IN THE MATTER OF	*	
	*	
THE CONVERSION OF	*	
	*	BEFORE THE
UNIVERSITY OF MARYLAND	*	
	*	MARYLAND HEALTH CARE
SHORE MEDICAL CENTER AT	*	
	*	COMMISSION
DORCHESTER TO A	*	
	*	No. _____
FREESTANDING MEDICAL FACILITY	*	
	*	

* * * * * * * * * * * * * *

NOTICE OF INTENT TO SEEK EXEMPTION
FROM CERTIFICATE OF NEED REVIEW FOR THE
CONVERSION OF UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT DORCHESTER TO A FREESTANDING MEDICAL FACILITY

Shore Health System, Inc. ("SHS"), doing business as University of Maryland Shore Medical Center at Dorchester ("UM SMC at Dorchester") and University of Maryland Shore Medical Center at Easton ("UM SMC at Easton") (collectively, the "Applicant"), by the undersigned counsel, provides notice that it is seeking approval from the Maryland Health Care Commission to convert UM SMC at Dorchester to a freestanding medical facility.

For the reasons set forth in the attached Request for Exemption, SHS respectfully requests that the Commission grant an exemption from Certificate of Need ("CON") review for the conversion of UM SMC at Dorchester to a freestanding medical facility and for associated capital expenditures.

Respectfully submitted,

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July 6, 2018

IN THE MARYLAND HEALTH CARE COMMISSION

REQUEST FOR EXEMPTION FROM CERTIFICATE OF NEED REVIEW

to
Convert University of Maryland
Shore Medical Center at Dorchester
to a Freestanding Medical Facility

Applicant
Shore Health System, Inc.
d/b/a UM Shore Medical Center at Dorchester
and UM Shore Medical Center at Easton
July 6, 2018

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BACKGROUND

University of Maryland Shore Medical Center at Dorchester ("UM SMC at Dorchester") is an acute care hospital with 18 licensed MSGA beds and 24 licensed psychiatric beds located at 300 Byrn Street, Cambridge, Maryland 21613. University of Maryland Shore Medical Center at Easton ("UM SMC at Easton") is a 104-bed licensed acute care hospital, with 79 MSGA beds, 17 obstetrics beds, and eight pediatric beds located at 219 South Washington Street, Easton, Maryland 21601. UM SMC at Dorchester is the only acute general hospital in Dorchester County and UM SMC at Easton is the only acute general hospital in Talbot County.

In 1996, UM SMC at Easton (at the time, The Memorial Hospital at Easton) merged with UM SMC at Dorchester (at the time, Dorchester General Hospital) to form Shore Health System, Inc. ("SHS"), a unified network of medical services with the combined resources of community hospitals, physicians, and outpatient centers. In 2006, SHS affiliated with the University of Maryland Medical System ("UMMS"), and, as of July 1, 2013, SHS joined with the University of Maryland Chester River Health System at Chestertown and other facilities to become University of Maryland Shore Regional Health, Inc. ("UM SRH"), a community based, not-for-profit health system. These mergers have permitted UM SRH and UMMS to continue the commitment to the rural five county mid-Eastern Shore of Maryland, with expanded and improved clinical services, programs and facilities, and physician recruitment. UM SRH is the sole corporate member of SHS. UM SRH is dedicated to maintaining and improving the health of the people in the communities it serves through an integrated health delivery system that provides the highest quality of care to all.

In addition to UM SMC at Dorchester and UM SMC at Easton, UM SRH consists of: (1) UM SMC at Chestertown is a 21-bed acute care hospital, with 20 MSGA beds and one pediatric bed located at 100 Brown Street, Chestertown, Maryland 21620; (2) The Requard Rehabilitation Center, a 20-bed inpatient acute rehabilitation hospital currently located at UM SMC at Easton; (3) UM Shore Emergency Center at Queenstown ("UM Shore EC Queenstown"), a freestanding medical facility, located at 125 Shoreway Drive, Queenstown, Maryland 21658 approximately 19 miles from UM SMC at Easton; (4) UM SRH Cancer Center and Requard Radiation Oncology Center, located in Easton approximately one mile from UM SMC at Easton; (5) The Diagnostic and Imaging Center and Clark Comprehensive Breast Center located in Easton approximately one mile from UM SMC at Easton; (6) a network of diagnostic laboratory and/or imaging facilities located in Denton, Centreville, Cambridge, and Chestertown; (7) outpatient rehabilitation centers located in Denton, Cambridge, and Easton; and (8) a regional network of employed primary care and specialty physicians and providers in all five counties of the mid-Shore region.

The existing UM SMC at Dorchester was constructed in phases between 1906 and 1960, with numerous renovations and improvements throughout the years. Although UM SRH has been committed to maintaining the facility and has undertaken capital expenditures to make infrastructure, clinical equipment, and information technology improvements, the existing physical plant has outlived its useful life. As discussed more fully herein, renovation of the facility is not cost-effective and the approximately 11 acre site on the waterfront in Cambridge is more suitable today for redevelopment benefitting the City of Cambridge and Dorchester County, and their economic development and job creation efforts. Relocation and continuation of UM SMC at Dorchester as an acute general hospital was considered but determined not to be

cost effective and is inconsistent with the direction of the State of Maryland's health care planning regarding hospital utilization.

Consistent with local and national healthcare trends and to best promote access to convenient and quality care for the population it serves, the Applicant proposes to convert UM SMC at Dorchester to a freestanding medical facility ("FMF") to be developed approximately one mile from the existing hospital to an easily accessible, highly visible site within Cambridge Marketplace, at the intersection of US Route 50 and Woods Road and opposite the City of Cambridge's Public Safety Center. The proposed project resulting from the conversion of UM SMC at Dorchester to an FMF will be referred to as the "University of Maryland Shore Medical Center at Cambridge" ("UM SMC at Cambridge"). Contemporaneous with this Request for Exemption from CON Review, the Applicants have sought a Request for Exemption to merge and consolidate certain beds and services of UM SMC at Dorchester and UM SMC at Easton by relocating 17 MSGA beds and 12 psychiatric beds from UM SMC at Dorchester to UM SMC at Easton upon opening of the new FMF building based on projected need in fiscal year 2022.

For some time, several acute general hospitals in Maryland have been exploring options to reconfigure and modernize facilities in the face of aging physical plants and declining utilization for acute inpatient admissions, while recognizing the continued need to provide high quality and effective care to the communities they serve. Through legislation enacted in 2016, Chapter 420, Acts of 2016 ("Senate Bill 707"), the General Assembly, with the urging of the Maryland Health Care Commission (the "Commission"), elected to use the FMF as the preferred facility type for the conversion of acute general hospitals by amending Maryland Code, Health-General to: (1) authorize a CON exemption process for conversion of an existing hospital to an FMF along with associated capital expenditures; and (2) authorize the Health

Services Cost Review Commission ("HSCRC") to regulate rates for outpatient services in an FMF, including observation services and ancillary services needed to support emergency and observation services. As contemplated by this enactment, acute general hospitals converting to FMFs are authorized to provide a much broader array of services in order to continue to treat patients with more complex and more acute health care needs than the three currently established Maryland FMFs, none of which converted from an acute general hospital serving a community. The existing FMFs in Maryland lack many capabilities, such as observation services, that hospitals converting to FMFs will require to continue to serve the converting hospital's community. Otherwise, hospital conversions to FMFs will leave substantial gaps in health care services needed by communities formerly served by a hospital. This is particularly true with respect to UM SMC at Dorchester, which has served the residents of Dorchester County and portions of Talbot and Caroline Counties for more than 100 years. It is the sole hospital in Dorchester County.

Pursuant to amended Health-General § 19-120 and the State Health Plan Chapter for Freestanding Medical Facilities, COMAR 10.24.19 (the "State Health Plan"), an acute general hospital may convert to an FMF if it follows certain procedures and demonstrates that: (1) the conversion is consistent with the State Health Plan; (2) the conversion will result in the delivery of more efficient and effective health care services; and (3) the conversion is in the public interest. For the reasons set forth more fully below, the proposed conversion of UM SMC at Dorchester to UM SMC at Cambridge satisfies each of these criteria. Accordingly, the Applicant requests that the Commission grant an exemption from CON review to permit conversion of UM SMC at Dorchester to an FMF and for associated capital expenditures.

I. COMPREHENSIVE PROJECT DESCRIPTION

UM SMC at Dorchester's conversion to an FMF is part of UM SRH's plan to create an optimal patient care delivery system for the future health care needs of Dorchester County residents and for residents of southern Talbot and Caroline counties, which comprise a primary service area population of 52,401. The Applicant proposes to locate the facility at Cambridge Marketplace, located just off US Highway Route 50 and Woods Road in Cambridge, approximately one mile from UM SMC at Dorchester. UM SRH and the owner of the proposed site have executed a letter of intent for purchase of the proposed site at Cambridge Marketplace and are in the process of negotiating a purchase agreement.

The services at Cambridge Marketplace will be organized on an approximately 14 acre medical campus, to be known as "UM Shore Medical Campus at Cambridge," around two main components: (1) UM SMC at Cambridge, an approximate 42,000 gross square feet FMF located with high visibility near the front of the medical campus; and (2) the UM Shore Medical Pavilion ("UM SMP at Cambridge"), a medical office building of approximately 51,000 gross square feet divided into two floors with pediatrics, obstetrics and gynecology, other medical specialists, laboratory, imaging, physical therapy, outpatient services, and a physician outpatient surgery center with one operating room and procedure rooms. While the UM SMP at Cambridge is not a component of this Certificate of Need Exemption request, the adjacent medical pavilion is important for ensuring the community's access to necessary health care services on a single, easily accessible, and integrated medical campus. Further, the land purchase and development of this new medical campus in a previously abandoned shopping center represents a highly visible community redevelopment project of significant benefit to the revitalization of Cambridge and Dorchester County.

In conjunction with the conversion of UM SMC at Dorchester to an FMF and pursuant to a separate exemption request, the Applicant is proposing to merge and consolidate a portion of the inpatient beds and services located at UM SMC at Dorchester to UM SMC at Easton, approximately 15 miles away. The Applicant proposes to relocate 17 medical/surgical/critical care beds and 12 psychiatric beds, and incorporate these beds into the existing hospital at UM SMC at Easton. Once the new FMF opens, the inpatient beds from UM SMC at Dorchester are moved to the hospital in Easton, and the existing hospital building in Cambridge has been vacated, the existing hospital building will be demolished. The waterfront site where the hospital currently sits will be made available for community redevelopment and revitalization through agreements that have been reached with the City of Cambridge and Dorchester County.

A. The New FMF Building

The proposed FMF – "UM SMC at Cambridge" – will include the following features:

1. A main public entry and reception/check-in area with four public toilets;
2. An emergency department with a total of 23 patient care rooms and related staff and support space, including:
    a. One triage area at 610 square feet;
    b. Sixteen private exam rooms at 158 square feet each;
    c. Two private bariatric exam rooms at 212 square feet each;
    d. Resuscitation/Critical Care suite with two treatment bays, each at 243 square feet;
    e. Seven patient toilets and four staff toilets;

f. A self-contained behavioral health suite with three exams rooms, all negative pressure/all-hazard rooms, at 165 square feet each and one patient toilet, and related staff and support space;

g. An intensive outpatient treatment suite for behavioral health and substance use disorder services and related staff and support space;

h. An observation suite with nine private patient rooms, each at 150 square feet, and one bariatric patient room at 200 square feet, all rooms with private toilet rooms at 35 square feet, and related staff and support space;

i. A diagnostic imaging suite including x-ray, ultrasound, and CT, with related staff and support space;

j. A modern, efficient nursing station with full view of emergency department rooms;

k. Laboratory services that will be operational 24/7/365;

l. A covered, pull-through ambulance entrance with space for at least four ambulances under cover; related exterior decontamination space, interior patient decontamination space, EMS/ambulance work room, and an emergency provider check in station for patient hand-off;

m. Pyxis medication stations, stocked and monitored under UM SRH Pharmacy Services using protocols developed and implemented at the UM Shore EC Queenstown;

n. Related general staff and support spaces, including materials management with dedicated delivery entrance, clean supply, environmental services, security,

information technology, nourishment, mechanical/electrical/plumbing, generator, and medical gas storage; and

3. Designated adjacent parking for law enforcement and EMS vehicles, as well as public parking sufficient for the capacity of the facility by local code.

As described above and in accordance with recent statutory changes allowing hospital conversions to FMFs, UM SMC at Cambridge will be different from the existing UM Shore EC Queenstown, which does not include observation beds. UM SMC at Cambridge will include a full service emergency department, open 24/7/365, with the capability of caring for patients of all ages categorized in EMS priority levels 2 through 4 as well as EMS priority level 1 patients who suffer from either an unsecured airway, are in *extremis*, or suffer from a stroke if an accredited primary or comprehensive stroke facility is greater than 15 additional minutes. UM SMC at Cambridge will have the ability to rapidly transfer those who cannot be definitively cared for at the facility via interfacility ambulance services provided by a contracted commercial vendor with defined response times, or via air transport from the FMF's onsite helipad to other hospitals and tertiary centers. UM SMC at Cambridge will maintain its MIEMSS approved EMS Base Station designation currently at UM SMC at Dorchester to provide necessary communication with EMS providers in order to direct patients to the appropriate level of service; such communications are required for all EMS priority 1 and 2 patients before arrival at a UM SRH emergency medical facility.

The Applicant anticipates maintaining nearly the same level of emergency and observation services at UM SMC at Cambridge as are currently provided at UM SMC at Dorchester, with the exception of limited non-stroke EMS priority 1 patients or patients requiring inpatient medical/surgical, psychiatric, or surgical capabilities. Patients requiring these acute

levels of service, who arrive as walk-ins or by ambulance, will be transferred from UM SMC at Cambridge to UM SMC at Easton or other acute care facilities, as needed. Patients requiring observation stays will be cared for at UM SMC at Cambridge unless its observation unit is at full capacity or the patient's condition deteriorates and warrants an acute care admission or transfer to a tertiary facility.

UM SMC at Cambridge will be staffed by Board Certified Emergency Medicine physicians and nursing staff specializing in emergency medicine, with 24 hours of emergency physician staffing and 10 hours of emergency Advanced Practice Clinicians staffing per day. Patients in the observation unit at UM SMC at Cambridge will be cared for by personnel capable of caring for this type of patient, including nursing staff capable of providing appropriate care.

Additionally, the three-bed behavioral health suite will be supported by personnel trained in caring for patients suffering from psychiatric conditions and incorporating the skilled services of the Behavioral Health Response Team ("BHRT") and the best practice of telemedicine for psychiatric consults in the emergency department. Certain specialty services that are currently provided at UM SMC at Dorchester via telemedicine in conjunction with UM SMC at Easton will continue to be accessible to patients at UM SMC at Cambridge. UM SMC at Cambridge will utilize current established clinical protocols and order sets, electronic medical records, technology, and medication administration for the full range of clinical diagnoses.

The UM SMC at Cambridge facility was designed in accordance with the Facilities Guidelines Institute, Guidelines for Design and Construction of Hospitals and Outpatient Facilities 2014 Edition ("FGI Guidelines"), the 2015 National Fire and Protection Association 101 Life Safety Code, and the 2015 International Building Code. More specifically, UM SMC at Cambridge was designed considering the FGI Guidelines Part 2 – Hospitals, Section 2.2-3

Diagnostic and Treatment Facilities, and Section 2.3 – Specific Requirements for Freestanding Emergency Departments.

The Applicant has provided project drawings, including one copy of full scale drawings, at **Exhibit 2.**

B. Project Budget, Schedule, and Bond Obligations

The total project budget for the FMF is $42,383,869, exclusive of the adjacent UM SMP at Cambridge. The proposed project, as well as the other capital projects for which the Applicant is seeking approval from the Commission, will be funded through bonds and interest income from bond proceeds. Construction of the proposed project is projected to take approximately 16 months with a proposed opening in the summer of 2021.

SHS, the owner of UM SMC at Easton and UM SMC at Dorchester, is one of 13 members of the UMMS Corporation "Obligated Group." Each of the Obligated Group Members are jointly and severally liable for the repayment of the following outstanding bond obligations: Maryland Health and Higher Educational Facilities Authority ("MHHEFA") Series 2007A Bonds, Series 2008D/E Bonds, Series 2008F Bonds, Series 2010 Bonds, Series 2013 Bonds, Series 2015 Bonds, Series 2016 A-F Bonds, Series 2017A Bonds, Series 2017B/C Bonds, Series 2017 D/E Bonds, and the MHHEFA Pooled Loan Program.

The Applicants have also completed hospital CON **Tables A** through **L**, which are attached as **Exhibit 1**. **CON Tables A**, **B**, **C**, **D**, **E**, **I**, **J**, **K,** and **L** relate to the FMF and CON **Tables F**, **G**, and **H** provide SHS's projected operations, including the proposed project and consolidation of MSGA and psychiatric beds from UM SMC at Dorchester to UM SMC at Easton**.** All assumptions underlying these tables are also provided with **Exhibit 1.**

II. THE CONVERSION OF UM SMC AT DORCHESTER TO UM SMC AT CAMBRIDGE IS CONSISTENT WITH THE STATE HEALTH PLAN, COMAR 10.24.19.

The conversion of UM SMC at Dorchester to UM SMC at Cambridge is consistent with the State Health Plan Chapter for Freestanding Medical Facilities, COMAR 10.24.19 (the "State Health Plan").

A. Location - COMAR 10.24.19.04(C)(4).

(4) The Commission shall require that a freestanding medical facility created through the conversion of a general hospital remain on the site of, or on a site adjacent to, the converting general hospital unless:

(a) The converting general hospital is the only general hospital in the jurisdiction or is one of only two general hospitals in the jurisdiction and both belong to the same merged asset system; and

(b) The site is within a five-mile radius and in the primary service area of the converting general hospital.

The State Health Plan requires that an FMF established as a result of a general hospital conversion remain on the site of, or immediately adjacent to, the converting general hospital, unless the converting hospital is the only hospital in the jurisdiction and the proposed site is within a five-mile radius and in the primary service area of the converting general hospital. (COMAR 10.24.19.04(C)(4)). SHS proposes to locate UM SMC at Cambridge approximately one mile away from the converting hospital at the Cambridge Marketplace at the intersection of US Route 50 and Woods Road in Cambridge. The proposed site is within UM SMC at Dorchester's primary service area.

B. UM SMC at Easton's Compliance With COMAR 10.24.10.04(A) – COMAR 10.24.19.04(C)(5)

(5) The parent hospital shall demonstrate compliance with applicable general standards in COMAR 10.24.10.04A.

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF shall demonstrate compliance with applicable general standards in COMAR 10.24.1.0.04A. (*See* COMAR 10.24.19.04(C)(5)). SHS complies with each of these standards.

1. Information Regarding Charges.

> Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:
>
> (a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;
>
> (b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and
>
> (c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

SHS's policy, implemented at both UM SMC at Dorchester and UM SMC at Easton, relating to transparency in health care pricing complies with this standard and is attached as **Exhibit 3**. This policy will be extended to UM SMC at Cambridge when it opens. The most recent list of representative charges for inpatient and outpatient services is attached as **Exhibit 4** and can also be found on UM SRH's website at the following link: https://www.umms.org/shore/patients-visitors/for-patients/billing-insurance.

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. COMAR 10.24.10 10
>
> (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.

(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.

SHS's financial assistance policy, implemented at both UM SMC at Easton and UM SMC at Dorchester, complies with this standard and is attached as **Exhibit 5**. This policy will be implemented at UM SMC at Cambridge when it opens. The policy states that UM SMC at Easton and UM SMC at Dorchester will make a determination of probable eligibility within two (2) business days following a patient's request for charity care services, application for medical assistance, or both. (*See* **Exhibit 5**, p. 5).

Notices regarding the availability of financial assistance are posted in the admissions offices, the business offices, and emergency departments of the two hospitals, and notice of financial assistance is provided at admission or preadmission to each person who seeks services in the hospitals. A copy of that notice is attached as **Exhibit 6**. An annual notice regarding UM SRH's financial assistance policy is also published in the *Star Democrat, Bay Times, Times Record, Kent County News, Dorchester Star, and Record Observer*. Copies of recent newspaper notices are attached as **Exhibit 7**.

As shown in Table 1 below, neither UM SMC at Easton nor UM SMC at Dorchester are in the bottom quartile in terms of percentage of charity care to total operating expense for acute general hospitals in the State of Maryland.

Table 1
HSCRC Community Benefit Report, Data Excerpts
FY2017

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	%	
Holy Cross Hospital	$413,796,889	$31,396,990	7.59%	1st Quartile
Garrett County Hospital	$46,818,203	$2,792,419	5.96%	
St. Agnes	$433,986,000	$21,573,282	4.97%	
Doctors Community	$193,854,072	$6,756,740	3.49%	
Adventist Washington Adventist*	$219,120,045	$7,442,497	3.40%	
Western Maryland Health System	$322,835,314	$10,385,555	3.22%	
UM Prince Georges Hospital Center	$286,955,092	$9,166,191	3.19%	
Mercy Medical Center	$464,031,500	$14,411,600	3.11%	
Holy Cross Germantown	$97,124,985	$2,819,650	2.90%	
Johns Hopkins Bayview Medical Center	$613,834,000	$16,951,000	2.76%	
UM Laurel Regional Hospital	$93,884,647	$2,521,365	2.69%	
UM Midtown	$204,226,000	$5,174,000	2.53%	
Frederick Memorial	$350,118,000	$8,081,000	2.31%	2nd Quartile
UM Harford Memorial	$84,926,000	$1,927,000	2.27%	
Atlantic General	$117,342,233	$2,569,517	2.19%	
Ft. Washington	$42,883,433	$928,769	2.17%	
UM Baltimore Washington	$334,210,000	$6,703,000	2.01%	
Calvert Hospital	$135,047,535	$2,694,783	2.00%	
Peninsula Regional	$432,141,737	$8,301,400	1.92%	
McCready	$16,564,839	$307,205	1.85%	
UM St. Joseph	$341,335,000	$6,105,000	1.79%	
UM SMC at Dorchester	$42,909,000	$647,362	1.51%	
MedStar Harbor Hospital	$187,002,302	$2,816,043	1.51%	
Meritus Medical Center	$309,163,913	$4,596,841	1.49%	3rd Quartile
UM SMC at Easton	$190,646,000	$2,786,102	1.46%	
MedStar St. Mary's Hospital	$168,757,516	$2,458,649	1.46%	
MedStar Good Samaritan	$282,735,786	$4,078,427	1.44%	
UMMC	$1,470,095,000	$20,308,000	1.38%	
Howard County Hospital	$260,413,000	$3,368,222	1.29%	
UM Charles Regional Medical Center	$117,918,178	$1,474,409	1.25%	
MedStar Southern Maryland	$243,629,886	$3,014,042	1.24%	
Lifebridge Northwest Hospital	$240,547,439	$2,734,207	1.14%	
Shady Grove*	$323,661,835	$3,646,551	1.13%	
Suburban Hospital	$283,346,000	$3,168,000	1.12%	

UM Upper Chesapeake	$284,219,000	$3,014,000	1.06%	
MedStar Franklin Square	$508,539,888	$5,147,814	1.01%	4th Quartile
MedStar Union Memorial	$443,482,532	$4,426,976	1.00%	
Johns Hopkins Hospital	$2,307,202,000	$21,697,000	0.94%	
Union Hospital of Cecil County	$157,260,383	$1,411,673	0.90%	
LifeBridge Sinai	$727,868,000	$6,526,756	0.90%	
MedStar Montgomery General	$160,725,287	$1,322,823	0.82%	
UM SMC at Chestertown	$46,048,000	$373,000	0.81%	
Anne Arundel Medical Center	$561,392,000	$4,450,854	0.79%	
Bon Secours	$113,068,120	$675,245	0.60%	
GBMC	$419,396,862	$2,085,315	0.50%	
Carroll Hospital Center	$197,802,000	$790,716	0.40%	
All Hospitals	**$15,292,865,451**	**$276,027,989**	**1.80%**	
Excluded:				
Levindale	$73,760,005	$1,341,932	1.82%	
UM Rehabilitation and Ortho Institute	$107,006,000	$2,271,000	2.12%	
Adventist Rehab of Maryland*	$43,589,181	$502,712	1.15%	
Sheppard Pratt	$221,570,405	$5,473,873	2.47%	
Adventist Behavioral Health Rockville*	$40,204,927	$1,451,432	3.61%	
Mt. Washington Pediatrics	$55,412,291	$382,465	0.69%	
* The Adventist Hospital System has requested and received permission to report their Community Benefit activities on a CY Basis. This allows them to more accurately reflect their true activities during the Community Benefit Cycle. The numbers listed in the FY 2017 Amount in Rates for Charity Care, DME, and NSPI Column as well as the Medicaid Deficit Assessments from the Inventory spreadsheets reflect the Commission's activities for FY17 and therefore will be different from the numbers reported by the Adventist Hospitals.				

Source: http://www.hscrc.state.md.us/Documents/HSCRC_Initiatives/CommunityBenefits/CBR-FY17/FiscalYear17HCBFinancialReport20180501.xlsx

Accessed June 5, 2018.

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; COMAR 10.24.10 11

(ii) Accredited by the Joint Commission; and

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

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

UM SMC at Easton and UM SMC at Dorchester are licensed by the State of Maryland and accredited by The Joint Commission. Their licenses and accreditation certificates are attached collectively as **Exhibit 8**. They are also in compliance with the Conditions of Participation of the Medicare and Medicaid programs. UM SMC at Cambridge, as a provider-based department of UM SMC at Easton under 42 C.F.R. § 413.65 and Health-General § 19-3A-01(3), will comply with requirements issued by the Maryland Department of Health for licensure as an FMF, be accredited by the Joint Commission, and will comply with all conditions of participation in the Medicare and Medicaid programs.

The Commission has recognized that "subpart (b) of [COMAR 10.24.10.04(A)(3)] is essentially obsolete in that it requires an improvement plan for any measure that falls within the bottom quartile of all hospitals' reported performance on that measure as reported in the most recent Maryland [Hospital Evaluation Performance Guide], which has been reengineered with a different focus, and no longer compiles percentile standings." (*In re Dimensions Health Corporation*, Docket No. 13-16-2351, Decision at 19 (Sept. 30, 2016)).

UM SMC at Cambridge will be a provider-based department of UM SMC at Easton. UM SMC at Easton scored "better than average" or "average" on 49 of the 72 quality measures. For an additional 13 quality measures, UM SMC at Easton did not have sufficient data to report. UM SMC at Easton scored "below average" on 10 quality measures. **Exhibit 9** identifies those quality measures for which UM SMC at Easton scored "below average" along with its corrective action plans for these measures.

C. Licensure – COMAR 10.24.19.04(C)(6)

(6) The applicants shall document that the proposed FMF will meet licensure standards established by DHMH.

The State Health Plan Chapter requires that applicants demonstrate that the proposed FMF will meet licensure standards established by the Department of Health. UM SMC at Cambridge will meet or exceed licensure standards established by the Department of Health.

D. Financial Assistance and Charity Care – COMAR 10.24.19.04(C)(7)

(7) The applicants shall establish and maintain financial assistance and charity care policies at the proposed freestanding medical facility that match the parent hospital's policies and that are in compliance with COMAR 10.24.10.

The State Health Plan requires that applicants seeking to establish an FMF through conversion of an acute general hospital establish and maintain financial assistance and charity care policies at the proposed FMF that match the parent hospital's policies and that comply with COMAR 10.24.10. Submitted as **Exhibit 5** is UM SRH's financial assistance policy currently in effect at both UM SMC at Easton and UM SMC at Dorchester, which complies with COMAR 10.24.10. This same policy will be implemented at UM SMC at Cambridge.

E. Emergency Department Visits in UM SMC - Dorchester's Service Area for the Last Five Years – COMAR 10.24.19.04(C)(8)(a)

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

(a) Provide the number of emergency department visits and FMF visits by residents in the converting hospital's service area for at least the most recent five years;

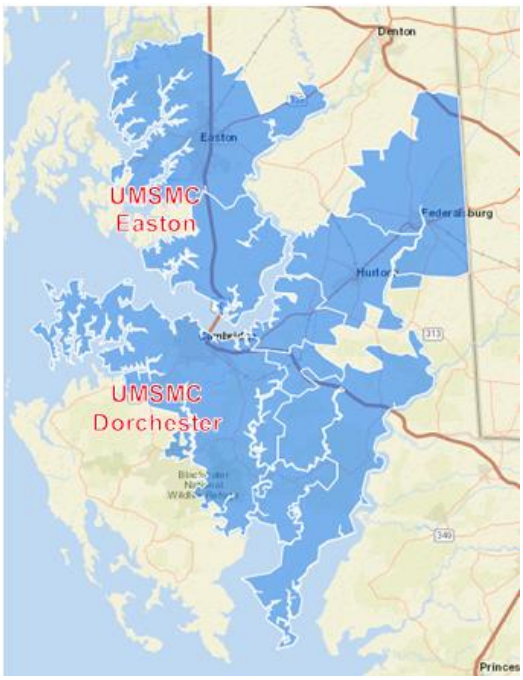
The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF provide the number of emergency department visits and FMF visits by residents in the converting hospital's service area for at least the most recent five years.

1. Definition of UM SMC at Cambridge Service Area

In fiscal year 2017, 85% of UM SMC at Dorchester's emergency department visits came from residents of eight (8) Zip Codes in Dorchester, Caroline, and Talbot Counties (*i.e.*, UM SMC at Dorchester's ED Service Area and UM SMC at Cambridge Service Area) as listed and depicted in Table 2 below.

Table 2
UM SMC at Dorchester Emergency Department Service Area
FY 2017

ZipCode	City
21613	Cambridge, MD
21643	Hurlock, MD
21631	East New Market, MD
21632	Federalsburg, MD
21835	Linkwood, MD
21601	Easton, MD
21869	Vienna, MD
21673	Trappe, MD



2. Historical Emergency Department Utilization in Service Area

In fiscal year 2017, residents of the UM SMC at Dorchester ED Service Area made 36,920 visits to Maryland hospital emergency departments. As shown in Table 3 below, of these 36,920 emergency department visits, 45.0% were to UM SMC at Dorchester, 45.5% were to UM SMC at Easton, and 3.4% were to Peninsula Regional Medical Center.

Table 3
UM SMC at Dorchester ED Service Area Visits
FY2013 – FY2017

Hospital	Historical ED Service Area Visits 2013	2014	2015	2016	2017	2017 % of Total	2013-2017 % Change
UM SMC at Easton	19,276	18,458	18,627	18,567	16,815	45.5%	-12.8%
UM SMC at Dorchester	18,494	17,234	18,111	17,396	16,596	45.0%	-10.3%
PRMC	1,195	1,220	1,335	1,351	1,253	3.4%	4.9%
Hospitals with <1000 visits	1,942	2,032	2,121	2,073	2,256	6.1%	16.2%
Total Service Area ED visits	40,907	38,944	40,194	39,387	36,920	100.0%	-9.7%

Source: St. Paul statewide non-confidential utilization data tapes

Utilization of all hospital emergency departments by residents of this service area declined 9.7% between fiscal years 2013 and 2017, with utilization of the emergency department at UM SMC at Dorchester decreasing by 10.3%. UM SMC at Dorchester ED had a total of 16,596 ED visits in FY 2017 from residents of its service area. The establishment of UM SMC at Cambridge is critical to ensure that access to emergency services for this service area population continues. Other area hospitals, especially UM SMC at Easton, would be overwhelmed if UM SMC at Cambridge were not developed to the proposed size and with the proposed capabilities to meet the needs of the service area population. Further, UM SMC at Easton could not accommodate a significant increase in emergency visits upon conversion of UM SMC at Dorchester to the UM SMC at Cambridge without UM SMC at Easton's own major capital improvements to its emergency department.

F. Availability and Accessibility of Emergent, Urgent, and Primary Care – COMAR 10.24.19(C)(8)(b)

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

* * * *

(b) Assess the availability and accessibility of emergent, urgent, and primary care services otherwise available to the population to be served, including information on the number and location of other hospital emergency

> departments, FMFs, and urgent care centers in the service area of the converting hospital or within five miles of any zip code area in the service area of the converting hospital.

The State Health Plan requires that that applicants seeking to convert an acute general hospital to an FMF assess the availability and accessibility of emergent, urgent, and primary care services otherwise available to the population to be served, including information on the number and location of other hospital emergency departments, FMFs, and urgent care centers in the service area of the converting hospital or within five miles of any Zip Code in the service area of the converting hospital.

UM SMC at Easton is located approximately 15 miles from UM SMC at Cambridge and within UM SMC at Cambridge's Service Area. The next closest acute general hospitals to UM SMC at Cambridge using public roadways are: Peninsula Regional Medical Center – 31.3 miles, Nanticoke Memorial Hospital – 27.4 miles, and Atlantic General Hospital – 53.8 miles. Also, UM Shore EC at Queenstown, an FMF, is located 35.4 miles from UM SMC at Cambridge.

