CERTIFICATE OF NEED APPLICATION

SPECIAL PSYCHIATRIC HOSPITAL

THE UNIVERSITY OF MARYLAND

UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS AT

HAVRE de GRACE

Applicant:

University of Maryland Upper Chesapeake Health System, Inc.

August 4, 2017

TABLE OF CONTENTS

Page

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION....1
1. FACILITY.... 1
2. OWNER.... 1
3. APPLICANT. 1
4. NAME OF LICENSEE OR PROPOSED LICENSEE 1
5. LEGAL STRUCTURE OF APPLICANT 2
6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED.... 2
7. TYPE OF PROJECT 4
8. PROJECT DESCRIPTION 4
A. Executive Summary of the Project: 4
B. Comprehensive Project Description: 5
I. Project Overview 6
II. Harford and Cecil County Regional Collaborative for Behavioral Health Planning 7
III. UC Behavioral Health Physical Plant and Project Design 8
IV. Construction Plans....10
9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES....11
10. REQUIRED APPROVALS AND SITE CONTROL....11
11. PROJECT SCHEDULE 13
12. PROJECT DRAWINGS 14
13. FEATURES OF PROJECT CONSTRUCTION....14
PART II - PROJECT BUDGET....17
PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE 18
PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3)....20
COMAR 10.24.10 – ACUTE CARE HOSPITAL SERVICES CHAPTER 21
.04 STANDARDS 21
A. General Standards....21
(1) Information Regarding Charges. 21
(2) Charity Care Policy. 21
(3) Quality of Care....22

COMAR 10.24.07 – PSYCHIATRIC SERVICES CHAPTER 25
APPROVAL POLICIES 25
Availability 25
Accessibility 28
Accessibility: Variant LHPA Standard 31
Quality 33
Acceptability 34
10.24.01.08G(3)(b). Need. 36
10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives. 47
A. Planning Process for the Proposed Project and Alternatives Considered 47
B. Marshall Valuation Service Analysis 55
10.24.01.08G(3)(d). Viability of the Proposal. 61
10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need. 62
10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System. 64

For internal staff use

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **University of Maryland Upper Chesapeake Medical Campus Behavioral Health Pavilion**

Address:

210 Barker Lane	**Havre De Grace**	**21708**	**Harford**
Street	City	Zip	County

Name of Owner (if differs from applicant):

2. OWNER

Name of owner: **University of Maryland Upper Chesapeake Health System, Inc.**

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

Legal Name of Project Applicant
University of Maryland Upper Chesapeake Health System, Inc.

Address:

520 Upper Chesapeake Drive	**Bel Air**	**21014**	**MD**	**Harford**
Street	City	Zip	State	County

Telephone: **443-643-3374**

Name of Owner/Chief Executive: **Lyle E. Sheldon, FACHE**

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from applicant:

University of Maryland Upper Chesapeake Medical Center, Inc.

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

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

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☒	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation Maryland - 06/20/1984
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☐	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☐	

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

A. Lead or primary contact:

Name and Title: Robin Luxon, FACHE, Vice President, Corporate Planning, Marketing & Business Development, University of Maryland Upper Chesapeake Health System

Mailing Address:

520 Upper Chesapeake Drive	Bel Air	21014	MD
Street	City	Zip	State

Telephone: 443-643-3741

E-mail Address (required): RLuxon@uchs.org

Fax:

B. Additional or alternate contact:

Name and Title: Joseph E. Hoffman III, Executive Vice President/CFO and Compliance Officer, University of Maryland Upper Chesapeake Health System

Mailing Address:

520 Upper Chesapeake Drive	Bel Air	21014	MD
Street	City	Zip	State

Telephone: 443-643-3340

E-mail Address (required): JHoffman@uchs.org

Fax:

Name and Title: Aaron Rabinowitz, Vice President, General Counsel, University of Maryland Upper Chesapeake Health System

Mailing Address:

520 Upper Chesapeake Drive	Bel Air	21014	MD
Street	City	Zip	State

Telephone: 443-643-3374

E-mail Address (required): ARabinowitz@uchs.org

Fax:

Name and Title: Andrew L. Solberg, A.L.S. Healthcare Consultant Services

Mailing Address:

5612 Thicket Lane	Columbia	21044	MD
Street	City	Zip	State

Telephone: 410-730-2664

E-mail Address (required): asolberg@earthlink.net

Fax:

Name and Title: James C. Buck, Gallagher Evelius & Jones, LLP

Mailing Address:

218 North Charles Street	Baltimore	21201	MD
Street	City	Zip	State

Telephone: 410-347-1353

E-mail Address (required): jbuck@gejlaw.com

Fax: 410-468-2786

7. TYPE OF PROJECT

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

If approved, this CON would result in:

(1)	A new health care facility built, developed, or established	☒
(2)	An existing health care facility moved to another site	☐
(3)	A change in the bed capacity of a health care facility	☐
(4)	A change in the type or scope of any health care service offered by a health care facility	☐
(5)	A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf	☐

8. PROJECT DESCRIPTION

A. Executive Summary of the Project:

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

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

Applicant Response:

University of Maryland Upper Chesapeake Health System, Inc. ("UM UCH") seeks to establish the University of Maryland Upper Chesapeake Medical Campus Behavioral Health Pavilion ("UC Behavioral Health"), a secure, self-contained, and state-of-the-art 67,632 square foot special psychiatric hospital on a thirty-two acre parcel of land located at 210 Barker Lane in Havre De Grace, Maryland, located just off of Interstate 95.[1] The proposed psychiatric hospital

1. The overall 67,632 square feet includes 55,524 of space dedicated exclusively to UC Behavioral Health and a 52% allocation of 23,285 square feet of public and administrative space that will be shared between UC Behavioral Health and the freestanding medical facility that will be developed on top of UC Behavioral Health. Accordingly, 12,108 square feet of space to be shared between UC Behavioral Health and the freestanding medical facility (52% of 23,285) has been allocated to the proposed project. The allocation of shared space between the UC Behavioral Health and the freestanding medical facility was calculated pro-rata based on the gross square foot size of each facility.

includes a forty (40) bed adult psychiatric inpatient unit organized into three separate "neighborhoods" to serve male and female patients from young adults (over age 18) to seniors. One twelve (12) bed neighborhood will be principally dedicated to geriatric psychiatry. The other two neighborhoods will each contain fourteen (14) adult non-geriatric psychiatric beds. In addition to inpatient behavioral health services, UC Behavioral Health will provide a broad array of outpatient services, including a partial hospitalization program, an intensive outpatient program, and a variety of outpatient, ambulatory behavioral health services, which will allow patients to transition through multiple stages of treatment at one centralized location.

The proposed special psychiatric hospital is part of an overall strategic plan by UM UCH to create an optimal patient care delivery system for the future health care needs of Harford and Cecil County residents, which comprise a population of 360,000. Contemporaneous with this application, UM UCH's constituent hospitals have applied for exemptions from Certificate of Need ("CON") review to convert the University of Maryland Harford Memorial Hospital ("HMH") to a freestanding medical facility and to transfer inpatient MSGA beds from HMH to the University of Maryland Upper Chesapeake Medical Center ("UCMC") as part of a merger and consolidation of these two facilities.

If the Maryland Health Care Commission approves the conversion of HMH to a freestanding medical facility, HMH's currently licensed twenty-nine (29) psychiatric beds will be delicensed, thereby leaving a vacuum in inpatient psychiatric services in northeast Maryland which UM UCH proposes to fill with the proposed UC Behavioral Health. Additionally, if the Commission approves UM UCH's proposed UC Behavioral Health, Union Hospital of Cecil County is expected to delicense its eleven (11) currently licensed psychiatric beds. Thus, the proposed project will consolidate and replace acute psychiatric capacity in Harford and Cecil Counties in a location central to the two acute general hospitals that will remain following the conversion of HMH to a freestanding medical facility. The proposed project will maintain convenient patient access to inpatient and outpatient behavioral health services while achieving efficiencies and overall cost savings for the health care delivery system.

The total projected cost of the special psychiatric hospital is $52,421,120.

B. Comprehensive Project Description:

The description must include details, as applicable, regarding:

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

Applicant Response:

PROJECT DESCRIPTION

I. Project Overview

UM UCH is a community based, not-for-profit health system located in Harford County, Maryland. UM UCH is dedicated to maintaining and improving the health of the people in the communities it serves through an integrated health delivery system that provides the highest quality of care to all. UM UCHS has been affiliated with the University of Maryland Medical System ("UMMS") since 2009, and in late 2013, UM UCHS formally merged into UMMS in order to continue its commitment to the growing northeast Maryland area with expanded clinical services, programs and facilities, and physician recruitment. UM UCHS presently consists of: (1) HMH, an acute care hospital with 57 licensed medical/surgical/gynecological/addictions ("MSGA") beds and 29 licensed psychiatric beds located in Havre de Grace; (2) UCMC, a 171-bed licensed acute care hospital, with 160 MSGA beds, 10 obstetrics beds, and 1 pediatric bed, located in Bel Air; (3) the Patricia D. and M. Scot Kaufman Cancer Center (an affiliate of the University of Maryland Marlene and Stewart Greenebaum Cancer Center) located on the campus of UCMC; and (4) the Senator Bob Hooper House, a residential hospice facility in Forest Hill.

HMH was constructed in phases between 1943 and 1972. Although UM UCH has been committed to maintaining the facility and has undertaken capital expenditures to make infrastructure, clinical equipment, and information technology improvements, the existing physical plant has simply outlived its useful life. Renovation of the facility is not cost-effective and the nine (9) acre site in downtown Havre De Grace is surrounded by existing developed parcels, limiting a practical opportunity for renovation or expansion. Consistent with local and national healthcare trends and to best promote access to convenient and quality care for the population it serves, UM UCHS proposes to transition portions of HMH to a multi-service facility to be located on an approximate ninety-seven (97) acre property known as the Upper Chesapeake Health Medical Campus at Havre de Grace ("UC Medical Campus at Havre de Grace"), approximately three miles from the existing HMH campus and conveniently located off of Interstate 95. As described above, UC Behavioral Health will replace and consolidate acute psychiatric services in Harford and Cecil Counties in one centralized location. UC Behavioral Health will be connected with a freestanding medical facility ("UC FMF") that will be a fully functional, full service emergency department, open 24/7 with the capability of caring for patients experiencing medical emergencies. Moreover, UC FMF will also have a dedicated unit for patients suffering from behavioral health emergencies and will conveniently screen and transfer such patients on-site to UC Behavioral Health if an inpatient stay is warranted. Both of these facilities will be located on Lot 1, on the UC Medical Campus at Havre de Grace, which lot is approximately thirty-two (32) acres. UC FMF will also support the medical needs of UC Behavioral Health patients by providing imaging, diagnostic, laboratory, and pharmacy services to UC Behavioral Health patients requiring such services.

Also planned for the UC Medical Campus at Havre de Grace is a medical office building at which patients can receive primary and specialty care physician services, as well as a full complement of outpatient radiology services, laboratory testing, pharmacy services, and physical and occupational rehabilitation services.

II. Harford and Cecil County Regional Collaborative for Behavioral Health Planning

In 2015, UM UCH, its constituent hospitals (HMH and UCMC), and Union Hospital of Cecil County ("Union Hospital") created the Regional Collaborative for Behavioral Health ("Regional Collaborative") to create a public/private behavioral health partnership across the two suburban/rural counties. The goal of the Regional Collaborative is to coordinate and facilitate access to services for individuals in need of behavioral health services.

Prior to the Regional Collaborative, behavioral health in Harford and Cecil Counties was under-resourced, lacking in psychiatric providers and program services. Inadequate access to behavioral health services required residents to travel long distances to receive care and resulted in unserved needs. Further impacting the inadequacy of services was the use of hospital MSGA units for behavioral health treatment space which requires significant and frequent upgrades and renovations to ensure patient safety, mitigate risk, and provide an appropriate physical space to facilitate optimal behavioral health treatment for the population served. Continuous environmental disruptions negatively affected patient experience and the respective hospital's behavioral health team members' satisfaction.

As part of the Regional Collaborative's strategic planning process, a new hospital campus was envisioned to best serve the behavioral health needs of the region and to fulfill the Regional Collaborative's mission to create a healthier and vibrant community through provision of regionally coordinated, exceptional behavioral health care utilizing the latest, evidenced-based treatment modalities and services.

UM UCH has determined that consolidation and centralization of acute behavioral health hospital services for the Regional Collaborative's service area will assist in solving several regional access issues while also developing a hub-and-spoke model for the provision of acute and outpatient behavioral health services. UM UCH determined that combining and consolidating acute behavioral health services into a new, state-of-the-art, forty (40) bed facility with single patient rooms would provide a safer care environment with modern safety and security tools, utilize consistent standards of assessment and treatment, provide better patient experiences, leading to better patient outcomes. Consolidation and centralization of acute behavioral health hospital services will also create opportunities for enhanced employee engagement, more effective recruitment and retention strategies, more efficient staff utilization, and a much improved environment for patients and families. Union Hospital supports UM UCH's assessment and the proposed project.

While building toward this new campus, the Regional Collaborative partners have been empowered to create a true continuum of care across the region. An array of outpatient behavioral health services continues to be developed at HMH, including outpatient psychotherapy, medication management, an intensive outpatient program, and a partial hospitalization program. These outpatient programs will be fully established and integrated upon the opening of the UC Behavioral Health and will be relocated to UC Behavioral Health to support regional efforts of avoiding unnecessary admissions and providing a continuum of post-discharge and outpatient services to ensure patients' successful transitions back into the community. Maintaining an array of inpatient and outpatient behavioral health services at UC Behavioral Health will improve access to care for patients and their families.

Additional “spokes” (outpatient and crisis services) are also being developed at UCMC and Union Hospital to provide patients with fluid access to an array of behavioral health services. More specifically, UCMC will provide outpatient therapy and medication management services in addition to behavioral health consultation services in MSGA units, in its emergency department, as well as at community primary care and specialty practices. Additionally, a Behavioral Health Crisis Center is contemplated to address immediate behavioral health needs while diverting patients from emergency departments and with the goal of reducing unnecessary inpatient utilization.

Regional Collaborative members have also been partnering with other providers to provide enhanced access and more efficient and effective referrals and patient handoffs following acute inpatient behavioral health admissions. Partnering efforts with community-based providers has already begun to pay dividends. Nationally known Ashley Addiction Services is providing substance use disorder outpatient and intensive outpatient services at both the UCMC and Union Hospital campuses. The intent is for Ashley to provide similar services at the Union Crisis Center and likely, UC Behavioral Health. Discussions are underway to create a stronger partnership with Upper Bay Counseling Services, which is the largest single provider of community-based behavioral health services in the region. Further, UM UCH is engaged in ongoing efforts with UMMS to access tele-psychiatry tools, provide for resident rotations, and other educational opportunities to enhance behavioral health services across the region. Other partnership efforts are ongoing in the continued effort to create easy access to care, enhance treatment options, and provide exceptional patient experience within any location and service in the regional system of care.

The proposed project is central to the Regional Collaborative’s efforts and continued success in coordinating and facilitating access to behavioral health services at the appropriate acuity level.

III. UC Behavioral Health Physical Plant and Project Design

The UC Medical Campus at Havre de Grace will be organized around two main program components: (1) UC Behavioral Health, a 67,632 gross square foot, special psychiatric hospital located on the building’s ground floor; and (2) an approximate 61,977 gross square foot freestanding medical facility on the building’s first floor. The combined total gross square footage of these components is approximately 129,609. Both facilities have been designed to be constructed considering existing topography at UC Medical Campus at Havre de Grace. UC Behavioral Health, on the ground floor, will be constructed into the side of a hill and the freestanding medical facility will be stacked on top UC Behavioral Health with a separate entrance.

UC Behavioral Health will provide both inpatient and outpatient behavioral health services. UC Behavioral Health is organized and designed around the following ten fundamental elements of behavioral health delivery: 1. Self-direction; 2. Individualized and person-centered care; 3. Empowerment; 4. Holistic; 5. Achievement of full potential; 6. Strength-based; 7. Peer support; 8. Respect; 9. Responsibility; and 10. Hope. The programming and design of the proposed project is framed by the following guiding principles:

1. Behavioral health services should be recovery-oriented;

2. Behavioral health services should be provided in a therapeutically enriching environment;

3. Behavioral health services should be provided in a safe and secure environment;

4. Behavioral health services should be integrated and coordinated; and

5. Behavioral health services should be provided in settings that respect and can accommodate a diverse range of populations and care needs.

Both UC Behavioral Health and UC FMF were designed in accordance with the Facilities Guidelines Institute, Guidelines for Design and Construction Of Hospitals and Outpatient Facilities 2014 Edition ("FGI Guidelines"), the 2015 National Fire and Protection Association 101 Life Safety Code, and the 2015 International Building Code. More specifically, UC Behavioral Health was designed in accordance with the FGI Guidelines, Part 2 – Hospitals; Section 2.5 – Specific Requirements for Psychiatric Hospitals. The proposed project meets the requirements of the FGI Guidelines while also taking advantage of provisions allowing for dual-use of certain program spaces (i.e. consultation, conference and charting rooms; space for group therapy and quiet space; and building support spaces which are shared with the freestanding medical facility on the floor above).

1. Inpatient Programming Space

The proposed inpatient programmatic space has forty (40) private rooms, each 11' x 15', and is organized into three (3) patient neighborhoods. Two of the three neighborhoods will serve a general adult population (male and female, over 18 years of age) suffering from one or more non-geriatric psychiatric diagnoses. Each of these neighborhoods will have fourteen (14) beds and is organized around a central great room containing the activities of daily living, therapy, staff and support spaces. The third neighborhood will serve the geriatric population (male and female) suffering from neurological disorders such as Alzheimer's and/or Dementia. The geriatric neighborhood has twelve (12) beds and is organized around a central great room containing the activities of daily living, therapy, staff and support spaces. Each neighborhood has access to a secure courtyard allowing patients to have safe access to the outside. The courtyards also bring natural daylight into the main great room of each neighborhood.

Patients admitted to any of the inpatient neighborhoods that have been diagnosed with a co-occurring medical diagnosis or issue will receive a medical assessment and follow-up during their course of treatment by a medicine specialist (e.g. internist, hospitalist) dedicated to serving UC Behavioral Health inpatients. The medicine specialist will work closely with the applicable inpatient unit psychiatrist/psychiatric nurse practitioner to ensure integrated treatment of all co-occurring patient diagnoses and issues.

Patients will be admitted to the inpatient neighborhoods directly from other acute general or special hospitals or following an assessment at the freestanding medical facility located on the floor above. Two intake centers are centrally located within UC Behavioral Health to receive patients and process their admissions.

Please note the FGI Guidelines do not require minimum or maximum ranges of overall program area/square footage, but rather prescribe minimum requirements, including some minimum square footage/clear floor area requirements based on the functional program for the project (e.g., Section 2.5-2.2.2.2 Patient Bedroom Space requirements. Patient bedrooms shall have a minimum clear floor area of 100 square feet for single-bed rooms). The proposed project currently includes 169.7 square feet for the single-bed patient rooms. This allows for the patient bed and other required furniture such as a chair and patient storage and writing desk to be accommodated in the room, leaving more than the 100 square feet of clear floor area as required by the FGI Guidelines.

With forty (40) inpatient beds, the proposed project is: (1) 1,970.25 gross square feet per inpatient bed, including the outpatient behavioral health therapy program and the facility support space; and (2) 1,597.73 gross square feet per inpatient bed, including the facility support space, but not including the outpatient behavioral health therapy program. This proposed project/program square footage per bed falls well within the expected and customary range for such facilities.

2. Outpatient Programming Space

UC Behavioral Health's outpatient programming space includes 14,900 gross square feet. Co-locating these services on the same site as the inpatient behavioral health program and the freestanding medical facility with a behavioral health crisis space creates a stronger, integrated behavioral health program to maximize the efficiency of space, staffing, and operations. The proposed project will increase patient, family, and staff satisfaction and enhance outcomes for the patient populations being served. It will also afford greater and easier access to the appropriate level of care for behavioral health patients across the region.

The outpatient behavioral health program will include program support spaces for an intensive outpatient program, a partial hospitalization program, group and individual therapy, and counseling services along with required staff and support spaces.

Outpatients using the intensive outpatient, partial hospitalization, and group and individual therapy programs will arrive and access the facility via the outpatient behavioral health entry located on the ground floor of the building. This entrance will also have a drive-through canopy. A staff entry is located at the rear of the facility, adjacent to the loading dock.

3. Ancillary and Support Space

Education space, conference space, and dietary and dining services are also located on the ground floor. Also included on the ground floor are administration, information technology, support services, including materials management and loading dock, mechanical, electrical and plumbing spaces, environmental services, medical gas, linen storage, and public bathrooms. This ancillary and support services area, consisting of approximately 23,285 gross square feet, will be shared between UC Behavioral Health and the freestanding medical facility.

IV. Construction Plans

The total project is expected to take fifty-two (52) months from grant of a CON through completion of construction. Building design, site approvals, permitting, and pre-construction site work, including extensive grading of the project site, will take approximately twenty-three

months after the grant of a CON. UM UCH will obligate 51% of capital expenditures through a binding construction contract within twenty-three (23) months. Within four (4) months of entering into a construction contract, construction will commence. Construction will be completed within twenty-five (25) months. The proposed construction plan is consistent with the performance requirements set forth at COMAR 10.24.01.12(C)(3).

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

Applicant Response:

Table B is attached at **Exhibit 1**.

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

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

Applicant Response:

Table A is attached at **Exhibit 1**.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: ___32__ 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 project site is situated within the City of Havre de Grace in Harford County and is zoned Mixed Office Employment ("MOE"). Pursuant to Havre de Grace City Code Article VIII, Sections 205-29 *et seq*., hospital and medical office uses are permitted in the MOE zone. The project site is located on proposed Lot 1, a 32 acre lot, on the north campus of the project site known as Upper Chesapeake Health Medical Campus at Havre de Grace. The north campus consists of 6 lots on 62.12 acres. The site plan for the north campus was approved by the Havre de Grace Planning Commission on January 14, 2013 and remains valid through January 1, 2018. The approved site plan will require minor revisions due to the amended building configuration and parking layout on Lot 1. The Havre de Grace Department of Planning has determined these revisions to be minor and the site plan does not require additional review or approval by the Planning Commission.

The Maryland Department of Environment ("MDE") has issued permits for construction of 600,000 gallon water tank, booster station and water main plans and updates to the Graceview Water Pumping Station to service the project site.

Storm water management and sediment erosion control plans will require approval by the Havre de Grace Department of Public Works and Harford County Soil Conservation District. UM UCH anticipates approvals its storm water design and sediment and erosion control plans by July 1, 2018. Upon approval of these

plans, UM UCH must seek a grading permit to commence grading on the project site. Following CON approval, UM UCH anticipates issuance of a grading permit from the City of Havre de Grace by August 1, 2018.

UM UCH also has applied to the MDE for a permit to fill a small amount of wetlands and disturbance of wetland buffers. UM UCH has received comments from the MDE and anticipates receipt of a permit by June 1, 2018.

In order to remove an existing house and farm structures on the project site, UM UCH will need to apply for a demolition permit from the Havre de Grace Department of Public Works. A demolition permit is expected to be issued by October 15, 2017.

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

(1) Owned by: The proposed site of Lot 1 is owned by UCHS/UMMS Venture, LLC, a joint venture between UM UCH and UMMS, organized for the purpose of facilitating and enhancing the quality of health care within Harford and Cecil Counties. A copy of the ALTA/ASCM Land Title Survey showing the overall land holdings at the UC Medical Campus at Havre de Grace of UCHS/UMMS Venture, LLC, Upper Chesapeake Land Development, LLC, a subsidiary of UM UCH, and UCHS/UMMS Real Estate Trust, another joint venture between UCH and UMMS, is attached as **Exhibit 3**. Copies of deeds for these land holdings are also attached as **Exhibit 3**.

Please provide a copy of the deed.

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

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

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

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

11. PROJECT SCHEDULE

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

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date	23	months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	4	months
Completion of project from capital obligation or purchase order, as applicable	25	months
Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract		months
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.		months
Initiation of Construction within 4 months of the effective date of the binding construction contract.		months
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract		months
Fill out the following section for each phase. (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase		months
Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date		months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1		months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.		months
To Be Completed for each subsequent Phase of Construction		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase		months
Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase		months

	Completion of each phase within 24 months of the effective date of binding construction contract for that phase		months

12. PROJECT DRAWINGS

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

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

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

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

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

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

Applicant Response:

See **Exhibit 2**.

13. FEATURES OF PROJECT CONSTRUCTION

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

Applicant Response:

Tables C and **D** are attached at **Exhibit 1**.

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

Applicant Response:

Utilities (water, sewerage, electricity, etc.) must be brought to the property line. The applicant and its consultants have discussed the proposed project with the City of Havre de Grace and utility companies to ensure that utility access will be accomplished in time for construction of the proposed buildings upon CON approval.

The property is identified on the Harford County Water and Sewer Master Plan as W3 and S3, 0-5 year service area category. The property is required to be within the service area as shown on the Master Plan prior to plan approvals.

A. Water: A 600,000 gallon elevated water tank, water booster station and water mains are required to serve the entire UC Medical Campus at Havre de Grace of which Lot 1 is only a portion. The water tank and upgraded water mains will also serve nearby properties. In addition, upgrades to the existing Graceview Water Booster Station are needed. The upgrades to serve the "third pressure zone" include three new pumps and electrical improvements. Construction of the tank and water main upgrade is anticipated to take one year and construction is anticipated to commence concurrent with mass grading operations on the project site.

B. Sewer: A 12" sewer main must be extended from Monarchos Drive to the project site. The sewer mains from the property to the City of Havre de Grace treatment plant runs through three existing sewage pumping stations, which have adequate carrying capacity for the project site. Extension of the sewer to the project site, Lot 1, is planned to take two months. No additional easements are needed.

C. Storm Drains: A conveyance system will be designed and built to collect surface runoff from parking lots and drives. Roof drain connections will also be designed and built to collect runoff from the proposed buildings into the storm drain conveyance system. There is an existing pond on site which is planned to be enhanced and enlarged to provide quantity management for additional storm drain runoff. A series of Best Management Practices (BMP) such as bio-retention and general wetlands will be designed and built to provide water quality measures in compliance with local and Maryland Department of the Environment requirements. Construction of the storm water management practices will occur after mass grading operations are complete and are anticipated to take two months. The storm drain conveyance system will be completed prior to paving operations and completed during the construction of the building.

D. Natural Gas: Natural gas is provided by Baltimore Gas & Electric (BGE). Existing BGE gas mains are located in Bulle Rock Parkway and will need to be extended to the project site. BGE has indicated there is sufficient pressure and quantity of natural gas in the area to serve the proposed project. The extension of the gas main will occur during building construction.

E. Electrical Power: BGE is the electric provider. Existing electric lines are located nearby along MD Route 155. Underground electric lines will be required to be extended from MD Route 155 to the property. BGE has indicated there is adequate power in the area to meet the needs of the project on Lot 1. The extension of the electric lines will occur early in the building construction phase.

F. Telephone: Verizon is the principal telephone provider in the area. Verizon has indicated there are lines in the area to provide service to the proposed project. Underground lines will need to be extended to the property line. The extension of the communication lines will occur during the building construction.

PART II - PROJECT BUDGET

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

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

Applicant Response:

Table E is attached at **Exhibit 1**.

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

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

   University of Maryland Upper Chesapeake Health System, Inc., 520 Upper Chesapeake Drive, Bel Air, MD 21014.

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

   Not applicable.

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

   No.

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

   No.

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2,

above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

No.

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

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

August 1, 2017
Date

Signature of Owner or Board-designated Official

President and Chief Executive Officer
Position/Title

Lyle E. Sheldon
Printed Name

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

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

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

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

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

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

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

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

COMAR 10.24.10 – ACUTE CARE HOSPITAL SERVICES CHAPTER

.04 STANDARDS

A. General Standards.

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

(1) Information Regarding Charges.

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

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;
(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and
(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

Applicant Response:

UM UCH's policy, implemented at both UCMC and HMH, relating to transparency in health care pricing complies with this standard and is attached as **Exhibit 4**. This policy will be extended to UC Behavioral Health when it opens.

(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 ED 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.

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

Applicant Response:

UM UCH's financial assistance policy, implemented at both UCMC and HMH, complies with this standard and is attached as **Exhibit 5**. This policy will be implemented at UC Behavioral Health upon opening.

(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.

(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 percent level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

Applicant Response:

UC Behavioral Health will comply with requirements issued by Maryland Department of Health (formerly the Department of Health and Mental Hygiene) for licensure as a special psychiatric hospital, be accredited by the Joint Commission, and comply with all conditions of participation in the Medicare and Medicaid programs.

The Commission has recognized that "subpart (b) of this standard is essentially obsolete in that it requires an improvement plan for any measure that falls within the bottom quartile of all hospitals' reported performance on that measure as reported in the most recent Maryland [Hospital Evaluation Performance Guide], which has been reengineered with a different focus,

and no longer compiles percentile standings." *In re Dimensions Health Corporation*, Docket No. 13-16-2351, Decision at 19 (Sept. 30, 2016).

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

Table 1
Below-Average Quality Measures and Corrective Action

Quality Measure	Corrective Action Plan
Communication	
How often did doctors always communicate well with patients?	UCMC's Patient Experience Plan includes several strategies to improve physician communication including: language of caring education, direct observations of physician interactions with patients, and structured bedside rounding with physicians and nurses to communicate each patient's plan of care and to answer patient questions.
Were patients always given information about what to do during their recovery at home?	UCMC's Patient Experience Committee as well as the Transition of Care Committee work plans include revision of patient discharge educational materials and the implementation of a new interactive patient engagement system to include patient specific education plans, patient portal registration, and an extensive library of education videos.
Environment	
How often did patients always receive help quickly from hospital staff?	UCMC's Patient Experience Plan includes several strategies to improve responsiveness to patient needs including hourly care rounds and change of shift report at the patient's bedside. New reports have been developed to monitor and improve response time to patient call bells.
How often was the area around patients' rooms always kept quiet at night?	UCMC is implementing several strategies to reduce noise including noise stoplights at nurses station to increase staff awareness of noise levels, reducing noise from delivery carts by changing cart wheels, reducing deliveries during night hours ,and implementing "quiet times" at designated times to promote uninterrupted rest.

Quality Measure	Corrective Action Plan
Satisfaction Overall	
Would patients recommend the hospital to friends and family?	UCMC is currently expanding its Patient and Family Advisory Council to facilitate active participation on hospital committees to ensure that patient input is included in the development of hospital policies and procedures. UCMC is also increasing community awareness of hospital services through ongoing community education forums and enhanced social media strategies.
Wait Times	
How long patients spent in the emergency department before being sent home? How long patients spent in the emergency department before they were seen by a healthcare professional?	In furtherance of UM UCH's fiscal year 2018 strategic objective for efficient care, a process improvement team has been charged to review Emergency Department ("ED") throughput and efficiency. Specifically, the work group will utilize the organization's IMPRV methodology to improve the ED's average length of stay and the times from "door to doctor." Executive oversight for this initiative will be driven through the Patient & Family Centered Care Oversight Committee and performance improvements will be monitored through an system-wide scorecard.
Results of Care	
Dying within 30-days after getting care in the hospital for a heart attack.	An HSCRC-funded grant program was implemented during FY2017. The Wellness Action Teams of Cecil & Harford (WATCH) program provides home visits with a team consisting of an RN, pharmacist, and case manager to monitor and improve medication compliance and disease management for patients with congestive heart failure and other comorbid conditions associated with heart attack, e.g., hypertension and diabetes mellitus. This initiative will help to ensure that proper care is provided to patients who received care for a heart attack at UCMC.

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

COMAR 10.24.07 – PSYCHIATRIC SERVICES CHAPTER

APPROVAL POLICIES

Availability

AP 1a. The projected maximum bed need for child, adolescent, and adult acute psychiatric beds is calculated using the Commission's statewide child, adolescent, and adult acute psychiatric bed need projection methodologies specified in this section of the State Health Plan. Applicants for Certificates of Need must state how many child, adolescent, and adult acute psychiatric beds they are applying for in each of the following categories: net acute psychiatric bed need, and/or state hospital conversion bed need.

Applicant Response:

The proposed project includes forty (40) adult psychiatric beds to be organized into three units or neighborhoods. Two separate units will each include fourteen (14) beds to treat non-geriatric adult patients suffering from one or more psychiatric diagnoses. A third unit will include

twelve (12) adult geriatric psychiatric beds to treat patients suffering primarily from a neurological disorder such as Alzheimer's and/or Dementia.

There is no current or recent Commission statewide child, adolescent, or adult bed need projection. Moreover, the bed need projection methodologies set forth in the State Health Plan for Psychiatric Services are outdated and obsolete. UM UCH has projected need for the proposed facility in response to Standard 10.24.01.08G(3)(b), pp. 36-46.

AP 1b. A Certificate of Need applicant must document that it has complied with any delicensing requirements in the State Health Plan or in the Hospital Capacity Plan before its application will be considered.

Applicant Response:

This standard is inapplicable; there are no delicensing requirements applicable to the proposed project.

AP 1c. The Commission will not docket a Certificate of Need application for the "state hospital conversion bed need" as defined, unless the applicant documents written agreements with the Mental Hygiene Administration. The written agreements between the applicant and the Mental Hygiene Administration will specify:

(i) the applicant's agreement to screen, evaluate, diagnose and treat patients who would otherwise be admitted to state psychiatric hospitals. These patients will include: the uninsured and underinsured, involuntary, Medicaid and Medicare recipients;

(ii) that an equal or greater number of operating beds in state facilities which would have served acute psychiatric patients residing in the jurisdiction of the applicant hospital will be closed and delicensed, when the beds for the former state patients become operational;

(iii) that all patients seeking admission to the applicant's facility will be admitted to the applicant's facility and not be transferred to the state psychiatric hospital unless the applicant documents that the patient cannot be treated in its facility; and

(iv) that the applicant and the Mental Hygiene (MHA) Administration will be responsible for assuring financial viability of the services, including the payment of bad debt by DHMH as specified in the written agreement between MHA and the applicant.

Applicant Response:

This standard is inapplicable; the proposed project does not involve state hospital conversion beds.

AP 1d. Preference will be given to Certificate of Need applicants applying for the "net adjusted acute psychiatric bed need," as defined, who sign a written agreement with the Mental Hygiene Administration as described in part (i) and (iii) of Standard AP 1 c.

Applicant Response:

This standard is inapplicable; this project does not involve a comparative review.

AP 2a. All acute general hospitals with psychiatric units must have written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 days a week with no special limitation for weekends or late night shifts.

Applicant Response:

This standard is inapplicable; the proposed project does not involve an acute general hospital with a psychiatric unit.

AP 2b. Any acute general hospital containing an identifiable psychiatric unit must be an emergency facility, designated by the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition.

Applicant Response:

This standard is inapplicable; the proposed project does not involve an acute general hospital with a psychiatric unit.

AP 2c. Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.

Applicant Response:

This standard is inapplicable; the proposed project does not involve an acute general hospital with a psychiatric unit.

AP 3a. Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

Applicant Response:

UC Behavioral Health's acute inpatient psychiatric program will include each of the services required by this standard. The program will be accredited by the Joint Commission.

AP 3b. In addition to the services mandated in Standard 3a., inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills, psychoeducational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.

Applicant Response:

This standard is inapplicable because the proposed project does not involve either inpatient child or adolescent acute psychiatric services.

AP 3c. All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.

Applicant Response:

This standard is inapplicable; the proposed project does not involve an acute general hospital.

AP 4a. A Certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.

Applicant Response:

UC Behavioral Health seeks a Certificate of Need for adult acute psychiatric beds only.

AP 4b. Certificate of Need applicants proposing to provide two or more age specific acute psychiatric services must provide that physical separations and clinical/programmatic distinctions are made between the patient groups.

Applicant Response:

Based on the definition of age-specific acute psychiatric services defined in Standard AP 4a., this standard is inapplicable because the proposed project does not involve two or more age-specific psychiatric service lines. UC Behavioral Health seeks a CON for adult acute psychiatric beds only. UC Behavioral Health proposes to establish clinically district adult geriatric and non-geriatric programs. The adult geriatric program will be housed in its own neighborhood separate from the two neighborhoods serving adult non-geriatric behavioral health patients.

Accessibility

AP 5. Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:

(i) intake screening and admission;

(ii) arrangements for transfer to a more appropriate facility for care if medically indicated; or

(iii) necessary evaluation to define the patient's psychiatric problem and/or

(iv) emergency treatment.

Applicant Response:

1. **Intake screening and admissions**: Upon referral for inpatient admission to UC Behavioral Health from the freestanding medical facility, each case will be reviewed by on-site behavioral health consultants (evaluators) and the on-call psychiatrist/psychiatric nurse practitioner to evaluate the case and make an appropriate admission decision. Personnel in the freestanding medical facility will ensure medical stability prior to any inpatient psychiatric admission. The freestanding medical facility will determine the cases as categories I, II or III as appropriate. UC Behavioral Health will also accept direct admissions from acute general hospitals and special hospitals. Patients being referred for direct admission will be processed for admission through two patient intake centers centrally located at UC Behavioral Health.

2. **Transfers to more appropriate facilities for care if medically indicated**: If a patient is in need of medical attention that exceeds UC Behavioral Health's ability to effectively treat the individual, the patient will be transported to the freestanding medical facility on the floor above if appropriate or the nearest, appropriate general acute care hospital (likely UCMC or Union Hospital) utilizing the most appropriate transportation for that individual case or the freestanding.

3. **Necessary evaluation to define the patient's psychiatric problem**: All patients admitted for acute psychiatric care from the freestanding medical facility will have had an initial behavioral health assessment completed by a behavioral health consultant in the freestanding medical facility and a full psychiatric assessment will be completed by the inpatient unit psychiatrist/psychiatric nurse practitioner within 24 hours of admission. Patients directly admitted from acute general hospitals, emergency departments, or other special hospitals, will undergo a full psychiatric assessment by the inpatient unit psychiatrist/psychiatric nurse practitioner within 24 hours of admission.

4. **Emergency treatment**: UC Behavioral Health's inpatient unit is designed to stabilize and treat the acute behavioral health conditions of individuals who present a danger to themselves or others. UC Behavioral Health's inpatient units will provide all necessary interventions via 24/7 nursing and on-site or on-call psychiatrists/psychiatric nurse practitioners. Assessment and interventions for presenting co-occurring medical conditions will be assessed at triage and on an ongoing basis via nursing and the on-site or on-call psychiatrists/psychiatric nurse practitioners with referral for on-unit medical consultation as necessary.

A copy of UM UCH's current Emergency Department Behavioral Health Protocols is attached as **Exhibit 6**. A copy UM UCH's current Transportation Standard Operating Procedure is attached as **Exhibit 7**. A copy of UM UCH's current Behavioral Health Inpatient Admission Policies and Procedures are attached as **Exhibit 8**. Each of these protocols, policies, and procedures will be updated as appropriate upon opening of UC Behavioral Health.

AP 6. All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special populations including: children, adolescents, patients with secondary diagnosis of substance use, and geriatric patients, either through direct treatment or referral.

Applicant Response:

As set forth in the comprehensive project description, UC Behavioral Health intends to provide two (2) units of general behavioral health acute inpatient care (mental illness and co-occurring secondary substance use) and one (1) unit of Geriatric Behavioral Health acute inpatient care (mental illness and secondary substance use).

Copies of UM UCH's Patient Safety and Quality Plan, a Patient Safety and Quality Plan Addendum for UC Behavioral Health, and Behavioral Health Performance Improvement Plan is attached as **Exhibit 9**.

AP 7. An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.

Applicant Response:

UC Behavioral Health's inpatient units will routinely accept patients who are admitted as either "voluntary" or "involuntary" with regard to their legal status and without discrimination. UC Behavioral Health will accept patients admitted on certificates.

AP 8. All acute general hospitals and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the Health Services Cost Review Commission for the most recent 12 month period.

Applicant Response:

UC Behavioral Health intends to provide a level of uncompensated care that equals or exceeds the average of uncompensated for acute psychiatric patients in the service area.

As explained in the response to COMAR 10.24.01.08G(3)(b) below, UC Behavioral Health's projected service area includes Harford and Cecil Counties. The current providers of acute psychiatric services in this service area include HMH and Union Hospital. UC Behavioral Health's percentage of uncompensated care is projected to be based on HMH's fiscal year 2016 uncompensated care of 6.17%. This level of uncompensated care was published in the HSCRC's Final Recommendations for the Uncompensated Care Policy for Rate Year 2018, dated July 12, 2017, that is based on FY2016 data. This is the most recent data that is available and reflects the level of uncompensated care for the entire hospital.

HMH's percentage of uncompensated care is greater than the average 5.49% of uncompensated care provided by HMH and Union Hospital, the two acute general hospitals providing psychiatric services in the health service area. (Table 2).

Table 2
Harford Memorial Hospital Uncompensated Care

Hospital Name	FY 2016 Percent UCC from the RE Schedule
University of Maryland Harford Memorial Hospital	6.17%
Union Hospital of Cecil County	4.80%
Average UCC in the Health Service Area	**5.49%**

Source: HSCRC's Final Recommendations for the Uncompensated Care Policy for Rate Year 2018, dated July 12, 2017

AP 9. If there are no child acute psychiatric beds available within a 45 minute travel time under normal road conditions, then an acute child psychiatric patient may be admitted, if appropriate, to a general pediatric bed. These hospitals must develop appropriate treatment protocols to ensure a therapeutically safe environment for those child psychiatric patients treated in general pediatric beds.

Applicant Response:

This standard is inapplicable; the proposed project does not involve child or adolescent services. Additionally, child/adolescent services are available within a 45 minute travel time to Baltimore.

Accessibility: Variant LHPA Standard

(Western Maryland) One-way travel time by car for 90 percent of the population from the jurisdiction(s) where acute psychiatric bed need is identified should be within 30 minutes for adults and 45 minutes for children and adolescents. (This standard supersedes the 1983-1988 State Health Plan Overview Standards 0 1a and 0 1b.)

Applicant Response:

This standard is inapplicable because the project is not in Western Maryland.

AP 10. Expansion of existing adult acute psychiatric bed capacity will not be approved in any hospital that has a psychiatric unit that does not meet the following occupancy standards for two consecutive years prior to formal submission of the application.

Psychiatric Bed Range (PBR)	Occupancy Standards
PBR <20	80%
20 ≤PBR <40	85%
PBR ≥40	90%

Applicant Response:

This standard is inapplicable because the proposed project does not involve expansion of existing adult care psychiatric beds.

AP 11. Private psychiatric hospitals applying for a Certificate of Need for acute psychiatric beds must document that the age-adjusted average total cost for an acute (≤ 30 days) psychiatric admission is no more than the age-adjusted average total cost per acute psychiatric admission in acute general psychiatric units in the local health planning area.

Applicant Response:

The local health planning region was defined as Baltimore City, Harford, Cecil, Anne Arundel, Baltimore, Carroll, and Howard Counties. The average age adjusted charge per case was based on fiscal year 2016 total cases and average charge per case for each age group in the local health planning region. After adjusting for the UC Behavioral Health fiscal year 2022 projected cases and case mix index, the age adjusted average charge per case for the local health planning area totaled of $11,874. When compared to UC Behavioral Health's fiscal year 2022 projected age adjusted charge per case, priced leveled to fiscal year 2016 prices, the average aged adjusted charge per cases was $11,445 or 3.6% less than the local health planning region.

Table 3
Local Health Planning Region Age-Adjusted Psychiatric Discharges

	Health Planning Area Acute Hospitals [1]				UC Behavioral Health		
	A	B	C	D = B/C	E	F	G = D*E*F
Age Group	Cases	Average Charge per Case	CMI	Average Charge per Case @ CMI of 1.0	UC Behavioral Health Projected Cases	UC Behavioral Health Projected Case Mix	UC Behavioral Health Cases @ Health Area Average
Ages 0-4	6	$29,059	0.9832	$29,557	-	-	$0
Ages 5-14	849	13,040	0.5957	21,890	-	-	-
Ages 15-44	10,036	9,921	0.6372	15,570	817	0.5708	7,259,496
Ages 45-54	3,736	10,511	0.6667	15,764	279	0.5938	2,609,112
Ages 55-64	2,330	13,360	0.7075	18,882	200	0.6134	2,320,273
Ages 65-74	821	17,897	0.7760	23,063	168	1.0524	4,068,487
Ages 75-84	388	17,900	0.7788	22,984	69	1.0393	1,648,708
Ages 85+	316	14,143	0.7653	18,481	35	1.0848	711,622
Total	**18,482**	**$11,217**	**0.6616**	**$16,956**	**1,568**	**0.6641**	**$18,617,697**
Average Age Adjusted Charge per Case in Local Health Planning Region							**$11,874**
UC Behavioral Health Projected Charge per Case [2]							**$11,445**

Notes:
[1] Health planning region includes Harford County, Baltimore City, Baltimore County, Anne Arundel County, Carroll County, Howard County, and Cecil County
[2] UC Behavioral Health FY 2022 projected charge per case price levelled to FY 2016 prices
[3] Includes DRGs 750-760 and 779-790

Quality

AP 12a. Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

Applicant Response:

All inpatient behavioral health services at UC Behavioral Health will be under the clinical supervision of a qualified psychiatrist who is trained and qualified to provide the leadership required for acute psychiatric inpatient services. Dr. Richard Lewis, M.D., is a board certified psychiatrist who serves as the Chair of Psychiatry for UM UCH and as the Medical Director for the Regional Collaborative for Behavioral Health for Harford and Cecil Counties. He provides clinical supervision to all psychiatrists, psychiatric nurse practitioners, and clinical psychologists presently on staff at UM UCH. All psychiatrists on staff meet the training requirements and are certified by the American Board of Psychiatry and Neurology. UM UCH's Chairman/Medical Director monitors and evaluates the quality and appropriateness of services and treatment provided by its medical staff. It is anticipated the two general behavioral health inpatient units at UC Behavioral Health will be overseen by a medical director (currently expected to be Brittni Jones, DO) and the specialty geriatric unit will be overseen by a geriatric psychiatrist to serve as geriatric medical director.

AP 12b. Staffing of acute psychiatric programs should include therapies for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven day per week treatment program.

Applicant Response:

The multidisciplinary team at UC Behavioral Health will include psychiatrists, psychiatric nurse practitioners, licensed clinical social workers, clinical psychologists, registered nurses, nursing aides, licensed clinical professional counselors, family therapists, and occupational/recreation therapists. Patients will be assigned a social worker/therapist during the course of their inpatient stay. Upon discharge, each patient will receive an individual aftercare plan that will have been developed by the treatment team in collaboration with the patient and their supports as appropriate. A care navigator will follow-up with all patients after discharge to confirm an appointment within a lesser level of care, assure the referral to that services was helpful and offer any additional supports as warranted.

UC Behavioral Health's inpatient treatment programs will serve as short-term acute care service that provides active treatment and programming for patients seven days per week. A psychiatrist/psychiatric nurse practitioner will see patients during the week and on weekends and at least one will be on call 24/7. Social workers and activity therapists will provide group and individual therapy seven days per week.

AP 12c. Child and/or adolescent acute psychiatric units must include staff who have experience and training in child and/or adolescent acute psychiatric care, respectively.

Applicant Response:

This standard is inapplicable because the proposed project does not involve child or adolescent psychiatric units.

AP 13. Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

Applicant Response:

UC Behavioral Health's continuum of care will combine many programs, policies, practices and resources within the system to treat behavioral health disorders in support of affected individuals. The continuum will include services ranging from acute inpatient to outpatient services such as partial hospitalization, intensive outpatient, individual and group therapy, and medication management. In addition, an array of outpatient (including specialty such as substance use) services are available in the region and referrals will be made to any/all of these services as appropriate. At discharge, patients admitted to the behavioral health units will be referred to services appropriate to their needs and based on their choice that could be within the health system array of services or to another community provider. Upon discharge, the hospital unit will follow-up to the referral site with appropriate information to ensure an effective handoff.

Acceptability

AP 14. Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

(i) the local and state mental health advisory council(s);

(ii) the local community mental health center(s);

(iii) the Department of Health and Mental Hygiene; and

(iv) the city/county mental health department(s).

Letters from other consumer organizations are encouraged.

Applicant Response:

Letters in support of the proposed project, including from local mental health advisory councils, departments, and mental health centers, are attached as **Exhibit 10.**

Table 4
Local Health Planning Region Age-Adjusted Psychiatric Discharges

	Health Planning Area Acute Hospitals [1]				UC Behavioral Health		
	A	B	C	D = B/C	E	F	G = D*E*F
Age Group	Cases	Average Charge per Case	CMI	Average Charge per Case @ CMI of 1.0	UC Behavioral Health Projected Cases	UC Behavioral Health Projected Case Mix	UC Behavioral Health Cases @ Health Area Average
Ages 0-4	6	$29,059	0.9832	$29,557	-	-	$0
Ages 5-14	849	13,040	0.5957	21,890	-	-	-
Ages 15-44	10,036	9,921	0.6372	15,570	817	0.5708	7,259,496
Ages 45-54	3,736	10,511	0.6667	15,764	279	0.5938	2,609,112
Ages 55-64	2,330	13,360	0.7075	18,882	200	0.6134	2,320,273
Ages 65-74	821	17,897	0.7760	23,063	168	1.0524	4,068,487
Ages 75-84	388	17,900	0.7788	22,984	69	1.0393	1,648,708
Ages 85+	316	14,143	0.7653	18,481	35	1.0848	711,622
Total	**18,482**	**$11,217**	**0.6616**	**$16,956**	**1,568**	**0.6641**	**$18,617,697**
Average Age Adjusted Charge per Case in Local Health Planning Region							**$11,874**
UC Behavioral Health Projected Charge per Case [2]							**$11,445**

Notes:
[1] Health planning region includes Harford County, Baltimore City, Baltimore County, Anne Arundel County, Carroll County, Howard County, and Cecil County
[2] UC Behavioral Health FY 2022 projected charge per case price levelled to FY 2016 prices
[3] Includes DRGs 750-760 and 779-790

10.24.01.08G(3)(b). Need.

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

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

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

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

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

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

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

Applicant Response:

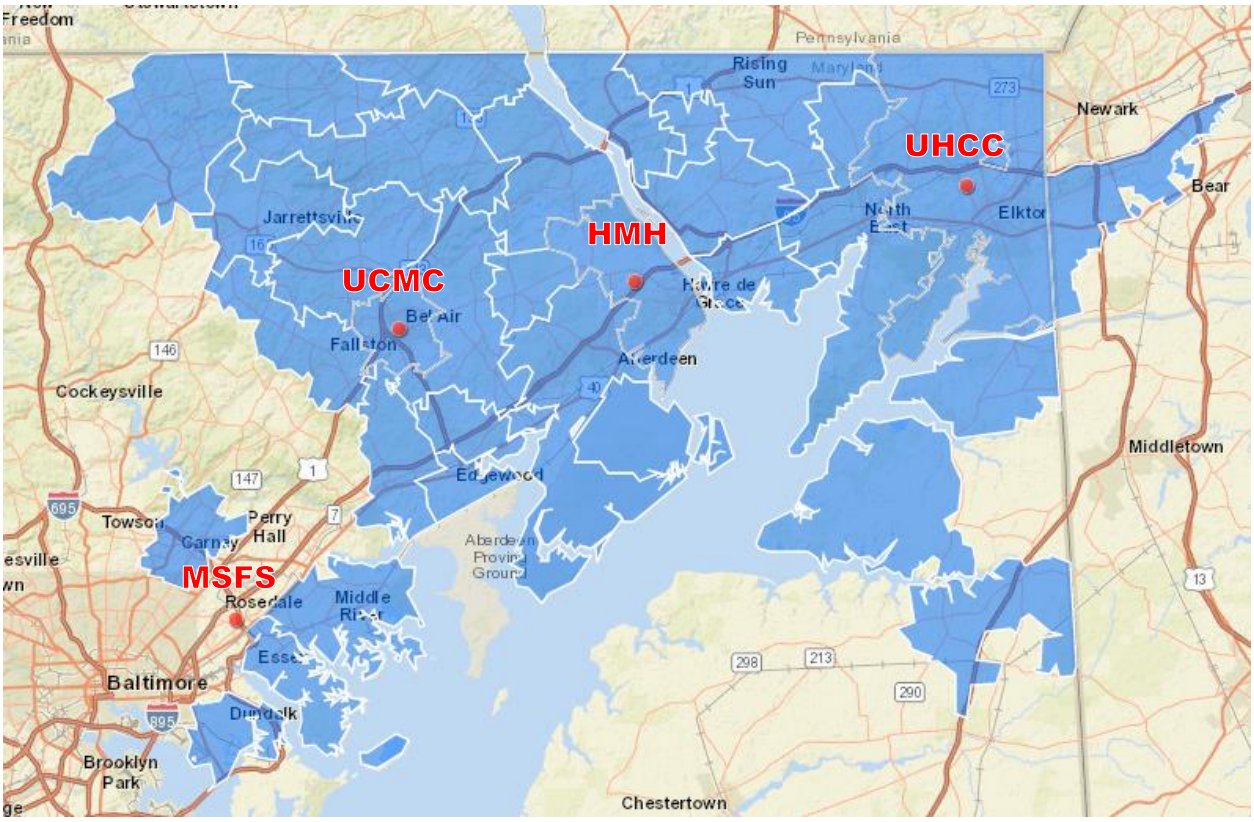
The Commission has recognized that many of the standards in the State Health Plan Chapter for Psychiatric Services are "out of date due to dramatic changes in use of hospital psychiatric beds (especially with respect to average length of stay) and changes in the role and scope of State psychiatric hospital facilities that have occurred since its development" and that the State Health Plan "does not have an applicable need analysis." *In re Sheppard Pratt at Elkridge*, Docket No. 15-152367, Staff Report and Recommendation at 5, 13 (Sept. 20, 2016).

To project psychiatric bed need for UC Behavioral Health, UM UCH utilized a modified medical/surgical/gynecological/addictions ("MSGA") need analysis. UM UCH separately calculated need for its proposed geriatric and adult non-geriatric programs. The projected need

for inpatient psychiatric beds and outpatient utilization reflect the methodology and assumptions described below.

1. Defining UC Behavioral Health's New Service Area

The proposed UC Behavioral Health special psychiatric hospital is expected to replace both the existing twenty-six (26) licensed psychiatric beds at Harford Memorial Hospital ("HMH") and the eleven (11) licensed psychiatric beds at Union Hospital of Cecil County ("Union Hospital"). As a result, to project the proposed UC Behavioral Health service area, UM UCH combined the fiscal year 2016 discharges by zip code for the adult (aged 18 and over) psychiatric cohort at both HMH and Union Hospital. Pediatric discharges were excluded from this analysis because HMH does not currently provide psychiatric inpatient treatment to pediatric patients and UC Behavioral Health will not provide pediatric psychiatric services either. UM UCH identified the service area for UC Behavioral Health as the top 85% of discharges by zip code for HMH's and Union Hospital's FY2016 combined adult psychiatric discharges.



As presented in the map above and below in Table 5, UC Behavioral Health's proposed service area for the adult (age 18+) psychiatric cohort is defined by zip codes that span Harford, Cecil, Baltimore, and Kent Counties in Maryland as well as New Castle County, Delaware. As shown in Table 5, zip codes for combined adult psychiatric discharges for HMH and Union Hospital are ranked from highest to lowest to identify the top 85% of total discharges.

Table 5
Defining UC Behavioral Health's Service Area
Psychiatric Discharges Age 18+
FY2016

#	Zip Code	Community	County	Discharges HMH	Discharges UHCC	Discharges Total	Cumulative % of Discharges
1	21921	Elkton	Cecil County	22	309	331	17.1%
2	21001	Aberdeen	Harford County	194	8	202	27.6%
3	21040	Edgewood	Harford County	137	1	138	34.7%
4	21014	Bel Air	Harford County	126	2	128	41.3%
5	21078	Havre De Grace	Harford County	119	4	123	47.7%
6	21901	North East	Cecil County	17	83	100	52.9%
7	21009	Abingdon	Harford County	91	1	92	57.6%
8	21015	Bel Air	Harford County	63	1	64	60.9%
9	21904	Port Deposit	Cecil County	34	17	51	63.6%
10	21903	Perryville	Cecil County	30	19	49	66.1%
11	21050	Forest Hill	Harford County	46	2	48	68.6%
12	21085	Joppa	Harford County	41	4	45	70.9%
13	21017	Belcamp	Harford County	42	-	42	73.1%
14	21911	Rising Sun	Cecil County	17	24	41	75.2%
15	21918	Conowingo	Cecil County	12	9	21	76.3%
16	21047	Fallston	Harford County	20	-	20	77.3%
17	21084	Jarrettsville	Harford County	16	-	16	78.2%
18	21154	Street	Harford County	15	-	15	78.9%
19	21028	Churchville	Harford County	10	1	11	79.5%
20	21915	Chesapeake City	Cecil County	-	11	11	80.1%
21	21220	Middle River	Baltimore County	10	-	10	80.6%
22	21914	Charlestown	Cecil County	-	10	10	81.1%
23	21917	Colora	Cecil County	8	1	9	81.6%
24	21005	Aberdeen Proving Ground	Harford County	8	-	8	82.0%
25	21919	Earleville	Cecil County	1	6	7	82.4%
26	21132	Pylesville	Harford County	7	-	7	82.7%
27	21034	Darlington	Harford County	6	-	6	83.0%
28	21922	Elkton	Cecil County	-	6	6	83.3%
29	19702	Newark	New Castle County	-	6	6	83.7%
30	21635	Galena	Kent County	-	5	5	83.9%
31	21222	Dundalk	Baltimore County	3	2	5	84.2%
32	21160	Whiteford	Harford County	5	-	5	84.4%
33	21234	Parkville	Baltimore County	4	-	4	84.6%
34	21221	Essex	Baltimore County	3	1	4	84.8%
35	21161	White Hall	Baltimore County	4	-	4	85.0%
		Subtotal 2016 Service Area		**1,111**	**533**	**1,644**	
		Out of Service Area		150	139	289	15.0%
		Total Psychiatric Discharges (1)		1,261	672	1,933	100.0%

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

Based on UC Behavioral Health's projected future service area, population projections through 2021 were obtained from Nielsen Claritas for both the 18-64 age cohort and the 65+ age cohort, which are reflected below in **Table 6.** The 18-64 age cohort is only expected to grow by 0.1% from 2016 to 2021 while the 65+ age cohort is expected to grow by 20.2%. Combined, the total service area population is projected to grow by 4.0% from 2016 to 2021.

Table 6
UC Behavioral Health's Historical and Projected Service Area Population
2010 – 2021

Age Group	Service Area Population 2010 Pop	2010 % of Total	2016 Pop	2016 % of Total	2021 Pop	2021 % of Total	% Change in Population 2010-16	2016-21
18-64	383,155	83.3%	387,727	80.5%	388,074	77.5%	1.2%	0.1%
65+	76,608	16.7%	93,778	19.5%	112,681	22.5%	22.4%	20.2%
Total	459,763	100.0%	481,505	100.0%	500,755	100.0%	4.7%	4.0%

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

Using the compounded annual growth rate from 2016 to 2021, as set forth in Table 4, population projections were extrapolated through 2024 and applied to UM Behavioral Health's fiscal years. Table 7 below depicts the projected service area population for both the 18-64 and 65+ age cohorts through 2024. Combined, the total population is expected to grow by 0.8% per year for a total growth of 6.8% from FY2016 to FY2024.

Table 7
UC Behavioral Health's Historical and Projected Service Area Population
FY2015 - FY2024

	Historical FY2015	Historical FY2016	Projected FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	% Change FY16-FY24
Service Area Population											
18-64	**386,962**	**387,727**	**387,797**	**387,866**	**387,935**	**388,004**	**388,074**	**388,143**	**388,212**	**388,282**	*0.1%*
65+	**90,670**	**93,778**	**97,286**	**100,925**	**104,701**	**108,618**	**112,681**	**116,897**	**121,270**	**125,806**	*34.2%*
Total	**477,631**	**481,505**	**485,083**	**488,791**	**492,636**	**496,622**	**500,755**	**505,039**	**509,482**	**514,088**	*6.8%*
%Change	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	

2. UC Behavioral Health's Geriatric and Non-Geriatric Programs

UM UCH proposes to establish two separate psychiatric programs at UC Behavioral Health: (1) a twelve (12) bed geriatric unit; and (2) two, fourteen (14) bed adult, non-geriatric units, housing a total of twenty-eight (28) non-geriatric adult psychiatric beds.

a. Geriatric Program

UC Behavioral Health's geriatric program is defined by the diagnosis codes listed below in Table 8. The geriatric program is generally characterized as serving patients suffering from a neurological disorder such as Alzheimer's and/or Dementia. Although there is no age restriction on patients that will be treated in the geriatric program for psychiatric disorders, such patients are primarily projected to be in the 65+ age cohort.

Table 8
Definition of Geriatric Psychiatric Patients

ICD Code	Diagnosis Description
292.81	Medication-induced delirium
293.00	Delirium due to another medical condition
294.20	Dementia, unspecified
294.21	Dementia, unspecified
294.80	Other persistent mental disorders due to conditions classified elsewhere
294.90	Unspecified persistent mental disorders due to conditions classified elsewhere
331.00	Alzheimer's Disease
331.19	Other frontotemporal dementia
331.40	Obstructive hydrocephalus
331.50	Idiopathic normal pressure hydrocephalus
331.82	Dementia with Lewy Bodies
331.83	Mild cognitive impairment
780.09	Other Specified Delirium
F01.50	Vascular dementia without behavioral disturbance
F01.51	Vascular dementia with behavioral disturbance
F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance
F02.81	Dementia in other diseases classified elsewhere with behavioral disturbance
F03.90	Unspecified dementia
F03.91	Unspecified dementia with behavioral disturbance
F05.0	Delirium due to another medical condition
G30.0	Alzheimer's disease with early onset
G30.1	Alzheimer's disease with late onset
G30.8	Other Alzheimer's disease
G30.9	Alzheimer's disease, unspecified
G31.84	Mild cognitive impairment
R41.0	Disorientation
R41.82	Altered Mental Status, Unspecified
R41.9	Unspecified symptoms and signs involving cognitive functions and awareness

*b. **Non-Geriatric Program***

UC Behavioral Health's adult non-geriatric program is defined as treating patients suffering from one or more psychiatric diagnoses, excluding those diagnoses listed on Table 8 above.

3. UC Behavioral Health Use Rates

Use rates for both the geriatric and non-geriatric patient populations were established based on historical trends and expectations that inpatient hospital utilization will be reduced through the development of more expansive outpatient services. Use rates were calculated and projected per 1,000 population.

*a. **Geriatric Program Use Rates***

Geriatric use rates in UC Behavioral Health's service area declined in fiscal 2015, but then increased in FY2016. Going forward, though, a reduction in use rates for this cohort is

projected as a result of continued population health initiatives and other efforts to ensure patients are treated in the lowest acuity setting for their needs. As a result, geriatric psychiatric use rates are expected to decline by 3.9% annually between fiscal years 2017 and 2021 for a cumulative decline of 17.9% (Table 9) from fiscal year 2016 to fiscal year 2024.

Table 9
UC Behavioral Health's Historical and Projected Use Rates
18-64 and 65+ Geriatric Psychiatric Patients
FY2015 - FY2024

	Historical		Projected								% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY16-FY24
Use Rate											
Geriatric											
18-64	**0.11**	**0.21**	**0.20**	**0.19**	**0.18**	**0.18**	**0.17**	**0.17**	**0.17**	**0.17**	
%Change	*-30.7%*	*86.3%*	-3.9%	-3.9%	-3.9%	-3.9%	*-3.9%*	*0.0%*	*0.0%*	*0.0%*	*-17.9%*
65+	**4.7**	**5.3**	**5.1**	**4.9**	**4.7**	**4.5**	**4.4**	**4.4**	**4.4**	**4.4**	
%Change	*-8.7%*	*14.3%*	-3.9%	-3.9%	-3.9%	-3.9%	*-3.9%*	*0.0%*	*0.0%*	*0.0%*	*-17.9%*

*b. **Non-Geriatric Program Use Rates***

The use rates for non-geriatric psychiatric patients in UC Behavioral Health's service area declined by a weighted average of 4.8% in fiscal year 2015 but then increased by a weighted average of 0.2% in fiscal year 2016. Going forward, though, the non-geriatric psychiatric use rate is expected to decline by 6.1% annually between fiscal year 2017 and 2024 for a cumulative reduction of 26.9% (Table 10). This reduction in use rates is attributed to population health initiatives and shifting lower acuity inpatient psychiatric cases to HMH's Outpatient Psychiatric Clinic and Intensive Outpatient Program. In addition, patients with 1 and 2 day lengths of stays currently treated at HMH will be shifted to HMH's partial hospitalization program with the start of that program in fiscal year 2019. HMH's partial hospitalization program will continue at UC Behavioral Health once operational.

Table 10
UC Behavioral Health's Historical and Projected Use Rates
18-64 and 65+ Non-Geriatric Psychiatric Patients
FY2015 – FY2024

	Historical		Projected								% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY16-FY24
Use Rate											
Non-Geriatric											
18-64	**29.7**	**29.9**	**28.1**	**26.4**	**24.8**	**23.3**	**21.9**	**21.9**	**21.9**	**21.9**	
%Change	*-4.3%*	*0.7%*	-6.1%	-6.1%	-6.1%	-6.1%	*-6.1%*	*0.0%*	*0.0%*	*0.0%*	*-26.9%*
65+	**9.0**	**8.9**	**8.3**	**7.8**	**7.3**	**6.9**	**6.5**	**6.5**	**6.5**	**6.5**	
%Change	*-5.5%*	*-1.4%*	-6.1%	-6.1%	-6.1%	-6.1%	*-6.1%*	*0.0%*	*0.0%*	*0.0%*	*-26.9%*

Use rates for both the geriatric and non-geriatric programs are projected to remain constant after fiscal year 2021.

4. Service Area Discharges

While the geriatric psychiatric discharges are projected to increase with the significant projected growth in population in the 65+ age cohort, total projected psychiatric discharges are projected to decline 23.7% between fiscal years 2016 and 2024 (Table 11).

Table 11
UC Behavioral Health's Historical and Projected Service Area Discharges
Geriatric and Non-Geriatric Psychiatric Patients
FY2015 – FY2024

	Historical		Projected								% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY16-FY24
Service Area Discharges											
Geriatric											
18-64	**43**	**80**	**77**	**74**	**71**	**68**	**66**	**66**	**66**	**66**	***-17.8%***
65+	**422**	**499**	**497**	**496**	**495**	**493**	**492**	**510**	**529**	**549**	***10.1%***
Subtotal	**465**	**579**	**574**	**570**	**565**	**561**	**557**	**576**	**595**	**615**	***6.2%***
Non-Geriatric											
18-64	**11,506**	**11,607**	**10,905**	**10,246**	**9,626**	**9,044**	**8,498**	**8,499**	**8,501**	**8,502**	***-26.7%***
65+	**815**	**831**	**809**	**789**	**769**	**749**	**730**	**757**	**786**	**815**	***-1.9%***
Subtotal	**12,321**	**12,437**	**11,714**	**11,034**	**10,395**	**9,793**	**9,227**	**9,256**	**9,286**	**9,317**	***-25.1%***
Total	**12,785**	**13,016**	**12,288**	**11,604**	**10,960**	**10,355**	**9,785**	**9,832**	**9,881**	**9,932**	***-23.7%***

5. Market Share

The initial expected market share at UC Behavioral Health was calculated within the planned service area based on the number of fiscal year 2016 psychiatric discharges for the 18-64 and 65+ age cohorts at both HMH and Union Hospital as a percentage of total psychiatric discharges within the service area.

a. UC Behavioral Health Geriatric Program Market Share

While UC Behavioral Health's geriatric psychiatric market share increased in fiscal year 2016, it is projected to remain constant from fiscal year 2017 through the end of the projection period in fiscal year 2024 (Table 12).

Table 12
UC Behavioral Health's Historical and Projected Market Share
Geriatric Psychiatric
FY2015 - FY2024

	Historical		Projected								% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY16-FY24
Market Share											
Geriatric											
18-64	**35.1%**	**48.9%**	**48.9%**	**48.9%**	**48.9%**	**48.9%**	**48.9%**	**48.9%**	**48.9%**	**48.9%**	
%Change	*-1.8%*	*39.3%*	0.0%	0.0%	0.0%	0.0%	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
65+	**23.0%**	**23.7%**	**23.7%**	**23.7%**	**23.7%**	**23.7%**	**23.7%**	**23.7%**	**23.7%**	**23.7%**	
%Change	*-10.6%*	*2.9%*	0.0%	0.0%	0.0%	0.0%	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

b. UC Behavioral Health Non-Geriatric Program Market Share

UC Behavioral Health's market share, as measured by non-geriatric psychiatric discharges at HMH and Union Hospital, declined in fiscal year 2015, but then increased in fiscal year 2016. The increase in fiscal year 2016 is expected to continue in fiscal year 2017 based on partial year actual utilization. Market share is projected to remain constant through fiscal year 2024 (Table 13).

