MARYLAND HEALTH CARE COMMISSION

_____

MATTER/DOCKET NO.

_____

DATE DOCKETED

HOSPITALS
APPLICATION FOR CERTIFICATE OF NEED

ALL PAGES THROUGHOUT THE APPLICATION, ATTACHMENTS AND EXHIBITS SHOULD BE NUMBERED CONSECUTIVELY.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1.a. Shore Health System, Inc.
Legal Name of Project Applicant
(i.e. Licensee or Proposed Licensee)

b. 219 South Washington St.

c. Easton 21601 Talbot
City Zip County

d. 410-822-1000
Telephone

e. Kenneth Kozel, President,CEO
Name of Owner/Chief Executive

2.a. N/A
Legal Name of Project Co-Applicant
(i.e. if more than one applicant)

b. _____
Street

c. _____
City Zip County

d. _____
Telephone

e. _____
Name of Owner/Chief Executive

3.a. Memorial Hospital at Easton
Name of Facility

b. 10000 Longwoods Rd.
Street (Project Site)

c. Easton 21601 Talbot
City Zip County

4. _____
Name of Owner (if different than applicant)

5.a. N/A
Representative of
Co-Applicant

b. _____
Street

c. _____
City Zip County

d. _____
Telephone

6. Person(s) to whom questions regarding this application should be directed: (Attach sheets if additional persons are to be contacted)

a.	Michael Silgen, Vice President Name and Title	a. Jack C. Tranter, Esq. Name and Title
b.	Memorial Hospital at Easton 219 South Washington St. Street	Gallagher Evelius & Jones LLP b. 218 N. Charles St., Suite 400 Street
c.	Easton 21601 Talbot City Zip County	c. Baltimore 21201 Balto. City City Zip County
d.	410-822-1000 Ext. 5696 Telephone No.	d. 410-347-1370 Telephone No.
e.	4410-822-7834 Fax No.	e. 410-468-2786 Fax No.
f.	msilgen@shorehealth.org E-mail Address	f. jtranter@gejlaw.com E-mail address
g.	Andrew L. Solberg Name and Title	g. Thomas C. Dame, Esq. Name and Title
h.	A.L.S. Healthcare Consultant Services 5612 Thicket Lane Street	h. Gallagher Evelius & Jones LLP 218 N. Charles St., Suite 400 Street
i.	Columbia 21044 Howard City Zip County	i. Baltimore 21201 Baltimore City City Zip County
j.	(410) 730-2664 Telephone No.	j. (410) 347 1331 Telephone No.
k.	410-730-6775 Fax No.	k. (410)-468-2786 Fax No
l.	asolberg@earthlink.net E-mail Address	l. tdame@gejlaw.com E-mail Address

7. Brief Project Description (for identification only; see also item #14):

Construction of a new hospital to replace Memorial Hospital at Easton.

8. Legal Structure of Licensee (check one from each column):

a.	b.	c.
Governmental ___	Sole Proprietorship ___	To be Formed ___
Proprietary ___	Partnership ___	Existing x

Nonprofit __x__ Corporation x
Subchapter "S" ___

9. Current Physical Capacity and Proposed Changes: (Staff will also provide separately a detailed spreadsheet on which the applicant will display current and proposed physical bed capacity by location.)

Service	Current Physical Beds	Beds to be Added or Reduced	Total Beds if Project is Approved
M/S/G/A	77 Beds	5	82
Pediatrics	8 Beds	–2	6
Obstetrics	17 Beds	–3	14
ICU/CCU Care	10 Beds	–	10
Psychiatry	_____ Beds	-	_
Rehabilitation	20 Bed	-6	14
Chronic	_____ Beds	-	_
Other (Specify	_____Beds	-	_
TOTAL BEDS	132 Beds	-6	126

10. Project Location and Site Control:

A. Site Size __235__ 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.)

The 2010 Town Comprehensive Plan designates the project site for future development as a "regional-scale", "campus-style facility" containing a new hospital, medical offices and related services. Similarly, the 2005 County Comprehensive Plan, as amended by County Resolution No. 159, designates the Property as a "primary growth area" or "Priority Development Area" appropriate for "a regional medical health care facility and related uses." The Talbot County Comprehensive Water and Sewer Plan designates the project site for immediate service by the Town of Easton's water and sewer systems. The project site was annexed by the Town of Easton on January 21, 2010. The Town adopted a new, specialized zoning district that is intended to facilitate the development of a regional medical campus, including a hospital. Concurrent with annexation, the Town amended its zoning map to apply the new Regional Healthcare (RH) zoning district to the entire project site. Pursuant to Article 23A, Section 9(c) of the Annotated Code of Maryland, the Talbot County Council expressly approved the RH rezoning of the project site.

The proposed hospital is a permitted use under the RH zoning district. As such, Shore Health System, Inc. (SHS) must obtain site plan approval from the Town of Easton Planning Commission, but no variances, special exceptions, or legislative land use approvals are required for development of the project. SHS is in the process of negotiating a Developers Rights and Responsibilities Agreement (DRRA) with both the Town and County. This agreement will contractually vest SHS' rights in the existing RH zoning for a period of 30 years and memorialize the parties' responsibilities for infrastructure required for the project. SHS expects to conclude the DRRA negotiations and have the DRRA fully executed and recorded prior to CON approval.

The Town site plan review process will be initiated shortly after submittal of the CON application. The timeframe for completion of this process is dependent, in part, on the nature and extent of public participation and municipal comments and revisions. SHS expects to complete the site plan approval process by November 2012. All other State and local approvals incidental to the development approval process, such as forest conservation, stormwater management, sediment and erosion control, wetland permitting, local and State Highway Administration access permitting, will be obtained concurrent with the site plan review process.

C. Site Control:

(1) Title held by: The project site is comprised of two parcels of record, both of which are currently owned by Talbot County, Maryland. SHS holds options to acquire the project site from the County; the assignments of such options to SHS are recorded among the Land Records of Talbot County, Maryland in Liber 1750, folios 404 and 407. SHS intends to exercise its options and become the fee simple owner of the project site.

(2) Options to purchase held by: _____
(i) Expiration date of option _____
(ii) Is option renewable? _____ If yes, please explain
_____
_____
(iii)Cost of 0ption _____

(3) Land Lease held by: _____N/A_____
(i) Expiration date of lease _____
(ii) Is lease renewable _____ If yes, please explain
_____
_____
(iii)Cost of Lease _____

(4) Option to lease held by: _____
(i) Expiration date of option _____
(ii) Is option renewable?_____ If yes, please explain
_____
_____
(iii)Cost of option _____

(5) If site is not controlled by ownership, lease, or option, please explain how site control will be obtained._____
_____

(INSTRUCTION: IN COMPLETING ITEMS 11, 12 & 13, PLEASE NOTE APPLICABLE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

11. Project Implementation Target Dates (for construction or renovation projects):
    A. Obligation of Capital Expenditure ___1___months from approval date.
    B. Beginning Construction ___2____ months from capital obligation.
    C. Pre-Licensure/First Use __34_____ months from capital obligation.
    D. Full Utilization __2___ months from first use.

12. Project Implementation Target Dates (for projects not involving construction or renovations):

    A. Obligation of Capital Expenditure _____ months from approval date.
    B. Pre-Licensure/First Use _____ months from capital obligation.
    C. Full Utilization _____ months from first use.

13. Project Implementation Target Dates (for new service projects not involving a capital expenditure):

    A. Obligation of Capital Expenditure _____ months from approval date.
    B. Pre-Licensure/First Use _____ months from capital obligation.
    C. Full Utilization _____ months from first use.

14. Project Description:

Describe the project's construction and renovation plan, and all services to be provided following completion of the project.

See page 11

15. Project Drawings:

Projects involving renovations or new construction should include architectural drawings of the current facility (if applicable), the new facility (if applicable), and the proposed new configuration. These drawings should include, as applicable:

1) the number and location of nursing stations,
2) approximate room sizes,
3) number of beds to a room,
4) number and location of bath rooms,
5) any proposed space for future expansion, and
6) the "footprint" and location of the facility on the proposed or existing site.

See **Exhibit 1**.

16. Features of Project Construction:

A. Please Complete **"CHART 1. PROJECT CONSTRUCTION CHARACTERISTICS AND COSTS"** describing the applicable characteristics of the project, if the project involves new construction or renovation.

B. Explain any plans for bed expansion subsequent to approval which are incorporated in the project's construction plan.

The building is to be constructed to accommodate one additional floor on top of the patient tower. It is also designed to be able to expand horizontally. In addition, the footprint of the building was designed before MHE's licensed bed complement was reduced by four beds as a result of the "140% Rule" for FY 2013. Consequently, there are four rooms being shelled that were anticipated to be patient rooms: 2 shelled ICU rooms, 1 shelled Neuro room, and 1 shelled Joint room. In addition, the space for the Rehabilitation unit was designed prior to a decline in volume in 2012. Consequently, the space equivalent to 6 rooms will be shelled as a result of the decision to reduce the number of rooms from 20 to 14. Lastly, there are 1,648 SF of shell space on the second floor that has yet to be assigned.

C. Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.

Utilities (water, electricity, sewage, etc.) must be brought to the property line. Costs are included in the project budget to do so. SHS has already begun speaking with the County and with utlity companies to assure that this will be accomplished in time for construction of the new buildings.

A. Water: A new 12-inch water loop will be extended from the terminus of the existing water main at the Goldsborough Neck Road/Hailem School Road intersection along the easterly edge of Hailem

School Road to the north end of the project site. The main will then follow the northerly property line to the proposed 400,000 gallon elevated water storage tank. A second new main will be extended up relocated Longwoods Road, following the northerly property line to the proposed water tank to complete the system loop. Two (2) independent service laterals to the hospital, one from the water main along the northern property line and a second from Longwoods Road, will enter the building at the central plant, near the truck loading dock. The proposed water system is designed to deliver 1,600 gpm at 20 psi for fire suppression with a 90-minute duration, as mandated by the University of Maryland Medical System insurance provider. The estimated average daily domestic water demand is estimated to be 225,000 gpd.

B. Sanitary Sewer: The first phase of the sanitary sewer will consist of a conventional gravity sewer with pumping station and force main. The gravity sewer will consist of a PVC main and pre-cast concrete manholes set at intervals along the sewer main. Some manholes will be stubbed out for future use. The pump station will be constructed out of concrete and have two (2) pumps for pumping wastewater through a 12" force main to the Town of Easton's existing sewer collection system. Phase II will consist of a conventional gravity sewer that will receive wastewater from future facility and development around the hospital and will connect into the Phase I sewer system.

C. Storm Drains: Catch basins will be located as required to intercept surface runoff from the drives and parking lots. Roof drain connections are anticipated along the perimeter of the hospital. Pipe for storm drains will typically be smooth interior HOPE. Reinforced concrete pipe may be used in public rights-of-way as required by the Town of Easton and/or State of Maryland. The increase in hard surface areas will require the design and installation of a stormwater management system to reduce discharge rates to those presently exiting the site into the receiving channels. Water quality treatment will be provided onsite by BMPs (Best Management Practices) such as bio-retention areas, landscape infiltration, grass swales, and stormwater planters. Quantitative management and channel protection will be provided in extended detention dry ponds in compliance with Maryland Department of the Environment (MDE) and Federal Aviation Administration (FAA) stormwater requirements.

D. Natural Gas: Natural gas is provided by Easton Utilities (EU). EU has indicated there is sufficient pressure and quantity of natural gas to serve this project.

E. Electric Power: Easton Utilities is the electric utility. As mentioned above, overhead electric lines will be relocated underground and adequate electric service will be brought to the hospital site.

F. Telephone: Verizon is the principal telephone service provider in this area. Existing overhead lines on existing Route 662 will be relocated underground along the revised Route 662 alignment and adequate phone service will be provided for the hospital campus.

Chart 1. Project Construction Characteristics and Costs			
Base Building Characteristics	Complete if Applicable		
	New Construction		Renovation
	Tower 1	Tower 2	
Class of Construction			
Class A	X	X	
Class B			
Class C			
Class D			
Type of Construction/Renovation			
Low			
Average			
Good	X	X	
Excellent			
Number of Stories	6 Plus Mechanical Penthouse	2	
Total Square Footage	300,678	58,250	
Basement	n/a	n/a	
First Floor	101,957	29,125	
Second Floor	68,645	29,125	
Third Floor	40,921	n/a	
Fourth Floor	34,222	n/a	
Fifth Floor	32,035	n/a	
Sixth Floor	18,222	n/a	
Penthouse	4,676	n/a	
Perimeter in Linear Feet			
Basement	n/a	n/a	
First Floor	1863' 7"	635' 8"	
Second Floor	1131' 8"	635' 8"	
Third Floor	1234' 8"	n/a	
Fourth Floor	1255' 1"	n/a	
Fifth Floor	1026' 9"	n/a	
Sixth Floor	661' 3"	n/a	
Penthouse	398'	n/a	

Wall Height (floor to eaves)			
Basement	n/a	n/a	
First Floor	16'	16'	
Second Floor	16'	16'	
Third Floor	14'	n/a	
Fourth Floor	14'	n/a	
Fifth Floor	14'	n/a	
Sixth Floor	16'8" (includes parapet)	n/a	
Penthouse	18'	n/a	
Elevators			
Type *Passenger* *Freight*	Passenger / Service Type: Traction Type: Traction	See Tower 1 Column	
Number	Public - 5 (18 stps); Patient/Service - 3 (19 stps); Trauma - 1 (6 stps)	See Tower 1 Column	
Sprinklers (Wet or Dry System)	Wet	See Tower 1 Column	
Type of HVAC System	Excellent Grade - Forced Air: VAV/Constant Volume Digitally Controlled	See Tower 1 Column	
Type of Exterior Walls	Glass Curtain Wall; Brick Veneer; Metal Panels; Cultured Stone	See Tower 1 Column	
Chart 1. Project Construction Characteristics and Costs (cont.)			
	Costs	Costs	Costs
Site Preparation Costs	$36,015,484		
Normal Site Preparation*	$1,085,488		
“Inside the Loop” (The portion of the site to be used by the Hospital)			
Demolition	$25,000		
Paving and Roads	$4,140,494		
Storm Drains	$2,377,558		
Rough Grading	$1,419,437		
Landscaping	$2,136,906		
Sediment Control & Stabilization	$201,087		
Helipad	$598,648		

Water	$58,558		
Sewer	$93,692		
Outside the Loop (Pertaining to the larger site, outside of the area used by the hospital, Considered Off-site Costs)			
Normal Site Work	$461,177		
Sediment Controls	$221,905		
Rough Grading	$528,315		
Stormwater Drains	$1,083,977		
Paving and Roads	$5,351,458		
Landscaping	$150,493		
Water	$1,125,436		
Sewer	$677,278		
Gas	$244,420		
Electrical Ductbanks & Raceways	$2,887,287		
Communication Cabling - Verizon, etc.	$1,125,478		
Upsize Pump Station - 327 - 900 EDU's	$1,531,200		
Upsize Forcemain - 8" - 12"	$2,717,312		
SHS Share of Electrical Extension - Looped 25kV Feeder from Sub 2 & Sub 3	$3,397,000		
Gas Extension to RMC Building Site	$689,000		
MAN Loop Feed	$106,500		
Other County Charges	$1,580,380		
Building and Permit Items (Inside the Loop)			
Canopy	$992,358		
Premium for Labor Shortages on Eastern Shore Projects	$9,389,478		
LEED Silver Premium	$5,007,722		
Siesmic Costs	$2,503,861		
Signs	$1,000,000		
Jurisdictional Hook-up Fees	$1,852,215		
Impact Fees	$1,539,819		

*As defined by Marshall Valuation Service. Copies of the definitions may be obtained by contacting staff of the Commission.

PROJECT DESCRIPTION

I. MEMORIAL HOSPITAL AT EASTON

Emergency Hospital, a 32-bed predecessor of The Memorial Hospital at Easton ("MHE" or the "Hospital"), officially opened its doors on January 28, 1907, on South Washington Street in Easton. One of the driving forces for opening a hospital on the Mid-Shore was that physicians wanted to treat their patients close to home instead of referring them to Baltimore for care. From its beginnings, Emergency Hospital was a regional provider of medical care, serving people in Talbot, Caroline and Queen Anne's Counties.

In 1915, following the largest fundraising effort the community had ever seen, a new hospital was built on South Washington Street, a structure that is still part of the Memorial Hospital complex. After two expansions in 1920 and 1929, the name of the hospital was changed to The Memorial Hospital at Easton, in 1943, to honor local men and women who served in both world wars and the many volunteers whose service helped establish the Emergency Hospital.

Over many years, the MHE building was expanded and includes components dating from 1915, 1975, 1982, and 2006.

In 1996, MHE merged with Dorchester General Hospital ("DGH") to form Shore Health System ("SHS"), a unified network of medical services with the combined resources of community hospitals, physicians and outpatient centers. In 2012, US News and World Report ranked MHE as the ninth best hospital in Maryland and Number 1 on the Eastern Shore.

II. SHORE HEALTH SYSTEM

With 2,100 employees, a 200-member medical staff and hundreds of volunteers, SHS is the primary provider of healthcare services in the four-county Mid-Shore region, offering a full range of primary and specialty care services to more than 100,000 people. In 2006, SHS joined the University of Maryland Medical System ("UMMS").

A. Facilities and Services

SHS includes two hospitals with more than 190 acute care beds, including a 20-bed acute rehabilitation unit at MHE and a 16-bed behavioral health unit at DGH (expanding to 24 beds in October 2012). SHS also operates the 14-bed Queen Anne's Emergency Center, Maryland's only rural free-standing emergency center.

SHS offers specialty services for cancer care, surgery, pain management, diabetes management, wound healing, medical rehabilitation, behavioral health, joint replacement, digestive health, sleep disorders, home health care and hospice care. Cardiovascular and pulmonary services include testing and procedures, cardiac catheterization and an accredited cardio-pulmonary fitness and wellness program. Surgical services include minimally invasive and robotic assisted surgical procedures and an ambulatory surgery center in Easton.

SHS also includes a network of outpatient centers offering diagnostic imaging and laboratory testing, primary care and specialty treatment, and rehabilitation services in Talbot, Dorchester, Caroline and Queen Anne's Counties. In partnership with the University of Maryland Medical Center and the University of Maryland School of Medicine, SHS operates kidney transplant and dialysis vascular access clinics to help people who are candidates for kidney transplant and dialysis prepare for these treatments.

B. Physician Practices

The SHS medical staff includes physicians, physicians' assistants, nurse midwives, and nurse practitioners. Physicians who practice at MHE and DGH specialize in family medicine, internal medicine and provide a full range of clinical specialties, including emergency medicine, cardiology, oncology, pediatrics, pulmonology, radiology, orthopedics, obstetrics, gynecology, anesthesiology, surgery, neurology, physical medicine and rehabilitation, and ophthalmology. They also consult with hospitalists who are on staff 24 hours a day.

Shore Clinical Foundation ("SCF"), a SHS affiliate, provides medical management for employed physicians and practices. SHS physicians provide primary care at offices in Centreville and Denton, pediatric care at practices in Easton and Cambridge, and specialty care in otolaryngology, general surgery, endocrinology, psychiatry, gynecology, urology, neurosurgery, neurology, physical medicine and rehabilitation, and sleep medicine.

C. Honors and Accreditations

In addition to meeting all the Joint Commission standards, SHS maintains accreditation in many clinical areas, including diabetes education, stroke care, ultrasound and mammography, cardiovascular and pulmonary rehabilitation, clinical laboratory testing, sleep medicine, and vascular and echocardiography testing. The Requard unit is also accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF"). Requard is accredited as of 2012 in both comprehensive rehabilitation and specifically for stroke rehabilitation. CARF is an independent, nonprofit accrediting body whose mission is to promote the quality, value and optimal outcomes of rehabilitation services provided in hospitals and nursing homes.

In 2009, SHS achieved Magnet® recognition for excellence in nursing services from the American Nurses Credentialing Center's Magnet Recognition Program. This achievement

followed six years of intensive preparation and documentation to demonstrate that SHS provides the best nursing care, the highest quality patient care, and the most supportive and innovative working environment for nursing professionals.

The Commission on Cancer of the American College of Surgeons granted a three-year accreditation with commendation to the Shore Regional Cancer Program in 2009 and another three year accreditation in 2012. The Commission on Cancer accreditation program acknowledges cancer treatment facilities that deliver quality patient care with a focus on prevention, early diagnosis, pre-treatment evaluation, optimal treatment, rehabilitation, surveillance for recurrent disease, support services and end-of-life care. The Shore Regional Cancer Program, which includes the Requard Radiation Oncology Center, the Lenny Satchell Chemotherapy Suite, the DGH Outpatient Chemotherapy Center and the Shore Regional Breast Center, combines sophisticated technology and skilled clinical practitioners and social workers who guide patients through diagnosis and treatment while providing the social and financial resources they need to transition to life as a cancer survivor.

In 2009, SHS's Requard Center for Acute Rehabilitation earned its three-year CARF accreditation . The Requard Center is part of a comprehensive network of rehabilitation services that include inpatient acute physical, occupational and speech therapy, and outpatient centers for continued treatment in Easton, Denton, Cambridge, and Queenstown. Physical therapists at the Balance Center in Cambridge assists physicians in the diagnosis and treatment of patients with balance problems associated with dizziness/vertigo, musculoskeletal disorders, and neurologic conditions. The Requard Center's 2012 CARF accreditation includes CIIRP (Comprehensive Integrated Inpatient Rehabilitation Program) and SSP (Stroke Specialty Program).

MHE is designated as a Primary Stroke Center by the Maryland Institute for Emergency Medical Management Systems. In 2010, the Primary Stroke Center earned a Silver Award from the American Heart Association and American Stroke Association. The award recognizes hospitals that demonstrate compliance with the seven Get With The Guidelines® stroke achievement measures. The Silver Award acknowledges that SHS has met the guidelines for providing the highest standards of stroke care for 12 consecutive months.

The Joint Replacement Center at MHE is a CareFirst BlueCross BlueShield Blue Distinction Center for Knee and Hip Replacement. The specialty center is also a UnitedHealth Premium® Specialty Center for Total Joint Replacement. In addition to positive patient outcomes, the selection criteria used in evaluating the Joint Replacement Center for these distinctions were the experience, training and number of cases performed by the center's orthopedic surgeons; the use of proven best medical practices, such as surgical checklists and other standardized processes to streamline patient care; and the preoperative education available to patients.

SHS/MHE won the 2012 Minogue Award for Safety Innovation from the Maryland Patient Safety Council.

In 2012, MHE was ranked by *US News and World Report* as one of the ten top acute care hospitals in Maryland. (See http://health.usnews.com/best-hospitals/area/md) As the ranking noted, MHE performed nearly at the level of nationally ranked U.S. News Best Hospitals in 9 adult specialties (Diabetes & Endocrinology, Gastroenterology, Geriatrics, Gynecology, Nephrology, Neurology & Neurosurgery, Orthopedics, Pulmonology, and Urology). The magazine also noted that MHE scored high in patient safety, demonstrating commitment to reducing accidents and medical mistakes.

D. Community Support

Volunteers from the DGH and MHE auxiliaries donate time, talent and money that support programs and services made available to the community at the two SHS hospitals and at outpatient centers around the region.

III. THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM

UMMS is dedicated to providing quality health care through a market-responsive regional system composed of a world-class academic medical center partnered with the University of Maryland School of Medicine ("UMSOM") and premier community and specialty hospitals. Over the last 28 years, UMMS has grown significantly to become an eleven-hospital, Maryland-based health care delivery system. UMMS includes a large urban academic medical center, an urban community hospital, a suburban community hospital, six rural hospitals and two specialty hospitals. UMMS' impact on the health and well-being of Marylanders is significant by any measure. UMMS generates nearly $4 billion in economic activity in Maryland. It has 19,000 employees, approximately 2,300 licensed beds, 120,000 annual patient admissions, and gross patient revenues of $3 billion. UMMS supports an estimated 13,400 additional jobs through the purchase of goods and services. As the largest health system serving the State of Maryland, UMMS also provided more than $168 million in community benefits in Fiscal Year 2011. These community services include medical education, subsidized programs, community funding, civic involvement, community service programs, and charity care. UMMS includes the following institutions:

- Baltimore Washington Medical Center ("BWMC") is a not-for-profit corporation operating as a licensed 307-bed hospital. BWMC opened in 1965 and primarily serves residents of northern Anne Arundel County. BWMC became affiliated with UMMS in 2000 and was recently named a "Top 100" hospital for intensive care outcomes.

- Chester River Hospital Center ("CRHC") is a 42-bed acute care hospital located in rural Kent County; it serves residents of Kent and Queen Anne's counties. CRHC is affiliated with a 97-bed nursing and rehabilitation center and a home care and hospice agency. CRHC joined UMMS in July 2008.

- Civista Medical Center ("Civista"), located in La Plata, Maryland, is a not-for-profit corporation that serves as a licensed 110-bed hospital. Civista, which opened in 1939, serves the residents of Southern Maryland and joined UMMS in July 2011.

- DGH is a 46-bed hospital, providing 24-hour emergency services. DGH principally serves the residents of Dorchester County while also serving as the regional provider of inpatient adult acute behavioral health services. Shore Health System (of which DGH is a part) became affiliated with UMMS in 2006.

- Harford Memorial Hospital ("HMH") is a non-profit acute care facility located in Havre de Grace, Maryland. HMH is an 89 licensed-bed facility that as a member of Upper Chesapeake Health and became affiliated with UMMS in 2009.

- Kernan Orthopaedics and Rehabilitation Hospital ("Kernan") is a private not for profit corporation that operates a 161-licensed bed hospital specializing in medical/surgical acute care and rehabilitation. Kernan has 9 progressive care/medical/surgical beds and 152 rehabilitation beds which includes 100 rehabilitation beds, 36 chronic and 16 dually licensed chronic/rehabilitation beds. Kernan also operates an outpatient therapy facility and a variety of outpatient clinics.

- Maryland General Hospital ("MGH") is a not for profit hospital corporation operating a 235-licensed bed acute care hospital. A community teaching hospital facility located in Baltimore Maryland, MGH was originally organized in 1881 by a group of Baltimore physicians to serve as a teaching hospital for medical students. MGH became affiliated with UMMS in 1999.

- MHE is a 132 licensed-bed hospital, which includes the 20-bed Requard Center for Acute Rehabilitation. MHE principally serves the residents of Caroline, Dorchester, Talbot, Queen Anne's, and Kent Counties. Shore Health System (of which MHE is a part) became affiliated with UMMS in 2006.

- Mt. Washington Pediatric Hospital ("MWPH") is a private not for profit hospital corporation which operates a 102-licensed bed children specialty and rehabilitation facility in Baltimore, seven miles from UMMC. MWPH operates 15 special pediatric rehabilitation beds in leased space at Prince Georges Hospital Center. MWPH has been providing services since 1922. It became affiliated with BWMC in September 1997 and, since July 2006, is owned by UMMS and The Johns Hopkins Health System (50% each).

- University of Maryland Medical Center ("UMMC"), located on the west side of downtown Baltimore, provides highly specialized tertiary and quaternary care for the entire state and region. UMMC is an 800 licensed-bed medical center that provides

a broad range of inpatient and outpatient services and functions as a teaching hospital.

- Upper Chesapeake Medical Center ("UCMC") is a 181 licensed-bed hospital that serves residents of northeastern Maryland. As a member of Upper Chesapeake Health, UCMC affiliated with UMMS in July 2009 in order to continue delivering excellence in care.

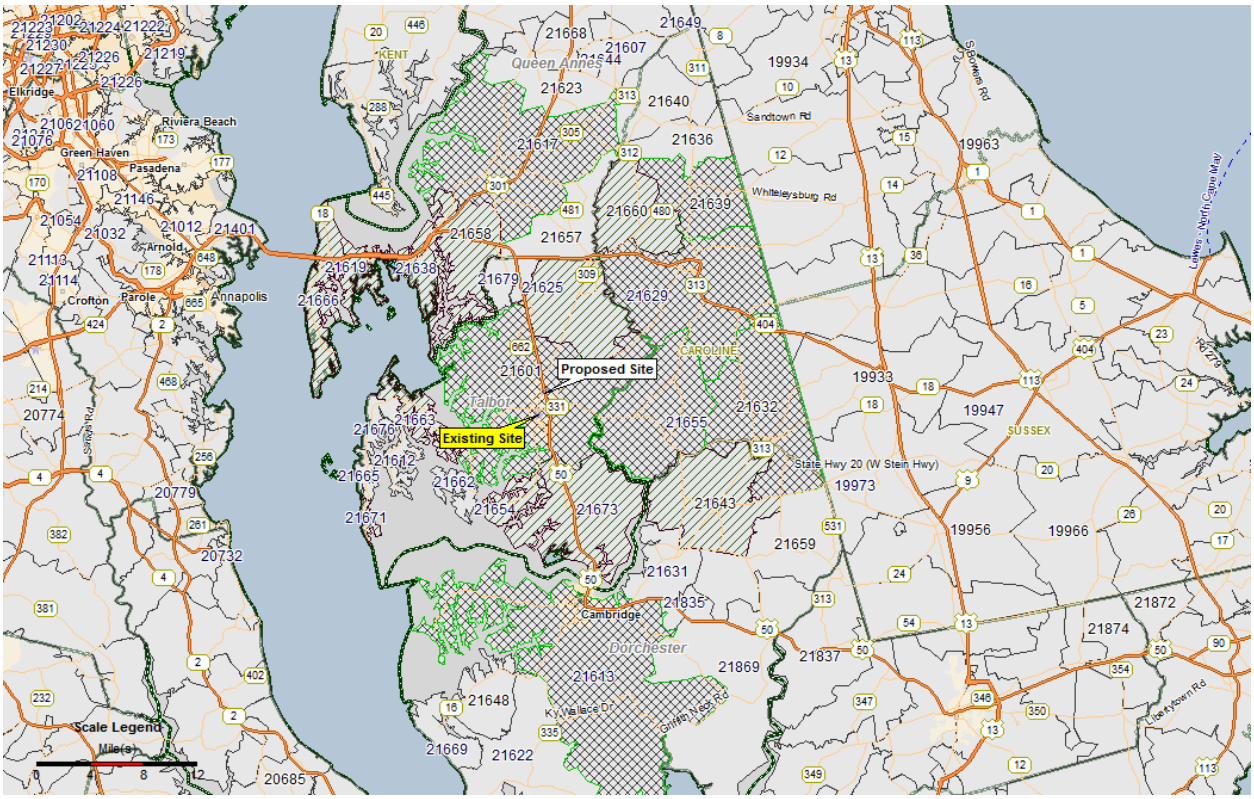
UMMS is governed by a board of directors and is neither owned by the State of Maryland nor governed by the University of Maryland. UMMC is the System's academic medical center, serving the region and Baltimore City with a full continuum of services.

IV. THE PROPOSED PROJECT

Today, MHE is a regional medical center. MHE's Primary Service Area includes Zip Codes in Talbot, Dorchester, Caroline, and Queen Anne Counties, as does its Secondary Service Area. (See Figure 1.) In fact, the majority of acute admissions to MHE come from outside of Talbot County. . The proposed project involves relocating the Hospital to a site approximately 3.5 miles north of the present location. The proposed new location is on Longwoods Road near the intersection of Route 50,

The existing facility is comprised of four components from different eras. A small portion of the building was built in 1915. The majority of the building, including most of the inpatient units, was constructed in 1975. A smaller five story inpatient addition was added in 1982. Lastly, a one story ambulatory and emergency wing was constructed in 2006. However, the majority of the building was constructed in 1975 and 1982. (A diagram showing the existing building and the years when the different components were constructed is included in **Exhibit 2**.)

Figure 1
Primary and Secondary Service Areas
MHE
CY 2011



Primary Service Area

Secondary Service Area

The existing building is deficient in many ways (see the discussion under 10.24.01.08G(3)(b). - Need). It is not designed for modern, family oriented medicine. It is undersized in various critical areas (such as the size of the operating rooms). It does not have adequate parking (sharing its parking lot with a synagogue). The footprint of the Hospital building cannot be expanded (being surrounded by residential areas) and is inconvenient for the many patients from outside Easton who have to drive into downtown Easton to access the Hospital. Although the outpatient component is newer, it was

designed to be an addition to the older building components and, therefore, suffers from considerable limitations.

SHS engaged The Schachinger Group (TSG) to conduct departmental interviews, meeting with representatives from many clinical and service-oriented departments. The numerous findings as to existing physical space deficiencies and limitations affected nearly every department in the hospital. A summary is presented below, followed by issues specific to departments identified in the TSG's interviews.

Summary of Concerns About Existing Physical Space

- Location and accessibility of supplies are not optimal. Hoarding of supplies is common. Night and weekend supply searches occur often by nursing staff.
- An inordinate amount of staff time is taken with supply and inventory ordering, tracking, and maintenance. Much of the work is manual. Par levels may be higher than necessary to mitigate supply chain problems.
- General lack of storage throughout the hospital has resulted in inefficient use of staff time and cluttered hallways. Patient rooms have been closed and used for storage as no central storage area for beds and other necessary equipment exists. A semi-private bed area on almost every floor has been closed for storing beds, computer carts, blood pressure cuffs, and other equipment.
- The elevators are too small for larger patient transports and are inconveniently located, both in terms of physical location and difficulty getting there through the corridors. Elevator protocol leaves some departments with very long wait times. Patients in transport are frequently exposed to public spaces.
- Concerns were voiced regarding cleaning certain equipment or transporting equipment to be cleaned. Locations for equipment storage rooms have been debated; centralized versus a more common call for decentralized storage on patient floors. The request to have EVS clean equipment was heard and responded to positively "assuming staff levels are appropriate."
- Clean and especially soiled utility rooms must be sized appropriately for the units. The existing soiled utility rooms are considerably under sized.
- Par levels need better management. There is no way to electronically reconcile supplies to inventory, so a lot of time is spent doing it manually. A better system is needed for tracking, billing, and reordering supplies. Some form of automation, bar-codes or similar, was mentioned as desirable.
- Signage is not adequate as people get lost, especially in major intersections like one near the main lobby and the elevators.

ED

- There is no elevator near the ED. It is a long trip to the main hospital elevators, especially to the helipad elevator. The trip to an elevator includes maneuvering many corners. In addition, there are no oversized elevators for patient transport. It is

difficult for a critical care team to squeeze into the elevator. The helipad elevator, which typically handles larger teams, is reportedly smaller than the other elevators in the hospital. This elevator is also used extensively by materials management for supply transport.

- While the ED does not have many extra beds and stretchers (maybe 2), there is no storage space for storing the extras.
- The PTS station is located in the middle of the nurses' station, which is not ideal because a column blocks lines of sight within the area.
- Location and accessibility of supplies is an issue; the supply room is down a hallway (about 200 feet away) and is not convenient or near the nurses' station. Centralized supplies in ED (Pyxis stations preferred) would reduce staff steps required. Because there is no central supply, the nurses tend to hoard high-demand items as they do not know when they will get more. Reducing the amount of steps to get supplies to make things more accessible in general would be welcomed.
- Patient care equipment is stored at various locations. A yellow sticker (tag) method (clean, in-use, soiled) is used to track the status of individual equipment items. The results are not consistent due to human input and error. There is no organization for charging, and no method for locating items. Tracking systems are desired.
- There are two soiled utility rooms, one for ED and one for Express Care. Neither are large enough for trash and dirty supplies (particularly bedside commodes). Ideally, they would like three rooms: soiled, clean room, storage room.
- Environmental Services has a small storage space in the ED, however additional room is needed to store cubicle curtains.
- There is no practical storage space for dietary carts. Special delivery trays are often left on top of the nurse station counters. There is no collection area for dirty trays; a pick up / drop off location is needed.

Dietary

- There are long waits for elevators, especially when one is down.

Imaging

- Elevator sizes are an issue. One can barely access the control panel when transporting a patient by bed, as the bed barely fits in the elevator. When the patient is transported with additional equipment and a multiple person team, the elevator is cramped.

Infection Control

- Clean and soiled utility rooms are inadequately sized for current usage. The new ambulatory center is also having same space issues. They are working on a plan to accomplish better separation; problem was with original design. (The space was acquired.)
- Need for all single-patient rooms is great due to drug resistance problem because sometimes need to isolate patients and sometimes have to close off a bed to isolate.
- Isolation supplies are kept on a cart outside the room, which are in the way and create clutter. Nurse servers, it was felt, are hard to keep clean and provide chance for infection.

- Separate rooms for clean and soiled are preferred by the Joint Commission, not just by carts; this is a big challenge. Curtains are used for separation in some areas, including scopes. Custom ultrasonic equipment travels in and out of soiled rooms, even after cleaning.
- Placement of sinks is not ideal. Sinks should be placed closer to room exit, with a trash can on the way to the sink. There should be more sinks outside patient rooms.
- All units have negative pressure isolation room(s); there is a need for more.
- Bed storage is an issue, as extra beds are typically left out in the hallway or even on the loading dock.
- Deliveries from vendors / suppliers to Materials Management cannot be stored on the floors in the containers that they arrived in. They must be unpacked for storage.
- Sinks aren't deep enough. Design & depth of sinks needs to be considered.

Inpatient Care Services/Nursing

- The warehouse where most supplies are stored is too far away from the clinical areas, which is critical during the hours when Materials Management is not staffed and nursing supervisors are required to find necessary items.
- An area is needed for storing supplies and equipment that has been cleaned and is ready for use. Dirty equipment is stored wherever space is found, such as closets, to keep the hallway clear. When needed, equipment has to be located and the status (clean/soiled) is often unknown. Much time is wasted looking for things.
- Storage is a major concern. Having no central storage area for beds and other necessary equipment, a semi-private bed area on almost every floor has been closed for storing beds, computer carts, blood pressure cuffs, and other equipment. Many items are stored in the hallways. Because of the transition to electronic records, there should be a computer located at every bed side. The existing utility rooms have electric panels on the inside walls, reducing the ability for optimum storage.
- Nurses must often locate, clean, and store the equipment necessary for their functions. This takes valuable time away from patient care. With no central supply, you can't requisition items and have them delivered on an on-call basis. There should be adequate space and EVS staff to pick up soiled items, clean, return, and put away.
- The elevators are too small to transport a patient with patient care equipment and the necessary transport team. There are a large number of bariatric patients at SHS and transportation of those patients requires additional equipment and staff, as well as wider doorways. The elevators, which have metal floors, are very noisy and bumpy which is disruptive to the patient during transport.

Laboratory

- The lab is currently in a space that was not originally designed to be a lab. Layout for the new hospital needs to be reconfigured with blood bank in front, supervisor offices segregated, more open layout not compartmentalized, better access to phone, printers, and computers. There should be total automation.

Linen Services

- On the floors, linens are stored in a variety of areas, depending on space and department. Storage areas include linen closets, clean utility rooms, and hallways.

Materials Management

- Multi-levels of receiving and supply storage are not efficient. Traffic patterns and busy intersections within the hospital are not optimal. The ideal dock area at the new facility would be well lit with a receded overhang that is high enough to not be damaged by large trucks. The docks should be 48" high with a generous ramp and a large staging area.
- Pallet racking is currently located in undesirable locations but there is no place to move it. Paper/Forms and other bulky stuff are stored at the dock because of bulk and weight. Most unit supplies arrive on pallets.
- Emergency supplies are located in trailers on the campus and in off-site, rented, climate controlled storage. These should all be stored on site.
- IT storage room is needed as well. Placement will depend on where the IT department is eventually located.
- The cylinder farm is located in the dock bay area. Replenishments are ordered once per week and delivered on Tuesdays. H and K gases are stored by the docks and E gases are stored near the cylinder farm in cages. For the new facility, a tank/cylinder farm that is inside or at least covered is preferred.
- Bulk gas is automatically refilled by the vendor when the meter reaches a certain level, so deliveries are unscheduled. While the delivery truck is refilling the tanks, the truck must park across the loading dock bay, blocking the loading dock.

Outpatient Services and Surgery

- There is no Central Supply to store and supply what is used by multiple departments, so multiples of the same supplies are spread throughout the building. Multiples are common and unnecessary, and there are a lot of special orders. Materials Management does not have the necessary space for this storage.
- The elevators are not large enough to support the equipment and large teams. The gap between the door and the floor is large and catches the wheels of beds, carts, and gurneys. The location of the service elevators is inconvenient to the OR and travel involves multiple turns, corners, and intersections. Easy access between the OR and ICU is requested for the new facility, whether by adjacency or by elevator.

Pharmacy

- The hospital has a 6" Translogic (Swisslog) Pneumatic Tube System. Most stations are not located within the secure nursing area, making it inconvenient. It is also loud; having been installed after the hospital was built. It has been changed at least once.

Plant Operations (Engineering/Maintenance)

- The maintenance area is located in a bay beside the receiving dock. They are short on equipment storage space for items such as televisions, wheelchairs, and beds. They need expanded organized storage with standard wire shelving and sufficient space to navigate around them. Drawers, pipe racks, and lumber racks are

necessary. The existing facility uses large amounts of lumber at off-site facilities, though they hope to reduce use of lumber in future.
- Storage is the major issue with Bio-Med, which has 2,500 pieces of equipment. There is no central storage; their equipment is located throughout the hospital.

Respiratory Services

- The outpatient services performed by the department are on the 3rd & 4th floors, which is not convenient. Patients often have problems with wayfinding. They have left a departmental flyer with the registration desk staff, who have been encouraged to give to patients so they can find their way to the department. This flyer is not always distributed and patients are often lost when attempting to locate the department.
- There is no Pneumatic Tube Station in Respiratory Care or the Cath Lab. Drugs are received through the Pyxis system, which is working adequately for their needs.
- Elevators are an issue at the existing facility when moving equipment. When there is no equipment involved, the respiratory staff typically uses the stairs. The size of the elevators and usage by other departments makes it difficult to transport equipment, and the wait times for available space to transport via elevators are long.
- The department has limited contact with EVS and do not often use the soiled utility room because there is not enough room in the soiled utility rooms to process soiled ventilators.

Sterile Processing and Surgery

- The cart washer can only handle one cart at a time, with a cycle of 20-30 minutes. A backup of 2 to 4 carts is common and very limited storage for the cleaned carts waiting to be filled; the staff must work around these extra carts. There is also no storage for prepared case carts, which line up in the OR area.
- There are storage issues with portable equipment. This equipment should be stored at point of use, but there is not enough space or enough staff; it is stored where ever space can be found.
- Two double-well sinks are in Sterile Processing, but only one is utilized due to storage issues.

The proposed project is needed to replace an aged facility that has deficiencies in nearly every department.

The new facility will be located on a 235-acre parcel (comprised of two smaller parcels being purchased from Talbot County) at the intersection of Longwoods Road and Route 50, just north of the Easton Municipal Airport. The site is predominantly a “green-fields” site, not all of which will be used for the Hospital. The remainder of the parcel will be used for future development. As a green-fields site, utilities will have to be brought to the

site lines. Negotiations for this are well underway, as reflected above in response to CON Application question 16c.

Like the existing Hospital building, the new building will be licensed for 112 acute care beds and 20 Special Hospital/Rehabilitation beds. The configuration of the acute care beds will be as follows: 92 MSGA beds, 14 Obstetric Beds, and 6 Pediatric beds.

The new facility will include two towers, connected by the first floor level of the building. The six story Tower 1 will include the inpatient units and surgery suite, and the two story Tower 2 will include the hospital laboratory, clinics, and other administrative and support areas.

The first floor of Tower 1 will include:

- Central Energy Plant
- Environmental services
- Material Management
- Facilities
- Kitchen
- Dining
- Imaging
- Cardiopulmonary/Vascular Services
- Emergency/Express Care
- Registration
- Lobby

The second floor of Tower 1 will include:

- Sterile Processing
- Information/Technology
- Pharmacy
- Pediatric Inpatient Unit
- 8 bed Observation Unit
- Catheterization Labs
- PACU
- Surgery Suite
- Minor Procedure Suite
- Prep/Stage II Recovery
- Chapel

The third floor of Tower 1 will include:

- MSGA Unit
- OB, Delivery, C-Section, and Nursery

The fourth floor of Tower 1 will include:

- MSGA Unit
- 14 Bed Requard (Rehabilitation) Unit

The fifth floor of Tower 1 will include:

- Inpatient Dialysis Unity
- ICU
- Telemetry Unit
- Respiratory Therapy

The sixth floor of Tower 1 will include:

- MSGA Unit

The first floor of Tower 2 will include:

- Gift Shop
- Security
- Education Center
- Infusion Center
- Pain Management
- Behavioral Health
- Nursing Administration
- Outpatient Lab Draw
- Child Advocacy
- UMMS Diabetes & Endocrinology Center
- Cardio Fitness & Wellness

The second floor of Tower 2 will include:

- Laboratory
- Pre-Anesthesia Testing
- Hospitalist Suite
- Anatomic Pathology
- Human Resources
- Quality Team
- Medical Staff Lounge
- Executive Administration

SHS has not yet determined the use of the existing campus. The Planning Committee of the Shore Health Board has directed MHE President Ken Kozel to convene a special study group to begin the process to analyze and direct the disposition of the old Memorial Hospital site. It is envisioned that a committee of approximately 10 leaders from the community will be invited to join SHS and UMMS leaders to solicit community input and expert developers' guidance to explore the options that could be considered. Shore Health will start this process this fall after submitting the CON application.

PART II - PROJECT BUDGET

(INSTRUCTION: All estimates for 1.a.-d., 2.a.-h., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

1. **Capital Costs:**

a. **New Construction**

(1)	Building	$125,193,045
(2)	Fixed Equipment (not in Building)	
(3)	Land Purchase	$2,000,000
(4)	Site Development	$36,015,484
(5)	Architect/Engineering Fees	$17,400,000
(6)	Permits (Building, Utilities, Etc.)	$4,107,718
	SUBTOTAL	$184,716,247

b. **Renovations**

(1)	Building	$0
(2)	Fixed Equipment (not included in construction	$0
(3)	Architect/Engineering Fees	$0
(4)	Permits (Building, Utilities, Etc.)	$0
	SUBTOTAL	$0

c. **Other Capital Costs**

(1)	Major Movable Equipment	$22,000,000
(2)	Minor Movable Equipment	$4,100,000
(3)	Kitchen / Servery Equipment	
(4)	Building / Wayfinding Signage	
(5)	BR Insurance / Commissioning	
(6)	Relocation Expenses	
(7)	Contingencies	$7,000,000
(8)	Other (Specify) IT/Integration/ Communications /Commissioning	$18,200,000
	SUBTOTAL	$51,300,000
	TOTAL CURRENT CAPITAL COSTS (a - c)	$236,016,247

d. Non-Current Capital Costs

(1)	Inflation 27 mos at MHCC Index 11.3 - 14.4	$4,679,795

(2)	Capitalized Construction Interest	$24,901,333
TOTAL PROSOSED CAPITAL COSTS (a - e)		$265,597,375

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	$600,000
b.	Bond Discount	$970,000
c.	Legal Fees, Printing, etc.	$700,000
d.	Consultant Fees	
	CON Application Assistance	$100,000
	Other (Accounting)	$300,000
e.	Liquidation of Existing Debt	$0
f.	Debt Service Reserve Fund	$14,973,000
g.	Principal Amortization Reserve Fund	$0
h.	Other	$0
TOTAL (a - h)		$17,643,000

3.	Working Capital Startup Costs	
TOTAL USES OF FUNDS (1 - 3)		$283,240,375

B. Sources of Funds for Project:

1.	Cash	$9,969,159
2.	Pledges:Gross less allowance for uncollectable = Net	
3.	Gift, bequests	
4.	Interest income (gross)	
5.	Authorized Bonds	$242,771,216
6.	Mortgage	
7.	Working capital loans	
8.	Grants or Appropriation	
	(a) Federal	
	(b) State	$2,500,000
	(c) Local	
9.	Other (Specify) Fundraising $28M	$28,000,000
TOTAL SOURCES OF FUNDS (1 - 9)		$283,240,375

Lease Costs:

a. Land	$_____ x _____ = $_____
b. Building	$_____ x _____ = $_____
c. Major Movable Equipment	$_____ x _____ = $_____
d. Minor Movable Equipment	$_____ x _____ = $_____
e. Other (Specify)	$_____ x _____ = $_____

PART III - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3): **(INSTRUCTION: Each applicant must respond to all criteria included in COMAR 10.24.01.08G(3), listed below.)**

10.24.01.08G(3)(a) - The State Health Plan.

List each applicable standard from each appropriate chapter of the State Health Plan and provide a direct, concise response explaining the project's consistency with that standard. In cases where standards require specific documentation, please include the documentation as a part of the application.

ACUTE CARE CHAPTER GENERAL POLICIES - COMAR 10.24.10.04A

Policy 3.0 Acute care hospital services will be provided in the most cost-effective manner possible consistent with appropriately meeting the need for such services and providing appropriate access to such services.

MHE is a low cost hospital, providing hospital services in the most cost-effective manner possible consistent with appropriately meeting the need for such services and providing appropriate access to such services. In order to remain low cost, SHS has regionalized services such as Obstetrics and Acute Inpatient Psychiatry between its two hospitals. This project has been planned in a manner that will maintain affordable hospital services throughout MHE's five county region.

Policy 3.1 All Marylanders will have reasonable geographic and financial access to appropriate acute care hospital services. All Maryland hospitals and health systems will strive to address the needs of underserved populations and to reduce identified ethnic and racial disparities in the provision of acute hospital care.

MHE, SHS, and UMMS strive to address the needs of underserved populations and to reduce identified ethnic and racial disparities in the provision of acute hospital care. MHE performs well on the measure used by the MHCC to judge whether its charity care provision is appropriate for its population. (See Standard .04A(2) – Charity Care Policy.)

Policy 3.2 All Maryland hospitals and health systems will consider smart and sustainable growth policies as well as green design principles in hospital siting decisions and facility design choices.

MHE's proposed location is within a Priority Funding Area. (See Standard .04B(5) – Cost-Effectiveness.)

Low-impact, sustainable design is an important principle supported by SHS. The team for this project has evaluated and incorporated sustainable strategies and energy efficiency systems for the replacement hospital. As the project design develops, the team will continue to review and choose appropriate sustainable strategies for this project.

The project has been registered under the U.S. Green Building Council's LEED certification program at the LEED Silver level. The following summaries address the team's approach to incorporating specific sustainable strategies into the early design of the project.

Sustainable Site

The project's site development will incorporate strategies to help limit the environmental impact on the local ecosystem. An erosion and sedimentation control plan will be implemented to reduce pollution caused by construction activities. In addition, a stormwater management plan will help reduce the amount of runoff as well as the amount of pollutants that collect in the runoff. Cool roof materials will be chosen to reduce the heat island effect on the building.

Water & Energy Reduction

Water reduction for the project site will be achieved through the selection of native and adapted plant species. In addition, the building will use high-efficiency/ low flow fixtures for plumbing fixtures such as toilets, urinals, showers, and lavatories. A high performance

building envelope as well as efficient mechanical and lighting systems will help with energy reduction for the hospital.

Materials & Resources

The project team will use building materials and finishes that have recycled content and/or produced locally. Additionally, materials will be used that have a low volatile organic compound (VOCs) content.

Indoor Environmental Quality

An indoor air quality plan will be put in place that addresses proper ventilation methods both during and after construction. In addition, pollutants will be reduced by the incorporation of walk-off mats in all entrances, use of filtration media, and proper design for any rooms with hazardous chemicals or gases.

Green Operations

After the hospital is built, the operation team will implement various strategies to maintain the facility such as Recycling, Green Cleaning, and Sustainable Purchasing.

Policy 3.3 Hospitals and health systems will continuously and systematically work to improve the quality and safety of the care they provide. This will include planning and implementing integrated electronic health record systems that contribute to infection control, patient safety, and quality improvement and implementing the capability for sharing electronic health information, including clinical data, with other health care providers.

Exhibit 3 includes a newspaper article from *The Star Democrat* reporting that MHE was recently ranked by *US News and World Report* as one of the ten top acute care hospitals in Maryland. (See http://health.usnews.com/best-hospitals/area/md and http://www.stardem.com/news/local_news/article_f505e15a-d542-11e1-975b-001a4bcf887a.html.) MHE has also performed well on the quality measures used by the

MHCC. (See Standard .04A (3) – Quality of Care.) This project includes $16,000,000 in software and related costs to implement a new electronic health record system that contributes to infection control, patient safety, and quality improvement and implementing the capability for sharing electronic health information, including clinical data, with other health care providers.

Policy 3.4 Specialized acute care services should be provided on a coordinated, regional basis.

MHE is a regional medical center, serving a five county area in the mid-shore: Talbot, Caroline, Dorchester, Kent, and Queen Anne Counties. SHS has implemented regionalization through locating obstetrical services at MHE and psychiatric inpatient services at DGH. Recently, UMMS has consolidated the obstetrical service previously located at Chester River Hospital at MHE. This project was planned to acknowledge and enhance MHE's role as a regional medical center. Also, the Requard Center was originally intended and has proven to be very much a "regional" service, serving the five county region.

Policy 3.5 The all-payer hospital rate setting system will be retained as an essential mechanism to contain increases in hospital and health system costs for all payers and as a means for promoting the maintenance of financial stability in the Maryland hospital system. The CON program will appropriately coordinate its capital project review activities with the hospital rate setting system with the objective of containing the cost of hospital facilities and services.

MHE, SHS, and UMMS are very supportive of retaining the all-payer system. MHE has already begun discussion this project with the Staff of the Health Services Cost Review Commission and will provide them with information to review the financial aspects and implications of this project.

ACUTE CARE CHAPTER GENERAL STANDARDS - COMAR 10.24.10.04A

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.

SHS has a written policy in place that meets the requirements of this standard. *See* **Exhibit 4**. The current list of representative services and charges that is readily available to the public, both at MHE and on the Hospital's internet web site (http://www.shorehealth.org/services/billing/), is attached as **Exhibit 5**. A policy is in place to respond promptly to individual requests for information regarding current charges for specific services and procedures. *See* **Exhibit 4**. The policy addresses staff training. All of the existing policies and procedures will be used at the new hospital.

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.

SHS provides inpatient and other care to all patients regardless of the ability to pay. A copy of the Hospital's Financial Assistance Policy is attached as **Exhibit 6**. Notices regarding the availability of charity care at the Hospital are posted in the Emergency Department and in the Admission and Business Offices. A copy of that notice is attached as **Exhibit 7**. An annual notice is published in the *Star Democrat* newspaper (*see* **Exhibit 8)**. Each patient or patient representative is advised of MHE's charity care policy at the time of admission or outpatient registration. The Hospital's Financial Assistance Policy specifically states, "SHS will make a determination of probable eligibility within two business days following a patient's request for charity care services, application for medical assistance, or both." Financial counselors assist individuals to prepare and file all documents required to seek charity care at the Hospital. All existing policies and procedures will be used at the new hospital.

(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.

As related in the FY2011 HSCRC Community Benefit Report, the Hospital ranks 23rd out of 46 hospitals for charity care as a percentage of total operating expenses.

Quartile	Rank	Hospital	Charity Care	Total Operating Expenses	Percentage
1st Quartile	1	Prince George's Hospital Center	$22,603,000	$242,965,900	9.30%
	2	Bon Secours Hospital	$12,562,380	$135,427,187	9.28%
	3	Chester River Hospital Center	$4,509,800	$55,032,000	8.19%
	4	Garrett County Memorial Hospital	$2,765,783	$35,606,008	7.77%
	5	Laurel Regional Hospital	$6,457,000	$94,179,100	6.86%
	6	Edward W. McCready Memorial Hospital	$987,906	$17,313,509	5.71%
	7	Holy Cross Hospital of Silver Spring	$19,235,553	$389,986,549	4.93%
	8	Dorchester General Hospital	$2,036,690	$41,944,947	4.86%
	9	Saint Agnes Hospital	$17,920,497	$380,659,763	4.71%
	10	Maryland General Hospital	$8,173,000	$178,038,000	4.59%
2nd Quartile	11	Montgomery General Hospital	$5,962,000	$133,009,700	4.48%
	12	Washington Adventist Hospital	$9,117,152	$211,836,413	4.30%
	13	Meritus Medical Center (formerly Washington County Hospital Association)	$11,515,068	$270,510,801	4.26%
	14	Western Maryland Health System	$12,443,989	$293,906,377	4.23%
	15	Johns Hopkins Bayview Medical Center	$21,235,606	$504,690,000	4.21%
	16	University of Maryland Hospital	$49,770,761	$1,249,077,000	3.98%
	17	Shady Grove Adventist Hospital	$10,323,710	$269,589,155	3.83%
	18	Harbor Hospital	$7,036,300	$183,840,500	3.83%
	19	Calvert Memorial Hospital	$4,317,996	$115,707,400	3.73%
	20	Mercy Medical Center	$12,057,000	$386,361,000	3.12%
	21	Union Memorial Hospital	$11,807,500	$384,090,500	3.07%
	22	Saint Mary's Hospital	$3,387,500	$112,047,400	3.02%
3rd Quartile	23	Memorial Hospital at Easton	$4,238,270	$140,221,608	3.02%
	24	Peninsula Regional Medical Center	$10,603,500	$366,862,000	2.89%
	25	Harford Memorial Hospital	$2,546,397	$88,883,000	2.86%
	26	Franklin Square Hospital	$10,808,600	$410,262,600	2.63%
	27	Baltimore Washington Medical Center	$7,907,000	$319,612,000	2.47%
	28	Frederick Memorial Hospital	$7,810,600	$332,418,000	2.35%
	29	Good Samaritan Hospital of Maryland	$6,547,400	$300,220,500	2.18%
	30	Howard County General Hospital	$4,704,963	$226,186,000	2.08%

	31	James Lawrence Kernan Hospital	$1,730,000	$90,594,000	1.91%
	32	Upper Chesapeake Medical Center	$3,679,633	$194,088,000	1.90%
	33	Johns Hopkins Hospital	$29,978,000	$1,648,599,000	1.82%
	34	Northwest Hospital Center	$3,692,000	$204,008,000	1.81%
4th Quartile	35	Union Hospital of Cecil County	$2,415,495	$135,590,000	1.78%
	36	Civista Medical Center	$1,762,608	$102,090,948	1.73%
	37	Sinai Hospital of Baltimore	$10,981,000	$651,313,000	1.69%
	38	Atlantic General Hospital	$1,475,240	$88,062,865	1.68%
	39	Suburban Hospital	$4,007,000	$241,360,000	1.66%
	40	Carroll County General Hospital	$3,011,868	$188,182,000	1.60%
	41	Fort Washington Medical Center	$602,822	$40,954,995	1.47%
	42	Southern Maryland Hospital Center	$3,102,367	$227,132,278	1.37%
	43	Anne Arundel Medical Center	$5,896,911	$439,610,000	1.34%
	44	Saint Joseph Medical Center	$4,369,778	$330,327,712	1.32%
	45	Greater Baltimore Medical Center	$4,868,278	$392,667,399	1.24%
	46	Doctors Community Hospital	$2,128,738	$194,523,558	1.09%

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.

The Hospital is licensed by the Department of Health and Mental Hygiene, is accredited by The Joint Commission, and is in compliance with all Medicare and Medicaid conditions of participation. Copies of the Hospital's license and most recent accreditation letter are attached as **Exhibit 9**.

(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.

MHE has scored over the 90% level on all but one of the quality measures in the most recent publication of the MHCC's Maryland Hospital Performance Evaluation Guide published on the MHCC website.[1] The scores are shown in Table 6.2 The one indicator in which MHE scored lower than 90% is for "Children and their Caregivers Who Received a Home Management Plan of Care Document." Figure 2 shows the hospitals for which there is a score for this indicator, ranked from the highest score to the lowest score. As Figure 2 shows, the MHE score is the 13th of 19 hospitals' scores. Hence, MHE does not fall in the bottom quartile of all hospitals: (19/4) X 3 = 14.25.

Table 6
MHE Quality Measure Performance Scores

Measure	Number of Cases	Hospital Performance
Heart Attack (AMI) Performance Over Time		
Giving you aspirin when you arrive	58	98%
Giving you aspirin when you leave	34	97%
Giving the recommended medication	N/A	N/A
Providing advice or counseling on how to stop smoking	N/A	N/A
Giving you beta blockers when you leave	30	100%
AMI patients whose time from hospital arrival to primary PCI is 90 minutes or less	N/A	N/A
Heart Failure (HF) Performance Over Time		
Giving full instructions when you leave the hospital	257	95%
Performing the recommended heart function test	334	100%

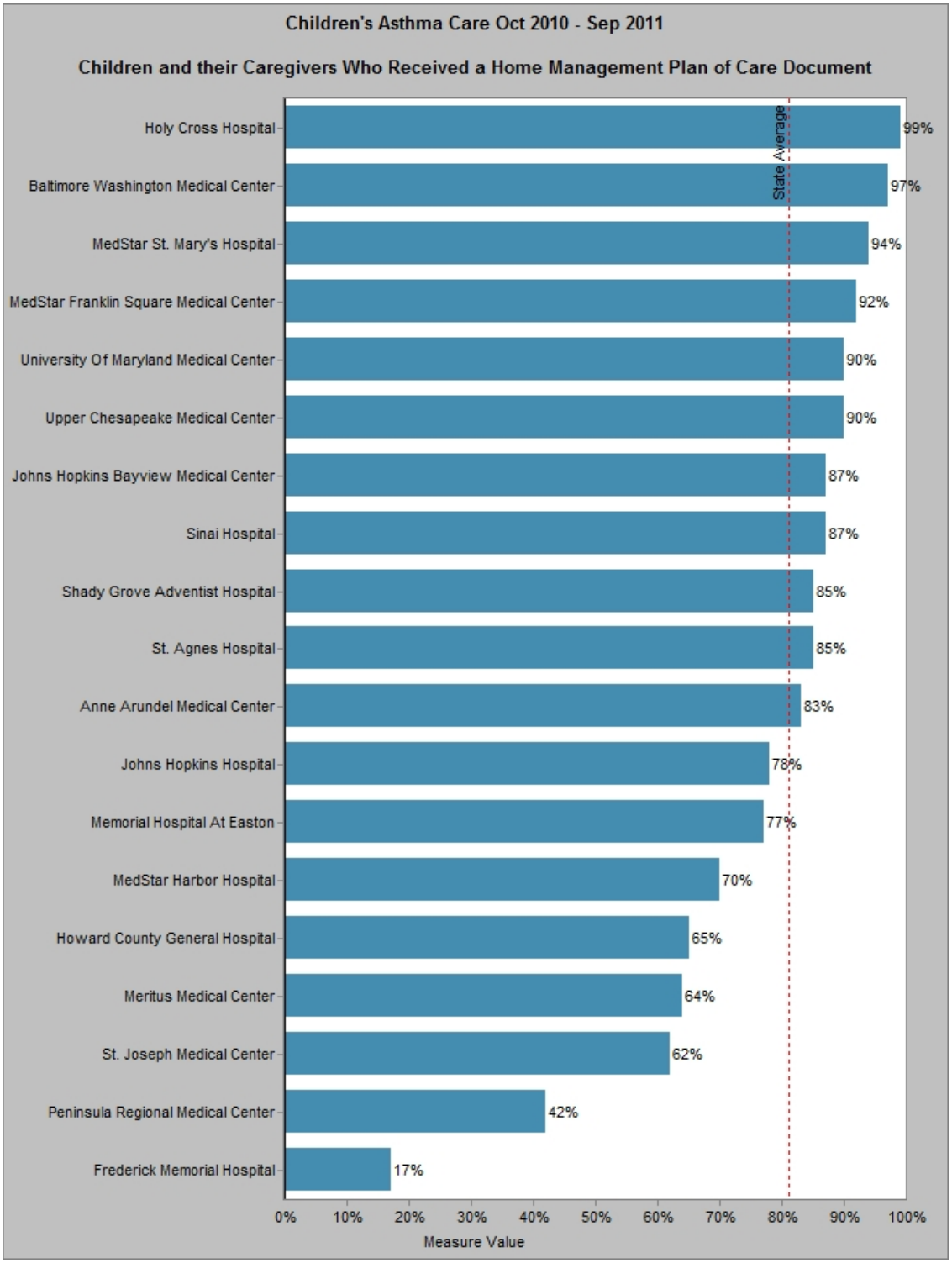
1 According to the website, the data were last updated on 4/10/2012; Measurement Timeframe: Oct 2010 - Sep 2011.

2 Tables 1 – 5 appear on pages 139 – 160.

	Giving the recommended medication	97	96%
	Providing advice or counseling on how to stop smoking	55	100%
Pneumonia (PN) Performance Over Time			
	Giving you a vaccination against pneumonia	185	96%
	Performing the recommended blood test	184	96%
	Providing advice or counseling on how to stop smoking	38	100%
	Giving antibiotics in a timely fashion	165	99%
	Given the Most Appropriate Initial Antibiotic(s)	106	98%
	Assessed and Given Influenza Vaccination	143	97%
Surgical Care Improvement Project (SCIP) Performance Over Time			
	Preventing Infection		
	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	478	99%
	Prophylactic Antibiotic Selection for Surgical Patients	480	100%
	Prophylactic Antibiotic Discontinued Within 24 Hours After Surgery End Time	471	98%
	Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Blood Glucose	N/A	N/A
	Surgery Patients with Appropriate Hair Removal prior to surgery	665	100%
	Managing Heart Drugs		
	Surgery patients who received the appropriate Beta-Blocker during the perioperative period	216	91%
	Preventing Blood Clots		
	Surgery patients whose doctors ordered treatments to prevent blood clots	304	97%
	Surgery patients who received treatment at the appropriate time to help prevent blood clots	303	95%
Children's Asthma Care (CAC) Performance Over Time			
	Children Who Received Reliever Medication While Hospitalized for Asthma	31	100%
	Children Who Received Systemic Corticosteroid Medication	31	100%
	Children and their Caregivers Who Received a Home Management Plan of Care Document	31	77%

Source: MHCC Website

Figure 2
Children and their Caregivers Who Received a Home Management Plan of Care Document
All Hospitals for which There Is a Score—Ranked from Highest to Lowest Score



PROJECT REVIEW STANDARDS

COMAR 10.24.10.04B

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.**

SHS initially considered four alternative sites. As part of its analysis of the sites, SHS compared the driving time from each of the ZIP Codes in all five counties to each site. In that analysis, the average drive time to the proposed site was estimated to be shorter than the average drive time to MHE's existing location.

To address this standard requirement that travel time be addressed based on "its likely service area population," MHE performed a new study using Google Maps to determine the travel time from each ZIP Code in its service area to each of the four alternative sites. For the proposed site, the Talbot County Community Center (located on the adjacent property) was used as a proxy, as an address does not yet exist for the proposed hospital.

MHE's PSA includes seven Zip Codes. Its SSA includes of eleven Zip Codes. See Table 7 below.

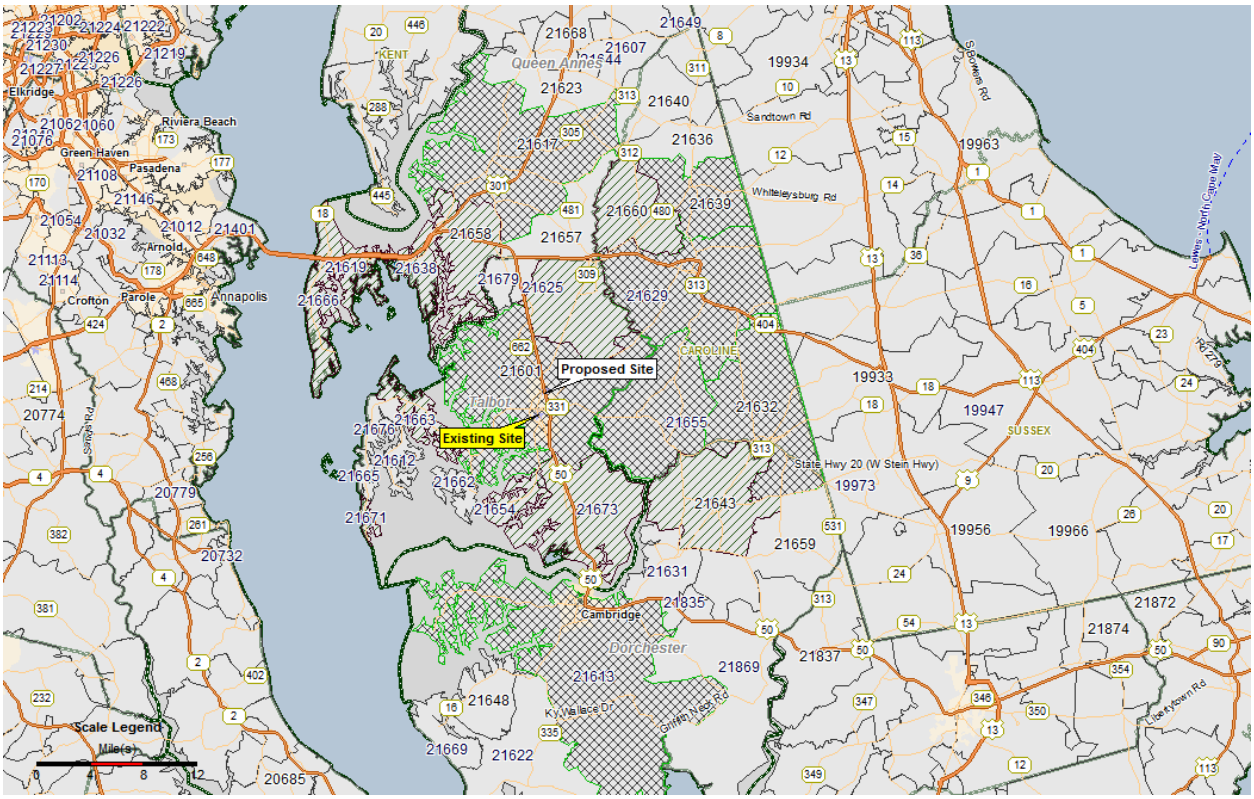
Table 7
MHE Primary and Secondary Service Areas
CY 2011

Zip Code	Total	% of Discharges	Cumulative %
Primary Service Area			
21601	2,294	27.2%	27.2%
21629	732	8.7%	35.9%
21613	558	6.6%	42.5%
21655	482	5.7%	48.2%
21632	480	5.7%	53.9%
21617	324	3.8%	57.7%
21639	305	3.6%	61.3%
Subtotal	5,175	61.3%	61.3%
Secondary Service Area			
21663	297	3.5%	64.9%
21660	293	3.5%	68.3%
21643	284	3.4%	71.7%
21625	223	2.6%	74.3%
21673	185	2.2%	76.5%
21638	168	2.0%	78.5%
21666	139	1.6%	80.2%
21658	137	1.6%	81.8%
21671	107	1.3%	83.1%
21619	104	1.2%	84.3%
21654	86	1.0%	85.3%
Subtotal	2,023	24.0%	85.3%
All Other Zip Codes	1,238	14.7%	100.0%
Total	8,436		

Source: MHE

These Service Areas are shown in Figure 3.

Figure 3
Primary and Secondary Service Areas
MHE
CY 2011



Primary Service Area

Secondary Service Area

To obtain the average drive time to each site in minutes, MHE first determined the drive time that Google Maps estimated from the Post Office in each Zip Code listed above to each site. MHE then multiplied the drive time times by the 2012 and 2017 population in each Zip Code, according to Claritas data, to obtain the weighted average drive time. The products of the drive times for the population for each ZIP Code were summed and divided by the total service area population to obtain the total weighted average drive time to each site. This analysis is shown in Table 8 below.

The total weighted average drive time for the 2017 service population to each site is summarized below. As this summary shows, the proposed site has a slightly lower average drive time than the other three sites.

	219 South Washington St., Easton (Existing Site)	Easton Bypass & Oxford Rd., Easton 21601	10028 Ocean Gateway (Community Center) Easton 21601 (Proposed Site)	Route 50 and 404, Wye Mill 21679
Average Drive Time in Minutes	24.00	25.60	23.29	24.39

However, when the travel times are multiplied by the service area population, the travel time savings associated with the proposed site are significant. For example, in total, the proposed site would save 101,171 minutes (or 1,686.2 hours) of drive time compared to the existing site. (In Table 3, 3,441,201 minutes for the service area population to the existing site minus 3,340,030 minutes to the proposed site = 101,171 person minutes; 101,171/60 minutes per hour = 1,686.2 hours.)

Table 8 - Driving Time Analysis

		Distance (in miles)				Travel Time (in minutes)					2012 Weighted Travel Time (in minutes)					2017 Weighted Travel Time (in minutes)				
		219 South Washington St., Easton 21601	Easton Bypass & Oxford Rd., Easton 21601	10028 Ocean Gateway (Community Center) Easton 21601	Route 50 and 404, Wye Mill 21679	219 South Washington St., Easton 21601	Easton Bypass & Oxford Rd., Easton 21601	10028 Ocean Gateway (Community Center) Easton 21601	Route 50 and 404, Wye Mill 21679	2012 Claritas Population	219 South Washington St., Easton 21601	Easton Bypass & Oxford Rd., Easton 21601	10028 Ocean Gateway (Community Center) Easton 21601	Route 50 and 404, Wye Mill 21679	2017 Claritas Population	219 South Washington St., Easton 21601	Easton Bypass & Oxford Rd., Easton 21601	10028 Ocean Gateway (Community Center) Easton 21601	Route 50 and 404, Wye Mill 21679
County	**Zip and Town**																		
Caroline	21629 - Denton	17	18	19	14	28	30	29	26	9,819	274,932	294,570	284,751	255,294	10,327	289,156	309,810	299,483	268,502
	21632 - Federalsburg	20	21	23	30	31	34	34	41	6,508	201,748	221,272	221,272	266,828	6,563	203,453	223,142	223,142	269,083
	21639 - Greensboro	23	24	21	15	36	38	31	23	4,539	163,404	172,482	140,709	104,397	4,762	171,432	180,956	147,622	109,526
	21655 - Preston	12	12	15	22	19	21	22	29	5,121	97,299	107,541	112,662	148,509	5,220	99,180	109,620	114,840	151,380
	21660 - Ridgely	18	19	16	11	30	32	25	20	3,989	119,670	127,648	99,725	79,780	4,207	126,210	134,624	105,175	84,140
Dorchester	21613 - Cambridge	16	16	20	28	24	24	27	35	17,779	426,696	426,696	480,033	622,265	18,219	437,256	437,256	491,913	637,665
	21643 - Hurlock	19	20	22	29	30	32	33	40	5,995	179,850	191,840	197,835	239,800	6,350	190,500	203,200	209,550	254,000
Talbot	21601 - Easton	0.5	1	4	12	2	3	8	16	24,167	48,334	72,501	193,336	386,672	25,763	51,526	77,289	206,104	412,208
	21625 - Cordova	10	10	7	8	18	21	13	18	2,676	48,168	56,196	34,788	48,168	2,784	50,112	58,464	36,192	50,112
	21654 - Oxford	10	9	15	32	17	14	27	32	1,191	20,247	16,674	32,157	38,112	1,162	19,754	16,268	31,374	37,184
	21663 - Saint Michaels	10	11	14	21	15	15	22	29	3,361	50,415	50,415	73,942	97,469	3,317	49,755	49,755	72,974	96,193
	21671 - Tilghman	23	24	27	34	31	32	39	46	753	23,343	24,096	29,367	34,638	739	22,909	23,648	28,821	33,994
	21673 - Trappe	8	8	12	20	15	14	17	24	3,313	49,695	46,382	56,321	79,512	3,409	51,135	47,726	57,953	81,816
Queen Anne's	21617 - Centreville	22	22	17	9	34	37	26	16	10,456	355,504	386,872	271,856	167,296	11,666	396,644	431,642	303,316	186,656
	21619 - Chester	27	28	22	19	37	39	29	28	6,069	224,553	236,691	176,001	169,932	6,416	237,392	250,224	186,064	179,648
	21638 - Grasonville	22	23	18	10	33	35	24	15	5,085	167,805	177,975	122,040	76,275	5,393	177,969	188,755	129,432	80,895

		Distance (in miles)				Travel Time (in minutes)					2012 Weighted Travel Time (in minutes)					2017 Weighted Travel Time (in minutes)			
		219 South Washington St., Easton 21601	Easton Bypass & Oxford Rd., Easton 21601	10028 Ocean Gateway (Community Center) Easton 21601	Route 50 and 404, Wye Mill 21679	219 South Washington St., Easton 21601	Easton Bypass & Oxford Rd., Easton 21601	10028 Ocean Gateway (Community Center) Easton 21601	Route 50 and 404, Wye Mill 21679	2012 Claritas Population	219 South Washington St., Easton 21601	Easton Bypass & Oxford Rd., Easton 21601	10028 Ocean Gateway (Community Center) Easton 21601	Route 50 and 404, Wye Mill 21679	2017 Claritas Population	219 South Washington St., Easton 21601	Easton Bypass & Oxford Rd., Easton 21601	10028 Ocean Gateway (Community Center) Easton 21601	Route 50 and 404, Wye Mill 21679
County	**Zip and Town**																		
	21658 - Queenstown	20	21	15	7	34	36	26	15	3,815	129,710	137,340	99,190	57,225	3,937	133,858	141,732	102,362	59,055
	21666 - Stevensville	28	29	23	15	39	41	30	20	12,341	481,299	505,981	370,230	246,820	12,704	495,456	520,864	381,120	254,080
Total Service Area										132,329	3,159,008	3,365,564	3,065,791	3,215,328	138,506	3,303,921	3,521,903	3,199,821	3,346,361
Average Drive Time (in minutes)											**23.9**	**25.4**	**23.2**	**24.3**		**23.9**	**25.4**	**23.1**	**24.2**
Contiguous ZIP Codes Not In the Top 85% but Within the Service Area Boundaries																			
	21657 - Queen Anne	14	15	11	6	24	27	19	12	1,153	27,672	31,131	21,907	13,836	1,251	30,024	33,777	23,769	15,012
	21679 - Wye Mills	12	13	8	2	18	21	10	4	429	7,722	9,009	4,290	1,716	451	8,118	9,471	4,510	1,804
	21631 - East New Market	20	24	23	30	31	33	35	42	3,117	96,627	102,861	109,095	130,914	3,198	99,138	105,534	111,930	134,316
Total Geographic Area										137,028	3,291,029	3,508,565	3,201,083	3,361,794	143,406	3,441,201	3,670,685	3,340,030	3,497,493
Average Drive Time (in minutes)											**24.0**	**25.6**	**23.4**	**24.5**		**24.0**	**25.6**	**23.3**	**24.4**

Source: Google Maps, http://maps.google.com, 2012;

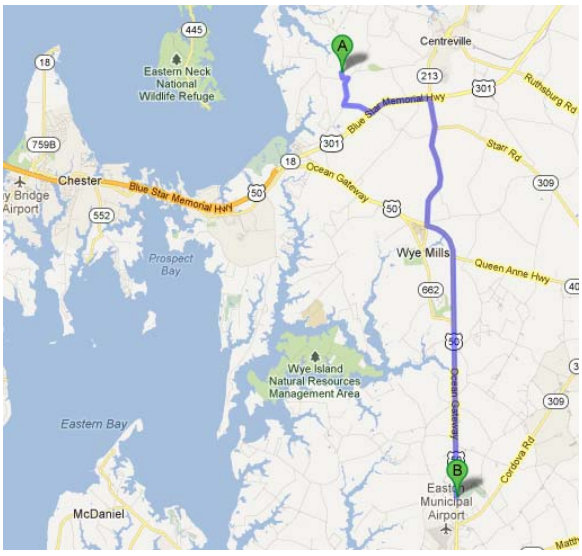
United States Postal Service, http://www.usps.com, 2012;

The Nielsen Company, Site Reports, July 2012;

ASR Planning, Inc.

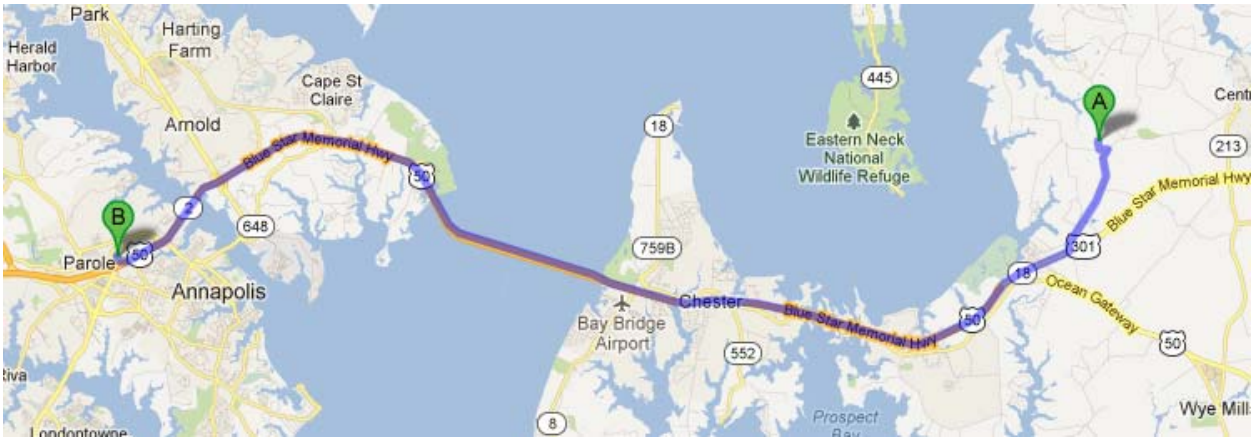
In addition, the proposed site makes acute inpatient services available at MHE within 30 minutes for more people than is the case at the existing location. According to Claritas data, the estimated population living within a 30 minute driving time of MHE's current site is 67,426 in 2012 and 70,215 in 2017. Claritas estimates that the population living with a 30 minute driving time of MHE's proposed site is 71,543 in 2012 and 75,415 in 2017. Of course, MHE recognizes that some portions of this population have access to other area hospitals, as well. However, MHE is the only hospital in Talbot County, and there are no hospitals located in Caroline and Queen Anne's Counties. MHE is the closest hospital for residents of both Caroline and Queen Anne's Counties.

For example, according to Google Maps, the proposed site is 18 miles and 28 minutes from "Queen Anne's County" (the precise location in Queen Anne's County was designated by Google Maps).



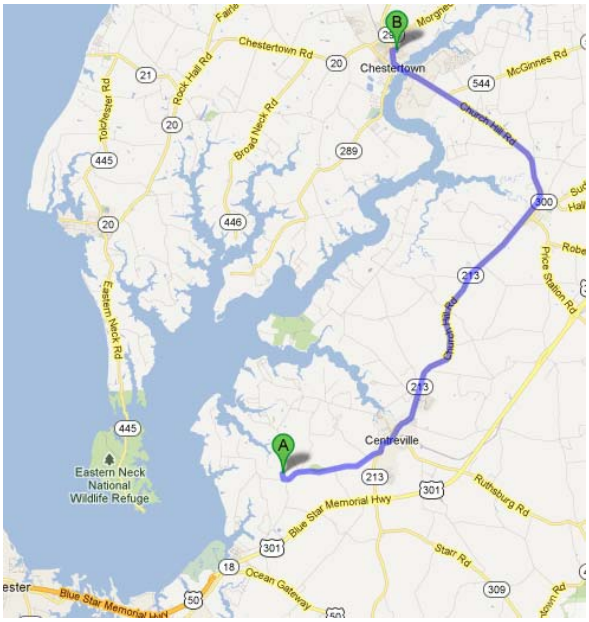
Source: Google Maps

Anne Arundel Medical Center is 27 miles and 38 minutes from the same site.



