IN THE MARYLAND HEALTH CARE COMMISSION
Matter No. 19-19-EX010

MODIFIED REQUEST FOR EXEMPTION FROM CERTIFICATE OF NEED REVIEW

to
Convert Edward W. McCready Memorial Hospital
to a Freestanding Medical Facility

Joint Applicants

McCready Foundation d/b/a Edward W. McCready Hospital and
Peninsula Regional Medical Center, Inc.

October 24, 2019

#680418

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MODIFIED REQUEST FOR EXEMPTION FROM CERTIFICATE OF NEED REVIEW FOR THE CONVERSION OF EDWARD W. MCREADY HOSPITAL TO A FREESTANDING MEDICAL FACILITY

McCready Foundation, Inc. d/b/a Edward W. McCready Memorial Hospital ("McCready Hospital") and Peninsula Regional Medical Center, Inc. ("PRMC") as joint applicants, by the undersigned counsel, seek approval from the Maryland Health Care Commission (the "Commission") to convert McCready Hospital to a freestanding medical facility. For the reasons set forth more fully below, McCready Hospital and PRMC respectfully request that the Commission grant an exemption from Certificate of Need ("CON") review for the conversion of McCready Hospital to a freestanding medical facility and for associated capital expenditures.

BACKGROUND

McCready Hospital is an acute care hospital with three licensed MSGA beds located in Crisfield, Maryland. It is the only hospital in Somerset County, Maryland and founded in 1919. In addition to McCready Hospital, McCready Foundation, Inc. ("McCready Foundation") owns and operates an outpatient rehabilitation clinic, the Alice B. Tawes Nursing & Rehabilitation Center, and the Chesapeake Cove Assisted Living, each of which is located adjacent to McCready Hospital.

Peninsula Regional Health System, Inc. ("PRHS") is the leading integrated health care delivery system on the Delmarva Peninsula. PRHS is the sole corporate member of PRMC, a 266-bed licensed acute care hospital, with 225 MSGA beds, 20 obstetrics beds, 8 pediatric beds, and 13 psychiatric beds located in Salisbury, Wicomico County, Maryland. The Maryland Health Care Commission also recently granted PRMC a CON to establish 15 child and adolescent psychiatric beds. PRMC, which has been providing care to the region since 1897, offers the widest array of specialty and subspecialty services on the Delmarva Peninsula with the most experienced team of providers, and offers a full range of services, including neurosurgery, cardiothoracic surgery, joint replacement, emergency/trauma care, wound care, and comprehensive cancer care. PRHS has been first to offer local patients open heart surgery in 1974, robotic surgery in 2007, and the region's first hybrid operating room in 2018 for the minimally invasive treatment of brain lesions and aneurysms. PRMC also provides community health services through a network of family medicine and specialty care offices across Delmarva, health pavilions in Millsboro, Delaware and Ocean Pines, Maryland, and with its Wagner Wellness Van. In addition, PRHS has strengthened

health services across Delmarva by entering into medical partnerships in key health services including nursing home, durable medical equipment, home care, urgent care, surgery, medical imaging, weight loss, and more.

In an effort to improve access to quality health care services, enhance personnel recruitment, develop resources for new and existing programs, maintain and enhance medical services for the under-insured and underserved, to facilitate the coordination of health care services throughout the Delmarva Peninsula, including Somerset County, and to achieve the best outcomes at the lowest cost consistent with Maryland's Total Cost of Care Model Agreement with the Centers for Medicare and Medicaid Services ("CMS"), PRHS and McCready Foundation entered into an affiliation agreement on June 26, 2019 (the "Affiliation Agreement"). Pursuant to the Affiliation Agreement, PRHS will become the sole corporate member of the McCready Foundation, and each component of McCready Foundation will become participants in PRHS's regional health care delivery system. Following the Affiliation, PHRS will continue to operate the Alice B. Tawes Nursing & Rehabilitation Center and Chesapeake Cove Assisted Living facility. A condition precedent to consummation of the Affiliation between PRHS and the McCready Foundation, however, is that PRMC and McCready Hospital receive all regulatory approvals necessary to convert McCready Hospital to a freestanding medical facility, including approval of this Request for Exemption from CON Review and adequate rate support from the Health Services Cost Review Commission ("HSCRC").

McCready Hospital is unique in the State of Maryland with respect to its size, complement of HSCRC-regulated services, as well as its economically disadvantaged service area population. Somerset County is one of the poorest jurisdictions in the state, and without an FMF to replace McCready Hospital, the existing service area will lack access to health care resources.

In recent years, changes in health care delivery have resulted in steadily declining inpatient utilization at McCready Hospital such that it is no longer viable as an acute general hospital. In fiscal year 2012, McCready Hospital was licensed for nine (9) MSGA beds. Since then, the number of licensed inpatient beds has continually decreased based on the annual licensed bed benchmarking at 140% of the hospital's average daily census. While currently licensed for only three (3) MSGA beds, McCready Hospital struggles to maintain an average daily census of 3 patients, which jeopardizes its ability to maintain licensure as a hospital.

McCready Hospital's main physical plant and engineering systems were built in 1980, are incapable of supporting a host of modern clinical functions, and have outlived their useful life. Portions of the hospital also encroach on the 100 foot critical area buffer of Daugherty Creek, a tributary of the Chesapeake Bay. The hospital sits only nine feet above the high-tide water level, and while the hospital's clinical space has never flooded, support areas have flooded. Renovation of McCready Hospital at its existing site is neither cost effective nor would it address continued flooding concerns.

McCready Hospital's financial performance has also suffered as a result of declining utilization. In fiscal year 2017, McCready Hospital lost more than $821,000 from operations; its operating margin was negative 5.1 percent. In fiscal year 2018, McCready Hospital incurred an operating loss of more than $764,000 and its operating margin was negative 4.4 percent. More

recently, in the fall of 2018, McCready Hospital required a $1 million increase to its global budget from the HSCRC in order to continue operations and to meet its cash flow needs.

In sum, McCready Hospital is no longer viable as an acute general hospital in the long term. Closing McCready Hospital, however, would leave a vacuum of emergency, observation, and outpatient clinic care to the economically disadvantaged residents of the hospital's service area. As a result and for the reasons set forth herein, the Applicants request approval from the Maryland Health Care Commission to convert McCready Hospital to a freestanding medical facility as described more fully herein.

COMPREHENSIVE PROJECT DESCRIPTION

McCready Hospital's conversion to an FMF, to be known as "McCready Health Pavilion," is part of PRHS's plan to create an optimal patient care delivery system for the future health care needs of residents of the southern Eastern Shore. The Applicants propose to convert McCready to an FMF in two phases. Initially and following all regulatory approvals, McCready will commence FMF operations in the existing building using existing space configurations with minor capital expenditures to provide FMF services ("Phase One"). Following construction of a new FMF facility to be built on a 10-acre campus at 4660 Crisfield Highway, Crisfield, Maryland 21817, approximately three (3) miles from the existing hospital campus, the FMF will be relocated to the newly constructed facility ("Phase Two").

During both Phase One and Phase Two, McCready Health Pavilion's emergency department will be staffed in accordance with regulations issued by the Department of Health, Office of Health Care Quality, and be staffed at all times with one physician trained in emergency medicine, a sufficient number of registered nurses and other professionals to provide advanced life support, a radiology technologist, and a laboratory technician. It will also have a full time Administrative Director, who will act as a liaison with PRMC, and a Medical Director, who will provide clinical oversight of McCready Health Pavilion. In both Phase One and Phase Two, McCready Health Pavilion will provide the following services, which the HSCRC has confirmed its willingness to include within PRMC's Global Budget Revenue cap:

- Primary Care Clinic
- Behavioral Health Clinic
- Emergency Department Services and Supporting Ancillaries
- Observation Services and Supporting Ancillaries
- Infusion
- Imaging
    - Radiography
    - Computed Tomography (CT)
    - Ultrasound[1]

[1] The imaging and laboratory services will operate 24/7 to support the emergency department as well as observation services being offered at McCready Health Pavilion. Imaging services, with the exception of ultrasound, will be available to referred walk-in patients who are not being treated in either the emergency or observation departments. Lab services will not be

McCready Health Pavilion will maintain the same level of emergency and observation services currently provided at McCready Hospital, the only exception being patients who require transport to an acute general hospital based on Maryland Institute for Emergency Medical Services Systems ("MIEMSS") protocols. Patients requiring acute inpatient services will be transferred from McCready Health Pavilion to PRMC or other acute facilities as needed. Patients requiring observation stays would be transferred only in the event that McCready Health Pavilion's two-bed observation unit is at full capacity or the patients' condition deteriorates and warrants an acute care admission or transfer to a tertiary facility. Inter-facility transfers and transports to other facilities as necessary will be supported by having a dedicated commercial ambulance service.

A. Phase One of McCready Health Pavilion Operations

In Phase One, McCready Health Pavilion will be operated in the existing hospital building, in which existing outpatient services will be consolidated on the first floor to ensure efficient FMF operations. Much of the existing hospital space will be vacated as acute inpatient and surgical services will be transferred to PRMC or other facilities as required for each patient's health care needs.

On the first floor, McCready Hospital's emergency department and behavioral health clinic will remain in their current locations. Clinic services, including physical therapy, speech therapy, and family medicine primary care will also be consolidated and also housed on the first floor. The existing surgical suite on the first floor will be closed and surgical services will be transitioned to PRMC. PRMC will incur $215,000 in capital costs to: (1) develop an airborne infection isolation room at a cost of $70,000; (2) modify toilet facilities to remove barriers and ensure compliance with ADA standards at a cost of $100,000; and (3) replace the nurse call system at a cost of $45,000.

In sum, in Phase One, McCready Health Pavilion will consist of:

1. An emergency department for up to six patients, including an airborne infection isolation room, resuscitation room, and a human decontamination room;

2. Two observation beds adjacent to the emergency department;

3. An outpatient behavioral health facility with a group room, three consultation rooms, and three private offices;

4. A diagnostic imaging suite with Radiography, computed tomography or CT, ultrasound, and a PACS reading room;

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available to walk-in patients in the regulated space, however there will be an unregulated blood draw station available for walk-in patients.

5. A laboratory with specimen collection areas for blood and urine as well as space for selected analyzers;

6. Outpatient Rehabilitation Medicine with gym space and two exam/private treatment rooms;

7. A regulated clinic with exam rooms and support spaces to accommodate up to four providers simultaneously;[2] and

8. Administration, staff, and support spaces.

The second floor, which presently comprises McCready Hospital's inpatient unit and pharmacy, will be closed, as will cardiac rehabilitation.[3] Services currently provided at McCready Hospital that would not be available at McCready Health Pavilion include inpatient services, surgical services, electrocardiography, occupational therapy, and magnetic resonance imaging.

B. Phase Two of McCready Health Pavilion Operations

Phase Two of McCready Health Pavilion, will follow construction of a new FMF facility that will be 23,990 gross square feet and 20,997 departmental gross square feet. Once the new FMF facility is built, it will continue to maintain an array of rate regulated outpatient services, including emergency and observation services, associated ancillary services including imaging and

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[2] McCready Hospital currently operates a primary care and specialty care outpatient clinic on its campus in a building adjacent to and on the campus of the main hospital. The clinic is staffed by family medical and internal medicine physicians, a nurse practitioner, and a general surgeon. Several private-practice physicians, including cardiologists and a podiatrist, also maintain office hours at the clinic to accommodate area patients of McCready Hospital's underserved service area. The Health Services Cost Review Commission ("HSCRC") regulates the rates of professional services charged to patients of the McCready outpatient clinic, and the clinic's operations are included within McCready's Global Budget Revenue ("GBR"). Following the conversion of McCready Hospital to an FMF, PRMC will continue to operate the primary care and specialty care clinic as a rate-regulated service at McCready Health Pavilion and has received preliminary approval from the HSCRC to do so. In Phase Two of McCready Health Pavilion's operations, the clinic will be housed in the FMF facility as reflected in **Revised Exhibit 2** to the Applicants' Modified Request for Exemption from CON Review.

[3] McCready Hospital does not currently operate as a retail pharmacy; the pharmacy serves only patients of McCready Hospital. As a result, the closure of McCready Hospital's pharmacy will not affect the community's accessibility to pharmacy services. There are two private retail pharmacies located in Crisfield, including "Crisfield Discount Pharmacy" and "Marion Pharmacy," neither of which will be negatively affected by the closure of McCready Hospital's pharmacy. McCready Health Pavilion will have automated dispensing cabinets to service the pharmacy needs of its emergency and observation patients.

laboratory services, a family medicine primary care clinic, and a behavioral health clinic. Speech and physical therapy, infusion, and laboratory blood draw services will also be provided at the FMF.

McCready Health Pavilion will be a fully functional, full service emergency department, open 24/7 with the capability of caring for patients categorized in EMS priority levels 2 through 4.

The facility will include the following features:

1. An emergency department with one triage room at 140 square feet, three treatment rooms, each at 140 square feet, one resuscitation room at 250 square feet, two secure holding rooms, each being 80 square feet, two patient toilets, one staff toilet, as well as related staff and support spaces; including an ambulance entrance and decontamination facilities;

2. A two bed observation unit with each patient room being approximately 120 square feet each;

3. A regulated clinic, which will continue the regulated primary and specialty care clinic that presently exists at McCready Hospital, with eight exam rooms at 120 square feet each, and related staff and support spaces;

4. A diagnostic imaging suite with x-ray, CT, and related staff and support spaces;

5. Space for outpatient behavioral health services with two consultation rooms at 100 square feet each, one group therapy room at 200 square feet, and related staff and support spaces;

6. A rehabilitation space for physical therapy with an open gym at 1,418 square feet, two private therapy rooms at 110 square feet each, and related staff and support spaces;

7. A laboratory and automated medication dispensing system; and

8. Administration and staff support spaces.

McCready Health Pavilion will be designed in accordance with the Facilities Guidelines Institute, Guidelines for Design and Construction of Hospitals 2018 Edition ("FGI Guidelines"), the 2015 National Fire and Protection Association 101 Life Safety Code, and the 2018 International Building Code. More specifically, McCready Health Pavilion will be designed considering the FGI Guidelines Part 2 – Hospitals, Section 2.2-3 Diagnostic and Treatment Facilities, and Section 2.3 – Specific Requirements for Freestanding Care Facilities.

The total project budget for Phase Two of McCready Health Pavilion is $25,589,294. The proposed project will be funded through a bond issuance by PRHS.

PRMC intends to complete the construction for Phase Two of McCready Health Pavilion within approximately 33 months following Commission approval of this request for exemption from CON review. Construction of the new facility is projected to take place according to the following project schedule: (1) commitment of approved capital expenditure within 18 months following Commission approval of the CON exemption; (2) and completion of construction within 15 months after commitment of approved capital expenditure.

The Applicants have provided project drawings, including two copies of full scale drawings of McCready Health Pavilion Phase Two at **Revised Exhibit 2**. The Applicants have also completed hospital CON **Tables A – K**, which are provided at **Revised Exhibit 1**. **Tables A – E** present physical bed capacity, department square feet, construction characteristics, construction costs, and project budget for McCready Health Pavilion Phase Two. **Tables F – K** present utilization and financial projections that include a comprehensive statement of assumptions related to revenue and expenses and financial performance for McCready Health Pavilion, as well as for PRMC, which will be the parent of McCready Health Pavilion.

As instructed by the staff of the Maryland Health Care Commission and as set forth below, the Applicants have addressed each standard of the State Health Plan Chapter for Freestanding Medical Facilities.

10.24.19.04 Standards

A. General Standards for Certificate of Need.

(1) The parent hospital shall be the applicant for a Certificate of Need to establish, relocate, or expand a freestanding medical facility.

Applicants' response: This standard is not applicable because PRMC and McCready Hospital are not seeking a CON and because 10.24.19.04(C)(3)(b) requires that an application to convert an acute general hospital to a freestanding medical facility "be filed with the converting hospital and its parent hospital as joint applicants."

(2) The applicant shall address and meet the applicable general standards in COMAR 10.24.10.04A in addition to the applicable standards in this chapter.

Applicants' response: This standard is not applicable because PRMC and McCready Hospital are not seeking a CON.

(3) The applicant shall document that it is consistent with the licensure standards established by DHMH.

Applicants' response: This standard is not applicable because PRMC and McCready Hospital are not seeking a CON.

(4) The applicant 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.

Applicants' response: This standard is not applicable because PRMC and McCready Hospital are not seeking a CON.