Within UM SMC at Cambridge's Service Area, the Applicant has identified four urgent care centers and their proximity to UM SMC at Cambridge by public roadway travel as set forth in Table 4. Despite the presence of these urgent care centers, emergency department visits at UM SMC at Dorchester and other area hospitals have not declined sufficiently to permit the closure of emergency services in UM SMC at Cambridge's Service Area. Furthermore, the limited hours of operation of these urgent care centers does not provide an alternative for patients experiencing emergency medical conditions during after-hours. The development of UM SMC at Cambridge with the proposed level of emergency treatment spaces, observation beds, and ancillary equipment is critical to ensure continued access to emergency and observation services for the service area population. Because UM SMC at Cambridge is in a rural area where patients

have few alternatives for accessing emergency services, ensuring it is sized appropriately to handle the projected volumes from its service area is essential to ensure that the next closest facility, UM SMC at Easton's ED, does not become overwhelmed by increased patient volume due to the conversion.

Table 4
Urgent Care Centers in UM SMC at Cambridge's Service Area

Urgent Care Center	Address	Hours of Operations	Distance to UM SMC at Cambridge
Your Doc's In	300 Sunburst Highway Cambridge, MD 21613	8am-8pm Monday-Friday 8am-6pm Weekends	0.8 miles
Your Doc's In	8163 Ocean Gateway Easton, MD 21601	8am-8pm Monday-Friday 8am-6pm Weekends	16.4 miles
Choice One Urgent Care	28522C Marlboro Avenue Easton, MD 21601	8am-8pm Monday-Sunday	16.9 miles
Choice One Urgent Care	8 Denton Plaza Denton, MD 21629	8am-8pm Monday-Sunday	31.1 miles

G. The Proposed Conversion of UM SMC at Dorchester to an FMF is Consistent UM SRH's Community Health Needs Assessment – COMAR 10.24.19.04(C)(8)(c).

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

* * * *

(c) Demonstrate that the proposed conversion is consistent with the converting hospital's most recent community health needs assessment;

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF demonstrate that the proposed conversion is consistent with the converting hospital's most recent community health needs assessment. UM SRH completed the most recent Community Health Needs Assessment in 2016. A copy of the Community Health Needs

Assessment is provided as **Exhibit 10**. The Community Health Needs Assessment findings revolved around the following areas of focus: 1) Chronic Disease Management; 2) Behavioral Health; 3) Access to care; 4) Cancer; and 5) Outreach and Education.

UM SRH promotes and supports optimal health in the community through population health initiatives and programs which will be supported by UM SMC at Cambridge. UM SRH's goal is to transform its care delivery model from a focus on inpatient care, to a focus on building healthy communities through enhancing outpatient services, coordination with existing community health providers, and coordination and management of chronic conditions for patients with complex care needs.

UM SRH provides post-discharge support for patients with complex, chronic health conditions. Transitional Nurse Navigators ("TNNs") assist these patients in achieving a successful transition from inpatient care to their home or community setting. The program is initially focused on patients with some of the top diagnoses for readmissions: heart failure, chronic obstructive pulmonary disease, and pneumonia patients. Prior to and after discharge, eligible patients receive consultations and post discharge phone calls to facilitate follow-up care, assistance with scheduling physician visits, and coordination of care with post-acute and community agencies. Care coordination, including the services of TNNs, will be provided to patients of UM SMC at Cambridge.

Beyond the TNN program, UM SRH provides medication reconciliation and compliance education to patients and will provide these services at UM SMC at Cambridge. The pharmacist conducts a chart review to determine changes and discrepancies in medication regimen and provides follow-up engagement with patients to ensure greater clarity in physician–patient communication.

The 2016 Community Health Needs Assessment also identified a need for additional behavioral health services. UM SRH established the Behavioral Health Bridge Clinic (the "Bridge Clinic") in October 2015 to improve access to urgent community psychiatric care. The Bridge Clinic currently serves patients discharged from UM SMC at Dorchester's behavioral health inpatient unit who are unable to access psychiatric care in the community due to a shortage of psychiatric providers. The scope of behavioral health services planned for the UM SMC at Cambridge campus is intended to strongly support and provide added services to meet the well-recognized need within the community for comprehensive mental health services. The Bridge Clinic will continue to serve patients of the UM SMC at Cambridge Service Area. In addition, UM SMC at Cambridge has been designed to include a dedicated behavioral health suite with three secure behavioral health treatment spaces and intensive outpatient behavioral health services in order to fulfill the need for these services.

Strategic deployment of technology is also critical to optimizing patients' health in the region. UM SRH has successfully implemented a telemedicine program providing acute behavioral health assessment, palliative care consults, pediatric emergency medicine, wound and ostomy care consults, emergency department to emergency department consults, and intends to expand its telemedicine offerings in the future. UM SRH's Behavioral Health Response Team ("BHRT"), comprised of specially trained counselors, social workers, and psychiatrists responds to requests from the three UM SRH hospital emergency departments and UM Shore EC at Queenstown to provide assessment of patients with behavioral health needs. UM SMC at Cambridge will provide emergency psychiatric evaluation and stabilization. The facility will have three secure behavioral health treatment spaces. Additionally, telemedicine and intensive outpatient behavioral health services, effective alternatives and/or extensions of inpatient care

will be provided. Outpatient addictions treatment and follow-up for long acting psychiatric medications are also envisioned. Patients who need inpatient behavioral health services will, if appropriate to the patient's needs and consistent with the patient's preferences, be transferred to the UM SMC at Easton inpatient behavioral health unit, which will have sufficient capacity to handle appropriate behavioral health patients transferred from the UM SMC at Cambridge.

UM SRH also has an extensive partnership with CRISP to benefit the communities it serves. CRISP-hosted care management documentation allows all providers with the appropriate patient relationship the ability to view patient interactions that occur between office visits. This system also helps different stakeholders understand what other providers are engaged with the patient to avoid duplication of services. County Health Departments have begun using this system as well, enabling CRISP to become the closest version of a personal health record for patients since it is not confined to a hospital or ambulatory electronic medical record. The Applicant intends to extend its collaborative efforts with CRISP to UM SMC at Cambridge.

UM SRH also offers support groups, classes, and screenings to help people identify and manage a variety of health conditions, including diabetes, cancer, stroke recovery, addiction, and mental illness. UM SRH will also make administrative and conference room space available on the Cambridge Marketplace campus for education and outreach efforts.

The previously outlined population health strategies represent a significant investment by UM SRH to not only meet the needs of individuals in the community with chronic conditions but also to improve access to care and coordination of care as one of many vital strategies. Additionally, as previously mentioned, UM SRH is planning to build a medical office building at Cambridge Marketplace adjacent to UM SMC at Cambridge that will house physician practices

and various outpatient services in order to provide access to additional providers for residents of UM SMC at Cambridge's Service Area.

H. Number and Size of Emergency Treatment Spaces – COMAR 10.24.19.04(C)(8)(d)

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

*** * * ***

(d) Demonstrate that the number of treatment spaces and the size of the FMF proposed by the applicant are consistent with the applicable guidance included in the most current edition of Emergency Department Design: A Practical Guide to Planning for the Future, published by the American College of Emergency Physicians, based on reasonably projected levels of visit volume.

(i) Demonstrate that the proposed number of treatment spaces is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of treatment spaces.

(ii) Demonstrate that the building gross square footage is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for additional building gross square footage.

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF demonstrate the proposed number and size of emergency treatment spaces and the size of the FMF proposed by the applicant are consistent with applicable guidance included in the most current edition of the *Emergency Department Design: A Practical Guide to Planning for the Future*, published by the American College of Emergency Physicians (the "ACEP Guide"), based on reasonably projected visit volume. Further, the State Health Plan requires that an applicant demonstrate that the proposed number of treatment spaces is consistent with the low range guidance in the ACEP Guide, *unless*, based on the particular characteristics of

the population to be served, the applicant demonstrates the need for a greater number of treatment spaces. Finally, the State Health Plan requires that an applicant demonstrate that the building gross square footage is consistent with the low range guidance, *unless*, based on the particular characteristics of the population to be served, the applicant demonstrates the need for additional building gross square footage.

1. The Number and Size of UM SMC at Cambridge's Emergency Department Treatment Spaces is Consistent with an Average of the ACEP High and Low Range Guidelines.

As presented in Table 3 above and Table 5 below, emergency department visits to UM SMC at Dorchester from its service area zip codes declined by 10.3% between fiscal years 2013 and 2017. Emergency department visits from outside of UM SMC at Dorchester's ED Service Area also declined by 7.9% between 2013 and 2017, as shown in Table 5 below.

Table 5
UM SMC at Dorchester Historical Emergency Department Visits
FY2013 – FY2017

	Emergency Department Visits to UM SMC at Dorchester					
Service Area	FY2013	FY2014	FY2015	FY2016	FY2017	FY13-FY17 % Change
Inpatient	1,699	1,555	1,783	1,603	1,654	*-2.6%*
Outpatient	16,795	15,679	16,328	15,793	14,942	*-11.0%*
Subtotal Svc Area	18,494	17,234	18,111	17,396	16,596	*-10.3%*
Outside Svc Area	3,071	2,928	3,035	3,135	2,827	*-7.9%*
Total	21,565	20,162	21,146	20,531	19,423	*-9.9%*

Source: St. Paul statewide non-confidential utilization data tapes

Using 2017 as the base year and driven by population growth of 0.2% a year, the applicants project that the UM SMC at Cambridge will experience 19,640 emergency department visits by fiscal year 2024 (*see* Table 6).

Table 6
Historical and Projected Emergency Department Visits
FY2015 – FY2024

	Historical			Projected at Dorchester				Projected at FMF			% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Emergency Department Visits											
Inpatient Visits	2,138	1,972	2,011	2,014	2,017	2,021	2,024	2,027	2,030	2,033	1.1%
Outpatient Visits	19,008	18,559	17,412	17,440	17,467	17,495	17,523	17,551	17,579	17,607	1.1%
Total	**21,146**	**20,531**	**19,423**	**19,454**	**19,485**	**19,516**	**19,547**	19,578	19,609	19,640	1.1%
%Change		*-2.9%*	*-5.4%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	

In addressing the number of emergency department treatment spaces that are needed to care for the emergency department patients and its consistency with ACEP guidance, it should be noted that the ACEP Guide categorizes emergency department designs into low, mid, and high range using 16 factors. The Guide indicates, though, that these low, mid, and high ranges are "general guideline[s]" used to set "preliminary benchmarks for sizing emergency departments," which can be adjusted for "each unique emergency department project" and that the size parameters are merely "estimates." (*Id*. at 109, 116-117).

It is anticipated that the emergency department at the FMF will operate similar to the emergency department currently at UM SMC at Dorchester and that the type of patients and services provided will be the same. As such, an analysis of the emergency department utilization at UM SMC at Dorchester is used to compare the future FMF to the ACEP guidelines.

As presented in Table 7, nine or 56% of the sixteen factors fall in the "mid-range". These mid-range factors include: (a) 13.8% of patients will be expected to be admitted to a hospital; (b) the average length of stay of patients in the emergency department is 3.0 hours;

(c) turnaround time for diagnostic testing is approximately 60 minutes; (d) 5.3% of the patients have behavioral health diagnoses; (e) 25% of patients are non-urgent; (f) 17.4% of patients are expected to be older than 65; (g) general imaging services will be provided within the emergency department; (h) there will be limited family amenities; and (i) the FMF will provide moderate administrative and teaching space (*see* Table 7).

Table 7
UM SMC at Dorchester Comparison to ACEP Guide

	ED Visits per Bed Range			Proposed
Factor	**Low**	**Medium**	**High**	**FMF**
% Admitted Patients	< 8%	12-20%	> 25%	Mid (13.8%)
ALOS	<2.25 Hours	2.5-3.75 Hours	>4 Hours	Mid (3.01)
Private Rooms	Few	Majority	All	High (All)
Inner Waiting and Result Waiting Areas	Available	Limited	Pts. Stay in Bay	High (Patients stay)
Location of Observation Beds	Outside ED	Limited	Inside ED	Low (Outside ED)
Boarding of Admitted Pts.	Stay < 60 Min	Stay 90-120 Min	Stay Over 150 Min.	Low (Stay < 60 Min)
Turnaround Time Dx Tests	< 45 Minutes	60 Minutes	> 90 Minutes	Mid (60 Minutes)
% Behavioral Health Patients	< 3%	4-6%	>7	Mid (5.3%)
% Nonurgent Pts.	>45%	25-45%	<25%	Mid (25-45%)
Age of Patient	<10% Age 65+	10-20% Age 65+	>20% Age 65+	Mid (17.4%)
Imaging w/n ED	No	General and CT	Extensive	Mid (General and CT)
Family Amenities	None	Limited Consult	Multiple Consult, Grieving	Mid (Limited Consult)
Specialty Components: Geriatrics	None	Designated Area	Module with Support	Low (None)
Specialty Components: Pediatrics	None	Designated Area	Module with Support	Low (None)
Specialty Components: Detention	None	Designated Area	Module with Support	Low (None)
Admin/Teaching Space	Minimal	Moderate	Extensive	Mid (Moderate)

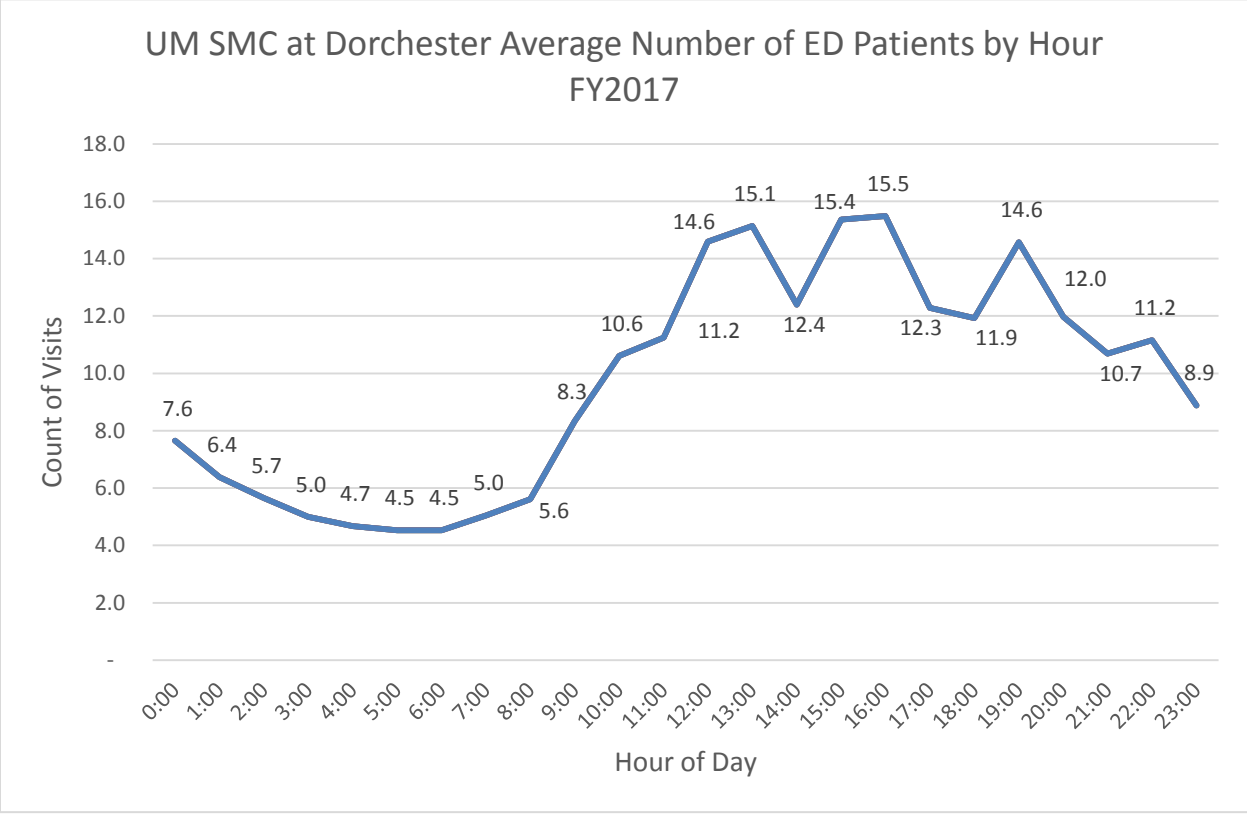
Source: Factors = Emergency Department Design: A Practical Guide to Planning for the Future, published by the American College of Emergency Physicians
Proposed FMF = LRH managemet reports and input by LRH Department of Emergency Medicine Medical Director

Two factors fall in the "high range" including: (a) the FMF will have all private rooms; and (b) patients will stay in their treatment bays while waiting. Only five factors fall in the "low range." As such, the Applicant expects that the FMF will fall in the mid-range based on the ACEP Guide criteria.

The applicable edition of the ACEP Guide (2d. ed. 2014), Figure 5.1 estimates treatment space need per emergency department visits in five thousand visit increments, starting at 10,000 visits per year. (ACEP Guide, p. 116). Using the ACEP Guide is problematic, though, in that it

addresses only the *average* number of patients in the emergency department in a year to determine the number of emergency department treatment spaces. The ACEP Guide does not address surge issues or account for the peak number of patients in an emergency department, each of which will require a treatment space. In fiscal year 2017, there was an average hourly census of 9.7 patients in the UM SMC at Dorchester emergency department. However, UM SMC at Dorchester experienced a peak census of 15.5 patients in the emergency department in the same year (Table 8).

Table 8
UM SMC at Dorchester
Average Number of ED Patients by Hour
FY 2017



The peak utilization represents a 59% increase over the average hourly number of patients. Sizing to address UM SMC at Dorchester's peak volume, therefore, requires a 59% add-on to the projected emergency department visits before applying the ACEP guidelines of treatment spaces per number of emergency department visits.

In the ACEP Guide, Figure 5.1, UM SMC at Dorchester's peak emergency department visit projections fall within the ACEP grouping of 30,000 annual visits. The ACEP Guide "low range" projects a need for 21 treatment spaces with this number of annual visits. The "high range" projects a need for 25 treatment spaces. As UM SMC at Dorchester considers the characteristics of its current emergency department and the future FMF to be in the "mid-range" of the ACEP Guide criteria, UM SMC at Dorchester calculates the average of the "low range' and 'high range' treatment spaces which results in an expected need for 23 emergency department treatment spaces in the new FMF facility (Table 9).

Table 9
Projected Need for Emergency Department Treatment Spaces

	Historical		Projected at Dorchester				Projected at FMF		
	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Dorchester ED Visits	**20,531**	**19,423**	**19,454**	**19,485**	**19,516**	**19,547**	**19,578**	**19,609**	**19,640**
% Change		*-5.4%*	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Average ED Patients		9.7							
Peak ED Patients		15.5							
Adjustment for Peak Period		159%							
Annualized Peak Period Visits		**30,894**	**30,943**	**30,992**	**31,041**	**31,091**	**31,140**	**31,190**	**31,239**
ACEP Visits per Bed[(1)]									
High Bed Need	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Low Bed Need	1,429	1,429	1,429	1,429	1,429	1,429	1,429	1,429	1,429
Average	1,315	1,315	1,315	1,315	1,315	1,315	1,315	1,315	1,315
ED Bed Need									
Based on Peak Visits		**23.5**	**23.5**	**23.6**	**23.6**	**23.7**	**23.7**	**23.7**	**23.8**
Requested Beds							**23**	**23**	**23**

Note (1): Reflects American College of Emergency Physicians guidelines for 30,000 ED visits.

Source for ED visit data: St. Paul statewide non-confidential utilization data tapes.

Of these 23 treatment spaces, UM SMC at Dorchester plans to dedicate three of them for patients with behavioral health diagnoses or a need for isolation. In fiscal year 2017, 1,036 or 5.3% of UM SMC at Dorchester emergency department visits were diagnosed with a behavioral health condition. With population growth, UM SMC at Dorchester is projected to have 1,048 behavioral health emergency department visits by fiscal year 2024. The challenge with using the ACEP Guide to size the number of behavioral health treatments spaces for less than 10,000 visits is that the guidelines suggest a range of 909 to 1,250 visits per treatment space. This utilization reflects 2.5 to 3.4 patients per treatment space per day with average lengths of stay between 7.0 to 9.6 hours. In fiscal year 2017, UM SMC at Dorchester's behavioral health emergency department patients experienced a peak average length of stay of 12.6 hours. With an average length of stay of 12.6 hours per visit, there is an expected average daily census of 1.5 patients with behavioral health diagnosis. Combined with a need for an isolation bed, there is need for three dedicated treatment spaces for these types of patients.

Presented in the ACEP Guide, Figure 5.1 sets forth estimates for departmental gross square feet. Based on these guidelines, the expected size of these treatment spaces will be approximately 838 square feet per treatment space which is an average of ACEP's "low range" guide of 800 square feet and "high range" guide of 875 square feet. With 23 treatment spaces in the UM SMC at Cambridge, the ACEP guide provides for 19,274 departmental gross square feet. With a 1.25 multiplier for building gross square feet, the ACEP guide for 23 treatment spaces equals 24,092 square feet. The proposed project is within the ACEP Guide's "low range" and "high range" guidelines as it proposes 23 emergency department treatment spaces, all housed within 18,673 departmental gross square feet.

I. The Number and Size of UM SMC at Cambridge's Observation Treatment Spaces is Consistent with the Population to be Served – COMAR 10.24.19.04(C)(8)(e).

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

*** * * ***

(e) Demonstrate that the proposed number and size of observation spaces for the FMF are consistent with applicable guidance included in the most current edition of *Emergency Department Design: A Practical Guide to Planning for the Future,* published by the American College of Emergency Physicians, based on reasonably projected levels of visit volume and average patient time in observation spaces.

(i) Demonstrate that the FMF will achieve at least 1,100 visits per year per observation space, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of observation spaces; 10.24.19

(ii) Demonstrate that the size of each observation space does not exceed 140 square feet, exclusive of any toilet or bathing area incorporated into an individual observation space, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for larger observation spaces.

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF demonstrate the proposed number and size of observation spaces is consistent with applicable guidance included in the most current edition of the ACEP Guide, based on reasonably projected levels of visit volumes. The ACEP Guide does not provide a projection regarding need for the number of treatment spaces. Instead, the ACEP Guide contains the following guidance from its author:

> [G]enerally program[s] [clinical decision unit or observation] spaces in the range of 900 to 1,100 patients per space annually. Use the lower number if your patients use the [clinical decision unit] for 12+ hours, and use the higher number if your patients use the space for 8 to 12 hours.

(ACEP Guide, p. 273). The State Health Plan also states that applicants must demonstrate that the FMF will achieve 1,100 visits per year per observation space, *unless*, based on the particular characteristics of the population to be served, the applicants demonstrate the need for a greater number of observation spaces. (COMAR 10.24.19.04(C)(8)(e)(i)).

1. The Number of UM SMC at Cambridge's Observation Spaces is Based on the Particular Characteristics of the Population to be Served.

As presented in Table 10 below, between fiscal years 2015 and 2017, observation cases at UM SMC at Dorchester increased by 22.2%. In fiscal year 2017, these patients stayed for an average of 47.1 hours or approximately 2.0 days.

Table 10
UM SMC at Dorchester Historical Observation Cases and Hours
FY2015 – FY2017

	Historical			% Change
	FY2015	FY2016	FY2017	FY15-FY17
Observation Cases	603	597	737	*22.2%*
Observation Hours	22,826	23,221	34,696	*52.0%*
Observation Hours per Case	37.9	38.9	47.1	*24.4%*
Observation Days per Case	*1.6*	*1.6*	*2.0*	*24.4%*

The Applicant projects the need for observation treatment spaces at UM SMC at Cambridge will grow with the projected increase in emergency department visits, which is expected to grow 0.2% a year with population growth. The cumulative growth between FY 2017 and FY 2024 is 1.1%. (See Table 11).

Table 11
Historical and Projected Observation Cases
FY2015 – FY2024

	Historical			Projected at Dorchester				Projected at FMF			% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Observation Cases	**603**	**597**	**737**	**738**	**739**	**741**	**742**	**743**	**744**	**745**	*1.1%*
%Change		*-1.0%*	*23.5%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	

After averaging 37.4 hours per observation case in the prior four years, the average length of stay for observation cases at UM SMC at Dorchester increased to 47.1 hours per case in fiscal year 2017. Averaging the average hours per observation case in fiscal years 2016 and 2017, the Applicant projects an average of 43.0 hours per observation case for the projection period. The resulting ALOS projected for observation patients at UM SMC at Cambridge is 1.79 days.

For observation patients projected to stay an average of 43 hours at UM SMC at Cambridge, it is unreasonable to apply the ACEP Guide recommendation of 1,100 visits per observation space – which equals three visits per observation bed per day or approximately eight hours per visit – to project the need for observation spaces, particularly when historical data and observation use rates are known and projections of observation use at UM SMC at Cambridge can be reasonably projected.[1] To this end, the projected average length of stay for observation cases at UM SMC at Cambridge is 5.4 times longer than the eight hour stays contemplated by the ACEP Guide recommendation for programming at 1,100 visits per observation space per year.

Applying the ACEP Guide's recommendation of 1,100 observation visits per observation space would result in only one observation space at UM SMC at Cambridge. One observation

[1] It should also be noted that the ACEP Guide standard incorporated into the State Health Plan is based on the experience of a single architect, the author of the ACEP Guide, and not a broader data analysis of trends in observation utilization, average observation lengths of stay, or use rate demographics.

space would be grossly inadequate to serve the needs of the service area population, overwhelm UM SMC at Easton and other area hospitals with transfers from UM SMC at Cambridge for patients who could otherwise be safely and effectively treated in observation at the FMF, and result in significant increased costs to the health delivery system in the form of interfacility ambulance transfers. Such transfers could also jeopardize patient care outcomes and patient satisfaction. Moreover, the increased number of transports resulting from a lack of observation treatment spaces at UM SMC at Cambridge would be certain to burden EMS providers. Through the Applicant's discussions with the service area community, the community expects the UM SMC at Cambridge to provide the same level of observation and emergency services as currently provided at UM SMC at Dorchester.

The Applicant assumed 70% occupancy of observation beds at UM SMC at Cambridge and sized the observation unit to accommodate peak occupancy. This is a more appropriate method than using the ACEP Guide to project observation bed need for a hospital converting to an FMF. The Applicant's projections are based on the following factors: (1) the small number of observation cases at UM SMC at Cambridge; (2) the fact that there will be no MSGA beds to accommodate any overflow of observation cases; and (3) any overflow of observation cases would necessitate potentially unnecessary inter-facility transports.

Similar to the need to size the emergency department for peak utilization, there is a need to appropriately size the observation unit to ensure that each patient will have a treatment space. In fiscal year 2017, UM SMC at Dorchester had an average daily census of 6.7 observation patients. During the same time period, UM SMC at Dorchester experienced an average peak utilization census of 13 observation patients, a 95% increase over the average number of patients.

Sizing to UM SMC at Dorchester's peak volume requires this 95% add-on to the projected number of observation beds before applying the ACEP guidelines.

Based on the assumptions presented above, there is a projected need for ten observation beds in fiscal year 2024 at UM SMC at Cambridge. (See Table 12).

Table 12
Projected Need for Observation Beds
FY2015 – FY2024

	Historical			Projected at Dorchester				Projected at FMF		
	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Observation Cases	603	597	737	738	739	741	742	743	744	745
% Change	*31.1%*	*-1.0%*	*21.6%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*
Avg Hours Per Case	37.9	38.9	47.1	43.0	43.0	43.0	43.0	43.0	43.0	43.0
Total Observation Hours	22,826	23,221	34,696	31,731	31,781	31,832	31,883	31,933	31,984	32,035
Observation Days	951	968	1,446	1,322	1,324	1,326	1,328	1,331	1,333	1,335
Average Daily Census	2.6	2.7	4.0	3.6	3.6	3.6	3.6	3.6	3.7	3.7
Average Observation Cases			6.7							
Peak Observation Cases			13.0							
Adjustment for Peak Period			195%							
Annualized Peak Period ADC	5.1	5.2	7.7	7.1	7.1	7.1	7.1	7.1	7.1	7.1
Occupancy Target	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
Peak Bed Need	**7.3**	**7.4**	**11.1**	**10.1**	**10.1**	**10.1**	**10.2**	**10.2**	**10.2**	**10.2**
Requested Beds								**10**	**10**	**10**

The proposed number of observation treatment spaces at UM SMC at Cambridge, a total of ten, is consistent with the needs and characteristics of the population to be served.

2. The Size of UM SMC at Cambridge's Observation Treatment Spaces is Consistent with Licensing Standards – COMAR 10.24.19.04(C)(8)(e)(ii).

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF demonstrate that the size of each observation space at the FMF not exceed 140 square feet, exclusive of any toilet or bathing area incorporated into an individual observation space, *unless* based on the particular characteristics of the population to be served,

the applicant demonstrates the need for larger observation spaces. (COMAR 10.24.19.04(C)(8)(e)(ii)).

The ACEP Guide generally recommends a square footage range of 135 to 150 for each observation room. (ACEP Guide, p. 157.) However, the ACEP Guide also states that, "if you decide to equip the [observation] rooms with standard inpatient hospital beds, you'll need larger rooms – 150 to 160 [square feet]." (*Id*. at 271).

Because the projected average length of stay of patients in observation at UM SMC at Cambridge is 43 hours, significantly longer than the ACEP Guide considers, the observation unit has been planned to use standard inpatient hospital beds rather than gurneys. To comply with licensing regulations and modern standards of care, UM SMC at Cambridge has been designed to comply with the 2014 FGI Guidelines. Pursuant to 2014 FGI Guideline 2.2-3.2.2.2, observation beds require a minimum clear floor area of 120 square feet. Further, because the observation rooms may accommodate patients for 48 hours and there will be no inpatient beds in which to house patients at UM SMC at Cambridge, the observation rooms have been designed to create a comfortable patient stay and to allow visitors. Nine of UM SMC at Cambridge's observation rooms have been designed to be 150 square feet, exclusive of in room toilet and bathing areas. The tenth observation space is a bariatric observation space that has been sized to 200 square feet. These sizes allow for a standard hospital bed in each observation room and other required furniture such as side chairs and storage to be accommodated in the room while satisfying the minimum requirement of 120 square feet of clear floor area.

In sum, the size of UM SMC at Cambridge's observation treatment spaces is needed to meet the needs of the population to be served and to comply with licensing standards.

J. Utilization, Revenue, and Expense Projections – COMAR 10.24.19.04(C)(8)(f)

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

* * * *

(f) Provide utilization, revenue, and expense projections for the FMF, along with a comprehensive statement of the assumptions used to develop the projections, and demonstrate that:

(i) The utilization projections are consistent with observed historic trends in ED use by the population in the FMF's projected service area;

(ii) The utilization projections for rate-regulated outpatient services under Health-General Article §19-201(d)(ii) and (iv) and COMAR 10.37.10.07-2 are consistent with the observed historic trends by the population in the FMF's projected service area.

(iii) The revenue estimates for emergency services and other outpatient services specified by the HSCRC under Health-General Article §19-201(d)(iv) and COMAR 10.37.10.07-2 are consistent with utilization projections and the most recent HSCRC payment policies for FMFs;

(iv) The staffing assumptions and expense projections for emergency services and any other rate-regulated outpatient services under Health-General Article §19-201(d)(ii) and (iv) and COMAR 10.37.10.07-2 are based on current expenditure levels, utilization projections, and staffing levels experienced by the applicant hospital's ED and with the recent experience of similar FMFs; and

(v) Within three years of opening, the combined FMF and parent hospital will generate net positive operating income.

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF provide utilization, revenue, and expense projections for the FMF, along with a comprehensive statement of the assumptions used to develop the projects. The Applicant has completed **Tables A** through **L**, which are submitted as **Exhibit 1**. Included in **Exhibit 1** for **Tables F**, **G**, **H**, **I**, **J** and **K** are utilization and financial projections that include a comprehensive statement of assumptions related to utilization, revenue, expenses and financial performance for

UM SMC at Cambridge, UM SMC at Dorchester, and UM SMC at Easton, the parent hospital for UM SMC at Cambridge. Table **F** includes utilization projection and assumptions that reflect both the inpatient and outpatient utilization of UM SMC at Dorchester and UM SMC at Easton, as well as outpatient emergency department visits, observation cases, and related outpatient ancillary services at UM SMC at Cambridge.

1. UM SMC at Cambridge Emergency Department Utilization

The projection of emergency department visits at UM SMC at Cambridge assumes the continuation of existing emergency services with annual population growth through fiscal year 2024. This projection includes the creation of a distinct unit within the emergency department for psychiatric and isolation patients beginning in fiscal year 2022. The projected emergency visits are presented in Table 6.

2. UM SMC at Cambridge Observation Utilization

As almost all observation cases come through the emergency department at UM SMC at Dorchester, the applicant projects changes in observation cases consistent with that of the emergency department in fiscal years 2018 through 2024. The projected Observation cases are presented in Table 11.

3. Laboratory and Imaging

Laboratory and imaging services are projected to grow and decline in relation to the projection of emergency and observation patients that are presented above.

4. Projected UM SMC at Cambridge Revenue

The presentation of projected revenue in **Tables H** and **K** reflect the utilization projections presented above and the 2018 regulated Global Budget Revenue ("GBR") assumptions related to update factors, demographic adjustments, revenue variability, and uncompensated care. These assumptions are included with the tables.