Source: Google Maps

Chester River Hospital Center is 20.5 miles and 37 minutes from the same site.



Source: Google Maps

These travel times demonstrate that the proposed site will be the closest hospital for Queen Anne's County. The same type analysis similarly shows that the proposed site will be the closest Maryland hospital for Talbot County and for Caroline County residents, as well.

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.

(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.

MHE is licensed to operate 112 acute care beds in FY13, including 87 MSGA beds, 17 obstetrical beds, and eight pediatric beds. MHE proposes to reconfigure its 112 acute care beds at the replacement hospital and operate 92 MSGA beds, 14 obstetrical beds and

six pediatric beds at the new location. Since MHE's "total bed capacity" will not exceed "the most recent annual calculation of bed capacity," the proposed project is consistent with Subsection (c)(i) of this standard. Increasing MSGA bed capacity at the replacement hospital by five MSGA beds (to 92 MSGA beds) is also consistent with this Subsection (c)(ii) of this standard because the minimum jurisdictional MSGA bed need for Talbot County in 2018 is 126 MSGA beds. See 37 *Maryland Register* 589-91 (March 26, 2010). Finally, in terms of pediatric beds, Subsection (c) of this standard is inapplicable as MHE is not proposing additional pediatric beds.

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.

Inapplicable, this project does not involve establishment of a new pediatric service.

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

---

Over the past three years, MHE has been one of the lowest cost hospitals in the State on the HSCRC's Reasonableness of Charges (ROC) report. The last published report in Spring 2011 identified MHE as being 3.00% below the average of its Peer Group.

MHE Recent ROC Performance

Date of ROC	% Below Peer Group
Spring 2009	5.50% Below
Spring 2010	8.95% Below
Spring 2011	3.00% Below

Because MHE is consistently below its Peer Group average on the ROC, the calculation of MHE's Debt to Capitalization and Average Age of Plant and comparison to the Peer Group average is not required.

(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.

This project does not propose to eliminate any services.

MHE proposes to reduce the number of Pediatric beds from 8 to 6. As CON Formset Table 1 (Statistical Projections, See response to COMAR 10.24.01.08G(3)(b). Need) shows, MHE's Pediatric unit has operated at less than 25 percent occupancy for the last two years. This will not reduce the amount of access for pediatric patients but is projected to increase occupancy to above 25% and still be able to accommodate peak admission periods.

Similarly, MHE is proposing to reduce the number of OB beds from 17 to 14. CON Formset Table 1 shows that MHE's OB unit has operated at approximately 35% occupancy for the last two years. As demonstrated in the discussion of need for OB beds in COMAR 10.24.01.08G(3)(b) – Need, 14 beds will be needed to accommodate OB admissions at the 99 percent confidence level.

None of the proposed changes in this project will impact access for indigent and/or uninsured patients. MHE will continue to care for patients regardless of their ability to pay.

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.

SHS began evaluating alternatives to the proposed project in 2005 as it developed its due diligence for its affiliation with the University of Maryland Medical System. At that time, the Planning Committee of the Board of Directors requested that Senior Management prepare an analysis of physical alternatives that were available to SHS to best assure its long-term ability to thrive. The Planning Committee established a process whereby it would evaluate the alternatives and make a recommendation to the Board. That process began in July, 2005 and was concluded with a presentation to the Board in October, 2005.

Background

When the alternative analyses were conducted, the population of the Eastern Shore of Maryland was growing rapidly. SHS identified itself with the five-county region of Talbot County, Dorchester County, Caroline County, Queen Anne's County, and Kent County. In 2005, the population of the five-county region was estimated by the Maryland Department of Planning to be 163,850 residents. This region was expected to grow by 5 percent to 172,000 in 2010 and 9 percent to 178,700 in 2015. Within the region, Queen Anne's County was expected to grow at an even faster rate. Queen Anne's County was expected to grow by more than 17 percent between 2005 and 2015. Although the Maryland

Department of Planning did not acknowledge it at the time, Caroline County was also expected to grow rapidly. Caroline County had approved several large housing developments that were expected to add significant population as metropolitan Washington D.C. residents sought more affordable housing. As these housing developments came on line, SHS projected that Caroline County's population would grow by more than 18 percent between 2005 and 2015. SHS wanted to make sure that the physical solutions to its facility constraints continued to adequately provide for the needs of these growing communities.

The population of the five-county service area was also expected to continue to age over the planning horizon. By 2004, the percentage of the population aged 65 and older in Talbot County was already 20.8 percent, as compared to the national average of 12.4 percent. Dorchester County and Kent County similarly had disproportionately large senior populations with 18.1 and 18.9 percent, respectively. The Eastern Shore of Maryland was projected to continue to attract more seniors as retirees from Maryland, Virginia, Delaware, and New Jersey relocated to this highly desirable area. This growing senior population was expected to have a significant impact on health service needs because they use health services at a much greater rate than the younger population. SHS wanted to make sure that its facilities solution continued to adequately provide services for the senior citizens in the service area.

SHS also noted that there was a need for more physicians in the five-county service area. There was a shortage of both primary care physicians and specialists serving the region. Furthermore, a significant number of physicians on the medical staff at MHE and Dorchester General Hospital were approaching retirement age and could be cutting back or ending their practices within the next 5 to 10 years. In 2005, SHS estimated that the five-

county service area needed 22 additional primary care physicians, just to serve the current residents of the area. The shortage was expected to grow as the population grew and some of the existing physicians retired. The same was true for certain specialist physicians as well, especially surgeons. The existing members of the medical staffs at MHE and DGH indicated that it was difficult to recruit new physicians into their practice. The recruitment difficulties were partially due to physician reimbursement inequities on the Eastern Shore, but also due to the physical environments of the hospitals. Without an ongoing supply of new physicians to meet the needs of the service area going forward, SHS believed that more people would be forced to seek medical care at greater distances from their homes. Although physician recruitment for SHS would require many aspects, SHS wanted to make sure that the physical solution for its facilities would enhance physician recruitment.

In consumer research conducted at the time, the residents and community leaders in Queen Anne's County expressed a strong interest in having a hospital located in their area. This research consisted of both telephone and face-to-face interviews. Among the telephone interviewees from all five service area counties, nearly 60 percent indicated that they were likely to use a new hospital in Queen Anne's County. Among Queen Anne's County residents their interest in a Queen Anne's facility was even higher. Face-to-face interviews indicated that there was significant variation of opinion as to the best location for a hospital in Queen Anne's County. Some thought it needed to be located on Kent Island or in Grasonville. Others thought it needed to be centrally located in the middle of the County (presumably in or near Centreville). Still others argued for a location near Chesapeake College in Wye Mills to take advantage of potential synergies between the two organizations. Later face-to-face interviews with residents in Talbot and Dorchester County

strongly objected to relocation of hospital services to Queen Anne's County. The residents of Caroline County were mixed in their reaction to a relocation of a hospital to Queen Anne's County. Some interviewees argued that Caroline County would be a better site for a new hospital. Others preferred a location in northern Talbot County while some still thought that Easton was the best site for a hospital. SHS needed the facilities solution for its hospitals to address the needs and concerns of the residents throughout the five-county service area.

In summary, SHS believed that the optimal facility solution for MHE would need to address several Primary objectives:

1. *Accommodate the growth of the population in the five-county service area.* The facility solutions were evaluated based on the volume projections generated by the growing population. SHS projected the volume of both inpatient admissions and clinical service workloads based on the population size and current use rates. Market shares for each facility solutions were calculated for each community and applied to the volumes. A master facility plan was developed for each facility to determine the amount of square footage required to support the projected volumes in each department. The solutions were rated on their ability to provide the needed square footage.

2. *Provide for the special needs of the growing senior citizens population.* Senior citizens use healthcare resources at a much greater rate than their younger counterparts. The use rates of the senior citizens were built into the volume projections for each site. As above, the sites were rated on their ability to provide the needed square footage. Seniors also have a special need for simple wayfinding. The facility solutions and site configurations for each site were evaluated on their ability to support simple wayfinding.

3. *Improve access to hospital services for all of the residents of the five-county region*. The access to hospital services was measured by a drive time analysis. The drive time from each community in the hospital's service area to each of the alternative sites was measured using online mapping software. The drive time was weighted for the population of each community, and then aggregated. The site with the lowest aggregate drive time was considered to have the best access for all residents of the service area.

4. *Enhance physician recruitment to the Eastern Shore.* As indicated in previous discussions, recruiting new physicians to the Eastern Shore is challenging, due to both its rural nature and reimbursement issues. In interviews with existing physicians and community leaders, the majority of participants believed that physician recruitment would be enhanced only with new hospital facilities. Renovation of existing facilities was not believed to provide any enhancement. Therefore, each site alternative was evaluated for this objective based on whether it provided a new or renovated hospital.

The analysis of alternatives was based on these factors, as they compared to the capital and operating costs of each alternative.

Analysis of the Alternatives

To begin the process, the Planning Committee identified seven different alternatives for potential consideration. These alternatives were as follows:

1. Redevelopment of the existing hospital campuses (in Easton and Cambridge)
2. Development of ambulatory care facilities throughout the service area
3. Relocation of MHE to a new site within Easton
4. Relocation of MHE to a new site in northern Talbot County
5. Relocation of MHE to a new site in Queen Anne's County
6. Development of a new hospital in Queen Anne's County
7. Development of a specialty hospital in Queen Anne's County.

Several of the alternatives were reviewed and eliminated before the financial analyses were performed. Alternative 2, development of ambulatory care facilities, was

identified as too critical to SHS success to be a separate alternative. Rather, the Planning Committee decided to add this alternative to each of the relocation alternatives so that each would have an ambulatory care component. Alternative 5 was believed to be politically infeasible to pursue, and the Planning Committee decided to drop it from consideration. Alternatives 6 and 7 were also dropped from consideration because the expansion of SHS to a three-hospital system was expected at the time to create too many operational inefficiencies to be viable and would still require the complete redevelopment of the MHE campus. As a result of these eliminations, the Planning Committee was left with three alternatives: (1) redevelopment of the existing hospital campuses, (2) relocation of the MHE to a new site within Easton, and (3) relocation of the MHE to a new site in northern Talbot County.

Redevelopment of Existing Campuses (Alternative 1)

Master site and development plans were prepared for both the DGH campus and the MHE campus. These plans were developed by an architectural firm that was familiar with both hospitals and had provided services to SHS for a number of years. The plans were based on volume projections for inpatient and outpatient services. The Planning Committee excluded the development of any off-campus ambulatory care facilities to minimize the capital expenditures related to this scenario.

To calculate future volumes, senior management used the following formula:

Future (2015) Service Area Population **times**
Discharge Rate per 1,000 Population **times**
Projected SHS Market Share **times**
In-migration Factor **times**
Average Length of Stay **divided by**
Target Occupancy **equals**
Required Beds

The volumes at both DGH and MHE were expected to grow due to the growing population base. In 2005, the two SHS hospitals had a combined total of 14,200 discharges. In this scenario, SHS senior management expected to see an increase to 15,100 combined discharges by 2015. At 80 percent occupancy, MHE will need 153 beds while DGH would require 64 beds.

The master site and facility plan for the MHE campus assumed that a combination of renovation and new construction would be developed to provide appropriate space for the anticipated volumes of each department. The space would also be reconfigured to provide optimal intra- and inter-departmental proximities. Funds were also allocated in the plan to correct any infrastructure deficiencies such as roofing, HVAC, power and fenestration (windows). Although the master plan does not assume the purchase of any additional land to resolve parking and site access issues, funds were allocated to modify the existing land to improve these issues to the extent possible. The master site and facility plan for DGH similarly corrected space deficiencies with renovation and new construction, resolved infrastructure issues, and improved site issues.

The evaluation of the existing site in meeting the primary objectives of the project is presented in the following table.

Table 9: Redevelopment of the Existing Campuses
Evaluation of Achieving Primary Project Objectives

Objective	Measurement	Measure	Ranking
1. Needs of growing population	Square footage of facility as a percent of square footage requirement	100%	1
2. Needs of senior citizens - space	Square footage of facility as a percent of square footage requirement	100%	1
- wayfinding	Quality of wayfinding	poor	3
3. Improve access for all residents	Aggregate drive time	3,159,008 minutes	1
4. Enhance physician recruitment	New or renovated hospital	renovated	3
Total			9

Of the three alternatives, Alternative 1 had the worst (highest) score in meeting the primary project objectives.

The architects assumed that the renovation and expansion projects needed to complete the two master site and facility plans would have to be phased out, over time. Using their recent experience with construction costs on similar projects and escalating those costs out to the mid-point of construction, the architects calculated the total project costs of the two master plans. They were:

- MHE - $38,888,000
- DGH - $56,723,000

These capital project costs do not include the expansion project at MHE for a new Emergency Department and expanded ambulatory services. This project, which was under consideration at the time of these alternative analyses, was carried in the capital budget at $32,581,000. Also in 2005 was a capital expenditure of $2,200,000 for the development of an acute rehabilitation unit. The capital budget also included an annual expenditure of $8,000,000 for routine equipment replacement after $11,815,000 in FY2005 and $7,500,000 in FY2006.

Using these capital investments, senior management requested their accountants to develop a set of financial projections for Alternative 1. A summary of these projections is presented in the following table.

Table 10: Key Financial Indicators, Alternative 1
Redevelopment of Existing Campuses

	Budget	Projected							
	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Operating Income	$3,548	$6,010	$5,513	$5,482	($1,702)	($5,788)	($5,432)	($5,432)	($5,082)	($5,269)
Excess of Revenue Over Expense	$4,667	$6,758	$6,345	$6,431	($632)	($4,644)	($4,251)	($4,251)	($3,886)	($4,057)
Cash	$32,418	$37,455	$44,665	$52,247	$56,622	$57,344	$57,854	$58,252	$58,653	$58,663
Long Term Debt	54,043	86,428	83,714	183,781	179,925	175,963	171,888	167,692	163,366	158,901
Net Assets	92,569	99,327	105,672	112,102	111,471	106,827	101,688	97,437	93,552	89,494
Total Capitalization	146,612	185,755	189,386	295,884	291,396	282,791	273,577	265,129	256,917	248,395
Operating Margin	2.2%	3.5%	3.0%	2.8%	-0.8%	-2.7%	-2.8%	-2.3%	-2.1%	-2.1%
Excess Margin	2.9%	3.9%	3.5%	3.3%	-0.3%	-0.3%	-2.3%	-1.8%	-1.6%	-1.6%
Debt Service Coverage	3.8	3.0	3.1	3.2	1.5	1.5	1.6	1.6	1.6	1.5
Days Cash on Hand	81	87	98	109	108	104	100	96	92	87
Debt to Capitalization	0.37	0.47	0.44	0.62	0.62	0.62	0.63	0.63	0.64	0.64

Source: KPMG, Shore Health System, Summary of Financial Projections for Incremental Volumes, October 2005.

Based on the volume projections for this alternative, SHS would expect to begin incurring operating losses in fiscal year 2010. By 2015, SHS would be carrying nearly $159 million in long term debt. The organization's operating margin, excess margin, debt service coverage, days cash on hand and debt to capitalization are significantly below both Moody's and Standard & Poor's medians for A-rated bonds. The implication of these variances is that SHS would have difficulty in securing debt to finance the proposed projects.

Relocation of MHE to a New Site in Easton (Alternative 2)

This alternative assumed that MHE will be replaced with a new facility elsewhere within the City of Easton. At the time these alternatives were developed, senior

management assumed that the new facility would be developed on a sixty-acre parcel of land owned by SHS in southwestern Easton on the Easton Bypass (Route 322) at Oxford Road. At the time of these analyses, the proposed project property in northern Easton on Route 50 near the Community Center was not available, and so was not considered. The new hospital was expected to open in fiscal year 2011. As in Alternative 1, Dorchester General Hospital was scheduled to undergo the necessary expansions and renovations established in its master site and facility plan. Additionally, SHS expected to develop a new ambulatory care facility in Queen Anne's County. The new facility would be developed in Grasonville, at an undesignated site, and would include physician offices, an after-hours clinic, an ambulatory surgery center, and an array of diagnostic and treatment services. This new ambulatory care center was expected to open in fiscal year 2008.

Using the same formula for projecting volumes as was used in Alternative 1, Senior Management generated a set of discharge and workload projections for a replacement hospital on a new site in Easton. Volumes at both DGH and MHE were expected to grow at a faster rate than Alternative 1. In Alternative 1, the two SHS hospitals had a combined total of 15,100 discharges by 2015. In this scenario, SHS senior management expected to see an increase to 17,200 combined discharges by 2015. At 80 percent occupancy, MHE will need 165 beds while DGH would require 64 beds.

The evaluation of a new site in Easton in meeting the primary objectives of the project is presented in the following table.

Table 11: Relocation of Memorial to a New Site in Easton
Evaluation of Achieving Primary Project Objectives

Objective	Measurement	Measure	Ranking
1. Needs of growing population	Square footage of facility as a percent of square footage requirement	100%	1
2. Needs of senior citizens - space	Square footage of facility as a percent of square footage requirement	100%	1
- wayfinding	Quality of wayfinding	excellent	1
3. Improve access for all residents	Aggregate drive time	3,365,564 minutes	3
4. Enhance physician recruitment	New or renovated hospital	new	1
Total			7

Of the three alternatives, Alternative 2 had the middle score of achieving the primary project objectives.

To calculate the capital cost of this project, a conceptual space budget was prepared for each department in the new facility. The space budget was based on the 2015 discharge and workload projections for the replacement hospital on a new site in Easton. These volume projections indicated that the new hospital facility would require approximately 377,000 square feet including all of the various inpatient units and clinical departments, as well as support and administrative functions and infrastructure elements such as corridors, mechanical and power plant, and public spaces. Construction costs were calculated using the square footage for each department and area times a construction cost weighting factor for each department times an average cost per square foot for hospital construction. Overall, the construction costs were estimated to be approximately $250 per square foot, or approximately $95 million.

To develop total project costs, the costs of additional project elements were added to the construction costs. Senior management assumed that the sixty-acre site would require approximately $9 million in site development costs. No assumptions were made regarding

the potential costs of demolishing, reusing or selling the existing campus facilities of MHE once the new hospital was opened. Technology and equipment costs were estimated at approximately $35 million. Professional fees were estimated at $11 million while contingent expenses were estimated at $15 million. In total, the project was expected to cost $164 million in 2005 dollars. When the costs were escalated to the mid-point of construction, the total project costs were estimated to be $194 million.

In addition to the project cost of the new hospital, Alternative 2 also included capital costs for the necessary renovation and expansion of DGH. The capital cost of this effort was estimated at $57 million, the same as in Alternative 1. The ambulatory care center in Queen Anne's County also needed to be included in the cost of Alternative 2. Senior Management estimated that the building would require approximately 32,000 square feet and would cost $18.6 million. As in Alternative 1, a capital expenditure of $2,200,000 for the development of an acute rehabilitation unit was included, but the Emergency Department project was not included. The capital budget also included an annual expenditure of $7,000,000 for routine equipment replacement after $11,815,000 in FY2005 and $7,500,000 in FY2006. These annual capital expenditures were less than those presented in Alternative 1 because the new hospital facility would reduce the need for replacement equipment.

Using these capital investments, senior management requested their accountants to develop a set of financial projections for Alternative 2. A summary of these projections is presented in Table 12.

Table 12: Key Financial Indicators, Alternative 2
Relocation to a New Site in Easton

	Budget	Projected							
	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Operating Income	$3,548	$4,874	$6,268	$5,170	($13,817)	($6,895)	($5,414)	($2,656)	$151	$2,674
Excess of Revenue Over Expense	$4,667	$5,622	$7,084	$6,104	($13,037)	($7,376)	($2,646)	($2,646)	$188	$2,771
Cash	$32,418	$36,370	$43,692	$32,916	($41,722)	($9,519)	($9,608)	($8,113)	($4,414)	$1,383
Long Term Debt	54,043	51,395	49,052	263,068	229,035	224,241	219,275	214,126	208,781	203,226
Net Assets	92,569	98,191	105,275	111,378	98,341	90,966	85,558	82,913	83,100	85,871
Total Capitalization	146,612	149,586	154,327	374,446	327,376	315,206	304,834	297,039	291,881	289,097
Operating Margin	2.2%	2.8%	3.4%	2.6%	-6.6%	-3.1%	-2.3%	-1.1%	0.1%	1.0%
Excess Margin	2.9%	3.3%	3.9%	3.1%	-6.2%	-6.2%	-2.3%	-1.1%	0.1%	1.0%
Debt Service Coverage	3.8	3.7	4.4	4.4	1.1	1.2	1.3	1.4	1.5	1.6
Days Cash on Hand	81	85	96	66	(75)	(16)	(16)	(12)	(6)	2
Debt to Capitalization	0.37	0.34	0.32	0.70	0.70	0.71	0.72	0.72	0.72	0.70

Source: KPMG, Shore Health System, Summary of Financial Projections for Incremental Volumes, October 2005.

Based on the volume projections for this alternative, SHS would expect to begin incurring operating losses in fiscal year 2010, but these would diminish over time and by 2014 would be generating a small profit. By 2015, SHS would be carrying nearly $203 million in long term debt. As in Alternative 1, the organization's operating margin, excess margin, debt service coverage, days cash on hand and debt to capitalization are below both Moody's and Standard & Poor's medians for A-rated bonds, but in Alternative 2 the organization is much closer to these medians. SHS would still have some difficulty in securing debt to help finance Alternative 2, but much less difficulty than Alternative 1.

Relocation of MHE to a New Site in Northern Talbot County (Alternative 3)

This alternative assumed that MHE will be replaced with a new facility outside of the city of Easton, but still within the northern limits of Talbot County. At the time these alternatives were developed, no specific site had been selected, but the site was presumed to be in the proximity of Routes 50 and 404. The new hospital was expected to open in fiscal year 2011. As in Alternatives 1 and 2, DGH was scheduled to undergo the necessary

expansions and renovations established in its master site and facility plan. Additionally, SHS expected to develop two new ambulatory care facilities. One new facility would be developed in Grasonville, at an undesignated site, and would include physician offices, an after-hours clinic, an ambulatory surgery center, and an array of diagnostic and treatment services. This new ambulatory care center was expected to open in fiscal year 2008. A second new facility would be developed in Federalsburg, in Caroline County and would include physician offices, an after-hours clinic and an array of diagnostic and treatment services. This second ambulatory care center was expected to be opened in fiscal year 2011.

Based on these assumptions, SHS expected to see market share growth following the opening of both the ambulatory care centers and the new hospital. In Queen Anne's County, MHE would experience gain in market share when the ambulatory care center opens and again when the new hospital opens. As compared to Alternatives 1 and 2, this alternative would see MHE's market share increase in Queen Anne's County by 7 percent in 2010 and by 11.7 percent in 2015. In Caroline County, SHS expected to see market growth as a result of the new ambulatory care center in Federalsburg and the opening of the new hospital. By 2010, SHS would expect to experience a 3.8 percent growth in MHE's market share and a 6.7 percent growth by 2015. In Talbot County, the new hospital facility was also expected to improve market share. By 2010, market share for MHE would grow 3.6 percent. By 2015 MHE's market share would grow 5.5 percent. In Dorchester County, because the new hospital will be further away, senior management assumed that MHE will lose market share (3.8% in 2010 and 4.8% in 2015) but DGH will gain market share (2.8% in 2010 and 4.0% in 2015). The new hospital opening in Easton was not expected to have

any impact in Kent County. MHE would maintain steady market share in Kent County through the planning period.

Based on these market share assumptions, and using the same formula for projecting volumes as was used in Alternatives 1 and 2, senior management generated a set of discharge and workload projections for a replacement hospital on a new site in northern Talbot County. With the improved market share projections, the volumes at both DGH and MHE were expected to grow at a faster rate than Alternatives 1 and 2. In Alternative 1, the two SHS hospitals had a combined total of 15,100 discharges by 2015. In Alternative 2, SHS senior management expected to see an increase to 17,200 combined discharges by 2015. In this scenario, SHS Senior Management expected to see an increase to 18,200 discharges. At 80 percent occupancy, MHE will need 176 beds while DGH would require 67 beds.

The evaluation of the site in northern Talbot County in meeting the primary objectives of the project is presented in the following table.

Table 13: Relocation of Memorial to a New Site in Northern Talbot County
Evaluation of Achieving Primary Project Objectives

Objective	Measurement	Measure	Ranking
1. Needs of growing population	Square footage of facility as a percent of square footage requirement	100%	1
2. Needs of senior citizens - space	Square footage of facility as a percent of square footage requirement	100%	1
- wayfinding	Quality of wayfinding	excellent	1
3. Improve access for all residents	Aggregate drive time	3,254,604 minutes	2
4. Enhance physician recruitment	New or renovated hospital	new	1
Total			6

Of the three alternatives, Alternative 3 had the best (lowest) scores in achieving the primary project objectives.

To calculate the capital cost of this project, a conceptual space budget was prepared for each department in the new facility. As in Alternative 2, the space budget was based on the 2015 discharge and workload projections for the replacement hospital on a new site in northern Talbot County. These volume projections indicated that the new hospital facility would require approximately 386,000 square feet including all of the various inpatient units and clinical departments, as well as support and administrative functions and infrastructure elements such as corridors, mechanical and power plant, and public spaces. Construction costs were calculated using the square footage for each department and area times a construction cost weighting factor for each department times an average cost per square foot for hospital construction. Overall, the construction costs were estimated to be approximately $250 per square foot, or approximately $97 million.

To develop total project costs, the costs of additional project elements were added to the construction costs. Although no site was selected, a sixty-acre site was assumed and would cost approximately $37,000 per acre, or $2.2 million. Senior management assumed that the sixty-acre site would require approximately $9 million in site development costs. No assumptions were made regarding the potential costs of demolishing, reusing or selling the existing campus facilities of MHE once the new hospital was opened. Technology and equipment costs were estimated at approximately $35 million. Professional fees were estimated at $11 million while contingent expenses were estimated at $15 million. In total the project was expected to cost $170 million in 2005 dollars. When the costs were escalated to the mid-point of construction, the total project costs were estimated to be $201 million.

In addition to the project cost of the new hospital, Alternative 3 also included capital costs for the necessary renovation and expansion of DGH. The capital cost of this effort was estimated at $57 million, the same as in Alternatives 1 and 2. The two ambulatory care centers also needed to be included in the cost of Alternative 3. Senior Management estimated that the Queen Anne's County building would require approximately 32,000 square feet and would cost $18.6 million. The Caroline County facility would be smaller, 15,000 square feet, and would cost $10 million. As in Alternatives 1 and 2, a capital expenditure of $2,200,000 for the development of an acute rehabilitation unit was included, but the Emergency Department project was not included. The capital budget also included an annual expenditure of $7,000,000 for routine equipment replacement after $11,815,000 in FY2005 and $7,500,000 in FY2006. These annual capital expenditures were less than those presented in Alternative 1 because the new hospital facility would reduce the need for replacement equipment.

Using these capital investments, senior management requested their accountants to develop a set of financial projections for Alternative 3. A summary of these projections is presented in Table 14.

Table 14: Key Financial Indicators, Alternative 3
Relocation to a New Site in Northern Talbot County

	Budget	Projected							
	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Operating Income	$3,548	$5,535	$7,118	$5,773	($14,296)	($7,441)	($2,361)	($2,361)	$903	$3,897
Excess of Revenue Over Expense	$4,667	$6,284	$7,942	$6,449	($13,488)	($7,445)	($2,306)	($2,306)	$994	$4,064
Cash	$32,418	$36,949	$26,539	$34,806	($9,900)	($6,778)	($6,642)	($4,503)	$291	$7,657
Long Term Debt	54,043	51,395	49,052	276,529	271,753	237,407	232,278	226,955	221,423	215,667
Net Assets	92,569	98,853	106,795	113,244	99,756	92,312	86,812	84,506	85,500	89,564
Total Capitalization	146,612	150,248	155,847	389,773	371,510	329,719	319,090	311,461	306,922	305,231
Operating Margin	2.2%	3.2%	3.9%	2.9%	-6.7%	-3.2%	-2.3%	-0.9%	0.3%	0.3%
Excess Margin	2.9%	3.6%	4.3%	3.2%	-6.3%	-6.3%	-2.2%	-0.9%	0.4%	1.4%
Debt Service Coverage	3.8	3.9	4.6	4.5	1.1	1.2	1.3	1.4	1.6	1.7
Days Cash on Hand	81	86	58	69	(17)	(11)	(10)	(7)	0	10
Debt to Capitalization	0.37	0.34	0.31	0.71	0.73	0.72	0.73	0.73	0.72	0.71

Source: KPMG, Shore Health System, Summary of Financial Projections for Incremental Volumes, October 2005.

Based on the volume projections for this alternative, SHS would expect to begin incurring operating losses in fiscal year 2010, but these would diminish over time and by 2014 would be generating a profit. By 2015, SHS would be carrying nearly $215 million in long term debt. As in Alternatives 1 and 2, the organization's operating margin, excess margin, debt service coverage, days cash on hand and debt to capitalization are below both Moody's and Standard & Poor's medians for A-rated bonds, but in Alternative 2 the organization is closer to these medians. SHS would still have some difficulty in securing debt to help finance Alternative 3, but much less difficulty than Alternative 1 and somewhat less difficulty than Alternative 2.

Comparison of the Alternatives

When the Board reviewed these three alternatives in October 2005 they believed that all three would resolve the current space problems at MHE and DGH. The redevelopment of the existing campuses (Alternative 1) did not resolve MHE's site constraint issues as well as either of the two new site options (Alternatives 2 and 3).

Furthermore, redevelopment of the existing campuses would cause SHS to experience the worst financial performance. The new hospital in Easton would generate positive operating margins, but not as positive as a new hospital in northern Talbot County. Similarly, the new hospital in Easton would generate positive cash flows, debt to capitalization and debt service coverage, but not as strong as a new hospital in northern Talbot County. The Board believed that the two new hospital alternatives would be equal in attracting new physicians to the Eastern Shore, but that the new facility in northern Talbot County would be better at reducing the chance of a competitor trying to get approval for a hospital in Queen Anne's County.

Based on these comparisons, the Board decided to proceed into its affiliation with UMMS with Alternative 3 as its preferred option. This option would be used to establish the financial investments to be made by UMMS but was not considered to be the final selection of a site for a new hospital. SHS finalized its affiliation with UMMS in April 2006.

Subsequent Alternatives Considered

In the autumn of 2006 the public was made aware of the conditions of the new affiliation between SHS and UMMS. Even though most people understood the need for a larger, more accessible campus, a great deal of concern was expressed about moving the hospital out of Easton. After several months, the Talbot County Commissioners proposed to give SHS a parcel of land north of the Easton airport. The land was adjacent to Easton and could be annexed by the City to provide utilities and services to the site. At the same time the Maryland legislature approved an enabling law which would allow UMMS to build a freestanding Emergency Center in Queen Anne's County. UMMS also announced that it was entering into discussions to affiliate with Chester River Health System in Kent County.

Given all of these new factors, the Board at SHS decided to re-evaluate the site options for its new hospital. The Planning Committee was reconvened in April 2007 to review the site options for a new hospital and select the site that provided the best solution for the community while making the best business case for SHS. The Committee met monthly until December 2008 when it presented its findings and recommendations to the SHS Board.

The Planning Committee started by comparing the site SHS owned at the Easton Bypass and Oxford Road to the site offered by the Talbot County Commission and a site near the intersection of Routes 50 and 404. Due to the market share advantages of the northern sites, consideration of the Oxford Road site was discontinued shortly after the study was initiated.

A drive time analysis was conducted to compare the accessibility of the Talbot County Commission proposed site (hereafter referred to as the Community Center site) to the Routes 50 and 404 site. Because of the distribution of the population throughout the service area, the Community Center site is somewhat more accessible to the service area population than the site in northern Talbot County.

During the elapsed time from the first analyses to the subsequent study, several conditions in the market had changed. Most significantly, there was rapid inflation in construction costs throughout the Mid-Atlantic States. UMMS predicted that hospital construction costs would inflate at a rate of 10.5 percent in 2008 and 2009 and 3.5 percent annually thereafter. At those rates hospital construction cost per square foot could more than double from the projections made in 2005.

Also, MHE's market share had improved between 2004 and 2008. Anne Arundel Medical Center had finished moving to its new campus in 2001, and MHE experienced a decline in its market share throughout the mid-Shore region. By 2006, MHE's market share had begun to recover and by 2008 its market share was back to its 2002 levels.

SHS decided that a strong ambulatory care strategy would be needed to protect its market share from competitors outside of the Eastern Shore. The Planning Committee evaluated developing several sites in Queen Anne's County and Caroline County. These included the freestanding Emergency Center approved by the Maryland legislature, new physician offices and ambulatory facilities in Grasonville and Federalsburg, and new or replacement ambulatory facilities in Denton and Centreville. Table 15 summarizes the projects and capital costs.

Table 15: Capital Costs of Ambulatory Facilities Strategy

	PROJECT SCHEDULE		SQUARE	2008 PROJECT	ESCALATION	ESTIMATED
	START	OCCUPY	FEET	COST	COST	PRICE
FREESTANDING ED		7/1/2010				$14,400,000
DENTON ACC/POB	1/1/2009	7/1/2010	12,700	$8,500,000	$1,500,000	$10,000,000
GRASONVILLE ACC POB	1/1/2010	7/1/2011	23,190	$11,700,000	$3,000,000	$14,700,000
FEDERALSBURG POB	1/1/2011	7/1/2012	11,900	$6,100,000	$1,800,000	$7,900,000
CENTREVILLE ACC/POB	1/1/2012	7/1/2013	24,200	$11,100,000	$3,700,000	$14,800,000
						$61,800,000

Source: ASR Planning, Inc. and Insight Health Partners, October 2008.

Development of a new hospital at either of the two campuses presented several financial issues. SHS hoped that it could develop the new hospital on the Community Center campus by 2013. Because of adverse pressure from the community and presumed Certificate of Need challenges, SHS assumed that if it pursued the option of developing the site at Routes 50 and 404, it would be delayed by at least two years. A new hospital on this site could not be opened until at least 2015. Because of the inflation of hospital

construction costs, development of either project on these schedules was determined to be beyond the financial capability of SHS. As a result, the alternatives were re-evaluated under two new sets of development parameters. Either the projects would be delayed until 2022 to allow SHS to build sufficient debt capacity to make the projects affordable, or the projects would be started as considered above, but phased-in over time. The capital costs of the two projects under the delaying scenario are presented in Table 16.

Table 16: Capital Costs of Two Projects

	Community Center Alternative	50/404 Alternative
Beds	**187**	**194**
Site Development	**$4,900,000**	**$9,800,000**
Site Cost	**$2,000,000**	**$7,150,000**
Construction	**$191,286,900**	**$200,869,950**
Contingency	**$19,128,690**	**$20,086,995**
Fees	**$22,954,428**	**$24,104,394**
Furnishings/Equipment	**$57,386,070**	**$60,260,985**
Soft Costs	**$11,477,214**	**$12,052,197**
Total, 2007 Dollars	**$309,133,302**	**$334,324,521**
Project Start Date	**1/1/2020**	**1/1/2020**
Project Occupancy Date	**7/1/2022**	**7/1/2022**
Project Cost Escalated to Midpoint of Construction	**$577,353,893**	**$624,402,361**

Source: ASR Planning, Inc. and Insight Health Partners, October 2008.

The capital costs of the facility at Routes 50 and 404 were greater than those at the Community Center site for several reasons. First, the hospital would contain 194 beds versus 187 beds and would therefore need to be bigger. Also, SHS would have to acquire the land for the Routes 50 and 404 site on the market and would have to pay the market value. By contrast, the Talbot County Commission had offered to give SHS a portion of the land at the Community Center site free of charge, and arranged to get the remainder of the land at a cost of approximately $2 million. The City of Easton and the County also promised to bring the major utilities to the site. By comparison, the site at Routes 50 and

404 would be expensive to develop since utilities would have to be brought from long distances and SHS would have to develop its own sewage treatment facility. In the final analysis, the capital costs of the site at Routes 50 and 404 would be $47 million more than the capital costs at the Community Center site.

In the end, it was clear to the Board that the replacement at the proposed site best met the primary objectives, had the support of MHE's stakeholders, and was the most cost-effective alternative.

(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.

Inapplicable

(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.

The proposed site is within a Priority Funding Area. (see **Exhibit 10**.)

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.

MHE acknowledges that it has the burden of proof to demonstrate need for services for which need is not separately projected in the State Health Plan. Please see the narrative under 10.24.01.08G(3)(b) (Need) where need for acute rehabilitation beds, emergency department space, surgical capacity and obstetrical beds are discussed.

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.

MHE will include two separate towers, one of which (six stories) includes inpatient services. This tower will be called Tower 1 for purposes of this application. The other tower (two stories) will house predominantly outpatient and support services, and will be called Tower 2. However, both towers are being constructed to hospital standards. Consequently, MHE has calculated different MVS benchmarks for each tower and then calculated a consolidated benchmark against which the project costs are compared.

As shown below, the cost per square foot of the new construction is lower than the MVS benchmark. A complete Marshall Valuation Service ("MVS") analysis is included as **Exhibit 11**.

I. Marshall Valuation Service
Valuation Benchmark– New Construction - Tower 1

Type		Hospital
Construction Quality/Class		Good/A
Stories		6
Perimeter		1,196
Average Floor to Floor Height		15.3
Square Feet		296,002
f.1	Average floor Area	49,334

A. Base Costs			
	Basic Structure	$	336.71
	Elimination of HVAC cost for adjustment		0
	HVAC Add-on for Mild Climate		0
	HVAC Add-on for Extreme Climate		0
Total Base Cost			$336.71
Adjustment for Departmental Differential Cost Factors			1.17
Adjusted Total Base Cost			$392.96
B. Additions			
	Elevator (If not in base)		$0.00
	Other		$0.00
Subtotal			$0.00
Total			$392.96
C. Multipliers			
Perimeter Multiplier			0.908749002
	Product		$357.10
Height Multiplier			1.076405989
	Product		$384.39
Multi-story Multiplier			1.015
	Product		$390.15
D. Sprinklers			
	Sprinkler Amount		$2.22
Subtotal			$392.38
E. Update/Location Multipliers			
Update Multiplier			1.04
	Product		$408.07
Location Multipier			1
	Product		$408.07
Calculated Square Foot Cost Standard			**$408.07**

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.

Floor	Department	PROPOSED Dept. Area SF	MVS Department Name	MVC Differential Cost Factor	Cost Factor x SF
1	**Diagnostic & Treatment**				
	Cardiopulmonary/Vascular: Non-Invasive	5,026	Outpatient Department	0.99	4,976
	Emergency Department	19,394	Emergency Suite	1.18	22,885
	Imaging	17,179	Radiology	1.22	20,958
	Maryland Express Care	644	Offices	0.96	618
	Subtotal DGSF	***42,243***			
1	**Administrative & Public Services**				
	Admitting/Registration	2,097	Offices	0.96	2,013
	Lobby	2,116	Public Space	0.8	1,693
	Subtotal DGSF	***4,213***			
1	**Support Services**				
	Body Holding	342	Storage and Refrigeration	1.6	547
	Central Employee Locker Room	1,039	EmployeeFacilities	0.8	831
	EVS/Linen[2]	3,986	Laundry	1.68	6,696
	Facilities Management[2]	4,189	Offices	0.96	4,021
	Food & Nutrition	10,953	Dietary	1.52	16,649
	Materials Management/Receiving Dock	5,606	Storage and Refrigeration	1.6	8,970
	Subtotal DGSF	***26,115***			
1	**Clinics**				
	Breast Center	-			
	Coumadin(Anti-Thrombosis Clinic)[3]	-			
	Sleep Disorders Center	-			
	Specialty Clinic	-			
	National Wound Healing Center	-			
	Subtotal DGSF	***-***			
1	**Central Plant**	**14,420**	Mechanical Equipment and Shops	0.7	10,094

	Interdepartmental Circulation	**12,029**	Internal Circulation, Corridors	0.6	7,217
	Mechanical/Electrical Equipment Rooms	**1,354**			
	Mechanical Shafts	-	Mechanical Equipment and Shops	0.7	0
	Electrical Rooms	712	Mechanical Equipment and Shops	0.7	498
	IT Rooms	642	Mechanical Equipment and Shops	0.7	449
1	***Level 01 Subtotal DGSF***	***100,374***			
	Exterior Wall Allowance	**1,583**			
	Level 01 Total DGSF	***101,957***			
Floor	**Department**	**PROPOSED Dept. Area SF**	**MVS Department Name**	**MVC Differential Cost Factor**	**Cost Factor x SF**
2	**Inpatient**				
	Pediatrics	5,682	Inpatient Units	1.06	6,023
	Observation	1,929	Inpatient Units	1.06	2,045
	Subtotal DGSF	***7,611***			
2	**Diagnostic & Treatment**				
	Interventional Suite: Surgery & Cath Lab	24,472	Operating Suite, Total	1.59	38,910
	Prep/Stage II/Recovery	9,055	Operating Suite, Total	1.59	14,397
	Subtotal DGSF	***33,527***			
2	**Shell**	***2,442***	Unassigned Areas	0.5	1,221
2	**Administrative & Public Services**				
	Chapel/Pastoral Care	559	*Public Space*	0.8	447
	Information Technology	2,659	Offices	0.96	2,553
	Nurse Staffing	645	Offices	0.96	619
	Subtotal DGSF	***3,863***			
2	**Support Services**				
	Pharmacy	4,033	Pharmacy	1.33	5,364
	Sterile Processing	6,109	Central Sterile Supply	1.54	9,408
	Subtotal DGSF	***10,142***			
2	**Interdepartmental Circulation**	**7,265**	Internal Circulation, Corridors	0.6	4,359

2	**Mechanical/Electrical Equipment Rooms**	**1,360**			
	Mechanical Shafts	**238**	Mechanical Equipment and Shops	0.7	167
	Electrical Rooms	678	Mechanical Equipment and Shops	0.7	475
	IT Rooms	444	Mechanical Equipment and Shops	0.7	311
2	***Level 02 Subtotal DGSF***	***66,210***			
	Exterior Wall Allowance	**2,435**			
2	***Level 02 Total DGSF***	***68,645***			

Floor	Department	PROPOSED Dept. Area SF	MVS Department Name	MVC Differential Cost Factor	Cost Factor x SF
3	**Inpatient**				
	Medical	13,207	Inpatient Units	1.06	13,999
	Shared Support - Medical/Surgical	-	Inpatient Units	1.06	0
	Perinatal - LDRP	22,351	Obstetrical Suite Only	1.44	32,185
	Subtotal DGSF	***35,558***			
3	**Interdepartmental Circulation**	**3,146**	Internal Circulation, Corridors	0.6	4,359
3	**Mechanical/Electrical Equipment Rooms**	**1,330**			
	Mechanical Shafts	426	Mechanical Equipment and Shops	0.7	167
	Electrical Rooms	460	Mechanical Equipment and Shops	0.7	475
	IT Rooms	444	Mechanical Equipment and Shops	0.7	311
3	***Level 03 Subtotal DGSF***	***40,034***			
	Exterior Wall Allowance	**887**			
3	***Level 03 Total DGSF***	***40,921***			

Floor	Department	PROPOSED Dept. Area SF	MVS Department Name	MVC Differential Cost Factor	Cost Factor x SF
4	**Inpatient**				
	Neuro/Joint Center	12,782	Inpatient Units	1.06	13,549
	Requard Center	15,974	Physical Medicine	1.09	17,412
	Subtotal DGSF	***28,756***			
4	**Interdepartmental Circulation**	**3,327**	Internal Circulation, Corridors	0.6	4,359

4	**Mechanical/Electrical Equipment Rooms**	**1,266**			
	Mechanical Shafts	568	Mechanical Equipment and Shops	0.7	167
	Electrical Rooms	460	Mechanical Equipment and Shops	0.7	475
	IT Rooms	238	Mechanical Equipment and Shops	0.7	311
4	***Level 04 Subtotal DGSF***	***33,349***			
	Exterior Wall Allowance	**873**			
4	***Level 04 Total DGSF***	***34,222***			

Floor	Department	PROPOSED Dept. Area SF	MVS Department Name	MVC Differential Cost Factor	Cost Factor x SF
5	**Inpatient**				
	Intensive Care	9,918	Inpatient Units	1.06	10,513
	Telemetry	12,722	Inpatient Units	1.06	13,485
	Subtotal DGSF	***22,640***			
5	**Diagnostic & Treatment**				
	Respiratory Therapy	1,621	Offices	0.96	1,122
	Inpatient Dialysis	2,157	Inpatient Units	1.06	2,286
	Subtotal DGSF	***3,778***			
5	**Interdepartmental Circulation**	**3,593**	Internal Circulation, Corridors	0.6	4,359
5	**Mechanical/Electrical Equipment Rooms**	**1,266**			
	Mechanical Shafts	568	Mechanical Equipment and Shops	0.7	167
	Electrical Rooms	460	Mechanical Equipment and Shops	0.7	475
	IT Rooms	238	Mechanical Equipment and Shops	0.7	311
5	***Level 05 Subtotal DGSF***	***31,277***			
	Exterior Wall Allowance	**758**			
5	***Level 05 Total DGSF***	***32,035***			

Floor	Department	PROPOSED Dept. Area SF	MVS Department Name	MVC Differential Cost Factor	Cost Factor x SF
6	**Inpatient**				
	Surgical	15,153	Inpatient Units	1.06	16,062

	Subtotal DGSF	***15,153***			
6	**Interdepartmental Circulation**	**1,835**	Internal Circulation, Corridors	0.6	4,359
6	**Mechanical/Electrical Equipment Rooms**	**762**			
	Mechanical Shafts	284	Mechanical Equipment and Shops	0.7	167
	Electrical Rooms	240	Mechanical Equipment and Shops	0.7	475
	IT Rooms	238	Mechanical Equipment and Shops	0.7	311
6	***Level 06 Subtotal DGSF***	***17,750***			
	Exterior Wall Allowance	***472***			
6	***Level 06 Total DGSF***	***18,222***			
	Subtotal DGSF	***288,994***		1.17	337,274
	Subtotal Exterior Wall Allowance	***7,008***			
	Total DGSF	***296,002***			

II. Marshall Valuation Service
Valuation Benchmark– New Construction – Tower 2

Type			Hospital
Construction Quality/Class			Good/A
Stories			2
Perimeter			636
Average Floor to Floor Height			16.00
Square Feet			29,125
	Average floor Area		29,125
A. Base Costs			
	Basic Structure	$	336.71
	Elimination of HVAC cost for adjustment		0
	HVAC Add-on for Mild Climate		0
	HVAC Add-on for Extreme Climate		0
Total Base Cost			$336.71

Adjustment for Departmental Differential Cost Factors 1.05

Adjusted Total Base Cost		$355.07
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$355.07
C. Multipliers		
Perimeter Multiplier		0.902205063
	Product	$320.35
Height Multiplier		1.092
	Product	$349.82
Multi-story Multiplier		1.000
	Product	$349.82
D. Sprinklers		
	Sprinkler Amount	$2.94
Subtotal		$352.76
E. Update/Location Multipliers		
Update Multiplier		1.04
	Product	$366.87
Location Multipier		1
	Product	$366.87
Calculated Square Foot Cost Standard		**$366.87**

Similarly to Tower 1, Tower 2's MVS benchmark is impacted by the Adjustment for Departmental Differential Cost Factor. The calculation of the average factor is shown below.

Floor	Department	PROPOSED Dept. Area SF	MVS Department Name	MVC Differential Cost Factor	Cost Factor x SF
1	**Diagnostic & Treatment**				0
	Outpatient Lab Draw	698	Outpatient Department	0.99	691
	Subtotal DGSF	***698***			
1	**Administrative & Public Services**				0
	Auxiliary	250	Volunteer Areas	0.8	200
	Education Center & Medical Library	5,941	Offices	0.96	5,703
	Gift Shop	676	Public Space	0.8	541
	Nursing Administration	1,176	Offices	0.96	1,129
	Switch Board	124	Mechanical Equipment and Shops	0.7	167
	Subtotal DGSF	***8,167***			
1	**Support Services**				
	Security[2]	733	Offices	0.96	704
	Subtotal DGSF	***733***			
1	**Clinics**				0
	Behavioral Health	730	Outpatient Department	0.99	723
	Cardio Fitness & Wellness	3,367	Physical Medicine	1.09	3,670
	Child Advocacy Center	1,372	Outpatient Department	0.99	1,358
	Infusion Center	2,273	Outpatient Department	0.99	2,250
	UMMS Diabetes Center	3,158	Outpatient Department	0.99	3,126
	Pain Management Center	2,728	Outpatient Department	0.99	2,701
	Shared Waiting Area	572	Outpatient Department	0.99	566
	Subtotal DGSF	***14,200***			
1	**Interdepartmental Circulation**	**4,209**	**Internal Circulation, Corridors**	0.6	4,359
1	**Mechanical/Electrical Equipment Rooms**	**330**			
	Mechanical Shafts	-	Mechanical Equipment and Shops	0.7	167

	Electrical Rooms	130	Mechanical Equipment and Shops	0.7	475
	IT Rooms	200	Mechanical Equipment and Shops	0.7	311
1	***Level 01 Subtotal DGSF***	***28,337***			
	Exterior Wall Allowance	**788**			
1	***Level 01 Total DGSF***	***29,125***			
Floor	**Department**	**PROPOSED Dept. Area SF**	**MVS Department Name**	**MVC Differential Cost Factor**	**Cost Factor x SF**
2	**Diagnostic & Treatment**				
	Clinical Laboratory	9,917	Laboratories	1.15	11,405
	Anatomic Pathology[1]	2,036	Laboratories	1.15	2,341
	Pre-Anesthesia Testing	1,030	Outpatient Department	0.99	1,020
	Subtotal DGSF	***12,983***			
2	**Administrative & Public Services**				
	CIM/Medical Staff/Quality Team	4,580	Offices	0.96	4,397
	Executive Administration	4,663	Offices	0.96	4,476
	Hospitalist Suite	502	Offices	0.96	482
	Human Resources	1,072	Offices	0.96	1,029
	Medical Staff Lounge	471	Offices	0.96	452
	Subtotal DGSF	***11,288***			
2	**Interdepartmental Circulation**	**3,650**	**Internal Circulation, Corridors**	0.6	4,359
2	**Mechanical/Electrical Equipment Rooms**	**405**			
	Mechanical Shafts	108	Mechanical Equipment and Shops	0.7	167
	Electrical Rooms	98	Mechanical Equipment and Shops	0.7	475
	IT Rooms	199	Mechanical Equipment and Shops	0.7	311

2	***Level 02 Subtotal DGSF***	***28,326***			
	Exterior Wall Allowance	**799**			
2	***Level 02 Total DGSF***	***29,125***			
	Subtotal DGSF	***56,663***		1.05	59,753
	Subtotal Exterior Wall Allowance	***1,587***			
	Total DGSF	***58,250***			

III. Marshall Valuation Service
Valuation Benchmark– Mechanical Penthouse

Type		Mechanical Penthouse
Construction Quality/Class		Good/A
Stories		7
Perimeter		398
Average Floor to Floor Height		18.0
Square Feet		4,676
f.1	Average floor Area	4,676
A. Base Costs		
	Basic Structure	$ 74.45
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$74.45
Adjustment for Departmental Differential Cost Factors		N/A
Adjusted Total Base Cost		$74.45
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$74.45
C. Multipliers		
Perimeter Multiplier		1.068048

	Product	$79.52
Height Multiplier		1.076406
	Product	$85.59
Multi-story Multiplier		1.020
	Product	$87.30
D. Sprinklers		
	Sprinkler Amount	$4.52
Subtotal		$91.82
E. Update/Location Multipliers		
Update Multiplier		1.04
	Product	$95.50
Location Multipier		1
	Product	$95.50
Calculated Square Foot Cost Standard		**$95.50**

IV. Consolidated MVS Benchmark

	MVS Benchmark	Sq. Ft.	Total Cost Based on MVS
Benchmark			
Tower 1	$408.07	296,002	$120,790,706.62
Mechanical Penthouse	$95.50	4,676	$446,541.06
Tower 2	$366.87	58,250	$21,370,097.97
Consolidated	**$397.31**	358,928	$142,607,345.65

V. Cost of New Construction

A. Base Calculations	**Actual**	**Per Sq. Foot**
Building	$125,193,045	$348.80
Fixed Equipment		$0.00
Site Preparation	$36,015,484	$100.34
Architectual Fees	$17,400,000	$48.48
Permits	$4,107,718	$11.44
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$182,716,247	$509.06

However, as related below, this project includes expenditures for items not included in the MVS average. As shown below, there are costs both in areas called “Inside the

Loop" and "Outside the Loop." The entire real estate parcel is not allocated to the Hospital. Only the portion of the site called "Inside the Loop" is hospital related, and the remainder of the site will be used for future, non-hospital related development. However, the project costs include all of the costs related to the entire site. Consequently, the costs related to the portion of the parcel that is not related to the hospital ("Outside the Loop") are being subtracted from the comparison, as off-site costs.

Inside the Loop	**Project Costs**	
Canopy	$992,358	Building
Premium for Labor Shortages/Remote Location on Eastern Shore Projects	$9,389,478	Building
LEED Silver Premium	$5,007,722	Building
Siesmic Costs	$2,503,861	Building
Signs	$1,000,000	Building
Jurisdictional Hook-up Fees	$1,852,215	Permits
Impact Fees	$1,539,819	Permits
Paving and Roads	$4,140,494	Site
Demolition	$25,000	Site
Storm Drains	$2,377,558	Site
Rough Grading	$1,419,437	Site
Landscaping	$2,136,906	Site
Sediment Control & Stabilization	$201,087	Site
Helipad	$598,648	Site
Water	$58,558	Site
Sewer	$93,692	Site
Outside the Loop		
Normal Site Work	$461,177	Site
Sediment Contorls	$221,905	Site
Rough Grading	$528,315	Site
Stormwater Drains	$1,083,977	Site
Paving and Roads	$5,351,458	Site
Landscaping	$150,493	Site
Water	$1,125,436	Site
Sewer	$677,278	Site
Gas	$244,420	Site

Inside the Loop	Project Costs	
Electrical Ductbanks & Raceways	$2,887,287	Site
Communication Cabling - Verizon, etc.	$1,125,478	Site
Upsize Pump Station - 327 - 900 EDU's	$1,531,200	Site
Upsize Forcemain - 8" - 12"	$2,717,312	Site
SHS Share of Electrical Extension - Looped 25kV Feeder from Sub 2 & Sub 3	$3,397,000	Site
SHS Share of Gas Extension to RMC Building Site	$689,000	Site
MAN Loop Feed	$106,500	Site
Other County Charges	$1,580,380	Site
Total Cost Adjustments	$57,215,447	

Explanation of Extraordinary Costs

- Demolition - The project requires a small amount of demolition. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A - Good General Hospital per Section 1, page 3 of the Marshall Valuation Service.

- Premium for Labor Shortages/Remote Location on Eastern Shore Projects – Whiting Turner, the cost estimator on this project, has included a 7.5% premium (based on Building Costs) due to labor shortages and costs of transporting equipment and construction materials that they have experienced on the Eastern Shore. Please see **Exhibit 12**, which includes a letter from Whiting Turner attesting to the need for this premium. In Section 99, Page 1, MVS recognizes the potential for a 2%-10% premium for Abnormal Shortages and for a 5%-15% for Remote Areas.

- LEED Silver Premium - Whiting Turner has included a 4% premium (based on Building Costs only) due to constructing this building to LEED Silver standards. The potential for a 0%-7% premium is recognized by MVS in Section 99, Page 1.

- Seismic Costs - Whiting Turner has included a 2% premium (based on Building Costs only) due to constructing this building to the necessity of building in seismic protection factors. The potential for a 2%-5% premium is recognized by MVS in Section 99, Page 1.

- Signs, Canopy, Jurisdictional Hook-up Fees, Impact Fees, Paving and Roads , Storm Drains, Rough Grading, Landscaping, and Sediment Control & Stabilization – These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the Marshall Valuation Service.

- Helipad - Land improvement costs, such as helipads, are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A -Good General

Hospital per Section 1, page 3 of the Marshall Valuation Service. (While helipads are not specifically mentioned, MHE considers it a land improvement cost.)

- Water and Sewer– This project requires the extension of utilities to the perimeter of the hospital related portion of the site (i.e., to the outer boundary of the "Inner Loop"). These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the Marshall Valuation Service.

- All Outer Loop Costs – These are considered off-site costs, as they relate to a portion of the parcel that is not hospital related. Off-site costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the Marshall Valuation Service.

- Capitalized Construction Interest on Extraordinary Costs - Capital interest shown on the project budget sheet is for the entire costs of the hospital building. The costs associated with this line item also apply to the extraordinary costs. Because the Capitalized Construction Interest only associate with the costs in the "Building" budget line are considered in the MVS analysis, it is appropriate to adjust the cost of each of the above items that are in the Building costs to include the associated capitalized construction interest.

- Architectural and Engineering Fees Related to Extraordinary Costs – A&E Fees are typically a percentage of the total cost of Building and Site Preparation, including extraordinary costs. Consequently, like Capitalized Interest, if the extraordinary costs are removed from the comparison, their related A&E Fees should also be removed. This was accomplished by calculating the percent that the original A&E Fees comprised of the Building and Site Prep costs, multiplying that percentage times the sum of the extraordinary costs, and subtracting that number from the original A&E fees.

Eliminating all of the extraordinary costs reduces the project costs that should be compared to the MVS estimate to $380.62. As noted below, the project's cost per square foot is below the MVS benchmark.

C. Adjusted Project Cost		**Per Square Foot**
Building	$106,299,626	$296.16
Fixed Equipment		$0.00
Site Preparation	$1,085,490	$3.02
Architectual Fees	$11,590,584	$32.29
Permits	$715,684	$1.99
Subtotal	$119,691,384	$333.47
Capitalized Construction Interest	$14,486,957	$40.36

Total	$134,178,341	$373.83

VI. Comparison to the MVS Benchmark

MVS Benchmark	$397.31
The Project	$373.83
Difference	-$23.48

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.

Inapplicable

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.

The average square feet/bed of the inpatient nursing units in the proposed facility is 497 sf/bed, using the definition in the Acute Care Chapter. The average sf/bed varies by the type of nursing unit. The six-bed pediatric unit and the ten-bed ICU exceed the standard because they have very few beds. The perinatal (OB) unit also exceeds the standard because all of MHE's beds in that unit will be LDRP (labor, delivery, recovery, postpartum) beds, which require more space than a typical patient bed. However, the overall average is reduced to below the benchmark because the Medical/Surgical units, have fewer square feet per bed than the standard. A summary of the calculations is shown below. The detailed analysis is included in **Exhibit 13.**

ROOM/FUNCTION	NEW-ADDITIONAL		
	NSF	BEDS	SF/BED
PEDIATRICS	3,649	6	608.2
MEDICAL	9,075	20	453.8
PERINATAL / LDRP	9,700	14	692.9
JOINT / NEURO	8,221	18	456.7
Telemetry	8,953	22	407.0
ICU	6,507	10	650.7
SURGICAL	9,562	22	434.6
BLDG TOTAL	55,667	112	
BLDG SF/BED			497.0

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.

Inapplicable, the Hospital is not a "high cost" hospital. On the most recent Reasonableness of Charges screen on the HSCRC web site (FY 2011), MHE is 3% below the mean for its peer group, as related below.

PEER GROUP 2		-1.86%
210023	Anne Arundel Medical Center	-0.69%
210061	Atlantic General Hospital	4.64%
210039	Calvert Memorial Hospital	-3.81%
210033	Carroll Hospital Center	-2.48%
210030	Chester River Hospital Center	7.92%
210035	Civista Medical Center	-0.56%
210051	Doctors Community Hospital	4.48%
210010	Dorchester General Hospital	-4.42%
210060	Fort Washington Medical Center	-3.79%
210005	Frederick Memorial Hospital	-3.51%
210017	Garrett County Memorial Hospital	-6.58%
210006	Harford Memorial Hospital	3.27%
210048	Howard County General Hospital	-1.91%
210055	Laurel Regional Hospital	7.75%
210045	McCready Memorial Hospital	53.05%
210037	Memorial Hospital at Easton	-3.00%
210018	Montgomery General Hospital	4.64%
210040	Northwest Hospital Center	4.26%
210019	Peninsula Regional Medical Center	-2.24%
210057	Shady Grove Adventist Hospital	-0.92%
210054	Southern Maryland Hospital Center	1.77%
210007	St. Joseph Medical Center	1.69%
210028	St. Mary's Hospital	3.23%
210032	Union of Cecil	-2.98%
210049	Upper Chesapeake Medical Center	-3.01%
210016	Washington Adventist Hospital	6.41%
210001	Washington County Hospital	-8.64%
210027	Western Maryland Regional Medical Center	2.97%

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

(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

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

MHE is already a very efficient hospital. It is important to note that MHE is a "Total Patient Revenue System" ("TPR") hospital. Under this rate system, the HSCRC provides assurance of a certain amount of revenue each year, independent of the number of patients treated and the amount of services, either inpatient or outpatient, provided to these patients. If volumes go down, MHE has to increase prices, and if volumes go up, MHE has to decrease prices. Volume will not drive net revenue, only expenses will do so. Consequently, MHE has every incentive to become more efficient.

Where MHE has been able to become more efficient, it has attempted to do so. This can be evidenced through CON Formset Tables 1 and 5. Table 17 below shows evidence of this. For the acute inpatient units (plus observation), MHE has not been able to project that it will increase the number of Admissions per FTE because of the projected aging of the population and expected increases in intensity of cases. In the Requard unit, the number of Admissions/Direct Care FTEs will stay the same. In the ED and in surgery (based on the surgical cases in the discussion under Need), the number of cases/FTE will increase. If all of the inpatient admissions (including Observation) are divided by the total

number of FTEs in Table 5, the number of admissions/FTE is unchanged between 2013 and 2017.

Table 17
Units of Measure, FTEs, Cases/FTE
Various Units and All Admissions
MHE
2013 and 2017

	2013	2017
MSG/Ped/OB/Observation		
Direct Care FTEs	240	247.8
Admissions	8,970	9,112
Cases/FTE	37.41	36.77
Rehab		
FTEs	21.6	21.6
Admissions	459	459
Cases/FTE	21.25	21.25
	2013	2017
ED		
FTEs	61.1	64.5
Cases	37,264	39,449
Cases/FTE	609.89	611.41
Surgery		
FTEs	61.5	64.2
Cases	4,944	5,928
Cases/FTE	80.39	92.33
Total Admissions + Observation	10,398	10,733
Total FTEs	1,018.6	1,055.1
Adm/FTE	10.2	10.2

A number of facets of this project have been designed to improve efficiency. They include:

Bed Units. The bed units, all private patient rooms are designed to improve staff efficiency. The rooms have been mocked up to simulate room work flow for staff, patients and family. The location of the charting alcove with the nurse server provides critical supplies close by. All of these are improvements over the aged nursing units, and non-standardized care areas of the existing hospital. Additionally, the sweeping triangular form minimizes unit-wide circulation to key rooms and reduced footsteps for the caregiver by as much as 30% over their current race-track configuration in most units. The location of the bariatric rooms near the patient elevators, as well as the location of the elevators between the units, further improves work flow and efficiency processes. Other things that foster improved efficiency are the location of the gym/rehab space on the unit for Ortho/Rehab, the location of ICU with Step Down Unit and Respiratory Therapy, and the co-location of Requard with Joint/Neuro/Spine Units.

Imaging. Imaging efficiency is achieved by both locating convenient to the primary public spine, as well as its direct adjacency to emergency and close relationship to the patient/service elevators for inpatient imaging. Internally, the department is designed to operate at optimum efficiency by separating inpatient and outpatient flows, and building in synergies between imaging service modalities, such as a dedicated cardiac imaging center and a women's imaging center.

Surgery. Surgery offers the biggest improvement over the existing facility where departments are fragmented by other departments, prep/recovery is fragmented and central sterile is more remote than desired. In the new facility, the prep and recovery area is designed to flex between prep and stage II recovery in standardized rooms that can flex with patient flow. The outpatient access is less than 90' from the front door to check-in.

Prep and Recovery is closely located to both the minor procedure suite as well as the major OR's and Cath Room. Pacu is located to minimize transport from the OR suite, as well as to the patient elevators for inpatients. Central Sterile is located directly adjacent to the OR suite for more timely and efficienty processing of sterile supplies. Furthermore, all invasive procedure suites were co-located in one new department to take advantage of a shared prep/recovery/pacu platform that improves nurse efficiency. Within the OR suite, the standardized OR's allow for maximum utilization and the central core allows for staging of case carts for optimum throughput.

This same mind toward efficiency holds true for materials management, lab and pharmacy. All located to shorten the distance for delivery of supplies or specimens and medications.

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.**

The new facility is designed with patient and staff safety as a core design element. This begins with the organization of the facility with clear separation of public and staff/service corridors to improve patient privacy, and staff efficiency. The 100% private room facility will help reduce medication errors and infections, and will feature standardized patient care areas in both the patient units as well as in the surgical suite. The units themselves are designed to be as efficient as possible, locating key supplies to minimize staff travel distances by as much as 30% over their existing facilities. This includes placing

nurse servers outside of each two patient rooms. Both computers in rooms, as well as charting between the rooms will facilitate safe delivery of medications allowing for bedside barcode checking of medications, as well as great visibility of the staff of the patients. The investment in patient care units with fewer beds/unit than in the existing hospital further helps with both localizing resources, minimizing staff travel distances, and opening up visibility of patients, while controlling noise in the units.

Patient handling and movement is also a key aspect of patient and staff safety, as the elevators are centralized to minimize patient transport distances. On the floors, bariatric designed rooms are located close to the patient elevators to minimize staff handling, and the all the rooms are planned to accommodate patient lifts.

In the diagnostic areas, the invasive procedure rooms are all located together convenient to patient prep and recovery. The OR's, Cath Room, Prep and Pacu are all standardized, with daylight in both patient care and staff areas to help with recovery and fatigue. To help with stress, the facility will feature embedded way finding for patients and family. This means that all public areas, both circulation and waiting, are oriented to the exterior with views of where they parked. This minimizes the distances patients have to travel, and helps alleviate congestion and confusion within staff/service only areas. Another example of efficient design in diagnostic areas is the location of departments to streamline services. Central Sterile Processing is located adjacent to Surgery. Lab and Pharmacy are located adjacent to surgery and immediately next to the service elevators. The gym for Rehab and Ortho patients is located on the patient floor, with corridors designed to promote ambulating in the units.

In all areas, patient privacy is a key factor in safety. As part of the planning process, acoustical design is an increased consideration and now required by the 2010 guidelines. As such, materials and finishes are being selected that not only soften footfalls for wear and tear of staff, but also help absorb noise. This is in addition to three-walled rooms in prep for privacy and the private rooms in the patient care units.

As a Greenfield replacement facility we are afforded the opportunity to design both to the current 2010 guidelines for acoustics, patient safety and patient handling, as well as to design a facility that is readily adaptable to new services and ever changing technologies. The infrastructure is being planned accordingly. The floor to floor height accommodates larger technologies, the first two floor plates feature a regular grid that allows for adaptability over time to new modalities and services. For future flexibility, the hospital departments are carefully planned to allow for horizontal expansion without disruption to existing services. As an added measure, a mobile technology dock is being planned to further allow for any unanticipated technology needs until more permanent solutions can be incorporated.

One of the other features of the proposed facility is that given its location along Route 50, the building is sited and the emergency department is planned to allow for scalability in the event of contingency events. This includes both provisions for mass decontamination, flow of the department and flexible use of spaces in such demanding situations.

Some of the other features that improve patient safety over the existing facility include:

- Co-location of related support functions to maximize efficiency
- Universal patient room design

- Dedicated trauma/patient elevator
- NICU – Level I Nursery
- Directed traffic flow into building (main entrance) past security
- Automation of technology and patient records
- Upgrade to ADA/ANSI standards
- Reduced patient transfer distances (surgery to short stay recovery, ED to ICU, ED to helipad, nursery/LDRP to helipad, etc.)
- Appropriate number of prep/recovery bays
- Increased telemetry capability
- Direct access from C-section to nursery/NICU
- Rehab stairs at each floor in lieu of using enclosed stairwells
- Charting/observation at each patient room
- Airborne infection isolation rooms on every patient unit

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) 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.

A comprehensive statement of assumptions is included in **Exhibit 14.**

As one can see from Table 3, MHE projects excess of revenues over expenses. However this does assume the approval of a rate increase by the HSCRC, which is discussed elsewhere in this application.

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 *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.

Inapplicable, this project proposes the relocation of its existing emergency department ("ED"), not the establishment of a new department. Nor does this application propose the expansion of MHE's ED. MHE's current ED has thirty two treatment bays, as will the ED in the replacement hospital, as related below.

	Adult		Pediatric	
	Existing	Proposed	Existing	Proposed
General	17	17	0	3
Fast Track	10	6	0	0
GYN	2	2	0	0
Resuscitation	1	2	0	0
Psych	2	2	0	0
Total	32	29	0	3
Rapid Diagnostic and other Triage	2	5	0	0
Total all treatment spaces	32	32		

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.

Inapplicable, this project does not involve the expansion of the Hospital's existing emergency department.

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 Services Cost Review Commission.

The building is to be constructed to accommodate one additional floor on top of the patient tower. It is also designed to be able to expand horizontally. In addition, the footprint of the building was designed before MHE's licensed bed complement was reduced by four beds as a result of the "140% Rule" for FY 2013. Consequently, there are four rooms being shelled that were anticipated to be patient rooms: 2 shelled ICU rooms, 1 shelled Neuro room, and 1 shelled Joint room. In addition, the space for the Rehabilitation unit was designed prior to a decline in volume in 2012. Consequently, the space equivalent of 6 rooms will be shelled as a result of the decision to reduce the number of rooms from 20 to 14. Lastly, there are 1,648 SF of shell space on the second floor that has yet to be assigned. None of the shell space is on the uppermost floor.

COMAR 10.24.12 - OB SERVICES CHAPTER

Section .04 - Review Standards – The standards in this section are intended to guide Certificate of Need and CON exemption reviews involving acute hospital inpatient obstetric services.

Section .04(1) - The Maryland Perinatal System Standards. Each applicant shall demonstrate the ability of the proposed obstetric program and nursery to comply with all essential requirements of Maryland's Perinatal System Standards, as defined in the perinatal standards, for either a Level I or Level II perinatal center.

MHE currently has a Level I nursery, as will the proposed replacement facility. **Exhibit 15** includes a self-assessment (provided by the Maryland Department of Health and Mental Hygiene) that MHE performed in October 2011 as part of its designation evaluation. It shows that MHE met all of the perinatal standards for Level I with the exception of the following:

4.4 For a hospital without a physician board-certified in maternal-fetal medicine on the medical staff, there is a written agreement with a consultant who is board-certified or an active candidate for board-certification in maternal-fetal medicine to be available 24 hours a day.

Subsequently, MHE took steps to assure that this (and other standards) are met. The obstetricians at MHE have relationships with various facilities based on their preferences. While there is no formal written contract, Maternal – Fetal conferences are being held monthly at SHS offered by a Maternal – Fetal Medicine physician from John Hopkins. SHS is also a member of the larger UMMS, which now provides consultation.

6.8 The hospital shall have an International Board Certified Lactation Consultant on full-time staff who shall have programmatic responsibility for lactation support services which shall include education and training of additional hospital staff members in order to ensure availability seven days per week of dedicated lactation support.

Currently, there is a full-time Board Certified Lactation Consultant who provides education and training of additional hospital staff members. In addition, SHS is a member of the larger UMMS which now provides consultation.

6.13 The hospital shall have genetic diagnostic and counseling services or written consultation and referral agreements for these services in place.

SHS is a member of the larger UMMS which now provides consultation.

MHE is now in compliance with all of the Level I standards.

Section .04(2) - <u>Nursery</u>. An applicant shall demonstrate that the level of perinatal care, including newborn nursery services, will be consistent with the needs of the applicant's proposed service area.

MHE's nursery is currently a level I nursery. MHE is not proposing any change in designation. This level is appropriate for MHE's OB service area. More than 90 percent of the births in the five county area are normal births. The percent of low birth weight and very low birth weight births are close to statewide averages. See Table 18. MHE transports women and infants (either by ground or air) who are high risk to hospitals with a higher level nursery, such as University of Maryland Medical Center, Johns Hopkins Hospital, and Anne Arundel Medical Center. The determination of what neonates are transported out of MHE's Level 1 Nursery is based on gestational age and clinical condition of the neonate. Birth weight is not a single criterion for transport. MHE's policy is to transport stable prenatal patients with gestational age less than 35 weeks. If a patient is

unstable and delivery is necessary, the clinical condition of the neonate is the determining factor for transport.

Neonatal transfer follow up is provided by the Maryland Neonatal Transport Program from UMMS and the Johns Hopkins Transport Nurse from Johns Hopkins Hospital. Both entities communicate by email and telephone for follow up. For Maternal transport follow up, MHE receives information from the Johns Hopkins Transport Liaison.

Table 18
Total Births, Low Birth Weight Births, Very Low Birth Weight Births
Queen Anne's, Kent, Caroline, Talbot, and Dorchester Counties
CY 2010

	Total Births	Low Birth Weight		Very Low Birth Weight	
		#	%	#	%
Kent	166	18		2	
Queen Anne's	487	51		7	
Caroline	432	37		9	
Talbot	357	24		4	
Dorchester	381	43		11	
Total	1,823	173	9.5%	33	1.81%
Maryland	73,783	6,491	8.8%	1,295	1.76%

Source: Maryland Vital Statistics Annual Report 2010
http://dhmh.maryland.gov/vsa/Documents/10annual.pdf

Section .04(3) - <u>Charity Care Policy</u>. Each hospital shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to obstetric services regardless of an individual's ability to pay. Public notice and information regarding a hospital's charity care policy shall be in a format understandable by the target population, and shall include, at a minimum, the following:

(a) annual notice by a method of dissemination appropriate to the hospital's patient population (for example, radio, television, newspaper);

(b) posted notices in the admissions office, business office and emergency areas within the hospital, and

(c) individual notice provided to each person who seeks services in the hospital at the time of community outreach efforts, prenatal services, preadmission, or admission.

As related above, the replacement hospital's charity care policy will be consistent with these requirements.

Section .04(4) - <u>Medicaid Access</u>. The applicant shall provide, in its community needs assessment for obstetric services, a plan describing how the applicant will assure access to hospital obstetric services for Medical Assistance enrollees, including:

(a) an estimate of the number of Medical Assistance enrollees in its primary service area

(b) the number of physicians that will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.

MHE provides care to all individuals, regardless of ability to pay or who their payors are. According to Maryland Department of Health and Mental Hygiene's Maryland Medicaid eHealth Statistics there were an average of 6,151 Medicaid enrollees in Talbot County in FY 2012 (http://www.chpdm-ehealth.org/mco/mco-enrollment_action.cfm). The web site provides data for each month in the fiscal year. MHE averaged the monthly data.

All of the obstetricians and pediatricians with privileges at MHE participate in the Medical Assistance Program. There are nine obstetricians and thirteen pediatricians.

Section .04(5) - <u>Outreach</u>. Each applicant shall document an outreach program for obstetric patients in its service area who may not have adequate prenatal care, and provide hospital services to treat those patients. The program shall address adequate prenatal care, prevention of low birth weight and infant mortality, and shall target the uninsured, under-insured, and indigent patients in the hospital's primary service area, as defined in COMAR 10.24.01.B.

MHE works closely with many partners. Entry into the healthcare system occurs through many referral sources. The hospitals (including DGH and Chester River), the County Health Departments, Community Centers, local physicians, schools, social services agencies, and other organizations in the five counties identify women who need prenatal care, prevention of low birth weight and infant mortality, and uninsured, under-insured, and indigent patients. Of course, families may refer women who think that they may be pregnant and people refer themselves for services.

MHE's program accommodates referrals for obstetric and gynecologic care for underserved women in all five counties from any of these sources.

In addition, MHE offers dozens of classes in the community, including:

- Planning for baby's arrival - Take A Childbirth Education Class
- Labor and delivery – Lamaze
- Successful Breastfeeding
- Health & Wellness Classes.
- Labor & Delivery Class
- Childbirth Class
- Classes and Support Groups Focus on Managing Diabetes
- Pneumonia - Antibiotic and Antiviral Drug Classes
- Mindfulness-Based Stress Reduction
- Blood Pressure Screenings
- Breast Cancer Screenings
- Cancer Support Groups
- Pregnancy and Infant Loss
- New Mom, New Baby & Infant Safety
- Big Brother & Big Sister
- Infant CPR

- Labor & Delivery I, II, III
- Stroke Survivor Support Group
- Us Too Prostate Support Group
- Shore Kids Camp
- Overcoming Your Fear of Flying
- Look Good…Feel Better
- Shore Kids Camp
- Safe Sitter Class
- Breast cancer – Chemotherapy

There is no financial barrier to attend these classes, as there is no charge for any participant.

Many of these entities identify people who need medical care (not only women who need prenatal care) by an offhand comment made by a family member. In terms of prenatal care, whenever a woman in need of medical care is identified, either by a Health Department, social service agency, school, at an MHE class, or other source, the woman is referred to the Local Health Department which evaluates the situation to assure that the family has all the resources it needs (not only regarding the pregnancy). Working with the Health Department, MHE assigns the woman to one of the seven MHE Obstetricians, and she is then a patient of that Obstetrician. No women are turned away. Every woman who needs an obstetrician becomes a private patient of an MHE Obstetrician.

As Table 19 shows, MHE's OB service area has a lower percentage of births that had "Late or No Prenatal Care" compared to the state of Maryland, as a whole. Also, the MHE OB service area had a significantly higher percent of births that had "First Trimester Prenatal Care" than did the state as a whole.

Table 19
Births with "Late or No Prenatal Care" and "1st Trimester Prenatal Care"
Queen Anne's, Kent, Caroline, Talbot, and Dorchester Counties
CY 2010

	Total Births	Late or No Prenatal Care		1st Trimester Prenatal Care	
		#	%	#	%
Kent	166	8		126	
Queen Anne's	487	15		408	
Caroline	432	25		321	
Talbot	357	17		282	
Dorchester	381	26		278	
Total	1,823	91	5.0%	1,415	77.6%
Maryland	73,783	4,668	6.3%	41,999	56.9%

Source: Maryland Vital Statistics Annual Report 2010
http://dhmh.maryland.gov/vsa/Documents/10annual.pdf

Section .04(6) - <u>Community Benefit Analysis</u>. Each applicant proposing to establish a new obstetric program will develop and submit a Community Benefit Program Plan addressing and quantifying the unmet community needs in obstetric and perinatal care within the applicant's anticipated service area population, and providing a detailed description of the manner in which the proposed perinatal program will meet these needs, and the resources required. At a minimum, the Community Benefit Program must include:

(a) a needs assessment related to obstetric and nursery services for the proposed program's service area population;

(b) a description of the manner in which the proposed perinatal program will satisfy unmet needs identified in the needs assessment and/or a description of programs related to and developed in conjunction with the proposed perinatal program to meet needs identified in the needs assessment, including information on the structure, staffing and funding of such programs;

(c) documentation of involvement in program planning and support for the Plan by other agencies, organizations or institutions which will be involved with the applicant in implementing the Plan;

(d) measurable and time-limited goals and objectives for the unmet needs addressed by the Plan which allow for evaluation of Plan implementation; and

(e) a description of and a time-line for the process of evaluating successful implementation of the Community Benefit Program Plan.

(f) Applicants must commit to implementation of the Community Benefit Program Plan and continuing commitment to the Plan as a condition of CON approval, and as an ongoing condition of providing obstetric services.

(g) Applicants must agree to submit an Annual Report to the Commission which will include:

(i) an evaluation of the achievement of the goals and objectives of the Community Benefit Program Plan; and

(ii) information on staffing levels and the total costs of any programs implemented as part of the Community Benefit Program Plan.

Inapplicable, this project does not involve a new obstetric service.

Section .04(7) - <u>Source of Patients</u>. An applicant for an obstetric service shall demonstrate that the majority of its patients will come from its primary service area.

In CY 2011, 64.3 percent of MHE's OB admissions came from its primary service area.

MHE does not anticipate that this will change at the new facility.

Section .04(8) - <u>Staffing</u>. Each applicant shall provide information on the proposed staffing, associated number and type of FTEs, projected expenses per FTE category and total expenses for labor and delivery, post-partum and nursery services, including nurse staffing, non-nurse staffing and physician coverage, at year three and at maximum projected volumes.

Staffing at third-year projected volumes is estimated to be:

Employee Category	FTE	FTE Replacement Factor	Total Expense	Comments
Staff Nurse (RN)	24.6	18.6%	$3,070,347	All RNs are cross-trained to L&D, Nursery, Post-partum, and outpatient testing/triage. This is an LDRP unit.
Per diem RN	4.575			These are the replacement factor FTEs
Clinical Coordinators	2.4			
Nurse Practitioner	0			
Surgical Technician (ST)	4.2	14.28%	$258,959	
Per Diem ST	0.6			These are the replacement factor FTEs
Nurse Manager	1.0		$124,237	Includes benefits
Unit Secretary (US)	2.8	3.6%	$107,266	
Per diem US	0.1			These are the replacement factor FTEs
Lactation Consultant	1.0		$92,674	
Midwife	2			Not a part of the nursing staff. Credentialed through the Medical staff office and employed by private physician practices.
Overtime			$34,161	All employee categories
On-Call			$12,302	All employee categories
TOTAL	41.775		$3,699,946	Midwives not included in total

Section .04(9) - <u>Non-metropolitan Jurisdictions</u>. A proposed obstetrics program in non-metropolitan jurisdictions, as defined in the chapter, shall demonstrate that physicians with admitting privileges to provide obstetric services have offices for patient visits within the primary service area.

All of the obstetricians practicing at MHE have offices in Easton, which is within the primary service area.

Section .04(10) - Designated Bed Capacity. An applicant shall designate a number of the beds from within the hospital's licensed acute care beds that will comprise the proposed obstetric program.

The replacement hospital will have 14 obstetric beds.

Section .04(11) - Minimum Volume.

(a) An applicant for an obstetrics program must be able to demonstrate to the Commission's satisfaction that the proposed program can achieve a minimum volume of 1,000 admissions annually in metropolitan jurisdictions, or 500 cases annually in non-metropolitan jurisdictions, within 36 months of initiation of the program.