C. Exemption from Certificate of Need Review to Convert a General Hospital to a Freestanding Medical Facility

(1) A freestanding medical facility created through conversion from a general hospital shall only retain patients overnight for observation stays.

Applicants' response: Following the conversion of McCready Hospital to McCready Health Pavilion, patients will only be retained overnight for observation stays and for treatment in McCready Health Pavilion's emergency department. McCready Health Pavilion will not admit patients for acute inpatient stays.

(2) Each notice, documentation, or other information regarding a proposed conversion of a general hospital to a freestanding medical facility that is required by Section C of this regulation or by COMAR 30.08.15.03 shall be provided simultaneously to the Commission and to the Maryland Institute for Emergency Medical Services Systems.

Applicants' response: The Applicants have and will continue to provide simultaneously to the Commission and the MIEMSS all notices, documentation, or other information regarding the proposed conversion that are required by Section C of COMAR 10.24.19 or by COMAR 30.08.15.03. *See* **Exhibit 11** (July 30, 2019 Letter Providing Notice of Intent to Convert to a Freestanding Medical Facility and Enclosing Request for Exemption from CON Review); **Exhibit 12** (September 4, 2019 Letter Transmitting Summary of the August 20, 2019 Public Informational Hearing held by the Applicants).

(3) A notice of intent to seek an exemption from Certificate of Need review to convert a general hospital to an FMF shall:

(a) Be filed in the form and manner specified by the Commission, which may require a pre-filing meeting with Commission staff to discuss the proposed project, publication requirements, and plans for a public informational hearing.

Applicants' response: The Applicants met with the Commission staff prior to filing its Notice of Intent to Seek Exemption from CON Review for the Conversion of McCready Memorial Hospital to a Freestanding Medical Facility ("Exemption Request") to discuss the proposed project, and filed the July 30, 2019 Exemption Request in the form and manner specified by the Commission staff. The Applicants further consulted with Commission staff prior to filing this Modified Exemption Request.

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(b) Be filed with the converting hospital and its parent hospital as joint applicants;

Applicants' response: PRMC and McCready Hospital have filed the original Exemption Request and this Modified Request for Exemption as joint applicants. Following all regulatory approvals necessary to convert McCready Hospital to McCready Health Pavilion, PRMC will become the parent of McCready Health Pavilion.

(c) Only be accepted by the Commission for filing after:

(i) The converting hospital publishes on its website and otherwise makes available to the general public and community stakeholders, at least 14 days before holding a public informational hearing, the hospital's proposed transition plan that addresses, at a minimum, job retraining and placement for employees displaced by the hospital conversion, plans for transitioning acute care services previously provided on the hospital campus to residents of the hospital service area, and plans for the hospital's physical plant and site.

Applicants' response: The Applicants will comply with this standard before holding a public informational hearing.

(ii) The converting hospital, in consultation with the Commission, and after providing at least 14 days' notice on the homepage of its website and in a newspaper of daily circulation in the jurisdiction where the hospital is located, holds a public informational hearing that addresses the reasons for the conversion, plans for transitioning acute care services previously provided by the hospital to residents of the hospital service area, plans for addressing the health care needs of residents of the hospital service area, plans of the hospital or the merged asset system that owns or controls the hospital for retraining and placement of displaced employees, plans for the hospital's physical plant and site, and the proposed timeline for the conversion.

(iii) Within ten working days after the public informational hearing, the converting hospital provides a written summary of the hearing and all written feedback provided by the general public and from community stakeholders to the Governor, Secretary of DHMH, the governing body of the jurisdiction in which the hospital is located, the local health department and local board of health for the jurisdiction in which the hospital is located, the Commission, and the Senate Finance Committee, House Health and Government Operations Committee, and members of the General Assembly who represent the district in which the hospital is located;

Applicants' response: The Applicants filed the Exemption Request to convert McCready Hospital to a freestanding medical facility on July 30, 2019. In consultation with the Commission staff, McCready Foundation and PRMC held a public informational hearing on August 22, 2019,

beginning at 6:00 p.m. at the McCready Hospital Community Room, Alice B. Tawes Nursing and Rehabilitation Center, 201 Hall Highway in Crisfield, Maryland.

Before holding the public informational hearing, the Applicants exceeded their regulatory obligations to ensure that the hearing was well attended. PRMC published notice of the hearing date and location on McCready Foundation's website's homepage and in the print and electronic versions of the The Daily Times, a newspaper of daily circulation, between August 6 and August 19, 2019. PRMC also purchased advertisements in the County News, a Somerset County newspaper, which circulates less than daily, announcing the date and location of the public hearing on August 7 and August 14, 2019. Examples of the advertisements published in The Daily Times and County News are attached as **Exhibit 13**. PRMC also published a notice of the public hearing on its website and on its Facebook page on August 2 and August 15, 2019.

McCready Foundation also published its transition plan on its website, which addressed job retraining and placement of employees displaced by the conversion, plans for transitioning acute care services previously provided at McCready Hospital to residents of the service area, and plans for the hospital's physical plant and site. A screen shot of McCready's website providing notice of the public informational hearing and a link to the Applicants' transition plan is provided as **Exhibit 16**. The transition plan that was linked to McCready's website via an instruction to "click here to view more information on the transition plan" is also attached at **Exhibit 16**. A written summary of the public informational hearing was distributed on September 4, 2019, and was provided to several members of the Commission staff on that date. A cover letter transmitting a summary of the initial public informational hearing is attached as **Exhibit 12**. The Applicants understand that Commission maintains on file a complete copy of summary of the public informational hearing in the Commission's file, 19-19-EX010.

(iv) The State Emergency Medical Services Board has determined that the proposed conversion of the general hospital to an FMF will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system;

Applicants' response: The Applicants understand that the EMS Board plans to consider whether the conversion of McCready Hospital to a freestanding medical facility will continue to maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system at a special meeting of the EMS Board.

(v) The applicants receive a determination from HSCRC, issued pursuant to COMAR 10.37.10.07-2D, regarding each outpatient service to be provided at the proposed FMF for which the applicants seek rate regulation.

Applicants' response: The Applicants will notify the Commission when and if the HSCRC approves each outpatient service at McCready Health Pavilion for which the Applicants seek rate regulation.

(vi) The applicants receive approved rates from HSCRC for each rate-regulated outpatient service at the proposed FMF; and

Applicants' response: The Applicants will comply with this standard. The Applicants do not anticipate that the HSCRC will approve rates for each rate regulated service to be provided at McCready Health Pavilion in Phase Two until construction of the facility is complete or nearly complete.

(vii) The applicants provide any additional information determined by Commission staff as necessary for the notice of intent to seek an exemption to convert to an FMF to be complete.

Applicants' response: The Applicants will provide any additional information determined by the Commission staff as necessary for approval of the conversion of McCready Hospital to a freestanding medical facility.

(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.

Applicants' response: McCready Hospital is on the only acute general hospital in Somerset County. In Phase One, McCready Hospital will commence FMF operations on its existing campus. In Phase Two, McCready Health Pavilion's project site, 4660 Crisfield Highway, Crisfield, Maryland, Maryland, is within McCready's primary service area and is located approximately three (3) miles from McCready Hospital via public roadways. The proposed project complies with the location standards.

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

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:

Applicants' response: PRMC's policy relating to transparency in health care pricing complies with this standard and is attached as **Exhibit 3**. This policy will be extended to McCready Health Pavilion when it opens.

(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;

Applicants' response: PRMC's policy attached as **Exhibit 3** provides as follows:

Peninsula Regional Medical Center's Finance Department will post a representative list of services and charges on the PRMC website. PRMC will respond to individual requests for current charges for specific services/procedures.

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The attached List of Representative Charges will be posted on the PRMC website by the Finance Budget, Cost & Reimbursement Office on a quarterly basis. The information will be updated each calendar quarter and posted within 45 days of the end of each quarter.

The List of Representative Charges will be distributed to staff each time prices change. This list is available to the public from the Financial Counselor upon request. Requests for estimates of charges for procedures/services are provided by the following:

Outpatient Diagnostic Testing –

- If requested in person – by the Financial Counselor
- If requested by phone – by the Centralized Scheduling Office

Outpatient Surgery and Procedures – by the Centralized Scheduling Office
Inpatient Services –

- If requested by phone – by the Patient Financial Services collection personnel
- If requested in person – by the Financial Counselor who will contact the collections team.

Information available for charge estimation:

1. Rates sheet. This list is updated whenever prices are changed, and revisions will come from the Budget and Reimbursement Office.

2. Service item master listing for charges. This list is updated periodically and revisions will come from the Budget and Reimbursement Office.

3. Observation charges. This charge is updated periodically and revisions will come from the Budget and Reimbursement Office.

4. A listing of average OR minutes by procedure. Two lists are generated, one in ICD-10 order (worksheet = avg. min), the second list is in alphabetic description order (worksheet = avg. min-desc.). These lists are updated periodically and revisions will come from the Budget and Reimbursement Office.

Note: Contact Budget and Reimbursement Office if an annual update is not received.

PRMC maintains a list of frequently occurring charges on its website, which can be found at the following Internet address:

https://www.peninsula.org/sites/default/files/average-charge-summary-qe-06-30-19.pdf

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

Applicants' response: PRMC's policy on "Charges – Estimates and Information to Patients and Public" states that, "PRMC will respond to individual requests for current charges for specific services/procedures," and that "[The] list [of representative charges] is available to the public from the Financial Counselor upon request." **Exhibit 3** at p. 1. With respect to patient correspondence, PRMC's policy provides, "It is important that the patient understand that the estimate is subject to change and is only an estimate. The actual charges incurred may be higher or lower than shown. See example correspondence which may be formalized and sent via mail or may be used in phone conversations to ensure continuity of message presented." **Exhibit 3** at p. 2. Further staff are instructed to "[d]ocument in EPIC, account notes; the estimated charges and the method and date of communication to patient." **Exhibit 3** at p. 2.

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

Applicants' response: PRMC's policy on "Charges – Estimates and Information to Patients and Public" provides, "PRMC will provide staff training to ensure that inquiries for its services are appropriately handled." *See* **Exhibit 3** at p. 1.

Charity Care Policy.

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

(a) The policy shall provide:

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

(ii) Minimum Required Notice of Charity Care Policy.

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

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

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.

Applicants' response: PRMC's Uncompensated Care / Financial Assistance Policy, complies with this standard and is attached as **Revised Exhibit 4**. PRMC's Uncompensated Care / Financial Assistance Policy complies with COMAR 10.24.10.04A(2). Section (c) on page 3 of PRMC's Uncompensated Care / Financial Assistance Policy provides that, "[p]reliminary eligibility will be made within 2 business days based upon receipt of sufficient information to determine probably eligibility. A letter will be mailed to patients notifying them of their eligibility status. Following preliminary approval, patients must submit a completed application and any supporting documentation requested (if not done previously). Upon final approval, a financial assistance discount will be applied to the patient's responsibility." This policy will be implemented at McCready Health Pavilion when it opens.

The table below provides quotes from PRMC's Uncompensated Care / Financial Assistance Policy and demonstrates that PRMC complies with this standard.

	Quote from the policy	**Section citation**
10.24.01.04A(2) (2) Charity Care Policy. Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.(a) The policy shall provide:		
(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a	"c. Preliminary eligibility will be made within 2 business days based upon receipt of sufficient information to determine probable eligibility. A letter will be mailed to patients notifying them of their eligibility status. Following preliminary approval, patients must submit a completed application and any supporting documentation requested (if not done previously). Upon final	Page 3, Procedure § (c)

determination of probable eligibility.	approval, a financial assistance discount will be applied to the patient's responsibility in accordance with Finance Division policy FD-030. "	
(ii) Minimum Required Notice of Charity Care Policy.		
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;	"If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies. In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, PRMC will provide care at reduced or zero cost. When no third party assistance is available to cover the total bill and the patient indicates that they have insufficient funds, Financial Assistance (FA) will be offered. The Maryland State Uniform Financial Assistance application, Financial Assistance Policy, Patient Collection Practice Policy, and plain language summary, can be obtained by one of the following ways: a. Available free of charge and upon request by calling (410) 543-7436 or (877) 729-7762. b. Are located in the registration areas. c. Downloaded from the hospital website: https://www.peninsula.org/patients-visitors/patient-forms https://www.peninsula.org/patients-visitors/patient-billing-information d. The plain language summary is inserted in the Admission packet and with all patient statements. e. Through signs posted in the main registration areas. f. Annual notification in the local newspaper. g. The application is available in English and Spanish. No other language constitutes a group that is 5% or more, or more than 1,000 residents (whichever is less) of the population in our primary service area (Worcester, Wicomico and Somerset Counties) based on U.S. Census data. h. For patients who have difficulty in filling out an application, the information can be taken orally by calling (410) 912-6957 or in person at	Page 3, Procedure Introduction

	the Financial Counselor's Office located in the Frank B. Hanna Outpatient Center." An annual ad is placed in the Daily Times newspaper. A copy of which is provided below:  NOTICE OF AVAILABILITY OF FINANCIAL ASSISTANC Peninsula Regional Medical Center provides financial assistance to patients based on their income, assets, and financial needs. We may be able to help you access governmental programs or assist you with payment plans. A reasonable amount of our services are provided free or at a reduced charge to persons who cannot afford to pay for medical care. If you would like information on our financial assistance policy, or are not able to pay for all or part of the care you need, please contact the financial services office at 410-543-7436 or 800-235-8640, visit our website at www.peninsula.org or write to: Patient Financial Services Peninsula Regional Medical Center P.O. Box 2496 Salisbury, MD 21802-2498	
Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital.	Notices regarding the charity care policy are described in "signs posted in the main registration areas," including the admission office, registration areas, business offices, emergency department and other entrances patients are entering to receive care. *See* response above.	*See* Page 2, Procedure Introduction (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.	Individual notices are provided upon admission to each person seeking services. PRMC's policy states: "The plain language summary is inserted in the Admission packet and with all patient statements."	Page 2, Procedure Introduction (d).

(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.

Applicants' response: As shown in **Table 1** below, neither PRMC nor McCready are in the bottom quartile in terms of the percentage of charity care to total operating expenses for acute general hospitals in the State of Maryland. This standard is, therefore, not applicable.

Table 1
HSCRC Community Benefit Report
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 January 30, 2019.

Quality of Care.
An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

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

(ii) Accredited by the Joint Commission; and

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

Applicants' response: McCready Hospital's and PRMC's licenses from the Maryland Department of Health, Office of Health Care Quality, most recent Joint Commission accreditations, most recent verifications of CMS 855a Medicare enrollment forms Novitas Solutions, the Medicare Administrative Contractor for Maryland, and verifications from the Maryland Department of Health Medicaid website are submitted herewith as **Exhibits 14** and **15**, respectively.

(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.

Applicants' response: McCready Health Pavilion, as a provider-based department of PRMC 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, Office of Health Care Quality (formerly the Department of Health and Mental Hygiene) for licensure as a freestanding medical facility, will 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).

