits *(State method of calculating benefits below) :*			-			-			**(1.00)**		**(1)**
18% of Staff & Physician labor FY21-26											
TOTAL COST	***3,641.9***		***$316,613,718.00***	***1.0***		***$50,000***	***0.0***		***-$1***		***$316,663,717***

REVISED

EXHIBIT 2

PROMISE PROJECT

6701 CHARLES STREET
TOWSON, MD 21204

ARCHITECT
HORD COPLAN MACHT, INC.
750 E. PRATT STREET SUITE 1100
BALTIMORE, MD 21202
TEL. 410.837.7311
FAX 410.837.6530

CIVIL
SITE RESOURCES, INC.
14315 JARRETTSVILLE PIKE
PHOENIX, MD 21131
TEL. 410.683.3388
FAX 410.683.3389

STRUCTURAL
MORABITO CONSULTANTS
952 RIDGEBROOK ROAD
SPARKS GLENCOE, MD 21152
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FAX 410.467.4132

MEP
LEACH WALLACE ASSOCIATES, INC.
6522 MEADOWRIDGE ROAD SUITE #1
ELKRIDGE, MD 21075
TEL. 410.579.8100
FAX 410.540.9041

3D PERSPECTIVE - SOUTHWEST

DRAWING INDEX

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Site Resources, Inc.
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STRUCTURAL
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MEP
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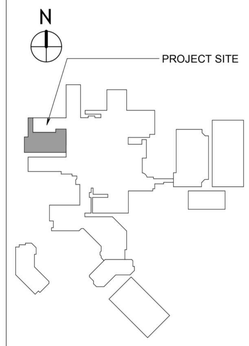
GBMC
GREATER BALTIMORE MEDICAL CENTER

PROMISE PROJECT

6701 CHARLES STREET
TOWSON, MD 21204



KEY PLAN

hord | coplan | macht

ARCHITECTURE
LANDSCAPE ARCHITECTURE
PLANNING
INTERIOR DESIGN

PROFESSIONAL CERTIFICATION. I CERTIFY THAT THESE DOCUMENTS WERE PREPARED OR APPROVED BY ME, AND THAT I AM A DULY LICENSED ARCHITECT UNDER THE LAWS OF THE STATE OF MARYLAND
LICENSE NUMBER:
EXPIRATION DATE:

no.	date	revision

Project Name
PROMISE PROJECT

Project Number
219043.10

Date
07/12/2019

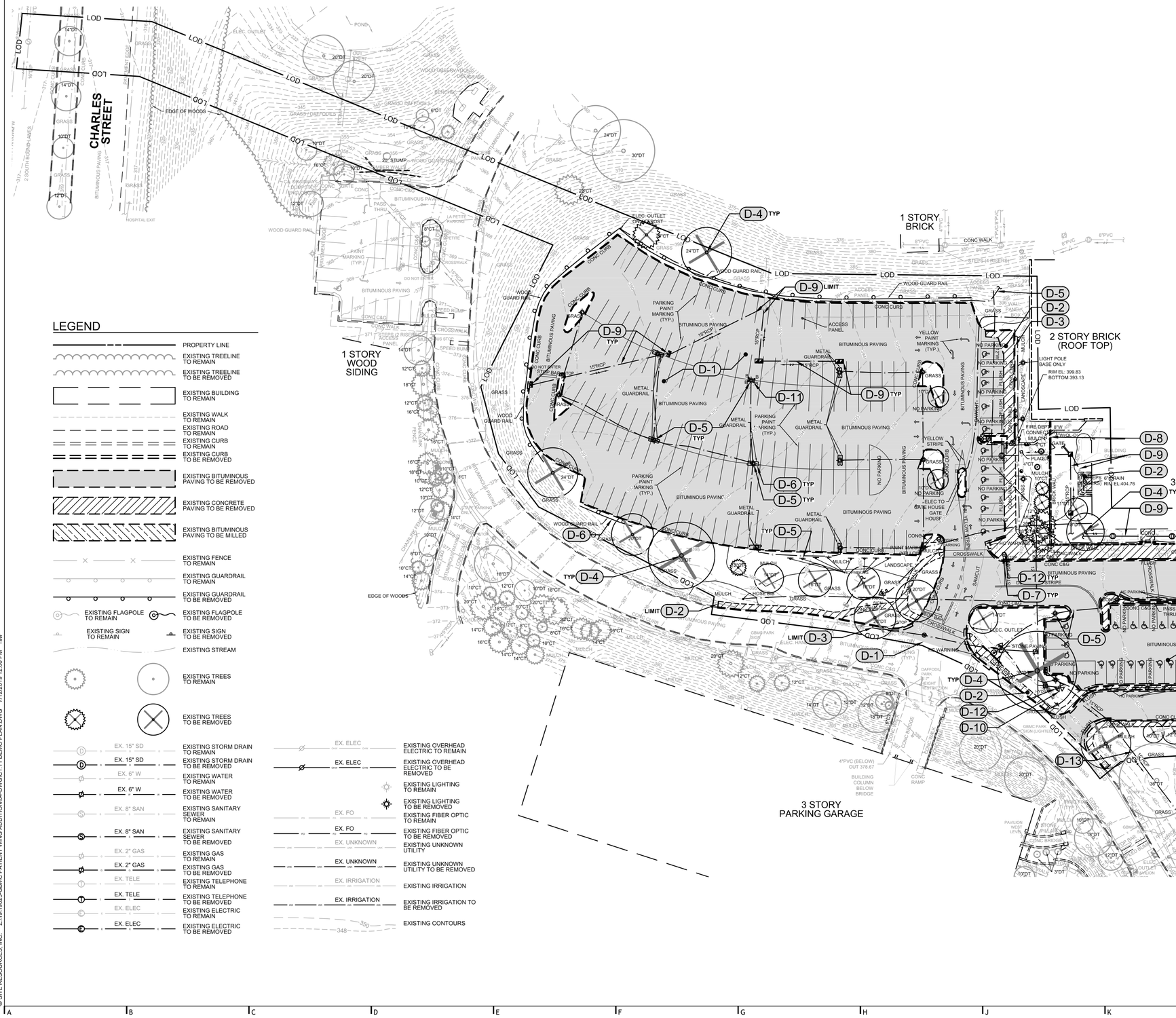
Scale

Drawing
COVER SHEET

A0.0

PROJECT DRAWINGS

7/12/2019 3:06:19 PM
C:\Users\gmorgan\Documents\219043_GBMC Bed Tower_2019_gmorgan.rvt



LEGEND

- PROPERTY LINE
- EXISTING TREELINE TO REMAIN
- EXISTING TREELINE TO BE REMOVED
- EXISTING BUILDING TO REMAIN
- EXISTING WALK TO REMAIN
- EXISTING ROAD TO REMAIN
- EXISTING CURB TO REMAIN
- EXISTING CURB TO BE REMOVED
- EXISTING BITUMINOUS PAVING TO BE REMOVED
- EXISTING CONCRETE PAVING TO BE REMOVED
- EXISTING BITUMINOUS PAVING TO BE MILLED
- EXISTING FENCE TO REMAIN
- EXISTING GUARDRAIL TO REMAIN
- EXISTING GUARDRAIL TO BE REMOVED
- EXISTING FLAGPOLE TO REMAIN
- EXISTING FLAGPOLE TO BE REMOVED
- EXISTING SIGN TO REMAIN
- EXISTING SIGN TO BE REMOVED
- EXISTING STREAM
- EXISTING TREES TO REMAIN
- EXISTING TREES TO BE REMOVED
- EX. 15" SD — EXISTING STORM DRAIN TO REMAIN
- EX. 15" SD — EXISTING STORM DRAIN TO BE REMOVED
- EX. 6" W — EXISTING WATER TO REMAIN
- EX. 6" W — EXISTING WATER TO BE REMOVED
- EX. 8" SAN — EXISTING SANITARY SEWER TO REMAIN
- EX. 8" SAN — EXISTING SANITARY SEWER TO BE REMOVED
- EX. 2" GAS — EXISTING GAS TO REMAIN
- EX. 2" GAS — EXISTING GAS TO BE REMOVED
- EX. TELE — EXISTING TELEPHONE TO REMAIN
- EX. TELE — EXISTING TELEPHONE TO BE REMOVED
- EX. ELEC — EXISTING ELECTRIC TO REMAIN
- EX. ELEC — EXISTING ELECTRIC TO BE REMOVED
- EX. ELEC — EXISTING OVERHEAD ELECTRIC TO REMAIN
- EX. ELEC — EXISTING OVERHEAD ELECTRIC TO BE REMOVED
- EXISTING LIGHTING TO REMAIN
- EXISTING LIGHTING TO BE REMOVED
- EX. FO — EXISTING FIBER OPTIC TO REMAIN
- EX. FO — EXISTING FIBER OPTIC TO BE REMOVED
- EX. UNKNOWN — EXISTING UNKNOWN UTILITY
- EX. UNKNOWN — EXISTING UNKNOWN UTILITY TO BE REMOVED
- EX. IRRIGATION — EXISTING IRRIGATION
- EX. IRRIGATION — EXISTING IRRIGATION TO BE REMOVED
- 350 / 348 — EXISTING CONTOURS

DEMOLITION NOTES

- D-1 SAW CUT AT LIMITS SHOWN AND REMOVE EXISTING ASPHALT PAVEMENT.
- D-2 REMOVE EXISTING CONCRETE PAVEMENT TO NEAREST JOINT BEYOND LIMITS SHOWN. SAW CUT AT JOINT.
- D-3 REMOVE EXISTING CURB & GUTTER. SAW CUT AT LIMIT IF MORE THAN 24" FROM NEAREST JOINT, OTHERWISE REMOVE TO NEAREST JOINT.
- D-4 REMOVE EXISTING TREE, STUMP AND ROOTS.
- D-5 REMOVE EXISTING ELECTRIC AND ASSOCIATED LIGHTING OR OTHER STRUCTURES TO LIMITS SHOWN ON PLAN.
- D-6 REMOVE EXISTING GUARD RAIL & FOUNDATION.
- D-7 REMOVE EXISTING SITE FURNISHING. COORDINATE WITH OWNER ANY ITEMS TO BE RELOCATED OR SALVAGED.
- D-8 REMOVE EXISTING WALL AND FOUNDATION.
- D-9 REMOVE EXISTING STORM DRAIN AND ASSOCIATED STRUCTURES TO LIMITS SHOWN.
- D-10 REMOVE EXISTING WATER AND ASSOCIATED STRUCTURES TO LIMITS SHOWN.
- D-11 REMOVE EXISTING BOLLARD.
- D-12 REMOVE EXISTING SIGN.
- D-13 ABANDON AND FILL WITH FLOWABLE FILL EXISTING STORM DRAIN UNDER TREE TO REMAIN. CONTRACTOR TO BRICK UP OPENING IN DOWNHILL STRUCTURE.

ARCHITECT
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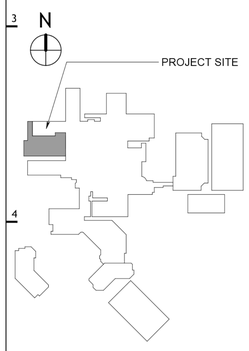
6701 CHARLES STREET
TOWSON, MD 21204



ARCHITECTURE
LANDSCAPE ARCHITECTURE
PLANNING
INTERIOR DESIGN

PROFESSIONAL CERTIFICATION
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no.	date	revision

Project Name

Project Number
219043.10

Date
07/12/2019

Scale
AS NOTED

Drawing
EXISTING CONDITIONS & DEMOLITION PLAN

C1.0

PROJECT DRAWINGS

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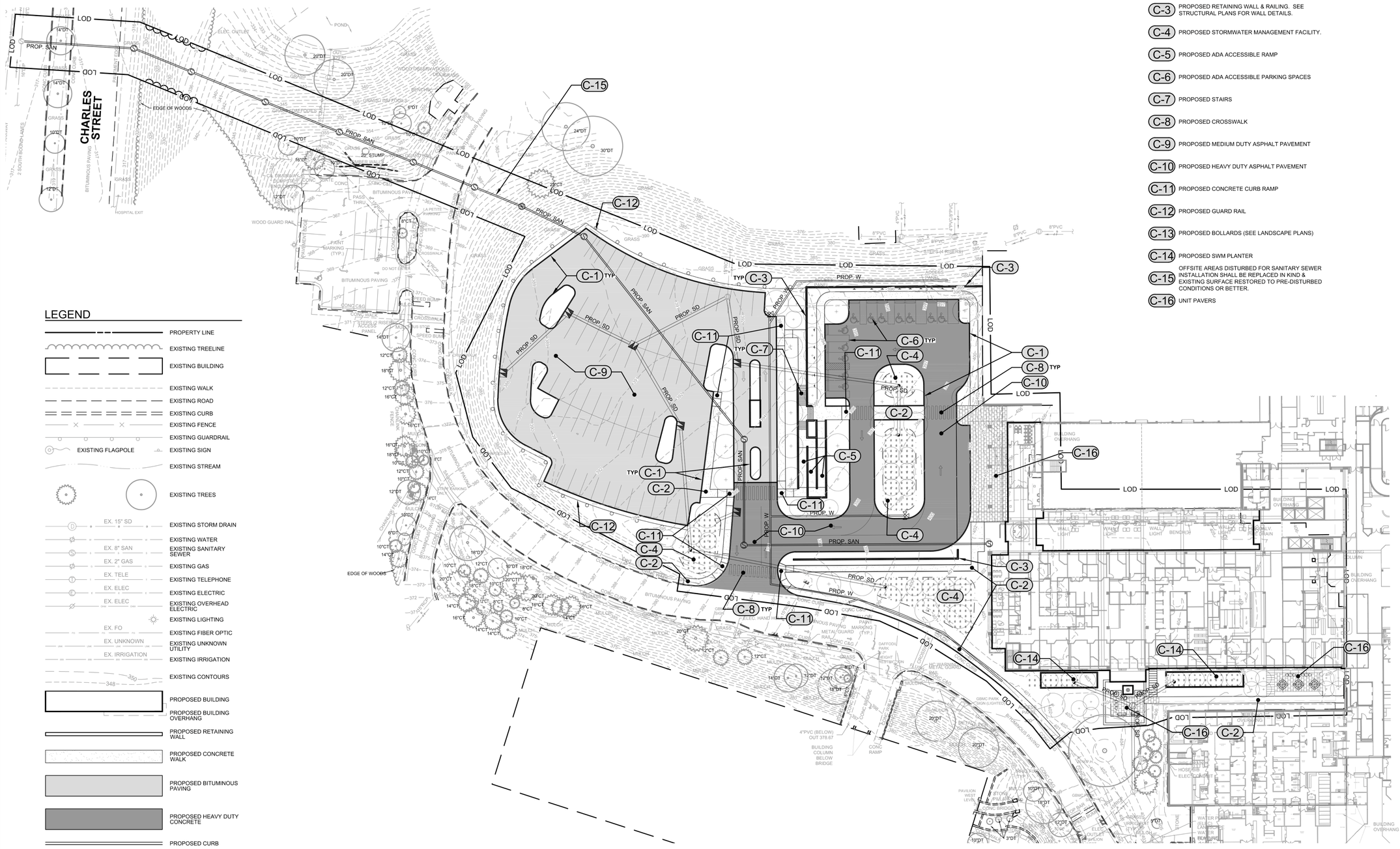

LEGEND

- PROPERTY LINE
- EXISTING TREELINE
- EXISTING BUILDING
- EXISTING WALK
- EXISTING ROAD
- EXISTING CURB
- EXISTING FENCE
- EXISTING GUARDRAIL
- EXISTING FLAGPOLE
- EXISTING SIGN
- EXISTING STREAM
- EXISTING TREES
- EX. 15" SD — EXISTING STORM DRAIN
- EXISTING WATER
- EX. 8" SAN — EXISTING SANITARY SEWER
- EX. 2" GAS — EXISTING GAS
- EX. TELE — EXISTING TELEPHONE
- EX. ELEC — EXISTING ELECTRIC
- EX. ELEC — EXISTING OVERHEAD ELECTRIC
- EXISTING LIGHTING
- EX. FO — EXISTING FIBER OPTIC
- EX. UNKNOWN — EXISTING UNKNOWN UTILITY
- EX. IRRIGATION — EXISTING IRRIGATION
- 350 / 348 — EXISTING CONTOURS
- PROPOSED BUILDING
- PROPOSED BUILDING OVERHANG
- PROPOSED RETAINING WALL
- PROPOSED CONCRETE WALK
- PROPOSED BITUMINOUS PAVING
- PROPOSED HEAVY DUTY CONCRETE
- PROPOSED CURB
- PROPOSED GUARDRAIL
- PROPOSED SIGN
- PROPOSED HEAVY DUTY CONCRETE
- PROPOSED WOODSLINE
- PROP. 15" SD — PROPOSED STORM DRAIN
- PROP. 6" WATER — PROPOSED WATER
- PROP. 8" SAN — PROPOSED SANITARY SEWER

CONSTRUCTION NOTES

- C-1 PROPOSED CURB & GUTTER
- C-2 PROPOSED CONCRETE WALK
- C-3 PROPOSED RETAINING WALL & RAILING. SEE STRUCTURAL PLANS FOR WALL DETAILS.
- C-4 PROPOSED STORMWATER MANAGEMENT FACILITY.
- C-5 PROPOSED ADA ACCESSIBLE RAMP
- C-6 PROPOSED ADA ACCESSIBLE PARKING SPACES
- C-7 PROPOSED STAIRS
- C-8 PROPOSED CROSSWALK
- C-9 PROPOSED MEDIUM DUTY ASPHALT PAVEMENT
- C-10 PROPOSED HEAVY DUTY ASPHALT PAVEMENT
- C-11 PROPOSED CONCRETE CURB RAMP
- C-12 PROPOSED GUARD RAIL
- C-13 PROPOSED BOLLARDS (SEE LANDSCAPE PLANS)
- C-14 PROPOSED SWM PLANTER
- C-15 OFFSITE AREAS DISTURBED FOR SANITARY SEWER INSTALLATION SHALL BE REPLACED IN KIND & EXISTING SURFACE RESTORED TO PRE-DISTURBED CONDITIONS OR BETTER.
- C-16 UNIT PAVERS

ARCHITECT
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GREATER BALTIMORE MEDICAL CENTER

PROMISE PROJECT

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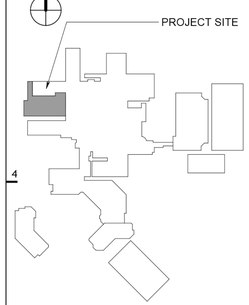

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PLANNING
INTERIOR DESIGN

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no.	date	revision

Project Name

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Date
07/12/2019

Scale
AS NOTED

Drawing
SITE PLAN

C1.1

PROJECT DRAWINGS

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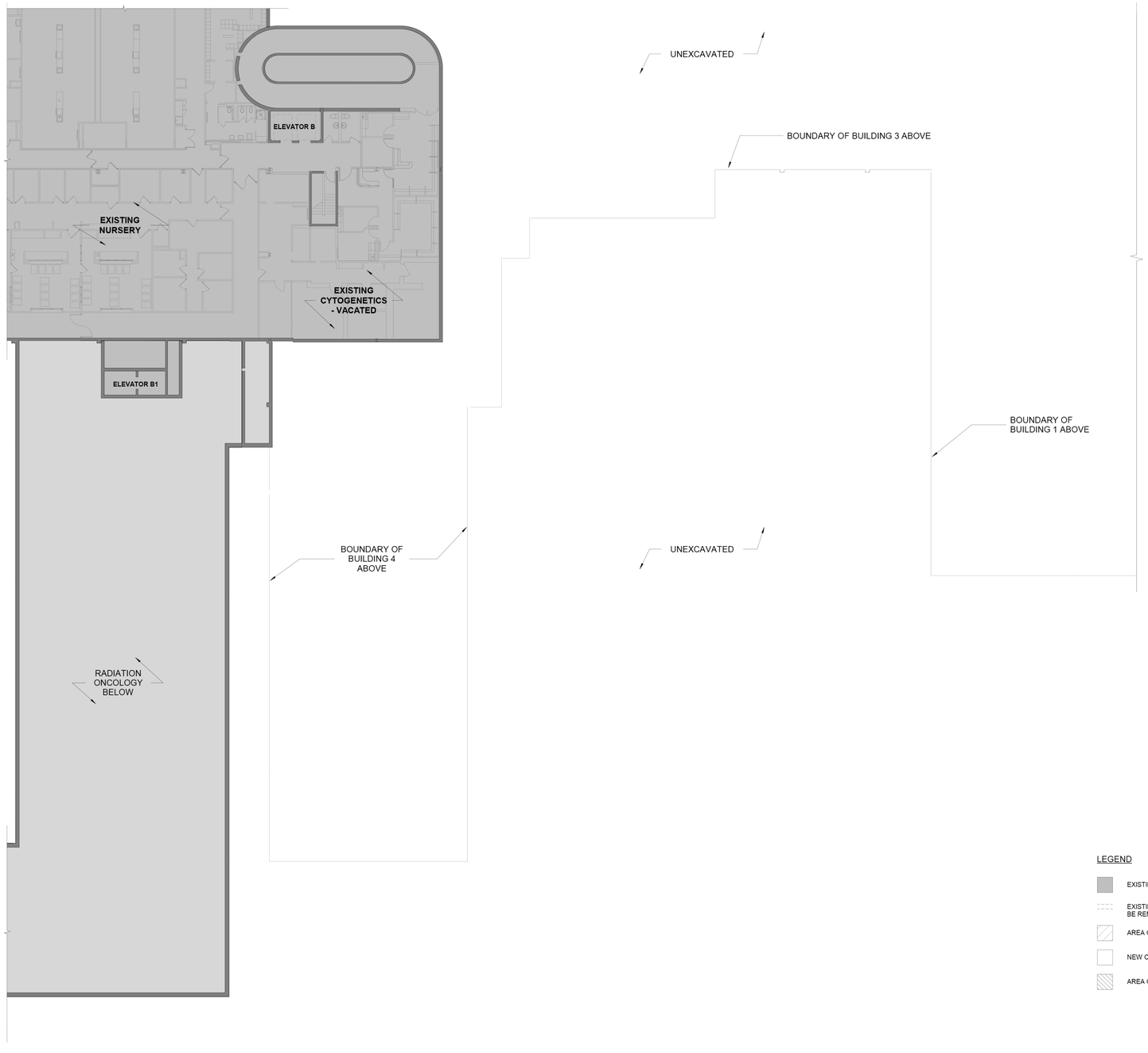

LEGEND

- EXISTING CONDITIONS
- EXISTING CONSTRUCTION TO BE REMOVED
- AREA OF RENOVATION
- NEW CONSTRUCTION
- AREA OF NEW WORK ABOVE

1 LEVEL 2 - EXISTING FLOOR PLAN
A4.0 | A1.2 1/16" = 1'-0"

0 8 16 32

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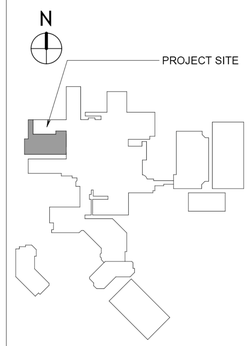

KEY PLAN

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Scale
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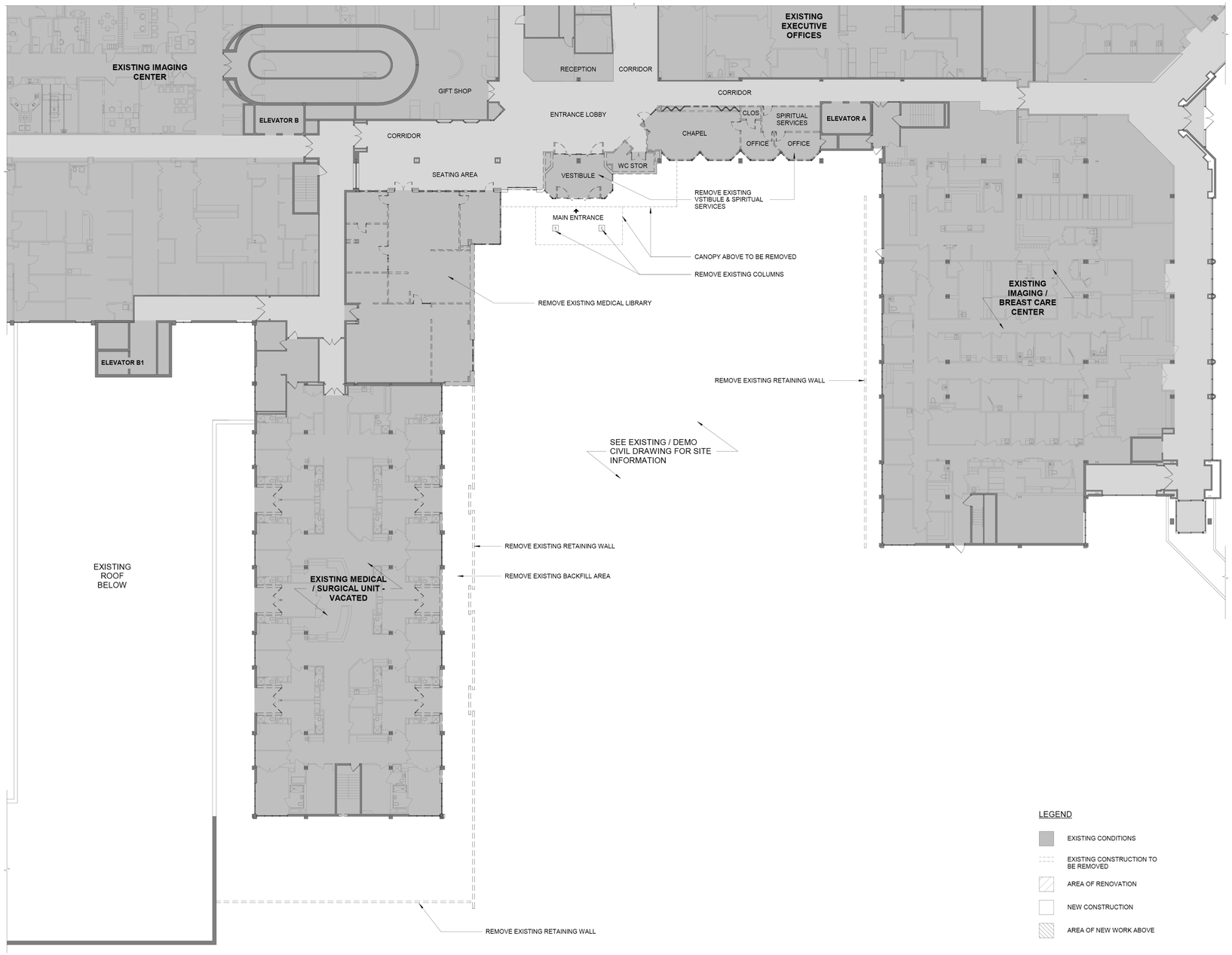
Drawing
LEVEL 2 - EXISTING FLOOR PLAN

A1.2

PROJECT DRAWINGS



1 LEVEL 3 - EXISTING FLOOR PLAN

A2.09 | A1.3 1/16" = 1'-0"

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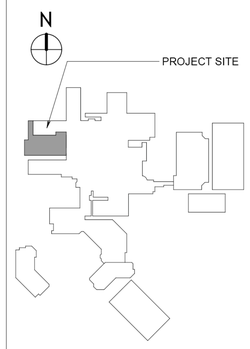

KEY PLAN

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Scale
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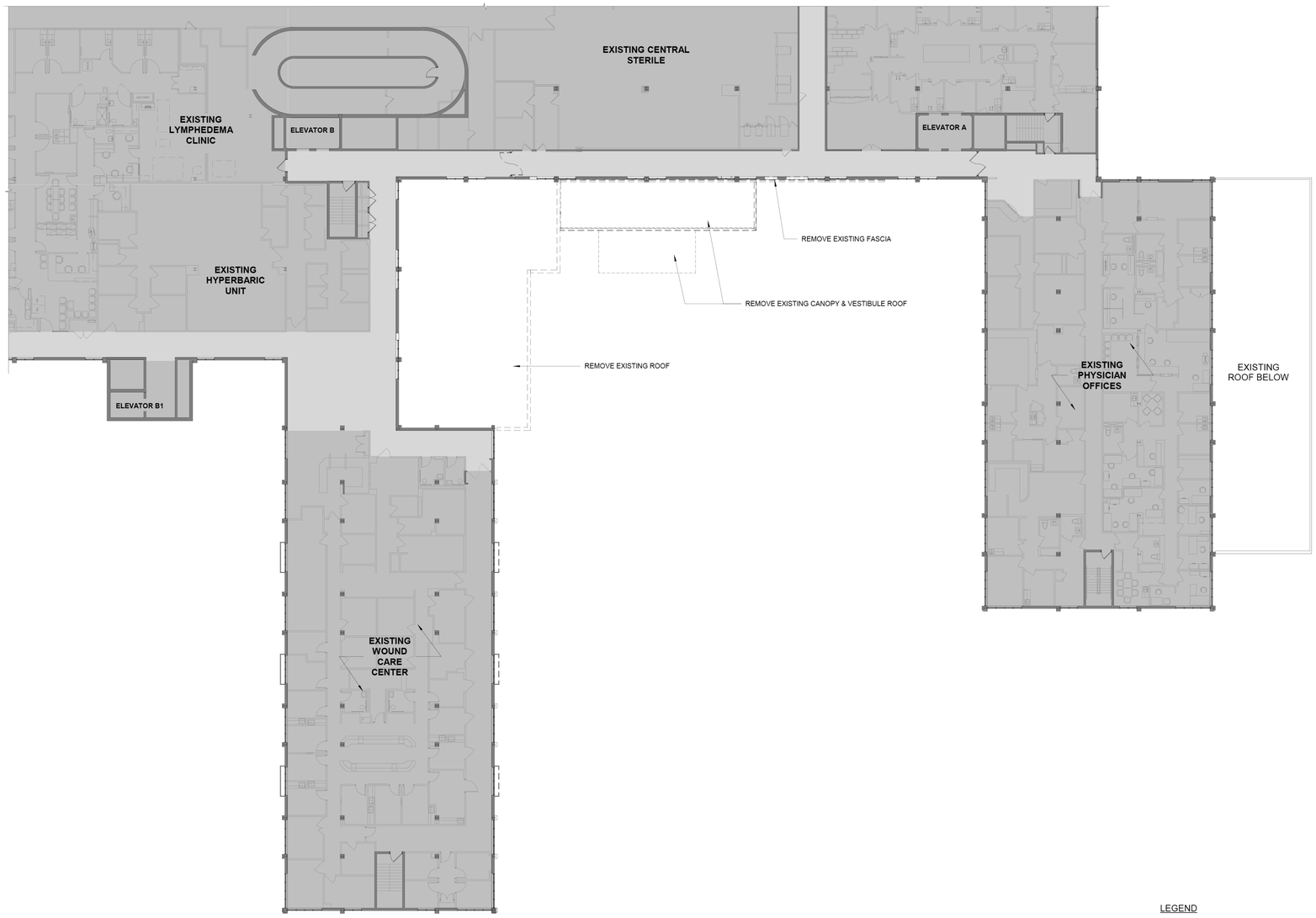
Drawing
LEVEL 3 - EXISTING FLOOR PLAN

A1.3

PROJECT DRAWINGS



LEGEND

- EXISTING CONDITIONS
- EXISTING CONSTRUCTION TO BE REMOVED
- AREA OF RENOVATION
- NEW CONSTRUCTION
- AREA OF NEW WORK ABOVE

1 LEVEL 4 - EXISTING FLOOR PLAN
A2.09 | A1.4 1/16" = 1'-0"

0 8 16 32

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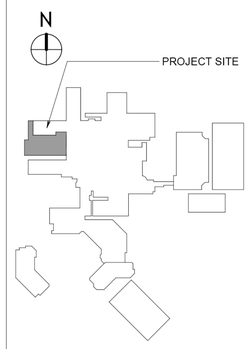

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Date
07/12/2019

Scale
1/16" = 1'-0"

