IN THE MARYLAND HEALTH CARE COMMISSION

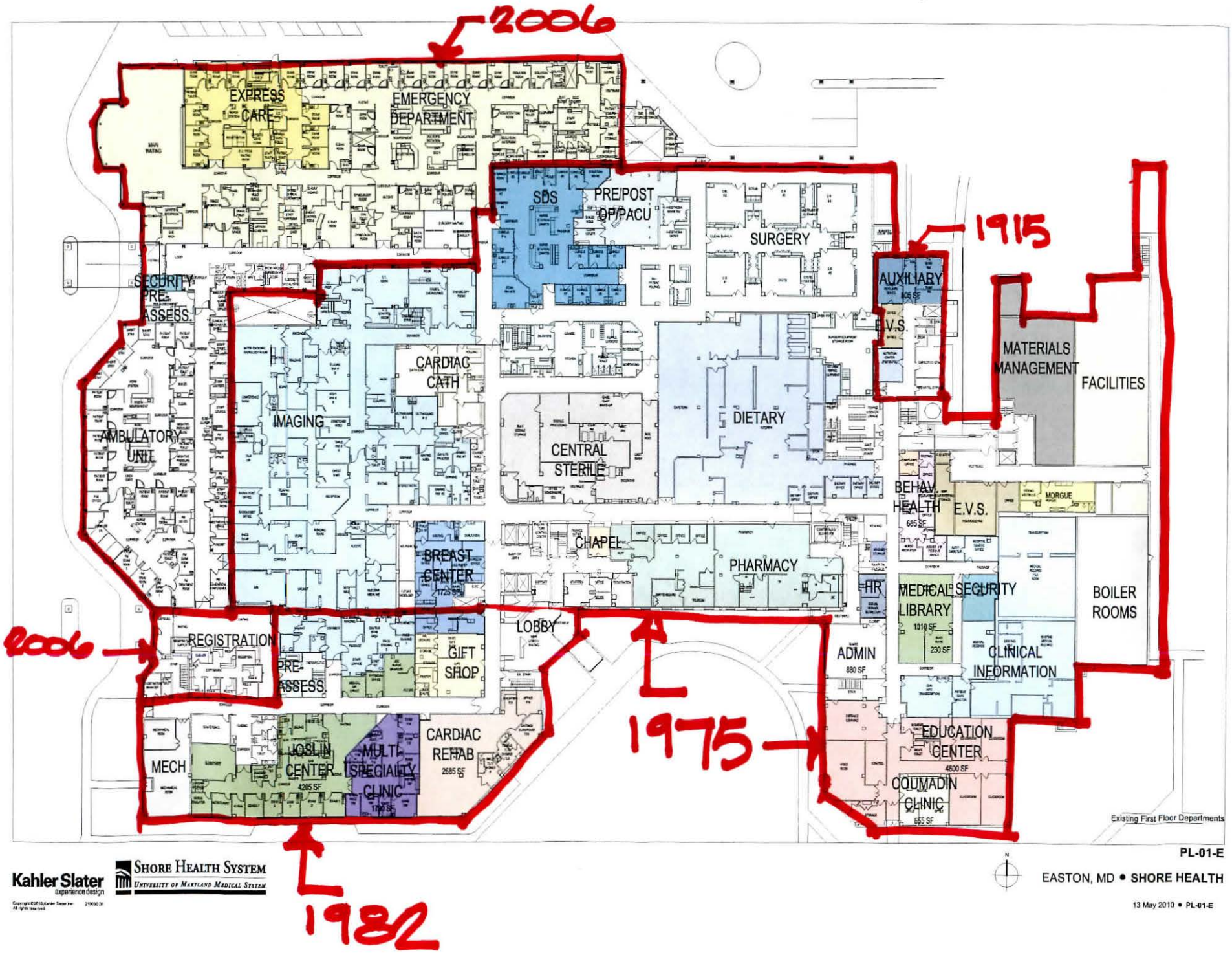
APPLICATION FOR CERTIFICATE OF NEED

for the
Replacement and Relocation of
University of Maryland Shore Medical Center at Easton

Applicant
Shore Health System, Inc.
September 7, 2018

VOLUME 2
EXHIBITS 3 - 19

EXHIBIT 3



Kahler Slater experience design

SHORE HEALTH SYSTEM
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

PL-01-E

EASTON, MD • SHORE HEALTH

13 May 2010 • PL-01-E

EXHIBIT 4

TALBOT COUNTY FINANCE OFFICE
RECORDATION TAX
AMT: $29580.00
DATE: 10/28/2015
INITIALS: DPierce
Prop ID: Multiple Parcels

EXEMPT FROM COUNTY TRANSFER TAX PURSUANT TO SECTION 172-17 OF THE TALBOT COUNTY CODE (CONVEYANCE BY A POLITICAL SUBDIVISION OF THE STATE)

DEED

THIS DEED is dated as of October 23, 2015, from **TALBOT COUNTY, MARYLAND**, a charter county and political subdivision of the State of Maryland ("Grantor"), to **SHORE HEALTH SYSTEM, INC.**, a Maryland corporation ("Grantee").

THE GRANTOR, for a consideration of TWO MILLION, FOUR HUNDRED SIXTY FOUR THOUSAND SIX HUNDRED FIFTY SEVEN AND 53/100 DOLLARS ($2,464,657.53), grants, conveys and assigns to the Grantee, its successors and assigns, in fee simple, the real property located in Talbot County, Maryland, and described as follows:

PARCEL ONE:

All that lot or parcel of land containing 12.538 acres and being shown and designated as Lot 1 on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 461.

PARCEL TWO:

All that lot or parcel of land containing 19.800 acres and being shown and designated as Lot 2 on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 460, which lot includes the area of land designed on such plat as "Part of Parcel 38 to be Conveyed to Lot 2, 0.013 acres ±".

PARCEL THREE:

All that lot or parcel of land containing 77.075 acres and being shown and designated as Lot 3 on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, pages 461 and 462.

PARCEL FOUR:

All that lot or parcel of land containing 89.710 acres and being shown and designated as Lot 5 on those plats entitled "Plat of Subdivision, Lot 1 through 7,

Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, pages 463 and 464.

PARCEL FIVE:

All that lot or parcel of land containing 1.029 acres and being shown and designated as Parcel A on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 460.

PARCEL SIX:

All that lot or parcel of land shown and designated as "Land Intended to be Dedicated to the State Highway Administration, 3.826 acres," on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 460, which lot includes the area of land designed on such plat as "Part of Parcel 38 to be Dedicated to the State Highway Administration 0.032 acres ±."

PARCEL SEVEN:

All that lot or parcel of land shown and designated as "SWM Parcel 5A, Land Intended to be Dedicated to the State Highway Administration, 3.679 acres," on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 460.

PARCEL EIGHT:

All that lot or parcel of land shown and designated as "Medical Center Drive (Commercial Local Street) SHA Plat 59004 Variable Width" and "Relocated Md. Rte. 662C (Rural Local Roadway) SHA Plats 59003 and 59004 Variable Width", "Land Intended to be Dedicated to the State Highway Administration, 5.976 acres," on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 460.

THIS IS TO CERTIFY THAT THE PROPERTY DESCRIBED HEREIN HAS BEEN TRANSFERRED ON THE ASSESSMENT RECORDS OF TALBOT COUNTY.

DAVID H. EWING
SUPERVISOR OF ASSESSMENTS
PER R ANDREW HOLLIS, FIN. OFFICER cc 2
10/28/2015cc

CERTIFICATION IS MADE THAT ALL TAXES DUE ON THE PROPERTY INDICATED IN THIS DEED HAVE BEEN PAID.
FINANCE OFFICER OF TALBOT COUNTY
R ANDREW HOLLIS, FIN. OFFICER cc
DATE 10/28/2015cc

LIBER2304 FOLIO433

PARCEL NINE:

All that lot or parcel of land shown and designated as "Relocated Md. Rte. 662C (Rural Local Roadway) SHA Plats 59004 and 59005 Variable Width", "Land Intended to be Dedicated to the State Highway Administration, 3.354 acres," on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 461.

PARCEL TEN:

All that lot or parcel of land shown and designated as "SWM Parcel 4B, Land Intended to be Dedicated to the State Highway Administration, 1.509 acres," on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 461.

PARCEL ELEVEN:

All that lot or parcel of land shown and designated as "SWM Parcel 4A, Land Intended to be Dedicated to the State Highway Administration, 4.809 acres," on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 461.

FOR TITLE, SEE: (i) Confirmatory Deed from Talbot County, Maryland, to Talbot County, Maryland, dated August 10, 2007, and recorded among the Land Records of Talbot County, Maryland, in Liber MAS 2005, folio 139; being all the same property contained in Deed from Carole Parris Young and Clarke L. Parris by W. Thomas Fountain, Attorney-in-Fact to Talbot County, Maryland, dated December 16, 2005, and recorded among the Land Records of Talbot County, Maryland, in Liber MAS 1402, folio 672; and (ii) Deed from Ann Littleton O'Brien, Carole Parris and Clarke L. Parris to Talbot County, Maryland, dated August 8, 1988, and recorded among the Land Records of Talbot County, Maryland, in Liber MAS 656, folio 127; and (iii) Deed from Nettie Marie Jones to Talbot County, Maryland, dated March 25, 1977, and recorded among the Land Records of Talbot County, Maryland, in Liber JTB 510, folio 339; and (iv) Deed from Clarke L. Parris and Carole Parris Young to Talbot County, Maryland, dated January 18, 2008, and recorded among the Land Records of Talbot County, Maryland, in Liber MAS 1597, folio 343.

TOGETHER WITH all improvements thereupon, and the rights, alleys, ways, waters, easements, privileges, appurtenances and advantages belonging or appertaining thereto.

TO HAVE AND TO HOLD the real property hereby conveyed to the Grantee, its successors and assigns, in fee simple, forever.

THE FOREGOING CONVEYANCE was duly authorized and is hereby made in accordance with law: the Talbot County Council has duly authorized the same by adoption of Resolution No. 153 on July 8, 2008, following a public hearing held on June 10, 2008 and continued to June 24, 2008 and July 8, 2008, which hearing was duly advertised, including the proposed terms of this conveyance and compensation to be received and the opportunity to comment or object, on May 16, 23 and 30, 2008 in *The Star Democrat*, a newspaper printed and regularly circulated in Talbot County, Maryland.

BUT SUBJECT, HOWEVER, to the following restrictive covenants, conditions, and reservations, which covenants, conditions, restrictions and reservations shall apply to and run with and bind the land hereby conveyed, as follows:

FIRST, a covenant that the real property shall be used only for agriculture and/or regional health care facilities, including, at a minimum an acute care hospital, and related medical and support uses consistent with uses permitted under a Regional Health Care or similar zoning district adopted by the Town of Easton.

SECOND, a covenant that, within five (5) years following the date hereof, Grantee shall commence planning and design of an acute care hospital on the property hereby conveyed ("Property"). Except for delays caused by *force majeure*, if construction of an acute care hospital is not substantially completed within fifteen (15) years after the date hereof, Grantor shall have the right at any time within five (5) years thereafter to require Grantee to convey the Property to Grantor. Upon Grantor's written notice to Grantee that it wishes to reacquire the Property, Grantee shall transfer the Property to Grantor within ninety (90) days and Grantor shall return to Grantee the consideration (set forth hereinabove) paid by Grantee to Grantor for the Property. If Grantor does not give written notice within the five (5) year period, this covenant is extinguished and of no further force and effect.

THIRD: The above restrictive covenants shall be subordinated to any lien or other instrument securing any loan, bond issue, or other financing obtained and used to construct an acute care hospital and related or supporting facilities, so that, in the event of a *bona fide* default in the repayment of any secured obligation incurred to obtain construction financing, and sale of the Property under the terms of any instrument securing performance of that financial obligation, the Property may be sold by the secured party at such sale free and clear of the covenant.

FOURTH: This grant and conveyance is subject to a certain Annexation Agreement and Public Facilities Agreement dated December 8, 2009 by and between the TOWN OF EASTON, a Maryland municipal corporation ("Town"), Grantor and Grantee, recorded among the Land Records of Talbot County, Maryland, at Liber MAS 1757, folio 12-90, and to the terms of Town Resolution No. 5955, "A RESOLUTION TO ANNEX CERTAIN LANDS OWNED BY TALBOT COUNTY, MARYLAND, INTO THE TOWN OF EASTON LOCATED ON THE WEST SIDE OF US ROUTE 50 AND CONSISTING OF 276.479 ± ACRES OF LAND, MORE OR LESS, AND TO PROVIDE FOR THE TERMS AND CONDITIONS OF THE ANNEXATION", recorded among the Land Records of Talbot County, Maryland, at Liber MAS

1768, folio 252-271.

FIFTH: This grant and conveyance is subject to a certain Development Rights and Responsibilities Agreement by and between the Town, Grantor and Grantee recorded among the Land Records of Talbot County Maryland, at Liber MAS 2206, folio 266-398, which includes, among others and without limitation, the following terms, covenants, conditions, and restrictions:

(A) Reference to the Development Rights and Responsibilities Agreement shall be included in any deed for all or portion(s) of the Property during the Term of such Agreement, but failure to include such reference shall not impact the effectiveness of the Development Rights and Responsibilities Agreement. (Liber 2206, folio 284, Para. 2.6.2).

(B) If Shore Health System, Inc., proceeds with Development of the Property, initial construction, other than grading, drainage and infrastructure improvements, shall include construction of at least the first phase of an "accredited acute care hospital" (as defined by the Annexation Agreement) on the Property. When all phases of construction of the hospital are complete, the "accredited acute care hospital" constructed on the Property shall contain at least 100 beds. (Liber 2206, folio 286, Para. 2.9(c)).

(C) In the event of any transfer of land located in Section One prior to Development of an acute care hospital on the Property, such transferee shall also demonstrate, to the Town and County's reasonable satisfaction, the transferee's capability to Develop the minimum acute care hospital and infrastructure required by the Annexation Agreement and this Agreement. (Liber 2206, folio 284, Para. 2.6.3).

THE GRANTOR covenants to warrant specially the real property hereby conveyed, and to execute such further assurances of the real property as may be requisite.

THE GRANTOR claims exemption from the tax withholding requirements of Md. Tax-General Art. §10-912 and whose representative certifies under the penalties of perjury, that such Grantor, being the Transferor hereunder, is a charter county and political subdivision of the State of Maryland.

AND THE GRANTEE joins herein for the purpose of expressly covenanting and agreeing that the covenants, conditions, restrictions and reservations set forth in this Deed shall be binding upon the said Grantee, its successors and assigns, and upon the real property hereby conveyed.

SIGNATURES ON FOLLOWING PAGES

IN WITNESS WHEREOF the Grantor has caused this Deed to be duly executed on its behalf by a duly authorized representative.

GRANTOR:

TALBOT COUNTY, MARYLAND

By: _____
Corey W. Pack, President
Talbot County Council

Acknowledgement

STATE OF MARYLAND, COUNTY OF TALBOT, TO WIT:

I HEREBY CERTIFY, that on this 26th day of October, 2015, before me, the subscriber, a Notary Public of the State of Maryland, personally appeared COREY W. PACK, who acknowledged himself to be the President of the TALBOT COUNTY COUNCIL, the chief executive of Talbot County, Maryland, a charter county and political subdivision of the State of Maryland, and that he as such President, being authorized so to do, executed the foregoing Deed for the purposes therein contained by signing the name of said Talbot County, Maryland, by himself as President.

AS WITNESS my hand and Notarial seal.

Susan W. Moran
Notary Public

My commission expires: 3/6/2017

SUSAN W. MORAN NOTARY PUBLIC TALBOT COUNTY, MD

AND IN WITNESS WHEREOF the Grantee joins herein for the purpose of expressly covenanting and agreeing that the covenants, conditions, restrictions and reservations set forth in this Deed shall be binding upon the said Grantee, its successors and assigns, and upon the real property hereby conveyed.

GRANTEE:

SHORE HEALTH SYSTEM, INC.

By: _____
Kenneth D. Kozel, President and CEO

Acknowledgement

STATE OF MARYLAND, COUNTY OF TALBOT, TO WIT:

I HEREBY CERTIFY, that on this 21st day of October, 2015, before me, a Notary Public of the aforesaid State, personally appeared KENNETH D. KOZEL, President and CEO of Shore Health System, Inc., who was known to me (or satisfactorily proven) to be the person whose name is subscribed to the foregoing Deed, and acknowledged that he executed the same for the purposes therein contained as the fully authorized agent of said Shore Health System, Inc.

WITNESS my hand and Notarial Seal.

My Commission expires: 1/27/2016

_____
Notary Public

LINDA E. RUANE NOTARY PUBLIC TALBOT COUNTY, MD MY COMMISSION EXPIRES 01-27-2016

Agricultural Transfer Tax

Amount $ -0-

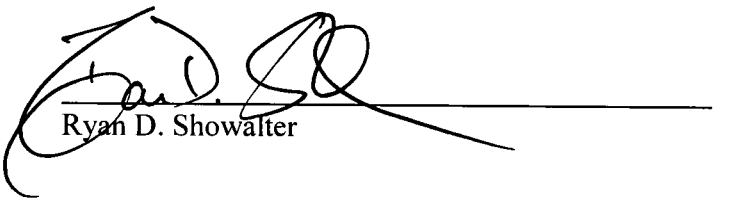
Signature R ANDREW HOLLIS, FIN. OFFICER ac
10/28/2015 ac

Agricultural Transfer Tax Due in the Amount of $ _____

David H. Ewing
Supervisor of Assessments
Per _____

Attorney Certification

This instrument has been prepared by the undersigned, an attorney duly admitted to practice before the Court of Appeals of Maryland.



Ryan D. Showalter

Return recorded document to:
Pamela C. Raymond
Miles & Stockbridge P.C.
100 Light Street, 4th Floor
Baltimore, Maryland 21202

Mary Ann Shortall, Clerk
Circuit Court For Talbot County
11 N. Washington St., Suite 16
Easton, Maryland 21601

License and Recording
(410) 822-2611 Ext. 4

```
LR - Deed (w Taxes)
Recording Fee no RT
                    20.00
Grantor/Grantee Name:
TalbotCo/Shore Health
Reference/Contro) #:
2304/432
LR - Deed (with Taxes)
Surcharge           40.00
LR - Deed State
Transfer Tax 12,323.29
LR - County Transfer
Tax - linked         0.00
LR - Non-Resident Tax
- linked             0.00
=========================
SubTotal:     12,383.29
=========================
Total:        12,383.29
10/28/2015  04:09
                   CC20-LL
#5077430 CC0205 -
Talbot
County/CC02.05.02 -
Register 02
```

DOCUMENT VALIDATION
(excluded from page count)

State of Maryland Land Instrument Intake Sheet

[ ] City [X] County: Talbot

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

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

1 Type(s) of Instruments ([ ] Check Box if Addendum Intake Form is Attached.)

X	Deed		Mortgage		Other		Other
	Deed of Trust		Lease				

2 Conveyance Check Box

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

3 Tax Exemptions (if Applicable) Cite or Explain Authority

Recordation	
State Transfer	
County Transfer	

4 Consideration and Tax Calculations

Consideration Amount		Finance Office Use Only	
Purchase Price/Consideration	$ 2,464,657.53	**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**	$

5 Fees

Amount of Fees	Doc. 1	Doc. 2	
Recording Charge	$ 20.00	$	**Agent:**
Surcharge	$ 40.00	$	**Tax Bill:**
State Recordation Tax	$ 29,580.00	$	
State Transfer Tax	$ 12,323.29	$	**C.B. Credit:**
County Transfer Tax	$	$	
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	Map	Parcel No.	Var. LOG
	See attached.				

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

Location/Address of Property Being Conveyed (2)

Longwoods Road

Other Property Identifiers (if applicable)

Longwoods Road – N of Easton

Residential [ ] or Non-Residential [X] AG | **Fee Simple [X] or Ground Rent [ ] Amount:**

Partial Conveyance? [ ] Yes [X] No | Description/Amt. of SqFt/Acreage Transferred:

If Partial Conveyance, List Improvements Conveyed:

7 Transferred From & To

Doc. 1 – Grantor(s) Name(s)	Doc. 2 – Grantor(s) Name(s)
Talbot County, Maryland	
Doc. 1 - Owner(s) of Record, if Different from Grantor(s)	**Doc. 2 – Owner(s) of Record, if Different from Grantor(s)**

8 Transferred To & From

Doc. 1 – Grantee(s) Name(s)	Doc. 2 – Grantee(s) Name(s)
Shore Health System, Inc.	

New Owner's (Grantee) Mailing Address

219 S. Washington Street, Easton, Maryland 21601

9 Other Names to Be Indexed

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

10 Contact/Mail Information

Instrument Submitted By or Contact Person

Name: Ryan D. Showalter
Firm: Miles & Stockbridge, P.C.
Address: 101 Bay Street, Suite 2, Easton, Maryland 21601
Phone: 410-820-0259

[X] Return to Contact Person
[ ] Hold for Pickup
[ ] Return Address Provided

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

Assessment Information

[ ] 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: _____
[X] 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			Geo.	Map	Sub	Block
Land			Zoning	Grid	Plat	Lot
Buildings			Use	Parcel	Section	Occ. Cd.
Total			Town Cd.	Ex. St.	Ex. Cd.	

REMARKS:

LIBER2304 FOLIO441

4843-2727-0694

Intake Sheet Continuation Page

Talbot County, Maryland and Shore Health System, Inc.
Longwoods Road

6. Description of Property

Property	District	Tax ID No.	Grantor Liber/folio	Map	Parcel/Acreage
Longwoods Road	01	01-040650	2005/139	0017	0075 12.538 AC – Lot 1 on subdivision plat
Longwoods Road	01	01-040650	2005/139	0017	0075 19.800 AC – Lot 2 on subdivision plat
Longwoods Road	01	P/O 01-040650 01-113771	2005/139 1597/343	0017	0075 0129 77.075 AC - Lot 3 on subdivision plat
Longwoods Road	01	01-113771	1597/343	0017	0129 89.710 AC – Lot 4 on subdivision plat
Longwoods Road	01	01-040650	2005/139	0017	0075 1.029 AC – Parcel A on subdivision plat
Longwoods Road	01	01-040650	2005/139	0017	0075 3.826 AC – Land intended to be dedicated to State Highway Administration on subdivision plat
Longwoods Road	01	01-040650	2005/139	0017	0075 3.679 AC – SWM Parcel 5A on subdivision plat
Longwoods Road	01	01-040650	2005/139	0017	0075 5.976 AC – Medical Center Drive on subdivision plat
Longwoods Road	01	01-040650	2005/139	0017	0075 3.354 AC – Relocated MD Rte. 662C on subdivision plat

Longwoods Road	01	01-040650	2005/139	0017	0075 1.509 AC – SWM Parcel 4B on subdivision plat
Longwoods Road	01	01-040650	2005/139	0017	0075 4.809 AC – SWM Parcel 4A on subdivision plat

EXHIBIT 5

SHORE HEALTH UNIVERSITY OF MARYLAND MEDICAL SYSTEM	ADMINISTRATIVE POLICY & PROCEDURE	POLICY NO:	LD-66
		REVISED:	11/12
	PUBLIC DISCLOSURE OF CHARGES	PAGE #:	1 of 2
		SUPERSEDES	09/12

CROSS REFERENCE

Administrative Policy LD-34: Financial Assistance

SCOPE

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

PURPOSE

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

BENEFITS

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

1.0 POLICY

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

2.0 PROCEDURE

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

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

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

Gerard M. Walsh, Chief Operating Officer

Effective	09/12
Revised	11/12 (Minor Editorial Revision)
Approved	Walter Zajac, Sr. Vice President / CFO

EXHIBIT 6

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Estimated Charges for Inpatient Admissions

APR DRG	Shore Medical Center at Dorchester - Medical/Surgical Cases	Charge Range Minimum	Charge Range Maximum	Estimated Average Charge
133	PULMONARY EDEMA & RESPIRATORY FAILURE	$ 2,549	$ 53,089	$ 14,919
194	HEART FAILURE	$ 2,079	$ 79,064	$ 11,737
201	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	$ 2,404	$ 23,043	$ 8,235
720	SEPTICEMIA & DISSEMINATED INFECTIONS	$ 3,937	$ 46,618	$ 16,397
140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	$ 3,047	$ 34,160	$ 11,028
139	OTHER PNEUMONIA	$ 4,716	$ 28,065	$ 10,631
249	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	$ 2,799	$ 33,272	$ 7,066
463	KIDNEY & URINARY TRACT INFECTIONS	$ 3,659	$ 47,725	$ 9,814
45	CVA & PRECEREBRAL OCCLUSION W INFARCT	$ 3,819	$ 31,263	$ 11,685
383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	$ 3,282	$ 21,762	$ 9,537

APR DRG	Shore Medical Center at Dorchester - Psychiatric Cases			
753	BIPOLAR DISORDERS	$ 1,272	$ 75,636	$ 8,488
754	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	$ 2,998	$ 26,041	$ 7,322
750	SCHIZOPHRENIA	$ 1,486	$ 85,778	$ 10,812
751	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	$ 1,272	$ 76,045	$ 9,994
755	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	$ 1,272	$ 90,121	$ 7,885
756	ACUTE ANXIETY & DELIRIUM STATES	$ 2,810	$ 16,393	$ 6,997
775	ALCOHOL ABUSE & DEPENDENCE	$ 1,259	$ 20,019	$ 9,424
758	CHILDHOOD BEHAVIORAL DISORDERS	$ 2,268	$ 11,777	$ 6,009
757	ORGANIC MENTAL HEALTH DISTURBANCES	$ 3,875	$ 31,308	$ 13,156
773	OPIOID ABUSE & DEPENDENCE	$ 1,259	$ 16,657	$ 6,769

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Estimated Charges for Inpatient Admissions

APR DRG	Shore Medical Center at Easton - Medical/Surgical Cases	Charge Range Minimum	Charge Range Maximum	Estimated Average Charge
133	PULMONARY EDEMA & RESPIRATORY FAILURE	$ 2,867	$ 122,936	$ 15,199
302	KNEE JOINT REPLACEMENT	$ 9,336	$ 45,162	$ 17,443
301	HIP JOINT REPLACEMENT	$ 8,308	$ 46,171	$ 17,522
201	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	$ 2,226	$ 59,404	$ 7,558
720	SEPTICEMIA & DISSEMINATED INFECTIONS	$ 2,198	$ 121,572	$ 18,531
194	HEART FAILURE	$ 2,573	$ 39,229	$ 9,259
139	OTHER PNEUMONIA	$ 2,056	$ 48,943	$ 10,793
45	CVA & PRECEREBRAL OCCLUSION W INFARCT	$ 3,403	$ 159,693	$ 15,527
304	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK	$ 16,754	$ 64,276	$ 31,118
253	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE	$ 3,813	$ 37,502	$ 10,183
APR DRG	**Shore Medical Center at Easton - Pediatric Cases**			
139	OTHER PNEUMONIA	$ 2,177	$ 14,173	$ 6,591
141	ASTHMA	$ 3,575	$ 16,635	$ 7,320
225	APPENDECTOMY	$ 6,790	$ 16,233	$ 10,211
138	BRONCHIOLITIS & RSV PNEUMONIA	$ 3,957	$ 12,261	$ 8,097
463	KIDNEY & URINARY TRACT INFECTIONS	$ 4,514	$ 13,336	$ 7,069
249	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	$ 3,112	$ 8,314	$ 5,380
383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	$ 4,981	$ 16,631	$ 8,579
51	VIRAL MENINGITIS	$ 6,506	$ 8,112	$ 7,309
143	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES	$ 2,839	$ 8,854	$ 5,846
144	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES	$ 3,686	$ 6,508	$ 5,097

Estimated Charges for Inpatient Admissions

APR DRG		Charge Range Minimum	Charge Range Maximum	Estimated Average Charge
APR DRG	**Shore Medical Center at Easton - Obstetric Cases**			
560	VAGINAL DELIVERY	$ 1,754	$ 16,631	$ 8,411
540	CESAREAN DELIVERY	$ 3,926	$ 21,536	$ 10,411
566	OTHER ANTEPARTUM DIAGNOSES	$ 1,510	$ 22,444	$ 5,155
561	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE	$ 1,775	$ 18,474	$ 5,771
542	VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC STERILIZATION &/OR D&C	$ 6,986	$ 17,219	$ 10,531
541	VAGINAL DELIVERY W STERILIZATION &/OR D&C	$ 6,419	$ 16,826	$ 11,474
544	D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY FOR OBSTETRIC DIAGNOSES	$ 5,981	$ 14,220	$ 9,869
APR DRG	**Shore Medical Center at Easton - Rehabilitation Cases**			
860	REHABILITATION	$ 1,855	$ 124,986	$ 23,172

Estimated Charges for Inpatient Admissions

APR DRG	Shore Medical Center at Chestertown - Medical/Surgical Cases	Charge Range Minimum	Charge Range Maximum	Estimated Average Charge
133	PULMONARY EDEMA & RESPIRATORY FAILURE	$ 3,211	$ 48,781	$ 14,053
720	SEPTICEMIA & DISSEMINATED INFECTIONS	$ 4,256	$ 70,942	$ 18,384
201	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	$ 3,060	$ 30,132	$ 8,754
463	KIDNEY & URINARY TRACT INFECTIONS	$ 3,217	$ 59,985	$ 11,705
194	HEART FAILURE	$ 3,094	$ 39,302	$ 10,972
139	OTHER PNEUMONIA	$ 3,042	$ 70,103	$ 10,959
383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	$ 3,328	$ 22,836	$ 9,409
302	KNEE JOINT REPLACEMENT	$ 19,280	$ 77,213	$ 41,288
420	DIABETES	$ 2,693	$ 39,629	$ 9,080
663	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS	$ 3,027	$ 40,607	$ 10,737

University of Maryland Shore Regional Health

Estimated Charges for Common Inpatient Procedures

ICD-10 Code	Procedure	Charge Range		Estimated Average Charge
		Minimum	Maximum	
Shore Medical Center at Dorchester				
HZ2ZZZZ	Detoxification Services for Substance Abuse Treatment	$ 2,121	$ 26,041	$ 9,421
30233N1	Transfusion of Nonautologous Red Blood Cells into Peripheral Vein, Percutaneous Approach	$ 3,408	$ 139,858	$ 17,861
5A09357	Assistance with Respiratory Ventilation, Less than 24 Consecutive Hours, Continuous Positive Airway Pressure	$ 3,276	$ 55,467	$ 13,968
5A1D60Z	Performance of Urinary Filtration, Multiple	$ 6,807	$ 79,064	$ 19,040
0FT44ZZ	Resection of Gallbladder, Percutaneous Endoscopic Approach	$ 9,135	$ 31,718	$ 17,373
0BH17EZ	Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening	$ 4,891	$ 128,863	$ 28,716
5A09457	Assistance with Respiratory Ventilation, 24-96 Consecutive Hours, Continuous Positive Airway Pressure	$ 5,181	$ 28,113	$ 13,462
5A1D00Z	Performance of Urinary Filtration, Single	$ 4,170	$ 13,062	$ 7,183
02HV33Z	Insertion of Infusion Device into Superior Vena Cava, Percutaneous Approach	$ 8,255	$ 39,014	$ 19,672
05HB33Z	Insertion of Infusion Device into Right Basilic Vein, Percutaneous Approach	$ 10,922	$ 40,387	$ 21,342
Shore Medical Center at Easton				
3E0234Z	Introduction of Serum, Toxoid and Vaccine into Muscle, Percutaneous Approach	$ 693	$ 26,289	$ 2,475
10E0XZZ	Delivery of Products of Conception, External Approach	$ 1,754	$ 16,826	$ 8,417
10D00Z1	Extraction of Products of Conception, Low Cervical, Open Approach	$ 3,926	$ 21,536	$ 10,390
0VTTXZZ	Resection of Prepuce, External Approach	$ 1,045	$ 13,644	$ 2,660
5A09357	Assistance with Respiratory Ventilation, Less than 24 Consecutive Hours, Continuous Positive Airway Pressure	$ 1,575	$ 122,975	$ 15,107
30233N1	Transfusion of Nonautologous Red Blood Cells into Peripheral Vein, Percutaneous Approach	$ 1,937	$ 71,435	$ 13,339
0SRC0J9	Replacement of Right Knee Joint with Synthetic Substitute, Cemented, Open Approach	$ 11,351	$ 51,275	$ 17,025
0SRD0J9	Replacement of Left Knee Joint with Synthetic Substitute, Cemented, Open Approach	$ 11,189	$ 45,162	$ 17,305
4A023N7	Measurement of Cardiac Sampling and Pressure, Left Heart, Percutaneous Approach	$ 3,606	$ 71,702	$ 13,769
HZ2ZZZZ	Detoxification Services for Substance Abuse Treatment	$ 2,013	$ 36,715	$ 9,299
Shore Medical Center at Chestertown				
5A09357	Assistance with Respiratory Ventilation, Less than 24 Consecutive Hours, Continuous Positive Airway Pressure	$ 3,800	$ 70,103	$ 14,999
30233N1	Transfusion of Nonautologous Red Blood Cells into Peripheral Vein, Percutaneous Approach	$ 3,037	$ 157,275	$ 18,356
02HV33Z	Insertion of Infusion Device into Superior Vena Cava, Percutaneous Approach	$ 4,256	$ 51,683	$ 17,427
0FT44ZZ	Resection of Gallbladder, Percutaneous Endoscopic Approach	$ 9,482	$ 32,694	$ 15,557
0SRC0J9	Replacement of Right Knee Joint with Synthetic Substitute, Cemented, Open Approach	$ 19,280	$ 69,039	$ 41,009
5A09457	Assistance with Respiratory Ventilation, 24-96 Consecutive Hours, Continuous Positive Airway Pressure	$ 5,931	$ 70,942	$ 22,189
0D9670Z	Drainage of Stomach with Drainage Device, Via Natural or Artificial Opening	$ 5,847	$ 97,036	$ 17,114
0SRD0J9	Replacement of Left Knee Joint with Synthetic Substitute, Cemented, Open Approach	$ 22,586	$ 71,746	$ 39,635
0DB78ZX	Excision of Stomach, Pylorus, Via Natural or Artificial Opening Endoscopic, Diagnostic	$ 4,203	$ 45,103	$ 11,388
0DJ08ZZ	Inspection of Upper Intestinal Tract, Via Natural or Artificial Opening Endoscopic	$ 3,419	$ 53,660	$ 13,409

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT EASTON
Estimated Charges for Common Ancillary Services

LABORATORY

Procedure	Estimated Charge
Complete cbc w/auto diff wbc	$ 20.15
Comprehen metabolic panel	$ 50.52
Assay of troponin quant	$ 66.67
Assay of magnesium	$ 12.15
Urinalysis auto w/scope	$ 18.61
Assay of ck (cpk)	$ 13.59
Creatine mb fraction	$ 34.42
Prothrombin time	$ 16.11
Urinalysis auto w/o scope	$ 8.01
Metabolic panel total ca	$ 22.26
Thromboplastin time partial	$ 16.16
Reagent strip/blood glucose	$ 16.77
Assay of lipase	$ 16.14
Urine pregnancy test	$ 20.05
Urine culture/colony count	$ 40.16
Drug Screen	$ 62.81
Assay thyroid stim hormone	$ 30.98
Assay of amylase	$ 12.08
Tissue exam by pathologist	$ 222.69
Assay of natriuretic peptide	$ 60.57
Blood typing serologic abo	$ 8.06
Blood typing serologic rh(d)	$ 8.06
Blood culture for bacteria	$ 130.03
Rbc antibody screen	$ 24.14
Influenza assay w/optic	$ 109.88

RADIOLOGY

Procedure	Estimated Charge
Ct head/brain w/o dye	$ 97.05
Ct abd & pelv w/contrast	$ 321.07
Ct abd & pelvis w/o contrast	$ 259.13
Ct angiography chest	$ 441.28
Ct neck spine w/o dye	$ 128.97
Mri brain stem w/o & w/dye	$ 1,146.50
Mri brain stem w/o dye	$ 620.81
Mri lumbar spine w/o dye	$ 639.22
Mri abdomen w/o & w/dye	$ 2,197.51
Mri neck spine w/o dye	$ 631.84
Us guide vascular access	$ 63.23
Ob us < 14 wks single fetus	$ 498.19
Us exam pelvic complete	$ 502.23
Us exam abdom complete	$ 558.52
Transvaginal us non-ob	$ 498.84
Chest x-ray 2vw frontal&latl	$ 140.35
Chest x-ray 1 view frontal	$ 96.43
X-ray exam of knee 3	$ 147.14
X-ray exam of hand	$ 145.04
X-ray exam l-2 spine 4/>vws	$ 278.03
Ntsty modul rad tx dlvr smpl	$ 881.08
Ntsty modul rad tx dlvr cplx	$ 864.95
Radiation treatment delivery	$ 595.88
Guidance for radiaj tx dlvr	$ 155.82
Radiation physics consult	$ 162.35

SHORE MEDICAL CENTER AT EASTON
Estimated Charges for Common Outpatient Procedures

OUTPATIENT SURGERY	Charge Range		
Procedure	**Minimum**	**Maximum**	**Average Estimated Charge**
Fetal non-stress test	$ 1,050	$ 3,109	$ 1,287
Egd biopsy single/multiple	$ 742	$ 19,779	$ 2,989
Therapeutic procd strg endur	$ 4,463	$ 20,486	$ 10,432
Hysteroscopy biopsy	$ 1,897	$ 8,656	$ 3,169
Fna w/image	$ 935	$ 2,330	$ 1,221
Insert tunneled cv cath	$ 1,942	$ 7,819	$ 3,929
Colpopexy intraperitoneal	$ 8,490	$ 18,574	$ 11,942
Ra tracer id of sentinl node	$ 5,480	$ 16,915	$ 10,492
Insert mesh/pelvic flr addon	$ 6,835	$ 18,574	$ 11,768
Repair bladder defect	$ 6,661	$ 17,937	$ 11,314

SHORE MEDICAL CENTER AT DORCHESTER
Estimated Charges for Common Ancillary Services

LABORATORY

Procedure	Estimated Charge
Complete cbc w/auto diff wbc	$ 27.41
Comprehen metabolic panel	$ 64.72
Assay of troponin quant	$ 82.20
Assay of magnesium	$ 16.55
Urinalysis auto w/scope	$ 24.57
Assay of ck (cpk)	$ 18.33
Urinalysis auto w/o scope	$ 10.95
Prothrombin time	$ 21.80
Metabolic panel total ca	$ 30.48
Assay thyroid stim hormone	$ 40.89
Creatine mb fraction	$ 45.07
Assay of lipase	$ 22.01
Lipid panel	$ 51.92
Thromboplastin time partial	$ 21.91
Reagent strip/blood glucose	$ 20.84
Urine pregnancy test	$ 27.46
Drug Screen	$ 82.31
Urine culture/colony count	$ 54.64
Culture screen only	$ 55.26
Vitamin d 25 hydroxy	$ 41.09
Glycosylated hemoglobin test	$ 54.70
Assay of natriuretic peptide	$ 82.28
Influenza assay w/optic	$ 142.96
Assay of amylase	$ 16.24
Assay of creatinine	$ 5.45

RADIOLOGY

Procedure	Estimated Charge
Ct head/brain w/o dye	$ 79.47
Ct abd & pelv w/contrast	$ 240.52
Ct abd & pelvis w/o contrast	$ 141.16
Ct thorax w/o dye	$ 131.53
Ct thorax w/dye	$ 167.41
Mri lumbar spine w/o dye	$ 679.58
Mri brain stem w/o & w/dye	$ 1,240.23
Mri neck spine w/o dye	$ 691.36
Mri brain stem w/o dye	$ 728.13
Mri jnt of lwr extre w/o dye	$ 890.74
Us exam abdom complete	$ 451.79
Us exam abdo back wall comp	$ 436.91
Ultrasound breast limited	$ 350.78
Us exam pelvic complete	$ 413.69
Us exam of head and neck	$ 429.58
Chest x-ray 2vw frontal&latl	$ 102.39
Radiologic examination, chest 2 views	$ 103.29
X-ray exam of foot	$ 127.88
X-ray exam l-2 spine 4/>vws	$ 189.58
X-ray exam of knee 3	$ 145.09
X-ray exam of shoulder	$ 108.23
Chest x-ray 1 view frontal	$ 77.52
X-ray exam of ankle	$ 119.81
X-ray exam of hand	$ 123.93
X-ray exam hip uni 2-3 views	$ 156.84

SHORE MEDICAL CENTER AT DORCHESTER
Estimated Charges for Common Outpatient Procedures

OUTPATIENT SURGERY	Charge Range		
Procedure	**Minimum**	**Maximum**	**Average Estimated Charge**
Therapeutic procd strg endur	$ 7,686	$ 18,742	$ 11,385
Laparoscopic cholecystectomy	$ 6,913	$ 13,131	$ 10,931
Abd paracentesis w/imaging	$ 1,302	$ 2,754	$ 2,157
Prp i/hern init reduc >5 yr	$ 5,248	$ 15,417	$ 7,423
Rpr umbil hern reduc > 5 yr	$ 4,070	$ 12,180	$ 7,088
Egd biopsy single/multiple	$ 1,653	$ 13,799	$ 3,899
Repair of hammertoe	$ 2,967	$ 9,028	$ 5,852
Rpr ventral hern init reduc	$ 6,457	$ 15,417	$ 10,346
Colonoscopy w/lesion removal	$ 2,042	$ 4,039	$ 3,290
Colonoscopy and biopsy	$ 1,786	$ 4,039	$ 3,192

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT CHESTERTOWN
Estimated Charges for Common Ancillary Services

LABORATORY

Procedure	Estimated Charge
Complete cbc w/auto diff wbc	$ 26.14
Comprehen metabolic panel	$ 58.79
Assay thyroid stim hormone	$ 39.10
Lipid panel	$ 49.23
Metabolic panel total ca	$ 29.18
Urinalysis auto w/scope	$ 23.35
Prothrombin time	$ 20.21
Assay of troponin quant	$ 82.67
Urinalysis auto w/o scope	$ 10.28
Urine culture/colony count	$ 51.40
Glycosylated hemoglobin test	$ 51.96
Reagent strip/blood glucose	$ 17.70
Assay of ck (cpk)	$ 17.44
Assay of lipase	$ 20.60
Thromboplastin time partial	$ 20.71
Assay of magnesium	$ 15.41
Creatine mb fraction	$ 45.90
Urine pregnancy test	$ 26.02
Influenza assay w/optic	$ 121.23
Vitamin d 25 hydroxy	$ 38.63
Strep a ag ia	$ 64.55
Culture screen only	$ 51.06
Culture aerobic identify	$ 27.90
Tissue exam by pathologist	$ 196.50
Drug Screen	$ 77.71

RADIOLOGY

Procedure	Estimated Charge
Ct head/brain w/o dye	$ 136.60
Ct abd & pelv w/contrast	$ 410.11
Ct abd & pelvis w/o contrast	$ 239.83
Ct thorax w/o dye	$ 220.50
Ct angiography chest	$ 437.93
Mri lumbar spine w/o dye	$ 689.25
Mri brain stem w/o dye	$ 715.44
Mri neck spine w/o dye	$ 678.45
Mri jnt of lwr extre w/o dye	$ 875.23
Mri joint upr extrem w/o dye	$ 892.40
Breast tomosynthesis bi	$ 140.78
Us exam pelvic complete	$ 504.93
Us exam of head and neck	$ 522.68
Ultrasound breast limited	$ 423.49
Transvaginal us non-ob	$ 580.15
Chest x-ray 2vw frontal&latl	$ 125.27
Radiologic examination, chest 2 views	$ 122.71
X-ray exam of foot	$ 149.90
Screening mammography, bilateral (2-view study (	$ 684.67
X-ray exam of knee 3	$ 182.00
X-ray exam l-2 spine 4/>vws	$ 232.06
X-ray exam of ankle	$ 145.72
X-ray exam of shoulder	$ 137.64
Dxa bone density axial	$ 221.17
X-ray exam hip uni 2-3 views	$ 192.84

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT CHESTERTOWN
Estimated Charges for Common Outpatient Procedures

OUTPATIENT SURGERY	Charge Range		
Procedure	**Minimum**	**Maximum**	**Average Estimated Charge**
Colonoscopy w/ablation	$ 1,407	$ 3,689	$ 2,218
Egd biopsy single/multiple	$ 1,158	$ 11,471	$ 2,411
Colorectal scrn; hi risk ind	$ 1,079	$ 4,803	$ 1,857
Egd diagnostic brush wash	$ 702	$ 11,768	$ 2,280
Therapeutic procd strg endur	$ 9,309	$ 20,706	$ 14,690
Colon ca scrn not hi rsk ind	$ 1,560	$ 2,560	$ 1,828
Diagnostic colonoscopy	$ 1,313	$ 2,983	$ 1,900
Colonoscopy and biopsy	$ 1,699	$ 3,178	$ 2,305
Colonoscopy w/lesion removal	$ 2,198	$ 4,131	$ 2,663
Prp i/hern init reduc >5 yr	$ 3,919	$ 8,206	$ 5,617

EXHIBIT 7

University of Maryland Medical Center University of Maryland Medical Center Midtown Campus University of Maryland Rehabilitation & Orthopaedic Institute University of Maryland St. Joseph Medical Center University of Maryland Baltimore Washington Medical Center University of Maryland Shore Medical Center at Chestertown University of Maryland Shore Medical Center at Dorchester University of Maryland Shore Medical Center at Easton	**The University of Maryland Medical System** **Central Business Office** **Policy & Procedure**	*Policy #:*	TBD
		Effective Date:	09/01/2017
	Subject: **FINANCIAL ASSISTANCE**	*Page #:*	1 of 11
		Supersedes:	07-01-2017

POLICY

This policy applies to The University of Maryland Medical System (UMMS) following entities:

- University of Maryland Medical Center (UMMC)
- University of Maryland Medical Center Midtown Campus (MTC)
- University of Maryland Rehabilitation & Orthopaedic Institute (UMROI)
- University of Maryland St. Joseph Medical Center (UMSJMC)
- University of Maryland Baltimore Washington Medical Center (UMBWMC)
- University of Maryland Shore Medical Center at Chestertown (UMSMCC)
- University of Maryland Shore Medical Center at Dorchester (UMSMCD)
- University of Maryland Shore Medical Center at Easton (UMSME)

UMMS is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation.