(b) As a condition of approval, the applicant shall accept a requirement that it will close the obstetric program, and its authority to operate will be revoked, if:

(i) it fails to meet the minimum annual volume for any 24 consecutive month period, and

(ii) it fails to provide good cause for its failure to attain the minimum volume, and a feasible corrective action plan for how it will achieve the minimum volume within a two-year period.

Inapplicable. MHE is not applying for a new OB service.

Section .04(12) - Impact on the Health Care System.

(a) An application for a new perinatal program will be approved only if its likely impact on the volumes of obstetric discharges at any existing obstetric program, after the three year start-up period, will not exceed 20 percent of an existing program's current or projected volume.

(b) When determining whether to approve an application for an obstetrics program the Commission will consider whether an existing program's payer mix of obstetrics patients will significantly change as a result of the proposed program, and the existing program will have to

care for a disproportionate share of the indigent obstetrics patients in its service area; and

(c) When determining whether to approve an application for an obstetrics program the Commission will also consider the impact on a hospital with an existing program that has undertaken a capital expenditure project for which it has pledged pursuant to H-G Article §19-123(k) not to increase rates for that project, so long as the pledge was based, at least in part, on assumptions about obstetric volumes.

Inapplicable. MHE is not applying for a new perinatal program.

Section .04(13) - <u>Financial Feasibility</u>.

Hospitals applying for a Level I or II perinatal program must clearly demonstrate that the hospital has the financial and non-financial resources necessary to implement the project, and that the average charge per admission for new perinatal programs will be less than the current statewide average charge for Level I and Level II perinatal programs. When determining whether to approve an application for an obstetric program, the Commission will consider the following:

(a) the applicant's projected sources of funds to meet the program's total expenses for the first three years of operation,

(b) the proposed unit rates and/or average charge per case for the perinatal services,

(c) evidence that the perinatal service will be financially feasible at the projected volumes and at the minimum volume standards in the Plan, and

(d) the written opinions or recommendations of the HSCRC.

Inapplicable. MHE is not applying for a new perinatal program.

COMAR 10.24.09 INPATIENT REHABILITATION SERVICES

COMAR 10.24.09(D)(1) - Licensure, Certification, and Accreditation.

Unless otherwise exempted by an appropriate waiver, each applicant shall be able to demonstrate ongoing compliance with all federal, state, and local health and safety regulations.

MHE is in compliance with all applicable regulations, accreditation standards, and certification standards. A copy of the hospital's most recent Joint Commission and CARF accreditation certificates are attached as **Exhibit 16**.

COMAR 10.24.09(D)(2) - Transfer and Referral Agreements.

> **Each applicant shall provide documentation prior to licensure that the facility will have written transfer referral agreements with facilities, agencies, and organizations that:**
>
> **Are capable of managing cases which exceed its own capabilities; and**
>
> **Provide alternative treatment programs appropriate to the needs of the persons it serves.**

MHE has written transfer policies in place to ensure the appropriate treatment of patients requiring transfers to other facilities. The hospital also has established written transfer agreements with other healthcare facilities to ensure the continuum of care for patients requiring transfer to another facility or entity. Internal policies regarding patient transfers to other facilities and examples of patient transfer agreements with other facilities can be found in **Exhibit 17.**

All area transfer facilities and agencies have had a long standing relationship with MHE to admit patients even at times of higher census. Many facilities now employ nurses and others to serve as onsite evaluators and liaisons between their facility and MHE. This typically optimizes the knowledge of each other's occupancy status and needs as well as teamwork on individual referrals.

Communication and collaboration between MHE and area SNFs and Home Health agencies is regularly and effectively addressed by way of the Continuum of Care (COC) Committee held quarterly at MHE. This committee includes representation by administrators, directors of nursing, and sometimes medical directors from all SNF/LTC facilities, Home Health agencies, Hospice, and other services throughout the Talbot, Dorchester and Caroline Counties. The committee serves many purposes largely involving information sharing pertaining to changes and new services.

COMAR 10.24.09(D)(3) - <u>Research</u>.

Each applicant shall demonstrate in what ways, if any, it intends to address research projects.

(a) Prior to initiation of the research, the research proposal shall be:

(i) Reviewed by each participating institution's Institutional Review Board (IRB) or an equivalent institutional body such as an ethics committee, consistent with the U.S. Department of Health and Human Services guidelines on the protection of human subjects, 45 CFR 46, and

(ii) If a participating institution does not have an IRB, the proposal shall have written documentation from that institution on its institutional readiness to support the patient care protocol;

(b) The research proposal shall receive a majority of its funding from the participating institution or a federal agency, other public

agency, or private nonprofit foundation that has authority over research on human subjects; and

(c) The funding agency, foundation, or institution has no financial affiliation with entities that stand to gain economically from the conduct or outcome of the trial.

The Requard Center for Acute Rehabilitation does not currently pursue research studies. However, the Center has collected substantial data and benchmarked it against national databases, such as UDSMR, through use of its FIM outcomes methodology, Med Tel post discharge follow-up databases, NDNQI nursing database, and satisfaction databases such as Healthstream. Further, the Requard Center participates as a member of the UMMS Post Acute study group which uses additional internal databases for data collection and analysis specific to improvements in falls prevention, infection control, clinical outcomes, efficiency, and hospital readmissions.

In lieu of formal research projects and investigations, the program periodically reviews, analyzes, and acts on its clinical outcomes information as well as health and safety practices and other indicators of program performance through an interdisciplinary Program Evaluation process, as required by CARF. This process requires ongoing involvement by not only members of the program, itself, but also various other "stakeholders" including patients, physicians/ medical staff, medical peer review organizations, payers, other healthcare providers, community members and organizations, and others. These ongoing relationships, especially with physicians and other providers, are intended to result in a number of reviews and potential research investigations of effectiveness, efficiency, and other indicators of contributory beneficial performance by the program to the community.

The Requard Center has recently had outcomes projects accepted for presentation at national rehabilitation meetings,

SHS has an established Institutional Review Board and a Nursing Research Council that serves to facilitate proper oversight/support of research or collaborative projects with other providers. Furthermore, ongoing collaboration among UMMS, its Kernan Hospital, and UMSOM, the Requard Center has begun preliminary work on research in the area of stroke recovery and rehabilitation.

10.24.01.08G(3)(b). Need.

For purposes of evaluating an application under this subsection, 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.

Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. For applications proposing to address the need of special population groups identified in this criterion, please specifically identify those populations that are underserved and describe how this Project will address their needs.

MHE is located in Easton, Talbot County and is the only hospital in Talbot County. As shown previously, both its Primary and Secondary Service Areas include Zip Codes in Talbot, Dorchester, Caroline, and Queen Anne Counties. According to Claritas data, the population in MHE's Primary Service Area ("PSA") is projected to grow by 5.3% between 2012 and 2017. The PSA's 65+ population is projected to grow by 16.8%. The total population in the Secondary Service Area ("SSA") is projected to grow by 3.8%, while the 65+ population is expected to grow by 18.1%. In total, the service area is projected to grow by 4.7%, with the 65+ population growing by 17.3%.

Table 20
MHE's PSA & SSA Population
By Age Cohort
2012 and 2017

	0-14			15-64			65+			Total		
	2012	2017	% Change	2012	2017	% Change	2012	2017	% Change	2012	2017	% Change
Primary Service Area												
21601	4,103	4,335	5.7%	14,627	15,121	3.4%	5,437	6,307	16.0%	24,167	25,763	6.6%
21613	3,092	3,279	6.0%	11,205	11,037	-1.5%	3,482	3,902	12.1%	17,779	18,218	2.5%
21617	2,011	2,082	3.5%	6,969	7,665	10.0%	1,476	1,919	30.0%	10,456	11,666	11.6%
21629	1,704	1,843	8.2%	6,579	6,676	1.5%	1,536	1,808	17.7%	9,819	10,327	5.2%
21632	1,457	1,516	4.0%	4,190	4,085	-2.5%	861	962	11.7%	6,508	6,563	0.8%
21639	964	1,028	6.6%	3,090	3,138	1.6%	485	596	22.9%	4,539	4,762	4.9%
21655	960	984	2.5%	3,490	3,442	-1.4%	671	794	18.3%	5,121	5,220	1.9%
Subtotal	14,291	15,067	5.4%	50,150	51,164	2.0%	13,948	16,288	16.8%	78,389	82,519	5.3%
Secondary Service Area												
21619	1,109	1,085	-2.2%	4,033	4,185	3.8%	927	1,146	23.6%	6,069	6,416	5.7%
21625	492	505	2.6%	1,749	1,754	0.3%	435	525	20.7%	2,676	2,784	4.0%
21638	860	855	-0.6%	3,307	3,433	3.8%	918	1,105	20.4%	5,085	5,393	6.1%
21643	1,159	1,287	11.0%	4,009	4,091	2.0%	827	972	17.5%	5,995	6,350	5.9%
21654	137	133	-2.9%	702	657	-6.4%	352	372	5.7%	1,191	1,162	-2.4%
21658	699	676	-3.3%	2,508	2,532	1.0%	608	729	19.9%	3,815	3,937	3.2%
21660	941	1,012	7.5%	2,606	2,663	2.2%	442	532	20.4%	3,989	4,207	5.5%
21663	425	427	0.5%	1,843	1,735	-5.9%	1,093	1,155	5.7%	3,361	3,317	-1.3%
21666	2,755	2,626	-4.7%	8,242	8,389	1.8%	1,344	1,687	25.5%	12,341	12,702	2.9%
21671	77	71	-7.8%	469	440	-6.2%	207	228	10.1%	753	739	-1.9%
21673	595	602	1.2%	2,101	2,080	-1.0%	617	727	17.8%	3,313	3,409	2.9%
Subtotal	9,249	9,279	0.3%	31,569	31,959	1.2%	7,770	9,178	18.1%	48,588	50,416	3.8%
Total	23,540	24,346	3.4%	81,719	83,123	1.7%	21,718	25,466	17.3%	126,977	132,935	4.7%

There are two hospitals located in the PSA and SSA, MHE and DGH in Cambridge, Dorchester County. Since DGH is part of SHS, services at both MHE and DGH are coordinated. In 1996, Obstetrical Services were consolidated at MHE, and Psychiatric Services were consolidated at DGH. Chester River Hospital Center, in Chestertown, Kent County, is also part of the UMMS system. In 2012, inpatient Obstetrical services were also consolidated into MHE, and Chester River closed its inpatient OB Unit. In addition, Chester

River closed its inpatient Pediatric Unit, and children requiring inpatient admission are referred to MHE. MHE has become a regional medical center serving the five county Mid-Shore area.

As discussed above, the inpatient component of the existing MHE was constructed in the late 1970s and mid 1980s and is in need of substantial redesign and upgrade. Though the outpatient component is newer, it was designed to be an addition to the older building components and, therefore, suffers from considerable limitations. As explained in the Project Description, SHS engaged The Schachinger Group (TSG) to conduct departmental interviews, meeting with representatives from many clinical and service-oriented departments. The Project Description includes a summary of the findings on deficiencies in existing physical space that affect nearly every department in the hospital. The primary need for this project is the need to replace an aged, problematic building with a modern, state of the art facility that is more convenient for the entire service area.

Need for Acute Inpatient Beds

MHE is currently licensed for 112 acute inpatient beds. MHE is not proposing a change in the total number of beds at the new facility. MHE will exercise its right to reconfigure the number of beds in each service within the 112 bed total.

Service	Current Licensed Beds	Beds to be Added or Reduced	Total Beds if Project is Approved
M/S/G/A	77 Beds	5	82
Pediatrics	8 Beds	–2	6
Obstetrics	17 Beds	–3	14
ICU/CCU Care	10 Beds	–	10
TOTAL BEDS	112 Beds	–	112

According to the most recent MSGA bed Need projections in the Acute Care Chapter of the State health Plan (COMAR 10.24.10.04), (published in the Maryland Register, Date: March 26, 2010, Volume 37 • Issue 7 • Pages 589-591) the minimum MSGA bed need in Talbot County in 2018 is 126 beds, and the maximum MSGA bed need is 136. The proposed additional MSGA 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 the Acute Inpatient Services Chapter.

Similarly, the Commission's bed need projections for Pediatric beds show a both a minimum and maximum need for 7 beds in Talbot County in 2018. The proposed 6 Pediatric beds at the new facility beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology.

Obstetrical Bed Need

MHE is proposing to reduce its number of Obstetrical ("OB") beds from its current 17 beds to 14.

There is a need for 14 OB beds. Table 21 shows the number of OB admissions at MHE by Zip Code in CY 2011 by Zip Code in MHE's PSA and SSA. MHE also shows the female population age 15-44 in 2011 (interpolated from the difference between 2000 and 2012 using the CAGR) and the resultant use rate per 1,000 population. MHE then applied that use rate times the projected 2017 female 15-44 population to calculate the projected number of admissions from each Zip Code in the PSA and SSA. MHE projects 1,163 OB admissions in 2017. MHE then multiplied this times the CY 2011 OB average length of stay of 2.26 days to project 2,623 patient days. Therefore the Average Daily Census ("ADC") in

2017 will be 7.19 (2,623/365=7.19). MHE used the following methodology to project bed need:

$$ADC + 2.33(\sqrt{ADC}) = \text{Bed Need}^{3}$$

$$7.19 + 2.33(\sqrt{7.19}) = 13.4 \text{ Beds}$$

Table 21
OB Admissions, Female Age 15-44 Population,
And Projected 2017 OB Bed Need

Zip Code	Admissions #	Admissions %	2011 Pop Female 15-44	Adm/1,000	2017 Pop Female 15-44	2017 Adm
Primary Service Area						
21601	221		3,869	57	3,949	226
21629	105		1,793	59	1,773	104
21613	204		3,221	63	3,096	196
21655	61		956	64	889	57
21632	69		1,298	53	1,249	66
21617	32		1,870	17	2,028	35
21639	65		945	69	922	63
Subtotal	757	64.2%	13,952	54	13,906	747
Secondary Service Area						
21663	19		422	45	409	18
21660	34		754	45	754	34
21643	54		1,200	45	1,214	55
21625	16		464	34	461	16
21673	33		532	62	517	32
21638	11		833	13	841	11
21666	7		2,220	3	2,145	7
21658	6		598	10	586	6
21671	7		104	67	90	6
21619	8		1,102	7	1,083	8
21654	7		142	49	131	6
Subtotal	202	17.1%	8,370	24	8,231	199
PSA&SSA	959	81.3%				946
All Other Zip Codes	220	18.7%				217
Total	1,179	1.0000				1,163

3 This formula has been used by the Commission in the past and many other health planning agencies to assure that there will be an available bed for OB patients 99 percent of the time.

ALOS	2.26
Pt. Days	2,623
ADC	7.19
Sq.Rt ADC	2.68
2.33XSqRt	6.25
Beds	13.43

Need for Special Hospital – Rehabilitation Beds

MHE currently has 20 Special Hospital – Rehabilitation beds in its inpatient rehabilitation unit (the "Requard Center"). MHE is proposing to reduce the number of inpatient rehabilitation beds at the new facility to 14. The State Health Plan (COMAR 10.24.09 Inpatient Rehabilitation Services) does not include any bed need projections. Because MHE seeks only to relocate its existing inpatient rehabilitation beds, not increase the number of beds in its region, it is not necessary to demonstrate need for the beds. Nevertheless, MHE prepared a bed need analysis, which is described below.

The Requard Center serves the five county mid-Shore Region. The data on admissions in CY 2011 in Table 22 below show that Talbot, Dorchester, Caroline, Queen Anne's, and Kent counties provided 482 admissions, or 96%, of the Requard Center's 502 admissions. (482/502 = 0.96).

Table 22
Requard Center Admissions CY2011

County	CY 2011
Anne Arundel, MD	2
Caroline, MD	94
Dorchester, MD	106
Kent, MD	8
Prince Georges, MD	1
Queen Anne's, MD	50
Somerset, MD	1
Talbot, MD	224
Wicomico, MD	3
DE	7
PA	1
VA	1
Other States	4
TOTAL	502

MHE has calculated inpatient rehabilitation bed need for 2018 and 2020 using the following methodology. (See **Exhibit 18**.)

MHE calculated the total number of rehabilitation admissions (to any Maryland provider) from each of the five counties for the years 2007, 2008, 2009, 2010, and 2011. The data were aggregated into the following age cohorts: 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, and 75+.

Using Maryland Department of Planning ("MDP") population projections, MHE calculated the 2007, 2008, 2009, 2010, 2011, 2018, and 2020 population in the age cohorts listed above for each of the five mid-shore counties. MDP population projections are provided in five year intervals (2010, 2015, and 2020). MHE calculated the population in interim years by using the Compound Average Growth Rate ("CAGR") for the relevant years. For example, to obtain the population for 2011, MHE calculated the CAGR for the change in population between 2010 and 2015 and multiplied it by the 2010 population and added it to the 2010 population. To obtain population estimates for 2007-2009, MHE had to use the same CAGR between 2010 and 2015 and subtract the result from the 2010 population because MDP did not provide population estimates for 2005 in its most recent update.

MHE then divided the number of inpatient rehabilitation cases in 2007-2011 (by county and age cohort) by the relevant population to obtain use rates. MHE then calculated the average use rate for the five year period (by county and age cohort). MHE multiplied the average use rate times the projected population of each county by age cohort.

In CY 2011, there were 652 rehabilitation admissions in the five county region (to any Maryland provider). This is projected to grow to 771 in 2018 and 810 in 2020.

MHE applied the 2011 average length of stay at the Requard Center to calculate the total number of expected patient days. MHE then divided the expected patient days by 365 to obtain the average daily census and divided the result by 85% occupancy to obtain the projected number of needed beds. Based on these calculations, there will be 22.5 rehabilitation beds needed to serve the five county area in 2018 and 23.7 in 2020.

In CY 2011, the Requard Center had a 74% market share in the five county region. Furthermore, in FY 2012, the Requard Center experienced a 16.16% decline in admissions due to changes it made to its admission criteria. MHE believes that this reduction will continue into the future. (MHE has to make the adjustment in this way because MHE used 2011 data for its need calculations. Comparable 2012 data are not yet available.) When both factors are taken into account, the Requard Center would need 14.46 beds in 2017. MHE believes that these projections demonstrate that the proposed reduction to 14 beds is needed and is reasonable.

Table 23
Summary Calculations of Rehabilitation Bed Need
Talbot, Dorchester, Caroline Queen Anne, and Kent Countie
2018 and 2020

Age Cohorts:	**15-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**	**Total**
2011 Total	3	11	14	48	101	173	302	652
2011 ALOS	7.33	14.71	10.33	9.04	8.88	9.19	8.86	
2017 Total	5.77	11.54	15.09	41.37	80.95	199.93	398.10	752.74
2017 Pt. Days	42.28	169.86	155.92	374.03	718.94	1,837.47	3,528.83	6,827.33
							ADC	18.71
							MHE Mkt Shr	78.4%
							2012 Adj.	83.8%
							MHE ADC	12.29
							@ 85% Occ.	14.46

Emergency Department

As stated previously, MHE is not seeking an expansion in the number of treatment bays, as shown below.

	Adult		Pediatric	
	Existing	Proposed	Existing	Proposed
General	17	17	0	3
Fast Track	10	6	0	0
GYN	2	2	0	0
Resuscitation	1	2	0	0
Psych	2	2	0	0
Total	32	29	0	3
Rapid Diagnostic and other Triage	2	5	0	0
Total all treatment spaces	32	32		

MHE's ED volume grew 18% from FY 1998 through FY 2010, growing from 32,302 visits in 1998 to 38,323 visits in 2010. (38,323/32,302 = 0.18) On October 4, 2010, the Queen Anne's Emergency Center opened in Queenstown, MD, approximately 21 miles from MHE. This had an immediate and dramatic impact on MHE's ED volumes, which declined 8.4% In FY 2011. (38,323 – 35,104 = 3,219; 3,219/38,323 = 0.084) However, in FY 2012, the number of ED visits to MHE rebounded by 4.7%, increasing to 36,737 visits. (36,737 – 35,104 = 1,633; 1,633/35,104 = 0.0465) The historical volumes are shown in Table 24.

Table 24
Historical ED Volume
MHE
1998 – 2010

Year	ED Visits
FY1998 Actual	32,302
FY1999 Actual	32,532
FY2000 Actual	34,621
FY2001 Actual	35,016
FY2002 Actual	36,221
FY2003 Actual	35,053
FY2004 Actual	37,900
FY2005 Actual	37,921
FY2006 Actual	38,363
FY2007 Actual	37,319
FY2008 Actual	36,535
FY2009 Actual	38,077
FY2010 Actual	38,323
FY2011 Actual	35,104
FY2012 Actual	36,737

Source: MHE

MHE anticipates that the ED volume will continue to grow. MHE calculated the Compound Average Growth Rate ("CAGR") between 1998 and 2010 (0.014345345). This means that the volume grew at a constant rate of 1.435% per year. MHE did not include FY 2011 in the calculation because that is the fiscal year in which the Queen Anne's Emergency Center opened, an event which is not likely to occur again. The application of the CAGR to MHE's volumes after the opening of Queen Anne's Emergency Center will account for the decline caused by the opening of that facility. For example, while the FY2012 MHE ED volume was 4.6% higher than its FY 2011 volume, it is still lower than the FY 2010 volumes.

Consequently, MHE applied the 1.435% CAGR in future years through 2020 to project the number of ED visits, as shown in Table 25.

Table 25
Projected ED Volume
MHE
2013 – 2020

Year	ED Visits
2013	37,264
2014	37,799
2015	38,341
2016	38,891
2017	39,449
2018	40,015
2019	40,589
2020	41,171

The proposed ED is actually smaller than the departmental gross square feet ("DGSF") size benchmark in the American College of Emergency Physicians ("ACEP") Guide entitled *Emergency Department Design*. On pages 69-71, the Guide presents, in chart form, the factors that should be considered in planning the size of the ED. The information on the proposed Germantown hospital is presented below. The ACEP Guidelines use "Low Range" and "High Range" thresholds for certain measures to determine the appropriate size for an ED. Criteria 1-11 in Table 26 show the factors that go into determining if an ED should be planned larger or smaller. If the facts for any given hospital under the criteria fall in the "Low Range" category, the ED could be smaller than if the majority falls in the "High Range" Category. Criteria 12 and 13 show the number of DGSF and the number of treatment bays that would be required in both the high and low range categories at various projected ED volumes.

Table 26 shows that, based on the ACEP Guide, an ED at MHE's projected volumes would require between 22,238 and 29,388 DGSF. MHE's ED will be 20,096 DGSF in size. This is below the low end of the ACEP DGSF range, despite the fact that MHE anticipates that it will exceed the high end threshold in four of the eleven ACEP factors and will be

between the low and the high end thresholds in four of the factors. Therefore, MHE believes that it is using the proposed space efficiently.

Table 26
American College of Emergency Physicians ("ACEP") Guide
Emergency Department Design
"Low Range" and "High Range" Thresholds
and MHE Comparison
Emergency Department

		Low	**High**	**Existing Hospital**	**Proposed Hospital**
1	ALOS	<2.5 Hours	>3.5 Hours	6.5	**4**
2	Location of Observation Beds	Outside ED	Inside ED	N/A	*Outside*
3	Time to Admit	<60 Minutes	> 90 Minutes	2 Hours	1 Hour
4	Turnaround Time Dx Tests	<31 Minutes	> 60 Minutes	52 Min.	50 Min.
5	% Admitted Patients	< 18%	> 23%	17.00%	18.00%
6	% Nonurgent/%Urgent	>1.1/1	>1/1.1	1/1.87	**1/2**
7	Age of Patient	<20% Age 65+	>25% Age 65+	22.3%	***26-27%***
8	Admin/Teaching Space	Minimal	Extensive	Minimal	*Minimal*
9	Imaging w/n ED	No	Yes	No	*No*
10	Specialty Components	No	Yes	Yes	**Yes**
11	Flight/Trauma Services	No	Yes	No	No
	Projected DGSF			**21,220**	**20,096**
	Projected Annual Visits			36,737	41,000
12	DGSF 40,000 Visits	21,875	28,875		
	DGSF 50,000 Visits	25,500	34,000		
	DGSF Calculated at SMH Volumes	22,238	29,388		
13	Treatment Bays 40,000 Visits	25	33		
	Treatment Bays 50,000 Visits	30	40		
	Treatment Bays Calculated at Projected Volumes	26	34		
	Proposed Number of Treatment Bays				32

MHE believes that it is using its proposed space efficiently. It is not seeking an increase in ED treatment bays. The Commission should provide flexibility to MHE in the way it proposes to use its efficient footprint.

In two approved CON applications of which we are aware [Montgomery General Hospital (Docket # 06-16-21860 and University of Maryland Medical Center (Docket No. 09-

24-2300)], applicants have proposed more treatment bays than indicated by the ACEP Guidelines in less square footage than indicated by the Guidelines. The Commission approved both CON applications and provided them with flexibility in the way they used their efficient footprints, as MHE requests here.

Operating Rooms

MHE needs to replace its surgical suite. Most of the operating rooms are not sufficient in size to house the equipment necessary for contemporary complex surgery. Even some of the ENT cases now use Brain Lab equipment which take up a significant footprint. Another larger piece of equipment is the robot which consists of three very large pieces of equipment. As a result, the OR setting at MHE has no space flexibility. Although MHE staff have tried to utilize the rooms as "universal," it really is logistically impossible due to the size. Two of the operating rooms are larger (OR 1 and 6) and therefore many of the cases require MHE to use them in order to allow appropriate clearances (examples are neuro, laparoscopic chole, larger vascular cases, major ENT, all ORTHO). When the robot was acquired, in order to keep from damaging the equipment, an alcove was constructed in two of the ORs (OR 1 and 5) so it is within these two rooms that MHE focuses its current robotic surgery volume.

MHE currently has six ORs and is proposing to maintain six ORs at the new facility. Surgical volumes have been growing. Table 27 shows that the OR volumes have been exceeding the MHCC's definition of optimal capacity.

Table 27
Historical OR Volumes
MHE
2008 - 2012

	Cases			Minutes			Cleanup Minutes	Total	% of Capacity
	Inpt.	Outpt.	Total	Inpt.	Outpt.	Total	37.8	Minutes	122,400
2008	1,304	2,677	3,981	159,280	182,440	341,720	135,354	477,074	65.0%
2009	1,667	3,331	4,998	204,612	234,088	438,700	169,932	608,632	82.9%
2010	1,623	3,280	4,903	196,131	221,792	417,923	166,702	584,625	79.6%
2011	1,551	3,601	5,152	193,140	253,729	446,869	175,168	622,037	84.7%
2012	1,359	3,371	4,730	173,989	265,773	439,762	160,820	600,582	81.8%

Source: MHE, Volumes include only OR Cases,
excluding endoscopies, cystoscopies, C-sections, and other procedure room cases.

MHE used 37.8 minutes of turnaround time ("TAT") per case. SHS's Director of Surgical and Ambulatory Services has tracked the TAT on 90 percent of MHE's inpatient and outpatient OR cases in FY 2012. Cleanup time varies by specialty. Unlike urban hospitals which may have many nurses, residents, and other staff who help "turn over" an OR, MHE has a limited number of staff members who are available to do this. On average, the turnover time at MHE was 37.81 minutes in FY 2012.

Table 28
Average Turnaround Time Per Case
MHE
FY 2012

	Cases	Average TAT
ENT	255	39
GENERAL	1,251	38
GYN	733	34
NEURO	366	44
ORTHO	632	40
UROLOGY	1,066	36.5
Total	4,303	37.81

Source: MHE

MHE recognizes that the volumes declined in FY 2012. Rural hospitals face issues not faced by urban or suburban hospitals. Rural hospitals have a more difficult time

recruiting and maintaining surgeons, and volumes are sensitive to surgeon availability. OR volumes declined in FY 2012 because MHE lost two general surgeons. Temporary staff surgeons, provided by Locum Tenens, were brought in to cover after hours and on the weekends, but their volumes are very small.

However, MHE believes that its volumes will grow in the future. MHE has recruited two surgeons who will be joining the staff this year. In addition, MHE is expanding the types of surgery that it performs. Robotic surgery has recently expanded due to the addition of a second GYN surgeon who uses robotic techniques. In addition, the minimally invasive neurosurgery program has increased this year. Minimally invasive procedures take more time in the OR and require more cleanup time than non-minimally invasive cases. MHE has also recently added a breast surgeon. MHE is growing a breast surgery center of excellence and that it will be doing more complex surgery in the future. MHE also has an urologist who specializes in female urology. This program has attracted cases from around the Eastern Shore, and its volumes continue to climb.

MHE believes that the decline in volume in FY 2012 is an anomaly that was caused by the loss of two general surgeons.

As at other hospitals, surgeons desire to have "blocked" time so that they can better plan and make better use of their time. Due to the wide geographic area that MHE's physicians cover, they have offices in most of the five counties on the Mid-Shore. Using block scheduling is essential to maintaining a reliable schedule for the physicians without having to reschedule an entire office of patients. For some MHE surgeons, patients have to wait 4 - 6 weeks to obtain their surgery. Thus, the maintenance of six ORs is crucial to the ability of MHE to adequately serve the community.

MHE has been very conservative in its projections of need. It has projected future need based on the Compound Average Growth Rate ("CAGR") of inpatient and outpatient cases between 2008 and 2012, in spite of the fact that MHE believes that the decline in volumes in 2012 is an anomaly. Projections show that MHE will need 8.9 ORs in 2020.

Table 29
OR Need
MHE
Through 2020

	Cases			Minutes			Cleanup Minutes	Total	OR Need @
	Inpt.	Outpt.	Total	Inpt.	Outpt.	Total	37.810365	Minutes	97,920
2008	1,304	2,677	3,981	159,280	182,440	341,720	150,523	492,243	5.0
2009	1,667	3,331	4,998	204,612	234,088	438,700	188,976	627,676	6.4
2010	1,623	3,280	4,903	196,131	221,792	417,923	185,384	603,307	6.2
2011	1,551	3,601	5,152	193,140	253,729	446,869	194,799	641,668	6.6
2012	1,359	3,371	4,730	173,989	265,773	439,762	178,843	618,605	6.3
2013	1,373	3,571	4,944	175,795	281,539	457,334	186,937	644,272	6.6
2014	1,387	3,783	5,170	177,620	298,240	475,860	195,486	671,346	6.9
2015	1,402	4,007	5,409	179,464	315,932	495,396	204,515	699,912	7.1
2016	1,416	4,245	5,661	181,327	334,673	516,001	214,053	730,054	7.5
2017	1,431	4,497	5,928	183,210	354,527	537,737	224,130	761,867	7.8
2018	1,446	4,763	6,209	185,112	375,557	560,669	234,778	795,448	8.1
2019	1,461	5,046	6,507	187,034	397,836	584,870	246,030	830,900	8.5
2020	1,476	5,345	6,821	188,976	421,436	610,411	257,921	868,333	8.9

The proposed ORs are approx. 620 square feet and are universal in type, centered around a central core. A robot alcove will be built into one of the hallways around the periphery. The size and suspending monitoring equipment from the wall will allow a greater footprint to accommodate equipment. The clearances around the equipment will provide for a safer environment for the staff, but also for the patients as the infection control exposure risk that results from performing complex surgery in a limited space will be reduced. The universality of the ORs will allow flexibility in not just the type of cases performed, but also will afford the opportunity to use them to decrease turnover and get

patients to surgery more expeditiously. Likewise, the opportunity for the offices to schedule freely rather than posting staff having to consider the size of the room will facilitate expeditious movement of patients.

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY

	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
1. Admissions								
a. M\S/G/A	7,111	7,052	6,280	6,119	6,070	6,022	5974	5950
b. Pediatric	475	320	285	253	255	257	259	262
c. Obstetric	1,145	1,096	1,007	970	1,018	1,066	1114	1162
d. Intensive Care	360	356	317	317	319	321	323	326
e. Coronary Care								
f. Psychiatric	-	-	-	-				
g. Rehabilitation	656	599	444	459	459	459	459	459
h. Chronic								
i. Other (Nursery)	1,091	1,096	1,007	970	1,018	1,066	1114	1162
j. TOTAL	10,838	10,518	9,340	9,087	9,139	9,191	9,243	9,321

Table 1 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
2. Patient Days								
a. M\S/G/A	25,105	26,193	24,818	23,946	23,893	23,844	23,795	23,866
b. Pediatric	830	644	610	563	566	571	575	582
c. Obstetric	2,528	2,421	2,177	2,199	2,301	2,409	2,518	2,626
d. Intensive Care	1,538	1,567	1,485	1,618	1,627	1,637	1,647	1,663
e. Coronary Care								
f. Psychiatric	-	-	-	-				
g. Rehabilitation	5,010	4,640	3,890	3,899	3,897	3,897	3,897	3,897
h. Chronic								
i. Other (Nursery)	2,213	2,421	2,177	2,199	2,301	2,409	2,518	2,626
j. TOTAL	37,224	37,885	35,157	34,424	34,584	34,767	34,950	35,260

Table 1 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
3. Average Length of Stay								
a. M\S/G/A	3.53	3.71	3.95	3.91	3.94	3.96	3.98	4.01
b. Pediatric	1.75	2.01	2.14	2.22	2.22	2.22	2.22	2.22
c. Obstetric	2.21	2.21	2.16	2.27	2.26	2.26	2.26	2.26
d. Intensive Care	4.27	4.4	4.68	5.1	5.1	5.1	5.1	5.1

e. Coronary Care	-	-	-	-	-	-	-	-
f. Psychiatric	-	-	-	-	-	-	-	-
g. Rehabilitation	7.64	7.75	8.76	8.50	8.49	8.49	8.49	8.49
h. Chronic	-	-	-	-	-	-	-	-
i. Other (Specify)	2.03	2.21	2.16	2.27	2.26	2.26	2.26	2.26
j. TOTAL	3.43	3.6	3.76	3.79	3.78	3.78	3.78	3.78

Table 1 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
4. Occupancy Percentage*								
a. M\S/G/A	76%	84%	84%	85%	85%	85%	80%	80%
b. Pediatric	28%	22%	21%	19%	19%	20%	26%	27%
c. Obstetric	41%	39%	35%	35%	37%	39%	49%	51%
d. Intensive Care	42%	43%	41%	44%	45%	45%	45%	46%
e. Coronary Care	-	-	-	-	-	-	-	-
f. Psychiatric	-	-	-	-	-	-	-	-
g. Rehabilitation	69%	64%	53%	53%	53%	53%	76%	76%
h. Chronic	-	-	-	-	-	-	-	-
i. Other (Specify)	34%	37%	33%	33%	35%	37%	38%	40%
j. TOTAL	63%	66%	63%	63%	63%	64%	66%	67%
5. Number of Licensed Beds								
a. M\S/G/A	90	85	81	77	77	77	82	82
b. Pediatric	8	8	8	8	8	8	6	6
c. Obstetric	17	17	17	17	17	17	14	14
d. Intensive Care	10	10	10	10	10	10	10	10
e. Coronary Care								
f. Psychiatric								
g. Rehabilitation	20	20	20	20	20	20	14	14
h. Chronic								
i. Other (Nursery)	18	18	18	18	18	18	18	18
j. TOTAL	163	158	154	150	150	150	144	144

Table 1 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
6. Outpatient Visits								
a. Emergency	31,837	35,104	36,737	37,264	37,799	38,341	38,891	39,449
b. Outpatient dept.	20,998	23,953	22,365	22,589	22,995	23,432	23,877	24,331

c. Other (Observation)	-	550	1,146	1,311	1,335	1,360	1,386	1,412
d. TOTAL	52,835	59,607	60,248	61,164	62,129	63,133	64,154	65,192

* Number of beds and occupancy percentage should be reported on the basis of licensed beds.

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT

Note: MHE is not providing Table 2 (which would be the same as Table 1) based on conversations with CON Staff on other projects. MHE recognizes that CON Staff has the right to request MHE to complete Table 2.

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20____	20____
1. Admissions				
a. M/S/G/A				
b. Pediatric				
c. Obstetric				
d. Intensive Care				
e. Coronary Care				
f. Psychiatric				
g. Rehabilitation				
h. Chronic				
i. Other (Specify)				
j. TOTAL				
2. Patient Days				
a. M/S/G/A				
b. Pediatric				
c. Obstetric				
d. Intensive Care				
e. Coronary Care				
f. Psychiatric				
g. Rehabilitation				
h. Chronic				
i. Other (Specify)				

Table 2 cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20____	20____
3. Average Length of Stay				
a. M/S/G/A				
b. Pediatric				
c. Obstetric				
d. Intensive Care				
e. Coronary Care				
f. Psychiatric				
g. Rehabilitation				
h. Chronic				
i. Other (Specify)				
4. Occupancy Percentage*				
a. M/S/G/A				
b. Pediatric				
c. Obstetric				
d. Intensive Care				
e. Coronary Care				
f. Psychiatric				
g. Rehabilitation				
h. Chronic				
i. Other (Specify)				

Table 2 cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20____	20____
5. Number of Licensed Beds				
a. M/S/G/A				
b. Pediatric				
c. Obstetric				
d. Intensive Care				
e. Coronary Care				
f. Psychiatric				
g. Rehabilitation				
h. Chronic				
i. Other (Specify)				

(INSTRUCTION: All applicants should complete this table.)

10.24.01.08G(3)(c). - <u>Availability of More Cost-Effective Alternatives</u>.

For purposes of evaluating an application under this subsection, the Commission shall compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly or a more effective alternative for meeting the needs identified.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project which will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics that the Commission should take into account.

See Section .06B(3) above.

10.24.01.08G(3)(d). Viability of the Proposal.

For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and non-financial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Please include in your response:

a. Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented.

b. Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility.

c. A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.

d. All applicants shall provide a detailed list of proposed patient charges for affected services.

Audited Financial Statements are included in **Exhibit 19.**

Any additional volumes for the Hospital are the result of population growth. This project will not result in any reduction of volumes from facilities offering similar services in the area. There will not be an impact on costs or charges at the other facilities in the area.

As stated previously, MHE is a TPR hospital. The Hospital, therefore, has the incentive to reduce length of stay, ancillary testing, unnecessary admissions and readmissions, as well as improve efficiency in the provision of services while treating patients in a manner consistent with appropriate, high quality medical care. Only hospitals in single hospital jurisdictions can participate in the TPR program.

When a hospital not on the TPR program builds a replacement facility, it is able to generate revenue to pay for the debt service on the new hospital because the new facility will generally enjoy higher volumes. This is not the case for a TPR hospital, which, essentially, is penalized for higher volumes. Consequently, MHE will seek a rate increase, raise its assured revenue, to enable it to have adequate revenue to cover the additional debt service. To our knowledge, MHE is the first TPR hospital to build a replacement facility.

As part of a partial rate application to be filed with the Health Services Cost Review Commission (HSCRC) in September 2012, MHE is requesting an increase in rates from the HSCRC to account for the increase in capital costs associated with the proposed project.

The total cost of the project is $283 million of which $243 million will be funded through debt. Depreciation and interest expense (i.e. capital costs) related to the Project are projected to equal $20.6 million by FY17. This cost will be phased in over two years as components of the project become operational in FY16.

As presented and justified in MHE's partial rate application, MHE is requesting 85% funding of these costs. Applying MHE's RY 2012 mark-up of 1.1230 results in gross revenue related to the project of $15.9 million. This represents an overall increase in MHE's FY 2012 regulated revenue of 8.61%.

MHE has already begun discussions with the HSCRC about the requested rate increase.

(INSTRUCTIONS: Table 3, "Revenue and Expenses - Entire Facility **(including the proposed project)" is to be completed by existing facility applicants only. Applicants for new facilities should not complete Table 3. Specify whether data are for calendar year or fiscal year. All projected revenue and expense figures should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application. Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses.) Table 4,** "Revenues and Expenses - Proposed Project," **is to be completed by each applicant for the proposed project only, using the same instructions outlined above for Table 3.**

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
1. Revenue		SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE
a. Inpatient Services	$ 95,278,600							
b. Outpatient Services	65,490,600							
c. Gross Patient Services Revenues	160,769,200	173,497,318	184,253,259	186,220,528	188,470,949	190,748,565	203,306,578	216,034,133
d. Allowance for Bad debt	4,236,594	5,391,828	7,101,833	8,021,144	8,118,785	8,217,096	8,746,289	9,282,621
e. Contractual Allowance	16,378,961	18,633,681	21,768,847	22,001,273	22,267,152	22,536,244	24,019,927	25,523,641
f. Charity Care	2,739,281	3,674,124	2,924,725	3,348,098	3,390,605	3,432,152	3,624,059	3,818,541
g. Net Patient Services Revenue	137,414,364	145,797,685	152,457,854	152,850,013	154,694,407	156,563,073	166,916,302	177,409,330
h. Other Operating Revenues (Specify)	1,806,811	4,140,354	1,973,877	2,750,365	2,750,365	2,750,365	2,750,365	2,750,365
i. Net Operating Revenues	139,221,175	149,938,039	154,431,731	155,600,378	157,444,772	159,313,438	169,666,667	180,159,695

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
2. Expenses								
a. Salaries, Wages. And Professional Fees, (including fringe benefits)	$ 71,411,890	$ 74,253,305	$ 74,204,911	$80,557,061	$ 81,088,310	$ 81,628,524	$ 82,642,973	$ 83,299,016
b. Contractual Services	24,456,064	24,608,309	26,679,222	28,588,038	29,284,784	29,486,272	30,859,909	29,873,118
c. Interest on Current Debt	2,186,211	2,778,462	3,616,202	4,114,645	3,537,700	3,432,358	3,325,967	3,208,819
d. Interest on Project Debt	-	-	-				5,170,889	10,124,579
e. Current Depreciation	11,944,011	10,750,217	10,246,329	11,296,978	10,755,019	4,639,046	5,205,469	6,078,099
f. Project Depreciation							5,247,948	10,495,895
g. Current Amortization								
h. Project Amortization					97,900	106,800	106,800	106,800
i. Supplies	23,190,072	26,490,957	27,988,639	29,270,553	28,854,957	28,277,541	27,664,977	27,896,842
j. Other Expenses (Impairment Loss)					46,669,784			
k. Total Operating Expenses	133,188,248	138,881,250	142,735,303	153,827,275	200,288,454	147,570,541	160,224,932	171,083,168
3. Income								
a. Income from Operation	6,032,927	11,056,789	11,696,428	1,773,103	(42,843,682)	11,742,897	9,441,735	9,076,527
b. Non-Operating Income	8,472,033	7,960,026	(836,760)	7,215,807	5,947,522	6,299,798	6,553,370	6,855,417

c. Subtotal	14,504,960	19,016,814	10,859,668	8,988,910	(36,896,160)	18,042,695	15,995,105	15,931,944
d. Income Taxes								
e. Net Income (Loss)	$ 14,504,960	$ 19,016,814	$ 10,859,668	$ 8,988,910	$ (36,896,160)	$ 18,042,695	$ 15,995,105	$ 15,931,944

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
4. Patient Mix:								
A. Percent of Total Revenue								
1) Medicare	48.8%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%
2) Medicaid	15.9%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%
3) Blue Cross	14.9%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%
4) Commercial Insurance	16.6%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%
5) Self Pay	3.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%
6) Other (Managed care)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B. Percent of Patient Days\Visits\Procedures (as applicable)								
1) Medicare	48.8%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%
2) Medicaid	15.9%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%
3) Blue Cross	14.9%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%
4) Commercial Insurance	16.6%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%
5) Self Pay	3.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%
6) Other (Managed care)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

(INSTRUCTION: ALL APPLICANTS OPERATING EXISTING FACILITIES MUST SUBMIT THEIR MOST RECENT AUDITED FINANCIAL STATEMENTS)

NOTE: Memorial Hospital Easton is a TPR hospital. TPR does not distinguish between Inpatient and Outpatient

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTION: Each applicant should complete this table for the proposed project only)

Note: MHE is not providing Table 4 based on conversations with CON Staff on other projects. MHE recognizes that CON Staff has the right to request MHE to complete Table 4.

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20____	20____
1. Revenues				
a. Inpatient Services				
b. Outpatient Services				
c. Gross Patient Service Revenue				
d. Allowance for Bad Debt				
e. Contractual Allowance				
f. Charity Care				
g. Net Patient Care Service Revenues				
h. Other Operating Revenues (Specify)				
i. Net Operating Revenue				
2. Expenses				
a. Salaries, Wages and Professional Fees (including fringe benefits)				
b. Contracted Services				
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation				
g. Current Amortization				
h. Project Amortization				
i. Supplies				
j. Other Expenses (Specify)				
k. Total Operating Expenses				

Table 4 cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20____	20____
3. Income				
a. Income from Operation				
b. Non-Operating Income				
c. Subtotal				
d. Income Taxes				
e. Net Income (Loss)				
4. Patient Mix: **A. Percent of Total Revenue**				
1) Medicare				
2) Medicaid				
3) Blue Cross				
4) Commercial Insurance				
5) Self-Pay				
6) Other (Specify)				
7) TOTAL	100%	100%	100%	100%
B. Percent of Patient Days\Visits\Procedures (as applicable)				
1) Medicare				
2) Medicaid				
3) Blue Cross				
4) Commercial Insurance				
5) Self-Pay				
6) Other (Specify)				
7) TOTAL	100%	100%	100%	100%

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

To meet this subsection, an applicant shall demonstrate compliance with all conditions applied to previous Certificates of Need granted to the applicant.

List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1990, and their status.

MHE has had two CONs since 1990. They are attached at **Exhibit 20.**

- In July 2003, MHE received a CON for the "Capital Renovation and Expansion to Memorial Hospital at Easton." 03-20-2112
- In September 2005, MHE received a CON for the "Establishment of a Twenty-Bed Acute Inpatient Rehabilitation Unit at The Memorial Hospital at Easton." 03-20-2128

There were no specific Conditions placed on either CON. Both projects were completed as approved.

10.24.01.08G(3)(f). Impact on Existing Providers.

For evaluation under this subsection, an applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.

Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.

Complete Table 5

---

1. **An assessment of the sources available for recruiting additional personnel;**

2. **Recruitment and retention plan for those personnel believed to be in short supply;**

   For existing facilities, a report on average vacancy rate and turnover rates for affected positions,

The proposed project will have no negative effects on other providers and will have positive effects on the health care system as a whole.

- This project will have no impact on the cost and charges of other providers. The project does not include any new services.

- The project will improve geographic or demographic access, as discussed previously. (See Standard .04B(1) – Geographic Accessibility)

- The project will address and resolve considerable deficiencies in the current site. (See 10.24.01.08G(3)(b), Need)

- MHE believes that the project will assist MHE in recruiting and retaining physicians, which is a challenge in a rural area.

- The existing MHE has 38 semi-private rooms. (See **Exhibit 21**, Physical Bed Chart). The new MHE, of course, will have all private rooms. Higher occupancy rates than are achievable with semi-private rooms. Private rooms also enhance

patient satisfaction and family involvement, reduce the risk of infection, and reduce the need for transfers due to patient incompatibility.

Copies of letters of support will be submitted to the Commission.

MHE utilizes various recruitment strategies as listed:

- Succession planning – promote from within
- Workforce development - this is part of the HR Strategic Plan
- Offer various scheduling options through Supplemental Staffing (Relief, Per Diem, Short Term Assignment, and Float pool)
- Relocation assistance
- Tuition Reimbursement
- Employee Referrals
- Shared Governance (chaired by a staff nurse; nurses participate in unit & hospital committees)
- Professional Advancement Program - Provides professional opportunities for nurses who demonstrate advance nursing knowledge
- Career Fairs - An alumnus sometimes attends a career fair with recruiters when possible
- Critical Care /Graduate University - 4 - 9 month Residency program for New RN Graduates
- Meet monthly with nursing leadership to review vacancy, turnover, new initiatives and strategies to fill future needs.
- Awareness of generational needs - College graduates thrive on quick delivery and constant feedback while some seasoned workers prefer face to face interaction and phone calls instead of text
- Internships
- Offer a shadow session in addition to the interview to show candidate what it is really like working here
- MHE uses fewer print ads – it uses specialty websites (i.e. nurse.com)
- Long term relationships with nursing schools – MHE is a clinical site
- Members of Maryland Association of Healthcare Recruiters and National Association of Healthcare Recruiters to stay up to date on recruitment strategies in the state & nationwide
- MHE is a Magnet organization (A designation conferred by the American Nurses Credentialing Center, recognizing environments that foster nursing retention and quality of care.)
- Personalized interviews – Return calls promptly, behavioral interviewing, assess professional development, assess Magnet qualities and cultural fit, offer SHS bag with promotional items to interviewing candidates, provide benefit summary as part of Total Rewards – the goal is to create positive and memorable impressions
- MHE rarely offers sign on bonus or utilize recruitment agencies for staff positions but do consider for difficult to fill positions

In addition to the current approaches, MHE will strengthen social networking (Facebook, Linked-in), increase employee referrals, and incorporate videos or podcast on the career website.

By 2012 year end, MHE will introduce PeopleFluent, an integrated Talent Management system. The system is currently in use at most of the UMMS hospitals. This is a state of the art, on-line recruitment and selection solution that will increase the efficiency of screening applicants, expand the pool of potential candidates by making better use of web-based recruitment tools and improve the communication between candidates, Human Resources and hiring managers thereby making the recruitment and selection process more efficient and more effective. MHE is aware of the importance of raising the hospital's profile on the career website and will utilize the Communications/Marketing Department for its expertise.

The Vacancy and Turnover Rate for Nursing at MHE for the past two years are as follows:

	Vacancy	Turnover
FY2011	3.26	8.038
FY2012	4.03	4.555

TABLE 5 MANPOWER INFORMATION

(INSTRUCTION: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project.)

(INSTRUCTION: FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours.)

Position Title	Current FTE's (FY 13 Budget)	Change In FTE's (2017 Projected)	Average Salary (@ 2080 Hrs) (incl. Benefits)	Contractual Employee Cost	Total Cost
Administration:					
Health Information Management					
Records Coordinator	20.0	0.5	47,967	Employee	982,588
Coder	11.0	0.3	65,446	Employee	737,355
Patient Accounting					
Account Representative	45.4	1.1	46,609	Employee	2,165,793
Scheduling					
Scheduler	24.6	0.6	44,938	Employee	1,130,814
Admitting					
Coordinator	1.2	0.0	111,934	Employee	137,576
Nursing Administration					
Coordinator	4.7	0.1	131,844	Employee	634,689
Other	1.0	0.0	39,206	Employee	40,156
Clinical Resource Management					
Case Manager	9.9	0.2	88,289	Employee	895,252
Social Worker	4.5	0.1	61,772	Employee	284,714
Human Resources					
Recruiter	1.8	0.0	72,861	Employee	135,425
Purchasing					
Buying Agent	1.4	0.0	51,599	Employee	73,773
Other					
Child Care Center	8.2	0.2	40,373	Employee	339,088
Management and Administrative Services	105.7	2.6	95,558	Employee	10,342,903
Physician Stipend				Contractual	48,000
Total Administration	**239.3**	**5.8**			**17,948,125**

Direct Care					
MedSurg, Ped, OB, and ICU Nursing Floors					
Tech	57.5	1.9	41,187	Employee	2,447,851
RN	156.0	5.2	102,767	Employee	16,567,049
Other	26.3	0.9	41,076	Employee	1,116,609
Physician Subsidy				Contractual	1,075,586
Physician Stipend				Contractual	339,000
Acute Rehab Nursing					
Tech	1.8	0.0	38,498	Employee	69,296
RN	11.7	0.0	101,857	Employee	1,191,730
Other	8.1	0.0	57,618	Employee	466,709
Physician Stipend				Contractual	50,000
Emergency Department					
Tech	15.5	0.9	41,118	Employee	673,012
RN	39.7	2.2	99,095	Employee	4,154,396
Other	5.9	0.3	45,703	Employee	284,747
Physician Subsidy				Contractual	1,051,000
Operating Room					
Tech	12.1	0.5	54,452	Employee	687,864
RN	29.8	1.3	97,463	Employee	3,032,177
Other	11.7	0.5	52,168	Employee	637,225
Physician Stipend				Contractual	24,000
Anesthesiology					
Other	1.0	0.0	43,996	Employee	45,932
Physician Subsidy				Contractual	1,100,000
Physician Stipend				Contractual	45,000
PACU					
RN	6.9	0.3	93,478	Employee	673,375
Sleep Center					
Tech	3.5	0.2	110,887	Employee	405,181
Other	1.0	0.0	40,991	Employee	42,795
Physician Stipend				Contractual	4,000
IV Therapy					
RN	4.7	0.2	98,377	Employee	482,714
Other	2.0	0.1	46,312	Employee	96,700
Pharmacy					
Pharmacist	12.0	0.5	151,169	Employee	1,893,850
Tech	13.2	0.6	38,848	Employee	535,357
Respiratory					
Tech	14.7	0.6	95,924	Employee	1,472,121
Other	1.0	0.0	52,733	Employee	55,053
Physician Stipend				Contractual	10,800

Speech Therapy					
Pathologist	2.2	0.1	104,523	Employee	240,068
Physical Therapy					
Therapist/Aide	15.3	0.7	80,884	Employee	1,291,977
Other	1.0	0.0	51,908	Employee	54,192
Physician Stipend				Contractual	12,000
Occupational Therapy					
Therapist/Aide	5.6	0.2	90,301	Employee	527,938
Radiology					
Tech	14.6	0.6	76,372	Employee	1,164,098
Other	14.5	0.6	48,925	Employee	740,624
Physician Stipend				Contractual	200,000
Ultrasound					
Sonographer	1.0	0.0	72,428	Employee	75,614
Nuclear Medicine					
Tech	2.0	0.1	128,467	Employee	268,240
CAT Scan					
Tech	1.9	0.1	100,283	Employee	198,922
RN	1.0	0.0	105,669	Employee	110,319
Radiology Interventional					
RN	1.1	0.0	108,267	Employee	124,333
Tech	2.5	0.1	103,492	Employee	270,115
MRI					
Tech	1.7	0.1	100,645	Employee	178,625
EKG					
Tech	3.6	0.2	37,367	Employee	140,439
Other	0.5	0.0	48,771	Employee	25,459
Cardio Ultrasound					
Tech	2.5	0.1	94,616	Employee	246,947
Diabetes Center					
RN	1.6	0.1	93,214	Employee	155,705
Tech	1.0	0.0	52,561	Employee	54,874
Other	2.0	0.1	41,798	Employee	87,274
EEG					
Tech	0.5	0.0	87,053	Employee	45,442
Lab					
Tech	53.1	2.3	76,980	Employee	4,267,503
Other	5.2	0.2	43,204	Employee	234,545
Physician Stipend				Contractual	313,000
Radiation Therapy					
RN	1.9	0.1	103,263	Employee	204,833
Tech	13.8	0.6	114,141	Employee	1,644,457
Other	6.5	0.3	45,498	Employee	308,749

Outpatient Chemotherapy					
RN	4.0	0.2	93,959	Employee	392,371
Other	1.0	0.0	46,450	Employee	48,494
Physician Stipend				Contractual	302,000
Cardiac Cath Lab					
RN	3.0	0.1	88,748	Employee	277,960
Tech	2.0	0.1	98,787	Employee	206,267
Outpatient Vascular Lab					
Tech	3.0	0.1	109,220	Employee	342,076
Other	1.0	0.0	37,180	Employee	38,816
Physician Stipend				Contractual	2,400
Outpatient Clinics					
RN	9.8	0.4	108,954	Employee	1,119,372
Tech	8.5	0.4	72,178	Employee	644,041
Other	4.1	0.2	47,552	Employee	205,921
Physician Stipend				Contractual	19,800
Outpatient Cardiac Rehab Services					
RN	2.0	0.1	107,448	Employee	224,351
Tech	2.0	0.1	78,226	Employee	163,335
Other	0.5	0.0	42,569	Employee	22,221
Ambulance Services					
RN	2.8	0.1	98,214	Employee	287,100
Total Direct Care	**636.5**	**25.3**			**58,213,945**

Support :					
Central Sterile					
Tech	8.1	0.4	48,023	Employee	406,103
Other	1.0	0.0	37,283	Employee	38,924
Food & Nutrition					
Other	35.9	1.2	38,544	Employee	1,430,220
Plant Operations					
Mechanic	18.5	0.8	65,528	Employee	1,265,607
Other	1.0	0.0	53,762	Employee	56,128
Environmental Services					
Aide	47.5	1.6	39,333	Employee	1,931,075
Security					
Officer	10.5	0.5	51,606	Employee	565,700
Hospital Education					

Educator	11.9	0.5	87,135	Employee	1,079,875
Other	1.4	0.1	50,981	Employee	74,297
Distribution					
Clerk	7.0	0.3	39,664	Employee	289,018
Total Support	142.7	5.4			7,136,946
Total Report	1,018.6	36..5			83,299,016

(INSTRUCTION: Indicate method of calculating benefits percentage):

The benefits percentage, currently 31.687% of total salaries, is based upon the historical experience of total benefits to total salaries.

PART IV - 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 and its implementation.

   Owner: Shore Health System, Inc.

   Responsible Individual: Kenneth Kozel, President and CEO, Shore Health System

   Address (both): 219 South Washington St., Easton, Maryland 21601

2. Are the applicant, owners, or the responsible persons listed above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

The Responsible individual has been involved in the management of the following health care facilities:

President, UCH Hospitals and COO, Upper Chesapeake Health System ("UCH")	January 2011 – October 2011
Executive Vice President, Chief Operating Officer (UCH)	June 2009 – December 2010
Sr. Vice President and Chief Operating Officer (UCH)	May 2005 – June 2009
Vice President, Operations (UCH)	January 2004 – May 2005
Assistant Vice President, Ambulatory Services and Business Development (UCH)	July 2003 – January 2004
Director, Ambulatory Services (UCH) & Director, Laboratory Services, Harford Memorial Hospital ("HMH")	March 2002 – July 2003
Director, Laboratory Services (HMH)	February 1997 – March 2002

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to number 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, 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

4. Are any facilities with which the applicant is involved, or have any facilities with which the applicant has in the past been involved (listed in response to Question 2, above) ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to actions to suspend the licensure or certification at the applicant's facility or facilities listed in response to Question 2?

If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable governmental authority.

No

5. Have the applicant, owners or responsible individuals listed in response to Question 1, above, ever pled guilty to 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 the date(s) of conviction(s) 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 proposed or existing facility.[4]

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.

9/6/12
Date

Signature of Owner or
Board-designated Official

4 The affirmations of the other individuals who provided information in this Application are attached collectively as Exhibit 22.

HKS

OWNER
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

SHORE HEALTH SYSTEM

ARCHITECT
HKS ARCHITECTS INC.

STRUCTURAL ENGINEER
O'DONNELL & NACCARATO

MEP ENGINEERS
HIGHLAND ASSOCIATES

INTERIORS
TURNER NUCCI ASSOCIATES

LANDSCAPE
MAHAN RYKIEL ASSOCIATES

INFORMATION TECHNOLOGY
SMITH SECKMAN REID, INC.

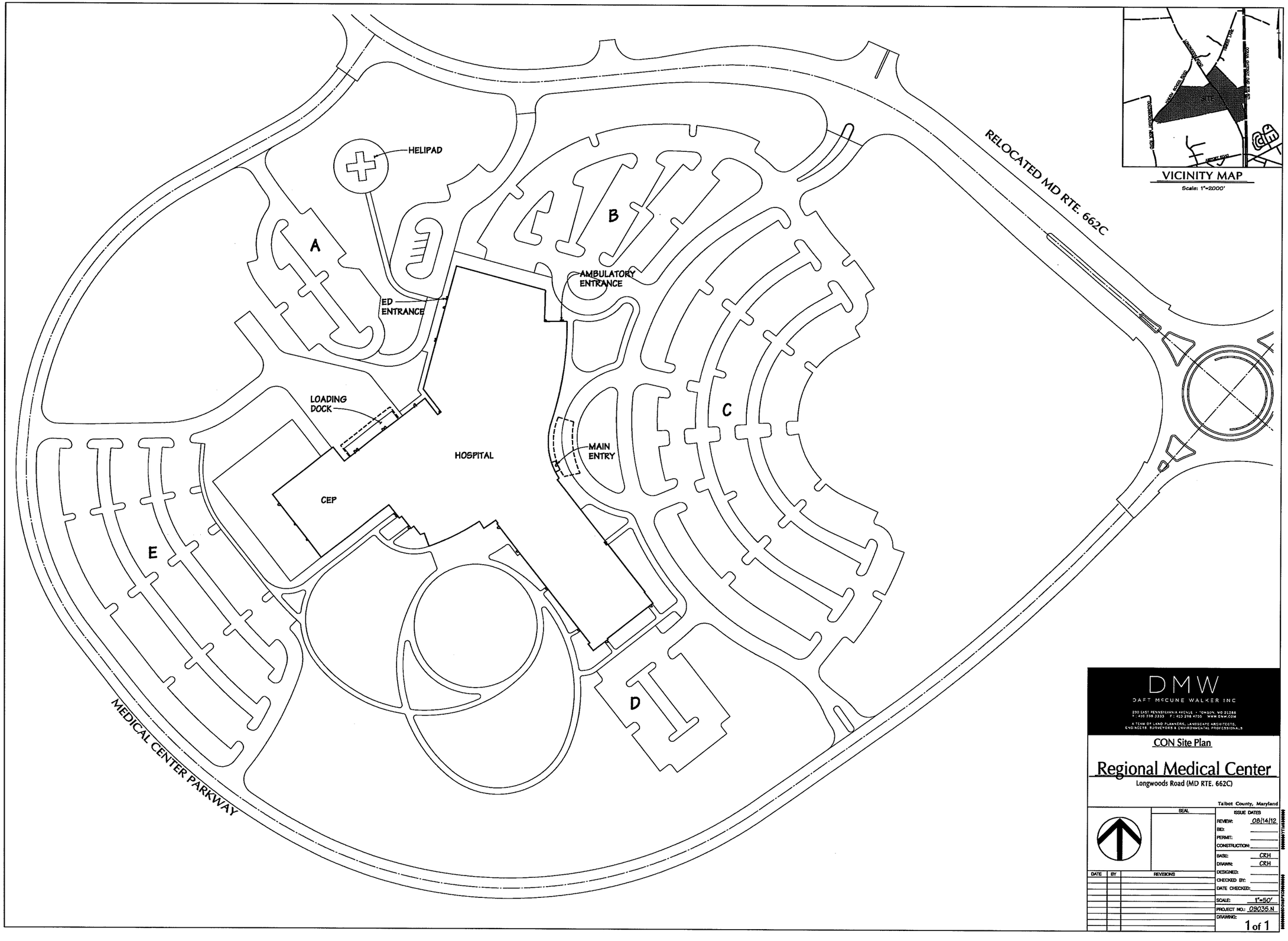
FOOD SERVICE
L2M FOOD SERVICE DESIGN GROUP

MEDICAL EQUIPMENT
MITCHELL PLANNING ASSOCIATES

SHORE HEALTH SYSTEM
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

REPLACEMENT HOSPITAL
EASTON, MARYLAND

CON SUBMISSION
AUGUST 10, 2012
HKS PROJECT # 13213.000



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DAFT McCUNE WALKER INC
200 EAST PENNSYLVANIA AVENUE • TOWSON, MD 21286
P: 410 296 3333 F: 410 296 4705 www.DMW.COM
A TEAM OF LAND PLANNERS, LANDSCAPE ARCHITECTS, ENGINEERS, SURVEYORS & ENVIRONMENTAL PROFESSIONALS

CON Site Plan

Regional Medical Center

Longwoods Road (MD RTE. 662C)

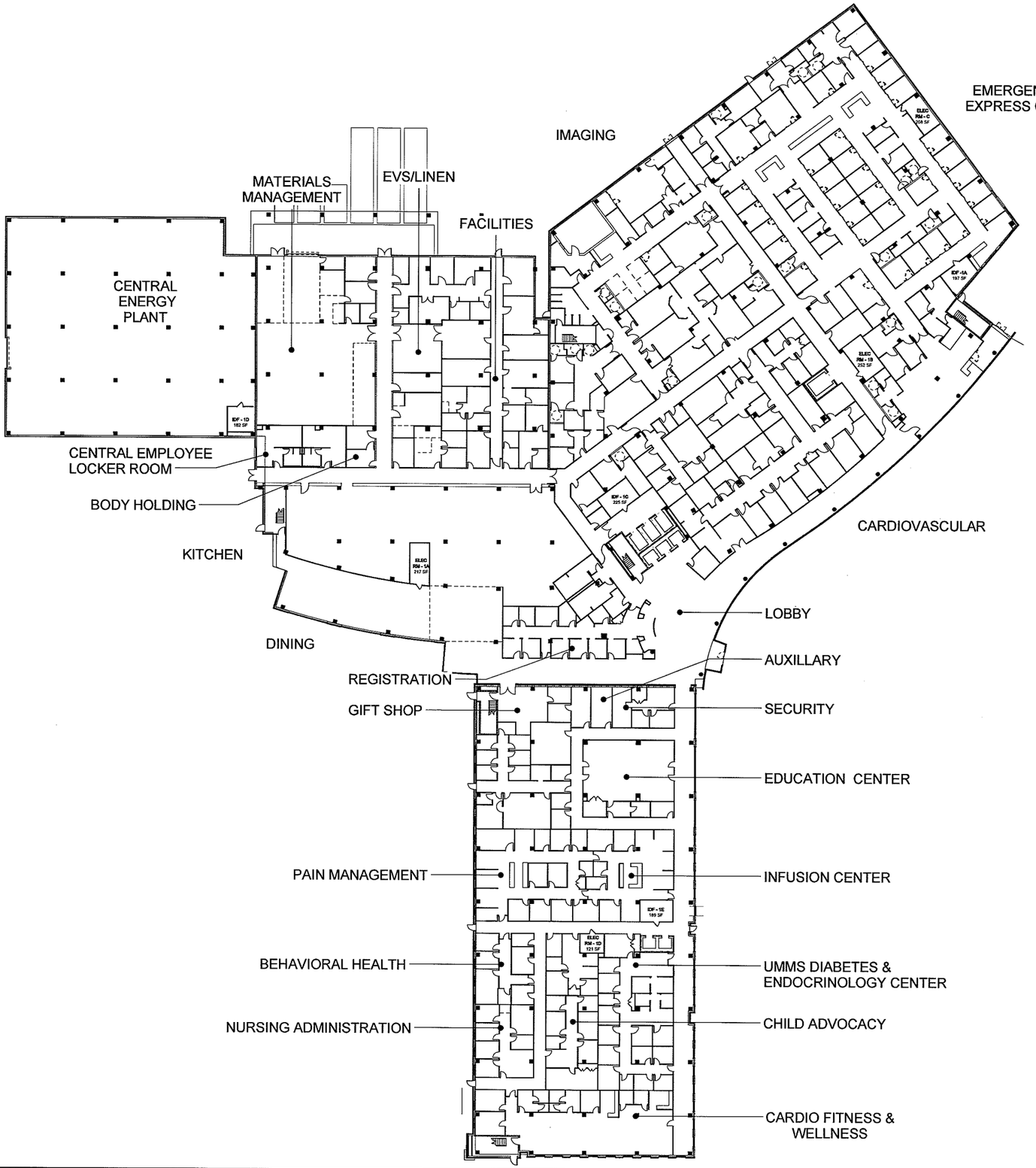
Talbot County, Maryland

SEAL

DATE	BY	REVISIONS

ISSUE DATES
REVIEW: 08/14/12
BID:
PERMIT:
CONSTRUCTION:

BASE: CKH
DRAWN: CKH
DESIGNED:
CHECKED BY:
DATE CHECKED:
SCALE: 1"=50'
PROJECT NO.: 09035.N
DRAWING: 1 of 1



01 LEVEL 01 - OVERALL
3/64" = 1'-0"

PLOT DATE:
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HKS

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UNIVERSITY OF MARYLAND MEDICAL SYSTEM

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Baltimore, MD 21201

Shore Health System
219 S. Washington Street
Easton, MD 21601

OWNER'S CONSULTANT
FM Global
2100 Reston Parkway, Suite 600
Reston, VA 20191

INTERIM REVIEW ONLY

These documents are incomplete, and are released for interim review only and are not intended for regulatory approval, permit, or construction purposes.

Architect: XXXXXX
Arch. Reg. No.: XXXX
Date: XX/XX/XXXX

REVISION
NO. DESCRIPTION DATE

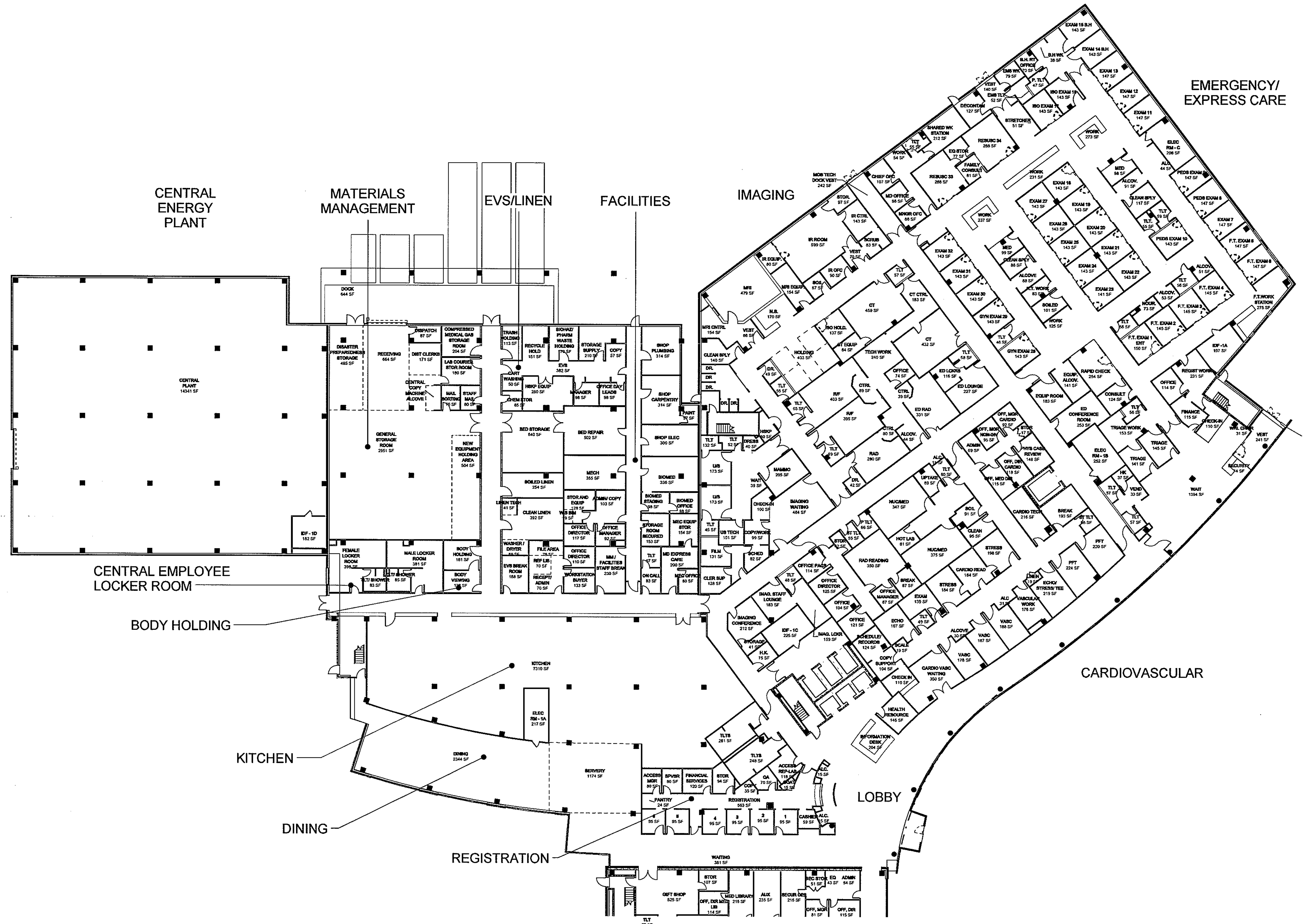
HKS PROJECT NUMBER
13213.011

DATE
AUGUST 10, 2012

ISSUE
CON SUBMISSION

SHEET TITLE
FLOOR PLAN - LEVEL 01- OVERALL

SHEET NO.
A2.010



01 LEVEL 01 - SECTOR 01
1/16" = 1'-0"

PLOT DATE: 8/9/2012 6:18:48 PM

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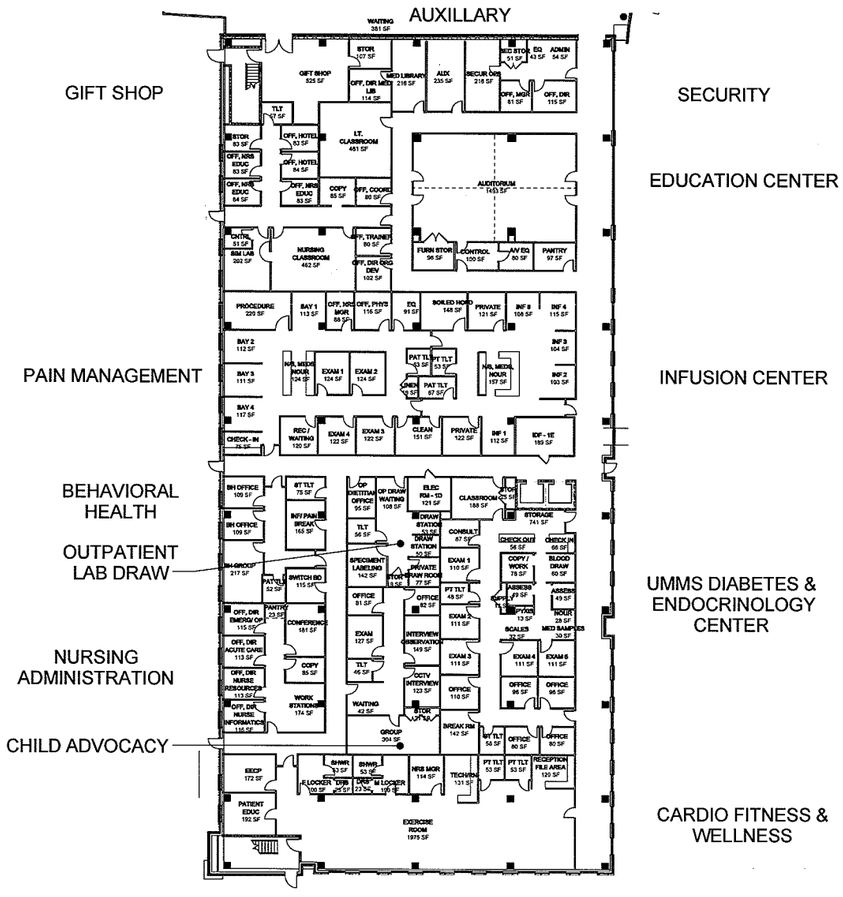
REVISION NO.	DESCRIPTION	DATE

HKS PROJECT NUMBER
13213.011
DATE
AUGUST 10, 2012
ISSUE
CON SUBMISSION

SHEET TITLE
FLOOR PLAN - LEVEL 01 - SECTOR 01
SHEET NO.
A2.011



01 LEVEL 01 - SECTOR 02
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PLOT DATE
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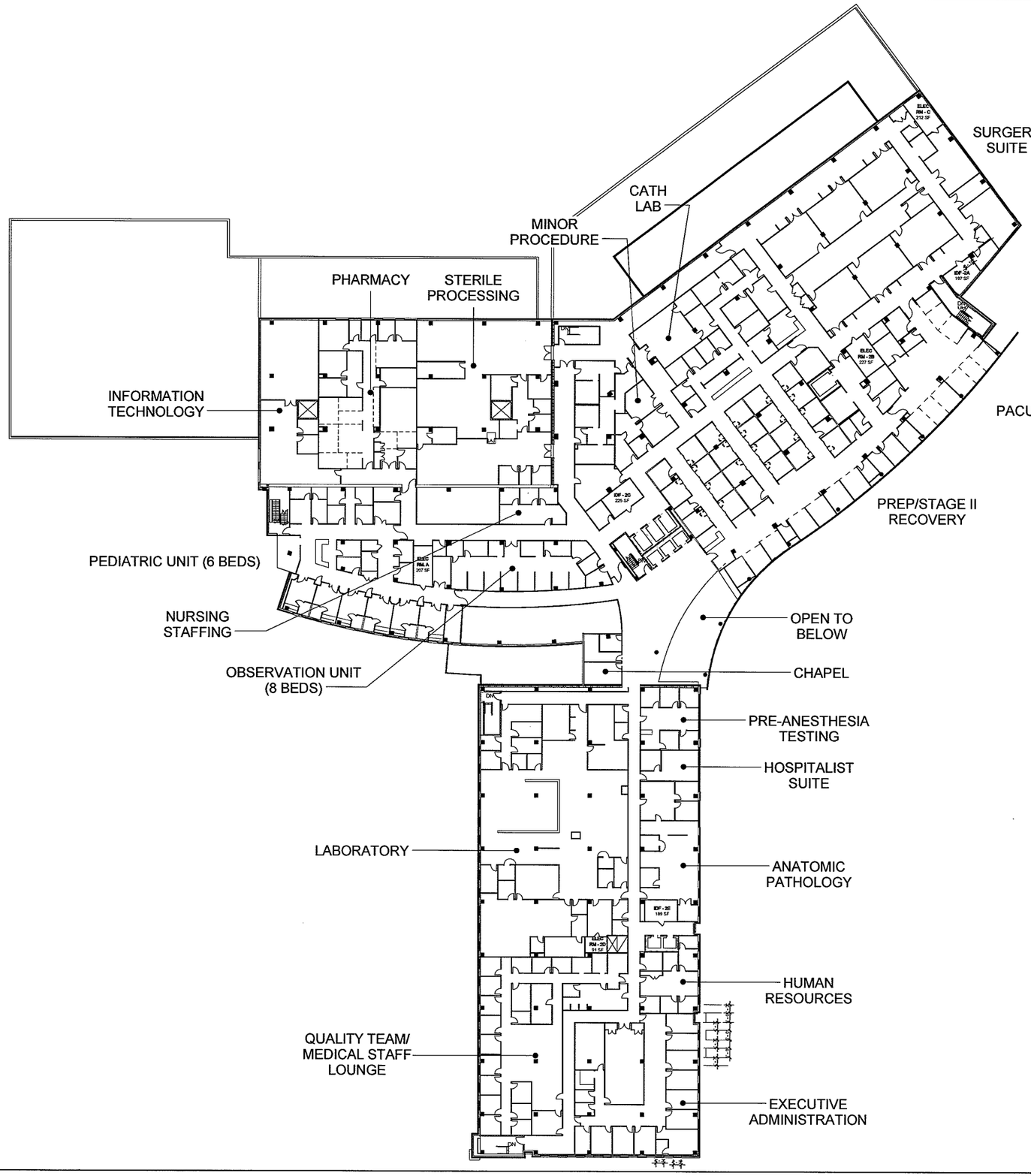
SHEET TITLE
FLOOR PLAN - LEVEL 01 - SECTOR 02
SHEET NO.
A2.012



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DATE
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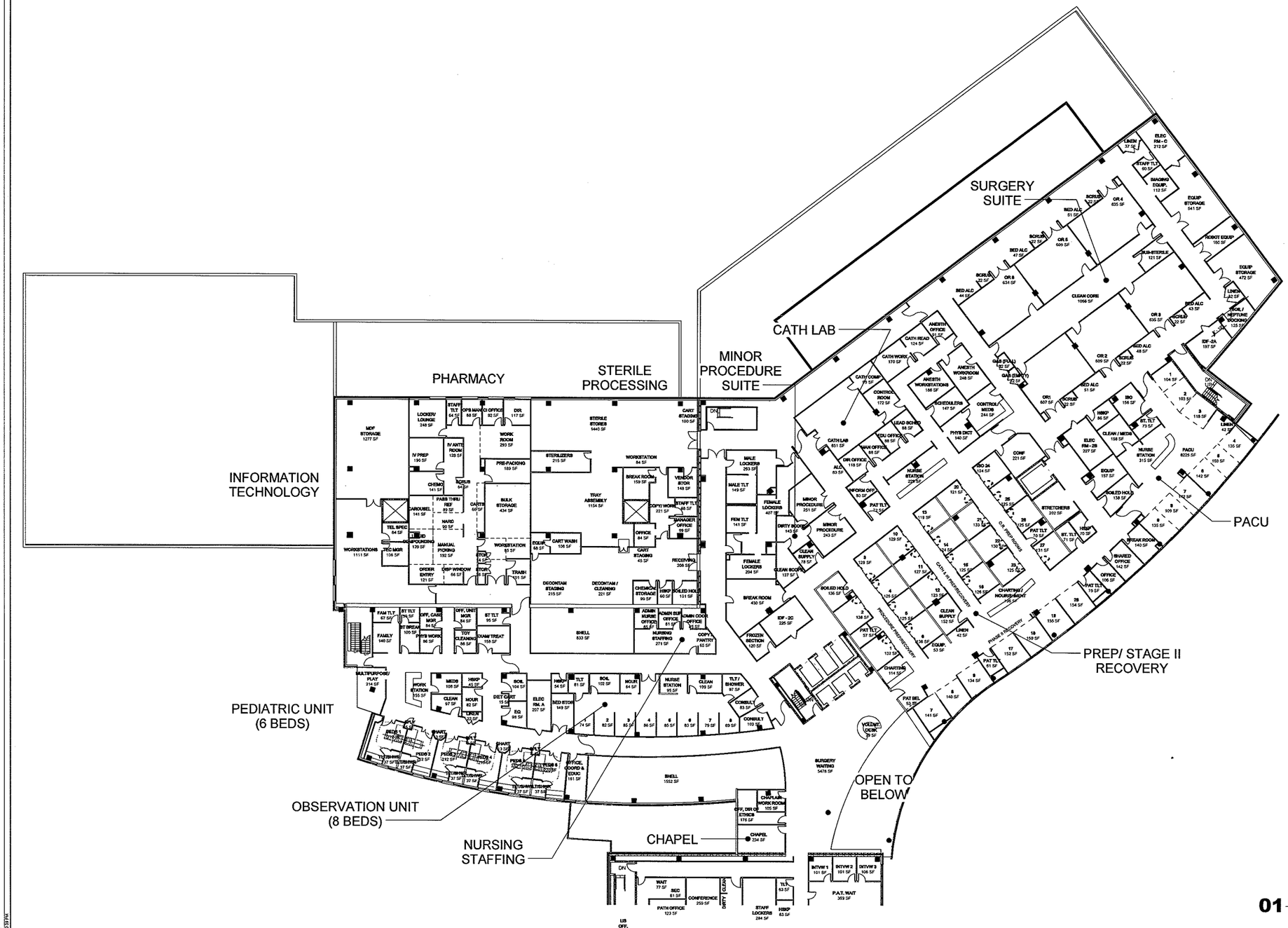
SHEET TITLE
FLOOR PLAN - LEVEL 02 - OVERALL

