GALLAGHER
EVELIUS & JONES LLP
ATTORNEYS AT LAW

August 3, 2018

VIA HAND DELIVERY

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

Re: Application for Certificate of Need
Establishment of 16-Bed Inpatient Acute Psychiatric Unit at
University of Maryland Medical Center

Dear Ms. Potter:

On behalf of applicant University of Maryland Medical Center, we are submitting six copies of its Application for Certificate of Need to establish a 16-Bed Inpatient Acute Psychiatric Unit at UMMC and related exhibits, along with one set of full-size project drawings. Also enclosed is a CD containing searchable PDF files of the application and exhibits, a Word version of the application, and native Excel spreadsheets of the MHCC tables.

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

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

Sincerely,

Thomas C. Dame

Ella R. Aiken

TCD/ERA:blr
Enclosures

#634502
006551-0237

cc: Kevin McDonald, Chief, Certificate of Need
Paul Parker, Director, Center for Health Care Facilities Planning & Development
Suellen Wideman, Esq., Assistant Attorney General
Leana S. Wen, M.D., MSc., Baltimore City Health Commissioner
Megan M. Arthur, Esq., Senior Vice-President & General Counsel
Sandra H. Benzer, Esq., Associate Counsel, UMMS
Mohan Suntha, M.D., MBA, President and CEO
Sarah M. Edwards, DO, Assistant Professor of Psychiatry, UMMC
Dana D. Farrakhan, FACHE, Sr. VP, Strategy, Community and Business Development
Joseph E. Hoffman III, Senior Vice President and Chief Financial Officer, UMMC
Craig Fleischmann, Senior Vice President, Finance, UMMC
Leonard Taylor, Jr., Senior Vice President for Asset Planning, UMMS
Greg D. Raymond, MS, MBA, RN, Vice President of Nursing and Patient Care Services, Clinical Practice & Professional Development, Neuroscience, Behavioral Health, UMMC
Brian Sturm, Senior Director, Financial and Capital Planning, UMMS
Scott Tinsley-Hall, Director, Strategic Planning, UMMC
Linda Whitmore, Director for Project Development, UMMC
Bret Elam, Project Manager, UMMS
Kevin Day, Project Architect, Living Design Lab
Andrew L. Solberg, A.L.S. Healthcare Consultant Services

IN THE MARYLAND HEALTH CARE COMMISSION

APPLICATION FOR CERTIFICATE OF NEED

to
Establish 16-Bed
Inpatient Acute Psychiatric Unit
at UMMC

Applicant
University of Maryland Medical Center

August 3, 2018

TABLE OF CONTENTS

Page

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION....1

PART II - PROJECT BUDGET....10

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE....11

PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3)....13

COMAR 10.24.07. PSYCHIATRIC SERVICES—STANDARDS....14

Availability....14

Accessibility....18

Cost....21

Quality....21

Continuity....22

Acceptability....22

COMAR 10.24.10. ACUTE CARE CHAPTER....24

.04A. GENERAL STANDARDS....24

Standard .04A(1) – Information Regarding Charges....24

Standard .04A(2) – Charity Care Policy....24

Standard .04A(3) – Quality of Care....27

COMAR 10.24.10 ACUTE CARE CHAPTER....29

.04B. PROJECT REVIEW STANDARDS....29

Standard .04B(1) – Geographic Accessibility....29

Standard .04B(2) – Identification of Bed Need and Addition of Beds....29

Standard .04B(3) – Minimum Average Daily Census for Establishment of a Pediatric Unit....30

Standard .04B(4) – Adverse Impact....30

Standard .04B(5) – Cost-Effectiveness....31
Standard .04B (6) – Burden of Proof Regarding Need....34
Standard .04B(7) – Construction Cost of Hospital Space....34
Standard .04B(8) – Construction Cost of Non-Hospital Space....35
Standard .04B(9) – Inpatient Nursing Unit Space....35
Standard .04B(10) – Rate Reduction Agreement....36
Standard .04B(11) – Efficiency....36
Standard .04B(12) – Patient Safety....37
Standard .04B(13) – Financial Feasibility....38
Standard .04B(14) – Emergency Department Treatment Capacity and Space....39
Standard .04B(15) – Emergency Department Expansion....40
Standard .04B(16) – Shell Space....40
10.24.01.08G(3)(b). NEED....41
10.24.01.08G(3)(c). AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES....49
10.24.01.08G(3)(d). VIABILITY OF THE PROPOSAL....51
10.24.01.08G(3)(e). COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED....53
10.24.01.08G(3)(f). IMPACT ON EXISTING PROVIDERS AND THE HEALTH CARE DELIVERY SYSTEM....54
Table of Exhibits....56
Table of Tables....56
Table of Figures....56

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 Medical Center

Address:

22 S. Greene Street	Baltimore	21201	Baltimore City
Street	City	Zip	County

Name of Owner (if differs from applicant):

2. OWNER

Name of owner:

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

Legal Name of Project Applicant

University of Maryland Medical Center, LLC

Address:

22 S. Greene Street	Baltimore	21201	MD	Baltimore City
Street	City	Zip	State	County

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

Name of Owner/Chief Executive: Mohan Suntha, MD, MBA, President and CEO

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

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

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

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☒	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation Maryland, 2014
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: Dana Farrakhan, FACHE, Senior Vice President, Strategy, Community and Business Development

Mailing Address:

University of Maryland Medical Center			
22 S. Greene Street	Baltimore	21201	Maryland
Street	City	Zip	State

Telephone: 410-328-1314

E-mail Address (required): DFarrakhan@umm.edu

Fax: 410-328-8664

B. Additional or alternate contact:

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

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

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

Name and Title: Ella R. Aiken
Mailing Address:
Gallagher Evelius & Jones LLP

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

Telephone: 410-951-1420
E-mail Address (required): eaiken@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

(A1) Brief project description

Applicant University of Maryland Medical Center ("UMMC") seeks approval for the establishment of a 16-bed inpatient acute psychiatric unit for treatment of children and adolescents, thereby adding adolescent services to UMMC's inpatient psychiatric services. The Child and Adolescent (C&AU) will replace the current 12-bed inpatient acute psychiatry unit UMMC currently operates for latency aged children. The proposed unit will be located in new facilities constructed space that will be renovated for the purpose on the 11th floor of the North Hospital. The unit is being established to meet an urgent and critical need for inpatient adolescent psychiatry beds while maintaining UMMC's capacity to treat latency aged children.

The project does not require an increase in the total licensed beds for UMMC. (See MHCC Form Tables, Exhibit 1, Table A). In establishing and providing the new adolescent inpatient acute psychiatry services, UMMC will incur both capital and operating expenses, including the addition of full-time employees. UMMC reserves the right to seek future additional rate charging authority from the Health Services Cost Review Commission ("HSCRC") to help fund this project, and UMMC has projected in this CON application additional future regulated revenue to assure the future financial success of the project and UMMC.

(A2) Rationale for the project

There are not enough inpatient acute psychiatric beds for adolescent patients in the four counties (Anne Arundel County, Baltimore City, Baltimore County and Howard County) UMMC defines as its service area for adolescent psychiatry. The demand for services has increased. Discharges have risen by 5% since fiscal year 2016. At the same time, length of stay has increased 6.1% compounding the need for more beds. As a consequence, patients wait much too long for beds.

In fiscal year 2018 nearly 600 adolescents sought treatment in the UMMC pediatric emergency department with some form of psychiatric need. 70 of these patients waited up to 7 days for an admission to an inpatient acute psychiatric facility and 45 more patients waited for an inpatient bed up to 11 days before being determined they were stable enough to be discharged with outpatient services. The delay of treatment for these young people in a health crisis is unacceptable. While accommodating adolescent patients in a pediatric emergency department is presently necessary and well intentioned, these treatment spaces are neither designed nor staffed to deliver acute behavioral health care. Thus, this practice may place the patient and staff at safety risk. The current "care model" is extremely inefficient. As a safety precaution, UMMC often must assign one or more hospital security officers as "sitters" for disruptive and often violent adolescent patients awaiting admission to an inpatient acute psychiatric bed.

UMMC's community partners recognize the deficits in behavioral health case as well. The UMMC Community Needs Health Assessment published in June 2015 listed greater access to better behavioral/mental health services as one of the needs consistently stated in community focus groups.

(3) Total cost of the project

The total capital cost of implement the project is estimated to be $9.5 million.

(4) Master Facility Plans

The proposed project is the third phase of a comprehensive four phase plan to modernize the UMMC behavioral health facilities at the Midtown and Downtown campuses.

Phase One- Remove or reduce ligature risks in existing behavioral health areas consistent with the Veterans Administration Behavioral Health Risk Assessment and the recommendations in the Patient Safety Standards, Materials and Systems Guidelines, New York State Office of Mental Health. Work was completed in April 2018

Phase Two – Renovate and expand the adult inpatient psychiatric unit on the Midtown Campus pursuant to a determination of CON coverage issued by the Maryland Health Care Commission (the "Commission") dated July 19, 2016. This project is under construction and is due to open in December 2018.

Phase Three (the subject of this application) – Create a 16 bed child and adolescent inpatient psychiatry unit on the Downtown campus to serve latency age patients presently in 12 bed Downtown P4G unit and adolescent patients not presently accommodated. Planned and will proceed pending approval of this application.

Phase Four – Renovation of geriatric psychiatric facilities on the UMMC Downtown campus.

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

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

Applicant Response

(B1) Construction, renovation, and demolition plans

The project consists of a "gut" renovation of the west side of the 11th floor of the North Hospital (N11W). The space was previously an adult inpatient psychiatry unit and an acute medicine unit. The space will be completely renovated for the new purpose. The project also

includes 1,200 square feet of renovation to the existing 12th floor behavioral health unit as the child & adolescent staff will share some of that space.

The new facility will feature private and semi-private sleeping rooms and the variety of rooms and environments required by the Facility Guidelines and recommended by current best (evidenced-based) practice.

While the unit will provide care for female and male latency age and adolescent patients, the care model will manage these as separate populations. Thus the patient side of the facility will be arranged to separate children from adolescents temporally and spatially. The facility also will allow for the separation by gender in sleeping and toileting activity. The staff side of the facility is organized around shared resources and space. The unit is designed to provide a physical frame to support the inherent dualities of treatment:

- Provide privacy, and yet encourage social interaction.
- Create the sense of protection/personal safety, and yet not have blind spots or hidey holes where patients cannot be observed for their own and other patient's safety.
- Tightly control access and egress from and to the unit, but not feel confining or confined.
- Be constructed so the physical environment can sustain "hard use/abuse," but does not look or feel institutional or forensic.
- Designed and constructed to absolutely minimize ligature and other self-harm risk, and also feel warm and welcoming.

The new facility will include features that are friendly to families, children, and adolescents, enabling the family, as appropriate, to participate in care.

Utility services to the unit are supplied from the existing infrastructure in the North Hospital.

(B2) Changes in square footage of departments and units;

See MHCC Form Tables, Exhibit 1, Table B.

(B3) Physical plant or location changes

The present mechanical, electrical, and plumbing (MEP) infrastructure at the UMMC Downtown campus is adequate to serve the area identified for renovation. The project includes all new MEP services within the project area and modifications to the controls systems as necessitated by the design.

(B4) Changes to affected services following completion of the project

The current bed inventory will be changed to add adolescent psychiatric inpatient beds and improve the treatment environment for latency aged child psychiatric inpatient services.

(B5) Multi-phase project description

The project is planned as a single phase of construction.

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

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

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

Applicant Response

See MHCC Form Tables, Exhibit 1, Table A.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: The project will affect a total of 13,799 gross departmental square feet. See MHCC Form Tables, Exhibit 1, Table B for additional information.

Applicant Response

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

Applicant Response

Not applicable, the project does not require any zoning or land use approvals.

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

(1) Owned by: The project will be constructed within the existing UMMC facility, which is owned by University of Maryland Medical System Corporation
Please provide a copy of the deed.

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

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

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

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

11. PROJECT SCHEDULE

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

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date	**8**	months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	**1**	months
Completion of project from capital obligation or purchase order, as applicable	**12**	months

12. PROJECT DRAWINGS

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

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

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

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

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

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

Applicant Response

Project drawings are attached as Exhibit 2.

13. FEATURES OF PROJECT CONSTRUCTION

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

Applicant Response

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

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

Applicant Response

The present water, sewer, electrical power, emergency power, heating ventilation and air conditioning, fire suppression, detection and alarm, and electronic security systems (the utilities) that service the hospital and the 11 floor of the North Hospital are adequate to serve the new use of the space.

PART II - PROJECT BUDGET

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

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

Applicant Response

See Exhibit 1, MHCC Form Tables, Table E.

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

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

   Owner: University of Maryland Medical Center, LLC

   Responsible Individual: Mohan Suntha, M.D., MBA, President and CEO, University of Maryland Medical Center, University and Midtown Campuses

   Address: 22 Greene Street, Baltimore, Maryland 21201

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.

   From 2012 through 2016, Dr. Suntha was President and CEO of University of Maryland St. Joseph Medical Center (7601 Osler Drive, Towson, Maryland 21204). From 2009 until 2012, Dr. Suntha was Vice President for System Program Development for the University of Maryland Medical System (250 W. Pratt Street, Baltimore, Maryland 21201).

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.

The Applicant notes that this response is limited to information relevant to University of Maryland Medical Center, University Campus for active (not historical) compliance inquiries and investigations.

On June 19, 2018, the Office of Health Care Quality of the Maryland Department of Health conducted a survey on behalf of the Centers for Medicare and Medicaid Services and identified several alleged deficiencies in the behavioral health unit at UMMC. UMMC received the deficiency report on July 17, 2018 and is in the process of preparing a response and plan of correction.

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.

7/31/2018
Date


Signature of Owner or Board-designated Official

President and CEO
Position/Title

Mohan Suntha, M.D., MBA
Printed Name

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

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

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

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

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

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

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

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

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

Applicable State Health Plan Chapter include COMAR 10.24.07, the Psychiatric Services Section, and COMAR 10.24.10, Acute Hospital Services.

COMAR 10.24.07. PSYCHIATRIC SERVICES—STANDARDS

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 Commission has determined that Standards AP 1a – 1d are no longer applicable because they are based on an obsolete bed need projection. In re Anne Arundel Medical Center Mental Health Hospital, Docket No. 16-02-2375, Decision at p. 9 (April 19, 2018). Accordingly, UMMC prepared a bed need assessment for its proposed project based on hospital utilization patterns and other indicators that identify community need. Please refer to the response to COMAR 10.24.01.08G(3)(b) for the Applicant's bed need analysis.

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

Inapplicable, there are no delicensing requirements applicable to this project and the Commission has determined that the standard is based on an obsolete bed need projection. In re Anne Arundel Medical Center Mental Health Hospital, Docket No. 16-02-2375, Decision at p. 9 (April 19, 2018).

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

Inapplicable, this project does not involve state hospital conversion beds and the Commission has determined that the standard is based on an obsolete bed need projection. In re Anne Arundel Medical Center Mental Health Hospital, Docket No. 16-02-2375, Decision at p. 9 (April 19, 2018).

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 1c.

Applicant Response

Inapplicable, this is a not a comparative review and the Commission has determined that the standard is based on an obsolete bed need projection. In re Anne Arundel Medical Center Mental Health Hospital, Docket No. 16-02-2375, Decision at p. 9 (April 19, 2018).

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

UMMC operates a dedicated Psychiatric Emergency Services ("PES") treatment area as a physically separate part of the Adult Emergency Department. Availability for emergency psychiatric care through PES is 24 hours a day, 7 days a week without limitations for weekends, holidays or late night shifts. In addition, the inpatient psychiatric units at this facility provide 24 hour a day, 7 day a week physician coverage using psychiatric medical residents, and covering faculty psychiatrists from the University of Maryland School of Medicine.

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

UMMC is an emergency facility that is designated by the Maryland Department of Health to perform evaluations of persons believed to have a mental disorder and brought to UMMC on an emergency petition.

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

Applicant Response

All inpatient psychiatric units include the capability to use seclusion rooms, if necessary. The design for the reconstructed space will include the capability to use a seclusion room if necessary for the safety of patients. Also, the Pediatric Emergency Department ("PED") includes an emergency holding area.

AP3a. 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

UMMC currently offers a comprehensive array of child psychiatric services at this facility that will be extended to include the psychiatric adolescent population:

- Chemotherapy – Treatment ordered by licensed prescribing practitioners, and administered by Registered Nursing staff on routine and as needed bases
- Individualized psychotherapy – Treatment provided by members of the multidisciplinary team as the scope of license permits
- Group therapy – Group therapy treatments offered by nursing, social work, and occupational therapy disciplines
- Family therapy – Family therapy treatments offered by psychiatrists, nursing, social work, and occupational therapy disciplines
- Social Services – Social services primarily addressed through social work staff
- Adjunctive therapies – Occupational therapies offered; recreational therapies managed by nursing and occupational therapy staff.

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

The multidisciplinary treatment team (referenced in response to Standard AP 3a.) develops an Individualized Treatment Plan ("ITP") for each patient. The ITP is reviewed daily on rounds, and adjusted to meet the treatment goals as they evolve through the course of the child's inpatient stay. The ITP addresses 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 patients and family.

The design for the combined child and adolescent inpatient psychiatric unit will include physical barriers designed to keep the populations separated.

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

Applicant Response

Psychiatric consultation services are provided directly through University of Maryland Psychiatric Department psychiatrists and residents.

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

UMMC seeks this CON for the addition of adolescent inpatient psychiatric services.

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

Physical separation between latency age children and adolescents will be included in the redesign. Programmatic distinctions will be made through individualized treatment plans and group therapies.

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

For all patients requesting admission to this facility, the following services are offered:

- Intake screening and admission – conducted by all disciplines according to their scope of practice.
- Arrangements to transfer to a more appropriate facility for care if medically indicated will be provided through in-house medical/surgical consultation. As a tertiary medical center, UMMC offers a full array of medical and surgical services, which allows admitted patients to have access to these services should the patient's condition warrant medical or surgical intervention during their hospitalization. If necessary, patients are transferred in-house to units that specialize in the treatment of medical or surgical conditions.
- Evaluation to define the patient's psychiatric problem and/or emergency treatment – All patients admitted to the psychiatric inpatient units at this facility are provided a full evaluation by licensed psychiatric providers.
- Emergency treatment is available among the full array of services at UMMC.

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 abuse, and geriatric patients, either through direct treatment or referral.

Applicant Response

Individualized quality assurance programs for each population are carried out through staff from UMMC's Department of Quality and Safety, in collaboration with the multidisciplinary treatment team. Age specific treatment protocols and treatment protocols for dual diagnosis patients are established through direct assessment and treatment the multidisciplinary team. Attached as Exhibit 3 is a Plan for Improving Organizational Performance for adolescent psychiatric services.

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 a patient's legal status rather than clinical criteria.

Applicant Response

Admission criteria for psychiatric inpatients are based on the availability of appropriate clinical programming. Patients are not excluded based on legal status. In particular, UMMC accepts involuntary admissions based upon emergency petitions.

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

UMMC's inpatient psychiatry services intends to provide a level of uncompensated care that equals or exceeds the average of uncompensated for acute inpatient services in the service area.

UMMC's inpatient psychiatry service area includes Baltimore City, Baltimore County and Anne Arundel County. The current providers of acute inpatient services in UMMC's service area are summarized below in Table 1. UMMC's percentage of uncompensated care in fiscal year 2017 was 4.35% compared to 4.17% for its service area. This level of uncompensated care was published in the HSCRC's Final Recommendations for the Uncompensated Care Policy for Rate Year 2018, which is based on FY2017 data. This is the most recent data that is available and reflects the level of uncompensated care for the entire hospital.

UMMC's percentage of uncompensated care for inpatient psychiatry services of 4.80% is greater than the acute inpatient average 4.17%.

Table 1
FY 2017 Uncompensated Care Percentages

Baltimore City	
Bon Secours Hospital	2.47%
MedStar Good Samaritan Hospital	3.97%
MedStar Harbor Hospital Center	4.71%
Johns Hopkins Bayview Med. Center	4.11%
Johns Hopkins	2.63%
Mercy Medical Center, Inc.	4.27%
St. Agnes Hospital	4.00%
Sinai Hospital	3.29%
MedStar Union Memorial Hospital	3.11%
Univ. of Maryland Medical Center	4.35%
Univ. of Maryland Medical Center Midtown Campus	7.29%
Univ. of Maryland Medical Center Rehab and Ortho Inst.	5.91%
Baltimore County	
MedStar Franklin Square Hospital	3.54%
Greater Baltimore Medical Center	3.30%
Northwest Hospital Center, Inc.	4.81%
Sheppard & Enoch Pratt Hospital	4.05%
Univ. of Maryland St. Joseph Medical Center	4.12%
Anne Arundel County	
Anne Arundel General Hospital	2.95%
Univ. of Maryland Baltimore Washington Medical Center	6.36%
Average Service Area	4.17%
Univ. of Maryland Medical Center (Acute Inpatient Services)	4.35%
Univ. of Maryland Medical Center (Inpatient Psychiatric Services)	4.90%

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

Not applicable. UMMC provides child acute psychiatric beds. Also, several other hospitals within 45 minute travel time from UMMC provide child acute psychiatric beds.

Cost

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%
PBF ≥40	90%

Applicant Response

Not applicable. The Applicant does not seek to expand existing adult psychiatric bed capacity.

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

Not applicable. The Applicant is a general acute hospital, not a private psychiatric hospital.

Quality

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

Applicant Response

All patients who are admitted to UMMC are admitted under the direct clinical supervision of University of Maryland Department of Psychiatry faculty member, who is boarded and licensed in the State of Maryland to provide psychiatric care.

AP 12b. Staffing of acute psychiatric programs should include therapists 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, especially the social worker following the patient's case, ensuring that appropriate aftercare, including follow-up outpatient visits are scheduled prior to discharge of the patient from the inpatient psychiatric facility. Medical nursing teams provide therapies seven days each 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

Current staff members are proficient and competent in the care of latency age children. Prior to the opening and admission of the adolescent population, training and competency validation will be conducted for all disciplines using UMMC's orientation and training model, which involves peer to peer training with evidence-based resources to guide competency evaluation. Moreover, UMMC will recruit additional staff with relevant experience and training in adolescent care.

Continuity

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

Please see the written policies attached as Exhibits 4 and5.

Acceptability

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

(i) the local and state mental health advisory council(s);
(ii) the local community mental health center(s);
(iii) the Department of Health and Mental Hygiene; and
(iv) the city/county mental health department(s).

Letters from other consumer organizations are encouraged.

Applicant Response

Letters of support are attached as Exhibit 6, including letters from the Baltimore City Health Department and the Maryland Department of Health. Additional letters of support may be provided after filing.

COMAR 10.24.10. ACUTE CARE CHAPTER

.04A. GENERAL STANDARDS

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

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

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

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

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

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

Applicant Response:

UMMC complies with this Standard. Its policy is attached as Exhibit 7 and is available on its website at the following web address: https://www.umms.org/ummc/patients-visitors/for-patients/estimated-charges.

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

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

(a) The policy shall provide:

(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for

medical assistance, or both, the hospital must make a determination of probable eligibility.

(ii) Minimum Required Notice of Charity Care Policy.

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

2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and

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

Applicant Response:

Applicant's Financial Assistance policy is attached as Exhibit 8. Public notice is provided through publication on UMMC's website at https://www.umms.org/ummc/patients-visitors/for-patients/financial-assistance. Notices of the Financial Assistance policy are posted in the admissions office, business office, and emergency department. See, e.g., Exhibit 9, a copy of the notice of the financial assistance policy posted by the registration desk in the hospital's main lobby. Individual notice regarding the Financial Assistance policy is provided at the time of preadmission or admission to each person who seeks services at UMMC.

(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:

Not applicable. According to the HSCRC's Maryland Hospital Community Benefit Report for FY 2017, published May 2018, UMMC's provision of charity care does not fall within the bottom quartile of all Maryland hospitals, as reflected in the following table.