Drawing
LEVEL 4 - EXISTING FLOOR PLAN

A1.4

PROJECT DRAWINGS

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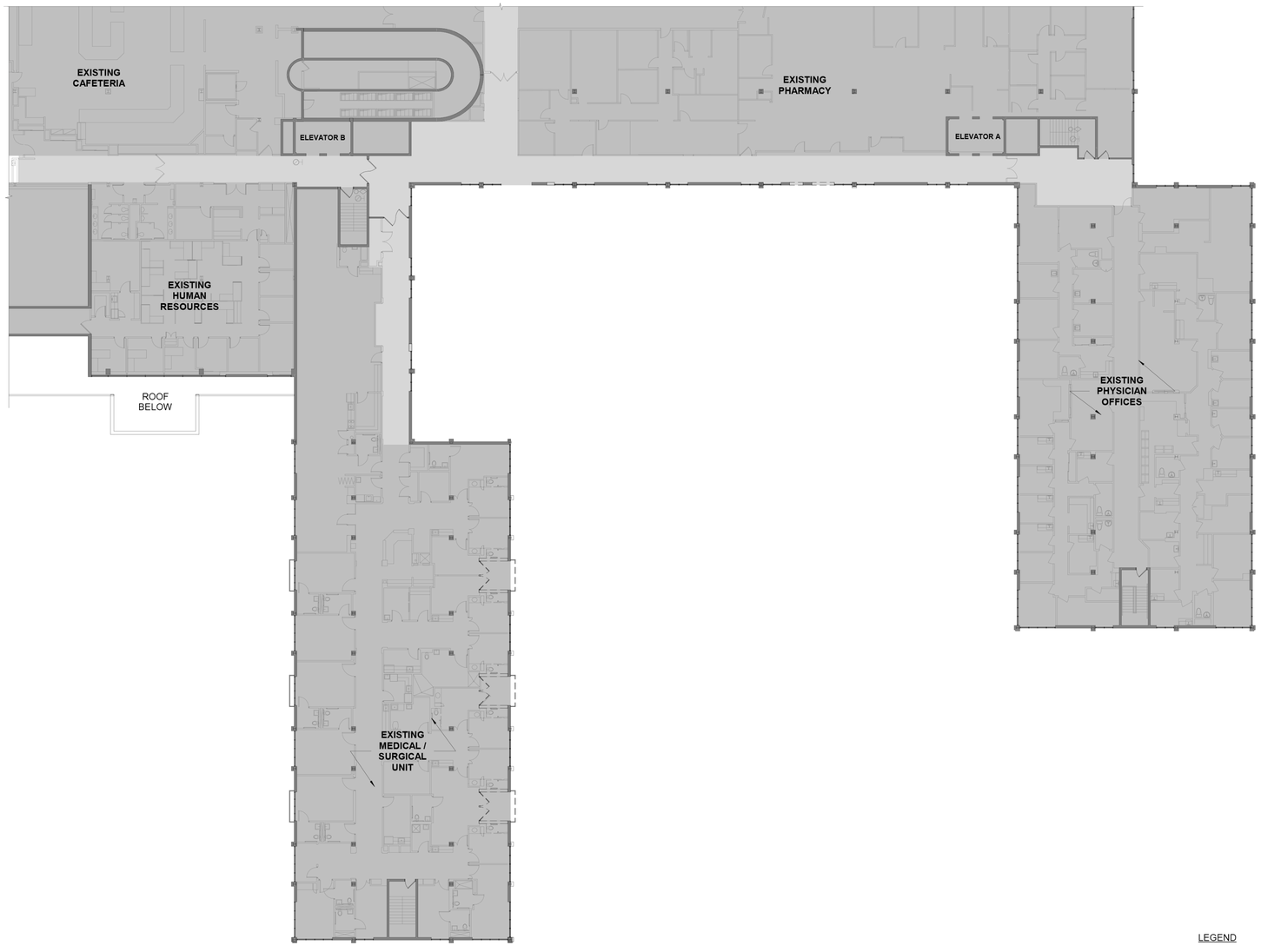

LEGEND

- EXISTING CONDITIONS
- EXISTING CONSTRUCTION TO BE REMOVED
- AREA OF RENOVATION
- NEW CONSTRUCTION
- AREA OF NEW WORK ABOVE

1 LEVEL 5 - EXISTING FLOOR PLAN
A2.09 | A1.5 1/16" = 1'-0"

0 8 16 32

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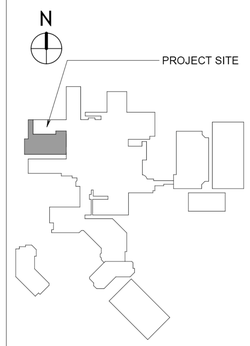

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Scale
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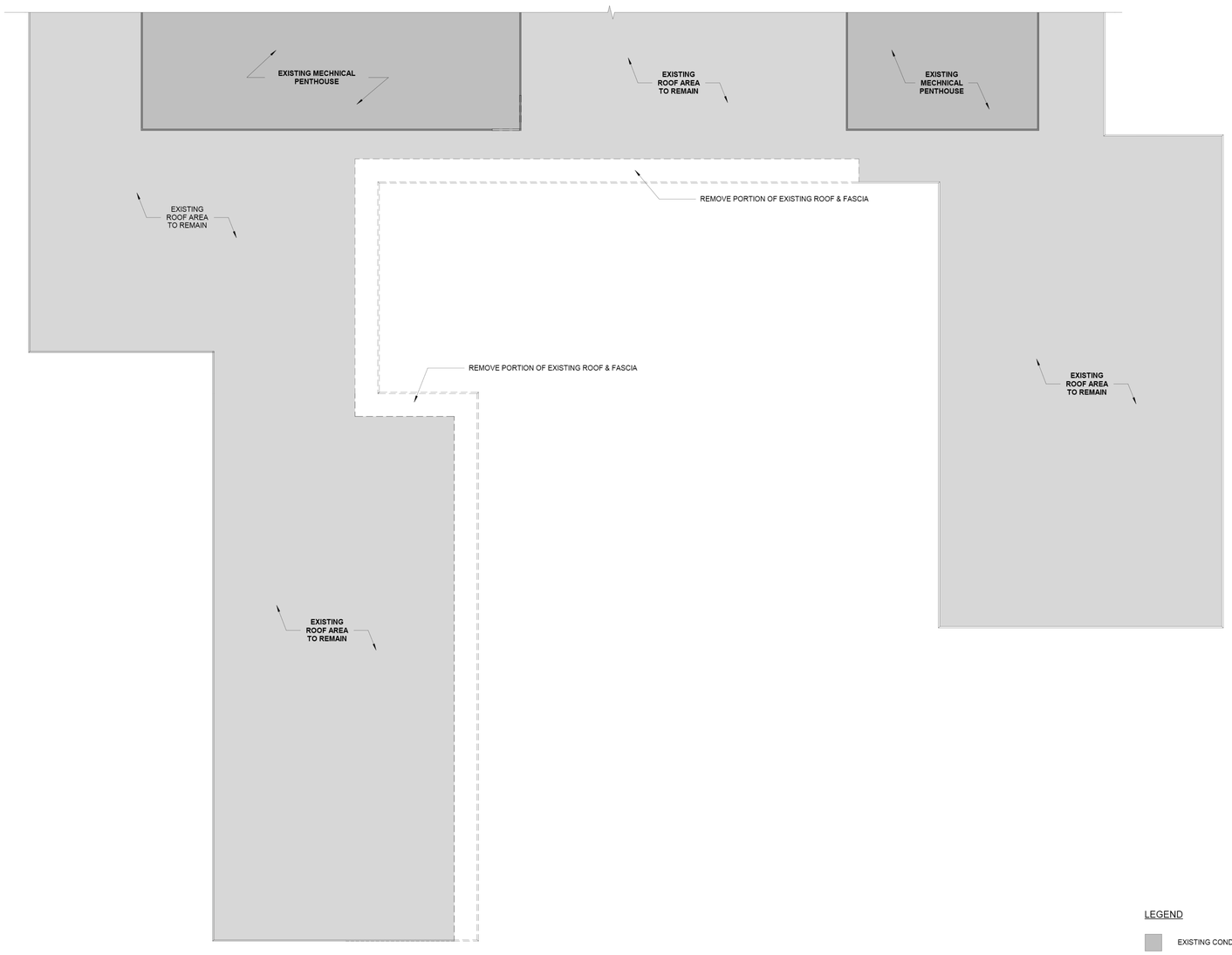
Drawing
LEVEL 5 - EXISTING FLOOR PLAN

A1.5

PROJECT DRAWINGS



LEGEND

- EXISTING CONDITIONS
- EXISTING CONSTRUCTION TO BE REMOVED
- AREA OF RENOVATION
- NEW CONSTRUCTION
- AREA OF NEW WORK ABOVE

1 LEVEL 6 - PENTHOUSE EXISTING FLOOR PLAN
A2.09 | A1.6 1/16" = 1'-0"

0 8 16 32

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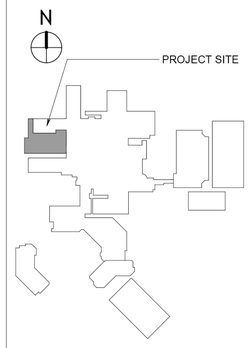

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Date
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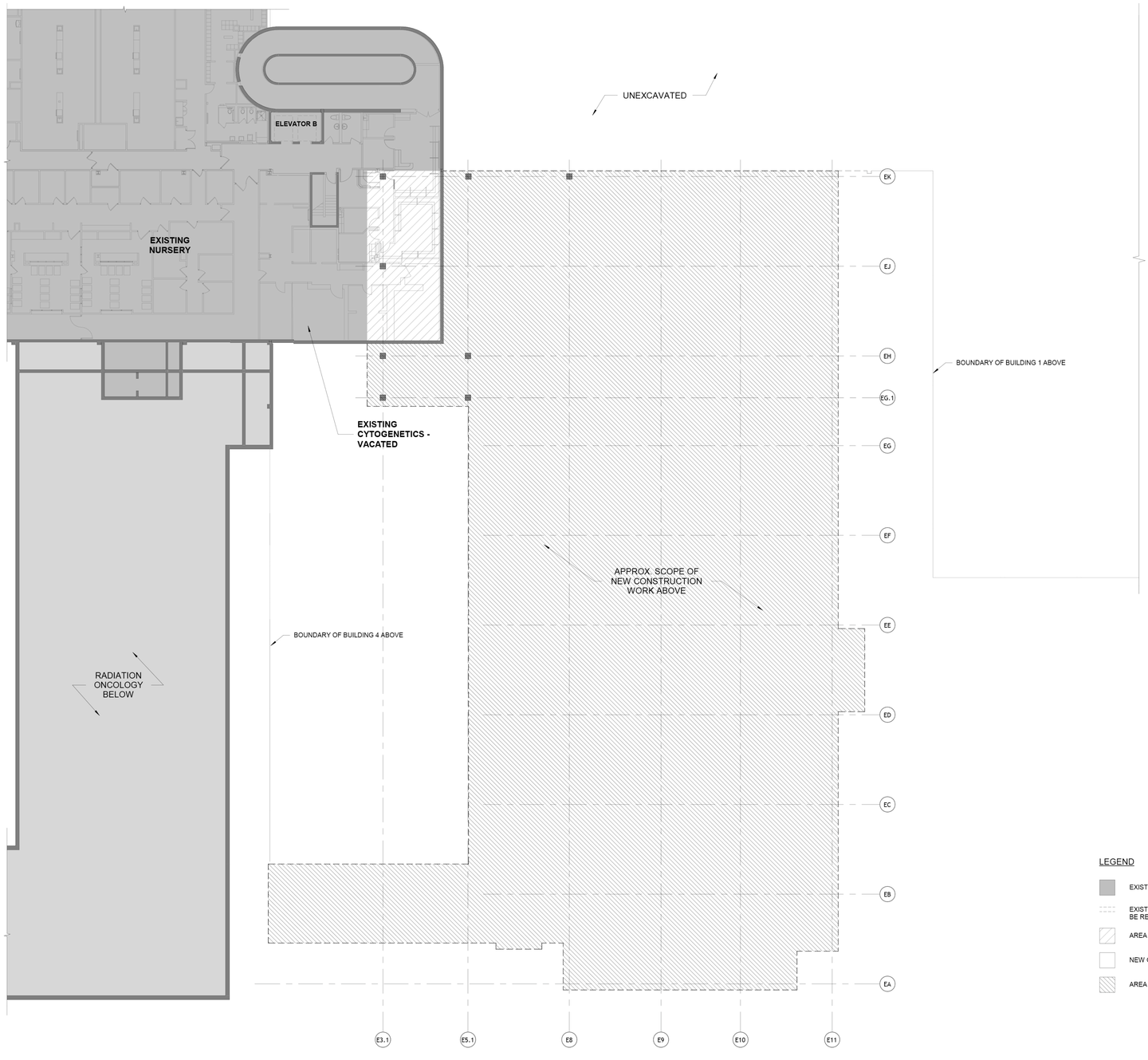
Scale
1/16" = 1'-0"

Drawing
LEVEL 6 - PENTHOUSE EXISTING FLOOR PLAN

A1.6

PROJECT DRAWINGS



1 LEVEL 2 - FLOOR PLAN
A4.0 A2.2 1/16" = 1'-0"

LEGEND

- EXISTING CONDITIONS
- EXISTING CONSTRUCTION TO BE REMOVED
- AREA OF RENOVATION
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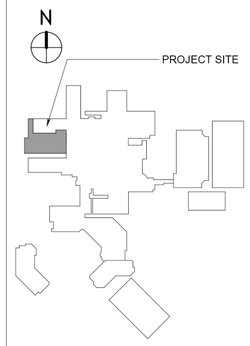

KEY PLAN

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Scale
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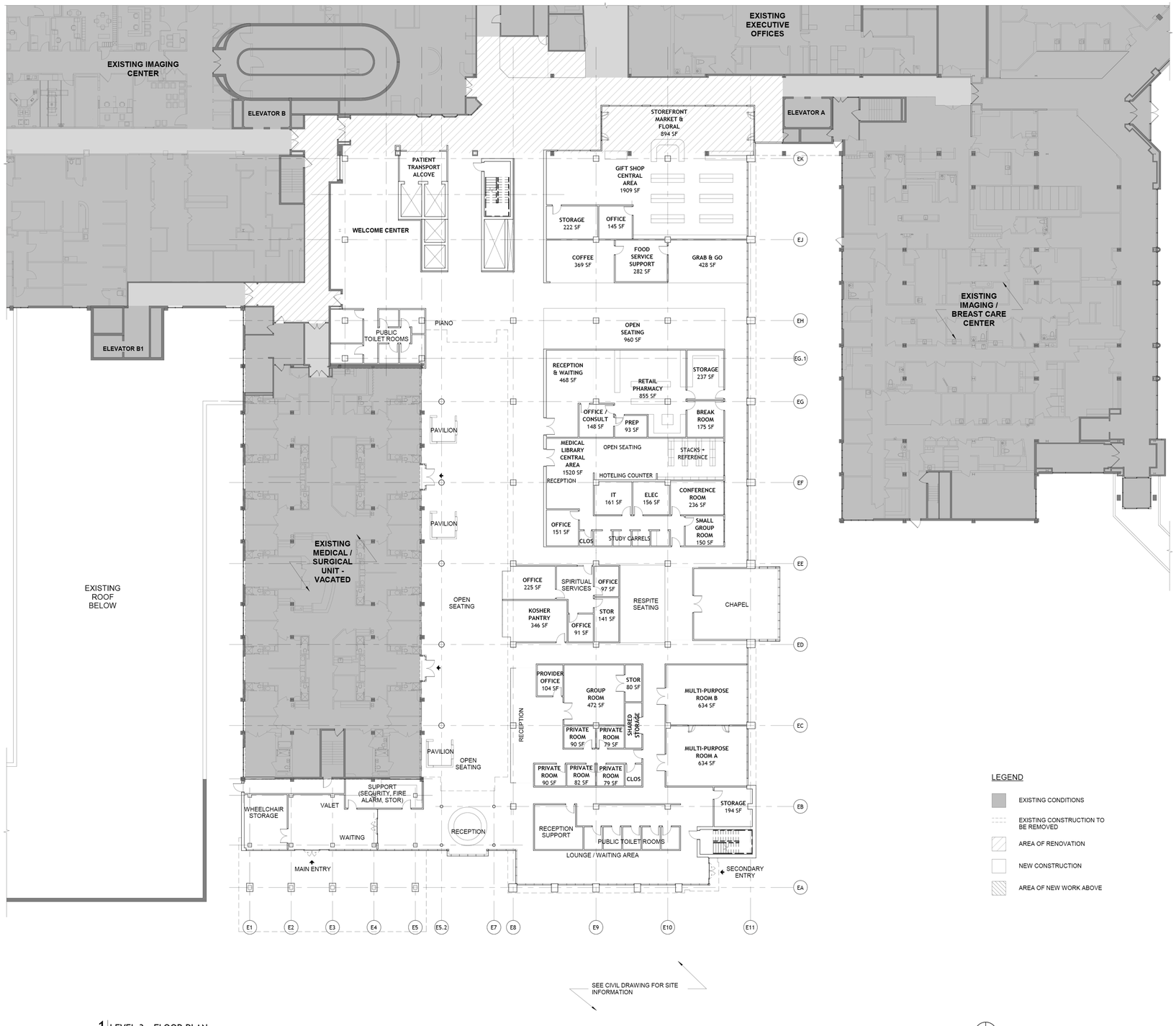
Drawing
LEVEL 2 - FLOOR PLAN

A2.2

PROJECT DRAWINGS



1 LEVEL 3 - FLOOR PLAN

A2.09 | A2.3 | 1/16" = 1'-0"

LEGEND

- EXISTING CONDITIONS
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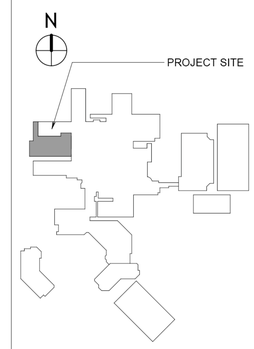

KEY PLAN

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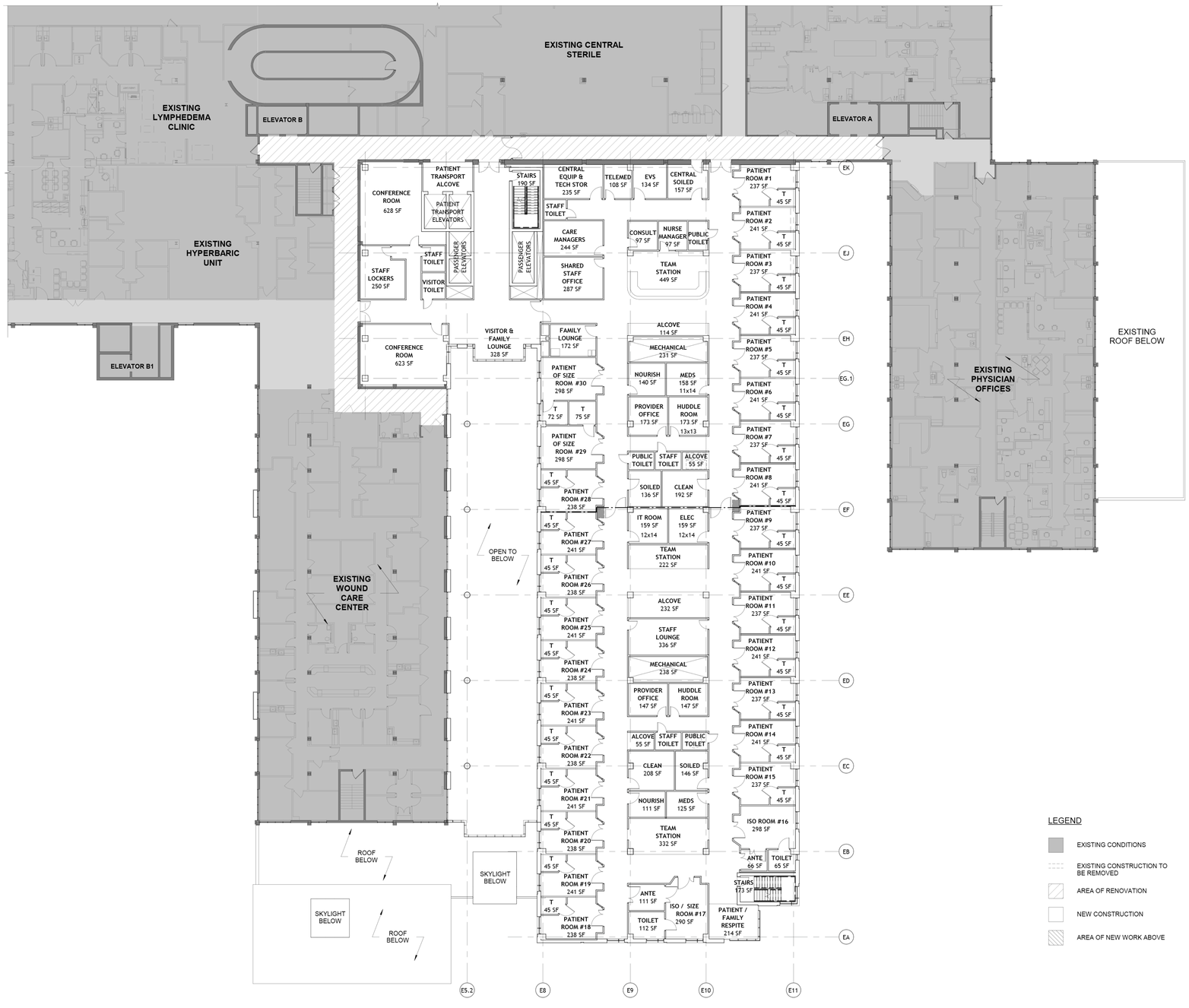
LEVEL 3 - FLOOR PLAN

A2.3

PROJECT DRAWINGS



1 LEVEL 4 - FLOOR PLAN

A2.09 | A2.4 | 1/16" = 1'-0"

LEGEND

- EXISTING CONDITIONS
- EXISTING CONSTRUCTION TO BE REMOVED
- AREA OF RENOVATION
- NEW CONSTRUCTION
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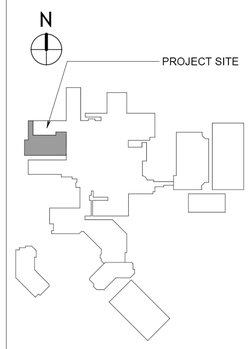

KEY PLAN

hord | coplan | macht

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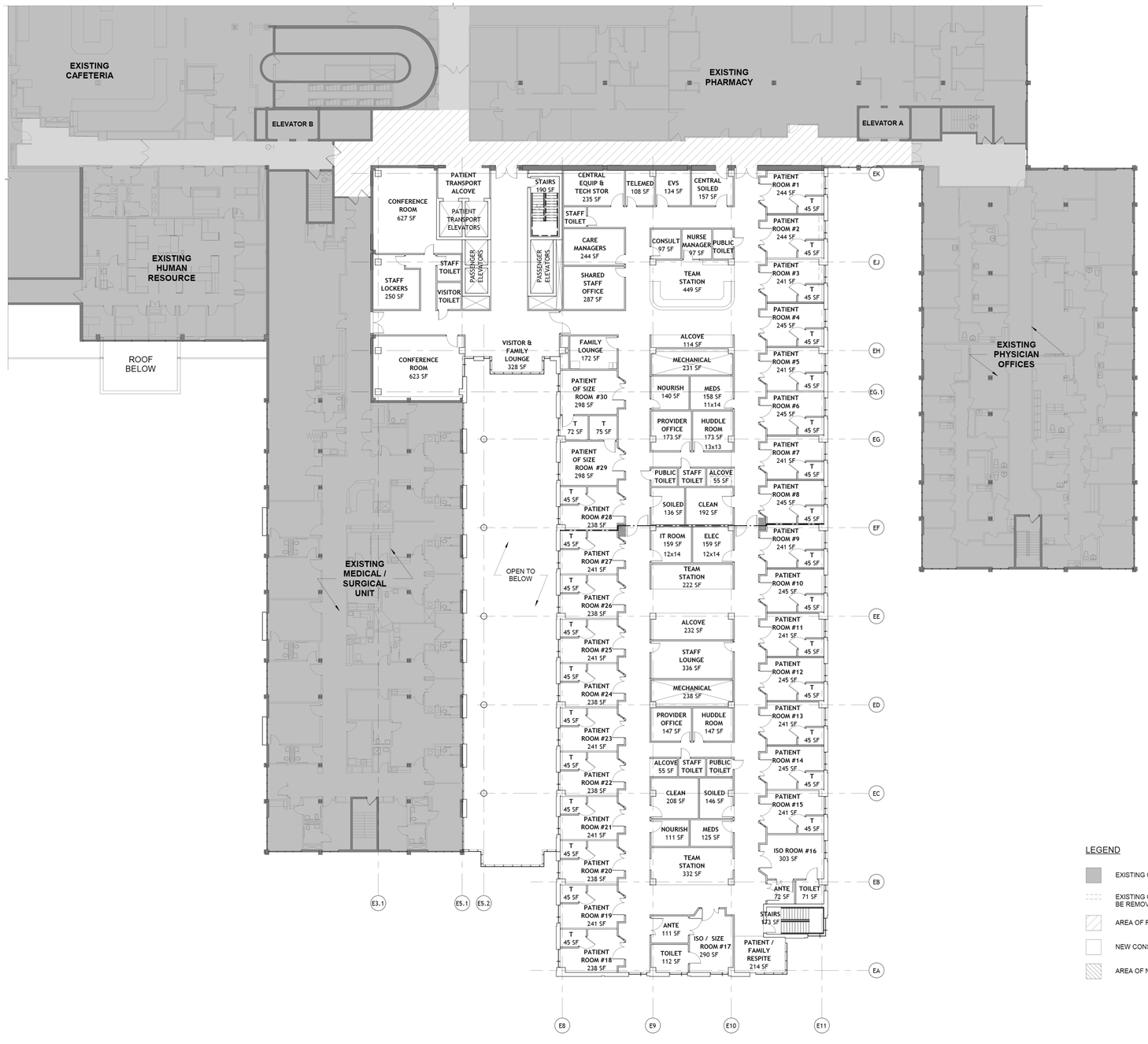
Drawing
LEVEL 4 - FLOOR PLAN

A2.4

PROJECT DRAWINGS

7/12/2019 2:55:22 PM
C:\Users\gmorgan\Documents\219043_GBMC Bed Tower_2019_gmorgan.rvt



1 LEVEL 5 - FLOOR PLAN

A2.09 | A2.5 | 1/16" = 1'-0"

LEGEND

- EXISTING CONDITIONS
- EXISTING CONSTRUCTION TO BE REMOVED
- AREA OF RENOVATION
- NEW CONSTRUCTION
- AREA OF NEW WORK ABOVE

0 8 16 32

ARCHITECT
Hord Coplan Macht, Inc.
700 E. Pratt St, Suite 1200 Baltimore, MD 21202
p. 410.837.7311 f. 410.837.6530

CIVIL
Site Resources, Inc.
14315 Jarrettsville Pike Phoenix, MD 21131
p. 410.683.3388 f. 410.683.3389

STRUCTURAL
Morabito Consultants
952 Ridgebrook Rd. Sparks Glencoe, MD 21152
p. 410.467.2377 f. 410.467.4132

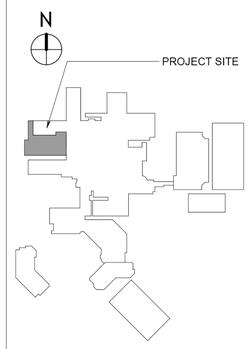
MEP
Leach Wallace Associates, Inc.
6522 Meadowridge Rd. #1 Elkridge, MD 21075
p. 410.579.8100 f. 410.540.9041

GBMC

GREATER BALTIMORE MEDICAL CENTER

PROMISE PROJECT

6701 CHARLES STREET
TOWSON, MD 21204



KEY PLAN

hord | coplan | macht

ARCHITECTURE
LANDSCAPE ARCHITECTURE
PLANNING
INTERIOR DESIGN

PROFESSIONAL CERTIFICATION. I CERTIFY THAT THESE DOCUMENTS WERE PREPARED OR APPROVED BY ME, AND THAT I AM A DULY LICENSED ARCHITECT UNDER THE LAWS OF THE STATE OF MARYLAND
LICENSE NUMBER:
EXPIRATION DATE:

no.	date	revision

Project Name
PROMISE PROJECT

Project Number
219043.10

Date
07/12/2019

Scale
1/16" = 1'-0"

Drawing
LEVEL 5 - FLOOR PLAN

A2.5

PROJECT DRAWINGS

7/12/2019 2:55:23 PM
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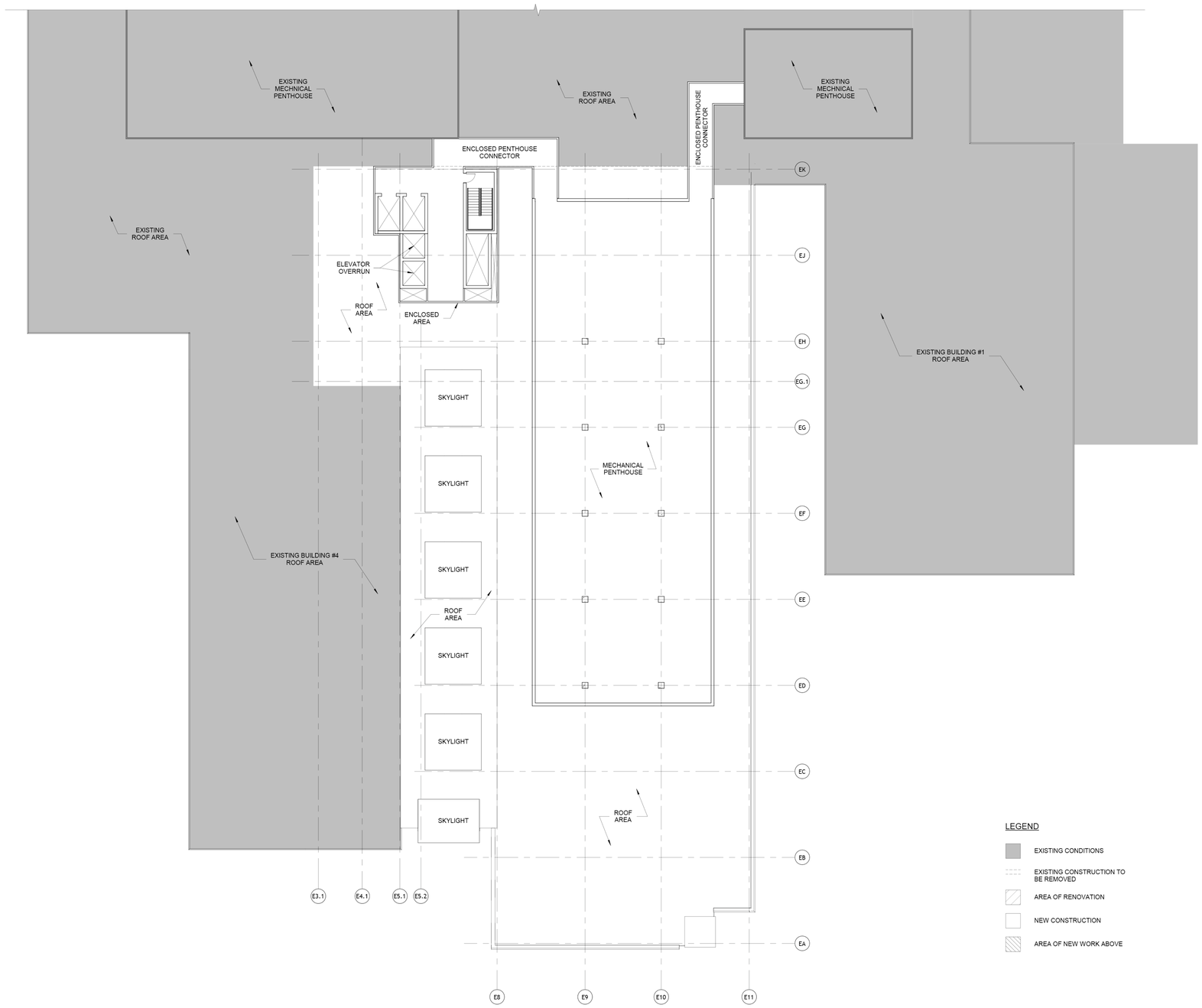


LEGEND

- EXISTING CONDITIONS
- EXISTING CONSTRUCTION TO BE REMOVED
- AREA OF RENOVATION
- NEW CONSTRUCTION
- AREA OF NEW WORK ABOVE

1 LEVEL 6 - PENTHOUSE FLOOR PLAN

A2.09 | A2.6 1/16" = 1'-0"

0 8 16 32

ARCHITECT
Hord Coplan Macht, Inc.
700 E. Pratt St, Suite 1200 Baltimore, MD 21202
p. 410.837.7311 f. 410.837.6530

CIVIL
Site Resources, Inc.
14315 Jarrettsville Pike Phoenix, MD 21131
p. 410.683.3388 f. 410.683.3389

STRUCTURAL
Morabito Consultants
952 Ridgebrook Rd. Sparks Glencoe, MD 21152
p. 410.467.2377 f. 410.467.4132

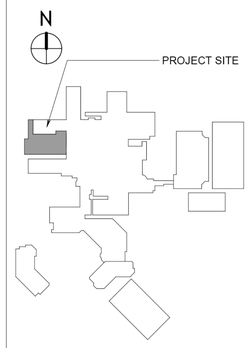
MEP
Leach Wallace Associates, Inc.
6522 Meadowridge Rd. #1 Elkridge, MD 21075
p. 410.579.8100 f. 410.540.9041

GBMC

GREATER BALTIMORE MEDICAL CENTER

PROMISE PROJECT

6701 CHARLES STREET
TOWSON, MD 21204



KEY PLAN

hord | coplan | macht

ARCHITECTURE
LANDSCAPE ARCHITECTURE
PLANNING
INTERIOR DESIGN

PROFESSIONAL CERTIFICATION. I CERTIFY THAT THESE DOCUMENTS WERE PREPARED OR APPROVED BY ME, AND THAT I AM A DULY LICENSED ARCHITECT UNDER THE LAWS OF THE STATE OF MARYLAND
LICENSE NUMBER:
EXPIRATION DATE:

no.	date	revision

Project Name
PROMISE PROJECT

Project Number
219043.10

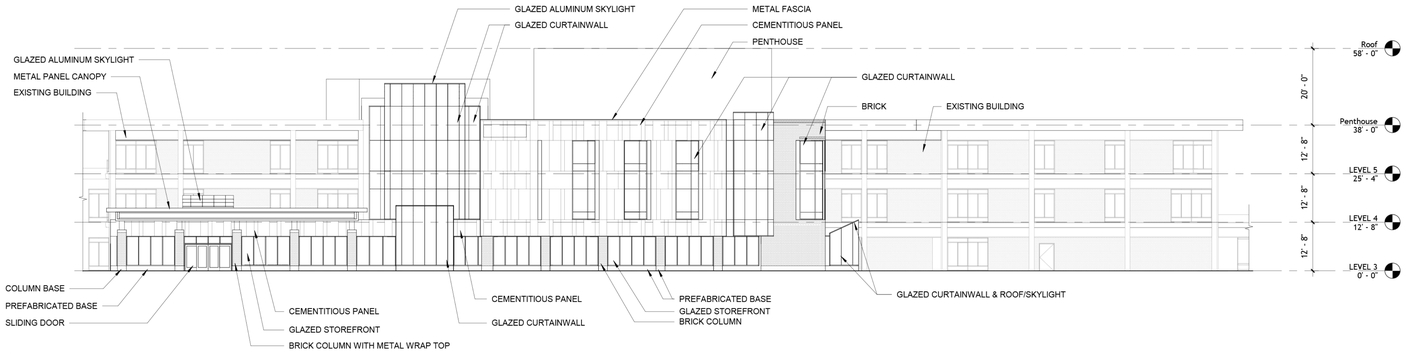
Date
07/12/2019

Scale
1/16" = 1'-0"