Also incorporated into the revenue projections and described in the list of assumptions are assumptions related to the redistribution of the GBR with the transformation of UM SMC at Dorchester to an FMF. SHS will request that the HSCRC allow SHS to retain, in its GBR cap, 50% of the revenue at UM SMC at Dorchester related to patients that will seek care at other providers after the closing of UM SMC at Dorchester. Keeping this revenue will allow SHS to fund the capital costs and other strategic initiatives associated with the transformation of UM SMC at Dorchester and SHS. This form of funding will have no impact on the Maryland Demonstration Model while allowing for funding of needed capital investments.

5. Projected UM SMC at Cambridge Staffing and Expenses

The presentation of projected staffing at the FMF, as presented in Table **L**, reflects the outpatient services and changes in volumes presented above and assumptions related to expense inflation, expense variability with changes in volumes and one-time adjustments to the projection of staffing and expenses when UM SMC at Dorchester converts to an FMF in fiscal year 2022. Included in the one-time adjustments to staffing and related expenses are the reduction of 113 FTEs and $8 million of salaries and benefits in fiscal year 2022 as the staff at UM SMC at Dorchester are transitioned to UM SMC at Cambridge and UM SMC at Easton (Table 13). The discussion of the Transition Plan for UM SMC at Dorchester explains how UM SRH will

address placement and training of employees through the conversion process of UM SMC at Dorchester. (See Section IV.E, *supra*).

Table 13
Projected Reduction in Staffing and Related Salaries and Benefits
($ in thousands)

Projected FY2022						
	DGH Prior	FTEs	FTEs Retained			
Departments	to Closure	Eliminated	FMF	Easton	MOB	Total
Inpatient Units	116.6	38.9	-	77.7	-	77.7
Outpatient Units	79.8	11.8	48.5	10.1	9.4	68.0
Overhead Department	75.4	62.7	12.7	-	-	12.7
Total FTEs	271.8	113.4	61.2	87.8	9.4	158.4
Salaries & Benefits	$ 23,583	$ 7,963	$ 5,250	$ 903	$ 9,468	$ 15,621

In addition to savings associated with salaries and benefits, there are other efficiencies, totaling $1.2 million, related to the movement of outpatient services to a smaller right-sized FMF. Combined with reductions in salaries and benefits, there is a projected reduction of $9.1 million of operating expenses associated with the projects (Table 14).

Table 14
Projected Reduction in Operating Expenses
($ in thousands)

	Projected FY2022
Cost Savings Enabled by the Project	
Salary & Benefit Savings	$ 7,963
Utilities	698
Supplies	481
Total	$ 9,142

While the project will enable significant efficiencies in fiscal year 2022, there are new expenses that are added to the financial projection related to EPIC implementation ($5 million in fiscal year 2019), physician contracting, and other strategic initiatives (Table 15).

Table 15
Additional Fixed Costs
($ in thousands)

	Projected						
Additional Fixed Costs	2018	2019	2020	2021	2022	2023	2024
EPIC Go-Live & Training Costs	$ -	$ 5,000	$ -	$ -	$ -	$ -	$ -
EPIC / IT Support Costs	228	$ 388	$ 390	$ 549	$ 551	$ 551	$ 551
Community Medical Grp (revenue improvem	(722)	(750)	(731)	(1,849)	(1,289)	(1,289)	(1,289)
Strategic Priority Operating Investments	139	800	1,970	3,108	4,247	4,247	4,247
Total	$ (355)	$ 5,438	$ 1,629	$ 1,808	$ 3,509	$ 3,509	$ 3,509

Beginning in fiscal year 2022, the retention of 50% of revenue associated with patients that will seek care at other providers following the transformation of UM SMC at Dorchester to an FMF, will enable SHS to fund initiatives related to ambulatory and physician network development, population health initiatives, and its regional vision.

6. Projected UM SMC at Cambridge Financial Performance

As presented in **Table K**, UM SMC at Cambridge is projected to incur small operating losses in fiscal years 2022 through 2024 as the new facility is appropriately sized to the outpatient volumes. UM SMC at Cambridge's operating losses in fiscal years 2022 through 2024 will be absorbed by the operating profits of UM SMC at Easton, its parent company, which are presented in **Table H**. As shown in **Table H**, UM SMC at Easton will generate positive operating income throughout the projection period.

K. The Proposed Construction Costs are Reasonable and Consistent with Industry Experience – COMAR 10.24.19.04(C)(8)(h).

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

* * * *

(h) Demonstrate that the proposed construction cost of the FMF is reasonable and consistent with current industry cost experience in Maryland, as provided in Regulation .04B(5) of this chapter.

The State Health Plan requires that construction costs of the project be reasonable and consistent with industry cost experience in Maryland. The following compares the project costs to the Marshall Valuation Service ("MVS") benchmark.

I. Marshall Valuation Service
Valuation Benchmark

Type		Hospital
Construction Quality/Class		Good/A
Stories		6
Perimeter		881
Average Floor to Floor Height		14.0
Square Feet		42,238
f.1	Average floor Area	42,238
A. Base Costs		
	Basic Structure	$374.00
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$374.00
Adjustment for Departmental Differential Cost Factors		1.10
Adjusted Total Base Cost		$411.55

B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$411.55
C. Multipliers		
Perimeter Multiplier		0.899755083
	Product	$370.30
Height Multiplier		1.046
	Product	$387.33
Multi-story Multiplier		1.000
	Product	$387.33
D. Sprinklers		
	Sprinkler Amount	$3.50
Subtotal		$390.83
E. Update/Location Multipliers		
Update Multiplier		1.03
	Product	$402.56
Location Multiplier		0.98
	Product	$394.50
Calculated Square Foot Cost Benchmark		**$394.50**

The MVS estimate for this project is impacted by the adjustment for departmental differential cost factor. In Section 87, p. 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				
Emergency Department	17,170	Emergency Suite	1.18	20,261
Observation Unit	6,493	Inpatient Unit	1.06	6,883
Behavioral Health Emergency Department	1,503	Emergency Suite	1.18	1,774
Emergency Entry/Intake/Waiting	5,106	Offices	0.98	5003.88
Imaging	4,017	Radiology	1.22	4,901
Laboratory	2,347	Laboratories	1.15	2,699
Intensive Outpatient Therapy	1,973	Outpatient Department	0.99	1,953
Building Support	2,589	Offices	0.96	2,485
Exterior Wall	1,040	Unassigned Space	0.5	520
Total	**42,238**		**1.10**	**46,479**

A. Base Calculations	**Actual**	**Per Sq. Foot**
Building	$12,058,599	$285.49
Fixed Equipment		$0.00
Site Preparation	$3,150,000	$74.58
Architectural Fees	$1,320,000	$31.25
Permits	$390,000	$9.23
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$16,918,599	$400.55

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**
Site Demolition Costs	$400,000	Site	
Storm Drains	$250,000	Site	
Rough Grading	$200,000	Site	
Paving	$300,000	Site	
Exterior Signs	$50,000	Site	
Landscaping	$100,000	Site	
Covered Walkway	$250,000	Site	

B. Extraordinary Cost Adjustments			
Unsuitable Material Allowance	$50,000	Site	
Helipad	$500,000	Site	
LEED Silver Green Building Premium	$42,000	Site	
MBE Participation Cost Premium	$42,000	Site	
LEED Silver Green Building Premium	$482,344	Building	$134,493
MBE Participation Cost Premium	$482,344	Building	$134,493
Utility Connection Fees	$100,000	Permits	$27,883
Total Cost Adjustments	$3,248,688		$296,870

Associated capitalized interest and loan placement fees should be excluded from the comparison for those items which are also excluded from the comparison. Since only capitalized interest and loan placement fees relating to the building costs are included in the MVS analysis, they have only been eliminated from the extraordinary costs that are in the building cost item. This was calculated as follows, using a canopy as an example:

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

Explanation of Extraordinary Costs

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

Premium for Minority Business Enterprise Requirement (MBE) – The Applicant 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.

Building	$11,093,911	$262.65
Fixed Equipment	$0	$0.00
Site Preparation	$966,000	$22.87
Architectural Fees	$1,320,000	$31.25
Permits	$290,000	$6.87
Subtotal	$13,669,911	$323.64
Capitalized Construction Interest	$3,065,465	$72.58
Total	$16,735,376	$396.22

Building associated capitalized interest and loan placement fees were calculated as follows:

Hospital	**New**	**Renovation**	**Total**		
Building Cost	$12,058,599	$0			
Subtotal Cost (w/o Cap Interest)	$16,918,599	$0	$16,918,599		
New/Total (This is the percentage that New Construction costs comprise of the total of New Construction and Renovation Costs)	100.0%	0.0%	Cap Interest	**Loan placement fees**	**Total**
Total Project Cap Interest &Financing [(Subtotal Cost/Total Cost) x Total Cap Interest]	$4,717,463	$0	$4,197,187	$520,275	$4,717,463
Building/Subtotal	71.3%				
Building Cap Interest & Loan Place	$3,362,335				
Associated with Extraordinary Costs	$296,870				
Applicable Cap Interest & Loan Place	$3,065,465				

As noted below, the project's cost per square foot is very close to the MVS benchmark.

MVS Benchmark	$394.50
The Project	$396.22
Difference	$1.71
%	0.43%

III. THE CONVERSION OF UM SMC AT DORCHESTER TO A FREESTANDING MEDICAL FACILITY WILL RESULT IN THE DELIVERY OF MORE EFFICIENT AND EFFECTIVE HEALTH CARE SERVICES.

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF demonstrate that the conversion to an FMF will result in the delivery of more efficient and effective health care services, including an explanation of why the services proposed for the FMF cannot be provided at other area hospital EDs, FMFs, or other health care facilities, and demonstrate why other less expensive models of care delivery cannot meet the needs of the population to be served. (COMAR 10.24.17.04(C)(8)(i)).

In addressing the efficiency and cost effectiveness of health care service delivery, the Applicant incorporates by reference the assessment of the availability and accessibility of emergent and urgent care in UM SMC at Cambridge's Service Area as set forth in Section II.F. above.

An FMF in Cambridge is needed. UM SMC at Easton, the next closest emergency department, is approximately 15 miles away. In FY 2017, UM SMC at Easton handled 45.5% of ED visits from residents of the UM SMC at Cambridge's Service Area. It is not capable of accommodating the additional 19,423 emergency visits currently treated at UM SMC at Dorchester's emergency department or the 19,640 visits projected for UM SMC at Cambridge in 2024. UM SMC at Easton is the only other acute general hospital in UM SMC at Cambridge's Service Area. The next closest hospital emergency departments are approximately 30 miles away. Therefore, if an FMF is not built in Cambridge and UM SMC at Easton becomes overwhelmed with ED patient visits, it would result in reduced access to emergency services and poor health outcomes for residents of the UM SMC at Cambridge Service Area, as it would be

more difficult for patients to timely access emergency services due to the additional travel distance.

Major capital improvements would be needed to expand the UM SMC at Easton ED to accommodate the additional emergency room visit volumes from UM SMC at Dorchester. It would not be cost effective to invest in this major capital project to expand the UM SMC at Easton ED given that UM SRH intends in the next several months to file a new Certificate of Need application for the replacement and relocation of the existing UM SMC at Easton facility.

There are a number of factors that drive patient selection for site-of-service. One factor is a patient's inability to discern the lowest level of care for their presenting need(s). Another factor is the limited hours of operation of urgent care centers (see Table 4). As shown in Table 8, a significant number of patients seek emergency treatment between 8:00 PM and 8:00 AM, when urgent cares in the service area are closed.

UM SRH has engaged in numerous population health initiatives as described in Section II.G above. Despite these ongoing efforts, the number of emergency department visits from UM SMC at Dorchester ED's projected service area has not seen an appreciable decline in utilization. As the need projections demonstrate (see Section II.H), the utilization projections are consistent with observed historic trends in emergency department use by the population in the FMF's projected service area. The projections are based on population projections and use rates.

Table F (included in **Exhibit 1**) presents utilization projections for both the inpatient and outpatient utilization of UM SMC at Easton through and UM SMC at Dorchester through fiscal year 2021, and inpatient and outpatient utilization of UM SMC at Easton and outpatient emergency department visits, observation cases, and related outpatient ancillary services at UM SMC at Cambridge starting in FY 2022. **Table I** presents utilization projections for UM SMC at

Dorchester through FY 2021 and for UM SMC at Cambridge starting in FY 2022, including the outpatient emergency department visits, observation cases, and related outpatient ancillary services.

Tables G, **H**, **J** and **K** (included in **Exhibit 1**) present revenue estimates for emergency services that are consistent with the utilization projections and the most recent HSCRC payment policies for FMFs. Included with both the utilization and financial projections are comprehensive statements of assumptions for UM SMC at Cambridge, as well as SHS.

The staffing assumptions and related labor expense projections for emergency and other FMF services are based on current expenditure levels, utilization projections, and staffing levels experienced by the converting hospital's emergency department, as well as recent experience of similar FMFs.

Finally, the current UM SMC at Dorchester facility is not an efficient or cost effective solution for continuing to provide needed services to residents of its services area. The current hospital facility is approximately 199,000 square feet and is not appropriately sized based on its utilization levels. Once the FMF relocates in fiscal year 2022 to the new FMF building, which will be appropriately sized at approximately 42,000 SF, it will result in significant operational cost efficiencies. Table 16 below provides a comparison of building related operating expenses at UM SMC at Dorchester in fiscal year 2017 to the same expenses in the new FMF building. The Applicant projects that it will reduce its building operational costs by approximately 73% simply due to the reduced costs of relocating to the smaller, right-sized facility.

Table 16
Comparison of Operational Costs per
Square Foot in Existing Building and New FMF

Bldg Related Operating Expense	Actual UM SMC at Dorchester FY2017	Projected UM SMC at Cambridge FY2022
Utilities and Water	$ 797,696	$ 189,486
Environmental Services	810,944	180,198
Secuity & Maintenance	1,543,686	473,962
Total	$ 3,152,326	$ 843,645

In addition, as discussed in Section II.J.5 above, there is a projected reduction of $9.1M in operational efficiencies resulting from the conversion to an FMF and consolidation of inpatient services at UM SMC at Easton.

The FMF is projected to generate small operating losses in the fiscal years 2022 to 2024 as the facility is appropriately sized to its outpatient volumes. However, the combined FMF and parent health system will generate net positive operating income during every year of the projection period.

IV. THE CONVERSION OF UM SMC AT DORCHESTER TO A FREESTANDING MEDICAL FACILITY IS IN THE PUBLIC INTEREST.

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF demonstrate the conversion is in the public interest, based on an assessment of the converting hospital's long-term viability as a general hospital through addressing such matters as: (i) trends in the hospital's inpatient utilization for the previous five years in the context of statewide trends; (ii) the financial performance of the hospital over the past five years and in the context of the statewide financial performance of Maryland hospitals; (iii) the age of the physical plant relative to other Maryland hospitals and the investment required to maintain

and modernize the physical plant; (iv) the availability of alternative sources for acute care inpatient and outpatient services that will no longer be provided on the campus after conversion to a freestanding medical facility; (v) the adequacy and appropriateness of the hospital's transition plan; and (vi) an assessment of the parent hospital's projected financial performance or the projected financial performance of the parent hospital and other health care facilities that share a global budget with the parent hospital.

The conversion of UM SMC at Dorchester to UM SMC at Cambridge is in the public interest with respect to each of these criteria based on the analyses presented below.

A. The Conversion of UM SMC at Dorchester to UM SMC at Cambridge is in the Public Interest Based on UM SMC at Dorchester's Inpatient Utilization for the Previous Five Years in the Context of Statewide Trends.

Table 17 presents a 15.7% decline in UM SMC at Dorchester's inpatient admissions between fiscal years 2014 and 2018. This decline is almost twice the 8.2% reduction experienced statewide.

Table 17
Comparison of Historical Admissions to Statewide Trends
FY2013 – FY2018

	Admissions					% Change
	FY2014	FY2015	FY2016	FY2017	FY2018 (1)	FY14-FY18
UM SMC at Dorchester	2,408	2,606	2,404	2,524	2,030	-15.7%
Statewide	602,547	583,885	569,994	564,644	553,340	-8.2%

Note (1): FY2018 results are annualized based on the first nine months of the fiscal year.
Source: HSCRC Experience Reports, rate center ADM

The decreasing number of admissions at UM SMC at Dorchester has created a financial hardship for the hospital with the cost of maintaining the hospital infrastructure, in addition to its declining financial margin. The declining margin is demonstrated in Section IV.B below.

Continuing to operate the current facility with reduced volumes is not in the public's best interest. Converting to an outpatient-focused FMF that is right-sized to current utilization levels is in the public interest.

B. The Conversion of UM SMC at Dorchester to UM SMC at Cambridge is in the Public Interest Based on UM SMC at Dorchester's Financial Performance Over the Past Five Years and in the Context of the Statewide Financial Performance of Maryland Hospitals.

As presented in Table 18, UM SMC at Dorchester generated operating margins ranging from 12.9% in fiscal year 2013 to 1.7% in fiscal year 2017. The most recent year's operating margin of 1.7% is below the statewide average of 2.8%.

Table 18
Comparison of Operating Margins to Statewide Financial Performance
FY2013 – FY2017

	Operating Margin (1)					Change
	FY2013	FY2014	FY2015	FY2016	FY2017	FY13 - FY17
UM SMC at Dorchester	12.9%	14.0%	14.3%	11.1%	1.7%	-86.9%
Statewide RE Schedule	1.3%	3.1%	3.7%	3.3%	2.8%	161.5%

Note (1): Includes both regulated and unregulated financial results.
Source: Annual Filing RE Schedule

The continued decline in operating margin at UM SMC Dorchester is not in the public's best interest. Converting to an FMF that is financially sustainable is in the public interest.

C. The Conversion of UM SMC at Dorchester to UM SMC at Cambridge is in the Public Interest Based on the Age of UM SMC at Dorchester's Physical Plant Relative to Other Maryland Hospitals and the Investment Required to Maintain and Modernize the Physical Plant

UM SMC at Dorchester was constructed in three different phases, the oldest of which dates to at least 1914. The core of the existing building was completed in 1974. In 1992, building and grounds renovations included expansion and renovation of the emergency room,

and cosmetic improvements of parts of the ground floor, including a new mammography area. However, the hospital was originally built on that site more than 100 years ago, and parts of the original hospital structure are incorporated into the current hospital.

As presented in Table 19, the average age of UM SMC at Dorchester's physical plant was 14.4 years in fiscal year 2016. This compares to the Maryland statewide average of 10.2 years. In a publication by Moody's Investors Service, dated August 21, 2017, the median average age of plant for hospitals that it rates is 11.2 years. The Maryland statewide average is less than the Moody's median while UM SMC at Dorchester is greater. Due to the removal of the H1 schedule from the HSCRC Annual Filing, average plant age information is not available for the state for fiscal year 2017.

Table 19
Comparison of Average Age of Plant to Statewide Trends
FY2012 – FY2016

	Average Age of Plant (years)				
	2012	2013	2014	2015	2016
UM SMC at Dorchester	15.7	14.4	15.4	15.8	14.4
Statewide Average	9.0	9.1	10.0	10.0	10.2

Source: Annual Filings. This information was not reported in FY2017 filings.

For UM SMC at Dorchester to achieve the statewide average it would require approximately $32 million in capital expenditures to modernize its physical plant. This estimate of capital expenditures reflects the level of investment in assets with a 25-year useful life that would be required to increase annual depreciation expense to achieve a 10.2 year average age of plant.

This investment is supported by a study that UM SMC at Dorchester conducted to assess the capital investments that would be required to improve the UM SMC at Dorchester facilities. This study found that a minimum of $37 million would be required to improve the following aspects of the existing facility:

- Brick and stucco veneer replacement
- Roof replacement
- Window replacement
- Emergency power generator and utility transformer replacement
- Air handling unit replacement (original building systems)
- Hot and chilled water system replacement
- Fire pump and sprinkler replacement
- Medical gas / vacuum system replacement
- American Disabilities Act upgrades
- Department renovations
    - Emergency
    - Cardiology
    - Radiology
    - Administration (walls cracking)
- Telephone system replacement

In addition, the existing hospital is comprised of approximately 199,000 net square feet which will require almost three times as much annual expense to continue to operate the existing plant versus a smaller facility with approximately 42,000 square feet. Spending this amount of money to modernize and maintain an aged facility is not in the public's best interest, especially when taking into account the facility's declining inpatient utilization and financial margins.

While similar to the cost of improving UM SMC at Dorchester, investing $42 million in a new, right-sized facility is in the public interest.

D. The Conversion of UM SMC at Dorchester to UM SMC at Cambridge is in the Public Interest Taking into Consideration the Alternative Sources for Acute Care Inpatient and Outpatient Services That Will no Longer be Provided on the Campus After Conversion to a Freestanding Medical Facility.

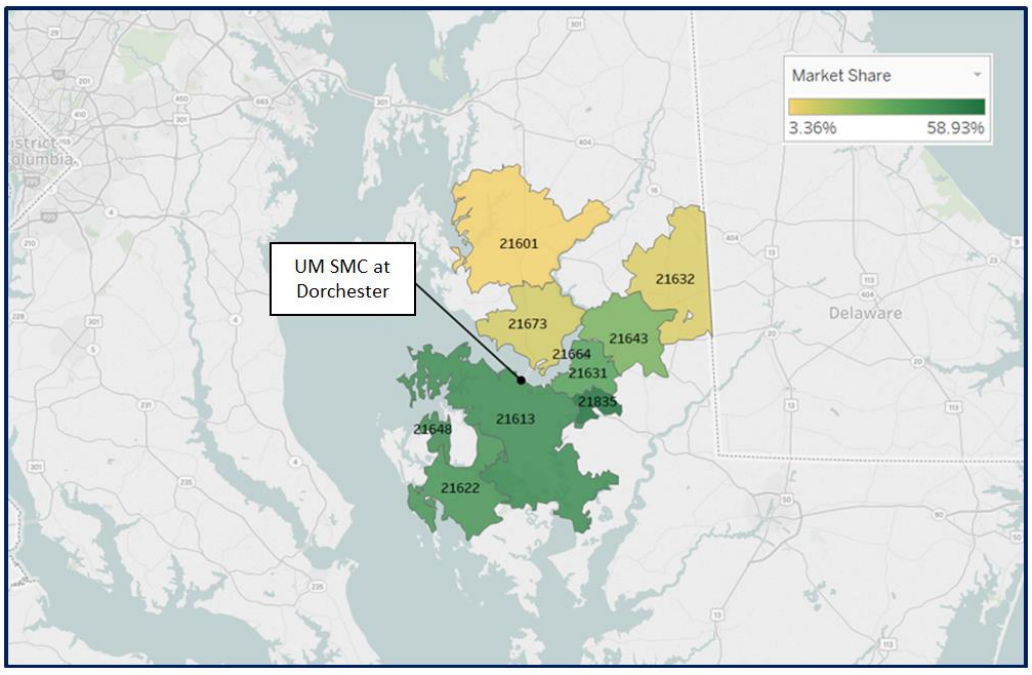
As previously noted, contemporaneous with this Request for Exemption from CON Review, the Applicants have sought a Request for Exemption to merge and consolidate a portion of UM SMC at Dorchester's inpatient services with UM SMC at Easton in order to ensure continued access to these services for residents currently served by UM SMC at Dorchester. As discussed in the merger and consolidation request for CON exemption, all of the psychiatric discharges at UM SMC at Dorchester are expected to shift to UM SMC at Easton. UM SMC at Dorchester is proposing to transfer 12 psychiatric beds to UM SMC at Easton to accommodate these additional psychiatric patients. While the majority of UM SMC at Dorchester's MSGA discharges will shift to UM SMC at Easton, the Applicant is projecting that in fiscal year 2022 22.2% of UM SMC at Dorchester's medical discharges will move to other service area hospitals as presented in Table 20 below. UM SMC at Dorchester is also proposing to transfer 17 MSGA beds to UM SMC at Easton to accommodate these additional medical-surgical patients.

Table 20
Projected Shift of UM SMC at Dorchester Medical and Surgical Discharges
FY2022

UMSMC-D MSGA Discharges	Projected FY2022	% of Total
Medical Discharges	1,376	92.6%
Surgical Discharges	110	7.4%
Reduction in UMSMC-D MSGA Discharges	1,486	100.0%
Shift to UMSMC-E	(1,155)	-77.7%
Shift to Other Hospitals	(331)	-22.3%
Increase at Other Hospitals	(1,486)	-100.0%
Remaining UMSMC-D MSGA Discharges	-	-

The MSGA service area for UM SMC at Dorchester is defined as the set of Zip Codes from which 85% of UM SMC at Dorchester's medical-surgical admissions originate, as presented below in Figure 1and in Table 4 with the zip codes sorted from the most to least admissions.

Figure 1
UM SMC at Dorchester's FY2017 MSGA Service Area



As shown in Table 21 below, in fiscal year 2017, UM SMC at Easton had the greatest market share of 46.4% in UM SMC at Dorchester's service area. Peninsula Regional Medical Center had a 5.8% market share and is expected to receive some of UM SMC at Dorchester's medical discharges when it converts to an FMF.

Table 21
UM SMC at Dorchester Inpatient Discharge Market Share
In Inpatient Service Area
FY2017

Hospital Name	Non-Psych, Non-OB / Newborn, Discharges	Market Share
UM SMC at Easton	2,961	46.4%
UM SMC at Dorchester	1,704	26.7%
UMMC	429	6.7%
Peninsula Regional Medical Center	368	5.8%
Anne Arundel Medical Center	247	3.9%
The Johns Hopkins Hospital	231	3.6%
Other hospitals with <100 admissions	443	6.9%
Total Service Area Inpatient Admissions	6,383	100.0%

Source: St. Pauls Non-Confidential Data Tapes

These data show that UM SMC at Easton is already the predominant MSGA provider of inpatient services to residents residing in UM SMC at Dorchester's service area. It is in the public interest to allow UM SMC at Dorchester to convert to an FMF and focus on outpatient services, while consolidating inpatient services at UM SMC at Easton.

All outpatient services that are currently provided on the UM SMC at Dorchester campus will continue to be available to the community on the UM SMC at Cambridge campus at Cambridge Marketplace.

E. The Conversion of UM SMC at Dorchester to UM SMC at Cambridge is in the Public Interest Taking into Consideration the Adequacy and Appropriateness of UM SRH's Transition Plan.

UM SMC at Dorchester is part of UM SRH, the region's premier provider of coordinated health care services, inpatient and ambulatory, in the five counties of Maryland's mid-Shore region. UM SRH is a proud member of UMMS. The mission of UM SRH is ***Creating Healthier Communities Together***, a reflection of its dedication and commitment to work with community partners, including physicians, other providers, and health and social services collaborators, to improve the health status of people who live and work in Maryland's mid-Shore region. UM SRH's vision is to be the region's leader in patient centered health care. In a rural and often economically disadvantaged region such as the mid-Shore, with a population of approximately 175,000 people spread out over nearly 2,000 square miles, the challenges of health care delivery and access are significant. In addition, rural health care providers have challenges with recruiting and retaining physicians and other clinicians and obtaining sufficient reimbursement to cover their costs. These issues are not new to the region or its primary health care system, UM SRH.

In addition to these challenges related to rural health care delivery, the landscape of health care delivery is changing across the nation and in Maryland. Health care delivery is shifting from hospital-centric care to patient- and people-centric care, with a focus on wellness, preventive care, primary care, and diagnostics. Health care planning and resource allocation has focused on planning delivery sites that are more accessible to residents. Patients have become "consumers" of health care and are defining their needs from their own perspectives. The 2016 UM SRH Community Health Needs Assessment shows a consumer-defined need in the mid-Shore region for access to outpatient services, primary care, and specialists to support prevention

and management of chronic disease, including behavioral health and addiction services. Communities also define safety net needs related to urgent care and emergency medical care, which will continue to be important to citizens' health and well-being.

UM SRH's goal, in response to the Community Health Needs Assessment and its strategic planning work, is to address each of the consumer-defined needs in concert with the information gathered from UM SRH physicians, community partners, and UMMS. UM SRH's plan for conversion of UM SMC at Dorchester to a freestanding medical facility, a facility that provides 24/7 emergency services as well as diagnostic, imaging and lab services, and observation services, is the result of input from hundreds of patients, providers, community partners and leadership, obtained over more than two years of study and planning.

The transition plan for UM SMC at Dorchester began as early as 2015, as part of UM SRH's regional plan to transform health care. In the first year of its new strategic plan, the UM SRH Board of Directors and its planning committee launched a Strategic Services Delivery Workgroup and subsequently, a Strategic Service Delivery Council. Both groups engaged physicians, providers, leadership, management, community health care partners, and elected officials in a review of regional health care needs as well as national and state trends in health care. The Service Delivery Council then assembled into five subcouncils, each chaired by a dyad of management and physician leaders and comprised of internal and external stakeholders in the fields of primary care, specialty care, surgical care, behavioral health, and oncology. The resulting recommendations were compiled by the Service Delivery Council, recommended for adoption by the UM SRH Board Strategic Planning Committee, and approved by the UM SRH Board and UMMS in 2016. This Strategic Service Delivery Plan, which defined needs and

services at appropriate levels and facility types throughout the region, was then widely shared with community leaders, organizations, citizens, and elected officials.

The Strategic Service Delivery Plan envisioned that the Maryland General Assembly would allow hospitals to convert to an FMF, and a new statutory and regulatory framework would be implemented to govern hospitals converting to FMFs. UMMS and UM SRH participated in commenting on the legislation and regulations that would make hospital conversions to FMFs possible in Maryland. As the Strategic Service Delivery Plan was being communicated and legislation was moving ahead, UM SRH continued the discussions it had already begun with its physician leaders in Dorchester County regarding the possibility of converting the aged hospital in Dorchester to an FMF. With physician support for the concept, including the relocation of inpatient beds to nearby UM SMC at Easton, just 15 miles away, UM SRH expanded the discussion to include the local public health officer, emergency medical services ("EMS"), local and state elected officials, and ultimately, to the full community in a series of community listening sessions during 2017. With overwhelmingly positive feedback from all of these sources, the Boards of UMMS and UM SRH approved moving forward with the detailed plan development for the conversion of UM SMC at Dorchester to an FMF in Cambridge with an adjacent medical pavilion with a complement of ambulatory services.

During late 2017 and early 2018, detailed planning work began on a location for the new medical campus, on facility design and site planning, services identification, budget and financing, and on early transition planning for three essential areas: (1) the plan to transition acute care services previously provided at UM SMC at Dorchester and the related transportation impact; (2) the plan to transition, retrain, and place employees of UM SMC at Dorchester; and (3) the plan for the existing UM SMC at Dorchester physical plant and site. Although the

proposed conversion and transition are not scheduled to occur until 2021, there has been steady focus and measurable accomplishment on the transition planning and the steps needed to bring it to fruition by 2021.

1. Plan for Transitioning of Acute Care Services Previously Provided at UM SMC at Dorchester

The projected timeline for transitioning acute care services presently provided at UM SMC at Dorchester will depend upon several milestones, in particular the regulatory approval of the plan to convert UM SMC at Dorchester to an FMF, to be called UM SMC at Cambridge. In conjunction with the conversion, UM SRH is seeking to move 17 inpatient MSGA beds and 12 inpatient psychiatric beds from UM SMC at Dorchester to UM SMC at Easton in order to ensure adequate access to these services for residents of the service area. UM SRH estimates that regulatory approval for conversion and transfer of these beds could take approximately six months, with groundbreaking occurring once all approvals have been finalized and permits obtained. Construction for the FMF and adjacent medical pavilion, which will be called the UM Shore Medical Pavilion at Cambridge and at the inpatient facility at Easton to accommodate the inpatient medical/surgical and behavioral health beds that will be transferred from UM SMC at Dorchester to UM SMC at Easton is anticipated to take approximately 16 months. The projected opening of the FMF and transfer of beds to UM SMC at Easton is the summer of 2021.

UM SMC at Dorchester will continue providing the full complement of services that it provides today until the conversion occurs. Upon conversion, a portion of UM SMC at Dorchester's inpatients beds will be moved to UM SMC at Easton and UM SMC at Cambridge will open on a new campus conveniently located approximately one mile from the existing UM SMC at Dorchester site at the intersection of US Route 50 and Woods Road in Cambridge. UM

SMC at Cambridge will provide 24/7 emergency services and be staffed by board certified University of Maryland Emergency Medicine physicians and advanced practice providers that will serve patients of all ages. UM SMC at Cambridge will continue to accept and care for all EMS priority levels as defined by established protocols and will continue to communicate as a base station with EMS providers to coordinate care that is appropriate for patients' needs and in their best interests. The FMF will also continue to provide the necessary diagnostic testing, including imaging and laboratory services, and will provide short-term observation services for the management of certain types of patients who do not meet inpatient criteria. Telemedicine consultations for behavioral health and other specialty services are currently provided for in all of UM SRH's emergency departments and will continue at UM SMC at Cambridge.