SHEET NO.
A2.020



01 LEVEL 02 - SECTOR 01
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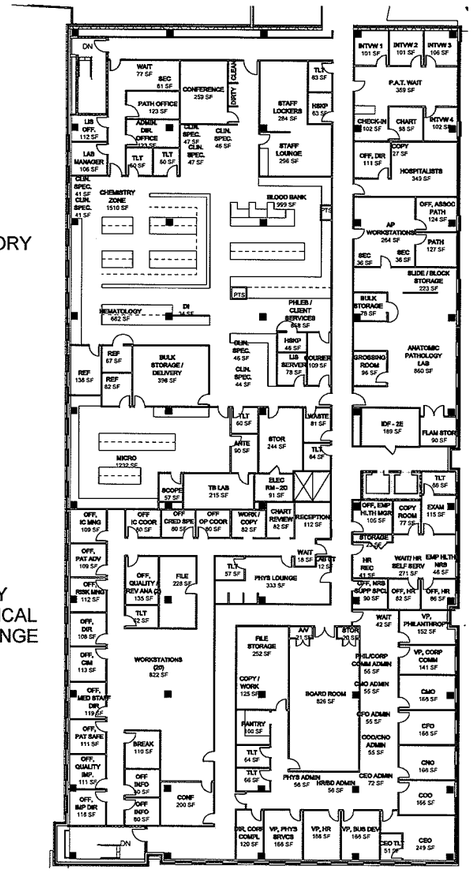
SHEET TITLE
FLOOR PLAN - LEVEL 02 - SECTOR 01
SHEET NO.
A2.021

LABORATORY

QUALITY TEAM/MEDICAL STAFF LOUNGE



PRE-ANESTHESIA TESTING

HOSPITALIST SUITE

ANATOMIC PATHOLOGY

HUMAN RESOURCES

EXECUTIVE ADMINISTRATION

01 LEVEL 02 - SECTOR 02
1/16" = 1'-0"

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8/9/2012 2:13:19 PM

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SHEET TITLE
FLOOR PLAN - LEVEL 02 - SECTOR 02
SHEET NO.
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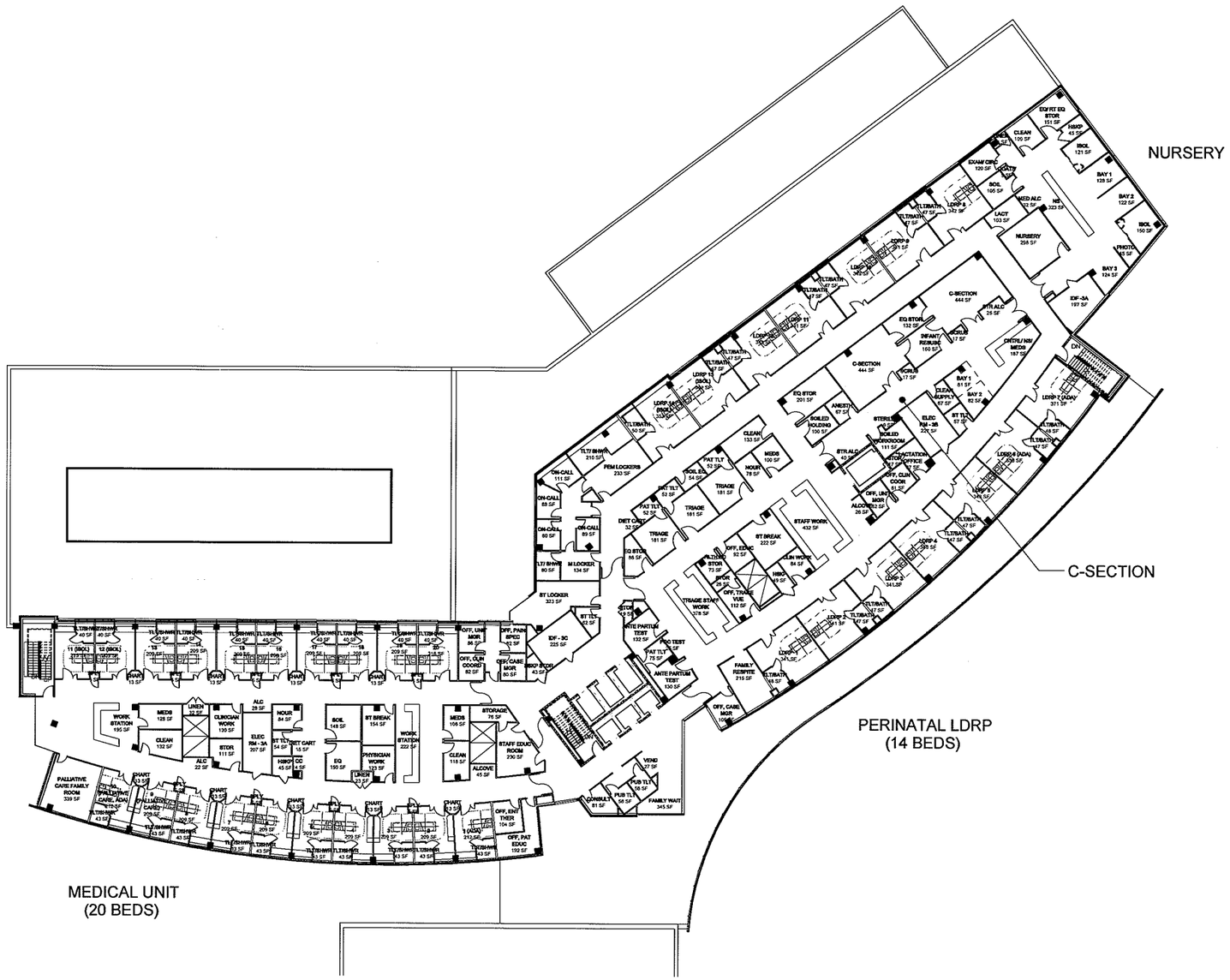

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PLOT DATE:
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KEY PLAN

REVISION
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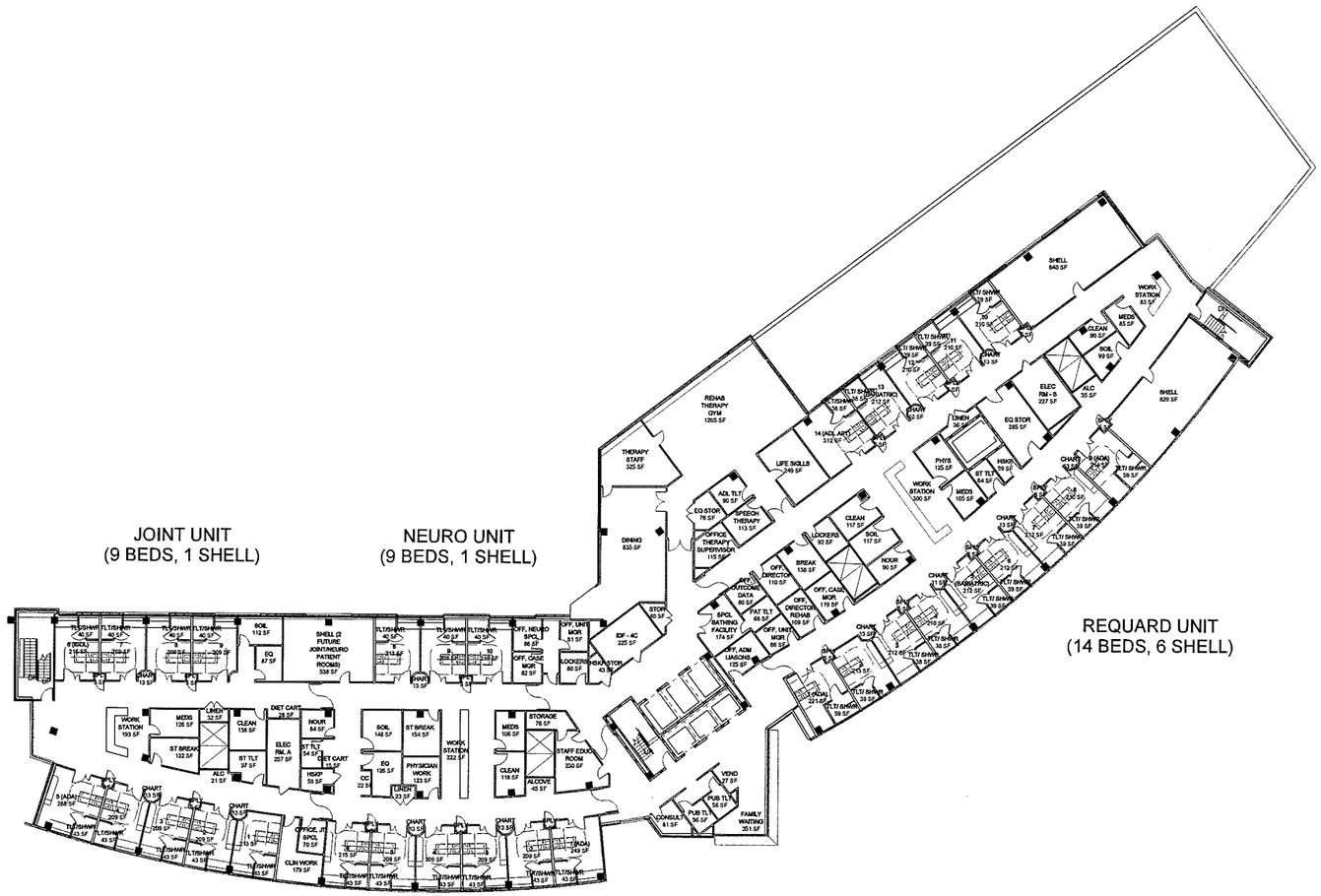
SHEET TITLE
FLOOR PLAN - LEVEL 03

SHEET NO.
A2.031



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PLOT DATE
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KEY PLAN

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FLOOR PLAN - LEVEL 04

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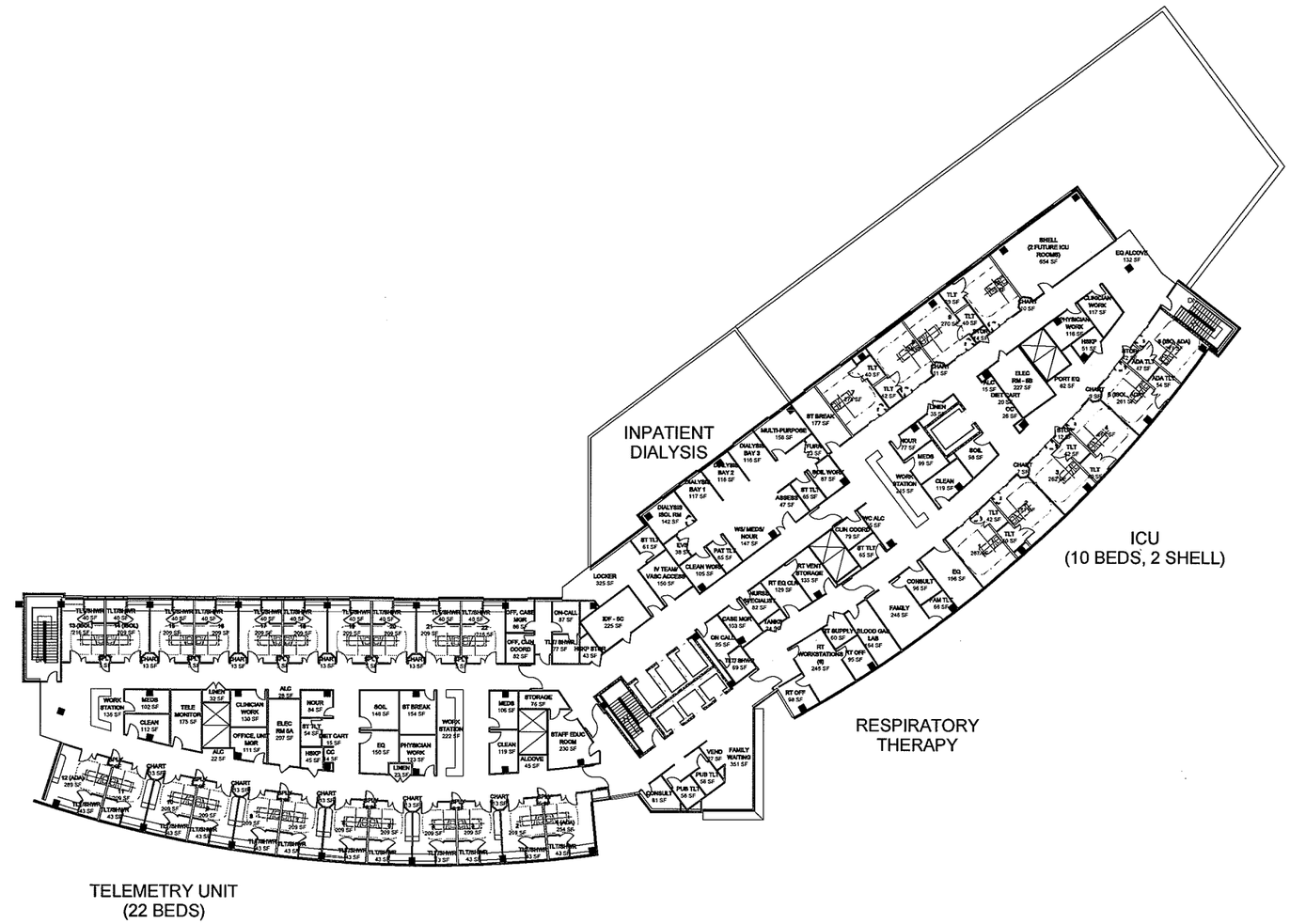
A2.041



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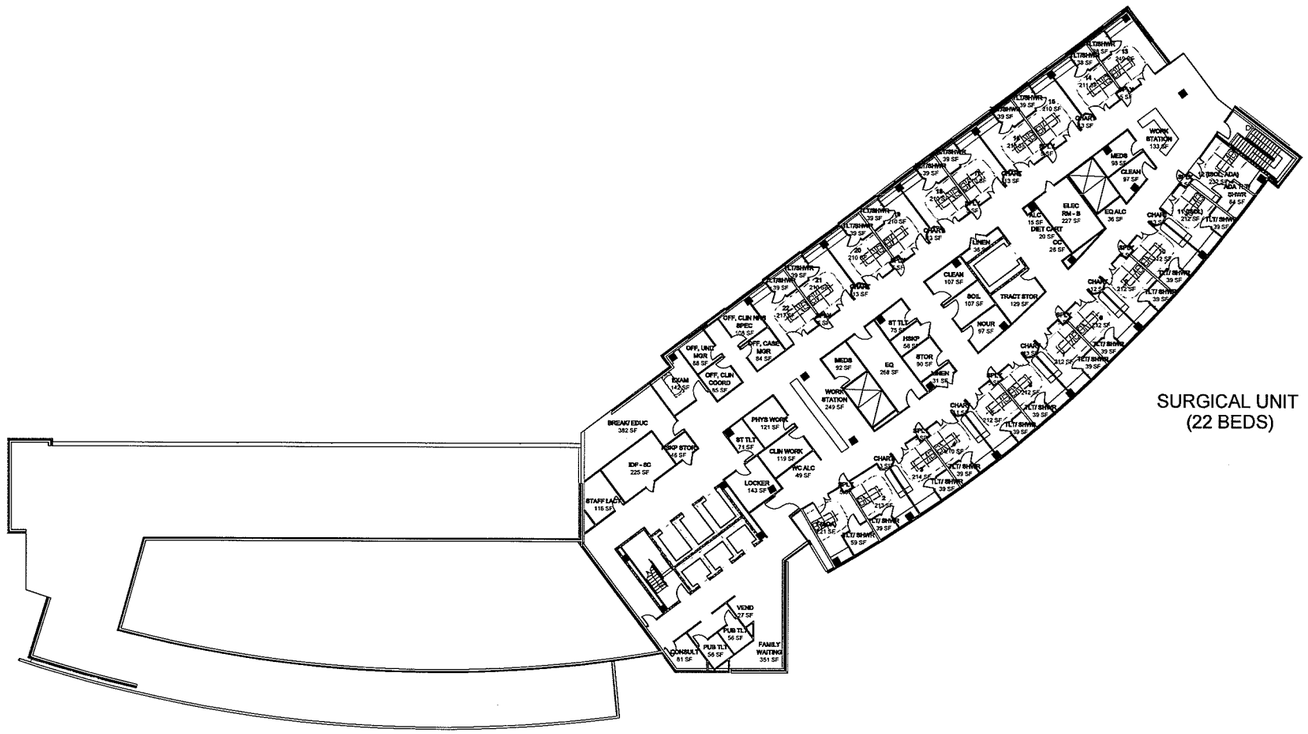
SHEET TITLE
FLOOR PLAN - LEVEL 05

SHEET NO.
A2.051



01 LEVEL 06
1/16" = 1'-0"

PLOT DATE:
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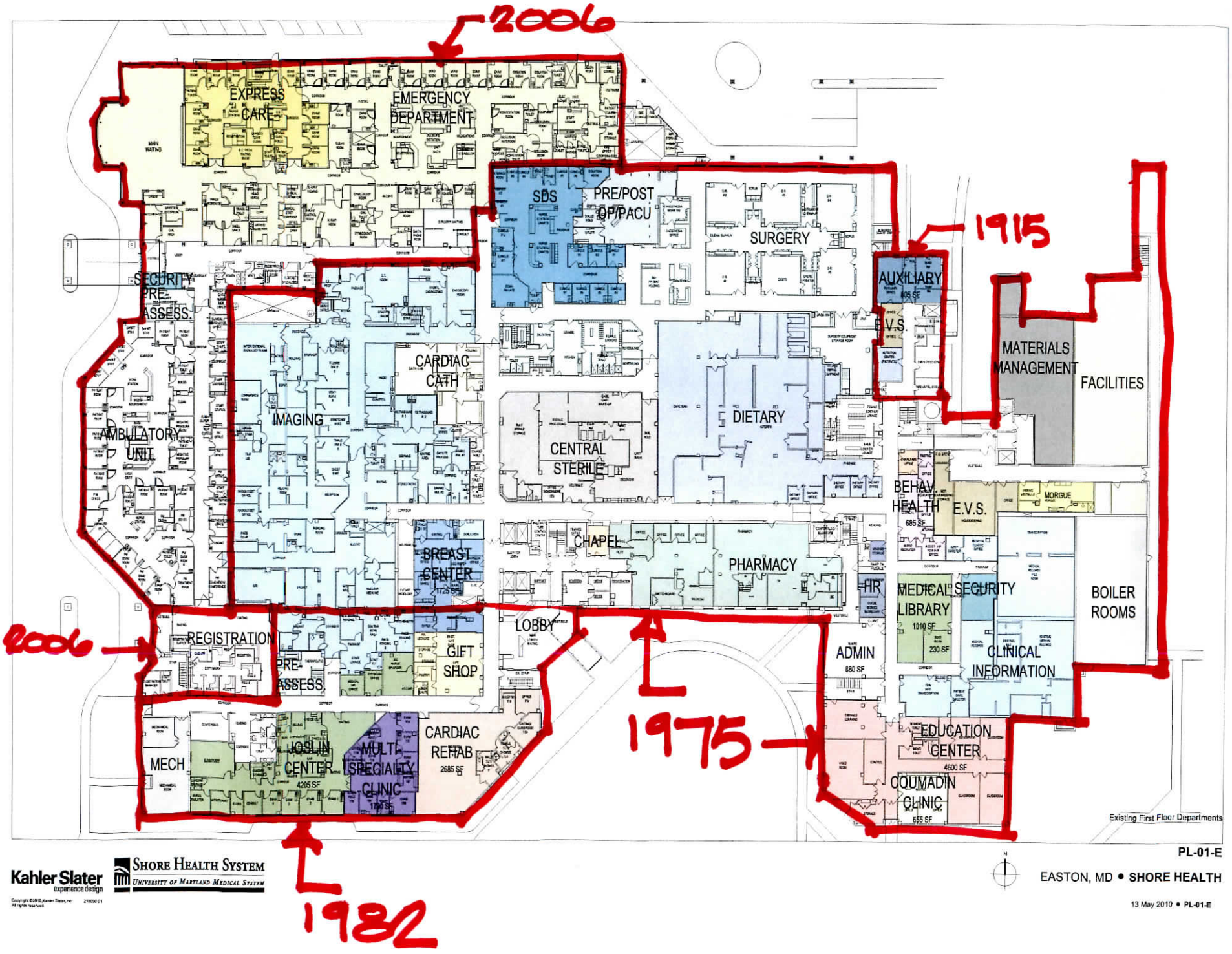
SHEET TITLE
FLOOR PLAN - LEVEL 06

SHEET NO.
A2.061



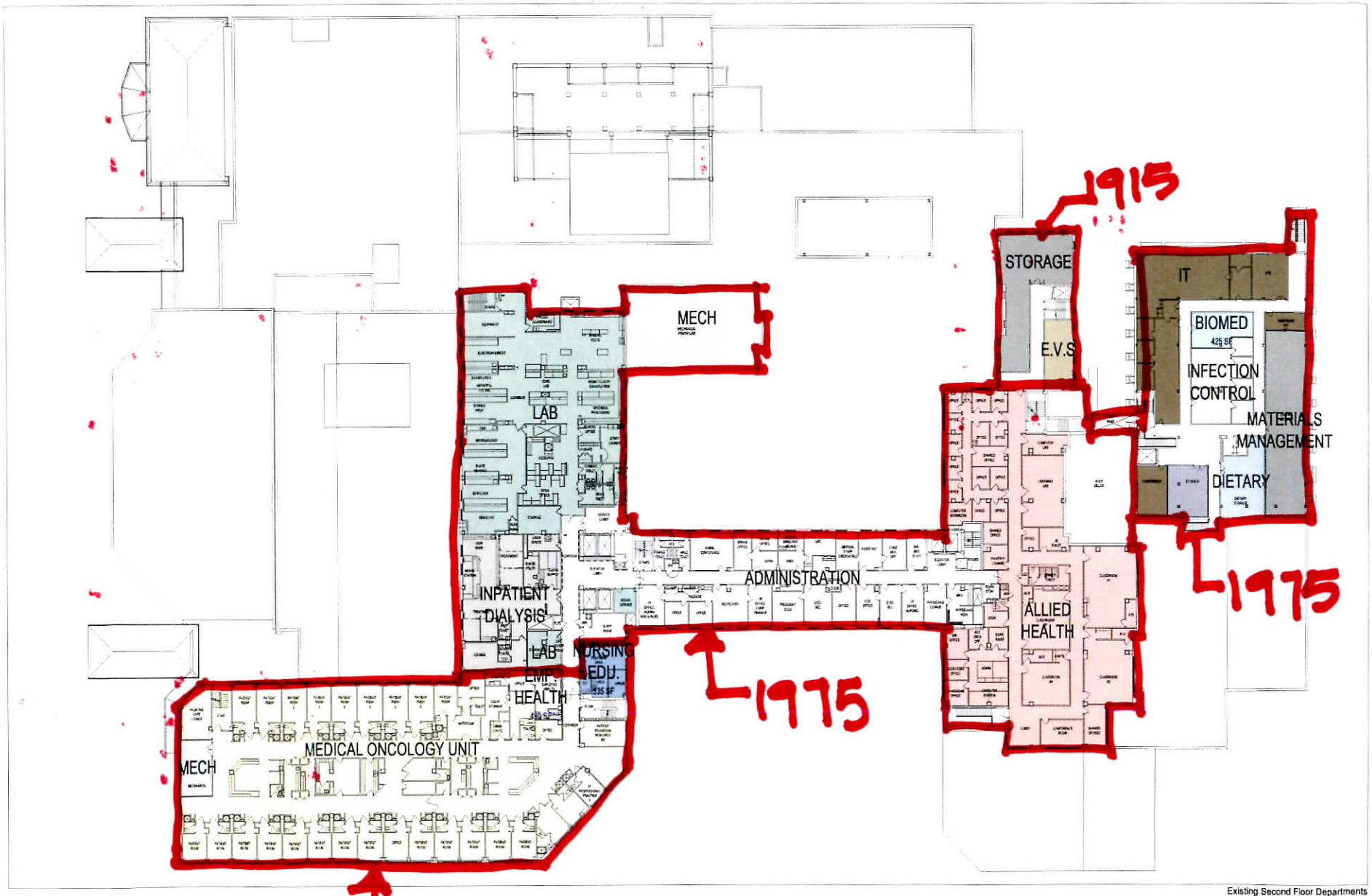
Kahler Slater experience design

SHORE HEALTH SYSTEM
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

PL-01-E

EASTON, MD • SHORE HEALTH

13 May 2010 • PL-01-E



Existing Second Floor Departments

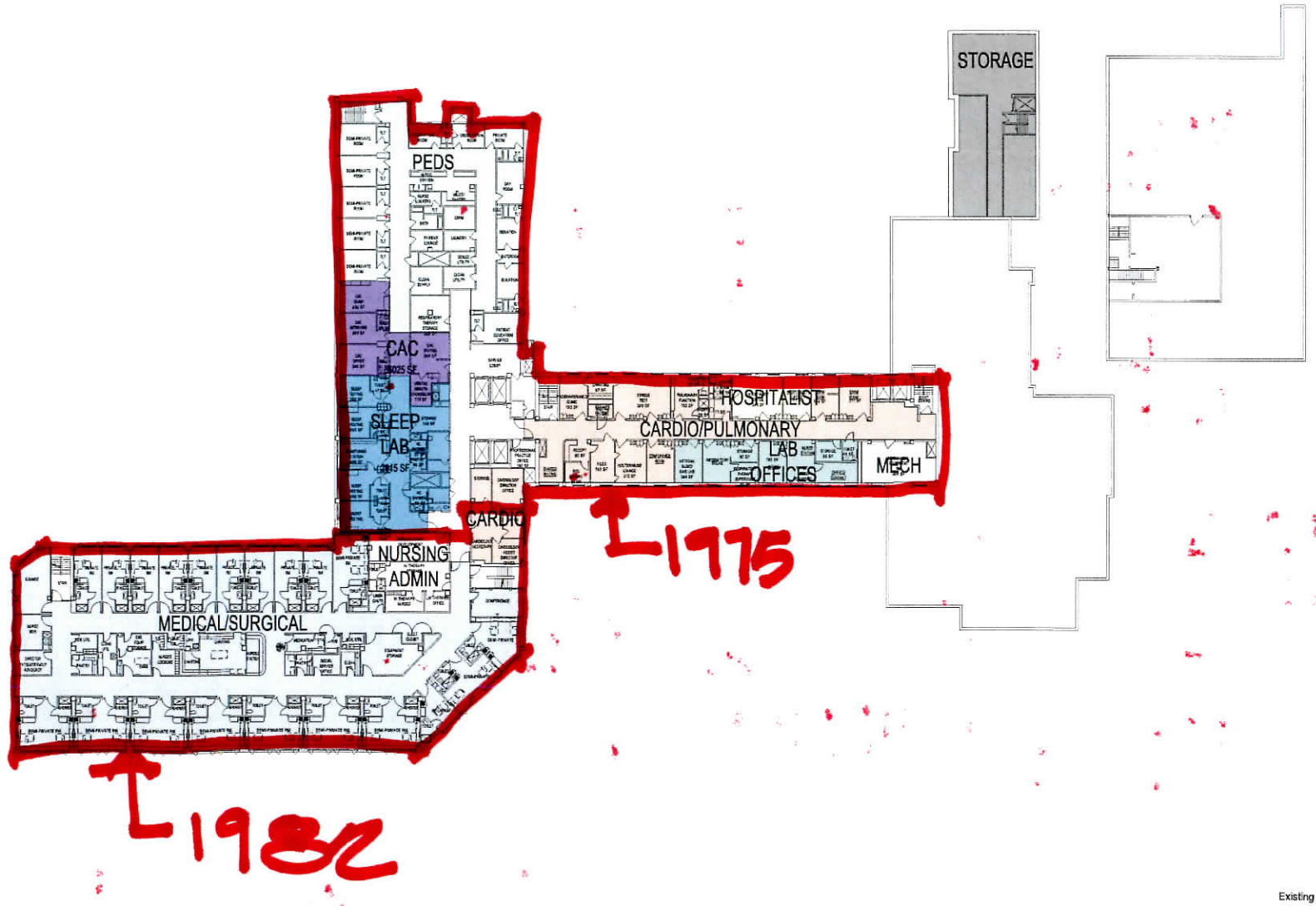
Kahler Slater experience design

SHORE HEALTH SYSTEM
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

PL-02-E

EASTON, MD • SHORE HEALTH

13 May 2010 • PL-02-E



Existing Third Floor Departments

PL-03-E

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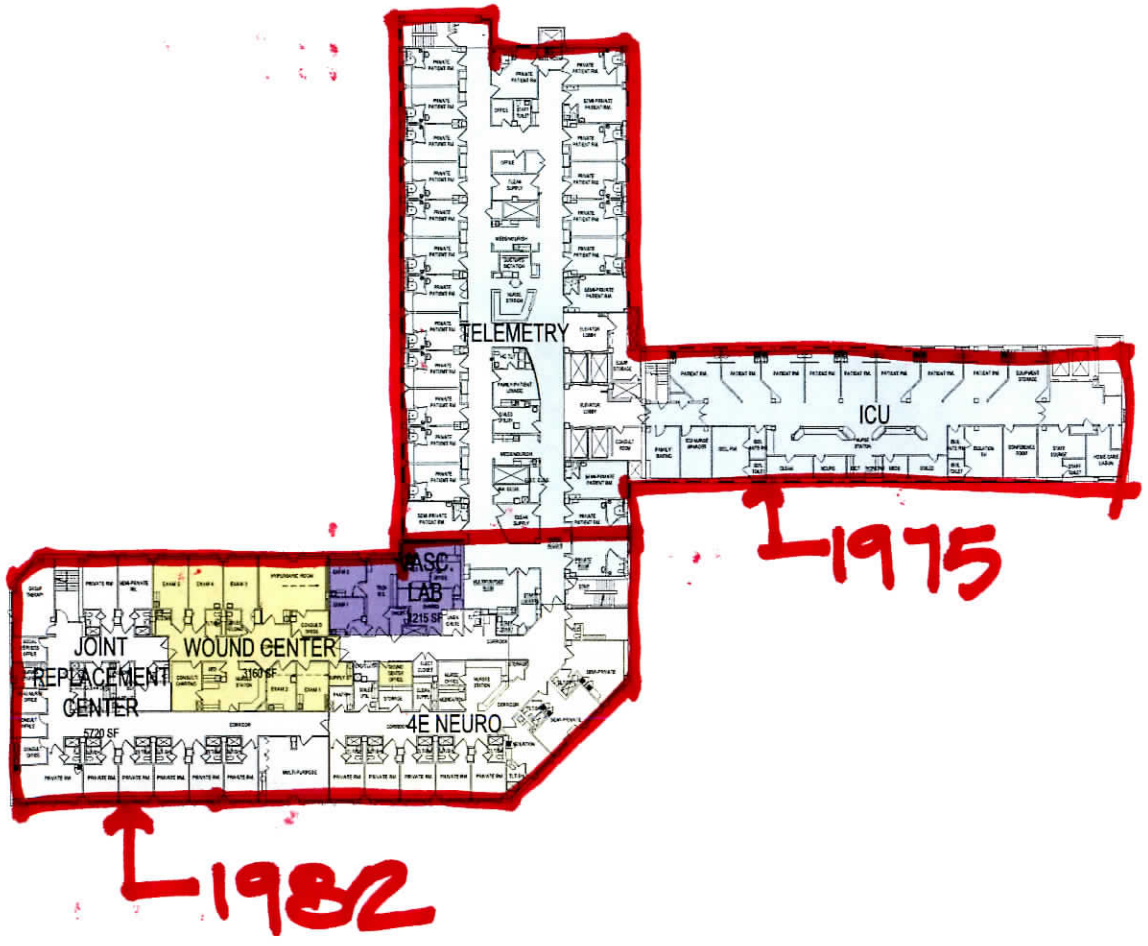
13 May 2010 • PL-03-E

Kahler Slater experience design

SHORE HEALTH SYSTEM
UNIVERSITY OF MARYLAND MEDICAL SYSTEM



Existing Fourth Floor Departments

PL-04-E

EASTON, MD • SHORE HEALTH

13 May 2010 • PL-04-E

Kahler Slater experience design

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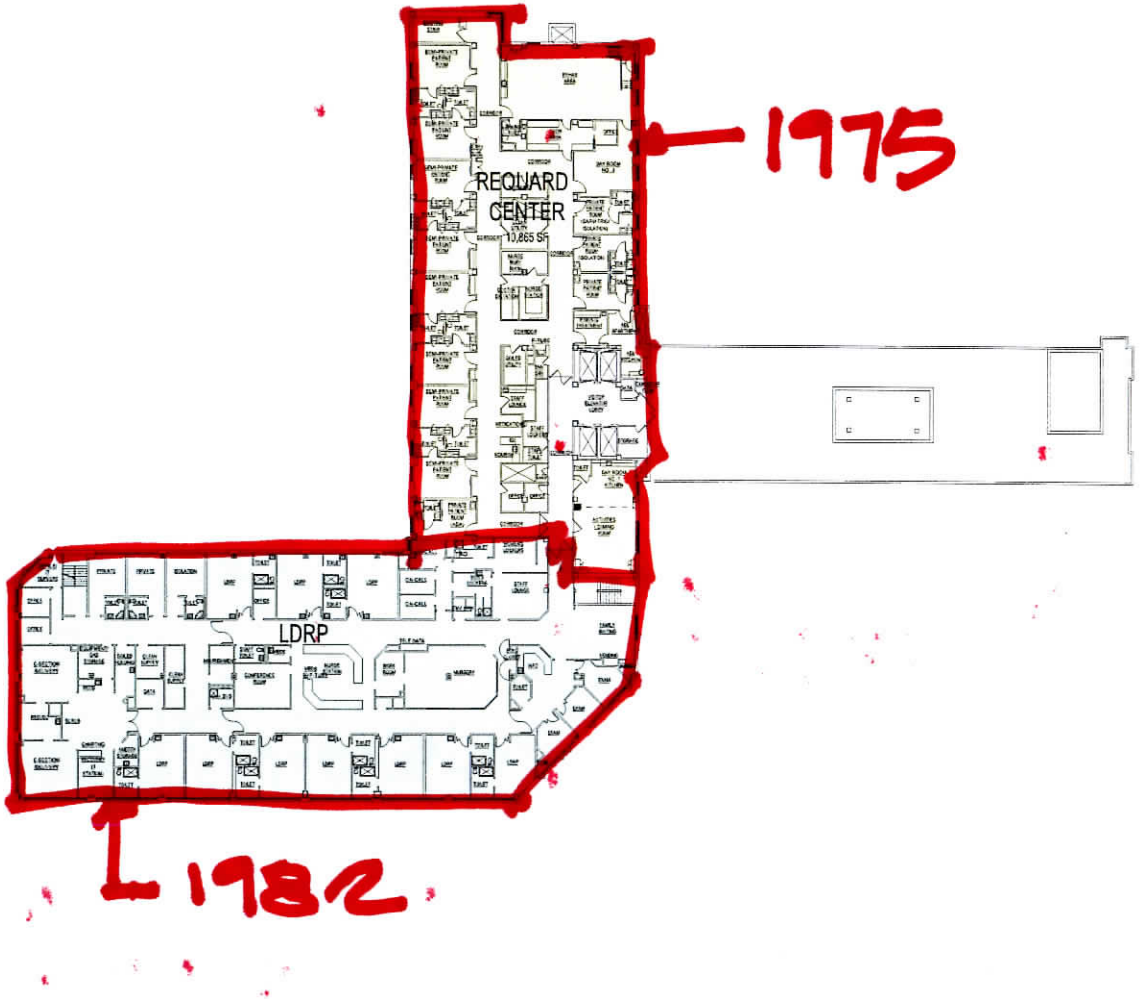

Existing Fifth Floor Departments

PL-05-E

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13 May 2010 • PL-05-E

Kahler Slater
experience design

SHORE HEALTH SYSTEM
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

Memorial ranked best on Shore

Newsmagazine names Easton hospital to Md. top 10

By TONY RUSSO
Business Editor

EASTON — Memorial Hospital at Easton, part of Shore Health System, was recently named one of the top 10 hospitals in the state by *U.S. News and World Report*.

The magazine ranks hospitals nationally and regionally each year. The hospital was ranked ninth in Maryland and recognized as one of the country's high-performing hospitals in nine specialties. A member of the University of Maryland Medical System, Shore Health was also ranked No. 1 on the Eastern Shore by the report.

While hospital representatives were gratified by the recognition, they understand the ranking comes from the constant and rigorous self-evaluation of hospital standards.

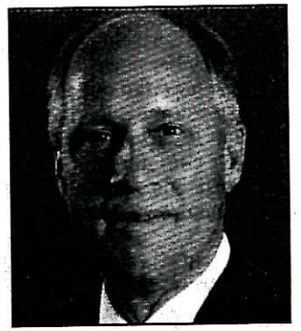
Shore Health tracks patient and department statistics as a way of ensuring it is constantly improving care.

According to Shore Health President and CEO Ken Kozel, Memorial Hospital self-evaluates ranking in three ways. The first and most important is measuring its current successes against its past ones.

"We constantly want to improve," Kozel said. "The best way to measure that is comparing ourselves to ourselves."

Shore Health also compares itself to other hospitals in the University of Maryland System and other hospitals in the state. But the comparison isn't about ranking so much as it is about ongoing improvement.

"These rankings reveal what Shore Health strives for in our hospitals and outpatient centers — to provide exceptional care every day to the patients we serve," he said. "While *U.S. News and World Report* specifically recognizes the Memorial Hospital at Easton, Shore Health's quality outcomes and patient satisfaction data for all of our programs and services make up this award criteria."



KEN KOZEL

For example, the hospital worked to achieve magnet status,which "recognizes healthcare organizations for quality patient care, nursing excellence and innovations in professional nursing practice," according to the American Nurses Credentialing Center.

Kozel said it strove to get this certification because meeting those standards was a way of ensuring hospital practices were consistent with the highest standards of nursing.

"If you can get that designation, you are providing some

See **MEMORIAL** Page A7 1/24/12

MEMORIAL

From Page A1

of the best nursing care in the world," Kozel said.

Shore Health attained the credentials to improve the patient experience, the process just happened to help distinguish the hospital among its peers.

As Kozel reviewed the rankings, almost every area the rankings considered was an area in which Shore Health has been working to improve.

The primary statistics, according to the report, include survival rates and morbidity. Other important statistics, though, are age based. A high ranking is tied to a hospital's ability to accept adults of all ages for a given procedure. This has as much to do with the talent of the physicians as it does the tools they have to work with.

"We invest in technologies because they provide the docs the ability to provide better care," Kozel said. "We did it to improve patient outcomes, but it turned out to be an important part of the ranks as well."

The most gratifying part of the ranking, according to Kozel, was the number of adult specialties for which the hospital was acknowledged.

Shore Health was in the top 25 percent of all hospitals in the nation in the following departments: diabetes and endocrinology, gastroenterology, geriatrics, gynecology, nephrology, neurology and neurosurgery, orthopedics, pulmonology and urology.

"It really does show the teamwork," Kozel said of being ranked so high in so many varied categories. It is attributable, he said, to the combined work of everyone who works or volunteers at the hospital.

The complete rankings and methodology are available at http://health.usnews.com/best-hospitals/area/md.

To learn more about Shore Health System, visit www.shorehealth.org.

SHORE HEALTH UNIVERSITY OF MARYLAND MEDICAL SYSTEM	ADMINISTRATIVE POLICY & PROCEDURE	POLICY NO:	LD-66
		EFFECTIVE:	09/12
	PUBLIC DISCLOSURE OF CHARGES	PAGE #:	1 of 2
		SUPERSEDES	N/A

CROSS REFERENCE

Administrative Policy LD-34: Financial Assistance

SCOPE

This policy applies to Shore Health System ("SHS") acute care hospitals located in the State of Maryland; Memorial Hospital at Easton and Dorchester General Hospital.

PURPOSE

To provide financial information to the communities we serve, the public and individual patients and payors with regard to the charges related to the services we provide.

BENEFITS

Increase awareness of the cost of hospital care and make information available to the public to improve care decision making, planning and patient satisfaction.

1.0 POLICY

Information regarding hospital services and charges shall be made available to the public. A representative list of services and charges shall be made available to the public in written form at the hospital(s) and via the SHS website. Individual patients or their designated payor representative may request an estimate of charges for a specific procedure or service. This policy applies to all patients, regardless of race, creed, gender, age, national origin or financial status. Printed public notification regarding the program will be made semi-annually.

2.0 PROCEDURE

2.1 For the provision of information to the public concerning charges for services, a representative list of services and charges will be available to the public in written form at the hospital and also via the SHS website. The information will be updated regularly and average actual charges will be consistent with hospital rates as approved by the Maryland Health Services Cost Review Commission (HSCRC). The Patient Financial Services Department shall be responsible for ensuring the information's accuracy and updating it on a regular basis. The Patient Financial Services Department shall be responsible for ensuring that the written information is available to the public at the hospitals. The Corporate Communications Department will ensure that the information is available to the public on the SHS website.

2.2 Individuals or their payor representative may make a request for an estimate of charges for any scheduled or non-scheduled diagnostic test or service. Requests for an estimate of charges are handled by the Financial Counselors in the Patient Financial Services Department and/or Schedulers in Community-Wide Scheduling.

2.3 The Patient Financial Services Department is responsible for ensuring that appropriate training and orientation is provided to their staff related to charge estimates and the CDM alpha-browse/estimator tool. Requirements for the Financial Counselors and Schedulers training to ensure that inquiries regarding charges for its services are appropriately handled include education on all necessary estimator tools both during their initial training and on annual job competencies.

Gerard M. Walsh, Chief Operating Officer

Effective	09/12
Approved	Walter Zajac, Sr. Vice President / CFO

Estimated Charges for Common Outpatient Procedures as of March 31, 2012

Code	Procedure	Charge Range Minimum	Charge Range Maximum	Estimated Average Charge
	Memorial Hospital at Easton, Md.			
19000	Puncture aspiration of cyst of breast	$505	$1,742	$755
19301	Partial Mastectomy	$5,549	$9,324	$6,911
20552	Trigger Point injections	$581	$3,423	$1,347
22851	Application of intervertebral biomechanical device	$10,275	$29,476	$16,475
38525	Excision of nodes	$4,568	$11,022	$6,329
52332	Cystourethroscopy with insertion of stent	$2,725	$6,820	$4,802
57240	Anteroposterior colporrhaphy	$3,061	$14,037	$8,288
57282	Vaginal Colpopexy	$7,778	$14,314	$10,466
57288	Sling operation for stress incontinence	$6,537	$12,109	$9,828
63047	Lumbar Laminectomy	$6,556	$11,521	$8,418

Estimated Charges for Common Ancillary Services as of July 31, 2012
Memorial Hospital at Easton, Md

LABORATORY Procedure	Estimated Charge
Basic Metabolic Panel	$22.29
Blood Culture	$80.24
CBC	$20.20
Comprehensive Metabolic Panel	$30.31
Glucose (POC)	$8.74
Hematocrit	$8.03
Hemoglobin	$8.03
Lipase	$15.78
Magnesium, Serum	$12.24
Pregnancy test (UCG)	$19.62
Prothrombintime (PT)	$16.00
Thyroid Stjmulating Hormone	$32.41
Troponin (I)	$49.94
Urinalysis	$8.01
Urinalysis with Micro Auto	$18.22
Urine Culture	$40.27
Venipuncture Blood Draw Charge	$15.73

RADIOLOGY Procedure	Estimated Charge
X-Ray Chest 2 View	$109.17
X-Ray Chest Single View	$72.83
X-Ray Foot 3 View	$99.31
X-Ray Abdomen Series	$219.18
X-Ray Shoulder 2 View	$99.28
X-Ray Knee 3 View	$105.94
Ultrasound Abdominal	$450.31
Digital Mammogram- Diagnostic Bilateral with CAD	$537.66
Cat Scan Brain without Contrast	$82.81
Cat Scan Abdomen/Pelvis with Contrast	$135.24
Cat Scan Abdomen/Pelvis without Contrast	$108.22
Cat Scan C-Spine without Contrast	$108.30
MRI Brain with/without Contrast	$636.40
MRI L-Spine with/without Contrast	$372.68
MRI Brain without Contrast	$348.11
MRI C-Spine without Contrast	$363.20
MRA Brain without Contrast	$638.85

Estimated Charges for Common Inpatient Procedures as of March 31, 2012

Procedure	Charge Range		Estimated
	Minimum	Maximum	Average Charge
Memorial Hospital at Easton			
Manual assisted delivery	$3,528	$9,413	$6,708
Circumcision	$1,756	$3,228	$2,955
Low cervical cesearan delivery	$4,814	$9,053	$8,911
Venous catherization	$11,185	$128,315	$21,295
Total knee replacement	$16,227	$24,921	$16,957
Total hip relacement	$16,537	$18,340	$17,381
Esophagogastroduodenoscopy with closed biopsy	$3,617	$13,191	$11,041
Small intestinal endoscopy	$7,350	$18,332	$12,343
Left heart cardiac catheterization	$6,056	$12,005	$7,749
Open reduction with internal fixation of the femur	$14,558	$99,706	$18,470
Laparoscopic cholecystectomy	$10,536	$34,396	$13,279
Laparoscopic appendectomy	$6,907	$10,531	$8,231

SHORE HEALTH SYSTEM UNIVERSITY OF MARYLAND MEDICAL SYSTEM	ADMINISTRATIVE POLICY & PROCEDURE	POLICY NO:	LD-34
		REVISED:	8/12
	FINANCIAL ASSISTANCE	PAGE #:	1 of 9
		SUPERSEDES	2/11

1.0 POLICY

1.1 This policy applies to Shore Health System ("SHS"). Shore Health System 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 medically necessary care based on their individual financial situation. The hospitals covered by this policy include:

- The Memorial Hospital at Easton
- Dorchester General Hospital

1.2 It is the policy of SHS to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance should be made, the criteria for eligibility and the steps for processing applications.

1.3 SHS will publish the availability of Financial Assistance on a yearly basis in the local newspapers and will post notices of availability at appropriate intake locations as well as the Billing Office. Notice of availability will also be sent to patients on patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided to patients receiving inpatient services with their Summary Bill and made available to all patients upon request.

1.4 Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

1.5 SHS retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent services, applications to the Financial Assistance Program will be completed, received and evaluated retrospectively and will not delay patients from receiving care.

2.0 PROGRAM ELIGIBILITY

2.1 Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor, SHS strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further SHS commitment to our mission to provide healthcare to those residing in the neighborhoods surrounding our hospital, SHS reserves the right to grant Financial Assistance without formal application being made by our patients. The zip codes for the SHS primary service area are included in ***Attachment A***. Additionally, patients residing outside of our primary service area may receive Financial Assistance on a one-time basis for a specific episode of care.

2.2 Specific exclusions to coverage under the Financial Assistance program include the following:

2.2.1 Services provided by healthcare providers not affiliated with SHS (e.g., home health services).

2.2.2 Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, Workers Compensation or Medicaid), are not eligible for the Financial Assistance Program. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made considering medical and programmatic implications.

2.2.3 Unpaid balances resulting from cosmetic or other non-medically necessary services.

2.2.4 Patient convenience items.

2.2.5 Patient meals and lodging.

2.2.6 Physician charges related to the date of service are excluded from SHS' Financial Assistance Policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.

2.3 Patients may become ineligible for Financial Assistance for the following reasons:

2.3.1 Refusal to provide requested documentation or providing incomplete information.

2.3.2 Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid or other insurance programs that deny access to SHS due to insurance plan restrictions/limits.

2.3.3 Failure to pay co-payments as required by the Financial Assistance Program.

2.3.4 Failure to keep current on existing payment arrangements with SHS.

2.3.5 Failure to make appropriate arrangements on past payment obligations owed to SHS (including those patients who were referred to an outside collection agency for a previous debt).

2.3.6 Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program.

2.4 Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.

2.5 Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance eligibility criteria (See Section 3 below). If patient qualifies for COBRA coverage, patient's financial

ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services and for their overall personal health.

2.6 Coverage amounts will be calculated based upon 200-300% of income as defined by federal poverty guidelines and follows the sliding scale included in ***Attachment B***.

3.0 PRESUMPTIVE FINANCIAL ASSISTANCE

3.1 Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for Financial Assistance, but there is no Financial Assistance form and/or supporting documentation on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with Financial Assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, SHS reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining Financial Assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only Financial Assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

3.1.1 Active Medical Assistance pharmacy coverage.

3.1.2 Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums).

3.1.3 Primary Adult Care ("PAC") coverage.

3.1.4 Homelessness.

3.1.5 Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs.

3.1.6 Maryland Public Health System Emergency Petition patients.

3.1.7 Participation in Women, Infants and Children Programs ("WIC").

3.1.8 Food Stamp eligibility.

3.1.9 Eligibility for other state or local assistance programs.

3.1.10 Patient is deceased with no known estate.

3.1.11 Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.

3.2 Patients who present to the Outpatient Emergency Department but are not admitted as inpatients and who reside in the hospitals' primary service area may not need to complete a Financial Assistance Application but may be granted presumptive Financial Assistance based upon the following criteria:

3.2.1 Reside in primary service area (address has been verified).

3.2.2 Lack health insurance coverage.

3.2.3 Not enrolled in Medical Assistance for date of service.

3.2.4 Indicate an inability to pay for their care.

3.2.5 Financial Assistance granted for these Emergency Department visits shall be effective for the specific date of service and shall not extend for a six (6) month period.

3.3 Specific services or criteria that are ineligible for Presumptive Financial Assistance include:

3.3.1 Purely elective procedures (e.g., cosmetic procedures) are not covered under the program.

3.3.2 Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive Financial Assistance Program until the Maryland Medicaid Psych Program has been billed.

3.3.3 Qualifying Non-U.S. citizens are to be processed for reimbursement through the Federal Program for Undocumented Alien Funding for Emergency Care (a.k.a. Section 1011) prior to financial assistance consideration.

4.0 MEDICAL HARDSHIP

4.1 Patients falling outside of conventional income or Presumptive Financial Assistance criteria are potentially eligible for bill reduction through the Medical Hardship program. Uninsured Medical Hardship criteria is State defined as:

4.1.1 Combined household income less than 500% of federal poverty guidelines.

4.1.2 Having incurred collective family hospital medical debt at SHS exceeding 25% of the combined household income during a 12 month period. The 12 month period begins with the date the Medical Hardship application was submitted.

4.1.3 The medical debt excludes co-payments, co-insurance and deductibles.

4.2 Patient Balance after Insurance
SHS applies the State established income, medical debt and time frame criteria to patient balance after insurance applications.

4.3 Coverage amounts will be calculated based upon 0 - 500% of income as defined by federal poverty guidelines and follow the sliding scale included in **Attachment B.**

4.4 If determined eligible, patients and their immediate family are certified for a 12-month period effective with the date on which the reduced cost medically necessary care was initially received.

4.5 Individual patient situation consideration:

4.5.1 SHS reserves the right to consider individual patient and family financial situation to grant reduced cost care in excess of State established criteria.

4.5.2 The eligibility duration and discount amount is patient-situation specific.

4.5.3 Patient balance after insurance accounts may be eligible for consideration.

4.5.4 Cases falling into this category require management level review and approval.

4.6 In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance Programs, SHS is to apply the greater of the two discounts.

4.7 Patient is required to notify SHS of their potential eligibility for this component of the Financial Assistance Program.

5.0 ASSET CONSIDERATION

5.1 Assets are generally not considered as part of Financial Assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient responsibility without causing undue hardship. Individual patient financial situation such as the ability to replenish the asset and future income potential are taken into consideration whenever assets are reviewed.

5.2 Under current legislation, the following assets are exempt from consideration:

5.2.1 The first $10,000 of monetary assets for individuals and the first $25,000 of monetary assets for families.

5.2.2 Up to $150,000 in primary residence equity.

5.2.3 Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans.

Generally this consists of plans that are tax exempt and/or have penalties for early withdrawal.

6.0 APPEALS

6.1 Patients whose financial assistance applications are denied have the option to appeal the decision.

6.2 Appeals can be initiated verbally or written.

6.3 Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

6.4 Appeals are documented within the third party data and workflow tool. They are then reviewed by the next level of management above the representative who denied the original application.

6.5 If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.

6.6 The escalation can progress up to the Chief Financial Officer who will render a final decision.

6.7 A letter of final determination will be submitted to each patient who has formally submitted an appeal.

7.0 PATIENT REFUND

7.1 Patients applying for Financial Assistance up to 2 years after the service date who have made account payment(s) greater than $25 are eligible for refund consideration.

7.2 Collector notes, and any other relevant information, are deliberated as part of the final refund decision. In general, refunds are issued based on when the patient was determined unable to pay compared to when the payments were made.

7.3 Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for refund.

8.0 JUDGEMENTS

If a patient is later found to be eligible for Financial Assistance after a judgment has been obtained or the debt submitted to a credit reporting agency, SHS shall seek to vacate the judgment and/or strike the adverse credit information.

9.0 PROCEDURES

9.1 Each Service Access area will designate a trained person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Customer Service, etc.

9.2 Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

9.2.1 Staff will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage.

9.2.2 Preliminary data will be entered into a third party data exchange system to determine probable eligibility. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.

9.2.3 SHS will not require documentation beyond that necessary to validate the information on the Maryland State Uniform Financial Assistance Application.

9.2.4 Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance.

9.2.5 Patients will have thirty (30) days to submit required documentation to be considered for eligibility. If no data is received within 20 days, a reminder letter will be sent notifying that the case will be closed for inactivity and the account referred to bad debt collection services if no further communication or data is received from the patient. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to.

9.3 In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit:

9.3.1 A copy of their most recent Federal Income Tax Return (if married and filing separately, then also 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); proof of disability income (if applicable).

9.3.2 A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations or documentation of how they are paying for living expenses.

9.3.3 Proof of Social Security income (if applicable).

9.3.4 A Medical Assistance Notice of Determination (if applicable).

9.3.5 Proof of U.S. citizenship or lawful permanent residence status (green card).

9.3.6 Reasonable proof of other declared expenses.

9.3.7 If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.

9.4 A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on SHS guidelines. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility. SHS will make a determination of probable eligibility within two business days following a patient's request for charity care services, application for medical assistance, or both.

9.4.1 If the patient does qualify for financial clearance, appropriate personnel will notify the treating department who may then schedule the patient for the appropriate service.

9.4.2 If the patient does not qualify for financial clearance, appropriate personnel will notify the clinical staff of the determination and the non-emergent/urgent services will not be scheduled. A decision that the patient may not be scheduled for non-emergent/urgent services may be reconsidered upon request.

9.5 Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. With the exception of Presumptive Financial Assistance cases which are date of service specific eligible and Medical Hardship who have twelve (12) calendar months of eligibility. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance.

9.6 The following may result in the reconsideration of Financial Assistance approval:

9.6.1 Post-approval discovery of an ability to pay.

9.6.2 Changes to the patient's income, assets, expenses or family status which are expected to be communicated to SHS.

9.7 SHS will track patients with 6 or 12 month certification periods utilizing either eligibility coverage cards and/or a unique insurance plan code(s). However, it is ultimately the responsibility of the patient or guarantor to advise of their eligibility status for the program at the time of registration or upon receiving a statement.

9.8 If patient is determined to be ineligible, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

_____

Gerard M. Walsh, Chief Operating Officer

Effective	10/05
Approved	Shore Health System Board of Directors: 06/22/05
Revised	07/10 (Minor Changes)
Revised	02/11
Submitted	Walter Zajac, Sr. Vice President/CFO
	Samuel Harris, Director Patient Financial Services
Approved	SHS Board of Directors:

ATTACHMENTS:

- Attachment A - Zip Codes for Coverage Areas
- Attachment B - Sliding Scale

ZIP CODES FOR COVERAGE AREAS

The following zip codes represent the coverage areas for the respective Entities:

21601, 21607, 21609, 21610, 21612, 21613, 21617, 21619, 21620, 21620, 21622, 21623, 21624, 21625, 21626, 21627, 21628, 21629, 21631, 21632, 21634, 21635, 21636, 21638, 21639, 21640, 21641, 21643, 21644, 21645, 21647, 21648, 21649, 21650, 21651, 21651, 21652, 21653, 21654, 21655, 21656, 21657, 21657, 21658, 21659, 21660, 21661, 21662, 21663, 21664, 21665, 21666, 21667, 21668, 21669, 21670, 21671, 21672, 21673, 21675, 21676, 21677, 21678, 21679, 21690, 21835, 21869

SHORE HEALTH SYSTEM UNIVERSITY OF MARYLAND MEDICAL SYSTEM	SLIDING SCALE	POLICY NO:	LD-34
		REVISED:	08/12
	ATTACHMENT B TO FINANCIAL ASSISTANCE POLICY	PAGE #:	1 of 1
		SUPERSEDES	02/11

		% of Federal Poverty Level Income										
		200%	210%	220%	230%	240%	250%	260%	270%	280-290%	300% - 499%	
Size of	FPL	Approved % of Financial Assistance										
Family Unit	Income	100%	90%	80%	70%	60%	50%	40%	30%	20%	25% of Income	
1	$10,830	$21,660	$22,743	$23,826	$24,909	$25,992	$27,075	$28,158	$29,241	$30,324	$32,490	$54,150
2	$14,570	$29,140	$30,597	$32,054	$33,511	$34,968	$36,425	$37,882	$39,339	$40,796	$43,710	$72,850
3	$18,310	$36,620	$38,451	$40,282	$42,113	$43,944	$45,775	$47,606	$49,437	$51,268	$54,930	$91,550
4	$22,050	$44,100	$46,305	$48,510	$50,715	$52,920	$55,125	$57,330	$59,535	$61,740	$66,150	$110,250
5	$25,790	$51,580	$54,159	$56,738	$59,317	$61,896	$64,475	$67,054	$69,633	$72,212	$77,370	$128,950
6	$29,530	$59,060	$62,013	$64,966	$67,919	$70,872	$73,825	$76,778	$79,731	$82,684	$88,590	$147,650
7	$33,270	$66,540	$69,867	$73,194	$76,521	$79,848	$83,175	$86,502	$89,829	$93,156	$99,810	$166,350
8	$37,010	$74,020	$77,721	$81,422	$85,123	$88,824	$92,525	$96,226	$99,927	$103,628	$111,030	$185,050

Patient Income and Eligibility Examples:

Example #1	Example #2	Example #3
- Patient earns $53,000 per year - There are 5 people in the patient's family - The % of potential Financial Assistance coverage would equal 90% (they earn more than $51,580 but less than $54,159)	- Patient earns $37,000 per year - There are 2 people in the patient's family - The % of potential Financial Assistance coverage would equal 40% (they earn more than $36,425 but less than $37,882)	- Patient earns $54,000 per year - There is 1 person in the family - The balance owed is $20,000 - This patient qualifies for Hardship coverage, owes$13,500 (25% of $54,000)

Notes: FPL = Federal Poverty Levels

Effective	02/11

SHORE HEALTH SYSTEM
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

Financial Assistance Program

Shore Health System is dedicated to assisting our community members with obtaining medical care regardless of their ability to pay.

If you:

- **Do not have medical insurance**
- **Do not have funds to pay for your medical care**
- **Do not qualify for Medical Assistance benefits**

you may be eligible for benefits through our Financial Assistance Program. Please ask to speak to a Financial Counselor or a Patient Financial Service Representative. They will assist you in determining if you are potentially eligible for benefits under this program.

You may also contact our Patient Financial Services business office directly at:

410-822-1000 ext. 1020
or
800-876-3364

Thank you for choosing Shore Health System.

SHORE HEALTH SYSTEM
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

PROGRAMA DE AYUDA FINANCIERA

Shore Health System está avocada a prestar ayuda a nuestra Comunidad, a fin de que sus miembros puedan obtener servicios de asistencia médica, sin importar que los pagos no puedan ser efectuados.

Si Ud.:

- **No tiene seguro médico**
- **No tiene dinero para pagar los servicios de asistencia médica**
- **No califica para obtener los beneficios de asistencia médica**

Puede ser seleccionado para obtener beneficios a través de nuestro Programa de Ayuda Financiera. Por favor, solicite hablar con nuestro Representante Financiero o nuestro Representante del Servicio Financiero para Pacientes. Ellos le ayudarán a determinar si Ud. califica para obtener estos beneficios.

Asimismo, puede contactar a nuestra Oficina de Servicios Financieros, llamados a los siguientes teléfonos:

410-822-1000, Anexo 1020
O
800-876-3364

GRACIAS POR ELEGIR SHORE HEALTH SYSTEM.

Chesapeake Publishing & Printing
P.O. Box 600
29088 Airpark Drive
Easton, MD 21601

Phone:**(410) 770-4000** Fax:**(410) 770-4012**

09/04/12

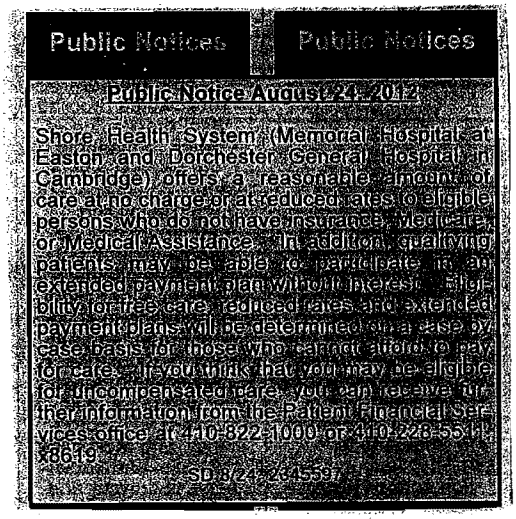
AFFIDAVIT OF PUBLICATION

STATE OF : MARYLAND

COUNTY OF: TALBOT

Personally appeared 08/24/12 before me, Rocky Brooks of the Star Democrat, Chesapeake Publishing and Printing, a daily newspaper printed and published in the City of Easton, County of Talbot County, State of Maryland, who, being duly sworn states that an advertisement of uncompensated care **was published in the:**
Star Democrat 08/24/12
US-ChesapeakeInternet 08/24/12

Dennis Sheely
Regional Advertising Director



Public Notices | Public Notices

Public Notice August 24, 2012

Shore Health System (Memorial Hospital at Easton and Dorchester General Hospital in Cambridge) offers a reasonable amount of care at no charge or at reduced rates to eligible persons who do not have insurance, Medicare, or Medical Assistance. In addition, qualifying patients may be able to participate in an extended payment plan without interest. Eligibility for free care, reduced rates and extended payment plans will be determined on a case by case basis for those who cannot afford to pay for care. If you think that you may be eligible for uncompensated care, you can receive further information from the Patient Financial Services office at 410-822-1000 or 410-228-5511 x8619.

SD 8/24 2045377

DORCHESTER BANNER

Published in Cambridge, Dorchester County

The Banner, Friday, August 24, 2012

PUBLIC NOTICE

Shore Health System (Memorial Hospital at Easton and Dorchester General Hospital in Cambridge) offers a reasonable amount of care at no charge or at reduced rates to eligible persons who do not have insurance, Medicare or Medical Assistance. In addition, qualifying patients may be able to participate in an extended payment plan without interest. Eligibility for free care, reduced rates and extended payment plans will be determined on a case by case basis for those who cannot afford to pay for care. If you think that you may be eligible for uncompensated care, you can receive further information from the Patient Financial Services office at 410-822-1000 or 410-228-5511, x8619.

424699 DB 8/24/2012

This hereby certifies that the annexed Notice was published in the Dorchester Banner in its issue of

August 24, 2012

Shore Health System
Memorial Hospital at Easton

Easton, 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

January 30, 2010

Accreditation is customarily valid for up to 39 months.

David L. Nahrwold, M.D.

Organization ID #6276
Print/Reprint Date: 1/31/11

Mark Chassin, M.D.

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

License No. 20-003

Issued to: Memorial Hospital At Easton
219 South Washington Street
Easton, MD 21601

Type of Facility: Acute General Hospital
Special Hospital - Rehabilitation

Date Issued: January 29, 2010

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.

Expiration Date: April 29, 2013

Nancy B. Grimm
Director

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

3/10 - Melissa
* Shawn received same

TOWN OF EASTON

P. O. Box 520
Easton, Maryland 21601

March 4, 2010

Richard E. Hall, Secretary
Maryland Department of Planning
301 West Preston Street
Baltimore, Maryland 21201

Re: Shore Health System/UMMS Hospital Relocation and Medical Campus; Certification of Priority Funding Area

Dear Secretary Hall:

This letter is a request to designate parcels recently annexed into the Town of Easton as Priority Funding Areas (PFA). As Easton's Mayor and on behalf of the Easton Town Council I offer the attached supporting documentation as certification that The Town of Easton has annexed, via Resolution No. 5955, lands owned by Talbot County and Shore Health System, Inc. into the Town of Easton. The annexation is generally located on the west side of U.S. Route 50 and consists of 276.479 acres. The annexation was approved by the Easton Town Council December 7, 2009 and became effective January 21, 2010. This annexation meets the qualifications for designation as a PFA under the "Smart Growth" Areas Act of 1997. In addition, the area was previously designated as a PFA in Talbot County in May of 2009 .

Ordinance No. 561 was approved in conjunction with the annexation resolution establishing original Town zoning for the annexed parcels. The annexation is made up of three parcels (A, B, & C) totaling 276.479 acres and are shown on the attached plat. Parcels "A & B" have been zoned **Regional Healthcare (RH)** and Parcel "C" has been zoned **Governmental/Institutional (G/I).** Both of these classifications were recently created by the Town primarily to accommodate this anticipated annexation. The area qualifies as an employment zone based on the zoning established which permits a regional hospital and ancillary uses on parcels "A & B" and public recreational uses on parcel "C". Furthermore, the property is designated in the Talbot County Master Water and Sewer Plan as "W-1/S-1," for immediate priorty water and sewer service.

I understand that this certification will be filed by the Department, that the Department may include comments as part of the file, and that the Department will coordinate with State funding agencies to inform them about the property's designation as a PFA. If you have any questions about this certification, please contact Town Planner Tom Hamilton at (410) 822-1943.

Sincerely,

Robert C. Willey

Robert Willey
Mayor

Enc. (copies: Res. 5955, Ord. 561, Dept. of Planning annexation letter)

cc: Shawn Kiernan MDP
Sharon VanEmburgh, Town Attorney
Tom Hamilton, Town Planner

ORDINANCE NO. 561

AN ORDINANCE OF THE TOWN OF EASTON AMENDING THE OFFICIAL ZONING MAP OF THE TOWN OF EASTON TO APPLY AN ORIGINAL ZONING CLASSIFICATION OF REGIONAL HEALTHCARE AND GOVERNMENTAL/INSTITUTIONAL TO THREE PARCELS OF LAND ANNEXED TO THE TOWN OF EASTON BY RESOLUTION NO. 5955 LOCATED ON THE WEST SIDE OF U.S. ROUTE 50 AND CONSISTING OF 276.479 ACRES OF LAND, MORE OR LESS

Introduced by: Mr. Lesher

WHEREAS, the Town of Easton (the "Town") is authorized by the Maryland Annotated Code, Article 23A Section 19(s) to exercise planning and zoning jurisdiction in any area annexed by it; and

WHEREAS, the Town of Easton is authorized by Maryland Annotated Code (the "Code") Article 66B, §4.01 *et seq.* to enact and administer a zoning ordinance, which ordinance is Chapter 28 of the Easton Town Code; and

WHEREAS, the Town is authorized by Article 66B, §4.02 of the Code to divide land within the municipal boundaries into zoning districts in a manner it deems best suited to execute the purposes of Article 66B; and

WHEREAS, the Town is authorized by Article 66B, §§4.04 and 4.05 of the Code to amend, supplement, modify or repeal sections of the zoning ordinance; and

WHEREAS, the Town has acted pursuant to its authority under Article 23A, Section 19 of the Code to introduce Resolution No. 5955 (the "Resolution") to expand its municipal boundaries by annexing lands adjacent to the present Town boundaries as requested by Talbot County, Maryland ("County") and Shore Health System, Inc. ("SHS"). The area proposed for annexation includes portions of three parcels owned by the County located on the west side of US Route 50, north of the Town's existing municipal boundary, consisting of a total of 276.479± acres of land, more or less (the "Annexation Property") comprised of: Tax Map 17, Parcel 75, containing 88.08 acres of land, more or less, of which 86.975 acres is proposed for annexation ("Parcel 'A'"); Tax Map 17, Parcel 129, containing 148.06 acres of land, more or less, of which 145.870 acres is proposed for annexation ("Parcel 'B'"); and Tax Map 17, Parcel 38, containing 43.67 acres of land, more or less, of which 43.633 acres is proposed for annexation ("Parcel 'C'"). The Annexation Property is shown on a plat titled "ANNEXATION 2009, TOWN OF EASTON OF THE LANDS OF

TALBOT COUNTY, MARYLAND IN THE FIRST ELECTION DISTRICT, TALBOT COUNTY, MARYLAND", prepared by Christopher Waters Professional Land Surveying, last revised August 4, 2009 (the "Annexation Plat"), which is Exhibit "A" to this Ordinance and to the Resolution.

WHEREAS, Regional Healthcare (RH) and Governmental/Institutional (G/I), the zoning designations established pursuant to Ordinance No. 560 and proposed by Petitioners for the Annexation Property, are consistent with relevant provisions of the Town Comprehensive Plan; and

WHEREAS, the Town Planning Commission considered the annexation and zoning requests during its public meeting on September 24, 2009 and recommended that the Easton Town Council annex the Annexation Property and zone such land as Regional Healthcare (RH) or Governmental/Institutional (G/I) as indicated herein; and

WHEREAS, the Easton Town Council finds that it is in the best interest of the Town to amend the Official Zoning Map of the Town to include the annexed property and to establish Regional Healthcare (RH) and Governmental/Institutional (G/I) zoning for such property; and

WHEREAS, the Easton Town Council held a duly noticed public hearing on this Ordinance on November 16, 2009.

Now, therefore, the Town of Easton hereby ordains as follows:

Section 1. Incorporation. The Annexation Plat attached hereto as Exhibit A is incorporated herein by reference.

Section 2. Modification of Official Zoning Map Boundaries. The Official Zoning Map of the Town of Easton is hereby amended to add those certain parcels or tracts of land annexed pursuant to Resolution No. 5955 (the "County Zoning Amendment Area"), which Annexation Property described on the Annexation Plat and is also described in a metes and bounds description prepared by Christopher Waters Professional Land Surveying entitled "Annexation, Town of Easton, Lands of Talbot County, Maryland", which is Exhibit "B" to said Resolution.

Section 3. Designation of Zoning for County Zoning Amendment Area. The County Zoning Amendment Area, as depicted by the Annexation Plat, shall be assigned classification of Regional Healthcare (RH) or Governmental/Institutional (G/I) as follows: (i) the annexed portions of Parcels A & B shall be zoned Regional Healthcare (RH), and (ii) the annexed portion of Parcel C

shall be zoned Governmental/Institutional (G/I). In accordance with Section 107 of the Zoning Ordinance, the amendment shall be made on the Official Zoning Map promptly after adoption of this Ordinance by the Easton Town Council with an entry on the Official Zoning Map as follows: "On Dec 7, 2009, by official action of the Town Council, the following changes were made in the Official Zoning Map: (1) 276.4791± acres, located generally east of Hailem School Road, south of Hiners Lane and west of Maryland Route 50 (including a portion of the Maryland Route 662 right-of-way) and lying contiguous to the corporate boundaries of the Town of Easton, are added hereto; (2) 232.845± acres of said lands are zoned and designated Regional Healthcare (RH); (3) 43.633± acres of said lands are zoned and designated Governmental/Institutional (G/I)", which entry shall be signed by the Mayor and Council attested by the Town Clerk.

Section 4. County Zoning Consent. The proposed Regional Healthcare (RH) and Governmental/Institutional (G/I) zoning classifications permit land uses that are different from the land uses allowed under the current County zoning classifications applicable to the Annexation Property. In accordance with Article 23A, Section 9(c) of the Code, if Talbot County expressly approves, the Town can place the annexed land in zoning classifications that allow different land uses. The classification of the Annexation Property in the Regional Healthcare (RH) and Governmental/Institutional (G/I) zoning districts is contingent upon the Town's receiving the express consent of the County prior to the effective date of this Ordinance.

Section 5. Survival. Except as amended herein, the remainder of the Official Zoning Map and the remaining terms of existing ordinances shall remain in full force and effect.

Section 6. Effective Date. In accordance with Article 23A, Section 19 and Article 66B, Sections 4.04 and 4.05 of the Code and Article II, Section 9 of the Easton Town Charter, this Ordinance shall become effective upon the later of: (a) the effective date of the Annexation Resolution pursuant to which the land area that it the subject of this Ordinance is annexed to the Town of Easton, (b) ten (10) days after the Town Council's public hearing on this Ordinance, or (c) twenty (20) calendar days after approval by the Mayor or passage of this Ordinance by the Council over the Mayor's veto.

Section 7. Severability. The Easton Town Council intends that, if a court of competent jurisdiction issues a final decision holding that any part of this ordinance is invalid, the remaining provisions hereof remain in full force and effect.

Ford	-	Yea
Wendowski	-	Yea
Malone	-	Yea
Lesher	-	Yea
Cook	-	Yea

I hereby certify that the above Ordinance was passed by a yea and nay vote of the Council this 7th day of December, 2009.

John Ford
John F. Ford, President

Delivered to the Mayor by me this 7th day of December, 2009.

Kathy M. Ruf
Kathy M. Ruf, Town Clerk

APPROVED: December 7, 2009

Date: December 7, 2009

Robert C. Willey
Robert C. Willey, Mayor

EFFECTIVE DATE: January 21, 2010.

Maryland Department of Planning

Martin O'Malley
Governor
Anthony G. Brown
Lt. Governor

Richard Eberhart Hall
Secretary
Matthew J. Power
Deputy Secretary

March 18, 2010

Mr. Robert Willey
Mayor
Town of Easton
P.O. Box 520
Easton, Maryland 21601

Re: Shore Health System/UMMS Hospital Relocation and Medical Campus; Certification of Priority Funding Area

Dear Mayor Willey:

Thank you for your March 4, 2010 letter regarding the status of the Priority Funding Area for the Shore Health System Hospital Relocation and Medical Campus. The Maryland Department of Planning (MDP) has assessed these areas based on the criteria for Priority Funding Areas contained in Finance and Procurement Article §5-7B-02.

Our understanding is that the annexed parcels being added to the PFA are consistent with current growth policies. The properties are also in the approved 10 year County Water and Sewer Plan as areas planned for service. These parcels are zoned as RH, regional healthcare and as G/I, governmental-institutional. Additionally, the area is inside a primary growth area in the Talbot County Comprehensive Land Use Plan as well as the Town of Easton's growth area. It is also designated as an area to be used primarily for employment.

The subject properties therefore meet all the designation requirements for Priority Funding Area certification. Accordingly, the Priority Funding Area maps prepared by the Maryland Department of Planning will be updated to reflect these changes and will be provided to the appropriate State funding agencies.

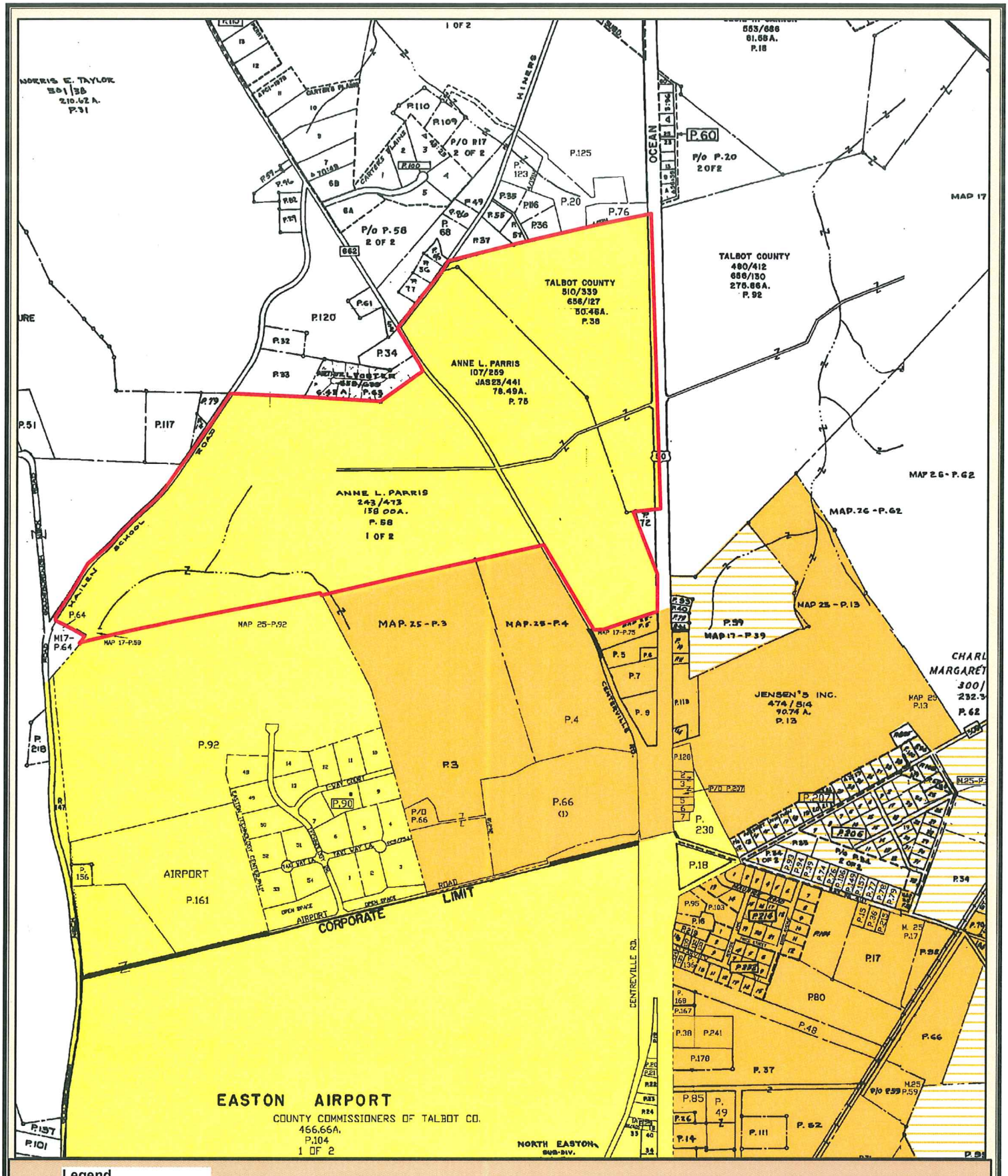
Thank you again for your letter. I look forward to working with you on future Smart Growth efforts. If you need anything further or have any additional questions please contact me at 410-767-4500.