Drawing
LEVEL 6 - PENTHOUSE FLOOR PLAN

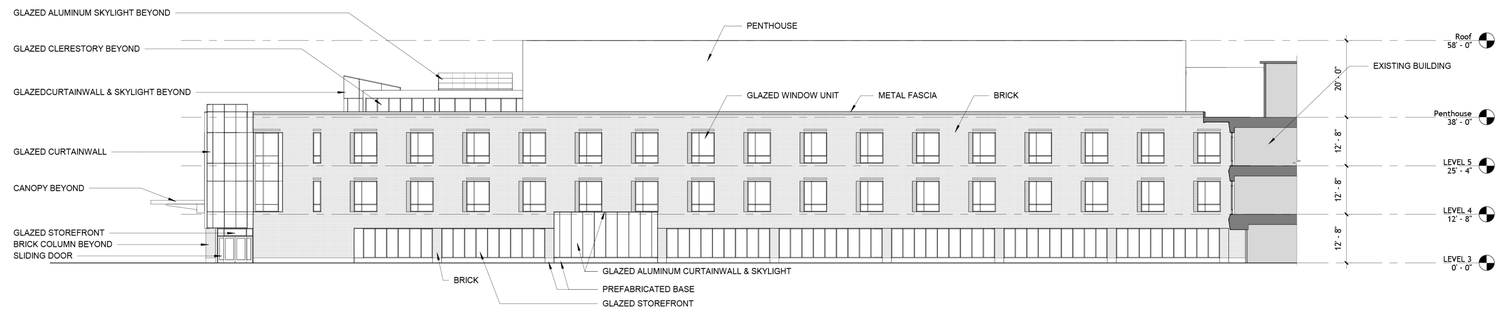
A2.6

PROJECT DRAWINGS



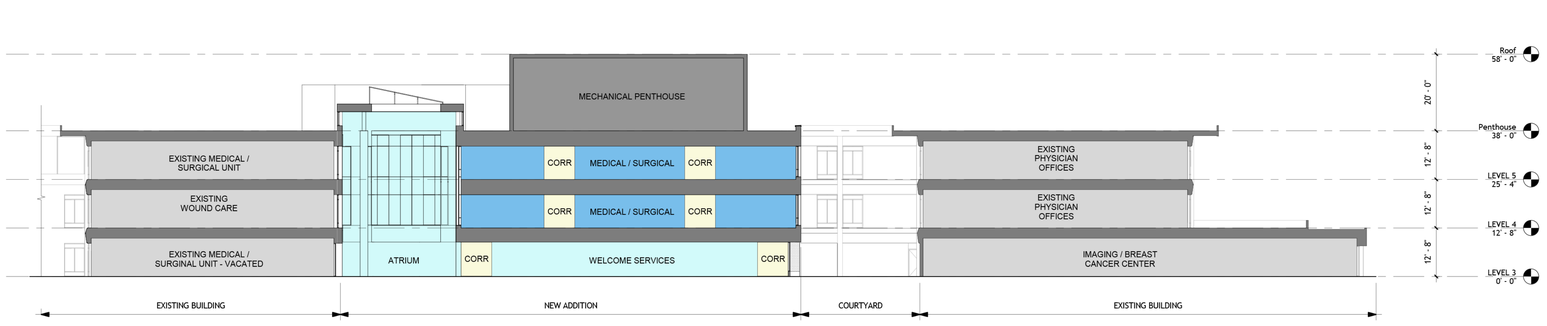
1 WEST ELEVATION

A2.00 | A4.0 1/16" = 1'-0"



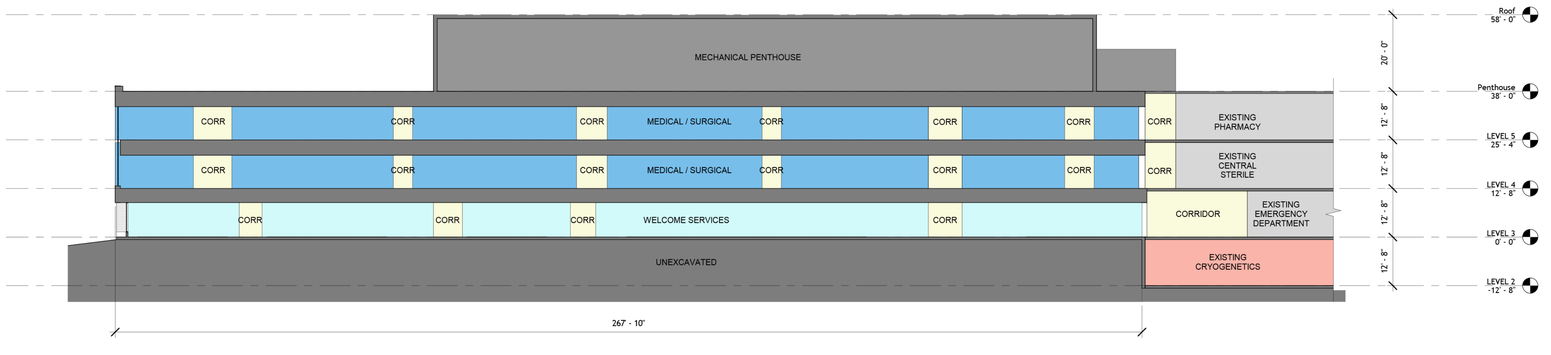
2 SOUTH ELEVATION

A2.00 | A4.0 1/16" = 1'-0"



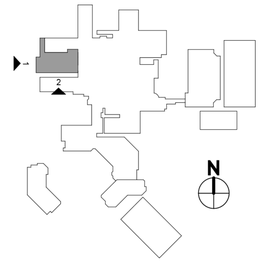
3 STACKING DIAGRAM - CROSS SECTION

A4.0 1/16" = 1'-0"

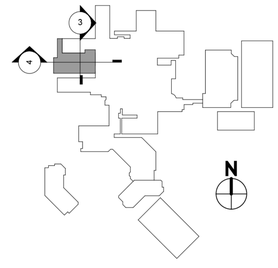


4 STACKING DIAGRAM - LONGITUDINAL SECTION

A2.09 | A4.0 1/16" = 1'-0"



KEY PLAN



KEY PLAN

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p. 410.579.8100 f. 410.540.9041

GBMC

GREATER BALTIMORE MEDICAL CENTER

PROMISE PROJECT

6701 CHARLES STREET
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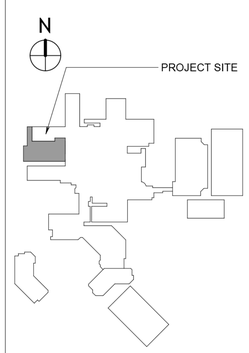

KEY PLAN

hord | coplan | macht

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PLANNING
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LICENSE NUMBER:
EXPIRATION DATE:

no.	date	revision

Project Name
PROMISE PROJECT

Project Number
219043.10

Date
07/12/2019

Scale
As indicated

Drawing
EXTERIOR ELEVATIONS & STACKING DIAGRAMS

A4.0

PROJECT DRAWINGS

7/12/2019 2:55:28 PM
C:\Users\mgnorgan\Documents\219043_GBMC Bed Tower_2019_gnorgan.rvt

EXHIBIT 3

JOHN A. OLSZEWSKI, JR.
County Executive

June 27, 2019

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Greater Baltimore Medical Center (GBMC) HealthCare

Dear Mr. Steffen:

I am writing to express support of the Certificate of Need application submitted by Greater Baltimore Medical Center (GBMC) to build a three-story addition, including 60 inpatient beds.

GBMC HealthCare is a vital employer and health care provider in our community. This capital improvement is necessary to support maintaining and improving GBMC HealthCare's ability to significantly benefit patients' care and comfort. In keeping with GBMC's promise to the community *to provide every patient, every time, with the quality of care we would want for our own families*, this project will modernize patient rooms that have been in place since the hospital opened in 1965. During this process, the smallest inpatient rooms will be eliminated, as they are not suited for today's advanced care, equipment and medical teams.

I respectfully request that the Maryland Health Care Commission approve GBMC HealthCare's Certificate of Need application.

Sincerely,

John A. Olszewski, Jr.
County Executive

Historic Courthouse | 400 Washington Avenue | Towson, Maryland 21204-4665 | Phone 410-887-2450 | Fax 410-887-4049
johnnyo@baltimorecountymd.gov | www.baltimorecountymd.gov

COMPTROLLER of MARYLAND
Serving the People

Peter Franchot
Comptroller

June 26, 2019

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Greater Baltimore Medical Center (GBMC) HealthCare

Dear Mr. Steffen:

I am writing to express my strong support of the Certificate of Need application submitted by Greater Baltimore Medical Center (GBMC) to build a three-story addition including 60 inpatient beds.

GBMC HealthCare is a vital employer and health care provider in our community. To maintain its status, this capital improvement is necessary. The project will modernize patient rooms that opened in 1965 to fulfill GBMC's promise to the community *to provide every patient, every time, with the quality of care we would want for our own families*. A three-story addition will be incorporated into the existing hospital building. This addition will include 60 inpatient beds, eliminating the smallest inpatient rooms and that are not suited for today's advanced care, equipment and medical teams.

Sixty new patient-centered rooms will create medically necessary space and elevate a patient's sense of comfort and control. The direct impact to patients is significant.

I respectfully request that the Maryland Health Care Commission approve GBMC HealthCare's Certificate of Need application. Should you have any questions, please do not hesitate to contact my deputy chief of staff, Emmanuel Welsh, at ewelsh@comp.state.md.us or 410-260-6266.

Sincerely,

Peter Franchot
Comptroller

80 Calvert Street • P.O. Box 466, Annapolis, Maryland 21404-0466 • 410-260-7801 • 1-800-552-3941 (MD)
Fax: 410-974-3808 • Maryland Relay 711 • TTY 410-260-7157 • pfranchot@comp.state.md.us

COUNTY COUNCIL OF BALTIMORE COUNTY
COURT HOUSE, TOWSON, MARYLAND 21204

DAVID MARKS
COUNCILMAN, FIFTH DISTRICT
COUNCIL5@BALTIMORECOUNTYMD.GOV

COUNCIL OFFICE: 410-887-3384
FAX: 410-887-5791

June 26, 2019

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Greater Baltimore Medical Center (GBMC) HealthCare

Dear Mr. Steffen:

I am writing to express my strong support of the Certificate of Need application submitted by Greater Baltimore Medical Center (GBMC) to build a three-story addition including 60 inpatient beds.

GBMC HealthCare is a vital employer and health care provider in our community. To maintain its status, this capital improvement is necessary. The project will modernize patient rooms that opened in 1965 to fulfill GBMC's promise to the community *to provide every patient, every time, with the quality of care we would want for our own families.* A three-story addition will be incorporated into the existing hospital building. This addition will include 60 inpatient beds, eliminating the smallest inpatient rooms and that are not suited for today's advanced care, equipment and medical teams.

Sixty new patient-centered rooms will create medically necessary space and elevate a patient's sense of comfort and control. The direct impact to patients is significant.

I respectfully request that the Maryland Health Care Commission approve GBMC HealthCare's Certificate of Need application.

Sincerely,

David Marks
Baltimore County Councilman

CHRIS WEST
Legislative District 42
Baltimore County

Judicial Proceedings Committee

Vice Chair, Baltimore County
Senate Delegation

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Annapolis Office
James Senate Office Building
11 Bladen Street, Room 303
Annapolis, Maryland 21401
410-841-3648 · 301-858-3648
800-492-7122 *Ext.* 3648
Chris.West@senate.state.md.us

District Office
1134 York Road, Suite 200
Lutherville -Timonium, MD 21093
410-823-7087

June 27, 2019

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Greater Baltimore Medical Center (GBMC) HealthCare

Dear Mr. Steffen:

I am writing to express my strong support of the Certificate of Need application submitted by Greater Baltimore Medical Center (GBMC) to build a three-story addition including 60 inpatient beds.

As you know, GBMC HealthCare is a vital employer and health care provider in our community. To maintain its status, this capital improvement is necessary. The project will modernize patient rooms that opened in 1965 to fulfill GBMC's promise to the community *to provide every patient, every time, with the quality of care we would want for our own families*. A three-story addition will be incorporated into the existing hospital building. This addition will include 60 inpatient beds, eliminating the smallest inpatient rooms and that are not suited for today's advanced care, equipment and medical teams.

Sixty new patient-centered rooms will create medically necessary space and elevate a patient's sense of comfort and control. The direct impact to patients is significant.

I respectfully request that the Maryland Health Care Commission approve GBMC HealthCare's Certificate of Need application.

Sincerely,

Senator Chris West
42nd Legislative District

HEIDI S. KENNY(MD, DC, PA)
JAMES KELLY-LIEB (MD)

KENNY
LAW GROUP, LLC

11426 YORK ROAD | 1ST FLOOR
COCKEYSVILLE, MARYLAND 21030

OFFICE 410.415.7071
FAX 410.415.7161
WWW.KENNY-LAW.COM

July 8, 2019

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Greater Baltimore Medical Center (GBMC) HealthCare

Dear Mr. Steffen:

On behalf of GBMC HealthCare's Philanthropy Committee, I write to express my support of the Certificate of Need application submitted by Greater Baltimore Medical Center (GBMC) to build a three-story addition including 60 inpatient beds.

The purpose of the capital project is to modernize patient rooms that opened in 1965 to fulfill GBMC's promise to the community *to provide every patient, every time, with the quality of care we would want for our own families*. A three-story addition will be incorporated into the existing hospital building. This addition will include 60 inpatient beds, eliminating the smallest inpatient rooms and that are not suited for today's advanced care, equipment and medical teams.

Sixty new patient-centered rooms will create medically necessary space and elevate a patient's sense of comfort and control. The direct impact to patient care and our community is significant.

I urge the Maryland Health Care Commission approve GBMC HealthCare's Certificate of Need application.

Sincerely,

Heidi Kenny-Berman, Esq.
Chair, Philanthropy Committee
GBMC HealthCare

GBMC

July 8th, 2019

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Greater Baltimore Medical Center (GBMC) HealthCare

Dear Mr. Steffen:

On behalf of GBMC's Patient and Family Advisory Council (PFAC), I support the Certificate of Need application submitted by Greater Baltimore Medical Center (GBMC) to build a three-story addition including 60 inpatient beds.

The purpose of the capital project is to modernize patient rooms that opened in 1965 to fulfill GBMC's promise to the community *to provide every patient, every time, with the quality of care we would want for our own families*. A three-story addition will be incorporated into the existing hospital building. This addition will include 60 inpatient beds, eliminating the smallest inpatient rooms and that are not suited for today's advanced care, equipment and medical teams.

Sixty new patient-centered rooms will create medically necessary space and elevate a patient's sense of comfort and control.

I respectfully request that the Maryland Health Care Commission approve GBMC HealthCare's Certificate of Need application.

Sincerely,

Cate O'Connor-Devlin 7/8/2019.

Cate O'Connor-Devlin
Senior Director of Patient Experience

May 30, 2019

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Greater Baltimore Medical Center (GBMC) HealthCare

Dear Mr. Steffen:

I am writing on behalf of The Presbyterian Eye, Ear, and Throat Charity Hospital Board of Governors to express my strong support for the Certificate of Need application submitted by Greater Baltimore Medical Center (GBMC HealthCare) to build a three-story addition including 60 inpatient medical/telemetry beds. As a representative of one of the founding hospital's that merged to create GBMC in 1965, it is with extreme confidence that we send this letter as we believe that GBMC has earned its national reputation through the foresight of its founders, the commitment of its leaders, and the talent and energy of its staff.

The purpose of the capital project is to modernize patient rooms that opened in 1965 to fulfill GBMC's promise to the community *to provide every patient, every time, with the quality of care we would want for our own families*. A three-story addition will be incorporated into the existing hospital building. This addition will include 60 inpatient medical/telemetry beds, eliminating the smallest inpatient rooms that are not suited for today's advanced care, equipment and medical teams.

Sixty new patient-centered rooms will create medically necessary space, and elevate a patient's sense of comfort and control. The direct impact to GBMC patients and our community is significant.

I respectfully request that the Maryland Health Care Commission approve GBMC HealthCare's Certificate of Need application.

Sincerely,

Stephen Plano
President, The Presbyterian Eye, Ear, and Throat Charity Hospital Board

GBMC

Department of Anesthesiology
John J. Kuchar, Jr., M.D.
Chairman, Department of Anesthesiology

Office: 443-849-2202
Fax: 443-849-3241

June 21, 2019

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Greater Baltimore Medical Center (GBMC) HealthCare

Dear Mr. Steffen:

As a member of the GBMC HealthCare medical staff, I enthusiastically support the Certificate of Need application submitted by Greater Baltimore Medical Center (GBMC) to build a three-story addition including 60 inpatient beds.

The purpose of the capital project is to modernize patient rooms that opened in 1965 to fulfill GBMC's promise to the community *to provide every patient, every time, with the quality of care we would want for our own families*. A three-story addition will be incorporated into the existing hospital building. This addition will include 60 inpatient beds, replacing our present unsuitably small inpatient rooms that are not adequate for today's advanced care, equipment and medical teams.

Sixty new patient-centered rooms will create medically necessary space, and elevate a patient's sense of comfort and control. The direct impact to GBMC patients and our community is significant.

I respectfully request that the Maryland Health Care Commission approve GBMC HealthCare's Certificate of Need application.

Sincerely,

John J. Kuchar, MD
Chairman, Department of Anesthesiology

GBMC
HEALTHCARE

Neal M. Friedlander, M.D., F.A.C.P.
Chairman, Department of Medicine

Administrative Office: (443) 849-2680
Fax: (443) 849-6812

DonWander A. Doswell
Executive Assistant

June 21, 2019

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Greater Baltimore Medical Center (GBMC) HealthCare

Dear Mr. Steffen:

As a member of the GBMC HealthCare medical staff, I support the Certificate of Need application submitted by Greater Baltimore Medical Center (GBMC) to build a three-story addition including 60 inpatient beds.

The purpose of the capital project is to modernize patient rooms that opened in 1965 to fulfill GBMC's promise to the community *to provide every patient, every time, with the quality of care we would want for our own families.* A three-story addition will be incorporated into the existing hospital building. This addition will include 60 inpatient beds, eliminating the smallest inpatient rooms and that are not suited for today's advanced care, equipment and medical teams.

I urge the Maryland Health Care Commission to approve GBMC HealthCare's Certificate of Need application. This project will better meet the current needs of patients and allow GBMC HealthCare to adapt to the changing health care needs of our community.

Sincerely,

Neal M. Friedlander, M.D., F.A.C.P.
Chairman Department of Medicine

GBMC

MELISSA SPARROW, M.D.
Chief of Staff

Office: 443-849-2370
Fax: 443-849-3776

June 24, 2019

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Greater Baltimore Medical Center (GBMC) HealthCare

Dear Mr. Steffen:

I am writing on behalf of GBMC HealthCare's Medical Staff representing 1,100 physicians who serve the local community by providing high quality healthcare at GBMC Hospital, multiple Primary Care office sites, and Gilchrist. GBMC HealthCare's Medical Staff strongly supports the Certificate of Need application submitted by Greater Baltimore Medical Center (GBMC) to build a three-story addition to the hospital that will create space for 60 new inpatient beds.

The purpose of the capital project is to modernize patient rooms that were opened in 1965 to fulfill GBMC's promise to the community *to provide every patient, every time, with the quality of care we would want for our own families*. The three-story addition will be incorporated into the existing hospital building. This addition of 60 inpatient beds will eliminate the smallest inpatient rooms that are no longer suited for today's advanced levels of care, interdisciplinary medical teams, and state-of-the-art technology and equipment. We also recognize from listening to the voice of our customers, that patients feel more comfortable and able to be supported by families when they have rooms that can accommodate visitors. Family advocacy and social support has been shown to vital to healing process. Thus, the direct impact of this construction project to GBMC patients and our community will be significant.

I respectfully request that the Maryland Health Care Commission approve GBMC HealthCare's Certificate of Need application. Sixty new inpatient rooms will better meet the needs of our patient population and allow GBMC Healthcare to adapt to the changing needs of our community.

Sincerely,

Melissa Sparrow, MD, FAAP
Chief of Staff

Women's Hospital Foundation, Inc.
102 W. Pennsylvania Avenue
Suite 600
Towson, MD 21204

Catherine J. Boyne
President, Board of Directors
whfpresident@gmail.com

July 1, 2019

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Greater Baltimore Medical Center (GBMC) HealthCare

Dear Mr. Steffen:

I am writing on behalf of The Women's Hospital Foundation representing one of the two founding hospitals that merged to form Greater Baltimore Medical Center (GBMC) over 50 years ago. The Women's Hospital Foundation strongly supports the Certificate of Need application submitted by Greater Baltimore Medical Center (GBMC) to build a three-story addition including 60 inpatient beds.

The purpose of the capital project is to modernize patient rooms that opened in 1965 to fulfill GBMC's promise to the community *to provide every patient, every time, with the quality of care we would want for our own families*. A three-story addition will be incorporated into the existing hospital building. This addition will include 60 inpatient beds, eliminating the smallest inpatient rooms, when built 50 years ago were state of the art and now are not suited for today's advanced care, equipment and medical teams.

Sixty new patient-centered rooms will create medically necessary space, and elevate a patient's sense of comfort and control. The direct clinical impact to GBMC patients and our community is significant and will continue the tradition of patient-centered care established by the Women's Hospital in 1882.

On behalf of the Foundation Board, I respectfully request that the Maryland Health Care Commission approve GBMC HealthCare's Certificate of Need application.

Sincerely,

Catherine J. Boyne
President

TOWSON
CHAMBER OF COMMERCE

July 12, 2019

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Greater Baltimore Medical Center (GBMC) HealthCare

Dear Mr. Steffen:

I am writing on behalf of the Towson Chamber of Commerce to express our support of the Certificate of Need application submitted by Greater Baltimore Medical Center (GBMC) to build a three-story addition including 60 inpatient beds.

The purpose of the capital project is to modernize patient rooms that opened in 1965 to fulfill GBMC's promise to the community *to provide every patient, every time, with the quality of care we would want for our own families*. A three-story addition will be incorporated into the existing hospital building. This addition will include 60 inpatient beds, eliminating the smallest inpatient rooms and that are not suited for today's advanced care, equipment and medical teams.

Sixty new patient-centered rooms will create medically necessary space, and elevate a patient's sense of comfort and control. The direct impact to GBMC patients and our community is significant.

GBMC HealthCare's presence in Towson is vital to our community's health. This project will make Towson a better place to live, visit and work.

I respectfully request that the Maryland Health Care Commission approve GBMC HealthCare's Certificate of Need application.

Sincerely,

Nancy Hafford
Executive Director, Towson Chamber Of Commerce

Mission Statement: The Towson Chamber of Commerce, Inc. Promotes the Business Environment in Towson

GBMC

RADIATION ONCOLOGY HEALTHCARE, P.A.

ROBERT K. BROOKLAND, M.D. F.A.C.R.O., F.A.C.R.
Chairman
Department of Radiation Oncology

SHEILA K. RIGGS RADIATION ONCOLOGY CENTER
443 849 2540
FAX 443 849 2595
rbrookla@gbmc.org

July 15, 2019

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Greater Baltimore Medical Center (GBMC) HealthCare

Dear Mr. Steffen:

As a member of the GBMC HealthCare medical staff, I support the Certificate of Need application submitted by Greater Baltimore Medical Center (GBMC) to build a three-story addition including 60 inpatient beds.

The purpose of the capital project is to modernize patient rooms that opened in 1965 to fulfill GBMC's promise to the community *to provide every patient, every time, with the quality of care we would want for our own families*. A three-story addition will be incorporated into the existing hospital building. This addition will include 60 inpatient beds, eliminating the smallest inpatient rooms and that are not suited for today's advanced care, equipment and medical teams.

Sixty new patient-centered rooms will create medically necessary space and elevate a patient's sense of comfort and control. The direct impact to patients is significant and helps GBMC HealthCare adapt to the changing health care needs of our community.

I respectfully request that the Maryland Health Care Commission approve GBMC HealthCare's Certificate of Need application.

Sincerely,

Robert K. Brookland, MD
Chairman, Department of Radiation Oncology

ADVANCED RADIOLOGY

Advanced Radiology, P.A.
7253 Ambassador Road
Baltimore, MD 21244-2714

June 26, 2019

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Greater Baltimore Medical Center (GBMC) HealthCare

Dear Mr. Steffen:

I am writing to express my strong support for the GBMC Certificate of Need application submitted by Greater Baltimore Medical Center (GBMC) to build a three-story addition including 60 inpatient beds.

The purpose of the capital project is to modernize patient rooms that opened in 1965 to fulfill GBMC's promise to the community *to provide every patient, every time, with the quality of care we would want for our own families*. A three-story addition will be incorporated into the existing hospital building. This addition will include 60 inpatient beds, eliminating the smallest inpatient rooms and that are not suited for today's advanced care, equipment and medical teams.

I urge the Maryland Health Care Commission to approve GBMC HealthCare's Certificate of Need application. This project will better meet the current needs of patients and allow GBMC HealthCare to adapt to the changing health care needs of our community.

Sincerely,

Kenneth E. Ames
Senior Vice President – Mid-Atlantic Operations

EXHIBIT 4

THIS DEED, Made this 10th day of May, in the year one thousand nine hundred and sixty-three, by and between THE TRUSTEES OF THE SHEPPARD AND ENOCH PRATT HOSPITAL, a body corporate, duly incorporated under the Laws of the State of Maryland, party of the first part, Grantor, and GREATER BALTIMORE MEDICAL CENTER, INC., a body corporate, duly incorporated under the Laws of the State of Maryland, party of the second part, Grantee.

NOW, THEREFORE, THIS DEED WITNESSETH: That in consideration of the premises and the sum of Five Dollars ($5.00), the receipt of which is hereby acknowledged, the said party of the first part does hereby grant and convey, subject to and with the benefit of the covenants, conditions, restrictions, reservations and easements hereinafter set forth, unto the said party of the second part, its successors and assigns, in fee simple, all that piece or parcel of land situate, lying and being in the Ninth Election District of Baltimore County, State of Maryland, and described as follows, to wit:

BEGINNING for the same at a point in the third line of a parcel of land which by a Deed dated March 4, 1918 and recorded among the Land Records of Baltimore County in Liber W.P.C. No. 493, folio 473, was conveyed by the Title Guarantee and Trust Company to The Trustees of the Sheppard and Enoch Pratt Hospital, said point being distant south 26 degrees 23 minutes west, as the courses are referred to the true meridian, 101.36 feet measured along said third line from a stone heretofore set at the beginning of said line, and running thence, for lines of division as now made through the land of the Grantor herein, the nine following courses and distances, viz: south 45 degrees 06 minutes 34 seconds east 167.51 feet to a concrete monument, south 59 degrees 57 minutes east 310 feet to a concrete monument, south 06 degrees 44 minutes 36 seconds east 198.66 feet to a concrete monument, south 53 degrees 53 minutes 59 seconds west 155 feet to a concrete monument, south 80 degrees 00 minutes west 165 feet to a concrete monument, south 24 degrees 25 minutes 09 seconds west 147.50 feet to a concrete monument, south 06 degrees 37 minutes 31 seconds east 297 feet to a concrete monument, south 40 degrees 40 minutes east 240 feet to a concrete monument and south 52 degrees 00 minutes west 433.40 feet to the northeast right of way line of Charles Street Avenue, as laid out on Plat No. 10747 of the State Roads Commission of Maryland, thence, binding on the northeasternmost, the easternmost and the southeasternmost right of way lines of Charles Street Avenue, as laid out on Plats Nos. 10747, 10748, 10749 and 16837 of the State Roads Commission of Maryland, the thirty-five following lines, viz: northwesterly, by a line curving toward the left, having a radius of 653.11 feet, for a distance of 148.53 feet (the chord of said arc bearing north 38 degrees 34 minutes 56 seconds west 148.21 feet), north 44 degrees 54 minutes 10 seconds east 35 feet, north 47 degrees 28 minutes 20 seconds west 57.03 feet, south 40 degrees 09 minutes 10 seconds west 35 feet, northwesterly, by a line curving toward the left, having a radius of 653.11 feet, for a distance of 162.44 feet (the chord of said arc bearing north 56 degrees 58 minutes 20 seconds west 162.02 feet), north 25 degrees 54 minutes 10 seconds east 30 feet, north 66 degrees 28 minutes 20 seconds west 56.61 feet, south 21 degrees 09 minutes 10 seconds west 30 feet, northwesterly, by a line curving toward the left, having a radius of 653.11 feet, for a distance of 2.87 feet (the chord of said arc bearing north 68 degrees 58 minutes 23 seconds west 2.85 feet), north 69 degrees 05 minutes 56 seconds west 47.35 feet, north 20 degrees 54 minutes 04 seconds east 30 feet, north 69 degrees 05 minutes 56 seconds west 50 feet, south 20 degrees 54 minutes 04 seconds west 30 feet, north 69 degrees 05 minutes 56 seconds west 355.71 feet, northwesterly, by a line curving toward the right, having a radius of 553.11 feet for a distance of

155.26 feet (the chord of said arc bearing north 61 degrees 03 minutes 28 seconds west 154.74 feet), north 36 degrees 59 minutes east 25 feet, north 50 degrees 38 minutes 30 seconds west 43.77 feet, south 41 degrees 44 minutes west 25 feet, northwesterly, by a line curving toward the right, having a radius of 553.11 feet, for a distance of 206.35 feet (the chord of said arc bearing north 37 degrees 34 minutes 45 seconds west 205.15 feet), north 63 degrees 06 minutes 30 seconds east 35 feet, northwesterly, by a line curving toward the right, having a radius of 518.11 feet, for a distance of 128.86 feet (the chord of said arc bearing north 19 degrees 46 minutes west 128.53 feet), north 69 degrees 03 minutes west 41.42 feet, northerly, by a line curving toward the right, having a radius of 553.11 feet, for a distance of 134.96 feet (the chord of said arc bearing north 03 degrees 16 minutes 36 seconds west 134.63 feet), north 03 degrees 42 minutes 49 seconds east 752.84 feet, south 86 degrees 17 minutes 11 seconds east 40 feet, north 03 degrees 42 minutes 49 seconds east 50 feet, north 54 degrees 17 minutes 11 seconds west 47.17 feet, north 03 degrees 42 minutes 49 seconds east 166.57 feet, northeasterly, by a line curving toward the right, having a radius of 1095.92 feet, for a distance of 438.43 feet (the chord of said arc bearing north 15 degrees 10 minutes 20 seconds east 435.49 feet), south 63 degrees 21 minutes 54 seconds east 10 feet, north 28 degrees 25 minutes east 67.88 feet, north 43 degrees 30 minutes 30 seconds east 56.53 feet, north 56 degrees 41 minutes 50 seconds east 141.32 feet, north 58 degrees 28 minutes 05 seconds east 138.17 feet and north 62 degrees 12 minutes 02 seconds east 21.50 feet, and thence leaving the right of way lines of Charles Street Avenue and running for lines of division, the four following courses and distances, viz: south 37 degrees 46 minutes 55 seconds east 1085.85 feet to a concrete monument, south 07 degrees 05 minutes west 180 feet to a concrete monument, south 02 degrees 40 minutes 53 seconds east 115.22 feet to a concrete monument and south 45 degrees 06 minutes 34 seconds east 36.04 feet to the place of beginning. Containing 57.933 acres of land, more or less.

SUBJECT to the easement areas as shown on Plats Nos. 10747, 10748, 10749 and 16387 of the State Roads Commission of Maryland.

BEING a part of the land described in the three following Deeds, viz:

(1) Deed dated July 10, 1858 and recorded among the Land Records of Baltimore County in Liber G.H.C. No. 22, folio 274, from Rachel P. Brown, widow, et al, Trustees, to the Trustees of the Sheppard Asylum;

(2) Deed dated November 8, 1858 and recorded among said Land Records in Liber G.H.C. No. 23, folio 468, from Rebecca Bowen et al to the Trustees of the Sheppard Asylum; and

(3) Deed dated March 4, 1918 and recorded among said Land Records in Liber W.P.C. No. 493, folio 473, from the Title Guarantee and Trust Company to The Trustees of the Sheppard and Enoch Pratt Hospital.

BY the Acts of the General Assembly of 1898, Chapter 17, Trustees of the Sheppard Asylum changed its corporate name to The Trustees of the Sheppard and Enoch Pratt Hospital.

TOGETHER with the buildings and improvements thereupon; and the rights, alleys, ways, waters, privileges, appurtenances and advantages to the same belonging or in anywise appertaining.

TO HAVE AND TO HOLD said piece or parcel of land, with the appurtenances aforesaid, unto and to the use of the said party of the second part, its successors and assigns, in fee simple, forever, free and clear of any and all of the terms, conditions and restrictions contained in the Agreement dated June 11, 1960, between the party of the first part and the Hospital for the Women of Maryland, Inc. and the

Presbyterian Eye, Ear and Throat Charity Hospital, Inc., recorded among the Land Records of Baltimore County in Liber W.J.R. No. 3715, folio 385, except such terms, conditions and restrictions as are incorporated in this Deed, subject, nevertheless, to and with the benefit of the following covenants, conditions, restrictions, reservations and easements, which shall run with and bind and enure to the benefit of the land hereby conveyed and all subsequent owners and occupants thereof and which shall run with and bind and enure to the benefit of the land retained by the Grantor and all subsequent owners and occupants thereof:-

1. That in the event the party of the second part shall not begin constructing hospital buildings on the parcel of land hereby conveyed within five (5) years from the date hereof, the party of the second part will resell said parcel of land to the party of the first part at the purchase price thereof and the party of the first part will repurchase said land for said purchase price.