Table 2
FY 2017 Community Benefit Analysis
Source: HSCRC Community Benefit Report, FY 2017

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	Charity Care % of Total Hosp. Operating Income	Ranking	Percentile
Holy Cross Hospital	$413,796,889	$31,396,990	7.6%	1	1.85%
Garrett County Hospital	$46,818,203	$2,792,419	6.0%	2	3.70%
St. Agnes	$433,986,000	$21,573,282	5.0%	3	5.56%
Adventist Behavioral Health Rockville*	$40,204,927	$1,451,432	3.6%	4	7.41%
Doctors Community	$193,854,072	$6,756,740	3.5%	5	9.26%
Adventist Washington Adventist*	$219,120,045	$7,442,497	3.4%	6	11.11%
Western Maryland Health System	$322,835,314	$10,385,555	3.2%	7	12.96%
UM Prince Georges Hospital Center	$286,955,092	$9,166,191	3.2%	8	14.81%
Mercy Medical Center	$464,031,500	$14,411,600	3.1%	9	16.67%
Holy Cross Germantown	$97,124,985	$2,819,650	2.9%	10	18.52%
Johns Hopkins Bayview Medical Center	$613,834,000	$16,951,000	2.8%	11	20.37%
UM Laurel Regional Hospital	$93,884,647	$2,521,365	2.7%	12	22.22%
UM Midtown	$204,226,000	$5,174,000	2.5%	13	24.07%
Sheppard Pratt	$221,570,405	$5,473,873	2.5%	14	25.93%
Frederick Memorial	$350,118,000	$8,081,000	2.3%	15	27.78%
UM Harford Memorial	$84,926,000	$1,927,000	2.3%	16	29.63%
Atlantic General	$117,342,233	$2,569,517	2.2%	17	31.48%
Ft. Washington	$42,883,433	$928,769	2.2%	18	33.33%
UM Rehabilitation and Ortho Institute	$107,006,000	$2,271,000	2.1%	19	35.19%
UM Baltimore Washington	$334,210,000	$6,703,000	2.0%	20	37.04%
Calvert Hospital	$135,047,535	$2,694,783	2.0%	21	38.89%
Peninsula Regional	$432,141,737	$8,301,400	1.9%	22	40.74%
McCready	$16,564,839	$307,205	1.9%	23	42.59%
Levindale	$73,760,005	$1,341,932	1.8%	24	44.44%
Average	$304,507,851	$5,527,912	1.8%	25	46.30%
UM St. Joseph	$341,335,000	$6,105,000	1.8%	26	48.15%
UM Shore Medical Dorchester	$42,909,000	$647,362	1.5%	27	50.00%
MedStar Harbor Hospital	$187,002,302	$2,816,043	1.5%	28	51.85%
Meritus Medical Center	$309,163,913	$4,596,841	1.5%	29	53.70%
UM Shore Medical Easton	$190,646,000	$2,786,102	1.5%	30	55.56%
MedStar St. Mary's Hospital	$168,757,516	$2,458,649	1.5%	31	57.41%
MedStar Good Samaritan	$282,735,786	$4,078,427	1.4%	32	59.26%

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	Charity Care % of Total Hosp. Operating Income	Ranking	Percentile
UMMC	$1,470,095,000	$20,308,000	1.4%	33	61.11%
Howard County Hospital	$260,413,000	$3,368,222	1.3%	34	62.96%
UM Charles Regional Medical Center	$117,918,178	$1,474,409	1.3%	35	64.81%
MedStar Southern Maryland	$243,629,886	$3,014,042	1.2%	36	66.67%
Adventist Rehab of Maryland*	$43,589,181	$502,712	1.2%	37	68.52%
Lifebridge Northwest Hospital	$240,547,439	$2,734,207	1.1%	38	70.37%
Shady Grove*	$323,661,835	$3,646,551	1.1%	39	72.22%
Suburban Hospital	$283,346,000	$3,168,000	1.1%	40	74.07%
UM Upper Chesapeake	$284,219,000	$3,014,000	1.1%	41	75.93%
MedStar Franklin Square	$508,539,888	$5,147,814	1.0%	42	77.78%
MedStar Union Memorial	$443,482,532	$4,426,976	1.0%	43	79.63%
Johns Hopkins Hospital	$2,307,202,000	$21,697,000	0.9%	44	81.48%
Union Hospital of Cecil County	$157,260,383	$1,411,673	0.9%	45	83.33%
LifeBridge Sinai	$727,868,000	$6,526,756	0.9%	46	85.19%
MedStar Montgomery General	$160,725,287	$1,322,823	0.8%	47	87.04%
UM Shore MedicalChestertown	$46,048,000	$373,000	0.8%	48	88.89%
Anne Arundel Medical Center	$561,392,000	$4,450,854	0.8%	49	90.74%
Mt. Washington Pediatrics	$55,412,291	$382,465	0.7%	50	92.59%
Bon Secours	$113,068,120	$675,245	0.6%	51	94.44%
GBMC	$419,396,862	$2,085,315	0.5%	52	96.30%
Carroll Hospital Center	$197,802,000	$790,716	0.4%	53	98.15%
All Hospitals	**$15,834,408,260**	**$287,451,403**	1.8%	54	100.00%

* According the HSCRC FY 2017 Community Benefit Report, "the Adventist Hospital System requested and received permission to report its community benefit activities on a calendar year basis to more accurately reflect true activities during the community benefit cycle." Report at p. 44, available at http://www.hscrc.state.md.us/Documents/HSCRC_Initiatives/CommunityBenefits/CBR-FY17/FY2017CommunityBenefitReport20180501.pdf.

Standard .04A(3) – Quality of Care.

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

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

(ii) Accredited by the Joint Commission; and

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

Applicant Response:

UMMC is licensed by the Department of Health and Mental Hygiene, is accredited by The Joint Commission, and is in compliance with all Medicare and Medicaid conditions of participation. Copies of UMMC's license and most recent accreditation letter are attached as Exhibits 10 and 11.

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

Applicant Response:

UMMC received a "Below Average" ranking in 67 Quality Measures in the most recent Maryland Hospital Performance Evaluation Guide. An action plan for each of these quality measures is described in Exhibit 12.

COMAR 10.24.10 ACUTE CARE CHAPTER

.04B. PROJECT REVIEW STANDARDS

Standard .04B(1) – Geographic Accessibility

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

Applicant Response:

Inapplicable.

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

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

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

(b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection.

(c) Additional MSGA or pediatric beds may be developed or put into operation only if:

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

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

(iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant

hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or

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

Applicant Response:

Inapplicable. UMMC does not seek to add MSGA or pediatric beds.

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

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

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

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

Applicant Response:

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

Standard .04B(4) – Adverse Impact

A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:

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

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Applicant Response:

Inapplicable. At this time, the Applicant does not seek a rate increase, but it reserves the right to do so in the future.

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

Applicant Response:

Inapplicable. The project will not reduce services.

Standard .04B(5) – Cost-Effectiveness

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

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

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

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

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

Applicant Response:

As explained in response to part (b) below, the project involves limited objectives. Therefore, UMMC need not undertake the analysis in part (a).

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

Applicant's Response

The proposed project is one "involving limited objectives," and there is only one practical approach to achieving the objectives.

A. The Proposed Project Involves Limited Objectives.

Part (b) of the standard states that a project involving limited objectives includes, but is not limited to, "the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization." As explained below, the proposed project is similar to these examples of limited objective projects.

1. Introduction of a new single service.

The first example in part (b) of the standard is a project limited to the introduction of a new single service. In this application, UMMC proposes to expand the age of the children it admits into its existing inpatient child acute psychiatry unit to include adolescents from 13 to 17 years old. Thus, the project is even more limited than the introduction of a single service in that UMMC merely seeks to expand the age cohort of an existing service.

2. Expansion of capacity for a single service.

Another example of limited objective project is a project for the expansion of capacity for a single service. UMMC proposes to expand the number of inpatient beds for children from 12 to 16 so it can serve adolescent patients between the ages of 13 and 17 (without expanding the total number of beds at UMMC). Currently, adolescent patients must be placed in other facilities around the region, often after very long delays before admission. Thus, the proposal constitutes the expansion of a single service.

3. Renovation of an existing facility for purposes of modernization.

Finally, part (b) provides the example of a project limited to renovation for modernization. UMMC seeks to renovate existing facilities on the 11th floor of the North Hospital in order to provide modern, code compliant, and appropriate therapeutic facilities for its pediatric patients. Today pediatric psychiatric patients are treated in facilities that do not have many of the elements that are considered current standard of care, including private bedrooms and bathrooms and a variety of environments in which to treat patients and manage their conditions such as sensory rooms and quiet rooms. Thus, the proposal is a renovation project for the purpose of modernization.

B. The Proposal is the Only Practical Approach to Achieve the Limited Objectives.

For a number of reasons, renovation of the N11W space at the UMMC for the child and adolescent inpatient unit is the only practical approach to providing requisite space for this urgent need:

- There is an established child and adolescent behavioral health program on the downtown campus that is closely affiliated with, and serves as a component of, the Maryland Hospital for Children, also located on the downtown campus. Locating these services in the same facility enables care coordination and service delivery.
- UMMC Downtown operates a pediatric emergency department, which is the primary intake point for children and adolescents in crisis. Locating the acute inpatient psychiatric facility at the same location is optimal. Clinical best practice is to locate as much of the acute care continuum at one site. This scenario is best so that patients will not have to suffer through the disruption of a transfer. It is also best for the patient's family who will not have to travel from one site to another to stay close to their loved one and engaged in their care. Finally, it is best for staff members involved in many different aspects of child and adolescent behavioral health care. Locating the unit at UMMC Downtown with other pediatric behavioral health services enhances the efficiency of the delivery of services.
- N11W is well suited to be renovated for this purpose. It contains the right amount of space in accordance with the Guidelines for Design and Construction of Hospitals, published by the Facility Guidelines Institute (the "FGI Guidelines"), for a 16 bed inpatient child and adolescent unit.
- N11W will soon be vacated. It is the only area of the approximate size required that will be vacant at UMMC Downtown. This enables the creation of the unit without displacing any occupants and incurring the added disruption and expense of enabling moves.
- Renovating vacant space for a new behavioral health unit allows the existing program to continue undisturbed while the new unit is constructed. Renovating a vacant unit also is quicker, less expensive, and less risky than renovating occupied behavioral health space.
- N11W is located near other behavioral health units. This facilitates providing behavioral health appropriate food services, environmental services, materials management, facility engineering, and security services and in turn reduces safety and security risks to patients, families and staff.
- The current eight bed latency age unit does not have enough space to accommodate the new program requirements and is not a viable option.

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

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

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

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

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

Applicant Response:

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

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

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

Applicant Response:

UMMC addresses the need for the project in response to COMAR 10.24.01.08G(3)(b).

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

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

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

Applicant Response:

The narrative attached as Exhibit 13 compares the project costs to the Marshall Valuation Service ("MVS") benchmark. As described in further detail in that analysis, Applicant believes the project is consistent with the MVS benchmark.

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

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

Applicant Response:

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

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

Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost for the space that exceeds the per bed square footage limitation in this standard, or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

Applicant Response:

The new unit will exceed 500 square feet per bed. However, UMMC is not actively seeking a rate increase (but reserves the right to do so).

The FGI Guidelines govern space standards for healthcare construction. Adding the basic spaces that are required by the FGI Guidelines for 16 patients results in programmed space of approximately 13,799 square feet with a total cost per square foot of $694.25.

Standard .04B(10) – Rate Reduction Agreement

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

Applicant Response:

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

Standard .04B(11) – Efficiency

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

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

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

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

Applicant Response:

The addition of adolescent psychiatric inpatient beds is anticipated to improve the flow of this population out of the facility's pediatric emergency department. In accomplishing this end, a reduction in resources currently utilized in the pediatric emergency department to ensure a safe environment for adolescents appropriate for inpatient psychiatric care is expected to decrease, reducing the cost of security.

This project will not increase the total number of beds for the care of psychiatric inpatients, so total volume increase is not expected.

Standard .04B(12) – Patient Safety

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety. A hospital proposing to replace or expand its physical plant shall provide an analysis of patient safety features included for each facility or service being replaced or expanded, and document the manner in which the planning and design of the project took patient safety into account.

Applicant Response:

Patient and staff safety are among the key reasons UMMC is undertaking the project. Today, the child inpatient psychiatry unit occupies space that was originally planned a generation ago. While the area has been subject to several small renovations and is code compliant, it is not the nurturing, safe behavioral health environment with the range of treatment spaces and bedrooms that UMMC desires to provide for its patient population. Currently, adolescent patients are confined to a small area of the pediatric emergency department while they wait for a scarce bed in another facility.

The new facility is based on the current edition of the FGI Guidelines and incorporates safety features supported by research into behavioral health environments reviewed by the Center for Health Design. The unit is organized to provide a variety of environments for patients, including de-escalation areas, respite rooms, sensory rooms, seclusion areas, as well as a variety of group environments for active play, therapy, and group interaction. Some of these areas are double functioning. The unit is designed to be a ligature resistant environment where staff can interact with and observe patients without blind corners and hidey holes. The unit is organized so the latency age patients are at all times separated from the adolescents. For the staff, the unit is designed so staff are not “back to the patient.” Staff will be within eye and/or earshot of colleagues and can if necessary quickly and safely separate a patient who is acting out to protect the patient, other patients or themselves. The unit also includes “off stage” space for staff respite.

The materials and furniture, fixtures and equipment are consistent with those identified in the current version of the Patient Safety Standards, Materials and Systems Guidelines, New York State Office of Mental Health. As an additional safety risk mitigation strategy, the design and construction will be evaluated by the design team, the clinical team, and the UMMC safety officer using the current edition Veterans Administration Mental Health Environment of Care Checklist (MHEOCC) during design, construction, and pre-occupancy.

Standard .04B(13) – Financial Feasibility

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

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

(b) Each applicant must document that:

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

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

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

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

Applicant Response:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Applicant Response:

Inapplicable. The Applicant is not proposing a new or expanded emergency department.

Standard .04B(15) – Emergency Department Expansion

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

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

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

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

Applicant Response:

Inapplicable. The Applicant is not proposing expansion of emergency department treatment capacity.

Standard .04B(16) – Shell Space

(a) Unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective.

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

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

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

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

(c) Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.

(d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Services Cost Review Commission.

Applicant Response:

Inapplicable. The proposed project does not include shell space.

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 purpose of the proposed project is to increase the availability of inpatient psychiatric services to the adolescent population (ages 13 through 17) in the Central Maryland region. There is significant unmet need in this region, and UMMC seeks to add eight adolescent psychiatry beds to meet a portion of this need. The analysis below relies upon data that include use-rate and population demand and unmet need at UMMC and two University of Maryland Medical System ("UMMS") affiliate hospitals, University of Maryland Baltimore Washington Medical Center ("UM BWMC") and University of Maryland St. Joseph Medical Center ("UM SJMC"). The analysis also considers additional unmet demand in the service area.

Based on the analysis, there is sufficient need to support the proposed program and approval of this application will not have a significant adverse effect on existing programs in the State of Maryland.

Service Area Definition

UMMC's service area for the proposed inpatient adolescent psychiatry service is Anne Arundel County, Baltimore City, Baltimore County and Howard County, depicted in Figure 1 below. This service area is based on the top counties for 80% of UMMC's FY2018 patient origin for the existing child psychiatry unit.

Figure 1
Map of Proposed Inpatient Adolescent Psychiatry Service Area

Adolescent Population Estimates

The adolescent population is defined as age 13 years through age 17 years. COMAR 10.24.07 (Definitions). Population estimates for the service area were obtained by Claritas for calendar years 2016 through 2019 and five year projections through 2024. Within the service area, there are approximately 148,567 adolescents. Between 2019 and 2024, Claritas projects a 4% growth within the service area. Baltimore City has the fastest growing adolescent population over the next five years with projected growth of 6.2% followed by Anne Arundel County with projected growth of 5.3%.

Table 3
Adolescent Population Estimates for Proposed Service Area
2016-2024

	2016 *Est.*	2017 *Est.*	2018 *Est.*	2019 *Est.*	2020 *Proj.*	2021 *Proj.*	2022 *Proj.*	2023 *Proj.*	2024 *Proj.*	% Change 2019-2024
Anne Arundel County	35,732	35,611	35,405	35,855	36,238	36,621	37,004	37,387	37,769	5.3%
Baltimore City	34,361	34,157	33,271	33,048	33,461	33,874	34,287	34,700	35,113	6.2%
Baltimore County	50,289	50,327	50,030	50,502	50,841	51,180	51,519	51,858	52,197	3.4%
Howard County	23,198	23,223	23,215	23,508	23,504	23,499	23,494	23,489	23,488	-0.1%
4-County Total	**143,580**	**143,318**	**141,921**	**142,913**	**144,044**	**145,174**	**146,304**	**147,434**	**148,567**	**4.0%**

Source: Claritas, July 2018

Adolescent Psychiatric Projected Discharges in the Four County Service Area Based on Use Rate

Table 4
Projected Adolescent Psychiatric Service Area Discharges
2016-2024

	2016	2017	2018	2019	2020	2021	2022	2023	2024
Population	143,580	143,318	141,921	142,913	144,044	145,174	146,304	147,434	148,567
Use Rate*	9.64	9.74	9.74	9.74	9.74	9.74	9.74	9.74	9.74
Discharges	1,398	1,396	1,382	1,392	1,403	1,414	1,425	1,436	1,447

*Use Rate from Sheppard Pratt CON submitted 4/10/15 and total discharges calculated based on that use rate multiplied by service area population

Due to the delay in receiving the private psychiatric data from the HSCRC, UMMC has used the statewide use rate provided in the Sheppard Pratt CON application submitted on 4/10/2015 for the establishment of Sheppard Pratt Hospital at Elkridge. UMMC applied this use rate to the service area population to project total adolescent psychiatry discharges each year through 2024. Since the use rate is held constant, the growth mirrors the population growth between 2019 and 2024 of four percent. UMMC expects to receive more recent data from the HSCRC by August 10, 2018 and will submit updated use rates within a reasonable amount of time after receipt.

Adolescent Psychiatric Inpatient Discharges for Four County Service Area

Service area inpatient discharges for adolescent psychiatry increased by 5.0 % between fiscal year 2016 to fiscal year 2018. At the same time, average length of stay increased by 6.1%, compounding the need for more inpatient beds to treat adolescent psychiatry patients.

Table 5
Adolescent Psychiatry Discharges by Acute Care Hospital
FY2016-FY2018
Acute Care Hospitals (1)

	FY2016	FY2017	FY2018
JOHNS HOPKINS	350	306	379
FRANKLIN SQUARE	311	268	277
MONTGOMERY GENERAL	19	22	29
CARROLL COUNTY	23	27	23
SUBURBAN	3	4	17
UMMC	8	10	13
CALVERT MEMORIAL	7	11	11
UMMC MIDTOWN			5
ANNE ARUNDEL			3
HOPKINS BAYVIEW		2	-
UM SJMC		3	-
ST. MARYS			-
SINAI		1	-
Grand Total Discharges	**721**	**654**	**757**
Grand Total Days	**5,529**	**5,359**	**6,168**
Average Length of Stay	**7.67**	**8.19**	**8.14**

(Note 1): Please note: Due to the delay in securing the private psychiatry hospital data from the HSCRC, only acute care hospitals are shown above. This analysis will be updated when UMMC receives the private psychiatric hospital data, which UMMC expects to receive on August 10, 2018.

UMMC Pediatric Emergency Department Patient Demand

In fiscal year 2017, UMMC's pediatric emergency department ("PED") treated 585 patients who had either a primary or secondary psychiatric diagnosis. Of these patients treated in the PED, 118 patients were transferred to an inpatient psychiatric facility, six of whom required admission to an inpatient pediatric general acute bed at UMMC until an inpatient psychiatric bed could be secured. An additional 30 patients were not transferred due to delay in transfer to another hospital. These patients waited for a bed in the PED for two days or greater, and would have benefited from an inpatient bed if one could have been secured. Instead, these patients were stabilized in the PED until it was medically safe to discharge them with outpatient psychiatric support services. Thus, a total of 148 patients (118 + 30) were eligible for inpatient care in FY17. The length of stay for these 148 adolescent psychiatric PED patients ranged from one to seven days with 67% greater than 24 hours and 35% greater 48 hours.

In fiscal year 2018, UMMC's PED treated a total of 873 patients who had a primary or secondary psychiatric diagnosis, a 49% increase from fiscal year 2017. UMMC transferred 70 of these patients to an inpatient psychiatric facility, six of whom required admission to a pediatric general acute bed until an inpatient psychiatric bed could be secured. The 70 patients transferred to an inpatient facility waited from one to nine days with an average wait time of 33 hours to be transferred. Of the patients who were not discharged to an inpatient psychiatric facility, 45 patients

had a length of stay between two and 11 days in the PED and would have benefited from an inpatient psychiatric bed if one could have been secured. Instead, these patients were stabilized in the PED until it was medically safe to discharge them with outpatient psychiatric support services. Thus, a total of at least 115 patients (70 + 45) were eligible for inpatient care in FY18. The length of stay for PED patients needing an inpatient psychiatric bed ranged from 1 to 11 days with 67% having greater than 24 hours and 35% greater than 48 hours.

Referrals from Pediatric General Acute Unit

In fiscal year 2018 there were 20 additional patients transferred to inpatient psychiatric facilities from the pediatric general acute care floor following treatment of medical conditions. These patients also waited extensively to be transferred to an inpatient psychiatry facility similar to the PED patients.

Outpatient Adolescent Care Direct Admission

The University of Maryland School of Medicine faculty within the Department of Psychiatry and Division of Child & Adolescent Psychiatry currently provide outpatient services to adolescents. Approximately 40 patients per year are admitted through direct admissions from their practice and other consults across UMMC. These patients also wait extensively to be transferred to an inpatient psychiatry facility similar to the pediatric ED patients.

UMMS Affiliate Hospital Patient Demand

Within the defined four county service area, UMMS has two other affiliated hospitals that would benefit from expanded access to inpatient adolescent psychiatry services.

UM BWMC has the second busiest emergency room in the State of Maryland. In FY2018, UM BWMC treated 469 adolescent patients with psychiatric needs. Of these, 163 patients were transferred to inpatient psychiatric facilities. These patients waited to be transferred to an inpatient psychiatric facility on average more than 12 hours. (*Source: Director of Behavioral Health Services at UM BWMC)*

UM SJMC treated 97 adolescent patients with psychiatric needs in its emergency department during FY2018. Of these, 37 patients were transferred to inpatient psychiatric facilities. These patients waited to be transferred to an inpatient psychiatric facility on average more than 24 hours. (*Source: Transformation Coordinator at UM SJMC)*

UMMC estimates that 25% of the adolescent psychiatric volumes transferred to an inpatient facility from UM BWMC (41 patients) and UM SJMC (nine patients) would be redirected to UMMC's new proposed inpatient service. This percentage is similar to the current transfer rate of pediatric patients from these two hospitals to UMMC.

Factors Contributing to Increasing Demand Over the Next Five Years

There is increasing demand among the adolescent population that will exacerbate the shortage of inpatient beds in the State of Maryland and Nationwide.

- Adolescent suicide rates are increasing. According to the Center for Disease Control and Prevention ("CDC"), the suicide rate for males age 15-19 increased 31% from 2007 to 2015. The rate for females doubled from 2007 to 2015 and was the highest since tracking began in 1975. (https://www.cdc.gov/mmwr/volumes/66/wr/mm6630a6.htm)
- Depression and anxiety are on the rise due to bullying. According to the CDC, 18.2% of Maryland high school students have been bullied on school property and 14.1% have been bullied through electronic means. (https://nccd.cdc.gov/YouthOnline/App/Results.aspx?LID=MD)
- Exposure to violence. According to the Baltimore City Health Department, 30 percent of children in Baltimore City have Adverse Childhood Experience (ACE) scores of 2 or more, meaning that they have experienced more than two incidences of events such as domestic violence, living with someone with an alcohol/drug problem, the death of a parent, or being a victim/witness of neighborhood violence. (https://health.baltimorecity.gov/state-health-baltimore-winter-2016/state-health-baltimore-white-paper-2017)
- Identification of social/emotional and mental health needs in the school system is increasing the demand for adolescent mental health services. While at the same time, the stigma of seeking care is decreasing. As the stigma of mental illness decreases, more people will seek care for themselves and family members.

UMMC: Projected Bed Need for Adolescent Inpatient Psychiatry Services

Based on the market and program assumptions above, UMMC projects a total of 271 patients in Year 1 and 280 admissions by year 5. Approximately 48% of these admissions would originate from UMMC's PED.

Table 6
Projected 5 Year Adolescent Psychiatry Admissions

	Year 1	Year 2	Year 3	Year 4	Year 5
UMMC Pediatric ED Referrals	130	131	132	133	134
UMMC Referrals from IP Pediatric General Acute Unit	20	20	20	20	21
UM Direct Admits from Outpatient Clinics	41	41	41	42	42
Admits from UMMS Affiliate Hospitals	50	50	51	51	52
Unmet Need in Market	30	30	31	31	31
TOTAL DISCHARGES	**271**	**272**	**275**	**277**	**280**

UMMC projects that the average length of stay for the proposed adolescent psychiatry unit will be 8.6 days. This is based on the average length of stay of the top two acute care hospital programs in the State of Maryland (Johns Hopkins Hospital and MedStar Franklin Square Medical Center) over the past two years for adolescent psychiatric patients. Based on the average length of stay and an occupancy rate of 85%, UMMC projects a bed need of eight beds by year 5. This bed capacity would accommodate current and projected patients who seek care at UMMC through

UMMC's PED, outpatient clinics and a portion of our affiliate hospitals. These beds would be co-located with UMMC's child psychiatry beds for efficiency.

Table 7
Total UMMC Bed Need for Proposed Inpatient Adolescent Psychiatry Unit

	Year 1	Year 2	Year 3	Year 4	Year 5
Total Discharges	271	272	275	277	280
ALOS	8.6	8.6	8.6	8.6	8.6
Total Days	2,331	2,339	2,365	2,382	2,408
Occupancy Rate Assumption	85%	85%	85%	85%	85%
Bed Need at UMMC	**7.51**	**7.54**	**7.62**	**7.68**	**7.76**

In summary, there is a need for additional inpatient adolescent psychiatry beds in the four county service area of Anne Arundel County, Baltimore City, Baltimore County and Howard County. This is evident in the psychiatric volume growth and the extensive wait times experienced by UMMC's patients that present in UMMC's PED as well as in emergency departments at UM BWMC and UM SJMC. There is projected growth in adolescent inpatient psychiatric volumes in the service area and an increase in the length of stay of these patients, indicating the acuity of the patients is rising. There is evidence that the growth of these volumes will continue as the prevalence of suicide, depression, anxiety, and bullying for this population increase according to the CDC, and children are being exposed to more violence according to the Baltimore City Health Department. While it is a positive trend that the stigma of mental illness is decreasing and the social awareness of the disease is rising, this too creates more demand as people are more comfortable seeking treatment for themselves and their family members. As evident in the impact analysis, there will not be a significant effect on the volumes of other providers of adolescent inpatient psychiatry in Maryland. A new eight bed inpatient adolescent psychiatry unit at UMMC will improve the timeliness, quality, and coordination of care for adolescent patients in the service area.

In response to the need for modernization of an existing facility, please see the discussion of patient safety in the response to COMAR § 10.24.01.08G(3)(c), Availability of More Cost-Effective Alternatives, below.

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

Constructing a new child and adolescent behavioral health unit on N11W is the most cost effective option for providing inpatient acute behavioral health services to up to 16 patients at the same time for UMMC patients. The proposed unit combined unit:

- Avoids the duplication of staff that would be necessary if there were two separate units;
- Avoids the duplication of facilities that would be necessary if there were two separate units;
- Avoids a reduction in capacity that would be necessary to house both populations in the current space;
- Avoids having to close the current space and eliminate services while the current location was modified to accommodate the two groups; and

- Reduces the utilization of the Pediatric Emergency Department and the Security Department resources to manage the extended stay of adolescent patients while they await an available bed in the community.

For many years, UMMC has considered the challenges of managing adolescent behavioral health patients who present to the UMMC Pediatric Emergency Department ("PED") and require an inpatient admission. The practice has been to hold the patient under the supervision of a sitter or, in the case of a violent patient a security guard, in the PED pending admission to an available bed in the region. Because of the scarcity of inpatient adolescent acute behavioral health beds, the time between the decision to admit and admission is rarely quick and often can last many days. During the wait, the patient is monitored, but does not receive the behavioral health care she/he will receive in the inpatient setting. Moreover, holding an adolescent patient who needs inpatient behavioral health care in the emergency room is stressful on the PED staff and diverts PED resources from their primary mission. The PED is not an appropriate facility for holding an adolescent in a behavioral health crisis for more than a few hours.

The existing inpatient pediatric psychiatry facilities are not adequate for the intended purpose. UMMC determined that due to the size and configuration of the existing pediatric inpatient acute psychiatry unit on P4G, it could not adequately manage adolescent patients on the unit along with latency age children. The proposal is to provide space for the adolescents without reducing capacity for latency age patients. There is not enough space on P4G to do so.

