UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Executive Office
520 Upper Chesapeake Drive, Suite 405
Bel Air, MD 21014
443-643-3302 | 443-643-3334 FAX
umuch.org

November 21, 2018

VIA EMAIL & HAND DELIVERY

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

Re: Certificate of Need Application – Development of Special Psychiatric Hospital
University of Maryland Upper Chesapeake Health System

Dear Ms. Potter:

On behalf of the University of Maryland Upper Chesapeake Health System, we are submitting four copies of its Certificate of Need Application and related exhibits. One set of full-size sets of project drawings will be provided at a later date. Also enclosed is a CD containing searchable PDF files of the application and exhibits, a WORD version of the application, and native Excel spreadsheets of the MHCC tables.

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

James Buck
Gallagher, Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore, Maryland 21201
410-347-1353
jbuck@gejlaw.com

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

#646406
011888-0023

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

Sincerely,

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

Enclosures

cc: Paul Parker, Director, Center for Health Care Facilities Planning and Development
Kevin McDonald, Chief, Certificate of Need Program
Suellen Wideman, Esq., Assitant Attorney General
Steve Witman, Senior Vice President and Chief Financial Officer, UM UCHS
Robin Luxon, Vice President, Corporate Planning, Marketing and Business Development, UM UCHS
Aaron Rabinowitz, Vice President and General Counsel, UM UCHS
Russell Moy, M.D., Acting Harford County Health Officer
Laurie Humphries, Acting Cecil County Health Officer
Gregory Wm. Branch, M.D., MBA, CPE, FACP, Baltimore County Health Officer
Leland Spencer, MD, MPH, Kent County Health Officer
Alison G. Brown, MPH, Senior Vice President and Chief Strategy Officer University of Maryland Medical System
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
James Buck, Gallagher, Evelius & Jones LLP

CERTIFICATE OF NEED APPLICATION

SPECIAL PSYCHIATRIC HOSPITAL

THE UNIVERSITY OF MARYLAND

UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS AT

ABERDEEN

Applicant:

University of Maryland Upper Chesapeake Health System, Inc.

November 21, 2018

#628734
011888-0023

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For internal staff use

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

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

Address:

635 McHenry Road	**Aberdeen**	**21001**	**Harford**
Street	City	Zip	County

Name of Owner (if differs from applicant):
Merritt-AD, LLC

2. OWNER

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

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

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

Address:

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

Telephone: **443-643-3374**

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

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

University of Maryland Upper Chesapeake Medical Center, Inc.

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

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

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

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

A. Lead or primary contact:

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

Mailing Address:

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

Telephone: 443-643-3741

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

Fax:

B. Additional or alternate contact:

Name and Title: Stephen Witman, Senior Vice President, Chief Financial Officer, University of Maryland Upper Chesapeake Health System

Mailing Address:

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

Telephone: 443-643-3340
E-mail Address (required): SWitman@uchs.org
Fax:

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

Mailing Address:

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

Telephone: 443-643-3374
E-mail Address (required): ARabinowitz@uchs.org
Fax:

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

Mailing Address:

3601 Greenway #710	Baltimore	21218	MD
Street	City	Zip	State

Telephone: 410-730-2664
E-mail Address (required): asolberg@earthlink.net
Fax:

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

Mailing Address:

218 North Charles Street	Baltimore	21201	MD
Street	City	Zip	State

Telephone: 410-347-1353
E-mail Address (required): jbuck@gejlaw.com
Fax: 410-468-2786

7. TYPE OF PROJECT

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

If approved, this CON would result in:

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

8. PROJECT DESCRIPTION

A. Executive Summary of the Project:

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

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

Applicant Response:

University of Maryland Upper Chesapeake Health System, Inc. ("UM UCH") seeks to establish the University of Maryland Upper Chesapeake Medical Campus Behavioral Health Pavilion ("UC Behavioral Health"), a secure, self-contained, and state-of-the-art 72,444 square foot special psychiatric hospital on a thirty-two acre parcel of land located at 635 McHenry Road, Aberdeen, Maryland, 21001.[1] The proposed psychiatric hospital includes a forty (40) bed

1. The overall 72,444 square feet includes 59,986 of space dedicated exclusively to UC Behavioral Health and a 51% allocation of 25,408 square feet of public and administrative space that will be shared between UC Behavioral Health and the freestanding medical facility that will be developed on below UC Behavioral Health. Accordingly, 12,957 square feet of space to be shared between UC Behavioral Health and the freestanding medical facility (51% of 25,408) has been allocated to the proposed project. The allocation of shared space between the UC Behavioral Health and the freestanding medical facility was calculated pro-rata based on the gross square foot size of each facility.

adult psychiatric inpatient unit organized into two "neighborhoods" to serve male and female patients from young adults (over age 18) to seniors. One fifteen (15) bed neighborhood will be principally dedicated to geriatric psychiatry. The other neighborhood will contain twenty-five (25) adult non-geriatric psychiatric beds. In addition to inpatient behavioral health services, UC Behavioral Health will provide a broad array of outpatient services, including a partial hospitalization program, an intensive outpatient program, and a variety of outpatient, ambulatory behavioral health services, which will allow patients to transition through multiple stages of treatment at one centralized location.

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

If the Maryland Health Care Commission approves the conversion of HMH to a freestanding medical facility, HMH's currently licensed twenty-eight (28) psychiatric beds will be delicensed, thereby leaving a vacuum in inpatient psychiatric services in northeast Maryland which UM UCH proposes to fill with the proposed UC Behavioral Health. The proposed project will maintain convenient patient access to inpatient and outpatient behavioral health services while achieving efficiencies and overall cost savings for the health care delivery system.

The total projected cost of the special psychiatric hospital is $53,889,154. The proposed project and as well as the other capital projects for which UM UCH and its constituent hospitals have sought approval from the Commission will be funded through a combination of $200 million in tax exempt debt and $3.7 million of interest earned on bond proceeds. The bonds are anticipated to be issued in fiscal year 2020 through the University of Maryland Medical System.

B. Comprehensive Project Description:

The description must include details, as applicable, regarding:

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

Applicant Response:

PROJECT DESCRIPTION

I. Project Overview

UM UCH is a community based, not-for-profit health system located in Harford County, Maryland. UM UCH is dedicated to maintaining and improving the health of the people in the communities it serves through an integrated health delivery system that provides the highest quality of care to all. UM UCH has been affiliated with the University of Maryland Medical System ("UMMS") since 2009, and in late 2013, UM UCH formally merged into UMMS in order to continue its commitment to the growing northeast Maryland area with expanded clinical services, programs and facilities, and physician recruitment. UM UCH presently consists of: (1) HMH, an acute care hospital with 54 licensed medical/surgical/gynecological/addictions ("MSGA") beds and 28 licensed psychiatric beds located in Havre de Grace; (2) UCMC, a 149-bed licensed acute care hospital, with 138 MSGA beds, 10 obstetrics beds, and 1 pediatric bed, located in Bel Air; (3) the Patricia D. and M. Scot Kaufman Cancer Center (an affiliate of the University of Maryland Marlene and Stewart Greenebaum Cancer Center) located on the campus of UCMC; (4) the Klein Ambulatory Care Center located on the campus of UCMC; (5) the Senator Bob Hooper House, a residential hospice facility in Forest Hill; and (6) Upper Chesapeake Medical Services, a physician practice group.

HMH was constructed in phases between 1943 and 1972. Although UM UCH has been committed to maintaining the facility and has undertaken capital expenditures to make infrastructure, clinical equipment, and information technology improvements, the existing physical plant has simply outlived its useful life. Renovation of the facility is not cost-effective and the nine (9) acre site in downtown Havre de Grace is surrounded by existing developed parcels, limiting a practical opportunity for renovation or expansion. Consistent with local and national healthcare trends and to best promote access to convenient and quality care for the population it serves, UM UCH proposes to transition portions of HMH to a multi-service facility to be located on a 35.63 acre property known as the Upper Chesapeake Health Medical Campus at Aberdeen ("UC Medical Campus at Aberdeen"), four and four-fifths (4.8) miles from the existing HMH campus and conveniently located near Interstate 95. As described above, UC Behavioral Health will replace and expand psychiatric services currently provided by HMH. UC Behavioral Health will be connected with a freestanding medical facility ("UC FMF") that will be a fully functional, full service emergency department, open 24/7 with the capability of caring for patients experiencing medical emergencies. Moreover, UC FMF will also have a dedicated unit for patients suffering from behavioral health emergencies and will conveniently screen and transfer such patients on-site to UC Behavioral Health if an inpatient stay is warranted. Both of these facilities will be located on the UC Medical Campus at Aberdeen, which is approximately thirty-five (35) acres. UC FMF will also support the medical needs of UC Behavioral Health patients by providing imaging, diagnostic, laboratory, and pharmacy services to UC Behavioral Health patients requiring such services.

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

II. UM UCH Behavioral Health Planning

While building toward the proposed UC Behavioral Health, UM UCH has developed an array of outpatient behavioral health services at HMH, including outpatient psychotherapy, medication management, an intensive outpatient program, and a partial hospitalization program. These outpatient programs will be fully established and integrated upon the opening of the UC Behavioral Health and will be relocated to UC Behavioral Health to support continuing efforts to avoid unnecessary admissions and provide a continuum of post-discharge and outpatient services to ensure patients' successful transitions back into the community. Maintaining an array of inpatient and outpatient behavioral health services at UC Behavioral Health will improve access to care for patients and their families.

UM UCH is also developing outpatient and crisis services in Bel Air and to provide patients with fluid access to a host of behavioral health services. More specifically, UCMC will provide behavioral health therapy and medication management services in addition to behavioral health consultation services in MSGA units when clinically indicated, in its emergency department, as well as at community primary care and specialty practices. Additionally, a Harford Crisis Center has been opened in Bel Air approximately one mile from the UCMC campus representing a community partnership between UM UCH, Health Harford, the Harford County government, and the Harford County Health Department. The Crisis Center will address immediate behavioral health needs while diverting select patients from emergency departments with the goal of reducing unnecessary emergency department and inpatient utilization.

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

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

III. UC Behavioral Health Physical Plant and Project Design

The UC Medical Campus at Aberdeen will be organized around two main program components: (1) UC Behavioral Health, a 72,444 gross square foot, special psychiatric hospital located on the building's second and third floors; and (2) an approximate 69,300 gross square foot freestanding medical facility on the building's first floor. The combined total gross square footage of these components is approximately 141,744. UC Behavioral Health will house

outpatient behavioral health services in 14,728 departmental square feet in the existing medical office building on the property adjacent to the site of UC Behavioral Health. Patients will access the outpatient unit via an entrance in the new building, take an elevator to the third floor, and then walk across a 751 square foot elevated skywalk.

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

1. Behavioral health services should be recovery-oriented;

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

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

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

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

Both UC Behavioral Health and UC FMF were designed in accordance with the Facilities Guidelines Institute, Guidelines for Design and Construction Of Hospitals and Outpatient Facilities 2018 Edition ("FGI Guidelines"), the 2015 National Fire and Protection Association 101 Life Safety Code, and the 2018 International Building Code. More specifically, UC Behavioral Health was designed in accordance with the FGI Guidelines, Part 2 – Hospitals; Section 2.5 – Specific Requirements for Psychiatric Hospitals. The proposed project meets the requirements of the FGI Guidelines while also taking advantage of provisions allowing for dual-use of certain program spaces (i.e. consultation, conference and charting rooms; space for group therapy and quiet space; and building support spaces which are shared with the freestanding medical facility on the floor above).

Table 1 below reflects the square footage of both UC FMF and UC Behavioral Health, with shared space allocated 51% to UC Behavioral Health and 49% to UC FMF.

Table 1
Department Gross Square Footage UC FMF and UC Behavioral Health

	UC Behavioral Health	UC FMF	Total
Total Floor Plate Square Footage	59,487	56,849	116,336
Dedicated Departmental Square Footage	59,487	56,849	116,336
Shared Space	12,597	12,451	25,408

Allocation			
Shared Space Allocation %	51%	49%	100%
Total Gross Departmental Square Feet Consistent with Table B	72,444	69,300	141,744

1. Inpatient Programming Space

The proposed inpatient programmatic space has forty (40) private rooms and is organized into two (2) patient neighborhoods. One twenty-five (25) bed neighborhood will serve a general adult population (male and female, over 18 years of age) suffering from one or more non-geriatric psychiatric diagnoses. The other neighborhood will serve the geriatric population (male and female) suffering from neurological disorders such as Alzheimer's and/or Dementia. The geriatric neighborhood has fifteen (15) beds and is organized around a central great room containing the activities of daily living, therapy, staff and support spaces. Each neighborhood has access to a secure courtyard allowing patients to have safe access to the outside. The courtyards also bring natural daylight into the main great room of each neighborhood.

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

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

Please note the FGI Guidelines do not require minimum or maximum ranges of overall program area/square footage, but rather prescribe minimum requirements, including some minimum square footage/clear floor area requirements based on the functional program for the project (e.g., Section 2.5-2.2.2.2 Patient Bedroom Space requirements. Patient bedrooms shall have a minimum clear floor area of 100 square feet for single-bed rooms). The proposed project currently includes single-bed patient rooms in rooms ranging from 175 to 236 square feet. This allows for the patient bed and other required furniture such as a chair and patient storage and writing desk to be accommodated in the room, leaving more than the 100 square feet of clear floor area as required by the FGI Guidelines.

With forty (40) inpatient beds, the proposed project is: (1) 1,811 gross square feet per inpatient bed, including the outpatient behavioral health therapy program and the facility support space; and (2) approximately 1,424 gross square feet per inpatient bed, including the facility support space, but not including the outpatient behavioral health therapy program and a bridge connection to the outpatient area. This proposed project/program square footage per bed falls well within the expected and customary range for such facilities.[2]

2 In *In re Sheppard Pratt at Elkridge*, Docket No. 15-15-2367, the Commission approved an 85-bed special psychiatric hospital that was 155,707 gross square feet, equaling 1,832 gross

2. Outpatient Programming Space

UC Behavioral Health's outpatient programming space includes 14,728 gross square feet with a 751 square foot skywalk connection. Co-locating these services on the same site as the inpatient behavioral health program and the freestanding medical facility with a behavioral health crisis space creates a stronger, integrated behavioral health program to maximize the efficiency of space, staffing, and operations. The proposed project will increase patient, family, and staff satisfaction and enhance outcomes for the patient populations being served. It will also afford greater and easier access to the appropriate level of care for behavioral health patients across the service area.

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

3. Ancillary and Support Space

Education space, conference space, and dietary and dining services are also located on the ground floor. Also included on the ground floor are administration, information technology, support services, including materials management and loading dock, mechanical, electrical and plumbing spaces, environmental services, medical gas, linen storage, and public bathrooms. This ancillary and support services area, consisting of approximately 25,408 gross square feet, will be shared between UC Behavioral Health and the co-located freestanding medical facility.

IV. Construction Plans

The total project is expected to take fifty-two (52) months from grant of a CON through completion of construction. Building design, site approvals, permitting, and pre-construction site work, including extensive grading of the project site, will take approximately twenty-three months after the grant of a CON. UM UCH will obligate 51% of capital expenditures through a binding construction contract within twenty-three (23) months. Within four (4) months of entering into a construction contract, construction will commence. Construction will be completed within twenty-five (25) months. The proposed construction plan is consistent with the performance requirements set forth at COMAR 10.24.01.12(C)(3).

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

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square feet per inpatient bed. *See* Staff Report and Recommendation at 1, 17 (Sept. 20, 2016). UC Behavioral Health is well within the square foot per bed range approved by the Commission for the relocation of Sheppard Pratt at Elkridge. Similarly, in *In re Anne Arundel*, Docket No. 16-02-2375, the Commission approved a 16-bed special psychiatric hospital that was 56,236 or approximately 3,514 gross square feet per bed. *See* Staff Report and Recommendation at 1-2 (March 26, 2018); Anne Arundel Medical Center Mental Health Hospital Modified Certificate of Need Application at Table B (August 2, 2016). Even excluding 5,568 partial hospitalization programming space and 15,329 total feet of shell space, the Commission-approved 16-bed special psychiatric hospital equaled approximately 2,208 gross square feet per bed.

Applicant Response:

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

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

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

Applicant Response:

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

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: ___35.63_ acres

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

The project site is situated within the City of Aberdeen in Harford County and is zoned B-3 Highway Commercial. Pursuant to the Aberdeen Development Code, hospital and medical office uses are permitted in the B-3 zone. The project site is located on Lot 1, a 35.228-acre lot and Lot 2, a 0.405-acre lot as recorded among Plat Book 136 folios 37 and 38 titled Aberdeen Corporate Park. Access to Lot 1 is through Parcel A, a 0.7112-acre parcel known as McHenry Road recorded among Plat Book 88, folio 79.

The site consists of the partially developed office park known as Aberdeen Corporate Park. Existing Office Building #3 has been constructed along with much of the parking lot, landscaping, stormwater management, dry utility lines, water and sewer service lines and access from Middleton Road.

On October 22, 2018 the Aberdeen Mayor and City Council approved the Preliminary Site for a Freestanding Medical Facility, Medical Offices utilizing the existing building and a third Medical Office building. The total floor area approved included 236,270 square feet.

A secondary entrance from Maryland Route 22 is proposed as a right in and right out. Plans are under design and an access permit from Maryland State Highway Administration Access Division is anticipated in early 2019.

Storm water management and sediment erosion control plans will require approval by the Aberdeen Department of Public Works and Harford County Soil Conservation District. UM UCH anticipates approvals its storm water design and sediment and erosion control plans by July 1, 2019. Upon approval of these plans, UM UCH must seek a grading permit to commence grading on the project site. Following CON approval, UM UCH anticipates issuance of a grading permit from the City of Aberdeen by August 1, 2019.

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

(1) Owned by: Merritt-AD, LLC

Please provide a copy of the deed.

(2) Options to purchase held by: University of Maryland – Upper Chesapeake Health System, Inc.

Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: _____

Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: _____

Please provide a copy of the option to lease as an attachment.

(5) Other: A copy of the Agreement of Sale is attached is **Exhibit 3**

Explain and provide legal documents as an attachment.

11. PROJECT SCHEDULE

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

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date	23	months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	4	months
Completion of project from capital obligation or purchase order, as applicable	25	months
Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract		months
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.		months
Initiation of Construction within 4 months of the effective date of the binding construction contract.		months
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract		months

Fill out the following section for each phase. (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase		months
Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date		months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1		months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.		months
To Be Completed for each subsequent Phase of Construction		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase		months
Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase		months
Completion of each phase within 24 months of the effective date of binding construction contract for that phase		months

12. PROJECT DRAWINGS

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

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

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

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

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

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

Applicant Response:

See **Exhibit 2**.

13. FEATURES OF PROJECT CONSTRUCTION

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

Applicant Response:

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

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

Applicant Response:

Utilities (water, sewerage, electricity, etc.) have been constructed to the property line and extended on site.

The property is identified on the Harford County Water and Sewer Master Plan as W3 and S3, 0-5-year service area category. Pursuant to a memorandum dated September 26, 2018 to the City of Aberdeen from ARRO, the city's consultant, there is adequate water and sewer capacity and water pressure to serve the proposed project.

A. Water: Public water is constructed to the site. A master meter is constructed along Md Route 22 and a private water system is constructed on site.

B. Sewer: Public sewer main is constructed to the site. Private sewer system has been constructed on site.

C. Storm Drains: A conveyance system was built to collect surface runoff from parking lots and drives. Roof drain connections will also be designed and built to collect runoff from the proposed buildings into the storm drain conveyance system. There is an existing stormwater management pond on site which has been designed to provide quantity management for storm drain runoff. A series of Best Management Practices (BMP) will be designed and built to provide additional water quality measures in compliance with local and Maryland Department of the Environment for the proposed construction.

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

E. Electrical Power: BGE is the electric provider. Existing electric lines are located on site. The extension of the electric line to the proposed building will occur early in the building construction phase.

F. Telephone: Verizon is the principal telephone provider in the area. Communication lines are located on site. The extension of the communication lines to the proposed building will occur during the building construction phase.

PART II - PROJECT BUDGET

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

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

Applicant Response:

Table E is attached at **Exhibit 1**. Table E shows the cost of the FMF in the "other structure column" and the combined costs of the psychiatric special hospital and the FMF in the "total column." As set forth in footnote 1 above, shared space and associated costs of construction were allocated 51% to UC Behavioral Health and 49% to UC FMF. This represents a pro rata allocation based on the overall size of each facility in relation to the total Dedicated Departmental Square Footage of each facility. *See also* Table 1 above.

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

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

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

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

   Not applicable.

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

   No.

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

   No.

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

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

No.

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

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

11/19/18
Date

Signature of Owner or Board-designated Official

President and Chief Executive Officer
Position/Title

Lyle E. Sheldon
Printed Name

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

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

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

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

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

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

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

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

COMAR 10.24.10 – ACUTE CARE HOSPITAL SERVICES CHAPTER

.04 STANDARDS

A. General Standards.

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

(1) Information Regarding Charges.

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

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

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

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

Applicant Response:

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

(2) Charity Care Policy.

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

(a) The policy shall provide:

(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

(ii) Minimum Required Notice of Charity Care Policy.

1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;

2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and ED areas within the hospital; and
3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

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

Applicant Response:

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

(3) Quality of Care.

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:
   (i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;
   (ii) Accredited by the Joint Commission; and
   (iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90 percent level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

Applicant Response:

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

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

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

UCMC will be the licensee of UC Behavioral Health. UCMC ranked "better than average" or "average" on fifty (50) of the seventy-two (72) quality measures. For an additional eleven (11) quality measures, UCMC did not have sufficient data to report. UCMC ranked "below average" on only eleven (11) quality measures. Table 2 below, identifies those quality measures for which UCMC was ranked "below average" along with UCMC's corrective action plan:

Table 2
Below-Average Quality Measures and Corrective Action

Quality Measure	Corrective Action Plan
COPD- Chronic Obstructive Pulmonary Disease	
Dying within 30-days after getting care in the hospital for chronic obstructive pulmonary disease (COPD).	As a part of UCMC's Patient and Family Centered Care Oversight Council, a multi-disciplinary COPD Workgroup has been created to focus on transitions of care. There are various scopes of work being implemented by the workgroup. The development of new pathway and order sets are in progress to reduce clinical variation in the COPD management. In addition, UCMC is working to increase patient education through video and pulmonary consults as needed.
Communication	
How often did doctors always communicate well with patients?	UCMC's Patient Experience Plan includes several strategies to improve physician communication including: language of caring education, direct observations of physician interactions with patients, and structured bedside rounding with physicians and nurses to communicate each patient's plan of care and to answer patient questions.
Were patients always given information about what to do during their recovery at home?	UCMC's Patient Experience Committee as well as the Transition of Care Committee work plans include revision of patient discharge educational materials and the implementation of a new interactive patient engagement system to include patient specific education plans, patient portal registration, and an extensive library of education videos.
Environment	
How often was patients' pain always well-	UM UCH's Pain Management Steering

Quality Measure	Corrective Action Plan
controlled?	Committee work plan includes several strategies for improving pain management including pain medication reassessment monitoring, RN education, designated pain management RN specialist and palliative care program. UCMC has also included pain assessment during hourly care rounds and shift hand-off communication.
How often was the area around patients' rooms always kept quiet at night?	UCMC is implementing several strategies to reduce noise including noise stoplights at nurses station to increase staff awareness of noise levels, reducing noise from delivery carts by changing cart wheels, reducing deliveries during night hours ,and implementing "quiet times" at designated times to promote uninterrupted rest.
Wait Times	
How long patients spent in the emergency department before being sent home? How long patients spent in the emergency department before they were seen by a healthcare professional?	In furtherance of UM UCH's fiscal year 2019 strategic objective for efficient care, a process improvement team has been charged to review Emergency Department ("ED") throughput and efficiency. Specifically, the work group will utilize the organization's IMPRV methodology to improve the ED's average length of stay and the times from "door to doctor." Executive oversight for this initiative will be driven through the Patient & Family Centered Care Oversight Committee and performance improvements will be monitored through a system-wide scorecard.
Heart Attack and Chest Pain	
Patients with heart attack who received aspirin on arrival to the hospital.	UCMC is actively developing a plan to ensure that all patients with heart attack receive aspirin on arrival to the hospital.

Quality Measure	Corrective Action Plan
Practice Patterns	
Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses.	During FY18, three new CT scanners were installed within UCH (2 at UCMC and one at HMH). All three new scanners have the newest software and X-ray tube technology assuring low dose CT scans. A dose monitoring software, Radimetrics, was also purchased to monitor patient exposures during the CT scans allowing UCH to benchmark and watch for any outliers or trends with dose. During calendar year 2018, January through October measuring period, zero patients underwent CT of the sinus when ordered for a CT of the brain.
Results of Care - Death	
How often patients die in the hospital after bleeding from stomach or intestines.	All-cause mortality is an area of focus on UCMC's fiscal year 2019 Operating Plan. It also constitutes 15% of its Quality Based Reimbursement. A multidisciplinary project team has been deployed to determine both clinical interventions and documentation optimization to better understand the root causes driving any below average performance In addition, under the Safety domain, potentially preventable complications are being tracked, evaluated, and preventive efforts focused on opportunities for improvement.
How often patients die in the hospital after fractured hip.	UM UCH implemented a Geriatric Hip Fracture Program in April 2017. The primary focus of the program is to improve clinical care for acute hip fractures seen at UM UCMC and UM HMH. Following implementation of the program, there has been a decreases in average length of stay, time from admission to surgery, 30 day readmission rates, and 1 year all-cause mortality. In addition, the Geriatric Hip Fracture program has implemented a process to identify patients with an increased risk of a large bone fracture to provide preventative care coordination.

COMAR 10.24.07 – PSYCHIATRIC SERVICES CHAPTER

APPROVAL POLICIES

Availability

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

Applicant Response:

The proposed project includes forty (40) adult psychiatric beds to be organized into two units or neighborhoods. One neighborhood will each include twenty-five (25) beds to treat non-geriatric adult patients suffering from one or more psychiatric diagnoses. A second neighborhood will include fifteen (15) adult geriatric psychiatric beds to treat patients suffering primarily from a neurological disorder such as Alzheimer's and/or Dementia.

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

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

Applicant Response:

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

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

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

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

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

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

Applicant Response:

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

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

Applicant Response:

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

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

Applicant Response:

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

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

Applicant Response:

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

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

Applicant Response:

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

AP 3a. Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy,

group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

Applicant Response:

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

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

Applicant Response:

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

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

Applicant Response:

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

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

Applicant Response:

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

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

Applicant Response:

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

phase of life issues which arise in the generally older population and adjusted to accommodate the cognitive impairment common in this group. There will be a larger general medical consultation, physical therapy, and occupational therapy presence. Though family involvement will be a focus on all units, the geriatric population will require a more consistent, structured approach.

Accessibility

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

(i) intake screening and admission;

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

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

(iv) emergency treatment.

Applicant Response:

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

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

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

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

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

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

Applicant Response:

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

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

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

Applicant Response:

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

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

Applicant Response:

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

As explained in the response to COMAR 10.24.01.08G(3)(b) below, UC Behavioral Health's projected service area includes Harford and Cecil Counties. The current providers of acute psychiatric services in this service area include HMH and Union Hospital. UC Behavioral Health's percentage of uncompensated care is projected to be based on HMH's fiscal year 2017 uncompensated care of 6.77%. This level of uncompensated care was published in the HSCRC's Final Recommendations for the Uncompensated Care Policy for Rate Year 2019, dated July 11, 2018, that is based on fiscal year 2017 data. This is the most recent data that is available and reflects the level of uncompensated care for the entire hospital.

HMH's percentage of uncompensated care is greater than the average 5.45% of uncompensated care provided by HMH and Union Hospital, the two acute general hospitals providing psychiatric services in the health service area. (Table 3).

Table 3
Harford Memorial Hospital Uncompensated Care

Hospital Name	FY2017 % UCC
UM Harford Memorial Hospital	6.77%
Union Hospital of Cecil County	4.13%
Average of UC in the Health Service Area	5.45%

Source: Final Recommendations for the Uncompensated Care Policy for Rate Year 2019

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

Applicant Response:

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

Accessibility: Variant LHPA Standard

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

Applicant Response:

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

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

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

Applicant Response:

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

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

Applicant Response:

The local health planning region was defined as Baltimore City, Harford, Cecil, Anne Arundel, Baltimore, Carroll, and Howard Counties. The average age adjusted charge per case was based on fiscal year 2017 total cases and average charge per case for each age group in the local health planning region. After adjusting for the UC Behavioral Health fiscal year 2022 projected cases and case mix index, the age adjusted average charge per case for the local health planning area totaled of $13,931. *See* Table 4 below. When compared to UC Behavioral Health's fiscal year 2022 projected age adjusted charge per case, priced leveled to fiscal year 2017 prices, the average aged adjusted charge per cases was $13,756 or 1.3% less than the local health planning region. The source of case and discharge data in Table 4 is 2017 HSCRC abstract data (final). Age adjustment was done by calculating the health planning region's charge per case at a case mix index ("CMI") of 1.0 within the pre-determined age groups (see Table 4) and then multiplying these numbers by UC Behavioral Health's projected case volume. By doing so, UC Behavioral Health reached a total revenue number that could be compared to UC Behavioral Health.

Table 4
Local Health Planning Region Age-Adjusted Psychiatric Discharges

	Health Planning Area Acute Hospitals [1]				UCBH Projection		
	A	B	C	D = B/C	E	F	G = D*E*F
Age Group	Cases	Average Charge per Case	CMI	Average Charge per Case @ CMI of 1.0	UCBH Projected Cases	UCBH Projected Case Mix	UCBH Cases @ Health Area Average
Ages 0-4	5	$7,507	0.9178	$8,179	-	-	$0
Ages 5-14	943	13,729	0.6287	21,838	-	-	-
Ages 15-44	9,927	11,109	0.6687	16,612	668	0.6062	6,729,102
Ages 45-54	2,968	12,337	0.6995	17,637	235	0.6072	2,517,465
Ages 55-64	2,128	15,442	0.7451	20,725	260	0.6610	3,568,331
Ages 65-74	768	20,988	0.8400	24,986	126	1.3246	4,171,899
Ages 75-84	376	20,904	0.9517	21,963	57	1.3246	1,654,432
Ages 85+	243	13,900	0.9231	15,058	20	1.3246	398,223
Total	**17,358**	**$12,680**	**0.6985**	**$18,153**	**1,367**	**0.7235**	**$19,039,452**
Average Age and CMI Adjusted Charge per Case in Local Health Planning Region							**$13,931**
UCBH Projected Charge per Case [2]							**$13,756**

Notes:
[1] Health planning region includes Harford County, Baltimore City, Baltimore County, Anne Arundel County, Carroll County, Howard County, and Cecil County
[2] UCBH FY 2022 projected charge per case price levelled to FY 2017 prices
[3] Includes DRGs 750-760 and 779-790
[4] Based on FY 2018 final HSCRC abstract data

The charge/case for the planning region was calculated by dividing the $19,039,452 reflected in the far right column of Table 4 by UC Behavioral Health's 1,367 projected cases. *See* Table 5 below for calculation of UC Behavioral Health charge/case.

Table 5
UC Behavioral Health Projected Charge Per Case Price Leveled to FY 2017 Prices

Projected FY 2022 Inpatient Revenue at UCBH	$21,507,005
Deflation Factor	-12.6%
Projected FY 2017 Inpatient Revenue at UCBH	$18,799,275
Projected Cases	1,367
Projected FY 2017 Charge per Case	**$13,756**

Quality

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

Applicant Response:

All inpatient behavioral health services at UC Behavioral Health will be under the clinical supervision of a qualified psychiatrist who is trained and qualified to provide the leadership required for acute psychiatric inpatient services. Dr. Richard Lewis, M.D., is a board certified psychiatrist who serves as the Chair of Psychiatry for UM UCH. He provides clinical supervision to all psychiatrists, psychiatric nurse practitioners, and clinical psychologists presently on staff at UM UCH. All psychiatrists on staff meet the training requirements and are certified by the American Board of Psychiatry and Neurology. UM UCH's Chairman/Medical Director monitors and evaluates the quality and appropriateness of services and treatment provided by its medical staff. Dr. Adam Rosenblatt, M.D., will serve as the Director of Geriatric Psychiatry and oversee the geriatric unit.

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

Applicant Response:

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

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

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

Applicant Response:

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

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

Applicant Response:

UC Behavioral Health's continuum of care will combine many programs, policies, practices and resources within the system to treat behavioral health disorders in support of affected individuals. The continuum will include services ranging from acute inpatient to outpatient services such as partial hospitalization, intensive outpatient, individual and group therapy, and medication management. In addition, an array of outpatient (including specialty such as substance use) services are available in the region and referrals will be made to any/all of these services as appropriate. At discharge, patients admitted to the behavioral health units will be referred to services appropriate to their needs and based on their choice that could be within the health system array of services or to another community provider. Upon discharge, the hospital unit will follow-up to the referral site with appropriate information to ensure an effective handoff. A copy of UM Upper Chesapeake Health's polices relating to Interdisciplinary Discharge Planning for Behavioral Health and Patient Transfers are submitted herewith as **Exhibits 10** and 11, respectively.

Acceptability

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

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

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

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

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

Letters from other consumer organizations are encouraged.

Applicant Response:

UCH will supplement this Application with letters in support of the proposed project, as well as letters of acknowledgement from local mental health advisory councils and departments, mental health centers, and the Maryland Department of Health.

10.24.01.08G(3)(b). Need.

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

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

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

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

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

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

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

Applicant Response:

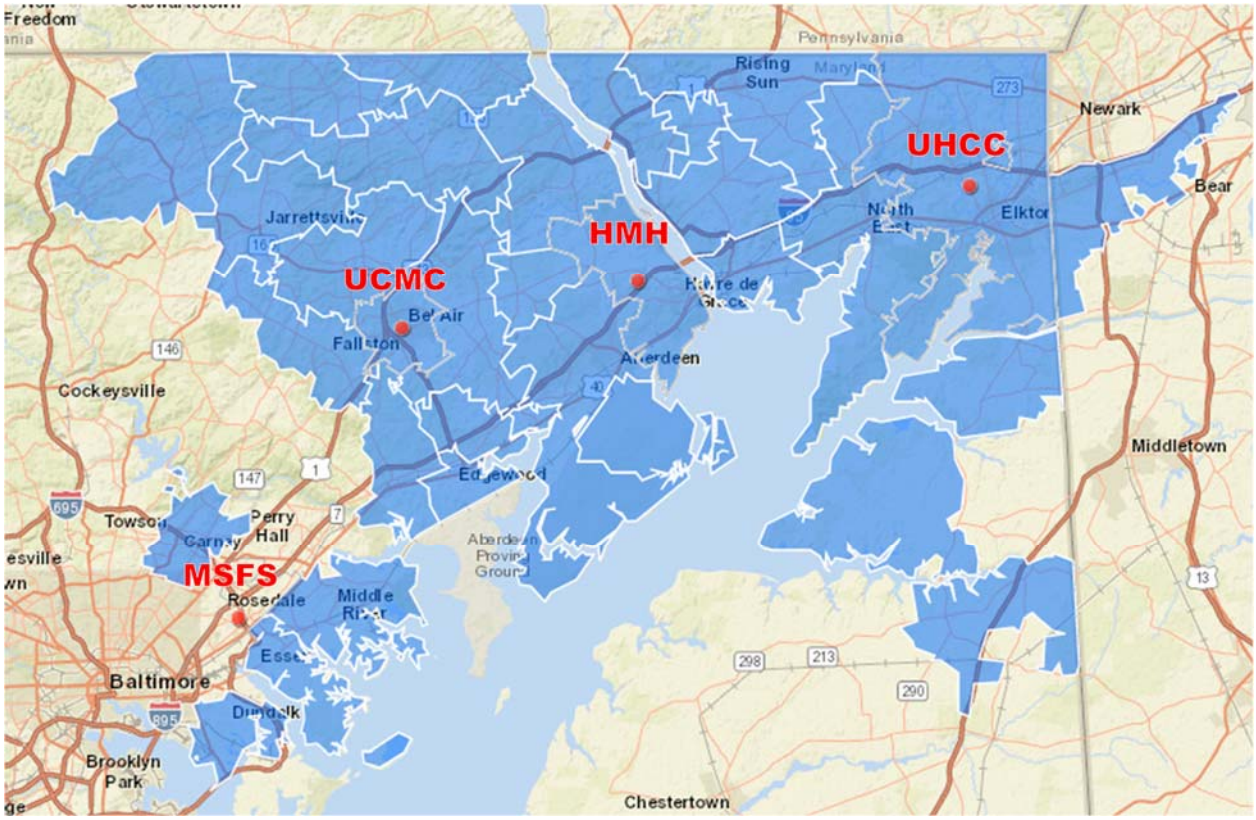
The Commission has recognized that many of the standards in the State Health Plan Chapter for Psychiatric Services are "out of date due to dramatic changes in use of hospital psychiatric beds (especially with respect to average length of stay) and changes in the role and scope of State psychiatric hospital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

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

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

1. Defining UC Behavioral Health's New Service Area

The proposed UC Behavioral Health special psychiatric hospital is expected to replace the existing twenty-eight (28) licensed psychiatric beds at Harford Memorial Hospital ("HMH"). Because of the proposed addition of a new geriatric program, UM UCH analyzed the utilization of inpatient psychiatric services at all hospitals in northeast Maryland. To project the proposed UC Behavioral Health service area, UM UCH therefore combined the fiscal year 2017 discharges by zip code for the adult (aged 18 and over) psychiatric cohort at HMH and other hospitals in northeast Maryland. Pediatric discharges were excluded from this analysis because HMH does not currently provide psychiatric inpatient treatment to pediatric patients and UC Behavioral Health will not provide pediatric psychiatric services either. UM UCH identified the service area for UC Behavioral Health as the zip codes that comprise the top 85% of adult psychiatric discharges at HMH and other northeast Maryland hospitals.



As presented in the map above and below in Table 6, UC Behavioral Health's proposed service area for the adult (age 18+) psychiatric cohort is defined by zip codes that span Harford, Cecil, Baltimore, and Kent Counties in Maryland as well as New Castle County, Delaware. As shown in Table 6, the zip codes for adult psychiatric discharges from HMH and other northeast Maryland hospitals are ranked from highest to lowest to identify the top 85% of total discharges.

Table 6
Defining UC Behavioral Health's Service Area
Psychiatric Discharges Age 18+
FY2017

#	Zip Code	Community	County	Total Discharges	Cummulative % of Discharges
1	21001	Aberdeen	Harford	160	13.0%
2	21040	Edgewood	Harford	159	25.9%
3	21014	Bel Air	Harford	115	35.2%
4	21078	Havre De Grace	Harford	101	43.4%
5	21009	Abingdon	Harford	86	50.4%
6	21015	Bel Air	Harford	75	56.4%
7	21050	Forest Hill	Harford	50	60.5%
8	21085	Joppa	Harford	43	64.0%
9	21903	Perryville	Cecil	41	67.3%
10	21017	Belcamp	Harford	40	70.6%
11	21921	Elkton	Cecil	24	72.5%
12	21904	Port Deposit	Cecil	23	74.4%
13	21901	North East	Cecil	17	75.8%
14	21028	Churchville	Harford	16	77.0%
15	21047	Fallston	Harford	16	78.3%
16	21154	Street	Harford	16	79.6%
17	21911	Rising Sun	Cecil	15	80.9%
18	21918	Conowingo	Cecil	11	81.8%
19	21005	Aberdeen Proving Ground	Harford	9	82.5%
20	21034	Darlington	Harford	8	83.1%
21	21084	Jarrettsville	Harford	8	83.8%
22	21917	Colora	Cecil	6	84.3%
23	21132	Pylesville	Harford	6	84.8%
24	21220	Middle River	Baltimore	3	85.0%
25	21914	Charlestown	Cecil	2	85.2%
26	19711	Newark	New Castle	2	85.3%
27	21620	Chestertown	Kent	2	85.5%
		Subtotal Service Area		**1,054**	**85.5%**
		Out of Service Area		179	14.5%
		Total FY2017 Psychiatric Discharges		1,233	100.0%

Source: St. Paul's Statewide Non-Confidential Patient Level Detail

Based on UC Behavioral Health's projected future service area, population projections through 2021 were obtained from Nielsen Claritas for both the 18-64 age cohort and the 65+ age cohort, which are reflected below in Table 7**.** The 18-64 age cohort is only expected to grow by 0.1% from 2016 to 2021 while the 65+ age cohort is expected to grow by 20.2%. Combined, the total service area population is projected to grow by 4.0% from 2016 to 2021.

Table 7
UC Behavioral Health's Historical and Projected Service Area Population
2010 – 2021

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

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

Using the compounded annual growth rate from 2016 to 2021, as set forth in Table 7, population projections were extrapolated through 2024 and applied to UM Behavioral Health's fiscal years. Table 8 below depicts the projected service area population for both the 18-64 and 65+ age cohorts through 2024. Combined, the total population is expected to grow by 0.8% per year for a total growth of 6.0% from FY2017 to FY2024.

Table 8
UC Behavioral Health's Historical and Projected Service Area Population
FY2015 - FY2024

	Historical FY2015	FY2016	FY2017	Projected FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	% Change FY17-FY24
Service Area Population											
18-64	**386,962**	**387,727**	**387,797**	**387,866**	**387,935**	**388,004**	**388,074**	**388,143**	**388,212**	**388,282**	*0.1%*
65+	**90,670**	**93,778**	**97,286**	**100,925**	**104,701**	**108,618**	**112,681**	**116,897**	**121,270**	**125,806**	*29.3%*
Total	**477,631**	**481,505**	**485,083**	**488,791**	**492,636**	**496,622**	**500,755**	**505,039**	**509,482**	**514,088**	*6.0%*
%Change	*0.8%*	*0.8%*	*0.7%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.9%*	*0.9%*	*0.9%*	

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

UM UCH proposes to establish two separate psychiatric programs at UC Behavioral Health: (1) a fifteen (15) bed geriatric unit; and (2) one adult, non-geriatric unit, housing a total of twenty-five (25) non-geriatric adult psychiatric beds. With the opening of UC Behavioral Health in fiscal year 2022, UC Behavioral Health will be capable of safely and effectively treating certain patients with co-occurring medical diagnoses. As a result, UM UCH anticipates that certain patients, particularly geriatric patients, who suffer from co-occurring medical and behavioral health diagnoses and who currently receive treatment in MSGA units, will be candidates for admission to UC Behavioral Health. Patients admitted to UC Behavioral Health who are diagnosed with co-occurring medical diagnoses will receive a medical assessment and follow-up during their course of treatment by a medicine specialist (e.g. internist, hospitalist) dedicated to serving the inpatient behavioral health units. The medicine specialist will work closely with the inpatient unit psychiatrist/psychiatric nurse practitioner to ensure an integrated treatment approach. Having this medicine specialist will enable UC Behavioral Health to annually capture approximately 150 patients suffering from co-occurring medical and behavioral

health diagnoses who had previously been treated in MSGA units at HMH, UCMC, and other Maryland acute care hospitals.

a. Geriatric Program

UC Behavioral Health's geriatric program is defined by the diagnosis codes listed below in Table 9. The geriatric program is generally characterized as serving patients suffering from a neurological disorder such as Alzheimer's and/or Dementia. Although there is no age restriction on patients that will be treated in the geriatric program for psychiatric disorders, such patients are primarily projected to be in the 65+ age cohort.

Table 9
Definition of Geriatric Psychiatric Patients

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

b. Non-Geriatric Program

UC Behavioral Health's adult non-geriatric program is defined as treating patients suffering from one or more psychiatric diagnoses, excluding those diagnoses listed on Table 9 above.

3. UC Behavioral Health Use Rates

Use rates for both the geriatric and non-geriatric patient populations were established based on historical trends in use rates that were calculated and projected per 1,000 population. The historical use rates presented in Table 10 and 11 below are based on the calculation of psychiatric discharges for residents in UC Behavioral Health's projected service area from acute and specialty hospitals in Maryland and Delaware divided by the estimated population in the service area. The service area psychiatric discharges used in the calculation of use rates were obtained from following sources:

- The St. Paul Group's non-confidential abstract patient level database for acute hospitals in Maryland
- The St. Paul Group's summarized database of discharges for specialty hospitals in Maryland
- Delaware Health Information Network summarized database of discharges for hospitals in Delaware.

As presented in Table 8 above, the population estimate for 2016 was obtained from Nielsen Claritas. The population estimate for 2015 was interpolated between the estimates of population obtained from Nielsen Claritas for 2010 and 2016 using the compounded annual growth rate between these years. The population estimate for 2017 was interpolated between the estimates of population obtained from Nielsen Claritas for 2016 and 2021 using the compounded annual growth rate between these years.

The projected use rates presented in Table 10 and Table 11 below are based on the application of assumptions regarding future changes in use rates to the historical calculated use rates. The assumptions regarding future changes in use rates are described below for geriatric and non-geriatric services.

a. Geriatric Program Use Rates

Geriatric use rates in UC Behavioral Health's service area declined in fiscal 2015, but then increased in fiscal years 2016 and 2017. Going forward, future use rates are assumed to remain constant, at each age cohort level, with those experienced in fiscal year 2017, while aging of the population will drive a higher overall use rate by fiscal year 2024 (Table 10).

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

	Historical			Projected							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Use Rate											
Geriatric											
18-64	**0.11**	**0.21**	**0.20**	**0.20**	**0.20**	**0.20**	**0.20**	**0.20**	**0.20**	**0.20**	
%Change	-30.7%	86.3%	-3.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*0.0%*
65+	**4.8**	**5.5**	**5.6**	**5.6**	**5.6**	**5.6**	**5.6**	**5.6**	**5.6**	**5.6**	
%Change	-9.0%	14.9%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*0.0%*
Total	**1.0**	**1.2**	**1.3**	**1.3**	**1.3**	**1.4**	**1.4**	**1.4**	**1.5**	**1.5**	
% Change	-9.5%	23.9%	2.7%	2.5%	2.5%	2.5%	2.5%	2.5%	2.4%	2.4%	*18.6%*

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

The use rates for non-geriatric psychiatric patients in UC Behavioral Health's service area declined by a weighted average of 4.8% in fiscal year 2015 but then increased by a weighted average of 0.1% in fiscal year 2016 and 0.4% in fiscal year 2017. Going forward, use rates at the age cohort level are assumed to remain constant, while aging of the population is projected to drive a decline of 0.5% annually from fiscal year 2017 to fiscal year 2024, for a cumulative reduction of 3.7% (Table 11).

Table 11
UC Behavioral Health's Historical and Projected Use Rates
18-64 and 65+ Non-Geriatric Psychiatric Patients
FY2015 – FY2024

	Historical			Projected							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Use Rate											
Non-Geriatric											
18-64	**29.7**	**29.9**	**30.3**	**30.3**	**30.3**	**30.3**	**30.3**	**30.3**	**30.3**	**30.3**	
%Change	-4.3%	0.7%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*0.0%*
65+	**9.0**	**8.9**	**8.7**	**8.7**	**8.7**	**8.7**	**8.7**	**8.7**	**8.7**	**8.7**	
%Change	-5.5%	-1.4%	-2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*0.0%*
Total	**25.8**	**25.8**	**25.9**	**25.8**	**25.7**	**25.6**	**25.4**	**25.3**	**25.1**	**25.0**	
% Change	-4.8%	0.1%	0.4%	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%	-0.6%	-0.6%	*-3.7%*

4. Service Area Discharges

The projected service area discharges presented in Table 12 below are based on the multiplication of projected population times the projected use rates in each year. With the growth in population and shift to older patients with higher use rates, geriatric psychiatric discharges are projected to increase by 25.7% from fiscal year 2017 to 2024. Non-geriatric psychiatric discharges are projected to increase by 2.1% with limited increases in population under the age of 65. (Table 12). In total, service area psychiatric discharges are projected to grow by 3.2% between fiscal years 2017 and 2024.

Table 12
UC Behavioral Health's Historical and Projected Service Area Discharges
Geriatric and Non-Geriatric Psychiatric Patients
FY2015 – FY2024

	Historical			Projected							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Service Area Discharges											
Geriatric											
18-64	**43**	**80**	**77**	**77**	**77**	**77**	**77**	**77**	**78**	**78**	***0.1%***
65+	**436**	**519**	**542**	**562**	**583**	**605**	**627**	**651**	**675**	**701**	***29.3%***
Subtotal	**479**	**599**	**619**	**639**	**660**	**682**	**705**	**728**	**753**	**778**	***25.7%***
Non-Geriatric											
18-64	**11,506**	**11,607**	**11,744**	**11,746**	**11,748**	**11,750**	**11,752**	**11,754**	**11,756**	**11,758**	***0.1%***
65+	**815**	**831**	**842**	**873**	**906**	**940**	**975**	**1,012**	**1,049**	**1,089**	***29.3%***
Subtotal	**12,321**	**12,437**	**12,586**	**12,619**	**12,654**	**12,690**	**12,727**	**12,766**	**12,806**	**12,847**	***2.1%***
Total	**12,800**	**13,036**	**13,205**	**13,259**	**13,315**	**13,372**	**13,432**	**13,494**	**13,559**	**13,625**	***3.2%***

5. Market Share

The historical geriatric and non-geriatric market share at UC Behavioral Health, as presented in Tables Table 13 andTable 14 below, were calculated within the planned service area based on the number of psychiatric discharges at HMH and UCMC in fiscal years 2015 and 2017 for the 18-64 and 65+ age cohorts as percentages of the total geriatric and non-geriatric psychiatric discharges within the service area. The service area discharges include discharges from acute and specialty hospitals in Maryland, as well as all hospitals in Delaware that were obtained from The St. Paul Group's non-confidential abstract patient level database for acute hospitals in Maryland, The St. Paul Group's summarized database of discharges for specialty hospitals in Maryland, and the Delaware Health Information Network summarized database of discharges for hospitals in Delaware.

The projected market share for geriatric and non-geriatric services is based on the application of assumptions regarding future changes in market share to the historical calculated market share. The assumptions regarding future changes in market share are described below for geriatric and non-geriatric services.

a. UC Behavioral Health Geriatric Program Market Share

UC Behavioral Health's geriatric psychiatric market share decreased in fiscal years 2015 through 2017 (Table 13).

Table 13
UC Behavioral Health's Historical Market Share
Geriatric Psychiatric
FY2015 - FY2017

	Historical		
	FY2015	FY2016	FY2017
Geriatric Market Share			
Maryland Non-Academic Acute Hospitals			
UC Behavioral Health (HMH+UCMC)	24.4%	23.9%	17.3%
Johns Hopkins Bayview Medical Center	9.6%	11.5%	14.4%
Franklin Square Hospital	6.3%	9.5%	8.9%
Union Hospital of Cecil County	1.9%	5.5%	4.4%
St. Joseph Medical Center	2.1%	1.7%	1.8%
Other Non-Academic Acute Hospitals	9.2%	5.7%	6.5%
Subtotal Non-Academic Acute Hospitals	53.4%	57.8%	53.1%
Maryland Academic Acute Hospitals	1.7%	3.3%	2.4%
Maryland Specialty Hospitals	42.2%	34.1%	39.7%
Subtotal Maryland	97.2%	95.2%	95.2%
Delaware	2.8%	4.8%	4.8%
Total	100.0%	100.0%	100.0%

Although it lost market share in previous years, UC Behavioral Health's market share is projected to remain constant, by age cohort, from fiscal years 2017 through 2021. It will then increase in fiscal year 2022 with the introduction of a dedicated geriatric program at UC Behavioral Health and then remain constant, by age cohort, until the end of the projection period in fiscal year 2024 (Table 14). The increase in market share in fiscal year 2022 reflects an expected capture of approximately 50% of geriatric psychiatric discharges historically cared for at other non-academic acute hospitals in Maryland.

Table 14
UC Behavioral Health's Historical and Projected Market Share
Geriatric Psychiatric
FY2015 - FY2024

	Historical			Projected							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Market Share											
Geriatric											
18-64	**32.7%**	**35.1%**	**19.4%**	**19.4%**	**19.4%**	**19.4%**	**19.4%**	**29.7%**	**29.7%**	**29.7%**	
%Change	-8.4%	7.1%	-44.8%	0.0%	0.0%	0.0%	0.0%	53.3%	0.0%	0.0%	*-15.4%*
65+	**23.6%**	**22.2%**	**17.0%**	**17.0%**	**17.0%**	**17.0%**	**17.0%**	**26.0%**	**26.0%**	**26.0%**	
%Change	-8.1%	-6.1%	-23.4%	0.0%	0.0%	0.0%	0.0%	53.3%	0.0%	0.0%	*53.3%*
Total	**24.4%**	**23.9%**	**17.3%**	**17.3%**	**17.3%**	**17.3%**	**17.2%**	**26.4%**	**26.4%**	**26.4%**	
% Change	-9.1%	-2.1%	-27.7%	-0.1%	-0.1%	-0.1%	-0.1%	53.2%	0.0%	0.0%	*52.7%*

*b. **UC Behavioral Health Non-Geriatric Program Market Share***

UC Behavioral Health's market share of non-geriatric psychiatric discharges increased from fiscal year 2015 to 2017 (Table 15).

Table 15
UC Behavioral Health's Historical Market Share
Non-Geriatric Psychiatric
FY2015 - FY2017

	Historical		
	FY2015	FY2016	FY2017
Non-Geriatric Market Share			
Maryland Non-Academic Acute Hospitals			
UC Behavioral Health (HMH+UCMC)	8.2%	8.4%	8.4%
Johns Hopkins Bayview Medical Center	2.2%	1.9%	2.2%
Franklin Square Hospital	5.2%	5.6%	5.8%
Union Hospital of Cecil County	3.8%	3.8%	3.1%
St. Joseph Medical Center	1.3%	1.3%	1.4%
Other Non-Academic Acute Hospitals	3.0%	3.1%	3.1%
Subtotal Non-Academic Acute Hospitals	23.7%	24.0%	24.0%
Maryland Academic Acute Hospitals	1.9%	1.4%	1.4%
Maryland Specialty Hospitals	69.6%	69.8%	69.9%
Subtotal Maryland	95.2%	95.2%	95.2%
Delaware	4.8%	4.8%	4.8%
Total	100.0%	100.0%	100.0%

Based on actual experience, UC Behavioral is expected to lose some market share in fiscal year 2018, but market share is then projected to remain constant, by age cohort, through fiscal year 2024 (Table 16).

Table 16
UC Behavioral Health's Historical and Projected Market Share
Non-Geriatric Psychiatric
FY2015 - FY2024

	Historical			Projected							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Market Share											
Non-Geriatric											
18-64	**8.3%**	**8.3%**	**8.6%**	**8.4%**	**8.4%**	**8.4%**	**8.4%**	**8.4%**	**8.4%**	**8.4%**	
%Change	-4.5%	0.1%	3.4%	-2.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*-2.9%*
65+	**7.2%**	**8.9%**	**5.5%**	**4.5%**	**4.5%**	**4.5%**	**4.5%**	**4.5%**	**4.5%**	**4.5%**	
%Change	37.2%	23.0%	-38.7%	-17.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*-17.7%*
Total	**8.2%**	**8.4%**	**8.4%**	**8.1%**	**8.1%**	**8.1%**	**8.1%**	**8.1%**	**8.0%**	**8.0%**	
% Change	-2.8%	1.4%	0.4%	-3.6%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	*-4.3%*

6. Out-of-Service Area Discharges

UC Behavioral Health's historical out-of-service area discharges, expressed as a percentage of UC Behavioral Health's service area discharges and presented in Table 17 and Table 18 below, are based on the division of historical psychiatric discharges from HMH and UCMC related to zip codes outside of the UC Behavioral Health service area by HMH and UCMC's historical psychiatric discharges from zip codes within the service area.

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

UC Behavioral Health attracted out-of-service area geriatric discharges beginning in fiscal year 2017. Measured as a percentage of service area discharges, out-of-service area geriatric discharges are expected to remain constant at the 2017 level through fiscal year 2024 (Table 17).

Table 17
UC Behavioral Health's Out-of-Service Area Discharges Expressed as a Percentage of Service Area Discharges Geriatric Psychiatric
FY2015 - FY2024

	Historical			Projected							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Out-of-Service Area Discharges % of Service Area Discharges											
Geriatric											
18-64	**0.0%**	**0.0%**	**13.3%**	**13.3%**	**13.3%**	**13.3%**	**13.3%**	**13.3%**	**13.3%**	**13.3%**	
%Change	*0.0%*	*0.0%*	*13.3%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
65+	**0.0%**	**0.0%**	**4.3%**	**4.3%**	**4.3%**	**4.3%**	**4.3%**	**4.3%**	**4.3%**	**4.3%**	
%Change	*0.0%*	*0.0%*	*4.3%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

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

UC Behavioral Health's non-geriatric out-of-service area discharges declined in fiscal years 2015 through 2017 as a percentage of service area discharges, but are expected to remain constant at the 2017 level through fiscal year 2024 (Table 18).

Table 18
UC Behavioral Health's Out-of-Service Area Discharges Expressed as a Percentage of of Service Area Discharges Non-Geriatric Psychiatric
FY2015 - FY2024

	Historical			Projected							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Out-of-Service Area Discharges % of Service Area Discharges											
Non-Geriatric											
18-64	**17.3%**	**13.8%**	**13.0%**	**13.0%**	**13.0%**	**13.0%**	**13.0%**	**13.0%**	**13.0%**	**13.0%**	
%Change	*-6.0%*	*-3.6%*	*-0.8%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
65+	**8.5%**	**4.1%**	**17.4%**	**17.4%**	**17.4%**	**17.4%**	**17.4%**	**17.4%**	**17.4%**	**17.4%**	
%Change	*-7.4%*	*-7.4%*	*-7.4%*	*-7.4%*	*-7.4%*	*-7.4%*	*-7.4%*	*-7.4%*	*-7.4%*	*-7.4%*	*0.0%*

7. Inpatient Psychiatric Discharges

Psychiatric discharges at HMH increased from fiscal year 2015 to 2017. Based on actual experience, though, psychiatric discharges at HMH declined by 3.1% in fiscal year 2018. Beginning in fiscal year 2019, the psychiatric discharges are projected to grow by 0.5% per year due primarily to the aging of the population. With the opening of a geriatric psychiatric program in fiscal year 2022, UC Behavioral Health will capture additional market share. Combined with population growth, total psychiatric discharges are projected to increase by 12.3% from fiscal year 2017 to 2024 (Table 19).

Table 19
UC Behavioral Health's Historical and Inpatient Psych Discharges
FY2015 – FY2024

	Historical			Projected							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Inpatient - Discharges											
HMH	**1,226**	**1,236**	**1,233**	**1,195**	**1,201**	**1,207**	**1,213**	**-**	**-**	**-**	
UC Behavioral Health											
Geriatric	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**203**	**210**	**216**	
Non-Geriatric	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**1,164**	**1,166**	**1,168**	
Total	**1,226**	**1,236**	**1,233**	**1,195**	**1,201**	**1,207**	**1,213**	**1,367**	**1,375**	**1,385**	
% Change		*0.8%*	*-0.2%*	*-3.1%*	*0.5%*	*0.5%*	*0.5%*	*12.7%*	*0.6%*	*0.7%*	*12.3%*

8. UC Behavioral Health Average Length of Stay

The average length of stay ("ALOS") of adult psychiatric patients at HMH increased from fiscal year 2015 to 2017. Based on actual experience, the ALOS increased further in fiscal year 2018 and is expected to continue to increase through fiscal year 2021 as the population ages and existing short stay discharges are shifted to the outpatient setting with the establishment of a partial hospitalization program. The ALOS of patients age 18-64 is expected to approach 6.2 days with the shift of short stay discharges to the outpatient setting. The ALOS of patients age 65+ is 11.5 days in fiscal year 2018. As the population ages to include more 65+ year old patients and the short stay discharges associated with patients ages 18-64 are shifted to the outpatient setting, the resulting ALOS will naturally increase (Table 20).

Beginning with its projected opening in fiscal year 2022, UC Behavioral Health will have two adult psychiatric inpatient programs to treat both geriatric and non-geriatric patients. Patients treated in the geriatric program will require more services and have a longer average length of stay of 20.75 days. This longer length of stay reflects the ALOS for geriatric psychiatric patients at Sheppard and Enoch Pratt Hospital in fiscal year 2016. Separating the geriatric patients with longer lengths of stay, reduces the projected ALOS for patients treated in the non-geriatric program to 6.2 days. The ALOS for both the geriatric and non-geriatric programs will remain constant, at the age cohort level, from fiscal year 2022 through the end of the projection period (Table 20).

Table 20
UC Behavioral Health's Historical and Projected Inpatient Psych ALOS
FY2015 – FY2024

	Historical			Projected						
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
ALOS (days)										
HMH	5.60	6.07	6.07	6.47	6.78	7.08	7.10			
UC Behavioral Health										
Geriatric								20.75	20.75	20.74
Non-Geriatric								6.20	6.20	6.20

9. UC Behavioral Health Occupancy

UM UCH reviewed the *State Health Plan* section on "State Health Plan for Facilities and Services: Overview, Psychiatric Services, and Emergency Medical Services" (COMAR 10.21.07) (which dates back to 1984) and found that there is only one reference to psychiatric facility specific occupancy rates. This can be found on page AP-11, under standard AP 10, which states:

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

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

UM UCH believes that this standard is outdated. Instead, UC Behavioral Health's inpatient bed occupancy was projected at 80%. While less than the 85% included in the outdated State Health Plan for Psychiatric Services, COMAR 10.24.07 (Need Projection Methodology (A)(7)) for facilities of this size, it is much higher than the jurisdictional minimum occupancy standard of 70% applicable to MSGA beds with an average daily census of between 0-49 inpatients.

10. UC Behavioral Health Bed Need

At 80% occupancy, UC Behavioral Health's geriatric unit is expected to drive a need for 15 beds by fiscal year 2024. The non-geriatric unit is projected to drive a need for 25 beds with the opening of the new facility in fiscal year 2022 through the end of the projection period in fiscal year 2024 (Table 21).

Table 21
UC Behavioral Health Projected Inpatient Psych Bed Need
FY2022 – FY2024

	Projected		
	FY2022	FY2023	FY2024
Bed Need			
Geriatric	**14**	**15**	**15**
Non-Geriatric	**25**	**25**	**25**
Total	**39**	**40**	**40**

Table F is submitted with as **Exhibit 1**, and reflects psychiatric services at HMH and UC Behavioral Health combined along with the operations of UCMC and UC FMF.

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

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

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

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

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

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

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

Applicant Response:

A. Planning Process for the Proposed Project and Alternatives Considered

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

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

better serve the populations of Harford and Cecil Counties within an integrated health delivery system. The proposed project involves construction of a new specialty psychiatric hospital at the UC Medical Campus at Aberdeen. Also planned at the same time as the proposed project, UM UCH proposes to develop a freestanding medical facility on the UC Medical Campus at Aberdeen and relocate other acute inpatient services from HMH to UCMC.

The primary alternatives to the proposed project included:

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

2. Relocation of HMH's acute inpatient psychiatric beds and outpatient services to UCMC, with UM UCH developing a freestanding medical facility on the UC Medical Campus at Aberdeen. HMH would also transfer MSGA beds to UCMC; and

3. Maintaining all behavioral health services on the HMH campus and relocating emergency services to a freestanding medical facility and relocating acute inpatient and surgical services to UCMC's campus.

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

a. Coordination of health care services across the continuum of communities served by UM UCH to improve efficiency, patient outcomes, and reduce redundancy of clinical care services;

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

c. Efficient use of capital expenditures; and

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

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

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

a. Coordination of health care services across the continuum

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

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

Under Alternative 1, total per capita health care expenditures would increase due to the need for rate increases from the HSCRC to support the capital costs and increased depreciation and interest expenses.

c. *Efficient use of capital expenditures*.

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

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

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

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

While the capital cost associated with a renovating and constructing new space at HMH varied based on the scope of construction and renovation, the cost of bringing the entire facility to modern standards is estimated to be $239.3 million (updated to a midpoint of construction in 2020). The project scope included new operating rooms, a new radiology suite, infrastructure upgrades and emergency department renovations (Table 22).

Table 22
Estimated HMH Renovation Costs

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

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

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

2. Alternative #2 - Relocate HMH's Acute Inpatient Psychiatric Beds and Outpatient Services and MSGA Beds to UCMC, Develop a New FMF on UCH Medical Campus at Aberdeen.

UM UCH evaluated the relocation of HMH's behavioral health services to UCMC's campus in Bel Air. UCMC would build a two-level expansion to house MSGA beds transferred from HMH. There were several key findings.

e. Coordination of health care services across the continuum

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

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

Alternative 2 would increase the cost of care in the community due to the need for a rate increase from the HSCRC to support the increased capital costs and depreciation and interest expenses. Additionally, a new psychiatric unit at UCMC would not provide the Maryland health care system with cost savings.

g. Efficient use of capital expenditures.

Relocation of both acute and outpatient behavioral health services as well as MSGA services from HMH to UCMC could not be accommodated in a three-level expansion above the Kaufman Cancer Center. Rather, there would need to be two separate expansion projects at UCMC. A two-level addition above the Kaufman Cancer Center, projected to cost $78,618,810, would house observation beds as a result of MSGA beds being transferred from HMH to UCMC. A separate expansion above one of UCMC's existing patient bed towers would house acute and outpatient behavioral health services. This additional expansion is projected to cost $83 million. Finally, the development of the FMF as a stand-alone facility would cost $58,259,844 because project site costs would not be shared with another facility.

The cumulative effect of relocating inpatient MSGA beds, relocating psychiatric beds, and growing existing and needed outpatient services on UCMC's campus along with the projected volume of 13,625 behavioral health outpatient visits would trigger the need for a new parking garage. The projected costs above do not include additional costs associated with construction of a new parking garage.

h. Modern, innovatively designed facilities with future expansion capability

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

3. Alternative #3 - Maintain All Behavioral Health Services on the HMH Campus, Relocate Emergency Service to a Free Standing FMF, and Relocate Acute Inpatient Services to UCMC's Campus.

UM UCH also evaluated maintaining all behavioral health services on the HMH campus and relocating both emergency services to a freestanding medical facility and acute inpatient and surgical services to UCMC's campus. There were several key findings.

a. Coordination of health care services across the continuum

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

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

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

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

c. Efficient use of capital expenditures.

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

Moreover, Alternative 3 would require extensive capital expenditures to renovate HMH's existing psychiatric unit and to accommodate expansion of outpatient services. Total capital expenditures were estimated to be $65.6 million at HMH, plus $58,259,844 for the freestanding medical facility to be located at the UHC Medical Campus at Havre de Grace as a stand-alone facility, plus $78,618,810 for a two-level expansion above the Kaufman Cancer Center at UCMC to house observation beds after MSGA beds were transferred from HMH to UCMC.

d. Modern, innovatively designed facilities with future expansion capability

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

4. Alternative #4 - Relocate Psychiatric Beds into a New Special Psychiatric Hospital on the UC Medical Campus at Aberdeen, Construct a Freestanding Medical Facility on the UC Medical Campus at Aberdeen, and Relocate MSGA beds from HMH to UCMC.

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

a. Coordination of health care services across the continuum

UM UCH determined that Alternative 4 (which includes the proposed project) will result in improved care coordination across UM UCH's service area. The new special psychiatric hospital will be centrally located within UM UCH's Service area and between the two remaining acute general hospitals in the service area – UCMC and Union Hospital. This will lead to better patient access, better service to the populations of Harford and Cecil Counties, and improve behavioral health service provider recruitment and retention.

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

A new special psychiatric hospital would provide Maryland system saving of $2.8 million annually due to the special psychiatric hospital's reimbursement being based on the Medicare prospective payment system and a reduction in rates for Medicaid utilization. The Maryland system savings was calculated using assuming the rates that Medicare will pay UC Behavioral health will be approximately 35% below what Medicare currently pays in the current regulated settings at HMH. Potential reduction in Medicaid payments was not considered in this calculation.

Pending an agreement with the HSCRC regarding distribution of HMH's global budget revenue, an increase in rates from the HSCRC will not be required under Alternative 4, which includes the proposed project. UM Upper Chesapeake Health is negotiating with the HSCRC to reallocate revenue from HMH's global budget revenue cap to cover capital expenses and volume redistribution at UC Behavioral Health, UCMC, and UC FMF. Assuming that a sufficient amount of HMH's global budget revenue cap is reallocated within UM UCH, UM UCH anticipates that an increase in rates will not be required under Alternative 4.

c. Efficient use of capital expenditures.

Alternative 4 provides for an efficient use of capital expenditures. The new special psychiatric hospital projected capital cost is $53,889,154.

The new FMF will cost $52,723,779. The FMF would cost approximately $6,972,020 less if built as a stand-along facility because project site work and other costs can be shared with another facility as opposed to being constructed at different times in different locations. In other words, UC FMF would cost approximately $6,972,020 more if built as a stand-alone facility.

The three-level expansion at UCMC with one floor of shell space will cost $81,789,216.

d. Modern, innovatively designed facilities with future expansion capability

Alternative 4 – which includes the proposed project – allows for both modern, innovatively designed facilities and future expansion of services. The new special psychiatric hospital will offer expanded inpatient psychiatric services including a new dedicated geriatric psychiatric unit as well as expanded and new outpatient behavioral health programs. This would include an expanded outpatient psychiatric clinic and intensive outpatient services and a new partial hospitalization program. Further, there is room for future expansion of the UC Medical Campus at Aberdeen.

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

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

Table 23 below summarizes how UCH evaluated the performance of each of the alternatives relative to the four objectives, scoring each in from 0-5.

Table 23
Ranking of the Alternatives

	Coordination of health care services across the continuum	Reduce the total per capita health care expenditures	Efficient use of capital expenditures	Innovatively designed facilities with future expansion capability	Total
1. Partial and/or Full Renovation and Expansion of UM HMH ($239.3M)	3	0	0	3	6
2. Relocate UM HMH's Acute Inpatient Psychiatric Beds and Outpatient Services to UM UCMC. New FMF on Aberdeen Site and Two Story Expansion at UCMC to house observation beds. ($219.8)	3	0	3	3	9
3. Maintain All Behavioral Services on the UC-HMH Campus and Relocate Both Emergency Service to a Free Standing FMF and Acute Inpatient and Surgical Services to UCMC's Campus. ($202.5M)	3	0	3	3	9
4. Construct a New Specialty Psychiatric Hospital and FMF on the Aberdeen Site and a three story addition at UCMC ($188.4M)	5	5	5	4	19

B. Marshall Valuation Service Analysis

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

Marshall Valuation Service
Valuation Benchmark

Type		Hospital
Construction Quality/Class		Good/A
Stories		3
Perimeter		475
Average Floor to Floor Height		15.0
Square Feet		57,716
f.1	Average floor Area	14,429
A. Base Costs		
	Basic Structure	$365.78
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$365.78
Adjustment for Departmental Differential Cost Factors		0.96
Adjusted Total Base Cost		$352.47
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$352.47
C. Multipliers		
Perimeter Multiplier		0.93103325
	Product	$328.16
Height Multiplier		1.07
	Product	$350.81

Multi-story Multiplier		1.000
	Product	$350.81
D. Sprinklers		
	Sprinkler Amount	$3.31
Subtotal		$354.11
E. Update/Location Multipliers		
Update Multiplier		1.07
	Product	$378.90
Location Multipier		1.01
	Product	$382.69
Calculated Square Foot Cost Standard		**$382.69**

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

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
Inpatient Care Services	40,175	Inpatient Unit	1.06	42,586
Connector	751	Internal Circulation	0.6	451
Maintenance	625	Mechanical Equipment and Shops	0.7	437
Circulation	1,877	Internal Circulation	0.6	1,126
Mechanical	344	Mechanical Equipment and Shops	0.7	240
Receiving	292	Emergency Suite	1.18	345
Dietary	898	Public Space	0.8	718
Maintenance	3,165	Mechanical Equipment and Shops	0.7	2,216

Maintenance Staff Lounge and Lockers	381	Employee Facilities	0.8	305
Nursing Staff Lounge and Lockers	339	Employee Facilities	0.8	271
Provider Staff Lounge and Lockers	551	Employee Facilities	0.8	441
Provider Offices	281	Offices	0.96	270
Housekeeping	259	Housekeeping	1.31	339
Storage	890	Storage and Refrigeration	1.6	1,424
Mechanical	1,604	Mechanical Equipment and Shops	0.7	1,123
Public Dining	499	Dining Room	0.95	474
Public Toilets	174	Public Space	0.8	139
Public Conf	436	Public Space	0.8	349
Shared Vertical Circulation	485	Internal Circulation	0.6	291
Shared Exterior Walls	438	Unassigned	0.5	219
Shared Circulation	2,265	Internal Circulation	0.6	1,359
Exterior Walls	988	Unassigned	0.5	494
TOTAL	57,716		0.96361399	55,616

Cost of New Construction

A. Base Calculations	**Actual**	**Per Sq. Foot**
Building	$19,349,171	$320.71
Fixed Equipment		$0.00
Site Preparation	$2,108,248	$34.94
Architectual Fees	$2,083,087	$34.53
Permits	$986,504	$16.35
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$24,527,010	$406.53

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

	Project Costs	**Associated Cap Interest & Financing**

Site Demolition Costs	$30,517	Site	
Storm Drains	$5,253	Site	
Rough Grading	$12,760	Site	
Paving	$174,495	Site	
Exterior Signs on building	$24,960	Site	
Landscaping	$96,049	Site	
Walls	$37,519	Site	
Yard Lighting	$20,110	Site	
Dewatering	$75,038	Site	
Sediment Control & Stabilization	$17,409	Site	
Helipad	$36,754	Site	
Premium for Minority Business Enterprise Requirement	$84,330	Site	
Canopy	$85,000	Building	$21,935
Pneumatic Tube System	$104,000	Building	$26,838
Pedestrian Bridge	$1,000,000	Building	$258,057
Jurisdictional Hook-up Fees	$608,933	Building	$157,140
Premium for Minority Business Enterprise Requirement	$773,967	Building	$180,104
Jurisdictional Hook-up Fees	$102,648	Permits	
Total Cost Adjustments	$3,289,742	14.7%	$644,073

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

1. Explanation of Extraordinary Costs

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

1. Overhead Pedestrian Bridge to the outpatient services.

2. Premium for Minority Business Enterprise Requirement – UMMS projects include a premium for Minority Business Enterprises that would not be in the average cost of hospital construction. This premium was projected to be 4%. UMMS consulted with its cost

estimators/construction managers on the impact on project budgets of targeting 25% inclusion of MBE subcontractors or suppliers as part of its projects, and their conservative estimate is that it adds 3-4% to the costs, compared to projects that do not include MBE subcontractors or suppliers. This estimate has been confirmed through UMMS' experience with past construction jobs. UMMS now uses this percentage in all of its construction cost estimates.