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

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

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be

offered to patients whose accounts are with a collection agency and may apply only to those accounts on which a judgment has not been granted.

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

University of Maryland St. Joseph Medical Center (UMSJMC) adopted this policy effective June 1, 2013.

University of Maryland Medical Center Midtown Campus (MTC) adopted this policy effective September 22, 2014.

University of Maryland Baltimore Washington Medical Center (UMBWMC) adopted this policy effective July 1, 2016.

University of Maryland Shore Medical Center at Chestertown (UMSMCC) adopted this policy effective September 1, 2017.

University of Maryland Shore Medical Center at Dorchester (UMSMCD) adopted this policy effective September 1, 2017.

University of Maryland Shore Medical Center at Easton (UMSMCE) adopted this policy effective September 1, 2017.

PROGRAM ELIGIBILITY

Consistent with their 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, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

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

1. Services provided by healthcare providers not affiliated with UMMS hospitals (e.g., durable medical equipment, home health services)
2. Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, or Workers Compensation), are not eligible for the Financial Assistance Program.

a. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications.

3. Unpaid balances resulting from cosmetic or other non-medically necessary services
4. Patient convenience items
5. Patient meals and lodging
6. Physician charges related to the date of service are excluded from UMMS financial assistance policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.

Patients may be ineligible for Financial Assistance for the following reasons:

1. Refusal to provide requested documentation or provide incomplete information.
2. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to the Medical Center due to insurance plan restrictions/limits.
3. Failure to pay co-payments as required by the Financial Assistance Program.
4. Failure to keep current on existing payment arrangements with UMMS.
5. Failure to make appropriate arrangements on past payment obligations owed to UMMS (including those patients who were referred to an outside collection agency for a previous debt).
6. Refusal to be screened for other assistance programs prior to submitting an application to the Financial Clearance Program.
7. Refusal to divulge information pertaining to a pending legal liability claim
8. Foreign-nationals traveling to the United States seeking elective, non-emergent medical care

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

Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor/Coordinator 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.

Coverage amounts will be calculated based upon 200-300% of income as defined by Maryland State Department of Health and Mental Hygiene Medical Assistance Planning Administration Income Eligibility Limits for a Reduced Cost of Care.

Presumptive Financial Assistance

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

a. Active Medical Assistance pharmacy coverage
b. SLMB coverage
c. PAC coverage
d. Homelessness
e. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
f. Medical Assistance spend down amounts
g. Eligibility for other state or local assistance programs
h. Patient is deceased with no known estate
i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
j. Non-US Citizens deemed non-compliant
k. Non-Eligible Medical Assistance services for Medical Assistance eligible patients
l. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID)
m. Bankruptcy, by law, as mandated by the federal courts
n. St. Clare Outreach Program eligible patients
o. UMSJMC Maternity Program eligible patients

p. UMSJMC Hernia Program eligible patients

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

a. Purely elective procedures (example – Cosmetic) are not covered under the program.

b. Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive financial assistance program until the Maryland Medicaid Psych program has been billed.

PROCEDURES

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.
2. Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
   a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.
   b. Preliminary data will be entered into a third party data exchange system to determine probably eligibility. 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.
   c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance. Determination of Probable Eligibility will be provided within two business days following a patient's request for charity care services, application for medical assistance, or both.
   d. Upon receipt of the patient's application, they will have thirty (30) days to submit the required documentation to be considered for eligibility. If no data is received within the 30 days, a denial letter will be sent notifying that the case is now closed for lack of the required documentation. 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.

e. 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.

3. There will be one application process for UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE. The patient is required to provide a completed Financial Assistance Application orally or in writing. In addition, the following may be required:

   a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable). If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...

   b. A copy of their most recent pay stubs (if employed) or other evidence of income.

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

   d. Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.

A written request for missing information will be sent to the patient. Oral submission of needed information will be accepted, where appropriate.

4. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UMMS guidelines.

   a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Coordinator will recommend the patient's level of eligibility and forward for a second and final approval.

      i) If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.
      ii) If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
         (1) A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Clinical Chair.

5. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.

6. Once a patient is approved for Financial Assistance, Financial Assistance coverage may be effective for the month of determination, up to 3 years prior, and up to six (6) calendar months in to the future. However, there are no limitations on the Financial Assistance eligibility period. Each eligibility period will be determined on a case-by-case basis. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be communicated to the Financial Assistance Program Department. All Extraordinary Collections Action activities, as defined below, will be terminated once the patient is approved for financial assistance and all the patient responsible balances are paid.

   Extraordinary Collection Actions (ECAs) may be taken on accounts that have not been disputed or are not on a payment arrangement. Except in exceptional circumstances, these actions will occur no earlier than 120 days from submission of first bill to the patient and will be preceded by notice 30 days prior to commencement of the action. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.

   i) Garnishments may be applied to these patients if awarded judgment.

   ii) A lien will be placed by the Court on primary residences within Baltimore City. The facility will not pursue foreclosure of a primary residence but may maintain our position as a secured creditor if a property is otherwise foreclosed upon.

   iii) Closed account balances that appear on a credit report or referred for judgment/garnishment may be reopened should the patient contact the facility regarding the balance report. Payment will be expected from the patient to resolve any credit issues, until the facility deems the balance should remain written off.

7. If a patient is determined to be ineligible, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.
8. A letter of final determination will be submitted to each patient who has formally submitted an application.
9. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. Refunds may be issued back to the patient for credit balances, due to patient payments, resulted from approved financial assistance on considered balance(s). Payments received for care rendered during the financial assistance eligibility window will be refunded, if the amount exceeds the patient's determined responsibility by $5.00 or more.
10. Patients who have access to other medical care (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Assistance Program.

11. The Financial Assistance Program will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications in determining eligibility for the UMMS Financial Assistance program. This includes accepting FPI's application requirements.
12. The Financial Assistance Program will accept all other University of Maryland Medical System hospital's completed financial assistance applications in determining eligibility for the program. This includes accepting each facility's application format.
13. The Financial Assistance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.
14. Where there is a compelling educational and/or humanitarian benefit, Clinical staff may request that the Financial Clearance Executive Committee consider exceptions to the Financial Assistance Program guidelines, on a case-by-case basis, for Financial Assistance approval.
    a. Faculty requesting Financial Clearance/Assistance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.
    b. The Chief Medical Officer will notify the attending physician and the Financial Assistance staff of the Financial Clearance Executive Committee determination.

Financial Hardship

The amount of uninsured medical costs incurred at either, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE will be considered in determining a patient's eligibility for the Financial Assistance Program. The following guidelines are outlined as a separate, supplemental determination of Financial Assistance, known as Financial Hardship. Financial Hardship will be offered to all patients who apply for Financial Assistance.

Medical Financial Hardship Assistance is available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy, but for whom:

1) Their medical debt incurred at our either UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE exceeds 25% of the Family Annual Household Income, which is creating Medical Financial Hardship; and
2) who meet the income standards for this level of Assistance.

For the patients who are eligible for both, the Reduced Cost Care under the primary Financial Assistance criteria and also under the Financial Hardship Assistance criteria, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE will grant the reduction in charges that are most favorable to the patient.

Financial Hardship is defined as facility charges incurred here at either UMMC, MTC, UMROI, UMSJMC and UMBWMC for medically necessary treatment by a family household over a twelve (12) month period that exceeds 25% of that family's annual income.

Medical Debt is defined as out of pocket expenses for the facility charges incurred here at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE for medically necessary treatment.

Once a patient is approved for Financial Hardship Assistance, coverage will be effective starting the month of the first qualifying date of service and up to the following twelve (12) calendar months from the application evaluation completion date. Each patient will be evaluated on a case-by-case basis for the eligibility time frame according to their spell of illness/episode of care. It will cover the patient and the immediate family members living in the household for the approved reduced cost and eligibility period for medically necessary treatment. Coverage shall not apply to elective or cosmetic procedures. However, the patient or guarantor must notify the hospital of their eligibility at the time of registration or admission. In order to continue in the program after the expiration of each eligibility approval period, each patient must reapply to be reconsidered. In addition, patients who have been approved for the program must inform the hospitals of any changes in income, assets, expenses, or family (household) status within 30 days of such change(s).

All other eligibility, ineligibility, and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance criteria, unless otherwise stated above.

Appeals

- Patients whose financial assistance applications are denied have the option to appeal the decision.
- Appeals can be initiated verbally or written.
- Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
- Appeals are documented within the third party data and workflow tool. They are then reviewed by the next level of management above the representative who denied the original application.
- If the first level of appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
- The escalation can progress up to the Chief Financial Officer who will render a final decision.
- A letter of final determination will be submitted to each patient who has formally submitted an appeal.

Judgments

If a patient is later found to be eligible for Financial Assistance after a judgment has been obtained or the debt submitted to a credit reporting agency, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE shall seek to vacate the judgment and/or strike the adverse credit information.

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

MD DHMH 2017 Income Elig Limit Guidelines		Income Level Up to 200% Pt Resp 0%	S L I	Income Level Pt Resp 10%	Income Level Pt Resp 20%	Income Level Pt Resp 30%	Income Level Pt Resp 40%	Income Level Pt Resp 50%	Income Level Pt Resp 60%	Income Level Pt Resp 70%	Income Level Pt Resp 80%	Income Level Pt Resp 90%
HH	100% MD DHMH	100% Charity	D	90% Charity	80% Charity	70% Charity	60% Charity	50% Charity	40% Charity	30% Charity	20% Charity	10% Charity
Size	Max	Max	I	Max	Max	Max	Max	Max	Max	Max	Max	Max
1	**$16,643**	**$33,286**	N	$34,430	$36,615	$38,279	$39,943	$41,608	$43,272	$44,936	$46,600	$49,928
2	**$22,411**	**$44,822**	G	$47,063	$49,304	$51,545	$53,786	$56,028	$58,269	$60,510	$62,751	$67,232
3	**$28,180**	**$56,360**		$59,178	$61,996	$64,814	$67,632	$70,450	$73,268	$76,086	$78,904	$84,539
4	**$33,948**	**$67,896**	S	$71,291	$74,686	$78,080	$81,475	$84,870	$88,265	$91,660	$95,054	$101,843
5	**$39,716**	**$79,432**	C	$83,404	$87,375	$91,347	$95,318	$99,290	$103,262	$107,233	$111,205	$119,147
6	**$45,485**	**$90,970**	A	$95,519	$100,067	$104,616	$109,164	$113,713	$118,261	$122,810	$127,358	$136,454
7	**$51,253**	**$102,506**	L	$107,631	$112,757	$117,882	$123,007	$128,133	$133,258	$138,383	$143,508	$153,758
8	**$57,022**	**$114,044**	E	$119,746	$125,448	$131,151	$136,853	$142,555	$148,257	$153,959	$159,662	$171,065

Effective 7/1/17

EXHIBIT 8

Help for Patients to Pay Hospital Care Costs

If you cannot pay for all or part of your care from our hospital, you may be able to get **free** or **lower cost** services.

PLEASE NOTE:

1. We treat all patients needing emergency care, no matter what they are able to pay.
2. Services provided by physicians or other providers may not be covered by the hospital Financial Assistance Policy. You can call (800) 876-3364 ext 8619 if you have questions.

HOW THE PROCESS WORKS:

When you become a patient, we ask if you have any health insurance. We will not charge you more for hospital services than we charge people with health insurance. The hospital will:

1. Give you information about our financial assistance policy or
2. Offer you help with a counselor who will help you with the application.

HOW WE REVIEW YOUR APPLICATION:

The hospital will look at your ability to pay for care. We look at your income and family size. You may receive free or lower costs of care if:

1. Your income or your family's total income is low for the area where you live, or
2. Your income falls below the federal poverty level if you had to pay for the full cost of your hospital care, minus any health insurance payments.

PLEASE NOTE: If you are able to get financial help, we will tell you how much you can get. If you are not able to get financial help, we will tell you why not.

HOW TO APPLY FOR FINANCIAL HELP:

1. Fill out a Financial Assistance Application Form.
2. Give us all of your information to help us understand your financial situation.
3. Turn the Application Form into us.

PLEASE NOTE: The hospital must screen patients for Medicaid before giving financial help.

OTHER HELPFUL INFORMATION:

1. You can get a free copy of our Financial Assistance Policy and Application Form:
   - Online at: UMShoreregional.org/patients/financial-assistance
   - In person at the Financial Assistance Department - Shore Health System, 29515 Canvasback Drive Easton MD 21601
   - By mail: call(800) 876-3364 ext 8619 to request a copy
2. You can call the Financial Assistance Office if you have questions or need help applying. You can also call if you need help in another language. Call: (800) 876-3364 ext 8619

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Ayuda para que los Pacientes Paguen los Costos de Atención Hospitalaria

Si no puede afrontar todos los costos de la atención que recibió del hospital o una parte de ellos, es posible que reciba servicios gratuitos o a un costo reducido.

TENGA EN CUENTA LO SIGUIENTE:

1. Brindamos tratamiento a todos los pacientes que necesitan atención de urgencia, independientemente de lo que puedan pagar.
2. Es posible que los servicios brindados por los médicos u otros prestadores no estén cubiertos por la Política de Asistencia Financiera del hospital. Puede llamar al (800) 876-3364 ext. 8619 si tiene dudas.

CÓMO FUNCIONA EL PROCESO:

Cuando usted se convierte en nuestro paciente, le preguntaremos si tiene seguro médico. No le cobraremos más por los servicios hospitalarios que lo que les cobramos a las personas con seguro médico. El hospital hará lo siguiente:

1. Le brindará información acerca de nuestra Política de Asistencia Financiera o
2. Le ofrecerá ayuda por medio de un asesor que lo asistirá con la solicitud.

CÓMO REVISAR SU SOLICITUD:

El hospital evaluará su capacidad para pagar por la atención. Tendremos en cuenta sus ingreso y el tamaño de su familia. Es posible que reciba atención gratuita o a un costo reducido en los siguientes casos:

1. Sus ingresos o los ingresos totales de su familia son bajos para la zona en donde vive, o
2. Sus ingresos caerían por debajo del índice federal de pobreza si tuviera que pagar los costos totales de su atención hospitalaria, menos cualquier costo relacionado con el seguro médico.

TENGA EN CUENTA LO SIGUIENTE: Si usted puede obtener asistencia financiera, le informaremos el monto que puede recibir. Si usted no puede obtener asistencia financiera, le informaremos los motivos de la decisión.

CÓMO SOLICITAR ASISTENCIA FINANCIERA:

1. Complete un Formulario de Solicitud de Asistencia Financiera.
2. Brinde su información para ayudarnos a conocer su situación financiera.
3. Envíenos el Formulario de Solicitud.

TENGA EN CUENTA LO SIGUIENTE: El hospital podrá evaluar a los pacientes para determinar si son elegibles para Medicaid antes de otorgarles asistencia financiera.

OTRA INFORMACIÓN ÚTIL:

1. Puede obtener una copia gratuita de nuestra Política de Asistencia Financiera y del Formulario de Solicitud de las siguientes formas:
    - En línea en (to be added by Communications)
    - En persona en el Departamento de Asistencia Financiera - Shore Health System 29515 Canvasback Drive Easton MD 21601
    - Por correo postal llame al (800) 876-3364 ext. 8619 para solicitar una copia.
2. Puede llamar a la Oficina de Asistencia Financiera si tiene preguntas o necesita ayuda para presentar una solicitud. También puede llamarnos si necesita ayuda para recibir información en otro idioma. Llame al: (800) 876-3364 ext. 8619

EXHIBIT 9

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Hostile language and the way things ought to be

MARK SHIELDS

It's an established American tradition to call people what they wish to be called. That's why after he converted religions, nearly everyone — except a few die-hard bigots — called the heavyweight champion Muhammad Ali instead of Cassius Clay. Marion Morrison chose to become John Wayne. Ilyena Lydia Vasilievna Mironov would later become Dame Helen Mirren, and Caryn Johnson would achieve fame and fortune as Whoopi Goldberg.

But some Republicans, included among them the current GOP president, regularly choose to ignore this national custom by refusing to address or refer to their political adversaries as belonging to — what it has been almost universally called since 1828 — the Democratic Party. Instead, by deliberately dropping the last two letters and ungrammatically substituting an adjective for a noun, some partisans seek to disparage the party of Thomas Jefferson and Andrew Jackson.

Recently, Marc Short, the presidential assistant with the challenging responsibility of managing this White House's relations with the House and the Senate, was interviewed one-on-one on PBS NewsHour by Amna Nawaz. Facing an election year in which the Republican congressional majority is clearly threatened, Short insisted on referring to the presidencies of Bill Clinton and Barack Obama as "Democrat administrations." President Trump had tweeted late last year about getting "no Democrat votes" in the Senate for his budget plan and the "Wacky Congresswoman" who was "killing the "Democrat Party" — a term which is harsher to the ear than the more melodic "Democratic" and supposedly robs the Democrats of all popular identification with the appealing virtues of social equality and anti-snobbishness.

Ever since Wisconsin's redbaiting — and, eventually, censured — Joseph R. McCarthy popularized the epithet "Democrat Party," conservative partisans have mostly employed it publicly as a sort of secret verbal handshake to prove one's GOP credentials while disparaging the other guys.

There have been happy exceptions. In 2008, the year Republicans nominated Arizona Sen. and maverick John McCain, the Party platform committee voted down a proposal to call the opposition the "Democrat Party" in the platform. Then-Mississippi Gov. and committee Chairman Haley Barbour explained, "We probably should use what the actual name is," a position endorsed by one Indiana committee member who argued, "We should afford them the respect they are entitled and call them by their legal name."

Just as most Irish-Americans reject being called "micks," and Catholics don't like to be referred to as adherents of the "Church of Rome" any more than Jewish Americans appreciate being told they are "of the Hebrew persuasion," members of the Democratic Party do not like to be told they belong to the "Democrat Party."

If the Republicans are sincerely interested in winning in 2020, for what would be only the second time having a majority of the national vote in the last eight presidential elections, they — and their leader, President Donald J. Trump — could begin by calling their fellow Americans across the aisle members of the Democratic Party. Sometimes it's not just how you say it; it really is what you say.

To find out more about Mark Shields and read his past columns, visit the Creators Syndicate webpage at www.creators.com.

Time to stop the abusers

JENNIFER RUBIN

It's quite difficult to write about the White House Correspondents' Association dinner when you think the worst kind of journalism is about journalists' reaction to a party thrown for journalists to honor journalists (and raise money). Let's get a few things out of the way:

I've never liked these soirees, which convey a false and inappropriate chumminess between reporters and the people they cover. I was in favor of dumping the thing years ago; I'm delighted if others now agree.

In an era when the media has been labeled the enemy of the people — and Republican officeholders agree — there certainly is no need to yuk it up with those contemptuous of the First Amendment. Doing so conveys that their crusade against the media is not a serious matter.

Sarah Huckabee Sanders was insulted for lying, not for her looks. The point of the jokes in question was her disdain for the truth, not her eye makeup. ("She burns facts, and then she uses the ash to create a perfect smoky eye.")

President Donald Trump is certainly meaner, more vulgar and more inappropriate than Michelle Wolf. And let's not forget that Wolf is a comedian, not a reporter, and has no obligation to uphold any social or professional standards that would apply to the media. (By definition, comedians flout standards of social and professional restraint.) Still, the media should have more dignity than the president (a low bar) and is going to be held responsible for the words of its featured guest.

The White House Correspondents' Association leadership is sadly misguided if it thinks the purpose of the evening is to "offer a unifying message about our shared commitment to a vigorous and free press while honoring civility." The media may uphold those values, but the administration so obviously does not, so this statement suggests either a stunning degree of obliviousness or a propensity to adhere to phony "balance." (Trump says the sky is pink with purple spots; others think it is blue.)

You don't need a self-indulgent, extravagant party to raise money for journalism scholarships. A credit card or checkbook is sufficient.

Now that we have this out of the way, we have a few ideas about what can be done going forward.

First, cut out the on-camera White House news conferences. To be clear, Sanders repeatedly misleads or innocently offers misleading information (on every upcoming firing/resignation, for one thing, and even on what the president did and did not say). Putting her on live TV to tell falsehoods is not news. It is enabling the destruction of objective truth. The media surely should get the White House position or response on matters on which it reports. ("The White House denied that H.R. McMaster would be leaving, but it has made similar statements regarding other officials who were then promptly fired.") However, this does not require a televised event in which the press secretary shows sullen contempt for the media as an institution and evidences no shame in dissembling.

Second, because of the propensity of this administration to lie about easily ascertained facts and events in the works, virtually every utterance from an administration figure should be couched as "the White House claimed" or "the White House argued." Virtually nothing can or should be taken at face value. When the White House repeats a falsehood after being shown incontrovertible evidence that it is a falsehood, the honest term is "lying."

Third, instead of a glitzy affair, the media and the country would benefit from an annual lunch to highlight the latest Freedom House report on press freedom. In addition to foreign abuses, the media, regardless of who is in power, should review the current administration's attacks on the free press and efforts to limit access. Rather than a third-rate comedian, the host might be *The Washington Post's* Jason Rezaian, who was held captive in Iran from July 2014 to January 2016; the parents of Daniel Pearl, the *Wall Street Journal* reporter beheaded by Islamist terrorists; or members of the punk-feminist band Pussy Riot, who were imprisoned by Russia. Media freedom isn't a joke these days, and if the media does not take it seriously, who will?

Democrats and the trap of Trump impeachment

BYRON YORK

George W. Bush was in terrible political shape in the spring of 2006. The Iraq war was going disastrously, and voters were tired of the president, whose job approval rating in the RealClearPolitics average of polls was around 35 percent. (Bush's disapproval rating was around 60 percent.) The upcoming November '06 midterms were shaping up as a debacle for Republicans, who seemed likely to lose control of both houses of Congress.

Things were so bad that a part of the Democratic base looked toward the midterms openly hoping to impeach Bush on the charge that he had lied the country into war. One leader of that movement was Rep. John Conyers, who stood to become chairman of the House Judiciary Committee if Democrats won. Conyers' committee would originate articles of impeachment.

The problem, for Democrats, was voters. Now matter how much they wanted to make changes on Capitol Hill, and no matter how much they disapproved of Bush, they didn't want to impeach the president. Democratic candidates were stuck between their anti-Bush base and the larger electorate.

The impeachment talk was so worrisome to party leaders that Rep. Nancy Pelosi, who stood to become speaker if Democrats won the House, told her conference in May 2006 that "impeachment is off the table."

Pelosi would repeat that at various times during the campaign, and in November, on the day after Democrats won a smashing victory and she was poised to become speaker, she said in her first news conference, "Democrats are not about getting even; Democrats are about getting results. I have said before and I say again, impeachment is off the table."

Indeed, impeachment was off the table, as Bush served his last two years with a Democratic House and Senate. And then Democrats won everything in 2008.

Now, it is again spring in a midterm year, and there is again talk of impeaching a Republican president if Democrats win the House. Pelosi is still around and hopes to become speaker again. What's not clear is whether her 2006 impeachment strategy will work with today's Democratic party.

In a new Quinnipiac poll, 71 percent of Democrats say they would like to see President Trump impeached if Democrats win the House. Just 21 percent oppose the idea, while 8 percent aren't sure. By way of contrast, 38 percent of independents support impeachment, while 54 percent oppose.

So where does that leave Pelosi and other Democratic leaders? Her instincts are as cautious as they were in 2006 — and at this moment, Trump's job approval rating in the RealClearPolitics average, around 42 percent, is higher than Bush's was when Pelosi declared Bush impeachment off the table.

But 71 percent — those Democrats who want to see Trump impeached — is a big number. It suggests that Pelosi, or whoever leads House Democrats if the party wins in November, might not be able to overrule the base and simply declare impeachment a non-starter.

"Many Democrats in D.C. don't want to move forward on impeachment and think they can avoid it," tweeted *National Review's* Ramesh Ponnuru recently, after release of the Quinnipiac results. "I suspect they're wrong."

While Republicans have plenty of problems of their own, they are keenly aware of the Democrats' impeachment dilemma. And GOP strategists want to use that dilemma to make Democrats more uncomfortable and to juice up the Republican base. The argument to Republican and independent voters is easy: The economy is strong, Trump is enacting a conservative wish list, America is showing strength abroad — and all Democrats want to do is impeach the president.

"It's a base motivator," says a GOP strategist working to keep control of Congress. "We have to remind (voters) that the things Democrats want to do are not mainstream. There are a lot of Americans who can't stand Trump, but they don't think he should be impeached."

The president himself is already raising the specter of his own impeachment as a way to fire up GOP voters. "We have to keep the House, because if we listen to Maxine Waters, she's going around saying, 'We will impeach him,'" Trump said April 28 at a campaign-style rally in Washington, Mich.

Of course, there's a huge wild card in any discussion of Trump, the midterms and impeachment, and that is what happens in the Russia investigation. If some new, devastating evidence comes to light from special counsel Robert Mueller, the entire dynamic could change, and Trump could lose some support in the GOP and find himself in real danger of impeachment.

But all those Democrats are ready to impeach Trump right now. They don't need any new revelations. Unless something big changes, they could be a bigger problem for their own leadership than for the president.

Byron York is chief political correspondent for The Washington Examiner.

Final lane opened on Severn River Bridge

ANNAPOLIS — Governor Larry Hogan Monday, April 30, announced the opening of the fourth eastbound lane on the US 50 Bridge over the Severn River, a full month ahead of schedule. The completion of this construction project is a major transportation milestone that will reduce congestion for hundreds of thousands of Anne Arundel County residents and visitors who travel over the Severn River Bridge in Annapolis each year. The governor was joined by Anne Arundel County Executive Steve Schuh, House Speaker Mike Busch, House Minority Leader Nic Kipke, and other local elected officials for the announcement.

"For far too long, this stretch of Route 50 has been a serious bottleneck that was a constant headache for many Marylanders, as well as commuters and vacationers trying to reach the Eastern Shore," said Hogan. "I am pleased that with the opening today, we have successfully completed this project a full month ahead of schedule, and just in time for summer. Motorists will now enjoy a safer, more efficient ride through Annapolis and to the Eastern Shore."

The project shifted the existing median barrier and restriped the lanes to provide seven through-travel lanes — four lanes on US 50 east, three lanes on US 50 west — from Rowe Boulevard across the Severn River to the MD 2/MD 450 interchange. The fourth lane was originally scheduled for completion by Memorial Day weekend.

"Part of a $3.7 billion construction program statewide, the Severn River Bridge project represents our dedicated approach to delivering solutions and keeping Maryland open for business," said MDOT SHA Administrator Greg Slater. "It is important to note that the collaboration and cooperation with our contractor allowed us to deliver this fourth lane early and get people over the bridge safely and with less delay."

Construction began just after Labor Day in 2017. As part of the construction, crews shifted the median barrier and reduced its width from three to two feet and connected what was originally two structures to create space for the additional lane. The contractor, Joseph B. Fay Construction Inc. of Glen Burnie, will complete additional work on the shoulders, guardrails, roadway signage, and surrounding areas through the summer. The eastbound fourth lane will remain open uninterrupted for daytime travel, however, nighttime lane closures will continue as needed on weeknights between 7 p.m. and 5 a.m. Sunday through Thursday.

The average daily traffic on this section of US 50 is 126,000 vehicles per day, with that number ballooning to more than 145,000 on a typical summer Friday.

Twilley celebrates 40 years with Shore United Bank

RALPH TWILLEY

STEVENSVILLE — Shore United Bank, a member of Shore Bancshares community of companies, has recognized Ralph Twilley for his 40 years of dedicated service.

Twilley started his career with Centreville National Bank in February 1978. Twilley joined the lending team as a loan officer and continues to serve the community through his lending expertise today.

Currently, Twilley is a vice president, commercial lender, focusing on meeting customers personal and commercial lending needs. His office is at the branch in Stevensville.

Twilley graduated from Salisbury State College in 2005 with a bachelor's degree in business administration. He completed Maryland Bankers School in 1982. With the goal of continuing his education, he graduated from the Maryland Executive School of Banking in 2007.

"Ralph is an exceptional member of the lending team. His knowledge and experience are an asset to the loan process for all his customers. We are fortunate to have Ralph on our team for the past 40 years," said Heather Bacher, market manager of Shore United Bank.

Twilley currently serves as a board member for the Queen Anne's County Chamber of Commerce and Mid-Shore Pro Bono. He is a past board member for the Queen Anne's County Little League, the Queen Anne's County Free Library, and the Centreville United Methodist Church.

Meetings scheduled on Bay Crossing Study

BALTIMORE — As part of the Chesapeake Bay Crossing Study: Tier I NEPA (Bay Crossing Study), the Maryland Transportation Authority will host a series of public meetings to provide all interested parties an update on the project. At the meetings, attendees will have the opportunity to learn about the project's purpose and need, scoping activities and public comments received to date, the environmental review process and the alternative cooridor development and screening process.

The purpose of the Bay Crossing Study is to consider corridors for providing additional traffic capacity and access across the Chesapeake Bay to improve mobility, travel reliability and safety at the existing Bay Bridge, while considering financial viability and environmental responsibility. The range of corridors will not be presented at these meetings.

Staff will be available to answer questions. No formal presentation will be given, and the same information will be provided at each meeting. All meeting materials will be available at baycrossingstudy.com to view prior to the meetings and for those who choose not to attend in person. Comments may be provided at the meetings, online or by email or U.S. Mail.

All meetings will be held from 6 to 8 p.m. on the following dates:

- Tuesday, May 8, Calvert High School, 600 Dares Beach Road, Prince Frederick, MD 20678.
- Wednesday, May 9, Broadneck High School, 1265 Green Holly Dr., Arnold, MD 21409.
- Thursday, May 10, Kent County Middle School, 402 E. Campus Ave., Chestertown, MD 21620.
- Wednesday. May 16, Middle River Middle School, 800 Middle River Road, Middle River, MD 21220.
- Thursday, May 17, Cambridge-South Dorchester High School, 2475 Cambridge Beltway, Cambridge, MD 21613.
- Tuesday, May 22, Chesapeake College, 1000 College Circle, Wye Mills, MD 21679.

Locations will be accessible to individuals with disabilities. Individuals who require auxiliary aids should contact MDTA at 410-537-10000 (711 for Maryland Relay) no later than three days before the date they wish to attend.

KERRIGAN

From Page 5

the journey, which he estimates will take them through as many as 13 states. "So we figure it'll be about a 32-day trip."

The pair will traverse several mountain ranges, ride past the Grand Canyon, cross the Great Plains, and go over the 2,320-mile-long Mississippi River. And they'll be filming and broadcasting their progress as they go.

But why go on such a grueling journey?

"I was one of the lucky ones," Kerrigan said, referring to the lifesaving heart transplant he received just before Christmas, 2013. "But other people aren't so lucky."

Around 20 people in the U.S. die every day due to a lack of a suitable organ transplant, Kerrigan said. "And my number one thing to do on this trip is to get that number down."

His goal is to raise $100,000 in donations for the United Network for Organ Sharing (UNOS), a nonprofit that operates the only organ procurement and transportation network, or OPTN, in the U.S.

"They're working on a system that will allow people to get matched with organ donations a lot faster," Kerrigan said, mentioning that nearly 115,000 people nationwide currently wait for an organ donor. "All the money — 100 percent — goes into new program they're starting that helps people find their organs faster."

That's not the only thing Kerrigan intends to do.

"That's one reason that we're doing it, and another reason we're doing it is, I'm filming a documentary about it," the 2016 St. Michaels High graduate said. "We're working with some people from a group called Rusted Rooster Media to get the whole thing produced."

Kerrigan said he got the idea a few months back. "My story's a good story," he said, "but to just tell my story over and over, well, that would get boring.

"So, eventually, what I want to do is have an outdoors TV show," Kerrigan said. "But in it, I want to take some other people who've faced adversity and have them tell their stories.

"People have beaten cancer. There are wounded warriors who have stories to tell," Kerrigan added. "I want more people to learn how to conquer adversity. ... Everyone needs to know there's always hope."

The beginnings of the cross-country fundraiser idea came to Kerrigan a few months back.

"At that point, it had been a year and a half since I had ridden a bike," he recalled. "And my stamina isn't what it used to be. So it's taken some work."

Receiving a new heart means several significant changes in life, and lifestyle, Kerrigan explained.

"My stamina, as I said, isn't what it was," he said, adding the anti-rejection medications any organ recipient must take suppress the recipient's natural immune system. "I can't swim in the (Chesapeake) Bay anymore. I can't eat raw food anymore. Everything has to be well-done.

"When I get sick, I stay sick a lot longer," Kerrigan said. "A three-day cold for other people becomes a month-long cold for me. So, I have to avoid germy things, getting too dirty, and if there are a lot of sick people around, I have to be away from that."

Despite such concerns, Kerrigan said, he "never lets it get in my way."

By doing this, Kerrigan added, "I want to put myself through the test, to show people you can go through adversity, and it shouldn't slow you down."

The idea, which came to him during mid-winter, was an instant plan for Kerrigan and Kinney. "We wanted to do it as soon as I mentioned it," Kerrigan said. "We decided to do it before we even knew anything about it, about what it would involve."

But why riding a bike? Why not a walk, which would still test one's stamina, or some other mode of travel?

"I just want to experience new places, and that's the fastest way to do it," Kerrigan said, "and the most physically demanding, rather than taking five months to do it like walking would."

Over the last several weeks, the plan has begun to take shape. Friday, the duo received several thousand flyers to hand out, soliciting donations. Kerrigan's page on the Everyday Hero website set up for donors, https://give.everydayhero.com/us/brandon-kerrigan, has already received more than $2,000.

Kerrigan's training over the past few weeks has been intense. Bike rides of up to 90 miles a day, combined with regular trips to work out at Hearthstone Health and Fitness in Easton, have helped his endurance and strength increase drastically.

"My legs have doubled in size from where they were," Kerrigan said.

The plan for the actual ride, Kerrigan said, consists of two planned 4-hour sessions each day, one in the morning, and another after lunchtime.

The two will take turns in the lead, Kerrigan said. "We'll draft one another when we can, when we need to, and we'll alternate."

But the terrain across the United States isn't very much like Delmarva; the average elevation of land is over 1,000 feet above sea level. Kerrigan and Kinney will go through the Sierra Nevada, Rocky, Ozark, and Appalachian Mountains along the way.

How does one train on an area as flat as Delmarva for all the elevation changes?

Planning and pushing, Kerrigan said. To compensate for the increases in elevation, which can be "as much as 800 feet in one day," he said. "I get on the StairMaster at Hearthstone with 50 pounds on my back — and I just walk up the stairs for as long as I can."

How much of an interruption of one's life is such an undertaking?

"I was at West Virginia University, and pursuing my dream in outdoor television," Kerrigan said. "So that's where I am right now, but right in the middle of living it."

The planned documentary, produced with help from Rusted Rooster Media, is part of a campaign called "Be Alive," Kerrigan said.

"We've been packing, preparing, for a month now," Kerrigan said. "There's a lot to think about, what to take, what you'll need. ... We plan on camping most of the time."

As is often the case, one journey, Kerrigan said, might lead to another in the future. "If I can do this, I think I can do almost anything."

"I've got a lot of support from (sponsorship help by Easton Cycle and Sport) friends, family, and community," Kerrigan said, "and I've got that mindset. So I'm hoping for success."

"I'm really looking forward to it all," he added. "If this is successful maybe I'll climb Mount Kilimanjaro (in Tanzania, Africa), or something like that."

More information about Kerrigan and Kinney's plan can be found on the Pray for Brandon page on Facebook, which can be found at https://www.facebook.com/groups/710061975687200/about/.

Kerrigan's progress can be followed on Instagram at: brandon__kerrigan (two underscores).

For more information about the United Network for Organ Sharing, visit www.unos.org.

Follow me on Twitter: @SDBaysideSports.

Jury finds teen innocent in alleged sexual assault

By TRISH MCGEE
pmcgee@thekentcountynews.com

CHESTERTOWN — A Kent County jury of nine men and three women found a Baltimore teenager not guilty of all charges related to an alleged sexual assault at Washington College in September 2016 that resulted in his dismissal from the college.

Jurors deliberated for about an hour and a half April 26 before acquitting Fope Moses Fadojutimi, 18, of second-degree rape, second- and fourth-degree sex offenses, and second-degree assault.

Fadojutimi was the only defense witness. He testified that all the sexual contact he had with his accuser was consensual.

The *Kent County News* does not name survivors of alleged sexual assault.

The woman in this case was a classmate of Fadojutimi's. She told the jury that he sexually assaulted her in her dorm room in the early morning of Sept. 7, 2016.

She acknowledged that they had a "romantic encounter" a couple of days earlier when she allowed him to sleep in the extra bed in her room; that they had exchanged numerous text messages, some of which laid out boundaries moving forward in their relationship; and that she let him into her room at about 1 a.m. Sept. 7.

In direct testimony that lasted nearly an hour, the woman told the jurors that Fadojutimi sexually assaulted her.

Initially she did not protest, she said, because she "felt frozen."

"I knew that I wanted to say something, but I couldn't," the woman testified. She said she was afraid and "the fear put me in a state where I couldn't move, I couldn't say anything."

At some point her "reactions kicked in," she testified, and she was able to tell Fadojutimi, "This is not what I want. I want you to stop."

"I told him 'no' more than five times and tried to push him off me," the woman testified. She said she tried to scoot up in her bed to get away from him, but that he overpowered her.

Afterward, Fadojutimi kissed her on her forehead and left her dorm room.

Several students saw Fadojutimi walking down the hallway; two of them came into the woman's room to ask what had happened.

She quickly sent them away without telling them anything, the woman said.

Almost immediately, she sent Fadojutimi a text message that said, "I let it get too far. I had to stop it."

She testified that she sent the text message, which was read aloud, to protect herself and "to settle him down some."

"I didn't know what he was capable of. ... I took false responsibility for what had happened. ... I was in a frantic state," she told the jury. "He had just seen two people walk into my room, and I didn't know what he was thinking."

She was worried about retaliation, said told prosecutor G. Robert Mowell.

"I wanted to cover and make sure I was safe in it," she said when asked what was the purpose of the text message.

"Were you the one who let it get to far?" Mowell asked.

"No," the woman answered.

After sending the text message, the woman testified that she called her closest friend on campus to say that she had been sexually assaulted. She also called the college's office of public safety and a rape hotline.

She sought out counseling services on campus and talked to the college's Title IX coordinator, Candace Wannamaker, who oversees all complaints of sexual violence.

The woman said she continues to receive counseling and takes medication after being diagnosed with post traumatic stress disorder and an anxiety disorder.

She said she doesn't sleep much.

Still a student at Washington College, she has made changes that include making sure people call before she allows them in her room. She also has a single-occupancy room with only one bed.

The woman did not report the alleged sexual assault to the Chestertown Police Department until May 2017.

The CPD served Fadojutimi with an arrest warrant on June 12. Fadojutimi, accompanied by an attorney, came to the police station to be served the warrant.

Under questioning by Mowell, the woman said she delayed in reporting to police because of "fear."

She said she ultimately came forward because "I was tired of him having the satisfaction of me keeping quiet about this."

Sobbing, she identified Fadojutimi in court as the man who allegedly sexually assaulted her.

Under cross-examination by defense attorney George Oswinkle, the woman acknowledged that Fadojutimi that did not threaten her in any way, that she did not protest and that she did not call for help.

But, she said, "letting him in (the room) is not an invitation to rape."

Wannamaker, who testified for the defense, was recognized by the court as an expert in traumatic stress.

She said she has seen the student "hundreds of hours" since the incident and that the student has reacted to trauma in various stages — including the freeze and function modes.

Wannamaker said she encouraged the student on several occasions to report the allegations to police.

In his defense, Fadojutimi said he and the student had consensual sex. "Everything seemed copacetic," he said.

"When she said she doesn't want to to do this anymore, I stopped, gave her a kiss on the forehead, said good night and left," he testified.

In his closing argument, Mowell portrayed rape as a crime of secrecy. "Most of the time the only two people who know what happened are the defendant and the victim."

Two conflicting stories were presented in court. He asked the jury to chose to believe the story that made the most sense.

Oswinkle argued that there was no threat, no coercion and no force, therefore there was no rape.

"People on both sides made bad decisions, but it does not constitute a crime," he said.

After receiving instructions from Circuit Court Judge J. Frederick Price, the jurors were sent out to deliberate at 5:45 p.m.

They sent a note to the judge at 6:40 p.m. asking for a better understanding of second-degree assault, and were brought back into the courtroom so Price could re-instruct them on the elements of the offense.

The jury returned at 7:07 p.m. with not guilty verdicts on all accounts.

This was the second trial in as many months for Fadojutimi, who was accused of another sexual assault on campus in September 2016. He was found not guilty of second-degree rape, second-degree sex offense and second-degree assault.

He is awaiting sentencing on conviction of a misdemeanor charge of fourth-degree sex offense. The maximum penalty is one year in jail and a $1,000 fine.

Fadojutimi was 17 at the time of the alleged offenses but was charged as an adult.

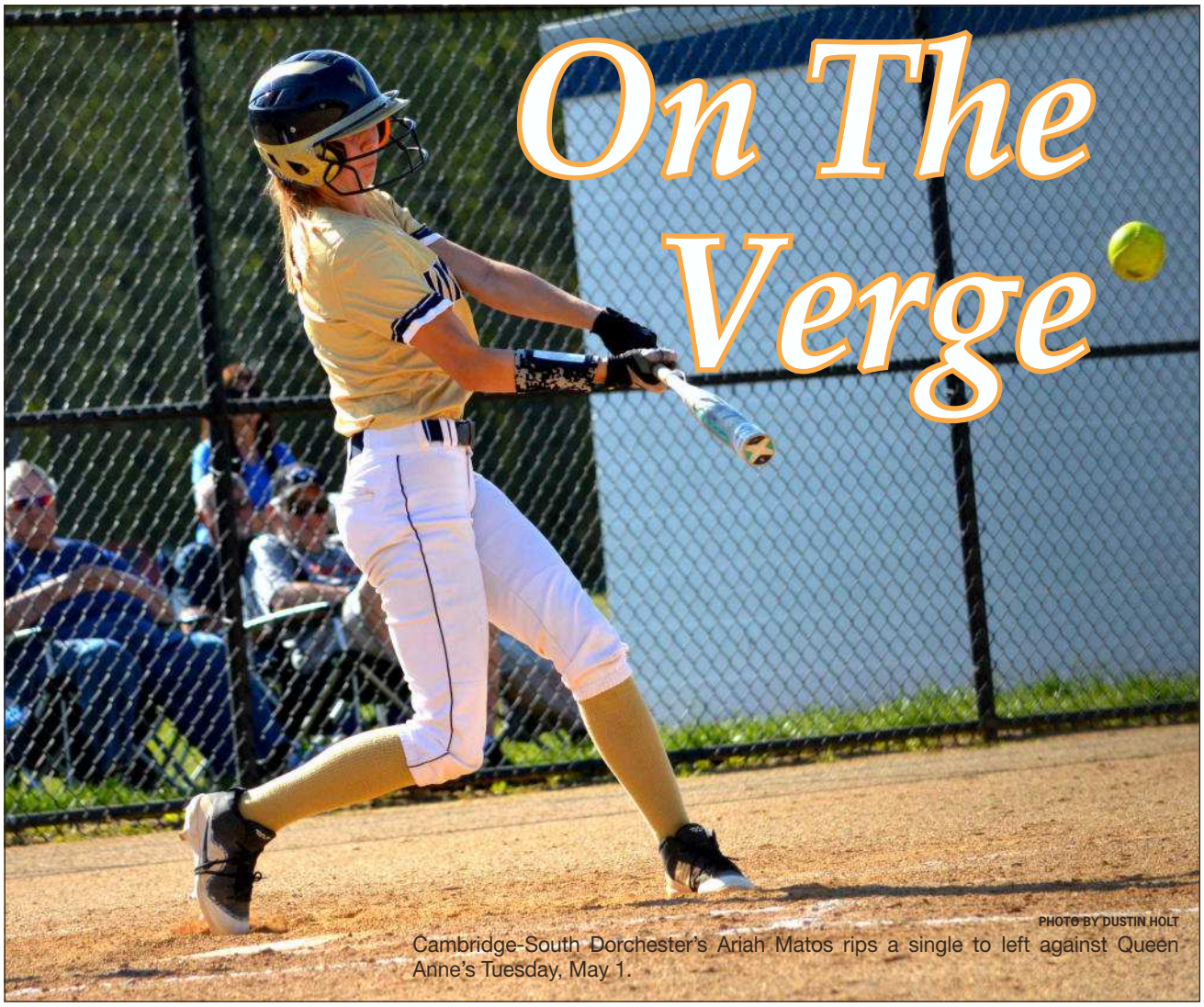

PHOTO BY DUSTIN HOLT

Cambridge-South Dorchester's Ariah Matos rips a single to left against Queen Anne's Tuesday, May 1.

Pleasants fans 14 as C-SD moves one win from first division crown

By DAVID INSLEY
dinsley@stardem.com

CAMBRIDGE — With the North Bayside title race going down to the wire, Cambridge-South Dorchester High's softball team found itself trailing early Tuesday against Queen Anne's County.

"We opened up hitting, putting the ball into play," Lions head coach Kim Rementer-Betts said. "But then, they came back on us, and we kind of got off our game.