The existing unit has all semi-private patient bedrooms and shared restrooms. The social and treatment spaces are small. When the current unit is occupied by seven or more children and the staff, the area begins to get crowded.

It would be very difficult to manage adolescent children and latency age children on the current unit. The adolescent patients' sleeping and toileting arrangements must be separated from the latency aged children. Treatment also should be age appropriate. Given the limited space on the current unit separating treatment by time and location will be extremely complex.

As discussed above in section .04B(5) COST-EFFECTIVENESS, N11W is the best option for meeting this need on the UMMC Downtown campus at this time.

There are no viable population health alternatives to managing an adolescent who is in a behavioral health crisis who warrants inpatient treatment. UMMC department of psychiatry presently operates a very robust community focused and community based behavioral health program. Patients who can be managed in an outpatient and community based system are being managed that way. This proposal is for those conditions that cannot be managed via a population health alternative. Their condition requires inpatient treatment until the acute phase is past after which the patient will be returned to a community based system of care.

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

UMMC has adequate operating reserves to fund the project. Initially, UMMC will not seek a rate adjustment, but reserves the right to do so. UMMC will not seek to borrow funds to fund the project.

The project was designed and is being detailed by a licensed health care architect who was selected through a competitive best value selection process. The architect and the architect's professional engineers will produce the contract documents used for permitting and construction. The contract will be assigned to a construction manager based a complete set of drawings and specifications. The latter will include the UMMC design standards.

The completed work will be independently commissioned to confirm the dynamic systems are operating as designed and specified. As mentioned in response to Standard .04B(12) Patient Safety, the design and the construction will be evaluated for risk to patients using the Veterans

Administration Mental Health Environment of Care Checklist (MHEOCC). The risks identified will be preferably mitigated by the physical environment and where that is not possible through documented operational means.

The timeline for construction was developed by UMMC Project Development Department based on their experience with project of similar scope. The timeline was also confirmed as reasonable during the process of selecting the architect and engineers. They were asked to comment on the schedule and agreed it is reasonable.

Project Performance Metrics

Performance Requirement	**Means of meeting and measuring**	**Target**
Project accomplishes desired objectives within planned budget	Comparison of the owner's written project objectives and program with scope contained in cost validated schematic design	Design meets stated project objectives
Project is constructed within planned schedule	Critical path schedule management and use of UMMC's change control discipline to minimize schedule slippage	"First patient date" is within date set in construction contract and as amended by owner initiated changes
Project as designed is completed within approved budget	UMMC's change control discipline to minimize owner changes, well-coordinated drawings to minimize change orders, monthly cost reconciliation	Final cost is within contracted amount adjusted for owner initiated changes.

Pursuant to COMAR § 10.24.01.12.C, Performance Requirements, if this application is approved, UMMC will have 24 months to obligate not less than 51% of the approved capital expenditure. From that date, UMMC will have four months to initiate construction and 24 months to complete the project (to run concurrently).

UMMC anticipates meeting the performance requirements if the application is approved. UUMC anticipates obligating not less than 51% of the approved capital within eight months, and thereafter initiating construction within one month and completing construction within 12 months.

Audited financial statements are attached as Exhibit 14.

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

UMMC received a Certificate of Need on March 18, 2010, Docket No. 09-24-2300, to expand trauma, critical care and emergency services at a capital cost of $176,728,000. A copy of the Final Order is attached as Exhibit 15. UMMC completed the approved project and complied with the conditions of the Certificate of Need.

UMMC received a Certificate of Need in 2001 for the construction of an ambulatory building. UMMC later withdrew that Certificate on Need and did not complete the project.

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

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

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

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

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

c) On costs to the health care delivery system.

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

Applicant Response

The likely volume impact to other inpatient adolescent psychiatry facilities is projected in the following Table 8. UMMC transferred most of its psychiatric adolescent patients requiring admission to the Psychiatric Institute of Washington, Sheppard Pratt Health System and MedStar Franklin Square Hospital. UMMC projects that, if this project is approved, 85 patients would be redirected from Sheppard Pratt Health System by Year 5, which would represent less than 3.5% of Sheppard Pratt's adolescent volume. UMMC projects that 106 patients would be redirected from the Psychiatric Institute of Washington by year 5. Treating these patients at UMMC would allow patients to remain in state and improve family engagement. Many of UMMC's patient families do not have the ability to leave the state and visit their loved ones. Thirty-six patients would be redirected from MedStar Franklin Square, which represents 11% of the adolescent patient volume at that hospital. With unmet need in the market, UMMC expects that MedStar Franklin Square would be able to backfill this volume quickly and that the shift would not compromise the financial viability of MedStar's program.

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

Table 8
Impact to Existing Inpatient Adolescent Psychiatry Programs

	FY2018 Total Adolescent Psychiatric Discharges*	Percent Impact	Year 1 Shift to UMMC	Year 2 Shift to UMMC	Year 3 Shift to UMMC	Year 4 Shift to UMMC	Year 5 Shift to UMMC
Sheppard Pratt Health System	TBD	TBD	83	83	84	85	85
Psychiatric Institute of Washington	NA	NA	102	103	104	105	106
MedStar Franklin Square	336	11%	35	35	35	35	36
Johns Hopkins Hospital	489	0%	1	1	1	1	1
All other facilities	684	3%	20	20	20	20	20
MONTGOMERY GENERAL	191	0%					
CALVERT MEMORIAL	176	0%					
CARROLL COUNTY	127	0%					
SUBURBAN	111	0%					
ST. MARYS	39	0%					
UMMC	27	0%					
UMMC MIDTOWN	5	0%					
UM PRINCE GEORGES	4	0%					
ANNE ARUNDEL	3	0%					
UM SMC at DORCHESTER	1	0%					
SINAI	1	0%					
TOTAL	**1,509**		**241**	**242**	**244**	**246**	**248**

*annualized based on 9 months, source: HSCRC discharge database
Sheppard Pratt volumes will be updated when data is received from the HSCRC; expected by August 10, 2018.

Based on the above impact analysis, the proposed eight bed inpatient adolescent psychiatry unit will not significantly impact existing providers' volumes enough to compromise the financial viability of the existing programs. The impact on Sheppard Pratt Health System will be calculated when UMMC receives the requested data from the HSCRC (expected by August 10, 2018). However, the April 2015 CON submission from Sheppard Pratt for the new facility at Elkridge indicates a projected FY2022 adolescent volume at Sheppard Pratt's two locations of 2,399, making the projected impact of the proposed UMMC program on Sheppard Pratt 3.5%.

The proposed project will have minimal financial impact on existing providers and the Maryland's health care delivery system. UMMC is not requesting an increase to its Global Budgeted Revenue (GBR) associated with the addition of adolescent psychiatric inpatient beds. UMMC will charge its approved unit rates for services provided to adolescent psychiatric inpatients. As a result, UMMC's total charges per unit of service provided should decrease.

Table of Exhibits

Exhibit	Description
1.	MHCC tables
2.	Project drawings
3.	Quality Improvement Plan for Adolescent Psychiatric Services
4.	Policy for Admission, Transfer and Discharge
5.	Policy for Discharge Planning
6.	Letters of support
7.	Information Regarding Charges
8.	Financial Assistance Policy
9.	Posted Notice of Financial Assistance Policy
10.	MDH Hospital License 2018
11.	The Joint Commission Hospital Accreditation Certificates
12.	Quality of Care Action Plan
13.	Marshall Valuation Service analysis
14.	FY17 audited financial statements
15.	CON Final Order (Docket No. 09-24-2300)

Table of Tables

Table	Description
Table 1 FY 2017 Uncompensated Care Percentages	20
Table 2 FY 2017 Community Benefit Analysis Source: HSCRC Community Benefit Report, FY 2017	26
Table 3 Adolescent Population Estimates for Proposed Service Area 2016-2024	44
Table 4 Projected Adolescent Psychiatric Service Area Discharges 2016-2024	44
Table 5 Adolescent Psychiatry Discharges by Acute Care Hospital FY2016-FY2018 Acute Care Hospitals (1)	45
Table 6 Projected 5 Year Adolescent Psychiatry Admissions	47
Table 7 Total UMMC Bed Need for Proposed Inpatient Adolescent Psychiatry Unit	48
Table 8 Impact to Existing Inpatient Adolescent Psychiatry Programs	55

Table of Figures

Figure	Description
Figure 1 Map of Proposed Inpatient Adolescent Psychiatry Service Area	43

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

August 3, 2018
Date

Mohan Suntha, MD, MBA
President and Chief Executive Officer
UMMC

#630381
006551-0237

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

August 3, 2018
Date

Sarah M. Edwards, DO
Assistant Professor of Psychiatry
UMMC

#630378
006551-0237

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

August 3, 2018
Date

Dana Farrakhan
Senior Vice-President, Strategy,
Community & Business Development
UMMC

#630370
006551-0237

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

August 3, 2018
Date

Joseph E. Hoffman III
Senior Vice President and Chief Financial Officer
UMMC

#630372
006551-0237

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

August 3, 2018
Date

Craig Fleischmann
Senior Vice President, Finance
UMMC

#630369
006551-0237

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

August 3, 2018
Date

Leonard Taylor, Jr.
Senior Vice President for Asset Planning
UMMS

#630376
006551-0237

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

August 3, 2018
Date

Greg D. Raymond, MS, MBA, RN
Vice President of Nursing and Patient Care Services, Clinical Practice & Professional Development, Neuroscience, Behavioral Health
UMMC

#630379
006551-0237

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

August 3, 2018
Date

Brian Sturm
Senior Director, Financial and Capital Planning
UMMS

#630368
006551-0237

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

August 3, 2018
Date

Scott Tinsley-Hall
Director, Strategic Planning
UMMC

#630367
006551-0237

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

August 3, 2018
Date

Linda Whitmore
Director for Project Development
UMMC

#630374
006551-0237

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

August 3, 2018
Date

Bret Elam
Project Manager
UMMS

#630375
006551-0237

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

August 3, 2018
Date

Kevin Day
Project Architect
Living Design Lab

#630382
006551-0237

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

August 3, 2018
Date

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

#630366
006551-0237

EXHIBIT 1

EXHIBIT 1

Name of Applicant: University of Maryland Medical Center, LLC

Date of Submission: 8/3/2018

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

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

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTION: 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. See additional instruction in the column to the right of the table.
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: July 1, 2018	Based on Physical Capacity: Room Count: Private	Room Count: Semi-Private	Room Count: Total Rooms	Bed Count: Physical Capacity	Hospital Service	Location (Floor/Wing)*	Based on Physical Capacity: Room Count: Private	Room Count: Semi-Private	Room Count: Total Rooms	Bed Count: Physical Capacity
ACUTE CARE							**ACUTE CARE**					
General Medical/Surgical*	Vascular Surgery, Medical Acute 11E, Medical Acute N10E, Surgical Acute, Medical Telemetry N13, Neurocare Acute, Orthopedic Acute, Transplant IMC, Neurocare Stepdown, Cardiac Surgery Stepdown, Surgical IMC, Medical IMC	**296**	170	40	210	250	**General Medical/Surgical***	Vascular Surgery, Medical Acute 11E, Medical Acute N10E, Surgical Acute, Medical Telemetry N13, Neurocare Acute, Orthopedic Acute, Transplant IMC, Neurocare Stepdown, Cardiac Surgery Stepdown, Surgical IMC, Medical IMC	170	40	210	250
SUBTOTAL Gen. Med/Surg*		**296**	**170**	**40**	**210**	**250**	**SUBTOTAL Gen. Med/Surg***		**170**	**40**	**210**	**250**
ICU/CCU	Neurocare ICU, Cardiac Surgery ICU, Medical ICU, Surgical ICU	**115**	95	2	97	99	**ICU/CCU**	Neurocare ICU, Cardiac Surgery ICU, Medical ICU, Surgical ICU	95	2	97	99
Medical Cardiac Critical Care	Cardiac Care Unit, Cardiac Progressive Care Unit	**46**	27	7	34	41		Cardiac Care Unit, Cardiac Progressive Care Unit	27	7	34	41
Shock Trauma	Neurotrauma IMC, Neurotrauma CC, Multitrauma IMC, Multitrauma CC, Select Trauma IMC, Acute Care	**115**	104	2	106	108		Neurotrauma IMC, Neurotrauma CC, Multitrauma IMC, Multitrauma CC, Select Trauma IMC, Acute Care	104	2	106	108
Oncology	Gudelsky BMT C9W, Medical Oncology	**67**	52	0	52	52		Gudelsky BMT C9W, Medical Oncology	52	0	52	52
TOTAL MSGA		**639**	**448**	**51**	**499**	**550**	**TOTAL MSGA**		**448**	**51**	**499**	**550**
Obstetrics	Inpatient Perinatal GYN	**35**	22	0	22	22	**Obstetrics**	Inpatient Perinatal GYN	22	0	22	22
Pediatrics	Pediatric Acute Care, Pediatric ICU	**59**	37	11	48	59	**Pediatrics**	Pediatric Acute Care, Pediatric ICU	37	11	48	59

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTION: 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. See additional instruction in the column to the right of the table.
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: July 1, 2018	Based on Physical Capacity: Room Count Private	Semi-Private	Total Rooms	Bed Count: Physical Capacity	Hospital Service	Location (Floor/Wing)*	Based on Physical Capacity: Room Count Private	Semi-Private	Total Rooms	Bed Count: Physical Capacity
Psychiatric		**56**	**2**	**26**	**28**	**54**	**Psychiatric**		**16**	**14**	**30**	**44**
Acute Psychiatric - Adult	N11W, N12W	**31**	1	15	16	31	Acute Psychiatric - Adult	N12W	1	7	8	15
Acute Psychiatric - Child	P4G	**12**	0	5	5	10	Acute Psychiatric - Child	N11W	6	1	7	8
Acute Psychiatric - Adolescent	N/A	**0**	0	0	0	0	Acute Psychiatric - Adolescent	N11W	8	0	8	8
Acute Psychiatric - Geriatric	N12E	**13**	1	6	7	13	Acute Psychiatric - Geriatric	N12E	1	6	7	13
TOTAL ACUTE		**789**	**509**	**88**	**597**	**685**	**TOTAL ACUTE**		**523**	**76**	**599**	**675**
NON-ACUTE CARE							**NON-ACUTE CARE**					
Dedicated Observation**		**10**	6	**2**	8	10	**Dedicated Observation****		6	2	8	10
Newborn Nursery		**24**	24	**0**	24	24	**Newborn Nursery**		24	0	24	24
Neonatal ICU		**52**	52	**0**	52	52	**Rehabilitation**		52	0	52	52
Rehabilitation		**0**	0	**0**	0	0	**Rehabilitation**		0	0	0	0
Comprehensive Care		**0**	0	**0**	0	0	**Comprehensive Care**		0	0	0	0
Other *(Specify/add rows as needed)*		**0**	0	**0**	0	0	**Other** *(Specify/add rows as needed)*		0	0	0	0
TOTAL NON-ACUTE		**86**	**82**	**2**	**84**	**86**	**TOTAL NON-ACUTE**		**82**	**2**	**84**	**86**
HOSPITAL TOTAL		**875**	**591**	**90**	**681**	**771**	**HOSPITAL TOTAL**		**605**	**78**	**683**	**761**

* 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
Patient Rooms	**2,055**		**1,775**		**1,775**
Patient Activity Area	**872**		**1,235**		**1,235**
Toilets	**554**		**858**		**858**
Seclusion Suite/ Sensory Room	**254**		**269**		**269**
OT (school, group, interview)	**1,172**		**1,235**		**1,235**
Intake/ Exam	**421**		**411**		**411**
Offices	**1,845**		**1,141**		**1,141**
Conference	**183**		**473**		**473**
Storage	**477**		**586**		**586**
Corridor/ Lobby	**3,367**		**3,217**		**3,217**
12 Patient	551				**0**
12 Toilet	111		93		**93**
12 Offices	478		462		**462**
12 Seclusion Suite/ Sensory Room/ OT	224		457		**457**
12 Gym			460		**460**
12 Corridor	1,235		1,127		**1,127**
Total	**13,799**		**13,799**		

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**	
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Fifth Floor		
Sixth Floor		
Seventh Floor		
Eighth Floor		
Ninth Floor		
Tenth Floor		
Eleventh Floor		11,200
Twelfth Floor		2,599
Average Square Feet		**6,900**
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Fifth Floor		
Sixth Floor		
Seventh Floor		
Eighth Floor		
Ninth Floor		
Tenth Floor		
Eleventh Floor		505
Twelfth Floor		195
Total Linear Feet		**700**
Average Linear Feet		**350**
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Fifth Floor		
Sixth Floor		
Seventh Floor		
Eighth Floor		
Ninth Floor		
Tenth Floor		
Eleventh Floor		13
Twelfth Floor		13
Average Wall Height		
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		6 existing
Freight		1 existing service elevator
Sprinklers	**Square Feet Covered**	
Wet System		13,799
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project	Centrally fed horizontal distribution system	
Type of Exterior Walls for proposed project	Existing exterior walls	

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		
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs		
Site Demolition Costs		
Storm Drains		
Rough Grading		
Hillside Foundation		
Paving		
Exterior Signs		
Landscaping		
Walls		
Yard Lighting		
Other *(Specify/add rows if needed)*		
Sediment Control & Stabilization		
Helipad		
Water		
Sewer		
Premium for Minority Business Enterprise Requirement		
Outside the Loop		
Subtotal On-Site excluded from Marshall Valuation Costs	**$0**	
OFFSITE COSTS		
Roads		
Utilities		

TABLE E. PROJECT BUDGET

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

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

	Hospital Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building			$0
(2) Fixed Equipment			$0
(3) Site and Infrastructure			$0
(4) Architect/Engineering Fees			$0
(5) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$0**	**$0**
b. Renovations			
(1) Building	$7,422,000		$7,422,000
(2) Fixed Equipment (not included in construction)	$0		$0
(3) Architect/Engineering Fees	$600,000		$600,000
(4) Permits (Building, Utilities, Etc.)	$75,000		$75,000
SUBTOTAL	**$8,097,000**	**$0**	**$8,097,000**
c. Other Capital Costs			
(1) Movable Equipment	$600,000		$600,000
(2) Contingency Allowance	$682,000		$682,000
(3) Gross interest during construction period			$0
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$1,282,000***	***$0***	**$1,282,000**
TOTAL CURRENT CAPITAL COSTS	**$9,379,000**	**$0**	**$9,379,000**
d. *Land Purchase*			
e. Inflation Allowance	$146,000		$146,000
TOTAL CAPITAL COSTS	**$9,525,000**	**$0**	**$9,525,000**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c CON Application Assistance			
c1. Legal Fees	**$35,000**		$35,000
c2. Other (Specify/add rows if needed)	**$20,000**		$20,000
d. Non-CON Consulting Fees			
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund			$0
f Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$55,000***	***$0***	**$55,000**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$9,580,000***	***$0***	***$9,580,000***
B. Sources of Funds			
1. Cash	**$9,580,000**	**$0**	$9,580,000
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
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 *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$9,580,000***	***$0***	**$9,580,000**
	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

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	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**			
1. DISCHARGES										
a. General Medical/Surgical*	21,903	20,637	20,297	20,483	20,144	20,251	20,359			
b. ICU/CCU	2,804	2,846	2,826	2,834	2,849	2,864	2,878			
Total MSGA	**24,707**	**23,483**	**23,123**	**23,317**	**22,993**	**23,115**	**23,237**	**0**	**0**	**0**
c. Pediatric	1,585	1,768	1,782	1,796	1,810	1,825	1,839			
d. Obstetric	1,997	2,110	2,118	2,120	2,125	2,135	2,140			
e. Acute Psychiatric	1,129	1,173	1,064	933	1,393	1,396	1,400			
Total Acute	***29,418***	***28,534***	***28,087***	***28,166***	***28,321***	***28,471***	***28,616***	***0***	***0***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL DISCHARGES	***29,418***	***28,534***	***28,087***	***28,166***	***28,321***	***28,471***	***28,616***	***0***	***0***	***0***
2. PATIENT DAYS										
a. General Medical/Surgical*	122,044	121,180	122,499	123,759	118,039	117,558	117,106			
b. ICU/CCU	70,332	70,453	70,085	70,283	70,655	71,027	71,374			
Total MSGA	**192,376**	**191,633**	**192,584**	**194,042**	**188,694**	**188,585**	**188,481**	**0**	**0**	**0**
c. Pediatric	5,396	5,151	5,346	5,388	5,431	5,474	5,517			
d. Obstetric	6,031	6,562	6,587	6,593	6,609	6,640	6,655			
e. Acute Psychiatric	12,950	13,407	12,236	10,730	16,020	16,054	16,100			
Total Acute	***216,753***	***216,753***	***216,753***	***216,753***	***216,753***	***216,753***	***216,753***	***0***	***0***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	***216,753***	***216,753***	***216,753***	***216,753***	***216,753***	***216,753***	***216,753***	***0***	***0***	***0***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**			
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	5.6	5.9	6.0	6.0	5.9	5.8	5.8	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	25.1	24.8	24.8	24.8	24.8	24.8	24.8	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	7.8	8.2	8.3	8.3	8.2	8.2	8.1	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	3.4	2.9	3.0	3.0	3.0	3.0	3.0	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	3.0	3.1	3.1	3.1	3.1	3.1	3.1	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	11.5	11.4	11.5	11.5	11.5	11.5	11.5	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	7.4	7.6	7.7	7.7	7.7	7.6	7.6	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	7.4	7.6	7.7	7.7	7.7	7.6	7.6	#DIV/0!	#DIV/0!	#DIV/0!
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*	416	433	450	450	450	450	450			
b. ICU/CCU	241	241	241	241	241	241	241			
Total MSGA	**657**	**674**	**691**	**691**	**691**	**691**	**691**	**0**	**0**	**0**
c. Pediatric	59	59	59	59	59	59	59			
d. Obstetric	30	30	35	35	35	35	35			
e. Acute Psychiatric	56	56	56	56	56	56	56			
Total Acute	***802***	***819***	***841***	***841***	***841***	***841***	***841***	***0***	***0***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL LICENSED BEDS	***802***	***819***	***841***	***841***	***841***	***841***	***841***	***0***	***0***	***0***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**			
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	80.4%	76.7%	74.6%	75.3%	71.9%	71.6%	71.3%	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	80.0%	80.1%	79.7%	79.9%	80.3%	80.7%	81.1%	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	**80.2%**	**77.9%**	**76.4%**	**76.9%**	**74.8%**	**74.8%**	**74.7%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Pediatric	25.1%	23.9%	24.8%	25.0%	25.2%	25.4%	25.6%	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	55.1%	59.9%	51.6%	51.6%	51.7%	52.0%	52.1%	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	63.4%	65.6%	59.9%	52.5%	78.4%	78.5%	78.8%	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	**74.0%**	**72.5%**	**70.6%**	**70.6%**	**70.6%**	**70.6%**	**70.6%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**74.0%**	**72.5%**	**70.6%**	**70.6%**	**70.6%**	**70.6%**	**70.6%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS										
a. Emergency Department	54,868	67,311	68,811	68,811	69,004	69,383	69,751			
b. Same-day Surgery	18,025	11,638	11,638	11,638	11,671	11,735	11,797			
c. Laboratory										
d. Imaging										
e. Other (Specify/add rows of needed)	227,600	257,684	261,821	261,821	262,554	263,998	265,397			
TOTAL OUTPATIENT VISITS	***300,493***	***336,633***	***342,270***	***342,270***	***343,229***	***345,116***	***346,945***	***0***	***0***	***0***
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.

NOTE: UMMC has supplied total discharges and total days, historical and projected, for the requested bed types. Many patients spend days in an ICU/CCU bed, adding to the patient days total for that category, and are then then transferred to another bed type and before being discharged. As a result, the automatic calculation set up in the table provides an inflated average length of stay for the ICU/CCU category.

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**			
1. REVENUE										
a. Inpatient Services	$ 1,099,703	$ 1,182,602	$ 1,212,884	$ 1,214,304	$ 1,219,108	$ 1,224,283	$ 1,229,625			
b. Outpatient Services	$ 528,085	$ 522,811	$ 536,908	$ 532,866	$ 534,887	$ 537,065	$ 539,313			
Gross Patient Service Revenues	***$ 1,627,788***	***$ 1,705,413***	***$ 1,749,792***	***$ 1,747,170***	***$ 1,753,995***	***$ 1,761,348***	***$ 1,768,938***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 218,553	$ 250,863	$ 253,814	$ 253,434	$ 254,424	$ 255,490	$ 256,591			
d. Contractual Allowance										
e. Charity Care										
Net Patient Services Revenue	***$ 1,409,235***	***$ 1,454,550***	***$ 1,495,978***	***$ 1,493,736***	***$ 1,499,571***	***$ 1,505,858***	***$ 1,512,347***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 103,393	$ 98,393	$ 99,733	$ 99,733	$ 99,733	$ 99,733	$ 99,733			
g. State Grants (Specify/add rows if needed)	$ -	$ 3,150	$ 3,150	$ 3,150	$ 3,150	$ 3,150	$ 3,150			
NET OPERATING REVENUE	***$ 1,512,628***	***$ 1,556,093***	***$ 1,598,861***	***$ 1,596,619***	***$ 1,602,455***	***$ 1,608,741***	***$ 1,615,230***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 591,338	$ 605,954	$ 625,074	$ 624,148	$ 627,175	$ 629,623	$ 630,840			
b. Contractual Services	$ 268,691	$ 262,524	$ 258,507	$ 257,642	$ 259,027	$ 260,313	$ 261,081			
c. Interest on Current Debt	$ 31,385	$ 30,427	$ 29,795	$ 29,008	$ 28,170	$ 27,259	$ 26,306			
d. Interest on Project Debt		$ -	$ -	$ -	$ -	$ -	$ -			
e. Current Depreciation	$ 96,108	$ 98,227	$ 103,385	$ 104,291	$ 100,986	$ 100,357	$ 101,323			
f. Project Depreciation		$ -		$ -	$ 360	$ 719	$ 719			
g. Current Amortization		$ -	$ -	$ -	$ -	$ -	$ -			
h. Project Amortization		$ -	$ -	$ -	$ -	$ -	$ -			
i. Supplies	$ 344,288	$ 350,950	$ 365,820	$ 364,548	$ 366,557	$ 368,476	$ 369,660			
j. Other Expenses (Specify/add rows if needed)	$ 16,054	$ 41,646	$ 42,891	$ 42,827	$ 42,975	$ 43,024	$ 42,993			
k. Physician Services (Specify/add rows if needed)	$ 134,767	$ 137,809	$ 138,989	$ 138,542	$ 139,268	$ 139,921	$ 140,298			
TOTAL OPERATING EXPENSES	***$ 1,482,631***	***$ 1,527,537***	***$ 1,564,461***	***$ 1,561,006***	***$ 1,564,519***	***$ 1,569,692***	***$ 1,573,220***	***$ -***	***$ -***	***$ -***

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**			
3. INCOME										
a. Income From Operation	**$ 29,997**	**$ 28,556**	**$ 34,400**	**$ 35,613**	**$ 37,936**	**$ 39,049**	**$ 42,011**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income	$ 109,321	$ 12,785	$ 10,610	$ 11,664	$ 12,265	$ 13,108	$ 13,856			
SUBTOTAL	***$ 139,318***	***$ 41,341***	***$ 45,010***	***$ 47,277***	***$ 50,201***	***$ 52,157***	***$ 55,867***	***$ -***	***$ -***	***$ -***
c. Income Taxes	$ -	$ -	$ -	$ -	$ -	$ -				
NET INCOME (LOSS)	***$ 139,318***	***$ 41,341***	***$ 45,010***	***$ 47,277***	***$ 50,201***	***$ 52,157***	***$ 55,867***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%			
2) Medicaid	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%			
3) Blue Cross	15.0%	11.0%	11.0%	11.0%	11.0%	11.0%	11.0%			
4) Commercial Insurance	15.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%			
5) Self-pay	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%			
6) Other	5.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%			
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare										
2) Medicaid										
3) Blue Cross										
4) Commercial Insurance										
5) Self-pay										
6) Other										
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

INFORMATION NOT REPORTED ON.