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

C. Adjusted Project Cost		**Per Square Foot**
Building	$16,777,271	$278.08
Fixed Equipment	$0	$0.00
Site Preparation	$1,493,053	$24.75
Architectual Fees	$2,083,087	$34.53
Permits	$883,856	$14.65
Subtotal	$21,237,268	$352.00
Capitalized Construction Interest	$3,295,017	$54.61
Total	$24,532,286	$406.61

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

Hospital	New	Renovation	Total		
Building Cost	$19,349,171				
Subtotal Cost (w/o Cap Interest)	$24,527,010		$24,527,010		
Subtotal/Total	100.0%	0.0%	Net Interest	Financing	Total
Total Project Cap Interest &Financing [(Subtotal Cost/Total Cost) X Total Cap Interest & Financing]	$4,993,192	$0	$4,537,481	$455,711	$4,993,192
Building/Subtotal	78.9%				
Building Cap Interest & Financing	$3,939,091				
Associated with Extraordinary Costs	$644,073				
Applicable Cap Interest & Loan Place.	$3,295,017				

As noted below, the project's cost per square foot is within 15% of the MVS benchmark.

MVS Benchmark	$382.69
The Project	$406.61
Difference	$23.92
	6.25%

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

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

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

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

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

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

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

Applicant Response:

The proposed project and as well as the other capital projects for which UM UCH and its constituent hospitals have sought approval from the Commission will be funded through a combination of $200.0 million in tax exempt debt and $3.7 million of interest earned on bond proceeds. The bonds are anticipated to be issued in fiscal year 2020 through the University of Maryland Medical System.

The applicant has completed **Tables A**, **B**, **C**, **D**, **E**, **I, J**, and **K**, which are related to the proposed project, as well as the projected utilization and financial performance of UC Behavioral Health. These tables are included with **Exhibit 1. Table I** includes utilization projections that reflect both the inpatient and outpatient utilization of UC Behavioral Health and related outpatient ancillary services. Also enclosed with **Exhibit 1** are **Tables F**, **G**, and **H** that cover the entire utilization and financial performance of all UM UCH hospital facility components, including UCMC and HMH during the period from fiscal year 2015 to fiscal year 2021 and UCMC, UC FMF, and UC Behavioral Health between fiscal years 2022 and 2024. The financial projection assumptions related to revenue, expenses and financial performance underlying Tables G, H, J and K are also provided with Exhibit 1. **Table K** reflects that UC Behavioral

Health will generate approximately $661,000 and $862,000 annually in operating income between fiscal years 2022 and 2024. Additionally, **Exhibit 1** includes a **Table L** that incorporates the workforce for UC Behavioral Health in fiscal year 2024. Included in the figures are full-time equivalent employees ("FTEs") dedicated to the provision of services to patients at UC Behavioral Health.

The community is supportive of the proposed project and this Application will be supplemented with letters of support**.** UM UCH has submitted the most recent, audited, consolidated financial statements of the University of Maryland Medical System at **Exhibit 12**.

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

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

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

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

Applicant Response:

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

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

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

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

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

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

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

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

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

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

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project[3];

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

c) On costs to the health care delivery system.

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

Applicant Response:

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

The proposed project will improve access to behavioral health services in the service area by creating a hub-and-spoke model for the provision of outpatient behavioral health services with additional outpatient services being delivered UCMC. Further, the proposed project includes the development of specialized geriatric inpatient psychiatric services, which presently does not exist in the service area market. This project not only ensures access to behavioral health services in the service area but also will improve patient handoffs across a continuum of providers, thereby leading to improved patient outcomes and transitions back to the community. Moreover, centralizing the service area's acute behavioral health services will solve several regional behavioral health delivery issues, including service provider recruitment and retention.

Pending an agreement with the HSCRC regarding distribution of HMH's global budget revenue, an increase in rates from the HSCRC will not be required under Alternative 4, which includes the proposed project. UM Upper Chesapeake Health is negotiating with the HSCRC to reallocate revenue from HMH's global budget revenue cap to cover capital expenses and volume redistribution at UC Behavioral Health, UCMC, and UC FMF. Assuming that a sufficient

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

amount of HMH's global budget revenue cap is reallocated within UM UCH, UM UCH anticipates that an increase in rates will not be required under Alternative 4 described in response to COMAR 10.24.01.08G(3)(c).

Pending final approval from the HSCRC regarding distribution of HMH's global budget revenue, the proposed project would also provide Maryland system saving of $2.8 million annually due to the hospital's reimbursement being based on the Medicare prospective payment system and a reduction in rates for Medicaid utilization.

Table of Exhibits

Table of Tables

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

November 19, 2018
Date

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

#600532
011888-0023

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

November 19, 2018
Date

Stephen Witman
Senior Vice President, Chief Financial Officer
University of Maryland Upper Chesapeake Health System

#646235
011888-0023

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

November 19, 2018
Date

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

#600530
011888-0023

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

November 19, 2018
Date

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

#600548
011888-0023

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

November 19, 2018
Date

Paul Muddiman
Vice President
Morris & Ritchie Associates, Inc.

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

November 19, 2018

11/19/18

Date

Ed Anderson
Project Executive
ERDMAN

#600549
011888-0023

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

November 19, 2018
Date

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

#600532
011888-0023

EXHIBIT 1

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

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

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

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

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

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

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

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

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Inpatient Care Services		40,175			40,175
Connector		751			751
Outpatient Care Services			14,728		14,728
Maintenance		625			625
Circulation		1,877			1,877
Mechanical		344			344
Receiving		292			292
Dietary		898			898
Maintenance		3,165			3,165
Maintnenance Staff Lounge and Lockers		381			381
Nursing Staff Lounge and Lockers		339			339
Provider Staff Lounge and Lockers		551			551
Provider Offices		281			281
Housekeeping		259			259
Storage		890			890
Mechanical		1,604			1,604
Public Dining		499			499
Public Toilets		174			174
Public Conf		436			436
Shared Vertical Circulation		485			485
Shared Exterior Walls		438			438
Shared Circulation		2,265			2,265
Exterior Walls		988			988
Total		57,716	14,728		72,444

TABLE C. CONSTRUCTION CHARACTERISTICS

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

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

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Lower Level	12,957	
First Floor	0	
Second Floor	43,161	
Third Floor	1,598	
Existing Third Floor		14,728
Average Square Feet	**14,429**	**14,728**
Perimeter in Linear Feet	**Linear Feet**	
Lower Level	483	
First Floor	0	
Second Floor	1,142	
Third Floor	275	
Existing Third Floor		724
Total Linear Feet	**1,595**	**724**
Average Linear Feet	**475**	**724**
Wall Height (floor to eaves)	**Feet**	
Lower Level	15'	
First Floor	15'	
Second Floor	15'	
Third Floor	15'	
Existing Third Floor		15'
Average Wall Height	**15'**	
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	3	
Freight	1	
Sprinklers	**Square Feet Covered**	
Wet System	57,716	14,728
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project	VAV, Ducted return, AHUs with chilled and hot water	
Type of Exterior Walls for proposed project	Masonry	

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

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

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation	$1,493,053	
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs		
Site Demolition Costs	$30,517	
Storm Drains	$5,253	
Rough Grading	$12,760	
Paving	$174,495	
Exterior Signs on building	$24,960	
Landscaping	$96,049	
Walls	$37,519	
Yard Lighting	$20,110	
Dewatering	$75,038	
Sediment Control & Stabilization	$17,409	
Helipad	$36,754	
Premium for Minority Business Enterprise Requirement	$84,330	
Subtotal On-Site excluded from Marshall Valuation Costs	**$615,194**	
OFFSITE COSTS		
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs	**$0**	
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$615,194**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$2,108,248**	**$0**
BUILDING COSTS		
Normal Building Costs	$16,777,271	
Subtotal included in Marshall Valuation Costs	$16,777,271	
Canopy	$85,000	
Pneumatic Tube System	$104,000	
Pedestrian Bridge	$1,000,000	
Jurisdictional Hook-up Fees	$608,933	
Premium for Minority Business Enterprise Requirement	$773,967	
Subtotal Building Costs excluded from Marshall Valuation Costs	**$2,571,900**	
TOTAL Building Costs included and excluded from Marshall Valuation Service*	**$19,349,171**	**#REF!**
A&E COSTS		
Normal A&E Costs	$2,083,087	
Subtotal included in Marshall Valuation Costs	**$2,083,087**	
Subtotal A&E Costs excluded from Marshall Valuation Costs	**$0**	
TOTAL A&E Costs included and excluded from Marshall Valuation Service*	**$2,083,087**	**$0**
PERMIT COSTS		
Normal Permit Costs	$883,856	
Subtotal included in Marshall Valuation Costs	**$883,856**	
Jurisdictional Hook-up Fees	$102,648	
Subtotal Permit Costs excluded from Marshall Valuation Costs	**$102,648**	
TOTAL Permit Costs included and excluded from Marshall Valuation Service*	**$986,504**	**$0**

TABLE E. PROJECT BUDGET

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

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

	FMF	BHH	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building	$21,662,478	$19,349,171	$41,011,649
(2) Fixed Equipment			$0
(3) Site and Infrastructure	$1,993,356	$2,108,248	$4,101,604
(4) Architect/Engineering Fees	$2,241,008	$2,083,087	$4,324,095
(5) Permits (Building, Utilities, Etc.)	$956,053	$986,504	$1,942,557
SUBTOTAL	**$26,852,895**	**$24,527,010**	**$51,379,905**
b. Renovations			
(1) Building		$2,476,709	$2,476,709
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees		$157,921	$157,921
(4) Permits (Building, Utilities, Etc.)		$20,000	$20,000
SUBTOTAL	**$0**	**$2,654,630**	**$2,654,630**
c. Other Capital Costs			
(1) Movable Equipment	$8,410,098	$8,853,903	$17,264,001
(2) Contingency Allowance	$3,526,299	$3,603,554	$7,129,854
(3) Gross interest during construction period	$4,439,767	$4,537,481	$8,977,247
(4) Other (Specify/add rows if needed)			$0
SUBTOTAL	***$16,376,164***	***$16,994,938***	**$33,371,102**
TOTAL CURRENT CAPITAL COSTS	**$43,229,058**	**$44,176,579**	**$87,405,637**
d. *Land Purchase*	**$2,197,329**	**$2,299,294**	**$4,496,623**
e. Inflation Allowance	$1,174,762	$1,204,515	$2,379,278
TOTAL CAPITAL COSTS	**$46,601,150**	**$47,680,387**	**$94,281,538**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	**$445,396**	**$455,711**	$901,107
b. Bond Discount			$0
c CON Application Assistance			
c1. Legal Fees	**$110,322**	**$110,322**	$220,644
c2. Other (Specify/add rows if needed)	**$884,309**	**$884,309**	$1,768,618
d. Non-CON Consulting Fees			
d1. Legal Fees	**$227,508**	**$227,508**	$455,016
d2. Other (Specify/add rows if needed)	**$1,181,081**	**$1,181,081**	$2,362,163
e. Debt Service Reserve Fund	**$3,274,012**	**$3,349,835**	$6,623,847
f Other (Specify/add rows if needed)			$0
SUBTOTAL	***$6,122,629***	***$6,208,766***	**$12,331,395**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$52,723,779***	***$53,889,154***	***$106,612,933***
B. Sources of Funds			
1. Cash			$0
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds	**$51,716,745**	**$52,859,861**	$104,576,606
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other (Interest Earned on Trusteed Assets)	$1,007,034	$1,029,293	$2,036,327
TOTAL SOURCES OF FUNDS	***$52,723,779***	***$53,889,154***	$106,612,933
	Hospital Building	***Other Structure***	***Total***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY (UCMC + UC FMF + HMH + UC BEHAVIORAL HEALTH + OBSERVATION)

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. DISCHARGES									
a1. General Medical/Surgical* UCMC	9,082	8,974	8,061	8,241	8,427	8,619	11,404	11,660	11,925
a2. General Medical/Surgical* HMH	2,931	3,034	3,021	3,087	3,155	3,226			
a3. Observation UCMC	11,410	12,127	13,930	13,985	14,043	14,106	14,523	14,618	14,717
a4. Observation UC FMF							5,606	5,606	5,606
a5. Observation HMH	3,896	4,019	4,443	4,458	4,474	4,491			
General MSGA & Observation	**27,319**	**28,154**	**29,455**	**29,770**	**30,099**	**30,442**	**31,534**	**31,884**	**32,249**
b1. ICU/CCU UCMC	814	860	842	860	879	899	1,186	1,212	1,240
b2. ICU/CCU HMH	203	179	175	179	183	187			
Total MSGA	**28,336**	**29,193**	**30,472**	**30,809**	**31,161**	**31,528**	**32,720**	**33,097**	**33,488**
c. Pediatric	94	123	108	107	106	105	121	120	119
d. Obstetric	1,381	1,366	1,296	1,299	1,301	1,304	1,307	1,310	1,312
e1. Acute Psychiatric HMH	1,236	1,233	1,195	1,201	1,207	1,213			
e2. Acute Psychiatric UC Behavioral Health							1,367	1,375	1,385
Total Acute	***31,047***	***31,915***	***33,071***	***33,416***	***33,776***	***34,150***	***35,514***	***35,902***	***36,304***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL DISCHARGES	***31,047***	***31,915***	***33,071***	***33,416***	***33,776***	***34,150***	***35,514***	***35,902***	***36,304***
2. PATIENT DAYS									
a1. General Medical/Surgical* UCMC	37,389	35,932	32,685	33,441	34,226	35,039	46,125	47,215	48,346
a2. General Medical/Surgical* HMH	13,472	13,246	12,318	12,601	12,896	13,201			
a3. Observation UCMC	12,169	13,243	13,841	13,890	13,941	13,996	22,033	22,177	22,327
a4. Observation UC FMF							7,008	7,008	7,008
a5. Observation HMH	4,670	4,813	4,788	4,802	4,818	4,834	-		
General MSGA & Observation	**67,700**	**67,234**	**63,631**	**64,734**	**65,881**	**67,070**	**75,166**	**76,400**	**77,681**
b1. ICU/CCU UCMC	3,600	3,415	3,342	3,419	3,500	3,583	4,708	4,818	4,933
b2. ICU/CCU HMH	1,515	1,496	1,465	1,499	1,534	1,571			
Total MSGA	**72,815**	**72,145**	**68,439**	**69,653**	**70,914**	**72,224**	**79,874**	**81,219**	**82,614**
c. Pediatric	232	335	234	232	245	251	249	246	244
d. Obstetric	2,806	2,776	2,512	2,517	2,522	2,528	2,533	2,538	2,544
e1. Acute Psychiatric HMH	7,502	7,486	7,737	8,138	8,542	8,609			
e2. Acute Psychiatric UC Behavioral Health							11,421	11,574	11,734
Total Acute	***83,355***	***82,741***	***78,922***	***80,541***	***82,224***	***83,612***	***94,076***	***95,578***	***97,135***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL PATIENT DAYS	***83,355***	***82,741***	***78,922***	***80,541***	***82,224***	***83,612***	***94,076***	***95,578***	***97,135***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY (UCMC + UC FMF + HMH + UC BEHAVIORAL HEALTH + OBSERVATION)

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)									
a1. General Medical/Surgical* UCMC	4.1	4.0	4.1	4.1	4.1	4.1	4.0	4.0	4.1
a2. General Medical/Surgical* HMH	4.6	4.4	4.1	4.1	4.1	4.1			
a3. Observation UCMC	1.1	1.1	1.0	1.0	1.0	1.0	1.5	1.5	1.5
a4. Observation UC FMF							1.25	1.25	1.25
a5. Observation HMH	1.2	1.2	1.1	1.1	1.1	1.1			
General MSGA & Observation	2.5	2.4	2.2	2.2	2.2	2.2	2.4	2.4	2.4
b1. ICU/CCU UCMC	4.4	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
b2. ICU/CCU HMH	7.5	8.4	8.4	8.4	8.4	8.4			
Total MSGA	2.6	2.5	2.2	2.3	2.3	2.3	2.4	2.5	2.5
c. Pediatric	2.5	2.7	2.2	2.2	2.3	2.4	2.1	2.1	2.1
d. Obstetric	2.0	2.0	1.9	1.9	1.9	1.9	1.9	1.9	1.9
e1. Acute Psychiatric HMH	6.1	6.1	6.5	6.8	7.1	7.1			
e2. Acute Psychiatric UC Behavioral Health							8.4	8.4	8.5
Total Acute	2.7	2.6	2.4	2.4	2.4	2.4	2.6	2.7	2.7
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL AVERAGE LENGTH OF STAY	2.7	2.6	2.4	2.4	2.4	2.4	2.6	2.7	2.7
4. NUMBER OF LICENSED BEDS									
a1. General Medical/Surgical* UCMC	128	123	112	114	117	120	158	162	165
a2. General Medical/Surgical* HMH	45	44	41	42	43	44			
a3. Observation UCMC	42	46	48	48	48	48	76	76	77
a4. Observation UC FMF							24	24	24
a5. Observation HMH	16	17	16	16	17	17			
General MSGA & Observation	**231**	**230**	**217**	**221**	**225**	**229**	**258**	**262**	**266**
b1. ICU/CCU UCMC	14	14	14	14	14	14	17	17	17
b2. ICU/CCU HMH	6	6	6	6	6	7			
Total MSGA	**251**	**250**	**237**	**241**	**245**	**249**	**275**	**278**	**283**
c. Pediatric	1	1	1	1	1	1	1	1	1
d. Obstetric	10	10	10	10	10	10	10	10	10
e1. Acute Psychiatric HMH	26	26	26	28	29	29			
e2. Acute Psychiatric UC Behavioral Health							40	40	40
Total Acute	***288***	***287***	***274***	***280***	***285***	***289***	***326***	***329***	***334***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL LICENSED BEDS	***288***	***287***	***274***	***280***	***285***	***289***	***326***	***329***	***334***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY (UCMC + UC FMF + HMH + UC BEHAVIORAL HEALTH + OBSERVATION)

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:*** *Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a1. General Medical/Surgical* UCMC	80.2%	79.8%	80.2%	80.2%	80.1%	80.1%	80.0%	80.1%	80.2%
a2. General Medical/Surgical* HMH	82.0%	82.5%	82.3%	82.2%	82.2%	82.2%			
a3. Observation UCMC	79.4%	78.9%	79.0%	79.3%	79.6%	79.9%	79.4%	79.9%	79.4%
a4. Observation UC FMF							80.0%	80.0%	80.0%
a5. Observation HMH	80.0%	79.9%	80.0%	80.2%	80.0%	79.8%			
General MSGA & Observation	80.4%	80.2%	80.3%	80.4%	80.4%	80.5%	79.9%	80.0%	80.0%
b1. ICU/CCU UCMC	70.5%	66.8%	65.4%	66.9%	68.5%	70.1%	75.9%	80.0%	80.0%
b2. ICU/CCU HMH	69.2%	68.3%	66.9%	68.5%	70.0%	61.5%			
Total MSGA	**79.6%**	**79.1%**	**79.1%**	**79.3%**	**79.5%**	**79.3%**	**79.6%**	**80.0%**	**80.0%**
c. Pediatric	63.6%	91.8%	64.1%	63.6%	67.1%	68.7%	68.1%	67.5%	66.9%
d. Obstetric	76.9%	76.0%	68.8%	69.0%	69.1%	69.3%	69.4%	69.5%	69.7%
e1. Acute Psychiatric HMH	79.1%	78.9%	81.5%	79.6%	80.7%	81.3%			
e2. Acute Psychiatric UC Behavioral Health							78.2%	79.3%	80.4%
Total Acute	**79.4%**	**79.0%**	**78.9%**	**78.9%**	**79.2%**	**79.2%**	**79.1%**	**79.6%**	**79.7%**
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL OCCUPANCY %	**79.4%**	**79.0%**	**78.9%**	**78.9%**	**79.2%**	**79.2%**	**79.1%**	**79.6%**	**79.7%**
6. OUTPATIENT VISITS									
a1. Emergency Department UCMC (Total)	65,251	64,502	61,445	61,812	62,181	62,553	63,041	63,418	63,797
a2. Emergency Department UC FMF (Total)							27,106	27,227	27,348
a3. Emergency Department HMH (Total)	29,520	28,356	26,743	26,862	26,981	27,101			
b1. Same-day Surgery Cases UCMC	5,890	5,678	5,621	5,652	5,685	5,719	5,753	5,791	5,830
b2. Same-day Surgery Cases HMH	1,169	1,210	1,234	1,240	1,246	1,252			
c1. Laboratory RVUs UCMC	11,182,649	12,048,570	11,494,331	10,945,039	11,228,867	11,453,817	14,782,750	15,082,236	15,392,589
c2. Laboratory RVUs HMH	2,803,257	2,695,784	2,487,416	2,554,276	2,599,157	2,645,591			
c3. Laboratory RVUs UC Behavioral Health							1,804,190	1,828,452	1,853,615
d1. Imaging RVUs UCMC	1,772,683	1,905,329	1,809,354	1,722,888	1,767,567	1,802,977	2,326,993	2,374,136	2,422,989
d2. Imaging RVUs HMH	590,035	615,566	582,398	598,053	608,561	619,433			
d3. Imaging RVUs UC Behavioral Health							495,722	502,356	509,234
e. Psych Emergency Department									
f1. Outpatient Psych Clinic HMH	5,052	5,646	5,759	5,874	5,992	6,111			
f2. Outpatient Psych Clinic UC Behavioral Health							6,234	6,358	6,485
g1. Intensive Outpatient Psych Program HMH	1,190	1,443	1,362	1,286	1,214	1,146			
g2. Intensive Outpatient Psych Program UC Behavioral Health							1,593	1,625	1,658
h1. Partial Hospitalization Program HMH				1,300	2,600	2,600			
h2. Partial Hospitalization Program UC Behavioral Health							3,900	5,200	5,200
TOTAL OUTPATIENT VISITS	***16,456,696***	***17,372,083***	***16,475,662***	***15,924,282***	***16,310,051***	***16,628,300***	***19,517,282***	***19,896,799***	***20,288,744***
7. OBSERVATIONS**									
a1. Number of Patients UCMC	11,410	12,127	13,930	13,985	14,043	14,106	14,523	14,618	14,717
a2. Number of Patients UC FMF							5,606	5,606	5,606
a3. Number of Patients HMH	3,896	4,019	4,443	4,458	4,474	4,491			
b1. Hours UCMC	292,060	317,843	332,191	333,349	334,589	335,915	528,801	532,243	535,846
b2. Hours UC FMF							168,192	168,192	168,192
b3. Hours HMH	112,075	115,522	114,915	115,254	115,620	116,014			

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

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a

TABLE G. REVENUES & EXPENSES, UNINFLATED - UPPER CHESAPEAKE HEALTH SYSTEM

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Gross patient services revenue	540,220	558,961	538,479	536,269	537,497	537,055	539,283	541,526
Gross Patient Service Revenues	***$ 540,220***	***$ 558,961***	***$ 538,479***	***$ 536,269***	***$ 537,497***	***$ 537,055***	***$ 539,283***	***$ 541,526***
c. Allowance For Bad Debt	14,027	14,080	14,266	14,200	14,237	13,706	13,773	13,839
d. Contractual Allowance	75,402	85,596	93,732	95,854	96,016	99,960	100,241	100,524
e. Charity Care	14,970	14,471	6,536	6,499	6,516	5,812	5,842	5,872
Net Patient Services Revenue	***$ 435,821***	***$ 444,814***	***$ 423,945***	***$ 419,716***	***$ 420,727***	***$ 417,577***	***$ 419,427***	***$ 421,291***
f. Other Operating Revenues (Specify/add rows if needed)	271	3,093	3,255	2,955	2,955	2,843	2,843	2,843
NET OPERATING REVENUE	***$ 436,092***	***$ 447,908***	***$ 427,200***	***$ 422,671***	***$ 423,682***	***$ 420,420***	***$ 422,271***	***$ 424,134***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 244,970	$ 234,694	$ 246,185	247,564	$ 247,714	$ 243,607	$ 243,542	$ 244,210
b. Contractual Services	13,253	10,071	10,029	10,180	10,328	8,558	8,700	8,840
c. Interest on Current Debt	8,150	9,808	9,523	9,271	8,964	8,643	8,313	8,030
d. Interest on Project Debt	-	-	-	-	-	8,961	8,794	8,619
e. Current Depreciation	22,137	22,922	23,591	22,634	23,518	23,042	23,979	24,980
f. Project Depreciation	-	-	-	-	-	7,438	7,438	7,438
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	83,351	84,045	64,830	66,164	67,476	66,901	67,795	68,717
j. Other Expenses (Specify/add rows if needed)	58,623	65,064	55,238	54,902	52,043	49,875	49,329	48,821
TOTAL OPERATING EXPENSES	***$ 430,484***	***$ 426,605***	***$ 409,396***	***$ 410,714***	***$ 410,043***	***$ 417,024***	***$ 417,890***	***$ 419,655***
3. INCOME								
a. Income From Operation	**$ 5,608**	**$ 21,303**	**$ 17,804**	**$ 11,957**	**$ 13,640**	**$ 3,396**	**$ 4,381**	**$ 4,480**
b. Non-Operating Income	18,640	17,578	10,085	8,487	7,815	9,075	9,513	10,135
SUBTOTAL	***$ 24,248***	***$ 38,881***	***$ 27,889***	***$ 20,443***	***$ 21,455***	***$ 12,471***	***$ 13,893***	***$ 14,615***
c. Income Taxes	-	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ 24,248***	***$ 38,881***	***$ 27,889***	***$ 20,443***	***$ 21,455***	***$ 12,471***	***$ 13,893***	***$ 14,615***

TABLE G. REVENUES & EXPENSES, UNINFLATED - UPPER CHESAPEAKE HEALTH SYSTEM

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%
2) Medicaid	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%
3) Blue Cross	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%
4) Commercial Insurance	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%
5) Self-pay	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
6) Other	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days								
Total MSGA								
1) Medicare	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%
2) Medicaid	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
3) Blue Cross	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%
4) Commercial Insurance	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%
5) Self-pay	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
6) Other	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table G – Key Financial Projection Assumptions for UM Upper Chesapeake Health System (Excludes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Upper Chesapeake Health System FY2019 projected results, including Upper Chesapeake Medical Center, Harford Memorial Hospital, Upper Chesapeake Medical Services, Upper Chesapeake Health System (Parent entity) and several other entities that comprise the majority of UCHS with assumptions identified below.	
Projection period reflects FY2019 – FY2024	
Volumes	- Refer to COE Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
• Gross Charges	
o Update Factor	- Based on each entity's FY2019 projected operating results. Removed where appropriate
o Demographic and Other Rate Adjustment	- Based on each entity's FY2019 projected operating results.
o Variable Cost Factor	- Based on each entity's FY2019 projected operating results.
• Revenue Deductions	
o Contractual Allowances	- Based on each entity's FY2019 projected operating results.
o Charity Care	- Based on each entity's FY2019 projected operating results.
o Allowance for Bad Debt	- Based on each entity's FY2019 projected operating results.
Other Revenue	- Based on each entity's FY2019 projected operating results.
Expenses	
• Inflation	- 0.0% increase per year
o Salaries and Benefits	- 0.0%
o Professional Fees	- 0.0%
o Supplies	- 0.0%
o Purchased Services	- 0.0%
o Other Operating Expenses	- 0.0%
• Expense Volume Driver	- For the hospital entities, identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	
o Salaries and Benefits	- Ranges from 10% for overhead departments to 100% for inpatient nursing units
o Professional Fees	- 0% for all cost centers except inpatient nursing (50%) and Laboratory (100%)
o Supplies & Drugs	- Ranges from 0% for overhead departments to 100% for the Emergency Department
o Purchased Services	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
• Other Operating Expenses	- Beginning in FY2019 and F2020, 340B savings is assumed at UCMC, however the savings is offset by the increased cost of the implementation of the following systems: electronic medical records (EPIC), human resource module (Lawson), and time and attendance system (Kronos). - At UCMC beginning in FY2019, a $3.6M performance improvement plan is assumed with an incremental $900k of performance improvement per year assumed throughout the projection period. - At Upper Chesapeake Medical Services (physicians) a $72k performance improvement plan is assumed beginning in FY2019, increasing to a $766k cumulative performance improvement plan by FY2024.
• Interest Expense – Existing Debt	- Continued amortization of existing debt and related interest expense: - 4.75% interest on $55.3M 2008C Series bonds - 4.75% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Interest Expense – New Debt (Project Related)	- 4.5% interest on $200.0M bonds over 30 years
• Depreciation and Amortization	- Average life of 26 years on $183M (less land and debt service reserve fund) of construction project expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures	- Total $146.5M of routine and other (non project related) capital spend over the projection period.

TABLE H. REVENUES & EXPENSES, INFLATED - UPPER CHESAPEAKE HEALTH SYSTEM

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. GROSS REVENUE								
a. Gross Patient Service Revenues	$ 540,220	$558,961	$ 538,479	$549,140	$563,606	$576,659	$592,947	$609,704
Gross Patient Service Revenues	***540,220***	***$ 558,961***	***$ 538,479***	***$ 549,140***	***$ 563,606***	***$ 576,659***	***$ 592,947***	***$ 609,704***
b. Allowance For Bad Debt	$ 14,027	$ 14,080	$ 14,266	$ 14,541	$ 14,928	$ 14,717	$ 15,143	$ 15,582
c. Contractual Allowance	75,402	85,596	93,732	98,154	100,681	107,331	110,216	113,180
d. Charity Care	14,970	14,471	6,536	6,655	6,833	6,240	6,423	6,611
Net Patient Services Revenue	***435,821***	***$ 444,814***	***$ 423,945***	***$ 429,789***	***$ 441,164***	***$ 448,370***	***$ 461,165***	***$ 474,331***
e. Other Operating Revenues (Specify/add rows if needed)	271	3,093	3,255	2,985	3,014	2,929	2,959	2,988
NET OPERATING REVENUE	***436,092***	***$ 447,908***	***$ 427,200***	***$ 432,774***	***$ 444,179***	***$ 451,299***	***$ 464,124***	***$ 477,320***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 244,970	$ 234,694	$ 246,185	$ 253,258	$ 259,240	$ 260,805	$ 266,732	$ 273,616
b. Contractual Services	13,253	10,071	10,029	10,485	10,957	9,352	9,792	10,248
c. Interest on Current Debt	8,150	9,808	9,523	9,271	8,964	8,643	8,313	8,030
d. Interest on Project Debt						8,961	8,794	8,619
e. Current Depreciation	22,137	22,922	23,591	22,634	23,518	23,042	23,979	24,980
f. Project Depreciation						7,438	7,438	7,438
g. Current Amortization								
h. Project Amortization								
i. Supplies	83,351	84,045	64,830	68,149	71,585	73,104	76,304	79,662
j. Other Expenses (Specify/add rows if needed)	58,623	65,064	55,238	56,000	54,146	52,927	53,395	53,903
TOTAL OPERATING EXPENSES	***$ 430,484***	***$ 426,605***	***$ 409,396***	***$ 419,796***	***$ 428,409***	***$ 444,272***	***$ 454,748***	***$ 466,495***
3. INCOME								
a. Income From Operation	**$ 5,608**	**$ 21,303**	**$ 17,804**	**$ 12,977**	**$ 15,769**	**$ 7,027**	**$ 9,376**	**$ 10,825**
b. Non-Operating Income	18,640	17,578	10,085	8,487	7,815	9,075	9,513	10,135
SUBTOTAL	***$ 24,248***	***$ 38,881***	***$ 27,889***	***$ 21,464***	***$ 23,585***	***$ 16,102***	***$ 18,889***	***$ 20,960***
c. Income Taxes	-	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ 24,248***	***$ 38,881***	***$ 27,889***	***$ 21,464***	***$ 23,585***	***$ 16,102***	***$ 18,889***	***$ 20,960***

TABLE H. REVENUES & EXPENSES, INFLATED - UPPER CHESAPEAKE HEALTH SYSTEM

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%
2) Medicaid	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%
3) Blue Cross	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%
4) Commercial Insurance	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%
5) Self-pay	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
6) Other	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days								
1) Medicare	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%
2) Medicaid	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
3) Blue Cross	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%
4) Commercial Insurance	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%
5) Self-pay	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
6) Other	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table H - Key Financial Projection Assumptions for UM Upper Chesapeake Health System(Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Upper Chesapeake Health System FY2019 projected results, including Upper Chesapeake Medical Center, Harford Memorial Hospital, Upper Chesapeake Medical Services, Upper Chesapeake Health System (Parent entity) and several other entities that comprise the majority of UCHS with assumptions identified below.

Projection period reflects FY2020 – FY2024

Volumes	- Refer to CON Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
• Gross Charges	
o Update Factor	- Based on each entity's FY2019 projected operating results.
o Demographic and Other Rate Adjustment	- Based on each entity's FY2019 projected operating results.
o Variable Cost Factor	- Based on each entity's FY2019 projected operating results.
• Revenue Deductions	
o Contractual Allowances	- Based on each entity's FY2019 projected operating results.
o Charity Care	- Based on each entity's FY2019 projected operating results.
o Allowance for Bad Debt	- Based on each entity's FY2019 projected operating results.
Other Revenue	
Other Revenue	- Based on each entity's FY2019 projected operating results.
Expenses	
• Inflation	
o Salaries and Benefits	- 2.3%
o Professional Fees	- 3.0%
o Supplies	- 3.0%
o Purchased Services	- 3.0%
o Other Operating Expenses	- 2.0%
• Expense Volume Driver	- For the hospital entities, identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	
o Salaries and Benefits	- Ranges from 10% for overhead departments to 100% for inpatient nursing units
o Professional Fees	- 0% for all cost centers except inpatient nursing (50%) and Laboratory (100%)
o Supplies & Drugs	- Ranges from 0% for overhead departments to 100% for the Emergency Department
o Purchased Services	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
• Other Operating Expenses	- Beginning in FY2019 and F2020, 340B savings is assumed at UCMC, however the savings is offset by the increased cost of the implementation of the following systems: electronic medical records (EPIC), human resource module (Lawson), and time and attendance system (Kronos). - At UCMC beginning in FY2019, a $3.6M performance improvement plan is assumed with an incremental $900k of performance improvement per year assumed throughout the projection period. - At Upper Chesapeake Medical Services (physicians) a $72k performance improvement plan is assumed beginning in FY2019, increasing to a $766k cumulative performance improvement plan by FY2024.
• Interest Expense – Existing Debt	- Continued amortization of existing debt and related interest expense: - 4.75% interest on $55.3M 2008C Series bonds - 4.75% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Interest Expense – Project Debt	- 4.5% interest on $200.0M bonds over 30 years
• Depreciation and Amortization	- Average life of 26 years on $183M (less land and debt service reserve fund) of construction project expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures	- Total $146.5M of routine and other (non project related) capital spend over the projection period.

TABLE I. STATISTICAL PROJECTIONS - ENTIRE UC Behavioral Health

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. DISCHARGES									
a. General Medical/Surgical*									
b. ICU/CCU									
Total MSGA									
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric							1,367	1,375	1,385
Total Acute							***1,367***	***1,375***	***1,385***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL DISCHARGES							***1,367***	***1,375***	***1,385***
2. PATIENT DAYS									
a. General Medical/Surgical*									
b. ICU/CCU									
Total MSGA									
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric							11,421	11,574	11,734
Total Acute							***11,421***	***11,574***	***11,734***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL PATIENT DAYS							***11,421***	***11,574***	***11,734***

TABLE I. STATISTICAL PROJECTIONS - ENTIRE UC Behavioral Health

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)									
a. General Medical/Surgical*									
b. ICU/CCU									
Total MSGA									
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric							8.4	8.4	8.5
Total Acute								8.4	8.5
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL AVERAGE LENGTH OF STAY							8.4	8.4	8.5
4. NUMBER OF LICENSED BEDS									
a. General Medical/Surgical*									
b. ICU/CCU									
Total MSGA									
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric							40	40	40
Total Acute							***40***	***40***	***40***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL LICENSED BEDS							***40***	***40***	***40***

TABLE I. STATISTICAL PROJECTIONS - ENTIRE UC Behavioral Health

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a. General Medical/Surgical*									
b. ICU/CCU									
Total MSGA									
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric							78.2%	79.3%	80.4%
Total Acute							**78.2%**	**79.3%**	**80.4%**
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL OCCUPANCY %							**78.2%**	**79.3%**	**80.4%**
6. OUTPATIENT VISITS									
a. Emergency Department									
b. Same-day Surgery									
c. Laboratory							1,804,190	1,828,452	1,853,615
d. Imaging							495,722	502,356	509,234
e. Psych Emergency Department									
f. Outpatient Psych Clinic							6,234	6,358	6,485
g. Intensive Outpatient Psych Program							1,593	1,625	1,658
h. Partial Hospitalization Program							3,900	5,200	5,200
TOTAL OUTPATIENT VISITS							***2,311,638***	***2,343,992***	***2,376,192***
7. OBSERVATIONS**									
a. Number of Patients									
b. Hours									

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

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

TABLE J. REVENUES & EXPENSES, UNINFLATED - PROJECT SPECIFIC - UC Behavioral Health

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Inpatient Services	$ -	$ -	$ -	$ -	$ -	$ 20,267	$ 20,379	$ 20,497
b. Outpatient Services	-	-	-	-	-	8,176	8,251	8,328
Gross Patient Service Revenues	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 28,442***	***$ 28,630***	***$ 28,824***
c. Allowance For Bad Debt	-	-	-	-	-	887	892	898
d. Contractual Allowance	-	-	-	-	-	5,122	5,156	5,191
e. Charity Care	-	-	-	-	-	-	-	-
Net Patient Services Revenue	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 22,433***	***$ 22,582***	***$ 22,735***
f. Other Operating Revenues (Specify/add rows if needed)	-	-	-	-	-	121	120	119
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 22,555***	***$ 22,702***	***$ 22,854***
2. EXPENSES								
a. Salaries & Wages (including benefits)	-	-	-	-	-	13,434	13,518	13,650
b. Contractual Services	-	-	-	-	-	388	388	388
c. Interest on Current Debt	-	-	-	-	-	442	425	411
d. Interest on Project Debt	-	-	-	-	-	2,742	2,691	2,638
e. Current Depreciation	-	-	-	-	-	-	-	-
f. Project Depreciation	-	-	-	-	-	2,234	2,271	2,384
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	-	-	-	-	-	688	699	707
j. Other Expenses (Specify/add rows if needed)	-	-	-	-	-	2,165	2,158	2,151
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 22,094***	***$ 22,150***	***$ 22,328***
3. INCOME								
a. Income From Operation	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 461***	***$ 551***	***$ 526***
b. Non-Operating Income	-	-	-	-	-	-	-	-
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 461***	***$ 551***	***$ 526***
c. Income Taxes	-	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 461***	***$ 551***	***$ 526***

TABLE J. REVENUES & EXPENSES, UNINFLATED - PROJECT SPECIFIC - UC Behavioral Health

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

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

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

Projection is based on the Harford Memorial Hospital (HMH) FY2019 results with assumptions identified below.	
Projection period reflects FY2022 – FY2024	
Volumes	- Refer to CON Table I, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
• Gross Charges	
o Update Factor	- 0.00% annual increase in FY2022 – FY2024
o Demographic and Other Rate Adjustment	- No demographic adjustment
o Variable Cost Factor	- HMH Psychiatric revenue will shift to UC Behavioral Health at a 100% variable cost factor.
o Geriatric Psychiatry Change	- Geriatric Psychiatry charge per day calculated using state-wide average Geriatric Psychiatry utilization profile multiplied by projected rates
o Partial Hospitalization Psychiatry Charges	- Outpatient Partial Hospitalization Psychiatry charges calculated by multiplying visits by projected PDC rate
o Other	- Removed assessments and quality from HMH rates and changed the mark-up based on HMH FY2018 Psychiatric payer mix
• Revenue Deductions	
o Contractual Allowances	- Based on FY2018 HMH Psychiatric payer mix and remains constant at 16.4% of gross revenue per year - Medicare contractual adjustments reflect an inpatient Medicare per diem rate that is 64% of the assumed charge per visit based on Sheppard Pratt average per diem -Outpatient is assumed to be the same as inpatient - Assumes Medicaid will pay HSCRC rates
o Charity Care	- Based on FY2016 HMH uncompensated care and remains constant at 0.5% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	- Based on FY2016 HMH uncompensated care and remains constant at 3.1% of gross revenue per year - No overfunding or underfunding of UCC
Other Revenue	
o Cafeteria Revenue and Other Operating Revenue	- 0.0% increase per year
Expenses	
• Inflation	- 0.0% increase per year
o Salaries and Benefits	- 0.0%
o Professional Fees	- 0.0%
o Supplies	- 0.0%
o Purchased Services	- 0.0%
o Other Operating Expenses	- 0.0%
• Expense Volume Driver	- Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	
o Salaries and Benefits	- Ranges from 10% for overhead departments to 100% for inpatient nursing units.
o Professional Fees	- 0% for all cost centers except inpatient nursing (50%) and Laboratory (100%).
o Supplies & Drugs	- Ranges from 0% for overhead departments to 100% for the Emergency Department.
o Purchased Services	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
• Other Operating Expenses	- Additional adjustments totalling approximately $3.0M were made to reduce Pharmacy and other operating expenses and UCHS overhead allocations to reflect Psychiatric specific services and a smaller facility
• Interest Expense – Existing Debt	- 5.2% allocation of the following debt amortization of existing debt and related interest expense: - 4.75% interest on $55.3M 2008C Series bonds - 4.75% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Interest Expense – Project Debt	- 4.5% interest on $52.9M bonds over 30 years
• Depreciation and Amortization	- Average life of 26 years on $47.8M of construction project expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures	- $0.5M in FY2022, growing to $1.0M in FY2023 and $1.2M in FY2024

TABLE K. REVENUES & EXPENSES, INFLATED - PROJECT SPECIFIC - UC Behavioral Health

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Inpatient Services	$ -	$ -	$ -	$ -	$ -	$ 21,507	$ 22,059	$ 22,630
b. Outpatient Services	-	-	-	-	-	8,676	8,931	9,194
Gross Patient Service Revenues	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 30,183***	***$ 30,990***	***$ 31,825***
c. Allowance For Bad Debt	-	-	-	-	-	941	966	992
d. Contractual Allowance	-	-	-	-	-	5,436	5,581	5,731
e. Charity Care	-	-	-	-	-	-	-	-
Net Patient Services Revenue	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 23,806***	***$ 24,443***	***$ 25,101***
f. Other Operating Revenues (Specify/add rows if needed)	-	-	-	-	-	129	130	131
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 23,935***	***$ 24,573***	***$ 25,233***
2. EXPENSES								
a. Salaries & Wages (including benefits)	-	-	-	-	-	14,383	14,806	15,294
b. Contractual Services	-	-	-	-	-	424	436	450
c. Interest on Current Debt	-	-	-	-	-	442	425	411
d. Interest on Project Debt	-	-	-	-	-	2,742	2,691	2,638
e. Current Depreciation	-	-	-	-	-	-	-	-
f. Project Depreciation	-	-	-	-	-	2,234	2,271	2,384
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	-	-	-	-	-	752	786	820
j. Other Expenses (Specify/add rows if needed)	-	-	-	-	-	2,297	2,336	2,375
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 23,275***	***$ 23,752***	***$ 24,370***
3. INCOME								
a. Income From Operation	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 661**	**$ 821**	**$ 862**
b. Non-Operating Income	-	-	-	-	-	-	-	-
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 661***	***$ 821***	***$ 862***
c. Income Taxes						-	-	-
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ 661***	***$ 821***	***$ 862***

TABLE K. REVENUES & EXPENSES, INFLATED - PROJECT SPECIFIC - UC Behavioral Health

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

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

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

Projection is based on the Harford Memorial Hospital (HMH) FY2019 projected results with assumptions identified below.	
Projection period reflects FY2022 – FY2024	
Volumes	- Refer to CON Table I, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
- Gross Charges	
o Update Factor	- 1.90% annual increase in FY2022 – FY2024
o Demographic and Other Rate Adjustment	- No demographic adjustment
o Variable Cost Factor	- HMH Psychiatric revenue will shift to UC Behavioral Health at a 100% variable cost factor.
o Geriatric Psychiatry Change	- Geriatric Psychiatry charge per day calculated using state-wide average Geriatric Psychiatry utilization profile multiplied by projected rates
o Partial Hospitalization Psychiatry Charges	- Outpatient Partial Hospitalization Psychiatry charges calculated by multiplying visits by projected PDC rate
o Other	- Removed assessments and quality from HMH rates and changed the mark-up based on HMH FY2018 Psychiatric payer mix
- Revenue Deductions	
o Contractual Allowances	- Based on FY2018 HMH Psychiatric payer mix and remains constant at 16.4% of gross revenue per year - Medicare contractual adjustments reflect an inpatient Medicare per diem rate that is 64% of the assumed charge per visit based on Sheppard Pratt average per diem -Outpatient is assumed to be the same as inpatient - Assumes Medicaid will pay HSCRC rates
o Charity Care	- Based on FY2016 HMH uncompensated care and remains constant at 0.5% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	- Based on FY2016 HMH uncompensated care and remains constant at 3.1% of gross revenue per year - No overfunding or underfunding of UCC
Other Revenue	
o Cafeteria Revenue and Other Operating Revenue	- 1.0% increase per year
Expenses	
- Inflation	
o Salaries and Benefits	- 2.3%
o Professional Fees	- 3.0%
o Supplies	- 3.0%
o Purchased Services	- 3.0%
o Other Operating Expenses	- 2.0%
- Expense Volume Driver	- Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
- Expense Variability with Volume Changes	
o Salaries and Benefits	- Ranges from 10% for overhead departments to 100% for inpatient nursing units.
o Professional Fees	- 0% for all cost centers except inpatient nursing (50%) and Laboratory (100%).
o Supplies & Drugs	- Ranges from 0% for overhead departments to 100% for the Emergency Department.
o Purchased Services	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
- Other Operating Expenses	- Additional adjustments totalling approximately $3.0M were made to reduce Pharmacy and other operating expenses and UCHS overhead allocations to reflect Psychiatric specific services and a smaller facility
- Interest Expense – Existing Debt	- 5.2% allocation of the following debt amortization of existing debt and related interest expense: - 4.75% interest on $55.3M 2008C Series bonds - 4.75% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
- Interest Expense – Project Debt	- 4.5% interest on $52.9M bonds over 30 years
- Depreciation and Amortization	- Average life of 26 years on $47.8M of construction project expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures	- $0.5M in FY2022, growing to $1.0M in FY2023 and $1.2M in FY2024

TABLE L. WORKFORCE INFORMATION - UC Behavioral Health

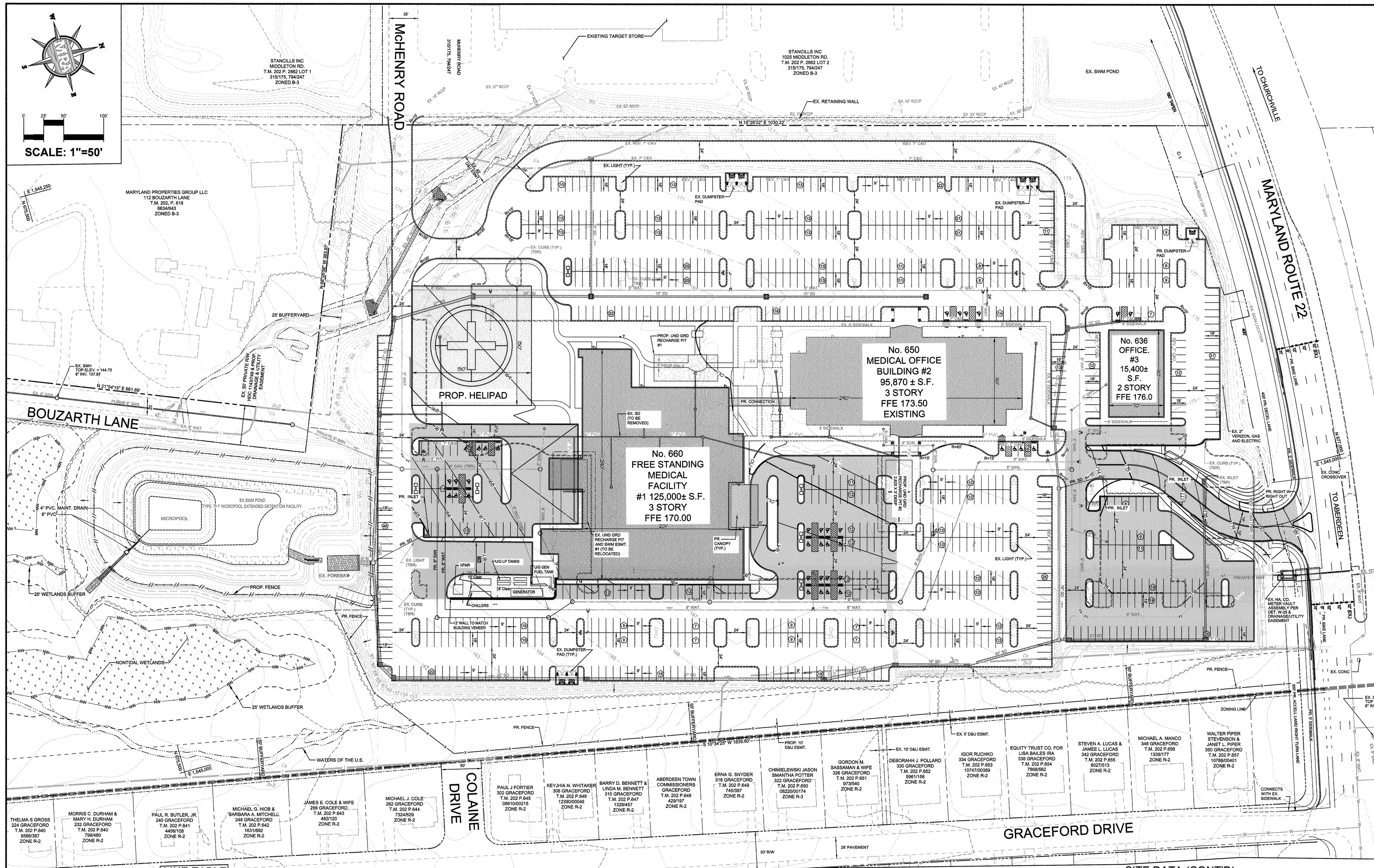
INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted)*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Medical Staff Administration										0.2	$18.17
Quality & Health Information Management										1.8	$104.32
Fiscal Services										0.5	$33.57
Spirituality										0.0	$3.18
Patient Accounting										1.0	$48.59
Centralized Scheduling										0.7	$28.93
Admitting										3.9	$86.55
MIS										1.3	$115.77
Telecommunications										0.1	$8.93
Administration										0.2	$51.93
Safety										0.1	$8.37
Nursing Administration										0.9	$103.10
Hospital Education										0.6	$50.87
Quality Management										0.4	$28.88
Readmission										0.6	$50.93
Clinical Resource Management										0.5	$51.05
Distribution										0.6	$21.60
Volunteers										0.1	$8.63
Human Resources										0.4	$29.27
Healthlink										0.0	$2.54
Performance Improvements										0.4	$45.98
HC Epidemiology & Infection Control										0.1	$7.43
Guest Services										0.1	$8.70
Purchasing										0.3	$15.99
Risk Management										0.1	$14.80
General Hospital										1.4	$76.71
Total Administration			$0			$0			$0	16.5	$1,025

TABLE L. WORKFORCE INFORMATION - UC Behavioral Health

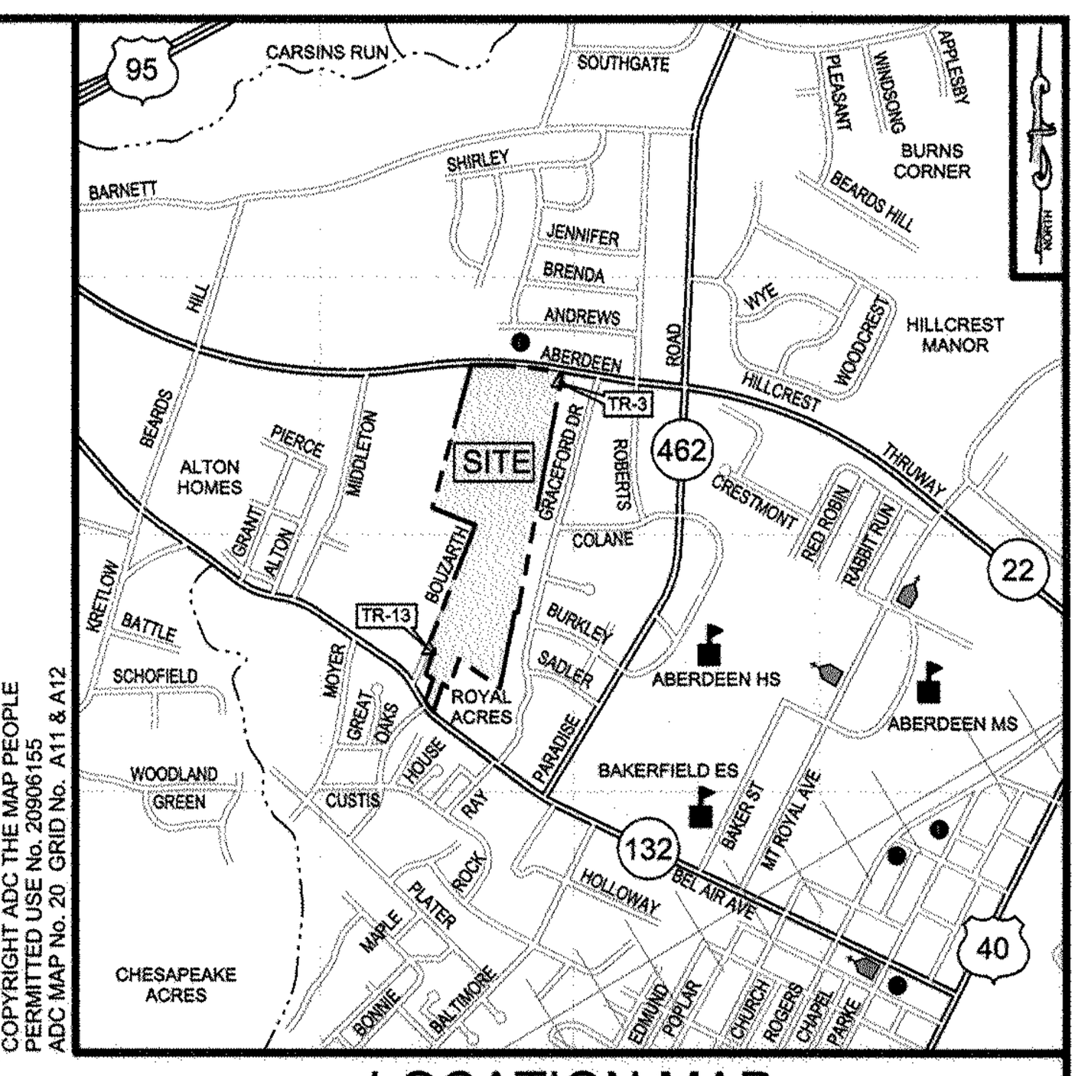
Direct Care Staff *(List general categories, add rows if needed)*										
Partial Hospitalization Psych			$0			$0			$0	8.9	$754.48
Behavioral Health			$0			$0			$0	75.6	$6,044.18
Outpatient Psychiatric Clinic			$0			$0			$0	11.3	$961.36
Intensive Outpatient Psychiatry			$0			$0			$0	2.3	$189.24
Emergency Department			$0			$0			$0	4.9	$388.57
IV Therapy			$0			$0			$0	0.4	$33.62
Pharmacy			$0			$0			$0	2.8	$263.29
Respiratory Therapy			$0			$0			$0	0.1	$9.76
Physical Therapy			$0			$0			$0	0.3	$18.28
Occupational Therapy			$0			$0			$0	0.2	$23.32
Radiology			$0			$0			$0	0.4	$30.35
Nuclear Medicine			$0			$0			$0	0.0	$0.37
Cat Scan			$0			$0			$0	0.1	$7.56
MRI			$0			$0			$0	0.0	$2.56
Cardiovascular Institute			$0			$0			$0	0.1	$4.65
Electroencephalography			$0			$0			$0	0.0	$1.76
Laboratory			$0			$0			$0	2.1	$132.57
Total Direct Care			$0			$0			$0	109.6	$8,866
Support Staff *(List general categories, add rows if needed)*										
Nutritional Services			$0			$0			$0	8.4	$321
Plant Operations			$0			$0			$0	4.0	$252
Bio Med			$0			$0			$0	0.1	$4
Environmental Services			$0			$0			$0	11.0	$342
Security			$0			$0			$0	8.5	$311
Print Shop			$0			$0			$0	0.1	$4
Total Support			$0			$0			$0	31.9	$1,234
REGULAR EMPLOYEES TOTAL			$0			$0			$0	158.0	$11,125
2. Contractual Employees										
Administration *(List general categories, add rows if needed)*										
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*										
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*										
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below)* :											**$ 2,525**
22.7% of Salaries											
TOTAL COST	***0.0***		***$0***	***0.0***		***$0***	***0.0***		***$0***		***$13,650***

EXHIBIT 2



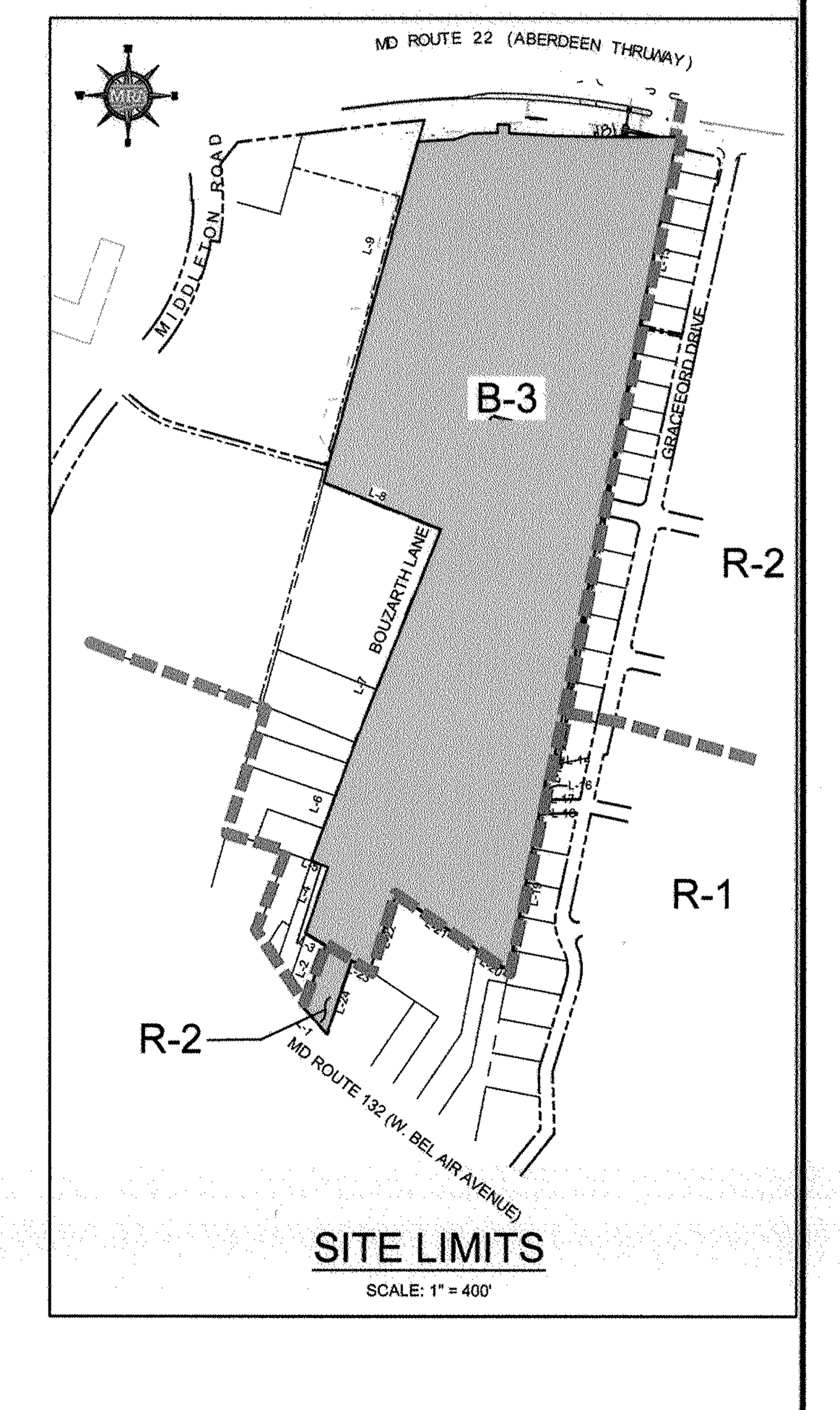
PLAN VIEW

SCALE: 1" = 50'



LOCATION MAP

SCALE: 1" = 1,500'



SITE LIMITS

SCALE: 1" = 400'

LINE TABLE

LINE	ANGLE	DISTANCE	LINE	ANGLE	DISTANCE
L1	N 41°14'36" W	99.61'	L13	S 10°34'25" W	1839.80'
L2	N 18°50'39" E	190.58'	L14	S 78°48'14" W	26.25'
L3	N 58°32'12" W	66.35'	L15	S 11°01'20" W	100.07'
L4	N 18°42'50" E	200.20'	L16	N 88°51'32" E	4.00'
L5	N 68°43'13" W	51.74'	L17	S 10°52'52" W	41.99'
L6	N 20°11'52" E	364.04'	L18	S 88°03'17" W	4.01'
L7	N 21°54'15" E	661.69'	L19	S 10°58'16" W	459.49'
L8	N 68°05'56" W	363.97'	L20	N 55°27'41" W	105.89'
L9	N 15°26'22" E	1030.22'	L21	N 55°27'41" W	285.46'
L10	N 70°50'34" E	100.57'	L22	S 18°41'00" W	234.89'
L11	S 87°45'00" E	143.88'	L23	N 60°22'59" W	60.67'
L12	S 87°29'05" E	69.69'	L24	S 18°21'31" W	223.19'

CURVE TABLE

CURVE	DELTA	RADIUS	ARC	CHORD BEARING	CHORD	TANGENT
C-1	2°21'56"	2177.83'	89.92'	N86°21'30"E	89.91'	44.96'
C-2	8°44'59"	2208.83'	337.31'	S85°35'04"E	336.98'	168.98'

SOILS DATA

SYMBOL	SOIL SERIES	SLOPE	HYDRIC	HIGHLY ERODIBLE	PRIME AGRICULTURAL	SEPTIC LIMITATIONS	HYDROLOGIC CLASSIFICATION
BeB	BELTSVILLE	2-5%	LIMITED	YES	NO	YES	C
Cx	CUT/FILL LAND	-	NO	NO	NO	NO	C
DcB	DELANCO	3-8%	LIMITED	YES	YES	YES	C
En	ELKTON	-	YES	YES	NO	YES	D
MkB	MATAPEAKE	2-5%	NO	YES	YES	NO	B
Sa	SAND/GRAVEL	-	LIMITED	NO	NO	NO	A

OWNER

SIGNED: scott zoy DATE: 10/17/18

PROPOSED WASTERWATER/WATER USE CALCULATIONS

WASTEWATER FLOW PROJECTION

BUILDING	AREA	CALCULATION		AVG. DAILY
#1	125,000 SF	FIXTURE COUNT	=	7,470 GPD
#2	95,870 SF	[95,870 SF] x [.09 GPD/SF]	=	8,628 GPD
#3	15,400 SF	[15,400 SF] x [.09 GPD/SF]	=	1,386 GPD

TOTAL = 17,484 GPD

WATER FLOW PROJECTION

BUILDING	AREA	CALCULATION		AVG. DAILY (ADD)	MAX. DAILY (MDD)
#1	125,000 SF	FIXTURE COUNT	=	7,993 GPD x 1.6 =	12,789 GPD
#2	95,870 SF	[95,870 SF] x [.09 GPD/SF]	=	8,628 GPD x 1.6 =	13,805 GPD
#3	15,400 SF	[15,400 SF] x [.09 GPD/SF]	=	1,386 GPD x 1.6 =	2,218 GPD
				TOTAL =	28,812 GPD

LEGEND

- EXISTING ZONING LINE
- EXISTING CURB (TO REMAIN)
- EXISTING CURB (TO BE REMOVED)
- PROPOSED CURB
- PROPOSED FENCE
- EXISTING 1' INTERVAL CONTOUR (112)
- EXISTING 5' INTERVAL CONTOUR (110)
- BUILDING
- NEW PARKING AREA
- EXISTING WOODY VEGETATION
- EX. ADJOINING PROPERTY LINE
- SOILS LINE AND DESIGNATION (KeB2 / EmB)
- WATERS OF THE U.S.
- LIMIT OF 25' NONTIDAL WETLANDS BUFFER
- LIMIT OF NONTIDAL WETLANDS (NW)
- EXISTING WATER LINE
- EXISTING SANITARY SEWER
- EXISTING EASEMENT
- EXISTING ELECTRIC
- EXISTING VERIZON
- EXISTING GAS
- PROPOSED EDGE OF PAVEMENT/CURBLINE
- RIGHT-OF-WAY (R/W) LINE
- BOUNDARY/PROPERTY LINE
- PROPOSED BUILDING
- PROPOSED 1' CONTOUR
- PROPOSED 5' CONTOUR
- PROPOSED STORM DRAIN AND INLET
- EX. STORM DRAIN, INLET & MANHOLE
- PROP. WATER LINE & FIRE HYDRANT
- PROP. SANITARY SEWER & MANHOLE
- EX. LIGHT POLE
- PR. LIGHT POLE
- EX. SIDEWALK
- PR. SIDEWALK

NOTE: ALL UTILITES ARE CONSIDERED EXISTING UNLESS LABELED PR. FOR PROPOSED

SITE DATA:

1. CONTRACT PURCHASER: UCH / UMMS REAL ESTATE TRUST, 520 UPPER CHESAPEAKE DRIVE, SUITE 405, BEL AIR, MARYLAND 21014, CONTACT: MS. ROBIN LUXON
2. OWNER: MERRITT PROPERTIES, LLC, 2066 LORD BALTIMORE DRIVE, BALTIMORE, MARYLAND 21244, CONTACT: MR. DAN PALLACE, P.E.

SITE ADDRESS: 635-660 McHENRY RD, ABERDEEN, MD, 21001-0000

3. PROPERTY INFORMATION: T.M. 202 PARCEL: 620
LOT 1: 635-660 McHENRY RD 34.94 ± AC. ZONED B-3 HIGHWAY COMMERCIAL DISTRICT
LOT 2: 641 W. BEL AIR AVE. 17,635 ± SF. ZONED R-2 MEDIUM DENSITY RESIDENTIAL DISTRICT
4. PROJECT AREA: 35.63 AC. (BASED ON ALTA SURVEY)
5. EXISTING USE: DEVELOPED-EXISTING VACANT OFFICE BUILDING AND PARKING
6. PROPOSED USE:

PRODUCT TYPE	BLDG. HT.	GROSS S.F.	TOTAL S.F.
FREESTANDING MEDICAL FACILITY (FMF) #1	48'	125,000±	
EXISTING MEDICAL OFFICE #2	48'	95,870±	
OFFICE #3	30'	15,400±	236,270±

7. PARKING:
REQUIRED (PER ZONING CODE):
FMF: 1 P.S. / INPATIENT AND/OR OUTPATIENT BED (90) PLUS 2 SPACES PER 3 EMPLOYEES ON THE LARGEST WORK SHIFT (125) PLUS 1 SPACE PER STAFF DOCTOR (10) = 225 P.S.
MEDICAL OFFICE: 1 P.S. / 300 S.F. @ 95,870 S.F. = 320 P.S.
OFFICE: 1 P.S. / 300 S.F. @ 15,400 S.F. = 52 P.S.
TOTAL: 597 P.S. (MIN. # OF ACCESSIBLE SPACES REQUIRED = 12 P.S.)

*PROPOSED SEATING & EMPLOYEE TOTALS ARE ESTIMATES AND MAY VARY.

PROVIDED:
FMF: 609 P.S.
MED OFFICE: 320 P.S.
OFFICE: 100 P.S.
TOTAL: 1,029 P.S.

8. THERE IS NO 100-YEAR FEMA FLOODPLAIN AS EVIDENCED BY THE FEMA 'FIRM' MAP PANEL NO. 24025C0193 E; EFFECTIVE DATE: APRIL 19, 2016.
9. THE SITE BOUNDARY WAS PREPARED BY MORRIS & RITCHIE ASSOCIATES, INC ON JULY 8, 2010.
10. THE SITE IS NOT LOCATED IN THE CHESAPEAKE BAY CRITICAL AREA.
11. THERE IS NO KNOWN PLANT AND WILDLIFE HABITAT OF STATE OR FEDERAL IMPORTANCE ON-SITE.
12. THERE ARE NO KNOWN HISTORICAL AREAS PRESENT ON SITE.
13. A) STORM WATER MANAGEMENT (SWM) WAS DESIGNED, AND APPROVED UNDER THE 2000 MDE REGULATIONS, AND IS GRAND FATHERED FROM THE 2007 REGULATIONS.
B) THE APPROVED ABERDEEN CORPORATE PARK IMPERVIOUS= 12.3 ± AC. THE UCH SITE PLAN IMPERVIOUS = 12.2 ±AC. THEREFORE, THE EXISTING SWM POND REQUIRES NO REVISIONS.
C) THE EXISTING UNDERGROUND RECHARGE PIT IS TO BE RELOCATED AS SHOWN ON THE SITE PLAN.
14. PUBLIC WATER AND SANITARY SEWER IS PROVIDED BY THE CITY OF ABERDEEN. ALL EXISTING AND PROPOSED ON-SITE UTILITIES SHALL BE PRIVATELY OWNED AND MAINTAINED.

SITE DATA (CONT'D):

15. ALL OPEN SPACE, STORMWATER MANAGEMENT FACILITIES, ROADS, AND ON-SITE UTILITIES SHALL BE MAINTAINED BY OWNER / DEVELOPER.
16. THE WETLAND LIMITS SHOWN HEREWITH ARE FROM A WETLAND DELINEATION COMPLETED BY MCCARTHY AND ASSOCIATES, INC. IN FEBRUARY 2009.
17. EXACT DIMENSIONS AND LOCATIONS OF PROPOSED SIGNAGE ARE TO BE DETERMINED BY FINAL DESIGN.
18. LANDSCAPE SUMMARY:
PARKING LOT AREA: 10.37± AC. X 10% LANDSCAPE AREA = 1.037 AC. REQUIRED
1,016 SPACES @ 1 TREE / 10 SPACES = 102 TREES PLANTED
PER THE CODE OF THE CITY OF ABERDEEN, SECTION 142-25 (8). SEE THE FINAL LANDSCAPE PLAN FOR DETAILS.
BUFFERYARD: 10' MIN. PLANTING STRIP ALONG PROPERTY LINE TO SCREEN INCOMPATIBLE USES
A COMBINATION OF EXISTING VEGETATION TO REMAIN AND PROPOSED PLANTINGS IS PROVIDED ALONG PROPERTY LINES AT A MINIMUM OF 10' IN WIDTH, AND TYPICAL OF 50' IN WIDTH ADJACENT TO RESIDENTIAL USES.
PER THE CODE OF THE CITY OF ABERDEEN, SECTION 142-30. SEE THE FINAL LANDSCAPE PLAN FOR DETAILS.
19. A SITE LANDSCAPING AND LIGHTING PLAN, AND FOREST CONSERVATION PLAN WILL BE PROVIDED DURING FINAL DESIGN. (10 % OF THE REQUIRED PARKING AREAS SHALL BE LANDSCAPED. PLEASE REFER TO THE ABERDEEN DEVELOPMENT CODE, CHAPTER 235 SECTION 30. LANDSCAPING, LIGHTING, AND BUFFER YARDS.
20. A SIGNAGE PLAN WILL BE PROVIDED AT FINAL DESIGN.
21. FINAL LOCATIONS FOR FIRE HYDRANTS, VALVES, WATER AND SEWER LINES, PUMPING STATIONS, SHALL BE DETERMINED ON THE CONSTRUCTION PLANS.