"She (C-SD pitcher Madison Pleasants) struck out seven or eight of us in a row at one point, and that's unlike us," Rementer-Betts said. "And it spiraled on us. And then they started beating themselves up about it."

Despite the early deficit, the Vikings put together a 10-hit attack and took advantage of seven Lions errors en route to a 9-2 victory that kept them in contention for their first North Bayside softball title in school history.

Cambridge-SD (14-2 overall, 6-1 North Bayside) inched closer to idle St. Michaels (12-4, 7-1) and can clinch the division crown on Friday if it defeats Easton in a game that will be picked up in the top of the eighth inning with the Vikings holding a 4-3 lead with two on and no outs. Cambridge-SD defeated St. Michaels in their second meeting of the season and would clinch the title via tiebreaker. Should the Vikings lose to Easton on Friday, St. Michaels would win the division.

"Today was big, obviously, it was big," C-SD head coach Kareem Otey said after her team stretched its winning streak to eight. "I think this year, one of the things that we've done well is answer back when someone scores. We're able to battle back."

See **VIKINGS**
Page 13

NEWS IN BRIEF

Incendiary device leads to fire in Church Hill

CHURCH HILL — An incendiary device — more commonly known as a Molotov cocktail — was thrown Tuesday, May 1, into the front yard of a Church Hill home, the state fire marshal's office said.

The fire at 305 Oakmont Ave. was reported about 10:34 p.m. by homeowners Michael and Darlene Kuechler, according to a press release from the Office of the State Fire Marshal.

Firefighters from the Church Hill Volunteer Fire Department responded and placed the fire under control. The fire burned vegetation only.

Anyone with information regarding this fire is asked to contact the state fire marshal's office at 410-822-7609.

Cocaine recovered in elementary school zone

SUDLERSVILLE — School officials contacted the Queen Anne's Sheriff's Office on Wednesday, April 25 when a woman not on the approved school contact list attempted to pick up a child from Sudlersville Elementary School.

According to the report from the sheriff's office, deputies responded to the school in reference to a disturbance. Upon their arrival, the deputies made contact with school officials who asked police to have a male removed from the property, police said. The female, Melissa Markow of Chestertown, had attempted with Chris Markow to pick up a child from the school prior to dismissal and their erratic behavior alerted school employees to contact the sheriff's office.

Further investigation by the deputies led to the recovery of suspected crack cocaine and drug paraphernalia from a vehicle. Melissa Markow — who witnesses observed originally in the vehicle — had left the scene, but returned and was placed under arrest.

Markow, 27, of 8306 Beaver Court, Chestertown, is charged with possession of crack cocaine and possession of paraphernalia.

She was ordered held without bail.

Deputies were unable to locate Chris Markow after the suspected narcotics was located.

PHOTO BY DANIEL MCCREARY

Saturday Sunset near Centreville

On Saturday evening, April 28, Centreville resident and amateur photographer Daniel McCreary captured rain clouds approaching during sunset. The result is a photograph that captures the arrival of spring to rural Queen Anne's County.

EXHIBIT 10

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

License No. 20-003

Issued to:

University Of Maryland Shore Medical Center At Easton
219 South Washington Street
Easton, MD 21601

Type of Facility: Acute General Hospital
Special Hospital - Rehabilitation with 20 beds

Date Issued: July 1, 2018

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Section 318 Annotated Code of Maryland, 1982 Edition, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Patricia Tomasko May, MD

Director

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

EXHIBIT 11

The Joint Commission

March 8, 2016

Re: # 6276
CCN: #210037
Program: Hospital
Accreditation Expiration Date: December 19, 2018

Kenneth D. Kozel
President and Chief Executive Officer
Shore Regional Health
219 S. Washington St
Easton, Maryland 21601

Dear Mr. Kozel:

This letter confirms that your December 15, 2015 - December 18, 2015 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on February 29, 2016 and the successful on-site unannounced Medicare Deficiency Follow-up event conducted on January 26, 2016, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of December 19, 2015. We congratulate you on your effective resolution of these deficiencies.

§482.12 Governing Body
§482.13 Patient's Rights
§482.41 Physical Environment
§482.42 Infection Control
§482.51 Surgical Services

The Joint Commission is also recommending your organization for continued Medicare certification effective December 19, 2015. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

Chesapeake Cardiology Cardiovascular Diagnostic Laboratory
522 Idlewild Ave, Easton, MD, 21601

Queen Anne's Emergency Center
d/b/a Univ of Maryland Shore Emergency Center at Queenstown
115 Shoreway Dr., Queenstown, MD, 21658

The Joint Commission

Shore Health System, Inc
d/b/a Univ of Maryland Shore Medical Center at Easton
219 South Washington Street, Easton, MD, 21601-2491

Shore Health System, Inc
d/b/a Univ of Maryland Shore Medical Center at Dorchester
300 Byrn Street, Cambridge, MD, 21613

Shore Medical Pavilion
d/b/a University of Maryland Shore Medical Pavilion at Queenstown
125 Shoreway Dr, Queenstown, MD, 21658

Univ of Maryland Shore Reg Health Diag and Imaging Center
838 S. 5th Avenue, Denton, MD, 21629

Univ of Maryland Shore Reg Health Diag and Imaging Center
10 Martin Court, Easton, MD, 21601

Univ of Maryland Shore Regional Health Integrative Medicine
607 Dutchmans Lane, Suite B, Easton, MD, 21601

University of Maryland Shore Regional Health Cancer Center
509 Idlewild Avenue, Easton, MD, 21601-2491

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 3 /Survey and Certification Staff

The Joint Commission

March 8, 2016

Kenneth D. Kozel, MBA, FACHE
President and Chief Executive Officer
Shore Regional Health
219 S. Washington St
Easton, MD 21601

Joint Commission ID #: 6276
Program: Behavioral Health Care Accreditation
Accreditation Activity: 45-day Evidence of Standards Compliance
Accreditation Activity Completed: 03/08/2016

Dear Mr. Kozel:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Behavioral Health Care

This accreditation cycle is effective beginning December 18, 2015. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

EXHIBIT 12

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030
Date Accessed: 3/18/2018

Ratings for Health Conditions and Topics
Ratings shown here are compared to State Average

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
COPD-Chronic Obstructive Pulmonary Disease				
	Results of Care			
1	Dying within 30-days after getting care in the hospital for chronic obstructive pulmonary disease (COPD)	Average	8.9 (7.2 - 11.0)	
2	Returning to the hospital after getting care for chronic obstructive pulmonary disease (COPD)	Average	19.6 (17.4 - 22.0)	
Childbirth				
	Practice Patterns			
3	Percentage of births (deliveries) that are C-sections	Better than average	26.0773 (23.2168, 28.9379)	
4	How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)	Below average	1.7391 (0.0000, 4.1284)	Vaginal birth after cesarean section is not programmatically allowed at UM SRH due to a lack of ability to meet American College of Obstetricians and Gynecologists' guidelines for this type of program, which include having anesthesia and pediatric services available 24/7, in-house.
5	How often babies in the hospital are delivered using cesarean section when this is the mother's first birth.	Better than average	15.5696 (13.0413, 18.0979)	
6	How often babies are born vaginally when the mother has had a C-section in the past (includes complications)	Below average	2.3810 (0.0000, 5.0430)	See explanation to measure number 4 above.
7	Newborn deliveries scheduled 1-3 weeks earlier than medically necessary	Better than average	0%	
Combined Quality and Safety Ratings				
	Deaths			

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030
Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
8	Patients who died in the hospital after having one of six common conditions.	Average	1.0017 (0.8008, 1.2026)	
	Patient Safety			
9	How well this hospital keeps patients safe based on eleven patient safety problems	Average	0.8646 (0.5349, 1.1944)	
Consumer Ratings				
	Communication			
10	How often did nurses always communicate well with patients?	Better than average	79%	
11	How often did doctors always communicate well with patients?	Average	78%	
12	How often did staff always explain about medicines before giving them to patients?	Below average		The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) are of high priority for UM SRH, and this issue is addressed in the UM SRH Strategic Plan and Annual Operating Plan for FY 2018 under Patient Experience: Empowering Meaningful Care Relationships. UM SRH's goals are to: 1. Ensure each owner understands the Press Ganey (PG) reports and her/his area's performance. 2. Support each owner in identifying priorities and specific actions to address patients' feedback/opinions of their care experience. 3. Support each owner in balancing global priorities (nurse communication, physician communication, and environment—cleanliness & quietness) with individual area priorities. 4. Support each owner in action planning and execution of actions that will enable sustainable improvement. In addition to the emphases on HCAHPS, in January 2017 UM Shore Medical Center at Easton's Pharmacy Department increased clinical pharmacist presence on inpatient units. In addition, in November 2017, UM SRH's Patient Experience Director worked with its clinical managers and directors to build "push" reports for each department, including the Pharmacy Department and Senior Leadership Team. The HCAHPS score on "Communication and Medicines" is trending up from 54.8 in Q1 of 2016 to 77.1 in Q3 of 2017.
13	Were patients always given information about what to do during their recovery at home?	Below average	84%	In addition to the emphasis on HCAHPS, Easton and the other campuses throughout implemented a new leader rounding format around June 2017 that is standardized across units. At the same time, UM SRH implemented Care Transition Rounds (CTR) to address discharge planning. Additionally, in October 2017, UM SRH hired a full complement of Transitional Nurse Navigators (TNNs) to follow high risk patients throughout the continuum of care.

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030

Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
14	How well do patients understand their care when they leave the hospital?	Below average	46%	The HCAHPS score for communication on recovery is trending up from 86.5 in Q1 of 2016 to 89.2 in Q3 of 2017. HCAHPS are of high priority for UM SRH and is addressed in the UM SRH Strategic Plan and Annual Operating Plan for FY 18. Specifically, a Care Coordination Action Plan was developed to address this measure. In addition, as discussed in response to measure number 13, UM SRH has implemented CTRs to address discharge planning and hired TNNs to follow high risk patients throughout the continuum of care. The HCAHPS score for this measure is trending up from 47.4 in Q1 of 2016 to 66.9 in Q3 of 2017.
	Environment			
15	How often were the patients' rooms and bathrooms always kept clean?	Better than average	73%	
16	How often did patients always receive help quickly from hospital staff?	Better than average	67%	
17	How often was patients' pain always well-controlled?	Better than average	68%	
18	How often was the area around patients' rooms always kept quiet at night?	Below average	49%	The Patient Experience Committee has been working with departments and units throughout the organization. A Quietness Campaign was implemented from January through March 2017, which included initiatives to reduce noise: wheels were replaced on carts, new dietary carts were purchased, Quietness signs were posted in hallways and elevators, quiet hours were established on units and within departments, individual units and departments developed action plans to address specifics issues within their own areas. Scores from Press Ganey are monitored monthly and individual reports are pushed out to units and departments. The HCAHPS score on Quietness at night is trending up from 39.1 in Q1 of 2016 to 56.4 in Q3 of 2017.
	Satisfaction Overall			
19	How do patients rate the hospital overall?	Below average	60%	As discussed in response to measure number 12, HCAHPS are of high priority for UM SRH and is addressed in the UM SRH Strategic Plan and Annual Operating Plan for FY 18. A number of new initiatives have been implemented to improve patient experience and satisfaction, including: 1. HEART – Service Excellence and Service Recovery (implemented early 2017). This is a program from Cleveland Clinic that helps UM SRH employees understand their role in creating a positive patient experience and establish and sustain a culture of service excellence by empowering employees to interact with patients, visitors, and each other in a caring and compassionate way.
20	Would patients recommend the hospital to friends and family?	Below Average	58%	

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030
Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
				2. Executive rounds (implemented June 2016). This is a tool that allows UM SRH senior leaders to engage executives with frontline staff and demonstrate that the organization is committed to solving issues and improving experiences of patients and customers. 3. Cleanliness Focus (implemented August 2016). UM SRH implemented this initiative to improve patients' perception of cleanliness and to understand best practices to help patients heal by managing their perception of cleanliness. 4. Admission Rounds (implemented March 2017). UM SRH implemented this initiative to raise the visibility and engagement of nurse leaders and increase interaction with patients by welcoming newly admitted patients to the unit and introducing leaders in order for patient and family to have appropriate contacts if they have issues or concerns. Since implementation of these various initiatives, patient complaints and grievances have been trending down from 216 in Q1 or 2017 to 109 in Q3 of 2017. In addition, the HCAHPS score on Rate the Hospital have been trending up from 60.8 in Q1 2016 to 73.2 in Q3 of 2017.
	Wait Times			
21	How long patients spent in the emergency department before leaving for their hospital room	Better than average	365 minutes	
22	How long patients spent in the emergency department after the doctor decided the patient would stay in the hospital before leaving for their hospital room	Better than average	119 minutes	
23	How long patients spent in the emergency department before being sent home	Better than average	136 minutes	
24	How long patients spent in the emergency department before they were seen by a healthcare professional	Better than average	24 minutes	
25	How long patients who came to the emergency department with broken bones had to wait before receiving pain medication.	Better than average	60 minutes	

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030

Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
26	Patients who left the emergency department without being seen	Better than average	2%	
Flu Prevention				
	Protecting Patients			
27	Patients in the hospital who got the flu vaccine if they were likely to get flu	Average	99%	
Heart Attach and Chest Pain				
	Recommended Care - Outpatient			
28	How long patients with chest pain or possible heart attack waited to be transferred to another hospital for a procedure	Average	57 minutes	
29	Patients with a heart attack who received aspirin on arrival to the hospital	Average	98%	
30	How long patients who come to the hospital with chest pain or possible heart attack waited to get a test that detects heart damage after a heart attack	Average	7 minutes	
	Results of Care			
31	How often patients die in the hospital after heart attack	Average	3.1761 (0.0000, 8.7247)	
32	Dying within 30-days after getting care in the hospital for a heart attack	Average	14.1 (11.2 - 17.5)	
33	Returning to the hospital after getting care for a heart attack	Average	16.5 (13.7 - 19.4)	
Heart Failure				
	Results of Care			
34	How often patients die in the hospital after heart failure	Average	3.3636 (1.4480, 5.2792)	
35	Dying within 30-days after getting care in the hospital for heart failure	Average	11.8 (9.9 - 14.1)	

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030

Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
36	Returning to the hospital after getting care for heart failure	Average	19.7 (17.5 - 22.0)	
Heart Surgeries and Procedures				
37	Recommended Care How often the hospital uses a procedure to find blocked blood vessels in the heart on both sides of the heart instead of on only one side.	Average	6.4516 (0.3364, 12.5668)	
	Results of Care			
38	Death rate for CABG	Not enough data to report		
39	Rate of unplanned readmission for CABG	Not enough data to report		
Hip or Knee Replacement Surgery				
	Results of Care			
40	Returning to the hospital after getting hip or knee replacement surgery	Average	4.1 (3.1 - 5.4)	
41	Complications after hip or knee replacement surgery	Average	2.6 (1.8 - 3.8)	
Imaging				
	Practice Patterns			
42.	Patients who come to the hospital with low back pain who had an MRI without trying recommended treatments first, such as physical therapy (If a number is high, it may mean the facility is doing too many unnecessary MRIs for low back pain.)	Below average	40.40%	UM SRH is implementing processes in imaging department and working with the physicians to ensure use of best practices. Education will be provided utilizing evidence-based practices on the current recommendations prior to performing the MRI. The initial education will be provided by July 2018 and possibly a second round will be planned in a year if improvements are not seen on this measure. UM SRH intends to see significant improvements in the next 24 months.
43	Contrast material (dye) used during abdominal CT scan	Below average	7%	UM SRH is working with imaging and radiologists to utilize evidence-based best practices. CTs both prior to and after the administration of intravenous contrast are not routinely performed at UM SRH. Those cases are limited to CT urograms and categorization of abdominal masses to limit radiation doses to the patient. Evidence-based methods for evaluation of other modalities will be used. Best practice guidelines such as the American College of

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030

Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
				Radiology (ACR) appropriateness criteria will be utilized to educate providers and referring physicians, and, where appropriate, UM SRH will change its protocols. UM SRH intends to see significant improvements in the next 24 months.
44	Contrast material (dye) used during thorax CT scan	Average	.20%	
45	Patients who had a low-risk surgery and received a heart-related test, such as an MRI, at least 30 days prior to their surgery though they do not have a heart condition	Average	4.70%	
46	Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses.	Average	1.70%	
Patient Safety				
	Results of Care - Complications			
47	How often the hospital accidentally makes a hole in a patient's lung	Average	0.2768 (0.0000, 0.9592)	
48	How often patients accidentally get cut or have a hole poked in an organ that was not part of the surgery or procedure	Average	1.3970 (0.0000, 2.9947)	
49	Number of patients who get a blood transfusion and have a problem or reaction to the blood they get	Not enough data to report		
50	Returning to the hospital for any unplanned reason within 30 days after being discharged	Average	15.1 (14.4 - 15.9)	
51	Patients who developed a blood clot while in the hospital and did not get treatment that could have prevented it	Not enough data to report		
52	Number of times a medical tool was accidentally left in a patient's body during surgery or procedure	Not enough data to report		
	Results of Care - Deaths			

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030

Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
53	How often patients die in the hospital after bleeding from stomach or intestines	Average	1.3736 (0.0000, 3.7735)	
54	How often patients die in the hospital after fractured hip	Average	2.5229 (0.0000, 5.2932)	
55	How often patients die in the hospital while getting care for a condition that rarely results in death	Average	0.0000 (0.0000, 0.8581)	
Pneumonia				
	Results of Care - Deaths			
56	How often patients die in the hospital while getting care for pneumonia	Average	5.4022 (3.0753, 7.7290)	
57	Dying within 30-days after getting care in the hospital for pneumonia	Average	16.7 (14.6 - 19.1)	
58	Returning to the hospital after getting care for pneumonia	Average	17.1 (14.9 - 19.4)	
Stroke				
	Results of Care			
59	How often patients who came in after having stroke subsequently died in the hospital.	Average	7.1496 (3.6067, 10.6925)	
60	Death rate for stroke patients	Average	15.3(12.8, 18.4)	
61	Rate of unplanned readmission for stroke patients	Average	13.1(10.8, 15.7)	

	Practice Patterns			
62	Number of surgeries to remove part of the esophagus	Not enough data to report	-	
63	Number of surgeries to remove part of the	Not enough	-	

UM Shore Medical Center at Easton
Quality Measures Exhibit

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Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
	pancreas	data to report		
64	Number of surgeries to fix the artery that carries blood to the lower body when it gets too large	Not enough data to report	-	
	Results of Care - Deaths			
65	How often patients die in the hospital during or after surgery on the esophagus	Not enough data to report	-	
66	How often patients die in the hospital during or after pancreas surgery	Not enough data to report	-	
67	How often patients die in the hospital during or after a surgery to fix the artery that carries blood to the lower body when it gets too large	Not enough data to report	-	
Surgical Patient Safety				
	Results of Care			
68	How often surgical patients die in the hospital because a serious condition was not identified and treated	Average	157.2296 (10.9910, 303.4683)	
69	How often patients in the hospital had to use a breathing machine after surgery because they could not breathe on their own	Average	0.0000 (0.0000, 7.5667)	
70	How often patients in the hospital get a blood clot in the lung or leg vein after surgery	Average	5.5409 (2.1535, 8.9282)	
71	How often patients accidentally get cut or have a hole poked in an organ that was not part of the surgery or procedure	Average	1.3970 (0.0000, 2.9947)	
72	Number of times a medical tool was accidentally left in a patient's body during surgery or procedure	Not enough data to report		

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030

Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
Healthcare Associated Infections (HAI)				
	Surgical Site Infections (SSI)	Same		
	Central Line-Associated Blood Stream Infections (CLABSI)	Not enough data to calculate		
	Health Care Worker Vaccinations (HCW)	Better than average		
	Clostridium Difficile Infections (CDI)	Same		
	Methicillin-Resistant Staphylococcus Aureus Infections (MRSA)	Same		
	Catheter-Associated Urinary Tract Infections (CAUTI)	Same		

EXHIBIT 13

3/10 - Melissa
* Shawn received same

TOWN OF EASTON

P. O. Box 520
Easton, Maryland 21601

March 4, 2010

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

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

Dear Secretary Hall:

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

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

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

Sincerely,

Robert C. Willey

Robert Willey
Mayor

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

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

ORDINANCE NO. 561

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

Introduced by: Mr. Lesher

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

John Ford
John F. Ford, President

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

Kathy M. Ruff
Kathy M. Ruff, Town Clerk

APPROVED: December 7, 2009

Date: December 7, 2009

Robert C. Willey
Robert C. Willey, Mayor

EFFECTIVE DATE: January 21, 2010.

Maryland Department of Planning

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

Richard Eberhart Hall
Secretary
Matthew J. Power
Deputy Secretary

March 18, 2010

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

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

Dear Mayor Willey:

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

Our understanding is that the annexed parcels being added to the PFA are consistent with current growth policies. The properties are also in the approved 10 year County Water and Sewer Plan as areas planned for service. These parcels are zoned as RH, regional healthcare and as G/I, governmental-institutional. Additionally, the area is inside a primary growth area in the Talbot County Comprehensive Land Use Plan as well as the Town of Easton's growth area. It is also designated as an area to be used primarily for employment.

The subject properties therefore meet all the designation requirements for Priority Funding Area certification. Accordingly, the Priority Funding Area maps prepared by the Maryland Department of Planning will be updated to reflect these changes and will be provided to the appropriate State funding agencies.

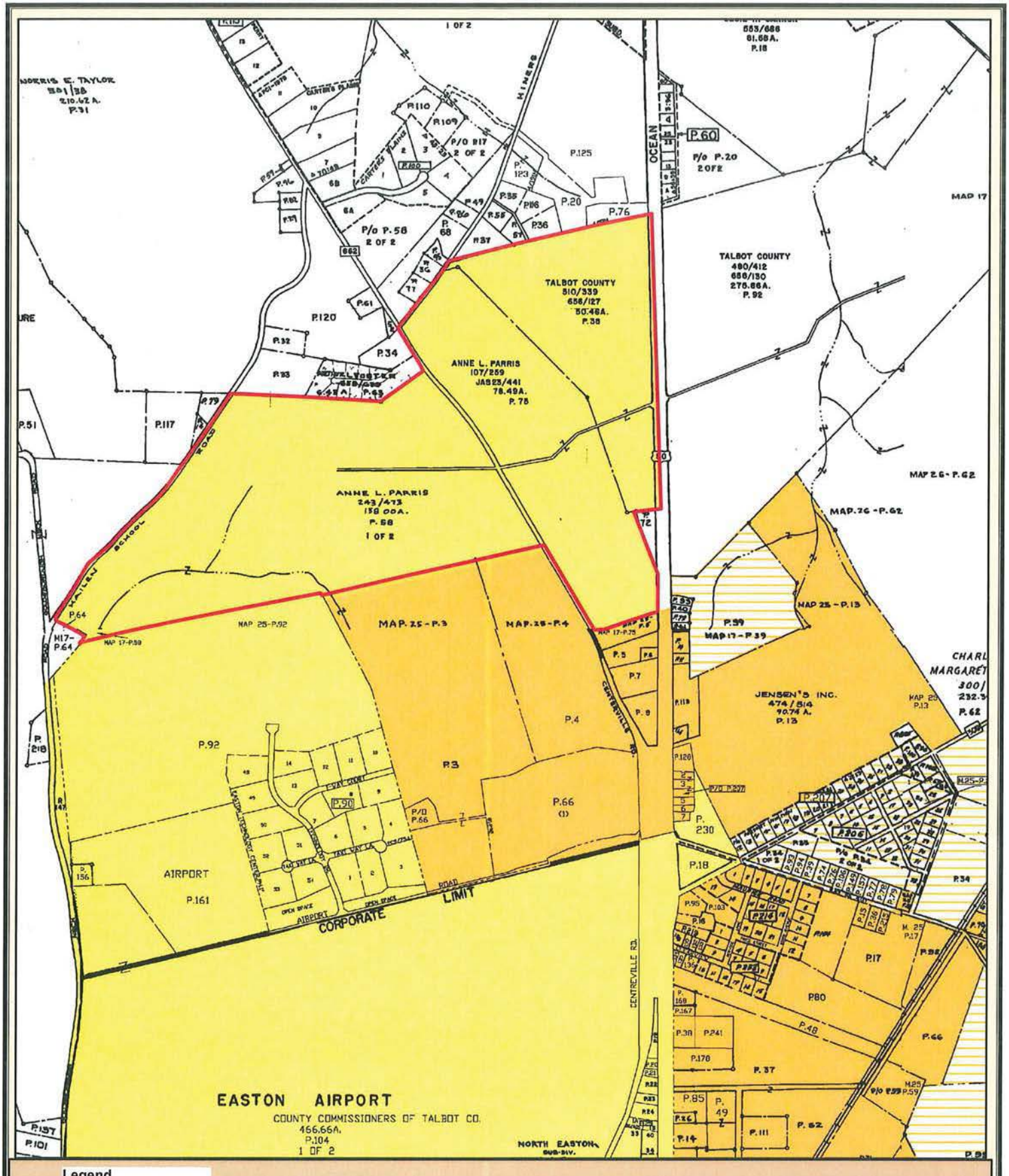
Thank you again for your letter. I look forward to working with you on future Smart Growth efforts. If you need anything further or have any additional questions please contact me at 410-767-4500.

301 West Preston Street • Suite 1101 • Baltimore, Maryland 21201-2305
Telephone: 410.767.4500 • Fax: 410.767.4480 • Toll Free: 1.877.767.6272 • TTY Users: Maryland Relay
Internet: www.MDP.state.md.us

Sincerely,

Stephanie Martins
Director, Land Use Planning Analysis

CC: Shawn Kiernan, MDP
Sharon VanEmburgh, Town Attorney
Tom Hamilton, Town Planner, Town of Easton
Sandy Coyman, Planning Officer, Talbot County
Matthew J. Power, Deputy Secretary, MDP
Richard Josephson, Director of Planning Services, MDP
Melissa Appler, MDP



Legend

- Easton Hospital Site
- Municipal PFA
- Municipal PFA Comment Area
- Annexed but not PFA
- PFA
- PFA Comment Area

PRIORITY FUNDING AREAS
Easton, Maryland

MDP

Maryland Department of Planning
March 2010

0.1 0.05 0 0.1 Miles

EXHIBIT 14

LEVEL 3 - 27 BED MED/SURG (26 MED/SURG & 1 PEDS)

	NEW - ADDITIONAL		
ROOM/FUNCTION	QTY	NSS/EACH	TOTAL NSF
1	1	202	202
1 (ADA)	1	220	220
2	1	201	201
2	1	202	202
3	1	202	202
3	1	208	208
4	1	202	202
4 (LIFT)	1	201	201
5 (ADA)	1	252	252
5 (ISOL, LIFT)	1	202	202
6	1	200	200
6 (ISOL)	1	200	200
7	1	200	200
7	1	207	207
8	1	202	202
8	1	203	203
9	1	203	203
9	1	203	203
10	1	203	203
10	1	203	203
11	1	203	203
11	1	203	203
12	1	215	215
12	1	203	203
ALC	1	25	25
CC	1	19	19
CHART	1	23	23
CHART	10	22	220
CHART	1	19	19
DIET CART	1	8	8
DIET CART	1	14	14
EQ	1	137	137
EQ ALC	1	92	92
HSKP	1	60	60
HSKP	1	59	59
HSKP STOR	1	42	42
LINEN	1	23	23
LINEN	1	23	23
LOCKERS	1	85	85
MED/ CLEAN	1	196	196
MED/ CLEAN	1	207	207
MED/SURG 1	1	207	207

MED/SURG 2	1	203	203
MEDS / SUPPLIES	1	142	142
NOUR	1	85	85
OFF, CASE MGR	1	91	91
OFF, NEURO SPCL	1	83	83
OFF, UNIT MGR	1	85	85
OFFICE, CDI (2)	1	107	107
OFFICE, JT SPCL	1	103	103
PEDS	1	207	207
PHYSICIAN WORK	1	119	119
SEATING	1	102	102
SOILED HOLD	1	120	120
SOILED HOLDING	1	127	127
ST BREAK	1	140	140
ST BREAK	1	130	130
ST TLT	1	55	55
STAFF EDUC/ MULTIPURPOSE R	1	234	234
STAFF STATION	1	114	114
STOR	1	17	17
STOR	1	79	79
STR ALC	1	23	23
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	41	41
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	57	57
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	41	41
TLT/SHWR	1	41	41
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	58	58
TLT/SHWR	1	39	39
TLT/SHWR	1	40	40
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38

TLT/SHWR	1	38	38
ALCOVE	1	14	14
ALCOVE	1	11	11
SUPPLY CABINET	23	7	161
MULTI-PURPOSE	1	137	137
WORK STATION	1	219	219
WORK STATION	1	294	294
SUBTOTAL			**10,692**
SHARED SUPPORT			**330**
TOTAL NET			**11,022**
TOAL # BEDS			**27**
DGSF/BED			**408**

LEVEL 3 - PERINATAL / LDRP

	NEW - ADDITIONAL		
ROOM/FUNCTION	QTY	NSS/EACH	TOTAL NSF
ALCOVE	1	40	40
ALCOVE - PHOTO	1	35	35
CC	1	12	12
CHART	1	22	22
CLEAN SUPPLY	1	127	127
CLIN WORK	1	112	112
EQ STOR	1	231	231
EQUIPMENT STORAGE	1	280	280
FAMILY RESPITE	1	215	215
FEM LOCKERS	1	254	254
HLTH ED STOR	1	65	65
HSKP	1	41	41
LACTATION	1	74	74
LACTATION OFFICE	1	108	108
LINEN	1	23	23
M LOCKER	1	150	150
MED STAFF LOCKER	1	226	226
MEDS	1	95	95
NOUR	1	92	92
OB 1 - LDRP (ADA)	1	340	340
OB 2 - LDRP	1	340	340
OB 3 - LDRP (ISOL)	1	343	343
OB 4 - LDRP (ISOL)	1	341	341
OB 5 - LDRP	1	340	340
OB 6 - LDRP	1	340	340
OB 7 - LDRP	1	376	376
OB 8 - LDRP	1	345	345
OB 9 - LDRP	1	346	346
OB 10 - LDRP	1	348	348
OB 11 - LDRP	1	343	343
OB 12 ANTEPARTUM	1	211	211
OB 13 ANTEPARTUM	1	203	203
OFF, CASE MGR	1	78	78
OFF, CLIN COORD	1	96	96
OFF, EDUC	1	81	81
OFF, TRACE VUE	1	95	95
OFF, UNIT MGR	1	123	123
OFFICE	1	163	163
SOILED WORKROOM	1	170	170
ST BREAK	1	172	172
ST TLT	1	59	59
STAFF WORK	1	322	322

TLT	1	50	50
TLT/ SHWR	1	58	58
TLT/ SHWR	1	38	38
TLT/ SHWR	1	38	38
TLT/BATH	1	43	43
TLT/BATH	1	43	43
TLT/BATH	1	43	43
TLT/BATH	1	43	43
TLT/BATH	1	43	43
TLT/BATH	1	43	43
TLT/BATH	1	44	44
TLT/BATH	1	44	44
TLT/BATH	1	44	44
TLT/BATH	1	44	44
SUBTOTAL			**8,395**
SHARED SUPPORT			**330**
TOTAL NET			**8,725**
TOAL # BEDS			**13**
DGSF/BED			**671**

LEVEL 3 - SHARED SUPPORT

	NEW - ADDITIONAL		
ROOM/FUNCTION	QTY	NSS/EACH	TOTAL NSF
CONSULT	1	106	106
FAMILY WAIT	1	424	424
PUB TLT	1	51	51
PUB TLT	1	51	51
VENDING	1	27	27
TOTAL NET			**659**
# BEDS			**N/A**
NSF/UNIT			**330**

INCLUDED IN UNIT TOTALS

LEVEL 4 - 28 BED MED/SURG UNIT (26 ADULT & 2 PALLIATIVE)

	NEW - ADDITIONAL		
ROOM/FUNCTION	QTY	NSS/EACH	TOTAL NSF
1 (ADA)	1	222	222
2	1	202	202
3	1	201	201
4	1	202	202
5	1	202	202
6 (ISOL)	1	200	200
7 (ISOL)	1	200	200
8	1	202	202
9	1	200	200
10	1	202	202
11 (PALLIATIVE CARE)	1	202	202
12 (PALLIATIVE CARE, ADA)	1	227	227
13	1	207	207
14	1	202	202
15	1	203	203
16	1	203	203
17	1	203	203
18	1	203	203
19	1	203	203
20	1	203	203
21 (LIFT)	1	203	203
22 (LIFT)	1	203	203
23	1	215	215
24	1	244	244
25	1	206	206
26	1	209	209
27	1	199	199
28	1	215	215
ALC	1	28	28
ALC	1	25	25
CC	1	14	14
CHART	1	22	22
CHART	1	22	22
CHART	1	22	22
CHART	1	22	22
CHART	1	19	19
CHART	1	23	23
CHART	1	22	22
CHART	1	22	22
CHART	1	22	22
CHART	1	22	22
CHART	1	22	22

CLINICIAN WORK	1	124	124
DIET CART	1	8	8
EQ	1	137	137
EQUIPMENT STORAGE	1	87	87
FAM TLT/SHWR	1	53	53
HSKP	1	45	45
HSKP STOR	1	47	47
LINEN	1	23	23
LINEN	1	23	23
MED / CLEAN	1	185	185
MED/ CLEAN	1	196	196
MED/ CLEAN	1	152	152
NOUR	1	85	85
NOUR.	1	28	28
OFF, CASE MGR (2)	1	113	113
OFFICE	1	72	72
OFFICE	1	71	71
PALLIATIVE CARE FAMILY ROOM	1	199	199
PHYSICIAN WORK	1	118	118
SOILED HOLD	1	85	85
SOILED HOLDING	1	148	148
ST BREAK	1	139	139
ST TLT	1	55	55
STAFF EDUC/ MULTIPURPOSE R	1	234	234
STAFF STATION	1	167	167
STOR	1	17	17
STOR	1	103	103
STOR	1	153	153
STOR.	1	50	50
STORAGE	1	79	79
STR ALC	1	26	26
SEATING	1	102	102
SUPPLY CABINETS	14	7	98
SUPPLY CABINETS	1	4	4
TLT	1	58	58
TLT/ SHWR	1	40	40
TLT/ SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	58	58

TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	39	39
TLT/SHWR	1	63	63
TLT/SHWR	1	40	40
TLT/SHWR	1	41	41
TLT/SHWR	1	41	41
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	51	51
WORK STATION	1	201	201
WORK STATION	1	222	222
WORKROOM	1	126	126
SUBTOTAL			**10,047**
SHARED SUPPORT			**337**
TOTAL NET			**10,384**
TOAL # BEDS			**28**
DGSF/BED			**371**

LEVEL 4 - SHARED SUPPORT

	NEW - ADDITIONAL		
ROOM/FUNCTION	QTY	NSS/EACH	TOTAL NSF
CONSULT	1	106	106
FAMILY WAITING	1	438	438
PUB TLT	1	51	51
PUB TLT	1	51	51
VENDING	1	27	27
TOTAL NET			**673**
# BEDS			**N/A**
NSF/UNIT			**337**

INCLUDED IN UNIT TOTALS

LEVEL 5 - 16 BED ICU

	NEW - ADDITIONAL		
ROOM/FUNCTION	QTY	NSS/EACH	TOTAL NSF
5 (ISOL)	1	274	274
6 (ISOL)	1	270	270
ALC	1	11	11
ALC	1	38	38
ALCOVE	1	41	41
CASE MGR	1	124	124
CHART	1	19	19
CHART	1	17	17
CHART	1	18	18
CHART	1	18	18
CHART	1	18	18
CHART	1	18	18
CHART	1	20	20
CHART	1	17	17
CLIN COORD	1	122	122
CONSULT	1	100	100
DIET CART	1	12	12
EQ ALC	1	38	38
EQ ALC	1	41	41
EQ STOR	1	76	76
EVS	1	50	50
FAM TLT	1	82	82
FAMILY	1	162	162
ICU ON CALL	1	104	104
LINEN	1	40	40
MED/ CLEAN	1	245	245
MULTI-PURPOSE	1	116	116
NOUR	1	117	117
NURSE EDUC SPECIALIS	1	130	130
PAT TLT	1	36	36
PAT TLT	1	36	36
PAT TLT	1	36	36
PAT TLT	1	35	35
PAT TLT	1	36	36
PAT TLT	1	36	36
PAT TLT	1	37	37
PAT TLT	1	35	35
PATIENT RM 11	1	268	268
PATIENT RM 14	1	280	280
PATIENT RM 15	1	263	263
PATIENT RM 16	1	269	269
PATIENT RM 1	1	277	277

PATIENT RM 2	1	268	268
PATIENT RM 3	1	275	275
PATIENT RM 7	1	274	274
PATIENT RM 8	1	299	299
PATIENT RM 9	1	307	307
PATIENT RM 10	1	262	262
PATIENT RM 12	1	263	263
PATIENT RM 13	1	265	265
PATIENT RM 4	1	269	269
PORT EQ	1	28	28
RT EQ CLN	1	127	127
RT SUPPLY	1	199	199
SEATING	1	124	124
SOILED HOLDING	1	84	84
ST BREAK	1	193	193
ST TLT	1	61	61
ST TLT	1	49	49
STORAGE	1	121	121
SUPPLY CABINETS	4	7	28
SUPPLY CABINETS	4	5	20
TANKS	1	47	47
TLT	1	36	36
TLT	1	38	38
TLT	1	35	35
TLT	1	37	37
TLT	1	37	37
TLT	1	38	38
TLT	1	36	36
TLT	1	36	36
TLT/ SHWR	1	65	65
WORK STATION	1	131	131
SUBTOTAL			**7,760**
SHARED SUPPORT			**758**
TOTAL NET			**8,518**
TOAL # BEDS			**16**
DGSF/BED			**532**

LEVEL 5 - 25 BED MED/SURG UNIT (TELEMETRY BEDS)

	NEW - ADDITIONAL		
ROOM/FUNCTION	QTY	NSF/EACH	TOTAL NSF
1 (ADA)	1	220	220
2	1	202	202
3	1	205	205
4	1	201	201
5	1	202	202
6 (ISOL)	1	200	200
7 (ISOL)	1	200	200
8	1	202	202
9	1	201	201
10	1	202	202
11	1	202	202
12 (ADA)	1	252	252
13	1	200	200
14	1	207	207
15	1	202	202
16	1	203	203
17	1	203	203
18	1	203	203
19	1	203	203
20	1	203	203
21	1	203	203
22	1	202	202
23	1	202	202
24	1	203	203
25	1	207	207
ALC	1	28	28
ALC	1	25	25
ALC	1	11	11
CC	1	15	15
CHART	1	22	22
CHART	1	22	22
CHART	1	22	22
CHART	1	22	22
CHART	1	22	22
CHART	1	22	22
CHART	1	22	22
CHART	1	20	20
CHART	1	22	22
CHART	1	22	22
CHART	1	22	22
CHART	1	19	19
CLINICIAN WORK	1	124	124

DIET CART	1	8	8
EQ	1	137	137
HSKP	1	45	45
LINEN	1	23	23
LINEN	1	23	23
MED/ CLEAN	1	151	151
MED/ CLEAN	1	196	196
NOUR	1	85	85
OFFICE, CASE MGR (2)	1	113	113
PHYSICIAN WORK	1	114	114
SEATING	1	87	87
SOILED HOLDING	1	148	148
ST BREAK	1	135	135
ST TLT	1	55	55
STOR	1	103	103
STORAGE	1	79	79
STR ALC	1	26	26
SUPPLY CABINETS	11	7	77
TELE MONITOR	1	153	153
TLT/SHWR	1	39	39
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
TLT/SHWR	1	53	53
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	40	40
TLT/SHWR	1	57	57
TLT/SHWR	1	40	40
TLT/SHWR	1	39	39
TLT/SHWR	1	38	38
TLT/SHWR	1	38	38
WORK STATION	1	192	192
WORK STATION	1	222	222

SUBTOTAL			**8,772**
SHARED SUPPORT			**758**
TOTAL NET			**9,530**
TOAL # BEDS			**25**
DGSF/BED			**381**

LEVEL 5 - SHARED SUPPORT

	NEW - ADDITIONAL		
ROOM/FUNCTION	QTY	NSF/EACH	TOTAL NSF
CONSULT	1	106	106
FAMILY WAITING	1	448	448
HSKP STOR	1	42	42
IV TEAM/	1	206	206
LOCKER	1	325	325
PUB TLT	1	51	51
PUB TLT	1	51	51
STAFF EDUC/ MULTIPURPOSE R(	1	242	242
STOR	1	17	17
VENDING	1	27	27
TOTAL NET			**1,515**
# BEDS			**N/A**
NSF/UNIT			**758**

INCLUDED IN UNIT TOTALS

LEVEL 6 - 12 BED BEHAVIORAL HEALTH UNIT

	NEW - ADDITIONAL		
ROOM/FUNCTION	QTY	NSF/EACH	TOTAL NSF
1	1	210	210
2	1	205	205
3	1	204	204
4	1	199	199
5	1	210	210
6	1	242	242
7	1	248	248
8	1	203	203
9	1	203	203
10	1	203	203
11	1	203	203
12	1	214	214
ADA TLT/ SHWR	1	41	41
CHART	1	22	22
CHART	1	22	22
CHART	1	24	24
CHART	1	23	23
CONFER. / TREATMENT PLANNI	1	305	305
CONSULT	1	139	139
DAY ROOM / DINING	1	574	574
EQ STOR	1	76	76
EQUIP	1	50	50
GROUP THERAPY / QUIET ACTIV	1	338	338
LINEN	1	40	40
LOUNGE / LOCKERS	1	324	324
MEDS	1	103	103
MULTI PURPOSE	1	116	116
OFFICE	1	97	97
OFFICE	1	89	89
OFFICE	1	98	98
OFFICE	1	91	91
QUIET ROOM	1	68	68
SEATING ALCOVE	1	126	126
SEC/ WORK ROOM	1	316	316
SECLUSION ROOM	1	99	99
SOILED HOLDING	1	84	84
SPLY / PATIENT EFFECTS	1	256	256
ST TLT	1	58	58
ST TLT	1	61	61
STAFF STATION	1	469	469
STO	1	12	12
STO	1	11	11

STO	1	17	17
STO	1	17	17
STO.	1	15	15
STO.	1	15	15
STOR	1	10	10
THERAPIST WORKROOM	1	197	197
TLT	1	66	66
TLT/ SHWR	1	38	38
TLT/ SHWR	1	38	38
TLT/ SHWR	1	38	38
TLT/ SHWR	1	38	38
TLT/ SHWR	1	41	41
TLT/ SHWR	1	41	41
TLT/ SHWR	1	41	41
TLT/ SHWR	1	41	41
TLT/ SHWR	1	41	41
TLT/ SHWR	1	38	38
TLT/ SHWR	1	38	38
VEST	1	57	57
VISIT RM	1	139	139
SUBTOTAL			**7,642**
OFF UNIT SUPPORT			**711**
TOTAL NET			**8,353**
TOAL # BEDS			**12**
DGSF/BED			**696**

LEVEL 6 - SUPPORT

	NEW - ADDITIONAL		
ROOM/FUNCTION	QTY	NSF/EACH	TOTAL NSF
EVS	1	80	80
FAMILY WAITING	1	434	434
LIBRARY OFFICE	1	86	86
TLT	1	56	56
TLT	1	55	55
TOTAL NET			**711**
# BEDS			**N/A**
NSF/UNIT			**711**

INCLUDED IN UNIT TOTAL

EXHIBIT 15

PRIMARY ACUTE STROKE PATIENT TRANSFER AGREEMENT BETWEEN THE MEMORIAL HOSPITAL AT EASTON, INC. AND THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION

EFFECTIVE DATE: December 15, 2006

PURPOSE: In response to state regulations addressing the care of acute stroke patients, the **MEMORIAL HOSPITAL AT EASTON,INC**, a health care facility owned and operated by Shore Health System, Inc. (the "Facility"), enters into this transfer agreement with the **University of Maryland Medical Center**, a health care facility owned and operated by University of Maryland Medical System Corporation ("UMMC"). The purpose of the agreement is to establish a process for the transfer and care of acute stroke patients requiring neurosurgical intervention.

POLICY

A. POINT OF CONTACT:

UMMC's Maryland ExpressCare (*"ExpressCare"*), will be the sole source of contact throughout the process. All inquiries related to patient transport should go through *ExpressCare*. This process allows for the most timely and efficient utilization of resources and avoids conflicting communications.

B. REQUEST FOR TRANSPORT:

1. A member of the Facility's stroke team will contact *ExpressCare* at (410) 328-1234, upon determining that the patient requires neurosurgical intervention for acute stroke-related conditions such as subarachnoid hemorrhage or acute intracerebral hemorrhage. The number for *ExpressCare* is.
2. Upon reaching *ExpressCare*, the Facility Stroke Team will:
   a. Identify the Facility and notify *ExpressCare* that a transfer of an acute stroke patient for neurosurgical intervention is necessary.
   b. Provide *ExpressCare* with logistical information, patient demographics, clinical information and any other requested information.
   c. If the patient requires transport to UMMC, the Facility Stroke Team will fax the patient's "face sheet" with demographic data to *ExpressCare* at (410) 328-1235.
3. If a member of the UMMC medical staff medical accepts the patient for transfer and appropriate resources are available, *ExpressCare* will timely dispatch the Maryland *ExpressCare* Team, which will include a registered nurse, to transport the patient from the Facility to UMMC.
4. If the patient transfer is accepted and a bed is available but a Maryland *ExpressCare* Team is not available to effect the transfer, the following will occur:
   a. *ExpressCare* will check the availability of other Advanced Life Support ("ALS") vendor resources. If a Critical Care team is available, *ExpressCare* will dispatch the team in order to respond in a timely manner.
   b. If vendor resources are exhausted and no Critical Care Team is available, *ExpressCare* will then call the Facility to indicate the lack of Critical Care transport availability to accompany patient during transport with dispatched ALS team. Facility will then dispatch a qualified registered nurse to accompany the patient during transport.