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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**			
1. REVENUE										
a. Inpatient Services	$ 1,099,703	$ 1,182,602	$ 1,212,884	$ 1,241,748	$ 1,275,268	$ 1,316,445	$ 1,358,944			
b. Outpatient Services	$ 528,085	$ 522,811	$ 536,908	$ 549,631	$ 564,475	$ 582,781	$ 601,671			
Gross Patient Service Revenues	***$ 1,627,788***	***$ 1,705,413***	***$ 1,749,792***	***$ 1,791,379***	***$ 1,839,742***	***$ 1,899,225***	***$ 1,960,615***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt										
d. Contractual Allowance	$ 218,553	$ 250,863	$ 253,814	$ 259,846	$ 266,862	$ 275,490	$ 284,395			
e. Charity Care										
Net Patient Services Revenue	***$ 1,409,235***	***$ 1,454,550***	***$ 1,495,978***	***$ 1,531,533***	***$ 1,572,880***	***$ 1,623,736***	***$ 1,676,220***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 100,193	$ 98,393	$ 99,733	$ 99,733	$ 99,733	$ 99,733	$ 99,733			
g. State Grants (Specify/add rows if needed)	$ 3,200	$ 3,150	$ 3,150	$ 3,150	$ 3,150	$ 3,150	$ 3,150			
NET OPERATING REVENUE	***$ 1,512,628***	***$ 1,556,093***	***$ 1,598,861***	***$ 1,634,415***	***$ 1,675,763***	***$ 1,726,619***	***$ 1,779,103***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 591,338	$ 605,954	$ 625,074	$ 640,297	$ 659,006	$ 681,065	$ 702,507			
b. Contractual Services	$ 268,691	$ 262,524	$ 258,507	$ 264,153	$ 272,024	$ 281,447	$ 290,621			
c. Interest on Current Debt	$ 31,385	$ 30,427	$ 29,795	$ 29,008	$ 28,170	$ 27,259	$ 26,306			
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -			
e. Current Depreciation	$ 96,108	$ 98,227	$ 103,385	$ 104,291	$ 100,986	$ 100,357	$ 101,323			
f. Project Depreciation	$ -	$ -	$ -	$ -	$ 360	$ 719	$ 719			
g. Current Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -			
h. Project Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -			
i. Supplies	$ 344,288	$ 350,950	$ 365,820	$ 374,721	$ 385,941	$ 399,419	$ 412,549			
j. Other Expenses (Specify/add rows if needed)	$ 16,054	$ 41,646	$ 42,891	$ 43,615	$ 44,391	$ 45,307	$ 46,157			
k. Physician Services (Specify/add rows if needed)	$ 134,767	$ 137,809	$ 138,989	$ 142,718	$ 146,949	$ 151,997	$ 156,911			
TOTAL OPERATING EXPENSES	***$ 1,482,631***	***$ 1,527,537***	***$ 1,564,461***	***$ 1,598,803***	***$ 1,637,828***	***$ 1,687,570***	***$ 1,737,092***	***$ -***	***$ -***	***$ -***
3. INCOME										
a. Income From Operation	**$ 29,997**	**$ 28,556**	**$ 34,400**	**$ 35,613**	**$ 37,936**	**$ 39,049**	**$ 42,011**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income	$ 109,321	$ 12,785	$ 10,610	$ 11,664	$ 12,265	$ 13,108	$ 13,856			
SUBTOTAL	***$ 139,318***	***$ 41,341***	***$ 45,010***	***$ 47,277***	***$ 50,201***	***$ 52,157***	***$ 55,867***	***$ -***	***$ -***	***$ -***
c. Income Taxes	$ -	$ -	$ -	$ -	$ -	$ -	$ -			
NET INCOME (LOSS)	***$ 139,318***	***$ 41,341***	***$ 45,010***	***$ 47,277***	***$ 50,201***	***$ 52,157***	***$ 55,867***	***$ -***	***$ -***	***$ -***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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**			
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%			
2) Medicaid	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%			
3) Blue Cross	15.0%	11.0%	11.0%	11.0%	11.0%	11.0%	11.0%			
4) Commercial Insurance	15.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%			
5) Self-pay	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%			
6) Other	5.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%			
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare										
2) Medicaid										
3) Blue Cross										
4) Commercial Insurance										
5) Self-pay										
6) Other										
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

INFORMATION NOT REPORTED ON.

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (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.

	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 J and K.						
Indicate CY or FY	**FY21**	**FY22**	**FY23**				
1. DISCHARGES							
a. General Medical/Surgical*	0	0	0				
b. ICU/CCU	0	0	0				
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0				
d. Obstetric	0	0	0				
e. Acute Psychiatric	876	876	876				
Total Acute	***876***	***876***	***876***	***0***	***0***	***0***	***0***
f. Rehabilitation	0	0	0				
g. Comprehensive Care	0	0	0				
h. Other (Specify/add rows of needed)	0	0	0				
TOTAL DISCHARGES	***876***	***876***	***876***	***0***	***0***	***0***	***0***
2. PATIENT DAYS							
a. General Medical/Surgical*	0	0	0				
b. ICU/CCU	0	0	0				
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0				
d. Obstetric	0	0	0				
e. Acute Psychiatric	4,719	4,719	4,719				
Total Acute	***4719***	***4719***	***4719***	***0***	***0***	***0***	***0***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL PATIENT DAYS	***4,719***	***4,719***	***4,719***	***0***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY							
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	5.4	5.4	5.4	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	5.4	5.4	5.4	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	5.4	5.4	5.4	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (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.

	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 J and K.						
Indicate CY or FY	**FY21**	**FY22**	**FY23**				
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	16	16	16				
Total Acute	***16***	***16***	***16***	***0***	***0***	***0***	***0***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL LICENSED BEDS							
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	80.8%	80.8%	80.8%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	**80.8%**	**80.8%**	**80.8%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS							
a. Emergency Department							
b. Same-day Surgery							
c. Laboratory							
d. Imaging							
e. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***
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 - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I 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.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, 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	**FY21**	**FY22**	**FY23**				
1. REVENUE							
a. Inpatient Services	$ 13,580,098	$ 13,580,098	$ 13,580,098				
b. Outpatient Services							
Gross Patient Service Revenues	***$ 13,580,098***	***$ 13,580,098***	***$ 13,580,098***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 189,532	$ 189,532	$ 189,532				
d. Contractual Allowance	$ 818,927	$ 818,927	$ 818,927				
e. Charity Care	$ 125,602	$ 125,602	$ 125,602				
Net Patient Services Revenue	***$ 12,446,037***	***$ 12,446,037***	***$ 12,446,037***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$ 12,446,037***	***$ 12,446,037***	***$ 12,446,037***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 4,857,842	$ 4,857,842	$ 4,857,842				
b. Contractual Services	$ 72,710	$ 72,710	$ 72,710				
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 719,762	$ 719,762	$ 719,762				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 82,571	$ 82,571	$ 82,571				
j. Other Expenses (Specify)	$ 1,228,452	$ 1,228,452	$ 1,228,452				
TOTAL OPERATING EXPENSES	***$ 6,961,338***	***$ 6,961,338***	***$ 6,961,338***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ 5,484,699**	**$ 5,484,699**	**$ 5,484,699**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ 5,484,699***	***$ 5,484,699***	***$ 5,484,699***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ 5,484,699***	***$ 5,484,699***	***$ 5,484,699***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I 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.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, 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	**FY21**	**FY22**	**FY23**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare							
2) Medicaid	85.3%	85.3%	85.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	3.9%	3.9%	3.9%				
5) Self-pay	1.9%	1.9%	1.9%				
6) Other							
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare							
2) Medicaid	85.7%	85.7%	85.7%				
3) Blue Cross	8.7%	8.7%	8.7%				
4) Commercial Insurance	3.8%	3.8%	3.8%				
5) Self-pay	1.8%	1.8%	1.8%				
6) Other							
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION : After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. 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.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, 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	**FY21**	**FY22**	**FY23**				
1. REVENUE							
a. Inpatient Services	$ 13,580,098	$ 13,973,921	$ 14,379,165				
b. Outpatient Services							
Gross Patient Service Revenues	***$ 13,580,098***	***$ 13,973,921***	***$ 14,379,165***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 189,531.88	$ 195,028.31	$ 200,684.13				
d. Contractual Allowance	$ 818,926.87	$ 842,675.75	$ 867,113.34				
e. Charity Care	$ 125,602.33	$ 129,244.79	$ 132,992.89				
Net Patient Services Revenue	***$ 12,446,037***	***$ 12,806,972***	***$ 13,178,374***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE	***$ 12,446,037***	***$ 12,806,972***	***$ 13,178,374***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 4,857,842	$ 5,003,578	$ 5,153,685				
b. Contractual Services	$ 72,710	$ 74,892	$ 77,138				
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 719,762	$ 719,762	$ 719,762				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 82,571	$ 85,048	$ 87,600				
j. Other Expenses (Specify/add rows of needed)	$ 1,228,452	$ 1,253,021	$ 1,278,081				
TOTAL OPERATING EXPENSES	***$ 6,961,338***	***$ 7,136,301***	***$ 7,316,266***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ 5,484,699**	**$ 5,670,672**	**$ 5,862,108**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ 5,484,699***	***$ 5,670,672***	***$ 5,862,108***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ 5,484,699***	***$ 5,670,672***	***$ 5,862,108***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION : After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. 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.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, 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	**FY21**	**FY22**	**FY23**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare							
2) Medicaid	85.3%	85.3%	85.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	3.9%	3.9%	3.9%				
5) Self-pay	1.9%	1.9%	1.9%				
6) Other							
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare							
2) Medicaid	85.7%	85.7%	85.7%				
3) Blue Cross	8.7%	8.7%	8.7%				
4) Commercial Insurance	3.8%	3.8%	3.8%				
5) Self-pay	1.8%	1.8%	1.8%				
6) Other							
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE L. WORKFORCE INFORMATION

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

	CURRENT ENTIRE FACILITY			***PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)***			***OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)***			***PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT***	
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)*											
			$0			$0			$0	0.0	$0
Directors/Managers/Sr. Administrators	365.3	$111,356	$40,678,347			$0			$0	365.3	$40,678,347
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration	365.3		$40,678,347			$0			$0	365.3	$40,678,347
Direct Care Staff *(List general categories, add rows if needed)*											
RNs	2,346.0	$80,038	187,768,819	9.4	$80,038	$749,960			$0	2,355.4	$188,518,779
Clinical Professionals	1,144.3	$93,415	106,894,785	8.0	$90,938	$727,504			$0	1,152.3	$107,622,289
Clinical Techs	426.2	$72,279	30,802,419			$0			$0	426.2	$30,802,419
Non-Licensed Clinical	948.0	$38,945	36,919,860	4.0	$52,000	$208,000			$0	952.0	$37,127,860
Residents	583.0	$60,746	35,414,918			$0				583.0	
Total Direct Care	5,447.4		$397,800,800	21.4		$1,685,464			$0	5,468.8	$399,486,264
Support Staff *(List general categories, add rows if needed)*											
Administrative and Clerical	502.2	$41,985	21,085,707	2.0	$31,200	$62,400			$0	504.2	$21,148,107
All Other Support	716.4	$37,165	26,623,148			$0			$0	716.4	$26,623,148
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support	1,218.6		47,708,854.5	2.0		62,400.0			$0	1,220.6	$47,771,254
REGULAR EMPLOYEES TOTAL	***7,031.3***		***486,188,002***	***23.4***		***1,747,864***			$0	7,054.7	$487,935,865

TABLE L. WORKFORCE INFORMATION

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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT	
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)*
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)*											
RNs	35.5	$137,864	4,894,282			$0			$0	35.5	$4,894,282
Clinical Professionals	9.9	$119,493	1,178,278			$0			$0	9.9	$1,178,278
Clinical Techs			-			$0			$0	0.0	$0
Non-Licensed Clinical	3.6	$49,753	178,613			$0			$0	3.6	$178,613
Total Direct Care Staff	49.0		$6,251,174			$0			$0	49.0	$6,251,174
Support Staff *(List general categories, add rows if needed)*											
Administrative and Clerical	17.0	$41,520	706,255			$0			$0	17.0	$706,255
All Other Support	58.1	$32,930	1,913,562			$0			$0	58.1	$1,913,562
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff	75.1		$2,619,818			$0			$0	75.1	$2,619,818
CONTRACTUAL EMPLOYEES TO	***124.1***		***8,870,991***			$0			$0	124.1	$8,870,991
Benefits *(State method of calculating benefits below)* **:**			**110,894,621**								
22.81% of regular employee sala											
TOTAL COST	***7,155.4***		***$605,953,614***	***23.4***		***$1,747,864***	***0.0***		***$0***		***$496,806,857***

CON Submission for Adolescent Behavioral Health Program

Comprehensive Statement of Assumptions Used to Complete Tables F-L[1]

BASIS:

The basis of the projected income statement is the University of Maryland Medical Center's (UMMC) fiscal year 2019 operating budget for the period of July 1, 2018 through June 30, 2019. This serves as the base period for the application of assumptions as to anticipated changes in volumes, variable cost assumptions and other factors in subsequent periods.

REVENUE:

Volume

Refer to Table F for a comprehensive statement of volume assumptions.

Patient Service Revenue

Patient revenue consists of charges for daily routine services and inpatient ancillary services performed during a patient's stay in the hospital and for charges related to outpatient ancillary and emergency services. It is assumed that the University of Maryland Medical Center's case-mix index will remain constant at the fiscal year 2019 level throughout the projected period of fiscal year 2023. See below for the percentage changes of total inpatient and outpatient revenue throughout the projected period:

	Fiscal 2020 Projection	Fiscal 2021 Projection	Fiscal 2022 Projection	Fiscal 2023 Projection
HSCRC Inflation	2.40%	2.40%	2.90%	2.90%
Other Rates	0.03%	0.05%	-0.21%	-0.20%
Volume	0.00%	0.28%	0.55%	0.53%
	2.43%	2.73%	3.24%	3.23%

Allowances:

Allowances represent deductions from patient revenue including third-party contractual allowances, provision for bad debts, and charity care. The projection assumes that the allowances throughout the projection period are 14.5% of gross patient service revenue based on the fiscal year 2019 budget.

Allowances for Third Party Contractual Adjustments

It is assumed that UMMC will experience no significant changes in its current payor mix in the projected periods.

[1] See the MVS analysis for assumptions regarding project costs.

Bad Debt Provision and Charity Care

The provision for bad debts and charity care includes uncollectable accounts, charity care and write-offs for Medicaid patients with length of stays in excess of Medicaid payment limits (uncompensated care). It is assumed that UMMC will experience no significant changes in its current payor mix in the projected periods.

Other Operating Revenue

Other operating revenue includes state support and miscellaneous revenues such as cafeteria sales, rental revenue and parking revenue.

State grants also includes the State of Maryland's operating and capital support for the Shock Trauma Center and the Comprehensive Cancer Center. It is assumed no change in other revenue or state grants will occur throughout the projected period of fiscal year 2023.

EXPENSE:

The weighted average variable cost factor of the expenses listed below (excluding depreciation and interest) is 60.0%. The weighted average inflation factor for operating expenses in fiscal year 2020 is 2.7%. The weighted average inflation factor for operating expenses between fiscal years 2021-2023 is 3.0%.

In addition, historical performance improvement actions are layered into each major expense category to account for a shortfall in revenue inflation. Also included in each major expense category are historical fixed expense additions, which are not related to volume or inflation increases.

FTEs, Salaries and Wages:

The financial projection assumes an increase of 0.7% or 49 full-time equivalent (FTE) personnel over the fiscal year 2019 budget. This is driven by the impact of volume changes, in which the projection model assumes the direct and indirect patient care workforce is 50% variable with changes in patient days. UMMC is anticipating no change in the FTEs per adjusted occupied bed over the projection period. This is based on the assumption that the fixed, non-direct patient care staff does not increase over the projection period. In addition, the staffing for direct patient care does not change over the projection period.

Employee Fringe Benefits:

The fringe benefits are calculated as percentage of total salaries and wages. Fringe benefits include health insurance, pension short- and long-term disability, life insurance and employer share of FICA. The projection model assumes these costs are 21.9% of salaries and wages throughout the projection period.

Contractual Services:

The projection model assumes 70% of purchased service expenses are variable with changes in the equivalent patient days. Purchased services include but are not limited to housekeeping, food service and ancillary medical care services such as dialysis, perfusion and other services.

Interest Expense:

The projection model assumes the payment of interest expense on existing debt and capital leases.

Depreciation & Amortization:

Property, plant and equipment capital expenditures are stated at cost. Deprecation is then computed over the estimated useful life of the asset using the straight-line deprecation methodology and a one-half year convention. See useful lives below:

Assets:	**Average Lives**
Information technology	5 years
Medical equipment	5 years
Building improvements, renovation and infrastructure	15 years

The projection assumes the new building is opened in fiscal year 2021, therefore a half-year of deprecation of the building and additional related costs (e.g. equipment) will occur in fiscal year 2021.

Supplies:

The projection model assumes 75% of supply costs are variable with changes in the equivalent patient days. Supplies include medical supplies, drugs, non-medical supplies and office supplies.

Other Expense:

The projection model assumes 65% of physician services are variable with changes in the equivalent patient days.

The projection model also assumes that other expenses, such as insurance, utilities, repairs and maintenance are not variable with changes in the equivalent patient days.

NON-OPERATING REVENUE:

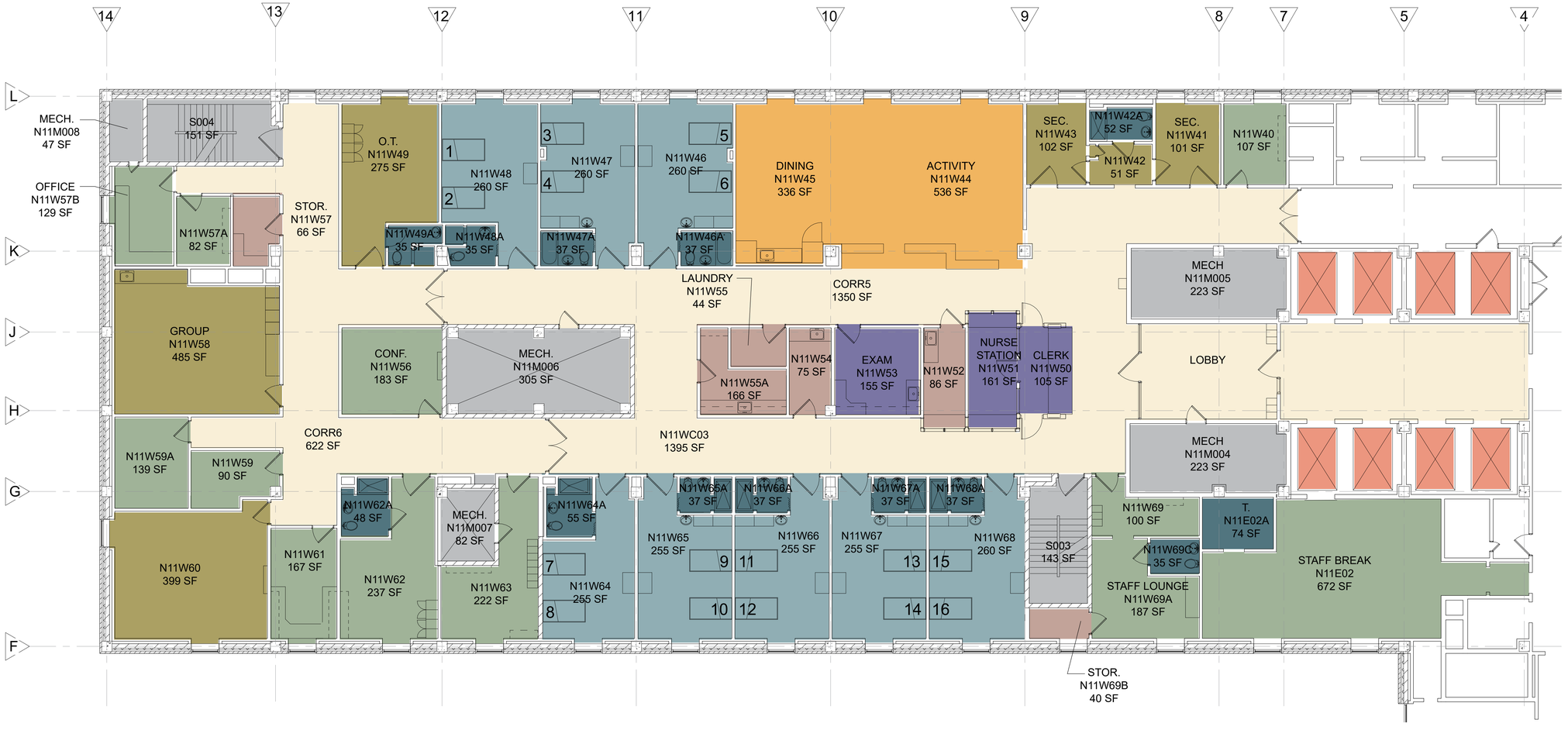
Non-operating revenues include interest income on cash, cash equivalents and investments, accrued retirement costs and gain/ (losses) on joint-ventures.