2. That the party of the first part will permit the establishment of easements and other appropriate means of access over its retained land for all utilities, except roads, necessary for the operation of a hospital by the party of the second part on the land hereby conveyed, in such locations as shall be mutually agreed upon between the parties hereto; and the party of the second part will likewise permit the establishment and maintenance of easements and other appropriate means of access for similar purpose by the party of the first part over the land conveyed hereby.

3. Each of the parties hereto covenants and agrees that it, and its successors and assigns, will consent to and approve in writing, and in no way object to or oppose any rezoning to permit any type of residential, hospital, educational or religious use of all or any part of the property hereby conveyed to the party of the second part or owned by the party of the first part in Baltimore County, whether said zoning is sought to be obtained by either of said parties, or their successors or assigns, and it is understood and agreed by both parties that this covenant shall not preclude either party, its successors or assigns, from seeking and attempting to obtain rezoning of the property hereby conveyed or the property now owned by the party of the first part in Baltimore County for uses other than those specified hereinabove.

AND the said Grantor covenants that it will warrant specially the property hereby granted and conveyed, and that it will execute such further assurances of said land as may be requisite.

WITNESS the signature of THE TRUSTEES OF THE SHEPPARD AND ENOCH PRATT HOSPITAL, the Grantor herein, by the hand of Blair Forbush, its President, and its corporate seal hereto affixed; and

WITNESS ALSO the signature of GREATER BALTIMORE MEDICAL CENTER, INC., the Grantee herein, by the hand of John E Motz, its President, and its

corporate seal hereto affixed.

ATTEST:

Alfred W. Strahan
Secretary
ALFRED W STRAHAN

THE TRUSTEES OF THE SHEPPARD AND ENOCH PRATT HOSPITAL

By Bliss Forbush
President
BLISS FORBUSH

Barry Bowers
Secretary
BARRY BOWERS

GREATER BALTIMORE MEDICAL CENTER, INC.

By John E. Metz
President
JOHN E. METZ

STATE OF MARYLAND, BALTIMORE CITY, TO WIT:

I HEREBY CERTIFY that on this 10th day of May, 1963, before me, a Notary Public of said State, personally appeared Bliss Forbush who acknowledged himself to be the President of THE TRUSTEES OF THE SHEPPARD AND ENOCH PRATT HOSPITAL, a corporation, and that he, as such President, being authorized so to do, executed the foregoing instrument for the purposes therein contained by signing, in my presence, the name of said corporation by himself as President.

WITNESS my hand and Notarial Seal.

George M Bugby
Notary Public
GEORGE M. BUGBY

My commission expires: 5/3/65

TRANSFER TAX NOT REQUIRED

Norman W. Wood
Director of Finance

Per: E. H. Schlueter
Authorized Signature

STATE OF MARYLAND, BALTIMORE CITY, TO WIT:

I HEREBY CERTIFY that on this 10th day of May, 1963, before me, a Notary Public of said State, personally appeared John E. Metz, who acknowledged himself to be the President of GREATER BALTIMORE MEDICAL CENTER, INC., a corporation, and that he, as such President, being authorized to so do, executed the foregoing instrument for the purposes therein contained by signing, in my presence, the name of said corporation by himself as President.

WITNESS my hand and Notarial Seal.

George M Bugby
Notary Public
GEORGE M. BUGBY

My commission expires: 5/3/65

Filed for record MAY 10 1963 at 1 P.M.
Recorded by THE TITLE GUARANTEE COMPANY
Receipt No. 29835

EXHIBIT 5

Current Status: *Active*			**PolicyStat ID:** *6665608*
	Origination:	*7/15/2019*	
	Effective:	*7/15/2019*	
	Last Approved:	*7/15/2019*	
	Last Revised:	*7/15/2019*	
	Next Review:	*7/14/2022*	
	Owner:	*Joshua Campbell: Executive Director of Reimbursement*	
	Department:	*Finance*	
	Regulation/Accreditation:		
	Applicability:	*GBMC*	

Hospital Charges

POLICY STATEMENT

GBMC is committed to providing pricing information for the services we provide to the communities we serve. Disclosure of the cost of hospital care allows for improved care decision making and patient satisfaction. The hospital will make available price estimates of common procedures as well as its Charge Description Master.

DEFINITIONS

A. Charge Description Master ("CDM"): A detailed list of each individual service that may be provided at the hospital and the corresponding charge / fee.

B. Representative list of services and charges: A list containing: (1) the average charge per case for the ten most frequently occurring inpatient diagnoses (determined by APR-DRG) for discharged medical /surgical patients, and also for discharged obstetrical, pediatric, and acute psychiatric patients, if the hospital operates an inpatient unit for any of these latter three services; and (2) the average charge per procedure for the ten most frequently occurring outpatient procedures (defined by CPT codes) in three clinical areas: diagnostic imaging; outpatient surgery; and laboratory services. This list is to be updated, with respect to APR-DRGs, CPT codes, and charges, at least quarterly.

PROCEDURES FOR STANDARD WORK

A. **REPRESENTATIVE LIST OF SERVICES & CHARGES**:

1. In order to provide the public with estimated charge information for hospital services, a CDM, will be made available on the GBMC website (https://www.gbmc.org/hospital-charges). On a quarterly basis the Reimbursement Department will publish the CDM in a downloadable Excel format.
2. GBMC will also maintain a representative list of services and charges, which will be updated on a quarterly basis. The representative list of services and charges will be made available in writing at the hospital, and on the GBMC website.

B. **PATIENT ESTIMATE INQUIRIES**: In addition to posting price estimates for common procedures, GBMC also provides the ability for prospective patients to obtain pricing estimates via individual requests. The Patient Financial Services Department is available 7:00am to 3:30pm Monday through Friday at (443) 849-4411 to provide charge estimates for services provided by the hospital. The Patient Financial Services Department is committed to responding to charge inquiries within two business days with

estimates that are valid for 30 days.

C. **STAFF TRAINING & EDUCATION:** The Patient Financial Services Department is responsible for providing the appropriate training to staff members to ensure they are capable of responding to inquiries regrading charges for hospital services. Both during initial training and routine training sessions, staff will be apprised of their competency in addressing price estimate inquiries.

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
	LAURIE BEYER	7/15/2019
	Joshua Campbell	7/12/2019

Applicability

GBMC

EXHIBIT 6

Current Status: *Active*	**PolicyStat ID:** *6663586*
Origination:	*6/19/2019*
Effective:	*7/15/2019*
Last Approved:	*7/15/2019*
Last Revised:	*7/15/2019*
Next Review:	*7/14/2022*
Owner:	*Joshua Campbell: Executive Director of Reimbursement*
Department:	*Finance*
Regulation/Accreditation:	
Applicability:	*GBMC, GBMC Health Partners*

Financial Assistance

POLICY STATEMENT

GBMC 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 emergent and medically necessary care based on their individual financial situation.

All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent/ urgent services, applications for financial assistance will be completed and evaluated retrospectively and will not delay a patient from receiving care.

GBMC patients, depending on their financial condition and subject to the criteria in this policy, may be eligible to receive medical assistance (Medicaid), financial assistance or extended payment plans. To be consistent in the provision of financial assistance with all members of the community, GBMC applies definitive criteria, outlined herein, when making its financial assistance determination.

This policy covers all hospital facility services and services provided by GBMC physician practices/practice groups delivering emergent or medically necessary care. This policy does not cover emergent or medically necessary care provided by non-employed providers with privileges at GBMC (see **Exhibit A** for a listing of GBMC Physician Practices and Practice Groups covered under this policy).

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.

GBMC will give notice of its Financial Assistance Policy by providing access on its website and patient portal; providing notice of the policy in a newspaper with circulation in GBMC's service area on an annual basis; providing hard copies upon request and by mail free of charge; by providing notice and information about the policy on its billing statements, as part of the pre-admission, registration and discharge process; and, by displaying information about the policy at the Billing Office and all hospital registration points, which includes the Emergency Department. Upon request, GBMC will translate the policy into all primary languages of all significant patient populations in the community with limited English proficiency.

DEFINITIONS

A. Eligible Services: Services considered medically necessary may be eligible for financial assistance. Services considered elective are not eligible for financial assistance. Services for patients who incur additional out-of-pocket expenses by going out of their health insurance network, as specified by their insurance carrier, are not eligible for consideration.

B. Liquid Assets: Cash, securities, promissory notes, stocks, bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property easily convertible to cash. A safe harbor of $150,000 in equity in a patient's primary residence shall not be considered an asset convertible to cash. Equity in other real property shall be subject to liquidation. Liquid Assets do not include retirement assets to which the IRS has granted preferential tax treatment.

PROCEDURES FOR STANDARD WORK

A. **APPLICATION REQUIREMENTS**

1. Self-pay patients who are scheduled for non-emergency surgery must complete a financial assistance application prior to the scheduled procedure or be required to pay a deposit prior to the surgery.
2. Patients meeting eligibility criteria for medical assistance (Medicaid) must apply and be determined ineligible prior to GBMC's final financial assistance determination.
3. GBMC requires patients to submit a Maryland Uniform Financial Assistance Application (**Exhibit B**) and any of the applicable documentation listed on the financial assistance application letter (**Exhibit C**) or otherwise requested by GBMC that applies to the patient and other adult members of the household, including but not limited to:
    a. Two (2) most recent paystubs for patient and any other person whose income is considered part of the family income, as defined by Medicaid regulations;
    b. A copy of patient's Federal Income Tax Return (if married and filing separately, then a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income, as defined by Medicaid regulations);
    c. A copy of patient's or household member's Social Security award letter, if applicable;
    d. A copy of patient's Medical Assistance determination letter, if applicable;
    e. Proof of disability income, if applicable;
    f. If unemployed, proof of unemployment (e.g. Statement from the Office of Unemployment Insurance);
    g. Proof of citizenship and Maryland residence;
    h. Relevant statements regarding Liquid Assets.

B. **REVIEW PROCESS**

1. To qualify for financial assistance, in any form, a patient must supply all requested documentation and proof to the requesting GBMC Collection Manager or Financial Assistance Coordinator. Failure

to supply requested information or documentation within fifteen (15) days of the date of a request from GBMC may result in a patient's ineligibility for financial assistance.

2. Following a patient's request for financial assistance, application for medical assistance, or both, GBMC will render and communicate to the patient a probable eligibility determination within two (2) business days.

    a. Probable Eligibility: GBMC will provide the patient a probable eligibility determination within two (2) business days of request. To provide a probable eligibility determination, GBMC will utilize the patient's completed and submitted Maryland Uniform Financial Assistance Application **(Exhibit B).** Please note that supporting documentation with the application will assist in the probable determination, but is not required. However, supporting documentation will be required for the final determination

    b. Final eligibility determination will be based on all criteria and requirements set forth in this policy.

3. Each patient must agree to a credit bureau report as a condition of consideration for financial assistance.

4. If a patient is approved for financial assistance or a payment plan, he/she will receive a financial assistance award letter. If a patient is denied financial assistance, he/she will receive a denial letter to the address listed in the financial assistance application.

5. Patients have the right to request an appeal of any denial by responding to the denial letter within fifteen (15) days of the date of the denial letter. Appeals will be reviewed by the Executive Director of Revenue Cycle Management, who will review the documentation submitted and make a determination based on this policy's criteria. The Executive Director of Revenue Cycle Management's decision is final, and patients who appeal an initial determination will receive a final appeal determination letter thirty days prior to any additional collection efforts.

6. Financial assistance awards apply to all open accounts at the time of the financial assistance award and are valid for six months from the date of the financial assistance award for non-Medicare patients and for one year for Medicare patients.

7. Patients with open accounts less than $100 in totality are not eligible for financial assistance.

8. Accounts previously sent to GBMC's Collections Department and written-off as bad debt will not be eligible for financial assistance and will remain bad debt.

C. **COLLECTION EFFORTS:** The billing cycle will initiate fifteen 15 days after date of the denial letter. Three (3) billings statements are sent in 30-day intervals in attempt to collect the outstanding amounts. If there is no collection or payment arrangements made, the outstanding amounts are sent to a collection agency. If a patient files for bankruptcy during the financial assistance application process, award period, or during any collection efforts, the patient should provide written notification from the U.S. Bankruptcy Court to the GBMC Collection Manager.

D. **FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA**

1. For each patient, the percentage of the current Federal Poverty Level ("FPL") will be calculated, based on modified adjust gross income, as defined in the Federal Poverty Guidelines, and family size.

2. For patients 300% FPL or lower, GBMC will provide 100% financial assistance for Eligible Services if

the patient and adult household members have Liquid Assets of $15,000 or less.

3. For patients 301%-500% FPL, GBMC will provide 50% financial assistance for Eligible Services if the patient and adult household members have Liquid Assets of $15,000 or less.
4. For patient's 501% FPL, financial assistance will not be provided by GBMC.

E. **EXCLUSION CRITERIA**

1. Uninsured and under-insured patients who do not meet the financial assistance criteria.
2. Patients who have insurance and chose self-pay for Eligible Services.
3. Patients seeking assistance for non-medically necessary services, including cosmetic procedures.
4. Non-United States citizens and non-Maryland residents.
5. Patients who are non-compliant with enrollment for publicly funded healthcare programs, charity care programs and other forms of financial assistance.
6. Patients who fail to provide accurate and complete financial information within the time frames stated in this FAP.

F. **ASSUMPTIVE FINANCIAL ASSISTANCE:** Assumptive Financial Assistance is a program run in partnership with the TransUnion credit reporting agency. Self-pay accounts for Maryland residents are referred to TransUnion, who utilizes a proprietary credit scoring system to determine the likelihood and ability to pay based on estimated income and family size. The results from the TransUnion credit score are compared to GBMC's Financial Assistance eligibility criteria and a decision is made to write off or to pursue collection on certain accounts.

G. **PAYMENT PLANS**

1. If a patient does not qualify for financial assistance, he/she may request a payment plan of equal monthly payments to pay the balance in full over a maximum of eighteen (18) months, with minimum monthly payments no less than twenty-five ($25) dollars per month.
2. Payment plans are not available for outstanding accounts less than $100.
3. If approved for a payment plan, a patient is set up under a contract in GBMC's medical record system, Epic, and monthly statements will be generated and sent to the patient, indicating the monthly payment amount, due date and balance.
4. Failure to pay under a payment plan by the due date will result in termination of the payment plan and the delinquent account will be sent to the GBMC Collection Manager for collection efforts after a final demand letter is sent and thirty days (30) from the date of the demand letter have passed.

Attachments:

Exhibit A - GBMC Practices
Exhibit B - Maryland Uniform Financial Assistance Application
Exhibit C - Patient Information Sheet and Fullfillment Requirements

Approval Signatures

Step Description	Approver	Date
	LAURIE BEYER	7/15/2019
	Joshua Campbell: Executive Director of Reimbursement	7/12/2019

Applicability

GBMC, GBMC Health Partners

EXHIBIT 7

GREATER BALTIMORE MEDICAL CENTER FINANCIAL ASSISTANCE POLICY

GBMC is committed to providing financial assistance to those who are unable to pay medical bills not covered by insurance. Our mission is to provide medical care and service of the highest quality to each patient leading to health, healing, and hope, regardless of a person's financial situation. All patients presenting for emergency services will be treated as immediately as possible. Financial issues will never delay a patient from receiving care.

Depending on your individual situation, you may be eligible for financial assistance through the local Departments of Social Services. We encourage patients and families who are undergoing financial hardships to pursue Maryland Medicaid and other programs through the Maryland Department of Health. GBMC can also offer assistance to those who are experiencing difficulty paying their hospital bills. Our Patient Financial Services Department may be able to aid those who do not carry medical insurance or face significant co-pay and/or deductible charges that are challenging to manage due to personal hardship or financial distress. Within two business days following a patient's request for charity care services, application for medical assistance, or both, GBMC shall make a determination of probable eligibility.

These policies cover all hospital facility services and services provided by GBMC physician practices and groups delivering emergent or medically necessary care. These policies do not cover care provided by providers with privileges at GBMC who are not affiliated with a GBMC employed practice. For more information on which physician practices and groups are covered, please contact us.

GBMC Patient Financial Services

Our representatives are available to assist you Monday-Friday 8 a.m. - 5 p.m. You can reach us by calling 443-849-2450 (press 1) or toll-free at 1-800-626-7766 (press 1). Visit our website at https://www.gbmc.org/financialsupport.

POLÍTICA DE ASISTENCIA FINANCIERA DEL GREATER BALTIMORE MEDICAL CENTER (GBMC)

El GBMC ha asumido el compromiso de brindarles asistencia financiera a todas las personas que no pueden pagar las cuentas médicas que el seguro no cubre. Nuestra misión es brindar asistencia y servicio médico de máxima calidad a cada paciente para que esté saludable, sane y tenga esperanza, sin importar cuál sea su situación financiera. Todos los pacientes que se acerquen para obtener servicios de emergencia recibirán atención médica lo más rápido posible. Nunca se demorará la atención a un paciente por problemas financieros.

Según la situación de cada persona, usted podría ser elegible para obtener asistencia financiera mediante los departamentos de servicios sociales de cada ciudad. Animamos a los pacientes y a sus familias que estén atravesando una situación financiera compleja que busquen ser parte de Maryland Medicaid y otros programas a través del Departamento de Salud de Maryland. GBMC también puede brindar asistencia a las personas que estén atravesando dificultades para pagar cuentas hospitalarias. Nuestro Departamento de Servicios Financieros al Paciente podría ayudar a aquellas personas que no tengan seguro médico o que adeuden copagos o cargos deducibles importantes que sean difíciles de pagar debido a dificultades personales o financieras. En un plazo de dos días hábiles posteriores al pedido del paciente de servicios médicos de caridad, presentación de una solicitud de asistencia médica, o ambas, GBMC tomará una decisión sobre elegibilidad probable.

Estas políticas cubren todos los servicios de instalaciones médicas y los servicios provistos por médicos y grupos de GBMC que ofrecen atención médica o de emergencia. Estas políticas no cubren la asistencia de proveedores con privilegios en GBMC que no están afiliados con las prácticas empleadas por GBMC. Para obtener más información sobre qué prácticas de médicos y grupos se cubren, contáctese con nosotros.

Servicios Financieros al Paciente de GBMC

Nuestros representantes podrán atenderlo de lunes a viernes de 8 a. m. a 5 p. m. Puede llamarnos al 443-849-2450 (presione 1) o a la línea gratuita 1-800-626-7766 (presione 1). Visite nuestro sitio web https://www.gbmc.org/financialsupport.

GBMC

FROM PAGE ONE

ORGANS

From page 1

of those children, like Syah, have severe heart problems. With a kinked aorta, holes in her heart and two right ventricles, the shape of Syah's heart is rare, making surgical repairs complicated. But using 3D-printed models of her heart, doctors at the University of Maryland Medical Center were able to anticipate the anatomical differences they would find when they cut open Syah's chest, increasing the chances for a shorter and successful surgery.

Such models, made from patients' own images, are becoming more common in U.S. hospitals, allowing doctors to better plan for complicated cardiovascular and orthopedic surgeries. The 3D-printing technology also is used to make custom prosthetic limbs and surgical tools, and even a drug to treat epilepsy — some of the more than 100 printed medical devices approved in recent years by the U.S. Food and Drug Administration.

There's more on the horizon, such as printed skin made with living cells to cover wounds and burns.

Research into printing human organs is in the beginning stages.

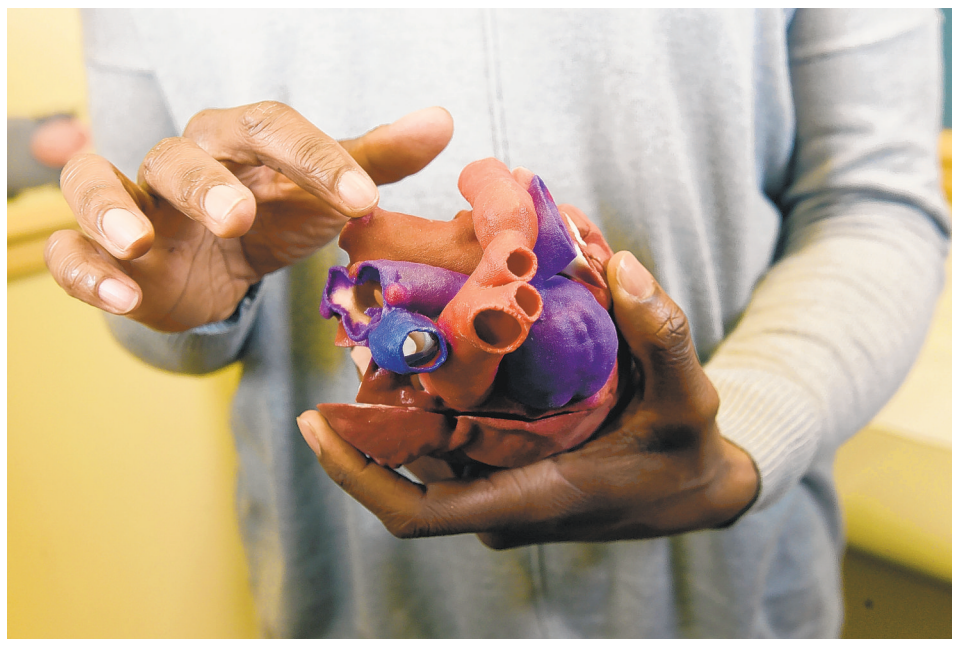
The 3D printers that layer powder and liquid versions of plastics, ceramics and metals have been around since the 1980s and explored for medical uses since the 1990s. But advances are now propelling the field more quickly, including the printing of living tissue using cells. A forecast from Allied Market Research projects the health care market for 3D printing to grow to $2.3 billion by 2020, an increase of 26 percent from 2015. But hurdles remain, analysts say including the high cost of equipment and lack of insurance reimbursements, compatibility with human bodies and lack of expertise.

The University of Maryland Medical Center has been adding to its 3D capabilities and partnering with the U.S. Department of Veterans Affairs to perfect uses that largely center on modeling body parts including hearts and blood vessels, and more recently shoulders, to aid in surgical planning, said Dr. Jeffrey Hirsch, the section chief of community radiology for the University of Maryland Medical Center who printed models of Syah's heart.

Doctors knew Syah's heart was compromised while she was in utero, though they didn't know the extent of her condition until she was born.

Images of Syah's heart after birth confirmed she had a coarctation, or kink, in her aorta, the main blood vessel that delivers oxygen-rich blood from the heart to the body. She also had a large hole connecting the two lower chambers of her heart, which should not be open to each other. She lived in the neonatal intensive care unit for the first month of her life.

"This is my first child and the day I left the hospital and she wasn't home with me it was like a panic attack," Seimah said.



KIM HAIRSTON/BALTIMORE SUN

Dr. Carissa Baker-Smith is a pediatric cardiologist with the University of Maryland Medical Center who helped a baby with two congenital heart defects using 3D printing technology. Baker-Smith looks at a recent 3D-printed model of the girl's heart, made larger than the actual size. A similar model helped doctors understand the best approach for her surgery.

During Syah's first surgery, doctors repaired her aorta and placed a band on the pulmonary artery to prevent too much blood from rushing to her lungs instead of her body. The second surgery to address the hole in her heart was more complicated, and doctors had several options for procedures to pursue. That's where the models came in.

"It wasn't clear exactly what the relationship was between that hole that divided the two lower chambers of her heart and the two big vessels coming off of the heart," said Dr. Carissa Baker-Smith, Syah's pediatric cardiologist at the University of Maryland Medical Center.

Hirsch's models gave them a better picture. One model, made of gray and black plastic, was enlarged several times and split in two pieces held together by magnets to allow doctors to look inside. The second model was solid and true to size, small enough to cradle in the palm of your hand.

"It was very clear from the 3D printing of the heart that the hole in the wall that separated the two lower chambers of Syah's heart was too far and distant from the big vessels that come off the heart, and that there was no way in which we'd be able to put a patch in that allows one big artery to come from one chamber and one big artery to come from another," Baker-Smith said. "So ultimately that gave us a game plan and I think resulted in a very good outcome. So less amount of time that she needed to be in the operating room. And she's doing quite well now."

Printing a patient's organ starts with two-dimensional images — CT scans often work best — that are plugged into software to create a printable file. Hirsch printed the plastic model of Syah's heart using one of two tabletop printers in his lab at the downtown hospital at the time, and he sent the other file for the life-size heart to a third-party vendor. The lab has since added a larger, $80,000 printer, acquired through a donation.

Baker-Smith said such models could help other doctors make better decisions for their patients.

"In terms of being able to hold the heart in your hand and really kind of twist it and turn it and look at all the intricacies and sort of the relationships for our kids with complex congenital heart disease, I see it being an invaluable resource," Baker-Smith said.

Syah was the first pediatric cardiac patient whose heart Hirsch printed. He's partnered with several departments at the hospital to create models and prostheses for his colleagues and their patients. In addition to surgical planning, he said he often sees 3D printing used in procedures like facial reconstruction following trauma, opening up the skull in infant brain surgery, inner-ear prostheses and surgeries to remove bone tumors.

Before modeling with 3D printing, "the only way to do that was essentially by guesswork, and so they get a much cleaner result," said Hirsch, also an assistant professor in the University of Maryland School of Medicine's department of radiology.

Recently, Hirsch has been working with Dr. Kenneth C. Wang, a fellow radiologist and assistant professor who also serves at the Veterans Affairs hospital in Baltimore. They've worked to create models for shoulder replacement surgeries.

Shoulder replacements have a far higher fail rate over a decade than knees because the bones are thinner and made far more fragile by trauma, arthritis and age, Wang said. Modeling someone's specific shoulder allows a surgeon not only to see the anatomy more clearly but also to map where all the new hardware will go.

"We can show them the pictures, but when we put a model in their hands it's an epiphany for them," Wang said. "They say, 'I can see what's going on.' "

Wang and colleagues from the VA, Walter Reed National Military Medical Center, the University of Maryland and elsewhere published a paper in the Journal of Digital Imaging that found 3D printed models were more beneficial for surgical planning than CT images.

Wang is waiting for approvals from the FDA to use specific software before expanding use of shoulder modeling.

Government statistics show that there are about 53,000 shoulder replacement surgeries annually, and Wang said many could be modeled first.

Eventually, the actual joints could be widely printed and implanted. Wang said research is needed to determine such things as what is the most durable printed materials and how to avoid titanium or plastic splinters, for example. And study is needed to see whether patients fare better over time with printed parts.

At Maryland and the VA center, he and Hirsch largely design and print models on their own time with a lot of donated materials. They need to determine a more formal and funded process to handle requests from surgeons. In addition to staff time, the supplies of plastic, resin, gypsum or metal can work out to under $10 a model to $100 or more.

But they expect the 3D technology will continue to advance and the uses to proliferate.

The technology had spread largely as a result of individuals tinkering with personal 3D printers, said Bill Decker, chairman of the Association for 3D Printing, a national industry organization.

"There are people just playing in that space," Decker said.

But the medical implications are serious. Some popular applications of 3D printing in health care have become household names — like Invisalign, a braces alternative, and cochlear implants for restoring hearing.

University and industry researchers are working on printing living things, from bacteria to organs made from stem cells.

"It's futuristic," Decker said. "You can mix bacteria with another substance, and the substance prints and the bacteria stays alive. ... If they can 3D print bacteria, they can 3D print vaccines."

For Syah and her parents, the clearest benefit, however, was simply letting doctors see how her defective heart worked before they cut into her tiny chest.

"I think it gave them the clearest idea of what was going on," Seimah said.

GREATER BALTIMORE MEDICAL CENTER FINANCIAL ASSISTANCE POLICY

GBMC is committed to providing financial assistance to those who are unable to pay medical bills not covered by insurance. Our mission is to provide medical care and service of the highest quality to each patient leading to health, healing, and hope, regardless of a person's financial situation. All patients presenting for emergency services will be treated as immediately as possible. Financial issues will never delay a patient from receiving care.

Depending on your individual situation, you may be eligible for financial assistance through the local Departments of Social Services. We encourage patients and families who are undergoing financial hardships to pursue Maryland Medicaid and other programs through the Maryland Department of Health. GBMC can also offer assistance to those who are experiencing difficulty paying their hospital bills. Our Patient Financial Services Department may be able to aid those who do not carry medical insurance or face significant co-pay and/or deductible charges that are challenging to manage due to personal hardship or financial distress. Within two business days following a patient's request for charity care services, application for medical assistance, or both, GBMC shall make a determination of probable eligibility.

These policies cover all hospital facility services and services provided by GBMC physician practices and groups delivering emergent or medically necessary care. These policies do not cover care provided by providers with privileges at GBMC who are not affiliated with a GBMC employed practice. For more information on which physician practices and groups are covered, please contact us.

GBMC Patient Financial Services

Our representatives are available to assist you Monday-Friday 8 a.m. - 5 p.m. You can reach us by calling 443-849-2450 (press 1) or toll-free at 1-800-626-7766 (press 1). Visit our website at https://www.gbmc.org/financialsupport.

POLÍTICA DE ASISTENCIA FINANCIERA DEL GREATER BALTIMORE MEDICAL CENTER (GBMC)

El GBMC ha asumido el compromiso de brindarles asistencia financiera a todas las personas que no pueden pagar las cuentas médicas que el seguro no cubre. Nuestra misión es brindar asistencia y servicio médico de máxima calidad a cada paciente para que esté saludable, sane y tenga esperanza, sin importar cuál sea su situación financiera. Todos los pacientes que se acerquen para obtener servicios de emergencia recibirán atención médica lo más rápido posible. Nunca se demorará la atención a un paciente por problemas financieros.

Según la situación de cada persona, usted podría ser elegible para obtener asistencia financiera mediante los departamentos de servicios sociales de cada ciudad. Animamos a los pacientes y a sus familias que estén atravesando una situación financiera compleja que busquen ser parte de Maryland Medicaid y otros programas a través del Departamento de Salud de Maryland. GBMC también puede brindar asistencia a las personas que estén atravesando dificultades para pagar cuentas hospitalarias. Nuestro Departamento de Servicios Financieros al Paciente podría ayudar a aquellas personas que no tengan seguro médico o que adeuden copagos o cargos deducibles importantes que sean difíciles de pagar debido a dificultades personales o financieras. En un plazo de dos días hábiles posteriores al pedido del paciente de servicios médicos de caridad, presentación de una solicitud de asistencia médica, o ambas, GBMC tomará una decisión sobre elegibilidad probable.

Estas políticas cubren todos los servicios de instalaciones médicas y los servicios provistos por médicos y grupos de GBMC que ofrecen atención médica o de emergencia. Estas políticas no cubren la asistencia de proveedores con privilegios en GBMC que no están afiliados con las prácticas empleadas por GBMC. Para obtener más información sobre qué prácticas de médicos y grupos se cubren, contáctese con nosotros.

Servicios Financieros al Paciente de GBMC

Nuestros representantes podrán atenderlo de lunes a viernes de 8 a. m. a 5 p. m. Puede llamarnos al 443-849-2450 (presione 1) o a la línea gratuita 1-800-626-7766 (presione 1). Visite nuestro sitio web https://www.gbmc.org/financialsupport.

GBMC

EXHIBIT 8

GBMC

Greater Baltimore Medical Center

Reseña en lenguaje simple de la Política de Asistencia Financiera

Tratamos a todos los pacientes que necesitan atención de emergencia, sin importar su capacidad de pago.

Ayuda para que los pacientes puedan pagar sus costos de atención médica

Si usted no puede pagar la totalidad o alguna parte de sus costos de atención médica, es probable que usted pueda recibir servicios gratuitos o de costos inferiores para aquellos servicios que resulten médicamente necesarios.

❖ **Cómo funciona el trámite:**

Cuando usted pase a ser paciente, nosotros
- Le brindaremos información sobre nuestra política de asistencia financiera
- Lo ayudaremos con su inscripción en programas financiados con fondos públicos

Nosotros debemos evaluar a los pacientes aptos para recibir el servicio de Medicaid antes de brindarles ayuda económica. Tanto los servicios de emergencia como los que resultan médicamente necesarios provistos a un residente de Maryland resultan elegibles para este programa.

❖ **¿Cómo solicitarla?**

- Llene un Formulario de Solicitud de Asistencia Financiera (el formulario se encuentra disponible en el sitio web de GBMC)
- Suministre toda la información requerida y solicitada para que GBMC pueda evaluar su situación económica de conformidad con sus criterios (véase la política)
- Presente el Formulario de Solicitud

❖ **Cómo revisamos su solicitud:**

Nosotros analizaremos su capacidad de pago. Vemos sus ingresos y el tamaño de su familia.
- Si sus ingresos están por debajo del 300% del nivel federal de pobreza, es probable que resulte elegible para recibir atención gratuita.
- Si sus ingresos se encuentran entre el 301% y el 500% del nivel federal de pobreza, es posible que usted resulte elegible para recibir atención de costos reducidos.
- A la persona que resulte elegible para recibir asistencia en virtud de esta política para afrontar los servicios de atención médica de emergencia u otros que resulten médicamente necesarios jamás se le cobrará más que los montos generalmente facturados (AGB, por su sigla en inglés) que aquel individuo que no resulte elegible para recibir asistencia.

GBMC le proveerá una determinación de elegibilidad probable dentro de los dos días hábiles posteriores a la presentación del pedido. Si usted resulta elegible para recibir ayuda financiera, le diremos en qué proporción resulta elegible su factura. Si usted no resulta elegible para recibir ayuda financiera, le explicaremos el por qué de tal rechazo y le ofreceremos un plan de pagos.