Xerox - Linda Pittman

C. UMMC ACCEPTANCE OF TRANSFERRED PATIENTS:

If a UMMC medical staff member accepts the patient for transfer and appropriate resources are available, UMMC will receive and provide treatment to the transferred patient to care for the acute stroke patient once the initial triage, assessment and treatment have been completed by the Facility.

D. NO TRANSPORT NECESSARY:

The Facility will notify *ExpressCare* if the transfer is later determined to be unnecessary.

E. ADVISORY NOTICE PRIOR TO ADMINISTERING TISSUE PLASMINOGEN ACTIVATOR

To the extent possible, a member of the Facility's stroke team will contact the *ExpressCare*, to indicate that the Facility's Stroke Team will be administering tissue-plasminogen activator ("t-PA") or similar intravenous acute stroke intervention to a patient.

F. ADMINISTRATIVE PROVISIONS

1. Any modification of this agreement, including any extension , shall be effective only if in writing and signed on behalf of both parties
2. This agreement does not create a joint venture or partnership between UMMC and the Facility.
3. This agreement shall be governed by the law of the State of Maryland; the parties agree to be subject to the jurisdiction of the Maryland courts.
4. The Facility may not assign this Agreement.
5. This agreement may be executed and delivered in one or more counterparts (including by facsimile transmission), each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

Agreed to and approved this 6th day of December, 2006

THE MEMORIAL HOSPITAL AT EASTON, INC.
A health care facility owned and operated by Shore Health System, Inc.

By: _____
Joseph P. Ross
President and Chief Executive Officer

UNIVERSITY OF MARYLAND MEDICAL CENTER
A health care facility owned and operated by the University of Maryland Medical System Corporation

By: _____
Name: Alison G. Brown, MPH
Title: Senior Vice President

TRANSFER AGREEMENT

This Transfer Agreement is entered into on May 20, 2008, by and between Chester River Health System ("Chester River") and The Memorial Hospital at Easton, a health care facility owned and operated by Shore Health System, Inc. ("Shore Health").

WHEREAS, both parties desire to assure continuity of care and treatment appropriate to the needs of each patient and to use the skills, resources, and physical plant of both parties in a coordinated and cooperative fashion to improve patient care at both the acute and post-acute stages of illness.

NOW, THEREFORE, in consideration of the mutual advantages occurring to the parties hereto, Hospital and Shore Health hereby covenant and agree with each other as follows:

1. Both parties agree to make a concerted effort to transfer patients as soon as practical when the need for transfer from Chester River to Shore Health has been determined by the patient's attending physician, provided, however, all eligibility conditions for admission must be met and documented in the patient's medical record.

2. Chester River agrees to send with each patient at the time of transfer or, in the case of any emergency as promptly as possible after the transfer, an abstract of the patient's medical record including:

   (A) the current medical findings,
   (B) diagnosis,
   (C) a brief summary of the course of treatment followed,
   (D) all other administrative and social information useful to provide continuing care to the patient; using the transfer and referral form mutually agreed upon.

3. Chester River, after promptly notifying Shore Health of the impending transfer of a patient and after Shore Health consents to accept such patient, shall assume the responsibility to arrange for appropriate and safe transportation of the patient, his/her personal effects and valuables, and shall provide any necessary care while he/she is being transferred.

4. Charges for services performed by either Chester River or Shore Health for patients transferred from the other institution pursuant to this Agreement, shall be collected by the institution rendering such services, directly from the patient, third party payers, or the other sources normally billed by the institution; and neither party shall have any liability to the other for such charges except to the extent that such liabilities would exist separate and apart from this Agreement.

5. The parties agree that the transfer of a patient pursuant to this Agreement shall not be predicated upon discrimination based on race, religion, national origin, age, sex, physical condition or economic status. The parties also agree that the transfer or receipt of patients shall not be based upon a patient's inability to pay for services rendered by the transferring or receiving institution or a patient's source of payment.

6. All patient transfers pursuant to this Agreement must be accomplished in a medically appropriate manner from physician to physician and from institution to institution by: (i) the use of appropriate life support measures which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to stabilize the patient prior to transfer and to sustain the patient during the transfer; (ii) the provision of appropriate personnel and equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use for the transfer; (iii) the transfer of all necessary records for continuing the care for the patient; and (iv) the consideration of the availability of appropriate facilities, services, and staff for providing care for the patient. The parties agree that before moving a patient, Chester River shall explain the reasons for the transfer and any alternative to the patient or a legally authorized representative of the patient. If it is necessary to move the patient immediately to protect the health, safety or welfare of the patient, Chester River may give the explanation of the reasons for the transfer concurrently with the transfer.

7. The parties agree to recognize the right of a patient to request transfer into the care of a physician and institution of the patient's own choosing and to recognize and comply with all federal and state requirements relating to the transfer of patients.

8. Chester River agrees not to transfer a patient with an emergency medical condition that has not been stabilized unless: (i) the patient, or a legally responsible person acting on the patient's behalf, after being informed of Chester River's obligations under law and of the risk of transfer, requests in writing transfer to another institution; (ii) a licensed physician has signed a certification which includes a summary of the risks and benefits that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another institution outweigh the increased risks to the patient and, in the case of labor, to the unborn child from effecting the transfer; or (iii) if a licensed physician is not physically present at the time a patient is transferred, a qualified medical person has signed a certification described in subparagraph (ii) above after a license physician, in consultation with the person, has made the determination described in subparagraph (ii) above and subsequently countersigns the certificate.

9. All notices hereunder by either party to the other party shall be in writing, delivered personally or by overnight courier, and shall be deemed to have been duly given when delivered personally or one day after delivered to the overnight carrier, charges prepaid, and properly addressed to the respective parties at the addresses shown following each party's signature to this Agreement.

10. This Agreement shall be effective from the date of signing by both parties and shall continue in effect, except that either party may withdraw by giving 60 days written notice to the other party of its intention to terminate this Agreement. However, this Agreement shall be declared null and void and shall be immediately terminated should either party fail to maintain its licensure or certification status.

11. Both parties represent and warrant that, during the term of this Agreement, each shall comply with all applicable state and federal laws and regulations and shall remain in good standing with applicable accrediting organizations.

12. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other institution, on either a limited or general basis, while this Agreement is in effect.

13. This Agreement may be modified or amended by the mutual agreement of the parties, however, any such modification or amendment shall be attached to and become a part of this Agreement. This Agreement shall be construed in accordance with the laws of the State of Maryland.

CHESTER RIVER HEALTH SYSTEM, INC.

By: _____

Name: SCOTT D BURLESON

Title: Executive Vice President

100 Brown Street
Chestertown, Maryland 21620

SHORE HEALTH SYSTEM, INC.

By: _____

Name: GERARD M. WALSH

Title: Sr. V.P. & C.O.O.

219 South Washington Street
Easton, Maryland 21601

GENERAL TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (hereinafter "Agreement"), is effective December 1, 2013, by and between University of Maryland Shore Regional Health, Inc., including Shore Medical Center at Easton, Shore Medical Center at Dorchester, and Shore Medical Center at Chestertown (hereinafter "Health Care Facility") located at 219 South Washington Street, Easton, MD 21601, and Alfred I. duPont Hospital for Children, of The Nemours Foundation, a Florida not-for-profit corporation (hereinafter "AIDHC") located at 1600 Rockland Road, Wilmington, Delaware, 19803. Both Health Care Facility and AIDHC are hereinafter referred to as "Parties" to this Agreement and each may be referred to as "Institution".

WITNESSETH

WHERAS, Health Care Facility is a not-for-profit corporation that operates a health care system to provide access to patient care for the residents of its service area; and

WHEREAS, The Nemours Foundation is a not-for-profit corporation that operates a hospital to provide pediatric patient care; and

WHEREAS, the parties desire to provide reasonable assurance that the transfer of patients will be properly effected between the institutions when a transfer is either medically appropriate as determined by the referring physician or when the patient requests the transfer;

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Health Care Facility and AIDHC agree as follows:

1. Term. This Agreement shall commence on the day and year first above written and shall continue for a period of five (5) years, unless terminated earlier by either Institution as set forth below.

2. Patient Transfer. The patient's attending physician will determine when transfer of a patient, from one Institution to the other is appropriate. When a decision to transfer has been made, the transferring Institution shall contact the receiving Institution as far in advance of the anticipated transfer as possible to obtain the receiving Institution's consent to the transfer. Prior to moving the patient, the transferring Institution must receive confirmation from the receiving Institution that it can accept the patient.

3. Patient Records. Each Institution agrees to adopt standard forms for medical and administrative information to accompany the patient from one Institution to the other. The information shall include, but not be limited to, an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption. Each Institution agrees to supplement the above information as necessary for the maintenance of the patient during transport and treatment upon arrival at the receiving Institution.

4. Personal Effects. The transferring party shall transfer the patient's personal effects, including money and valuables, and information pertaining to same. A list prepared by the transferring party of all personal effects shall be transferred with the patient and shall include the signature of the person making the list. An attempt should be made to have family members

or friends voluntarily transfer such personal effects if possible. The receiving party shall, as soon as practical upon patient arrival, document that all personal effects were received or will notify the transferring facility if items were lost.

5. Medical Information. The transferring party agrees to transmit with each patient at the time of transfer, or in case of an emergency, as promptly as possible thereafter, all available pertinent medical and other records necessary to continue the patient's treatment without interruption and to provide identifying and other information, which must include:

(a) A completed interagency communication summary to include; as applicable

- current medical findings;
- diagnosis;
- rehabilitation potential;
- brief summary of the course of treatment followed at Health Care Facility;
- nursing and dietary information useful in care of the patient;
- administrative and pertinent social information;
- post-discharge plan of care;
- all other information required by law or deemed necessary.

(b) Documentation of any known Health Care Treatment Directive, including any durable power of attorney for health care decisions, living will, guardianship papers or withholding of resuscitation orders.

(c) Documentation of (i) the name of the person requesting the transfer, (ii) the fact that the patient or person with authority to act on the patient's behalf consented to the transfer (except in emergencies), (iii) the name of the person at the receiving party who accepted the transfer.

6. Patient Consent to Transfer. The transferring Institution shall have responsibility for obtaining the appropriate consent to the transfer to the other Institution, prior to the transfer. This should include the patient's attending physician's signature authorizing the transport.

7. Charges. The patient/parent is primarily responsible for payment for care received at either Institution and for the costs to transport the patient for the transfer. Prior to transfer, except in urgent circumstances, the patient/parent should be required, if competent, to acknowledge the obligation to pay for such care at the receiving Institution and the transport costs. Each Institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either Institution to look to the other Institution to pay for services rendered to a patient transferred by virtue of this Agreement.

8. Transport. The transferring party shall arrange for appropriate and safe transportation of the patient in compliance with applicable laws, regulations and Joint Commission standards.

9. Return of Patient to Health Care Facility. When the Receiving party is AIDHC, the Health Care Facility shall be expected to be available for the return of the transferred patient when:

(a) the patient's medical condition has stabilized and the patient is ready for discharge from AIDHC, and

(b) the patient has needs for continued care appropriate to the scope of services provided by the Health Care Facility.

10. Liability. Each Institution shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other Institution.

11. Indemnification. Each party (the "Indemnifying Party") will defend, indemnify and hold the other parties and the other parties' employees, officers, governing body and medical staff members, physicians, agents, representatives and affiliates (collectively the "Indemnified Parties") harmless against any and all claims, suits, proceedings, demands, liabilities, losses, damages, penalties, fines, interest, costs and attorney's fees which may be brought, claimed or asserted against or incurred by the Indemnified Parties, and which arise from or result from the Indemnified Party's provision or failure to provide any of the Services described in this Agreement or from any negligence or other tortious or wrongful act or omission by the Indemnifying party or its employees, physicians, contractors or representatives. This provision shall survive termination of this Agreement.

12. Insurance. Each Institution agrees to obtain and maintain in force during the term of the Agreement professional and general liability insurance with minimum limits of $1 million per occurrence or claim and $3 million annual aggregate. Upon request, each Institution will provide the other with a certificate of insurance verifying such coverage at all times this Agreement is in effect. Each Institution shall notify the other at least thirty (30) days prior to cancellation, reduction or material change in coverage. If the insurance is on a "claims made" basis, each Institution agrees to purchase appropriate tail coverage for claims, demands or actions reported in future years for acts or omissions during the term of this Agreement. If either Institution fails to obtain or maintain the insurance coverage provided herein, the other party may terminate this Agreement. The parties may satisfy this requirement through an actuarially sound plan of self insurance.

13. Termination.

13.1 Voluntary Termination. This Agreement may be terminated by either Institution for any reason, by giving thirty (30) days written notice of its intention to withdraw from this Agreement, and by ensuring the continuity of care to patients who already are involved in the transfer process. To this end, the terminating Institution will be required to meet its commitments under the Agreement to all patients for whom the other Institution has begun the transfer process in good faith.

13.2 Involuntary Termination. This Agreement may be terminated immediately upon the occurrence of any of the following:

13.2.1 Either Institution is destroyed to such an extent that the patient care provided by such Institution cannot be carried out adequately;

13.2.2 Either Institution loses its license or accreditation;

13.2.3 Either Institution is no longer able to provide the service for which this Agreement was sought;

13.2.4 Either Institution is in material default under any of the terms of this Agreement; or

13.2.5 Either Institution becomes a Sanctioned Provider as defined in Appendix A.

14. Independent Contractor Status. The Parties are independent contractors and neither Institution is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by either Institution, nor shall it in any way alter the control of the management, assets and affairs of the respective Parties. Neither Institution, by virtue of the Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other Institution to this Agreement.

15. Regulatory Compliance. The Parties agree to abide by all applicable federal, state and local laws and regulations, to include the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the Health Insurance Portability and Accountability Act ("HIPAA"), and federal and state anti-kickback laws. This agreement is not intended to violate the Anti-Kickback or Stark laws and it is not the purpose, nor is it a requirement of this Agreement to offer or receive any remuneration or inducement in exchange for the referral of any patient or other health care business between the parties.

16. Discrimination. The Parties agree that the primary consideration of both is care of patients according to their needs. Health Care Facility and AIDHC agree to admit and assign patients without regard to race, color, sex, age, national origin, religious creed or sexual preference.

17. Advertising and Public Relations. Neither Institution shall use the name of the other Institution in any promotional or advertising material unless review and approval of the intended advertisement first shall be obtained from the Institution whose name is to be used. The Parties shall deal with each other publicly and privately in an atmosphere of mutual respect and support, and each Institution shall maintain good public and patient relations and efficiently handle complaints and inquiries with respect to transferred or transferring patients.

18. Modification of Waiver. If either Institution to this Agreement waives a breach of one of the provisions of this Agreement by the other Institution, that waiver shall neither operate nor be construed as a waiver of a subsequent similar breach of a provision hereof.

19. Governing Law. This Agreement is made and entered into and shall be governed and construed in accordance with the laws of the State of Delaware.

20. Assignment. The Agreement shall not be assigned in whole or in part by either Institution hereto without the express written consent of the other Institution.

21. Invalid Provision. In the event that any portion of the Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the Parties hereto in the same manner as if the invalid or unenforceable provision were not a part of the Agreement.

22. Amendment. This Agreement may be amended at any time by a written Agreement signed by the Parties hereto.

23. Notice. Any and all notices and other communications required or permitted to be given hereunder shall be made in writing and effective upon receipt. Such notices shall be personally delivered, sent by registered or certified mail, by a nationally recognized overnight delivery service or sent by facsimile or electronic mail with confirmation, addressed as follows, unless such address is changed by written notice hereunder:

If to Health Care Facility:

University of Maryland Shore Regional Health, Inc.
219 South Washington Street
Easton, MD 21601
Attn: President & CEO

If to AIDHC:

Alfred I. duPont Hospital for Children
1600 Rockland Road
Wilmington, DE 19803
Attn: Diane Hochstuhl
E-mail: dhochstu@nemours.org

With a copy to:

Office of Contracts Administration
The Nemours Foundation
10140 Centurion Parkway North
Jacksonville, FL 32256
Fax: 904.697.4070
E-mail: oca@nemours.org

24. Entire Agreement. This Agreement constitutes the entire agreement between the Parties and contains all of the agreements between them with respect to the subject matter hereof and supersedes any and all other agreements, either oral or in writing, between the Parties with respect to the subject matter hereof.

25. Assignment. This Agreement may not be assigned in whole or in part by any Party without the express written consent of the other Party.

26. Counterparts and Electronic Signature. This Agreement may be executed in two or more counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. Delivery of an executed signature page to the Agreement by facsimile transmission or .PDF will be as effective as delivery of a manually signed counterpart.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed by persons duly authorized to bind the Parties to perform their respective obligations hereunder, as of the date first written above.

ALFRED I. duPONT HOSPITAL FOR CHILDREN OF THE NEMOURS FOUNDATION

By: M. Kay Holbrook
Name: M. Kay Holbrook
Title: Associate Administrator
Date: 12/2/13

UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH, INC.

By:
Name: Kenneth Kozel
Title: President & CEO
Date: 12/12/13

APPENDIX A

"Sanctioned Provider" means a Person who:

1. is currently under indictment or prosecution for, or has been convicted of:

a) any offense related to the delivery of an item or service under the Medicare or Medicaid programs or any program funded under Title V or Title XX of the Social Security Act (the Maternal Child Health Services Program or the Block Grants to States for Social Services programs, respectively),

b) a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service,

c) fraud, theft, embezzlement or other financial misconduct in connection with the delivery of a health care item or service,

d) obstructing an investigation of any crime referred to in i) through iii) above, or

e) unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

2. has been required to pay any civil monetary penalty under 42 U.S.C. §1128A, regarding false, fraudulent or impermissible claims under, or payments to induce a reduction or limitation of health care services to beneficiaries of, any state or Federal health care program, or is currently the subject of any investigation or proceeding which may result in such payment; or

3. has been excluded from participation in the Medicare, Medicaid or Maternal and Child Health Services (Title V) program, or any program funded under the Block Grants to States for Social Services (Title XX) program.

ORIGINAL

STEMI PATIENT TRANSFER
MEMORANDUM OF UNDERSTANDING

THIS MEMORANDUM OF UNDERSTANDING ("MOU") is made and entered into by and between Peninsula Regional Medical Center, located at 100 East Carroll Street, Salisbury, Maryland ("PRMC") and Shore Health System, Inc. ("SHS"), on behalf of its wholly owned and operated acute care hospitals, The Memorial Hospital, located at 219 S. Washington Street, Easton, Maryland and Dorchester General Hospital, located at 300 Bryn Street, Cambridge, MD 21613, (individually and collectively referred to herein as SHS facilities).

RECITALS:

WHEREAS, SHS facilities do not perform certain cardiac procedures that may be required by patients presenting with ST-segment elevation MI ("STEMI patients");

WHEREAS, PRMC does perform such procedures and further is a designated by the Maryland Institute for Emergency Medical Services Systems (MIEMSS) designated Cardiac Interventional Center (CIC);

WHEREAS, SHS desires to arrange for the provision of needed cardiology and cardiac services to its STEMI patients and facilitate the continuity of their care by transferring such patients to PRMC in order to receive the necessary cardiac procedures; and

WHEREAS, PRMC desires to accept such transfers and to provide such services to SHS's transferred STEMI patients;

NOWTHEREFORE, in consideration of the mutual covenants and agreements set forth herein, PRMC, and SHS agree as follows;

1. **TRANSFER OF PATIENTS.** All transfers between any SHS facility and PRMC shall be performed in accordance with applicable federal and state statutes and regulations, the standards of The Joint Commission, and the MIEMMS Interhospital Transfer Guidelines. In addition, in the course of effectuating a transfer addressed by this MOU, both SHS and PRMC shall adhere to their own reasonable policies and procedures applicable to patient transfers. Both PRMC and SHS agree to retain data regarding performance measures of services provided under this MOU as may be necessary for purposes of certification and/or accreditation. Neither the acceptance of the transfer of a STEMI a patient nor the refusal to accept the transfer of a STEMI patient shall be predicated upon arbitrary, capricious, or unreasonable grounds or discrimination or based upon the patient's inability to pay for services rendered by either PRMC or SHS.

2. **RESPONSIBILITIES OF THE TRANSFERRING FACILITY.** SHS facilities shall evaluate for transfer all patients determined to be STEMI patients as

defined by the MIEMMS regulations at COMAR 30.08.16.01. If a SHS facility determines transfer of a STEMI patient is appropriate, decides to transfer such STEMI patient to PRMC, and concludes the transfer to PRMC meets the MIEMMS Interhospital Transfer Guidelines such SHS facility, as the "Transferring Facility," shall be responsible for performing or ensuring performance of the following:

a. Provide for a member of the nursing staff or the patient's attending physician to contact the Peninsula Access Center using the contact information set forth in Section 12;

b. Provide, within its capabilities, evaluation of the patient for transfer, medical screening and stabilizing treatment of the patient prior to transfer;

c. Arrange for the patient's safe and appropriate transportation to PRMC, the use of appropriate equipment and personnel and the appropriate care for the patient during transfer, in accordance with applicable federal and state laws and regulations and the MIEMMS Interhospital Transfer Guidelines;

d. Select an authorized representative of the Transferring Facility to coordinate the patient's transfer ("Designated Representative") and provide the name of such designated representative to the Receiving Facility.

e. Communicate to the Receiving Facility the Receiving Physician, defined as the treating physician's or patient's choice of physician or cardiology practice to receive the patient once transferred to the Receiving Facility, the physician providing coverage for chosen Physician or cardiology group, or if those Receiving Physicians are unavailable, the on-call cardiologist, all of whom shall be properly credentialed, licensed and experienced cardiologists ("Receiving Physician");

f. Forward to the Receiving Physician and the Receiving Facility a copy of those portions of the patient's medical record that are available at the time of transfer and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of transfer. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible via the fax number in Section 12.

g. Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items.

3. RESPONSIBILITIES OF THE RECEIVING FACILITY. PRMC's responsibility for the patient's care, as the "Receiving Facility," shall begin when the

patient arrives at or is admitted to the Receiving Facility. Specifically, the Receiving Facility shall be responsible for performing or ensuring performance of the following:

a. Arrange for the availability of the Receiving Physician requested by the patient's treating physician or the patient. If such physician is not reasonably available, provide for a properly credentialed, licensed and experienced Receiving Physician.

b. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the Receiving Physician with the receipt and treatment of the patient transferred, maintain a call roster of eligible Receiving Physicians at the Receiving Facility and provide, on request, the name of a Receiving Physician requested based on standing orders or the Receiving Physician providing coverage for that Receiving Physician's group, or the on-call Receiving Physician, to the Transferring Facility.

c. Reserve beds, facilities, and services as appropriate for STEMI patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a Receiving Physician. Transferred STEMI patients shall be treated in the emergency department, sent to the cardiac catheterization laboratory, directly admitted to a patient room, and/or sent to the operating room, as appropriate based on the patient's medical needs.

d. Select an authorized representative of the Receiving Facility to coordinate the patient's transfer ("designated representative") and provide the name of such designated individual to the Transferring Facility.

e. When the Transferring Facility cannot arrange for necessary personnel or equipment, and when appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the Transferring Physician (Physician at SHS who is responsible for the patient prior to transfer) and Receiving Physician.

f. Maintain the confidentiality of the patient's medical records in accordance with applicable state and federal law.

g. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medial records in accordance with applicable state and federal law, (ii) for the receipt of the patient into the facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient.

h. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider, including the MIEMMS standards for the transfer of STEMI patients.

4. BILLING. All charges incurred with respect to any services performed by either PRMC or SHS for transferred STEMI patients shall be billed and collected by the

party furnishing such services. In addition, it is understood that professional fees will be billed by the physicians or other professional providers at SHS facilities and/or PRMC that may participate in the care and treatment of the patient. Both SHS and PRMC agree to provide information in its possession to the other and to physicians/providers sufficient to enable the treating providers to bill for services provided..

5. DISCHARGE. When the transferred patient is ready for discharge as appropriate to the patient's medical condition, the Receiving Physician shall contact the Transferring Physician or the patient's primary care physician.

6. COMPLIANCE WITH LAW. SHS and PRMC shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of medical records, confidentiality or patient information, and the rules and standards of MIEMMS for the transfer and treatment of STEMI patients, as well as with all standards promulgated by any relevant accrediting agency.

7. RESPONSIBILITY; INSURANCE. SHS and PRMC shall be responsible for their own acts and omissions in the performance of their duties, and the acts and omissions of their own employees and agents. In addition, each party shall maintain, throughout the term of this MOU, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party, and shall provide evidence of that coverage upon request.

8. TERM; TERMINATION.

a. Term; Renewal. The initial term of this MOU ("Initial Term") shall be for a period of 3 year(s), commencing on 5-18, 2011 unless sooner terminated herein. At the end of the Initial Term and upon mutual written agreement of the parties, this MOU may be renewed for subsequent additional terms of one (1) year ("Renewal Terms").

b. Holdover. In the event the parties continue to abide by the terms of this MOU after the expiration of the Initial Term or any Renewal Term, without renewing the MOU in accordance with Section 8.a., this MOU shall continue on a month-to-month basis.

c. Termination Without Cause. Either party may terminate this MOU without cause upon thirty (30) days written notice to the other party.

d. Termination for Breach. Either party may terminate this MOU upon breach by the other party of any material provision of this MOU, provided the breach continues for five (5) days after receipt by the breaching party of written notice of the breach from the non-breaching party.

e. Immediate Termination. Either party may terminate this MOU immediately upon the occurrence of any of the following events:

i. The other party's closure or discontinuation of operation to such an extent that patient care cannot be carried out adequately.

ii. The other party's loss of its license, conviction of a criminal offense related to health care, inclusion on a federal agency's list of entities and individuals who are debarred, excluded or otherwise ineligible for federal program participation.

9. ENTIRE AGREEMENT; MODIFICATION. This MOU contains the entire understanding of the parties with respect to the subject matter and supersedes all prior agreements, oral or written, and all other communications between the parties relating to the subject matter. This MOU may not be amended or modified except by mutual agreement.

10. GOVERNING LAW. This Agreement shall be construed in accordance with the laws of the State of Maryland. The provisions of this Paragraph shall survive expiration or other termination of this MOU regardless of the cause of the termination.

11. PARTIAL INVALIDITY. If any provision of this MOU is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this MOU.

12. NOTICES. All notices by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to PRMC: Peninsula Regional Medical Center
100 East Carroll Street
Salisbury, Maryland 21801
Attn: Executive Director
Guerrieri Heart and Vascular Institute
Fax: 410-912-5757

Peninsula Access Center 410-543-4722

If to SHS: Shore Health System, Inc.
219 South Washington Street
Easton, Maryland 21601
Attn: Director of Cardiology

or to such other persons or places as any party may from time to time designate by written notice to the other.

13. WAIVER. A waiver by any party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. ASSIGNMENT; BINDING EFFECT. Neither party shall assign or transfer, in whole or in part, this MOU or any of their rights, duties or obligations under this MOU without the prior written consent of the other party, and any assignment or transfer by any party without such consent shall be null and void. This MOU shall inure to the benefit of and be binding upon the parties and their respective heirs, representatives, successors and permitted assignees.

THE PARTIES have executed this Agreement on 5-25, 2011

SHORE HEALTH SYSTEM, INC.

By: _____
Gerard M. Walsh
Interim President and CEO

Date: 5-18-11

PENINSULA REGIONAL MEDICAL CENTER

By: _____
Margaret (Peggy) M. Naleppa, DR.M.
President/CEO

Date: 5-25-2011

PATIENT TRANSFER AGREEMENT

THIS AGREEMENT ("Agreement") is made this 16th day of November 2000, by and between Shore Health System of Maryland and **PENINSULA REGIONAL MEDICAL CENTER,** a Maryland corporation ("Peninsula Regional")(each, a "Party").

WHEREAS:

1. Both Parties to this Agreement are providers of health care services which seek to improve the treatment of patients by providing continuity of care and treatment appropriate to the needs of each such patient;

2. Neither Party offers all services needed by its patients and both wish to make provision for the transfer of its patients for additional needed services;

3. At least one Party does have facilities offering services needed by patients of the other Party and is licensed to provide such services;

4. Each Party needs assurance of a referral mechanism to provide these services to its patients which the Party does not offer; and

5. This Agreement is intended to cover the circumstances where patients may be transferred by either Party to the other. The terms of the Agreement refer to the "Transferor Institution" and "Transferee Institution." Depending upon the circumstances, either Party may be either a "Transferor Institution" or a "Transferee Institution." If a Party is transferring patients, then it is the "Transferor Institution." If a Party is receiving patients, then it is the "Transferee Institution."

NOW, THEREFORE, in consideration of the common aims, interests and mutual advantages accruing to the parties, the Parties covenant and agree as follows

1. **Recitals**. The above recitals are specifically incorporated by reference and hereby made a part of this Agreement,

2. **Autonomy**. The governing authorities of each Party shall have exclusive control of the management, assets and affairs of their respective institutions. Neither Party by virtue of this Agreement assumes any liability for any debts or obligations of any nature incurred by the other party to this Agreement. Neither party will assume responsibility for the care rendered to the patient by the other institution.

3. Each Party shall notify the other of it's designated representative(s) for the purpose of implementing this Agreement. In the event that Transferor Institution has a patient in need of services it does not provide and which Transferee Institution does provide, Transferor Institution will contact the designated representative of Transferee Institution who will recommend to Transferor Institution whether the

patient should be transferred from Transferor Institution to Transferee Institution. It shall be the responsibility of the Transferor Institution to determine that the patient can be transferred without harm. If Transferee Institution recommends that the patient be transferred to Transferee Institution, then the designated representative shall confirm to the Transferor Institution that the Transferee Institution consents to the transfer and that the patient meets Transferee Institution's admission criteria relating to appropriate bed, the patient's required level of care, and physician and other services necessary to treat the patient. The designated representative of Transferee Institution shall accept or arrange for acceptance of such patient on behalf of Transferee Institution and shall arrange for all necessary administrative authorizations for the transfer. The transfer of any such patients from Transferor Institution to Transferee Institution will be effected in accordance with federal and state law and regulations. Transferee Institution and Transferor Institution mutually agree to exercise their best efforts to provide for prompt admission of these patients to Transferee Institution.

4. In the event of transfer, it shall be the responsibility of the patient's physician at Transferor Institution to determine the safest and most appropriate means to transfer the patient to Transferee Institution. Transferor Institution will provide or arrange for an ambulance or other transport equipment which is able to provide appropriate treatment during transport. The Transferor Institution will provide medically appropriate personnel and equipment that a reasonable and prudent physician exercising ordinary care would use for the transfer. The transport shall use medically appropriate life-support measures that a reasonable and prudent physician exercising ordinary care would use to stabilize the patient before transfer and to sustain the patient during the transfer. Transferor Institution shall be solely responsible for all costs, or for the arrangement of coverage of all costs, or transporting the patient, including the costs of any necessary personnel, Transferor Institution shall he responsible for notifying Transferee Institution of the impending transfer, providing explanations of the reason for the transfer and any alternatives to the transfer to the patient or patient's Parent(s) or legal guardian(s), as well as obtaining approval for the transfer from such person. Transferor institution shall be solely responsible for assuring that all transfers under this Agreement comply with all federal and/or State requirements which govern the transfer of patients.

5. In compliance with 42 USCA 1395dd, 42 C.F.R. 489.24, Md. Health-Gen. Code Ann. 19-308.2, and COMAR 10. 07. 01. 23, Transferor Institution will provide a copy of the patient's medical records to Transferee Institution. This shall include medical records related to the patient's emergency medical condition, history and physical observations of signs, symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies or telephone reports of the studies, treatment provided, x-rays, results of any tests, written informed consent to the transfer (or physician certification as to the necessity of transfer), copies of any relevant signed consent forms, and any advance directives or other legal guidance believed by Transferor Institution to be currently in effect. A medication

schedule for the previous twelve (12) hours with dose and administration will be provided. These records should accompany the patient at the time of the transfer. For an emergent patient, the medical record may be faxed (within one hour) if time does not allow for photocopying.

6. As soon as a transfer has been made, it shall be the responsibility of Transferor Institution to advise the financially responsible party or agency of the transfer. Each party to this Agreement is solely responsible for all matters pertaining to billing and collecting its own patient charges. Neither party shall have any liability to the other for such charges nor shall be liable for any debts, obligations or claims of a financial or legal nature to the other party.

7. To maintain the quality of care to the transferred patients, all cases will be reviewed by Transferee Institution's Quality Assurance Department. The result of these reviews will be promptly communicated to Transferor Institution.

8. Transferor Institution and Transferee Institution agree that they will provide and ensure maximum confidentiality accorded by law with regard to all medical, business or other records generated in accordance with this Agreement.

9. Nothing in this Agreement shall be construed as limiting the rights of either Party to affiliate or contract with any other institution while this Agreement is in effect.

10. Neither Party shall use the name of the other Party in any promotion or advertising unless prior written approval of the intended use is obtained from the Party whose name is to be used.

11. This Agreement supersedes any relevant prior agreements between the Parties. This Agreement may be modified or amended from time to time by mutual agreement of the Parties and such modifications or amendments shall he attached to and become a part of this Agreement. This Agreement may not be assigned by either Party without the prior written consent of the other. This Agreement shall be construed and enforced in accordance with the laws of the State of Maryland.

12. Neither Party shall be entitled to compensation from the other Party for any services provided under this Agreement.

13. Transferor Institution shall be solely responsible for complying with State and Federal laws and regulations governing patient transfers. Transferor Institution shall not use the patient's inability to pay or source of payment for the patient as a reason to transfer the patient.

14. All notices hereunder shall be in writing and shall be deemed to have been duly given if delivered in hand or sent by registered or certified mail, postage prepaid,

to each Party at the address set forth below. Either Party may designate a different address by written notice given in the manner provided herein.

If to Peninsula Regional:

Peninsula Regional Medical Center
100 East Carroll Street
Salisbury, MD 21801
Attn: President

If to Shore Health System of Maryland:

Shore Health System of Maryland
219 S. Washington Street
Easton, MD 21601
Attn: Administrator

15. This Agreement shall commence as of the date set forth above and shall continue in effect for one year unless it is terminated by either Party. This Agreement shall be renewed for additional terms of one (1) year each in the absence of notice of intent not to renew given by either party. This Agreement may be terminated at any time by an authorized representative of the parties to this Agreement by providing the other Party with 30 days' prior written notice. However, this Agreement shall be automatically terminated if either Party has its license to operate revoked by the State of Maryland, its ability to participate in the Medicare and/or Medicaid programs is terminated, or if it loses accreditations by the Joint Commission or Accreditation of Healthcare organizations.

IN WITNESS WHEREOF, the authorized representatives of the parties to this Agreement have caused their respective principal's name to be subscribed to this Agreement.

PENINSULA REGIONAL MEDICAL CENTER
a Maryland corporation

Sharon R. Hassington

By: _____
Authorized Representative
Date: 11/17/00

_____

By: _____
Authorized Representative
Date: 11/27/00

prmc\patient transfer agr. 1109

AGREEMENT BETWEEN
EASTERN SHORE HOSPITAL CENTER
AND
SHORE HEALTH SYSTEM, INC.

THIS AGREEMENT, entered into and effective this _ day of April 2014 by and between Eastern Shore Hospital Center, a non-profit corporation organized and existing under the laws of Maryland (hereinafter referred to as "ESHC") and Shore Health System, a non-profit corporation organized and existing under the laws of Maryland that owns and operates University of Maryland Shore Medical Center at Easton and University of Maryland Shore Medical Center at Dorchester in Cambridge, Maryland (collectively hereinafter referred to as "Shore Health").

WHEREAS, both parties desire, by means of this Agreement, to facilitate the timely provision of services to ESHC patients; and to insure the continuity and quality of care and treatment appropriate to the needs of patients at ESHC and/or Shore Health by utilizing the knowledge and resources of both parties in a coordinated and cooperative effort; and

WHEREAS, ESHC, a state-operated psychiatric facility located in Cambridge, MD, consists of three (3) psychiatric units and a separately licensed assisted living program (ALP).

WHEREAS, some ESHC patients require certain medical service that are not available onsite at ESHC for their patients/residents

WHEREAS, Shore Health provides certain medical services and is willing to provide services to patients from ESHC as set forth herein.

NOW THEREFORE, in consideration of the mutual advantages accruing to the parties hereto and their respective patients and in consideration of the mutual covenants hereinafter set forth, the parties, with the intention to be legally bound, agree as follows:

I. Conditions of Transfer

Each party agrees to exercise its best efforts to provide for the provision of services of any patient transported from the other facility provided that:

A. A licensed physician who is a member of the medical staff of either party has designated that such services are medically appropriate.

B. All conditions and requirements of provision of services are met, including confirmation of acceptance of the patient by the receiving facility.

C. Adequate and appropriate capacity to provide services is available in the receiving facility to accommodate the patient.

D. The sending facility has received confirmation from the receiving facility that the receiving facility will accept the patient.

II. Admission Process

ESHC agrees that it and its physicians and/or medical staff will abide by the following notification procedures when patients are transported to Shore Health: the sending physician at ESHC shall contact the appropriate Emergency Department attending physician at Shore Health who will evaluate the patient and determine appropriate disposition. In the event there is one (1) ESHC physician treating two injured patients that require emergency care and no additional physician coverage at ESHC is available to such physician, the patient with the most serious injuries will be sent to the Emergency Department, and the patient with less serious injuries will be managed at ESHC; provided that ESCH shall utilize best efforts to notify Shore Health of such transfer in advance via telephone.

III. Transport

A. The sending facility agrees to:

1) Arrange for and carry out appropriate transportation of the patient to the receiving facility, including selection of the mode of transport, using appropriate life support measures, if necessary, to stabilize the patient prior to transport and during transport and providing appropriate health practitioner(s) and equipment to accompany the patient;

2) Complete and forward to the receiving facility, at the time of transport, an approved transport record form;

3) Transport with the patient his/her personal effects and provide documentation of presence or absence of personal items on the medical record/valuables sheet; including a notation if given to patient, family member or placed in hospital safe; and

4) Transmit with each patient at the time of transport copies of the patient's medical record or an abstract of pertinent medical and other records necessary for identification of the patient and continuation of uninterrupted and proper treatment. Such medical and other information should include where applicable:

a) History of the injury or illness;
b) Current medical findings;
c) Diagnosis;
d) Laboratory and radiology findings, including copies of radiological films, where appropriate;
e) Rehabilitation potential;

f) Brief summary of the courses of treatment followed up to the time of transport including medications given and route of administration, fluids given, by type and volume;
g) Nursing information useful in the care of the patient;
h) Patient's third party billing data;
i) Pertinent administrative information as required; and
j) Current surrogate (in the event that the patient is incompetent) and/or next-of-kin information.

5) In the event of an emergency as reasonably determined by the sending facility, the following information will be sent by the sending facility with the patient:

a) History of injury or illness
b) Current medical findings
c) Brief summary of the courses of treatment follow up to the time of the transport, including medications given, and route of administration, fluids given, by type and volume.
d) All other information will be faxed within ten (10) minutes of the patient leaving ESHC for the Shore Health emergency room.

6) Obtain the consent to transport from the patient's legally authorized representative, except in emergency situations where the delay to obtain such consent would seriously jeopardize the patient's life or health.

7) Direct inquiries about the patient or his/her care to the patient's attending physician and to no other medical staff member(s).

B. The receiving facility agrees to:

1) Assume responsibility for the patient's care, including providing full inpatient, outpatient and emergency services as appropriate, upon arrival of the transported patient at the receiving facility;

2) Acknowledge on such forms as may be provided by the sending facility, receipt of the patient's effects and medical records.

C. ESHC agrees to promptly accept patients for readmission upon the reasonable determination of both parties that such patients are appropriate for re-admission from a medical perspective.

IV. Payment for Services

The patient is primarily responsible for payment for care received at the institution and, prior to transport, (in non-emergent cases), the patient (or his/her surrogate decision maker) shall be required to acknowledge the obligation to pay for such at the receiving

institution. Each institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either institution to look to the other to pay for services rendered to a patient transported by virtue of this Agreement, except to the extent that such liability would exist separate and apart from this Agreement.

V. Compliance

Each institution shall comply with all applicable federal, state and local laws, and all requirements imposed by, or pursuant to the regulations of the Department of Health and Human Services and any other applicable governmental agency.

VI. Insurance

Each year that this Agreement is in effect, within thirty (30) days of the anniversary of the execution of this Agreement, each party shall provide to the other written verification that:

A. It has professional liability insurance or adequate self-insurance, in limits as required in accordance with applicable laws of the State of Maryland.

B. That all members of its medical staff are covered by professional liability insurance in limits as required in accordance with applicable laws of the State of Maryland.

C. That all of its employees who may be involved in the transfer of patients are covered by adequate and reasonable limits of workers' compensation, health, and motor vehicle insurance as required in accordance with applicable laws of the State of Maryland.

VII. Indemnification

A. ESHC agrees that it shall defend, indemnify and hold harmless Shore Health, its officers, directors, agents, and employees from and against any and all costs, demands, liabilities, settlements or verdicts, including reasonable attorneys fees, arising out of any claim, demand, action or suit brought by, on behalf of or as a derivative action of any patient or other person for any damages, injuries, or death to persons or property arising out of or in connection with (i) ESHC performance or failure to perform its duties hereunder; or (ii) any act or omission of ESHC, its agents or employees which occurred prior to the admission by Shore Health of any patient transported from ESHC.

B. Shore Health agrees that it shall defend, indemnify and hold harmless ESHC, its officers, directors, agents and employees from and against any and all costs, demands, liabilities, settlements, or verdicts, including reasonable attorneys fees, arising out of any claim, demand, action or suit brought by, on behalf of or as a derivative action of any patient or other person for any damages, injuries or death to persons or property arising out of or in connection with (i) Shore Health's

performance or failure to perform its duties hereunder; or (ii) any act or omission of Shore Health, its agents or employees, which occurred prior to the admission or acceptance by ESHC of any patient transported from Shore Health.

VIII. Confidentiality of Medical Records

All reasonable efforts will be made by both parties to preserve the confidential nature of the patient's medical records and to safeguard the rights of the patients as to medical and/or other privileged information contained within said records in accordance with applicable state and federal laws and regulations.

IX. Duration and Termination of Agreement

The Agreement shall continue in effect indefinitely, except that either party may terminate this Agreement by giving sixty (60) days' notice in writing to the other party of its intention to terminate. Termination shall be effective at the end of the sixty (60) days' notice period. However, if either party shall have its license to operate revoked or suspended by the State, have its accreditation suspended or revoked or placed on probation by any accrediting body or if any governmental agency suspends, revokes or places such party of probation, then the affected party shall immediately notify the other hospital, and this Agreement shall terminate as of the date such suspension, revocation or probation becomes effective.

X. Modification of Agreement

This Agreement may be modified or amended from time to time by mutual written agreement of the parties and any such modification or amendments shall be attached to and become part of this Agreement.

XI. Autonomy of Institutions

Each party to this Agreement is an independent contractor and shall have exclusive control over the policies, management, assets and affairs of its respective institution. Neither party by virtue of this Agreement assumes any liability for any debts or obligations of a financial or legal nature incurred by the other party. Nothing in this Agreement shall be construed as creating a partnership, joint venture, principal-agent or master-servant relationship between the parties, their agents, employees or representatives.

XII. Non-exclusivity

Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other hospital, nursing home or other health care entity or organization on either a limited or a general basis while this Agreement is in effect.

XIII. Non-Discrimination

Both parties attest that they are an equal opportunity employer that offers employment without regard to race, color, religious creed, disability, ancestry, national or ethnic origin, age, sex, or veteran status. This agreement shall be construed and carried out in a non-discriminatory manner without regard to race, color, religious creed, disability, ancestry, national or ethnic origin, age, sex, veteran status or ability to pay.

XIII. Miscellaneous

A. Each party agrees to provide to the other, upon reasonable request, any information deemed relevant by the requesting party to determine if the other party is able to provide the necessary facilities, care and/or treatment for a particular patient, group of patients or types of patients.

B. Neither party shall use the name of the other in any promotional or advertising material without the written approval of the other party.

C. Any communication required herein shall be in writing addressed as follows:

1) Any notice to ESHC:

2) Any notice to Shore Health:
Shore Health System, Inc.
219 S. Washington Street
Easton, Maryland 21601
Attn: Chief Medical Officer

D. No patient, physician, payor or other third party is intended to be a third party beneficiary under this Agreement and no action to enforce the terms of this Agreement may be brought against any party by any person who is not a party to this Agreement.

E. Neither party may transfer, assign, pledge or delegate any or all of its duties or interest in this Agreement without the prior written consent of the other, which consent shall not be unreasonably withheld.

F. This Agreement shall be binding upon and inure to the benefit of the successors or assigns of the parties.

G. This Agreement constitutes the entire agreement between the parties and contains all of the agreements between them with respect to the subject matter and supercedes any and all other agreements, either oral or in writing, between the parties with respect to the subject matter. This Agreement may be modified or amended by a mutual, written agreement signed by the parties.

H. No waiver of any term or condition of this Agreement by either party shall be deemed a continuing or further waiver of the same term or condition or a waiver of any other term or condition of this Agreement.

I. In the event any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue or to be binding upon the parties in the same manner as if the invalid or unenforceable provision were not a part of this Agreement.

J. The headings above the various provisions of this Agreement have been included only in order to make it easier to locate the subject covered by each provision; they are not to be used in construing this Agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed the day and the year written below.