SELECT FINANCIAL PROFITABILITY RATIOS:

See table below for select financial profitability ratios starting in fiscal year 2019 through the projected period:

	Fiscal 2019 Budget	Fiscal 2020 Projection	Fiscal 2021 Projection	Fiscal 2022 Projection	Fiscal 2023 Projection
Operating Margin	2.20%	2.20%	2.30%	2.30%	2.40%
Operating EBIDA Margin	10.50%	10.30%	10.00%	9.70%	9.60%
Excess Margin	2.80%	2.90%	3.00%	3.00%	3.10%

EXHIBIT 2



PROGRAM LEGEND

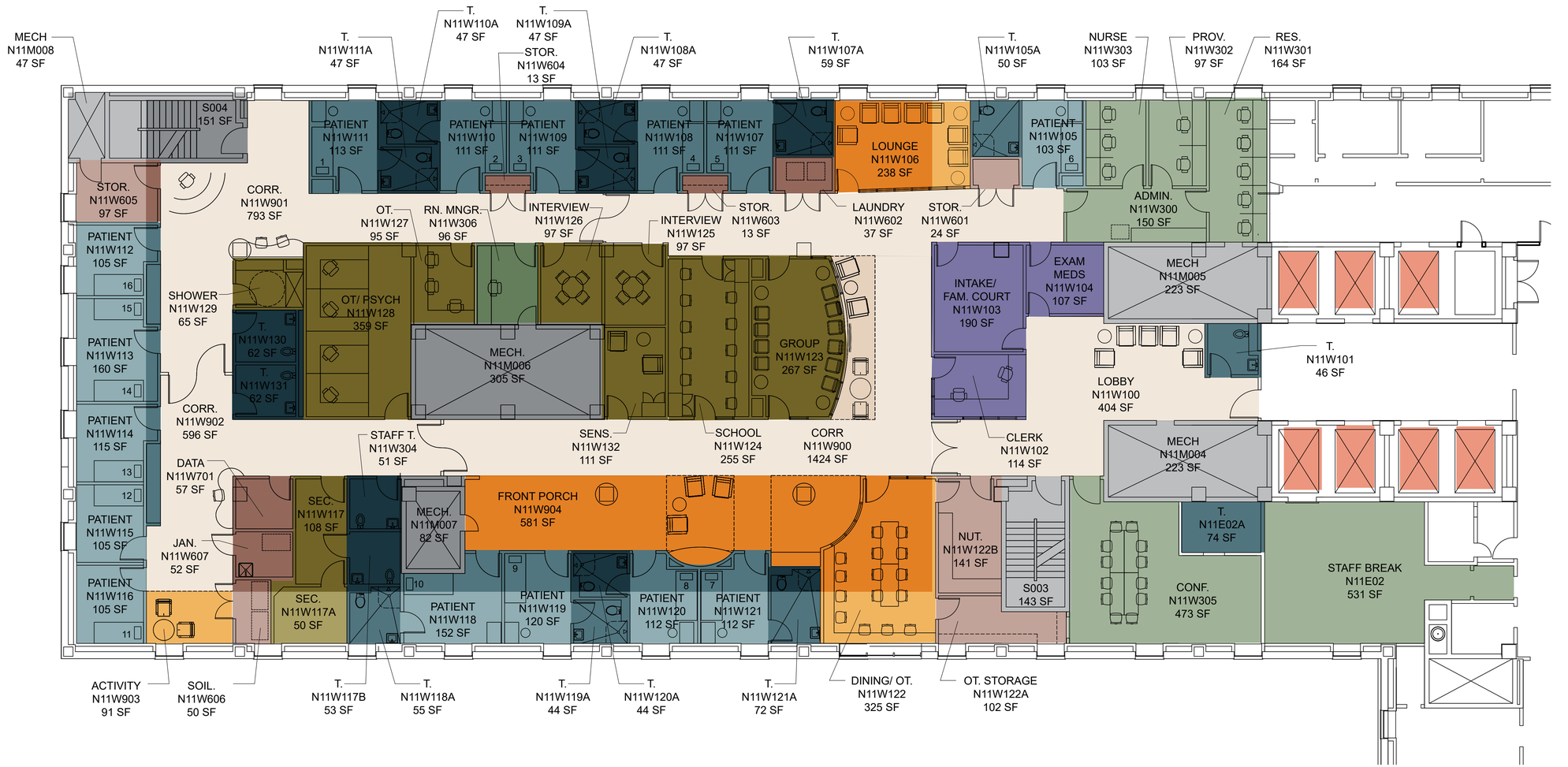
- MECHANICAL
- PATIENT SERVICES
- STAFF SPACES
- BUIDING SERVICES
- INTAKE/ EXAM
- PATIENT ACTIVITY
- PATIENT ROOM
- BATHROOM
- CIRCULATION

UMMC Child & Adolescent Psychiatric Unit Renovation - N11W - Existing

August 3, 2018

1/8” = 1’-0”

LIVING DESIGN LAB

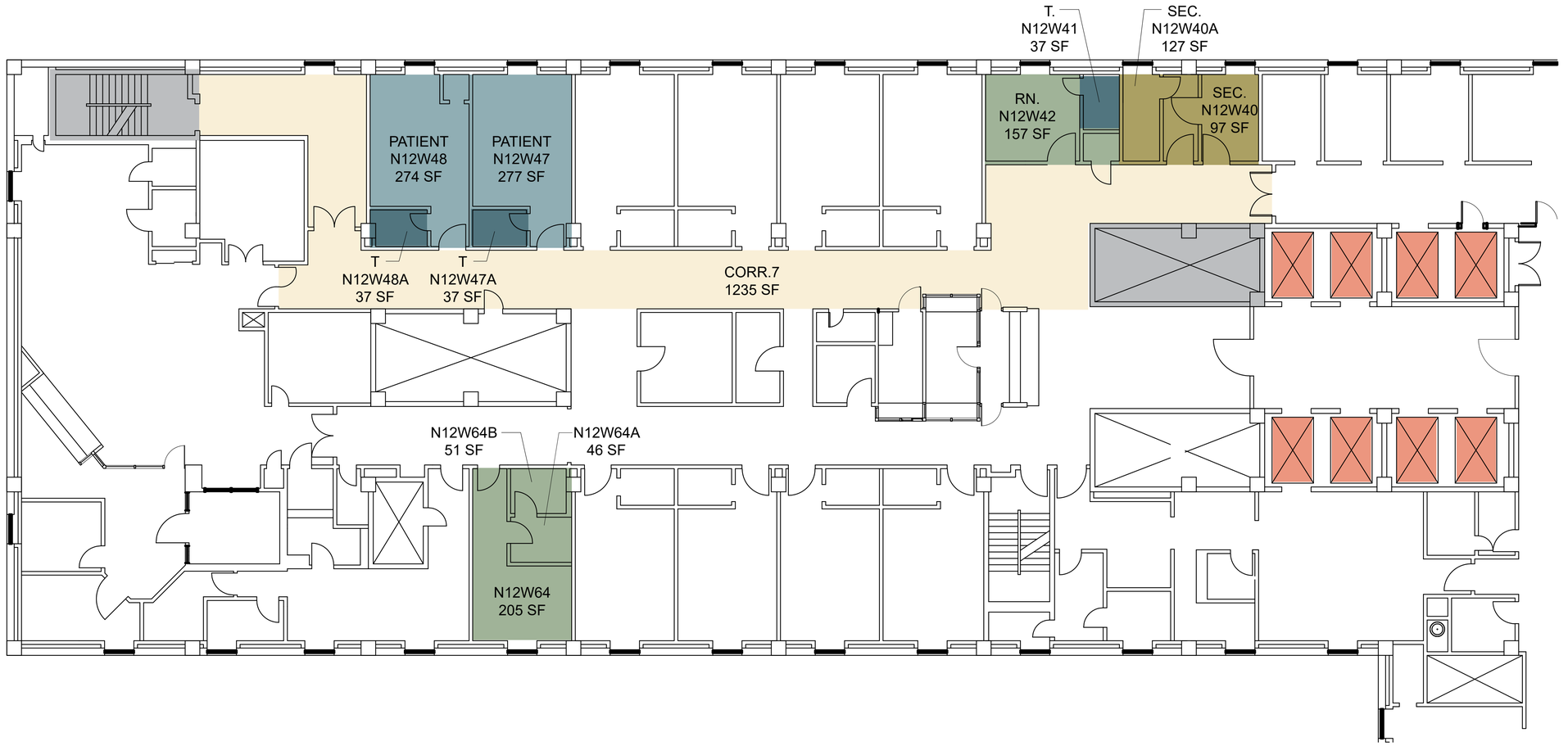


UMMC Child & Adolescent Psychiatric Unit Renovation - N11W - PROPOSED

August 3, 2018

1/8" = 1'-0"

LIVING DESIGN LAB



PROGRAM LEGEND

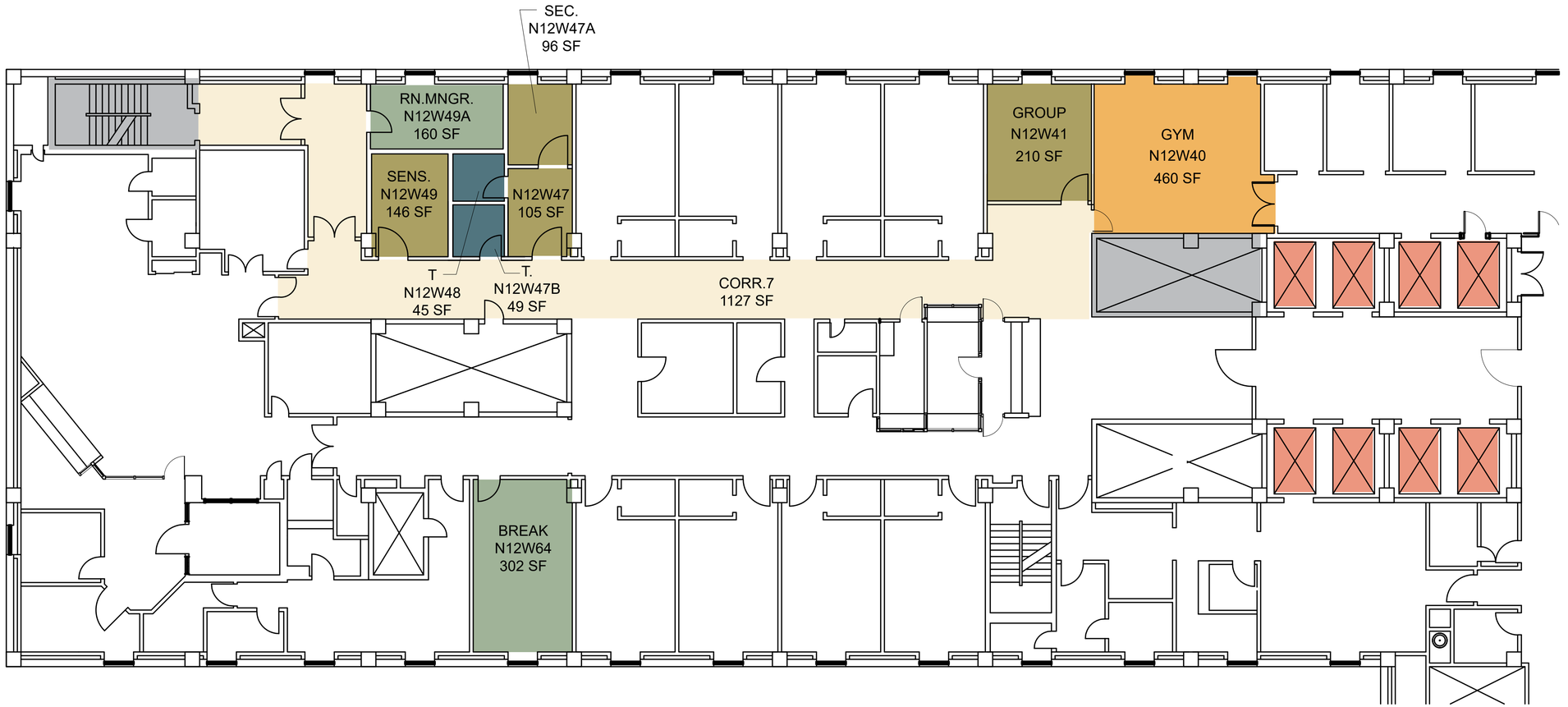
- MECHANICAL
- PATIENT SERVICES
- STAFF SPACES
- BUIDING SERVICES
- INTAKE/ EXAM
- PATIENT ACTIVITY
- PATIENT ROOM
- BATHROOM
- CIRCULATION

UMMC Child & Adolescent Psychiatric Unit Renovation - N12W - EXISTING

August 3, 2018

1/8” = 1’-0”

LIVING DESIGN LAB



PROGRAM LEGEND

- MECHANICAL
- PATIENT SERVICES
- STAFF SPACES
- BUIDING SERVICES
- INTAKE/ EXAM
- PATIENT ACTIVITY
- PATIENT ROOM
- BATHROOM
- CIRCULATION

UMMC Child & Adolescent Psychiatric Unit Renovation - N12W - PROPOSED

August 3, 2018

1/8” = 1’-0”

LIVING DESIGN LAB

PROJECT LOCATION

UMMC Child & Adolescent Psychiatric Unit Renovation - **N11W - NORTH ELEVATION**

August 3, 2018

1/8" = 1'-0"

LIVING DESIGN LAB

EXHIBIT 3

Revised
October 2017

UNIVERSITY OF MARYLAND MEDICAL CENTER
Plan for Improving Organizational Performance

I. MISSION, VISION, AND BEHAVIORAL STANDARDS

We Heal, We Teach, We Discover, We Care.

Our Mission
University of Maryland Medical Center is the academic flagship of the University of Maryland Medical System. Its mission is to provide healthcare services for the Baltimore community, the State of Maryland and the nation. In partnership with the University of Maryland School of Medicine and the University of Maryland health professional schools, we are committed to: Delivering superior healthcare, training the next generation of health professionals, and discovering ways to improve health outcomes worldwide.

Our Vision
To deliver high valued and compassionate health care.
University of Maryland Medical Center will be known for providing high value and compassionate care, improving health in Maryland and beyond, educating future health care leaders and discovering innovative ways to advance medicine worldwide.

Our Behavioral Standards

- Accountability
- Appearance
- Communication
- Respect
- Service

II. GOALS AND OBJECTIVES

The Quality Assurance and Performance Improvement (QAPI) plan is designed to assess, monitor and improve the delivery of care to our patients. It is accomplished by a data-driven system that assesses patient care services, systems, and support processes in an ongoing manner to identify improvement opportunities and proactive strategies that will improve patient outcomes, patient safety, patient satisfaction, employee safety and professional/ administrative practice.

This plan is designed to:

A. Align leadership, medical staff, nursing and other clinical services, support services and all entities toward achievement of the annual goals and the strategic plan.
B. To focus, coordinate and integrate organizational wide patient safety and continuous improvement activities.
C. Create a high reliability system for quality, employee safety and patient safety.
D. To establish processes that systematically measure, assess, refine and ultimately improve patient care and safety.

E. 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.
F. To promote team work and group responsibility in identifying and implementing opportunities for improvement.
G. Identify and act on opportunities for improvement in the health care delivery system.
H. To provide a framework for defining quality and continuous improvement opportunities through:
    a. setting priorities for the scope of the plan
    b. selecting measures that are meaningful and address the needs of the patient
    c. Identifying the frequency of data collection
    d. Collection of Data
    e. Performing data analysis to identify trends and outliers
    f. Implementing and reporting actions taken to resolve the identified problems
    g. Prioritizing improvement initiatives when necessary
I. To maintain a plan for a non-punitive approach to identifying and reporting medical errors and managing all types of occurrences ranging from near misses to sentinel events.
J. To enhance effective organizational and clinical decision making.
K. To achieve the appropriate balance between good outcomes, excellent care, services and costs.
L. To establish mechanisms for the disclosure of information related to errors;
M. Ensure compliance with applicable regulatory and accreditation requirements

III. AUTHORITY/ACCOUNTABILITY

Board of Directors
Responsibility for the quality of patient care and services provided in the Medical Center rests with the University of Maryland Medical Center Board of Directors. The Board directs the organized medical staff and Medical Center Leadership Group to implement a planned and systematic process for measuring quality and improving performance.

UMMC Board of Directors Quality, Patient Safety and Patient Care Committee
The primary goals of the Patient Quality and Safety Committee are to: 1) improve the quality of care delivered, 2) increase the effectiveness of performance improvement initiatives, 3) approve the strategies to improve the health status of our patients and community, 4) minimize the risk of injury to patients and staff, 5) decrease the financial risk resulting from medical errors, and 6) oversee status reports from Regulatory agencies.

The Committee will achieve these goals by performing the following functions: Monitoring processes of hospital quality and performance improvement committees; Monitoring processes associated with the initial appointment and reappointment of physician and allied health practitioner members of the Medical Staff; Maintaining responsibility for performance improvement, patient care quality, safety and risk management and graduate medical education; Monitoring Quality-Based reimbursement initiatives as well as other essential quality metrics; Approve the plan to maintain and improve clinical quality and patient safety throughout the organization.

Management of Medical Center
The Executive Leadership consists of the President and Chief Executive Officer of the Medical Center, the Executive Vice President and Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, Senior Vice President for Operations and Support Services, Chief Financial Officer,

Senior Vice President for Communications and Public Affairs, and Senior Vice President of Strategy, Community and Business Development. The Executive Leadership is accountable for the overall performance of the Medical Center and for allocating resources to achieve objectives.

Medical Staff Leadership
The Medical Executive Committee, following guidelines from the Medical Staff Bylaws directs activities of the organized medical staff. The Medical Executive Committee oversees the quality, safety and efficiency of the medical care provided to patients in the Medical Center, and ensures ethical conduct and competent clinical performance of the medical staff.

Performance Improvement Steering Committee
The Medical Executive Committee and Executive leadership charges the Performance Improvement Steering Committee to develop and oversee implementation of the plan for improving performance and to assess and monitor the organization's performance; to respond to external review of the organization's performance; and to receive reports and monitor outcomes from the medical staff subcommittees and clinical departments.

IV. ORGANIZED STRUCTURES TO ACHIEVE RESULTS

The Performance Improvement Steering Committee
Oversees clinical performance improvement led by medical staff subcommittees and multi-disciplinary groups of the medical staff and other disciplines. 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. Developing and monitoring performance indicators that measure performance compared to expectations.
4. Monitoring existing processes to evaluate the performance of a function or process.
5. 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.

Medical Leadership
Multi-disciplinary efforts to improve the quality, safety and outcomes of clinical services are managed within the structures of the organized medical staff. The medical staff of the University of Maryland Medical Center is organized into services and committees. The Medical Executive

Committee of the medical staff receives and acts on reports and recommendations of the clinical services, medical staff monitoring functions, credentials review and privileging, and pertinent results of hospital-wide activities.

V. METHODOLOGY FOR PERFORMANCE IMPROVEMENT

The University of Maryland Medical Center uses a variety of process improvement techniques, including Six Sigma and Lean for reducing systems variability, and Plan Do Study Act for more rapid cycle improvement. The Medical Center is committed to data driven benchmark and improvements.

Plan Do Study Act
Plan-Do-Study-Act (PDSA) is a methodology to implement when making changes to improve. It is based on breaking down change into manageable chunks by testing change on a micro level and analyzing the results to validate improvement before implementing across the organization.

Root cause analysis
A process improvement and error or defect prevention tool that examines the individual processes within a system, identifies the control or decision points, and uses a series of "why" questions to determine the reasons for variations in the process paths.

Lean
Lean is a performance improvement approach characterized by the elimination of waste. It is based on respect for people, managing for daily improvement, standard work, visual cues, flow and other principles. A process that is lean uses the appropriate amount of manpower, materials, money, machines, space etc to get the job done on time and without defects.

Six Sigma
Six Sigma is a rigorous and disciplined methodology that utilizes data and statistical analysis to measure and improve an organization's operational performance, practices and systems. Six Sigma identifies and prevents defects in manufacturing and service-related processes. It simply means a measure of quality that strives for near perfection.

VI. MECHANISM FOR PRIORITIZATION OF IMPROVEMENT EFFORTS

The process for identifying quality and safety continuous improvement initiatives involves the following:

Annual Operating Plan
Achievement of the Annual Operating Plan objectives will be pursued through five pillars (people, service, innovation, safety & quality, and stewardship) that are integrated in the Medical Center's 2014-2018 strategic plan. They are highly interdependent, and reflect how the institution conducts its operations. At the core is a commitment to excellence with a goal of transforming the patient experience by providing the safest care anywhere, exceeding patient expectations and becoming an even greater place to work.

Departmental and Unit Level Opportunities
Service Line or Unit Level opportunities may be determined based on the following:

- Proactive risk assessment of high risk processes
- High volume, high risk, problem-prone processes
- Patient safety and error reduction/ prevention
- Patient Outcomes
- Evidence-based care
- Infection Prevention
- Patient Experience/ Satisfaction
- Operational efficiency
- Staff Safety

UMMC's Quality Performance Improvement Priorities for FY 2018 are:

1. Build Capacity and Capabilities of the organization through education of IMPRV tools and strategies to provide focused performance improvement at all levels
2. Achieve the expected score of potentially preventable complications for all hospital specific MHAC conditions
3. Achieve the Quality Based Reimbursement composite score of __ or greater through initiatives in the following areas:
    a. National Hospital Quality Measures
    b. Mortality Rates
4. Achieve benchmark efficiency gains in Perioperative Services to ensure improved patient flow throughout the organization

VII. MEASUREMENT/ASSESSMENT

Data Management
Data collection is systemic and organized, and is utilized to establish performance baselines, describe process capability, and sustain performance. The Quality Department works in collaboration with departments/individuals collecting data to ensure reliability, validity, completeness and accuracy of the data. The Quality Department is responsible for data collection on selected quality initiatives at UMMC.

The Department supports quality & process improvements and patient safety activities by:

1. Gathering/coordinating information needed by the quality & process improvement and patient safety program.
2. Providing guidance and consultation to the Board, medical staff, leaders and other hospital staff.
3. Providing support and consultation to departments responsible for data collection and performance improvement and patient safety initiatives.
4. Providing expertise in the data analysis arena.
5. Documenting improvement activities via complete, timely and reliable reports.
6. Submitting data to external agencies, the corporate quality office, and all stakeholders within established timeframes.
7. Establishing and managing systems to ensure confidentiality of all data related information.

8. Maintaining appropriate documentation of quality and process improvement activities, including cumulative profile findings, studies, etc.
9. Providing continuing education on topics and tools related to performance improvement and patient safety.

Quality and process improvement and patient safety reports include analysis of aggregate data and statistical analysis, when indicated. Performance goals and measure indicators are reflected on dashboards and reports. Tools utilized for analysis may include dashboards, bar charts, control charts, Pareto charts, histograms, root cause analysis, failure mode effects analysis and hospital developed tools.

Data is analyzed and compared over time to identify levels of performance, patterns, trends, and variation. Benchmark comparisons are identified that trigger focused assessment and evaluation of the function, process, and/or care provided. External sources are used for benchmark comparison when available. Internal comparisons are utilized when external benchmarks are not available or when internal benchmarks result in better performance. Results of data analysis are used to identify improvement opportunities, identify service delivery performance goals and indicators.

UMMC participates in several external performance measurement systems, including but not limited to Vizient, National Health Safety Network (NHSN) and the Press Ganey Patient Satisfaction Survey.

Ongoing Assessment

The collection of data is the basis for determining the level of performance of existing processes, the outcomes resulting from these processes, and for identifying opportunities for improvements in the health care delivery system. To provide useful data, measurement is systematic, relates to relevant dimensions of performance, and is at the appropriate breadth and frequency. Interpretation of the data answers questions such as: what is the degree of conformance to process and outcome objectives? How stable is a process? How consistent are the outcomes? How can a stable process be improved?

Monthly and/or quarterly dashboards are submitted through the Performance Improvement Structure. The Performance Improvement Steering Committee reviews data related to quality committees, the Annual Operating Plan and on-going key initiatives. Reviews may include the following elements:

Key patient focused and organization functions
Patient's and other's needs and expectations, and the degree to which these are met (satisfaction)
Performance targets
Specific patient-populations
High volume, high-risk, and problem prone processes

Externally Defined Measures

The Medical Center is required by State, Federal and private organizations to meet specific standards and regulations. Compliance with these standards and regulations are necessary for the facility to be licensed to provide healthcare, to qualify for Medicare and Medical Assistance reimbursement, to provide graduate medical education, and to provide assurance to the community that the organization provides quality healthcare by a qualified and competent staff.

Data on important processes and outcomes are collected including measures related to accreditation and other requirements.

VIII. QUALITY EDUCATION

Continuing education and self-learning for all staff is promoted. The commitment to quality and process improvement & patient safety begins with each employee. Staff is asked to provide input into quality and process initiatives, and is routinely solicited for their feedback regarding initiatives. Staff perception, opinion, perceptions, and recommendations are collected via the Employee Engagement Survey, Culture of Safety Survey, Town Hall Meetings, and a variety of ongoing forums. The organization strives to provide opportunities to train and enhance staff and leadership awareness of continuous quality, process improvement and patient safety strategies. Outcomes are communicated to stakeholders via a variety of mechanisms, including but not limited to annual program reports, dashboards, staff meetings, town meetings, and newsletters

IX. COMMUNICATION AND REPORTS

Results and performance improvement activities are communicated to the appropriate committees and governing bodies as depicted in the Performance Improvement Structure. This reporting is designed to allow each group to determine whether the expected activities are being carried out, what significant issues were identified and what improvements were made. Outcomes are communicated to stakeholders via a variety of mechanisms, including but not limited to annual program reports, dashboards, staff meetings, town meetings, and newsletters.

X. AMENDMENTS AND REVISIONS

Major revisions to this plan are to be presented to the Executive leadership, the Performance Improvement Steering Committee and/or the Medical Executive Committee. Edits may be needed to respond to changes in the community, unanticipated adverse occurrences, changing regulatory requirements, the needs of the hospital's major patient populations and/or results of performance improvement activities.

EXHIBIT 4

UNIVERSITY of MARYLAND MEDICAL CENTER

Origination:	*12/2004*
Effective:	*06/2017*
Last Approved:	*06/2017*
Last Revised:	*06/2017*
Next Review:	*05/2020*
Owner:	*Kimmith Jones: Dir Translat to Nrs Practic*
Area:	*Provision of Care: Care of Patients*
Policy Type:	*Hospital Clinical Policy*
Applicability:	*UMMC University Campus*

Admission, Transfer, and Discharge

I. POLICY

A. **OBJECTIVES**

1. To establish guidelines for the admission, transfer, and discharge of patients at the University of Maryland Medical Center (UMMC).

B. **INDICATION FOR USE**

1. This policy applies to the following patient categories within the Medical Center for adult and pediatric patients:
   a. Inpatients
   b. Observation patients
   c. Ambulatory patients pending admission
   d. Transferred
   e. Discharged
   f. Shock Trauma Inpatients
   g. Behavioral Health Inpatients
   h. Discharge and Readmissions

C. **DEFINITIONS**

Elective Admission	The patient's condition permits adequate time to schedule the availability of a suitable accommodation. An elective admission can be delayed without substantial risk to the health of the individual.
Urgent Admission	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.
Emergent Admission	The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room or Trauma Resuscitation unit, or Critical Resuscitation Unit

Transfer	The movement of the patient from one unit to another within the confines of the hospital. It is primarily associated with a change in level of care.
Discharge	To release the patient from the current course of care. It is associated with the transition of the patient out of the hospital and to another care setting or home.
Bed Management System	Electronic System used to monitor bed availability in the Medical Center
Electronic Health Record (EHR)	An application used to electronically capture/ document patient medical record information, financial information, registration, and inpatient movement processing.
Boarder	Patients on a unit other than the unit that was requested by the service/team.

II. RESPONSIBILITY

Providers	• All patient admissions and observation cases, transfers or discharges require a Provider order. • Admitting or accepting team assumes responsibility of patients entire medical care independent of location (ie boarder patients) while they are on that service. • When requesting an inpatient admission or placement in observation status, provider will enter an order in the EHR that communicates electronically to the ***Admitting Office and notifies the Patient Placement Center.*** • A transfer order is entered into the EHR when a patient changes a level of care, is transferred to another service, or when a patient is post-op from the General or STC Operating rooms. • Patients being discharged from the Medical Center have an appropriate Provider's order indicating the patient's discharge status. The Provider or Licensed Independent Practitioner (LIP) communicates the order immediately to the appropriate nursing personnel.
Nursing & Patient Care Services Staff	• All admissions, changes in level of care, transfer of service and discharges are initiated by Provider order.
Admitting	• Receives, transcribes and verifies the integrity of information required for the registration application. Registration application **will not be completed without required information.** • Incomplete information will be resolved by the Admitting Specialist via patient interview.
Case Management Social Work	Patients are screened early on in their admission for discharge planning, care coordination, etc. by the Care Management Team.
Medical Records	Medical Records personnel pick up the patient's medical record within 24 hours of discharge.

Individual departments	Specific departmental procedures in support of the admission, transfer, and discharge policy goals, beyond those listed below are the responsibility of individual departments.

III. PROCEDURE

A. Admission and Observation

1. The admitting service assumes responsibility for the care of the patient while the patient is admitted to that service. Should the patient be transferred to another service, the service accepting that patient assumes responsibility for the patient at the time of transfer and until such a time as discharge or transfer to another service.
2. Any admission to inpatient or observation bed, the provider must provide the required information as required by Patient Placement Center or Admitting Office:
    a. Patient name, name of parent or other responsible party (if pediatric patient)
    b. Social security number (if applicable)
    c. [Patient] type requested
    d. Level of Care
    e. Isolation Status
    f. Special Requirements
    g. Admission Source
    h. Date of Birth
    i. Gender
    j. Address
    k. Contact number
    l. Diagnosis
    m. Procedure
    n. Provider or LIP Information
        1. Admitting
        2. Attending
        3. Referring
    o. Insurance Information
    p. Individual Completing the Form
3. Submissions are entered electronically or via a physical order in the electronic health record (EHR).
4. No more white cards should be faxed to admitting, the provider enters an order which opens an encounter for admission.
5. The unit Charge RN places electronic notification in the Bed Management System to the Patient Placement Center for the request of an inpatient bed.
    a. Elective Admissions – Whenever possible, an electronic order is entered by the Provider/LIP ten (10) days prior to the elective admission and electronically or manually submitted to the Patient Access Admitting Coordinator Office. If the admission is not approved, the Patient Access

Admitting Coordinator (PAAC) will notify the Provider, operating room and posting office. It will be the responsibility of the Provider or LIP to notify the patient.

b. Emergency Admissions/Direct Admits –an electronic order is completed by the Provider/LIP in the Electronic Health Record prior to the unit and room assignment.

c. Before or upon arrival to a unit, an electronic transfer order will be placed in electronic health record.