Patients who present at UM SMC Cambridge and are assessed to be in need of inpatient medical, surgical, or critical care will, subject to the patient's expressed preferences, be transferred to UM SMC at Easton. These patients will be stabilized at UM SMC at Cambridge by emergency physicians and clinical staff and the interfacility call system will be initiated to establish physician to physician communication and to coordinate acceptance and transport of the patient to UM SMC at Easton, another UMMS inpatient facility, or a facility which the patient chooses or meets the patient's specific needs. Because it currently operates three hospitals and an FMF in Queenstown across a wide geography and in relative isolation from the rest of the State and because UM SMC at Easton is already a regional hub for certain inpatient services such as PCI, stroke, obstetrics, pediatrics and acute rehabilitation, UM SRH already has a well-defined and regularly monitored plan for transports in place and will continue to monitor and refine it as needed.

As previously mentioned, UM SRH is proposing to relocate inpatient MSGA and psychiatric bed capacity from UM SMC at Dorchester to UM SCM at Easton and appropriate staffing and support services as part of the conversion. UM SMC at Easton plans to make necessary renovations in its existing building for the additional beds and necessary support functions for these services. UM SMC at Easton will complete its renovations, the beds will be operational, and staff transitions will be complete at the time of the conversion to make the transition as seamless as possible.

Patients who arrive at UM SMC at Cambridge and are in need of behavioral health services will continue to receive the same emergency assessment and care as are presently provided at UM SMC at Dorchester, including assessment by the Behavioral Health Response Team ("BHRT") and consultation with psychiatrists and clinicians via telemedicine where appropriate. The FMF will have an intensive outpatient behavioral health program for adult patients and additional outpatient behavioral health services will be located in the adjacent UM SMP at Cambridge. Patients who need adult inpatient behavioral health services will, appropriate to their needs and preferences, be transferred to the inpatient adult behavioral health unit which is being relocated from UM SMC at Dorchester to UM SMC at Easton. The inpatient behavioral health unit at UM SMC at Dorchester is a regional service at present and when the unit is relocated to UM SMC at Easton it will be sized appropriately to continue to meet the inpatient behavioral health beds needs of adult patients from around the region.

2. Transportation Planning

Transportation to and from emergency services, both in FMFs and hospitals is a critical component of successful transition planning and ultimately, to the transformation of health care

delivery that provides efficient and effective care with optimal outcomes. To this end, UM SRH has had a unique opportunity to work on effective regional transportation, in particular, providing interfacility hospital-to-hospital transports for more than 20 years for patients in need of regional specialty services and providing FMF-to-hospital transports for more than eight years for patients seen at the UM Shore EC at Queenstown in need of inpatient or other specialty services.

For nearly a decade, UM SRH has had a continuing and effective contractual relationship with the region's predominant provider of interfacility ground medical transportation services, Best Care Ambulance, Inc. ("Best Care"). Best Care has base sites located throughout the region from which it deploys EMT-staffed, licensed ambulances for transports between UM SRH hospital emergency departments and FMF and outside the region to facilities of a patient's choice or facilities with specialty services. The interfacility transport services provided by Best Care under its contract with UMMS and UM SRH are already regional. Best Care's operational and quality metrics are reviewed quarterly as part of the UM SRH Interfacility Transport Committee, which includes representatives of nursing, critical care, and emergency medicine clinicians, Maryland ExpressCare, and leadership from Best Care. UMMS and UM SRH's discussions with Best Care are ongoing as regional programs expand and the conversion of UM SMC at Dorchester to an FMF brings opportunities for further collaboration and expanded services. UMMS and UM SRH intend to amend their contract with Best Care, as needed, to accommodate the needs for additional interfacility transports.

UM SRH is also participating in discussions with UMMS and its ExpressCare service to facilitate transfers and admissions via a central access center within the UMMS system and elsewhere as appropriate, to provide ambulance services for basic life support ("BLS"), advanced

life support ("ALS"), and critical care patient transportation for UM SRH patients through Maryland ExpressCare or a licensed vendor ambulance service, 24 hours per day, seven days per week. ExpressCare, already in use on the mid-Shore and contractually supported by Best Care, will undergo further UMMS refinements and ultimately will provide a coordinating center for all transports, including those by helicopter, which are currently coordinated by UMMS or other receiving institution. A modern helipad is located at each of UM SRH's hospitals and UM SMC at Cambridge will also have a helipad adjacent to the FMF that will be used for air transports.

3. Plan for Job Retraining and Placement of UM SMC at Dorchester Employees

The wellbeing and future of the UM SRH team members working at UM SMC at Dorchester has been a focus since the beginning discussions regarding the conversion of the hospital to an FMF. As UM SRH has fine-tuned its projected future patient volumes and staffing needs, it has developed a clearer picture of the staffing resources that will be needed at the FMF and adjacent medical pavilion in Cambridge, as well as in connection with the inpatient beds being transferred to UM SMC at Easton. Clinical staffing at the FMF will likely be similar to the current UM SMC at Dorchester emergency department. UM SRH also anticipates transferring clinical and support staff to cover the acute inpatient services being transferred from UM SMC at Dorchester to UM SMC at Easton, but there will be some overlap with existing staff at Easton.

To address the very specific assessment of staffing needs and plans necessary to adapt through reassignment and training for new jobs, UM SRH has formed a Workforce Transition and Development Task Force (the "Task Force") whose efforts will get underway in the second half of calendar year 2018 and will continue through 2021. The Task Force will involve a

collaborative process and perspective from across multiple disciplines, including nursing, providers, clinical and ancillary support, facility management, human resources, and local community training and education resources. The Task Force's first priority will be to determine the total workforce needs and appropriate placements at UM SMC at Cambridge, the adjacent medical pavilion, and UM SMC at Easton in 2021 based on current UM SMC at Dorchester staff, taking into consideration retirements and anticipated attrition over the next three year period. The Task Force will next review options and make recommendations regarding alternative placements within UM SRH and UMMS for any displaced employees, as well as identify training options and match employees with resources in the event of displacement. The Task Force will keep UM SMC at Dorchester team members well-informed throughout its process by engaging them early on in discussions and working with them throughout the transition process.

Once the Task Force has refined its projections and identified the appropriate team members needed for the FMF, adjacent medical pavilion, and acute services that will be transitioning to UM SMC at Easton, as well as the needs within the full UM SRH system, focused outreach efforts will be made with each team member regarding the transition plan and options. UM SRH Human Resources representatives will meet and work one-on-one with employees to provide information about resources and opportunities available to them. The top priority will be to match team members with employment opportunities; consideration will be given to placement within the employee's current county of work, to the extent options match need. UM SRH will also provide training, career shadow days, and other resources to help staff transition to new roles. In addition, UM SRH plans to provide a link to other position vacancies within the UMMS system to connect those staff members who would prefer to transfer to

another UMMS facility with additional job opportunities. By identifying open positions and offering additional training, UM SRH is hopeful that it will be able to place all staff within UM SRH or UMMS, should employees elect to stay within the system. UM SRH will also work with local workforce development services to link displaced staff or staff members who want to pursue other opportunities with resources regarding other job opportunities in the community.

UM SRH leadership has worked over the years to build meaningful relationships with community partners, such as Chesapeake College, the Eastern Shore Area Health Education Center, and regional economic and workforce development offices. These relationships will help UM SRH and its team members understand their options for learning new skills to expand their job placement opportunities, if they choose to do so. Preliminary discussions have been held with these community resources and they will participate in the Task Force's discussions and decisions. Job fairs, onsite career training, and certification courses are among the options UM SRH will evaluate as part of the workforce transition plan, which will evolve over the next three years.

4. Plan for the Existing UM SMC at Dorchester Plant and Site

Once the FMF building is complete, emergency and ancillary services will relocate to the FMF on the new campus in Cambridge along with outpatient services that will relocate to the medical pavilion. At that time, UM SRH intends to relocate the inpatient beds from UM SMC at Dorchester to UM SMC at Easton. The existing hospital building in Cambridge is planned for decommissioning and demolition and the site will be vacated in order to sell it for redevelopment in support of the Cambridge/Dorchester County Waterfront Development vision, advancing economic development in the city, county, and the region. Dorchester County, the City of

Cambridge, and UM SRH have signed a Letter of Intent to outline the future property sale of the existing UM SMC at Dorchester site to the newly incorporated body, Cambridge Waterfront Development, Inc. ("CWDI") in order to include the hospital property in a waterfront development project that will enhance destination recreation, job creation, and commerce in Cambridge, its port, and Dorchester County.

V. THE CONVERSION OF UM SMC AT DORCHESTER TO AN FMF IS IN THE PUBLIC INTEREST BASED ON AN ASSESSMENT OF UM SMC AT EASTON'S PROJECTED FINANCIAL PERFORMANCE.

While UM SMC at Cambridge is expected to incur small operating losses in fiscal years 2022 through 2024, these losses will be absorbed by the operating profits of UM SMC at Easton, its parent company**,** which benefit from a positive financial contribution from the shift of inpatient beds from UM SMC at Dorchester. As shown in Table **H**, UM SMC at Easton will generate positive operating income throughout the projection period.

CONCLUSION

For all of the reasons set forth above, the Applicant respectfully requests that the Commission authorize the conversion of UM SMC at Dorchester to a freestanding medical facility and associated capital expenditures.

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4.	Representative List of Charges
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6.	Notices regarding availability of financial assistance
7.	Newspaper notices regarding availability of financial assistance
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I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption and its exhibits are true and correct to the best of my knowledge, information, and belief.

7/2/18
Date

Kenneth D. Kozel
President & CEO
UM Shore Regional Health

#632159
012516-0006

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

6/27/2018
Date

Robert Frank, MBA
Senior Regional Vice President,
Operations
UM Shore Regional Health

#632157
012516-0006

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

June 27 2018
Date

William Huffner, M.D., MBA,
FACEP, FACHE
Senior Vice President, Medical Affairs
and Chief Medical Officer
UM Shore Regional Health

#632155
012516-0006

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

6/27/2018
Date

Ruth Ann Jones
Ruth Ann Jones, Ed.D., MSN, RN, NEA-BC
Senior Vice President, Patient Care Services and Chief Nursing Officer
UM Shore Regional Health

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

June 28, 2018
Date

Patti K. Willis
Patti Willis
Senior Vice President, Strategy & Communications
UM Shore Regional Health

#569256
012516-0003

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

6/27/18
Date

JoAnne Hahey
Chief Financial Officer
UM Shore Regional Health

#632160
012516-0006

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

6/29/18
Date

Darryl Mealy
Vice President of Construction and
Facilities Planning
University of Maryland Medical System

#632162
012516-0006

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

JUNE 27, 2018
Date

Eileen English
Eileen English, AIA, CSI, EDAC, LEED AP
Principal
Hord Coplan Macht

#632154
012516-0006

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

6/27/18
Date

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

#632153
012516-0006

EXHIBIT 1

Name of Applicant:	Shore Health System, Inc. dba University of Maryland Shore Medical Center at Dorchester and University of Maryland Shore Medical Center at Easton
Date of Submission:	6-Jul-18

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

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

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

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

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/2017	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity				
			Room Count			Bed Count			Room Count			Bed Count	
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity	
ACUTE CARE							**ACUTE CARE**						
General Medical/ Surgical*		16			0	0	**General Medical/ Surgical***				0	0	
Medical Surgical	2 East		11	14	25	39					0	0	
Palliative Care	2nd Floor		2	0	2	2					0	0	
					0	0					0	0	
					0	0					0	0	
SUBTOTAL Gen. Med/Surg*		**16**	**13**	**14**	**27**	**41**	**SUBTOTAL Gen. Med/Surg***						
ICU/CCU	2nd Floor	**6**	16	0	16	16	**ICU/CCU**				0	0	
Other *(Specify/add rows as needed)*					0	0					0	0	
TOTAL MSGA							**TOTAL MSGA**						
Obstetrics					0	0	**Obstetrics**				0	0	
Pediatrics					0	0	**Pediatrics**				0	0	
Psychiatric	1st Floor	**24**	2	11	13	24	**Psychiatric**				0	0	
TOTAL ACUTE		**46**	**31**	**25**	**56**	**81**	**TOTAL ACUTE**		**0**	**0**	**0**	**0**	
NON-ACUTE CARE							**NON-ACUTE CARE**						
Dedicated Observation**					0	0	**Dedicated Observation****	1st Floor	10	**0**	10	10	
Rehabilitation					0	0	**Rehabilitation**				0	0	
Comprehensive Care					0	0	**Comprehensive Care**				0	0	
Other *(Specify/add rows as needed)*					0	0	**Other** *(Specify/add rows as needed)*		0	**0**	0	0	
									0	**0**	0	0	
									0	**0**	0	0	
TOTAL NON-ACUTE							**TOTAL NON-ACUTE**		**10**	**0**	**10**	**10**	
HOSPITAL TOTAL		**46**	**31**	**25**	**56**	**81**	**HOSPITAL TOTAL**		**10**	**0**	**10**	**10**	

* 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
Emergency Department		17,170			17,170
Observation Unit		6,493			6,493
Behavioral Health Emergency Department		1,503			1,503
Emergency Entry/Intake/Waiting		5,106			5,106
Imaging		4,017			4,017
Laboratory		2,347			2,347
Intensive Outpatient Therapy		1,973			1,973
Building Support		2,589			2,589
Exterior Wall		1,040			1,040
					0
					0
					0
					0
					0
					0
					0
Total		42,238			42,238

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	0	
First Floor	42,238	
Second Floor	0	
Third Floor	0	
Fourth Floor	0	
Average Square Feet	**42,238**	
Perimeter in Linear Feet	**Linear Feet**	
Basement	0	
First Floor	881	
Second Floor	0	
Third Floor	0	
Fourth Floor	0	
Total Linear Feet	**881**	
Average Linear Feet	**881**	
Wall Height (floor to eaves)	**Feet**	
Basement	n/a	
First Floor	14	
Second Floor	n/a	
Third Floor	n/a	
Fourth Floor	n/a	
Average Wall Height	**14**	
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	0	
Freight	0	
Sprinklers	**Square Feet Covered**	
Wet System	42,238	
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project		
Type of Exterior Walls for proposed project	Brick Veneer on Metal Stud with Continuous Insulation and Stud Cavity Insulation; Aluminum Storefront Windows	

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	$966,000	
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs	**$966,000**	
Site Demolition Costs	$400,000	
Storm Drains	$250,000	
Rough Grading	$200,000	
Hillside Foundation		
Paving	$300,000	
Exterior Signs	$50,000	
Landscaping	$100,000	
Walls		
Yard Lighting		
Other *(Specify/add rows if needed)*		
Sediment Control & Stabilization		
Helipad	$500,000	
Covered Walkway	$250,000	
Unsuitable Material Allowance	$50,000	
Premium for Minority Business Enterprise Requirement	$42,000	
LEED Silver Green Building Premium	$42,000	
Subtotal On-Site excluded from Marshall Valuation Costs	**$2,184,000**	
OFFSITE COSTS		
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs	**$0**	
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$2,184,000**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$3,150,000**	**$0**
BUILDING COSTS		
Normal Building Costs	$11,093,911	
Subtotal included in Marshall Valuation Costs	$11,093,911	
Canopy		
Premium for Labor Shortages on Eastern Shore Projects		
LEED Silver Premium	$482,344	
Siesmic Costs		
Pneumatic Tube System		
Signs		
Premium for Minority Business Enterprise Requirement	$482,344	
Subtotal Building Costs excluded from Marshall Valuation Costs	**$964,688**	
TOTAL Building Costs included and excluded from Marshall Valuation Service*	**$12,058,599**	**$0**
A&E COSTS		
Normal A&E Costs	$1,320,000	
Subtotal included in Marshall Valuation Costs	**$1,320,000**	
Subtotal A&E Costs excluded from Marshall Valuation Costs	**$0**	
TOTAL A&E Costs included and excluded from Marshall Valuation Service*	**$1,320,000**	**$0**
PERMIT COSTS		
Normal Permit Costs	$290,000	
Subtotal included in Marshall Valuation Costs	**$290,000**	
Jurisdictional Hook-up Fees	$100,000	
Impact Fees		
Subtotal Permit Costs excluded from Marshall Valuation Costs	**$100,000**	
TOTAL Permit Costs included and excluded from Marshall Valuation Service*	**$390,000**	**$0**

TABLE E. PROJECT BUDGET

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

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

				Hospital Building	Other Structure -	Total
A.	**USE OF FUNDS**					
	1.	**CAPITAL COSTS**				
		a.	**New Construction**			
		(1)	Building	$12,058,599		$12,058,599
		(2)	Fixed Equipment			$0
		(3)	Site and Infrastructure	$3,150,000		$3,150,000
		(4)	Architect/Engineering Fees	$1,320,000		$1,320,000
		(5)	Permits (Building, Utilities, Etc.)	$390,000		$390,000
			SUBTOTAL	**$16,918,599**	**$0**	**$16,918,599**
		b.	**Renovations**			
		(1)	Building			$0
		(2)	Fixed Equipment (not included in construction)			$0
		(3)	Architect/Engineering Fees			$0
		(4)	Permits (Building, Utilities, Etc.)			$0
			SUBTOTAL	**$0**	**$0**	**$0**
		c.	**Other Capital Costs**			
		(1)	Movable Equipment	$6,191,073		$6,191,073
		(2)	Contingency Allowance	$4,647,776		$4,647,776
		(3)	Gross interest during construction period	$4,197,187		$4,197,187
		(4)	Other - Owner Enabling	$75,000		$75,000
						$0
			SUBTOTAL	***$15,111,036***	***$0***	**$15,111,036**
			TOTAL CURRENT CAPITAL COSTS	**$32,029,635**	**$0**	**$32,029,635**
		d.	***Land Purchase***	**$6,000,000**		$6,000,000
		e.	**Inflation Allowance**	$817,552		$817,552
			TOTAL CAPITAL COSTS	**$38,847,188**	**$0**	**$38,847,188**
	2.	**Financing Cost and Other Cash Requirements**				
		a.	Loan Placement Fees	**$520,275**		$520,275
		b.	Bond Discount			$0
		c	CON Application Assistance			
			c1. Legal Fees	**$45,000**		$45,000
			c2. Other (Specify/add rows if needed)	**$20,000**		
		d.	Non-CON Consulting Fees			
			d1. Legal Fees			$0
			d2. Other (Specify/add rows if needed)	**$150,000**		$150,000
		e.	Debt Service Reserve Fund	**$2,801,407**		$2,801,407
		f	Other *(Specify/add rows if needed)*			$0
			SUBTOTAL	***$3,536,682***	***$0***	**$3,536,682**
	3.	**Working Capital Startup Costs**				$0
			TOTAL USES OF FUNDS	***$42,383,869***	***$0***	***$42,383,869***
B.	**Sources of Funds**					
	1.	**Cash**				$0
	2.	**Philanthropy (to date and expected)**				$0
	3.	**Authorized Bonds**		**$41,971,875**		$41,971,875
	4.	**Interest Income from bond proceeds listed in #3**		**$411,995**		$411,995
	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	***$42,383,870***		**$42,383,870**
				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 - SHORE HEALTH SYSTEM

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. See additional instruction in the column to the right of the table.

	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	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. DISCHARGES									
a. General Medical/Surgical*	8,011	8,234	7,266	7,294	7,339	7,385	7,110	7,157	7,206
b. ICU/CCU	236	254	224	225	227	228	220	221	223
Total MSGA	**8,247**	**8,488**	**7,490**	**7,520**	**7,565**	**7,613**	**7,330**	**7,379**	**7,429**
c. Pediatric	125	106	62	62	61	61	60	60	60
d. Obstetric	1,050	1,057	1,174	1,202	1,230	1,259	1,289	1,319	1,350
e. Acute Psychiatric	648	544	556	556	557	557	558	558	559
Total Acute	***10,070***	***10,195***	***9,282***	***9,339***	***9,413***	***9,490***	***9,237***	***9,316***	***9,398***
f. Rehabilitation	344	357	346	350	355	360	364	369	374
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL DISCHARGES	***10,414***	***10,552***	***9,628***	***9,690***	***9,768***	***9,849***	***9,602***	***9,686***	***9,772***
2. PATIENT DAYS									
a. General Medical/Surgical*	35,447	37,297	31,378	30,689	30,085	29,503	27,538	26,989	26,394
b. ICU/CCU	2,107	2,047	1,753	1,710	1,671	1,632	1,558	1,522	1,483
Total MSGA	**37,554**	**39,344**	**33,132**	**32,400**	**31,756**	**31,135**	**29,097**	**28,511**	**27,878**
c. Pediatric	292	245	152	151	150	149	148	147	146
d. Obstetric	2,513	2,570	2,888	2,956	3,026	3,097	3,170	3,245	3,322
e. Acute Psychiatric	4,417	3,917	3,790	3,793	3,796	3,799	3,803	3,807	3,811
Total Acute	***44,776***	***46,076***	***39,961***	***39,300***	***38,728***	***38,180***	***36,218***	***35,710***	***35,156***
f. Rehabilitation	3,567	3,394	3,632	3,679	3,727	3,776	3,827	3,878	3,930
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL PATIENT DAYS	***48,343***	***49,470***	***43,593***	***42,979***	***42,455***	***41,956***	***40,045***	***39,588***	***39,086***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)									
a. General Medical/Surgical*	4.4	4.5	4.3	4.2	4.1	4.0	3.9	3.8	3.7
b. ICU/CCU	8.9	8.1	7.8	7.6	7.4	7.2	7.1	6.9	6.7
Total MSGA	4.6	4.6	4.4	4.3	4.2	4.1	4.0	3.9	3.8
c. Pediatric	2.3	2.3	2.5	2.5	2.5	2.5	2.5	2.5	2.5
d. Obstetric	2.4	2.4	2.5	2.5	2.5	2.5	2.5	2.5	2.5
e. Acute Psychiatric	6.8	7.2	6.8	6.8	6.8	6.8	6.8	6.8	6.8
Total Acute	4.4	4.5	4.3	4.2	4.1	4.0	3.9	3.8	3.7
f. Rehabilitation	10.4	9.5	10.5	10.5	10.5	10.5	10.5	10.5	10.5
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL AVERAGE LENGTH OF STAY	4.6	4.7	4.5	4.4	4.3	4.3	4.2	4.1	4.0

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - SHORE HEALTH SYSTEM

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. See additional instruction in the column to the right of the table.

	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	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
4. NUMBER OF LICENSED BEDS									
a. General Medical/Surgical*	94	94	94	98	96	94	88	86	84
b. ICU/CCU	16	16	16	16	16	16	11	11	11
Total MSGA	**110**	**110**	**110**	**114**	**112**	**110**	**99**	**97**	**95**
c. Pediatric	8	8	8	1	1	1	1	1	1
d. Obstetric	17	17	17	12	12	12	12	13	13
e. Acute Psychiatric	24	24	24	12	12	12	12	12	12
Total Acute	***159***	***159***	***159***	***139***	***137***	***135***	***125***	***123***	***121***
f. Rehabilitation	20	20	20	13	14	14	14	14	14
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL LICENSED BEDS	***179***	***179***	***179***	***152***	***150***	***148***	***139***	***137***	***135***
5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a. General Medical/Surgical*	103.3%	108.7%	91.5%	85.6%	85.9%	86.3%	85.3%	85.7%	86.1%
b. ICU/CCU	36.1%	35.0%	30.0%	29.3%	28.6%	28.0%	38.8%	37.9%	36.9%
Total MSGA	**93.5%**	**98.0%**	**82.5%**	**77.7%**	**77.7%**	**77.8%**	**80.2%**	**80.3%**	**80.4%**
c. Pediatric	10.0%	8.4%	5.2%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
d. Obstetric	40.5%	41.4%	46.5%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%
e. Acute Psychiatric	50.4%	44.7%	43.3%	86.6%	86.7%	86.7%	86.8%	86.9%	87.0%
Total Acute	**77.2%**	**79.4%**	**68.9%**	**77.6%**	**77.7%**	**77.7%**	**79.6%**	**79.7%**	**79.7%**
f. Rehabilitation	48.9%	46.5%	49.8%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL OCCUPANCY %	**74.0%**	**75.7%**	**66.7%**	**77.4%**	**77.4%**	**77.5%**	**79.1%**	**79.2%**	**79.2%**
6. OUTPATIENT VISITS									
a. Emergency Department (IP and OP)	72,661	67,955	68,071	68,186	68,309	68,440	68,579	68,726	68,881
b. Same-day Surgery OP Visits	3,329	3,333	3,338	3,343	3,349	3,355	2,886	2,892	2,900
c. Laboratory OP RVUs	4,401,015	4,271,265	4,276,814	4,282,371	4,288,548	4,295,359	4,271,304	4,279,408	4,288,193
d. Imaging OP RVUs	776,132	768,199	769,179	770,160	771,252	772,458	767,808	769,245	770,805
e. MRI OP RVUs	29,250	26,290	26,316	26,342	26,372	26,406	12,697	12,727	12,759
TOTAL OUTPATIENT VISITS	***5,282,387***	***5,137,042***	***5,143,717***	***5,150,403***	***5,157,830***	***5,166,018***	***5,123,273***	***5,132,998***	***5,143,537***
7. OBSERVATIONS**									
a. Number of Patients	2,071	2,476	2,480	2,484	2,489	2,494	2,499	2,504	2,510
b. Hours	81,332	110,662	107,830	108,013	108,208	108,414	108,634	108,866	109,111

* 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 G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM

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

	Most Recent Years (Actual)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Inpatient Services	$ 131,796	$ 129,172	130,886	130,886	130,886	133,362	133,362	133,362
b. Outpatient Services	177,167	185,931	181,525	181,525	181,525	176,830	176,830	176,830
Gross Patient Service Revenues	***308,963***	***315,103***	***312,411***	***312,411***	***312,411***	***310,192***	***310,192***	***310,192***
c. Allowance For Bad Debt	-	7,126	7,772	7,646	7,523	7,115	6,997	6,883
d. Contractual Allowance	67,802	58,378	56,169	58,943	60,382	62,129	63,645	65,198
e. Charity Care	-	2,770	2,789	2,736	2,685	2,583	2,534	2,486
Net Patient Services Revenue	***241,161***	***246,829***	***245,680***	***243,085***	***241,821***	***238,365***	***237,015***	***235,625***
f. Other Operating Revenues (Specify/add rows if needed)	4,576	4,305	4,367	4,367	4,367	4,032	4,032	4,032
NET OPERATING REVENUE	***$ 245,737***	***$ 251,134***	***$ 250,047***	***$ 247,452***	***$ 246,188***	***$ 242,397***	***$ 241,047***	***$ 239,657***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 120,913	$ 112,640	$ 113,646	$ 113,526	$ 113,417	$ 107,520	$ 108,240	$ 108,980
b. Professional Fees	11,137	11,707	11,707	11,707	11,707	11,605	11,595	11,585
c. Interest on Current Debt	2,983	3,602	4,004	3,955	3,907	3,859	3,812	3,765
d1. Interest on Project Debt - FMF	-	-	-	-	-	2,090	2,054	2,016
d2. Interest on Project Debt - Easton	-	-	-	-	-	424	417	409
e. Current Depreciation	17,976	18,269	19,215	18,711	17,292	13,889	12,800	11,735
f1. Project Depreciation - FMF	-	-	-	-	-	1,780	1,816	1,852
f2. Project Depreciation - Easton	-	-	-	-	-	330	330	330
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	38,148	38,533	38,475	38,739	39,012	37,962	38,231	38,509
j. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)	42,398	44,163	43,711	43,887	44,068	53,042	53,264	53,490
k. Fixed Cost Additions	-	-	5,438	1,629	1,808	3,509	3,509	3,509
TOTAL OPERATING EXPENSES	**$ 233,555**	**$ 228,914**	**$ 236,195**	**$ 232,155**	**$ 231,211**	**$ 236,011**	**$ 236,067**	**$ 236,180**
3. INCOME								
a. Income From Operation	**$ 12,182**	**$ 22,220**	**$ 13,852**	**$ 15,297**	**$ 14,977**	**$ 6,386**	**$ 4,980**	**$ 3,477**
b. Non-Operating Income								
SUBTOTAL	***$ 12,182***	***$ 22,220***	***$ 13,852***	***$ 15,297***	***$ 14,977***	***$ 6,386***	***$ 4,980***	***$ 3,477***
c. Income Taxes								
NET INCOME (LOSS)	***$ 12,182***	***$ 22,220***	***$ 13,852***	***$ 15,297***	***$ 14,977***	***$ 6,386***	***$ 4,980***	***$ 3,477***

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM

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

	Most Recent Years (Actual)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%
2) Medicaid	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%
3) Blue Cross	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
4) Commercial Insurance	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%
5) Self-pay	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
6) Other	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days								
1) Medicare	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%
2) Medicaid	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%
3) Blue Cross	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%
4) Commercial Insurance	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
5) Self-pay	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
6) Other	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table G –
Key Financial Projection Assumptions for UM Shore Health System
(Does not include HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the UM Shore Health System (SHS) FY2017 actual financial performance with assumptions identified below. SHS includes Memorial Hospital at Easton, Dorchester General Hospital and Queen Anne's Emergency Center.	
Projection period reflects FY2018 – FY2024	
Volumes	- Refer to historical and projected utilization in Table F
Patient Revenue • Gross Charges	
o Update Factor	- 0.00% annual increase in FY2019 – FY2024
o Demographic Adjustment	- 0.00% annual increase in FY2019 – FY2024
o Other Rate Adjustments	- 0.00% annual increase in FY2019 – FY2024 based on historical experience
o Variable Cost Factor	- 100% variable cost factor associated with outpatient services shifted to the FMF and inpatient services shifted to Easton in FY2022 - 50% variable cost factor associated with the loss of volumes to other providers
o Redistribution of Dorchester General Hospital Revenue	- Shore Health System (SHS) will retain 50% of revenue related to volumes that will be lost to other providers in FY2022 (Retained Revenue) - $4.3M of SHS's Retained Revenue will be apportioned to the FMF to cover its depreciation and interest expense - Remainder of SHS's Retained Revenue will be apportioned to Memorial Hospital of Easton to cover its depreciation and interest expense associated with renovations and to fund ambulatory and physician network development and population health initiatives
• Revenue Deductions	- Continuation of 2017 deductions from revenue (contractual allowances, denials, charity, bad debts, assessments, UCC pool receipts) as percentages of gross revenue
Other Operating Revenue	- Remains constant from FY2018 with the exception of a loss of other operating revenue at FMF in FY2022
Expenses • Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses	- 0.0% weighted average annual increase that reflects the following: - 0.0% - 0.0% - 0.0% - 0.0% - 0.0%

• Expense Variability with Volume Changes o Salaries and Benefits o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses	 - 80% - 0% - 80% - 50% - 0%
• Building Related Operating Expense	- Incremental building operating costs (utilities, housekeeping, maintenance, security) calculated for the FMF's new square feet
• Interest Expense	
o Existing Debt	- Continued amortization of existing debt and related interest expense
o Project Debt	- Amortization of the following debt issuance over 30 years at 5.0% • $42.0M for construction of the new FMF • $8.4M for renovations at Easton • $33.1M for construction of a new MOB
• Depreciation and Amortization	- 30 year useful life for new construction and renovations - 7 year useful life for new equipment - 7 year useful life for routine capital expenditures
• Additional Incremental Expenses	- New expenses related to EPIC implementation ($5 million in fiscal year 2019), physician contracting and other strategic initiatives as follows: • $5.4M in FY2019 • $1.6M in FY2020 • $1.8M in FY2021 • $3.5M in FY2022-FY2024
	- The retention of 50% of revenue associated with patients that will seek care at other providers following the transformation of Dorchester to an FMF, will enable SHS to fund $8.2M of initiatives related to ambulatory and physician network development and population health initiatives.