Table 13
UC Behavioral Health's Historical and Projected Market Share
Non-Geriatric Psychiatric
FY2015 - FY2024

	Historical		Projected								% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY16-FY24
Market Share											
Non-Geriatric											
18-64	**12.2%**	**12.1%**	**12.8%**	**12.8%**	**12.8%**	**12.8%**	**12.8%**	**12.8%**	**12.8%**	**12.8%**	
%Change	*-1.8%*	*-0.5%*	5.8%	0.0%	0.0%	0.0%	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*5.8%*
65+	**10.2%**	**12.9%**	**13.6%**	**13.6%**	**13.6%**	**13.6%**	**13.6%**	**13.6%**	**13.6%**	**13.6%**	
%Change	*28.7%*	*26.5%*	5.4%	0.0%	0.0%	0.0%	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*5.4%*

6. Out-of-Service Area Discharges

a. UC Behavioral Health Geriatric Program Out-of-Service Area Discharges

UC Behavioral Health's geriatric program out-of-service area discharges, measured by discharges at HMH and Union Hospital, declined in fiscal years 2015 and 2016 as a percentage of total discharges, but is expected to level off and remain constant through fiscal year 2024 (Table 14).

Table 14
UC Behavioral Health's Out-of-Service Area Discharges % of Service Area Discharges
Geriatric Psychiatric
FY2015 - FY2024

	Historical		Projected								% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY16-FY24
Out-of-Service Area Discharges % of Service Area Discharges											
Geriatric											
18-64	**6.7%**	**5.1%**	**5.1%**	**5.1%**	**5.1%**	**5.1%**	**5.1%**	**5.1%**	**5.1%**	**5.1%**	
%Change	*-7.0%*	*-1.5%*	0.0%	0.0%	0.0%	0.0%	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
65+	**11.3%**	**8.5%**	**8.5%**	**8.5%**	**8.5%**	**8.5%**	**8.5%**	**8.5%**	**8.5%**	**8.5%**	
%Change	*-7.0%*	*-1.5%*	0.0%	0.0%	0.0%	0.0%	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

b. UC Behavioral Health Non-Geriatric Program Out-of-Service Area Discharges

UC Behavioral Health's non-geriatric program out-of-service area discharges, measured by discharges at HMH and Union Hospital, declined in fiscal years 2015 and 2016 as a percentage of total discharges, but is expected to level off and remain constant through fiscal year 2024 (Table 15).

Table 15
UC Behavioral Health's Out-of-Service Area Discharges % of Service Area Discharges
Non-Geriatric Psychiatric
FY2015 - FY2024

	Historical		Projected								% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY16-FY24
Out-of-Service Area Discharges % of Service Area Discharges											
Non-Geriatric											
18-64	**22.1%**	**18.6%**	**18.6%**	**18.6%**	**18.6%**	**18.6%**	**18.6%**	**18.6%**	**18.6%**	**18.6%**	
%Change	*-6.2%*	*-3.5%*	0.0%	0.0%	0.0%	0.0%	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
65+	**12.0%**	**6.5%**	**6.5%**	**6.5%**	**6.5%**	**6.5%**	**6.5%**	**6.5%**	**6.5%**	**6.5%**	
%Change	*4.6%*	*5.5%*	0.0%	0.0%	0.0%	0.0%	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

7. Inpatient Psychiatric Discharges

In fiscal year 2016, the combined psychiatric discharges at HMH and Union Hospital increased by 1.0%, but then declined by 5.0% in fiscal year 2017. As a result of population health initiatives, psychiatric discharges are projected to continue to decline by 5.6% per year between fiscal years 2018 and 2021.

Additionally, UC Behavioral Health will be capable of safely and effectively treating certain patients with co-occurring medical diagnoses. As a result, UM UCH anticipates that certain patients, particularly geriatric patients, who suffer from co-occurring medical and behavioral health diagnoses and who currently receive treatment in MSGA units, will be candidates for admission to UC Behavioral Health. With the opening of UC Behavioral Health in fiscal year 2022, patients admitted to UC Behavioral Health who are diagnosed with co-occurring medical diagnoses will receive a medical assessment and follow-up during their course of treatment by a medicine specialist (e.g. internist, hospitalist) dedicated to serving the

inpatient behavioral health units. The medicine specialist will work closely with the inpatient unit psychiatrist/psychiatric nurse practitioner to ensure an integrated treatment approach. Having this medicine specialist will enable UC Behavioral Health to annually capture approximately 150 patients suffering from co-occurring medical and behavioral health diagnoses who had previously been treated in MSGA units at HMH, UCMC, and Union Hospital.

Even with these projected utilization increases in fiscal year 2022, total psychiatric discharges are projected to decline by 15.1% between fiscal years 2016 and 2024 (Table 16).

Table 16
UC Behavioral Health's Historical and Inpatient Psych Discharges
FY2015 – FY2024

	Historical		Projected								% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY16-FY24
Inpatient - Discharges											
HMH	**1,222**	**1,230**	**1,172**	**1,106**	**1,044**	**986**	**931**	**-**	**-**	**-**	
UHCC	**628**	**638**	**602**	**568**	**536**	**506**	**478**	**-**	**-**	**-**	
UC Behavioral Health											
Geriatric	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**165**	**170**	**175**	
Non-Geriatric	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**1,402**	**1,407**	**1,411**	
Total	**1,850**	**1,868**	**1,774**	**1,674**	**1,580**	**1,492**	**1,408**	**1,567**	**1,576**	**1,586**	*-15.1%*
% Change		*1.0%*	*-5.0%*	*-5.6%*	*-5.6%*	*-5.6%*	*-5.6%*	*11.3%*	*0.6%*	*0.6%*	

8. UC Behavioral Health Average Length of Stay

The average length of stay ("ALOS") of adult psychiatric patients at HMH is projected to remain constant at 6.10 days between fiscal years 2016 and 2018 before growing to 6.44 in between fiscal years 2019 and 2020. The projected increase in ALOS results from a projected shift of short one and two day inpatient admissions to the outpatient setting with the establishment of HMH's partial hospitalization program commencing in fiscal year 2019. Because there will be fewer short stay admissions, the ALOS for adult psychiatric admissions will necessarily increase. The ALOS is then projected to remain constant until the opening of UC Behavioral Health, which will also offer a partial hospitalization program.

Beginning with its projected opening in fiscal year 2022, UC Behavioral Health will have two adult psychiatric inpatient programs to treat both geriatric and non-geriatric patients. Patients treated in the geriatric program will require more services and have a longer average length of stay of 20.67 days. This longer length of stay reflects the ALOS for geriatric psychiatric patients at Sheppard and Enoch Pratt Hospital in fiscal year 2016. Separating the geriatric patients with longer lengths of stay, reduces the projected ALOS for patients treated in the non-geriatric program to 6.24 days. The ALOS for both the geriatric and non-geriatric programs will remain constant from fiscal year 2022 through the end of the projection period (Table 17).

Table 17
UC Behavioral Health's Historical and Projected Inpatient Psych ALOS
FY2015 – FY2024

	Historical		Projected							
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
ALOS (days)										
HMH	5.62	6.10	6.10	6.10	6.44	6.80	6.80			
UC Behavioral Health										
Geriatric								20.67	20.67	20.67
Non-Geriatric								6.24	6.24	6.24

9. UC Behavioral Health Occupancy

UC Behavioral Health's inpatient bed occupancy was conservatively projected at 85% which is consistent with the outdated State Health Plan for Psychiatric Services, COMAR 10.24.07 (Need Projection Methodology (A)(7)), and much higher than the jurisdictional minimum occupancy standard of 70% applicable to MSGA beds with an average daily census of between 0-49 inpatients.

10. UC Behavioral Health Bed Need

At 85% occupancy, UC Behavioral Health's geriatric unit is expected to drive a need for 11 beds in fiscal year 2022 growing to 12 beds in fiscal year 2024. The non-geriatric unit is projected to drive a need for 28 beds with the opening of the new facility in fiscal year 2022 through the end of the projection period in fiscal year 2024 (Table 18).

Table 18
UC Behavioral Health Projected Inpatient Psych Bed Need
FY2022 – FY2024

	Projected		
	FY2022	FY2023	FY2024
Bed Need			
Geriatric	**11**	**11**	**12**
Non-Geriatric	**28**	**28**	**28**
Total	**39**	**39**	**40**

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

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

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

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

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

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

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

Applicant Response:

A. Planning Process for the Proposed Project and Alternatives Considered

HMH has been serving Havre de Grace and the surrounding community with acute medical inpatient and behavioral health, outpatient, surgical, and emergency services for more than 100 years. Portions of HMH's current physical plant date to 1943 with most of the facility having been constructed between 1958 and 1972. While UM UCH has invested significant operational and capital resources over the years to renovate and maintain the facility, the physical structure of the building is well beyond its useful life, has numerous infrastructure issues, is cost prohibitive to maintain for the long-term, and would require significant capital expenditures for a partial or full renovation of the facility. Renovation and expansion opportunities are also constrained by the nine acre site in downtown Havre de Grace, which is surrounded by existing developed parcels.

Over the past decade, UM UCH has considered many alternatives to the transformation and modernization of HMH to improve access and services to the community it serves and to

better serve the populations of Harford and Cecil Counties within an integrated health delivery system. The proposed project involves construction of a new specialty psychiatric hospital at the UC Medical Campus at Havre de Grace coupled with consolidation of Union Hospital's acute inpatient psychiatric beds, with Union Hospital maintaining outpatient behavioral health services on its campus. Also planned at the same time as the proposed project, UM UCH proposes to develop a freestanding medical facility on the UC Medical Campus at Havre de Grace and relocate other acute inpatient services from HMH to UCMC.

The primary alternatives to the proposed project included:

1. Partial and/or full renovation and expansion of HMH;

2. Relocation of HMH's acute inpatient psychiatric beds and outpatient services to UCMC, with UM UCH developing a freestanding medical facility on the UC Medical Campus at Havre de Grace. Under this alternative, Union Hospital would maintain its acute psychiatric beds. HMH would also transfer MSGA beds to UCMC; and

3. Maintaining all behavioral health services on the HMH campus and relocating emergency services to a freestanding medical facility and relocating acute inpatient and surgical services to UCMC's campus. Under this alternative, Union Hospital would also maintain its acute psychiatric beds.

The following four objectives were broadly considered when evaluating each of the three alternatives. The overarching and primary objective – to maintain access to health care services for residents of UM UCH's service area – is not listed. Alternatives that did not accomplish this overarching and primary objective, such as simply closing HMH, were rejected without further analysis.

a. Coordination of health care services across the continuum of hospital systems in Northeastern Maryland to improve efficiency, patient outcomes, and reduce redundancy of clinical care services;

b. Reduction in the total per capita health care expenditures for service area residents by reducing unnecessary acute care hospital utilization;

c. Efficient use of capital expenditures; and

d. Establishment of modern, innovatively designed facilities with future expansion capability.

1. Alternative 1 - Partial and/or Full Renovation and Expansion of UM HMH

In 2006, UM UCH engaged an architect and construction management company to determine the feasibility of renovating HMH. There were several key findings from this engagement.

a. Coordination of health care services across the continuum

Coordination of care across the continuum would not be improved; it could only be maintained.

b. *Reduction in the total per capita health care expenditures for service area residents by reducing unnecessary acute care hospital utilization*.

Under Alternative 1, total per capita health care expenditures would increase due to the need for rate increases from the HSCRC to support the capital costs and increased depreciation and interest expenses. Further, Union Hospital's low acute psychiatric census renders continued provision of acute, inpatient psychiatric services inefficient and Alternative 1 did not address this factor.

c. *Efficient use of capital expenditures*.

UM UCH determined renovation of HMH (Alternative 1) would not result in the efficient use of capital expenditures. First, the operating rooms and radiology suite could not be renovated, primarily due to shallow, nine foot-six inch floor-to-slab height in core which would not allow modern equipment, lighting, and HVAC. As a consequence, the operating rooms and radiology suite would need to be reconstructed elsewhere on the HMH campus, which space is limited due to existing developed parcels surrounding HMH.

The existing emergency department is obsolete and lacking patient privacy. As a result, current patient flow is inefficient. Due to HMH's existing configuration, HMH's emergency department could not be expanded absent significant relocation of other services and is further constrained by HMH's limited campus expansion possibilities.

Several parts of the building would require costly asbestos abatement in any renovation project. Further, several areas of the hospital would need to be upgraded to current life safety standards. Renovation would also require significant upgrades to the HVAC and electrical systems.

All of the acute and psychiatric beds are semi-private and many of the patient rooms have not been updated in several decades. Converting these rooms to private rooms in accordance with today's standards would be costly and require a complete bed tower renovation.

While the capital cost associated with a renovating and constructing new space at HMH varied based on the scope of construction and renovation, the cost of bringing the entire facility to modern standards is estimated to be $239.3 million (updated to a midpoint of construction in 2020). The project scope included new operating rooms, a new radiology suite, infrastructure upgrades and emergency department renovations (Table 19).

Table 19
Estimated HMH Renovation Costs

Description	Total (in Millions)
Bed Tower Renovations (total 107 beds):	$152.7
3rd - 4th floor for complete renovation for private rooms	
Improved and relocated Central Sterile Supply, Pharmacy, and Lab	
ED Renovation/Data Center Relocation	$5.2
New OR Suite	$16.2
New Radiology	$15.1
Critical infrastructure upgrades	$6.2
Surface Parking Addition	$0.5
Demolition	$1.2
Subtotal	$201.1
Financing Cost (19%)	$38.2
Total	$239.3

d. Modern, innovatively designed facilities with future expansion capability.

Because Alternative 1 considered renovation of the existing building, the innovation potential was limited by the existing infrastructure. Furthermore, the extensive renovation required for this alternative would have been disruptive to HMH's ability to provide patient care services during the renovation. Future expansion, though limited, would be possible on the site.

2. Alternative #2 - Relocate HMH's Acute Inpatient Psychiatric Beds and Outpatient Services and MSGA Beds to UCMC, Develop a New FMF on UCH Havre de Grace Campus, and Maintain Union Hospital's Inpatient Acute Care Psychiatric Beds.

UM UCH evaluated the relocation of HMH's behavioral health services to UCMC's campus in Bel Air. In this scenario, Union Hospital would maintain its acute psychiatric beds. While UCMC would build a two-level expansion to house MSGA beds transferred from HMH. There were several key findings.

a. Coordination of health care services across the continuum

Coordination of care across the continuum would not be improved through Alternative 2. UCMC's campus lacks adequate contiguous space to the inpatient psychiatric beds for existing and proposed new behavioral health outpatient programs would make the program inefficient.

b. Reduction in the total per capita health care expenditures for service area residents by reducing unnecessary acute care hospital utilization.

Alternative 2 would increase the cost of care in the community due to the need for a rate increase from the HSCRC to support the increased capital costs and depreciation and interest expenses. Additionally, a new psychiatric unit at UCMC would not provide the Maryland health care system with cost savings. And again, Union Hospital's low acute psychiatric census renders continued provision of acute, inpatient psychiatric services inefficient and Alternative 2 did not address this factor.

c. Efficient use of capital expenditures.

Relocation of both acute and outpatient behavioral health services as well as MSGA services from HMH to UCMC could not be accommodated in a three-level expansion above the Kaufman Cancer Center. Rather, there would need to be two separate expansion projects at UCMC. A two-level addition above the Kaufman Cancer Center, projected to cost $70,479,695, would house MSGA beds transferred from HMH to UCMC. A separate expansion above one of UCMC's existing patient bed towers would house acute and outpatient behavioral health services. This additional expansion is projected to cost $83 million. Finally, the development of the FMF as a stand-alone facility would cost $58,259,844 because project site costs would not be shared with another facility.

The cumulative effect of relocating inpatient MSGA beds, relocating psychiatric beds, and growing existing and needed outpatient services on UCMC's campus along with the projected volume of 13,638 behavioral health outpatient visits would trigger the need for a new parking garage. The projected costs above do not include additional costs associated with construction of a new parking garage.

d. Modern, innovatively designed facilities with future expansion capability

The new construction at UCMC that would be required for Alternative 2 would allow for modern design. It would, however, further limit the ability to expand on the UCH campus, which is already limited.

3. Alternative #3 - Maintain All Behavioral Health Services on the UC-HMH Campus and Relocate Both Emergency Service to a Free Standing FMF and Acute Inpatient Services to UCMC's Campus. UHCC Would Maintain Its Psychiatric Beds in Elkton, Maryland.

UM UCH also evaluated maintaining all behavioral health services on the HMH campus and relocating both emergency service to a freestanding medical facility and acute inpatient and

surgical services to UCMC's campus. Under this alternative, Union Hospital would maintain its acute psychiatric beds. There were several key findings.

a. Coordination of health care services across the continuum

Coordination of care across the continuum would not be improved; it would only be maintained.

b. *Reduction in the total per capita health care expenditures for service area residents by reducing unnecessary acute care hospital utilization.*

Under Alternative 3, there would be major operational cost inefficiencies created by the duplication of overhead and support services on multiple campuses and UM UCH's overall financial performance would suffer as a result of these inefficiencies. There would also be a need for ongoing and incremental capital expenditures associated with the need to maintain the aging HMH facility. Overall, these inefficiencies and costs would lead to an increase the cost of care in the community due to the need for a rate increase from the HSCRC to support the increased capital costs and associated depreciation and interest expenses.

As with Alternatives 1 and 2, Alternative 3 also did not address Union Hospital's low acute psychiatric census, which renders continued provision of acute, inpatient psychiatric services inefficient.

Finally, maintaining behavioral health services at HMH would not provide Maryland health system savings.

c. Efficient use of capital expenditures.

UM UCH determined that it would be too costly to construct only a freestanding medical facility on the UHC Medical Campus at Havre de Grace due to extensive site acquisition and development costs being allocated to just one service.

Moreover, Alternative 3 would require extensive capital expenditures to renovate HMH's existing psychiatric unit and to accommodate expansion of outpatient services. Total capital expenditures were estimated to be $65.6 million at HMH, plus $58,259,844 for the freestanding medical facility to be located at the UHC Medical Campus at Havre de Grace as a stand-alone facility, plus $70,479,695 for a two-level expansion above the Kaufman Cancer Center at UCMC to house MSGA beds transferred from HMH.

d. Modern, innovatively designed facilities with future expansion capability

The freestanding medical facility would be able to be innovatively designed. Even with the significant renovation at HMH, however, any future designs would be limited by the existing infrastructure without undertaking significantly more new construction and renovations. There would be room for expansion at UHC Medical Campus at Havre de Grace and, potentially, expansion capability at HMH if the vacated space at the hospital could be re-purposed (at even more cost). As said previously, however, the existing building infrastructure has outlived its useful life.

4. Alternative #4 - Consolidate HMH's and Union Hospital's Acute Psychiatric Beds into a New Special Psychiatric Hospital with Union Hospital Maintaining Outpatient Behavioral Health Services, Construct a Freestanding Medical Facility on the UC Medical Campus at Havre de Grace, and Relocate MSGA beds from HMH to UCMC.

UM UCH evaluated a new UC Havre de Grace Medical Campus that would include a freestanding medical facility ("FMF") and a special psychiatric hospital. There were several key findings.

a. Coordination of health care services across the continuum

UM UCH determined that Alternative 4 (which includes the proposed project) will result in improved care coordination across the continuum of hospitals in Northeastern Maryland. UM UCH and Union Hospital have established a two-county behavioral health joint venture that will oversee the distribution of all behavioral health services in Harford and Cecil Counties. The new special psychiatric hospital will be centrally located within this region and between the two remaining acute general hospitals in the service area – UCMC and Union Hospital. This will lead to better patient access, better service to the populations of Cecil and Harford Counties, and improve behavioral health service provider recruitment and retention. Alternative 4 is the only alternative which addresses Union Hospital's low acute psychiatric census, which renders continued provision of acute, inpatient psychiatric services inefficient.

b. Reduce the total per capita health care expenditures for service area residents by reducing unnecessary acute care hospital utilization.

A new special psychiatric hospital would provide Maryland system saving of $3.1 million annually due to the special psychiatric hospital's reimbursement being based on the Medicare prospective payment system and a reduction in rates for Medicaid utilization. Pending an agreement with the HSCRC regarding distribution of HMH's global budget revenue, an increase in rates from the HSCRC will not be required under Alternative 4, which includes the proposed project.

c. Efficient use of capital expenditures.

Alternative 4 provides for an efficient use of capital expenditures. The new special psychiatric hospital projected capital cost is $56,265,809.

The new FMF will cost $51,962,824. The FMF would cost approximately $6,972,020 less if built as a stand-along facility because project site work and other costs can be shared with another facility.

The three-level expansion at UCMC with one floor of shell space will cost $74,379,294.

d. Modern, innovatively designed facilities with future expansion capability

Alternative 4 – which includes the proposed project – allows for both modern, innovatively designed facilities and future expansion of services. The new special psychiatric hospital will offer expanded inpatient psychiatric services including a new dedicated geriatric

psychiatric unit as well as expanded and new outpatient behavioral health programs. This would include an expanded outpatient psychiatric clinic and intensive outpatient services and a new partial hospitalization program. Further, there is room for future expansion of the UC Medical Campus at Havre de Grace.

With respect to the relocation of MSGA beds from HMH to UCMC, construction of one shelled floor allows for the future expansion of Kaufman Cancer Center services.

Based on these factors it was determined that a new special psychiatric hospital and freestanding medical facility at UC Medical Campus at Havre de Grace was the most efficient use of capital, provided the most savings to the public for the Havre de Grace Community and all of UCH's service area, and was able to best achieve each of UM UCH's objectives, including the overarching and primary objective of maintaining access to health care services for residents of UM UCH's service area.

Table 20 below summarizes how UCH evaluated the performance of each of the alternatives relative to the four objectives, scoring each in from 0-5.

Table 20
Ranking of the Alternatives

	Coordination of health care services across the continuum	Reduce the total per capita health care expenditures	Efficient use of capital expenditures	Innovatively designed facilities with future expansion capability	Total
1. Partial and/or Full Renovation and Expansion of UM HMH ($239.3M)	3	0	0	3	6
2. Relocate UM HMH's Acute Inpatient Psychiatric Beds and Outpatient Services to UM UCMC and Maintain UHCC's Inpatient Acute Care Psychiatric Beds. New FMF on Bulle Rock Site and Two Story Expansion at UCMC to house MSGA beds. ($211.7M)	3	0	3	3	9
3. Maintain All Behavioral Services on the UC-HMH Campus and Relocate Both Emergency Service to a Free Standing FMF and Acute Inpatient and Surgical Services to UCMC's Campus. UHCC Would Maintain Its Psychiatric Beds in Elkton, Maryland ($194.3M)	3	0	3	3	9
4. Construct a New Specialty Psychiatric Hospital and FMF on the Bulle Rock Site and Relocate UHCC's Acute Inpatient Psychiatric Beds to a New Specialty Psychiatric Hospital with UHCC Maintaining Outpatient Behavioral Health Services in Elkton, Maryland. ($182.6M)	5	5	5	4	19

B. Marshall Valuation Service Analysis

The construction cost of the proposed facility is reasonable. The following compares the project costs to the Marshall Valuation Service ("MVS") benchmark.

I. Marshall Valuation Service Valuation Benchmark

Type		Hospital
Construction Quality/Class		Good/A
Stories		1
Perimeter		1,595
Average Floor to Floor Height		17.0
Square Feet		66,840
f.1	Average floor Area	66,840
A. Base Costs		
	Basic Structure	$365.78
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$365.78
Adjustment for Departmental Differential Cost Factors		0.98
Adjusted Total Base Cost		$359.59
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$359.59
C. Multipliers		
Perimeter Multiplier		0.908922388
	Product	$326.84

Height Multiplier		1.12
	Product	$364.43
Multi-story Multiplier		1.000
	Product	$364.43
D. Sprinklers		
	Sprinkler Amount	$3.14
Subtotal		$367.57
E. Update/Location Multipliers		
Update Multiplier		1.03
	Product	$378.60
Location Multipier		1.01
	Product	$382.38
Calculated Square Foot Cost Standard		**$382.38**

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

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
Inpatient Care Services	37,115	Inpatient Unit	1.06	39,342
Outpatient Care Services	14,901	Outpatient Department	0.99	14,752
Receiving	469	Storage and Refrigeration	1.6	751
Maintenance	1,000	Mechanical Equipment and Shops	0.7	700
Maintenance Staff Lounge and Lockers	288	Employee Facilities	0.8	230
Nursing Staff Lounge and Lockers	323	Employee Facilities	0.8	258
Provider Staff Lounge and Lockers	632	Employee Facilities	0.8	506
Provider Offices	570	Offices	0.96	547
Housekeeping	374	Housekeeping	1.31	490

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
Storage	964	Storage and Refrigeration	1.6	1,542
Mechanical	2,851	Mechanical Equipment and Shops	0.7	1,996
Public Dining	681	Dining Room	0.95	647
Public Toilets	251	Public Space	0.8	201
Public Conf	705	Public Space	0.8	564
Shared Circulation	3,251	Internal Circulation, Corridors	0.6	1,951
Shared Exterior Walls	559	Unassigned Areas	0.5	280
Exterior Walls	1,906	Unassigned Areas	0.5	953
TOTAL	66,840		0.983079764	65,709

1. Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
Building	$19,948,816	$298.45
Fixed Equipment	In Building	$0.00
Site Preparation	$4,988,255	$74.63
Architectual Fees	$2,362,640	$35.35
Permits	$343,850	$5.14
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$27,643,560	$413.58

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

B. Extraordinary Cost Adjustments

	Project Costs		Associated Cap Interest & Loan Place.
Site Demolition Costs	$998,221	Site	
Storm Drains	$690,669	Site	
Rough Grading	$698,145	Site	
Hillside Foundation	$0	Site	
Paving	$741,935	Site	
Exterior Signs	$100,000	Site	

B. Extraordinary Cost Adjustments

	Project Costs		Associated Cap Interest & Loan Place.
Landscaping	$479,061	Site	
Walls	$60,018	Site	
Yard Lighting	$76,390	Site	
Other (Specify/add rows if needed)	$0	Site	
Sediment Control & Stabilization	$122,166	Site	
Helipad		Site	
Water Storage Tank	$368,872	Site	
Water Booster Station	$252,720	Site	
Premium for Minority Business Enterprise Requirement	$71,761	Site	
Canopy	$85,000	Building	$22,057
Exterior high impact glazing and integral blinds	$217,167	Building	$56,354
Interior premiums	$400,832	Building	$104,015
Fire protection premiums	$57,063	Building	$14,808
Plumbing premiums	$123,719	Building	$32,105
HVAC premiums	$45,845	Building	$11,897
Electrical premiums	$203,352	Building	$52,769
Pneumatic tube	$300,000	Building	$77,849
Premium for Minority Business Enterprise Requirement	$276,331	Building	$71,707
Jurisdictional Hook-up Fees	$213,850	Permits	
Total Cost Adjustments	$6,583,117	26.0%	$443,562

Associated Capitalized Interest and Loan Placement Fees should be excluded from the comparison for those items which are also excluded from the comparison. Since only Capitalized Interest and Loan Placement fees relating to the Building costs are included in the MVS analysis, we have only eliminated them for the Extraordinary Costs that are in the Building cost item. This was calculated as follows, using the Canopy as an example:

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

2. <u>Explanation of Extraordinary Costs</u>

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

a. Exterior enclosure

Because this is a Psychiatric hospital, all exterior windows will be high impact tempered, laminated glazing with integral window blinds that protect the inpatients from breaking the glass or using the blinds to harm themselves.

b. Interior construction

Because this is a Psychiatric hospital, all patient areas will be designed with anti-ligature, tamper and vandal resistant features including: specialty door hardware, continuous hinges, grab bars and handles that are non-pass through. Walls will be constructed of high impact drywall. Interior glazing will also consist of high impact tempered, laminated glass. All patient room ceiling will be high and constructed of drywall in lieu of lower acoustical ceilings.

c. *Fire Protection*

Because this is a Psychiatric hospital, all sprinkler heads will be concealed anti-ligature, tamper and vandal resistant.

d. Plumbing

Because this is a Psychiatric hospital, all patient area plumbing fixtures will be anti-ligature, tamper and vandal resistant. All med gas outlets require locked box covers.

e. HVAC

Because this is a Psychiatric hospital, all ceiling diffusers will be anti-ligature, tamper and vandal resistant.

f. Electrical

Because this is a Psychiatric hospital, all patient areas will have light fixtures and electrical outlets that are anti-ligature, tamper and vandal resistant.

g. Premium for Minority Business Enterprise Requirement

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

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

C. Adjusted Project Cost	Adjusted Project Costs	Per Square Foot
Building	$18,239,507	$272.88
Fixed Equipment		$0.00
Site Preparation	$328,296	$4.91
Architectual Fees	$2,362,640	$35.35
Permits	$130,000	$1.94
Subtotal	$21,060,443	$315.09
Capitalized Construction Interest	$4,733,109	$70.81
Total	$25,793,552	$385.90

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

Hospital	**New**	**Renovation**	**Total**		
Building Cost	$19,948,816	$0			
Subtotal Cost (w/o Cap Interest)	$27,643,560	$0	$27,643,560		
Subtotal/Total	**100.0%**	**0.0%**	**Cap Interest**	**Loan Placement Fees**	**Total**
Total Project Cap Interest &Loan Place. [(Subtotal Cost/Total Cost) X Total Cap Interest & Loan Place.]	$7,173,438	$0	$6,896,471	$276,967	$7,173,438
Building/Subtotal	72.2%	0%			
Building Cap Interest & Loan Place.	$5,176,670	$0			
Associated with Extraordinary Costs	$443,562				
Applicable Cap Interest & Loan Place.	$4,733,109				

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

MVS Benchmark	$382.38
The Project	$385.90
Difference	$3.52
	0.92%

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

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

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

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

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

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

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

Applicant Response:

The proposed project and as well as the other capital projects for which UM UCH and its constituent hospitals have sought approval from the Commission will be funded through a combination of $6,000,000 in operating cash, interest earned on bond proceeds of $2,908,675, and $184,750,000 in tax exempt bonds. The bonds are anticipated to be issued in fiscal year 2019 through the University of Maryland Medical System.

Tables G, H, and **L** are attached at **Exhibit 1**. The assumptions for each Table are included in **Exhibit 1.**

The community is supportive of the proposed project. Letters of support are attached as **Exhibit 10.** UM UCH has submitted the most recent, audited, consolidated financial statements of the University of Maryland Medical System at **Exhibit 11**.

As set forth in the Project Schedule, the proposed project complies with performance requirements set forth at COMAR 10.24.01.12(C)(3).

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

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

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

Applicant Response:

UM UCH and its affiliates have complied with all terms and conditions of Certificates of Need issued since 2000.

On May 19, 2005, the Commission issued a CON authorizing UCMC to construct a three-story addition. This CON did not include any conditions. Construction of the addition is complete and this space is operational. On February 14, 2006, the Commission approved a Modification Request seeking Commission approval to add one floor of shell space as the top (fourth) floor of the addition approved on May 19, 2005. Two conditions were imposed in conjunction with the CON; i.e., that UCMC not finish the shell space without obtaining Commission approval and not seek an adjustment of rates that would include depreciation and interest costs associated with the construction of the shell space until UCMC obtains Commission to fit-out that space. UCMC is in compliance with both conditions.

On November 15, 2007, the Commission issued a CON authorizing fit-out of the shell space floor approved for construction in February 2006. This CON includes the two conditions quoted below.

1. Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude the cost associated with the excess square footage of the new nursing units, which is calculated to be $852,002, using the fully adjusted Marshall Valuation Service estimated cost per square foot for the new construction; and

2. Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude the construction cost found to be in excess of the applicable Marshall Valuation Service benchmark cost, which is calculated to be $434,670, using the fully adjusted Marshall Valuation Service estimated cost per square foot for the new construction (adjusted for the previous excess space cost adjustment).

In 2008, the shell space was fit out and UCMC has not applied for a rate increase in conjunction with fit-out of the shell space floor.

On Jun 11, 2009, the Commission issued a CON authorizing HMH to renovate hospital space to add 16 MSGA beds as well to create family space and storage in a unit that formerly housed 17 nursing home beds. This CON was granted without conditions and successfully implemented the following year.

10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

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

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

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project[2];

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

c) On costs to the health care delivery system.

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

Applicant Response:

The opening of the proposed new facility in fiscal year 2022 will shift all of HMH's and Union Hospital's inpatient psychiatric patients to UC Behavioral Health. The proposed project will not adversely affect utilization of acute psychiatric services at facilities other than HMH and Union Hospital.

The proposed project will improve access to behavioral health services in the service area by creating a hub-and-spoke model for the provision of outpatient behavioral health services, with acute psychiatric services being centrally located between the two acute general hospitals in the service area and outpatient services being delivered at all three location. This project not only ensures access to behavioral health services in the service area but also will improve patient handoffs across a continuum of providers, thereby leading to improved patient outcomes and transitions back to the community. Moreover, centralizing the service area's acute behavioral health services will solve several regional behavioral health delivery issues, including service provider recruitment and retention.

Pending final approval from the HSCRC regarding distribution of HMH's global budget revenue, the proposed project would also provide Maryland system saving of $3.1 million annually due to the hospital's reimbursement being based on the Medicare prospective payment system and a reduction in rates for Medicaid utilization

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

Table of Exhibits

Exhibit	Description
1	MHCC Tables
2	Project Drawings
3	Deeds and ALTA/ASCM Land Title Survey
4	Policy Regarding Charges
5	Financial Assistance Policy
6	Emergency Department Behavioral Health Protocols
7	Transportation Standard Operating Procedure
8	Inpatient Admission Policies and Procedures
9	Patient Safety and Quality Plan
10	Letters of Support
11	Consolidated Financial Statements

Table of Tables

	Description
Table 1	Below-Average Quality Measures and Corrective Action
Table 2	Harford Memorial Hospital Uncompensated Care
Table 3	Local Health Planning Region Age-Adjusted Psychiatric Discharges
Table 4	Local Health Planning Region Age-Adjusted Psychiatric Discharges
Table 5	Defining UC Behavioral Health's Service Area Psychiatric Discharges Age 18+ FY2016
Table 6	UC Behavioral Health's Historical and Projected Service Area Population 2010 – 2021
Table 7	UC Behavioral Health's Historical and Projected Service Area Population FY2015 - FY2024
Table 8	Definition of Geriatric Psychiatric Patients
Table 9	UC Behavioral Health's Historical and Projected Use Rates 18-64 and 65+ Geriatric Psychiatric Patients FY2015 - FY2024
Table 10	UC Behavioral Health's Historical and Projected Use Rates 18-64 and 65+ Non-Geriatric Psychiatric Patients FY2015 – FY2024
Table 11	UC Behavioral Health's Historical and Projected Service Area Discharges Geriatric and Non-Geriatric Psychiatric Patients FY2015 – FY2024
Table 12	UC Behavioral Health's Historical and Projected Market Share Geriatric Psychiatric FY2015 - FY2024
Table 13	UC Behavioral Health's Historical and Projected Market Share Non-Geriatric Psychiatric FY2015 - FY2024
Table 14	UC Behavioral Health's Out-of-Service Area Discharges % of Service Area Discharges Geriatric Psychiatric FY2015 - FY2024
Table 15	UC Behavioral Health's Out-of-Service Area Discharges % of Service Area Discharges Non-Geriatric Psychiatric FY2015 - FY2024
Table 16	UC Behavioral Health's Historical and Inpatient Psych Discharges FY2015 – FY2024
Table 17	UC Behavioral Health's Historical and Projected Inpatient Psych ALOS FY2015 – FY2024
Table 18	UC Behavioral Health Projected Inpatient Psych Bed Need FY2022 – FY2024
Table 19	Estimated HMH Renovation Costs
Table 20	Ranking of the Alternatives

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

August 1, 2017
Date

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

#600532
011888-0023

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

August 1, 2017
Date

Joseph E. Hoffman, III
Executive Vice President / Chief Financial Officer and Compliance Officer
University of Maryland Upper Chesapeake Health System

#600531
011888-0023

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

August 1, 2017
Date

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

#600530
011888-0023

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

August 1, 2017
Date

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

#600530
011888-0023

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

August 1, 2017
Date

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

#600532
011888-0023

I hereby declare and affirm under the penalties of perjury that the facts stated in Sections 10.A., 10.B., 10.C.(1), and 13.B., of this application and its related attachments are true and correct to the best of my knowledge, information, and belief.

August 1, 2017
Date

Paul Muddiman
Vice President
Morris & Ritchie Associates, Inc.

#600532
011888-0023

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

August 1, 2017
Date

John Ford AIA, LEED AP, EDAC
Senior Design Architect
ERDMAN

#600550
011888-0023

EXHIBIT 1

Name of Applicant: University of Maryland Upper Chesapeake Health System, Inc.

Date of Submission: Friday, August 4, 2017

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

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

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

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

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/201_	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
ACUTE CARE							**ACUTE CARE**					
General Medical/ Surgical*					0	0	**General Medical/ Surgical***				0	0
					0	0					0	0
					0	0					0	0
					0	0					0	0
					0	0					0	0
SUBTOTAL Gen. Med/Surg*							**SUBTOTAL Gen. Med/Surg***					
ICU/CCU					0	0	**ICU/CCU**				0	0
Other *(Specify/add rows as needed)*					0	0					0	0
TOTAL MSGA							**TOTAL MSGA**					
Obstetrics					0	0	**Obstetrics**				0	0
Pediatrics					0	0	**Pediatrics**				0	0
Psychiatric					0	0	**Psychiatric**		40		40	40
TOTAL ACUTE		**0**	**0**	**0**	**0**	**0**	**TOTAL ACUTE**		**40**	**0**	**40**	**40**
NON-ACUTE CARE							**NON-ACUTE CARE**					
Dedicated Observation**					0	0	**Dedicated Observation****				0	0
Rehabilitation					0	0	**Rehabilitation**				0	0
Comprehensive Care					0	0	**Comprehensive Care**				0	0
Other *(Specify/add rows as needed)*					0	0	**Other** *(Specify/add rows as needed)*				0	0
TOTAL NON-ACUTE							**TOTAL NON-ACUTE**					
HOSPITAL TOTAL		**0**	**0**	**0**	**0**	**0**	**HOSPITAL TOTAL**		**40**	**0**	**40**	**40**

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

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

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

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

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Inpatient Care Services		37,115			37,115
Outpatient Care Services		14,901			14,901
Receiving		469			469
Maintenance		1,000			1,000
Maintenance Staff Lounge and Lockers		288			288
Nursing Staff Lounge and Lockers		323			323
Provider Staff Lounge and Lockers		632			632
Provider Offices		570			570
Housekeeping		374			374
Storage		964			964
Mechanical		2,851			2,851
Public dining		681			681
Public Toilets		251			251
Public Conf		705			705
Shared Circulation		3,251			3,251
Shared Exterior Walls		559			559
Exterior Walls		1,906			1,906
Total		66,840			66,840

TABLE C. CONSTRUCTION CHARACTERISTICS

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

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

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Ground Floor	66,840	
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Average Square Feet	**66,914**	
Perimeter in Linear Feet	**Linear Feet**	
Ground Floor	1,595	
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Total Linear Feet	**1,595**	
Average Linear Feet	**1,595**	
Wall Height (floor to eaves)	**Feet**	
Ground Floor	17'	
First Floor	17'	
Second Floor		
Third Floor		
Fourth Floor		
Average Wall Height	**17'**	
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		
Freight		
Sprinklers	**Square Feet Covered**	
Wet System	66,840	
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project	VAV, Ducted return, AHUs with chilled and hot water	
Type of Exterior Walls for proposed project	Masonry	

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

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

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS	**4,988,255**	
Normal Site Preparation	$328,296.49	
Utilities from Structure to Lot Line	$0	
Subtotal included in Marshall Valuation Costs	**$328,296.49**	
Site Demolition Costs	$998,221	
Storm Drains	$690,669	
Rough Grading	$698,145	
Paving	$741,935	
Exterior Signs	$100,000	
Landscaping	$479,061	
Walls	$60,018	
Yard Lighting	$76,390	
Sediment Control & Stabilization	$122,166	
Water Storage Tank	$368,872	
Water Booster Station	$252,720	
Premium for Minority Business Enterprise Requirement	$71,761	
Subtotal On-Site excluded from Marshall Valuation Costs	**$4,659,958**	
OFFSITE COSTS		
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Other (Specify/add rows if needed)		
Subtotal Off-Site excluded from Marshall Valuation Costs	**$0**	
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$4,659,958**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$4,988,255**	**$0**
BUILDING COSTS	**$19,948,816**	
Normal Building Costs	$18,239,507	
Subtotal included in Marshall Valuation Costs	**$18,239,507**	
Canopy	$85,000	
Exterior high impact glazing and integral blinds	$217,167	
Interior premiums	$400,832	
Fire protection premiums	$57,063	

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

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

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
Plumbing premiums	$123,719	
HVAC premiums	$45,845	
Electrical premiums	$203,352	
Pneumatic tube	$300,000	
Premium for Minority Business Enterprise Requirement	$276,331	
Subtotal Building Costs excluded from Marshall Valuation Costs	**$1,709,309**	
TOTAL Building Costs included and excluded from Marshall Valuation Service*	**$19,948,816**	**$0**
A&E COSTS	**$2,362,640**	
Normal A&E Costs	$2,362,640	
Subtotal included in Marshall Valuation Costs	**$2,362,640**	
Subtotal A&E Costs excluded from Marshall Valuation Costs	**$0**	
TOTAL A&E Costs included and excluded from Marshall Valuation Service*	**$2,362,640**	**$0**
PERMIT COSTS	**$343,850**	
Normal Permit Costs	$130,000	
Subtotal included in Marshall Valuation Costs	**$130,000**	
Jurisdictional Hook-up Fees	$213,850	
Impact Fees		
Subtotal Permit Costs excluded from Marshall Valuation Costs	**$213,850**	
TOTAL Permit Costs included and excluded from Marshall Valuation Service*	**$343,850**	**$0**

TABLE E. PROJECT BUDGET

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

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

		Hospital Building	Other Structure	Total
A.	**USE OF FUNDS**			
1.	**CAPITAL COSTS**			
a.	**New Construction**			
(1)	Building	$19,948,816		$19,948,816
(2)	Fixed Equipment	In Building		$0
(3)	Site and Infrastructure	$4,988,255		$4,988,255
(4)	Architect/Engineering Fees	$2,362,640		$2,362,640
(5)	Permits (Building, Utilities, Etc.)	$343,850		$343,850
	SUBTOTAL	**$27,643,560**	**$0**	**$27,643,560**
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**	**$0**	**$0**
c.	**Other Capital Costs**			
(1)	Movable Equipment	$11,106,159		$11,106,159
(2)	Contingency Allowance	$3,874,972		$3,874,972
(3)	Gross interest during construction period	$6,896,471		$6,896,471
(4)	Other (Specify/add rows if needed)			$0
	SUBTOTAL	***$21,877,602***	***$0***	**$21,877,602**
	TOTAL CURRENT CAPITAL COSTS	**$49,521,162**	**$0**	**$49,521,162**
d.	***Land Purchase***			
e.	**Inflation Allowance**	$2,004,710		$2,004,710
	TOTAL CAPITAL COSTS	**$51,525,872**	**$0**	**$51,525,872**
2.	**Financing Cost and Other Cash Requirements**			
a.	Loan Placement Fees	**$276,967**		$276,967
b.	Bond Discount	**$227,113**		$227,113
c	CON Application Assistance			
	c1. Legal Fees	**$20,000**		$20,000
	c2. Other (Specify/add rows if needed)	**$143,000**		
d.	Non-CON Consulting Fees			
	d1. Legal Fees	**$20,000**		$20,000
	d2. Other (Specify/add rows if needed)	**$492,000**		$492,000
e.	Debt Service Reserve Fund	**$3,560,857**		$3,560,857
f	Other (Specify/add rows if needed)			$0
	SUBTOTAL	***$4,739,937***	***$0***	**$4,739,937**
3.	**Working Capital Startup Costs**			$0
	TOTAL USES OF FUNDS	***$56,265,809***	***$0***	***$56,265,809***
B.	**Sources of Funds**			
1.	**Cash**			$0
2.	**Philanthropy (to date and expected)**			$0
3.	**Authorized Bonds**	**$55,393,700**		$55,393,700
4.	**Interest Income from bond proceeds listed in #3**	**$872,110**		$872,110

TABLE E. PROJECT BUDGET

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

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

	Hospital Building	Other Structure	Total
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other (Specify/add rows if needed)			$0
TOTAL SOURCES OF FUNDS	***$56,265,809***		**$56,265,809**

	Hospital Building	Other Structure	Total
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other (Specify/add rows if needed)			$0

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

TABLE F. STATISTICAL PROJECTIONS - ENTIRE UC Behavioral Health

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. DISCHARGES										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA										
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric								1,567	1,576	1,586
Total Acute								***1,567***	***1,576***	***1,586***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL DISCHARGES								***1,567***	***1,576***	***1,586***
2. PATIENT DAYS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA										
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric								12,157	12,285	12,418
Total Acute								***12,157***	***12,285***	***12,418***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS								***12,157***	***12,285***	***12,418***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA										

TABLE F. STATISTICAL PROJECTIONS - ENTIRE UC Behavioral Health

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric								7.8	7.8	7.8
Total Acute								7.8	7.8	7.8
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL AVERAGE LENGTH OF STAY								7.8	7.8	7.8
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA										
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric								40	40	40
Total Acute								***40***	***40***	***40***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL LICENSED BEDS								***40***	***40***	***40***
5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE: *Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA										
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric								83.3%	84.1%	85.1%
Total Acute								**83.3%**	**84.1%**	**85.1%**

TABLE F. STATISTICAL PROJECTIONS - ENTIRE UC Behavioral Health

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL OCCUPANCY %								**83.3%**	**84.1%**	**85.1%**
6. OUTPATIENT VISITS										
a. Emergency Department										
b. Same-day Surgery										
c. Laboratory								1,813,871	1,822,216	1,830,644
d. Imaging								496,726	499,044	501,386
e. Psych Emergency Department										
f. Outpatient Psych Clinic								6,234	6,358	6,485
g. Intensive Outpatient Psych Program								1,929	1,941	1,953
h. Partial Hospitalization Program								3,900	5,200	5,200
TOTAL OUTPATIENT VISITS								***2,322,660***	***2,334,759***	***2,345,667***
7. OBSERVATIONS**										
a. Number of Patients										
b. Hours										

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

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

Table F – Volume Projection Assumptions for UC Behavioral Health

1) Projection period reflects FY2022 – FY2024	
2) Projection is based on the Harford Memorial Hospital (HMH) FY2018 budget with assumptions identified below.	
3) Volumes • Inpatient Volumes • Outpatient Volumes o Outpatient Utilization o Partial Hospitalization Program o UC Behavioral Health Outpatient PHP Service Area Visits by County o Partial Hospitalization Programs at HMH / UC Behavioral Health	Inpatient Volumes: See Need assessment Outpatient Volumes: <u>Outpatient Utilization</u> Outpatient Psychiatric utilization will reflect the continuation of Psychiatric clinic and Intensive Outpatient Program services currently provided at HMH with 2.0% annual growth plus the startup of a Partial Hospitalization Program (PHP) in FY2019. <u>Partial Hospitalization Program</u> From FY2012 to FY2016 PHP visits grew from 5,036 to 20,746 or an increase in use rate of 299.1% (10.8 to 43.1). Eighty-five percent (85%) of existing PHP patients in UC Behavioral Health's service area reside in Baltimore County. Partial hospitalization services are underutilized by Harford and Cecil County residents. Combined with the growth in PHP utilization in the service area from FY2012 to FY2016, UM UCH expects to open a partial hospitalization program at HMH in FY2019 and to shift appropriate short stay inpatient psychiatric admissions to the outpatient setting. A partial hospitalization program at HMH which will continue at UC Behavioral Health will provide access to this underutilized service. It will take two years for the partial hospitalization program at HMH to reach its capacity at 2,600 visits with a capacity of 10 patients per day. With the opening of UC Behavioral Health, capacity will be expanded to 20 patients per day and utilization is expected to grow to 5,200 visits by FY2024. Utilization of the partial hospitalization program at HMH is expected to include a shift of HMH inpatients with inpatient stays of 1 and 2 days before increasing at UC Behavioral Health with additional capacity. On average partial hospitalization patients will require 15 visits compared to a single discharge in an inpatient setting.

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - UC Behavioral Health

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE										
a. Inpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 23,360	$ 23,497	$ 23,640
b. Outpatient Services	-	-	-	-	-	-	-	7,265	7,339	7,414
Gross Patient Service Revenues	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 30,624***	***$ 30,836***	***$ 31,054***
c. Allowance For Bad Debt	-	-	-	-	-	-	-	955	961	968
d. Contractual Allowance	-	-	-	-	-	-	-	5,319	5,355	5,393
e. Charity Care	-	-	-	-	-	-	-	164	165	166
Net Patient Services Revenue	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 24,187***	***$ 24,354***	***$ 24,527***
f. Other Operating Revenues (Specify/add rows if needed)	-	-	-	-	-	-	-	48	48	48
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 24,235***	***$ 24,402***	***$ 24,574***
2. EXPENSES										
a. Salaries & Wages (including benefits)	-	-	-	-	-	-	-	15,610	15,713	15,820
b. Contractual Services	-	-	-	-	-	-	-	449	449	449
c. Interest on Current Debt	-	-	-	-	-	-	-	477	458	443
d. Interest on Project Debt	-	-	-	-	-	-	-	2,413	2,368	2,321
e. Current Depreciation	-	-	-	-	-	-	-	-	-	-
f. Project Depreciation	-	-	-	-	-	-	-	2,504	2,541	2,670
g. Current Amortization	-	-	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-	-	-
i. Supplies	-	-	-	-	-	-	-	342	353	359
j. Other Expenses (Specify/add rows if needed)	-	-	-	-	-	-	-	3,506	3,506	3,506
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 25,301***	***$ 25,390***	***$ 25,568***
3. INCOME										
a. Income From Operation	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ (1,066)**	**$ (988)**	**$ (994)**
b. Non-Operating Income	-	-	-	-	-	-	-	-	-	-
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ (1,066)***	***$ (988)***	***$ (994)***
c. Income Taxes	-	-	-	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ (1,066)***	***$ (988)***	***$ (994)***

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - UC Behavioral Health

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare								36.2%	36.2%	36.2%
2) Medicaid								41.3%	41.3%	41.3%
3) Blue Cross								6.1%	6.1%	6.1%
4) Commercial Insurance								12.5%	12.5%	12.5%
5) Self-pay								1.1%	1.1%	1.1%
6) Other								2.7%	2.7%	2.7%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare								35.8%	35.8%	35.8%
2) Medicaid								41.6%	41.6%	41.6%
3) Blue Cross								6.2%	6.2%	6.2%
4) Commercial Insurance								12.6%	12.6%	12.6%
5) Self-pay								1.0%	1.0%	1.0%
6) Other								2.8%	2.8%	2.8%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***

Table G – Key Financial Projection Assumptions for UC Behavioral Health (Excludes HSCRC Annual Update Factors & Expense Inflation)

1) Projection period reflects FY2022 – FY2024	
2) Projection is based on the Harford Memorial Hospital (HMH) FY2018 budget with assumptions identified below.	
3) Volumes	Refer to CON Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
4) Patient Revenue	
• Gross Charges	
o Update Factor	0.0% annual increase
o Demographic Adjustment	No demographic adjustment
o Variable Cost Factor	HMH Psychiatric revenue will shift to UC Behavioral Health at a 100% variable cost factor, while revenue from UHCC will shift at 50%
o Geriatric Psychiatry Change	Geriatric Psychiatry charge per day calculated using state-wide average Geriatric Psychiatry utilization profile multiplied by projected rates
o Partial Hospitalization Psychiatry Changes	Outpatient Partial Hospitalization Psychiatry charges calculated by multiplying visits by projected PDC rate
o Other	Removed assessments and quality from HMH rates and changed the mark-up based on HMH FY2016 Psychiatric payer mix
• Revenue Deductions	
o Contractual Allowances	Based on FY2016 HMH Psychiatric payer mix and remains constant at 17.4% of gross revenue per year - Medicare contractual adjustments reflect an inpatient Medicare per diem rate that is 65% of the assumed charge per visit based on Sheppard Pratt average per diem - Outpatient is assumed to be the same as inpatient - Assumes Medicaid will pay HSCRC rates
o Charity Care	Based on FY2016 HMH uncompensated care and remains constant at 0.5% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	Based on FY2016 HMH uncompensated care and remains constant at 3.1% of gross revenue per year - No overfunding or underfunding of UCC
5) Other Revenue	
• Cafeteria Revenue	0.0% increase per year
6) Expenses	
• Inflation	0.0% increase per year
• Expense Volume Driver	Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	Identified at the cost center level
o Salaries and Benefits	Ranges from 10% for overhead departments to 100% for inpatient nursing units.
o Professional Fees	0% for all cost centers except inpatient nursing (50%) and Laboratory (100%).

o Supplies	Ranges from 0% for overhead departments to 100% for the Emergency Department.
o Purchased Services	Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	Ranges from 0% for overhead departments to 50% for certain ancillary and support departments
• Other Operating Expense Adjustments	Additional adjustments totalling approximately $3.4M were made to reduce Pharmacy and other operating expenses and UCHS overhead allocations to reflect Psychiatric specific services and a smaller facility
• Interest Expense o Existing Debt	5.2% allocation of the following UCHS debt: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
o Project Debt	4.5% interest on $55.4M bonds over 30 years
• Depreciation and Amortization	Average life of 26 years on $55.4M of construction project expenditures and 10 years on routine capital expenditures
7) Routine Capital Expenditures	$0.4M in FY2022, growing to $1.3M in FY2021 and $2.6M in FY2024

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - UC Behavioral Health

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE										
a. Inpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25,955	$ 26,604	$ 27,274
b. Outpatient Services	-	-	-	-	-	-	-	8,060	8,297	8,542
Gross Patient Service Revenues	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 34,015***	***$ 34,901***	***$ 35,816***
c. Allowance For Bad Debt	-	-	-	-	-	-	-	1,060	1,088	1,116
d. Contractual Allowance	-	-	-	-	-	-	-	5,907	6,061	6,220
e. Charity Care	-	-	-	-	-	-	-	182	187	192
Net Patient Services Revenue	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 26,865***	***$ 27,565***	***$ 28,287***
f. Other Operating Revenues (Specify/add rows if needed)	-	-	-	-	-	-	-	47	48	48
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 26,913***	***$ 27,613***	***$ 28,336***
2. EXPENSES										
a. Salaries & Wages (including benefits)	-	-	-	-	-	-	-	16,151	16,631	17,129
b. Contractual Services	-	-	-	-	-	-	-	470	484	498
c. Interest on Current Debt	-	-	-	-	-	-	-	477	458	443
d. Interest on Project Debt	-	-	-	-	-	-	-	2,413	2,368	2,321
e. Current Depreciation	-	-	-	-	-	-	-	-	-	-
f. Project Depreciation	-	-	-	-	-	-	-	2,504	2,541	2,670
g. Current Amortization	-	-	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-	-	-
i. Supplies	-	-	-	-	-	-	-	321	348	369
j. Other Expenses (Specify/add rows if needed)	-	-	-	-	-	-	-	4,104	4,252	4,404
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 26,440***	***$ 27,083***	***$ 27,834***
3. INCOME										
a. Income From Operation	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 473***	***$ 530***	***$ 502***
b. Non-Operating Income	-	-	-	-	-	-	-	-	-	-
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 473***	***$ 530***	***$ 502***
c. Income Taxes								-	-	-
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 473***	***$ 530***	***$ 502***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare								36.2%	36.2%	36.2%
2) Medicaid								41.3%	41.3%	41.3%
3) Blue Cross								6.1%	6.1%	6.1%
4) Commercial Insurance								12.5%	12.5%	12.5%
5) Self-pay								1.1%	1.1%	1.1%
6) Other								2.7%	2.7%	2.7%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - UC Behavioral Health

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare								35.8%	35.8%	35.8%
2) Medicaid								41.6%	41.6%	41.6%
3) Blue Cross								6.2%	6.2%	6.2%
4) Commercial Insurance								12.6%	12.6%	12.6%
5) Self-pay								1.0%	1.0%	1.0%
6) Other								2.8%	2.8%	2.8%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***

Table H – Key Financial Projection Assumptions for UC Behavioral Health (Includes HSCRC Annual Update Factors & Expense Inflation)

1) Projection period reflects FY2022 – FY2024	
2) Projection is based on the Harford Memorial Hospital (HMH) FY2018 budget with assumptions identified below.	
3) Volumes	Refer to CON Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
4) Patient Revenue	
• Gross Charges	
o Update Factor	1.9% annual increase
o Demographic Adjustment	No demographic adjustment
o Variable Cost Factor	HMH Psychiatric revenue will shift to UC Behavioral Health at a 100% variable cost factor, while revenue from UHCC will shift at 50%
o Geriatric Psychiatry Change	Geriatric Psychiatry charge per day calculated using state-wide average Geriatric Psychiatry utilization profile multiplied by projected rates
o Partial Hospitalization Psychiatry Changes	Outpatient Partial Hospitalization Psychiatry charges calculated by multiplying visits by projected PDC rate
o Other	Removed assessments and quality from HMH rates and changed the markup based on HMH FY2016 Psychiatric payer mix
• Revenue Deductions	
o Contractual Allowances	Based on FY2016 HMH Psychiatric payer mix and remains constant at 17.4% of gross revenue per year - Medicare contractual adjustments reflect an inpatient Medicare per diem rate that is 65% of the assumed charge per visit based on Sheppard Pratt average per diem - Outpatient is assumed to be the same as inpatient - Assumes Medicaid will pay HSCRC rates
o Charity Care	Based on FY2016 HMH uncompensated care and remains constant at 0.5% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	Based on FY2016 HMH uncompensated care and remains constant at 3.1% of gross revenue per year - No overfunding or underfunding of UCC
5) Other Revenue	
• Cafeteria Revenue	1.0% increase per year
6) Expenses	
• Inflation	
o Salaries and Benefits	2.3% increase per year
o Professional Fees	3.0% increase per year
o Supplies	4.3% increase per year
o Purchased Services	3.0% increase per year
o Other Operating Expenses	2.0% increase per year
• Expense Volume Driver	Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	Identified at the cost center level
o Salaries and Benefits	Ranges from 10% for overhead departments to 100% for inpatient nursing units.

o Professional Fees	0% for all cost centers except inpatient nursing (50%) and Laboratory (100%).
o Supplies	Ranges from 0% for overhead departments to 100% for the Emergency Department.
o Purchased Services	Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	Ranges from 0% for overhead departments to 50% for certain ancillary and support departments
• Other Operating Expense Adjustments	Additional adjustments totalling approximately $3.4M were made to reduce Pharmacy and other operating expenses and UCHS overhead allocations to reflect Psychiatric specific services and a smaller facility
• Interest Expense o Existing Debt	5.2% allocation of the following UCHS debt: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
o Project Debt	4.5% interest on $55.4M bonds over 30 years
• Depreciation and Amortization	Average life of 26 years on $55.4M of construction project expenditures and 10 years on routine capital expenditures
7) Routine Capital Expenditures	$0.4M in FY2022, growing to $1.3M in FY2021 and $2.6M in FY2024

TABLE L. WORKFORCE INFORMATION - UC Behavioral Health

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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted)*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Medical Staff Administration										0.3	$19.22
Quality & Health Information Management										2.5	$161.88
Fiscal Services										0.6	$48.32
Spirituality										0.2	$10.86
Patient Accounting										1.4	$74.09
Centralized Scheduling										1.2	$49.66
Admitting										5.5	$214.17
MIS										1.9	$170.35
Telecommunications										0.2	$11.67
Administration										0.3	$39.50
Safety										0.3	$18.90
Nursing Administration										4.8	$501.14
Hospital Education										2.2	$176.24
Quality Management										0.5	$40.36
Readmission										0.9	$79.03
Clinical Resource Management										1.3	$103.74
Distribution										2.7	$92.43
Volunteers										0.2	$12.86
Human Resources										0.6	$42.51
Healthlink										0.1	$4.52
Performance Improvements										0.5	$54.53
HC Epidemiology & Infection Control										0.4	$34.90

TABLE L. WORKFORCE INFORMATION - UC Behavioral Health

Guest Services										0.5	$32.37
Purchasing										1.2	$75.00
Risk Management										0.2	$22.18
General Hospital										-0.9	$127.35
Total Administration			$0			$0			$0	29.6	$2,218
Direct Care Staff *(List general categories, add rows if needed)*											
Partial Hospitalization Psych			$0			$0			$0	11.1	$1,093.52
Behavioral Health			$0			$0			$0	66.3	$6,150.35
Outpatient Psychiatric Clinic			$0			$0			$0	7.6	$748.22
Intensive Outpatient Psychiatry			$0			$0			$0	2.3	$178.53
Emergency Department			$0			$0			$0	4.6	$383.17
IV Therapy			$0			$0			$0	1.4	$129.96
Pharmacy			$0			$0			$0	4.0	$398.31
Respiratory Therapy			$0			$0			$0	0.2	$13.41
Physical Therapy			$0			$0			$0	0.3	$18.26
Occupational Therapy			$0			$0			$0	0.2	$22.23
Radiology			$0			$0			$0	0.4	$25.80
Nuclear Medicine			$0			$0			$0	0.0	$0.29
Cat Scan			$0			$0			$0	0.1	$9.02
MRI			$0			$0			$0	0.0	$1.80
Cardiovascular Institute			$0			$0			$0	0.2	$5.84
Electroencephalography			$0			$0			$0	0.0	$2.06
Laboratory			$0			$0			$0	1.1	$69.27
Total Direct Care			$0			$0			$0	99.7	$9,250
Support Staff *(List general categories, add rows if needed)*											
Nutritional Services			$0			$0			$0	12.0	$370
Plant Operations			$0			$0			$0	4.0	$256
Bio Med			$0			$0			$0	0.1	$4
Environmental Services			$0			$0			$0	11.0	$362
Security			$0			$0			$0	7.7	$296
Print Shop			$0			$0			$0	0.1	$8
Total Support			$0			$0			$0	34.8	$1,296
REGULAR EMPLOYEES TOTAL			$0			$0			$0	164.1	$12,764
2. Contractual Employees											

TABLE L. WORKFORCE INFORMATION - UC Behavioral Health

Administration *(List general categories, add rows if needed)*										
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*										
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*										
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below)* **:**											**$ 3,056**
23.9% of Salaries											
TOTAL COST	***0.0***		***$0***	***0.0***		***$0***	***0.0***		***$0***		***$15,820***

EXHIBIT 2

ERDMAN
ERDMAN COMPANY

UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS

Document Release

06-08-17	DRAFT CON SUBMITTAL

Drn: RSLAYTON Chk:

Sheet Name
SITE PLAN

Scale: 1" = 50'

Sheet Number
C101

HAVRE DE GRACE, MD
628620

GENERAL NOTES

1. Parking lot dimensions are from face of curb to face of curb unless noted othewise
2. It shall be the responsibility of the subcontractors to notify all applicable utility companies who may be affected by the proposed work. The subcontractor shall make every effort to protect existing utility lines and shall repair any damages at their own expense. The subcontractors shall also coordinate their activities with other subcontractors to ensure compliance with the project schedule.
3. All site concrete shall have a minimum 28 day compressive strength of 4000 psi, a slump of 4", an air content of 6% and a maximum water to cement ratio of 0.48

SITE LEGEND

EXISTING

- Contours — 100
- Spot elevations — 100.0
- Trees to be saved
- Trees to be removed
- Storm sewer main / lateral — 12 ST
- Sanitary sewer main / lateral — 6 SA
- Water main / lateral — 4 W
- Gas main / lateral — GAS
- Overhead Electrical service — OH/E
- Underground electric service — UG/E
- Overhead Telephone service — OH/T
- Underground Telephone service — UG/T

PROPOSED:

- Contours — 100
- Spot elevations — 100.0
- Trees
- Shrubs
- Storm sewer main / lateral — 12 ST
- Sanitary sewer main / lateral — 6 SA
- Water main / lateral — 4 W
- Gas main / lateral — GAS
- Overhead Electrical service — OH/ E
- Underground Electric service — UG/ E
- Overhead Telephone service — OH/ T
- Underground Telephone service — UG/ T
- Cable Television service — COMM

MISCELLANEOUS:

- Property line — N 90° 0' 0" E 11.32'
- Setback line
- Silt fence — SF
- Site Phasing line
- Water line
- 100 Yr. Flood line
- Contract Limit line

LANDSCAPING

- Construction fence — X
- Irrigation Area Zone line
- Landscape Edging line
- Mowing line
- Planting code symbol (Base Bid Plant) — Plant Qty. / Plant Code
- Planting code symbol (Add Alternate Plant) — Plant Qty. / Plant Code

SYMBOLS

- Existing Parking lights
- Proposed Parking lights
- Soil boring location & Number — B1

EXISTING	PROPOSED	
		Precast Flaired end section
		Concrete Headwall
		Storm Catchbasins
		Sanitary & Storm Manhole
C.O.	C.O.	Storm gooseneck / Cleanout
		Storm inlet protection
		Fire Hydrant
W.V.	W.V.	Siamese Connection / Water Valve
W	W	Water Meter
G	G	Gas Meter
		Power pole
		Handicap signs
		Flag pole
		Concrete Bollard
		Conc. filled Pipe Bollard
		Light Bollard
		Flood light
		Concrete pavement Slope Arrow

ERDMAN COMPANY
One Erdman Place
Madison, Wisconsin 53717
Phone 608.410.8000 | Fax 608.410.8500

UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH MEDICAL CENTER

Document Release

7–24–15	REVISED ESTIMATE PLAN
7–15–15	REVISED ESTIMATE PLAN
06–15–15	ESTIMATING PLAN

Drn: KJL Chk:

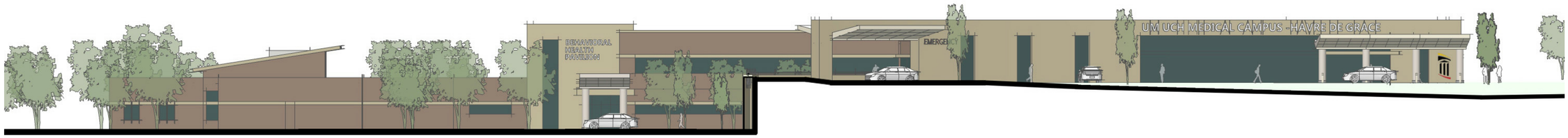
Sheet Name

C101 SITE PLAN - C101 SITE PLAN

Scale:

Sheet Number

Havre De Grace, MD
6246



EAST ELEVATION

NORTH ELEVATION

WEST ELEVATION

SOUTH ELEVATION

NOT FOR CONSTRUCTION

ERDMAN
healthcare real estate solutions

11 North Washington Street, Suite 300
Rockville, Maryland 20850
Phone: (301) 217-0826
Fax: (301) 217-0751

UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS

No.	Description	Date
4	PROJECT ANALYSIS (CON) ROUND TWO	07/31/15
3	PROJECT ANALYSIS (CON)	06/05/15

Document Release

Drn:BHEBERT Chk:Checker

Sheet Name
PROPOSED ELEVATIONS

Scale:

Sheet Number
A103

HAVRE DE GRACE, MD
Job 628620

ERDMAN
healthcare real estate solutions

11 North Washington Street, Suite 300
Rockville, Maryland 20850
Phone: (301) 217-0826
Fax: (301) 217-0751

UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS

No.	Description	Date
4	PROJECT ANALYSIS (CON) ROUND TWO	07/31/15
3	PROJECT ANALYSIS (CON)	06/05/15
2	PROGRESS PLAN	05/26/15
1	PROGRESS PLAN	05/15/15

Document Release

Drn: BHEBERT Chk: Checker

Sheet Name

PROPOSED GROUND FLOOR AND DEPARTMENT PLAN

Scale: **1/16" = 1'-0"**

Sheet Number

A100

HAVRE DE GRACE, MD
Job 628620

NOT FOR CONSTRUCTION

7/30/2015 9:22:39 AM C:\Revit Projects\w_j\kent-de-grace_md_628620_BHebert.rvt

NOT FOR CONSTRUCTION

ERDMAN
healthcare real estate solutions

11 North Washington Street, Suite 300
Rockville, Maryland 20850
Phone: (301) 217-0826
Fax: (301) 217-0751

UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS

No.	Description	Date
4	PROJECT ANALYSIS (CON) ROUND TWO	07/31/15
3	PROJECT ANALYSIS (CON)	06/05/15

Document Release

Drn: BHEBERT Chk: Checker

Sheet Name

PROPOSED ROOF PLAN

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

Sheet Number

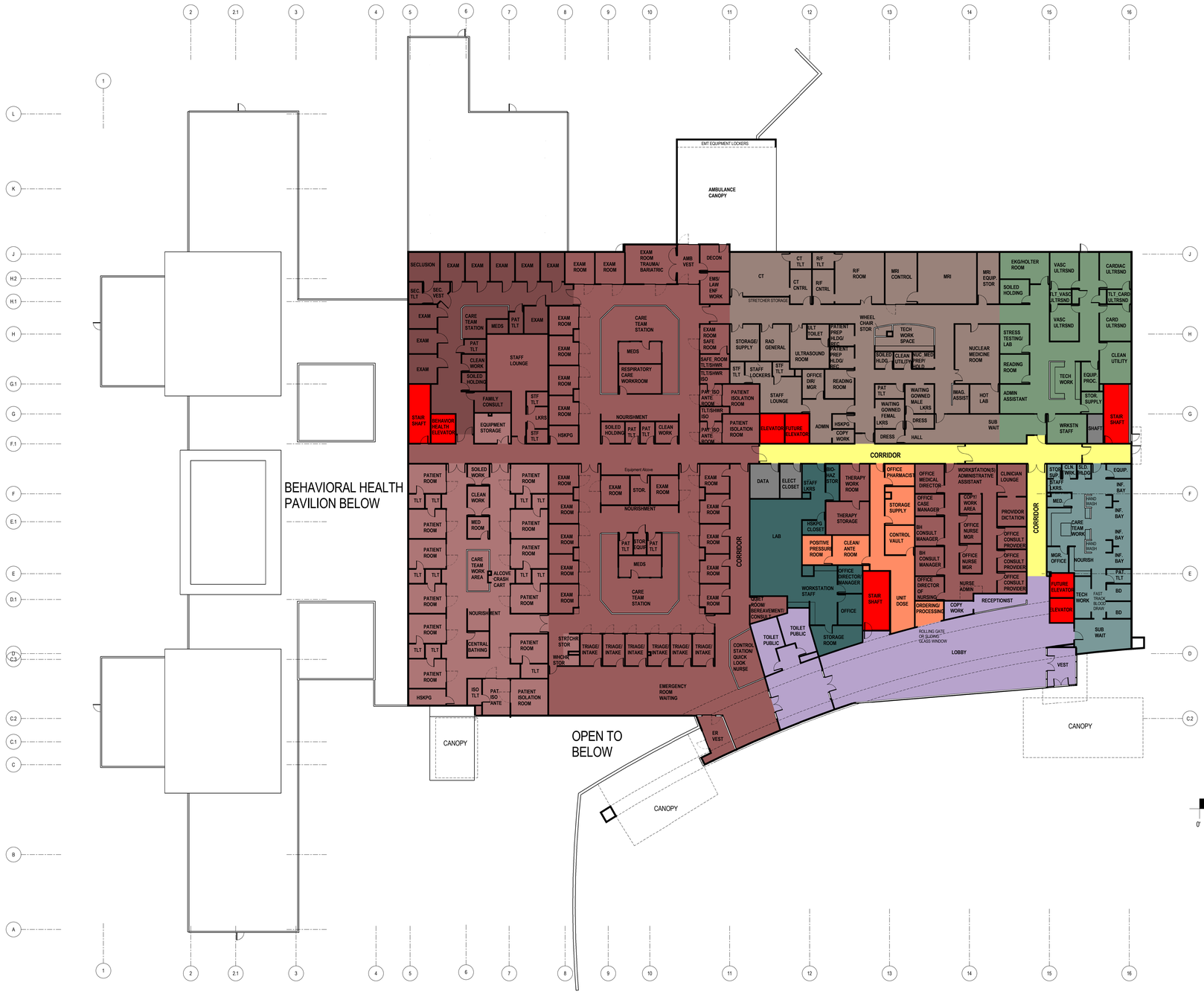
A102

HAVRE DE GRACE, MD
Job 628620

ERDMAN
healthcare real estate solutions

11 North Washington Street, Suite 300
Rockville, Maryland 20850
Phone: (301) 217-0826
Fax: (301) 217-0751

UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS



No.	Description	Date
4	PROJECT ANALYSIS (CON) ROUND TWO	07/31/15
3	PROJECT ANALYSIS (CON)	06/05/15
2	PROGRESS PLAN	05/26/15
1	PROGRESS PLAN	05/15/15

Document Release

Drn:BHEBERT Chk:Checker

Sheet Name

PROPOSED FIRST FLOOR AND DEPARTMENT PLAN

Scale: **1/16" = 1'-0"**

Sheet Number

A101

HAVRE DE GRACE, MD
Job 628620

NOT FOR CONSTRUCTION

EXHIBIT 3

(1)

IMP FD SURE $ 20.00
RECORDING FEE 20.00
RECORDATION T 5,880.60

DEED

THIS DEED is made this 11th day of June, 2008, by and between **MTBR VENTURES LLC**, a Pennsylvania limited liability company ("Grantor") and **UPPER CHESAPEAKE LAND DEVELOPMENT, LLC**, a Maryland limited liability company ("Grantee").