DATE	REVISIONS

CITY OF ABERDEEN
DEPARTMENT OF PUBLIC WORKS - CITY ENGINEER
APPROVED: [signature] DATE: 10/25/2018

CITY OF ABERDEEN
DEPARTMENT OF PUBLIC WORKS - DIRECTOR
APPROVED: Kyle Torster DATE: 10/25/2018

CITY OF ABERDEEN
PLANNING COMMISSION - CHAIRMAN
APPROVED: [signature] DATE: 11/1/18

CITY OF ABERDEEN
PLANNING & COMMUNITY DEVELOPMENT - DIRECTOR
APPROVED: Phyllis Grover DATE: 11/1/18

CITY OF ABERDEEN
MAYOR
APPROVED: [signature] DATE: 11/5/2018

CONTRACT PURCHASER / DEVELOPER
SIGNED: Lyle E. [signature] DATE: 10.17.18

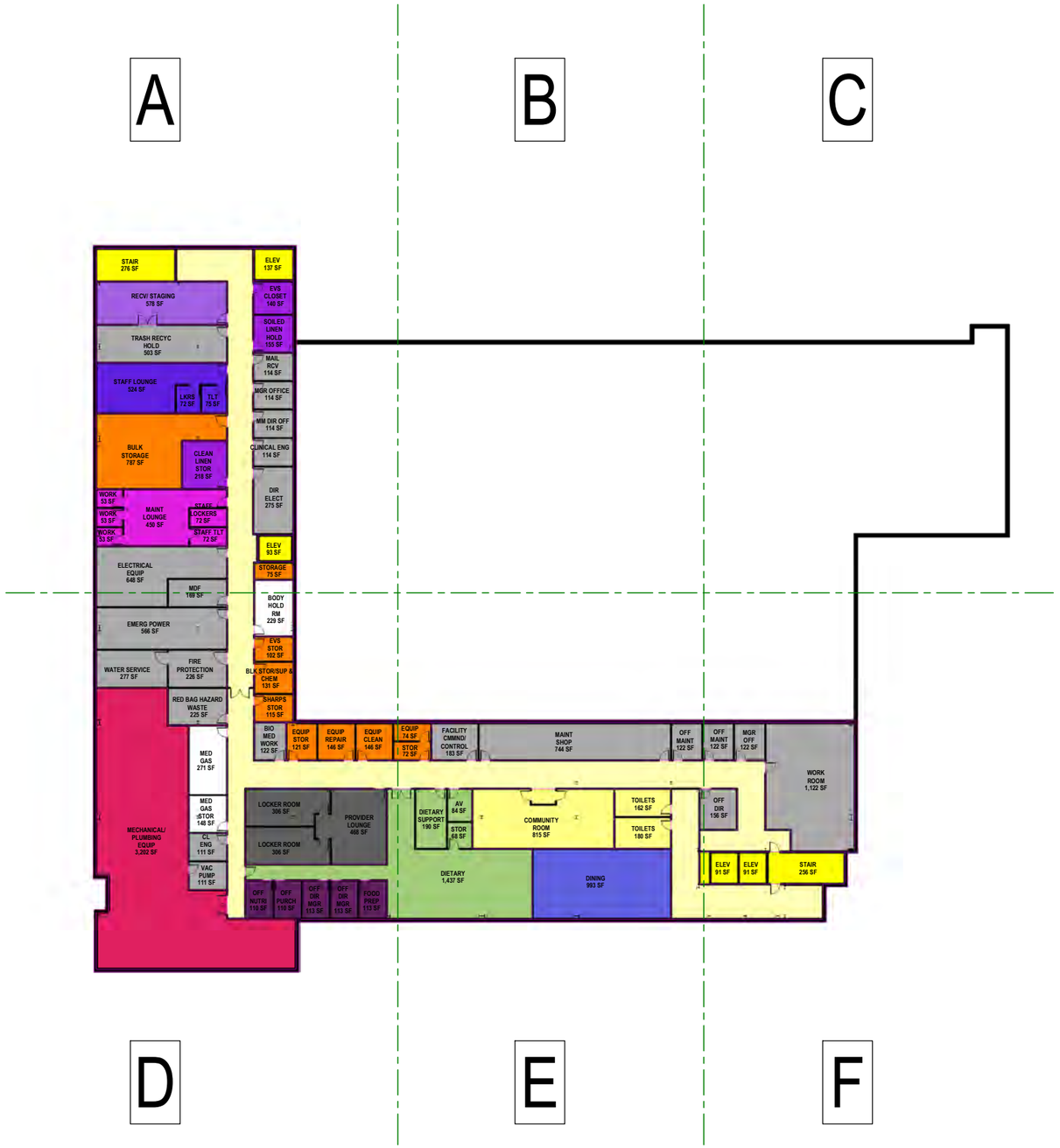
PROFESSIONAL CERTIFICATION
"I (JEFF MATTHAI) HEREBY CERTIFY THAT THESE DOCUMENTS WERE PREPARED OR APPROVED BY ME, AND THAT I AM A DULY LICENSED PROFESSIONAL ENGINEER UNDER THE LAWS OF THE STATE OF MARYLAND, LICENSE NO. EXPIRATION DATE: 7-27-19"

MRA

MORRIS & RITCHIE ASSOCIATES, INC.
ENGINEERS, ARCHITECTS, PLANNERS, SURVEYORS & LANDSCAPE ARCHITECTS
3445-A BOX HILL CORPORATE CENTER DRIVE
ABINGDON, MARYLAND 21009
PHONE (410) 515-9000
FAX (410) 515-9002

PRELIMINARY SITE PLAN SHEET
FOR
UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH
ABERDEEN CORPORATE PARK
CITY OF ABERDEEN
2ND ELECTION DISTRICT — HARFORD COUNTY, MARYLAND

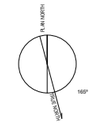
JOB NO:	15402X2
SCALE:	1" = 50'
DATE:	10/16/2018
DRAWN BY:	SFQ
DESIGN BY:	PTM / JEM
REVIEW BY:	JEM
SHEET:	1 OF 1



LOWER LEVEL DEPARTMENT AREAS

NOT TO SCALE

AREA SF	DEPARTMENTS
4,441	CIRCULATION
1,762	DIETARY
6,206	ENGINEERING AND MAINTENANCE
508	HOUSEKEEPING
748	MAINT LOUNGE/LKR
3,144	MECH
665	NURSE LOUNGE/LKR
1,080	PROVIDER LOUNGE/LKR
550	PROVIDER OFFICES
979	PUBLIC DINING
855	PUBLIC SPACE
342	PUBLIC TOILETS
572	RECEIVING
859	SHARED EXTERIOR WALL
1,745	STORAGE
951	VERTICAL CIRCULATION



ERDMAN

One Erdman Place P.O. Box 44975
Madison, Wisconsin 53717
Phone: (608) 410-8000
FAX: (608) 410-8500

Architectural Services Provided By:
ERDMAN ARCHITECTURE, LLC
COA# AX010514

Architect of Record

UNIVERSITY OF MARYLAND -

UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS

NOT FOR CONSTRUCTION

No.	Description	Date
	Document Release	

Dm:Author Chk:Checker

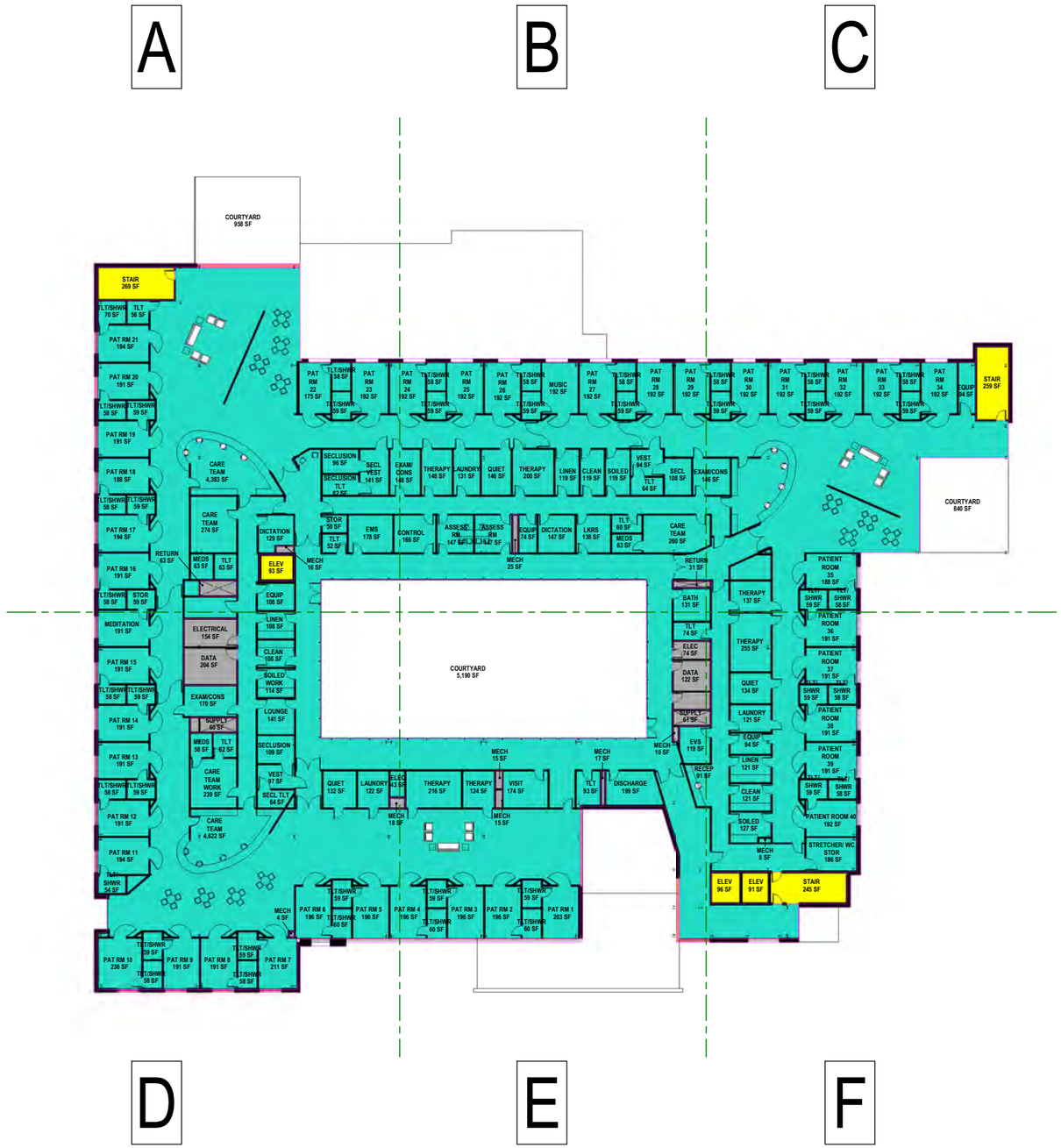
Sheet Name
LOWER LEVEL DEPARTMENT AREAS

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

Sheet Number
A100B

ABERDEEN, MD

JOB #654100



SECOND FLOOR DEPARTMENT AREAS

NOT TO SCALE

AREA SF	DEPARTMENTS
969	ENGINEERING AND MAINTENANCE
988	EXTERIOR WALL
40,175	INPATIENT CARE SERVICES
1,030	VERTICAL CIRCULATION

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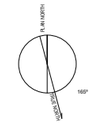
COA# AX010514

Architect of Record

UNIVERSITY OF MARYLAND -

UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS



NOT FOR CONSTRUCTION

No.	Description	Date
	Document Release	

Dm:Author Chk:Checker

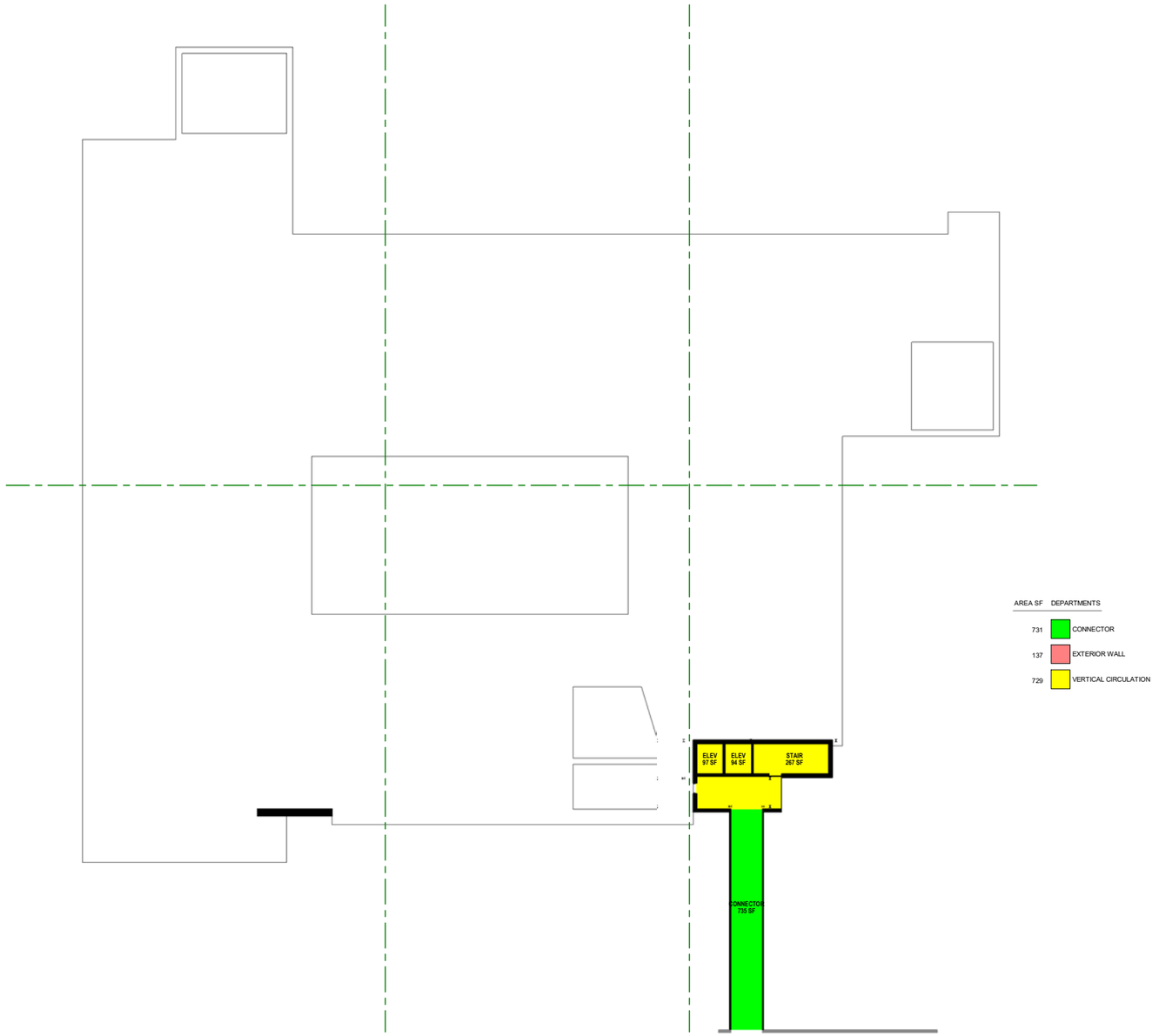
Sheet Name
SECOND FLOOR DEPARTMENT AREAS

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

Sheet Number
A102-B

ABERDEEN, MD

JOB #654100



AREA SF	DEPARTMENTS
731	CONNECTOR
137	EXTERIOR WALL
729	VERTICAL CIRCULATION

THIRD FLOOR DEPARTMENT AREAS

NOT TO SCALE

ERDMAN

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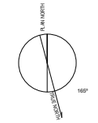
Architectural Services Provided By:
ERDMAN ARCHITECTURE, LLC
COA# AX010514

Architect of Record

UNIVERSITY OF MARYLAND -

UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS



NOT FOR CONSTRUCTION

No.	Description	Date
	Document Release	

Dm:Author Chk:Checker

Sheet Name
THIRD FLOOR DEPARTMENT AREAS

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

Sheet Number
A103B-A

ABERDEEN, MD

JOB #654100

AREA SF	DEPARTMENTS
14,728	BEH. HEALTH OUTPATIENT CARE SERVICES
	NEW RAISED FLOOR

EXISTING THIRD FLOOR DEPARTMENT AREAS

NOT TO SCALE

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FAX: (608) 410-8500

Architectural Services Provided By:
ERDMAN ARCHITECTURE, LLC
COA# AX010514

Architect of Record

UNIVERSITY OF MARYLAND -

UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS

NOT FOR CONSTRUCTION

No.	Description	Date
	Document Release	

Dm:Author Chk:Checker

Sheet Name
EXISTING THIRD FLOOR DEPARTMENT AREAS

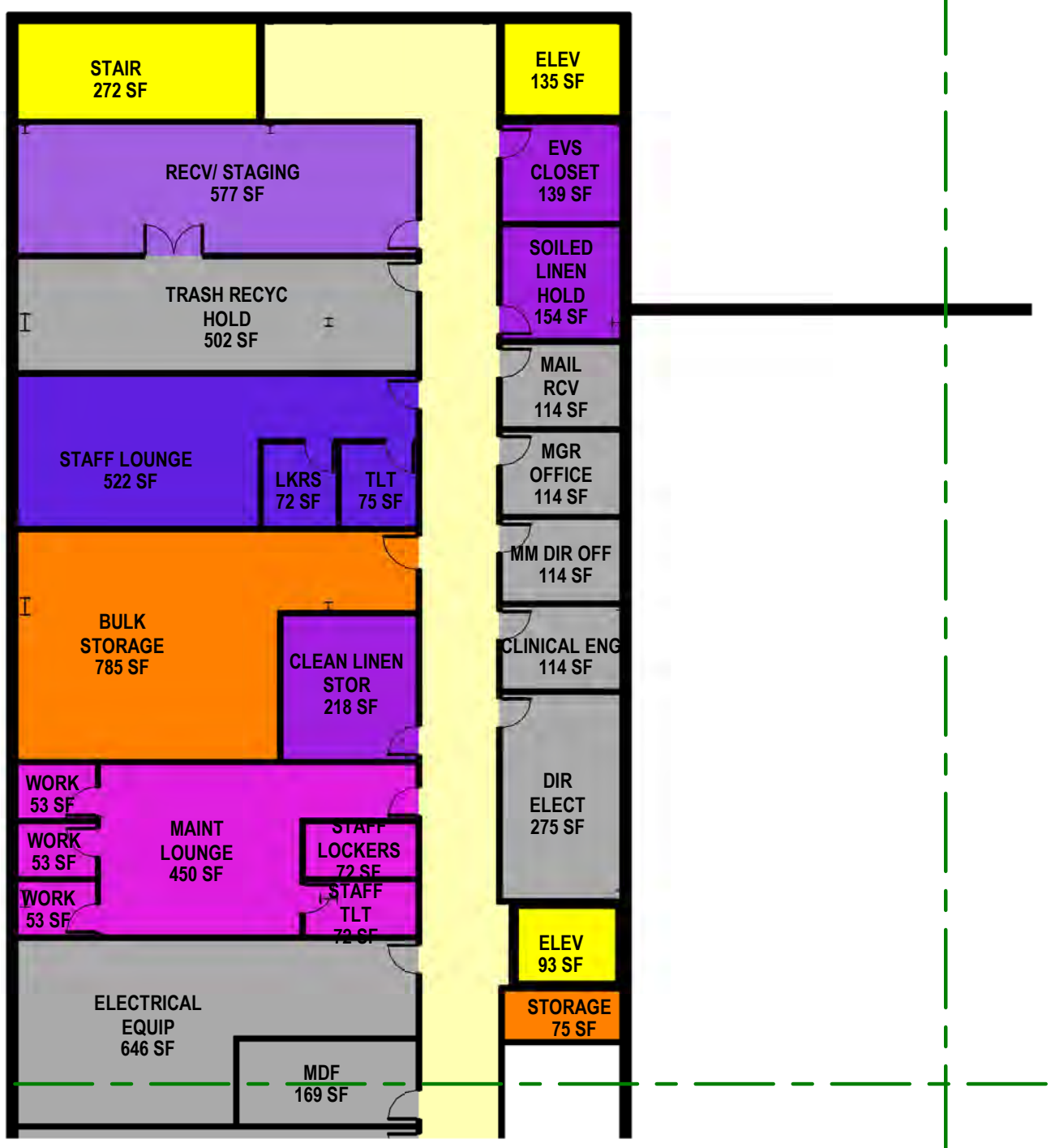
Scale: **1/16" = 1'-0"**

Sheet Number
A103B-B

ABERDEEN, MD

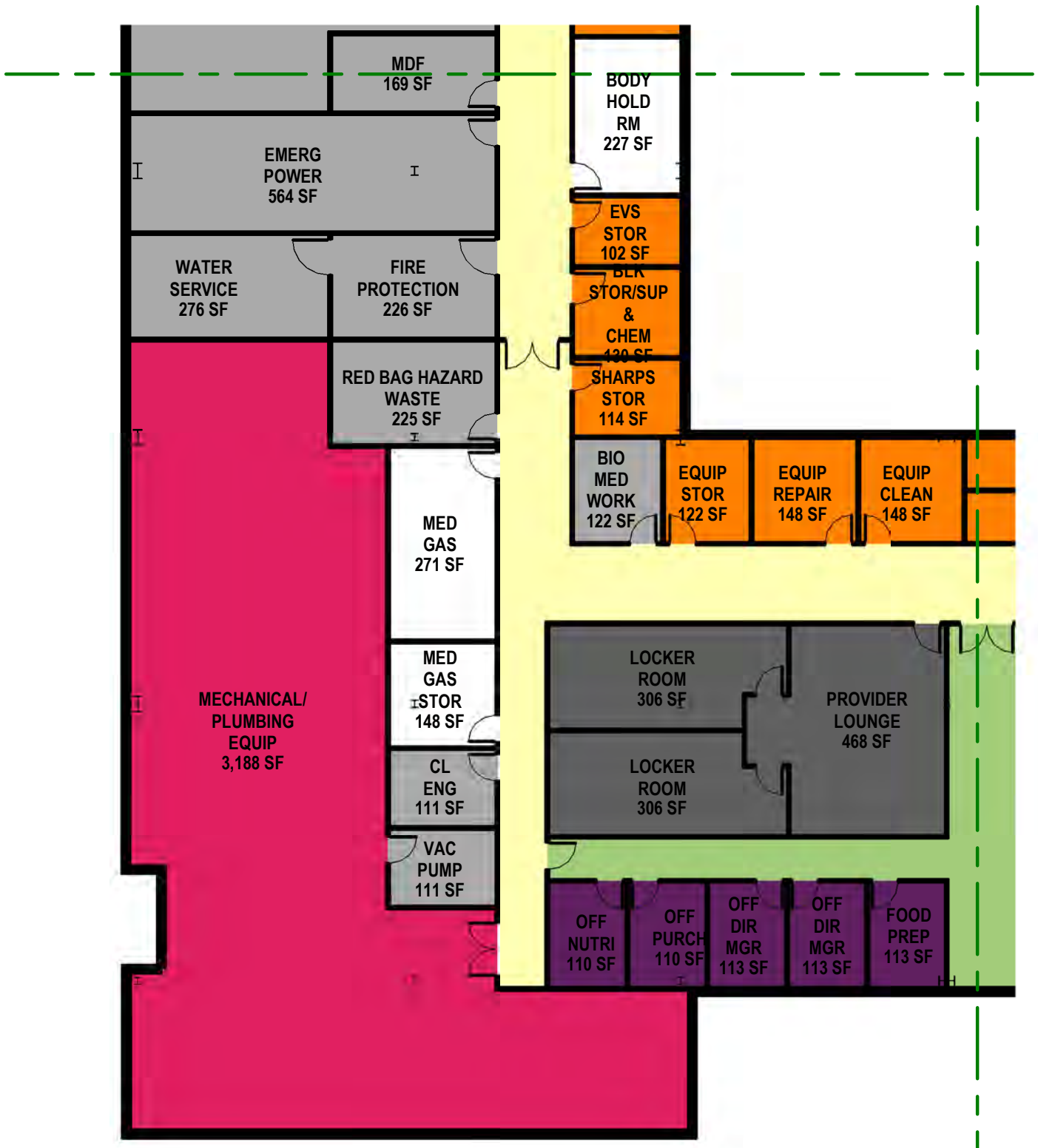
JOB #654100

A



LOWER LEVEL - 11x17 A

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



D

LOWER LEVEL - 11x17 D

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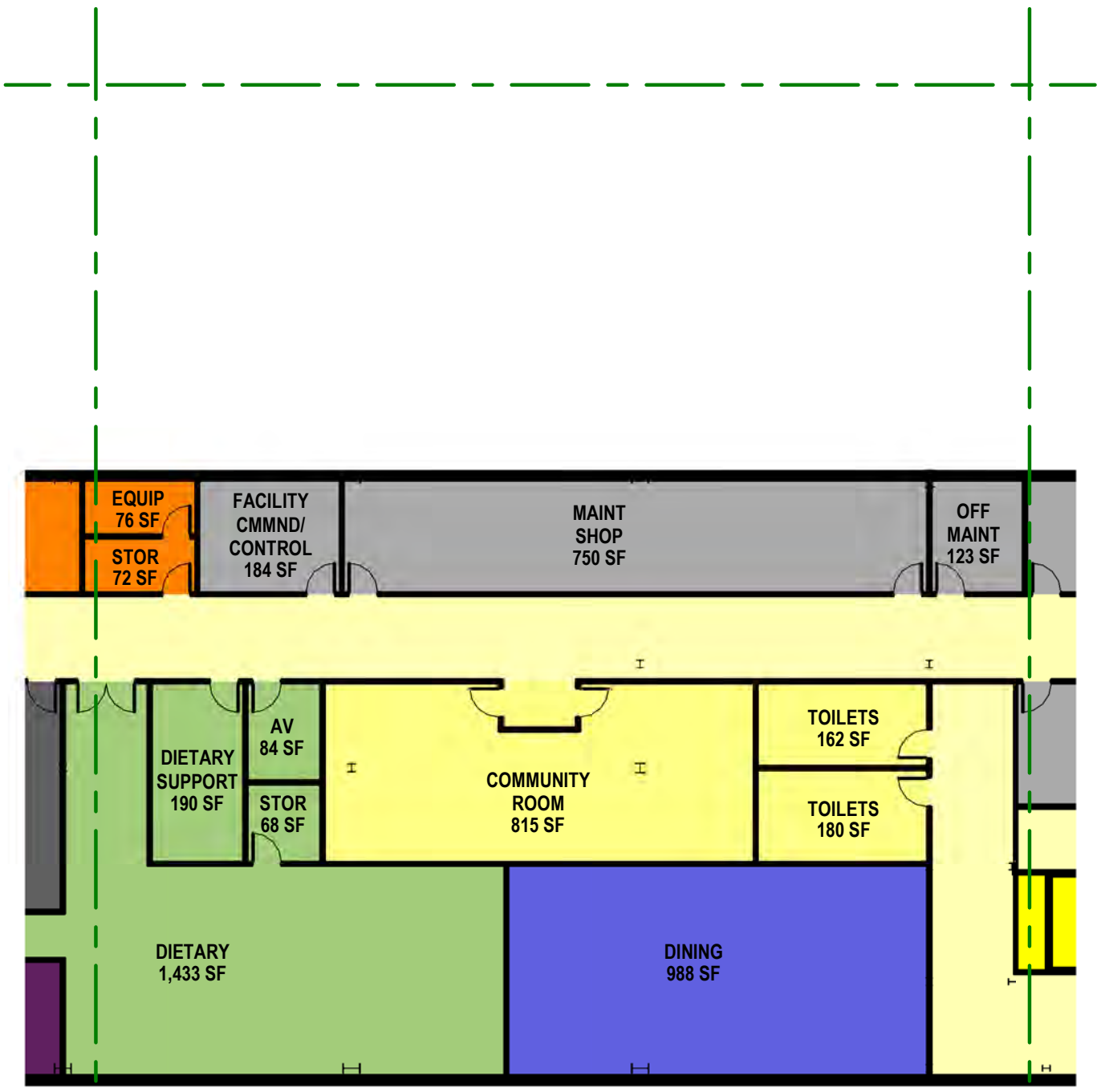

E

LOWER LEVEL - 11x17 E

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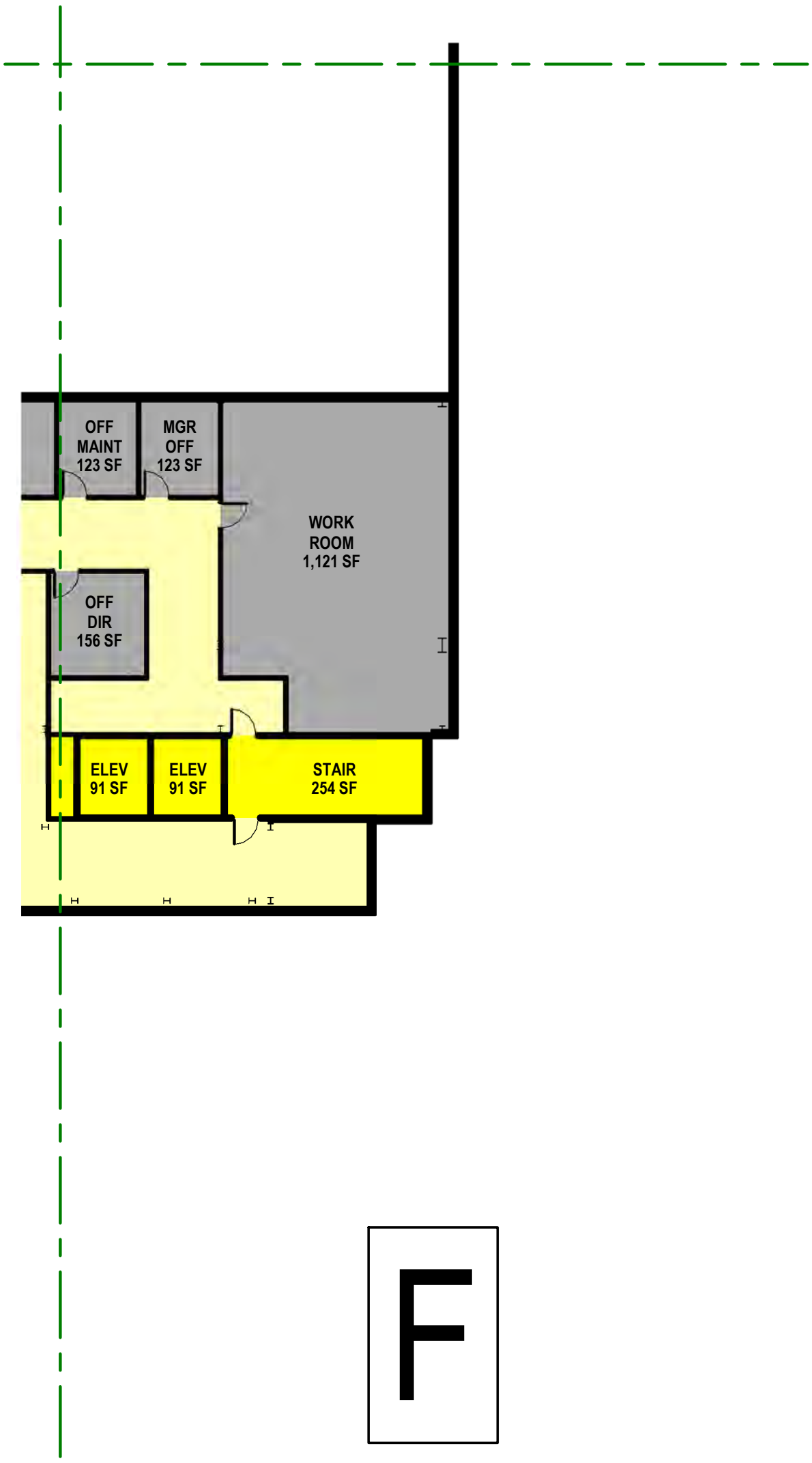
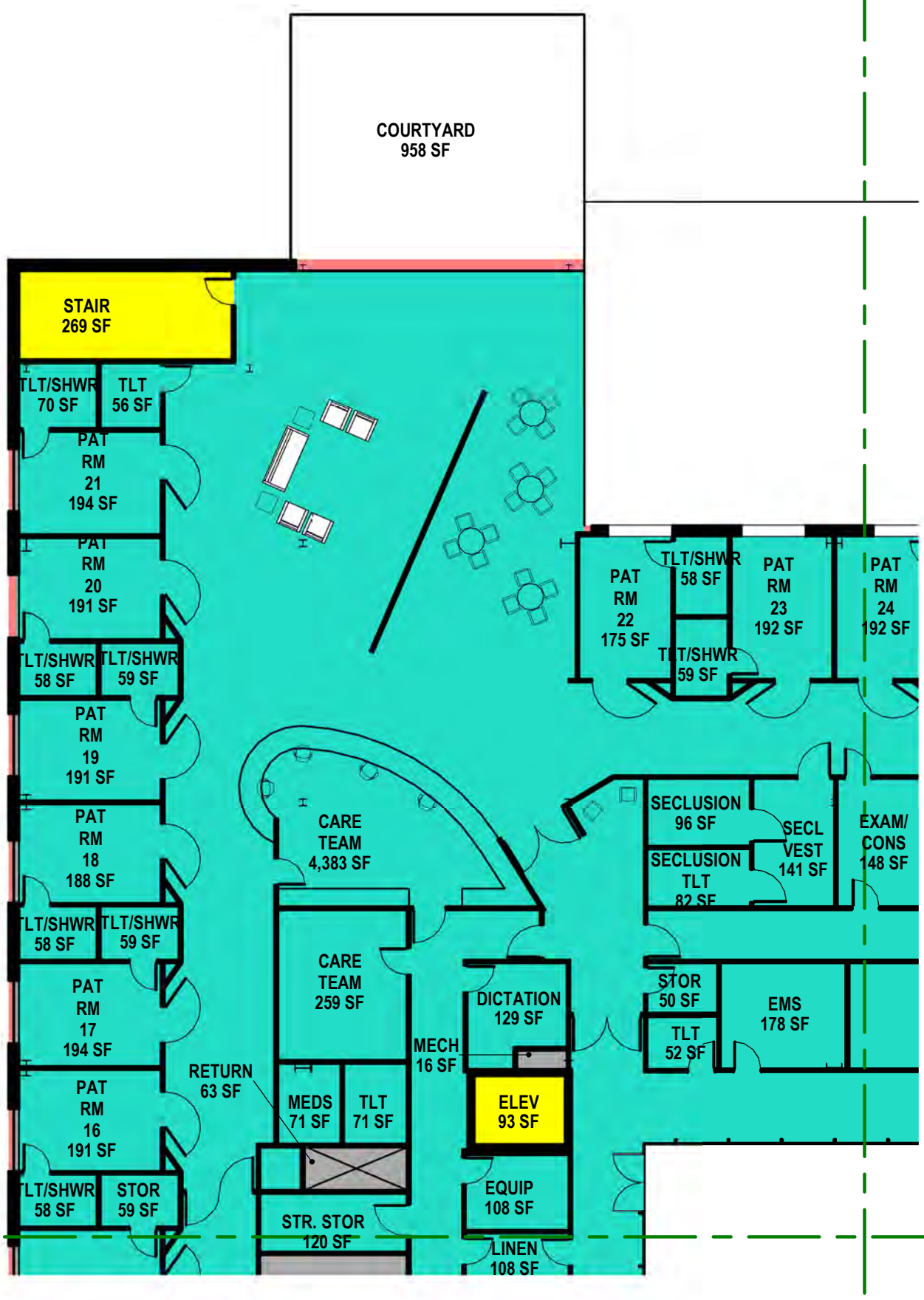


F

LOWER LEVEL - 11x17 F

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

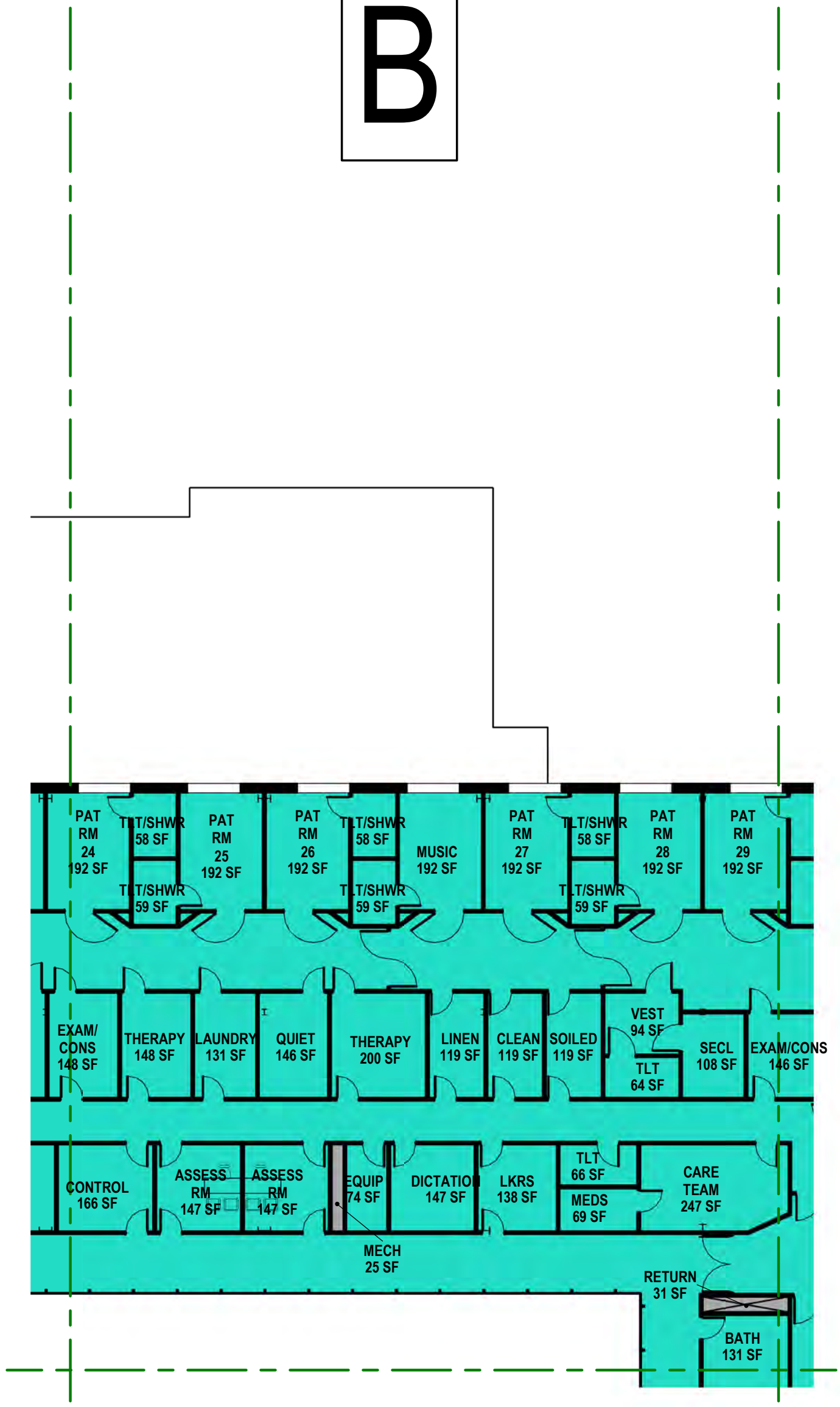
A



SECOND FLOOR PLAN - 11x17 A

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

B



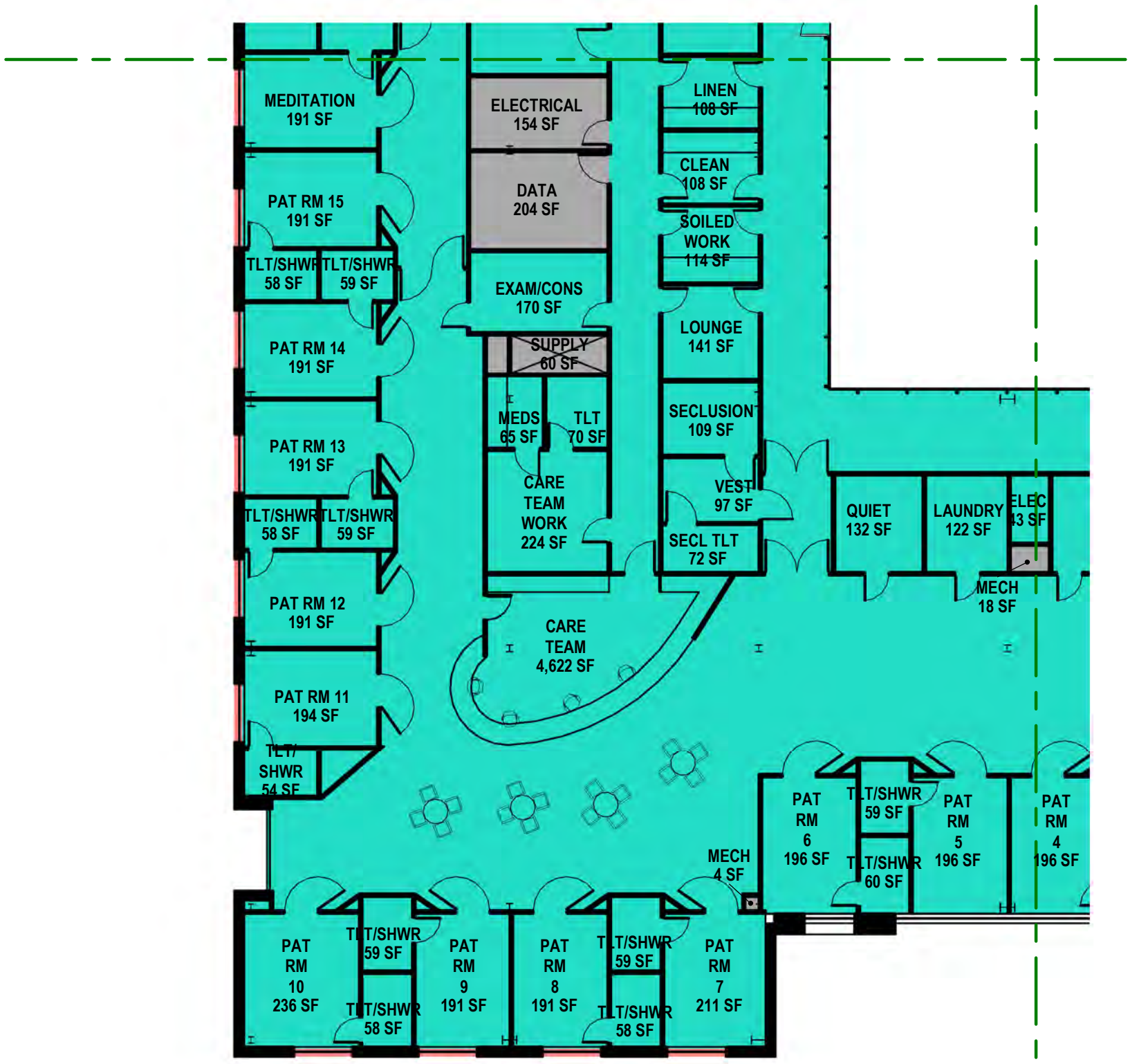
SECOND FLOOR PLAN - 11x17 B

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

C

SECOND FLOOR PLAN - 11x17 C

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



D

SECOND FLOOR PLAN - 11x17 D

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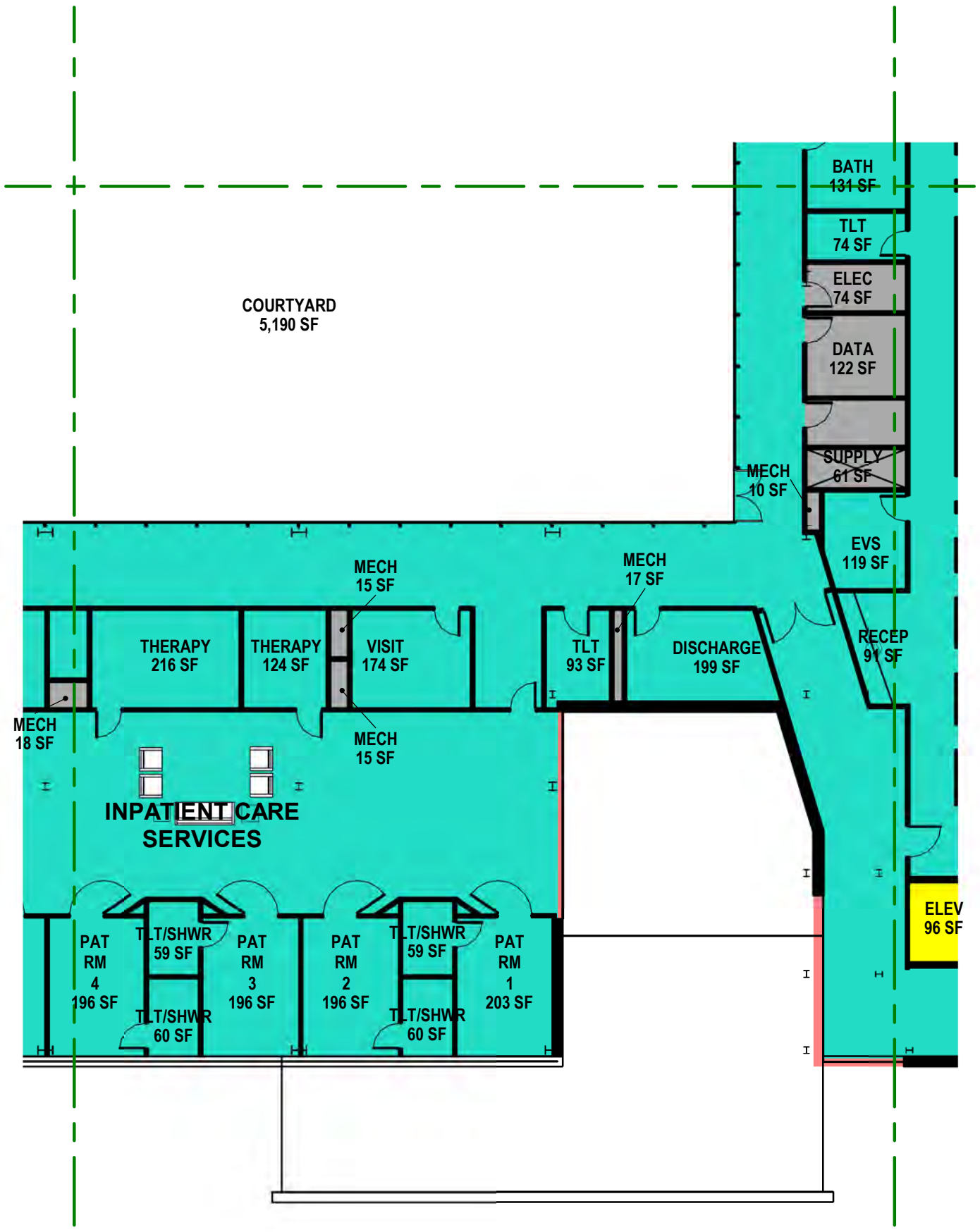

E

SECOND FLOOR PLAN - 11x17 E

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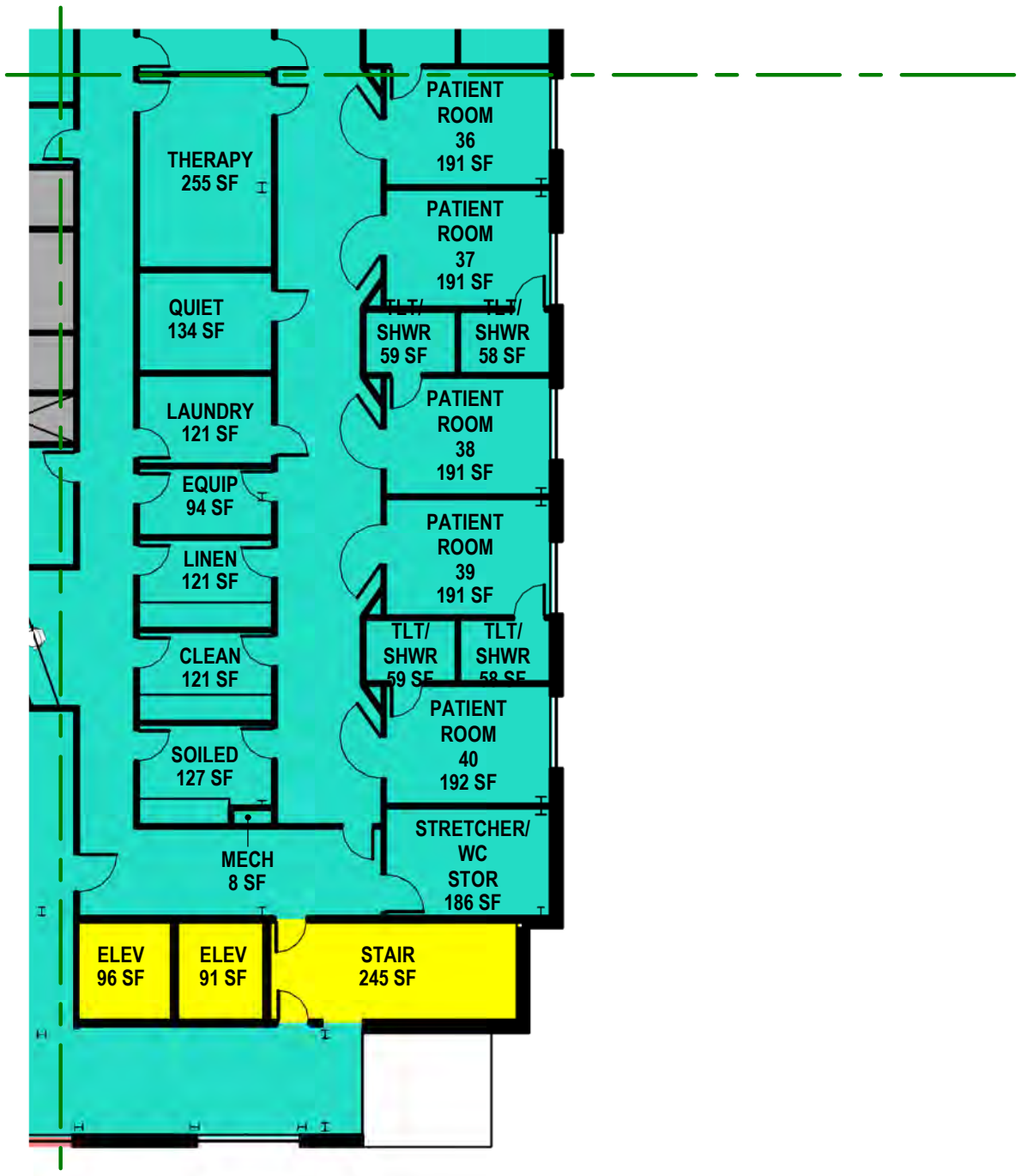

F

SECOND FLOOR PLAN - 11x17 F

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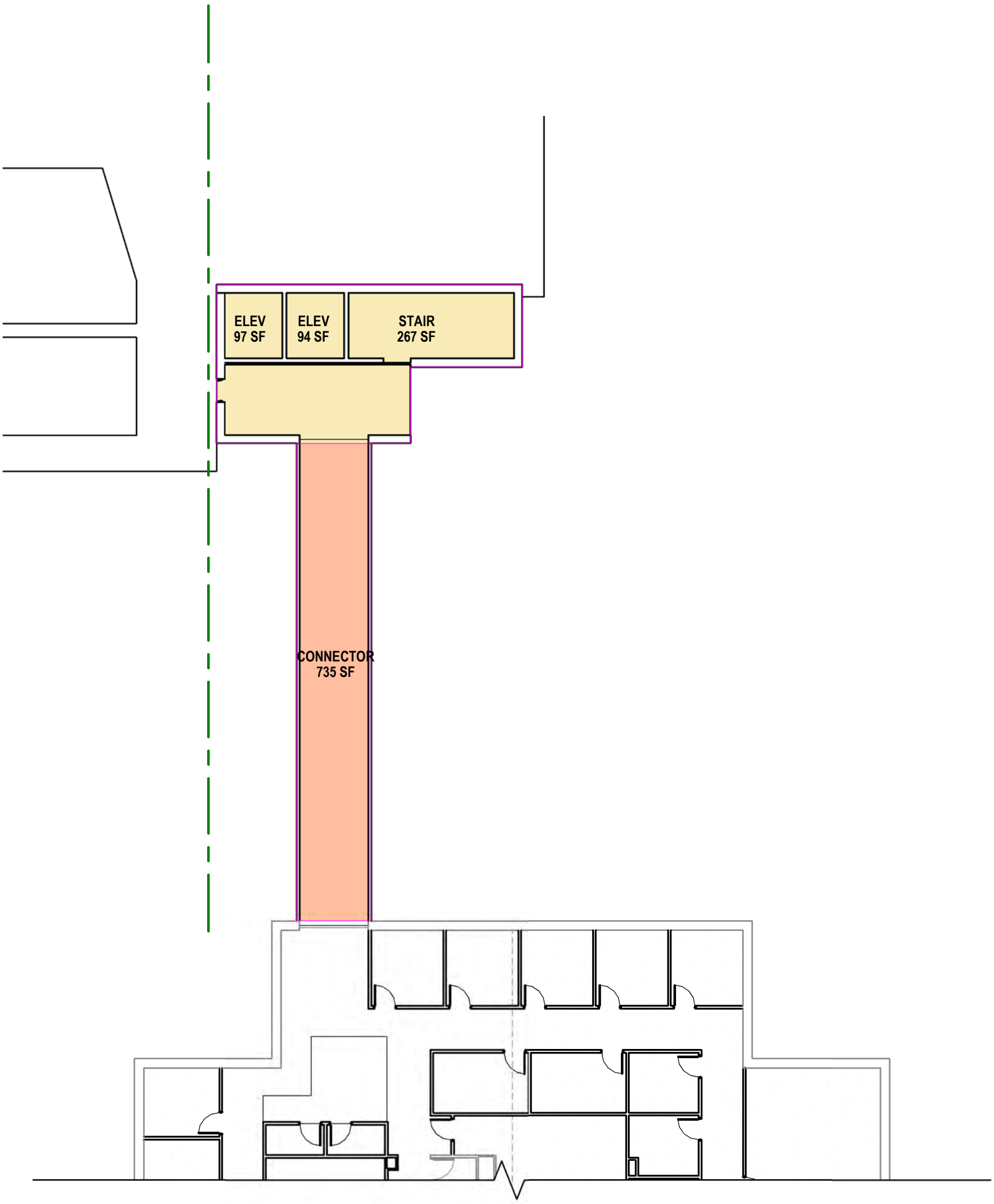
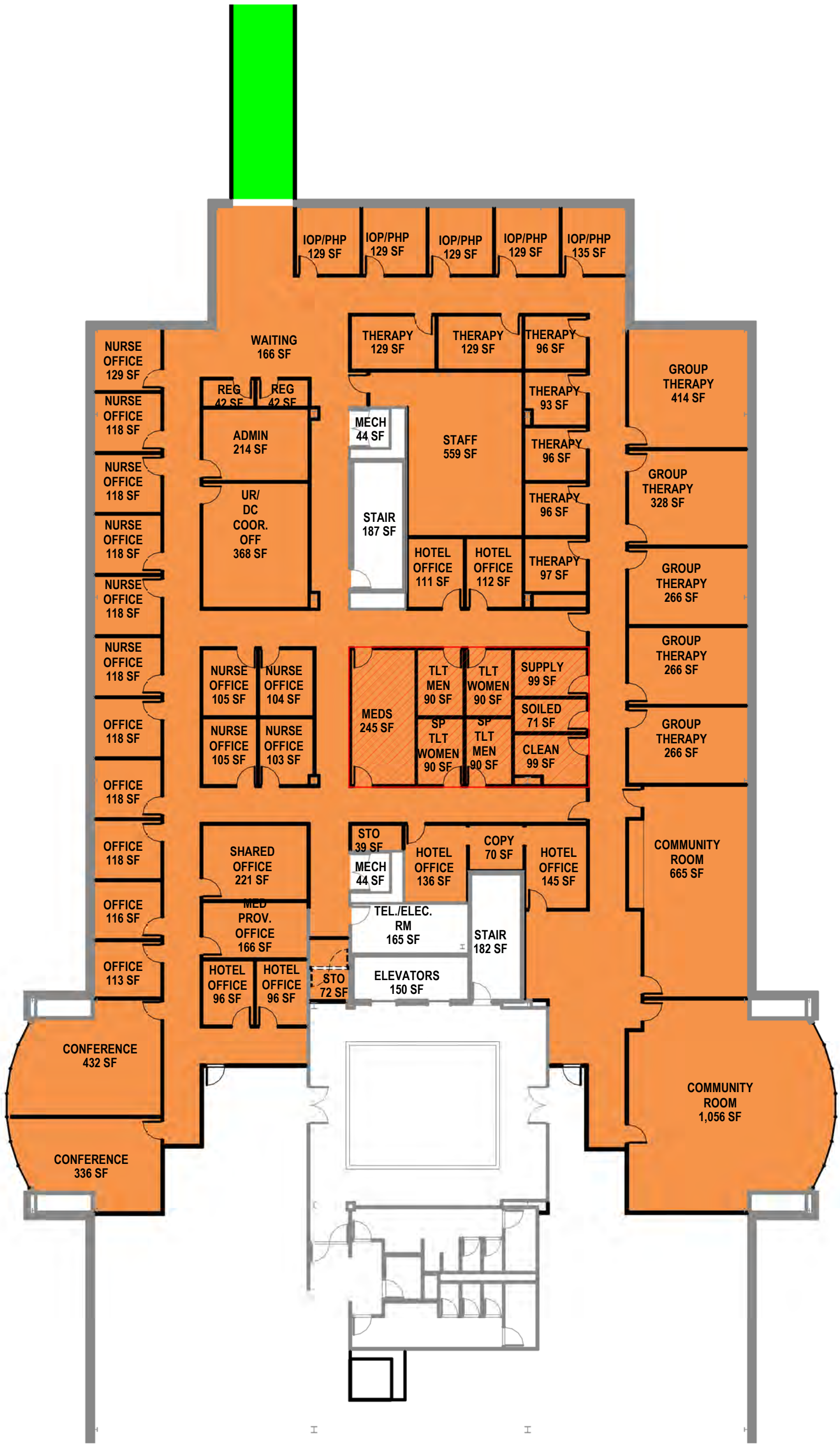


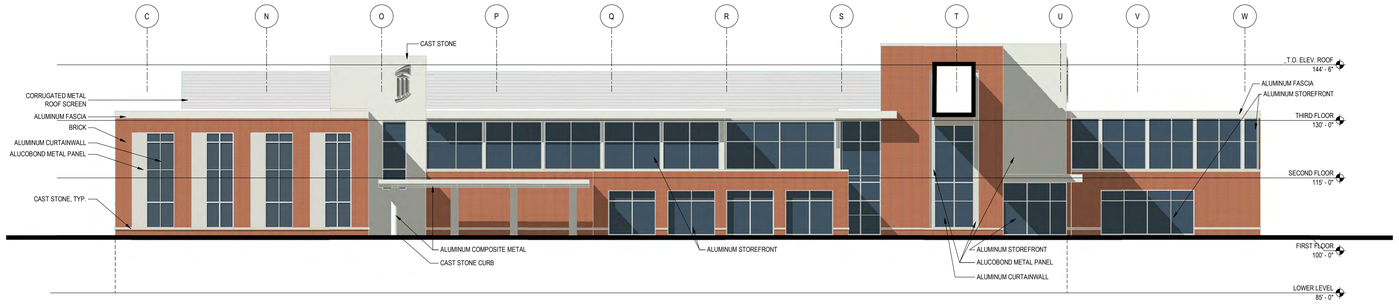
THIRD FLOOR + CONNECTOR 11x17

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



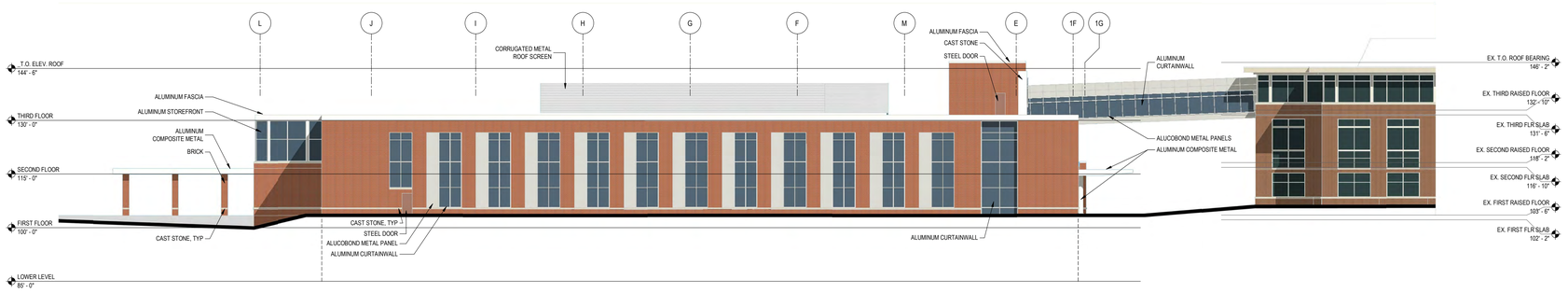
EXISTING THIRD FLOOR - 11 x 17

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



1 NORTH ELEVATION

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



2 EAST ELEVATION

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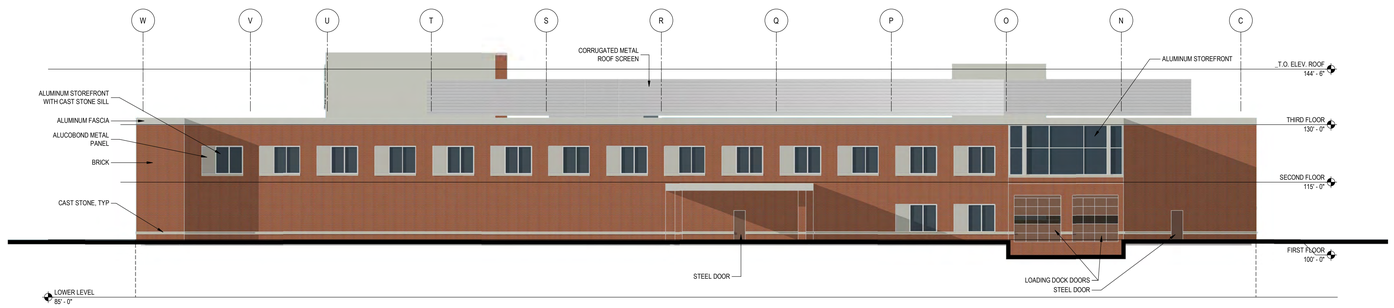

3 SOUTH ELEVATION

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

4 WEST ELEVATION

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

10/3/2018 10:34:25 AM C:\Revit Projects\ad_Aberdeen_639920_LOarnut.rvt

ERDMAN

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COA# AX010514

Architect of Record

UNIVERSITY OF MARYLAND -

UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS

NOT FOR CONSTRUCTION

No.	Description	Date
16	CON SUBMITTAL	06/05/18
15	CON SUBMITTAL	05/18/18
14	CON SUBMITTAL	04/09/18
11	CON SUBMITTAL	07/19/17
9	DRAFT CON SUBMITTAL	06/08/17
8	SCOPE PRICING	05/15/17
4	PROJECT ANALYSIS (CON) ROUND TWO	07/31/15
3	PROJECT ANALYSIS (CON)	06/05/15

Document Release

Drn:BHEBERT Chk:Checker

Sheet Name
EXTERIOR ELEVATIONS

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

Sheet Number
A105

ABERDEEN, MD

JOB #654100

EXHIBIT 3

AGREEMENT OF SALE

THIS AGREEMENT OF SALE ("**Agreement**") is made by and between MERRITT-AD, LLC ("**Seller**") and UNIVERSITY OF MARYLAND – UPPER CHESAPEAKE HEALTH SYSTEM, INC. ("**Buyer**"). This Agreement is effective as of the latest date set forth under the signatures of Buyer and Seller below (the "**Effective Date**").

W I T N E S S E T H:

For and in consideration of the mutual covenants hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. SALE AND PURCHASE. Subject to all terms, conditions, and covenants herein contained, Seller hereby agrees to sell to Buyer and Buyer hereby agrees to purchase from Seller certain land and improvements located in the City of Aberdeen, Harford County (the "**County**"), known as Aberdeen Corporate Park, 635-660 McHenry Road, Aberdeen, MD 21001, consisting of +/- 35.64 acres of improved land and one (1) class A office building containing +/- 90,000 square feet of rentable space, together with a private right of way known as "McHenry Road" containing 0.711 acres of land as more particularly described on **Exhibit A** attached hereto and made a part hereof, together with all rights of way or use, riparian rights, water rights, mineral rights, servitudes, easements, tenements, hereditaments, and appurtenances benefitting or belonging to the real property or in any way appertaining thereto (the "**Property**").

2. PURCHASE PRICE FOR PROPERTY.

2.1. Purchase Price. The purchase price ("**Purchase Price**") for the Property shall be Eighteen Million Dollars ($18,000,000.00).

2.2. Deposit. Within three (3) business days after the Effective Date, Buyer shall deliver to Escrow Agent (defined below), as a good faith cash deposit securing performance of its obligations hereunder, the amount of One Hundred Thousand Dollars ($100,000.00), hereinafter referred to as the "**Deposit**". Provided Buyer elects to proceed to Closing (defined below) following the expiration of the Feasibility Period, the Deposit shall be non-refundable to Buyer except as provided herein with respect to a failed condition precedent to Closing or in the event Seller defaults under its obligations set forth in this Agreement.

2.3. Payment of Purchase Price. At Closing hereunder, the Deposit shall be credited against the Purchase Price and Buyer shall pay the balance of the Purchase Price to Seller by escrow company check or wired funds.

3. FEASIBILITY PERIOD AND RIGHT OF ENTRY.

3.1. Feasibility Period. Buyer and Seller entered into a letter agreement (the "**Letter Agreement**") dated May 31, 2018, pursuant to which Seller provided Buyer with the opportunity to commence its due diligence investigation of the Property on June 4, 2018. Pursuant to the Letter Agreement, Buyer shall have until November 2, 2018 (the "**Feasibility Period**") to conduct a comprehensive investigation and evaluation of all aspects of the Property and its suitability for Buyer's purposes, in such scope and detail as may be required by Buyer, in its sole opinion and at its sole expense, including, without limitation, (a) a study of the physical condition of the Property, (b) a determination as to the compliance of the Property with all applicable zoning (permitting a free standing medical facility and specialty hospital for behavioral health beds and any related health issues, including a 45 bed inpatient facility, and other site improvements as reflected on the site plan (the "**Site Plan**"), in the form attached hereto as **Schedule 3.1**, and made a part hereof), subdivision, environmental, and other governmental laws, rules and regulations, (c) an inspection to determine the presence or absence of hazardous materials on the Property or any other environmental problem, (d) the making of a survey of the Property, (e) and such other inspections and tests as Buyer may deem necessary or appropriate.

3.2. Termination of Agreement. Unless Buyer gives Seller written notice of its election to proceed to Closing on or before the expiration date of the Feasibility Period, upon the expiration of the Feasibility Period this Agreement shall terminate with no further action by either party hereto, whereupon Escrow Agent shall return the Deposit to Buyer and the parties shall have no further obligations to each other.

3.3. Right of Entry. Commencing on the date of the Letter Agreement and continuing until Closing or the termination of this Agreement, Buyer shall have the right to enter the Property with personnel and materials at any time, and from time to time, to make such inspections, surveys, engineering studies, tests, and other studies as Buyer may deem reasonably necessary or appropriate. If Buyer does not elect to proceed to Closing, Buyer shall restore the Property to substantially the same condition as existed immediately before any test that results in a material alteration to the Property. Buyer shall hold Seller harmless from and against any claim for personal injury or damage to property of a third party resulting from Buyer's entry onto the Property. The foregoing indemnification excludes all loss liability, damage, claim, injury or expense, including attorney's fees, arising from or relating to any environmental conditions discovered as a result of Buyer's investigations. Notwithstanding any other provision of this Agreement, Buyer's indemnification and restoration obligations under this Paragraph shall survive termination of this Agreement for a period of one (1) year. Upon request from Seller, Buyer shall provide Seller with evidence of general liability insurance covering liability

arising from Buyer's activities and the activities of its employees and agents on the Property.

3.4. Delivery of Materials. Buyer acknowledges that Seller previously delivered to Buyer a copy of all surveys, plats, plans, title reports, title policies, environmental, wetland and forest studies and all other materials in Seller's possession or commissioned by Seller within the last three (3) years and reasonably accessible by Seller (collectively the "**Due Diligence Materials**"). If this Agreement terminates, Buyer shall return the Due Diligence Materials to Seller within ten (10) days after the expiration of the Feasibility Period or the date of Buyer's notice to Seller that it is terminating this Agreement, whichever is earlier.

4. REPRESENTATIONS AND WARRANTIES OF SELLER AND BUYER.

4.1. Seller's Representations. Seller makes the following representations and warranties as of the Effective Date and as of the Closing Date (defined below):

4.1.1. Due Diligence Deliveries. The Due Diligence Materials delivered or to be delivered to Buyer are true, complete and, with respect to the Due Diligence Materials prepared by Seller, accurate in all material aspects. To Seller's knowledge, none of the Due Diligence Materials prepared by third parties are inaccurate or materially misleading.

4.1.2. Title. Seller has good and marketable fee simple title to the Property, free and clear of all liens and encumbrances, except for those matters recorded among the Land Records of the County prior to the Effective Date, and Seller covenants to cause all liens that secure the payment of monetary obligations to be released or satisfied by Seller on or before Closing.

4.1.3. Condemnation. No proceeding in eminent domain or condemnation is pending or, to the best of Seller's knowledge, threatened against all or any portion of the Property.

4.1.4. Assessments. No assessments for public improvements have been made against the Property which remain unpaid and all such assessments which have been or could be levied for public improvements ordered, commenced, or completed prior to the date of this Agreement have been or shall be paid in full by Seller prior to Closing.

4.1.5. No Leases. There are no leases affecting the Property or any part thereof and there are no third parties having or claiming possession of all or any portions of the Property.

4.1.6. Other Agreements. Seller has not made and will not make any commitments or representations to the applicable federal, state and local governmental authorities, or to adjoining or surrounding property owners which would in any manner be binding upon Buyer or which would in any way limit or interfere with Buyer's ability to use the Property for any and all permitted uses under the applicable zoning laws, whether permitted by right, conditional use, or special exception. Seller has not granted any person any contract right or other legal right to the use of any portion of the Property or to furnish or use of any facility or amenity on or relating to the Property, except as set forth in covenants recorded among the Land Records of Harford County.

4.1.7. Unrecorded Covenants. The Property is not subject to any unrecorded restrictive covenant or equitable servitude of any kind which would in any way limit the free choice of Buyer to use the Property for any and all permitted uses under the applicable zoning laws, whether permitted by right, conditional use, or special exception.

4.1.8. Litigation and Proceedings. No suit, action, or otherwise proceeding has been instituted or, to the best of Seller's knowledge, threatened before any court or administrative agency and Seller has not received any notice of any suit, action, or other proceeding which could result in an order or decree affecting Seller's ability to perform its obligations under this Agreement.

4.1.9. No Forfeitures. Seller will, during the term of this Agreement, keep any mortgage(s) against the Property current and not in default and pay taxes and other public charges against the Property so as to avoid forfeiture of Buyer's rights under this Agreement.

4.1.10. Bankruptcy. No petition of bankruptcy or for the appointment of a receiver or trustee has been filed by or against Seller, no insolvency proceeding has been commenced against Seller, and Seller has not failed generally to pay its debts as they come due.

4.1.11. Power and Authority. Seller is a limited liability company, duly organized, validly existing, and in good standing under the laws of the State of Maryland. Seller has the power to execute and perform this Agreement. All necessary consents and approvals from Seller have been obtained. The persons executing this Agreement on behalf of Seller are duly empowered to bind Seller to perform its obligations hereunder. Seller will provide evidence of the power and authority of the person(s) acting on its behalf promptly upon request therefor from Buyer.

4.1.12. Foreign Person. Seller is not a "foreign person" as contemplated in Section 1445 of the Internal Revenue Code of 1986, as amended. At Closing hereunder, Seller shall execute an Affidavit in the form required by the Internal

Revenue Service and satisfactory to Buyer's counsel to exempt Buyer and Seller from any withholding requirements under Section 1445.

4.1.13. Resident. Seller is a "resident entity" within the meaning of Section 10-912 of the Tax-General Article, Annotated Code of Maryland. At Closing hereunder, Seller shall execute a Statement of Resident Entity in the form required by the State of Maryland to exempt Buyer from any withholding requirements under Section 10-912 of the Tax-General Article, Annotated Code of Maryland.

4.2. Buyer's Representations. Buyer makes the following representations and warranties as of the Effective Date and as of the Closing Date:

4.2.1. Power and Authority. Buyer is a corporation, duly organized, validly existing, and in good standing under the laws of the State of Maryland and has the power and authority to enter into this Agreement and to purchase the Property. The persons who executed this Agreement on behalf of Buyer and who will execute the closing documents have full power and authority to act on behalf of and to bind Buyer.

4.2.2. Bankruptcy. No petition of bankruptcy or for the appointment of a receiver or trustee has been filed by or against Buyer, no insolvency proceeding has been commenced against Buyer, and Buyer has not failed generally to pay its debts as they come due.

5. TITLE; PROPERTY CONDITION.

5.1. Title to be Conveyed. Seller shall convey to Buyer at Closing good and marketable fee simple title to the Property, free and clear of all liens and encumbrances, except for Permitted Encumbrances (defined below).

5.2. Title Review. During the Feasibility Period, Buyer shall have the right to obtain a report regarding the status of title to the Property from a licensed title insurance company of its choice. In the event the condition of title is unacceptable to Buyer for any reason, Buyer shall have the right to terminate this Agreement on or before the expiration date of the Feasibility Period or to permit this Agreement to expire at the end of the Feasibility Period. If Buyer elects to proceed to Closing under this Agreement then Buyer shall accept title to the Property subject to instruments of record as of the date of Buyer's title commitment, excluding mortgages or deeds of trust or other liens securing indebtedness or evidencing judgments against Seller which shall be released or satisfied by Seller on or before Closing (the "**Permitted Encumbrances**").

5.3. Title Defect. If at any time during the term of this Agreement, Buyer's title company reports that Seller does not hold good and marketable fee simple title to the Property insurable at the title company's regular rates, then Seller shall take

such actions as are necessary or appropriate to correct the title defects. If Seller is unable to cure the title defect within thirty (30) days or if the cost to cure such title defect will exceed Fifty Thousand Dollars ($50,000.00), then Seller shall give Buyer written notice thereof and Buyer shall have the right to elect, within five (5) business days after Seller's notice is received, either (a) to purchase the Property with an equitable reduction in the Purchase Price not to exceed Fifty Thousand Dollars ($50,000.00), in which event the title shall be deemed to be satisfactory to Buyer and the parties shall proceed to Closing in accordance with the terms of this Agreement or (b) to terminate this Agreement, in which event the Deposit shall be returned to Buyer and, except for any indemnities contained herein, the parties shall have no further obligations to each other. Notwithstanding the foregoing, if the title defect described arises from an encumbrance placed on the Property after the Effective Date or the effective date of Buyer's title insurance commitment, whichever is earlier, other than encumbrances which will be satisfied with the proceeds of Closing, without the prior written consent of Buyer, then Seller shall be obligated to cure such defect, at Seller's sole cost and expense, within a thirty (30) days after written notice from Buyer or Seller shall be in default hereof and Buyer may pursue all rights and remedies available to it under this Agreement.