EASTERN SHORE HOSPITAL CENTER

Chief Executive Officer

5-12-14
Date

Witness

SHORE HEALTH SYSTEM, INC.

Chief Executive Officer

6/5/14
Date

Witness

EASTERN SHORE HOSPITAL CENTER

Acting Clinical Director

5.12.14
Date

Witness

EXHIBIT 16

HKS

DAVID KLAHN
VICE PRESIDENT

September 7, 2018

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: University of Maryland Shore Medical Center at Easton
CON Application for Replacement Hospital
HKS Project No.: 19782.008

To whom it may concern:

HKS is the architectural design firm that is designing the proposed University of Maryland Shore Medical Center at Easton. I am confirming that the architectural design of the operating rooms suite at the proposed facility complies with Section 2.2 of the FGI Guidelines.

If you have any questions, you may contact me directly.

Regards,

David Klahn
Vice President

2100 EAST CARY STREET, SUITE 100 RICHMOND, VA 23223 | 804-644-8400 (main) +804-644-8469 (fax) | www.hksinc.com

EXHIBIT 17

THE MARYLAND PERINATAL SYSTEM STANDARDS

Revised June 2014

Recommendations of the Perinatal Clinical Advisory Committee

MEMBERS OF THE PERINATAL CLINICAL ADVISORY COMMITTEE

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Johns Hopkins Medicine

Robert Atlas, MD
Chair, Department of Obstetrics and Gynecology
Mercy Medical Center
MedChi, The Maryland State Medical Society

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Maryland Institute for Emergency Medical Services Systems (MIEMSS)

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Chief, Division of Neonatology
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Level IIIC

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Shady Grove Adventist Hospital
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Renee Webster
Assistant Director
DHMH—Office of Health Care Quality
Office of Health Care Quality

S. Lee Woods, MD, PhD
Director, Office of Surveillance and Quality Initiatives
Maryland Department of Health and Mental Hygiene

Invited to participate but not represented:

National Association of Social Workers, Maryland Chapter

Maryland Medicaid Program

PCAC Staff:

Alison Whitney, MSW, MPH
Program Coordinator, Office of Family Planning and Home Visiting
Maryland Department of Health and Mental Hygiene

THE MARYLAND PERINATAL SYSTEM STANDARDS
REVISED NOVEMBER 2013

STANDARD	TITLE	SUMMARY
I	Organization	Refers to the administration of a hospital perinatal program
II	Obstetrical Unit Capabilities	Refers to the resources of equipment, supplies, and personnel needed for the delivery unit within the hospital
III	Neonatal Unit Capabilities	Refers to the resources of equipment, supplies, and personnel needed for the neonatal units within the hospital
IV	Obstetrical Personnel	Describes the roles, responsibilities, and availability of obstetrical personnel in the perinatal program
V	Pediatric Personnel	Describes the roles, responsibilities, and availability of pediatric personnel in the perinatal program
VI	Other Personnel	Describes the roles, responsibilities, and availability of other personnel in the perinatal program
VII	Laboratory	Refers to the resources of equipment, supplies, and personnel needed for the laboratory unit within the hospital
VIII	Diagnostic Imaging Capabilities	Refers to the resources of equipment, supplies, and personnel needed for diagnostic imaging capabilities within the hospital
IX	Equipment	Refers to the availability of specific equipment needed for the perinatal program
X	Medications	Refers to the availability of specific medications needed for the perinatal program
XI	Education Programs	Refers to the need for education for all health care providers involved in providing perinatal care and to the roles and responsibilities of the hospitals in education

XII	Performance Improvement	Describes the performance improvement process that is required for hospital perinatal programs
XIII	Policies and Protocols	Identifies the administrative and medical policies and protocols that shall be in place for a perinatal program

Revision June 2014:

The Maryland Perinatal System Standards were updated in November, 2013. In June, 2014, Standards 5.10, 5.11 and 5.12 were revised as currently written and the definition of telemedicine was added.

LIST OF DEFINITIONS

I Level I hospitals have perinatal programs that provide basic care to pregnant women and infants, as described by these standards. These hospitals provide delivery room and well newborn nursery care for physiologically stable infants ≥ 35 weeks gestation. Other than emergency stabilization pending transport, the neonatal services do not provide positive pressure ventilatory support. Board-certified pediatricians or family medicine physicians have programmatic responsibility for these services. These neonatal services do not provide pediatric subspecialty or emergent neonatal surgical specialty services. Maternal care is limited to gestations of ≥35 weeks that are maternal risk appropriate. Board-certified physicians or active candidates for board-certification in obstetrics/gynecology or family medicine with advanced training and privileges for obstetrical care with a formal arrangement with a physician board-certified or an active candidate for board-certification in obstetrics/gynecology have programmatic responsibility for obstetrical services. These hospitals do not receive primary infant or maternal referrals.

II Level II hospitals have perinatal programs that provide specialty care to pregnant women and infants, as described by these standards. These hospitals provide delivery room and acute specialized care for moderately ill infants ≥ 1500 grams and ≥ 32 weeks gestation with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis. Board-certified neonatal-perinatal medicine subspecialists have programmatic responsibility for the neonatal services. The neonatal services (special care nurseries) provide mechanical ventilation for up to 24 hours and/or continuous positive airway pressure. The neonatal services may provide limited pediatric subspecialty services. They do not provide emergent neonatal surgical specialty services. Maternal care is limited to term and preterm gestations of ≥ 32 weeks that are maternal risk appropriate. Board-certified obstetricians have responsibility for programmatic management of obstetrical services. These hospitals do not receive primary infant or maternal referrals.

III Level III hospitals have perinatal programs that provide subspecialty care for pregnant women and infants, as described by these standards. These hospitals provide acute delivery room and neonatal intensive care unit (NICU) care for infants of all birth weights and gestational ages. Board-certified neonatal-perinatal medicine subspecialists have programmatic responsibility for neonatal services. These services offer continuous availability of neonatologists. The neonatal services provide sustained life support with multiple modes of neonatal ventilation that may include advanced respiratory support, such as high frequency ventilation. In addition, inhaled nitric oxide may or may not be used. A full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists, and pediatric ophthalmologists are readily accessible on site or by prearranged consultative agreement at a closely related institution. Neonatal care capabilities include advanced imaging, with interpretation on an urgent basis, including computed tomography, magnetic resonance imaging, and echocardiography. Maternal care spans the range of normal term gestation care to the

management of extreme prematurity and moderately complex maternal complications. Board-certified obstetricians have programmatic responsibility for obstetrical services. Board-certified maternal-fetal medicine specialists have programmatic responsibility for high-risk obstetrical services. Level III perinatal hospitals accept risk-appropriate maternal and neonatal transports.

IV Level IV hospitals have perinatal programs that provide comprehensive subspecialty obstetrical and neonatal care services, as described by these standards. These hospitals provide acute delivery room and NICU care for infants of all birth weights and gestational ages, including those with complex and critical illness. Board-certified neonatal-perinatal medicine subspecialists have programmatic responsibility for neonatal services. These services offer continuous availability of neonatologists. Advanced modes of neonatal ventilation and life-support are provided, including high frequency ventilation and nitric oxide, and extracorporeal membrane oxygenation (ECMO) may be provided. These neonatal services provide a full range of pediatric medical subspecialists, pediatric surgical specialists and subspecialists, pediatric anesthesiologists, and pediatric ophthalmologists continuously available. These neonatal services have the capability to provide surgical repair of complex congenital or acquired conditions. Maternal care spans the range of normal term gestation care to that of highly complex or critically ill mothers. In addition, the obstetrical services include management of fetuses who are extremely premature or have complex problems that render significant risk of preterm delivery and postnatal complications. Board-certified maternal-fetal medicine subspecialists have programmatic responsibility for the services and are continuously available. Level IV perinatal hospitals accept maternal and neonatal transports. In collaboration with the Department of Health and Mental Hygiene (DHMH) and the Maryland Institute for Emergency Medical Services Systems (MIEMSS), the Level IV hospitals are expected to take leadership roles in organization and provision of maternal and neonatal issues including, but not limited to, patient transport, outreach education, and professional training.

Board-certified: a physician certified by an American Board of Medical Specialties Member Board, or the equivalent.

Continuously available: a resource available at all times.

Dedicated: a resource assigned to or for the exclusive use by a unit and not shared with any other unit.

Immediately available: a resource available as soon as it is requested.

In-house: physically present in the hospital.

Programmatic responsibility: the writing, review and maintenance of practice guidelines, policies and procedures; development of operating budget (in collaboration with hospital administration and other program directors); evaluation and guiding of the purchase of equipment; planning, development and coordinating of educational programs (in-hospital and/or outreach as applicable); participation in the evaluation of perinatal care; and participation in perinatal quality improvement and patient safety activities.

Readily available: a resource available for use a short time after it is requested.

Telemedicine: the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located. Telemedicine must include at least two forms of communication and be in compliance with COMAR 10.32.05.

30 minutes: in-house within thirty (30) minutes under normal driving conditions which include, but are not limited to, weather, traffic, and other circumstances that may be beyond the individual's control.

E Essential requirement for level of perinatal center

O Optional requirement for level of perinatal center

NA Not Applicable

NOTE: More details regarding the content of care for each perinatal level of care are contained in the *Guidelines for Perinatal Care, 7th Edition*, American Academy of Pediatrics and American College of Obstetricians and Gynecologists, 2012.

THE MARYLAND PERINATAL SYSTEM STANDARDS
REVISED NOVEMBER 2013

	I	II	III	IV
STANDARD I. ORGANIZATION				
1.1 The hospital's Board of Directors, administration, and medical and nursing staff shall demonstrate commitment to its specific level of perinatal center designation and to the care of perinatal patients. This commitment shall be demonstrated by:				
a) A Board resolution that the hospital agrees to meet the Maryland Perinatal System Standards for its specific level of designation and assures that all perinatal patients shall receive medical care commensurate with that designation	E **Yes**	E	E	E
b) Submission of patient care data to the Maryland Department of Health and Mental Hygiene (DHMH) and the Maryland Institute for Emergency Medical Services Systems (MIEMSS) for system and quality management	E **Yes**	E	E	E
c) A Board resolution, bylaws, contracts, and budgets, indicating the hospital's commitment to the financial, human, and physical resources and to the infrastructure that are necessary to support the hospital's level of designation.	E **Yes**	E	E	E
1.2 The hospital shall be licensed by the Maryland Department of Health and Mental Hygiene (DHMH) as an acute care hospital.	E **Yes**	E	E	E
1.3 The hospital shall be accredited by The Joint Commission.	E **Yes**	E	E	E

		I	II	III	IV
1.4	The hospital shall have a certificate of need (CON) issued by the Maryland Health Care Commission (MHCC) for its neonatal intensive care unit and/or approval from the Health Services Cost Review Commission (HSCRC) for a neonatal intensive care unit cost center.	NA	NA	E	E
1.5	The hospital shall obtain and maintain current equipment and technology, as described in these standards, to support optimal perinatal care for the level of the hospital's perinatal center designation.	E **Yes**	E	E	E
1.6	If maternal or neonatal air transports are accepted, then the hospital shall have a heliport, helipad, or access to a helicopter landing site near the hospital.	NA	NA	E	E
1.7	The hospital shall provide specialized maternal and neonatal transport capability and have extensive statewide perinatal educational outreach programs in both specialties in collaboration with MIEMSS and DHMH.	NA	NA	O	E
STANDARD II.	**OBSTETRICAL UNIT CAPABILITIES**				
2.1	The hospital shall demonstrate its capability of providing uncomplicated and complicated obstetrical care through written standards, protocols, or guidelines, including those for the following:				
	a) unexpected obstetrical care problems	E **Yes**	E #	E	E
	b) fetal monitoring, including internal scalp electrode monitoring	E **Yes**	E	E	E

	I	II	III	IV
c) initiating a cesarean delivery within 30 minutes of the decision to deliver	E **Yes**	E	E	E
d) selection and management of obstetrical patients at a maternal risk level appropriate to its capability	E **Yes**	E	E	E
e) management of all obstetrical patients	NA	NA	NA	E
2.2 The hospital shall be capable of providing critical care services appropriate for obstetrical patients, as demonstrated by having a critical care unit and a board-certified critical care specialist as an active member of the medical staff.	NA	O	E	E
2.3 The hospital shall have a written plan for initiating maternal transports to an appropriate level.	E **Yes**	E	E	E
2.4 A written protocol for the acceptance of maternal transports shall be in place.	NA	NA	E	E
STANDARD III. NEONATAL UNIT CAPABILITIES				
3.1 The hospital shall demonstrate its capability of providing uncomplicated and complicated neonatal care through written standards, protocols, or guidelines, including those for the following:				
a) resuscitation and stabilization of the neonate according to the current American Academy of Pediatrics/American Heart Association (AAP/AHA) *Neonatal Resuscitation Program* (NRP) guidelines	E **Yes**	E	E	E
b) selection and management of neonatal patients at a neonatal risk level appropriate to its capability	E **Yes**	E	E	E

	I	II	III	IV
c) management of all neonatal patients, including those requiring advanced modes of neonatal ventilation and life-support, pediatric subspecialty services, and pediatric specialty and subspecialty surgical services	NA	NA	NA	E
STANDARD IV. OBSTETRICAL PERSONNEL				
LEADERSHIP				
4.1 A physician board-certified or an active candidate for board-certification in obstetrics/gynecology or family medicine with advanced training and privileges for obstetrical care with a formal arrangement with a physician board-certified or an active candidate for board-certification in obstetrics/gynecology shall be a member of the medical staff and have programmatic responsibility for obstetrical services.	E **Yes**	NA	NA	NA
4.2 A physician board-certified in obstetrics/gynecology shall be a member of the medical staff and have programmatic responsibility for obstetrical services.	O **Yes**	E	E	E
4.3 A physician (or physicians) board-certified or an active candidate for board-certification in maternal-fetal medicine shall be a member of the medical staff and have programmatic responsibility for high-risk obstetrical services.	NA	O	E	E
COVERAGE FOR URGENT OBSTETRICAL ISSUES				
4.4 A hospital without a physician board-certified in maternal-fetal medicine on the hospital staff shall have a written agreement with a consultant who is board-certified or an active candidate for board-certification in maternal-fetal medicine to be available 24 hours a day.	E **Yes**	E	NA	NA

		I	II	III	IV
4.5	The hospital shall have a maternal-fetal medicine physician on the medical staff, in active practice and, if needed, in-house within 30 minutes.	O	O	E	E
4.6	A physician with obstetrical privileges or certified nurse-midwife with obstetrical privileges shall be readily available to the delivery area when a patient is in active labor.	E **Yes**	NA	NA	NA
4.7	A physician board-certified or an active candidate for board-certification in obstetrics/gynecology or family medicine with obstetrical privileges shall be readily available to the delivery area when a patient is in active labor.	O **Yes**	E	NA	NA
4.8	A physician board-certified or an active candidate for board-certification in obstetrics/gynecology shall be present in-house 24 hours a day and immediately available to the delivery area when a patient is in active labor.	O **No**	O	E	E
4.9	A physician with obstetrical privileges or a certified nurse-midwife with obstetrical privileges shall be present at all deliveries.	E **Yes**	E	E	E
4.10	A physician board-certified or an active candidate for board-certification in anesthesiology shall be a member of the medical staff and have programmatic responsibility for obstetrical anesthesia services.	E **Yes**	E	E	E

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		I	II	III	IV
STANDARD V.	**PEDIATRIC PERSONNEL**				
LEADERSHIP					
5.1	A physician board-certified in pediatrics or family medicine shall be a member of the medical staff, have privileges for neonatal care, and have programmatic responsibility for neonatal unit services. For hospitals without a physician board-certified in pediatrics, there shall be a written agreement which provides consultation with a board-certified pediatrician 24 hours a day.	E **Yes**	NA	NA	NA
5.2	A physician board-certified in neonatal-perinatal medicine shall be a member of the medical staff and have programmatic responsibility for neonatal services.	NA	E	E	E
COVERAGE FOR URGENT NEONATAL ISSUES					
5.3	For hospitals without a physician board-certified in neonatal-perinatal medicine on staff, there shall be a written agreement which provides access to consultation with physicians board-certified in neonatal-perinatal medicine 24 hours a day.	E **Yes**	NA	NA	NA
5.4	NRP trained professional(s) with experience in acute care of the depressed newborn and skilled in neonatal endotracheal intubation and resuscitation shall be immediately available to the delivery and neonatal units.	E **Yes**	E	E	E
5.5	A physician who has completed postgraduate pediatric training, a nurse practitioner or physician assistant with privileges for neonatal care appropriate to the level of the nursery shall be immediately available when an infant requires services including, but not limited to, FiO2 > 40%, assisted ventilation, or cardiovascular support.	NA	E	NA	NA

		I	II	III	IV
5.6	A physician who has completed postgraduate pediatric training, a nurse practitioner or physician assistant with privileges for neonatal care appropriate to the level of the nursery shall be present in-house 24 hours a day and assigned to the delivery area and neonatal units and not shared with other units in the hospital.	NA	O	E	E
5.7	A physician board-certified or an active candidate for board certification in neonatal-perinatal medicine, if needed, shall be available to be present in-house within 30 minutes.	NA	O	E	E
NEONATAL SUBSPECIALTY CARE					
5.8	The hospital shall have written consultation and referral agreements in place with pediatric cardiology, pediatric surgery, and ophthalmology. The hospital shall have an organized program for the monitoring, treatment, and follow-up of retinopathy of prematurity.	O **Yes**	E	NA	NA
5.9	The hospital shall have on staff an ophthalmologist with experience in neonatal retinal examination and an organized program for the monitoring, treatment, and follow-up of retinopathy of prematurity.	NA	O	E	E
5.10	The hospital shall have the following pediatric subspecialists on staff, in active practice and, if needed, readily available in house or via telemedicine: cardiology, neurology, and general pediatric surgery.	NA	O	E	NA
5.11	The hospital shall have on staff, in active practice and, if needed, in-house within 30 minutes, the following pediatric subspecialties: cardiology, endocrinology, gastroenterology, genetics, hematology, nephrology, neurology, and pulmonology.	NA	O	O	E

		I	II	III	IV
5.12	The hospital shall have on staff, in active practice and, if needed, in-house within 30 minutes, general pediatric surgery and the following pediatric surgical subspecialties: cardiothoracic surgery, neurosurgery, ophthalmology, orthopedic surgery, and plastic surgery.	NA	O	O	E
STANDARD VI.	**OTHER PERSONNEL**				
6.1	A physician board-certified or an active candidate for board-certification in anesthesiology or a nurse-anesthetist shall be available so that cesarean delivery may be initiated per hospital protocol as stated in Standard 2.1c.	E **Yes**	E	E	E
6.2	A physician board-certified or an active candidate for board-certification in anesthesiology or a nurse-anesthetist shall be readily available to the delivery area when a patient is in active labor.	O	E	NA	NA
6.3	A physician board-certified or an active candidate for board-certification in anesthesiology shall be present in-house 24 hours a day, readily available to the delivery area.	O	O	E	E
6.4	If the hospital performs neonatal surgery, then a board-certified anesthesiologist with experience in neonatal anesthesia shall be present for the surgery.	NA	NA	E	E
6.5	The hospital shall have a physician on the medical staff with privileges for providing critical interventional radiology services for: a) obstetrical patients b) neonatal patients	 O NA	 O NA	 E O	 E E

		I	II	III	IV
6.6	The hospital shall have obstetrical and neonatal diagnostic imaging available 24 hours a day, with interpretation by physicians with experience in maternal and/or neonatal disease and its complications.	E **Yes**	E	E	E
6.7	The hospital shall have on staff a registered dietician or other health care professional with knowledge of and experience in the management of obstetrical and neonatal parenteral/enteral nutrition.	O **Yes**	O	E	E
6.8	The hospital shall have at least one full-time equivalent International Board Certified Lactation Consultant(s) who shall have programmatic responsibility for lactation support services which shall include education and training of additional hospital staff members in order to ensure availability of lactation support seven days per week.	E **Yes**	E	E	E
6.9	The hospital shall have a licensed social worker with a Master's degree (either an LGSW, Licensed Graduate Social Worker, or an LCSW, Licensed Certified Social Worker) and experience in psychosocial assessment and intervention with women and their families readily available to the perinatal service.	E **Yes**	NA	NA	NA
6.10	The hospital shall have a licensed social worker with a Master's degree (either an LGSW, Licensed Graduate Social Worker, or an LCSW, Licensed Certified Social Worker) and experience in psychosocial assessment and intervention with women and their families dedicated to the perinatal service.	O **Yes**	E	E	E

		I	II	III	IV
6.11	The hospital shall have a licensed social worker with a Master's degree (either an LGSW, Licensed Graduate Social Worker, or an LCSW, Licensed Certified Social Worker) and experience in psychosocial assessment and intervention with women and their families dedicated to the NICU.	NA	NA	E	E
6.12	The hospital shall have respiratory therapists skilled in neonatal ventilator management:				
	a) readily available when an infant is receiving or anticipated to need assisted ventilation	NA	E	NA	NA
	b) present in-house 24 hours a day	NA	O	E	NA
	c) dedicated to the NICU 24 hours a day	NA	NA	O	E
6.13	The hospital shall have at least one occupational or physical therapist with neonatal expertise.	NA	O	E	E
6.14	The hospital shall have at least one individual skilled in evaluation and management of neonatal feeding and swallowing disorders such as a speech-language pathologist.	NA	O	E	E
6.15	The hospital shall have genetic diagnostic and counseling services or written consultation and referral agreement(s) for these services in place.	E **Yes**	E	E	E
6.16	The hospital shall have a pediatric neurodevelopmental follow-up program or written referral agreement(s) for neurodevelopmental follow-up.	O **No**	O	E	E

		I	II	III	IV
6.17	The hospital perinatal program shall have on its administrative staff a registered nurse with a Master's or higher degree in nursing or a health-related field and experience in high-risk obstetrical and/or neonatal nursing who shall have programmatic responsibility for the obstetrical and neonatal nursing services.	E **Yes**	E	E	E
6.18	The hospital perinatal program shall have on its staff a registered nurse with a Master's or higher degree in nursing and experience in high-risk obstetrical and/or neonatal nursing responsible for staff education.	E **Yes**	E	E	E
6.19	The hospital perinatal service shall have: a) A registered nurse skilled in the recognition and nursing management of complications of labor and delivery readily available if needed to the labor and delivery unit 24 hours a day. b) A registered nurse skilled in the recognition and management of complications in women and newborns readily available to the obstetrical unit 24 hours a day. c) A registered nurse with demonstrated training and experience in the assessment, evaluation and care of patients in labor present at all deliveries. d) A registered nurse with demonstrated training and experience in the assessment, evaluation, and care of newborns readily available to the neonatal unit 24 hours a day.	E **Yes**	E	E	E
6.20	A hospital perinatal program that performs neonatal surgery shall have nurses on staff with special expertise in perioperative management of neonates.	NA	NA	E	E

		I	II	III	IV
6.21	The hospital shall have a written plan to address registered nurse/patient ratios recommended in the current *Guidelines For Perinatal Care* and AWHONN Guidelines.	E **Yes**	E	E	E
STANDARD VII. LABORATORY					
7.1	The programmatic leaders of the perinatal service in conjunction with the hospital laboratory shall establish laboratory processing and reporting times to ensure that these are appropriate for samples drawn from obstetrical and neonatal patients with specific consideration for the acuity of the patient and the integrity of the samples.	E **Yes**	E	E	E
7.2	The hospital laboratory shall demonstrate the capability to immediately receive, process, and report urgent/emergent obstetrical and neonatal laboratory requests.	E **Yes**	E	E	E
7.3	The hospital laboratory shall have a process in place to report critical values to the obstetrical and neonatal services.	E **Yes**	E	E	E
7.4	Laboratory results from standard maternal antepartum testing shall be available to the providers caring for the mother and the neonate prior to discharge. If test results are not available or if testing was not performed prior to admission, such testing shall be performed during the hospitalization of the mother and results shall be available prior to discharge of the newborn.	E **Yes**	E	E	E
7.5	The hospital shall have the capacity to conduct rapid HIV testing 24 hours a day.	E **Yes**	E	E	E

		I	II	III	IV
7.6	The hospital shall have available the equipment and trained personnel to perform newborn hearing screening prior to discharge on all infants born at or transferred to the institution and report screening results as required by COMAR 10.11.02	E **Yes**	E	E	E
7.7	The hospital shall have available the equipment and trained personnel to perform critical congenital heart disease screening prior to discharge on all infants born at or transferred to the institution and report screening results as required by COMAR 10.52.15.	E **Yes**	E	E	E
7.8	Blood bank technicians shall be present in-house 24 hours a day.	E **Yes**	E	E	E
7.9	The hospital shall have access to molecular, cytogenic, and biochemical genetic testing.	E **Yes**	E	E	E
STANDARD VIII.	**DIAGNOSTIC IMAGING CAPABILITIES**				
8.1	The hospital shall have the capability of providing emergency ultrasound imaging and interpretation for obstetrical patients 24 hours a day	E **Yes**	E	E	E
8.2	The hospital shall have the capability of providing portable x-ray imaging and interpretation for neonatal patients 24 hours a day.	E **Yes**	E	E	E
8.3	The hospital shall have the capability of providing portable head ultrasound and interpretation for neonatal patients.	O **Yes**	E	E	E

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		I	II	III	IV
8.4	The hospital shall have the capability on campus of providing computerized tomography (CT) and magnetic resonance imaging (MRI).	O **Yes**	O	E	E
8.5	Neonatal echocardiography equipment and experienced technician shall be available on campus as needed with interpretation by a pediatric cardiologist.	O **Yes**	O	E	E
8.6	The hospital shall have a pediatric cardiac catheterization laboratory and appropriate staff.	NA	NA	O	E
8.7	The hospital shall have the capability of providing interventional radiology services for: a) obstetrical patients b) neonatal patients	 O NA **Yes**	 O NA	 E O	 E E
STANDARD IX.	EQUIPMENT				
9.1	The hospital shall have all of the following equipment and supplies immediately available for existing patients and for the next potential patient: a) O2 analyzer, stethoscope, intravenous infusion pumps b) radiant heated bed in delivery room and available in the neonatal units c) oxygen hood with humidity d) bag and masks and/or T-piece resuscitator capable of delivering a controlled concentration of oxygen to the infant e) orotracheal tubes	E **Yes**	E	E	E

		I	II	III	IV
	f) aspiration equipment g) laryngoscope h) umbilical vessel catheters and insertion tray i) cardiac monitor j) pulse oximeter k) phototherapy unit l) doppler blood pressure for neonates m) cardioversion/defibrillation capability for mothers and neonates n) resuscitation equipment for mothers o) resuscitation equipment for neonates including equipment outlined in the current NRP p) individual oxygen, air, and suction outlets for mothers and neonates q) emergency call system for both obstetrical and neonatal units as well as an emergency communication system among units				
9.2	The hospital shall have a neonatal stabilization bed set up and equipment available at all times for an emergency admission.	E **Yes**	E	E	E
9.3	The hospital shall have fetal diagnostic testing and monitoring equipment for:				
	a) fetal heart rate monitoring b) ultrasound examinations c) amniocentesis	E E O **Yes**	E E O	E E E	E E E
9.4	The hospital shall have the capability to monitor neonatal intra-arterial pressure.	O **No**	E	E	E

		I	II	III	IV
9.5	The hospital shall have the capability on campus of providing laser coagulation for retinopathy of prematurity.	NA	O	E	E
9.6	The hospital shall have the capability on campus of providing a full range of invasive maternal monitoring including central venous pressure and arterial pressure monitoring.	NA **Yes**	O	E	E
9.7	The hospital shall have appropriate equipment (including back-up equipment) for neonatal respiratory care as well as protocols for the use and maintenance of the equipment as required by its level of neonatal care.	E **Yes**	E	E	E
9.8	The hospital shall have the capability of providing advanced ventilatory support for neonates of all birth weights.	NA **Yes**	NA	O	E
9.9	The hospital shall have the capability of providing continuing therapeutic hypothermia.	NA	NA	O	E
STANDARD X.	MEDICATIONS				
10.1	Emergency medications, as listed in the current NRP guidelines, shall be present in the delivery area and neonatal units.	E **Yes**	E	E	E

	I	II	III	IV
10.2 The following medications shall be immediately available to the neonatal units: a) Antibiotics, anticonvulsants, and emergency cardiovascular drugs b) Surfactant, prostaglandin E1	 E O **Yes**	 E E	 E E	 E E
10.3 All emergency resuscitation medications to initiate and maintain resuscitation, in accordance with Advanced Cardiac Life Support (ACLS) guidelines of the American Heart Association, shall be present in the delivery area.	E **Yes**	E	E	E
10.4 The following medications shall be in the delivery area: a) Oxytocin (Pitocin) b) Methylergonovine (Methergine) c) 15-methyl prostaglandin F2 (Prostin) d) Misoprostol (Cytotec) e) Carboprost tromethamine (Hemabate)	E **Yes**	E	E	E
STANDARD XI. EDUCATION PROGRAMS				
11.1 The hospital shall have identified minimum competencies for perinatal clinical staff, not otherwise credentialed, that are assessed prior to independent practice and on a regular basis thereafter.	E **Yes**	E	E	E
11.2 The hospital shall provide continuing education programs for physicians, nurses, and allied health personnel on staff concerning the treatment and care of obstetrical and neonatal patients.	E **Yes**	E	E	E

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11.3 A hospital that accepts maternal or neonatal primary transports shall provide the following to the referring hospital/providers: a) Guidance on indications for consultation and referral of patients at high risk b) Information about the accepting hospital's response times and clinical capabilities c) Information about alternative sources for specialized care not provided by the accepting hospital d) Guidance on the pre-transport stabilization of patients e) Feedback on the pre-transport and post-transport care of patients	NA	NA	E	E
STANDARD XII. PERFORMANCE IMPROVEMENT				
12.1 The hospital shall have a multi-disciplinary continuous quality improvement program for improving maternal and neonatal health outcomes that includes initiatives to promote patient safety including safe medication practices, Universal Protocol to prevent surgical error, and educational programs to improve communication and team work.	E **Yes**	E	E	E
12.2 The hospital shall conduct internal perinatal case reviews which include all maternal, intrapartum fetal, and neonatal deaths, as well as all maternal and neonatal transports.	E **Yes**	E	E	E
12.3 The hospital shall utilize a multidisciplinary forum to conduct quarterly performance reviews of the perinatal program. This review shall include a review of trends, all deaths, all transfers, all very low birth weight infants, problem identification and solution, issues identified from the quality management process, and systems issues.	E **Yes**	E	E	E

		I	II	III	IV
12.4	The hospital shall participate with the Department of Health and Mental Hygiene and local health department Fetal and Infant Mortality Review and Maternal Mortality Review programs.	E **Yes**	E	E	E
12.5	The hospital shall participate in the collaborative collection and assessment of data with the Department of Health and Mental Hygiene and/or the Maryland Institute for Emergency Medical Services Systems for the purpose of improving perinatal health outcomes.	E **Yes**	E	E	E
12.6	The hospital shall maintain membership in the Vermont Oxford Network. **We are members of the MD Patient Safety Center Collaborative "Neonatal Abstinence"**	O **No**	O	E	E
STANDARD XIII. POLICIES AND PROTOCOLS					
13.1	The hospital shall have written policies and protocols for the initial stabilization and continuing care of all obstetrical and neonatal patients appropriate to the level of care rendered at its facility.	E **Yes**	E	E	E
13.2	The hospital shall have maternal and neonatal resuscitation protocols.	E **Yes**	E	E	E
13.3	The hospital medical staff credentialing process shall include documentation of competency to perform obstetrical and neonatal invasive procedures appropriate to its designated level of care.	E **Yes**	E	E	E
13.4	The hospital shall have written guidelines for accepting or transferring mothers or neonates as "back transports" including criteria for accepting the patient and patient information on the required continuing care.	E **Yes**	E	E	E

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		I	II	III	IV
13.5	The hospital shall have a licensed neonatal transport service or written agreement with a licensed neonatal transport service.	E **Yes**	E	E	E
13.6	The hospital shall have policies that allow families (including siblings) to be together in the hospital following the birth of an infant and that promote parental involvement in the care of the neonate including those in the NICU.	E **Yes**	E	E	E
13.7	The hospital shall have a policy to eliminate deliveries by induction of labor or by cesarean section prior to 39 weeks gestation without a medical indication. The hospital shall have a systematic internal review process to evaluate any occurrences and a plan for corrective action.	E **Yes**	E	E	E
13.8	The hospital shall have a written protocol to respond to massive obstetrical hemorrhage, including a plan to maximize accuracy in determining blood loss.	E **Yes**	E	E	E

EXHIBIT 18

carf INTERNATIONAL

A Three-Year Accreditation is issued to

University of Maryland Shore Regional Health/Requard Center for Acute Rehabilitation

for the following program(s)/service(s):

Inpatient Rehabilitation Programs - Hospital (Adults)
Inpatient Rehabilitation Programs - Hospital: Stroke Specialty Program (Adults)

This accreditation is valid through
April 30, 2021

The accreditation seals in place below signify that the organization has met annual conformance requirements for quality standards that enhance the lives of persons served.

This accreditation certificate is granted by authority of:

Richard Forkosh
Chair
CARF International Board of Directors

Brian J. Boon, Ph.D.
President/CEO
CARF International

EXHIBIT 19

PRIMARY ACUTE STROKE PATIENT TRANSFER AGREEMENT BETWEEN THE MEMORIAL HOSPITAL AT EASTON, INC. AND THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION

EFFECTIVE DATE: December 15, 2006

PURPOSE: In response to state regulations addressing the care of acute stroke patients, the **MEMORIAL HOSPITAL AT EASTON,INC**, a health care facility owned and operated by Shore Health System, Inc. (the "Facility"), enters into this transfer agreement with the **University of Maryland Medical Center**, a health care facility owned and operated by University of Maryland Medical System Corporation ("UMMC"). The purpose of the agreement is to establish a process for the transfer and care of acute stroke patients requiring neurosurgical intervention.

POLICY

A. POINT OF CONTACT:

UMMC's Maryland ExpressCare (*"ExpressCare"*), will be the sole source of contact throughout the process. All inquiries related to patient transport should go through *ExpressCare*. This process allows for the most timely and efficient utilization of resources and avoids conflicting communications.

B. REQUEST FOR TRANSPORT:

1. A member of the Facility's stroke team will contact *ExpressCare* at (410) 328-1234, upon determining that the patient requires neurosurgical intervention for acute stroke-related conditions such as subarachnoid hemorrhage or acute intracerebral hemorrhage. The number for *ExpressCare* is.
2. Upon reaching *ExpressCare*, the Facility Stroke Team will:
   a. Identify the Facility and notify *ExpressCare* that a transfer of an acute stroke patient for neurosurgical intervention is necessary.
   b. Provide *ExpressCare* with logistical information, patient demographics, clinical information and any other requested information.
   c. If the patient requires transport to UMMC, the Facility Stroke Team will fax the patient's "face sheet" with demographic data to *ExpressCare* at (410) 328-1235.
3. If a member of the UMMC medical staff medical accepts the patient for transfer and appropriate resources are available, *ExpressCare* will timely dispatch the Maryland *ExpressCare* Team, which will include a registered nurse, to transport the patient from the Facility to UMMC.
4. If the patient transfer is accepted and a bed is available but a Maryland *ExpressCare* Team is not available to effect the transfer, the following will occur:
   a. *ExpressCare* will check the availability of other Advanced Life Support ("ALS") vendor resources. If a Critical Care team is available, *ExpressCare* will dispatch the team in order to respond in a timely manner.
   b. If vendor resources are exhausted and no Critical Care Team is available, *ExpressCare* will then call the Facility to indicate the lack of Critical Care transport availability to accompany patient during transport with dispatched ALS team. Facility will then dispatch a qualified registered nurse to accompany the patient during transport.

Xerox - Linda Pittman

C. UMMC ACCEPTANCE OF TRANSFERRED PATIENTS:

If a UMMC medical staff member accepts the patient for transfer and appropriate resources are available, UMMC will receive and provide treatment to the transferred patient to care for the acute stroke patient once the initial triage, assessment and treatment have been completed by the Facility.

D. NO TRANSPORT NECESSARY:

The Facility will notify *ExpressCare* if the transfer is later determined to be unnecessary.

E. ADVISORY NOTICE PRIOR TO ADMINISTERING TISSUE PLASMINOGEN ACTIVATOR

To the extent possible, a member of the Facility's stroke team will contact the *ExpressCare*, to indicate that the Facility's Stroke Team will be administering tissue-plasminogen activator ("t-PA") or similar intravenous acute stroke intervention to a patient.

F. ADMINISTRATIVE PROVISIONS

1. Any modification of this agreement, including any extension , shall be effective only if in writing and signed on behalf of both parties
2. This agreement does not create a joint venture or partnership between UMMC and the Facility.
3. This agreement shall be governed by the law of the State of Maryland; the parties agree to be subject to the jurisdiction of the Maryland courts.
4. The Facility may not assign this Agreement.
5. This agreement may be executed and delivered in one or more counterparts (including by facsimile transmission), each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

Agreed to and approved this 6th day of December, 2006

THE MEMORIAL HOSPITAL AT EASTON, INC.
A health care facility owned and operated by Shore Health System, Inc.

By: _____
Joseph P. Ross
President and Chief Executive Officer

UNIVERSITY OF MARYLAND MEDICAL CENTER
A health care facility owned and operated by the University of Maryland Medical System Corporation

By: _____
Name: Alison G. Brown, MPH
Title: Senior Vice President

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TRANSFER AGREEMENT

between

THE MEMORIAL HOSPITAL AT EASTON, MD., INC.

and

CAROLINE NURSING HOME, INC.

THIS TRANSFER AGREEMENT (the "Agreement") is executed and effective as of December 17, 1998 (the "Effective Date"), by and between The Memorial Hospital at Easton, Md., (the "Hospital") and Caroline Nursing Home, Inc. (the "Nursing Home").

RECITALS

WHEREAS, the Nursing Home, a skilled nursing facility located in Denton, Maryland, desires to enter into an arrangement with a nearby acute care hospital in order to ensure the continuity of quality care for patients of the Nursing Home and to facilitate the timely and appropriate transfer of such patients between the Hospital and the Nursing Home;

WHEREAS, the Hospital is willing to cooperate in facilitating medically appropriate transfers of patients between the Nursing Home and the Hospital;

NOW, THEREFORE, the Hospital and the Nursing Home agree as follows:

Section 1. Requisites of Transfer

1.1 Prior to Transfer. In the event the physician of a patient from the Nursing Home determines that acute care services available at the Hospital are medically appropriate, the Nursing Home immediately shall notify the Hospital of the need to transfer a patient. Prior to any such transfer, or, in the case of emergency, as promptly as possible, the Nursing Home shall:

A. Ensure that the physician has properly documented the need for such transfer in the patient's medical record.

B. Except in the case of emergency, obtain written confirmation from the Hospital that it can accept the patient from the Nursing Home;

C. Discuss with the patient or his or her legal representative the reason for the proposed transfer and any available alternatives. The Nursing Home shall have full responsibility for obtaining the consent of the patient or the patient's legal representative prior to the transfer.

D. Notify the next of kin of the patient or another appropriate responsible person or family member regarding the anticipated transfer.

1.2 **Admission by the Hospital**. The Hospital agrees to admit a patient transferred from the Nursing Home, subject to all conditions of this Agreement, all admission eligibility requirements of the Hospital in effect at the time, and the availability of adequate and appropriate bed space for the transferred patient. All transfers and admissions shall be conducted in accordance with applicable federal and state law and regulations and the applicable policies and procedures of the Hospital.

1.3 **Transfer Documentation**. The Nursing Home shall send with each patient at the time of transfer, or in the case of emergency, as promptly as possible, the patient's medical record, completed transfer forms, and any other information pertinent to the medical condition and treatment of the patient. The Nursing Home and the Hospital agree to develop a standard form document which shall accompany the patient in any transfer to the Hospital or to the Nursing Home from the Hospital. The standard form shall include such information as current medical findings, diagnosis, a brief summary of the present course of treatment, nursing and dietary information, ambulation status and pertinent administrative and social information. If the patient is returning to the Nursing Home after treatment, the Hospital shall provide similar transfer documentation to the Nursing Home.

1.4 **Safe Transport**. The Nursing Home shall be responsible for effecting the transfer of the patient, including the arranging for appropriate and safe transportation and care of the patient during the transfer in accordance with applicable federal and state laws and regulations. The Hospital's responsibility for the patient's care shall begin when the patient is admitted to the Hospital, either as an inpatient or an outpatient. If the patient is returning to the Nursing Home, the Hospital shall be responsible for effecting the safe transfer of a patient from the Hospital to the Nursing Home in accordance with applicable federal and state laws and regulations.

1.5 **Personal Effects**. The Nursing Home shall be responsible for the transfer or other appropriate disposition of personal effects, particularly money and valuables, and information related to these items.

1.6 **Medical Records**. The Nursing Home and the Hospital each shall maintain a separate medical record for each transferred patient in accordance with its rules and regulations and shall maintain the confidentiality of patient information. The Nursing Home and the Hospital shall comply with all applicable federal and state laws and regulations, including without limitation, laws and regulations governing the maintenance of medical records and the confidentiality of patient information.

1.7 **Charges for Services.** Charges for services performed by either the Hospital or the Nursing Home shall be collected by or on behalf of the facility rendering such services directly from the patient, third party payor or other payor as appropriate. Neither facility shall have any liability to the other for such charges.

1.8 **Insurance**. The Hospital and the Nursing Home each shall maintain, throughout the Agreement, liability insurance coverage in amounts acceptable to the other, and shall provide evidence of such coverage upon request.

Section 2. Relationship of Parties

2.1 Governance; Liabilities. The governing body of each of the Nursing Home and the Hospital shall exclusive control of policies, management, assets and affairs of its respective institutions. Neither party shall assume any liability by virtue of this Agreement for any debts or other obligations incurred by the other party.

2.2. Non-exclusivity. Nothing in this Agreement shall be construed as limiting the rights of either party to contract with any other facility on a limited or general basis.

Section 3 Term; Termination

3.1 Term. The initial term of this Agreement shall be for a period of one (1) year commencing on the Effective Date, unless sooner terminated as provided herein. This Agreement shall renew annually for successive one (1) year terms.

3.2 Termination. Either party may terminate this Agreement at any time, with or without cause, upon (30) days prior written notice to the other party. This Agreement shall be terminated automatically should either the Hospital or the Nursing Home fail to maintain its State facility licensure, Medicare or Medicaid certification, or insurance coverage as required in Section 2.4 hereof.

Section 4. Miscellaneous

4.1 Entire Agreement. This Agreement contains the entire agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

4.2 Waiver. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

4.3 Assignment. Neither party may assign or transfer this Agreement or any of its rights, duties or obligations under this Agreement without the prior written consent of the other party.

4.4 Notices. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by Federal express or express mail, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

To the Hospital:

219 S. Washington Street
Easton, Maryland 21601

To the Nursing Home:

Caroline Nursing Home, Inc.
520 Kerr Avenue
Denton, MD 21629

4.5 Compliance. The parties agree to comply with all laws, rules and regulations, including JCAHO requirements, relating to the subject of this Agreement.

4.6 Governing Law. This Agreement shall be construed in accordance with the laws of the State of Maryland.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives as of the day and year first written above.

The Memorial Hospital at Easton, Md.	Caroline Nursing Home, Inc.
By: Larry F. Hepner	By:
Larry F. Hepner	
Title: Vice President, Patient Care Services	Title: Administrator

TRANSFER AGREEMENT

This Transfer Agreement is entered into on May 20, 2008, by and between Chester River Health System ("Chester River") and The Memorial Hospital at Easton, a health care facility owned and operated by Shore Health System, Inc. ("Shore Health").

WHEREAS, both parties desire to assure continuity of care and treatment appropriate to the needs of each patient and to use the skills, resources, and physical plant of both parties in a coordinated and cooperative fashion to improve patient care at both the acute and post-acute stages of illness.

NOW, THEREFORE, in consideration of the mutual advantages occurring to the parties hereto, Hospital and Shore Health hereby covenant and agree with each other as follows:

1. Both parties agree to make a concerted effort to transfer patients as soon as practical when the need for transfer from Chester River to Shore Health has been determined by the patient's attending physician, provided, however, all eligibility conditions for admission must be met and documented in the patient's medical record.

2. Chester River agrees to send with each patient at the time of transfer or, in the case of any emergency as promptly as possible after the transfer, an abstract of the patient's medical record including:

   (A) the current medical findings,
   (B) diagnosis,
   (C) a brief summary of the course of treatment followed,
   (D) all other administrative and social information useful to provide continuing care to the patient; using the transfer and referral form mutually agreed upon.

3. Chester River, after promptly notifying Shore Health of the impending transfer of a patient and after Shore Health consents to accept such patient, shall assume the responsibility to arrange for appropriate and safe transportation of the patient, his/her personal effects and valuables, and shall provide any necessary care while he/she is being transferred.

4. Charges for services performed by either Chester River or Shore Health for patients transferred from the other institution pursuant to this Agreement, shall be collected by the institution rendering such services, directly from the patient, third party payers, or the other sources normally billed by the institution; and neither party shall have any liability to the other for such charges except to the extent that such liabilities would exist separate and apart from this Agreement.

5. The parties agree that the transfer of a patient pursuant to this Agreement shall not be predicated upon discrimination based on race, religion, national origin, age, sex, physical condition or economic status. The parties also agree that the transfer or receipt of patients shall not be based upon a patient's inability to pay for services rendered by the transferring or receiving institution or a patient's source of payment.