NOW THEREFORE, THIS DEED WITNESSETH, that for no monetary consideration but in consideration of the issuance of all the membership interests in Grantee to Grantor, same being the actual consideration paid, and other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, Grantor does grant and convey to Grantee, its successors and assigns, in fee simple, all of those lots or parcels of land situate in Harford County, State of Maryland, and described in more detail on Exhibit A attached hereto and incorporated herein, which property has an assessed value of Eight Hundred Ninety-One Thousand Dollars ($891,000.00).

20 -
20 60
5880 -
4455 -
K

TR TAX STATE 4,455.00

SUBJECT to all covenants, easements and restrictions of record and **RESERVING** unto Grantor an easement for access, ingress and regress, and, as necessary, the installation and maintenance of utilities, in common with Grantee, on, over, under and through that private road known as Resonance Way and to the use of the storm water management area as shown on the plat at 115/21 and facilities therein, the terms of which easement shall be more fully described in a Deed and Declaration of Easement agreement to be recorded hereafter among the aforesaid land records, and to the terms of a Declaration of Covenants to be recorded hereafter.

TOTAL 10,375.60
Total 10,375.60

TOGETHER WITH any buildings thereupon, and the rights, alleys, ways, waters, privileges, appurtenances and advantages thereto belonging, or in anywise appertaining.

TO HAVE AND TO HOLD the described lots or parcels of land and premises to Grantee, its successors and assigns, in fee simple.

RECPT # 56712

AND by the execution of this Deed Grantor hereby certifies under penalties of perjury that the actual consideration paid or to be paid, including the amount of any mortgage or deed of trust outstanding or assumed by Grantee, is in the sum total as stated above and that Grantor is a "resident entity" as defined in Code of Maryland Regulations (COMAR) 03.04.12.02B(11) for purposes of the exemption described in Section 10-912 of the Tax-General Article, Annotated Code of Maryland.

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

JJR JK Blk # 1277
Jun 17, 2008 09:50 am

21321-1
F:\REAL ESTATE\47539.Bulle Rock\054.Upper Chesapeake Health Sale\Deed - Upper Chesapeake Bulle Rock.v3.doc

IN WITNESS WHEREOF, Grantor has caused this Deed to be executed under seal on the day and year herein first written.

WITNESS:

MTBR VENTURES LLC
By: MTBR LLC

By: _____(SEAL)
Name: Richard M. Alter
Title: Authorized Person

STATE OF MARYLAND,
CITY/COUNTY OF Anne Arundel, to wit:

I HEREBY CERTIFY, that on this 10th day June, 2008, before me, the subscriber, a Notary Public of the State aforesaid, personally appeared Richard M. Alter who acknowledged himself to be an Authorized Person of MTBR LLC, the sole member of MTBR Ventures LLC, a Pennsylvania limited liability company, and that he as such Authorized Person, being authorized so to do, executed the foregoing instrument for the purposes therein contained by signing in my presence, the name of the limited liability company by himself in such capacity.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

Notary Public

My Commission Expires: 5/1/09

TAMERA LYNNE COLLETTI
NOTARY PUBLIC
ANNE ARUNDEL COUNTY, MD
Com. Expires 05-01-09

21321-1
F:\REAL ESTATE\47539.Bulle Rock\054.Upper Chesapeake Health Sale\Deed - Upper Chesapeake Bulle Rock.v3.doc

ATTORNEY CERTIFICATION

This is to certify that the foregoing instrument was prepared by or under the supervision and direction of the undersigned, an attorney admitted to practice in the State of Maryland.

Ann Clancy Cotton/by CH

HARFORD COUNTY MARYLAND
TRANSFER TAX PD $ 7910.00 cash 6/13/08
ALL OTHER TAXES PAID

PROPERTY PRESENTLY NOT ON WATER & SEWER SYSTEM PER: MC
DATE: 6/13/08 HARFORD COUNTY

ALL MUNICIPAL TAXES
AND CHARGES PAID
ABERDEEN: _____
BEL AIR: _____
HdeG: MC 6/13/08

EXHIBIT A

BEING for the first all that lot or parcel of ground situate and lying in the City of Havre de Grace in the Sixth Election District of Harford County, State of Maryland, containing 26.619 acres, more or less, and being known and designated as Lot No. 1 as shown on the plat entitled "Revised Final Plat One, Land of Blenheim, L.L.C., et al", which plat is recorded among the Plat Records of Harford County in Plat Book J.J.R. No. 113, folio 29, such 26.619 acre parcel being known as No. 760 Bulle Rock Parkway, saving and excepting therefrom all that property known and designated as Lot No. 1 as shown on the plat entitled "Final Plat One, Bulle Rock Corporate Campus", which plat is recorded among the Plat Records of Harford County in Plat Book J.J.R. No. 115, folio 21.

BEING for the second all that lot or parcel of ground situate and lying in the City of Havre de Grace in the Sixth Election District of Harford County, State of Maryland, containing 0.649 acres, more or less, and being known and designated as Resonance Way, a Private Road, as shown on the plat entitled "Final Plat One, Bulle Rock Corporate Campus", which plat is recorded among the Plat Records of Harford County in Plat Book J.J.R. No. 115, folio 21.

SUBJECT, as to the second parcel, to a perpetual easement for ingress, egress, access and utilities from and between that lot or parcel of land commonly known as 100 Resonance Way and shown as Lot 1 on the above described plat recorded in Liber 115 at folio 21 and Bulle Rock Parkway.

GRANTOR ADDRESS:
(In the State of Maryland)

MTBR Ventures LLC
c/o Manekin, LLC
8601 Robert Fulton Drive, Suite 200
Columbia, MD 21046

GRANTEE ADDRESS:

Upper Chesapeake Land Development, LLC
c/o Manekin, LLC
8601 Robert Fulton Drive, Suite 200
Columbia, MD 21046

RETURN ADDRESS:

Ann Clary Gordon
Shapiro Sher Guinot & Sandler
36 S. Charles Street
Suite 2000
Baltimore, MD 21201
(410) 385-4225

Tax ID # and Street Address for Property Transferred:

Remainder of Lot 1 — ID# 06-059635 — 760 Bulle Rock Parkway

Resonance Way (private road) – No ID# exists – see plat 115/21 for location

State of Maryland Land Instrument Intake Sheet

☐ Baltimore City ☒ County: Harford

Information provided is for the use of the Clerk's Office, State Department of Assessments and Taxation, and County Finance Office Only
(Type or Print in Black Ink Only - All Copies Must Be Legible)

1 Type(s) of Instruments

x	Deed		Mortgage		Other:		
	Deed of Trust		Lease				

2 Conveyance Type Check Box

	Improved Sale Arms-Length [1]		Unimproved Sale Arms-Length [2]		Mult. Accounts Arms-Length [3]		Not an Arms-Length Sale [9]

3 Tax Exemptions (if Applicable) Cite or Explain Authority

Recordation	Transfer taxes are based on the assessed value of the property which is $891,000.00
State Transfer	
County Transfer	

Space Reserved for Circuit Court Clerk Recording Violation

4 Consideration and Tax Calculations

Consideration Amount		Finance Office Use Only	
Purchase Price/Consideration		**Transfer and Recordation Tax Consideration**	
Any New Mortgage		Transfer Tax Consideration	$
Balance of Existing Mortgage		X ( ) % =	$
Other		Less Exemption Amount -	$
		Total Transfer Tax =	$
Other		Recordation Tax Consideration	$
		X ( ) % =	$
Full Cash Value		TOTAL DUE	$

5 Fees

Amount of Fees	Doc. 1	Doc. 2	Agent
Recording Charge	20.00	.00	
Surcharge	20.00	.00	Tax Bill:
State Recordation Tax	5880.60	.00	
State Transfer Tax	4455.00	.00	C.B. Credit:
County Transfer Tax (if Applicable)	8910.00	.00	
Other			Ag. Tax/Other:
Other			

6 Description of Property

SDAT requires submission of all applicable information. A Maximum of 40 characters will be indexed in accordance with the priority cited in Real Property Article Section 3-104(g)(3)(i).

District	Property Tax ID No. (1)	Grantor Liber/Folio	Map	Parcel No.	Var. LOG
06	059635	2983/341			☐

Subdivision Name	Lot (3a)	Block (3b	Sect/AR(3c	Plat Ref.	Sq. Ft./Acreage (4)
Land of Blenheim	1			113/29	26.62 ac

Location/Address of Property Being Conveyed (2)
760 Bulle Rock Parkway, Havre de Grace, MD 21078

Other Property Identifiers (if applicable)	Water Meter Account No.

Residential ☐ **or Non-Residential** ☒ | **Fee Simple** ☐ **or Ground Rent** ☐ **Amount:**

Partial Conveyance? ☐ **Yes** ☒ **No** | Description/Amt. Of Sq. Ft./Acreage Transferred:

If Partial Conveyance, List Improvements Conveyed:

7 Transferred From

Doc. 1 - Grantor(s) Name(s)	Doc. 2 - Grantor(s) Name(s)
MT&R Ventures LLC	
Doc. 1 - Owner(s) of Records, if Different from Grantor(s)	**Doc. 2 - Owner(s) of Record, if Different from Grantor(s)**

8 Transferred To

Doc. 1 - Grantee(s) Names	Doc. 2 - Grantee(s) Name(s)
Upper Chesapeake Land Development, LLC	

New Owner's (Grantee) Mailing Address
8601 Robert Fulton Drive, Suiet 200, Columbia, MD 21046-2278

9 Other Names to be Indexed

Doc. 1 - Additional Names to be Indexed (Optional)	Doc. 2 - Additional Names to be Indexed (Optioned)

10 Contact/Mail Information

Instrument Submitted By or Contact Person	
Name:	Beth Book
Firm:	Residential Title & Escrow Company
Address:	1829 Reisterstown Road Ste. 380, Baltimore, MD 21208
Phone:	410-653-3400

X Return to Contact Person
☐ Hold for Pickup
☐ Return Address Provided

Space Reserved for County Validation

11 Assessment Information

IMPORTANT: *BOTH* THE ORIGINAL DEED *AND* A PHOTOCOPY MUST ACCOMPANY EACH TRANSFER

	Yes	x	No	Will the property being conveyed be the grantee's principal residence?
	Yes	x	No	Does transfer include personal property? If yes, identify:
	Yes	X	No	Was property surveyed? If yes, attach copy of survey (if recorded, no copy required).

Assessment Use Only - Do Not Write Below This Line

☐ Terminal Verification ☐ Agricultural Verification ☐ Whole ☐ Part ☐ Tran. Process Verification

Transfer Number: Date Received: Deed Reference: Assigned Property No:

Year	19	19	Geo.	Map	Sub	Block	
Land			Zoning	Grid	Plat	Lot	
Buildings			Use	Parcel	Section	Occ. Cd.	
Total			Town Cd.	Ex. St.	Ex. Cd.		

REMARKS:

Distribution: Clerk's Office, SDAT, Office of Finance, Prepare

(1) 1/1

THIS DEED, Made this 15th day of July, 2010, by and between **2236 LEVEL ROAD LLC,** a Maryland limited liability company, Grantor, and **UCHS/UMMS REAL ESTATE TRUST,** a Maryland business trust, Grantee.

WITNESSETH, That in consideration of the sum of **ONE MILLION FIVE HUNDRED SEVENTY FIVE THOUSAND AND 00/100 DOLLARS ($1,575,000.00)**, the actual consideration paid, and other good and valuable consideration, the receipt of which is hereby acknowledged, the said Grantor does grant and convey to the Grantee, its successors and/or assigns, in fee simple, all that parcel of land situate in Harford County, State of Maryland, and described as follows, that is to say:

20 / 20 / 10395 / 7875 / K

SEE EXHIBIT A ATTACHED HERETO FOR LEGAL DESCRIPTION

TOGETHER WITH the buildings thereupon, and the rights, alleys, ways, waters, privileges, appurtenances and advantages thereto belonging, or in anywise appertaining.

SUBJECT TO all covenants, easements and restrictions of record or visible upon inspection.

BEING the same property described in a Deed dated August 16, 2005 and recorded among the Land Records of Harford County in Liber 6309, folio 170 from Blanche Virginia Stamper unto 2236 Level Road LLC.

BY the execution of this Deed, the Grantor hereby certifies under the penalties of perjury that the actual consideration paid or to be paid, including the amount of any mortgage or deed of trust outstanding and assumed, is as hereinbefore set forth.

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

TO HAVE AND TO HOLD the described parcel of land and premises to the said Grantee, its successors and/or assigns, in fee simple.

[signature on following page]

INP FD SURE $	20.00
RECORDING FEE	20.00
RECORDATION T	10,395.00
TR TAX STATE	7,875.00
TOTAL	18,310.00
Rest# HA03	Rcpt # 17348
JJR JD	Blk # 3145
Jul 23, 2010	11:20 am

IN WITNESS WHEREOF, Grantor has executed this Deed under seal on the day and year herein first written.

WITNESS:

2236 LEVEL ROAD LLC,
a Maryland limited liability company

Margaret Larson

By: _____ (SEAL)
Richard M. Alter
Authorized Person

STATE OF MARYLAND

CITY/COUNTY OF Anne Arundel, **to wit:**

I HEREBY CERTIFY, That on this 13th day of July, 2010, before me, the subscriber, a Notary Public of the State aforesaid, personally appeared Richard M. Alter, who acknowledged himself to be the Authorized Person of **2236 LEVEL ROAD LLC**, and that he, as such Authorized Person, being authorized so to do, executed the within instrument in the capacity therein stated and for the purposes therein contained.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

Tamera Lynne Colletti
NOTARY PUBLIC

My Commission Expires: 5/21/2013

TAMERA LYNNE COLLETTI
NOTARY PUBLIC
ANNE ARUNDEL COUNTY MD
Com. Expires 05/21/2013

THIS IS TO CERTIFY THAT THE WITHIN INSTRUMENT HAS BEEN PREPARED BY OR UNDER THE SUPERVISION OF THE UNDERSIGNED MARYLAND ATTORNEY.

HARFORD COUNTY MARYLAND
TRANSFER TAX PD $ 15,700.00
ALL OTHER TAXES PAID 7/22/10

Ann Clary Gordon
ANN CLARY GORDON

RETURN TO:

Commonwealth Land Title
Insurance Company
1 North Charles Street, Suite 400
Baltimore, Maryland 21201
Attention: Sherry Dorsey/2610-00103

PROPERTY PRESENTLY NOT ON WATER & SEWER SYSTEM PER: CLL
DATE: 7/22/10 HARFORD COUNTY

ALL MUNICIPAL TAXES
AND CHARGES PAID
ABERDEEN: _____
BEL AIR: _____
HdeG: CLL 7/22/10

EXHIBIT A

0.972 Acre Parcel of Land Located on the East Side of Barker Lane and South of Maryland Route 155, City of Havre de Grace, Sixth Election District, Harford County, Maryland.

BEGINNING for the same at a point at the intersection of the southwesterly side of Barker Lane, 60 feet wide, as shown on State Roads Commission Plat No. 27620 with the northerly side of Panhandle "A" and the southerly side of the panhandle of Lot 1 as shown on the plat entitled "Final Plat, Land of James C. Barker" and recorded among the Land Records of Harford County, Maryland in Plat Book CGH 60, Folio 87, thence leaving the said panhandle of Lot 1 and binding on the division line between the said Barker Lane and the said Panhandle "A", as now surveyed, with bearings referred to the Maryland Coordinate System (NAD'83/91),

1. South 61° 44' 01" East 51.99 feet a point at the intersection of the said Barker Lane with the southerly outline of the aforesaid Panhandle "A", thence leaving the said Barker Lane and binding on the southerly and easterly outline of the said Panhandle "A", three courses, viz:

2. North 75° 38' 49" West 786.01 feet,

3. South 39° 46' 33" West 800.00 feet, and

4. South 17° 13' 47" East 204.56 feet to a point at the end of the second or N. 54* 50' W 200.0 ft. line of a deed from James C. Barker to Martin T. Stamper and Blanche Virginia Stamper, his wife, dated December 21, 1970 and recorded among the aforesaid Land Records in Liber 864, Folio 482, thence binding reversely on all of the second, first, and fourth and part of the third lines of the said deed, four courses, viz:,

5. South 63° 13' 45" East 200.00 feet,

6. South 26°46'15" West 100.00 feet,

7. North 63° 13' 45" West 200.00 feet, and

8. North 26° 46' 15" East 82.00 feet, thence leaving the aforesaid third line and binding on the westerly outline of the aforesaid Panhandle "A",

9. North 17° 13' 47" West 224.29 feet to a point and to intersect the southeasterly outline of the aforesaid panhandle of Lot 1, thence binding on the division lines between the said Panhandle "A" and the panhandle of Lot 1, two courses, viz:

CONTINUATION OF EXHIBIT A

10. North 39° 46' 33" East 814.69 feet, and

11. South 75° 38' 49" East 743.45 feet to the place of beginning.

CONTAINING 0.972 acres of land, more or less.

Certification of Exemption from Withholding Upon Disposition of Maryland Real Estate Affidavit of Residence or Principal Residence

Based on the certification below, Transferor claims exemption from the tax withholding requirements of § 10-912 of Maryland's Tax General Article. Section 10-912 states that certain tax payments must be withheld when a deed or other instrument that affects a change in ownership of real property is recorded. The requirements of § 10-912 do not apply when a transferor provides a certification of Maryland residence or certification that the transferred property is the transferor's principal residence.

1. Transferor Information
Name of Transferor 2236 LEVEL ROAD LLC

2. Reason for Exemption		
Resident Status	☐	I, Transferor, am a resident of the State of Maryland.
	☒	Transferor is a resident entity under § 10-912(A)(4) of Maryland's Tax General Article, I am an agent of Transferor, and I have authority to sign this document on Transferor's behalf. * OR Resident entity
Principal Residence	☐	Although I am no longer a resident of the State of Maryland, the Property is my principal residence as defined in IRC § 121.

* Established or Registered more than 90 Days prior to Settlement

Under penalty of perjury, I certify that I have examined this declaration and that, to the best of my knowledge, it is true, correct, and complete.

3a. Individual Transferors	
Witness	Name
	Signature

3b. Entity Transferors	
Margaret Larson Witness/Attest	**2236 LEVEL ROAD LLC** Name of Entity
	By:
	Richard M. Alter Name
	Authorized Person Title

2610-00103

State of Maryland Land Instrument Intake Sheet

☐ Baltimore City ☒ County: Harford

Information provided is for the use of the Clerk's Office, State Department of Assessments and Taxation, and County Finance Office only.

(Type or Print in Black Ink Only - All Copies Must Be Legible)

Space Reserved for Circuit Court Clerk Recording Validation

Type(s) of Instruments

(☐ Check Box If Addendum Intake Form is Attached.)

[1] Deed [ ] Mortgage [ ] Other:
[ ] Deed of Trust [ ] Lease [ ] Other: [ ] Other:

Conveyance Type (Check Box)

☐ Improved Sale Arms-Length *[1]* ☐ Unimproved Sale Arms-Length *[2]* ☐ Multiple Accounts Arms-Length *[3]* ☐ Not an Arms-Length Sale *[9]*

Tax Exemptions (if Applicable) Cite or Explain Authority

Recordation	
State Transfer	
County Transfer	

Consideration and Tax Calculations

Consideration Amount		Finance Office Use Only	
Purchase Price/Consideration	1,575,000.00	Transfer and Recordation Tax Consideration	
Any New Mortgage		Transfer Tax Consideration	
Balance of Existing Mortgage		X ( ) % =	
Other:		Less Exemption Amount -	
		Total Transfer Tax =	
Other:		Recordation Tax Consideration	
		X ( ) per $500 =	
Full Cash Value		TOTAL DUE	

Fees

Amount of Fees	Doc.1	Doc. 2	
Recording Charge	20.00		Agent:
Surcharge	20.00		Tax Bill:
State Recordation Tax	10,395.00		C.B. Credit:
State Transfer Tax	7,875.00		
County Transfer Tax	15,750.00		Ag. Tax/Other:
Other			
Other			

Description of Property

SDAT requires submission of all applicable information. A maximum of 40 characters will be indexed in accordance with the priority cited in Real Property Article Section 3-104(g)(3)(i).

District	Property Tax ID No. (1)	Grantor Liber/Folio	Map	Parcel No.	Var. LOG ☐ (5)
06	007457				

Subdivision Name	Lot 3(a)	Block(3b)	Sect/AR(3c)	Plat Ref.	SqFt/Acreage(4)
					42253 SF

Location / Address of Property Being Conveyed (2)

2236-A Level Road

Other Property Identifiers (if applicable) | Water Meter Account No.

Residential ☐ or Non-Residential ☒ | Fee simple ☒ or Ground Rent ☐ Amount:

Partial Conveyance? ☐ Yes ☒ No | Description/Amt. of SqFt/Acreage Transferred:

If Partial Conveyance, List Improvements Conveyed:

Transferred From

Doc.1 - Grantor(s) Name(s)	Doc. 2 - Grantor(s) Names(s)
2236 Level Road LLC	
Doc. 1 Owner(s) of Record, if different from Grantor(s)	Doc. 2 Owner(s) of Record, if different from Grantor(s)

Transferred To

Doc. 1 - Grantee(s) Name(s)	Doc. 2 - Grantee(s) Name(s)
UCHS/UMMS Real Estate Trust	

New Owner's (Grantee) Mailing Address

520 Upper Chesapeake Drive, Suite 405, Bel Air, Md. 21014

Other Names to be Indexed

Doc. 1 - Additional Names to be Indexed (Optional)	Doc. 2-Additional Names to be Indexed (Optional)

Contact/Mail Information

Instrument Submitted By or Contact Person

Name: Sherry Dorsey
Firm: Commonwealth Land Title Insurance Company
Address: 1 North Charles Street, Suite 400, Baltimore, MD 21201
Phone: 410-230-9595

☒ Return to Contact Person
☐ Hold for Pickup
☐ Return Address Provided

IMPORTANT: *BOTH* THE ORIGINAL DEED *AND* A PHOTOCOPY MUST ACCOMPANY EACH TRANSFER

Assessment Information

☐ Yes ☒ No Will the property being conveyed be the grantee's principal residence?
☐ Yes ☒ No Does transfer include personal property? If yes, identify:
☐ Yes ☒ No Was property surveyed? If yes, attach copy of survey (if recorded, no copy required).

Assessment Use Only - Do Not Write Below This Line

☐ Terminal Verification ☐ Agricultural Verification ☐ Whole ☐ Part ☐ Tran. Process Verification

Transfer Number: Date Received: Deed Reference: Assigned Property No.:

Year	20	20	Geo.	Map	Sub	Block
Land			Zoning	Grid	Plat	Lot
Buildings			Use	Parcel	Section	Occ.Cd.
Total			Town Cd.	Ex.St.	Ex.Cd.	

REMARKS:

(2) 1/2

THIS DEED, Made this 15th day of July, 2010, by and between **ROUTE 155, LLC, a Maryland limited liability companies**, Grantor, and **UCHS/UMMS REAL ESTATE TRUST, a Maryland business trust**, Grantee.

WITNESSETH, That in consideration of the sum of **TWO MILLION THREE HUNDRED FIFTY THOUSAND AND 00/100 DOLLARS ($2,350,000.00)**, the actual consideration paid, and other good and valuable consideration, the receipt of which is hereby acknowledged, the said Grantor does grant and convey to the Grantee, its successors and/or assigns, in fee simple, all that parcel of land situate in Harford County, State of Maryland, and described as follows, that is to say:

20 -
20 -
15,510 -
11,750 -
K

SEE EXHIBIT A ATTACHED HERETO FOR LEGAL DESCRIPTION

TOGETHER WITH the buildings thereupon, and the rights, alleys, ways, waters, privileges, appurtenances and advantages thereto belonging, or in anywise appertaining.

BEING the same property described in Deed dated April 18, 1998 and recorded among the Land Records of Harford County in Liber 2748, folio 534 from D.L.B. Joint Venture unto Route 155, LLC.

BY the execution of this Deed, the Grantor hereby certifies under the penalties of perjury that the actual consideration paid or to be paid, including the amount of any mortgage or deed of trust outstanding, is as hereinbefore set forth.

AND the said Grantor hereby covenants that it has not done or suffered to be done any act, matter or thing whatsoever, to encumber the property hereby conveyed; that it will warrant specially the property hereby granted; and that it will execute such further assurances of the same as may be requisite.

TO HAVE AND TO HOLD the described parcel of land and premises to the said Grantee, its successors and/or assigns, in fee simple.

IN WITNESS WHEREOF, Grantor has executed this Deed under seal on the day and year herein first written.

IMP FD SURE $	20.00
RECORDING FEE	20.00
RECORDATION T	15,510.00
TR TAX STATE	11,750.00
TOTAL	27,300.00
Rcpt # HA83	Rcpt # 17949
JJR JD	Blk # 3148
Jul 23, 2010	11:25 am

JUL 23, 2010

WITNESS:

ROUTE 155, LLC,
a Maryland limited liability company

BY: George W. Clampet (SEAL)
Name: George W. Clampet
Title: Member

BY: Ralph W. Norton (SEAL)
Name: Ralph W. Norton
Title: Member

STATE OF Maryland,

~~CITY~~/COUNTY OF Harford, to wit:

I HEREBY CERTIFY, That on this 15th day of July, 2010, before me, the subscriber, a Notary Public of the State aforesaid, personally appeared George W. Clampet, who acknowledged himself to be the Member of ROUTE 155, LLC, and that he/she as such Member being authorized so to do, executed the within instrument in the capacity therein stated and for the purposes therein contained by himself as such Member.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

Notary Public

My Commission Expires: 8-1-10

STATE OF Maryland,

~~CITY~~/COUNTY OF Harford, to wit:

I HEREBY CERTIFY, That on this 15th day of July, 2010, before me, the subscriber, a Notary Public of the State aforesaid, personally appeared Ralph W. Norton, who acknowledged himself to be the Member of ROUTE 155, LLC, and that he/she as such Member being authorized so to do, executed the within instrument in the capacity therein stated and for the purposes therein contained by himself as such Member.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

Notary Public

My Commission Expires: 8-1-10

L MUNICIPAL TAXES
D CHARGES PAID
ABERDEEN:
BEL AIR:
HdeG: CLE Hsles

THIS IS TO CERTIFY THAT THE WITHIN INSTRUMENT HAS BEEN PREPARED BY OR UNDER THE SUPERVISION OF THE UNDERSIGNED MARYLAND ATTORNEY.

HARFORD COUNTY MARYLAND
TRANSFER TAX PD $ $23,500.00 CLE
ALL OTHER TAXES PAID 7/22/10

JEFFREY W THOMSEN

RETURN TO:

Commonwealth Land Title
Insurance Company
1 North Charles Street, Suite 400
Baltimore, Maryland 21201
Attention: Sherry Dorsey/2610-00097

2

PROPERTY PRESENTLY NOT ON WATER & SEWER SYSTEM PER: CLE
DATE: 7/22/10 HARFORD COUNTY

AGRICULTURAL TRANSFER TAX IN THE AMOUNT OF $ Letter of Intent #4
Received for transfer 10-11 6.04AC
State Department of Assessments & Taxation of Harford County
C Escalera 7-22-10
By Date

LIBER 08733 FOLIO 009

EXHIBIT A

All that lot or parcel of land, situate and lying in the Second Election District of Harford County, State of Maryland, near the City of Havre de Grace, at and near Maryland Route No. 155 and bounding on the southwesterly right of way line of Ramp "A" as shown on State Road Commission of Maryland Plat No. 27620 of Northeastern Expressway, now named John F. Kennedy Memorial Highway, particularly described as follows: Beginning for the same at a stone heretofore set at the southwesterly most corner of the parcel of land conveyed by and described in a Deed from Carrie Mitchell to Mary Ethel Mitchell Cooper, dated November 14, 1931, and recorded among the Land Records of Harford County in Liber SWC No. 221, folio 330, thence running with and binding on the northwesterly outline of the last mentioned parcel, being a line of division between the lands of Mary Ethel Mitchell Cooper and the lands of James C. Baker and Pearl F. Barker, his wife, as now surveyed, North 28 degrees 26 minutes 36 seconds East 171.24 feet to a stone heretofore set; thence continuing this same direction, North 28 degrees 26 minutes 36 seconds East 8.81 feet to intersect the southwesterly right of way line of Ramp "A" as shown on the aforementioned State Roads Commission of Maryland Plat; thence leaving the Cooper Lands and thence running with and binding on the right of way line of the aforesaid Ramp "A", the following four courses, viz: North 67 degrees 34 minutes 33 seconds West 384.32 feet, thence North 81 degrees 09 minutes 29 seconds West 283.95 feet to a point of curve, thence by a curve to the left of radius 1205.23 feet, an arc distance of 241.06 feet to a point of compound curve; thence by a curve to the left or radius 1839.86 feet, an arc distance of 324.74 feet; running with and binding on the dividing line between the lands of the Barkers and the lands formerly owned by Horace H. Moore and now owned by the State of Maryland, to the use of the State Roads Commission of Maryland, South 22 degrees 56 minutes 56 seconds West 217.61 feet; thence leaving the State Roads Commission land, formerly the Moore lands, and running through and across the lands of the grantors for new lines of division, the following eight courses, viz: North 82 degrees 57 minutes 21 seconds East 541.05 feet; thence 72 degrees 09 minutes 26 seconds East 56.95 feet to a point on the northerly side of a gravel lane of the grantors, James C. Barker and Pearl F. Barker, his wife used by them for access from other property owned by them to State Route No. 155; thence binding on the northerly side of said lane, South 87 degrees 53 minutes 34 seconds East 60.30 feet; South 81 degrees 19 minutes 44 seconds East 168.69 feet; South 76 degrees 07 minutes 34 seconds East 122.14 feet; South 71 degrees 32 minutes 14 seconds East 128.34 feet; and South 67 degrees 05 minutes 24 seconds East 127.62 feet; thence leaving said lane, North 28 degrees 26 minutes 36 seconds East 23.28 feet to the beginning thereof; containing 6.04 acres of land, more or less according to a survey made August 9, 1963 by Frederick Ward Associates and as laid down and shown on a plat recorded in a Deed dated February 16, 1965 and recorded among the Land Records of Harford County in Liber No. 669, folio 113.

CONTINUATION OF EXHIBIT A

File No.2610-00097

Together with the benefit of a right of way established by Deed dated February 16, 1965 from James C. Barker and Pearl F. Barker, his wife and The Citizens National Bank of Havre De Grace unto George J. Williams, Sammy Williams and Steve Williams and recorded among the Land Records of Harford County in Liber 669, folio 113.

Certification of Exemption from Withholding Upon Disposition of Maryland Real Estate Affidavit of Residence or Principal Residence

Based on the certification below, Transferor claims exemption from the tax withholding requirements of § 10-912 of Maryland's Tax General Article. Section 10-912 states that certain tax payments must be withheld when a deed or other instrument that affects a change in ownership of real property is recorded. The requirements of § 10-912 do not apply when a transferor provides a certification of Maryland residence or certification that the transferred property is the transferor's principal residence.

1. Transferor Information

Name of Transferor

ROUTE 155, LLC

2. Reason for Exemption

Resident Status

☐ I, Transferor, am a resident of the State of Maryland.

☑ Transferor is a resident entity under § 10-912(A)(4) of Maryland's Tax General Article, I am an agent of Transferor, and I have authority to sign this document on Transferor's behalf. * or Resident entity

Principal Residence

☐ Although I am no longer a resident of the State of Maryland, the Property is my principal residence as defined in IRC § 121.

* established or registered more than 90 days prior to Settlement

Under penalty of perjury, I certify that I have examined this declaration and that, to the best of my knowledge, it is true, correct, and complete.

3a. Individual Transferors

Witness

Name

Signature

3b. Entity Transferors

ROUTE 155, LLC

Witness/Attest

Name of Entity

By: George W. Clompet

Name: Ralph W. Norton

Title: George W. Clompet, member
Ralph W. Norton, member

2610-00097

State of Maryland Land Instrument Intake Sheet

☐ Baltimore City ☒ County: Harford

Information provided is for the use of the Clerk's Office, State Department of Assessments and Taxation, and County Finance Office only.

(Type or Print in Black Ink Only - All Copies Must Be Legible)

Space Reserved for Circuit Court Clerk Recording Validation

Type(s) of Instruments

(☐ Check Box If Addendum Intake Form is Attached.)

[1] Deed [ ] Mortgage [ ] Other:

[ ] Deed of Trust [ ] Lease [ ] Other: [ ] Other:

Conveyance Type (Check Box)

☐ Improved Sale Arms-Length *[1]* ☐ Unimproved Sale Arms-Length *[2]* ☐ Multiple Accounts Arms-Length *[3]* ☐ Not an Arms-Length Sale *[9]*

Tax Exemptions (if Applicable) Cite or Explain Authority

Recordation	
State Transfer	
County Transfer	

Consideration and Tax Calculations

Consideration Amount	
Purchase Price/Consideration	2,350,000.00
Any New Mortgage	
Balance of Existing Mortgage	
Other:	
Other:	
Full Cash Value	

Finance Office Use Only	
Transfer and Recordation Tax Consideration	
Transfer Tax Consideration	
X( ) % =	
Less Exemption Amount -	
Total Transfer Tax =	
Recordation Tax Consideration	
X ( ) per $500 =	
TOTAL DUE	

Fees first doc is release

Amount of Fees	**Doc.1**	**Doc. 2**
Recording Charge	20.00	
Surcharge	20.00	
State Recordation Tax	15,510.00	
State Transfer Tax	11,750.00	
County Transfer Tax	23,500.000	
Other		
Other		

Agent:

Tax Bill:

C.B. Credit:

Ag. Tax/Other:

Description of Property

SDAT requires submission of all applicable information. A maximum of 40 characters will be indexed in accordance with the priority cited in Real Property Article Section 3-104(g)(3)(i).

District	**Property Tax ID No. (1)**	**Grantor Liber/Folio**	**Map**	**Parcel No.**	**Var. LOG** ☐ (5)
06	008402				

Subdivision Name	**Lot 3(a)**	**Block(3b)**	**Sect/AR(3c)**	**Plat Ref.**	**SqFt/Acreage(4)**
					6.04

Location / Address of Property Being Conveyed (2)

Route 155

Other Property Identifiers (if applicable)	**Water Meter Account No.**

Residential ☐ **or Non-Residential** ☒ **Fee simple** ☒ **or Ground Rent** ☐ **Amount:**

Partial Conveyance? ☐ **Yes** ☒ **No** Description/Amt. of SqFt/Acreage Transferred:

If Partial Conveyance, List Improvements Conveyed:

Transferred From

Doc.1 - Grantor(s) Name(s)	**Doc. 2 - Grantor(s) Names(s)**
Route 155, LLC	
Doc. 1 Owner(s) of Record, if different from Grantor(s)	**Doc. 2 Owner(s) of Record, if different from Grantor(s)**

Transferred To

Doc. 1 - Grantee(s) Name(s)	**Doc. 2 - Grantee(s) Name(s)**
UCHS/UMMS Real Estate Trust	

New Owner's (Grantee) Mailing Address

520 Upper Chesapeake Drive, Suite 405, Bel Air, Md. 21014

Other Names to be Indexed

Doc. 1 - Additional Names to be Indexed (Optional)	**Doc. 2-Additional Names to be Indexed (Optional)**

Contact/Mail Information

Instrument Submitted By or Contact Person
Name: Sherry Dorsey
Firm: Commonwealth Land Title Insurance Company
Address: 1 North Charles Street, Suite 400, Baltimore, MD 21201
Phone: 410-230-9595

☒ Return to Contact Person

☐ Hold for Pickup

☐ Return Address Provided

IMPORTANT: *BOTH* THE ORIGINAL DEED *AND* A PHOTOCOPY MUST ACCOMPANY EACH TRANSFER

Assessment Information

☐ Yes ☒ No Will the property being conveyed be the grantee's principal residence?

☐ Yes ☒ No Does transfer include personal property? If yes, identify:

☐ Yes ☒ No Was property surveyed? If yes, attach copy of survey (if recorded, no copy required).

Assessment Use Only - Do Not Write Below This Line

☐ Terminal Verification ☐ Agricultural Verification ☐ Whole ☐ Part ☐ Tran. Process Verification

Transfer Number: Date Received: Deed Reference: Assigned Property No.:

Year	20	20	Geo	Map	Sub	Block
Land			Zoning	Grid	Plat	Lot
Buildings			Use	Parcel	Section	Occ.Cd.
Total			Town Cd.	Ex.St.	Ex.Cd.	

REMARKS: Letter of consent #4 6.04 AC 7-22-10

LIBER 08733 FOLIO 013

THIS DEED, made this 15th day of July, 2009, by and between **STEWART GETZ, Esquire, and JAMES P. BARKER, Successor co-Trustees of the trust under the will of James C. Barker,** Parties of the First Part, **MONTGOMERY C. M. GREEN,** by R. Jonathan M. Green his Attorney-in-Fact, **ELIZABETH WATTS GREEN,** by R. Jonathan M. Green her Attorney-in-Fact, **JOHN RODGERS MEIGS GREEN,** by R. Jonathan M. Green his Attorney-in-Fact, and **R. JONATHAN M. GREEN**, Parties of the Second Part, (the Parties of the First and Second Parts being collectively referred to as "Grantors"), and **UCHS/UMMS REAL ESTATE TRUST,** a Maryland business trust, Grantee.

WITNESSETH, That in consideration of the sum of **TWO MILLION SIX HUNDRED NINETY THOUSAND THREE HUNDRED THIRTY and 87/100 DOLLARS ($2,690,330.87)**, the actual consideration paid, and other good and valuable consideration, the receipt of which is hereby acknowledged, the said Grantors do grant and convey to the Grantee, its successors and assigns, in Fee Simple, all that parcel of land situate in Harford County, State of Maryland, and described as follows, that is to say:

SEE LEGAL DESCRIPTION ATTACHED HERETO AS "EXHIBIT A"

REFERENCE IS MADE TO Limited Power of Attorney made by Montgomery C.M. Green, Elizabeth Watts Green and John Rodgers Meigs Green unto R. Jonathan M. Green recorded or intended to be recorded among the Land Records of Harford County immediately prior hereto.

TOGETHER WITH the buildings thereupon, and the rights, alleys, ways, waters, privileges, appurtenances and advantages thereto belonging, or in anywise appertaining.

BY the execution of this Deed, the Grantors hereby certify under the penalties of perjury that the actual consideration paid or to be paid, including the amount of any mortgage or deed of trust outstanding, is as hereinbefore set forth.

AND the said Parties of the Second Part hereby covenant that they have not done or suffered to be done any act, matter or thing whatsoever, to encumber the property hereby conveyed; that they will warrant specially the property hereby granted; and that they will execute such further assurances of the same as may be requisite.

TO HAVE AND TO HOLD the described parcel of land and premises to the said Grantee, its successors and assigns forever in Fee Simple.

IN WITNESS WHEREOF, Grantors have executed this Deed under seal on the day and year herein first written.

WITNESS:

_____ (SEAL)
STEWART GETZ, Esquire, Successor co-Trustee of the trust under the will of James C. Barker

_____ (SEAL)
JAMES P. BARKER, Successor co-Trustee of the trust under the will of James C. Barker

IMP FD SURC $	20.00
RECORDING FEE	20.00
RECORDATION T	17,757.30
TR TAX STATE	13,451.65
NON-RESIDENT	72,639.30
TOTAL	103,888.25
Rcpt HA03	Rcpt # 18053
JJR TBR	Blk # 3381
Jul 26, 2010	12:31 PM

R. JONATHAN M. GREEN (SEAL)
R. JONATHAN M. GREEN, Attorney-in-Fact for MONTGOMERY C. M. GREEN

R. JONATHAN M. GREEN (SEAL)
R. JONATHAN M. GREEN, Attorney-in-Fact for ELIZABETH WATTS GREEN

R. JONATHAN M. GREEN (SEAL)
R. JONATHAN M. GREEN, Attorney-in-Fact for JOHN RODGERS MEIGS GREEN

R. JONATHAN M. GREEN (SEAL)
R. JONATHAN M. GREEN

STATE OF Maryland,
~~CITY~~ COUNTY OF Harford, to wit:

I HEREBY CERTIFY, that on this 15th day of July, 2010, before me, the subscriber, a Notary Public of the State aforesaid, personally appeared **STEWART GETZ, Esquire, Successor co-Trustee of the trust under the will of James C. Barker** known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same for the purposes therein contained, and in my presence signed and sealed the same.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

NOTARY PUBLIC

My Commission Expires: 8-1-10

STATE OF Maryland,
~~CITY~~ COUNTY OF Harford, to wit:

I HEREBY CERTIFY, that on this 15th day of July, 2010, before me, the subscriber, a Notary Public of the State aforesaid, personally appeared **JAMES P. BARKER, Successor co-Trustee of the trust under the will of James C. Barker** known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same for the purposes therein contained, and in my presence signed and sealed the same.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

NOTARY PUBLIC

My Commission Expires: 8-1-10

STATE OF Maryland,

~~CITY~~/COUNTY OF Harford, to wit:

I HEREBY CERTIFY, That on this 15th day of July, 2010, before me, the subscriber, a Notary Public of the State aforesaid, personally appeared **R. JONATHAN M. GREEN, Attorney-in-Fact for MONTGOMERY C. M. GREEN,** known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and in pursuance of the power and authority set forth in the Power of Attorney herein before mentioned, acknowledged, the foregoing to be the act of said **R. JONATHAN M. GREEN** as such Attorney-in-Fact and further made oath in due form of law that at the time of the execution of the within instrument, he did not have actual knowledge of the revocation or termination of the above mentioned Power of Attorney by death or any cause whatsoever, and acknowledged that he executed the same for the purposes therein contained, and in my presence signed and sealed the same.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

Nancy Dotson Socci
NOTARY PUBIC

My Commission Expires: 8-1-10

STATE OF Maryland,

~~CITY~~/COUNTY OF Harford, to wit:

I HEREBY CERTIFY, That on this 15th day of July, 2010, before me, the subscriber, a Notary Public of the State aforesaid, personally appeared **R. JONATHAN M. GREEN, Attorney-in-Fact for ELIZABETH WATTS GREEN,** known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and in pursuance of the power and authority set forth in the Power of Attorney herein before mentioned, acknowledged, the foregoing to be the act of said **R. JONATHAN M. GREEN** as such Attorney-in-Fact and further made oath in due form of law that at the time of the execution of the within instrument, he did not have actual knowledge of the revocation or termination of the above mentioned Power of Attorney by death or any cause whatsoever, and acknowledged that he executed the same for the purposes therein contained, and in my presence signed and sealed the same.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

Nancy Dotson Socci
NOTARY PUBIC

My Commission Expires: 8-1-10

STATE OF Maryland,

~~CITY~~/COUNTY OF Harford, to wit:

I HEREBY CERTIFY, That on this 15th day of July, 2010, before me, the subscriber, a Notary Public of the State aforesaid, personally appeared **R. JONATHAN M. GREEN, Attorney-in-Fact for JOHN RODGERS MEIGS GREEN,** known to me (or satisfactorily

proven) to be the person whose name is subscribed to the within instrument, and in pursuance of the power and authority set forth in the Power of Attorney herein before mentioned, acknowledged, the foregoing to be the act of said **R. JONATHAN M. GREEN** as such Attorney-in-Fact and further made oath in due form of law that at the time of the execution of the within instrument, he did not have actual knowledge of the revocation or termination of the above mentioned Power of Attorney by death or any cause whatsoever, and acknowledged that he executed the same for the purposes therein contained, and in my presence signed and sealed the same.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

NOTARY PUBIC

My Commission Expires: 8-1-10

STATE OF Maryland,

COUNTY OF Harford, **to wit:**

I HEREBY CERTIFY, that on this 15th day of July, 2010, before me, the subscriber, a Notary Public of the State aforesaid, personally appeared **R. JONATHAN M. GREEN** known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same for the purposes therein contained, and in my presence signed and sealed the same.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

NOTARY PUBLIC

My Commission Expires: 8-1-10

THIS IS TO CERTIFY THAT THE WITHIN INSTRUMENT HAS BEEN PREPARED BY OR UNDER THE SUPERVISION OF THE UNDERSIGNED MARYLAND ATTORNEY.

JEFFREY W THOMPSON

RETURN TO:

Commonwealth Land Title
Insurance Company
One North Charles Street
Suite 400
Baltimore, Maryland 21201
File No. 2610-00098

HARFORD COUNTY MARYLAND
TRANSFER TAX PD $ 26,903.31 cle
ALL OTHER TAXES PAID 7/26/10

PROPERTY PRESENTLY NOT ON WATER & SEWER SYSTEM PER: cle
DATE: 7/26/10 HARFORD COUNTY AGRICULTURAL TRANSFER TAX IN THE AMOUNT OF $ Letter of Intent #5
Received for transfer 10-11 13.7AC
State Department of Assessments & Taxation of Harford County
By C Ercolano Date 7-22-10

ALL MUNICIPAL TAXES
AND CHARGES PAID
ABERDEEN:
BEL AIR:
HdeG: cle 7/26/10

EXHIBIT A

Beginning for the same at a point in the Southeasternmost Right of Way Line and Right of Way Line of Through Highway (Ramp "A") of the connection between the Northeastern Expressway and Maryland Route 155, said point of beginning being the intersection of the aforesaid Southeasternmost Right of Way Line and Right of Way Line of Through Highway (Ramp "A") with the Line of Division between the property which by deed dated April 26, 1946 and recorded among the Land Records of Harford County in Liber 295, folio 291, from Carrie V. Mitchell to James C. Barker and Pearl P. Barker, his wife and the property which by deed dated December 20, 1947 and recorded among the Land Records of Harford County in Liber 311, folio 379 from Marian Moore, et ux and Beulah Moore, et al. to Horace Moore, said point of beginning being situated 70 feet measured radially to the right of Station 112+05+ of the Base Line of Right of Way (Ramp "A"), as said Base Line of Right of Way is delineated on the State Roads Commission's Plat numbered 34908, running thence and binding along the aforesaid Line of Division in a Southwesterly direction 1938'+, thence in a Northwesterly direction 584'+ to intersect the aforesaid Southeasternmost Right of Way line and Right of Way Line of Through Highway, running thence and binding thereon in a Northeasterly direction 935"+, thence in a Northwesterly direction 100'+, thence in a Northeasterly direction by a curve to the right having a radius of 1839.86' for a distance of 773'+ to the place of beginning.

Containing 13.70 acres plus or minus

The above described parcel of land being subject to the Perpetual Easement Area for outlet ditch of the State Roads Commission of Maryland shown cross hatched on the State Roads Commission's Plat numbered 34908.

The above described parcel of land being subject to the Drainage Provisions of the State Road Commission of Maryland as indicated on the State Roads Commission's plat numbered 34908.

The above described parcel of land being subject to the Denial of Access Provisions of the State Roads Commission of Maryland as indicated on the Plat numbered 34908.

Title to an undivided one-half interest is vested in STEWART GETZ, Esquire, and JAMES P. BARKER, Successor co-Trustees of the trust under the will of James C. Barker (Estate No. 26,722 in the Orphans' Court, Harford County), pursuant to an Order of the Circuit Court of Harford County dated February 12, 2010 in a cause entitled "In the matter of the Testamentary Trust of James C. Barker", Case No. 12-C-07-002261MP.

Title to the remaining undivided one-half interest is vested in MONTGOMERY C. M. GREEN, ELIZABETH WATTS GREEN, JOHN RODGERS MEIGS GREEN and R. JONATHAN M. GREEN by virtue of a Deed of Distribution dated July ____, 2010 and recorded among the Land Records of Harford County in Liber _____, folio ___.

Certification of Exemption from Withholding Upon Disposition of Maryland Real Estate Affidavit of Residence or Principal Residence

Based on the certification below, Transferor claims exemption from the tax withholding requirements of § 10-912 of Maryland's Tax General Article. Section 10-912 states that certain tax payments must be withheld when a deed or other instrument that affects a change in ownership of real property is recorded. The requirements of § 10-912 do not apply when a transferor provides a certification of Maryland residence or certification that the transferred property is the transferor's principal residence.

1. Transferor Information
Name of Transferor **R. JONATHAN M. GREEN**

2. Reason for Exemption	
Resident Status	☑ I, Transferor, am a resident of the State of Maryland. ☐ Transferor is a resident entity under § 10-912(A)(4) of Maryland's Tax General Article, I am an agent of Transferor, and I have authority to sign this document on Transferor's behalf.
Principal Residence	☐ Although I am no longer a resident of the State of Maryland, the Property is my principal residence as defined in IRC § 121.

Under penalty of perjury, I certify that I have examined this declaration and that, to the best of my knowledge, it is true, correct, and complete.

3a. Individual Transferors	
Witness	Name: R. JONATHAN M. GREEN Signature
Witness	Name:

Certification of Exemption from Withholding Upon Disposition of Maryland Real Estate Affidavit of Residence or Principal Residence

Based on the certification below, Transferor claims exemption from the tax withholding requirements of § 10-912 of Maryland's Tax General Article. Section 10-912 states that certain tax payments must be withheld when a deed or other instrument that affects a change in ownership of real property is recorded. The requirements of § 10-912 do not apply when a transferor provides a certification of Maryland residence or certification that the transferred property is the transferor's principal residence.

1. Transferor Information
Name of Transferor **TRUST UNDER THE WILL OF JAMES C. BARKER**

2. Reason for Exemption	
Resident Status	☐ I, Transferor, am a resident of the State of Maryland. ☒ Transferor is a resident entity under § 10-912(A)(4) of Maryland's Tax General Article, I am an agent of Transferor, and I have authority to sign this document on Transferor's behalf.
Principal Residence	☐ Although I am no longer a resident of the State of Maryland, the Property is my principal residence as defined in IRC § 121.

Under penalty of perjury, I certify that I have examined this declaration and that, to the best of my knowledge, it is true, correct, and complete.

3a. Individual Transferors	
Witness	Name
	Signature

3b. Entity Transferors	
Witness/Attest	TRUST UNDER THE WILL OF JAMES C. BARKER Name of Entity
	By: STEWART GRITZ, ESQUIRE, Trustee Name
Witness/Attest	TRUST UNDER THE WILL OF JAMES C. BARKER Name of Entity
	By: JAMES P. BARKER, Trustee Name

AF

01

IMP FD SURE $ 20.00
RECORDING FEE 20.00
TOTAL 40.00
Rest# HA04 Rcpt # 12226

JJR PH Blk # 279

Jul 27, 2010 03:34 PM

Confirmatory Deed Pursuant to Articles Of Transfer

THIS CONFIRMATORY DEED, dated July 15, 2010, from **SU-EL, INCORPORATED** a Maryland corporation, acting pursuant to action of its Stockholders and its Board of Directors, Grantor, to **UCHS/UMMS REAL ESTATE TRUST,** a Maryland business trust, Grantee.

The Grantor has sold to the Grantee all or substantially all of the property and assets of the Grantor, including the property described below, which is located in Harford County, Maryland.

The Grantor has filed Articles of Transfer with the State Department of Assessments and Taxation of the State of Maryland, which Articles of Transfer have been duly approved by that Department. Title to the property described below has been transferred by the Articles of Transfer, but the Grantor and the Grantee deem it desirable to evidence the transfer by this Confirmatory Deed.

The Grantor, for a consideration of Five Hundred Fifty Thousand and no/100 Dollars ($550,000.00) in accordance with the provisions of Section 3-115(b)(2)(i) of the Corporations and Associations Article of the Annotated Code of Maryland, hereby confirms, grants, and conveys to the Grantee, its successors and assigns, forever, in fee simple, all the lot of ground located in Harford County, Maryland, and described as follows:

See Exhibit A attached hereto and made a part hereof by reference

Together with all improvements thereon, and the rights, alleys, ways, waters, easements, privileges, appurtenances and advantages belonging or in anywise appurtenant thereto.

To have and to hold the property hereby conveyed unto the Grantee, its successors and assigns, in fee simple, forever.

The Grantor covenants to warrant specially the property and to execute such further assurances of the property as may be requisite.

IN TESTIMONY WHEREOF the Grantor has caused this Deed to be executed on its behalf by its duly authorized President.

ATTEST: **SU-EL, INCORPORATED**

Eleanor M. Ferguson
ELEANOR M. FERGUSON, Secretary

By: Leonard E. Ferguson (SEAL)
LEONARD E. FERGUSON, President

STATE OF MARYLAND, COUNTY OF Harford ; To wit:

I HEREBY CERTIFY that on this 15th day of July, 2010, before me, a Notary Public in and for the State of Maryland, personally appeared LEONARD E. FERGUSON, who acknowledged himself to be the president of SU-EL, INCORPORATED and that as such president, being authorized so to do, he executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself as president.

Witness my hand and notarial seal.

My Commission Expires: 8-1-10

Notary Public

This instrument has been prepared by the undersigned, an attorney, under such attorney's supervision, or by one of the parties named in this instrument.

Jeffrey W. Thompson

LIBER 08736 FOLIO 418

HARFORD CRD COUNTY MARYLAND
TRANSFER TAX PD $ 0
ALL OTHER TAXES PAID mg 7/27/10

PROPERTY PRESENTLY NOT ON WATER & SEWER SYSTEM PER: mg
DATE: 7/27/10 HARFORD COUNTY

~~ALL MUNICIPAL~~ TAXES AND CHARGES PAID
ABERDEEN:
BEL AIR:
HdeG: pd 7/27/10 mg

EXHIBIT A

0.883 Acre Parcel of Land Located on the South Side of Maryland Route 155, City of Havre de Grace, Sixth Election District, Harford County, Maryland.

BEGINNING for the same at an iron bar heretofore set in the southwesterly right of way line of Maryland Route 155 as shown on State Roads Commission Plat Number 19580, said iron bar being at the northernmost corner of the land conveyed by and described in a deed from A. Freeborn Brown, Executor under the Last Will and Testament of Mary Ethel Mitchell to Su El, Inc., dated March 27, 1969 and recorded among the Land Records of Harford County, Maryland in Liber 808, Page 462, said iron bar also being at the end of the second or north 28°26'36" east 8.81 foot line of a deed from D.L.B. Joint Venture, John Dougan, H. Richard Lyttle, Irene A. Lyttle, Harold H. Boyer and Joyce T. Boyer to Route 155. LLC, dated April 18, 1998 and recorded among the said Land Records in Liber 2748, Folio 0534, thence leaving the said second line and binding on the said right of way line and binding on the northeasterly outline of the said land of Su El, Inc., as now surveyed, with bearings referred to the Maryland Coordinate System (NAD'83/91), two courses, viz:

1. South 67° 04' 53" East 133.91 feet to a pin and cap heretofore set, and
2. South 61° 12' 58" East 68.30 feet to a pin and cap heretofore set at the easternmost corner of the last mentioned parcel, thence leaving the aforesaid Level Road and binding on the division line between the last mentioned parcel of land and a parcel of land conveyed by and described in a deed from Baltimore Gas and Electric Company and Bankers Trust Company, Trustee to Montgomery C. M. Green and John Rogers Meigs Green, dated May 24, 1973 and recorded among the aforesaid Land Records in Book 930, Page 855,
3. South 28° 48' 58" West 141.68 feet to a concrete monument heretofore planted at a corner of the right of way of Barker Lane, 60 feet wide, as shown on State Roads Commission Plat Number 27620, thence binding on the said right of way, two courses, viz:
4. South 28° 48' 58" West, continuing the same course, 52.81 feet, and
5. North 61° 44' 02" West 85.00 feet, thence leaving the aforesaid Barker Lane and binding on the southwesterly outline of the land described in the first mentioned deed,
6. North 60° 47' 47" West 117.98 feet to the beginning point of the secondly mentioned deed, thence binding on the first and second lines of the said deed, and binding on the northwesterly outline of the aforesaid land of Su El, Inc.,
7. North 29° 16' 51" East 180.71 feet to the place of beginning.

BEING all of the remainder of the land conveyed by and described in a deed from A. Freeborn Brown, Executor under the Last Will and Testament of Mary Ethel Mitchell to Su El, Inc., dated March 27, 1969 and recorded among the Land Records of Harford County, Maryland in Liber 808, Page 462.

2010

MARYLAND FORM

Certification of Exemption from Withholding Upon Disposition of Maryland Real Estate Affidavit of Residence or Principal Residence

Based on the certification below, Transferor claims exemption from the tax withholding requirements of §10-912 of the Tax-General Article, Annotated Code of Maryland. Section 10-912 provides that certain tax payments must be withheld and paid when a deed or other instrument that effects a change in ownership of real property is presented for recordation. The requirements of §10-912 do not apply when a transferor provides a certification of Maryland residence or certification that the transferred property is the transferor's principal residence.

1. Transferor Information

Name of Transferor

SU EL, INCORPORATED

2. Reasons for Exemption

Resident Status

☐ I, Transferor, am a resident of the State of Maryland.

☑ Transferor is a resident entity as defined in Code of Maryland Regulations (COMAR) 03.04.12.02B(11), I am an agent of Transferor, and I have authority to sign this document on Transferor's behalf.

Principal Residence

☐ Although I am no longer a resident of the State of Maryland, the Property is my principal residence as defined in IRC 121 and is recorded as such with the State Department of Assessments and Taxation.

Under penalty of perjury, I certify that I have examined this declaration and that, to the best of my knowledge, it is true, correct, and complete.

3a. Individual Transferors

Witness

Name

Signature

3b. Entity Transferors

LIV. SL A.

Witness/Attest

SU EL, INCORPORATED

Name of Entity

By Leonard E. Ferguson

LEONARD E. FERGUSON

Name

Pres.

Title

09-49

LIBER 08736 FOLIO 420

2610-00135

State of Maryland Land Instrument Intake Sheet

☐ **Baltimore City** ☒ **County: HARFORD**

Information provided is for the use of the Clerk's Office, State Department of Assessments and Taxation, and County Finance Office only.

(Type or Print in Black Ink Only - All Copies Must Be Legible)

Space Reserved for Circuit Court Clerk Recording Validation

Type(s) of Instruments	(☐ Check Box If Addendum Intake Form is Attached.) [1] Deed [ ] Mortgage [ ] Other: [ ] Deed of Trust [ ] Lease [ ] Other: [ ] Other:
Conveyance Type (Check Box)	☐ Improved Sale Arms-Length *[1]* ☐ Unimproved Sale Arms-Length *[2]* ☐ Multiple Accounts Arms-Length *[3]* ☐ Not an Arms-Length Sale *[9]*
Tax Exemptions (if Applicable) Cite or Explain Authority	**Recordation** Section 3-115(b)(2)(i) of Corporations and Associations **State Transfer** Article of Annotated Code **County Transfer**

Consideration and Tax Calculations

Consideration Amount		**Finance Office Use Only**	
Purchase Price/Consideration		**Transfer and Recordation Tax Consideration**	
Any New Mortgage		Transfer Tax Consideration	
Balance of Existing Mortgage		X ( ) % =	
Other:		Less Exemption Amount -	
		Total Transfer Tax =	
Other:		Recordation Tax Consideration	
		X ( ) per $500 =	
Full Cash Value		TOTAL DUE	

Fees

Amount of Fees	**Doc.1**	**Doc. 2**	
Recording Charge	20.00		Agent:
Surcharge	20.00		Tax Bill:
State Recordation Tax			
State Transfer Tax			C.B. Credit:
County Transfer Tax			
Other			Ag. Tax/Other:
Other			

Description of Property

SDAT requires submission of all applicable information. A maximum of 40 characters will be indexed in accordance with the priority cited in Real Property Article Section 3-104(g)(3)(i).

District	**Property Tax ID No. (1)**	**Grantor Liber/Folio**	**Map**	**Parcel No.**	**Var. LOG** ☐ **(5)**
	06-007619				

Subdivision Name	**Lot 3(a)**	**Block(3b)**	**Sect/AR(3c)**	**Plat Ref.**	**SqFt/Acreage(4)**
					0.91

Location / Address of Property Being Conveyed (2)

W S Level Road

Other Property Identifiers (if applicable)	**Water Meter Account No.**

Residential ☐ **or Non-Residential** ☒ | **Fee simple** ☒ **or Ground Rent** ☐ **Amount:**

Partial Conveyance? ☐ **Yes** ☒ **No** | Description/Amt. of SqFt/Acreage Transferred:

If Partial Conveyance, List Improvements Conveyed:

Transferred From

Doc.1 - Grantor(s) Name(s)	**Doc. 2 - Grantor(s) Names(s)**
Su-El, Incorporated	
Doc. 1 Owner(s) of Record, if different from Grantor(s)	**Doc. 2 Owner(s) of Record, if different from Grantor(s)**

Transferred To

Doc. 1 - Grantee(s) Name(s)	**Doc. 2 - Grantee(s) Name(s)**
UCHS/UMMS Real Estate Trust	

New Owner's (Grantee) Mailing Address

520 Upper Chesapeake Drive, Suite 405, Bel Air, Md 21014

Other Names to be Indexed

Doc. 1 - Additional Names to be Indexed (Optional)	**Doc. 2-Additional Names to be Indexed (Optional)**

Contact/Mail Information

Instrument Submitted By or Contact Person	
Name: Sherry Dorsey	☒ Return to Contact Person
Firm: Commonwealth Land Title Insurance Company	☐ Hold for Pickup
Address: 1 North Charles Street, Suite 400, Baltimore, MD 21201	☐ Return Address Provided
Phone: 410-230-9595	

IMPORTANT: *BOTH* THE ORIGINAL DEED *AND* A PHOTOCOPY MUST ACCOMPANY EACH TRANSFER

Assessment Information

☐ Yes ☒ No Will the property being conveyed be the grantee's principal residence?

☐ Yes ☒ No Does transfer include personal property? If yes, identify:

☐ Yes ☒ No Was property surveyed? If yes, attach copy of survey (if recorded, no copy required).

Assessment Use Only - Do Not Write Below This Line

☐ Terminal Verification ☐ Agricultural Verification ☐ Whole ☐ Part ☐ Tran. Process Verification

Transfer Number: Date Received: Deed Reference: Assigned Property No.:

Year	20	20	Geo.	Map	Sub	Block
Land			Zoning	Grid	Plat	Lot
Buildings			Use	Parcel	Section	Occ.Cd.
Total			Town Cd.	Ex.St.	Ex.Cd.	

REMARKS:

LIBER 08736 FOLIO 421

D/1

THIS DEED, Made this 15th day of July, 2010, by and between **HAROLD E. BARKER**, Grantor, party of the first part and **UCHS/UMMS REAL ESTATE TRUST, a Maryland business trust**, Grantee, party of the second part.

WITNESSETH, That in consideration of the sum of **ONE MILLION AND 00/100 DOLLARS ($1,000,000.00)**, the actual consideration paid, and other good and valuable consideration, the receipt of which is hereby acknowledged, the said party of the first part does grant and convey to the party of the second part, Grantee, its successors and assigns, in fee simple, all that parcel of land situate in Harford County, State of Maryland, and described as follows, that is to say:

20-
20
11600-
5000
JK

SEE EXHIBIT A ATTACHED HERETO FOR LEGAL DESCRIPTION

BEING the same property described in Deed dated October 14, 1987 and recorded among the Land Records of Harford County in Liber 1448, folio 1015 from James C. Barker unto Harold E. Barker.