5.4. CONDITION OF PROPERTY. EXCEPT AS EXPRESSLY SET FORTH IN THIS AGREEMENT OR THE DOCUMENTS DELIVERED BY THE SELLER AT CLOSING, BUYER HEREBY ACKNOWLEDGES THAT SELLER MAKES NO REPRESENTATION OR WARRANTY, EXPRESS OR IMPLIED, WITH RESPECT TO ANY ASPECT OF THE PROPERTY, AND BUYER IS ACQUIRING THE PROPERTY IN "AS IS, WHERE IS, WITH ALL FAULTS" CONDITION ON THE DATE OF CLOSING. THE TERMS OF THIS SECTION 5.4 SHALL SURVIVE CLOSING WITHOUT LIMITATION.

5.5. Title Company. The title company performing the title report on the Property on behalf of Buyer is Mid-Atlantic Title, LLC (the **"Title Company"**). The Title Company shall conduct the Closing.

6. CONDITIONS TO CLOSING: Settlement of the purchase of the Property ("**Closing**") shall be conditioned on satisfaction of the following matters (the "**Conditions to Closing**"):

6.1. Zoning Approval. Buyer, at Buyer's sole cost and expense, shall have obtained approval from the City of Aberdeen to amend the zoning entitlements on the Property to remove the height restrictions or to raise them to a level acceptable to Buyer and that permits a heliport on the Property.

6.2. Board Approval. Buyer shall have obtained approval from its Board of Directors to purchase the Property.

6.3. Final Approval of Right-In-Right-Out at Maryland Rt. 22 ("**RIRO**"). Seller, at Seller's sole cost and expense, shall have obtained full and final unappealable approvals for all permits, including, but not limited to, State Highway Administration access permits, any construction permits, etc., for the RIRO at the location shown on the plan (the "**RIRO Plan**") dated March 14, 2018, prepared by Morris & Ritchie Associates, Inc. (Job #16283), a copy of which was provided to Buyer.

6.4. Site Plan Approval. Buyer at Buyer's sole cost and expense, shall have obtained approval of a Site Plan (attached as **Schedule 3.1** and made a part hereof), for its development of the Property as a freestanding medical facility with related improvements in form and substance acceptable to Buyer, in its sole discretion, including approval of a new Traffic Study commissioned by Buyer, at Buyer's expense.

6.5. Construction of the RIRO. Seller shall have constructed the RIRO in accordance with approved plans. Buyer shall pay all costs incurred by Seller in connection with the RIRO up to a maximum amount of Seven Hundred Fifty Thousand Dollars ($750,000) (the "**RIRO Reimbursement**") at Closing. Buyer acknowledges that the RIRO will enter the Property at the location shown on the RIRO Plan. Buyer will have the opportunity to determine the direction that the driveway will take upon entering the Property before Seller commences construction. The deadline for Buyer to determine the direction of the driveway (the "**Driveway Deadline**") will be established by Seller based upon satisfaction of the condition set forth in Section 6.3 above, but shall not be less than thirty (30) days after Seller gives Buyer written notice of the Driveway Deadline. Seller will use good faith reasonable efforts to provide Buyer with regular updates on the status of the RIRO Plan approval so that Buyer has time to determine the direction of the driveway on the Property. If Buyer fails to give Seller a decision regarding the direction of the driveway by the Driveway Deadline and such failure continues for ten (10) days after written notice thereof from Seller to Buyer, then Seller's obligation shall be only to construct the entrance to the point where the driveway would make a turn in one direction or another on the Property and substantial completion of such construction shall be sufficient to satisfy this Condition to Closing. Notwithstanding the foregoing, the parties may agree to construct the RIRO after Closing pursuant to a post-closing agreement mutually agreed upon by Seller and Buyer, whereby the parties thereto agree to, among other terms, fully cooperate with each other and all governmental agencies to accomplish the construction of the RIRO with the required bonding and permits, and in which event, the provisions of Sections 6.3 and 6.5 hereunder shall survive Closing.

Both parties shall use commercially reasonable good faith efforts and act with due diligence to satisfy the Conditions to Closing. Buyer shall satisfy or waive the condition described in Section 6.2 above on or before the Driveway Deadline. If the Conditions to Closing described in Sections 6.1, 6.3, 6.4, or 6.5 cannot be satisfied due to the refusal of the applicable governmental authorities to grant the requisite approvals, then upon the

failure of such Condition to Closing, either party may terminate this Agreement by giving written notice to the other. In such event or if all of the Conditions to Closing are not satisfied by December 31, 2019, then unless Buyer waives all unsatisfied Conditions to Closing and proceeds to Closing, this Agreement will terminate, the Deposit will be refunded to Buyer and, except for matters that expressly survive the termination of this Agreement, the parties will have no further obligations to each other.

7. CLOSING. Closing shall occur on or before the date that is thirty (30) days after all of the Conditions to Closing are satisfied or waived, but not later than December 31, 2019 (the "**Closing Date**"). Buyer shall give Seller five (5) business days prior written notice of the date, time, and location of Closing which shall be in the Baltimore metropolitan area or by escrow with the Title Company.

7.1. Deliveries by Seller. At Closing, Seller shall execute and deliver the following to Buyer:

7.1.1. A special warranty deed with covenants of further assurances conveying all of Seller's right, title and interest in and to the Property to Buyer or its designee, in fee simple in accordance with this Agreement;

7.1.2. A FIRPTA non-foreign person affidavit in a form acceptable to Buyer;

7.1.3. A Statement of Resident Entity in the form required by Maryland law;

7.1.4. A Bill of Sale conveying all of Seller's right, title, and interest in and to any personal property located on the Property;

7.1.5. Evidence of Seller's power and authority to convey the Property, including a Certificate of Good Standing issued by the Maryland State Department of Assessments and Taxation, and evidence of the authority of the individual executing the instruments of conveyance on behalf of Seller;

7.1.6. A counterpart of a Settlement Statement (the "**Settlement Sheet**") setting forth the Purchase Price and other payments and expenses of closing; and

7.1.7. Any other documents as are reasonably required to consummate the Closing.

7.2. Deliveries by Buyer. At Closing, Buyer shall pay the Purchase Price for the Property and the RIRO Reimbursement to Seller and shall execute and deliver the following:

7.2.1. A counterpart of the Settlement Sheet; and

7.2.2. Any other documents as are reasonably required to consummate the Closing.

7.3. Adjustments, Taxes, and Closing Costs.

7.3.1. Transfer and Recordation Taxes. All transfer and recordation taxes imposed upon the recordation of the deed to the Property, whether federal, state, county, or municipal taxes, shall be divided evenly between the parties; provided, however, that any agricultural transfer taxes due and payable shall be paid by Seller.

7.3.2. Real Estate Taxes. All real estate taxes shall be apportioned to the Closing Date and assumed and paid thereafter by Buyer.

7.3.3. Public or Private Charge Adjustments. All public, governmental, or private charges or assessments, general or special, against the Property which are or may be payable on an annual basis (including front foot benefit charges, assessments, liens or encumbrances for public or private improvements completed or commenced on or prior to the Effective Date, or subsequent thereto) shall be adjusted as of the Closing Date and shall be assumed and paid thereafter by Buyer, whether assessments have been levied or not as of the Closing Date.

7.4. Buyers' Expenses of Closing. The cost of examination of the title, the title insurance covering Buyer's interest in the Property as owner, or any lender's title insurance for the benefit of Buyer's lender, the tax or lien certificates, conveyance, notary fees and recording charges, and any other fees or charges assessed by Buyer's title insurance company, shall be paid by Buyer, at its sole cost and expense; including any settlement fee charged by Buyer's Title Company to conduct settlement.

8. CONDEMNATION. If, at or prior to Closing, all or a portion of the Property (i) shall be subject to or the object of a condemnation proceeding, or (ii) written notice of any such contemplated proceeding or offer is issued, or (iii) a proceeding is instituted by any governmental authority having the power of eminent domain, or (iv) an offer to purchase in lieu of condemnation is made to Seller, then, and in any of such events, Buyer shall have the right, at its sole option, to terminate this Agreement by written notice to Seller within ten (10) days after the date on which Seller notifies Buyer of any such event. If such notice is given within ten (10) days prior to the date designated for Closing, the Closing Date shall be extended so that Buyer will have the full ten (10) day period in which to make its election. If Buyer elects to terminate this Agreement, it shall immediately become null and void, and of no further force and effect, at law or in equity. If Buyer elects not to terminate this Agreement within such ten (10) day period, then the parties shall proceed to Closing and all proceeds (or Seller's right to

such proceeds) with respect to such condemnation, notice, proceeding or offer shall be assigned to Buyer at Closing. Seller shall give Buyer prompt written notice of any such Condemnation, notice, proceeding or offer and, if Buyer elects to proceed to Closing, a representative of Buyer shall participate with Seller in all meetings and negotiations with the condemning authority. In such event, Seller shall not enter into any settlement agreements with the condemning authorities without the prior written consent of Buyer, which consent shall not be unreasonably withheld.

9. DESTRUCTION / RISK OF LOSS. The risk of loss or damage to the Property before the Closing Date by fire, other casualty, act of God, or any other event shall be borne by the Seller. If before Closing, the Property or any portion thereof is damaged by fire, other casualty, act of God or other event, then, and in any of such events, Seller shall immediately give Buyer written notice thereof and Buyer shall have the right, at its sole option, to terminate this Agreement by written notice to Seller within five (5) days after the date on which Buyer receives Seller's notice, but in any event, not later than the Closing Date. If Buyer elects to terminate this Agreement, or Buyer fails to respond to Seller's notice aforesaid, the Escrow Agent shall return the Deposit to Buyer and, except for the indemnities contained herein, the parties shall have no further obligations to each other. If Buyer elects not to terminate this Agreement within such five (5) day period, then the parties shall proceed to Closing and (i) all insurance proceeds (or Seller's right to such proceeds) with respect to such damage or casualty, less amounts spent buy Seller to restore the improvements on the Property, shall be paid or assigned to or become the property of Buyer at Closing, (ii) the Purchase Price shall be reduced by the amount of any deductible under the Seller's policy of casualty or property damage insurance unless Seller has spent such amount to restore improvements on the Property, and (iii) Seller shall repair any minor damage to the Property and take all other actions necessary or appropriate to secure the Property and make it safe for use and occupancy.

10. DEFAULT.

10.1. Default by Buyer. In the event Buyer fails to perform or breaches any of its obligations hereunder, Seller shall be entitled to retain as fixed, agreed and liquidated damages and as Seller's sole remedy, the Deposit paid by Buyer hereunder, whereupon this Agreement shall terminate and neither party shall have any further liability hereunder, except for any indemnities contained herein. The parties hereto agree that in the event of a default by Buyer, the actual damages thereby incurred by Seller would be difficult to measure and that the receipt of the Deposit by Seller would represent reasonable compensation to Seller on account of such default.

10.2. Default by Seller. If Seller fails to perform or breaches any of its representations, warranties, covenants, or other obligations hereunder, Buyer shall have the right to (a) terminate this Agreement and be reimbursed by Seller for its out of pocket

expenses to negotiate this Agreement and investigate the purchase of the Property, including its due diligence costs up to a maximum amount of One Hundred Thousand and No/100 Dollars ($100,000.00) or (b) to pursue the remedy of specific performance. If Buyer elects to terminate this Agreement, Buyer shall provide Seller with reasonable evidence of its expenses and shall submit its invoice for reimbursement within one hundred twenty (120) days after the date of Seller's default. If a default is discovered subsequent to Closing, then Buyer shall have the right to pursue all remedies available to it at law or in equity; provided, however, that Buyer's damages shall be limited to compensatory damages and shall be capped at One Hundred Thousand and No/100 Dollars ($100,000.00).

11. ESCROW PROVISIONS. Snee, Lutche, Helmlinger & Spielberger, P.A. (the "**Escrow Agent**") shall act as escrow agent hereunder. The Escrow Agent's duties shall be as follows:

11.1. Hold Escrow Fund. Escrow Agent shall hold the Deposit in its escrow account (the "**Escrow Account**").

11.2. Dispute. If at any time Escrow Agent is unable to determine to whom the Deposit should be delivered, or if a dispute develops between Buyer and Seller concerning to whom the Deposit should be delivered, then Escrow Agent shall demand joint written instructions from Buyer and Seller. If Escrow Agent does not receive joint written instructions within ten (10) days after demand therefor, Escrow Agent shall have the right, by Bill of Interpleader, to deliver the Deposit into a court of competent jurisdiction selected by Escrow Agent and to interplead Buyer and Seller in respect thereof. Thereafter, Escrow Agent shall be discharged of any obligations in connection with this Agreement.

11.3. Expenses. No fee or charge shall be due or payable to Escrow Agent for its services as escrow holder. All reasonable costs and expenses incurred by Escrow Agent in performing its duties shall be divided evenly between the parties.

11.4. Limitation on Duty. In joining herein, Escrow Agent undertakes only to perform the duties and obligations imposed upon Escrow Agent under the terms of this Agreement and does not undertake to perform any of the covenants, terms, and provisions incumbent upon Seller and Buyer.

11.5. Limitation and Liability. Escrow Agent assumes no liability in connection herewith, except for negligence or willful misconduct. Escrow Agent shall not be responsible for the validity, correctness or genuineness of any document or notice referred to in this Agreement. In the event of a dispute under this Agreement, Escrow Agent may seek advice from its own counsel and shall be fully protected in any action taken by it, in good faith, in accordance with the advice of its counsel.

12. GENERAL PROVISIONS.

12.1. Entire Agreement. This Agreement constitutes the sole, final and entire agreement and understanding of the parties hereto and they shall not be bound by any terms, conditions, statements or representations, oral or written, not contained herein. This Agreement may not be changed orally, but only by an agreement in writing signed and executed by both parties to this Agreement.

12.2. Waivers. No exercise or waiver, in whole or in part, of any right or remedy provided for in this Agreement shall operate as a waiver of any other right or remedy, except as otherwise herein provided. No delay on the part of any party in the exercise of any right or remedy shall operate as a waiver thereof.

12.3. Notices. All notices required or permitted to be provided or furnished by either party to the other party shall be in writing and shall be delivered in person with signed receipt, by hand, by commercial overnight service delivery, or by United States certified mail, postage prepaid, return receipt requested. Notices may also be sent by facsimile or email provided that a copy of such notice is sent by a commercial overnight delivery service on the date the email or facsimile is sent, including a copy of the evidence of delivery of the email or facsimile, whereupon such notice shall be deemed to have been given and received on the date sent. All notices shall be deemed to have been given and received on the date sent, if sent by hand; on the first business day after the date sent, if sent by a commercial overnight delivery service; and three (3) days after the date sent, if sent by United States certified mail, postage prepaid, return receipt requested. Notices to Buyer shall be delivered to Buyer c/o Mr. Lyle Sheldon, FACHE, President and CEO of University of Maryland, Upper Chesapeake Health System, Inc., 500 Chesapeake Drive, Bel Air, MD 21014, with a copy to Joseph F. Snee, Jr., Esquire, Snee, Lutche, Helmlinger & Spielberger, P.A., 112 S. Main Street, Bel Air, MD 21014, facsimile (410) 893-8774, email: jsnee@slhslaw.com. Notices to Seller shall be delivered to Seller c/o Merritt Properties, LLC, 2066 Lord Baltimore Drive, Baltimore, Maryland 21244, Attention: Mr. Scott E. Dorsey, facsimile (410) 298-9644; email: sdorsey@merrittproperties.com, with a copy to Cynthia A. Berman, Kramon & Graham, P.A., One South Street, Suite 2600, Baltimore, Maryland 21202, facsimile (410) 361-8220, email: cberman@kg-law.com.

12.4. Broker Fees and Commissions. Seller and Buyer hereby covenant and warrant to each other that neither of them has dealt with a broker or any other person who may be entitled to a commission or finder's fee arising out the sale of the Property contemplated by this Agreement, except for Cushman & Wakefield (the "**Broker**"), who worked on behalf of Buyer. Each party does hereby indemnify and hold harmless the other from and against any loss, claim, damage or liability, including court costs and reasonable attorney's fees, which the other may suffer, incur, or expend arising out of or

in any way related to a claim by any person or entity other than Broker for commissions or fees in breach of this warranty. Seller shall be solely responsible of the payment of a commission of two and one-half (2.5%) of the Purchase Price (the "**Commission**") to Broker in connection with this Agreement. Buyer shall pay any amounts due to Broker over and above the Commission payable by Seller.

12.5. Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, all of which taken together, shall be deemed to be a single agreement.

12.6. Successors and Assigns. This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective heirs, personal representatives, successors and assigns. Buyer shall have the right to assign this Agreement to any affiliate in its sole discretion without the prior consent of Seller. Buyer shall not assign this Agreement to any unrelated third party without the prior written consent of Seller, which consent may be withheld is Seller's sole discretion. For purposes of this Agreement, An "affiliate" of Buyer shall mean any corporation, partnership, limited liability company, association or other legal entity which, directly or indirectly, controls or is controlled by or is under common control with Buyer. For purposes of the definition of "affiliate," the word "control" (including "controlled by" and "under common control with" as used with respect to any corporation, partnership, limited liability company or association), shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policy of a particular corporation, partnership, limited liability company or association, whether through the ownership of voting interests or by contract or otherwise.

12.7. Time. Time is of the essence in the performance of all terms in this Agreement. If any time period designated herein expires on a Saturday, Sunday, or holiday, defined to mean a day when federal banks are not required to be open for business in Harford County, Maryland, then such time period shall be extended to the next day that is not a Saturday, Sunday or holiday. The term "business day" as used herein shall mean any weekday on which federally insured banks are required to be open for business in Baltimore, Maryland.

12.8. Governing Law; Venue; and Jurisdiction. This Agreement shall be governed by and construed in accordance with the laws of the State of Maryland without regard to principles of conflicts of law. The parties consent to the exclusive jurisdiction of any state or federal court in the State of Maryland. The parties agree that such venue is the most convenient forum for all parties and each party waives any objection to venue and any objection based on a more convenient forum in any action instituted pursuant to this Agreement.

12.9. Waiver of Jury Trial. The parties hereto, for themselves and their respective successors and assigns, hereby irrevocably waive any and all right to a trial by jury with respect to any lawsuit, action, proceeding, counter-claim or other litigation based upon or arising out of or otherwise relating to this Agreement and the transactions described herein. The parties further agree that they shall not seek to consolidate any such lawsuit, action, proceeding, counter-claim or other litigation procedure arising with respect to this Agreement or the transactions described herein with any proceeding in which trial by jury has not been waived.

12.10. Headings. The headings set forth at the beginning of each of the sections of this Agreement are inserted for convenience of reference only, and do not form a part of this Agreement or limit, expand, or otherwise change the meaning of any provision of this Agreement.

12.11. Representation by Counsel. Both parties to this Agreement have been represented by counsel or have had an opportunity to be represented and all provisions of this Agreement have been fully negotiated. No provision shall be interpreted against either party merely because such provision was drafted by such party or such party's counsel.

12.12. Partial Invalidity. If any provision of this Agreement shall for any reason be held invalid or unenforceable by any court, governmental agency or arbitrator of competent jurisdiction, such invalidity or unenforceability shall not affect any other provision, and this Agreement shall be construed as if such invalid or unenforceable provision had never been contained herein.

12.13. Survival. All representations, covenants, and indemnities contained in this Agreement shall survive Closing and delivery of a deed to the Property for a period of one (1) year.

12.14. Terrorism. Seller and Buyer represent that they are in compliance with the requirements of Executive Order No. 133224, 66 Fed. Reg. 49079 (September 25, 2001) (the "**Order**") and other similar requirements contained in the rules and regulations of the Office of Foreign Assets Control, Department of the Treasury ("**OFAC**") and any enabling legislation or other executive orders or regulations in respect thereof. The Order and such rules, regulations, legislation or orders are collectively hereinafter in this Agreement sometimes called the "**Orders**". Seller and Buyer further represent that they: (i) are not listed on the Specially Designated Nationals and Blocked Persons List maintained by OFAC pursuant to the Order and/or on any other list of terrorists or terrorist organizations maintained pursuant to any of the rules and regulations of OFAC or pursuant to any other applicable Orders (such lists are sometimes in this Agreement referred to, collectively, as the "Lists"); (ii) are not a person or entity who has been determined by competent authority to be subject to the prohibitions contained in the

Orders; or (iii) are not owned or controlled by, and does not act for or on behalf of, any person or entity on the Lists or any other personal entity who has been determined by competent authority to be subject to the prohibitions contained in the Orders.

12.15. Entire Agreement. This constitutes the entire agreement between the parties with respect to the purchase and sale of the Property and supersedes any prior letters of intent, correspondence or prior agreements whether written or oral. In the event of any conflict between the terms and conditions of this Agreement and the Letter Agreement, the terms and conditions of this Agreement shall control.

12.16. Prevailing Party. In addition to the remedies set forth in this Agreement, in the event suit is brought by either party for a breach of any provision of this Agreement, then the prevailing party in the suit is entitled to recover from the other party all costs and expenses incurred, including attorneys' fees.

12.17. Like-Kind Exchange. The parties agree that, if either party should elect to engage in a tax deferred like-kind exchange under Section 1031 of the Internal Revenue Code of 1986, as amended (a "**Like-Kind Exchange**"), each party shall cooperate in executing such documentation as is reasonably necessary to effectuate such Like-Kind Exchange, including the assignment of this Agreement to a qualified intermediary; provided, that (i) in no event shall the non-requesting party be named as the grantee in any deed of conveyance or as a party in any other document or instrument to be recorded among the land records of the jurisdiction where the exchange property is situated; (ii) the non-requesting party shall have no liability whatsoever in respect of the exchange property or its acquisition, or for the failure of the transaction to qualify as a Like-Kind Exchange; (iii) the consummation of closing with respect to the exchange property shall be at the sole cost and expense of the party requesting the Like-Kind Exchange, and the non-requesting party shall not be required to incur any cost or expense whatsoever in connection therewith; and (iv) although each party shall reasonably cooperate in the event either party shall elect to cause closing hereunder and in respect of the exchange property to occur simultaneously, it is nonetheless expressly understood and agreed that Closing under this Agreement shall not be delayed by reason of the Like-Kind Exchange.

12.18. Confidentiality. From and after the Effective Date, neither Buyer nor Seller shall make any public disclosure of the terms of this transaction, either before or after Closing without the prior written consent of the other, except as follows: (a) Seller and Buyer may issue a press release concerning the sale of the Property on or after the Closing Date, provided that such press release contains only the names of Seller and Buyer, the Closing Date, and other customary quotes usually included in a press release of this nature and; provided further that the form of the press release is approved in advance by both parties, (b) either party may disclose information with respect to the transaction contemplated herein, if and to the extent that such disclosure is required by

applicable law or a court or other binding order or by applicable administrative rule or regulation or order of any regulatory or supervisory agency or authority with competent jurisdiction over such matter or as part of any filing required to satisfy the Conditions to Closing; (c) the parties may disclose any information with respect to the transaction contemplated herein to any of their respective current or prospective lenders, members, officers, directors, trustees, employees, investors, consultants, advisors, attorneys, accountants, agents, representatives, partners and/or shareholders; provided that all of the foregoing are advised of the confidential nature of such information, matters, terms and provisions, or (d) Seller, Buyer and/or any affiliate of Seller or Buyer of any tier making any public statement, filing or other disclosure may disclose such information that any of them reasonably believes is required under applicable securities laws. Each of the parties hereto shall deliver a copy of a proposed press release to the other at least three (3) business days prior to the issuance thereof. The provisions of this Section shall survive the Closing or termination of this Agreement without restriction or limitation. Notwithstanding the foregoing, this confidentiality provision shall not apply to disclosure of the Purchase Price, the identity of the Buyer, or any other information regarding the transaction that is in the public domain or disclosed in public records on and after Closing.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the parties have executed this Agreement of Sale, intending to create a binding agreement as of the Effective Date.

WITNESS:

SELLER:

MERRITT-AD, LLC

By: _____
Name: Scott E Dorsey
Title: CEO

Date of Execution: 10/24/18

WITNESS:

BUYER:

UNIVERSITY OF MARYLAND – UPPER CHESAPEAKE HEALTH SYSTEM, INC.

_____
Ann Rabinowitz

By: _____
Name: Lyle E Sheldon
Title: President/CEO

Date of Execution: 10.24.18

4 : 10/23/18
16 : 9162.doc
307682

The undersigned Escrow agent has executed this instrument to acknowledge its receipt of the Deposit and its agreement to be bound by the terms and conditions of this Agreement affecting the Escrow Agent.

WITNESS/ATTEST:

Name: Colleen Fay Helmlinger
Title: Secretary

SNEE, LUTCHE, HELMLINGER & SPIELBERGER, P.A.

By: _____

Name: Joseph F. Snee, Jr.
Title: President

EXHIBIT A

Property Description

Parcel 1

35.633 Acre Parcel of Land, Land of Chesapeake Bank of Maryland, City of Aberdeen, Second Election District, Harford County, Maryland.

Beginning for the same at an X-cut heretofore set in a concrete flume on the northerly side of Bel Air Avenue and at the beginning point of deed from 612 Aberdeen Venture, a Maryland general partnership, and Remle, Inc., a Maryland corporation, to 612 LLC, a Maryland limited liability company, dated July 30, 2003 and recorded among the Land Records of Harford County, Maryland in Liber JJR. 4825, Folio 0264, thence binding on the said Bel Air Avenue and on the first line of the said deed, as now surveyed, with bearings referred to the Maryland Coordinate System (NAD'83/91),

1. North 41° 14' 36" West 99.61 feet to a "CNA" pin & cap heretofore set, thence leaving the said Bel Air Avenue and binding on all of the second through ninth lines of the aforesaid deed, eight courses, viz:

2. North 18° 50' 39" East 190.58 feet to a "CNA" pin & cap heretofore set,

3. North 58° 32' 12" West 66.35 feet to a pipe heretofore set on the southeasterly side of Bouzarth Lane,

4. North 18° 42' 50" East 200.20 feet along the southeasterly side of Bouzarth Lane to a "CNA" pin & cap heretofore set,

5. North 68° 43' 13" West, crossing the said Bouzarth Lane, 51.74 feet to a "CNA" pin & cap heretofore set,

6. North 20° 11' 52" East 364.04 feet along the northwesterly side of Bouzarth Lane to a "CNA" pin & cap heretofore set,

7. North 21° 54' 15" East 661.69 feet along the southeasterly side of Bouzarth Lane to a "CNA" pin & cap heretofore set

8. North 68° 05' 56" West, leaving the said Bouzarth Lane, 363.97 feet to a "CNA" pin & cap heretofore set, and

9. North 15° 26' 22" East 1030.22 feet to a "CNA" pin & cap heretofore set and to intersect the southerly right of way line of the Northern Freeway, Maryland Route

22, as shown on State Roads Commission Plat Nos. 37395 and 37396, thence binding on the said right of way line and on the tenth through fourteenth lines of the first mentioned deed, five courses, viz,

10. By a non-tangent curve to the right with a radius of 2177.83 feet and an arc length of 89.92 feet, said curve being subtended by a chord bearing North 86° 21' 30" East 89.91 feet, to a "CNA" pin & cap heretofore set,

11. North 70° 50' 34" East 100.57 feet to a "CNA" pin & cap heretofore set at a point of curvature,

12. By a non-tangent curve to the right with a radius of 2208.83 feet and an arc length of 337.31 feet, said curve being subtended by a chord bearing South 85° 35' 04" East 336.98 feet, to a "CNA" pin & cap heretofore set

13. South 87° 45' 00" East 143.88 feet to a "CNA" pin & cap heretofore set, and

14. South 87° 29' 05" East 69.69 feet to a "CNA" pin & cap heretofore set, thence leaving the aforesaid Northern Freeway and binding on all of the fifteenth line of the aforesaid deed, binding in part on the rear of Lots 1 through 10 as shown on the plat entitled "Aberdeen Hills - Section I" and recorded among the aforesaid Land records in Plat Book GCB 5, Folio 29, and binding in part on the rear of Lots 30 through 27, the west end of Colaine Drive, and Lots 25 through 19 as shown on the plat entitled "Paradise Manor Section A" and recorded among the aforesaid Land Records i n Plat Book GCB 4, Page 29,

15. South 10° 34' 25" West 1839.80 feet to a "CNA" pin and cap heretofore set at the southwest corner of the said Lot 19 and to intersect the north side of Lot 9 as shown on the plat entitled "Plat of Brookhaven" and recorded among the aforesaid Land Records in Plat Book GCB 4, Page 70, thence binding on the sixteenth line of the aforesaid deed and on the division line between the said Lots 9 and 19,

16. South 78° 48' 14" West 26.25 feet to a 1" pipe heretofore set, thence binding on the west side of the aforesaid Lot 9 and binding on the seventeenth line of the aforesaid,

17. South 11° 01 ' 20" West 100.07 feet to a "CNA" pin and cap heretofore set on the northern side of Burkley Avenue and the south side of Lot 9 of the last-mentioned plat, thence binding on the said Burkley Avenue and the said Lot 9 and binding on the eighteenth line of the aforesaid deed,

18. North 88° 51' 32" East 4.00 feet to a "CNA" pin and cap heretofore set, thence leaving the aforesaid Lot 9 and crossing the said Burkley Avenue and binding on the nineteenth line of the aforesaid deed,

19. South 10° 52' 52" West 41.99 feet to a "CNA" pin and cap heretofore set on the south side of the said Burkley Avenue and on the east side of Lot 8 as shown on the last mentioned plat, thence binding on the said Burkley Avenue and on the twentieth line of the aforesaid deed

20. South 88° 03' 17" West 4.01 feet to a "CNA" pin and cap heretofore set, thence leaving the said Burkley Avenue and binding on the west side of Lots 8 through 5 and part of Lot 4 as shown on the last mentioned plat, and binding on the twenty-first line of the aforesaid deed,

21. South 10° 58' 16" West 459.49 feet to a metal fence post heretofore set, thence leaving the said Lot 4 and binding on the twenty-second through twenty-sixth lines of the aforesaid deed, five courses, viz:

22. North 55° 27' 41" West 105.89 feet to a "CNA" pin & cap heretofore set,

23. North 55° 27' 41" West 285.46 feet to a "CNA" pin & cap heretofore set,

24. South 18° 41' 00" West 234.89 feet to a pipe heretofore set,

25. North 60° 22' 59" West 60.67 feet to a "CNA" pin & cap heretofore set, and

26. South 18° 21' 31" West 223.19 feet to the place of beginning.

Containing 35.633 acres of land, more or less.

Being also Lots 1 and 2 as shown on that certain final plat of subdivision entitled "Aberdeen Corporate Park" dated September 14, 2010, and recorded among the Land Records of Harford County, Maryland in Liber J.J.R. No. 136, No. 37.

Together with the benefit of the Utilities, Landscaping, Lighting and Signage easements as set forth in Paragraph 4 of Agreement regarding Mc Henry Road dated August 30, 2010 by and between Merritt - AD, LLC, and Stancills Inc., recorded among the Land Records of Harford County in Liber J.J.R. No. 8811, folio 226.

Saving and Excepting all of that land conveyed by Merritt-AD, LLC to the State Highway Administration of the Department of Transportation pursuant to a Deed dated April 10, 2014, and recorded among the Land Records of Harford County, Maryland in Liber J.J.R. No. 10717, No. 1.

Parcel 2

0.711 Acre Parcel of Land, Land of Stancills, Inc., City of Aberdeen, Second Election District, Harford County, Maryland.

Beginning for the same at a point at the southwesterly comer of Parcel "A" as shown on a plat entitled "Final Plat, Stancill's Middelton Road" and recorded among the Land Records of Harford County, Maryland in Plat Book CGH 88, Folio 79, said point being in and distant 49.84 feet from the beginning of the ninth or North 15°25'10" East 1030.26 foot line of deed from 612 Aberdeen Venture, a Maryland general partnership, and Remle, Inc., a Maryland corporation, to 612 LLC, a Maryland limited liability company, dated July 30, 2003 and recorded among the said Land Records in Liber JJR. 4825, Folio 264, thence leaving the said ninth line and binding on the southerly and southwesterly outline of the said Parcel "A", as now surveyed, with bearings referred to the Maryland Coordinate System (NAD'83/91), four courses, viz:

1. North 74° 33' 38" West 447.64 feet to a point of curvature

2. By a tangent curve to the right with a radius of 275.00 feet and an arc length of 116.96 feet, said curve being subtended by a chord bearing North 62° 22' 35" West 116.08 feet, to a point of tangency

3. North 50° 11' 32" West 46.15 feet, and

4. South 84° 48' 28" West 21.21 feet to a point and to intersect the southeasterly right of way line of Middelton Road as shown on the last mentioned plat, thence binding thereon,

5. North 39° 48' 28" East 80.00 feet to a "Corp 342" pin & cap heretofore set, thence leaving the said Middelton Road and binding on the northeasterly and northerly outline of the aforesaid

6. South 05° 11' 32" East 21.21 feet to a "Corp 342" pin & cap heretofore set,

7. South 50° 11' 32" East 46.15 feet to a to a "Corp 342" pin & cap heretofore set at a point of curvature,

8. By a tangent curve to the left with a radius of 225.00 feet and an arc length of 95.69 feet, said curve being subtended by a chord bearing South 62° 22' 35" East 94.97 feet, to a point of tangency, and

9. South 74° 33' 38" East 447.64 feet to a to a "Corp 342" pin & cap heretofore set and to intersect the aforesaid ninth line of the aforesaid deed, thence

binding reversely on part of the said ninth line and binding on the southerly end of the aforesaid Parcel "A",

10. South 15° 26' 22" West 50.00 feet to the place of beginning, Containing 0.711 acres of land, more or less.

Being all of Parcel "A" as shown on a plat entitled "Final Plat, Stancill's Middelton Road" and recorded among the Land Records of Harford County, Maryland in Plat Book CGH 88, Folio 79;

Being also the land conveyed by and described in a deed from Stancills, Inc. to Merritt-AD, LLC dated August 30, 2010 and recorded among the Land Records of Harford County, Maryland in Liber J.J.R. No. 8811, Folio 206.

SCHEDULE 3.1

Site Plan

Attached

EXHIBIT 4

Upper Chesapeake Health

Subject: Estimate of Charges

Origin Date: 1/7/11

Approved by: _____

Craig Willig, Vice President of Finance

To provide for transparency in health care pricing

Policy

Upper Chesapeake Health (UCH) shall publicly disclose, on a continuous basis, price estimates for such items, products, services, or procedures in accordance with current Legislation.

Manner of Disclosure

- Shall be made in an open and conspicuous manner;
- Shall be made available at the point of service, in print, and on the Internet; and
- UCH provides estimated charges for the most commonly used inpatient, outpatient, and ancillary services. The information is reviewed semi-annually by the Director of Reimbursement and updated when appropriate.

The amounts are estimates of charges for hospital procedures and services only.

Procedures

UCH promptly responds to individual requests for current charges for specific services/procedures.

- Patients seeking estimates of procedures/services that are not listed on the UCH Common Procedure chart will be encouraged to call the Cashier (443-643-1663).
- The UM Upper Chesapeake Health website will include a listing of current rates for common services; to be updated semi-annually
- If the Cashier is unable to provide the estimate, the Director of Reimbursement will be consulted.
- An estimate will be provided within three business days of receiving the request.

All Patient Accounting, Patient Access, Guest Services, and Administrative Personnel are knowledgeable of the process for providing estimates of charges.

DEVELOPER:

Patient Access, UCH

Reviewed / Revised: 7/1/17

ORIGIN DATE: 1/2011

NEXT REVIEW DATE: 7/2018

EXHIBIT 5

Upper Chesapeake Health

Subject: Financial Assistance Policy

Effective Date: 01/2013

Approved by: _____

Joseph E. Hoffman, Sr. VP CFO

_____

Board of Directors

To provide financial relief to patients unable to meet their financial obligation to Upper Chesapeake Health.

1. **Policy**
    a. This policy applies to Upper Chesapeake Health (UCH). UCH is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.
    b. It is the policy of UCH to provide Financial Assistance (FA) based on indigence or high medical expenses (Medical Financial Hardship program) for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for FA should be made, the criteria for eligibility, and the steps for processing applications.
    c. UCH will post notices of availability at appropriate intake locations as well as the Patient Accounting Office. Notice of availability will also be sent to patients on patient bills. Signs will be posted in key patient access areas. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge and will be available to all patients upon request. A written estimate of total charges, excluding the emergency department, will be available to all patients upon request.
    d. FA may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include a

review of the patient's existing medical expenses and obligations, including any accounts having gone to bad debt.

e. Payments made for care received during the financial assistance eligibility window that exceed the patients determined responsibility will be refunded if that amount exceeds $5.00
    i. Collector notes, and any other relevant information, are deliberated as part of the final refund decision; in general refunds are issued based on when the patient was determined unable to pay compared to when the payments were made
    ii. Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for a refund
f. UCH retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services or diagnosed-cancer care will be treated regardless of their ability to pay, except as noted under 2. d. iv. below.

2. Program Eligibility

a. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UCH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further the UCH commitment to our mission to provide healthcare to the surrounding community, UCH reserves the right to grant financial assistance without formal application being made by our patients.
b. Specific exclusions to coverage under the FA program include the following:
    i. Physician charges are excluded from UCH's FA policy. Patients who wish to pursue FA for physician related bills must contact the physician directly
    ii. Generally, the FA program is not available to cover services that are 100% denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications
    iii. Unpaid balances resulting from cosmetic or other non-medically necessary services
c. Patients may become ineligible for FA for the following reasons:
    i. Refusal to provide requested documentation or provide incomplete information

ii. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, Motor Vehicle or other insurance programs that deny access to UCH due to insurance plan restrictions/limits
iii. Refusal to be screened for other assistance programs prior to submitting an application to the FA program

d. Determination for Financial Assistance eligibility will be based on assets, income, and family size. Please note the following:
   i. Liquid assets greater than $15,000 for individuals, and $25,000 for families will disqualify the patient for 100% assistance.
   ii. Equity of $150,000 in a primary residence will be excluded from the calculation for determination of financial assistance; and
   iii. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans will not be used for determination of financial assistance.
   iv. Non-citizens/non-residents of the United States may only qualify for Financial Assistance under these circumstances: 1. an initial visit for emergency care or 2. if qualified for presumptive Medical Assistance upon inpatient admission or prior to outpatient treatments for cancer care, and only after a determination by the Financial Counselor/Director of Patient Accounting and/or V.P. of Finance. See the Upper Chesapeake Health Self Pay Billing policy for criteria for beginning outpatient cancer care for these patients.

e. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a FA application unless they meet Presumptive FA (see section 3 below) eligibility criteria. If a patient qualifies for COBRA coverage, the patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.
f. Free medically necessary care will be awarded to patients with family income at or below 200 percent of the Federal Poverty Level (FPL).
g. Reduced-cost, medically necessary care will be awarded to low-income patients with family income between 200 and 300 percent of the FPL

h. If a patient requests the application be reconsidered after a denial determination made by the Financial Counselor, the Director of Patient Accounting will review the application for final determination.
i. Payment plans can be offered for all self-pay balances by our Self Pay Vendor. Payment plans are available to uninsured patients with family income between 200 to 500 FPL.

3. Presumptive Financial Assistance

a. Patients may also be considered for Presumptive Financial Assistance eligibility with proof of enrollment in one of the programs listed below. There are instances when a patient may appear eligible for FA, but there is no FA form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patent with FA. In the event there is no evidence to support a patient's eligibility for FA, UCH reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100-percent write-off of the account balance. Presumptive FA eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
    i. Active Medical Assistance pharmacy coverage
    ii. Special Low Income Medicare Beneficiary (SLMB) coverage (covers Medicare Part B premiums)
    iii. Primary Adult Care coverage (PAC)
    iv. Homelessness
    v. Medical Assistance and Medicaid Managed Care patients for services provided in the ED beyond coverage of these programs
    vi. Maryland Public Health System Emergency Petition (EP) patients (balance after insurance)
    vii. Participation in Women, Infants and Children Program (WIC)
    viii. Supplemental Nutritional Assistance Program (SNAP)
    ix. Eligibility for other state or local assistance programs
    x. Deceased with no known estate
    xi. Determined to meet eligibility criteria established under former State Only Medical Assistance Program
    xii. Households with children in the free or reduced lunch program
    xiii. Low-income household Energy Assistance Program

xiv. Self-Administered Drugs (in the outpatient environment only)
xv. Medical Assistance Spenddown amounts

b. Specific services or criteria that are ineligible for Presumptive FA include:
   i. Purely elective procedures (e.g. cosmetic procedures) are not covered under the program
   ii. Uninsured patients seen in the ED under EP will not be considered under the presumptive FA program until the Maryland Medicaid Psych program has been billed

4. Procedures

a. The Financial Counselor will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage
b. The Financial Counselor will consult via phone or meet with patients who request FA to determine if they meet preliminary criteria for assistance.
   i. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility
   ii. All applications will be tracked and after eligibility is determined, a letter of final determination will be submitted to the patient
   iii. Patients will have fifteen days to submit required documentation to be considered for eligibility. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to. The financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent.
c. There will be one application process for UCH. The patient is required to provide a completed FA application. In addition, the following may be required:
   i. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return)
   ii. Proof of disability income (if applicable)
   iii. A copy of their three most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income
   iv. A Medical Assistance Notice of Determination (if applicable)
   v. Proof of U.S. citizenship or lawful permanent residence status (green card)
   vi. Reasonable proof of other declared expenses may be taken in to consideration

vii. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
viii. A Verification of No Income Letter (if there is no evidence of income)
ix. Three most recent bank statements

Written request for missing information will be sent to the patient. Where appropriate, oral submission of needed information will be accepted.

d. A patient can qualify for FA either through lack of sufficient income, insurance or catastrophic medical expenses. Within two (2) business days following a patient's request for Financial Assistance, application for Medical Assistance, or both, the hospital will make a determination of probable eligibility. Completed applications will be forwarded to the Manager of Patient Accounting who will determine approval for adjustments up to $10,000. Adjustments of $10,000 or greater will be forwarded to the V.P. of Finance for an additional approval.
e. Once a patient is approved for FA, eligibility will be extended to the following accounts:
    i. All accounts in an FB (Final Billed) status
    ii. All accounts in a BD (Bad Debt) status that were transferred within one year of the service date of the oldest FB account being adjusted using the current application
    iii. All future visits within 6 months of the application date
f. Social Security beneficiaries with lifelong disabilities may become eligible for FA indefinitely and may not need to reapply
g. UCH does not report debts owed to credit reporting agencies.
h. In rare cases, accounts may warrant Extraordinary Collection Actions (ECAs). Once an account has met the following criteria, the account is closed by the collection agency as "uncollectible" and forwarded back to Patient Accounting for review to establish grounds for legal action. UCH reserves the right to place a lien on a patient's income, residence and/or automobile. This only occurs after all efforts to resolve the debt have been exhausted.

    Criteria:

    i. The debt is valid
    ii. The account is equal to or greater than 120 days old
    iii. Patient refuses to acknowledge the debt
    iv. Upon review and investigation, we have determined liquid assets are available (checking, savings, stocks, bonds or money market accounts)

v. The VP of Finance must authorize legal action

Action will be preceded by notice 30 days prior to commencement. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.

5. Financial Hardship

a. Financial Hardship is a separate, supplemental determination of Financial Assistance and may be available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy
b. Financial Hardship Assistance is defined as facility charges incurred at UCH owned hospitals or physician practices for medically necessary treatment by a family household that exceeds 25% of the family's annual income. Family annual income must be less than 500% of the Federal Poverty Limit
c. Once a patient is approved for Financial Hardship Assistance, coverage may be effective starting with the first qualifying date of service and the following twelve (12) months
d. Financial Hardship Assistance may cover the patient and the immediate family members living in the same household. Each family member may be approved for the reduced cost and eligibility period for medically necessary treatment.
e. Coverage will not apply to elective or cosmetic procedures.
f. In order to continue in the program after the expiration of an eligibility period, each patient (family member) must reapply to be considered.
g. Patients who have been approved for the program should inform UCH of any changes in income, assets, expenses or family (household) status within 30 days of such changes
h. All other eligibility, ineligibility and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance, unless otherwise stated

DEVELOPER:

Patient Financial Counselor, UCH

Reviewed / Revised: 04/2016

ORIGIN DATE: 10/2010

Upper Chesapeake Health

Subject: Financial Assistance Policy

Effective Date: 03//2018

Approved by: _____

Steve Witman, Sr. VP CFO

_____

Board of Directors

To provide financial relief to patients unable to meet their financial obligation to Upper Chesapeake Health.

1. **Policy**
    a. This policy applies to Upper Chesapeake Health (UCH). UCH is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.
    b. It is the policy of UCH to provide Financial Assistance (FA) based on indigence or high medical expenses (Medical Financial Hardship program) for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for FA should be made, the criteria for eligibility, and the steps for processing applications.
    c. UCH will post notices of availability at appropriate intake locations as well as the Patient Accounting Office. Notice of availability will also be sent to patients on patient bills. Signs will be posted in key patient access areas. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge and will be available to all patients upon request. A written estimate of total charges, excluding the emergency department, will be available to all patients upon request.
    d. FA may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include a

review of the patient's existing medical expenses and obligations, including any accounts having gone to bad debt.

e. Payments made for care received during the financial assistance eligibility window that exceed the patients determined responsibility will be refunded if that amount exceeds $5.00
    i. Collector notes, and any other relevant information, are deliberated as part of the final refund decision; in general refunds are issued based on when the patient was determined unable to pay compared to when the payments were made
    ii. Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for a refund
f. UCH retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services or diagnosed-cancer care will be treated regardless of their ability to pay, except as noted under 2. d. iv. below.

2. Program Eligibility

a. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UCH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further the UCH commitment to our mission to provide healthcare to the surrounding community, UCH reserves the right to grant financial assistance without formal application being made by our patients.
b. Specific exclusions to coverage under the FA program include the following:
    i. Physician charges are excluded from UCH's FA policy. Patients who wish to pursue FA for physician related bills must contact the physician directly. For a list of physicians providing emergency and other medically necessary care in the hospital facility, whose services are not covered under this policy, please visit our website or contact our Financial Assistance Department at (443) 843-5092.
    ii. Generally, the FA program is not available to cover services that are 100% denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications
    iii. Unpaid balances resulting from cosmetic or other non-medically necessary services

c. Patients may become ineligible for FA for the following reasons:
    i. Refusal to provide requested documentation or provide incomplete information
    ii. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, Motor Vehicle or other insurance programs that deny access to UCH due to insurance plan restrictions/limits
    iii. Refusal to be screened for other assistance programs prior to submitting an application to the FA program
d. Determination for Financial Assistance eligibility will be based on assets, income, and family size. Please note the following:
    i. Liquid assets greater than $15,000 for individuals, and $25,000 for families will disqualify the patient for 100% assistance.
    ii. Equity of $150,000 in a primary residence will be excluded from the calculation for determination of financial assistance; and
    iii. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans will not be used for determination of financial assistance.
    iv. Non-citizens/non-residents of the United States may only qualify for Financial Assistance under these circumstances: 1. an initial visit for emergency care or 2. if qualified for presumptive Medical Assistance upon inpatient admission or prior to outpatient treatments for cancer care, and only after a determination by the Financial Counselor/Director of Patient Accounting and/or V.P. of Finance. See the Upper Chesapeake Health Self Pay Billing policy for criteria for beginning outpatient cancer care for these patients.
e. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a FA application unless they meet Presumptive FA (see section 3 below) eligibility criteria. If a patient qualifies for COBRA coverage, the patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.
f. Free medically necessary care will be awarded to patients with family income at or below 200 percent of the Federal Poverty Level (FPL).

g. Reduced-cost, medically necessary care will be awarded to low-income patients with family income between 200 and 300 percent of the FPL
h. If a patient requests the application be reconsidered after a denial determination made by the Financial Counselor, the Director of Patient Accounting will review the application for final determination.
i. Payment plans can be offered for all self-pay balances by our Self Pay Vendor. Payment plans are available to uninsured patients with family income between 200% to 500% of the FPL.

3. Presumptive Financial Assistance

a. Patients may also be considered for Presumptive Financial Assistance eligibility with proof of enrollment in one of the programs listed below. There are instances when a patient may appear eligible for FA, but there is no FA form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patent with FA. In the event there is no evidence to support a patient's eligibility for FA, UCH reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100-percent write-off of the account balance. Presumptive FA eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
    i. Active Medical Assistance pharmacy coverage
    ii. Special Low Income Medicare Beneficiary (SLMB) coverage (covers Medicare Part B premiums)
    iii. Homelessness
    iv. Medical Assistance and Medicaid Managed Care patients for services provided in the ED beyond coverage of these programs
    v. Maryland Public Health System Emergency Petition (EP) patients (balance after insurance)
    vi. Participation in Women, Infants and Children Program (WIC)
    vii. Supplemental Nutritional Assistance Program (SNAP)
    viii. Eligibility for other state or local assistance programs
    ix. Deceased with no known estate
    x. Determined to meet eligibility criteria established under former State Only Medical Assistance Program
    xi. Households with children in the free or reduced lunch program

xii. Low-income household Energy Assistance Program
xiii. Self-Administered Drugs (in the outpatient environment only)
xiv. Medical Assistance Spenddown amounts

b. Specific services or criteria that are ineligible for Presumptive FA include:
   i. Purely elective procedures (e.g. cosmetic procedures) are not covered under the program
   ii. Uninsured patients seen in the ED under EP will not be considered under the presumptive FA program until the Maryland Medicaid Psych program has been billed

4. Procedures

a. The Financial Counselor will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage
b. The Financial Counselor will consult via phone or meet with patients who request FA to determine if they meet preliminary criteria for assistance.
   i. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility
   ii. All applications will be tracked and after eligibility is determined, a letter of final determination will be submitted to the patient
   iii. Patients will have fifteen days to submit required documentation to be considered for eligibility. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to. The financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent.
c. There will be one application process for UCH. The patient is required to provide a completed FA application. In addition, the following may be required:
   i. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return)
   ii. Proof of disability income (if applicable)
   iii. A copy of their three most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income
   iv. A Medical Assistance Notice of Determination (if applicable)
   v. Proof of U.S. citizenship or lawful permanent residence status (green card)

vi. Reasonable proof of other declared expenses may be taken in to consideration
vii. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
viii. A Verification of No Income Letter (if there is no evidence of income)
ix. Three most recent bank statements

Written request for missing information will be sent to the patient. Where appropriate, oral submission of needed information will be accepted.

d. A patient can qualify for FA either through lack of sufficient income, insurance or catastrophic medical expenses. Within two (2) business days following a patient's request for Financial Assistance, application for Medical Assistance, or both, the hospital will make a determination of probable eligibility. Completed applications will be forwarded to the Manager of Patient Accounting who will determine approval for adjustments up to $10,000. Adjustments of $10,000 or greater will be forwarded to the Director of Patient Financial Services and the V.P. of Finance for an additional approval.
e. Once a patient is approved for FA, eligibility will be extended to the following accounts:
    i. All accounts in an AR (Accounts Receivable) status
    ii. All accounts in a BD (Bad Debt) status that were transferred within one year of the service date of the oldest AR account being adjusted using the current application
    iii. All future visits within 6 months of the application date
f. Social Security beneficiaries with lifelong disabilities may become eligible for FA indefinitely and may not need to reapply
g. UCH does not report debts owed to credit reporting agencies.
h. In rare cases, accounts may warrant Extraordinary Collection Actions (ECAs). Once an account has met the following criteria, the account is closed by the collection agency as "uncollectible" and forwarded back to Patient Accounting for review to establish grounds for legal action. UCH reserves the right to place a lien on a patient's income, residence and/or automobile. This only occurs after all efforts to resolve the debt have been exhausted.

    Criteria:

    i. The debt is valid
    ii. The account is equal to or greater than 120 days old
    iii. Patient refuses to acknowledge the debt

iv. Upon review and investigation, we have determined liquid assets are available (checking, savings, stocks, bonds or money market accounts)
v. The VP of Finance must authorize legal action

Action will be preceded by notice 30 days prior to commencement. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.

5. Financial Hardship

a. Financial Hardship is a separate, supplemental determination of Financial Assistance and may be available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy
b. Financial Hardship Assistance is defined as facility charges incurred at UCH owned hospitals or physician practices for medically necessary treatment by a family household that exceeds 25% of the family's annual income. Family annual income must be less than 500% of the Federal Poverty Limit
c. Once a patient is approved for Financial Hardship Assistance, coverage may be effective starting with the first qualifying date of service and the following twelve (12) months
d. Financial Hardship Assistance may cover the patient and the immediate family members living in the same household. Each family member may be approved for the reduced cost and eligibility period for medically necessary treatment.
e. Coverage will not apply to elective or cosmetic procedures.
f. In order to continue in the program after the expiration of an eligibility period, each patient (family member) must reapply to be considered.
g. Patients who have been approved for the program should inform UCH of any changes in income, assets, expenses or family (household) status within 30 days of such changes
h. All other eligibility, ineligibility and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance, unless otherwise stated
i. See Attachment A for the sliding scale reduced cost of care.

6. Amounts Generally Billed

a. An individual who is eligible for assistance under this policy for emergency or other medically necessary care will never be charged more than the amounts generally billed (AGB) to an individual who is not eligible for

assistance. The charges to which a discount will apply are set by the State of Maryland's rate regulation agency (HSCRC) and are the same for all payers (i.e. commercial insurers, Medicare, Medicaid or self-pay).

Reviewed / Revised: 03/2018

ORIGIN DATE: 10/2010

NEXT REVIEW DATE: 03/2019

1/23/2018

% discount	MAX/MIN	Family 1	Family 2	Family 3	Family 4	Family 5	Family 6	Family 7	Family 8
Fed Pov Guideline		$12,140.00	$16,460.00	$20,780.00	$25,100.00	$29,420.00	$33,740.00	$38,060.00	$42,380.00
MHA Guidelines now at 200% of FPL									
100%	up to	$ 24,280.00	$ 32,920.00	$ 41,560.00	$ 50,200.00	$ 58,840.00	$ 67,480.00	$ 76,120.00	$ 84,760.00
90%	Min	$ 24,281.00	$ 32,921.00	$ 41,561.00	$ 50,201.00	$ 58,841.00	$ 67,481.00	$ 76,121.00	$ 84,761.00
	Max	$ 26,708.00	$ 36,212.00	$ 45,716.00	$ 55,220.00	$ 64,724.00	$ 74,228.00	$ 83,732.00	$ 93,236.00
80%	Min	$ 26,709.00	$ 36,213.00	$ 45,717.00	$ 55,221.00	$ 64,725.00	$ 74,229.00	$ 83,733.00	$ 93,237.00
	Max	$ 27,922.00	$ 37,858.00	$ 47,794.00	$ 57,730.00	$ 67,666.00	$ 77,602.00	$ 87,538.00	$ 97,474.00
70%	Min	$ 27,923.00	$ 37,859.00	$ 47,795.00	$ 57,731.00	$ 67,667.00	$ 77,603.00	$ 87,539.00	$ 97,475.00
	Max	$ 29,136.00	$ 39,504.00	$ 49,872.00	$ 60,240.00	$ 70,608.00	$ 80,976.00	$ 91,344.00	$ 101,712.00
60%	Min	$ 29,137.00	$ 39,505.00	$ 49,873.00	$ 60,241.00	$ 70,609.00	$ 80,977.00	$ 91,345.00	$ 101,713.00
	Max	$ 30,350.00	$ 41,150.00	$ 51,950.00	$ 62,750.00	$ 73,550.00	$ 84,350.00	$ 95,150.00	$ 105,950.00
50%	Min	$ 30,351.00	$ 41,151.00	$ 51,951.00	$ 62,751.00	$ 73,551.00	$ 84,351.00	$ 95,151.00	$ 105,951.00
	Max	$ 31,564.00	$ 42,796.00	$ 54,028.00	$ 65,260.00	$ 76,492.00	$ 87,724.00	$ 98,956.00	$ 110,188.00
40%	Min	$ 31,565.00	$ 42,797.00	$ 54,029.00	$ 65,261.00	$ 76,493.00	$ 87,725.00	$ 98,957.00	$ 110,189.00
	Max	$ 32,778.00	$ 44,442.00	$ 56,106.00	$ 67,770.00	$ 79,434.00	$ 91,098.00	$ 102,762.00	$ 114,426.00
30%	Min	$ 32,779.00	$ 44,443.00	$ 56,107.00	$ 67,771.00	$ 79,435.00	$ 91,099.00	$ 102,763.00	$ 114,427.00
	Max	$ 33,992.00	$ 46,088.00	$ 58,184.00	$ 70,280.00	$ 82,376.00	$ 94,472.00	$ 106,568.00	$ 118,664.00
20%	Min	$ 33,993.00	$ 46,089.00	$ 58,185.00	$ 70,281.00	$ 82,377.00	$ 94,473.00	$ 106,569.00	$ 118,665.00
	Max	$ 35,206.00	$ 47,734.00	$ 60,262.00	$ 72,790.00	$ 85,318.00	$ 97,846.00	$ 110,374.00	$ 122,902.00
10%	Min	$ 35,207.00	$ 47,735.00	$ 60,263.00	$ 72,791.00	$ 85,319.00	$ 97,847.00	$ 110,375.00	$ 122,903.00
	Max	$ 36,420.00	$ 49,380.00	$ 62,340.00	$ 75,300.00	$ 88,260.00	$ 101,220.00	$ 114,180.00	$ 127,140.00

EXHIBIT 6

Behavioral Health Protocols for the UCH Emergency Department

Original: 08/08
Revised: 04/12

March 5, 2012

To Whom It May Concern:

We, the undersigned agree to the revised Emergency Department Laboratory Testing Policy for patients requiring Behavioral Health Services. In addition, the admission criteria to the Upper Chesapeake Behavioral Health Services will be amended. Under the Exclusion Criteria, number one, "Intoxication (BAL > or = 100)" will be changed to "Intoxication."

Syed W. Rizvi, M.D.
Chair, Department of Psychiatry

3/20/12
Date

Fermin Barrueto M.D.
Chair, Department of Emergency Medicine

3/6/2012
Date

Emergency Department Laboratory Testing Policy for Patients Requiring Behavioral Health Services

1. Blood Alcohol Testing
   - Patients with an initial blood alcohol of 180-200 mg/dl do not need to have their levels redrawn provided that they are evaluated 5 hours after the initial blood draw.

   - Patients with an initial blood alcohol of 160-179mg/dL do not need to have their levels redrawn provided that they are evaluated 4 hours after the initial blood draw.

   - Patients with an initial blood alcohol of 140-159 mg/dL do not need to have their levels redrawn provided that they are evaluated 3 hours after the initial blood draw.

   - Patients with an initial blood alcohol of 120-139 mg/dL, do not need to have their levels redrawn provided that they are evaluated 2 hours after the initial blood draw.

   - Patients with an initial blood alcohol of 100-119 mg/dL do not need to have their levels redrawn provided that they are evaluated 1 hour after the initial blood draw.

   - For patients requiring admission to the Behavioral Health Unit, the physician will sign, date, and time the admission paperwork only after the necessary alcohol clearance time has elapsed per the above stated criteria.

2. Laboratory testing does not need to be performed on psychiatric patients who are being discharged from the Emergency Department. Laboratory testing does not need to be performed before assessment by a Behavioral Heath Evaluator, provided that the patient is clinically sober. If there is any indication that the patient may be intoxicated, then a blood alcohol level mist be sent, and the evaluation will be performed when the patient is medically sober.

3. The urine toxicology screen should be performed in the Emergency Department. However, in the event that the patient is unable to give a specimen in a reasonable amount of time, the patient may be transferred to the Behavioral Health Unit without the urine toxicology screen at the discretion of the admitting psychiatrist.

4. The TCA screen does not need to be performed as part of the urine drug screen.

BEHAVIORAL HEALTH PROTOCOLS
UCH EMERGENCY DEPARTMENT

TABLE OF CONTENTS

APPENDIX

CRITERIA FOR TRIAGING PATIENTS TO BEHAVIORAL HEALTH SERVICES

PURPOSE: To expedite the care and disposition of patients in the emergency department who are in need of behavioral health services.

POLICY: All patients will be assessed by the ED physician and assigned to category I, II, or III according to written guidelines.

CRITERIA FOR CATEGORY I (Admitted to Inpatient Service):

1. There is evidence the patient has harmed or attempted to harm him/herself in a manner which is potentially lethal or disabling.
2. There is evidence the patient has harmed or attempted to harm others, due to a mental illness, in a manner which is potentially lethal or disabling.

CRITERIA FOR CATEGORY II (Requires Further Evaluation):

The patient exhibits any one or more of the following:

1. The patient has harmed or attempted to harm self or others without clear lethal intent and requires further evaluation to determine level of care needs.
2. The patient has made recent verbal threats to harm self or others.
3. The patient exhibits:
    a. bizarre behavior or
    b. disorganized thought process
    c. psychotic thought or content
4. The patient is not agreeable to a referral to the Mobile Crisis Team or other community resource.
5. The patient has been brought to the ED with an emergency petition, with apparent cause.

CRITERIA FOR CATEGORY III (Referred to Community Resources):

1. The patient presents to the ED voluntarily.
2. There is no evidence of imminent danger to self or others:
    a. Denies plan or intent to harm self or others.
    b. There are no reports by patient or others of recent self harm
    c. There are no reports by patient or others of recent aggressive behavior due to a mental illness.
    d. There are no reports of recent verbal threats to harm self or others.
3. The patient:
    a. Is alert and oriented
    b. Presents a logical stream of thought
    c. Is not intoxicated
    d. Agrees to a referral to community resource.

Upper Chesapeake Health Behavioral Health Services

Emergency Department Categories for Psychiatric Patients

Category I:

The patient meets all criteria for admission to Behavioral Health inpatient. The management of the patients is completed by the Upper Chesapeake Health Emergency Department team; this includes all preauthorization and completion of all necessary documentation for the medical record.

Category II:

The patient requires further psychiatric evaluation by the on-call evaluators to determine an appropriate admission status. The on-call evaluator will arrive to the Emergency Department within one hour of the initial contact/request. Recommendations to the Upper Chesapeake Emergency Department physician will be provided, and the on-call psychiatrist* will be consulted. The on-call evaluator will be available to the Emergency Department case manager to provide additional clinical information. The Upper Chesapeake Health Emergency Department team will obtain all preauthorization, and complete all necessary documentation for the medical record.

Category III:

It is determined that the patient requires a psychiatric community provided, and is discharged from the Upper Chesapeake Emergency Department. The Mobile Crisis Team is available to the Upper Chesapeake Emergency Department physician to provide psychiatric community referral information.

*The psychiatrist on call is available for telephone consultation to the Emergency Department physician for questions, concerns or clarification.

BEHAVIORAL HEALTH
PROTOCOL FOR CATEGORY I

PURPOSE: To expedite the care and disposition of patients who are assessed as Category I.

POLICY: All patients will be seen by the emergency department physician and assigned to Category I, II, or III based on written guidelines.

PROCEDURE:

Category I

- The Emergency Department (ED) physician consults with the psychiatrist on-call to determine whether there is clear indication for admission.
- At the request of ED staff, the Admissions/Registration staff identifies and contacts the appropriate third-party payer to verify benefits and to request a return call from the MCO case manager to authorize admission. The required information is documented on the preauthorization form.
- The MCO case manager returns the call to the Admission /registration staff and is transferred to the ED physician for clinical information.
- Once authorization is given, the ED physician documents the authorization number and number of authorized days on the medical record. This information is provided to the Admission/Registration staff for entry into Meditech.
- In the event a return call by the MCO case manager is not received after one hour, Admission/Registration staff will contact the MCO to inform them the patient will be admitted to the BHU, when appropriate.
- Voluntary Admission: The ED staff completes all necessary forms for voluntary admission, signed by the patients and the ED physician, where indicated. (See Appendix.)
- Involuntary Admission: The ED physician writes a brief progress note which includes the patient's medical history, current symptoms and diagnosis, and an explanation of why the patient meets criteria for involuntary admission, and completes and signs all necessary forms. (See Appendix).
- The patient is transferred to the HMH BHU according to established procedures.

Patients Requiring Admission to Another Facility

- Patients referred to other inpatient facilities require the following information, to be sent via fax :
    - The physician's progress note stating reason for admission
    - Relevant laboratory reports
    - The face sheet
    - Copy of insurance card
    - The *original* legal paperwork, (Voluntary and Involuntary Admission forms, E.P.), *must accompany the patient*. Copies are retained for the UC medical record. See Appendix for required forms for Admission
- The receiving facility will contact the ED when they have received all necessary information and accepted the patient for admission.

- The patient is transferred according to established procedures.

BEHAVIORAL HEALTH
PROTOCOL FOR CATEGORY II

PURPOSE: To expedite the care and disposition of patients assessed as Category II.

POLICY: All patients will be seen by the Emergency Department physician and assigned to Category I, II, or III according to written guidelines.

PROCEDURE:
Category II

- The ED physician consults with the on-call psychiatrist if categorization is in question.
- The ED physician requests a consultation with the ED behavioral health evaluator after assigning the patient to Category II.
- The on-call evaluator will respond to the page within 30 minutes and will arrive in the ED within on hour unless involved in other crisis situation, in which case they will provide an ETA.
- The ED physician will provide the ED on-call evaluator with the reason for the consultation request.
- The behavioral health on-call evaluator will:
    - Assess the patient
    - Consult with the psychiatrist on call, as required
    - Provide a written evaluation, utilizing the Upper Chesapeake assessment form
    - Consult with the ED physician regarding disposition and provide outpatient referrals, when indicated.
    - Notify the Admission/Registration staff of need to request preauthorization for admission, when applicable
    - Be available to talk with the MCO case manager to provide clinical information
    - Provide the authorization number and authorized days to the Admission/Registration staff
    - Complete all necessary forms for Voluntary or Involuntary Admission
    - Arrange admission to another facility, when indicated
    - Provide written documentation and a verbal report to the ED charge nurse regarding disposition status prior to leaving the ED
- In the event the MCO case manager does not call to review the case for authorization one hour after the initial request by UCH, the Admission/Registration staff will notify the MCO of the patient's admissions to the BHU at HMH.
- Following completion of the evaluation and necessary forms, the patient is discharged by the ED physician or admitted to a psychiatry facility according to established procedures.

BEHAVIORAL HEALTH
PROTOCOL FOR CATEGORY III PATIENTS

PURPOSE: To expedite the care and disposition of patients in the emergency department who are assessed as Category III

POLICY: All patients will be seen by the emergency department physician and assigned to Category I, II, or III according to written guidelines.

PROCEDURE:

- The ED physician determines the patient meets Category III criteria.
- The emergency department staff pages the on-call evaluator to speak with the patient by telephone to make referral and/or arrangements for a face-to-face visit, if indicated.
- The discharge checklist may be used as a guideline for discharge instructions.

BEHAVIORAL HEALTH
GUIDELINE FOR DISCHARGE INSTRUCTIONS
CATEGORY III PATIENTS

Meets Category III criteria

Agreeable to Mobile Crisis Team referral

Mobile Crisis team contacted

Date_____ Time_____

Available to speak with patient:

Appointment arranged_____

or

Referral given_____

or

Message left_____

Evaluator on call contacted to provide referral and/or relay message to MCT.

NOT PART OF THE MEDICAL RECORD

Chemical Dependency

Generally, efforts to secure admission to an inpatient detox or treatment program from the Emergency Department is a time consuming and fruitless prospect, resulting in hours of wasted time for the patient, family, and staff. Most managed care companies will not authorize admission to such programs until the patient has been assessed and recommended for admission *by the receiving facility*. The Behavioral Health Unit at HMH does not admit patients for the primary purpose of detox, or C.D. treatment. Assessment and recommendations from the psychiatric consultant in the ED are not sufficient to satisfy the MCO that the patient meets criteria for inpatient chemical dependency treatment. The receiving facility generally requires the *patient* make an intake appointment, which is scheduled during regular business hours. The MCO will approve admission based on the intake assessment and recommendation from the receiving facility. There are a very few exceptions to this procedure, but the vast majority of patients seeking this service *will not* be admitted from the ED. At best, the patient may be referred to an inpatient program for assessment (versus admission). The patient is usually capable of making the necessary telephone calls and arranging the intake appointment, and should be encouraged to do so.

Uninsured patients have no less difficulty securing admission, and may be given the referral list to arrange their own treatment. The Mobile Crisis Team is available, by telephone, to assist both insured and uninsured patients in finding resources.

BEHAVIORAL HEALTH
GENERAL ADMISSION CRITERIA AND
REQUIRED FORMS

VOLUNTARY ADULT

Criteria

The patient:

- Must be 16 year or older
- Must have a mental disorder that is susceptible to care or treatment
- Must be able to understand the nature of the request for treatment
- Must be able to give consent to retention by the facility (must be able to request release).
- Must be provided with information printed on the Application for Voluntary Admission (Health General Article, Annotated Code of Maryland) in order to make an informed decision about hospitalization
- The Application for Voluntary Admission must be singed by a physician licensed to practice medicine in the state of Maryland and by the patient.

Forms

- DHMH-4 (Request for Voluntary Admission)

INVOLUNTARY ADULT

Criteria

The patient:

- Has a mental disorder that is susceptible to care or treatment
- Needs continued treatment for the protection of the individual or another (imminent danger of suicidal or homicidal behavior)
- Is unable or unwilling to be voluntarily admitted
- Has no available less restrictive option for care that is consistent with his/her welfare

Forms

- Two DHMH-2s (Physician Certificates)
- One Supplemental DHMH-2 (Six Questions)
- DHMH-34 (Application for Involuntary Admission)*
- The Emergency Petition

PREAUTHORIZATION PROCEDURES FOR BEHAVIORAL HEALTH ADMISSIONS

I. PURPOSE: To comply with preauthorization requirements of third-party payers.

II. POLICY: The Admissions/Registration staff will request preauthorization for patients requiring admission and document the information on the appropriate forms.

III. PROCEDURE:

- At the request of the ED staff or the on-call evaluator, the Admissions/Registration staff identifies and contacts the appropriate insurance company or MCO, providing demographic and policy information, and requests a call back for preauthorization for admission, providing the name and contact number of the person giving clinical information, (ED physician or on-call evaluator).
- The MCO or insurance representative verifies benefits and contacts the case manager for authorization.
- The Admissions/Registration staff documents the required information on the preauthorization form and places on patient chart. (See attached)
- The MCO case manager contacts the ED physician or the on-call evaluator for clinical information.
- The MCO case manager provides the authorization number and the number of authorized days which is related to the Admissions/Registration staff for entry into the Meditech system.
- In the event a return call is not received after one hour, Admissions/Registration staff notifies the MCO of the patient's admission to the Behavioral Health Unit.

PREAUTHORIZATION WORKSHEET

DATE:_____
TIME:_____

PATIENT NAME _____

DOB_____ SS#_____

INSURANCE CO. & POLICY # _____

MCO Contacted _____

COMMENTS _____

_____

_____

_____

Authorizing Case Manager _____

Phone # _____ **Call returned**_____
(Date & Time)

Authorized to: HMH Other_____

Number of Days Authorized _____ Authorization #_____

UR to Contact _____

Comments: _____

_____

_____

_____

BEHAVIORAL HEALTH
PROTOCOL FOR PATIENTS
REQUESTING CHEMICAL DEPENDENCY TREATMENT

PURPOSE: To expedite the care and disposition for patients seeking detoxification and/or Chemical dependency treatment

POLICY: Sheppard Pratt does not provide assessment and placement for patients seeking detoxification, or other chemical dependency treatment. Patients will be medically stabilized and referred.

PROCEDURE:

- The ED physician provides medical evaluation and treatment as deemed appropriate.
- Patients who are medically stable are referred for treatment by contacting the on-call evaluator who will provide available resources and information.

PLEASE SEE APPENDIX FOR FURTHER INFORMATION

Admission Criteria to Upper Chesapeake Behavioral Health Services

Inclusion Criteria for Psychiatric Admissions:

1. Immediate danger to self/others as evidenced by verbal threats or observed behavior
2. Evidence of impaired judgment due to a psychiatric condition likely to endanger self/others
3. Evidence of treatment failure likely to result in behavior dangerous to self/others
4. Multiple suicide attempts (or other episodes of dangerous behaviors due to psychiatric condition) within a short period of time
5. Inability to contract for safety outside of the hospital in association with an active psychiatric condition
6. Disabling psychiatric condition for which no effective treatment alternative exists

Exclusion Criteria (based on physician collaborative review):

1. Intoxication
2. Medically unstable
3. Documented history of assaultive behavior against hospital staff
4. Persons under police custody or against whom active charges have been filed
5. Specialty services not available at time patient presents in emergency room

References:

Brennan DF, Betzelos S, Reed R, Falk JL. Ethanol elimination rates in an ED population. Am J Emerg Med 1995; 13(3):276-80

Lexicomp Online- Alcohol (Ethyl):
http://online.lexi.com/action/doc/retrieve/docid/patch_f/6294

EXHIBIT 7

UNIVERSITY of MARYLAND UPPER CHESAPEAKE HEALTH	PAGE: Page 1 of	POLICY/PROCEDURE /SOP NO: CRM
	ORIGINAL DATE: 12.2003	
	APPROVAL DATE:	EFFECTIVE DATE: Reviewed Date: 01.2006, 01.2009, 04.2012, 08.2015 Revised Date: 01.2006, 01.2009, 04.2012, 08.2015
POLICY/PROCEDURE/SOP TITLE: Transportation	FUNCTION/OWNER: CRM Policy Oversite Committee	

Standard Operating Procedure

KEY WORDS: (if applicable)

1. OBJECTIVES/PURPOSE:

- To outline the process by which Clinical Resource Management facilitates safe and appropriate transportation options to patients being discharged from a UMC UCMC or UM HMH

2. SCOPE/APPLICABILITY:

- The Standard Operating Procedure (SOP) will be applied in the Clinical Resource Management (CRM) Department. Team Member education will also be included in the scope of this SOP.