McCready will be a provider-based department of PRMC. Quality is an important cornerstone of PRMC, and recently, CMS has awarded PRMC (5) stars for quality outcomes and Healthgrades has recognized PRMC as one of America's Best 250 hospitals. Of the 68 measures applicable to Peninsula Regional Medical Center, only 7 were below the state average. Table 2 below, identifies those quality measures for which PRMC was ranked "below average" along with PRMC's corrective action plan:

Table 2
PRMC Below-Average Quality Measures and Corrective Action

Quality Measure	Corrective Action Plan
Childbirth	
How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)	As a framework for a woman-centered model of care, Peninsula Regional and obstetrician physician providers support VBAC (Vaginal Birth after Cesarean) in discussion with the patient. To improve the overall health outcomes for both mother and baby, a set of guidelines are emphasized to help sort out the complexities of birth after a cesarean. Factors for consideration in discussion with the patient for informed decision making include i.e. maternal age, BMI, previous spontaneous labor, prior vaginal birth, hypertension, shoulder dystocia, increased estimated baby weigh, short inter-pregnancy interval, preeclampsia, ethnicity, and type of uterine incision.
How often babies are born vaginally when the mother has had a C-section in the past (includes complications)	A team centered approach is key as the obstetrician, nursing staff and patient review and discuss their options alternately weighing the benefits and risks (C-section charts are used to determine if they are a potential candidate). If the patient decides that they would like to trial labor, there is a consent that they have to sign noting all of the risks, including uterine rupture. If the baby is in vertex position and there are no maternal complications on admission to Labor and Delivery, the mother begins her trial of labor. The ultimate goal is to prevent the first C-

Quality Measure	Corrective Action Plan
	section to reduce morbidity and mortality. The obstetricians have stated that they review the repeat. Providing clarity through education to patients is a cornerstone of Peninsula Regional's OB program with a message that having a vaginal birth after a C-section can be a safe choice for most women.
Communication	
How often did doctors always communicate well with patients?	PRMC has implemented multidisciplinary rounds with our patients on each of the medical and surgical floors. This entails the entire care team (doctors, nurses, patient care managers, and ancillary as appropriate) having a discussion about each patient together so that the team is aligned on the plan for the day. Then the provider (physician or APP) provides that communication to the patient. From that plan, the nurses document on the patient's white board, the key goals for the day related to the plan as well as the anticipated discharge dates so the family members can be prepared ahead of time for discharge. This action item came initially from the Service Excellence team, but then we formed a Discharge Team who found that the existing rounds were not occurring regularly, so they have implemented it with a new focus and will be monitoring compliance.
Environment	
How often was the area around patients' rooms always kept quiet at night?	PRMC has developed a team around this who identified that "noise at night" included visual noise of lights along with sound. This team implemented standard work for noise at night which included offering the patients eye shields, tea or water, and ear plugs. They also shut the patient's door (if the patient agrees to do so). PCU and ICU have implemented "quiet times" during the day when they turn the lights down and ask that visitors and personnel avoid interrupting the patient's rest during these times. Lastly, the Clinical Quality Specialists for the maternity unit did a DMAIC project on nightly interruptions and they were able to modify their care processes

Quality Measure	Corrective Action Plan
	so that interruptions in the new mother's sleep were reduced through the night. Hospital-wide, a change in visitor policy has been implemented. Visiting hours are 8:00 a.m. to 8:00 p.m. and patients and guests are asked to silence their cell phones after 8:00 p.m.
Wait Times	
How long patients who came to the emergency department with broken bones had to wait before receiving pain medication.	In an effort to improve the arrival time to medication time for patients with bone fractures presenting to the ED, PRMC has implemented the following initiatives: • Collected a comprehensive list of patients that were coded as having a bone fracture and presenting through the ED. • Identified ED providers to determine trends and provide additional education as appropriate. • Further analyzed the data to determine the time intervals where we were deficient and the time in which most patients received their medications (ie: 15-30 min after arrival, 30-45 minutes etc.) • Identified which patients arrived by EMS and were medicated prior to arrival by EMS that impacted the measure by showing a longer time between arrival to medication. This measure continues to be monitored and a standing agenda item at our fragility fracture team monthly meeting
Flu Prevention	
Patients in the hospital who got the flu vaccine if they were likely to get flu.	Peninsula Regional maintains an Immunization team comprised of a multidisciplinary team across clinical, pharmacy, and administrative functions. The team has in place the following action plan: a) developed and shared with staff a Flu vaccine information and MAR documentation tips with one point lessons. b) improving the screening process within the EPIC electronic medical record so accurate counts of patients who are likely to get the flu and have not received/refuse the vaccine are properly documented.

Quality Measure	Corrective Action Plan
	c) a manager report was created to real time visibility on patients. d) conducting education sessions on proper vaccination protocols across the entire medical staff. e) evaluating evidence based best practices and working with IT to implement decision support and hard stops to ensure vaccinations are addressed
Results of Care - Death	
How often patients die in the hospital after during or after pancreas surgery.	In the past year Peninsula Regional has had a very low volume (8) of pancreatic surgery cases. Several were "Whipples" which have poor outcomes and prognosis. By the time these patients have surgery they are typically in Stage 4 and the probability for a good outcome is diminished. Peninsula Regional continues to emphasize through its community health and wellness initiatives that early detection is key and that early screening methods are especially important. A blood test that identifies a specific substance in the blood that is highly indicative of cancer, such as the PSA test for prostate cancer is important. Unfortunately, pancreatic cancer is diagnosed primarily through the use of CT and MRI and currently there is no standard diagnostic tool or established early detection method for pancreatic cancer. (Pancreatic Cancer Action Network) Peninsula Regional will share these outcomes with our Oncologists as we do with most all of these cases and continue to develop the most efficacious and quality driven plan for pancreatic surgery.

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

Applicants' response: McCready Health Pavilion will meet or exceed licensure standards established by the Department of Health.

(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.

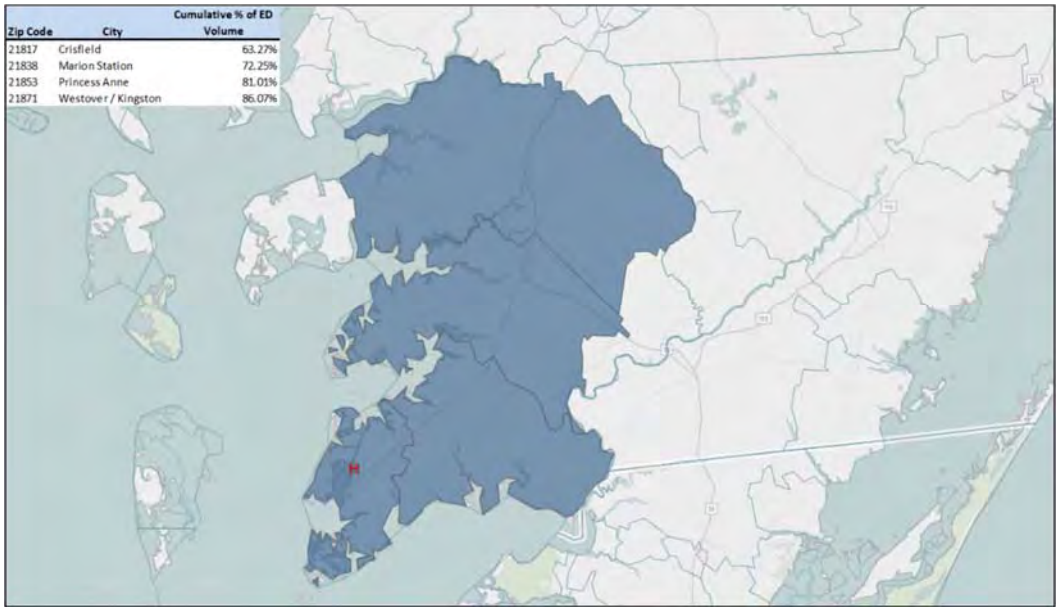
Applicants' response: Submitted as **Revised Exhibit 4** is PRMC's current financial assistance policy currently in effect, which policy complies with COMAR 10.24.10. This same policy as may be updated prior to the proposed opening of McCready Health Pavilion will be established and maintained at the McCready Health Pavilion.

(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;

Applicants' response: In fiscal year 2018, 85% of McCready Hospital's emergency department visits came from residents of 4 zip codes in Somerset County as listed in Table 3 below.

Table 3
McCready Hospital ED Service Area
Fiscal Year 2018



In fiscal year 2018, there were 12,585 visits to Maryland hospital emergency departments by residents of McCready Hospital's ED service area (*see* Table 4). This utilization represents a 5.7% increase from the utilization of hospital emergency departments by residents of this service area since fiscal year 2014. McCready Hospital's emergency department utilization by residents of its

service area declined by 1.6% from 4,506 visits in fiscal year 2014 to 4,432 visits in fiscal year 2018. *See* Table 4 below.

Table 4
McCready Hospital's Service Area Emergency Department Visits
FY2014 – FY2018

Hospital Name	FY2014	FY2015	FY2016	FY2017	FY2018	FY2018 Market Share	FY2014 - FY2018 % Volume Change
Peninsula Regional Medical Center	6,989	7,761	7,985	8,063	7,717	61.32%	10.42%
McCready Memorial Hospital	4,506	4,795	4,654	4,652	4,432	35.22%	(1.64%)
Atlantic General Hospital	175	137	164	202	171	1.36%	(2.29%)
Johns Hopkins Hospital	44	47	26	42	47	0.37%	6.82%
UM Shore Medical Center at Easton	14	11	33	25	31	0.25%	121.43%
UM Shore Medical Center at Dorchester	12	35	21	21	22	0.17%	83.33%
University of Maryland Medical Center	15	14	21	21	19	0.15%	26.67%
All Other Hospitals	156	139	136	146	146	1.16%	(6.41%)
Total Service Area ED Visits	**11,911**	**12,939**	**13,040**	**13,172**	**12,585**	**100.00%**	**5.66%**
McCready Memorial Hospital - Total ED Visits	5,062	5,405	5,169	5,227	4,924		-2.73%

Notes:
[1]Source: HSCRC Final FY2014 - FY2018 Abstract Data
[2]Excludes Chronic (defined as daily service code 9) and categorical cases
[3]OP ED Defined Using HSCRC Market Shift Service Lines, IP ED Defined as Cases Having ED Units
[4]Service Area: 21817, 21838, 21853, 21871

McCready Memorial Hospital 5 Year Average	
Service Area	4,608
Total	5,157

The conversion of McCready Hospital to McCready Health Pavilion is necessary to continue to provide access to emergency and observation services for the service area population. Additionally, the emergency service area volume demonstrates that there is clearly a need for an emergency care provider in Somerset County.

McCready Hospital's 4,432 emergency department service area visits in fiscal year 2018 represented 35.2% of the total service area emergency department visits. In total, McCready Hospital had 4,924 emergency department visits in fiscal year 2018, and it averaged 5,157 total emergency department visits between fiscal years 2014 and 2018.

The only other hospital with greater market share of emergency department visits in the service area is PRMC, which already has a fully utilized emergency department. Without McCready Health Pavilion to absorb the volume of emergency department cases presently seen at McCready Hospital, in the event the hospital were to close or no longer able to maintain its license as a hospital, emergency visit increases at PRMC could strain available resources and require additional expansion of PRMC's emergency department.

(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.

Applicants' response: McCready Health Pavilion has been designed to provide similar emergency and observation services as have been historically provided at McCready Hospital. Accordingly, the Applicants projected McCready Health Pavilion service area ("FMF Service Area") and number of emergency department visits is based on historical utilization at McCready Hospital. Within McCready Health Pavilion's Service Area, there are no other acute general hospitals and no freestanding medical facilities providing emergency services. The Applicants have identified the following urgent care centers and listed their proximity to McCready Hospital by roadway travel set forth in Table 5**.**

Table 5
Urgent Care Centers in McCready Health Pavilion Service Area

Urgent Care Center	Address	Hours of Operation	Distance to McCready
Lower Shore Immediate Care	12302 Somerset Ave A, B, Princess Anne, MD 21853	8am - 8pm Monday-Friday 8am - 6pm Saturday 9am - 5pm Sunday	20.1 miles
Your Doc's In	1511 Ocean Hwy, Pocomoke City, MD 21851	8am - 8pm Monday-Friday 8am - 6pm Saturday-Sunday	22.3 miles

As shown in Table 5**,** there are two urgent care centers in the projected service area. And, as reflected in **Table 4** above, emergency department visits at McCready Hospital have not appreciably declined as a result of operation of these urgent care centers. The continuance of 24/7 emergency services in McCready Health Pavilion's Service Area is critical to providing the residents of Somerset County ready access to emergency care. To this end, the McCready Health Intermediate Care Facility, an urgent care center operated by McCready Foundation and located within McCready Health Pavilion's Service Area in Princess Anne, was not financially viable and closed in June 2019.

Furthermore, the limited hours of operation of the urgent care centers in the service area does not provide an alternative for patients experiencing emergency medical conditions when those facilities are closed. To this end, approximately 33% of McCready Hospital's emergency department visits take place between the hours of 8 p.m. and 8 a.m., when none of the two urgent care centers in the service area are open. *See* Table 6 below.

Table 6
McCready Hospital Emergency Department Visits by Hour FY 2018

Time	Patients in ED	% of Total
8:00 PM	301	5.74%
9:00 PM	249	4.75%
10:00 PM	191	3.64%
11:00 PM	122	2.33%
12:00 AM	105	2.00%
1:00 AM	75	1.43%
2:00 AM	66	1.26%
3:00 AM	75	1.43%
4:00 AM	45	0.86%
5:00 AM	61	1.16%
6:00 AM	77	1.47%
7:00 AM	132	2.52%
8:00 AM	223	4.25%
8:00 PM - 8:00AM	1,722	32.83%
9:00 AM - 7:00 PM	3,523	67.17%
Total	**5,245**	**100.00%**

Moreover, 54% of McCready Hospital's emergency department and other outpatient visits are Medicaid beneficiaries or self-pay patients in 2018. Non-regulated urgent care facilities could not financially absorb the volume of even all non-emergent cases currently seen at McCready Hospital. The lack of transportation infrastructure in Somerset County compounds the lack of access to emergency care for residents of the McCready Health Pavilion's Service Area. The nearest hospitals are PRMC approximately 30 miles from McCready Hospital and Atlantic General, which is approximately 40 miles from McCready Hospital. Accordingly, development of McCready Health Pavilion with the proposed level of beds and ancillary equipment is critical to ensure continued access to emergency services for the service area population.

Within McCready Hospital's service area, Chesapeake Health Care in Princess Anne provides adult medicine, pediatric medicine, mental health, Ob/Gyn services. Additionally, Princess Anne Family Medicine in Princess Anne employs two physicians that provide primary care services.

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

Applicants' response: In 2017, McCready Hospital completed its most recent community health assessment, which was prepared in conjunction with the Business Economic and

Community Outreach Network ("BEACON") at Salisbury University. The health assessment process was completed with assistance from the Somerset County Health Department. McCready Hospital's 2017 health assessment is included at **Exhibit 5.**

In defining the "community" for purposes of assessing health needs, McCready Hospital took into consideration relevant facts and circumstances that drive community health, including the geographic area served by the hospital facility, segment populations with specific needs, and disease states of significant incidence. McCready Hospital's defined community includes medically underserved, low-income, or minority populations who live in the service area from which the hospital draws its patients. In addition, in determining its patient populations for purposes of defining its community, McCready Hospital took into account all patients without regard to whether (or how much) patients or their insurers pay for care received or whether patients are or were eligible for assistance under the hospital's financial assistance policy.

The assessment addressed and identified significant community health needs in Somerset County. Input was solicited from County residents using interviews and surveys. Through a prioritization process involving a variety of community stakeholders and community-based organizations, the following were identified as priority community health needs:

- Access to Healthcare
- Healthcare Affordability
- Behavioral Health
  - Alcohol and Substance Abuse
  - Alzheimer's/Dementia
- Metabolic Syndrome
  - Obesity
  - Diabetes
  - Heart Disease
- Cancer

The conversion of McCready Hospital to an FMF is consistent with the community health needs assessment. The transition of McCready Hospital to McCready Health Pavilion will allow PRMC, as McCready Health Pavilion's parent hospital, to provide needed outpatient clinical services within an efficient and modern facility, integrated with other community providers and agencies. The array of services to meet community healthcare needs will include the following:

- Emergency Medicine Services available 24 hours a day, seven days a week
  - Imaging and diagnostic services to support the emergency department
- Observation / Clinical Decision Unit to treat and monitor patients to determine the need for inpatient care
- Behavioral Health Services
- Clinical Services

Access to care is critical to the Crisfield community and Somerset County residents more generally. Access to primary care physicians is a particular need. There are very few primary care providers in Somerset County and none in Crisfield outside of the hospital campus. The lack of primary care providers limits patient options to receive preventative and routine care. McCready

Health Pavilion in Crisfield will continue to provide family medicine primary care services for this population through the rate regulated FMF, insuring access to quality care.

Further, McCready Health Pavilion will provide:

- Speech and physical therapy;
- Lab services, including a draw station;
- Imaging Services consisting of diagnostic radiology, CT, and ultrasound for emergency and observation patients;
- Walk in lab services and imaging, excluding ultrasound.