TOGETHER WITH the buildings thereupon, and the rights, alleys, ways, waters, privileges, appurtenances and advantages thereto belonging, or in anywise appertaining.

70
20
A

BY the execution of this Deed, the party of the first part hereby certifies under the penalties of perjury that the actual consideration paid or to be paid, including the amount of any mortgage or deed of trust outstanding, is as hereinbefore set forth.

AND the said party of the first part hereby covenants that he has not done or suffered to be done any act, matter or thing whatsoever, to encumber the property hereby conveyed; that he will warrant specially the property hereby granted; and that he will execute such further assurances of the same as may be requisite.

TO HAVE AND TO HOLD the described parcel of land and premises to the said party of the second part, Grantee, its successors and assigns, in fee simple.

IN WITNESS WHEREOF, Grantor have executed this Deed under seal on the day and year herein first written.

WITNESS:

Harold E Barker
HAROLD E. BARKER

IMP FD SURE $ 20.00
RECORDING FEE 20.00
RECORDIATION T 6,600.00
TR TAX STATE 5,000.00
TOTAL 11,640.00
Rest# HA03 Rcpt # 17945
JJR JD Blk # 3138
Jul 23, 2010 11:12 am

IMP FD SURE $ 20.00
RECORDING FEE 20.00
TOTAL 40.00
Rest# HA03 Rcpt # 22076
JJR Sep 10, 2010 Blk # 1838 2:38 pm

Sep 10, 2010 2:38

SEE SEPARATE PAGE FOR ACKNOWLEDGEMENT AND CERTIFICATION

This Deed is re-recorded in order to correct a typographical error in the name of the Grantee.

LIBER 08808 FOLIO 443

~~LIBER 08732 FOLIO 490~~

ATTACHED TO AND MADE A PART OF A DEED FROM HAROLD E. BARKER

STATE OF Maryland,

~~CITY~~ COUNTY OF Harford, **to wit:**

I HEREBY CERTIFY, That on this 15th day of July, 2010, before me, the subscriber, a Notary Public of the State aforesaid, personally appeared **HAROLD E. BARKER** known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same for the purposes therein contained, and in my presence signed and sealed the same.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

Jeney Dodson Sacci
NOTARY PUBLIC

My Commission Expires: 8-1-10

S

THIS IS TO CERTIFY THAT THE WITHIN INSTRUMENT HAS BEEN PREPARED BY OR UNDER THE SUPERVISION OF THE UNDERSIGNED MARYLAND ATTORNEY.

JEFFREY W THOMPSON

RD COUNTY MARYLAND
ER TAX PD $ 0
ER TAXES PAID 9/10/10

PROPERTY PRESENTLY NOT ON WATER
& SEWER SYSTEM PER:
DATE: 9/10/10 HARFORD COUNTY

RETURN TO:

Commonwealth Land Title
Insurance Company
1 North Charles Street, Suite 400
Baltimore, Maryland 21202
Attn: Sherry Dorsey/File No.2610-00099

HARFORD COUNTY MARYLAND
TRANSFER TAX PD $ 10,000.00 exempt
ALL OTHER TAXES PAID

ALL MUNICIPAL TAXES
AND CHARGES PAID
ABERDEEN:
BEL AIR:
HdeG: exempt

PROPERTY PRESENTLY NOT ON WATER
& SEWER SYSTEM PER: exempt
DATE: HARFORD COUNTY

ALL MUNICIPAL TAXES
AND CHARGES PAID
ABERDEEN: pd 9/10/10
BEL AIR:
HdeG:

EXHIBIT A

All that lot of ground situate and lying in the Sixth Election District of Harford County, Maryland, on the southwest side of Barker Lane, described as follows:

Lot No. 1, as shown on a subdivision plat entitled, "Final Plat, Land of James C. Barker", recorded among the Land Records of Harford County in Plat Book CGH No. 60, folio 87.

Together with the use in common of the common driveway easement established by Declaration of Common Driveway Easements dated October 14, 1987 and recorded among the Land Records of Harford County in Liber 1448, folio 1012 by James C. Barker and Blanche Virginia Stamper.

Certification of Exemption from Withholding Upon Disposition of Maryland Real Estate Affidavit of Residence or Principal Residence

Based on the certification below, Transferor claims exemption from the tax withholding requirements of § 10-912 of Maryland's Tax General Article. Section 10-912 states that certain tax payments must be withheld when a deed or other instrument that affects a change in ownership of real property is recorded. The requirements of § 10-912 do not apply when a transferor provides a certification of Maryland residence or certification that the transferred property is the transferor's principal residence.

1. Transferor Information

Name of Transferor

HAROLD E. BARKER

2. Reason for Exemption

Resident Status	☑ I, Transferor, am a resident of the State of Maryland. ☐ Transferor is a resident entity under § 10-912(A)(4) of Maryland's Tax General Article, I am an agent of Transferor, and I have authority to sign this document on Transferor's behalf.
Principal Residence	☐ Although I am no longer a resident of the State of Maryland, the Property is my principal residence as defined in IRC § 121.

Under penalty of perjury, I certify that I have examined this declaration and that, to the best of my knowledge, it is true, correct, and complete.

3a. Individual Transferors

Witness

HAROLD E. BARKER

Harold E Barker

Name

Signature

3b. Entity Transferors

Witness/Attest

Name of Entity

By:

Name

Title

2610-00099

State of Maryland Land Instrument Intake Sheet

☐ Baltimore City ☒ County: Harford

Information provided is for the use of the Clerk's Office, State Department of Assessments and Taxation, and County Finance Office only.

(Type or Print in Black Ink Only - All Copies Must Be Legible)

Space Reserved for Circuit Court Clerk Recording Validation

Type(s) of Instruments

(☐ Check Box If Addendum Intake Form is Attached.)

[1] Deed [ ] Mortgage [ ] Other:

[ ] Deed of Trust [ ] Lease [ ] Other: [ ] Other:

Conveyance Type (Check Box)

☐ Improved Sale Arms-Length *[1]* ☐ Unimproved Sale Arms-Length *[2]* ☐ Multiple Accounts Arms-Length *[3]* ☐ Not an Arms-Length Sale *[9]*

Tax Exemptions (if Applicable) Cite or Explain Authority

Recordation	
State Transfer	
County Transfer	

Consideration and Tax Calculations

Consideration Amount		Finance Office Use Only	
Purchase Price/Consideration	1,000,000.00	Transfer and Recordation Tax Consideration	
Any New Mortgage		Transfer Tax Consideration	
Balance of Existing Mortgage		X ( ) % =	
Other:		Less Exemption Amount -	
		Total Transfer Tax =	
Other:		Recordation Tax Consideration	
		X ( ) per $500 =	
Full Cash Value		TOTAL DUE	

Fees first doc is release

Amount of Fees	Doc.1	Doc. 2	
Recording Charge	20.00		Agent:
Surcharge	20.00		Tax Bill:
State Recordation Tax	6,600.00		C.B. Credit:
State Transfer Tax	5,000.00		Ag. Tax/Other:
County Transfer Tax	10,000.000		
Other			
Other			

Description of Property

SDAT requires submission of all applicable information. A maximum of 40 characters will be indexed in accordance with the priority cited in Real Property Article Section 3-104(g)(3)(i).

District	Property Tax ID No. (1)	Grantor Liber/Folio	Map	Parcel No.	Var. LOG ☐ (5)
06	042929				

Subdivision Name	Lot 3(a)	Block(3b)	Sect/AR(3c)	Plat Ref.	SqFt/Acreage(4)
	1				2.48

Location / Address of Property Being Conveyed (2)

2234 Barker Lane

Other Property Identifiers (if applicable)	Water Meter Account No.

Residential ☐ **or Non-Residential** ☒ | **Fee simple** ☒ **or Ground Rent** ☐ **Amount:**

Partial Conveyance? ☐ **Yes** ☒ **No** | Description/Amt. of SqFt/Acreage Transferred:

If Partial Conveyance, List Improvements Conveyed:

Transferred From

Doc.1 - Grantor(s) Name(s)	Doc. 2 - Grantor(s) Names(s)
Harold E. Barker	
Doc. 1 Owner(s) of Record, if different from Grantor(s)	**Doc. 2 Owner(s) of Record, if different from Grantor(s)**

Transferred To

Doc. 1 - Grantee(s) Name(s)	Doc. 2 - Grantee(s) Name(s)
UCHS/UMMS Real Estate Trust	

New Owner's (Grantee) Mailing Address

520 Upper Chesapeake Drive, Suite 405, Bel Air, Md. 21014

Other Names to be Indexed

Doc. 1 - Additional Names to be Indexed (Optional)	Doc. 2-Additional Names to be Indexed (Optional)

Contact/Mail Information

Instrument Submitted By or Contact Person	
Name: Sherry Dorsey	☒ Return to Contact Person
Firm: Commonwealth Land Title Insurance Company	☐ Hold for Pickup
Address: 1 North Charles Street, Suite 400, Baltimore, MD 21201	☐ Return Address Provided
Phone: 410-230-9595	

IMPORTANT: *BOTH* THE ORIGINAL DEED *AND* A PHOTOCOPY MUST ACCOMPANY EACH TRANSFER

Assessment Information

☐ Yes ☒ No Will the property being conveyed be the grantee's principal residence?

☐ Yes ☒ No Does transfer include personal property? If yes, identify:

☐ Yes ☒ No Was property surveyed? If yes, attach copy of survey (if recorded, no copy required).

Assessment Use Only - Do Not Write Below This Line

☐ Terminal Verification ☐ Agricultural Verification ☐ Whole ☐ Part ☐ Tran. Process Verification

Transfer Number: Date Received: Deed Reference: Assigned Property No.:

Year	20	20	Geo.	Map	Sub	Block
Land			Zoning	Grid	Plat	Lot
Buildings			Use	Parcel	Section	Occ.Cd.
Total			Town Cd.	Ex.St.	Ex Cd.	

REMARKS:

LIBER 08808 FOLIO 447

LIBER 08732 FOLIO 94

MARYLAND COORDINATE SYSTEM (NAD83/91)

I-95 - JOHN F. KENNEDY MEMORIAL HIGHWAY

(SRC PLAT NOS. 21247 & 21249)

BASELINE OF R/W

NORTH-BOUND LANES

RAMP

BASELINE OF R/W

(DEED 603/152, SRC PLAT NO. 26801)

RIGHT OF WAY LINE OF THROUGH HIGHWAY

R=1839.86' A=1103.36'
CHD=N 62°31'11" E 1086.90'

CONC. MON. FND

N 63°52'39" W 0.40'

P/C FND

PERPETUAL EASEMENT FOR OUTLET DITCH AS SHOWN ON SRC PLAT NOS. 26350 & 34908 (814/348)

SRC PLAT NO. 21620 (DEED 613/501)

R=1223.23' A=240.83'
CHD=N 85°29'41" E 240.55'

PIPE FND.

PROBABLE LOCATION 545/247

STONE FND

S 67°54'05" E 283.38'

MARYLAND ROUTE 155 - LEVEL ROAD

(SRC PLAT NO. 21620)

S 67°54'05" E 396.09'

IRON BAR FND

RIGHT OF WAY LINE OF THROUGH HIGHWAY

S 67°54'05" E 1.85'

PROBABLE LOCATION 545/247

P/C FND

S 81°42'39" E 8.85'

COMMITMENT NO. 2610-00135

LAND OF SU EL INCORPORATED (DEED 808/462) 0.883 AC.±

N 69°44'02" E 85.00'

141.84'

S 20°48'50" W 142.28'

LAND OF MONTGOMERY M. GREEN, TRUSTEE, et al 130/255

S 69°44'02" W 60.00'

LAND OF SHA 613/501

S 81°42'39" E 8.85'

REVERT. SLOPE ESMT. SRC PLAT NO. 21620 (DEED 613/501)

20' "PROMISED" EASEMENT IN DEED 823/545

R=890.00' A=411.06'
CHD=S 55°15'11" E 407.29'

LAND OF MONTGOMERY M. GREEN, TRUSTEE 823/545

S.R.C. MON. FND

BARKER LANE

REVERT. SLOPE ESMT. SRC PLAT NO. 21620 (DEED 613/501)

S 20°54'22" E 67.12'

LAND OF ROUTE 155 LLC (DEED 2748/534) (6.016 Acres) COMMITMENT NO. 2610-00097 (FORMERLY 664/113)

LAND OF STEWART GETZ, ESQUIRE AND JAMES P. BARKER, SUBSTITUTE CO-TRUSTEES CASE NO. 12-C-07-002261 MP (DEED 611/408) COMMITMENT NO. 2610-00046 (I)

LAND OF ALBERT J. A. YOUNG, SUCCESSOR TRUSTEE, STEWART GETZ, ESQUIRE AND JAMES P. BARKER, SUBSTITUTE CO-TRUSTEES CASE NOS. 12-C-05-001828 AND 12-C-07-002261 MP (DEED 814/348, 848/205) (SRC PLAT NO. 34908) COMMITMENT NO. 2610-00048 (13.690 Acres)

(SRC PLAT NOS. 26801 & 26802)

N 21°47'05" E 811.29'

RIGHT OF WAY LINE OF THROUGH HIGHWAY

N 48°57'10" E 129.88'

P/C FND

P/C FND

PERPETUAL EASEMENT TO DISCHARGE FLOW OF WATER SRC PLAT NO. 34908 (814/348)

(SHA PLAT NO. 45583)

APPROX. ℄ STREAM

LAND OF BASIL D. STANLEY 414/410

N 30°19'45" W 825.57'

APPROX. ℄ STREAM

LAND OF KAREN T. H. TURK, et al 6116/0046

STONE FND

LOT I LAND OF JAMES C. BARKER PLAT CGH 60-87

LAND OF HAROLD E. BARKER 1448/1015 COMMITMENT NO. 2610-00049

(2.484 Acres±)

DECLARATION OF COMMON DRIVEWAY EASEMENT 1448/1012

PANHANDLE "A" PLAT 60-87, DEED 1448/1010 (SHOULD HAVE REPLACED 50' R/W IN 864/482(?), BUT DID NOT)

EXISTING DRIVEWAY (TYPICAL)

30' R/W 664/113

TOTAL ENCLOSED AREA: 73.398 ACRES ±

LAND OF STEWART GETZ, ESQUIRE AND JAMES P. BARKER, SUBSTITUTE CO-TRUSTEES CASE NO. 12-C-07-002261 MP (DEED 611/408) COMMITMENT NO. 2610-00046 (I)

POSSIBLE LOCATION OF UNDEFINED 50' R/W IN 864/482

LAND OF 2236 LEVEL ROAD LLC 6304/0170 (0.972 Acres)

COMMITMENT NO. 2610-00103

(FORMERLY 864/482)

EXISTING DRIVEWAY (TYPICAL)

(45.709 Acres±)
(PARCELS I, II & III)

LAND OF STEWART GETZ, ESQUIRE AND JAMES P. BARKER, SUBSTITUTE CO-TRUSTEES CASE NO. 12-C-07-002261 MP (DEED 611/408) COMMITMENT NO. 2610-00046 (I)

LAND OF STEWART GETZ, ESQUIRE AND JAMES P. BARKER, SUBSTITUTE CO-TRUSTEES CASE NO. 12-C-07-002261 MP (DEED 4122/0413) COMMITMENT NO. 2610-00046 (II)

LAND OF MONTGOMERY M. GREEN, TRUSTEE 823/545 & 4122/468 COMMITMENT NO. 2610-00104 (3.644 Acres±)

REVERT. SLOPE ESMT. SRC PLAT NO. 21620 (DEED 613/501)

FORMER 18' TEMPORARY GRADING EASEMENT (EXPIRED JULY 1, 2007)

30' LANDSCAPE EASEMENT (4122/0501)

R=180.00' A=340.23'
CHD=S 30°29'34" W 516.25'

(4122/0468)

P/C FND

S 19°04'20" W 238.01'

PARKWAY

R=681.54' A=421.45'
CHD=S 54°05'01" W 420.85'

S 28°42'23" W 245.11'

ROCK

R=890.00' A=511.84'
CHD=S 11°59'17" W 504.82'

LAND OF MONTGOMERY M. GREEN, TRUSTEE 823/545 & 4122/468

LAND OF KAREN T. H. TURK, et al 6116/0046

LOT I REVISED FINAL PLAT ONE LAND OF BLENHEIM, LLC, et al JLR 119-24

PERPETUAL DRAINAGE AND UTILITY EASEMENT 1093/0448 (SEE ALSO 4511/0422 & 5906/0665)

S 86°50'51" W 800.50'

LAND OF STEWART GETZ, ESQUIRE AND JAMES P. BARKER, SUBSTITUTE CO-TRUSTEES CASE NO. 12-C-07-002261 MP (DEED 4122/0445) COMMITMENT NO. 2610-00046 (III)

STONE FND

S 86°04'48" W 129.71'

S 12°28'41" E 129.71'

STONE FND

LOT 1 FINAL PLAT ONE BULLE ROCK CORPORATE CAMPUS 134/115-21

BULLE

LAND OF MONTGOMERY M. GREEN, TRUSTEE 848/205

GENERAL NOTES:

1. The location of streams, roads, driveways, structures and utility poles have been taken from aerial photogrammetry done in April, 2007.
2. Flood Zone Designation: X, or Areas determined to be outside 500-year floodplain

TITLE EXCEPTION REVIEW NOTES:

1. The documents: 288/338, 607/232, 1284/0822, 1680/0617, and 4122/0468 listed as exceptions in Commitment No. 2610-00096 do not affect the land shown on this plat. 605/244 grants a 100' snow-fence easement from the State right of way line. Agreement in 6503/0482 was released by Agreement in 6053/665. The 50' Right of Way in 864/482 cannot be plotted. The other exceptions, 545/247, 664/113, 1448/1012, 4122/0521, 4511/0422, 7093/0448 and Plat 60-87 are shown hereon.
2. 605/244, (SRC Plat Nos. 26352, 21247, & 21249) listed as an exceptions in Commitment No. 2610-00097 grants a 100' snow-fence easement from the State right of way line. SRC Plat No. 21260 was not included in title report and is not available on line (could it be a transposition of SRC Plat No. 21620, which is shown hereon?). 664/113 (SRC Plat No. 21620) and 545/247 are shown hereon.
3. The documents: 666/0480 and 1284/0822 listed as exceptions in Commitment No. 2610-00098 do not affect the land shown on this plat. 603/152 (SRC Plat Nos. 26800, 26801 & 26802) grants a 100' snow-fence easement from the State right of way line. The other exceptions, 814/348, a prior deed for the parcel, reserves the right to the SRC to discharge drainage and a drainage easement as shown on SRC Plat No 34908 and hereon.
4. The 50' Right of Way in 864/482, listed as an exception in Commitment No. 2610-00099, cannot be plotted. The other exceptions, 664/113, 1448/1012, Plat 60-87, and 545/247 are shown hereon.
5. The 50' Right of Way in 864/482, listed as an exception in Commitment No. 2610-00103, cannot be plotted. The other exceptions, 545/247, 1448/1012, and Plat 60-87 are shown hereon.
6. The documents: 288/338, 514/411 (SRC Plat Nos. 19576, 19579, 23421, & 23422), 607/232, 1284/0822, 1680/0617, 4122/0506, and 5865/385, listed as exceptions in Commitment No. 2610-00104, do not affect the land shown on this plat.The other exceptions, 613/501 (SRC Plat No. 21620) and 823/545 are shown hereon.
7. 825/1, (SRC Plat No. 26352) listed as an exception in Commitment No. 2610-00135 provides for the denial of access from Level Road. 541/574 affects the property as shown hereon.

SURVEYOR'S CERTIFICATION

This is to certify that this map or plat and the survey on which it is based were made in accordance with the "Minimum Standard Detail Requirements for ALTA/ACSM Land Title Surveys," jointly established and adopted by ALTA and NSPS in 2005, and includes items 1, 3, 4, 8, 11(a), and 15 of Table A thereof. Pursuant to the accuracy standards as adopted by ALTA and NSPS and in effect on the date of this certification, undersigned further certifies that in my professional opinion, as a land surveyor registered in the State of Maryland, the Relative Positional Accuracy of this survey does not exceed that which is specified therein.

Date: 7/12/10

Edward F. Kelly
MD Registered Property Line Surveyor No. 159

MORRIS & RITCHIE ASSOCIATES, INC.
ENGINEERS, ARCHITECTS, PLANNERS, SURVEYORS & LANDSCAPE ARCHITECTS
3445-A Box Hill Corporate Center Drive
Abingdon, Maryland 21009
Phone: 410-515-9000
Fax: 410-515-9002

STATE OF MARYLAND — EDWARD F. KELLY — No. 159 — REGISTERED PROPERTY LINE SURVEYOR

ALTA/ACSM LAND TITLE SURVEY LAND OF ALBERT J. A. YOUNG, SUCCESSOR TRUSTEE, STEWART GETZ, ESQUIRE AND JAMES P. BARKER, SUBSTITUTE CO-TRUSTEES, MONTGOMERY C. M. GREEN, et al, ROUTE 155, LLC, 2236 LEVEL ROAD LLC, SU-EL, INC., AND HAROLD L. BARKER CITY OF HAVRE DE GRACE SIXTH ELECTION DISTRICT - HARFORD COUNTY, MARYLAND

SCALE: 1"=100'	DATE: 7/6/10	DRAWN BY: EFK	REVIEWED BY: EFK	JOB NO. 15402

G:\15402\SURVEY\15402_ALTA_Plat4.pro

EXHIBIT 4

Upper Chesapeake Health

Subject: Estimate of Charges

Origin Date: 1/7/11

Approved by: _____

Craig Willig, Vice President of Finance

To provide for transparency in health care pricing

Policy

Upper Chesapeake Health (UCH) shall publicly disclose, on a continuous basis, price estimates for such items, products, services, or procedures in accordance with current Legislation.

Manner of Disclosure

- Shall be made in an open and conspicuous manner;
- Shall be made available at the point of service, in print, and on the Internet; and
- UCH provides estimated charges for the most commonly used inpatient, outpatient, and ancillary services. The information is reviewed semi-annually by the Director of Reimbursement and updated when appropriate.

The amounts are estimates of charges for hospital procedures and services only.

Procedures

UCH promptly responds to individual requests for current charges for specific services/procedures.

- Patients seeking estimates of procedures/services that are not listed on the UCH Common Procedure chart will be encouraged to call the Cashier (443-643-1663).
- The UM Upper Chesapeake Health website will include a listing of current rates for common services; to be updated semi-annually
- If the Cashier is unable to provide the estimate, the Director of Reimbursement will be consulted.
- An estimate will be provided within three business days of receiving the request.

All Patient Accounting, Patient Access, Guest Services, and Administrative Personnel are knowledgeable of the process for providing estimates of charges.

DEVELOPER:

Patient Access, UCH

Reviewed / Revised: 7/1/17

ORIGIN DATE: 1/2011

NEXT REVIEW DATE: 7/2018

EXHIBIT 5

Upper Chesapeake Health

Subject: Financial Assistance Policy

Effective Date: 01/2013

Approved by: _____

Joseph E. Hoffman, Sr. VP CFO

_____

Board of Directors

To provide financial relief to patients unable to meet their financial obligation to Upper Chesapeake Health.

1. **Policy**
    a. This policy applies to Upper Chesapeake Health (UCH). UCH is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.
    b. It is the policy of UCH to provide Financial Assistance (FA) based on indigence or high medical expenses (Medical Financial Hardship program) for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for FA should be made, the criteria for eligibility, and the steps for processing applications.
    c. UCH will post notices of availability at appropriate intake locations as well as the Patient Accounting Office. Notice of availability will also be sent to patients on patient bills. Signs will be posted in key patient access areas. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge and will be available to all patients upon request. A written estimate of total charges, excluding the emergency department, will be available to all patients upon request.
    d. FA may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include a

review of the patient's existing medical expenses and obligations, including any accounts having gone to bad debt.

e. Payments made for care received during the financial assistance eligibility window that exceed the patients determined responsibility will be refunded if that amount exceeds $5.00
    i. Collector notes, and any other relevant information, are deliberated as part of the final refund decision; in general refunds are issued based on when the patient was determined unable to pay compared to when the payments were made
    ii. Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for a refund
f. UCH retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services or diagnosed-cancer care will be treated regardless of their ability to pay, except as noted under 2. d. iv. below.

2. Program Eligibility

a. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UCH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further the UCH commitment to our mission to provide healthcare to the surrounding community, UCH reserves the right to grant financial assistance without formal application being made by our patients.
b. Specific exclusions to coverage under the FA program include the following:
    i. Physician charges are excluded from UCH's FA policy. Patients who wish to pursue FA for physician related bills must contact the physician directly
    ii. Generally, the FA program is not available to cover services that are 100% denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications
    iii. Unpaid balances resulting from cosmetic or other non-medically necessary services
c. Patients may become ineligible for FA for the following reasons:
    i. Refusal to provide requested documentation or provide incomplete information

ii. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, Motor Vehicle or other insurance programs that deny access to UCH due to insurance plan restrictions/limits
iii. Refusal to be screened for other assistance programs prior to submitting an application to the FA program

d. Determination for Financial Assistance eligibility will be based on assets, income, and family size. Please note the following:
   i. Liquid assets greater than $15,000 for individuals, and $25,000 for families will disqualify the patient for 100% assistance.
   ii. Equity of $150,000 in a primary residence will be excluded from the calculation for determination of financial assistance; and
   iii. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans will not be used for determination of financial assistance.
   iv. Non-citizens/non-residents of the United States may only qualify for Financial Assistance under these circumstances: 1. an initial visit for emergency care or 2. if qualified for presumptive Medical Assistance upon inpatient admission or prior to outpatient treatments for cancer care, and only after a determination by the Financial Counselor/Director of Patient Accounting and/or V.P. of Finance. See the Upper Chesapeake Health Self Pay Billing policy for criteria for beginning outpatient cancer care for these patients.

e. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a FA application unless they meet Presumptive FA (see section 3 below) eligibility criteria. If a patient qualifies for COBRA coverage, the patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.
f. Free medically necessary care will be awarded to patients with family income at or below 200 percent of the Federal Poverty Level (FPL).
g. Reduced-cost, medically necessary care will be awarded to low-income patients with family income between 200 and 300 percent of the FPL

h. If a patient requests the application be reconsidered after a denial determination made by the Financial Counselor, the Director of Patient Accounting will review the application for final determination.
i. Payment plans can be offered for all self-pay balances by our Self Pay Vendor. Payment plans are available to uninsured patients with family income between 200 to 500 FPL.

3. Presumptive Financial Assistance

a. Patients may also be considered for Presumptive Financial Assistance eligibility with proof of enrollment in one of the programs listed below. There are instances when a patient may appear eligible for FA, but there is no FA form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patent with FA. In the event there is no evidence to support a patient's eligibility for FA, UCH reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100-percent write-off of the account balance. Presumptive FA eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
    i. Active Medical Assistance pharmacy coverage
    ii. Special Low Income Medicare Beneficiary (SLMB) coverage (covers Medicare Part B premiums)
    iii. Primary Adult Care coverage (PAC)
    iv. Homelessness
    v. Medical Assistance and Medicaid Managed Care patients for services provided in the ED beyond coverage of these programs
    vi. Maryland Public Health System Emergency Petition (EP) patients (balance after insurance)
    vii. Participation in Women, Infants and Children Program (WIC)
    viii. Supplemental Nutritional Assistance Program (SNAP)
    ix. Eligibility for other state or local assistance programs
    x. Deceased with no known estate
    xi. Determined to meet eligibility criteria established under former State Only Medical Assistance Program
    xii. Households with children in the free or reduced lunch program
    xiii. Low-income household Energy Assistance Program

xiv. Self-Administered Drugs (in the outpatient environment only)
xv. Medical Assistance Spenddown amounts

b. Specific services or criteria that are ineligible for Presumptive FA include:
   i. Purely elective procedures (e.g. cosmetic procedures) are not covered under the program
   ii. Uninsured patients seen in the ED under EP will not be considered under the presumptive FA program until the Maryland Medicaid Psych program has been billed

4. Procedures

a. The Financial Counselor will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage
b. The Financial Counselor will consult via phone or meet with patients who request FA to determine if they meet preliminary criteria for assistance.
   i. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility
   ii. All applications will be tracked and after eligibility is determined, a letter of final determination will be submitted to the patient
   iii. Patients will have fifteen days to submit required documentation to be considered for eligibility. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to. The financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent.
c. There will be one application process for UCH. The patient is required to provide a completed FA application. In addition, the following may be required:
   i. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return)
   ii. Proof of disability income (if applicable)
   iii. A copy of their three most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income
   iv. A Medical Assistance Notice of Determination (if applicable)
   v. Proof of U.S. citizenship or lawful permanent residence status (green card)
   vi. Reasonable proof of other declared expenses may be taken in to consideration

vii. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
viii. A Verification of No Income Letter (if there is no evidence of income)
ix. Three most recent bank statements

Written request for missing information will be sent to the patient. Where appropriate, oral submission of needed information will be accepted.

d. A patient can qualify for FA either through lack of sufficient income, insurance or catastrophic medical expenses. Within two (2) business days following a patient's request for Financial Assistance, application for Medical Assistance, or both, the hospital will make a determination of probable eligibility. Completed applications will be forwarded to the Manager of Patient Accounting who will determine approval for adjustments up to $10,000. Adjustments of $10,000 or greater will be forwarded to the V.P. of Finance for an additional approval.
e. Once a patient is approved for FA, eligibility will be extended to the following accounts:
    i. All accounts in an FB (Final Billed) status
    ii. All accounts in a BD (Bad Debt) status that were transferred within one year of the service date of the oldest FB account being adjusted using the current application
    iii. All future visits within 6 months of the application date
f. Social Security beneficiaries with lifelong disabilities may become eligible for FA indefinitely and may not need to reapply
g. UCH does not report debts owed to credit reporting agencies.
h. In rare cases, accounts may warrant Extraordinary Collection Actions (ECAs). Once an account has met the following criteria, the account is closed by the collection agency as "uncollectible" and forwarded back to Patient Accounting for review to establish grounds for legal action. UCH reserves the right to place a lien on a patient's income, residence and/or automobile. This only occurs after all efforts to resolve the debt have been exhausted.

    Criteria:

    i. The debt is valid
    ii. The account is equal to or greater than 120 days old
    iii. Patient refuses to acknowledge the debt
    iv. Upon review and investigation, we have determined liquid assets are available (checking, savings, stocks, bonds or money market accounts)

v. The VP of Finance must authorize legal action

Action will be preceded by notice 30 days prior to commencement. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.

5. Financial Hardship

a. Financial Hardship is a separate, supplemental determination of Financial Assistance and may be available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy
b. Financial Hardship Assistance is defined as facility charges incurred at UCH owned hospitals or physician practices for medically necessary treatment by a family household that exceeds 25% of the family's annual income. Family annual income must be less than 500% of the Federal Poverty Limit
c. Once a patient is approved for Financial Hardship Assistance, coverage may be effective starting with the first qualifying date of service and the following twelve (12) months
d. Financial Hardship Assistance may cover the patient and the immediate family members living in the same household. Each family member may be approved for the reduced cost and eligibility period for medically necessary treatment.
e. Coverage will not apply to elective or cosmetic procedures.
f. In order to continue in the program after the expiration of an eligibility period, each patient (family member) must reapply to be considered.
g. Patients who have been approved for the program should inform UCH of any changes in income, assets, expenses or family (household) status within 30 days of such changes
h. All other eligibility, ineligibility and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance, unless otherwise stated

DEVELOPER:

Patient Financial Counselor, UCH

Reviewed / Revised: 04/2016

ORIGIN DATE: 10/2010

EXHIBIT 6

Behavioral Health Protocols for the UCH Emergency Department

Original: 08/08
Revised: 04/12

March 5, 2012

To Whom It May Concern:

We, the undersigned agree to the revised Emergency Department Laboratory Testing Policy for patients requiring Behavioral Health Services. In addition, the admission criteria to the Upper Chesapeake Behavioral Health Services will be amended. Under the Exclusion Criteria, number one, "Intoxication (BAL > or = 100)" will be changed to "Intoxication."

Syed W. Rizvi, M.D.
Chair, Department of Psychiatry

3/20/12
Date

Fermin Barrueto M.D.
Chair, Department of Emergency Medicine

3/6/2012
Date

Emergency Department Laboratory Testing Policy for Patients Requiring Behavioral Health Services

1. Blood Alcohol Testing
   - Patients with an initial blood alcohol of 180-200 mg/dl do not need to have their levels redrawn provided that they are evaluated 5 hours after the initial blood draw.

   - Patients with an initial blood alcohol of 160-179mg/dL do not need to have their levels redrawn provided that they are evaluated 4 hours after the initial blood draw.

   - Patients with an initial blood alcohol of 140-159 mg/dL do not need to have their levels redrawn provided that they are evaluated 3 hours after the initial blood draw.

   - Patients with an initial blood alcohol of 120-139 mg/dL, do not need to have their levels redrawn provided that they are evaluated 2 hours after the initial blood draw.

   - Patients with an initial blood alcohol of 100-119 mg/dL do not need to have their levels redrawn provided that they are evaluated 1 hour after the initial blood draw.

   - For patients requiring admission to the Behavioral Health Unit, the physician will sign, date, and time the admission paperwork only after the necessary alcohol clearance time has elapsed per the above stated criteria.

2. Laboratory testing does not need to be performed on psychiatric patients who are being discharged from the Emergency Department. Laboratory testing does not need to be performed before assessment by a Behavioral Heath Evaluator, provided that the patient is clinically sober. If there is any indication that the patient may be intoxicated, then a blood alcohol level mist be sent, and the evaluation will be performed when the patient is medically sober.

3. The urine toxicology screen should be performed in the Emergency Department. However, in the event that the patient is unable to give a specimen in a reasonable amount of time, the patient may be transferred to the Behavioral Health Unit without the urine toxicology screen at the discretion of the admitting psychiatrist.

4. The TCA screen does not need to be performed as part of the urine drug screen.

BEHAVIORAL HEALTH PROTOCOLS
UCH EMERGENCY DEPARTMENT

TABLE OF CONTENTS

- Triage Protocol Flowchart
- Criteria for Triaging Patients to Behavioral Health Services
- Emergency Department Categories for Psychiatric Patients
- Protocol for Category I
- Protocol for Category II
- Protocol for Category III
- General Admission Criteria and Required Forms
- Preauthorization Procedures for BH Admissions
- Preauthorization Worksheet
- Protocol for C.D./Detox Treatment Requests

APPENDIX

Admission Criteria and Process Protocol for admissions to Behavioral Health Services	i
Application for Voluntary Admission form	ii
Application for Involuntary Admission form	iii
Petition for Emergency Evaluation form	iv
Community Referral Resource List	v
Preauthorization Resource	vi
Required Forms for Admission	vii

CRITERIA FOR TRIAGING PATIENTS TO BEHAVIORAL HEALTH SERVICES

PURPOSE: To expedite the care and disposition of patients in the emergency department who are in need of behavioral health services.

POLICY: All patients will be assessed by the ED physician and assigned to category I, II, or III according to written guidelines.

CRITERIA FOR CATEGORY I (Admitted to Inpatient Service):

1. There is evidence the patient has harmed or attempted to harm him/herself in a manner which is potentially lethal or disabling.
2. There is evidence the patient has harmed or attempted to harm others, due to a mental illness, in a manner which is potentially lethal or disabling.

CRITERIA FOR CATEGORY II (Requires Further Evaluation):

The patient exhibits any one or more of the following:

1. The patient has harmed or attempted to harm self or others without clear lethal intent and requires further evaluation to determine level of care needs.
2. The patient has made recent verbal threats to harm self or others.
3. The patient exhibits:
    a. bizarre behavior or
    b. disorganized thought process
    c. psychotic thought or content
4. The patient is not agreeable to a referral to the Mobile Crisis Team or other community resource.
5. The patient has been brought to the ED with an emergency petition, with apparent cause.

CRITERIA FOR CATEGORY III (Referred to Community Resources):

1. The patient presents to the ED voluntarily.
2. There is no evidence of imminent danger to self or others:
    a. Denies plan or intent to harm self or others.
    b. There are no reports by patient or others of recent self harm
    c. There are no reports by patient or others of recent aggressive behavior due to a mental illness.
    d. There are no reports of recent verbal threats to harm self or others.
3. The patient:
    a. Is alert and oriented
    b. Presents a logical stream of thought
    c. Is not intoxicated
    d. Agrees to a referral to community resource.

Upper Chesapeake Health Behavioral Health Services

Emergency Department Categories for Psychiatric Patients

Category I:

The patient meets all criteria for admission to Behavioral Health inpatient. The management of the patients is completed by the Upper Chesapeake Health Emergency Department team; this includes all preauthorization and completion of all necessary documentation for the medical record.

Category II:

The patient requires further psychiatric evaluation by the on-call evaluators to determine an appropriate admission status. The on-call evaluator will arrive to the Emergency Department within one hour of the initial contact/request. Recommendations to the Upper Chesapeake Emergency Department physician will be provided, and the on-call psychiatrist* will be consulted. The on-call evaluator will be available to the Emergency Department case manager to provide additional clinical information. The Upper Chesapeake Health Emergency Department team will obtain all preauthorization, and complete all necessary documentation for the medical record.

Category III:

It is determined that the patient requires a psychiatric community provided, and is discharged from the Upper Chesapeake Emergency Department. The Mobile Crisis Team is available to the Upper Chesapeake Emergency Department physician to provide psychiatric community referral information.

*The psychiatrist on call is available for telephone consultation to the Emergency Department physician for questions, concerns or clarification.

BEHAVIORAL HEALTH
PROTOCOL FOR CATEGORY I

PURPOSE: To expedite the care and disposition of patients who are assessed as Category I.

POLICY: All patients will be seen by the emergency department physician and assigned to Category I, II, or III based on written guidelines.

PROCEDURE:

Category I

- The Emergency Department (ED) physician consults with the psychiatrist on-call to determine whether there is clear indication for admission.
- At the request of ED staff, the Admissions/Registration staff identifies and contacts the appropriate third-party payer to verify benefits and to request a return call from the MCO case manager to authorize admission. The required information is documented on the preauthorization form.
- The MCO case manager returns the call to the Admission /registration staff and is transferred to the ED physician for clinical information.
- Once authorization is given, the ED physician documents the authorization number and number of authorized days on the medical record. This information is provided to the Admission/Registration staff for entry into Meditech.
- In the event a return call by the MCO case manager is not received after one hour, Admission/Registration staff will contact the MCO to inform them the patient will be admitted to the BHU, when appropriate.
- Voluntary Admission: The ED staff completes all necessary forms for voluntary admission, signed by the patients and the ED physician, where indicated. (See Appendix.)
- Involuntary Admission: The ED physician writes a brief progress note which includes the patient's medical history, current symptoms and diagnosis, and an explanation of why the patient meets criteria for involuntary admission, and completes and signs all necessary forms. (See Appendix).
- The patient is transferred to the HMH BHU according to established procedures.

Patients Requiring Admission to Another Facility

- Patients referred to other inpatient facilities require the following information, to be sent via fax :
    - The physician's progress note stating reason for admission
    - Relevant laboratory reports
    - The face sheet
    - Copy of insurance card
    - The *original* legal paperwork, (Voluntary and Involuntary Admission forms, E.P.), *must accompany the patient*. Copies are retained for the UC medical record. See Appendix for required forms for Admission
- The receiving facility will contact the ED when they have received all necessary information and accepted the patient for admission.

- The patient is transferred according to established procedures.

BEHAVIORAL HEALTH
PROTOCOL FOR CATEGORY II

PURPOSE: To expedite the care and disposition of patients assessed as Category II.

POLICY: All patients will be seen by the Emergency Department physician and assigned to Category I, II, or III according to written guidelines.

PROCEDURE:
Category II

- The ED physician consults with the on-call psychiatrist if categorization is in question.
- The ED physician requests a consultation with the ED behavioral health evaluator after assigning the patient to Category II.
- The on-call evaluator will respond to the page within 30 minutes and will arrive in the ED within on hour unless involved in other crisis situation, in which case they will provide an ETA.
- The ED physician will provide the ED on-call evaluator with the reason for the consultation request.
- The behavioral health on-call evaluator will:
    - Assess the patient
    - Consult with the psychiatrist on call, as required
    - Provide a written evaluation, utilizing the Upper Chesapeake assessment form
    - Consult with the ED physician regarding disposition and provide outpatient referrals, when indicated.
    - Notify the Admission/Registration staff of need to request preauthorization for admission, when applicable
    - Be available to talk with the MCO case manager to provide clinical information
    - Provide the authorization number and authorized days to the Admission/Registration staff
    - Complete all necessary forms for Voluntary or Involuntary Admission
    - Arrange admission to another facility, when indicated
    - Provide written documentation and a verbal report to the ED charge nurse regarding disposition status prior to leaving the ED
- In the event the MCO case manager does not call to review the case for authorization one hour after the initial request by UCH, the Admission/Registration staff will notify the MCO of the patient's admissions to the BHU at HMH.
- Following completion of the evaluation and necessary forms, the patient is discharged by the ED physician or admitted to a psychiatry facility according to established procedures.

BEHAVIORAL HEALTH
PROTOCOL FOR CATEGORY III PATIENTS

PURPOSE: To expedite the care and disposition of patients in the emergency department who are assessed as Category III

POLICY: All patients will be seen by the emergency department physician and assigned to Category I, II, or III according to written guidelines.

PROCEDURE:

- The ED physician determines the patient meets Category III criteria.
- The emergency department staff pages the on-call evaluator to speak with the patient by telephone to make referral and/or arrangements for a face-to-face visit, if indicated.
- The discharge checklist may be used as a guideline for discharge instructions.

BEHAVIORAL HEALTH
GUIDELINE FOR DISCHARGE INSTRUCTIONS
CATEGORY III PATIENTS

Meets Category III criteria

Agreeable to Mobile Crisis Team referral

Mobile Crisis team contacted

Date_____ Time_____

Available to speak with patient:

Appointment arranged_____

or

Referral given_____

or

Message left_____

Evaluator on call contacted to provide referral and/or relay message to MCT.

NOT PART OF THE MEDICAL RECORD

Chemical Dependency

Generally, efforts to secure admission to an inpatient detox or treatment program from the Emergency Department is a time consuming and fruitless prospect, resulting in hours of wasted time for the patient, family, and staff. Most managed care companies will not authorize admission to such programs until the patient has been assessed and recommended for admission *by the receiving facility*. The Behavioral Health Unit at HMH does not admit patients for the primary purpose of detox, or C.D. treatment. Assessment and recommendations from the psychiatric consultant in the ED are not sufficient to satisfy the MCO that the patient meets criteria for inpatient chemical dependency treatment. The receiving facility generally requires the *patient* make an intake appointment, which is scheduled during regular business hours. The MCO will approve admission based on the intake assessment and recommendation from the receiving facility. There are a very few exceptions to this procedure, but the vast majority of patients seeking this service *will not* be admitted from the ED. At best, the patient may be referred to an inpatient program for assessment (versus admission). The patient is usually capable of making the necessary telephone calls and arranging the intake appointment, and should be encouraged to do so.

Uninsured patients have no less difficulty securing admission, and may be given the referral list to arrange their own treatment. The Mobile Crisis Team is available, by telephone, to assist both insured and uninsured patients in finding resources.

BEHAVIORAL HEALTH
GENERAL ADMISSION CRITERIA AND
REQUIRED FORMS

VOLUNTARY ADULT

Criteria

The patient:

- Must be 16 year or older
- Must have a mental disorder that is susceptible to care or treatment
- Must be able to understand the nature of the request for treatment
- Must be able to give consent to retention by the facility (must be able to request release).
- Must be provided with information printed on the Application for Voluntary Admission (Health General Article, Annotated Code of Maryland) in order to make an informed decision about hospitalization
- The Application for Voluntary Admission must be singed by a physician licensed to practice medicine in the state of Maryland and by the patient.

Forms

- DHMH-4 (Request for Voluntary Admission)

INVOLUNTARY ADULT

Criteria

The patient:

- Has a mental disorder that is susceptible to care or treatment
- Needs continued treatment for the protection of the individual or another (imminent danger of suicidal or homicidal behavior)
- Is unable or unwilling to be voluntarily admitted
- Has no available less restrictive option for care that is consistent with his/her welfare

Forms

- Two DHMH-2s (Physician Certificates)
- One Supplemental DHMH-2 (Six Questions)
- DHMH-34 (Application for Involuntary Admission)*
- The Emergency Petition

PREAUTHORIZATION PROCEDURES FOR BEHAVIORAL HEALTH ADMISSIONS

I. PURPOSE: To comply with preauthorization requirements of third-party payers.

II. POLICY: The Admissions/Registration staff will request preauthorization for patients requiring admission and document the information on the appropriate forms.

III. PROCEDURE:

- At the request of the ED staff or the on-call evaluator, the Admissions/Registration staff identifies and contacts the appropriate insurance company or MCO, providing demographic and policy information, and requests a call back for preauthorization for admission, providing the name and contact number of the person giving clinical information, (ED physician or on-call evaluator).
- The MCO or insurance representative verifies benefits and contacts the case manager for authorization.
- The Admissions/Registration staff documents the required information on the preauthorization form and places on patient chart. (See attached)
- The MCO case manager contacts the ED physician or the on-call evaluator for clinical information.
- The MCO case manager provides the authorization number and the number of authorized days which is related to the Admissions/Registration staff for entry into the Meditech system.
- In the event a return call is not received after one hour, Admissions/Registration staff notifies the MCO of the patient's admission to the Behavioral Health Unit.

PREAUTHORIZATION WORKSHEET

DATE:_____
TIME:_____

PATIENT NAME _____

DOB_____ SS#_____

INSURANCE CO. & POLICY # _____

MCO Contacted _____

COMMENTS _____

_____

_____

_____

Authorizing Case Manager _____

Phone # _____ **Call returned**_____
(Date & Time)

Authorized to: HMH Other_____

Number of Days Authorized _____ Authorization #_____

UR to Contact _____

Comments: _____

_____

_____

_____

BEHAVIORAL HEALTH
PROTOCOL FOR PATIENTS
REQUESTING CHEMICAL DEPENDENCY TREATMENT

PURPOSE: To expedite the care and disposition for patients seeking detoxification and/or Chemical dependency treatment

POLICY: Sheppard Pratt does not provide assessment and placement for patients seeking detoxification, or other chemical dependency treatment. Patients will be medically stabilized and referred.

PROCEDURE:

- The ED physician provides medical evaluation and treatment as deemed appropriate.
- Patients who are medically stable are referred for treatment by contacting the on-call evaluator who will provide available resources and information.

PLEASE SEE APPENDIX FOR FURTHER INFORMATION

Admission Criteria to Upper Chesapeake Behavioral Health Services

Inclusion Criteria for Psychiatric Admissions:

1. Immediate danger to self/others as evidenced by verbal threats or observed behavior
2. Evidence of impaired judgment due to a psychiatric condition likely to endanger self/others
3. Evidence of treatment failure likely to result in behavior dangerous to self/others
4. Multiple suicide attempts (or other episodes of dangerous behaviors due to psychiatric condition) within a short period of time
5. Inability to contract for safety outside of the hospital in association with an active psychiatric condition
6. Disabling psychiatric condition for which no effective treatment alternative exists

Exclusion Criteria (based on physician collaborative review):

1. Intoxication
2. Medically unstable
3. Documented history of assaultive behavior against hospital staff
4. Persons under police custody or against whom active charges have been filed
5. Specialty services not available at time patient presents in emergency room

References:

Brennan DF, Betzelos S, Reed R, Falk JL. Ethanol elimination rates in an ED population. Am J Emerg Med 1995; 13(3):276-80

Lexicomp Online- Alcohol (Ethyl):
http://online.lexi.com/action/doc/retrieve/docid/patch_f/6294

EXHIBIT 7

UNIVERSITY of MARYLAND UPPER CHESAPEAKE HEALTH	PAGE: Page 1 of	POLICY/PROCEDURE /SOP NO: CRM
	ORIGINAL DATE: 12.2003	
	APPROVAL DATE:	EFFECTIVE DATE: Reviewed Date: 01.2006, 01.2009, 04.2012, 08.2015 Revised Date: 01.2006, 01.2009, 04.2012, 08.2015
POLICY/PROCEDURE/SOP TITLE: Transportation	FUNCTION/OWNER: CRM Policy Oversite Committee	

Standard Operating Procedure

KEY WORDS: (if applicable)

1. OBJECTIVES/PURPOSE:

- To outline the process by which Clinical Resource Management facilitates safe and appropriate transportation options to patients being discharged from a UMC UCMC or UM HMH

2. SCOPE/APPLICABILITY:

- The Standard Operating Procedure (SOP) will be applied in the Clinical Resource Management (CRM) Department. Team Member education will also be included in the scope of this SOP.

3. PREREQUISITES:

- Interdisciplinary team member education

4. RESPONSIBLITIES:

- CRM team member – proper identification, referral, coordination and facilitation of transportation
- Any member of the Interdisciplinary Team – Identify patients who will require assistance with transportation at discharge

5. PROCEDURE:

5.1 General Information

a. Transportation arrangements will be made based on the patient's medical conditions, safety concerns, team recommendations and patient or family request.
b. A list of transportation providers is available on the UCH Intranet>Case Management>Transportation

c. CRM will speak with members of the multidisciplinary team regarding safe options for transport

a. Check the Rehabilitation interventions

i. The Rehabilitation team will often make recommendations on how patient would best be transported

d. CRM will speak with patient and/or family about their preferences for transport and recommendations of the team – if any

e. Some Assisted Livings/Boarding Homes provide their own transportation

a. Usually is depends on staffing at the facility, time of day, etc.

f. CRM does not arrange for transportation for acute to acute transfers

5.2 Coordinating Transportation

a. Prior to setting up transport

a. CRM will verify with the patient and/or family where the patient will be going at the time of transport

b. CRM should verify with the patient and/or their family and facility (if appropriate) when transport is to occur

5.3 Ambulance transport

a. There are two types

a. Advanced Life Support (ALS)

i. Requires RN monitoring during transport

ii. Ventilator dependent

iii. Continuous intravenous devices

iv. Continuous cardiac (EKG) monitoring

v. The patient is comatose and requires trained monitoring

b. Basic Life Support (BLS)

i. Criteria – must meet one of the following

a. Must be considered bed bound

a. The patient is unable to get out of bed safely with one person assisting

b. Unable to get up from bed without assistance

c. Unable to ambulate AND Unable to sit in a chair – including a wheelchair

d. The patient cannot support themselves safely when seated in a wheelchair

i. Why

e. All other types of transportation must be contraindicated

f. Any other means would endanger the patient's health

g. Be Specific

h. Additional helpful documentation

i. oral pain meds, antipsychotics

ii. pressure sores

iii. trunk instability

iv. Document the JHH Fall Risk Score

c. When going to acute rehab or out of county closest accepting facility must be documented

d. Insurance

a. CRM will remind patient/family that despite all of the documentation provided there is still no guarantee that Medicare will cover ambulance transport

b. Most insurance companies will cover ambulance transport if the above criteria are met

d. CRM will verify benefits and obtain authorization and identify preferred providers for commercial insurances – including MA MCO's

e. A Certificate of Medical Necessity should be completed for Medicare and some other commercial insurance

i. complete in and fax thru eDischarge

5.3 Wheelchair Van

a. A wheelchair van can be used in the event that a patient does not meet the criteria to be transported by ambulance or their family does not feel comfortable transporting the patient in a private vehicle

b. Criteria

a. The patient must be able to independently sit in a wheelchair

b. The patient must be able to transfer independently from the bed to the wheelchair or at least transfer with minimal assistance from the attendant

c. The patient can be on self-administered 02 but the transportation company does not supply the 02

c. Insurance

a. Wheelchair vans are not covered by most insurances including Medicare

b. Wheelchair van service providers usually require payment at time of transport if insurance will not authorize or benefits are not available

c. CRM will facilitate a conversation with the patient and/or their family regarding cost and payment options- i.e.: cash, check or credit card

d. Cost will be verified with transportation provider and shared with family

5.4 Coordination of transportation

a. Demographic information – face sheet

b. The patient's height and weight

c. Isolation precautions

d. Oxygen requirements – if any

e. If the patient is going to a private residence – are there any steps?

f. Time requested

5.5 Cab Vouchers

a. Are provided only when a patient is safe to be transported in a car

b. It has been determined that there are no family and friends who can assist with transportation

c. Bus transport is also not an option

5.6 Medical Assistance (MA) Transportation

a. MA will cover transportation for SOME MA recipients

b. Each county has certification forms that must be completed for transport –

a. Available in eDischarge

c. Harford County phone number 410-638-1671

a. Must use Transcare for ambulance transportation
410-242-9000 phone/410-649-2253 fax

b. Must use Davi Transportation Services for wheel chair vans
443-768-6879 phone/410-654-0091 fax

d. MA transport can verify benefits

e. MA transport will either set up transport or inform you of the provider

f. MA transport will provide you with an authorization number for ambulance or wheelchair van arrangements

g. Requests must be received Monday thru Friday by 2pm

h. They do not answer the phone after 2pm

5.7 Harford County Transportation Services

a. Harford County has public bus service with various routes throughout the county 410-838-2562

b. Schedules are available on the Harford County Government website

c. The bus comes to the main entrance of both hospitals.

d. It comes to UCMC about every 15 minutes

e. It comes to HMH about every 2 hours

5.8 Documentation

a. All transportation arrangements must be documented on the CRM DC Plan and in the progress notes section of the EMR.

b. If CRM paid for transportation please be sure to reflect this when documenting on the CRM Discharge Plan

6. REFERENCES:

- Transportation Provider List – UCH Intranet>Case Management>Transportation

7. DEFINITIONS:

- CRM –Clinical Resource Management
- EMR – Electronic Medical Record
- MA –Medical Assistance
- MCO's - Managed Care Organizations

STAKEHOLDERS:

Reviewed by:	Date:
Alexis Rivers	
Debbie Gebhardt	
Debi Cheng	

APPROVED BY:	Title	Date
Alexis Rivers	Director, CRM	

APPROVED BY:	Date
Digital signature and date are on file in Reference Library	

EXHIBIT 8

UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH

BEHAVIORAL HEALTH SERVICES

TITLE: ADMISSION CRITERIA AND PROCESS PROTOCOL FOR BEHAVIORAL HEALTH SERVICES

Approved by:

Director of Behavioral Health Services: _____
Chief of Psychiatry/Medical Director: _____
Vice President of Patient Services: _____

Original Date:	6/95							
Reviewed Date:	9/97	4/08	10/14					
Revised Date:	9/97	1/99	9/99	11/03	7/06	4/08	1/11	7/13

PURPOSE: To facilitate appropriate and timely admissions to the Behavioral Health Services unit (BHU).

POLICY: The Behavioral Health Services unit will provide inpatient acute mental health services for those patients that have been evaluated and meet admission criteria.

PROCEDURE:

I. Voluntary Admission

A. A voluntary patient is defined as any patient age 18 and over and experiencing a primary acute psychiatric illness or an exacerbation of a chronic condition that impairs the patient's ability to function independently and/or is dangerous to oneself or others, and agrees to treatment. (See attachment A: Admission Criteria/Limitations).

B. Voluntary status requires:
1. A signed Application for Voluntary Agreement endorsed by a licensed physician.
2. Patients must be able to comprehend the status of their admission and their need for treatment.
3. Ability to take prescribed medications as ordered.

4. Ability to participate in milieu and therapeutic groups.
5. Ability to meet with the psychiatrist daily.
6. Ability to participate in discharge planning.
7. Patients must be medically stable and not require intensive medical treatment.
8. Pregnant patients greater than 12 weeks gestation will not be admitted

C. In accordance with Maryland Health General Law 10-803, voluntarily admitted patients may request, in writing, their intent to leave the hospital within three days. If a guardian signs the Voluntary Admission Agreement for the patient, they must submit the three-day notice.
   1. Patients must request, in writing, their intent to leave the hospital by completing Harford Memorial Hospital Behavioral Health Services three-day notice.
   2. If the treating psychiatrist determines that the patient meets criteria for certification for involuntary admission, then the certification process will be completed in accordance with Maryland Health General Law 10-803.
   3. A three-day Notice retraction must be reviewed and signed by a physician in order to validate its acceptance.

D. Observation Status: A patient may be placed in observation status per the physician order. The patient will be evaluated by the physician within 24 hours and a decision made to either admit the patient or discharge the patient.

II. Involuntary Admissions

Observation Status

A. Defined. Observation Status is defined as the interval between the time an individual is involuntarily confined in the facility and the time he/she is voluntarily admitted, released either by the attending psychiatrist or psychologist or by the Administrative Law Judge, or retained as an involuntary patient by an Administrative Law Judge. During the observation period the observee shall receive care and treatment as medically required but may not, absent an emergency, be forced to take medication. The purpose of observation is for assessment of need for involuntary admission, voluntary admission, or release without admission.

B. Observation Status Initiated at Time of Admission. The hospital admitting nursing person is responsible to initiate the process leading to a hearing for involuntary admission when an individual is brought in for observation. The following forms must be completed on all involuntary admissions prior to arrival on the unit: (1) Application for Involuntary Admission (form DHMH - 34) completed and signed by a person who has a legitimate interest in the welfare of the individual; (2) two copies of the State of Maryland Certification by Physician or Psychologist (DHMH-2

REV.3/90), completed and signed by either two physicians licensed to practice in the State of Maryland, or by one physician and one Maryland licensed psychologist listed in the National Register; (3) a report which explains how and why the individual meets each of the five certification criteria and summarizes the individual's medical history and current symptoms; and (4) if the individual is an emergency evaluee, copy of a fully-completed Petition for Emergency Evaluation.

1. If the individual has been transferred from an inpatient facility after that facility completed application and certificates for involuntary admission, these documents are required in addition to a copy of the individual's most recent treatment plan, the discharge summary, and copies of all voluntary and involuntary admissions documents relating to the admission to that inpatient facility.

2. Within twelve hours of the commencement of the observation period, Admissions team members will read and explain in clear and understandable terms the Notification to Patient of Admission Status and Rights (form DHMH-35) and the Notice of Hearing (form OAH-1051). The Notification to Patient of Admission Status and Rights must be completed, signed, and made a permanent part of the observee's record. A copy of the notification must also be given to the observee. The Notice of Hearing will be completed, signed, and given to the observee. Remaining copies of the Notice of Hearing should be filed in the observee's record.

3. Once the above process is completed, nursing team members will call the Involuntary Admission Hearing Office to inform them of the pending hearing. The Involuntary Admission Hearing Office must be informed by Wednesday of any hearing.

C. Observation Status Initiated During an Inpatient Stay.

1. If the treating physician of the treatment team determines that a voluntary patient meets the criteria for certification or if a patient submits a Three-Day Notice and the treating physician of the treatment team determines that the patient at the time meets the criteria for certification for INVOLUTARY ADMISSION, then the certification process may be initiated by informing unit nursing team members and the social worker.

2. The nursing team members will use the Certification Process Checklist throughout the certification process. The RN or social worker on the unit will sign the Application for Involuntary

Admission (DHMH-34). Then nursing team members will contact two Harford Memorial Hospital licensed physicians or one licensed physician and one licensed psychologist listed on the National register, who will examine the individual and determine if and why each of the five certification criteria is met.

3. Within twelve hours of the completion of the second certificate, nursing team members must complete the Notification to Individual of Admission Status and Rights and the Notice of Hearing, review both with the observee, and give the observee copies of these forms.

D. Roles and Responsibilities during the Observation period.

1. Psychiatrist (M.D.), Psychiatric Resident (M.D.) or Psychologist (Ph.D.) (all licensed):
   a. Assisted by the treatment team, the physician determines whether the observee meets the following criteria:
      (1) The individual has a mental disorder.
      (2) The individual needs inpatient care or treatment.
      (3) The individual presents a danger to the life or safety of the individual or of others.
      (4) The individual is unable or unwilling to be admitted voluntarily.
      (5) There is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual.

   b. If the observee meets each of the above criteria, a hearing will be scheduled. If the observee is also refusing recommended psychiatric medication, a Clinical Review Panel may be scheduled to convene as soon as possible after the hearing. To request a Clinical Review Panel, the Patient Rights Advisors' Office must be contacted.

   c. If the observee does not meet the above criteria, the physician must determine if the observee meets all the criteria for Voluntary Admission as follows:
      (1) The individual has a mental disorder;
      (2) The mental disorder is susceptible to care or treatment;
      (3) The individual understands the nature of the request

for treatment;

(4) The individual is able to give continuous assent to retention by the facility; and

(5) The individual is able to ask for release.

d. If the observee meets the above criteria, he/she may sign an Application for Voluntary Admission for endorsement by a licensed physician. The hearing should be canceled. The licensed physician or his/her designee must also complete the Notification to Individual of Admission Status and Rights designating the changed status, review it with the patient, and give the patient a copy of this form.

e. If the observee does not meet the criteria for involuntary admission and does not sign an Application for Voluntary Admission, then the observee must be released from observation and the hearing canceled. The observee's record must state that the individual is being "Released from Observation Status."

2. Social Worker:

a. Shall be responsible for these functions:

(1) Shall inform the family/surrogate of the date, time and place of the hearing, and assist them in preparing for the hearing if their evidence is to be given (to be determined in conjunction with the treatment team and the hearing presenter).

(2) Shall notify the hearing office of any family/others who will be attending the hearing or who will be available for telephone testimony.

(3) Shall provide family support as necessary.

b. May be called upon in regards to any of the following functions:

(1) May assist the observee in obtaining and communicating with counsel;

(2) May assist the family/surrogate in understanding the nature and implications of the hearing;

(3) May be called upon by the physician to attend the hearing.

3. Hearing Presenter: Using the Involuntary Checklist from the admissions process, the presenter obtains any documentation

required for the individual's hearing, notifies the physician or designee of any documentation problems or concerns, and makes recommendations to the physician or designee and the risk manager regarding proceeding to hearing.

E. Individuals' Right to Access to Legal Counsel: Individuals on observation may obtain private legal counsel, and in so doing may obtain the assistance of the assigned social worker or the Patient Rights Advisor. Harford County Lawyer Referral Services can be contacted for assistance in obtaining private legal counsel. Should an individual not have or want private legal counsel, referral will be made to the Public Defender's Office by the Hearing Presenter.

F. The Hearing

An administrative hearing must be held to determine whether the observee may be involuntarily committed under Maryland law. An impartial Administrative Law Judge will hear the case and decide whether the observee is to be admitted to or released from the Hospital.

1. Schedule of Hearings

a. Hearings are usually conducted on Fridays, and must be held within ten calendar days of the observee's confinement unless a postponement has been arranged. The observee's hearing will take place on the Friday following confinement. For individuals entering the hospital on observation after midnight on Tuesday, the hearing will be held the following week in order to allow the observee time to obtain legal counsel and to allow an adequate period for observation.

b. The date of the hearing may be postponed or continued by the Administrative Law Judge for good cause shown, but in any event, the hearing shall be concluded and a decision made within 17 calendar days from the date of confinement. If an observee and/or his/her legal counsel requests a different hearing date, every effort will be made to schedule the hearing at a time acceptable to all involved.

2. Observee's Rights

    a. The observee must be present at the hearing unless he/she refuses or waives the right to attend. Any waiver must be knowingly and intelligently made by the observee in the presence of the Administrative Law Judge and the observee's legal representative. The observee's lawyer, the Administrative Law Judge, and the Hospital team members will determine if the hearing will be held on the unit. If the hearing is to be held on the unit, a room with a phone jack may be required.
    b. Hearings are held with the observee, a nursing team member escort, his/her attorney, his/her physician, the Administrative Law Judge, the Hearing Presenter, a member of the hospital's Department of Security, and any called witnesses. The observee may request that witnesses not be present during aspects of the hearing.

3. Roles and Responsibilities during the Hearing

    a. Hearing Presenter: The Hearing Presenter presents the legal documentation leading to the observee's confinement, calls witnesses for the Hospital, and guides their testimony.
    b. Physician
        1. Definition
        For purposes of testimony at a hearing for involuntary admission, the term "physician" is defined as (a) a physician who is identified as a specialist in psychiatry by the Board of Physician Quality Assurance; or (b) an individual licensed under Health Occupations Article, Title 18, Annotated Code of Maryland, to practice psychology; or (c) a physician licensed under Health Occupations Article, Title 14, Annotated Code of Maryland in the residency program in psychiatry and under the supervision of the psychiatrist who is responsible for the treatment of the individual who is the subject of the hearing.
        2. Examination; attendance
        The physician who has examined the observee within 48 hours of the hearing must be in attendance at the hearing. If attendance is not possible, the physician must identify another physician meeting the above definition and notify the Hearing Office of the change prior to the hearing.

3. Postponements
   If for any reason the hearing is postponed, a short addendum may be dictated by the date of the following hearing to update the report regarding the observee's condition.

c. Resident in Psychiatry (unlicensed) May be called as a material witness by the hearing presenter and/or may be directed by the physician to draft the hearing note.

d. Social Worker
While the social worker has no legally mandated role in the hearing for INVOLUNTARY ADMISSION, he/she may be a key player in the hearing, should family members be called as witnesses.

4. Hearing Outcomes

a. Retained
If an observee is retained by the Administrative Law Judge, he/she is certified for involuntary admission for six months (180 Days) at the hospital. The patient may obtain legal counsel to appeal this decision. Pending further judicial decision, it is the physician's decision as to when the patient will be discharged before the end of the six-month period. If the patient remains in the hospital, the physician must then decide whether discharge is appropriate, whether to accept an Application for Voluntary Admission, or whether the patient meets the criteria for certification and should again go to hearing (see above, I.C.).

b. Released

1. **From observation status initiated at time of admission.** If an observee is released prior to the hearing, the physician shall note in the observee's record that the observee was "released from observation status." If an observee is released by the Administrative Law Judge, the physician shall note in the observee's record that the observee was released at hearing for INVOLUTARY ADMISSION by the Administrative Law Judge. The entire record must be filed separately from the medical record in the medical records department.
2. **From observation status initiated during an inpatient stay.** A discharge summary is required for Harford Memorial Hospital inpatients released following a change-in-status hearing (see above I.C.), although documentation of the

observation period and outcome should be limited to "the patient was released at a hearing for INVOLUNTARY ADMISSION on [date] after having submitted a three-day notice on [date]. All documentation pertinent to the hearing itself (copies of the Certification by Physician or Psychologist, etc.) must be filed separately from the medical record.

3. **And the physician determines that the individual still/again meets the criteria for certification.** If the individual is released by the Administrative Law Judge and the individual's physician determines, based on the individual's behavior and clinical condition after the hearing, that the individual meets the requirements for certification by a physician or psychologist, the physician may complete and file a Petition for Emergency Evaluation with the Security Department once the individual has been give the opportunity to leave the hospital (see above, I.D. for a full description of this process).

III. The following medical record documentation is required for patients readmitted within 30 days:

A. An admission order is written. Standing and other admission orders are entered as indicated.

B. A readmission note is written in the progress notes. This note should include reason for readmission, mental status, interim history, admission diagnosis, and initial treatment plan.

C. The necessity for a Physical Exam and Medical History should be reviewed and a clinical judgment made regarding the need to complete a full or partial medical history and physical examination

D. Supplemental information and psychosocial assessment from the previous admission may be added to the Psychosocial History.

E. An Individual Treatment Plan is due within 72 hours. The treatment plan from the previous admission can be used as a reference document. Treatment Plan Reviews will be due weekly thereafter.

IV. Admissions from UCMC ED

ED medical staff will assign a category to the patient after she or he has been medically cleared. (See attached *Emergency Department Categories for Psychiatric Patients*)

A. Admissions to UCH BHS unit:
   1. The ER evaluator is to call or fax the BHS unit to give comprehensive clinical and insurance information to the charge nurse. The charge nurse on the BHS unit is to verify that authorization has been received from the appropriate insurance carrier and accept the admission.
   2. The BHS unit charge nurse is to notify Admitting of the admission.

B. Transfers to other acute psychiatric units will be coordinated by the Emergency Department evaluator in collaboration with the ER charge nurse.

V. Admissions from UCH inpatient Medical services

A. Medical physician requests psychiatric consultation
B. Psychiatrist evaluates patient and determines clinical appropriateness for inpatient acute psychiatric services and notifies BHS unit charge nurse.
C. Payer clearance is obtained by case manager assigned to work with the patient. BHS unit team members will serve as a resource and obtain insurance authorization when case management is not available.
D. Admission of patient:
   1. Medical physician will write order for discharge from the medical floor. The accepting psychiatrist will write admission orders for the BHS unit.
   2. Medical nursing team members and BHS unit nursing team members will coordinate the discharge from the medical unit and the admission to the BHS unit.