3. PREREQUISITES:

- Interdisciplinary team member education

4. RESPONSIBLITIES:

- CRM team member – proper identification, referral, coordination and facilitation of transportation
- Any member of the Interdisciplinary Team – Identify patients who will require assistance with transportation at discharge

5. PROCEDURE:

5.1 General Information

a. Transportation arrangements will be made based on the patient's medical conditions, safety concerns, team recommendations and patient or family request.
b. A list of transportation providers is available on the UCH Intranet>Case Management>Transportation

c. CRM will speak with members of the multidisciplinary team regarding safe options for transport

a. Check the Rehabilitation interventions

i. The Rehabilitation team will often make recommendations on how patient would best be transported

d. CRM will speak with patient and/or family about their preferences for transport and recommendations of the team – if any

e. Some Assisted Livings/Boarding Homes provide their own transportation

a. Usually is depends on staffing at the facility, time of day, etc.

f. CRM does not arrange for transportation for acute to acute transfers

5.2 Coordinating Transportation

a. Prior to setting up transport

a. CRM will verify with the patient and/or family where the patient will be going at the time of transport

b. CRM should verify with the patient and/or their family and facility (if appropriate) when transport is to occur

5.3 Ambulance transport

a. There are two types

a. Advanced Life Support (ALS)

i. Requires RN monitoring during transport

ii. Ventilator dependent

iii. Continuous intravenous devices

iv. Continuous cardiac (EKG) monitoring

v. The patient is comatose and requires trained monitoring

b. Basic Life Support (BLS)

i. Criteria – must meet one of the following

a. Must be considered bed bound

a. The patient is unable to get out of bed safely with one person assisting

b. Unable to get up from bed without assistance

c. Unable to ambulate AND Unable to sit in a chair – including a wheelchair

d. The patient cannot support themselves safely when seated in a wheelchair

i. Why

e. All other types of transportation must be contraindicated

f. Any other means would endanger the patient's health

g. Be Specific

h. Additional helpful documentation

i. oral pain meds, antipsychotics

ii. pressure sores

iii. trunk instability

iv. Document the JHH Fall Risk Score

c. When going to acute rehab or out of county closest accepting facility must be documented

d. Insurance

a. CRM will remind patient/family that despite all of the documentation provided there is still no guarantee that Medicare will cover ambulance transport

b. Most insurance companies will cover ambulance transport if the above criteria are met

d. CRM will verify benefits and obtain authorization and identify preferred providers for commercial insurances – including MA MCO's

e. A Certificate of Medical Necessity should be completed for Medicare and some other commercial insurance

i. complete in and fax thru eDischarge

5.3 Wheelchair Van

a. A wheelchair van can be used in the event that a patient does not meet the criteria to be transported by ambulance or their family does not feel comfortable transporting the patient in a private vehicle

b. Criteria

a. The patient must be able to independently sit in a wheelchair

b. The patient must be able to transfer independently from the bed to the wheelchair or at least transfer with minimal assistance from the attendant

c. The patient can be on self-administered 02 but the transportation company does not supply the 02

c. Insurance

a. Wheelchair vans are not covered by most insurances including Medicare

b. Wheelchair van service providers usually require payment at time of transport if insurance will not authorize or benefits are not available

c. CRM will facilitate a conversation with the patient and/or their family regarding cost and payment options- i.e.: cash, check or credit card

d. Cost will be verified with transportation provider and shared with family

5.4 Coordination of transportation

a. Demographic information – face sheet

b. The patient's height and weight

c. Isolation precautions

d. Oxygen requirements – if any

e. If the patient is going to a private residence – are there any steps?

f. Time requested

5.5 Cab Vouchers

a. Are provided only when a patient is safe to be transported in a car

b. It has been determined that there are no family and friends who can assist with transportation

c. Bus transport is also not an option

5.6 Medical Assistance (MA) Transportation

a. MA will cover transportation for SOME MA recipients

b. Each county has certification forms that must be completed for transport –

a. Available in eDischarge

c. Harford County phone number 410-638-1671

a. Must use Transcare for ambulance transportation
410-242-9000 phone/410-649-2253 fax

b. Must use Davi Transportation Services for wheel chair vans
443-768-6879 phone/410-654-0091 fax

d. MA transport can verify benefits

e. MA transport will either set up transport or inform you of the provider

f. MA transport will provide you with an authorization number for ambulance or wheelchair van arrangements

g. Requests must be received Monday thru Friday by 2pm

h. They do not answer the phone after 2pm

5.7 Harford County Transportation Services

a. Harford County has public bus service with various routes throughout the county 410-838-2562

b. Schedules are available on the Harford County Government website

c. The bus comes to the main entrance of both hospitals.

d. It comes to UCMC about every 15 minutes

e. It comes to HMH about every 2 hours

5.8 Documentation

a. All transportation arrangements must be documented on the CRM DC Plan and in the progress notes section of the EMR.

b. If CRM paid for transportation please be sure to reflect this when documenting on the CRM Discharge Plan

6. REFERENCES:

- Transportation Provider List – UCH Intranet>Case Management>Transportation

7. DEFINITIONS:

- CRM –Clinical Resource Management
- EMR – Electronic Medical Record
- MA –Medical Assistance
- MCO's - Managed Care Organizations

STAKEHOLDERS:

Reviewed by:	Date:
Alexis Rivers	
Debbie Gebhardt	
Debi Cheng	

APPROVED BY:	Title	Date
Alexis Rivers	Director, CRM	

APPROVED BY:	Date
Digital signature and date are on file in Reference Library	

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Revised Date: 01.2006, 01.2009, 04.2012, 08.2015</td></tr>
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CRM Policy Oversite Committee</td></tr>
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EXHIBIT 8

UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH

BEHAVIORAL HEALTH SERVICES

TITLE: ADMISSION CRITERIA AND PROCESS PROTOCOL FOR BEHAVIORAL HEALTH SERVICES

Approved by:

Director of Behavioral Health Services: _____
Chief of Psychiatry/Medical Director: _____
Vice President of Patient Services: _____

Original Date:	6/95
Reviewed Date:	9/97 4/08 10/14 11/18
Revised Date:	9/97 1/99 9/99 11/03 7/06 4/08 1/11 7/13 11/18

PURPOSE: To facilitate appropriate and timely admissions to the Behavioral Health Services unit (BHU).

POLICY: The Behavioral Health Services unit will provide inpatient acute mental health services for those patients that have been evaluated and meet admission criteria.

PROCEDURE:

I. Voluntary Admission

A. A voluntary patient is defined as any patient age 18 and over and experiencing a primary acute psychiatric illness or an exacerbation of a chronic condition that impairs the patient's ability to function independently and/or is dangerous to oneself or others, and agrees to treatment. (See attachment A: Admission Criteria/Limitations).

B. Voluntary status requires:
1. A signed Application for Voluntary Agreement endorsed by a licensed physician or Nurse Practitioner.
2. Patients must be able to comprehend the status of their admission and their need for treatment.
3. Ability to take prescribed medications as ordered.

4. Ability to participate in milieu and therapeutic groups.
5. Ability to meet with the psychiatrist daily.
6. Ability to participate in discharge planning.
7. Patients must be medically stable and not require intensive medical treatment.
8. Pregnant patients greater than 12 weeks gestation will not be admitted

C. In accordance with Maryland Health General Law 10-803, voluntarily admitted patients may request, in writing, their intent to leave the hospital within three days. If a guardian signs the Voluntary Admission Agreement for the patient, they must submit the three-day notice.
   1. Patients must request, in writing, their intent to leave the hospital by completing Harford Memorial Hospital Behavioral Health Services three-day notice.
   2. If the treating psychiatrist determines that the patient meets criteria for certification for involuntary admission, then the certification process will be completed in accordance with Maryland Health General Law 10-803.
   3. A three-day Notice retraction must be reviewed and signed by a physician in order to validate its acceptance.

D. Observation Status: A patient may be placed in observation status per the physician order. The patient will be evaluated by the physician within 24 hours and a decision made to either admit the patient or discharge the patient.

II. Involuntary Admissions

Observation Status

A. Defined. Observation Status is defined as the interval between the time an individual is involuntarily confined in the facility and the time he/she is voluntarily admitted, released either by the attending psychiatrist or psychologist or by the Administrative Law Judge, or retained as an involuntary patient by an Administrative Law Judge. During the observation period the observee shall receive care and treatment as medically required but may not, absent an emergency, be forced to take medication. The purpose of observation is for assessment of need for involuntary admission, voluntary admission, or release without admission.

B. Observation Status Initiated at Time of Admission. The hospital admitting nursing person is responsible to initiate the process leading to a hearing for involuntary admission when an individual is brought in for observation. The following forms must be completed on all involuntary admissions prior to arrival on the unit: (1) Application for Involuntary Admission (form DHMH - 34) completed and signed by a person who has a legitimate interest in the welfare of the individual; (2) two copies of the State of Maryland Certification by Physician or Psychologist (DHMH-2

REV.3/90) completed and signed by either two physicians licensed to practice in the State of Maryland, or by one physician and one Maryland licensed psychologist or mental health nurse practitioner listed in the National Register; (3) a report which explains how and why the individual meets each of the five certification criteria and summarizes the individual's medical history and current symptoms; and (4) if the individual is an emergency evaluee, copy of a fully-completed Petition for Emergency Evaluation.

1. If the individual has been transferred from an inpatient facility after that facility completed application and certificates for involuntary admission, these documents are required in addition to a copy of the individual's most recent treatment plan, the discharge summary, and copies of all voluntary and involuntary admissions documents relating to the admission to that inpatient facility.

2. Within twelve hours of the commencement of the observation period, Admissions team members will read and explain in clear and understandable terms the Notification to Patient of Admission Status and Rights (form DHMH-35) and the Notice of Hearing (form OAH-1051). The Notification to Patient of Admission Status and Rights must be completed, signed, and made a permanent part of the observee's record. A copy of the notification must also be given to the observee. The Notice of Hearing will be completed, signed, and given to the observee. Remaining copies of the Notice of Hearing should be filed in the observee's record.

3. Once the above process is completed, nursing team members will call the Involuntary Admission Hearing Office to inform them of the pending hearing. The Involuntary Admission Hearing Office must be informed by Wednesday of any hearing.

C. <u>Observation Status Initiated During an Inpatient Stay</u>.

1. If the treating physician of the treatment team determines that a voluntary patient meets the criteria for certification or if a patient submits a Three-Day Notice and the treating physician of the treatment team determines that the patient at the time meets the criteria for certification for INVOLUTARY ADMISSION, then the certification process may be initiated by informing unit nursing team members and the social worker.

2. The nursing team members will use the Certification Process Checklist throughout the certification process. The RN or social

worker on the unit will sign the Application for Involuntary Admission (DHMH-34). Then nursing team members will contact two Harford Memorial Hospital licensed physicians or one licensed physician and one licensed psychologist or mental health nurse practitioner listed on the National register, who will examine the individual and determine if and why each of the five certification criteria is met.

3. Within twelve hours of the completion of the second certificate, nursing team members must complete the Notification to Individual of Admission Status and Rights and the Notice of Hearing, review both with the observee, and give the observee copies of these forms.

D. Roles and Responsibilities during the Observation period.

1. Psychiatrist (M.D.), Nurse Practitioner, Psychiatric Resident (M.D.) or Psychologist (Ph.D.) (all licensed):
   a. Assisted by the treatment team, the physician determines whether the observee meets the following criteria:
      (1) The individual has a mental disorder.
      (2) The individual needs inpatient care or treatment.
      (3) The individual presents a danger to the life or safety of the individual or of others.
      (4) The individual is unable or unwilling to be admitted voluntarily.
      (5) There is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual.

   b. If the observee meets each of the above criteria, a hearing will be scheduled. If the observee is also refusing recommended psychiatric medication, a Clinical Review Panel may be scheduled to convene as soon as possible after the hearing. To request a Clinical Review Panel, the Patient Rights Advisors' Office must be contacted.

   c. If the observee does not meet the above criteria, the physician must determine if the observee meets all the criteria for Voluntary Admission as follows:
      (1) The individual has a mental disorder;
      (2) The mental disorder is susceptible to care or

treatment;

(3) The individual understands the nature of the request for treatment;

(4) The individual is able to give continuous assent to retention by the facility; and

(5) The individual is able to ask for release.

d. If the observee meets the above criteria, he/she may sign an Application for Voluntary Admission for endorsement by a licensed physician. The hearing should be canceled. The licensed physician or his/her designee must also complete the Notification to Individual of Admission Status and Rights designating the changed status, review it with the patient, and give the patient a copy of this form.

e. If the observee does not meet the criteria for involuntary admission and does not sign an Application for Voluntary Admission, then the observee must be released from observation and the hearing canceled. The observee's record must state that the individual is being "Released from Observation Status."

2. Social Worker:

a. Shall be responsible for these functions:

(1) Shall inform the family/surrogate of the date, time and place of the hearing, and assist them in preparing for the hearing if their evidence is to be given (to be determined in conjunction with the treatment team and the hearing presenter).

(2) Shall notify the hearing office of any family/others who will be attending the hearing or who will be available for telephone testimony.

(3) Shall provide family support as necessary.

b. May be called upon in regards to any of the following functions:

(1) May assist the observee in obtaining and communicating with counsel;

(2) May assist the family/surrogate in understanding the nature and implications of the hearing;

(3) May be called upon by the physician to attend the hearing.

3. Hearing Presenter: Using the Involuntary Checklist from the admissions process, the presenter obtains any documentation required for the individual's hearing, notifies the physician or designee of any documentation problems or concerns, and makes recommendations to the physician or designee and the risk manager regarding proceeding to hearing.

E. Individuals' Right to Access to Legal Counsel: Individuals on observation may obtain private legal counsel, and in so doing may obtain the assistance of the assigned social worker or the Patient Rights Advisor. Harford County Lawyer Referral Services can be contacted for assistance in obtaining private legal counsel. Should an individual not have or want private legal counsel, referral will be made to the Public Defender's Office by the Hearing Presenter.

F. The Hearing

An administrative hearing must be held to determine whether the observee may be involuntarily committed under Maryland law. An impartial Administrative Law Judge will hear the case and decide whether the observee is to be admitted to or released from the Hospital.

1. Schedule of Hearings

a. Hearings are usually conducted on Fridays, and must be held within ten calendar days of the observee's confinement unless a postponement has been arranged. The observee's hearing will take place on the Friday following confinement. For individuals entering the hospital on observation after midnight on Tuesday, the hearing will be held the following week in order to allow the observee time to obtain legal counsel and to allow an adequate period for observation.

b. The date of the hearing may be postponed or continued by the Administrative Law Judge for good cause shown, but in any event, the hearing shall be concluded and a decision made within 17 calendar days from the date of confinement. If an observee and/or his/her legal counsel requests a different hearing date, every effort will be made to schedule the hearing at a time acceptable to all involved.

Admission Policy

Attachment B

ADMISSION CRITERIA FOR THE VOLUNTARY PATIENT

A. The individual's emotional/behavioral/mental condition is such that it significantly impairs his/her ability to function in the community, school, home, or other environment.

B. The condition is susceptible to care or treatment.

C. The individual understands the nature of the request for treatment.

D. The individual is medically stable, not requiring intensive medical treatment. No pregnant patient greater than 12 weeks gestation will be admitted.

E. The individual is able to participate in group activities, and to contribute to his/her self-care.

F. The individual is able to continually assent to retention by the facility.

G. The individual is able to ask for release.

Attachment C

General Admission Criteria/Limitations

The Behavioral Health Unit is a general adult unit. Patients usually stay a short period of time until they are stabilized to be discharged home or to another level of care. General criteria for admission are:

a. The patient must be experiencing a primary acute psychiatric illness or an exacerbation of a chronic mental health condition.
b. The patient must be over 18 years of age.
c. The patient is a potential threat to her/his own physical well being or the well being of others severe enough to impair the patient's ability to function independently, due to behavioral manifestations of a mental disorder.
d. The severity of the patient's condition negates less restrictive alternative community treatment, and the inaccessibility of indicated outpatient treatment has been verified.
e. The patient needs medically managed and registered-nurse-supervised skilled observation and evaluation.
f. The patient requires high dose or intensive medications, or somatic and psychological treatment with potentially dangerous side effects.
g. Patients admitted must be able to participate in therapeutic group activities since this is one of the primary milieu treatment modalities.

Some limitations of the program include but are not limited to the following:

a. The program is able to provide for isolation of patients with infectious diseases or reduced resistance to disease contingent upon the patient's ability to participate in unit programming.
b. Patients who are diagnosed with a primary chemical dependency illness or a primary diagnosis of mental retardation would not be considered appropriate for admission. A dually diagnosed person, if s/he meets the other admission criteria, would be appropriate.
c. Patients whose medical status prevents them from participating in a milieu program would not be appropriate for admission.
d. Patients requiring cardiac monitoring, intra cardiac invasive monitoring, peritoneal dialysis or endotracheal intubation ventilator management would not be appropriate for admission.
e. The Chief of Psychiatry and Medical Director, in conjunction with the Director of Behavioral Health Services and Hospital Administration, may exercise the right to refuse to admit a patient, or require a patient to be transferred from the Behavioral Health Services unit, when it is felt that appropriate care and patient safety cannot be reasonably assured, or that the patient presents a continuous risk of great magnitude to the welfare of others, or of disruption of the treatment of

others. Assistance in referral or transfer, as indicated, to a more appropriate setting will be provided by treatment and/or administrative team members.

f. A demand for beds beyond capacity will warrant the development of a waiting list, which will be prioritized by the acuity of the patient.

EXHIBIT 9

UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH
PATIENT SAFETY AND QUALITY PLAN
FY2018

I. Statement of Purpose

Upper Chesapeake Health, having established the vision to become the preferred, integrated health care system creating the healthiest community in Maryland, is committed to the provision of compassionate, high quality, clinically effective health care in a safe environment coupled with trust, integrity and respect for all. In support of this commitment, the Board of Directors and Hospital Leadership endorse an integrated, systematic quality, safety and continuous improvement program to improve patient outcomes, improve efficiency and effectiveness and reduce risk.

II. Overall Patient Safety and Quality Plan Objectives

A. To focus and coordinate organization wide patient safety and continuous improvement activities;
B. To focus and coordinate organization wide patient safety and continuous improvement activities;
C. To provide a framework for defining quality and continuous improvement opportunities, that includes:
    1. setting priorities for the scope of the plan;
    2. selecting measures that are meaningful and that address the needs of the patient;
    3. identifying the frequency of data collection;
    4. measuring the performance of processes that support patient care;
    5. collecting data;
    6. analyzing the data to identify trends, patterns and performance levels, including the adequacy of staffing to include number, skill mix and competency for sentinel events and root cause analyses;
    7. statistical tools and techniques are used to analyze and display data;
    8. implementing and reporting actions taken to resolve the identified problems;
    9. prioritizing improvement initiatives when necessary;
    10. evaluating actions to confirm they resulted in improvement;
    11. taking action(s) when improvement is not achieved or there are not sustained improvements;
    12. reporting issues, including staffing, through the PI structure reporting in Section VI ;
    13. prioritizing improvement initiatives when there are more opportunities than can be managed at one time;
D. To provide a framework for defining quality and continuous improvement opportunities, setting priorities for the scope, measuring and assessing performance, evaluating results and implementing improvement actions;
E. To include patients and families and capture the "voice of the patient" to provide the finest in care, courtesy and service;
F. To develop strategies to improve efficiency, effectiveness and reduce operational waste;
G. To define, support and maintain a Just Culture, providing structure for individual and organizational accountability.
H. To maintain an environment that supports safety and does not tolerate conscious disregard of clear risks to patients or reckless behavior, while recognizing that even competent team members make mistakes.

I. To facilitate communication and reporting of all performance improvement and patient safety activities to leadership, team members, medical staff and volunteers;
J. To support analysis of "good catch" event and current trends, including Sentinel Event Alerts to proactively assess risk in current processes and to consider safety for all new services and process design/redesign;
K. To achieve the appropriate balance between good outcomes, excellent care, services and costs;
L. To enhance effective organizational and clinical decision making;
M. To promote team work and group responsibility in identifying and implementing opportunities for improvement;
N. To establish mechanisms for the disclosure of information related to errors.

III. Performance Improvement Model

UCH has adopted the IMPRV methodology, which is based on UCH's Culture of Excellence to improve performance.

A. The phases of IMPRV are:

1. Identify – Clearly identify the problem, develop a charter and a justification for Executive Sponsorship.
2. Measure - Thoroughly understand the current state, develop a data collection plan, create a comprehensive Value Stream Map and collect baseline data.
3. Process – Assess and analyze process data to identify root cause of waste or inefficiency.
4. Re-think – Create a more efficient process and develop a full scale implementation plan of improvement solutions.
5. Validate – Implement solutions, ensure accuracy and provide comprehensive training for improvement, sustainment and ownership.

B. IMPRV Tools – Multiple tools have been created to assist in this process (See Attachment A). The following is a sample of tools used in process improvement:

1. Charter
2. SIPOC (Suppliers, Inputs, Process, Outputs, Customer)
3. Process Mapping
4. PDCAC (Plan, Do, Check, Act, Communicate)

IV. Continuous Improvement Process

The process for identifying quality and safety continuous improvement initiatives involves the following:

A. Senior Leadership develops annual objectives and defines metrics to address and support improvement of Patient Quality and Safety, Service, Care for Mind, Body and Spirit and Finance and Growth. These objectives are identified through review of internal data, annual risk assessment, external benchmarks, sentinel event alerts and regulatory requirements. Priorities are assigned based on involvement with risk, volume, mission, patient satisfaction, clinical outcome, safety, efficiency, financial stability and growth.

Data is collected, systematically analyzed, using appropriate statistical technique by departments, committees, cross-functional teams and/or work groups to determine measureable outcomes and

goals. Actions are implemented to improve the performance of processes, obtain the desired outcome and enhance patient safety. Monthly and/or quarterly reports are submitted through the Safety and Quality Organizational Structure (See Attachment B).

V. Just Culture

Just Culture principles are the foundation of accountability. UMUCH fosters the Just Culture by applying these principles in response to adverse events or near misses. Applicable principles are defined as:

A. Human Error is an inadvertent slip or lapse. Human error is expected, so systems are designed to help people do the right thing and avoid doing the wrong thing. The response to human error is to provide support to the person who made the error. The investigation will focus on how the system can be altered to prevent the error from happening again.
B. At-Risk Behavior is to consciously choose an action without realizing the level of risk of an unintended outcome. The response is to counsel the person as to why the behavior is risky, investigate the reasons they chose this behavior, and enact system improvements if necessary.
C. Reckless Behavior or negligence is choosing an action with knowledge and conscious disregard of the risk of harm. The response will result in disciplinary action.

VI. Scope of the Patient Safety and Quality Plan

A. The Safety and Quality Plan integrates all Hospital and Medical Staff departments within UCH. Departmental indicators to support the organizational objectives and align their initiatives with the annual Operating Plan are described in Section IV above. The results are reported through the organizational structure referenced above.

The FY2018 Organizational Objectives are structured to support Patient Centered Care and are organized around the Safety, Quality, Empathy, and Efficiency domains.

1. Safety
    a. Hospital Acquired Infection (HAI) Bundle
    b. MHAC Achievement
2. Quality
    a. Sepsis
    b. COPD
    c. CCTA
    d. CHF
    e. CDU Pathways
    f. Transition of Care
3. Empathy
    a. Team member recruitment, engagement, and development
    b. Patient and family engagement
    c. Care coordination and teamwork
4. Efficiency
    a. Provider workflows
    b. Discharge process coordination
    c. Emergency Department

d. CDU implementation
e. Centralized transport model

Hospital and Medical Staff Ongoing Indicators are also monitored. Some are generic screening indicators and others are determined based on identified opportunities for improvement, the need to monitor new processes or in response to complaints, surveys or inspections performed by external accreditation, licensing, regulatory and reimbursement agencies.

B. Focused Root Cause Analysis and Process Improvement Strategy to Reduce the Risk of Medical/Health Care Errors (Proactive Risk Assessment)

1. Proactive identification and management of potential risks to patient safety have the obvious advantage of preventing adverse occurrences, rather than simply reacting when they occur. This approach also avoids the barriers to understanding created by hindsight bias and the fear of disclosure, embarrassment, blame, and punishment that can arise in the wake of an actual event. UCH Hospitals have a proactive program for identification and reduction of adverse events through the use of self-assessments, the Good Catch and Near Miss reporting system, research and dissemination of literature regarding published information on adverse events that seriously harm patients.

2. UCH Hospitals seek to reduce the risk of sentinel events and medical/health care system error-related occurrences by conducting internal proactive risk assessment activities and by using available information about sentinel events, claims data and the like from organizations that provide similar care and services. This effort is undertaken so that processes, functions and services can be designed or redesigned to prevent such occurrences in the organization.

3. Process Improvement Strategies
   A. Risk Reductions
      1. Risk assessments, reporting criteria, a non-punitive reporting culture, the Good Catch reporting system and Failure Mode Effects Analysis (FMEA) are all tools designed to proactively identify circumstances that present a risk of patient harm. Risk assessments and focused Root Cause Analyses are conducted on an ongoing basis recognizing high volume/low risk and, likewise, high risk/low volume activities. The Good Catch system, in the Notification System, is a tool developed to collect data regarding circumstances that could create an adverse outcome if left unimproved. The Root Cause Analysis (RCA) methodology of investigation is applied for such circumstances, particularly those where there is a risk of imminent patient, visitor or team member harm. The results of these risk assessment interventions are reviewed by the Patient Safety and Quality Council semi-annually.
      2. To further support proactive risk reduction the Patient Safety and Quality Council selects a high-risk process, based on the annual risk assessment to conduct a RCA or FMEA for intensive assessment and analysis at least annually. The selection of this process is guided by data received from sources referenced above, including sentinel event data and patient safety risk factors identified by the Joint Commission. The selected process is analyzed for undesirable process variation and for the associated potential for adverse patient impact. A RCA or FMEA is also conducted, as appropriate, to enable targeted process and/or system redesign necessary to achieving the desired reduction in patient risk. The Patient Safety and Quality Council oversees the implementation of the redesign efforts and assesses the effectiveness of the

modifications made. Periodic re-assessment is undertaken to validate that the effectiveness of the redesigned process is sustained over time.

B. Patient Safety and Quality

1. The Patient Safety and Quality Council completes a Culture of Safety organizational assessment biennial basis to measure the perceptions of patient safety throughout Upper Chesapeake. The results of these self-assessments are reported to the Patient Safety and Quality Council for oversight and recommended action. Medical staff issues identified are reported to the PIC and/or MEC for action.

2. The Sentinel Event Policy establishes a linkage between the Sentinel Event analysis and the Hospitals' performance improvement efforts through quarterly reporting by the Patient Safety Officer to the Patient Safety and Quality Council, Performance Improvement Committee and Quality of Care Committee. The report includes results and trends from identified Sentinel Events, salient investigatory findings from RCAs and resulting process changes. (See UCH Sentinel Event Policy.)

3. Participation in University of Maryland System and VHA collaboratives and Maryland Patient Safety Center initiatives that allows an exchange of ideas, best practices and benchmarking.

4. The Capacity and Efficiency Steering Committee works to maximize the efficient use of capacity to enhance the flow of patients through operational improvements.

VII. Delineation of Responsibility

A. Board of Directors

The Board of the Directors has the ultimate responsibility for ensuring the delivery of quality patient care. This authority is delegated to the Quality of Care Committee who provides oversight. The Patient Safety and Quality Council, Performance Improvement Committee, Hospital Leadership and Medical Staff oversee the development and implementation of the methods for monitoring the delivery of patient care. (See Attachment B)

B. Quality of Care Committee

This Committee of the Board of Directors was established to oversee the quality and safety activities by monitoring and evaluating the Patient Safety and Quality Plan of the Hospitals and reporting to the Board of Directors. This Committee is responsible for:

1. Meeting at least quarterly and reporting to the Board of Directors;
2. Serving as a forum for quality and safety issues;
3. Reviewing the activities of the quality and safety program through summary reports submitted through the Quality and Safety Committee structure (See Attachment I);
4. Establishing priorities and providing direction to the Medical Executive Committee and Hospital Leadership.

C. President/CEO

The Board of Directors delegates to the President/CEO of Upper Chesapeake Health the authority and accountability of the Quality and Safety Program. The President delegates the

responsibility for the development and implementation of the Quality and Safety Plan to the SVP/CMO and VP for Performance Improvement.

D. Patient Safety and Quality Council

This Patient Safety and Quality Council (PSQC) is a multi-disciplinary committee that provides oversight, coordination, and integration of all quality and patient safety activities throughout the Hospitals. This is accomplished through the receipt of summary reports of all monitoring activities. The Hospitals' Vice President of Performance Improvement chairs this Council. The Chief Operating Officer serves as a member and provides senior leadership to the Council. The Vice President for Patient Services, Directors of Quality Management, Performance Improvement and Health Information Management and Risk Management, as well as representation from the medical staff, clinical and non-clinical directors and staff members serve on the Council. Ad hoc members are also scheduled to attend based upon the reports to be presented. Representatives from the Council also serve on the Performance Improvement Committee and the Quality of Care Committee to enhance communication and a functional link between the Hospitals, Medical Staff and governing body. The Council duties include:

1. Meeting at least ten months per year;
2. Identifying processes to improve;
3. Setting goals for safety initiatives based on the organizational Patient Safety Risk Assessment and monitoring progress related to those goals;
4. Selecting FMEA's and RCA's as deemed necessary;
5. Reviewing measures of performance, both process and outcome for all patient care and organizational functions;
6. Providing oversight for analysis of reported events, trends, sentinel event alerts and making recommendations in order to ensure a safe patient environment;
7. Prioritizing opportunities for improvement in order of importance, considering those that affect a larger percentage of patients, place patients at risk, or are problem prone;
8. Appointing a work group or chartering a process action team to investigate and recommend process improvements within timeline established by the PSQC;
9. Providing oversight of departmental indicators for outcome compliance and reviewing corrective action plans for appropriateness;
10. Providing oversight of the Sentinel Event Core Team designated to undertake root cause analysis of sentinel events and is considered a medical review committee;
11. Providing direction and oversight for application of learning from The Joint Commission Sentinel Event Alerts and their impact on improvement for UCH Hospitals;
12. Reviewing resource utilization-clinical effectiveness as it relates to quality of care and make recommendations for action when necessary;
13. Referring medical staff issues to the PIC;
14. Reviewing issues referred from the PIC and making recommendation for action plan when necessary;
15. Reviewing issues referred from the Accreditation Compliance Council and making recommendations for action plan when necessary;
16. Reviewing the Patient Safety and Quality Plan annually.

E. Medical Executive Committee reviews and approves, through receipt of minutes and summary reports, as defined in the Medical Staff Bylaws, all recommendations and actions that pertain to the Medical Staff.

F. Performance Improvement Committee

The Medical Executive Committee delegates the oversight responsibility for performance improvement monitoring, assessment and evaluation of patient care services provided by the Medical Staff to the Performance Improvement Committee (PIC). Specific duties include:

1. Coordinating the medical staff quality and safety program to ensure that necessary processes and structures are in place to carry out performance improvement activities and that all services and disciplines collaborate to create a culture that is focused on performance improvement.

2. Establishing performance expectations for new, existing, and modified processes.

3. Reviewing the outcome of peer review activities and recommending action to the MEC. Reviewing the outcome of peer review activities, taking final action on collegial interventions and recommending any action with the potential for a reduction in clinical privileges to the MEC for final approval to the responsibilities of the Performance Improvement Committee.

4. Developing and monitoring performance indicators that measure performance compared to expectations.

5. Monitoring existing processes to evaluate the performance of a function or process.

6. Reviewing summaries and aggregate data to:

    a. Compare performance internally over time to similar processes in other organizations, and to other external sources of information.

    b. Conduct ongoing professional practice evaluation to identify trends that impact quality of care and patient safety, including:

        1. patterns of operative and other procedures performed and their outcome

        2. patterns of blood and pharmaceutical usage

        3. morbidity and mortality data identified through ongoing monitoring of ongoing indicators,

        4. other relevant criteria as determined by the medical staff,

        5. adverse events related to deep or moderate sedation

        6. major discrepancies or patterns of discrepancies between preoperative and postoperative diagnoses,

        7. significant adverse events associated with anesthesia.

G. Identifying and monitoring performance measures related to the following processes:

1. Medication use – The Pharmacy and Therapeutics Committee reviews the appropriateness, safety and effectiveness of the prophylactic, empiric and therapeutic use of drugs, adverse drug reactions and significant medication errors through the review and analysis of individual and aggregate patterns of variations of drug practice and reports their results to the MEC.

2. Operative and other procedures that place patients at risk – The PIC recommends approval of the procedures to be reviewed annually based on being high-volume, high-risk and problem prone. The review includes the evaluation of appropriateness of the procedure performed, whether tissue is removed or not, the acceptability of the procedure chosen, complications, and preoperative and postoperative discrepancies.

3. Use of blood and blood components – The Blood Utilization Review Committees of each hospital review procedures for distribution, handling, use and administration of whole blood and blood components, the adequacy of transfusion services, actual or suspected transfusion reactions and blood usage, including the amounts requested, used and wasted. The appropriateness of transfusions are routinely reported to the PIC for oversight. Other issues are reported to PIC when input or action by the medical staff is necessary.

4. Medical record review – The medical staff reviews a representative sample of records for accuracy, timeliness and legible completion while performing peer review. Action is taken on documentation issues by the appropriate department and reported to PIC through the quarterly peer review summary.

5. Care or services provided to high-risk populations

6. Clinical Effectiveness – The PIC reviews reports to evaluate the appropriateness of hospital admissions, length of stays, discharge practices, use of medical and hospital resources, and medical necessity for continued hospital services and makes recommendations for action when necessary.

7. Patient and team member complaints involving the medical staff when action by the Committee is necessary.

8. Patient satisfaction.

9. Significant departures from established patterns of clinical practice

10. the JC sentinel event alerts

11. Identifying opportunities for improvement and prioritizing issues for more focused review; making recommendations for further study through workgroups or Process Action Teams to the Medical Executive Committee.

12. Identifying changes that will lead to improved performance and reduced risk of sentinel events and making appropriate recommendations for action to the Medical Executive

Committee.

13. Reviewing summary reports of sentinel events and "near miss" cases; making recommendations for corrective actions that include measuring the effectiveness of process and system improvements in reducing risk.

14. Integrating Risk Management findings into the Committee's ongoing monitoring; making recommendations when necessary to assist in reducing risk and making changes that improve performance and patient safety.

15. Reviewing all QIO citations and/or quality issues received by the medical staff; making recommendations for corrective action.

16. Review and approval of the Patient Safety and Quality Plan.

17. Formulating a written Utilization Review Plan for the System, to be approved by the System Medical Executive Committee, the Senior Vice President, Medical Affairs/CMO and the Board of Directors.

18. Meetings, Reports and Recommendations:

    a. The PIC shall meet at least ten times per year and shall maintain a permanent record of its findings, proceedings and actions.

    b. The PIC shall make a written report after each meeting to the System Medical Executive Committee and the Senior Vice President, Medical Affairs/CMO.

    c. If the PIC detects a problem with clinical competency, patient care or treatment, infraction of the Medical Staff Bylaws, Credentialing Policy, Organization and Functions Manual, Allied Health Practitioner Policy, Medical Staff and Departmental Rules and Regulations, other policies, procedures or protocols of the System or Medical Staff, professional ethics or unacceptable conduct on the part of any individual appointed to the Medical Staff, it will notify the individual in writing and permit a written response and/or afford the individual an opportunity to meet with it prior to making a final report. The PIC will notify the individual in a timely way if he or she is complying with relevant recommendations or whether further problems have been detected.

    d. The PIC is responsible for documenting results in minutes, which may be submitted at any time, but no later than the conclusion of the review process.

H. The Accreditation Compliance Council is an administrative council established to monitor adherence to and compliance with all hospital accrediting bodies, specifically The Joint

Commission's National Patient Safety Goal and Hospital Accreditation Standards. The Council reports to the Patient Safety and Quality Council.

I. The Capacity and Efficiency Steering Committee is an administrative committee established to maximize the efficient use of capacity by enhancing the throughput and flow of patients. The Committee's objectives are to improve throughput, expand access to UCH services, enhance current policies and procedures..

J. Patient and Family Centered Care
UCH has a adopted a Patient and Family Centered Care model that is an approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients and families. This approach shapes policies, programs, facility design and staff day to day interactions.

K. Allied Health Practitioner Review Committee is responsible for monitoring performance indicators that measure performance compared to expectations of the Allied Health Practitioners.

L. Leadership
At UCH Hospitals, leaders include the governing board, senior leadership, hospital leadership, the elected officers and appointed members of the medical staff and department directors. They are responsible for identifying and reporting circumstances and processes that pose a potential quality or safety risk to patients and visitors or actual events which jeopardize the patient's well-being. They shall actively participate in the implementation of the Quality and Safety Plan and be responsible for systematically measuring and assessing performance, implementing actions to improve performance, reassessing for appropriate action and sustained improvement and allocating adequate resources for assessing and improving patient care and organizational functions and are responsible for communicating all safety and quality data, both positive and negative trends, to the team members. The leaders will ensure safe practices by holding all direct reports accountable, performing appropriate evaluations and taking action when necessary as defined in the UCH Standards of Conduct Policy.

M. Medical Staff Department Chairmen
The Medical Staff Department Chairmen are also responsible for the Professional Practice Evaluation of all members of the Medical Staff (See UCH Professional Practice Evaluation Policy).

N. Patient Safety Officer
The Performance Improvement Manager/Patient Safety Officer is responsible for the coordination, and operational oversight and implementation of the Patient Safety Program. This includes collaboration with the Risk Management Department for conducting proactive patient safety risk assessments, analysis and action plan development for identified patient risks and tracking and trending reporting occurrences, including Near Miss and Sentinel Events. The Patient Safety Officer will provide regular reports to the Quality of Care Committee, Performance Improvement Committee and Patient Safety and Quality and Council, as the committee for oversight for this plan. These reports shall include trends of Near Miss and actual errors/events. Sentinel Events and Good Catch process improvement interventions and monitors (Ref COMAR 10.07.06.03).

VIII. Terms and Tools Defined

A. Adverse Event / Incident - An unintended act or failure to act which leads to an unexpected outcome not related to the natural course of the patient's illness or underlying disease condition. This event is any occurrence that is not consistent with the normal operations of Upper Chesapeake Health or the anticipated disease/treatment process of a patient. (See UCH Incidents/Event Tracking System and The Reporting of Unusual Events Policies.)

- Level 1 adverse event - an adverse event that results in death or serious disability. (*A Sentinel Event* - See below) [Such events require a *Root Cause Analysis* and are reportable to DHMH]
- Level 2 adverse event - an adverse event that requires a medical intervention to prevent death or serious disability. (*A Sentinel Event* - See below) [Such events require a *Root Cause Analysis*]
- Level 3 adverse event - an adverse event that does not result in death or serious disability and does not require any medical intervention to prevent death or serious disability. [Such events require investigation and/or trending]
- Near-miss - a situation that could have resulted in an adverse event but did not, either by chance or through timely intervention. (Can be a Sentinel Event – see below) [Such events require investigation and/or trending.

B. Case Study - a methodology designed as a teaching tool developed to broaden our team members understanding of a process-review approach to error. Actual events and "Good Catch' scenarios are used. This too is intended to support a non-punitive culture of safety.

C. Complaint - any concern raised by a patient, family member or visitor, written or verbal, regarding the infringement of patient's rights. Any complaints of a clinical nature or alleging a clinical error or Near Miss are referred to Risk Management for investigation. Actionable items will be tracked as an "Event".

D. Notification Tracking System - A data base accessible by all team members and medical staff utilized as a data collection tool for reporting and trending Good Catches and Events pertaining to patient and visitor safety. Components include, but are not limited to, complaints, patient care events, non-clinical physician and team member conduct, the good catch and compliments.

E. Failure Mode Effects Analysis - A systematic methodology designed to identify and prevent process failures before they occur. This is often utilized to proactively review processes in an effort to predict and prevent injury caused by a system or process failure.

F. Good Catch - A set of circumstances that may lead to patient or visitor injury if the process is left unchanged. A Good Catch is identifying and reporting the existence of those hazardous conditions before the Adverse Event or Near Miss occurs.

G. IMPRV Tools – are tools that provide a standard system-wide approach to process improvement.

H. Medical Review Committees - Function as confidential peer review committee as defined in Health Occupations Article, §1-401 et seq., Annotated Code of Maryland. These committees include:

1. Patient Safety and Quality Council
2. Performance Improvement Committee
3. Infection Control Committee
4. Pharmacy and Therapeutics Committee
5. Department and Service Line Peer Review Committees
6. Multi-disciplinary Evaluation Committee
7. Sentinel Event Review Teams
8. Accreditation Compliance Council

I. Patient Safety - Ensuring freedom from accidental injury while receiving health care services.

J. Patient Safety Review – classification used when a root cause analysis is completed and reported for "near miss" events not meeting the definition of Sentinel Event.

K. Risk Assessment - A periodic review process, which is designed to assess the risks associated with the delivery of patient care in a specific setting or service. The assessment tool is a set of indicators/criteria by which an analysis of processes is evaluated and/or measured. The goal is to proactively identify process improvement opportunities to ensure the delivery of safe patient care.

L. Root Cause Analysis (RCA) - A process for identifying the root causes or causal factors that underlie variation in performance that can result in an Adverse or Sentinel Event. A root cause analysis is required for Level 1 and Level 2 sentinel events, as well as those "near miss" events that could have resulted in a sentinel event if not otherwise avoided.

M. Sentinel Event - An unexpected occurrence involving unanticipated death or serious physical or psychological injury, or the risk thereof. A Sentinel Event specifically includes unanticipated death or major loss of function not related to the natural course of the patient's illness or underlying condition; such events specifically include, but are not limited to, unexpected death of a full term infant; suicide of an inpatient; infant abduction or discharge to the wrong family; a patient rape; significant blood transfusion reactions; surgery on the wrong body part or patient. These Events are considered Level 1 Events that require immediate internal reporting, a root cause analysis and are reportable to DHMH (See UCH Sentinel Events Policy.)

IX. Reporting Mechanisms

To effectively reduce adverse patient outcomes, there must be an environment that supports identification and learning from errors and system failures. This program defines an integrated and easily accessible reporting mechanism for all team members and medical staff and a non-punitive culture that supports open communication, data dissemination and education.

A. Non-Punitive Reporting

The UCH Hospitals recognize that if we are to succeed in creating a safe environment for our patients and visitors, we must create an environment in which it is safe for caregivers to report and learn from Events and Near Misses. The Hospitals promote openness and requires that errors be reported, while ensuring that most reported errors be handled without the threat of punitive action.

1. The Hospitals recognize that most clinical incidents are due to a failure of systems. The goal is to identify and track errors in order to continuously improve those systems and to provide necessary education to prevent reoccurrence. Reporting of errors identified as being due to a failure of process or systems will not be subject to disciplinary action in accordance with hospital policy.

2. All events, particularly those of a clinical nature, need to be reported immediately. If a team member reports the Event within 48 hours, there will be no disciplinary action taken for that Event. It is expected, by the implementation of the 48-hour policy that more complete disclosure will occur. This will not, however, negate the initiation of additional education and training for team members, if warranted.
3. This policy will not protect team members who consistently fail to participate in detection, reporting and remediation to prevent errors. Nor will it protect team members from disciplinary action where it is determined that the error may have been the result of criminal activity, criminal intent or an egregious act and/or omission on the part of the team member. A team member who knowingly fails to report a clinical error will be subject to disciplinary action in accordance with existing hospital policy.

B. Notification Tracking System

The Notification System has been developed as a data collection tool for the reporting of Events, Near Misses, Complaints and the Good Catch as each relates to the identification and prevention of patient and visitor harm. The PI Department provides trending, analysis and dissemination of the data, concerning circumstances that are not consistent with the normal operations of the health system or the anticipated disease/treatment process of the patient in order to prevent reoccurrence, improve quality care and ensure patient and visitor safety. Electronic event reporting through the Meditech application and an Notification Hotline (ext. 1133) is accessible to all team members and medical staff. (See UCH Event Tracking System and The Reporting of Unusual Events Policies.)

C. Sentinel Events

When a Sentinel Event occurs, appropriate individuals are notified and an immediate investigation is undertaken. The Sentinel Event Policy defines the reporting structure and oversight responsibilities for the Sentinel Event Team, a medical review committee. Initially Sentinel Events are reported directly to Risk Management, and the Department Director and or the Vice President of the involved service areas and/or Vice President for Performance Improvement. Guidelines for the analysis of the Event exist to determine why the incident occurred and how to reduce the likelihood of reoccurrence. Within fifteen days of the occurrence or knowledge thereof, a Sentinel Event Team will convene to begin the root cause analysis and the development of a risk reduction strategy and action plan. The Departments of Risk Management, Performance Improvement and the Patient Safety Committee provide oversight for this process. (Reference - Administrative Policy Manual - Sentinel Events)

D. Patient Complaint/Grievance

All Complaints are entered and tracked through the Event Tracking Notification System and trended and referred, as appropriate, for departmental action. Complaints are correlated with patient satisfaction surveys pertinent to inpatient, outpatient, and emergency services. Those Complaints involving clinical issues are referred to the Risk Management Department for investigation according to the mechanisms in place for Event/Error investigation. Should a complaint meet the criteria of a grievance, as defined by policy, a written response defining the investigation and action taken is shared with the patient/family. (Reference - Administrative Policy Manual - Patient/Guest Complaints, Grievances and Compliments)

E. Inter-hospital Notification of Level 1 or Level 2 Adverse Event

1. If a UCH hospital admits a patient with a condition resulting from an adverse event that Risk Management determines may be related to care that was provided at another Maryland hospital and that appears to be unknown to the other hospital at the time of discharge, RM shall notify and provide any necessary information to the appropriate medical review committee at the hospital where the adverse event allegedly occurred.
2. If a UCH hospital receives notification from another facility of an occurrence of an adverse event that resulted from an admission at a UCH hospital, it will be reported immediately to Risk Management and an investigation will commence at the direction of the Patient Safety and Quality Council (a confidential medical review committee.) In accordance with this Plan, as appropriate, a root cause analysis will be conducted, notice provided to DHMH Office of Healthcare Quality, and disclosure to the patient/family will occur by the Risk Management Department.
3. All communication that occurs in accordance with this provision is confidential under Health Occupations Article, §1-401, Annotated Code of Maryland.

F. Reports to Maryland Department of Health and Mental Hygiene, Office of Healthcare Quality

1. Risk Management shall report any Level 1 adverse event to the DHMH within 5 days of the Risk Management's determination and or knowledge that the event occurred.
2. Risk Management shall submit the Root Cause Analysis and Action Plan for the Level 1 adverse event to the Department within 60 days of the hospital's knowledge of the occurrence.
3. Any Root Cause Analysis and any other medical review committee information submitted to the Department and the identity of individuals appointed to the interdisciplinary root cause analysis team are confidential under Health Occupations Article, §1-401, Annotated Code of Maryland and may not be discoverable, disclosed, or admissible as evidence in any civil action or available under the Maryland Public Information Act.

G. Support for Patient, Family, Caregiver

The delivery of patient services at Upper Chesapeake Health occurs through organized and systematic processes designed to ensure the delivery of safe, effective, and timely care and treatment. Delivery of patient care encompasses the recognition of concepts underlying both health and disease, patient teaching and learning processes, patient advocacy, spirituality and a holistic approach to the processes of care delivery. Upper Chesapeake Health, the Medical Staff, Professional Nursing and other allied health care professionals comprise a multidisciplinary team which functions collaboratively to achieve positive patient outcomes. In all instances patients, and when appropriate, family members are involved in the patient's plan of care. This involvement is intended to include sharing of information, which includes unexpected or adverse outcomes including errors or incidents that have an impact on the outcome and/or are deemed a Sentinel Event.

Support services are available to patients' families, Medical Staff, and caregivers alike in managing and dealing with adverse outcomes. When an adverse event occurs with significant consequences for the patient or family, appropriate support from within the hospital is mobilized and coordinated by Risk Management to assist the patient, family, and the caregiver(s). Support may include access to such resources as Pastoral Care, Social Services, Guest Services, Risk Management, and Palliative Care. At all times the caregivers involved

are included in the investigation and process improvement efforts following an Event, Near Miss or Sentinel Event.

H. Medical Disclosure

When a Sentinel Event or outcome differs significantly from the anticipated plan of care the patient and, when appropriate, families are informed. This occurs as soon as reasonably possible. The attending physician who is responsible for the overall care of the patient should, in most instances, participate in disclosures, along with Risk Management. This disclosure of adverse outcomes resulting from medical error should be incorporated in the ongoing conversation regarding the patient's care and treatment, which begins at the time of admission, between the hospital personnel, medical staff, patient and family (See UCH Medical Disclosure Policy).

IX. Communication and Education to Enhance Patient Safety and Reduce the Risk of Medical/Health Care Errors

A. Communication with Patient & Family/Significant Other

1. Patient's rights and responsibilities are explained upon admission via the Patient Handbook and Plan of Care folders. This communication includes methods to report concerns and insights about safe patient care. (Reference – Administrative Policy Manual - Patient's Rights and Responsibilities)
2. Patient and family education regarding safe and effective use of medication and medical equipment is accomplished through direct team member education of patient and families in accordance with their job descriptions and within their scope of practice or through the video on demand system (Reference – Administrative Policy Manual - Patient and Family Education; Pharmacy Policy Manual - Monographs; Nursing Policy Manual – Drug-Nutrient Interaction Counseling - Caring for You). Documentation of this education process is done through computerized progress notes, educational records/forms and patient pathways.
3. Education about potential drug-food interaction and counseling on nutrition and modified diet is accomplished through Pharmacy Monograph, nursing handouts, special diets and referral to appropriate team members. (Reference – Administrative Policy Manual - Patient and Family Education)
4. Educational rights and responsibilities as an integral component of the overall plan of care are defined in the Administrative Policy Manual - Patient's Rights and Responsibilities. Patients and families are encouraged to participate to the best of their ability in decision-making regarding their care, to ask questions, to provide information concerning educational needs and to communicate understanding/or lack thereof, during educational activities.

B. Performance Improvement and IMPRV Training for UCH Team Members:

1. All new team members receive patient safety and quality training during orientation. Leaders, Department Directors, managers and supervisors receive PI awareness training through department leader meetings and presentations.

2. The IMPROV training approach is provided through:
    a. Executive workshops (3 hours) to provide Senior Leadership with an overview of IMPROV methodology and ensure strategic alignment
    b. Awareness Training (4 hours) is provided 3-4 times per year for team members and provides a high level of understanding of IMPRV methodology and toolkit.
    c. Practitioner Training (40 Hours) 2-3 times per year to provide a comprehensive and hands-on training of IMPROV techniques and tools.

C. Internal Communication/Education and On-Going Training

The program fosters communication and coordination among individuals and departments. To coordinate and integrate patient care and to improve quality and patient safety, UCH supports a culture that emphasizes cooperation and communication. An open communication system facilitates an interdisciplinary approach to providing patient care. The following are methods of communication among services and individual team members as they relate to the dissemination of information and education for the purposes of improving patient safety. This dissemination is done so with the utmost care to protect the confidentiality of personal health information. Any required disclosures are done so in accordance with this same protection.

1. Monthly Departmental/Unit Event Tracking Reporting. The intent is for department managers/supervisors to share adverse Events and Near Miss data with team members to assist in identifying trends and improve processes to ensure patient safety on a department/unit specific level.
2. Performance improvement results are communicated by articles in hospital and physician newsletters; chartered process action team reports and presentations; team leader discussions in department meetings, recognition and award programs recognizing individual and team participation in performance improvement; the Patient Safety Intranet site; and Quality Council report to the PIC and the Quality of Care Committee.
3. The Patient Safety Officer reports on adverse event trends and Sentinel Events and their associated process improvements to the Quality Council and Performance Improvement Committee of the Medical Staff, which information in turn is communicated to the Quality of Care Committee.
4. Department reports are reviewed quarterly through the PI Report Card and presented to the Patient Safety and Quality Council, PIC and Quality of Care Committee. Assessments, recommendations and feedback are reported to the department.
5. Data collected internally or externally regarding lessons learned or best practices are shared departmentally by way of case studies. These case studies are designed to improve the process improvement analysis skills which, in turn, are to be applied to departmental process evaluation. These results are shared with team members and improve communication with and education of patients.
6. Patient Safety Walkabouts are conducted at each Hospital by the PI Patient Safety Coordinator and Leadership to promote an atmosphere of mutual trust in which all team members can talk freely about safety problems and how to solve them, without fear of blame or punishment.

X. Quality and Safety Program Resources

The Quality Management, Performance Improvement and Risk Management Departments support and facilitate organizational quality and safety activities. Resources are provided to assist

Hospital departments, team members and medical staff with identification of appropriate data resources, retrieval of data development, coordination of the activities and analysis of data to support and evaluate all improvement efforts.

XI. Confidentiality

All information related to the performance improvement activities performed by the medical staff in accordance with this plan is confidential and protected. Due to the sensitive nature of all data, reports and minutes generated under medical review, confidentiality will be protected by all Hospital team members regardless of the level of their participation. All reference to patients, team members and physicians will be made to protect patient/physician identity.

XII. Conflict of Interest

No healthcare provider or other individual involved in quality and performance improvement activities shall be allowed to make peer review decisions in any case in which he/she is professionally involved.

XIII. Annual Review of Plan Effectiveness

The Patient Safety and Program will be reviewed annually through the established structure to assure that the structure and function of the program are achieving major goals and objectives as defined in the mission of the Hospitals.

References:

- TJC Accreditation Manual for Hospitals
- CMS Conditions of Participation
- Code of Ethical Conduct
- Risk Management Plan
- Sentinel Event Policy
- Patient & Family Education Policy
- Patient's Rights and Responsibility Policy
- COMAR 10.07.06 – Hospital Patient Safety Program (2004)
- Event Tracking System and the Reporting of Unusual Events Policy
- Disclosing Medical Adverse Outcomes, Including Sentinel Events
- Performance Improvement Plan
- Hospital Plan for Patient Care and Services
- Patient Complaints and/or Allegation of Violations of Patient Rights Policy

David Branch
VP of Performance Improvement
Chairperson, Quality and Safety Committee

7/6/17
Date

Lyle E. Sheldon, President/CEO
University of Maryland Upper Chesapeake Health

7.6.17
Date

Roger Schneider, Chairman of the Board
University of Maryland Upper Chesapeake Health

7/6/17
Date

ADDENDUM

UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH

BULLE ROCK CAMPUS

PATIENT SAFETY AND QUALITY PLAN

I. Statement of Purpose

Upper Chesapeake Behavioral Health Bulle Rock is committed to the provision of compassionate, high quality, clinically effective healthcare in a safe environment coupled with trust, integrity, and respect for all. The Upper Chesapeake Health system supports an integrated, systematic quality, safety and continuous improvement program to improve patient outcomes, improve efficiency and effectiveness and reduce risk. Behavioral Health serves adults 18 and older with mental health diagnoses and includes patients with a secondary diagnosis of substance abuse and geriatric patients (including those geriatric patients with a secondary substance use diagnosis).

Overall Patient Safety and Quality Plan Objectives for Behavioral Health

A. In mental health care, quality is a measure of whether services increase the likelihood of desired mental health outcomes and are consistent with current evidence-based practice. This definition incorporates two components. For people with mental disorders, their families and the population as a whole, it emphasizes that services should produce positive outcomes. For practitioners, service planners and policy makers, it emphasizes the best use of current knowledge and technology.

Improved quality means that mental health services should:

1. preserve the dignity of people with mental disorders;
2. provide accepted and relevant clinical and non-clinical care aimed at reducing the impact of the disorder and improving the quality of life of people with mental disorders;
3. use interventions which help people with mental disorders to cope by themselves with their mental health disabilities;
4. make more efficient and effective use of scarce mental health resources;
5. ensure that quality of care is improved in all areas, including mental health promotion, prevention, treatment and rehabilitation in primary health care, outpatient and inpatient

B. To maintain an environment that supports safety
C. To provide a framework for defining quality and continuous improvement opportunities, setting priorities for the scope, measuring and assessing performance, evaluating results and implementing improvement actions
D. To include patients and their families in a multidisciplinary collaborative care approach
E. To ensure that resources are used efficiently
F. To continue to integrate behavioral health into primary care practices
G. To provide a framework for defining quality and continuous improvement opportunities, setting priorities for the scope, measuring and assessing performance, evaluating results and implementing improvement actions
H. To facilitate communication and reporting of all performance improvement and patient safety activities to leadership, team members, and medical staff
I. To promote team work and group responsibility in identifying and implementing opportunities for improvement
J. To achieve the appropriate balance between good outcomes, excellent care, services and costs

II. Scope of the Patient Safety and Quality Plan

A. The Safety and Quality Plan supports the organizational objectives structured to support Patient-Centered Care organized around Safety, Quality, Empathy, and Efficiency domains.

The following pertain to Behavioral Health:

1. **Safety**
    a. Reduction of Restraints and Seclusion
    b. Use of Assessment tools to screen for violence, depression, anxiety, trauma and dementia
    c. Provide safe environment for geriatric patients and those patients with dementia
2. **Quality**
    a. Bedside Shift report
    b. Multidisciplinary rounds
    c. Plan of Care
    d. Discharge planning
    e. Reducing readmissions
    f. Group curriculum for geriatric patients/adult patients

g. Integrated care in primary care practices
h. Patient Satisfaction

3. **Empathy**
   a. Team member recruitment, engagement and educational development
   b. Patient and Family engagement
   c. Care coordination and teamwork

4. **Efficiency**
   a. Consultation services and discharge process coordination
   b. Turnaround times in Emergency Department for consults

PERFORMANCE IMPROVEMENT PLAN

The primary objective of the Performance Improvement (PI) Plan is to establish and articulate the measures of success that align with FY17 Departmental Objectives and UM UCH Strategic Operating Plan. Department Leaders will partner with their respective PI Consultant to navigate the PI Plan Process and ensure that chosen indicators support organization-wide priorities. The scope of the performance indicators will incorporate quality, patient safety/experience, and operational efficiency. The PI Plan Process consists of three phases which focus on identifying, monitoring, and reporting on the "critical few" indicators that measure not just performance, but organizational SUCCESS.

Planning

The goal of the Planning Phase is to develop a comprehensive PI Plan that focuses on the critical few success factors. This phase requires that department leaders gather input from their team and work with their PI Consultant in order to define and measure departmental priorities from a PI perspective.

Activities:

- ✓ Defining the strategic priorities that measure success in the department.
- ✓ Reviewing indicators from the previous year to determine the need to continue, revise, or discontinue the measure.
- ✓ Identifying indicators that will measure success from a quality, safety, or efficiency perspective.
- ✓ Establishing goals based on the analysis of baseline data (previous year), external benchmark data, or previous internal performance results.
- ✓ Developing a performance threshold. The threshold represents the minimum point of achievement based upon the current performance baseline and goal.
- ✓ Reviewing plan with appropriate Vice President for completion and approval.

Monitoring

The goal of the Monitoring Phase is to record and analyze data for the metrics stated in the PI Plan and work on improvement opportunities identified. If a measure does not meet the target, the department leader will partner with the PI Consultant to create a quarterly Performance Improvement Action Plan with the corrective actions to be taken.

Activities:

- ✓ Complying with data collection, frequency, and source of measurement.
- ✓ Analyzing the data and identifying improvement opportunities.
- ✓ Entering quarterly Measures of Success data into PI Quarterly Indicator Report on the SharePoint Performance Improvement Site under Monitoring.
- ✓ When necessary, completing a PI Action Plan for measures not meeting the goal.

Reporting and Improving

The Reporting and Improving Phase of the PI Plan process provides the results of the Monitoring Phase to departments and leadership at least on a quarterly basis. Department leaders will report an action plan for measures not meeting the target to the appropriate committee and share success stories.

- Quality and safety indicators are reported to the Patient Safety and Quality Council (PSQC).
- Efficiency indicators are reported to the Capacity and Efficiency Steering Committee.
- Patient Experience indicators are reported to the Patient Experience Steering Committee.

All committees report to the Quality of Care Committee of the Board of Directors.

Activities:

- ✓ Department meetings.
- ✓ Completing PI Action Plan for measures not meeting goal.
- ✓ Engagement between department leader and PI Consultant to utilize the IMPRV toolkit where applicable and support the department in executing the PI Action Plan.
- ✓ Presenting PI Action Plans and success stories at relevant committee meetings (when appropriate).

DEFINITION OF SUCCESS

Please identify the department's Key Priorities for the fiscal year.

1) Increase Patient Experience Scores by providing the Behavioral Health Patient a Person -Centered Model of Care.
2) Assure Behavioral Health Patient Safety by striving for complete and accurate seclusion and restraint documentation monitored in real time.

MEASURES OF SUCCESS

The Measures of Success include performance goals for each indicator, as well as relevant information regarding the metric and how it is measured.

- ✓ Benchmark/Baseline: Reference point established based on the analysis of previous internal performance results (e.g., last fiscal year) or external benchmarks, if available.
- ✓ Performance Goal: Target that we want to achieve for the indicator.
- ✓ Performance Threshold: Minimum point of achievement for the indicator based upon the current performance baseline and goal.

Measure 1	
Name of Measure/Indicator	Patient Experience
Method of Collection (How will data be measured?)	Press Ganey survey
Data Source (e.g., Meditech)	Press Ganey
Frequency of Measurement	Quarterly
Benchmark/Baseline	
Performance Goal	Meet 50% on overall average score
Performance Threshold	Meet 35% on overall average score
Responsible for Monitoring	Claire Kidwell RN, Nurse Manager

Measure 2	
Name of Measure/Indicator	Patient Safety- complete and accurate seclusion and restraint documentation
Method of Collection (How will data be measured?)	Real time monitoring
Data Source (e.g., Meditech)	Medical record and Meditech
Frequency of Measurement	As needed
Benchmark/Baseline	85%
Performance Goal	90%
Performance Threshold	85%
Responsible for Monitoring	Claire Kidwell RN, Nurse Manager

Measure 3	
Name of Measure/Indicator	
Method of Collection (How will data be measured?)	
Data Source (e.g., Meditech)	
Frequency of Measurement	
Benchmark/Baseline	
Performance Goal	
Performance Threshold	
Responsible for Monitoring	

EXHIBIT 10

UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH HOSPITAL

TITLE: **INTERDISCIPLINARY DISCHARGE PLANNING: BEHAVIORAL HEALTH** **Page 1**

APPROVED BY:
Medical Director Behavioral Health Services

_____

Original Date: 10/11/17

PURPOSE:
To provide a collaborative, interdisciplinary approach to meet a patient's individualized needs at the time of discharge from Behavioral Health Services that addresses continuity of care, ongoing treatment, and/or referral to other, more appropriate services.

POLICY:

I. UM Upper Chesapeake Health utilizes an interdisciplinary approach to identify, discuss and coordinate the provision of an effective discharge plan that may occur across a continuum of care, treatment or services, in accordance with the individual's needs, strengths, preferences, and goals. All clinical disciplines are responsible for the coordination of patient care.

II. The interdisciplinary and collaborative approach uses the following key elements to planning patient care and the discharge plan.
   - A. Integrate assessment findings in the discharge planning process.
   - B. Develop a plan of care that includes measurable patient care goals/outcomes.
   - C. A patient's physical and psychosocial needs will be assessed for continuing care.
   - D. Planning for transfer or discharge involves the individual served, his or her family, if applicable, and staff.
   - E. Provide patient and family education which includes:
     1. The reason he/she is being discharged
     2. The anticipated need for continued care, treatment and/or referral to more appropriate services after discharge.
     3. Education on how to obtain further care, treatment or services to meet their identified needs
     4. Works with the individual and/or their support (s) to ensure discharge instructions and appropriate next steps are clear and understood.

III. UM Upper Chesapeake Health utilizes a proactive interdisciplinary approach to coordinate the provision of a safe and appropriate discharge plan. The healthcare team strives to achieve early identification of discharge planning needs so that the

Complexities of arranging and following through with a comprehensive plan are anticipated and managed.

IV. To optimize compliance with a patient's post-hospital plan of care, an assessment of the patient's actual and potential discharge planning needs shall be initiated upon admission. A plan to meet these needs shall be developed, and interventions to meet specific discharge planning goals shall be designed. The plan shall be monitored and revised as necessary throughout the patient's hospital stay.

V. UM UCH will not recommend or show preference for one service over another and shall leave the choice of the service provider to the patient and/or his or her family.

PROCEDURE:

I. Interdisciplinary Discharge Planning Procedure

A. Plan for care, treatment and service is based on:

1. Data collected from appropriate disciplines' specific assessments.
2. Input obtained from the patient and family as indicated and acceptable to the patient.

B. Individualized and measurable goals/outcomes

1. Disciplines, as appropriate, develop plans of care and identify individualized goals/outcomes in collaboration with the patient, family and/or other supports.

C. Monitoring of the effectiveness of plans of care and readiness for discharge:

1. The Treatment team reviews/updates plans of care with the patient, based on the needs and desires of the patient.
2. Address additional discharge planning needs with the patient based on change of condition/status or situation.
3. The Treatment team will review, with the patient/family, readiness for discharge, including patient/family perspectives, aftercare services needed, and connection to additional resources and entitlements.

II. Collaborative process to coordinate care, treatment and services.

A. The registered nurse assigned to care for the patient on a daily basis:

1. Reviews:
   a) Target date of discharge
   b) Planned discharge disposition
   c) Interdisciplinary goals and outcomes

2. Coordinates appropriate resources to meet the on-going needs of the patient
   a) Makes referrals/recommendations for other discipline involvement in care
   b) Participates in multidisciplinary rounding

3. Reviews Plan of Care/Discharge Plan with patient and family

B. The, RN, Social Worker, Case Manager, physician, and other disciplines collaborate on the case of the patient.

1. Topics of discussion include:
   a) acute case criteria
   b) discharge plans
   c) patient/family educational needs
   d) available resources
   e) peer recovery services
2. The patient and/or family, whenever possible, are included in the discussion.

III. Discharge Process

A. Discharge

1. Social Work
   a) Identifies payor to determine resource options for patient care needs.
   b) Finalizes plans with patient/family or post-acute facility/agency.
      A) Assesses patient/family readiness for discharge.
      B) Coordinates aftercare appointments for continuing care providers including, but not limited to, outpatient, IOP, PHP, PRP, RRP, ALF, SU Services, Peer Recovery Support, etc. When possible, in-person hand-offs will be completed with continuing care services.
      C) Provides education regarding continuing care, treatment and service that the patient will need.
      D) Confirms transportation, medications, etc.
      E) Confirms understanding of discharge plan with patient/family.
      F) Verifies that required documentation is prepared and communicated.

         At the time of discharge or transfer, the hospital informs other service providers who will provide care, treatment, or services to the patient the following:

         1. The reason for the patient's discharge or transfer
         2. The patient's physical and psychosocial status
         3. A summary of care, treatment, medications and services it provided to the patient
         4. The patient's progress toward goals.
         5. A list of community resources or referrals made or provided to the patient.
   c) Coordinates transport to home or referred resource

Provides appropriate information regarding the care and services provided during the inpatient stay to the post-acute facility or agency.

2. Nursing

a) Verifies that required test results and consults are completed.

b) Reviews the discharge instructions and medication reconciliation with the patient/caregiver and provides them with a written copy.

c) Coordinates the discharge of patient to family/caregiver, ambulance personnel and/or post-acute facility.

d) Discharge to Another Acute Facility

A) Transfer arrangements

B) Ambulance transport

C) Notifies caregiver

3. Physician

a) Discharge Order and Summary

A) Provides necessary orders to allow for post-acute services to be coordinated

B) Assesses patient and determines if discharge is safe.

C) Dictates discharge summary in a timely manner to facilitate discharge. The discharge summary includes the reason for hospitalization, procedures performed, care, treatment, and services provided, condition and disposition at discharge, information provided to patient/family, and provisions for follow-up care.

D) Completes medication reconciliation.

b) Discharge Instructions – Discharge Routine

A) Complete the EMR Discharge Routine process and sign the home medication list. Documents included are as follows:

- Discharge instructions including home diet, activity, follow-up care, prescriptions, equipment needs, return to work/school, etc.
- Disease/condition and medication education/instructions
- Home medications list

c) The physician discusses discharge plan with the patient/caregiver prior to or at the time of discharge and ensures the plan is understood.

4. High Risk Case Manager

a) High Risk Case Manager may be involved with discharge planning for patients at high risk for readmission, history of multiple Emergency Room Visits, history of noncompliance with

discharge plan or to assist with coordination of services at discharge.

b) Patient and Family are included in the discharge plan.

IV. Transfer

A. Medical Staff and clinical team members should use available information to assess the risk of transport.

B. See “Patient Transfer” policy in Hospital/Administrative Policy Manual.

C. Associated policies: DHMH COMAR 10.21.05, The Joint Commission policy CTS 06.02.01-CTS 06.02.05

EXHIBIT 11

UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH HOSPITALS
HOSPITAL/ADMINISTRATIVE POLICY MANUAL

TITLE: PATIENT TRANSFER

APPROVED BY:
President/CEO: _____

APPROVED BY Medical Executive Committee on: 4/06, 3/11, 8/14

Original Date: 7/96
Reviewed Date: 6/98, 11/12
Revised Date: 2/00, 2/02, 3/06; 3/07, 3/09, 2/11, 12/12, 9/13, 8/14

PURPOSE: To describe methods and procedures required for transfers of patients to a higher level of care within UCH hospitals, or between UCH hospitals, from UCH hospitals to other acute care facilities, and for local diagnostic and/or treatment related services (on or off campus) unavailable to inpatients at UCH hospitals.

Other Associated Policies/Documents:

- *Transporting Patients within the Hospital Campus*. Includes on campus transfers to the UCH Physician's Pavilions and the Ambulatory Care Center, and transporting methods and requirements for in-house transporting of patients.
- *Acute Patient Transfer Form* (This form provides structure and ensures compliance with EMTALA transfer guidelines.)
- *EMTALA Plan*

POLICY: All patient transfers will be conducted in a safe manner, and when appropriate in strict compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

For all transfers the following elements are required. These tools will assist in making the appropriate arrangements for transfer, provide necessary hand off communication to and from receiving locations, and documenting the necessity of the transfer.

- *Acute Patient Transfer Form*
- *Ticket-to-Ride* Hand-off Communication
- A Physician Order for the transfer

PROCEDURES:

A. Transfers Between UCH Hospitals

1. **Emergencies (Medical/Surgical)**:
    a. UCMC will accept all patients from HMH needing emergency surgery where life or limb is at risk, regardless of bed availability, as long as a surgeon accepting the case has been identified and the procedure is one UCMC is prepared to perform.
    b. The patient will be transported directly to the OR or ICU (bypassing the ED).
    c. Admitting will be responsible for registering the patient at UCMC.

d. Coordinating the Transfer:
    1. The AC/Nursing Support Coordinator, along with the Charge Nurse, from HMH and UCMC will coordinate to arrange the transfer. The Transferring Physician is responsible for obtaining an accepting Intensivist and/or Surgeon; initiating the chain of command, as needed, to secure transfer.
e. The *Acute Patient Transfer Form* must be completed before transfer.
f. The Receiving Intensivist at UCMC is responsible for the following:
    1. the need to clear a bed in ICU to receive the surgical emergency or manage the patient in PACU
    2. identifying the patient most ready to be transferred to a lower level of care to make a bed available the surgical emergency;
    3. care of the surgical emergency patient until the patient's care is assumed by surgeon.
g. The UCMC Support Coordinator will assist in locating available bed space and coordinating staff support.
h. The Receiving ICU Clinical Nurse Manager (or designee) / AC is responsible for facilitating the relocation of existing ICU patient(s) to a lower level of care as directed by the Intensivist.
i. The Sending AC (or designee) will ensure that the most timely and safe transport occurs. This includes responsibility for arranging the most appropriate mode of transport, and ensuring full communication with accepting unit.
    1. The Unit will gather pertinent medical records to include any records not available in the Meditech system. This should include copies of progress notes, if the patient has had an extended length of stay, progress notes of the most recent 7 days would be sufficient.
    2. The sending unit will follow the below algorithms to arrange transport:

Note: All Harford County Medical Assistance patients must have Transcare contacted as first option of transport. All ETA expectations below are in place for Transcare. If unable to meet these expectations, continue with below algorithms.

STEMI Transport Leaving HMH:

a. Call Hart to Heart directly. If they cannot provide 30 minute ETA, call Express Care Communication Center (X1234) for Express Care unit from UCMC. If they cannot provide 30 minute ETA, call 911 and request ALS transport.
b. If an EMS crew is already located in the ED, they may be requested to provide the STEMI transport prior to contacting commercial companies, however they have the right to refuse the transport until all commercial transport companies have been contacted and demonstrated inability to respond within 30 minute expectation.
c. If a nurse is required and transport company cannot provide one in a timely manner so as not to delay the transport, HMH will send a nurse to manage the medications. This nurse must have 2 years critical care experience, current ACLS, and base station training.

NON-STEMI Priority One Transport Leaving HMH:

a. Call Express Care Communication Center (X1234) to arrange transportation with a 30-45 minute ETA expectation. Order of requests should be Hart to Heart, Express Care ambulance, Harford County 911.
b. If a nurse is required and transport company cannot provide one in a timely manner so as not to delay the transport, HMH will send a nurse to manage the medications. This nurse must have 2 years critical care experience, current ACLS, and base station training.

Priority Two Transport

a. Call Express Care Communication Center (X1234) to arrange transportation with a 45 to 60 minute ETA expectation.

Routine Discharges

a. Call Express Care Communication Center (X1234) to arrange routine discharge transport with 60 to 180 minute ETA expectation.

Wheelchair Transport Services

a. Call Express Care Communication Center (X1234) to pre-schedule with a minimum 24 hour notice.