McCready Health Pavilion will remain part of the PRHS's integrated health system as an outpatient department of PRMC. Patients and residents who receive outpatient medical services at McCready Health Pavilion will continue to have access to community health programs and services to address their health needs. Programs and activities to identify FMF patients who are impacted by social determinants of health risk factors, diagnoses of chronic disease, and who require behavioral health education and support will continue, and likely improve given the PRMC's resources. Additionally, as is the case currently, patients treated in McCready Health Pavilion's emergency department or discharged from the FMF will be provided care transition and coordination support to ensure positive health outcomes and to avoid unnecessary hospital stays and readmissions. Patients at the FMF will have access to post discharge care management and care coordination services through PRMC. Those identified as high risk will have access to telephonic post discharge care management. Post-discharge care management and care coordination will include use of care coordinators who will call patients post discharge, coordinate provider follow up, perform a medication reconciliation and health education, and evaluate patients for need with support with social determinants of health. Care coordinators will support patients with care coordination services such as remote patient monitoring, community health worker follow-up, and community based education. Patients seeing a provider within PRMC's integrated care network will have direct access to the office care coordination staff after discharge with similar services as well as access to the in-office care coordinator.

Conversion of McCready Hospital to McCready Health Pavilion will also support and advance PRMC's objective to improve community health in the lower Eastern Shore area. PRMC is improving and adapting current health programs to positively impact the overall health and wellness of the community and achieve population health management objectives. This service expansion is being achieved through collaborative partnerships with community organizations as well as with state and local health agencies. PRMC and McCready Hospital both actively solicit information from community stakeholders and other community-based organizations to assess the health needs in their communities. PRMC and McCready Hospital each serve as health focused community organizations and provide staff expertise and other resources, including hosting meetings at their facilities, and also provide health screening services at local community events. PRMC is developing more health initiatives to promote disease prevention and to raise awareness of risks associated with health conditions, including asthma, diabetes, and mental health. PRMC has also worked with local and state health officials to develop and implement programs that address the County's health plan goals.

Through McCready Hospital's affiliation with PRMC, patients of McCready Health Pavilion's service area will have access to the full range of outpatient services at PRMC and PRHS-affiliated locations, including:

- Cardiac & Pulmonary Rehabilitation
- Chemotherapy and infusion services
- Radiation therapy
- Diabetes Education and Support Services
- Breast Center – mammography and diagnostics
- Behavioral Health – outpatient counseling, partial hospitalization program
- Wound & hyperbaric treatment
- Sleep Lab
- ALS Clinic
- Endoscopy
- Coumadin Clinic
- Cardiac Stress Test
- Pulmonary function testing
- Medical Nutritional Therapy
- Pediatric Diabetes Management
- HealthFest
- Drive-Thru Flu Clinic
- Atrial Fibrillation Surgical Management Clinic
- Fitness Plus and Adult Fitness and Maintenance
- Corelife Delmarva
- Peninsula Stroke Center
- Spine Services
- Orthopedic and Occupational Health Rehab
- Lactation Consultations
- Yomingo childbirth and newborn care electronic education
- Prepared Childbirth classes
- Newborn Care classes
- Cancer Survivorship
- Prostate Cancer Group
- Head and Neck Cancer Group
- Cancer Exercise program
- Cancer Cooking and Nutrition
- Lymphedema Management
- Pediatric Endocrinology
- Pain Management
- Gastroenterology services
- Neurology services
- Endocrinology services

- Outpatient surgical procedures
- Hemodialysis
- Renal Support Group

In addition, greater alignment with community partners will allow PRHS to deploy additional services to residents in the McCready Hospital service area. PRHS has a clinically integrated network; Peninsula Regional Clinically Integrated Network ("PRCIN"). McCready Health Pavilion will be able to take advantage of the services of the Care Transformation Organization, part of the PRCIN. These services include improved access, care management, comprehensive care coordination across the continuum of health care services.

Partnerships with McCready Hospital, PRHS, and the residents of Smith Island via community health workers with access to a telehealth hub are already in place and would be expected to be part of the care provided by McCready Health Pavilion.

Services currently provided by Mac, Inc. Area Agency on Aging and funded by PRHS for community education for chronic disease management, fall prevention, depression, and other evidence-based classes would be supported at McCready Health Pavilion.

Access to telehealth providers for specialty care, behavioral health services, and care coordination would be potential opportunities for McCready Health Pavilion to expand community access to health care services. McCready Health Pavilion in Crisfield, partnered with an array of other outpatient health services and the support of PRHS, will provide comprehensive outpatient medical services, as well as health education and preventative health programs to address the identified needs of the community. Services provided on the campus of McCready Health Pavilion and at a variety of community locations will ensure appropriate access to care and community based resources to improve the overall health of residents within Crisfield and surrounding communities.

(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.

Applicants' response: As noted above, at McCready Health Pavilion, the Applicants propose to maintain the same level of emergency department services currently provided McCready Hospital, with the exception of those EMS patients that need to be transported to an acute general hospital under MIEMSS protocols. Between fiscal years 2014 and 2018, McCready Hospital experienced an average of 4,608 emergency department visits per year from the primary service area, and 5,157 total emergency department visits per year. *See* **Table 4** above. In fiscal year 2018, McCready Hospital's emergency department experienced 5,032 patient visits with an average length of stay of approximately 2.14 hours or 128 minutes.

The Applicants project that that McCready Health Pavilion is likely to see a similar but slightly less number of emergency patients than were historically seen at McCready Hospital for a number of reasons. First, McCready Health Pavilion, like McCready Hospital, is located in a remote location in Somerset County. The nearest hospitals are PRMC approximately 30 miles from McCready Health Pavilion, Atlantic General, which is approximately 40 miles from McCready Hospital, and Riverside Memorial Hospital in Onancock, Virginia, which is approximately 53.5 miles from McCready Health Pavilion. In the event of an emergency medical condition, the Applicants do not anticipate that patients will drive dozens of additional miles to an acute general hospital.

Second, recently updated MIEMSS protocols permit EMS providers to transport the following classifications of patients to an FMF: (1) priority 1 patients who are in extremis; (2) stable priority 2 patients; (3) all priority 3 patients; and (4) all priority 4 patients. In this regard, McCready Health Pavilion anticipates receiving the vast majority of patients who are currently brought to McCready Hospital via EMS transport.

Third, as reflected on Table 6 of the Request for Exemption from CON Review, approximately 33% of McCready Hospital's emergency department visits occurred between 8 p.m. and 8 a.m. At these times, neither of the two urgent care centers, which are approximately 20 miles from McCready Hospital are open. The Applicants project that patients who may otherwise present to these urgent care centers will continue to visit McCready Health Pavilion for urgent and emergent care.

The Applicants will also engage in extensive community education regarding the capabilities of McCready Health Pavilion to ensure the facility is used to its fullest potential. To this end, at its recent public informational hearing, the Applicants informed the community that McCready Health Pavilion will be staffed by the same emergency room physicians as those that currently staff the emergency departments at both PRMC and Atlantic General.

The American College of Emergency Physicians, *Emergency Department Design: A Practical Guide to Planning for the Future* ("ACEP Guide") estimates the number of treatment spaces needed to accommodate emergency department visits starting at 10,000 per year. At a level of 10,000 visits per year, the ACEP Guide "low range" projects a need for eight treatment spaces. McCready Health Pavilion has been designed to have a total of five (5) emergency department treatment spaces, including three treatment rooms, each at 140 square feet, one resuscitation room at 250 square feet, one secure holding room being 80 square feet. McCready Health Pavilion will also have one triage room at 140 square feet, which emergency treatment will not be provided. In sum, the number and size of McCready Health Pavilion's emergency department treatment space is consistent with the ACEP Guide "low range" recommendations.

Finally, the Applicants note that the ACEP Guide itself is described by its author "as a starting point" for emergency department planning with "general guideline[s]" to be used for internal planning 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." *See* ACEP Guide at 106-109. Indeed, as the ACEP Guide states:

> there's no magic formula for a set number of examination rooms and square footage calculations for a certain number of patient visits. *There's no "if you see 'X' number of patients in a year, your department should be 'Y' square feet with 'Z' number of patient care spaces."* There are too many variables to consider. We can't reduce space programming to 'one size fits all'. The key is for you to understand how your unique variables will affect your space need, and the biggest impact is your turnaround time for patients using examination spaces.

ACEP Guide at 106 (emphasis added).

In short, McCready Health Pavilion has been designed to accommodate the service area population based on historic utilization trends and operations.

> **(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**.

Applicants' response: Including 540 square feet allocated to the emergency department waiting area, the emergency department at McCready Health Pavilion is a total of 5,107 square feet. Excluded from this calculation are components of McCready Health Pavilion that are not contemplated by the ACEP Guide low range within the emergency department, including administrative space, imaging, laboratory, and observation services. Also excluded are other components of McCready Health Pavilion not contemplated by the ACEP Guide for an emergency department, including the family medicine primary care clinic, physical therapy services, and outpatient behavioral health services.

The ACEP Guide low range for the minimum number of 10,000 visits estimates the size of the emergency department to be 6,000 departmental square feet. The overall size of McCready Health Pavilion's emergency department is consistent the ACEP Guide "low range" guidance.

> **(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**;

Applicants' response: As noted above, at McCready Health Pavilion the Applicants propose to maintain the same level of observation services currently provided at McCready Hospital. In fiscal year 2018, McCready Hospital had 131 observation cases. The average observation length of stay was 22.7 hours, for a total of 124 observation days. At a projected occupancy rate of 70% consistent with the State Health Chapter for Acute Hospital Services for a facility with less than 50 beds, the Applicants project a need for one observation bed at McCready Health Pavilion. *See* **Table 7** below.

Table 7
McCready Memorial Hospital Observation Utilization
Fiscal Year 2018

McCready Memorial Hospital Observation Utilization
Fiscal Year 2018

Bed Need Calc	**McCready Memorial Hospital Observation Bed Need**
FY2018 Observation Cases	131
FY2018 Observation Hours	2,978
Average Hours Per Case	22.73
Observation Days	124
Observation Average Daily Census	0.34
Occupancy Target	70%
Projected Observation Bed Need	**0.49**

Notes:
[1]Source: HSCRC Final FY2018 Abstract Data
[2]Outpatient Only
[3]Units Calculated using Charges/Actual FY2018 Rate

While the Applicants only project a need for one observation bed, the Applicants propose to maintain two observation beds at McCready Health Pavilion because McCready Health Pavilion will already have the requisite staff and resources to house patients in observation and there will be no additional costs other than minimal initial construction costs. Not having an additional observation bed could result in unnecessary transfers of patients requiring observation services to PRMC approximately 30 miles away or other appropriate facilities even further away in the event that only a single observation bed at McCready Health Pavilion was occupied. Accordingly, the Applicants have demonstrated a need for two observation beds at McCready Health Pavilion consistent with the needs of the population to be served.

(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.

Applicants' response: The Applicants propose two observations rooms, each at 120 square feet. The Applicants comply with this standard.

(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;

Applicants' response: Emergency department utilization projections from McCready Health Pavilion were consistent with observed historic trends in emergency department use by the population in the McCready Health Pavilion's projected service area but trended slightly downward. In fiscal year 2017, McCready Memorial Hospital's use rate was 220 per 1,000 in McCready's service area, consisting of zip codes 21817, 21838, 21853, and 21871. In fiscal year 2018, the projected use rate per 1,000 was 205. Both historical and projected use rates are outlined below in Table 8 below.

Table 8
ED Service Use Rate Trend, FY2017 – FY2025

	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025
Emergency Department Visits	5,006	4,830	4,709	4,709	4,709	4,709	4,709	4,709	4,709
Population Estimate	22,705	22,861	22,979	22,979	22,979	22,979	22,979	22,979	22,979
Hospital Use Rate Per 1000	220.48	211.28	204.94	204.94	204.94	204.94	204.94	204.94	204.94

(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.

Applicants' response: The utilization projections for rate-regulated outpatient services at McCready Health Pavilion are consistent with the observed historic trends by the population in the FMF's projected service area. As shown in Table 9 below, use rates for the regulated services remain relatively stable from FY2017 to FY2019, and FY2019 utilization projections were projected to carry forward into future years.

Table 9
Regulated Service Use Rate Trend, FY2017 – FY2025

Visits	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025
Imaging	1,704	1,739	1,683	1,683	1,683	1,683	1,683	1,683	1,683
Clinic	8,871	9,504	9,105	9,105	9,105	9,105	9,105	9,105	9,105
Infusion	48	145	64	64	64	64	64	64	64
Observation	192	132	96	96	96	96	96	96	96
Population Estimate	22,705	22,861	22,979	22,979	22,979	22,979	22,979	22,979	22,979
Hospital Use Rate Per 1000	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025
Imaging	75.05	76.07	73.23	73.23	73.23	73.23	73.23	73.23	73.23
Clinic	390.72	415.74	396.25	396.25	396.25	396.25	396.25	396.25	396.25
Infusion	2.11	6.34	2.79	2.79	2.79	2.79	2.79	2.79	2.79
Observation	8.46	5.77	4.18	4.18	4.18	4.18	4.18	4.18	4.18

(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;

Applicants' response: The revenue estimates for emergency services and other outpatient services at McCready Health Pavilion were based on a Global Budget Revenue (GBR) for the McCready Health Pavilion that was discussed and agreed upon between PRMC and the HSCRC. The revenue estimates were based on the schedule provided by the HSCRC, which is submitted herewith as **Exhibit 8**, adjusted for inflation.

(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

Applicants' response: McCready Health Pavilion is projected to operate with 80.6 FTEs per **Revised Exhibit 1, Table L**. This figure is based on the operation of the emergency room at 24 hours a day, seven days a week. The remaining direct care FTEs are consistent with current levels and salaries were based on current rates. The 39.6 decrease in FTEs from the current 120.2 FTEs at McCready Hospital result from the elimination of the inpatient services and outpatient surgical service areas.

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

Applicants' response: Enclosed as **Revised Exhibit 1**, Applicants have completed **Tables A**, **B**, **C**, **D**, **E**, **I, J**, and **K**, which include the projected shift of inpatient admissions from McCready Hospital to PRMC, as well as the projected utilization and financial performance of

PRMC, inclusive of the McCready Health Pavilion which becomes a department of PRMC beginning in fiscal year 2020. **Table I** includes utilization projections that reflect both the inpatient and outpatient utilization of PRMC and outpatient emergency department visits, observation cases, and related outpatient ancillary services at McCready Health Pavilion. Also enclosed with **Revised Exhibit 1**, are **Tables F**, **G**, and **H** that cover the entire utilization and financial performance of all PRMC components, including during the period from fiscal year 2017 to fiscal year 2024, and McCready and McCready Health Pavilion between fiscal years 2020 and 2024. The financial projection assumptions related to revenue, expenses and financial performance underlying **Tables G, H, J** and **K** are also submitted with **Revised Exhibit 1**. Additionally, **Revised Exhibit 1** includes a **Table L** that incorporates the workforce for McCready Hospital's emergency department in fiscal year 2017 and McCready Health Pavilion in fiscal year 2024. Included in the figures are full-time equivalent employees ("FTEs") dedicated to the provision of services to patients when they are in the emergency department. 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. The presentation of projected staffing at McCready Health Pavilion, as presented in **Table L**, reflects the 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 expense when McCready Hospital closes and McCready Health Pavilion opens in fiscal year 2020.

Two years of PRHS' consolidated financial statements are attached as **Exhibit 6**, and two years of McCready Foundation's consolidated financial statements are attached as **Exhibit 7**.

(g) Demonstrate that each operating room at the FMF will be utilized at an optimal level within three years consistent with the standards in COMAR 10.24.11 for operating room capacity and needs assessment for dedicated outpatient operating rooms and that the design is consistent with requirements in COMAR 10.24.11 for health care facilities with surgical capacity.

Applicants' response: This Standard is not applicable; no operating rooms are proposed at McCready Health Pavilion.

(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.

Applicants' response: The proposed construction cost of McCready Health Pavilion is reasonable and consistent with industry cost experience in Maryland as reflected by the Marshall Valuation Service benchmark calculation presented below.