VI. <u>Direct Admissions</u>

The following steps must be followed to arrange for the direct admission of acutely ill psychiatric patients to the Behavioral Health Services unit at Harford Memorial Hospital.

A. The community health care provider (e.g., primary therapist or medical physician) will call the inpatient psychiatric unit at Harford Memorial Hospital.
B. Intake information will be obtained by an RN on the Behavioral Health Services unit. The RN will carefully document demographics, insurance, and clinical information including diagnosis codes for all five DSM-IV Axes.
C. Pertinent laboratory data, clinical notes, and signed Voluntary/Involuntary Admission forms should be faxed to the Behavioral Health Services unit for

review by the RN coordinating the admission and the psychiatrist on call.

D. It is the responsibility of the referring therapist, medical physician, or ER consultant to provide insurance information to the Behavioral Health Services Unit staff for the patient being referred to the inpatient unit.

E. The clinical information obtained from the referring provider should be discussed with the attending psychiatrist for direct admission to the Behavioral Health unit.

Note: It is the responsibility of the attending psychiatrist or the psychiatrist on call to determine the need for additional medical clearance. The attending psychiatrist has the option of discussing the proposed admission directly with the referring provider. When a patient is referred to the emergency room for medical clearance only, it is not necessary to have a second psychiatric evaluation in the emergency room prior to admission to the Behavioral Health Services unit.

F. Nursing team members of the Behavioral Health Services unit will notify Admitting of a direct admission and provide Admissions with the following information:

1. Authorization number
2. Phone number called
3. Name of individual from insurance company who provided clearance for admission.

The patient in the therapist's office, medical physician's office, or other referring provider will sign a Voluntary Admission form prior to being brought to the inpatient unit for hospitalization.

Once the patient is cleared for admission, he/she is to be brought directly to the 5th tower for admission to the Behavioral Health Service.

G. Prior to entering the locked unit, the patient should sign the following forms:

1. Application for Voluntary Admission (see attachment B)
2. No Smoking Notification (Referring provider must inform the patient that Harford Memorial Hospital is a non-smoking facility.)

If the patient refuses to sign the above documents, the patient should be referred back to the provider, providing there is no question regarding the patient's safety.

<u>If there is a question of safety</u>, the patient should be referred to the emergency room and a process for involuntary commitment to the inpatient service should be initiated. The patient will be given a) a copy of rights, b) program schedule, c) programs rules and expectations, and d) a patient information folder.

H. The Behavioral Health Services unit Case Manager will provide continued-stay review with the insurance carrier the following business day.

VII. Admissions from another facility (*voluntary* or *involuntary*)

The following procedure must be followed to arrange for admission of acutely ill psychiatric patients from another facility to the Behavioral Health Services unit at Harford Memorial Hospital.

A. The facility will call the inpatient Behavioral Health unit at Harford Memorial Hospital.
B. Intake information will be faxed by the referring facility to the Behavioral Health unit. The intake information will include demographics, insurance, signed voluntary or involuntary forms, pertinent laboratory data, and clinical information including diagnosis codes for all five DSM-IV Axes.
C. It is the responsibility of the referring facility to provide insurance information to the Behavioral Health Services unit staff for the patient being referred to the BHS unit. It is imperative that nursing team members record the name of the person with whom they speak, the time, and any verification numbers they are given.
D. The clinical information obtained from the referring facilitator should be discussed with the attending psychiatrist for admission to the Behavioral Health unit.
   Note: It is the responsibility of the attending psychiatrist or the psychiatrist on call to determine the need for additional medical clearance. The attending psychiatrist has the option of discussing the proposed admission directly with the referring provider.
E. Nursing team members of the Behavioral Health Services unit will notify Admitting of an admission from another facility and will provide Admitting with the following information:
   1. Authorization number
   2. Phone number called
   3. Name of the individual from the insurance company who provided clearance for the admission

   The patient will sign a Voluntary Admission form or the completed certification paperwork prior to being brought to the Behavioral Health unit for hospitalization.

   Once the patient is cleared for admission, she/he is to be brought directly to the Behavioral Health unit for admission.

F. Prior to entering the locked unit, the patient should sign the Application for Voluntary Admission (see attachment B).
G. After arriving on the Behavioral Health unit, the patient should sign the following forms:

1. Notification of Admission Status and Rights
2. No Smoking Notification (the referring provider must inform the patient that Harford Memorial Hospital is a non-smoking facility.)
3. Releases of Information

H. The Behavioral Health unit Case Manager will provide continued-stay review with the insurance carrier the following business day.

VIII. Behavioral Health Services unit discharges to Medical units

A. Psychiatric attending physician requests medical consultation

B. Medical physician evaluates patient and determines need for treatment on a medical unit

1. Medical physician will write orders for discharge from the BHU and admission to medical service.
2. Referring medical physician must ensure that receiving medical physician is a participating provider with the payer. This applies in the event that the receiving physician is the referring physician.

C. BHU team members will communicate with referring medical physician to ensure that Item B2. (above) was verified.

D. BHU team members will notify the bed coordinator for the bed assignment, nursing unit and payer of admission.

E. Admitting office obtains concurrent authorization for medical admission, per policy, on the next business day.

F. BHU and medical unit nursing team members will coordinate the patient move to the medical unit.

G. Case Management team members will perform admission review with the payer as per policy.

FORMS: State of Maryland form DHMH 33 *Notification to Individual of Admission Status and Rights*
Application for Involuntary Admission
Certification by Physician or Psychologist
Specific Information to Accompany Physician's Certificate
Involuntary Admission Timeline
State of Maryland form OAH 1051 *Involuntary Admission to Mental Health Facility Notice of Hearing*
State of Maryland form OAH 1053 *Certification*
Observation Status Only

EQUIPMENT MANUALS: N/A

REFERENCE: Code of Maryland Regulations, Title 10, Subtitle 803
Stuart, G. and Laraia, M., *Principles of Psychiatric Nursing*, 8th Edition, 2005
The Joint Commission. *Provision of Care, Treatment, and Services*, 2009.

Admission Policy

Attachment B

ADMISSION CRITERIA FOR THE VOLUNTARY PATIENT

A. The individual's emotional/behavioral/mental condition is such that it significantly impairs his/her ability to function in the community, school, home, or other environment.

B. The condition is susceptible to care or treatment.

C. The individual understands the nature of the request for treatment.

D. The individual is medically stable, not requiring intensive medical treatment. No pregnant patient greater than 12 weeks gestation will be admitted.

E. The individual is able to participate in group activities, and to contribute to his/her self-care.

F. The individual is able to continually assent to retention by the facility.

G. The individual is able to ask for release.

Attachment C

General Admission Criteria/Limitations

The Behavioral Health Unit is a general adult unit. Patients usually stay a short period of time until they are stabilized to be discharged home or to another level of care. General criteria for admission are:

a. The patient must be experiencing a primary acute psychiatric illness or an exacerbation of a chronic mental health condition.
b. The patient must be over 18 years of age.
c. The patient is a potential threat to her/his own physical well being or the well being of others severe enough to impair the patient's ability to function independently, due to behavioral manifestations of a mental disorder.
d. The severity of the patient's condition negates less restrictive alternative community treatment, and the inaccessibility of indicated outpatient treatment has been verified.
e. The patient needs medically managed and registered-nurse-supervised skilled observation and evaluation.
f. The patient requires high dose or intensive medications, or somatic and psychological treatment with potentially dangerous side effects.
g. Patients admitted must be able to participate in therapeutic group activities since this is one of the primary milieu treatment modalities.

Some limitations of the program include but are not limited to the following:

a. The program is able to provide for isolation of patients with infectious diseases or reduced resistance to disease contingent upon the patient's ability to participate in unit programming.
b. Patients who are diagnosed with a primary chemical dependency illness or a primary diagnosis of mental retardation would not be considered appropriate for admission. A dually diagnosed person, if s/he meets the other admission criteria, would be appropriate.
c. Patients whose medical status prevents them from participating in a milieu program would not be appropriate for admission.
d. Patients requiring cardiac monitoring, intra cardiac invasive monitoring, peritoneal dialysis or endotracheal intubation ventilator management would not be appropriate for admission.
e. The Chief of Psychiatry and Medical Director, in conjunction with the Director of Behavioral Health Services and Hospital Administration, may exercise the right to refuse to admit a patient, or require a patient to be transferred from the Behavioral Health Services unit, when it is felt that appropriate care and patient safety cannot be reasonably assured, or that the patient presents a continuous risk of great magnitude to the welfare of others, or of disruption of the treatment of

others. Assistance in referral or transfer, as indicated, to a more appropriate setting will be provided by treatment and/or administrative team members.

f. A demand for beds beyond capacity will warrant the development of a waiting list, which will be prioritized by the acuity of the patient.

EXHIBIT 9

UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH
PATIENT SAFETY AND QUALITY PLAN
FY2018

I. Statement of Purpose

Upper Chesapeake Health, having established the vision to become the preferred, integrated health care system creating the healthiest community in Maryland, is committed to the provision of compassionate, high quality, clinically effective health care in a safe environment coupled with trust, integrity and respect for all. In support of this commitment, the Board of Directors and Hospital Leadership endorse an integrated, systematic quality, safety and continuous improvement program to improve patient outcomes, improve efficiency and effectiveness and reduce risk.

II. Overall Patient Safety and Quality Plan Objectives

A. To focus and coordinate organization wide patient safety and continuous improvement activities;
B. To focus and coordinate organization wide patient safety and continuous improvement activities;
C. To provide a framework for defining quality and continuous improvement opportunities, that includes:
    1. setting priorities for the scope of the plan;
    2. selecting measures that are meaningful and that address the needs of the patient;
    3. identifying the frequency of data collection;
    4. measuring the performance of processes that support patient care;
    5. collecting data;
    6. analyzing the data to identify trends, patterns and performance levels, including the adequacy of staffing to include number, skill mix and competency for sentinel events and root cause analyses;
    7. statistical tools and techniques are used to analyze and display data;
    8. implementing and reporting actions taken to resolve the identified problems;
    9. prioritizing improvement initiatives when necessary;
    10. evaluating actions to confirm they resulted in improvement;
    11. taking action(s) when improvement is not achieved or there are not sustained improvements;
    12. reporting issues, including staffing, through the PI structure reporting in Section VI ;
    13. prioritizing improvement initiatives when there are more opportunities than can be managed at one time;
D. To provide a framework for defining quality and continuous improvement opportunities, setting priorities for the scope, measuring and assessing performance, evaluating results and implementing improvement actions;
E. To include patients and families and capture the "voice of the patient" to provide the finest in care, courtesy and service;
F. To develop strategies to improve efficiency, effectiveness and reduce operational waste;
G. To define, support and maintain a Just Culture, providing structure for individual and organizational accountability.
H. To maintain an environment that supports safety and does not tolerate conscious disregard of clear risks to patients or reckless behavior, while recognizing that even competent team members make mistakes.

I. To facilitate communication and reporting of all performance improvement and patient safety activities to leadership, team members, medical staff and volunteers;
J. To support analysis of "good catch" event and current trends, including Sentinel Event Alerts to proactively assess risk in current processes and to consider safety for all new services and process design/redesign;
K. To achieve the appropriate balance between good outcomes, excellent care, services and costs;
L. To enhance effective organizational and clinical decision making;
M. To promote team work and group responsibility in identifying and implementing opportunities for improvement;
N. To establish mechanisms for the disclosure of information related to errors.

III. Performance Improvement Model

UCH has adopted the IMPRV methodology, which is based on UCH's Culture of Excellence to improve performance.

A. The phases of IMPRV are:

1. Identify – Clearly identify the problem, develop a charter and a justification for Executive Sponsorship.
2. Measure - Thoroughly understand the current state, develop a data collection plan, create a comprehensive Value Stream Map and collect baseline data.
3. Process – Assess and analyze process data to identify root cause of waste or inefficiency.
4. Re-think – Create a more efficient process and develop a full scale implementation plan of improvement solutions.
5. Validate – Implement solutions, ensure accuracy and provide comprehensive training for improvement, sustainment and ownership.

B. IMPRV Tools – Multiple tools have been created to assist in this process (See Attachment A). The following is a sample of tools used in process improvement:

1. Charter
2. SIPOC (Suppliers, Inputs, Process, Outputs, Customer)
3. Process Mapping
4. PDCAC (Plan, Do, Check, Act, Communicate)

IV. Continuous Improvement Process

The process for identifying quality and safety continuous improvement initiatives involves the following:

A. Senior Leadership develops annual objectives and defines metrics to address and support improvement of Patient Quality and Safety, Service, Care for Mind, Body and Spirit and Finance and Growth. These objectives are identified through review of internal data, annual risk assessment, external benchmarks, sentinel event alerts and regulatory requirements. Priorities are assigned based on involvement with risk, volume, mission, patient satisfaction, clinical outcome, safety, efficiency, financial stability and growth.

Data is collected, systematically analyzed, using appropriate statistical technique by departments, committees, cross-functional teams and/or work groups to determine measureable outcomes and

goals. Actions are implemented to improve the performance of processes, obtain the desired outcome and enhance patient safety. Monthly and/or quarterly reports are submitted through the Safety and Quality Organizational Structure (See Attachment B).

V. Just Culture

Just Culture principles are the foundation of accountability. UMUCH fosters the Just Culture by applying these principles in response to adverse events or near misses. Applicable principles are defined as:

A. Human Error is an inadvertent slip or lapse. Human error is expected, so systems are designed to help people do the right thing and avoid doing the wrong thing. The response to human error is to provide support to the person who made the error. The investigation will focus on how the system can be altered to prevent the error from happening again.
B. At-Risk Behavior is to consciously choose an action without realizing the level of risk of an unintended outcome. The response is to counsel the person as to why the behavior is risky, investigate the reasons they chose this behavior, and enact system improvements if necessary.
C. Reckless Behavior or negligence is choosing an action with knowledge and conscious disregard of the risk of harm. The response will result in disciplinary action.

VI. Scope of the Patient Safety and Quality Plan

A. The Safety and Quality Plan integrates all Hospital and Medical Staff departments within UCH. Departmental indicators to support the organizational objectives and align their initiatives with the annual Operating Plan are described in Section IV above. The results are reported through the organizational structure referenced above.

The FY2018 Organizational Objectives are structured to support Patient Centered Care and are organized around the Safety, Quality, Empathy, and Efficiency domains.

1. Safety
    a. Hospital Acquired Infection (HAI) Bundle
    b. MHAC Achievement
2. Quality
    a. Sepsis
    b. COPD
    c. CCTA
    d. CHF
    e. CDU Pathways
    f. Transition of Care
3. Empathy
    a. Team member recruitment, engagement, and development
    b. Patient and family engagement
    c. Care coordination and teamwork
4. Efficiency
    a. Provider workflows
    b. Discharge process coordination
    c. Emergency Department

d. CDU implementation
e. Centralized transport model

Hospital and Medical Staff Ongoing Indicators are also monitored. Some are generic screening indicators and others are determined based on identified opportunities for improvement, the need to monitor new processes or in response to complaints, surveys or inspections performed by external accreditation, licensing, regulatory and reimbursement agencies.

B. Focused Root Cause Analysis and Process Improvement Strategy to Reduce the Risk of Medical/Health Care Errors (Proactive Risk Assessment)

1. Proactive identification and management of potential risks to patient safety have the obvious advantage of preventing adverse occurrences, rather than simply reacting when they occur. This approach also avoids the barriers to understanding created by hindsight bias and the fear of disclosure, embarrassment, blame, and punishment that can arise in the wake of an actual event. UCH Hospitals have a proactive program for identification and reduction of adverse events through the use of self-assessments, the Good Catch and Near Miss reporting system, research and dissemination of literature regarding published information on adverse events that seriously harm patients.

2. UCH Hospitals seek to reduce the risk of sentinel events and medical/health care system error-related occurrences by conducting internal proactive risk assessment activities and by using available information about sentinel events, claims data and the like from organizations that provide similar care and services. This effort is undertaken so that processes, functions and services can be designed or redesigned to prevent such occurrences in the organization.

3. Process Improvement Strategies
   A. Risk Reductions
      1. Risk assessments, reporting criteria, a non-punitive reporting culture, the Good Catch reporting system and Failure Mode Effects Analysis (FMEA) are all tools designed to proactively identify circumstances that present a risk of patient harm. Risk assessments and focused Root Cause Analyses are conducted on an ongoing basis recognizing high volume/low risk and, likewise, high risk/low volume activities. The Good Catch system, in the Notification System, is a tool developed to collect data regarding circumstances that could create an adverse outcome if left unimproved. The Root Cause Analysis (RCA) methodology of investigation is applied for such circumstances, particularly those where there is a risk of imminent patient, visitor or team member harm. The results of these risk assessment interventions are reviewed by the Patient Safety and Quality Council semi-annually.
      2. To further support proactive risk reduction the Patient Safety and Quality Council selects a high-risk process, based on the annual risk assessment to conduct a RCA or FMEA for intensive assessment and analysis at least annually. The selection of this process is guided by data received from sources referenced above, including sentinel event data and patient safety risk factors identified by the Joint Commission. The selected process is analyzed for undesirable process variation and for the associated potential for adverse patient impact. A RCA or FMEA is also conducted, as appropriate, to enable targeted process and/or system redesign necessary to achieving the desired reduction in patient risk. The Patient Safety and Quality Council oversees the implementation of the redesign efforts and assesses the effectiveness of the

modifications made. Periodic re-assessment is undertaken to validate that the effectiveness of the redesigned process is sustained over time.

B. Patient Safety and Quality

1. The Patient Safety and Quality Council completes a Culture of Safety organizational assessment biennial basis to measure the perceptions of patient safety throughout Upper Chesapeake. The results of these self-assessments are reported to the Patient Safety and Quality Council for oversight and recommended action. Medical staff issues identified are reported to the PIC and/or MEC for action.

2. The Sentinel Event Policy establishes a linkage between the Sentinel Event analysis and the Hospitals' performance improvement efforts through quarterly reporting by the Patient Safety Officer to the Patient Safety and Quality Council, Performance Improvement Committee and Quality of Care Committee. The report includes results and trends from identified Sentinel Events, salient investigatory findings from RCAs and resulting process changes. (See UCH Sentinel Event Policy.)

3. Participation in University of Maryland System and VHA collaboratives and Maryland Patient Safety Center initiatives that allows an exchange of ideas, best practices and benchmarking.

4. The Capacity and Efficiency Steering Committee works to maximize the efficient use of capacity to enhance the flow of patients through operational improvements.

VII. Delineation of Responsibility

A. Board of Directors

The Board of the Directors has the ultimate responsibility for ensuring the delivery of quality patient care. This authority is delegated to the Quality of Care Committee who provides oversight. The Patient Safety and Quality Council, Performance Improvement Committee, Hospital Leadership and Medical Staff oversee the development and implementation of the methods for monitoring the delivery of patient care. (See Attachment B)

B. Quality of Care Committee

This Committee of the Board of Directors was established to oversee the quality and safety activities by monitoring and evaluating the Patient Safety and Quality Plan of the Hospitals and reporting to the Board of Directors. This Committee is responsible for:

1. Meeting at least quarterly and reporting to the Board of Directors;
2. Serving as a forum for quality and safety issues;
3. Reviewing the activities of the quality and safety program through summary reports submitted through the Quality and Safety Committee structure (See Attachment I);
4. Establishing priorities and providing direction to the Medical Executive Committee and Hospital Leadership.

C. President/CEO

The Board of Directors delegates to the President/CEO of Upper Chesapeake Health the authority and accountability of the Quality and Safety Program. The President delegates the

responsibility for the development and implementation of the Quality and Safety Plan to the SVP/CMO and VP for Performance Improvement.

D. Patient Safety and Quality Council

This Patient Safety and Quality Council (PSQC) is a multi-disciplinary committee that provides oversight, coordination, and integration of all quality and patient safety activities throughout the Hospitals. This is accomplished through the receipt of summary reports of all monitoring activities. The Hospitals' Vice President of Performance Improvement chairs this Council. The Chief Operating Officer serves as a member and provides senior leadership to the Council. The Vice President for Patient Services, Directors of Quality Management, Performance Improvement and Health Information Management and Risk Management, as well as representation from the medical staff, clinical and non-clinical directors and staff members serve on the Council. Ad hoc members are also scheduled to attend based upon the reports to be presented. Representatives from the Council also serve on the Performance Improvement Committee and the Quality of Care Committee to enhance communication and a functional link between the Hospitals, Medical Staff and governing body. The Council duties include:

1. Meeting at least ten months per year;
2. Identifying processes to improve;
3. Setting goals for safety initiatives based on the organizational Patient Safety Risk Assessment and monitoring progress related to those goals;
4. Selecting FMEA's and RCA's as deemed necessary;
5. Reviewing measures of performance, both process and outcome for all patient care and organizational functions;
6. Providing oversight for analysis of reported events, trends, sentinel event alerts and making recommendations in order to ensure a safe patient environment;
7. Prioritizing opportunities for improvement in order of importance, considering those that affect a larger percentage of patients, place patients at risk, or are problem prone;
8. Appointing a work group or chartering a process action team to investigate and recommend process improvements within timeline established by the PSQC;
9. Providing oversight of departmental indicators for outcome compliance and reviewing corrective action plans for appropriateness;
10. Providing oversight of the Sentinel Event Core Team designated to undertake root cause analysis of sentinel events and is considered a medical review committee;
11. Providing direction and oversight for application of learning from The Joint Commission Sentinel Event Alerts and their impact on improvement for UCH Hospitals;
12. Reviewing resource utilization-clinical effectiveness as it relates to quality of care and make recommendations for action when necessary;
13. Referring medical staff issues to the PIC;
14. Reviewing issues referred from the PIC and making recommendation for action plan when necessary;
15. Reviewing issues referred from the Accreditation Compliance Council and making recommendations for action plan when necessary;
16. Reviewing the Patient Safety and Quality Plan annually.

E. Medical Executive Committee reviews and approves, through receipt of minutes and summary reports, as defined in the Medical Staff Bylaws, all recommendations and actions that pertain to the Medical Staff.

F. Performance Improvement Committee

The Medical Executive Committee delegates the oversight responsibility for performance improvement monitoring, assessment and evaluation of patient care services provided by the Medical Staff to the Performance Improvement Committee (PIC). Specific duties include:

1. Coordinating the medical staff quality and safety program to ensure that necessary processes and structures are in place to carry out performance improvement activities and that all services and disciplines collaborate to create a culture that is focused on performance improvement.

2. Establishing performance expectations for new, existing, and modified processes.

3. Reviewing the outcome of peer review activities and recommending action to the MEC. Reviewing the outcome of peer review activities, taking final action on collegial interventions and recommending any action with the potential for a reduction in clinical privileges to the MEC for final approval to the responsibilities of the Performance Improvement Committee.

4. Developing and monitoring performance indicators that measure performance compared to expectations.

5. Monitoring existing processes to evaluate the performance of a function or process.

6. Reviewing summaries and aggregate data to:

    a. Compare performance internally over time to similar processes in other organizations, and to other external sources of information.

    b. Conduct ongoing professional practice evaluation to identify trends that impact quality of care and patient safety, including:

        1. patterns of operative and other procedures performed and their outcome

        2. patterns of blood and pharmaceutical usage

        3. morbidity and mortality data identified through ongoing monitoring of ongoing indicators,

        4. other relevant criteria as determined by the medical staff,

        5. adverse events related to deep or moderate sedation

        6. major discrepancies or patterns of discrepancies between preoperative and postoperative diagnoses,

        7. significant adverse events associated with anesthesia.

G. Identifying and monitoring performance measures related to the following processes:

1. Medication use – The Pharmacy and Therapeutics Committee reviews the appropriateness, safety and effectiveness of the prophylactic, empiric and therapeutic use of drugs, adverse drug reactions and significant medication errors through the review and analysis of individual and aggregate patterns of variations of drug practice and reports their results to the MEC.

2. Operative and other procedures that place patients at risk – The PIC recommends approval of the procedures to be reviewed annually based on being high-volume, high-risk and problem prone. The review includes the evaluation of appropriateness of the procedure performed, whether tissue is removed or not, the acceptability of the procedure chosen, complications, and preoperative and postoperative discrepancies.

3. Use of blood and blood components – The Blood Utilization Review Committees of each hospital review procedures for distribution, handling, use and administration of whole blood and blood components, the adequacy of transfusion services, actual or suspected transfusion reactions and blood usage, including the amounts requested, used and wasted. The appropriateness of transfusions are routinely reported to the PIC for oversight. Other issues are reported to PIC when input or action by the medical staff is necessary.

4. Medical record review – The medical staff reviews a representative sample of records for accuracy, timeliness and legible completion while performing peer review. Action is taken on documentation issues by the appropriate department and reported to PIC through the quarterly peer review summary.

5. Care or services provided to high-risk populations

6. Clinical Effectiveness – The PIC reviews reports to evaluate the appropriateness of hospital admissions, length of stays, discharge practices, use of medical and hospital resources, and medical necessity for continued hospital services and makes recommendations for action when necessary.

7. Patient and team member complaints involving the medical staff when action by the Committee is necessary.

8. Patient satisfaction.

9. Significant departures from established patterns of clinical practice

10. the JC sentinel event alerts

11. Identifying opportunities for improvement and prioritizing issues for more focused review; making recommendations for further study through workgroups or Process Action Teams to the Medical Executive Committee.

12. Identifying changes that will lead to improved performance and reduced risk of sentinel events and making appropriate recommendations for action to the Medical Executive

Committee.

13. Reviewing summary reports of sentinel events and "near miss" cases; making recommendations for corrective actions that include measuring the effectiveness of process and system improvements in reducing risk.

14. Integrating Risk Management findings into the Committee's ongoing monitoring; making recommendations when necessary to assist in reducing risk and making changes that improve performance and patient safety.

15. Reviewing all QIO citations and/or quality issues received by the medical staff; making recommendations for corrective action.

16. Review and approval of the Patient Safety and Quality Plan.

17. Formulating a written Utilization Review Plan for the System, to be approved by the System Medical Executive Committee, the Senior Vice President, Medical Affairs/CMO and the Board of Directors.

18. Meetings, Reports and Recommendations:

    a. The PIC shall meet at least ten times per year and shall maintain a permanent record of its findings, proceedings and actions.

    b. The PIC shall make a written report after each meeting to the System Medical Executive Committee and the Senior Vice President, Medical Affairs/CMO.

    c. If the PIC detects a problem with clinical competency, patient care or treatment, infraction of the Medical Staff Bylaws, Credentialing Policy, Organization and Functions Manual, Allied Health Practitioner Policy, Medical Staff and Departmental Rules and Regulations, other policies, procedures or protocols of the System or Medical Staff, professional ethics or unacceptable conduct on the part of any individual appointed to the Medical Staff, it will notify the individual in writing and permit a written response and/or afford the individual an opportunity to meet with it prior to making a final report. The PIC will notify the individual in a timely way if he or she is complying with relevant recommendations or whether further problems have been detected.

    d. The PIC is responsible for documenting results in minutes, which may be submitted at any time, but no later than the conclusion of the review process.

H. The Accreditation Compliance Council is an administrative council established to monitor adherence to and compliance with all hospital accrediting bodies, specifically The Joint

Commission's National Patient Safety Goal and Hospital Accreditation Standards. The Council reports to the Patient Safety and Quality Council.

I. The Capacity and Efficiency Steering Committee is an administrative committee established to maximize the efficient use of capacity by enhancing the throughput and flow of patients. The Committee's objectives are to improve throughput, expand access to UCH services, enhance current policies and procedures..

J. Patient and Family Centered Care
UCH has a adopted a Patient and Family Centered Care model that is an approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients and families. This approach shapes policies, programs, facility design and staff day to day interactions.

K. Allied Health Practitioner Review Committee is responsible for monitoring performance indicators that measure performance compared to expectations of the Allied Health Practitioners.

L. Leadership
At UCH Hospitals, leaders include the governing board, senior leadership, hospital leadership, the elected officers and appointed members of the medical staff and department directors. They are responsible for identifying and reporting circumstances and processes that pose a potential quality or safety risk to patients and visitors or actual events which jeopardize the patient's well-being. They shall actively participate in the implementation of the Quality and Safety Plan and be responsible for systematically measuring and assessing performance, implementing actions to improve performance, reassessing for appropriate action and sustained improvement and allocating adequate resources for assessing and improving patient care and organizational functions and are responsible for communicating all safety and quality data, both positive and negative trends, to the team members. The leaders will ensure safe practices by holding all direct reports accountable, performing appropriate evaluations and taking action when necessary as defined in the UCH Standards of Conduct Policy.

M. Medical Staff Department Chairmen
The Medical Staff Department Chairmen are also responsible for the Professional Practice Evaluation of all members of the Medical Staff (See UCH Professional Practice Evaluation Policy).

N. Patient Safety Officer
The Performance Improvement Manager/Patient Safety Officer is responsible for the coordination, and operational oversight and implementation of the Patient Safety Program. This includes collaboration with the Risk Management Department for conducting proactive patient safety risk assessments, analysis and action plan development for identified patient risks and tracking and trending reporting occurrences, including Near Miss and Sentinel Events. The Patient Safety Officer will provide regular reports to the Quality of Care Committee, Performance Improvement Committee and Patient Safety and Quality and Council, as the committee for oversight for this plan. These reports shall include trends of Near Miss and actual errors/events. Sentinel Events and Good Catch process improvement interventions and monitors (Ref COMAR 10.07.06.03).

VIII. Terms and Tools Defined

A. Adverse Event / Incident - An unintended act or failure to act which leads to an unexpected outcome not related to the natural course of the patient's illness or underlying disease condition. This event is any occurrence that is not consistent with the normal operations of Upper Chesapeake Health or the anticipated disease/treatment process of a patient. (See UCH Incidents/Event Tracking System and The Reporting of Unusual Events Policies.)

- Level 1 adverse event - an adverse event that results in death or serious disability. (*A Sentinel Event* - See below) [Such events require a *Root Cause Analysis* and are reportable to DHMH]
- Level 2 adverse event - an adverse event that requires a medical intervention to prevent death or serious disability. (*A Sentinel Event* - See below) [Such events require a *Root Cause Analysis*]
- Level 3 adverse event - an adverse event that does not result in death or serious disability and does not require any medical intervention to prevent death or serious disability. [Such events require investigation and/or trending]
- Near-miss - a situation that could have resulted in an adverse event but did not, either by chance or through timely intervention. (Can be a Sentinel Event – see below) [Such events require investigation and/or trending.

B. Case Study - a methodology designed as a teaching tool developed to broaden our team members understanding of a process-review approach to error. Actual events and "Good Catch' scenarios are used. This too is intended to support a non-punitive culture of safety.

C. Complaint - any concern raised by a patient, family member or visitor, written or verbal, regarding the infringement of patient's rights. Any complaints of a clinical nature or alleging a clinical error or Near Miss are referred to Risk Management for investigation. Actionable items will be tracked as an "Event".

D. Notification Tracking System - A data base accessible by all team members and medical staff utilized as a data collection tool for reporting and trending Good Catches and Events pertaining to patient and visitor safety. Components include, but are not limited to, complaints, patient care events, non-clinical physician and team member conduct, the good catch and compliments.

E. Failure Mode Effects Analysis - A systematic methodology designed to identify and prevent process failures before they occur. This is often utilized to proactively review processes in an effort to predict and prevent injury caused by a system or process failure.

F. Good Catch - A set of circumstances that may lead to patient or visitor injury if the process is left unchanged. A Good Catch is identifying and reporting the existence of those hazardous conditions before the Adverse Event or Near Miss occurs.

G. IMPRV Tools – are tools that provide a standard system-wide approach to process improvement.

H. Medical Review Committees - Function as confidential peer review committee as defined in Health Occupations Article, §1-401 et seq., Annotated Code of Maryland. These committees include:

1. Patient Safety and Quality Council
2. Performance Improvement Committee
3. Infection Control Committee
4. Pharmacy and Therapeutics Committee
5. Department and Service Line Peer Review Committees
6. Multi-disciplinary Evaluation Committee
7. Sentinel Event Review Teams
8. Accreditation Compliance Council

I. Patient Safety - Ensuring freedom from accidental injury while receiving health care services.

J. Patient Safety Review – classification used when a root cause analysis is completed and reported for "near miss" events not meeting the definition of Sentinel Event.

K. Risk Assessment - A periodic review process, which is designed to assess the risks associated with the delivery of patient care in a specific setting or service. The assessment tool is a set of indicators/criteria by which an analysis of processes is evaluated and/or measured. The goal is to proactively identify process improvement opportunities to ensure the delivery of safe patient care.

L. Root Cause Analysis (RCA) - A process for identifying the root causes or causal factors that underlie variation in performance that can result in an Adverse or Sentinel Event. A root cause analysis is required for Level 1 and Level 2 sentinel events, as well as those "near miss" events that could have resulted in a sentinel event if not otherwise avoided.

M. Sentinel Event - An unexpected occurrence involving unanticipated death or serious physical or psychological injury, or the risk thereof. A Sentinel Event specifically includes unanticipated death or major loss of function not related to the natural course of the patient's illness or underlying condition; such events specifically include, but are not limited to, unexpected death of a full term infant; suicide of an inpatient; infant abduction or discharge to the wrong family; a patient rape; significant blood transfusion reactions; surgery on the wrong body part or patient. These Events are considered Level 1 Events that require immediate internal reporting, a root cause analysis and are reportable to DHMH (See UCH Sentinel Events Policy.)

IX. Reporting Mechanisms

To effectively reduce adverse patient outcomes, there must be an environment that supports identification and learning from errors and system failures. This program defines an integrated and easily accessible reporting mechanism for all team members and medical staff and a non-punitive culture that supports open communication, data dissemination and education.

A. Non-Punitive Reporting

The UCH Hospitals recognize that if we are to succeed in creating a safe environment for our patients and visitors, we must create an environment in which it is safe for caregivers to report and learn from Events and Near Misses. The Hospitals promote openness and requires that errors be reported, while ensuring that most reported errors be handled without the threat of punitive action.

1. The Hospitals recognize that most clinical incidents are due to a failure of systems. The goal is to identify and track errors in order to continuously improve those systems and to provide necessary education to prevent reoccurrence. Reporting of errors identified as being due to a failure of process or systems will not be subject to disciplinary action in accordance with hospital policy.

2. All events, particularly those of a clinical nature, need to be reported immediately. If a team member reports the Event within 48 hours, there will be no disciplinary action taken for that Event. It is expected, by the implementation of the 48-hour policy that more complete disclosure will occur. This will not, however, negate the initiation of additional education and training for team members, if warranted.
3. This policy will not protect team members who consistently fail to participate in detection, reporting and remediation to prevent errors. Nor will it protect team members from disciplinary action where it is determined that the error may have been the result of criminal activity, criminal intent or an egregious act and/or omission on the part of the team member. A team member who knowingly fails to report a clinical error will be subject to disciplinary action in accordance with existing hospital policy.

B. Notification Tracking System

The Notification System has been developed as a data collection tool for the reporting of Events, Near Misses, Complaints and the Good Catch as each relates to the identification and prevention of patient and visitor harm. The PI Department provides trending, analysis and dissemination of the data, concerning circumstances that are not consistent with the normal operations of the health system or the anticipated disease/treatment process of the patient in order to prevent reoccurrence, improve quality care and ensure patient and visitor safety. Electronic event reporting through the Meditech application and an Notification Hotline (ext. 1133) is accessible to all team members and medical staff. (See UCH Event Tracking System and The Reporting of Unusual Events Policies.)

C. Sentinel Events

When a Sentinel Event occurs, appropriate individuals are notified and an immediate investigation is undertaken. The Sentinel Event Policy defines the reporting structure and oversight responsibilities for the Sentinel Event Team, a medical review committee. Initially Sentinel Events are reported directly to Risk Management, and the Department Director and or the Vice President of the involved service areas and/or Vice President for Performance Improvement. Guidelines for the analysis of the Event exist to determine why the incident occurred and how to reduce the likelihood of reoccurrence. Within fifteen days of the occurrence or knowledge thereof, a Sentinel Event Team will convene to begin the root cause analysis and the development of a risk reduction strategy and action plan. The Departments of Risk Management, Performance Improvement and the Patient Safety Committee provide oversight for this process. (Reference - Administrative Policy Manual - Sentinel Events)

D. Patient Complaint/Grievance

All Complaints are entered and tracked through the Event Tracking Notification System and trended and referred, as appropriate, for departmental action. Complaints are correlated with patient satisfaction surveys pertinent to inpatient, outpatient, and emergency services. Those Complaints involving clinical issues are referred to the Risk Management Department for investigation according to the mechanisms in place for Event/Error investigation. Should a complaint meet the criteria of a grievance, as defined by policy, a written response defining the investigation and action taken is shared with the patient/family. (Reference - Administrative Policy Manual - Patient/Guest Complaints, Grievances and Compliments)

E. Inter-hospital Notification of Level 1 or Level 2 Adverse Event

1. If a UCH hospital admits a patient with a condition resulting from an adverse event that Risk Management determines may be related to care that was provided at another Maryland hospital and that appears to be unknown to the other hospital at the time of discharge, RM shall notify and provide any necessary information to the appropriate medical review committee at the hospital where the adverse event allegedly occurred.
2. If a UCH hospital receives notification from another facility of an occurrence of an adverse event that resulted from an admission at a UCH hospital, it will be reported immediately to Risk Management and an investigation will commence at the direction of the Patient Safety and Quality Council (a confidential medical review committee.) In accordance with this Plan, as appropriate, a root cause analysis will be conducted, notice provided to DHMH Office of Healthcare Quality, and disclosure to the patient/family will occur by the Risk Management Department.
3. All communication that occurs in accordance with this provision is confidential under Health Occupations Article, §1-401, Annotated Code of Maryland.

F. Reports to Maryland Department of Health and Mental Hygiene, Office of Healthcare Quality

1. Risk Management shall report any Level 1 adverse event to the DHMH within 5 days of the Risk Management's determination and or knowledge that the event occurred.
2. Risk Management shall submit the Root Cause Analysis and Action Plan for the Level 1 adverse event to the Department within 60 days of the hospital's knowledge of the occurrence.
3. Any Root Cause Analysis and any other medical review committee information submitted to the Department and the identity of individuals appointed to the interdisciplinary root cause analysis team are confidential under Health Occupations Article, §1-401, Annotated Code of Maryland and may not be discoverable, disclosed, or admissible as evidence in any civil action or available under the Maryland Public Information Act.

G. Support for Patient, Family, Caregiver

The delivery of patient services at Upper Chesapeake Health occurs through organized and systematic processes designed to ensure the delivery of safe, effective, and timely care and treatment. Delivery of patient care encompasses the recognition of concepts underlying both health and disease, patient teaching and learning processes, patient advocacy, spirituality and a holistic approach to the processes of care delivery. Upper Chesapeake Health, the Medical Staff, Professional Nursing and other allied health care professionals comprise a multidisciplinary team which functions collaboratively to achieve positive patient outcomes. In all instances patients, and when appropriate, family members are involved in the patient's plan of care. This involvement is intended to include sharing of information, which includes unexpected or adverse outcomes including errors or incidents that have an impact on the outcome and/or are deemed a Sentinel Event.

Support services are available to patients' families, Medical Staff, and caregivers alike in managing and dealing with adverse outcomes. When an adverse event occurs with significant consequences for the patient or family, appropriate support from within the hospital is mobilized and coordinated by Risk Management to assist the patient, family, and the caregiver(s). Support may include access to such resources as Pastoral Care, Social Services, Guest Services, Risk Management, and Palliative Care. At all times the caregivers involved

are included in the investigation and process improvement efforts following an Event, Near Miss or Sentinel Event.

H. Medical Disclosure

When a Sentinel Event or outcome differs significantly from the anticipated plan of care the patient and, when appropriate, families are informed. This occurs as soon as reasonably possible. The attending physician who is responsible for the overall care of the patient should, in most instances, participate in disclosures, along with Risk Management. This disclosure of adverse outcomes resulting from medical error should be incorporated in the ongoing conversation regarding the patient's care and treatment, which begins at the time of admission, between the hospital personnel, medical staff, patient and family (See UCH Medical Disclosure Policy).

IX. Communication and Education to Enhance Patient Safety and Reduce the Risk of Medical/Health Care Errors

A. Communication with Patient & Family/Significant Other

1. Patient's rights and responsibilities are explained upon admission via the Patient Handbook and Plan of Care folders. This communication includes methods to report concerns and insights about safe patient care. (Reference – Administrative Policy Manual - Patient's Rights and Responsibilities)
2. Patient and family education regarding safe and effective use of medication and medical equipment is accomplished through direct team member education of patient and families in accordance with their job descriptions and within their scope of practice or through the video on demand system (Reference – Administrative Policy Manual - Patient and Family Education; Pharmacy Policy Manual - Monographs; Nursing Policy Manual – Drug-Nutrient Interaction Counseling - Caring for You). Documentation of this education process is done through computerized progress notes, educational records/forms and patient pathways.
3. Education about potential drug-food interaction and counseling on nutrition and modified diet is accomplished through Pharmacy Monograph, nursing handouts, special diets and referral to appropriate team members. (Reference – Administrative Policy Manual - Patient and Family Education)
4. Educational rights and responsibilities as an integral component of the overall plan of care are defined in the Administrative Policy Manual - Patient's Rights and Responsibilities. Patients and families are encouraged to participate to the best of their ability in decision-making regarding their care, to ask questions, to provide information concerning educational needs and to communicate understanding/or lack thereof, during educational activities.

B. Performance Improvement and IMPRV Training for UCH Team Members:

1. All new team members receive patient safety and quality training during orientation. Leaders, Department Directors, managers and supervisors receive PI awareness training through department leader meetings and presentations.

2. The IMPROV training approach is provided through:
    a. Executive workshops (3 hours) to provide Senior Leadership with an overview of IMPROV methodology and ensure strategic alignment
    b. Awareness Training (4 hours) is provided 3-4 times per year for team members and provides a high level of understanding of IMPRV methodology and toolkit.
    c. Practitioner Training (40 Hours) 2-3 times per year to provide a comprehensive and hands-on training of IMPROV techniques and tools.

C. Internal Communication/Education and On-Going Training

The program fosters communication and coordination among individuals and departments. To coordinate and integrate patient care and to improve quality and patient safety, UCH supports a culture that emphasizes cooperation and communication. An open communication system facilitates an interdisciplinary approach to providing patient care. The following are methods of communication among services and individual team members as they relate to the dissemination of information and education for the purposes of improving patient safety. This dissemination is done so with the utmost care to protect the confidentiality of personal health information. Any required disclosures are done so in accordance with this same protection.

1. Monthly Departmental/Unit Event Tracking Reporting. The intent is for department managers/supervisors to share adverse Events and Near Miss data with team members to assist in identifying trends and improve processes to ensure patient safety on a department/unit specific level.
2. Performance improvement results are communicated by articles in hospital and physician newsletters; chartered process action team reports and presentations; team leader discussions in department meetings, recognition and award programs recognizing individual and team participation in performance improvement; the Patient Safety Intranet site; and Quality Council report to the PIC and the Quality of Care Committee.
3. The Patient Safety Officer reports on adverse event trends and Sentinel Events and their associated process improvements to the Quality Council and Performance Improvement Committee of the Medical Staff, which information in turn is communicated to the Quality of Care Committee.
4. Department reports are reviewed quarterly through the PI Report Card and presented to the Patient Safety and Quality Council, PIC and Quality of Care Committee. Assessments, recommendations and feedback are reported to the department.
5. Data collected internally or externally regarding lessons learned or best practices are shared departmentally by way of case studies. These case studies are designed to improve the process improvement analysis skills which, in turn, are to be applied to departmental process evaluation. These results are shared with team members and improve communication with and education of patients.
6. Patient Safety Walkabouts are conducted at each Hospital by the PI Patient Safety Coordinator and Leadership to promote an atmosphere of mutual trust in which all team members can talk freely about safety problems and how to solve them, without fear of blame or punishment.

X. Quality and Safety Program Resources

The Quality Management, Performance Improvement and Risk Management Departments support and facilitate organizational quality and safety activities. Resources are provided to assist

Hospital departments, team members and medical staff with identification of appropriate data resources, retrieval of data development, coordination of the activities and analysis of data to support and evaluate all improvement efforts.

XI. Confidentiality

All information related to the performance improvement activities performed by the medical staff in accordance with this plan is confidential and protected. Due to the sensitive nature of all data, reports and minutes generated under medical review, confidentiality will be protected by all Hospital team members regardless of the level of their participation. All reference to patients, team members and physicians will be made to protect patient/physician identity.

XII. Conflict of Interest

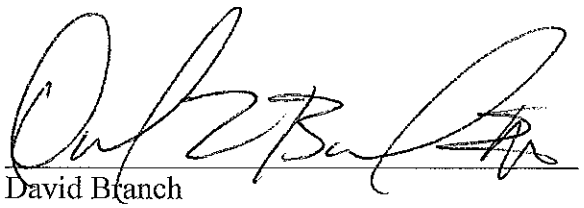
No healthcare provider or other individual involved in quality and performance improvement activities shall be allowed to make peer review decisions in any case in which he/she is professionally involved.

XIII. Annual Review of Plan Effectiveness

The Patient Safety and Program will be reviewed annually through the established structure to assure that the structure and function of the program are achieving major goals and objectives as defined in the mission of the Hospitals.

References:

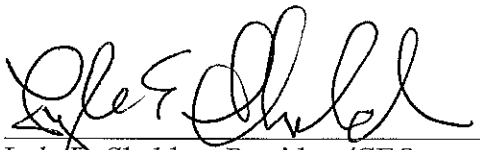
- TJC Accreditation Manual for Hospitals
- CMS Conditions of Participation
- Code of Ethical Conduct
- Risk Management Plan
- Sentinel Event Policy
- Patient & Family Education Policy
- Patient's Rights and Responsibility Policy
- COMAR 10.07.06 – Hospital Patient Safety Program (2004)
- Event Tracking System and the Reporting of Unusual Events Policy
- Disclosing Medical Adverse Outcomes, Including Sentinel Events
- Performance Improvement Plan
- Hospital Plan for Patient Care and Services
- Patient Complaints and/or Allegation of Violations of Patient Rights Policy



7/6/17

David Branch
VP of Performance Improvement
Chairperson, Quality and Safety Committee

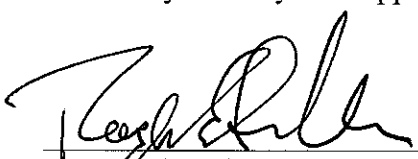
Date



7.6.17

Lyle E. Sheldon, President/CEO
University of Maryland Upper Chesapeake Health

Date



7/6/17

Roger Schneider, Chairman of the Board
University of Maryland Upper Chesapeake Health

Date

ADDENDUM

UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH

BULLE ROCK CAMPUS

PATIENT SAFETY AND QUALITY PLAN

I. Statement of Purpose

Upper Chesapeake Behavioral Health Bulle Rock is committed to the provision of compassionate, high quality, clinically effective healthcare in a safe environment coupled with trust, integrity, and respect for all. The Upper Chesapeake Health system supports an integrated, systematic quality, safety and continuous improvement program to improve patient outcomes, improve efficiency and effectiveness and reduce risk. Behavioral Health serves adults 18 and older with mental health diagnoses and includes patients with a secondary diagnosis of substance abuse and geriatric patients (including those geriatric patients with a secondary substance use diagnosis).

Overall Patient Safety and Quality Plan Objectives for Behavioral Health

A. In mental health care, quality is a measure of whether services increase the likelihood of desired mental health outcomes and are consistent with current evidence-based practice. This definition incorporates two components. For people with mental disorders, their families and the population as a whole, it emphasizes that services should produce positive outcomes. For practitioners, service planners and policy makers, it emphasizes the best use of current knowledge and technology.

Improved quality means that mental health services should:

1. preserve the dignity of people with mental disorders;
2. provide accepted and relevant clinical and non-clinical care aimed at reducing the impact of the disorder and improving the quality of life of people with mental disorders;
3. use interventions which help people with mental disorders to cope by themselves with their mental health disabilities;
4. make more efficient and effective use of scarce mental health resources;
5. ensure that quality of care is improved in all areas, including mental health promotion, prevention, treatment and rehabilitation in primary health care, outpatient and inpatient

B. To maintain an environment that supports safety
C. To provide a framework for defining quality and continuous improvement opportunities, setting priorities for the scope, measuring and assessing performance, evaluating results and implementing improvement actions
D. To include patients and their families in a multidisciplinary collaborative care approach
E. To ensure that resources are used efficiently
F. To continue to integrate behavioral health into primary care practices
G. To provide a framework for defining quality and continuous improvement opportunities, setting priorities for the scope, measuring and assessing performance, evaluating results and implementing improvement actions
H. To facilitate communication and reporting of all performance improvement and patient safety activities to leadership, team members, and medical staff
I. To promote team work and group responsibility in identifying and implementing opportunities for improvement
J. To achieve the appropriate balance between good outcomes, excellent care, services and costs

II. Scope of the Patient Safety and Quality Plan

A. The Safety and Quality Plan supports the organizational objectives structured to support Patient-Centered Care organized around Safety, Quality, Empathy, and Efficiency domains.

The following pertain to Behavioral Health:

1. **Safety**
    a. Reduction of Restraints and Seclusion
    b. Use of Assessment tools to screen for violence, depression, anxiety, trauma and dementia
    c. Provide safe environment for geriatric patients and those patients with dementia
2. **Quality**
    a. Bedside Shift report
    b. Multidisciplinary rounds
    c. Plan of Care
    d. Discharge planning
    e. Reducing readmissions
    f. Group curriculum for geriatric patients/adult patients

g. Integrated care in primary care practices
h. Patient Satisfaction

3. **Empathy**
   a. Team member recruitment, engagement and educational development
   b. Patient and Family engagement
   c. Care coordination and teamwork

4. **Efficiency**
   a. Consultation services and discharge process coordination
   b. Turnaround times in Emergency Department for consults

PERFORMANCE IMPROVEMENT PLAN

The primary objective of the Performance Improvement (PI) Plan is to establish and articulate the measures of success that align with FY17 Departmental Objectives and UM UCH Strategic Operating Plan. Department Leaders will partner with their respective PI Consultant to navigate the PI Plan Process and ensure that chosen indicators support organization-wide priorities. The scope of the performance indicators will incorporate quality, patient safety/experience, and operational efficiency. The PI Plan Process consists of three phases which focus on identifying, monitoring, and reporting on the "critical few" indicators that measure not just performance, but organizational SUCCESS.

Planning

The goal of the Planning Phase is to develop a comprehensive PI Plan that focuses on the critical few success factors. This phase requires that department leaders gather input from their team and work with their PI Consultant in order to define and measure departmental priorities from a PI perspective.

Activities:

- ✓ Defining the strategic priorities that measure success in the department.
- ✓ Reviewing indicators from the previous year to determine the need to continue, revise, or discontinue the measure.
- ✓ Identifying indicators that will measure success from a quality, safety, or efficiency perspective.
- ✓ Establishing goals based on the analysis of baseline data (previous year), external benchmark data, or previous internal performance results.
- ✓ Developing a performance threshold. The threshold represents the minimum point of achievement based upon the current performance baseline and goal.
- ✓ Reviewing plan with appropriate Vice President for completion and approval.

Monitoring

The goal of the Monitoring Phase is to record and analyze data for the metrics stated in the PI Plan and work on improvement opportunities identified. If a measure does not meet the target, the department leader will partner with the PI Consultant to create a quarterly Performance Improvement Action Plan with the corrective actions to be taken.

Activities:

- ✓ Complying with data collection, frequency, and source of measurement.
- ✓ Analyzing the data and identifying improvement opportunities.
- ✓ Entering quarterly Measures of Success data into PI Quarterly Indicator Report on the SharePoint Performance Improvement Site under Monitoring.
- ✓ When necessary, completing a PI Action Plan for measures not meeting the goal.

Reporting and Improving

The Reporting and Improving Phase of the PI Plan process provides the results of the Monitoring Phase to departments and leadership at least on a quarterly basis. Department leaders will report an action plan for measures not meeting the target to the appropriate committee and share success stories.

- Quality and safety indicators are reported to the Patient Safety and Quality Council (PSQC).
- Efficiency indicators are reported to the Capacity and Efficiency Steering Committee.
- Patient Experience indicators are reported to the Patient Experience Steering Committee.

All committees report to the Quality of Care Committee of the Board of Directors.

Activities:

- ✓ Department meetings.
- ✓ Completing PI Action Plan for measures not meeting goal.
- ✓ Engagement between department leader and PI Consultant to utilize the IMPRV toolkit where applicable and support the department in executing the PI Action Plan.
- ✓ Presenting PI Action Plans and success stories at relevant committee meetings (when appropriate).

DEFINITION OF SUCCESS

Please identify the department's Key Priorities for the fiscal year.

1) Increase Patient Experience Scores by providing the Behavioral Health Patient a Person -Centered Model of Care.
2) Assure Behavioral Health Patient Safety by striving for complete and accurate seclusion and restraint documentation monitored in real time.

MEASURES OF SUCCESS

The Measures of Success include performance goals for each indicator, as well as relevant information regarding the metric and how it is measured.

- ✓ Benchmark/Baseline: Reference point established based on the analysis of previous internal performance results (e.g., last fiscal year) or external benchmarks, if available.
- ✓ Performance Goal: Target that we want to achieve for the indicator.
- ✓ Performance Threshold: Minimum point of achievement for the indicator based upon the current performance baseline and goal.

Measure 1	
Name of Measure/Indicator	Patient Experience
Method of Collection (How will data be measured?)	Press Ganey survey
Data Source (e.g., Meditech)	Press Ganey
Frequency of Measurement	Quarterly
Benchmark/Baseline	
Performance Goal	Meet 50% on overall average score
Performance Threshold	Meet 35% on overall average score
Responsible for Monitoring	Claire Kidwell RN, Nurse Manager

Measure 2	
Name of Measure/Indicator	Patient Safety- complete and accurate seclusion and restraint documentation
Method of Collection (How will data be measured?)	Real time monitoring
Data Source (e.g., Meditech)	Medical record and Meditech
Frequency of Measurement	As needed
Benchmark/Baseline	85%
Performance Goal	90%
Performance Threshold	85%
Responsible for Monitoring	Claire Kidwell RN, Nurse Manager

Measure 3	
Name of Measure/Indicator	
Method of Collection (How will data be measured?)	
Data Source (e.g., Meditech)	
Frequency of Measurement	
Benchmark/Baseline	
Performance Goal	
Performance Threshold	
Responsible for Monitoring	

EXHIBIT 10

Letter Type: Special Psychiatric Hospital

1) Harford County Mental Health Addictions Advisory Council
2) Union Hospital of Cecil County
3) Harford County Office on Mental Health
4) Addiction Connection Resources
5) Cecil County Core Service Agency
6) Keypoint Health Services, Inc.
7) Upper Bay Counseling
8) West Cecil Health/Beacon Health
9) Sheppard Pratt, Harford County Crisis System
10) National Alliance on Mental Illness

MENTAL HEALTH ADDICTIONS ADVISORY COUNCIL

Mr. Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Certificate of Need to Construct a Special Psychiatric Hospital

Dear Mr. Parker:

On behalf of the Harford County Mental Health & Addictions Advisory Council (HCMHAAC), I write to express full support for the Certificate of Need application to be filed by UM Upper Chesapeake Health System proposing to construct a special psychiatric hospital in Havre de Grace, Maryland.

UM Upper Chesapeake Health System & HCMHAAC work closely together to collaborate a coordinated care continuum for the community. As part of our responsibilities as a Council, we advocate for the comprehensive approach to prevention & treatment of mental illnesses & addictions. Our council works, in collaboration with many of those who provide care, to determine the needs of such programming to allow our citizen's access to the comprehensive care. UM Upper Chesapeake Health System is the only hospital to provide community care within our County & a valuable partner of HCMHAAC by participating in our council meetings, providing feedback as we strategically plan for a robust system of care specifically for the increasing number of county resident's requiring care for mental illness, addictions, and those with a co-occurring diagnosis. As a Council, we feel there is a dire need to expand access to provider's, facilities, and such as to meet the needs of our community.

Behavioral health, specifically mental health and substance use, access, prevention and treatment, have been top priorities in Harford/Cecil County's community health needs assessment. UM Upper Chesapeake Health System's proposed forty-bed specialty psychiatric hospital will improve access to behavioral health care for the residents of northeast Maryland by offering a continuum of care in one centralized, convenient location.

Mr. Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Certificate of Need to Construct a Special Psychiatric Hospital

In particular, the facility will provide a much needed treatment resource for a co-occurring mental health and substance use issues. In addition, UM Upper Chesapeake Health System's proposed geriatric psychiatry program will allow treatment of an aging population closer to home. Currently, many geriatric patients in UM Upper Chesapeake Health's service area that require inpatient behavioral health services are transferred many miles from their community. The proposed outpatient behavioral health services, including partial hospitalization, intensive outpatient, individualized counseling sessions, coupled with collaborative relationships with other mental health and substance use providers, will afford accessible treatment, recovery, and support.

The Harford County Mental Health & Addictions Advisory Council strongly supports UM Upper Chesapeake Health System's proposed specialty psychiatric hospital and urges the Maryland Health Care Commission to approve the Certificate of Need Application.

Please feel free to contact me if you require any additional information.

Sincerely,

Mary L Bunch

Mary E. Bunch, President
Harford County Mental Health
& Addictions Advisory Council

UNION HOSPITAL

Mr. Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Certificate of Need to Construct a Special Psychiatric Hospital

Dear Mr. Parker:

On behalf Union Hospital and its Board of Directors, I write to express our full support for the Certificate of Need application to be filed by UM Upper Chesapeake Health System proposing to construct a special psychiatric hospital in Havre de Grace, Maryland.

As you know, Union Hospital of Cecil County and UM Upper Chesapeake Health System have collaborated on this project, envisioning a regional, two-county approach to delivering exceptional care for those in need of Behavioral Health services. Our two organizations thought it better to consolidate the inpatient behavioral health beds at the current Harford Memorial Hospital and at Union hospital of Cecil County into the proposed special psychiatric hospital in Havre de Grace, Maryland. In this way, our organizations would be able to attract high quality physicians, nurses, and support staff in the future and provide more comprehensive behavioral health services to our communities.

Behavioral health access and substance abuse prevention have been top priorities in Harford and Cecil Counties' community health needs assessments. UM Upper Chesapeake Health System's proposed forty-bed specialty psychiatric hospital will improve access to behavioral health care for the residents of northeast Maryland by offering a continuum of care in one centralized, convenient location.

In particular, the facility will provide a much-needed resource for a growing population suffering from co-occurring mental health and substance abuse issues. Further, UM Upper Chesapeake Health System's proposed geriatric psychiatry program will allow treatment of an aging population closer to home. Currently, many geriatric patients in UM Upper Chesapeake Health's service area that require inpatient behavioral health services are transferred many miles from their community. The proposed outpatient behavioral health services, including partial hospitalization, intensive outpatient, individualized counseling sessions, coupled with collaborative relationships with other mental health and substance use providers, will afford accessible treatment, recovery, and support.

Union Hospital of Cecil County and its Board of Directors strongly support UM Upper Chesapeake Health System's proposed specialty psychiatric hospital and urges the Maryland Health Care Commission to approve the Certificate of Need Application.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information.

Regards,

Richard C. Szumel, MD
President and CEO
Union Hospital of Cecil County
410-392-7009
rszumel@uhcc.com

Office on Mental Health
Core Service Agency of Harford County, Inc

125 N. Main Street,
Rear Entrance
Bel Air, Maryland 21014

410.803.8726 Phone
410.803.8732 Fax
www.harfordmentalhealth.org

July 11, 2017

Mr. Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Certificate of Need to Construct a Special Psychiatric Hospital

Dear Mr. Parker:

On behalf of the Office on Mental Health/Core Service Agency of Harford County, Inc. (OMH/CSA), I write to express full support for the Certificate of Need application to be filed by UM Upper Chesapeake Health System proposing to construct a special psychiatric hospital in Havre de Grace, Maryland.

The OMH/CSA and UM Upper Chesapeake Health continually work together on matters related to behavioral health. Staff from our agency and the hospital regularly meet to discuss hospital diversion strategies for individuals who may not meet the needs for emergency department interventions. In addition, this group works with local mental health providers to ensure high cost utilizers are connected to community providers in an effort to increase stability of the individual and increase independence within the community. Most recently hospital staff have participated in trainings facilitated by our agency's staff to work with individuals who need assistance in applying for Social Security benefits. This training allows the case manager to "bypass" the lengthy wait one normally has when applying for these benefits.

Behavioral health, specifically mental health and substance use, access, prevention and treatment, have been top priorities in Harford/Cecil County's community health needs assessment. UM Upper Chesapeake Health System's proposed forty-bed specialty psychiatric hospital will improve access to behavioral health care for the residents of northeast Maryland by offering a continuum of care in one centralized, convenient location.

In particular, the facility will provide a much needed treatment resource for a co-occurring mental health and substance use issues. In addition, UM Upper Chesapeake

Health System's proposed geriatric psychiatry program will allow treatment of an aging population closer to home. Currently, many geriatric patients in UM Upper Chesapeake Health's service area who require inpatient behavioral health services are transferred many miles from their community. The proposed outpatient behavioral health services, including partial hospitalization, intensive outpatient, individualized counseling sessions, coupled with collaborative relationships with other mental health and substance use providers, will afford accessible treatment, recovery, and support.

The Office on Mental Health/Core Service Agency of Harford County, Inc. strongly supports UM Upper Chesapeake Health System's proposed specialty psychiatric hospital and urges the Maryland Health Care Commission to approve the Certificate of Need Application.

Please feel free to contact me if you require any additional information.

Sincerely,

Jessica Kraus
Executive Director

ADDICTION CONNECTIONS RESOURCE, INC.

1804 Harford Road
Fallston, Maryland 21084
PHONE: 443-417-6405
E-MAIL: gwlw13@msn.com

Mr. Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Certificate of Need to Construct a Special Psychiatric Hospital

Dear Mr. Parker:

On behalf of Addiction Connections Resource, Inc. (ACR), I write to express full support for the Certificate of Need application to be filed by UM Upper Chesapeake Health System proposing to construct a special psychiatric hospital in Havre de Grace, Maryland.

ACR is a 501 c 3 nonprofit agency that provides treatment referrals and placements, family support services, and training opportunities-- all of which focus on prevention, treatment, and recovery of substance use disorder. For several years, ACR has enjoyed a positive working relationship with UM Upper Chesapeake Health, collaborating on emergency department referrals, public education and awareness activities, and shared implementation of county, state, and federal health care policies. ACR maintains steady communication with UM Upper Chesapeake Health: ACR's board president serves on the hospital's board of directors. As a member of Governor Hogan's Emergency Opioid and Heroin Task Force, I know more about the shortage of resources for mental health and substance abuse than most and I fully support the UM Upper Chesapeake's concept of a behavioral health unit.

Behavioral health, specifically mental health and substance use, access, prevention and treatment, have been top priorities in Harford/Cecil County's community health needs assessment. UM Upper Chesapeake Health System's proposed forty-bed specialty psychiatric hospital will improve access to behavioral health care for the residents of northeast Maryland by offering a continuum of care in one centralized, convenient location.

In particular, the facility will provide a much needed treatment resource for a co-occurring mental health and substance use issues. In addition, UM Upper Chesapeake Health System's proposed geriatric psychiatry program will allow treatment of an aging population closer to home. Currently, many geriatric patients in UM Upper Chesapeake Health's service area that require inpatient behavioral health services are transferred many miles from their community. The proposed outpatient behavioral health services, including partial hospitalization, intensive outpatient, individualized counseling sessions, coupled with collaborative relationships with other mental health and substance use providers, will afford accessible treatment, recovery, and support.

Addiction Connection Resource strongly supports UM Upper Chesapeake Health System's proposed specialty psychiatric hospital and urges the Maryland Health Care Commission to approve the Certificate of Need Application.

Please feel free to contact me if you require any additional information.

Linda Williams

Sincerely,

CECIL COUNTY
HEALTH
DEPARTMENT

JOHN M. BYERS HEALTH CENTER • 401 BOW STREET • ELKTON, MD 21921

STEPHANIE GARRITY M.S., HEALTH OFFICER
WWW.CECILCOUNTYHEALTH.ORG

July 25, 2017

Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Certificate of Need to Construct a Special Psychiatric Hospital

Dear Mr. Parker:

On behalf of the Cecil County Core Service Agency (CCCSA), I write to express our full support for the Certificate of Need application to be filed by UM Upper Chesapeake Health System proposing to construct a special psychiatric hospital in Havre de Grace, Maryland.

The CCCSA and Union Hospital of Cecil County maintain a collaborative relationship in address the behavioral health needs in Ceil County. Union Hospital of Cecil County has developed a leadership role in behavioral health planning and with the county Health Improvement Plan. Union Hospital is consistently represented in local meetings and is a member of the Cecil County CSA Advisory Council. The relationship is defined by mutual respect and we welcome expansion in services to continue to address the needs of Cecil County behavioral health consumers.

The Behavioral health access and substance abuse prevention have been top priorities in Cecil County's community health needs assessment. UM Upper Chesapeake Health System's proposed forty-bed specialty psychiatric hospital will improve access to behavioral health care for the residents of northeast Maryland by offering a continuum of care in one centralized, convenient location.

In particular, the facility will provide a much needed resource for a growing population suffering from co-occurring mental health and substance abuse issues. Further, UM Upper Chesapeake Health System's proposed geriatric psychiatry program will allow treatment of an aging population. Currently, many geriatric patients in UM Upper Chesapeake Health's service area that require inpatient behavioral health services are transferred many miles from their community. The proposed outpatient behavioral health services, including partial hospitalization, intensive outpatient, individualized counseling sessions, coupled with

collaborative relationships with other mental health and substance use providers, will afford accessible treatment, recovery, and support.

The CCCSA strongly supports UM Upper Chesapeake Health System's proposed specialty psychiatric hospital and urges the Maryland Health Care Commission to approve the Certificate of Need Application.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information.

Sincerely,

Shelly Gulledge

Shelly Gulledge, CSA Director
Cecil County Health Department

Key Point
HEALTH SERVICES, INC.
OUTPATIENT MENTAL HEALTH PROGRAMS
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

ADMINISTRATION
135 N. Parke Street
Aberdeen, MD 21001
443-625-1590

KARL D. WEBER, PhD
Chief Executive Officer

Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

July 18, 2017

Re: Key Point Health Services, Inc. letter in Support of UM Upper Chesapeake Health System, Inc.'s Certificate of Need to Construct a Special Psychiatric Hospital

Dear Mr. Parker:

On behalf of Key Point Health Services, I write to express Key Points full support for the Certificate of Need application to be filed by UM Upper Chesapeake Health System proposing to construct a special psychiatric hospital in Havre de Grace, Maryland.

Key Point is a large private non-profit mental health care provider in Maryland and has outpatient clinics and adjunct mental health services in Harford and Cecil Counties. UM Upper Chesapeake Health System has been a valuable partner in assisting Key Point with a continuum of physical and mental health care and the addition of a new psychiatric facility will greatly improve care in Harford and Cecil County.

Behavioral health access and substance abuse prevention have been top priorities in [Harford/Cecil] County's community health needs assessment [for Harford/Cecil] County.] UM Upper Chesapeake Health System's proposed forty-bed specialty psychiatric hospital will improve access to behavioral health care for the residents of northeast Maryland by offering a continuum of care in one centralized, convenient location.

In particular, the facility will provide a much needed resource for a growing population suffering from co-occurring mental health and substance abuse issues. Further, UM Upper Chesapeake Health System's proposed geriatric psychiatry program will allow treatment of an aging population closer to home. Currently, many geriatric patients in UM Upper Chesapeake Health's service area that require inpatient behavioral health services are transferred many miles from their community. The proposed outpatient behavioral health services, including partial hospitalization, intensive outpatient, individualized counseling sessions, coupled with collaborative relationships with other mental health and substance use providers, will afford accessible treatment, recovery, and support.

Key Point strongly supports UM Upper Chesapeake Health System's proposed specialty psychiatric hospital and urges the Maryland Health Care Commission to approve the Certificate of Need Application.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information.

Respectfully,

Karl Weber

Karl Weber, PhD
CEO

Upper Bay Counseling & Support Services, Inc.

Suanne Blumberg, LCPC
Chief Executive Officer

Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Certificate of Need to Construct a Special Psychiatric Hospital

Dear Mr. Parker:

On behalf of Upper Bay Counseling & Support Services, I am writing to express Upper Bay Counseling & Support Services' full support for the Certificate of Need application to be filed by UM Upper Chesapeake Health System proposing to construct a special psychiatric hospital in Havre de Grace, Maryland.