3. When the transport service arrives the primary care nurse for the patient contacts the nurse on the accepting Unit to give report.

k. Delays in excess of 30 minutes from decision to transfer to acceptance by a surgeon shall trigger the Staff to initiate the Chain of Command to secure medical or administrative personnel to facilitate the transfer.
l. Delays in excess of 2 hours from decision to transfer to actual transport shall trigger the Staff to initiate the Chain of Command to secure medical or administrative personnel to facilitate the transfer.

2. Specialty Related Transfers / Non-Emergent (to include Behavioral Health (BHU), Family Birthplace, Pediatrics, or Surgical Evaluations)

a. The transferring physician is responsible for contacting the accepting unit and securing an accepting physician.
b. The accepting physician will determine the transfer location i.e. directly to the unit or the Emergency Department.
c. The *Acute Patient Transfer Form* must be completed before transfer.

d. The Charge Nurse ensures all pertinent medical records are copied, to include lab and x-ray reports and obtains MRI and CT films to be sent with the patient at the time of transfer.
    1. The transferring and accepting physicians determine if ALS or BLS transport is required and the Charge Nurse or designee contacts the transport service. If ambulance company determines a different level of transport service is required, based upon Maryland State EMS Protocols, this information is reported to the physician for documentation in the medical record. If the transporting service cannot provide timely and adequately trained personnel, UCH Nursing and or Medical Staff Administration will evaluate the efficacy of sending UCH personnel with appropriate transport training as the patient requires, and as required by Maryland Law. This nurse will have 2 years critical care experience, current ACLS, and Base Station training. They will provide care within the scope of practice of the hospital RN.
e. When the transport service arrives the primary care nurse for the patient contacts the nurse on the accepting unit to give report.
f. Psychiatric Patients - Transfers of any patient being transferred to or from a psychiatric unit will be accompanied by either:
    1. an ambulance attendant or other individual of the same sex, whenever possible
    2. the parent, spouse, adult sibling or adult offspring of the patient

B. Off Campus Specialty Services

Temporary Off Campus transfers apply to inpatients transferred for diagnostic testing or medical/surgical services not offered on the campuses of Upper Chesapeake Hospitals, such as Open-MRI, TEE, ERCP, Oral Surgery, etc.

1. The Attending/Transferring Physician is responsible for writing an Order for the offsite service. A planned daily/weekly trip during the same admission requires only one order and one form.
2. The Attending/Transferring Physician is responsible for documenting by way of the *Acute Patient Transfer Form*, the necessity of the transfer, risks & benefits, and the patient's condition. The *Form* must be completed by the physician before transferring the patient.
3. Nursing staff or Unit Secretary will make scheduling arrangements for the procedure/test and direction sought as to special preparations needed such as diet restrictions or contrast prior to transfer, as well as addressing 'current treatments in progress' as indicated on the *Acute Patient Transfer Form*.
4. The transferring and accepting physicians determine if ALS or BLS transport is required and the charge nurse or designee contacts the transport service. If ambulance company determines a different level of transport service is required, based upon Maryland State EMS Protocols, this information is reported to the physician for documentation in the medical record.
5. Nursing team members prepare the patient for transport and complete a *Ticket to Ride* as the hand off communication to the receiving location.
    a. The nurse will prepare the patient for transfer and have the medical record (including a copy of the medication reconciliation administration record) ready to accompany the patient.

b. Team members caring for the patient will address toileting needs, medication needs and nutrition/fluid needs prior to the arrival of the transporter(s) to the unit.
c. The department housing the patient is responsible to assure that the patient is ready for transport in a timely manner.

6. When the transport service arrives the primary care nurse for the patient contacts the accepting facility to give report.
7. The receiving facility will be responsible for the patient upon arrival and is expected to utilize EMS services should the patient's condition deteriorate and need to be emergently returned to the hospital.

C. On Campus Specialty Services (UCMC)

Temporary On Campus Transfers apply to inpatients transferred to UCMC Physician Pavilions and Ambulatory Care Center

1. The Attending Physician writes an Order for a medical or surgical 'consult and treat' for the patient.
    a. If the provider/consultant requests the patient be seen in his/her private office during an inpatient admission, there will be direct physician to physician communication between the consulting and attending physicians regarding the appropriateness/medical necessity for the patient to leave the unit.
    b. The Attending Physician will write the Order for the off campus transport for the intended care/treatment/service.
2. The Attending/Transferring Physician is responsible for documenting by way of the *Acute Patient Transfer Form*, the necessity of the transfer, risks & benefits, and the patient's condition. The *Form* must be completed by the physician before transferring the patient.
3. Nursing staff or Unit Secretary will make scheduling arrangements for the procedure/test and direction sought as to special preparations needed such as diet restrictions or contrast prior to transfer, as well as addressing 'current treatments in progress' as indicated on the *Acute Patient Transfer Form*.
4. Nursing team members prepare the patient for transport and complete a *Ticket to Ride* as the hand off communication to the receiving location.
    a. The nurse will prepare the patient for transfer and have the medical record (including a copy of the medication reconciliation administration record) ready to accompany the patient.
    b. Team members caring for the patient will address toileting needs, medication needs and nutrition/fluid needs prior to leaving the unit.
    c. The department housing the patient is responsible to assure that the patient is transported in a timely manner.
5. The registered nurse or PCT will accompany the patient to the physician's office / location with necessary equipment or Oxygen, the patient record,
    a. Patients on O2 during transport must have their O2 placement and setting verified by the nurse prior to release of the patient and transport.
6. Upon return, the physician's office will provide hand-off report occurs to the patient's nurse and the complete *Ticket to Ride*.

7. The Consulting/Treating Physician will provide a brief procedural note for any interventions that were performed or any medication administered in the office setting, for the inpatient record.

D. Transfers to External Acute Care Facility

1. The transferring physician is responsible for contacting the accepting unit and securing an accepting physician at the receiving facility.
2. The accepting physician will determine the transfer location i.e. directly to the unit or the Emergency Department.
3. The *Acute Patient Transfer Form* must be completed before transfer documenting the reason for transfer, patient's condition, consent, risks and benefits and other salient information contained in the form.
4. The Charge Nurse ensures all pertinent medical records are copied, to include lab and x-ray reports and obtains MRI and CT films to be sent with the patient at the time of transfer.
5. The transferring and accepting physicians determine if ALS or BLS transport is required and the charge nurse or designee contacts the transport service. If ambulance company determines a different level of transport service is required, based upon Maryland State EMS Protocols, this information is reported to the physician for documentation in the medical record.
    1. If the transporting service cannot provide timely and adequately trained personnel, UCH Nursing and or Medical staff Administration will evaluate the efficacy of sending UCH personnel with appropriate training and experience as the patient requires, including 2 years critical care nursing experience, current ACLS, and Base Station training. They will provide care within the scope of the hospital RN.
6. When the transport service arrives the primary care nurse for the patient contacts the nurse / unit at the accepting facility to give report.
7. Psychiatric Patients - Transfers of any patient being transferred to or from a psychiatric unit will be accompanied by either:
    a. an ambulance attendant or other individual of the same sex, whenever possible
    b. the parent, spouse, adult sibling or adult offspring of the patient

E. Transfer Documentation

1. An *Acute Patient Transfer Form*
    a. The *Form* must be completed for all patients transferred from a UCH hospital inpatient setting to an off-site location, including on-campus services, before the patient leaves the Unit.
    b. Completing this documentation is the responsibility of the physician transferring the patient, the nurse assigned to the patient's care at the time of the transfer, and a charge nurse or Administrative Coordinator.
    c. An *Acute Patient Transfer* Form is <u>not necessary</u> for lateral transfers within the same hospital. This includes patient transfers to Radiation Oncology for treatment.
        i. UCH *Ticket to Ride* will accompany patients transferred between UCH hospitals and for temporary transfers to outpatient services as defined above.
    d. If the transferring physician is not physically present in the hospital, the physician portions of the Form may be completed by a PA provided that:
        i. The PA documents consultation with the transferring physician on the Transfer Form.

e. The Director/Clinical Nurse Manager/Charge Nurse of the unit caring for the patient, or the Administrative Coordinator, must check the completeness of the *Acute Patient Transfer Form*, bring issues to the attention of the responsible physician or nurse for correction prior to the transfer.
f. Distribution of the *Form* is outlined on the *Form* itself. (One copy will be retained in the medical record, a second copy will be sent to the receiving facility and, for review purposes, the third copy will be forwarded as indicated and considered the transfer log.)

2. UCH *Ticket to Ride* will accompany patients transferred between UCH hospitals and for temporary transfers outpatient services as defined above.
3. Additional documentation regarding care provided by UCH personnel during the transfer, if any, shall be completed on the *Acute Patient Transfer Form*, if able or on a progress note.

F. Reasons for Transfer

1. The only reasons for which a patient may be transferred from a UCH hospital to another acute care facility are:
    a. the patient's request for transfer despite being assured of the availability of care at UCH;
    b. the patient's need for a specialized capability not available at the transferring UCH hospital.
2. Temporary transfers to outpatient setting for diagnostic and or treatment services not readily available are permitted and procedurally defined above.
3. UCH nursing personnel shall report any proposed transfer not supported by these to their Department Director, the Administrative Coordinator or the Administrator On Call on an urgent basis, and Risk Management/Corporate Compliance.

G. Certification of Condition

1. Before any patient may be transferred from a UCH Hospital to another acute care facility the transferring physician must make one of the following certifications in writing regarding the patient's condition:
    a. the patient has been stabilized such that within a reasonable degree of medical probability, no material deterioration of the individual's condition (or the condition of a mother and her unborn child) is likely to result from the transfer;
    b. the patient's condition has not stabilized, however, the patient will benefit from a higher level of care that outweighs the risks associated with transfer; or
    c. the patient is in labor, however the benefits of transfer outweigh the potential risks to the mother and her unborn child(ren).
2. The physician will document this Certification in writing on the *Acute Patient Transfer Form* and include:
    a. Risks of Transfer and
    b. Benefits of Care at the other facility considered in reaching this certification.

H. Patient Consent and Refusal

1. No patient will be transferred between or from a UCH hospital without the patient's or the patient's surrogate decision maker's informed consent to the transfer, except in the case of transfer for inpatient hospitalization following involuntary commitment.

UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH HOSPITALS
HOSPITAL/ADMINISTRATIVE POLICY MANUAL

TITLE: PATIENT TRANSFER

APPROVED BY:
President/CEO: _____

APPROVED BY Medical Executive Committee on: 4/06, 3/11, 8/14

Original Date: 7/96
Reviewed Date: 6/98, 11/12
Revised Date: 2/00, 2/02, 3/06; 3/07, 3/09, 2/11, 12/12, 9/13, 8/14

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d. Coordinating the Transfer:
    1. The AC/Nursing Support Coordinator, along with the Charge Nurse, from HMH and UCMC will coordinate to arrange the transfer. The Transferring Physician is responsible for obtaining an accepting Intensivist and/or Surgeon; initiating the chain of command, as needed, to secure transfer.
e. The *Acute Patient Transfer Form* must be completed before transfer.
f. The Receiving Intensivist at UCMC is responsible for the following:
    1. the need to clear a bed in ICU to receive the surgical emergency or manage the patient in PACU
    2. identifying the patient most ready to be transferred to a lower level of care to make a bed available the surgical emergency;
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g. The UCMC Support Coordinator will assist in locating available bed space and coordinating staff support.
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i. The Sending AC (or designee) will ensure that the most timely and safe transport occurs. This includes responsibility for arranging the most appropriate mode of transport, and ensuring full communication with accepting unit.
    1. The Unit will gather pertinent medical records to include any records not available in the Meditech system. This should include copies of progress notes, if the patient has had an extended length of stay, progress notes of the most recent 7 days would be sufficient.
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STEMI Transport Leaving HMH:

a. Call Hart to Heart directly. If they cannot provide 30 minute ETA, call Express Care Communication Center (X1234) for Express Care unit from UCMC. If they cannot provide 30 minute ETA, call 911 and request ALS transport.
b. If an EMS crew is already located in the ED, they may be requested to provide the STEMI transport prior to contacting commercial companies, however they have the right to refuse the transport until all commercial transport companies have been contacted and demonstrated inability to respond within 30 minute expectation.
c. If a nurse is required and transport company cannot provide one in a timely manner so as not to delay the transport, HMH will send a nurse to manage the medications. This nurse must have 2 years critical care experience, current ACLS, and base station training.

NON-STEMI Priority One Transport Leaving HMH:

a. Call Express Care Communication Center (X1234) to arrange transportation with a 30-45 minute ETA expectation. Order of requests should be Hart to Heart, Express Care ambulance, Harford County 911.
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a. Call Express Care Communication Center (X1234) to arrange transportation with a 45 to 60 minute ETA expectation.

Routine Discharges

a. Call Express Care Communication Center (X1234) to arrange routine discharge transport with 60 to 180 minute ETA expectation.

Wheelchair Transport Services

a. Call Express Care Communication Center (X1234) to pre-schedule with a minimum 24 hour notice.

3. When the transport service arrives the primary care nurse for the patient contacts the nurse on the accepting Unit to give report.

k. Delays in excess of 30 minutes from decision to transfer to acceptance by a surgeon shall trigger the Staff to initiate the Chain of Command to secure medical or administrative personnel to facilitate the transfer.
l. Delays in excess of 2 hours from decision to transfer to actual transport shall trigger the Staff to initiate the Chain of Command to secure medical or administrative personnel to facilitate the transfer.

2. Specialty Related Transfers / Non-Emergent (to include Behavioral Health (BHU), Family Birthplace, Pediatrics, or Surgical Evaluations)

a. The transferring physician is responsible for contacting the accepting unit and securing an accepting physician.
b. The accepting physician will determine the transfer location i.e. directly to the unit or the Emergency Department.
c. The *Acute Patient Transfer Form* must be completed before transfer.

d. The Charge Nurse ensures all pertinent medical records are copied, to include lab and x-ray reports and obtains MRI and CT films to be sent with the patient at the time of transfer.
    1. The transferring and accepting physicians determine if ALS or BLS transport is required and the Charge Nurse or designee contacts the transport service. If ambulance company determines a different level of transport service is required, based upon Maryland State EMS Protocols, this information is reported to the physician for documentation in the medical record. If the transporting service cannot provide timely and adequately trained personnel, UCH Nursing and or Medical Staff Administration will evaluate the efficacy of sending UCH personnel with appropriate transport training as the patient requires, and as required by Maryland Law. This nurse will have 2 years critical care experience, current ACLS, and Base Station training. They will provide care within the scope of practice of the hospital RN.
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    1. an ambulance attendant or other individual of the same sex, whenever possible
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B. Off Campus Specialty Services

Temporary Off Campus transfers apply to inpatients transferred for diagnostic testing or medical/surgical services not offered on the campuses of Upper Chesapeake Hospitals, such as Open-MRI, TEE, ERCP, Oral Surgery, etc.

1. The Attending/Transferring Physician is responsible for writing an Order for the offsite service. A planned daily/weekly trip during the same admission requires only one order and one form.
2. The Attending/Transferring Physician is responsible for documenting by way of the *Acute Patient Transfer Form*, the necessity of the transfer, risks & benefits, and the patient's condition. The *Form* must be completed by the physician before transferring the patient.
3. Nursing staff or Unit Secretary will make scheduling arrangements for the procedure/test and direction sought as to special preparations needed such as diet restrictions or contrast prior to transfer, as well as addressing 'current treatments in progress' as indicated on the *Acute Patient Transfer Form*.
4. The transferring and accepting physicians determine if ALS or BLS transport is required and the charge nurse or designee contacts the transport service. If ambulance company determines a different level of transport service is required, based upon Maryland State EMS Protocols, this information is reported to the physician for documentation in the medical record.
5. Nursing team members prepare the patient for transport and complete a *Ticket to Ride* as the hand off communication to the receiving location.
    a. The nurse will prepare the patient for transfer and have the medical record (including a copy of the medication reconciliation administration record) ready to accompany the patient.

b. Team members caring for the patient will address toileting needs, medication needs and nutrition/fluid needs prior to the arrival of the transporter(s) to the unit.
c. The department housing the patient is responsible to assure that the patient is ready for transport in a timely manner.

6. When the transport service arrives the primary care nurse for the patient contacts the accepting facility to give report.
7. The receiving facility will be responsible for the patient upon arrival and is expected to utilize EMS services should the patient's condition deteriorate and need to be emergently returned to the hospital.

C. On Campus Specialty Services (UCMC)

Temporary On Campus Transfers apply to inpatients transferred to UCMC Physician Pavilions and Ambulatory Care Center

1. The Attending Physician writes an Order for a medical or surgical 'consult and treat' for the patient.
    a. If the provider/consultant requests the patient be seen in his/her private office during an inpatient admission, there will be direct physician to physician communication between the consulting and attending physicians regarding the appropriateness/medical necessity for the patient to leave the unit.
    b. The Attending Physician will write the Order for the off campus transport for the intended care/treatment/service.
2. The Attending/Transferring Physician is responsible for documenting by way of the *Acute Patient Transfer Form*, the necessity of the transfer, risks & benefits, and the patient's condition. The *Form* must be completed by the physician before transferring the patient.
3. Nursing staff or Unit Secretary will make scheduling arrangements for the procedure/test and direction sought as to special preparations needed such as diet restrictions or contrast prior to transfer, as well as addressing 'current treatments in progress' as indicated on the *Acute Patient Transfer Form*.
4. Nursing team members prepare the patient for transport and complete a *Ticket to Ride* as the hand off communication to the receiving location.
    a. The nurse will prepare the patient for transfer and have the medical record (including a copy of the medication reconciliation administration record) ready to accompany the patient.
    b. Team members caring for the patient will address toileting needs, medication needs and nutrition/fluid needs prior to leaving the unit.
    c. The department housing the patient is responsible to assure that the patient is transported in a timely manner.
5. The registered nurse or PCT will accompany the patient to the physician's office / location with necessary equipment or Oxygen, the patient record,
    a. Patients on O2 during transport must have their O2 placement and setting verified by the nurse prior to release of the patient and transport.
6. Upon return, the physician's office will provide hand-off report occurs to the patient's nurse and the complete *Ticket to Ride*.

7. The Consulting/Treating Physician will provide a brief procedural note for any interventions that were performed or any medication administered in the office setting, for the inpatient record.

D. Transfers to External Acute Care Facility

1. The transferring physician is responsible for contacting the accepting unit and securing an accepting physician at the receiving facility.
2. The accepting physician will determine the transfer location i.e. directly to the unit or the Emergency Department.
3. The *Acute Patient Transfer Form* must be completed before transfer documenting the reason for transfer, patient's condition, consent, risks and benefits and other salient information contained in the form.
4. The Charge Nurse ensures all pertinent medical records are copied, to include lab and x-ray reports and obtains MRI and CT films to be sent with the patient at the time of transfer.
5. The transferring and accepting physicians determine if ALS or BLS transport is required and the charge nurse or designee contacts the transport service. If ambulance company determines a different level of transport service is required, based upon Maryland State EMS Protocols, this information is reported to the physician for documentation in the medical record.
    1. If the transporting service cannot provide timely and adequately trained personnel, UCH Nursing and or Medical staff Administration will evaluate the efficacy of sending UCH personnel with appropriate training and experience as the patient requires, including 2 years critical care nursing experience, current ACLS, and Base Station training. They will provide care within the scope of the hospital RN.
6. When the transport service arrives the primary care nurse for the patient contacts the nurse / unit at the accepting facility to give report.
7. Psychiatric Patients - Transfers of any patient being transferred to or from a psychiatric unit will be accompanied by either:
    a. an ambulance attendant or other individual of the same sex, whenever possible
    b. the parent, spouse, adult sibling or adult offspring of the patient

E. Transfer Documentation

1. An *Acute Patient Transfer Form*
    a. The *Form* must be completed for all patients transferred from a UCH hospital inpatient setting to an off-site location, including on-campus services, before the patient leaves the Unit.
    b. Completing this documentation is the responsibility of the physician transferring the patient, the nurse assigned to the patient's care at the time of the transfer, and a charge nurse or Administrative Coordinator.
    c. An *Acute Patient Transfer* Form is <u>not necessary</u> for lateral transfers within the same hospital. This includes patient transfers to Radiation Oncology for treatment.
        i. UCH *Ticket to Ride* will accompany patients transferred between UCH hospitals and for temporary transfers to outpatient services as defined above.
    d. If the transferring physician is not physically present in the hospital, the physician portions of the Form may be completed by a PA provided that:
        i. The PA documents consultation with the transferring physician on the Transfer Form.

e. The Director/Clinical Nurse Manager/Charge Nurse of the unit caring for the patient, or the Administrative Coordinator, must check the completeness of the *Acute Patient Transfer Form*, bring issues to the attention of the responsible physician or nurse for correction prior to the transfer.
f. Distribution of the *Form* is outlined on the *Form* itself. (One copy will be retained in the medical record, a second copy will be sent to the receiving facility and, for review purposes, the third copy will be forwarded as indicated and considered the transfer log.)

2. UCH *Ticket to Ride* will accompany patients transferred between UCH hospitals and for temporary transfers outpatient services as defined above.
3. Additional documentation regarding care provided by UCH personnel during the transfer, if any, shall be completed on the *Acute Patient Transfer Form*, if able or on a progress note.

F. Reasons for Transfer

1. The only reasons for which a patient may be transferred from a UCH hospital to another acute care facility are:
    a. the patient's request for transfer despite being assured of the availability of care at UCH;
    b. the patient's need for a specialized capability not available at the transferring UCH hospital.
2. Temporary transfers to outpatient setting for diagnostic and or treatment services not readily available are permitted and procedurally defined above.
3. UCH nursing personnel shall report any proposed transfer not supported by these to their Department Director, the Administrative Coordinator or the Administrator On Call on an urgent basis, and Risk Management/Corporate Compliance.

G. Certification of Condition

1. Before any patient may be transferred from a UCH Hospital to another acute care facility the transferring physician must make one of the following certifications in writing regarding the patient's condition:
    a. the patient has been stabilized such that within a reasonable degree of medical probability, no material deterioration of the individual's condition (or the condition of a mother and her unborn child) is likely to result from the transfer;
    b. the patient's condition has not stabilized, however, the patient will benefit from a higher level of care that outweighs the risks associated with transfer; or
    c. the patient is in labor, however the benefits of transfer outweigh the potential risks to the mother and her unborn child(ren).
2. The physician will document this Certification in writing on the *Acute Patient Transfer Form* and include:
    a. Risks of Transfer and
    b. Benefits of Care at the other facility considered in reaching this certification.

H. Patient Consent and Refusal

1. No patient will be transferred between or from a UCH hospital without the patient's or the patient's surrogate decision maker's informed consent to the transfer, except in the case of transfer for inpatient hospitalization following involuntary commitment.

2. Obtaining informed consent to the transfer is the responsibility of the physician recommending the transfer. Documenting the consent or the patient's involuntary commitment on the *Acute Patient Transfer Form* is a nursing responsibility.
3. Patient refusals to accept transfers that are recommended by a physician shall be documented in the patient record or on an *Against Medical Advice Form.*
4. Prior to any transfer to due to the change in a patient's condition or need for a change in level of care within the hospitals, communication should occur between a member of the care team and the patient's family and/or surrogate decision maker, and consent obtained as appropriate. This does not apply to transfers for operational needs, such as bed placement or availability.

I. Other Requirements

1. Continuing care - Prior to transferring a patient to another acute care facility, all necessary medical treatment within the capabilities available at the UCH hospital will be provided in order to minimize risks of the transfer to the patient's health and, in the case of a woman in labor, the health of her unborn child.
2. Records - UCH will send receiving hospitals copies of all necessary medical records related to the individual's condition which is available at the time of transfer. Copies of additional records, such as laboratory results, which become available after the patient has left the UCH facility, will also be sent to the receiving hospital as soon as possible. These records may be sent by fax.
3. Care during transfer - UCH will assure care of the patient during the transfer by appropriate levels of life support, personnel and equipment. Determining the required level of support, personnel and equipment is the responsibility of the transferring physician. If the transporting service cannot provide timely and adequately trained personnel, UCH Nursing and or Medical staff Administration will evaluate the efficacy of sending UCH personnel with appropriate training and experience as the patient requires. This nurse will have 2 years critical care experience, current ACLS, and Base Station training. They will provide care within the scope of practice of the hospital RN.
4. Transfer orders and discharge summaries - For patients transferred from an inpatient unit to another acute care facility, the transferring physician must provide transfer orders and a discharge summary of the patient's hospitalization at UCH. Discharge summaries for transferred patients are queued to a priority status for transcription.
5. Transfers due to the failure or refusal of an on-call physician to appear - If a patient must be transferred to another hospital due to the refusal or failure of an on-call physician to appear:
    a. the physician's name and address must be documented on the *Acute Patient Transfer Form* and,
    b. before the transfer takes place, the physician's department chairperson and the Administrator on Call must be notified of the physician's refusal/failure to appear so that alternative coverage, if possible, may be obtained.
6. Improper Transfers from Other facilities - If any patient is received from another facility in a manner that suggests that the other facility may have violated the federal Emergency Medical Treatment and Active Labor Act (EMTALA), the receiving nurse must notify the Administrative Coordinator and/or the Administrator on Call on an urgent basis so that the facility can determine if it has an obligation to report the transfer to the appropriate agency.
7. Psychiatric Patients - Transfers of any patient being transferred to or from a psychiatric unit will be accompanied by either:
    i. an ambulance attendant or other individual of the same sex, whenever possible
    ii. the parent, spouse, adult sibling or adult offspring of the patient

J. Patient Transfer by Helicopter

1. All measures will be taken to ensure the safety of all persons/property during the arrival and departure of helicopters at either hospital.
2. Upper Chesapeake Medical Center (UCMC):
    a. Upon notification that UCMC will be receiving a helicopter, the following procedure will be followed:
        i. The Emergency Department will notify the following :
            1. Administrative Coordinator/Charge Nurse
            2. Security (2444)
        ii. The following information will be provided to the above:
            1. The reason the helicopter is coming
            2. The Estimated Time of Arrival (ETA)
    b. A member of the nursing team may assist in the transportation of the patient to or from the helicopter, however, the placement of the patient in the helicopter will be under the direction of the Flight Paramedic.
    c. The Landing Zone (LZ) is located off the Emergency Department.
    d. Upon notification of an inbound helicopter, a Security Officer will respond to the LZ.
        i. The Security Officer will ensure the area is cleared of people and any debris that could be blown around as a result of rotor wash from the main and/or tail rotors of the aircraft.
        ii. During the arrival and departure of the aircraft, Upper Chesapeake Drive will be closed to pedestrian/vehicular traffic in the area potentially affected by debris.
        iii. If necessary, the Facilities Services Team may be utilized to assist.
        iv. The Security Officer will remain at the LZ until the helicopter has departed to ensure no unauthorized pedestrians approach the aircraft.
        v. During this period, all hospital team members will turn their heads away from the helicopter to avoid blowing debris.
    e. The Team Member entrance and doors adjacent to the Emergency Department will be closed during the arrival and departure of the aircraft.
    f. The Security Officer will submit a Security Report outlining the circumstances any time a helicopter arrives. If any unusual event occurs (i.e., debris is blown into a vehicle causing damage), that too will be documented in the report.
3. Harford Memorial Hospital (HMH):
    a. Due to its proximity to homes, there is no helipad at Harford Memorial Hospital.
    b. Helicopter transfers to and from Harford Memorial Hospital will be made at the helipad located at the Maryland Army National Guard Complex, located on Old Bay Lane.
    c. To arrange helicopter transfer, HMH ED Charge Nurse, AC, or designee will contact Express Care Communication Center (X1234). Express Care Communication Center will contact Hart to Heart to determine their availability to provide ground transport from helipad to hospital and return trip. If Hart to Heart is not available, Express Care Communication Center will contact Harford County 911 to arrange for transport.

d. Upon arrival at the helipad, the Flight Paramedic will be transported to Harford Memorial by commercial ambulance, or when not available, Harford County Ambulance/Fire Personnel. Patients will be transported to and/or from the helipad by ambulance, utilizing the ambulance stretcher. The patient will be transferred to the aviation stretcher at the helipad.
e. The transfer of all patients will be done at the direction of the Flight Paramedic.
f. All Harford Memorial Hospital Team Members will make every effort to assist the Fire/Ambulance Company and flight crew.

REFERENCES:

42 U.S.C. 1395 dd
42 C.F.R. 489.24
Md. Code Ann. Health-Gen. 10-625, 10-807 and 19.308.2
COMAR 10.07.01.23

EXHIBIT 12

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Financial Statements and Schedules

June 30, 2017 and 2016

(With Independent Auditors' Report Thereon)

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Table of Contents

KPMG LLP
1 East Pratt Street
Baltimore, MD 21202-1128

Independent Auditors' Report

The Board of Directors
University of Maryland Medical System Corporation:

We have audited the accompanying consolidated financial statements of the University of Maryland Medical System Corporation and Subsidiaries (the Corporation), which comprise the consolidated balance sheets as of June 30, 2017 and 2016, and the related consolidated statements of income, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the University of Maryland Medical System Corporation and Subsidiaries as of June 30, 2017 and 2016, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary information in Schedules 1-8 is presented for purposes of additional

analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

Baltimore, Maryland
October 26, 2017

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2017 and 2016

(In thousands)

Assets		2017	2016
Current assets:			
Cash and cash equivalents	$	476,201	523,169
Assets limited as to use, current portion		50,940	51,412
Accounts receivable:			
Patient accounts receivable, less allowance for doubtful accounts of $219,806 and $202,298 as of June 30, 2017 and 2016, respectively		378,148	331,055
Other		84,709	97,887
Inventories		60,883	59,738
Prepaid expenses and other current assets		36,023	25,381
Total current assets		1,086,904	1,088,642
Investments		742,949	645,534
Assets limited as to use, less current portion		776,387	750,179
Property and equipment, net		2,092,103	2,086,546
Investments in joint ventures		82,094	71,906
Other assets		328,867	323,275
Total assets	$	5,109,304	4,966,082
Liabilities and Net Assets			
Current liabilities:			
Trade accounts payable	$	271,602	249,543
Accrued payroll and benefits		233,544	253,337
Advances from third-party payors		131,941	124,717
Lines of credit		125,000	180,000
Short-term financing		—	150,000
Other current liabilities		182,688	147,522
Long-term debt subject to short-term remarketing arrangements		28,440	32,515
Current portion of long-term debt		40,937	37,592
Total current liabilities		1,014,152	1,175,226
Long-term debt, less current portion and amount subject to short-term remarketing arrangements		1,550,490	1,422,604
Other long-term liabilities		334,274	352,605
Interest rate swap liabilities		194,524	273,037
Total liabilities		3,093,440	3,223,472
Net assets:			
Unrestricted		1,711,329	1,459,280
Temporarily restricted		266,025	246,265
Permanently restricted		38,510	37,065
Total net assets		2,015,864	1,742,610
Total liabilities and net assets	$	5,109,304	4,966,082

See accompanying notes to consolidated financial statements.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended June 30, 2017 and 2016

(In thousands)

	2017	2016
Unrestricted revenues, gains and other support:		
Patient service revenue (net of contractual adjustments)	$ 3,669,619	3,544,050
Provision for bad debts	(184,597)	(176,198)
Net patient service revenue	3,485,022	3,367,852
Other operating revenue:		
State support	18,200	3,200
Premium revenue	268,060	140,958
Other revenue	136,408	156,939
Total unrestricted revenues, gains and other support	3,907,690	3,668,949
Operating expenses:		
Salaries, wages and benefits	1,836,434	1,751,856
Expendable supplies	704,724	674,994
Purchased services	538,698	552,426
Medical claims expense	252,118	127,636
Contracted services	226,690	216,562
Depreciation and amortization	219,749	200,764
Interest expense	57,197	57,464
Total operating expenses	3,835,610	3,581,702
Operating income	72,080	87,247
Nonoperating income and expenses, net:		
Contributions	5,425	3,769
St. Joseph escrow settlement	—	34,275
Equity in net income (loss) of joint ventures	3,856	(298)
Investment income, net	35,496	21,111
Change in fair value of investments	54,175	(36,443)
Change in fair value of undesignated interest rate swaps	76,797	(78,429)
Loss on early extinguishment of debt	(26,427)	—
Other nonoperating losses, net	(38,043)	(31,033)
Excess of revenues over expenses	$ 183,359	199

See accompanying notes to consolidated financial statements.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2017 and 2016

(In thousands)

	Unrestricted net assets	Temporarily restricted net assets	Permanently restricted net assets	Total
Balance at June 30, 2015	$ 1,457,227	245,653	36,201	1,739,081
Excess of revenues over expenses	199	—	—	199
Investment gains, net	—	(968)	(52)	(1,020)
State support for capital	—	4,364	—	4,364
Contributions, net	—	15,884	469	16,353
Net assets released from restrictions used for operations and nonoperating activities	—	(7,067)	—	(7,067)
Net assets released from restrictions used for purchase of property and equipment	10,417	(10,417)	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	(1,545)	—	(1,545)
Change in ownership interest of joint ventures	566	(36)	—	530
Amortization of accumulated loss of discontinued designated interest rate swap	1,765	—	—	1,765
Change in funded status of defined benefit pension plans	(10,643)	—	—	(10,643)
Asset reclassifications at request of donor	(847)	400	447	—
Other	596	(3)	—	593
Increase in net assets	2,053	612	864	3,529
Balance at June 30, 2016	1,459,280	246,265	37,065	1,742,610
Excess of revenues over expenses	183,359	—	—	183,359
Investment gains, net	—	4,519	489	5,008
State support for capital	—	23,029	—	23,029
Contributions, net	—	20,632	893	21,525
Net assets released from restrictions used for operations and nonoperating activities	—	(2,868)	—	(2,868)
Net assets released from restrictions used for purchase of property and equipment	33,038	(33,038)	—	—
Change in economic and beneficial interests in the net assets of related organizations	—	4,395	63	4,458
Change in ownership interest of joint ventures	397	1,266	—	1,663
Amortization of accumulated loss of discontinued designated interest rate swap	1,716	—	—	1,716
Change in funded status of defined benefit pension plans	34,353	—	—	34,353
Asset reclassifications at request of donor	(1,853)	1,853	—	—
Other	1,039	(28)	—	1,011
Increase in net assets	252,049	19,760	1,445	273,254
Balance at June 30, 2017	$ 1,711,329	266,025	38,510	2,015,864

See accompanying notes to consolidated financial statements.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2017 and 2016

(In thousands)

	2017	2016
Cash flows from operating activities:		
Increase in net assets	$ 273,254	3,529
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	219,749	200,764
Provision for bad debts	184,597	176,198
Amortization of bond premium and deferred financing costs	919	1,944
Net realized gains and change in fair value of investments	(83,907)	28,046
Loss on early extinguishment of debt	26,427	—
Equity in net (income) loss of joint ventures	(3,856)	298
Change in economic and beneficial interests in net assets of related organizations	(4,458)	1,545
Change in fair value of interest rate swaps	(78,513)	76,665
Change in funded status of defined benefit pension plans	(34,353)	10,643
Restricted contributions, grants and other support	(21,525)	(16,353)
Change in operating assets and liabilities:		
Patient accounts receivable	(231,690)	(174,069)
Other receivables, prepaid expenses, other current assets and other assets	(8,700)	(45,510)
Inventories	(1,145)	(484)
Trade accounts payable, accrued payroll and benefits, other current liabilities and other long-term liabilities	57,976	22,842
Advances from third-party payors	7,224	(4,495)
Net cash provided by operating activities	301,999	281,563
Cash flows from investing activities:		
Purchases and sales of investments and assets limited as to use, net	8,691	47,619
Purchases of alternative investments	(175,688)	(120,788)
Sales of alternative investments	132,211	46,544
Acquisition of UM Health Plans, net of cash acquired	—	(30,747)
Purchases of property and equipment	(231,257)	(215,691)
(Contributions to)/distributions from joint ventures, net	(688)	3,031
Net cash used in investing activities	(266,731)	(270,032)

(Continued)

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2017 and 2016

(In thousands)

		2017	2016
Cash flows from financing activities:			
Proceeds from long-term debt	$	653,396	51,350
Repayment of long-term debt and capital leases		(698,460)	(54,171)
Draws on lines of credit, net		(55,000)	35,600
Payment of debt issuance costs		(3,697)	—
Restricted contributions, grants and other support		21,525	16,353
Net cash (used in) provided by financing activities		(82,236)	49,132
Net (decrease) increase in cash and cash equivalents		(46,968)	60,663
Cash and cash equivalents, beginning of year		523,169	462,506
Cash and cash equivalents, end of year	$	476,201	523,169
Supplemental disclosures of cash flow information:			
Cash paid during the year for interest, net of amounts capitalized	$	56,330	56,478
Amount included in accounts payable for construction in progress		29,164	23,213
Supplemental disclosures of noncash information:			
Capital leases	$	1,276	2,309

See accompanying notes to consolidated financial statements.

(1) Organization and Summary of Significant Accounting Policies

(a) Organization

The University of Maryland Medical System Corporation (the Corporation or UMMS) is a private, not-for-profit corporation providing comprehensive healthcare services through an integrated regional network of hospitals and related clinical enterprises. UMMS was created in 1984 when its founding hospital was privatized by the State of Maryland. Over its 30 year history, UMMS evolved into a multi-hospital system with academic, community and specialty service missions reaching primarily across Maryland. In continuing partnership with the University of Maryland School of Medicine, UMMS operates healthcare programs that improve the physical and mental health of thousands of people each day.

The accompanying consolidated financial statements include the accounts of the Corporation, its wholly owned subsidiaries, and entities controlled by the Corporation. In addition, the Corporation maintains equity interests in various unconsolidated joint ventures, which are described in note 4. The significant operating divisions of the Corporation are described in further detail below.

All material intercompany balances and transactions have been eliminated in consolidation.

(i) Recent Acquisitions & Divestitures

University of Maryland Health Ventures, LLC (UMHV), a wholly owned subsidiary of UMMS, acquired 100% of the stock of Riverside Health, Inc. (Riverside) and its affiliates on August 17, 2015 (the Purchase Date). Concurrent with the transaction, Riverside Health, Inc. was renamed University of Maryland Medical System Health Plans, Inc. (UM Health Plans).

UM Health Plans is a holding company that operates as a managed healthcare and insurance organization in the State of Maryland and includes the following subsidiaries: University of Maryland Health Partners, formerly Riverside Health of Maryland, Inc. (UMHP), University of Maryland Health Advantage, Inc., formerly Riverside Advantage, Inc. (UMHA), Riverside Health of Delaware, Inc. (RHDE), and Riverside Health DC, Inc.

The transaction is described in more detail below.

(ii) University of Maryland Medical Center (Medical Center)

The University of Maryland Medical Center, which is a major component of UMMS, is an 816-bed academic medical center located in Baltimore. The Medical Center has served as the teaching hospital of the School of Medicine of the University System of Maryland, Baltimore since 1823. While the Corporation is not affiliated with the University System of Maryland, clinical faculty members of the School of Medicine serve as medical staff of the Medical Center.

The Medical Center is comprised of two operating divisions: University Hospital, which includes the Greenebaum Cancer Center, and Shock Trauma Center. University Hospital, which generates approximately 80% of the Medical Center's admissions and patient days, is a tertiary teaching hospital providing over 70 clinical services and programs. The Greenebaum Cancer Center specializes in the treatment of cancer patients and is a site for clinical cancer research. The Shock Trauma Center, which specializes in emergency treatment of patients suffering severe trauma, generates approximately 20% of admissions and patient days.

The Medical Center's operations include g, LLC (UCARE), a physician hospital organization of which the Corporation has a majority ownership interest and therefore consolidates, and 36 South Paca Street, LLC, a wholly owned subsidiary of the Corporation that operates a residential apartment building.

The Corporation has certain agreements with various departments of the University of Maryland School of Medicine concerning the provision of professional and administrative services to the Corporation and its patients. Total expense under these agreements in the years ended June 30, 2017 and 2016 was approximately $158,649,000 and $152,155,000, respectively.

(iii) University of Maryland Rehabilitation and Orthopaedic Institute (ROI)

ROI is comprised of a medical/surgical and rehabilitation hospital in Baltimore with 134 licensed beds, including 88 rehabilitation beds, 36 chronic care beds, 10 medical/surgical beds, and off-site physical therapy facilities.

A related corporation, The James Lawrence Kernan Endowment Fund, Inc. (Kernan Endowment), is governed by a separate, independent board of directors and is required to hold investments and income derived therefrom for the exclusive benefit of ROI. Accordingly, the accompanying consolidated financial statements reflect an economic interest in the net assets of the Kernan Endowment.

(iv) University of Maryland Medical Center Midtown Campus (Midtown)

Midtown is located in Baltimore city and is comprised of University of Maryland Midtown Hospital (UM Midtown), a 208-bed acute care hospital and a wholly owned subsidiary providing primary care.

(v) University of Maryland Baltimore Washington Medical System, Inc. (Baltimore Washington)

Baltimore Washington is located in Anne Arundel County, a suburb of Baltimore city, and is a health system comprised of University of Maryland Baltimore Washington Medical Center (UM Baltimore Washington), a 319-bed acute care hospital providing a broad range of services, and several wholly owned subsidiaries providing emergency physician and other services.

Baltimore Washington Medical Center Foundation, Inc. (BWMC Foundation) is governed by a separate, independent board of directors and is required to hold investments and income derived therefrom for the exclusive benefit of UM Baltimore Washington. Accordingly, the accompanying consolidated financial statements reflect an economic interest in the net assets of the BWMC Foundation.

(vi) University of Maryland Shore Regional Health System (Shore Regional)

Shore Regional is a health system located on the Eastern Shore of Maryland. Shore Regional owns and operates University of Maryland Memorial Hospital (UM Memorial), a 132-bed acute care hospital providing inpatient and outpatient services in Easton, Maryland; University of Maryland Dorchester Hospital (UM Dorchester), a 41-bed acute care hospital providing inpatient and outpatient services in Cambridge, Maryland; University of Maryland Chester River Hospital Center (UM Chester River), a 41-bed acute care hospital providing inpatient and outpatient services to the residents of Kent and Queen Anne's counties; Shore Emergency Center at Queenstown (Shore Emergency Center), a free-standing emergency center; Memorial Hospital Foundation (Memorial Foundation), a nonprofit corporation established to solicit donations for the benefit of UM Memorial; Chester River Health Foundation (Chester River Foundation), a nonprofit corporation established to solicit donations for the benefit of UM Chester River; and several other subsidiaries providing various outpatient and home care services.

Dorchester General Hospital Foundation, Inc. (Dorchester Foundation) is governed by a separate, independent board of directors to raise funds on behalf of UM Dorchester. Shore Regional does not have control over the policies or decisions of the Dorchester Foundation, and accordingly, the accompanying consolidated financial statements reflect a beneficial interest in the net assets of the Dorchester Foundation.

(vii) University of Maryland Charles Regional Health System, Inc. (Charles Regional)

Charles Regional owns and operates University of Maryland Charles Regional Medical Center (UM Charles Regional), which is comprised of a 121-bed acute care hospital and other community healthcare resources providing inpatient and outpatient services to the residents of Charles County in Southern Maryland.

(viii) University of Maryland St. Joseph Health System, LLC (St. Joseph)

St. Joseph owns and operates University of Maryland St. Joseph Medical Center (UM St. Joseph), a 232-bed, Catholic acute care hospital located in Towson, Maryland, as well as other subsidiaries providing inpatient and outpatient services to the residents of Baltimore County.

(ix) University of Maryland Upper Chesapeake Health System (Upper Chesapeake)

Upper Chesapeake is a health system located in Harford County, Maryland. Upper Chesapeake's healthcare delivery system includes two acute care hospitals, University of Maryland Upper Chesapeake Medical Center (UM Upper Chesapeake), a 181-bed acute care hospital and University of Maryland Harford Memorial Hospital (UM Harford Memorial), an 89-bed acute care hospital; a physician practice; a captive insurance company; a land holding company; and Upper Chesapeake Health Foundation.

(x) University of Maryland Medical System Foundation, Inc. (UMMS Foundation)

The UMMS Foundation, a not-for-profit foundation, was established for the purpose of soliciting contributions on behalf of the Corporation.

(xi) University of Maryland Community Medical Group, LLC (CMG)

CMG is a physician network that employs more than 300 primary care physicians, specialists and advanced practice providers. CMG is a wholly owned subsidiary of UMMS and has over 75 locations across the state of Maryland.

(xii) University of Maryland Medical System Health Plans Inc. (UM Health Plans)

UM Health Plans (formerly Riverside Health Inc.), a Delaware corporation, is a public sector managed healthcare company based in Baltimore, Maryland. UM Health Plans is the parent company of: University of Maryland Health Partners (UMHP) which provides managed care health coverage to Medicaid recipients throughout Maryland; University of Maryland Health Advantage, Inc. (UMHA), a Medicare Advantage Plan; Riverside Health of Delaware Inc. (RHDE) and Riverside Health DC, Inc.

On August 17, 2015, UMHV, a wholly owned subsidiary of UMMS, purchased all of the outstanding shares of UM Health Plans for approximately $42,250,000 in cash, net working capital and convertible promissory notes. In addition, the Stock Purchase Agreement included an earn-out payment clause for the previous stockholders of UM Health Plans, the final computation of which is not to be determined until March 31, 2020. This earn-out could result in an undiscounted payment ranging from $7,000,000 to $106,500,000 depending on the performance and membership of both plans. UMHV has recorded a contingent consideration liability representing a discounted estimate of the future payment of the earn-out provision of approximately $35,700,000, which is included within other long-term liabilities in the accompanying consolidated balance sheets.

The acquisition was accounted for under the purchase accounting method for business combinations and the financial position and results of operations of UM Health Plans were consolidated by the Corporation beginning on August 17, 2015.

The following table summarizes the estimated fair value of UM Health Plan's assets acquired and liabilities assumed at August 17, 2015 (the acquisition date) (in thousands):

Assets:		
Current assets	$	29,786
Property and equipment		3,750
Goodwill		42,020
Other long-term assets		46,638
Total assets	$	122,194

(Continued)

Liabilities:		
Current liabilities	$	28,226
Long-term liabilities		16,249
Total liabilities		44,475
Net assets:		
Unrestricted		77,719
Temporarily restricted		—
Total net assets		77,719
Total liabilities and net assets	$	122,194

The following table summarizes the Corporation's pro forma consolidated results as though the acquisition date occurred at July 1, 2015 (in thousands):

Operating revenues	$	3,685,503
Net operating income		85,969
Changes in net assets:		
Unrestricted	$	775
Temporarily restricted		612
Permanently restricted		864
Total changes in net assets	$	2,251

(b) Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with U.S. generally accepted accounting principles.

(c) Cash Equivalents

Cash and cash equivalents consist of cash and interest-bearing deposits with maturities of three months or less from the date of purchase.

(d) Investments and Assets Limited as to Use

The Corporation's investment portfolios are classified as trading, and are reported in the consolidated balance sheets at their fair value, based on quoted market prices, at June 30, 2017 and 2016. Unrealized holding gains and losses on trading securities with readily determinable market values are

included in nonoperating income. Investment income, including realized gains and losses, is included in nonoperating income in the accompanying consolidated statements of operations.

Assets limited as to use include investments set aside at the discretion of the board of directors for the replacement or acquisition of property and equipment, investments held by trustees under bond indenture agreements and self-insurance trust arrangements, and assets whose use is restricted by donors. Such investments are stated at fair value. Amounts required to meet current liabilities have been included in current assets in the consolidated balance sheets. Changes in fair values of donor-restricted investments are recorded in temporarily restricted net assets unless otherwise required by the donor or state law.

Assets limited as to use also include the Corporation's economic interests in financially interrelated organizations (note 12).

Alternative investments are recorded under the equity method of accounting. Underlying securities of these alternative investments may include certain debt and equity securities that are not readily marketable. Because certain investments are not readily marketable, their fair value is subject to additional uncertainty, and therefore values realized upon disposition may vary significantly from current reported values.

Investments are exposed to certain risks such as interest rate, credit, and overall market volatility. Due to the level of risk associated with certain investment securities, changes in the value of investment securities could occur in the near term, and these changes could materially differ from the amounts reported in the accompanying consolidated financial statements.

(e) Inventories

Inventories, consisting primarily of drugs and medical/surgical supplies, are carried at the lower of cost or market, on a first-in, first-out basis.

(f) Economic Interests in Financially Interrelated Organizations

The Corporation recognizes its rights to assets held by recipient organizations, which accept cash or other financial assets from a donor and agree to use those assets on behalf of or transfer those assets, the return on investment of those assets, or both, to the Corporation. Changes in the Corporation's economic interests in these financially interrelated organizations are recognized in the consolidated statements of changes in net assets.

(g) Property and Equipment

Property and equipment are stated at cost, or estimated fair value at date of contribution, less accumulated depreciation. Depreciation is provided on a straight-line basis over the estimated useful

lives of the depreciable assets using half-year convention. The estimated useful lives of the assets are as follows:

Buildings	20 to 40 years
Building and leasehold improvements	5 to 15 years
Equipment	3 to 15 years

Interest costs incurred on borrowed funds less interest income earned on the unexpended bond proceeds during the period of construction are capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(h) Deferred Financing Costs

Costs incurred related to the issuance of long-term debt, which are included in long-term debt, are deferred and are amortized over the life of the related debt agreements or the related letter of credit agreements using the effective-interest method.

(i) Goodwill

Goodwill is an asset representing the future economic benefits arising from other assets acquired in a business combination that are not individually identified and separately recognized. Goodwill is evaluated for impairment at least annually using a qualitative assessment to determine whether there are events or circumstances that indicate it is more likely than not that the fair value of the reporting unit is less than its carrying value, which determines whether a quantitative goodwill impairment test is necessary. Under the quantitative assessment, the fair value of the reporting unit is compared with its carrying value (including goodwill). If the fair value of the reporting unit is less than its carrying value, goodwill impairment exists for the reporting unit and the entity must record an impairment loss. As of June 30, 2017 and 2016, the Corporation had one reporting unit, which included all subsidiaries of the Corporation and held goodwill on its consolidated balance sheet of $90,830,000.

Based on the Corporation’s qualitative assessment, it was determined that there was no goodwill impairment for the years ended June 30, 2017 or 2016. Accumulated impairment loss was $0 at June 30, 2017 and 2016.

The changes in the carrying amount of goodwill are as follows (in thousands):

		2017	2016
Goodwill, beginning of year	$	90,830	48,810
Current year acquisitions		—	42,020
Goodwill, end of year	$	90,830	90,830

(j) Contingent Consideration for Business Acquisitions

Acquisitions may include contingent consideration payments based on future financial measures of an acquired company. Contingent consideration is required to be recognized at fair value as of the acquisition date. The fair value of these liabilities is estimated based on financial projections of the acquired companies and estimated probabilities of achievement and discount the liabilities to present value using a weighted average cost of capital. Contingent consideration is valued using significant inputs that are not observable in the market, which are defined as Level 3 inputs pursuant to fair value measurement accounting. At each reporting date, the contingent consideration obligation is revalued to estimated fair value and changes in fair value subsequent to the acquisition are reflected in operating income in the consolidated statements of operations. Changes in the fair value of contingent consideration obligations may result from changes in discount periods and rates, changes in the timing and amount of revenue and/or earnings estimates, and changes in probability assumptions with respect to the likelihood of achieving the various earn-out criteria.

(k) Impairment of Long-Lived Assets

Long-lived assets, such as property, plant, and equipment, and purchased intangibles subject to amortization, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by comparing the carrying amount of an asset to estimated undiscounted future cash flows expected to be generated by the asset. If the carrying amount of an asset exceeds its estimated future cash flows, an impairment charge is recognized in the amount by which the carrying amount of the asset exceeds the fair value of the asset. Assets to be disposed of would be separately presented in the consolidated balance sheets and reported at the lower of the carrying amount or fair value less costs to sell, and are no longer depreciated. The assets and liabilities of a disposed group classified as held for sale would be presented separately in the appropriate asset and liability sections of the consolidated balance sheets.

No impairment losses were recorded for the years ended June 30, 2017 or 2016.

(l) Investments in Joint Ventures

When the Corporation does not have a controlling interest in an entity, but exerts a significant influence over the entity, the Corporation applies the equity method of accounting.

(m) Self-Insurance

Under the Corporation's self-insurance programs (general and professional liability, workers' compensation, and employee health and long-term disability benefits), claims are reflected as a

present-value liability based upon actuarial estimates and reported and incurred but not reported claims analysis, taking into consideration the severity of incidents and the expected timing of claim payments.

(n) Net Assets

The Corporation classifies net assets based on the existence or absence of donor-imposed restrictions. Unrestricted net assets represent contributions, gifts, and grants, which have no donor-imposed restrictions or which arise as a result of operations. Temporarily restricted net assets are subject to donor-imposed restrictions that must or will be met either by satisfying a specific purpose and/or passage of time. Permanently restricted net assets are subject to donor-imposed restrictions that must be maintained in perpetuity. Generally, the donors of these assets permit the use of all or part of the income earned on related investments for specific purposes. The restrictions associated with these net assets generally pertain to patient care, specific capital projects, and funding of specific hospital operations and community outreach programs.

(o) Net Patient Service Revenue and Provision for Uncollectible Accounts

Patient service revenue for the Medical Center, ROI, Midtown, Baltimore Washington, Shore Regional, Charles Regional, St. Joseph, and Upper Chesapeake reflects actual charges to patients based on rates established by the State of Maryland Health Services Cost Review Commission (HSCRC) in effect during the period in which the services are rendered, net of contractual adjustments. Contractual adjustments represent the difference between amounts billed as patient service revenue and amounts allowed by third-party payors. Such adjustments include discounts on charges as permitted by the HSCRC. See note 18 for further discussion on the HSCRC and regulated rates.

The Corporation records revenues and accounts receivable from patients and third-party payors at their estimated net realizable value. Revenue is reduced for anticipated discounts under contractual arrangements and for charity care. An estimated provision for bad debts is recorded in the period the related services are provided based upon anticipated uncompensated care, and is adjusted as additional information becomes available.

The provision for bad debts is based upon management’s assessment of historical and expected net collections considering historical business and economic conditions, trends in healthcare coverage, and other collection indicators. Periodically throughout the year, management assesses the adequacy of the allowance for uncollectible accounts based upon historical write-off experience by payor category. The results of this review are then used to make modifications to the provision for bad debts and to establish an allowance for uncollectible receivables. After collection of amounts due from insurers, the Corporation follows internal guidelines for placing certain past due balances with collection agencies.

For receivables associated with services provided to patients who have third-party coverage, the Corporation analyzes contractually due amounts and provides an allowance for bad debts, allowance for contractual adjustments, provision for bad debts, and contractual adjustments on accounts for which the third-party payor has not yet paid or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely. For receivables associated with self-pay patients or with balances remaining after the third-party coverage has already paid, the Corporation records a significant provision for bad debts in the period of service on the basis of its historical collections, which indicates that many patients ultimately do not pay the portion of their bill for which they are financially responsible. The difference between the discounted rates and the amounts collected after all reasonable collection efforts have been exhausted is charged against the allowance for doubtful accounts. The change in the allowance for doubtful accounts was as follows during the years ended June 30 (in thousands):

		2017	2016
Beginning allowance for doubtful accounts	$	202,298	248,054
Plus provision for bad debt		184,597	176,198
Less bad debt write-offs		(167,089)	(221,954)
Ending allowance for doubtful accounts	$	219,806	202,298

The change in the allowance for doubtful accounts during 2017 is attributable to changes in trends experienced in the collection of the related patient receivables.

(p) Premium Revenue and Medical Claims Expense

Premium revenue consists of amounts received from the State of Maryland and the Centers for Medicare and Medicaid Services (CMS) by the Corporation's managed care organization for providing medical services to subscribing participants, regardless of services actually performed. The managed care organization provides services primarily to enrolled Medicaid and Medicare beneficiaries. This revenue is recognized ratably over the contractual period for the provision of services. Medical expenses of the managed care organization include actuarially determined estimates of the ultimate costs for both reported claims and claims incurred but unreported and are included in purchased services on the consolidated statements of operations and changes in net assets.

(Continued)

(q) Charity Care

The Corporation is committed to providing quality healthcare to all, regardless of one's ability to pay. Patients who meet the criteria of its charity care policy receive services without charge or at amounts less than its established rates. The criteria for charity care consider the household income in relation to the federal poverty guidelines. The Corporation provides services at no charge for patients with adjusted gross income equal to or less than 200% of the federal poverty guidelines. For uninsured patients with adjusted gross income greater than 200% of the federal poverty guidelines, a sliding scale discount is applied. Income and asset information obtained from patient credit reporting data are used to determine patients' ability to pay. The Corporation maintains records to identify and monitor the level of charity care it furnished under its charity care policy. The charity care policies of the new affiliates are generally consistent with that of the Corporation's policy.

Due to the complexity of the eligibility process, the Corporation provides eligibility services to patients free of charge to assist in the qualification process. These eligibility services include, but are not limited to, the following:

- Financial assistance brochures and other information are posted at each point of service. When patients have questions or concerns, they are encouraged to call a toll-free number to reach customer service representatives during the business day. Financial assistance programs are published on the Corporation's Web site and included on the statements provided to patients.
- The Corporation offers assistance to patients in completing the applications for Medicaid or other government payment assistance programs, or applying for care under the Corporation's charity care policy, if applicable. The Corporation also employs an external firm to assist in the eligibility process.
- Any patient, whether covered by insurance or not, may meet with a UMMS representative and receive financial counseling from UMMS' dedicated financial assistance unit.

The Corporation recognizes that a large number of uninsured and insured patients meet the charity care guidelines but do not respond to the Corporation's attempts to obtain necessary financial information. In these instances, the Corporation uses credit reporting data to properly classify these unpaid balances as charity care as opposed to bad debt expense. Utilization of income and asset information and credit reporting data indicate the vast majority of amounts reported as provision for bad debts represent amounts due from patients that would otherwise qualify for charity benefits but do not respond to the Corporation's attempts to obtain the necessary financial information. In these cases, reasonable collection efforts are pursued, but yield few collections. Amounts determined to meet the criteria under the charity care policy are not reported as net patient service revenue.

The amounts reported as charity care represent the cost of rendering such services. Costs incurred are estimated based on the cost-to-charge ratio for each hospital and applied to charity care charges. The Corporation estimates the total direct and indirect costs to provide charity care were $36,195,000 and $48,149,000 for the years ended June 30, 2017 and 2016, respectively.

(r) Nonoperating Income and Expenses, Net

Other activities that are only indirectly related to the Corporation's primary business of delivering healthcare services are recorded as nonoperating income and expenses, and include investment income, equity in the net income of joint ventures, general donations and fund-raising activities, escrow settlements, gains on sale of joint venture interest, changes in fair value of investments, changes in fair value of undesignated interest rate swaps, settlement payments on interest rate swaps that do not qualify for hedge accounting treatment, and loss on early extinguishment of debt. Settlement payments on interest rate swaps were approximately $23,469,000 and $25,289,000 for the years ended June 30, 2017 and 2016, respectively, and are reported within other nonoperating losses, net.

(s) Derivative Financial Instruments

The Corporation records derivative and hedging activities on the consolidated balance sheets at their respective fair values.

The Corporation utilizes derivative financial instruments to manage its interest rate risks associated with long-term tax-exempt debt. The Corporation does not hold or issue derivative financial instruments for trading purposes.

The Corporation's specific goals are to (a) manage interest rate sensitivity by modifying the reprising or maturity characteristics of some of its tax-exempt debt, and (b) lower unrealized appreciation or depreciation in the market value of the Corporation's fixed-rate tax-exempt debt when that market value is compared with the cost of the borrowed funds. The effect of this unrealized appreciation or depreciation in market value, however, will generally be offset by the income or loss on the derivative instruments that are linked to the debt.

The Corporation formally documents all hedge relationships between hedging instruments and hedged items, as well as its risk-management objective and strategy for undertaking various hedge transactions. On the date the derivative contract is entered into, the Corporation may designate the derivative as either a hedge of the fair value of a recognized or forecasted liability (fair value hedge) or a hedge of the variability of cash flows to be received or paid related to a recognized liability (cash flow hedge), provided the derivative instrument meets certain criteria related to its effectiveness. This process includes linking all derivatives that are designated as fair value or cash flow hedges to specific liabilities on the consolidated balance sheets. The Corporation also formally assesses, both at the hedge's inception and on an ongoing basis, whether the derivatives that are used in hedging transactions are highly effective in offsetting changes in fair values or cash flows of hedged items.

All derivative instruments are reported as other assets or interest rate swap liabilities in the consolidated balance sheets and measured at fair value. Derivatives not designated as hedges or not meeting effectiveness criteria are carried at fair value with changes in the fair value recognized in other nonoperating income and expenses. For the years ended June 20, 2017 and 2016, none of the Corporation's derivatives qualify for hedge accounting.

Changes in the fair value of derivative instruments are included in or excluded from the excess of revenues over expenses depending on the use of the derivative and whether it qualifies for hedge accounting treatment. Changes in the fair value of a derivative that is designated and qualifies as a fair value hedge, along with the changes in the fair value of the hedged item related to the risk being hedged, are included in the excess of revenues over expenses. Changes in the fair value of a derivative that is designated as a cash flow hedge are excluded from the excess of revenues over expenses to the extent that the hedge is effective until the excess of revenues over expenses is affected by the variability of cash flows in the hedged transaction. Changes in the fair value that relate to ineffectiveness are included in the excess of revenues over expenses as interest expense.

(t) Excess of Revenue over Expenses

The consolidated statements of operations includes a performance indicator, excess of revenue over expenses. Changes in unrestricted net assets that are excluded from the performance indicator, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions, which, by donor restrictions, were to be used for the purpose of acquiring such assets), pension-related changes other than net periodic pension costs, change in the fair value of derivatives that qualify for hedge accounting, and other items that are required by generally accepted accounting principles to be reported separately.

(u) Income Taxes

The Corporation and most of its subsidiaries are not-for-profit corporations formed under the laws of the State of Maryland, organized for charitable purposes and recognized by the Internal Revenue Service as tax-exempt organizations under Section 501(c)(3) of the Internal Revenue Code pursuant to Section 501(a) of the Code. The effect of the taxable status of its for-profit subsidiaries is not material to the consolidated financial statements.

The Corporation has net operating loss carryforwards on for-profit and unrelated business activities of approximately $59,189,000 and $51,888,000 as of June 30, 2017 and June 30, 2016, respectively, which expire at various dates through 2031. The Corporation’s remaining deferred tax assets, which consist primarily of the net operating loss carryforwards, of approximately $23,676,000 at June 30, 2017 and $20,755,000 at June 30, 2016 are fully reserved as they are not expected to be utilized. The Corporation has a deferred tax liability in the amount of $17,356,000 and $17,361,000 related to indefinite-lived intangibles at June 30, 2017 and June 30, 2016, respectively, which is included in other long-term liabilities on the accompanying consolidated balance sheets.

The Corporation follows a threshold of more likely than not for recognition and derecognition of tax positions taken or expected to be taken in a tax return. Management does not believe that there are any unrecognized tax benefits that should be recognized.

(v) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Corporation are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the promise becomes unconditional. Contributions are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction is satisfied, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets released from restrictions. Such amounts are classified as other revenue or transfers and additions to property and equipment.

Contributions to be received after one year are discounted at an appropriate discount rate commensurate with the risks involved. An allowance for uncollectible contributions receivable is provided based upon management's judgment including such factors as prior collection history, type of contributions, and nature of fund-raising activity.

The Corporation follows accounting guidance for classifying the net assets associated with donor-restricted endowment funds held by organizations that are subject to an enacted version of the Uniform Prudent Management Institutional Funds Act of 2006 (UPMIFA).

(w) Fair Value Measurements

The following methods and assumptions were used by the Corporation in estimating the fair value of its financial instruments:

Cash and cash equivalents, accounts receivable, assets limited as to use, investments, trade accounts payable, accrued payroll and benefits, other accrued expenses, and advances from third-party payors – The carrying amounts reported in the consolidated balance sheets approximate the related fair values.

Pension plan assets – The Corporation applies Accounting Standards Update (ASU) No. 2009-12, *Fair Value Measurements and Disclosures (Topic 820): Investments in Certain Entities That Calculate Net Asset per Share (or Its Equivalent)*, to its pension plan assets. The guidance permits, as a practical expedient, fair value of investments within its scope to be estimated using the net asset value (NAV) or its equivalent. The alternative investments classified within of the fair value hierarchy have been recorded using the (NAV).

The Corporation discloses its financial assets, financial liabilities, and fair value measurements of nonfinancial items according to the fair value hierarchy required by GAAP that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted market prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted market prices (unadjusted) in active markets for identical assets or liabilities that the Corporation has the ability to access at the measurement date.

- Level 2 inputs are inputs other than quoted market prices including within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.
- Level 3 inputs are unobservable inputs for the asset or liability.

Assets and liabilities classified as Level 1 are valued using unadjusted quoted market prices for identical assets or liabilities in active markets. The Corporation uses techniques consistent with the market approach and the income approach for measuring fair value of its Level 2 and Level 3 assets and liabilities. The market approach is a valuation technique that uses prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities. The income approach generally converts future amounts (cash flows or earnings) to a single present value amount (discounted).

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

As of June 30, 2017 and 2016, the Level 2 assets and liabilities listed in the fair value hierarchy tables below utilize the following valuation techniques and inputs:

(i) Cash Equivalents

The fair value of investments in cash equivalent securities, with maturities within three months of the date of purchase, is determined using techniques that are consistent with the market approach. Significant observable inputs include reported trades and observable broker-dealer quotes.

(ii) U.S. Government and Agency Securities

The fair value of investments in U.S. government, state, and municipal obligations is primarily determined using techniques consistent with the income approach. Significant observable inputs to the income approach include data points for benchmark constant maturity curves and spreads.

(iii) Corporate Bonds

The fair value of investments in U.S. and international corporate bonds, including commingled funds that invest primarily in such bonds and foreign government bonds, is primarily determined using techniques that are consistent with the market approach. Significant observable inputs include benchmark yields, reported trades, observable broker-dealer quotes, issuer spreads, and security specific characteristics, such as early redemption options.

(iv) Collateralized Corporate Obligations

The fair value of collateralized corporate obligations is primarily determined using techniques consistent with the income approach, such as a discounted cash flow model. Significant observable inputs include prepayment speeds and spreads, benchmark yield curves, volatility measures, and quotes.

(v) Derivative Liabilities

The fair value of derivative contracts is primarily determined using techniques consistent with the market approach. Derivative contracts include interest rate, credit default, and total return swaps. Significant observable inputs to valuation models include interest rates, treasury yields, volatilities, credit spreads, maturity, and recovery rates.

(x) Commitments and Contingencies

Liabilities for loss contingencies arising from claims, assessments, litigation, fines, penalties, and other sources are recorded when it is probable that a liability has been incurred and the amount can be reasonably estimated. Legal costs incurred in connection with loss contingencies are expensed as incurred.

(y) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(z) New Accounting Pronouncements

The Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. This ASU establishes principles for reporting useful information to users of financial statements about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers. The ASU requires that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. ASU No. 2014-09 is effective for fiscal year 2019. The Corporation expects to record a decrease in net patient service revenue related to self-pay patients and a corresponding decrease in bad debt expense upon the adoption of the standard.

The FASB issued ASU No. 2015-03, *Interest – Imputation of Interest*. This ASU requires that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. The recognition and measurement guidance for debt issuance costs are not affected by the amendments in this ASU. ASU No. 2015-03 is effective for fiscal year 2017. The Corporation adopted ASU No. 2015-03 for fiscal year 2017 and the change has been applied retrospectively to July 1, 2015, which resulted in a decrease in assets and liabilities of $8,451,000 and $9,531,000, respectively, for the years ended June 30, 2017 and 2016.

The FASB issued ASU No. 2015-07, *Fair Value Measurement (Topic 820) Disclosures for Investments in Certain Entities that Calculate Net Asset Value per Share*. This ASU removes the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using the NAV per share practical expedient. The amendments also remove the requirement to make certain disclosures for all investments that are eligible to be measured at fair value using the NAV per share practical expedient. Rather, those disclosures are limited to investments for which the entity has elected to measure the fair value using that practical expedient. The Corporation adopted ASU No. 2015-07 for fiscal year 2017. This change has been applied retrospectively to July 1, 2015 and was a disclosure only impact. There was no impact on the consolidated balance sheets, consolidated statements of operations, or consolidated statements of changes in net assets.

The FASB issued ASU No. 2016-02, *Leases (Topic 842)*, which will require lessees to recognize most leases on balance sheet, increasing their reported assets and liabilities – sometimes very significantly. This update was developed to provide financial statement users with more information about an entity's leasing activities, and will require changes in processes and internal controls. The adoption of ASU No. 2016-02 is effective fiscal year 2020, and will require application of the new guidance at the beginning of the earliest comparable period presented. Early adoption is permitted. The Corporation is in the process of assessing the impact the adoption of this standard will have on the consolidated financial statements.

The FASB issued ASU No. 2016-14, *Not-for-Profit Entities (Topic 958)*, to improve the current net asset classification requirements and information presented in financial statements and notes about a not-for-profit entity's liquidity, financial performance, and cash flows. This update requires not-for-profit entities to present two classes of net assets (net assets with donor restrictions and net assets without donor restrictions), rather than the three classes of net assets currently required, and other qualitative information regarding the entity's liquidity, financial performance, and cash flows. The amendments in this update are effective for annual financial statements issued for fiscal years beginning after December 15, 2017 and for interim periods within fiscal years beginning after December 15, 2018. Early adoption is permitted. The Corporation is in the process of assessing the impact the adoption of this standard will have on the consolidated financial statements.

The FASB issued ASU No. 2014-15, *Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern (Topic 205-40)*. This ASU establishes the requirement for management to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the entity's ability to continue as a going concern within one year after the date that the financial statements are issued. Management's evaluation should be based on relevant conditions and events that are known and reasonably knowable at the date that the financial statements are issued. The Corporation adopted ASU No. 2014-15 for fiscal year 2017. Management performed an evaluation as required in this amendment and determined there are no conditions or events that raise substantial doubt about the Corporation's ability to continue as a going concern.

The FASB issued ASU No. 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. The amendments in this ASU require that an employer report the service cost component in the same line item or items as other compensation costs arising from services rendered by the pertinent employees during the period. The other components of net benefit cost as defined in paragraphs 715-30-35-4 and 715-60-35-9 are required to be presented in the income statement separately from the service cost component and outside a subtotal of income from operations, if one is presented. The amendments also allow only the service cost component to be eligible for capitalization when applicable (e.g., as a cost of internally manufactured inventory or a self-constructed asset). ASU No. 2017-07 is effective for fiscal year 2020. This ASU requires retrospective application to all prior periods presented. The Corporation does not anticipate that the adoption of this ASU will have a material impact on its financial position and results of operations.

(2) Investments and Assets Limited as to Use

The carrying values of Assets Limited as to Use were as follows at June 30 (in thousands):

	2017	2016
Investments held for collateral	$ 122,646	177,998
Debt service and reserve funds	54,411	66,712
Construction funds – held by the Corporation	107,490	41,986
Board designated funds	109,466	117,502
Self-insurance trust funds	180,220	154,327
Funds restricted by donors	60,751	55,181
Economic and beneficial interests in the net assets of related organizations (note 12)	192,343	187,885
Total Assets Limited as to Use	827,327	801,591
Less amounts available for current liabilities	(50,940)	(51,412)
Total Assets Limited as to Use, less current portion	$ 776,387	750,179

(Continued)

The carrying values of Assets Limited as to Use were as follows at June 30, 2017 (in thousands):

	Investments held for collateral	Debt service and reserve funds	Construction funds	Board designated funds	Self-insurance trust funds	Funds restricted by donors	Economic and beneficial interests	Total
Cash and cash equivalents	$ 4,958	31,624	97,562	10,154	12,991	7,850	—	165,139
Corporate bonds	—	—	633	13,334	2,883	6,483	—	23,333
Collateralized corporate obligations	—	—	220	109	—	258	—	587
U.S. government and agency securities	117,688	22,787	283	140	283	331	—	141,512
Common stocks, including mutual funds	—	—	2,479	49,225	—	23,409	—	75,113
Alternative investments	—	—	6,313	36,504	—	22,420	—	65,237
Assets held by other organizations	—	—	—	—	164,063	—	192,343	356,406
Total Assets Limited as to Use	$ 122,646	54,411	107,490	109,466	180,220	60,751	192,343	827,327

The carrying values of Assets Limited as to Use were as follows at June 30, 2016 (in thousands):

	Investments held for collateral	Debt service and reserve funds	Construction funds	Board designated funds	Self-insurance trust funds	Funds restricted by donors	Economic and beneficial interests	Total
Cash and cash equivalents	$ 52,568	41,826	32,385	16,656	11,178	7,567	—	162,180
Corporate bonds	—	—	680	18,212	2,904	6,690	—	28,486
Collateralized corporate obligations	—	—	91	45	—	153	—	289
U.S. government and agency securities	125,430	24,886	268	133	204	449	—	151,370
Common stocks, including mutual funds	—	—	2,513	46,114	—	16,601	—	65,228
Alternative investments	—	—	6,049	36,342	—	23,721	—	66,112
Assets held by other organizations	—	—	—	—	140,041	—	187,885	327,926
Total Assets Limited as to Use	$ 177,998	66,712	41,986	117,502	154,327	55,181	187,885	801,591

Self-insurance trust funds include amounts held by the Maryland Medicine Comprehensive Insurance Program (MMCIP) for payment of malpractice claims. These assets consist primarily of stocks, fixed-income corporate obligations, and alternative investments. MMCIP is a funding mechanism for the Corporation's malpractice insurance program. As MMCIP is not an insurance provider, transactions with MMCIP are recorded under the deposit method of accounting. Accordingly, the Corporation accounts for its participation in MMCIP by carrying limited-use assets representing the amount of funds contributed to MMCIP and recording a liability for claims, which is included in other current and other long-term liabilities in the accompanying consolidated balance sheets.