6. All patient transfers pursuant to this Agreement must be accomplished in a medically appropriate manner from physician to physician and from institution to institution by: (i) the use of appropriate life support measures which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to stabilize the patient prior to transfer and to sustain the patient during the transfer; (ii) the provision of appropriate personnel and equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use for the transfer; (iii) the transfer of all necessary records for continuing the care for the patient; and (iv) the consideration of the availability of appropriate facilities, services, and staff for providing care for the patient. The parties agree that before moving a patient, Chester River shall explain the reasons for the transfer and any alternative to the patient or a legally authorized representative of the patient. If it is necessary to move the patient immediately to protect the health, safety or welfare of the patient, Chester River may give the explanation of the reasons for the transfer concurrently with the transfer.

7. The parties agree to recognize the right of a patient to request transfer into the care of a physician and institution of the patient's own choosing and to recognize and comply with all federal and state requirements relating to the transfer of patients.

8. Chester River agrees not to transfer a patient with an emergency medical condition that has not been stabilized unless: (i) the patient, or a legally responsible person acting on the patient's behalf, after being informed of Chester River's obligations under law and of the risk of transfer, requests in writing transfer to another institution; (ii) a licensed physician has signed a certification which includes a summary of the risks and benefits that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another institution outweigh the increased risks to the patient and, in the case of labor, to the unborn child from effecting the transfer; or (iii) if a licensed physician is not physically present at the time a patient is transferred, a qualified medical person has signed a certification described in subparagraph (ii) above after a license physician, in consultation with the person, has made the determination described in subparagraph (ii) above and subsequently countersigns the certificate.

9. All notices hereunder by either party to the other party shall be in writing, delivered personally or by overnight courier, and shall be deemed to have been duly given when delivered personally or one day after delivered to the overnight carrier, charges prepaid, and properly addressed to the respective parties at the addresses shown following each party's signature to this Agreement.

10. This Agreement shall be effective from the date of signing by both parties and shall continue in effect, except that either party may withdraw by giving 60 days written notice to the other party of its intention to terminate this Agreement. However, this Agreement shall be declared null and void and shall be immediately terminated should either party fail to maintain its licensure or certification status.

11. Both parties represent and warrant that, during the term of this Agreement, each shall comply with all applicable state and federal laws and regulations and shall remain in good standing with applicable accrediting organizations.

12. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other institution, on either a limited or general basis, while this Agreement is in effect.

13. This Agreement may be modified or amended by the mutual agreement of the parties, however, any such modification or amendment shall be attached to and become a part of this Agreement. This Agreement shall be construed in accordance with the laws of the State of Maryland.

CHESTER RIVER HEALTH SYSTEM, INC.

By: _____

Name: SCOTT D BURLESON

Title: Executive Vice President

100 Brown Street
Chestertown, Maryland 21620

SHORE HEALTH SYSTEM, INC.

By: _____

Name: GERARD M. WALSH

Title: Sr. V.P. & C.O.O.

219 South Washington Street
Easton, Maryland 21601

FOR COMPANY USE ONLY:
Clinic #: 11176

PATIENT TRANSFER AGREEMENT

This **PATIENT TRANSFER AGREEMENT** (the "Agreement") is made as of the last date of signature (the "Effective Date"), by and between **Shore Health System, Inc.** (hereinafter "Hospital") and **Total Renal Care, Inc.**, a California corporation and subsidiary of DaVita HealthCare Partners Inc. ("Company").

RECITALS

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between Hospital and the following free-standing dialysis clinic owned and operated by Company:

Queen Anne Home Training
125 Shoreway Drive, Ste. 330
Queenstown, MD 21658

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities; and

WHEREAS, the parties wish to facilitate the continuity of care and the timely transfer of patients and records between the facilities.

WHEREAS, only a patient's attending physician (not Company or the Hospital) can refer such patient to Company for dialysis treatments.

NOW THEREFORE, in consideration of the premises herein contained and for other good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged, the parties agree as follows:

1. **HOSPITAL OBLIGATIONS.** In accordance with the policies and procedures as hereinafter provided, and upon the recommendation of an attending physician, a patient of Company may be transferred to Hospital.

(a) Hospital agrees to exercise its best efforts to provide for prompt admission of patients provided that all usual, reasonable conditions of admission are met. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission (the "Commission") and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Transfer record forms shall be completed in detail and signed by the physician or nurse in charge at Company and must accompany the patient to the receiving institution.

(b) Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility.

2. **COMPANY OBLIGATIONS.**

(a) Upon transfer of a patient to Hospital, Company agrees:

i. That it shall transfer any needed personal effects of the patient, and information relating to the same, and shall be responsible therefore until signed for by a representative of Hospital;

ii. Original medical records kept by each of the parties shall remain the property of that institution; and

iii. That transfer procedures shall be made known to the patient care personnel of each of the parties.

(b) Company agrees to transmit with each patient at the time of transfer, or in case of an emergency, as promptly as possible thereafter, an abstract of pertinent medical and other records necessary to continue the patient's treatment without interruption and to provide identifying and other information, to include:

i. current medical findings;

ii. diagnosis;

iii. rehabilitation potential;

iv. discharge summary;

v. a brief summary of the course of treatment followed;

vi. nursing and dietary information;

vii. ambulating status; and

viii. administrative and pertinent social information.

(c) Company agrees to readmit to its facilities patients who have been transferred to Hospital for medical care as clinic capacity allows. Hospital agrees to keep the administrator or designee of Company advised of the condition of the patients that will affect the anticipated date of transfer back to Company and to provide as much notice of the transfer date as possible. Company shall assign readmission priority for its patients who have been treated at Hospital and who are ready to transfer back to Company.

3. **BILLING, PAYMENT, AND FEES.** Hospital and Company each shall be responsible for billing the appropriate payor for the services it provides, respectively, hereunder. Company shall not act as guarantor for any charges incurred while the patient is a patient in Hospital.

4. **HIPAA.** Hospital and Company agree to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Hospital and Company acknowledge and agree that from time to time, HIPAA may require modification to this Agreement for compliance purposes. Hospital and Company further acknowledge and agree to comply with requests by the other party hereto related to HIPAA.

5. **STATUS AS INDEPENDENT CONTRACTORS.** The parties acknowledge and agree that their relationship is solely that of independent contractors. Governing bodies of Hospital and Company shall have exclusive control of the policies, management, assets, and affairs of their respective facilities. Nothing in this Agreement shall be construed as limiting the right of either to affiliate or contract with any other Hospital or facility on either a limited or general basis while this Agreement is in effect. Neither party shall use the name of the other in any promotional or advertising material unless review and approval of the intended use shall be obtained from the party whose name is to be used and its legal counsel.

6. **INSURANCE.** Each party shall secure and maintain, or cause to be secured and maintained during the term of this Agreement, comprehensive general liability, property damage, and workers compensation insurance in amounts generally acceptable in the industry, and professional liability insurance providing minimum limits of liability of $1,000,000 per occurrence and $3,000,000 in aggregate. Each party shall deliver to the other party certificate(s) of insurance evidencing such insurance coverage upon execution of this Agreement, and annually thereafter upon the request of the other party. Each party shall provide the other party with not less than thirty (30) days prior written notice of any change in or cancellation of any of such insurance policies. Said insurance shall survive the termination of this Agreement.

7. **INDEMNIFICATION.**

(a) Hospital Indemnity. Hospital hereby agrees to defend, indemnify and hold harmless Company and its shareholders, affiliates, officers, directors, employees, and agents for, from and against any claim, loss, liability, cost and expense (including, without limitation, costs of investigation and reasonable attorney's fees), directly or indirectly relating to, resulting from or arising out of any action or failure to act arising out of this Agreement by Hospital and its staff regardless of whether or not it is caused in part by Company or its officers, directors, agents, representatives, employees, successors and assigns. This indemnification provision shall not be effective as to any loss attributable exclusively to the negligence or willful act or omission of Company.

(b) Company Indemnity. Company hereby agrees to defend, indemnify and hold harmless Hospital and its shareholders, affiliates, officers, directors, employees, and agents for, from and against any claim, loss, liability, cost and expense (including, without limitation, costs of investigation and reasonable attorney's fees), directly or indirectly relating to, resulting from or arising out of any action or failure to act arising out of this Agreement by Company and its staff regardless of whether or not it is caused in part by or its officers, directors, agents, representatives, employees, successors and assigns. This indemnification provision shall not be

effective as to any loss attributable exclusively to the negligence or willful act or omission of Hospital.

(c) Survival. The indemnification obligations of the parties shall continue in full force and effect notwithstanding the expiration or termination of this Agreement with respect to any such expenses, costs, damages, claims and liabilities which arise out of or are attributable to the performance of this Agreement prior to its expiration or termination.

8. DISPUTE RESOLUTION. Any dispute which may arise under this Agreement shall first be discussed directly with representatives of the departments of the parties that are directly involved. If the dispute cannot be resolved at this level, it shall be referred to administrative representatives of the parties for discussion and resolution.

(a) Informal Resolution. Should any dispute between the parties arise under this Agreement, written notice of such dispute shall be delivered from one party to the other party and thereafter, the parties, through appropriate representatives, shall first meet and attempt to resolve the dispute in face-to-face negotiations. This meeting shall occur within thirty (30) days of the date on which the written notice of such dispute is received by the other party.

(b) Resolution Through Mediation. If no resolution is reached through informal resolution, pursuant to Section 8(a) above, the parties shall, within forty-five (45) days of the first meeting referred to in Section 8(a) above, attempt to settle the dispute by formal mediation. If the parties cannot otherwise agree upon a mediator and the place of the mediation within such forty-five (45) day period, the American Arbitration Association ("AAA") in the State of Maryland shall administer the mediation. Such mediation shall occur no later than ninety (90) days after the dispute arises. All findings of fact and results of such mediation shall be in written form prepared by such mediator and provided to each party to such mediation. In the event that the parties are unable to resolve the dispute through formal mediation pursuant to this Section 8(b), the parties shall be entitled to seek any and all available legal remedies.

9. TERM AND TERMINATION. This Agreement shall be effective for an initial period of one (1) year from the Effective Date and shall continue in effect indefinitely after such initial term, except that either party may terminate by giving at least sixty (60) days notice in writing to the other party of its intention to terminate this Agreement. If this Agreement is terminated for any reason within one (1) year of the Effective Date of this Agreement, then the parties hereto shall not enter into a similar agreement with each other for the services covered hereunder before the first anniversary of the Effective Date. Termination shall be effective at the expiration of the sixty (60) day notice period. However, if either party shall have its license to operate its facility revoked by the State or become ineligible as a provider of service under Medicare or Medicaid laws, this Agreement shall automatically terminate on the date such revocation or ineligibility becomes effective.

10. AMENDMENT. This Agreement may be modified or amended from time to time by mutual written agreement of the parties, signed by authorized representatives thereof, and any such modification or amendment shall be attached to and become part of this Agreement. No

oral agreement or modification shall be binding unless reduced to writing and signed by both parties.

11. **ENFORCEABILITY/SEVERABILITY.** The provisions of this Agreement are severable. The invalidity or unenforceability of any term or provisions hereto in any jurisdiction shall in no way affect the validity or enforceability of any other terms or provisions in that jurisdiction, or of this entire Agreement in any other jurisdiction.

12. **COMPLIANCE RELATED MATTERS.** The parties agree and certify that this Agreement is not intended to generate referrals for services or supplies for which payment maybe made in whole or in part under any federal health care program. The parties will comply with statutes, rules, and regulations as promulgated by federal and state regulatory agencies or legislative authorities having jurisdiction over the parties.

13. **EXCLUDED PROVIDER.** Each party represents that neither that party nor any entity owning or controlling that party has ever been excluded from any federal health care program including the Medicare/Medicaid program or from any state health care program. Each party further represents that it is eligible for Medicare/Medicaid participation. Each party agrees to disclose immediately any material federal, state, or local sanctions of any kind, imposed subsequent to the date of this Agreement, or any investigation which commences subsequent to the date of this Agreement, that would materially adversely impact Company's ability to perform its obligations hereunder.

14. **NOTICES.** All notices, requests, and other communications to any party hereto shall be in writing and shall be addressed to the receiving party's address set forth below or to any other address as a party may designate by notice hereunder, and shall either be (a) delivered by hand, (b) sent by recognized overnight courier, or (c) by certified mail, return receipt requested, postage prepaid.

If to Hospital:	University of Maryland Shore Regional Health 219 S. Washington Street Easton, MD 21601 Attention: Administrator
If to Company:	Total Renal Care, Inc. c/o: DaVita HealthCare Partners Inc. 2245 Rolling Run Drive Windsor Mill, MD 21244 Attention: Division Vice President
With copies to:	Total Renal Care, Inc. c/o: DaVita HealthCare Partners Inc. 5200 Virginia Way Brentwood, TN 37027 Attention: Group General Counsel

DaVita HealthCare Partners Inc.
2000 16th Street, 12th Floor
Denver, Colorado 80202
Attention: Chief Legal Officer

All notices, requests, and other communication hereunder shall be deemed effective (a) if by hand, at the time of the delivery thereof to the receiving party at the address of such party set forth above, (b) if sent by overnight courier, on the next business day following the day such notice is delivered to the courier service, or (c) if sent by certified mail, five (5) business days following the day such mailing is made.

15. **ASSIGNMENT.** This Agreement shall not be assigned in whole or in part by either party hereto without the express written consent of the other party, except that Company may assign this Agreement to one of its affiliates or subsidiaries without the consent of Hospital.

16. **COUNTERPARTS.** This Agreement may be executed simultaneously in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Copies of signatures sent by facsimile shall be deemed to be originals.

17. **NON-DISCRIMINATION.** All services provided by Hospital hereunder shall be in compliance with all federal and state laws prohibiting discrimination on the basis of race, color religion, sex national origin, handicap, or veteran status.

18. **WAIVER.** The failure of any party to insist in any one or more instances upon performance of any terms or conditions of this Agreement shall not be construed as a waiver of future performance of any such term, covenant, or condition, and the obligations of such party with respect thereto shall continue in full force and effect.

19. **GOVERNING LAW.** The laws of the State of Maryland shall govern this Agreement.

20. **HEADINGS.** The headings appearing in this Agreement are for convenience and reference only, and are not intended to, and shall not, define or limit the scope of the provisions to which they relate.

21. **ENTIRE AGREEMENT.** This Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes any and all other agreements, either oral or written, between the parties (including, without limitation, any prior agreement between Hospital and Company or any of its subsidiaries or affiliates) with respect to the subject matter hereof.

22. **APPROVAL BY DAVITA HEALTHCARE PARTNERS INC. ("DAVITA") AS TO FORM.** The parties acknowledge and agree that this Agreement shall take effect and be legally binding upon the parties only upon full execution hereof by the parties and upon approval by DaVita as to the form hereof.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement the day and year first above written.

Hospital:

Shore Health System, Inc.

By: DocuSigned by: Kenneth Kozel 0ADC9D009EEB416...

Name: Kenneth Kozel

Its: President/CEO

Date: April 11, 2014

Company:

Total Renal Care, Inc.

By: DocuSigned by: Steven DeVore BE5F0AEE111C468...

Name: Steven DeVore

Its: Division Vice President

Date: April 11, 2014

APPROVED AS TO FORM ONLY:

By: DocuSigned by: Troy Arnlund D398194FC51B436...

Name: Troy Arnlund

Its: Group General Counsel

DocuSign SECURED

Certificate of Completion

Envelope Number: 7CF6AF2CB14C47CDA1A8E7DC2F147914 — Status: Completed

Subject: Please DocuSign this document: Patient Transfer Agmt - Queen Anne Home Training #11176_Shore Health

Source Envelope:

Document Pages: 7 — Signatures: 3 — Envelope Originator:
Certificate Pages: 5 — Initials: 0 — Angie King
AutoNav: Enabled — 2000 16th Street
EnvelopeId Stamping: Enabled — Denver, CO 80202
angie.king@davita.com
IP Address: 50.140.68.252

Record Tracking

Status: Original — Holder: Angie King — Location: DocuSign
4/8/2014 10:53:16 AM PT — angie.king@davita.com

Signer Events	Signature	Timestamp
Kenneth Kozel kkozel@shorehealth.org President/CEO Security Level: Email, Account Authentication (None) Electronic Record and Signature Disclosure: Accepted: 4/11/2014 11:08:34 AM PT ID: 44f0dc21-8cdf-4b1c-9b3d-ee4e5c08be71	DocuSigned by: kenneth kozel CADC9D089EEB416... Using IP Address: 134.192.250.21	Sent: 4/8/2014 10:55:42 AM PT Viewed: 4/8/2014 3:01:53 PM PT Signed: 4/11/2014 11:09:54 AM PT
Troy Arnlund Troy.arnlund@davita.com Group General Counsel Security Level: Email, Account Authentication (None) Electronic Record and Signature Disclosure: Accepted: 4/11/2014 11:12:52 AM PT ID: 59cc928c-32ab-417d-b8fb-ff28795439bd	DocuSigned by: Troy Arnlund D398194FC51B438... Using IP Address: 207.41.203.5	Sent: 4/11/2014 11:09:56 AM PT Viewed: 4/11/2014 11:12:52 AM PT Signed: 4/11/2014 11:13:01 AM PT
Steven DeVore Steven.devore@davita.com Division Vice President Security Level: Email, Account Authentication (None) Electronic Record and Signature Disclosure: Accepted: 4/11/2014 12:30:05 PM PT ID: adccc42c-f61c-40c2-9c00-44019e6d74ca	DocuSigned by: Steven DeVore BE5F8AEE111C408... Using IP Address: 98.117.46.138	Sent: 4/11/2014 11:13:03 AM PT Viewed: 4/11/2014 12:30:05 PM PT Signed: 4/11/2014 12:30:42 PM PT

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
Angie King angie.king@davita.com GGC Paralegal DaVita Healthcare Partners Inc. Security Level: Email, Account Authentication (None) Electronic Record and Signature Disclosure: Not Offered ID:	COPIED	Sent: 4/11/2014 12:30:44 PM PT Resent: 4/11/2014 12:30:50 PM PT Viewed: 4/11/2014 12:33:25 PM PT
John Rundle john.rundle@davita.com Security Level: Email, Account Authentication (None) Electronic Record and Signature Disclosure: Not Offered ID:	COPIED	Sent: 4/11/2014 12:30:45 PM PT
Katie Ingram katie.ingram@davita.com Security Level: Email, Account Authentication (None) Electronic Record and Signature Disclosure: Not Offered ID:	COPIED	Sent: 4/11/2014 12:30:45 PM PT Viewed: 4/11/2014 12:46:22 PM PT

Notary Events	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	4/11/2014 12:30:46 PM PT
Certified Delivered	Security Checked	4/11/2014 12:30:46 PM PT
Signing Complete	Security Checked	4/11/2014 12:30:46 PM PT
Completed	Security Checked	4/11/2014 12:30:46 PM PT

Electronic Record and Signature Disclosure

CONSUMER DISCLOSURE

From time to time, DaVita (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through the DocuSign, Inc. (DocuSign) electronic signing system. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the â€˜I agreeâ€™ button at the bottom of this document.

Getting paper copies

At any time, you may request from us a paper copy of any record provided or made available electronically to you by us. You will have the ability to download and print documents we send to you through the DocuSign system during and immediately after signing session and, if you elect to create a DocuSign signer account, you may access them for a limited period of time (usually 30 days) after such documents are first sent to you. After such time, if you wish for us to send you paper copies of any such documents from our office to you, you will be charged a $0.00 per-page fee. You may request delivery of such paper copies from us by following the procedure described below.

Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. To indicate to us that you are changing your mind, you must withdraw your consent using the DocuSign â€˜Withdraw Consentâ€™ form on the signing page of a DocuSign envelope instead of signing it. This will indicate to us that you have withdrawn your consent to receive required notices and disclosures electronically from us and you will no longer be able to use the DocuSign system to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through the DocuSign system all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures

electronically from us.

How to contact DaVita:

You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:

To contact us by email send messages to: jennifer.vanhyning@davita.com

To advise DaVita of your new e-mail address

To let us know of a change in your e-mail address where we should send notices and disclosures electronically to you, you must send an email message to us at jennifer.vanhyning@davita.com and in the body of such request you must state: your previous e-mail address, your new e-mail address. We do not require any other information from you to change your email address..

In addition, you must notify DocuSign, Inc. to arrange for your new email address to be reflected in your DocuSign account by following the process for changing e-mail in the DocuSign system.

To request paper copies from DaVita

To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an e-mail to jennifer.vanhyning@davita.com and in the body of such request you must state your e-mail address, full name, US Postal address, and telephone number. We will bill you for any fees at that time, if any.

To withdraw your consent with DaVita

To inform us that you no longer want to receive future notices and disclosures in electronic format you may:

i. decline to sign a document from within your DocuSign session, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;

ii. send us an e-mail to jennifer.vanhyning@davita.com and in the body of such request you must state your e-mail, full name, US Postal Address, and telephone number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

Required hardware and software

Operating Systems:	WindowsÂ® 2000, WindowsÂ® XP, Windows VistaÂ®; Mac OSÂ® X
Browsers:	Final release versions of Internet ExplorerÂ® 6.0 or above (Windows only); Mozilla Firefox 2.0 or above (Windows and Mac); Safariâ„¢ 3.0 or above (Mac only)
PDF Reader:	AcrobatÂ® or similar software may be required to view and print PDF files
Screen Resolution:	800 x 600 minimum
Enabled Security Settings:	Allow per session cookies

** These minimum requirements are subject to change. If these requirements change, you will be asked to re-accept the disclosure. Pre-release (e.g. beta) versions of operating systems and browsers are not supported.

Acknowledging your access and consent to receive materials electronically

To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please verify that you were able to read this electronic disclosure and that you also were able to print on paper or electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format on the terms and conditions described above, please let us know by clicking the â€˜I agreeâ€™ button below.
By checking the â€˜I agreeâ€™ box, I confirm that:

- I can access and read this Electronic CONSENT TO ELECTRONIC RECEIPT OF ELECTRONIC CONSUMER DISCLOSURES document; and

- I can print on paper the disclosure or save or send the disclosure to a place where I can print it, for future reference and access; and

- Until or unless I notify DaVita as described above, I consent to receive from exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to me by DaVita during the course of my relationship with you.

TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT ("Agreement") shall be effective as of the 1st day of January, 2009 ("Commencement Date"), by and between **Envoy of Denton, LLC d/b/a Envoy of Denton** ("Facility") and **The Memorial Hospital at Easton, MD, Inc.** ("Hospital").

RECITALS

WHEREAS, Hospital is licensed and certified as an **[acute care hospital]** in the State of Maryland, and is approved for participation in the Medicare and Medicaid programs;

WHEREAS, Facility is a licensed and certified nursing facility in the State of Maryland;

WHEREAS, Federal and State laws require that Facility maintain a written agreement with a hospital in close proximity for timely admission of patients who develop complications or require inpatient medical treatment; and

WHEREAS, both parties to this Agreement desire to assure continuity of care and treatment appropriate to the needs of each patient in the Facility and the Hospital.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

ARTICLE I
AUTONOMY

The parties agree that each shall continue to have the exclusive control of the management, business and properties of their respective institutions, and that neither party by virtue of this Agreement assumes any liability for any debts or obligations of the other party to the Agreement, or any responsibility for the moral or legal obligations of the other party.

ARTICLE II
TRANSFER OF PATIENTS

2.1 Transfer of Patient to Hospital.

2.1.1 Hospital agrees to admit patients from the Facility as promptly as possible in accordance with its established admission policy. Patients declared as emergencies by their physicians will be admitted without delay. Transfers shall be effected only when medically appropriate as determined by patient's attending physician.

2.1.2 Facility shall arrange for appropriate and safe transportation and care of the patient during transfer to the Hospital, in accordance with applicable Federal and State laws and regulations.

2.2 Transfer of Patient to Facility.

2.2.1 Facility agrees to readmit the patient transferred to the Hospital in accordance with its established admission policy to the first available bed after having been notified by the Hospital that the patient is ready to be discharged. Transfers shall be effected only when medically appropriate as determined by patient's attending physician.

2.2.2 Facility will keep the Hospital advised of any foreseeable problem in the readmission of a patient during the patient's stay in the Hospital.

2.2.3 Hospital shall arrange for appropriate and safe transportation and care of the patient during transfer to the Facility, in accordance with applicable Federal and State laws and regulations.

2.2.4 Hospital will provide Facility with a written discharge summary of all pertinent medical information necessary for the care and treatment of patient at Facility.

2.3 Notice of Transfer. Hospital and Facility will give notice to the other party as far in advance as practicable of an impending transfer.

2.4 Exchange of Records and Information. Hospital and Facility agree to transfer medical records and other information that may be necessary or useful in the care and treatment of patients transferred hereunder, as required and permitted by all applicable Federal and State laws. Such information shall be provided by Hospital and Facility in advance, when possible, and in any event at the time of the transfer, and shall be recorded on a transfer and referral form that is mutually acceptable to both parties. Medical information shall include, as applicable, current history, medical diagnosis, rehabilitation potential, summary of course of treatment followed, nursing and dietary needs, prognosis, and pertinent administrative and social information.

2.5 Transfer of Personal Effects. Procedures for effecting the transfer of personal effects and valuables shall be developed by the parties. Each party shall designate an appropriate individual with responsibility for transfers of personal effects. A standard form shall be adopted and used by both parties for effecting the transfer of a patient's personal effects and valuables and ensuring security and accountability thereof.

2.6 Disaster and Evacuation. In the event of a disaster of any kind wherein the evacuation of the patients becomes necessary, patients at Facility shall be transferred to Hospital, subject to bed availability.

2.7 Billing. All claims or charges incurred with respect to any services performed by either party for patients received through transfer from the other party pursuant to this Agreement shall be billed and collected by the party providing such services directly from the patient, third party payer, Medicare or Medicaid, or other source appropriately billed by that party.

ARTICLE III
TERM AND TERMINATION

3.1 Term. The term of this Agreement shall commence as of the Commencement Date, and shall be for a term of one (1) year therefrom, unless terminated in accordance with the provisions set forth in Section 3.2 herein, or unless extended as provided herein. Thereafter, this Agreement shall automatically be renewed for an additional period of one (1) year unless either party terminates this Agreement in accordance with the provisions set forth in Section 3.2 herein. To the extent that this Agreement is automatically renewed, each such renewal term shall be upon the same terms and conditions of the immediately preceding renewal term.

3.2 Termination.

3.2.1 This Agreement may be terminated by either party for any reason by written notice to the other party of at least sixty (60) days, in the form required by Section 5.4 hereof, or upon mutual agreement evidenced in writing.

3.2.2 Facility may terminate this Agreement immediately if Hospital becomes the target of an investigation by any government agency for the violation of any law, if Hospital is charged, convicted or pleads guilty or no contest to any violation of the law, if Hospital enters into any settlement agreement with any government agency, if Facility believes Hospital is violating any law, or if this Agreement causes Facility not to be in compliance with any law.

3.2.3 Upon the occurrence of any of the following events, this Agreement shall automatically be terminated: (1) revocation, suspension, probation or non-renewal of any and all licenses and registrations issued to Hospital or Facility by any applicable agency or governmental authority of the State of Maryland; and (2) termination of the Hospital's or Facility's provider agreement for Medicare or either party being deemed an "excluded party" for purposes of any Federal healthcare program.

3.3 Effect of Termination. The parties acknowledge and agree that in the event of termination of this Agreement by either party or through any of the occurrences outlined herein, neither party shall have any further obligations hereunder except: for obligations accruing prior to the date of termination, and for obligations, promises, or covenants contained herein which are expressly made to extend beyond the term of this Agreement.

ARTICLE IV
RECORDS

4.1 Maintenance of Records. Hospital and Facility agree to keep and supply records in such form and for such duration as may be required by all applicable Federal and State statutes and regulations.

4.2 Access to Books and Records. Until the expiration of four (4) years after the furnishing of services pursuant to this Agreement, Hospital shall, upon written request, make available to the Secretary of the Department of Health and Human Services (HHS), the Comptroller General, or any of their duly authorized representatives, this Agreement, and any books, documents and records that are necessary to certify the nature and extent of the costs incurred by Facility under this Agreement. This provision will apply if the amount paid under the Agreement is $10,000 or more over a twelve (12) month period. The availability of Hospital's books, documents and records will at all times be subject to such criteria and procedures for seeking access as may be promulgated by the Secretary of HHS in regulations, and other applicable laws. Hospital's disclosure under this provision will not be construed as a waiver of any legal rights to which Hospital or Facility may be entitled under statute or regulation.

4.3 Subcontractors. If Hospital delegates to or performs any of its duties pursuant to this Agreement through a subcontractor, with a value or cost of $10,000 or more over a twelve (12) month period, then Hospital represents, warrants and agree that it will include a provision in the agreement with the subcontractor substantially similar to Section 4.2 above.

4.4 Medical Records. Medical records kept by each party shall remain the property of that party, but a copy of current orders or a written statement of the patient's diagnosis, mental and physical condition shall accompany the patient at the time of transfer.

4.5 HIPAA. Each of the parties hereby represents and warrants and covenants that it is presently taking and will continue to take all actions necessary to assure that it shall, on or before each applicable compliance date and continuously thereafter, comply with Public Law 104-191 of August 21, 1996, known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations, including without limitation, the Standards for Electronic Transactions and Code Sets (45 CFR Parts 160 and 162), the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164), the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Parts 160 and 164) and such other regulations that may, from time to time, be promulgated thereunder.

ARTICLE V
MISCELLANEOUS

5.1 Non-exclusivity. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other hospital or nursing facility on either a limited or general basis while this Agreement is in effect.

5.2 Marketing & Advertising. Neither party shall use the name, logo, symbol or trademark of the other party in any promotional material, unless review and approval of the intended use is first obtained in writing from the party whose name is to be used.

5.3 Governing Law. This Agreement has been executed and delivered in, and shall be interpreted, construed, and enforced pursuant to and in accordance with the laws of the State of Maryland, without reference to the conflicts of law provisions thereof.

5.4 Notices. Any notice, demand or communication required, permitted or desired to be given hereunder shall be deemed effectively given when personally delivered or mailed by prepaid certified mail, return receipt requested, addressed as follows:

If to Facility:	*If to Hospital:*
Envoy of Denton	The Memorial Hospital at Easton, MD, Inc.
420 Colonial Drive	219 S. Washington St.
Denton, MD 21629	Easton, MD 21601
ATT: Executive Director	ATT: President & CEO

Any party may change its address by giving notice in accordance with the provisions of this subparagraph.

5.5 Assignment. No assignment of this Agreement or the rights and obligations hereunder shall be valid without the express prior written consent of both parties hereto; provided, however, that this Agreement may be assigned without the consent of the other party, by Hospital or Facility to any successor entity, which as a result of a merger, acquisition of stock, acquisition of significant assets or other reorganization, operates all or a substantial portion of the Hospital or Facility. Any purported assignment of this Agreement which violates the provisions of this Section 5.5 shall be null, void and of no force or effect.

5.6 Waiver of Breach. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be a waiver of any subsequent breach of the same or other provision hereof.

5.7 Severability. In the event any provision of this Agreement is held to be unenforceable for any reason, the unenforceability thereof shall not affect the remainder of this Agreement, which shall remain in full force and effect and enforceable in accordance with its terms.

5.8 Gender and Number. Whenever the context hereof requires, the gender of all words shall include the masculine, feminine, and neuter, and the number of all words shall include the singular and plural.

5.9 Entire Agreement. This Agreement constitutes the entire Agreement of the parties with respect to the subject matter hereof, and all prior and contemporaneous understandings, agreements and representations, whether oral or written, with respect to such matters are superseded.

5.10 Amendments. This Agreement may only be amended, modified, waived or discharged by the written consent of both parties.

5.11 Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be an original, but all of which shall be deemed to constitute one instrument.

5.12 Compliance With Laws.

5.12.1 Both parties agree to comply with all applicable Federal and State laws prohibiting discrimination against persons on account of race, sex, color, age, religion, national origin, or disability, including without limitation the Civil Rights Act of 1964 and the Maryland Human Relations Act, October 27, 1955, Public Law 744 as amended and/or further adopted.

5.12.2 Both parties certifies that they and their employees and agents comply with, are not under investigation for violations of, and have never been convicted of or sanctioned for violations of, any Federal and State laws governing the Medicare and Medicaid programs (including but not limited to, provisions regarding the billing of services and the referral of patients), laws relating to patient abuse or neglect, health care fraud, and laws governing controlled substances. Furthermore, both parties certifies that they and their employees are not "excluded persons" for purposes of any Federal healthcare program.

5.12.3 Both parties are in compliance, and will maintain compliance, with all billing and claims submission laws and regulations during the term of this Agreement. Both parties further agrees to abide by any applicable requirements of the other parties corporate compliance program.

5.12.4 Nothing in this Agreement shall be construed as an offer or payment by one party to the other party (or any affiliate of the other party) of any remuneration for patient referrals, or for recommending or arranging for the purchase, lease or order of any item of service for which payment may be made in whole or in part by Medicare or Medicaid. Any payment made between the parties is intended to represent the fair market value of the supplies and/or services to be rendered by the respective party hereunder and is not in any way related to or dependent upon referrals by and between Facility and Hospital. Furthermore, it is the stated intent of both parties that nothing contained in this Agreement is or shall be construed as an endorsement for any act of either party.

5.12.5 Hospital certifies that all services provided pursuant to this Agreement shall be performed in accordance with all Federal, State and local laws applicable to such services and in conformity with the highest professional standards.

5.13 Independent Contractors. None of the provisions of this Agreement shall create or be construed to create any relationship between the parties other than that of independent entities contracting for the sole purpose of effecting the provisions of this Agreement. Neither Hospital nor Facility, nor any of their respective agents or employees, shall be construed to be the agent, employee or representative of the other.

5.14 Binding Effect. This Agreement shall be binding upon the parties hereto and their respective heirs, executors, administrators, successors and permitted assigns.

5.15 Incorporation of Recitals. The aforesaid Recitals are hereby incorporated into this Agreement as if fully set forth herein.

5.16 Dispute Resolution. In the even a dispute between Hospital and Facility arises out of or is related to any part of this contractual Agreement, Hospital and Facility shall meet and negotiate in good faith to attempt to resolve the dispute. In the event the dispute is not resolved within 30 days of the date one party sent written notice of the dispute to the other party, and if either party wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with this section. Any arbitration under this Section shall be conducted by the National Arbitration Forum, under the Code of Procedure then in effect, and judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction thereof. The place of arbitration shall be Baltimore, Maryland. The arbitrators shall decide legal issues pertaining to the dispute, controversy or claim pursuant to the laws of the State of Maryland. Subject to the control of the arbitrators, or as the parties may otherwise mutually agree, the parties shall have the right to conduct reasonable discovery pursuant to the Federal Rules of Civil Procedure. The arbitrators shall not have the authority to award punitive damages, but shall have authority to award equitable relief. THE PARTIES UNDERSTAND THAT THEY ARE KNOWINGLY AND WILLINGLY EXPRESSLY WAIVING A RIGHT TO JURY TRIAL CONCERNING ANY MATTERS RELATING TO THIS AGREEMENT.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the date first above written.

FACILITY	HOSPITAL
By: _____	By: _____
Name: JOHN B. HENRY	Name: GERARD M. WALSH
Title: ADMINISTRATOR	Title: SR. V.P. + COO.

GENERAL TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (hereinafter "Agreement"), is effective July 25, 2018, by and between University of Maryland Shore Regional Health. (hereinafter "Health Care Facility") located at 219 South Washington Street, Easton, MD 21601, and Alfred I. duPont Hospital for Children, of The Nemours Foundation, a Florida not-for-profit corporation (hereinafter "AIDHC") located at 1600 Rockland Road, Wilmington, Delaware, 19803. Both Health Care Facility and AIDHC are hereinafter referred to as "Parties" to this Agreement and each may be referred to as "Institution".

WITNESSETH

WHERAS, Health Care Facility is a not-for-profit corporation that operates a health system to provide access to patient care for the residents of its service area; and

WHEREAS, The Nemours Foundation is a not-for-profit corporation that operates a hospital that provides pediatric patient care and is designated as a Level I Pediatric trauma center; and

WHEREAS, the parties desire to provide reasonable assurance that the transfer of patients will be properly effected between the institutions when a transfer is either medically appropriate as determined by the referring physician or when the patient requests the transfer;

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Health Care Facility and AIDHC agree as follows:

1. Term. This Agreement shall commence on the day and year first above written and shall continue for a period of five (5) years, unless terminated earlier by either Institution as set forth below.

2. Patient Transfer. The patient's attending physician will determine when transfer of a patient, from one Institution to the other is appropriate. Health Care Facility that request a transfer acknowledge that the appropriate transfer of individuals with unstabilized emergency medical conditions that require specialized services should not routinely be made over great distances, bypassing closer hospitals with the necessary capability and capacity to care for the unstabilized emergency medical condition. When a decision to transfer has been made, the transferring Institution shall contact the receiving Institution as far in advance of the anticipated transfer as possible to obtain the receiving Institution's consent to the transfer. Prior to moving the patient, the transferring Institution must receive confirmation from the receiving Institution that it can accept the patient. Physician to physician communication and discussion of patient illness and/or injuries, and best mode of transport, can be facilitated by contacting AIDHC Transport Communication Center at 800-962-0023.

3. Patient Records. Each Institution agrees to adopt standard forms for medical and administrative information to accompany the patient from one Institution to the other. The information shall include, but not be limited to, an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption. Each Institution agrees to supplement the above information as necessary for the maintenance of the patient during transport and treatment upon arrival at the receiving Institution.

4. Personal Effects. The transferring party shall transfer the patient's personal effects, including money and valuables, and information pertaining to same. A list prepared by the transferring party of all personal effects shall be transferred with the patient and shall include the signature of the person making the list. An attempt should be made to have family members or friends voluntarily transfer such personal effects if possible. The receiving party shall, as soon as practical upon patient arrival, document that all personal effects were received or will notify the transferring facility if items were lost.

5. Medical Information. The transferring party agrees to transmit with each patient at the time of transfer, or in case of an emergency, as promptly as possible thereafter, all available pertinent medical and other records necessary to continue the patient's treatment without interruption and to provide identifying and other information, which must include:

(a) A completed interagency communication summary to include; as applicable

- current medical findings;
- diagnosis;
- rehabilitation potential;
- brief summary of the course of treatment followed at Health Care Facility;
- nursing and dietary information useful in care of the patient;
- administrative and pertinent social information;
- post-discharge plan of care;
- all other information required by law or deemed necessary.

(b) Documentation of any known Health Care Treatment Directive, including any durable power of attorney for health care decisions, living will, guardianship papers or withholding of resuscitation orders.

(c) Documentation of (i) the name of the person requesting the transfer, (ii) the fact that the patient or person with authority to act on the patient's behalf consented to the transfer (except in emergencies), (iii) the name of the person at the receiving party who accepted the transfer.

6. Patient Consent to Transfer. The transferring Institution shall have responsibility for obtaining the appropriate consent to the transfer to the other Institution, prior to the transfer. This should include the patient's attending physician's signature authorizing the transport.

7. Charges. The patient/parent is primarily responsible for payment for care received at either Institution and for the costs to transport the patient for the transfer. Prior to transfer, except in urgent circumstances, the patient/parent should be required, if competent, to acknowledge the obligation to pay for such care at the receiving Institution and the transport costs. Each Institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either Institution to look to the other Institution to pay for services rendered to a patient transferred by virtue of this Agreement.

8. Transport. The transferring party shall arrange for appropriate and safe transportation of the patient in compliance with applicable laws, regulations and Joint Commission standards.

9. Return of Patient to Health Care Facility. When the Receiving party is AIDHC, the Health Care Facility shall be expected to be available for the return of the transferred patient when:

(a) the patient's medical condition has stabilized and the patient is ready for discharge from AIDHC, and

(b) the patient has needs for continued care appropriate to the scope of services provided by the Health Care Facility.

10. Liability. Each Institution shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other Institution.

11. Indemnification. Each party (the "Indemnifying Party") will defend, indemnify and hold the other parties and the other parties' employees, officers, governing body and medical staff members, physicians, agents, representatives and affiliates (collectively the "Indemnified Parties") harmless against any and all claims, suits, proceedings, demands, liabilities, losses, damages, penalties, fines, interest, costs and attorney's fees which may be brought, claimed or asserted against or incurred by the Indemnified Parties, and which arise from or result from the Indemnified Party's provision or failure to provide any of the Services described in this Agreement or from any negligence or other tortuous or wrongful act or omission by the Indemnifying party or its employees, physicians, contractors or representatives. This provision shall survive termination of this Agreement.

12. Insurance. Each Institution agrees to obtain and maintain in force during the term of the Agreement professional and general liability insurance with minimum limits of $1 million per occurrence or claim and $3 million annual aggregate. Upon request, each Institution will provide the other with a certificate of insurance verifying such coverage at all times this Agreement is in effect. Each Institution shall notify the other at least thirty (30) days prior to cancellation, reduction or material change in coverage. If the insurance is on a "claims made" basis, each Institution agrees to purchase appropriate tail coverage for claims, demands or actions reported in future years for acts or omissions during the term of this Agreement. If either Institution fails to obtain or maintain the insurance coverage provided herein, the other party may terminate this Agreement. The parties may satisfy this requirement through an actuarially sound plan of self insurance.

13. Termination.

13.1 Voluntary Termination. This Agreement may be terminated by either Institution for any reason, by giving thirty (30) days written notice of its intention to withdraw from this Agreement, and by ensuring the continuity of care to patients who already are involved in the transfer process. To this end, the terminating Institution will be required to meet its commitments under the Agreement to all patients for whom the other Institution has begun the transfer process in good faith.

13.2 Involuntary Termination. This Agreement may be terminated immediately upon the occurrence of any of the following:

13.2.1 Either Institution is destroyed to such an extent that the patient care provided by such Institution cannot be carried out adequately;

13.2.2 Either Institution loses its license or accreditation;

13.2.3 Either Institution is no longer able to provide the service for which this Agreement was sought;

13.2.4 Either Institution is in material default under any of the terms of this Agreement; or

13.2.5 Either Institution becomes a Sanctioned Provider as defined in Appendix A.

14. Independent Contractor Status. The Parties are independent contractors and neither Institution is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by either Institution, nor shall it in any way alter the control of the management, assets and affairs of the respective Parties. Neither Institution, by virtue of the Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other Institution to this Agreement.

15. Regulatory Compliance. The Parties agree to abide by all applicable federal, state and local laws and regulations, to include the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the Health Insurance Portability and Accountability Act ("HIPAA"), and federal and state anti-kickback laws. This agreement is not intended to violate the Anti-Kickback or Stark laws and it is not the purpose, nor is it a requirement of this Agreement to offer or receive any remuneration or inducement in exchange for the referral of any patient or other health care business between the parties.

16. Discrimination. The Parties agree that the primary consideration of both is care of patients according to their needs. Health Care Facility and AIDHC agree to admit and assign patients without regard to race, color, sex, age, national origin, religious creed or sexual preference.

17. Advertising and Public Relations. Neither Institution shall use the name of the other Institution in any promotional or advertising material unless review and approval of the intended advertisement first shall be obtained from the Institution whose name is to be used. The Parties shall deal with each other publicly and privately in an atmosphere of mutual respect and support, and each Institution shall maintain good public and patient relations and efficiently handle complaints and inquiries with respect to transferred or transferring patients.

18. Modification of Waiver. If either Institution to this Agreement waives a breach of one of the provisions of this Agreement by the other Institution, that waiver shall neither operate nor be construed as a waiver of a subsequent similar breach of a provision hereof.

19. Governing Law. This Agreement is made and entered into and shall be governed and construed in accordance with the laws of the State of Delaware.

20. Assignment. The Agreement shall not be assigned in whole or in part by either Institution hereto without the express written consent of the other Institution.

21. Invalid Provision. In the event that any portion of the Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to

continue to be binding upon the Parties hereto in the same manner as if the invalid or unenforceable provision were not a part of the Agreement.

22. Amendment. This Agreement may be amended at any time by a written Agreement signed by the Parties hereto.

23. Notice. Any and all notices and other communications required or permitted to be given hereunder shall be made in writing and effective upon receipt. Such notices shall be personally delivered, sent by registered or certified mail, by a nationally recognized overnight delivery service or sent by facsimile or electronic mail with confirmation, addressed as follows, unless such address is changed by written notice hereunder:

If to Health Care Facility:

University of Maryland Shore Regional Health
219 South Washington Street
Easton, MD 21601
Attn: President

If to AIDHC:

Alfred I. duPont Hospital for Children
1600 Rockland Road, ARB 166
Wilmington, DE 19803
Attn: Sean Elwell
E-mail: Sean.Elwell@nemours.org

With a copy to:

Office of Contracts Administration
The Nemours Foundation
10140 Centurion Parkway North
Jacksonville, FL 32256
Fax: 904.697.4070
E-mail: oca@nemours.org

24. Entire Agreement. This Agreement constitutes the entire agreement between the Parties and contains all of the agreements between them with respect to the subject matter hereof and supersedes any and all other agreements, either oral or in writing, between the Parties with respect to the subject matter hereof.

25. Counterparts and Electronic Signature. This Agreement may be executed in two or more counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. Delivery of an executed signature page to the Agreement by facsimile transmission or .PDF will be as effective as delivery of a manually signed counterpart.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed by persons duly authorized to bind the Parties to perform their respective obligations hereunder, as of the date first written above.