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM

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

	Most Recent Year (Actual)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Inpatient Services	$ 131,796	$ 129,172	$ 134,080	$ 137,351	$ 140,703	$ 146,863	$ 150,446	$ 154,117
b. Outpatient Services	177,167	185,931	185,954	190,491	195,139	194,731	199,482	204,349
Gross Patient Service Revenues	***308,963***	***315,103***	***320,034***	***327,843***	***335,842***	***341,593***	***349,928***	***358,466***
c. Allowance For Bad Debt	-	7,126	7,962	8,024	8,088	7,835	7,894	7,954
d. Contractual Allowance	67,802	58,378	57,540	58,943	60,382	62,129	63,645	65,198
e. Charity Care	-	2,770	2,858	2,872	2,886	2,845	2,859	2,873
Net Patient Services Revenue	***241,161***	***246,829***	***251,675***	***258,003***	***264,487***	***268,784***	***275,530***	***282,441***
f. Other Operating Revenues (Specify/add rows if needed)	4,576	4,305	4,367	4,367	4,367	4,032	4,032	4,032
NET OPERATING REVENUE	***$ 245,737***	***$ 251,134***	***$ 256,042***	***$ 262,370***	***$ 268,854***	***$ 272,816***	***$ 279,562***	***$ 286,473***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 120,913	$ 112,640	$ 116,260	$ 118,809	$ 121,424	$ 117,759	$ 121,273	$ 124,911
b. Professional Fees	11,137	11,707	12,011	12,324	12,644	12,860	13,183	13,514
c. Interest on Current Debt	2,983	3,602	4,004	3,955	3,907	3,859	3,812	3,765
d1. Interest on Project Debt - FMF	-	-	-	-	-	2,090	2,054	2,016
d2. Interest on Project Debt - Easton	-	-	-	-	-	424	417	409
e. Current Depreciation	17,976	18,269	19,215	18,711	17,292	13,889	12,800	11,735
f1. Project Depreciation - FMF	-	-	-	-	-	1,780	1,816	1,852
f2. Project Depreciation - Easton	-	-	-	-	-	330	330	330
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	38,148	38,533	39,629	41,099	42,629	42,726	44,321	45,982
j. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)	42,398	44,163	44,585	45,660	46,765	57,414	58,807	60,238
k. Fixed Cost Additions	-	-	5,438	1,629	1,808	3,509	3,509	3,509
TOTAL OPERATING EXPENSES	**$ 233,555**	**$ 228,914**	**$ 241,142**	**$ 242,186**	**$ 246,470**	**$ 256,641**	**$ 262,321**	**$ 268,261**
3. INCOME								
a. Income From Operation	**$ 12,182**	**$ 22,220**	**$ 14,900**	**$ 20,184**	**$ 22,384**	**$ 16,175**	**$ 17,241**	**$ 18,212**
b. Non-Operating Income								
SUBTOTAL	***$ 12,182***	***$ 22,220***	***$ 14,900***	***$ 20,184***	***$ 22,384***	***$ 16,175***	***$ 17,241***	***$ 18,212***
c. Income Taxes								
NET INCOME (LOSS)	***$ 12,182***	***$ 22,220***	***$ 14,900***	***$ 20,184***	***$ 22,384***	***$ 16,175***	***$ 17,241***	***$ 18,212***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM

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

	Most Recent Year (Actual)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%
2) Medicaid	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%
3) Blue Cross	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
4) Commercial Insurance	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%
5) Self-pay	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
6) Other	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days								
Total MSGA								
1) Medicare	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%
2) Medicaid	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%
3) Blue Cross	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%
4) Commercial Insurance	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
5) Self-pay	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
6) Other	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

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

Projection is based on the UM Shore Health System (SHS) FY2017 actual financial performance with assumptions identified below. SHS includes Memorial Hospital at Easton, Dorchester General Hospital and Queen Anne's Emergency Center.	
Projection period reflects FY2018 – FY2024	
Volumes	- Refer to historical and projected utilization in Table F
Patient Revenue • Gross Charges	
o Update Factor	- 2.0% annual increase in FY2019 – FY2024
o Demographic Adjustment	- 0.29% annual increase in FY2019 – FY2024
o Other Rate Adjustments	- 0.15% annual increase in FY2019 – FY2024 based on historical experience
o Variable Cost Factor	- 100% variable cost factor associated with outpatient services shifted to the FMF and inpatient services shifted to Easton in FY2022 - 50% variable cost factor associated with the loss of volumes to other providers
o Redistribution of Dorchester General Hospital Revenue	- Shore Health System (SHS) will retain 50% of revenue related to volumes that will be lost to other providers in FY2022 (Retained Revenue) - $4.3M of SHS's Retained Revenue will be apportioned to the FMF to cover its depreciation and interest expense - Remainder of SHS's Retained Revenue will be apportioned to Memorial Hospital of Easton to cover its depreciation and interest expense associated with renovations and to fund ambulatory and physician network development and population health initiatives
• Revenue Deductions	- Continuation of 2017 deductions from revenue (contractual allowances, denials, charity, bad debts, assessments, UCC pool receipts) as percentages of gross revenue
Other Operating Revenue	- Remains constant from FY2018 with the exception of a loss of other operating revenue at FMF in FY2022
Expenses	

• Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses	- 2.5% weighted average annual increase that reflects the following: - 2.25% - 2.75% - 3.0% - 2.8% - 2.0%
• Expense Variability with Volume Changes o Salaries and Benefits o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses	 - 80% - 0% - 80% - 50% - 0%
• Building Related Operating Expense	- Incremental building operating costs (utilities, housekeeping, maintenance, security) calculated for the FMF's new square feet
• Interest Expense	
o Existing Debt	- Continued amortization of existing debt and related interest expense
o Project Debt	- Amortization of the following debt issuance over 30 years at 5.0% • $42.0M for construction of the new FMF • $8.4M for renovations at Easton • $33.1M for construction of a new MOB
• Depreciation and Amortization	- 30 year useful life for new construction and renovations - 7 year useful life for new equipment - 7 year useful life for routine capital expenditures
• Additional Incremental Expenses	- New expenses related to EPIC implementation ($5 million in fiscal year 2019), physician contracting and other strategic initiatives as follows: • $5.4M in FY2019 • $1.6M in FY2020 • $1.8M in FY2021 • $3.5M in FY2022-FY2024
	- The retention of 50% of revenue associated with patients that will seek care at other providers following the transformation of Dorchester to an FMF, will enable SHS to fund $8.2M of initiatives related to ambulatory and physician network development and population health initiatives.

TABLE I. STATISTICAL PROJECTIONS - UM SMC AT DORCHESTER (FY2016-FY2021) & UM SMC AT CAMBRIDGE (FY2022-FY2024)

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. See additional instruction in the column to the right of the table.

	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	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. DISCHARGES									
a. General Medical/Surgical*	1,688	1,917	1,418	1,413	1,423	1,433			
b. ICU/CCU	50	57	42	42	42	43			
Total MSGA	**1,738**	**1,974**	**1,460**	**1,455**	**1,465**	**1,475**	**0**	**0**	**0**
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric	648	544	556	556	557	557			
Total Acute	***2,386***	***2,518***	***2,016***	***2,011***	***2,022***	***2,033***	***0***	***0***	***0***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL DISCHARGES	***2,386***	***2,518***	***2,016***	***2,011***	***2,022***	***2,033***	***0***	***0***	***0***
2. PATIENT DAYS									
a. General Medical/Surgical*	7,120	8,373	6,192	6,171	6,214	6,257			
b. ICU/CCU	188	220	163	163	164	165			
Total MSGA	**7,308**	**8,593**	**6,356**	**6,334**	**6,377**	**6,422**	**0**	**0**	**0**
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric	4,417	3,917	3,790	3,793	3,796	3,799			
Total Acute	***11,725***	***12,510***	***10,145***	***10,127***	***10,173***	***10,221***	***0***	***0***	***0***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL PATIENT DAYS	***11,725***	***12,510***	***10,145***	***10,127***	***10,173***	***10,221***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)									
a. General Medical/Surgical*	4.2	4.4	4.4	4.4	4.4	4.4	0.0	0.0	0.0
b. ICU/CCU	3.7	3.9	3.9	3.9	3.9	3.9	0.0	0.0	0.0
Total MSGA	4.2	4.4	4.4	4.4	4.4	4.4	0.0	0.0	0.0
c. Pediatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
d. Obstetric	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
e. Acute Psychiatric	6.8	7.2	6.8	6.8	6.8	6.8	0.0	0.0	0.0
Total Acute	4.9	5.0	5.0	5.0	5.0	5.0	0.0	0.0	0.0
f. Rehabilitation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL AVERAGE LENGTH OF STAY	4.9	5.0	5.0	5.0	5.0	5.0	0.0	0.0	0.0

TABLE I. STATISTICAL PROJECTIONS - UM SMC AT DORCHESTER (FY2016-FY2021) & UM SMC AT CAMBRIDGE (FY2022-FY2024)

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. See additional instruction in the column to the right of the table.

	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	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
4. NUMBER OF LICENSED BEDS									
a. General Medical/Surgical*	17	17	17	19	19	19			
b. ICU/CCU	6	6	6	6	6	6			
Total MSGA	**23**	**23**	**23**	**25**	**25**	**25**	**0**	**0**	**0**
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric	24	24	24	12	12	12			
Total Acute	***47***	***47***	***47***	***37***	***37***	***37***	***0***	***0***	***0***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL LICENSED BEDS	***47***	***47***	***47***	***37***	***37***	***37***	***0***	***0***	***0***
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a. General Medical/Surgical*	114.8%	134.9%	99.8%	89.0%	89.6%	90.2%	0.0%	0.0%	0.0%
b. ICU/CCU	8.6%	10.1%	7.4%	7.4%	7.5%	7.5%	0.0%	0.0%	0.0%
Total MSGA	**87.1%**	**102.4%**	**75.7%**	**69.4%**	**69.9%**	**70.4%**	**0.0%**	**0.0%**	**0.0%**
c. Pediatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
d. Obstetric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
e. Acute Psychiatric	50.4%	44.7%	43.3%	86.6%	86.7%	86.7%	0.0%	0.0%	0.0%
Total Acute	**68.3%**	**72.9%**	**59.1%**	**75.0%**	**75.3%**	**75.7%**	**0.0%**	**0.0%**	**0.0%**
f. Rehabilitation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL OCCUPANCY %	**68.3%**	**72.9%**	**59.1%**	**75.0%**	**75.3%**	**75.7%**	**0.0%**	**0.0%**	**0.0%**
6. OUTPATIENT VISITS									
a. Emergency Department (IP and OP)	20,531	19,423	19,454	19,485	19,516	19,547	19,578	19,609	19,640
b. Same-day Surgery OP Visits	490	475	475	475	475	476	-	-	-
c. Laboratory OP RVUs	1,358,638	1,323,333	1,323,739	1,324,146	1,324,719	1,325,464	1,294,867	1,295,940	1,297,192
d. Imaging OP RVUs	262,336	250,775	250,852	250,929	251,038	251,179	245,381	245,584	245,821
e. MRI OP RVUs	17,630	13,715	13,719	13,723	13,729	13,737	-	-	-
TOTAL OUTPATIENT VISITS	***1,659,625***	***1,607,721***	***1,608,239***	***1,608,758***	***1,609,478***	***1,610,403***	***1,559,826***	***1,561,133***	***1,562,653***
7. OBSERVATIONS**									
a. Number of Patients	597	737	738	739	741	742	743	744	745
b. Hours	23,221	34,696	31,731	31,781	31,832	31,883	31,933	31,984	32,035

* 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 - UM SMC AT CAMBRIDGE (FMF)

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	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE							
a. Inpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
b. Outpatient Services	-	-	-	-	18,962	18,962	18,962
Gross Patient Service Revenues	**-**	**-**	**-**	**-**	***18,962***	***18,962***	***18,962***
c. Allowance For Bad Debt	-	-	-	-	1,053	1,053	1,053
d. Contractual Allowance	-	-	-	-	2,226	2,226	2,226
e. Charity Care	-	-	-	-	156	156	156
Net Patient Services Revenue	**-**	**-**	**-**	**-**	***15,526***	***15,526***	***15,526***
f. Other Operating Revenues (Specify)	-	-	-	-			
NET OPERATING REVENUE	**$ -**	**$ -**	**$ -**	**$ -**	***$ 15,526***	***$ 15,526***	***$ 15,526***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ -	$ -	$ -	$ -	$ 4,684	$ 4,689	$ 4,695
b. Professional Fees	-	-	-	-	1,778	1,778	1,778
c. Interest on Current Debt	-	-	-	-	207	204	202
d. Interest on Project Debt	-	-	-	-	2,090	2,054	2,016
e. Current Depreciation	-	-	-	-	-	-	-
f. Project Depreciation	-	-	-	-	1,780	1,816	1,852
g. Current Amortization	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-
i. Supplies	-	-	-	-	733	734	735
j. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)	-	-	-	-	4,862	4,863	4,864
TOTAL OPERATING EXPENSES	**$ -**	**$ -**	**$ -**	**$ -**	**$ 16,134**	**$ 16,139**	**$ 16,142**
3. INCOME							
a. Income From Operation	**$ -**	**$ -**	**$ -**	**$ -**	**$ (608)**	**$ (612)**	**$ (615)**
b. Non-Operating Income	-	-	-	-	-	-	-
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ -***	***$ (608)***	***$ (612)***	***$ (615)***
c. Income Taxes	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ -***	***$ (608)***	***$ (612)***	***$ (615)***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - UM SMC AT CAMBRIDGE (FMF)

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	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare					36.6%	36.6%	36.6%
2) Medicaid					36.0%	36.0%	36.0%
3) Blue Cross					9.0%	9.0%	9.0%
4) Commercial Insurance					13.8%	13.8%	13.8%
5) Self-pay					3.0%	3.0%	3.0%
6) Other					1.8%	1.8%	1.8%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***

Table J –
Key Financial Projection Assumptions for UM SMC at Cambridge
(Does not include HSCRC Annual Update Factors & Expense Inflation)

Projection is based on UM Shore Medical Center at Dorchester FY2017 actual financial performance of its outpatient services with assumptions identified below.	
Projection period reflects FY2018 – FY2024	
Volumes	- Refer to historical and projected utilization in Table F and Sections H and I related to the methodology, assumptions and projections of ED and Observation utilization
Patient Revenue • Gross Charges o Update Factor	- 0.00% annual increase in FY2019 – FY2024
o Demographic Adjustment	- 0.00% annual increase in FY2019 – FY2024
o Other Rate Adjustments	- 0.00% annual increase in FY2019 – FY2024 based on historical experience
o Variable Cost Factor	- 100% variable cost factor associated with regulated outpatient services shifted from Dorchester General Hospital to the FMF in FY2022 - Shore Health System (SHS) will retain 50% of revenue related to volumes that will be lost to other providers in FY2022 (Retained Revenue) - $4.3M of SHS's Retained Revenue will be apportioned to the FMF to cover its depreciation and interest expense
o Redistribution of Dorchester General Hospital Revenue	- Continuation of 2017 deductions from revenue (contractual allowances, denials, charity, bad debts, assessments) as percentages of gross revenue - Historical UCC pool receipts for outpatient services at Dorchester General Hospital are incorporated into the regulated revenue for the FMF
• Revenue Deductions	
Other Operating Revenue	- Historical other operating revenue at Dorchester General Hospital is eliminated in the FMF beginning in FY2022
Expenses • Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses	- 0.0% weighted average annual increase that reflects the following: - 0.0% - 0.0% - 0.0% - 0.0% - 0.0%
• Expense Variability with Volume Changes o Salaries and Benefits	

o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses	- 80% - 0% - 80% - 50% - 0%
• Building Related Operating Expense	- Incremental building operating costs (utilities, housekeeping, maintenance, security) calculated for the FMF's new square feet
• Interest Expense	- Amortization of $42.0M for construction of the new FMF over 30 years at 5.0%
• Depreciation and Amortization	- 30 year useful life for new construction and renovations - 7 year useful life for new equipment - 7 year useful life for routine capital expenditures

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - UM SMC AT CAMBRIDGE (FMF)

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	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE							
a. Inpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
b. Outpatient Services	-	-	-	-	20,439	20,938	21,448
Gross Patient Service Revenues	***-***	***-***	***-***	***-***	***20,439***	***20,938***	***21,448***
c. Allowance For Bad Debt	-	-	-	-	1,160	1,188	1,217
d. Contractual Allowance	-	-	-	-	2,400	2,458	2,518
e. Charity Care	-	-	-	-	172	176	181
Net Patient Services Revenue	***-***	***-***	***-***	***-***	***16,707***	***17,115***	***17,533***
f. Other Operating Revenues (Specify/add rows of needed)	-	-	-	-	-	-	-
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ -***	***$ 16,707***	***$ 17,115***	***$ 17,533***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ -	$ -	$ -	$ -	$ 5,250	$ 5,374	$ 5,501
b. Professional Fees	-	-	-	-	1,997	2,042	2,088
c. Interest on Current Debt	-	-	-	-	207	204	202
d. Interest on Project Debt	-	-	-	-	2,090	2,054	2,016
e. Current Depreciation	-	-	-	-	-	-	-
f. Project Depreciation	-	-	-	-	1,780	1,816	1,852
g. Current Amortization	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-
i. Supplies	-	-	-	-	822	841	861
j. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)	-	-	-	-	5,088	5,200	5,316
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ -***	***$ -***	***$ 17,233***	***$ 17,532***	***$ 17,836***
3. INCOME							
a. Income From Operation	**$ -**	**$ -**	**$ -**	**$ -**	**$ (526)**	**$ (417)**	**$ (303)**
b. Non-Operating Income	-	-	-	-	-	-	-
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ -***	***$ (526)***	***$ (417)***	***$ (303)***
c. Income Taxes	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ -***	***$ (526)***	***$ (417)***	***$ (303)***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - UM SMC AT CAMBRIDGE (FMF)

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	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare					36.6%	36.6%	36.6%
2) Medicaid					36.0%	36.0%	36.0%
3) Blue Cross					9.0%	9.0%	9.0%
4) Commercial Insurance					13.8%	13.8%	13.8%
5) Self-pay					3.0%	3.0%	3.0%
6) Other					1.8%	1.8%	1.8%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***

Table K –
Key Financial Projection Assumptions for UM SMC at Cambridge (Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on UM Shore Medical Center at Dorchester FY2017 actual financial performance of its outpatient services with assumptions identified below.	
Projection period reflects FY2018 – FY2024	
Volumes	- Refer to historical and projected utilization in Table F and Sections H and I related to the methodology, assumptions and projections of ED and Observation utilization
Patient Revenue • Gross Charges	
o Update Factor	- 2.0% annual increase in FY2019 – FY2024
o Demographic Adjustment	- 0.29% annual increase in FY2019 – FY2024
o Other Rate Adjustments	- 0.15% annual increase in FY2019 – FY2024 based on historical experience
o Variable Cost Factor	- 100% variable cost factor associated with regulated outpatient services shifted from Dorchester General Hospital to the FMF in FY2022
o Redistribution of Dorchester General Hospital Revenue	- Shore Health System (SHS) will retain 50% of revenue related to volumes that will be lost to other providers in FY2022 (Retained Revenue) - $4.3M of SHS's Retained Revenue will be apportioned to the FMF to cover its depreciation and interest expense - Continuation of 2017 deductions from revenue (contractual allowances, denials, charity, bad debts, assessments) as percentages of gross revenue - Historical UCC pool receipts for outpatient services at Dorchester General Hospital are incorporated into the regulated revenue for the FMF
• Revenue Deductions	
Other Operating Revenue	- Historical other operating revenue at Dorchester General Hospital is eliminated in the FMF beginning in FY2022

Expenses	
• Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses	- 2.5% weighted average annual increase that reflects the following: - 2.25% - 2.75% - 3.0% - 2.8% - 2.0%
• Expense Variability with Volume Changes o Salaries and Benefits o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses	- 80% - 0% - 80% - 50% - 0%
• Building Related Operating Expense	- Incremental building operating costs (utilities, housekeeping, maintenance, security) calculated for the FMF's new square feet
• Interest Expense	- Amortization of $42.0M for construction of the new FMF over 30 years at 5.0%
• Depreciation and Amortization	- 30 year useful life for new construction and renovations - 7 year useful life for new equipment - 7 year useful life for routine capital expenditures

TABLE L. WORKFORCE INFORMATION for UM SMC at Cambridge

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.

	Entire Current Facility			***PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)***			***OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)***			***PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) ****	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
Emergency			$0			$0			$0	22.7	$1,536,563
Laboratory Svcs										11.7	$773,831
Observation										7.0	$349,956
Diagnostic Imaging										4.3	$262,709
Sbh Partial Hosp Program										2.1	$142,395
Computed Tomography										0.9	$71,358
Nuclear Medicine										0.0	$2,607
Total Direct Care			$0			$0			$0	48.7	$ 3,139,419
Support Staff *(List general categories, add rows if needed)*											
Case Management			$0			$0			$0	1.6	$126,583
Security			$0			$0			$0	7.6	$280,455
Environmental Services			$0			$0			$0	2.5	$71,947
Maintenance			$0			$0			$0	1.0	$49,230
Total Support			$0			$0			$0	12.7	$ 528,215
REGULAR EMPLOYEES TOTAL			$0			$0			$0	61.3	$3,667,634

TABLE L. WORKFORCE INFORMATION for UM SMC at Cambridge

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.

	Entire Current Facility			***PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)***			***OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)***			***PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) ****	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below)***:**											**$1,026,938**
28.0% of Salary Expense											
TOTAL COST	***0.0***		***$0***	***0.0***		***$0***	***0.0***		***$0***		***$4,694,572***

EXHIBIT 2

CONCEPT SKETCH

UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH

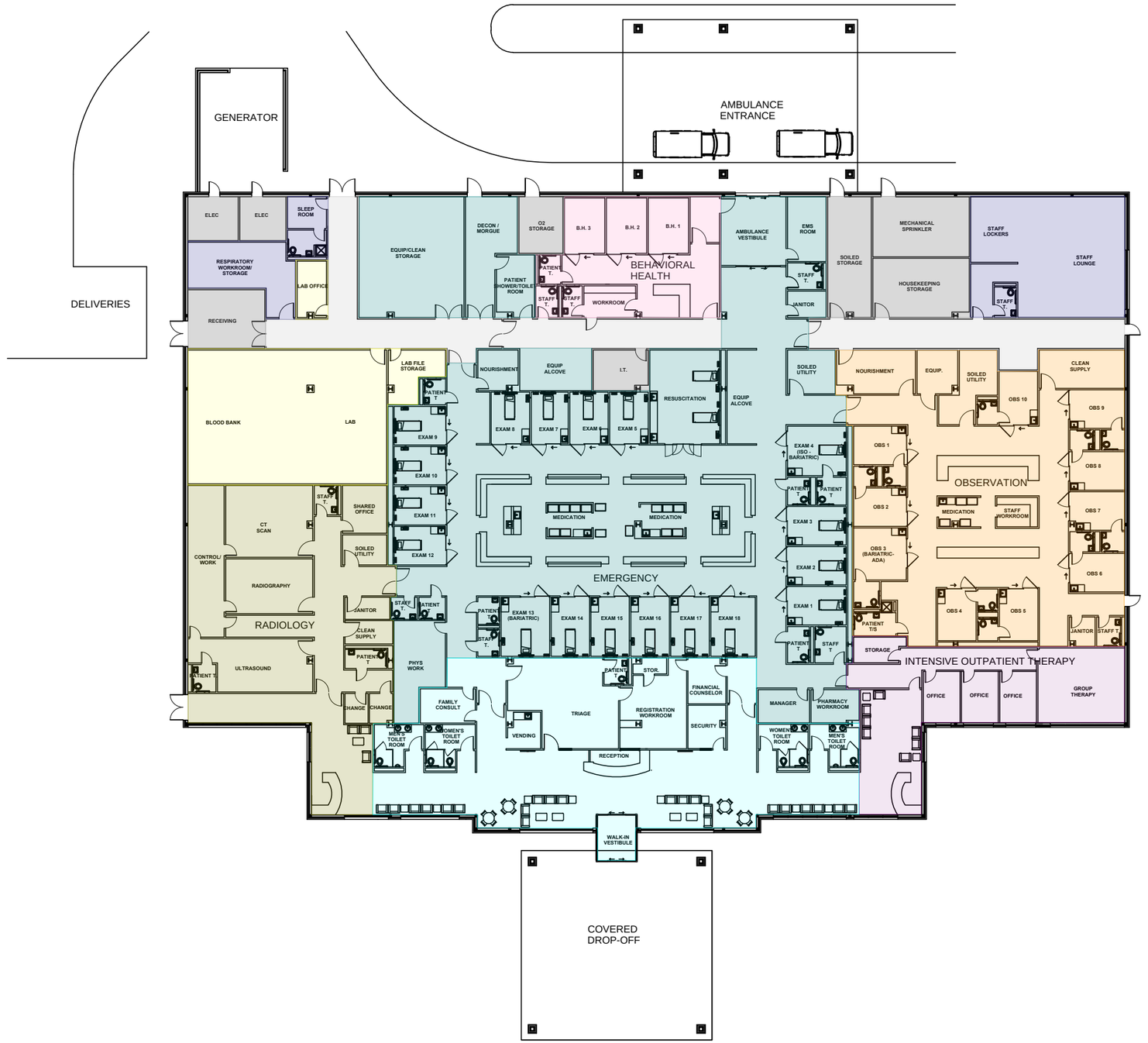
FREESTANDING MEDICAL FACILITY, CAMBRIDGE, MD

NOT TO SCALE

JUNE 11, 2018

hord | coplan | macht
750 E. Pratt Street, Suite 1100 Baltimore MD 21202
410.837.7311 | www.hcm2.com

CONCEPT PLAN



UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH

FREESTANDING MEDICAL FACILITY, CAMBRIDGE, MD

1/32" = 1'-0"

JUNE 11, 2018

hord | coplan | macht

750 E. Pratt Street, Suite 1100 Baltimore MD 21202
410.837.7311 | www.hcm2.com

CONCEPT SITE PLAN

UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH

CAMBRIDGE, MD

SCALE: 1"=60'

JUNE 11, 2018

hord | coplan | macht
750 E. Pratt Street, Suite 1100 Baltimore MD 21202
410.837.7311 | www.hcm2.com

EXHIBIT 3

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

CROSS REFERENCE

Administrative Policy LD-34: Financial Assistance

SCOPE

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

PURPOSE

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

BENEFITS

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

1.0 POLICY

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

2.0 PROCEDURE

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

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

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

Gerard M. Walsh, Chief Operating Officer

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

EXHIBIT 4

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Estimated Charges for Inpatient Admissions

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

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

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Estimated Charges for Inpatient Admissions

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

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

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Estimated Charges for Inpatient Admissions

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

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Estimated Charges for Inpatient Admissions

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

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

University of Maryland Shore Regional Health

Estimated Charges for Common Inpatient Procedures

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

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT EASTON
Estimated Charges for Common Ancillary Services

LABORATORY

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

RADIOLOGY

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

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT EASTON
Estimated Charges for Common Outpatient Procedures

OUTPATIENT SURGERY

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

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT DORCHESTER
Estimated Charges for Common Ancillary Services

LABORATORY

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

RADIOLOGY

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

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT DORCHESTER
Estimated Charges for Common Outpatient Procedures

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

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT CHESTERTOWN
Estimated Charges for Common Ancillary Services

LABORATORY

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

RADIOLOGY

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

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT CHESTERTOWN
Estimated Charges for Common Outpatient Procedures

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

EXHIBIT 5

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

POLICY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PROGRAM ELIGIBILITY

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

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

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

   a. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications.
3. Unpaid balances resulting from cosmetic or other non-medically necessary services
4. Patient convenience items
5. Patient meals and lodging
6. Physician charges related to the date of service are excluded from UMMS financial assistance policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.

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

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

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

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

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

Presumptive Financial Assistance

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

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

p. UMSJMC Hernia Program eligible patients

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

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

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

PROCEDURES

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.
2. Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
   a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.
   b. Preliminary data will be entered into a third party data exchange system to determine probably eligibility. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
   c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance. Determination of Probable Eligibility will be provided within two business days following a patient's request for charity care services, application for medical assistance, or both.
   d. Upon receipt of the patient's application, they will have thirty (30) days to submit the required documentation to be considered for eligibility. If no data is received within the 30 days, a denial letter will be sent notifying that the case is now closed for lack of the required documentation. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to. The Financial

Assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Financial Hardship

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

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

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

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

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

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

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

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

Appeals

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

Judgments

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

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

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

Effective 7/1/17

EXHIBIT 6

Help for Patients to Pay Hospital Care Costs

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

PLEASE NOTE:

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

HOW THE PROCESS WORKS:

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

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

HOW WE REVIEW YOUR APPLICATION:

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

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

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

HOW TO APPLY FOR FINANCIAL HELP:

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

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

OTHER HELPFUL INFORMATION:

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

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Ayuda para que los Pacientes Paguen los Costos de Atención Hospitalaria

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

TENGA EN CUENTA LO SIGUIENTE:

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

CÓMO FUNCIONA EL PROCESO:

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

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

CÓMO REVISAR SU SOLICITUD:

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

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

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

CÓMO SOLICITAR ASISTENCIA FINANCIERA:

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

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

OTRA INFORMACIÓN ÚTIL:

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

EXHIBIT 7

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Hostile language and the way things ought to be

MARK SHIELDS

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

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

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

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

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

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

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

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

Time to stop the abusers

JENNIFER RUBIN

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

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

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

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

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

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

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

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

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

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

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

Democrats and the trap of Trump impeachment

BYRON YORK

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Byron York is chief political correspondent for The Washington Examiner.

Final lane opened on Severn River Bridge

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

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

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

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

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

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

Twilley celebrates 40 years with Shore United Bank

RALPH TWILLEY

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

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

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

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

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

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

Meetings scheduled on Bay Crossing Study

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

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

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

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

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

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

KERRIGAN

From Page 5

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

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

But why go on such a grueling journey?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Follow me on Twitter: @SDBaysideSports.

Jury finds teen innocent in alleged sexual assault

By TRISH MCGEE
pmcgee@thekentcountynews.com

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"No," the woman answered.

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

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

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

She said she doesn't sleep much.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PHOTO BY DUSTIN HOLT

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

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

By DAVID INSLEY
dinsley@stardem.com

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

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

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

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

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

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

See **VIKINGS**
Page 13

NEWS IN BRIEF

Incendiary device leads to fire in Church Hill

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

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

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

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

Cocaine recovered in elementary school zone

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

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

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

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

She was ordered held without bail.

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

PHOTO BY DANIEL MCCREARY

Saturday Sunset near Centreville

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

EXHIBIT 8

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No 20-003

Issued to:

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

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

Date Issued: December 18, 2015

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

Expiration Date: March 18, 2019

Patricia Tomsko May MD

Director

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

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 09-002

Issued to:

University Of Maryland Shore Medical Center At Dorchester
300 Bryn Street
Cambridge, MD 21613

Type of Facility: Acute General Hospital

Date Issued: December 18, 2015

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

Expiration Date: March 18, 2019

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The Joint Commission

March 8, 2016

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

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

Dear Mr. Kozel:

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

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

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

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

This recommendation applies to the following locations:

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

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

The Joint Commission

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

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

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

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

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

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

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

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

Sincerely,

Mark Pelletier

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

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

The Joint Commission

March 8, 2016

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

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

Dear Mr. Kozel:

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

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

- Comprehensive Accreditation Manual for Behavioral Health Care

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

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

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

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

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

EXHIBIT 9

UM Shore Medical Center at Easton
Quality Measures Exhibit

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

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

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

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Date Accessed: 3/18/2018

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

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

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

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

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

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

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Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030
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Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
53	How often patients die in the hospital after bleeding from stomach or intestines	Average	1.3736 (0.0000, 3.7735)	
54	How often patients die in the hospital after fractured hip	Average	2.5229 (0.0000, 5.2932)	
55	How often patients die in the hospital while getting care for a condition that rarely results in death	Average	0.0000 (0.0000, 0.8581)	
Pneumonia				
	Results of Care - Deaths			
56	How often patients die in the hospital while getting care for pneumonia	Average	5.4022 (3.0753, 7.7290)	
57	Dying within 30-days after getting care in the hospital for pneumonia	Average	16.7 (14.6 - 19.1)	
58	Returning to the hospital after getting care for pneumonia	Average	17.1 (14.9 - 19.4)	
Stroke				
	Results of Care			
59	How often patients who came in after having stroke subsequently died in the hospital.	Average	7.1496 (3.6067, 10.6925)	
60	Death rate for stroke patients	Average	15.3(12.8, 18.4)	
61	Rate of unplanned readmission for stroke patients	Average	13.1(10.8, 15.7)	
	Practice Patterns			
62	Number of surgeries to remove part of the esophagus	Not enough data to report	-	
63	Number of surgeries to remove part of the	Not enough	-	

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

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

EXHIBIT 10

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Community Health Needs Assessment & Implementation Plan

Executive Summary

FY2017-FY2019

Approved by: Shore Regional Health Board - 5/25/2016

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Executive Summary

Overview

University of Maryland Shore Regional Health (UM SRH) is a regional, nonprofit, medical delivery care network formed on July 1, 2013, through the consolidation of two University of Maryland partner entities, the former Shore Health and the former Chester River Health.

UM SRH network serves the Mid-Shore region, which includes Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties. In addition to its three hospitals — University of Maryland Shore Medical Center at Chestertown (SMC at Chestertown), the University of Maryland Shore Medical Center at Dorchester (SMC at Dorchester), and the University of Maryland Shore Medical Center at Easton (SMC at Easton) — UM SRH includes the University of Maryland Shore Emergency Center at Queenstown and the University of Maryland Shore Medical Pavilion at Queenstown, the University of Maryland Shore Nursing and Rehabilitation Center at Chestertown, and a broad array of inpatient and outpatient services in locations throughout the five-county region.

SMC at Easton is situated at the center of the Mid-Shore area and thus serves a large rural geographic area (all 5 counties of the Mid-Shore). SMC at Dorchester is located approximately 18 miles from Easton and primarily serves Dorchester County and portions of Caroline County. SMC at Chestertown located in Chestertown, Kent County serves the residents of Kent County, portions of Queen Anne's and Caroline Counties and the surrounding areas.