B. Transfer

1. When requesting a patient transfer, an electronic transfer order is placed in the electronic health record. by the Provider or LIP. Transfer orders are initiated under the following conditions:
   a. Changes in level of care
   b. Transferred to another service
   c. Post-op from the General or STC Operating rooms
2. The electronic transfer order indicates the name of the attending Provider/LIP and the service to which the patient is being transferred to, if applicable.
   a. The transferring Provider verbally communicates to the inpatient Charge RN that an order has been electronically placed in electronic health record.
3. The unit Charge RN places electronic notification in the bed management system to the Patient Placement Center for the request of an inpatient bed.
4. Once the patient arrives on the unit.
   a. Nursing staff have the following options regarding registration transactions.
   b. Change patient location (transfer – by receiving unit only) by performing transactions directly in the patient financial database.
   c. Note: Shock Trauma Center (STC) and Psychiatric patients are not considered transfers for an inpatient bed within UMMC requires an electronic order for discharge/readmit (see D below).

C. Discharge

1. When requesting a patient discharge, an electronic discharge order is placed in the electronic health record. Discharge orders include the following elements:
   a. Patient disposition (home, facility, rehab, etc.)
   b. Date
   c. Time
2. The discharging Provider verbally communicates to the inpatient unit Charge RN that an order has been electronically placed in the electronic health record.
3. It is the responsibility of the discharging unit to enter into the registration application notifications in the electronic health record or enter transactions directly into the financial application once the patient is discharged from the unit.
4. Nursing staff have the following options regarding registration application transactions:
   a. change patient location (discharge – by discharging unit only) by performing transactions directly in the electronic health record.
5. Medical Record personnel pick up patient's medical record within 24 hrs of discharge.

D. Discharge/Readmit

1. Inpatient admissions moving from Shock Trauma Center (STC) to the Medical Center; a provider will place a discharge/readmit order in the electronic health record. This discharge/readmit order will generate a discharge from STC, an admission order for the Medical Center and bed request for bed management system.
2. Inpatient admissions moving from the Medical Center to Shock Trauma Center (STC); a provider will place a discharge/readmit order in the electronic health record. This discharge/readmit order will generate a discharge from the Medical Center, an admission order for Shock Trauma Center (STC) and bed request for bed management system.
3. Inpatient admissions moving from behavioral health (Psychiatric) to the Medical Center; a provider will place a discharge/readmit order in the electronic health record. This discharge/readmit order will generate a discharge from behavioral health, an admission order for the Medical Center and bed request for bed management system.
4. Inpatient admissions moving from the Medical Center to behavioral health (Psychiatric); a provider will place a discharge/readmit order in the electronic health record. This discharge/readmit order will generate a discharge from the Medical Center, an admission order to behavior health (Psychiatric) and bed request for bed management system.

IV. REPORTABLE CONDITIONS

A. Provider will be notified of the availability of bed or level of care if bed is not available at requested time and appropriate level of care

B. Provider and/or Admitting staff will be aware of patients isolation status (as available) and will notify the receiving unit prior to patient arrival

V. DOCUMENTATION

See above

VI. SUPPORTIVE INFORMATION

A. **SEE ALSO**
None

B. **REFERENCES**
None

C. **COMMUNICATION AND EDUCATION**

1. This policy will be communicated to the appropriate UMMC personnel via the following channels:
   a. The revised policy will be placed in the Policy and Procedure Manual on the UMMC Intranet site
   b. Re-education and revisions will be communicated via Medical Staff, Patient Care Service and Nursing meetings and publications as needed.

DEVELOPER(S)

Policy revised by Patient Administrative Services, Manager of Patient Placement Center , Care Management Team ,Medical Records reviewed by Department of Clinical Practice and Professional Development and

Department of Clinical Effectiveness.

Attachments:

No Attachments

Applicability

UMMC University Campus

EXHIBIT 5

UNIVERSITY of MARYLAND MEDICAL CENTER

Origination:	*11/2013*
Effective:	*11/2016*
Last Approved:	*11/2016*
Last Revised:	*11/2016*
Next Review:	*11/2019*
Owner:	*Kerry Sobol: Director, Patient Experience*
Area:	*Ethics, Rights and Responsibilities*
Policy Type:	*Hospital Clinical Policy*
Applicability:	*UMMC University Campus*

Discharge Planning

I. POLICY

A. **OBJECTIVES**

At an early stage of hospitalization, all patients will be evaluated for discharge planning needs. Any inpatient who is identified to be at risk for adverse health consequences or negative outcomes without the benefits of appropriate discharge planning shall have a plan developed and monitored for appropriateness as the patient progresses in their medical treatment. The goal is to map a safe and sustainable plan aimed at minimizing likelihood of re-hospitalization for reasons that could have been prevented. A registered nurse, social worker or other appropriately qualified personnel must develop or supervise the development of the discharge evaluation. The responsible personnel should have experience in discharge planning, knowledge of psychosocial and physical factors that affect functional status at discharge and knowledge of the community resources to meet post-discharge clinical and social needs. Reducing preventable hospital readmissions is a priority for patient safety.

Interdisciplinary discharge planning will be provided to patients in acute care to facilitate the transition of the patient from the hospital and through the continuum and / or to the appropriate post-hospital environment or to another health-care facility.

Discharge planning includes, but is not limited to identifying patient, estimating the length of service needed, identifying method of reimbursement, and establishing a feedback mechanism where indicated. Once a patient has been identified as having post-discharge needs, it is necessary to periodically re-evaluate physical, emotional, and social status, since these factors may affect his or her readiness for discharge.

B. **INDICATION FOR USE**

The discharge planning process applies to all inpatients.

C. **DEFINITIONS**

Care Management	Case management, Social Work, Utilization Management
SNF's	Skilled Nursing Facilities
HHA's	Home Health Agencies
Environment	The setting from which the patient was admitted to the hospital.

II. RESPONSIBILITY

Physician/ NP/PA	• Request care management consult • Complete medication reconciliation at discharge • Complete discharge instructions and discharge summary including follow up appointments
Case Manager	• Review Rehab recommendations if applicable and make appropriate referrals to rehab and skilled nursing facilities • Arrange for home health • Arrange for needed supplies/equipment (DME) • Partner with social work
Social Worker	• Conduct psychosocial assessments to evaluate psychosocial barriers to safe and sustainable discharge • Arrange for hospice (home and inpatient) • Arrange for assisted living facilities • Arrange for shelter • Coordinate petition for guardianship • Partner with case management
Registered Nurse	• Provide patient education • Provide supplies, such as materials for changing dressing on wounds, needed immediately post-discharge • Provide patient/representative with a list of all medications that patient should be taking after discharge, with clear indications of changes from the patient's pre-admission medications. • Provide written discharge instructions to patient/representative
Rehabilitation Service	• Provide recommendations for level of care • Provide patient equipment needed post discharge as applicable (ex:crutches, canes) • Educate patient on use of equipment

III. PROCEDURE

1. **UMMC Care Management staff shall:**

   A. Screen all patients early in hospitalization to determine which ones are at risk of adverse health consequences/readmission post-discharge. Screening is completed by:

      - Chart review,
      - Patient/family interview, and/or
      - Interdisciplinary rounds

   B. The patient or the health care team which includes provider, RN, PT/OT/Speech can request a discharge evaluation.

   C. Evaluate individual medical, psychosocial, and nursing care needs including an evaluation of a

patient's capacity for self-care, their goals, the possibility of the patient being cared for in the environment from which he/she entered the organization, and the caregiver's ability to support the patient.

D. Determine whether there is community based or other health care services available for them including:
   - Home health, attendant care, and other community-based services;
   - Hospice or palliative care
   - Respiratory therapy
   - Rehabilitation services
   - End Stage Renal Dialysis Services
   - Pharmaceuticals and related supplies
   - Nutritional consultation/supplemental diets;
   - Medical equipment and related supplies
   - Home and physical environment modifications
   - Transportation services
   - Meal services
   - Household services
   - Transitional Care Teams
   - Outpatient Case Managers

E. Develop a discharge plan with the patient/family in collaboration with the physician to identify services to meet the patient's post discharge needs. This includes providing education to the patient/ family about post-acute services.

F. Disclose to the patient the relationship, if any, between UMMC and any post discharge provider/ service before the patient chooses a post discharge provider/service. Provide the patient with a copy of the "Letter of Disclosure" from the Department of Care Management

G. Inform the patient/family of their freedom to choose among providers and when possible respect their preferences.

H. Determine availability of services available under the payer/insurers or discuss out-of-pocket expenses.

I. If the patient has no preference of a post discharge provider/service or their preference isn't available, then UMMC Care Management staff will notify the patient who the default service/provider will be and the relationship between the provider/service and UMMC, if any.

J. Patient has the right to self-determination and has the right to refuse the discharge recommendations of the health care team.

K. Inform the post discharge provider/service personnel of the patient's choice.

L. Routinely reassess patients for changes that warrant adjustments to the discharge plan.

M. If Care Manager has difficulty implementing a discharge plan they should review with their team leader, then manager and if still not resolved the case should be referred to the Discharge Focus Group (DFG) by emailing dfg@umm.edu

N. Discuss the finalized discharge plan with the patient/family.

O. Implement the discharge plan prior to discharge

2. **Post discharge provider/service personnel may not be allowed contact with any patient until UMMC staff makes a referral to them.**

   A. Post discharge providers/service personnel shall wear vendor badges.

IV. REPORTABLE CONDITIONS

Not wanting an evaluation is a reportable condition. In the case of a patient not wanting to be evaluated for discharge needs you must do the following:

- Document in the patient's record that he/she did not want to be evaluated.

V. DOCUMENTATION

- Document in the patient's electronic medical record the discharge planning evaluation
- Document in the patient's electronic medical record that the results of the evaluation were discussed with the patient or the patient's representative
- Document in the patient's electronic medical record whether the patient accepts the results of the evaluation (not necessary for the hospital to obtain a signature from the patient).
- Document that choices of post discharge providers were given
- Document patient's choice of a post discharge provider/service
- Document the arrangements made for initial implementation of the discharge plan, including any training or materials provided to the patient or patient's informal caregiver or representative.
- Document reason if the patient's request for a HHA or SNF is not able to be met.
- Necessary documentation will be provided to the patient's follow up ambulatory care provider or post-acute facilities.

VI. SUPPORTIVE INFORMATION

a. **SEE ALSO**
   CC—1301: Vendor Relationships
   MM – 014: Medication Reconciliation
   PROE – 003: Code Status
   Letter of Disclosure (attachment)

b. **REFERENCES**
   CMS- Center for Medicare & Medicaid Services
   S&C: 13-32-HOSPITAL

c. **COMMUNICATION AND EDUCATION**

   i. This policy will be communicated to the appropriate UMMC personnel via the following channels:

      1. The revised policy will be placed in the Policy and Procedure Manual on the UMMC Intranet site
      2. Re-education and revisions will be communicated via Medical Staff and Nursing meetings and publications as needed.

DEVELOPER(S):

Director of Care Management and Regulatory Compliance

Attachments:

No Attachments

Applicability

UMMC University Campus

EXHIBIT 6

LETTERS OF SUPPORT

Name	Title	Affiliation
Paula Blackwell	Executive Director	Baltimore Area Health Education Center
Robert Chrencik	President & CEO	University of Maryland Medical System
Dr. E. Albert Costello	Councilman	Baltimore City Council
Dr. Jill A. Czinn	Chair, Dept. of Pediatrics	University of Maryland School of Medicine
Eric Hathaway, Sr.	Senior Pastor	Union Baptist Church
Robert R. Neall	Secretary	Maryland Department of Health
Alison Perkins-Cohen	Chief of Staff	Baltimore City Public Schools
Dr. Steven J. Perman	President	University of Maryland Baltimore
Rev. D. Alvin C. Pugh	Mayor	City of Baltimore
Dr. J ay A. RachBeisel	Vice Chair, Clinical Affairs, Dept. of Psychiatry	University of Maryland School of Medicine and University of Maryland Medical Center
Catherine E. Reece	Executive Vice President for Medical Affairs	University of Maryland School of Medicine
Dr. Leana Wen	Commissioner of Health	Baltimore City Health Department

Baltimore
AHEC

August 3, 2018

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

Dear Mr. Steffen,

I am writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to establish an inpatient adolescent psychiatry service.

As you may well know, there is a critical shortage of inpatient adolescent psychiatry services in Baltimore City and surrounding counties. Demand for these services is rising and serious delays in care for this population are unfortunately all too common across the Baltimore metropolitan region. Adolescents with behavioral health needs typically wait in the Pediatric Emergency Department for as long as 10 days before an appropriate inpatient bed becomes available at another facility, further exacerbating the already serious mental health challenges of these young people.
The establishment of an inpatient adolescent psychiatry unit at UMMC would help alleviate this shortage and the resulting lengthy delays in care. It would provide the timely, high-quality care to help meet the increasing demands of this population, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for an available bed at another facility.

UMMC and the faculty physicians of the University of Maryland School of Medicine currently provide high-quality and compassionate inpatient behavioral health care to younger children (ages 5-12) and to adults, as well as outpatient services for all age groups. Given this existing expertise in the face of a glaring lack of services for adolescents in Baltimore City and surrounding counties, we strongly support the establishment of an Adolescent Inpatient Psychiatry service at UMMC. I strongly urge you to support their Certificate of Need application.

Sincerely,

Paula E. Blackwell
Executive Director

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

250 W. Pratt Street
24th Floor
Baltimore, Maryland 21201-6829
www.umms.org

CORPORATE OFFICE

July 27, 2018

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ben:

I am writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to establish an inpatient adolescent psychiatry service.

As you may well know, there is a critical shortage of inpatient adolescent psychiatry services in Baltimore City and surrounding counties. Demand for these services is rising and serious delays in care for this population are unfortunately all too common across the Baltimore metropolitan region. Adolescents with behavioral health needs typically wait in the Pediatric Emergency Department for as long as 10 days before an appropriate inpatient bed becomes available at another facility, further exacerbating the already serious mental health challenges of these young people.

The establishment of an inpatient adolescent psychiatry unit at UMMC would help alleviate this shortage and the resulting lengthy delays in care. It would provide the timely, high-quality care to help meet the increasing demands of this population, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for an available bed at another facility.

UMMC and the faculty physicians of the University of Maryland School of Medicine currently provide high-quality and compassionate inpatient behavioral health care to younger children (ages 5-12) and to adults, as well as outpatient services for all age groups. Given this existing expertise in the face of a glaring lack of services for adolescents in Baltimore City and surrounding counties, we strongly support the establishment of an Adolescent Inpatient Psychiatry service at UMMC. I strongly urge you to support their Certificate of Need application.

Sincerely,

Robert A. Chrencik
President and Chief Executive Officer
University of Maryland Medical System

Chairman, Budget & Appropriations Committee
Chairman, Judiciary & Legislative Investigations Committee
Chairman, Biennial Audits Oversight Commission
Chairman, Stormwater Remediation Oversight Committee

Land Use & Transportation Committee
Taxation, Finance, & Economic Development Committee

Eric T. Costello
Baltimore City Council, 11th District

City Hall, Room 527
100 N Holliday Street
Baltimore, MD 21202

(o) 410-396-4816
(m) 443-813-1457
(e) eric.costello@baltimorecity.gov

July 29, 2018

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

Dear Mr. Steffen,

I am writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to establish an inpatient adolescent psychiatry service. As you may well know, there is a critical shortage of inpatient adolescent psychiatry services in Baltimore City and surrounding counties. Demand for these services is rising and serious delays in care for this population are unfortunately all too common across the Baltimore metropolitan region. Adolescents with behavioral health needs typically wait in the Pediatric Emergency Department for as long as 10 days before an appropriate inpatient bed becomes available at another facility, further exacerbating the already serious mental health challenges of these young people.

The establishment of an inpatient adolescent psychiatry unit at UMMC would help alleviate this shortage and the resulting lengthy delays in care. It would provide the timely, high-quality care to help meet the increasing demands of this population, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for an available bed at another facility.

UMMC and the faculty physicians of the University of Maryland School of Medicine currently provide high-quality and compassionate inpatient behavioral health care to younger children (ages 5-12) and to adults, as well as outpatient services for all age groups. Given this existing expertise in the face of a glaring lack of services for adolescents in Baltimore City and surrounding counties, we strongly support the establishment of an Adolescent Inpatient Psychiatry service at UMMC. I strongly urge you to support their Certificate of Need application.

Should you have questions, please feel free to contact me directly at eric.costello@baltimorecity.gov or 410-396-4816.

Sincerely,

E. T. Costello

Eric. T. Costello
Baltimore City Council, 11th District

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

STEVEN J. CZINN, MD
The Drs. Rouben and Violet Jiji Endowed Professor of Pediatrics and
Chairman

Department of Pediatrics

22 S. Greene Street, Room N5E17
Baltimore, MD 21201
410 328 6777 | 410 328 8742 FAX
sczinn@som.umaryland.edu

www.medschool.umaryland.edu/pediatrics

August 3, 2018

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

Dear Mr. Steffen,

I am writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to establish an inpatient adolescent psychiatry service.

As you may well know, there is a critical shortage of inpatient adolescent psychiatry services in Baltimore City and surrounding counties. Demand for these services is rising and serious delays in care for this population are unfortunately all too common across the Baltimore metropolitan region. Adolescents with behavioral health needs typically wait in the Pediatric Emergency Department for as long as 10 days before an appropriate inpatient bed becomes available at another facility, further exacerbating the already serious mental health challenges of these young people.

The establishment of an inpatient adolescent psychiatry unit at UMMC would help alleviate this shortage and the resulting lengthy delays in care. It would provide the timely, high-quality care to help meet the increasing demands of this population, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for an available bed at another facility.

UMMC and the faculty physicians of the University of Maryland School of Medicine currently provide high-quality and compassionate inpatient behavioral health care to younger children (ages 5-12) and to adults, as well as outpatient services for all age groups. Given this existing expertise in the face of a glaring lack of services for adolescents in Baltimore City and surrounding counties, we strongly support the establishment of an Adolescent Inpatient Psychiatry service at UMMC. I strongly urge you to support their Certificate of Need application.

Sincerely,

Steven J. Czinn, MD, FAAP, FACG, AGAF
The Drs. Rouben and Violet Jiji Endowed Professor of Pediatrics and
Chair, Department of Pediatrics

Union Baptist Church

1219 Druid Hill Avenue • Baltimore, MD 21217
Tel. 410-523-6880 • Fax 410-523-3202
Email: office@unionbaptistmd.org
Website: unionbaptistmd.org
#UBC4U

The Servant Church: To Worship, To Serve, and To Empower

August 3, 2018

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

Dear Mr. Steffen:

I'm writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to establish an inpatient adolescent psychiatry service.

As you may well know, there is a critical shortage of inpatient adolescent psychiatry services in Baltimore City and the surrounding counties. Demand for these services is rising and serious delays in care for this population are unfortunately all too common across the Baltimore metropolitan region. Adolescents with behavioral health needs typically wait in the Pediatric Emergency Department for as long as 10 days before an appropriate inpatient bed becomes available at another facility, further exacerbating the already serious mental health challenges of these young people.

The establishment of an inpatient adolescent psychiatry unit at UMMC would help alleviate this shortage and the resulting lengthy delays in care. It would provide the timely, high quality care to help meet the increasing demands of this population, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for an available bed at another facility. UMMC and the faculty of physicians of the University of Maryland School of Medicine currently provide high-quality and compassionate inpatient behavioral health care to younger children (ages 5-12) and to adults, as well as outpatient services for all age groups. Given this existing expertise in the face of a glaring lack of services for adolescents in Baltimore City and surrounding counties, I strongly support the establishment of an Adolescent Inpatient Psychiatry service at UMMC. I urge you to support their Certificate of Need (CON) application.

Sincerely,

Rev. D. Alvin C. Hathaway, Sr.,
Senior Pastor

MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

August 2, 2018

Robert E. Moffit, PhD., Chairman
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Moffit and Commissioners:

I write to express the Maryland Department of Health's support for the University of Maryland Medical Center's (UMMC) certificate of need application to the Commission to establish an inpatient adolescent psychiatry unit.

There is a critical shortage of inpatient adolescent psychiatry services, both in Baltimore City and the surrounding counties, as well as statewide. Demand for these services is rising and serious delays in care for this population are unfortunately all too common across the Baltimore metropolitan region. I understand that some adolescents with behavioral health needs may wait in the University's Pediatric Emergency Department for as long as 10 days before an appropriate inpatient bed becomes available at another facility. The length of stay further exacerbates the serious mental health challenges of these young people.

The establishment of an inpatient adolescent psychiatry unit at UMMC would help alleviate this shortage and the resulting delays in care. UMMC and the faculty physicians of the University of Maryland School of Medicine currently provide high-quality and compassionate inpatient behavioral health care to younger children (ages 5-12) and to adults, as well as outpatient services for all age groups.

I urge that the Commission move in an expeditious manner to review the certificate of need application and approve filling a gap in our state's mental and behavioral health treatment system.

Please do not hesitate to contact me if you have any questions at 410.767.4639.

Sincerely,

Robert R. Neall
Secretary

BALTIMORE CITY PUBLIC SCHOOLS

July 31, 2018

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Steffen,

I am writing to express the full support of Baltimore City Public Schools (City Schools) for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to establish an inpatient adolescent psychiatry service.

As you may well know, there is a critical shortage of inpatient adolescent psychiatry services in Baltimore City and surrounding counties. Demand for these services is rising and serious delays in care for this population are unfortunately all too common across the Baltimore metropolitan region. Adolescents with behavioral health needs typically wait in the Pediatric Emergency Department for as long as ten days before an appropriate inpatient bed becomes available at another facility, further exacerbating the mental health challenges of these young people.

The establishment of an inpatient adolescent psychiatry unit at UMMC would help alleviate this shortage and the resulting lengthy delays in care. It would provide timely, high-quality care to help meet the increasing demands of this population, alleviating their stress from being transferred and delayed in their treatment as they wait for an available bed at another facility.

UMMC and the faculty physicians of the University of Maryland School of Medicine currently provide high-quality and compassionate inpatient behavioral health care to younger children (ages 5-12) and to adults, as well as outpatient services for all age groups. Given this existing expertise in the face of a glaring lack of services for adolescents in Baltimore City and surrounding counties, we strongly support the establishment of an Adolescent Inpatient Psychiatry service at UMMC. I urge you to support their Certificate of Need application.

Sincerely,

Allison Perkins-Cohen
Chief of Staff

UNIVERSITY of MARYLAND
BALTIMORE

JAY A. PERMAN, MD
President

220 North Arch Street, 14th Floor
Baltimore, MD 21201
410 706 7002 | 410 706 0500 FAX

www.umaryland.edu

August 3, 2018

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

Dear Mr. Steffen,

I am writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to establish an inpatient adolescent psychiatry service.

As you may well know, there is a critical shortage of inpatient adolescent psychiatry services in Baltimore City and surrounding counties. Demand for these services is rising and serious delays in care for this population are unfortunately all too common across the Baltimore metropolitan region. Adolescents with behavioral health needs typically wait in the Pediatric Emergency Department for as long as 10 days before an appropriate inpatient bed becomes available at another facility, further exacerbating the already serious mental health challenges of these young people.

The establishment of an inpatient adolescent psychiatry unit at UMMC would help alleviate this shortage and the resulting lengthy delays in care. It would provide the timely, high-quality care to help meet the increasing demands of this population, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for an available bed at another facility.

UMMC and the faculty physicians of the University of Maryland School of Medicine currently provide high-quality and compassionate inpatient behavioral health care to younger children (ages 5-12) and to adults, as well as outpatient services for all age groups. Given this existing expertise in the face of a glaring lack of services for adolescents in Baltimore City and surrounding counties, we strongly support the establishment of an Adolescent Inpatient Psychiatry service at UMMC. I strongly urge you to support their Certificate of Need application.

Sincerely,

Jay A. Perman, MD
President

CATHERINE E. PUGH
MAYOR

100 Holliday Street, Room 250
Baltimore, Maryland 21202

August 3, 2018

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

Dear Mr. Steffen,

I am writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to establish an inpatient adolescent psychiatry service.

As you may well know, there is a critical shortage of inpatient adolescent psychiatry services in Baltimore City and surrounding counties. Demand for these services is rising and serious delays in care for this population are unfortunately all too common across the Baltimore metropolitan region. Adolescents with behavioral health needs typically wait in the Pediatric Emergency Department for as long as 10 days before an appropriate inpatient bed becomes available at another facility, further exacerbating the already serious mental health challenges of these young people.

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UMMC and the faculty physicians of the University of Maryland School of Medicine currently provide high-quality and compassionate inpatient behavioral health care to younger children (ages 5-12) and to adults, as well as outpatient services for all age groups. Given this existing expertise in the face of a glaring lack of services for adolescents in Baltimore City and surrounding counties, we strongly support the establishment of an Adolescent Inpatient Psychiatry service at UMMC. I strongly urge you to support their Certificate of Need application.

Sincerely,

Catherine E. Pugh
Mayor
City of Baltimore

phone: 410.396.3835 fax: 410.576.9425 email: mayor@baltimorecity.gov

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

Jill A. RachBeisel M.D.
Vice Chair for Clinical Affairs
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August 1, 2018

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

Dear Mr. Steffen,

I am writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to establish an inpatient adolescent psychiatry service.

As you may well know, there is a critical shortage of inpatient adolescent psychiatry services in Baltimore City and surrounding counties. Demand for these services is rising and serious delays in care for this population are unfortunately all too common across the Baltimore metropolitan region. Adolescents with behavioral health needs typically wait in the Pediatric Emergency Department for as long as 10 days before an appropriate inpatient bed becomes available at another facility, further exacerbating the already serious mental health challenges of these young people.