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

I. Marshall Valuation Service
Valuation Benchmark

Type		Hospital
Construction Quality/Class		Good/A
Stories		1
Perimeter		780
Average Floor to Floor Height		12.0
Square Feet		25,172
f.1	Average floor Area	25,172
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		0.99
Adjusted Total Base Cost		$369.39
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$369.39
C. Multipliers		
Perimeter Multiplier		0.925558656
	Product	$341.89
Height Multiplier		1.000
	Product	$341.89
Multi-story Multiplier		1.000
	Product	$341.89

D. Sprinklers

	Sprinkler Amount	$3.82
Subtotal		$345.71

E. Update/Location Multipliers

Update Multiplier		1.08
	Product	$373.36
Location Multipier		0.98
	Product	$365.90

Calculated Square Foot Cost Benchmark **$365.90**

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

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
Emergency Department	5,096	Emergency Suite	1.18	6,013
Clinic	2,245	Outpatient Department	0.99	2,223
Lobby and Consolidated Waiting	2,000	Public Space	0.8	1,600
Rehabilitation Medicine	2,875	Physical Medicine	1.09	3133.75
Laboratory	1,051	Laboratories	1.15	1,209
Imaging	2,200	Radiology	1.22	2,684
Outpatient Behavioral Medicine	1,226	Outpatient Department	0.99	1,214
Administration	1,887	Offices	0.96	1,812
Support Services	2,397	Service Departments	1.2	2,876
Exterior Wall and Building Gross Factor	4,195	Unassigned Space	0.5	2,098
	25,172		0.99	24,861

Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
Building	$8,949,885	$355.54
Fixed Equipment	$0	$0.00
Site Preparation	$4,800,000	$190.69
Architectural Fees	$1,200,000	$47.67
Permits	$300,000	$11.92
Capitalized Construction Interest	Calculated Below	Calculated Below

Subtotal	$15,249,885	$605.82

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	$75,000	Site	
Storm Drains	$120,000	Site	
Rough Grading	$200,000	Site	
Wetlands Premium	$1,350,000	Site	
Forest Conservation Premium	$110,000	Site	
Deep Foundation	$500,000	Site	
Paving	$400,000	Site	
Exterior Signs	$25,000	Site	
Landscaping	$125,000	Site	
Walls	$75,000	Site	
Yard Lighting	$25,000	Site	
Covered Walkway	$100,000	Site	
Remote Area Premium	$480,000	Site	
MBE Participation Cost Premium	$192,000	Site	
Remote Area Premium	$894,989	Building	$41,623
MBE Participation Cost Premium	$357,995	Building	$16,649
Utility Connection Fees	$250,000	Permits	
Total Cost Adjustments	$5,279,984		$58,272

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

(Cost of the MBE Participation Cost Premium/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 in contained in the MVS average costs in the MVS Guide (at Section 1, Page 3) but that are specific to this project and would not be in the average cost of a hospital project.

1. Premium for Minority Business Enterprise Requirement – The Applicant projects that the project will include a premium for Minority Business Enterprises that would not be in the average cost of hospital construction. This premium was projected to be 4%.
2. This building is being constructed on a wetlands site, which necessitates costs that would not be in the average cost of hospital construction.
3. This is located in a rural county, and the Applicant has been told that there will be a premium to bring construction workers and materials to the area. MVS acknowledges that remote locations will increase construction costs by 5% to 15% in Section 99, Page 1.

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

C. Adjusted Project Cost	**Adjusted Project Costs**	**Per Square Foot**
Building	$7,696,901	$305.77
Fixed Equipment	$0	$0.00
Site Preparation	$1,023,000	$40.64
Architectural Fees	$1,200,000	$47.67
Permits	$50,000	$1.99
Subtotal	$9,969,901	$396.06
Capitalized Construction Interest	$357,954	$14.22
Total	$10,327,855	$410.28

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

Hospital	New	Renovation	Total		
Building Cost	$8,949,885	$113,346			
Subtotal Cost (w/o Cap Interest)	$15,249,885	$163,346	$15,413,231		
Subtotal/Total	98.9%	1.1%	Cap Interest	Loan Placement Fees	Total
Total Project Cap Interest &Financing [(Subtotal Cost/Total Cost) X Total Cap Interest]	$709,214	$7,597	$444,583	$272,228	$716,811
Building/Subtotal	58.7%	69.4%			

Building Cap Interest & Loan Place.	$416,225	$5,271
Associated with Extraordinary Costs	$58,272	
Applicable Cap Interest & Loan Place.	$357,954	

As noted below, the project's cost per square foot exceeds the MVS benchmark by less than 15%.

MVS Benchmark	$365.90
The Project	$410.28
Difference	$44.39
%	12.13%

(i) 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.

Applicants' response: As shown in Table 5 above, there are two urgent care centers in McCready Hospital's service area. Moreover, as reflected in **Table 4** above, emergency department visits at McCready Hospital have not declined as a result of operation of these urgent care centers, both are more than 20 miles from McCready Hospital.

The continuance of 24/7 emergency services in McCready Health Pavilion's Service Area is critical to providing the residents of Somerset County ready access to emergency care. Furthermore, the limited hours of operation of the two urgent care centers in McCready Hospital's service area does not provide an alternative for patients experiencing emergency medical conditions after-hours. To this end, approximately 33% of McCready Hospital's emergency department visits take place between the hours of 8 p.m. and 8 a.m., when none of the two urgent care centers in the service area are open. *See* Table 6 above.

A 24/7 urgent care center would not be a more efficient and cost effective option compared to McCready Health Pavilion due to the expected reimbursement based on the expected payer mix. Indeed, an urgent care center would not be viable due to the payer mix of patients in the service area. For fiscal year 2018, McCready Health Pavilion's service area was 39% Medicaid and 6.4% Charity/Self Pay which would result in substantially less reimbursement than current levels in a rate regulated setting. *See* Table 10 below. Reduced reimbursement resulting from such a payer mix could not be mitigated by reduced expenses due to the minimal staffing requirements of a 24/7 urgent care center. McCready Foundation previously operated an urgent care center in Princess Anne, however, it was not financially viable due to the payer mix and reduced reimbursement rates, and, therefore, the urgent care center was closed in June, 2019.

Table 10
McCready Health Pavilion Service Area Emergency Department Payer Mix, FY2018

Payer	ED Charges	% of Total
Medicare	$1,745,388	35.0%
Medicaid	1,950,774	39.1%
Commercial	894,939	17.9%
Charity/Self-Pay	317,669	6.4%
Other	82,540	1.7%
Total	$4,991,310	100.0%

Source: HSCRC FY2018 Abstract data

Additionally, due to the payer mix, an urgent care center could not provide certain needed services in the community that McCready currently provides and is planned to be provided in McCready Health Pavilion, including the rate-regulated primary and specialty care clinic and behavioral health clinic. Such services would not be financially viable without HSCRC regulated rates as those services are currently provided by McCready Hospital. Indeed, in fiscal year 2018, 54% of McCready Hospital's emergency department and other outpatient visits were Medicaid and self-pay patients.

Finally, local Somerset County EMS providers would be burdened by having to transport hundreds of patients annually to either PRMC or Atlantic General. In fiscal year 2018, 565 patients arrived to McCready Hospital's emergency department by ambulance.

Despite the fact that a rate-regulated freestanding medical facility is required to meet the needs of service area population previously served by McCready Hospital, PRMC will continue to actively engage in a marketing campaign entitled "Where to Go For Care," which is designed to educate patients about seeking treatment in less costly alternatives to a hospital emergency department. The marketing materials are distributed at all hospital events by physician liaisons, at PRMC's flu clinic, at health fairs, and at outpatient physician practice locations. PRMC plans television appearances to discuss the "Where to Go for Care" program and coordinates with local health departments to educate patients about less costly treatment options other than a hospital emergency department for lower acuity conditions. PRMC's "Where to Go for Care" materials are enclosed as **Exhibit 10** and available on PRMC's website at the following web address:

https://www.peninsula.org/patients-visitors/where-go-care

(j) Demonstrate that 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;

Applicants' response: As presented in Table 11 below, between fiscal years 2013 and 2018, McCready Hospital has seen an inpatient volume decline of 21% compared to a 14% decline in acute care hospital admissions across the State of Maryland.

Table 11
McCready Hospital vs Statewide Admission Trends
FY2013 – FY2018

	McCready Memorial Hospital							
Admission Category	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2013 - FY2018 Change	FY2013 - FY2018 % Change
Medical/Surgical	295	321	298	281	274	232	(63)	-21.36%
Psychiatry	-	-	-	-	-	-	-	0.00%
Obstetrics	-	-	-	-	-	-	-	0.00%
Rehabilitation	-	-	-	-	-	-	-	0.00%
Chronic Care	-	-	-	-	-	-	-	0.00%
Total Admissions	295	321	298	281	274	232	(63)	-21.36%
YOY % Change		8.81%	-7.17%	-5.70%	-2.49%	-15.33%		

	Statewide Acute Care Hospitals							
Admission Category	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2013 - FY2018 Change	FY2013 - FY2018 % Change
Medical/Surgical	672,690	610,609	609,798	609,585	607,428	573,172	(99,518)	-14.79%
Psychiatry	34,077	35,331	35,886	35,366	37,958	36,905	2,828	8.30%
Obstetrics	81,364	77,217	78,190	76,578	75,089	71,072	(10,292)	-12.65%
Rehabilitation	8,606	8,154	7,794	6,754	6,474	5,804	(2,802)	-32.56%
Chronic Care	1,847	2,117	1,832	1,966	2,236	2,090	243	13.16%
Total Admissions	798,584	733,428	733,500	730,249	729,185	689,043	(109,541)	-13.72%
YOY % Change		-8.16%	0.01%	-0.44%	-0.15%	-5.51%		
McCready vs Statewide % Change		**16.97%**	**-7.17%**	**-5.26%**	**-2.35%**	**-9.82%**	**-**	**-7.64%**

Notes:
[1]Source: FY2013 - FY2018 HSCRC Experience Reports
[2]Acute Care Hospital Only, Excluding Normal Newborn and Premature Nursery

McCready Hospital's decline in inpatient admissions has created a financial hardship for McCready Foundation as the cost of maintaining the hospital's infrastructure with declining admissions is adding to its financial losses. Continuing to operate the current hospital with reduced volumes is not viable from a licensure standpoint or in the public's best interest. Instead, converting to an outpatient focused FMF that is right sized to current utilization and that will provide an array of services to meet the service area's needs is in the public interest.

(ii) The financial performance of the hospital over the past five years and in the context of the statewide financial performance of Maryland hospitals;

Applicants' response: As presented in Table 12 below, McCready Hospital's financial performance has been declining over the past five years. In fiscal year 2014, McCready Hospital's operating margin was a positive 15.24% but has been negative in each year since. Further, McCready Hospital's financial performance in 2014 was bolstered by significant one-time "meaningful use" funding associated with adoption of electronic health records. McCready's Hospital's operating margins are significantly worse than statewide performance which ranged from 3.02% to 3.36% over the same period.

Table 12
Comparison of McCready Hospital Operating Margins to Statewide Financial Performance

FY2013 – FY2018

	Total Operating Margin						
Total Operating Margin Trend	**FY2013**	**FY2014**	**FY2015**	**FY2016**	**FY2017**	**FY2018**	**FY2013 - FY2018 Change**
McCready Memorial Hospital	3.11%	15.24%	-3.78%	-5.20%	-4.72%	-4.65%	-7.77%
Statewide Acute Care Hospitals	1.32%	3.02%	3.65%	3.27%	2.84%	3.36%	2.04%
Variance	**1.79%**	**12.22%**	**-7.43%**	**-8.48%**	**-7.56%**	**-8.01%**	**-9.80%**

Notes:
[1]FY2013 - FY2018 RE Schedules from Annual Filing
[2]Acute Care Facilities Only
[3]FY2017 Numbers Used for FY2018 December Filing Hospitals

Consistent with the decline in inpatient admissions presented above, the continued decline in operating margin at McCready is not in the public's best interest. Converting the hospital to McCready Health Pavilion which is projected to be profitable in Phase One and operate at a marginal loss in comparison to PRMC's financial operations in Phase Two is in the public interest.

(iii) The age of the physical plant relative to other Maryland hospitals and the investment required to maintain and modernize the physical plant;

Applicants' response: As presented in Table 13 below**,** the average age of McCready Hospital's physical plant was 12.9 years in fiscal year 2016 rising to 14.1 years in fiscal year 2018. This compares to the statewide average of 11.5 years. In a publication by Moody's Investor Service, dated September 8, 2016, the median average age of plant for hospitals that Moody's rates was 11.0 years. Due to removal of the H1schedule from the Statewide Hospital Disclosure Report beginning in state fiscal year 2017, the statewide average age of the physical plant is not available for fiscal years 2017 and 2018. In sum, the age of McCready Hospital's physical plant is older than the statewide average.

Table 13
Comparison of McCready Hospital Average Age of Plant to Statewide Trends
FY2014 – FY2018[4]

	FY2014	FY2015	FY2016	FY2017	FY2018
McCready Memorial Hospital	12.6	11.7	12.9	11.2	14.1
Statewide Average (Years)	12.0	12.0	11.5	N/A	N/A

Source: McCready Memorial From Audited Financial Statements; Statewide from Annual Filing H1 Schedule
[1]H1 Schedule Discontinued in FY2017

Certain construction characteristics and the facility's location, however, render renovation of McCready Hospital not cost-effective. The main hospital building was constructed in 1980. The hospital's size is much larger than needed to operate as an FMF. Its geometry is irregular, especially on the ground floor, and the location of fire stairs and elevators render the facility inefficient. To address architectural and current code deficiencies, which are grandfathered, would require that the facility be totally gutted and renovated. Renovation of the facility would need to take place in phases in order to continue to provide patient care services at the facility. The engineering infrastructure is approximately forty (40) years old and has been maintained on a tight budget. Replacing the engineering infrastructure would be complicated due to the need to keep the facility in operation during any renovation. PRMC commissioned a study which concluded that renovation costs would equal or exceed the cost of new construction. A copy of the renovation cost study prepared by CallisonRTKL is attached as **Exhibit 9**.

Moreover, as noted above, portions of the facility encroach upon the 100 foot critical area buffer of Daugherty Creek and the hospital sits only nine (9) feet above the high-tide line. While the hospital's clinical space has never flooded, support areas have flooded.

For these reasons, converting McCready Hospital to McCready Health Pavilion to be housed in a new facility in Crisfield well outside of the high-tide level and flood plain is in the public interest.

(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; and

Applicants' response: As presented in Table 14 below, McCready Hospital only accounted for 9.8% of acute inpatient discharges in its service area in fiscal year 2018. PRMC

[4] The average age of McCready Hospital's physical plant in Table 10 was calculated by dividing the hospital's accumulated depreciation by the depreciation in each fiscal year in accordance with the methodology set forth in schedule H1 of the Statewide Hospital Disclosure Report. In fact, McCready Hospital's main hospital building is approximately forty (40) years old.

already dominates the inpatient market in McCready Hospital's service area with 74.4% market share in fiscal year 2018.

Table 14
McCready Hospital Service Area Inpatient Discharge Market Share
Fiscal Year 2018

Hospital Name	FY2018 Inpatient Discharges	Market Share
Peninsula Regional Medical Center	1,500	74.37%
McCready Memorial Hospital	197	9.77%
Atlantic General Hospital	80	3.97%
Healthsouth Chesapeake Rehab Hospital	73	3.62%
Johns Hopkins Hospital	57	2.83%
University of Maryland Medical Center	34	1.69%
UM Shore Medical Center at Easton	14	0.69%
All Other Hospital	62	3.07%
Total Service Area	**2,017**	**100.00%**

Source: St. Pauls Non-Confidential Data Tapes

Additionally, as presented in Table 15 below, McCready Hospital accounted for 35.22% of emergency room visits in its service area in fiscal year 2018. In contrast, PRMC accounted for 61.32% of emergency room visits in McCready Hospital's service area in fiscal year 2018. With PRMC already providing the majority of patient care to McCready Hospital's service area population, it is in the public interest to convert McCready Hospital to McCready Health Pavilion, which will continue to provide access to emergency, observation, and other outpatient services needed by the service area population.

Table 15
McCready Hospital Service Area ED Discharge Market Share
Fiscal Year 2018

Hospital Name	FY2018	FY2018 Service Area Market Share
Peninsula Regional Medical Center	7,717	61.32%
McCready Memorial Hospital	4,432	35.22%
Atlantic General Hospital	171	1.36%
Johns Hopkins Hospital	47	0.37%
UM Shore Medical Center at Easton	31	0.25%
UM Shore Medical Center at Dorchester	22	0.17%
University of Maryland Medical Center	19	0.15%
Anne Arundel Medical Center	10	0.08%
All Other Hospitals	136	1.08%
Total Service Area ED Visits	**12,585**	**100.00%**

Notes:
[1]Source: HSCRC Final FY2014 - FY2018 Abstract Data
[2]Excludes Chronic (defined as daily service code 9) and categorical cases
[3]OP ED Defined Using HSCRC Market Shift Service Lines, IP ED Defined as Cases Having ED Units

(iv) **The adequacy and appropriateness of the hospital's transition plan**.