Upper Bay Counseling & Support Services and UM Upper Chesapeake Health Systems have a long history of working closely together to provide the best care for the residents in both Harford and Cecil Counties. Through our on-going collaborative work we have been able to improve access to both medical and behavioral health services. Together we work to reduce barriers and provide services in the least restrictive environment. We work closely with the emergency department staff, inpatient staff, and primary care staff to ensure those who need behavioral health services are assessed and offered appropriate treatment quickly.

Behavioral health access and substance use disorder treatment have been top priorities in both Harford and Cecil County's community health needs assessment. UM Upper Chesapeake Health System's proposed forty-bed specialty psychiatric hospital will improve access to behavioral health care for the residents of northeast Maryland by offering a continuum of care in one centralized, convenient location.

In particular, the facility will provide a much needed resource for a growing population suffering from co-occurring mental health and substance abuse issues. Further, UM Upper Chesapeake Health System's proposed geriatric psychiatry program will allow treatment of an aging population closer to home. Currently, many geriatric patients in UM Upper Chesapeake Health's service area that require inpatient behavioral health services are transferred many miles from their community. Recent research has shown that opioid misuse is a growing problem with the geriatric population and that specialized services are in demand. The proposed outpatient behavioral health services, including partial hospitalization, intensive outpatient, individualized counseling sessions, focus on special population needs, coupled with collaborative relationships with other mental health and substance use providers, will afford accessible treatment, recovery, and support.

Upper Bay Counseling & Support Services strongly supports UM Upper Chesapeake Health System's proposed specialty psychiatric hospital and urges the Maryland Health Care Commission to approve the Certificate of Need Application.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information.

Sincerely,

Suanne Blumberg

Suanne Blumberg, LCPC
Chief Executive Officer

WEST CECIL
HEALTH CENTER

Community Health Care
Within Reach

www.westcecilhealth.org

49 Rock Springs Road
P.O. Box 99
Conowingo, MD 21918

410.378.9696 *tel*
877.378.9696 *toll free*
410.378.0787 *fax*

Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Certificate of Need to Construct a Special Psychiatric Hospital

Dear Mr. Parker:

On behalf West Cecil Health Center, I write to express West Cecil Health Center's full support for the Certificate of Need application to be filed by UM Upper Chesapeake Health System proposing to construct a special psychiatric hospital in Havre de Grace, Maryland.

West Cecil Health Center has had a significant collaborative relationship with UM Upper Chesapeake Health. UM Upper Chesapeake Health provided support for the inception of West Cecil Health Center's first satellite site in Havre de Grace. The organizations also maintain a strong referral relationship. Because West Cecil Health Center is an FQHC, the organization is able to offer sliding fee discounts to non-insured and under-insured patients; UM Upper Chesapeake Health agrees to honor our mutual patients with financial assistance. Noninsured patients who present to the Emergency Department without a Primary Care Provider are referred to West Cecil Health Center for affordable healthcare services. UM Upper Chesapeake Health and West Cecil Health Center's relationship has allowed both organizations to become integral parts of providing healthcare in our rural communities.

Behavioral health access and substance abuse prevention have been top priorities in Cecil County's community health needs assessment Cecil County. UM Upper Chesapeake Health System's proposed forty-bed specialty psychiatric hospital will improve access to behavioral health care for the residents of northeast Maryland by offering a continuum of care in one centralized, convenient location.

In particular, the facility will provide a much needed resource for a growing population suffering from co-occurring mental health and substance abuse issues. Further, UM Upper Chesapeake Health System's proposed geriatric psychiatry program will allow treatment of an aging population closer to home. Currently, many geriatric patients in UM Upper Chesapeake Health's

service area that require inpatient behavioral health services are transferred many miles from their community. The proposed outpatient behavioral health services, including partial hospitalization, intensive outpatient, individualized counseling sessions, coupled with collaborative relationships with other mental health and substance use providers, will afford accessible treatment, recovery, and support.

West Cecil Health Center strongly supports UM Upper Chesapeake Health System's proposed specialty psychiatric hospital and urges the Maryland Health Care Commission to approve the Certificate of Need Application.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information through email at jness@westcecilhealth.org or by phone at 443-731-2971.

Sincerely,

John Ness, Interim CEO

Harford County
MOBILE CRISIS TEAM

Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Certificate of Need to Construct a Special Psychiatric Hospital

Dear Mr. Parker:

On behalf of the Sheppard Pratt Harford County Mobile Crisis Team (Mobile Crisis Team), I write to express our full support for the Certificate of Need application to be filed by UM Upper Chesapeake Health System proposing to construct a special psychiatric hospital in Havre de Grace, Maryland.

The Mobile Crisis Team works closely with the UM Upper Chesapeake Health System in a number of ways. Our team works closely with the entire Behavioral Health Department. The emergency department behavioral health evaluators helps to defer patients from unnecessary inpatient treatment, especially after hours by working together with the mobile crisis team for bridge appointments until connection to outpatient care is arranged. We work with patients who are frequent users of emergency services to attempt to decrease the unnecessary use. Mobile Crisis also offers assistance to current UM UCHS Outpatient Behavioral Health services clients as an urgent contact when the outpatient department is closed. Inpatient clients, when discharged, receive information on the Mobile Crisis Team as a resource if necessary and at times are provided bridge appointments with Mobile Crisis for a solid discharge plan. Primary care and specialty offices, such as OB/GYN and the Cancer Center refer their patients in need of behavioral health services as well, when the UM UCHS Behavioral Health services are closed or otherwise unable to accommodate the patient.

Behavioral health access and substance abuse prevention have been top priorities in Harford County's community health needs assessment. UM Upper Chesapeake Health System's proposed forty-bed specialty psychiatric hospital will improve access to behavioral health care for the residents of northeast Maryland by offering a continuum of care in one centralized, convenient location.

In particular, the facility will provide a much needed resource for a growing population suffering from co-occurring mental health and substance abuse issues. Further, UM Upper Chesapeake Health System's proposed geriatric psychiatry

Harford County
MOBILE CRISIS TEAM

program will allow treatment of an aging population closer to home. Currently, many geriatric patients in UM Upper Chesapeake Health's service area that require inpatient behavioral health services are transferred many miles from their community. The proposed outpatient behavioral health services, including partial hospitalization, intensive outpatient, individualized counseling sessions, coupled with collaborative relationships with other mental health and substance use providers, will afford accessible treatment, recovery, and support.

The Mobile Crisis Team strongly supports UM Upper Chesapeake Health System's proposed specialty psychiatric hospital and urges the Maryland Health Care Commission to approve the Certificate of Need Application.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information.

Sincerely,

Susan Lichtfuss, LGPC
Program Manager
Harford County Mobile Crisis Team
104 N. Main Street, Suite 201
Bel, Air, MD 21014
A Program of the Sheppard Pratt Health System

NAMI Maryland
National Alliance on Mental Illness

10630 Little Patuxent Parkway, Suite 475
Columbia, MD 21044
Phone: 410.884.8691 Fax: 410.884.8695
Email: info@namimd.org Web: www.namimd.org

July 8, 2017

Mr. Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Certificate of Need to Construct a Special Psychiatric Hospital

Dear Mr. Parker:

On behalf of NAMI Maryland, I write to express full support for the Certificate of Need application to be filed by UM Upper Chesapeake Health System proposing to construct a special psychiatric hospital in Havre de Grace, Maryland.

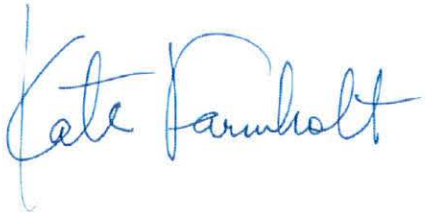
NAMI Maryland provides free peer education and support to families and individuals affected by mental health conditions and co-occurring substance use, as well as community and provider education and advocacy to improve systems and increase access to effective treatment. NAMI Maryland works directly and through local volunteers in Harford and Cecil Counties, and across the state of Maryland. We are pleased to continue our collaboration with Upper Chesapeake Health and look forward to working with their staff, families, patients and the community.

Our stakeholders, especially those in Harford and Cecil Counties, would greatly benefit from this proposed treatment facility. Behavioral health, specifically mental health and substance use, access, prevention and treatment, have been top priorities in Harford/Cecil County's community health needs assessment. UM Upper Chesapeake Health System's proposed forty-bed specialty psychiatric hospital will improve access to behavioral health care for the residents of northeast Maryland by offering a continuum of care in one centralized, convenient location.

In particular, the facility will provide a much needed treatment resource for a co-occurring mental health and substance use issues. In addition, UM Upper Chesapeake Health System's proposed geriatric psychiatry program will allow treatment of an aging population closer to home. Currently, many geriatric patients in UM Upper Chesapeake Health's service area that require inpatient behavioral health services are transferred many miles from their community. The proposed outpatient behavioral health services, including partial hospitalization, intensive outpatient, individualized counseling sessions, coupled with collaborative relationships with other mental health and substance use providers, will afford accessible treatment, recovery, and support.

NAMI Maryland strongly supports UM Upper Chesapeake Health System's proposed specialty psychiatric hospital and urges the Maryland Health Care Commission to approve the Certificate of Need Application. Please feel free to contact me if you require any additional information.

Sincerely,



Kathryn S. Farinholt, Executive Director

Letter Type: General

1) Senator J.B. Jennings
2) Delegate Susan McComas
3) Delegate Teresa Reilly (mailed letter directly to Paul Parker on 7/19/ 17)
4) Harford County Executive Barry Glassman
    a. Harford County Economic Development Board (covered under CE Glassman's letter)
5) Harford County Council President Richard Slutzky
6) Bel Air Mayor Susan Burdette
7) Cecil County Executive Dr. Alan McCarthy
8) Harford County Chamber of Commerce
9) Harford County Health Department
10) UM Upper Chesapeake Health Medical Staff Leadership

J. B. Jennings
Legislative District 7
Baltimore and Harford Counties

Minority Leader

Finance Committee

Executive Nominations

Legislative Policy Committee

The Senate of Maryland
Annapolis, Maryland 21401

❑ *Annapolis Office*
James Senate Office Building
11 Bladen Street, Room 423
Annapolis, Maryland 21401
410-841-3706 · 301-858-3706
800-492-7122 *Ext.* 3706
Fax 410-841-3750 · 301-858-3750
JB.Jennings@senate.state.md.us

❑ *District Office*
141 N. Main Street, Suite K
Bel Air, Maryland 21014
443-371-2772

August 1, 2017

Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Proposed Modernization and Transfiguration of Clinical Services

Dear Mr. Parker:

I write to express my full support for UM Upper Chesapeake Health System's plan to undertake capital expenditures to develop an optimal integrated care delivery system for the future health care needs of the 360,000 residents of Harford and Cecil Counties in which patients will receive quality care, in the appropriate setting, at lower costs.

Most residents of Harford and western Cecil Counties are currently served by UM Upper Chesapeake Health System's two hospital locations; UM Upper Chesapeake Medical Center in Bel Air and Harford Memorial Hospital in Havre de Grace. Harford Memorial Hospital was constructed in phases between 1943 and 1972. Unfortunately, the aging physical plant has now outlived its useful life, but further renovation of the facility is neither cost-effective nor practical. UM Upper Chesapeake Health System's plan for the transformation of Harford Memorial Hospital is the culmination of more than five years of strategic planning in consultation with local and state officials, medical staff leadership, community health care providers, community stakeholders, and industry leading consultants.

Included in UM Upper Chesapeake Health System's transformative plan is the development of a multi-services medical campus in Havre de Grace at the Bulle Rock property owned by UM Upper Chesapeake Health System, only three miles from Harford Memorial Hospital and conveniently located off of Interstate 95. The Bulle Rock campus is planned to house a state-of-the-art forty-bed psychiatric hospital offering specialized inpatient and outpatient psychiatric services in one central location. Also planned for the Bulle Rock campus is a fully functional emergency department that will be open 24 hours a day, 7 days a week, and capable of handling the volume and the severity of most emergency cases currently handled by Harford Memorial Hospital. A

helipad and dedicated, onsite ambulance will ensure rapid transport for those patients requiring transfer to a higher level of care. Finally, a new medical office building on the Bulle Rock campus will provide enhanced access to regionalized specialty physician services and expanded wellness and prevention services. The development of the Bulle Rock campus will continue to provide access to needed health care services in the community formerly served by Harford Memorial Hospital.

UM Upper Chesapeake Health System also plans to consolidate general inpatient hospital services at UM Upper Chesapeake Medical Center by constructing a three level addition. This centralization of inpatient hospital services will allow UM Upper Chesapeake Health System to achieve economies of scale and provide more efficient, cost effective inpatient care in a modern environment.

Once implemented, UM Upper Chesapeake Health System's regional delivery system model will ensure access to care and achieve goals of federal and state regulators to promote population health, improve patient outcomes, and reduce costs. As an added benefit, the modernization and renovation proposals are projected to generate up to 975 annual construction jobs and have a $435 million positive economic impact for Harford County during the construction period. Upon completion of the new facilities, most of Harford Memorial Hospital's existing team members will be transitioned to either the Bulle Rock or Bel Air campuses, while those not transferred will receive retraining and placement services or retirement packages. The net annual economic impact of UM Upper Chesapeake Health System's strategic plan is projected to generate $13.1 million in additional wages and contribute a $39.5 million economic benefit to Harford County.

I strongly support UM Upper Chesapeake Health System's transformative plans for the Bulle Rock and Bel Air campuses and urge that each of the integrated projects be approved.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information.

Sincerely,

J.B. Jenn

Senator J.B. Jennings

SUSAN K. MCCOMAS
Legislative District 34B
Harford County

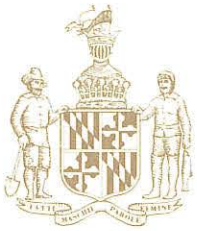
DEPUTY MINORITY WHIP

Judiciary Committee
Family Law Subcommittee
Juvenile Law Subcommittee

Rules and Executive
Nominations Committee

Joint Committees
Administrative, Executive,
and Legislative Review
Legislative Ethics

President
Women Legislators of Maryland



The Maryland House of Delegates
ANNAPOLIS, MARYLAND 21401

Annapolis Office
The Maryland House of Delegates
6 Bladen Street, Room 319
Annapolis, Maryland 21401
410-841-3272 · 301-858-3272
800-492-7122 *Ext.* 3272
Fax 410-841-3202 · 301-858-3202
Susan.McComas@house.state.md.us

District Office
P. O. Box 1204
9 West Courtland Street
Suite 100
Bel Air, Maryland 21014
410-836-9449 · 410-838-5187
Fax 410-838-5768

July 29, 2017

Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Proposed Modernization and Transfiguration of Clinical Services

Dear Mr. Parker:

As a representative of Legislative District 34B in the Maryland General Assembly, I write to express my full support for UM Upper Chesapeake Health System's plan to undertake capital expenditures to develop an optimal integrated care delivery system for the future health care needs of the 360,000 residents of Harford and Cecil Counties in which patients will receive quality care, in the appropriate setting, at lower costs.

Most residents of Harford and western Cecil Counties are currently served by UM Upper Chesapeake Health System's two hospital locations; UM Upper Chesapeake Medical Center in Bel Air and Harford Memorial Hospital in Havre de Grace. Harford Memorial Hospital was constructed in phases between 1943 and 1972. Unfortunately, the aging physical plant has now outlived its useful life, but further renovation of the facility is neither cost-effective nor practical. UM Upper Chesapeake Health System's plan for the transformation of Harford Memorial Hospital is the culmination of more than five years of strategic planning in consultation with local and state officials, medical staff leadership, community health care providers, community stakeholders, and industry leading consultants.

Included in UM Upper Chesapeake Health System's transformative plan is the development of a multi-services medical campus in Havre de Grace at the Bulle Rock property owned by UM Upper Chesapeake Health System, only three miles from Harford Memorial Hospital and conveniently located off of Interstate 95. The Bulle Rock campus is planned to house a state-of-the-art forty-bed psychiatric hospital offering specialized inpatient and outpatient psychiatric services in one central location. Also planned for the Bulle Rock campus is a fully functional emergency department that will be open 24 hours a day, 7 days a week, and capable of handling the volume and the severity of most emergency cases currently handled by Harford Memorial Hospital. A helipad and dedicated, onsite ambulance will ensure rapid transport for those patients requiring transfer to a higher level of care. Finally, a new medical office building on the Bulle Rock campus will provide enhanced access to regionalized specialty physician services and expanded wellness and prevention services. The development of the Bulle Rock campus will continue to provide access to needed health care services in the community formerly served by Harford Memorial Hospital.

UM Upper Chesapeake Health System also plans to consolidate general inpatient hospital services at UM Upper Chesapeake Medical Center by constructing a three level addition. This centralization of inpatient hospital services will allow UM Upper Chesapeake Health System to achieve economies of scale and provide more efficient, cost effective inpatient care in a modern environment.

Once implemented, UM Upper Chesapeake Health System's regional delivery system model will ensure access to care and achieve goals of federal and state regulators to promote population health, improve patient outcomes, and reduce costs. As an added benefit, the modernization and renovation proposals are projected to generate up to 975 annual construction jobs and have a $435 million positive economic impact for Harford County during the construction period. Upon completion of the new facilities, most of Harford Memorial Hospital's existing team members will be transitioned to either the Bulle Rock or Bel Air campuses, while those not transferred will receive retraining and placement services or retirement packages. The net annual economic impact of UM Upper Chesapeake Health System's strategic plan is projected to generate $13.1 million in additional wages and contribute a $39.5 million economic benefit to Harford County.

I strongly support UM Upper Chesapeake Health System's transformative plans for the Bulle Rock and Bel Air campuses and urge that each of the integrated projects be approved.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information.

Sincerely yours,

Susan K. McComas
Legislative District 34 B

July 18, 2017

Mr. Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Proposed Modernization and Transfiguration of Clinical Services

Dear Mr. Parker:

I am writing to express full support for UM Upper Chesapeake Health System's plan to undertake capital expenditures to develop an optimal integrated care delivery system for the future health care needs of the 360,000 residents of Harford and Cecil Counties in which patients will receive quality care, in the appropriate setting, at lower costs.

Most residents of Harford and western Cecil Counties are currently served by UM Upper Chesapeake Health System's two hospital locations: UM Upper Chesapeake Medical Center in Bel Air and Harford Memorial Hospital in Havre de Grace. Harford Memorial Hospital was constructed in phases between 1943 and 1972. Unfortunately, the aging physical plant has now outlived its useful life, but further renovation of the facility is neither cost-effective nor practical. UM Upper Chesapeake Health System's plan for the transformation of Harford Memorial Hospital is the culmination of more than five years of strategic planning in consultation with local and state officials, medical staff leadership, community health care providers, community stakeholders, and industry leading consultants.

Included in UM Upper Chesapeake Health System's transformative plan is the development of a multi-services medical campus in Havre de Grace at the Bulle Rock property owned by UM Upper Chesapeake Health System, only three miles from Harford Memorial Hospital and conveniently located off of Interstate 95. The Bulle Rock campus is planned to house a state-of-the-art forty-bed psychiatric hospital offering specialized inpatient and outpatient psychiatric services in one central location. Also planned for the Bulle Rock campus is a fully functional emergency department that will be open 24 hours a day, 7 days a week, and capable of handling the volume

and the severity of most emergency cases currently handled by Harford Memorial Hospital. A helipad and dedicated, onsite ambulance will ensure rapid transport for those patients requiring transfer to a higher level of care. Finally, a new medical office building on the Bulle Rock campus will provide enhanced access to regionalized specialty physician services and expanded wellness and prevention services. The development of the Bulle Rock campus will continue to provide access to needed health care services in the community formerly served by Harford Memorial Hospital.

UM Upper Chesapeake Health System also plans to consolidate general inpatient hospital services at UM Upper Chesapeake Medical Center by constructing a three level addition. This centralization of inpatient hospital services will allow UM Upper Chesapeake Health System to achieve economies of scale and provide more efficient, cost effective inpatient care in a modern environment.

Once implemented, UM Upper Chesapeake Health System's regional delivery system model will ensure access to care and achieve goals of federal and state regulators to promote population health, improve patient outcomes, and reduce costs. As an added benefit, the modernization and renovation proposals are projected to generate up to 975 annual construction jobs and have a $435 million positive economic impact for Harford County during the construction period. Upon completion of the new facilities, most of Harford Memorial Hospital's existing team members will be transitioned to either the Bulle Rock or Bel Air campuses, while those not transferred will receive retraining and placement services or retirement packages. The net annual economic impact of UM Upper Chesapeake Health System's strategic plan is projected to generate $13.1 million in additional wages and contribute a $39.5 million economic benefit to Harford County.

I strongly support UM Upper Chesapeake Health System's transformative plans for the Bulle Rock and Bel Air campuses and urge that each of the integrated projects be approved.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information.

Sincerely,

Delegate

BARRY GLASSMAN
HARFORD COUNTY EXECUTIVE

BILLY BONIFACE
DIRECTOR OF ADMINISTRATION

July 10, 2017

Mr. Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Proposed Modernization and Transfiguration of Clinical Services

Dear Mr. Parker:

On behalf of UM Upper Chesapeake Health System, I write to express Harford County's full support for UM Upper Chesapeake Health System's plan to undertake capital expenditures to develop an optimal integrated care delivery system for the future health care needs of the approximately 260,000 residents of Harford County in which patients will receive quality care, in the appropriate setting, at lower costs.

Most residents of Harford County are currently served by UM Upper Chesapeake Health System's two hospital locations; UM Upper Chesapeake Medical Center in Bel Air and Harford Memorial Hospital in Havre de Grace. Harford Memorial Hospital was constructed in phases between 1943 and 1972. Unfortunately, the aging physical plant has now outlived its useful life, but further renovation of the facility is neither cost-effective nor practical. UM Upper Chesapeake Health System's plan for the transformation of Harford Memorial Hospital is the culmination of more than five years of strategic planning in consultation with local and state officials, medical staff leadership, community health care providers, community stakeholders, and industry leading consultants.

Included in UM Upper Chesapeake Health System's transformative plan is the development of a multi-services medical campus in Havre de Grace at the Bulle Rock property owned by UM Upper Chesapeake Health System, only three miles from Harford Memorial Hospital and conveniently located off of Interstate 95. The Bulle Rock campus is planned to house a state-of-the-art forty-bed psychiatric hospital offering specialized inpatient and outpatient psychiatric services in one central location. Also planned for the Bulle Rock campus is a fully functional emergency department that will be open 24 hours a day, 7 days a week, and capable of handling the volume and the severity of most emergency cases currently handled by Harford Memorial Hospital. A helipad and dedicated, onsite ambulance will ensure rapid transport for those patients requiring transfer to a higher level of care. Finally, a new medical office building on the

Bulle Rock campus will provide enhanced access to regionalized specialty physician services and expanded wellness and prevention services. The development of the Bulle Rock campus will continue to provide access to needed health care services in the community formerly served by Harford Memorial Hospital.

UM Upper Chesapeake Health System also plans to consolidate general inpatient hospital services at UM Upper Chesapeake Medical Center by constructing a three level addition. This centralization of inpatient hospital services will allow UM Upper Chesapeake Health System to achieve economies of scale and provide more efficient, cost effective inpatient care in a modern environment.

Once implemented, UM Upper Chesapeake Health System's regional delivery system model will ensure access to care and achieve goals of federal and state regulators to promote population health, improve patient outcomes, and reduce costs. As an added benefit, the modernization and renovation proposals are projected to generate up to 975 annual construction jobs and have a $435 million positive economic impact for Harford County during the construction period. Upon completion of the new facilities, most of Harford Memorial Hospital's existing team members will be transitioned to either the Bulle Rock or Bel Air campuses, while those not transferred will receive retraining and placement services or retirement packages. The net annual economic impact of UM Upper Chesapeake Health System's strategic plan is projected to generate $13.1 million in additional wages and contribute a $39.5 million economic benefit to Harford County.

I strongly support UM Upper Chesapeake Health System's transformative plans for the Bulle Rock and Bel Air campuses and urge that each of the integrated projects be approved.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information.

With every good wish, I remain

Very truly yours,

Barry Glassman
Harford County Executive

CC: William K Boniface, Director of Administration
Bradley Killian, Director, Planning and Zoning
Paul Lawder, Director, Inspections, Licensing and Permits
Karen Holt, Director, Economic Development

BG/tmw

COUNTY COUNCIL OF HARFORD COUNTY, MARYLAND

RICHARD C. SLUTZKY
President

MIKE PERRONE, JR.
District A

JOSEPH M. WOODS
District B

JAMES V. "CAPT'N JIM" McMAHAN
District C

CHAD R. SHRODES
District D

PATRICK S. VINCENTI
District E

CURTIS L. BEULAH
District F

July 6, 2017

Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Proposed Modernization and Transfiguration of Clinical Services

Dear Mr. Parker:

On behalf of the County Council of Harford County Maryland, I write to express the County Council of Harford County Maryland's full support for UM Upper Chesapeake Health System's plan to undertake capital expenditures to develop an optimal integrated care delivery system for the future health care needs of the 360,000 residents of Harford and Cecil Counties in which patients will receive quality care, in the appropriate setting, at lower costs.

Most residents of Harford and western Cecil Counties are currently served by UM Upper Chesapeake Health System's two hospital locations; UM Upper Chesapeake Medical Center in Bel Air and Harford Memorial Hospital in Havre de Grace. Harford Memorial Hospital was constructed in phases between 1943 and 1972. Unfortunately, the aging physical plant has now outlived its useful life, but further renovation of the facility is neither cost-effective nor practical. UM Upper Chesapeake Health System's plan for the transformation of Harford Memorial Hospital is the culmination of more than five years of strategic planning in consultation with local and state officials, medical staff leadership, community health care providers, community stakeholders, and industry leading consultants.

Included in UM Upper Chesapeake Health System's transformative plan is the development of a multi-services medical campus in Havre de Grace at the Bulle Rock property owned by UM Upper Chesapeake Health System, only three miles from Harford Memorial Hospital and conveniently located off of Interstate 95. The Bulle Rock campus is planned to house a state-of-the-art forty-bed psychiatric hospital offering specialized inpatient and outpatient psychiatric services in one central location. Also planned for the Bulle Rock campus is a fully functional emergency department that will be open 24 hours a day, 7 days a week, and capable of handling the volume

and the severity of most emergency cases currently handled by Harford Memorial Hospital. A helipad and dedicated, onsite ambulance will ensure rapid transport for those patients requiring transfer to a higher level of care. Finally, a new medical office building on the Bulle Rock campus will provide enhanced access to regionalized specialty physician services and expanded wellness and prevention services. The development of the Bulle Rock campus will continue to provide access to needed health care services in the community formerly served by Harford Memorial Hospital.

UM Upper Chesapeake Health System also plans to consolidate general inpatient hospital services at UM Upper Chesapeake Medical Center by constructing a three-level addition. This centralization of inpatient hospital services will allow UM Upper Chesapeake Health System to achieve economies of scale and provide more efficient, cost effective inpatient care in a modern environment.

Once implemented, UM Upper Chesapeake Health System's regional delivery system model will ensure access to care and achieve goals of federal and state regulators to promote population health, improve patient outcomes, and reduce costs. As an added benefit, the modernization and renovation proposals are projected to generate up to 975 annual construction jobs and have a $435 million positive economic impact for Harford County during the construction period. Upon completion of the new facilities, most of Harford Memorial Hospital's existing team members will be transitioned to either the Bulle Rock or Bel Air campuses, while those not transferred will receive retraining and placement services or retirement packages. The net annual economic impact of UM Upper Chesapeake Health System's strategic plan is projected to generate $13.1 million in additional wages and contribute a $39.5 million economic benefit to Harford County.

The County Council of Harford County, Maryland, strongly supports UM Upper Chesapeake Health System's transformative plans for the Bulle Rock and Bel Air campuses and urge that each of the integrated projects be approved.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information.

Sincerely,

Richard C. Slutzky
Council President

RCS:sms

TOWN OF BEL AIR
MARYLAND

39 N. Hickory Avenue • Bel Air, MD 21014

Administration 410-638-4550
410-879-2711
Administration Fax 410-879-9225
www.belairmd.org

BOARD OF COMMISSIONERS
Susan U. Burdette
Philip L. Einhorn
Brendan P. Hopkins
Robert M. Preston
Patrick T. Richards

TOWN ADMINISTRATOR
L. Jesse Bane

July 11, 2017

Mr. Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Proposed Modernization and Transfiguration of Clinical Services

Dear Mr. Parker:

On behalf of the Town of Bel Air, I write to express the Town of Bel Air's full support for UM Upper Chesapeake Health System's plan to undertake capital expenditures to develop an optimal integrated care delivery system for the future health care needs of the 360,000 residents of Harford and Cecil Counties in which patients will receive quality care, in the appropriate setting, at lower costs.

Most residents of Harford and western Cecil Counties are currently served by UM Upper Chesapeake Health System's two hospital locations; UM Upper Chesapeake Medical Center in Bel Air and Harford Memorial Hospital in Havre de Grace. Harford Memorial Hospital was constructed in phases between 1943 and 1972. Unfortunately, the aging physical plant has now outlived its useful life, but further renovation of the facility is neither cost-effective nor practical. UM Upper Chesapeake Health System's plan for the transformation of Harford Memorial Hospital is the culmination of more than five years of strategic planning in consultation with local and state officials, medical staff leadership, community health care providers, community stakeholders, and industry leading consultants.

Included in UM Upper Chesapeake Health System's transformative plan is the development of a multi-services medical campus in Havre de Grace at the Bulle Rock property owned by UM Upper Chesapeake Health System, only three miles from Harford Memorial Hospital and conveniently located off of Interstate 95. The Bulle Rock campus is planned to house a state-of-the-art forty-bed psychiatric hospital offering specialized inpatient and outpatient psychiatric

services in one central location. Also planned for the Bulle Rock campus is a fully functional emergency department that will be open 24 hours a day, 7 days a week, and capable of handling the volume and the severity of most emergency cases currently handled by Harford Memorial Hospital. A helipad and dedicated, onsite ambulance will ensure rapid transport for those patients requiring transfer to a higher level of care. Finally, a new medical office building on the Bulle Rock campus will provide enhanced access to regionalized specialty physician services and expanded wellness and prevention services. The development of the Bulle Rock campus will continue to provide access to needed health care services in the community formerly served by Harford Memorial Hospital.

UM Upper Chesapeake Health System also plans to consolidate general inpatient hospital services at UM Upper Chesapeake Medical Center by constructing a three level addition. This centralization of inpatient hospital services will allow UM Upper Chesapeake Health System to achieve economies of scale and provide more efficient, cost effective inpatient care in a modern environment.

Once implemented, UM Upper Chesapeake Health System's regional delivery system model will ensure access to care and achieve goals of federal and state regulators to promote population health, improve patient outcomes, and reduce costs. As an added benefit, the modernization and renovation proposals are projected to generate up to 975 annual construction jobs and have a $435 million positive economic impact for Harford County during the construction period. Upon completion of the new facilities, most of Harford Memorial Hospital's existing team members will be transitioned to either the Bulle Rock or Bel Air campuses, while those not transferred will receive retraining and placement services or retirement packages. The net annual economic impact of UM Upper Chesapeake Health System's strategic plan is projected to generate $13.1 million in additional wages and contribute a $39.5 million economic benefit to Harford County.

I strongly support UM Upper Chesapeake Health System's transformative plans for the Bulle Rock and Bel Air campuses and urge that each of the integrated projects be approved.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information.

Sincerely,

Susan U. Burdette

Susan U. Burdette, Commissioner (Chair)

Alan J. McCarthy
County Executive

Alfred C. Wein, Jr.
Director of Administration

Office: 410.996.5202
Fax: 800-863-0947

County Information
410.996.5200
410.658.4041

CECIL COUNTY, MARYLAND
Office of the County Executive
200 Chesapeake Boulevard, Suite 2100, Elkton, MD 21921

Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Proposed Modernization and Transfiguration of Clinical Services

Dear Mr. Parker:

On behalf of Cecil County Government, I write to express my full support for UM Upper Chesapeake Health System's plan to undertake capital expenditures to develop an optimal integrated care delivery system for the future health care needs of the 360,000 residents of Harford and Cecil Counties in which patients will receive quality care, in the appropriate setting, at lower costs.

Most residents of Harford and western Cecil Counties are currently served by UM Upper Chesapeake Health System's two hospital locations; UM Upper Chesapeake Medical Center in Bel Air and Harford Memorial Hospital in Havre de Grace. Harford Memorial Hospital was constructed in phases between 1943 and 1972. Unfortunately, the aging physical plant has now outlived its useful life, but further renovation of the facility is neither cost-effective nor practical. UM Upper Chesapeake Health System's plan for the transformation of Harford Memorial Hospital is the culmination of more than five years of strategic planning in consultation with local and state officials, medical staff leadership, community health care providers, community stakeholders, and industry leading consultants.

Included in UM Upper Chesapeake Health System's transformative plan is the development of a multi-services medical campus in Havre de Grace at the Bulle Rock property owned by UM Upper Chesapeake Health System, only three miles from Harford Memorial Hospital and conveniently located off of Interstate 95. The Bulle Rock campus is planned to house a state-of-the-art forty-bed psychiatric hospital offering specialized inpatient and outpatient psychiatric services in one central location. Also planned for the Bulle Rock campus is a fully functional emergency department that will be open 24 hours a day, 7 days a week, and capable of handling the volume and the severity of most emergency cases currently handled by Harford Memorial Hospital. A helipad and dedicated, onsite ambulance will ensure rapid transport for those patients requiring transfer to a higher level of care. Finally, a new medical office building on the Bulle Rock campus will provide enhanced access to regionalized specialty physician services and expanded wellness and prevention services. The development of the Bulle Rock campus will continue to provide access to needed health care services in the community formerly served by Harford Memorial Hospital.

UM Upper Chesapeake Health System also plans to consolidate general inpatient hospital services at UM Upper Chesapeake Medical Center by constructing a three level addition. This centralization of inpatient hospital services will allow UM Upper Chesapeake Health System to achieve economies of scale and provide more efficient, cost effective inpatient care in a modern environment.

Once implemented, UM Upper Chesapeake Health System's regional delivery system model will ensure access to care and achieve goals of federal and state regulators to promote population health, improve patient outcomes, and reduce costs. As an added benefit, the modernization and renovation proposals are projected to generate up to 975 annual construction jobs and have a $435 million positive economic impact for Harford County during the construction period. Upon completion of the new facilities, most of Harford Memorial Hospital's existing team members will be transitioned to either the Bulle Rock or Bel Air campuses, while those not transferred will receive retraining and placement services or retirement packages. The net annual economic impact of UM Upper Chesapeake Health System's strategic plan is projected to generate $13.1 million in additional wages and contribute a $39.5 million economic benefit to Harford County.

I strongly support UM Upper Chesapeake Health System's transformative plans for the Bulle Rock and Bel Air campuses and urge that each of the integrated projects be approved.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information.

Respectfully,

Alan J. McCarthy
County Executive

HARFORD COUNTY CHAMBER OF COMMERCE

Paul Parker, Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Proposed Modernization and Transfiguration of Clinical Services

Dear Mr. Parker:

On behalf of the Harford County Chamber of Commerce, I write to express the Harford County Chamber's full support for UM Upper Chesapeake Health System's plan to undertake capital expenditures to develop an optimal integrated care delivery system for the future health care needs of the 360,000 residents of Harford and Cecil Counties in which patients will receive quality care, in the appropriate setting, at lower costs.

Most residents of Harford and western Cecil Counties are currently served by UM Upper Chesapeake Health System's two hospital locations; UM Upper Chesapeake Medical Center in Bel Air and Harford Memorial Hospital in Havre de Grace. Harford Memorial Hospital was constructed in phases between 1943 and 1972. Unfortunately, the aging physical plant has now outlived its useful life, but further renovation of the facility is neither cost-effective nor practical. UM Upper Chesapeake Health System's plan for the transformation of Harford Memorial Hospital is the culmination of more than five years of strategic planning in consultation with local and state officials, medical staff leadership, community health care providers, community stakeholders, and industry leading consultants.

Included in UM Upper Chesapeake Health System's transformative plan is the development of a multi-services medical campus in Havre de Grace at the Bulle Rock property owned by UM Upper Chesapeake Health System, only three miles from Harford Memorial Hospital and conveniently located off of Interstate 95. The Bulle Rock campus is planned to house a state-of-the-art forty-bed psychiatric hospital offering specialized inpatient and outpatient psychiatric services in one central location. Also planned for the Bulle Rock campus is a fully functional emergency department that will be open 24 hours a day, 7 days a week, and capable of handling the volume and the severity of most emergency cases currently handled by Harford Memorial Hospital. A helipad and dedicated, onsite ambulance will ensure rapid transport for those patients requiring transfer to a higher level of care. Finally, a new medical office building on the Bulle Rock campus will provide enhanced access to regionalized specialty physician services and expanded wellness and prevention services. The development of the Bulle Rock campus will continue to provide access to needed health care services in the community formerly served by Harford Memorial Hospital.

UM Upper Chesapeake Health System also plans to consolidate general inpatient hospital services at UM Upper Chesapeake Medical Center by constructing a three level addition. This centralization of inpatient hospital services will allow UM Upper Chesapeake Health System to achieve economies of scale and provide more efficient, cost effective inpatient care in a modern environment.

Once implemented, UM Upper Chesapeake Health System's regional delivery system model will ensure access to care and achieve goals of federal and state regulators to promote population health, improve patient outcomes, and reduce costs. As an added benefit, the modernization and renovation proposals are projected to generate up to 975 annual construction jobs and have a $435 million positive economic impact for Harford County during the construction period. Upon completion of the new facilities, most of Harford Memorial

108 South Bond Street
Bel Air, Maryland 21014

Ph. 410.838.2020 | Fx. 410.893.4715
www.harfordchamber.org

Hospital's existing team members will be transitioned to either the Bulle Rock or Bel Air campuses, while those not transferred will receive retraining and placement services or retirement packages. The net annual economic impact of UM Upper Chesapeake Health System's strategic plan is projected to generate $13.1 million in additional wages and contribute a $39.5 million economic benefit to Harford County.

As the premier business advocate in the county, the Harford County Chamber of Commerce strongly supports UM Upper Chesapeake Health System's transformative plans for the Bulle Rock and Bel Air campuses and urges that each of the integrated projects be approved.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information.

Sincerely,

Angela

Angela Rose
President and CEO
Harford County Chamber of Commerce

Public Health
Prevent. Promote. Protect.
Harford County
Health Department

Harford County Health Department

Main Office: 120 S. Hays Street • P.O. Box 797 • Bel Air, Maryland 21014

Russell W. Moy, MD, MPH • Acting Health Officer
Marcy Austin • Deputy Health Officer

July 11, 2017

Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Proposed Modernization and Transfiguration of Clinical Services

Dear Mr. Parker:

On behalf of the Harford County Health Department, I write to express our full support for UM Upper Chesapeake Health System's plan to undertake capital expenditures to develop an optimal integrated care delivery system for the future health care needs of the 360,000 residents of Harford and Cecil Counties in which patients will receive quality care, in the appropriate setting, at lower costs.

Most residents of Harford and western Cecil Counties are currently served by UM Upper Chesapeake Health System's two hospital locations: UM Upper Chesapeake Medical Center in Bel Air and Harford Memorial Hospital in Havre de Grace. Harford Memorial Hospital was constructed in phases between 1943 and 1972. Unfortunately, the aging physical plant has now outlived its useful life, but further renovation of the facility is neither cost-effective nor practical. UM Upper Chesapeake Health System's plan for the transformation of Harford Memorial Hospital is the culmination of more than five years of strategic planning in consultation with local and state officials, medical staff leadership, community health care providers, community stakeholders, and industry leading consultants.

Included in UM Upper Chesapeake Health System's transformative plan is the development of a multi-services medical campus in Havre de Grace at the Bulle Rock property owned by UM Upper Chesapeake Health System, only three miles from Harford Memorial Hospital and conveniently located off of Interstate 95. The Bulle Rock campus is planned to house a state-of-the-art forty-bed psychiatric hospital offering specialized inpatient and outpatient psychiatric services in one central location. Also planned for the Bulle Rock campus is a fully functional emergency department that will be open 24 hours a day, 7 days a week, and capable of handling the volume and the severity of most emergency cases currently handled by Harford Memorial Hospital. A helipad and dedicated, onsite ambulance will ensure rapid

transport for those patients requiring transfer to a higher level of care. Finally, a new medical office building on the Bulle Rock campus will provide enhanced access to regionalized specialty physician services and expanded wellness and prevention services. The development of the Bulle Rock campus will continue to provide access to needed health care services in the community formerly served by Harford Memorial Hospital.

UM Upper Chesapeake Health System also plans to consolidate general inpatient hospital services at UM Upper Chesapeake Medical Center by constructing a three level addition. This centralization of inpatient hospital services will allow UM Upper Chesapeake Health System to achieve economies of scale and provide more efficient, cost effective inpatient care in a modern environment.

Once implemented, UM Upper Chesapeake Health System's regional delivery system model will ensure access to care and achieve goals of federal and state regulators to promote population health, improve patient outcomes, and reduce costs. As an added benefit, the modernization and renovation proposals are projected to generate up to 975 annual construction jobs and have a $435 million positive economic impact for Harford County during the construction period. Upon completion of the new facilities, most of Harford Memorial Hospital's existing team members will be transitioned to either the Bulle Rock or Bel Air campuses, while those not transferred will receive retraining and placement services or retirement packages. The net annual economic impact of UM Upper Chesapeake Health System's strategic plan is projected to generate $13.1 million in additional wages and contribute a $39.5 million economic benefit to Harford County.

I strongly support UM Upper Chesapeake Health System's transformative plans for the Bulle Rock and Bel Air campuses and urge that each of the integrated projects be approved.

Thank you for your consideration of this matter. Please feel free to contact me if you require any additional information.

Sincerely,

Russell W. Moy, MD, MPH
Acting Health Officer
Harford County Health Department

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

520 Upper Chesapeake Drive
Bel Air, MD 21014
uchs.org

July 12, 2017

Paul Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
paul.parker@maryland.gov

Re: Letter in Support of UM Upper Chesapeake Health System, Inc.'s Proposed Modernization and Transfiguration of Clinical Services

Dear Mr. Parker:

On behalf of the medical staff at UM Upper Chesapeake Health, we write to express the medical staff's full support for UM Upper Chesapeake Health System's plan to undertake capital expenditures to develop an optimal integrated care delivery system for the future health care needs of the 360,000 residents of Harford and Cecil Counties in which patients will receive quality care, in the appropriate setting, at lower costs.

Most residents of Harford and western Cecil Counties are currently served by UM Upper Chesapeake Health System's two hospital locations; UM Upper Chesapeake Medical Center in Bel Air and Harford Memorial Hospital in Havre de Grace. Harford Memorial Hospital was constructed in phases between 1943 and 1972. Unfortunately, the aging physical plant has now outlived its useful life, but further renovation of the facility is neither cost-effective nor practical. UM Upper Chesapeake Health System's plan for the transformation of Harford Memorial Hospital is the culmination of more than five years of strategic planning in consultation with local and state officials, medical staff leadership, community health care providers, community stakeholders, and industry leading consultants.

Included in UM Upper Chesapeake Health System's transformative plan is the development of a multi-services medical campus in Havre de Grace at the Bulle Rock property owned by UM Upper Chesapeake Health System, only three miles from Harford Memorial Hospital and conveniently located off of Interstate 95. The Bulle Rock campus is planned to house a state-of-the-art forty-bed psychiatric hospital offering specialized inpatient and outpatient psychiatric services in one central location. Also planned for the Bulle Rock campus is a fully functional emergency department that will be open 24 hours a day, 7 days a week, and capable of handling the volume and the severity of most emergency cases currently handled by Harford Memorial Hospital. A helipad and dedicated, onsite ambulance will ensure rapid transport for those patients requiring transfer to a higher level of care. Finally, a new medical office building on the Bulle Rock campus will provide enhanced access to regionalized specialty physician services and expanded wellness and prevention services. The development of the Bulle Rock campus will continue to provide access to needed health care services in the community formerly served by Harford Memorial Hospital.

UM Upper Chesapeake Health System also plans to consolidate general inpatient hospital services at UM Upper Chesapeake Medical Center by constructing a three level addition. This centralization of inpatient hospital

services will allow UM Upper Chesapeake Health System to achieve economies of scale and provide more efficient, cost effective inpatient care in a modern environment.

Once implemented, UM Upper Chesapeake Health System's regional delivery system model will ensure access to care and achieve goals of federal and state regulators to promote population health, improve patient outcomes, and reduce costs. As an added benefit, the modernization and renovation proposals are projected to generate up to 975 annual construction jobs and have a $435 million positive economic impact for Harford County during the construction period. Upon completion of the new facilities, most of Harford Memorial Hospital's existing team members will be transitioned to either the Bulle Rock or Bel Air campuses, while those not transferred will receive retraining and placement services or retirement packages. The net annual economic impact of UM Upper Chesapeake Health System's strategic plan is projected to generate $13.1 million in additional wages and contribute a $39.5 million economic benefit to Harford County.

We strongly support UM Upper Chesapeake Health System's transformative plans for the Bulle Rock and Bel Air campuses and urge that each of the integrated projects be approved.

Thank you for your consideration of this matter.

Best regards,

Angela Poppe Ries, M.D.
President, Medical Staff

Michael Abraham, M.D.
Chair, Department of Emergency Medicine

Jason Birnbaum, M.D.
Chair, Department of Medicine

Kimmie Cass, M.D.
Chair, Department of Pediatrics

Mark Gonze, M.D.
Chair, Department of Surgery

Kathleen Gotzmann, M.D.
Chair, Department of Obstetrics/Gynecology

V. Dixon King, M.D.
Chair, Department of Pathology

Richard Lewis, M.D.
Chair, Department of Psychiatry

Nick Lomis, M.D.
Chair, Department of Radiology

Rodger Oursler, M.D.
Chair, Department of Anesthesiology

EXHIBIT 11

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Financial Statements and Schedules

June 30, 2016 and 2015

(With Independent Auditors' Report Thereon)

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Table of Contents

	Page
Independent Auditors' Report	1
Consolidated Financial Statements:	
Consolidated Balance Sheets	3
Consolidated Statements of Operations	4
Consolidated Statements of Changes in Net Assets	5
Consolidated Statements of Cash Flows	6
Notes to Consolidated Financial Statements	8
Supplementary Information	
Schedule 1 – Consolidating Balance Sheet Information by Division, June 30, 2016	56
Schedule 2 – Consolidating Balance Sheet Information by Division, June 30, 2015	76
Schedule 3 – Consolidating Operations Information by Division, year ended June 30, 2016	78
Schedule 4 – Consolidating Operations Information by Division, year ended June 30, 2015	88
Schedule 5 – Combining Balance Sheet Information of the Obligated Group, June 30, 2016	89
Schedule 6 – Combining Balance Sheet Information of the Obligated Group, June 30, 2015	91
Schedule 7 – Combining Operations and Changes in Net Assets Information of the Obligated Group, year ended June 30, 2016	93
Schedule 8 – Combining Operations and Changes in Net Assets Information of the Obligated Group, year ended June 30, 2015	94

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 financial statements of the University of Maryland Medical System Corporation and Subsidiaries (the Corporation), which comprise the consolidated balance sheets as of June 30, 2016 and 2015, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the University of Maryland Medical System Corporation and Subsidiaries as of June 30, 2016 and 2015, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary information in Schedules 1-8 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

KPMG LLP

October 27, 2016

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2016 and 2015

(In thousands)

Assets	2016	2015
Current assets:		
Cash and cash equivalents	$ 523,169	462,506
Assets limited as to use, current portion	51,412	50,417
Accounts receivable:		
Patient accounts receivable, less allowance for doubtful accounts of $202,298 and $248,054 as of June 30, 2016 and 2015, respectively	331,055	325,563
Other	97,887	68,949
Inventories	59,738	59,254
Prepaid expenses and other current assets	25,381	25,279
Total current assets	1,088,642	991,968
Investments	645,534	500,931
Assets limited as to use, less current portion	750,179	888,585
Property and equipment, net	2,086,546	2,058,129
Investments in joint ventures	71,906	74,600
Other assets	323,275	218,633
Total assets	$ 4,966,082	4,732,846
Liabilities and Net Assets		
Current liabilities:		
Trade accounts payable	$ 249,543	261,239
Accrued payroll and benefits	253,337	243,848
Advances from third-party payors	124,717	129,212
Lines of credit	180,000	144,400
Short-term financing	150,000	—
Other current liabilities	147,522	115,295
Long-term debt subject to short-term remarketing arrangements	32,515	51,732
Current portion of long-term debt	37,592	33,298
Total current liabilities	1,175,226	979,024
Long-term debt, less current portion and amount subject to short-term remarketing arrangements	1,422,604	1,559,144
Other long-term liabilities	352,605	259,225
Interest rate swap liabilities	273,037	196,372
Total liabilities	3,223,472	2,993,765
Net assets:		
Unrestricted	1,459,280	1,457,227
Temporarily restricted	246,265	245,653
Permanently restricted	37,065	36,201
Total net assets	1,742,610	1,739,081
Total liabilities and net assets	$ 4,966,082	4,732,846

See accompanying notes to consolidated financial statements.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended June 30, 2016 and 2015

(In thousands)

	2016	2015
Unrestricted revenues, gains and other support:		
Patient service revenue (net of contractual adjustments)	$ 3,544,050	3,373,236
Provision for bad debts	(176,198)	(145,328)
Net patient service revenue	3,367,852	3,227,908
Other operating revenue:		
State support	3,200	3,200
Premium revenue	140,958	—
Other revenue	156,939	142,436
Total unrestricted revenues, gains and other support	3,668,949	3,373,544
Operating expenses:		
Salaries, wages and benefits	1,751,856	1,648,338
Expendable supplies	674,994	639,828
Purchased services	680,062	512,287
Contracted services	216,562	214,214
Depreciation and amortization	200,764	182,231
Interest expense	57,464	58,936
Total operating expenses	3,581,702	3,255,834
Operating income	87,247	117,710
Nonoperating income and expenses, net:		
Contributions	3,769	11,385
St. Joseph escrow settlement	34,275	—
Equity in net income (loss) of joint ventures	(298)	8,603
Gain on sale of joint venture interest	—	39,350
Investment income, net	21,111	28,273
Change in fair value of investments	(36,443)	(30,029)
Change in fair value of undesignated interest rate swaps	(78,429)	(22,237)
Fair value impairment adjustment	—	(11,483)
Loss on early extinguishment of debt	—	(8,794)
Other nonoperating losses, net	(31,033)	(37,676)
Excess of revenues over expenses	$ 199	95,102

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, 2016 and 2015

(In thousands)

	Unrestricted net assets	Temporarily restricted net assets	Permanently restricted net assets	Total
Balance at June 30, 2014	$ 1,351,895	241,386	36,050	1,629,331
Excess of revenues over expenses	95,102	—	—	95,102
Capital distribution to minority interest holders	(1,011)	—	—	(1,011)
Investment gains, net	—	1,350	29	1,379
State support for capital	—	14,261	—	14,261
Contributions, net	—	14,597	662	15,259
Net assets released from restrictions used for operations and nonoperating activities	—	(5,813)	—	(5,813)
Net assets released from restrictions used for purchase of property and equipment	17,654	(17,654)	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	(2,114)	—	(2,114)
Change in ownership interest of joint ventures	(173)	(61)	—	(234)
Amortization of accumulated loss of discontinued designated interest rate swap	1,812	—	—	1,812
Change in funded status of defined benefit pension plans	(7,992)	—	—	(7,992)
Asset reclassifications at request of donor	293	244	(537)	—
Other	(353)	(543)	(3)	(899)
Increase in net assets	105,332	4,267	151	109,750
Balance at June 30, 2015	1,457,227	245,653	36,201	1,739,081
Excess of revenues over expenses	199	—	—	199
Investment gains, net	—	(968)	(52)	(1,020)
State support for capital	—	4,364	—	4,364
Contributions, net	—	15,884	469	16,353
Net assets released from restrictions used for operations and nonoperating activities	—	(7,067)	—	(7,067)
Net assets released from restrictions used for purchase of property and equipment	10,417	(10,417)	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	(1,545)	—	(1,545)
Change in ownership interest of joint ventures	566	(36)	—	530
Amortization of accumulated loss of discontinued designated interest rate swap	1,765	—	—	1,765
Change in funded status of defined benefit pension plans	(10,643)	—	—	(10,643)
Asset reclassifications at request of donor	(847)	400	447	—
Other	596	(3)	—	593
Increase in net assets	2,053	612	864	3,529
Balance at June 30, 2016	$ 1,459,280	246,265	37,065	1,742,610

See accompanying notes to consolidated financial statements.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2016 and 2015

(In thousands)

	2016	2015
Cash flows from operating activities:		
Increase in net assets	$ 3,529	109,750
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	200,764	182,231
Provision for bad debts	176,198	145,328
Amortization of bond premium and deferred financing costs	1,944	1,153
Net realized gains and change in fair value of investments	28,046	15,813
Loss on early extinguishment of debt	—	8,794
Gain on sale of joint venture interest	—	(39,350)
Equity in net income of joint ventures	298	(8,603)
Decrease in economic and beneficial interests in net assets of related organizations	1,545	2,114
Fair value impairment adjustment	—	11,483
Change in fair value of interest rate swaps	76,665	20,425
Change in funded status of defined benefit pension plans	10,643	7,992
Restricted contributions, grants and other support	(16,353)	(15,259)
Change in operating assets and liabilities:		
Patient accounts receivable	(174,069)	(112,846)
Other receivables, prepaid expenses, other current assets and other assets	(45,510)	31,793
Inventories	(484)	(2,702)
Trade accounts payable, accrued payroll and benefits, other current liabilities and other long-term liabilities	22,842	14,759
Advances from third-party payors	(4,495)	5,600
Net cash provided by operating activities	281,563	378,475
Cash flows from investing activities:		
Purchases and sales of investments and assets limited as to use, net	47,619	73,863
Purchases of alternative investments	(120,788)	(106,489)
Sales of alternative investments	46,544	41,893
Acquisition of UM Health Plans, net of cash acquired	(30,747)	—
Purchases of property and equipment	(215,691)	(208,729)
Distributions from joint ventures	3,031	4,796
Net cash used in investing activities	(270,032)	(194,666)

(Continued)

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2016 and 2015

(In thousands)

		2016	2015
Cash flows from financing activities:			
Proceeds from long-term debt	$	51,350	86,604
Repayment of long-term debt and capital leases		(54,171)	(139,347)
Draws on lines of credit, net		35,600	27,400
Payment of debt issuance costs		—	1,059
Restricted contributions, grants and other support		16,353	15,259
Net cash provided by (used in) financing activities		49,132	(9,025)
Net increase in cash and cash equivalents		60,663	174,784
Cash and cash equivalents, beginning of year		462,506	287,722
Cash and cash equivalents, end of year	$	523,169	462,506
Supplemental disclosures of cash flow information:			
Cash paid during the year for interest, net of amounts capitalized	$	56,478	54,482
Amount included in accounts payable for construction in progress		23,213	32,953
Supplemental disclosures of noncash information:			
Capital leases	$	2,309	—

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 a private, not-for-profit corporation providing comprehensive healthcare services through an integrated regional network of hospitals and related clinical enterprises. UMMS was created in 1984 when its founding hospital was privatized by the State of Maryland. Over its 30 year history, UMMS evolved into a multi-hospital system with academic, community and specialty service missions reaching primarily across Maryland. In continuing partnership with the University of Maryland School of Medicine, UMMS operates healthcare programs that improve the physical and mental health of thousands of people each day.

The accompanying consolidated financial statements include the accounts of the Corporation, its wholly owned subsidiaries, and entities controlled by the Corporation. In addition, the Corporation maintains equity interests in various unconsolidated joint ventures, which are described in note 4. The significant operating divisions of the Corporation are described in further detail below.

All material intercompany balances and transactions have been eliminated in consolidation.

Recent Acquisitions & Divestitures

University of Maryland Health Ventures, LLC (UMHV), a wholly owned subsidiary of UMMS, acquired 100% of the stock of Riverside Health, Inc. (Riverside) and its affiliates on August 17, 2015 (the Purchase Date). Concurrent with the transaction, Riverside Health, Inc. was renamed University of Maryland Medical System Health Plans, Inc. (UM Health Plans).

UM Health Plans is a holding company that operates as a managed healthcare and insurance organization in the State of Maryland and includes the following subsidiaries: Riverside Health of Maryland, Inc. (RHMI), University of Maryland Health Advantage, Inc., formerly Riverside Advantage, Inc. (UMHA), Riverside Health of Delaware, Inc. (RHDE), and Riverside Health DC, Inc.

The transaction is described in more detail below.

University of Maryland Medical Center (Medical Center)

The University of Maryland Medical Center, which is a major component of UMMS, is an 816-bed academic medical center located in Baltimore. The Medical Center has served as the teaching hospital of the School of Medicine of the University System of Maryland, Baltimore since 1823. While the Corporation is not affiliated with the University System of Maryland, clinical faculty members of the School of Medicine serve as medical staff of the Medical Center.

The Medical Center is comprised of two operating divisions: University Hospital, which includes the Greenebaum Cancer Center, and Shock Trauma Center. University Hospital, which generates approximately 80% of the Medical Center's admissions and patient days, is a tertiary teaching hospital providing over 70 clinical services and programs. The Greenebaum Cancer Center specializes in the treatment of cancer patients and is a site for clinical cancer research. The Shock Trauma Center, which

(Continued)

specializes in emergency treatment of patients suffering severe trauma, generates approximately 20% of admissions and patient days.

The Medical Center's operations include UniversityCARE, LLC (UCARE), a physician hospital organization of which the Corporation has a majority ownership interest and therefore consolidates, and 36 South Paca Street, LLC, a wholly owned subsidiary of the Corporation that operates a residential apartment building.

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 patients. Total expense under these agreements in the years ended June 30, 2016 and 2015 was approximately $152,155,000 and $146,831,000, respectively.

University of Maryland Rehabilitation and Orthopaedic Institute (ROI)

ROI is comprised of a medical/surgical and rehabilitation hospital in Baltimore with 134 licensed beds, including 88 rehabilitation beds, 36 chronic care beds, 10 medical/surgical 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 ROI. Accordingly, the accompanying consolidated financial statements reflect an economic interest in the net assets of the Kernan Endowment.

University of Maryland Medical Center Midtown Campus (Midtown)

Midtown is located in Baltimore city and is comprised of University of Maryland Midtown Hospital (UM Midtown), a 208-bed acute care hospital and a wholly owned subsidiary providing primary care.

University of Maryland Baltimore Washington Medical System, Inc. (Baltimore Washington)

Baltimore Washington is located in Anne Arundel County, a suburb of Baltimore city, and is a health system comprised of University of Maryland Baltimore Washington Medical Center (UM Baltimore Washington), a 319-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 UM Baltimore Washington. Accordingly, the accompanying consolidated financial statements reflect an economic interest in the net assets of the BWMC Foundation.

University of Maryland Shore Regional Health System (Shore Regional)

Shore Regional is a health system located on the Eastern Shore of Maryland. Shore Regional owns and operates University of Maryland Memorial Hospital (UM Memorial), a 132-bed acute care hospital providing inpatient and outpatient services in Easton, Maryland; University of Maryland Dorchester Hospital (UM Dorchester), a 41-bed acute care hospital providing inpatient and outpatient

services in Cambridge, Maryland; University of Maryland Chester River Hospital Center (UM Chester River), a 41-bed acute care hospital providing inpatient and outpatient services to the residents of Kent and Queen Anne's counties; Shore Emergency Center at Queenstown (Shore Emergency Center), a free-standing emergency center; Memorial Hospital Foundation (Memorial Foundation), a nonprofit corporation established to solicit donations for the benefit of UM Memorial; Chester River Health Foundation (Chester River Foundation), a nonprofit corporation established to solicit donations for the benefit of UM Chester River; 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 UM Dorchester. Shore Regional 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.

University of Maryland Charles Regional Health System, Inc. (Charles Regional)

Charles Regional owns and operates University of Maryland Charles Regional Medical Center (UM Charles Regional), which is comprised of a 121-bed acute care hospital and other community healthcare resources providing inpatient and outpatient services to the residents of Charles County in Southern Maryland.

University of Maryland St. Joseph Health System, LLC (St. Joseph)

St. Joseph owns and operates University of Maryland St. Joseph Medical Center (UM St. Joseph), a 232-bed, Catholic acute care hospital located in Towson, Maryland, as well as other subsidiaries providing inpatient and outpatient services to the residents of Baltimore County.

University of Maryland Upper Chesapeake Health System (Upper Chesapeake)

Upper Chesapeake is a health system located in Harford County, Maryland. Upper Chesapeake's healthcare delivery system includes two acute care hospitals, University of Maryland Upper Chesapeake Medical Center (UM Upper Chesapeake), a 181-bed acute care hospital and University of Maryland Harford Memorial Hospital (UM Harford Memorial), an 89 – bed acute care hospital; a physician practice; a captive insurance company; a land holding company; and Upper Chesapeake Health Foundation.

University of Maryland Medical System Foundation, Inc. (UMMS Foundation)

The UMMS Foundation, a not-for-profit foundation, was established for the purpose of soliciting contributions on behalf of the Corporation.

University of Maryland Community Medical Group, LLC (CMG)

CMG is a physician network that employs more than 300 primary care physicians, specialists and advanced practice providers. CMG is a wholly owned subsidiary of UMMS and has over 75 locations across the state of Maryland.

University of Maryland Medical System Health Plans Inc. (UM Health Plans)

UM Health Plans (formerly Riverside Health Inc.), a Delaware corporation, is a public sector managed healthcare company based in Baltimore, Maryland. UM Health Plans is the parent company of: Riverside Health of Maryland, Inc. (RHMI) which provides managed care health coverage to Medicaid recipients throughout Maryland; University of Maryland Health Advantage, Inc. (UMHA), a Medicare Advantage Plan; Riverside Health of Delaware Inc. (RHDE) and Riverside Health DC, Inc.

On August 17, 2015, UMHV, a wholly owned subsidiary of UMMS, purchased all of the outstanding shares of UM Health Plans for approximately $42,250,000 in cash, net working capital and convertible promissory notes. In addition, the Stock Purchase Agreement included an earn-out payment clause for the previous stockholders of UM Health Plans, the final computation of which is not to be determined until March 31, 2020. This earn-out could result in an undiscounted payment ranging from $7,000,000 to $106,500,000 depending on the performance and membership of both plans. UMHV recorded a contingent consideration representing a discounted estimate of the future payment of the earn-out provision of approximately $35,700,000 at the acquisition date, which is included within other long-term liabilities in the accompanying consolidated balance sheets.

The acquisition was accounted for under the purchase accounting method for business combinations and the financial position and results of operations of UM Health Plans were consolidated by the Corporation beginning on August 17, 2015.

The following table summarizes the estimated fair value of UM Health Plan's assets acquired and liabilities assumed at August 17, 2015 (the acquisition date).

Assets:		
Current assets	$	29,786
Property and equipment		3,750
Goodwill		42,020
Other long-term assets		46,638
Total assets	$	122,194
Liabilities:		
Current liabilities	$	28,226
Long-term liabilities		16,249
Total liabilities		44,475
Net assets:		
Unrestricted		77,719
Temporarily restricted		—
Total net assets		77,719
Total liabilities and net assets	$	122,194

(Continued)

The following table summarizes the Corporation's pro forma consolidated results as though the acquisition date occurred at July 1:

	2016	2015
Operating revenues	$ 3,685,503	3,503,844
Net operating income	85,969	118,371
Changes in net assets:		
Unrestricted	775	105,993
Temporarily restricted	612	4,267
Permanently restricted	864	151
Total changes in net assets	$ 2,251	110,411

(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, 2016 and 2015. 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 statements 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 using half-year convention. 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, which are included in other assets, 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.

(i) Goodwill

Goodwill is an asset representing the future economic benefits arising from other assets acquired in a business combination that are not individually identified and separately recognized. Goodwill is reviewed for impairment at least annually. A qualitative assessment of whether it is more likely than not that the fair value of the reporting unit is less than its carrying value is performed, which determines whether a quantitative goodwill impairment test is necessary. The goodwill impairment test is a two-step test. Under the first step, the fair value of the reporting unit is compared with its carrying value (including goodwill). If the fair value of the reporting unit is less than its carrying value, an indication of goodwill impairment exists for the reporting unit and the entity must perform step two of the impairment test (measurement). Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step two does not need to be performed.

No impairment loss was recorded for the years ended June 30, 2016 or 2015.

(j) Contingent Consideration for Business Acquisitions

Acquisitions may include contingent consideration payments based on future financial measures of an acquired company. Contingent consideration is required to be recognized at fair value as of the acquisition date. We estimate the fair value of these liabilities based on financial projections of the acquired companies and estimated probabilities of achievement and discount the liabilities to present value using a weighted average cost of capital. Contingent consideration is valued using significant inputs that are not observable in the market which are defined as Level 3 inputs pursuant to fair value measurement accounting. At each reporting date, the contingent consideration obligation is revalued to estimated fair value and changes in fair value subsequent to the acquisition are reflected in operating income in the consolidated statements of operations. Changes in the fair value of contingent consideration obligations may result from changes in discount periods and rates, changes in the timing and amount of revenue and/or earnings estimates and changes in probability assumptions with respect to the likelihood of achieving the various earn-out criteria.

(k) 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.

No impairment losses were recorded other than those disclosed specifically in the financial statements for the years ended June 30, 2016 or 2015.

(l) 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.

(m) Self-Insurance

Under the Corporation's self-insurance programs (general and professional liability, workers' compensation and employee health and long-term disability benefits), claims are reflected as a present value liability based upon actuarial estimates and reported and incurred but not reported claims analysis, taking into consideration the severity of incidents and the expected timing of claim payments.

(n) 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.

(o) Net Patient Service Revenue and Provision for Uncollectible Accounts

Patient service revenue for the Medical Center, ROI, Midtown, Baltimore Washington, Shore Regional, Charles Regional, St. Joseph, and Upper Chesapeake 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. See note 18 for further discussion on the HSCRC and regulated rates.

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.

For receivables associated with services provided to patients who have third-party coverage, the Corporation analyzes contractually due amounts and provides an allowance for bad debts, allowance for contractual adjustments, provision for bad debts, and contractual adjustments on accounts for which the third-party payor has not yet paid or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely. For receivables associated with self-pay patients or with balances remaining after the third-party coverage has already paid, the Corporation records a significant provision for bad debts in the period of service on the basis of its historical collections, which indicates that many patients ultimately do not pay the portion of their bill for which they are financially responsible. The difference between the discounted rates and the amounts collected after all reasonable collection efforts have been exhausted is charged against the allowance for doubtful accounts. The change in the allowance for doubtful accounts was as follows during the years ended June 30:

		2016	2015
Beginning allowance for doubtful accounts	$	(248,054)	(210,958)
Plus provision for bad debt		(176,198)	(145,328)
Less bad debt write-offs		221,954	108,232
Ending allowance for doubtful accounts	$	(202,298)	(248,054)

The change in the allowance for doubtful accounts during 2016 is attributable to changes in trends experienced in the collection of the related patient receivables.

The Health Information Technology for Economic and Clinical Health (HITECH) Act was signed into law in February 2009. In the context of the HITECH Act, certain healthcare entities must implement a certified Electronic Health Record (EHR) in an effort to promote the adoption and "meaningful use" of health information technology (HIT). The HITECH Act includes significant monetary incentives meant to encourage the adaptation of an EHR system. During the years ended June 30, 2016 and 2015, the Corporation recognized "meaningful use" incentive payments totaling $7,948,000 and $12,126,000, respectively, which are included in other operating revenue in the consolidated statements of operations.

(Continued)

(p) Premium Revenue and Medical Claims Expense

Premium revenue consists of amounts received from the State of Maryland and the Centers for Medicare and Medicaid Services (CMS) by the Corporation's managed care organization for providing medical services to subscribing participants, regardless of services actually performed. The managed care organization provides services primarily to enrolled Medicaid and Medicare beneficiaries. This revenue is recognized ratably over the contractual period for the provision of services. Medical expenses of the managed care organization include actuarially determined estimates of the ultimate costs for both reported claims and claims incurred but unreported and are included in purchased services on the consolidated statements of operations and changes in net assets.

(q) Charity Care

The Corporation is committed to providing quality healthcare to all, regardless of their ability to pay. Patients who meet the criteria of its charity care policy receive services without charge or at amounts less than its established rates. The criteria for charity care consider the household income in relation to the federal poverty guidelines. The Corporation provides services at no charge for patients with adjusted gross income equal to or less than 200% of the federal poverty guidelines. For uninsured patients with adjusted gross income greater than 200% of the federal poverty guidelines, a sliding scale discount is applied. Income and asset information obtained from patient credit reporting data are used to determine patients' ability to pay. The Corporation maintains records to identify and monitor the level of charity care it furnished under its charity care policy. The charity care policies of the new affiliates are generally consistent with that of the Corporation's policy.