❖ **Otra información útil:**

La Política de Asistencia Financiera y la Solicitud se encuentran disponibles:
- Por Internet en https://www.gbmc.org/financialsupport
- por correo llamando al (443) 849-2450
- en persona en cualquiera de nuestras áreas de registración

6701 N. Charles Street, Baltimore Maryland 21204

www.GBMC.org

GBMC

Greater Baltimore Medical Center

Financial Assistance Policy-Plain Language Summary

We treat all patients needing emergency care, no matter the ability to pay.

Help for Patients to Pay Healthcare Care Costs

If you cannot pay for all or part of your health care costs you may be able to get free or lower cost services for medically necessary services.

❖ **How the process works:**

When you become a patient, we
- give you information about our financial assistance policy
- assist with enrollment into publicly funded programs

We must screen patients for Medicaid before giving financial help. Emergent or medically necessary services provided to Maryland resident are eligible for this program.

❖ **How to apply?**

- Fill out a Financial Assistance Application Form (form is on GBMC website)
- Provide all required and requested information so that GBMC may evaluate your financial situation in accordance with its criteria (see policy)
- Turn in the Application Form

❖ **How we review your application:**

We will look at your ability to pay. We look at your income and family size.
- If your income is less than 300% of the federal poverty level, then you may be eligible for free care.
- If your income is between 301%-500% of the federal poverty level, you may be eligible for lower cost of care.
- 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.

GBMC will provide you with a probable eligibility determination within two business days of the request. If you are eligible for financial help, we will tell you how much of your bill is eligible. If you are not eligible for financial help, we will explain why and offer you a payment plan.

❖ **Other helpful information:**

Financial Assistance Policy and Application available by
- online at https://www.gbmc.org/financialsupport
- by mail by calling (443) 849-2450
- in person at any of our registration areas

6701 N. Charles Street, Baltimore Maryland 21204

www.GBMC.org

EXHIBIT 9

Maryland Hospital Community Benefit Financial Report: FY 2018
https://hscrc.state.md.us/Pages/init_cb.aspx
Accessed 6/18/19

	Hospital	Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	CB Reported Charity Care % of Operating Expenses	
1	210004	Holy Cross	$413,981,550	$31,485,836	7.61%	First Quartile
2	210011	St. Agnes Hospital	$452,096,000	$23,954,876	5.30%	
3	210017	Garrett County Memorial Hospital	$51,150,258	$2,550,792	4.99%	
4	210065	Holy Cross German Town	$100,707,482	$4,839,365	4.81%	
5	210051	Doctors Community Hospital	$195,871,667	$8,862,484	4.52%	11.25
6	210003 & 210055	UM Capital Region	$285,839,000	$12,147,000	4.25%	
7	210039	Calvert Memorial Hospital	$131,906,976	$5,547,029	4.21%	
8	210027	Western Maryland Hospital	$323,338,357	$10,489,666	3.24%	
9	210008	Mercy Medical Center, Inc.	$483,817,200	$14,621,887	3.02%	
10	210029	Johns Hopkins Bayview Med. Center	$632,548,000	$18,957,000	3.00%	
11	210016	Washington Adventist Hospital	$243,708,768	$6,640,537	2.72%	
12	210028	MedStar St. Marys Hospital	$162,218,677	$3,983,754	2.46%	Second Quartile
13	210060	Fort Washington Medical Center	$42,237,402	$928,769	2.20%	
14	210006	Univ. of Maryland Harford Memorial Hospital	$87,719,000	$1,903,000	2.17%	
15	210034	MedStar Harbor Hospital Center	$183,508,480	$3,820,520	2.08%	
16	210061	Atlantic General Hospital	$127,458,282	$2,567,553	2.01%	
17	210005	Frederick Memorial Hospital	$340,036,000	$6,785,000	2.00%	
18	210043	Univ. of Maryland Baltimore Washington Medical Center	$344,997,000	$6,845,000	1.98%	
19	210062	MedStar Southern Maryland Hospital	$247,677,692	$4,843,585	1.96%	
20	210056	MedStar Good Samaritan Hospital	$259,072,976	$4,954,141	1.91%	
21	210045	McCready Foundation, Inc.	$18,107,925	$326,004	1.80%	
22	210019	Peninsula Regional Medical Center	$427,360,744	$7,604,900	1.78%	
23	210038	Univ. of Maryland Medical Center Midtown Campus	$223,093,000	$3,962,000	1.78%	Third Quartile
24	210010	Univ. of Maryland Shore Medical Center at Dorchester	$40,094,943	$704,387	1.76%	
25	210048	Howard County General Hospital	$265,393,000	$4,598,000	1.73%	
26	210049	Univ. of Maryland Upper Chesepeake Medical Center	$262,553,000	$4,313,000	1.64%	
27	210063	Univ. of Maryland St. Josephs Medical Center	$337,972,000	$5,281,000	1.56%	
28	210001	Meritus Medical Center	$314,735,209	$4,718,533	1.50%	
29	210037	Univ. of Maryland Shore Medical Center at Easton	$187,273,586	$2,800,988	1.50%	
30	210022	Suburban Hospital Association,Inc	$295,311,000	$4,386,000	1.49%	
31	210024	MedStar Union Memorial Hospital	$449,182,066	$6,610,504	1.47%	
32	210002 & 218992	Univ. of Maryland Medical Center	$1,522,227,000	$22,057,000	1.45%	
33	210015	MedStar Franklin Square Hospital	$518,888,097	$7,344,175	1.42%	
34	210018	MedStar Montgomery General Hospital	$165,450,371	$1,847,698	1.12%	Fourth Quartile
35	210032	Union Hospital of Cecil County	$164,054,488	$1,822,394	1.11%	
36	210009	Johns Hopkins	$2,396,322,000	$26,475,000	1.10%	
37	210030	Univ. of Maryland Shore Medical Center at Chestertown	$46,259,300	$475,000	1.03%	
38	210057	Shady Grove Adventist Hospital	$337,019,361	$2,979,569	0.88%	
39	210012	Sinai Hospital	$752,831,000	$6,360,600	0.84%	
40	210040	Northwest Hospital Center, Inc.	$244,796,678	$2,067,000	0.84%	
41	210035	Univ. of Maryland Charles Regional Medical Center	$120,993,920	$971,260	0.80%	
42	210023	Anne Arundel General Hospital	$558,534,000	$3,923,800	0.70%	
43	210013	Bon Secours Hospital	$109,675,296	$488,596	0.45%	
44	210044	Greater Baltimore Medical Center	$504,347,676	$1,710,711	0.34%	
45	210033	Carroll County General Hospital	$195,292,000	$546,974	0.28%	

210058	UMROI	$109,216,000	$2,258,000	2.07%
210064	Levindale	$77,169,000	$1,018,600	1.32%
213300	Mt. Washington Peds	$58,944,476	$86,541	0.15%
214000	Sheppard Pratt	$234,132,619	$4,605,738	1.97%
213029	Adventist Rehabilitation	$46,858,266	$252,630	0.54%
4013	Adventist Behavioral Health Rockville*	$49,561,380	$1,415,734	2.86%

FY 2018 Community Benefit Analysis, by Hospital Ranked by Total Community Benefit Expense

	Hospital	Hospital Name	Number of Employees	Total Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2017 Amount in Rates for Charity Care, DME, and NSPI*	Total Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care	
1	210009	Johns Hopkins	0	7,079	$2,396,322,000	$272,875,357	11.39%	$147,081,575	$125,793,781	5.25%	$26,475,000	First Quartile
2	210002 & 218992	Univ. of Maryland Medical Center	8,899	3,919	$1,522,227,000	$212,918,463	13.99%	$135,234,465	$77,683,998	5.10%	$22,057,000	
3	210029	Johns Hopkins Bayview Med. Center	3,446	3,421	$632,548,000	$83,958,769	13.27%	$41,100,679	$42,858,090	6.78%	$18,957,000	
4	210003 & 210055	UM Capital Region	2,603	4,160	$285,839,000	$78,564,066	27.49%	$18,494,489	$60,069,577	21.02%	$12,147,000	
5	210012	Sinai Hospital	4,992	2,295	$752,831,000	$58,913,086	7.83%	$22,701,641	$36,211,445	4.81%	$6,360,600	
6	210008	Mercy Medical Center, Inc.	3,551	2,489	$483,817,200	$57,442,772	11.87%	$21,105,897	$36,336,875	7.51%	$14,621,887	
7	210027	Western Maryland Hospital	1,979	252	$323,338,357	$53,781,549	16.63%	$9,768,650	$44,012,899	13.61%	$10,489,666	
8	210011	St. Agnes Hospital	0	0	$452,096,000	$51,743,113	11.45%	$31,677,797	$20,065,315	4.44%	$23,954,876	
9	210004	Holy Cross	3,461	4,696	$413,981,550	$51,218,319	12.37%	$32,650,121	$18,568,199	4.49%	$31,485,836	
10	210019	Peninsula Regional Medical Center	2,794	349	$427,360,744	$50,423,375	11.80%	$8,615,991	$41,807,384	9.78%	$7,604,900	
11	210023	Anne Arundel General Hospital	4,746	3,277	$558,534,000	$50,281,740	9.00%	$5,241,716	$45,040,023	8.06%	$3,923,800	
12	210044	Greater Baltimore Medical Center	0	4,380	$504,347,676	$42,577,897	8.44%	$10,977,339	$31,600,558	6.27%	$1,710,711	Second Quartile
13	210015	MedStar Franklin Square Hospital	3,013	2,616	$518,888,097	$41,489,808	8.00%	$17,669,649	$23,820,159	4.59%	$7,344,175	
14	210063	Univ. of Maryland St. Josephs Medical Center	2,378	25	$337,972,000	$38,134,583	11.28%	$5,765,973	$32,368,610	9.58%	$5,281,000	
15	210038	Univ. of Maryland Medical Center Midtown Camp	1,423	250	$223,093,000	$37,972,794	17.02%	$9,165,486	$28,807,308	12.91%	$3,962,000	
16	210024	MedStar Union Memorial Hospital	2,263	664	$449,182,066	$37,410,521	8.33%	$21,397,237	$16,013,284	3.56%	$6,610,504	
17	210016	Washington Adventist Hospital	1,342	5,914	$243,708,768	$35,087,712	14.40%	$7,634,930	$27,452,781	11.26%	$6,640,537	
18	210037	Univ. of Maryland Shore Medical Center at Easton	1,143	1,060	$187,273,586	$31,622,263	16.89%	$2,594,101	$29,028,162	15.50%	$2,800,988	
19	210005	Frederick Memorial Hospital	1964	134	$340,036,000	$30,721,235	9.03%	$6,678,838	$24,042,397	7.07%	$6,785,000	
20	210057	Shady Grove Adventist Hospital	1,994	6,324	$337,019,361	$28,444,407	8.44%	$3,447,593	$24,996,814	7.42%	$2,979,569	
21	210048	Howard County General Hospital	1,752	2,580	$265,393,000	$26,930,941	10.15%	$4,982,536	$21,948,406	8.27%	$4,598,000	
22	210022	Suburban Hospital Association,Inc	1,786	0	$295,311,000	$25,543,204	8.65%	$4,572,896	$20,970,308	7.10%	$4,386,000	
23	210013	Bon Secours Hospital	589	17,917	$109,675,296	$24,668,422	22.49%	$730,964	$23,937,457	21.83%	$488,596	Third Quartile
24	210043	Univ. of Maryland Baltimore Washington Medical	2,200	2,936	$344,997,000	$23,691,460	6.87%	$7,068,198	$16,623,262	4.82%	$6,845,000	
25	210001	Meritus Medical Center	2,707	312	$314,735,209	$23,564,918	7.49%	$5,057,885	$18,507,033	5.88%	$4,718,533	
26	210034	MedStar Harbor Hospital Center	1,125	682	$183,508,480	$22,870,652	12.46%	$10,451,356	$12,419,296	6.77%	$3,820,520	
27	210039	Calvert Memorial Hospital	1,300	376	$131,906,976	$18,375,823	13.93%	$4,425,743	$13,950,080	10.58%	$5,547,029	
28	210056	MedStar Good Samaritan Hospital	1,722	1,594	$259,072,976	$18,360,426	7.09%	$10,577,237	$7,783,188	3.00%	$4,954,141	
29	210062	MedStar Southern Maryland Hospital	1,221	8,212	$247,677,692	$18,050,703	7.29%	$5,356,630	$12,694,073	5.13%	$4,843,585	
30	210028	MedStar St. Marys Hospital	1,200	5,000	$162,218,677	$17,492,296	10.78%	$4,513,378	$12,978,918	8.00%	$3,983,754	
31	210033	Carroll County General Hospital	1,793	2,080	$195,292,000	$15,781,944	8.08%	$1,056,643	$14,725,301	7.54%	$546,974	
32	210049	Univ. of Maryland Upper Chesepeake Medical Cer	2,156	2,183	$262,553,000	$15,439,651	5.88%	$5,583,667	$9,855,984	3.75%	$4,313,000	
33	210040	Northwest Hospital Center, Inc.	1,767	723	$244,796,678	$13,729,621	5.61%	$2,857,179	$10,872,442	4.44%	$2,067,000	
34	210051	Doctors Community Hospital	1,604	1,444	$195,871,667	$13,508,198	6.90%	$8,958,029	$4,550,169	2.32%	$8,862,484	Fourth Quartile
35	210061	Atlantic General Hospital	950	95	$127,458,282	$13,401,211	10.51%	$2,828,191	$10,573,020	8.30%	$2,567,553	
36	210030	Univ. of Maryland Shore Medical Center at Cheste	241	1,260	$46,259,300	$12,388,833	26.78%	$472,539	$11,916,295	25.76%	$475,000	
37	210035	Univ. of Maryland Charles Regional Medical Cent	0	1,868	$120,993,920	$11,528,332	9.53%	$1,114,829	$10,413,503	8.61%	$971,260	
38	210010	Univ. of Maryland Shore Medical Center at Dorch	284	1,460	$40,094,943	$10,346,219	25.80%	$687,909	$9,658,310	24.09%	$704,387	
39	210065	Holy Cross German Town	674	356	$100,707,482	$9,403,754	9.34%	$5,465,624	$3,938,129	3.91%	$4,839,365	
40	210032	Union Hospital of Cecil County	1,372	2,140	$164,054,488	$8,693,334	5.30%	$1,658,143	$7,035,191	4.29%	$1,822,394	
41	210006	Univ. of Maryland Harford Memorial Hospital	994	936	$87,719,000	$7,721,886	8.80%	$1,580,226	$6,141,660	7.00%	$1,903,000	
42	210018	MedStar Montgomery General Hospital	1,721	60	$165,450,371	$6,332,705	3.83%	$2,583,041	$3,749,664	2.27%	$1,847,698	
43	210017	Garrett County Memorial Hospital	439	10	$51,150,258	$3,169,409	6.20%	$2,505,578	$663,831	1.30%	$2,550,792	
44	210060	Fort Washington Medical Center	408	416	$42,237,402	$2,368,122	5.61%	$1,135,799	$1,232,323	2.92%	$928,769	
45	210045	McCready Foundation, Inc.	273	8	$18,107,925	$652,490	3.60%	$245,299	$407,192	2.25%	$326,004	

FY 2018 Community Benefit Analysis, by Hospital Ranked by Total Community Benefit Expense

Hospital	Hospital Name	Number of Employees	Total Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2017 Amount in Rates for Charity Care, DME, and NSPI*	Total Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
	All Hospitals	**84,654**	**113,419**	**$15,957,155,168**	**$1,735,694,875**	**10.88%**	**$658,262,266**	**$1,077,432,608**	**6.75%**	**$307,463,530**
		1,764	**2,315**	**$325,656,228**	**$35,422,344**	**10.69%**		**7.83%**		**$6,274,766**
210058	UMROI	667	0	$109,216,000	$9,418,991	8.62%	$3,937,587	$5,481,404	5.02%	$2,258,000
210064	Levindale	884	126	$77,169,000	$3,327,824	4.31%	$60,313	$3,267,511	4.23%	$1,018,600
213300	Mt. Washington Peds	672	3,151	$58,944,476	$1,476,802	2.51%	$58,586	$1,418,216	2.41%	$86,541
214000	Sheppard Pratt	2,782	724	$234,132,619	$16,611,638	7.09%	$2,670,488	$13,941,150	5.95%	$4,605,738
213029	Adventist Rehabilitation	499	841	$46,858,266	$2,710,713	5.78%	$59,505	$2,651,207	5.66%	$252,630
4013	Adventist Behavioral Health Rockville*	397	752	$49,561,380	$5,299,339	10.69%	$0	$5,299,339	10.69%	$1,415,734

* The Adventist Hospital System has requested and received permission to report their Community Benefit

FY 2018 Community Benefit Analysis, by Hospital Ranked by Total CB as % of Total Operating Expense

	Hospital	Hospital Name	Number of Employees	Total Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2017 Amount in Rates for Charity Care, DME, and NSPI*	Total Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care	
1	210003 & 210055	UM Capital Region	2,603	4,160	$285,839,000	$78,564,066	27.49%	$18,494,489	$60,069,577	21.02%	$12,147,000	First Quartile
2	210030	Univ. of Maryland Shore Medical Center at Chest	241	1,260	$46,259,300	$12,388,833	26.78%	$472,539	$11,916,295	25.76%	$475,000	
3	210010	Univ. of Maryland Shore Medical Center at Dorch	284	1,460	$40,094,943	$10,346,219	25.80%	$687,909	$9,658,310	24.09%	$704,387	
4	210013	Bon Secours Hospital	589	17,917	$109,675,296	$24,668,422	22.49%	$730,964	$23,937,457	21.83%	$488,596	
5	210038	Univ. of Maryland Medical Center Midtown Camp	1,423	250	$223,093,000	$37,972,794	17.02%	$9,165,486	$28,807,308	12.91%	$3,962,000	
6	210037	Univ. of Maryland Shore Medical Center at Easter	1,143	1,060	$187,273,586	$31,622,263	16.89%	$2,594,101	$29,028,162	15.50%	$2,800,988	
7	210027	Western Maryland Hospital	1,979	252	$323,338,357	$53,781,549	16.63%	$9,768,650	$44,012,899	13.61%	$10,489,666	
8	210016	Washington Adventist Hospital	1,342	5,914	$243,708,768	$35,087,712	14.40%	$7,634,930	$27,452,781	11.26%	$6,640,537	
9	210002 & 218992	Univ. of Maryland Medical Center	8,899	3,919	$1,522,227,000	$212,918,463	13.99%	$135,234,465	$77,683,998	5.10%	$22,057,000	
10	210039	Calvert Memorial Hospital	1,300	376	$131,906,976	$18,375,823	13.93%	$4,425,743	$13,950,080	10.58%	$5,547,029	
11	210029	Johns Hopkins Bayview Med. Center	3,446	3,421	$632,548,000	$83,958,769	13.27%	$41,100,679	$42,858,090	6.78%	$18,957,000	
12	210034	MedStar Harbor Hospital Center	1,125	682	$183,508,480	$22,870,652	12.46%	$10,451,356	$12,419,296	6.77%	$3,820,520	Second Quartile
13	210004	Holy Cross	3,461	4,696	$413,981,550	$51,218,319	12.37%	$32,650,121	$18,568,199	4.49%	$31,485,836	
14	210008	Mercy Medical Center, Inc.	3,551	2,489	$483,817,200	$57,442,772	11.87%	$21,105,897	$36,336,875	7.51%	$14,621,887	
15	210019	Peninsula Regional Medical Center	2,794	349	$427,360,744	$50,423,375	11.80%	$8,615,991	$41,807,384	9.78%	$7,604,900	
16	210011	St. Agnes Hospital	0	0	$452,096,000	$51,743,113	11.45%	$31,677,797	$20,065,315	4.44%	$23,954,876	
17	210009	Johns Hopkins	0	7,079	$2,396,322,000	$272,875,357	11.39%	$147,081,575	$125,793,781	5.25%	$26,475,000	
18	210063	Univ. of Maryland St. Josephs Medical Center	2,378	25	$337,972,000	$38,134,583	11.28%	$5,765,973	$32,368,610	9.58%	$5,281,000	
19	210028	MedStar St. Marys Hospital	1,200	5,000	$162,218,677	$17,492,296	10.78%	$4,513,378	$12,978,918	8.00%	$3,983,754	
20	210061	Atlantic General Hospital	950	95	$127,458,282	$13,401,211	10.51%	$2,828,191	$10,573,020	8.30%	$2,567,553	
21	210048	Howard County General Hospital	1,752	2,580	$265,393,000	$26,930,941	10.15%	$4,982,536	$21,948,406	8.27%	$4,598,000	
22	210035	Univ. of Maryland Charles Regional Medical Cent	0	1,868	$120,993,920	$11,528,332	9.53%	$1,114,829	$10,413,503	8.61%	$971,260	
23	210065	Holy Cross German Town	674	356	$100,707,482	$9,403,754	9.34%	$5,465,624	$3,938,129	3.91%	$4,839,365	Third Quartile
24	210005	Frederick Memorial Hospital	1964	134	$340,036,000	$30,721,235	9.03%	$6,678,838	$24,042,397	7.07%	$6,785,000	
25	210023	Anne Arundel General Hospital	4,746	3,277	$558,534,000	$50,281,740	9.00%	$5,241,716	$45,040,023	8.06%	$3,923,800	
26	210006	Univ. of Maryland Harford Memorial Hospital	994	936	$87,719,000	$7,721,886	8.80%	$1,580,226	$6,141,660	7.00%	$1,903,000	
27	210022	Suburban Hospital Association,Inc	1,786	0	$295,311,000	$25,543,204	8.65%	$4,572,896	$20,970,308	7.10%	$4,386,000	
28	210044	Greater Baltimore Medical Center	0	4,380	$504,347,676	$42,577,897	8.44%	$10,977,339	$31,600,558	6.27%	$1,710,711	
29	210057	Shady Grove Adventist Hospital	1,994	6,324	$337,019,361	$28,444,407	8.44%	$3,447,593	$24,996,814	7.42%	$2,979,569	
30	210024	MedStar Union Memorial Hospital	2,263	664	$449,182,066	$37,410,521	8.33%	$21,397,237	$16,013,284	3.56%	$6,610,504	
31	210033	Carroll County General Hospital	1,793	2,080	$195,292,000	$15,781,944	8.08%	$1,056,643	$14,725,301	7.54%	$546,974	
32	210015	MedStar Franklin Square Hospital	3,013	2,616	$518,888,097	$41,489,808	8.00%	$17,669,649	$23,820,159	4.59%	$7,344,175	
33	210012	Sinai Hospital	4,992	2,295	$752,831,000	$58,913,086	7.83%	$22,701,641	$36,211,445	4.81%	$6,360,600	
34	210001	Meritus Medical Center	2,707	312	$314,735,209	$23,564,918	7.49%	$5,057,885	$18,507,033	5.88%	$4,718,533	Fourth Quartile
35	210062	MedStar Southern Maryland Hospital	1,221	8,212	$247,677,692	$18,050,703	7.29%	$5,356,630	$12,694,073	5.13%	$4,843,585	
36	210056	MedStar Good Samaritan Hospital	1,722	1,594	$259,072,976	$18,360,426	7.09%	$10,577,237	$7,783,188	3.00%	$4,954,141	
37	210051	Doctors Community Hospital	1,604	1,444	$195,871,667	$13,508,198	6.90%	$8,958,029	$4,550,169	2.32%	$8,862,484	
38	210043	Univ. of Maryland Baltimore Washington Medical	2,200	2,936	$344,997,000	$23,691,460	6.87%	$7,068,198	$16,623,262	4.82%	$6,845,000	
39	210017	Garrett County Memorial Hospital	439	10	$51,150,258	$3,169,409	6.20%	$2,505,578	$663,831	1.30%	$2,550,792	
40	210049	Univ. of Maryland Upper Chesepeake Medical Ce	2,156	2,183	$262,553,000	$15,439,651	5.88%	$5,583,667	$9,855,984	3.75%	$4,313,000	
41	210040	Northwest Hospital Center, Inc.	1,767	723	$244,796,678	$13,729,621	5.61%	$2,857,179	$10,872,442	4.44%	$2,067,000	
42	210060	Fort Washington Medical Center	408	416	$42,237,402	$2,368,122	5.61%	$1,135,799	$1,232,323	2.92%	$928,769	
43	210032	Union Hospital of Cecil County	1,372	2,140	$164,054,488	$8,693,334	5.30%	$1,658,143	$7,035,191	4.29%	$1,822,394	
44	210018	MedStar Montgomery General Hospital	1,721	60	$165,450,371	$6,332,705	3.83%	$2,583,041	$3,749,664	2.27%	$1,847,698	
45	210045	McCready Foundation, Inc.	273	8	$18,107,925	$652,490	3.60%	$245,299	$407,192	2.25%	$326,004	

FY 2018 Community Benefit Analysis, by Hospital Ranked by Total CB as % of Total Operating Expense

Hospital	Hospital Name	Number of Employees	Total Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2017 Amount in Rates for Charity Care, DME, and NSPI*	Total Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
	All Hospitals	**86,205**	**113,545**	**$16,143,540,168**	**$1,748,441,689**	**10.83%**	**$662,260,166**	**$1,086,181,523**	**6.73%**	**$310,740,130**
		1,724	**2,226**	**$316,540,003**	**$34,283,170**	**10.53%**		**7.71%**		**$6,092,944**
	* The Adventist Hospital System has requested and received permission to report their Community Benefit									
210058	UMROI	667	0	$109,216,000	$9,418,991	8.62%	$3,937,587	$5,481,404	5.02%	$2,258,000
210064	Levindale	884	126	$77,169,000	$3,327,824	4.31%	$60,313	$3,267,511	4.23%	$1,018,600
213300	Mt. Washington Peds	672	3,151	$58,944,476	$1,476,802	2.51%	$58,586	$1,418,216	2.41%	$86,541
214000	Sheppard Pratt	2,782	724	$234,132,619	$16,611,638	7.09%	$2,670,488	$13,941,150	5.95%	$4,605,738
213029	Adventist Rehabilitation	499	841	$46,858,266	$2,710,713	5.78%	$59,505	$2,651,207	5.66%	$252,630
4013	Adventist Behavioral Health Rockville*	397	752	$49,561,380	$5,299,339	10.69%	$0	$5,299,339	10.69%	$1,415,734

FY 2018 Community Benefit Analysis, by Hospital Ranked by Total Net CB minus Charity Care, DME, NSPI in Rates

	Hospital	Hospital Name	Number of Employees	Total Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2017 Amount in Rates for Charity Care, DME, and NSPI*	Total Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care	
1	210009	Johns Hopkins	0	7,079	$2,396,322,000	$272,875,357	11.39%	$147,081,575	$125,793,781	5.25%	$26,475,000	First Quartile
2	210002 & 218992	Univ. of Maryland Medical Center	8,899	3,919	$1,522,227,000	$212,918,463	13.99%	$135,234,465	$77,683,998	5.10%	$22,057,000	
3	210003 & 210055	UM Capital Region	2,603	4,160	$285,839,000	$78,564,066	27.49%	$18,494,489	$60,069,577	21.02%	$12,147,000	
4	210023	Anne Arundel General Hospital	4,746	3,277	$558,534,000	$50,281,740	9.00%	$5,241,716	$45,040,023	8.06%	$3,923,800	
5	210027	Western Maryland Hospital	1,979	252	$323,338,357	$53,781,549	16.63%	$9,768,650	$44,012,899	13.61%	$10,489,666	
6	210029	Johns Hopkins Bayview Med. Center	3,446	3,421	$632,548,000	$83,958,769	13.27%	$41,100,679	$42,858,090	6.78%	$18,957,000	
7	210019	Peninsula Regional Medical Center	2,794	349	$427,360,744	$50,423,375	11.80%	$8,615,991	$41,807,384	9.78%	$7,604,900	
8	210008	Mercy Medical Center, Inc.	3,551	2,489	$483,817,200	$57,442,772	11.87%	$21,105,897	$36,336,875	7.51%	$14,621,887	
9	210012	Sinai Hospital	4,992	2,295	$752,831,000	$58,913,086	7.83%	$22,701,641	$36,211,445	4.81%	$6,360,600	
10	210063	Univ. of Maryland St. Josephs Medical Center	2,378	25	$337,972,000	$38,134,583	11.28%	$5,765,973	$32,368,610	9.58%	$5,281,000	
11	210044	Greater Baltimore Medical Center	0	4,380	$504,347,676	$42,577,897	8.44%	$10,977,339	$31,600,558	6.27%	$1,710,711	
12	210037	Univ. of Maryland Shore Medical Center at Easton	1,143	1,060	$187,273,586	$31,622,263	16.89%	$2,594,101	$29,028,162	15.50%	$2,800,988	Second Quartile
13	210038	Univ. of Maryland Medical Center Midtown Campu	1,423	250	$223,093,000	$37,972,794	17.02%	$9,165,486	$28,807,308	12.91%	$3,962,000	
14	210016	Washington Adventist Hospital	1,342	5,914	$243,708,768	$35,087,712	14.40%	$7,634,930	$27,452,781	11.26%	$6,640,537	
15	210057	Shady Grove Adventist Hospital	1,994	6,324	$337,019,361	$28,444,407	8.44%	$3,447,593	$24,996,814	7.42%	$2,979,569	
16	210005	Frederick Memorial Hospital	1964	134	$340,036,000	$30,721,235	9.03%	$6,678,838	$24,042,397	7.07%	$6,785,000	
17	210013	Bon Secours Hospital	589	17,917	$109,675,296	$24,668,422	22.49%	$730,964	$23,937,457	21.83%	$488,596	
18	210015	MedStar Franklin Square Hospital	3,013	2,616	$518,888,097	$41,489,808	8.00%	$17,669,649	$23,820,159	4.59%	$7,344,175	
19	210048	Howard County General Hospital	1,752	2,580	$265,393,000	$26,930,941	10.15%	$4,982,536	$21,948,406	8.27%	$4,598,000	
20	210022	Suburban Hospital Association,Inc	1,786	0	$295,311,000	$25,543,204	8.65%	$4,572,896	$20,970,308	7.10%	$4,386,000	
21	210011	St. Agnes Hospital	0	0	$452,096,000	$51,743,113	11.45%	$31,677,797	$20,065,315	4.44%	$23,954,876	
22	210004	Holy Cross	3,461	4,696	$413,981,550	$51,218,319	12.37%	$32,650,121	$18,568,199	4.49%	$31,485,836	
23	210001	Meritus Medical Center	2,707	312	$314,735,209	$23,564,918	7.49%	$5,057,885	$18,507,033	5.88%	$4,718,533	Third Quartile
24	210043	Univ. of Maryland Baltimore Washington Medical	2,200	2,936	$344,997,000	$23,691,460	6.87%	$7,068,198	$16,623,262	4.82%	$6,845,000	
25	210024	MedStar Union Memorial Hospital	2,263	664	$449,182,066	$37,410,521	8.33%	$21,397,237	$16,013,284	3.56%	$6,610,504	
26	210033	Carroll County General Hospital	1,793	2,080	$195,292,000	$15,781,944	8.08%	$1,056,643	$14,725,301	7.54%	$546,974	
27	210039	Calvert Memorial Hospital	1,300	376	$131,906,976	$18,375,823	13.93%	$4,425,743	$13,950,080	10.58%	$5,547,029	
28	210028	MedStar St. Marys Hospital	1,200	5,000	$162,218,677	$17,492,296	10.78%	$4,513,378	$12,978,918	8.00%	$3,983,754	
29	210062	MedStar Southern Maryland Hospital	1,221	8,212	$247,677,692	$18,050,703	7.29%	$5,356,630	$12,694,073	5.13%	$4,843,585	
30	210034	MedStar Harbor Hospital Center	1,125	682	$183,508,480	$22,870,652	12.46%	$10,451,356	$12,419,296	6.77%	$3,820,520	
31	210030	Univ. of Maryland Shore Medical Center at Chester	241	1,260	$46,259,300	$12,388,833	26.78%	$472,539	$11,916,295	25.76%	$475,000	
32	210040	Northwest Hospital Center, Inc.	1,767	723	$244,796,678	$13,729,621	5.61%	$2,857,179	$10,872,442	4.44%	$2,067,000	
33	210061	Atlantic General Hospital	950	95	$127,458,282	$13,401,211	10.51%	$2,828,191	$10,573,020	8.30%	$2,567,553	
34	210035	Univ. of Maryland Charles Regional Medical Cente	0	1,868	$120,993,920	$11,528,332	9.53%	$1,114,829	$10,413,503	8.61%	$971,260	Fourth Quartile
35	210049	Univ. of Maryland Upper Chesepeake Medical Cen	2,156	2,183	$262,553,000	$15,439,651	5.88%	$5,583,667	$9,855,984	3.75%	$4,313,000	
36	210010	Univ. of Maryland Shore Medical Center at Dorche	284	1,460	$40,094,943	$10,346,219	25.80%	$687,909	$9,658,310	24.09%	$704,387	
37	210056	MedStar Good Samaritan Hospital	1,722	1,594	$259,072,976	$18,360,426	7.09%	$10,577,237	$7,783,188	3.00%	$4,954,141	
38	210032	Union Hospital of Cecil County	1,372	2,140	$164,054,488	$8,693,334	5.30%	$1,658,143	$7,035,191	4.29%	$1,822,394	
39	210006	Univ. of Maryland Harford Memorial Hospital	994	936	$87,719,000	$7,721,886	8.80%	$1,580,226	$6,141,660	7.00%	$1,903,000	
40	210051	Doctors Community Hospital	1,604	1,444	$195,871,667	$13,508,198	6.90%	$8,958,029	$4,550,169	2.32%	$8,862,484	
41	210065	Holy Cross German Town	674	356	$100,707,482	$9,403,754	9.34%	$5,465,624	$3,938,129	3.91%	$4,839,365	
42	210018	MedStar Montgomery General Hospital	1,721	60	$165,450,371	$6,332,705	3.83%	$2,583,041	$3,749,664	2.27%	$1,847,698	
43	210060	Fort Washington Medical Center	408	416	$42,237,402	$2,368,122	5.61%	$1,135,799	$1,232,323	2.92%	$928,769	
44	210017	Garrett County Memorial Hospital	439	10	$51,150,258	$3,169,409	6.20%	$2,505,578	$663,831	1.30%	$2,550,792	
45	210045	McCready Foundation, Inc.	273	8	$18,107,925	$652,490	3.60%	$245,299	$407,192	2.25%	$326,004	