In FY2015, UM SRH provided care for 11,346 inpatient admissions, 4,884 outpatient surgical cases, and 79,784 emergency department visits. UM SRH is licensed for 182 acute care beds. Beyond Shore Regional Health Medical Center facilities in FY2015, UM SRH provided over 18,000 hours of community health services through education and outreach programs, screenings, support groups, and other initiatives that meet the

community health care needs. In addition, UM SRH provides a community outreach section on the UM SRH public web site to announce upcoming community health events and activities in addition to posting the triennial Community Health Needs Assessment (CHNA).
http://umms.org/shore-health/about/~/media/systemhospitals/shore/pdfs/about/chna.pdf

Our Mission and Vision

UM SRH's organization's mission and vision statements set the framework for the community benefit program. As University of Maryland Shore Regional Health expands the regional healthcare network, we have explored and renewed our mission, vision and values to reflect a changing health care environment and our communities' needs. With input from physicians, team members, patients, health officers, community leaders, volunteers and other stakeholders, the Board of University of Maryland Shore Regional Health has adopted a new, five-year Strategic Plan.

The Strategic Plan supports our **Mission**, **Creating Healthier Communities Together**, and our **Vision**, to be the **region's leader in patient centered health care**. Our goal is to provide quality health care services that are comprehensive, accessible, and convenient, and that address the needs of our patients, their families and our wider communities.
Link to Strategic Plan:
http://umshoreregional.org/~/media/systemhospitals/shore/pdfs/about/srm-4014-handoutmech.pdf?la=en

Process

I. Establishing the Assessment and Infrastructure

To complete a comprehensive assessment of the needs of the community, the Association for Community Health Improvement's (ACHI) 6-step Community Health Assessment Process was utilized as an organizing methodology. The UM SRH Community Health Planning Council served as the lead team to conduct the Community Health Needs Assessment (CHNA) with input from The University of Maryland Medical System (UMMS) Community Health Improvement Committee, community leaders, the public, health experts, and the 5 health departments that serve the Mid-Shore. The UM SRH Community Health Planning Council adopted the following ACHI 6-step process (See Figure 1) to lead the assessment process and the additional 5-component assessment (See Figure 2) and engagement strategy to lead the data collection methodology.

The assessment was designed to:

- Develop a comprehensive profile of health status, quality of care and care management indicators for residents of the Mid-Shore area overall and by county.
- Identify a set of priority health needs (public health and health care) for follow-up.
- Provide recommendations on strategies that can be undertaken by health providers, public health, communities, policy makers and others to follow up on the information provided, so as to improve the health status of Mid-Shore residents.
- Provide access to the data and assistance to stakeholders who are interested in using it.

Figure 1 - ACHI 6-Step Community Health Assessment Process

According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a community health needs assessment either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and beginning in 2013, perform an assessment at least every three years thereafter. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public. For the purposes of this report, a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish community health priorities, and includes the following: (1) A description of the process used to conduct the assessment; (2) With whom the hospital has worked; (3) How the hospital took into account input from community members and public health experts; (4) A description of the community served; and (5) A description of the health needs identified through the assessment process.

Figure 2 – 5-Step Assessment & Engagement Model

Data was collected from the five major areas illustrated above to complete a comprehensive assessment of the community's needs. Data is presented in Section III of this summary. UM SRH participates in a wide variety of local coalitions including, several sponsored by the Mid-Shore State Health Improvement Process (SHIP), Local Health Departments (Caroline, Dorchester, Kent, Queen Anne's, Talbot Counties), Cancer Coalition, Tobacco Coalition, as well as partnerships with many community-based organizations like American Cancer Society (ACS), Susan G. Komen Foundation, American Diabetes Association (ADA) and American Heart Association (AHA) to name a few.

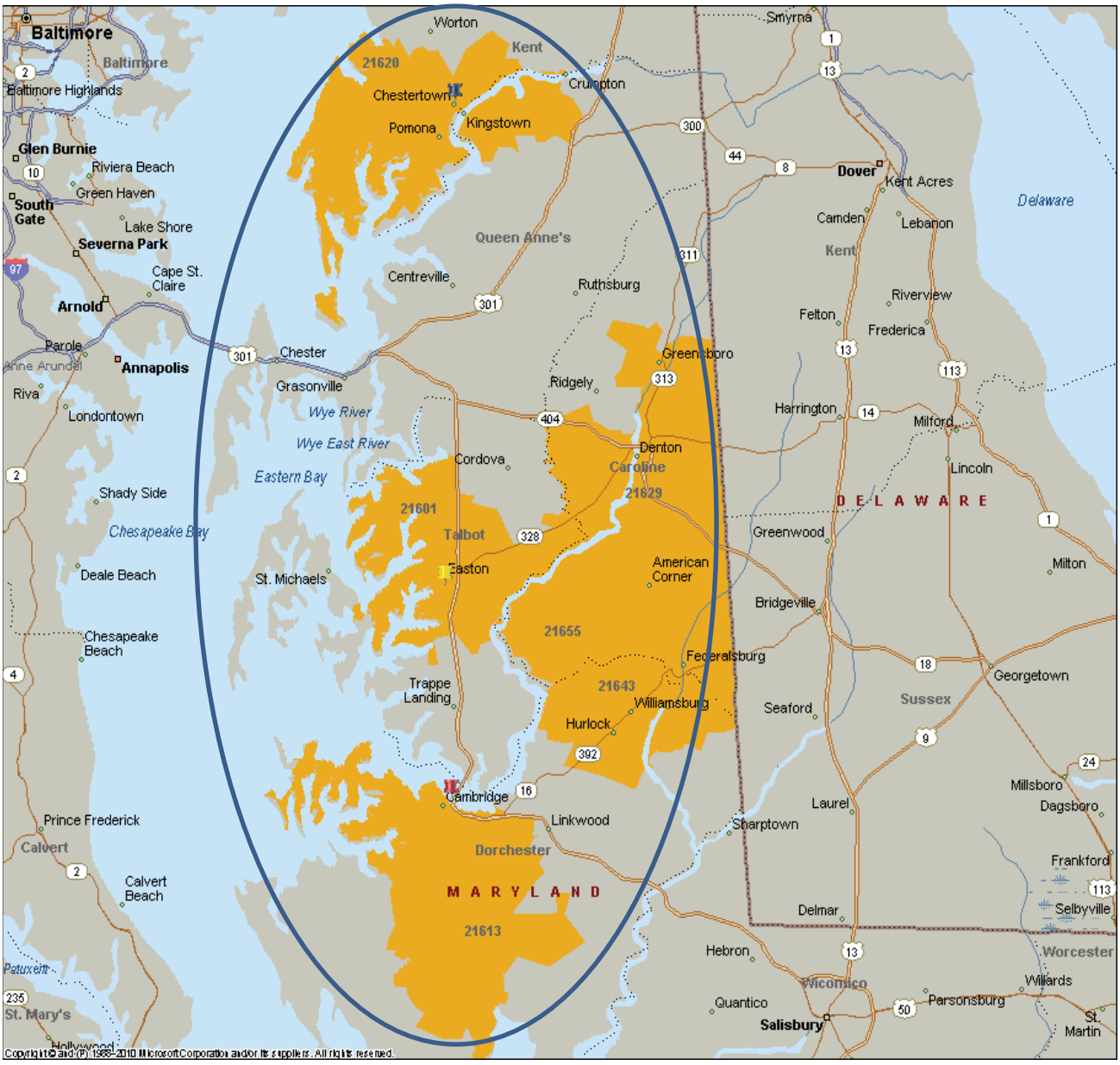
II. Defining the Purpose and Scope

Primary Community Benefit Service Area

For purposes of community benefits programming and this report, Shore Regional Health's Community Benefit Service Area is defined as the Maryland counties of Caroline, Dorchester, Kent, Queen Anne's and Talbot.

5 County CBSA- Caroline, Dorchester, Kent, Queen Anne's, Talbot

The zip codes included in the cumulative total of 80% of all admissions is the primary community benefit service area (CBSA) for UM SRH and comprise the geographic scope of this assessment. (Figure 3)



Yellow Highlighted ZIP Codes – Top 65% of Market Discharges, Top 80% Circled in Blue

Figure 3 – Top University of Maryland Shore Regional Health

FY15 Admissions by Zip Code

Primary ZIPs (Top 65% of Cases) and Secondary ZIPs (66%-80% of Cases)

Hospital	ZIP Code	Total Cases	% of Cases	Cumu. %
UMMC @ Chestertown	**21620 - Chestertown**	**804**	**48.9%**	**48.9%**
	21661 - Rock Hall	**220**	**13.4%**	**62.2%**
	21678 - Worton	115	7.0%	69.2%
	21651 - Millington	108	6.6%	75.8%
	21617 - Centreville	76	4.6%	80.4%
UMMC @ Dorchester	**21613 - Cambridge**	**1306**	**56.2%**	**56.2%**
	21643 - Hurlock	**179**	**7.7%**	**63.9%**
	21631 - East New Market	111	4.8%	68.7%
	21601 - Easton	109	4.7%	73.4%
	21664 - Secretary	47	2.0%	75.4%
	21835 - Linkwood	44	1.9%	77.3%
	21632 - Federalsburg	43	1.9%	79.1%
	21673 - Trappe	41	1.8%	80.9%
UMMC @ Easton	**21601 - Easton**	**2173**	**26.0%**	**26.0%**
	21613 - Cambridge	**925**	**11.1%**	**37.0%**
	21629 - Denton	**736**	**8.8%**	**45.8%**
	21632 - Federalsburg	**428**	**5.1%**	**51.0%**
	21655 - Preston	**390**	**4.7%**	**55.6%**
	21643 - Hurlock	**348**	**4.2%**	**59.8%**
	21639 - Greensboro	**314**	**3.8%**	**63.5%**
	21663 - Saint Michaels	299	3.6%	67.1%
	21617 - Centreville	286	3.4%	70.5%
	21660 - Ridgely	279	3.3%	73.9%
	21673 - Trappe	215	2.6%	76.4%
	21625 - Cordova	199	2.4%	78.8%
	21620 - Chestertown	142	1.7%	80.5%

III. Collecting and Analyzing Data

Using the above framework (Figures 1 & 2), data was collected from multiple sources, groups, and individuals and integrated into a comprehensive document which was utilized on April 1, 2016, at a special session of the Community Health Planning Council. During that strategic planning session, priorities were identified using the collected data and an adapted version of the Catholic Health Association's (CHA) priority setting criteria. The identified priorities were also validated by the Mid-Shore Local Health Improvement Coalition. UM SRH used primary and secondary sources of data as well as quantitative and qualitative data and consulted with numerous individuals and organizations during the CHNA, including community leaders, community partners, the University of Maryland Health Improvement Committee, the general public, local health experts, and the Health Officers representing the 5 counties of the Mid-Shore.

A) Community Perspective

The community's perspective was obtained through one widely-distributed survey offered to the public via several methods throughout Mid-Shore. A 6-item survey queried residents to identify their top health concerns and their top barriers in accessing health care. (See Appendiix 1 for the actual survey/results)

Methods

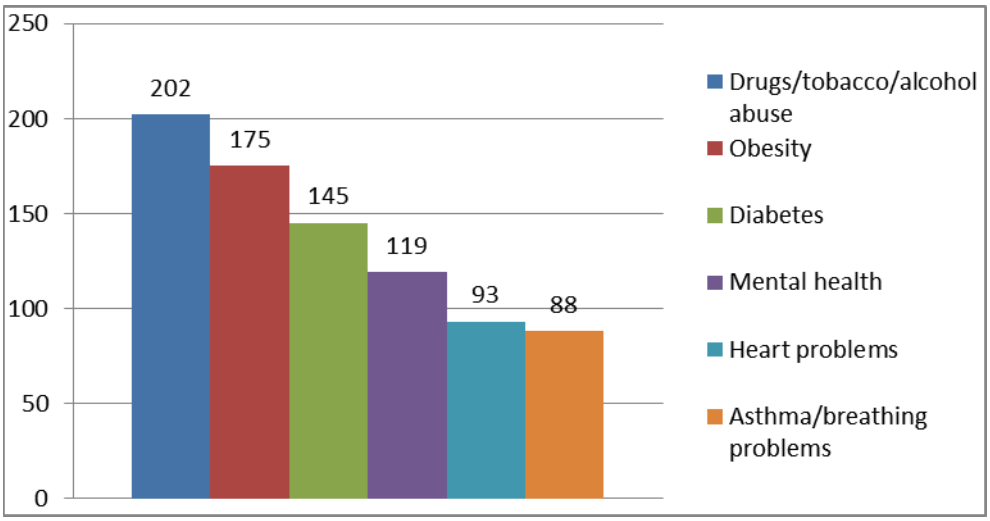
- 6-item survey distributed in FY2016 using the following methods:
  - Survey insert in ***Maryland Health Matters*** (health newsletter) distributed to over 77,266 households within the CBSA
  - Online survey posted to http://umshoreregional.org/news-and-events/news/2016/community-health-needs-assessment-survey for community to complete
  - Waiting rooms (Ambulatory clinics and EDs)
  - Health fairs and events in neighborhoods within UM SRH's CBSA

Results

- Top 5 Health Concerns: (See Chart 1 below)
    1. Drugs/tobacco/alcohol abuse
    2. Obesity
    3. Diabetes
    4. Mental Health
    5. Heart Problems

Analysis by CBSA targeted zip codes revealed the same top health concerns and top health barriers with little deviation from the overall DHMH State Health Improvement Process (SHIP) data which reports state and county level data on critical health measures.

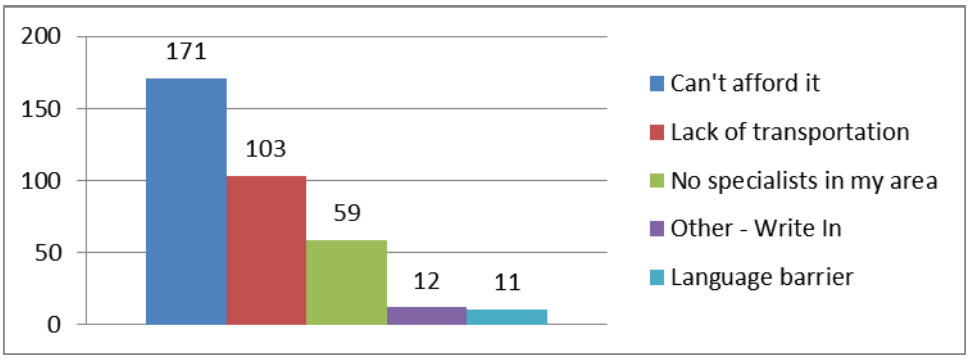
Chart 1 - Community's Top Health Concerns



THE SAMPLE SIZE WAS 323 MID-SHORE RESIDENTS FROM THE IDENTIFIED CBSA.

- Top 3 Barriers to Health Care: (See Chart 2 below)
    1. Can't afford it
    2. Lack of transportation
    3. No specialists in my area

Chart 2 – Community's Top Barriers to Healthcare



- In addition to the survey, UM SRH hosted 8 Listening Sessions throughout the region. The public was invited to share their perspective on the health needs of the community (See Appendix 2 for listening session questionnaire/results)

  - ☐ Online questionnaire posted to http://umshoreregional.org/ for community to complete
  - ☐ Distributed to attendees of listening sessions

Results

- Top 3 Health Problems or Needs:
  1. Access to Care- diagnostics, specialists, primary care
  2. Transportation
  3. Preventive Care

B) Health Experts

Methods

- Reviewed & included National Prevention Strategy Priorities, Maryland State Health Improvement Plan (SHIP) indicators, data from Rural Health Association, and Robert Wood Johnson County Rankings and Roadmaps, Hospital Inpatient Readmissions and High Utilizer data.
- Reviewed data from Rural Health Association summit in October 2015.
  -Progress to date on SHIP measures were presented as related to activities in rural communities and workforce development.
- Conducted stakeholder meeting with Community Providers and Health Officers August 2015
- Conducted stakeholder meeting with Local Health Improvement Coalition March 2016
- The providers' perspective was obtained through a 6-item survey distributed to the medical staff of UM SRH. The survey queried providers of care to identify the community's top health concerns and top barriers in accessing health care.

Results

- Community Providers and Health Officers Top Health Priorities and Top Action Items included:
  - ☐ Improve communication and synergy between agencies of the Mid-Shore
  - ☐ Look for ways to partner and support each other
- SHIP: 39 Objectives in 5 Focus Areas for the State (Figure 4), includes targets for Caroline, Dorchester, Kent, Queen Anne's, Talbot counties:
  - While progress has been made since 2013 - each county's progress varies widely on meeting the identified targets at the state level. Wide disparities exist within the CBSA territory. (See Appendix 3 for SHIP data by county)

County SHIP Measures (see: http://dhmh.maryland.gov/ship/Pages/home.aspx)

- Caroline County has met 18 of 39 SHIP goals
- Dorchester County has met 14 of 39 SHIP goals
- Kent County has met 15 of 39 SHIP goals
- Queen Anne's has met 27 of 39 SHIP goals
- Talbot County has met 21 of 39 SHIP goals

- Mid-Shore Health Status (LHIC) Priority Areas: Top Priority Areas (See Figure 4) The following priorities have been identified as having significant impact on vulnerable populations in all 5 counties:
  1. Adolescent Obesity

2. Adolescent Tobacco Use
3. Diabetes Related Emergency Department Visits

- Analysis of provider survey revealed the same top health concerns and top health barriers with little deviation from the community (consumer survey) and overall DHMH State Health Improvement Process (SHIP) data (See Appendix 4 for actual survey/results).
    1. Drugs/tobacco/alcohol abuse
    2. Obesity
    3. Diabetes
    4. Mental Health
    5. Heart Problems
- Top 3 Barriers to Health Care:
    1. Can't afford it
    2. Lack of transportation
    3. No specialists in my area

Figure 4 – National, State, and Local Health Priorities

Robert Wood Johnson County Health Rankings	Maryland State Health Improvement Plan 2015 5 Focus Areas	Mid-Shore Local Health Improvement Coalition (LHIC) Priority Areas
Health Behaviors 1. Tobacco Use 2. Diet & Exercise 3. Alcohol & Drug Use 4. Sexual Activity	Healthy Beginnings	Reduce Adolescent Obesity
Clinical Care 1. Access to Care 2. Quality of Care	Healthy Living	Reduce Adolescent Tobacco Use
Social & Economic Factors 1. Education 2. Employment 3. Income 4. Family & Social Support 5. Community Safety	Healthy Communities	Reduce Diabetes Related Emergency Department Visits
Physical Environment 1. Air & Water Quality 2. Housing & Transit	Access to Health Care	
	Quality Preventive Care	

C) Community Leaders

Methods

- UM SRH hosted a focus group in collaboration with the Mid-Shore Local Health Improvement Coalition and other community-based organization partners (Appendix 5, page 2) to share their perspectives on health needs (March 14, 2016)

Results

- Consensus reached that social determinants of health (and "upstream factors") are key elements that determine health outcomes
- Top needs and barriers were identified as well as potential suggestions for improvement and collaboration. (See Appendix 5 for details)
- Top Needs:
  - Health Literacy
  - Access to Care (transportation, workforce)
  - Mental/Behavioral Health
  - Coordination of Care (people, data)
  - Chronic Disease Management (prevention, obesity, smoking, hypertension)
  - Preventative Care Management (screenings, education)
- Top Barriers:
  - Transportation- no public transportation, limited infrastructure-not cost effective
  - Work force- not enough licensed professionals
  - Reliable data- Lack of inter-agency collaboration – working in silos
  - Focusing on the outcome and not the root of the problems (i.e. SDoH)
- Suggestions for Improvement:
  - Leverage existing resources
  - Increase collaboration
  - Focus on Social Determinants of Health

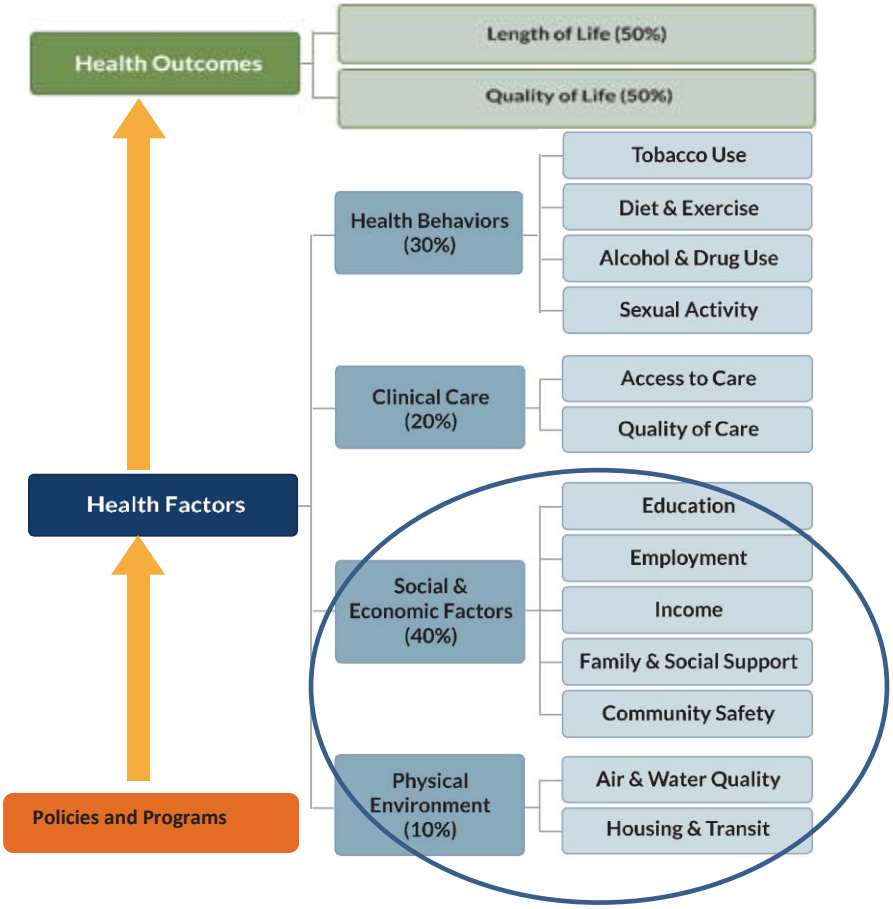
D) Social Determinants of Health (SDoH)

Methods

- Reviewed data from identified Health Department's DHMH data
- Reviewed data from Robert Wood Johnson Foundation, County Health Rankings & Roadmaps. (See Appendix 6)

Results

The *County Health Rankings & Roadmaps* report explores the wide gaps in health outcomes throughout Maryland and what is driving those differences. The report finds health is influenced by every aspect of how and where we live. Access to affordable housing, safe neighborhoods, job training programs and quality early childhood education are examples of important changes that can put people on a path to a healthier life even more than access to medical care. But access to these opportunities varies county to county. This limits choices and makes it hard to be healthy.



- Top SDoHs impacting health on the Mid-Shore as reported in the Robert Wood Johnson County Health Rankings & Roadmaps 2016 report are:
  - ☐ Low Education Attainment (Dorchester and Caroline)
  - ☐ High Poverty Rate (Dorchester 16.5%, Caroline 14.4%, Kent 13.2%) Children in Poverty (Dorchester 29%, Caroline 24%, Kent, 22%)
  - ☐ High Unemployment Rate (Dorchester 9.7%)
  - ☐ Severe Housing Problems (Dorchester 20%)

Local Health Context

- The five counties differ significantly in their capacity to:
  - Provide accessible public health interventions in the public schools
  - Establish relationships and involvement within their respective minority communities
  - Involve and sustain interest from their local Commissioners that set policy and funding priorities for the county
- Additional contextual factors to be considered include those factors that uniquely challenge rural communities:
  - Subpopulations within counties have higher uninsured, unemployed, and low income residents
  - Lack of public transportation system with difficulty accessing health services
  - Limited number of non-profits and private organizations as stakeholders to help share in filling gaps
  - Health workforce shortage that includes primary care, behavioral health and specialty care.

E) Health Statistics/Indicators

Methods

Review annually and for this triennial survey the following:

- **Local data sources:**
  - DHMH SHIP Progress Report 2014-2016
  - Hospital High Utilizers Report
  - Maryland Chartbook of Minority Health And Minority Health Disparities Data
  - HSCRC and CRISP data

- **National trends and data:**
  - Healthy People 2020
  - Robert Wood Johnson County Health Rankings
  - Centers for Disease Control reports/updates

Results

- Outcomes Summary for CBSA territory
  -Top 3 Causes of Death, Mid-Shore in rank order:
    1. Heart Disease
    2. Cancer
    3. Stroke

IV. Selecting Priorities

Analysis of all quantitative and qualitative data described in the above section identified these top five areas of need within the Mid-Shore Counties. These top priorities represent the intersection of documented unmet community health needs and the organization's key strengths and mission. These priorities were identified and approved by the Community Health Planning Council (See Appendix 9) and validated with the health experts from the Health Departments.

- **Results**: Prioritizaion- with one being the greatest:
  1. Chronic Disease Management (obesity, hypertension, diabetes, smoking)
  2. Behavioral Health
  3. Access to care
  4. Cancer
  5. Outreach & Education (preventive care, screenings, health literacy)

V. Documenting and Communicating Results

The completion of this community health needs assessment marks a milestone in community involvement and participation with input from the community stakeholders, the general public, UM SRH, and health experts. This report will be posted on the UM SRH website under the Community Health Needs section, http://umshoreregional.org/about/community-health-needs-assessment-and-action-pla. Highlights of this report will also be documented in both the Community Benefits Annual Report filed with the Health Services Cost Review Commission and the UMMS Community Health Improvement Report. Reports and data will also be shared with our community partners and community leaders as we work together to make a positive difference in our community by empowering and building healthy communities.

VI. Planning for Action and Monitoring Progress

A) Priorities & Implementation Planning

Based on the above assessment, findings, and priorities, the Community Health Planning Council agreed to incorporate our identified priorities with Maryland's State Health Improvement Plan (SHIP). Using SHIP as a framework, the following

matrix was created to show the integration of our identified priorities and their alignment with SHIP's Focus Areas (See Table 1). UM SRH will also track the progress with long-term outcome objectives measured through the Maryland's Department of Health & Mental Hygiene (DHMH). Short-term programmatic objectives, including process and outcome metrics will be measured annually by UM SRH for each priority area through the related programming. Adjustments will be made to annual plans as other issues emerge or through our annual program evaluation.

Because UM SRH serves the Mid-Shore region, priorities may need to be adjusted rapidly to address an urgent or emergent need in the community, (i.e. disaster response or infectious disease issue). The CHNA prioritized needs for the Sustained and Strategic Response Categories and the Rapid and Urgent Response Categories' needs will be determined on an as-needed basis.

UM SRH will provide leadership and support within the communities served at a variety of response levels. Rapid and Urgent response levels will receive priority over sustained and strategic initiatives as warranted.

- **Rapid Response -** Emergency response to local, national, and international disasters, i.e. civil unrest, terrorist attack, weather disasters – earthquake, blizzards
- **Urgent Response -** Urgent response to episodic community needs, i.e. H1N1/Flu response
- **Sustained Response -** Ongoing response to long-term community needs, i.e. obesity and tobacco prevention education, health screenings, workforce development
- **Strategic Response -** Long-term strategic leadership at legislative and corporate levels to leverage relationships to promote health-related policy or reform and build key networks

Future Community Health Needs Assessments will be conducted every three years and strategic priorities will be re-evaluated then. All community benefits reporting will occur annually to meet state and federal reporting requirements.

B) Unmet Community Needs

Several additional topic areas were identified by the Community Health Planning Council during the CHNA process including: transportation and workforce development. While UM SRH will focus the majority of our efforts on the identified strategic programs outlined in the table below, we will review the complete set of needs identified in the CHNA for future collaboration and work. These areas, while still important to the health of the community, will be met through other health care organizations with our

assistance as available. UM SRH identified core priorities which are the intersection of the identified community needs and the organization's key strengths and mission. The following table summarizes the programs either currently in use or to be developed to address the identified health priorities.

Table 1 - UM SRH Strategic Programs and Partners FY17-19

Maryland SHIP Focus Area	UM SRH Priorities	UM SRH Strategic Community Programs	UM SRH Partners
Healthy Beginnings	**Outreach & Education**	Prenatal Education & Services, Shore Kids Camp	Local Health Depts., Community Physicians, American Diabetes Association Talbot County Children's Advocacy Center, Talbot County Depart. of Social Services (TCDSS)
Healthy Living	**Reduce Obesity/Tobacco Use**	Diabetes Education Series, Diabetes Support Group, Radio Broadcasts on Health Topics, Ask the Expert Series Smoking Cessation, Tobacco Prevention Ed	Community Senior Centers, UM Center for Diabetes and Endocrinology, Health Departments Talbot Tobacco Coalition, American Cancer Society
Healthy Communities	**Safe Homes/ Trauma Prevention**	Shore Rehabilitation Services-Balance Center, Mobile Integrated Community Health Program, Children's Advocacy Center, Programs for the Aging	ENT physicians, Local Health Depts., Shore Wellness Partners QA County Dept. of Emergency Services, QA County Dept. of Health, (MIEMSS),QA County Commissioners, QA County Addictions & Prevention Services, QA County Area Agency on Aging, DHMH, Homeports
Access to Healthcare	**Primary Care, Specialists Care, Behavioral Health**	Shore Wellness Partners, Critical Care Access to emergency medications, Shore Regional Breast Center Wellness for Women Program, Discharge Follow-up Clinic, Bridge Clinic-Behavioral Health	Local Health Depts., Competent Care Connections (Health Enterprise Zone), Community Physicians, SRH Care Transitions Provider Consortiums, Skilled Nursing Facilities, Home Health Agencies, Hospices

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Community Health Needs Assessment Survey

Help us build a healthier community by taking the **University of Maryland Shore Regional Health** survey by Dec. 23. This information will help us provide much-needed outreach and wellness programs in the area, keeping you and your family as healthy as possible. The results from this survey are confidential. Thank you for your participation.

Gender: ☐ Male ☐ Female

Age:

☐ 19 or younger ☐ 31–39 years ☐ 50–59 years ☐ 70–79 years ☐ 86 or older
☐ 20–30 years ☐ 40–49 years ☐ 60–69 years ☐ 80–85 years

Race/ethnic group(s):

☐ African American ☐ Caucasian ☐ Other (please specify) _____
☐ Asian/Pacific Islander ☐ Hispanic

What is your ZIP code? _____

What are some of the biggest health problems in your community?

☐ Drugs/tobacco/alcohol abuse
☐ Obesity
☐ Lack of fresh food choices
☐ Domestic violence
☐ Diabetes
☐ Heart problems
☐ Asthma/breathing problems
☐ Mental health
☐ Preventive care such as mammograms
☐ Other (please specify) _____

What are the top two health problems in your community? (Please select only two.)

☐ Drugs/tobacco/alcohol abuse
☐ Obesity
☐ Lack of fresh food choices
☐ Domestic violence
☐ Diabetes
☐ Heart problems
☐ Asthma/breathing problems
☐ Mental health
☐ Preventive care such as mammograms
☐ Other (please specify) _____

What keeps you and people in your community from getting needed health care?

☐ Lack of transportation
☐ Language barrier
☐ Can't afford it
☐ No specialists in my area
☐ Other (please specify) _____

NAME (please print) _____

ADDRESS _____

CITY/STATE/ZIP _____

TELEPHONE _____

EMAIL _____

Mail back our survey by **Dec. 23** for a chance to win an **Amazon gift card**!

Or take the survey online at **umshoreregional.org/survey**.