ALFRED I. duPONT HOSPITAL FOR CHILDREN OF THE NEMOURS FOUNDATION

By: _____

Name: Jane Mericle, MHS-CL, BSN, RN, CENP

Title: Chief Nurse Executive Operational Vice President

Date: 8/3/18

UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH

By: _____

Name: Kenneth D. Kozel

Title: President + CEO

Date: 7/25/18

APPENDIX A

"Sanctioned Provider" means a Person who:

1. is currently under indictment or prosecution for, or has been convicted of:

a) any offense related to the delivery of an item or service under the Medicare or Medicaid programs or any program funded under Title V or Title XX of the Social Security Act (the Maternal Child Health Services Program or the Block Grants to States for Social Services programs, respectively),

b) a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service,

c) fraud, theft, embezzlement or other financial misconduct in connection with the delivery of a health care item or service,

d) obstructing an investigation of any crime referred to in i) through iii) above, or

e) unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

2. has been required to pay any civil monetary penalty under 42 U.S.C. §1128A, regarding false, fraudulent or impermissible claims under, or payments to induce a reduction or limitation of health care services to beneficiaries of, any state or Federal health care program, or is currently the subject of any investigation or proceeding which may result in such payment; or

3. has been excluded from participation in the Medicare, Medicaid or Maternal and Child Health Services (Title V) program, or any program funded under the Block Grants to States for Social Services (Title XX) program.

GENERAL TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (hereinafter "Agreement"), is made and entered into by and between the University of Maryland Shore Regional Health, Inc., including University of Maryland Shore Medical Center at Easton and University of Maryland Shore Medical Center at Dorchester (hereinafter "UM SRH") located at 219 South Washington Street, Easton, MD 21601, and Chesapeake Woods Center (hereinafter "Center") located at 525 Glenburn Avenue, Cambridge, MD. Both UM SRH and Center are hereinafter referred to as "Parties" to this Agreement and each may be referred to as "Institution."

WITNESSETH

WHEREAS, UM SRH is a not-for-profit corporation that operates a health care system to provide access to patient care; and

WHEREAS, Center is a for-profit corporation that operates a nursing home facility

WHEREAS, the parties desire to provide reasonable assurance that the transfer of patients will be properly effected between the institutions when a transfer is either medically appropriate as determined by the referring physician or when the patient requests the transfer;

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, UM SRH and Center agree as follows:

1. Term. This Agreement shall commence June 1, 2014 and shall continue for a period of five (5) years, unless terminated earlier by either Institution as set forth below.
2. Patient Transfer. The patient's attending physician will determine when transfer of a patient, from one Institution to the other is appropriate. When a decision to transfer has been made, the transferring Institution shall contact the receiving Institution as far in advance of the anticipated transfer as possible to obtain the receiving Institution's consent to the transfer. Prior to moving the patient, the

transferring Institution must receive confirmation from the receiving Institution that it can accept the patient.

3. Patient Records. Each Institution agrees to adopt standard forms for medical and administrative information to accompany the patient from one Institution to the other. The information shall include, but not be limited to, an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption. Each Institution agrees to supplement the above information as necessary for the maintenance of the patient during transport and treatment upon arrival at the receiving Institution.
4. Medical Information. The transferring party agrees to transmit with each patient at the time of transfer, or in case of an emergency, as promptly as possible thereafter, all available pertinent medical and other records necessary to continue the patient's treatment without interruption and to provide identifying and other information, which must include:
    a. A completed interagency communication summary to include, as applicable
        - Current medical findings;
        - Diagnosis;
        - Rehabilitation potential;
        - Brief summary of the course of treatment
        - Nursing and dietary information useful in care of the patient;
        - Administrative and pertinent social information;
        - Post-discharge plan of care;
        - All other information required by law or deemed necessary.
    b. Documentation of any known Health Care Treatment Directive, including any durable power of attorney for health care decisions, living will, guardianship papers or withholding of resuscitation orders.
    c. Documentation of (i) the name of the person requesting the transfer, (ii) the fact that the patient or person with authority to act on the patient's behalf consented to the transfer (except in emergencies), (iii) the name of the person at the receiving party who accepted the transfer.
5. Patient Consent to Transfer. The transferring Institution shall have responsibility for obtaining the appropriate consent to the transfer to the other Institution, prior to the transfer. This should include the patient's attending physician's signature authorizing the transport.
6. Charges. The patient is primarily responsible for payment for care received at either Institution and for the costs to transport the patient for the transfer. Prior to

transfer, except in urgent circumstances, the patient should be required, if competent, to acknowledge the obligation to pay for such care at the receiving Institution and the transport costs. Each Institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either Institution to look to the other Institution to pay for services rendered to the patient transferred by virtue of this Agreement.

7. Transport. The transferring party shall arrange for appropriate and safe transportation of the patient in compliance with applicable laws, regulation and Joint Commission standards.
8. Return of Patient to Center. When the Receiving party is UM SRH, the Center shall be expected to be available for the return of the transferred patient when:
    a. the patient's medical condition has stabilized and the patient is ready for discharge from UM SRH, and
    b. the patient has needs for continued care appropriate to the scope of services provided by the Center.
9. Liability. Each Institution shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other Institution.
10. Indemnification. Each Party (the "Indemnifying Party") will defend, indemnify and hold the other parties and the other parties' employees, officers, governing body and medical staff members, physicians, agents, representatives and affiliates (collectively the "Indemnified Parties") harmless against any and all claims, suits, proceedings, demand, liabilities, losses, damages, penalties, fines, interest, costs and attorney's fees which may be brought, claimed or asserted against or incurred by the Indemnified Parties, and which arise from or result from the Indemnified Party's provision or failure to provide any of the Services described in this Agreement or from any negligence or other tortuous or wrongful act or omission by the Indemnifying party or its employees, physicians, contractors or representatives. This provision shall survive termination of this Agreement.
11. Insurance. Each Institution agrees to obtain and maintain in force during the term of the Agreement professional and general liability insurance with minimum limits of $1 million per occurrence or claim and $3 million annual aggregate. Upon request, each Institution will provide the other with a certificate of insurance verifying such coverage at all times this Agreement is in effect. Each Institution shall notify the other at least thirty (30) days prior to cancellation, reduction or material change in coverage. If the insurance is on a "claims made" basis, each Institution agrees to

purchase appropriate tail coverage for claims, demands or action reported in future years for acts or omissions during the term of this Agreement. If either Institution fails to obtain and maintain the insurance coverage provided herein, the other party may terminate this Agreement. The parties may satisfy this requirement through an actuarially sound plan of self insurance.

12. Termination.

13.1 Voluntary Termination. This Agreement may be terminated by either Institution for any reason, by giving thirty (30) days written notice of its intention to withdraw from this Agreement, and by ensuring the continuity of care to patients who already are involved in the transfer process. To this end, the terminating Institution will be required to meet its commitments under the Agreement to all patients for whom the other Institution has begun the transfer process in good faith.

13.2 Involuntary Termination. This Agreement may be terminated immediately upon the occurrence of any of the following:

13.2.1 Either the Institution is destroyed to such an extent that the patient care provided by such Institution cannot be carried out adequately;

13.2.2 Either Institution loses its license or accreditation;

13.2.3 Either Institution is no longer able to provide the services for which this Agreement was sought;

13.2.4 Either Institution is in material default under any of the terms of this Agreement; or

13.2.5 Either Institution becomes a Sanctioned Provider as defined in Appendix A.

13. Independent Contractor Status. The Parties are independent contractors and neither Institution is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by either Institution, nor shall it in any way alter the control of the management, assets and affairs of the respective Parties. Neither Institution, by virtue of the Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other Institution to this Agreement.

14. Regulatory Compliance. The Parties agree to abide by all applicable federal, state and local laws and regulations, to include the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the Health Insurance Portability and Accountability Act ("HIPAA"), and federal and state anti-kickback laws. This agreement is not intended

to violate the Anti-Kickback or Stark laws and it is not the purpose, nor is it a requirement of this Agreement to offer or receive any remuneration or inducement in exchange for the referral of any patient or other health care business between the parties.

15. Discrimination. The Parties agree that the primary consideration of both is care of patients according to their needs. UM SRH and Center agree to admit and assign patients without regard to race, color, sex, age, national origin, religious creed or sexual preference.

16. Advertising and Public Relations. Neither Institution shall use the name of the other Institution in any promotional or advertising material unless review and approval of the intended advertisement first shall be obtained from the Institution whose name is to be used. The Parties shall deal with each other publicly and privately in a atmosphere of mutual respect and support, and each Institution shall maintain good public and patient relation and efficiently handle complaints and inquiries with respect to transferred or transferring patients.

17. Modification of Waiver. If either Institution to this Agreement waives a breach of one of the provisions of this Agreement by the other Institution, that waiver shall neither operate nor be construed as a waiver of a subsequent similar breach of a provision hereof.

18. Governing Law. This Agreement is made and entered into and shall be governed and construed in accordance with the laws of the State of Maryland.

19. Assignment. The Agreement shall not be assigned in whole or in part by either Institution hereto without the express written consent of the other Institution.

20. Invalid Provision. In the event that any portion of the Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the Parties hereto in the same manner as if the invalid or unenforceable provision were not a part of the Agreement.

21. Amendment. This Agreement may be amended at any time by a written Agreement signed by the Parties hereto.

22. Notice. Any and all notices and other communications required or permitted to be given hereunder shall be made in writing and effective upon receipt. Such notices shall be personally delivered, sent by registered or certified mail, by a nationally

recognized overnight delivery service or sent by electronic mail with confirmation, addressed as follows, unless such address is changed by written notice hereunder:

If to UM SRH:

University of Maryland Shore Regional Health, Inc.
219 South Washington Street
Easton, MD 21601
Attn: President and CEO
Email: kkozel@shorehealth.org

If to Center:

Chesapeake Woods Center
Genesis Health Care
525 Glenburn Avenue
Cambridge, MD 21613
Attn: Administrator

23. Entire Agreement. This Agreement constitutes the entire agreement between the Parties and contains all of the agreements between them with respect to the subject matter hereof and supersedes any and all other agreements, either oral or in writing, between the Parties with respect to the subject matter hereof.

24. Assignment. This Agreement may not be assigned in whole or in part by any Party without the express written consent of the other Party.

25. Counterparts and Electronic Signature. This Agreement may be executed in two or more counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. Delivery of an executed signature page to the Agreement by facsimile transmission or .PDF will be as effective as delivery of a manually signed counterpart.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed by persons duly authorized to bind the Parties to perform their respective obligations hereunder, as of the date first written above.

CHESAPEAKE WOODS CENTER

By: _____

Name: Caroline Hergenrother

Title: Administrator

Date: 5/19/14

UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH, INC.

By: _____

Name: Kenneth Kozel

Title: President & CEO

Date: 6/4/14

APPENDIX A

"Sanctioned Provider" means a Person who:

1. Is currently under indictment or prosecution for, or has been convicted of:
    a. Any offense related to the delivery of an item or service under the Medicare or Medicaid programs or any program funded under Title V or Title XX of the Social Security Act (the Maternal Child Health Services Program or the Block Grants to States for Social Services programs, respectively),
    b. A criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service,
    c. Fraud, theft, embezzlement or other financial misconduct in connection with the delivery of a health care item or service,
    d. Obstructing an investigation of any crime referred to in i) through iii) above, or
    e. Unlawful manufacture, distribution, prescription or dispensing of a controlled substance;
2. Has been required to pay any civil monetary penalty under 42 U.S.C. § 1128A, regarding false, fraudulent or impermissible claims under, or payments to induce a reduction or limitation of health care services to beneficiaries of, any state or Federal health care program, or is currently the subject of any investigation or proceeding which may result in such payment; or
3. Has been excluded from participation in the Medicare, Medicaid or Maternal and Child Health Services (Title V) program, or any program funded under the Block Grants to States for Social Services (Title XX) program.

TRANSFER AGREEMENT

Between

THE MEMORIAL HOSPITAL AT EASTON, MD. INC.

And

SHORE HEALTH SURGERY CENTER

THIS TRANSFER AGREEMENT (the "Agreement") is executed and effective as of April 1, 2010 (the "Effective Date"), by and between The Memorial Hospital at Easton, MD., (the "Hospital") (an acute care hospital owned and operated by Shore Health System, Inc. a Maryland non-stock corporation, hereafter referred to as the "Corporation") and Shore Health Surgery Center (the "Center"), a licensed ambulatory surgery center owned and operated by the Corporation.

WHEREAS, both parties desire to assure continuity of care and treatment appropriate to the needs of each patient and to use the skills, resources, and physical plant of both parties in a coordinated and cooperative fashion to improve patient care at both the acute and post-acute stages of illness.

NOW THEREFORE, in consideration of the mutual advantages occurring to the parties hereto, Hospital and Center hereby covenant and agree with each other as follows:

1. Both parties agree to make a concerted effort to transfer patients as soon as practical when the need for transfer from Center to Hospital has been determined by the patient's attending physician, provided, however, all eligibility conditions for admission must be met and documented in the patient's medical record.

2. Center agrees to send with each patient at the time of transfer or, in the case of any emergency as promptly as possible after the transfer, an abstract of the patient's medical record including:

    a. The current medical findings,
    b. Diagnosis,
    c. A brief summary of the course of treatment followed,
    d. All other administrative and social information useful to provide continuing care to the patient; using the transfer and referral form mutually agreed upon.

3. Center, after promptly notifying Hospital of the impending transfer of a patient and after Hospital consents to accept such patient, shall assume the responsibility to arrange for appropriate and safe transportation of the patient, his/her personal effects and valuables, and shall provide any necessary care while he/she is being transferred.

4. Charges for services performed by either Center or Hospital for patients transferred from the other institution pursuant to this Agreement, shall be collected by the institution rendering such services, directly from the patient, third party payers, or the other sources normally billed by the institution; and neither party shall have any liability to the other for such charges except to the extent that such liabilities would exist separate and apart from this Agreement.

5. The parties agree that the transfer of a patient pursuant to this Agreement shall not be predicated upon discrimination based on race, religion, national origin, age, sex, physical condition or economic status. The parties also agree that the transfer or receipt of patients shall not be based upon a patient's inability to pay for services rendered by the transferring or receiving institution or a patient's source of payment.

6. All patient transfers pursuant to this Agreement must be accomplished in a medically appropriate manner from physician to physician and institution to institution by: (i) the use of appropriate life support measures which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to stabilize the patient prior to transfer and to sustain the patient during the transfer; (ii) the provision of appropriate personnel and equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use for the transfer; (iii) the transfer of all necessary records for continuing the care for the patient; and (iv) the consideration of the availability of appropriate facilities, services, and staff for providing care for the patient. The parties agree that before moving a patient, Center shall explain the reasons for the transfer and any alternative to the patient or a legally authorized representative of the patient. If it is necessary to move the patient immediately to protect the health, safety or welfare of the patient, Center may give the explanation of the reasons for the transfer concurrently with the transfer.

7. The parties agree to recognize the right of a patient to request transfer into the care of a physician and institution of the patient's own choosing and to recognize and comply with all federal and state requirements relating to the transfer of patients.

8. Center agrees not to transfer a patient with an emergency medical condition that has not been stabilized unless: (i) the patient, or a legally responsible person acting on the patient's behalf, after being informed of the Center's obligations under law and of the risk of transfer, requests in writing transfer to another institution; (ii) a licensed physician has signed a certification which includes a summary of the risks and benefits that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another institution outweigh the increased risks to the patient and, in the case of labor, to the unborn child from effecting the transfer; or (iii) if a licensed physician is not physically present at the time a patient is transferred, a qualified medical person has signed a certification described in subparagraph (ii) above after a licensed physician, in consultation with the person, has made the

determination described in subparagraph (ii) above and subsequently countersigns the certificate.

9. All notices hereunder by either party to the other party shall be in writing, delivered personally or by overnight courier, and shall be deemed to have been duly given when delivered personally or one day after delivered to the overnight carrier, charges prepaid, and properly addressed to the respective parties at the addresses shown following each party's signature to the Agreement.

10. This Agreement shall be effective from the date of signing by both parties and shall continue in effect, except that either party may withdraw by giving sixty (60) days written notice to the other party of its intention to terminate this Agreement. However, the Agreement shall be declared null and void and shall be immediately terminated should either party fail to maintain its licensure or certification status.

11. Both parties represent and warrant that, during the term of this Agreement, each shall comply with all applicable state and federal laws and regulations and shall remain in good standing with applicable accrediting organizations.

12. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other institution, on either a limited or general basis, while this Agreement is in effect.

13. This Agreement may be modified or amended by the mutual agreement of the parties, however, any such modification or amendment shall be attached to and become a part of this Agreement. This Agreement shall be construed in accordance with the laws of the State of Maryland.

Shore Health Surgery Center
505 Dutchman's Lane
Easton, MD 21601

By: _____

Name: Christopher J. Parker

Title: Sr. VP Pt. Care Services/CNO

The Memorial Hospital at Easton
219 S Washington Street
Easton, MD 21601

By: _____

Name: Joseph P. Ross

Title: President

AGREEMENT BETWEEN
EASTERN SHORE HOSPITAL CENTER
AND
SHORE HEALTH SYSTEM, INC.

THIS AGREEMENT, entered into and effective this _ day of April 2014 by and between Eastern Shore Hospital Center, a non-profit corporation organized and existing under the laws of Maryland (hereinafter referred to as "ESHC") and Shore Health System, a non-profit corporation organized and existing under the laws of Maryland that owns and operates University of Maryland Shore Medical Center at Easton and University of Maryland Shore Medical Center at Dorchester in Cambridge, Maryland (collectively hereinafter referred to as "Shore Health").

WHEREAS, both parties desire, by means of this Agreement, to facilitate the timely provision of services to ESHC patients; and to insure the continuity and quality of care and treatment appropriate to the needs of patients at ESHC and/or Shore Health by utilizing the knowledge and resources of both parties in a coordinated and cooperative effort; and

WHEREAS, ESHC, a state-operated psychiatric facility located in Cambridge, MD, consists of three (3) psychiatric units and a separately licensed assisted living program (ALP).

WHEREAS, some ESHC patients require certain medical service that are not available onsite at ESHC for their patients/residents

WHEREAS, Shore Health provides certain medical services and is willing to provide services to patients from ESHC as set forth herein.

NOW THEREFORE, in consideration of the mutual advantages accruing to the parties hereto and their respective patients and in consideration of the mutual covenants hereinafter set forth, the parties, with the intention to be legally bound, agree as follows:

I. Conditions of Transfer

Each party agrees to exercise its best efforts to provide for the provision of services of any patient transported from the other facility provided that:

A. A licensed physician who is a member of the medical staff of either party has designated that such services are medically appropriate.

B. All conditions and requirements of provision of services are met, including confirmation of acceptance of the patient by the receiving facility.

C. Adequate and appropriate capacity to provide services is available in the receiving facility to accommodate the patient.

D. The sending facility has received confirmation from the receiving facility that the receiving facility will accept the patient.

II. Admission Process

ESHC agrees that it and its physicians and/or medical staff will abide by the following notification procedures when patients are transported to Shore Health: the sending physician at ESHC shall contact the appropriate Emergency Department attending physician at Shore Health who will evaluate the patient and determine appropriate disposition. In the event there is one (1) ESHC physician treating two injured patients that require emergency care and no additional physician coverage at ESHC is available to such physician, the patient with the most serious injuries will be sent to the Emergency Department, and the patient with less serious injuries will be managed at ESHC; provided that ESCH shall utilize best efforts to notify Shore Health of such transfer in advance via telephone.

III. Transport

A. The sending facility agrees to:

1) Arrange for and carry out appropriate transportation of the patient to the receiving facility, including selection of the mode of transport, using appropriate life support measures, if necessary, to stabilize the patient prior to transport and during transport and providing appropriate health practitioner(s) and equipment to accompany the patient;

2) Complete and forward to the receiving facility, at the time of transport, an approved transport record form;

3) Transport with the patient his/her personal effects and provide documentation of presence or absence of personal items on the medical record/valuables sheet; including a notation if given to patient, family member or placed in hospital safe; and

4) Transmit with each patient at the time of transport copies of the patient's medical record or an abstract of pertinent medical and other records necessary for identification of the patient and continuation of uninterrupted and proper treatment. Such medical and other information should include where applicable:

a) History of the injury or illness;
b) Current medical findings;
c) Diagnosis;
d) Laboratory and radiology findings, including copies of radiological films, where appropriate;
e) Rehabilitation potential;

f) Brief summary of the courses of treatment followed up to the time of transport including medications given and route of administration, fluids given, by type and volume;
g) Nursing information useful in the care of the patient;
h) Patient's third party billing data;
i) Pertinent administrative information as required; and
j) Current surrogate (in the event that the patient is incompetent) and/or next-of-kin information.

5) In the event of an emergency as reasonably determined by the sending facility, the following information will be sent by the sending facility with the patient:

a) History of injury or illness
b) Current medical findings
c) Brief summary of the courses of treatment follow up to the time of the transport, including medications given, and route of administration, fluids given, by type and volume.
d) All other information will be faxed within ten (10) minutes of the patient leaving ESHC for the Shore Health emergency room.

6) Obtain the consent to transport from the patient's legally authorized representative, except in emergency situations where the delay to obtain such consent would seriously jeopardize the patient's life or health.

7) Direct inquiries about the patient or his/her care to the patient's attending physician and to no other medical staff member(s).

B. The receiving facility agrees to:

1) Assume responsibility for the patient's care, including providing full inpatient, outpatient and emergency services as appropriate, upon arrival of the transported patient at the receiving facility;

2) Acknowledge on such forms as may be provided by the sending facility, receipt of the patient's effects and medical records.

C. ESHC agrees to promptly accept patients for readmission upon the reasonable determination of both parties that such patients are appropriate for re-admission from a medical perspective.

IV. Payment for Services

The patient is primarily responsible for payment for care received at the institution and, prior to transport, (in non-emergent cases), the patient (or his/her surrogate decision maker) shall be required to acknowledge the obligation to pay for such at the receiving

institution. Each institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either institution to look to the other to pay for services rendered to a patient transported by virtue of this Agreement, except to the extent that such liability would exist separate and apart from this Agreement.

V. Compliance

Each institution shall comply with all applicable federal, state and local laws, and all requirements imposed by, or pursuant to the regulations of the Department of Health and Human Services and any other applicable governmental agency.

VI. Insurance

Each year that this Agreement is in effect, within thirty (30) days of the anniversary of the execution of this Agreement, each party shall provide to the other written verification that:

A. It has professional liability insurance or adequate self-insurance, in limits as required in accordance with applicable laws of the State of Maryland.

B. That all members of its medical staff are covered by professional liability insurance in limits as required in accordance with applicable laws of the State of Maryland.

C. That all of its employees who may be involved in the transfer of patients are covered by adequate and reasonable limits of workers' compensation, health, and motor vehicle insurance as required in accordance with applicable laws of the State of Maryland.

VII. Indemnification

A. ESHC agrees that it shall defend, indemnify and hold harmless Shore Health, its officers, directors, agents, and employees from and against any and all costs, demands, liabilities, settlements or verdicts, including reasonable attorneys fees, arising out of any claim, demand, action or suit brought by, on behalf of or as a derivative action of any patient or other person for any damages, injuries, or death to persons or property arising out of or in connection with (i) ESHC performance or failure to perform its duties hereunder; or (ii) any act or omission of ESHC, its agents or employees which occurred prior to the admission by Shore Health of any patient transported from ESHC.

B. Shore Health agrees that it shall defend, indemnify and hold harmless ESHC, its officers, directors, agents and employees from and against any and all costs, demands, liabilities, settlements, or verdicts, including reasonable attorneys fees, arising out of any claim, demand, action or suit brought by, on behalf of or as a derivative action of any patient or other person for any damages, injuries or death to persons or property arising out of or in connection with (i) Shore Health's

performance or failure to perform its duties hereunder; or (ii) any act or omission of Shore Health, its agents or employees, which occurred prior to the admission or acceptance by ESHC of any patient transported from Shore Health.

VIII. Confidentiality of Medical Records

All reasonable efforts will be made by both parties to preserve the confidential nature of the patient's medical records and to safeguard the rights of the patients as to medical and/or other privileged information contained within said records in accordance with applicable state and federal laws and regulations.

IX. Duration and Termination of Agreement

The Agreement shall continue in effect indefinitely, except that either party may terminate this Agreement by giving sixty (60) days' notice in writing to the other party of its intention to terminate. Termination shall be effective at the end of the sixty (60) days' notice period. However, if either party shall have its license to operate revoked or suspended by the State, have its accreditation suspended or revoked or placed on probation by any accrediting body or if any governmental agency suspends, revokes or places such party of probation, then the affected party shall immediately notify the other hospital, and this Agreement shall terminate as of the date such suspension, revocation or probation becomes effective.

X. Modification of Agreement

This Agreement may be modified or amended from time to time by mutual written agreement of the parties and any such modification or amendments shall be attached to and become part of this Agreement.

XI. Autonomy of Institutions

Each party to this Agreement is an independent contractor and shall have exclusive control over the policies, management, assets and affairs of its respective institution. Neither party by virtue of this Agreement assumes any liability for any debts or obligations of a financial or legal nature incurred by the other party. Nothing in this Agreement shall be construed as creating a partnership, joint venture, principal-agent or master-servant relationship between the parties, their agents, employees or representatives.

XII. Non-exclusivity

Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other hospital, nursing home or other health care entity or organization on either a limited or a general basis while this Agreement is in effect.

XIII. Non-Discrimination

Both parties attest that they are an equal opportunity employer that offers employment without regard to race, color, religious creed, disability, ancestry, national or ethnic origin, age, sex, or veteran status. This agreement shall be construed and carried out in a non-discriminatory manner without regard to race, color, religious creed, disability, ancestry, national or ethnic origin, age, sex, veteran status or ability to pay.

XIII. Miscellaneous

A. Each party agrees to provide to the other, upon reasonable request, any information deemed relevant by the requesting party to determine if the other party is able to provide the necessary facilities, care and/or treatment for a particular patient, group of patients or types of patients.

B. Neither party shall use the name of the other in any promotional or advertising material without the written approval of the other party.

C. Any communication required herein shall be in writing addressed as follows:

1) Any notice to ESHC:

2) Any notice to Shore Health:
Shore Health System, Inc.
219 S. Washington Street
Easton, Maryland 21601
Attn: Chief Medical Officer

D. No patient, physician, payor or other third party is intended to be a third party beneficiary under this Agreement and no action to enforce the terms of this Agreement may be brought against any party by any person who is not a party to this Agreement.

E. Neither party may transfer, assign, pledge or delegate any or all of its duties or interest in this Agreement without the prior written consent of the other, which consent shall not be unreasonably withheld.

F. This Agreement shall be binding upon and inure to the benefit of the successors or assigns of the parties.

G. This Agreement constitutes the entire agreement between the parties and contains all of the agreements between them with respect to the subject matter and supercedes any and all other agreements, either oral or in writing, between the parties with respect to the subject matter. This Agreement may be modified or amended by a mutual, written agreement signed by the parties.

H. No waiver of any term or condition of this Agreement by either party shall be deemed a continuing or further waiver of the same term or condition or a waiver of any other term or condition of this Agreement.

I. In the event any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue or to be binding upon the parties in the same manner as if the invalid or unenforceable provision were not a part of this Agreement.

J. The headings above the various provisions of this Agreement have been included only in order to make it easier to locate the subject covered by each provision; they are not to be used in construing this Agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed the day and the year written below.

EASTERN SHORE HOSPITAL CENTER

Chief Executive Officer

5-12-14
Date

Witness

SHORE HEALTH SYSTEM, INC.

Chief Executive Officer

6/5/14
Date

Witness

EASTERN SHORE HOSPITAL CENTER

Acting Clinical Director

5.12.14
Date

Witness

FOR COMPANY USE ONLY:
Clinic #: 0810

PATIENT TRANSFER AGREEMENT

This **PATIENT TRANSFER AGREEMENT** (the "Agreement") is made as of the 12th day of October, 2009 (the "Effective Date"), by and between **SHORE HEALTH SYSTEM d/b/a Easton Memorial Hospital** (hereinafter "Hospital") and **RENAL TREATMENT CENTERS – MID-ATLANTIC, INC.**, a Delaware corporation and subsidiary of DaVita Inc. ("Company").

RECITALS

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between Hospital and the following free-standing dialysis clinic owned and operated by Company:

Easton Dialysis
402 Marvel Court
Easton, MD 21601

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities; and

WHEREAS, the parties wish to facilitate the continuity of care and the timely transfer of patients and records between the facilities.

WHEREAS, only a patient's attending physician (not Company or the Hospital) can refer such patient to Company for dialysis treatments.

NOW THEREFORE, in consideration of the premises herein contained and for other good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged, the parties agree as follows:

1. **HOSPITAL OBLIGATIONS.** In accordance with the policies and procedures as hereinafter provided, and upon the recommendation of an attending physician, a patient of Company may be transferred to Hospital.

(a) Hospital agrees to exercise its best efforts to ensure the prompt admission of patients as necessary, provided that all usual, reasonable conditions of admission are met. In doing so, Hospital agrees to accept and treat patients in emergency situations requiring transfer of a patient from Company to Hospital. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of the Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO") and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Transfer record forms shall be completed in detail and signed by the physician or nurse in charge at Company and must accompany the patient to the receiving institution.

(b) Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility.

2. COMPANY OBLIGATIONS.

(a) Upon transfer of a patient to Hospital, Company agrees:

i. That it shall transfer any needed personal effects of the patient, and information relating to the same, and shall be responsible therefore until signed for by a representative of Hospital;

ii. Original medical records kept by each of the parties shall remain the property of that institution; and

iii. That transfer procedures shall be made known to the patient care personnel of each of the parties.

(b) Company agrees to transmit with each patient at the time of transfer, or in case of an emergency, as promptly as possible thereafter, an abstract of pertinent medical and other records necessary to continue the patient's treatment without interruption and to provide identifying and other information, to include:

i. current medical findings;

ii. diagnosis;

iii. rehabilitation potential;

iv. discharge summary;

v. a brief summary of the course of treatment followed;

vi. nursing and dietary information;

vii. ambulating status; and

viii. administrative and pertinent social information.

(c) Company agrees to readmit to its facilities patients who have been transferred to Hospital for medical care as clinic capacity allows. Hospital agrees to keep the administrator or designee of Company advised of the condition of the patients that will affect the anticipated date of transfer back to Company and to provide as much notice of the transfer date as possible. Company shall assign readmission priority for its patients who have been treated at Hospital and who are ready to transfer back to Company.

3. **BILLING, PAYMENT, AND FEES.** Hospital and Company each shall be responsible for billing the appropriate payor for the services it provides, respectively, hereunder. Company shall not act as guarantor for any charges incurred while the patient is a patient in Hospital.

4. **HIPAA.** Hospital and Company agree to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Hospital and Company acknowledge and agree that from time to time, HIPAA may require modification to this Agreement for compliance purposes. Hospital and Company further acknowledge and agree to comply with requests by the other party hereto related to HIPAA.

5. **STATUS AS INDEPENDENT CONTRACTORS.** The parties acknowledge and agree that their relationship is solely that of independent contractors. Governing bodies of Hospital and Company shall have exclusive control of the policies, management, assets, and affairs of their respective facilities. Nothing in this Agreement shall be construed as limiting the right of either to affiliate or contract with any other Hospital or facility on either a limited or general basis while this Agreement is in effect. Neither party shall use the name of the other in any promotional or advertising material unless review and approval of the intended use shall be obtained from the party whose name is to be used and its legal counsel.

6. **INSURANCE.** Each party shall secure and maintain, or cause to be secured and maintained during the term of this Agreement, comprehensive general liability, property damage, and workers compensation insurance in amounts generally acceptable in the industry, and professional liability insurance providing minimum limits of liability of $1,000,000 per occurrence and $3,000,000 in aggregate. Each party shall deliver to the other party certificate(s) of insurance evidencing such insurance coverage upon execution of this Agreement, and annually thereafter upon the request of the other party. Each party shall provide the other party with not less than thirty (30) days prior written notice of any change in or cancellation of any of such insurance policies. Said insurance shall survive the termination of this Agreement.

7. **INDEMNIFICATION.**

(a) Hospital Indemnity. Hospital hereby agrees to defend, indemnify and hold harmless Company and its shareholders, affiliates, officers, directors, employees, and agents for, from and against any claim, loss, liability, cost and expense (including, without limitation, costs of investigation and reasonable attorney's fees), directly or indirectly relating to, resulting from or arising out of any action or failure to act arising out of this Agreement by Hospital and its staff regardless of whether or not it is caused in part by Company or its officers, directors, agents, representatives, employees, successors and assigns. This indemnification provision shall not be effective as to any loss attributable exclusively to the negligence or willful act or omission of Company.

(b) Company Indemnity. Company hereby agrees to defend, indemnify and hold harmless Hospital and its shareholders, affiliates, officers, directors, employees, and agents for, from and against any claim, loss, liability, cost and expense (including, without limitation, costs of investigation and reasonable attorney's fees), directly or indirectly relating to, resulting from or arising out of any action or failure to act arising out of this Agreement by Company and its

staff regardless of whether or not it is caused in part by or its officers, directors, agents, representatives, employees, successors and assigns. This indemnification provision shall not be effective as to any loss attributable exclusively to the negligence or willful act or omission of Hospital.

(c) Survival. The indemnification obligations of the parties shall continue in full force and effect notwithstanding the expiration or termination of this Agreement with respect to any such expenses, costs, damages, claims and liabilities which arise out of or are attributable to the performance of this Agreement prior to its expiration or termination.

8. DISPUTE RESOLUTION. Any dispute which may arise under this Agreement shall first be discussed directly with representatives of the departments of the parties that are directly involved. If the dispute cannot be resolved at this level, it shall be referred to administrative representatives of the parties for discussion and resolution.

(a) Informal Resolution. Should any dispute between the parties arise under this Agreement, written notice of such dispute shall be delivered from one party to the other party and thereafter, the parties, through appropriate representatives, shall first meet and attempt to resolve the dispute in face-to-face negotiations. This meeting shall occur within thirty (30) days of the date on which the written notice of such dispute is received by the other party.

(b) Resolution Through Mediation. If no resolution is reached through informal resolution, pursuant to Section 8(a) above, the parties shall, within forty-five (45) days of the first meeting referred to in Section 8(a) above, attempt to settle the dispute by formal mediation. If the parties cannot otherwise agree upon a mediator and the place of the mediation within such forty-five (45) day period, the American Arbitration Association ("AAA") in the State of Maryland shall administer the mediation. Such mediation shall occur no later than ninety (90) days after the dispute arises. All findings of fact and results of such mediation shall be in written form prepared by such mediator and provided to each party to such mediation. In the event that the parties are unable to resolve the dispute through formal mediation pursuant to this Section 8(b), the parties shall be entitled to seek any and all available legal remedies.

9. TERM AND TERMINATION. This Agreement shall be effective for an initial period of one (1) year from the Effective Date and shall continue in effect indefinitely after such initial term, except that either party may terminate by giving at least sixty (60) days notice in writing to the other party of its intention to terminate this Agreement. If this Agreement is terminated for any reason within one (1) year of the Effective Date of this Agreement, then the parties hereto shall not enter into a similar agreement with each other for the services covered hereunder before the first anniversary of the Effective Date. Termination shall be effective at the expiration of the sixty (60) day notice period. However, if either party shall have its license to operate its facility revoked by the State or become ineligible as a provider of service under Medicare or Medicaid laws, this Agreement shall automatically terminate on the date such revocation or ineligibility becomes effective.

10. AMENDMENT. This Agreement may be modified or amended from time to time by mutual written agreement of the parties, signed by authorized representatives thereof, and any

such modification or amendment shall be attached to and become part of this Agreement. No oral agreement or modification shall be binding unless reduced to writing and signed by both parties.

11. **ENFORCEABILITY/SEVERABILITY.** The provisions of this Agreement are severable. The invalidity or unenforceability of any term or provisions hereto in any jurisdiction shall in no way affect the validity or enforceability of any other terms or provisions in that jurisdiction, or of this entire Agreement in any other jurisdiction.

12. **COMPLIANCE RELATED MATTERS.** The parties agree and certify that this Agreement is not intended to generate referrals for services or supplies for which payment maybe made in whole or in part under any federal health care program. The parties will comply with statutes, rules, and regulations as promulgated by federal and state regulatory agencies or legislative authorities having jurisdiction over the parties.

13. **EXCLUDED PROVIDER.** Each party represents that neither that party nor any entity owning or controlling that party has ever been excluded from any federal health care program including the Medicare/Medicaid program or from any state health care program. Each party further represents that it is eligible for Medicare/Medicaid participation. Each party agrees to disclose immediately any material federal, state, or local sanctions of any kind, imposed subsequent to the date of this Agreement, or any investigation which commences subsequent to the date of this Agreement, that would materially adversely impact Company's ability to perform its obligations hereunder.

14. **NOTICES.** All notices, requests, and other communications to any party hereto shall be in writing and shall be addressed to the receiving party's address set forth below or to any other address as a party may designate by notice hereunder, and shall either be (a) delivered by hand, (b) sent by recognized overnight courier, or (c) by certified mail, return receipt requested, postage prepaid.

If to Hospital:
Shore Health System d/b/a Easton
Memorial Hospital
219 South Washington Street
Easton, MD 21601
Attn: Gerard M. Walsh
Senior Vice President and COO

If to Company:
Renal Treatment Centers – Mid-Atlantic, Inc.
C/o: DaVita Inc.
5200 Virginia Way
Brentwood, TN 37027
Attn: Group General Counsel

With copies to: Easton Dialysis
C/o: DaVita Inc.
402 Marvel Court
Easton, MD 21601
Attn: Facility Administrator

DaVita Inc.
601 Hawaii Street
El Segundo, California 90245
Attention: General Counsel

All notices, requests, and other communication hereunder shall be deemed effective (a) if by hand, at the time of the delivery thereof to the receiving party at the address of such party set forth above, (b) if sent by overnight courier, on the next business day following the day such notice is delivered to the courier service, or (c) if sent by certified mail, five (5) business days following the day such mailing is made.

15. ASSIGNMENT. This Agreement shall not be assigned in whole or in part by either party hereto without the express written consent of the other party, except that Company may assign this Agreement to one of its affiliates or subsidiaries without the consent of Hospital.

16. COUNTERPARTS. This Agreement may be executed simultaneously in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Copies of signatures sent by facsimile shall be deemed to be originals.

17. NON-DISCRIMINATION. All services provided by Hospital hereunder shall be in compliance with all federal and state laws prohibiting discrimination on the basis of race, color religion, sex national origin, handicap, or veteran status.

18. WAIVER. The failure of any party to insist in any one or more instances upon performance of any terms or conditions of this Agreement shall not be construed as a waiver of future performance of any such term, covenant, or condition, and the obligations of such party with respect thereto shall continue in full force and effect.

19. GOVERNING LAW. The laws of the State of Maryland shall govern this Agreement.

20. HEADINGS. The headings appearing in this Agreement are for convenience and reference only, and are not intended to, and shall not, define or limit the scope of the provisions to which they relate.

21. ENTIRE AGREEMENT. This Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes any and all other agreements,

either oral or written, between the parties (including, without limitation, any prior agreement between Hospital and Company or any of its subsidiaries or affiliates) with respect to the subject matter hereof.

22. **APPROVAL BY DAVITA INC. ("DAVITA") AS TO FORM.** The parties acknowledge and agree that this Agreement shall take effect and be legally binding upon the parties only upon full execution hereof by the parties and upon approval by DaVita Inc. as to the form hereof.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement the day and year first above written.

Hospital:

Shore Health System d/b/a Easton Memorial Hospital

By: _____
Name: GERARD H. WALSH
Title: SR V.P & C.O.O.

Company:

Renal Treatment Centers – Mid-Atlantic, Inc., a Delaware corporation

By: _____
Name: Joan Guest
Title: Regional Operations Director

Approved by DaVita as to form only:

By: _____
Name: Edwin C. Lunsford, III
Title: Group General Counsel

SHORE HEALTH SYSTEM, INC
AND
CANDLE LIGHT COVE

TRANSFER AGREEMENT

This Agreement made this 11th day of April, 2013, by and between **Candle Light Cove and Alzheimer's Care,** a Maryland limited liability corporation, with a principal place of business at 106 W Earle Avenue, Easton Maryland and **Shore Health System.**

Recitals

Candle Light Cove and Alzheimer's Care desires to secure for residents of Candle Light Cove ("Residents") an available bed(s) at Shore Health System, in the event of a situation that requires an emergency evacuation.

Now, therefore, for good and valuable consideration, the receipt of which is hereby acknowledged, Candle Light Cove and Shore Health System agree as follows:

1. Candle Light Cove shall operate the Facility at a first class level consistent with similar first class facilities in Maryland.
    a. At such time as there is a Resident who is in immediate need of evacuation due to an emergency, Candle Light Cove shall contact Shore Health System.
    b. Shore Health System shall have the right to determine if space is available for Residents of Candle Light Cove that are in need of emergency evacuation.
    c. Shore Health System agrees to support Candle Light Cove in the emergency evacuation of its residents regardless of creed, race, gender, religious preferences or any of class as protected by law.

2. Both parties agree that the placement of Residents would be on a temporary basis until such time as a more permanent placement can be obtained.

3. This Agreement shall be in effect until either party terminates this agreement.

4. All statements, notices and mailings of any nature contemplated hereunder shall be sufficient if delivered to Candle Light Cove, 106 W Earle Ave, Easton MD and Shore Health System, 219 South Washington Street, Easton MD.

5. Each provision of this Agreement will be deemed separate from each other provision and the invalidity or unenforceability of any provision will not affect the validity or enforceability of the balance of this Agreement.

6. This Agreement is to be construed as a Maryland contract and sets forth the entire contract between parties. It shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns and may be canceled, modified or amended only by a written instrument executed by both Shore Health System and Candle Light Cove.

Candle Light Cove

By: Lynne Ewing

Title: Executive Director

Date: 4/11/13

Shore Health System, Inc.

By: [signature]

Title: Sr. V.P. + C.O.O.

Date: 4-24-13

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Addendum to MOU

January 9, 2017

University of Maryland Shore Regional Health (UMSRH), located at 219 S. Washington Street, Easton Maryland, has an understanding with Candle Light Cove that would allow Candle Light Cove to relocate its residents to a UMSRH facility in the event that Candle Light Cove is not able to relocate its residents to their second building on their own property. With this understanding, Candle Light Cove staff would be responsible for providing all related care. It is also understood that this emergency off-site shelter is a temporary relocation only.

Kenneth D. Kozel
President & CEO

PATIENT TRANSFER AGREEMENT

THIS AGREEMENT ("Agreement") is made this 16th day of November 2000, by and between Shore Health System of Maryland and **PENINSULA REGIONAL MEDICAL CENTER,** a Maryland corporation ("Peninsula Regional")(each, a "Party").

WHEREAS:

1. Both Parties to this Agreement are providers of health care services which seek to improve the treatment of patients by providing continuity of care and treatment appropriate to the needs of each such patient;

2. Neither Party offers all services needed by its patients and both wish to make provision for the transfer of its patients for additional needed services;

3. At least one Party does have facilities offering services needed by patients of the other Party and is licensed to provide such services;

4. Each Party needs assurance of a referral mechanism to provide these services to its patients which the Party does not offer; and

5. This Agreement is intended to cover the circumstances where patients may be transferred by either Party to the other. The terms of the Agreement refer to the "Transferor Institution" and "Transferee Institution." Depending upon the circumstances, either Party may be either a "Transferor Institution" or a "Transferee Institution." If a Party is transferring patients, then it is the "Transferor Institution." If a Party is receiving patients, then it is the "Transferee Institution."

NOW, THEREFORE, in consideration of the common aims, interests and mutual advantages accruing to the parties, the Parties covenant and agree as follows

1. **Recitals**. The above recitals are specifically incorporated by reference and hereby made a part of this Agreement,

2. **Autonomy**. The governing authorities of each Party shall have exclusive control of the management, assets and affairs of their respective institutions. Neither Party by virtue of this Agreement assumes any liability for any debts or obligations of any nature incurred by the other party to this Agreement. Neither party will assume responsibility for the care rendered to the patient by the other institution.

3. Each Party shall notify the other of it's designated representative(s) for the purpose of implementing this Agreement. In the event that Transferor Institution has a patient in need of services it does not provide and which Transferee Institution does provide, Transferor Institution will contact the designated representative of Transferee Institution who will recommend to Transferor Institution whether the

patient should be transferred from Transferor Institution to Transferee Institution. It shall be the responsibility of the Transferor Institution to determine that the patient can be transferred without harm. If Transferee Institution recommends that the patient be transferred to Transferee Institution, then the designated representative shall confirm to the Transferor Institution that the Transferee Institution consents to the transfer and that the patient meets Transferee Institution's admission criteria relating to appropriate bed, the patient's required level of care, and physician and other services necessary to treat the patient. The designated representative of Transferee Institution shall accept or arrange for acceptance of such patient on behalf of Transferee Institution and shall arrange for all necessary administrative authorizations for the transfer. The transfer of any such patients from Transferor Institution to Transferee Institution will be effected in accordance with federal and state law and regulations. Transferee Institution and Transferor Institution mutually agree to exercise their best efforts to provide for prompt admission of these patients to Transferee Institution.

4. In the event of transfer, it shall be the responsibility of the patient's physician at Transferor Institution to determine the safest and most appropriate means to transfer the patient to Transferee Institution. Transferor Institution will provide or arrange for an ambulance or other transport equipment which is able to provide appropriate treatment during transport. The Transferor Institution will provide medically appropriate personnel and equipment that a reasonable and prudent physician exercising ordinary care would use for the transfer. The transport shall use medically appropriate life-support measures that a reasonable and prudent physician exercising ordinary care would use to stabilize the patient before transfer and to sustain the patient during the transfer. Transferor Institution shall be solely responsible for all costs, or for the arrangement of coverage of all costs, or transporting the patient, including the costs of any necessary personnel, Transferor Institution shall he responsible for notifying Transferee Institution of the impending transfer, providing explanations of the reason for the transfer and any alternatives to the transfer to the patient or patient's Parent(s) or legal guardian(s), as well as obtaining approval for the transfer from such person. Transferor institution shall be solely responsible for assuring that all transfers under this Agreement comply with all federal and/or State requirements which govern the transfer of patients.