301 West Preston Street • Suite 1101 • Baltimore, Maryland 21201-2305
Telephone: 410.767.4500 • Fax: 410.767.4480 • Toll Free: 1.877.767.6272 • TTY Users: Maryland Relay
Internet: www.MDP.state.md.us

Sincerely,

Stephanie Martins
Director, Land Use Planning Analysis

CC: Shawn Kiernan, MDP
Sharon VanEmburgh, Town Attorney
Tom Hamilton, Town Planner, Town of Easton
Sandy Coyman, Planning Officer, Talbot County
Matthew J. Power, Deputy Secretary, MDP
Richard Josephson, Director of Planning Services, MDP
Melissa Appler, MDP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78.49A.
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ANNE L. PARRIS
243/473
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276.66A.
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JENSEN'S INC.
474/814
90.74 A.
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Legend
Easton Hospital Site
Municipal PFA
Municipal PFA Comment Area
Annexed but not PFA
PFA
PFA Comment Area
PRIORITY FUNDING AREAS
Easton, Maryland
MDP
Maryland Department of Planning
March 2010
0.1 0.05 0 0.1 Miles

Marshall Valuation Service Analysis
A.L.S. HEALTHCARE CONSULTANT SERVICES
SHORE REGIONAL MEDICAL CENTER
Tower 1

I. The Marshall and Swift Guideline

				M&S Page #
a	Type		Hospital	Gen. Hospital or Conval. Hosp.
b	Construction Quality/Class		Good/A	
c	Stories		6	
d	Perimeter		1,196	for use in Perimtr Adj.
e	Average Floor to Floor Height		15.3	
f	Square Feet		296,002	
	f.1 Average floor Area		49,334	for use in Perimtr Adj.
	A. Base Costs			
g	Basic Structure	$	336.71	Section 15-24 - 26
h	Elimination of HVAC cost for adjustment		0	Section 15-25
I	HVAC Add-on for Mild Climate		0	Section 15-25
j	HVAC Add-on for Extreme Climate		0	Section 15-25
k	**Total Base Cost**		$336.71	Section 15-25
	Adjustment for Departmental Differential Cost Factors		1.17	
	Adjusted Total Base Cost		$392.96	
	B. Additions			
l	Elevator (If not in base)		$0.00	Section 15-36
m	Other		$0.00	Section 15-25
n	**Subtotal**		$0.00	
o	**Total**		$392.96	
	C. Multipliers			
p	Perimeter Multiplier		0.908749002	15-37 Interpolated
q	Product		$357.10	
r	Height Multiplier		1.076405989	15-37
s	Product		$384.39	
t	Multi-story Multiplier		1.015	15-25
u	Product		$390.15	
	D. Sprinklers			
v	Sprinkler Amount		$2.22	15-36
w	**Subtotal**		$392.38	
	E. Update/Location Multipliers			
x	Update Multiplier		1.04	99-3
y	Product		$408.07	
z	Location Multipier		1	99-5
aa	Product		$408.07	
bb	**Calculated Square Foot Cost Standard**		**$408.07**	

Marshall Valuation Service Analysis
A.L.S. HEALTHCARE CONSULTANT SERVICES
SHORE REGIONAL MEDICAL CENTER
Tower 2

	I. The Marshall and Swift Guideline			M&S Page #
a	Type		Hospital	
b	Construction Quality/Class		Good/A	
c	Stories		2	for use in Perimtr Adj.
d	Perimeter		636	
e	Average Floor to Floor Height		16.00	
f	Square Feet		29,125	for use in Perimtr Adj.
	Average floor Area		29,125	
	A. Base Costs			Section 15-19
g	Basic Structure	$	336.71	Section 15-25
h	Elimination of HVAC cost for adjustment		0	Section 15-25
I	HVAC Add-on for Mild Climate		0	Section 15-25
j	HVAC Add-on for Extreme Climate		0	Section 15-25
k	**Total Base** Cost		$336.71	
	Adjustment for Departmental Differential Cost Factors		1.05	
	Adjusted Total Base Cost		$355.07	
	B. Additions			Section 15-36
l	Elevator (If not in base)		$0.00	Section 15-25
m	Other		$0.00	
n	**Subtotal**		$0.00	
o	**Total**		$355.07	
	C. Multipliers			15-37
p	Perimeter Multiplier		0.902205063	Interpolated
q	Product	$	320.35	
				15-37
r	Height Multiplier		1.092	
s	Product		$349.82	
				15-25
t	Multi-story Multiplier		1.000	
u	Product		$349.82	
	D. Sprinklers			15-36
v	Sprinkler Amount		$2.94	
w	**Subtotal**		$352.76	
	E. Update/Location Multipliers			99-3
x	Update Multiplier		1.04	
y	Product		$366.87	
				99-5
z	Location Multipier		1	
aa	Product		$366.87	
bb	**Calculated Square Foot Cost Standard**		**$366.87**	

A.L.S., 9/6/2012

Marshall Valuation Service Analysis
A.L.S. HEALTHCARE CONSULTANT SERVICES
SHORE REGIONAL MEDICAL CENTER
Mechanical Penthouse

I. The Marshall and Swift Guideline

				M&S Page #	
a	Type		Mechanical Penthouse	Mechanical Penthouse	
b	Construction Quality/Class		Good/A		
c	Stories		7		
d	Perimeter		398	for use in Perimtr Adj.	
e	Average Floor to Floor Height		18.0		
f	Square Feet		4,676		
	f.1	Average floor Area	4,676	for use in Perimtr Adj.	
	A. Base Costs				
g		Basic Structure	$ 74.45	Section 15-24 - 26	
h		Elimination of HVAC c	0	Section 15-25	
I		HVAC Add-on for Mild	0	Section 15-25	
j		HVAC Add-on for Extr	0	Section 15-25	
k	**Total Base Cost**		$74.45	Section 15-25	
	Adjustment for Departmental Differential Cost Factors		N/A		
	Adjusted Total Base Cost		$74.45		
	B. Additions				
l		Elevator (If not in base	$0.00	Section 15-36	
m		Other	$0.00	Section 15-25	
n	**Subtotal**		$0.00		
o	**Total**		$74.45		
	C. Multipliers				
p	Perimeter Multiplier		1.068048	15-37	Interpolated
q		Product	$79.52		
r	Height Multiplier		1.076406	15-37	
s		Product	$85.59		
t	Multi-story Multiplier		1.020	15-25	

u	Product	$87.30	
	D. Sprinklers		
v	Sprinkler Amount	$4.52	15-36
w	**Subtotal**	$91.82	
	E. Update/Location Multipliers		
x	Update Multiplier	1.04	99-3
y	Product	$95.50	
z	Location Multipier	1	99-5
aa	Product	$95.50	
bb	**Calculated Square Foot Cost S**	**$95.50**	

Marshall Valuation Service Analysis
A.L.S. HEALTHCARE CONSULTANT SERVICES
SHORE REGIONAL MEDICAL CENTER
Consolidated MVS Estimate

Benchmark	MVS Benchmark	Sq. Ft.	Total Cost Based on MVS
Tower 1	$408.07	296,002	$120,790,706.62
Mechanical Penthouse	$95.50	4,676	$446,541.06
Tower 2	$366.87	58,250	$21,370,097.97
Consolidated	**$397.31**	358,928	$142,607,345.65

Marshall Valuation Service Analysis
A.L.S. HEALTHCARE CONSULTANT SERVICES
SHORE REGIONAL MEDICAL CENTER

II. The Project

A. Base Calculations	Actual	Per Sq. Foot
Building	$125,193,045	$348.80
Fixed Equipment		$0.00
Site Preparation	$36,015,484	$100.34
Architectual Fees	$17,400,000	$48.48
Permits	$4,107,718	$11.44
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$182,716,247	$509.06

B. Extraordinary Cost Adjustments

	Project Costs	
Inside the Loop		
Canopy	$992,358	Building
Premium for Labor Shortages on Eastern Shore Proje	$9,389,478	Building
LEED Silver Premium	$5,007,722	Building
Siesmic Costs	$2,503,861	Building
Signs	$1,000,000	Building
Jurisdictional Hook-up Fees	$1,852,215	Permits
Impact Fees	$1,539,819	Permits
Paving and Roads	$4,140,494	Site
Demolition	$25,000	Site
Storm Drains	$2,377,558	Site
Rough Grading	$1,419,437	Site
Landscaping	$2,136,906	Site
Sediment Control & Stabilization	$201,087	Site
Helipad	$598,648	Site
Water	$58,558	Site
Sewer	$93,692	Site
Outside the Loop		
Normal Site Work	$461,177	Site
Sediment Contorls	$221,905	Site
Rough Grading	$528,315	Site

Stormwater Drains	$1,083,977	Site
Paving and Roads	$5,351,458	Site
Landscaping	$150,493	Site
Water	$1,125,436	Site
Sewer	$677,278	Site
Gas	$244,420	Site
Electrical Ductbanks & Raceways	$2,887,287	Site
Communication Cabling - Verizon, etc.	$1,125,478	Site
Upsize Pump Station - 327 - 900 EDU's	$1,531,200	Site
Upsize Forcemain - 8" - 12"	$2,717,312	Site
SHS Share of Electrical Extension - Looped 25kV Fee	$3,397,000	Site
SHS Share of Gas Extension to RMC Building Site	$689,000	Site
MAN Loop Feed	$106,500	Site
Other County Charges	$1,580,380	Site
Total Cost Adjustments	$57,215,447	

C. Adjusted Project Cost		**Per Square Foot**
Building	$106,299,626	$296.16
Fixed Equipment		$0.00
Site Preparation	$1,085,490	$3.02
Architectual Fees	$11,590,584	$32.29
Permits	$715,684	$1.99
Subtotal	$119,691,384	$333.47
Capitalized Construction Interest	$14,486,957	$40.36
Total	$134,178,341	$373.83

MVS Benchmark	$397.31	
The Project	$373.83	
Difference	-$23.48	-$8,429,005
	-5.91%	**-$6,743,204**
		-$224,773

SHORE REGIONAL MEDICAL CENTER
Departmental Gross Square Feet - Tower 1

Floor	Department	EXISTING Dept. Area SF	PROPOSED Dept. Area SF	MVS Department Name	MVC Differential Cost	Cost Factor x SF
1	**Diagnostic & Treatment**					
	Cardiopulmonary/Vascular: Non-Invasive	6,065	5,026	Outpatient Department	0.99	4,976
	Emergency Department	21,220	19,394	Emergency Suite	1.18	22,885
	Imaging	16,465	17,179	Radiology	1.22	20,958
	Maryland Express Care	-	644	Offices	0.96	618
	Subtotal DGSF	***43,750***	***42,243***			
1	**Administrative & Public Services**					
	Admitting/Registration	3,410	2,097	Offices	0.96	2,013
	Lobby	1,400	2,116	Public Space	0.8	1,693
	Subtotal DGSF	***4,810***	***4,213***			
1	**Support Services**					
	Body Holding	-	342	Storage and Refrigeration	1.6	547
	Central Employee Locker Room	-	1,039	EmployeeFacilities	0.8	831
	EVS/Linen[2]	9,295	3,986	Laundry	1.68	6,696
	Facilities Management[2]	-	4,189	Offices	0.96	4,021
	Food & Nutrition	10,320	10,953	Dietary	1.52	16,649
	Materials Management/Receiving Dock	6,530	5,606	Storage and Refrigeration	1.6	8,970
	Subtotal DGSF	***26,145***	***26,115***			
1	**Clinics**					
	Breast Center	1,725	-			
	Coumadin(Anti-Thrombosis Clinic)[3]	925	-			
	Sleep Disorders Center	2,230	-			
	Specialty Clinic	1,570	-			
	National Wound Healing Center	3,160	-			
	Subtotal DGSF	***9,610***	***-***			
1	**Central Plant**		**14,420**	Mechanical Equipment and Shops	0.7	10,094
	Interdepartmental Circulation		**12,029**	Internal Circulation, Corridors	0.6	7,217
	Mechanical/Electrical Equipment Rooms		**1,354**			
	Mechanical Shafts		-	Mechanical Equipment and Shops	0.7	0
	Electrical Rooms		712	Mechanical Equipment and Shops	0.7	498
	IT Rooms		642	Mechanical Equipment and Shops	0.7	449
1	***Level 01 Subtotal DGSF***		***100,374***			
	Exterior Wall Allowance		**1,583**			
	Level 01 Total DGSF		***101,957***			

Floor	Department	EXISTING Dept. Area SF	PROPOSED Dept. Area SF	MVS Department Name	MVC Differential Cost	Cost Factor x SF
2	**Inpatient**					
	Pediatrics	6,025	5,682	Inpatient Units	1.06	6,023
	Observation	-	1,929	Inpatient Units	1.06	2,045
	Subtotal DGSF	***6,025***	***7,611***			
2	**Diagnostic & Treatment**					
	Interventional Suite: Surgery & Cath Lab	20,265	24,472	Operating Suite, Total	1.59	38,910
	Prep/Stage II/Recovery	14,425	9,055	Operating Suite, Total	1.59	14,397

	Subtotal DGSF	***34,690***	***33,527***			
2	**Shell**	**-**	***2,442***	Unassigned Areas	0.5	1,221
2	**Administrative & Public Services**					
	Chapel/Pastoral Care	160	559	*Public Space*	0.8	447
	Information Technology	3,005	2,659	Offices	0.96	2,553
	Nurse Staffing	-	645	Offices	0.96	619
	Subtotal DGSF	***3,165***	***3,863***			
2	**Support Services**					
	Pharmacy	4,570	4,033	Pharmacy	1.33	5,364
	Sterile Processing	4,600	6,109	Central Sterile Supply	1.54	9,408
	Subtotal DGSF	***9,170***	***10,142***			
2	**Interdepartmental Circulation**		**7,265**	Internal Circulation, Corridors	0.6	4,359
2	**Mechanical/Electrical Equipment Rooms**		**1,360**			
	Mechanical Shafts		**238**	Mechanical Equipment and Shops	0.7	167
	Electrical Rooms		678	Mechanical Equipment and Shops	0.7	475
	IT Rooms		444	Mechanical Equipment and Shops	0.7	311
2	***Level 02 Subtotal DGSF***		***66,210***			
	Exterior Wall Allowance		**2,435**			
2	***Level 02 Total DGSF***		***68,645***			
Floor	**Department**	**EXISTING Dept. Area SF**	**PROPOSED Dept. Area SF**	**MVS Department Name**	**MVC Differential Cost**	**Cost Factor x SF**
3	**Inpatient**					
	Medical	14,830	13,207	Inpatient Units	1.06	13,999
	Shared Support - Medical/Surgical	560	-	Inpatient Units	1.06	0
	Perinatal - LDRP	16,070	22,351	Obstetrical Suite Only	1.44	32,185
	Subtotal DGSF	***31,460***	***35,558***			
3	**Interdepartmental Circulation**		**3,146**	Internal Circulation, Corridors	0.6	4,359
3	**Mechanical/Electrical Equipment Rooms**		**1,330**			
	Mechanical Shafts		426	Mechanical Equipment and Shops	0.7	167
	Electrical Rooms		460	Mechanical Equipment and Shops	0.7	475
	IT Rooms		444	Mechanical Equipment and Shops	0.7	311
3	***Level 03 Subtotal DGSF***		***40,034***			
	Exterior Wall Allowance		**887**			
3	***Level 03 Total DGSF***		***40,921***			
Floor	**Department**	**EXISTING Dept. Area SF**	**PROPOSED Dept. Area SF**	**MVS Department Name**	**MVC Differential Cost**	**Cost Factor x SF**
4	**Inpatient**					
	Neuro/Joint Center	9,980	12,782	Inpatient Units	1.06	13,549
	Requard Center	12,740	15,974	Physical Medicine	1.09	17,412
	Subtotal DGSF	***22,720***	***28,756***			
4	**Interdepartmental Circulation**		**3,327**	Internal Circulation, Corridors	0.6	4,359
4	**Mechanical/Electrical Equipment Rooms**		**1,266**			

	Mechanical Shafts		568	Mechanical Equipment and Shops	0.7	167
	Electrical Rooms		460	Mechanical Equipment and Shops	0.7	475
	IT Rooms		238	Mechanical Equipment and Shops	0.7	311
4	***Level 04 Subtotal DGSF***		***33,349***			
	Exterior Wall Allowance		**873**			
4	***Level 04 Total DGSF***		***34,222***			
Floor	**Department**	**EXISTING Dept. Area SF**	**PROPOSED Dept. Area SF**	**MVS Department Name**	**MVC Differential Cost**	**Cost Factor x SF**
5	**Inpatient**					
	Intensive Care	6,505	9,918	Inpatient Units	1.06	10,513
	Telemetry	12,665	12,722	Inpatient Units	1.06	13,485
	Subtotal DGSF	***19,170***	***22,640***			
5	**Diagnostic & Treatment**					
	Respiratory Therapy	565	1,621	Offices	0.96	1,122
	Inpatient Dialysis	2,410	2,157	Inpatient Units	1.06	2,286
	Subtotal DGSF	***2,975***	***3,778***			
5	**Interdepartmental Circulation**		**3,593**	Internal Circulation, Corridors	0.6	4,359
5	**Mechanical/Electrical Equipment Rooms**		**1,266**			
	Mechanical Shafts		568	Mechanical Equipment and Shops	0.7	167
	Electrical Rooms		460	Mechanical Equipment and Shops	0.7	475
	IT Rooms		238	Mechanical Equipment and Shops	0.7	311
5	***Level 05 Subtotal DGSF***		***31,277***			
	Exterior Wall Allowance		**758**			
5	***Level 05 Total DGSF***		***32,035***			
Floor	**Department**	**EXISTING Dept. Area SF**	**PROPOSED Dept. Area SF**	**MVS Department Name**	**MVC Differential Cost**	**Cost Factor x SF**
6	**Inpatient**					
	Surgical	14,705	15,153	Inpatient Units	1.06	16,062
	Subtotal DGSF	***14,705***	***15,153***			
6	**Interdepartmental Circulation**		**1,835**	Internal Circulation, Corridors	0.6	4,359
6	**Mechanical/Electrical Equipment Rooms**		**762**			
	Mechanical Shafts		284	Mechanical Equipment and Shops	0.7	167
	Electrical Rooms		240	Mechanical Equipment and Shops	0.7	475
	IT Rooms		238	Mechanical Equipment and Shops	0.7	311
6	***Level 06 Subtotal DGSF***		***17,750***			
	Exterior Wall Allowance		**472**			
6	***Level 06 Total DGSF***		***18,222***			
	Subtotal DGSF		***288,994***		1.17	337,274
	Subtotal Exterior Wall Allowance		***7,008***			
	Total DGSF		***296,002***			

SHORE REGIONAL MEDICAL CENTER

Departmental Gross Square Feet - Tower 2

Floor	Department	EXISTING Dept. Area SF	PROPOSED Dept. Area SF	MVS Department Name	MVC Differential Cost Factor	Cost Factor x SF
1	**Diagnostic & Treatment**					0
	Outpatient Lab Draw	400	698	Outpatient Department	0.99	691
	Subtotal DGSF	***400***	***698***			
1	**Administrative & Public Services**					0
	Auxiliary	805	250	Volunteer Areas	0.8	200
	Education Center & Medical Library	5,405	5,941	Offices	0.96	5,703
	Gift Shop	1,185	676	Public Space	0.8	541
	Nursing Administration	1,835	1,176	Offices	0.96	1,129
	Switch Board	-	124	Mechanical Equipment and Shops	0.7	167
	Subtotal DGSF	***9,230***	***8,167***			
1	**Support Services**					
	Security[2]	-	733	Offices	0.96	704
	Subtotal DGSF	***-***	***733***			
1	**Clinics**					0
	Behavioral Health	1,110	730	Outpatient Department	0.99	723
	Cardio Fitness & Wellness	2,685	3,367	Physical Medicine	1.09	3,670
	Child Advocacy Center	1,310	1,372	Outpatient Department	0.99	1,358
	Infusion Center	1,725	2,273	Outpatient Department	0.99	2,250
	UMMS Diabetes Center	4,225	3,158	Outpatient Department	0.99	3,126
	Pain Management Center	2,318	2,728	Outpatient Department	0.99	2,701
	Shared Waiting Area	-	572	Outpatient Department	0.99	566
	Subtotal DGSF	***13,373***	***14,200***			
1	**Interdepartmental Circulation**		**4,209**	**Internal Circulation, Corridors**	0.6	4,359
1	**Mechanical/Electrical Equipment Rooms**		**330**			
	Mechanical Shafts		-	Mechanical Equipment and Shops	0.7	167
	Electrical Rooms		130	Mechanical Equipment and Shops	0.7	475
	IT Rooms		200	Mechanical Equipment and Shops	0.7	311
1	***Level 01 Subtotal DGSF***		***28,337***			
	Exterior Wall Allowance		**788**			
1	***Level 01 Total DGSF***		***29,125***			
Floor	**Department**	**EXISTING Dept. Area SF**	**PROPOSED Dept. Area SF**	**MVS Department Name**	**MVC Differential Cost Factor**	**Cost Factor x SF**
2	**Diagnostic & Treatment**					
	Clinical Laboratory	9,885	9,917	Laboratories	1.15	11,405
	Anatomic Pathology[1]	-	2,036	Laboratories	1.15	2,341
	Pre-Anesthesia Testing	1,010	1,030	Outpatient Department	0.99	1,020
	Subtotal DGSF	***10,895***	***12,983***			

2	**Administrative & Public Services**					
	CIM/Medical Staff/Quality Team	6,160	4,580	Offices	0.96	4,397
	Executive Administration	5,250	4,663	Offices	0.96	4,476
	Hospitalist Suite	528	502	Offices	0.96	482
	Human Resources	795	1,072	Offices	0.96	1,029
	Medical Staff Lounge	1,675	471	Offices	0.96	452
	Subtotal DGSF	***14,408***	***11,288***			
2	**Interdepartmental Circulation**		**3,650**	**Internal Circulation, Corridors**	0.6	4,359
2	**Mechanical/Electrical Equipment Rooms**		**405**			
	Mechanical Shafts		108	Mechanical Equipment and Shops	0.7	167
	Electrical Rooms		98	Mechanical Equipment and Shops	0.7	475
	IT Rooms		199	Mechanical Equipment and Shops	0.7	311
2	***Level 02 Subtotal DGSF***		***28,326***			
	Exterior Wall Allowance		**799**			
2	***Level 02 Total DGSF***		***29,125***			
	Subtotal DGSF		***56,663***		1.05	59,753
	Subtotal Exterior Wall Allowance		***1,587***			
	Total DGSF		***58,250***			

M&S Method for Interpolating Area and Perimeter Factor

Tower 1

		Perimeter		
		1000	1196	1200
Area	40000	0.91		0.923
	49334			
	50000	0.897		0.908

1000	1195.5	1200	
0.91		0.923	
0.897866233	**0.908749**	0.9089995	
0.897		0.908	

Area Interpolation

1	0.91	-	0.897	=	0.013
2	49333.67	-	40000	=	9333.666667
3	50000	-	40000	=	10000
4	9333.667	/	10000	=	0.933366667
5	0.013	*	0.933367	=	0.012133767
6	0.91	-	0.012134	=	0.897866233
7	0.923	-	0.908	=	0.015
8	0.015	*	0.933367	=	0.0140005
9	0.923	-	0.014001	=	0.9089995

Perimeter Interpolation

10	1200	-	1000	=	200
11	1195.5	-	1000	=	195.5
12	195.5	/	200	=	0.9775
13	0.909	-	0.897866	=	0.011133267
14	0.011133	*	0.9775	=	0.010882768
15	0.897866	+	0.010883	=	0.908749002

New

Total Square	296,002	
Basement		
1st Floor	101,957	
2nd Floor	68,645	
3rd Floor	40,921	
4th Floor	34,222	
5th Floor	32,035	
6th Floor	18,222	
Penthouse		
Average	**49334**	
Perimeter		
Basement		
1st Floor	1,863.58	
2nd Floor	1,131.67	
3rd Floor	1,235	
4th Floor	1255.08	
5th Floor	1026.75	
6th Floor	661.25	
Penthouse		
Average	**1196**	
Wall Height (floor to eaves)		Height X sf
Basement		-
1st Floor	16.00	1,631,312
2nd Floor	16.00	1,098,320
3rd Floor	14.00	572,894
4th Floor	14.00	479,108
5th Floor	14.00	448,490
6th Floor	16.75	305,219
Penthouse		
Average	**15.32**	4,535,343

15.32199951 Height

Capitalized Construction Allocation

	New	Renovation	Total
Building Cost	$125,193,045	$0	
Subtotal Cost (w/c	$182,716,247	$0	$182,716,247
Subtotal/Total	100.0%	0.0%	
Total Project Cap	$24,901,333	$0	$24,901,333
Building/Subtotal	68.5%	#DIV/0!	
Building Cap Inter	$17,061,831	#DIV/0!	

Wall Height Interpolation

15	1.069	
15.32		
16	1.092	

1	1.069	-	1.092	=	-0.023
2	15	-	15	=	0.322
3	16	-	15	=	1
4	0.32199951	/	1	=	0.322
5	-0.023	*	0.322	=	-0.00741
6	1.069	-	-0.007	=	**1.076406**

Sprinkler

250,000	2.28
296,002	
300,000	2.22

1	2.28	-	2.22	=	0.06
2	296,002	-	250000	=	46002
3	300000	-	250000	=	50000
4	46002	/	50000	=	0.92004
5	0.06	*	0.92	=	0.055202
6	2.28	-	0.0552	=	**2.224798**

M&S Method for Interpolating Area and Perimeter Factor

Tower 2

		Perimeter						
		600	636	700		600	635.75	700
Area	25,000	0.908		0.918		0.908		0.918
	29,125					0.898925	**0.902205063**	0.9081
	30,000	0.897		0.906		0.897		0.906

Area Interpolation

1	0.908	-	0.897	=	0.011
2	29125	-	25000	=	4125
3	30000	-	25000	=	5000
4	4125	/	5000	=	0.825
5	0.011	*	0.825	=	0.009075
6	0.908	-	0.009075	=	0.898925
7	0.918	-	0.906	=	0.012
8	0.012	*	0.825	=	0.0099
9	0.918	-	0.0099	=	0.9081

Perimeter Interpolation

10	700	-	600	=	100
11	635.75	-	600	=	35.75
12	35.75	/	100	=	0.3575
13	0.9081	-	0.898925	=	0.009175
14	0.009175	*	0.3575	=	0.00328
15	0.898925	+	0.00328	=	0.902205

	New		116500	233000	466000	932000						
			1271.5	2543	5086	10172						
Total Square	58,250				Sprinkler							
1	29,125					50000	3					
2	29,125					58,250.00	2.9373					
Average	**29,125.00**					75000	2.81				158.9375	25261.13
Perimeter												
1	635.75				1	3	-	2.81	=	0.19		
2	635.8				2	58,250	-	50000	=	8250		
Average	**635.8**				3	75000	-	50000	=	25000		
Wall Height (floor to eaves)		Wall Height Interpolat			4	8250	/	25000	=	0.33		
1	16				5	0.19	*	0.33	=	0.0627		
2	16.00	466000			6	3	-	0.0627	=	2.9373		
Average	**16.00**	466000		8								

M&S Method for Interpolating Area and Perimeter Factor Mechanical Penthouse

		Perimeter						
		300	398	400		300	398	400
Area	4,000	1.04		1.105		1.04		1.105
	4,676					1.01296	**1.06804776**	1.069172
	5,000	1		1.052		1		1.052

Area Interpolation

1	1.04	-	1	=	0.04
2	4676	-	4000	=	676
3	5000	-	4000	=	1000
4	676	/	1000	=	0.676
5	0.04	*	0.676	=	0.02704
6	1.04	-	0.02704	=	1.01296
7	1.105	-	1.052	=	0.053
8	0.053	*	0.676	=	0.035828
9	1.105	-	0.035828	=	1.069172

Perimeter Interpolation

10	400	-	300	=	100
11	398	-	300	=	98
12	98	/	100	=	0.98
13	1.069172	-	1.01296	=	0.056212
14	0.056212	*	0.98	=	0.055088
15	1.01296	+	0.055088	=	1.068048

New 9352 18704 37408 74816

0 0 0 0

Total Square	4,676
1	4,676
Average	**4,676.00**
Perimeter	
1	398
Average	**398.0**
Wall Height (floor to eaves)	
1	18
Average	**0.00**

Sprinkler

					3000	4.83		
					4,676.00	4.51994		
					5000	4.46	0	0
				1	4.83	-	4.46	= 0.37
Wall Height Interpolat				2	4,676	-	3000	= 1676
				3	5000	-	3000	= 2000
0				4	1676	/	2000	= 0.838
0	0			5	0.37	*	0.838	= 0.31006
				6	4.83	-	0.31006	= 4.51994

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WRITER'S DIRECT NUMBER IS
410-337-5885

August 23, 2012

Mr. Andrew L. Solberg
A.L.S. HEALTHCARE CONSULTANT SERVICES
5612 Thicket Lane
Columbia, Maryland 21044

Ref: Shore Health System Regional Medical Center MVS Evaluation

Dear Mr. Solberg:

I am writing to support of our position that a Modifying Adjustment for a Remote Area is appropriate for the Shore Health System – Regional Medical Center project.

The proposed Regional Medical Center is a new Class A - Good 6 story – 355,000 square foot full-range replacement hospital located in Easton, Maryland. The estimated total cost of construction is expected to be slightly more than $160 million dollars.

At $160 million dollars this will be the largest construction project constructed in the area in quite some time. As a matter of fact the major subcontracts themselves will exceed the value of any single project constructed in the area in recent years. The local subcontractor market, material suppliers, and skilled labor pool on the eastern shore will not be able to support this project and therefore we expect most of the labor and materials will be provided by contractors and suppliers based in the Baltimore-Washington metropolitan area. The cities of Baltimore and Washington are located approximately 62 and 70 miles respectively from the jobsite. This is too far a distance to expect workers to commute each day without some form of reimbursement for the time associated with the commute plus tolls. Some firms may offer to provide their employees with a per diem for local lodging and meals so they can stay in the area and avoid the commute. Additionally we may very well have to provide wage scale incentives, particularly if the overall economy improves and the construction market improves in the

Baltimore/Washington area. Either way there will be a premium paid to entice labor to the project.

In addition to the region's skilled labor shortage, most of the materials and equipment will also be supplied from the Baltimore-Washington area. The cost of the commute, inclusive of mileage, tolls, and time, again results in added costs. The only abundant natural resources available on the shore are softwood lumber and sand.

In an effort to quantify the impact on the overall project cost we offer the following:

I. Labor Cost Impact Analysis:

A. Commuting Compensation – Based on WT Subsistence

Daily Tolls: $4.00
Mileage above 40 miles: 132 miles – 40 miles = 92 miles @ $0.45 = $41.40. If you assume a 50% car pool rate = $20.70
Added Salary – based on mileage: 92 miles @ $0.25 = $23.00
Total Daily Commuting Compensation: $47.70
Total Hourly Commuting Compensation: $5.96

When this hourly premium is added to the various wage rates and the total estimated manhours for this project as indicated in the attached exhibit it results in a 16% increase in labor costs.

B. Temporary Housing Compensation – Daily Per Diem

Extended Stay Hotel Daily Rate: $80 per day (double occupancy) = $5 per hour.
Meal Allowance: $20 per day = $2.50 per hour.
Total Daily Per Diem = $7.5

Salary Compensation: 10% premium

When this premium is applied as indicated on the attached exhibit it results in a 30% increase in labor costs, however we would assume some contractor personnel would share housing and institute a domestic meal plan.

II. Material and Equipment Cost Impact Analysis:

The overall impact on materials and equipment is harder to calculate. The added freight charges amount to about $200 per load, however the cost impact of this is related to the commodity being delivered - the cheaper the unit price of the commodity the greater the proportional impact. We estimate the overall impact to be approximately 0.5% of material and equipment costs.

III. Total Remote Location Impact:

Based on a typical building project breakdown of 45% labor, and 55% material and equipment the impact of the aforementioned labor and material/equipment impact is calculated as a weighted average. Based on an estimated building cost of $125 million dollars yields the following:

Labor:	45% x $125M = $56,250,000 x 16% = $9,000,000
Material & Equipment:	55% x $125M = $88,000,000 x 0.5% = $343,750

TOTAL IMPACT: $9,343,750

Therefore based the above weighted average of labor and material/equipment costs total premium is 7.5%. This is within the prescribed range of 5% to 15% that MVS allows for Remote Areas.

Should you have any question or comments relative to the above please feel free to call me at 443-324-0376.

Sincerely,

The Whiting-Turner Contracting Company

Randy E. Thomas, CCM PSP
Senior Project Manager

WHITING-TURNER

ANTICPATED WAGE RATE PREMIUM CALCULATION FOR SHORE HEALTH RMC
EASTON, MARYLAND
August 23, 2012

A. Commuting Compensation

	PREVAILING WAGE	OPEN SHOP WAGE	AVERAGE					
	Talbot County Informational 8/23/2012	ROT 25% Less						
TRADE CLASSIFICATION	Estimated Hours*	Total Base Rate plus Fringes			Hourly Per Diem	Adjusted Hourly Rate	Extended BC Rates	Extended TC Adjusted Rates
Bricklayer	15,000	$ 35.51	$ 26.63	$ 31.07	$ 5.96	$ 37.03	$ 466,069	$ 555,469
Carpenter	200,000	$ 49.06	$ 36.80	$ 42.93	$ 5.96	$ 48.89	$ 8,585,500	$ 9,777,500
Electrician	270,000	$ 35.76	$ 26.82	$ 31.29	$ 5.96	$ 37.25	$ 8,448,300	$ 10,057,500
Glazier	40,000	$ 26.58	$ 19.94	$ 23.26	$ 5.96	$ 29.22	$ 930,300	$ 1,168,700
Ironworker - Reinforcing	50,000	$ 43.32	$ 32.49	$ 37.91	$ 5.96	$ 43.87	$ 1,895,250	$ 2,193,250
Laborer - Skilled	50,000	$ 32.79	$ 24.59	$ 28.69	$ 5.96	$ 34.65	$ 1,434,563	$ 1,732,563
Plumber	160,000	$ 46.28	$ 34.71	$ 40.50	$ 5.96	$ 46.46	$ 6,479,200	$ 7,432,800
Sheetmetal Worker	158,400	$ 50.79	$ 38.09	$ 44.44	$ 5.96	$ 50.40	$ 7,039,494	$ 7,983,558
Sprinklerfitter	20,000	$ 47.20	$ 35.40	$ 41.30	$ 5.96	$ 47.26	$ 826,000	$ 945,200
Pipefitter	160,000	$ 46.28	$ 34.71	$ 40.50	$ 5.96	$ 46.46	$ 6,479,200	$ 7,432,800
Total Skilled Labor OME	1,123,400						$ 42,583,875	$ 49,279,339
Average Wage Rate							$ 37.91	$ 43.87
WEIGHTED AVERAGE LABOR COST PREMIUM FOR EASTON, MARYLAND								**116%**

*** The Estimated Hours listed above do not represent all of the trades or labor on the project.**

B. Temporary Housing Compensation – Daily Per Diem

	PREVAILING WAGE	OPEN SHOP WAGE	AVERAGE					
	Talbot County Informational 8/23/2012	ROT 25% Less						
TRADE CLASSIFICATION	Estimated Hours*	Total Base Rate plus Fringes			Daily Per Diem	Hourly Rate - 10%	Extended BC Rates	Extended TC Adjusted Rates
Bricklayer	15,000	$ 35.51	$ 26.63	$ 31.07	$ 7.50	$ 41.68	$ 466,069	$ 625,176
Carpenter	200,000	$ 49.06	$ 36.80	$ 42.93	$ 7.50	$ 54.72	$ 8,585,500	$ 10,944,050
Electrician	270,000	$ 35.76	$ 26.82	$ 31.29	$ 7.50	$ 41.92	$ 8,448,300	$ 11,318,130
Glazier	40,000	$ 26.58	$ 19.94	$ 23.26	$ 7.50	$ 33.08	$ 930,300	$ 1,323,330
Ironworker - Reinforcing	50,000	$ 43.32	$ 32.49	$ 37.91	$ 7.50	$ 49.20	$ 1,895,250	$ 2,459,775
Laborer - Skilled	50,000	$ 32.79	$ 24.59	$ 28.69	$ 7.50	$ 39.06	$ 1,434,563	$ 1,953,019
Plumber	160,000	$ 46.28	$ 34.71	$ 40.50	$ 7.50	$ 52.04	$ 6,479,200	$ 8,327,120
Sheetmetal Worker	158,400	$ 50.79	$ 38.09	$ 44.44	$ 7.50	$ 56.39	$ 7,039,494	$ 8,931,443
Sprinklerfitter	20,000	$ 47.20	$ 35.40	$ 41.30	$ 7.50	$ 52.93	$ 826,000	$ 1,058,600
Pipefitter	160,000	$ 46.28	$ 34.71	$ 40.50	$ 7.50	$ 52.04	$ 6,479,200	$ 8,327,120
Total Skilled Labor OME	1,123,400						$ 42,583,875	$ 55,267,763
Average Wage Rate							$ 37.91	$ 49.20
WEIGHTED AVERAGE LABOR COST PREMIUM FOR EASTON, MARYLAND								**130%**

*** The Estimated Hours listed above do not represent all of the trades or labor on the project.**

INFORMATIONAL WAGE RATES

The wage rates listed below are published by the State of Maryland, Division of Labor and Industry, Prevailing Wage Unit.

The wage rates posted on this site are provided for **informational** purposes ONLY.

The wage and fringe rates may change between the time of issuance of the wage determinations and the award of the public works contract. Therefore, prior to the award of the public works contract, verification must be made with the public body, to insure that the rates contained in this determination are still prevailing.

These **Informational Prevailing Wage Rates** may not be substituted for the requirements of pre-advertisement for bids or onsite job posting for public work contracts that are funded with 50% of State funds and are over $500,000 in contract value.

TALBOT COUNTY | **BUILDING CONSTRUCTION** | **Print Date August 23, 2012**

CLASSIFICATION	MODIFICATION REASON	BASIC HOURLY RATE	BORROWED FROM	FRINGE BENEFIT PAYMENT
BALANCING TECHNICIAN	SR	$ 20.00		$3.99
BRICKLAYER	SR	$ 27.21	011	$8.30
BRICKLAYER/SAWMAN	SR	$ 24.84	510	$11.12
CARPENTER	SR	$ 30.07	035	$18.99
CEMENT MASON	SR	$ 23.60	011	$8.98
COMMUNICATION INSTALLER TECHNICIAN	SR	$ 23.15		$6.65 a+b
DRYWALL - SPACKLING, TAPING, & FINISHING	SR	$ 24.64	045	$7.91
ELECTRICIAN	SR	$ 23.20		$12.56
ELEVATOR MECHANIC	SR	$ 39.65	510	$26.43
FIREPROOFER - SPRAYER	SR	$ 21.00	027	$4.69
FIRESTOPPER	SR	$ 25.11	510	$7.36
GLAZIER	SR	$ 18.60	001	$7.98
INSULATION WORKER	SR	$ 31.79	035	$14.73
IRONWORKER	SR	$ 24.97	001	$15.02
IRONWORKER - FENCE ERECTOR	SR	$ 28.83	033	$14.80
IRONWORKER - ORNAMENTAL	SR	$ 28.58	031	$14.80
IRONWORKER - REINFORCING	SR	$ 26.38		$16.94
LABORER - AIR TOOL OPERATOR	SR	$ 18.49	023	$14.30
LABORER - ASPHALT PAVER	SR	$ 15.00	005	$3.40
LABORER - ASPHALT RAKER	SR	$ 16.54	005	$3.50
LABORER - BLASTER - DYNAMITE	SR	$ 18.49	023	$14.30
LABORER - BURNER	SR	$ 18.49	023	$14.30
LABORER - COMMON OR UNSKILLED	SR	$ 12.00	045	$0.28
LABORER - CONCRETE PUDDLER	SR	$ 18.49	023	$14.30
LABORER - CONCRETE SURFACER	SR	$ 18.49	023	$14.30
LABORER - CONCRETE TENDER	SR	$ 18.49	023	$14.30
LABORER - CONCRETE VIBRATOR	SR	$ 18.49	023	$14.30
LABORER - DENSITY GAUGE	SR	$ 18.49	023	$14.30
LABORER - FIREPROOFER - MIXER	SR	$ 16.50	027	$3.49
LABORER - GRADE CHECKER	SR	$ 18.49	023	$14.30
LABORER - HAND ROLLER	SR	$ 18.49	023	$14.30
LABORER - HAZARDOUS MATERIAL HANDLER	SR	$ 18.49	023	$14.30
LABORER - JACKHAMMER	SR	$ 18.49	023	$14.30
LABORER - LAYOUT	SR	$ 18.49	023	$14.30
LABORER - LUTEMAN	SR	$ 16.54	005	$3.50

CLASSIFICATION	MODIFICATION REASON	BASIC HOURLY RATE	BORROWED FROM	FRINGE BENEFIT PAYMENT
LABORER - MASON TENDER	SR	$ 18.49	023	$14.30
LABORER - MORTAR MIXER	SR	$ 18.49	023	$14.30
LABORER - PIPELAYER	SR	$ 18.49	023	$14.30
LABORER - PLASTERER - HANDLER	SR	$ 18.49	023	$14.30
LABORER - SCAFFOLD BUILDER	SR	$ 18.49	023	$14.30
LABORER - TAMPER	SR	$ 18.49	023	$14.30
MILLWRIGHT	SR	$ 27.22	023	$12.90
PAINTER	SR	$ 24.64	045	$7.91
PAINTER - BRIDGE	SR	$ 24.64	031	$7.91
PILEDRIVER	SR	$ 24.94	031	$8.18
PLASTERER	SR	$ 27.00	003	$5.95
PLUMBER	SR	$ 32.52		$13.76
POWER EQUIPMENT OPERATOR - ASPHALT DISTRIBUTOR	SR	$ 18.00	005	$3.58
POWER EQUIPMENT OPERATOR - BACKHOE	SR	$ 25.47	023	$13.35
POWER EQUIPMENT OPERATOR - BOBCAT	SR	$ 25.47	001	$13.35
POWER EQUIPMENT OPERATOR - BOOM TRUCK	SR	$ 32.11	031	$9.45
POWER EQUIPMENT OPERATOR - BULLDOZER	SR	$ 25.30	510	$11.55 a+b
POWER EQUIPMENT OPERATOR - CRANE	SR	$ 28.55	015	$14.55 a
POWER EQUIPMENT OPERATOR - CRANE - TOWER	SR	$ 34.00	031	$2.52
POWER EQUIPMENT OPERATOR - DRILL - RIG	SR	$ 27.64	001	$6.32
POWER EQUIPMENT OPERATOR - EXCAVATOR	SR	$ 15.00	045	$1.30
POWER EQUIPMENT OPERATOR - FORKLIFT	SR	$ 24.00	001	$5.77
POWER EQUIPMENT OPERATOR - GRADALL	SR	$ 25.95	510	$11.55
POWER EQUIPMENT OPERATOR - GRADER	SR	$ 25.03	005	$14.85 a
POWER EQUIPMENT OPERATOR - HOIST	SR	$ 25.47	001	$13.35
POWER EQUIPMENT OPERATOR - LOADER	SR	$ 25.47	023	$13.35
POWER EQUIPMENT OPERATOR - MASTER MECHANIC	SR	$ 25.22	001	$13.35
POWER EQUIPMENT OPERATOR - MILLING MACHINE	SR	$ 21.63	005	$3.24
POWER EQUIPMENT OPERATOR - OILER	SR	$ 25.47	001	$13.35
POWER EQUIPMENT OPERATOR - PAVER	SR	$ 24.92	001	$13.35
POWER EQUIPMENT OPERATOR - ROLLER - ASPHALT	SR	$ 24.92	001	$13.35
POWER EQUIPMENT OPERATOR - ROLLER - EARTH	SR	$ 24.92	001	$13.35
POWER EQUIPMENT OPERATOR - SCRAPER - PAN	SR	$ 25.47	001	$13.35
POWER EQUIPMENT OPERATOR - SCREED	SR	$ 25.03	005	$14.85
POWER EQUIPMENT OPERATOR - SWEEPER	SR	$ 24.27	001	$13.10
RESILIENT FLOOR/CARPET LAYER	SR	$ 26.36		$18.56
ROOFER/WATERPROOFER	SR	$ 21.95	023	$9.15
SHEETMETAL WORKER	SR	$ 37.09		$13.70
SPRINKLERFITTER	SR	$ 29.95	035	$17.25
STEAMFITTER/PIPEFITTER	SR	$ 32.52		$13.76
TILE & TERRAZZO FINISHER	SR	$ 20.48	035	$8.84
TILE & TERRAZZO MECHANIC	SR	$ 21.23	035	$8.84
TRUCK DRIVER - DUMP	SR	$ 20.14	001	$14.76
TRUCK DRIVER - LOWBOY	SR	$ 20.00	005	$3.16

CLASSIFICATION	MODIFICATION REASON	BASIC HOURLY RATE	BORROWED FROM	FRINGE BENEFIT PAYMENT

FRINGE REFERENCES AS NOTED:

a. PAID HOLIDAYS: New Year Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day & Christmas Day.

b. PAID VACATIONS: Employees with 1 year service - 1 week paid vacation;
2 years service - 2 weeks paid vacation;
10 years service - 3 weeks paid vacation.

c. PAID HOLIDAYS: New Year Day, Memorial Day, July 4th, Labor Day, Veteran's Day, Thanksgiving Day & Christmas Day.

These **Informational Prevailing Wage Rates** may not be substituted for the requirements of pre-advertisement or onsite job posting for public work contracts that are funded with 50% of State funds and are over $500,000 in contract value.

Modification Codes:

(AD) 17-209 Annual Determination from Survey Wage Data Received
(CH) 17-211 Commissioners' Hearing
(CR) 17-208 Commissioners' Review
(SR) 17-208 Survey Review by Staff

Each "Borrowed From" county is identified with the FIPS 3-digit county code unique for the specific jurisdiction in Maryland.

For additional information on the FIPS (Federal Information Processing Standard) code, see http://www.census.gov/datamap/fipslist/AllSt.txt

The Prevailing Wage rates appearing on this form were originally derived from Maryland's annual Wage Survey. The Commissioner of Labor & Industry encourages all contractors and interested groups to participate in the voluntary Wage Survey, detailing wage rates paid to workers on various types of construction throughout Maryland.

A mail list of both street and email addresses is maintained by the Prevailing Wage Unit to enable up-to-date prevailing wage information, including Wage Survey notices to be sent to contractors and other interested parties. If you would like to be included in the mailing list, please forward (1) your Name, (2) the name of your company (if applicable), (3) your complete postal mailing address, (4) your email address and (5) your telephone number to PWMAILINGLIST@dllr.state.md.us. Requests for inclusion can also be mailed to: Prevailing Wage, 1100 N. Eutaw Street - Room 607, Baltimore MD 21201-2201.

END OF REPORT

Exhibit 13
Inpatient Unit Program Space Per Bed

LEVEL 02 PEDIATRIC

ROOM/FUNCTION	NEW-ADDITIONAL			NOTES
	QTY	NSF/EACH	TOTAL NSF	
BED STOR	1	149	149	
CHART	1	13	13	
CHART	1	13	13	
CLEAN	1	97	97	
DIET CART	1	15	15	
EQ	1	98	98	
EXAM/ TREAT	1	158	158	
FAM TLT	1	67	67	
FAMILY	1	140	140	
HSKP	1	45	45	
LINEN	1	22	22	
MEDS	1	108	108	
MULTIPURPOSE/ PLAY	1	214	214	
NOUR	1	82	82	
OFF, CASE MGR	1	84	84	
OFF, UNIT MGR	1	84	84	
OFFICE, COORD & EDUC	1	161	161	
PEDS 1	1	212	212	
PEDS 2	1	212	212	
PEDS 3	1	212	212	
PEDS 4	1	213	213	
PEDS 5	1	212	212	
PEDS 6	1	220	220	
PHYS WORK	1	86	86	
SOIL	1	104	104	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
ST BREAK	1	100	100	
ST TLT	1	50	50	
TLT/SHWR	1	37	37	

TLT/SHWR	1	37	37	
TLT/SHWR	1	37	37	
TLT/SHWR	1	37	37	
TLT/SHWR	1	37	37	
TLT/SHWR	1	37	37	
TOY CLEANING	1	86	86	
WORK STATION	1	155	155	
SUBTOTAL NET			3649	
SHARED SUPPORT			0	
TOTAL NET			**3649**	
TOTAL # BEDS			**6**	
DGSF/BED			**608**	

LEVEL 03 SHARED SUPPORT

	NEW-ADDITIONAL			
ROOM/FUNCTION	**QTY**	**NSF/EACH**	**TOTAL NSF**	**NOTES**
CONSULT	1	81	81	
FAMILY WAIT	1	345	345	
HSKP STOR	1	43	43	
PUB TLT	1	56	56	
PUB TLT	1	56	56	
STAFF EDUC ROOM	1	230	230	
STORAGE	1	76	76	
VEND	1	27	27	
TOTAL NET			**914**	
TOTAL # BEDS			**N/A**	
NSF/UNIT			**457**	INCLUDED IN UNIT TOTALS BELOW

LEVEL 03 MEDICAL

	NEW-ADDITIONAL			
ROOM/FUNCTION	**QTY**	**NSF/EACH**	**TOTAL NSF**	**NOTES**
1 (ADA)	1	212	212	
2	1	209	209	

3	1	209	209	
4	1	209	209	
5	1	209	209	
6	1	209	209	
7	1	209	209	
8	1	209	209	
9 （PALLIATIVE CARE）	1	209	209	
10 （PALLIATIVE CARE, ADA）	1	212	212	
11 （ISOL）	1	215	215	
12 （ISOL）	1	209	209	
13	1	209	209	
14	1	209	209	
15	1	209	209	
16	1	209	209	
17	1	209	209	
18	1	209	209	
19	1	209	209	
20	1	216	216	
ALC	1	28	28	
ALC	1	22	22	
ALCOVE	1	45	45	
CC	1	14	14	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CLEAN	1	132	132	
CLEAN	1	118	118	
CLINICIAN WORK	1	130	130	
DIET CART	1	15	15	
EQ	1	150	150	

HSKP	1	45	45	
LINEN	1	32	32	
LINEN	1	23	23	
MEDS	1	126	126	
MEDS	1	106	106	
NOUR	1	84	84	
OFF, CASE MGR	1	80	80	
OFF, CLIN COORD	1	82	82	
OFF, ENT THER	1	104	104	
OFF, PAIN SPEC	1	82	82	
OFF, PAT EDUC	1	192	192	
OFF, UNIT MGR	1	86	86	
PALLIATIVE CARE FAMILY ROOM	1	339	339	
PHYSICIAN WORK	1	123	123	
SOIL	1	148	148	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
ST BREAK	1	154	154	
ST LOCKER	1	323	323	
ST TLT	1	62	62	
ST TLT	1	54	54	
STOR	1	111	111	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	

TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
WORK STATION	1	222	222	
WORK STATION	1	195	195	
SUBTOTAL NET			8618	
SHARED SUPPORT			457	
TOTAL NET			**9075**	
TOTAL # BEDS			**20**	
DGSF/BED			**454**	

LEVEL 03 PERINATAL /
LDRP UNIT

ROOM/FUNCTION	NEW-ADDITIONAL			NOTES
	QTY	NSF/EACH	TOTAL NSF	
ALCOVE	1	26	26	
CLEAN	1	133	133	
CLIN WORK	1	84	84	
DIET CART	1	32	32	
EQ STOR	1	201	201	
EQ STOR	1	88	88	
FAMILY RESPITE	1	216	216	
FEM LOCKERS	1	233	233	
HLTH ED STOR	1	73	73	
HSKP	1	49	49	

LACTATION OFFICE	1	87	87	
LDRP 2	1	341	341	
LDRP 3	1	341	341	
LDRP 4	1	340	340	
LDRP 5	1	343	343	
LDRP 6 (ADA)	1	355	355	
LDRP 7 (ADA)	1	371	371	
LDRP 8	1	342	342	
LDRP 9	1	341	341	
LDRP 10	1	342	342	
LDRP 11	1	341	341	
LDRP 12	1	341	341	
LDRP 13 (ISOL)	1	341	341	
LDRP 14 (ISOL)	1	353	353	
LDRP 1	1	341	341	
M LOCKER	1	134	134	
MEDS	1	100	100	
NOUR	1	78	78	
OFF, CASE MGR	1	105	105	
OFF, CLIN COOR	1	81	81	
OFF, EDUC	1	92	92	
OFF, TRACE VUE	1	112	112	
OFF, UNIT MGR	1	82	82	
ON-CALL	1	111	111	
ON-CALL	1	89	89	
ON-CALL	1	88	88	
ON-CALL	1	80	80	
PAT TLT	1	54	54	
PAT TLT	1	52	52	
PAT TLT	1	52	52	
SOIL EQ	1	54	54	
SOILED HOLDING	1	100	100	
ST BREAK	1	222	222	
ST TLT	1	57	57	
STAFF WORK	1	432	432	
STOR	1	26	26	
STOR	1	19	19	

STOR	1	17	17	
TLT/ SHWR	1	210	210	
TLT/ SHWR	1	80	80	
TLT/BATH	1	50	50	
TLT/BATH	1	48	48	
TLT/BATH	1	47	47	
TLT/BATH	1	47	47	
TLT/BATH	1	47	47	
TLT/BATH	1	47	47	
TLT/BATH	1	47	47	
TLT/BATH	1	47	47	
TLT/BATH	1	47	47	
TLT/BATH	1	47	47	
TLT/BATH	1	47	47	
TLT/BATH	1	47	47	
TLT/BATH	1	47	47	
TLT/BATH	1	47	47	
TLT/BATH	1	46	46	
SUBTOTAL NET			9243	
SHARED SUPPORT			457	
TOTAL NET			**9700**	
TOTAL # BEDS			**14**	
DGSF/BED			**693**	

LEVEL 04 SHARED SUPPORT

	NEW-ADDITIONAL			
ROOM/FUNCTION	**QTY**	**NSF/EACH**	**TOTAL NSF**	**NOTES**
CONSULT	1	81	81	
FAMILY WAITING	1	351	351	
HSKP STOR	1	43	43	
PAT TLT	1	66	66	
PUB TLT	1	56	56	
PUB TLT	1	56	56	
SPCL BATHING FACILITY	1	174	174	
STAFF EDUC ROOM	1	230	230	
STOR	1	40	40	

STORAGE	1	76	76	
VEND	1	27	27	
TOTAL NET			**1200**	
TOTAL # BEDS			**N/A**	
NSF/UNIT			**600**	INCLUDED IN UNIT TOTALS BELOW

LEVEL 04 JOINT / NEURO
UNIT

ROOM/FUNCTION	NEW-ADDITIONAL			NOTES
	QTY	NSF/EACH	TOTAL NSF	
1	1	213	213	
1 （ADA）	1	249	249	
2	1	209	209	
2	1	209	209	
3	1	209	209	
3	1	209	209	
4	1	209	209	
4	1	209	209	
5	1	209	209	
5 （ADA）	1	288	288	
6	1	215	215	
6 （ISOL）	1	216	216	
7	1	209	209	
8	1	213	213	
8	1	209	209	
9	1	209	209	
9	1	209	209	
10	1	216	216	
ALC	1	21	21	
ALCOVE	1	45	45	
CC	1	22	22	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	

CHART	1	13	13	
CHART	1	13	13	
CLEAN	1	138	138	
CLEAN	1	118	118	
CLIN WORK	1	176	176	
DIET CART	1	28	28	
DIET CART	1	15	15	
EQ	1	126	126	
EQ	1	87	87	
HSKP	1	59	59	
LINEN	1	32	32	
LINEN	1	23	23	
LOCKERS	1	80	80	
MEDS	1	126	126	
MEDS	1	106	106	
NOUR	1	84	84	
OFF, CASE MGR	1	82	82	
OFF, NEURO SPCL	1	86	86	
OFF, UNIT MGR	1	82	82	
OFFICE, JT SPCL	1	70	70	
PHYSICIAN WORK	1	123	123	
SOIL	1	148	148	
SOIL	1	112	112	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
ST BREAK	1	154	154	
ST BREAK	1	132	132	
ST TLT	1	97	97	
ST TLT	1	54	54	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	

TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
WORK STATION	1	222	222	
WORK STATION	1	193	193	
SUBTOTAL NET			7621	
SHARED SUPPORT			600	
TOTAL NET			**8221**	
TOTAL # BEDS			**18**	
DGSF/BED			**457**	

LEVEL 05 SHARED SUPPORT

	NEW-ADDITIONAL			
ROOM/FUNCTION	**QTY**	**NSF/EACH**	**TOTAL NSF**	**NOTES**
CONSULT	1	81	81	
FAMILY WAITING	1	351	351	
HSKP STOR	1	43	43	
IV TEAM/ VASC ACCESS	1	150	150	
LOCKER	1	325	325	
ON-CALL	1	87	87	
PUB TLT	1	56	56	
PUB TLT	1	56	56	

ST TLT	1	61	61	
STAFF EDUC ROOM	1	230	230	
STORAGE	1	76	76	
TLT/ SHWR	1	77	77	
VEND	1	27	27	
TOTAL NET			**1620**	
TOTAL # BEDS			**N/A**	
NSF/UNIT			**810**	INCLUDED IN UNIT TOTALS BELOW

LEVEL 05 ICU

ROOM/FUNCTION	NEW-ADDITIONAL			NOTES
	QTY	NSF/EACH	TOTAL NSF	
1	1	267	267	
2	1	261	261	
3	1	262	262	
4	1	261	261	
5 (ISOL, ADA)	1	261	261	
6 (ISO, ADA)	1	277	277	
7	1	274	274	
8	1	268	268	
9	1	270	270	
10	1	269	269	
ADA TLT	1	54	54	
ADA TLT	1	47	47	
CASE MGR	1	103	103	
CC	1	26	26	
CHART	1	11	11	
CHART	1	10	10	
CHART	1	9	9	
CHART	1	7	7	
CLEAN	1	119	119	
CLIN COORD	1	79	79	
CLINICIAN WORK	1	117	117	
CONSULT	1	96	96	
DIET CART	1	20	20	

EQ	1	196	196	
EQ ALCOVE	1	132	132	
FAM TLT	1	66	66	
FAMILY	1	246	246	
HSKP	1	51	51	
LINEN	1	35	35	
MEDS	1	99	99	
NOUR	1	77	77	
NURSE SPECIALIST	1	82	82	
ON CALL	1	95	95	
PHYSICIAN WORK	1	116	116	
PORT EQ	1	62	62	
SOIL	1	98	98	
ST BREAK	1	177	177	
ST TLT	1	65	65	
STOR	1	14	14	
STOR	1	12	12	
STOR	1	12	12	
TLT	1	42	42	
TLT	1	42	42	
TLT	1	42	42	
TLT	1	40	40	
TLT	1	40	40	
TLT	1	40	40	
TLT	1	40	40	
TLT	1	39	39	
TLT/ SHWR	1	69	69	
WC ALC	1	55	55	
WORK STATION	1	245	245	
SUBTOTAL NET			5697	
SHARED SUPPORT			810	
TOTAL NET			**6507**	
TOTAL # BEDS			**10**	
DGSF/BED			**651**	

LEVEL 05 TELEMETRY

ROOM/FUNCTION	NEW-ADDITIONAL			NOTES
	QTY	NSF/EACH	TOTAL NSF	
1 （ADA）	1	254	254	
2	1	209	209	
3	1	209	209	
4	1	209	209	
5	1	209	209	
6	1	209	209	
7	1	209	209	
8	1	209	209	
9	1	209	209	
10	1	209	209	
11	1	209	209	
12 （ADA）	1	289	289	
13 （ISOL）	1	216	216	
14 （ISOL）	1	209	209	
15	1	209	209	
16	1	209	209	
17	1	209	209	
18	1	209	209	
19	1	209	209	
20	1	209	209	
21	1	209	209	
22	1	216	216	
ALC	1	28	28	
ALC	1	22	22	
ALCOVE	1	45	45	
CC	1	14	14	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	

CHART	1	13	13	
CLEAN	1	119	119	
CLEAN	1	112	112	
CLINICIAN WORK	1	130	130	
DIET CART	1	15	15	
EQ	1	150	150	
HSKP	1	45	45	
LINEN	1	32	32	
LINEN	1	23	23	
MEDS	1	106	106	
MEDS	1	102	102	
NOUR	1	84	84	
OFF, CASE MGR	1	86	86	
OFF, CLIN COORD	1	82	82	
OFFICE, UNIT MGR	1	111	111	
PHYSICIAN WORK	1	123	123	
SOIL	1	148	148	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
ST BREAK	1	154	154	
ST TLT	1	54	54	
TELE MONITOR	1	175	175	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	

TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	43	43	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
TLT/SHWR	1	40	40	
WORK STATION	1	222	222	
WORK STATION	1	136	136	
SUBTOTAL NET			8143	
SHARED SUPPORT			810	
TOTAL NET			**8953**	
TOTAL # BEDS			**22**	
DGSF/BED			**407**	

LEVEL 06 SURGICAL

ROOM/FUNCTION	NEW-ADDITIONAL			NOTES
	QTY	NSF/EACH	TOTAL NSF	
1 (ADA)	1	221	221	
2	1	213	213	
3	1	214	214	
4	1	210	210	
5	1	212	212	
6	1	212	212	
7	1	212	212	
8	1	212	212	

9	1	212	212	
10	1	212	212	
11 (ISOL)	1	212	212	
12 (ISOL, ADA)	1	232	232	
13	1	249	249	
14	1	211	211	
15	1	210	210	
16	1	210	210	
17	1	210	210	
18	1	210	210	
19	1	210	210	
20	1	210	210	
21	1	210	210	
22	1	217	217	
ADA TLT/ SHWR	1	64	64	
ALC	1	15	15	
BREAK/ EDUC	1	382	382	
CC	1	26	26	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	13	13	
CHART	1	12	12	
CHART	1	11	11	
CLEAN	1	107	107	
CLEAN	1	97	97	
CLIN WORK	1	119	119	
CONSULT	1	81	81	
DIET CART	1	20	20	
EQ	1	268	268	
EQ ALC	1	36	36	
EXAM	1	142	142	
FAMILY WAITING	1	351	351	
HSKP	1	56	56	

HSKP STOR	1	46	46	
LINEN	1	36	36	
LINEN	1	31	31	
LOCKER	1	143	143	
MEDS	1	98	98	
MEDS	1	92	92	
NOUR	1	97	97	
OFF, CASE MGR	1	84	84	
OFF, CLIN COORD	1	85	85	
OFF, CLIN NRS SPEC	1	108	108	
OFF, UNIT MGR	1	88	88	
PHYS WORK	1	121	121	
PUB TLT	1	56	56	
PUB TLT	1	56	56	
SOIL	1	107	107	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
SPLY	1	5	5	
ST TLT	1	75	75	
ST TLT	1	71	71	
STOR	1	90	90	
TLT/ SHWR	1	59	59	
TLT/ SHWR	1	39	39	
TLT/ SHWR	1	39	39	
TLT/ SHWR	1	39	39	
TLT/ SHWR	1	39	39	
TLT/ SHWR	1	39	39	
TLT/ SHWR	1	39	39	
TLT/ SHWR	1	39	39	

TLT/ SHWR	1	39	39	
TLT/ SHWR	1	39	39	
TLT/ SHWR	1	39	39	
TLT/SHWR	1	39	39	
TLT/SHWR	1	39	39	
TLT/SHWR	1	39	39	
TLT/SHWR	1	39	39	
TLT/SHWR	1	39	39	
TLT/SHWR	1	39	39	
TLT/SHWR	1	39	39	
TLT/SHWR	1	39	39	
TLT/SHWR	1	38	38	
TLT/SHWR	1	38	38	
TRACT STOR	1	129	129	
VEND	1	27	27	
WC ALC	1	49	49	
WORK STATION	1	249	249	
WORK STATION	1	133	133	
SUBTOTAL NET			9562	
SHARED SUPPORT			0	
TOTAL NET			**9562**	
TOTAL # BEDS			**22**	
DGSF/BED			**435**	

SUMMARY

ROOM/FUNCTION	NEW-ADDITIONAL			NOTES
	NSF	BEDS	SF/BED	
PEDIATRICS	3,649	6	608.2	
MEDICAL	9,075	20	453.8	
PERINATAL / LDRP	9,700	14	692.9	
JOINT / NEURO	8,221	18	456.7	

TELEMETRY	8,953	22	407.0	
ICU	6,507	10	650.7	
SURGICAL	9,562	22	434.6	
BLDG TOTAL	55,667	112		
BLDG SF/BED			497.0	

Shore Health System, Inc
Key Financial Assumptions for CON Model

Volume - Admissions	
Med/Surg-	Decrease by less then 1%/year due to continued conversion of one day stays to observation and a reduction in readmissions
Pediatric-	Increase by less then 1%/year due to population growth
Obstetrics-	Increase by approx 4-5% / year due to population and closing of obstetrics service at ChesterRiver Health System
Intensive Care-	Increase by less then 1%/year due to population growth
Rehab-	No increase projected
Other(Nursery)-	Increase by approx 4-5% / year due to population and closing of obstetrics service at ChesterRiver Health System
Volume- Length of Stay	
Med/Surg-	Slight increase due to conversion of 1 day stays to observation
Pediatric-	Remains constant
Obstetrics-	Remains constant
Intensive Care-	Remains constant
Rehab-	Remains constant
Other(Nursery)-	Remains constant
Outpatient Visits	
Emergency-	Increasing by approx. 1.5% / year based on historic trends
Outpaitent -	Increasing by approx 2%/year based on historic trends
Other (observation)	Increasing by approx 2%/year based on further conversion of 1 day stays to observation
REVENUE	
Gross revenue	Based on Total Population formula plus request to HSCRC for additional rates
Allowance for Bad debt	Based as a % of gross revenue
Contractual Allowances	Based as a % of gross revenue
Charity Care	Based as a % of gross revenue
Other operating revenue	Held constant
EXPENSES	
Salaries/Wages/Prof. fees	FTE's are changed based on a variable factor of 70% applied to the increase/decrease in EIPA's . Benefits are % of wages and prof. fees are held constant.
Contractual Services	Increase based on 70% variable factor applied to increase/decrease in EIPA's. FY 16 has $1.2m in relocation expense.
Interest/Depreciation/Amortization	Broken out between current and project. Half year is used for depreciation in fy 16 and half year is used for amortization in fy 14.
Supplies	Increase based on 70% variable factor applied to increase/decrease in EIPA's. There are supply chain savings incorporated in each year bas
Other expense (impairment loss)	Loss from the write off of remaining book value at June 30, 2014, for the existing hospital building and 75% of equipment.
PAYOR MIX	Remains constant

ɜed on 5 year study.

Maryland Department of Health and Mental Hygiene

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, MD, Secretary

Maryland Perinatal System Standards

Level I and Level II Perinatal Center

Self-Assessment Tool

DIRECTIONS:

- Please review the Perinatal System Standard on the following pages. Definitions of terms used in the Standards are included on the first several pages.

- Please include the hospital name and self-designated level of perinatal care at the top of each page.

- Next to each Standard, indicate if your hospital is currently in compliance with that Standard for you level of care or not. If not, on a separate sheet please provide a brief description of difficulties encountered in achieving compliance and any changes or initiatives underway.

- Documentation of compliance with each Standard is noted in red under each category of Standards. Please have these documents available at the time of the site visit at you hospital. Do not send copies with this self-assessment tool.

- Please send the completed self assessment tool **no later than October 17, 2011** to:

  S. Lee Woods, M.D., Ph.D.
  Morbidity, Mortality, and Quality Review Committee
  Maryland Department of Health and Mental Hygiene
  201 W. Preston St., Room 309
  Baltimore, MD 21201

- If you have any questions, please contact Dr. Woods at (410) 767-6805 or SLWoodsMD@dhmh.state.md.us

LIST OF DEFINITIONS

I Level I hospitals have perinatal programs that provide basic care to pregnant women and infants, as described by these standards. These hospitals provide delivery room and normal newborn care for stable infants ≥ 35 weeks gestation. Maternal care is limited to term and near-term gestations that are maternal risk appropriate. A physician board-certified or an active candidate for board-certification in obstetrics/gynecology or family medicine with advanced training and privileges for obstetrical care with a formal arrangement with a physician board-certified or an active candidate for board-certification in obstetrics/gynecology shall be a member of the medical staff and have responsibility for programmatic management of obstetrical services. Other than emergency stabilization, the neonatal units do not provide mechanical ventilation. Board-certified pediatricians or family medicine physicians supervise these units. These neonatal units do not provide pediatric subspecialty or neonatal surgical specialty services. These hospitals do not receive primary infant or maternal referrals.

IIA Level IIA hospitals have perinatal programs that provide specialty care to pregnant women and infants, as described by these standards. These hospitals provide delivery room and specialized care for stable infants ≥ 1,500 grams and ≥ 32 weeks gestation. Maternal care is limited to term and preterm gestations that are maternal risk appropriate. Board-certified obstetrician has responsibility for programmatic management of obstetrical services. The neonatal units are supervised by Board-certified pediatricians. The neonatal units provide assisted ventilation only on a limited basis until the infant can be transferred to a higher-level facility. They do not provide pediatric subspecialty or neonatal surgical specialty services. These hospitals do not receive primary infant or maternal referrals.

IIB Level IIB hospitals have perinatal programs that provide specialty care to pregnant women and infants, as described by these standards. These hospitals provide delivery room and acute specialized care for infants ≥ 1,500 grams and ≥ 32 weeks gestation. Maternal care is limited to term and preterm gestations that are maternal risk appropriate. Board-certified obstetrician has responsibility for programmatic management of obstetrical services. The neonatal units are supervised by at least one Board-certified neonatal-perinatal medicine subspecialist. The neonatal units provide mechanical ventilation for up to 24 hours or continuous positive airway pressure. The neonatal units may provide limited pediatric subspecialty services. They do not provide neonatal surgical specialty services. These hospitals do not receive primary infant or maternal referrals.

IIIA Level IIIA hospitals have perinatal programs that provide subspecialty care for pregnant women and infants, as described by these standards. These hospitals provide acute delivery room and neonatal intensive care unit (NICU) care for infants ≥ 1,000 grams and ≥ 28 weeks gestation. Maternal care spans the range of normal term gestation care to the management of moderately complex maternal complications and moderate prematurity. Board-certified obstetrician has responsibility for programmatic management of obstetrical services. Board- certified maternal-fetal medicine specialist has responsibility for programmatic management of high-risk obstetrical services. The neonatal units are supervised by Board-certified neonatal-perinatal medicine subspecialists and offer continuous availability of neonatologists. The neonatal units provide conventional (e.g., tidal volume or continuous airway pressure) mechanical ventilation modes only. Additionally, the neonatal units may have available some pediatric subspecialty services. Neonatal units may perform minor surgical procedures, such as surgical placement of a central vein catheter or repair of an inguinal hernia. Level IIIA perinatal hospitals accept risk-appropriate maternal and neonatal transports.

IIIB Level IIIB hospitals have perinatal programs that provide subspecialty care for pregnant women and infants, as described by these standards. These hospitals provide acute delivery room and NICU care for infants of all birth weights and gestational ages. Maternal care spans the range of normal term gestation care to the management of extreme prematurity and moderately complex maternal complications. Board-certified obstetrician has responsibility for programmatic management of obstetrical services. Board-certified maternal-fetal medicine specialist has responsibility for programmatic management of high-risk obstetrical services. The neonatal units are supervised by Board-certified neonatal-perinatal medicine subspecialists and offer continuous availability of neonatologists. Neonatal units provide multiple modes of neonatal ventilation that may include advanced respiratory support, such as high frequency ventilation. In addition, inhaled nitric oxide may or may not be used. Pediatric, rather than adult, subspecialty services may be provided onsite or consultation may be provided at a closely related institution (geographically close institution which allows for emergency transport within 30 minutes travel time between institutions). Pediatric surgical and anesthesiology subspecialists may be on site or at a closely related institution to perform major surgery. Neonatal care capability includes advanced imaging, with interpretation on an urgent basis, including computed tomography, magnetic resonance imaging, and echocardiography. Level IIIB perinatal hospitals accept risk-appropriate maternal and neonatal transports.

IIIC Level IIIC hospitals have perinatal programs that provide comprehensive subspecialty obstetrical and neonatal care services, as described by these standards. These hospitals provide acute delivery room and NICU care for infants of all birth weights and gestational ages. Board-certified maternal-fetal medicine subspecialists supervise the units and their services are continuously available. Maternal care provided spans the range of normal term gestation care to that of highly complex or critically ill mothers. In addition, the obstetrical services include management of fetuses who are extremely premature or have complex problems that render significant risk of preterm, delivery, and postnatal complications. The neonatal units are supervised by Board-certified neonatal-perinatal subspecialists and offer continuous availability of neonatologists. Advanced modes of neonatal ventilation and life-support are provided, including high frequency ventilation, nitric oxide and/or extracorporeal membrane oxygenation (ECMO). These neonatal units provide extensive pediatric subspecialty services. Additionally, extensive pediatric subspecialty surgical services are continuously available, including pediatric cardio-thoracic open-heart surgery and pediatric neurosurgery. Level IIIC perinatal hospitals accept maternal and neonatal transports. Maryland's statewide maternal-neonatal transport system is under the leadership of Level IIIC perinatal hospitals in collaboration with DHMH and MIEMSS.

Board-certified: a physician certified by an American Board of Medical Specialties Member Board.

Immediately available: a resource available as soon as it is requested.

In-house: physically present in the hospital.

Programmatic responsibility: the writing, review and maintenance of practice guidelines; policies and procedures; development of operating budget (in collaboration with hospital administration and other program directors); evaluation and guiding of the purchase of equipment; planning, development and coordinating of educational programs (in-hospital and/or outreach as applicable); participation in the evaluation of perinatal care; and participation in perinatal quality improvement and patient safety activities.

Readily available: a resource available for use a short time after it is requested.

30 minutes: in-house within thirty (30) minutes under normal driving conditions which include, but are not limited to, weather, traffic, and other circumstances that may be beyond the individual's control.

E Essential requirement for level of perinatal center

O Optional requirement for level of perinatal center

NA Not Applicable

NOTE: More details regarding the content of care for each perinatal level of care are contained in the *Guidelines for Perinatal Care, 6th Edition*, American Academy of Pediatrics and American College of Obstetricians and Gynecologists, 2007.

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

	I	IIA	IIB	Compliance (yes / no)
STANDARD I. ORGANIZATION				
Provide documentation with Board resolutions, accreditation, policies, etc. at time of site visit				
1.1 The hospital's Board of Directors, administration, and medical and nursing staffs shall demonstrate commitment to its specific level of perinatal center designation and to the care of perinatal patients. This commitment shall be demonstrated by:				
a) A Board resolution that the hospital agrees to meet the Maryland Perinatal System Standards for its specific level of designation	E	E	E	YES
b) Participation in the Maryland Perinatal System, as described by this document, including submission of patient care data to the Maryland Department of Health and Mental Hygiene (DHMH) and the Maryland Institute for Emergency Medical Services Systems (MIEMSS), as appropriate, for system and quality management	E	E	E	YES
c) Assurance that all perinatal patients shall receive medical care commensurate with the level of the hospital's designation	E	E	E	YES
A Board resolution, bylaws, contracts, budgets -- all specific to the perinatal program -- indicating the hospital's commitment to the financial, human, and physical resources and to the infrastructure that are necessary to support the hospital's level of perinatal center designation Board resolution NO, but full board support.	E	E	E	YES
1.2 The hospital shall be licensed by the Maryland Department of Health and Mental Hygiene (DHMH) as an acute care hospital.	E	E	E	YES
1.3 The hospital shall be accredited by The Joint Commission.	E	E	E	YES
1.5 The hospital shall obtain and maintain current equipment and technology, as described in the Standards, to support optimal perinatal care for the level of the hospital's perinatal center designation.	E	E	E	YES

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

	I	IIA	IIB	Compliance (yes / no)
STANDARD II. OBSTETRICAL UNIT CAPABILITIES				
Provide documentation of unit capabilities with policies, protocols, guidelines, evidence of staff training requirements, etc. at time of site visit				
2.1 The hospital shall demonstrate its capability of providing uncomplicated and complicated obstetrical care through written standards, protocols, or guidelines, including those for the following:				
a) unexpected obstetrical care problems;	E	E	E	YES
b) fetal monitoring, including internal scalp electrode monitoring;	E	E	E	YES
c) initiating a cesarean delivery within 30 minutes of the decision to deliver;	E	E	E	YES
d) selection and management of obstetrical patients at a maternal risk level appropriate to its capability, or	E	E	E	YES
2.2 The hospital shall be capable of providing critical care services appropriate for obstetrical patients, as demonstrated by having a critical care unit and a board-certified critical care specialist as an active member of the medical staff.	NA	O	O	NA
2.3 The hospital shall have a written plan for initiating maternal transports to an appropriate level.	E	E	E	YES
STANDARD III. NEONATAL UNIT CAPABILITIES				
Provide documentation of unit capabilities with policies, protocols, guidelines, evidence of staff training requirements, etc. at time of site visit				

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

	I	IIA	IIB	Compliance (yes / no)
3.1 The hospital shall demonstrate its capability of providing uncomplicated and complicated neonatal care through written standards, protocols, or guidelines, including those for the following:				
a) resuscitation and stabilization of unexpected neonatal problems according to the most current Neonatal Resuscitation Program (NRP) guidelines;	E	E	E	YES
b) selection and management of neonatal patients at a neonatal risk level appropriate to its capability	E	E	E	YES
STANDARD IV. OBSTETRIC PERSONNEL				
Provide documentation of staffing and coverage patterns with *Curriculum Vitae* or resumes, call schedules, copies of written agreements, applicable policies, etc. at time of site visit				
LEADERSHIP				
4.1 A physician board-certified or an active candidate for board-certification in obstetrics/gynecology or family medicine with advanced training and privileges for obstetrical care with a formal arrangement with a physician board-certified or an active candidate for board-certification in obstetrics/gynecology shall be a member of the medical staff and have responsibility for programmatic management of obstetrical services.	E	NA	NA	YES
4.2 A physician board-certified in obstetrics/gynecology shall be a member of the medical staff and have responsibility for programmatic management of obstetrical services.	O	E	E	YES
4.3 A physician (or physicians) board-certified or an active candidate for board-certification in maternal-fetal medicine shall be a member of the medical staff and have responsibility for programmatic management of high-risk obstetrical services.	NA	O	O	NA
COVERAGE FOR URGENT OBSTETRICAL ISSUES				

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

		I	IIA	IIB	Compliance (yes / no)
4.4	For a hospital without a physician board-certified in maternal-fetal medicine on the medical staff, there is a written agreement with a consultant who is board-certified or an active candidate for board-certification in maternal-fetal medicine to be available 24 hours a day.	E	E	E	NO
4.5	The hospital shall have a maternal-fetal medicine physician on the medical staff, in active practice and, if needed, in-house within 30 minutes.	O	O	O	NO
4.7	A physician or certified nurse-midwife (with obstetrical privileges) shall be readily available to the delivery area when a patient is in active labor.	E	NA	NA	YES
4.8	A physician board-certified or an active candidate for board-certification in obstetrics/gynecology or family medicine (with obstetrical privileges) shall be readily available to the delivery area when a patient is in active labor.	O	E	E	YES
4.9	A physician board-certified or an active candidate for board-certification in obstetrics/gynecology shall be present in-house 24 hours a day and immediately available to the delivery area when a patient is in active labor.	O	O	O	NO
4.10	A physician or certified nurse-midwife (with obstetrical privileges) shall be present at all deliveries.	E	E	E	YES
4.11	A physician board-certified or an active candidate for board-certification in anesthesiology shall be a member of the medical staff and have responsibility for programmatic management of obstetrical anesthesia services.	E	E	E	YES

STANDARD V. PEDIATRIC PERSONNEL

Provide documentation of staffing and coverage patterns with *Curriculum Vitae* or resumes, call schedules, copies of all written agreements, applicable policies, etc. at time of site visit

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

	I	IIA	IIB	Compliance (yes / no)
LEADERSHIP				
5.1 A physician board-certified in pediatrics or family medicine shall be a member of the medical staff, have privileges for neonatal care, and have responsibility for neonatal unit services. For hospitals without a physician board-certified in pediatrics, there shall be a written agreement which provides consultation with a board-certified pediatrician 24 hours a day.	E	NA	NA	YES
5.2 A physician board-certified in pediatrics or in neonatal-perinatal medicine shall be a member of the medical staff, have privileges for neonatal care, and have responsibility for neonatal unit services.	O	E	NA	YES
5.3 A physician (or physicians) board-certified in neonatal-perinatal medicine shall be a member of the medical staff and have full-time responsibility for neonatal special care unit.	NA	O	E	NA
COVERAGE FOR URGENT NEONATAL ISSUES				
5.4 For hospitals without a physician board-certified in neonatal-perinatal medicine on staff, there shall be a written agreement which provides access to consultation with physicians board-certified in neonatal-perinatal medicine 24 hours a day. (Maryland Regional Neonatal Transport & Program)	E	E	NA	YES
5.5 Neonatal Resuscitation Program (NRP) trained professional(s) with experience in acute care of the depressed newborn and skilled in neonatal endotracheal intubation and resuscitation shall be immediately available to the delivery and neonatal units.	E	E	E	YES
5.6 A physician who has completed postgraduate pediatric training, a nurse practitioner or physician assistant with privileges for neonatal care appropriate to the level of the nursery shall be immediately available when an infant requires Level II neonatal services such as FiO2 > 40%, assisted ventilation, or cardiovascular support .	NA	E	E	NA

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

		I	IIA	IIB	Compliance (yes / no)
5.7	A physician who has completed postgraduate pediatric training, a nurse practitioner or physician assistant with privileges for neonatal care appropriate to the level of the nursery shall be immediately available 24 hours a day.	NA	O	O	NA
5.8	A physician who has completed postgraduate pediatric training, a nurse practitioner or physician assistant with privileges for neonatal care appropriate to the level of the nursery shall be present in-house 24 hours a day and assigned to the delivery area and neonatal units and not shared with other units in the hospital.	NA	O	O	NA
5.9	A physician board-certified or an active candidate for board certification in neonatal-perinatal medicine shall be available to be present in-house within 30 minutes.	NA	NA	O	NA
NEONATAL SUBSPECIALTY CARE					
5.10	The hospital shall have written consultation and referral agreements in place with pediatric nurse cardiology, pediatric surgery, and ophthalmology with experience and expertise in neonatal retinal examination. Pediatric Surgery & Opthalmology- NO	O	E	E	YES (cardiology)
5.11	The hospital shall have on staff an ophthalmologist with experience in neonatal retinal examination and a written consulting relationship with pediatric cardiologist(s) and pediatric surgeon(s).	NA	O	O	NA
5.12	The hospital shall have the following pediatric specialists on staff, in active practice and, if needed, in-house within 30 minutes: cardiology, neurology, genetics.	NA	NA	O	NA
5.13	The hospital shall have pediatric general surgeon(s), and the following pediatric specialists on staff, in active practice and, if needed, in-house within 30 minutes: hematology, endocrinology, pulmonary, gastrointestinal, renal.	NA	NA	O	NA

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

		I	IIA	IIB	Compliance (yes / no)
5.14	The hospital shall have the following pediatric surgical subspecialists on staff, in active practice and, if needed, in-house within 30 minutes: neurosurgery, cardiothoracic surgery, orthopedic surgery, plastic surgery, ophthalmology.	NA	NA	O	NA
STANDARD VI.	**OTHER PERSONNEL**				
	Provide documentation of staffing and coverage patterns with *Curriculum Vitae* or resumes, call schedules, copies of all written agreements, applicable policies, etc. at time of site visit				
6.1	A physician board-certified or an active candidate for board-certification in anesthesiology or a nurse-anesthetist shall be available so that cesarean delivery may be initiated per hospital protocol as stated in Standard 2.1c.	E	E	E	YES
6.2	A physician board-certified or an active candidate for board-certification in anesthesiology or a nurse-anesthetist (working under the supervision of a physician board-certified or an active candidate for board certification in anesthesiology) shall be readily available to the delivery area when a patient is in active labor.	O	E	E	YES
6.3	A physician board-certified or an active candidate for board-certification in anesthesiology shall be present in-house 24 hours a day, readily available to the delivery area.	O	O	O	NO
6.5	The hospital shall have a physician on the medical staff with privileges for providing critical interventional radiology services for obstetrical patients	O	O	O	YES
6.6	The hospital shall have obstetric and neonatal diagnostic imaging available 24 hours a day, with interpretation by physicians with experience in maternal and/or neonatal disease and its complications.	E	E	E	YES

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

		I	IIA	IIB	Compliance (yes / no)
6.7	The hospital shall have a registered dietician or other health care professional with knowledge of and experience in adult and neonatal parenteral/enteral high-risk management on staff.	O	O	O	Adult Only
6.8	The hospital shall have an International Board Certified Lactation Consultant on full-time staff who shall have programmatic responsibility for lactation support services which shall include education and training of additional hospital staff members in order to ensure availability seven days per week of dedicated lactation support.	E	E	E	NO- (Part-time)
6.9	The hospital shall have a licensed social worker with a Master's degree (either an LGSW, Licensed Graduate Social Worker, or an LCSW, Licensed Certified Social Worker) and experience in psychosocial assessment and intervention with women and their families readily available to the perinatal service.	E	NA	NA	YES
6.10	The hospital shall have a licensed social worker with a Master's degree (either an LGSW, Licensed Graduate Social Worker, or an LCSW, Licensed Certified Social Worker) and experience in psychosocial assessment and intervention with women and their families dedicated to the perinatal service.	O	E	E	NO
6.11	The hospital shall have a licensed social worker with a Master's degree (either an LGSW, Licensed Graduate Social Worker, or an LCSW, Licensed Certified Social Worker) and experience in psychosocial assessment and intervention with women and their families dedicated to the NICU.	O	O	O	NO
6.12	The hospital shall have respiratory therapists skilled in neonatal ventilator management: a) available when an infant is receiving assisted ventilation b) present in-house 24 hours a day	 NA NA	 NA NA	 E O	 YES YES
6.13	The hospital shall have genetic diagnostic and counseling services or written consultation and referral agreements for these services in place.	E	E	E	NO

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

		I	IIA	IIB	Compliance (yes / no)
6.14	The hospital shall have a pediatric neurodevelopmental follow-up program or written referral agreements for neurodevelopmental follow-up.	O	O	O	NO
6.15	The hospital perinatal program shall have on its administrative staff a registered nurse with a Master's or higher degree in nursing or a health-related field and experience in high-risk obstetric and neonatal nursing who shall have programmatic responsibility for the obstetrical and neonatal nursing services.	E	E	E	YES
6.16	A hospital perinatal program shall have nurses with special expertise in obstetrical and neonatal nursing identified for staff education.	E	E	E	YES
6.17	The hospital perinatal service shall have: a) A registered nurse skilled in the recognition and nursing management of complications of labor and delivery readily available if needed to the labor and delivery unit 24 hours a day. b) A registered nurse skilled in the recognition and management of complications in women and newborns readily available to the obstetrical unit 24 hours a day. c) A registered nurse with demonstrated training and experience in the assessment, evaluation and care of patients in labor present at all deliveries. d) A registered nurse with demonstrated training and experience in the assessment, evaluation, and care of newborns readily available to the neonatal unit 24 hours a day.	E	E	E	YES
6.19	The hospital shall have a written plan for assuring registered nurse/patient ratios as per current Guidelines for Perinatal Care.	E	E	E	YES

STANDARD VII. LABORATORY

Provide documentation of capabilities with policies, protocols, guidelines, etc. at time of site visit

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

		I	IIA	IIB	Compliance (yes / no)
7.1	The programmatic leaders of the perinatal service in conjunction with the hospital laboratory shall establish laboratory processing and reporting times to ensure that these are appropriate for samples drawn from obstetric and neonatal patients with specific consideration for the acuity of the patient and the integrity of the samples.	E	E	E	YES
7.2	The hospital laboratory shall demonstrate the capability to immediately receive, process, and report urgent/emergent obstetric and neonatal laboratory requests.	E	E	E	YES
7.3	The hospital laboratory shall have a process in place to report critical results to the obstetric and neonatal services.	E	E	E	YES
7.4	Laboratory results from standard maternal antepartum testing shall be available to the providers caring for the mother and the neonate prior to discharge. If test results are not available or if testing was not performed prior to admission, such testing shall be performed during the hospitalization of the mother and results available prior to discharge of the newborn.	E	E	E	YES
7.5	The hospital shall have the capacity to conduct rapid HIV testing 24 hours a day.	E	E	E	YES
7.6	The hospital shall have a laboratory capable of performing the following tests 24 hours a day: a) fetal scalp blood pH (if fetal scalp blood pH testing is being utilized at the hospital) b) fetal lung maturity tests (send out?)	E	E	E	 NA YES
7.7	The hospital shall have available the equipment and trained personnel to perform newborn hearing screening prior to discharge on all infants born at or transferred to the institution as required by the Universal Newborn Hearing Screening, Diagnosis, and Intervention Guidelines.	E	E	E	YES
7.8	Blood bank technicians shall be present in-house 24 hours a day.	E	E	E	YES

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

		I	IIA	IIB	Compliance (yes / no)
7.9	The hospital shall have molecular, cytogenic, and biochemical genetic testing available or written consultation and referral agreements for these services in place.	O	O	O	NO
STANDARD VIII. DIAGNOSTIC IMAGING CAPABILITIES					
	Provide documentation of capabilities with policies, protocols, guidelines, etc. at time of site visit				
8.1	Portable obstetric ultrasound equipment, with the services of appropriate support staff, shall be present in the delivery area.	O	E	E	YES
8.2	If portable obstetric ultrasound equipment is not present in the delivery area, then the equipment, with the services of appropriate support staff, shall be available to the delivery area.	E	NA	NA	YES
8.3	Portable x-ray equipment, with the services of appropriate support staff, shall be available to the neonatal units.	E	E	E	YES
8.4	Portable head ultrasound for newborns, with the services of appropriate support staff, shall be available to the neonatal units.	O	E	E	NO
8.5	Computerized tomography (CT) capability, with the services of appropriate support staff, shall be available on campus.	O	O	O	YES
8.6	Magnetic resonance imaging (MRI) capability, with the services of appropriate support staff, shall be available on campus.	O	O	O	YES
8.7	Neonatal echocardiography equipment and experienced technician shall be available on campus as needed with interpretation by pediatric cardiologist. Agreement with Dr. Ruckman UMMS	O	O	O	YES

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

		I	IIA	IIB	Compliance (yes / no)
8.8	The hospital shall have a pediatric cardiac catheterization laboratory and appropriate staff.	O	O	O	NO
8.9	The hospital shall have equipment for performing interventional radiology services for obstetrical patients	O	O	O	YES
STANDARD IX.	**EQUIPMENT**				
	Provide documentation of with policies, protocols, guidelines, etc. at time of site visit				
9.1	The hospital shall have all of the following equipment and supplies immediately available for existing patients and for the next potential patient:	E	E	E	
	a) O2 analyzer, stethoscope, intravenous infusion pumps				YES
	b) radiant heated bed in delivery room and available in the neonatal units				YES
	c) oxygen hood with humidity				YES
	d) bag and masks capable of delivering a controlled concentration of oxygen to the infant				YES
	e) orotracheal tubes				YES
	f) aspiration equipment				YES
	g) laryngoscope				YES
	h) umbilical vessel catheters and insertion tray				YES
	i) cardiac monitor				YES
	j) pulse oximeter				YES
	k) phototherapy unit				YES
	l) doppler blood pressure for neonates				YES
	m) cardioversion/defibrillation capability for mothers and neonates				YES
	n) resuscitation equipment for mothers and neonates				YES
	o) individual oxygen, air, and suction outlets for mothers and neonates				YES
	p) emergency call system				YES

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

		I	IIA	IIB	Compliance (yes / no)
9.2	The hospital shall have a neonatal intensive care unit bed set up and equipment available at all times for an emergency admission.	O	O	O	NO
9.3	The hospital shall have fetal diagnostic testing and monitoring equipment for:				
	a) non-stress and stress testing	E	E	E	YES
	b) ultrasound examinations	E	E	E	YES
	c) amniocentesis	O	E	E	YES
9.4	The hospital shall have the capability to monitor neonatal intra-arterial pressure.	O	O	E	NO
9.5	The hospital shall have laser coagulation capability for retinopathy of prematurity.	O	O	O	NO
9.6	The hospital shall have a full range of invasive maternal monitoring available to the delivery area, including equipment for central venous pressure and arterial pressure monitoring.	O	O	O	YES
9.7	The hospital shall have appropriate equipment (including back-up equipment) for neonatal respiratory care as well as protocols for the use and maintenance of the equipment as required by its defined level status.	E	E	E	YES
STANDARD X.	**MEDICATIONS**				
	Provide documentation of with policies, protocols, guidelines, etc. at time of site visit				
10.1	Emergency medications, as listed in the Neonatal Resuscitation Program of the American Academy of Pediatrics/American Heart Association (AAP/AHA), shall be present in the delivery area and neonatal units.	E	E	E	YES

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

	I	IIA	IIB	Compliance (yes / no)
10.2 The following medications shall be immediately available to the neonatal units: a) Antibiotics, anticonvulsants, and emergency cardiovascular drugs b) Surfactant, prostaglandin E1	 E O	 E O	 E E	 YES YES
10.3 All emergency resuscitation medications to initiate and maintain resuscitation, in accordance with Advanced Cardiac Life Support (ACLS) guidelines, shall be present in the delivery area.	E	E	E	YES
10.4 The following medications shall be in the delivery area or immediately available to the delivery area: a) Oxytocin (Pitocin) b) Methylergonovine (Methergine) c) 15-methyl prostaglandin F2 (Prostin) d) Misoprostol (Cytotec) e) Carboprost tromethamine (Hemabate)	E	E	E	 YES YES YES YES YES
STANDARD XI. EDUCATION PROGRAMS				
Provide documentation of with policies, protocols, guidelines, etc. at time of site visit				
11.1 The hospital shall have identified minimum competencies for perinatal clinical staff, not otherwise credentialed, that are assessed prior to independent practice and on a regular basis thereafter.	E	E	E	YES
11.2 The hospital shall provide continuing education programs for physicians, nurses, and allied health personnel on staff concerning the treatment and care of obstetrical and neonatal patients.	E	E	E	YES
STANDARD XII. PERFORMANCE IMPROVEMENT				
Provide documentation of with policies, protocols, guidelines, etc. at time of site visit				

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

		I	IIA	IIB	Compliance (yes / no)
12.1	The hospital shall have a multi-disciplinary continuous quality improvement program for improving maternal and neonatal health outcomes that includes initiatives to promote patient safety including safe medication practices, Universal Protocol to prevent surgical error, and educational programs to improve communication and team work.	E	E	E	YES
12.2	The hospital shall conduct internal perinatal case reviews which include all maternal, intrapartum fetal, and neonatal deaths, as well as all maternal and neonatal transports.	E	E	E	YES
12.3	The hospital shall utilize a multidisciplinary forum to conduct quarterly performance reviews of perinatal program. This review shall include a review of trends, all deaths, all transfers, all very low birth weight infants, problem identification and solution, issues identified from the quality management process, and systems issues.	E	E	E	YES
12.4	The hospital shall participate with the Department of Health and Mental Hygiene and local health department Fetal and Infant Mortality Review and Maternal Mortality Review programs.	E	E	E	YES
12.5	The hospital shall participate in the collaborative collection and assessment of data with the Department of Health and Mental Hygiene and/or the Maryland Institute for Emergency Medical Services Systems for the purpose of improving perinatal health outcomes.	E	E	E	YES
STANDARD XIII. POLICIES AND PROTOCOLS					
Provide documentation of with policies, protocols, guidelines, etc. at time of site visit					
13.1	The hospital shall have written policies and protocols for the initial stabilization and continuing care of all obstetrical and neonatal patients appropriate to the level of care rendered at its facility.	E	E	E	YES
13.2	The hospital shall have maternal and neonatal resuscitation protocols.	E	E	E	YES

Name of Institution: Shore Health System MHE **Self-designated level of perinatal care**: I

		I	IIA	IIB	Compliance (yes / no)
13.3	The hospital medical staff credentialing process shall include documentation of competency to perform obstetrical and neonatal invasive procedures appropriate to its designated level of care.	E	E	E	YES
13.4	The hospital shall have written guidelines for accepting or transferring mothers or neonates as "back transports" including criteria for accepting the patient and patient information on the required care.	E	E	E	YES
13.5	The hospital shall have a licensed neonatal transport service or written agreement with a licensed neonatal transport service.	E	E	E	YES
13.6	The hospital shall have policies that allow families (including siblings) to be together in the hospital following the birth of an infant and that promote parental involvement in the care of the neonate including the neonate in the NICU.	E	E	E	YES

Although not included in the Standards, does your hospital have a policy regarding non-medically indicated deliveries prior to 39 weeks gestation? If yes, please have a copy available at the time of the site visit.	Yes / No ☑

carf INTERNATIONAL

A Three-Year Accreditation is awarded to

Shore Health System/Requard Center for Acute Rehabilitation

for the following programs:

Inpatient Rehabilitation Programs - Hospital (Adults)
Inpatient Rehabilitation Programs - Hospital: Stroke Specialty Program (Adults)

This accreditation is valid through
April 2015

The accreditation seals in place below signify that the organization has met annual conformance requirements for quality standards that enhance the lives of persons served.