Applicants' response: McCready Foundation and PRMC's hospital transition plan is in the public interest.

1. Plan for Transitioning of Acute Care Services Previously Provided at McCready Hospital.

The projected timeline for transitioning of acute care services currently provided at McCready Hospital will depend on the timing of regulatory approvals. McCready and PRHS are engaged in ongoing planning in order to prepare for the first phase of the upcoming transition. Once opened, emergency services currently provided at McCready Hospital will continue to be provided at the freestanding medical facility to be known as McCready Health Pavilion. The facility's emergency treatment spaces will be staffed by board certified emergency physicians and continue to accept most EMS priority levels, except those that are critically ill or unstable. The facility will operate as an integrated department of PRMC. The freestanding medical facility will also continue to provide diagnostic testing, ancillary services, case management, and observation care.

Patients who present at the McCready Health Pavilion who need inpatient medical, surgical or critical care will, subject to the patient's individual medical needs and stated preference, be transferred to PRMC or another hospital as appropriate. All patients will be stabilized at McCready Health Pavilion by the emergency physician and clinical staff before being transferred.

2. Plan for Job Retraining and Placement of McCready Hospital Employees.

McCready Health Pavilion will be staffed according to federal and state requirements. McCready and PRHS are continuing to develop a staffing plan for operation of the freestanding medical facility. Any current McCready employees whose positions are eliminated upon conversion of McCready hospital to McCready Health Pavilion and who are otherwise qualified will be considered for open positions within PRHS, even if the available position is not identical to the position that was eliminated so long as the displaced employee could qualify for the available position with a reasonably limited amount of occupational training. PRHS has further committed to affording priority to McCready employees whose positions may be eliminated when considering placements in open positions within PRHS.

With due consideration of clinical, financial, and operational needs, PRHS's hiring of displaced McCready employees will be based on time of service with McCready and each employee's performance evaluations. Any displaced employees who are rehired by PRHS will be reinstated with their original date of hire and will be immediately eligible for benefits if rehired within twelve months of the effective date of their separation. Finally, severance pay will be offered to displaced McCready employees in varying amounts based on length of service. Part-time employees will be offered severance based on length of service on a pro-rated basis.

3. Plan for Existing McCready Hospital's Physical Plant

Once McCready Health Pavilion relocates in Phase Two to the newly constructed building described above, it is anticipated that McCready Hospital, which has outlived its useful life, will be torn down.

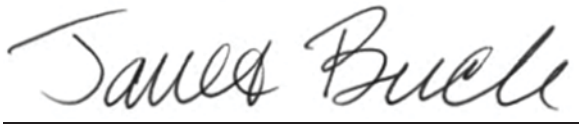
(k) Demonstrate that the conversion is in the public interest, based on an assessment of the parent hospital's projected financial performance or the projected financial performance of the parent hospital and other health care facilities that share a global budget with the parent hospital.

Applicants' response: As set forth in **Revised Exhibit 1**, **Tables G** and **H,** conversion of McCready Hospital to a freestanding medical facility is in the public interest based on the financial performance of McCready Health Pavilion and PRMC. In Phase One of McCready Health Pavilion's operations, it is projected to generate net income of $856,456 in FY 2020 and $399,468 in FY2021. *See* **Revised Exhibit 1, Table K.** While McCready Health Pavilion will generate net operating income loses in FY 2022-2024 associated with debt service on the bond placement, PRMC projects to generate net operating income within three years. *See* **Revised Exhibit 1, Table G.** And, without a freestanding medical facility, the residents of McCready Hospital's service area would lack access to emergency health care services and the other rate-regulated services to be offered by McCready Health Pavilion, including imaging and laboratory services, family medicine, behavioral health, speech and physical therapy, infusion, and laboratory blood draw services.

CONCLUSION

For all of the reasons set forth above, McCready Foundation, Inc. and PRMC respectfully request that the Commission authorize the conversion of McCready Hospital to a freestanding medical facility and associated capital expenditures.

Respectfully submitted,



James C. Buck
Gallagher, Evelius & Jones LLP
218 N. Charles Street, Suite 400
Baltimore, Maryland 21201

Counsel for Peninsula Regional Medical Center, Inc.

Table of Exhibits

Exhibit	Description
1 (Revised)	CON Tables and Assumptions
2 (Revised)	McCready Health Pavilion Project Drawings
3	PRMC Policy Regarding Charges
4 (Revised)	PRMC Charity Care Policy
5	Somerset County Community Health Needs Assessment
6	PRHS Consolidated Financial Statements Fiscal Years 2017-2018
7	McCready Foundation Consolidated Financial Statements Fiscal Years 2017-2018
8	HSCRC Revenue Estimates
9	CallisonRTKL McCready Hospital Renovation Concept Study
10	PRMC "Where to Go for Care" Marketing Materials
11	July 30, 2019 Letter Providing Notice of Intent to Convert to a Freestanding Medical Facility and Enclosing Request for Exemption from CON Review
12	September 4, 2019 Letter Transmitting Summary of the August 20, 2019 Public Informational Hearing
13	The Daily Times and County News Notices Regarding Public Informational Hearing
14	McCready Hospital License; Joint Commission Accreditation; Medicare 855a Enrollment Verification from Novitas; Medicaid Participation Verification
15	PRMC Hospital License; Joint Commission Accreditation; Medicare 855a Enrollment Verification from Novitas; Medicaid Participation Verification
16	Screen Shot of McCready Foundation Website

Table of Tables

I hereby declare and affirm under the penalties of perjury that the facts stated in the Modified Request for Exemption from CON Review to Convert McCready Hospital to a Freestanding Medical Facility and its exhibits are true and correct to the best of my knowledge, information, and belief.

10/23/19
Date

Steve Leonard
President/Chief Executive Officer
Peninsula Regional Health System, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in the Modified Request for Exemption from CON Review to Convert McCready Hospital to a Freestanding Medical Facility and its exhibits are true and correct to the best of my knowledge, information, and belief.

Oct. 23, 2019
Date

Kathleen Harrison
Chief Executive Officer
McCready Foundation, Inc.

#670722
012888-0002

I hereby declare and affirm under the penalties of perjury that the facts stated in the Modified Request for Exemption from CON Review to Convert McCready Hospital to a Freestanding Medical Facility and its exhibits are true and correct to the best of my knowledge, information, and belief.

10/24/19
Date

Bruce Ritchie
Vice President, Finance/Chief Financial Officer
Peninsula Regional Health System, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in the Modified Request for Exemption from CON Review to Convert McCready Hospital to a Freestanding Medical Facility and its exhibits are true and correct to the best of my knowledge, information, and belief.

October 23, 2019
Date

Camesha L Spence
Camesha Spence
Chief Financial Officer
McCready Foundation, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in the Modified Request for Exemption from CON Review to Convert McCready Hospital to a Freestanding Medical Facility and its exhibits are true and correct to the best of my knowledge, information, and belief.

10/23/2019
Date

Jonathan D. Mitchell
Jon Mitchell
Director of Budget, Cost, and Reimbursement
Peninsula Regional Health System, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in the Modified Request for Exemption from CON Review to Convert McCready Hospital to a Freestanding Medical Facility and its exhibits are true and correct to the best of my knowledge, information, and belief.

10/24/17
Date

Jim Gregory
Director of Accounting
Peninsula Regional Health System, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in the Modified Request for Exemption from CON Review to Convert McCready Hospital to a Freestanding Medical Facility and its exhibits are true and correct to the best of my knowledge, information, and belief.

10.23.2019
Date

Tom Anderson
Executive Director for Facilities &
Property Management
Peninsula Regional Medical Center, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in the Modified Request for Exemption from CON Review to Convert McCready Hospital to a Freestanding Medical Facility and its exhibits are true and correct to the best of my knowledge, information, and belief.

10/24/19
Date

Scott Phillips
Executive Director of Supply Chain and Support Systems
Peninsula Regional Medical Center, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in the Modified Request for Exemption from CON Review to Convert McCready Hospital to a Freestanding Medical Facility and its exhibits are true and correct to the best of my knowledge, information, and belief.

10/23/19

Date

Christopher Hall
Vice President, Strategy and Business Development/Chief Business Officer
Peninsula Regional Health System, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in the Modified Request for Exemption from CON Review to Convert McCready Hospital to a Freestanding Medical Facility and its exhibits are true and correct to the best of my knowledge, information, and belief.

10-23-2019

Melvin (Chip) R. Hurley Jr.

Date

Melvin (Chip) R. Hurley, Jr., CPA
FHFMA, CGMA
Managing Director
Berkeley Research Group

#670713
012888-0002

I hereby declare and affirm under the penalties of perjury that the facts stated in the Modified Request for Exemption from CON Review to Convert McCready Hospital to a Freestanding Medical Facility and its exhibits are true and correct to the best of my knowledge, information, and belief.

10/23/19
Date

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

#670712
012888-0002

REVISED

EXHIBIT 1

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

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

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

Before the Project							After Project Completion					
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/201_	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
ACUTE CARE							**ACUTE CARE**					
General Medical/ Surgical*	2nd Floor	3	6	8	14	22	**General Medical/ Surgical***				0	0
					0	0					0	0
					0	0					0	0
					0	0					0	0
					0	0					0	0
SUBTOTAL Gen. Med/Surg*		**3**	**6**	**8**	**14**	**22**	**SUBTOTAL Gen. Med/Surg***					
ICU/CCU		**0**	0	0	0	0	**ICU/CCU**				0	0
Other *(Specify/add rows as needed)*		**0**	0	0	0	0					0	0
TOTAL MSGA		**3**	**6**	**8**	**14**	**22**	**TOTAL MSGA**					
Obstetrics		**0**	**0**	**0**	0	0	**Obstetrics**				0	0
Pediatrics		**0**	**0**	**0**	0	0	**Pediatrics**				0	0
Psychiatric		**0**	**0**	**0**	0	0	**Psychiatric**				0	0
TOTAL ACUTE		**3**	**6**	**8**	**14**	**22**	**TOTAL ACUTE**		**0**	**0**	**0**	**0**
NON-ACUTE CARE							**NON-ACUTE CARE**					
Dedicated Observation**		**0**	**0**	**0**	0	0	**Dedicated Observation****			**2**	1	2
Rehabilitation		**0**	**0**	**0**	0	0	**Rehabilitation**				0	0
Comprehensive Care		**0**	**0**	**0**	0	0	**Comprehensive Care**				0	0
Other *(Specify/add rows as needed)*		**0**	**0**	**0**	0	0	**Other** *(Specify/add rows as needed)*				0	0
TOTAL NON-ACUTE		**0**	**0**	**0**	**0**	**0**	**TOTAL NON-ACUTE**					
HOSPITAL TOTAL		**3**	**6**	**8**	**14**	**22**	**HOSPITAL TOTAL**		**0**	**0**	**0**	**2**

* 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		5,096			5,096
Clinic		2,245			2,245
Lobby and Consolidated Waiting		2,000			2,000
Rehabilitation Medicine		2,875			2,875
Laboratory		1,051			1,051
Imaging		2,200			2,200
Outpatient Behavioral Medicine		1,226			1,226
Administration		1,887			1,887
Support Services		2,397			2,397
Exterior Wall and Building Gross Factor		4,195			4,195
					0
					0
					0
					0
					0
					0
Total		25,172			25,172

TABLE C. CONSTRUCTION CHARACTERISTICS

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

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

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		
First Floor	25,172	
Second Floor		
Third Floor		
Fourth Floor		
Average Square Feet		
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor	780	
Second Floor		
Third Floor		
Fourth Floor		
Total Linear Feet		
Average Linear Feet		
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor	12	
Second Floor		
Third Floor		
Fourth Floor		
Average Wall Height		
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		
Freight		
Sprinklers	**Square Feet Covered**	
Wet System	25,172	
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project		
Type of Exterior Walls for proposed project		

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	$327,000	
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs		
Site Demolition Costs	**$75,000**	
Storm Drains	**$120,000**	
Rough Grading	**$200,000**	
Wetlands Premium	**$1,700,000**	
Deep Foundation	**$500,000**	
Paving	**$400,000**	
Exterior Signs	**$25,000**	
Landscaping	**$125,000**	
Walls	**$75,000**	
Yard Lighting	**$25,000**	
Covered Walkway	**$100,000**	
Remote Area Premium	**$520,000**	
MBE Participation Cost Premium	$208,000	
Subtotal On-Site excluded from Marshall Valuation Costs	**$4,073,000**	
OFFSITE COSTS		
Roads		
Extending Utilities to Site Line	$800,000	
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs	**$800,000**	
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$4,873,000**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$5,200,000**	**$0**
BUILDING COSTS		
Normal Building Costs	$7,696,901	
Subtotal included in Marshall Valuation Costs		
Remote Area Premium	$894,989	
MBE Participation Cost Premium	$357,995	
Subtotal Building Costs excluded from Marshall Valuation Costs	**$1,252,984**	
TOTAL Building Costs included and excluded from Marshall Valuation Service*	**$8,949,885**	**$0**
A&E COSTS		
Normal A&E Costs	$1,200,000	
Subtotal included in Marshall Valuation Costs	**$1,200,000**	
Subtotal A&E Costs excluded from Marshall Valuation Costs	**$0**	
TOTAL A&E Costs included and excluded from Marshall Valuation Service*	**$1,200,000**	**$0**
PERMIT COSTS		
Normal Permit Costs	$50,000	
Subtotal included in Marshall Valuation Costs	**$50,000**	
Jurisdictional Hook-up Fees	$250,000	
Subtotal Permit Costs excluded from Marshall Valuation Costs	**$250,000**	
TOTAL Permit Costs included and excluded from Marshall Valuation Service*	**$300,000**	**$0**

*The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

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		$8,949,885	$8,949,885
(2) Fixed Equipment		$0	$0
(3) Site and Infrastructure		$4,800,000	$4,800,000
(4) Architect/Engineering Fees		$1,200,000	$1,200,000
(5) Permits (Building, Utilities, Etc.)		$300,000	$300,000
SUBTOTAL	**$0**	**$15,249,885**	**$15,249,885**
b. Renovations			
(1) Building	$113,346		$113,346
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees	$5,000		$5,000
(4) Permits (Building, Utilities, Etc.)	$15,000		$15,000
SUBTOTAL	**$133,346**	**$0**	**$133,346**
c. Other Capital Costs			
(1) Movable Equipment		$5,950,000	$5,950,000
(2) Contingency Allowance		$2,260,000	$2,260,000
(3) Gross interest during construction period		$444,583	$444,583
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$0***	***$8,654,583***	**$8,654,583**
TOTAL CURRENT CAPITAL COSTS	**$133,346**	**$23,904,468**	**$24,037,814**
d. *Land Purchase*		**$250,000**	$250,000
e. Inflation Allowance	$5,432	$973,820	$979,252
TOTAL CAPITAL COSTS	**$138,778**	**$25,128,288**	**$25,267,066**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees		**$272,228**	$272,228
b. Bond Discount			$0
c CON Application Assistance			$0
c1. Legal Fees		**$40,000**	$40,000
c2. Other (Specify/add rows if needed)		**$10,000**	$10,000
d. Non-CON Consulting Fees			$0
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund			$0
f Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$0***	***$322,228***	**$322,228**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$138,778***	***$25,450,516***	***$25,589,294***
B. Sources of Funds			
1. Cash		**$936,811**	$936,811
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds		**$24,652,483**	$24,652,483
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$0***	***$25,589,294***	***$25,589,294***
	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 - McCready Hospital

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. DISCHARGES										
a. General Medical/Surgical*	280	228	185	93						
b. ICU/CCU	0	0	0	0	0	0	0	0	0	
Total MSGA	**280**	**228**	**185**	**93**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0	0	0	0	0	0	0	
d. Obstetric	0	0	0	0	0	0	0	0	0	
e. Acute Psychiatric	0	0	0	0	0	0	0	0	0	
Total Acute	***280***	***228***	***185***	***93***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	0	0	0	0	0	0	0	0	0	
g. Comprehensive Care	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	
TOTAL DISCHARGES	***280***	***228***	***185***	***93***	***0***	***0***	***0***	***0***	***0***	***0***
2. PATIENT DAYS										
a. General Medical/Surgical*	864	759	613	307						
b. ICU/CCU	0	0	0	0	0	0	0	0	0	
Total MSGA	**864**	**759**	**613**	**307**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0	0	0	0	0	0	0	
d. Obstetric	0	0	0	0	0	0	0	0	0	
e. Acute Psychiatric	0	0	0	0	0	0	0	0	0	
Total Acute	***864***	***759***	***613***	***307***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	0	0	0	0	0	0	0	0	0	
g. Comprehensive Care	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	
TOTAL PATIENT DAYS	***864***	***759***	***613***	***307***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - McCready Hospital