5. In compliance with 42 USCA 1395dd, 42 C.F.R. 489.24, Md. Health-Gen. Code Ann. 19-308.2, and COMAR 10. 07. 01. 23, Transferor Institution will provide a copy of the patient's medical records to Transferee Institution. This shall include medical records related to the patient's emergency medical condition, history and physical observations of signs, symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies or telephone reports of the studies, treatment provided, x-rays, results of any tests, written informed consent to the transfer (or physician certification as to the necessity of transfer), copies of any relevant signed consent forms, and any advance directives or other legal guidance believed by Transferor Institution to be currently in effect. A medication

schedule for the previous twelve (12) hours with dose and administration will be provided. These records should accompany the patient at the time of the transfer. For an emergent patient, the medical record may be faxed (within one hour) if time does not allow for photocopying.

6. As soon as a transfer has been made, it shall be the responsibility of Transferor Institution to advise the financially responsible party or agency of the transfer. Each party to this Agreement is solely responsible for all matters pertaining to billing and collecting its own patient charges. Neither party shall have any liability to the other for such charges nor shall be liable for any debts, obligations or claims of a financial or legal nature to the other party.

7. To maintain the quality of care to the transferred patients, all cases will be reviewed by Transferee Institution's Quality Assurance Department. The result of these reviews will be promptly communicated to Transferor Institution.

8. Transferor Institution and Transferee Institution agree that they will provide and ensure maximum confidentiality accorded by law with regard to all medical, business or other records generated in accordance with this Agreement.

9. Nothing in this Agreement shall be construed as limiting the rights of either Party to affiliate or contract with any other institution while this Agreement is in effect.

10. Neither Party shall use the name of the other Party in any promotion or advertising unless prior written approval of the intended use is obtained from the Party whose name is to be used.

11. This Agreement supersedes any relevant prior agreements between the Parties. This Agreement may be modified or amended from time to time by mutual agreement of the Parties and such modifications or amendments shall he attached to and become a part of this Agreement. This Agreement may not be assigned by either Party without the prior written consent of the other. This Agreement shall be construed and enforced in accordance with the laws of the State of Maryland.

12. Neither Party shall be entitled to compensation from the other Party for any services provided under this Agreement.

13. Transferor Institution shall be solely responsible for complying with State and Federal laws and regulations governing patient transfers. Transferor Institution shall not use the patient's inability to pay or source of payment for the patient as a reason to transfer the patient.

14. All notices hereunder shall be in writing and shall be deemed to have been duly given if delivered in hand or sent by registered or certified mail, postage prepaid,

to each Party at the address set forth below. Either Party may designate a different address by written notice given in the manner provided herein.

If to Peninsula Regional:

Peninsula Regional Medical Center
100 East Carroll Street
Salisbury, MD 21801
Attn: President

If to Shore Health System of Maryland:

Shore Health System of Maryland
219 S. Washington Street
Easton, MD 21601
Attn: Administrator

15. This Agreement shall commence as of the date set forth above and shall continue in effect for one year unless it is terminated by either Party. This Agreement shall be renewed for additional terms of one (1) year each in the absence of notice of intent not to renew given by either party. This Agreement may be terminated at any time by an authorized representative of the parties to this Agreement by providing the other Party with 30 days' prior written notice. However, this Agreement shall be automatically terminated if either Party has its license to operate revoked by the State of Maryland, its ability to participate in the Medicare and/or Medicaid programs is terminated, or if it loses accreditations by the Joint Commission or Accreditation of Healthcare organizations.

IN WITNESS WHEREOF, the authorized representatives of the parties to this Agreement have caused their respective principal's name to be subscribed to this Agreement.

PENINSULA REGIONAL MEDICAL CENTER
a Maryland corporation

Sharon R. Hassington

By: _____
Authorized Representative
Date: 11/17/00

_____

By: _____
Authorized Representative
Date: 11/27/00

prmc\patient transfer agr. 1109

ORIGINAL

STEMI PATIENT TRANSFER
MEMORANDUM OF UNDERSTANDING

THIS MEMORANDUM OF UNDERSTANDING ("MOU") is made and entered into by and between Peninsula Regional Medical Center, located at 100 East Carroll Street, Salisbury, Maryland ("PRMC") and Shore Health System, Inc. ("SHS"), on behalf of its wholly owned and operated acute care hospitals, The Memorial Hospital, located at 219 S. Washington Street, Easton, Maryland and Dorchester General Hospital, located at 300 Bryn Street, Cambridge, MD 21613, (individually and collectively referred to herein as SHS facilities).

RECITALS:

WHEREAS, SHS facilities do not perform certain cardiac procedures that may be required by patients presenting with ST-segment elevation MI ("STEMI patients");

WHEREAS, PRMC does perform such procedures and further is a designated by the Maryland Institute for Emergency Medical Services Systems (MIEMSS) designated Cardiac Interventional Center (CIC);

WHEREAS, SHS desires to arrange for the provision of needed cardiology and cardiac services to its STEMI patients and facilitate the continuity of their care by transferring such patients to PRMC in order to receive the necessary cardiac procedures; and

WHEREAS, PRMC desires to accept such transfers and to provide such services to SHS's transferred STEMI patients;

NOWTHEREFORE, in consideration of the mutual covenants and agreements set forth herein, PRMC, and SHS agree as follows;

1. **TRANSFER OF PATIENTS.** All transfers between any SHS facility and PRMC shall be performed in accordance with applicable federal and state statutes and regulations, the standards of The Joint Commission, and the MIEMMS Interhospital Transfer Guidelines. In addition, in the course of effectuating a transfer addressed by this MOU, both SHS and PRMC shall adhere to their own reasonable policies and procedures applicable to patient transfers. Both PRMC and SHS agree to retain data regarding performance measures of services provided under this MOU as may be necessary for purposes of certification and/or accreditation. Neither the acceptance of the transfer of a STEMI a patient nor the refusal to accept the transfer of a STEMI patient shall be predicated upon arbitrary, capricious, or unreasonable grounds or discrimination or based upon the patient's inability to pay for services rendered by either PRMC or SHS.

2. **RESPONSIBILITIES OF THE TRANSFERRING FACILITY.** SHS facilities shall evaluate for transfer all patients determined to be STEMI patients as

defined by the MIEMMS regulations at COMAR 30.08.16.01. If a SHS facility determines transfer of a STEMI patient is appropriate, decides to transfer such STEMI patient to PRMC, and concludes the transfer to PRMC meets the MIEMMS Interhospital Transfer Guidelines such SHS facility, as the "Transferring Facility," shall be responsible for performing or ensuring performance of the following:

a. Provide for a member of the nursing staff or the patient's attending physician to contact the Peninsula Access Center using the contact information set forth in Section 12;

b. Provide, within its capabilities, evaluation of the patient for transfer, medical screening and stabilizing treatment of the patient prior to transfer;

c. Arrange for the patient's safe and appropriate transportation to PRMC, the use of appropriate equipment and personnel and the appropriate care for the patient during transfer, in accordance with applicable federal and state laws and regulations and the MIEMMS Interhospital Transfer Guidelines;

d. Select an authorized representative of the Transferring Facility to coordinate the patient's transfer ("Designated Representative") and provide the name of such designated representative to the Receiving Facility.

e. Communicate to the Receiving Facility the Receiving Physician, defined as the treating physician's or patient's choice of physician or cardiology practice to receive the patient once transferred to the Receiving Facility, the physician providing coverage for chosen Physician or cardiology group, or if those Receiving Physicians are unavailable, the on-call cardiologist, all of whom shall be properly credentialed, licensed and experienced cardiologists ("Receiving Physician");

f. Forward to the Receiving Physician and the Receiving Facility a copy of those portions of the patient's medical record that are available at the time of transfer and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of transfer. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible via the fax number in Section 12.

g. Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items.

3. RESPONSIBILITIES OF THE RECEIVING FACILITY. PRMC's responsibility for the patient's care, as the "Receiving Facility," shall begin when the

patient arrives at or is admitted to the Receiving Facility. Specifically, the Receiving Facility shall be responsible for performing or ensuring performance of the following:

a. Arrange for the availability of the Receiving Physician requested by the patient's treating physician or the patient. If such physician is not reasonably available, provide for a properly credentialed, licensed and experienced Receiving Physician.

b. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the Receiving Physician with the receipt and treatment of the patient transferred, maintain a call roster of eligible Receiving Physicians at the Receiving Facility and provide, on request, the name of a Receiving Physician requested based on standing orders or the Receiving Physician providing coverage for that Receiving Physician's group, or the on-call Receiving Physician, to the Transferring Facility.

c. Reserve beds, facilities, and services as appropriate for STEMI patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a Receiving Physician. Transferred STEMI patients shall be treated in the emergency department, sent to the cardiac catheterization laboratory, directly admitted to a patient room, and/or sent to the operating room, as appropriate based on the patient's medical needs.

d. Select an authorized representative of the Receiving Facility to coordinate the patient's transfer ("designated representative") and provide the name of such designated individual to the Transferring Facility.

e. When the Transferring Facility cannot arrange for necessary personnel or equipment, and when appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the Transferring Physician (Physician at SHS who is responsible for the patient prior to transfer) and Receiving Physician.

f. Maintain the confidentiality of the patient's medical records in accordance with applicable state and federal law.

g. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medial records in accordance with applicable state and federal law, (ii) for the receipt of the patient into the facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient.

h. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider, including the MIEMMS standards for the transfer of STEMI patients.

4. BILLING. All charges incurred with respect to any services performed by either PRMC or SHS for transferred STEMI patients shall be billed and collected by the

party furnishing such services. In addition, it is understood that professional fees will be billed by the physicians or other professional providers at SHS facilities and/or PRMC that may participate in the care and treatment of the patient. Both SHS and PRMC agree to provide information in its possession to the other and to physicians/providers sufficient to enable the treating providers to bill for services provided..

5. DISCHARGE. When the transferred patient is ready for discharge as appropriate to the patient's medical condition, the Receiving Physician shall contact the Transferring Physician or the patient's primary care physician.

6. COMPLIANCE WITH LAW. SHS and PRMC shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of medical records, confidentiality or patient information, and the rules and standards of MIEMMS for the transfer and treatment of STEMI patients, as well as with all standards promulgated by any relevant accrediting agency.

7. RESPONSIBILITY; INSURANCE. SHS and PRMC shall be responsible for their own acts and omissions in the performance of their duties, and the acts and omissions of their own employees and agents. In addition, each party shall maintain, throughout the term of this MOU, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party, and shall provide evidence of that coverage upon request.

8. TERM; TERMINATION.

a. Term; Renewal. The initial term of this MOU ("Initial Term") shall be for a period of 3 year(s), commencing on 5-18, 2011 unless sooner terminated herein. At the end of the Initial Term and upon mutual written agreement of the parties, this MOU may be renewed for subsequent additional terms of one (1) year ("Renewal Terms").

b. Holdover. In the event the parties continue to abide by the terms of this MOU after the expiration of the Initial Term or any Renewal Term, without renewing the MOU in accordance with Section 8.a., this MOU shall continue on a month-to-month basis.

c. Termination Without Cause. Either party may terminate this MOU without cause upon thirty (30) days written notice to the other party.

d. Termination for Breach. Either party may terminate this MOU upon breach by the other party of any material provision of this MOU, provided the breach continues for five (5) days after receipt by the breaching party of written notice of the breach from the non-breaching party.

e. Immediate Termination. Either party may terminate this MOU immediately upon the occurrence of any of the following events:

i. The other party's closure or discontinuation of operation to such an extent that patient care cannot be carried out adequately.

ii. The other party's loss of its license, conviction of a criminal offense related to health care, inclusion on a federal agency's list of entities and individuals who are debarred, excluded or otherwise ineligible for federal program participation.

9. ENTIRE AGREEMENT; MODIFICATION. This MOU contains the entire understanding of the parties with respect to the subject matter and supersedes all prior agreements, oral or written, and all other communications between the parties relating to the subject matter. This MOU may not be amended or modified except by mutual agreement.

10. GOVERNING LAW. This Agreement shall be construed in accordance with the laws of the State of Maryland. The provisions of this Paragraph shall survive expiration or other termination of this MOU regardless of the cause of the termination.

11. PARTIAL INVALIDITY. If any provision of this MOU is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this MOU.

12. NOTICES. All notices by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to PRMC: Peninsula Regional Medical Center
100 East Carroll Street
Salisbury, Maryland 21801
Attn: Executive Director
Guerrieri Heart and Vascular Institute
Fax: 410-912-5757

Peninsula Access Center 410-543-4722

If to SHS: Shore Health System, Inc.
219 South Washington Street
Easton, Maryland 21601
Attn: Director of Cardiology

or to such other persons or places as any party may from time to time designate by written notice to the other.

13. WAIVER. A waiver by any party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. ASSIGNMENT; BINDING EFFECT. Neither party shall assign or transfer, in whole or in part, this MOU or any of their rights, duties or obligations under this MOU without the prior written consent of the other party, and any assignment or transfer by any party without such consent shall be null and void. This MOU shall inure to the benefit of and be binding upon the parties and their respective heirs, representatives, successors and permitted assignees.

THE PARTIES have executed this Agreement on 5-25, 2011

SHORE HEALTH SYSTEM, INC.

By: _____
Gerard M. Walsh
Interim President and CEO

Date: 5-18-11

PENINSULA REGIONAL MEDICAL CENTER

By: _____
Margaret (Peggy) M. Naleppa, DR.M.
President/CEO

Date: 5-25-2011

TRANSFER AGREEMENT

This Transfer Agreement is entered into on 8-11-19, by and between Anne Arundel Health System, Inc. ("AAHS") and Queen Anne's Emergency Center ("Queen Anne"), a health care facility owned and operated by Shore Health System, Inc. ("Shore Health").

WHEREAS, both parties desire to assure continuity of care and treatment appropriate to the needs of each patient and to use the skills, resources, and physical plant of both parties in a coordinated and cooperative fashion to improve patient care at both the acute and post-acute stages of illness.

NOW, THEREFORE, in consideration of the mutual advantages occurring to the parties hereto, AAHS and Shore Health hereby covenant and agree with each other as follows:

1. Both parties agree to make a concerted effort to transfer patients as soon as practical when the need for transfer from Queen Anne to AAHS has been determined by the patient's attending physician, provided, however, all eligibility conditions for admission must be met and documented in the patient's medical record.

2. Queen Anne agrees to send with each patient at the time of transfer or, in the case of any emergency as promptly as possible after the transfer, an abstract of the patient's medical record including:

   (A) Current medical findings;
   (B) Diagnosis;
   (C) Brief summary of the course of treatment followed;
   (D) All other administrative and social information useful to provide continuing care to the patient; using the transfer and referral form mutually agreed upon.

3. Queen Anne, after promptly notifying AAHS of the impending transfer of a patient and after AAHS consents to accept such patient, shall assume the responsibility to arrange for appropriate and safe transportation of the patient, his/her personal effects and valuables, and shall provide any necessary care while he/she is being transferred.

4. Charges for services performed by either Queen Anne or AAHS for patients transferred from the other institution pursuant to this Agreement, shall be collected by the institution rendering such services, directly from the patient, third party payers, or the other sources normally billed by the institution; and neither party shall have any liability to the other for such charges except to the extent that such liabilities would exist separate and apart from this Agreement.

5. The parties agree that the transfer of a patient pursuant to this Agreement shall not be predicated upon discrimination based on race, religion, national origin, age, sex, physical condition or economic status. The parties also agree that the transfer or receipt of patients shall

not be based upon a patient's inability to pay for services rendered by the transferring or receiving institution or a patient's source of payment.

6. All patient transfers pursuant to this Agreement must be accomplished in a medically appropriate manner from physician to physician and from institution to institution by: (i) the use of appropriate life support measures which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to stabilize the patient prior to transfer and to sustain the patient during the transfer; (ii) the provision of appropriate personnel and equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use for the transfer; (iii) the transfer of all necessary records for continuing the care for the patient; and (iv) the consideration of the availability of appropriate facilities, services, and staff for providing care for the patient. The parties agree that before moving a patient, Queen Anne shall explain the reasons for the transfer and any alternative to the patient or a legally authorized representative of the patient. If it is necessary to move the patient immediately to protect the health, safety or welfare of the patient, Queen Anne may give the explanation of the reasons for the transfer concurrently with the transfer.

7. The parties agree to recognize the right of a patient to request transfer into the care of a physician and institution of the patient's own choosing and to recognize and comply with all federal and state requirements relating to the transfer of patients.

8. Queen Anne agrees not to transfer a patient with an emergency medical condition that has not been stabilized unless: (i) the patient, or a legally responsible person acting on the patient's behalf after being informed of Queen Anne's obligations under law and of the risk of transfer, requests in writing transfer to another institution; (ii) a licensed physician has signed a certification which includes a summary of the risks and benefits that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another institution outweigh the increased risks to the patient and, in the case of labor, to the unborn child from effecting the transfer; or (iii) if a licensed physician is not physically present at the time a patient is transferred, a qualified medical person has signed a certification described in subparagraph (ii) above after a license physician, in consultation with the person, has made the determination described in subparagraph (ii) above and subsequently countersigns the certificate.

9. All notices hereunder by either party to the other party shall be in writing, delivered personally or by overnight courier, and shall be deemed to have been duly given when delivered personally or one day after delivered to the overnight carrier, charges prepaid, and properly addressed to the respective parties at the addresses shown following each party's signature to this Agreement.

10. This Agreement shall be effective from the date of signing by both parties and shall continue in effect, except that either party may withdraw by giving sixty (60) days written notice to the other party of its intention to terminate this Agreement. However, this Agreement shall be declared null and void and shall be immediately terminated should either party fail to maintain its licensure or certification status.

11. Both parties represent and warrant that, during the term of this Agreement, each shall comply with all applicable state and federal laws and regulations and shall remain in good standing with applicable accrediting organizations.

12. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other institution, on either a limited or general basis, while this Agreement is in effect.

13. This Agreement may be modified or amended by the mutual agreement of the parties; however, any such modification or amendment shall be attached to and become a part of this Agreement. This Agreement shall be construed in accordance with the laws of the State of Maryland.

ANNE ARUNDEL HEALTH SYSTEM, INC.

By: _____

Name: Mitchell Schwartz MD

Title: Chief Med. Officer

2001 Medical Parkway
Annapolis, Maryland 21401

SHORE HEALTH SYSTEM, INC.

By: _____

Name: Gerard M. Walsh

Title: Sr. V.P. + C.O.O.

219 South Washington Street
Easton, Maryland 21601

FORT WASHINGTON MEDICAL CENTER
PATIENT TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (the "Agreement") is made as of this 16th day of May 2017, by and between FORT WASHINGTON MEDICAL CENTER and UNIVERSITY OF MARYLAND MEDICAL CENTER AT EASTON, each individually referred to herein as "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of this Agreement, and collectively as "facilities."

WITNESSETH:

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between the two facilities; and,

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities.

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties agree as follows:

1. TRANSFER OF PATIENTS. In the event any patient of either facility is deemed by the Transferring Facility as requiring the services of the Receiving Facility and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department, whichever is applicable, of the Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon discriminatory, unreasonable, arbitrary, or capricious reasons or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. RESPONSIBILITIES OF THE TRANSFERRING FACILITY. The Transferring Facility shall be responsible for performing or ensuring performance of the following:
    a. Provide, within its capabilities, stabilizing treatment of the patient prior to transfer;
    b. Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;
    c. Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility;
    d. Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;
    e. Prior to patient transfer, if for direct admission, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;
    f. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;
    g. Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;
    h. Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and a copy of the patient's executed Advance Directives. If all necessary and relevant medical records are not available at the time the

patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible;

i. Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items;

j. Notify the Receiving Facility of the estimated time of arrival of the patient;

k. Provide the Receiving Facility any information available about the patient's coverage under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district (ABN attached);

l. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

m. Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

n. Recognize the right of a patient to refuse to consent to treatment or transfer;

o. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility; and,

p. Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

3. RESPONSIBILITIES OF THE RECEIVING FACILITY. The Receiving Facility shall be responsible for performing or ensuring performance of the following:

a. Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility promptly after receipt of the request to transfer a patient with an emergency medical condition or in active labor;

b. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred, maintain a call roster of physicians at the Receiving Facility and provide, on request, the names of on-call physicians to the Transferring Facility;

c. Reserve beds, facilities, and services as appropriate for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by the Receiving Facility for an emergency;

d. Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility;

e. When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

f. Upon discharge of the patient back to the Transferring Facility, provide the Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department;

g. Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;

h. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into its facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient;

i. Provide for the return transfer of the patients to the Transferring Facility when requested by the patient or the Transferring Facility and ordered by the patient's attending/transferring physician, if the Transferring Facility has a statutory or regulatory obligation to provide health care assistance

to the patient, and if transferred back to the Transferring Facility, provide the items and services required of a Transferring Facility in Section 2 of this Agreement.

j. Provide the Transferring Facility any information available about the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

k. Upon request, provide current information concerning its eligibility standards and payment practices to the Transferring Facility and patient;

l. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

m. Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

4. BILLING. All claims or charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party payer, Medicare or Medicaid, or other sources appropriately billed by that facility, unless applicable law and regulations require that one facility bill the other facility for such services. In those cases in which the regulations apply, the facilities shall bill in accordance to the regulations that apply to skilled nursing facility prospective payment system ("SNF PPS") and consolidated billing. In those cases in which payment rates are consistent with SNF PPS regulations and have been negotiated, such payment shall be made in accordance with the payment fee schedule, available upon request. In addition, it is understood that professional fees will be billed by those physicians or other professional providers who actually participate in the care and treatment of the patient and who are entitled to bill for their professional services at usual and customary rates. Each facility agrees to provide information in its possession to the other facility and such physicians or professional providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payer.

5. TRANSFER, TRANSFER BACK; DISCHARGE; POLICIES. The transferring institution shall have the responsibility for arranging transportation of the patient to the receiving institution, including selection of the mode of transportation and provide the appropriate practitioner(s) to accompany the patient and shall transfer with the patient all relevant patient data, necessary to continue treatment without interruption, including, but not limited to, a copy of all applicable medical records, including progress notes and discharge summaries, available at the time of transfer; all informed written consents (including advance notice and written acknowledgments of costs which may not be covered by the patient's insurer or payor) (ABN) or certifications required by statute, rule or regulation; any administrative and pertinent identifying information; and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment to the patient, if applicable. The receiving institution's responsibility for the patient's care shall begin when the patient is formally admitted to that institution as a patient of that institution.

   The transferring institution agrees to receive the patient back from the receiving institution, if requested by the receiving institution, when the patient no longer requires the specialized care and facilities of the receiving institution and any requirements of patient consent and physician certification has been satisfied.

6. COMPLIANCE WITH LAW. Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. INDEMNIFICATION; INSURANCE. The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents, and shall indemnify and hold harmless the other party from and against any and all claims, liabilities, causes of action, losses, costs, damages and expenses (including reasonable attorney's fees) incurred by the other party as a result of such acts and omissions. [For MD Facilities] *In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional*

liability insurance and property damage insurance coverage in amounts not less than those required by state law [currently professional liability in MARYLAND is One Million ($1,000,000.00) per occurrence and Three Million ($3,000,000.00)] in the aggregate, and a party shall provide evidence of such coverage upon request. [For VIRGINIA Facilities] *In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts not less than those required by state law [currently, the minimum amount of Virginia professional liability insurance required is Two Million ($2,000,000.00) per occurrence plus an additional $50,000 on each July 1st for 20 years beginning July 1, 2012] and a party shall provide evidence of such coverage upon request.*

8. TERM; TERMINATION. The term of this Agreement shall be one (1) year, commencing on the 16th day of MAY, 2017, and ending on the 16th day of MAY, 2018, unless sooner terminated as provided herein. This Agreement shall be automatically renewed for successive terms of twelve (12) months unless one party notifies the other on or before ninety (90) days prior to the end of the then-current term, in writing, of its intent to terminate. Either party may terminate this Agreement without cause upon thirty (30) days advance written notice to the other party. Either party may terminate this Agreement upon breach by the other party of any provision of this Agreement, provided such breach continues for ten (10) days after receipt by the breaching party of written notice of such breach from the non-breaching party. This Agreement may be terminated immediately upon the occurrence of any of the following events:
    a. Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately, or
    b. Either facility loses its license, or Medicare certification.

9. ENTIRE AGREEMENT; MODIFICATION. This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

10. GOVERNING LAW. This Agreement shall be construed in accordance with the laws of the state in which the facility is located.

11. PARTIAL INVALIDITY. If any provision of this Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this Agreement.

12. NOTICES. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to UNIVERSITY OF MARYLAND MEDICAL CENTER AT EASTON:

Address: 219 South Washington Street
Easton, MD 21601
Attention: Mr. Kenneth Kozel, President
(410) 822-1000

If to FORT WASHINGTON MEDICAL CENTER:

Address: 174 Waterfront Street
Suite 225
Oxon Hill, MD 20745
Attention: Reginald Jones, President & CEO
(301) 686-9010

With copy to:

Address: 174 Waterfront Street
Suite 225
Oxon Hill, MD 20745
Attention: Donna Jennings, CCO
(276) 614-8804

or to such other persons or places as either party may from time to time designate by written notice to the other.

13. WAIVER. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. ASSIGNMENT; BINDING EFFECT. Facilities shall not assign or transfer, in whole or in part, this Agreement or any of Facilities' rights, duties or obligations under this Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. This Agreement shall inure to the benefit of and are binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

15. CHANGE IN LAW. Notwithstanding any other provision of this Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payer, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while this Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under this Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend this Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If this Agreement is not so amended in writing within seven (7) days after said notice was given, this Agreement shall terminate as of midnight local time on the third (3rd) day after said notice was given.

16. GOVERNMENT ACCESS TO AGREEMENT AND RECORDS. Each party shall, in accordance with 42 U.S.C. § 1395x(v)(1)(I) (Social Security Act § 1861(v)(1)(I)) and 42 C.F.R. § 420.300 *et seq.*, until the expiration of six (6) years after the furnishing of Medicare reimbursable services pursuant to this Agreement, upon proper written request, allow the comptroller General of the United States, the Department of Health and Human Services, and their duly authorized representatives access to this Agreement and to it's or its subcontractors' books, documents and records (as such terms are defined in 42 C.F.R. § 420-301) necessary to verify the nature and extent of costs of Medicare and/or Medicaid reimbursable services provided under this Agreement. In accordance with such laws and regulations, if Medicare reimbursable services provided by any party under this Agreement are carried out by means of a subcontract with an organization related to either party, and such related organization provides the services at a value or cost of $10,000 or more over a twelve-month period, then the subcontract between that party and the related organization shall contain a clause comparable to the clause specified in the preceding sentence. In the event any request for this Agreement or either party's books, documents, and records is made pursuant to Social Security Act § 1861(v)(1)(I) and associated regulations, that party shall promptly give notice of such request to the other party and provide that party with a copy of such request and, thereafter, consult and cooperate with that party concerning the proper response to such request. Additionally, each party shall provide the other with a copy of each book, document, and record made available to one or more persons and agencies pursuant to Social Security Act § 1861(v)(1)(I) or shall identify each such book, document, and record to the other party and shall grant that party access thereto for review and copying.

17. EXECUTION OF AGREEMENT. This Agreement shall not become effective or in force until all of the below named parties have fully executed this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year written above.

UNIVERSITY OF MARYLAND MEDICAL CENTER AT EASTON

By: _____

Name: KENNETH KOZEL

Title: CEO

Date: 5/16/17

FORT WASHINGTON MEDICAL CENTER

By: _____

Name: REGINALD JONES

Title: Interim President & CEO

Date: 5/16/17

FORT WASHINGTON MEDICAL CENTER
PATIENT TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (the "Agreement") is made as of this 12th day of May Shore 2017, by and between FORT WASHINGTON MEDICAL CENTER and UNIVERSITY OF MARYLAND MEDICAL CENTER AT CHESTERTOWN, each individually referred to herein as "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of this Agreement, and collectively as "facilities."

WITNESSETH:

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between the two facilities; and,

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities.

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties agree as follows:

1. TRANSFER OF PATIENTS. In the event any patient of either facility is deemed by the Transferring Facility as requiring the services of the Receiving Facility and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department, whichever is applicable, of the Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon discriminatory, unreasonable, arbitrary, or capricious reasons or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. RESPONSIBILITIES OF THE TRANSFERRING FACILITY. The Transferring Facility shall be responsible for performing or ensuring performance of the following:
    a. Provide, within its capabilities, stabilizing treatment of the patient prior to transfer;
    b. Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;
    c. Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility;
    d. Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;
    e. Prior to patient transfer, if for direct admission, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;
    f. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;
    g. Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;
    h. Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and a copy of the patient's executed Advance Directives. If all necessary and relevant medical records are not available at the time the

patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible;

i. Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items;

j. Notify the Receiving Facility of the estimated time of arrival of the patient;

k. Provide the Receiving Facility any information available about the patient's coverage under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district (ABN attached);

l. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

m. Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

n. Recognize the right of a patient to refuse to consent to treatment or transfer;

o. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility; and,

p. Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

3. RESPONSIBILITIES OF THE RECEIVING FACILITY. The Receiving Facility shall be responsible for performing or ensuring performance of the following:

a. Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility promptly after receipt of the request to transfer a patient with an emergency medical condition or in active labor;

b. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred, maintain a call roster of physicians at the Receiving Facility and provide, on request, the names of on-call physicians to the Transferring Facility;

c. Reserve beds, facilities, and services as appropriate for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by the Receiving Facility for an emergency;

d. Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility;

e. When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

f. Upon discharge of the patient back to the Transferring Facility, provide the Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department;

g. Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;

h. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into its facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient;

i. Provide for the return transfer of the patients to the Transferring Facility when requested by the patient or the Transferring Facility and ordered by the patient's attending/transferring physician, if the Transferring Facility has a statutory or regulatory obligation to provide health care assistance

to the patient, and if transferred back to the Transferring Facility, provide the items and services required of a Transferring Facility in Section 2 of this Agreement.

j. Provide the Transferring Facility any information available about the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

k. Upon request, provide current information concerning its eligibility standards and payment practices to the Transferring Facility and patient;

l. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

m. Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

4. BILLING. All claims or charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party payer, Medicare or Medicaid, or other sources appropriately billed by that facility, unless applicable law and regulations require that one facility bill the other facility for such services. In those cases in which the regulations apply, the facilities shall bill in accordance to the regulations that apply to skilled nursing facility prospective payment system ("SNF PPS") and consolidated billing. In those cases in which payment rates are consistent with SNF PPS regulations and have been negotiated, such payment shall be made in accordance with the payment fee schedule, available upon request. In addition, it is understood that professional fees will be billed by those physicians or other professional providers who actually participate in the care and treatment of the patient and who are entitled to bill for their professional services at usual and customary rates. Each facility agrees to provide information in its possession to the other facility and such physicians or professional providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payer.

5. TRANSFER, TRANSFER BACK; DISCHARGE; POLICIES. The transferring institution shall have the responsibility for arranging transportation of the patient to the receiving institution, including selection of the mode of transportation and provide the appropriate practitioner(s) to accompany the patient and shall transfer with the patient all relevant patient data, necessary to continue treatment without interruption, including, but not limited to, a copy of all applicable medical records, including progress notes and discharge summaries, available at the time of transfer; all informed written consents (including advance notice and written acknowledgments of costs which may not be covered by the patient's insurer or payor) (ABN) or certifications required by statute, rule or regulation; any administrative and pertinent identifying information; and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment to the patient, if applicable. The receiving institution's responsibility for the patient's care shall begin when the patient is formally admitted to that institution as a patient of that institution.

   The transferring institution agrees to receive the patient back from the receiving institution, if requested by the receiving institution, when the patient no longer requires the specialized care and facilities of the receiving institution and any requirements of patient consent and physician certification has been satisfied.

6. COMPLIANCE WITH LAW. Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. INDEMNIFICATION; INSURANCE. The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents, and shall indemnify and hold harmless the other party from and against any and all claims, liabilities, causes of action, losses, costs, damages and expenses (including reasonable attorney's fees) incurred by the other party as a result of such acts and omissions. [For MD Facilities] *In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional*

liability insurance and property damage insurance coverage in amounts not less than those required by state law [currently professional liability in MARYLAND is One Million ($1,000,000.00) per occurrence and Three Million ($3,000,000.00)] in the aggregate, and a party shall provide evidence of such coverage upon request. [For VIRGINIA Facilities] *In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts not less than those required by state law [currently, the minimum amount of Virginia professional liability insurance required is Two Million ($2,000,000.00) per occurrence plus an additional $50,000 on each July 1st for 20 years beginning July 1, 2012] and a party shall provide evidence of such coverage upon request.*

8. TERM; TERMINATION. The term of this Agreement shall be one (1) year, commencing on the 12th day of May, 2017, and ending on the 11th day of May, 2018, unless sooner terminated as provided herein. This Agreement shall be automatically renewed for successive terms of twelve (12) months unless one party notifies the other on or before ninety (90) days prior to the end of the then-current term, in writing, of its intent to terminate. Either party may terminate this Agreement without cause upon thirty (30) days advance written notice to the other party. Either party may terminate this Agreement upon breach by the other party of any provision of this Agreement, provided such breach continues for ten (10) days after receipt by the breaching party of written notice of such breach from the non-breaching party. This Agreement may be terminated immediately upon the occurrence of any of the following events:
    a. Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately, or
    b. Either facility loses its license, or Medicare certification.

9. ENTIRE AGREEMENT; MODIFICATION. This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

10. GOVERNING LAW. This Agreement shall be construed in accordance with the laws of the state in which the facility is located.

11. PARTIAL INVALIDITY. If any provision of this Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this Agreement.

12. NOTICES. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT CHESTERTOWN:

Address: 100 Brown Street
Chestertown, MD 21061
Attention: Mr. Scott Burleson, Executive Director
(410) 778-3300

If to FORT WASHINGTON MEDICAL CENTER:

Address: 174 Waterfront Street
Suite 225
Oxon Hill, MD 20745
Attention: Reginald Jones, President & CEO
(301) 686-9010

With copy to:

Address: 174 Waterfront Street
Suite 225
Oxon Hill, MD 20745
Attention: Donna Jennings, CCO
(276) 614-8804

or to such other persons or places as either party may from time to time designate by written notice to the other.

13. WAIVER. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. ASSIGNMENT; BINDING EFFECT. Facilities shall not assign or transfer, in whole or in part, this Agreement or any of Facilities' rights, duties or obligations under this Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. This Agreement shall inure to the benefit of and are binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

15. CHANGE IN LAW. Notwithstanding any other provision of this Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payer, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while this Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under this Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend this Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If this Agreement is not so amended in writing within seven (7) days after said notice was given, this Agreement shall terminate as of midnight local time on the third (3rd) day after said notice was given.

16. GOVERNMENT ACCESS TO AGREEMENT AND RECORDS. Each party shall, in accordance with 42 U.S.C. § 1395x(v)(1)(I) (Social Security Act § 1861(v)(1)(I)) and 42 C.F.R. § 420.300 *et seq.*, until the expiration of six (6) years after the furnishing of Medicare reimbursable services pursuant to this Agreement, upon proper written request, allow the comptroller General of the United States, the Department of Health and Human Services, and their duly authorized representatives access to this Agreement and to it's or its subcontractors' books, documents and records (as such terms are defined in 42 C.F.R. § 420-301) necessary to verify the nature and extent of costs of Medicare and/or Medicaid reimbursable services provided under this Agreement. In accordance with such laws and regulations, if Medicare reimbursable services provided by any party under this Agreement are carried out by means of a subcontract with an organization related to either party, and such related organization provides the services at a value or cost of $10,000 or more over a twelve-month period, then the subcontract between that party and the related organization shall contain a clause comparable to the clause specified in the preceding sentence. In the event any request for this Agreement or either party's books, documents, and records is made pursuant to Social Security Act § 1861(v)(1)(I) and associated regulations, that party shall promptly give notice of such request to the other party and provide that party with a copy of such request and, thereafter, consult and cooperate with that party concerning the proper response to such request. Additionally, each party shall provide the other with a copy of each book, document, and record made available to one or more persons and agencies pursuant to Social Security Act § 1861(v)(1)(I) or shall identify each such book, document, and record to the other party and shall grant that party access thereto for review and copying.

17. EXECUTION OF AGREEMENT. This Agreement shall not become effective or in force until all of the below named parties have fully executed this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year written above.

UNIVERSITY OF MARYLAND MEDICAL CENTER AT CHESTERTOWN

By: _____

Name: SCOTT D BURLESON, MBA, FACHE

Title: Executive Director

Date: 5/12/2017

FORT WASHINGTON MEDICAL CENTER

By: _____

Name: REGINALD JONES

Title: Interim President & CEO

Date: 5/12/2017

FORT WASHINGTON MEDICAL CENTER
PATIENT TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (the "Agreement") is made as of this 25th day of May 2017, by and between FORT WASHINGTON MEDICAL CENTER and UNIVERSITY OF MARYLAND MEDICAL CENTER DORCHESTER, each individually referred to herein as "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of this Agreement, and collectively as "facilities."

WITNESSETH:

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between the two facilities; and,

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities.

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties agree as follows:

1. TRANSFER OF PATIENTS. In the event any patient of either facility is deemed by the Transferring Facility as requiring the services of the Receiving Facility and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department, whichever is applicable, of the Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon discriminatory, unreasonable, arbitrary, or capricious reasons or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. RESPONSIBILITIES OF THE TRANSFERRING FACILITY. The Transferring Facility shall be responsible for performing or ensuring performance of the following:
    a. Provide, within its capabilities, stabilizing treatment of the patient prior to transfer;
    b. Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;
    c. Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility;
    d. Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;
    e. Prior to patient transfer, if for direct admission, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;
    f. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;
    g. Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;
    h. Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and a copy of the patient's executed Advance Directives. If all necessary and relevant medical records are not available at the time the

patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible;

i. Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items;

j. Notify the Receiving Facility of the estimated time of arrival of the patient;

k. Provide the Receiving Facility any information available about the patient's coverage under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district (ABN attached);

l. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

m. Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

n. Recognize the right of a patient to refuse to consent to treatment or transfer;

o. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility; and,

p. Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

3. RESPONSIBILITIES OF THE RECEIVING FACILITY. The Receiving Facility shall be responsible for performing or ensuring performance of the following:

a. Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility promptly after receipt of the request to transfer a patient with an emergency medical condition or in active labor;

b. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred, maintain a call roster of physicians at the Receiving Facility and provide, on request, the names of on-call physicians to the Transferring Facility;

c. Reserve beds, facilities, and services as appropriate for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by the Receiving Facility for an emergency;

d. Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility;

e. When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

f. Upon discharge of the patient back to the Transferring Facility, provide the Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department;

g. Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;

h. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into its facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient;

i. Provide for the return transfer of the patients to the Transferring Facility when requested by the patient or the Transferring Facility and ordered by the patient's attending/transferring physician, if the Transferring Facility has a statutory or regulatory obligation to provide health care assistance

to the patient, and if transferred back to the Transferring Facility, provide the items and services required of a Transferring Facility in Section 2 of this Agreement.

j. Provide the Transferring Facility any information available about the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

k. Upon request, provide current information concerning its eligibility standards and payment practices to the Transferring Facility and patient;

l. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

m. Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

4. BILLING. All claims or charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party payer, Medicare or Medicaid, or other sources appropriately billed by that facility, unless applicable law and regulations require that one facility bill the other facility for such services. In those cases in which the regulations apply, the facilities shall bill in accordance to the regulations that apply to skilled nursing facility prospective payment system ("SNF PPS") and consolidated billing. In those cases in which payment rates are consistent with SNF PPS regulations and have been negotiated, such payment shall be made in accordance with the payment fee schedule, available upon request. In addition, it is understood that professional fees will be billed by those physicians or other professional providers who actually participate in the care and treatment of the patient and who are entitled to bill for their professional services at usual and customary rates. Each facility agrees to provide information in its possession to the other facility and such physicians or professional providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payer.

5. TRANSFER, TRANSFER BACK; DISCHARGE; POLICIES. The transferring institution shall have the responsibility for arranging transportation of the patient to the receiving institution, including selection of the mode of transportation and provide the appropriate practitioner(s) to accompany the patient and shall transfer with the patient all relevant patient data, necessary to continue treatment without interruption, including, but not limited to, a copy of all applicable medical records, including progress notes and discharge summaries, available at the time of transfer; all informed written consents (including advance notice and written acknowledgments of costs which may not be covered by the patient's insurer or payor) (ABN) or certifications required by statute, rule or regulation; any administrative and pertinent identifying information; and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment to the patient, if applicable. The receiving institution's responsibility for the patient's care shall begin when the patient is formally admitted to that institution as a patient of that institution.

   The transferring institution agrees to receive the patient back from the receiving institution, if requested by the receiving institution, when the patient no longer requires the specialized care and facilities of the receiving institution and any requirements of patient consent and physician certification has been satisfied.

6. COMPLIANCE WITH LAW. Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. INDEMNIFICATION; INSURANCE. The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents, and shall indemnify and hold harmless the other party from and against any and all claims, liabilities, causes of action, losses, costs, damages and expenses (including reasonable attorney's fees) incurred by the other party as a result of such acts and omissions. [For MD Facilities] *In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional*

liability insurance and property damage insurance coverage in amounts not less than those required by state law [currently professional liability in MARYLAND is One Million ($1,000,000.00) per occurrence and Three Million ($3,000,000.00)] in the aggregate, and a party shall provide evidence of such coverage upon request. [For VIRGINIA Facilities] *In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts not less than those required by state law [currently, the minimum amount of Virginia professional liability insurance required is Two Million ($2,000,000.00) per occurrence plus an additional $50,000 on each July 1st for 20 years beginning July 1, 2012] and a party shall provide evidence of such coverage upon request.*

8. TERM; TERMINATION. The term of this Agreement shall be one (1) year, commencing on the 25th day of May, 2017, and ending on the 25th day of May, 2018, unless sooner terminated as provided herein. This Agreement shall be automatically renewed for successive terms of twelve (12) months unless one party notifies the other on or before ninety (90) days prior to the end of the then-current term, in writing, of its intent to terminate. Either party may terminate this Agreement without cause upon thirty (30) days advance written notice to the other party. Either party may terminate this Agreement upon breach by the other party of any provision of this Agreement, provided such breach continues for ten (10) days after receipt by the breaching party of written notice of such breach from the non-breaching party. This Agreement may be terminated immediately upon the occurrence of any of the following events:
    a. Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately, or
    b. Either facility loses its license, or Medicare certification.

9. ENTIRE AGREEMENT; MODIFICATION. This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

10. GOVERNING LAW. This Agreement shall be construed in accordance with the laws of the state in which the facility is located.

11. PARTIAL INVALIDITY. If any provision of this Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this Agreement.

12. NOTICES. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to UNIVERSITY OF MARYLAND MEDICAL CENTER DORCHESTER:

Address: 300 Byrn Street
Cambridge, MD 21613
Attention: Mr. Brian Leuter, Executive Director
(410) 228-5511

If to FORT WASHINGTON MEDICAL CENTER:

Address: 174 Waterfront Street
Suite 225
Oxon Hill, MD 20745
Attention: Reginald Jones, President & CEO
(301) 686-9010

With copy to:

Address: 174 Waterfront Street
Suite 225
Oxon Hill, MD 20745
Attention: Donna Jennings, CCO
(276) 614-8804

or to such other persons or places as either party may from time to time designate by written notice to the other.

13. WAIVER. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. ASSIGNMENT; BINDING EFFECT. Facilities shall not assign or transfer, in whole or in part, this Agreement or any of Facilities' rights, duties or obligations under this Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. This Agreement shall inure to the benefit of and are binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

15. CHANGE IN LAW. Notwithstanding any other provision of this Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payer, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while this Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under this Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend this Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If this Agreement is not so amended in writing within seven (7) days after said notice was given, this Agreement shall terminate as of midnight local time on the third (3rd) day after said notice was given.

16. GOVERNMENT ACCESS TO AGREEMENT AND RECORDS. Each party shall, in accordance with 42 U.S.C. § 1395x(v)(1)(I) (Social Security Act § 1861(v)(1)(I)) and 42 C.F.R. § 420.300 *et seq.*, until the expiration of six (6) years after the furnishing of Medicare reimbursable services pursuant to this Agreement, upon proper written request, allow the comptroller General of the United States, the Department of Health and Human Services, and their duly authorized representatives access to this Agreement and to it's or its subcontractors' books, documents and records (as such terms are defined in 42 C.F.R. § 420-301) necessary to verify the nature and extent of costs of Medicare and/or Medicaid reimbursable services provided under this Agreement. In accordance with such laws and regulations, if Medicare reimbursable services provided by any party under this Agreement are carried out by means of a subcontract with an organization related to either party, and such related organization provides the services at a value or cost of $10,000 or more over a twelve-month period, then the subcontract between that party and the related organization shall contain a clause comparable to the clause specified in the preceding sentence. In the event any request for this Agreement or either party's books, documents, and records is made pursuant to Social Security Act § 1861(v)(1)(I) and associated regulations, that party shall promptly give notice of such request to the other party and provide that party with a copy of such request and, thereafter, consult and cooperate with that party concerning the proper response to such request. Additionally, each party shall provide the other with a copy of each book, document, and record made available to one or more persons and agencies pursuant to Social Security Act § 1861(v)(1)(I) or shall identify each such book, document, and record to the other party and shall grant that party access thereto for review and copying.

17. EXECUTION OF AGREEMENT. This Agreement shall not become effective or in force until all of the below named parties have fully executed this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year written above.

UNIVERSITY OF MARYLAND MEDICAL CENTER DORCHESTER

By: _____

Name: Kenneth Kozel

Title: CEO

Date: 5/25/17

FORT WASHINGTON MEDICAL CENTER

By: _____

Name: REGINALD JONES

Title: Interim President & CEO

Date: 5/25/17