Due to the complexity of the eligibility process, the Corporation provides eligibility services to patients free of charge to assist in the qualification process. These eligibility services include, but are not limited to, the following:

- Financial assistance brochures and other information are posted at each point of service. When patients have questions or concerns, they are encouraged to call a toll-free number to reach customer service representatives during the business day. Financial assistance programs are published on the Corporation's Web site and included on the statements provided to patients.
- The Corporation offers assistance to patients in completing the applications for Medicaid or other government payment assistance programs, or applying for care under the Corporation's charity care policy, if applicable. The Corporation also employs an external firm to assist in the eligibility process.
- Any patient, whether covered by insurance or not, may meet with a UMMS representative and receive financial counseling from UMMS' dedicated financial assistance unit.

The Corporation recognizes that a large number of uninsured and insured patients meet the charity care guidelines but do not respond to the Corporation's attempts to obtain necessary financial information. In these instances, the Corporation uses credit reporting data to properly classify these unpaid balances as charity care as opposed to bad debt expense. Utilization of income and asset information and credit reporting data indicate the vast majority of amounts reported as provision for bad debts represent amounts due from patients that would otherwise qualify for charity benefits but do

not respond to the Corporation's attempts to obtain the necessary financial information. In these cases, reasonable collection efforts are pursued, but yield few collections. Amounts determined to meet the criteria under the charity care policy are not reported as net patient service revenue.

The amounts reported as charity care represent the cost of rendering such services. Costs incurred are estimated based on the cost-to-charge ratio for each hospital and applied to charity care charges. The Corporation estimates the total direct and indirect costs to provide charity care were $48,149,000 and $73,851,000 for the years ended June 30, 2016 and 2015, respectively.

(r) Nonoperating Income and Expenses, Net

Other activities that are only indirectly related to the Corporation's primary business of delivering healthcare services 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, escrow settlements, gains on sale of joint venture interest, changes in fair value of investments, changes in fair value of undesignated interest rate swaps, settlement payments on interest rate swaps that do not qualify for hedge accounting treatment, and loss on early extinguishment of debt. Settlement payments on interest rate swaps were approximately $25,289,000 and $26,241,000 for the years ended June 30, 2016 and 2015, respectively, and are included in other nonoperating losses on the accompanying statements of operations.

(s) Derivative Financial Instruments

The Corporation records derivative and hedging activities on the consolidated balance sheets 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.

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. 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. This process includes linking all derivatives that are designated as fair value or cash flow hedges to specific liabilities on the consolidated balance sheets. 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.

All derivative instruments are reported as other assets or interest rate swap liabilities in the consolidated balance sheets and measured at fair value. 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 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.

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 treatment. 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.

(t) Excess of Revenue over Expenses

The consolidated statements 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 the fair value of derivatives that qualify for hedge accounting, and other items that are required by generally accepted accounting principles to be reported separately.

(u) 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 has net operating loss carryforwards on for-profit and unrelated business activities of approximately $51,888,000 as of June 30, 2016, which expire at various dates through 2031. The Corporation's remaining deferred tax assets, which consist primarily of the net operating loss

carryforwards, of approximately $20,755,000 at June 30, 2016 are fully reserved as they are not expected to be utilized. The Corporation has a deferred tax liability in the amount of $17,361,000 related to indefinite lived intangibles, at June 30, 2016, which is included in other long-term liabilities on the accompanying consolidated balance sheets.

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.

(v) 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).

(w) Fair Value Measurements

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, trade accounts payable, accrued payroll and benefits, other accrued expenses and advances from third-party payors – The carrying amounts reported in the consolidated balance sheets approximate the related fair values.

Pension plan assets – The Corporation applies Accounting Standards Update (ASU) 2009-12, *Fair Value Measurements and Disclosures (Topic 820): Investments in Certain Entities That Calculate Net Asset per Share (or Its Equivalent)*, to its pension plan assets. The guidance permits, as a practical expedient, fair value of investments within its scope to be estimated using the net asset value or its equivalent. The alternative investments classified within Level 3 of the fair value hierarchy have been recorded using the Net Asset Value (NAV).

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, at June 30, 2016 and 2015, was approximately $1,485,865,000 and $1,472,007,000, respectively. The carrying amounts of other long-term debt reported in note 7 and on the consolidated balance sheets approximate the related fair values.

The Corporation discloses its financial assets, financial liabilities and fair value measurements of nonfinancial items according to the fair value hierarchy required by GAAP 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, 2016 and 2015, the Level 2 assets and liabilities listed in the fair value hierarchy tables below utilize the following valuation techniques and inputs:

(i) Cash Equivalents

The fair value of investments in cash equivalent securities, with maturities within three months of the date of purchase, is determined using techniques that are consistent with the market approach. Significant observable inputs include reported trades and observable broker-dealer quotes.

(Continued)

(ii) 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.

(iii) 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.

(iv) 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.

(v) 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.

(x) Commitments and Contingencies

Liabilities for loss contingencies arising from claims, assessments, litigation, fines, penalties and other sources are recorded when it is probable that a liability has been incurred and the amount can be reasonably estimated. Legal costs incurred in connection with loss contingencies are expensed as incurred.

(y) 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.

(z) New Accounting Pronouncements

The Financial Accounting Standards Board (FASB) issued Accounting Standards update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*. This ASU establishes principles for reporting useful information to users of financial statements about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers. The ASU requires that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. ASU 2014-09 is effective for fiscal year 2019. The Corporation expects to record a decrease in net patient service revenue related to self-pay patients and a corresponding decrease in bad debt expense upon the adoption of the standard.

The FASB issued ASU 2015-03, *Interest – Imputation of Interest*. This ASU requires that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. The recognition and measurement guidance for debt issuance costs are not affected by the amendments in this ASU. ASU 2015-03 is effective for fiscal year 2017. The Corporation does not anticipate that the adoption of this ASU will have a material impact on its financial position or its results of operations.

The FASB issued ASU 2015-07, *Fair Value Measurement (Topic 820) Disclosures for Investments in Certain Entities that Calculate Net Asset Value per Share*. This ASU removes the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using the net asset value per share practical expedient. The amendments also remove the requirement to make certain disclosures for all investments that are eligible to be measured at fair value using the net asset value per share practical expedient. Rather, those disclosures are limited to investments for which the entity has elected to measure the fair value using that practical expedient. ASU 2015-07 is effective for fiscal year 2017. The Corporation does not anticipate that the adoption of this ASU will have a material impact on its financial position or its results of operations.

The FASB issued ASU No. 2016-02, *Leases (ASU 2016-02)*, which will require lessees to recognize most leases on-balance sheet, increasing their reported assets and liabilities – sometimes very significantly. This update was developed to provide financial statement users with more information about an entity's leasing activities, and will require changes in processes and internal controls. The adoption of ASU 2016-02 is effective fiscal year 2020, and will require application of the new guidance at the beginning of the earliest comparable period presented. Early adoption is permitted. The Corporation is in the process of assessing the impact the adoption of this standard will have on the consolidated financial statements.

The FASB issued ASU No. 2016-14, *Not-for-Profit Entities (ASU 2016-14)*, to improve the current net asset classification requirements and information presented in financial statements and notes about a not-for-profit entity's liquidity, financial performance, and cash flows. This update requires not-for-profit entities to present two classes of net assets (net assets with donor restrictions and net assets without donor restrictions), rather than the three classes of net assets currently required, and other qualitative information regarding the entity's liquidity, financial performance, and cash flows. The amendments in this update are effective for annual financial statements issued for fiscal years

(Continued)

beginning after December 15, 2017 and for interim periods within fiscal years beginning after December 15, 2018. Early adoption is permitted. The Corporation is in the process of assessing the impact the adoption of this standard will have on the consolidated financial statements.

(2) Investments and Assets Limited as to Use

The carrying values of assets limited as to use were as follows at June 30 (in thousands):

	2016	2015
Investments held for collateral	$ 177,998	119,320
Debt service and reserve funds	66,712	64,588
Construction funds – held by trustee	—	7,852
Construction funds – held by the Corporation	41,986	119,782
Board designated funds	117,502	231,945
Self-insurance trust funds	154,327	150,052
Funds restricted by donors	55,181	56,033
Economic and beneficial interests in the net assets of related organizations (note 12)	187,885	189,430
Total assets limited as to use	801,591	939,002
Less amounts available for current liabilities	(51,412)	(50,417)
Total assets limited as to use, less current portion	$ 750,179	888,585

The carrying values of assets limited as to use were as follows at June 30, 2016 (in thousands):

	Investments held for collateral	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	$ 52,568	41,826	32,385	16,656	11,178	7,567	—	162,180
Corporate bonds	—	—	680	18,212	2,904	6,690	—	28,486
Collateralized corporate obligations	—	—	91	45	—	153	—	289
U.S. government and agency securities	125,430	24,886	268	133	204	449	—	151,370
Common stocks, including mutual funds	—	—	2,513	46,114	—	16,601	—	65,228
Alternative investments	—	—	6,049	36,342	—	23,721	—	66,112
Assets held by other organizations	—	—	—	—	140,041	—	187,885	327,926
Total assets limited as to use	$ 177,998	66,712	41,986	117,502	154,327	55,181	187,885	801,591

(Continued)

The carrying values of assets limited as to use were as follows at June 30, 2015 (in thousands):

	Investments held for collateral	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	$ —	31,799	94,556	36,570	9,835	6,615	—	179,375
Corporate bonds	—	—	3,292	39,071	2,434	8,783	—	53,580
Collateralized corporate obligations	—	—	931	736	—	65	—	1,732
U.S. government and agency securities	119,320	32,789	1,783	19,557	645	125	—	174,219
Common stocks, including mutual funds	—	—	10,146	85,272	—	23,313	—	118,731
Alternative investments	—	—	16,926	50,739	—	17,132	—	84,797
Assets held by other organizations	—	—	—	—	137,138	—	189,430	326,568
Total assets limited as to use	$ 119,320	64,588	127,634	231,945	150,052	56,033	189,430	939,002

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 carrying values of investments not limited as to use were as follows at June 30 (in thousands):

	2016	2015
Cash and cash equivalents	$ 42,382	9,404
Corporate bonds	52,175	49,567
Collateralized corporate obligations	5,567	12,543
U.S. government and agency securities	19,274	25,594
Common stocks	158,936	150,761
Alternative investments	367,200	253,062
	$ 645,534	500,931

Alternative investments include hedge fund, private equity, and commingled investment funds, which are valued using the equity method of accounting. The majority of these alternative investments are subject to 30 day or less notice requirements and are available to be redeemed on at least a monthly basis. There are funds, totaling approximately $6,000,000, which are subject to 31-60 day notice requirements and can be redeemed on at least a monthly basis. Of the funds with 31-60 day notice requirements, approximately

(Continued)

$3,700,000 are subject to lockup restrictions and are not available to be redeemed until certain time restrictions are met, which range from one to three years. Other funds, totaling approximately $80,700,000, are subject to over 60-day notice requirements and can be redeemed monthly, quarterly, or annually. Of the funds with over 60-day notice requirements, approximately $17,700,000 are subject to lockup restrictions and are not available to be redeemed until certain time restrictions are met, which range from one to three years. In addition, there are approximately $9,200,000 of other funds that are subject to lockup restrictions and are not available to be redeemed until certain time restrictions are met, which range from one to three years.

The following table presents investments and assets limited as to use that are measured at fair value on a recurring basis excluding alternative investments in the amount of $367,200 and $66,112, respectively, which are accounted for under the equity method, at June 30, 2016 (in thousands):

	Level 1	Level 2	Level 3	Total
Assets:				
Investments:				
Cash and cash equivalents	$ 42,382	—	—	42,382
Corporate bonds	39,215	12,960	—	52,175
Collateralized corporate obligations	—	5,567	—	5,567
U.S. government and agency securities	8,879	10,395	—	19,274
Common and preferred stocks, including mutual funds	158,817	119	—	158,936
	249,293	29,041	—	278,334
Assets limited as to use:				
Cash and cash equivalents	120,371	41,809	—	162,180
Corporate bonds	25,137	3,349	—	28,486
Collateralized corporate obligations	—	289	—	289
U.S. government and agency securities	125,922	25,448	—	151,370
Common and preferred stocks, including mutual funds	65,228	—	—	65,228
Investments held by other organizations	—	327,926	—	327,926
	336,658	398,821	—	735,479
	$ 585,951	427,862	—	1,013,813

(Continued)

The following table presents investments and assets limited as to use that are measured at fair value on a recurring basis excluding alternative investments in the amount of $253,062 and $84,797, respectively, which are accounted for under the equity method, at June 30, 2015 (in thousands):

	Level 1	Level 2	Level 3	Total
Assets:				
Investments:				
Cash and cash equivalents	$ 9,404	—	—	9,404
Corporate bonds	32,513	17,054	—	49,567
Collateralized corporate obligations	—	12,543	—	12,543
U.S. government and agency securities	19,792	5,802	—	25,594
Common and preferred stocks, including mutual funds	150,761	—	—	150,761
	212,470	35,399	—	247,869
Assets limited as to use:				
Cash and cash equivalents	139,726	39,649	—	179,375
Corporate bonds	48,791	4,789	—	53,580
Collateralized corporate obligations	—	1,732	—	1,732
U.S. government and agency securities	139,984	34,235	—	174,219
Common and preferred stocks, including mutual funds	118,731	—	—	118,731
Investments held by other organizations	—	326,568	—	326,568
	447,232	406,973	—	854,205
	$ 659,702	442,372	—	1,102,074

Changes to Level 1 and Level 2 securities between June 30, 2016 and 2015 were the result of strategic investments and reinvestments, interest income earnings, and changes in the fair value of investments.

(Continued)

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):

		2016	2015
Dividends and interest, net of fees	$	11,694	15,436
Net realized gains		11,559	15,277
Change in fair value of trading securities		(39,605)	(31,090)
Total investment return	$	(16,352)	(377)

Total investment return is classified in the consolidated statements of operations as follows for the years ended June 30 (in thousands):

		2016	2015
Nonoperating investment income	$	21,111	28,273
Change in fair value of unrestricted investments		(36,443)	(30,029)
Investment gains on restricted net assets		(1,020)	1,379
Total investment return	$	(16,352)	(377)

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):

		2016	2015
Land	$	142,256	140,549
Buildings		1,465,218	1,468,578
Building and leasehold improvements		775,638	698,128
Equipment		1,596,086	1,365,897
Construction in progress		119,031	220,407
		4,098,229	3,893,559
Less accumulated depreciation and amortization		(2,011,683)	(1,835,430)
	$	2,086,546	2,058,129

Interest cost capitalized was $0 for the years ended June 30, 2016 and 2015.

Remaining commitments on construction projects were approximately $47,591,000 at June 30, 2016.

(Continued)

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 $200,764,000 and $182,231,000, for the years ended June 30, 2016 and 2015, respectively.

(4) Investments in Joint Ventures

The Corporation has investments of $71,906,000 and $74,600,000 at June 30, 2016 and 2015, respectively, in the following unconsolidated joint ventures:

Joint venture	Business purpose	Ownership percentage	
		FY2016	FY2015
Shipley's Imaging Center, LLC	Freestanding imaging center	50%	50%
Maryland Care, Inc.	Managed care organization	(b)	20
Innovative Health Services, LLC	Third-party insurance claims processor	50	50
NAH/Sunrise of Severna Park, LLC	Senior living facility	(a)	(a)
Terrapin Insurance Company (Terrapin)	Healthcare professional liability insurance company	50	50
Mt. Washington Pediatric Hospital, Inc. (Mt. Washington)	Healthcare services	50	50
Central Maryland Radiation Oncology Center LLC	Healthcare services	50	50
Chesapeake-Potomac Healthcare Alliance	Healthcare services	33	33
Civista Ambulatory Surgery Center, Inc.	Ambulatory surgical services	50	50
NRH/CPT/St. Mary's/Civista Regional Rehab, LLC	Medical rehabilitative and therapy services	15	15
UM SJMC Choice One Urgent Care Centers	Urgent Care Centers	25	—
UM UCHS Choice One Urgent Care Centers	Urgent Care Centers	49	—
UM SRH Choice One Urgent Care Centers	Urgent Care Centers	49	—
Maryland eCare, LLC	Remote monitoring technology	14	14

(Continued)

Joint venture	Business purpose	Ownership percentage FY2016	Ownership percentage FY2015
MRI at St. Joseph Medical Center, LLC	Healthcare services	51%	51%
Advanced/Upper Chesapeake Health Center, LLC	Imaging Center	10	10

(a) UMMS sold its 50% ownership interest during June 2015.

(b) UMMS sold its 20% ownership interest during August 2015.

The Corporation recorded equity in net income (losses) of $(298,000) and $8,603,000 related to these joint ventures for the years ended June 30, 2016 and 2015, respectively.

During the year ended June 30, 2015, the Corporation sold its interest in North Arundel Senior Living, LLC and NAH/Sunrise of Severna Park, LLC (collectively referred to as Sunrise) and recognized a gain of approximately $39,500,000, which is recorded as a gain on sale of joint venture in the accompanying consolidated statements of operations.

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):

	2016				
	Mt. Washington	Terrapin	Choice One*	Others	Total
Current assets	$ 24,976	9,513	2,759	19,184	56,432
Noncurrent assets	83,436	199,572	3,620	16,121	302,749
Total assets	$ 108,412	209,085	6,379	35,305	359,181
Current liabilities	$ 14,437	105	448	4,947	19,937
Noncurrent liabilities	8,492	207,030	32	972	216,526
Net assets	85,483	1,950	5,899	29,386	122,718
Total liabilities and net assets	$ 108,412	209,085	6,379	35,305	359,181
Total operating revenue	$ 56,811	34,150	2,659	57,925	151,545
Total operating expenses	(53,853)	(31,515)	(3,137)	(52,071)	(140,576)
Total nonoperating gains/(losses), net	455	(2,635)	(6)	(5,560)	(7,746)
Contributions from owners	—	—	1,365	(3,971)	(2,606)
Other changes in net assets, net	(1,516)	—	5,018	(1,552)	1,950
Increase in net assets	$ 1,897	—	5,899	(5,229)	2,567

* Choice One is the combination of UM SJMC, UM UCHS, and UM SRH Choice One Urgent Care Centers

(Continued)

	2015			
	Mt. Washington	Terrapin	Others	Total
Current assets	$ 25,755	6,883	220,873	253,511
Noncurrent assets	79,335	192,522	90,715	362,572
Total assets	$ 105,090	199,405	311,588	616,083
Current liabilities	$ 13,850	638	173,772	188,260
Noncurrent liabilities	7,971	196,817	1,535	206,323
Net assets	83,269	1,950	136,281	221,500
Total liabilities and net assets	$ 105,090	199,405	311,588	616,083
Total operating revenue	$ 59,131	39,598	756,934	855,663
Total operating expenses	(54,086)	(41,228)	(718,161)	(813,475)
Total nonoperating gains/(losses), net	633	1,630	(13,566)	(11,303)
Contributions from owners	—	—	(9,079)	(9,079)
Other changes in net assets, net	(494)	—	(331)	(825)
Increase in net assets	$ 5,184	—	15,797	20,981

(5) Leases

The Corporation rents various equipment and facility space. Rent expense under these operating leases for the years ended June 30, 2016 and 2015 was approximately $24,594,000 and $26,684,000, respectively.

Future noncancelable minimum lease payments under operating leases are as follows for the years ending June 30 (in thousands):

2017	$ 12,177
2018	9,537
2019	9,191
2020	6,775
2021	6,133
Thereafter	17,928
	$ 61,741

(Continued)

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, 2021, whereby the lessor may require the Corporation to purchase the building for $37,000,000. As of June 30, 2016 and 2015, amounts of $36,744,000 and $36,353,000, respectively, representing obligations under the lease, have been recorded in other current liabilities.

As of June 30, 2016, amounts of $2,095,000 and $16,043,000 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):

	2016	2015
Land	$ 3,770	3,770
Buildings	29,230	29,230
Equipment	23,899	23,223
	56,899	56,223
Less accumulated amortization	(12,338)	(10,864)
	$ 44,561	45,359

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, 2016 (in thousands):

2017*	$ 42,544
2018	2,526
2019	2,024
2020	2,023
2021	1,164
Thereafter	14,774
Total minimum lease payments	65,055
Less amounts representing interest	(10,174)
Present value of net minimum lease payments	$ 54,881

* Presumes that the put option on the 99-year lease is exercised by the lessor.

(Continued)

(6) Lines of Credit

Lines of credit outstanding are as follows as of the years ended June 30 (in thousands):

2016					
Line number	Interest rate calculation	Interest rate as of June 30, 2016	Date of expiration	Total available	Outstanding amount
1	1-mo LIBOR + 2.20%	2.30%	Annually renewing	$ 75,000	75,000
2	1, 2 or 3 month LIBOR + 0.75%	3.50	10/3/2016	20,000	20,000
3	1-mo LIBOR + 0.20%	—	4/30/2016	—	—
4	1-mo LIBOR + 2.20%	—	Annually renewing	—	—
5	Prime + 0.50%	—	5/31/2016	—	—
6	Prime, LIBOR (1, 2, 3 or 6 month) or LIBOR w/daily reset	—	1/13/2016	—	—
7	1-mo LIBOR + 0.75%	1.24	12/31/2016	60,000	60,000
8	1-mo LIBOR + 0.85%	1.27	3/28/2017	25,000	25,000
	Total lines of credit			$ 180,000	180,000

2015					
Line number	Interest rate calculation	Interest rate as of June 30, 2015	Date of expiration	Total available	Outstanding amount
1	1-mo LIBOR + 2.20%	2.39%	Annually renewing	$ 20,000	7,500
2	1, 2 or 3 month LIBOR + 0.75%	0.94	7/15/2016	20,000	20,000
3	1-mo LIBOR + 0.20%	0.99	4/30/2016	10,000	10,000
4	1-mo LIBOR + 2.20%	2.39	Annually renewing	5,000	—
5	Prime + 0.50%	3.75	5/31/2016	12,000	12,000
6	Prime, LIBOR (1, 2, 3 or 6 month) or LIBOR w/daily reset	3.25	1/13/2016	10,000	10,000
7	1-mo LIBOR + 0.75%	0.94	12/31/2015	60,000	60,000
8	1-mo LIBOR + 0.85%	1.04	3/29/2016	25,000	24,900
	Total lines of credit			$ 162,000	144,400

(Continued)

(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)	2016	2015
MHHEFA project revenue bonds:				
Corporation issue, payments due annually on July 1:				
Series 2015 Bonds	2.00%–5.00%	2016–2042	$ 79,010	80,145
Series 2013 Bonds	2.00%–5.00%	2014–2044	350,300	353,650
Series 2012A-D Bonds	Variable rate	2014–2042[1]	213,200	214,290
Series 2010 Bonds	2.50%–5.25%	2011–2040	209,675	215,465
Series 2008D/E Bonds	Variable rate	2025–2042	105,000	105,000
Series 2008F Bonds	4.00%–5.25%	2009–2024	46,360	53,510
Series 2007A Bonds	Variable rate	2008–2035	87,750	90,295
Series 2005 Bonds	4.00%–5.50%	2006–2032	119,675	121,225
Series 1991B Bonds	7.00%	1992–2023	21,840	23,350
Upper Chesapeake issue, payments due annually on January 1:				
Series 2011B/C Bonds	Variable rate	2013–2040[1]	108,929	111,129
Series 2011A Bonds	3.67%	2012–2043[1]	47,090	48,095
Other long-term debt:				
UCHS Term Loan	Variable rate	2017	150,000	150,000
Charles County Government	3.05	Monthly, 2004–2021	5,456	6,486
Community Bank note payable	4.50	Monthly, 2014–2024	4,696	5,218
O'Dea Medical Arts L.P. mortgage	4.66	2009–2019	8,869	9,081
Term loans	1.62%–3.95%	2009–2022	60,018	30,557
Other loans and notes payable	3.25%–7.00%	Monthly, 1991–2025	2,498	2,975
Total debt			1,620,366	1,620,471
Less current portion of long-term debt			37,592	33,298
Less short-term financing			150,000	—
Less long-term debt subject to short-term remarketing agreements			32,515	51,732
			1,400,259	1,535,441
Plus unamortized premiums and discounts, net			22,345	23,703
			$ 1,422,604	1,559,144

1 Mandatory purchase options are due in the following (fiscal years), unless the bank and the Obligated Group agree to an extension: Series 2012A (2023), 2012B&C (2018), 2012D (2020), 2011A (2022), 2011B (2022), and 2011C (2018).

(Continued)

Pursuant to an Amended and Restated Master Loan Agreement dated August 1, 2012 (UMMS Master Loan Agreement), 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 UMMS 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 UMMS Master Loan Agreement includes the Medical Center, ROI, UM Midtown, UM Baltimore Washington, Shore Health (UM Memorial and UM Dorchester), UM Chester River, UM Charles Regional, UM St. Joseph, UM Upper Chesapeake, UM Harford Memorial, and the UMMS Foundation. Each member of the Obligated Group is jointly and severally liable for the repayment of the obligations under the UMMS Master Loan Agreement.

Under the terms of the UMMS 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 May 2015, the Corporation refunded $45,000,000 of the Series 2006A Bonds and $49,485,000 of the Series 2008C – UCHS Bonds. The refunding was completed using the proceeds of a new $80,145,000 fixed rate MHHEFA bond issue (the Series 2015 Bonds).

The Corporation has a term loan in the amount of $150,000,000 related to the acquisition of Upper Chesapeake, which expires on December 10, 2016. The Corporation intends to refinance this obligation prior to its maturity date, and has classified this obligation as a short-term financing and long-term debt at June 30, 2016 and 2015, respectively, in the consolidated balance sheets.

The payment of principal and interest on the Corporation's issue Series 1991B Bonds and its Series 2005 Bonds are each insured under a financial guaranty insurance policy. These policies insure the payment of principal, sinking fund installments and interest on the corresponding bonds. The insurance policies require the Obligated Group to adhere to the same covenants as those in the UMMS 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):

2017	$ 187,592
2018	38,860
2019	48,917
2020	41,665
2021	65,507
Thereafter	1,237,825
	$ 1,620,366

The Corporation's Series 2007A and 2008D-E Bonds 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

(Continued)

liquidity support for the timely payment of any bonds that are not successfully remarketed, the Corporation has entered into letter of credit agreements with three banking institutions. These agreements have terms that expire in 2016 through 2018. 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 letters 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, 2016.

The following table reflects the mandatory redemptions and 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, and mandatory purchase options are not extended:

2017	$ 220,107
2018	153,892
2019	77,282
2020	55,848
2021	65,507
Thereafter	1,047,730
	$ 1,620,366

The approximate interest rates on MHHEFA project revenue bonds bearing interest at variable rates were as follows at June 30:

	2016	2015
Series 2011B Bonds – UCHS Issue	1.51%	1.30%
Series 2011C Bonds – UCHS Issue	1.19	0.99
Series 2008D Bonds	0.38	0.02
Series 2008E Bonds	0.41	0.08
Series 2007A Bonds	0.46	0.07
Series 2012A Bonds	1.37	1.18
Series 2012B Bonds	1.07	0.88
Series 2012C Bonds	1.39	1.98
Series 2012D Bonds	1.31	1.13

(Continued)

Term loans outstanding are as follows at June 30 (in thousands):

	Interest rate	Interest rate as of June 30, 2016	Payable in fiscal year(s)	2016	2015
Term loan 1:					
Payable monthly beginning February 2012	1-mo LIBOR + 2.75%	—%	2012–2018	$ —	16,691
Term loan 2:					
Payable monthly beginning March 2012	Fixed rate	3.95	2012–2022	8,400	9,200
Term loan 3:					
Payable monthly beginning January 2012	Fixed rate	3.19	2012–2017	142	427
Term loan 4:					
Payable monthly beginning April 2012	Fixed rate	3.10	2012–2017	196	458
Term loan 5:					
Payable monthly beginning February 2010	1-mo LIBOR + 1.75%	2.46	2010–2018	3,056	3,281
Term loan 6:					
Payable monthly beginning October 2012	Fixed rate	2.80	2013–2018	228	411
Term loan 7:					
Payable monthly beginning November 2012	Fixed rate	2.80	2013–2018	52	89
Term loan 8:					
Payable monthly beginning November 2015	1-mo LIBOR + 1.95%	2.45	2016–2021	46,667	—
Term loan 9:					
Payable monthly beginning May 2016	Fixed rate	1.86	2016–2019	1,277	—
Total term loans (included in long-term debt)				$ 60,018	30,557

(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.

(Continued)

At June 30, 2016 and 2015, the Corporation's notional values of outstanding interest rate swaps were $782,455,000 and $791,936,000, respectively, the details of which were as follows (in thousands):

	Notional amount	Pay rate	Receive rate	Maturity date	Mark to market	Qualifies for hedge accounting treatment?
As of June 30, 2016:						
Swap #1	$ 88,090	3.59%	70% 1-month LIBOR	7/1/2031	$ (20,115)	No
Swap #2	84,000	3.93	68% 1-month LIBOR	7/1/2014	(41,582)	No
Swap #3	21,000	4.24	68% 1-month LIBOR	7/1/2041	(11,603)	No
Swap #4	36,425	3.99	67% 1-month LIBOR	7/1/2034	(10,921)	No
Swap #5	27,400	3.54	70% 1-month LIBOR	7/1/2031	(6,128)	No
Swap #6	196,000	3.93	68% 1-month LIBOR	7/1/2041	(97,040)	No
Swap #7	49,000	4.24	68% 1-month LIBOR	7/1/2041	(27,077)	No
Swap #8	84,975	4.00	67% 1-month LIBOR	7/1/2034	(25,554)	No
Swap #9	3,970	3.63	67% 1-month LIBOR	7/1/2032	(590)	No
Swap #10	106,625	3.92	67% 1-month LIBOR	1/1/2043	(39,754)	No
Swap #11	84,970	0.51	67% 1-month LIBOR + 0.5133%	1/1/2038	1,803	No
					(278,561)	
				Valuation adjustments	5,524	
Total	$ 782,455				$ (273,037)	

	Notional amount	Pay rate	Receive rate	Maturity date	Mark to market	Qualifies for hedge accounting treatment?
As of June 30, 2015:						
Swap #1	$ 89,171	3.59%	70% 1-month LIBOR	7/1/2031	$ (15,444)	No
Swap #2	84,000	3.93	68% 1-month LIBOR	7/1/2014	(28,822)	No
Swap #3	21,000	4.24	68% 1-month LIBOR	7/1/2041	(8,314)	No
Swap #4	37,400	3.99	67% 1-month LIBOR	7/1/2034	(8,612)	No
Swap #5	27,730	3.54	70% 1-month LIBOR	7/1/2031	(4,666)	No
Swap #6	196,000	3.93	68% 1-month LIBOR	7/1/2041	(67,262)	No
Swap #7	49,000	4.24	68% 1-month LIBOR	7/1/2041	(19,403)	No
Swap #8	87,275	4.00	67% 1-month LIBOR	7/1/2034	(20,168)	No
Swap #9	4,330	3.63	67% 1-month LIBOR	7/1/2032	(532)	No
Swap #10	109,050	3.92	67% 1-month LIBOR	1/1/2043	(29,445)	No
Swap #11	86,980	0.51	67% 1-month LIBOR + 0.5133%	1/1/2038	592	No
					(202,076)	
				Valuation adjustments	5,704	
Total	$ 791,936				$ (196,372)	

The mark-to-market values of the Corporation's interest rate swaps include a valuation adjustment representing the creditworthiness of the counterparties to the swaps.

(Continued)

On January 1, 2013, in accordance with ASC 815, *Derivatives and Hedging*, the Corporation elected to discontinue the cash flow hedging relationship for Swap #8. As of that date, the accumulated losses included in unrestricted net assets will be reclassified into earnings over the life of the Series 2007 bonds. For the years ended June 30, 2016 and 2015, $1,764,000 and $1,812,000, respectively, were reclassified from other changes in net assets into change in fair value of undesignated interest rate swaps. The accumulated losses included in unrestricted net assets were $(19,650,000) and $(21,415,000) at June 30, 2016 and 2015, respectively.

The Corporation recorded a net nonoperating loss on changes in the fair value of nonqualifying interest rate swaps of $(78,429,000) and $(22,237,000) for the years ended June 30, 2016 and 2015, respectively.

The swap agreements are included in the consolidated balance sheets at their fair value of $(273,037,000) and $(196,372,000) as of June 30, 2016 and 2015, respectively, an amount that is based on observable inputs other than quoted market prices in active markets for identical liabilities (Level 2 in the fair value hierarchy).

The Corporation is subject to a collateral posting requirement with two 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 $174,661,000 and $110,740,000 at June 30, 2016 and 2015, respectively. As of June 30, 2016 and 2015, the Corporation met its collateral posting requirement through the use of collateralized investments, which were selected and purchased by the Corporation and subsequently transferred to the custody of the swap counterparty. The amount of posted investments that is required to meet the collateral requirement is computed daily, and is accounted for as a component of the Corporation's assets limited as to use on the accompanying consolidated balance sheets as of that date. Any excess investment value is considered a component of the Corporation's unrestricted investment portfolio, and is included in investments on the accompanying consolidated balance sheets as of that date.

(9) Other Liabilities

Other liabilities consist of the following at June 30 (in thousands):

	2016	2015
Professional and general malpractice liabilities	$ 235,871	206,072
Capital lease obligations	54,881	55,585
Accrued pension obligations	42,761	25,481
Contingent consideration	35,700	—
Accrued interest payable	20,659	19,616
Deferred tax liability	17,361	—
Other miscellaneous	92,894	67,766
Total other liabilities	500,127	374,520
Less current portion	(147,522)	(115,295)
Other long-term liabilities	$ 352,605	259,225

(Continued)

Other miscellaneous liabilities primarily consist of unearned revenue, medical claims payable and patient credit balance liabilities.

(10) Retirement Plans

Employees of the Corporation are included in various retirement plans established by the Corporation, the Medical Center, ROI, Midtown, Baltimore Washington, Shore Regional, Charles Regional, St. Joseph, and Upper Chesapeake. 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. Following is a brief description of each of the retirement plans in which employees of the Corporation participate.

(a) Defined Benefit Plans

University of Maryland Medical Center Midtown Campus Retirement Plan for Non-Union Employees (Midtown Plan) – 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, Midtown froze the defined benefit pension plan.

Baltimore Washington Medical Center Pension Plan (Baltimore Washington 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.

Civista Health Inc. Retirement Plan and Trust (Charles Regional Plan) – A noncontributory defined benefit pension plan covering employees that have worked at least one thousand hours per year during three or more plan years. Plan benefits are accumulated based upon a combination of years of service and percent of annual compensation. Charles Regional makes annual contributions to the plan based upon amounts required to be funded under provisions of ERISA.

Upper Chesapeake Health System, Inc. Pension Plan and Trust – A noncontributory defined benefit pension plan covering substantially all employees of the various affiliates of Upper Chesapeake who have completed six months of employment and attained the age of twenty and a half years. Upper Chesapeake makes annual contributions to the plan equal to the minimum funding requirements pursuant to ERISA regulations. On December 31, 2005, Upper Chesapeake froze the defined benefit pension plan. On June 30, 2015, Upper Chesapeake terminated the defined benefit pension plan and

liquidation of its remaining benefit obligation using its plan assets will be completed by June 30, 2017. The benefit obligations for the year ended June 30, 2016 represents the annuities to be transferred.

On June 30, 2015, the Corporation amended the *Baltimore Washington Medical Center Pension Plan* to provide for the merger of the Midtown Plan and the Charles Regional Plan into the Baltimore Washington Plan and to change the name of the newly consolidated plan to the *University of Maryland Medical System Corporate Pension Plan* (the Corporate Plan). All provisions of the respective previous plans shall continue to apply to the respective applicable participants. In addition, as of June 30, 2015, all of the assets of the three formerly separate plans that were previously available only to pay benefits for their separate plan participants are now available to pay benefits for all participants under the newly consolidated Corporate 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 sheets. 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 tables set forth the combined benefit obligations and assets of the defined benefit plans at June 30 (in thousands):

		2016	2015
Change in projected benefit obligations:			
Benefit obligations at beginning of year	$	259,170	256,487
Settlements		(29,962)	(1,551)
Service cost		4,146	4,296
Interest cost		10,698	11,318
Actuarial loss		20,072	5,090
Benefit payments		(18,438)	(16,470)
Projected benefit obligations at end of year	$	245,686	259,170

		2016	2015
Change in plan assets:			
Fair value of plan assets at beginning of year	$	233,689	233,218
Actual return on plan assets		5,688	6,919
Settlements		(29,962)	(1,551)
Employer contributions		11,948	11,573
Benefit payments		(18,438)	(16,470)
Fair value of plan assets at end of year	$	202,925	233,689

(Continued)

The funded status of the plans and amounts recognized as accrued payroll and benefits and other long-term liabilities in the consolidated balance sheets at June 30 are as follows (in thousands):

		2016	2015
Funded status, end of period:			
Fair value of plan assets	$	202,925	233,689
Projected benefit obligations		245,686	259,170
Net funded status	$	(42,761)	(25,481)
Accumulated benefit obligation at end of year	$	239,375	253,362
Amounts recognized in consolidated balance sheets at June 30:			
Accrued payroll and benefits	$	(1,250)	—
Accrued pension obligation		(41,511)	(25,481)
	$	(42,761)	(25,481)

		2016	2015
Amounts recognized in unrestricted net assets at June 30:			
Net actuarial loss	$	(96,423)	(85,613)
Prior service cost		(648)	(815)
	$	(97,071)	(86,428)

The estimated amounts that will be amortized from unrestricted net assets into net periodic pension cost in fiscal 2016 are as follows:

Net actuarial loss	$	6,049
Prior service cost		162
	$	6,211

(Continued)

The components of net periodic pension cost for the years ended June 30 are as follows (in thousands):

		2016	2015
Service cost	$	4,146	4,295
Interest cost		10,698	11,318
Expected return on plan assets		(14,169)	(16,084)
Prior service cost recognized		67	171
Recognized gains or losses		17,743	6,094
Net periodic pension cost	$	18,485	5,794

The following table presents the weighted average assumptions used to determine benefit obligations for the plans at June 30:

	2016	2015
Discount rate	2.00%–3.95%	3.00%–4.61%
Rate of compensation increase (for nonfrozen plan)	2.50–4.50	2.50–4.50

The following table presents the weighted average assumptions used to determine net periodic benefit cost for the plans for the years ended June 30:

	2016	2015
Discount rate	3.00%–4.62%	4.40%–4.62%
Expected long-term return on plan assets	4.75–6.75	6.50–7.00
Rate of compensation increase (for nonfrozen plan)	2.50–4.50	2.50–4.50

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 considers the current level of expected returns on risk-free investments, the historical level of the risk premium 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 is then weighted based on the target allocation to develop the expected long-term rate of return on assets assumption for the portfolio.

(Continued)

The Corporation's pension plans' target allocation and weighted average asset allocations at the measurement date of June 30, 2016 and 2015, by asset category, are as follows:

Asset category	Target allocation	Percentage of plan assets as of June 30	
		2016	2015
Cash and cash equivalents	0–10%	9%	3%
Fixed income securities	40–60	47	42
Equity securities	10–30	20	34
Global asset allocation	10–20	20	16
Hedge funds	5–15	4	5
		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.

The table below presents the Corporation's combined investable assets of the defined benefit pension plans as of June 30, 2016 aggregated by the three level valuation hierarchy as described in note 1(w) (in thousands):

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 10,919	7,250	—	18,169
Corporate bonds	22,419	—	—	22,419
Gov't and agency bonds	21,218	—	—	21,218
Fixed income mutual funds	11,763	—	—	11,763
Common and preferred stocks	11,736	—	—	11,736
Equity mutual funds	19,627	—	—	19,627
Other mutual funds	11,852	—	—	11,852
Alternative investments	—	48,896	37,245	86,141
	$ 109,534	56,146	37,245	202,925

(Continued)

The table below presents the Corporation's combined investable assets of the defined benefit pension plans as of June 30, 2015, aggregated by the three level valuation hierarchy as described in note 1(w) (in thousands):

	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 3,931	3,533	—	7,464
Corporate bonds	27,213	—	—	27,213
Gov't and agency bonds	15,619	—	—	15,619
Fixed income mutual funds	30,183	—	—	30,183
Common and preferred stocks	30,051	—	—	30,051
Equity mutual funds	41,710	—	—	41,710
Other mutual funds	8,834	—	—	8,834
Alternative investments	—	31,208	41,407	72,615
	$ 157,541	34,741	41,407	233,689

Changes to Level 1 and Level 2 inputs between June 30, 2016 and 2015 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 (in thousands):

	Hedge funds
Balance as of June 30, 2014	$ 19,954
Additions/purchases	21,255
Withdrawals/sales	(151)
Net change in value	349
Balance as of June 30, 2015	41,407
Additions/purchases	2,830
Withdrawals/sales	(4,528)
Net change in value	(2,464)
Balance as of June 30, 2016	$ 37,245

The hedge fund-of-funds alternative investments held as of June 30, 2016 are subject to notice requirements of 30 days or less and are available to be redeemed on at least a monthly basis with the exception of one fund, totaling $7,300,000, which is subject to 70-day notice requirements and can be redeemed on a quarterly basis. None of the alternative investments are subject to any lock-up restrictions.

The Corporation expects to contribute $8,000,000 to its defined benefit pension plans for the fiscal year ending June 30, 2017.

(Continued)

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):

2017	$	66,685
2018		10,576
2019		10,597
2020		11,173
2021		11,267
2022–2026		70,928

The expected benefits to be paid are based on the same assumptions used to measure the Corporation's benefit obligation at June 30, 2016.

(b) Defined Contribution Plans

Corporation Pension Plan – A noncontributory defined contribution plan for all eligible Corporation employees not participating in the ROI Plan or the Midtown 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 ROI Plan or the Midtown 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 ROI employees hired prior to a certain date in 1996. Employee contributions to this plan are eligible for a matching contribution by ROI after participating employees have completed two years of credited service.

Midtown 401(k) Profit Sharing Plan for Union Employees – Defined contribution plan for substantially all union employees of Midtown. 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.

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.

Charles Regional Retirement Savings Plan – A contributory benefit plan covering substantially all full-time employees of Charles Regional. Employees are eligible for matching contributions after three years of service as defined in the plan.

Upper Chesapeake Retirement Plan – A defined contribution benefit plan which allows employees of Upper Chesapeake to contribute amounts tax-deferred up to certain limits allowable under IRS guidelines. Upper Chesapeake is required to match up to 100% of employee contributions up to 4% of employees' salaries, based on years of service. Upper Chesapeake is also required to make a contribution of 1% of each employee's salary for all employees who work more than 1,000 hours annually. Additional contributions are required to be made by Upper Chesapeake for employees aged 50 and older, who have completed 10 years of service. Employees vest in amounts contributed by Upper Chesapeake ratably over a five-year period.

Total annual retirement costs incurred by the Corporation for the previously discussed defined contribution plans were $40,064,000 and $38,163,000 for the years ended June 30, 2016 and 2015, 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):

		2016	2015
Facility construction and renovations, research, education, and other	$	58,380	56,223
Economic and beneficial interests in the net assets of related organizations		187,885	189,430
	$	246,265	245,653

Net assets were released from donor restrictions during the years ended June 30, 2016 and 2015 by expending funds satisfying the restricted purposes or by occurrence of other events specified by donors as follows (in thousands):

		2016	2015
Purchases of equipment and construction costs	$	10,417	17,654
Research, education, uncompensated care, and other		7,067	5,813
	$	17,484	23,467

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.

(Continued)

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, 2016			
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds	$ —	11,232	37,065	48,297

	June 30, 2015			
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds	$ —	13,265	36,201	49,466

(Continued)

(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):

	2016	2015
Economic interests in:		
UCH Legacy Funding Corporation	$ 150,000	150,000
The James Lawrence Kernan Hospital Endowment Fund, Incorporated	26,821	29,304
Baltimore Washington Medical Center Foundation, Inc.	7,960	7,022
Total economic interests	184,781	186,326
Beneficial interest in the net assets of Dorchester General Hospital Foundation, Inc.	3,104	3,104
	$ 187,885	189,430

The UCH Legacy Funding Corporation was formed in December 2013 to hold funds restricted for the benefit of Upper Chesapeake.

At the discretion of its board of trustees, the Kernan Endowment Fund may pledge securities to satisfy various collateral requirements on behalf of ROI and may provide funding to ROI 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.

Shore Regional maintains a beneficial interest in the net assets of Dorchester Foundation, a nonprofit corporation organized to raise funds on behalf of Dorchester Hospital. Shore Regional 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):

	2016	2015
Current assets	$ 2,891	3,700
Noncurrent assets	185,672	186,211
Total assets	$ 188,563	189,911
Current liabilities	$ 452	128
Noncurrent liabilities	226	353
Net assets	187,885	189,430
Total liabilities and net assets	$ 188,563	189,911

(Continued)

	2016	2015
Total operating revenue	$ 2,165	1,355
Total operating expense	(4,344)	(3,997)
Other changes in net assets	634	528
Total decrease in net assets	$ (1,545)	(2,114)

(13) State Support

The Corporation received $3,200,000 in support for the Shock Trauma Center operations from the State of Maryland, for the years ended June 30, 2016 and 2015.

The State of Maryland appropriates funds for construction costs incurred, equipment purchases made, and other capital support. The Corporation recognizes this support as the funds are expended for the intended projects. The Corporation expended and recorded $4,364,000 and $14,261,000 during the years ended June 30, 2016 and 2015, respectively.

(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):

	2016	2015
Healthcare services	$ 3,144,882	2,876,799
General and administrative	436,820	379,035
	$ 3,581,702	3,255,834

(Continued)

(15) Insurance

The Corporation maintains self-insurance programs for professional and general liability risks, employee health, employee long-term disability, and workers' compensation. Estimated liabilities have been recorded based on actuarial estimation of reported and incurred but not reported claims. The accrued liabilities for these programs as of June 30, 2016 and 2015 were as follows (in thousands):

	2016	2015
Professional and general malpractice liabilities	$ 235,871	206,072
Employee health	27,656	27,323
Employee long-term disability	12,661	15,219
Workers' compensation	17,610	19,027
Total self-insured liabilities	293,798	267,641
Less current portion	(68,500)	(68,596)
	$ 225,298	199,045

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. These accrued malpractice losses are discounted using a discount rate of 2.5%. In management's opinion, these accruals provide an adequate and appropriate loss reserve. The professional and general malpractice liabilities presented above include $141,625,000 and $129,185,000 as of June 30, 2016 and 2015, respectively, for which related insurance receivables have been recorded within other assets on the accompanying consolidated balance sheets.

The Corporation and each of 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 $125 million individually and $125 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 Faculty Physicians, Inc.

Total malpractice insurance expense for the Corporation during the years ended June 30, 2016 and 2015 was approximately $40,359,000 and $46,112,000, respectively.

(Continued)

(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 maintains cash accounts with highly rated financial institutions, which generally exceed federally insured limits. The Corporation has not experienced any losses from maintaining cash accounts in excess of federally insured limits, and as such, management does not believe the Corporation is subject to any significant credit risks related to this practice.

The Corporation had gross receivables from patients and third-party payors as follows at June 30:

	2016	2015
Medicare	25%	24%
Medicaid	25	25
Commercial insurance and HMOs	19	18
Blue Cross	11	10
Self-pay and others	20	23
	100%	100%

The Corporation recorded gross revenues from patients and third-party payors for the years ended June 30 as follows:

	2016	2015
Medicare	38%	39%
Medicaid	23	22
Commercial insurance and HMOs	19	19
Blue Cross	14	15
Self-pay and others	6	5
	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;

(Continued)

- 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.

The general healthcare industry environment is increasingly uncertain, especially with respect to the impact of Federal healthcare reform legislation, which was passed in 2010 and largely upheld by the U.S. Supreme Court in June 2012. Potential impacts of ongoing healthcare industry transformation include, but are not limited to (1) significant capital investments in healthcare information technology, (2) continuing volatility in the state and federal government reimbursement programs, (3) lack of clarity related to the health benefit exchange framework mandated by reform legislation, including important open questions regarding exchange reimbursement levels, and impact on the healthcare "demand curve" as the previously uninsured enter the insurance system, and (4) effective management of multiple major regulatory mandates, including the transition to ICD-10. This Federal healthcare reform legislation does not affect the consolidated financial statements for the year ended June 30, 2016.

(18) Maryland Health Services Cost Review Commission (HSCRC)

Effective July 1, 2013, the Health System and the Health Services Cost Review Commission (HSCRC) agreed to implement the Global Budget Revenue (GBR) methodology for the following hospitals: Medical Center, ROI, Midtown, Baltimore Washington, Charles Regional, St. Joseph, Shore Emergency Center, and Upper Chesapeake. The agreements will continue each year and on July 1 of each year thereafter, the agreements will renew for a one-year period unless it is canceled by the HSCRC or by the Corporation. The agreements were in place for the years ended June 30, 2016 and 2015. The GBR model is a revenue constraint and quality improvement system designed by the HSCRC to provide hospitals with strong financial incentives to manage their resources efficiently and effectively in order to slow the rate of increase in healthcare costs and improve healthcare delivery processes and outcomes. The GBR model is consistent with the Corporation's mission to provide the highest value of care possible to its patients and the communities it serves.

The GBR agreements establish a prospective, fixed revenue base "GBR cap" for the upcoming year. This includes both inpatient and outpatient regulated services. Under GBR, a hospital's revenue for all HSCRC regulated services is predetermined for the upcoming year, regardless of changes in volume, service mix intensity, or mix of inpatient or outpatient services that occurred during the year. The GBR agreement allows the Corporation to adjust unit rates, within certain limits, to achieve the overall revenue base for the Corporation at year end. Any overcharge or undercharge versus the GBR cap is prospectively added to the subsequent year's GBR cap. Although the GBR cap does not adjust for changes in volume or service mix, the GBR cap is adjusted annually for inflation, and for changes in payor mix and uncompensated care. The Corporation will receive an annual adjustment to its cap for the change in population in the Corporation's service areas. GBR is designed to encourage hospitals to operate efficiently by reducing utilization and managing patients in the appropriate care delivery setting. The HSCRC also may impose various other revenue adjustments which could be significant in the future.

For the years ended June 30, 2016 and 2015, Memorial Hospital, Dorchester Hospital, and CRHC continued their participation in 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. GBR and TPR are generally the same concept.

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, 2016 and 2015, the Corporation recognized a net distribution from the pool of $11,521,000 and $19,264,000, respectively, which is recorded as net patient service revenue.

(19) Subsequent Events

The Corporation evaluated all events and transactions that occurred after June 30, 2016 and through October 27, 2016, the date the consolidated financial statements were issued. Other than described below, the Corporation did not have any material recognizable subsequent events during the period.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2016

(In thousands)

Assets	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	Upper Chesapeake	UM Health Plans	UMMS Foundation	Community Med. Group	ECARE	Eliminations	Consolidated total
Current assets:														
Cash and cash equivalents	$ 385,209	6,218	11,907	28,231	22,038	13,790	3,910	49,428	1,540	—	898	—	—	523,169
Assets limited as to use, current portion	47,477	—	528	1,183	860	404	960	—	—	—	—	—	—	51,412
Accounts receivable:														
Patient accounts receivable, less allowance for doubtful accounts of $202,183	168,672	9,849	16,255	35,459	17,894	7,721	34,817	35,816	—	—	4,572	—	—	331,055
Other	172,525	9,666	15,991	40,626	14,838	2,786	14,345	9,377	22,770	—	2,147	209	(207,393)	97,887
Inventories	28,226	1,072	2,860	6,150	4,776	1,487	5,560	9,607	—	—	—	—	—	59,738
Prepaid expenses and other current assets	12,806	128	325	1,480	1,550	477	1,833	4,140	776	1,500	324	42	—	25,381
Total current assets	814,915	26,933	47,866	113,129	61,956	26,665	61,425	108,368	25,086	1,500	7,941	251	(207,393)	1,088,642
Investments	195,252	25,304	—	121,768	80,315	30,003	10,341	172,343	10,208	—	—	—	—	645,534
Assets limited as to use, less current portion:														
Investments held for collateral	125,487	—	3,700	8,000	—	—	—	40,811	—	—	—	—	—	177,998
Debt service funds	22,290	—	—	—	—	—	—	—	—	—	—	—	—	22,290
Construction funds	335	10,360	5,259	4,995	4,772	10,449	5,816	—	—	—	—	—	—	41,986
Board designated and escrow funds	—	—	—	—	78,209	3,576	—	17,757	—	17,950	10	—	—	117,502
Self-insurance trust funds	53,064	—	16,337	23,205	28,738	4,820	10,107	11,066	—	—	—	—	—	147,337
Funds restricted by donor	—	—	1,113	—	29,598	—	1,057	—	—	23,413	—	—	—	55,181
Economic and beneficial interests in the net assets of related organizations	197,438	28,355	437	7,960	3,105	—	9,503	—	—	—	—	—	(58,913)	187,885
	398,614	38,715	26,846	44,160	144,422	18,845	26,483	69,634	—	41,363	10	—	(58,913)	750,179
Property and equipment, net	913,959	48,190	99,309	262,303	178,578	97,781	210,395	259,210	5,306	—	9,346	2,169	—	2,086,546
Investments in joint ventures and other assets	676,735	—	12,908	18,733	9,875	7,919	17,579	218,812	86,587	6,561	—	—	(660,528)	395,181
Total assets	$ 2,999,475	139,142	186,929	560,093	475,146	181,213	326,223	828,367	127,187	49,424	17,297	2,420	(926,834)	4,966,082

(Continued)

Schedule 1

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2016

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	Upper Chesapeake	UM Health Plans	UMMS Foundation	Community Med. Group	ECARE	Eliminations	Consolidated total
Current liabilities:														
Trade accounts payable	$ 127,944	7,961	14,452	21,089	17,971	9,361	29,367	16,663	109	14	4,461	151	—	249,543
Accrued payroll and benefits	119,204	5,181	12,501	25,273	22,335	3,944	28,124	25,470	1,656	—	9,649	—	—	253,337
Advances from third-party payors	72,546	2,910	9,660	9,667	6,789	3,735	10,633	8,777	—	—	—	—	—	124,717
Lines of credit	180,000	—	—	—	—	—	—	—	—	—	—	—	—	180,000
Short-term financing	150,000	—	—	—	—	—	—	—	—	—	—	—	—	150,000
Other current liabilities	86,581	1,268	7,565	43,706	7,304	7,742	82,502	63,259	40,129	—	5,685	9,174	(207,393)	147,522
Long-term debt subject to short-term remarketing arrangements	32,515	—	—	—	—	—	—	—	—	—	—	—	—	32,515
Current portion of long-term debt	11,846	465	719	3,870	3,213	2,875	5,159	4,445	5,000	—	—	—	—	37,592
Total current liabilities	780,636	17,785	44,897	103,605	57,612	27,657	155,785	118,614	46,894	14	19,795	9,325	(207,393)	1,175,226
Long-term debt, less current portion	566,363	20,991	33,022	168,096	88,243	60,306	242,609	201,307	41,667	—	—	—	—	1,422,604
Other long-term liabilities	124,130	144	29,724	47,978	22,971	16,918	15,652	41,788	53,300	—	—	—	—	352,605
Interest rate swap liabilities	273,037	—	—	—	—	—	—	—	—	—	—	—	—	273,037
Total liabilities	1,744,166	38,920	107,643	319,679	168,826	104,881	414,046	361,709	141,861	14	19,795	9,325	(207,393)	3,223,472
Net assets:														
Unrestricted	1,035,728	71,734	77,736	232,454	267,012	76,239	(97,860)	308,990	(14,674)	22,599	(2,498)	(6,905)	(511,275)	1,459,280
Temporarily restricted	217,892	28,488	1,550	7,960	23,811	93	9,375	156,392	—	7,594	—	—	(206,890)	246,265
Permanently restricted	1,689	—	—	—	15,497	—	662	1,276	—	19,217	—	—	(1,276)	37,065
Total net assets	1,255,309	100,222	79,286	240,414	306,320	76,332	(87,823)	466,658	(14,674)	49,410	(2,498)	(6,905)	(719,441)	1,742,610
Total liabilities and net assets	$ 2,999,475	139,142	186,929	560,093	475,146	181,213	326,223	828,367	127,187	49,424	17,297	2,420	(926,834)	4,966,082

See accompanying independent auditors' report.

Schedule 1-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Medical Center & Affiliates (UMMC)

June 30, 2016

(In thousands)

Assets	University of Maryland Medical Center	University Specialty	36 South Paca	University CARE	Eliminations	University of Maryland Medical Center & Affiliates consolidated total
Current assets:						
Cash and cash equivalents	$ 383,678	—	1,531	—	—	385,209
Assets limited as to use, current portion	44,007	—	—	3,470	—	47,477
Accounts receivable:						
Patient accounts receivable, less allowance for doubtful accounts of $83,604	168,652	—	—	20	—	168,672
Other	178,002	—	97	22	(5,596)	172,525
Inventories	28,187	—	—	39	—	28,226
Prepaid expenses and other current assets	12,789	—	—	17	—	12,806
Total current assets	815,315	—	1,628	3,568	(5,596)	814,915
Investments	195,252	—	—	—	—	195,252
Assets limited as to use, less current portion:						
Investment held for collateral	125,487	—	—	—	—	125,487
Debt service funds	22,290	—	—	—	—	22,290
Construction funds	335	—	—	—	—	335
Board designated and escrow funds	—	—	—	—	—	—
Self-insurance trust funds	53,064	—	—	—	—	53,064
Funds restricted by donor	—	—	—	—	—	—
Economic interests in the net assets of related organizations	197,438	—	—	—	—	197,438
	398,614	—	—	—	—	398,614
Property and equipment, net	905,247	—	8,653	59	—	913,959
Investments in joint ventures and other assets	683,709	—	3,277	—	(10,251)	676,735
Total assets	$ 2,998,137	—	13,558	3,627	(15,847)	2,999,475

(Continued)

Schedule 1-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Medical Center & Affiliates (UMMC)

June 30, 2015

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center	University Specialty	36 South Paca	University CARE	Eliminations	University of Maryland Medical Center & Affiliates consolidated total
Current liabilities:						
Trade accounts payable	$ 126,770	—	142	1,032	—	127,944
Accrued payroll and benefits	119,166	—	—	38	—	119,204
Advances from third-party payors	72,546	—	—	—	—	72,546
Lines of credit	180,000	—	—	—	—	180,000
Short-term financing	150,000	—	—	—	—	150,000
Other current liabilities	86,475	—	5,021	681	(5,596)	86,581
Long-term debt subject to short-term remarketing arrangements	32,515	—	—	—	—	32,515
Current portion of long-term debt	11,846	—	—	—	—	11,846
Total current liabilities	779,318	—	5,163	1,751	(5,596)	780,636
Long-term debt, less current portion	566,363	—	—	—	—	566,363
Other long-term liabilities	124,114	—	16	—	—	124,130
Interest rate swaps	273,037	—	—	—	—	273,037
Total liabilities	1,742,832	—	5,179	1,751	(5,596)	1,744,166
Net assets:						
Unrestricted	1,035,724	—	8,379	1,876	(10,251)	1,035,728
Temporarily restricted	217,892	—	—	—	—	217,892
Permanently restricted	1,689	—	—	—	—	1,689
Total net assets	1,255,305	—	8,379	1,876	(10,251)	1,255,309
Total liabilities and net assets	$ 2,998,137	—	13,558	3,627	(15,847)	2,999,475

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Midtown Health, Inc. (Midtown)

June 30, 2016

(In thousands)

Assets	UM Midtown Health Systems, Inc.	UMMC Midtown Campus	UM Midtown Clin. Prac. Group	Eliminations	Midtown consolidated total
Current assets:					
Cash and cash equivalents	$ 145	11,362	400	—	11,907
Assets limited as to use, current portion	—	528	—	—	528
Accounts receivable:					
Patient accounts receivable, less allowance for doubtful accounts of $17,676	—	15,268	987	—	16,255
Other	1,698	14,293	—	—	15,991
Inventories	—	2,860	—	—	2,860
Prepaid expenses and other current assets	6	319	—	—	325
Total current assets	1,849	44,630	1,387	—	47,866
Investments	—	—	—	—	—
Assets limited as to use, less current portion:					
Investment held for collateral	—	3,700	—	—	3,700
Debt service funds	—	—	—	—	—
Construction funds	—	5,259	—	—	5,259
Board designated and escrow funds	—	—	—	—	—
Self-insurance trust funds	—	16,337	—	—	16,337
Funds restricted by donor	—	1,113	—	—	1,113
Economic interests in the net assets of related organizations	—	437	—	—	437
	—	26,846	—	—	26,846
Property and equipment, net	2,007	97,302	—	—	99,309
Investments in joint ventures and other assets	5,103	7,805	—	—	12,908
Total assets	$ 8,959	176,583	1,387	—	186,929

(Continued)

Schedule 1-b

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Midtown Health, Inc. (Midtown)

June 30, 2016

(In thousands)

Liabilities and Net Assets	UM Midtown Health Systems, Inc.	UMMC Midtown Campus	UM Midtown Clin. Prac. Group	Eliminations	Midtown consolidated total
Current liabilities:					
Trade accounts payable	$ 16	14,432	4	—	14,452
Accrued payroll and benefits	—	12,501	—	—	12,501
Advances from third-party payors	—	9,660	—	—	9,660
Lines of credit	—	—	—	—	—
Other current liabilities	513	5,676	1,376	—	7,565
Current portion of long-term debt	—	719	—	—	719
Total current liabilities	529	42,988	1,380	—	44,897
Long-term debt, less current portion	368	32,654	—	—	33,022
Other long-term liabilities	—	29,724	—	—	29,724
Total liabilities	897	105,366	1,380	—	107,643
Net assets:					
Unrestricted	8,062	69,667	7	—	77,736
Temporarily restricted	—	1,550	—	—	1,550
Permanently restricted	—	—	—	—	—
Total net assets	8,062	71,217	7	—	79,286
Total liabilities and net assets	$ 8,959	176,583	1,387	—	186,929

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, 2016

(In thousands)

Assets	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Shipley's	Eliminations	BWMS consolidated total
Current assets:								
Cash and cash equivalents	$ —	27,186	489	—	556	—	—	28,231
Assets limited as to use, current portion	—	1,183	—	—	—	—	—	1,183
Accounts receivable:								
Patient accounts receivable, less allowance for doubtful accounts of $33,925	—	29,646	5,007	806	—	—	—	35,459
Other	25,305	1,926	11,924	2,000	(529)	—	—	40,626
Inventories	—	6,150	—	—	—	—	—	6,150
Prepaid expenses and other current assets	—	1,261	22	281	(84)	—	—	1,480
Total current assets	25,305	67,352	17,442	3,087	(57)	—	—	113,129
Investments	—	121,768	—	—	—	—	—	121,768
Assets limited as to use, less current portion:								
Investment held for collateral	—	8,000	—	—	—	—	—	8,000
Debt service funds	—	—	—	—	—	—	—	—
Construction funds	—	4,995	—	—	—	—	—	4,995
Board designated and escrow funds	—	—	—	—	—	—	—	—
Self-insurance trust funds	—	23,205	—	—	—	—	—	23,205
Funds restricted by donor	—	—	—	—	—	—	—	—
Economic interests in the net assets of related organizations	—	7,960	—	—	—	—	—	7,960
	—	44,160	—	—	—	—	—	44,160
Property and equipment, net	—	241,592	—	3,030	17,681	—	—	262,303
Investments in joint ventures and other assets	223,636	18,703	—	1	26	—	(223,633)	18,733
Total assets	$ 248,941	493,575	17,442	6,118	17,650	—	(223,633)	560,093

(Continued)

Schedule 1-c

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Baltimore Washington Medical System (BWMS)

June 30, 2016

(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	Shipley's	Eliminations	BWMS consolidated total
Current liabilities:								
Trade accounts payable	$ —	21,886	257	672	(1,726)	—	—	21,089
Accrued payroll and benefits	1,302	23,101	870	—	—	—	—	25,273
Advances from third-party payors	—	9,667	—	—	—	—	—	9,667
Lines of credit	—	—	—	—	—	—	—	—
Other current liabilities	—	37,506	—	6,146	54	—	—	43,706
Current portion of long-term debt	—	3,645	—	—	225	—	—	3,870
Total current liabilities	1,302	95,805	1,127	6,818	(1,447)	—	—	103,605
Long-term debt, less current portion	—	165,078	—	—	3,018	—	—	168,096
Other long-term liabilities	—	46,874	—	1,291	(187)	—	—	47,978
Total liabilities	1,302	307,757	1,127	8,109	1,384	—	—	319,679
Net assets:								
Unrestricted	247,639	177,858	16,315	(1,991)	16,266	—	(223,633)	232,454
Temporarily restricted	—	7,960	—	—	—	—	—	7,960
Permanently restricted	—	—	—	—	—	—	—	—
Total net assets	247,639	185,818	16,315	(1,991)	16,266	—	(223,633)	240,414
Total liabilities and net assets	$ 248,941	493,575	17,442	6,118	17,650	—	(223,633)	560,093

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Shore Regional Health (Shore Regional)

June 30, 2016

(In thousands)

Assets	Shore Health System, Inc.	UM Shore Home Care	Queenstown ASC	UM Shore Nursing and Rehab.	Memorial Hospital Foundation, Inc. and Subsidiary	Chester River Consolidated Total	Eliminations	Shore Regional consolidated total
Current assets:								
Cash and cash equivalents	$ 14,619	34	1	1,474	—	5,910	—	22,038
Assets limited as to use, current portion	627	—	—	—	—	233	—	860
Accounts receivable:								
Patient accounts receivable, less allowance for doubtful accounts of $17,977	12,830	446	90	384	—	4,144	—	17,894
Other	6,296	2,007	—	5	3,502	3,028	—	14,838
Inventories	4,077	—	—	—	—	699	—	4,776
Prepaid expenses and other current assets	1,429	18	—	—	35	68	—	1,550
Total current assets	39,878	2,505	91	1,863	3,537	14,082	—	61,956
Investments	67,312	—	—	—	400	12,603	—	80,315
Assets limited as to use, less current portion:								
Debt service funds	—	—	—	—	—	—	—	—
Construction funds	234	—	—	—	—	4,538	—	4,772
Board designated and escrow funds	25,000	—	—	—	45,986	7,223	—	78,209
Self-insurance trust funds	22,603	—	—	84	—	6,051	—	28,738
Funds restricted by donor	4,683	—	—	—	22,004	2,911	—	29,598
Economic and beneficial interests in the net assets of related organizations	78,090	—	—	68	—	5,499	(80,552)	3,105
	130,610	—	—	152	67,990	26,222	(80,552)	144,422
Property and equipment, net	145,237	327	14	1,736	3,300	27,964	—	178,578
Investments in joint ventures and other assets	10,395	—	—	—	17	2,077	(2,614)	9,875
Total assets	$ 393,432	2,832	105	3,751	75,244	82,948	(83,166)	475,146

(Continued)

Schedule 1-d

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Shore Regional Health (Shore Regional)

June 30, 2016

(In thousands)

Liabilities and Net Assets	Shore Health System, Inc.	UM Shore Home Care	Queenstown ASC	UM Shore Nursing and Rehab.	Memorial Hospital Foundation, Inc. and Subsidiary	Chester River Consolidated Total	Eliminations	Shore Regional consolidated total
Current liabilities:								
Trade accounts payable	$ 13,688	7	10	642	6	3,618	—	17,971
Accrued payroll and benefits	18,990	219	—	274	24	2,828	—	22,335
Advances from third-party payors	5,946	—	—	65	—	778	—	6,789
Lines of credit	—	—	—	—	—	—	—	—
Other current liabilities	2,147	(8)	96	768	229	4,072	—	7,304
Current portion of long-term debt	3,087	—	—	30	—	96	—	3,213
Total current liabilities	43,858	218	106	1,779	259	11,392	—	57,612
Long-term debt, less current portion	83,786	—	—	45	—	4,412	—	88,243
Other long-term liabilities	12,696	—	—	266	—	10,009	—	22,971
Total liabilities	140,340	218	106	2,090	259	25,813	—	168,826
Net assets:								
Unrestricted	216,600	2,614	(1)	1,625	46,282	51,577	(51,685)	267,012
Temporarily restricted	22,283	—	—	36	17,490	2,982	(18,980)	23,811
Permanently restricted	14,209	—	—	—	11,213	2,576	(12,501)	15,497
Total net assets	253,092	2,614	(1)	1,661	74,985	57,135	(83,166)	306,320
Total liabilities and net assets	$ 393,432	2,832	105	3,751	75,244	82,948	(83,166)	475,146

See accompanying independent auditors' report.