This accreditation certificate is granted by authority of:

Kayda Johnson
Chair
CARF International Board of Directors

Brian J. Boon, Ph.D.
President/CEO
CARF International

carf carfccac carf CANADA

PATIENT TRANSFER AGREEMENT

THIS AGREEMENT ("Agreement") is made this 16th day of November 2000, by and between Shore Health System of Maryland and **PENINSULA REGIONAL MEDICAL CENTER,** a Maryland corporation ("Peninsula Regional")(each, a "Party").

WHEREAS:

1. Both Parties to this Agreement are providers of health care services which seek to improve the treatment of patients by providing continuity of care and treatment appropriate to the needs of each such patient;

2. Neither Party offers all services needed by its patients and both wish to make provision for the transfer of its patients for additional needed services;

3. At least one Party does have facilities offering services needed by patients of the other Party and is licensed to provide such services;

4. Each Party needs assurance of a referral mechanism to provide these services to its patients which the Party does not offer; and

5. This Agreement is intended to cover the circumstances where patients may be transferred by either Party to the other. The terms of the Agreement refer to the "Transferor Institution" and "Transferee Institution." Depending upon the circumstances, either Party may be either a "Transferor Institution" or a "Transferee Institution." If a Party is transferring patients, then it is the "Transferor Institution." If a Party is receiving patients, then it is the "Transferee Institution."

NOW, THEREFORE, in consideration of the common aims, interests and mutual advantages accruing to the parties, the Parties covenant and agree as follows

1. **Recitals**. The above recitals are specifically incorporated by reference and hereby made a part of this Agreement,

2. **Autonomy**. The governing authorities of each Party shall have exclusive control of the management, assets and affairs of their respective institutions. Neither Party by virtue of this Agreement assumes any liability for any debts or obligations of any nature incurred by the other party to this Agreement. Neither party will assume responsibility for the care rendered to the patient by the other institution.

3. Each Party shall notify the other of it's designated representative(s) for the purpose of implementing this Agreement. In the event that Transferor Institution has a patient in need of services it does not provide and which Transferee Institution does provide, Transferor Institution will contact the designated representative of Transferee Institution who will recommend to Transferor Institution whether the

patient should be transferred from Transferor Institution to Transferee Institution. It shall be the responsibility of the Transferor Institution to determine that the patient can be transferred without harm. If Transferee Institution recommends that the patient be transferred to Transferee Institution, then the designated representative shall confirm to the Transferor Institution that the Transferee Institution consents to the transfer and that the patient meets Transferee Institution's admission criteria relating to appropriate bed, the patient's required level of care, and physician and other services necessary to treat the patient. The designated representative of Transferee Institution shall accept or arrange for acceptance of such patient on behalf of Transferee Institution and shall arrange for all necessary administrative authorizations for the transfer. The transfer of any such patients from Transferor Institution to Transferee Institution will be effected in accordance with federal and state law and regulations. Transferee Institution and Transferor Institution mutually agree to exercise their best efforts to provide for prompt admission of these patients to Transferee Institution.

4. In the event of transfer, it shall be the responsibility of the patient's physician at Transferor Institution to determine the safest and most appropriate means to transfer the patient to Transferee Institution. Transferor Institution will provide or arrange for an ambulance or other transport equipment which is able to provide appropriate treatment during transport. The Transferor Institution will provide medically appropriate personnel and equipment that a reasonable and prudent physician exercising ordinary care would use for the transfer. The transport shall use medically appropriate life-support measures that a reasonable and prudent physician exercising ordinary care would use to stabilize the patient before transfer and to sustain the patient during the transfer. Transferor Institution shall be solely responsible for all costs, or for the arrangement of coverage of all costs, or transporting the patient, including the costs of any necessary personnel, Transferor Institution shall he responsible for notifying Transferee Institution of the impending transfer, providing explanations of the reason for the transfer and any alternatives to the transfer to the patient or patient's Parent(s) or legal guardian(s), as well as obtaining approval for the transfer from such person. Transferor institution shall be solely responsible for assuring that all transfers under this Agreement comply with all federal and/or State requirements which govern the transfer of patients.

5. In compliance with 42 USCA 1395dd, 42 C.F.R. 489.24, Md. Health-Gen. Code Ann. 19-308.2, and COMAR 10. 07. 01. 23, Transferor Institution will provide a copy of the patient's medical records to Transferee Institution. This shall include medical records related to the patient's emergency medical condition, history and physical observations of signs, symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies or telephone reports of the studies, treatment provided, x-rays, results of any tests, written informed consent to the transfer (or physician certification as to the necessity of transfer), copies of any relevant signed consent forms, and any advance directives or other legal guidance believed by Transferor Institution to be currently in effect. A medication

schedule for the previous twelve (12) hours with dose and administration will be provided. These records should accompany the patient at the time of the transfer. For an emergent patient, the medical record may be faxed (within one hour) if time does not allow for photocopying.

6. As soon as a transfer has been made, it shall be the responsibility of Transferor Institution to advise the financially responsible party or agency of the transfer. Each party to this Agreement is solely responsible for all matters pertaining to billing and collecting its own patient charges. Neither party shall have any liability to the other for such charges nor shall be liable for any debts, obligations or claims of a financial or legal nature to the other party.

7. To maintain the quality of care to the transferred patients, all cases will be reviewed by Transferee Institution's Quality Assurance Department. The result of these reviews will be promptly communicated to Transferor Institution.

8. Transferor Institution and Transferee Institution agree that they will provide and ensure maximum confidentiality accorded by law with regard to all medical, business or other records generated in accordance with this Agreement.

9. Nothing in this Agreement shall be construed as limiting the rights of either Party to affiliate or contract with any other institution while this Agreement is in effect.

10. Neither Party shall use the name of the other Party in any promotion or advertising unless prior written approval of the intended use is obtained from the Party whose name is to be used.

11. This Agreement supersedes any relevant prior agreements between the Parties. This Agreement may be modified or amended from time to time by mutual agreement of the Parties and such modifications or amendments shall he attached to and become a part of this Agreement. This Agreement may not be assigned by either Party without the prior written consent of the other. This Agreement shall be construed and enforced in accordance with the laws of the State of Maryland.

12. Neither Party shall be entitled to compensation from the other Party for any services provided under this Agreement.

13. Transferor Institution shall be solely responsible for complying with State and Federal laws and regulations governing patient transfers. Transferor Institution shall not use the patient's inability to pay or source of payment for the patient as a reason to transfer the patient.

14. All notices hereunder shall be in writing and shall be deemed to have been duly given if delivered in hand or sent by registered or certified mail, postage prepaid,

to each Party at the address set forth below. Either Party may designate a different address by written notice given in the manner provided herein.

If to Peninsula Regional:

Peninsula Regional Medical Center
100 East Carroll Street
Salisbury, MD 21801
Attn: President

If to Shore Health System of Maryland:

Shore Health System of Maryland
219 S. Washington Street
Easton, MD 21601
Attn: Administrator

15. This Agreement shall commence as of the date set forth above and shall continue in effect for one year unless it is terminated by either Party. This Agreement shall be renewed for additional terms of one (1) year each in the absence of notice of intent not to renew given by either party. This Agreement may be terminated at any time by an authorized representative of the parties to this Agreement by providing the other Party with 30 days' prior written notice. However, this Agreement shall be automatically terminated if either Party has its license to operate revoked by the State of Maryland, its ability to participate in the Medicare and/or Medicaid programs is terminated, or if it loses accreditations by the Joint Commission or Accreditation of Healthcare organizations.

IN WITNESS WHEREOF, the authorized representatives of the parties to this Agreement have caused their respective principal's name to be subscribed to this Agreement.

PENINSULA REGIONAL MEDICAL CENTER
a Maryland corporation

Sharon L. Harrington

By: _____
Authorized Representative
Date: 11/17/00

_____

By: _____
Authorized Representative
Date: 11/27/00

prmc\patient transfer agr. 1109

TRANSFER AGREEMENT

This Transfer Agreement is entered into on May 20, 2008, by and between Chester River Health System ("Chester River") and The Memorial Hospital at Easton, a health care facility owned and operated by Shore Health System, Inc. ("Shore Health").

WHEREAS, both parties desire to assure continuity of care and treatment appropriate to the needs of each patient and to use the skills, resources, and physical plant of both parties in a coordinated and cooperative fashion to improve patient care at both the acute and post-acute stages of illness.

NOW, THEREFORE, in consideration of the mutual advantages occurring to the parties hereto, Hospital and Shore Health hereby covenant and agree with each other as follows:

1. Both parties agree to make a concerted effort to transfer patients as soon as practical when the need for transfer from Chester River to Shore Health has been determined by the patient's attending physician, provided, however, all eligibility conditions for admission must be met and documented in the patient's medical record.

2. Chester River agrees to send with each patient at the time of transfer or, in the case of any emergency as promptly as possible after the transfer, an abstract of the patient's medical record including:

   (A) the current medical findings,
   (B) diagnosis,
   (C) a brief summary of the course of treatment followed,
   (D) all other administrative and social information useful to provide continuing care to the patient; using the transfer and referral form mutually agreed upon.

3. Chester River, after promptly notifying Shore Health of the impending transfer of a patient and after Shore Health consents to accept such patient, shall assume the responsibility to arrange for appropriate and safe transportation of the patient, his/her personal effects and valuables, and shall provide any necessary care while he/she is being transferred.

4. Charges for services performed by either Chester River or Shore Health for patients transferred from the other institution pursuant to this Agreement, shall be collected by the institution rendering such services, directly from the patient, third party payers, or the other sources normally billed by the institution; and neither party shall have any liability to the other for such charges except to the extent that such liabilities would exist separate and apart from this Agreement.

5. The parties agree that the transfer of a patient pursuant to this Agreement shall not be predicated upon discrimination based on race, religion, national origin, age, sex, physical condition or economic status. The parties also agree that the transfer or receipt of patients shall not be based upon a patient's inability to pay for services rendered by the transferring or receiving institution or a patient's source of payment.

6. All patient transfers pursuant to this Agreement must be accomplished in a medically appropriate manner from physician to physician and from institution to institution by: (i) the use of appropriate life support measures which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to stabilize the patient prior to transfer and to sustain the patient during the transfer; (ii) the provision of appropriate personnel and equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use for the transfer; (iii) the transfer of all necessary records for continuing the care for the patient; and (iv) the consideration of the availability of appropriate facilities, services, and staff for providing care for the patient. The parties agree that before moving a patient, Chester River shall explain the reasons for the transfer and any alternative to the patient or a legally authorized representative of the patient. If it is necessary to move the patient immediately to protect the health, safety or welfare of the patient, Chester River may give the explanation of the reasons for the transfer concurrently with the transfer.

7. The parties agree to recognize the right of a patient to request transfer into the care of a physician and institution of the patient's own choosing and to recognize and comply with all federal and state requirements relating to the transfer of patients.

8. Chester River agrees not to transfer a patient with an emergency medical condition that has not been stabilized unless: (i) the patient, or a legally responsible person acting on the patient's behalf, after being informed of Chester River's obligations under law and of the risk of transfer, requests in writing transfer to another institution; (ii) a licensed physician has signed a certification which includes a summary of the risks and benefits that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another institution outweigh the increased risks to the patient and, in the case of labor, to the unborn child from effecting the transfer; or (iii) if a licensed physician is not physically present at the time a patient is transferred, a qualified medical person has signed a certification described in subparagraph (ii) above after a license physician, in consultation with the person, has made the determination described in subparagraph (ii) above and subsequently countersigns the certificate.

9. All notices hereunder by either party to the other party shall be in writing, delivered personally or by overnight courier, and shall be deemed to have been duly given when delivered personally or one day after delivered to the overnight carrier, charges prepaid, and properly addressed to the respective parties at the addresses shown following each party's signature to this Agreement.

10. This Agreement shall be effective from the date of signing by both parties and shall continue in effect, except that either party may withdraw by giving 60 days written notice to the other party of its intention to terminate this Agreement. However, this Agreement shall be declared null and void and shall be immediately terminated should either party fail to maintain its licensure or certification status.

11. Both parties represent and warrant that, during the term of this Agreement, each shall comply with all applicable state and federal laws and regulations and shall remain in good standing with applicable accrediting organizations.

12. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other institution, on either a limited or general basis, while this Agreement is in effect.

13. This Agreement may be modified or amended by the mutual agreement of the parties, however, any such modification or amendment shall be attached to and become a part of this Agreement. This Agreement shall be construed in accordance with the laws of the State of Maryland.

CHESTER RIVER HEALTH SYSTEM, INC.

By: _____

Name: SCOTT D BURLESON

Title: Executive Vice President

100 Brown Street
Chestertown, Maryland 21620

SHORE HEALTH SYSTEM, INC.

By: _____

Name: GERARD M. WALSH

Title: Sr. V.P. & C.O.O.

219 South Washington Street
Easton, Maryland 21601

PRIMARY ACUTE STROKE PATIENT TRANSFER AGREEMENT BETWEEN THE MEMORIAL HOSPITAL AT EASTON, INC. AND THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION

EFFECTIVE DATE: December 15, 2006

PURPOSE: In response to state regulations addressing the care of acute stroke patients, the **MEMORIAL HOSPITAL AT EASTON,INC**, a health care facility owned and operated by Shore Health System, Inc. (the "Facility"), enters into this transfer agreement with the **University of Maryland Medical Center**, a health care facility owned and operated by University of Maryland Medical System Corporation ("UMMC"). The purpose of the agreement is to establish a process for the transfer and care of acute stroke patients requiring neurosurgical intervention.

POLICY

A. POINT OF CONTACT:

UMMC's Maryland ExpressCare ("*ExpressCare*"), will be the sole source of contact throughout the process. All inquiries related to patient transport should go through *ExpressCare*. This process allows for the most timely and efficient utilization of resources and avoids conflicting communications.

B. REQUEST FOR TRANSPORT:

1. A member of the Facility's stroke team will contact *ExpressCare* at (410) 328-1234, upon determining that the patient requires neurosurgical intervention for acute stroke-related conditions such as subarachnoid hemorrhage or acute intracerebral hemorrhage. The number for *ExpressCare* is.
2. Upon reaching *ExpressCare*, the Facility Stroke Team will:
   a. Identify the Facility and notify *ExpressCare* that a transfer of an acute stroke patient for neurosurgical intervention is necessary.
   b. Provide *ExpressCare* with logistical information, patient demographics, clinical information and any other requested information.
   c. If the patient requires transport to UMMC, the Facility Stroke Team will fax the patient's "face sheet" with demographic data to *ExpressCare* at (410) 328-1235.
3. If a member of the UMMC medical staff medical accepts the patient for transfer and appropriate resources are available, *ExpressCare* will timely dispatch the Maryland *ExpressCare* Team, which will include a registered nurse, to transport the patient from the Facility to UMMC.
4. If the patient transfer is accepted and a bed is available but a Maryland *ExpressCare* Team is not available to effect the transfer, the following will occur:
   a. *ExpressCare* will check the availability of other Advanced Life Support ("ALS") vendor resources. If a Critical Care team is available, *ExpressCare* will dispatch the team in order to respond in a timely manner.
   b. If vendor resources are exhausted and no Critical Care Team is available, *ExpressCare* will then call the Facility to indicate the lack of Critical Care transport availability to accompany patient during transport with dispatched ALS team. Facility will then dispatch a qualified registered nurse to accompany the patient during transport.

Xerox - Linda Pittman

C. UMMC ACCEPTANCE OF TRANSFERRED PATIENTS:

If a UMMC medical staff member accepts the patient for transfer and appropriate resources are available, UMMC will receive and provide treatment to the transferred patient to care for the acute stroke patient once the initial triage, assessment and treatment have been completed by the Facility.

D. NO TRANSPORT NECESSARY:

The Facility will notify *ExpressCare* if the transfer is later determined to be unnecessary.

E. ADVISORY NOTICE PRIOR TO ADMINISTERING TISSUE PLASMINOGEN ACTIVATOR

To the extent possible, a member of the Facility's stroke team will contact the *ExpressCare*, to indicate that the Facility's Stroke Team will be administering tissue-plasminogen activator ("t-PA") or similar intravenous acute stroke intervention to a patient.

F. ADMINISTRATIVE PROVISIONS

1. Any modification of this agreement, including any extension , shall be effective only if in writing and signed on behalf of both parties
2. This agreement does not create a joint venture or partnership between UMMC and the Facility.
3. This agreement shall be governed by the law of the State of Maryland; the parties agree to be subject to the jurisdiction of the Maryland courts.
4. The Facility may not assign this Agreement.
5. This agreement may be executed and delivered in one or more counterparts (including by facsimile transmission), each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

Agreed to and approved this 6th day of December, 2006

THE MEMORIAL HOSPITAL AT EASTON,INC.
A health care facility owned and operated by Shore Health System, Inc.

By: _____
Joseph P. Ross
President and Chief Executive Officer

UNIVERSITY OF MARYLAND MEDICAL CENTER
A health care facility owned and operated by the University of Maryland Medical System Corporation

By: _____
Name: Alison G. Brown, MPH
Title: Senior Vice President

AGREEMENT

HOSPITAL-EXTENDED CARE FACILITY

THIS AGREEMENT is made as of _____, by and between

The Memorial Hospital at Easton, MD., Inc.
(herein called "Hospital"), and

The Pines - Genesis Eldercare - Easton, MD.
(herein called "Facility").

WHEREAS, both Hospital and Facility have met all necessary requirements under Public Law 89-97 and Title VI, and,

WHEREAS, both Hospital and Facility desire, by means of this Agreement, to insure continuity of care and treatment appropriate to the needs of patients in the Memorial Hospital, and at The Pines - Genesis Eldercare, utilizing the knowledge and other resources of both facilities in a coordinated and cooperative fashion to improve the care of patients;

NOW THERFORE, THIS AGREEMENT WITNESSETH: That in consideration of the mutual advantages accruing to the parties hereto, Hospital and Facility hereby covenant and agree with each other as follows:

1. Subject to the policies and procedures to be established by the Liaison Committee, as hereinafter provided, upon the recommendation of an attending physician, who is a member of the medical staff of Hospital, such patient shall:

   (a) if a patient at Hospital, be admitted to Facility; or,

   (b) if a patient at Facility, be admitted to Hospital as promptly as possible under the circumstances.

2. If the patient or the responsible party does not object, the Hospital and Facility mutually agree to send with each patient at the time of transfer, or in the case of emergency, as promptly as possible, an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption and to provide essential identifying information. The Hospital and Facility will provide for the transfer or personal effects, particularly money and valuables and of information related to these items. The Liaison Committee shall develop referral form for this purpose.

3. All bills incurred with respect to services performed by either the Hospital or Facility for patients received from the other pursuant to this Agreement shall be collected by the institution rendering such services directly from the patient, third party insurance coverage or other sources normally billed by the institution, and neither Hospital nor Facility shall have any liability to the other for such charges; provided, however, that Hospital may bill Facility directly, and Facility assumes responsibility for payment to Hospital, for the reasonable cost of any emergency or out-patient services performed by Hospital for patients of Facility, at the request of Facility, if such services are not payable to Hospital under the terms of any third party insurance coverage. The Hospital will provide diagnostic services for all patients including Title XIX patients of the Facility.

4. Upon the signing hereof, a Liaison Committee shall be formed to facilitate the general implementation of this Agreement. Said Committee shall consist of the Administrators of the Facility and the Hospital and such other members as each may designate.

The committee shall have the responsibility to plan and supervise the initial implementation of this Agreement, establish and approve practices and procedures, conduct a periodic review, consider and resolve problems arising under the Agreement, and recommend revisions, as appropriate.

5. Any dispute which may arise under the Agreement shall first be discussed directly by the Departments of the two institutions that are directly involved. If the dispute cannot be resolved at this level, it shall be referred to the Liaison Committee for discussion and resolution.

SIGNED:

Memorial Hospital @ Easton
Hospital

Deidre A Rod
Signature

Sr VP & CFO
Title

6-13-03
Date

SIGNED:

The Pines - Genesis Elder Care
Facility

Stacy C. Radcliffe MHS
Signature

Administrator
Title

June 10, 2003
Date

#35 TA 1 Pt. Care

Transfer Agreement Between Memorial Hospital at Easton, MD., Inc.
and
The Johns Hopkins Hospital

This agreement; hereinafter referred to as "Agreement"; made between The Memorial Hospital at Easton, MD., Inc. a non-profit corporation organized and existing under the laws of the State of Maryland; hereinafter referred to as "Memorial".

and

The Johns Hopkins Hospital, a private, non-profit hospital operating under the laws of the State of Maryland; hereinafter referred to as "Hopkins".

Witnesseth:

Whereas, all parties to this Agreement want to ensure the accessibility, availability, continuity of services, and quality of care for all patients, utilizing the knowledge and resources of all parties in coordinated and cooperative fashion to improve the care of patients.

Now, therefore, in consideration of the mutual advantages to all parties hereto, the aforementioned parties hereby covenant and agree with each other as follows:

AUTHORITY:

The Board of Directors of Memorial and The Board of Trustees of Hopkins shall have exclusive control of the management, assets, and affairs of their respective institutions. Neither party by virtue of the Agreement assumes any responsibility for any debt, obligation, or liability of this Agreement, nor shall any clause of this Agreement be interpreted as authorizing either party to look to the other to pay for services rendered to a patient transferred by virtue of this Agreement.

TRANSFER OF PATIENT

1. When a patient's need for transfer from one of the above institutions to the other has been determined, the transferring institution will explain to the patient or his or her representative the reason for the transfer and any alternatives to the transfer.

2. The transferring institution will obtain confirmation from the receiving institution to admit the patient, as promptly as possible, and obtain confirmation that all conditions of eligibility for admission in effect at that time are met and bed space is available.

3. The transferring institution shall ensure that medically appropriate life-support measures are used to stabilize the patient before transfer and sustain the patient during transfer and that appropriate personnel and equipment are provided and used in the transfer.

4. The transferring facility will send with each patient, at the time of transfer, an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption. Such informa-tion may include a discharge summary, history and physical, consultation reports, lab work or any other pertinent patient data.

Disagreement and Appeal:

Any dispute which may arise under this Agreement shall first be discussed directly by the departments of the two entities that are directly involved. If the problem cannot be resolved, the matter can be referred for an Administrative Appeal. Memorial's President, or his Designee and Hopkins President, or his Designee, serving as the Appeal Board, will then resolve the problem.

Amendment of Agreement:

This Agreement may be modified or amended by mutual agreement of both parties and any such modification or amendment shall be attached to and become a part of this Agreement.

Termination of Agreement

This Agreement may be terminated by Memorial or Hopkins any time, as long as thirty (30) days written notice is given.

Holding Harmless Clause:

Memorial and Hopkins agree to hold each other absolutely harmless and indemnify same for any loss, damage, injury, or claim of loss, damage, or injury alleged by anyone as a result of the acts, negligent or otherwise, of employees, consultants, staff members of the guaranteeing or indemnifying agency done while the injured or damaged party was controlled by, treated by, or dealing with such indemnifying or guaranteeing agency.

In witness whereof, the parties have executed this Agreement on this 6th day of November, 1991.

Peter M. Synowiez
President
Memorial Hospital at Easton, MD., Inc.

11/7/91
Date

Hamilton Moses III M.D.
Vice President, Medical Affairs

11/6/91
Date

TA
2
Pt. care

TRANSFER AGREEMENT

between

DORCHESTER GENERAL HOSPITAL, INC.

and

CAROLINE NURSING HOME, INC.

THIS TRANSFER AGREEMENT (the "Agreement") is executed and effective as of December 17, 1998 (the "Effective Date"), by and between Dorchester General Hospital, Inc. (the "Hospital") and Caroline Nursing Home, Inc. (the "Nursing Home").

RECITALS

WHEREAS, the Nursing Home, a skilled nursing facility located in Denton, Maryland, desires to enter into an arrangement with a nearby acute care hospital in order to ensure the continuity of quality care for patients of the Nursing Home and to facilitate the timely and appropriate transfer of such patients between the Hospital and the Nursing Home;

WHEREAS, the Hospital is willing to cooperate in facilitating medically appropriate transfers of patients between the Nursing Home and the Hospital;

NOW, THEREFORE, the Hospital and the Nursing Home agree as follows:

Section 1. Requisites of Transfer

1.1 Prior to Transfer. In the event the physician of a patient from the Nursing Home determines that acute care services available at the Hospital are medically appropriate, the Nursing Home immediately shall notify the Hospital of the need to transfer a patient. Prior to any such transfer, or, in the case of emergency, as promptly as possible, the Nursing Home shall:

A. Ensure that the physician has properly documented the need for such transfer in the patient's medical record.

B. Except in the case of emergency, obtain written confirmation from the Hospital that it can accept the patient from the Nursing Home;

C. Discuss with the patient or his or her legal representative the reason for the proposed transfer and any available alternatives. The Nursing Home shall have full responsibility for obtaining the consent of the patient or the patient's legal representative prior to the transfer.

D. Notify the next of kin of the patient or another appropriate responsible person or family member regarding the anticipated transfer.

1.2 Admission by the Hospital. The Hospital agrees to admit a patient transferred from the Nursing Home, subject to all conditions of this Agreement, all admission eligibility requirements of the Hospital in effect at the time, and the availability of adequate and appropriate bed space for the transferred patient. All transfers and admissions shall be conducted in accordance with applicable federal and state law and regulations and the applicable policies and procedures of the Hospital.

1.3 Transfer Documentation. The Nursing Home shall send with each patient at the time of transfer, or in the case of emergency, as promptly as possible, the patient's medical record, completed transfer forms, and any other information pertinent to the medical condition and treatment of the patient. The Nursing Home and the Hospital agree to develop a standard form document which shall accompany the patient in any transfer to the Hospital or to the Nursing Home from the Hospital. The standard form shall include such information as current medical findings, diagnosis, a brief summary of the present course of treatment, nursing and dietary information, ambulation status and pertinent administrative and social information. If the patient is returning to the Nursing Home after treatment, the Hospital shall provide similar transfer documentation to the Nursing Home.

1.4 Safe Transport. The Nursing Home shall be responsible for effecting the transfer of the patient, including the arranging for appropriate and safe transportation and care of the patient during the transfer in accordance with applicable federal and state laws and regulations. The Hospital's responsibility for the patient's care shall begin when the patient is admitted to the Hospital, either as an inpatient or an outpatient. If the patient is returning to the Nursing Home, the Hospital shall be responsible for effecting the safe transfer of a patient from the Hospital to the Nursing Home in accordance with applicable federal and state laws and regulations.

1.5 Personal Effects. The Nursing Home shall be responsible for the transfer or other appropriate disposition of personal effects, particularly money and valuables, and information related to these items.

1.6 Medical Records. The Nursing Home and the Hospital each shall maintain a separate medical record for each transferred patient in accordance with its rules and regulations and shall maintain the confidentiality of patient information. The Nursing Home and the Hospital shall comply with all applicable federal and state laws and regulations, including without limitation, laws and regulations governing the maintenance of medical records and the confidentiality of patient information.

1.7 Charges for Services. Charges for services performed by either the Hospital or the Nursing Home shall be collected by or on behalf of the facility rendering such services directly from the patient, third party payor or other payor as appropriate. Neither facility shall have any liability to the other for such charges.

1.8 Insurance. The Hospital and the Nursing Home each shall maintain, throughout the Agreement, liability insurance coverage in amounts acceptable to the other, and shall provide evidence of such coverage upon request.

Section 2. Relationship of Parties

2.1 Governance; Liabilities. The governing body of each of the Nursing Home and the Hospital shall exclusive control of policies, management, assets and affairs of its respective institutions. Neither party shall assume any liability by virtue of this Agreement for any debts or other obligations incurred by the other party.

2.2. Non-exclusivity. Nothing in this Agreement shall be construed as limiting the rights of either party to contract with any other facility on a limited or general basis.

Section 3 Term; Termination

3.1 Term. The initial term of this Agreement shall be for a period of one (1) year commencing on the Effective Date, unless sooner terminated as provided herein. This Agreement shall renew annually for successive one (1) year terms.

3.2 Termination. Either party may terminate this Agreement at any time, with or without cause, upon (30) days prior written notice to the other party. This Agreement shall be terminated automatically should either the Hospital or the Nursing Home fail to maintain its State facility licensure, Medicare or Medicaid certification, or insurance coverage as required in Section 2.4 hereof.

Section 4. Miscellaneous

4.1 Entire Agreement. This Agreement contains the entire agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

4.2 Waiver. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

4.3 Assignment. Neither party may assign or transfer this Agreement or any of its rights, duties or obligations under this Agreement without the prior written consent of the other party.

4.4 Notices. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by Federal express or express mail, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

To the Hospital:

Dorchester General Hospital
300 Byrn Street
Cambridge, MD 21613

To the Nursing Home:

Caroline Nursing Home, Inc.
520 Kerr Avenue
Denton, MD 21629

4.5 Compliance. The parties agree to comply with all laws, rules and regulations, including JCAHO requirements, relating to the subject of this Agreement.

4.6 Governing Law. This Agreement shall be construed in accordance with the laws of the State of Maryland.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives as of the day and year first written above.

Dorchester General Hospital, Inc.

By: Larry F. Hepner

Larry F. Hepner

Title: Vice President, Patient Care Services

Caroline Nursing Home, Inc.

By:

Title: Administrator

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TRANSFER AGREEMENT

between

THE MEMORIAL HOSPITAL AT EASTON, MD., INC.

and

CAROLINE NURSING HOME, INC.

THIS TRANSFER AGREEMENT (the "Agreement") is executed and effective as of December 17, 1998 (the "Effective Date"), by and between The Memorial Hospital at Easton, Md., (the "Hospital") and Caroline Nursing Home, Inc. (the "Nursing Home").

RECITALS

WHEREAS, the Nursing Home, a skilled nursing facility located in Denton, Maryland, desires to enter into an arrangement with a nearby acute care hospital in order to ensure the continuity of quality care for patients of the Nursing Home and to facilitate the timely and appropriate transfer of such patients between the Hospital and the Nursing Home;

WHEREAS, the Hospital is willing to cooperate in facilitating medically appropriate transfers of patients between the Nursing Home and the Hospital;

NOW, THEREFORE, the Hospital and the Nursing Home agree as follows:

Section 1. Requisites of Transfer

1.1 Prior to Transfer. In the event the physician of a patient from the Nursing Home determines that acute care services available at the Hospital are medically appropriate, the Nursing Home immediately shall notify the Hospital of the need to transfer a patient. Prior to any such transfer, or, in the case of emergency, as promptly as possible, the Nursing Home shall:

A. Ensure that the physician has properly documented the need for such transfer in the patient's medical record.

B. Except in the case of emergency, obtain written confirmation from the Hospital that it can accept the patient from the Nursing Home;

C. Discuss with the patient or his or her legal representative the reason for the proposed transfer and any available alternatives. The Nursing Home shall have full responsibility for obtaining the consent of the patient or the patient's legal representative prior to the transfer.

D. Notify the next of kin of the patient or another appropriate responsible person or family member regarding the anticipated transfer.

1.2 Admission by the Hospital. The Hospital agrees to admit a patient transferred from the Nursing Home, subject to all conditions of this Agreement, all admission eligibility requirements of the Hospital in effect at the time, and the availability of adequate and appropriate bed space for the transferred patient. All transfers and admissions shall be conducted in accordance with applicable federal and state law and regulations and the applicable policies and procedures of the Hospital.

1.3 Transfer Documentation. The Nursing Home shall send with each patient at the time of transfer, or in the case of emergency, as promptly as possible, the patient's medical record, completed transfer forms, and any other information pertinent to the medical condition and treatment of the patient. The Nursing Home and the Hospital agree to develop a standard form document which shall accompany the patient in any transfer to the Hospital or to the Nursing Home from the Hospital. The standard form shall include such information as current medical findings, diagnosis, a brief summary of the present course of treatment, nursing and dietary information, ambulation status and pertinent administrative and social information. If the patient is returning to the Nursing Home after treatment, the Hospital shall provide similar transfer documentation to the Nursing Home.

1.4 Safe Transport. The Nursing Home shall be responsible for effecting the transfer of the patient, including the arranging for appropriate and safe transportation and care of the patient during the transfer in accordance with applicable federal and state laws and regulations. The Hospital's responsibility for the patient's care shall begin when the patient is admitted to the Hospital, either as an inpatient or an outpatient. If the patient is returning to the Nursing Home, the Hospital shall be responsible for effecting the safe transfer of a patient from the Hospital to the Nursing Home in accordance with applicable federal and state laws and regulations.

1.5 Personal Effects. The Nursing Home shall be responsible for the transfer or other appropriate disposition of personal effects, particularly money and valuables, and information related to these items.

1.6 Medical Records. The Nursing Home and the Hospital each shall maintain a separate medical record for each transferred patient in accordance with its rules and regulations and shall maintain the confidentiality of patient information. The Nursing Home and the Hospital shall comply with all applicable federal and state laws and regulations, including without limitation, laws and regulations governing the maintenance of medical records and the confidentiality of patient information.

1.7 Charges for Services. Charges for services performed by either the Hospital or the Nursing Home shall be collected by or on behalf of the facility rendering such services directly from the patient, third party payor or other payor as appropriate. Neither facility shall have any liability to the other for such charges.

1.8 Insurance. The Hospital and the Nursing Home each shall maintain, throughout the Agreement, liability insurance coverage in amounts acceptable to the other, and shall provide evidence of such coverage upon request.

Section 2. Relationship of Parties

2.1 Governance; Liabilities. The governing body of each of the Nursing Home and the Hospital shall exclusive control of policies, management, assets and affairs of its respective institutions. Neither party shall assume any liability by virtue of this Agreement for any debts or other obligations incurred by the other party.

2.2. Non-exclusivity. Nothing in this Agreement shall be construed as limiting the rights of either party to contract with any other facility on a limited or general basis.

Section 3 Term; Termination

3.1 Term. The initial term of this Agreement shall be for a period of one (1) year commencing on the Effective Date, unless sooner terminated as provided herein. This Agreement shall renew annually for successive one (1) year terms.

3.2 Termination. Either party may terminate this Agreement at any time, with or without cause, upon (30) days prior written notice to the other party. This Agreement shall be terminated automatically should either the Hospital or the Nursing Home fail to maintain its State facility licensure, Medicare or Medicaid certification, or insurance coverage as required in Section 2.4 hereof.

Section 4. Miscellaneous

4.1 Entire Agreement. This Agreement contains the entire agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

4.2 Waiver. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

4.3 Assignment. Neither party may assign or transfer this Agreement or any of its rights, duties or obligations under this Agreement without the prior written consent of the other party.

4.4 Notices. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by Federal express or express mail, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

To the Hospital:

219 S. Washington Street
Easton, Maryland 21601

To the Nursing Home:

Caroline Nursing Home, Inc.
520 Kerr Avenue
Denton, MD 21629

4.5 Compliance. The parties agree to comply with all laws, rules and regulations, including JCAHO requirements, relating to the subject of this Agreement.

4.6 Governing Law. This Agreement shall be construed in accordance with the laws of the State of Maryland.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives as of the day and year first written above.

The Memorial Hospital at Easton, Md.	Caroline Nursing Home, Inc.
By: Larry F. Hepner	By:
Larry F. Hepner	
Title: Vice President, Patient Care Services	Title: Administrator

TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT ("Agreement") shall be effective as of the 1st day of January, 2009 ("Commencement Date"), by and between **Envoy of Denton, LLC d/b/a Envoy of Denton** ("Facility") and **The Memorial Hospital at Easton, MD, Inc.** ("Hospital").

RECITALS

WHEREAS, Hospital is licensed and certified as an **[acute care hospital]** in the State of Maryland, and is approved for participation in the Medicare and Medicaid programs;

WHEREAS, Facility is a licensed and certified nursing facility in the State of Maryland;

WHEREAS, Federal and State laws require that Facility maintain a written agreement with a hospital in close proximity for timely admission of patients who develop complications or require inpatient medical treatment; and

WHEREAS, both parties to this Agreement desire to assure continuity of care and treatment appropriate to the needs of each patient in the Facility and the Hospital.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

ARTICLE I
AUTONOMY

The parties agree that each shall continue to have the exclusive control of the management, business and properties of their respective institutions, and that neither party by virtue of this Agreement assumes any liability for any debts or obligations of the other party to the Agreement, or any responsibility for the moral or legal obligations of the other party.

ARTICLE II
TRANSFER OF PATIENTS

2.1 Transfer of Patient to Hospital.

2.1.1 Hospital agrees to admit patients from the Facility as promptly as possible in accordance with its established admission policy. Patients declared as emergencies by their physicians will be admitted without delay. Transfers shall be effected only when medically appropriate as determined by patient's attending physician.

2.1.2 Facility shall arrange for appropriate and safe transportation and care of the patient during transfer to the Hospital, in accordance with applicable Federal and State laws and regulations.

2.2 Transfer of Patient to Facility.

2.2.1 Facility agrees to readmit the patient transferred to the Hospital in accordance with its established admission policy to the first available bed after having been notified by the Hospital that the patient is ready to be discharged. Transfers shall be effected only when medically appropriate as determined by patient's attending physician.

2.2.2 Facility will keep the Hospital advised of any foreseeable problem in the readmission of a patient during the patient's stay in the Hospital.

2.2.3 Hospital shall arrange for appropriate and safe transportation and care of the patient during transfer to the Facility, in accordance with applicable Federal and State laws and regulations.

2.2.4 Hospital will provide Facility with a written discharge summary of all pertinent medical information necessary for the care and treatment of patient at Facility.

2.3 Notice of Transfer. Hospital and Facility will give notice to the other party as far in advance as practicable of an impending transfer.

2.4 Exchange of Records and Information. Hospital and Facility agree to transfer medical records and other information that may be necessary or useful in the care and treatment of patients transferred hereunder, as required and permitted by all applicable Federal and State laws. Such information shall be provided by Hospital and Facility in advance, when possible, and in any event at the time of the transfer, and shall be recorded on a transfer and referral form that is mutually acceptable to both parties. Medical information shall include, as applicable, current history, medical diagnosis, rehabilitation potential, summary of course of treatment followed, nursing and dietary needs, prognosis, and pertinent administrative and social information.

2.5 Transfer of Personal Effects. Procedures for effecting the transfer of personal effects and valuables shall be developed by the parties. Each party shall designate an appropriate individual with responsibility for transfers of personal effects. A standard form shall be adopted and used by both parties for effecting the transfer of a patient's personal effects and valuables and ensuring security and accountability thereof.

2.6 Disaster and Evacuation. In the event of a disaster of any kind wherein the evacuation of the patients becomes necessary, patients at Facility shall be transferred to Hospital, subject to bed availability.

2.7 Billing. All claims or charges incurred with respect to any services performed by either party for patients received through transfer from the other party pursuant to this Agreement shall be billed and collected by the party providing such services directly from the patient, third party payer, Medicare or Medicaid, or other source appropriately billed by that party.

ARTICLE III
TERM AND TERMINATION

3.1 Term. The term of this Agreement shall commence as of the Commencement Date, and shall be for a term of one (1) year therefrom, unless terminated in accordance with the provisions set forth in Section 3.2 herein, or unless extended as provided herein. Thereafter, this Agreement shall automatically be renewed for an additional period of one (1) year unless either party terminates this Agreement in accordance with the provisions set forth in Section 3.2 herein. To the extent that this Agreement is automatically renewed, each such renewal term shall be upon the same terms and conditions of the immediately preceding renewal term.

3.2 Termination.

3.2.1 This Agreement may be terminated by either party for any reason by written notice to the other party of at least sixty (60) days, in the form required by Section 5.4 hereof, or upon mutual agreement evidenced in writing.

3.2.2 Facility may terminate this Agreement immediately if Hospital becomes the target of an investigation by any government agency for the violation of any law, if Hospital is charged, convicted or pleads guilty or no contest to any violation of the law, if Hospital enters into any settlement agreement with any government agency, if Facility believes Hospital is violating any law, or if this Agreement causes Facility not to be in compliance with any law.

3.2.3 Upon the occurrence of any of the following events, this Agreement shall automatically be terminated: (1) revocation, suspension, probation or non-renewal of any and all licenses and registrations issued to Hospital or Facility by any applicable agency or governmental authority of the State of Maryland; and (2) termination of the Hospital's or Facility's provider agreement for Medicare or either party being deemed an "excluded party" for purposes of any Federal healthcare program.

3.3 Effect of Termination. The parties acknowledge and agree that in the event of termination of this Agreement by either party or through any of the occurrences outlined herein, neither party shall have any further obligations hereunder except: for obligations accruing prior to the date of termination, and for obligations, promises, or covenants contained herein which are expressly made to extend beyond the term of this Agreement.

ARTICLE IV
RECORDS

4.1 Maintenance of Records. Hospital and Facility agree to keep and supply records in such form and for such duration as may be required by all applicable Federal and State statutes and regulations.

4.2 Access to Books and Records. Until the expiration of four (4) years after the furnishing of services pursuant to this Agreement, Hospital shall, upon written request, make available to the Secretary of the Department of Health and Human Services (HHS), the Comptroller General, or any of their duly authorized representatives, this Agreement, and any books, documents and records that are necessary to certify the nature and extent of the costs incurred by Facility under this Agreement. This provision will apply if the amount paid under the Agreement is $10,000 or more over a twelve (12) month period. The availability of Hospital's books, documents and records will at all times be subject to such criteria and procedures for seeking access as may be promulgated by the Secretary of HHS in regulations, and other applicable laws. Hospital's disclosure under this provision will not be construed as a waiver of any legal rights to which Hospital or Facility may be entitled under statute or regulation.

4.3 Subcontractors. If Hospital delegates to or performs any of its duties pursuant to this Agreement through a subcontractor, with a value or cost of $10,000 or more over a twelve (12) month period, then Hospital represents, warrants and agree that it will include a provision in the agreement with the subcontractor substantially similar to Section 4.2 above.

4.4 Medical Records. Medical records kept by each party shall remain the property of that party, but a copy of current orders or a written statement of the patient's diagnosis, mental and physical condition shall accompany the patient at the time of transfer.

4.5 HIPAA. Each of the parties hereby represents and warrants and covenants that it is presently taking and will continue to take all actions necessary to assure that it shall, on or before each applicable compliance date and continuously thereafter, comply with Public Law 104-191 of August 21, 1996, known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations, including without limitation, the Standards for Electronic Transactions and Code Sets (45 CFR Parts 160 and 162), the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164), the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Parts 160 and 164) and such other regulations that may, from time to time, be promulgated thereunder.

ARTICLE V
MISCELLANEOUS

5.1 Non-exclusivity. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other hospital or nursing facility on either a limited or general basis while this Agreement is in effect.

5.2 Marketing & Advertising. Neither party shall use the name, logo, symbol or trademark of the other party in any promotional material, unless review and approval of the intended use is first obtained in writing from the party whose name is to be used.

5.3 Governing Law. This Agreement has been executed and delivered in, and shall be interpreted, construed, and enforced pursuant to and in accordance with the laws of the State of Maryland, without reference to the conflicts of law provisions thereof.

5.4 Notices. Any notice, demand or communication required, permitted or desired to be given hereunder shall be deemed effectively given when personally delivered or mailed by prepaid certified mail, return receipt requested, addressed as follows:

If to Facility:	*If to Hospital:*
Envoy of Denton	The Memorial Hospital at Easton, MD, Inc.
420 Colonial Drive	219 S. Washington St.
Denton, MD 21629	Easton, MD 21601
ATT: Executive Director	ATT: President & CEO

Any party may change its address by giving notice in accordance with the provisions of this subparagraph.

5.5 Assignment. No assignment of this Agreement or the rights and obligations hereunder shall be valid without the express prior written consent of both parties hereto; provided, however, that this Agreement may be assigned without the consent of the other party, by Hospital or Facility to any successor entity, which as a result of a merger, acquisition of stock, acquisition of significant assets or other reorganization, operates all or a substantial portion of the Hospital or Facility. Any purported assignment of this Agreement which violates the provisions of this Section 5.5 shall be null, void and of no force or effect.

5.6 Waiver of Breach. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be a waiver of any subsequent breach of the same or other provision hereof.

5.7 Severability. In the event any provision of this Agreement is held to be unenforceable for any reason, the unenforceability thereof shall not affect the remainder of this Agreement, which shall remain in full force and effect and enforceable in accordance with its terms.

5.8 Gender and Number. Whenever the context hereof requires, the gender of all words shall include the masculine, feminine, and neuter, and the number of all words shall include the singular and plural.

5.9 Entire Agreement. This Agreement constitutes the entire Agreement of the parties with respect to the subject matter hereof, and all prior and contemporaneous understandings, agreements and representations, whether oral or written, with respect to such matters are superseded.

5.10 Amendments. This Agreement may only be amended, modified, waived or discharged by the written consent of both parties.

5.11 Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be an original, but all of which shall be deemed to constitute one instrument.

5.12 Compliance With Laws.

5.12.1 Both parties agree to comply with all applicable Federal and State laws prohibiting discrimination against persons on account of race, sex, color, age, religion, national origin, or disability, including without limitation the Civil Rights Act of 1964 and the Maryland Human Relations Act, October 27, 1955, Public Law 744 as amended and/or further adopted.

5.12.2 Both parties certifies that they and their employees and agents comply with, are not under investigation for violations of, and have never been convicted of or sanctioned for violations of, any Federal and State laws governing the Medicare and Medicaid programs (including but not limited to, provisions regarding the billing of services and the referral of patients), laws relating to patient abuse or neglect, health care fraud, and laws governing controlled substances. Furthermore, both parties certifies that they and their employees are not "excluded persons" for purposes of any Federal healthcare program.

5.12.3 Both parties are in compliance, and will maintain compliance, with all billing and claims submission laws and regulations during the term of this Agreement. Both parties further agrees to abide by any applicable requirements of the other parties corporate compliance program.

5.12.4 Nothing in this Agreement shall be construed as an offer or payment by one party to the other party (or any affiliate of the other party) of any remuneration for patient referrals, or for recommending or arranging for the purchase, lease or order of any item of service for which payment may be made in whole or in part by Medicare or Medicaid. Any payment made between the parties is intended to represent the fair market value of the supplies and/or services to be rendered by the respective party hereunder and is not in any way related to or dependent upon referrals by and between Facility and Hospital. Furthermore, it is the stated intent of both parties that nothing contained in this Agreement is or shall be construed as an endorsement for any act of either party.

5.12.5 Hospital certifies that all services provided pursuant to this Agreement shall be performed in accordance with all Federal, State and local laws applicable to such services and in conformity with the highest professional standards.

5.13 Independent Contractors. None of the provisions of this Agreement shall create or be construed to create any relationship between the parties other than that of independent entities contracting for the sole purpose of effecting the provisions of this Agreement. Neither Hospital nor Facility, nor any of their respective agents or employees, shall be construed to be the agent, employee or representative of the other.

5.14 Binding Effect. This Agreement shall be binding upon the parties hereto and their respective heirs, executors, administrators, successors and permitted assigns.

5.15 Incorporation of Recitals. The aforesaid Recitals are hereby incorporated into this Agreement as if fully set forth herein.

5.16 Dispute Resolution. In the even a dispute between Hospital and Facility arises out of or is related to any part of this contractual Agreement, Hospital and Facility shall meet and negotiate in good faith to attempt to resolve the dispute. In the event the dispute is not resolved within 30 days of the date one party sent written notice of the dispute to the other party, and if either party wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with this section. Any arbitration under this Section shall be conducted by the National Arbitration Forum, under the Code of Procedure then in effect, and judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction thereof. The place of arbitration shall be Baltimore, Maryland. The arbitrators shall decide legal issues pertaining to the dispute, controversy or claim pursuant to the laws of the State of Maryland. Subject to the control of the arbitrators, or as the parties may otherwise mutually agree, the parties shall have the right to conduct reasonable discovery pursuant to the Federal Rules of Civil Procedure. The arbitrators shall not have the authority to award punitive damages, but shall have authority to award equitable relief. THE PARTIES UNDERSTAND THAT THEY ARE KNOWINGLY AND WILLINGLY EXPRESSLY WAIVING A RIGHT TO JURY TRIAL CONCERNING ANY MATTERS RELATING TO THIS AGREEMENT.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the date first above written.

FACILITY	HOSPITAL
By: _____	By: _____
Name: JOHN B. HENRY	Name: GERARD H. WALSH
Title: ADMINISTRATOR	Title: SR. V.P. & COO.

Exhibit 18
Rehabilitation Need Projections

			Population								Cases									Use Rate							
			15-24	25-34	35-44	45-54	55-64	65-74	75+		15-24	25-34	35-44	45-54	55-64	65-74	75+			15-24	25-34	35-44	45-54	55-64	65-74	75+	
	Caroline	2007	4,237	3,691	4,463	5,360	3,819	2,186	2,031		5	4	4	6	11	18	29	77		1.18	1.08	0.90	1.12	2.88	8.23	14.28	
		2008	4,260	3,769	4,411	5,289	3,902	2,269	2,009		1	1	2	11	8	35	65	123		0.23	0.27	0.45	2.08	2.05	15.42	32.35	
		2009	4,283	3,849	4,359	5,218	3,987	2,356	1,988		3	2	10	18	12	30	90	165		0.70	0.52	2.29	3.45	3.01	12.73	45.27	
		2010	4,306	3,930	4,308	5,149	4,074	2,446	1,967			6	5	19	18	36	97	181		-	1.53	1.16	3.69	4.42	14.72	49.31	
		2011	4,329	4,011	4,257	5,080	4,161	2,536	1,946			3	4	13	28	31	44	123		-	0.75	0.94	2.56	6.73	12.22	22.61	
																			AVG:	0.42	0.83	1.15	2.58	3.82	12.67	32.76	
		2015	4,423	4,353	4,059	4,811	4,528	2,930	1,864																		
		2016	4,461	4,462	4,122	4,696	4,579	3,009	1,907																		
		2017	4,500	4,574	4,185	4,583	4,631	3,089	1,951		2	4	5	12	18	39	64	143									
		2018	4,538	4,688	4,250	4,473	4,683	3,172	1,996		2	4	5	12	18	40	65	146									
		2020	4,617	4,926	4,382	4,261	4,790	3,345	2,089		2	4	5	11	18	42	68	151									
	Dorchester Co.	2007	4,057	3,346	4,012	5,424	4,310	2,895	2,585		1	2	3	5	12	35	53	111		0.25	0.60	0.75	0.92	2.78	12.09	20.50	
		2008	3,983	3,409	3,965	5,342	4,413	2,989	2,585		1	1	7	9	14	41	48	121		0.25	0.29	1.77	1.68	3.17	13.72	18.57	
		2009	3,910	3,472	3,918	5,261	4,518	3,086	2,585			1	3	14	11	24	54	107		-	0.29	0.77	2.66	2.43	7.78	20.89	
		2010	3,838	3,537	3,872	5,181	4,625	3,186	2,585		3	2	3	19	13	33	69	142		0.78	0.57	0.77	3.67	2.81	10.36	26.69	
		2011	3,766	3,602	3,826	5,101	4,732	3,286	2,585			1	4	9	31	46	75	166		-	0.28	1.05	1.76	6.55	14.00	29.01	
																			AVG:	0.26	0.40	1.02	2.14	3.55	11.59	23.13	
		2015	3,493	3,873	3,647	4,794	5,187	3,720	2,585																		
		2016	3,492	3,899	3,709	4,691	5,280	3,821	2,641																		
		2017	3,491	3,926	3,771	4,590	5,375	3,924	2,697		1	2	4	10	19	45	62	143									
		2018	3,489	3,952	3,835	4,491	5,471	4,030	2,755		1	2	4	10	19	47	64	146									
		2020	3,487	4,006	3,966	4,300	5,669	4,251	2,875		1	2	4	9	20	49	67	152									
	Kent Co.	2007	3,357	1,670	2,166	3,132	2,743	1,988	2,038		5	1	3	1	2	10	14	36		1.49	0.60	1.39	0.32	0.73	5.03	6.87	
		2008	3,290	1,722	2,116	3,069	2,801	2,087	2,058			3		4	9	2	10	28		-	1.74	-	1.30	3.21	0.96	4.86	
		2009	3,224	1,775	2,067	3,007	2,860	2,191	2,077		1	5		4	10	7	11	38		0.31	2.82	-	1.33	3.50	3.20	5.30	
		2010	3,159	1,830	2,019	2,946	2,920	2,300	2,097		1	3		8	4	7	7	30		0.32	1.64	-	2.72	1.37	3.04	3.34	
		2011	3,094	1,885	1,971	2,885	2,980	2,409	2,117		2	4		3	3	7	10	29		0.65	2.12	-	1.04	1.01	2.91	4.72	
																			AVG:	0.55	1.78	0.28	1.34	1.96	3.03	5.02	
		2015	2,848	2,122	1,791	2,654	3,234	2,900	2,198																		
		2016	2,675	2,114	1,824	2,568	3,297	2,953	2,294																		
		2017	2,513	2,106	1,858	2,486	3,361	3,007	2,395		1	4	1	3	7	9	12	37									
		2018	2,360	2,098	1,893	2,406	3,426	3,062	2,500		1	4	1	3	7	9	13	37									
		2020	2,082	2,082	1,964	2,253	3,561	3,175	2,724		1	4	1	3	7	10	14	39									
	Queen Anne's Co.	2007	5,438	3,973	7,368	8,419	5,841	3,709	2,664				4	7	11	16	19	57		-	-	0.54	0.83	1.88	4.31	7.13	
		2008	5,448	4,092	7,142	8,427	6,029	3,886	2,733				2	7	7	24	38	78		-	-	0.28	0.83	1.16	6.18	13.90	
		2009	5,457	4,215	6,922	8,436	6,224	4,071	2,804		4		5	6	12	23	43	93		0.73	-	0.72	0.71	1.93	5.65	15.34	
		2010	5,467	4,341	6,709	8,444	6,424	4,265	2,876			1		8	7	19	49	84		-	0.23	-	0.95	1.09	4.45	17.04	
		2011	5,477	4,467	6,496	8,452	6,624	4,459	2,948			2	2	12	11	20	33	80		-	0.45	0.31	1.42	1.66	4.49	11.19	
																			AVG:	0.15	0.14	0.37	0.95	1.54	5.02	12.92	
		2015	5,515	5,010	5,710	8,486	7,491	5,327	3,257																		
		2016	5,573	5,122	5,761	8,275	7,725	5,463	3,416																		
		2017	5,631	5,236	5,812	8,070	7,967	5,603	3,583		1	1	2	8	12	28	46	98									
		2018	5,690	5,352	5,863	7,869	8,216	5,746	3,757		1	1	2	7	13	29	49	101									
		2020	5,810	5,593	5,968	7,483	8,738	6,043	4,133		1	1	2	7	13	30	53	108									
	Talbot Co.	2007	3,986	3,173	4,496	5,747	5,570	4,338	3,835		1	2	4	5	12	30	127	181		0.25	0.63	0.89	0.87	2.15	6.92	33.12	
		2008	3,947	3,265	4,398	5,683	5,619	4,516	3,910		1	1	2	5	24	78	194	305		0.25	0.31	0.45	0.88	4.27	17.27	49.62	
		2009	3,908	3,361	4,303	5,618	5,668	4,701	3,986		1	1	8	13	28	67	215	333		0.26	0.30	1.86	2.31	4.94	14.25	53.94	
		2010	3,870	3,459	4,209	5,555	5,718	4,894	4,064			2	3	15	26	56	211	313		-	0.58	0.71	2.70	4.55	11.44	51.92	
		2011	3,832	3,557	4,115	5,492	5,768	5,087	4,142		1	1	4	11	28	69	140	254		0.26	0.28	0.97	2.00	4.85	13.56	33.80	
																			AVG:	0.20	0.42	0.98	1.75	4.15	12.69	44.48	
		2015	3,683	3,979	3,761	5,245	5,971	5,938	4,469																		
		2016	3,691	4,019	3,806	5,112	6,029	6,046	4,631																		
		2017	3,698	4,059	3,852	4,983	6,088	6,156	4,799		1	2	4	9	25	78	213	332									
		2018	3,706	4,100	3,898	4,857	6,147	6,268	4,973		1	2	4	9	26	80	221	341									
		2020	3,721	4,183	3,992	4,615	6,267	6,498	5,341		1	2	4	8	26	82	238	361									

Exhibit 18
Rehabilitation Need Projections

									Age Cohorts:		15-24	25-34	35-44	45-54	55-64	65-74	75+	Total			MHE 2011 Market Share						
									2011 Total		3	11	14	48	101	173	302	652			0.78						
									2011 ALOS		7.33	14.71	10.33	9.04	8.88	9.19	8.86				0.83104						
									2017 Total		5.77	11.54	15.09	41.37	80.95	199.93	398.10	752.74		22	161.8571	144.6667	434	897	1590	2677	5926.524
									2017 Pt. Days		42.28	169.86	155.92	374.03	718.94	1,837.47	3,528.83	6,827.33									9.08976
																	ADC	18.71									
																	MHE Mkt Shr	78.4%									
																	2012 Adj.	83.8%									
																	MHE ADC	12.29									
																	@ 85% Occ.	14.46									

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Financial Statements and Schedules

June 30, 2011 and 2010

(With Independent Auditors' Report Thereon)

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Table of Contents

KPMG LLP
1 East Pratt Street
Baltimore, MD 21202-1128

Independent Auditors' Report

The Board of Directors
University of Maryland Medical System Corporation:

We have audited the accompanying consolidated balance sheets of the University of Maryland Medical System Corporation and Subsidiaries (the Corporation) as of June 30, 2011 and 2010, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Corporation's management. 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 of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the University of Maryland Medical System Corporation and Subsidiaries as of June 30, 2011 and 2010, and the results of their operations, changes in their net assets, and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Our audits were made for the purpose of forming an opinion on the basic consolidated financial statements taken as a whole. The supplementary information included in schedules 1 through 8 is presented for purposes of additional analysis and is not a required part of the basic consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audits of the basic consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

KPMG LLP

October 27, 2011

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2011 and 2010

(In thousands)

Assets	2011	2010
Current assets:		
Cash and cash equivalents	$ 217,517	238,548
Assets limited as to use, current portion	40,114	39,228
Accounts receivable:		
Patient accounts receivable, less allowance for doubtful accounts of $161,124 and $136,278 as of June 30, 2011 and 2010, respectively	262,421	249,127
Other	24,579	24,155
Inventories	32,181	30,230
Prepaid expenses and other current assets	51,871	67,681
Total current assets	628,683	648,969
Investments	406,850	281,108
Assets limited as to use, less current portion	505,466	490,119
Property and equipment, net	1,298,650	1,240,114
Deferred financing costs, net	7,547	8,661
Investments in joint ventures	169,220	107,851
Other assets	9,925	8,329
Total assets	$ 3,026,341	2,785,151
Liabilities and Net Assets		
Current liabilities:		
Trade accounts payable	$ 154,995	146,149
Accrued payroll and benefits	128,420	121,683
Advances from third-party payors	96,012	87,558
Lines of credit	54,600	63,300
Other current liabilities	87,643	83,958
Long-term debt subject to short-term remarketing arrangements	166,765	70,069
Current portion of long-term debt	24,242	36,442
Total current liabilities	712,677	609,159
Long-term debt, less current portion and amount subject to short-term remarketing arrangements	869,372	959,243
Other long-term liabilities	87,858	105,794
Interest rate swap liabilities	105,400	128,575
Total liabilities	1,775,307	1,802,771
Net assets:		
Unrestricted	1,142,835	894,949
Temporarily restricted	75,656	56,184
Permanently restricted	32,543	31,247
Total net assets	1,251,034	982,380
Total liabilities and net assets	$ 3,026,341	2,785,151

See accompanying notes to consolidated financial statements.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended June 30, 2011 and 2010

(In thousands)

	2011	2010
Unrestricted revenues, gains and other support:		
Net patient service revenue	$ 2,270,416	2,129,662
Other operating revenue:		
State support	3,200	3,200
Other revenue	70,588	66,106
Total unrestricted revenues, gains and other support	2,344,204	2,198,968
Operating expenses:		
Salaries, wages and benefits	1,041,344	988,399
Expendable supplies	380,222	357,793
Purchased services	336,281	312,381
Contracted services	139,710	140,844
Depreciation and amortization	129,012	117,766
Interest expense	40,341	40,051
Provision for bad debts	177,013	179,289
Total operating expenses	2,243,923	2,136,523
Operating income	100,281	62,445
Nonoperating income and expenses, net:		
Contributions	6,055	8,137
Equity in net income of joint ventures	20,534	3,514
Investment income	39,207	136
Change in fair value of investments	36,364	45,592
Change in fair value of undesignated interest rate swaps	18,640	(33,700)
Loss on early extinguishment of debt	—	(816)
Other nonoperating losses, net	(17,947)	(13,798)
Excess of revenues over expenses	203,134	71,510
Net assets released from restrictions used for the purchase of property and equipment	23,964	32,612
Other	20,788	(8,728)
Increase in unrestricted net assets	$ 247,886	95,394

See accompanying notes to consolidated financial statements.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2011 and 2010

(In thousands)

	Unrestricted net assets	Temporarily restricted net assets	Permanently restricted net assets	Total
Balance at June 30, 2009	$ 799,555	76,204	28,160	903,919
Excess of revenues over expenses	71,510	—	—	71,510
Investment gains, net	—	3,338	136	3,474
State support for capital	—	7,965	—	7,965
Contributions, net	—	21,011	2,866	23,877
Net assets released from restrictions used for operations and nonoperating activities	—	(5,890)	—	(5,890)
Net assets released from restrictions used for purchase of property and equipment	32,612	(32,612)	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	(14,986)	85	(14,901)
Change in ownership interest of joint ventures	3,478	1,141	—	4,619
Change in fair value of designated interest rate swaps	(7,410)	—	—	(7,410)
Change in funded status of defined benefit pension plans	(4,766)	—	—	(4,766)
Other	(30)	13		(17)
Increase (decrease) in net assets	95,394	(20,020)	3,087	78,461
Balance at June 30, 2010	894,949	56,184	31,247	982,380
Excess of revenues over expenses	203,134	—	—	203,134
Investment gains, net	—	5,102	177	5,279
State support for capital	—	21,565	—	21,565
Contributions, net	—	17,058	1,079	18,137
Net assets released from restrictions used for operations and nonoperating activities	—	(3,639)	—	(3,639)
Net assets released from restrictions used for purchase of property and equipment	23,964	(23,964)	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	3,324	40	3,364
Change in ownership interest of joint ventures	2,268	102	—	2,370
Change in fair value of designated interest rate swaps	2,298	—	—	2,298
Change in funded status of defined benefit pension plans	16,322	—	—	16,322
Other	(100)	(76)	—	(176)
Increase in net assets	247,886	19,472	1,296	268,654
Balance at June 30, 2011	$ 1,142,835	75,656	32,543	1,251,034

See accompanying notes to consolidated financial statements.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2011 and 2010

(In thousands)

	2011	2010
Cash flows from operating activities:		
Increase in net assets	$ 268,654	78,461
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	129,012	117,766
Provision for bad debts	177,013	179,289
Amortization of bond premium and deferred financing costs	1,562	1,178
Net realized gains and change in fair value of investments	(70,293)	(38,703)
Loss on early extinguishment of debt	—	816
Equity in net income of joint ventures	(20,534)	(3,514)
Contribution of land held for sale	—	(1,800)
Decrease in economic and beneficial interests in net assets of related organizations	(3,364)	14,901
Change in fair value of interest rate swaps	(23,175)	40,649
Change in funded status of defined benefit pension plans	16,322	4,766
Increase in patient accounts receivable	(190,307)	(186,637)
Increase in other receivables, prepaid expenses, other current assets and other assets	(6,431)	(8,635)
(Increase) decrease in inventories	(1,951)	1,323
(Decrease) increase in trade accounts payable, accrued payroll and benefits, other current liabilities and other long-term liabilities	(23,940)	27,047
Increase in advances from third-party payors	8,454	3,030
Restricted contributions, investment income and state support	(44,981)	(35,316)
Net cash provided by operating activities	216,041	194,621
Cash flows from investing activities:		
Purchases and sales of investments and assets limited as to use, net	(44,076)	(153,660)
Purchases of property and equipment	(169,198)	(141,686)
Distributions from joint ventures, net	4,388	1,924
Investment in joint ventures	(39,954)	(26,750)
Change in deposit for undesignated interest rate swaps on hand with swap counterparty	11,438	(13,420)
Net cash used in investing activities	(237,402)	(333,592)

(Continued)

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2011 and 2010

(In thousands)

		2011	2010
Cash flows from financing activities:			
Proceeds from long-term debt	$	26,750	245,942
Repayment of long-term debt and capital leases		(56,815)	(139,915)
(Repayments) draws on lines of credit, net		(8,700)	35,500
Change in deposit for designated interest rate swaps on hand with swap counterparty		3,514	(3,941)
Payment of debt issuance costs		—	(2,420)
Restricted contributions, investment income and state support		35,581	35,316
Net cash provided by financing activities		330	170,482
Net (decrease) increase in cash and cash equivalents		(21,031)	31,511
Cash and cash equivalents, beginning of year		238,548	207,037
Cash and cash equivalents, end of year	$	217,517	238,548
Supplemental disclosures of cash flow information:			
Cash paid during the year for interest	$	41,802	37,269
Amount included in accounts payable for construction in progress		17,146	11,981
Supplemental disclosures of noncash information:			
Capital leases	$	3,785	11,232
Contributed land		9,400	1,800

See accompanying notes to consolidated financial statements.

(1) Organization and Summary of Significant Accounting Policies

(a) Organization

The University of Maryland Medical System Corporation (the Corporation or UMMS) is engaged in providing comprehensive healthcare services through an integrated network of hospitals and other inpatient and outpatient clinical enterprises. The Corporation operates University Hospital, University of Maryland Marlene and Stewart Greenebaum Cancer Center (Greenebaum Cancer Center), and The R Adams Cowley Shock Trauma Center (Shock Trauma Center), collectively referred to as University of Maryland Medical Center (Medical Center) and is the sole member of The James Lawrence Kernan Hospital, Inc. (Kernan); University Specialty Hospital, Inc. (University Specialty); Maryland General Health Systems, Inc. (Maryland General); Baltimore Washington Medical System, Inc. (Baltimore Washington); Shore Health System, Inc. (Shore Health); Chester River Health System, Inc. (Chester River); University of Maryland Medical System Foundation, Inc. (UMMS Foundation); Shipley's Choice Medical Park, Inc. (Shipley's); and 36 South Paca Street, LLC (36 South Paca); each of which is described below. In addition, the Corporation has a majority interest in UniversityCARE, LLC (UCARE), and accordingly, it is a consolidated subsidiary of the Corporation. The Corporation also maintains equity interests in various unconsolidated joint ventures, which are described in note 4. All material intercompany balances and transactions have been eliminated in consolidation.

University of Maryland Medical Center

The Medical Center is comprised of three operating divisions: University Hospital, Greenebaum Cancer Center and Shock Trauma Center. University Hospital is a tertiary teaching hospital located in Baltimore with 565 licensed beds. The Greenebaum Cancer Center is a 51-bed program which specializes in the treatment of cancer patients. The Shock Trauma Center is a program with 115 licensed beds which provides both treatment to victims of trauma and training in establishing shock trauma systems.

The James Lawrence Kernan Hospital, Inc.

Kernan is comprised of a medical/surgical and rehabilitation hospital in Baltimore with 132 licensed beds, including 98 rehabilitation beds, 24 chronic care beds, 10 medical/beds; and off-site physical therapy facilities.

A related corporation, The James Lawrence Kernan Endowment Fund, Inc. (Kernan Endowment), is governed by a separate, independent board of directors and is required to hold investments and income derived therefrom for the exclusive benefit of Kernan. Accordingly, the accompanying consolidated financial statements reflect an economic interest in the net assets of the Kernan Endowment.

University Specialty Hospital, Inc.

University Specialty is a 180-bed facility located in Baltimore providing chronic care.

Maryland General Health Systems, Inc.

Maryland General is a West Baltimore health system comprised of Maryland General Hospital, a 213-bed acute care hospital; a wholly owned subsidiary providing primary care; and a noncontrolling 25% interest in a managed care organization providing services primarily to Medicaid patients.

A related corporation, Maryland General Community Health Foundation, Inc. (Maryland General Foundation), is required to hold investments and income derived therefrom for the exclusive benefit of Maryland General. As of June 30, 2011, Maryland General Foundation had contributed all of its assets to Maryland General Hospital in support of future capital projects.

Baltimore Washington Medical System, Inc.

Baltimore Washington is a health system comprised of Baltimore Washington Medical Center, a 311-bed acute care hospital providing a broad range of services, and several wholly owned subsidiaries providing emergency physician and other services.

Baltimore Washington Medical Center Foundation, Inc. (BWMC Foundation) is governed by a separate, independent board of directors and is required to hold investments and income derived therefrom for the exclusive benefit of Baltimore Washington Medical Center. Accordingly, the accompanying consolidated financial statements reflect an economic interest in the net assets of the BWMC Foundation.

Shore Health System, Inc.

Shore Health is a two-hospital health system located on the Eastern Shore of Maryland. Shore Health owns and operates Memorial Hospital, a 145-bed acute care hospital providing inpatient and outpatient services in Easton, Maryland; Dorchester Hospital, a 54-bed acute care hospital providing inpatient and outpatient services in Cambridge, Maryland; Memorial Hospital Foundation (Memorial Foundation), a nonprofit corporation established to solicit donations for the benefit of Memorial Hospital; and several other subsidiaries providing various outpatient and home care services.

Dorchester General Hospital Foundation, Inc. (Dorchester Foundation) is governed by a separate, independent board of directors to raise funds on behalf of Dorchester Hospital. Shore Health does not have control over the policies or decisions of the Dorchester Foundation, and accordingly, the accompanying consolidated financial statements reflect a beneficial interest in the net assets of the Dorchester Foundation.

Chester River Health System, Inc.

Chester River owns and operates Chester River Hospital Center (CRHC), a 53-bed acute care hospital providing inpatient and outpatient services to the residents of Kent and Queen Anne's counties; Chester River Health Foundation (Chester River Foundation), a nonprofit corporation established to solicit donations for the benefit of Chester River; and two other subsidiaries providing outpatient and homecare services.

University of Maryland Medical System Foundation, Inc.

The UMMS Foundation, a not-for-profit foundation, was established for the purpose of soliciting contributions on behalf of the Corporation.

36 South Paca Street, LLC

36 South Paca is a single-member limited liability company that owns and operates a residential apartment building near the Corporation's Baltimore campus.

UniversityCARE, LLC

UCARE, a physician hospital organization was established as a joint venture between the Corporation and University Physicians, Inc. (UPI). The purpose of UCARE is to operate an integrated healthcare services delivery system in a manner that integrates the teaching and research missions of the Corporation, UPI and their affiliates with the delivery of care in a cost efficient manner. The Corporation's ownership percentage and income (loss) sharing percentage is 90% and UPI's percentage is 10%. Accordingly, the assets, liabilities, unrestricted net assets and operations of UCARE are consolidated with the Corporation in the accompanying consolidated financial statements, and UPI's ownership interest is treated as a noncontrolling interest.

Shipley's Choice Medical Park, Inc.

Shipley's, a wholly owned subsidiary, is a 501(c) (2) title-holding corporation, formed for the purpose of managing property investments located in Anne Arundel County. The operations of Shipley's are solely comprised of the management of this property.

(b) Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with U.S. generally accepted accounting principles.

(c) Cash Equivalents

Cash and cash equivalents consist of cash and interest-bearing deposits with maturities of three months or less from the date of purchase.

(d) Investments and Assets Limited as to Use

The Corporation's investment portfolio is classified as trading, and is reported in the consolidated balance sheets at its fair value, based on quoted market prices, at June 30, 2011 and 2010. Unrealized holding gains and losses on trading securities with readily determinable market values are included in nonoperating income. Investment income, including realized gains and losses, is included in nonoperating income in the accompanying consolidated statement of operations.

Assets limited as to use include investments set aside at the discretion of the board of directors for the replacement or acquisition of property and equipment, investments held by trustees under bond indenture agreements and self-insurance trust arrangements, and assets whose use is restricted by donors. Such investments are stated at fair value. Amounts required to meet current liabilities have

been included in current assets in the consolidated balance sheets. Changes in fair values of donor-restricted investments are recorded in temporarily restricted net assets unless otherwise required by the donor or state law.

Assets limited as to use also include the Corporation's economic interests in financially interrelated organizations (note 12).

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.

Investments are exposed to certain risks such as interest rate, credit and overall market volatility. Due to the level of risk associated with certain investment securities, changes in the value of investment securities could occur in the near term, and these changes could materially differ from the amounts reported in the accompanying consolidated financial statements.