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UMMC and the faculty physicians of the University Of Maryland School Of Medicine currently provide high-quality and compassionate inpatient behavioral health care to younger children (ages 5-12) and to adults, as well as outpatient services for all age groups. Given this existing expertise in the face of a glaring lack of services for adolescents in Baltimore City and surrounding counties, we strongly support the establishment of an Adolescent Inpatient Psychiatry service at UMMC. I strongly urge you to support their Certificate of Need application.

Sincerely,

Jill RachBeisel MD

Jill A. RachBeisel M.D.
Vice Chair for Clinical Affairs/ Department of Psychiatry
University of Maryland School of Medicine and University of Maryland Medical Center

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

E. ALBERT REECE, MD, PhD, MBA
Vice President for Medical Affairs, University of Maryland
John Z. and Akiko K. Bowers Distinguished Professor and
Dean, University of Maryland School of Medicine

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August 3, 2018

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

Dear Mr. Steffen:

I am writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to establish an inpatient adolescent psychiatry service.

As you may well know, there is a critical shortage of inpatient adolescent psychiatry services in Baltimore City and surrounding counties. Demand for these services is rising and serious delays in care for this population are unfortunately all too common across the Baltimore metropolitan region. Adolescents with behavioral health needs typically wait in the Pediatric Emergency Department for as long as 10 days before an appropriate inpatient bed becomes available at another facility, further exacerbating the already serious mental health challenges of these young people.

The establishment of an inpatient adolescent psychiatry unit at UMMC would help alleviate this shortage and the resulting lengthy delays in care. It would provide the timely, high-quality care to help meet the increasing demands of this population, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for an available bed at another facility.

UMMC and the faculty physicians of the University of Maryland School of Medicine currently provide high-quality and compassionate inpatient behavioral health care to younger children (ages 5-12) and to adults, as well as outpatient services for all age groups. Given this existing expertise in the face of a glaring lack of services for adolescents in Baltimore City and surrounding counties, we strongly support the establishment of an Adolescent Inpatient Psychiatry service at UMMC. I strongly urge you to support their Certificate of Need application.

Sincerely yours,

E. Albert Reece, MD, PhD, MBA
Executive Vice President for Medical Affairs, UM Baltimore
John Z. and Akiko K. Bowers Distinguished Professor and
Dean, University of Maryland School of Medicine

BALTIMORE CITY HEALTH DEPARTMENT

1001 E. Fayette Street • Baltimore, Maryland 21202
Catherine E. Pugh, Mayor
Leana S. Wen, M.D., M.Sc., Commissioner of Health

August 3, 2018

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

Dear Mr. Steffen:

The Baltimore City Health Department is pleased to support the Certificate of Need application submitted by the University of Maryland Medical Center (UMMC) to establish an inpatient adolescent psychiatry service.

A critical shortage of inpatient adolescent psychiatry services exists in Baltimore City and the surrounding counties. Demand for these services is rising, and significant delays in care for this population are all too common across the Baltimore metropolitan region.

Adolescents with behavioral health needs typically wait in the pediatric emergency department for as long as 10 days before an appropriate inpatient bed becomes available at another facility, further exacerbating the already serious mental health challenges of these young people.

The establishment of an inpatient adolescent psychiatry unit at UMMC would help alleviate this shortage and the resulting delays in care. It would provide the timely, high-quality care to help meet the increasing demands of this population, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for an available bed at another facility.

UMMC and the faculty physicians of the University of Maryland School of Medicine provide high-quality and compassionate inpatient behavioral health care to younger children (ages 5-12) and to adults, as well as outpatient services for all age groups. Given this expertise in the face of a glaring lack of services for adolescents in Baltimore City and the surrounding counties, we strongly support the establishment of an adolescent inpatient psychiatry service at UMMC, and we urge you to support their Certificate of Need application.

Sincerely,

Leana Wen, M.D., M.Sc.
Commissioner of Health

EXHIBIT 7

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Reimbursement and Revenue Advisory Services

Estimated Average Charges for Common Procedures (updated 07/01/18)

The tables below provide estimated average charges for common inpatient and outpatient procedures at University of Maryland Medical Center. These tables are updated quarterly and are based on the patient charges actually incurred for these services during the previous twelve months. They may be used by patients to estimate the charge for services that they may incur. Please note that these are only estimates and are subject to change without notice. The actual cost of your procedure may be higher or lower based on factors specific to your case, such as your length of stay in the hospital and the complexity of your medical condition.

These estimates reflect hospital charges only. They do not include physician or other provider fees that are billed separately from the hospital fees. You may receive bills from multiple physicians for their services, including but not limited to your anesthesiologist, hospitalist, pathologist, radiologist, cardiologist, emergency room physician, and other specialist who participate in your care. If you have questions regarding the bill for their services, please contact the individual provider.

Most Frequent Inpatient Medical/Surgical Cases	Estimated Average Charge
SEPTICEMIA & DISSEMINATED INFECTIONS	$38,559.85
CRANIOTOMY EXCEPT FOR TRAUMA	$69,259.30
ASTHMA	$8,512.49
SICKLE CELL ANEMIA CRISIS	$13,962.75
PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI	$65,351.91
CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE	$25,033.85
SEIZURE	$19,203.85
MAJOR CARDIOTHORACIC REPAIR OF HEART ANOMALY	$83,996.92
DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK	$67,977.19
HEART FAILURE	$15,814.62

Most Frequent Inpatient Pediatric Cases	Estimated Average Charge
NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	$3,148.18
NEONATE BIRTHWT >2499G W MAJOR ANOMALY	$20,808.03
NEONATE BIRTHWT >2499G W OTHER SIGNIFICANT CONDITION	$12,049.08
NEONATE BWT 2000-2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	$6,542.02
NEONATE, BIRTHWT >2499G W RESP DIST SYND/OTH MAJ RESP COND	$23,610.12
NEONATE BWT 1500-1999G W RESP DIST SYND/OTH MAJ RESP COND	$52,023.06
NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM	$91,658.90
NEONATE BIRTHWT 1500-1999G W MAJOR ANOMALY	$67,130.57
NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM	$123,506.10
NEONATE BWT 1500-1999G W OR W/O OTHER SIGNIFICANT CONDITION	$38,487.68

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Reimbursement and Revenue Advisory Services

Most Frequent Inpatient Obstetric Cases	Estimated Average Charge
VAGINAL DELIVERY	$10,180.76
CESAREAN DELIVERY	$14,591.43
OTHER ANTEPARTUM DIAGNOSES	$13,086.60
POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE	$9,971.23
THREATENED ABORTION	$11,529.51
VAGINAL DELIVERY W STERILIZATION &/OR D&C	$12,963.12
VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC STERILIZATION &/OR D&C	$13,703.68
OTHER O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES	$17,965.70
ECTOPIC PREGNANCY PROCEDURE	$15,145.18

Most Frequent Inpatient Psychiatric Cases	Estimated Average Charge
SCHIZOPHRENIA	$33,360.10
MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	$23,242.86
CHILDHOOD BEHAVIORAL DISORDERS	$15,493.33
BIPOLAR DISORDERS	$21,880.48
DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	$13,272.23
ACUTE ANXIETY & DELIRIUM STATES	$12,395.31
ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	$14,427.38
ORGANIC MENTAL HEALTH DISTURBANCES	$27,671.34
DISORDERS OF PERSONALITY & IMPULSE CONTROL	$12,436.85
OTHER MENTAL HEALTH DISORDERS	$8,300.08

Most Frequent Outpatient Surgical Services	Estimated Average Charge
FETAL NON-STRESS TEST	$526.77
TRANSFUSION, BLOOD OR BLOOD COMPONENTS	$212.08
UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, STOMACH, AND EITHER THE DUODENUM AND/OR JEJUNUM AS APPROPRIATE; WITH BIOPSY, SINGLE OR MULTIPLE	$1,243.45
LARYNGOSCOPY, FLEXIBLE FIBEROPTIC; DIAGNOSTIC	$240.18
UNLISTED PROCEDURE, DENTOALVEOLAR STRUCTURES	$1,555.57
COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH BIOPSY, SINGLE OR MULTIPLE	$1,774.58
NASAL ENDOSCOPY, DIAGNOSTIC, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE)	$208.32
LARYNGOSCOPY, FLEXIBLE OR RIGID FIBEROPTIC, WITH STROBOSCOPY	$320.67
COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING, WITH OR WITHOUTCOLON DECOMPRESSION (SEPARATE PROCEDURE)	$1,690.10
BONE MARROW; BIOPSY, NEEDLE OR TROCAR	$997.84

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Reimbursement and Revenue Advisory Services

Most Frequent Laboratory Services	Estimated Average Charge
COMPREHENSIVE METABOLIC PANEL	$34.51
BLOOD COUNT; COMPLETE (CBC), AUTOMATED (HGB, HCT, RBC, WBC AND PLATELET COUNT) AND AUTOMATED DIFFERENTIAL WBC COUNT	$22.27
MAGNESIUM	$14.11
PHOSPHORUS INORGANIC (PHOSPHATE);	$4.73
PROTHROMBIN TIME;	$19.53
BLOOD COUNT; COMPLETE (CBC), AUTOMATED (HGB, HCT, RBC, WBC AND PLATELET COUNT)	$20.23
URINALYSIS, BY DIP STICK/TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN, KETONES, LEUKOCYTES, NITRITE, PH, PROTEIN, SPEC GRAV, UROBILINOGEN,ANYNUMBER OF CONSTITUENTS; AUTOMATED, W/ MICROSCOPY	$21.66
LACTATE DEHYDROGENASE (LD), (LDH);	$8.87
BLOOD TYPING; ABO	$8.84
BLOOD TYPING; RH (D)	$8.84

Most Frequent Outpatient Diagnostic Imaging Services	Estimated Average Charge
DOPPLER ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, PULSED WAVE AND/OR CONTINUOUS WAVE WITH SPECTRAL DISPLAY; FOLLOW-UP OR REPEAT STUDY	$103.91
COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST MATERIAL	$92.43
US, PRGNANT UTERUS, REAL TME W IMG DOCUMENTATION, F/U (EG, RE-EVAL, ORGAN SYST(S) SUSPECTED/CONFMED BE ABNORM PREVIOUS SCAN), TRANSABDOM APPR,/FETUS	$311.61
RADIOLOGIC EXAMINATION, CHEST, TWO VIEWS, FRONTAL AND LATERAL;	$112.20
FETAL BIOPHYSICAL PROFILE; WITHOUT NON-STRESS TESTING	$415.21
COMPUTED TOMOGRAPHY, THORAX; WITH CONTRAST MATERIAL(S)	$204.48
ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, LIMITED (EG, FETAL HEART BEAT, PLACENTAL LOCATION, FETAL POSITION AND/OR QUALITATIVE AMNIOTIC FLUID VOLUME), ONE OR MORE FETUSES	$305.11
RADIOLOGIC EXAMINATION, KNEE; ONE OR TWO VIEWS	$137.04
RADIOLOGIC EXAMINATION, ANKLE; COMPLETE, MINIMUM OF THREE VIEWS	$139.71
RADIOLOGIC EXAMINATION, CHEST; SINGLE VIEW, FRONTAL	$93.22

EXHIBIT 8

University of Maryland Medical Center University of Maryland Medical Center Midtown Campus University of Maryland Rehabilitation & Orthopaedic Institute University of Maryland St. Joseph Medical Center University of Maryland Baltimore Washington Medical Center University of Maryland Shore Medical Center at Chestertown University of Maryland Shore Medical Center at Dorchester University of Maryland Shore Medical Center at Easton	**The University of Maryland Medical System** **Central Business Office** **Policy & Procedure**	*Policy #:*	TBD
		Effective Date:	09/01/2017
	Subject: **FINANCIAL ASSISTANCE**	*Page #:*	1 of 9
		Supersedes:	07-01-2017

POLICY

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

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

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

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

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

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be offered to patients whose accounts are with a collection agency and may apply only to those accounts on which a judgment has not been granted.

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

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

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

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

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

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

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

PROGRAM ELIGIBILITY

Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

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

1. Services provided by healthcare providers not affiliated with UMMS hospitals (e.g., durable medical equipment, home health services)
2. Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, or Workers Compensation), are not eligible for the Financial Assistance Program.
   a. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications.
3. Unpaid balances resulting from cosmetic or other non-medically necessary services
4. Patient convenience items
5. Patient meals and lodging
6. Physician charges related to the date of service are excluded from UMMS financial assistance policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.

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

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

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

Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor/Coordinator and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

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

Presumptive Financial Assistance

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

a. Active Medical Assistance pharmacy coverage
b. SLMB coverage

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

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

a. Purely elective procedures (example – Cosmetic) are not covered under the program.
b. Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive financial assistance program until the Maryland Medicaid Psych program has been billed.

PROCEDURES

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.
2. Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.

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

c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance. Determination of Probable Eligibility will be provided within two business days following a patient's request for charity care services, application for medical assistance, or both.

d. Upon receipt of the patient's application, they will have thirty (30) days to submit the required documentation to be considered for eligibility. If no data is received within the 30 days, a denial letter will be sent notifying that the case is now closed for lack of the required documentation. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to. The Financial Assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. Refunds may be issued back to the patient for credit balances, due to patient payments, resulted from approved financial assistance on considered balance(s). Payments received for

care rendered during the financial assistance eligibility window will be refunded, if the amount exceeds the patient's determined responsibility by $5.00 or more.

10. Patients who have access to other medical care (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Assistance Program.
11. The Financial Assistance Program will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications in determining eligibility for the UMMS Financial Assistance program. This includes accepting FPI's application requirements.
12. The Financial Assistance Program will accept all other University of Maryland Medical System hospital's completed financial assistance applications in determining eligibility for the program. This includes accepting each facility's application format.
13. The Financial Assistance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.
14. Where there is a compelling educational and/or humanitarian benefit, Clinical staff may request that the Financial Clearance Executive Committee consider exceptions to the Financial Assistance Program guidelines, on a case-by-case basis, for Financial Assistance approval.
    a. Faculty requesting Financial Clearance/Assistance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.
    b. The Chief Medical Officer will notify the attending physician and the Financial Assistance staff of the Financial Clearance Executive Committee determination.

Financial Hardship

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

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

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

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

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

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

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

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

Appeals

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

Judgments

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

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

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

Effective 7/1/17

EXHIBIT 9

The University of Maryland Medical Center provides healthcare services to those in need regardless of an individuals ability to pay. Care may be provided without charge, or at a reduced charge, to those who do not have insurance, Medicare/Medical Assistance coverage, and are without the means to pay. An individual's eligibility to receive care without charge, at a reduced charge, or to pay for their care over time is determined on a case by case basis. Interested parties seeking to determine a patient's eligibility should direct their inquiries to the Financial Counseling Office at (410) 821-4140.

UNIVERSITY OF MARYLAND
MEDICAL CENTER
UNIVERSITY OF MARYLAND MEDICINE

EXHIBIT 10

MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

May 2, 2018

RECEIVED

MAY 04 2018

University of Maryland Medical Center
Executive Office

Mohan Suntha, President and CEO
University Of Maryland Medical Center
22 South Greene Street
Baltimore, MD 21201

Dear Dr. Suntha,

Based on legislation passed during the 2018 legislative session, the Office of Health Care Quality will eliminate license fees and expiration date effective July 1, 2018. Therefore, we are issuing new licenses to all facilities reflecting an effective date of July 1, 2018. Please continue to supply the findings of The Joint Commission's accreditation survey to the OHCQ at the address below:

The Hospital and HMO QA Unit
Spring Grove Center, Bland-Bryant Building
55 Wade Ave.
Catonsville, MD 21228

The Department of Health retains the authorities as specified in Health-General Article 19 and may revoke this license for failure to comply with its provisions. The license is the hospital's authority to operate an Acute General Hospital.

This license should be displayed in a conspicuous place, at or near the entrance to the hospital, plainly visible and easily read by the public.

Sincerely,

Anne Jones RN, BSN, MA
Acting Director, Hospital and HMO QA Unit

cc: Maryland Health Care Commission
Maryland Health Services Cost Review Commission
Office of Health Services
Division of Cost and Reimbursements
Ann Elliott, CareFirst Blue Cross
Baltimore City Health Department
License File

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

License No. 30-068

Issued to:

University Of Maryland Medical Center
22 South Greene Street
Baltimore, MD 21201

Type of Facility: Acute General Hospital

Date Issued: July 1, 2018

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

Patricia Tomasko May MD

Director

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

EXHIBIT 11

University of Maryland Medical Center

Baltimore, MD

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

October 21, 2017

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #6264
Print/Reprint Date: 01/19/2018

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

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

EXHIBIT 12

UNIVERSITY of MARYLAND MEDICAL CENTER

Adolescent Psychiatry CON Application
Quality of Care Section

For Each Below Average Rating, Please provide a short paragraph of Actions Underway at UMMC to Improve Performance

Ratings for Health Conditions and Topics

Ratings shown here are compared to State Average

Quality Measure	Rating	Risk-Adjusted Rates	Response Action Plan Underway
Patients who died in the hospital after having one of six common conditions.	Below average	1.2384 (1.0597, 1.4170)	**Actions:** 1. Cases are reviewed 2. Deaths are reviewed by quality department and sent to service line quality representatives 3. Trends are identified and quality improvement initiatives are developed 4. For specific conditions action plans see below
How often did doctors always communicate well with patients?	Below average	77%	**Actions: 1**) Continue PEP physician-patient communication program across all clinical faculty (Approximately 50% have received PEP training, with remainder to undergo this all-day training this year). 2) We provide physician-patient communication training to new, incoming residents and fellows, with additional courses planned for later this year. 3) Introduction of specialized chairs in patient rooms to enable eye-level and more personal communication with inpatients.
How often did staff always explain about medicines before giving them to patients?	Below average	59%	**Actions:** 1) Development and deployment of a standardized patient education pamphlet that covers the most common medications given for the population served in that service line. 2) Development and deployment of a "flag" alert in the Electronic Medical Record (EMR) anytime a new medication is ordered for a patient. The alert will provide the clinician (RN) with direction to teach the purpose and potential side-effects based on pharmacy data embedded in the alert. The responsible RN will conduct new medication teaching based on the alert, and document completion of teaching in the EMR. **Monitoring of performance:** Patient experience data for this metric are pushed to clinical leaders quarterly. Individual unit leaders have the ability to pull the data more frequently to assess improvement at the functional unit level.
Were patients always given information about what to do during their recovery at home?	Below average	85%	**Actions:** 1) Design and deployment of a standard admission/discharge packet that addresses organization of patient information on follow-up care. 2) Pilot a follow-up phone call process. Clinician calls patient within 1 week of discharge to check on discharged patient, reinforce discharge teaching, and answer questions. **Monitoring of performance:** Data for this metric are pushed to clinical leaders quarterly. Individual unit leaders have the ability to pull the data more frequently to assess improvement at the functional unit level.

UNIVERSITY of MARYLAND MEDICAL CENTER

Adolescent Psychiatry CON Application
Quality of Care Section

For Each Below Average Rating, Please provide a short paragraph of Actions Underway at UMMC to Improve Performance

Ratings for Health Conditions and Topics

Ratings shown here are compared to State Average

Quality Measure	Rating	Risk-Adjusted Rates	Response Action Plan Underway
How often were the patients' rooms and bathrooms always kept clean?	Below average	63%	**Actions:** 1) UMMC has contracted with an outside vendor in an effort to improve hospital cleanliness. 2) A process has been put in place where the nurse manager and EVS supervisor perform inpections on every room after discharge cleaning has occurred. 3) Initiatives have been instuted to build a more collaborative relationship between clinical staff and EVS staff. **Monitoring of performance:** Patient experience survey data is reviewed and monitored monthly with medical center leadership.
How often did patients always receive help quickly from hospital staff?	Below average	57%	**Actions:** 1) Unit specific data is shared with unit mangers and their supervisor. Nurse manager will work with senior nurses on the unit to improve responsiveness of staff by using a team approach to answer call bells and ensuring the call bell is within reach at all times. 2) Nurses engage in a bedside shift change hand-off at each transfer of care from one shift to another. With patient participation, the focus of hand-off is patient safety, introduction of nurse for shift, and specific patient needs/goals for the day. **Monitoring of performance:** Data for this metric are pushed to clinical leaders quarterly. Individual unit leaders have the ability to pull the data more frequently to assess improvement at the functional unit level.
How often was the area around patients' rooms always kept quiet at night?	Below average	53%	**Actions:** 1) Unit specific data is shared with unit mangers and their supervisor. Nurse manager will work with senior nurses on the unit to improve quietness at night and accountability of staff on off shifts to maintain a restful environment. 2) Work with facilities personnel to reduce the amount of unnecessary activity at night (i.e. trash removal). **Monitoring of performance:** Data for this metric (quiteness at night) are pushed to clinical leaders quarterly. Individual unit leaders have the ability to pull the data more frequently to assess improvement at the functional unit level.
How long patients spent in the emergency department before leaving for their hospital room	Below average	686 minutes	**Actions**: 1) Re-evaluate priorities/ performance of Medical Admitting Officer role in the ED. 2) Open Access Center (August FY19) - enhance real-time access/ flow data analytics. **Monitoring of performance:** Monthly reporting of departmental metrics to leadership in the ED and other key departmental leaders

UNIVERSITY of MARYLAND MEDICAL CENTER

Adolescent Psychiatry CON Application

Quality of Care Section

For Each Below Average Rating, Please provide a short paragraph of Actions Underway at UMMC to Improve Performance

Ratings for Health Conditions and Topics

Ratings shown here are compared to State Average

Quality Measure	Rating	Risk-Adjusted Rates	Response Action Plan Underway
How long patients spent in the emergency department after the doctor decided the patient would stay in the hospital before leaving for their hospital room	Below average	384 minutes	**Actions**: 1) Re-work process/ outcomes of Medicine IDR + enhance process/ flow of appropriate transfers to Midtown Campus to increase bed capacity and access to inpatient care units. 2) Further augment role of Physcian Administrator of the Day - key traige role within new Access Center . **Monitoring of performance**: Monthly reporting of departmental metrics
How long patients spent in the emergency department before being sent home	Below average	246 minutes	**Actions**: 1) Revised process (activated July FY19) to prioritize up-front flow. Intent by ED leaders is to reduce wait for d/c for pts being sent home as well as further prioritize flow of ESI-3/4/5 patients. 2) New process is intended to also augment screen and send numbers to Urgent Care and furhter decant up-front operations for the ED teams. **Monitoring of performance**: Monthly reporting of departmental metrics to leadership in the ED and other key departmental leaders
How long patients spent in the emergency department before they were seen by a healthcare professional	Below average	60 minutes	**Actions**: 1) Median door-to-triage time to be seen by a healthcare professional for FY18 - 14 mins. 2) Median door-to-provider time to be seen - 65 mins for FY18. 3) New ED -up-front process change intended to reduce time to waiting to see a provider (NP's in our process). **Monitoring of performance**: Monthly reporting of departmental metrics to leadership in the ED and other key departmental leaders
Patients who left the emergency department without being seen	Below average	4%	**Actions**: 1) Alternative destination processes for ED patients - further augmentation of process flow to Urgent Care and Care Coordination Centers. 2) New ED up-front flow process. 3) Use of an up-front Quick-Look RN to monitor arrivals and waiting-room. **Monitoring of performance**: Monthly reporting of departmental metrics to leadership in the ED and other key departmental leaders.
Patients in the hospital who got the flu vaccine if they were likely to get flu	Below average	88%	**Actions:** 1. Use of Banner for Nursing for real time alert 2. Quality Department concurrent support to ensure all identified patients receive vaccine 3.Targeted Flu education in September before initiation of flu season **Monitor Performance:** Flu Core Measure compliance

UNIVERSITY of MARYLAND MEDICAL CENTER

Adolescent Psychiatry CON Application
Quality of Care Section

For Each Below Average Rating, Please provide a short paragraph of Actions Underway at UMMC to Improve Performance

Ratings for Health Conditions and Topics

Ratings shown here are compared to State Average

Quality Measure	Rating	Risk-Adjusted Rates	Response Action Plan Underway
How often patients die in the hospital after heart attack	Below average	9.2614 (7.0091, 11.5138)	**Actions:** 1. Cases are reviewed 2. Deaths are reviewed by quality department and sent to service line quality representatives 3. Trends are identified and quality improvement initiatives are developed 4. Code STEMI process in place to ensure door to balloon time of <90 minutes 5. Alternative fibrinolytic pathway exists for patients who fall outside 90 minute window 6. Team meets monthly to review each case to idenify trends for process improvement opportunities **Monitor Performance:** Door to Balloon time, ED Wait Times, 12 Lead EKG review times
How often patients die in the hospital after heart failure	Below average	4.5231 (2.9304, 6.1158)	**Actions:** 1. Cases are reviewed 2. Deaths are reviewed by quality department and sent to service line quality representatives 3. Trends are identified and quality improvement initiatives are developed 4. Increasing volumes of advanced heart failure therapies to include Heart Transplantation and Ventricular Assist Device Implantation 5. Increasing usage of Temporary Mechanical Support (ECMO) to increase survival **Monitor Performance:** Various quality committees review volumes and appropriate usage and outcomes
Patients who had a low-risk surgery and received a heart-related test, such as an MRI, at least 30 days prior to their surgery though they do not have a heart condition	Below average	6.70%	**Actions:** The UM Heart and Vascular Center Leadership are reviewing cases to determine appropriate utilization of heart related tests for low-risk surgeries.
Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses.	Below average	5.40%	**Actions:** 1. Cases are reviewed 2. Deaths are reviewed by quality department and sent to service line quality representatives 3. Trends are identified and quality improvement initiatives are developed 4. For specific conditions action plans see below
How often the hospital accidentally makes a hole in a patient's lung	Below average	0.9250 (0.6226, 1.2274)	**Actions:** 1. Cases are reviewed 2. Deaths are reviewed by quality department and sent to service line quality representatives 3. Trends are identified and quality improvement initiatives are developed 4. For specific conditions action plans see below

UNIVERSITY of MARYLAND MEDICAL CENTER

Adolescent Psychiatry CON Application
Quality of Care Section

For Each Below Average Rating, Please provide a short paragraph of Actions Underway at UMMC to Improve Performance