Schedule 1-e

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Chester River Health System, Inc. (CRHS) a subsidiary of Shore Regional Health

June 30, 2016

(In thousands)

Assets	Chester River Hospital Center	Chester River Manor	UM Chester River Home Care	Chester River Health Foundation	Chester River consolidated total
Current assets:					
Cash and cash equivalents	$ 5,214	—	696	—	5,910
Assets limited as to use, current portion	233	—	—	—	233
Accounts receivable:					
Patient accounts receivable, less allowance for doubtful accounts of $2,294	3,928	—	216	—	4,144
Other	2,964	—	42	22	3,028
Inventories	699	—	—	—	699
Prepaid expenses and other current assets	63	—	5	—	68
Total current assets	13,101	—	959	22	14,082
Investments	10,461	—	1,413	729	12,603
Assets limited as to use, less current portion:					
Debt service funds	—	—	—	—	—
Construction funds	4,538	—	—	—	4,538
Board designated and escrow funds	5,000	—	—	2,223	7,223
Self-insurance trust funds	6,051	—	—	—	6,051
Funds restricted by donor	105	—	—	2,806	2,911
Economic interests in the net assets of related organizations	5,196	—	303	—	5,499
	20,890	—	303	5,029	26,222
Property and equipment, net	27,736	—	228	—	27,964
Investments in joint ventures and other assets	2,077	—	—	—	2,077
Total assets	$ 74,265	—	2,903	5,780	82,948

(Continued)

Schedule 1-e

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Chester River Health System, Inc. (CRHS) a subsidiary of Shore Regional Health

June 30, 2016

(In thousands)

Liabilities and Net Assets	Chester River Hospital Center	Chester River Manor	UM Chester River Home Care	Chester River Health Foundation	Chester River consolidated total
Current liabilities:					
Trade accounts payable	$ 3,546	—	58	14	3,618
Accrued payroll and benefits	2,694	—	134	—	2,828
Advances from third-party payors	778	—	—	—	778
Lines of credit	—	—	—	—	—
Other current liabilities	3,873	—	—	199	4,072
Current portion of long-term debt	96	—	—	—	96
Total current liabilities	10,987	—	192	213	11,392
Long-term debt, less current portion	4,412	—	—	—	4,412
Other long-term liabilities	10,009	—	—	—	10,009
Total liabilities	25,408	—	192	213	25,813
Net assets:					
Unrestricted	46,082	—	2,707	2,788	51,577
Temporarily restricted	1,487	—	4	1,491	2,982
Permanently restricted	1,288	—	—	1,288	2,576
Total net assets	48,857	—	2,711	5,567	57,135
Total liabilities and net assets	$ 74,265	—	2,903	5,780	82,948

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Charles Regional Health System, Inc. (Charles Regional)

June 30, 2016

(In thousands)

Assets	Charles Regional Health, Inc.	Charles Regional Medical Center, Inc.	Charles Regional Urgent Care	Charles Regional Care Partners, Inc. and Subsidiary	Charles Regional Health Foundation, Inc.	Eliminations	Charles Regional consolidated total
Current assets:							
Cash and cash equivalents	$ 79	11,285	614	431	1,381	—	13,790
Assets limited as to use, current portion	—	404	—	—	—	—	404
Accounts receivable:							
Patient accounts receivable, less allowance for doubtful accounts of $6,908	—	7,390	331	—	—	—	7,721
Other	2,726	976	—	(921)	5	—	2,786
Inventories	—	1,487	—	—	—	—	1,487
Prepaid expenses and other current assets	—	478	2	—	(3)	—	477
Total current assets	2,805	22,020	947	(490)	1,383	—	26,665
Investments	—	27,923	—	—	2,080	—	30,003
Assets limited as to use, less current portion:							
Debt service funds	—	—	—	—	—	—	—
Construction funds	—	10,449	—	—	—	—	10,449
Board designated and escrow funds	3,576	—	—	—	—	—	3,576
Self-insurance trust funds	—	4,820	—	—	—	—	4,820
Funds restricted by donor	—	—	—	—	—	—	—
Economic interests in the net assets of related organizations	—	4,898	—	—	—	(4,898)	—
	3,576	20,167	—	—	—	(4,898)	18,845
Property and equipment, net	20,016	74,373	753	—	2,639	—	97,781
Investments in joint ventures and other assets	904	6,985	—	30	—	—	7,919
Total assets	$ 27,301	151,468	1,700	(460)	6,102	(4,898)	181,213

(Continued)

Schedule 1-f

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Charles Regional Health System, Inc. (Charles Regional)

June 30, 2016

(In thousands)

Liabilities and Net Assets	Charles Regional Health, Inc.	Charles Regional Medical Center, Inc.	Charles Regional Urgent Care	Charles Regional Care Partners, Inc. and Subsidiary	Charles Regional Health Foundation, Inc.	Eliminations	Charles Regional consolidated total
Current liabilities:							
Trade accounts payable	$ —	8,996	196	—	169	—	9,361
Accrued payroll and benefits	—	3,944	—	—	—	—	3,944
Advances from third-party payors	—	3,735	—	—	—	—	3,735
Lines of credit	—	—	—	—	—	—	—
Other current liabilities	1,943	3,338	2,185	31	245	—	7,742
Current portion of long-term debt	643	2,207	—	—	25	—	2,875
Total current liabilities	2,586	22,220	2,381	31	439	—	27,657
Long-term debt, less current portion	4,744	54,797	—	—	765	—	60,306
Other long-term liabilities	—	16,918	—	—	—	—	16,918
Total liabilities	7,330	93,935	2,381	31	1,204	—	104,881
Net assets:							
Unrestricted	19,971	57,440	(681)	(491)	4,805	(4,805)	76,239
Temporarily restricted	—	93	—	—	93	(93)	93
Permanently restricted	—	—	—	—	—	—	—
Total net assets	19,971	57,533	(681)	(491)	4,898	(4,898)	76,332
Total liabilities and net assets	$ 27,301	151,468	1,700	(460)	6,102	(4,898)	181,213

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland St. Joseph Health System (SJHS)

June 30, 2016

(In thousands)

Assets	St. Joseph Medical Center	St. Joseph Medical Group	St. Joseph Properties	St. Joseph Orthopaedics	O'Dea Medical Arts	St. Joseph Foundation	Eliminations	St. Joseph consolidated total
Current assets:								
Cash and cash equivalents	$ 1,443	(156)	—	—	1,755	868	—	3,910
Assets limited as to use, current portion	960	—	—	—	—	—	—	960
Accounts receivable:								
Patient accounts receivable, less allowance for doubtful accounts of $17,282	30,765	2,720	—	1,329	3	—	—	34,817
Other	12,345	209	—	50	—	1,741	—	14,345
Inventories	5,537	—	—	23	—	—	—	5,560
Prepaid expenses and other current assets	968	614	(2)	149	104	—	—	1,833
Total current assets	52,018	3,387	(2)	1,551	1,862	2,609	—	61,425
Investments	—	—	—	—	—	10,341	—	10,341
Assets limited as to use, less current portion:								
Debt service funds	—	—	—	—	—	—	—	—
Construction funds	5,816	—	—	—	—	—	—	5,816
Board designated and escrow funds	—	—	—	—	—	—	—	—
Self-insurance trust funds	10,107	—	—	—	—	—	—	10,107
Funds restricted by donor	—	—	—	—	—	1,057	—	1,057
Economic interests in the net assets of related organizations	9,503	—	—	—	—	—	—	9,503
	25,426	—	—	—	—	1,057	—	26,483
Property and equipment, net	197,090	897	177	584	11,647	—	—	210,395
Investments in joint ventures and other assets	14,207	—	2,532	2,846	—	526	(2,532)	17,579
Total assets	$ 288,741	4,284	2,707	4,981	13,509	14,533	(2,532)	326,223

(Continued)

Schedule 1-g

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland St. Joseph Health System (SJHS)

June 30, 2016

(In thousands)

Liabilities and Net Assets	St. Joseph Medical Center	St. Joseph Medical Group	St. Joseph Properties	St. Joseph Orthopaedics	O'Dea Medical Arts	St. Joseph Foundation	Eliminations	St. Joseph consolidated total
Current liabilities:								
Trade accounts payable	$ 27,488	1,625	385	(284)	78	75	—	29,367
Accrued payroll and benefits	23,338	2,235	—	2,551	—	—	—	28,124
Advances from third-party payors	10,633	—	—	—	—	—	—	10,633
Lines of credit	—	—	—	—	—	—	—	—
Other current liabilities	2,984	50,793	4,572	23,990	36	127	—	82,502
Current portion of long-term debt	5,159	—	—	—	—	—	—	5,159
Total current liabilities	69,602	54,653	4,957	26,257	114	202	—	155,785
Long-term debt, less current portion	233,727	—	—	—	8,882	—	—	242,609
Other long-term liabilities	15,652	—	—	—	—	—	—	15,652
Total liabilities	318,981	54,653	4,957	26,257	8,996	202	—	414,046
Net assets:								
Unrestricted	(30,241)	(50,369)	(2,250)	(21,276)	4,513	4,295	(2,532)	(97,860)
Temporarily restricted	1	—	—	—	—	9,374	—	9,375
Permanently restricted	—	—	—	—	—	662	—	662
Total net assets	(30,240)	(50,369)	(2,250)	(21,276)	4,513	14,331	(2,532)	(87,823)
Total liabilities and net assets	$ 288,741	4,284	2,707	4,981	13,509	14,533	(2,532)	326,223

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Upper Chesapeake Health System (UCHS)

June 30, 2016

(In thousands)

Assets	Upper Chesapeake Medical Center	Harford Memorial Hospital	UCHS Properties	Health Ventures	Medical Services	Residential Hospice House	Upper Chesapeake Health Foundation	Upper Chesapeake Health System	Hospice of Harford County	Upper Chesapeake Insurance Co.	Upper Chesapeake Land Trust	Eliminations	Upper Chesapeake consolidated total
Current assets:													
Cash and cash equivalents	$ 29,652	19,400	12	—	319	27	18	—	—	—	—	—	49,428
Assets limited as to use, current portion	—	—	—	—	—	—	—	—	—	—	—	—	—
Accounts receivable:													
Patient accounts receivable, less allowance for doubtful accounts of $19,036	24,013	6,765	—	—	5,035	3	—	—	—	—	—	—	35,816
Other	—	—	—	39	(2)	—	6,905	11	—	2,424	—	—	9,377
Inventories	6,289	2,696	—	—	622	—	—	—	—	—	—	—	9,607
Prepaid expenses and other current assets	1,121	2,144	24	—	829	5	—	17	—	—	—	—	4,140
Total current assets	61,075	31,005	36	39	6,803	35	6,923	28	—	2,424	—	—	108,368
Investments	100,941	70,924	—	—	—	478	—	—	—	—	—	—	172,343
Assets limited as to use, less current portion:													
Investments held for swap collateral	40,811	—	—	—	—	—	—	—	—	—	—	—	40,811
Debt service funds	—	—	—	—	—	—	—	—	—	—	—	—	—
Construction funds	—	—	—	—	—	—	—	—	—	—	—	—	—
Board designated and escrow funds	—	—	—	—	—	—	17,757	—	—	—	—	—	17,757
Self-insurance trust funds	—	—	—	—	—	—	—	—	—	11,066	—	—	11,066
Funds restricted by donor	—	—	—	—	—	—	—	—	—	—	—	—	—
Economic interests in the net assets of related organizations	—	—	—	—	—	—	—	—	—	—	—	—	—
	40,811	—	—	—	—	—	17,757	—	—	11,066	—	—	69,634
Property and equipment, net	220,906	29,442	—	10	2,222	2,019	46	1,564	—	—	3,001	—	259,210
Investments in joint ventures and other assets	225,127	—	—	3,948	5	—	94	—	—	9,079	—	(19,441)	218,812
Total assets	$ 648,860	131,371	36	3,997	9,030	2,532	24,820	1,592	—	22,569	3,001	(19,441)	828,367

(Continued)

Schedule 1-h

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Upper Chesapeake Health System (UCHS)

June 30, 2016

(In thousands)

Liabilities and Net Assets	Upper Chesapeake Medical Center	Harford Memorial Hospital	UCHS Properties	Health Ventures	Medical Services	Residential Hospice House	Upper Chesapeake Health Foundation	Upper Chesapeake Health System	Hospice of Harford County	Upper Chesapeake Insurance Co.	Upper Chesapeake Land Trust	Eliminations	Upper Chesapeake consolidated total
Current liabilities:													
Trade accounts payable	$ 7,192	6,795	—	—	2,223	—	—	421	—	32	—	—	16,663
Accrued payroll and benefits	21,574	2,421	—	—	—	—	—	1,475	—	—	—	—	25,470
Advances from third-party payors	6,718	2,059	—	—	—	—	—	—	—	—	—	—	8,777
Other current liabilities	23,059	18,301	12	—	5,442	229	7,918	2,479	—	2,664	3,090	65	63,259
Current portion of long-term debt	4,445	—	—	—	—	—	—	—	—	—	—	—	4,445
Total current liabilities	62,988	29,576	12	—	7,665	229	7,918	4,375	—	2,696	3,090	65	118,614
Long-term debt, less current portion	175,354	25,953	—	—	—	—	—	—	—	—	—	—	201,307
Other long-term liabilities	24,490	1,158	—	—	—	—	—	1	—	18,678	—	(2,539)	41,788
Total liabilities	262,832	56,687	12	—	7,665	229	7,918	4,376	—	21,374	3,090	(2,474)	361,709
Net assets:													
Unrestricted	219,126	74,684	24	3,997	1,365	1,825	9,712	(2,784)	—	1,195	(89)	(65)	308,990
Temporarily restricted	166,902	—	—	—	—	478	5,914	—	—	—	—	(16,902)	156,392
Permanently restricted	—	—	—	—	—	—	1,276	—	—	—	—	—	1,276
Total net assets	386,028	74,684	24	3,997	1,365	2,303	16,902	(2,784)	—	1,195	(89)	(16,967)	466,658
Total liabilities and net assets	$ 648,860	131,371	36	3,997	9,030	2,532	24,820	1,592	—	22,569	3,001	(19,441)	828,367

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Health Plans

June 30, 2016

(In thousands)

Assets	UM Health Ventures	UM Health Plans	Eliminations	UM Health Plans consolidated total
Current assets:				
Cash and cash equivalents	$ —	1,540	—	1,540
Assets limited as to use, current portion	—	—	—	—
Accounts receivable:				
Patient accounts receivable, less allowance for doubtful accounts of $0	—	—	—	—
Other	5,938	16,832	—	22,770
Inventories	—	—	—	—
Prepaid expenses and other current assets	417	359	—	776
Total current assets	6,355	18,731	—	25,086
Investments	—	10,208	—	10,208
Assets limited as to use, less current portion:				
Investment held for collateral	—	—	—	—
Debt service funds	—	—	—	—
Construction funds	—	—	—	—
Board designated and escrow funds	—	—	—	—
Self-insurance trust funds	—	—	—	—
Funds restricted by donor	—	—	—	—
Economic interests in the net assets of related organizations	—	—	—	—
	—	—	—	—
Property and equipment, net	—	5,306	—	5,306
Investments in joint ventures and other assets	83,050	89,089	(85,552)	86,587
Total assets	$ 89,405	123,334	(85,552)	127,187

(Continued)

Schedule 1-i

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Health Plans

June 30, 2016

(In thousands)

Liabilities and Net Assets	UM Health Ventures	UM Health Plans	Eliminations	UM Health Plans consolidated total
Current liabilities:				
Trade accounts payable	$ —	109	—	109
Accrued payroll and benefits	1,095	561	—	1,656
Advances from third-party payors	—	—	—	—
Lines of credit	—	—	—	—
Other current liabilities	10,560	29,569	—	40,129
Current portion of long-term debt	5,000	—	—	5,000
Total current liabilities	16,655	30,239	—	46,894
Long-term debt, less current portion	41,667	—	—	41,667
Other long-term liabilities	35,700	17,600	—	53,300
Total liabilities	94,022	47,839	—	141,861
Net assets:				
Unrestricted	(4,617)	75,495	(85,552)	(14,674)
Temporarily restricted	—	—	—	—
Permanently restricted	—	—	—	—
Total net assets	(4,617)	75,495	(85,552)	(14,674)
Total liabilities and net assets	$ 89,405	123,334	(85,552)	127,187

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2015

(In thousands)

Assets	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	Upper Chesapeake	UMMS Foundation	ECARE	Eliminations	Consolidated total
Current assets:												
Cash and cash equivalents	$ 251,525	10,222	15,899	61,841	11,980	22,797	3,768	84,474	—	—	—	462,506
Assets limited as to use, current portion	46,377	—	764	1,294	948	485	549	—	—	—	—	50,417
Accounts receivable:												—
Patient accounts receivable, less allowance for doubtful accounts of $248,054	143,905	13,920	24,921	35,366	24,507	8,364	39,694	34,886	—	—	—	325,563
Other	160,906	(81)	1,658	1,096	8,582	982	(79,696)	—	—	249	(24,747)	68,949
Inventories	26,756	1,106	3,533	6,759	3,659	1,675	5,535	10,231	—	—	—	59,254
Prepaid expenses and other current assets	6,197	110	219	537	1,142	443	1,479	13,508	1,500	144	—	25,279
Total current assets	635,666	25,277	46,994	106,893	50,818	34,746	(28,671)	143,099	1,500	393	(24,747)	991,968
Investments	284,743	28,515	—	72,447	82,215	22,429	10,582	—	—	—	—	500,931
Assets limited as to use, less current portion:												
Investments held for collateral	77,603	—	3,700	8,000	—	—	—	30,017	—	—	—	119,320
Debt service funds	21,197	—	—	—	—	—	—	—	—	—	—	21,197
Construction funds	47,014	10,755	6,045	26,538	15,810	11,000	10,472	—	—	—	—	127,634
Board designated and escrow funds	—	—	—	—	77,013	7,081	—	124,874	22,977	—	—	231,945
Self-insurance trust funds	52,637	—	15,896	23,321	26,380	5,943	9,370	9,479	—	—	—	143,026
Funds restricted by donor	—	—	1,173	—	31,376	—	1,101	—	22,383	—	—	56,033
Economic and beneficial interests in the net assets of related organizations	200,020	30,680	432	7,022	3,105	—	9,503	—	—	—	(61,332)	189,430
	398,471	41,435	27,246	64,881	153,684	24,024	30,446	164,370	45,360	—	(61,332)	888,585
Property and equipment, net	922,861	46,354	98,649	253,540	172,150	91,983	215,891	253,876	—	2,825	—	2,058,129
Investments in joint ventures and other assets	661,818	—	16,958	16,520	13,177	6,371	13,280	217,172	5,965	—	(658,028)	293,233
Total assets	$ 2,903,559	141,581	189,847	514,281	472,044	179,553	241,528	778,517	52,825	3,218	(744,107)	4,732,846

(Continued)

Schedule 2

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2015

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	Upper Chesapeake	UMMS Foundation	ECARE	Eliminations	Consolidated total
Current liabilities:												
Trade accounts payable	$ 133,454	7,124	15,124	29,130	20,518	8,844	25,929	18,433	996	1,687	—	261,239
Accrued payroll and benefits	110,937	5,470	12,745	28,754	26,051	5,405	28,391	26,095	—	—	—	243,848
Advances from third-party payors	76,099	3,427	9,520	9,057	6,020	4,162	13,102	7,825	—	—	—	129,212
Lines of credit	132,400	—	—	—	—	12,000	—	—	—	—	—	144,400
Other current liabilities	86,145	4,031	6,770	(13,894)	10,108	1,878	3,762	35,118	—	6,124	(24,747)	115,295
Long-term debt subject to short-term remarketing arrangements	51,732	—	—	—	—	—	—	—	—	—	—	51,732
Current portion of long-term debt	12,971	482	888	3,714	3,299	2,751	4,938	4,255	—	—	—	33,298
Total current liabilities	603,738	20,534	45,047	56,761	65,996	35,040	76,122	91,726	996	7,811	(24,747)	979,024
Long-term debt, less current portion	723,590	21,419	33,955	171,779	91,583	63,105	247,961	205,752	—	—	—	1,559,144
Other long-term liabilities	110,797	415	22,910	38,486	21,532	13,260	8,954	42,871	—	—	—	259,225
Interest rate swap liabilities	167,520	—	—	—	—	—	—	28,852	—	—	—	196,372
Total liabilities	1,605,645	42,368	101,912	267,026	179,111	111,405	333,037	369,201	996	7,811	(24,747)	2,993,765
Net assets:												
Unrestricted	1,075,715	68,400	86,330	240,233	252,714	68,055	(98,724)	251,536	26,336	(4,593)	(508,775)	1,457,227
Temporarily restricted	220,510	30,813	1,605	7,022	24,670	93	6,815	156,504	6,930	—	(209,309)	245,653
Permanently restricted	1,689	—	—	—	15,549	—	400	1,276	18,563	—	(1,276)	36,201
Total net assets	1,297,914	99,213	87,935	247,255	292,933	68,148	(91,509)	409,316	51,829	(4,593)	(719,360)	1,739,081
Total liabilities and net assets	$ 2,903,559	141,581	189,847	514,281	472,044	179,553	241,528	778,517	52,825	3,218	(744,107)	4,732,846

See accompanying independent auditors' report.

Schedule 3

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division

Year ended June 30, 2016

(In thousands)

	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	UCHS	UM Health Plans	UMMS Foundation	Community Med. Group	ECARE	Eliminations	Consolidated total
Unrestricted revenues, gains and other support:														
Patient Service Revenue (net of contractual adjustments)	$ 1,429,329	108,435	209,573	419,168	318,917	133,783	425,406	436,284	—	—	64,007	—	(852)	3,544,050
Provision for bad debts	(64,664)	(7,015)	(18,354)	(36,972)	(13,070)	(5,146)	(16,131)	(14,846)	—	—	—	—	—	(176,198)
Net patient service revenue	1,364,665	101,420	191,219	382,196	305,847	128,637	409,275	421,438	—	—	64,007	—	(852)	3,367,852
Other operating revenue:														
State support	3,200	—	—	—	—	—	—	—	—	—	—	—	—	3,200
Premium Revenue	—	—	—	—	—	—	—	—	140,958	—	—	—	—	140,958
Other revenue	121,601	5,719	2,970	5,507	3,240	666	6,839	3,364	3	—	49,525	2,975	(45,470)	156,939
Total unrestricted revenue, gains and other support	1,489,466	107,139	194,189	387,703	309,087	129,303	416,114	424,802	140,961	—	113,532	2,975	(46,322)	3,668,949
Operating expenses:														
Salaries, wages and benefits	725,096	50,763	89,088	179,444	139,771	58,728	195,905	221,243	14,358	—	77,460	—	—	1,751,856
Expendable supplies	343,261	14,096	23,206	61,958	40,614	17,075	81,820	81,781	—	—	11,087	96	—	674,994
Purchased services	138,443	23,430	45,671	91,785	77,612	29,432	97,257	56,262	137,240	—	24,901	4,351	(46,322)	680,062
Contracted services	130,634	9,126	20,881	9,469	13,941	5,086	7,437	15,309	—	—	4,679	—	—	216,562
Depreciation and amortization	91,131	5,675	12,515	24,616	19,979	6,056	17,598	19,893	1,663	—	984	654	—	200,764
Interest expense	23,923	766	1,232	6,156	3,320	2,143	10,110	8,580	1,047	—		187	—	57,464
Total operating expenses	1,452,488	103,856	192,593	373,428	295,237	118,520	410,127	403,068	154,308	—	119,111	5,288	(46,322)	3,581,702
Operating income (loss)	36,978	3,283	1,596	14,275	13,850	10,783	5,987	21,734	(13,347)	—	(5,579)	(2,313)	—	87,247
Nonoperating income and expenses, net:														
Loss on early extinguishment of debt	—		—	—	—	—	—	—	—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	(78,429)		—	—	—	—	—	—	—	—	—	—	—	(78,429)
Other nonoperating gains and losses:														
Contributions	—		—	—	787	—	456	—	—	2,526	—	—	—	3,769
St. Joseph escrow settlement	34,275		—	—	—	—	—	—	—	—	—	—	—	34,275
Equity in net income of joint ventures	(1,629)		—	—	(178)	470	664	375	—	—	—	—	—	(298)
Investment income	10,642	636	38	2,343	6,153	316	145	409	148	281	—	—	—	21,111
Change in fair value of investments	(21,918)	(1,303)	23	(4,770)	(10,540)	(964)	(429)	4,446	—	(988)	—	—	—	(36,443)
Other nonoperating gains and losses	(10,392)	(390)	(605)	(3,297)	(3,077)	(675)	(5,246)	(3,384)	(1,614)	(2,353)	—	—	—	(31,033)
Total other nonoperating gains and losses	10,978	(1,057)	(544)	(5,724)	(6,855)	(853)	(4,410)	1,846	(1,466)	(534)	—	—	—	(8,619)
Excess (deficiency) of revenues over expenses	$ (30,473)	2,226	1,052	8,551	6,995	9,930	1,577	23,580	(14,813)	(534)	(5,579)	(2,313)	—	199

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for University of Maryland Medical Center & Affiliates (UMMC)

Year ended June 30, 2016

(In thousands)

	University of Maryland Medical Center							
	University Hospital	Shock Trauma Center	Subtotal	University Specialty	36 South Paca	University CARE	Eliminations	University of Maryland Medical Center & Affiliates consolidated total
Unrestricted revenues, gains and other support:								
Patient service revenue (net of contractual adjustments)	$ 1,237,079	190,580	1,427,659	—	—	1,670	—	1,429,329
Provision for bad debts	(52,392)	(12,321)	(64,713)	199	—	(150)	—	(64,664)
Net patient service revenue	1,184,687	178,259	1,362,946	199	—	1,520	—	1,364,665
Other operating revenue:								
State support	—	3,200	3,200	—	—	—	—	3,200
Other revenue	119,019	178	119,197	—	964	1,440	—	121,601
Total unrestricted revenue, gains and other support	1,303,706	181,637	1,485,343	199	964	2,960	—	1,489,466
Operating expenses:								
Salaries, wages and benefits	655,710	67,728	723,438	(7)	142	1,523	—	725,096
Expendable supplies	314,729	28,222	342,951	(1)	190	121	—	343,261
Purchased services	92,085	42,338	134,423	3	804	3,213	—	138,443
Contracted services	118,522	12,112	130,634	—	—	—	—	130,634
Depreciation and amortization	78,734	11,963	90,697	—	434	—	—	91,131
Interest expense	23,559	—	23,559	—	364	—	—	23,923
Total operating expenses	1,283,339	162,363	1,445,702	(5)	1,934	4,857	—	1,452,488
Operating income (loss)	20,367	19,274	39,641	204	(970)	(1,897)	—	36,978
Nonoperating income and expenses, net:								
Loss on early extinguishment of debt	—	—	—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	(78,429)	—	(78,429)	—	—	—	—	(78,429)
Other nonoperating gains and losses:								
Contributions	—	—	—	—	—	—	—	—
St. Joseph escrow settlement	34,275	—	34,275	—	—	—	—	34,275
Equity in net income of joint ventures	(4,305)	—	(4,305)	—	—	—	2,676	(1,629)
Investment income	9,142	1,500	10,642	—	—	—	—	10,642
Change in fair value of investments	(21,918)	—	(21,918)	—	—	—	—	(21,918)
Other nonoperating gains and losses	(10,582)	—	(10,582)	—	—	—	190	(10,392)
Total other nonoperating gains and losses	6,612	1,500	8,112	—	—	—	2,866	10,978
Excess (deficiency) of revenues over expenses	$ (51,450)	20,774	(30,676)	204	(970)	(1,897)	2,866	(30,473)

See accompanying independent auditors' report.

(Continued)

Schedule 3-b

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Midtown Health, Inc. (Midtown)

Year ended June 30, 2016

(In thousands)

	UM Midtown Health Systems, Inc.	UMMC Midtown Campus	UM Midtown Clin. Prac. Group	Eliminations	Midtown consolidated total
Unrestricted revenues, gains and other support:					
Patient service revenue (net of contractual adjustments)	$ —	208,590	5,720	(4,737)	209,573
Provision for bad debts	—	(17,596)	(758)	—	(18,354)
Net patient service revenue	—	190,994	4,962	(4,737)	191,219
Other operating revenue:					
State support	—	—	—	—	—
Other revenue	962	1,990	18	—	2,970
Total unrestricted revenue, gains and other support	962	192,984	4,980	(4,737)	194,189
Operating expenses:					
Salaries, wages and benefits	—	89,088	—	—	89,088
Expendable supplies	—	23,206	—	—	23,206
Purchased services	798	44,630	243	—	45,671
Contracted services	—	20,881	4,737	(4,737)	20,881
Depreciation and amortization	242	12,273	—	—	12,515
Interest expense	47	1,185	—	—	1,232
Total operating expenses	1,087	191,263	4,980	(4,737)	192,593
Operating income (loss)	(125)	1,721	—	—	1,596
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	—	—	—	—	—
Investment income	—	38	—	—	38
Change in fair value of investments	—	23	—	—	23
Other nonoperating gains and losses	—	(605)	—	—	(605)
Total other nonoperating gains and losses	—	(544)	—	—	(544)
Excess of revenues over expenses	$ (125)	1,177	—	—	1,052

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, 2016

(In thousands)

	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Shipley's	Eliminations	BWMS consolidated total
Unrestricted revenues, gains and other support:								
Patient service revenue (net of contractual adjustments)	$ —	375,219	39,522	6,571	—	—	(2,144)	419,168
Provision for bad debts	—	(17,584)	(19,165)	(223)	—	—	—	(36,972)
Net patient service revenue	—	357,635	20,357	6,348	—	—	(2,144)	382,196
Other operating revenue:								
State support	—	—	—	—	—	—	—	—
Other revenue	3,654	3,596	—	—	2,702	—	(4,445)	5,507
Total unrestricted revenue, gains and other support	3,654	361,231	20,357	6,348	2,702	—	(6,589)	387,703
Operating expenses:								
Salaries, wages and benefits	3,637	162,722	11,837	1,248	—	—	—	179,444
Expendable supplies	—	61,531	1	296	130	—	—	61,958
Purchased services	14,559	67,989	5,153	9,311	1,362	—	(6,589)	91,785
Contracted services	—	9,469	—	—	—	—	—	9,469
Depreciation and amortization	—	23,109	—	815	692	—	—	24,616
Interest expense	—	6,003	—	73	80	—	—	6,156
Total operating expenses	18,196	330,823	16,991	11,743	2,264	—	(6,589)	373,428
Operating income (loss)	(14,542)	30,408	3,366	(5,395)	438	—	—	14,275
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	22,533	—	—	—	—	—	(22,533)	—
Investment income	—	2,343	—	—	—	—	—	2,343
Change in fair value of investments	—	(4,770)	—	—	—	—	—	(4,770)
Other nonoperating gains and losses	—	(3,064)	—	(233)	—	—	—	(3,297)
Total other nonoperating gains and losses	22,533	(5,491)	—	(233)	—	—	(22,533)	(5,724)
Excess (deficiency) of revenues over expenses	$ 7,991	24,917	3,366	(5,628)	438	—	(22,533)	8,551

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Shore Regional Health (Shore Regional)

Year ended June 30, 2016

(In thousands)

	Shore Health System, Inc.	UM Shore Home Care	Queenstown ASC	UM Shore Nursing and Rehab.	Shore Med. Group	Memorial Hospital Foundation, Inc. and Subsidiary	Chester River Consolidated Total	Eliminations	SHS consolidated total
Unrestricted revenues, gains and other support:									
Patient service revenue (net of contractual adjustments)	$ 248,548	3,953	251	7,898	—	—	58,267	—	318,917
Provision for bad debts	(10,026)	(38)	(116)	(6)	—	—	(2,884)	—	(13,070)
Net patient service revenue	238,522	3,915	135	7,892	—	—	55,383	—	305,847
Other operating revenue:									
State support	—	—	—	—	—	—	—	—	—
Other revenue	2,758	—	220	7	—	—	255	—	3,240
Total unrestricted revenue, gains and other support	241,280	3,915	355	7,899	—	—	55,638	—	309,087
Operating expenses:									
Salaries, wages and benefits	112,434	2,885	304	4,449	—	—	19,699	—	139,771
Expendable supplies	34,184	77	102	739	—	—	5,512	—	40,614
Purchased services	41,225	1,420	19	2,580	16,539	—	15,829	—	77,612
Contracted services	8,569	—	(72)	9	—	—	5,435	—	13,941
Depreciation and amortization	15,662	76	2	256	—	—	3,983	—	19,979
Interest expense	3,154	—	—	6	—	—	160	—	3,320
Total operating expenses	215,228	4,458	355	8,039	16,539	—	50,618	—	295,237
Operating income (loss)	26,052	(543)	—	(140)	(16,539)	—	5,020	—	13,850
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	71	—	—	—	—	310	406	—	787
Equity in net income of joint ventures	(178)	—	—	—	—	—	—	—	(178)
Investment income (loss)	3,716	—	—	—	—	2,045	392	—	6,153
Change in fair value of investments	(6,261)	—	—	—	—	(3,529)	(750)	—	(10,540)
Other nonoperating gains and losses	(1,437)	—	—	—	—	(545)	(1,095)	—	(3,077)
Total other nonoperating gains and losses	(4,089)	—	—	—	—	(1,719)	(1,047)	—	(6,855)
Excess (deficiency) of revenues over expenses	$ 21,963	(543)	—	(140)	(16,539)	(1,719)	3,973	—	6,995

See accompanying independent auditors' report.

Schedule 3-e

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Chester River Health System, Inc. (CRHS) a subsidiary of Shore Regional Health

Year ended June 30, 2016

(In thousands)

	Chester River Hospital Center	Chester River Manor	UM Chester River Home Care	Chester River Health Foundation	Chester River consolidated total
Unrestricted revenues, gains and other support:					
Patient service revenue (net of contractual allowances)	$ 56,080	—	2,187	—	58,267
Provision for bad debts	(2,774)	—	(110)	—	(2,884)
Net patient service revenue	53,306	—	2,077	—	55,383
Other operating revenue:					
State support	—	—	—	—	—
Other revenue	255	—	—	—	255
Total unrestricted revenue, gains and other support	53,561	—	2,077	—	55,638
Operating expenses:					
Salaries, wages and benefits	18,011	—	1,688	—	19,699
Expendable supplies	5,464	—	48	—	5,512
Purchased services	15,571	—	258	—	15,829
Contracted services	5,435	—	—	—	5,435
Depreciation and amortization	3,971	—	12	—	3,983
Interest expense	160	—	—	—	160
Total operating expenses	48,612	—	2,006	—	50,618
Operating income	4,949	—	71	—	5,020
Nonoperating income and expenses, net:					
Loss on early extinguishment of debt	—	—	—	—	—
Other nonoperating gains and losses:					
Contributions	333	—	—	73	406
Equity in net income of joint ventures	—	—	—	—	—
Investment income	57	—	5	330	392
Change in fair value of investments	(382)	—	(39)	(329)	(750)
Other nonoperating gains and losses	(411)	—	—	(684)	(1,095)
Total other nonoperating gains and losses	(403)	—	(34)	(610)	(1,047)
Excess of revenues over expenses	$ 4,546	—	37	(610)	3,973

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Charles Regional Health (Charles Regional)

Year ended June 30, 2016

(In thousands)

	Charles Regional Health, Inc.	Charles Regional Medical Center, Inc.	Charles Regional Urgent Care	Charles Regional Care Partners, Inc. and Subsidiary	Charles Regional Health Foundation, Inc.	Eliminations	Charles Regional consolidated total
Unrestricted revenues, gains and other support:							
Patient service revenue (net of contractual adjustments)	$ —	132,762	1,021	—	—	—	133,783
Provision for bad debts	—	(4,903)	(67)	(176)	—	—	(5,146)
Net patient service revenue	—	127,859	954	(176)	—	—	128,637
Other operating revenue:							
State support	—	—	—	—	—	—	—
Other revenue	215	451	—	—	—	—	666
Total unrestricted revenue, gains and other support	215	128,310	954	(176)	—	—	129,303
Operating expenses:							
Salaries, wages and benefits	—	58,728	—	—	—	—	58,728
Expendable supplies	—	16,976	99	—	—	—	17,075
Purchased services	1,002	26,247	1,439	744	—	—	29,432
Contracted services	—	5,086	—	—	—	—	5,086
Depreciation and amortization	1,496	4,652	97	(189)	—	—	6,056
Interest expense	269	1,874	—	—	—	—	2,143
Total operating expenses	2,767	113,563	1,635	555	—	—	118,520
Operating income	(2,552)	14,747	(681)	(731)	—	—	10,783
Nonoperating income and expenses, net:							
Loss on early extinguishment of debt	—	—	—	—	—	—	—
Other nonoperating gains and losses:							
Contributions	—	—	—	—	—	—	—
Equity in net income of joint ventures	—	202	—	268	—	—	470
Investment income	66	206	—	—	44	—	316
Change in fair value of investments	—	(855)	—	—	(109)	—	(964)
Other nonoperating gains and losses	—	(740)	—	—	32	33	(675)
Total other nonoperating gains and losses	66	(1,187)	—	268	(33)	33	(853)
Excess of revenues over expenses	$ (2,486)	13,560	(681)	(463)	(33)	33	9,930

See accompanying independent auditors' report.

Schedule 3-g

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for University of Maryland St. Joseph Health System (SJHS)

Year ended June 30, 2016

(In thousands)

	St. Joseph Medical Center	St. Joseph Medical Group	St. Joseph Properties	St. Joseph Orthopaedics	O'Dea Medical Arts	St. Joseph Foundation	Eliminations	St. Joseph consolidated total
Unrestricted revenues, gains and other support:								
Patient service revenue (net of contractual adjustments)	$ 361,730	35,188	—	28,488	—	—	—	425,406
Provision for bad debts	(13,109)	(1,482)	—	(1,540)	—	—	—	(16,131)
Net patient service revenue	348,621	33,706	—	26,948	—	—	—	409,275
Other operating revenue:								
State support	—	—	—	—	—	—	—	—
Other revenue	5,196	8,287	1,570	87	2,643	—	(10,944)	6,839
Total unrestricted revenue, gains and other support	353,817	41,993	1,570	27,035	2,643	—	(10,944)	416,114
Operating expenses:								
Salaries, wages and benefits	134,867	41,998	—	19,040	—	—	—	195,905
Expendable supplies	80,224	1,164	—	432	—	—	—	81,820
Purchased services	70,455	14,382	2,181	11,765	1,348	1	(2,875)	97,257
Contracted services	15,382	124	—	—	—	—	(8,069)	7,437
Depreciation and amortization	16,877	113	19	144	445	—	—	17,598
Interest expense	9,685	—	—	—	425	—	—	10,110
Total operating expenses	327,490	57,781	2,200	31,381	2,218	1	(10,944)	410,127
Operating income (loss)	26,327	(15,788)	(630)	(4,346)	425	(1)	—	5,987
Nonoperating income and expenses, net:								
Loss on early extinguishment of debt	—	—	—	—	—	—	—	—
Other nonoperating gains and losses:								
Contributions	—	—	—	—	—	456	—	456
Equity in net income of joint ventures	664	—	—	—	—	—	—	664
Investment income	—	—	—	—	—	145	—	145
Change in fair value of investments	—	—	—	—	—	(429)	—	(429)
Other nonoperating gains and losses	(4,166)	2	—	—	—	(1,082)	—	(5,246)
Total other nonoperating gains and losses	(3,502)	2	—	—	—	(910)	—	(4,410)
Excess (deficiency) of revenues over expenses	$ 22,825	(15,786)	(630)	(4,346)	425	(911)	—	1,577

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Upper Chesapeake Health System (UCHS)

Year ended June 30, 2016

(In thousands)

	Upper Chesapeake Medical Center	Harford Memorial Hospital	UCHS Properties	Health Ventures	Medical Services	Residential Hospice House	Upper Chesapeake Health Foundation	Upper Chesapeake Health System	Hospice of Harford County	Upper Chesapeake Insurance Co.	Upper Chesapeake Land Trust	Eliminations	Upper Chesapeake consolidated total
Unrestricted revenues, gains and other support:													
Patient service revenue (net of contractual adjustments)	$ 293,812	93,717	—	—	48,449	306	—	—	—	—	—	—	436,284
Provision for bad debts	(8,082)	(4,511)	—	—	(2,234)	(19)	—	—	—	—	—	—	(14,846)
Net patient service revenue	285,730	89,206	—	—	46,215	287	—	—	—	—	—	—	421,438
Other operating revenue:													
State support	—	—	—	—	—	—	—	—	—	—	—	—	—
Other revenue	4,692	1,028	—	—	5,678	400	—	15,978	—	1,373	—	(25,785)	3,364
Total unrestricted revenue, gains and other support	290,422	90,234	—	—	51,893	687	—	15,978	—	1,373	—	(25,785)	424,802
Operating expenses:													
Salaries, wages and benefits	125,831	46,770	—	—	37,044	704	—	10,894	—	—	—	—	221,243
Expendable supplies	65,309	8,886	—	—	7,317	41	—	228	—	—	—	—	81,781
Purchased services	39,564	17,417	247	105	12,294	135	—	4,191	—	1,377	14	(19,082)	56,262
Contracted services	9,390	3,620	—	—	7,876	—	—	81	—	—	—	(5,658)	15,309
Depreciation and amortization	13,661	4,771	101	—	507	270	—	583	—	—	—	—	19,893
Interest expense	7,321	1,259	—	—	—	—	—	—	—	—	—	—	8,580
Total operating expenses	261,076	82,723	348	105	65,038	1,150	—	15,977	—	1,377	14	(24,740)	403,068
Operating income (loss)	29,346	7,511	(348)	(105)	(13,145)	(463)	—	1	—	(4)	(14)	(1,045)	21,734
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	—	—	—	375	—	—	—	—	—	—	—	—	375
Investment income	(42)	670	—	—	—	(9)	(214)	—	—	4	—	—	409
Change in fair value of investments	4,568	(180)	—	—	—	(3)	61	—	—	—	—	—	4,446
Other nonoperating gains and losses	(3,736)	—	—	—	—	—	352	—	—	—	—	—	(3,384)
Total other nonoperating gains and losses	790	490	—	375	—	(12)	199	—	—	4	—	—	1,846
Excess (deficiency) of revenues over expenses	$ 30,136	8,001	(348)	270	(13,145)	(475)	199	1	—	—	(14)	(1,045)	23,580

See accompanying independent auditors' report.

Schedule 3-i

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for University of Maryland Health Plans

Year ended June 30, 2016

(In thousands)

	UM Health Ventures	UM Health Plans	Eliminations	UM Health Plans consolidated total
Unrestricted revenues, gains and other support:				
Patient service revenue (net of contractual adjustments)	$ —	—	—	—
Provision for bad debts	—	—	—	—
Net patient service revenue	—	—	—	—
Other operating revenue:				
State support	—	—	—	—
Premium revenue	—	140,958	—	140,958
Other revenue	—	3	—	3
Total unrestricted revenue, gains and other support	—	140,961	—	140,961
Operating expenses:				
Salaries, wages and benefits	1,966	12,392	—	14,358
Expendable supplies	—	—	—	—
Purchased services	—	137,240	—	137,240
Contracted services	—	—	—	—
Depreciation and amortization	—	1,663	—	1,663
Interest expense	1,047	—	—	1,047
Total operating expenses	3,013	151,295	—	154,308
Operating income (loss)	(3,013)	(10,334)	—	(13,347)
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	—	—	—	—
Investment income	—	148	—	148
Change in fair value of investments	—	—	—	—
Other nonoperating gains and losses	—	(1,614)	—	(1,614)
Total other nonoperating gains and losses	—	(1,466)	—	(1,466)
Excess of revenues over expenses	$ (3,013)	(11,800)	—	(14,813)

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION
AND SUBSIDIARIES

Consolidating Operations Information by Division

Year ended June 30, 2015

(In thousands)

	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System Washington	Shore Regional	Charles Regional	St. Joseph Health	UCHS	UMMS Foundation	ECARE	Eliminations	Consolidated total
Unrestricted revenues, gains and other support:												
Patient Service Revenue (net of contractual adjustments)	$ 1,353,182	108,225	209,569	426,622	328,052	135,840	394,008	418,724	—	—	(986)	3,373,236
Provision for bad debts	(40,129)	(6,738)	(17,319)	(25,158)	(15,820)	(8,390)	(11,520)	(20,254)	—	—	—	(145,328)
Net patient service revenue	1,313,053	101,487	192,250	401,464	312,232	127,450	382,488	398,470	—	—	(986)	3,227,908
Other operating revenue:												
State support	3,200	—	—	—	—	—	—	—	—	—	—	3,200
Other revenue	104,231	4,614	2,237	8,737	3,488	849	8,472	7,553	—	2,936	(681)	142,436
Total unrestricted revenue, gains and other support	1,420,484	106,101	194,487	410,201	315,720	128,299	390,960	406,023	—	2,936	(1,667)	3,373,544
Operating expenses:												
Salaries, wages and benefits	678,025	53,676	92,381	206,003	165,302	59,787	192,833	200,324	—	7	—	1,648,338
Expendable supplies	308,119	16,384	23,382	69,177	42,327	20,159	83,920	76,349	—	11	—	639,828
Purchased services	142,821	21,769	39,558	71,566	64,599	24,496	90,054	54,784	—	4,157	(1,517)	512,287
Contracted services	128,649	8,801	24,784	12,398	12,513	4,166	7,787	15,116	—	—	—	214,214
Depreciation and amortization	83,705	4,854	11,995	22,267	17,644	4,848	14,388	21,897	—	633	—	182,231
Interest expense	27,604	726	1,193	6,632	3,330	2,264	9,705	7,293	—	189	—	58,936
Total operating expenses	1,368,923	106,210	193,293	388,043	305,715	115,720	398,687	375,763	—	4,997	(1,517)	3,255,834
Operating income (loss)	51,561	(109)	1,194	22,158	10,005	12,579	(7,727)	30,260	—	(2,061)	(150)	117,710
Nonoperating income and expenses, net:												
Loss on early extinguishment of debt	(1,756)	—	—	—	—	—	—	(7,038)	—	—	—	(8,794)
Change in fair value of undesignated interest rate swaps	(21,235)	—	—	—	—	—	—	(1,002)	—	—	—	(22,237)
Other nonoperating gains and losses:												—
Contributions	19	—	—	—	858	—	854	2,000	7,654	—	—	11,385
Gain on sale of joint venture	—	—	—	39,350	—	—	—	—	—	—	—	39,350
Equity in net income of joint ventures	2,510	—	3,783	—	222	74	1,617	397	—	—	—	8,603
Investment income	11,798	636	52	2,238	5,955	443	393	6,307	451	—	—	28,273
Change in fair value of investments	(15,404)	(792)	—	(2,846)	(5,429)	(592)	(485)	(3,712)	(769)	—	—	(30,029)
Fair value impairment adjustment	—	—	(11,483)	—	—	—	—	—	—	—	—	(11,483)
Other nonoperating gains and losses	(13,956)	(368)	(561)	(3,330)	(2,046)	(667)	(5,795)	(3,921)	(7,032)	—	—	(37,676)
Total other nonoperating gains and losses	(15,033)	(524)	(8,209)	35,412	(440)	(742)	(3,416)	1,071	304	—	—	8,423
Excess (deficiency) of revenues over expenses	$ 13,537	(633)	(7,015)	57,570	9,565	11,837	(11,143)	23,291	304	(2,061)	(150)	95,102

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2016

(In thousands)

Assets	University of Maryland Medical Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals*	UMMS Foundation	Eliminations	Obligated group total
Current assets:												
Cash and cash equivalents	$ 383,678	6,218	11,362	27,186	14,619	5,214	11,285	1,443	49,052	—	—	510,057
Assets limited as to use, current portion	44,007	—	528	1,183	627	233	404	960	—	—	—	47,942
Accounts receivable:												
Patient accounts receivable, less allowance for doubtful accounts of $174,267	168,652	9,849	15,268	29,646	12,830	3,928	7,390	30,765	30,778	—	—	309,106
Other	178,002	333	14,293	1,926	6,296	2,964	976	12,345	—	—	(84,596)	132,539
Inventories	28,187	1,072	2,860	6,150	4,077	699	1,487	5,537	8,985	—	—	59,054
Prepaid expenses and other current assets	12,789	128	319	1,261	1,429	63	478	968	3,265	1,500	—	22,200
Total current assets	815,315	17,600	44,630	67,352	39,878	13,101	22,020	52,018	92,080	1,500	(84,596)	1,080,898
Investments	195,252	25,304	—	121,768	67,312	10,461	27,923	—	171,865	—	—	619,885
Assets limited as to use, less current portion:												
Investments held for collateral	125,487	—	3,700	8,000	—	—	—	—	40,811	—	—	177,998
Debt service funds	22,290	—	—	—	—	—	—	—	—	—	—	22,290
Construction funds	335	10,360	5,259	4,995	234	4,538	10,449	5,816	—	—	—	41,986
Board designated and escrow funds	—	—	—	—	25,000	5,000	—	—	—	17,950	—	47,950
Self-insurance trust funds	53,064	—	16,337	23,205	22,603	6,051	4,820	10,107	—	—	—	136,187
Funds restricted by donor	—	—	1,113	—	4,683	105	—	—	—	23,413	—	29,314
Economic interests in the net assets of related organizations	197,438	30,838	437	7,960	78,090	5,196	4,898	9,503	—	—	(58,913)	275,447
	398,614	41,198	26,846	44,160	130,610	20,890	20,167	25,426	40,811	41,363	(58,913)	731,172
Property and equipment, net	905,247	48,190	97,302	241,592	145,237	27,736	74,373	197,090	250,348	—	—	1,987,115
Investments in joint ventures and other assets	683,709	—	7,805	18,703	10,395	2,077	6,985	14,207	225,127	6,561	(660,528)	315,041
Total assets	$ 2,998,137	132,292	176,583	493,575	393,432	74,265	151,468	288,741	780,231	49,424	(804,037)	4,734,111

* Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

(Continued)

Schedule 5

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2016

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals*	UMMS Foundation	Eliminations	Obligated group total
Current liabilities:												
Trade accounts payable	$ 126,770	7,949	14,432	21,886	13,688	3,546	8,996	27,488	13,987	14	—	238,756
Accrued payroll and benefits	119,166	5,076	12,501	23,101	18,990	2,694	3,944	23,338	23,995	—	—	232,805
Advances from third-party payors	72,546	2,910	9,660	9,667	5,946	778	3,735	10,633	8,777	—	—	124,652
Short-term financing	180,000	—	—	—	—	—	—	—	—	—	—	180,000
Lines of credit	150,000	—	—	—	—	—	—	—	—	—	—	150,000
Other current liabilities	86,475	(13,954)	5,676	37,506	2,147	3,873	3,338	2,984	41,360	—	(84,596)	84,809
Long-term debt subject to short-term remarketing arrangements	32,515	—	—	—	—	—	—	—	—	—	—	32,515
Current portion of long-term debt	11,846	465	719	3,645	3,087	96	2,207	5,159	4,445	—	—	31,669
Total current liabilities	779,318	2,446	42,988	95,805	43,858	10,987	22,220	69,602	92,564	14	(84,596)	1,075,206
Long-term debt, less current portion	566,363	20,991	32,654	165,078	83,786	4,412	54,797	233,727	201,307	—	—	1,363,115
Other long-term liabilities	124,114	144	29,724	46,874	12,696	10,009	16,918	15,652	25,648	—	—	281,779
Interest rate swap liabilities	273,037	—	—	—	—	—	—	—	—	—	—	273,037
Total liabilities	1,742,832	23,581	105,366	307,757	140,340	25,408	93,935	318,981	319,519	14	(84,596)	2,993,137
Net assets:												
Unrestricted	1,035,724	77,873	69,667	177,858	216,600	46,082	57,440	(30,241)	293,810	22,599	(511,275)	1,456,137
Temporarily restricted	217,892	30,838	1,550	7,960	22,283	1,487	93	1	166,902	7,594	(206,890)	249,710
Permanently restricted	1,689	—	—	—	14,209	1,288	—	—	—	19,217	(1,276)	35,127
Total net assets	1,255,305	108,711	71,217	185,818	253,092	48,857	57,533	(30,240)	460,712	49,410	(719,441)	1,740,974
Total liabilities and net assets	$ 2,998,137	132,292	176,583	493,575	393,432	74,265	151,468	288,741	780,231	49,424	(804,037)	4,734,111

* Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2015

(In thousands)

Assets	University of Maryland Medical Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals*	UMMS Foundation	Eliminations	Obligated group total
Current assets:												
Cash and cash equivalents	$ 249,790	10,222	15,362	59,774	7,351	3,276	20,680	1,186	84,070	—	—	451,711
Assets limited as to use, current portion	46,377	—	764	1,294	605	343	485	549	—	—	—	50,417
Accounts receivable:												
Patient accounts receivable, less allowance for doubtful accounts of $219,924	143,896	13,920	23,892	28,370	14,557	6,312	7,945	35,052	30,043	—	—	303,987
Other	164,633	(81)	2,777	1,143	958	1,035	535	(21,507)	—	—	(54,711)	94,782
Inventories	26,717	1,106	3,533	6,759	3,202	457	1,675	5,512	9,813	—	—	58,774
Prepaid expenses and other current assets	6,132	110	219	918	946	76	320	510	4,145	1,500	—	14,876
Total current assets	637,545	25,277	46,547	98,258	27,619	11,499	31,640	21,302	128,071	1,500	(54,711)	974,547
Investments	284,743	28,515	—	72,447	69,136	10,820	20,279	—	—	—	—	485,940
Assets limited as to use, less current portion:												
Investments held for collateral	77,603	—	3,700	8,000	—	—	—	—	30,017	—	—	119,320
Debt service funds	21,197	—	—	—	—	—	—	—	—	—	—	21,197
Construction funds	47,014	10,755	6,045	26,538	11,272	4,538	11,000	10,472	—	—	—	127,634
Board designated and escrow funds	—	—	—	—	25,000	5,000	—	—	106,724	22,977	—	159,701
Self-insurance trust funds	52,637	—	15,896	23,321	21,325	4,971	5,943	9,370	—	—	—	133,463
Funds restricted by donor	—	—	1,173	—	4,515	105	—	—	—	22,383	—	28,176
Economic interests in the net assets of related organizations	200,020	34,072	432	7,022	80,620	5,933	—	9,503	—	—	(61,332)	276,270
	398,471	44,827	27,246	64,881	142,732	20,547	16,943	29,345	136,741	45,360	(61,332)	865,761
Property and equipment, net	913,877	46,353	96,913	230,369	136,890	27,967	70,324	202,324	243,760	—	—	1,968,777
Investments in joint ventures and other assets	667,291	—	8,395	16,488	11,257	2,180	10,631	10,734	223,814	5,965	(658,028)	298,727
Total assets	$ 2,901,927	144,972	179,101	482,443	387,634	73,013	149,817	263,705	732,386	52,825	(774,071)	4,593,752

* Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

(Continued)

Schedule 6

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2015

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals*	UMMS Foundation	Eliminations	Obligated group total
Current liabilities:												
Trade accounts payable	$ 131,978	7,108	15,053	26,530	15,265	4,083	8,522	24,576	15,185	996	—	249,296
Accrued payroll and benefits	110,905	5,365	12,745	25,538	18,384	3,395	5,174	22,542	24,411	—	—	228,459
Advances from third-party payors	76,099	3,427	9,520	9,057	5,217	709	4,162	13,102	7,825	—	—	129,118
Lines of credit	132,400	—	—	—	—	—	12,000	—	—	—	—	144,400
Other current liabilities	85,534	(1,617)	6,770	42,677	2,138	7,005	1,271	2,966	14,005	—	(54,711)	106,038
Long-term debt subject to short-term remarketing arrangements	51,732	—	—	—	—	—	—	—	—	—	—	51,732
Current portion of long-term debt	12,971	482	689	3,489	3,177	92	2,126	4,938	4,255	—	—	32,219
Total current liabilities	601,619	14,765	44,777	107,291	44,181	15,284	33,255	68,124	65,681	996	(54,711)	941,262
Long-term debt, less current portion	723,590	21,419	33,374	168,723	86,872	4,659	56,917	238,885	205,752	—	—	1,540,191
Other long-term liabilities	110,780	415	22,909	37,541	13,069	8,175	13,260	8,954	28,237	—	—	243,340
Interest rate swap liabilities	167,520	—	—	—	—	—	—	—	28,852	—	—	196,372
Total liabilities	1,603,509	36,599	101,060	313,555	144,122	28,118	103,432	315,963	328,522	996	(54,711)	2,921,165
Net assets:												
Unrestricted	1,076,219	74,301	76,436	161,866	206,300	41,947	46,292	(52,259)	235,736	26,336	(508,775)	1,384,399
Temporarily restricted	220,510	34,072	1,605	7,022	22,951	1,660	93	1	168,128	6,930	(209,309)	253,663
Permanently restricted	1,689	—	—	—	14,261	1,288	—	—	—	18,563	(1,276)	34,525
Total net assets	1,298,418	108,373	78,041	168,888	243,512	44,895	46,385	(52,258)	403,864	51,829	(719,360)	1,672,587
Total liabilities and net assets	$ 2,901,927	144,972	179,101	482,443	387,634	73,013	149,817	263,705	732,386	52,825	(774,071)	4,593,752

* Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Operations and Changes in Net Assets Information – Obligated Group

Year ended June 30, 2016

(In thousands)

	University of Maryland Medical Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center	Shore Health System				Chester River Hospital Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals*	UMMS Foundation	Eliminations	Obligated group total
					Memorial Hospital	Dorchester General	QAEC	Subtotal							
Unrestricted revenues, gains and other support:															
Patient service revenue (net of contractual adjustments)	$ 1,427,659	107,692	208,590	375,219	196,846	46,056	5,646	248,548	56,080	132,762	361,730	387,529	—	(852)	3,304,957
Provision for bad debts	(64,713)	(6,948)	(17,596)	(17,584)	(7,230)	(2,101)	(695)	(10,026)	(2,774)	(4,903)	(13,109)	(12,593)	—	—	(150,246)
Net patient service revenue	1,362,946	100,744	190,994	357,635	189,616	43,955	4,951	238,522	53,306	127,859	348,621	374,936	—	(852)	3,154,711
Other operating revenue:															
State support	3,200	—	—	—	—	—	—	—	—	—	—	—	—	—	3,200
Other revenue	119,197	5,719	1,990	3,596	2,425	327	6	2,758	255	451	5,196	5,720	—	(441)	144,441
Total unrestricted revenue, gains and other support	1,485,343	106,463	192,984	361,231	192,041	44,282	4,957	241,280	53,561	128,310	353,817	380,656	—	(1,293)	3,302,352
Operating expenses:															
Salaries, wages, and benefits	723,438	50,054	89,088	162,722	86,401	22,826	3,207	112,434	18,011	58,728	134,867	172,601	—	—	1,521,943
Expendable supplies	342,951	14,078	23,206	61,531	30,320	3,255	609	34,184	5,464	16,976	80,224	74,195	—	—	652,809
Purchased services	134,423	23,244	44,630	67,989	32,420	8,074	731	41,225	15,571	26,247	70,455	56,981	—	(1,293)	479,472
Contracted services	130,634	9,126	20,881	9,469	5,388	2,285	896	8,569	5,435	5,086	15,382	13,010	—	—	217,592
Depreciation and amortization	90,697	5,674	12,273	23,109	11,965	2,784	913	15,662	3,971	4,652	16,877	18,432	—	—	191,347
Interest expense	23,559	766	1,185	6,003	2,484	155	515	3,154	160	1,874	9,685	8,580	—	—	54,966
Total operating expenses	1,445,702	102,942	191,263	330,823	168,978	39,379	6,871	215,228	48,612	113,563	327,490	343,799	—	(1,293)	3,118,129
Operating income (loss)	39,641	3,521	1,721	30,408	23,063	4,903	(1,914)	26,052	4,949	14,747	26,327	36,857	—	—	184,223
Nonoperating income and expenses, net:															
Loss on early extinguishment of debt	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	(78,429)	—	—	—	—	—	—	—	—	—	—	—	—	—	(78,429)
Other nonoperating gains and losses:															
Contributions	—	—	—	—	71	—	—	71	333	—	—	—	2,526	—	2,930
St. Joseph escrow settlement	34,275	—	—	—	—	—	—	—	—	—	—	—	—	—	34,275
Equity in net income of joint ventures	(4,305)	—	—	—	(136)	(37)	(5)	(178)	—	202	664	—	—	—	(3,617)
Investment income	10,642	636	38	2,343	3,716	—	—	3,716	57	206	—	628	281	—	18,547
Change in fair value of investments	(21,918)	(1,303)	23	(4,770)	(6,261)	—	—	(6,261)	(382)	(855)	—	4,388	(988)	—	(32,066)
Other nonoperating gains and losses	(10,582)	(390)	(605)	(3,064)	(1,111)	(287)	(39)	(1,437)	(411)	(740)	(4,166)	(3,736)	(2,353)	—	(27,484)
Total other nonoperating gains and losses	8,112	(1,057)	(544)	(5,491)	(3,721)	(324)	(44)	(4,089)	(403)	(1,187)	(3,502)	1,280	(534)	—	(7,415)
Excess (deficiency) of revenues over expenses	(30,676)	2,464	1,177	24,917	19,342	4,579	(1,958)	21,963	4,546	13,560	22,825	38,137	(534)	—	98,379
Net assets released from restrictions used for purchase of property and equipment	4,364	—	87	—	1,466	—	—	1,466	564	1,150	1,768	—	—	—	9,399
Change in unrealized gains on investments	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in economic and beneficial interest in the net assets of related organizations	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	—	—	—	—	(1,843)	—	—	(1,843)	(561)	133	—	—	—	—	(2,271)
Change in ownership interest of joint ventures	498	—	—	—	—	—	—	—	—	—	—	—	—	—	498
Capital transfers (to) from affiliate	(16,212)	1,100	400	(3,200)	(11,285)	—	—	(11,285)	—	—	(2,800)	12,331	(2,250)	(2,500)	(24,416)
Amortization of accumulated loss of discontinued designated interest rate swap	1,764	—	—	—	—	—	—	—	—	—	—	—	—	—	1,764
Change in funded status of defined benefit pension plans	—	—	(8,419)	(6,225)	—	—	—	—	(413)	(3,697)	—	8,111	—	—	(10,643)
Asset reclassifications at request of donor	—	—	—	—	—	—	—	—	—	—	—	—	(947)	—	(947)
Other	(233)	8	(14)	500	(1)	—	—	(1)	(1)	2	225	(505)	(6)	—	(25)
Increase (decrease) in unrestricted net assets	$ (40,495)	3,572	(6,769)	15,992	7,679	4,579	(1,958)	10,300	4,135	11,148	22,018	58,074	(3,737)	(2,500)	71,738

* Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

See accompanying independent auditors' report.

Schedule 8

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION
AND SUBSIDIARIES

Combining Operations and Changes in Net Assets Information – Obligated Group

Year ended June 30, 2015

(In thousands)

	University of Maryland Medical Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center	Shore Health System				Chester River Hospital Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals*	UMMS Foundation	Eliminations	Obligated group total
					Memorial Hospital	Dorchester General	QAEC	Subtotal							
Unrestricted revenues, gains and other support															
Patient service revenue (net of contractual adjustments)	$ 1,351,245	107,600	208,848	370,789	187,400	47,289	4,489	239,178	55,231	132,650	334,910	374,214	—	(986)	3,173,679
Provision for bad debts	(40,038)	(6,679)	(16,602)	(15,358)	(8,574)	(2,283)	(166)	(11,023)	(4,788)	(8,221)	(8,171)	(18,149)	—	—	(129,029)
Net patient service revenue	1,311,207	100,921	192,246	355,431	178,826	45,006	4,323	228,155	50,443	124,429	326,739	356,065	—	(986)	3,044,650
Other operating revenue:															
State support	3,200	—	—	—	—	—	—	—	—	—	—	—	—	—	3,200
Other revenue	101,603	4,556	1,288	2,949	2,932	307	6	3,245	259	544	4,903	8,474	—	(681)	127,140
Total unrestricted revenue, gains and other support	1,416,010	105,477	193,534	358,380	181,758	45,313	4,329	231,400	50,702	124,973	331,642	364,539	—	(1,667)	3,174,990
Operating expenses:															
Salaries, wages, and benefits	676,198	53,044	92,381	169,483	80,850	22,058	3,270	106,178	23,535	56,041	133,674	154,959	—	—	1,465,493
Expendable supplies	307,929	16,369	23,382	60,784	30,395	3,459	486	34,340	5,449	19,998	82,672	71,174	—	—	622,097
Purchased services	139,169	21,568	38,758	62,269	33,994	8,631	1,167	43,792	11,586	23,095	66,272	56,837	—	(1,517)	461,829
Contracted services	128,649	8,801	24,784	9,287	4,455	1,960	658	7,073	5,184	4,390	15,534	10,810	—	—	214,512
Depreciation and amortization	83,275	4,852	11,642	20,435	9,974	2,354	1,182	13,510	3,456	4,196	13,717	20,531	—	—	175,614
Interest expense	27,272	726	1,134	5,928	2,293	352	526	3,171	152	1,964	9,251	7,292	—	—	56,890
Total operating expenses	1,362,492	105,360	192,081	328,186	161,961	38,814	7,289	208,064	49,362	109,684	321,120	321,603	—	(1,517)	2,996,435
Operating income (loss)	53,518	117	1,453	30,194	19,797	6,499	(2,960)	23,336	1,340	15,289	10,522	42,936	—	(150)	178,555
Nonoperating income and expenses, net:															
Loss on early extinguishment of debt	(1,756)	—	—	—	—	—	—	—	—	—	—	(7,038)	—	—	(8,794)
Change in fair value of undesignated interest rate swaps	(21,235)	—	—	—	—	—	—	—	—			(1,002)	—	—	(22,237)
Other nonoperating gains and losses:															
Contributions	19	—	—	—	15	—	—	15	—	—	—	—	7,654	—	7,688
Equity in net income of joint ventures	260	—	—	—	167	48	7	222	—	74	1,617	—	—	—	2,173
Investment income	11,798	636	52	2,238	3,347	26	4	3,377	360	193	—	5,129	451	—	24,234
Change in fair value of investments	(15,404)	(792)	—	(2,846)	(2,491)	(20)	(3)	(2,514)	(450)	(393)	—	(3,299)	(769)	—	(26,467)
Other nonoperating gains and losses	(14,130)	(368)	(561)	(2,999)	(1,334)	(10)	(1)	(1,345)	(77)	(879)	(4,414)	(3,976)	(7,032)	—	(35,781)
Total other nonoperating gains and losses	(17,457)	(524)	(509)	(3,607)	(296)	44	7	(245)	(167)	(1,005)	(2,797)	(2,146)	304	—	(28,153)
Excess (deficiency) of revenues over expenses	13,070	(407)	944	26,587	19,501	6,543	(2,953)	23,091	1,173	14,284	7,725	32,750	304	(150)	119,371
Net assets released from restrictions used for purchase of property and equipment	14,669	160	383	150	938	—	—	938	1,353	—	641	152	—	—	18,446
Change in unrealized gains on investments	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in economic and beneficial interest in the net assets of related organizations	—	—	—	—	(14,762)	—	—	(14,762)	245	—	(921)	—	—	—	(15,438)
Change in ownership interest of joint ventures	278	—	—	—	—	—	—	—	—	—	—	—	—	—	278
Capital transfers (to) from affiliate	(3,452)	1,978	(600)	—	7,560	—	—	7,560	—	(15,051)	—	(12,751)	(2,702)	(2,500)	(27,518)
Amortization of accumulated loss of discontinued designated interest rate swap	1,812	—	—	—	—	—	—	—	—	—	—	—	—	—	1,812
Change in funded status of defined benefit pension plans	—	—	(2,499)	633	—	—	—	—	428	(992)	—	(5,562)	—	—	(7,992)
Asset reclassifications at request of donor	—	—	—	—	—	—	—	—	—	—	—	—	(201)	—	(201)
Other	(1)	(2)	1	2	1	—	—	1	4	(2,501)	77	315	—	150	(1,954)
Increase (decrease) in unrestricted net assets	$ 26,376	1,729	(1,771)	27,372	13,238	6,543	(2,953)	16,828	3,203	(4,260)	7,522	14,904	(2,599)	(2,500)	86,804

* Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

See accompanying independent auditors' report