Appendix 1

UMMS Shore Fall 2015 Survey Results

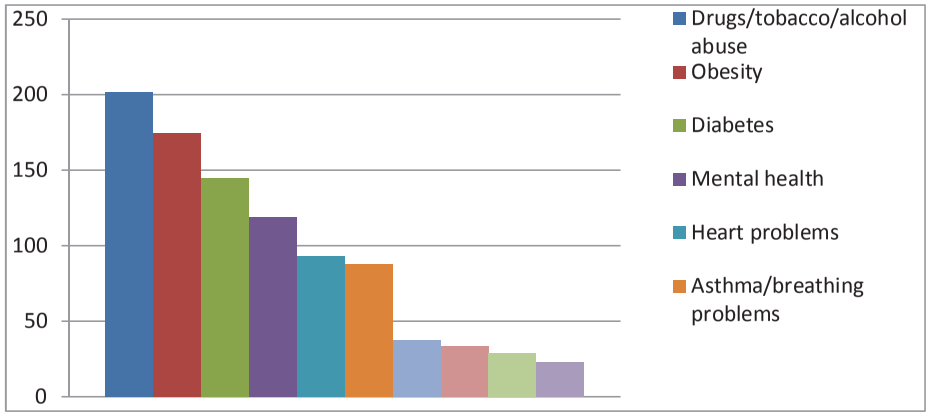
BRC-Mail in Response	289
Online Response	34
Total Response	323
Circulation	77,812
Rate	0.42%

	BRC	Online	Total	Rate
Gender:				
Male	75	2	77	23.84%
Female	209	29	238	73.68%
No Answer	5	3	8	2.48%
Total	289	34	323	100.00%
Age:				
19 or younger	9	0	9	2.79%
20-30 years	13	2	15	4.64%
31-39 years	17	10	27	8.36%
40-49 years	38	7	45	13.93%
50-59 years	57	8	65	20.12%
60-69 years	77	4	81	25.08%
70-79 years	54	0	54	16.72%
80-85 years	17	0	17	5.26%
86 and older	4	0	4	1.24%
No Answer	3	3	6	1.86%
Total	289	34	323	100.00%
Race/ethnic group(s):				
African American	53	5	58	17.96%
Asian/Pacific Islander	0	0	0	0.00%
Caucasian	222	25	247	76.47%
Hispanic	5	0	5	1.55%

Appendix 1

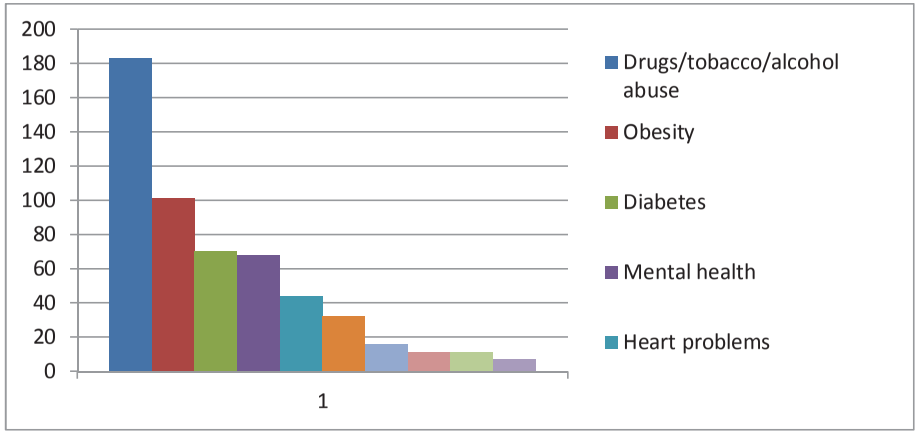
What are some of the biggest health problems in your community?

Drugs/tobacco/alcohol abuse	202	29	231	71.52%
Obesity	175	25	200	61.92%
Diabetes	145	18	163	50.46%
Mental health	119	22	141	43.65%
Heart problems	93	9	102	31.58%
Asthma/breathing problems	88	7	95	29.41%
Domestic violence	38	6	44	13.62%
Lack of fresh food choices	34	9	43	13.31%
Other - Write In	29	3	32	9.91%
Preventive care such as mammograms	23	3	26	8.05%



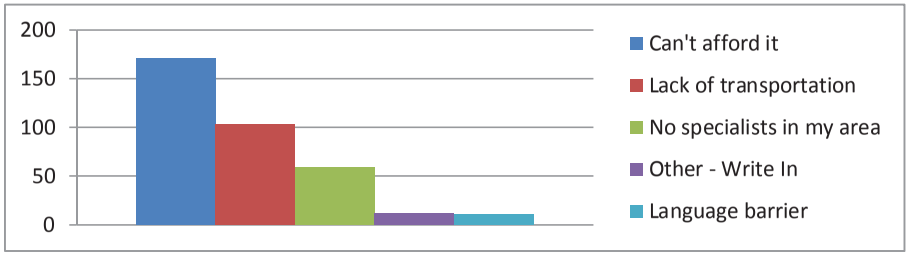
What are the top two health problems in your community?

Drugs/tobacco/alcohol abuse	183	25	208	64.40%
Obesity	101	16	117	36.22%
Diabetes	70	3	73	22.60%
Mental health	68	14	82	25.39%
Heart problems	44	0	44	13.62%
Asthma/breathing problems	32	1	33	10.22%
Lack of fresh food choices	16	0	16	4.95%
Domestic violence	11	1	12	3.72%
Other - Write In	11	2	13	4.02%
Preventive care such as mammograms	7	0	7	2.17%



What keeps you and people in your community from getting needed health care?

Can't afford it	171	17	188	58.20%
Lack of transportation	103	17	120	37.15%
No specialists in my area	59	14	73	22.60%
Other - Write In	12	8	20	6.19%
Language barrier	11	3	14	4.33%



Appendix 2

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Community Listening Sessions

3/29: Dorchester Library	3/30: Caroline Library	4/2: Rock Hall Fire House
4/5: Talbot Community Center	4/11: Hurlock Train Station	4/12: Goodwill Fire House
4/14: Kent County High School	4/24: Sudlersville Fire Department	

1. ACCESS TO CARE

- Do you have a Primary Care Provider (doctor or nurse practitioner)?
- How easy do you find it to understand the directions and information you are given by your health care providers?
- If you or someone you know has a chronic disease such as diabetes or congestive heart failure, how easy is it for you/him or her to manage?
  - What is your comfort level in:
    - Getting to the appropriate specialist
    - Understanding the disease
    - Obtaining and understanding prescribed medications
    - Maintaining ongoing (follow-up) care
  - What could UM Shore Regional Health do to help people better manage chronic diseases?

2. TRANSPORTATION

- Do you or someone you know have difficulties getting to and from medical appointments?
- Do you or someone you know rely on someone else to get to and from appointments?
  - If yes, do you rely on:
    - A family member
    - A friend
    - Public transportation
    - Cab or private driving service
- If you had a family member who was transferred from one medical facility to another for a higher level of care, would you have difficulty maintaining ongoing support of that person if:
  - Care was less than an hour away?
  - Care was an hour to an hour and a half away?
  - In Baltimore?

Creating Healthier Communities Together

Visit our website at UMShoreRegional.org to answer these questions online

3. TECHNOLOGY

- Do you own a computer, tablet or smart phone?
- Do you have access to the internet with hi-speed broadband?
  - If yes, would you be comfortable going online to:
    - Access your medical records and/or test results
    - Schedule an appointment
    - Communicate with your doctor
- If you had access to a call center that was staffed by a Nurse Navigator, would you find that helpful in coordinating care or answer questions about your health or the health of your family?
- Are you familiar with Telemedicine?
  Telemedicine (sometimes called telehealth) uses two-way, real time interactive communication between a patient, and a physician or practitioner at a distant site.
  - If you or someone you know needed access to a healthcare professional (particularly a higher level provider/specialist) who was an hour away or more, would you consider using telemedicine instead of traveling the distance or going without care?

4. COMMUNITY EDUCATION/SCREENINGS

- Did you know that UM Shore Regional Health provides many health education classes, seminars and support groups that are free?
- Do you or someone you know attend programs provided by UM SRH?
  - If yes,
    - Health education class
    - Support group
    - Information session
    - Health Screening
    - Ask the Expert
- What type of classes, events or screenings would be helpful to you, your family members or friends?
- Where are education/screening events most convenient for you, your family members or friends to attend?
- What are your barriers to living a healthy life?

What are the top three health problems or needs in your community?

1. _____
   _____
2. _____
   _____
3. _____
   _____

Appendix 2

2016 Community Listening Session Overview

Top Health Needs:

- Chronic disease management
- Addictions and Mental Health
- Diabetes
- Obesity
- Lung disease

- Access to Care: Primary Care
  Specialists: Gastroenterology, Infusion/chemotherapy, Ophthalmology, OB/GYN and Pediatrics (return to Chestertown), geriatrics, diagnostics

- Transportation
- Physician recruitment

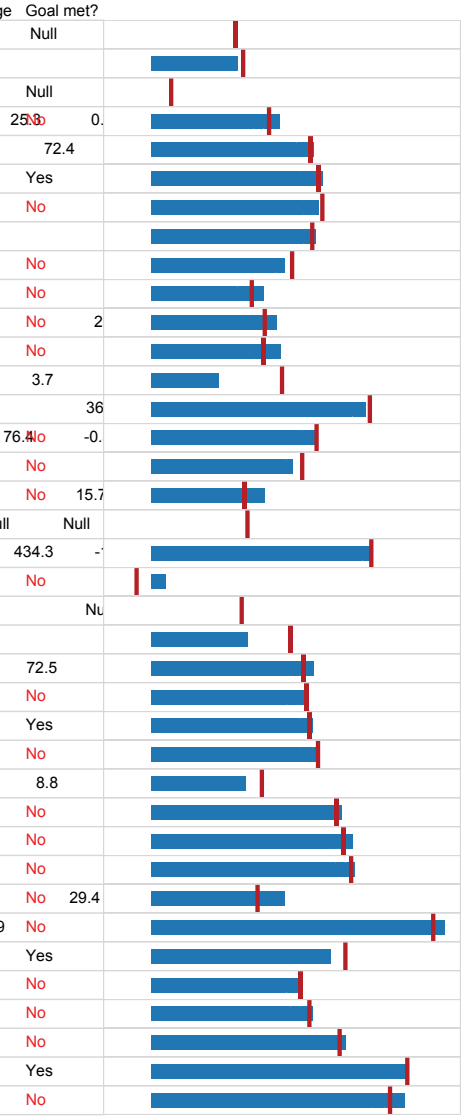
Date and Time	Location	County	Attendees
Tuesday, March 29, 5:30pm	Dorchester Library	Dorchester	0
Wednesday, March 30, 5:30pm	Caroline Library	Caroline	0
Saturday, April 2, 9:30am	Rock Hall Fire House	Kent	77
Tuesday, April 5, 5:30pm	Talbot Community Center	Talbot	4
Monday, April 11, 5:30pm	Hurlock Train Station	Dorchester	0
Tuesday, April 12, 5:30pm	Goodwill Fire House	Queen Anne's	6
Thursday, April 14, 5:30pm	Kent County High School	Kent	240
Sunday, April 24, 2:00pm	Sudlersville Fire Department	Queen Anne's	13
		TOTAL:	**340**

County	# of written surveys returned	# of online surveys returned
Caroline	0	1
Dorchester	0	1
Kent	49	3
Queen Anne's	0	1
Talbot	0	0
TOTAL:	**49**	**6**

Maryland State Health Improvement Process (SHIP)

Caroline County

Focus Area	Indicator	Value	Change	Goal met?
Healthy Beginnings	Infant death rate			Null
	Babies with Low birth weight			
	Sudden unexpected infant death rate	Null	Null	Null
	Teen birth rate			25.8
	Early prenatal care			72.4
	Students entering kindergarten ready to learn	95.0	1.0	Yes
	High school graduation rate			No
	Children receiving blood lead screening			
Healthy Living	Adults who are a healthy weight			No
	Children and adolescents who are obese			No
	Adults who currently smoke			No
	Adolescents who use tobacco products			No
	HIV incidence rate			3.7
	Chlamydia infection rate			
	Life expectancy			76.4
	Increase physical activity			No
Healthy Communities	Child maltreatment rate			No
	Suicide rate		Null	Null
	Domestic Violence			434.3
	Children with elevated blood lead levels			No
	Fall-related death rate			
	Pedestrian injury rate on public roads			
	Affordable Housing			72.5
Access to Health Care	Adolescents who received a wellness checkup in the last year	52.5	-2.8	No
	Children receiving dental care in the last year	69.9	4.9	Yes
	Persons with a usual primary care provider	82.7	-3.5	No
	Uninsured ED Visits			8.8
Quality Preventive Care	Age-adjusted mortality rate from cancer	174.2	-4.3	No
	Emergency Department visit rate due to diabetes	244.2	33.3	No
	Emergency Department visit rate due to Hypertension	257.8	-24.7	No
	Drug-induced death rate			No
	Emergency Department Visits Related to Mental Health	4369.6	-114.9	No
	Hospitalization rate related to Alzheimer's or dementia	123.7	-54.7	Yes
	Annual season influenza vaccinations			No
	Emergency department visit rate due to asthma	71.4	-4.2	No
	Age-adjusted mortality rate from heart disease	195.0	-11.9	No
	Emergency Department Visits for Addiction Related Conditions	1311.1	38.5	Yes
	Emergency department visit rate for dental care	1225.2	56.1	No

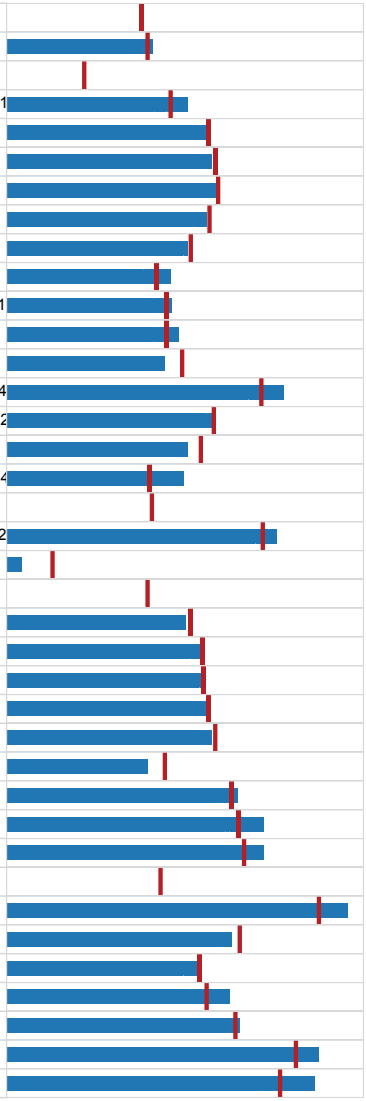


In the above chart, Change is from previous reporting period. Blue bar shows the county value and red line shows the MD 2017 Target.

Maryland State Health Improvement Process (SHIP)

Dorchester County

Focus Area	Indicator	Value	Change	Goal met?
Healthy Beginnings	Infant death rate	Null	Null	Null
	Babies with Low birth weight			No
	Sudden unexpected infant death rate	Null	Null	Null
	Teen birth rate			No
	Early prenatal care			
	Students entering kindergarten ready to learn	76.0	-1.0	No
	High school graduation rate			No
	Children receiving blood lead screening			No
Healthy Living	Adults who are a healthy weight			No
	Children and adolescents who are obese			No
	Adults who currently smoke			No
	Adolescents who use tobacco products			No
	HIV incidence rate			
	Chlamydia infection rate			No
	Life expectancy			No
	Increase physical activity			No
Healthy Communities	Child maltreatment rate			No
	Suicide rate	Null	Null	Null
	Domestic Violence			
	Children with elevated blood lead levels			
	Fall-related death rate	Null	Null	Null
	Pedestrian injury rate on public roads			
	Affordable Housing			
Access to Health Care	Adolescents who received a wellness checkup in the last year	54.3	-0.5	No
	Children receiving dental care in the last year	67.8	1.7	Yes
	Persons with a usual primary care provider	74.5	-12.0	No
	Uninsured ED Visits			
Quality Preventive Care	Age-adjusted mortality rate from cancer	187.6	-2.1	No
	Emergency Department visit rate due to diabetes	455.4	86.4	No
	Emergency Department visit rate due to Hypertension	465.4	-64.9	No
	Drug-induced death rate	Null	Null	Null
	Emergency Department Visits Related to Mental Health	8551.1	-19.9	No
	Hospitalization rate related to Alzheimer's or dementia	153.0	-14.7	Yes
	Annual season influenza vaccinations			No
	Emergency department visit rate due to asthma	141.8	9.5	No
	Age-adjusted mortality rate from heart disease	195.5	-6.8	No
	Emergency Department Visits for Addiction Related Conditions	3120.7	869.5	No
	Emergency department visit rate for dental care	2659.4	13.1	No

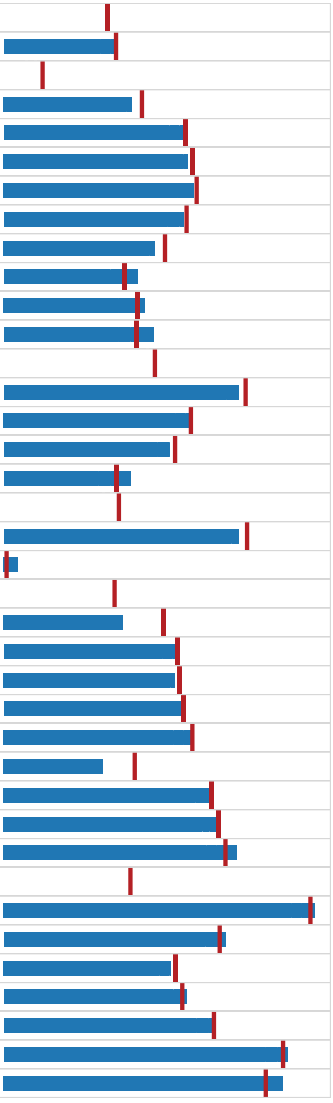


In the above chart, Change is from previous reporting period. Blue bar shows the county value and red line shows the MD 2017 Target.

Maryland State Health Improvement Process (SHIP)

Kent County

Focus Area	Indicator	Value	Change	Goal met?
Healthy Beginnings	Infant death rate			Null
	Babies with Low birth weight			No
	Sudden unexpected infant death rate	Null	Null	Null
	Teen birth rate			13.3
	Early prenatal care			71.9
	Students entering kindergarten ready to learn	75.0	-10.0	No
	High school graduation rate			No
	Children receiving blood lead screening			No
Healthy Living	Adults who are a healthy weight			No
	Children and adolescents who are obese			No
	Adults who currently smoke			No
	Adolescents who use tobacco products			No
	HIV incidence rate			0.0
	Chlamydia infection rate			
	Life expectancy			79.7
	Increase physical activity			No
Healthy Communities	Child maltreatment rate			No
	Suicide rate		Null	Null
	Domestic Violence			346.0
	Children with elevated blood lead levels			No
	Fall-related death rate			
	Pedestrian injury rate on public roads			
	Affordable Housing			52.0
Access to Health Care	Adolescents who received a wellness checkup in the last year	50.8	2.3	No
	Children receiving dental care in the last year	66.3	5.2	Yes
	Persons with a usual primary care provider	82.2	-11.4	No
	Uninsured ED Visits			5.4
Quality Preventive Care	Age-adjusted mortality rate from cancer	152.5	-15.2	No
	Emergency Department visit rate due to diabetes	209.4	-140.9	No
	Emergency Department visit rate due to Hypertension	334.7	87.8	No
	Drug-induced death rate			Null
	Emergency Department Visits Related to Mental Health	3590.3	169.9	No
	Hospitalization rate related to Alzheimer's or dementia	236.2	-49.1	No
	Annual season influenza vaccinations			No
	Emergency department visit rate due to asthma	71.2	34.3	No
	Age-adjusted mortality rate from heart disease	157.9	0.6	Yes
	Emergency Department Visits for Addiction Related Conditions	1538.3	-3.6	No
	Emergency department visit rate for dental care	1359.6	-216.1	No



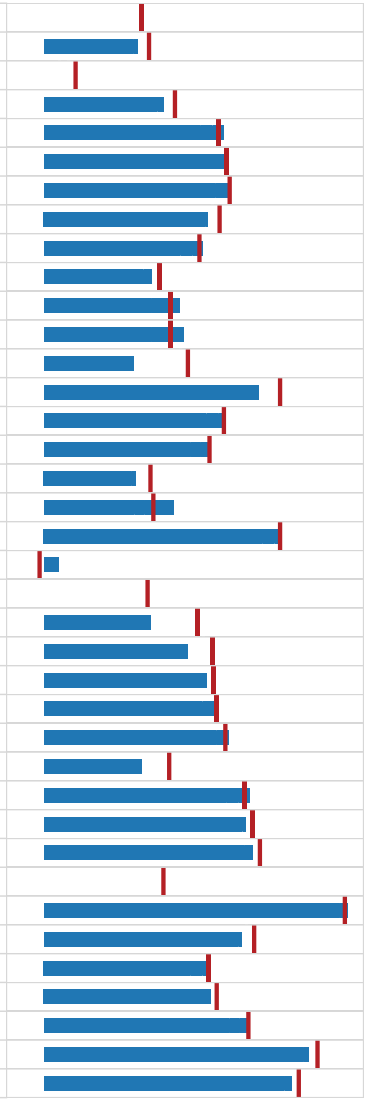
In the above chart, Change is from previous reporting period. Blue bar shows the county value and red line shows the MD 2017 Target.

Appendix 3

Maryland State Health Improvement Process (SHIP)

Queen Anne's County

Focus Area	Indicator	Value	Change	Goal met?
Healthy Beginnings	Infant death rate	Null	Null	Null
	Babies with Low birth weight	5.5	-1.9	Yes
	Sudden unexpected infant death rate	Null	Null	Null
	Teen birth rate	12.4	-1.7	Yes
	Early prenatal care	80.6	3.9	Yes
	Students entering kindergarten ready to learn	91.0	3.0	Yes
	High school graduation rate	94.0	0.5	No
	Children receiving blood lead screening	47.9	-4.0	No
Healthy Living	Adults who are a healthy weight	40.3	8.4	Yes
	Children and adolescents who are obese	8.9	-0.9	Yes
	Adults who currently smoke	19.8	2.6	No
	Adolescents who use tobacco products	22.5	-10.4	No
	HIV incidence rate	4.9	0.0	Yes
	Chlamydia infection rate	223.1	-11.6	Yes
	Life expectancy	79.4	0.0	No
	Increase physical activity	49.7	7.6	No
Healthy Communities	Child maltreatment rate	5.3	-1.2	Yes
	Suicide rate	16.7	Null	No
	Domestic Violence	439.0	202.4	Yes
	Children with elevated blood lead levels	0.5	0.1	No
	Fall-related death rate	Null	Null	Null
	Pedestrian injury rate on public roads	8.2	-4.2	Yes
	Affordable Housing	25.7	-3.5	No
Access to Health Care	Adolescents who received a wellness checkup in the last year	46.6	1.9	No
	Children receiving dental care in the last year	65.9	1.6	Yes
	Persons with a usual primary care provider	88.9	-2.1	Yes
	Uninsured ED Visits	6.5	-3.8	Yes
Quality Preventive Care	Age-adjusted mortality rate from cancer	176.9	-6.0	No
	Emergency Department visit rate due to diabetes	154.2	28.4	Yes
	Emergency Department visit rate due to Hypertension	187.8	26.6	Yes
	Drug-induced death rate	Null	Null	Null
	Emergency Department Visits Related to Mental Health	3435.4	449.2	No
	Hospitalization rate related to Alzheimer's or dementia	132.5	5.9	Yes
	Annual season influenza vaccinations	53.6	17.5	Yes
	Emergency department visit rate due to asthma	53.8	9.4	Yes
	Age-adjusted mortality rate from heart disease	164.7	0.3	Yes
	Emergency Department Visits for Addiction Related Conditions	1048.9	-92.4	Yes
	Emergency department visit rate for dental care	624.9	-61.5	Yes

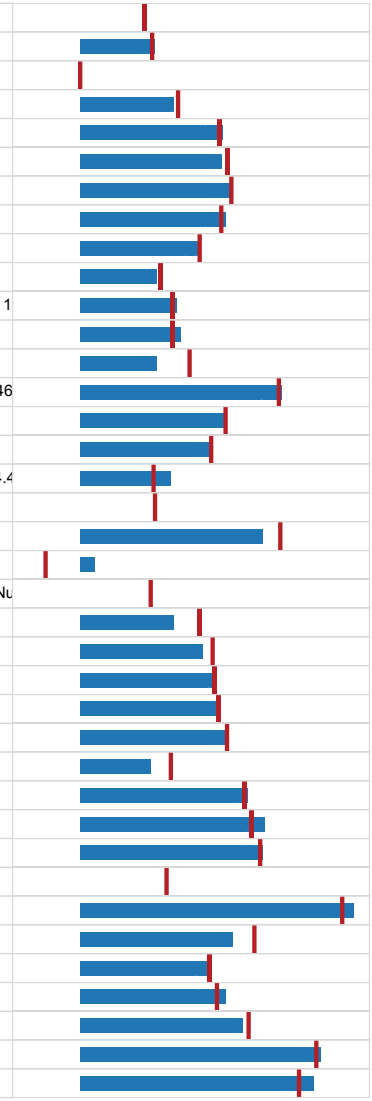


In the above chart, Change is from previous reporting period. Blue bar shows the county value and red line shows the MD 2017 Target.

Maryland State Health Improvement Process (SHIP)

Talbot County

Focus Area	Indicator	Value	Change	Goal met?
Healthy Beginnings	Infant death rate			Nu ll
	Babies with Low birth weight			No
	Sudden unexpected infant death rate	Null	Null	Null
	Teen birth rate	.7	-2.8	15Yes
	Early prenatal care	.2	-2.8	Yes 3
	Students entering kindergarten ready to learn	72.0	-6.0	No
	High school graduation rate			No
	Children receiving blood lead screening			
Healthy Living	Adults who are a healthy weight			No
	Children and adolescents who are obese			
	Adults who currently smoke			No 1
	Adolescents who use tobacco products	20.2	-11.3	No
	HIV incidence rate	9. 1	9.1	Yes
	Chlamydia infection rate			No 46
	Life expectancy	.3	0.3	81 Yes
	Increase physical activity			No
Healthy Communities	Child maltreatment rate			No 14.4
	Suicide rate	ll	NullNu	Null
	Domestic Violence	8.4	-14.6	25Yes
	Children with elevated blood lead levels			No
	Fall-related death rate			Nu
	Pedestrian injury rate on public roads	.9	-7.8	Yes
	Affordable Housing			40.0
Access to Health Care	Adolescents who received a wellness checkup in the last year	59.4	-0.3	Yes
	Children receiving dental care in the last year	68.8	0.8	Yes
	Persons with a usual primary care provider	87.5	-1.4	Yes
	Uninsured ED Visits			7. 6
Quality Preventive Care	Age-adjusted mortality rate from cancer	160.4	1.2	No
	Emergency Department visit rate due to diabetes	276.4	52.1	No
	Emergency Department visit rate due to Hypertension	265.1	24.4	No
	Drug-induced death rate	ll	Null	Null Nu
	Emergency Department Visits Related to Mental Health	4444.2	293.2	No
	Hospitalization rate related to Alzheimer's or dementia	99.7	-23.8	Yes
	Annual season influenza vaccinations	.2	-1.4	Yes
	Emergency department visit rate due to asthma	79.2	20.9	No
	Age-adjusted mortality rate from heart disease	136.6	-10.6	Yes
	Emergency Department Visits for Addiction Related Conditions	1587.6	41.5	No
	Emergency department visit rate for dental care	1246.3	198.0	No



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Appendix 4

Community Health Needs Assessment - Professional

University of Maryland Shore Regional Health

Help us build a healthier community by taking the University of Maryland Shore Regional Health survey by April 28, 2016. This information will help us provide much-needed outreach and wellness programs in the area. The results of this survey are confidential. Thank you for your participation.

1. What are some of the biggest health problems in your community?

- Drugs/tobacco/alcohol abuse
- Obesity
- Lack of fresh food choices
- Domestic violence
- Diabetes
- Heart problems
- Asthma/breathing problems
- Mental health
- Preventive care such as mammograms

Other (please specify)

* **2. What are the top two health problems in your community?**

- Drugs/tobacco/alcohol abuse
- Obesity
- Lack of fresh food choices
- Domestic violence
- Diabetes
- Heart problems
- Asthma/breathing problems
- Mental health
- Preventive care such as mammograms
- Other (please specify)

3. What keeps people in your community from getting needed healthcare?

- Lack of transportation
- Language barrier
- Can't afford it
- No specialists in my area
- Other (please specify)

4. What is your area of expertise/specialty?

5. How long have you served in healthcare?

- 0-5 years
- 6-10 years
- 11+ years

6. What counties do you primarily serve?

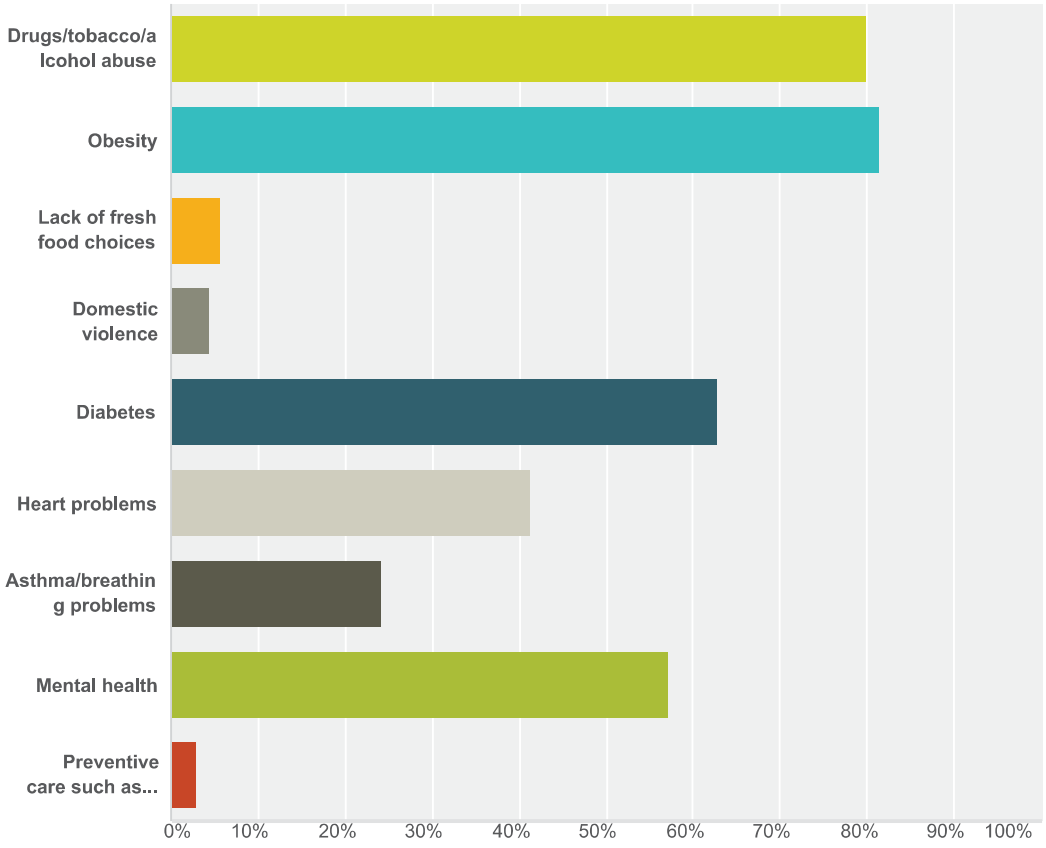
- Caroline
- Dorchester
- Kent
- Queen Anne's
- Talbot

Thank you for taking the time to respond.

Done

Q1 What are some of the biggest health problems in your community?

Answered: 70 Skipped: 0

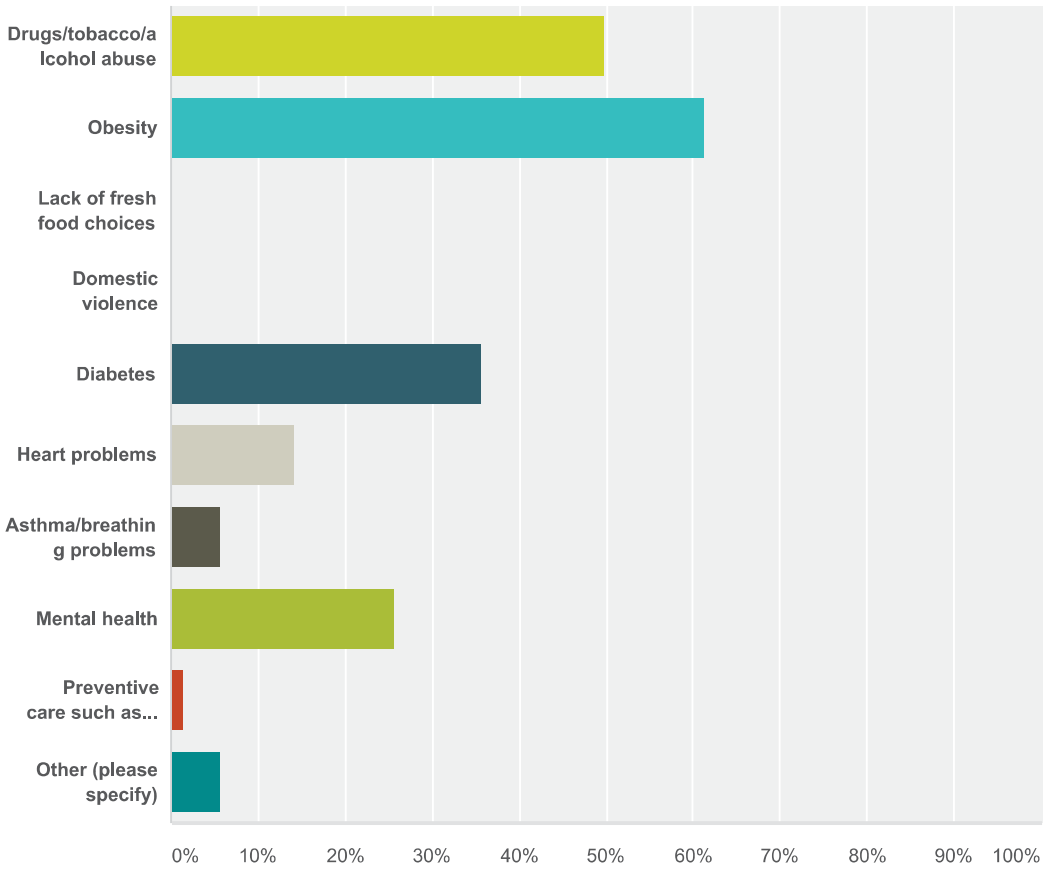


Answer Choices	Responses	
Drugs/tobacco/alcohol abuse	80.00%	56
Obesity	81.43%	57
Lack of fresh food choices	5.71%	4
Domestic violence	4.29%	3
Diabetes	62.86%	44
Heart problems	41.43%	29
Asthma/breathing problems	24.29%	17
Mental health	57.14%	40
Preventive care such as mammograms	2.86%	2
Total Respondents: 70		

#	Other (please specify)
1	poverty
2	Chronic Pain
3	neurodegenerative disorders
4	Cancer, especially skin cancer
5	Lack of transportation
6	high cancer rate

Q2 What are the top two health problems in your community? (Please select only two.)