(Continued)

The carrying values of investments were as follows at June 30 (in thousands):

	2017	2016
Cash and cash equivalents	$ 37,160	42,382
Corporate bonds	52,440	52,175
Collateralized corporate obligations	14,573	5,567
U.S. government and agency securities	22,195	19,274
Common stocks	181,117	158,936
Alternative investments:		
Hedge funds/private equity	110,830	56,400
Commingled funds	324,634	310,800
	$ 742,949	645,534

Alternative investments include hedge fund, private equity, and commingled investment funds, which are valued using the equity method of accounting. As of June 30, 2017, the majority of these alternative investments are subject to 30 day or less notice requirements and are available to be redeemed on at least a monthly basis. There are funds, totaling approximately $52,500,000, which are subject to 31-60 day notice requirements and can be redeemed monthly, quarterly, or annually. Other funds, totaling approximately $62,000,000, are subject to over 60-day notice requirements and can be redeemed monthly, quarterly, or annually. Of the funds with over 60-day notice requirements, approximately $13,500,000 are subject to lockup restrictions and are not available to be redeemed until certain time restrictions are met, which range from one to three years. In addition, there are approximately $6,200,000 of other funds that are subject to lockup restrictions and are not available to be redeemed until certain time restrictions are met, which range from one to three years. The Corporation had $2,990,000 of unfunded commitments in alternative investments as of June 30, 2017.

As of June 30, 2016, the majority of these alternative investments are subject to 30 day or less notice requirements and are available to be redeemed on at least a monthly basis. There are funds, totaling approximately $6,000,000, which are subject to 31-60 day notice requirements and can be redeemed on at least a monthly basis. Of the funds with 31-60 day notice requirements, approximately $3,700,000 are subject to lockup restrictions and are not available to be redeemed until certain time restrictions are met, which range from one to three years. Other funds, totaling approximately $80,700,000, are subject to over 60-day notice requirements and can be redeemed monthly, quarterly, or annually. Of the funds with over 60-day notice requirements, approximately $17,700,000 are subject to lockup restrictions and are not available to be redeemed until certain time restrictions are met, which range from one to three years. In addition, there are approximately $9,200,000 of other funds that are subject to lockup restrictions and are not available to be redeemed until certain time restrictions are met, which range from one to three years. The Corporation had $4,077,000 of unfunded commitments in alternative investments as of June 30, 2016.

(Continued)

The following table presents investments and assets limited as to use that are measured at fair value on a recurring basis excluding alternative investments in the amount of $435,464 and $65,237, respectively, which are accounted for under the equity method at June 30, 2017 (in thousands):

	Level 1	Level 2	Level 3	Total
Assets:				
Investments:				
Cash and cash equivalents	$ 37,160	—	—	37,160
Corporate bonds	31,421	21,019	—	52,440
Collateralized corporate obligations	—	14,573	—	14,573
U.S. government and agency securities	10,610	11,585	—	22,195
Common and preferred stocks, including mutual funds	180,999	118	—	181,117
	260,190	47,295	—	307,485
Assets limited as to use:				
Cash and cash equivalents	133,678	31,461	—	165,139
Corporate bonds	19,786	3,547	—	23,333
Collateralized corporate obligations	—	587	—	587
U.S. government and agency securities	118,127	23,385	—	141,512
Common and preferred stocks, including mutual funds	75,113	—	—	75,113
Investments held by other organizations	—	356,406	—	356,406
	346,704	415,386	—	762,090
	$ 606,894	462,681	—	1,069,575

(Continued)

The following table presents investments and assets limited as to use that are measured at fair value on a recurring basis excluding alternative investments in the amount of $367,200 and $66,112, respectively, which are accounted for under the equity method at June 30, 2016 (in thousands):

	Level 1	Level 2	Level 3	Total
Assets:				
Investments:				
Cash and cash equivalents	$ 42,382	—	—	42,382
Corporate bonds	39,215	12,960	—	52,175
Collateralized corporate obligations	—	5,567	—	5,567
U.S. government and agency securities	8,879	10,395	—	19,274
Common and preferred stocks, including mutual funds	158,817	119	—	158,936
	249,293	29,041	—	278,334
Assets limited as to use:				
Cash and cash equivalents	120,371	41,809	—	162,180
Corporate bonds	25,137	3,349	—	28,486
Collateralized corporate obligations	—	289	—	289
U.S. government and agency securities	125,922	25,448	—	151,370
Common and preferred stocks, including mutual funds	65,228	—	—	65,228
Investments held by other organizations	—	327,926	—	327,926
	336,658	398,821	—	735,479
	$ 585,951	427,862	—	1,013,813

Changes to Level 1 and Level 2 securities between June 30, 2017 and 2016 were the result of strategic investments and reinvestments, interest income earnings, and changes in the fair value of investments.

(Continued)

The Corporation's total return on its investments and assets limited as to use was as follows for the years ended June 30 (in thousands):

		2017	2016
Dividends and interest, net of fees	$	10,772	11,694
Net realized gains		26,827	11,559
Change in fair value of trading securities		57,080	(39,605)
Total investment return	$	94,679	(16,352)

Total investment return (loss) is classified in the consolidated statements of operations as follows for the years ended June 30 (in thousands):

		2017	2016
Nonoperating investment income	$	35,496	21,111
Change in fair value of unrestricted investments		54,175	(36,443)
Investment gains on restricted net assets		5,008	(1,020)
Total investment return (loss)	$	94,679	(16,352)

Investment return does not include the returns on the economic interests in the net assets of related organizations, the returns on the self-insurance trust funds, returns on undesignated interest rates swaps, or the returns on certain construction funds where amounts have been capitalized.

(3) Property and Equipment

The following is a summary of property and equipment at June 30 (in thousands):

		2017	2016
Land	$	148,905	142,256
Buildings		1,480,610	1,465,218
Building and leasehold improvements		808,738	775,638
Equipment		1,485,195	1,596,086
Construction in progress		132,740	119,031
		4,056,188	4,098,229
Less accumulated depreciation and amortization		(1,964,085)	(2,011,683)
	$	2,092,103	2,086,546

Interest cost capitalized was $0 for both years ended June 30, 2017 and 2016.

(Continued)

Remaining commitments on construction projects were approximately $59,735,000 at June 30, 2017.

Construction in progress includes building and renovation costs for assets that have not yet been placed into service. These costs relate to major construction projects as well as routine renovations under way at the Corporation's facilities.

(4) Investments in Joint Ventures

The Corporation has investments of $82,094,000 and $71,906,000 at June 30, 2017 and 2016, respectively, in the following unconsolidated joint ventures:

Joint venture	Business purpose	Ownership percentage FY 2017	Ownership percentage FY 2016
Shipley's Imaging Center, LLC	Freestanding imaging center	50 %	50 %
Maryland Care, Inc.	Managed care organization	(a)	(a)
Innovative Health Services, LLC	Third-party insurance claims processor	50	50
Terrapin Insurance Company (Terrapin)	Healthcare professional liability insurance company	50	50
Mt. Washington Pediatric Hospital, Inc. (Mt. Washington)	Healthcare services	50	50
Central Maryland Radiation Oncology Center LLC	Healthcare services	50	50
University of Maryland Medicine ASC, LLC	Ambulatory surgical services	50	—
Chesapeake-Potomac Healthcare Alliance	Healthcare services	33	33
Civista Ambulatory Surgery Center, Inc.	Ambulatory surgical services	50	50
NRH/CPT/St. Mary's/Civista Regional Rehab, LLC	Medical rehabilitative and therapy services	15	15
UM SJMC Choice One Urgent Care Centers	Urgent care centers	25	25
UM UCHS Choice One Urgent Care Centers	Urgent care centers	49	49
UM SRH Choice One Urgent Care Centers	Urgent care centers	49	49

(Continued)

Joint venture	Business purpose	Ownership percentage FY 2017	Ownership percentage FY 2016
Maryland eCare, LLC	Remote monitoring technology	14 %	14 %
MRI at St. Joseph Medical Center, LLC	Healthcare services	51	51
Advanced/Upper Chesapeake Health Center, LLC	Imaging center	10	10

(a) UMMS sold its 20% ownership interest during August 2015.

The Corporation recorded equity in net income (losses) of $3,856,000 and $(298,000) related to these joint ventures for the years ended June 30, 2017 and 2016, respectively.

The following is a summary of the Corporation's joint ventures' combined unaudited condensed financial information as of and for the years ended June 30 (in thousands):

	2017				
	Mt. Washington	Terrapin	Choice One*	Others	Total
Current assets	$ 26,025	24,240	3,470	21,646	75,381
Noncurrent assets	92,483	221,844	5,525	17,925	337,777
Total assets	$ 118,508	246,084	8,995	39,571	413,158
Current liabilities	$ 13,273	106	420	5,276	19,075
Noncurrent liabilities	8,255	244,028	183	1,033	253,499
Net assets	96,980	1,950	8,392	33,262	140,584
Total liabilities and net assets	$ 118,508	246,084	8,995	39,571	413,158
Total operating revenue	$ 58,271	(5,670)	5,702	47,439	105,742
Total operating expenses	(54,822)	(5,456)	(7,313)	(43,496)	(111,087)
Total nonoperating gains/(losses), net	4,722	11,126	—	11	15,859
Contributions from (to) owners	—	—	7,116	(65)	7,051
Other changes in net assets, net	3,326	—	344	(1,070)	2,600
Increase (decrease) in net assets	$ 11,497	—	5,849	2,819	20,165

* Choice One is the combination of UM SJMC, UM UCHS, and UM SRH Choice One Urgent Care Centers

(Continued)

	2016				
	Mt. Washington	Terrapin	Choice One*	Others	Total
Current assets	$ 24,976	9,513	2,759	19,184	56,432
Noncurrent assets	83,436	199,572	3,620	16,121	302,749
Total assets	$ 108,412	209,085	6,379	35,305	359,181
Current liabilities	$ 14,437	105	448	4,947	19,937
Noncurrent liabilities	8,492	207,030	32	972	216,526
Net assets	85,483	1,950	5,899	29,386	122,718
Total liabilities and net assets	$ 108,412	209,085	6,379	35,305	359,181
Total operating revenue	$ 56,811	34,150	2,659	57,925	151,545
Total operating expenses	(53,853)	(31,515)	(3,137)	(52,071)	(140,576)
Total nonoperating gains (losses), net	455	(2,635)	(6)	(5,560)	(7,746)
Contributions from (to) owners	—	—	1,365	(3,971)	(2,606)
Other changes in net assets, net	(1,516)	—	5,018	(1,552)	1,950
Increase (decrease) in net assets	$ 1,897	—	5,899	(5,229)	2,567

* Choice One is the combination of UM SJMC, UM UCHS, and UM SRH Choice One Urgent Care Centers

(5) Leases

The Corporation rents various equipment and facility space. Rent expense under these operating leases for the years ended June 30, 2017 and 2016 was approximately $25,215,000 and $24,594,000, respectively.

Future noncancelable minimum lease payments under operating leases are as follows for the years ending June 30 (in thousands):

2018	$ 12,080
2019	11,707
2020	8,475
2021	5,427
2022	4,396
Thereafter	12,460
	$ 54,545

(Continued)

The Corporation rents property used for administration under a 99-year lease. The lease was recorded as a capital lease, and the Corporation recorded assets at their respective fair values of $3,770,000 and $29,230,000 for land and buildings, respectively. The lease includes an option for the Corporation to purchase the property during the period from April 20, 2017 to February 28, 2021 for a purchase price of not less than $37,000,000 but not more than $45,000,000, as determined by appraisals. In addition, the lease agreement includes a put option exercisable through February 28, 2021, whereby the lessor may require the Corporation to purchase the building for $37,000,000. As of June 30, 2017 and 2016, amounts of $37,198,000 and $36,744,000, respectively, representing obligations under the lease have been recorded in other current liabilities.

As of June 30, 2017, amounts of $2,434,000 and $14,891,000 representing obligations under all other capital leases are included in other current liabilities and other long-term liabilities, respectively.

The following is a summary of all property and equipment under capital leases at June 30 (in thousands):

	2017	2016
Land	$ 3,770	3,770
Buildings	29,230	29,230
Equipment	25,176	23,899
	58,176	56,899
Less accumulated amortization	(18,129)	(12,338)
	$ 40,047	44,561

Future minimum lease payments under capital leases, together with the present value of the net minimum lease payments, are as follows as of June 30, 2017 (in thousands):

2018	$ 42,153
2019	2,460
2020	2,318
2021	1,187
2022	860
Thereafter	13,379
Total minimum lease payments	62,357
Less amounts representing interest	(7,834)
Present value of net minimum lease payments	$ 54,523

(Continued)

(6) Lines of Credit

Lines of credit outstanding are as follows as of the years ended June 30 (in thousands):

2017					
Line number	Interest rate calculation	Interest rate as of June 30, 2017	Date of expiration	Total available	Outstanding amount
1	1-month LIBOR + 0.70%	1.78 %	8/30/2017*	$ 250,000	125,000

* Date of expiration has since been extended to 8/31/2018

2016					
Line number	Interest rate calculation	Interest rate as of June 30, 2016	Date of expiration	Total available	Outstanding amount
1	1-month LIBOR + 2.20%	2.30 %	Annually renewing	$ 75,000	75,000
2	1, 2 or 3 month LIBOR + 0.75%	3.50	10/3/2016	20,000	20,000
3	1-month LIBOR + 0.75%	1.24	12/31/2016	60,000	60,000
4	1-month LIBOR + 0.85%	1.27	3/28/2017	25,000	25,000
	Total lines of credit			$ 180,000	180,000

(Continued)

(7) Long-Term Debt and Other Borrowings

Long-term debt consists of the following at June 30 (in thousands):

	Interest rate	Payable in fiscal year(s)	2017	2016
MHHEFA project revenue bonds:				
Corporation issue, payments due annually on July 1:				
Series 2017B/C Bonds	1.20%–5.00%	2018–2040	$ 273,810	—
Series 2017A Bonds	Variable rate	2017–2043[1]	46,220	—
Series 2016A-F Bonds	Variable rate	2017–2042[1]	321,515	—
Series 2015 Bonds	2.00%–5.00%	2016–2042	77,735	79,010
Series 2013 Bonds	2.00%–5.00%	2014–2044	346,850	350,300
Series 2012A-D Bonds	Variable rate	2014–2042	—	213,200
Series 2010 Bonds	2.00%–5.25%	2011–2040	62,835	209,675
Series 2008D/E Bonds	Variable rate	2025–2042	105,000	105,000
Series 2008F Bonds	4.00%–5.25%	2009–2024	40,415	46,360
Series 2007A Bonds	Variable rate	2008–2035	85,095	87,750
Series 2005 Bonds	4.00%–5.50%	2006–2032	—	119,675
Series 1991B Bonds	7.00 %	1992–2023	—	21,840
Upper Chesapeake issue, payments due annually January 1:				
Series 2011B/C Bonds	Variable rate	2013–2040	—	108,929
Series 2011A Bonds	3.67 %	2012–2043	—	47,090
MHHEFA Pooled Loan Program	Variable rate	2017–2035	8,022	—
Other long-term debt:				
UCHS Term Loan	Variable rate	2019	150,000	150,000
Term loans	1.86%–3.95%	2009–2022	56,540	60,018
Other loans, mortgages and notes payable	3.05%–7.00%	Monthly, 1991–2025	21,099	21,519
Total debt			1,595,136	1,620,366
Less current portion of long-term debt			40,937	37,592
Less short-term financing			—	150,000
Less long-term debt subject to short-term remarketing agreements			28,440	32,515
			1,525,759	1,400,259
Plus unamortized premiums and discounts, net			33,033	31,628
Plus unamortized deferred financing costs			(8,302)	(9,283)
			$ 1,550,490	1,422,604

(Continued)

[1] Mandatory purchase options are due in the following (fiscal years), unless the bank and the Obligated Group agree to an extension: Series 2016A (2024), 2016B (2022), 2016C&D (2024), 2016E&F (2027), and 2017A (2022).

Pursuant to an Amended and Restated Master Loan Agreement dated February 1, 2017 (UMMS Master Loan Agreement), the Corporation and several of its subsidiaries have issued debt through MHHEFA. As security for the performance of the bond obligation under the Master Loan Agreement, the Authority maintains a security interest in the revenue of the obligors. The UMMS Master Loan Agreement contains certain restrictive covenants. These covenants require that rates and charges be set at certain levels, limit incurrence of additional debt, require compliance with certain operating ratios and restrict the disposition of assets.

The Obligated Group under the UMMS Master Loan Agreement includes the Medical Center, ROI, UM Midtown, UM Baltimore Washington, Shore Health (UM Memorial and UM Dorchester), UM Chester River, UM Charles Regional, UM St. Joseph, UM Upper Chesapeake, UM Harford Memorial, and the UMMS Foundation. Each member of the Obligated Group is jointly and severally liable for the repayment of the obligations under the UMMS Master Loan Agreement.

Under the terms of the UMMS Master Loan Agreement and other loan agreements, certain funds are required to be maintained on deposit with the Master Trustee to provide for repayment of the obligations of the Obligated Group (note 2).

In September 2016, the Corporation refunded $212,065,000 of the Series 2012A-D Bonds. The refunding was completed using the proceeds of a new $212,785,000 variable-rate MHHEFA bond issue (the Series 2016A-D Bonds).

In October 2016, the Corporation refunded $108,420,000 of the Series 2011B/C (UCHS issue) Bonds. The refunding was completed using the proceeds of a new $108,730,000 variable rate MHHEFA bond issue (the Series 2016E/F Bonds).

In January 2017, the Corporation refunded $46,050,000 of the Series 2011A (UCHS issue) Bonds. The refunding was completed using the proceeds of a new $46,220,000 variable-rate MHHEFA bond issue (the Series 2017A Bonds).

In February 2017, the Corporation refunded $20,225,000 of the Series 1991B Bonds, $116,375,000 of the Series 2005 Bonds, and $140,885,000 of the Series 2010 Bonds. The refunding was completed using the proceeds of a new $273,810,000 fixed-rate MHHEFA bond issue (the Series 2017B/C Bonds).

The unamortized portion of issuance costs on the debt refunded by the Series 2016A-D Bonds, 2016E/F Bonds, 2017A Bonds, and 2017B/C Bonds was expensed as a loss on early extinguishment of debt during the year ended June 30, 2017.

The Corporation has a term loan in the amount of $150,000,000 related to the acquisition of Upper Chesapeake, which expires on March 1, 2019. The Corporation intends to refinance this obligation prior to its maturity date, and has classified this obligation as a long-term debt and short-term financing at June 30, 2017 and 2016, respectively, in the consolidated balance sheets.

(Continued)

In May 2017, the Corporation was authorized to borrow $19,000,000 of the Series 1985A/B Pooled Loan Program Bonds ($175,000,000 original MHHEFA Pooled Loan Program). These proceeds are to be used for the purchase, renovation and furnishing a new administrative building. As a participant in the Pooled Loan Program, the Corporation bears the full interest cost on the $19,000,000 and will draw-down on the funds as they are required to complete the project.

The payment of principal and interest on the Corporation's issue Series 1991B Bonds and its Series 2005 Bonds are each insured under a financial guaranty insurance policy. These policies insure the payment of principal, sinking fund installments, and interest on the corresponding bonds. The insurance policies require the Obligated Group to adhere to the same covenants as those in the UMMS Master Loan Agreement.

The aggregate annual future maturities of long-term debt according to the original terms of the Master Loan Agreement and all other loan agreements are as follows for the years ending June 30 (in thousands):

2018	$	40,937
2019		203,656
2020		43,579
2021		66,230
2022		47,604
Thereafter		1,193,130
	$	1,595,136

The Corporation's Series 2007A and 2008D-E Bonds are variable rate demand bonds requiring remarketing agents to purchase and remarket any bonds tendered before the stated maturity date. The reimbursement obligations with respect to the letters of credit are evidenced and secured by the respective bonds. To provide liquidity support for the timely payment of any bonds that are not successfully remarketed, the Corporation has entered into letter of credit agreements with three banking institutions. These agreements have terms that expire in 2020 through 2022. If the bonds are not successfully remarketed, the Corporation is required to pay an interest rate specified in the letter of credit agreement, and the principal repayment of bonds may be accelerated to require repayment in periods ranging from 20 to 60 months from the date of the failed remarketing. The Corporation has reflected the amount of its long-term debt that is subject to these short-term remarketing arrangements as a separate component of current liabilities in its consolidated balance sheets. In the event that bonds are not remarketed, the Corporation maintains available letters of credit and has the ability to access other sources to obtain the necessary liquidity to comply with accelerated repayment terms. All variable rate demand bonds were successfully remarketed as of June 30, 2017.

(Continued)

The following table reflects the mandatory redemptions and required repayment terms for the years ended June 30 (in thousands) of the Corporation's debt obligations in the event that the put options associated with variable rate demand bonds subject to short-term remarketing agreements were exercised, but not successfully remarketed, and mandatory purchase options are not extended:

2018	$	69,377
2019		276,250
2020		79,876
2021		66,230
2022		188,279
Thereafter		915,124
	$	1,595,136

The approximate interest rates on outstanding debt bearing interest at variable rates were as follows at June 30:

	2017	2016
Series 2011B Bonds – UCHS Issue	— %	1.51 %
Series 2011C Bonds – UCHS Issue	—	1.19
Series 2008D Bonds	0.90	0.38
Series 2008E Bonds	0.89	0.41
Series 2007A Bonds	0.91	0.46
Series 2012A Bonds	—	1.37
Series 2012B Bonds	—	1.07
Series 2012C Bonds	—	1.39
Series 2012D Bonds	—	1.31
Series 2016A Bonds	1.41	—
Series 2016B Bonds	1.27	—
Series 2016C Bonds	1.32	—
Series 2016D Bonds	1.52	—
Series 2016E Bonds	1.43	—
Series 2016F Bonds	1.41	—
Series 2017A Bonds	1.23	—
Series 1985 Pooled Loan Program (MHHEFA)	1.69	—
UCHS Term Loan	1.98	1.31

(Continued)

Term loans outstanding are as follows at June 30 (in thousands):

	Interest rate	Interest rate as of June 30, 2017	Payable in fiscal year(s)	2017	2016
Term loan 1:					
Payable monthly beginning March 2012	Fixed rate	3.95 %	2012–2022	$ 7,600	8,400
Term loan 2:					
Payable monthly beginning January 2012	Fixed rate	—	2012–2017	—	142
Term loan 3:					
Payable monthly beginning April 2012	Fixed rate	—	2012–2017	—	196
Term loan 4:					
Payable monthly beginning February 2010	1-month LIBOR + 2.00%	3.22 %	2010–2018	2,831	3,056
Term loan 5:					
Payable monthly beginning October 2012	Fixed rate	2.80 %	2013–2018	61	228
Term loan 6:					
Payable monthly beginning November 2012	Fixed rate	2.80 %	2013–2018	16	52
Term loan 7:					
Payable monthly beginning November 2015	1-month LIBOR + 1.95%	3.17 %	2016–2021	41,667	46,667
Term loan 8:					
Payable monthly beginning May 2016	Fixed rate	1.86 %	2016–2019	834	1,277
Term loan 9:					
Payable monthly beginning February 2017	Fixed rate	2.47 %	2017–2020	1,524	—
Term loan 10:					
Payable monthly beginning July 2017	Fixed rate	2.66 %	2018–2020	2,007	—
Total term loans (included in long-term debt)				$ 56,540	60,018

(8) Interest Rate Risk Management

The Corporation uses a combination of fixed and variable rate debt to finance capital needs. The Corporation maintains an interest rate risk-management strategy that uses interest rate swaps to minimize significant, unanticipated earnings fluctuations that may arise from volatility in interest rates.

(Continued)

At June 30, 2017 and 2016, the Corporation's notional values of outstanding interest rate swaps were $770,919,000 and $782,455,000, respectively, the details of which were as follows (in thousands):

	Notional amount	Pay rate	Receive rate	Maturity date	Mark to market
As of June 30, 2017:					
Swap #1	$ 85,809	3.59 %	70% 1-month LIBOR	7/1/2031	$ (13,430)
Swap #2	84,000	3.93	68% 1-month LIBOR	7/1/2014	(30,029)
Swap #3	21,000	4.24	68% 1-month LIBOR	7/1/2041	(8,573)
Swap #4	35,400	3.99	67% 1-month LIBOR	7/1/2034	(7,729)
Swap #5	26,680	3.54	70% 1-month LIBOR	7/1/2031	(4,066)
Swap #6	196,000	3.93	68% 1-month LIBOR	7/1/2041	(70,082)
Swap #7	49,000	4.24	68% 1-month LIBOR	7/1/2041	(20,006)
Swap #8	82,600	4.00	67% 1-month LIBOR	7/1/2034	(18,097)
Swap #9	3,580	3.63	67% 1-month LIBOR	7/1/2032	(376)
Swap #10	104,000	3.92	67% 1-month LIBOR	1/1/2043	(28,384)
Swap #11	82,850	0.51	67% 1-month LIBOR + 0.5133%	1/1/2038	1,058
					(199,714)
				Valuation adjustments	5,190
Total	$ 770,919				$ (194,524)

(Continued)

	Notional amount	Pay rate	Receive rate	Maturity date	Mark to market
As of June 30, 2016:					
Swap #1	$ 88,090	3.59 %	70% 1-month LIBOR	7/1/2031	$ (20,115)
Swap #2	84,000	3.93	68% 1-month LIBOR	7/1/2014	(41,582)
Swap #3	21,000	4.24	68% 1-month LIBOR	7/1/2041	(11,603)
Swap #4	36,425	3.99	67% 1-month LIBOR	7/1/2034	(10,921)
Swap #5	27,400	3.54	70% 1-month LIBOR	7/1/2031	(6,128)
Swap #6	196,000	3.93	68% 1-month LIBOR	7/1/2041	(97,040)
Swap #7	49,000	4.24	68% 1-month LIBOR	7/1/2041	(27,077)
Swap #8	84,975	4.00	67% 1-month LIBOR	7/1/2034	(25,554)
Swap #9	3,970	3.63	67% 1-month LIBOR	7/1/2032	(590)
Swap #10	106,625	3.92	67% 1-month LIBOR	1/1/2043	(39,754)
Swap #11	84,970	0.51	67% 1-month LIBOR + 0.5133%	1/1/2038	1,803
					(278,561)
				Valuation adjustments	5,524
Total	$ 782,455				$ (273,037)

The mark-to-market values of the Corporation's interest rate swaps include a valuation adjustment representing the creditworthiness of the counterparties to the swaps.

On January 1, 2013, in accordance with ASC 815, *Derivatives and Hedging*, the Corporation elected to discontinue the cash flow hedging relationship for Swap #8. As of that date, the accumulated losses included in unrestricted net assets will be reclassified into earnings over the life of the Series 2007 bonds. For the years ended June 30, 2017 and 2016, $1,716,000 and $1,764,000, respectively, were reclassified from other changes in net assets into change in fair value of undesignated interest rate swaps. The accumulated losses included in unrestricted net assets were $(17,934,000) and $(19,650,000) at June 30, 2017 and 2016, respectively.

The Corporation recorded a net nonoperating gain (loss) on changes in the fair value of nonqualifying interest rate swaps of $76,797,000 and $(78,429,000) for the years ended June 30, 2017 and 2016, respectively.

The swap agreements are included in the consolidated balance sheets at their fair value of $(194,524,000) and $(273,037,000) as of June 30, 2017 and 2016, respectively, an amount that is based on observable inputs other than quoted market prices in active markets for identical liabilities (Level 2 in the fair value hierarchy).

(Continued)

The Corporation is subject to a collateral posting requirement with two of its swap counterparties. Collateral posting requirements are based on the Corporation's long-term debt credit ratings, as well as the net liability position of total interest rate swap agreements outstanding with that counterparty. The amount of such posted collateral was $115,250,000 and $174,661,000 at June 30, 2017 and 2016, respectively. As of June 30, 2017 and 2016, the Corporation met its collateral posting requirement through the use of collateralized investments, which were selected and purchased by the Corporation and subsequently transferred to the custody of the swap counterparty. The amount of posted investments that is required to meet the collateral requirement is computed daily, and is accounted for as a component of the Corporation's assets limited as to use on the accompanying consolidated balance sheets as of that date. Any excess investment value is considered a component of the Corporation's unrestricted investment portfolio, and is included in investments on the accompanying consolidated balance sheets as of that date.

(9) Other Liabilities

Other liabilities consist of the following at June 30 (in thousands):

		2017	2016
Professional and general malpractice liabilities	$	234,569	235,871
Capital lease obligations		54,523	54,881
Accrued pension obligations		26,422	42,761
Contingent consideration		35,700	35,700
Accrued interest payable		18,870	20,659
Deferred tax liability, net		17,356	17,361
Unearned revenue		26,521	11,136
Other miscellaneous		103,001	81,758
Total other liabilities		516,962	500,127
Less current portion		(182,688)	(147,522)
Other long-term liabilities	$	334,274	352,605

Other miscellaneous liabilities primarily consist of medical claims payable and patient credit balance liabilities.

(Continued)

(10) Retirement Plans

Employees of the Corporation are included in various retirement plans established by the Corporation, the Medical Center, ROI, Midtown, Baltimore Washington, Shore Regional, Charles Regional, St. Joseph, and Upper Chesapeake. Participation by employees in their specific plan(s) has evolved based upon the organization by which they were first employed and the elections that they made at the times when their original employers became part of the Corporation. The following is a brief description of each of the retirement plans in which employees of the Corporation participate:

(a) Defined Benefit Plans

University of Maryland Medical Center Midtown Campus Retirement Plan for Non-Union Employees (Midtown Plan) – A noncontributory defined benefit plan covering substantially all nonunion employees. The benefits are based on years of service and compensation. Contributions to this plan are made to satisfy the minimum funding requirements of ERISA. In 2006, Midtown froze the defined benefit pension plan.

Baltimore Washington Medical Center Pension Plan (Baltimore Washington Plan) – A noncontributory defined benefit pension plan covering full-time employees who have been employed for at least one year and have reached 21 years of age.

Baltimore Washington Medical Center Supplemental Executive Retirement Plan – A noncontributory defined benefit pension plan for senior management level employees.

Chester River Health System, Inc. Pension Plan and Trust – A noncontributory defined benefit pension plan covering substantially all CRHC employees as well as employees of a subsidiary. The benefits are paid to retirees based upon age at retirement, years of service, and average compensation. Chester River's funding policy is to satisfy the minimum funding requirements of ERISA. Effective June 30, 2008, Chester River froze the defined-benefit pension plan.

Civista Health Inc. Retirement Plan and Trust (Charles Regional Plan) – A noncontributory defined benefit pension plan covering employees that have worked at least one thousand hours per year during three or more plan years. Plan benefits are accumulated based upon a combination of years of service and percent of annual compensation. Charles Regional makes annual contributions to the plan based upon amounts required to be funded under provisions of ERISA.

Upper Chesapeake Health System, Inc. Pension Plan and Trust – A noncontributory defined benefit pension plan covering substantially all employees of the various affiliates of Upper Chesapeake who have completed six months of employment and attained the age of twenty and a half years. Upper Chesapeake makes annual contributions to the plan equal to the minimum funding requirements pursuant to ERISA regulations. On December 31, 2005, Upper Chesapeake froze the defined benefit pension plan. On June 30, 2015, Upper Chesapeake terminated the defined benefit pension plan and liquidation of its remaining benefit obligation using its plan assets were completed by September 30, 2017. The benefit obligations for the year ended June 30, 2016 represented the annuities to be transferred.

(Continued)

On June 30, 2015, the Corporation amended the Baltimore Washington Medical Center Pension Plan to provide for the merger of the Midtown Plan and the Charles Regional Plan into the Baltimore Washington Plan and to change the name of the newly consolidated plan to the University of Maryland Medical System Corporate Pension Plan (the Corporate Plan). All provisions of the respective previous plans shall continue to apply to the respective applicable participants. All of the assets of the three formerly separate plans are now available to pay benefits for all participants under the newly consolidated Corporate Plan.

The Corporation recognizes the funded status (i.e., the difference between the fair value of plan assets and projected benefit obligations) of its defined benefit pension plans as an asset or liability in its consolidated balance sheets. The Corporation recognizes changes in the funded status in the year in which the changes occur as changes in unrestricted net assets. All defined benefit pension plans use a June 30 measurement date.

The following tables set forth the combined benefit obligations and assets of the defined benefit plans at June 30 (in thousands):

		2017	2016
Change in projected benefit obligations:			
Benefit obligations at beginning of year	$	245,686	259,170
Settlements		(55,324)	(29,962)
Service cost		4,502	4,146
Interest cost		7,299	10,698
Actuarial loss		(4,612)	20,072
Benefit payments		(15,527)	(18,438)
Projected benefit obligations at end of year	$	182,024	245,686

		2017	2016
Change in plan assets:			
Fair value of plan assets at beginning of year	$	202,925	233,689
Actual return on plan assets		12,560	5,688
Settlements		(55,324)	(29,962)
Employer contributions		10,968	11,948
Benefit payments		(15,527)	(18,438)
Fair value of plan assets at end of year	$	155,602	202,925

(Continued)

The funded status of the plans and amounts recognized as accrued payroll and benefits and other long-term liabilities in the consolidated balance sheets at June 30 are as follows (in thousands):

		2017	2016
Funded status, end of period:			
Fair value of plan assets	$	155,602	202,925
Projected benefit obligations		182,024	245,686
Net funded status	$	(26,422)	(42,761)
Accumulated benefit obligation at end of year	$	176,660	239,375
Amounts recognized in consolidated balance sheets at June 30:			
Accrued payroll and benefits	$	1,056	(1,250)
Accrued pension obligation		(27,478)	(41,511)
	$	(26,422)	(42,761)
Amounts recognized in unrestricted net assets at June 30:			
Net actuarial loss	$	(62,233)	(96,423)
Prior service cost		(485)	(648)
	$	(62,718)	(97,071)

The estimated amounts that will be amortized from unrestricted net assets into net periodic pension cost in fiscal year 2018 are as follows (in thousands):

Net actuarial loss	$	4,736
Prior service cost		162
	$	4,898

The components of net periodic pension cost for the years ended June 30 are as follows (in thousands):

		2017	2016
Service cost	$	4,502	4,146
Interest cost		7,299	10,698
Expected return on plan assets		(9,976)	(14,169)
Prior service cost recognized		20,814	67
Recognized gains or losses		6,351	17,743
Net periodic pension cost	$	28,990	18,485

(Continued)

The following table presents the weighted average assumptions used to determine benefit obligations for the plans at June 30:

	2017	2016
Discount rate	2.50%–4.11%	2.00%–3.95%
Rate of compensation increase (for nonfrozen plan)	3.00–4.50	2.50–4.50

The following table presents the weighted average assumptions used to determine net periodic benefit cost for the plans for the years ended June 30:

	2017	2016
Discount rate	2.00%–3.95%	3.00%–4.62%
Expected long-term return on plan assets	6.75	4.75–6.75
Rate of compensation increase (for nonfrozen plan)	2.50–4.50	2.50–4.50

The investment policies of the Corporation's pension plans incorporate asset allocation and investment strategies designed to earn superior returns on plan assets consistent with reasonable and prudent levels of risk. Investments are diversified across classes, sectors, and manager style to minimize the risk of loss. The Corporation uses investment managers specializing in each asset category, and regularly monitors performance and compliance with investment guidelines. In developing the expected long-term rate of return on assets assumption, the Corporation considers the current level of expected returns on risk-free investments, the historical level of the risk premium associated with the other asset classes in which the portfolio is invested, and the expectations for future returns of each asset class. The expected return for each asset class is then weighted based on the target allocation to develop the expected long-term rate of return on assets assumption for the portfolio.

The Corporation's pension plans' target allocation and weighted average asset allocations at the measurement date of June 30, 2017 and 2016, by asset category, are as follows:

Asset category	Target allocation	Percentage of plan assets as of June 30	
		2017	2016
Cash and cash equivalents	0–10%	5 %	9 %
Fixed income securities	40–60	32	47
Equity securities	10–30	26	20
Global asset allocation	10–20	27	20
Hedge funds	5–15	10	4
		100 %	100 %

(Continued)

Equity and fixed income securities include investments in hedge fund of funds that are categorized in accordance with each fund's respective investment holdings.

The table below presents the Corporation's combined investable assets of the defined benefit pension plans as of June 30, 2017, aggregated by the fair value hierarchy as described in note 1(w) (in thousands):

	Level 1	Level 2	Level 3	Investments Reported at NAV*	Total
Cash and cash equivalents	$ 1,694	6,639	—	—	8,333
Corporate bonds	—	—	—	—	—
Gov't and agency bonds	—	—	—	—	—
Fixed income mutual funds	11,495	—	—	—	11,495
Common and preferred stocks	10,993	—	—	—	10,993
Equity mutual funds	22,714	—	—	—	22,714
Other mutual funds	13,056	—	—	—	13,056
Alternative investments	18,240	28,431	—	42,340	89,011
	$ 78,192	35,070	—	42,340	155,602

* Fund investments reported at NAV as practical expedient

The table below presents the Corporation's combined investable assets of the defined benefit pension plans as of June 30, 2016, aggregated by the fair value hierarchy as described in note 1(w) (in thousands):

	Level 1	Level 2	Level 3	Investments Reported at NAV*	Total
Cash and cash equivalents	$ 10,919	7,250	—	—	18,169
Corporate bonds	22,419	—	—	—	22,419
Gov't and agency bonds	21,218	—	—	—	21,218
Fixed income mutual funds	11,763	—	—	—	11,763
Common and preferred stocks	11,736	—	—	—	11,736
Equity mutual funds	19,627	—	—	—	19,627
Other mutual funds	11,852	—	—	—	11,852
Alternative investments	22,386	30,375	—	33,380	86,141
	$ 131,920	37,625	—	33,380	202,925

* Fund investments reported at NAV as practical expedient

As noted in note 1(z), the Corporation adopted ASU No. 2015-07 for the year ended June 30, 2017. As a result of this adoption, at June 30, 2016, alternative investments in the amounts of $6,750,000 and $26,630,000 were reclassified from Level 2 and Level 3, respectively, in the fair value hierarchy to Investments reported at NAV.

ASU No. 2015-10, *Technical Corrections and Improvements*, amended the definition of readily determinable fair value to include equity securities in structures similar to mutual funds where the fair value per share is determined and published on a regular basis and is the basis for current transactions. The Corporation has reassessed the basis of fair value for its investments and concluded that certain investments have readily determinable fair values consistent with the amendment. As a result, fair value disclosures have been amended, and certain investments within the defined benefit plans have been reclassified to Level 1 and 2 investments within the fair value hierarchy. As a result of this adoption, at June 30, 2016, alternative investments in the amount of $22,386,000 were reclassified from Level 2 in the fair value hierarchy to Level 1. Alternative investments in the amount of $10,615,000 were reclassified from Level 3 in the fair value hierarchy to Level 2.

Alternative investments include hedge funds and commingled investment funds. The majority of these alternative investments held as of June 30, 2017 are subject to notice requirements of 30 days or less and are available to be redeemed on at least a monthly basis. There are funds, totaling $6,500,000, which are subject to notice requirements of 30-60 days and are available to be redeemed on a monthly or quarterly basis. Funds totaling $5,000,000 are subject to notice requirements of 90 days and can be redeemed monthly or quarterly. Of these funds, one fund totaling $1,200,000 is subject to a lock-up restriction of three years. The Corporation had no unfunded commitments as of June 30, 2017.

The alternative investments held as of June 30, 2016 are subject to notice requirements of 30 days or less and are available to be redeemed on at least a monthly basis with the exception of one fund, totaling $7,300,000, which is subject to 70-day notice requirements and can be redeemed on a quarterly basis. None of the alternative investments are subject to any lock-up restrictions. The Corporation had no unfunded commitments as of June 30, 2016.

The Corporation expects to contribute $9,260,000 to its defined benefit pension plans for the fiscal year ending June 30, 2017.

The following benefit payments, which reflect expected future employee service, as appropriate, are expected to be paid from plan assets in the following years ending June 30 (in thousands):

2018	$	10,478
2019		10,324
2020		10,543
2021		11,228
2022		17,477
2023–2027		61,273

The expected benefits to be paid are based on the same assumptions used to measure the Corporation’s benefit obligation at June 30, 2017.

(b) Defined Contribution Plans

Corporation Salary Reduction 403(b) Plan – A contributory benefit plan covering substantially all employees not participating in the plans described below. Employees are immediately eligible for elective deferrals of compensation as contributions to the plan. Employees are eligible for matching contributions after one year of service with a five-year gradual vesting schedule. Effective January 1, 2017, this plan was opened for new participants.

Corporation Pension Plan – A noncontributory defined contribution plan for all eligible Corporation employees not participating in the ROI Plan or the Midtown Plan described below. Contributions to this plan by the Corporation are determined as a fixed percentage of total employees' base compensation. Effective January 1, 2017, this plan was frozen to new participants.

Corporation Salary Reduction 403(b) Plan – A contributory benefit plan covering substantially all employees not participating in the plans described below. Employees are immediately eligible for elective deferrals of compensation as contributions to the plan. Effective July 29, 2016, the Baltimore Washington retirement plan was merged into this plan. Effective January 1, 2017, this plan was frozen to new participants.

Midtown 401(k) Profit Sharing Plan for Union Employees – Defined contribution plan for substantially all union employees of Midtown. Employer contributions to this plan are determined based on years of service and hours worked. Employees are immediately eligible for elective deferrals of compensation as contributions to the plan.

Baltimore Washington Retirement Plans – Defined contribution plans covering all employees of Baltimore Washington Medical Center and certain related entities. Effective July 29, 2016, this plan merged into the UMMS Voluntary 403(b) plan.

Shore Health System Retirement Plan – A contributory benefit plan covering substantially all employees of Shore Health. Employees are eligible for matching contributions after one year of service.

Chester River Retirement Plan – A contributory benefit plan covering substantially all employees of Chester River who have met the eligibility requirements. Employees are eligible for matching contributions after one year of service.

Charles Regional Retirement Savings Plan – A contributory benefit plan covering substantially all full-time employees of Charles Regional. Employees are eligible for matching contributions after three years of service as defined in the plan.

Upper Chesapeake Retirement Plan – A contributory benefit plan covering substantially all employees of Upper Chesapeake. Employees are eligible for elective deferrals of compensation as contributions to the plan. Employees are eligible for matching contributions after one year of service with a five-year gradual vesting schedule.

Total annual retirement costs incurred by the Corporation for the previously discussed defined contribution plans were $41,900,000 and $40,064,000 for the years ended June 30, 2017 and 2016, respectively. Such amounts are included in salaries, wages and benefits in the accompanying consolidated statements of operations.

(11) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are restricted primarily for the following purposes at June 30 (in thousands):

	2017	2016
Facility construction and renovations, research, education, and other	$ 73,682	58,380
Economic and beneficial interests in the net assets of related organizations	192,343	187,885
	$ 266,025	246,265

Net assets were released from donor restrictions during the years ended June 30, 2017 and 2016 by expending funds satisfying the restricted purposes or by occurrence of other events specified by donors as follows (in thousands):

	2017	2016
Purchases of equipment and construction costs	$ 33,038	10,417
Research, education, uncompensated care, and other	2,868	7,067
	$ 35,906	17,484

Permanently restricted net assets consist primarily of gifts to be held in perpetuity, the income from which may be used to fund the operations of the Corporation.

The Corporation's endowments consist of donor-restricted funds established for a variety of purposes. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

(a) Interpretation of Relevant Law

The Corporation has interpreted the Maryland Uniform Prudent Management of Institutional Funds Act (MUPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Corporation classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The

remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the organization in a manner consistent with the standard of prudence prescribed by MUPMIFA. In accordance with MUPMIFA, the Corporation considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

(1) The duration and preservation of the fund

(2) The purposes of the Corporation and the donor-restricted endowment fund

(3) General economic conditions

(4) The possible effect of inflation and deflation

(5) The expected total return from income and the appreciation of investments

(6) Other resources of the Corporation

(7) The investment policies of the Corporation.

Endowment net assets are as follows (in thousands):

	June 30, 2017			
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds	$ —	13,335	38,510	51,845

	June 30, 2016			
	Unrestricted	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds	$ —	11,232	37,065	48,297

(b) Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or MUPMIFA requires the Corporation to retain as a fund of perpetual duration. The Corporation does not have any donor-restricted endowment funds that are below the level that the donor or MUPMIFA requires.

(c) Investment Strategies

The Corporation has adopted policies for corporate investments, including endowment assets, that seek to maximize risk-adjusted returns with preservation of principal. Endowment assets include those assets of donor-restricted funds that the Corporation must hold in perpetuity or for a donor-specified period(s).The endowment assets are invested in a manner that is intended to hold a mix of investment assets designed to meet the objectives of the account. The Corporation expects its endowment funds, over time, to provide an average rate of return that generates earnings to achieve the endowment purpose.

To satisfy its long-term rate-of-return objectives, the Corporation relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Corporation employs a diversified asset allocation structure to achieve its long-term return objectives within prudent risk constraints.

The Corporation monitors the endowment funds' returns and appropriates average returns for use. In establishing this practice, the Corporation considered the long-term expected return on its endowment. This is consistent with the Corporation's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term, as well as to provide additional real growth through new gifts and investment return.

(12) Economic and Beneficial Interests in the Net Assets of Related Organizations

The Corporation is supported by several related organizations that were formed to raise funds on behalf of the Corporation and certain of its subsidiaries. These interests are accounted for as either economic or beneficial interests in the net assets of such organizations.

The following is a summary of economic and beneficial interests in the net assets of financially interrelated organizations as of June 30 (in thousands):

		2017	2016
Economic interests in:			
UCH Legacy Funding Corporation	$	150,000	150,000
The James Lawrence Kernan Hospital Endowment Fund, Incorporated		29,725	26,821
Baltimore Washington Medical Center Foundation, Inc.		9,222	7,960
Total economic interests		188,947	184,781
Beneficial interest in the net assets of Dorchester General Hospital Foundation, Inc.		3,396	3,104
	$	192,343	187,885

The UCH Legacy Funding Corporation was formed in December 2013 to hold funds restricted for the benefit of Upper Chesapeake.

(Continued)

At the discretion of its board of trustees, the Kernan Endowment Fund may pledge securities to satisfy various collateral requirements on behalf of ROI and may provide funding to ROI to support various clinical programs or capital needs.

BWMC Foundation was formed in July 2000 and supports the activities of Baltimore Washington Medical Center by soliciting charitable contributions on its behalf.

Shore Regional maintains a beneficial interest in the net assets of Dorchester Foundation, a nonprofit corporation organized to raise funds on behalf of Dorchester Hospital. Shore Regional does not have control over the policies or decisions of the Dorchester Foundation.

A summary of the combined unaudited condensed financial information of the financially interrelated organizations in which the Corporation holds an economic or beneficial interest as of June 30 is as follows (in thousands):

		2017	2016
Current assets	$	3,073	2,891
Noncurrent assets		189,927	185,672
Total assets	$	193,000	188,563
Current liabilities	$	532	452
Noncurrent liabilities		125	226
Net assets		192,343	187,885
Total liabilities and net assets	$	193,000	188,563
Total operating revenue	$	2,422	2,165
Total operating expense		(210)	(4,344)
Other changes in net assets		2,246	634
Total increase (decrease) in net assets	$	4,458	(1,545)

(13) State Support

The Corporation received $3,200,000 in support for the Shock Trauma Center operations from the State of Maryland, for both years ended June 30, 2017 and 2016. In addition, the Corporation received $15,000,000 in support of Dimensions Health System operations for the year ended June 30, 2017. See note 19 for further discussion over the affiliation with Dimensions Health System.

The State of Maryland appropriates funds for construction costs incurred, equipment purchases made, and other capital support. The Corporation recognizes this support as the funds are expended for the intended projects. The Corporation expended and recorded $23,029,000 and $4,364,000 during the years ended June 30, 2017 and 2016, respectively.

(Continued)

(14) Functional Expenses

The Corporation provides general healthcare services to residents within its geographic location. Expenses related to providing these services, based on management's estimates of expense allocations, are as follows for the years ended June 30 (in thousands):

		2017	2016
Healthcare services	$	3,368,273	3,144,882
General and administrative		467,337	436,820
	$	3,835,610	3,581,702

(15) Insurance

The Corporation maintains self-insurance programs for professional and general liability risks, employee health, employee long-term disability, and workers' compensation. Estimated liabilities have been recorded based on actuarial estimation of reported and incurred but not reported claims. The accrued liabilities for these programs as of June 30, 2017 and 2016 were as follows (in thousands):

		2017	2016
Professional and general malpractice liabilities	$	234,569	235,871
Employee health		33,130	27,656
Employee long-term disability		8,696	12,661
Workers' compensation		18,961	17,610
Total self-insured liabilities		295,356	293,798
Less current portion		(71,832)	(68,500)
	$	223,524	225,298

The Corporation provides for and funds the present value of the costs for professional and general liability claims and insurance coverage related to the projected liability from asserted and unasserted incidents, which the Corporation believes may ultimately result in a loss. These accrued malpractice losses are discounted using a discount rate of 2.5%. In management's opinion, these accruals provide an adequate and appropriate loss reserve. The professional and general malpractice liabilities presented above include $144,313,000 and $141,625,000 as of June 30, 2017 and 2016, respectively, for which related insurance receivables have been recorded within other assets on the accompanying consolidated balance sheets.

(Continued)

The Corporation and each of its affiliates are self-insured for professional and general liability claims up to the limits of $1.0 million on individual claims and $3.0 million in the aggregate on an annual basis. For amounts in excess of these limits, the risk of loss has been transferred to the Terrapin Insurance Company (Terrapin), an unconsolidated joint venture. Terrapin provides insurance for claims in excess of $1 million individually and $3 million in the aggregate up to $150 million individually and $150 million in the aggregate under claims made policies between the Corporation and Terrapin. For claims in excess of Terrapin's coverage limits, if any, the Corporation retains the risk of loss.

As discussed in note 4, Terrapin is a joint venture corporation in which a 50% equity interest is owned by the Corporation and a 50% equity interest is owned by Faculty Physicians, Inc.

Total malpractice insurance expense for the Corporation during the years ended June 30, 2017 and 2016 was approximately $36,367,000 and $40,359,000, respectively.

(16) Business and Credit Concentrations

The Corporation provides healthcare services through its inpatient and outpatient care facilities located in the State of Maryland. The Corporation generally does not require collateral or other security in extending credit; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits receivable under their health insurance programs, plans, or policies (e.g., Medicare, Medicaid, Blue Cross, workers' compensation, health maintenance organizations (HMOs), and commercial insurance policies).

The Corporation maintains cash accounts with highly rated financial institutions, which generally exceed federally insured limits. The Corporation has not experienced any losses from maintaining cash accounts in excess of federally insured limits, and as such, management does not believe the Corporation is subject to any significant credit risks related to this practice.

The Corporation had gross receivables from patients and third-party payors as follows at June 30:

	2017	2016
Medicare	25 %	25 %
Medicaid	20	25
Commercial insurance and HMOs	21	19
Blue Cross	11	11
Self-pay and others	23	20
	100 %	100 %

(Continued)

The Corporation recorded gross revenues from patients and third-party payors for the years ended June 30 as follows:

	2017	2016
Medicare	39 %	38 %
Medicaid	22	23
Commercial insurance and HMOs	20	19
Blue Cross	14	14
Self-pay and others	5	6
	100 %	100 %

(17) Certain Significant Risks and Uncertainties

The Corporation provides general acute healthcare services in the State of Maryland. The Corporation and other healthcare providers in Maryland are subject to certain inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the Federal Medicare and state Medicaid programs;
- Regulation of hospital rates by the State of Maryland Health Services Cost Review Commission;
- Government regulation, government budgetary constraints, and proposed legislative and regulatory changes; and
- Lawsuits alleging malpractice and related claims.

Such inherent risks require the use of certain management estimates in the preparation of the Corporation's consolidated financial statements and it is reasonably possible that a change in such estimates may occur.

The Medicare and state Medicaid reimbursement programs represent a substantial portion of the Corporation's revenues, and the Corporation's operations are subject to a variety of other federal, state, and local regulatory requirements. Failure to maintain required regulatory approvals and licenses and/or changes in such regulatory requirements could have a significant adverse effect on the Corporation.

Changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Corporation.

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. The Corporation's compliance with these laws and regulations can be subject to periodic governmental review and interpretation, which can result in regulatory action unknown or unasserted at this time. Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the ordinary course of business, none of which, in the opinion of management, are expected to result in losses in excess of insurance limits or have a materially adverse effect on the Corporation's financial position.

(Continued)

The federal government and many states have aggressively increased enforcement under Medicare and Medicaid antifraud and abuse laws and physician self-referral laws (STARK law and regulation). Recent federal initiatives have prompted a national review of federally funded healthcare programs. In addition, the federal government and many states have implemented programs to audit and recover potential overpayments to providers from the Medicare and Medicaid programs. The Corporation has implemented a compliance program to monitor conformance with applicable laws and regulations, but the possibility of future government review and enforcement action exists.

The general healthcare industry environment is increasingly uncertain, especially with respect to the impact of Federal healthcare reform legislation, which was passed in 2010 and largely upheld by the U.S. Supreme Court in June 2012. Potential impacts of ongoing healthcare industry transformation include but are not limited to (1) significant capital investments in healthcare information technology, (2) continuing volatility in the state and federal government reimbursement programs, (3) lack of clarity related to the health benefit exchange framework mandated by reform legislation, including important open questions regarding exchange reimbursement levels, and impact on the healthcare "demand curve" as the previously uninsured enter the insurance system, and (4) effective management of multiple major regulatory mandates, including the transition to ICD-10. This Federal healthcare reform legislation does not affect the consolidated financial statements for the year ended June 30, 2017.

(18) Maryland Health Services Cost Review Commission (HSCRC)

Effective July 1, 2013, the Health System and the Health Services Cost Review Commission (HSCRC) agreed to implement the Global Budget Revenue (GBR) methodology for the following hospitals: Medical Center, ROI, Midtown, Baltimore Washington, Charles Regional, St. Joseph, Shore Emergency Center, and Upper Chesapeake. The agreements will continue each year and on July 1 of each year thereafter; the agreements will renew for a one-year period unless it is canceled by the HSCRC or by the Corporation. The agreements were in place for the years ended June 30, 2017 and 2016. The GBR model is a revenue constraint and quality improvement system designed by the HSCRC to provide hospitals with strong financial incentives to manage their resources efficiently and effectively in order to slow the rate of increase in healthcare costs and improve healthcare delivery processes and outcomes. The GBR model is consistent with the Corporation's mission to provide the highest value of care possible to its patients and the communities it serves.

The GBR agreements establish a prospective, fixed revenue base "GBR cap" for the upcoming year. This includes both inpatient and outpatient regulated services. Under GBR, a hospital's revenue for all HSCRC regulated services is predetermined for the upcoming year, regardless of changes in volume, service mix intensity, or mix of inpatient or outpatient services that occurred during the year. The GBR agreement allows the Corporation to adjust unit rates, within certain limits, to achieve the overall revenue base for the Corporation at year-end. Any overcharge or undercharge versus the GBR cap is prospectively added to the subsequent year's GBR cap. Although the GBR cap does not adjust for changes in volume or service mix, the GBR cap is adjusted annually for inflation, and for changes in payor mix and uncompensated care. The Corporation will receive an annual adjustment to its cap for the change in population in the Corporation's service areas. GBR is designed to encourage hospitals to operate efficiently by reducing utilization and managing patients in the appropriate care delivery setting. The HSCRC also may impose various other revenue adjustments, which could be significant in the future.

(Continued)

For the years ended June 30, 2017 and 2016, Memorial Hospital, Dorchester Hospital, and CRHC continued their participation in Total Patient Revenue (TPR) agreements with the HSCRC. The TPR agreements establish an approved aggregate inpatient and outpatient revenue for regulated services to provide care for the patient population in the geographic region without regard for patient acuity or volumes.

The HSCRC utilizes a bad debt pool into which each of the regulated hospitals in Maryland participates. The funds in the bad debt pool are distributed to the hospitals that exceed the state average based upon the amount of uncompensated care delivered to patients during the year. For the years ended June 30, 2017 and 2016, the Corporation recognized a net distribution from the pool of $8,345,000 and $11,521,000, respectively, which is recorded as net patient service revenue.

(19) Subsequent Events

The Corporation evaluated all events and transactions that occurred after June 30, 2016 and through October 26, 2017, the date the consolidated financial statements were issued. Other than those described below, the Corporation did not have any material recognizable subsequent events during the period.

Effective September 1, 2017, the Corporation entered into an affiliation agreement with Dimensions Healthcare System and Subsidiaries (DHS) whereby the Corporation became the sole corporate member of DHS. DHS has changed its trade name to University of Maryland Capital Region Health (UMCRH) and is located in Prince George's County, Maryland, and includes an acute care hospital as well as several ambulatory and outpatient facilities. The Corporation, Prince George's County, the State of Maryland, and UMCRH began discussions in 2010 regarding the formation of a new regional healthcare system to serve Prince George's County and the surrounding region. The affiliation represents the culmination of this effort and includes plans to build a new state-of-the-art medical center in Largo, Maryland. The Corporation believe the residents of the region served by UMCRH will benefit from the affiliation with the Corporation through accelerated deployment of clinical programs and technologies and improved access to physicians. In accordance with the agreement, the county, the state, and the Corporation have each approved funding of $208,000,000 towards the construction of the new medical facility, as well as ongoing annual operating support.

The transaction will be accounted for under the guidance of ASU No. 2010-07, *Not-for-Profit Entities: Mergers and Acquisitions*, and accordingly, the Corporation will consolidate UMCRH at its fair value as of September 1, 2017. Such amounts are currently being determined. The Corporation does not expect the fair value adjustment recorded during the year ended June 30, 2018 to have a material impact on the Corporation's consolidated financial statements.

Excluding any impact from fair value accounting which is still being evaluated, the following table summarizes the Corporation's pro forma consolidated results as through the acquisition date occurred at June 30, 2017 (in thousands):

Operating revenues:		
The Corporation	$	3,907,690
UM Capital Region Health Combined		392,562
	$	4,300,252
Operating expenses:		
The Corporation	$	3,835,610
UM Capital Region Health Combined		393,481
	$	4,229,091
Net nonoperating revenues:		
The Corporation	$	111,279
UM Capital Region Health Combined		2,146
	$	113,425
Total net assets:		
The Corporation	$	2,016,864
UM Capital Region Health Combined		475,612
	$	2,492,476

Total net assets of UMCRH include $416,000,000 of restricted net assets, representing legislative commitments from Prince George's County and the State of Maryland to fund the construction of the new medical facility.

Schedule 1

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2017

(In thousands)

Assets	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	Upper Chesapeake	UM Health Plans	UMMS Foundation	Community Med. Group	ECARE	Eliminations	Consolidated total
Current assets:														
Cash and cash equivalents	$ 332,747	(83)	3,641	18,579	7,997	11,317	5,199	55,906	40,876	—	22	—	—	476,201
Assets limited as to use, current portion	46,797	—	432	1,228	814	342	1,327	—	—	—	—	—	—	50,940
Accounts receivable:														
Patient accounts receivable, less allowance for doubtful accounts of $219,805	173,672	11,530	14,421	49,169	26,499	8,614	43,388	45,634	—	—	5,221	—	—	378,148
Other	275,913	22,384	32,713	19,824	21,823	2,638	23,446	13,320	18,056	—	3,141	120	(348,669)	84,709
Inventories	28,598	1,106	3,071	6,131	4,588	1,391	5,613	10,385	—	—	—	—	—	60,883
Prepaid expenses and other current assets	16,092	116	1,048	1,132	1,854	818	2,040	9,958	331	1,500	571	563	—	36,023
Total current assets	873,819	35,053	55,326	96,063	63,575	25,120	81,013	135,203	59,263	1,500	8,955	683	(348,669)	1,086,904
Investments	232,394	29,013	3	136,194	99,570	33,535	11,539	190,493	10,208	—	—	—	—	742,949
Assets limited as to use, less current portion:														
Investments held for collateral	81,987	—	3,700	8,000	—	—	—	28,959	—	—	—	—	—	122,646
Debt service funds	10,438	—	—	—	—	—	—	—	—	—	—	—	—	10,438
Construction funds	46,264	14,203	8,081	10,051	9,970	10,651	8,270	—	—	—	—	—	—	107,490
Board designated and escrow funds	—	—	—	—	74,632	(107)	—	22,383	—	12,548	10	—	—	109,466
Self-insurance trust funds	72,828	—	16,776	23,028	33,120	6,707	7,891	12,903	—	—	—	—	—	173,253
Funds restricted by donor	—	—	1,116	—	32,756	—	1,525	—	—	25,354	—	—	—	60,751
Economic and beneficial interests in the net assets of related organizations	197,124	31,446	442	9,222	3,396	—	9,503	—	—	—	—	—	(58,790)	192,343
	408,641	45,649	30,115	50,301	153,874	17,251	27,189	64,245	—	37,902	10	—	(58,790)	776,387
Property and equipment, net	915,834	45,924	103,973	263,057	173,371	109,487	211,700	254,177	4,451	—	8,553	1,576	—	2,092,103
Investments in joint ventures and other assets	672,137	—	9,970	18,010	10,395	6,364	32,525	218,709	209,503	10,039	—	—	(776,691)	410,961
Total assets	$ 3,102,825	155,639	199,387	563,625	500,785	191,757	363,966	862,827	283,425	49,441	17,518	2,259	(1,184,150)	5,109,304

(Continued)

Schedule 1

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2017

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	Upper Chesapeake	UM Health Plans	UMMS Foundation	Community Med. Group	ECARE	Eliminations	Consolidated total
Current liabilities:														
Trade accounts payable	$ 141,737	9,249	17,285	22,456	21,183	9,160	26,554	18,628	933	154	3,703	560	—	271,602
Accrued payroll and benefits	108,519	5,489	10,144	21,106	19,681	4,206	25,538	26,567	2,378	—	9,916	—	—	233,544
Advances from third-party payors	79,155	3,568	10,706	9,951	6,466	2,593	11,089	8,413	—	—	—	—	—	131,941
Lines of credit	125,000	—	—	—	—	—	—	—	—	—	—	—	—	125,000
Short-term financing	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Other current liabilities	149,514	7,236	12,553	37,771	28,522	10,693	105,256	59,194	103,118	—	6,056	11,444	(348,669)	182,688
Long-term debt subject to short-term remarketing arrangements	28,440	—	—	—	—	—	—	—	—	—	—	—	—	28,440
Current portion of long-term debt	13,271	505	1,010	4,187	2,839	3,033	6,260	4,832	5,000	—	—	—	—	40,937
Total current liabilities	645,636	26,047	51,698	95,471	78,691	29,685	174,697	117,634	111,429	154	19,675	12,004	(348,669)	1,014,152
Long-term debt, less current portion	718,215	20,486	31,865	163,722	85,425	59,464	238,172	196,474	36,667	—	—	—	—	1,550,490
Other long-term liabilities	123,123	144	21,226	36,913	18,208	15,398	25,628	40,371	53,263	—	—	—	—	334,274
Interest rate swap liabilities	194,524	—	—	—	—	—	—	—	—	—	—	—	—	194,524
Total liabilities	1,681,498	46,677	104,789	296,106	182,324	104,547	438,497	354,479	201,359	154	19,675	12,004	(348,669)	3,093,440
Net assets:														
Unrestricted	1,200,794	77,383	93,040	258,297	279,315	87,117	(95,139)	350,019	82,066	17,777	(2,157)	(9,745)	(627,438)	1,711,329
Temporarily restricted	218,844	31,579	1,558	9,222	23,429	93	19,610	157,053	—	11,404	—	—	(206,767)	266,025
Permanently restricted	1,689	—	—	—	15,717	—	998	1,276	—	20,106	—	—	(1,276)	38,510
Total net assets	1,421,327	108,962	94,598	267,519	318,461	87,210	(74,531)	508,348	82,066	49,287	(2,157)	(9,745)	(835,481)	2,015,864
Total liabilities and net assets	$ 3,102,825	155,639	199,387	563,625	500,785	191,757	363,966	862,827	283,425	49,441	17,518	2,259	(1,184,150)	5,109,304

See accompanying independent auditors' report.

Schedule 1-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Medical Center & Affiliates (UMMC)

June 30, 2017

(In thousands)

Assets	University of Maryland Medical Center	36 South Paca	University CARE	Eliminations	University of Maryland Medical Center & Affiliates consolidated total
Current assets:					
Cash and cash equivalents	$ 328,162	2,543	2,042	—	332,747
Assets limited as to use, current portion	46,797	—	—	—	46,797
Accounts receivable:					
Patient accounts receivable, less allowance for doubtful accounts of $88,957	173,649	—	23	—	173,672
Other	283,680	42		(7,809)	275,913
Inventories	28,559	—	39	—	28,598
Prepaid expenses and other current assets	16,035	—	57	—	16,092
Total current assets	876,882	2,585	2,161	(7,809)	873,819
Investments	232,394	—	—	—	232,394
Assets limited as to use, less current portion:					
Investment held for collateral	81,987	—	—	—	81,987
Debt service funds	10,438	—	—	—	10,438
Construction funds	46,264	—	—	—	46,264
Board designated and escrow funds	—	—	—	—	—
Self-insurance trust funds	72,828	—	—	—	72,828
Funds restricted by donor	—	—	—	—	—
Economic interests in the net assets of related organizations	197,124	—	—	—	197,124
	408,641	—	—	—	408,641
Property and equipment, net	907,068	8,707	59	—	915,834
Investments in joint ventures and other assets	676,447	3,277	—	(7,587)	672,137
Total assets	$ 3,101,432	14,569	2,220	(15,396)	3,102,825

(Continued)

Schedule 1-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Medical Center & Affiliates (UMMC)

June 30, 2017

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center	36 South Paca	University CARE	Eliminations	University of Maryland Medical Center & Affiliates consolidated total
Current liabilities:					
Trade accounts payable	$ 140,720	159	858	—	141,737
Accrued payroll and benefits	108,479	—	40	—	108,519
Advances from third-party payors	79,155	—	—	—	79,155
Lines of credit	125,000	—	—	—	125,000
Short-term financing	—	—	—	—	—
Other current liabilities	149,408	6,902	1,013	(7,809)	149,514
Long-term debt subject to short-term remarketing arrangements	28,440	—	—	—	28,440
Current portion of long-term debt	13,271	—	—	—	13,271
Total current liabilities	644,473	7,061	1,911	(7,809)	645,636
Long-term debt, less current portion	718,215	—	—	—	718,215
Other long-term liabilities	123,107	16	—	—	123,123
Interest rate swaps	194,524	—	—	—	194,524
Total liabilities	1,680,319	7,077	1,911	(7,809)	1,681,498
Net assets:					
Unrestricted	1,200,580	7,492	309	(7,587)	1,200,794
Temporarily restricted	218,844	—	—	—	218,844
Permanently restricted	1,689	—	—	—	1,689
Total net assets	1,421,113	7,492	309	(7,587)	1,421,327
Total liabilities and net assets	$ 3,101,432	14,569	2,220	(15,396)	3,102,825

See accompanying independent auditors' report.

Schedule 1-b

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Midtown Health, Inc. (Midtown)

June 30, 2017

(In thousands)

Assets	UM Midtown Health Systems, Inc.	UMMC Midtown Campus	UM Midtown Clin. Prac. Group	Eliminations	Midtown consolidated total
Current assets:					
Cash and cash equivalents	$ 726	2,970	(55)	—	3,641
Assets limited as to use, current portion	—	432	—	—	432
Accounts receivable:					
Patient accounts receivable, less allowance for doubtful accounts of $17,621	287	14,012	122	—	14,421
Other	1,749	30,964	—	—	32,713
Inventories	—	3,071	—	—	3,071
Prepaid expenses and other current assets	549	499	—	—	1,048
Total current assets	3,311	51,948	67	—	55,326
Investments	—	3	—	—	3
Assets limited as to use, less current portion:					
Investment held for collateral	—	3,700	—	—	3,700
Debt service funds	—	—	—	—	—
Construction funds	—	8,081	—	—	8,081
Board designated and escrow funds	—	—	—	—	—
Self-insurance trust funds	—	16,776	—	—	16,776
Funds restricted by donor	—	1,116	—	—	1,116
Economic interests in the net assets of related organizations	—	442	—	—	442
	—	30,115	—	—	30,115
Property and equipment, net	4,630	99,343	—	—	103,973
Investments in joint ventures and other assets	3,403	6,567	—	—	9,970
Total assets	$ 11,344	187,976	67	—	199,387

(Continued)

Schedule 1-b

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Midtown Health, Inc. (Midtown)

June 30, 2017

(In thousands)

Liabilities and Net Assets	UM Midtown Health Systems, Inc.	UMMC Midtown Campus	UM Midtown Clin. Prac. Group	Eliminations	Midtown consolidated total
Current liabilities:					
Trade accounts payable	$ 235	17,046	4	—	17,285
Accrued payroll and benefits	—	10,144	—	—	10,144
Advances from third-party payors	—	10,706	—	—	10,706
Lines of credit	—	—	—	—	—
Other current liabilities	5,658	6,839	56	—	12,553
Current portion of long-term debt	228	782	—	—	1,010
Total current liabilities	6,121	45,517	60	—	51,698
Long-term debt, less current portion	140	31,725	—	—	31,865
Other long-term liabilities	—	21,226	—	—	21,226
Total liabilities	6,261	98,468	60	—	104,789
Net assets:					
Unrestricted	5,083	87,950	7	—	93,040
Temporarily restricted	—	1,558	—	—	1,558
Permanently restricted	—	—	—	—	—
Total net assets	5,083	89,508	7	—	94,598
Total liabilities and net assets	$ 11,344	187,976	67	—	199,387

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION
AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Baltimore Washington Medical System (BWMS)

June 30, 2017

(In thousands)

Assets	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Shipley's	Eliminations	BWMS consolidated total
Current assets:								
Cash and cash equivalents	$ —	18,724	187	—	(332)	—	—	18,579
Assets limited as to use, current portion	—	1,228	—	—	—	—	—	1,228
Accounts receivable:								
Patient accounts receivable, less allowance for doubtful accounts of $37,330	—	41,501	6,369	1,299	—	—	—	49,169
Other	151	1,408	14,475	2,000	1,790	—	—	19,824
Inventories	—	6,131	—	—	—	—	—	6,131
Prepaid expenses and other current assets	—	1,138	22	(36)	8	—	—	1,132
Total current assets	151	70,130	21,053	3,263	1,466	—	—	96,063
Investments	—	136,194	—	—	—	—	—	136,194
Assets limited as to use, less current portion:								
Investment held for collateral	—	8,000	—	—	—	—	—	8,000
Debt service funds	—		—	—	—	—	—	—
Construction funds	—	10,051	—	—	—	—	—	10,051
Board designated and escrow funds	—		—	—	—	—	—	—
Self-insurance trust funds	—	23,028	—	—	—	—	—	23,028
Funds restricted by donor	—	—	—	—	—	—	—	—
Economic interests in the net assets of related organizations	—	9,222	—	—	—	—	—	9,222
	—	50,301	—	—	—	—	—	50,301
Property and equipment, net	—	243,492	—	2,597	16,968	—	—	263,057
Investments in joint ventures and other assets	262,322	17,672	—	(310)	248	—	(261,922)	18,010
Total assets	$ 262,473	517,789	21,053	5,550	18,682	—	(261,922)	563,625

(Continued)

Schedule 1-c

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION
AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Baltimore Washington Medical System (BWMS)

June 30, 2017

(In thousands)

Liabilities and Net Assets	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Shipley's	Eliminations	BWMS consolidated total
Current liabilities:								
Trade accounts payable	$ (139)	22,259	241	836	(741)	—	—	22,456
Accrued payroll and benefits	1,401	18,847	858	—	—	—	—	21,106
Advances from third-party payors	—	9,951	—	—	—	—	—	9,951
Lines of credit	—	—	—	—	—	—	—	—
Other current liabilities	—	31,343	—	6,377	51	—	—	37,771
Current portion of long-term debt	—	3,962	—	—	225	—	—	4,187
Total current liabilities	1,262	86,362	1,099	7,213	(465)	—	—	95,471
Long-term debt, less current portion	—	161,116	—	—	2,606	—	—	163,722
Other long-term liabilities	—	36,049	—	864	—	—	—	36,913
Total liabilities	1,262	283,527	1,099	8,077	2,141	—	—	296,106
Net assets:								
Unrestricted	261,211	225,040	19,954	(2,527)	16,541	—	(261,922)	258,297
Temporarily restricted	—	9,222	—	—	—	—	—	9,222
Permanently restricted	—	—	—	—	—	—	—	—
Total net assets	261,211	234,262	19,954	(2,527)	16,541	—	(261,922)	267,519
Total liabilities and net assets	$ 262,473	517,789	21,053	5,550	18,682	—	(261,922)	563,625

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Shore Regional Health (Shore Regional)

June 30, 2017

(In thousands)

Assets	Shore Health System, Inc.	Shore Orthopedics	UM Shore Home Care	Queenstown ASC	UM Shore Nursing and Rehab.	Memorial Hospital Foundation, Inc. and Subsidiary	Chester River Consolidated Total	Eliminations	Shore Regional consolidated total
Current assets:									
Cash and cash equivalents	$ 8,955	298	35	—	368	—	(1,659)	—	7,997
Assets limited as to use, current portion	572	—	—	—	—	—	242	—	814
Accounts receivable:									
Patient accounts receivable, less allowance for doubtful accounts of $22,262	22,473	568	344	49	579	—	2,486	—	26,499
Other	2,692	2	1,221	—	20	4,277	13,611	—	21,823
Inventories	3,892	—	—	—	—	—	696	—	4,588
Prepaid expenses and other current assets	1,476	251	26	—	42	27	32	—	1,854
Total current assets	40,060	1,119	1,626	49	1,009	4,304	15,408	—	63,575
Investments	83,553	—	—	—	—	338	15,679	—	99,570
Assets limited as to use, less current portion:									
Debt service funds	—	—	—	—	—	—	—	—	—
Construction funds	5,432	—	—	—	—	—	4,538	—	9,970
Board designated and escrow funds	25,000	—	—	—	—	43,835	5,797	—	74,632
Self-insurance trust funds	25,492	—	—	—	301	—	7,327	—	33,120
Funds restricted by donor	5,029	—	—	—	—	23,644	4,083	—	32,756
Economic and beneficial interests in the net assets of related organizations	78,558	—	—	—	81	—	6,509	(81,752)	3,396
	139,511	—	—	—	382	67,479	28,254	(81,752)	153,874
Property and equipment, net	142,380	480	250	35	1,549	3,206	25,471	—	173,371
Investments in joint ventures and other assets	9,822	—	—	—	—	15	2,183	(1,625)	10,395
Total assets	$ 415,326	1,599	1,876	84	2,940	75,342	86,995	(83,377)	500,785

(Continued)

Schedule 1-d

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Shore Regional Health (Shore Regional)

June 30, 2017

(In thousands)

Liabilities and Net Assets	Shore Health System, Inc.	Shore Orthopedics	UM Shore Home Care	Queenstown ASC	UM Shore Nursing and Rehab.	Memorial Hospital Foundation, Inc. and Subsidiary	Chester River Consolidated Total	Eliminations	Shore Regional consolidated total
Current liabilities:									
Trade accounts payable	$ 17,471	173	10	18	544	2	2,965	—	21,183
Accrued payroll and benefits	15,175	750	241	—	296	22	3,197	—	19,681
Advances from third-party payors	5,618	—	—	—	111	—	737	—	6,466
Lines of credit	—	—	—	—	—	—	—	—	—
Other current liabilities	23,406	2,810		176	827	155	1,148	—	28,522
Current portion of long-term debt	2,705	—	—	—	30	—	104	—	2,839
Total current liabilities	64,375	3,733	251	194	1,808	179	8,151	—	78,691
Long-term debt, less current portion	81,081	—	—	—	36	—	4,308	—	85,425
Other long-term liabilities	12,374	—	—	—	379	—	5,455	—	18,208
Total liabilities	157,830	3,733	251	194	2,223	179	17,914	—	182,324
Net assets:									
Unrestricted	222,367	(2,134)	1,625	(110)	674	48,572	61,128	(52,807)	279,315
Temporarily restricted	20,708	—	—	—	43	15,225	5,361	(17,908)	23,429
Permanently restricted	14,421	—	—	—	—	11,366	2,592	(12,662)	15,717
Total net assets	257,496	(2,134)	1,625	(110)	717	75,163	69,081	(83,377)	318,461
Total liabilities and net assets	$ 415,326	1,599	1,876	84	2,940	75,342	86,995	(83,377)	500,785

See accompanying independent auditors' report.