	All Hospitals	**84,654**	**113,419**	**$15,957,155,168**	**$1,735,694,875**	**10.88%**	**$658,262,266**	**$1,077,432,608**	**6.75%**	**$307,463,530**	
		1,764	**2,315**	**$325,656,228**	**$35,422,344**	**10.69%**		**7.83%**		**$6,274,766**	

* The Adventist Hospital System has requested and received permission to report their Community Benefit activities on

210058	UMROI	667	0	$109,216,000	$9,418,991	8.62%	$3,937,587	$5,481,404	5.02%	$2,258,000
210064	Levindale	884	126	$77,169,000	$3,327,824	4.31%	$60,313	$3,267,511	4.23%	$1,018,600
213300	Mt. Washington Peds	672	3,151	$58,944,476	$1,476,802	2.51%	$58,586	$1,418,216	2.41%	$86,541
214000	Sheppard Pratt	2,782	724	$234,132,619	$16,611,638	7.09%	$2,670,488	$13,941,150	5.95%	$4,605,738
213029	Adventist Rehabilitation	499	841	$46,858,266	$2,710,713	5.78%	$59,505	$2,651,207	5.66%	$252,630
4013	Adventist Behavioral Health Rockville*	397	752	$49,561,380	$5,299,339	10.69%	$0	$5,299,339	10.69%	$1,415,734

FY 2018 Community Benefit Analysis, by Hospital Ranked by Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense

	Hospital	Hospital Name	Number of Employees	Total Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2017 Amount in Rates for Charity Care, DME, and NSPI*	Total Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care	
1	210030	Univ. of Maryland Shore Medical Center at Chester	241	1,260	$46,259,300	$12,388,833	26.78%	$472,539	$11,916,295	25.76%	$475,000	First Quartile
2	210010	Univ. of Maryland Shore Medical Center at Dorche	284	1,460	$40,094,943	$10,346,219	25.80%	$687,909	$9,658,310	24.09%	$704,387	
3	210013	Bon Secours Hospital	589	17,917	$109,675,296	$24,668,422	22.49%	$730,964	$23,937,457	21.83%	$488,596	
4	210003 & 210055	UM Capital Region	2,603	4,160	$285,839,000	$78,564,066	27.49%	$18,494,489	$60,069,577	21.02%	$12,147,000	
5	210037	Univ. of Maryland Shore Medical Center at Easton	1,143	1,060	$187,273,586	$31,622,263	16.89%	$2,594,101	$29,028,162	15.50%	$2,800,988	
6	210027	Western Maryland Hospital	1,979	252	$323,338,357	$53,781,549	16.63%	$9,768,650	$44,012,899	13.61%	$10,489,666	
7	210038	Univ. of Maryland Medical Center Midtown Camp	1,423	250	$223,093,000	$37,972,794	17.02%	$9,165,486	$28,807,308	12.91%	$3,962,000	
8	210016	Washington Adventist Hospital	1,342	5,914	$243,708,768	$35,087,712	14.40%	$7,634,930	$27,452,781	11.26%	$6,640,537	
9	210039	Calvert Memorial Hospital	1,300	376	$131,906,976	$18,375,823	13.93%	$4,425,743	$13,950,080	10.58%	$5,547,029	
10	210019	Peninsula Regional Medical Center	2,794	349	$427,360,744	$50,423,375	11.80%	$8,615,991	$41,807,384	9.78%	$7,604,900	
11	210063	Univ. of Maryland St. Josephs Medical Center	2,378	25	$337,972,000	$38,134,583	11.28%	$5,765,973	$32,368,610	9.58%	$5,281,000	
12	210035	Univ. of Maryland Charles Regional Medical Cente	0	1,868	$120,993,920	$11,528,332	9.53%	$1,114,829	$10,413,503	8.61%	$971,260	Second Quartile
13	210061	Atlantic General Hospital	950	95	$127,458,282	$13,401,211	10.51%	$2,828,191	$10,573,020	8.30%	$2,567,553	
14	210048	Howard County General Hospital	1,752	2,580	$265,393,000	$26,930,941	10.15%	$4,982,536	$21,948,406	8.27%	$4,598,000	
15	210023	Anne Arundel General Hospital	4,746	3,277	$558,534,000	$50,281,740	9.00%	$5,241,716	$45,040,023	8.06%	$3,923,800	
16	210028	MedStar St. Marys Hospital	1,200	5,000	$162,218,677	$17,492,296	10.78%	$4,513,378	$12,978,918	8.00%	$3,983,754	
17	210033	Carroll County General Hospital	1,793	2,080	$195,292,000	$15,781,944	8.08%	$1,056,643	$14,725,301	7.54%	$546,974	
18	210008	Mercy Medical Center, Inc.	3,551	2,489	$483,817,200	$57,442,772	11.87%	$21,105,897	$36,336,875	7.51%	$14,621,887	
19	210057	Shady Grove Adventist Hospital	1,994	6,324	$337,019,361	$28,444,407	8.44%	$3,447,593	$24,996,814	7.42%	$2,979,569	
20	210022	Suburban Hospital Association,Inc	1,786	0	$295,311,000	$25,543,204	8.65%	$4,572,896	$20,970,308	7.10%	$4,386,000	
21	210005	Frederick Memorial Hospital	1964	134	$340,036,000	$30,721,235	9.03%	$6,678,838	$24,042,397	7.07%	$6,785,000	
22	210006	Univ. of Maryland Harford Memorial Hospital	994	936	$87,719,000	$7,721,886	8.80%	$1,580,226	$6,141,660	7.00%	$1,903,000	
23	210029	Johns Hopkins Bayview Med. Center	3,446	3,421	$632,548,000	$83,958,769	13.27%	$41,100,679	$42,858,090	6.78%	$18,957,000	Third Quartile
24	210034	MedStar Harbor Hospital Center	1,125	682	$183,508,480	$22,870,652	12.46%	$10,451,356	$12,419,296	6.77%	$3,820,520	
25	210044	Greater Baltimore Medical Center	0	4,380	$504,347,676	$42,577,897	8.44%	$10,977,339	$31,600,558	6.27%	$1,710,711	
26	210001	Meritus Medical Center	2,707	312	$314,735,209	$23,564,918	7.49%	$5,057,885	$18,507,033	5.88%	$4,718,533	
27	210009	Johns Hopkins	0	7,079	$2,396,322,000	$272,875,357	11.39%	$147,081,575	$125,793,781	5.25%	$26,475,000	
28	210062	MedStar Southern Maryland Hospital	1,221	8,212	$247,677,692	$18,050,703	7.29%	$5,356,630	$12,694,073	5.13%	$4,843,585	
29	210002 & 218992	Univ. of Maryland Medical Center	8,899	3,919	$1,522,227,000	$212,918,463	13.99%	$135,234,465	$77,683,998	5.10%	$22,057,000	
30	210043	Univ. of Maryland Baltimore Washington Medical	2,200	2,936	$344,997,000	$23,691,460	6.87%	$7,068,198	$16,623,262	4.82%	$6,845,000	
31	210012	Sinai Hospital	4,992	2,295	$752,831,000	$58,913,086	7.83%	$22,701,641	$36,211,445	4.81%	$6,360,600	
32	210015	MedStar Franklin Square Hospital	3,013	2,616	$518,888,097	$41,489,808	8.00%	$17,669,649	$23,820,159	4.59%	$7,344,175	
33	210004	Holy Cross	3,461	4,696	$413,981,550	$51,218,319	12.37%	$32,650,121	$18,568,199	4.49%	$31,485,836	
34	210040	Northwest Hospital Center, Inc.	1,767	723	$244,796,678	$13,729,621	5.61%	$2,857,179	$10,872,442	4.44%	$2,067,000	Fourth Quartile
35	210011	St. Agnes Hospital	0	0	$452,096,000	$51,743,113	11.45%	$31,677,797	$20,065,315	4.44%	$23,954,876	
36	210032	Union Hospital of Cecil County	1,372	2,140	$164,054,488	$8,693,334	5.30%	$1,658,143	$7,035,191	4.29%	$1,822,394	
37	210065	Holy Cross German Town	674	356	$100,707,482	$9,403,754	9.34%	$5,465,624	$3,938,129	3.91%	$4,839,365	
38	210049	Univ. of Maryland Upper Chesepeake Medical Cen	2,156	2,183	$262,553,000	$15,439,651	5.88%	$5,583,667	$9,855,984	3.75%	$4,313,000	
39	210024	MedStar Union Memorial Hospital	2,263	664	$449,182,066	$37,410,521	8.33%	$21,397,237	$16,013,284	3.56%	$6,610,504	
40	210056	MedStar Good Samaritan Hospital	1,722	1,594	$259,072,976	$18,360,426	7.09%	$10,577,237	$7,783,188	3.00%	$4,954,141	
41	210060	Fort Washington Medical Center	408	416	$42,237,402	$2,368,122	5.61%	$1,135,799	$1,232,323	2.92%	$928,769	
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		1,764	**2,315**	**$325,656,228**	**$35,422,344**	**10.69%**		**7.83%**		**$6,274,766**

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213029	Adventist Rehabilitation	499	841	$46,858,266	$2,710,713	5.78%	$59,505	$2,651,207	5.66%	$252,630
4013	Adventist Behavioral Health Rockville*	397	752	$49,561,380	$5,299,339	10.69%	$0	$5,299,339	10.69%	$1,415,734

EXHIBIT 10

MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY
SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 03-015

Issued to:

Greater Baltimore Medical Center
6701 North Charles Street
Baltimore, MD 21204

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.

EXHIBIT 11

Greater Baltimore Medical Center

Baltimore, MD

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

October 14, 2017

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #6248
Print/Reprint Date: 01/09/2018

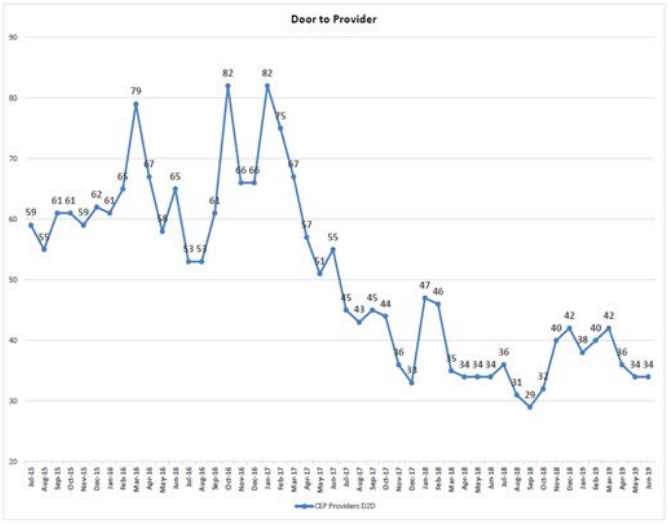
Mark R. Chassin, MD, FACP, MPP, MPH
President

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

EXHIBIT 12

Quality Measure	Corrective Action Plan
Practice Patterns	
Percentage of births (deliveries) that are C-sections	When risk is stratified, GBMC's percentage of births (deliveries) that are C-sections are: GBMC rate: 31.4% GBMC rate stratified by risk Low risk by age group (18-35 years): 26% Low risk by age AND Obesity (BMI): 16.63% GBMC's percentage of C-section births for low risk either by age grouper or age and obesity are well below the overall rate of 31.4%. GBMC serves patients who have had multiple births, women of advanced age, and patients of size which contribute significantly to the overall C-section percentage.
How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)	GBMC continues to educate practitioners and patients on the safest form of delivery after a previous delivery by C-section.
How often babies in the hospital are delivered using cesarean section when this is the mother's first birth.	GBMC's percentage of C-section births for low risk either by age group or age and obesity are well below the overall rate of 31.4%. GBMC serves patients who have had multiple births, women of advanced age, and patients of size which contribute significantly to the overall C-section percentage. GBMC continues to educate practitioners and patients on the safest form of delivery for both mother and baby.
How often babies are born vaginally when the mother has had a C-section in the past (includes complications)	GBMC continues to educate practitioners and patients on the safest form of delivery after a previous delivery by C-section.
Communication	
How often did staff always explain about medicines before giving them to patients?	GBMC continues to implement performance improvement initiatives designed to increase the amount and quality of the communication between providers and patients, including the deployment of Language of Caring for all employees.
Environment	
How often were the patients' rooms and bathrooms always kept clean?	GBMC continues to implement performance improvement initiatives designed to improve job instruction and standard work in the cleaning of patient rooms.

Quality Measure	Corrective Action Plan
Practice Patterns	
How often was the area around patients' rooms always kept quiet at night?	GBMC continues to implement performance improvement initiatives designed to educate providers and staff about the importance of quiet and rest for patients, especially during the night.
Wait Times	
How long patients spent in the emergency department before leaving for their hospital room	GBMC has seen small improvements in this metric. Steps taken to facilitate improvement include: 1. Work with transport to make the patient's movement from the ED faster as soon as there is a clean bed available in the hospital (auto-generated). 2. Work with nursing to expedite the report that a patient is ready to move (i.e., clean bed & admission orders entered). GBMC is currently moving towards electronic handoff, which should improve ease of report from department to department.
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	GBMC has identified the challenges related to the duration of stay after the doctor decided the patient would stay in the hospital before leaving for his/her hospital room. GBMC is currently focused on: 1. Efforts to expedite discharges so that GBMC has available beds for admissions. 2. Recruiting a capacity command position to more efficiently allocate beds appropriately and with clear admission guidelines.
How long patients spent in the emergency department before being sent home	Recognizing that this is an issue, GBMC has begun identifying common reasons for delayed discharge daily (including patients whose discharges are delayed while awaiting transfer to another facility/SNF/Psych) and working with our physician groups and discharge coordinators to create an action plan.

Quality Measure	Corrective Action Plan
Practice Patterns	
How long patients spent in the emergency department before they were seen by a healthcare professional	As shown in the chart below, the time spent in the emergency department before being seen by a healthcare professional has significantly decreased over last few of years. In June 2019, GBMC implemented a new triage unit in the ED which is designed to further reduce wait time. 
Patients who left the emergency department without being seen	GBMC deployed a new emergency room triage unit in June 2019 in order to expedite a patient's first initial patient contact and reduce the number of patients who leave without being seen.

Quality Measure	Corrective Action Plan
Practice Patterns	
Recommended Care—Outpatient	
Patients with a heart attack who received aspirin on arrival to the hospital	GBMC continues to follow its standard work in stroke and chest pain management and the delivery of aspirin on arrival.
How long patients who come to the hospital with chest pain or possible heart attack waited to get a test that detects heart damage after a heart attack	GBMC currently uses AHA guidelines to set its targets for goal time/outcomes. GBMC recently identified the need to place a second EKG machine in the triage area of the ED to account for multiple chest pain patients requiring EKG at one time. The deployment of the second EKG machine has since been accomplished.
Practice Patterns	
Contrast material (dye) used during abdominal CT scan	**TBD**
Contrast material (dye) used during thorax CT scan	**TBD**
Results of Care-Complications	
Patients who developed a blood clot while in the hospital and did not get treatment that could have prevented it	GBMC is aware of this issue and has created a multi-disciplinary team to generate an action plan to address this issue to improve quality outcomes.
Percentage of patients who received appropriate care for severe sepsis and septic shock	GBMC is aware of this issue and has created a multi-disciplinary team to generate an action plan to address this issue to improve quality outcomes.
Results of Care	
How often patients in the hospital get a blood clot in the lung or leg vein after surgery	GBMC is aware of this issue and has created a multi-disciplinary team to generate an action plan to address this issue to improve quality outcomes.

EXHIBIT 13

Standard .04B(7) – Construction Cost of Hospital Space

(a) The cost per square foot of hospital construction projects shall be no greater than the cost of good quality Class A hospital construction given in the Marshall and Swift Valuation Quarterly, updated to the nearest quarter using the Marshall and Swift update multipliers, and adjusted as shown in the Marshall and Swift guide as necessary for terrain of the site, number of levels, geographic locality, and other listed factors.

(b) Each Certificate of Need applicant proposing costs per square foot above the limitations set forth in the Marshall and Swift Guide must demonstrate that the higher costs are reasonable.

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

I. Marshall Valuation Service Valuation Benchmark

A. Hospital Building

Type		Hospital
Construction Quality/Class		Good/A
Stories		3
Perimeter		922
Average Floor to Floor Height		12.7
Square Feet		92,601
f.1	Average floor Area	30,867
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		0.97
Adjusted Total Base Cost		$362.97

B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$362.97
C. Multipliers		
Perimeter Multiplier		0.923251052
	Product	$335.11
Height Multiplier		1.046
	Product	$350.52
Multi-story Multiplier		1.000
	Product	$350.52
D. Sprinklers		
	Sprinkler Amount	$3.06
Subtotal		$353.58
E. Update/Location Multipliers		
Update Multiplier		1.09
	Product	$385.40
Location Multiplier		1
	Product	$385.40
Calculated Square Foot Cost Benchmark		**$385.40**

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				
Level 3 - Circulation & Seating - Atrium	4,601	Public Space	0.8	3,681
Level 3 - Circulation & Seating - New Addition	12,967	Public Space	0.8	10,374
Level 3 - Support & Reception	3,078	Offices	0.96	2,955
Level 3 - Spiritual / Chapel	2,043	Public Space	0.8	1,634
Level 3 - Gift Shop	2,326	Public Space	0.8	1,861
Level 3 - Food Service	1,360	Dining Room	0.95	1,292
Level 3 - Medical Library	2,230	Offices	0.96	2,141
Level 3 - Pharmacy	2,110	Pharmacy	1.33	2,806
Level 3 - Wellness	3,465	Offices	0.98	3,396
Level 3 - Welcome Center	1,411	Offices	0.98	1382.78
Level 4 - Med/Surg	26,240	Inpatient Units	1.06	27,814
Level 4 - Public Circulation	2,265	Internal Circulation, Corridors	0.6	1,359
Level 5 - Med/Surg	26,240	Inpatient Units	1.06	27,814
Level 5 - Public Circulation	2,265	Internal Circulation, Corridors	0.6	1,359
Total	92,601		**0.97**	89,869

B. <u>Mechanical Penthouse</u>

Type	Mechanical Penthouse
Construction Quality/Class	Excellent/A-B
Stories	3
Perimeter	812
Average Floor to Floor Height	20.00
Square Feet	13,482
Average floor Area	13,482

A. Base Costs		
	Basic Structure	$ 92.00
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$92.00
B. Additions		
	Elevator (If not in base)	$28.48
	Other	$0.00
	Subtotal	$28.48
Total		$120.48
C. Multipliers		
Perimeter Multiplier		1.00178824
	Product	$120.70
Height Multiplier		1.184
	Product	$142.91
Multi-story Multiplier		1.005
	Product	$143.62
D. Sprinklers		
	Sprinkler Amount	$0.00
	Subtotal	$143.62
E. Update/Location Multipliers		
Update Multiplier		1.09
	Product	$156.55
Location Multiplier		1
	Product	$156.55
Calculated Square Foot Cost Standard		**$156.55**

C. Consolidated Benchmark

	MVS Benchmark	Sq. Ft.	Total Cost Based on MVS
Standard			
"Tower" Component	$385.40	92,601	$35,688,788.89
Mechanical Penthouse	$156.55	13,482	$2,110,562.41
Consolidated	**$356.32**	106,083	$37,799,351.30

Cost of New Construction

A. Base Calculations	**Actual**	**Per Sq. Foot**
Building	$55,214,606	$520.48
Fixed Equipment		$0.00
Site Preparation	$8,393,957	$79.13
Architectual Fees	$5,294,254	$49.91
Permits	$393,594	$3.71
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$69,296,412	$653.23

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**
Site Demolition Costs	$150,000	Site	
Storm Drains	$720,000	Site	
Rough Grading	$2,902,632	Site	
Site Fire Protection Systems	$78,000	Site	
Rock Removal	$420,000	Site	
Sanitary Sewer Premium for Elevation and Charles St..	$828,000	Site	
Paving	$573,482	Site	
Exterior Signs	$120,000	Site	
Landscaping	$210,000	Site	
Walls	$168,000	Site	
Yard Lighting	$124,800	Site	

	Project Costs		Associated Cap Interest
Constricted Site	$419,698	Site	
Sanitary Sewer Charles Street	$600,000	Site	
LEED Silver Green Building Premium	$335,758	Site	
MBE Participation Cost Premium	$335,758	Site	
Atrium Premium	$7,745,898	Building	$691,926
Canopy	$1,021,200	Building	$91,222
Premium for Concrete Frame Construction	$1,080,000	Building	$96,474
Terracotta Rain Screen	$465,791	Building	$41,608
Above-average glass percentage for updated exterior design	$240,000	Building	$21,439
Laboratory Gas Quality Piping and Connection to Existing System	$245,454	Building	$21,926
DX Remote Condenser w/fan coil & piping	$183,664	Building	$16,406
Electrical, Patient Ground Modules	$127,722	Building	$11,409
Electrical, Isolation Power Panels	$52,276	Building	$4,670
Unconditioned Covered Utility Walkways on New Addition	$360,098	Building	$32,167
Required Atrium smoke evacuation system	$120,000	Building	$10,719
Pneumatic Tubes	$120,779	Building	$10,789
Concrete Mud Slab	$207,900	Building	$18,571
Misc. Roof Patching on Existing Building	$240,000	Building	$21,439
Constricted Site	$2,760,730	Building	$246,611
Connector Structures	$412,548	Building	$36,852
MPE Piping at Existing	$1,292,183	Building	$115,428
LEED Silver Green Building Premium	$2,208,584	Building	$197,288
MBE Participation Cost Premium	$2,208,584	Building	$197,288
Jurisdictional/Bldg Permit Review Fee	$320,594	Permits	
Storm Water Mgmt. Review Fee	$18,000	Permits	
Utility Connection Fees	$20,000	Permits	
Total Cost Adjustments	$29,438,134		$1,884,233

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 MBE Participation Cost Premium as an example:

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

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

C. Adjusted Project Cost	**Adjusted Project Costs**	**Per Square Foot**
Building	$34,121,195	$321.65
Fixed Equipment	$0	$0.00
Site Preparation	$407,829	$3.84
Architectual Fees	$5,294,254	$49.91
Permits	$35,000	$0.33
Subtotal	$39,858,278	$375.73
Capitalized Construction Interest	$3,047,979	$28.73
Total	$42,906,257	$404.46

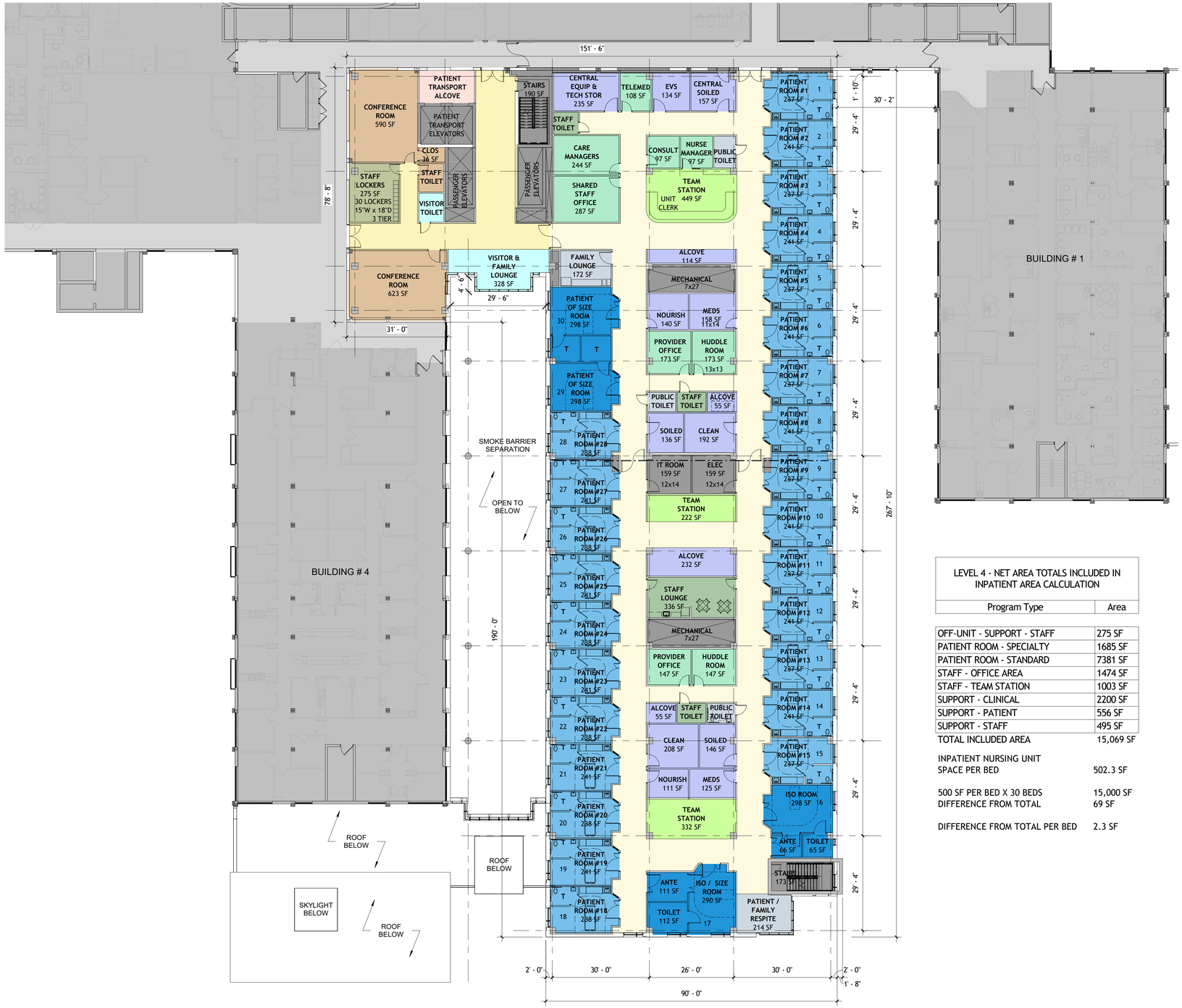
Building associated Capitalized Interest and Loan Placement Fees were calculated as follows:

Hospital	New	Renovation	Total		
Building Cost	$55,214,606	$3,432,929			
Subtotal Cost (w/o Cap Interest)	$69,296,412	$3,752,929	$73,049,341		
Subtotal/Total	94.9%	5.1%	Cap Interest	Loan Place-ment Fees	Total
Total Project Cap Interest &Financing [(Subtotal Cost/Total Cost) X Total Cap Interest]	$6,190,112	$335,242	$5,825,354	$700,000	$6,525,354
Building/Subtotal	79.7%	91.5%			
Building Cap Interest & Loan Place.	$4,932,212	$306,657			
Associated with Extraordinary Costs	$1,884,233				
Applicable Cap Interest & Loan Place.	$3,047,979				

As noted below, the project's cost per square foot exceeds the MVS benchmark.

MVS Benchmark	$356.32
The Project	$404.46
Difference	$48.14
%	13.51%

EXHIBIT 14



PROGRAM TYPE

- CIRCULATION - OFF-UNIT
- CIRCULATION - ON-UNIT
- CIRCULATION - PATIENT TRANSPORT
- OFF-UNIT - MULTI-DEPARTMENT
- OFF-UNIT - SUPPORT - STAFF
- OFF-UNIT - VISITOR
- PATIENT ROOM - SPECIALTY
- PATIENT ROOM - STANDARD
- SERVICE
- STAFF - OFFICE AREA
- STAFF - TEAM STATION
- SUPPORT - CLINICAL
- SUPPORT - PATIENT
- SUPPORT - STAFF

LEVEL 4 - NET AREA TOTALS INCLUDED IN INPATIENT AREA CALCULATION

Program Type	Area
OFF-UNIT - SUPPORT - STAFF	275 SF
PATIENT ROOM - SPECIALTY	1685 SF
PATIENT ROOM - STANDARD	7381 SF
STAFF - OFFICE AREA	1474 SF
STAFF - TEAM STATION	1003 SF
SUPPORT - CLINICAL	2200 SF
SUPPORT - PATIENT	556 SF
SUPPORT - STAFF	495 SF
TOTAL INCLUDED AREA	15,069 SF
INPATIENT NURSING UNIT SPACE PER BED	502.3 SF
500 SF PER BED X 30 BEDS	15,000 SF
DIFFERENCE FROM TOTAL	69 SF
DIFFERENCE FROM TOTAL PER BED	2.3 SF

LEVEL 4 - NET AREA TOTALS - NOT INCLUDED IN INPATIENT AREA CALCULATION

Program Type	Area
CIRCULATION - OFF-UNIT	1162 SF
CIRCULATION - ON-UNIT	5948 SF
CIRCULATION - PATIENT TRANSPORT	172 SF
OFF-UNIT - MULTI-DEPARTMENT	1317 SF
OFF-UNIT - VISITOR	397 SF
SERVICE	1148 SF

1 LEVEL 4 & 5 - TYPICAL FLOOR PLAN LAYOUT

A2.09 | A6.3 | 1/16" = 1'-0"

0 8 16 32

PROMISE PROJECT

6701 CHARLES STREET
TOWSON, MD 21204

LEVEL 4 & 5 - TYPICAL FLOOR PLAN LAYOUT WITH NET AREA CALCULATION

Scale: 1/16" = 1'-0"

hord | coplan | macht

07/12/2019

EXHIBIT 15

KPMG

GBMC HEALTHCARE, INC. AND SUBSIDIARIES

Consolidated Financial Statements and Consolidating Information

June 30, 2018 and 2017

(With Independent Auditors' Report Thereon)

GBMC HEALTHCARE, INC.
AND SUBSIDIARIES

Table of Contents

KPMG LLP
750 East Pratt Street, 18th Floor
Baltimore, MD 21202

Independent Auditors' Report

The Board of Directors
GBMC HealthCare, Inc.:

We have audited the accompanying consolidated financial statements of GBMC HealthCare, Inc. and its subsidiaries (the Company), which comprise the consolidated balance sheets as of June 30, 2018 and 2017, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of GBMC HealthCare, Inc. and its subsidiaries as of June 30, 2018 and 2017, and the results of their operations, changes in net assets and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary information in Schedules 1–3 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

October 4, 2018

GBMC HEALTHCARE, INC.
AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2018 and 2017

(In thousands)

Assets	2018	2017
Current assets:		
Cash	$ 34,850	33,092
Short-term investments and limited or restricted use funds	11,955	12,974
Patient accounts receivable, net of reserves of $12,652 and $17,927	54,001	62,401
Other receivables	15,831	15,262
Other current assets	10,809	10,164
Total current assets	127,446	133,893
Noncurrent assets:		
Investments and limited or restricted use funds	419,346	380,662
Property, plant and equipment, net	275,206	279,769
Other assets	36,070	31,196
Total noncurrent assets	730,622	691,627
Total assets	$ 858,068	825,520
Liabilities and Net Assets		
Current liabilities:		
Accounts payable and accrued expenses	$ 71,553	59,937
Insurance reserves, current	13,435	12,466
Advances from third-party payors	14,453	13,047
Current portion of long-term debt and capital lease liabilities	13,660	13,487
Other current liabilities	4,582	4,569
Total current liabilities	117,683	103,506
Noncurrent liabilities:		
Long-term debt	140,713	152,232
Capital lease liabilities	23,302	25,283
Insurance reserves	44,569	44,226
Pension liability	8,494	11,054
Other long-term liabilities	2,839	4,711
Total liabilities	337,600	341,012
Net assets:		
Unrestricted controlling interest	437,508	405,942
Unrestricted noncontrolling interest	5,142	5,150
Total unrestricted	442,650	411,092
Temporarily restricted	42,477	41,073
Permanently restricted	35,341	32,343
Total net assets	520,468	484,508
Total liabilities and net assets	$ 858,068	825,520

See accompanying notes to consolidated financial statements.

GBMC HEALTHCARE, INC.
AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended June 30, 2018 and 2017

(In thousands)

	2018	2017
Patient service revenue:		
Patient service revenue, net of contractual allowances	$ 561,205	542,349
Provision for uncollectible accounts	(13,799)	(17,807)
Net patient service revenue	547,406	524,542
Other operating revenue	15,023	14,442
Net assets released from restrictions	11,051	12,134
Total operating revenue	573,480	551,118
Operating expenses:		
Salaries, wages and employee benefits	350,371	345,349
Expendable supplies	92,789	86,884
Purchased services	78,833	75,366
Depreciation and amortization	40,795	35,401
Interest	6,566	6,917
Total operating expenses	569,354	549,917
Total operating income	4,126	1,201
Other income (loss):		
Contributions	2,014	3,322
Fund-raising expense	(3,144)	(3,532)
Investment income, net	27,635	34,853
Loss on extinguishment of debt	—	(8,845)
Total other income	26,505	25,798
Excess of revenues over expenses	$ 30,631	26,999

See accompanying notes to consolidated financial statements.