(e) Inventories

Inventories, consisting primarily of drugs and medical/surgical supplies, are carried at the lower of cost or market, on a first-in, first-out basis.

(f) Economic Interests in Financially Interrelated Organizations

The Corporation recognizes its rights to assets held by recipient organizations, which accept cash or other financial assets from a donor and agree to use those assets on behalf of or transfer those assets, the return on investment of those assets, or both, to the Corporation. Changes in the Corporation's economic interests in these financially interrelated organizations are recognized in the consolidated statements of changes in net assets.

(g) Property and Equipment

Property and equipment are stated at cost, or estimated fair value at date of contribution, less accumulated depreciation. Depreciation is provided on a straight-line basis over the estimated useful lives of the depreciable assets. The estimated useful lives of the assets are as follows:

Buildings	20 to 40 years
Building and leasehold improvements	5 to 20 years
Equipment	3 to 20 years

Interest costs incurred on borrowed funds less interest income earned on the unexpended bond proceeds during the period of construction are capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support 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) Deferred Financing Costs

Costs incurred related to the issuance of long-term debt are deferred and are amortized over the life of the related debt agreements or the related letter of credit agreements using the effective interest method. Accumulated amortization of such costs amounted to $7,708,000 and $6,594,000 as of June 30, 2011 and 2010, respectively. In connection with the refinancing of certain debt in the year ended June 30, 2010, the Corporation recorded a loss on early extinguishment of debt of $816,000, which consisted of the write-off of deferred financing costs.

(i) Impairment of Long-Lived Assets

Long-lived assets, such as property, plant, and equipment, and purchased intangibles subject to amortization, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by comparing the carrying amount of an asset to estimated undiscounted future cash flows expected to be generated by the asset. If the carrying amount of an asset exceeds its estimated future cash flows, an impairment charge is recognized in the amount by which the carrying amount of the asset exceeds the fair value of the asset. Assets to be disposed of would be separately presented in the consolidated balance sheets and reported at the lower of the carrying amount or fair value less costs to sell, and are no longer depreciated. The assets and liabilities of a disposed group classified as held for sale would be presented separately in the appropriate asset and liability sections of the consolidated balance sheets.

(j) Investments in Joint Ventures

When the Corporation does not have a controlling interest in an entity, but exerts a significant influence over the entity, the Corporation applies the equity method of accounting.

(k) Self-Insurance

Under the Corporation's self-insurance programs (general and professional liability, workers' compensation and employee health benefits), claims are reflected as a present value liability based upon actuarial estimates, including both reported and incurred but not reported claims taking into consideration the severity of incidents and the expected timing of claim payments.

(l) Net Assets

The Corporation classifies net assets based on the existence or absence of donor-imposed restrictions. Unrestricted net assets represent contributions, gifts and grants, which have no donor-imposed restrictions or which arise as a result of operations. Temporarily restricted net assets

are subject to donor-imposed restrictions that must or will be met either by satisfying a specific purpose and/or passage of time. Permanently restricted net assets are subject to donor-imposed restrictions that must be maintained in perpetuity. Generally, the donors of these assets permit the use of all or part of the income earned on related investments for specific purposes. The restrictions associated with these net assets generally pertain to patient care, specific capital projects and funding of specific hospital operations and community outreach programs.

(m) Net Patient Service Revenue and Provision for Uncollectible Accounts

Net patient service revenue for the Medical Center, Kernan, Maryland General, Baltimore Washington, Shore Health, Chester River and University Specialty reflects actual charges to patients based on rates established by the State of Maryland Health Services Cost Review Commission (HSCRC) in effect during the period in which the services are rendered, net of contractual adjustments. Contractual adjustments represent the difference between amounts billed as patient service revenue and amounts allowed by third-party payors. Such adjustments include discounts on charges as permitted by the HSCRC.

The Corporation records revenues and accounts receivable from patients and third-party payors at their estimated net realizable value. Revenue is reduced for anticipated discounts under contractual arrangements and for charity care. An estimated provision for bad debts is recorded in the period the related services are provided based upon anticipated uncompensated care, and is adjusted as additional information becomes available.

The provision for bad debts is based upon management's assessment of historical and expected net collections considering historical business and economic conditions, trends in healthcare coverage, and other collection indicators. Periodically throughout the year, management assesses the adequacy of the allowance for uncollectible accounts based upon historical write-off experience by payor category. The results of this review are then used to make modifications to the provision for bad debts and to establish an allowance for uncollectible receivables. After collection of amounts due from insurers, the Corporation follows internal guidelines for placing certain past due balances with collection agencies.

(n) Charity Care

The Corporation provides charity care to patients who are unable to pay. Such patients are identified based on information obtained from the patient and subsequent analysis. Because the Corporation does not expect collection of amounts determined to qualify as charity care, they are not reported as revenue. Based on established rates, the Corporation estimates $83,232,000 and $68,825,000 of charity care services were provided in the years ended June 30, 2011 and 2010, respectively.

(o) Nonoperating Income and Expenses, Net

Other activities that are largely unrelated to the Corporation's primary mission are recorded as nonoperating income and expenses, and include investment income, equity in the net income of joint ventures, general donations and fund-raising activities, and loss on early extinguishment of debt.

(p) Derivative Financial Instruments

The Corporation records derivative and hedging activities on the consolidated balance sheet at their respective fair values.

The Corporation utilizes derivative financial instruments to manage its interest rate risks associated with long-term tax-exempt debt. The Corporation does not hold or issue derivative financial instruments for trading purposes.

The Corporation's specific goals are to (a) manage interest rate sensitivity by modifying the repricing or maturity characteristics of some of its tax-exempt debt, and (b) lower unrealized appreciation or depreciation in the market value of the Corporation's fixed-rate tax-exempt debt when that market value is compared with the cost of the borrowed funds. The effect of this unrealized appreciation or depreciation in market value, however, will generally be offset by the income or loss on the derivative instruments that are linked to the debt.

All derivative instruments are reported as other assets or other long-term liabilities in the consolidated balance sheet and measured at fair value. On the date the derivative contract is entered into, the Corporation may designate the derivative as either a hedge of the fair value of a recognized or forecasted liability (fair value hedge) or a hedge of the variability of cash flows to be received or paid related to a recognized liability (cash flow hedge), provided the derivative instrument meets certain criteria related to its effectiveness. Derivatives not designated as hedges or not meeting effectiveness criteria are carried at fair value with changes in the fair value recognized in other nonoperating income and expenses.

The Corporation formally documents all hedge relationships between hedging instruments and hedged items, as well as its risk-management objective and strategy for undertaking various hedge transactions. This process includes linking all derivatives that are designated as fair value or cash flow hedges to specific liabilities on the consolidated balance sheet. The Corporation also formally assesses, both at the hedge's inception and on an ongoing basis, whether the derivatives that are used in hedging transactions are highly effective in offsetting changes in fair values or cash flows of hedged items.

Changes in the fair value of derivative instruments are included in or excluded from the excess of revenues over expenses depending on the use of the derivative and whether it qualifies for hedge accounting. Changes in the fair value of a derivative that is designated and qualifies as a fair value hedge, along with the changes in the fair value of the hedged item related to the risk being hedged, are included in the excess of revenues over expenses. Changes in the fair value of a derivative that is designated as a cash flow hedge are excluded from the excess of revenues over expenses to the extent that the hedge is effective until the excess of revenues over expenses is affected by the variability of cash flows in the hedged transaction. Changes in the fair value that relate to ineffectiveness are included in the excess of revenues over expenses as interest expense.

The Corporation discontinues hedge accounting prospectively when it determines that the derivative is no longer effective in offsetting changes in the fair value or cash flows of a hedged item, when the derivative expires or is sold, terminated or exercised, or when management determines that

designation of the derivative as a hedge instrument is no longer appropriate. When hedge accounting is discontinued and the derivative remains outstanding, all subsequent changes in fair value of the derivative are included in the excess of revenues over expenses.

(q) Excess of Revenue over Expenses

The consolidated statement of operations includes a performance indicator, excess of revenue over expenses. Changes in unrestricted net assets that are excluded from the performance indicator, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions, which, by donor restrictions, were to be used for the purpose of acquiring such assets), pension-related changes other than net periodic pension costs, change in fair value of derivatives that qualify for hedge accounting, and other items that are required by generally accepted accounting principles to be reported separately.

(r) Income Taxes

The Corporation and most of its subsidiaries are not-for-profit corporations formed under the laws of the State of Maryland, organized for charitable purposes and recognized by the Internal Revenue Service as tax-exempt organizations under Section 501(c)(3) of the Internal Revenue Code pursuant to Section 501(a) of the Code. The effect of the taxable status of its for-profit subsidiaries is not material to the consolidated financial statements. The Corporation paid approximately $195,000 in income taxes on its unrelated business activities in the year ended June 30, 2010. There were no income taxes paid on unrelated business activities in the year ended June 30, 2011. The Corporation has net operating losses of approximately $13.5 million as of June 30, 2011, which expire at various dates through 2031. The Corporation's deferred tax assets of approximately $5.4 million at June 30, 2011 are fully reserved as they are not expected to be utilized.

The Corporation follows a threshold of more-likely-than-not for recognition and derecognition of tax positions taken or expected to be taken in a tax return. Management does not believe that there are any unrecognized tax benefits that should be recognized.

(s) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Corporation are reported at 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 promise becomes unconditional. Contributions are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction is satisfied, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets released from restrictions. Such amounts are classified as other revenue or transfers and additions to property and equipment.

Contributions to be received after one year are discounted at an appropriate discount rate commensurate with the risks involved. An allowance for uncollectible contributions receivable is provided based upon management's judgment including such factors as prior collection history, type of contributions, and nature of fund-raising activity.

The Corporation follows accounting guidance for classifying the net assets associated with donor-restricted endowment funds held by organizations that are subject to an enacted version of the Uniform Prudent Management Institutional Funds Act of 2006 (UPMIFA).

(t) Fair Value Measurements

In January 2010, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2010-06 (ASU 2010-06), *Improving Disclosures about Fair Value Measurements*. ASU 2010-06 amends Accounting Standards Codification Topic 820, *Fair Value Measurements and Disclosures*, to require a number of additional disclosures regarding fair value measurements and disclosure of the amounts of significant transfers between Level 1 and Level 2 investments and the reasons for such transfers, the reasons for any transfers into or out of Level 3 investments, and disclosure of the policy for determining when transfers among levels are recognized. ASU 2010-06 also clarified that disclosures should be provided for each class of assets and liabilities and clarified the requirement to disclose information about the valuation techniques and inputs used in estimating Level 2 and Level 3 measurements. Effective in fiscal year 2011, ASU 2010-06 also requires that information in the reconciliation of recurring Level 3 measurements about purchases, sales, issuances and settlements be provided on a gross basis. The adoption of ASU 2010-06 only required additional disclosures and did not have an impact on the consolidated financial statements.

The following methods and assumptions were used by the Corporation in estimating the fair value of its financial instruments:

Cash and cash equivalents, accounts receivable, assets limited as to use, investments, accounts payable, accrued expenses and advances from third-party payors – The carrying amounts reported in the consolidated balance sheet approximate the related fair values.

Long-term debt – The fair value of the long-term debt issued through the Maryland Health and Higher Educational Facilities Authority (Authority or MHHEFA), based on quoted market prices for the same or similar issues, at June 30, 2011 and 2010, was approximately $1,018,753,000 and $1,040,208,000, respectively. The carrying amounts of other long-term debt reported in note 7 and on the consolidated balance sheet approximate the related fair values.

(u) New Accounting Pronouncements

In April 2009, the FASB issued ASU No. 2010-07, *Not-for-Profit Entities: Mergers and Acquisitions (Topic 958)*. This ASU established principles and requirements for how a not-for-profit entity determines whether a combination is a merger or an acquisition and makes other accounting literature fully applicable to not-for-profit entities. This ASU is effective for mergers for which the merger date is on or after the beginning of an initial reporting period beginning on or after December 15, 2009; therefore, effective for the Corporation January 1, 2010. This ASU is effective for acquisitions for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2009; therefore, effective for the Corporation on July 1, 2010. It may not be applied to mergers or acquisitions before those dates. The Corporation adopted the provisions of this guidance as of July 1, 2010. The adoption did not have an impact on

the Corporation's financial position or results of operations for the year ended June 30, 2011. The Corporation completed the acquisition of Civista Health, Inc. and Subsidiaries on July 1, 2011. The acquisition will be accounted for under the new guidance and accordingly, the acquired entity will be recorded by the Corporation at its fair value as of the date of acquisition. Refer to note 21 Subsequent Events for additional disclosure regarding the transaction.

ASU 2010-07 also amends previous guidance for the reporting of goodwill and other intangibles and noncontrolling interests in consolidated financial statements to make their provisions fully applicable to not-for-profit entities. This guidance establishes that goodwill be tested annually for impairment and an impairment loss be recognized if it is determined that the carrying amount of the reporting unit's net assets exceeds its fair value. Beginning on July 1, 2010, the Corporation applied the transition provisions of the guidance, which requires the Corporation to cease amortization of previously recognized goodwill and to test goodwill for impairment annually or more frequently if events or circumstances indicate that the carrying value of an asset may not be recoverable. The Corporation completed the transitional and annual goodwill impairment test. No adjustments to the carrying value of previously recognized goodwill were recorded during the year ended June 30, 2011.

In August 2010, the FASB issued ASU No. 2010-24, *Health Care Entities (Topic 954): Presentation of Insurance Claims and Related Insurance Recoveries*. The amendments in the ASU clarify that a health care entity may not net insurance recoveries against related claim liabilities. In addition, the amount of the claim liability must be determined without consideration of insurance recoveries. This ASU is effective for the Corporation on July 1, 2011.

In August 2010, the FASB issued ASU No. 2010-23, *Health Care Entities (Topic 954): Measuring Charity Care for Disclosure*. ASU 2010-23 is intended to reduce the diversity in practice regarding the measurement basis used in the disclosure of charity care. ASU 2010-23 requires that cost be used at the measurement basis for charity care disclosure purposes and that cost be identified as the direct and indirect cost of providing the charity care, and requires disclosure of the method used to identify or determine such costs. This ASU is effective for the Corporation on July 1, 2011.

In July 2011, the FASB issued ASU No. 2011-07, *Health Care Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debt, and the Allowance for Doubtful Accounts*. The ASU requires health care entities that recognize significant amounts of patient service revenue to present the provision for bad debts related to patient service revenue as a deduction from patient service revenue (net of contractual allowances and discounts) on their statement of operations. This ASU is effective for the Corporation on July 1, 2012, with early adoption permitted.

In September 2011, the FASB issued ASU No. 2011-08, *Intangibles – Goodwill and Other (Topic 350)*. This ASU is effective for fiscal years beginning after December 15, 2011, with early adoption permitted. This ASU is effective for the Corporation on July 1, 2012.

The Corporation does not anticipate that the adoption of the aforementioned pronouncements that will become effective in future fiscal years, will have a material impact on its financial position or its results of operations.

(v) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(2) Investments and Assets Limited as to Use

The fair value of assets limited as to use was as follows at June 30 (in thousands):

	2011	2010
Debt service and reserve funds	$ 76,967	74,160
Construction funds – held by trustee	75,027	123,877
Board designated funds	97,307	86,666
Construction funds – held by the Corporation	105,798	80,212
Self-insurance trust funds	99,663	84,920
Funds restricted by donors	49,016	41,073
Economic and beneficial interests in the net assets of related organizations (note 12)	41,802	38,439
Total assets limited as to use	545,580	529,347
Less amounts available for current liabilities	(40,114)	(39,228)
Total assets limited as to use, less current portion	$ 505,466	490,119

The composition and fair value of assets limited as to use were as follows at June 30, 2011 (in thousands):

	Debt service and reserve funds	Construction funds	Board designated funds	Self-insurance trust funds	Funds restricted by donors	Economic and beneficial interests	Total
Cash and cash equivalents	$ 33,491	73,904	9,773	477	7,317	—	124,962
Corporate bonds	—	2,928	2,862	1,117	4,349	—	11,256
Collateralized corporate obligations	—	1,684	1,627	3	287	—	3,601
U.S. government and agency securities	43,476	74,791	2,819	604	499	—	122,189
Common stocks, including mutual funds	—	13,804	39,617	1,036	23,894	—	78,351
Alternative investments	—	13,714	40,609	—	12,670	—	66,993
Assets held by other organizations	—	—	—	96,426	—	41,802	138,228
Total assets limited as to use	$ 76,967	180,825	97,307	99,663	49,016	41,802	545,580

(Continued)

The composition and fair value of assets limited as to use were as follows at June 30, 2010 (in thousands):

	Debt service and reserve funds	Construction funds	Board designated funds	Self-insurance trust funds	Funds restricted by donors	Economic and beneficial interests	Total
Cash and cash equivalents	$ 29,357	42,029	7,328	472	10,000	—	89,186
Corporate bonds	—	5,196	18,118	1,072	8,299	—	32,685
Collateralized corporate obligations	—	2,459	1,840	3	31	—	4,333
U.S. government and agency securities	44,803	127,937	3,038	587	197	—	176,562
Common stocks	—	13,674	26,738	1,006	15,143	—	56,561
Alternative investments	—	12,794	29,604	—	7,403	—	49,801
Assets held by other organizations	—	—	—	81,780	—	38,439	120,219
Total assets limited as to use	$ 74,160	204,089	86,666	84,920	41,073	38,439	529,347

Self-insurance trust funds include amounts held by the Maryland Medicine Comprehensive Insurance Program (MMCIP) for payment of malpractice claims. These assets consist primarily of stocks, fixed-income corporate obligations, and alternative investments. MMCIP is a funding mechanism for the Corporation's malpractice insurance program. As MMCIP is not an insurance provider, transactions with MMCIP are recorded under the deposit method of accounting. Accordingly, the Corporation accounts for its participation in MMCIP by carrying limited-use assets representing the amount of funds contributed to MMCIP and recording a liability for claims, which is included in other current and other long-term liabilities in the accompanying consolidated balance sheets.

The composition and fair value of investments not limited as to use were as follows at June 30 (in thousands):

	2011	2010
Cash and cash equivalents	$ 37,789	7,705
Corporate bonds	28,547	40,418
Collateralized corporate obligations	16,403	16,130
U.S. government and agency securities	28,421	26,875
Common stocks	147,967	97,569
Alternative investments	147,723	92,411
	$ 406,850	281,108

Investments at June 30, 2011 include $150,000,000 of funds for potential future commitments in accordance with the Affiliation Agreement with Upper Chesapeake Health System as discussed in note 4.

Alternative investments include hedge fund, private equity, and commingled fund investments, which are valued using the equity method of accounting.

Fair value disclosures related to the Corporation's investments and assets limited as to use are provided in note 19.

The Corporation's total return on its investments and assets limited as to use was as follows for the years ended June 30 (in thousands):

		2011	2010
Dividends and interest, net of fees	$	10,557	13,232
Net realized gains (losses)		30,107	(10,176)
Change in fair value of other-than-trading securities		—	—
Change in fair value of trading securities		40,186	48,879
Total investment gain	$	80,850	51,935

Total investment gain is classified in the consolidated statements of operations as follows for the years ended June 30 (in thousands):

		2011	2010
Nonoperating investment income	$	39,207	136
Other operating revenue		—	2,733
Change in fair value of unrestricted investments		36,364	45,592
Investment gains on restricted net assets		5,279	3,474
Total investment return	$	80,850	51,935

Investment return does not include the returns on the economic interests in the net assets of related organizations, the returns on the self-insurance trust funds, returns on undesignated interest rates swaps, or the returns on certain construction funds where amounts have been capitalized.

(3) Property and Equipment

The following is a summary of property and equipment at June 30 (in thousands):

		2011	2010
Land	$	82,279	72,945
Buildings		972,683	955,181
Building and leasehold improvements		445,868	433,071
Equipment		948,188	916,454
Construction in progress		141,624	84,513
		2,590,642	2,462,164
Less accumulated depreciation and amortization		(1,291,992)	(1,222,050)
	$	1,298,650	1,240,114

(Continued)

Interest cost capitalized was $2,942,000 and $1,501,000 (net of interest income of $200,000 and $374,000) for the years ended June 30, 2011 and 2010, respectively.

Remaining commitments on construction projects were approximately $100,927,000 at June 30, 2011.

Construction in progress includes building and renovation costs for assets that have not yet been placed into service. These costs relate to major construction projects as well as routine renovations under way at the Corporation's facilities.

Depreciation expense was $128,970,000 and $117,470,000 for the years ended June 30, 2011 and 2010, respectively.

(4) Investments in Joint Ventures

The Corporation has investments of $169,220,000 and $107,851,000 at June 30, 2011 and 2010, respectively, in the following unconsolidated joint ventures:

		Percent ownership	
Joint venture	**Business purpose**	**FY2011**	**FY2010**
Lithogroup, Inc.	Lithotripsy provider	25%	25%
Shipley's Imaging Center, LLC	Freestanding imaging center	50	50
Maryland Care, Inc.	Managed care organization	25	25
Innovative Health Services, LLC	Third-party insurance claims processor	50	50
Helen P. Denit Cancer Treatment Center, LLC	Cancer treatment services	—	50
NAH/Sunrise of Severna Park, LLC	Senior living facility	50	50
Terrapin Insurance Company (Terrapin)	Healthcare professional liability insurance company	50	50
Mt. Washington Pediatric Hospital, Inc. (Mt. Washington)	Healthcare services	50	50
UCHS/UMMS Venture, LLC	Healthcare services	49	34
Central Maryland Radiation Oncology Center LLC	Healthcare services	50	50

The Corporation recorded equity in net earnings of $20,534,000 and $3,514,000 related to these joint ventures for the years ended June 30, 2011 and 2010, respectively.

Effective June 26, 2009, the Corporation entered into a Membership Interest Purchase Agreement (Membership Agreement) with Upper Chesapeake Health System, Inc. (UCHS), a healthcare system located in Harford County, Maryland, whereby the Corporation purchased a 20% interest in the Upper Chesapeake Health System/University of Maryland Medical System Venture, LLC (UCHS/UMMS Venture, LLC) for $31,500,000. On October 1, 2009, the Corporation entered into an Affiliation Agreement with UCHS and the UCHS/UMMS Venture, LLC whereby the Corporation paid an additional $26,750,000 to UCHS/UMMS Venture, LLC for an additional 14% interest in the UCHS/UMMS Venture, LLC. This payment increased the Corporation's membership interest of the UCHS/UMMS Venture, LLC to 34%. In accordance with the Affiliation Agreement, the Corporation paid an additional $26,750,000 to UCHS/UMMS Venture, LLC on October 1, 2010. This payment increased the Corporation's membership interest in UCHS/UMMS Venture, LLC to 49%. In accordance with the Affiliation Agreement, the Corporation has designated $150 million for future capital improvements of UCHS/UMMS Venture, LLC. The Corporation has committed no less than $176 million to UCHS/UMMS Venture, LLC for future capital improvements over the next several years, which will increase the Corporation's membership interest in the UCHS/UMMS Venture, LLC to 100%.

The following is a summary of the Corporation's joint ventures' combined unaudited condensed financial information as of and for the years ended June 30 (in thousands):

	2011				
	Mt. Washington	**Terrapin**	**UCHS/UMMS Venture, LLC**	**Others**	**Total**
Current assets	$ 24,051	12,398	97,163	106,151	239,763
Noncurrent assets	47,759	117,524	280,831	70,833	516,947
Total assets	$ 71,810	129,922	377,994	176,984	756,710
Current liabilities	$ 9,555	3,092	51,643	94,637	158,927
Noncurrent liabilities	8,189	124,880	199,695	2,636	335,400
Net assets	54,066	1,950	126,656	79,711	262,383
Total liabilities and net assets	$ 71,810	129,922	377,994	176,984	756,710
Total operating revenue	$ 50,383	25,361	348,101	668,703	1,092,548
Total operating expenses	(46,455)	(34,826)	(340,285)	(644,939)	(1,066,505)
Total nonoperating gains/(losses), net	5,168	9,465	19,327	(9,139)	24,821
Other changes in net assets, net	654		30,920	(3,817)	27,757
Increase in net assets	$ 9,750	—	58,063	10,808	78,621

(Continued)

	2010				
	Mt. Washington	Terrapin	UCHS/UMMS Venture, LLC	Others	Total
Current assets	$ 25,450	22,584	68,282	118,293	234,609
Noncurrent assets	37,752	105,559	259,953	60,613	463,877
Total assets	$ 63,202	128,143	328,235	178,906	698,486
Current liabilities	$ 9,636	102	49,865	106,300	165,903
Noncurrent liabilities	9,250	126,091	209,777	3,703	348,821
Net assets	44,316	1,950	68,593	68,903	183,762
Total liabilities and net assets	$ 63,202	128,143	328,235	178,906	698,486
Total operating revenue	$ 48,901	24,942	294,636	514,305	882,784
Total operating expenses	(46,582)	(33,643)	(282,268)	(499,356)	(861,849)
Total nonoperating gains/(losses), net	2,244	8,701	(9,574)	1,734	3,105
Other changes in net assets, net	3,068	—	28,609	14,006	45,683
Increase in net assets	$ 7,631	—	31,403	30,689	69,723

(5) Leases

The Corporation rents various equipment and facility space. Rent expense under these operating leases for the years ended June 30, 2011 and 2010 was approximately $16,150,000 and $16,516,000, respectively.

Future noncancelable minimum lease payments under operating leases are as follows for the years ending June 30 (in thousands):

2012	$ 5,677
2013	4,541
2014	4,105
2015	3,626
2016	2,579
Thereafter	10,864
	$ 31,392

The Corporation rents property used for administration under a 99-year lease. The lease was recorded as a capital lease, and the Corporation recorded assets at their respective fair values of $3,770,000 and $29,230,000 for land and buildings, respectively. The lease includes an option for the Corporation to purchase the property during the period from April 20, 2017 to February 28, 2021 for a purchase price of not less than $37,000,000 but not more than $45,000,000 as determined by appraisals. In addition, the lease agreement includes a put option exercisable through February 28, 2013, whereby the lessor may require the

Corporation to purchase the building for $37,000,000. As of June 30, 2011 and 2010, amounts of $34,949,000 and $34,680,000, respectively, representing obligations under the lease have been recorded in other current liabilities.

As of June 30, 2011, amounts of $2,830,000 and $10,169,000 representing obligations under all other capital leases are included in other current liabilities and other long-term liabilities, respectively.

The following is a summary of all property and equipment under capital leases at June 30 (in thousands):

		2011	2010
Land	$	3,770	3,770
Buildings		29,230	29,230
Equipment		18,555	14,771
		51,555	47,771
Less accumulated amortization		(9,813)	(5,621)
	$	41,742	42,150

Future minimum lease payments under capital leases, together with the present value of the net minimum lease payments, are as follows as of June 30, 2011 (in thousands):

2012	$	6,183
2013		11,458
2014		4,256
2015		3,759
2016		3,505
Thereafter		39,807
Total minimum lease payments		68,968
Less amounts representing interest		(21,020)
Present value of net minimum lease payments	$	47,948

(6) Lines of Credit

The Medical Center had unsecured credit lines totaling $75,000,000 at June 30, 2011 and $65,000,000 at June 30, 2010, available for working capital purposes under bank credit agreements, of which $54,600,000 and $63,300,000 was outstanding at June 30, 2011 and 2010, respectively. Interest is charged on the outstanding balance based on one-month LIBOR plus a percentage spread (rates ranged from 0.99% – 3.25% at June 30, 2011).

(Continued)

Maryland General maintained an unsecured line of credit arrangement with a bank of $5,000,000, of which there was no outstanding balance as of June 30, 2011 or 2010. Interest is charged on the outstanding balance at one-month LIBOR plus 2.20% (2.39% at June 30, 2011).

Baltimore Washington maintained an unsecured line of credit arrangement with a bank of $5,000,000 at June 30, 2010, of which there was no outstanding balance as of June 30, 2010.

(7) Long-Term Debt and Other Borrowings

Long-term debt consists of the following at June 30 (in thousands):

	Interest rate	Payable in fiscal year(s)	2011	2010
MHHEFA project revenue bonds:				
Corporation issue, payments due annually on July 1:				
Series 2010 Bonds	2.00% – 5.25%	2011 – 2040	$ 237,210	242,385
Series 2008A-E Bonds	Variable rate	2025 – 2042	280,000	280,000
Series 2008F Bonds	4.00% – 5.25%	2009 – 2024	75,785	81,395
Series 2007A/B Bonds	Variable rate	2008 – 2035	137,320	137,420
Series 2006A Bonds	4.50% – 5.00%	2026 – 2042	45,000	45,000
Series 2005 Bonds	4.00% – 5.50%	2006 – 2032	138,590	141,390
Series 2004B Bonds	3.20% – 5.00%	2005 – 2025	28,165	29,565
Series 2002 Bonds	5.00%	2004 – 2013	2,785	4,085
Series 2001 Bonds	4.25% – 5.00%	2006 – 2012	1,275	2,410
Series 1991B Bonds	7.00%	1992 – 2023	27,315	27,315
Shore Health issue, payments due annually on July 1:				
Series 1998 Bonds	4.15% – 5.25%	2000 – 2020	21,115	22,955
MHHEFA pooled loan program:				
Chester River Issue, payments due semi-annually on July and January 1 Commercial paper series	Variable rate	1990 – 2013	630	865
MHHEFA variable rate demand bonds:				
Chester River Issue, payments due semi-annually on July and January 1 MHHEFA D	Variable rate	2004 – 2024	2,080	2,395
MHHEFA master lease and sublease	4.40%	2006 – 2013	1,170	1,765

(Continued)

	Interest rate	Payable in fiscal year(s)	2011	2010
Other long-term debt:				
North Arundel Senior Living, LLC Mortgage	Variable rate	Monthly, 2014	$ 10,909	11,167
Term loans	Variable rate	2010 – 2013	43,008	26,644
Other loans and notes payable	5.00% – 7.00%	Monthly, 1991 – 2023	4,462	4,990
			1,056,819	1,061,746
Less current portion of long-term debt			24,242	36,442
Less long-term debt subject to short-term remarketing agreements			166,765	70,069
			865,812	955,235
Plus unamortized premiums and discounts, net			3,560	4,008
			$ 869,372	959,243

Pursuant to a Master Loan Agreement dated June 20, 1991 (Master Loan Agreement), as amended, the Corporation and several of its subsidiaries have issued debt through MHHEFA. As security for the performance of the bond obligation under the Master Loan Agreement, the Authority maintains a security interest in the revenue of the obligors. The Master Loan Agreement contains certain restrictive covenants. These covenants require that rates and charges be set at certain levels, limit incurrence of additional debt, require compliance with certain operating ratios and restrict the disposition of assets.

The Obligated Group under the Master Loan Agreement includes the Medical Center, University Specialty, Kernan Hospital, Maryland General Hospital, Baltimore Washington Medical Center, and Shore Health. Each member of the Obligated Group is jointly and severally liable for the repayment of the obligations under the Master Loan Agreement. In January 2010, Chester River Health System and the UMMS Foundation were added to the Obligated Group.

Under the terms of the Master Loan Agreement and other loan agreements, certain funds are required to be maintained on deposit with the Master Trustee to provide for repayment of the obligations of the Obligated Group (note 2).

In January 2010, the Corporation refunded $95,905,000 of the Series 2008G, 2008H, and Shore Health issue Series 2004A bonds. The refunding was completed using the proceeds of a new $242,385,000 fixed-rate MHHEFA bond issue (the Series 2010 Bonds). The unamortized portion of issuance costs on the refunded debt of $816,000 was expensed as a loss on early extinguishment of debt during the year ended June 30, 2010.

The payment of principal and interest on the Series 2005 Bonds and the Series 2004B Bonds is insured under a financial guaranty insurance policy. This policy insures the payment of principal, sinking fund

installments and interest on the corresponding bonds. Premiums related to the policy as well as other costs incurred relating to the bond issuances were capitalized and are being amortized over the life of the bonds. The insurance policy requires the Obligated Group to adhere to the same covenants as those in the Master Loan Agreement.

The aggregate annual future maturities of long-term debt according to the original terms of the Master Loan Agreement and all other loan agreements are as follows for the years ending June 30 (in thousands):

2012	$	24,242
2013		52,987
2014		42,646
2015		23,262
2016		24,356
Thereafter		889,326
	$	1,056,819

The Corporation's Series 2007A/B and 2008A-E, and Chester River's MHHEFA Series D and Pooled Loan issuances, are variable rate demand bonds requiring remarketing agents to purchase and remarket any bonds tendered before the stated maturity date. The reimbursement obligations with respect to the letters of credit are evidenced and secured by the respective bonds. To provide liquidity support for the timely payment of any bonds that are not successfully remarketed, the Corporation has entered into letter of credit agreements with six banking institutions. These agreements have terms that expire in 2012 through 2014. If the bonds are not successfully remarketed, the Corporation is required to pay an interest rate specified in the letter of credit agreement, and the principal repayment of bonds may be accelerated to require repayment in periods ranging from 20 to 60 months from the date of the failed remarketing. The Corporation has reflected the amount of its long-term debt that is subject to these short-term remarketing arrangements as a separate component of current liabilities in its consolidated balance sheets. In the event that bonds are not remarketed, the Corporation maintains available lines of credit and has the ability to access other sources to obtain the necessary liquidity to comply with accelerated repayment terms. All variable rate demand bonds were successfully remarketed as of June 30, 2011.

The following table reflects the required repayment terms for the years ended June 30 (in thousands) of the Corporation's debt obligations in the event that the put options associated with variable rate demand bonds subject to short-term remarketing agreements were exercised, but not successfully remarketed:

2012	$	191,007
2013		253,097
2014		95,701
2015		23,262
2016		24,356
Thereafter		469,396
	$	1,056,819

The approximate interest rates on MHHEFA project revenue bonds bearing interest at variable rates were as follows at June 30:

	2011	2010
Series 2008A Bonds	0.20%	0.50%
Series 2008B Bonds	0.07	0.22
Series 2008C Bonds	0.09	0.26
Series 2008D Bonds	0.04	0.17
Series 2008E Bonds	0.08	0.29
Series 2007A Bonds	0.07	0.26
Series 2007B Bonds	0.07	0.28
Pooled Loan Program Series A and D, Chester River Issue	0.08	0.30

Chester River's MHHEFA Series D and Pooled Loan notes are secured by CRHS's buildings and equipment, as well as an irrevocable letter of credit, which expires in April 2012. Under the terms of the related loan and letter of credit agreements, Chester River is required to comply with certain restrictive covenants including maintenance of debt to equity and other financial tests.

In May 2006, CRHC entered into a Master Lease and Sublease Agreement (the CRHC Agreement) with MHHEFA and a financial institution to provide financing for CRHC to lease certain equipment essential or convenient for the operation of CRHC. The CRHC Agreement expires in May 2013. During the term of the CRHC Agreement, MHHEFA has legal title to the equipment, including any software license components. At the end of the CRHC Agreement, CRHC has the option to purchase the equipment for a notional amount of $1.

The Medical Center had term loans outstanding totaling $38,827,000 and $22,238,000 at June 30, 2011 and 2010, respectively. One loan ($11,600,000) is due in December 2011 and is charged interest at a rate of one-month LIBOR plus 0.29% (0.48% at June 30, 2011). The second loan ($26,750,000) is scheduled to be repaid commencing in January 2013 with 11 equal monthly installments, beginning February 2012, of $223,000 and a final installment for the remaining balance. This loan is charged interest monthly at one-month LIBOR plus 2.75% (2.9355% at June 30, 2011). The third loan ($477,000) was repaid in August 2011. Baltimore Washington had a term loan outstanding of $4,181,000 and $4,406,000 at June 30, 2011 and 2010, respectively, upon which interest is charged at a rate of one-month LIBOR plus 1.75% (2.19% at June 30, 2011).

(8) Interest Rate Risk Management

The Corporation uses a combination of fixed and variable rate debt to finance capital needs. The Corporation maintains an interest rate risk-management strategy that uses interest rate swaps to minimize significant, unanticipated earnings fluctuations that may arise from volatility in interest rates. At June 30, 2011 and 2010, the notional values of outstanding interest rate swaps were $609,669,000 and $609,869,000, respectively. The interest rate swap agreements provide the Corporation synthetically fixed interest rates ranging from 3.6% – 4.0% with termination dates in 2031 through 2041.

(Continued)

Certain swaps representing a total notional amount of $137,320,000 qualify as, and are designated as, cash flow hedges. Changes in the fair value of these designated swaps that effectively offset the variability of cash flows associated with the variable rate debt obligation initially are excluded from the excess of revenue over expenses and are reported as a change in the fair value of interest rate swap agreements included in the consolidated statement of changes in net assets. These amounts subsequently are reclassified into interest expense as a yield adjustment of the hedged debt obligation in the same period in which the related interest affects the excess of revenues over expenses. An unrealized gain (loss) on the designated swaps of $2,298,000 and $(7,410,000) is recorded in other changes in unrestricted net assets for the years ended June 30, 2011 and 2010, respectively. For the years ended June 30, 2011 and 2010, the Corporation recognized a net gain of $2,237,000 and $461,000, respectively, representing hedge ineffectiveness on the designated swaps, which is included in interest expense. The accumulated loss on changes in the fair value of designated swaps that is included in unrestricted net assets was $23,181,000 and $25,479,000 at June 30, 2011 and 2010.

Beginning in March 2008, previously designated cash flow hedging relationships were de-designated for accounting purposes. Accordingly, all changes in the fair value of the de-designated swaps since that date have been recognized in nonoperating gains (losses) in the accompanying consolidated statements of operations. The de-designated swaps represent a total notional amount of $380,000,000 as of June 30, 2011 and 2010. The Corporation recorded a net nonoperating gain (loss) on de-designated interest rate swaps of $18,640,000 and $(33,700,000) for the years ended June 30, 2011 and 2010, respectively.

The Corporation has a forward-starting swap agreement representing a total notional amount of $92,348,500 that takes effect on July 1, 2012. The forward-starting swap agreement provides the Corporation with a synthetically fixed interest rate of 3.6%.

The Corporation recognizes the fair value of interest rate swaps as a component of assets or liabilities, as appropriate. At June 30, 2011 and 2010, a liability representing the fair value of the Corporation’s interest rate swaps, including forward-starting swaps, amounts to $105,400,000 and $128,575,000, respectively.

The Corporation is subject to a collateral posting requirement with one of its swap counterparties. Collateral posting requirements are based on the Corporation’s long-term debt credit ratings, as well as the net liability position of total interest rate swap agreements outstanding with that counterparty. The amount of such posted collateral was $41,276,000 and $56,242,000 at June 30, 2011 and 2010, respectively, and is included as a component of other current assets on the Corporation’s consolidated balance sheets.

(9) Other Liabilities

Other liabilities consist of the following at June 30 (in thousands):

	2011	2010
Malpractice and other self-insurance liabilities	$ 51,104	53,228
Capital lease obligations	47,948	46,557
Accrued pension obligations	26,267	43,062
Accrued interest payable	14,580	14,793
Other	35,602	32,112
Total other liabilities	175,501	189,752
Less current portion	(87,643)	(83,958)
Other long-term liabilities	$ 87,858	105,794

(10) Retirement Plans

Employees of the Corporation are included in various retirement plans established by the Corporation, the Medical Center, Kernan, University Specialty, Maryland General, Baltimore Washington, Shore Health, Chester River, and the State of Maryland. Participation by employees in their specific plan(s) has evolved based upon the organization by which they were first employed and the elections that they made at the times when their original employers became part of the Corporation, if applicable. Following is a brief description of each of the retirement plans in which employees of the Corporation participate.

(a) Defined Benefit Plans

State of Maryland Retirement Plans – Defined benefit pension plans sponsored by the State of Maryland in which certain Medical Center and Kernan Hospital employees participate. As required by an agreement with the State of Maryland at the time the Medical Center became an independent not-for-profit organization, the Corporation makes annual contributions to these plans related to certain employees who participate in these plans. The total required contributions and annual installments were determined through actuarial analysis in 1984 and are being funded over a period of 32 years, the expected remaining service lives of the employees at that time. These contributions are for the purpose of funding the net periodic pension costs for all remaining employees participating in these plans. These contributions were fixed via agreement and the Corporation does not have any obligation to fund nor does it have the ability to reduce contributions if net periodic pension costs or the minimum funding requirements as defined by the Employee Retirement Income Security Act of 1974 (ERISA) differ from the fixed contribution. The Corporation expenses costs of this plan as related services are rendered by employees. At June 30, 2011 and 2010, the present value of the Corporation's remaining unfunded amounts under this agreement was $5,151,000 and $6,082,000, respectively. Information as to the funded status of these plans and their relationship to the accumulated benefit obligations as they relate specifically to the Corporation's employees is not available.

(Continued)

Maryland General Retirement Plan for Non – Union Employees – A noncontributory defined benefit plan covering substantially all nonunion employees. The benefits are based on years of service and compensation. Contributions to this plan are made to satisfy the minimum funding requirements of ERISA. In 2006, Maryland General froze the defined benefit pension plan.

Baltimore Washington Medical Center Pension Plan – A noncontributory defined benefit pension plan covering full-time employees who have been employed for at least one year and have reached 21 years of age.

Baltimore Washington Medical Center Supplemental Executive Retirement Plan – A noncontributory defined benefit pension plan for senior management level employees.

Chester River Health System, Inc. Pension Plan and Trust – A noncontributory defined benefit pension plan covering substantially all CRHC employees as well as employees of a subsidiary. The benefits are paid to retirees based upon age at retirement, years of service and average compensation. Chester River's funding policy is to satisfy the minimum funding requirements of ERISA. Effective June 30, 2008, Chester River froze the defined benefit pension plan.

The Corporation recognizes the funded status (i.e., difference between the fair value of plan assets and projected benefit obligations) of its defined benefit pension plans as an asset or liability in its consolidated balance sheet. The Corporation recognizes changes in the funded status in the year in which the changes occur as changes in unrestricted net assets. All defined benefit pension plans use a June 30 measurement date.

The following table sets forth the combined benefit obligations and assets of the defined benefit plans (excluding the State of Maryland Retirement Plan) at June 30 (in thousands):

		2011	2010
Change in projected benefit obligations:			
Benefit obligations at beginning of year	$	125,518	110,855
Plan amendment		—	—
Settlements		(1,373)	—
Service cost		2,649	2,176
Interest cost		6,213	6,433
Actuarial loss		(2,851)	10,351
Benefit payments		(4,821)	(4,297)
Projected benefit obligations at end of year	$	125,335	125,518
Change in plan assets:			
Fair value of plan assets at beginning of year	$	82,456	70,337
Actual return on plan assets		14,169	8,580
Settlements		(1,373)	—
Employer contributions		8,637	7,836
Benefit payments		(4,821)	(4,297)
Fair value of plan assets at end of year	$	99,068	82,456
Accumulated benefit obligation at end of year	$	120,226	120,027

The funded status of the plans and amounts recognized as other long-term liabilities in the consolidated balance sheets at June 30 are as follows (in thousands):

		2011	2010
Funded status, end of period:			
Fair value of plan assets	$	99,068	82,456
Projected benefit obligations		125,335	125,518
	$	(26,267)	(43,062)
Amounts recognized in unrestricted net assets at June 30:			
Net actuarial loss	$	(45,595)	(61,832)
Prior service cost		(534)	(619)
	$	(46,129)	(62,451)

(Continued)

The estimated amounts that will be amortized from unrestricted net assets into net periodic pension cost in fiscal 2012 are as follows:

Net actuarial loss	$	(3,490)
Prior service cost		(87)
	$	(3,577)

The components of net periodic pension cost for the years ended June 30 are as follows (in thousands):

		2011	2010
Service cost	$	2,649	2,176
Interest cost		6,213	6,433
Expected return on plan assets		(6,661)	(6,242)
Prior service cost recognized		85	85
Recognized gains or losses		5,878	3,158
Net periodic pension cost	$	8,164	5,610

The following table presents the weighted average assumptions used to determine benefit obligations for the plans at June 30:

	2011	2010
Discount rate	5.25%	5.00%
Rate of compensation increase (for nonfrozen plan)	5.00	5.00

The following table presents the weighted average assumptions used to determine net periodic benefit cost for the plans for the years ended June 30:

	2011	2010
Discount rate	5.00%	6.00%
Expected long-term return on plan assets	7.75	7.75% – 8.00%
Rate of compensation increase (for nonfrozen plan)	5.00	5.00%

The investment policies of the Corporation's pension plans incorporate asset allocation and investment strategies designed to earn superior returns on plan assets consistent with reasonable and prudent levels of risk. Investments are diversified across classes, sectors, and manager style to minimize the risk of loss. The Corporation uses investment managers specializing in each asset category, and regularly monitors performance and compliance with investment guidelines. In developing the expected long-term rate of return on assets assumption, the Corporation considered the current level of expected returns on risk-free investments, the historical level of the risk premium

(Continued)

associated with the other asset classes in which the portfolio is invested, and the expectations for future returns of each asset class. The expected return for each asset class was then weighted based on the target allocation to develop the expected long-term rate of return on assets assumption for the portfolio.

The Corporation's pension plans' target allocation and weighted average asset allocations at the measurement date of June 30, 2011 and 2010, by asset category, are as follows:

Asset category	Target allocation	Percentage of plan assets as of June 30	
		2011	2010
Cash and cash equivalents	0 – 10%	7%	22%
Fixed income securities	25 – 45%	27	14
Equity securities	30 – 50%	39	46
Global asset allocation	10 – 20%	17	—
Hedge funds	5 – 15%	10	18
		100%	100%

Equity and fixed income securities include investments in hedge fund of funds that are categorized in accordance with each fund's respective investment holdings. At both June 30, 2011 and 2010, the Corporation was in the process of implementing changes to its investment classification, which required the liquidation of certain assets, resulting in more cash on hand than targeted. This cash was used to purchase additional securities in subsequent periods in order to restore compliance with the target allocation.

The table below presents the Corporation's combined investable assets of the defined benefit pension plans, excluding the State of Maryland Retirement Plan, as of June 30, 2011 aggregated by the three level valuation hierarchy as described in note 19:

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 7,138	—	—	7,138
Fixed income mutual funds	22,536	—	—	22,536
Common and preferred stocks	6,549	—	—	6,549
Equity mutual funds	26,501	—	—	26,501
Other mutual funds	9,858	—	—	9,858
Alternative investments	—	16,594	9,892	26,486
	$ 72,582	16,594	9,892	99,068

(Continued)

The table below presents the Corporation's combined investable assets of the defined benefit pension plans, excluding the State of Maryland Retirement Plan, as of June 30, 2010, aggregated by the three level valuation hierarchy as described in note 19:

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 23,700	—	—	23,700
Fixed income mutual funds	4,477	—	—	4,477
Common and preferred stocks	33,253	—	—	33,253
Equity mutual funds	5,548	—	1,138	6,686
Other mutual funds	—	—	—	—
Alternative investments	—	—	14,340	14,340
	$ 66,978	—	15,478	82,456

Changes to Level 1 and Level 2 inputs between June 30, 2010 and June 30, 2011 were the result of strategic investments and reinvestments, interest income earnings, and changes in the fair value of investments.

Changes to the fair values based on the Level 3 inputs are summarized as follows:

	Equity mutual funds	Hedge funds	Total
Balance as of June 30, 2010	$ 1,138	14,340	15,478
Additions/purchases	—	8,160	8,160
Withdrawals/sales	(1,372)	(11,691)	(13,063)
Net change in value	234	(917)	(683)
Balance as of June 30, 2011	$ —	9,892	9,892

The following summarizes the redemption terms for the hedge fund-of-funds vehicles alternative investments held as of June 30, 2011:

	Fund 1	Fund 2
Redemption timing:		
Redemption frequency	Monthly	Quarterly
Required notice	20 days	70 days
Audit reserve:		
Percentage held back for audit reserve	—	—
Gates:		
Potential gate holdback	None	None
Potential gate release timeframe	N/A	N/A

(Continued)

The Corporation expects to contribute $10,303,000 to its defined benefit pension plans for the fiscal year ending June 30, 2012.

The following benefit payments, which reflect expected future employee service, as appropriate, are expected to be paid from plan assets in the following years ending June 30 (in thousands):

2012	$	3,962
2013		5,401
2014		5,994
2015		6,357
2016		6,641
2017 – 2019		47,698

The expected benefits to be paid are based on the same assumptions used to measure the Corporation's benefit obligation at June 30, 2011.

(b) Defined Contribution Plans

Corporation Pension Plan – A noncontributory defined contribution plan for all eligible Corporation employees not participating in the State of Maryland Retirement Plans, the Kernan Plan, the University Specialty Retirement Plan or the Maryland General Plan described below. Contributions to this plan by the Corporation are determined as a fixed percentage of total employees' base compensation.

Corporation Salary Reduction 403(b) Plan – A contributory benefit plan covering substantially all employees not participating in the State of Maryland Retirement Plans, the Kernan Plan, the University Specialty Retirement Plan or the Maryland General Plan described below. Employees are immediately eligible for elective deferrals of compensation as contributions to the plan.

Kernan Tax Sheltered Annuity Plan – A contributory benefit plan administered by an insurance company for Kernan employees hired prior to a certain date in 1996. Employee contributions to this plan are eligible for a matching contribution by Kernan after participating employees have completed two years of credited service.

University Specialty Retirement Plan – A defined contribution plan for substantially all full-time employees of University Specialty. Employer contributions are made at the discretion of University Specialty's board of directors. Employees may also make optional contributions within limits specified by the plan agreement.

Maryland General Hospital, Inc. 401(k) Profit Sharing Plan for Union Employees – Defined contribution plan for substantially all union employees of Maryland General. Employer contributions to this plan are determined based on years of service and hours worked. Employees are immediately eligible for elective deferrals of compensation as contributions to the plan.

(Continued)

Baltimore Washington Retirement Plans – Defined contribution plans covering all employees of Baltimore Washington Medical Center, and certain related entities. Employees are eligible for matching contributions after two years of service as defined in the plans.

Shore Health System Retirement Plan – A contributory benefit plan covering substantially all employees of Shore Health. Employees are eligible for matching contributions after one year of service.

Chester River Retirement Plan – A contributory benefit plan covering substantially all employees of Chester River who have met the eligibility requirements.

Total annual retirement costs incurred by the Corporation for the previously discussed defined contribution plans and the State of Maryland Retirement Plans were $22,794,000 and $22,051,000 for the years ended June 30, 2011 and 2010, respectively. Such amounts are included in salaries, wages and benefits in the accompanying consolidated statements of operations.

(11) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are restricted primarily for the following purposes at June 30 (in thousands):

	2011	2010
Facility construction and renovations, research, education, and other	$ 33,854	17,745
Economic and beneficial interests in the net assets of related organizations	41,802	38,439
	$ 75,656	56,184

Net assets were released from donor restrictions during the years ended June 30, 2011 and 2010 by expending funds satisfying the restricted purposes or by occurrence of other events specified by donors as follows (in thousands):

	2011	2010
Purchases of equipment and construction costs	$ 23,964	32,612
Research, education, uncompensated care, and other	3,639	5,890
	$ 27,603	38,502

Included in net assets released from donor restrictions during the year ended June 30, 2011 for research, professional education, faculty support, uncompensated care and other is $3,416,000 related to nonoperating activities of the Foundation.

Permanently restricted net assets consist primarily of gifts to be held in perpetuity, the income from which may be used to fund the operations of the Corporation.

The Corporation's endowments consist of donor-restricted funds established for a variety of purposes. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

(a) Interpretation of Relevant Law

The Corporation has interpreted the Maryland Uniform Prudent Management of Institutional Funds Act (MUPMIFA) as requiring the preservation of the fair value 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 Corporation classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. 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 organization in a manner consistent with the standard of prudence prescribed by MUPMIFA. In accordance with MUPMIFA, the Corporation considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

(1) The duration and preservation of the fund

(2) The purposes of the Corporation and the donor-restricted endowment fund

(3) General economic conditions

(4) The possible effect of inflation and deflation

(5) The expected total return from income and the appreciation of investments

(6) Other resources of the Corporation

(7) The investment policies of the Corporation.

Endowment net assets are as follows (in thousands):

	June 30, 2011			
	Unrestricted	**Temporarily restricted**	**Permanently restricted**	**Total**
Donor-restricted endowment funds	$ —	7,596	32,543	40,139

(Continued)

	June 30, 2010			
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds	$ —	4,930	31,247	36,177

(b) Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or MUPMIFA requires the Corporation to retain as a fund of perpetual duration. The Corporation does not have any donor-restricted endowment funds that are below the level that the donor or MUPMIFA requires.

(c) Investment Strategies

The Corporation has adopted policies for corporate investments, including endowment assets that seek to maximize risk-adjusted returns with preservation of principal. Endowment assets include those assets of donor-restricted funds that the Corporation must hold in perpetuity or for a donor-specified period(s).The endowment assets are invested in a manner that is intended to hold a mix of investment assets designed to meet the objectives of the account. The Corporation expects its endowment funds, over time, to provide an average rate of return that generates earnings to achieve the endowment purpose.

To satisfy its long-term rate-of-return objectives, the Corporation relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Corporation employs a diversified asset allocation structure to achieve its long-term return objectives within prudent risk constraints.

The Corporation monitors the endowment funds returns and appropriates average returns for use. In establishing this practice, the Corporation considered the long-term expected return on its endowment. This is consistent with the Corporation's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term as well as to provide additional real growth through new gifts and investment return.

(12) Economic and Beneficial Interests in the Net Assets of Related Organizations

The Corporation is supported by several related organizations that were formed to raise funds on behalf of the Corporation and certain of its subsidiaries. These interests are accounted for as either economic or beneficial interests in the net assets of such organizations.

The following is a summary of economic and beneficial interests in the net assets of financially interrelated organizations as of June 30 (in thousands):

	2011	2010
Economic interests in:		
The James Lawrence Kernan Hospital Endowment Fund, Incorporated	$ 33,354	27,522
Baltimore Washington Medical Center Foundation, Inc.	5,896	5,895
Maryland General Community Health Foundation, Inc.	—	2,672
Total economic interests	39,250	36,089
Beneficial interest in the net assets of Dorchester General Hospital Foundation, Inc.	2,552	2,350
	$ 41,802	38,439

At the discretion of its board of trustees, the Kernan Endowment Fund may pledge securities to satisfy various collateral requirements on behalf of Kernan and may provide funding to Kernan to support various clinical programs or capital needs.

BWMC Foundation was formed in July 2000 and supports the activities of Baltimore Washington Medical Center by soliciting charitable contributions on its behalf.

The Maryland General Foundation contributed the remainder of its assets, approximately $2,590,000 and $18,000,000 of funds during the years ended June 30, 2011 and 2010, respectively, to support future Emergency Department capital projects at Maryland General, which is included in contributions and change in economic and beneficial interest in net assets of related organizations in the accompanying consolidated statement of changes in net assets. The contribution made during the year ended June 30, 2011 constituted all of Maryland General Foundation's remaining assets.

Shore Health maintains a beneficial interest in the net assets of Dorchester Foundation, a nonprofit corporation organized to raise funds on behalf of Dorchester Hospital. Shore Health does not have control over the policies or decisions of the Dorchester Foundation.

A summary of the combined unaudited condensed financial information of the financially interrelated organizations in which the Corporation holds an economic or beneficial interest as of June 30 is as follows (in thousands):

		2011	2010
Current assets	$	3,753	3,017
Noncurrent assets		39,061	37,047
Total assets	$	42,814	40,064
Current liabilities	$	374	419
Noncurrent liabilities		638	1,206
Net assets		41,802	38,439
Total liabilities and net assets	$	42,814	40,064
Total operating revenue	$	7,125	286
Total operating expense		(3,066)	(220)
Other changes in net assets		(696)	(14,967)
Total increase (decrease) in net assets	$	3,363	(14,901)

(13) State Support

The Corporation received $3,200,000 in support for the Shock Trauma Center operations from the State of Maryland in each of the years ended June 30, 2011 and 2010.

The State of Maryland appropriates funds for specific construction costs incurred and equipment purchases made. The Corporation recognizes this support as the funds are expended for the intended projects. The Corporation expended and recorded $20,815,000 and $7,215,000 during the years ended June 30, 2011 and 2010, respectively.

For the year ended June 30, 2011 and 2010, the Corporation received $750,000 of capital support from the State of Maryland for Kernan.

(14) Functional Expenses

The Corporation provides general healthcare services to residents within its geographic location. Expenses related to providing these services, based on management's estimates of expense allocations, are as follows for the years ended June 30 (in thousands):

		2011	2010
Healthcare services	$	1,915,587	1,839,257
General and administrative		328,336	297,266
	$	2,243,923	2,136,523

(Continued)

(15) Insurance

The Corporation and its affiliates are self-insured for professional and general liability claims up to the limits of $1.0 million on individual claims and $3.0 million in the aggregate on an annual basis. For amounts in excess of these limits, the risk of loss has been transferred to the Terrapin Insurance Company (Terrapin), an unconsolidated joint venture. Terrapin provides insurance for claims in excess of $1 million individually and $3 million in the aggregate up to $75 million individually and $75 million in the aggregate under claims made policies between the Corporation and Terrapin. For claims in excess of Terrapin's coverage limits, if any, the Corporation retains the risk of loss.

As discussed in note 4, Terrapin is a joint venture corporation in which a 50% equity interest is owned by the Corporation and a 50% equity interest is owned by University Physicians, Inc.

Based upon estimates made by independent actuaries, the Corporation provides for and funds the present value of the costs for professional and general liability claims and insurance coverage related to the projected liability from asserted and unasserted incidents, which the Corporation believes may ultimately result in a loss, risk management expenses and the projected costs to adjudicate claims. These accrued malpractice losses are discounted using a discount rate of 2.5% and, in management's opinion, provide an adequate and appropriate loss reserve.

Claims asserted based upon occurrences prior to the inception of the current insurance programs and those prior to certain of the Corporation's component hospitals becoming participants in the insurance programs are covered by other insurance arrangements.

Total malpractice insurance expense for the Corporation during the years ended June 30, 2011 and 2010 was approximately $32,581,000 and $30,107,000, respectively.

The Corporation is involved in claims and litigation on malpractice matters, which arise in the normal course of business, none of which, in the opinion of management, is expected to result in losses in excess of insurance limits or have a materially adverse effect on the Corporation's financial position.

The Corporation, and substantially all of its subsidiaries, are self-insured for workers' compensation and employee health claims.

(16) Business and Credit Concentrations

The Corporation provides healthcare services through its inpatient and outpatient care facilities located in the State of Maryland. The Corporation generally does not require collateral or other security in extending credit; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits receivable under their health insurance programs, plans or policies (e.g., Medicare, Medicaid, Blue Cross, workers' compensation, health maintenance organizations (HMOs) and commercial insurance policies).

The Corporation had gross receivables from patients and third-party payors as follows at June 30:

	2011	2010
Medicare	20%	20%
Medicaid	33	37
Commercial insurance and HMOs	16	16
Blue Cross	12	12
Self-pay and others	19	15
	100%	100%

The Corporation recorded gross revenues from patients and third-party payors for the years ended June 30 as follows:

	2011	2010
Medicare	33%	34%
Medicaid	26	24
Commercial insurance and HMOs	16	17
Blue Cross	14	15
Self-pay and others	11	10
	100%	100%

(17) Certain Significant Risks and Uncertainties

The Corporation provides general acute healthcare services in the State of Maryland. The Corporation and other healthcare providers in Maryland 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 and related claims.

Such inherent risks require the use of certain management estimates in the preparation of the Corporation'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 Corporation's revenues, and the Corporation'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 Corporation.

Changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Corporation.

The healthcare industry is subject to numerous laws and regulations from federal, state and local governments. The Corporation's compliance with these laws and regulations can be subject to periodic governmental review and interpretation, which can result in regulatory action unknown or unasserted at this time. Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the ordinary course of business, none of which, in the opinion of management, are expected to result in losses in excess of insurance limits or have a materially adverse effect on the Corporation's financial position.

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). Recent federal initiatives have prompted a national review of federally funded healthcare programs. In addition, the federal government and many states have implemented programs to audit and recover potential overpayments to providers from the Medicare and Medicaid programs. The Corporation has implemented a 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 U.S. 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 does not affect the consolidated financial statements for the year ended June 30, 2011.

(18) Maryland Health Services Cost Review Commission (HSCRC)

Patient service revenue for hospital services is regulated by the HSCRC and recorded at rates established by the HSCRC. The Medical Center, Kernan, Maryland General, and Baltimore Washington have Charge Per Case (CPC) agreements with the HSCRC. The CPC agreements establish a prospectively approved average charge per inpatient case (inpatient cases are defined as hospital admissions plus births) and an estimated case mix index. These approved CPC targets are adjusted during the rate year for actual changes in case mix. The CPC agreements allow the hospital to adjust approved unit rates, within certain limits, to achieve the average charge per case targets for each rate year ending June 30. In 2011, the HSCRC implemented a charge per visit (CPV) methodology for hospital based outpatient services, which is similar in nature to the CPC inpatient methodology discussed above. The CPV methodology establishes prospectively approved average charges per outpatient visit for the majority of outpatient services provided. The remaining outpatient services are charged using the established HSCRC unit rates.

Shore Health and Chester River have Total Patient Revenue (TPR) agreements with the HSCRC. The TPR agreements establish an approved aggregate inpatient and outpatient revenue for regulated services to provide care for the patient population in the geographic region without regard for patient acuity or volumes.

The HSCRC utilizes a bad debt pool into which each of the regulated hospitals in Maryland participates. The funds in the bad debt pool are distributed to the hospitals that exceed the state average based upon the amount of uncompensated care delivered to patients during the year. For the years ended June 30, 2011 and 2010, the Corporation recognized a net distribution from the pool of $47,558,000 and $47,642,000, respectively, which is recorded as net patient service revenue.

(19) Fair Value of Financial Instruments

The Corporation has implemented the provisions of recent accounting guidance on fair value measurements of financial assets and financial liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis. This guidance established a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted market prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted market prices (unadjusted) in active markets for identical assets or liabilities that the Corporation has the ability to access at the measurement date.
- Level 2 inputs are inputs other than quoted market prices including within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.
- Level 3 inputs are unobservable inputs for the asset or liability.

Assets and liabilities classified as Level 1 are valued using unadjusted quoted market prices for identical assets or liabilities in active markets. The Corporation uses techniques consistent with the market approach and the income approach for measuring fair value of its Level 2 and Level 3 assets and liabilities. The market approach is a valuation technique that uses prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities. The income approach generally converts future amounts (cash flows or earnings) to a single present value amount (discounted).

The level in the fair value hierarchy within which a fair measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

As of June 30, 2011 and 2010, the Level 2 assets and liabilities listed in the fair value hierarchy tables below utilize the following valuation techniques and inputs:

(a) U.S. Government and Agency Securities

The fair value of investments in U.S. government, state, and municipal obligations is primarily determined using techniques consistent with the income approach. Significant observable inputs to the income approach include data points for benchmark constant maturity curves and spreads.

(b) Corporate Bonds

The fair value of investments in U.S. and international corporate bonds, including commingled funds that invest primarily in such bonds, and foreign government bonds is primarily determined using techniques that are consistent with the market approach. Significant observable inputs include benchmark yields, reported trades, observable broker/dealer quotes, issuer spreads, and security specific characteristics, such as early redemption options.

(c) Collateralized Corporate Obligations

The fair value of collateralized corporate obligations is primarily determined using techniques consistent with the income approach, such as a discounted cash flow model. Significant observable inputs include prepayment speeds and spreads, benchmark yield curves, volatility measures, and quotes.

(d) Derivative Liabilities

The fair value of derivative contracts is primarily determined using techniques consistent with the market approach. Derivative contracts include interest rate, credit default, and total return swaps. Significant observable inputs to valuation models include interest rates, Treasury yields, volatilities, credit spreads, maturity and recovery rates.

The following table presents assets and liabilities that are measured at fair value on a recurring basis at June 30, 2011 (in thousands):

	Level 1	Level 2	Level 3	Total
Assets:				
Investments:				
Cash and cash equivalents	$ 37,789	—	—	37,789
Corporate bonds	10,604	17,943	—	28,547
Collateralized corporate obligations	—	16,403	—	16,403
U.S. government and agency securities	10,568	17,853	—	28,421
Common and preferred stocks, including mutual funds	147,483	484	—	147,967
	206,444	52,683	—	259,127
Assets limited as to use:				
Cash and cash equivalents	88,869	36,093	—	124,962
Corporate bonds	7,162	4,094	—	11,256
Collateralized corporate obligations	—	3,601	—	3,601
U.S. government and agency securities	2,668	119,521	—	122,189
Common and preferred stocks, including mutual funds	77,209	1,142	—	78,351
Investments held by other organizations	—	96,426	—	96,426
	175,908	260,877	—	436,785
	$ 382,352	313,560	—	695,912
Liabilities:				
Interest rate swap liabilities	$ —	105,400	—	105,400

(Continued)

The following table presents assets and liabilities that are measured at fair value on a recurring basis at June 30, 2010 (in thousands):

	Level 1	Level 2	Level 3	Total
Assets:				
Investments:				
Cash and cash equivalents	$ 7,705	—	—	7,705
Corporate bonds	16,260	24,158	—	40,418
Collateralized corporate obligations	—	16,130	—	16,130
U.S. government and agency securities	13,924	12,951	—	26,875
Common and preferred stocks, including mutual funds	97,569	—	—	97,569
	135,458	53,239	—	188,697
Assets limited as to use:				
Cash and cash equivalents	89,186	—	—	89,186
Corporate bonds	13,691	18,994	—	32,685
Collateralized corporate obligations	—	4,332	—	4,332
U.S. government and agency securities	91,510	85,052	—	176,562
Common and preferred stocks, including mutual funds	55,555	1,007	—	56,562
Investments held by other organizations	—	81,780	—	81,780
	249,942	191,165	—	441,107
	$ 385,400	244,404	—	629,804
Liabilities:				
Interest rate swap liabilities	$ —	128,575	—	128,575

Changes to Level 1 and Level 2 inputs between June 30, 2010 and June 30, 2011 were the result of strategic investments and reinvestments, interest income earnings, and changes in the fair value of investments.

(20) Related Party Agreements

The Corporation has certain agreements with various departments of the University of Maryland School of Medicine concerning the provision of professional and administrative services to the Corporation and its

(Continued)

patients. Total expense under these agreements in the years ended June 30, 2011 and 2010 was approximately $97,160,000 and $98,144,000, respectively.

(21) Subsequent Events

The corporation evaluated all events and transactions that occurred after June 30, 2011 and through October 27, 2011. Other than described below, the Corporation did not have any material recognizable subsequent events during the period.

Effective July 1, 2011, the Corporation entered into an affiliation agreement with Civista Health, Inc. and Subsidiaries (Civista), a healthcare system located in Southern Maryland, whereby the Corporation became the sole corporate member of Civista. The Civista Medical Center, the largest component of Civista, has been operated by the Corporation under a management agreement that began in 2009. In accordance with the affiliation agreement, the Corporation paid Civista $4 million on July 1, 2011 to fund the purchase of the land on which Civista Medical Center is located. The Corporation has also transferred $2.5 million to Civista to support operational and capital initiatives, and has committed an additional $10 million for similar investments over the next five years.

The transaction will be accounted for under the guidance of ASU 2010-07, and accordingly, the Corporation will consolidate Civista at its fair value as of July 1, 2011. Such amounts are currently being determined. The Corporation does not expect the fair value adjustment recorded during the year ended June 30, 2012 to have a material impact on the Corporation’s consolidated financial statements.

Summarized pro forma unaudited historical cost basis combined balance sheet and statement of operations information for the Corporation, its subsidiaries and Civista for the year ended June 30, 2011 is as follows (in thousands):

Operating revenues:		
UMMS	$	2,344,204
Civista		108,613
Combined	$	2,452,817
Operating expenses:		
UMMS	$	2,243,923
Civista		106,423
Combined	$	2,350,346
Net nonoperating revenues:		
UMMS	$	102,853
Civista		1,672
Combined	$	104,525
Change in total net assets:		
UMMS	$	268,654
Civista		6,256
Combined	$	274,910
Total net assets:		
UMMS	$	1,251,034
Civista		24,362
Combined	$	1,275,396

Schedule 1

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2011

(In thousands)

Assets	University of Maryland Medical Center	University CARE	Kernan	University Specialty	Maryland General	Baltimore Washington	Shore Health	Chester River	UMMS Foundation	Shipley's	36 South Paca	Eliminations	Consolidated Total
Current assets:													
Cash and cash equivalents	$ 140,420	157	14,416	2,947	14,664	25,382	14,466	4,356	—	144	565	—	217,517
Assets limited as to use, current portion	37,469	—	—		986	833	471	355	—	—	—	—	40,114
Accounts receivable:													
Patient accounts receivable, less allowance for doubtful accounts of $161,124	152,030	163	12,026	5,606	13,523	39,571	30,081	9,421	—	—	—	—	262,421
Other	36,716	132	951	323	677	1,234	3,469	22	(2,672)	3,469	85	(19,827)	24,579
Inventories	18,119	39	990	616	2,043	6,014	3,774	586	—	—	—	—	32,181
Prepaid expenses and other current assets	39,391	11	105	24	300	8,954	1,150	682	1,500	—	—	(246)	51,871
Total current assets	424,145	502	28,488	9,516	32,193	81,988	53,411	15,422	(1,172)	3,613	650	(20,073)	628,683
Investments	304,671	—	13,154	5,303	—	48,420	30,162	5,140	—	—	—	—	406,850
Assets limited as to use, less current portion:													
Debt service funds	41,770	—	—	—	—	—	—	—	—	—	—	—	41,770
Construction funds	146,001	—	1,997	—	9,867	19,874	3,086	—	—	—	—	—	180,825
Board designated and escrow funds	—	—	—	—	—	—	60,096	5,000	32,211	—	—	—	97,307
Self-insurance trust funds	39,485	—	—	—	25,326	16,495	11,916	1,524	—	—	—	—	94,746
Funds restricted by donor	—	—	—	—	3,545	—	22,231	1,704	21,536	—	—	—	49,016
Economic and beneficial interests in the net assets of related organizations	56,843	—	34,982	407	735	5,896	2,552	—	—	—	—	(59,613)	41,802
	284,099	—	36,979	407	39,473	42,265	99,881	8,228	53,747	—	—	(59,613)	505,466
Property and equipment, net	717,512	—	36,592	20,025	93,667	269,170	119,120	24,493	1,807	6,336	9,928	—	1,298,650
Deferred financing costs, net	7,547	—	—	—	—	—	—	—	—	—	—	—	7,547
Investments in joint ventures and other assets	201,466	—	—	—	15,720	7,895	1,193	2,501	5,315	—	3,277	(58,222)	179,145
Total assets	$ 1,939,440	502	115,213	35,251	181,053	449,738	303,767	55,784	59,697	9,949	13,855	(137,908)	3,026,341

(Continued)

Schedule 1

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2011

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center	University CARE	Kernan	University Specialty	Maryland General	Baltimore Washington	Shore Health	Chester River	UMMS Foundation	Shipley's	36 South Paca	Eliminations	Consolidated Total
Current liabilities:													
Trade accounts payable	$ 103,712	806	5,763	3,347	9,732	23,073	5,772	2,339	84	57	310	—	154,995
Accrued payroll and benefits	71,642	77	4,243	2,909	12,252	20,497	14,142	2,886	—	—	—	(228)	128,420
Advances from third-party payors	66,844	—	3,596	4,697	6,468	8,112	5,287	1,008	—	—	—	—	96,012
Lines of credit	54,600	—	—	—	—	—	—	—	—	—	—	—	54,600
Other current liabilities	79,192	148	1,600	11,653	4,670	2,297	3,971	1,616	—	—	2,207	(19,711)	87,643
Long-term debt subject to short-term remarketing arrangements	164,055	—	—	—	—	—	—	2,710	—	—	—	—	166,765
Current portion of long-term debt	15,051	—	270	300	1,036	4,619	1,883	1,216	—	—	—	(133)	24,242
Total current liabilities	555,096	1,031	15,472	22,906	34,158	58,598	31,055	11,775	84	57	2,517	(20,072)	712,677
Long-term debt, less current portion	517,591	—	12,319	6,956	41,524	202,112	85,845	3,025	—	—	—	—	869,372
Other long-term liabilities	32,272	—	441	186	24,594	15,370	6,980	8,015	—	—	—	—	87,858
Interest rate swap liabilities	105,400	—	—		—	—	—	—	—	—	—	—	105,400
Total liabilities	1,210,359	1,031	28,232	30,048	100,276	276,080	123,880	22,815	84	57	2,517	(20,072)	1,775,307
Net assets:													
Unrestricted	657,739	(529)	51,866	4,796	76,497	167,762	155,506	31,266	34,925	9,892	11,338	(58,223)	1,142,835
Temporarily restricted	70,929	—	35,115	407	4,280	5,896	12,197	323	6,122	—	—	(59,613)	75,656
Permanently restricted	413	—	—		—	—	12,184	1,380	18,566	—	—	—	32,543
Total net assets	729,081	(529)	86,981	5,203	80,777	173,658	179,887	32,969	59,613	9,892	11,338	(117,836)	1,251,034
Total liabilities and net assets	$ 1,939,440	502	115,213	35,251	181,053	449,738	303,767	55,784	59,697	9,949	13,855	(137,908)	3,026,341

See accompanying independent auditors' report.

Schedule 1-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Maryland General Health Systems (MGHS)

June 30, 2011

(In thousands)

Assets	Maryland General Health Systems, Inc.	Maryland General Hospital	Maryland General Clin. Prac. Group	Eliminations	MGHS Consolidated Total
Current assets:					
Cash and cash equivalents	$ 51	14,551	62	—	14,664
Assets limited as to use, current portion	—	986	—	—	986
Accounts receivable:					
Patient accounts receivable, less allowance for doubtful accounts of $12,908	—	12,804	719	—	13,523
Other	48	1,403	(774)	—	677
Inventories	—	2,043	—	—	2,043
Prepaid expenses and other current assets	—	300	—	—	300
Total current assets	99	32,087	7	—	32,193
Investments	—	—	—	—	—
Assets limited as to use, less current portion:					
Debt service funds	—	—	—	—	—
Construction funds	—	9,867	—	—	9,867
Board designated and escrow funds	—	—	—	—	—
Self-insurance trust funds	—	25,326	—	—	25,326
Funds restricted by donor	—	3,545	—	—	3,545
Economic interests in the net assets of related organizations	—	735	—	—	735
	—	39,473	—	—	39,473
Property and equipment, net	2,175	91,492	—	—	93,667
Deferred financing costs, net	—	—	—	—	—
Investments in joint ventures and other assets	15,571	149	—	—	15,720
Total assets	$ 17,845	163,201	7	—	181,053

(Continued)

Schedule 1-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Maryland General Health Systems (MGHS)

June 30, 2011

(In thousands)

Liabilities and Net Assets	Maryland General Health Systems, Inc.	Maryland General Hospital	Maryland General Clin. Prac. Group	Eliminations	MGHS Consolidated Total
Current liabilities:					
Trade accounts payable	$ 12	9,720	—	—	9,732
Accrued payroll and benefits	—	12,252	—	—	12,252
Advances from third-party payors	—	6,468	—	—	6,468
Lines of credit	—	—	—	—	—
Other current liabilities	—	4,670	—	—	4,670
Current portion of long-term debt	152	884	—	—	1,036
Total current liabilities	164	33,994	—	—	34,158
Long-term debt, less current portion	1,304	40,220	—	—	41,524
Other long-term liabilities	1	24,593	—	—	24,594
Total liabilities	1,469	98,807	—	—	100,276
Net assets:					
Unrestricted	16,376	60,114	7	—	76,497
Temporarily restricted	—	4,280	—	—	4,280
Permanently restricted	—	—	—	—	—
Total net assets	16,376	64,394	7	—	80,777
Total liabilities and net assets	$ 17,845	163,201	7	—	181,053

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Baltimore Washington Medical System (BWMS)

June 30, 2011

(In thousands)

Assets	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Eliminations	BWMS Consolidated Total
Current assets:							
Cash and cash equivalents	$ —	24,561	710	111	—	—	25,382
Assets limited as to use, current portion	—	833	—	—	—	—	833
Accounts receivable:							
Patient accounts receivable, less allowance for doubtful accounts of $15,415	—	35,324	2,001	2,246	—	—	39,571
Other	30,476	1,234	3,939	—	(1,789)	(32,626)	1,234
Inventories	—	6,014	—	—	—	—	6,014
Prepaid expenses and other current assets	—	8,759	—	115	80	—	8,954
Total current assets	30,476	76,725	6,650	2,472	(1,709)	(32,626)	81,988
Investments	—	48,420	—	—	—	—	48,420
Assets limited as to use, less current portion:							
Debt service funds	—	—	—	—	—	—	—
Construction funds	—	19,874	—	—	—	—	19,874
Board designated and escrow funds	—	—	—	—	—	—	—
Self-insurance trust funds	—	16,495	—	—	—	—	16,495
Funds restricted by donor	—	—	—	—	—	—	—
Economic interests in the net assets of related organizations	—	5,896	—	—	—	—	5,896
	—	42,265	—	—	—	—	42,265
Property and equipment, net	—	243,873	—	11,270	14,027	—	269,170
Deferred financing costs, net	—	—	—	—	—	—	—
Investments in joint ventures and other assets	144,541	630	—	2,296	—	(139,572)	7,895
Total assets	$ 175,017	411,913	6,650	16,038	12,318	(172,198)	449,738

(Continued)

Schedule 1-b

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Baltimore Washington Medical System (BWMS)

June 30, 2011

(In thousands)

Liabilities and Net Assets	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Eliminations	BWMS Consolidated Total
Current liabilities:							
Trade accounts payable	$ 2	20,766	1,134	1,050	90	31	23,073
Accrued payroll and benefits	1,357	17,924	136	1,049	31	—	20,497
Advances from third-party payors	—	8,112	—	—	—	—	8,112
Lines of credit	—	—	—	—	—	—	—
Other current liabilities	—	24,434	—	10,520	—	(32,657)	2,297
Current portion of long-term debt	—	4,120	—	274	225	—	4,619
Total current liabilities	1,359	75,356	1,270	12,893	346	(32,626)	58,598
Long-term debt, less current portion	—	187,521	—	10,635	3,956	—	202,112
Other long-term liabilities	—	14,987	—	383	—	—	15,370
Total liabilities	1,359	277,864	1,270	23,911	4,302	(32,626)	276,080
Net assets:							
Unrestricted	173,658	128,153	5,380	(7,873)	8,016	(139,572)	167,762
Temporarily restricted	—	5,896	—	—	—	—	5,896
Permanently restricted	—	—	—	—	—	—	—
Total net assets	173,658	134,049	5,380	(7,873)	8,016	(139,572)	173,658
Total liabilities and net assets	$ 175,017	411,913	6,650	16,038	12,318	(172,198)	449,738

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Shore Health System (SHS)

June 30, 2011

(In thousands)

Assets	Shore Health System, Inc.	Memorial Hospital Foundation, Inc. and Subsidiary	Care Health Services, Inc.	Shore Health Enterprises, Inc. and Subsidiary	Shore Clinical Foundation, Inc.	Chesapeake Ear, Nose, Throat, Sinus, and Hearing Center, LLC	Chesapeake Neurological Surgery, LLC	Eliminations	SHS Consolidated Total
Current assets:									
Cash and cash equivalents	$ 13,585	—	289	36	556	—	—	—	14,466
Assets limited as to use, current portion	471	—	—	—	—	—	—	—	471
Accounts receivable:									
Patient accounts receivable, less allowance for doubtful accounts of $9,403	26,390	—	876	—	2,815	—	—	—	30,081
Other	4,276	201	2,882	—	529	—	—	(4,419)	3,469
Inventories	3,774	—	—	—	—	—	—	—	3,774
Prepaid expenses and other current assets	941	27	13	—	169	—	—	—	1,150
Total current assets	49,437	228	4,060	36	4,069	—	—	(4,419)	53,411
Investments	30,162	—	—	—	—	—	—	—	30,162
Assets limited as to use, less current portion:									
Debt service funds	—	—	—	—	—	—	—	—	—
Construction funds	3,086	—	—	—	—	—	—	—	3,086
Board designated and escrow funds	25,000	35,096	—	—	—	—	—	—	60,096
Self-insurance trust funds	11,916	—	—	—	—	—	—	—	11,916
Funds restricted by donor	3,852	18,379	—	—	—	—	—	—	22,231
Economic and beneficial interests in the net assets of related organizations	59,272	—	—	—	—	—	—	(56,720)	2,552
	103,126	53,475	—	—	—	—	—	(56,720)	99,881
Property and equipment, net	112,836	3,778	438	714	1,354	—	—	—	119,120
Deferred financing costs, net	—	—	—	—	—	—	—	—	—
Investments in joint ventures and other assets	8,799	24	—	—	—	—	—	(7,630)	1,193
Total assets	$ 304,360	57,505	4,498	750	5,423	—	—	(68,769)	303,767

(Continued)

Schedule 1-c

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Shore Health System (SHS)

June 30, 2011

(In thousands)

Liabilities and Net Assets	Shore Health System, Inc.	Memorial Hospital Foundation, Inc. and Subsidiary	Care Health Services, Inc.	Shore Health Enterprises, Inc. and Subsidiary	Shore Clinical Foundation, Inc.	Chesapeake Ear, Nose, Throat, Sinus, and Hearing Center, LLC	Chesapeake Neurological Surgery, LLC	Eliminations	SHS Consolidated Total
Current liabilities:									
Trade accounts payable	$ 5,406	4	105	—	257	—	—	—	5,772
Accrued payroll and benefits	13,019	11	237	—	875	—	—	—	14,142
Advances from third-party payors	5,287	—	—	—	—	—	—	—	5,287
Lines of credit	—	—	—	—	—	—	—	—	—
Other current liabilities	6,197	741	2	1,450	—	—	—	(4,419)	3,971
Current portion of long-term debt	1,883	—	—	—	—	—	—	—	1,883
Total current liabilities	31,792	756	344	1,450	1,132	—	—	(4,419)	31,055
Long-term debt, less current portion	85,845	—	—	—	—	—	—	—	85,845
Other long-term liabilities	6,837	29	—	—	114	—	—	—	6,980
Total liabilities	124,474	785	344	1,450	1,246	—	—	(4,419)	123,880
Net assets:									
Unrestricted	155,505	38,782	4,154	(700)	4,177	—	—	(46,412)	155,506
Temporarily restricted	12,197	8,674	—	—	—	—	—	(8,674)	12,197
Permanently restricted	12,184	9,264	—	—	—	—	—	(9,264)	12,184
Total net assets	179,886	56,720	4,154	(700)	4,177	—	—	(64,350)	179,887
Total liabilities and net assets	$ 304,360	57,505	4,498	750	5,423	—	—	(68,769)	303,767

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Chester River Health System, Inc. (CRHS)

June 30, 2011

(In thousands)

Assets	Chester River Hospital Center	Chester River Manor	Chester River Home Care and Hospice	Chester River Health Foundation	Eliminations	CRHS Consolidated Total
Current assets:						
Cash and cash equivalents	$ 2,050	748	376	1,182	—	4,356
Assets limited as to use, current portion	355	—	—	—	—	355
Accounts receivable:						
Patient accounts receivable, less allowance for doubtful accounts of $6,598	8,570	581	270	—	—	9,421
Other	196	16	5	—	(195)	22
Inventories	582	4	—	—	—	586
Prepaid expenses and other current assets	624	58	—	—	—	682
Total current assets	12,377	1,407	651	1,182	(195)	15,422
Investments	3,664	—	1,246	230	—	5,140
Assets limited as to use, less current portion:						
Debt service funds	—	—		—	—	—
Construction funds	—	—		—	—	—
Board designated and escrow funds	5,000	—		—	—	5,000
Self-insurance trust funds	1,524	—		—	—	1,524
Funds restricted by donor	22	—	73	1,609	—	1,704
Economic interests in the net assets of related organizations	4,962	16	417	—	(5,395)	—
	11,508	16	490	1,609	(5,395)	8,228
Property and equipment, net	22,007	2,155	331	—	—	24,493
Deferred financing costs, net	—	—	—	—	—	—
Investments in joint ventures and other assets	—	—	—	2,501	—	2,501
Total assets	$ 49,556	3,578	2,718	5,522	(5,590)	55,784

(Continued)

Schedule 1-d

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Chester River Health System, Inc. (CRHS)

June 30, 2011

(In thousands)

Liabilities and Net Assets	Chester River Hospital Center	Chester River Manor	Chester River Home Care and Hospice	Chester River Health Foundation	Eliminations	CRHS Consolidated Total
Current liabilities:						
Trade accounts payable	$ 1,930	382	24	3	—	2,339
Accrued payroll and benefits	2,526	219	141	—	—	2,886
Advances from third-party payors	1,004	4	—	—	—	1,008
Lines of credit	—	—	—	—	—	—
Other current liabilities	1,595	122	78	16	(195)	1,616
Long-term debt subject to short-term remarketing arrangements	2,710	—	—	—	—	2,710
Current portion of long-term debt	1,186	30	—	—	—	1,216
Total current liabilities	10,951	757	243	19	(195)	11,775
Long-term debt, less current portion	2,700	325	—	—	—	3,025
Other long-term liabilities	7,912	60	—	43	—	8,015
Total liabilities	21,563	1,142	243	62	(195)	22,815
Net assets:						
Unrestricted	26,362	2,436	2,403	3,851	(3,786)	31,266
Temporarily restricted	268	—	55	246	(246)	323
Permanently restricted	1,363	—	17	1,363	(1,363)	1,380
Total net assets	27,993	2,436	2,475	5,460	(5,395)	32,969
Total liabilities and net assets	$ 49,556	3,578	2,718	5,522	(5,590)	55,784

See accompanying independent auditors' report.