Answered: 70 Skipped: 0

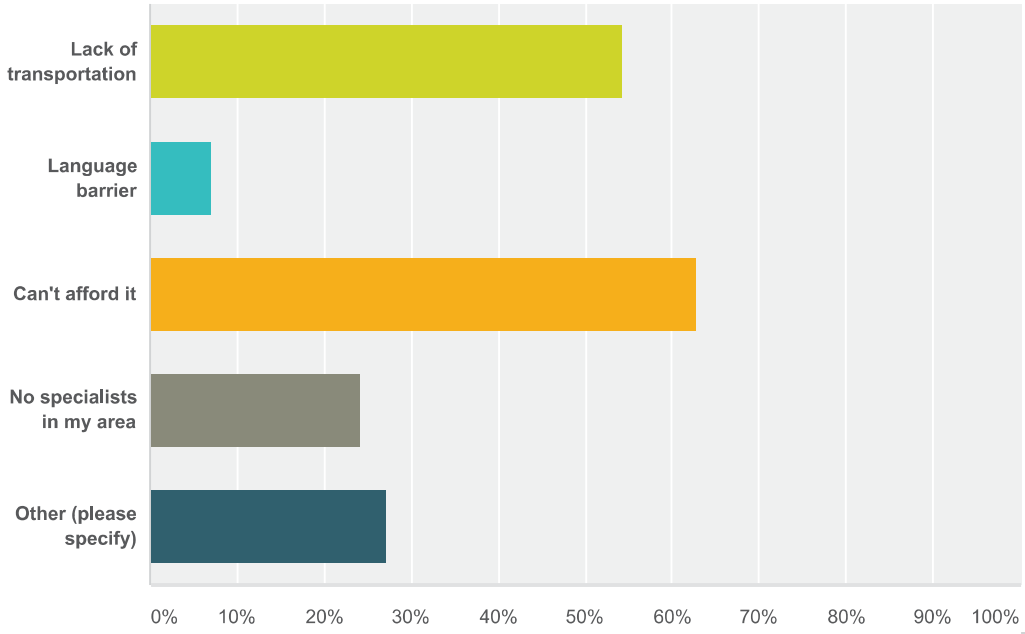


Answer Choices	Responses	
Drugs/tobacco/alcohol abuse	**50.00%**	35
Obesity	**61.43%**	43
Lack of fresh food choices	**0.00%**	0
Domestic violence	**0.00%**	0
Diabetes	**35.71%**	25
Heart problems	**14.29%**	10
Asthma/breathing problems	**5.71%**	4
Mental health	**25.71%**	18
Preventive care such as mammograms	**1.43%**	1
Other (please specify)	**5.71%**	4
Total Respondents: 70		

1	lack of transportation
2	Lost medical resources
3	high cancer rate
4	Dental care

Q3 What keeps people in your community from getting needed healthcare?

Answered: 70 Skipped: 0



Answer Choices	Responses	
Lack of transportation	**54.29%**	38
Language barrier	**7.14%**	5
Can't afford it	**62.86%**	44
No specialists in my area	**24.29%**	17
Other (please specify)	**27.14%**	19
Total Respondents: 70		

#	Other (please specify)
1	patient indiference
2	no accepting PCP
3	And shortage of primary care providers
4	lack of some specialtys
5	Deficiency in primary care providers
6	lack of primary care
7	this is an underserved area; huge retirement area and some practices have stopped taking new Medicare patients; and we lack Mental Health workers/Psychiatrists
8	No mental health coverage
9	few available physicians
10	Failure to follow-up/comply
11	neglect of preventative care
12	Not sure
13	Miseducation about prevenative care
14	Poor eating habits.
15	lack of health education/awareness

Q4 What is your area of expertise/specialty?

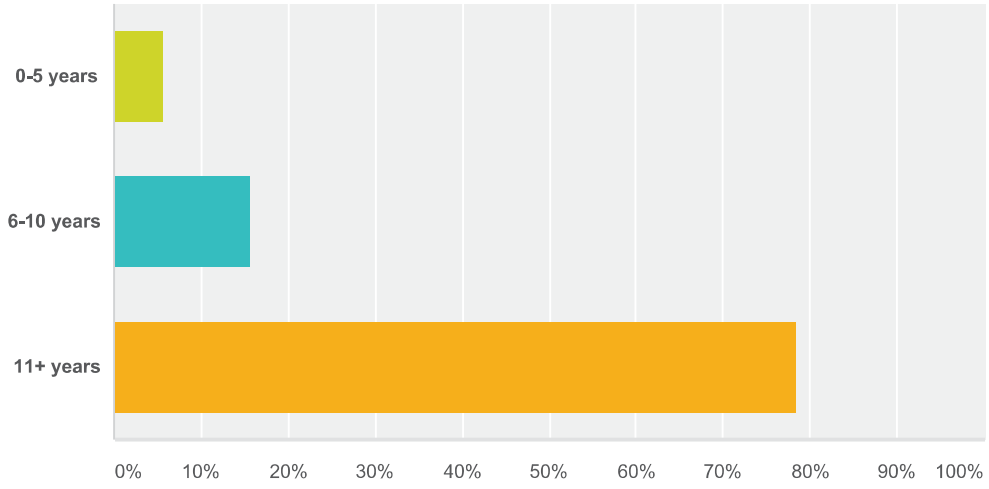
Answered: 67 Skipped: 3

#	Responses
1	pulmonary
2	cardiology
3	family
4	Emergency Medicine
5	Internal medicine/Pain Management
6	Pallitive care
7	Internal Medicine
8	Radiology
9	Anesthesia
10	Emergency medicine
11	Pediatric dental surgery
12	neurology
13	Family Practice
14	Emergency Medicine
15	emergency medicine
16	Family Medicine
17	Internal Medicine
18	Gen Surgery and Walk In Care/Primary
19	Orthopaedic
20	anesthesiology
21	Emergency Medicine
22	Cancer reconstruction
23	I am a specialist physician
24	Emergency Medicine
25	Emergency Medicine
26	Mental Health
27	Family Practice
28	EM
29	Urology
30	general surgery
31	Dermatology
32	er
33	ob/gyn
34	Orthopaedic surgery
35	Cardiology/Electrophysiology

36	Hospitalist	
37	Urology	
38	Radiology	
39	Anesthesia	
40	Family Medicine	
41	pediatrics	
42	Pediatrics	
43	Pediatrics	
44	Plastic surgery	
45	Emergency Medicine	
46	FP, Geriatrics, personalized health care	
47	Women's care	
48	pediatrics	
49	Obstetrics and Gynecology	
50	Dermatology	
51	Cardiology	
52	radiology	
53	surgery	
54	Emergency medicine	
55	Dermatology	
56	family	
57	podiatry	
58	Emergency medicine	
59	internal medicine	
60	EmergenCy medicine	
61	Hospitalist	
62	Family Medicine	
63	Ob/gyn	
64	Ortho	
65	Pediatrics	
66	transplant surgery	
67	Primary Care	

Q5 How long have you served in healthcare?

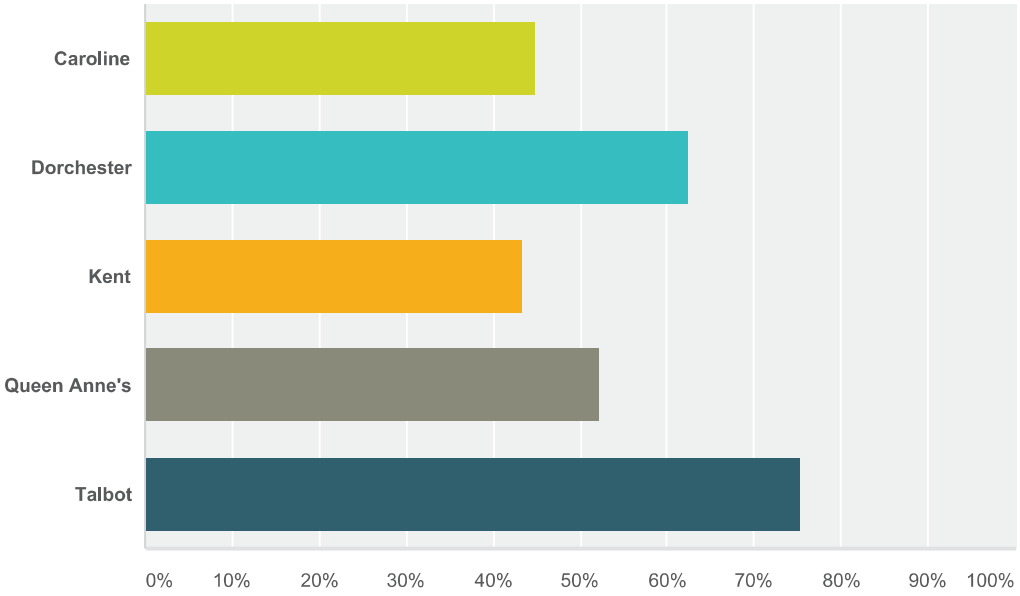
Answered: 70 Skipped: 0



Answer Choices	Responses	
0-5 years	5.71%	4
6-10 years	15.71%	11
11+ years	78.57%	55
Total		70

Q6 What counties do you primarily serve?

Answered: 69 Skipped: 1



Answer Choices	Responses	
Caroline	**44.93%**	31
Dorchester	**62.32%**	43
Kent	**43.48%**	30
Queen Anne's	**52.17%**	36
Talbot	**75.36%**	52
Total Respondents: 69		

Appendix 5

MID-SHORE LOCAL HEALTH IMPROVEMENT COALITION MEETING
March 14, 2016

HEALTH NEEDS:

1. Substance abuse treatment centers
2. Mental health
3. Longer-term care for both 1 and 2
4. Scarcity of providers for primary care-mainly in Easton
5. OB services-Anne Arundel and Talbot, Cecil
6. Health disparities for sub-populations
7. Health literacy-not engaged in plan of care-generational
8. Preventative care-cancer screenings
9. Asthma
10. Diabetes
11. Hypertension
12. Lack of adequate care coordination of non-clinical care
13. Multiple chronic disease-no money to pay
14. Navigating referral system-gaps in communication with providers (HIPPA-separate release form)
15. Access to care-after hours/weekends, etc.
16. Well-child on Saturdays
17. Appointments in the evening
18. Dental care-Medicaid access-
19. Multi-level care givers- need help
20. Interpreters-
21. Smoking rates are high in all 5 counties
22. Adolescent obesity
23. Prevention at earlier age
24. Peer pressure-regional health status-
25. Social condoning
26. Access to reasonably priced healthy food
27. Sexual activity leading to health issues
28. Self-care and management

BARRIERS:

1. Transportation- no public transportation, limited infrastructure-not cost effective
2. Work force- not enough licensed professionals
3. Expanded positions
4. Psychiatry position shortage
5. Health literacy
6. Insurance-Medicaid delay
7. Lack of funding for CHWs-currently grant funded
8. Look at time spent with minorities and substance abuse during visits
9. Time off work to complete exams

10. Solutions out there but cost of meds and beds available
11. Mobil crisis response team not 24/7-only 4 teams-not enough
12. Reliable data-in own silo-no coordinated data across the board.
13. Funding for MICH
14. Funding for health records interface
15. Integration of public and private sector
16. Referral gaps
17. DHMH-licensing forms-different boards
18. Medical assistance-enrolling-fall off without knowing-MCHP at each health department and social services
19. Physicians trained for clues on childhood trauma

WHAT WE CAN DO ABOUT IT?

1. Health literacy
2. Have CHW's integrated with hospital and primary care providers
3. CHWs bring social support/trust
4. Use telehealth/technology
5. Coordinated discharge planning and care-transition care of plan-mobile crisis response team-24/7 team
6. CRISP data-repository of info
7. Mobile integrated community health (MICH) pilot program-Queen Anne's County- 465 ED visits down to 135 in one year for those enrolled in the program
8. Coordinate with CareFirst on telemedicine
9. Community care plan
10. FQHC sending data to CRISP for clinical data for the county-Cecil County only at present
11. Behavioral health in CRISP as well- in test currently
12. School-based health programs-Talbot, Caroline and Dorchester only-telemedicine
13. Interpreter pool-schools, EMS, having trouble
14. ACE (adverse childhood events) study review
15. CDSMP (Chronic Disease Self-Management Program) classes
16. DPP (Diabetes Prevention Program) classes

COLLABORATOR/PARTNERSHIPS

1. CRISP-data program
2. LHIC-Local Health Improvement Coalition
3. HEZ- Health Enterprise Zone
4. MCT-Mobile Crisis Team
5. MICH-Mobile Integrated Community Health
6. MSMHS-Mid Shore Mental Health Systems
7. Payers
8. Choptank Community Health-FQHC

9. AHEC-Area Health Education Center
10. ABC-Associated Black Charities
11. MOTA-Minority Outreach and Technical Assistance
12. CHWs-Community Health Workers
13. ChesMRC-Chesapeake Multi-Cultural Resource Center
14. HMB-Healthiest Maryland Businesses
15. YMCA-Chesapeake and Dorchester
16. DHMH-Department of Health and Mental Hygiene
17. Law enforcement
18. First responders/EMS
19. LHD-Local Health Departments
20. MHCC-Maryland Health Care Connection
21. Consumer
22. Businesses/employers

Present: Carolyn Brooks, cbgerbrooks@gmail.com
Joseph Ciotola, Health Officer Queen Anne's county, joseph.ciotola@maryland.gov
Ashyrra Dotson, Executive Director Associated Black Charities, adotson@abc-md.org
Janet Fountain, Caroline County Outreach , janetfountain@aol.com
Jake Frego, Executive Director Easter Shore Area Health Education Centerjfrego@esahec.org
Viola Gibbs, mselephant@aol.com
Michelle Hammond, dorcasmission@yahoo.com
Roger Harrell, Health Officer Dorchester County, Roger.Harrell@maryland.gov
Erin Hill, Dorchester County Health Department Dri-Dock Recovery and Wellness Center, erinlhill@maryland.gov
Terri Hughes, Health Enterprise Zone (HEZ) Coordinatior, terri.hughes@maryland.gov
Holly Ireland Executive Director Mid-Shore Mental Health Systems, Inc., hireland@msmhs.org
Renee Kilroy, Executive Director AAMC Collaborative Care Network, rkilroy@AAHS.org
Carol Masden, Executive Director Eastern Shore Crisis Response, cmasden@santegroup.org
Kathleen McGrath, Regional Director Outreach & Business Development, kfmcgrath@umm.edu
Angela Mercier, Health Education Program Director HEZ, angela.mercier@maryland.gov
Wanda Molock, wanderful12001@yahoo.com
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Joyce Opher, Associated Black Charities, jopher@abc-md.org
Carrie Perry, Caplink Wellness, carrie@caplinkwellness.com
Chris Pettit, Shore Regional Health cpettit@umm.edu
Krista Pettit, Haven Ministries, kristapettit@gmail.com

	Maryland	Caroline (CR)	Dorchester (DO)	Kent (KE)	Queen Anne's (QA)	Talbot (TA)
Health Outcomes		23	19	18	6	7
Length of Life		23	18	16	5	10
Premature death	6,459	8,976	7,081	7,007	5,798	6,325
Quality of Life		22	20	19	7	4
Poor or fair health	13%	18%	16%	13%	10%	14%
Poor physical health days	3.0	3.8	3.2	3.5	3.1	3.1
Poor mental health days	3.2	4.0	3.0	3.4	3.2	3.0
Low birthweight	9.0%	8.5%	10.4%	9.9%	7.5%	6.7%
Health Factors		21	22	12	9	5
Health Behaviors		22	19	11	10	3
Adult smoking	15%	23%	18%	18%	18%	12%
Adult obesity	28%	33%	35%	28%	27%	28%
Food environment index	8.2	8.3	7.4	8.7	9.2	8.7
Physical inactivity	23%	29%	30%	25%	22%	22%
Access to exercise opportunities	94%	83%	62%	66%	79%	77%
Excessive drinking	15%	17%	15%	15%	23%	16%
Alcohol-impaired driving deaths	34%	47%	24%	40%	33%	32%
Sexually transmitted infections	451	373	513	272	198	354
Teen births	29	46	60	23	20	26
Clinical Care		24	20	11	14	3
Uninsured	12%	14%	13%	13%	10%	13%
Primary care physicians	1,131:1	3,272:1	2,325:1	961:1	2,558:1	1,121:1
Dentists	1,392:1	1,923:1	2,177:1	2,849:1	2,695:1	1,308:1
Mental health providers	502:1	2,335:1	441:1	604:1	1,128:1	287:1
Preventable hospital stays	54	76	72	73	63	51
Diabetic monitoring	84%	85%	86%	90%	85%	88%
Mammography screening	64.6%	63.5%	64.7%	70.6%	66.0%	74.5%
Social & Economic Factors		19	22	14	6	11
High school graduation	83%	87%	79%	93%	92%	89%
Some college	67.5%	45.7%	50.4%	55.1%	64.6%	62.6%
Unemployment	6.6%	7.5%	9.7%	7.1%	5.9%	6.8%
Children in poverty	14%	24%	29%	22%	11%	17%
Income inequality	4.5	4.3	4.7	4.8	3.9	4.6
Children in single-parent households	34%	34%	43%	37%	28%	33%
Social associations	9.0	10.1	11.7	15.8	9.1	13.9
Violent crime	506	356	504	339	250	223
Injury deaths	54	86	60	67	54	58
Physical Environment		9	15	2	3	7
Air pollution - particulate matter	12.5	12.1	12.2	12.2	12.3	12.3
Drinking water violations	16%	2%	3%	0%	0%	8%
Severe housing problems	17%	17%	20%	18%	15%	16%
Driving alone to work	73%	80%	80%	70%	79%	80%
Long commute - driving alone	47%	52%	34%	32%	52%	31%

Appendix 7

	CHNA Priority Martrix FY2016						
NEED → / CRITERIA ↓	**Access to Care** *(transportation, work force)*	**Behavioral Health**	**Coordination of Care** *(people, data)*	**Chronic Disease Management** *(prevention, obesity, smoking, hypertension, diabetes)*	**Outreach & Eduication** *(health literacy, screenings)*	**Total**	
1. Problem(s) greater in area compared to the state	4.9	4	3.4	4.4	3.5	**20.2**	
2. Impact on vulnerable populations is significant	4.8	5	4.7	4.9	3.9	**23.3**	
3. We can reduce long-term cost to the community by addressing this problem	4	4.6	4.3	4.7	4	**21.6**	
4. Major improvements in the quality of life can be made by addressing this problem	4.3	4.7	4.4	4.9	4.1	**22.4**	
5. Issue can be addressed with existing leadership and resources	1.5	1.6	2.4	2.5	2.9	**10.9**	
6. Progress can be made on this issue in the short term	2.2	2.4	3.9	2.8	3	**14.3**	
Total	**21.7**	**22.3**	**23.1**	**24.2**	**21.4**		

Appendix 8

Community Health Improvement Implementation Plan
FY2017-FY2019

Priority Area: Outreach & Education

Long Term Goals Supporting Maryland SHIP Healthy Beginnings and Healthy Communities, Quality Preventive Care

1) Reduce the percentage of births that are low birth weight (LBW): Caroline=6.6%,Dorchester=9.8%,Kent=8.6%,QA=5.5%,Talbot=8.7%, **MD 2017 Goal: 8.0%**

2) Increase the proportion of pregnant women starting prenatal care in the 1st trimester: Caroline=72.4%,Dorchester=72.8%,Kent=71.9%, QA=80.6%, Talbot=73.2%**, MD 2017 Goal: 66.9%**

3) Health Literacy: Improve the degree individuals obtain, process, and understand basic health information

Annual Objective	Strategy	Target Population	Actions Description	Process Measures	Resources/Partners
Reduce the percentage of births that are low birth weight	Provide education and information on healthy pregnancies, breastfeeding, and early infant care through engaging, evidence-based program	Women in all counties of the mid-shore Targeting counties where Maryland goal has not been met.	Participate in DHMH comprehensive Plan to Reduce Infant Mortality Offer free prenatal education for pregnant women and their partners.	Reach: 1) # of women enrolled Outcomes: 1) % of babies born> 37 wks gestation 2) % of babies born > 2500 grams 3) % of women initiating breastfeeding	Local Health Depts Choptank Community Health SRH Birthing Center Faith Based Partners Associated Black Charities
Increase the proportion of women seeking prenatal care in 1st trimester	Educate women to seek prenatal care within the 1st trimester		Distribute patient education materials to at-risk women on importance and availability of prenatal care through SHS communication channels		
Health Literacy Campaign	Educating providers to focus on patient needs that arise due to health literacy	Providers of Care	Internal health literacy campaign: 1) Video: highlights the importance of the impact of low health literacy on patients and how providers can better communicate with their patients 2) Assess written communication for clarity and plain language	Survey that asks staff what they learned after they watch the video	UMMS Community Health Improvement Committee, SRH care providers

Priority Area: Reduce Tobacco Use, Alcohol/Drug Abuse

Long-Term Goals Supporting Maryland State Health Improvement Plan (SHIP) Healthy Living:

1) **Increase the proportion of adults who are at a healthy weight:** Caroline=30.3%,Dorchester=32%,Kent=26.7%,QA=40.3%,Talbot=34.8%, **2017 MD Target: 36.6%**
2) **Reduce the proportion of children and adolescents who are obese:** Caroline=15%,Dorchester=17.1%,Kent=16.1%,QA=8.9%,Talbot=9.2%, **2017 MD Target: 10.7%**
3) **Reduce adults who currently smoke:** Caroline=22.5%,Dorchester=18.4%,Kent=19.6%,QA=19.6%,Talbot=17.5%, **2017 MD Target: 15.5%**
4) **Reduce adolescents who use tobacco products:** Caroline=25.4%,Dorchester=24.4%,Kent=25.7%,QA=22.5%,Talbot=20.2%, **2017 MD Target: 15.2%**

Annual Objective	Strategy	Target Population	Actions Description	Process Measures	Resources/Partners
Reduce adults who smoke Reduce adolescents who use tobacco products	Work with each of the 5 County Health Dept. to support programming to reduce use of tobacco products	All smokers on the mid-shore	The Cigarette Restitution Fund Program offers Smoking Cessation Counseling. Education for tobacco use prevention and cessation assistance is offered to community groups, school groups, and businesses.	Reach: Ongoing outreach/classes Outcomes: 1) # of people participating 2) # of people who quit smoking	SRH, Each Local Health Department has a coalition focused on tobacco-prevention and control
Promote recovery from drug or alcohol addiction through advocacy, education and support	1) Reduce the stigma about addiction and mental disorders 2) Advocacy for those in recovery 3)Engage in community activities that celebrate recovery and wellness	Population in recovery	Support community events raising awareness and providing support those affected by substance abuse, serving 5 counties of Mid-Shore, including: 1. Out of the Darkness, Suicide Prevention 2. Advocacy for naloxone, legislative forums in Centreville and Cambridge 3. Address alcohol, binge drinking, drug/substance abuse through partnerships listed 4. Sponsor peer support programs	Indicators suggest the quality of life for the target population of those in long-term recovery from alcohol or other drug addiction, improved as a result of the support and advocacy programs.	Behavioral Health Caroline Counseling Center, Caroline County Prevention Services, Chesapeake Treatment Services, Chesapeake Voyagers, Inc., Circuit Court of Talbot County, Problem Solving Court, Community Newspaper Project (Chestertown Spy and Talbot Spy),Dorchester County Addictions Program, Dri-Dock Recovery and Wellness Center, Kent County Department of Health Addiction Services, Mid Shore Mental Health Systems, Inc., Queen Anne's County Department of Health - Addictions Treatment and Prevention Services, University of Maryland Shore Behavioral Health Outpatient Addictions, Talbot Association of Clergy and Laity, Talbot County Health Department Addictions Program (TCAP) and Prevention, Parole and Probation, Talbot Partnership for Alcohol and Other Drug Abuse Prevention, University of Maryland Shore Regional Health, Warwick Manor

Appendix 8

Priority Area: Safe Homes, Trauma Prevention

Long-Term Goals Supporting Maryland State Health Improvement Plan (SHIP) Healthy Communities

1) Reduce fall-related death rate: County level data not available, 2017 MD Target: 7.7%

2) Reduce 911 calls and Emergency Department visits for non-life threatening medical reasons

3) Reduce child maltreatment rate: Caroline=15.7%,Dorchester=28.4%,Kent=12.5%,QA=5.3%,Talbot=14.4%, 2017 **MD Target: 8.3%**

Annual Objective	Strategy	Target Population	Actions Description	Process Measures	Resources/Partners
Reduce falls	Educate community on treatment options for balance disorders	Adults 65 or older report difficulty with balance or walking	Attend community events Provide education to community and physicians	Reach: 1) # of events featuring information 2) # of people attending events Outcomes: Self-reported knowledge/ awareness through Pre/Post Participant Survey	SRH Balance Center
Reduce 911 calls and over-utilization of ED for non-life threatening medical reasons	Improve health outcomes through multi-agency, integrated, and intervention-based healthcare	Medically fragile residents who have utilized 911 services five instances or more within a six-month period	Mobile Integrated Community Health Program: Individuals who qualify for the program can participate voluntarily at no cost, giving them access to a health care team who provide a scheduled home visit	Reach: Queen Anne's County residents Outcomes: 1) Reduction of 911 calls 2) Reduction of ED visits	QA County Dept. of Emergency Services, QA County Dept. of Health, (MIEMSS),QA County Commissioners, QA County Addictions & Prevention Services, QA County Area Agency on Aging, DHMH
Reduce child sexual and physical abuse	Coordinate efforts to ensure that victims of child sexual abuse/ assault, and non-offending family members, have access to support	Children from Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties	Provide forensic interviews, forensic medical examinations, advocacy services and mental health services to children and non-offending family members who may require services and support	Provide services to any/all victim of child sexual and physical abuse (at no charge) in a child-focused setting	Talbot County Children's Advocacy Center (CAC), pediatricians, SRH nurses trained in sexual assault forensic examinations, representatives

Appendix 8

Priority Area: Primary Care, Specialists Care, Behavioral Health

Long-Term Goals Supporting Maryland State Health Improvement Plan (SHIP) Focus Area: Access to Care and Quality Preventive Care
1) improve access to care
2) improve population health
3) reduce emergency department visits related to mental health

Annual Objective	Strategy	Target Population	Actions Description	Process Measures	Resources/Partners
1) Build capacity 2) Promote health equity 3) Reduce avoidable hospital utilization	Transform delivery models from a focus on inpatient care to focus on building healthier communities through enhancing outpatient services, coordination with existing community providers and when needed, direct coordination of chronic care for our most complex patients .	1) High utilizing patients who are not connected to ongoing primary care 2) Chronically ill patients with typical, long standing combinations of diabetes, CHF, COPD, and or prescribed between 5-15 medications. 3) Rural patients with long travel times to care providers and who often do not have access to information technology resources. 4) Patients with sub-acute mental illness, social isolation, and/or limited family support.	1) Organize and coordinate care with existing community services 2)Work with skilled nursing facilities to monitor re-hospitalization 3) Develop hospital operated discharge, chronic disease management and data coordination clinic. 4) Manage patients being discharged from the inpatient behavioral health unit through a Bridge Clinic which provides support while waiting for psychiatric care in the community.	Monitor utilization rates and readmission rates among patients receiving services from various organizations. Metrics: Measure 7and 30-day readmission rate per Skilled Nursing facility. Metric: Bridge Clinic monitor reductions in readmissions the behavioral health inpatient unity and return visits to the ED.	Shore Wellness Partners, SRH Discharge Follow-up Clinic, SRH Bridge Clinic-Behavioral Health Mobile Integrated, Marshy Hope, Corsica River, Community Behavioral Health, For All Seasons SRH Care Transitions Provider Consortiums, Skilled Nursing Facilities, Home Health Agencies, Hospices

Priority Area: Cancer, Chronic Disease- Obesity/Cardiovascular

Long-Term Goals Supporting Maryland State Health Improvement Plan (SHIP) Focus Area: Quality Preventive Care and Access to Care
1) Reduce emergency department visits due to diabetes
2) Reduce emergency department visits rate due to hypertension
3) Reduce deaths from heart disease
4) Reduce mortality rate from cancer

Annual Objective	Strategy	Target Population	Actions Description	Process Measures	Resources/Partners
Increase the proportion of adults who are at a healthy weight Reduce the proportion of youth who are obese	Provide education & information on the importance of healthy lifestyle through engaging, evidence-based programs	Engage targeted communities on healthy lifestyles through the sponsorship or provision of: - Community-wide education - Store Tours - Cooking Classes/Demos/Tastings - Community Screenings & Referrals	Engage targeted communities on healthy lifestyles through the sponsorship or provision of: - Community-wide education - Store Tours - Cooking Classes/Demos/Tastings - Community Screenings & Referrals (Blood pressure, BMI/Weights, & Cholesterol)	Reach: 1) # of campaigns 2) # of events featuring information 3) # of people attending events Outcomes: 1) # of people participating 2) # of pounds lost through DPP education 3) Self-reported knowledge/ awareness through Pre/Post Participant Survey	SRH nutrition educators, ADA, SRH nursing
Reduce the overall cancer death rate	Increase access to free cancer screenings	Increase breast screening levels among uninsured and underinsured women.	Shore Regional Breast Center Wellness for Women Program and Shore Regional Breast Center Case Worker The programs serve as a point of access into care for age and risk specific mammography screening, clinical breast exam, and genetic testing for breast cancer	1) # of women screened 2) # of women referred for treatment 3) Increased number of women surviving breast cancer by diagnosing them at an earlier stage	Local Health Departments
Decrease death and disability related to cardiovascular disease	Decrease death and disability related to critical illnesses where early intervention is possible and proven to be of benefit	Community served by EMS	Provide access to emergency cardiovascular medication for treatment of patients as encountered by local EMS services.	Successful field resuscitation and treatment of patients through early intervention as encountered by local EMS services.	Shore Regional Health Pharmacy, Local EMS units and the State of Maryland Institute for Emergency Medical Services System

Appendix 9

Community Health Planning Council Members

UM SRH Members

- Patti Willis – Regional Senior Vice President, Strategy and Communications
- Kathleen McGrath – Regional Director of Outreach & Business Development
- William Huffner, MD, MBA, FACEP, FACHE – Chief Medical Officer
- Adam Weinstein, MD – VP Medical Affairs
- Walter Atha, MD – Regional Director of Emergency Medicine
- Brian Leutner – Director of Oncology Services
- Iris Lynn Giraudo, RN, BSN – Readmissions Care Coordinator
- Linda Porter– Patient Access Manager
- Patricia Plaskon, PhD, LCSW-C, OSW-C – Coordinator of Oncology Social Work
- Rita Holley, MS, BSN, RN– Director of Shore Home Care
- Ruth Ann Jones EdD, MSN, RN, NEA-BC – Interim Sr. VP Clinical Services/CNO
- Sharon Stagg, RN, DNP, MPH, FNP-BC – Nurse Practitioner -Shore Regional Palliative Care
- Kevin Chapple, Pharm.D., BCPS, – Director of Pharmacy Operations
- Trish Rosenberry, MS, BSN, RN, – Director of Outpatient Services, Diabetes Center
- Stephen Eisemann, BS, RRT – Regional Manager Cardiovascular & Pulmonary Services
- Jackie Weston, BSN, RN-BC, – Nurse Manager for Shore Behavioral Health Services
- John Mistrangelo, ACSW, LCSW-C, – Program Administrator, Shore Behavioral Health Services
- Bill Roth - Senior Director, Care Transitions and Rehabilitation
- Elizabeth Todd MS, BSN, RN I-V,CRRN – Navigator, Shore Comprehensive Rehabilitation
- Robert Carroll – Director, Performance Measurement and Improvement
- Mary Jo Keefe RN,BSN, MSM – Director of Nursing
- Mary King RD, LD, CDE– Nutrition Services Coordinator
- Chris Pettit – Senior Planning Analyst
- Anna D'Acunzi – Manager, Financial Decision Support
- Greg Vasas – Decision Support Senior Analyst

Health Officer Members

- Joseph Ciotola MD – Health Officer of Queen Anne's County Department of Health
  – Medical Director for the Queen Anne's County Department of Emergency Services
- Leland Spencer MD – Health Officer of Caroline County and Kent Count
- Roger Harrell, MHA – Health Officer of Dorchester County
- Fredia Wadley, MD – Health Officer of Talbot County

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