GBMC HEALTHCARE, INC.
AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2018 and 2017

(In thousands)

	2018	2017
Excess of revenues over expenses	$ 30,631	26,999
Changes in unrestricted net assets:		
Pension-related changes other than net periodic pension costs	1,117	17,546
Net assets released for purchase of fixed assets	1,710	925
Distribution to noncontrolling interest	(1,900)	(1,550)
Increase in unrestricted net assets	31,558	43,920
Changes in temporarily restricted net assets:		
Contributions	9,374	10,836
Investment income, net	4,791	5,846
Net assets released for operations	(11,051)	(12,134)
Net assets released for purchase of fixed assets	(1,710)	(925)
Net asset reclass	—	(336)
Increase in temporarily restricted net assets	1,404	3,287
Changes in permanently restricted net assets:		
Contributions	2,951	2,404
Net unrealized gain on investments	47	85
Net asset reclass	—	(294)
Increase in permanently restricted net assets	2,998	2,195
Increase in net assets	35,960	49,402
Net assets, beginning of year	484,508	435,106
Net assets, end of year	$ 520,468	484,508

See accompanying notes to consolidated financial statements.

GBMC HEALTHCARE, INC.
AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2018 and 2017

(In thousands)

	2018	2017
Cash flows from operating activities:		
Increase in net assets	$ 35,960	49,402
Adjustments to reconcile increase in net assets to net cash provided by (used in) operating activities:		
Depreciation and amortization	40,795	35,401
Loss on extinguishment of debt	—	8,845
Provision for uncollectible accounts	13,799	17,807
Realized and unrealized gains on investments	(25,756)	(35,152)
Pension-related changes other than net periodic pension costs	(1,117)	(17,546)
Restricted investment income	(923)	(717)
Restricted contributions	(12,325)	(13,240)
Unrealized gains on joint ventures	(933)	(975)
Distribution to noncontrolling interest	1,900	1,550
Changes in assets and liabilities:		
Increase in patient accounts receivable	(5,399)	(25,779)
(Increase) decrease in other receivables and other assets	(2,831)	2,077
Increase (decrease) in accounts payable and accrued expenses, advances from third parties, current and noncurrent liabilities	7,312	(8,924)
Decrease in pension liability	(1,443)	(31,898)
Net cash provided by (used in) operating activities	49,039	(19,149)
Cash flows from investing activities:		
Change in investments and limited or restricted use funds	(5,987)	21,496
Purchases of alternative investments	(4,066)	(5,207)
Additions to property and equipment	(30,909)	(32,985)
Net cash used in investing activities	(40,962)	(16,696)
Cash flows from financing activities:		
Payment on long-term debt and capital lease liabilities	(13,487)	(12,301)
Payments for deferred financing costs	—	(740)
Defeasance of bonds	—	(73,720)
Proceeds from bond issuance	—	99,445
Proceeds from restricted contributions	9,068	11,171
Distributions to noncontrolling interest	(1,900)	(1,550)
Net cash provided by (used in) financing activities	(6,319)	22,305
Increase (decrease) in cash	1,758	(13,540)
Cash, beginning of year	33,092	46,632
Cash, end of year	$ 34,850	33,092
Cash paid during the year for interest	$ 5,786	6,605
Capital additions accrued but not paid	7,808	2,485

See accompanying notes to consolidated financial statements.

(1) Organization and Consolidation

GBMC HealthCare, Inc. (the Company), is a holding company for nonprofit companies, which includes: Greater Baltimore Medical Center, Inc. (Medical Center), Greater Baltimore Health Alliance, Physicians, LLC, GBMC Foundation, Inc., Gilchrist Hospice Care, Inc., GBMC Land, Inc., and GBMC Agency, Inc.

The Medical Center is a wholly owned not-for-profit hospital that provides inpatient, outpatient, emergency care, and physician services primarily for residents of the Baltimore metropolitan area. The Medical Center was formed by an agreement dated September 1, 1965, by the Hospital for Women of Maryland of Baltimore City and Presbyterian Eye, Ear and Throat Charity Hospital. In addition, the Medical Center has ownership of Ruxton Insurance Company, Ltd. (Ruxton), an insurance captive domiciled in Bermuda. Ruxton insures the risks for malpractice and general liability claims. Effective July 1, 2017, physician practices that were in GBMC Physicians, LLC, a subsidiary of GBMC Agency, Inc., were transferred to the Medical Center.

Greater Baltimore Health Alliance Physicians, LLC (GBHA) is a wholly owned not-for-profit accountable care organization which integrates community primary care with hospital and multi-specialty care in the Baltimore area.

GBMC Foundation, Inc. (Foundation) is a wholly owned not-for-profit organization which coordinates fundraising efforts to benefit the Company and its subsidiaries.

Gilchrist Hospice Care, Inc. d/b/a Gilchrist Services, Inc. (Hospice) is a wholly owned not-for-profit organization which provides inpatient and home hospice care in the greater Baltimore area. Hospice is the sole member of Joseph Richey House, Inc. (JRH), which provides inpatient hospice care in Baltimore city.

GBMC Land, Inc. (Land) is a wholly owned not-for-profit organization which operates Physicians Pavilion North, a medical building on the campus of the Medical Center.

GBMC Agency, Inc. (Agency) is a wholly owned for-profit organization which has ownership interest in various medical services companies as follows:

- Greater Baltimore Diagnostic Imaging Partnership (GBDIP), a diagnostic imaging company, which is 50% owned and consolidated in the financial statements of the Company.
- GBMC Pavilion West Medical Arts LLC, which owns and operates the five upper floors of Physicians Pavilion West, a medical office building on the campus of the Medical Center.
- GBMC Pavilion Medical Arts, LLC, which owns and operates Physicians Pavilion East, a medical office building on the campus of the Medical Center.

(2) Summary of Significant Accounting Policies

(a) Basis of Accounting

The accompanying consolidated financial statements have been prepared on an accrual basis of accounting in accordance with U.S. generally accepted accounting principles.

(b) Consolidation of Subsidiaries

The Company's consolidated financial statements include the subsidiaries in which the Company has 50% or more voting interests or when the Company is deemed to have control. Significant intercompany accounts and transactions have been eliminated in consolidation.

(c) Cash

Cash balances may exceed amounts insured by federal agencies and, therefore, bear a risk of loss. The Company has not experienced such losses on these funds.

(d) Limited or Restricted Use Funds Held

Limited or restricted use funds primarily include assets held by trustees under agreement. Such funds include assets set aside for bond repayment, malpractice costs, capital replacement, and amounts restricted by donors. Independent third parties designate the assets held by trustees under agreement. The limited or restricted use funds are classified as current or noncurrent based upon the timing and nature of their intended use.

(e) Inventories

Inventories, consisting of medical supplies and drugs are stated at the lower of cost or market, with cost being determined primarily under the first-in, first-out method and are included in other current assets.

(f) Investments and Investment Income

Investments include amounts designated by management for specific purposes, insurance reserves, plant replacement, and other purposes. The Company's investment portfolio is considered a trading portfolio, with the exception of the alternative investments, and is classified as current or noncurrent assets based on management's intention as to use. Limited or restricted use funds that are required for obligations classified as current liabilities are reported as current assets. Investments in marketable securities are measured at fair market value on the consolidated balance sheets. The fair value of the investments, with the exception of the alternative investments, is based on quoted market prices or dealer quotations. See note 4 for discussion of the measurement of fair value for investments.

Alternative investments are recorded under the equity method of accounting. Underlying securities of these alternative investments may include certain debt and equity securities that are not readily marketable. Because certain investments are not readily marketable, their fair value is subject to additional uncertainty, and therefore, values realized upon disposition may vary significantly from current reported values.

Investment income or loss (including realized gains and losses on investments, interest and dividends) on proceeds of borrowings that are held by a trustee, to the extent not capitalized, and investment income on assets deposited in the insurance captive investment are reported as other income. Investment income or loss (including unrealized and realized gains and losses on investments, interest and dividends) from all other unrestricted fund investments is included in excess of revenues over expenses unless restricted by donor or law. Investment income on investments of temporarily or

(In thousands)

permanently restricted net assets is recorded as an increase in temporarily or permanently restricted net assets to the extent restricted by the donor or law.

Investment income is recorded on the accrual basis. Purchases and sales of investments are reflected on a trade-date basis. Realized gains and losses on sales of investments are based on historical cost.

(g) Property, Plant and Equipment

Property, plant and equipment are recorded at cost or, if donated, at fair market value at date of gift. Depreciation is computed using the straight-line method over the estimated useful lives of the assets, which range from 2 to 50 years. The cost and accumulated depreciation relating to property, plant and equipment sold or retired are removed from the respective accounts at the time of disposition and the resulting gain or loss is reflected in other operating revenue in the consolidated statements of operations.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(h) Other Noncurrent Assets

Other assets comprise the following items:

	2018	2017
Reinsurance receivable	$ 14,259	15,207
Goodwill	7,593	7,593
Pledges receivable	12,489	6,698
Deferred leasing costs	1,104	1,186
Equity investments	247	225
Other	378	287
	$ 36,070	31,196

Goodwill is assessed annually for impairment at the reporting unit. The Company first assesses qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount as a basis for determining whether it is necessary to perform the two-step goodwill impairment tests as described in Accounting Standards Codification (ASC), Topic 350, *Intangibles – Goodwill and Other*. The more likely than not threshold is defined as having a likelihood of more than 50%.

(Continued)

In fiscal year 2012, the Company acquired an additional interest in Magnetic Imaging of Baltimore, LLC (MIB), which resulted in the Company having to consolidate MIB. The Company recorded this acquisition using the purchase accounting method and recorded goodwill of $7,593. At June 30, 2018 and 2017, the Company assessed the goodwill for its reporting unit, GBDIP, for impairment. The Company determined that it was not more likely than not that the fair value of GBDIP was less than its carrying amount. Accordingly, the Company concluded that goodwill was not impaired as of June 30, 2018 and 2017 without having to perform the two-step impairment test.

Deferred leasing costs include deferred leasing costs and prepaid land lease payments, which are amortized over the lease terms and expensed on a straight-line basis over the life of the related lease.

The Company accounts for its joint ventures using the equity method or at cost, as appropriate, and any income (loss) is included in other operating revenues in the consolidated statements of operations.

(i) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Company are reported at their fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose of the restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated financial statements.

(j) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Company has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Company in perpetuity.

JRH is one of six named beneficiaries of a charitable trust and receives annual distributions for 50 years, which began in 2005. The distributions are to be used for the unrestricted general charitable purpose of the JRH. After the 50 years, the trust corpus will be distributed to the charities as long as JRH continues to qualify as a charitable organization under Sections 171(c) and 2055(a) of the Internal Revenue Code. The corpus must be used to create an endowment fund that is permanently restricted, and the income should be used for the organization's unrestricted general charitable purpose. The fair value of the trust is included in permanently restricted net assets.

(k) Insurance Reserves

The provision for estimated insurance reserves include estimates of the ultimate costs for reported malpractice, health and workers' compensation claims and claims incurred but not reported.

(l) Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients and third-party payors for services rendered. Rates for the Medical Center's facility-based patient service charges are established in accordance with the regulations and rate methodologies of Maryland's rate-setting authority, the Health Services Cost Review Commission (HSCRC), an independent agency of the Maryland state government. With the exception of relatively small contractual allowances, the HSCRC allows a discount of 6.0% to Medicare and Medicaid as well as a 2.25% prompt pay discount for other participating payors. HSCRC regulations stipulate that all payors must reimburse the Medical Center on the basis of the charges approved by the HSCRC and billed by the Medical Center.

During the years ended June 30, 2018 and 2017, the Medical Center participated in the HSCRC Global Budget Revenue (GBR) methodology, which provides a revenue target and maximum amount of facility-based revenue for the Medical Center during a fiscal year, and is not intended to fluctuate during the fiscal year with respect to changes in volume. The GBR model is consistent with the Medical Center's mission of controlling utilization of acute-care services by managing a patient's total spectrum of medical care. The GBR agreement allows the Medical Center to adjust unit rates, within certain limits, to achieve the overall revenue base for the Medical Center at year-end. Any overcharge or undercharge versus the GBR cap is prospectively added to the subsequent year's GBR cap. While the GBR cap does not adjust for changes in volume or service mix, the GBR cap is adjusted annually for inflation, and for changes in payor mix, market share and uncompensated care. The HSCRC also may impose various other revenue adjustments that could be significant in the future.

Physician charges are not regulated by the HSCRC, and are primarily reimbursed by third-party payors at rates that are contractually agreed upon.

Hospice's net revenue is reported at the estimated net realizable amounts from third-party payors who pay on a per-diem basis.

Adjustments to patient service revenue for HSCRC related assessments, contractual allowances, discounts, denials, and financial assistance were $170,447 and $159,168 for the years ended June 30, 2018 and 2017, respectively.

(m) Allowance for Uncollectible Accounts

Patient accounts receivable are reduced by allowances for uncollectible accounts. In evaluating the collectibility of accounts receivable, the Company analyzes historical collections and write-offs and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for bad debts and provision for uncollectible accounts. Management regularly reviews its estimate and evaluates the sufficiency of the allowance for bad debts. The Company analyzes contractual amounts due from patients who have third-party coverage and provides an allowance for doubtful accounts and a provision for bad debts. For patient accounts receivable associated with self-pay patients, which includes those patients without existing insurance coverage for a portion of the bill, the Company records a significant provision for bad debts for patients that are unable or unwilling to pay for the portion of the bill representing their financial responsibility. Account balances are charged off against the allowance for doubtful accounts after all means of collection have been exhausted.

(Continued)

(In thousands)

The Company's allowance for doubtful accounts were 16% and 19% of gross accounts receivable as of June 30, 2018 and 2017, respectively. During 2018, the Company experienced increased collections as a result of the stabilization of the new electronic medical record and billing system, which decreased the allowance for doubtful account at June 30, 2018.

The activity in the allowance for bad debts is summarized as follows for the years ended June 30:

		2018	2017
Beginning balance	$	17,927	10,685
Provision for uncollectible accounts		13,799	17,807
Less write-offs		(19,074)	(10,565)
Ending balance	$	12,652	17,927

(n) Excess of Revenue over Expenses

The consolidated statements of operations include a performance indicator, excess of revenues over expenses. Changes in unrestricted net assets that are excluded from excess of revenues over expenses, consistent with industry practice include pension changes other than net periodic pension costs, contributions and distributions to noncontrolling investors, and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets).

(o) Financial Assistance and Community Benefits

As part of the Company's mission, it provides medical care without discrimination, including the ability of a patient to pay for services. Under the Company's Financial Assistance Policy, patients who meet certain financial based criteria can qualify for free care on all or a portion of the total patient bill. The Company recorded $3,339 and $2,121 of financial assistance during the years ended June 30, 2018 and 2017, respectively. The total direct and indirect cost of providing financial assistance was approximately $2,403 and $1,458 during the years ended June 30, 2018 and 2017, respectively.

In addition to its Financial Assistance Policy, the Company has a long-standing commitment of supporting the community through the provision of outreach services designed to address identified health and social issues. Specifically, the Company provides a variety of screening and early detection tests, wellness activities, social support services and educational seminars. A majority of these services are provided at either nominal or no cost to community members.

(p) Rental Income

Base rental income is recognized as revenue on a straight-line basis over the life of the lease. The difference between the rent recognized and the rental income as stipulated in the lease agreement has been recognized as a receivable in the accompanying consolidated balance sheets from inception of the lease. Rental income is included in other operating revenue in the accompanying consolidated statements of operations.

(Continued)

(q) Income Taxes

The Company is a not-for-profit corporation exempt from income taxes as described in section 501(c)(3) of the Internal Revenue Code and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. The Company is subject to income tax on unrelated business income.

Income taxes are provided for earnings (loss) of those taxable subsidiaries which are subject to federal and state income tax based on Agency's share of the subsidiaries' taxable income, whether or not distributed. Agency's share of these subsidiaries' net losses is deductible to the extent of Agency's tax basis in the subsidiaries.

The Financial Accounting Standards Board's (FASB) guidance on accounting for uncertainty in income taxes clarifies the accounting for uncertainty of income tax positions. This guidance defines the threshold for recognizing tax return positions in the consolidated financial statements as "more likely than not" that the position is sustainable, based on its technical merits. This standard also provides guidance on the measurement, classification and disclosure of tax return positions in the consolidated financial statements. The Company has adopted this guidance, and there were no amounts recorded in the consolidated financial statements as of and during the years ended June 30, 2018 and 2017 for uncertain tax positions.

GBMC Agency, Inc. and its subsidiaries are taxable entities. An operating loss carry forward of approximately $125,644 is available to offset future taxable income through the year 2038. Effective for tax years after December 31, 2017, the net operating loss carry forward is indefinite. As of June 30, 2018 and 2017, deferred tax assets of $38,156 and $54,370, respectively, consisting primarily of net operating loss carry forwards, were offset by a related valuation allowance.

On December 22, 2017, the President signed into law H.R.1, originally known as the Tax Cuts and Jobs Act. The new law includes several provisions that result in substantial changes to the tax treatment of tax-exempt organizations and their donors. The Company has reviewed these provisions and the potential impact and concluded the enactment of H.R.1 will not have a material effect on the operations of the organization.

(r) Going Concern

Management evaluates whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the entity's ability to continue as a going concern within one year after the date the financial statements are issued. As of the date of this report, there are no conditions or events that raise substantial doubt about the Company's ability to continue as a going concern.

(s) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make certain estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(t) New Accounting Pronouncements

The FASB issued Accounting Standard Update (ASU) No. 2014-09, *Revenue from Contracts with Customers (Topic 606),* which serves to supersede most existing revenue guidance, including guidance specific to the healthcare industry. This ASU establishes principles for reporting useful information to users of financial statements including increased disclosures about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers. Particularly, that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Company will adopt ASU No. 2014-09 on July 1, 2018 and as a result, substantially all amounts that were previously presented as provision for doubtful accounts in the Company's consolidated statements of operations will now be considered an implicit price concession resulting in a reduction in patient service revenue net of contractual allowances. The Company is currently finalizing its assessment of the impact of the adoption of ASU No. 2014-09.

The FASB issued ASU No. 2016-14, *Not-for-Profit Entities (Topic 958)*, which amends the requirements for financial statements and notes in ASC Topic 958, *Not-for-Profit Entities (NFP)*, and requires a NFP to:

- Reduce the number of net asset classes presented from three to two, with donor restrictions and without donor restrictions;
- Require all NFPs to present expenses by their functional and their natural classifications in one location in the financial statements;
- Require NFPs to provide quantitative and qualitative information about management of liquid resources and availability of financial assets to meet cash needs within one year of the balance sheet date;

The adoption of ASU No. 2016-14 is effective in fiscal year 2019, and is applied retrospectively in the year of adoption. The Company is currently finalizing its assessment of the impact of the adoption of ASU No. 2016-14.

The FASB issued ASU No. 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost.* The amendments in this ASU require that an employer report the service cost component in the same line item or items as other compensation costs arising from services rendered by the pertinent employees during the period. The other components of net benefit cost as defined in paragraphs 715-30-35-4 and 715-60–35-9 are required to be presented in the income statement separately from the service cost

(In thousands)

component and outside a subtotal of income from operations, if one is presented. The amendments also allow only the service cost component to be eligible for capitalization when applicable (for example, as a cost of internally manufactured inventory or a self-constructed asset). ASU No. 2017-07 is effective for fiscal year 2020. This ASU requires retrospective application to all prior periods presented. The Company is currently assessing the impact of the adoption of ASU No. 2017-07.

The FASB issued ASU No. 2016-02, *Leases (Topic 842),* which will require lessees to recognize most leases on-balance sheet, which will increase their reported assets and liabilities. The adoption of ASU No. 2016-02 is effective in fiscal year 2020, and will require application of the new guidance at the beginning of the earliest comparable period presented. Early adoption is permitted. The Company is currently assessing the impact of the adoption of ASU No. 2016-02, which is expected to increase the Company's assets and liabilities but not have a significant impact on the results of operations.

(3) Concentration of Credit Risk

The Company grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables and patient service revenue from patients and third parties as of June 30, 2018 and 2017 was as follows:

	Accounts receivable		Revenue	
	2018	2017	2018	2017
Medicare	35%	37%	43%	42%
Medicaid	6	5	4	3
Blue cross	12	12	12	14
HMO	21	21	21	23
Other third party-payors	23	21	19	17
Self-pay	3	4	1	1
Total	100%	100%	100%	100%

The Company provides general acute healthcare services in the state of Maryland. The Company and other healthcare providers are subject to certain inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the federal Medicare and state Medicaid programs
- Regulation of hospital rates by the State of Maryland Health Services Cost Review Commission
- Government regulation, government budgetary constraints and proposed legislative and regulatory changes, and
- Lawsuits alleging malpractice or other claims.

Such inherent risks require the use of certain management estimates in the preparation of the Company's consolidated financial statements and it is reasonably possible that a change in such estimates may occur.

The Medicare and state Medicaid reimbursement programs represent a substantial portion of the Company's revenues and the Company's operations are subject to a variety of other federal, state and local regulatory requirements. Failure to maintain required regulatory approvals and licenses and/or changes in such regulatory requirements could have a significant adverse effect on the Company.

Changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Company.

The federal government and many states have aggressively increased enforcement under Medicare and Medicaid anti-fraud and abuse laws and physician self referral laws (STARK law and regulation). Federal healthcare reform initiatives continue to prompt a national review of federally funded healthcare programs. In addition, the federal government and many states continue to fund programs to audit and recover potential overpayments to providers from the Medicare and Medicaid programs. The Company has a response program and compliance program to monitor conformance with applicable laws and regulations, but the possibility of future government review and enforcement action exists.

As a result of recently enacted and pending federal healthcare reform legislation, substantial changes are anticipated in the United States healthcare system. Such legislation includes numerous provisions affecting the delivery of healthcare services, the financing of healthcare costs, reimbursement to healthcare providers and the legal obligations of health insurers, providers and employers. These provisions are currently slated to take effect at specified times over the next decade. This federal healthcare reform legislation did not affect the 2018 or 2017 consolidated financial statements.

(4) Investments and Limited or Restricted Use Funds

Guidance for fair value measurements establishes a hierarchy of valuation inputs based on the extent to which the inputs are observable in the marketplace. Observable inputs reflect market data obtained from sources independent of the reporting entity and unobservable inputs reflect the entities own assumptions about how market participants would value an asset or liability based on the best information available. Valuation techniques used to measure fair value under current guidance must maximize the use of observable inputs and minimize the use of unobservable inputs. The guidance describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last one is considered unobservable, that may be used to measure fair value.

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used by the Company for financial instruments measured at fair value on a recurring basis. The three levels of inputs are as follows:

- Level 1 – Quoted prices in active markets for identical assets or liabilities.
- Level 2 – Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the same term of the assets or liabilities.

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(In thousands)

- Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement.

The tables below present the balances of assets measured at fair value by levels excluding alternative investments in the amount of $13,313 and $8,086, which are accounted for under the equity method, as of June 30, 2018 and 2017, respectively:

	June 30, 2018			
Assets	**Level 1**	**Level 2**	**Level 3**	**Total**
Managed cash funds	$ 29,411	—	—	29,411
Common stock	160,785	5,367	828	166,980
Foreign stock	14,680	—	—	14,680
Mutual funds	53,191	—	—	53,191
Mutual funds international	555	—	—	555
Total equity	229,211	5,367	828	235,406
Corporate debt securities	—	28,159	—	28,159
Bonds – treasury	13,792	—	—	13,792
Bonds – federal-agency-backed	—	5,173	—	5,173
Bonds – mortgage-backed	—	1,523	—	1,523
Bonds – fixed income	—	510	—	510
Mutual funds – fixed income	—	103,506	—	103,506
Municipal bonds	—	508	—	508
Total fixed income	13,792	139,379	—	153,171
Total investment and limited or restricted use funds	272,414	144,746	828	417,988
Current portion	11,955	—	—	11,955
Total noncurrent investment and limited or restricted use funds	$ 260,459	144,746	828	406,033

(Continued)

(In thousands)

Assets	June 30, 2017 Level 1	Level 2	Level 3	Total
Managed cash funds	$ 22,745	—	—	22,745
Common stock	148,623	4,246	728	153,597
Foreign stock	10,687	—	—	10,687
Mutual funds	53,221	—	—	53,221
Mutual funds international	638	—	—	638
Total equity	213,169	4,246	728	218,143
Corporate debt securities	—	26,999	—	26,999
Bonds – treasury	13,474	—	—	13,474
Bonds – federal-agency-backed	—	7,167	—	7,167
Bonds – mortgage-backed	—	2,038	—	2,038
Bonds – fixed income	—	445	—	445
Mutual funds – fixed income	—	93,734	—	93,734
Municipal bonds	—	805	—	805
Total fixed income	13,474	131,188	—	144,662
Total investment and limited or restricted use funds	249,388	135,434	728	385,550
Current portion	12,974	—	—	12,974
Total noncurrent investment and limited or restricted use funds	$ 236,414	135,434	728	372,576

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(In thousands)

As of June 30, 2018 and 2017, the alternative investments consisted of subscription partnership agreements with capital commitments of approximately $26.1 million and $21.0 million, respectively, which are subject to periodic distributions. These alternative investments are valued at fair value using net asset value (NAV) or its equivalent as determined by the General Partner in the absence of readily ascertainable market values. Distributions under this investment structure are made to investors through the liquidation of the underlying assets. All assets are unable to be fully distributed to the limited partners until the dissolution of the partnership, which may not be until a point in the future. The fair value of limited partnership interests is generally based on fair value capital balances reported by the underlying partnerships, subject to management review and adjustment. Security values of companies traded on exchanges, or quoted on NASDAQ, are based upon the last reported sales price on the valuation date. Security values of companies traded over the counter, but not quoted on NASDAQ, and securities for which no sale occurred on the valuation date are based upon the last quoted bid price. The value of any security for which a market quotation is not readily available may be its cost, provided however, that the General Partner adjusts such cost value to reflect any bona fide third party transactions in such a security between knowledgeable investors, of which the General Partner has knowledge. In the absence of any such third party transactions, the General Partner may use other information to develop a good faith determination of value. Examples include, but are not limited to, discounted cash flow models, absolute value models, and price multiple models. Inputs for these models may include, but are not limited to, financial statement information, discount rates, and salvage value assumptions.

The investment strategies within the alternative investments include strategies such as middle market growth, private equity, natural resources, and various other asset classes. The investments are subject to restrictions and are not available to be redeemed until certain time restrictions are met, which range from 7 to 10 years with a 2 year optional extension.

As of June 30, 2018 and 2017, the Level 3 investments consist of holdings of donated stock in a closely held company of $828 and $728, respectively. The value of the donated stock is based on independent appraisals obtained by the closely held company. There were no significant transfers between levels during the years ended June 30, 2018 and 2017.

Investments and limited or restricted use funds comprise the following uses and purposes at June 30:

		2018	2017
Funds for debt service	$	4,334	4,254
Insurance settlements		58,004	56,692
Donor restricted		58,609	57,464
Alternative investments		13,313	8,086
Unrestricted		297,041	267,140
	$	431,301	393,636

(Continued)

(In thousands)

Investment income and gains for investments and limited use funds comprise the following for the years ended June 30:

		2018	2017
Unrestricted income:			
Dividends and interest, net	$	5,794	4,915
Realized gains on sales of investments		16,170	7,730
Unrealized gains on investments		5,671	22,208
Total unrestricted income		27,635	34,853
Temporarily restricted income:			
Dividends and interest, net		923	717
Realized gains on sales of investments		2,613	1,465
Unrealized gains on investments		1,255	3,664
Total temporarily restricted income		4,791	5,846
Permanently restricted income:			
Unrealized gains on investments		47	85
		47	85
Total investment income, net	$	32,473	40,784

(5) Property, Plant and Equipment

The following is a summary of the cost of property, plant and equipment as of June 30:

		2018	2017
Land and land improvements	$	23,301	23,273
Buildings and building service equipment		406,929	387,295
Movable equipment		298,236	288,131
Capital leases		40,605	40,605
Construction in progress		9,157	4,821
		778,228	744,125
Less accumulated depreciation and amortization		(503,022)	(464,356)
Total property, plant and equipment, net	$	275,206	279,769

(Continued)

(In thousands)

	2018	2017
Depreciation expense	$ 40,459	34,956
Amortization expense	336	445
Total depreciation and amortization expense	$ 40,795	35,401

(6) Long-Term Debt

Long-term debt as of June 30 consisted of the following:

	2018	2017
MHHEFA project and refunding revenue bonds:		
2017 Capital One Bank term note – 3.8%	$ 25,725	25,725
Series 2017 bonds:		
2.66% term bonds	72,910	73,720
2015 PNC Bank term note – 2.3%	27,813	34,821
Series 2012 bonds:		
3.25% – 5.00% term bonds	3,475	3,475
Series 2011 bonds:		
2.50% – 5.75% term bonds	19,425	22,620
Series 1995 bonds:		
Variable rate serial bonds	4,115	4,540
Unamortized deferred financing costs	(1,071)	(1,230)
	152,392	163,671
Less current portion of long-term debt	(11,679)	(11,439)
	$ 140,713	152,232

On March 8, 2017, Maryland Health and Higher Education Facilities Authority (MHHEFA) issued $73,720 of tax-exempt Revenue Bonds, Series 2017, on behalf of the Company. The bond proceeds were used to refund a portion of the Series 2012 Revenue Bonds ($32,205) and a portion of the Series 2011 Revenue Bonds ($32,480) resulting in a $8,845 loss on extinguishment of debt. The Series 2017 bonds are due on July 1 in annual installments ranging from $810 in 2018 to $7,280 in 2034.

On March 8, 2017, the Company obtained a $25,725 taxable term note from Capital One, N.A. to fund the Company's nonunion defined benefit pension plan. The 2017 note is due in annual installments ranging from $2,445 in 2024 to $3,735 in 2032.

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On March 1, 2015, the Company obtained a $50,000 taxable term note from PNC Bank, National Association to finance components of the system-wide integrated health record conversion and other capital projects. The 2015 note is due in monthly installments of $647, expiring on March 1, 2022.

On April 11, 2012, MHHEFA issued $35,680 of tax-exempt Revenue Bonds, Series 2012, on behalf of the Company. The bond proceeds and limited use funds were used to refund Series 2001 Revenue Bonds ($40,265). Bond proceeds from the Series 2017 revenue bonds were used to refund a portion of the Series 2012 Revenue Bonds ($32,205). The Series 2012 Bonds are due on July 1 in installments of $1,710 in 2023 and $1,765 in 2024.

On April 20, 2011, MHHEFA issued $67,945 of tax-exempt Revenue Bonds, Series 2011, on behalf of the Company. The bond proceeds and limited use funds were used to finance construction and renovation to the hospital and to refund, a) the Series 2009 Revenue Bonds ($45,000); b) a portion of Series 2001 Revenue Bonds ($12,565); and c) the Series 1993 Revenue Bonds ($11,975). Bond proceeds from the Series 2017 revenue bonds were used to refund a portion of the Series 2011 Revenue Bonds ($32,480). The Series 2011 bonds are due on July 1 in annual installments ranging from $3,195 in 2018 to $3,660, with a final installment of $1,930 in 2025.

On October 4, 1995, MHHEFA issued $10,000 of tax-exempt Revenue Bonds, Series 1995, on behalf of the Company. The Series 1995 bonds are due on July 1 in annual installments ranging from $405 in 2017 to $590 in 2025. The bonds bear interest at a variable rate, which is determined on a weekly basis by the remarketing agent of the issue. The rate was 1.74% and 1.12% as of June 30, 2018 and 2017, respectively. The Series 1995 Bonds are supported by a Standby Bond Purchase Agreement issued by M&T Bank, covering the remaining portion of the obligation, effective through October 1, 2019.

The PNC 2015 note, Series 2017, 2012, 2011, and 1995 Revenue Bonds are collateralized equally and ratably by a lien on all gross receipts of the Company. The term note and bond proceeds were loaned to the Company pursuant to the Master Trust Indenture.

(Continued)

(In thousands)

The aggregate future maturities of long-term debt as of June 30, 2018 are as follows:

	Long-term debt
2019	$ 11,679
2020	12,046
2021	12,421
2022	10,868
2023	5,135
Thereafter	101,314
	153,463
Unamortized deferred financing costs	(1,071)
	$ 152,392

The fair value of the Company's long-term debt, which is estimated, based on quotes from underwriters, was approximately $151,624 and $167,341 as of June 30, 2018 and 2017, respectively.

Deferred financing costs related to long-term borrowings, are amortized on a straight-line basis, which approximates the effective interest rate method, over the life of the borrowings, which ranges from 2 to 30 years. The Company has incurred deferred financing costs related to the issuance of MHHEFA Series 2017, Series 2012, Series 2011, Series 1995 Revenue Bonds and 2017 Capital One and 2015 PNC Bank term note payables that have been capitalized. Accumulated amortization at June 30, 2018 and 2017 amounted to $1,405 and $1,260, respectively.

Under the Master Trust Indenture, the Company is required to maintain, among other covenants, a maximum annual debt service coverage ratio of not less than 1.1 to 1.0.

In 2018, the Company reinstituted a $20,000 line of credit expiring December 31, 2018, which bears interest at the LIBOR Daily Floating Rate. No amounts were drawn on this line during the year ended June 30, 2018.

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(In thousands)

(7) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets were released and are available for the following purposes as of and for the year ended June 30:

	Available balance		Released	
	2018	2017	2018	2017
Departmental needs	$ 17,772	18,301	8,544	9,436
Education	6,516	6,203	964	912
Uncompensated care	4,476	3,888	922	902
Research	2,308	2,353	620	777
Time restriction	2,207	949	1	107
Total temporarily restricted net assets	33,279	31,694	11,051	12,134
Purchase of equipment/construction	9,198	9,379	1,710	925
	$ 42,477	41,073	12,761	13,059

Permanently restricted net assets at June 30 are restricted to investment in perpetuity, the income from which is expendable to support:

	2018	2017
Departmental needs	$ 17,821	15,020
Uncompensated care	11,604	11,495
Education	2,878	2,792
Research	2,526	2,526
General support	512	510
Total permanently restricted net assets	$ 35,341	32,343

The Company's endowment fund consists of a $14 million endowment for Hospice as well as other donations from individual donors. The Company has no internal board-designated endowment funds recorded in unrestricted net assets. The net assets associated with the endowment are classified and reported based on the existence or absence of donor-imposed restrictions.