Schedule 2

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2010

(In thousands)

Assets	University of Maryland Medical Center	University CARE	Kernan	University Specialty	Maryland General	Baltimore Washington	Shore Health	Chester River	UMMS Foundation	Shipley's	36 South Paca	Eliminations	Consolidated Total
Current assets:													
Cash and cash equivalents	$ 175,378	124	9,161	2,219	11,635	16,493	17,903	5,029	—	110	496	—	238,548
Assets limited as to use, current portion	36,570	—	—	—	986	846	471	355	—	—	—	—	39,228
Accounts receivable:													
Patient accounts receivable, less allowance for doubtful accounts of $136,278	137,783	120	14,025	2,733	18,291	40,544	26,728	8,903	—	—	—	—	249,127
Other	40,926	227	1,631	193	522	366	2,459	512	—	3,019	69	(25,769)	24,155
Inventories	17,014	39	987	556	1,703	5,456	3,785	690	—	—	—	—	30,230
Prepaid expenses and other current assets	55,070	—	15	17	596	9,000	889	594	1,500	—	—	—	67,681
Total current assets	462,741	510	25,819	5,718	33,733	72,705	52,235	16,083	1,500	3,129	565	(25,769)	648,969
Investments	184,626	—	11,252	15,330	—	42,121	21,950	5,829	—	—	—	—	281,108
Assets limited as to use, less current portion:													
Debt service funds	39,553	—	—	—	—	—	—	—	—	—	—	—	39,553
Construction funds	160,185	—	—	—	8,602	28,315	6,987	—	—	—	—	—	204,089
Board designated and escrow funds	—	—	—	—	—	—	54,464	5,000	27,202	—	—	—	86,666
Self-insurance trust funds	38,393	—	—	—	22,738	11,529	7,351	288	—	—	—	—	80,299
Funds restricted by donor	—	—	—	—	958	—	18,297	1,447	20,371	—	—	—	41,073
Economic and beneficial interests in the net assets of related organizations	52,158	—	29,232	390	3,242	5,895	2,350	—	—	—	—	(54,828)	38,439
	290,289	—	29,232	390	35,540	45,739	89,449	6,735	47,573	—	—	(54,828)	490,119
Property and equipment, net	668,500	—	36,016	18,974	95,785	259,324	119,996	23,395	1,800	6,394	9,930	—	1,240,114
Deferred financing costs, net	8,661	—	—	—	—	—	—	—	—	—	—	—	8,661
Investments in joint ventures and other assets	146,393	—	—	—	13,350	6,967	361	2,506	4,057	—	3,277	(60,731)	116,180
Total assets	$ 1,761,210	510	102,319	40,412	178,408	426,856	283,991	54,548	54,930	9,523	13,772	(141,328)	2,785,151

(Continued)

Schedule 2

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2010

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center	University CARE	Kernan	University Specialty	Maryland General	Baltimore Washington	Shore Health	Chester River	UMMS Foundation	Shipley's	36 South Paca	Eliminations	Consolidated Total
Current liabilities:													
Trade accounts payable	$ 97,956	706	5,598	3,031	9,180	16,034	10,390	2,830	102	35	287	—	146,149
Accrued payroll and benefits	67,339	74	3,949	2,826	11,108	19,118	13,294	4,085	—	—	—	(110)	121,683
Advances from third-party payors	61,988	—	2,445	4,294	6,630	6,010	5,090	1,101	—	—	—	—	87,558
Lines of credit	63,300	—	—	—	—	—	—	—	—	—	—	—	63,300
Other current liabilities	69,794	506	853	13,943	12,024	5,076	3,840	1,130	—	—	1,889	(25,097)	83,958
Long-term debt subject to short-term remarketing arrangements	70,069	—	—	—	—	—	—	—	—	—	—	—	70,069
Current portion of long-term debt	27,162	—	259	300	1,107	4,444	1,808	1,362	—	—	—	—	36,442
Total current liabilities	457,608	1,286	13,104	24,394	40,049	50,682	34,422	10,508	102	35	2,176	(25,207)	609,159
Long-term debt, less current portion	595,578	—	12,590	7,256	42,547	206,725	88,158	6,951	—	—	—	(562)	959,243
Other long-term liabilities	36,114	—	441	357	33,942	19,400	6,293	9,247	—	—	—	—	105,794
Interest rate swap liabilities	128,575	—	—	—	—	—	—	—	—	—	—	—	128,575
Total liabilities	1,217,875	1,286	26,135	32,007	116,538	276,807	128,873	26,706	102	35	2,176	(25,769)	1,802,771
Net assets:													
Unrestricted	486,180	(776)	46,819	8,015	57,670	144,154	134,814	26,396	31,324	9,488	11,596	(60,731)	894,949
Temporarily restricted	56,742	—	29,365	390	4,200	5,895	9,221	75	5,124	—	—	(54,828)	56,184
Permanently restricted	413	—	—	—	—	—	11,083	1,371	18,380	—	—	—	31,247
Total net assets	543,335	(776)	76,184	8,405	61,870	150,049	155,118	27,842	54,828	9,488	11,596	(115,559)	982,380
Total liabilities and net assets	$ 1,761,210	510	102,319	40,412	178,408	426,856	283,991	54,548	54,930	9,523	13,772	(141,328)	2,785,151

See accompanying independent auditors' report.

Schedule 2-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Maryland General Health Systems (MGHS)

June 30, 2010

(In thousands)

Assets	Maryland General Health Systems, Inc.	Maryland General Hospital	Maryland General Clin. Prac. Group	Eliminations	MGHS Consolidated Total
Current assets:					
Cash and cash equivalents	$ 40	11,538	57	—	11,635
Assets limited as to use, current portion	—	986	—	—	986
Accounts receivable:					
Patient accounts receivable, less allowance for doubtful accounts of $11,118	—	17,485	806	—	18,291
Other	140	1,215	(833)	—	522
Inventories	—	1,703	—	—	1,703
Prepaid expenses and other current assets	—	596	—	—	596
Total current assets	180	33,523	30	—	33,733
Investments	—	—	—	—	—
Assets limited as to use, less current portion:					
Debt service funds	—	—	—	—	—
Construction funds	—	8,602	—	—	8,602
Board designated and escrow funds	—	—	—	—	—
Self-insurance trust funds	—	22,738	—	—	22,738
Funds restricted by donor	—	958	—	—	958
Economic interests in the net assets of related organizations	—	3,242	—	—	3,242
	—	35,540	—	—	35,540
Property and equipment, net	2,248	93,537	—	—	95,785
Deferred financing costs, net	—	—	—	—	—
Investments in joint ventures and other assets	13,187	163	—	—	13,350
Total assets	$ 15,615	162,763	30	—	178,408

(Continued)

Schedule 2-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Maryland General Health Systems (MGHS)

June 30, 2010

(In thousands)

Liabilities and Net Assets	Maryland General Health Systems, Inc.	Maryland General Hospital	Maryland General Clin. Prac. Group	Eliminations	MGHS Consolidated Total
Current liabilities:					
Trade accounts payable	$ 7	9,150	23	—	9,180
Accrued payroll and benefits	—	11,108	—	—	11,108
Advances from third-party payors	—	6,630	—	—	6,630
Lines of credit	—	—	—	—	—
Other current liabilities	—	12,024	—	—	12,024
Current portion of long-term debt	142	965	—	—	1,107
Total current liabilities	149	39,877	23	—	40,049
Long-term debt, less current portion	1,457	41,090	—	—	42,547
Other long-term liabilities	1	33,941	—	—	33,942
Total liabilities	1,607	114,908	23	—	116,538
Net assets:					
Unrestricted	14,008	43,655	7	—	57,670
Temporarily restricted	—	4,200	—	—	4,200
Permanently restricted	—	—	—	—	—
Total net assets	14,008	47,855	7	—	61,870
Total liabilities and net assets	$ 15,615	162,763	30	—	178,408

See accompanying independent auditors' report.

Schedule 2-b

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Baltimore Washington Medical System (BWMS)

June 30, 2010

(In thousands)

Assets	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Eliminations	BWMS Consolidated Total
Current assets:							
Cash and cash equivalents	$ —	15,472	620	381	20	—	16,493
Assets limited as to use, current portion	—	846	—	—	—	—	846
Accounts receivable:							
Patient accounts receivable, less allowance for doubtful accounts of $10,570	—	35,624	2,969	1,951	—	—	40,544
Other	28,332	366	2,359	—	(2,043)	(28,648)	366
Inventories	—	5,456	—	—	—	—	5,456
Prepaid expenses and other current assets	98	8,775	—	63	64	—	9,000
Total current assets	28,430	66,539	5,948	2,395	(1,959)	(28,648)	72,705
Investments	—	42,121	—	—	—	—	42,121
Assets limited as to use, less current portion:							
Debt service funds	—	—	—	—	—	—	—
Construction funds	—	28,315	—	—	—	—	28,315
Board designated and escrow funds	—	—	—	—	—	—	—
Self-insurance trust funds	—	11,529	—	—	—	—	11,529
Funds restricted by donor	—	—	—	—	—	—	—
Economic interests in the net assets of related organizations	—	5,895	—	—	—	—	5,895
	—	45,739	—	—	—	—	45,739
Property and equipment, net	—	232,965	—	12,044	14,315	—	259,324
Deferred financing costs, net	—	—	—	—	—	—	—
Investments in joint ventures and other assets	122,776	86	—	2,102	—	(117,997)	6,967
Total assets	$ 151,206	387,450	5,948	16,541	12,356	(146,645)	426,856

(Continued)

Schedule 2-b

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Baltimore Washington Medical System (BWMS)

June 30, 2010

(In thousands)

Liabilities and Net Assets	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Eliminations	BWMS Consolidated Total
Current liabilities:							
Trade accounts payable	$ 17	13,980	985	1,004	48	—	16,034
Accrued payroll and benefits	1,140	16,723	215	1,016	24	—	19,118
Advances from third-party payors	—	6,010	—	—	—	—	6,010
Lines of credit	—	—	—	—	—	—	—
Other current liabilities	—	26,920	—	6,804	—	(28,648)	5,076
Current portion of long-term debt	—	3,961	—	258	225	—	4,444
Total current liabilities	1,157	67,594	1,200	9,082	297	(28,648)	50,682
Long-term debt, less current portion	—	191,635	—	10,909	4,181	—	206,725
Other long-term liabilities	—	18,813	—	587	—	—	19,400
Total liabilities	1,157	278,042	1,200	20,578	4,478	(28,648)	276,807
Net assets:							
Unrestricted	150,049	103,513	4,748	(4,037)	7,878	(117,997)	144,154
Temporarily restricted	—	5,895	—	—	—	—	5,895
Permanently restricted	—	—	—	—	—	—	—
Total net assets	150,049	109,408	4,748	(4,037)	7,878	(117,997)	150,049
Total liabilities and net assets	$ 151,206	387,450	5,948	16,541	12,356	(146,645)	426,856

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Shore Health System (SHS)

June 30, 2010

(In thousands)

Assets	Shore Health System, Inc.	Memorial Hospital Foundation, Inc. and Subsidiary	Care Health Services, Inc.	Shore Health Enterprises, Inc. and Subsidiary	Shore Clinical Foundation, Inc.	Chesapeake Ear, Nose, Throat, Sinus, and Hearing Center, LLC	Chesapeake Neurological Surgery, LLC	Eliminations	SHS Consolidated Total
Current assets:									
Cash and cash equivalents	$ 16,946	—	463	51	383	53	7	—	17,903
Assets limited as to use, current portion	471	—	—	—	—	—	—	—	471
Accounts receivable:									
Patient accounts receivable, less allowance for doubtful accounts of $7,503	24,196	—	947	—	1,464	97	24	—	26,728
Other	7,806	125	2,873	—	139	—	342	(8,826)	2,459
Inventories	3,785	—	—	—	—	—	—	—	3,785
Prepaid expenses and other current assets	675	24	15	—	170	4	1	—	889
Total current assets	53,879	149	4,298	51	2,156	154	374	(8,826)	52,235
Investments	21,950	—	—	—	—	—	—	—	21,950
Assets limited as to use, less current portion:									
Debt service funds	—	—	—	—	—	—	—	—	—
Construction funds	6,987	—	—	—	—	—	—	—	6,987
Board designated and escrow funds	25,000	29,464	—	—	—	—	—	—	54,464
Self-insurance trust funds	7,351	—	—	—	—	—	—	—	7,351
Funds restricted by donor	3,285	15,012	—	—	—	—	—	—	18,297
Economic and beneficial interests in the net assets of related organizations	43,255	—	—	—	—	—	—	(40,905)	2,350
	85,878	44,476	—	—	—	—	—	(40,905)	89,449
Property and equipment, net	114,061	3,873	432	726	803	84	17	—	119,996
Deferred financing costs, net	—	—	—	—	—	—	—	—	—
Investments in joint ventures and other assets	8,396	26	—	—	—	—	—	(8,061)	361
Total assets	$ 284,164	48,524	4,730	777	2,959	238	391	(57,792)	283,991

(Continued)

Schedule 2-c

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Shore Health System (SHS)

June 30, 2010

(In thousands)

Liabilities and Net Assets	Shore Health System, Inc.	Memorial Hospital Foundation, Inc. and Subsidiary	Care Health Services, Inc.	Shore Health Enterprises, Inc. and Subsidiary	Shore Clinical Foundation, Inc.	Chesapeake Ear, Nose, Throat, Sinus, and Hearing Center, LLC	Chesapeake Neurological Surgery, LLC	Eliminations	SHS Consolidated Total
Current liabilities:									
Trade accounts payable	$ 9,674	2	133	—	250	20	311	—	10,390
Accrued payroll and benefits	12,068	19	318	—	756	131	2	—	13,294
Advances from third-party payors	5,090	—	—	—	—	—	—	—	5,090
Lines of credit	—	—	—	—	—	—	—	—	—
Other current liabilities	6,038	709	2	1,440	—	1,592	2,885	(8,826)	3,840
Current portion of long-term debt	1,808	—	—	—	—	—	—	—	1,808
Total current liabilities	34,678	730	453	1,440	1,006	1,743	3,198	(8,826)	34,422
Long-term debt, less current portion	88,158	—	—	—	—	—	—	—	88,158
Other long-term liabilities	6,210	26	—	—	57	—	—	—	6,293
Total liabilities	129,046	756	453	1,440	1,063	1,743	3,198	(8,826)	128,873
Net assets:									
Unrestricted	134,814	33,103	4,277	(663)	1,896	(1,505)	(2,807)	(34,301)	134,814
Temporarily restricted	9,221	6,463	—	—	—	—	—	(6,463)	9,221
Permanently restricted	11,083	8,202	—	—	—	—	—	(8,202)	11,083
Total net assets	155,118	47,768	4,277	(663)	1,896	(1,505)	(2,807)	(48,966)	155,118
Total liabilities and net assets	$ 284,164	48,524	4,730	777	2,959	238	391	(57,792)	283,991

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Chester River Health System, Inc. (CRHS)

June 30, 2010

(In thousands)

Assets	Chester River Hospital Center	Chester River Manor	Chester River Home Care and Hospice	Chester River Health Foundation	Eliminations	CRHS Consolidated Total
Current assets:						
Cash and cash equivalents	$ 2,646	700	504	1,179	—	5,029
Assets limited as to use, current portion	355	—	—	—	—	355
Accounts receivable:						
Patient accounts receivable, less allowance for doubtful accounts of $6,123	8,011	625	267	—	—	8,903
Other	1,235	3	22	—	(748)	512
Inventories	686	4	—	—	—	690
Prepaid expenses and other current assets	474	106	13	1	—	594
Total current assets	13,407	1,438	806	1,180	(748)	16,083
Investments	4,394	—	1,232	203	—	5,829
Assets limited as to use, less current portion:						
Debt service funds	—	—	—	—	—	—
Construction funds	—	—	—	—	—	—
Board designated and escrow funds	5,000	—	—	—	—	5,000
Self-insurance trust funds	288	—	—	—	—	288
Funds restricted by donor	26	—	73	1,348	—	1,447
Economic interests in the net assets of related organizations	4,748	11	422	—	(5,181)	—
	10,062	11	495	1,348	(5,181)	6,735
Property and equipment, net	21,084	2,106	205	—	—	23,395
Deferred financing costs, net	—	—	—	—	—	—
Investments in joint ventures and other assets	24	—	—	2,482	—	2,506
Total assets	$ 48,971	3,555	2,738	5,213	(5,929)	54,548

(Continued)

Schedule 2-d

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Chester River Health System, Inc. (CRHS)

June 30, 2010

(In thousands)

Liabilities and Net Assets	Chester River Hospital Center	Chester River Manor	Chester River Home Care and Hospice	Chester River Health Foundation	Eliminations	CRHS Consolidated Total
Current liabilities:						
Trade accounts payable	$ 2,483	340	4	3	—	2,830
Accrued payroll and benefits	3,637	315	133	—	—	4,085
Advances from third-party payors	1,056	45	—	—	—	1,101
Lines of credit	—	—	—	—	—	—
Other current liabilities	1,094	489	257	38	(748)	1,130
Current portion of long-term debt	1,335	27	—	—	—	1,362
Total current liabilities	9,605	1,216	394	41	(748)	10,508
Long-term debt, less current portion	6,596	355	—	—	—	6,951
Other long-term liabilities	9,122	60	—	65	—	9,247
Total liabilities	25,323	1,631	394	106	(748)	26,706
Net assets:						
Unrestricted	22,274	1,924	2,272	3,759	(3,833)	26,396
Temporarily restricted	20	—	55	(6)	6	75
Permanently restricted	1,354	—	17	1,354	(1,354)	1,371
Total net assets	23,648	1,924	2,344	5,107	(5,181)	27,842
Total liabilities and net assets	$ 48,971	3,555	2,738	5,213	(5,929)	54,548

See accompanying independent auditors' report.

Schedule 3

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division

Year ended June 30, 2011

(In thousands)

	University of Maryland Medical Center	University CARE	Kernan	University Specialty	Maryland General	Baltimore Washington	Shore Health	Chester River	UMMS Foundation	Shipley's	36 South Paca	Eliminations	Consolidated Total
Unrestricted revenues, gains and other support:													
Net patient service revenue	$ 1,276,194	2,755	95,419	52,512	183,146	363,481	231,862	66,133	—	—	—	(1,086)	2,270,416
Other operating revenue:													
State support	3,200	—	—	—	—	—	—	—	—	—	—	—	3,200
Other revenue	50,776	2,105	2,612	326	2,241	6,867	5,602	588	—	1,002	1,221	(2,752)	70,588
Total unrestricted revenue, gains and other support	1,330,170	4,860	98,031	52,838	185,387	370,348	237,464	66,721	—	1,002	1,221	(3,838)	2,344,204
Operating expenses:													
Salaries, wages and benefits	552,426	3,405	45,543	27,606	85,855	169,139	121,828	35,360	—	—	182	—	1,041,344
Expendable supplies	238,973	284	15,138	6,161	16,304	61,228	33,060	9,018	—	—	56	—	380,222
Purchased services	170,524	4,714	18,555	16,591	24,063	51,520	40,448	13,290	—	426	775	(4,625)	336,281
Contracted services	89,516	—	7,644	—	22,770	9,725	8,558	1,497	—	—	—	—	139,710
Depreciation and amortization	69,601	—	3,238	2,347	11,149	23,506	14,785	3,855	—	172	359	—	129,012
Interest expense	26,881	—	476	861	1,698	6,663	3,260	395	—	—	107	—	40,341
Provision for bad debts	101,153	278	6,107	4,467	19,697	34,520	8,595	2,196	—	—	—	—	177,013
Total operating expenses	1,249,074	8,681	96,701	58,033	181,536	356,301	230,534	65,611	—	598	1,479	(4,625)	2,243,923
Operating income (loss)	81,096	(3,821)	1,330	(5,195)	3,851	14,047	6,930	1,110	—	404	(258)	787	100,281
Nonoperating income and expenses, net:													
Loss on early extinguishment of debt	$ —	—	—	—	—	—	—	—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	18,640	—	—	—	—	—	—	—	—	—	—	—	18,640
Other nonoperating gains and losses:													
Contributions	—	—	—	—	—	—	206	591	5,258	—	—	—	6,055
Equity in net income of joint ventures	10,366	—	—	—	4,400	(182)	—	—	—	—	—	5,950	20,534
Investment income	25,543	—	1,151	1,275	290	4,241	1,707	638	4,362	—	—	—	39,207
Change in fair value of investments	16,500	—	766	700	152	2,836	12,915	752	1,743	—	—	—	36,364
Other nonoperating gains and losses	(9,420)	—	15	—	(550)	(2,821)	(1,814)	(404)	(2,954)	—	—	1	(17,947)
Total other nonoperating gains and losses	42,989	—	1,932	1,975	4,292	4,074	13,014	1,577	8,409	—	—	5,951	84,213
Excess (deficiency) of revenues over expenses	142,725	(3,821)	3,262	(3,220)	8,143	18,121	19,944	2,687	8,409	404	(258)	6,738	203,134
Net assets released from restrictions used for purchase of property and equipment	20,815	—	750	—	885	750	764	—	—	—	—	—	23,964
Change in unrealized gains on investments	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in ownership interest of joint ventures	2,268	—	—	—	—	—	—	—	—	—	—	—	2,268
Capital transfers (to) from affiliate	3,801	4,068	1,035	—	47	—	—	—	(4,883)	—	—	(4,068)	—
Change in fair value of designated interest rate swaps	2,298	—	—	—	—	—	—	—	—	—	—	—	2,298
Change in funded status of defined benefit pension plans	—	—	—	—	9,752	4,736	—	1,834	—	—	—	—	16,322
Other	(348)	—	—	1	—	1	(16)	349	75	—	—	(162)	(100)
Increase (decrease) in unrestricted net assets	$ 171,559	247	5,047	(3,219)	18,827	23,608	20,692	4,870	3,601	404	(258)	2,508	247,886

See accompanying independent auditors' report.

Schedule 3-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Maryland General Health Systems (MGHS)

Year ended June 30, 2011

(In thousands)

	Maryland General Health Systems, Inc.	Maryland General Hospital	Maryland General Clin. Prac. Group	Eliminations	MGHS Consolidated Total
Unrestricted revenues, gains and other support:					
Net patient service revenue	$ —	180,958	9,445	(7,257)	183,146
Other operating revenue:					
State support	—	—	—	—	—
Other revenue	889	1,347	5	—	2,241
Total unrestricted revenue, gains and other support	889	182,305	9,450	(7,257)	185,387
Operating expenses:					
Salaries, wages and benefits	—	85,855	—	—	85,855
Expendable supplies	—	16,304	—	—	16,304
Purchased services	747	23,307	9	—	24,063
Contracted services	—	22,770	7,257	(7,257)	22,770
Depreciation and amortization	455	10,694	—	—	11,149
Interest expense	103	1,595	—	—	1,698
Provision for bad debts	—	17,513	2,184	—	19,697
Total operating expenses	1,305	178,038	9,450	(7,257)	181,536
Operating income (loss)	(416)	4,267	—	—	3,851

(Continued)

Schedule 3-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Maryland General Health Systems (MGHS)

Year ended June 30, 2011

(In thousands)

	Maryland General Health Systems, Inc.	Maryland General Hospital	Maryland General Clin. Prac. Group	Eliminations	MGHS Consolidated Total
Nonoperating income and expenses, net:					
Loss on early extinguishment of debt	$ —	—	—	—	—
Change in fair value of undesignated interest rate swaps	—	—	—	—	—
Other nonoperating gains and losses:					
Contributions	—	—	—	—	—
Equity in net income of joint ventures	4,400	—	—	—	4,400
Investment income	—	290	—	—	290
Change in fair value of investments	—	152	—	—	152
Other nonoperating gains and losses	—	(550)	—	—	(550)
Total other nonoperating gains and losses	4,400	(108)	—	—	4,292
Excess of revenues over expenses	3,984	4,159	—	—	8,143
Net assets released from restrictions used for purchase of property and equipment	—	885	—	—	885
Change in unrealized gains on investments	—	—	—	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	—	—	—	—
Change in ownership interest of joint ventures	—	—	—	—	—
Capital transfers (to) from affiliate	(1,600)	1,647	—	—	47
Change in fair value of designated interest rate swaps	—	—	—	—	—
Change in funded status of defined benefit pension plans	—	9,752	—	—	9,752
Other	(16)	16	—	—	—
Increase in unrestricted net assets	$ 2,368	16,459	—	—	18,827

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Baltimore Washington Medical System (BWMS)

Year ended June 30, 2011

(In thousands)

	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Eliminations	BWMS Consolidated Total
Unrestricted revenues, gains and other support:							
Net patient service revenue	$ —	326,216	28,730	10,958	—	(2,423)	363,481
Other operating revenue:							
State support	—		—	—	—	—	—
Other revenue	3,406	3,292	—	2,891	2,101	(4,823)	6,867
Total unrestricted revenue, gains and other support	3,406	329,508	28,730	13,849	2,101	(7,246)	370,348
Operating expenses:							
Salaries, wages and benefits	3,406	147,837	10,577	7,319	—	—	169,139
Expendable supplies	—	60,399	—	829	—	—	61,228
Purchased services	—	49,277	4,448	3,738	1,303	(7,246)	51,520
Contracted services	—	7,830	—	1,895	—	—	9,725
Depreciation and amortization	—	22,001	—	959	546	—	23,506
Interest expense	—	5,813	—	736	114	—	6,663
Provision for bad debts	—	21,447	13,073	—	—	—	34,520
Total operating expenses	3,406	314,604	28,098	15,476	1,963	(7,246)	356,301
Operating income (loss)	—	14,904	632	(1,627)	138	—	14,047

(Continued)

Schedule 3-b

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Baltimore Washington Medical System (BWMS)

Year ended June 30, 2011

(In thousands)

	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Eliminations	BUMS Consolidated Total
Nonoperating income and expenses, net:							
Loss on early extinguishment of debt	$ —	—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	—	—	—	—	—	—	—
Other nonoperating gains and losses:							
Contributions	—	—	—	—	—	—	—
Equity in net income of joint ventures	202	—	—	(384)	—	—	(182)
Investment income	17,920	4,232	—	6	—	(17,917)	4,241
Change in fair value of investments	—	2,836	—	—	—	—	2,836
Other nonoperating gains and losses	—	(2,821)	—	—	—	—	(2,821)
Total other nonoperating gains and losses	18,122	4,247	—	(378)	—	(17,917)	4,074
Excess (deficiency) of revenues over expenses	18,122	19,151	632	(2,005)	138	(17,917)	18,121
Net assets released from restrictions used for purchase of property and equipment	750	750	—	—	—	(750)	750
Change in unrealized gains on investments	—	—	—	—	—	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	—	—	—	—	—	—
Change in ownership interest of joint ventures	—	—	—	—	—	—	—
Capital transfers (to) from affiliate	—	—	—	(1,831)	—	1,831	—
Change in fair value of designated interest rate swaps	—	—	—	—	—	—	—
Change in funded status of defined benefit pension plans	4,736	4,736	—	—	—	(4,736)	4,736
Other	1	3	—	—	—	(3)	1
Increase (decrease) in unrestricted net assets	$ 23,609	24,640	632	(3,836)	138	(21,575)	23,608

See accompanying independent auditors' report.

Schedule 3-c

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Shore Health System (SHS)

Year ended June 30, 2011

(In thousands)

	Shore Health System, Inc.	Memorial Hospital Foundation, Inc. and Subsidiary	Care Health Services, Inc.	Shore Health Enterprises, Inc. and Subsidiary	Shore Clinical Foundation, Inc.	Chesapeake Ear, Nose, Throat, Sinus, and Hearing Center, LLC	Chesapeake Neurological Surgery, LLC	Eliminations	SHS Consolidated Total
Unrestricted revenues, gains and other support:									
Net patient service revenue	$ 217,704	—	5,511	—	7,756	766	729	(604)	231,862
Other operating revenue:									
State support	—	—	—	—	—	—	—	—	—
Other revenue	6,301	—	87	57	627	1	—	(1,471)	5,602
Total unrestricted revenue, gains and other support	224,005	—	5,598	57	8,383	767	729	(2,075)	237,464
Operating expenses:									
Salaries, wages and benefits	106,570	—	4,005	—	9,925	1,021	887	(580)	121,828
Expendable supplies	32,302	—	269	—	455	25	9	—	33,060
Purchased services	37,317	—	1,311	21	3,091	191	155	(1,638)	40,448
Contracted services	6,990	—	18	—	1,010	—	540	—	8,558
Depreciation and amortization	14,484	—	35	12	211	24	19	—	14,785
Interest expense	3,260	—	—	61	—	—	—	(61)	3,260
Provision for bad debts	8,435	—	86	—	67	4	3	—	8,595
Total operating expenses	209,358	—	5,724	94	14,759	1,265	1,613	(2,279)	230,534
Operating income (loss)	14,647	—	(126)	(37)	(6,376)	(498)	(884)	204	6,930
Nonoperating income and expenses, net:									
Loss on early extinguishment of debt	—	—		—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	—			—	—	—	—	—	—
Other nonoperating gains and losses:									
Contributions	83	121	2	—	—	—	—	—	206
Equity in net income of joint ventures			—	—	—	—	—	—	—
Investment income (loss)	1,421	346	1	—	—	—	—	(61)	1,707
Change in fair value of investments	7,321	5,594	—	—	—	—	—	—	12,915
Other nonoperating gains and losses	(1,289)	(382)	—	—	—	—	—	(143)	(1,814)
Total other nonoperating gains and losses	7,536	5,679	3	—	—	—	—	(204)	13,014
Excess (deficiency) of revenues over expenses	22,183	5,679	(123)	(37)	(6,376)	(498)	(884)	—	19,944
Net assets released from restrictions used for purchase of property and equipment	764	—	—	—	—	—	—	—	764
Change in unrealized gains on investments	—	—	—	—	—	—	—	—	—
Change in economic and beneficial interests in the net assets of related organizations	5,680	—	—	—	—	—	—	(5,680)	—
Change in ownership interest of joint ventures	6,431	—	—	—	—	—	—	(6,431)	—
Capital transfers (to) from affiliate	(14,350)	—	—	—	8,657	2,002	3,691	—	—
Change in fair value of designated interest rate swaps	—	—	—	—	—	—	—	—	—
Change in funded status of defined benefit pension plans	—	—	—	—	—	—	—	—	—
Net losses from nonconsolidated subsidiaries	—	—	—	—	—	—	—	—	—
Other	(17)	—	—	—	—	1	—	—	(16)
Increase (decrease) in unrestricted net assets	$ 20,691	5,679	(123)	(37)	2,281	1,505	2,807	(12,111)	20,692

See accompanying independent auditors' report.

Schedule 3-d

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Chester River Health System, Inc. (CRHS)

Year ended June 30, 2011

(In thousands)

	Chester River Hospital Center	Chester River Manor	Chester River Home Care and Hospice	Chester River Health Foundation	Eliminations	CRHS Consolidated Total
Unrestricted revenues, gains and other support:						
Net patient service revenue	$ 55,065	8,494	2,574	—	—	66,133
Other operating revenue:						
State support	—	—	—	—	—	—
Other revenue	498	26	64	—	—	588
Total unrestricted revenue, gains and other support	55,563	8,520	2,638	—	—	66,721
Operating expenses:						
Salaries, wages and benefits	29,568	3,949	1,843	—	—	35,360
Expendable supplies	8,109	843	66	—	—	9,018
Purchased services	9,859	2,939	492	—	—	13,290
Contracted services	1,497	—	—	—	—	1,497
Depreciation and amortization	3,594	219	42	—	—	3,855
Interest expense	385	10	—	—	—	395
Provision for bad debts	2,020	103	73	—	—	2,196
Total operating expenses	55,032	8,063	2,516	—	—	65,611
Operating income	531	457	122	—	—	1,110

(Continued)

Schedule 3-d

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Chester River Health System, Inc. (CRHS)

Year ended June 30, 2011

(In thousands)

	Chester River Hospital Center	Chester River Manor	Chester River Home Care and Hospice	Chester River Health Foundation	Eliminations	CRHS Consolidated Total
Nonoperating income and expenses, net:						
Loss on early extinguishment of debt	$ —	—	—	—	—	—
Other nonoperating gains and losses:						
Contributions	—	—	—	591	—	591
Equity in net income of joint ventures	—	—	—	—	—	—
Investment income	592	—	14	32	—	638
Change in fair value of investments	752	—	—	—	—	752
Other nonoperating gains and losses	219	5	(5)	(406)	(217)	(404)
Total other nonoperating gains and losses	1,563	5	9	217	(217)	1,577
Excess of revenues over expenses	2,094	462	131	217	(217)	2,687
Net assets released from restrictions used for purchase of property and equipment	—	—	—	—	—	—
Change in unrealized gains on investments	—	—	—	—	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	—	—	—	—	—
Change in ownership interest of joint ventures	—	—	—	—	—	—
Capital transfers (to) from affiliate	—	—	—	—	—	—
Change in fair value of designated interest rate swaps	—	—	—	—	—	—
Change in funded status of defined benefit pension plans	1,834	—	—	—	—	1,834
Other	160	50	—	(125)	264	349
Increase in unrestricted net assets	$ 4,088	512	131	92	47	4,870

See accompanying independent auditors' report.

Schedule 4

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division

Year ended June 30, 2010

(In thousands)

	University of Maryland Medical Center	University CARE	Kernan	University Specialty	Maryland General	Baltimore Washington	Shore Health	Chester River	UMMS Foundation	Shipley's	36 South Paca	Eliminations	Consolidated Total
Unrestricted revenues, gains and other support:													
Net patient service revenue	$ 1,172,458	2,666	97,532	54,088	178,611	343,289	216,774	65,324	—	—	—	(1,080)	2,129,662
Other operating revenue:													
State support	3,200	—	—	—	—	—	—	—	—	—	—	—	3,200
Other revenue	47,786	2,144	2,488	221	2,174	7,063	3,393	660	—	988	1,147	(1,958)	66,106
Total unrestricted revenue, gains and other support	1,223,444	4,810	100,020	54,309	180,785	350,352	220,167	65,984	—	988	1,147	(3,038)	2,198,968
Operating expenses:													
Salaries, wages and benefits	507,010	3,500	46,161	28,482	86,133	165,344	115,155	36,442	—	—	172	—	988,399
Expendable supplies	226,144	263	15,127	6,011	15,551	55,129	29,629	9,891	—	1	47	—	357,793
Purchased services	146,365	4,419	18,279	14,331	26,162	53,745	38,851	12,878	—	455	742	(3,846)	312,381
Contracted services	90,508	—	7,636	—	22,793	9,157	9,590	1,160	—	—	—	—	140,844
Depreciation and amortization	61,797	—	3,358	2,068	9,888	22,601	14,256	3,336	—	159	303	—	117,766
Interest expense	28,748	—	536	885	1,205	5,754	2,451	405	—	—	67	—	40,051
Provision for bad debts	103,541	328	9,057	5,742	16,615	31,308	9,363	3,335	—	—	—	—	179,289
Total operating expenses	1,164,113	8,510	100,154	57,519	178,347	343,038	219,295	67,447	—	615	1,331	(3,846)	2,136,523
Operating income (loss)	59,331	(3,700)	(134)	(3,210)	2,438	7,314	872	(1,463)	—	373	(184)	808	62,445
Nonoperating income and expenses, net:													
Loss on early extinguishment of debt	(816)	—	—	—	—	—	—	—	—	—	—	—	(816)
Change in fair value of undesignated interest rate swaps	(33,700)	—	—	—	—	—	—	—	—	—	—	—	(33,700)
Other nonoperating gains and losses:													
Contributions	—	—	—	—	—	—	559	651	6,927	—	—	—	8,137
Equity in net income of joint ventures	(3,789)	—	—	—	3,367	186	—	—	—	—	—	3,750	3,514
Investment income (loss)	1,499	—	50	39	(428)	213	(2,577)	275	1,065	—	—	—	136
Change in fair value of investments	18,502	—	1,259	1,721	3,255	5,862	13,043	62	1,888	—	—	—	45,592
Other nonoperating gains and losses	(2,205)	—	—	33	(1,999)	(4,763)	(1,801)	(169)	(3,264)	—	—	370	(13,798)
Total other nonoperating gains and losses	14,007	—	1,309	1,793	4,195	1,498	9,224	819	6,616	—	—	4,120	43,581
Excess (deficiency) of revenues over expenses	38,822	(3,700)	1,175	(1,417)	6,633	8,812	10,096	(644)	6,616	373	(184)	4,928	71,510
Net assets released from restrictions used for purchase of property and equipment	7,336	—	750	—	26,563	1,000	1,090	—	(4,127)	—	—	—	32,612
Change in unrealized gains on investments	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in ownership interest of joint ventures	3,478	—	—	—	—	—	—	—	—	—	—	—	3,478
Capital transfers (to) from affiliate	—	3,769	—	—	—	—	—	1,977	—	—	—	(5,746)	—
Change in fair value of designated interest rate swaps	(7,408)	—	—	—	—	—	(2)	—	—	—	—	—	(7,410)
Change in funded status of defined benefit pension plans	—	—	—	—	(3,830)	(361)	—	(575)	—	—	—	—	(4,766)
Other	13	(29)	—	—	18	(2)	(11)	2	1	—	1	(23)	(30)
Increase (decrease) in unrestricted net assets	$ 42,241	40	1,925	(1,417)	29,384	9,449	11,173	760	2,490	373	(183)	(841)	95,394

See accompanying independent auditors' report.

Schedule 4-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Maryland General Health Systems (MGHS)

Year ended June 30, 2010

(In thousands)

	Maryland General Health Systems, Inc.	Maryland General Hospital	Maryland General Clin. Prac. Group	Eliminations	MGHS Consolidated Total
Unrestricted revenues, gains and other support:					
Net patient service revenue	$ —	175,997	9,492	(6,878)	178,611
Other operating revenue:					
State support	—	—	—	—	—
Other revenue	898	1,275	1	—	2,174
Total unrestricted revenue, gains and other support	898	177,272	9,493	(6,878)	180,785
Operating expenses:					
Salaries, wages and benefits	—	86,133	—	—	86,133
Expendable supplies	—	15,551	—	—	15,551
Purchased services	826	25,323	13	—	26,162
Contracted services	—	22,793	6,878	(6,878)	22,793
Depreciation and amortization	448	9,440	—	—	9,888
Interest expense	113	1,092	—	—	1,205
Provision for bad debts	—	14,013	2,602	—	16,615
Total operating expenses	1,387	174,345	9,493	(6,878)	178,347
Operating income (loss)	(489)	2,927	—	—	2,438

(Continued)

Schedule 4-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Maryland General Health Systems (MGHS)

Year ended June 30, 2010

(In thousands)

	Maryland General Health Systems, Inc.	Maryland General Hospital	Maryland General Clin. Prac. Group	Eliminations	MGHS Consolidated Total
Nonoperating income and expenses, net:					
Loss on early extinguishment of debt	$ —	—	—	—	—
Change in fair value of undesignated interest rate swaps	—	—	—	—	—
Other nonoperating gains and losses:					
Contributions	—	—	—	—	—
Equity in net income of joint ventures	3,367	—	—	—	3,367
Investment loss	—	(428)	—	—	(428)
Change in fair value of investments	—	3,255	—	—	3,255
Other nonoperating gains and losses	—	(1,999)	—	—	(1,999)
Total other nonoperating gains and losses	3,367	828	—	—	4,195
Excess of revenues over expenses	2,878	3,755	—	—	6,633
Net assets released from restrictions used for purchase of property and equipment	—	26,563	—	—	26,563
Change in unrealized gains on investments	—	—	—	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	—	—	—	—
Change in ownership interest of joint ventures	—	—	—	—	—
Capital transfers (to) from affiliate	220	(220)	—	—	—
Change in fair value of designated interest rate swaps	—	—	—	—	—
Change in funded status of defined benefit pension plans	—	(3,830)	—	—	(3,830)
Other	—	18	—	—	18
Increase in unrestricted net assets	$ 3,098	26,286	—	—	29,384

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Baltimore Washington Medical System (BWMS)

Year ended June 30, 2010

(In thousands)

	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Eliminations	BWMS Consolidated Total
Unrestricted revenues, gains and other support:							
Net patient service revenue	$ —	309,441	27,298	8,753	—	(2,203)	343,289
Other operating revenue:							
State support	—	—	—	—	—	—	—
Other revenue	3,238	3,251	—	2,464	2,216	(4,106)	7,063
Total unrestricted revenue, gains and other support	3,238	312,692	27,298	11,217	2,216	(6,309)	350,352
Operating expenses:							
Salaries, wages and benefits	3,238	146,988	9,917	5,201	—	—	165,344
Expendable supplies	—	54,425	—	704	—	—	55,129
Purchased services	—	50,292	5,230	3,287	1,245	(6,309)	53,745
Contracted services	—	8,457	—	700	—	—	9,157
Depreciation and amortization	—	21,124	—	943	534	—	22,601
Interest expense	—	4,904	—	762	88	—	5,754
Provision for bad debts	—	19,507	11,801	—	—	—	31,308
Total operating expenses	3,238	305,697	26,948	11,597	1,867	(6,309)	343,038
Operating income (loss)	—	6,995	350	(380)	349	—	7,314

(Continued)

Schedule 4-b

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Baltimore Washington Medical System (BWMS)

Year ended June 30, 2010

(In thousands)

	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Eliminations	BWMS Consolidated Total
Nonoperating income and expenses, net:							
Loss on early extinguishment of debt	$ —	—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	—	—	—	—	—	—	—
Other nonoperating gains and losses:							
Contributions	—	—	—	—	—	—	—
Equity in net income of joint ventures	186	—	—	—	—	—	186
Investment income	8,624	292	—	(82)	—	(8,621)	213
Change in fair value of investments	—	5,862	—	—	—	—	5,862
Other nonoperating gains and losses	—	(4,556)	—	(207)	—	—	(4,763)
Total other nonoperating gains and losses	8,810	1,598	—	(289)	—	(8,621)	1,498
Excess (deficiency) of revenues over expenses	8,810	8,593	350	(669)	349	(8,621)	8,812
Net assets released from restrictions used for purchase of property and equipment	1,000	1,000	—	—	—	(1,000)	1,000
Change in unrealized gains on investments	—	—	—	—	—	—	—
Change in economic and beneficial interests in the net assets of related organizations	(1,089)	—	—	—	—	1,089	—
Change in ownership interest of joint ventures	—	—	—	—	—	—	—
Capital transfers (to) from affiliate	—	—	—	(1,908)	—	1,908	—
Change in fair value of designated interest rate swaps	—	—	—	—	—	—	—
Change in funded status of defined benefit pension plans	(361)	(361)	—	—	—	361	(361)
Other	—	(1)	—	(2)	—	1	(2)
Increase in unrestricted net assets	$ 8,360	9,231	350	(2,579)	349	(6,262)	9,449

See accompanying independent auditors' report.

Schedule 4-c

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Shore Health System (SHS)

Year ended June 30, 2010

(In thousands)

	Shore Health System, Inc.	Memorial Hospital Foundation, Inc. and Subsidiary	Care Health Services, Inc.	Shore Health Enterprises, Inc. and Subsidiary	Shore Clinical Foundation, Inc.	Chesapeake Ear, Nose, Throat, Sinus, and Hearing Center, LLC	Chesapeake Neurological Surgery, LLC	Eliminations	SHS Consolidated Total
Unrestricted revenues, gains and other support:									
Net patient service revenue	$ 201,717	—	5,780	—	8,692	792	347	(554)	216,774
Other operating revenue:									
State support	—	—	—	—	—	—	—	—	—
Other revenue	4,455	—	16	57	259	42	—	(1,436)	3,393
Total unrestricted revenue, gains and other support	206,172	—	5,796	57	8,951	834	347	(1,990)	220,167
Operating expenses:									
Salaries, wages and benefits	103,374	—	3,948	—	7,398	913	52	(530)	115,155
Expendable supplies	28,857	—	290	—	441	40	1	—	29,629
Purchased services	36,112	—	1,214	23	2,567	199	234	(1,498)	38,851
Contracted services	5,907	—	18	—	3,059	—	606	—	9,590
Depreciation and amortization	14,019	—	36	12	141	29	19	—	14,256
Interest expense	2,451	—	—	84	—	—	—	(84)	2,451
Provision for bad debts	8,451	—	94	—	725	29	64	—	9,363
Total operating expenses	199,171	—	5,600	119	14,331	1,210	976	(2,112)	219,295
Operating income (loss)	7,001	—	196	(62)	(5,380)	(376)	(629)	122	872
Nonoperating income and expenses, net:									
Loss on early extinguishment of debt	—	—	—	—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	—	—	—	—	—	—	—	—	—
Other nonoperating gains and losses:									
Contributions	240	559	—	—	—	—	—	(240)	559
Equity in net income of joint ventures	—	—	—	—	—	—	—	—	—
Investment income (loss)	(1,216)	(1,278)	1	—	—	—	—	(84)	(2,577)
Change in fair value of investments	7,057	5,986	—	—	—	—	—	—	13,043
Other nonoperating gains and losses	(1,488)	(515)	—	—	—	—	—	202	(1,801)
Total other nonoperating gains and losses	4,593	4,752	1	—	—	—	—	(122)	9,224
Excess (deficiency) of revenues over expenses	11,594	4,752	197	(62)	(5,380)	(376)	(629)	—	10,096
Net assets released from restrictions used for purchase of property and equipment	1,090	—	—	—	—	—	—	—	1,090
Change in unrealized gains on investments	—	—	—	—	—	—	—	—	—
Change in economic and beneficial interests in the net assets of related organizations	4,332	—	—	—	—	—	—	(4,332)	—
Change in ownership interest of joint ventures	—	—	—	—	—	—	—	—	—
Capital transfers (to) from affiliate	(5,827)	—	—	—	5,827	—	—	—	—
Change in fair value of designated interest rate swaps	(2)	—	—	—	—	—	—	—	(2)
Change in funded status of defined benefit pension plans	—	—	—	—	—	—	—	—	—
Net losses from nonconsolidated subsidiaries	—	—	—	—	—	—	—	—	—
Other	(14)	1	—	1	—	—	1	—	(11)
Increase (decrease) in unrestricted net assets	$ 11,173	4,753	197	(61)	447	(376)	(628)	(4,332)	11,173

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Chester River Health System, Inc. (CRHS)

Year ended June 30, 2010

(In thousands)

	Chester River Hospital Center	Chester River Manor	Chester River Home Care and Hospice	Chester River Health Foundation	Eliminations	CRHS Consolidated Total
Unrestricted revenues, gains and other support:						
Net patient service revenue	$ 55,023	7,839	2,462	—	—	65,324
Other operating revenue:						
State support	—	—	—	—	—	—
Other revenue	575	2	83	—	—	660
Total unrestricted revenue, gains and other support	55,598	7,841	2,545	—	—	65,984
Operating expenses:						
Salaries, wages and benefits	30,265	4,306	1,706	—	165	36,442
Expendable supplies	9,041	793	57	—	—	9,891
Purchased services	10,113	2,220	545	—	—	12,878
Contracted services	1,160	—	—	—	—	1,160
Depreciation and amortization	3,130	198	8	—	—	3,336
Interest expense	393	14	—	—	(2)	405
Provision for bad debts	3,170	57	108	—	—	3,335
Total operating expenses	57,272	7,588	2,424	—	163	67,447
Operating income (loss)	(1,674)	253	121	—	(163)	(1,463)

(Continued)

Schedule 4-d

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Chester River Health System, Inc. (CRHS)

Year ended June 30, 2010

(In thousands)

	Chester River Hospital Center	Chester River Manor	Chester River Home Care and Hospice	Chester River Health Foundation	Eliminations	CRHS Consolidated Total
Nonoperating income and expenses, net:						
Loss on early extinguishment of debt	$ —	—	—	—	—	—
Other nonoperating gains and losses:						
Contributions	—	—	—	651	—	651
Equity in net income of joint ventures	—	—	—	—	—	—
Investment income	220	—	25	32	(2)	275
Change in fair value of investments	62	—	—	—	—	62
Other nonoperating gains and losses	364	7	(22)	(334)	(184)	(169)
Total other nonoperating gains and losses	646	7	3	349	(186)	819
Excess (deficiency) of revenues over expenses	(1,028)	260	124	349	(349)	(644)
Net assets released from restrictions used for purchase of property and equipment	205	—	—	(205)	—	—
Change in unrealized gains on investments	—	—	—	—	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	—	—	—	—	—
Change in ownership interest of joint ventures	—	—	—	—	—	—
Capital transfers (to) from affiliate	1,977	—	—	(23)	23	1,977
Change in fair value of designated interest rate swaps	—	—	—	—	—	—
Change in funded status of defined benefit pension plans	(575)	—	—	—	—	(575)
Other	(130)	2	(1)	—	131	2
Increase in unrestricted net assets	$ 449	262	123	121	(195)	760

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2011

(In thousands)

Assets	University of Maryland Medical Center	Kernan Hospital, Inc.	University Specialty Hospital, Inc.	Maryland General Hospital, Inc.	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Health System, Inc.	UMMS Foundation	Eliminations	Obligated Group Total
Current assets:										
Cash and cash equivalents	$ 140,420	14,416	2,947	14,551	24,561	13,585	—	—	—	210,480
Assets limited as to use, current portion	37,469		—	986	833	471	—	—	—	39,759
Accounts receivable:										
Patient accounts receivable, less allowance for doubtful accounts of $151,402	152,030	12,026	5,606	12,804	35,324	26,390	—	—	—	244,180
Other	36,716	6,314	323	1,403	1,234	4,276	—	(2,672)	(9,428)	38,166
Inventories	18,119	990	616	2,043	6,014	3,774	—	—	—	31,556
Prepaid expenses and other current assets	39,391	105	24	300	8,759	941	—	1,500	—	51,020
Total current assets	424,145	33,851	9,516	32,087	76,725	49,437	—	(1,172)	(9,428)	615,161
Investments	304,671	13,154	5,303	—	48,420	30,162	—	—	—	401,710
Assets limited as to use, less current portion:										
Debt service funds	41,770	—	—	—	—	—	—	—	—	41,770
Construction funds	146,001	1,997	—	9,867	19,874	3,086	—	—	—	180,825
Board designated and escrow funds	—	—	—	—	—	25,000	—	32,211	—	57,211
Self-insurance trust funds	39,485	—	—	25,326	16,495	11,916	—	—	—	93,222
Funds restricted by donor	—	—	—	3,545	—	3,852	—	21,536	—	28,933
Economic interests in the net assets of related organizations	56,843	34,982	407	735	5,896	59,272	—	—	(59,613)	98,522
	284,099	36,979	407	39,473	42,265	103,126	—	53,747	(59,613)	500,483
Property and equipment, net	717,512	36,569	20,025	91,492	243,873	112,836	—	1,807	—	1,224,114
Deferred financing costs, net	7,547	—	—	—	—	—	—	—	—	7,547
Investments in joint ventures and other assets	201,466	—	—	149	630	8,799	32,969	5,315	(34,733)	214,595
Total assets	$ 1,939,440	120,553	35,251	163,201	411,913	304,360	32,969	59,697	(103,774)	2,963,610

(Continued)

Schedule 5

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2011

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center	Kernan Hospital, Inc.	University Specialty Hospital, Inc.	Maryland General Hospital, Inc.	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Health System, Inc.	UMMS Foundation	Eliminations	Obligated Group Total
Current liabilities:										
Trade accounts payable	$ 103,712	5,763	3,347	9,720	20,766	5,406	—	84	—	148,798
Accrued payroll and benefits	71,642	4,138	2,909	12,252	17,924	13,019	—	—	(228)	121,656
Advances from third-party payors	66,844	3,596	4,697	6,468	8,112	5,287	—	—	—	95,004
Lines of credit	54,600	—	—	—	—	—	—	—	—	54,600
Other current liabilities	79,192	1,600	11,653	4,670	24,434	6,197	—	—	(9,005)	118,741
Long-term debt subject to short-term remarketing arrangements	164,055	—	—	—	—	—	—	—	—	164,055
Current portion of long-term debt	15,051	270	300	884	4,120	1,883	—	—	(133)	22,375
Total current liabilities	555,096	15,367	22,906	33,994	75,356	31,792	—	84	(9,366)	725,229
Long-term debt, less current portion	517,591	12,319	6,956	40,220	187,521	85,845	—	—	—	850,452
Other long-term liabilities	32,272	441	186	24,593	14,987	6,837	—	—	—	79,316
Interest rate swap liabilities	105,400	—	—	—	—	—	—	—	—	105,400
Total liabilities	1,210,359	28,127	30,048	98,807	277,864	124,474	—	84	(9,366)	1,760,397
Net assets:										
Unrestricted	657,739	57,444	4,796	60,114	128,153	155,505	31,266	34,925	(34,795)	1,095,147
Temporarily restricted	70,929	34,982	407	4,280	5,896	12,197	323	6,122	(59,613)	75,523
Permanently restricted	413	—	—	—	—	12,184	1,380	18,566	—	32,543
Total net assets	729,081	92,426	5,203	64,394	134,049	179,886	32,969	59,613	(94,408)	1,203,213
Total liabilities and net assets	$ 1,939,440	120,553	35,251	163,201	411,913	304,360	32,969	59,697	(103,774)	2,963,610

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2010

(In thousands)

Assets	University of Maryland Medical Center	Kernan Hospital, Inc.	University Specialty Hospital, Inc.	Maryland General Hospital, Inc.	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Health System, Inc.	UMMS Foundation	Eliminations	Obligated Group Total
Current assets:										
Cash and cash equivalents	$ 175,378	9,151	2,219	11,538	15,472	16,946	—	—	—	230,704
Assets limited as to use, current portion	36,570	—	—	986	846	471	—	—	—	38,873
Accounts receivable:										
Patient accounts receivable, less allowance for doubtful accounts of $128,261	137,783	13,881	2,733	17,485	35,624	24,196	—	—	—	231,702
Other	40,926	6,886	193	1,215	366	7,806	—	—	(10,567)	46,825
Inventories	17,014	987	556	1,703	5,456	3,785	—	—	—	29,501
Prepaid expenses and other current assets	55,070	15	17	596	8,775	675	—	1,500	—	66,648
Total current assets	462,741	30,920	5,718	33,523	66,539	53,879	—	1,500	(10,567)	644,253
Investments	184,626	11,252	15,330	—	42,121	21,950	—	—	—	275,279
Assets limited as to use, less current portion:										
Debt service funds	39,553	—	—	—	—	—	—	—	—	39,553
Construction funds	160,185	—	—	8,602	28,315	6,987	—	—	—	204,089
Board designated and escrow funds	—	—	—	—	—	25,000	—	27,202	—	52,202
Self-insurance trust funds	38,393	—	—	22,738	11,529	7,351	—	—	—	80,011
Funds restricted by donor	—	—	—	958	—	3,285	—	20,371	—	24,614
Economic interests in the net assets of related organizations	52,158	29,232	390	3,242	5,895	43,255	—	—	(54,828)	79,344
	290,289	29,232	390	35,540	45,739	85,878	—	47,573	(54,828)	479,813
Property and equipment, net	668,500	35,971	18,974	93,537	232,965	114,061	—	1,800	—	1,165,808
Deferred financing costs, net	8,661	—	—	—	—	—	—	—	—	8,661
Investments in joint ventures and other assets	146,393	—	—	163	86	8,396	27,842	4,057	(38,015)	148,922
Total assets	$ 1,761,210	107,375	40,412	162,763	387,450	284,164	27,842	54,930	(103,410)	2,722,736

(Continued)

Schedule 6

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2010

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center	Kernan Hospital, Inc.	University Specialty Hospital, Inc.	Maryland General Hospital, Inc.	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Health System, Inc.	UMMS Foundation	Eliminations	Obligated Group Total
Current liabilities:										
Trade accounts payable	$ 97,956	5,015	3,031	9,150	13,980	9,674	—	102	—	138,908
Accrued payroll and benefits	67,339	3,843	2,826	11,108	16,723	12,068	—	—	(110)	113,797
Advances from third-party payors	61,988	2,445	4,294	6,630	6,010	5,090	—	—	—	86,457
Lines of credit	63,300	—	—	—	—	—	—	—	—	63,300
Other current liabilities	69,794	845	13,943	12,024	26,920	6,038	—	—	(9,895)	119,669
Long-term debt subject to short-term remarketing arrangements	70,069	—	—	—	—	—	—	—	—	70,069
Current portion of long-term debt	27,162	259	300	965	3,961	1,808	—	—	—	34,455
Total current liabilities	457,608	12,407	24,394	39,877	67,594	34,678	—	102	(10,005)	626,655
Long-term debt, less current portion	595,578	12,590	7,256	41,090	191,635	88,158	—	—	(562)	935,745
Other long-term liabilities	36,114	441	357	33,941	18,813	6,210	—	—	—	95,876
Interest rate swap liabilities	128,575	—	—	—	—	—	—	—	—	128,575
Total liabilities	1,217,875	25,438	32,007	114,908	278,042	129,046	—	102	(10,567)	1,786,851
Net assets:										
Unrestricted	486,180	52,705	8,015	43,655	103,513	134,814	26,396	31,324	(38,015)	848,587
Temporarily restricted	56,742	29,232	390	4,200	5,895	9,221	75	5,124	(54,828)	56,051
Permanently restricted	413	—	—	—	—	11,083	1,371	18,380	—	31,247
Total net assets	543,335	81,937	8,405	47,855	109,408	155,118	27,842	54,828	(92,843)	935,885
Total liabilities and net assets	$ 1,761,210	107,375	40,412	162,763	387,450	284,164	27,842	54,930	(103,410)	2,722,736

See accompanying independent auditors' report.

Schedule 7

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Operations Information – Obligated Group

Year ended June 30, 2011

(In thousands)

	University of Maryland Medical Center							Baltimore Washington Medical Center	Shore Health System				Chester River Health System, Inc.	UMMS Foundation	Eliminations	Obligated Group Total
	University Hospital	Shock Trauma Center	Cancer Center	Subtotal	Kernan Hospital	University Specialty	Maryland General Hospital		Memorial Hospital	Dorchester General	QAEC	Subtotal				
Unrestricted revenues, gains and other support:																
Net patient service revenue	$ 1,035,336	193,030	47,828	1,276,194	94,263	52,512	180,958	326,216	164,741	50,010	2,953	217,704	—	—	(447)	2,147,400
Other operating revenue:																
State support	—	3,200	—	3,200	—	—	—	—	—			—	—	—	—	3,200
Other revenue	50,670	1	105	50,776	2,575	326	1,347	3,292	5,598	703	—	6,301	—	—	(575)	64,042
Total unrestricted revenue, gains and other support	1,086,006	196,231	47,933	1,330,170	96,838	52,838	182,305	329,508	170,339	50,713	2,953	224,005	—	—	(1,022)	2,214,642
Operating expenses:																
Salaries, wages, and benefits	481,050	52,905	18,471	552,426	44,786	27,606	85,855	147,837	79,647	24,848	2,075	106,570	—	—	—	965,080
Expendable supplies	194,436	24,629	19,908	238,973	15,127	6,161	16,304	60,399	26,492	5,385	425	32,302	—	—	—	369,266
Purchased services	105,486	52,793	12,245	170,524	18,284	16,591	23,307	49,277	28,805	8,297	215	37,317	—	—	(1,022)	314,278
Contracted services	76,243	10,046	3,227	89,516	7,644	—	22,770	7,830	3,527	2,027	1,436	6,990	—	—	—	134,750
Depreciation and amortization	62,857	4,455	2,289	69,601	3,206	2,347	10,694	22,001	11,413	2,560	511	14,484	—	—	—	122,333
Interest expense	26,881	—	—	26,881	476	861	1,595	5,813	2,779	91	390	3,260	—	—	—	38,886
Provision for bad debts	60,942	36,316	3,895	101,153	6,094	4,467	17,513	21,447	6,396	1,950	89	8,435	—	—	—	159,109
Total operating expenses	1,007,895	181,144	60,035	1,249,074	95,617	58,033	178,038	314,604	159,059	45,158	5,141	209,358	—	—	(1,022)	2,103,702
Operating income (loss)	78,111	15,087	(12,102)	81,096	1,221	(5,195)	4,267	14,904	11,280	5,555	(2,188)	14,647	—	—	—	110,940
Nonoperating income and expenses, net:																
Loss on early extinguishment of debt	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	18,640	—	—	18,640	—	—	—	—	—	—	—	—	—	—	—	18,640
Other nonoperating gains and losses:																
Contributions	—	—	—	—	—	—	—	—	83	—	—	83	—	5,258	—	5,341
Equity in net income of joint ventures	10,366	—	—	10,366	—	—	—	—	—	—	—	—	—	—	3,220	13,586
Investment income	22,771	1,966	806	25,543	280	1,275	290	4,232	692	15	—	707	—	4,362	—	36,689
Change in fair value of investments	16,500	—	—	16,500	1,637	700	152	2,836	8,035	—	—	8,035	—	1,743	—	31,603
Other nonoperating gains and losses	(9,420)	—	—	(9,420)	(185)	—	(550)	(2,821)	(1,071)	(218)	—	(1,289)	—	(2,954)	—	(17,219)
Total other nonoperating gains and losses	40,217	1,966	806	42,989	1,732	1,975	(108)	4,247	7,739	(203)	—	7,536	—	8,409	3,220	70,000
Excess (deficiency) of revenues over expenses	136,968	17,053	(11,296)	142,725	2,953	(3,220)	4,159	19,151	19,019	5,352	(2,188)	22,183	—	8,409	3,220	199,580
Net assets released from restrictions used for purchase of property and equipment	20,815	—	—	20,815	750	—	885	750	764	—	—	764	—	—	—	23,964
Change in unrealized gains on investments	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	—	—	—	—	—	—	—	5,680	—	—	5,680	—	—	—	5,680
Change in ownership interest of joint ventures	2,268	—	—	2,268	—	—	—	—	6,431	—	—	6,431	—	—	—	8,699
Capital transfers (to) from affiliate	3,801	—	—	3,801	1,035	—	1,647	—	(14,350)	—	—	(14,350)	—	(4,883)	—	(12,750)
Change in fair value of designated interest rate swaps	2,298	—	—	2,298	—	—	—	—	—	—	—	—	—	—	—	2,298
Change in funded status of defined benefit pension plans	—	—	—	—	—	—	9,752	4,736	—	—	—	—	—	—	—	14,488
Net gains from nonconsolidated subsidiaries	—	—	—	—	—	—	—	—	—	—	—	—	4,870	—	—	4,870
Other	(348)	—	—	(348)	1	1	16	3	(17)	—	—	(17)	—	75	—	(269)
Increase (decrease) in unrestricted net assets	$ 165,802	17,053	(11,296)	171,559	4,739	(3,219)	16,459	24,640	17,527	5,352	(2,188)	20,691	4,870	3,601	3,220	246,560

See accompanying independent auditors' report.

Schedule 8

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Operations Information – Obligated Group

Year ended June 30, 2010

(In thousands)

	University of Maryland Medical Center								Shore Health System						
	University Hospital	Shock Trauma Center	Cancer Center	Subtotal	Kernan Hospital	University Specialty	Maryland General Hospital	Baltimore Washington Medical Center	Memorial Hospital	Dorchester General	Subtotal	Chester River Health System, Inc.	UMMS Foundation	Eliminations	Obligated Group Total
Unrestricted revenues, gains and other support:															
Net patient service revenue	$ 940,075	175,990	56,393	1,172,458	95,846	54,088	175,997	309,441	154,346	47,371	201,717	—	—	(452)	2,009,095
Other operating revenue:															
State support	—	3,200	—	3,200	—	—	—	—	—	—	—	—	—	—	3,200
Other revenue	47,607	—	179	47,786	2,424	221	1,275	3,251	3,426	1,029	4,455	—	—	(631)	58,781
Total unrestricted revenue, gains and other support	987,682	179,190	56,572	1,223,444	98,270	54,309	177,272	312,692	157,772	48,400	206,172	—	—	(1,083)	2,071,076
Operating expenses:															
Salaries, wages, and benefits	438,885	50,628	17,497	507,010	44,887	28,482	86,133	146,988	78,414	24,960	103,374	—	—	—	916,874
Expendable supplies	184,160	24,013	17,971	226,144	15,104	6,011	15,551	54,425	23,337	5,520	28,857	—	—	—	346,092
Purchased services	89,905	40,370	16,090	146,365	16,930	14,331	25,323	50,292	26,847	9,265	36,112	—	—	(1,083)	288,270
Contracted services	77,651	9,147	3,710	90,508	7,636	—	22,793	8,457	3,823	2,084	5,907	—	—	—	135,301
Depreciation and amortization	55,132	4,219	2,446	61,797	2,990	2,068	9,440	21,124	11,339	2,680	14,019	—	—	—	111,438
Interest expense	28,721	—	27	28,748	556	885	1,092	4,904	2,186	265	2,451	—	—	—	38,636
Provision for bad debts	60,668	37,459	5,414	103,541	8,990	5,742	14,013	19,507	6,454	1,997	8,451	—	—	—	160,244
Total operating expenses	935,122	165,836	63,155	1,164,113	97,093	57,519	174,345	305,697	152,400	46,771	199,171	—	—	(1,083)	1,996,855
Operating income (loss)	52,560	13,354	(6,583)	59,331	1,177	(3,210)	2,927	6,995	5,372	1,629	7,001	—	—	—	74,221
Nonoperating income and expenses, net:															
Loss on early extinguishment of debt	(816)	—	—	(816)	—	—	—	—	—	—	—	—	—	—	(816)
Change in fair value of undesignated interest rate swaps	(33,700)	—	—	(33,700)	—	—	—	—	—	—	—	—	—	—	(33,700)
Other nonoperating gains and losses:															
Contributions	—	—	—	—	—	—	—	—	240	—	240	—	6,927	—	7,167
Equity in net income of joint ventures	(3,789)	—	—	(3,789)	—	—	—	—	—	—	—	—	—	1,417	(2,372)
Investment income (loss)	(1,273)	1,966	806	1,499	271	39	(428)	292	(1,255)	39	(1,216)	—	1,065	—	1,522
Change in fair value of investments	18,502	—	—	18,502	1,038	1,721	3,255	5,862	7,052	5	7,057	—	1,888	—	39,323
Other nonoperating gains and losses	(2,205)	—	—	(2,205)	20	33	(1,999)	(4,556)	(1,497)	9	(1,488)	—	(3,264)	—	(13,459)
Total other nonoperating gains and losses	11,235	1,966	806	14,007	1,329	1,793	828	1,598	4,540	53	4,593	—	6,616	1,417	32,181
Excess (deficiency) of revenues over expenses	29,279	15,320	(5,777)	38,822	2,506	(1,417)	3,755	8,593	9,912	1,682	11,594	—	6,616	1,417	71,886
Net assets released from restrictions used for purchase of property and equipment	7,336	—	—	7,336	750	—	26,563	1,000	1,090	—	1,090	—	(4,127)	—	32,612
Change in unrealized gains on investments	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	—	—	—	—	—	—	—	4,332	—	4,332	—	—	—	4,332
Change in ownership interest of joint ventures	3,478	—	—	3,478	—	—	—	—	—	—	—	—	—	—	3,478
Capital transfers (to) from affiliate	—	—	—	—	—	—	(220)	—	(5,827)	—	(5,827)	—	—	—	(6,047)
Change in fair value of designated interest rate swaps	(7,408)	—	—	(7,408)	—	—	—	—	(2)	—	(2)	—	—	—	(7,410)
Change in funded status of defined benefit pension plans	—	—	—	—	—	—	(3,830)	(361)	—	—	—	—	—	—	(4,191)
Net gains (losses) from nonconsolidated subsidiaries	—	—	—	—	—	—	—	—	—	—	—	760	—	—	760
Other	13	—	—	13	—	—	18	(1)	(14)	—	(14)	—	1	—	17
Increase (decrease) in unrestricted net assets	$ 32,698	15,320	(5,777)	42,241	3,256	(1,417)	26,286	9,231	9,491	1,682	11,173	760	2,490	1,417	95,437

See accompanying independent auditors' report.

MARYLAND HEALTH CARE COMMISSION

Certificate of Need

TO:	Jeffrey L. Johnson, Vice President Shore Health System The Memorial Hospital at Easton 219 South Washington Street Easton, Maryland 21601	September 14, 2004 (Date)
RE:	Establishment of a Twenty-Bed Acute Inpatient Rehabilitation Unit at The Memorial Hospital at Easton	03-20-2128 (Docket No.)

PROJECT DESCRIPTION

The Memorial Hospital at Easton ("Memorial-Easton"), a 132-bed acute general hospital in Talbot County on Maryland's Eastern Shore, has sought Certificate of Need ("CON") approval to establish a twenty-bed acute inpatient rehabilitation unit, providing comprehensive integrated inpatient rehabilitation ("CIIR") services in what is now the Memorial-Easton subacute care unit, on the hospital's fifth floor. The area intended for the proposed rehabilitation unit currently houses a skilled nursing unit with 33 comprehensive care facility beds; Memorial-Easton will seek authorization for temporary delicensure of these beds, and understands that it must obtain Commission action through an exemption from CON review for the permanent closure of the comprehensive care service at the hospital, pursuant to Health-General Article § 19-120(l)(2), Annotated Code of Maryland.

In order to convert its use to inpatient rehabilitation, Memorial-Easton will undertake a major interior renovation of the Five-South Unit, originally constructed in 1966, that would affect a total of 14,300 square feet of current hospital space. This includes 7,200 square feet to house the 20 inpatient rehabilitation beds (arrayed as 4 private and 8 semi-private patient rooms) and standard support space, to conform to the requirements of the 2001 edition of the *American Institute of Architects Guidelines for Design and Construction of Hospitals and Health Care Facilities*, and of the Americans with Disabilities Act; 4,200 square feet for rehabilitation spaces (including a gym, space for dining and recreation, and a kitchen and bathroom facilities for therapies related to activities of daily living) and also offices for the rehabilitation staff; 1,700 square feet for mechanical needs, utilities, stairs, elevators, and other structural details; and 1,200 square feet of space for use by staff of Memorial-Easton's Maternal Health Unit, to replace space taken by the rehabilitation renovations.

Memorial-Easton proposes to complete its construction-level architectural design for the rehabilitation unit within five months of CON approval, and to complete construction over 15 months, in two phases. Memorial-Easton estimates that the total cost to convert the 33-bed hospital-based skilled nursing facility to a 20-bed rehabilitation unit will be $4,287,520. Of this

total, proposed current capital costs account for $3,785,000, $422,520 is budgeted as an inflation allowance and for capitalized construction interest, and $80,000 is allocated to financing costs and other cash requirements, including legal and auditing costs. The source of funds for the Memorial-Easton project will be $230,000 in cash, and $4,057,520 in authorized bonds, issued by the Maryland Health and Higher Education Facilities Authority, although a later communication from Memorial-Easton explained that the hospital may also investigate the possibility of self-funding the project, rather than seeking a bond issue from MHHEFA.

ORDER

The Maryland Health Care Commission has reviewed Staff's report and recommendation on the Certificate of Need application submitted by The Memorial Hospital at Easton, and, based on this analysis and the record in this review, approved its application for Certificate of Need on September 14, 2004. The Commission imposed no additional conditions on the approval.

In accordance with COMAR 10.24.01.12C(3)(c), the project is subject to the following performance requirements:

1. Obligation of not less than 51% of the approved capital expenditure, as documented by a binding construction contract, by March 14, 2006, 18 months after the September 14, 2004 Certificate of Need approval;

2. Initiation of construction within four (4) months of the effective date of the binding construction contract;

3. Documentation from Memorial-Easton that it has completed the project; received a State license, if licensure is required, or has otherwise met all applicable legal requirements to begin operation; and has begun to provide the approved service, within 18 months of the effective date of the binding construction contract.

Memorial-Easton must notify the Commission when the hospital executes the binding construction contract, because the deadlines for meeting the second and third performance requirements are set based on the compliance with Performance Requirement 1.

Commission regulations at COMAR 10.24.01.13B require Memorial-Easton to submit quarterly status reports, beginning December 14, 2004, three months from the date of this Certificate of Need, and continuing through the completion of the project.

Before making any changes to the facts in the Certificate of Need application approved by the Commission, Memorial-Easton must notify the Commission in writing and receive Commission approval of each proposed change, including the obligation of any funds above those approved by the Commission in this Certificate of Need, in accordance with COMAR 10.24.01.17.

The project's 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 the project's drawings and specifications that the law requires to be submitted and approved prior to the initiation of construction.

Please acknowledge in writing within thirty days that you have received this Certificate of Need, and that you accept its terms and conditions.

MARYLAND HEALTH CARE COMMISSION

Barbara Gill McLean
Executive Director

cc: Carol Benner, Office of Health Care Quality
Kathleen Foster, Health Officer, Talbot County
Howard Jones, Office of Plans Review, DHMH
Robert Murray, Executive Director, HSCRC

MARYLAND HEALTH CARE COMMISSION

Certificate of Need

TO: Jeffrey L. Johnson, Vice President
Shore Health System
219 South Washington Street
Easton, Maryland 21601

July 17, 2003
(Date)

RE: Capital Renovation and Expansion to
Memorial Hospital at Easton

03-20-2112
(Docket Number)

PROJECT DESCRIPTION

The Memorial Hospital at Easton (Memorial-Easton), located in Talbot County, is a 132-bed acute general hospital with a 33-bed comprehensive care facility. The hospital provides a complete range of inpatient and outpatient services, and has served residents of Talbot, Caroline, Dorchester, Queen Anne's and surrounding counties since 1907. Memorial-Easton applied for Certificate of Need approval from the Maryland Health Care Commission to renovate its Telemetry Unit, relocate and expand its Emergency Department, reconfigure space for outpatient services, and upgrade its heating, ventilating, and air-conditioning system and other elements of its infrastructure. No new services will be initiated as part of this project, and no additional beds will be required as a result of the expansion and renovation. The project's total capital cost is estimated at $33,430,000. The Health Services Cost Review Commission reviewed the project's capital expenditure and financial projections and found it financially feasible, even without a 2.5 percent rate increase, for which Memorial-Hospital intends to apply.

This project will be completed in two primary phases over two years: Phase 1, the construction of the Telemetry Unit, is to begin in August 2003, and be completed in August 2004; Phase 2 of the project, construction of a new Emergency Department and Outpatient Services space, will begin in January 2004, and be completed in 2005.

ORDER

The Commission has reviewed Staff's analysis, and, based on Staff's recommendation and the record in this matter, has awarded the project a Certificate of Need.

Memorial-Easton must submit quarterly status reports to the Commission, beginning three months from the date of Certificate of Need approval, and continuing through the completion of the project. In accordance with COMAR 10.24.01.12B, .12C(3), and .12C(4), 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 no later than **July 17, 2005, 24** months after Certificate of Need approval.

2. Initiation of construction within **four (4) months** of the effective date of the binding construction contract;

3. Documentation from Memorial-Easton that the approved project has been completed, and has met all applicable legal requirements within **24** months of the required binding construction contract.

Failure to meet these performance requirements will render incomplete 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.

If it is necessary to make any changes to the approved project before the first use of the expanded and renovated facility, the Memorial Hospital at Easton must notify the Commission, and must receive Commission approval of the proposed change, including the obligation of any funds above those approved by the Commission in this Certificate of Need, in accordance with COMAR 10.24.01.17.

The project's architect or engineer is required to contact the Plans Review and Approval office of the Department of Health and Mental Hygiene, to ascertain the specific information concerning project drawings and specifications that the law requires to be submitted and approved prior to the initiation of construction.

Since this project will be undertaken by an existing, operating health care facility, and none of its components require separate or additional licensure, the Commission requests notification of the completion at least 30 days before first use of the new or renovated space.

Please acknowledge in writing within 30 days that you have received this Certificate of Need, and accept its terms and conditions.

MARYLAND HEALTH CARE COMMISSION

Barbara Gill McLean
Executive Director

BGM/at
cc: Carol Benner
Brian Dubey
Robert Murray

Exhibit 21
Physical Bed Chart

Hospital Name: Memorial Hospital at Easton **Date:** 8/16/2012

Inventory of Patient Room and Physical Bed Capacity

Existing Physical Capacity						After Project Completion						
		Room Count			Bed Count			Room Count			Bed Count	
Location (Floor/Building)	Hospital Service*	Total Rooms	Semi-Pvt	Private	Physical Capacity	Location (Floor/Building)	Hospital Service*	Total Rooms	Semi-Pvt	Private	Physical Capacity	NOTES
2 East	MedSurg	25	6	19	31	Level 02	Pediatric	6		6	6	
3 East	Surgical	20	10	10	30	Level 03	Obstetric	14		14	14	
4 East	Neuro	8	2	6	10	Level 03	General Med/Surg	20		20	20	
4 Center	ICU	10	0	10	10	Level 04	Joint/ Neuro	18		18	18	
4 East South	Joint	8	2	6	10	Level 04	Physical Rehab	20		20	20	One room used as private but has 2 sets gases
						Leve 05	Telemetry	22		22	22	
3 South	Sleep Lab	4	0	4	4	Level 05	Intensive/Critical Care	10		10	10	
5 East	Birthing C	7		7	7	Level 06	General Med/Surg	22		22	22	
Antepartum	Birthing C	6		6	6							four of these rooms have gases also for baby
OR section 5E	Birthing C	1		1	1							
PACU 5E	Birthing C	1		1	1							
Nursery 5E	Birthing C	10			0							birthing stations
Triage 5E	Birthing C	3		3	3							
3 Center	Resp/Cardio	7	1	6	8							These were once patient rooms and now are offices or work areas but have gases 6 rooms have single gases and the one one has 2 sets

Location (Floor/Building)	Existing Physical Capacity					After Project Completion						NOTES
		Room Count			Bed Count			Room Count			Bed Count	
	Hospital Service*	Total Rooms	Semi-Pvt	Private	Physical Capacity	Location (Floor/Building)	Hospital Service*	Total Rooms	Semi-Pvt	Private	Physical Capacity	
3 South	Peds	10	5	4	14							One room now used as an office but has two sets of gases to accommodate infant isolettes; A second room counted as a private has two sets of gases to accommodate isolettes.
4 South	Telemetry	24	4	20	28							
2 South	Renal	5	0	5	5							One room used as spill over but has no gases
5 South	Rehab	12	8	4	20							
	Procrit	1	0	1	1							
TOTAL		**162**	**38**	**113**	**189**			**132**	**0**	**132**	**132**	

* See list of service categories below

Totals by Service					Totals by Service				
General Med/Surg	97	25	72	122	**General Med/Surg**	82	0	82	82
Intensive/Critical Care	10	0	10	10	**Intensive/Critical Care**	10	0	10	10
Pediatric	10	5	4	14	**Pediatric**	6	0	6	6
Obstetric	28	0	18	18	**Obstetric**	14	0	14	14
Acute Psychiatric	0	0	0	0	**Acute Psychiatric**	0	0	0	0
Other (Renal, Procrit, Sleep, Rehab)	17	8	9	25	**Other (Rhab)**	20	0	20	20

Exhibit 22

AFFIRMATIONS

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.

Ruth Ann Jones
Signature

9/5/2012
Date

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.

Anthony Kelly
Signature

9.5.12
Date

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.

Kathleen McGrath
Signature

9/5/12
Date

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.

Signature Christopher Mitchell

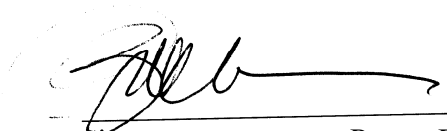
9/6/12

Date

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.

Signature Christopher Pettit Date 9/5/12

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.



Signature Penny Pink

9/5/2012

Date

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.

Signature William Roth

Date 9/5/12

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.

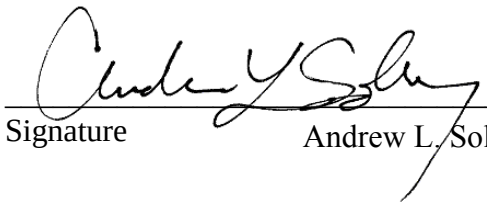
M. Silgu

Signature

9-5-2013

Date

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.



Signature Andrew L. Solberg

9/5//2012

Date

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.

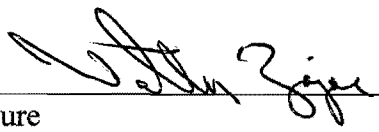
Patti L. Willis

Signature

09-05-12

Date

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.



Signature

9/5/2012

Date