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	3.1	3.3	3.3	3.3	0.0	0.0	0.0	0.0	0.0	0.0
b. ICU/CCU	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total MSGA	3.1	3.3	3.3	3.3	0.0	0.0	0.0	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	0.0
d. Obstetric	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
e. Acute Psychiatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Acute	3.1	3.3	3.3	3.3	0.0	0.0	0.0	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	0.0
g. Comprehensive Care	0.0	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	0.0
TOTAL AVERAGE LENGTH OF STAY	3.1	3.3	3.3	3.3	0.0	0.0	0.0	0.0	0.0	0.0
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*	3	3	3	3						
b. ICU/CCU	0	0	0	0						
Total MSGA	**3**	**3**	**3**	**3**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0	0						
d. Obstetric	0	0	0	0						
e. Acute Psychiatric	0	0	0	0						
Total Acute	***3***	***3***	***3***	***3***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	0	0	0	0						
g. Comprehensive Care	0	0	0	0						
h. Other (Specify/add rows of needed)	0	0	0	0						
TOTAL LICENSED BEDS	***3***	***3***	***3***	***3***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - McCready Hospital

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	78.9%	69.3%	56.0%	28.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
b. ICU/CCU	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total MSGA	**78.9%**	**69.3%**	**56.0%**	**28.0%**	**0.0%**	**0.0%**	**0.0%**	**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%	0.0%
d. Obstetric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
e. Acute Psychiatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Acute	**78.9%**	**69.3%**	**56.0%**	**28.0%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
f. Rehabilitation	0.0%	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%	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%	0.0%
TOTAL OCCUPANCY %	**78.9%**	**69.3%**	**56.0%**	**28.0%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS										
a. Emergency Department	5,006	4,830	4,709	4,709	4,709	4,709	4,709	4,709	4,709	
b. Same-day Surgery	380	370	204	102	0	0	0	0		
c. Laboratory	3,010	2,899	2,680	2,680	2,680	2,680	2,680	2,680	2,680	
d. Imaging	1,704	1,739	1,683	1,683	1,683	1,683	1,683	1,683	1,683	
e. Clinic	8,871	9,504	9,105	9,105	9,105	9,105	9,105	9,105	9,105	
f. Infusion	48	145	64	64	64	64	64	64	64	
g. Other (Specify/add rows of needed)	1,998	1,831	1,261	1,261	1,261	1,261	1,261	1,261	1,261	
TOTAL OUTPATIENT VISITS	***21,017***	***21,318***	***19,706***	***19,604***	***19,502***	***19,502***	***19,502***	***19,502***	***19,502***	***0***
7. OBSERVATIONS**										
a. Number of Patients	192	132	192	192	192	192	192	192	192	
b. Hours	4,820	3,242	4,820	4,820	4,820	4,820	4,820	4,820	4,820	

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

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - McCready Hospital

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	

** 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 - McCready Hospital and McCready Health Pavilion

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. REVENUE										
a. Inpatient Services	$ 3,269,905	$ 2,634,026	$ 2,038,511	$ 1,019,255	$ -	$ -	$ -	$ -		
b. Outpatient Services	$ 16,124,248	$ 17,543,063	$ 17,003,176	$ 16,121,894	$ 15,240,610	$ 14,460,646	$ 13,315,922	$ 12,951,162	$ 12,951,162	
Gross Patient Service Revenues	***$ 19,394,153***	***$ 20,177,089***	***$ 19,041,687***	***$ 17,141,149***	***$ 15,240,610***	***$ 14,460,646***	***$ 13,315,922***	***$ 12,951,162***	***$ 12,951,162***	***$ -***
c. Allowance For Bad Debt	$ 645,702	$ 1,152,504	$ 1,045,390	$ 1,010,386	$ 975,382	$ 925,465	$ 852,204	$ 828,860	$ 828,860	
d. Contractual Allowance	$ 3,511,546	$ 2,686,815	$ 2,986,246	$ 2,432,726	$ 1,859,727	$ 1,764,553	$ 1,624,868	$ 1,580,359	$ 1,580,359	
e. Charity Care	$ 307,205	$ 326,004	$ 400,311	$ 342,822	$ 304,812	$ 289,213	$ 266,318	$ 259,023	$ 259,023	
Net Patient Services Revenue	***$ 14,929,700***	***$ 16,011,766***	***$ 14,609,740***	***$ 13,355,215***	***$ 12,100,689***	***$ 11,481,415***	***$ 10,572,532***	***$ 10,282,920***	***$ 10,282,920***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 218,129	$ 178,893	$ 1,719,421	$ 1,012,701	$ 305,981	$ 305,981	$ 305,981	$ 305,981	$ 305,981	
NET OPERATING REVENUE	***$ 15,147,829***	***$ 16,190,659***	***$ 16,329,161***	***$ 14,367,916***	***$ 12,406,670***	***$ 11,787,396***	***$ 10,878,513***	***$ 10,588,901***	***$ 10,588,901***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 8,790,090	$ 9,016,570	$ 8,460,104	$ 6,777,738	$ 5,095,370	$ 5,095,370	$ 5,095,370	$ 5,095,370	$ 5,095,370	
b. Contractual Services	$ 3,253,674	$ 3,756,403	$ 3,858,249	$ 3,213,362	$ 2,568,476	$ 2,568,476	$ 2,568,476	$ 2,568,476	$ 2,568,476	
c. Interest on Current Debt	**$ 93,383**	**$ 87,694**	**$ 30,743**	**$ 15,638**	**$ 9,446**	**$ 5,646**	**$ 2,026**	**$ -**		
d. Interest on Project Debt					$ 1,232,624	$ 1,195,361	$ 1,156,235	$ 1,115,152	$ 1,072,015	
e. Current Depreciation	$ 992,657	$ 816,990	$ 680,341	$ 680,341	$ 680,341	$ 680,341	$ 226,780	$ 61,654	$ 61,654	
f. Project Depreciation				$ 18,184	$ 72,734	$ 72,734	$ 1,551,016	$ 2,268,238	$ 2,275,381	
g. Current Amortization										
h. Project Amortization										
i. Supplies	$ 1,484,990	$ 1,714,438	$ 1,760,921	$ 1,466,592	$ 1,172,264	$ 1,172,264	$ 1,172,264	$ 1,172,264	$ 1,172,264	
j. Other Expenses (Specify/add rows if needed)	$ 1,354,101	$ 1,563,326	$ 1,605,711	$ 1,337,325	$ 1,068,939	$ 1,068,939	$ 1,068,939	$ 1,068,939	$ 1,068,939	
TOTAL OPERATING EXPENSES	***$ 15,968,895***	***$ 16,955,421***	***$ 16,396,069***	***$ 13,509,180***	***$ 11,900,194***	***$ 11,859,131***	***$ 12,841,106***	***$ 13,350,093***	***$ 13,314,099***	***$ -***
3. INCOME										
a. Income From Operation	**$ (821,066)**	**$ (764,762)**	**$ (66,908)**	**$ 858,736**	**$ 506,476**	**$ (71,735)**	**$ (1,962,593)**	**$ (2,761,192)**	**$ (2,725,198)**	**$ -**
b. Non-Operating Income	$ 139,638	$ 75,185	$ 123,307	$ 104,654	$ 86,000	$ 86,000	$ 86,000	$ 86,000	$ 86,000	
SUBTOTAL	***$ (681,428)***	***$ (689,577)***	***$ 56,399***	***$ 963,390***	***$ 592,476***	***$ 14,265***	***$ (1,876,593)***	***$ (2,675,192)***	***$ (2,639,198)***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ (681,428)***	***$ (689,577)***	***$ 56,399***	***$ 963,390***	***$ 592,476***	***$ 14,265***	***$ (1,876,593)***	***$ (2,675,192)***	***$ (2,639,198)***	***$ -***

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - McCready Hospital and McCready Health Pavilion

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	47.1%	46.2%	48.3%	45.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	27.0%	27.0%	25.4%	27.1%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	9.2%	9.2%	9.0%	9.7%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	12.3%	13.0%	12.0%	12.5%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	2.8%	3.2%	4.3%	4.2%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	1.6%	1.3%	1.0%	1.1%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare	47.1%	46.2%	48.3%	45.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	27.0%	27.0%	25.4%	27.1%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	9.2%	9.2%	9.0%	9.7%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	12.3%	13.0%	12.0%	12.5%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	2.8%	3.2%	4.3%	4.2%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	1.6%	1.3%	1.0%	1.1%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***

Peninsula Regional Medical Center	
McCready Table Assumptions	
Table G	
Projection period reflects FY 2017 – FY 2025	
In the transition Year – FY 2020 – McCready will operate as a hospital from 7/01/2019 to 12/31/2019 and then as an FMF in place from 1/1/2020 to 10/31/2022; From 11/01/2022 the FMF will occupy the new building.	
Volumes	• See Table F for the volume projections
Patient Revenue • Gross Charges • Update Factor • Demographic Adjustment • Redistribution of McCready Revenue • Revenue Deductions	 • 0.0% annual increase in FY 2020-FY2025 • 0.0% per year • $2.5 million of McCready's inpatient GBR will shift to PRMC; $3.4 million of unregulated revenue also shifts to PRMC • Approximately 20% of gross revenue per year
Other Operating Revenues	• McCready will receive approximately $1.4million and $700k in FY 2019 and 2020 as a result of $1.6million placed in PRMC rate order • FY 2021-2025 resume to current levels and remains constant – about $305k
Expenses • Inflation • Interest Expense • Existing Debt • Project Debt • Depreciation • Existing • Project	 • 0.0% annual increase • McCready has little existing debt and related interest expense • Presumed borrowing of $24.9 million on 7/01/2020 at average interest rate of 5% • Existing depreciation until FY 2023 when new FMF building is completed; FY 2024 and 2025 depreciation amounts are related to legacy movable equipment that will transfer to the new building • FY 2020-2022 amounts are related to renovations needed for FMF in place; FY 2023 to 2025 primarily reflects new building depreciation over 20 years

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - McCready Hospital and McCready Health Pavilion

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. REVENUE										
a. Inpatient Services	$ 3,269,905	$ 2,634,026	$ 2,038,511	$ 1,019,255						
b. Outpatient Services	$ 16,124,248	$ 17,543,063	$ 17,003,176	$ 16,121,894	$ 15,431,118	$ 14,631,655	$ 13,477,812	$ 13,113,052	$ 13,440,878	
Gross Patient Service Revenues	***$ 19,394,153***	***$ 20,177,089***	***$ 19,041,687***	***$ 17,141,149***	***$ 15,431,118***	***$ 14,631,655***	***$ 13,477,812***	***$ 13,113,052***	***$ 13,440,878***	***$ -***
c. Allowance For Bad Debt	$ 645,702	$ 1,152,504	$ 1,045,390	$ 1,010,386	$ 987,574	$ 936,410	$ 862,565	$ 839,221	$ 860,201	
d. Contractual Allowance	$ 3,511,546	$ 2,686,815	$ 2,986,246	$ 2,432,726	$ 1,882,974	$ 1,785,420	$ 1,644,623	$ 1,600,113	$ 1,640,116	
e. Charity Care	$ 307,205	$ 326,004	$ 400,311	$ 342,822	$ 308,622	$ 292,633	$ 269,556	$ 262,261	$ 268,818	
Net Patient Services Revenue	***$ 14,929,700***	***$ 16,011,766***	***$ 14,609,740***	***$ 13,355,215***	***$ 12,251,948***	***$ 11,617,192***	***$ 10,701,068***	***$ 10,411,457***	***$ 10,671,743***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 218,129	$ 178,893	$ 1,719,421	$ 1,012,701	$ 305,981	$ 305,981	$ 305,981	$ 305,981	$ 305,981	
NET OPERATING REVENUE	***$ 15,147,829***	***$ 16,190,659***	***$ 16,329,161***	***$ 14,367,916***	***$ 12,557,929***	***$ 11,923,173***	***$ 11,007,049***	***$ 10,717,438***	***$ 10,977,724***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 8,790,090	$ 9,016,570	$ 8,460,104	$ 6,862,338	$ 5,197,277	$ 5,301,223	$ 5,407,247	$ 5,515,392	$ 5,625,700	
b. Contractual Services	$ 3,253,674	$ 3,756,403	$ 3,858,249	$ 3,261,591	$ 2,632,688	$ 2,698,506	$ 2,765,968	$ 2,835,117	$ 2,905,995	
c. Interest on Current Debt	**$ 93,383**	**$ 87,694**	**$ 30,743**	**$ 15,638**	**$ 9,446**	**$ 5,646**	**$ 2,026**	**$ -**		
d. Interest on Project Debt					$ 1,232,624	$ 1,195,361	$ 1,156,235	$ 1,115,152	$ 1,072,015	
e. Current Depreciation	$ 992,657	$ 816,990	$ 680,341	$ 680,341	$ 680,341	$ 680,341	$ 226,780	$ 61,654	$ 61,654	
f. Project Depreciation				$ 18,184	$ 72,734	$ 72,734	$ 1,551,016	$ 2,268,238	$ 2,275,381	
g. Current Amortization										
h. Project Amortization										
i. Supplies	$ 1,484,990	$ 1,714,438	$ 1,760,921	$ 1,488,604	$ 1,201,570	$ 1,231,610	$ 1,262,400	$ 1,293,960	$ 1,326,309	
j. Other Expenses (Specify/add rows if needed)	$ 1,354,101	$ 1,563,326	$ 1,605,711	$ 1,357,396	$ 1,095,662	$ 1,123,054	$ 1,151,130	$ 1,179,908	$ 1,209,406	
TOTAL OPERATING EXPENSES	***$ 15,968,895***	***$ 16,955,421***	***$ 16,396,069***	***$ 13,684,092***	***$ 12,122,342***	***$ 12,308,475***	***$ 13,522,802***	***$ 14,269,421***	***$ 14,476,460***	***$ -***
3. INCOME										
a. Income From Operation	**$ (821,066)**	**$ (764,762)**	**$ (66,908)**	**$ 683,824**	**$ 435,587**	**$ (385,302)**	**$ (2,515,753)**	**$ (3,551,983)**	**$ (3,498,736)**	**$ -**
b. Non-Operating Income	$ 139,638	$ 75,185	$ 123,307	$ 104,654	$ 86,000	$ 86,000	$ 86,000	$ 86,000	$ 86,000	
SUBTOTAL	***$ (681,428)***	***$ (689,577)***	***$ 56,399***	***$ 788,478***	***$ 521,587***	***$ (299,302)***	***$ (2,429,753)***	***$ (3,465,983)***	***$ (3,412,736)***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ (681,428)***	***$ (689,577)***	***$ 56,399***	***$ 788,478***	***$ 521,587***	***$ (299,302)***	***$ (2,429,753)***	***$ (3,465,983)***	***$ (3,412,736)***	***$ -***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	45.3%	44.1%	44.9%	45.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	25.9%	26.8%	26.2%	27.1%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	9.0%	9.0%	8.3%	9.7%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	12.9%	13.2%	12.6%	12.5%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	6.6%	6.5%	7.7%	4.2%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	0.5%	0.4%	0.3%	1.1%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - McCready Hospital and McCready Health Pavilion

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	45.3%	44.1%	44.9%	45.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	25.9%	26.8%	26.2%	27.1%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	9.0%	9.0%	8.3%	9.7%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	12.9%	13.2%	12.6%	12.5%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	6.6%	6.5%	7.7%	4.2%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	0.5%	0.4%	0.3%	1.1%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***