(Continued)

(In thousands)

The Company has interpreted the "Uniform Prudent Management of Institutional Funds Act" (UPMIFA) as requiring the preservation of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Company classifies as permanently restricted net assets the original value of the gifts donated to the permanent endowment. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Company in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, the Company considers the following factors in making a determination to appropriate or accumulate endowment funds:

- The duration and preservation of the fund
- The purposes of the Company and the donor-restricted endowment fund
- General economic conditions
- The possible effect of inflation and deflation
- The expected total return from income and the appreciation of investments
- Other resources of the organization
- The investment policies of the organization

The Company had the following activities among its endowment fund during the years ended June 30 delineated by net asset class:

	Unrestricted	Temporary restricted	Permanently restricted	Total
Endowment net assets, June 30, 2016	$ 1,598	13,266	30,148	45,012
Investment return:				
Investment income, net	37	694	—	731
Net depreciation (realized and unrealized)	260	4,877	85	5,222
Total investment return	297	5,571	85	5,953
Contributions	—	—	2,404	2,404
Net assets reclass	—	(336)	(294)	(630)
Appropriation of endowment assets for expenditure	(148)	(2,308)	—	(2,456)
Endowment net assets, June 30, 2017	1,747	16,193	32,343	50,283

(Continued)

(In thousands)

	Unrestricted	Temporary restricted	Permanently restricted	Total
Investment return:				
Investment income, net	$ 42	817	—	859
Net appreciation (realized and unrealized)	184	3,595	47	3,826
Total investment return	226	4,412	47	4,685
Contributions	—	—	2,951	2,951
Appropriation of endowment assets for expenditure	(158)	(2,551)	—	(2,709)
Endowment net assets, June 30, 2018	$ 1,815	18,054	35,341	55,210

(a) Endowment Funds with Deficits

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the value of the initial and subsequent donor gift amounts (deficit). When donor endowment deficits exist, they are classified as a reduction of unrestricted net assets. As of June 30, 2018 and 2017, there were no endowments with deficits.

(b) Return Objectives and Risk Parameters

The Company has adopted endowment investment and spending policies that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of endowment assets. Under this policy, the return objective for the endowment assets, measured over a full market cycle, shall be to maximize the return against a blended index, based on the endowment's target allocation applied to the appropriate individual benchmarks. The Company expects its endowment funds over time, to provide an average rate of return of approximately 7.5% annually. Actual returns in any given year may vary from this amount.

(c) Strategies Employed for Achieving Investment Objectives

To achieve its long-term rate of return objectives, the Company relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized gains) and current yields (interest and dividends). The Company targets a diversified asset allocation that places greater emphasis on equity-based investments to achieve its long-term objectives within prudent risk constraints.

(Continued)

(In thousands)

(d) Endowment Spending Allocation and Relationship of Spending Policy to Investment Objectives

The Board of Directors of the Company approves the method to be used to appropriate endowment funds for expenditure. The Company amended its endowment spending allocation policy to conform to UPMIFA, which was passed by Maryland on April 14, 2009 and limits annual endowment spending to 7% of the annual market value per year.

(8) Functional Expenses

The Company provides general healthcare services to residents within its geographic location. Expenses related to providing these services for the years ended June 30 were as follows:

		2018	2017
Health care services	$	506,375	479,155
General and administrative		62,979	70,762
Total operating expenses	$	569,354	549,917

(9) Leases

(a) Capital Leases

The Company is obligated under a long-term lease expiring in 2030 for the use of a medical office building. Payments increase at varying rates from $2,483 to $3,004 per year over the remaining life. Interest rates approximated 5.76% as of June 30, 2018 and 2017, respectively.

The Company leases medical equipment with annual payments ranging from $243 to $1,032 and the last lease expires in fiscal year 2020.

Scheduled principal and interest payments on capital lease and financing obligations are as follows:

		Payment	Principal
2019	$	3,353	1,981
2020		3,094	1,817
2021		2,975	1,790
2022		2,731	1,640
2023		2,731	1,737
Thereafter		19,804	16,318
		34,688	25,283
Less amount representing interest		(9,405)	—
	$	25,283	25,283

(Continued)

(In thousands)

(b) Operating Leases

The Company leases land, office space, and equipment under leases ranging from 2 to 13 years. Options to renew these leases range from 1 to 10 years.

Minimum future rental expense for the years subsequent to June 30 is as follows:

		Equipment	Facility	Total
2019	$	1,168	2,081	3,249
2020		1,168	2,027	3,195
2021		1,168	1,558	2,726
2022		1,168	1,424	2,592
2023		—	997	997
Thereafter		—	773	773
	$	4,672	8,860	13,532

Most of the Company's leases contain renewal options and provisions for pass-through of operating expenses and real estate taxes. These provisions are not included in the minimum future rental expense unless exercised. Rental expense, including pass-through, associated with the facility leases amounted to $3,284 and $2,750 for the years ended June 30, 2018 and 2017, respectively.

(10) Retirement Plans

(a) Defined Benefit Plan

The Company has two noncontributory defined benefit pension plans, Greater Baltimore Medical Center Retirement Plan (DB Non Union) and the Pension Plan for Members of the Bargaining Unit of Greater Baltimore Medical Center (DB Union), covering all full-time employees with at least one year of service. Benefits under the plans are determined based on increasing percentages (depending on years of service) of final average compensation. Annual contributions are made to these plans in accordance with the Employment Retirement Income Security Act (ERISA) regulations.

Effective June 30, 2007, the DB Non Union plan was frozen. As a result, no future benefits may be earned; however, employees are eligible to vest under the terms of the plan.

(Continued)

(In thousands)

The following tables set forth the plans' funded status and amounts recognized in the Company's consolidated financial statements as of June 30, 2018 and 2017. The change in benefit obligation, plan assets, and funded status of the pension plans is as follows:

		2018	2017
Change in benefit obligation:			
Benefit obligation at beginning of year	$	220,669	227,064
Service cost		1,042	1,161
Interest cost		8,458	8,435
Actuarial loss		(12,129)	(7,066)
Benefits paid		(10,956)	(8,925)
Benefit obligation at end of year	$	207,084	220,669
Change in plan assets:			
Fair value of plan assets at beginning of year	$	209,615	166,566
Actual return on plan assets		(744)	16,401
Employer contribution		675	35,573
Benefits paid		(10,956)	(8,925)
Fair value of plan assets at end of year	$	198,590	209,615
Funded status at end of year	$	(8,494)	(11,054)

Amounts recognized in unrestricted net assets as of June 30, 2018 and 2017 are as follows:

		2018	2017
Net prior service cost	$	(361)	(734)
Net actuarial loss		65,061	66,551
	$	64,700	65,817

(Continued)

(In thousands)

Components of net periodic benefit cost for the years ended June 30, 2018 and 2017 are as follows:

		2018	2017
Service cost	$	1,042	1,161
Interest cost		8,458	8,435
Expected return on plan assets		(15,353)	(13,138)
Amortization of prior service cost		(372)	(372)
Amortization of loss deferral		5,458	7,589
Net periodic pension benefit (income) cost	$	(767)	3,675

Amounts in unrestricted net assets expected to be recognized as a component of net periodic pension benefit cost in fiscal year 2019 are as follows:

Prior service cost	$	(361)
Net actuarial loss		5,842
	$	5,481

(i) Assumptions

The weighted average assumptions used in developing the projected pension benefit obligations for the plans as of June 30 were as follows:

	Union		Non Union	
	2018	2017	2018	2017
Discount rate	4.33%	3.97%	4.33%	3.97%
Rate of compensation increase	4.00	4.00	—	—

(Continued)

(In thousands)

The weighted average assumptions used to determine the net periodic benefit costs for the plans as of June 30 were as follows:

	Union		Non Union	
	2018	2017	2018	2017
Discount rate	3.97%	3.87%	3.97%	3.87%
Expected return on plan assets	7.50	7.50	7.50	7.50
Rate of compensation increase	4.00	4.00	—	—

The accumulated benefit obligation for the pension plans, which differs from the estimated actuarial present value of the projected benefit obligation because it is based on current rather than future compensation levels, was $204,872 and $217,676 as of June 30, 2018 and 2017, respectively. In 2017, GBMC adopted the new RP-2014 Mortality Table with generational improvements using projection scale MP-2016. In 2018, GBMC utilized the RP-2014 Mortality Table with generational improvements using projection scale MP-2017.

(ii) Expected Long-Term Rate of Return

The expected long-term rate of return assumption used was based on a total plan return estimation by looking at the current yields available from fixed-income and reasonable equity return assumption based on long-term market trends and applying this to the plan's asset mix. In addition, the actual long-term historical returns realized by the pension plans were taken into consideration.

(iii) Estimated Future Benefit Payments

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid as follows:

	Non union	Union	Total
2019	$ 8,950	1,585	10,535
2020	9,250	1,617	10,867
2021	9,576	1,651	11,227
2022	9,916	1,718	11,634
2023	10,072	1,810	11,882
2024–2028	53,084	10,338	63,422
Total	$ 100,848	18,719	119,567

(Continued)

(In thousands)

The Company's pension plan weighted average asset allocations as of June 30 by asset category were as follows:

	2018	2017
Equity securities	19%	20%
Debt securities	78	78
Cash and cash equivalents	3	2
	100%	100%

The following tables set forth by level, within the fair value hierarchy, the plan's assets at fair value as of June 30:

	June 30, 2018			
	Level 1	Level 2	Level 3	Total
Managed cash funds	$ 6,405	—	—	6,405
Common collective trust	—	9,925	—	9,925
Total fixed income	—	9,925	—	9,925
Common stock	7,453	—	—	7,453
Corporate bonds	—	144,851	—	144,851
Foreign stock	667	—	—	667
Mutual funds	20,467	—	—	20,467
Mutual funds international	8,822	—	—	8,822
Total equity	37,409	144,851	—	182,260
Total plan assets	$ 43,814	154,776	—	198,590

(Continued)

(In thousands)

	June 30, 2017			
	Level 1	Level 2	Level 3	Total
Managed cash funds	$ 3,706	—	—	3,706
Mutual funds – fixed income	—	142,734	—	142,734
Common collective trust	—	21,861	—	21,861
Total fixed income	—	164,595	—	164,595
Common stock	19,210	—	—	19,210
Foreign stock	1,529	—	—	1,529
Mutual funds	10,392	—	—	10,392
Mutual funds international	10,184	—	—	10,184
Total equity	41,315	—	—	41,315
Total plan assets	$ 45,021	164,595	—	209,616

The following is a description of the valuation methodologies used for assets measured at fair value:

Corporate bonds: Valued at unadjusted quoted market share prices within active markets or based on external price data of comparable securities.

Common and foreign stock and mutual funds: Valued at unadjusted quoted market share prices within active markets.

Mutual funds – fixed income: Valued at the net asset value (NAV) of shares held by the plans at year-end. Shares traded in an active market.

Common collective trust funds: Valued at fair value based on the NAV of the fund. NAV is determined by the bank sponsoring such funds dividing the fund's net assets at fair value by its units outstanding at the valuation date. The Company is required to provide a 90-day notice in order to redeem any amount of investment. There are no other restrictions or gates related to this fund.

(iv) Pension Investment Policies

The primary objective of the Medical Center's pension investment program is the long-term growth of capital consistent with the protection of principal during major market declines. The program utilizes several balanced managers and provides for asset allocation guidelines consistent with the Medical Center's risk exposure. The equity portion of the DB Union portfolio may range from 50% to 60% of total portfolio assets with a target of 55% measured at market value. The fixed-income

and cash equivalents portion of the DB Union portfolio may range from 40% to 50% of total portfolio assets with a target of 45% measured at market value. The distribution of the DB Union plan as of June 20, 2018 was 57% equities, fixed income 40%, and cash 3%. At June 30, 2018 the funded ratio of the plan was 69.3%. The investment program related to the DB Non Union portfolio, which was frozen effective June 30, 2007, has the added objective to protect the principal in preparation for future termination of the plan. A major strategy of the investment program for the DB Non Union portfolio is a de-risking strategy that periodically transfers investments from equity to fixed-income securities based upon pre-established ranges correlating to the funded ratio of the plan, which are managed by the Company's investment consultants. At June 30, 2018 the funded ratio of the plan was 101.4%. At this funding ratio, the equity portion of the DB Non Union portfolio may range from 13% to 23% of total portfolio assets with a target of 18% measured at market value. The fixed-income and cash equivalents portion may range from 77% to 87% of total portfolio assets with a target of 82% measured at market value. The distribution of the DB Non Union portfolio as of June 30, 2018 was 14% equities, fixed income 83%, and cash 3%.

The equity segment of the portfolio may include common and preferred stock, convertible securities, warrants, and cash equivalent securities. Equity holdings in any one industry should not exceed 20% of the equity portfolio, holdings in any one economic sector should not exceed 50% of the equity portfolio, and holdings in any one company should not exceed 8% of the equity portfolio. Cash equivalent positions should not exceed 10% of the equity managers' portfolio and no more than 15% of the total portfolio measured at market value shall be invested in small companies, defined as companies of less than $1 billion in market capitalization.

The fixed-income segment of the portfolio may include marketable bonds, preferred stocks, up to 20% in Securities and Exchange Commission (SEC) registered 144A securities, and cash equivalent securities. With the exception of securities issued by or guaranteed by the U.S. Treasury or U.S. government agencies and instrumentalities, the maximum position in a single issuer's securities should not exceed 3% of the portfolio at market value. The manager is expected to maintain a weighted average bond portfolio quality rating of at least "A." Exposure to below investment grade securities, that is less than "BBB," is limited to a maximum of 20% of the portfolio at market value.

(v) Contributions

The Company expects to contribute $2,700 to its DB Union and $0 DB Non Union pension plans in the fiscal year ending June 30, 2019.

(b) Defined Contribution Plan

Effective July 1, 2007, the Company established the GBMC, Inc. 401(a) Defined Contribution Plan (DC Non Union) covering all employees except those covered by the collective bargaining agreement, or employees in a zero hour or registry position. The Company contributes up to 2% of all eligible employee wages (basic contribution) to the plan and the Company matches up to 3% of employee wages of those who contribute to the Greater Baltimore Medical Center, Inc. Voluntary 403(b) Plan. At the discretion of the Board of Directors, the Company may contribute additional funds to the plan.

(In thousands)

Expenses for the defined contribution plan for June 30 were as follows:

		2018	2017
Basic contribution	$	2,923	2,749
Match contribution		4,252	4,011
Total contribution	$	7,175	6,760

Effective July 1, 2009, the Company established the GBMC, Inc. 401(a) Defined Contribution Plan for Members of the Bargaining Union of Greater Baltimore Medical Center (DC Union) for the members covered by a collective bargaining agreement. The Company matches up to 3% of eligible employee wages of those who contribute to the Greater Baltimore Medical Center, Inc. Voluntary 403(b) Plan. The Company contributed $96 and $91 for the years ended June 30, 2018 and 2017, respectively.

(c) Nonqualified Plan

The Company has a noncontributory, nonqualified deferred compensation plan for certain key employees. Benefits under the plan are determined based on increasing percentages (depending on years of service) of base pay. The Company recorded expense related to this plan of $780 and $751 for the years ended June 30, 2018 and 2017, respectively.

(11) Asserted and Unasserted Insurance Claims and Contingencies

The Company maintains an off-shore captive insurance company in Bermuda to provide coverage for medical malpractice claims. Reserve balances have been discounted at the rate of 3% for the years ended June 30, 2018 and 2017. The receivable for the expected reinsurance recoverable is recorded within other assets on the consolidated balance sheets. Retention on limits in which Ruxton assumes risk of loss is based on an annual occurrence basis of $4 million per occurrence and $19 million in aggregate. Amounts in excess of these limits are insured by highly rated commercial insurance companies.

As of June 30, 2018 and 2017, the Company was partially self-insured for workers' compensation and health insurance claims. The aggregate reserves for workers' compensation claims were determined and discounted at the rate of 2.3% and 2.1% for 2018 and 2017, respectively. The receivable for the expected reinsurance recoverable is recorded within other current assets on the consolidated balance sheets. The Company's excess workers' compensation policy is based on a per claim basis in excess of $350 plus a corridor deductible of $750.

The Company is subject to legal proceedings and claims, which arise from the ordinary course of business. In the opinion of management, the amount of ultimate liability with respect to the actions will not materially affect the consolidated financial position of the Company.

(Continued)

(In thousands)

The Company recorded reserve activity for claims and claims expense as follows:

	2018			
	Malpractice	Workers' Compensation	Health	Total
Insurance reserves for self-insured claims	$ 34,126	6,260	2,676	43,062
Reserves that are recoverable form reinsurance carrier	14,259	683	—	14,942
Total insurance accrual	48,385	6,943	2,676	58,004
Less current portion of insurance accrual	7,434	3,325	2,676	13,435
Total noncurrent insurance accrual	$ 40,951	3,618	—	44,569

	2017			
	Malpractice	Workers' Compensation	Health	Total
Insurance reserves for self-insured insured claims	$ 32,186	5,624	2,727	40,537
Reserves that are recoverable form reinsurance carrier	15,207	948	—	16,155
Total insurance accrual	47,393	6,572	2,727	56,692
Less current portion of insurance accrual	6,700	3,039	2,727	12,466
Total noncurrent insurance accrual	$ 40,693	3,533	—	44,226

(Continued)

(In thousands)

(12) Promises to Contribute

The Company has received unconditional and conditional promises to give. The pledge receivables are recorded on a discounted basis using the rate in effect at the time of the pledge. Such rates approximate 4%. The Company is the beneficiary of four charitable remainder trusts whose present value as of June 30, 2018 and 2017 was $1,291 and $1,262, respectively. Current pledge receivables are included in other receivables and noncurrent pledge receivables are included in other assets in the accompanying consolidated balance sheets.

		2018	2017
Due within 1 year	$	6,933	9,464
Due 1-5 year		8,370	6,226
Due over 5 year		5,041	1,262
Gross pledge receivables		20,344	16,952
Less discount and allowances		(1,135)	(1,000)
Net pledge receivables	$	19,209	15,952

(13) Controlling and Non-controlling Interest

The following table presents a reconciliation of the changes in consolidated unrestricted net assets attributable to the Company's controlling interest and non-controlling interest:

		Unrestricted net assets – controlling interest	Unrestricted net assets – noncontrolling interest	Total unrestricted net assets
Balance as of June 30, 2016	$	361,531	5,641	367,172
Excess of revenues over expenses		25,940	1,059	26,999
Pension related changes other than net periodic pension costs		17,546	—	17,546
Distributions to noncontrolling interest owners		—	(1,550)	(1,550)
Net assets released for purchase of fixed assets		925	—	925
Increase (decrease) in net assets		44,411	(491)	43,920
Balance as of June 30, 2017		405,942	5,150	411,092

(Continued)

(In thousands)

	Unrestricted net assets – controlling interest	Unrestricted net assets – noncontrolling interest	Total unrestricted net assets
Excess of revenues over expenses	$ 28,739	1,892	30,631
Pension related changes other than net periodic pension costs	1,117	—	1,117
Distributions to noncontrolling interest owners	—	(1,900)	(1,900)
Net assets released for purchase of fixed assets	1,710	—	1,710
Increase (decrease) in net assets	31,566	(8)	31,558
Balance as of June 30, 2018	$ 437,508	5,142	442,650

The non-controlling interest is comprised of:

- 50% interest in Greater Baltimore Diagnostic Imaging Partnership that provides medical imaging services on the campus of the Company.

(14) Subsequent Events

The Company has evaluated all events and transactions from the consolidated balance sheet date through October 4, 2018, the date the consolidated financial statements were issued, and determined there are no other items to be recognized or disclosed this period.

CONSOLIDATING INFORMATION

GBMC HEALTHCARE, INC.
AND SUBSIDIARIES

Consolidating Balance Sheet

June 30, 2018

(In thousands)

Assets	(Obligated Group) Greater Baltimore Medical Center, Inc.	Ruxton Insurance	GBMC Agency Inc. and Subsidiaries	Gilchrist Hospice Care Inc.	GBHA Inc.	GBMC Land Inc.	GBMC Healthcare Inc. (Parent)	Eliminating entries	Total
Current assets:									
Cash	$ 16,872	19	5,907	12,052	—	—	—	—	34,850
Short-term investments and limited or restricted use funds	4,344	6,326	—	1,285	—	—	—	—	11,955
Patient accounts receivable, net	46,645	—	1,744	5,612	—	—	—	—	54,001
Other receivables	8,204	2,271	1,280	3,261	—	815	—	—	15,831
Advances to affiliates	37,488	—	89	(6)	—	—	—	(37,571)	—
Other current assets	10,485	205	46	73	—	—	—	—	10,809
Total current assets	124,038	8,821	9,066	22,277	—	815	—	(37,571)	127,446
Investments and limited use funds	237,980	61,178	1,504	118,684	—	—	—	—	419,346
Interest in net assets of affiliate	—	—	—	—	—	—	520,778	(520,778)	—
Long-term receivables from affiliates	5,283	—	—	—	—	—	—	(5,283)	—
Property and equipment, net	247,698	—	14,445	11,503	241	1,319	—	—	275,206
Other noncurrent assets	10,535	14,260	8,291	3,473	—	213	—	(702)	36,070
Total assets	$ 625,534	84,259	33,306	155,937	241	2,347	520,778	(564,334)	858,068
Liabilities and Net Assets									
Current liabilities:									
Accounts payable and accrued expenses	$ 63,538	20	500	7,436	1	28	30	—	71,553
Insurance reserves current	5,192	8,090	—	153	—	—	—	—	13,435
Payable to affiliates	—	2,154	33,625	1,512	—	—	280	(37,571)	—
Advances from third-party payors	14,453	—	—	—	—	—	—	—	14,453
Current portion of long-term debt and capital lease liability	13,608	—	52	—	—	—	—	—	13,660
Other current liabilities	4,001	—	7	574	—	—	—	—	4,582
Total current liabilities	100,792	10,264	34,184	9,675	1	28	310	(37,571)	117,683
Long-term debt	140,713	—	—	—	—	—	—	—	140,713
Capital lease liabilities	23,302	—	—	—	—	—	—	—	23,302
Insurance reserves	3,310	40,952	—	307	—	—	—	—	44,569
Long-term payable to affiliate	—	—	(2,887)	—	7,611	559	—	(5,283)	—
Pension liability	8,494	—	—	—	—	—	—	—	8,494
Other long-term liabilities	1,137	—	1,087	615	—	—	—	—	2,839
Total liabilities	277,748	51,216	32,384	10,597	7,612	587	310	(42,854)	337,600
Net assets:									
Unrestricted – controlling	295,368	33,043	(4,220)	119,690	(7,371)	1,760	437,508	(438,270)	437,508
Unrestricted – noncontrolling	—	—	5,142	—	—	—	5,142	(5,142)	5,142
Total unrestricted	295,368	33,043	922	119,690	(7,371)	1,760	442,650	(443,412)	442,650
Temporarily restricted	34,373	—	—	8,104	—	—	42,477	(42,477)	42,477
Permanently restricted	18,045	—	—	17,546	—	—	35,341	(35,591)	35,341
	347,786	33,043	922	145,340	(7,371)	1,760	520,468	(521,480)	520,468
Total liabilities and net assets	$ 625,534	84,259	33,306	155,937	241	2,347	520,778	(564,334)	858,068

See accompanying independent auditors' report.

GBMC HEALTHCARE, INC.
AND SUBSIDIARIES

Consolidating Statement of Operations

Year ended June 30, 2018

(In thousands)

	(Obligated Group) Greater Baltimore Medical Center, Inc.	Ruxton Insurance	GBMC Agency Inc. and Subsidiaries	Gilchrist Hospice Care Inc.	GBHA Inc.	GBMC Land Inc.	GBMC Healthcare Inc. (Parent)	Eliminating entries	Total
Operating revenues:									
Patient service revenue net of contractual allowances	$ 488,948	—	12,754	59,503	—	—	—	—	561,205
Provision for uncollectible accounts	(12,041)	—	(535)	(1,223)	—	—	—	—	(13,799)
Net patient service revenue	476,907	—	12,219	58,280	—	—	—	—	547,406
Other operating revenue	10,727	13,911	6,158	187	—	3,236	—	(19,196)	15,023
Net assets released from restrictions	7,601	—	—	3,738	—	—	—	(288)	11,051
Total operating revenue	495,235	13,911	18,377	62,205	—	3,236	—	(19,484)	573,480
Operating expenses:									
Salaries, wages and employee benefits	308,292	—	2,940	38,911	1,042	345	7	(1,166)	350,371
Expendable supplies	88,160	—	770	3,826	2	31	—	—	92,789
Purchased services	66,904	9,987	6,437	10,988	76	3,003	39	(18,601)	78,833
Depreciation and amortization	36,282	—	2,679	1,479	99	256	—	—	40,795
Interest	6,560	—	6	—	—	—	—	—	6,566
Overhead	(1,852)	250	500	540	—	50	262	250	—
Total operating expenses	504,346	10,237	13,332	55,744	1,219	3,685	308	(19,517)	569,354
Operating (loss) income	(9,111)	3,674	5,045	6,461	(1,219)	(449)	(308)	33	4,126
Other income:									
Contributions	957	—	—	1,057	—	—	50	(50)	2,014
Fund-raising expense	(2,486)	—	—	(908)	—	—	—	250	(3,144)
Investment income (loss), net	19,765	(2,124)	(4)	9,998	—	—	—	—	27,635
Interests in net assets of affiliate	—	—	—	—	—	—	31,816	(31,816)	—
Excess (deficit) of revenues over expenses	$ 9,125	1,550	5,041	16,608	(1,219)	(449)	31,558	(31,583)	30,631

See accompanying independent auditors' report.

GBMC HEALTHCARE, INC.
AND SUBSIDIARIES

Consolidating Statement of Changes in Net Assets

Year ended June 30, 2018

(In thousands)

	(Obligated Group) Greater Baltimore Medical Center, Inc.	Ruxton Insurance	GBMC Agency Inc. and Subsidiaries	Gilchrist Hospice Care Inc.	GBHA Inc.	GBMC Land Inc.	GBMC Healthcare Inc. (Parent)	Eliminating entries	Total
Excess (deficit) of revenues over expenses	$ 9,125	1,550	5,041	16,608	(1,219)	(449)	31,558	(31,583)	30,631
Other unrestricted net assets:	—	—	—	—	—	—	—	—	
Pension-related changes other than net periodic pension costs	1,117	—	—	—	—	—	—	—	1,117
Net assets released for purchase of fixed assets	35	—	—	1,675	—	—	—	—	1,710
Distribution to noncontrolling interest	—	—	(1,900)	—	—	—	—	—	(1,900)
Transfers	951	—	(951)	—	—	—	—	—	—
Increase (decrease) in unrestricted net assets	11,228	1,550	2,190	18,283	(1,219)	(449)	31,558	(31,583)	31,558
Changes in temporarily restricted net assets:									
Contributions	7,813	—	—	1,849	—	—	—	(288)	9,374
Investment income, net	3,034	—	—	1,757	—	—	—	—	4,791
Interest in net assets of affiliate	—	—	—	—	—	—	1,404	(1,404)	—
Transfer of temporarily restricted assets	17	—	—	(17)	—	—	—	—	—
Net assets released for purchase of fixed assets	(35)	—	—	(1,675)	—	—	—	—	(1,710)
Net assets released for operations	(7,601)	—	—	(3,738)	—	—	—	288	(11,051)
Net asset reclass	—	—	—	—	—	—	—	—	—
Increase (decrease) in temporarily restricted net assets	3,228	—	—	(1,824)	—	—	1,404	(1,404)	1,404
Changes in permanently restricted net assets:									
Contributions	2,216	—	—	985	—	—	—	(250)	2,951
Interest in net assets of affiliate	—	—	—	—	—	—	2,998	(2,998)	—
Net unrealized loss on investments	—	—	—	47	—	—	—	—	47
Net asset reclass	—	—	—	—	—	—	—	—	—
Increase (decrease) in permanently restricted net assets	2,216	—	—	1,032	—	—	2,998	(3,248)	2,998
Increase (decrease) in net assets	16,672	1,550	2,190	17,491	(1,219)	(449)	35,960	(36,235)	35,960
Net assets, beginning of year	331,114	31,493	(1,268)	127,849	(6,152)	2,209	484,508	(485,245)	484,508
Net assets, end of year	$ 347,786	33,043	922	145,340	(7,371)	1,760	520,468	(521,480)	520,468

See accompanying independent auditors' report.

EXHIBIT 16

MARYLAND HEALTH CARE COMMISSION

Certificate of Need

TO: Larry Merlis
President & CEO
Greater Baltimore Medical Center
6701 N. Charles Street
Baltimore, Maryland 21204

October 18, 2001
(Date)

RE: Capital Construction and Renovation
to Greater Baltimore Medical Center
in Baltimore County

01-03-2082
(Docket Number)

PROJECT DESCRIPTION

Greater Baltimore Medical Center (GBMC) is a 323-bed acute care hospital located in Baltimore County, Maryland. GBMC has received Certificate of Need approval from the Maryland Health Care Commission to reconfigure its campus by renovating and adding to its existing space, in service areas identified by a comprehensive strategic planning process. The proposed project will modernize and expand the facility, while continuing to provide a full range of inpatient and outpatient services currently available on its campus. Upon completion, the project will add 90,020 gross square feet in new construction, and will renovate 75,600 gross square feet within the Hospital.

The GBMC project will be implemented in two phases, with the last phase to be completed by October 2005. Phase 1 will begin in July 2002 and proceed through November 2003. This period of the project will involve new construction and expansion of the Emergency Department. Additionally, space will be built for an eight-bed pediatric inpatient unit, four mixed-use operating rooms and supporting post anesthesia unit, and a 12-bed critical care unit. New space will also be added for the relocation of administrative offices. The dietary kitchen will be renovated, as well as other functional areas of the Hospital. This phase of the project will involve the construction of a pedestrian walkway that links various service areas of the Hospital. The construction of a new parking deck will also take place during this phase.

Phase 2 of the project is scheduled to begin in September 2003 and will proceed through September 2005. This phase of the project will involve relocating the CT Scan Department, and renovating the Radiology Department, expanding the Wound Care Center, expanding the patient medical library, relocating family waiting areas, and renovating and expanding various other support services throughout the Hospital. The construction phases overlap in some cases, but are designed to minimize the inevitable disruptions to GBMC's ongoing operations.

GBMC estimates that the proposed capital project will cost a total of $42,610,525; $35,280,076 of the total amount is for capital costs and $7,330,449 is for financing, consultant fees, and other related expenses.

ORDER

The recommended decision of MHCC staff has been reviewed by the Commission. Based on staff's recommendation and the evidence in the record, the project is hereby awarded a Certificate of Need. In accordance with Regulations .12C (3)(e), .12C (4), and .12F(2) of COMAR 10.24.01, the project is subject to the following performance requirements:

1. Obligation of not less than 51% of the certified capital expenditure as documented by binding construction contracts or equipment purchase orders for Construction Phase 1 as designated by GBMC within **18** months of the date of certification, which is **April 18, 2003**;

2. Obligation of not less than 51% of the certified capital expenditure for the entire project, including GBMC 1 and 2 as documented by binding construction contracts or equipment purchase orders within **24** months of the date of certification, which is **October 18, 2003**;

3. Initiation of construction within **four (4) months** of the effective date of the respective binding construction contracts;

4. Documentation that GBMC Phase 1 of the certified project has been completed, has been licensed if licensure is required, or has otherwise met all applicable legal requirements and that GBMC is providing the certified service or services within **24** months of the required binding construction contracts. If the contracts are obligated for Phase 1 by April 18, 2003, then that construction and licensure must be completed by **April 18, 2005**;

5. Documentation that the entire project, including GBMC Phases 1 and 2 of the certified project, has been completed, has been licensed if licensure is required, or has otherwise met all applicable legal requirements and is providing the certified service or services within **24** months of the required binding construction contracts. If the contracts are obligated for the remainder of the project by October 18, 2003, then that construction and licensure must be completed by **October 18, 2005**.

Failure to meet these performance requirements will render incomplete and unlicensed stages of this Certificate of Need void and of no further effect, subject to the Commission's finding and the requirements for due process found in COMAR 10.24.01.12.F through I.

Certificate of Need is a pre-requisite to licensure for certain types of health care facility, as set forth in Health-General Article §19-101 and §19-123, Annotated Code of Maryland, and is not a license to operate the facility.

If it is necessary to make any changes to the certified project before the approved first use of the facility, the Commission must be notified, and the holder of the Certificate of Need must receive Commission approval of the proposed change, including the obligation of any funds above those certified by the Commission at its initial approval of the project, in accordance with COMAR 10.24.01.17.

Your architect or engineer is required to contact the Plans Review and Approval section of the Department of Health and Mental Hygiene, to ascertain the specific information concerning your project's drawings and specifications that the law requires to be submitted and approved prior to the initiation of construction.

You must submit quarterly status reports to the Commission, beginning three months from the effective date of certification, and continuing through the completion of the project.

Pre-licensing approval must be requested from the Commission not less than 60 days nor more than 120 days prior to the planned date of first use. The request for pre-licensure certification will be reviewed in accordance with Regulation .18 of COMAR 10.24.01. For projects completed by an existing and operating facility, the Commission requests notification, no later than 30 days before first use of the new or renovated space. The project must receive pre-licensing approval from the Commission before the Office of Health Care Quality can issue a State license to operate the facility or service. For projects undertaken by a facility that is already licensed and operating, the Commission should be notified in writing of the time the new construction or renovation is ready for first use.

Acknowledgment of your receipt of this certification is required within thirty (30) days.

MARYLAND HEALTH CARE COMMISSION

Barbara G. McLean
Interim Executive Director

BGM/DR/rp

cc: Carol Benner
Brian Dubey
Robert Murray
RR File