Schedule 1-e

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Chester River Health System, Inc. (CRHS) a subsidiary of Shore Regional Health

June 30, 2017

(In thousands)

Assets	Chester River Hospital Center	Chester River Manor	UM Chester River Home Care	Chester River Health Foundation	Chester River consolidated total
Current assets:					
Cash and cash equivalents	$ (1,901)	—	242	—	(1,659)
Assets limited as to use, current portion	242	—	—	—	242
Accounts receivable:					
Patient accounts receivable, less allowance for doubtful accounts of $3,306	2,208	—	278	—	2,486
Other	13,308	—	300	3	13,611
Inventories	696	—	—	—	696
Prepaid expenses and other current assets	20	—	12	—	32
Total current assets	14,573	—	832	3	15,408
Investments	12,230	—	1,577	1,872	15,679
Assets limited as to use, less current portion:					
Debt service funds	—	—	—	—	—
Construction funds	4,538	—	—	—	4,538
Board designated and escrow funds	5,000	—	—	797	5,797
Self-insurance trust funds	7,327	—	—	—	7,327
Funds restricted by donor	105	—	—	3,978	4,083
Economic interests in the net assets of related organizations	6,270	—	239	—	6,509
	23,240	—	239	4,775	28,254
Property and equipment, net	25,257	—	214	—	25,471
Investments in joint ventures and other assets	2,183	—	—	—	2,183
Total assets	$ 77,483	—	2,862	6,650	86,995

(Continued)

Schedule 1-e

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Chester River Health System, Inc. (CRHS) a subsidiary of Shore Regional Health

June 30, 2017

(In thousands)

Liabilities and Net Assets	Chester River Hospital Center	Chester River Manor	UM Chester River Home Care	Chester River Health Foundation	Chester River consolidated total
Current liabilities:					
Trade accounts payable	$ 2,893	—	57	15	2,965
Accrued payroll and benefits	3,007	—	190	—	3,197
Advances from third-party payors	737	—	—	—	737
Lines of credit	—	—	—	—	—
Other current liabilities	1,102	—	—	46	1,148
Current portion of long-term debt	104	—	—	—	104
Total current liabilities	7,843	—	247	61	8,151
Long-term debt, less current portion	4,308	—	—	—	4,308
Other long-term liabilities	5,455	—	—	—	5,455
Total liabilities	17,606	—	247	61	17,914
Net assets:					
Unrestricted	55,913	—	2,606	2,609	61,128
Temporarily restricted	2,668	—	9	2,684	5,361
Permanently restricted	1,296	—	—	1,296	2,592
Total net assets	59,877	—	2,615	6,589	69,081
Total liabilities and net assets	$ 77,483	—	2,862	6,650	86,995

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION
AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Charles Regional Health System, Inc. (Charles Regional)

June 30, 2017

(In thousands)

Assets	Charles Regional Health, Inc.	Charles Regional Medical Center, Inc.	Charles Regional Urgent Care	Charles Regional Care Partners, Inc. and Subsidiary	Charles Regional Health Foundation, Inc.	Charles Regional Imaging Center	Eliminations	Charles Regional consolidated total
Current assets:								
Cash and cash equivalents	$ —	8,548	1	431	1,171	1,166	—	11,317
Assets limited as to use, current portion	—	342	—	—	—	—	—	342
Accounts receivable:								
Patient accounts receivable, less allowance for doubtful accounts of $6,689	—	8,396	166	—	—	52	—	8,614
Other	(1,050)	4,586	—	(920)	7	15	—	2,638
Inventories	—	1,391	—	—	—	—	—	1,391
Prepaid expenses and other current assets	1	784	10	—	23	—	—	818
Total current assets	(1,049)	24,047	177	(489)	1,201	1,233	—	25,120
Investments	—	31,145	—	—	2,390	—		33,535
Assets limited as to use, less current portion:								
Debt service funds	—	—	—	—	—	—	—	—
Construction funds	—	10,651	—	—	—	—	—	10,651
Board designated and escrow funds	(107)	—	—	—	—	—	—	(107)
Self-insurance trust funds	—	6,707	—	—	—	—	—	6,707
Funds restricted by donor	—	—	—	—	—	—	—	—
Economic interests in the net assets of related organizations	—	5,179	—	—	—	—	(5,179)	—
	(107)	22,537	—	—	—	—	(5,179)	17,251
Property and equipment, net	26,468	75,087	638	—	2,489	4,805		109,487
Investments in joint ventures and other assets	903	6,976	—	3,763	—	—	(5,278)	6,364
Total assets	$ 26,215	159,792	815	3,274	6,080	6,038	(10,457)	191,757

(Continued)

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UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION
AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Charles Regional Health System, Inc. (Charles Regional)

June 30, 2017

(In thousands)

Liabilities and Net Assets	Charles Regional Health, Inc.	Charles Regional Medical Center, Inc.	Charles Regional Urgent Care	Charles Regional Care Partners, Inc. and Subsidiary	Charles Regional Health Foundation, Inc.	Charles Regional Imaging Center	Eliminations	Charles Regional consolidated total
Current liabilities:								
Trade accounts payable	$ 1	8,268	195	1	(13)	708	—	9,160
Accrued payroll and benefits	—	4,206	—	—	—	—	—	4,206
Advances from third-party payors	—	2,593	—	—	—	—	—	2,593
Lines of credit	—	—	—	—	—	—	—	—
Other current liabilities	3,341	1,047	1,904	4,193	156	52	—	10,693
Current portion of long-term debt	670	2,337	—	—	26	—	—	3,033
Total current liabilities	4,012	18,451	2,099	4,194	169	760	—	29,685
Long-term debt, less current portion	6,274	52,457	—	—	733	—	—	59,464
Other long-term liabilities	—	15,398	—	—	—	—	—	15,398
Total liabilities	10,286	86,306	2,099	4,194	902	760	—	104,547
Net assets:								
Unrestricted	15,929	73,393	(1,284)	(920)	5,085	5,278	(10,364)	87,117
Temporarily restricted	—	93	—	—	93	—	(93)	93
Permanently restricted	—	—	—	—	—	—	—	—
Total net assets	15,929	73,486	(1,284)	(920)	5,178	5,278	(10,457)	87,210
Total liabilities and net assets	$ 26,215	159,792	815	3,274	6,080	6,038	(10,457)	191,757

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland St. Joseph Health System (SJHS)

June 30, 2017

(In thousands)

Assets	St. Joseph Medical Center	St. Joseph Medical Group	St. Joseph Properties	St. Joseph Orthopaedics	O'Dea Medical Arts	St. Joseph Foundation	UM Regional Supplier svcs	UM Regional Prof svcs	Eliminations	St. Joseph consolidated total
Current assets:										
Cash and cash equivalents	$ (1,201)	(464)	—	—	1,784	5,079	1	—	—	5,199
Assets limited as to use, current portion	1,327	—	—	—	—	—	—	—	—	1,327
Accounts receivable:										
Patient accounts receivable, less allowance for doubtful accounts of $16,045	37,685	3,572	—	1,328	—	—	500	303	—	43,388
Other	20,341	48	—	—	4	2,726	—	327	—	23,446
Inventories	5,435	—	—	—	—	—	175	3	—	5,613
Prepaid expenses and other current assets	1,026	545	181	115	137	—	—	36	—	2,040
Total current assets	64,613	3,701	181	1,443	1,925	7,805	676	669	—	81,013
Investments	—	—	—	—	—	11,539	—	—	—	11,539
Assets limited as to use, less current portion:										
Debt service funds	—	—	—	—	—		—	—	—	—
Construction funds	8,270	—	—	—	—		—	—	—	8,270
Board designated and escrow funds	—	—	—	—	—		—	—	—	—
Self-insurance trust funds	7,891	—	—	—	—		—	—	—	7,891
Funds restricted by donor	—	—	—	—	—	1,525	—	—	—	1,525
Economic interests in the net assets of related organizations	9,503	—	—	—	—		—	—	—	9,503
	25,664	—	—	—	—	1,525	—	—	—	27,189
Property and equipment, net	198,818	850	219	280	11,242	—	151	140	—	211,700
Investments in joint ventures and other assets	25,627	—	2,322	—	—	4,052	895	1,951	(2,322)	32,525
Total assets	$ 314,722	4,551	2,722	1,723	13,167	24,921	1,722	2,760	(2,322)	363,966

(Continued)

Schedule 1-g

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland St. Joseph Health System (SJHS)

June 30, 2017

(In thousands)

Liabilities and Net Assets	St. Joseph Medical Center	St. Joseph Medical Group	St. Joseph Properties	St. Joseph Orthopaedics	O'Dea Medical Arts	St. Joseph Foundation	UM Regional Supplier svcs	UM Regional Prof svcs	Eliminations	St. Joseph consolidated total
Current liabilities:										
Trade accounts payable	$ 25,140	866	591	(332)	(19)	26	230	52	—	26,554
Accrued payroll and benefits	20,743	2,428	—	2,017	—	—	167	183	—	25,538
Advances from third-party payors	11,089	—	—	—	—	—	—	—	—	11,089
Lines of credit	—	—	—	—	—	—	—	—	—	—
Other current liabilities	2,950	67,831	5,233	25,452	29	109	3,451	201	—	105,256
Current portion of long-term debt	6,260	—	—	—	—	—	—	—	—	6,260
Total current liabilities	66,182	71,125	5,824	27,137	10	135	3,848	436	—	174,697
Long-term debt, less current portion	229,474	—	—	—	8,698	—	—	—	—	238,172
Other long-term liabilities	25,628	—	—	—	—	—	—	—	—	25,628
Total liabilities	321,284	71,125	5,824	27,137	8,708	135	3,848	436	—	438,497
Net assets:										
Unrestricted	(6,563)	(66,574)	(3,102)	(25,414)	4,459	4,179	(2,126)	2,324	(2,322)	(95,139)
Temporarily restricted	1	—	—	—	—	19,609	—	—	—	19,610
Permanently restricted	—	—	—	—	—	998	—	—	—	998
Total net assets	(6,562)	(66,574)	(3,102)	(25,414)	4,459	24,786	(2,126)	2,324	(2,322)	(74,531)
Total liabilities and net assets	$ 314,722	4,551	2,722	1,723	13,167	24,921	1,722	2,760	(2,322)	363,966

See accompanying independent auditors' report.

Schedule 1-h

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Upper Chesapeake Health System (UCHS)

June 30, 2017

(In thousands)

Assets	Upper Chesapeake Medical Center	Harford Memorial Hospital	UCHS Properties	Health Ventures	Medical Services	Residential Hospice House	Upper Chesapeake Health Foundation	Upper Chesapeake Health System	Hospice of Harford County	Upper Chesapeake Insurance Co.	Upper Chesapeake Land Trust	Eliminations	Upper Chesapeake consolidated total
Current assets:													
Cash and cash equivalents	$ 26,476	27,804	23	—	178	6	1,419	—	—	—	—	—	55,906
Assets limited as to use, current portion	—	—	—	—	—	—	—	—	—	—	—	—	—
Accounts receivable:													
Patient accounts receivable, less allowance for doubtful accounts of $21,934	32,509	7,456	—	—	5,659	10	—	—	—	—	—	—	45,634
Other	12,094	—	—	—	—	—	—	—	—	1,226	—	—	13,320
Inventories	6,959	2,743	—	—	683	—	—	—	—	—	—	—	10,385
Prepaid expenses and other current assets	1,915	2,191	16	37	516	5	4,135	29	—	1,114	—	—	9,958
Total current assets	79,953	40,194	39	37	7,036	21	5,554	29	—	2,340	—	—	135,203
Investments	110,900	79,066	—	—	—	527	—	—	—	—	—	—	190,493
Assets limited as to use, less current portion:													
Investments held for swap collateral	28,959	—	—	—	—	—	—	—	—	—	—	—	28,959
Debt service funds	—	—	—	—	—	—	—	—	—	—	—	—	—
Construction funds	—	—	—	—	—	—	—	—	—	—	—	—	—
Board designated and escrow funds	—	—	—	—	—	—	22,383	—	—	—	—	—	22,383
Self-insurance trust funds	—	—	—	—	—	—	—	—	—	12,903	—	—	12,903
Funds restricted by donor	—	—	—	—	—	—	—	—	—	—	—	—	—
Economic interests in the net assets of related organizations	—	—	—	—	—	—	—	—	—	—	—	—	—
	28,959	—	—	—	—	—	22,383	—	—	12,903	—	—	64,245
Property and equipment, net	217,332	28,913	—	10	1,987	1,761	59	1,114	—	—	3,001	—	254,177
Investments in joint ventures and other assets	228,151	—	—	3,901	—	—	21	—	—	9,101	—	(22,465)	218,709
Total assets	$ 665,295	148,173	39	3,948	9,023	2,309	28,017	1,143	—	24,344	3,001	(22,465)	862,827

(Continued)

Schedule 1-h

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Upper Chesapeake Health System (UCHS)

June 30, 2017

(In thousands)

Liabilities and Net Assets	Upper Chesapeake Medical Center	Harford Memorial Hospital	UCHS Properties	Health Ventures	Medical Services	Residential Hospice House	Upper Chesapeake Health Foundation	Upper Chesapeake Health System	Hospice of Harford County	Upper Chesapeake Insurance Co.	Upper Chesapeake Land Trust	Eliminations	Upper Chesapeake consolidated total
Current liabilities:													
Trade accounts payable	$ 8,627	6,834	—	—	2,849	—	—	282	—	36	—	—	18,628
Accrued payroll and benefits	19,737	5,532	—	—	—	—	—	1,298	—	—	—	—	26,567
Advances from third-party payors	6,715	1,698	—	—	—	—	—	—	—	—	—	—	8,413
Other current liabilities	12,958	22,153	23	—	6,136	495	9,789	2,305	—	2,168	3,102	65	59,194
Current portion of long-term debt	4,832	—	—	—	—	—	—	—	—	—	—	—	4,832
Total current liabilities	52,869	36,217	23	—	8,985	495	9,789	3,885	—	2,204	3,102	65	117,634
Long-term debt, less current portion	171,619	24,855	—	—	—	—	—	—	—	—	—	—	196,474
Other long-term liabilities	22,528	1,134	—	—	—	—	—	1	—	20,945	—	(4,237)	40,371
Total liabilities	247,016	62,206	23	—	8,985	495	9,789	3,886	—	23,149	3,102	(4,172)	354,479
Net assets:													
Unrestricted	250,051	85,967	16	3,948	38	1,287	10,426	(2,743)	—	1,195	(101)	(65)	350,019
Temporarily restricted	168,228	—	—	—	—	527	6,526	—	—	—	—	(18,228)	157,053
Permanently restricted	—	—	—	—	—	—	1,276	—	—	—	—	—	1,276
Total net assets	418,279	85,967	16	3,948	38	1,814	18,228	(2,743)	—	1,195	(101)	(18,293)	508,348
Total liabilities and net assets	$ 665,295	148,173	39	3,948	9,023	2,309	28,017	1,143	—	24,344	3,001	(22,465)	862,827

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Health Plans

June 30, 2017

(In thousands)

Assets	UM Health Ventures	UM Health Plans	Eliminations	UM Health Plans consolidated total
Current assets:				
Cash and cash equivalents	$ —	40,876	—	40,876
Assets limited as to use, current portion	—	—	—	—
Accounts receivable:				
Patient accounts receivable, less allowance for doubtful accounts of $0	—	—	—	—
Other	—	18,056	—	18,056
Inventories	—	—	—	—
Prepaid expenses and other current assets	—	331	—	331
Total current assets	—	59,263	—	59,263
Investments	—	10,208	—	10,208
Assets limited as to use, less current portion:				
Investment held for collateral	—	—	—	—
Debt service funds	—	—	—	—
Construction funds	—	—	—	—
Board designated and escrow funds	—	—	—	—
Self-insurance trust funds	—	—	—	—
Funds restricted by donor	—	—	—	—
Economic interests in the net assets of related organizations	—	—	—	—
	—	—	—	—
Property and equipment, net	—	4,451	—	4,451
Investments in joint ventures and other assets	120,880	88,623	—	209,503
Total assets	$ 120,880	162,545	—	283,425

(Continued)

Schedule 1-i

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Health Plans

June 30, 2017

(In thousands)

Liabilities and Net Assets	UM Health Ventures	UM Health Plans	Eliminations	UM Health Plans consolidated total
Current liabilities:				
Trade accounts payable	$ 216	717	—	933
Accrued payroll and benefits	—	2,378	—	2,378
Advances from third-party payors	—	—	—	—
Lines of credit	—	—	—	—
Other current liabilities	53,885	49,233	—	103,118
Current portion of long-term debt	5,000	—	—	5,000
Total current liabilities	59,101	52,328	—	111,429
Long-term debt, less current portion	36,667	—	—	36,667
Other long-term liabilities	35,700	17,563	—	53,263
Total liabilities	131,468	69,891	—	201,359
Net assets:				
Unrestricted	(10,588)	92,654	—	82,066
Temporarily restricted	—	—	—	—
Permanently restricted	—	—	—	—
Total net assets	(10,588)	92,654	—	82,066
Total liabilities and net assets	$ 120,880	162,545	—	283,425

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2016

(In thousands)

Assets	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	Upper Chesapeake	UM Health Plans	UMMS Foundation	Community Med. Group	ECARE	Eliminations	Consolidated total
Current assets:														
Cash and cash equivalents	$ 385,209	6,218	11,907	28,231	22,038	13,790	3,910	49,428	1,540	—	898	—	—	523,169
Assets limited as to use, current portion	47,477	—	528	1,183	860	404	960	—	—	—	—	—	—	51,412
Accounts receivable:														
Patient accounts receivable, less allowance for doubtful accounts of $202,183	169,672	9,849	16,255	35,459	17,894	7,721	34,817	35,816	—	—	4,572	—	—	331,055
Other	172,525	9,666	15,991	40,626	14,838	2,786	14,345	9,377	22,770	—	2,147	209	(207,393)	97,887
Inventories	28,226	1,072	2,860	6,150	4,776	1,487	5,560	9,607	—	—	—	—	—	59,738
Prepaid expenses and other current assets	12,806	128	325	1,480	1,550	477	1,833	4,140	776	1,500	324	42	—	25,381
Total current assets	814,915	26,933	47,866	113,129	61,956	26,665	61,425	108,368	25,086	1,500	7,941	251	(207,393)	1,088,642
Investments	195,252	25,304	—	121,768	80,315	30,003	10,341	172,343	10,208	—	—	—	—	645,534
Assets limited as to use, less current portion:														
Investments held for collateral	125,487	—	3,700	8,000	—	—	—	40,811	—	—	—	—	—	177,998
Debt service funds	22,290	—	—	—	—	—	—	—	—	—	—	—	—	22,290
Construction funds	335	10,360	5,259	4,995	4,772	10,449	5,816	—	—	—	—	—	—	41,986
Board designated and escrow funds	—	—	—	—	78,209	3,576	—	17,757	—	17,950	10	—	—	117,502
Self-insurance trust funds	53,064	—	16,337	23,205	28,738	4,820	10,107	11,066	—	—	—	—	—	147,337
Funds restricted by donor	—	—	1,113	—	29,598	—	1,057	—	—	23,413	—	—	—	55,181
Economic and beneficial interests in the net assets of related organizations	197,438	28,355	437	7,960	3,105	—	9,503	—	—	—	—	—	(58,913)	187,885
	398,614	38,715	26,846	44,160	144,422	18,845	26,483	69,634	—	41,363	10	—	(58,913)	750,179
Property and equipment, net	913,959	48,190	99,309	262,303	178,578	97,781	210,395	259,210	5,306	—	9,346	2,169	—	2,086,546
Investments in joint ventures and other assets	676,735	—	12,908	18,733	9,875	7,919	17,579	218,812	86,587	6,561	—	—	(660,528)	395,181
Total assets	$ 2,999,475	139,142	186,929	560,093	475,146	181,213	326,223	828,367	127,187	49,424	17,297	2,420	(926,834)	4,966,082

(Continued)

Schedule 2

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2016

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	Upper Chesapeake	UM Health Plans	UMMS Foundation	Community Med. Group	ECARE	Eliminations	Consolidated total
Current liabilities:														
Trade accounts payable	$ 127,944	7,961	14,452	21,089	17,971	9,361	29,367	16,663	109	14	4,461	151	—	249,543
Accrued payroll and benefits	119,204	5,181	12,501	25,273	22,335	3,944	28,124	25,470	1,656	—	9,649	—	—	253,337
Advances from third-party payors	72,546	2,910	9,660	9,667	6,789	3,735	10,633	8,777	—	—	—	—	—	124,717
Lines of credit	180,000	—	—	—	—	—	—	—	—	—	—	—	—	180,000
Short-term financing	150,000	—	—	—	—	—	—	—	—	—	—	—	—	150,000
Other current liabilities	86,581	1,268	7,565	43,706	7,304	7,742	82,502	63,259	40,129	—	5,685	9,174	(207,393)	147,522
Long-term debt subject to short-term remarketing arrangements	32,515	—	—	—	—	—	—	—	—	—	—	—	—	32,515
Current portion of long-term debt	11,846	465	719	3,870	3,213	2,875	5,159	4,445	5,000	—	—	—	—	37,592
Total current liabilities	780,636	17,785	44,897	103,605	57,612	27,657	155,785	118,614	46,894	14	19,795	9,325	(207,393)	1,175,226
Long-term debt, less current portion	566,363	20,991	33,022	168,096	88,243	60,306	242,609	201,307	41,667	—	—	—	—	1,422,604
Other long-term liabilities	124,130	144	29,724	47,978	22,971	16,918	15,652	41,788	53,300	—	—	—	—	352,605
Interest rate swap liabilities	273,037	—	—	—	—	—	—	—	—	—	—	—	—	273,037
Total liabilities	1,744,166	38,920	107,643	319,679	168,826	104,881	414,046	361,709	141,861	14	19,795	9,325	(207,393)	3,223,472
Net assets:														
Unrestricted	1,035,728	71,734	77,736	232,454	267,012	76,239	(97,860)	308,990	(14,674)	22,599	(2,498)	(6,905)	(511,275)	1,459,280
Temporarily restricted	217,892	28,488	1,550	7,960	23,811	93	9,375	156,392	—	7,594	—	—	(206,890)	246,265
Permanently restricted	1,689	—	—	—	15,497	—	662	1,276	—	19,217	—	—	(1,276)	37,065
Total net assets	1,255,309	100,222	79,286	240,414	306,320	76,332	(87,823)	466,658	(14,674)	49,410	(2,498)	(6,905)	(719,441)	1,742,610
Total liabilities and net assets	$ 2,999,475	139,142	186,929	560,093	475,146	181,213	326,223	828,367	127,187	49,424	17,297	2,420	(926,834)	4,966,082

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division

Year ended June 30, 2017

(In thousands)

	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	UCHS	UM Health Plans	UMMS Foundation	Community Med. Group	ECARE	Eliminations	Consolidated total
Unrestricted revenues, gains and other support:														
Patient Service Revenue (net of contractual adjustments)	$ 1,482,557	115,107	226,153	423,060	325,782	137,928	434,315	452,276	—	—	73,474	—	(1,033)	3,669,619
Provision for bad debts	(73,931)	(7,266)	(20,133)	(35,205)	(11,498)	(6,462)	(13,646)	(16,455)	—	—	(1)	—	—	(184,597)
Net patient service revenue	1,408,626	107,841	206,020	387,855	314,284	131,466	420,669	435,821	—	—	73,473	—	(1,033)	3,485,022
Other operating revenue:														
State support	18,200	—	—	—	—	—	—	—	—	—	—	—	—	18,200
Premium Revenue	—	—	—	—	—	—	—	—	268,060	—	—	—	—	268,060
Other revenue	105,443	2,602	11,228	5,450	5,547	746	4,750	271	—	—	59,222	2,942	(61,793)	136,408
Total unrestricted revenue, gains and other support	1,532,269	110,443	217,248	393,305	319,831	132,212	425,419	436,092	268,060	—	132,695	2,942	(62,826)	3,907,690
Operating expenses:														
Salaries, wages and benefits	747,544	52,003	93,615	182,165	157,714	57,397	198,026	244,970	13,854	—	89,146	—	—	1,836,434
Expendable supplies	354,148	15,379	29,905	61,498	46,202	19,020	82,507	83,351	—	—	12,651	63	—	704,724
Purchased services	119,167	23,500	46,688	93,658	78,364	30,671	103,220	58,623	16,623	—	26,173	4,837	(62,826)	538,698
Medical Claims Expense	—	—	—	—	—	—	—	—	252,118	—	—	—	—	252,118
Contracted services	134,767	8,867	23,146	9,560	17,049	6,091	8,241	13,253	—	—	5,716	—	—	226,690
Depreciation and amortization	96,054	6,535	12,875	27,565	22,705	7,762	19,716	22,137	2,278	—	1,427	695	—	219,749
Interest expense	24,525	722	1,149	5,811	3,141	2,175	10,034	8,150	1,304	—	—	186	—	57,197
Total operating expenses	1,476,205	107,006	207,378	380,257	325,175	123,116	421,744	430,484	286,177	—	135,113	5,781	(62,826)	3,835,610
Operating income (loss)	56,064	3,437	9,870	13,048	(5,344)	9,096	3,675	5,608	(18,117)	—	(2,418)	(2,839)	—	72,080
Nonoperating income and expenses, net:														
Loss on early extinguishment of debt	(26,427)	—	—	—	—	—	—	—	—	—	—	—	—	(26,427)
Change in fair value of undesignated interest rate swaps	76,797	—	—	—	—	—	—	—	—	—	—	—	—	76,797
Other nonoperating gains and losses:														
Contributions	—	—	—	—	326	200	279	228	—	4,392	—	—	—	5,425
Equity in net income of joint ventures	3,038	—	—	(115)	(166)	48	834	217	—	—	—	—	—	3,856
Investment income	10,454	1,106	102	4,501	9,374	810	360	7,607	182	1,000	—	—	—	35,496
Change in fair value of investments	13,983	2,607	—	10,139	9,161	2,539	962	12,813	—	1,971	—	—	—	54,175
Other nonoperating gains and losses	(10,812)	(363)	(564)	(3,213)	(7,261)	(648)	(5,262)	(2,225)	(2,339)	(5,356)	—	—	—	(38,043)
Total other nonoperating gains and losses	16,663	3,350	(462)	11,312	11,434	2,949	(2,827)	18,640	(2,157)	2,007	—	—	—	60,909
Excess (deficiency) of revenues over expenses	$ 123,097	6,787	9,408	24,360	6,090	12,045	848	24,248	(20,274)	2,007	(2,418)	(2,839)	—	183,359

See accompanying independent auditors' report.

Schedule 3-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for University of Maryland Medical Center & Affiliates (UMMC)

Year ended June 30, 2017

(In thousands)

	University of Maryland Medical Center						
	University Hospital	Shock Trauma Center	Subtotal	36 South Paca	University CARE	Eliminations	University of Maryland Medical Center & Affiliates consolidated total
Unrestricted revenues, gains and other support:							
Patient service revenue (net of contractual adjustments)	$ 1,261,576	219,539	1,481,115	—	1,442	—	1,482,557
Provision for bad debts	(60,800)	(13,014)	(73,814)	—	(117)	—	(73,931)
Net patient service revenue	1,200,776	206,525	1,407,301	—	1,325	—	1,408,626
Other operating revenue:							
State support	15,000	3,200	18,200	—	—	—	18,200
Other revenue	102,963	276	103,239	929	1,275	—	105,443
Total unrestricted revenue, gains and other support	1,318,739	210,001	1,528,740	929	2,600	—	1,532,269
Operating expenses:							
Salaries, wages and benefits	678,468	67,458	745,926	130	1,488	—	747,544
Expendable supplies	324,277	29,571	353,848	191	109	—	354,148
Purchased services	74,090	41,633	115,723	746	2,698	—	119,167
Contracted services	122,497	12,270	134,767	—	—	—	134,767
Depreciation and amortization	83,438	12,227	95,665	389	—	—	96,054
Interest expense	24,165	—	24,165	360	—	—	24,525
Total operating expenses	1,306,935	163,159	1,470,094	1,816	4,295	—	1,476,205
Operating income (loss)	11,804	46,842	58,646	(887)	(1,695)	—	56,064
Nonoperating income and expenses, net:							
Loss on early extinguishment of debt	(26,427)	—	(26,427)	—	—	—	(26,427)
Change in fair value of undesignated interest rate swaps	76,797	—	76,797	—	—	—	76,797
Other nonoperating gains and losses:							
Contributions	—	—	—	—	—	—	—
Equity in net income of joint ventures	630	—	630	—	—	2,408	3,038
Investment income	10,454	—	10,454	—	—	—	10,454
Change in fair value of investments	13,983	—	13,983	—	—	—	13,983
Other nonoperating gains and losses	(10,981)	—	(10,981)	—	—	169	(10,812)
Total other nonoperating gains and losses	14,086	—	14,086	—	—	2,577	16,663
Excess (deficiency) of revenues over expenses	$ 76,260	46,842	123,102	(887)	(1,695)	2,577	123,097

See accompanying independent auditors' report.

Schedule 3-b

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Midtown Health, Inc. (Midtown)

Year ended June 30, 2017

(In thousands)

	UM Midtown Health Systems, Inc.	UMMC Midtown Campus	UM Midtown Clin. Prac. Group	Eliminations	Midtown consolidated total
Unrestricted revenues, gains and other support:					
Patient service revenue (net of contractual adjustments)	$ 661	224,909	3,400	(2,817)	226,153
Provision for bad debts	(52)	(19,757)	(324)	—	(20,133)
Net patient service revenue	609	205,152	3,076	(2,817)	206,020
Other operating revenue:					
State support	—	—	—	—	—
Other revenue	963	10,221	44	—	11,228
Total unrestricted revenue, gains and other support	1,572	215,373	3,120	(2,817)	217,248
Operating expenses:					
Salaries, wages and benefits	795	92,820	—	—	93,615
Expendable supplies	52	29,853	—	—	29,905
Purchased services	1,558	44,827	303	—	46,688
Contracted services	—	23,146	2,817	(2,817)	23,146
Depreciation and amortization	411	12,464	—	—	12,875
Interest expense	33	1,116	—	—	1,149
Total operating expenses	2,849	204,226	3,120	(2,817)	207,378
Operating income (loss)	(1,277)	11,147	—	—	9,870
Nonoperating income and expenses, net:					
Loss on early extinguishment of debt	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	—	—	—	—	—
Other nonoperating gains and losses:					
Contributions	—	—	—	—	—
Equity in net income of joint ventures	—	—	—	—	—
Investment income	—	102	—	—	102
Change in fair value of investments	—	—	—	—	—
Other nonoperating gains and losses	—	(564)	—	—	(564)
Total other nonoperating gains and losses	—	(462)	—	—	(462)
Excess (deficiency) of revenues over expenses	$ (1,277)	10,685	—	—	9,408

See accompanying independent auditors' report.

Schedule 3-c

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Baltimore Washington Medical System (BWMS)

Year ended June 30, 2017

(In thousands)

	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Shipley's	Eliminations	BWMS consolidated total
Unrestricted revenues, gains and other support:								
Patient service revenue (net of contractual adjustments)	$ —	382,961	35,797	6,388	—	—	(2,086)	423,060
Provision for bad debts	—	(19,775)	(15,193)	(237)	—	—	—	(35,205)
Net patient service revenue	—	363,186	20,604	6,151	—	—	(2,086)	387,855
Other operating revenue:								
State support	—	—	—	—	—	—	—	—
Other revenue	4,150	3,681	—	—	2,592	—	(4,973)	5,450
Total unrestricted revenue, gains and other support	4,150	366,867	20,604	6,151	2,592	—	(7,059)	393,305
Operating expenses:								
Salaries, wages and benefits	4,149	165,110	11,640	1,266	—	—	—	182,165
Expendable supplies	—	60,895	—	461	142	—	—	61,498
Purchased services	24,254	66,602	5,323	3,208	1,330	—	(7,059)	93,658
Contracted services	—	9,560	—	—	—	—	—	9,560
Depreciation and amortization	—	26,386	—	421	758	—	—	27,565
Interest expense	—	5,657	—	67	87	—	—	5,811
Total operating expenses	28,403	334,210	16,963	5,423	2,317	—	(7,059)	380,257
Operating income (loss)	(24,253)	32,657	3,641	728	275	—	—	13,048
Nonoperating income and expenses, net:								
Loss on early extinguishment of debt	—	—	—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	—	—	—	—	—	—	—	—
Other nonoperating gains and losses:								
Contributions	—	—	—	—	—	—	—	—
Equity in net income of joint ventures	48,611	(115)	—	—	—	—	(48,611)	(115)
Investment income	—	4,501	—	—	—	—	—	4,501
Change in fair value of investments	—	10,139	—	—	—	—	—	10,139
Other nonoperating gains and losses	—	(2,854)	—	(359)	—	—	—	(3,213)
Total other nonoperating gains and losses	48,611	11,671	—	(359)	—	—	(48,611)	11,312
Excess (deficiency) of revenues over expenses	$ 24,358	44,328	3,641	369	275	—	(48,611)	24,360

See accompanying independent auditors' report.

Schedule 3-d

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Shore Regional Health (Shore Regional)

Year ended June 30, 2017

(In thousands)

	Shore Health System, Inc.	Shore Orthopedics	UM Shore Home Care	Queenstown ASC	UM Shore Nursing and Rehab.	Shore Med. Group	Memorial Hospital Foundation, Inc. and Subsidiary	Chester River Consolidated Total	Eliminations	SHS consolidated total
Unrestricted revenues, gains and other support:										
Patient service revenue (net of contractual adjustments)	$ 249,692	7,691	3,480	257	8,012	—	—	56,650	—	325,782
Provision for bad debts	(8,531)	—	56	(126)	(100)	—	—	(2,797)	—	(11,498)
Net patient service revenue	241,161	7,691	3,536	131	7,912	—	—	53,853	—	314,284
Other operating revenue:										
State support	—	—	—	—	—	—	—	—	—	—
Other revenue	4,576	68	—	427	71	—	—	405	—	5,547
Total unrestricted revenue, gains and other support	245,737	7,759	3,536	558	7,983	—	—	54,258	—	319,831
Operating expenses:										
Salaries, wages and benefits	120,913	7,635	3,760	383	5,106	—	—	19,917	—	157,714
Expendable supplies	38,148	751	82	152	827	—	—	6,242	—	46,202
Purchased services	42,398	1,462	606	11	2,735	19,302	—	11,850	—	78,364
Contracted services	11,137	—	—	118	12	—	—	5,782	—	17,049
Depreciation and amortization	17,976	43	76	3	255	—	—	4,352	—	22,705
Interest expense	2,983	—	—	—	6	—	—	152	—	3,141
Total operating expenses	233,555	9,891	4,524	667	8,941	19,302	—	48,295	—	325,175
Operating income (loss)	12,182	(2,132)	(988)	(109)	(958)	(19,302)	—	5,963	—	(5,344)
Nonoperating income and expenses, net:										
Loss on early extinguishment of debt	—	—	—	—	—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	—	—	—	—	—	—	—	—	—	—
Other nonoperating gains and losses:										
Contributions	25	—	—	—	—	—	151	150	—	326
Equity in net income of joint ventures	(166)	—	—	—	—	—	—	—	—	(166)
Investment income (loss)	5,786	—	—	—	—	—	3,002	586	—	9,374
Change in fair value of investments	5,237	—	—	—	—	—	2,440	1,484	—	9,161
Other nonoperating gains and losses	(3,407)	—	—	—	—	—	(3,302)	(552)	—	(7,261)
Total other nonoperating gains and losses	7,475	—	—	—	—	—	2,291	1,668	—	11,434
Excess (deficiency) of revenues over expenses	$ 19,657	(2,132)	(988)	(109)	(958)	(19,302)	2,291	7,631	—	6,090

See accompanying independent auditors' report.

Schedule 3-e

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Chester River Health System, Inc. (CRHS) a subsidiary of Shore Regional Health

Year ended June 30, 2017

(In thousands)

	Chester River Hospital Center	Chester River Manor	UM Chester River Home Care	Chester River Health Foundation	Chester River consolidated total
Unrestricted revenues, gains and other support:					
Patient service revenue (net of contractual allowances)	$ 54,588	—	2,062	—	56,650
Provision for bad debts	(2,777)	—	(18)	(2)	(2,797)
Net patient service revenue	51,811	—	2,044	(2)	53,853
Other operating revenue:					
State support	—	—	—	—	—
Other revenue	403	—	—	2	405
Total unrestricted revenue, gains and other support	52,214	—	2,044	—	54,258
Operating expenses:					
Salaries, wages and benefits	18,097	—	1,820	—	19,917
Expendable supplies	6,191	—	47	4	6,242
Purchased services	11,488	—	366	(4)	11,850
Contracted services	5,782	—	—	—	5,782
Depreciation and amortization	4,338	—	14	—	4,352
Interest expense	152	—	—	—	152
Total operating expenses	46,048	—	2,247	—	48,295
Operating income	6,166	—	(203)	—	5,963
Nonoperating income and expenses, net:					
Loss on early extinguishment of debt	—	—	—	—	—
Other nonoperating gains and losses:					
Contributions	—	—	—	150	150
Equity in net income of joint ventures	—	—	—	—	—
Investment income	516	—	48	22	586
Change in fair value of investments	1,240	—	116	128	1,484
Other nonoperating gains and losses	(72)	—	—	(480)	(552)
Total other nonoperating gains and losses	1,684	—	164	(180)	1,668
Excess (deficiency) of revenues over expenses	$ 7,850	—	(39)	(180)	7,631

See accompanying independent auditors' report.

Schedule 3-f

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Charles Regional Health (Charles Regional)

Year ended June 30, 2017

(In thousands)

	Charles Regional Health, Inc.	Charles Regional Medical Center, Inc.	Charles Regional Urgent Care	Charles Regional Care Partners, Inc. and Subsidiary	Charles Regional Health Foundation, Inc.	Charles Regional Imaging Center	Eliminations	Charles Regional consolidated total
Unrestricted revenues, gains and other support:								
Patient service revenue (net of contractual adjustments)	$ —	136,289	1,584	—	—	55	—	137,928
Provision for bad debts	—	(6,428)	(32)	—	—	(2)	—	(6,462)
Net patient service revenue	—	129,861	1,552	—	—	53	—	131,466
Other operating revenue:								
State support	—	—	—	—	—	—	—	—
Other revenue	239	507	—	—	—	—	—	746
Total unrestricted revenue, gains and other support	239	130,368	1,552	—	—	53	—	132,212
Operating expenses:								
Salaries, wages and benefits	—	57,397	—	—	—	—	—	57,397
Expendable supplies	—	18,879	90	—	—	51	—	19,020
Purchased services	1,544	27,006	1,941	(1)	—	181	—	30,671
Contracted services	—	6,067	1	—	—	23	—	6,091
Depreciation and amortization	1,767	5,543	123	192	—	137	—	7,762
Interest expense	288	1,887	—	—	—	—	—	2,175
Total operating expenses	3,599	116,779	2,155	191	—	392	—	123,116
Operating income	(3,360)	13,589	(603)	(191)	—	(339)	—	9,096
Nonoperating income and expenses, net:								
Loss on early extinguishment of debt	—	—	—	—	—	—	—	—
Other nonoperating gains and losses:								
Contributions	—	200	—	—	—	—	—	200
Equity in net income of joint ventures	—	48	—	(238)	—	—	238	48
Investment income	63	702	—	—	45	—	—	810
Change in fair value of investments	—	2,268	—	—	271	—	—	2,539
Other nonoperating gains and losses	—	(434)	—	—	(34)	—	(180)	(648)
Total other nonoperating gains and losses	63	2,784	—	(238)	282	—	58	2,949
Excess (deficiency) of revenues over expenses	$ (3,297)	16,373	(603)	(429)	282	(339)	58	12,045

See accompanying independent auditors' report.

Schedule 3-g

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for University of Maryland St. Joseph Health System (SJHS)

Year ended June 30, 2017

(In thousands)

	St. Joseph Medical Center	St. Joseph Medical Group	St. Joseph Properties	St. Joseph Orthopaedics	O'Dea Medical Arts	St. Joseph Foundation	UM Regional Supplier Svcs	UM Regional Prof SVCS	Eliminations	St. Joseph consolidated total
Unrestricted revenues, gains and other support:										
Patient service revenue (net of contractual adjustments)	$ 370,211	34,177	—	24,281	—	—	2,004	3,642	—	434,315
Provision for bad debts	(10,577)	(1,562)	—	(1,464)	—	—	(43)	—	—	(13,646)
Net patient service revenue	359,634	32,615	—	22,817	—	—	1,961	3,642	—	420,669
Other operating revenue:										
State support	—	—	—	—	—	—	—	—	—	—
Other revenue	3,231	9,052	1,600	—	2,666	—	—	115	(11,914)	4,750
Total unrestricted revenue, gains and other support	362,865	41,667	1,600	22,817	2,666	—	1,961	3,757	(11,914)	425,419
Operating expenses:										
Salaries, wages and benefits	135,718	43,306	—	15,174	—	—	1,179	2,649	—	198,026
Expendable supplies	80,461	1,147	—	9	—	—	820	70	—	82,507
Purchased services	77,393	12,747	2,420	11,427	1,336	—	575	461	(3,139)	103,220
Contracted services	16,946	70	—	—	—	—	—	—	(8,775)	8,241
Depreciation and amortization	18,955	146	32	40	475	—	47	21	—	19,716
Interest expense	9,620	—	—	—	414	—	—	—	—	10,034
Total operating expenses	339,093	57,416	2,452	26,650	2,225	—	2,621	3,201	(11,914)	421,744
Operating income (loss)	23,772	(15,749)	(852)	(3,833)	441	—	(660)	556	—	3,675
Nonoperating income and expenses, net:										
Loss on early extinguishment of debt	—	—	—	—	—	—	—	—	—	—
Other nonoperating gains and losses:										
Contributions	—	—	—	—	—	279	—	—	—	279
Equity in net income of joint ventures	834	—	—	—	—	—	—	—	—	834
Investment income	—	—	—	—	—	360	—	—	—	360
Change in fair value of investments	—	—	—	—	—	962	—	—	—	962
Other nonoperating gains and losses	(4,040)	5	—	—	—	(1,227)	—	—	—	(5,262)
Total other nonoperating gains and losses	(3,206)	5	—	—	—	374	—	—	—	(2,827)
Excess (deficiency) of revenues over expenses	$ 20,566	(15,744)	(852)	(3,833)	441	374	(660)	556	—	848

See accompanying independent auditors' report.

Schedule 3-h

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Upper Chesapeake Health System (UCHS)

Year ended June 30, 2017

(In thousands)

	Upper Chesapeake Medical Center	Harford Memorial Hospital	UCHS Properties	Health Ventures	Medical Services	Residential Hospice House	Upper Chesapeake Health Foundation	Upper Chesapeake Health System	Hospice of Harford County	Upper Chesapeake Insurance Co.	Upper Chesapeake Land Trust	Eliminations	Upper Chesapeake consolidated total
Unrestricted revenues, gains and other support:													
Patient service revenue (net of contractual adjustments)	$ 306,683	94,328	—	—	50,918	347	—	—	—	—	—	—	452,276
Provision for bad debts	(9,849)	(5,207)	—	—	(1,361)	(38)	—	—	—	—	—	—	(16,455)
Net patient service revenue	296,834	89,121	—	—	49,557	309	—	—	—	—	—	—	435,821
Other operating revenue:													
State support	—	—	—	—	—	—	—	—	—	—	—	—	—
Other revenue	3,937	1,162	—	(321)	6,342	400	—	16,067	—	671	—	(27,987)	271
Total unrestricted revenue, gains and other support	300,771	90,283	—	(321)	55,899	709	—	16,067	—	671	—	(27,987)	436,092
Operating expenses:													
Salaries, wages and benefits	140,964	48,855	—	—	43,151	798	—	11,202	—	—	—	—	244,970
Expendable supplies	67,028	8,246	—	—	7,803	49	—	225	—	—	—	—	83,351
Purchased services	42,999	18,156	305	105	12,695	132	—	3,994	—	682	13	(20,458)	58,623
Contracted services	10,016	3,902	—	—	5,774	—	—	81	—	—	—	(6,520)	13,253
Depreciation and amortization	16,311	4,518	—	—	506	271	—	531	—	—	—	—	22,137
Interest expense	6,901	1,249	—	—	—	—	—	—	—	—	—	—	8,150
Total operating expenses	284,219	84,926	305	105	69,929	1,250	—	16,033	—	682	13	(26,978)	430,484
Operating income (loss)	16,552	5,357	(305)	(426)	(14,030)	(541)	—	34	—	(11)	(13)	(1,009)	5,608
Nonoperating income and expenses, net:													
Loss on early extinguishment of debt	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	—	—	—	—	—	—	—	—	—	—	—	—	—
Other nonoperating gains and losses:													
Contributions	—	—	—	—	—	—	228	—	—	—	—	—	228
Equity in net income of joint ventures	—	—	—	217	—	—	—	—	—	—	—	—	217
Investment income	2,889	2,409	—	—	—	53	2,245	—	—	11	—	—	7,607
Change in fair value of investments	6,995	5,733	—	—	—	(4)	89	—	—	—	—	—	12,813
Other nonoperating gains and losses	(2,225)	—	—	—	—	—	—	—	—	—	—	—	(2,225)
Total other nonoperating gains and losses	7,659	8,142	—	217	—	49	2,562	—	—	11	—	—	18,640
Excess (deficiency) of revenues over expenses	$ 24,211	13,499	(305)	(209)	(14,030)	(492)	2,562	34	—	—	(13)	(1,009)	24,248

See accompanying independent auditors' report.

Schedule 3-i

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for University of Maryland Health Plans

Year ended June 30, 2017

(In thousands)

	UM Health Ventures	UM Health Plans	Eliminations	UM Health Plans consolidated total
Unrestricted revenues, gains and other support:				
Patient service revenue (net of contractual adjustments)	$ —	—	—	—
Provision for bad debts	—	—	—	—
Net patient service revenue	—	—	—	—
Other operating revenue:				
State support	—	—	—	—
Premium revenue	(4,411)	272,471	—	268,060
Other revenue	—	—	—	—
Total unrestricted revenue, gains and other support	(4,411)	272,471	—	268,060
Operating expenses:				
Salaries, wages and benefits	220	13,634	—	13,854
Expendable supplies	—	—	—	—
Purchased services	37	16,586	—	16,623
Medical Claims Expense	—	252,118	—	252,118
Contracted services	—	—	—	—
Depreciation and amortization	—	2,278	—	2,278
Interest expense	1,304	—	—	1,304
Total operating expenses	1,561	284,616	—	286,177
Operating income (loss)	(5,972)	(12,145)	—	(18,117)
Nonoperating income and expenses, net:				
Loss on early extinguishment of debt	—	—	—	—
Change in fair value of undesignated interest rate swaps	—	—	—	—
Other nonoperating gains and losses:				
Contributions	—	—	—	—
Equity in net income of joint ventures	—	—	—	—
Investment income	—	182	—	182
Change in fair value of investments	—	—	—	—
Other nonoperating gains and losses	—	(2,339)	—	(2,339)
Total other nonoperating gains and losses	—	(2,157)	—	(2,157)
Excess (deficiency) of revenues over expenses	$ (5,972)	(14,302)	—	(20,274)

See accompanying independent auditors' report.

Schedule 4

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division

Year ended June 30, 2016

(In thousands)

	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	UCHS	UM Health Plans	UMMS Foundation	Community Med. Group	ECARE	Eliminations	Consolidated total
Unrestricted revenues, gains and other support:														
Patient Service Revenue (net of contractual adjustments)	$ 1,429,329	108,435	209,573	419,168	318,917	133,783	425,406	436,284	—	—	64,007	—	(852)	3,544,050
Provision for bad debts	(64,664)	(7,015)	(18,354)	(36,972)	(13,070)	(5,146)	(16,131)	(14,846)	—	—	—	—	—	(176,198)
Net patient service revenue	1,364,665	101,420	191,219	382,196	305,847	128,637	409,275	421,438	—	—	64,007	—	(852)	3,367,852
Other operating revenue:														
State support	3,200	—	—	—	—	—	—	—	—	—	—	—	—	3,200
Premium Revenue	—	—	—	—	—	—	—	—	140,958	—	—	—	—	140,958
Other revenue	121,601	5,719	2,970	5,507	3,240	666	6,839	3,364	3	—	49,525	2,975	(45,470)	156,939
Total unrestricted revenue, gains and other support	1,489,466	107,139	194,189	387,703	309,087	129,303	416,114	424,802	140,961	—	113,532	2,975	(46,322)	3,668,949
Operating expenses:														
Salaries, wages and benefits	725,096	50,763	89,088	179,444	139,771	58,728	195,905	221,243	14,358	—	77,460	—	—	1,751,856
Expendable supplies	343,261	14,096	23,206	61,958	40,614	17,075	81,820	81,781	—	—	11,087	96	—	674,994
Purchased services	138,443	23,430	45,671	91,785	77,612	29,432	97,257	56,262	137,240	—	24,901	4,351	(46,322)	680,062
Contracted services	130,634	9,126	20,881	9,469	13,941	5,086	7,437	15,309	—	—	4,679	—	—	216,562
Depreciation and amortization	91,131	5,675	12,515	24,616	19,979	6,056	17,598	19,893	1,663	—	984	654	—	200,764
Interest expense	23,923	766	1,232	6,156	3,320	2,143	10,110	8,580	1,047	—		187	—	57,464
Total operating expenses	1,452,488	103,856	192,593	373,428	295,237	118,520	410,127	403,068	154,308	—	119,111	5,288	(46,322)	3,581,702
Operating income (loss)	36,978	3,283	1,596	14,275	13,850	10,783	5,987	21,734	(13,347)	—	(5,579)	(2,313)	—	87,247
Nonoperating income and expenses, net:														
Loss on early extinguishment of debt	—		—	—	—	—	—	—	—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	(78,429)		—	—	—	—	—	—	—	—	—	—	—	(78,429)
Other nonoperating gains and losses:														
Contributions	—		—	—	787	—	456	—	—	2,526	—	—	—	3,769
St. Joseph escrow settlement	34,275		—	—	—	—	—	—	—	—	—	—	—	34,275
Equity in net income of joint ventures	(1,629)		—	—	(178)	470	664	375	—	—	—	—	—	(298)
Investment income	10,642	636	38	2,343	6,153	316	145	409	148	281	—	—	—	21,111
Change in fair value of investments	(21,918)	(1,303)	23	(4,770)	(10,540)	(964)	(429)	4,446	—	(988)	—	—	—	(36,443)
Other nonoperating gains and losses	(10,392)	(390)	(605)	(3,297)	(3,077)	(675)	(5,246)	(3,384)	(1,614)	(2,353)	—	—	—	(31,033)
Total other nonoperating gains and losses	10,978	(1,057)	(544)	(5,724)	(6,855)	(853)	(4,410)	1,846	(1,466)	(534)	—	—	—	(8,619)
Excess (deficiency) of revenues over expenses	$ (30,473)	2,226	1,052	8,551	6,995	9,930	1,577	23,580	(14,813)	(534)	(5,579)	(2,313)	—	199

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2017

(In thousands)

Assets	University of Maryland Medical Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals*	UMMS Foundation	Eliminations	Obligated group total
Current assets:												
Cash and cash equivalents	$ 328,162	(83)	2,970	18,724	8,955	(1,901)	8,548	(1,201)	54,280	—	—	418,454
Assets limited as to use, current portion	46,797	—	432	1,228	572	242	342	1,327	—	—	—	50,940
Accounts receivable:												
Patient accounts receivable, less allowance for doubtful accounts of $188,977	173,649	11,530	14,012	41,501	22,473	2,208	8,396	37,685	39,965	—	—	351,419
Other	283,680	576	30,964	1,408	2,692	13,308	4,586	20,341	12,094	—	(125,283)	244,366
Inventories	28,559	1,106	3,071	6,131	3,892	696	1,391	5,435	9,702	—	—	59,983
Prepaid expenses and other current assets	16,035	21,924	499	1,138	1,476	20	784	1,026	4,106	1,500	—	48,508
Total current assets	876,882	35,053	51,948	70,130	40,060	14,573	24,047	64,613	120,147	1,500	(125,283)	1,173,670
Investments	232,394	29,013	3	136,194	83,553	12,230	31,145	—	189,966	—	—	714,498
Assets limited as to use, less current portion:												
Investments held for collateral	81,987	—	3,700	8,000	—	—	—	—	28,959	—	—	122,646
Debt service funds	10,438	—	—	—	—	—	—	—	—	—	—	10,438
Construction funds	46,264	14,203	8,081	10,051	5,432	4,538	10,651	8,270	—	—	—	107,490
Board designated and escrow funds	—	—	—	—	25,000	5,000	—	—	—	12,548	—	42,548
Self-insurance trust funds	72,828	—	16,776	23,028	25,492	7,327	6,707	7,891	—	—	—	160,049
Funds restricted by donor	—	—	1,116	—	5,029	105	—	—	—	25,354	—	31,604
Economic interests in the net assets of related organizations	197,124	31,446	442	9,222	78,558	6,270	5,179	9,503	—	—	(59,790)	277,954
	408,641	45,649	30,115	50,301	139,511	23,240	22,537	25,664	28,959	37,902	(59,790)	752,729
Property and equipment, net	907,068	45,924	99,343	243,492	142,380	25,257	75,087	198,818	246,245	—	—	1,983,614
Investments in joint ventures and other assets	676,447	—	6,567	17,672	9,822	2,183	6,976	25,627	228,151	10,039	(660,528)	322,956
Total assets	$ 3,101,432	155,639	187,976	517,789	415,326	77,483	159,792	314,722	813,468	49,441	(845,601)	4,947,467

* Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

(Continued)

Schedule 5

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2017

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals*	UMMS Foundation	Eliminations	Obligated group total
Current liabilities:												
Trade accounts payable	$ 140,720	9,220	17,046	22,259	17,471	2,893	8,268	25,140	15,461	154	—	258,632
Accrued payroll and benefits	108,479	5,384	10,144	18,847	15,175	3,007	4,206	20,743	25,269	—	—	211,254
Advances from third-party payors	79,155	3,568	10,706	9,951	5,618	737	2,593	11,089	8,413	—	—	131,830
Short-term financing	—	—	—	—	—	—	—	—	—	—	—	—
Lines of credit	125,000	—	—	—	—	—	—	—	—	—	—	125,000
Other current liabilities	149,408	1,040	6,839	31,343	23,406	1,102	1,047	2,950	35,111	—	(125,283)	126,963
Long-term debt subject to short-term remarketing arrangements	28,440	—	—	—	—	—	—	—	—	—	—	28,440
Current portion of long-term debt	13,271	505	782	3,962	2,705	104	2,337	6,260	4,832	—	—	34,758
Total current liabilities	644,473	19,717	45,517	86,362	64,375	7,843	18,451	66,182	89,086	154	(125,283)	916,877
Long-term debt, less current portion	718,215	20,486	31,725	161,116	81,081	4,308	52,457	229,474	196,474	—	—	1,495,336
Other long-term liabilities	123,107	144	21,226	36,049	12,374	5,455	15,398	25,628	23,662	—	—	263,043
Interest rate swap liabilities	194,524	—	—	—	—	—	—	—	—	—	—	194,524
Total liabilities	1,680,319	40,347	98,468	283,527	157,830	17,606	86,306	321,284	309,222	154	(125,283)	2,869,780
Net assets:												
Unrestricted	1,200,580	83,846	87,950	225,040	222,367	55,913	73,393	(6,563)	336,018	17,777	(511,275)	1,785,046
Temporarily restricted	218,844	31,446	1,558	9,222	20,708	2,668	93	1	168,228	11,404	(207,767)	256,405
Permanently restricted	1,689	—	—	—	14,421	1,296	—	—	—	20,106	(1,276)	36,236
Total net assets	1,421,113	115,292	89,508	234,262	257,496	59,877	73,486	(6,562)	504,246	49,287	(720,318)	2,077,687
Total liabilities and net assets	$ 3,101,432	155,639	187,976	517,789	415,326	77,483	159,792	314,722	813,468	49,441	(845,601)	4,947,467

* Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION
AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2016

(In thousands)

Assets	University of Maryland Medical Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals*	UMMS Foundation	Eliminations	Obligated group total
Current assets:												
Cash and cash equivalents	$ 383,678	6,218	11,362	27,186	14,619	5,214	11,285	1,443	49,052	—	—	510,057
Assets limited as to use, current portion	44,007	—	528	1,183	627	233	404	960	—	—	—	47,942
Accounts receivable:												
Patient accounts receivable, less allowance for doubtful accounts of $174,267	168,652	9,849	15,268	29,646	12,830	3,928	7,390	30,765	30,778	—	—	309,106
Other	178,002	333	14,293	1,926	6,296	2,964	976	12,345	—	—	(84,596)	132,539
Inventories	28,187	1,072	2,860	6,150	4,077	699	1,487	5,537	8,985	—	—	59,054
Prepaid expenses and other current assets	12,789	128	319	1,261	1,429	63	478	968	3,265	1,500	—	22,200
Total current assets	815,315	17,600	44,630	67,352	39,878	13,101	22,020	52,018	92,080	1,500	(84,596)	1,080,898
Investments	195,252	25,304	—	121,768	67,312	10,461	27,923	—	171,865	—	—	619,885
Assets limited as to use, less current portion:												
Investments held for collateral	125,487	—	3,700	8,000	—	—	—	—	40,811	—	—	177,998
Debt service funds	22,290	—	—	—	—	—	—	—	—	—	—	22,290
Construction funds	335	10,360	5,259	4,995	234	4,538	10,449	5,816	—	—	—	41,986
Board designated and escrow funds	—	—	—	—	25,000	5,000	—	—	—	17,950	—	47,950
Self-insurance trust funds	53,064	—	16,337	23,205	22,603	6,051	4,820	10,107	—	—	—	136,187
Funds restricted by donor	—	—	1,113	—	4,683	105	—	—	—	23,413	—	29,314
Economic interests in the net assets of related organizations	197,438	30,838	437	7,960	78,090	5,196	4,898	9,503	—	—	(58,913)	275,447
	398,614	41,198	26,846	44,160	130,610	20,890	20,167	25,426	40,811	41,363	(58,913)	731,172
Property and equipment, net	905,247	48,190	97,302	241,592	145,237	27,736	74,373	197,090	250,348	—	—	1,987,115
Investments in joint ventures and other assets	683,709	—	7,805	18,703	10,395	2,077	6,985	14,207	225,127	6,561	(660,528)	315,041
Total assets	$ 2,998,137	132,292	176,583	493,575	393,432	74,265	151,468	288,741	780,231	49,424	(804,037)	4,734,111

* Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

(Continued)

Schedule 6

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2016

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals*	UMMS Foundation	Eliminations	Obligated group total
Current liabilities:												
Trade accounts payable	$ 126,770	7,949	14,432	21,886	13,688	3,546	8,996	27,488	13,987	14	—	238,756
Accrued payroll and benefits	119,166	5,076	12,501	23,101	18,990	2,694	3,944	23,338	23,995	—	—	232,805
Advances from third-party payors	72,546	2,910	9,660	9,667	5,946	778	3,735	10,633	8,777	—	—	124,652
Short-term financing	180,000	—	—	—	—	—	—	—	—	—	—	180,000
Lines of credit	150,000	—	—	—	—	—	—	—	—	—	—	150,000
Other current liabilities	86,475	(13,954)	5,676	37,506	2,147	3,873	3,338	2,984	41,360	—	(84,596)	84,809
Long-term debt subject to short-term remarketing arrangements	32,515	—	—	—	—	—	—	—	—	—	—	32,515
Current portion of long-term debt	11,846	465	719	3,645	3,087	96	2,207	5,159	4,445	—	—	31,669
Total current liabilities	779,318	2,446	42,988	95,805	43,858	10,987	22,220	69,602	92,564	14	(84,596)	1,075,206
Long-term debt, less current portion	566,363	20,991	32,654	165,078	83,786	4,412	54,797	233,727	201,307	—	—	1,363,115
Other long-term liabilities	124,114	144	29,724	46,874	12,696	10,009	16,918	15,652	25,648	—	—	281,779
Interest rate swap liabilities	273,037	—	—	—	—	—	—	—	—	—	—	273,037
Total liabilities	1,742,832	23,581	105,366	307,757	140,340	25,408	93,935	318,981	319,519	14	(84,596)	2,993,137
Net assets:												
Unrestricted	1,035,724	77,873	69,667	177,858	216,600	46,082	57,440	(30,241)	293,810	22,599	(511,275)	1,456,137
Temporarily restricted	217,892	30,838	1,550	7,960	22,283	1,487	93	1	166,902	7,594	(206,890)	249,710
Permanently restricted	1,689	—	—	—	14,209	1,288	—	—	—	19,217	(1,276)	35,127
Total net assets	1,255,305	108,711	71,217	185,818	253,092	48,857	57,533	(30,240)	460,712	49,410	(719,441)	1,740,974
Total liabilities and net assets	$ 2,998,137	132,292	176,583	493,575	393,432	74,265	151,468	288,741	780,231	49,424	(804,037)	4,734,111

* Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

See accompanying independent auditors' report.

Unrestricted

Schedule 7

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Operations and Changes in Net Assets Information – Obligated Group

Year ended June 30, 2017

(In thousands)

	University of Maryland Medical Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center	Shore Health System				Chester River Hospital Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals*	UMMS Foundation	Eliminations	Obligated group total
					Memorial Hospital	Dorchester General	QAEC	Subtotal							
Unrestricted revenues, gains and other support:															
Patient service revenue (net of contractual adjustments)	$ 1,481,115	114,438	224,909	382,961	198,566	45,354	5,772	249,692	54,588	136,289	370,211	401,011	—	(1,033)	3,414,181
Provision for bad debts	(73,814)	(7,188)	(19,757)	(19,775)	(5,861)	(2,044)	(626)	(8,531)	(2,777)	(6,428)	(10,577)	(15,056)	—	—	(163,903)
Net patient service revenue	1,407,301	107,250	205,152	363,186	192,705	43,310	5,146	241,161	51,811	129,861	359,634	385,955	—	(1,033)	3,250,278
Other operating revenue:															
State support	18,200	—	—	—	—	—	—	—	—	—	—	—	—	—	18,200
Other revenue	103,239	2,583	10,221	3,681	4,230	335	11	4,576	403	507	3,231	5,099	—	—	133,540
Total unrestricted revenue, gains and other support	1,528,740	109,833	215,373	366,867	196,935	43,645	5,157	245,737	52,214	130,368	362,865	391,054	—	(1,033)	3,402,018
Operating expenses:															
Salaries, wages, and benefits	745,926	51,275	92,820	165,110	91,466	25,767	3,680	120,913	18,097	57,397	135,718	189,819	—	—	1,577,075
Expendable supplies	353,848	15,357	29,853	60,895	34,202	3,441	505	38,148	6,191	18,879	80,461	75,274	—	—	678,906
Purchased services	115,723	23,315	44,827	66,602	33,965	7,372	1,061	42,398	11,488	27,006	77,393	61,155	—	(1,033)	468,874
Contracted services	134,767	8,867	23,146	9,560	7,254	2,977	906	11,137	5,782	6,067	16,946	13,918	—	—	230,190
Depreciation and amortization	95,665	6,535	12,464	26,386	14,137	3,192	647	17,976	4,338	5,543	18,955	20,829	—	—	208,691
Interest expense	24,165	722	1,116	5,657	2,480	160	343	2,983	152	1,887	9,620	8,150	—	—	54,452
Total operating expenses	1,470,094	106,071	204,226	334,210	183,504	42,909	7,142	233,555	46,048	116,779	339,093	369,145	—	(1,033)	3,218,188
Operating income (loss)	58,646	3,762	11,147	32,657	13,431	736	(1,985)	12,182	6,166	13,589	23,772	21,909	—	—	183,830
Nonoperating income and expenses, net:															
Loss on early extinguishment of debt	(26,427)	—	—	—	—	—	—	—	—	—	—	—	—	—	(26,427)
Change in fair value of undesignated interest rate swaps	76,797	—	—	—	—	—	—	—	—	—	—	—	—	—	76,797
Other nonoperating gains and losses:															
Contributions	—	—	—		25	—	—	25	—	200	—	—	4,392	—	4,617
Equity in net income of joint ventures	630	—	—	(115)	(126)	(35)	(5)	(166)	—	48	834	—	—	—	1,231
Investment income	10,454	1,106	102	4,501	5,786	—	—	5,786	516	702	—	5,298	1,000	—	29,465
Change in fair value of investments	13,983	2,607	—	10,139	5,237	—	—	5,237	1,240	2,268	—	12,728	1,971	—	50,173
Other nonoperating gains and losses	(10,981)	(363)	(564)	(2,854)	(2,589)	(716)	(102)	(3,407)	(72)	(434)	(4,040)	(2,225)	(5,356)	—	(30,296)
Total other nonoperating gains and losses	14,086	3,350	(462)	11,671	8,333	(751)	(107)	7,475	1,684	2,784	(3,206)	15,801	2,007	—	55,190
Excess (deficiency) of revenues over expenses	123,102	7,112	10,685	44,328	21,764	(15)	(2,092)	19,657	7,850	16,373	20,566	37,710	2,007	—	289,390
Net assets released from restrictions used for purchase of property and equipment	21,500	—	1,529	—	7,692	—	—	7,692	423	—	2,063	—	—	—	33,207
Change in unrealized gains on investments	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in economic and beneficial interest in the net assets of related organizations	—	—	—	—	1,304	—	—	1,304	—	—	—	—	—	—	1,304
Change in ownership interest of joint ventures	397	—	—	—	—	—	—	—	—	—	—	—	—	—	397
Capital transfers (to) from affiliate	18,280	(1,137)	(249)	(3,454)	(22,886)	—	—	(22,886)	(180)	(1,121)	1,269	(15,330)	(6,833)	—	(31,641)
Amortization of accumulated loss of discontinued designated interest rate swap	1,794	—	—	—	—	—	—	—	—	—	—	—	—	—	1,794
Change in funded status of defined benefit pension plans	—	—	4,570	6,308	—	—	—	—	1,738	705	—	21,032	—	—	34,353
Asset reclassifications at request of donor	—	—	—	—	—	—	—	—	—	—	—	(1,326)	—	—	(1,326)
Other	(217)	(2)	1,748	—	—	—	—	—	—	(4)	(220)	(58)	4	—	1,251
Increase (decrease) in unrestricted net assets	$ 164,856	5,973	18,283	47,182	7,874	(15)	(2,092)	5,767	9,831	15,953	23,678	42,028	(4,822)	—	328,729

* Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Operations and Changes in Net Assets Information – Obligated Group

Year ended June 30, 2016

(In thousands)

	University of Maryland Medical Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center	Shore Health System				Chester River Hospital Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals*	UMMS Foundation	Eliminations	Obligated group total
					Memorial Hospital	Dorchester General	QAEC	Subtotal							
Unrestricted revenues, gains and other support:															
Patient service revenue (net of contractual adjustments)	$ 1,427,659	107,692	208,590	375,219	196,846	46,056	5,646	248,548	56,080	132,762	361,730	387,529	—	(852)	3,304,957
Provision for bad debts	(64,713)	(6,948)	(17,596)	(17,584)	(7,230)	(2,101)	(695)	(10,026)	(2,774)	(4,903)	(13,109)	(12,593)	—	—	(150,246)
Net patient service revenue	1,362,946	100,744	190,994	357,635	189,616	43,955	4,951	238,522	53,306	127,859	348,621	374,936	—	(852)	3,154,711
Other operating revenue:															
State support	3,200	—	—	—	—	—	—	—	—	—	—	—	—	—	3,200
Other revenue	119,197	5,719	1,990	3,596	2,425	327	6	2,758	255	451	5,196	5,720	—	(441)	144,441
Total unrestricted revenue, gains and other support	1,485,343	106,463	192,984	361,231	192,041	44,282	4,957	241,280	53,561	128,310	353,817	380,656	—	(1,293)	3,302,352
Operating expenses:															
Salaries, wages, and benefits	723,438	50,054	89,088	162,722	86,401	22,826	3,207	112,434	18,011	58,728	134,867	172,601	—	—	1,521,943
Expendable supplies	342,951	14,078	23,206	61,531	30,320	3,255	609	34,184	5,464	16,976	80,224	74,195	—	—	652,809
Purchased services	134,423	23,244	44,630	67,989	32,420	8,074	731	41,225	15,571	26,247	70,455	56,981	—	(1,293)	479,472
Contracted services	130,634	9,126	20,881	9,469	5,388	2,285	896	8,569	5,435	5,086	15,382	13,010	—	—	217,592
Depreciation and amortization	90,697	5,674	12,273	23,109	11,965	2,784	913	15,662	3,971	4,652	16,877	18,432	—	—	191,347
Interest expense	23,559	766	1,185	6,003	2,484	155	515	3,154	160	1,874	9,685	8,580	—	—	54,966
Total operating expenses	1,445,702	102,942	191,263	330,823	168,978	39,379	6,871	215,228	48,612	113,563	327,490	343,799	—	(1,293)	3,118,129
Operating income (loss)	39,641	3,521	1,721	30,408	23,063	4,903	(1,914)	26,052	4,949	14,747	26,327	36,857	—	—	184,223
Nonoperating income and expenses, net:															
Loss on early extinguishment of debt	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	(78,429)	—	—	—	—	—	—	—	—	—	—	—	—	—	(78,429)
Other nonoperating gains and losses:															
Contributions	—	—	—	—	71	—	—	71	333	—	—	—	2,526	—	2,930
St. Joseph escrow settlement	34,275	—	—	—	—	—	—	—	—	—	—	—	—	—	34,275
Equity in net income of joint ventures	(4,305)	—	—	—	(136)	(37)	(5)	(178)	—	202	664	—	—	—	(3,617)
Investment income	10,642	636	38	2,343	3,716	—	—	3,716	57	206	—	628	281	—	18,547
Change in fair value of investments	(21,918)	(1,303)	23	(4,770)	(6,261)	—	—	(6,261)	(382)	(855)	—	4,388	(988)	—	(32,066)
Other nonoperating gains and losses	(10,582)	(390)	(605)	(3,064)	(1,111)	(287)	(39)	(1,437)	(411)	(740)	(4,166)	(3,736)	(2,353)	—	(27,484)
Total other nonoperating gains and losses	8,112	(1,057)	(544)	(5,491)	(3,721)	(324)	(44)	(4,089)	(403)	(1,187)	(3,502)	1,280	(534)	—	(7,415)
Excess (deficiency) of revenues over expenses	(30,676)	2,464	1,177	24,917	19,342	4,579	(1,958)	21,963	4,546	13,560	22,825	38,137	(534)	—	98,379
Net assets released from restrictions used for purchase of property and equipment	4,364	—	87	—	1,466	—	—	1,466	564	1,150	1,768	—	—	—	9,399
Change in unrealized gains on investments	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in economic and beneficial interest in the net assets of related organizations	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in ownership interest of joint ventures	—	—	—	—	(1,843)	—	—	(1,843)	(561)	133	—	—	—	—	(2,271)
Capital transfers (to) from affiliate	498	—	—	—	—	—	—	—	—	—	—	—	—	—	498
Amortization of accumulated loss of discontinued designated interest rate swap	(16,212)	1,100	400	(3,200)	(11,285)	—	—	(11,285)	—	—	(2,800)	12,331	(2,250)	(2,500)	(24,416)
Change in funded status of defined benefit pension plans	1,716	—	—	—	—	—	—	—	—	—	—	—	—	—	1,716
Asset reclassifications at request of donor	—	—	(8,419)	(6,225)	—	—	—	—	(413)	(3,697)	—	8,111	—	—	(10,643)
Other	—	—	—	—	—	—	—	—	—	—	—	—	(947)	—	(947)
	(233)	8	(14)	500	(1)	—	—	(1)	(1)	2	225	(505)	(6)	—	(25)
Increase (decrease) in unrestricted net assets	$ (40,543)	3,572	(6,769)	15,992	7,679	4,579	(1,958)	10,300	4,135	11,148	22,018	58,074	(3,737)	(2,500)	71,690

* Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

See accompanying independent auditors' report.