Ratings for Health Conditions and Topics — **Response Action Plan Underway**

Ratings shown here are compared to State Average

Quality Measure	Rating	Risk-Adjusted Rates	
Returning to the hospital for any unplanned reason within 30 days after being discharged	Below average	17.1 (15.7 - 17.9)	**Actions:** Between CY13 and CY16 the University of Maryland Medical Center reduced its all-hospital, risk adjusted readmission rate by 11.95%, a reduction that was 11% greater than the State average (10.75%). Between CY16 and CY17 the readmission rate increased slightly, by 2%. Since then we have launched a number of initiatives that focus on steps taken before readmission (an intensive ER social work/navigation initiative), after readmission (interdisciplinary discharge planning rounds), before discharge (re-enginnering discharge initiative) and after discharge (mobile integrated health using City fire department paramedics as well as community based care navigators). We are also working with nationally recognized expert in readmissions Dr. Amy Boutwell to continue our progress in reducing potentially avoidable utilization. **Monitoring of performance:** Performance is monitored through the Annual Operating Plan and reported to leadership on a quarterly basis.
How often patients die in the hospital after fractured hip	Below average	9.6711 (4.1503, 15.1919)	**Actions:** 1. Falls Committee reviews each fall and alerts deaths through Patient Safety structure 2. Death is reviewed by quality department and sent to service line quality representatives 3. Trends are identified and quality improvement initiatives are developed
How often patients who came in after having stroke subsequently died in the hospital.	Below average	12.6482 (11.1299, 14.1665)	**Actions:** 1. Comprehensive Stroke Center (CSC) team reviews each death to determine if it is preventable. 2. Weekly case review with interdisciplinary team members 3. Review criteria for patient transport to CSC 4. CSC Chairman peer review of all cause death, including the following departments: neurology, Neurocritical care, Neurosurgery, and Emergency Medicine
Death rate for stroke patients	Below average	20.8(17.5, 24.6)	**Actions:** 1. Comprehensive Stroke Center (CSC) team reviews each death to determine if it is preventable. 2. Weekly case review with interdisciplinary team members 3. Peer review 4. Weekly stroke division meetings to review mortality data 5. Monthly interdisciplinary morbidity and mortality reviews with Chairperson of Neurology
How often patients die in the hospital during or after a surgery to fix the artery that carries blood to the lower body when it gets too large	Below average	100.0000 (100.0000, 100.0000)	**Actions:** 1. Cases are reviewed 2. Deaths are reviewed by quality department and sent to service line quality representatives 3. Trends are identified and quality improvement initiatives are developed 4. Unexpected deaths are reviewed at the patient level by a provider on the service and brought to the committee for further review

UNIVERSITY of MARYLAND MEDICAL CENTER

Adolescent Psychiatry CON Application

Quality of Care Section

For Each Below Average Rating, Please provide a short paragraph of Actions Underway at UMMC to Improve Performance

Ratings for Health Conditions and Topics

Ratings shown here are compared to State Average

Quality Measure	Rating	Risk-Adjusted Rates	Response Action Plan Underway
How often surgical patients die in the hospital because a serious condition was not identified and treated	Below average	263.2969 (234.8064, 291.7874)	This measure is an AHRQ PSI that is calculated using claims based data. The CDE team reviews every PSI for documentation opportunities and potential quality of care issues. Every case identified with a PSI is shared with the appropriate medical/surgical service for case review and/or practice change; results are trended quarterly over time per service. In FY 2018, the rate for this PSI improved to 234.68 (not risk-adjusted; awaiting release of AHRQ ICD-10 software in 2019 for risk-adjustment)
How often patients in the hospital had to use a breathing machine after surgery because they could not breathe on their own	Below average	9.8603 (7.8859, 11.8347)	This measure is an AHRQ PSI that is calculated using claims based data. The CDE team reviews every PSI for documentation opportunities and potential quality of care issues. Every case identified with a PSI is shared with the appropriate medical/surgical service for case review and/or practice change; results are trended quarterly over time per service. In FY 2018, the rate for this PSI improved to 7.98 (not risk-adjusted; awaiting release of AHRQ ICD-10 software in 2019 for risk-adjustment)

EXHIBIT 13

Marshall Valuation Service Analysis

The following compares the project costs to the Marshall Valuation Service ("MVS") benchmark. Please note that this project involves renovation. Section 99, Page 1 of the MVS guide states:

REPAIR AND REMODEL: All costs in this manual are based on new construction. Typical repair work will run 10 to 20 higher because of restricted area, movement of materials, temporary supports, shoring, etc., and other contingencies not encountered in new construction, excluding demolition and removal.

No premium for renovation has been assumed in the following calculation for the MVS benchmark. However, the final comparison between the project costs/square foot and the benchmark should be viewed in the context of the MVS view of Repair and Remodeling costs.

The project includes complete redesign and installation of the sprinkler system and HVAC system. Hence, those costs have been included in the MVS benchmark. The elevators are not involved, so the elevator cost has been subtracted from the MVS benchmark.

I. Marshall Valuation Service Valuation Benchmark

Type		Hospital
Construction Quality/Class		Good/A
Stories		6
Perimeter		350
Average Floor to Floor Height		13.0
Square Feet		13,799
f.1	AveragefloorArea	6,900
A. Base Costs		
	BasicStructure	$374.00
	EliminationofHVACcostforadjustment	0
	HVACAdd-onforMildClimate	0
	HVACAdd-onforExtremeClimate	0
Total Base Cost		$374.00
Adjustment for Departmental Differential Cost Factors		0.93
Adjusted Total Base Cost		$349.34
B. Additions		
	Elevator(Ifnotinbase)	($5.93)
	Other	$0.00
Subtotal		($5.93)
TOTAL		$343.41

C. Multipliers		
Perimeter Multiplier		0.9794095
	Product	$336.34
Height Multiplier		1.023
	Product	$344.07
Multi-story Multiplier		1.045
	Product	$359.56
D. Sprinklers		
	SprinklerAmount	$3.94
Subtotal		$363.50
E. Update/Location Multipliers		
Update Multiplier		1.04
	Product	$378.04
Location Multiplier		1.02
	Product	$385.60
Calculated Square Foot Cost Benchmark		**$385.60**

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				
Patient Rooms	1,775	Inpatient Unit	1.06	1,882
Patient Activity Area	1,235	Inpatient Unit	1.06	1,309
Toilets	858	Inpatient Unit	1.06	909
Seclusion Suite/ Sensory Room	269	Inpatient Unit	1.06	285
OT (school, group, interview)	1,235	Adjunct Facilities	1.18	1,457
Intake/ Exam	411	Offices	0.96	395
Offices	1,141	Offices	0.96	1,095
Conference	473	Offices	0.96	454
Storage	586	Storage and Refrigeration	1.6	938
Corridor/ Lobby	3,217	Internal Circulation, Corridors	0.6	1,930
12 Toilet	93	Public Space	0.8	74
12 Offices	462	Offices	0.96	444

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
12 Seclusion Suite/ Sensory Room/ OT	457	Adjunct Facilities	1.18	539
12 Gym	460	Physical Medicine	1.09	501
12 Corridor	1,127	Internal Circulation, Corridors	0.6	676
Total	**13,799**		**0.93**	**12,889**

Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
Building	$7,422,000	$537.87
Fixed Equipment	$0	$0.00
Site Preparation	$0	$0.00
Architectural Fees	$600,000	$43.48
Permits	$75,000	$5.44
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$8,097,000	$586.78

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

B. Extraordinary Cost Adjustments			
	Project Costs		Associated Cap Interest & Financing
Demolition	$250,000	Building	$0
Adjacent Occupants Increase (Complex/congested areas)	$371,100	Building	$0
Infection Control Requirements	$300,000	Building	$0
Asbestos abatement	$200,000	Building	$0
Staff Duress System (technology)	$200,000	Building	$0
Security systems	$250,000	Building	$0
Premium for working in occupied units above and below for utility demolition and installation	$200,000	Building	$0
Premium for renting and using exterior building lift for materials	$200,000	Building	$0
Premium for finishes appropriate for Children's Unit	$100,000	Building	$0
Premium for Behavioral Health Hardware & Fixtures	$350,000	Building	$0
Premium for Minority Business Enterprise Requirement	$200,036	Building	$0
		Permits	$0
Total Cost Adjustments	$2,621,136		$0

Associated Capitalized Interest and Loan Placement Fees should be excluded from the comparison for those items which are also excluded from the comparison. However, there are no Capitalized Interest or Loan Placement Fees in this project.

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.

Demolition — The entire interior of the existing space will be "gutted."

Adjacent Occupants Increase (Complex/congested areas) — Working on an existing unit on the 11th and 12th floors with ongoing adjacent inpatient services poses complex phasing and congested areas. MVS states at Section 99, Page 1 that the premium for Complex/congested areas is 2%-5%. UMMC-M believes that the premium is at least 5%, given that all materials cannot be stored on-site and delivery of materials will have to be phased without affecting adjacent services. UMMC-M has assumed 5%.

Infection Control Requirements — Working in an occupied hospital requires rigorous infection control requirements to ensure dust does not impact adjacent patient care areas. These requirements include, but are not limited to, containment around the site perimeter, mechanical devices to vent the contaminated air outside the building, and protective coverings to be worn by all workers during construction.

Asbestos abatement — Given the age of the building we anticipated needing to abate multiple building elements within the site. These elements could include piping insulation, structure fire-proofing, and under-floor adhesive materials.

Staff Duress System (technology) — Staff safety on a behavioral health unit is critical given the violent tendencies which could be present in the patient population. A staff duress system involves wiring the floor to enable a system that will interact with tags that the staff carry with them at all times. If in danger, staff press the button on their tags, and the system summons other staff members and security personnel to their exact location. The installation includes physical cabling and conduits for antennae in the system.

Security systems — Staff safety on a behavioral health unit is critical given the violent tendencies which could be present in the patient population. This involves physical security elements such as card readers to limit access to certain areas and cameras in most areas for real-time surveillance and investigations using video recordings.

Premium for working in occupied units above and below for utility demolition and installation — The layout of the new unit requires work above and below the floor to remove existing utilities and install new utilities. The unit below is an occupied medical intermediate care unit, and the unit above is an occupied inpatient adult behavioral health unit. Working in both areas will requires rigorous protocols for infection control and safety and will be required to be done in multiple small phases so as not to impact the capacity and operations of those units.

Premium for renting and using exterior building lift for materials — The interior service elevator for this building is shared with other hospital operations, such as housekeeping, materials management, linen, etc… It which would require bringing construction bulk materials and removing debris through an adjacent medicine unit. Using this cart is not operationally feasible.

Therefore setting up and maintaining an exterior building lift for the duration of the work will be required.

Premium for finishes appropriate for Children's Unit — Pediatric units in general have brighter finishes than most other inpatient units. Children on a behavioral health unit are not typically medically sick and are, therefore, very ambulatory and interact a lot with the environment, which can be an important part of the healing process. We, therefore, anticipate a higher level of finishes for the space.

Premium for Behavioral Health Hardware & Fixtures — Patient safety is critical for a behavioral health unit, especially given that some patients may have a condition causing them to want to harm themselves or others. Fixtures that eliminate anchor points and don't present opportunities for weaponization are required in these spaces. These fixtures typically cost more money and have a longer lead time than normal commercial or hospital grade items.

Premium for Minority Business Enterprise Requirement (MBE) – UMMS projects include a premium for Minority Business Enterprises that would not be in the average cost of hospital construction. This premium was conservatively projected on this project to be 4% based on conversations with cost estimators.

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

C. Adjusted Project Cost	**Adjusted Project Costs**	**Per Square Foot**
Building	$4,800,864	$347.91
Fixed Equipment	$0	$0.00
Site Preparation	$0	$0.00
Architectural Fees	$600,000	$43.48
Permits	$75,000	$5.44
Subtotal	$5,475,864	$396.83
Capitalized Construction Interest	$0	$0.00
Total	$5,475,864	$396.83

As noted below, the project's cost per square foot approximate the MVS benchmark. As stated previously, the MVS Guide states at Section 99, Page 1 that "All costs in this manual are based on new construction. Typical repair work will run 10 to 20 higher…" Hence, UMMC-M believes it is consistent with the MVS benchmark.

MVS Benchmark	$385.60
The Project	$396.83
Difference	$11.23
%	2.91%

EXHIBIT 14

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

	Page
Independent Auditors' Report	1
Consolidated Financial Statements:	
Consolidated Balance Sheets	3
Consolidated Statements of Operations	4
Consolidated Statements of Changes in Net Assets	5
Consolidated Statements of Cash Flows	6
Notes to Consolidated Financial Statements	8
Supplementary Information	
Schedule 1 – Consolidating Balance Sheet Information by Division, June 30, 2017	61
Schedule 2 – Consolidating Balance Sheet Information by Division, June 30, 2016	81
Schedule 3 – Consolidating Operations Information by Division, year ended June 30, 2017	83
Schedule 4 – Consolidating Operations Information by Division, year ended June 30, 2016	93
Schedule 5 – Combining Balance Sheet Information of the Obligated Group, June 30, 2017	94
Schedule 6 – Combining Balance Sheet Information of the Obligated Group, June 30, 2016	96
Schedule 7 – Combining Operations and Changes in Net Assets Information of the Obligated Group, year ended June 30, 2017	98
Schedule 8 – Combining Operations and Changes in Net Assets Information of the Obligated Group, year ended June 30, 2016	99

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	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)

Schedule 1-f

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION
AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Charles Regional Health System, Inc. (Charles Regional)

June 30, 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.

EXHIBIT 15

IN THE MATTER OF	*	
	*	
University of Maryland	*	**BEFORE THE**
	*	
Medical Center	*	**MARYLAND HEALTH**
	*	
Docket No. 09-24-2300	*	**CARE COMMISSION**

****

FINAL ORDER

Based on the analysis and findings in the Staff Report and Recommendation, it is this 18th day of March 2010:

ORDERED, that the application for Certificate of Need by University of Maryland Medical Center, Docket No. 09-24-2300, to expand trauma, critical care and emergency services at a capital cost of $176,728,000.

1. The University of Maryland Medical Center will not disable gas lines in any existing patient rooms in order to implement this project unless such action is required to safely reconfigure the room to a non-patient room function and without the approval of the Maryland Health Care Commission. Upon completion of this project, the University of Maryland Medical Center will not place any of the 18 semi-private patient rooms being converted to private rooms into service as semi-private patient rooms or any of the nine patient rooms being converted to non-patient use back into service as patient rooms without Commission approval.

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 $28,196,229 cost associated with the excess construction and renovation costs, interest, and inflation. This figure includes the estimated new construction and renovation expenditure that exceeds the Marshall Valuation Service guideline cost and portions of the contingency allowance, inflation allowance, and capitalized construction interest estimate for the project that are based on the excess construction cost.

3. Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude the $2,384,374 cost associated with excess nursing unit space. This figure includes the estimated construction expenditure for the excess space and portions of the contingency allowance, inflation allowance, and capitalized construction interest estimate for the project that are based on the excess space.

Marilyn Moon, Ph.D.
CHAIR

STATE OF MARYLAND

Rex W. Cowdry, M.D.
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

Thursday, March 18, 2010
1:00 p.m.

AGENDA

1. **APPROVAL OF MINUTES**

2. **UPDATE OF ACTIVITIES**

   - Executive Direction
   - Center for Information Services and Analysis
   - Center for Health Care Financing and Policy
   - Center for Long-Term Care and Community-Based Services
   - Center for Hospital Services
   - Center for Health Information Technology

3. **LEGISLATIVE UPDATE**

4. **ACTION:** Certificate of Need

   - University of Maryland Medical Center (Docket No. 09-24-2300)

5. **PRESENTATION:** Health Care Spending in Maryland: How does Maryland Differ from Other States and Why?

6. **FINAL ACTION:** COMAR 10.25.06 – Maryland Medical Care Data Base and Data Collection

7. **UPDATE & POLICY DISCUSSION:** Small Group Market Modifications in SB 637/ HB 674 of 2009

8. **PRESENTATION:** Maryland Nursing Home Family Experience of Care Survey - 2009

9. **PRESENTATION:** Medical Expenditure Panel Survey: Maryland Sample through 2008

10. **ADJOURNMENT**

Marilyn Moon, Ph.D.
CHAIR

STATE OF MARYLAND

Rex W. Cowdry, M.D.
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION
4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

MARYLAND HEALTH CARE COMMISSION

Thursday, March 18, 2010

Minutes

Chair Moon called the public meeting to order at 1:08 p.m.

Commissioners present: Conway, Falcone, Fleig, Kan, Krumm, Lyles, McLean, Moore, Ontaneda-Bernales, and Worthington.

ITEM 1.

Approval of the Minutes

Commissioner McLean made a motion to approve the minutes of the February 18, 2010 meeting of the Commission, which was seconded by Commissioner Ontaneda-Bernales, and unanimously approved. Commissioner Conway made a motion to approve the February 5, 2010 and the March 8, 2010 teleconference meetings of the Commission, which was seconded by Commissioner Kan, and unanimously approved.

ITEM 2.

Update of Activities

Bruce Kozlowski, Director of the Center for Health Care Financing and Health Policy, said the Commission awarded Mr. Adewale Adeoye, a master's student at Morgan State University School of Community Health, an internship with the Commission to examine what factors influence disparities in health care utilization and outcomes using a unique survey conducted in East Baltimore.

David Sharp, Director of the Center for Health Information Technology, announced that the Commission will receive $9.3 million under the *American Recovery and Reinvestment Act of 2009* to implement the statewide health information exchange. This grant will be used to facilitate and expand the secure exchange of electronic health information among providers in an effort to improve the quality and efficiency of health care.

ITEM 3.

ACTION: LEGISLATIVE UPDATE

Rebecca Perry, Chief, Government Relations and Special Projects, provided an update on the following bills heard during the 2010 legislative session:

HB 929/SB 855 "Patient Centered Medical Home (PCMH)" – This bill was heard in both the Senate and the House. Ms. Perry noted that the Commission supported the bill with the Administration's amendments. She noted that the amendments include: "fine tuning" the Commission's role in the regulation and oversight of both the Maryland Patient Centered Medical Home program and single-carrier PCMH programs in Maryland; clarification of the participation of Medicaid managed care organizations and federally-qualified health center; and the inclusion of additional evaluation criteria.

SB 593/HB 699 "Freestanding Medical Facility" – This bill was also heard in both the Senate and House. Ms. Perry said the Commission opposed this legislation because of the immediate effect that all-payer rate-setting for these facilities is likely to have on health care costs in general and Medicaid payments in particular, and more importantly, because of the adverse long-term effects that a proliferation of freestanding medical facilities would have on efforts to create a higher quality, more cost-effective health care system. She noted that the following amendments have been drafted and circulated to Committee Chairs: 1) the provision of rates for FMF pilots; 2) inclusion of FMF in the Certificate of Need Program; 3) requiring the MHCC to report to the General Assembly regarding the effect of rates for pilot FMFs due December 2014; 4) development of a State Health Plan chapter to govern planning and determination of need for FMFs; and 5) a prohibition on the establishment of new FMFs prior to July 1, 2015.

SB 723/HB 1093 "Clinically Integrated Organizations" – This bill was heard in both the Senate and the House. If passed, it would allow certain carrier incentives and information sharing, otherwise prohibited by the Insurance Article. Ms. Perry said the Commission supported this bill with amendments that were drafted by the Commission, the Maryland Insurance Administration, and other key stakeholders. She said that the Chair of the Health and Government Operations Committee requested an evaluation of this new payment reform model.

SB 314/HB 147 "Assignment of Benefit (AOB)" - This legislation was heard in both the Senate and the House. Ms. Perry said this legislation allows AOB for all PPO providers. Hospital-based physicians have no additional requirements or restrictions; on-call physicians accepting AOB would receive specified reimbursements and be prohibited from balance billing; and other providers would be required to disclose the provider's out-of-network status, an estimate of likely charges, and the patient's liability for any amounts above what the carrier pays. She noted that the bill passed the Senate with amendments.

Commissioner McLean asked about the status of HB 1468/SB1074 "Nonparticipating Providers - Disclosure of Status and Charges" bill. Ms. Perry said SB1468 was heard in the Senate and a work session was formed to discuss the possibility of rolling HB 1468 into SB 625.

Ms. Perry said the Commission will study the following mandate bills that did not pass during the 2010 legislation session: HB 478/SB 663 – mandate that would prohibit a fourth pharmacy benefit tier with higher cost sharing; and HB 626/HB 523 – mandate that would require cost sharing for oral chemotherapy to be no greater than the cost sharing for infusion chemotherapy.

ITEM 4.

ACTION: Certificate of Need – University of Maryland Medical Center (Docket No. 09-24-2300)

The University of Maryland Medical Center (UMMC) applied for a Certificate of Need to expand its trauma, critical care, surgery, and emergency medicine facilities. Susan Myers, Health Policy Analyst, presented the staff recommendation. Ms. Myers said that the new building would connect to the existing Shock Trauma and Weinberg Buildings. She said that the new construction will total 140,660 square feet and the renovation will encompass 42,870 square feet of existing space in those buildings. She also noted that the estimated cost of the project is $176,728,000 and that UMMC proposed to fund this project with $67.1 million in borrowing, $50 million in State grant funding, $35 million in gifts and requests, $13 million in federal grant funding, $6.2 million in cash, and $5.4 million in interest income. To offset the depreciation and interest expense associated with the project, UMMC anticipates requesting an increase in the rates it charges, regulated by the Health Services Cost Review Commission. Ms. Myers said the new building would house expanded critical care services and expand adult and pediatric emergency department capacity. UMMC proposed to increase its acute care bed capacity to 729 beds. Staff recommended that the Commission approve this project, with conditions. Commissioner Krumm made a motion to adopt the staff recommendation, which was seconded by Commissioner Moore and unanimously approved. Commissioner McLean recused herself from this matter.

ACTION: Certificate of Need – University of Maryland Medical Center (Docket No. 09-24-2300) is hereby APPROVED.

ITEM 5.

PRESENTATION: Health Care Spending in Maryland: How does Maryland Differ from Other States and Why?

Ben Steffen, Director of the Center for Information Services and Analysis, presented the findings of the report, which compares per capita personal health care spending in Maryland to other states. He said some important factors in the health care environment are demographic and socio-economic characteristics of residents, supply side and market characteristics, as well as policy choices. Mr. Steffen noted that the report analyzed twenty-five factors that could affect health care spending and costs in Maryland and across the nation. He noted the following key findings from the report:

- In 2004, per capital health care spending in Maryland averaged $5,590 (6% above the national average and 17th highest among the 50 states.

- The average annual growth rate for Maryland was 4.2% from 1991 to 1998, increasing to 7.2% from 1998 to 2004. The average annual rate of growth was somewhat higher in the U.S. overall, compared to Maryland in the earlier period and somewhat lower in the later period. However, more recent data shows the average annual growth rate in the U.S. has continued to decline through 2008.

- Underlying geographic variation in health care spending is different in the utilization of services and the prices paid for those services. Utilization is driven by a range of complex, interrelated factors. Health status is a major determinant which is, in turn, influenced by health behaviors, age, income, race/ethnicity, and other socio-demographic characteristics.

ITEM 6.

FINAL ACTION: COMAR 10.25.06 – Maryland Medical Care Data Base and Data Collection

Ben Steffen, Director, Center for Information Service and Analysis, presented final regulations regarding the Maryland Medical Care Data Base and Data Collection. Mr. Steffen noted that the proposed regulations were approved at the November 19, 2009 meeting of the Commission and published in the *Maryland Register*. No public comments were received. Commissioner Moore made a motion to adopt the regulations as final, which was seconded by Commissioner Krumm and unanimously approved.

ACTION: COMAR 10.25.06 – Maryland Medical Care Data Base and Data Collection – Action on Final Regulations – ADOPTED as final regulations.

ITEM 7.

Update and Policy Discussion: Small Group Market Modifications in SB 637/HB 674 of 2009

Bruce Kozlowski, Director, Center for Health Care Financing and Health Policy, provided the Commission with a brief update on small group market reform. Mr. Kozlowski reviewed reform efforts from the past few years, including the Mercer report on "Options Available to Reform the Comprehensive Standard Health Benefit Plan", which was published in December 2007. He then reviewed the provisions of SB 637/HB 674 which was enacted during the 2009 legislative session. He said SB 637 incorporates a number of policy changes to the small group market. Mr. Kozlowski said that two of those provisions, allowing pre-existing condition limitations and rating on entry over three years will be impacted by federal health care reform.

ITEM 8.

PRESENTATION: Maryland Nursing Home Family Experience of Care Survey - 2009

Carol Christmyer, Chief of Long-Term Care Quality Initiatives, presented the results of the 2009 Maryland Nursing Home Family Experience of Care Survey. Ms. Christmyer said the purpose of the nursing home surveys are to provide: (1) subjective measurement of care and quality of life for public report; (2) comparative performance information for consumers engaged in a due diligence review; (3) identification of facilities exhibiting good performance; and (4) identification of facility-specific opportunities for improvement. She discussed the survey protocols, noting that family members respond to questions for long-stay residents, but short-stay residents respond for themselves. Ms. Christmyer provided the statewide family survey results in detail. She also provided preliminary short-stay resident respondent results, as well as long-stay family respondent results. Ms. Christmyer said the family survey report and results will be posted on the Commission's website following today's meeting.

ITEM 9.

PRESENTATION: Medical Expenditure Panel Survey: Maryland Sample through 2008

Linda Bartnyska, Chief of Cost & Quality Analysis, presented this biennial report that describes key characteristics of health insurance coverage provided through Maryland private-sector employers in 2008. She said that, based on the MEPS-IC report, approximately 88% of Maryland's private sector employees worked in establishments that offered health insurance, which mirrors the national average. Ms. Bartnyska said that firms with fewer than 10 employees had an average offer rate of 49% while firms with 1,000 or more employees had an average rate of 99%. She noted that data shows that employees working for small business employers in Maryland are less likely to have affordable, employer-sponsored health insurance than employees working for larger firms. Ms. Bartnyska said from 2002 to 2008, the average premium for single coverage in PPO-type products (the most common type of coverage) offered by private employers in Maryland increased by 34%, and the average premium for family coverage increased by 52%. She said that, unlike the offer rate, the percentage of enrolled employees at establishments that offer health insurance declined in Maryland from 2005 to 2008 from 67% to 61%. She noted that this decline was due to lower enrollment rates in two industry categories: agriculture, fishing, forestry, and construction (78% to 65%); and all others (85% to 71%). Ms. Bartnyska said the MEPS-IC- Maryland Sample through 2008 report will be available on the Commission's website following today's meeting.

ITEM 10.

ADJOURNMENT

There being no further business, the meeting was adjourned at 3:35 p.m., upon motion of Commissioner Krumm, which was seconded by Commissioner Lyles, and unanimously approved.