Peninsula Regional Medical Center	
McCready Table Assumptions	
Table H	
Projection period reflects FY 2017 – FY 2025	
In the transition Year – FY 2020 – McCready will operate as a hospital from 7/01/2019 to 12/31/2019 and then as an FMF in place from 1/1/2020 to 10/31/2022; From 11/01/2022 the FMF will occupy the new building.	
Volumes	• See Table F for the volume projections
Patient Revenue • Gross Charges • Update Factor • Demographic Adjustment • Redistribution of McCready Revenue • Revenue Deductions	 • 2.5% annual increase in FY 2021-FY2025 • 0.0% per year • $2.5 million of McCready's inpatient GBR will shift to PRMC; $3.4 million of unregulated revenue also shifts to PRMC • Approximately 20% of gross revenue per year
Other Operating Revenues	• McCready will receive approximately $1.4million and $700k in FY 2019 and 2020 as a result of $1.6million placed in PRMC rate order • FY 2021-2025 resume to current levels and remains constant – about $305k
Expenses • Inflation • Salaries • Contractual Services • Supplies • Other Exp • Interest Expense • Existing Debt • Project Debt • Depreciation • Existing • Project	 • 2.0% • 2.5% • 2.5% • 2.5% • McCready has little existing debt and related interest expense • Presumed borrowing of $24.9 million on 7/01/2020 at average interest rate of 5% • Existing depreciation until FY 2023 when new FMF building is completed; FY 2024 and 2025 depreciation amounts are related to legacy movable equipment that will transfer to the new building • FY 2020-2022 amounts are related to renovations needed for FMF in place; FY 2023 to 2025 primarily reflects new building depreciation over 20 years

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE - McCready Health Pavilion

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. DISCHARGES							
a. General Medical/Surgical*	0	0	0	0	0		
b. ICU/CCU	0	0	0	0	0		
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0	0	0		
d. Obstetric	0	0	0	0	0		
e. Acute Psychiatric	0	0	0	0	0		
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	0	0	0	0	0		
g. Comprehensive Care	0	0	0	0	0		
h. Other (Specify/add rows of needed)	0	0	0	0	0		
TOTAL DISCHARGES	***0***	***0***	***0***	***0***	***0***	***0***	***0***
2. PATIENT DAYS							
a. General Medical/Surgical*	0	0	0	0	0		
b. ICU/CCU	0	0	0	0	0		
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0	0	0		
d. Obstetric	0	0	0	0	0		
e. Acute Psychiatric	0	0	0	0	0		
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	0	0	0	0	0		
g. Comprehensive Care	0	0	0	0	0		
h. Other (Specify/add rows of needed)	0	0	0	0	0		
TOTAL PATIENT DAYS	***0***	***0***	***0***	***0***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY							
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE - McCready Health Pavilion

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*	0	0	0	0	0		
b. ICU/CCU	0	0	0	0	0		
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0	0	0		
d. Obstetric	0	0	0	0	0		
e. Acute Psychiatric	0	0	0	0	0		
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	0	0	0	0	0		
g. Comprehensive Care	0	0	0	0	0		
h. Other (Specify/add rows of needed)	0	0	0	0	0		
TOTAL LICENSED BEDS	***0***	***0***	***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*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS							
a. Emergency Department	2,355	4,709	4,709	4,709	4,709	4709	
b. Same-day Surgery	-	-	-	-	-	0	
c. Laboratory	1,340	2,680	2,680	2,680	2,680	2680	
d. Imaging	842	1,683	1,683	1,683	1,683	1683	
e. Clinic	4,553	9,105	9,105	9,105	9,105	9105	
f. Infusion	32	64	64	64	64	64	
g. Other (Specify/add rows of needed)	631	1,261	1,261	1,261	1,261	1261	
TOTAL OUTPATIENT VISITS	***9,751***	***19,502***	***19,502***	***19,502***	***19,502***	***19,502***	***0***
7. OBSERVATIONS**							
a. Number of Patients	96	192	192	192	192	192	
b. Hours	2410	4820	4820	4820	4820	4820	

*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 - McCready Health Pavilion

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 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. REVENUE							
a. Inpatient Services	$ -						
b. Outpatient Services	$ 7,620,305	$ 15,240,610	$ 14,460,646	$ 13,315,922	$ 12,951,162	$ 12,951,162	
Gross Patient Service Revenues	***$ 7,620,305***	***$ 15,240,610***	***$ 14,460,646***	***$ 13,315,922***	***$ 12,951,162***	***$ 12,951,162***	***$ -***
c. Allowance For Bad Debt	$ 487,691	$ 975,382	$ 925,465	$ 852,204	$ 828,860	$ 828,860	
d. Contractual Allowance	$ 929,864	$ 1,859,727	$ 1,764,553	$ 1,624,868	$ 1,580,359	$ 1,580,359	
e. Charity Care	$ 152,406	$ 304,812	$ 289,213	$ 266,318	$ 259,023	$ 259,023	
Net Patient Services Revenue	***$ 6,050,344***	***$ 12,100,689***	***$ 11,481,415***	***$ 10,572,532***	***$ 10,282,920***	***$ 10,282,920***	***$ -***
f. Other Operating Revenues (Specify)	$ 152,991	$ 305,981	$ 305,981	$ 305,981	$ 305,981	$ 305,981	
NET OPERATING REVENUE	***$ 6,203,335***	***$ 12,406,670***	***$ 11,787,396***	***$ 10,878,513***	***$ 10,588,901***	***$ 10,588,901***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 2,547,686	$ 5,095,370	$ 5,095,370	$ 5,095,370	$ 5,095,370	$ 5,095,370	
b. Contractual Services	$ 1,284,238	$ 2,568,476	$ 2,568,476	$ 2,568,476	$ 2,568,476	$ 2,568,476	
c. Interest on Current Debt	**$ 7,819**	**$ 9,446**	**$ 5,646**	**$ 2,026**	**$ -**	**$ -**	
d. Interest on Project Debt		$ 1,248,750	$ 1,217,939	$ 1,176,039	$ 1,133,820	$ 1,091,616	
e. Current Depreciation	$ 340,171	$ 680,341	$ 680,341	$ 226,780	$ 61,654	$ 61,654	
f. Project Depreciation	$ 46,364	$ 92,727	$ 92,727	$ 1,519,962	$ 2,238,937	$ 2,246,080	
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 586,132	$ 1,172,264	$ 1,172,264	$ 1,172,264	$ 1,172,264	$ 1,172,264	
j. Other Expenses (Specify)	$ 534,469	$ 1,068,939	$ 1,068,939	$ 1,068,939	$ 1,068,939	$ 1,068,939	
TOTAL OPERATING EXPENSES	**$ 5,346,879**	**$ 11,936,313**	**$ 11,901,702**	**$ 12,829,856**	**$ 13,339,460**	**$ 13,304,399**	**$ -**
3. INCOME							
a. Income From Operation	**$ 856,456**	**$ 470,357**	**$ (114,306)**	**$ (1,951,343)**	**$ (2,750,559)**	**$ (2,715,498)**	**$ -**
b. Non-Operating Income	43,000	86,000	86,000	86,000	86,000	86,000	
SUBTOTAL	***$ 899,456***	***$ 556,357***	***$ (28,306)***	***$ (1,865,343)***	***$ (2,664,559)***	***$ (2,629,498)***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ 899,456***	***$ 556,357***	***$ (28,306)***	***$ (1,865,343)***	***$ (2,664,559)***	***$ (2,629,498)***	***$ -***

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

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 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	42.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	28.8%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	42.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	28.8%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***

Peninsula Regional Medical Center	
McCready Table Assumptions	
Table J	
Projection period reflects FY 2020 – FY 2025	
In the transition Year – FY 2020 – reflects half year of FMF in place; Full year FMF in place from FY 2021 to 10/31/2022; From 11/01/2022 the FMF will occupy the new building	
Volumes	• See Table I for the volume projections
Patient Revenue • Gross Charges • See attached HSCRC schedule • Revenue Deductions	 • Approximately 20% of gross revenue per year
Other Operating Revenues	• FY 2021-2025 resume to current levels and remains constant – about $305k
Expenses • Inflation • Staffing • Transportation • Interest Expense • Existing Debt • Project Debt • Depreciation • Existing • Project	 • 0.0% annual increase • See Table L – Work Force • Assumes $400,000 in costs for inpatient ambulance transport to PRMC • McCready has little existing debt and related interest expense • Presumed borrowing of $24.9 million on 7/01/2020 at average interest rate of 5% • Existing depreciation until FY 2023 when new FMF building is completed; FY 2024 and 2025 depreciation amounts are related to legacy movable equipment that will transfer to the new building • FY 2020-2022 amounts are related to renovations needed for FMF in place; FY 2023 to 2025 primarily reflects new building depreciation over 20 years

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

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 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. REVENUE							
a. Inpatient Services							
b. Outpatient Services	$ 7,620,305	$ 15,431,118	$ 14,631,655	$ 13,477,812	$ 13,113,052	$ 13,440,878	
Gross Patient Service Revenues	***$ 7,620,305***	***$ 15,431,118***	***$ 14,631,655***	***$ 13,477,812***	***$ 13,113,052***	***$ 13,440,878***	***$ -***
c. Allowance For Bad Debt	$ 487,691	$ 987,574	$ 936,410	$ 862,565	$ 839,221	$ 860,201	
d. Contractual Allowance	$ 929,864	$ 1,882,974	$ 1,785,420	$ 1,644,623	$ 1,600,113	$ 1,640,116	
e. Charity Care	$ 152,406	$ 308,622	$ 292,633	$ 269,556	$ 262,261	$ 268,818	
Net Patient Services Revenue	***$ 6,050,344***	***$ 12,251,948***	***$ 11,617,192***	***$ 10,701,068***	***$ 10,411,457***	***$ 10,671,743***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)	$ 152,991	$ 305,981	$ 305,981	$ 305,981	$ 305,981	$ 305,981	
NET OPERATING REVENUE	***$ 6,203,335***	***$ 12,557,929***	***$ 11,923,173***	***$ 11,007,049***	***$ 10,717,438***	***$ 10,977,724***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 2,547,686	$ 5,197,277	$ 5,301,223	$ 5,407,247	$ 5,515,392	$ 5,625,700	
b. Contractual Services	$ 1,284,238	$ 2,632,688	$ 2,698,506	$ 2,765,968	$ 2,835,117	$ 2,905,995	
c. Interest on Current Debt	**$ 7,819**	**$ 9,446**	**$ 5,646**	**$ 2,026**	**$ -**	**$ -**	
d. Interest on Project Debt	$ -	$ 1,248,750	$ 1,217,939	$ 1,176,039	$ 1,133,820	$ 1,091,616	
e. Current Depreciation	$ 340,171	$ 680,341	$ 680,341	$ 226,780	$ 61,654	$ 61,654	
f. Project Depreciation	$ 46,364	$ 92,727	$ 92,727	$ 1,519,962	$ 2,238,937	$ 2,246,080	
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 586,132	$ 1,201,570	$ 1,231,610	$ 1,262,400	$ 1,293,960	$ 1,326,309	
j. Other Expenses (Specify/add rows of needed)	$ 534,469	$ 1,095,662	$ 1,123,054	$ 1,151,130	$ 1,179,908	$ 1,209,406	
TOTAL OPERATING EXPENSES	**$ 5,346,879**	**$ 12,158,461**	**$ 12,351,046**	**$ 13,511,552**	**$ 14,258,788**	**$ 14,466,760**	**$ -**
3. INCOME							
a. Income From Operation	**$ 856,456**	**$ 399,468**	**$ (427,873)**	**$ (2,504,503)**	**$ (3,541,350)**	**$ (3,489,036)**	**$ -**
b. Non-Operating Income	$ 43,000	$ 86,000	$ 86,000	$ 86,000	$ 86,000	$ 86,000	
SUBTOTAL	***$ 899,456***	***$ 485,468***	***$ (341,873)***	***$ (2,418,503)***	***$ (3,455,350)***	***$ (3,403,036)***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ 899,456***	***$ 485,468***	***$ (341,873)***	***$ (2,418,503)***	***$ (3,455,350)***	***$ (3,403,036)***	***$ -***

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

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 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	42.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	28.8%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	42.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	28.8%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***

Peninsula Regional Medical Center	
McCready Table Assumptions	
Table K	
Projection period reflects FY 2020 – FY 2025	
In the transition Year – FY 2020 – reflects half year of FMF in place; Full year FMF in place from FY 2021 to 10/31/2022; From 11/01/2022 the FMF will occupy the new building	
Volumes	• See Table I for the volume projections
Patient Revenue • Gross Charges • Update Factor • Demographic Adjustment • Revenue Deductions	 • 2.5% annual increase in FY 2021-FY2025 • 0.0% per year • Approximately 20% of gross revenue per year
Other Operating Revenues	• FY 2021-2025 resume to current levels and remains constant – about $305k
Expenses • Inflation • Salaries • Contractual Services • Supplies • Other Exp • Interest Expense • Existing Debt • Project Debt • Depreciation • Existing • Project	 • 2.0% • 2.5% • 2.5% • 2.5% • McCready has little existing debt and related interest expense • Presumed borrowing of $24.9 million on 7/01/2020 at average interest rate of 5% • Existing depreciation until FY 2023 when new FMF building is completed; FY 2024 and 2025 depreciation amounts are related to legacy movable equipment that will transfer to the new building • FY 2020-2022 amounts are related to renovations needed for FMF in place; FY 2023 to 2025 primarily reflects new building depreciation over 20 years

Rate Order 16,465,560

HSCRC Proposal **Option 6**

TOTAL McCready FMF

Based on 90% of McCready, YR 1 & 2; 85% YR 2; 80% YR 3 and After

McCready FMF	Yr 1 80% FY2020	Yr 2 90% FY2021	Yr 3 85% FY2022	Yr 4 80% FY2023	Yr 5 80% FY2024	
EMG	$ 2,750,634	$ 2,750,634	$ 2,597,821	$ 2,445,008	$ 2,445,008	
CL	$ 2,603,678	$ 2,603,678	$ 2,459,029	$ 2,314,380	$ 2,314,380	
LAB	$ 1,719,742	$ 1,719,742	$ 1,624,201	$ 1,528,660	$ 1,528,660	
RAD	$ 1,488,433	$ 1,488,433	$ 1,405,742	$ 1,323,052	$ 1,323,052	
CAT	$ 457,077	$ 457,077	$ 431,684	$ 406,290	$ 406,290	
IRC	$ 2,904	$ 2,904	$ 2,743	$ 2,581	$ 2,581	
RES	$ 209,101	$ 209,101	$ 197,485	$ 185,868	$ 185,868	
PTH	$ 689,352	$ 689,352	$ 651,055	$ 612,758	$ 612,758	
STH	$ 25,064	$ 25,064	$ 23,671	$ 22,279	$ 22,279	
OBV	$ 132,722	$ 132,722	$ 125,349	$ 117,975	$ 117,975	
MSS	$ 331,542	$ 331,542	$ 331,542	$ 271,262	$ 271,262	
CDS	$ 601,214	$ 601,214	$ 601,214	$ 491,902	$ 491,902	
FMF Total (A)	$ 11,011,463	$ 11,011,463	$ 10,451,535	$ 9,722,015	$ 9,722,015	$ (1,289,448) Savings per Year

TOTAL Peninsula Regional Inpatient

Based on 100% of PRMC's Rates Every Year

Based on 100% of PRMC's Rates Peninsula Permanent Shift	Yr 1 100%	Yr 2 100%	Yr 3 100%	Yr 4 100%	Yr 5 100%	
MSG	$ 745,772	$ 745,772	$ 745,772	$ 745,772	$ 745,772	
ADM	$ 44,482	$ 44,482	$ 44,482	$ 44,482	$ 44,482	
OR	$ 499,360	$ 499,360	$ 499,360	$ 499,360	$ 499,360	
ORC	$ 13,962	$ 13,962	$ 13,962	$ 13,962	$ 13,962	
ANS	$ 31,585	$ 31,585	$ 31,585	$ 31,585	$ 31,585	
SDS	$ 397,582	$ 397,582	$ 397,582	$ 397,582	$ 397,582	
EKG	$ 80,133	$ 80,133	$ 80,133	$ 80,133	$ 80,133	
OTH	$ 65,858	$ 65,858	$ 65,858	$ 65,858	$ 65,858	
MRI	$ 10,112	$ 10,112	$ 10,112	$ 10,112	$ 10,112	
MSS	$ 208,822	$ 208,822	$ 208,822	$ 208,822	$ 208,822	
CDS	$ 417,954	$ 417,954	$ 417,954	$ 417,954	$ 417,954	
Total Shift To Peninsula (B)	$ 2,515,623	$ 2,515,623	$ 2,515,623	$ 2,515,623	$ 2,515,623	$ (625,000) Additional Variable Cost
						$ 1,890,623 Profit
Total	$ 13,527,086	$ 13,527,086	$ 12,967,158	$ 12,237,638	$ 12,237,638	
RY19 GBR Target	$ 16,465,560	$ 16,465,560	$ 16,465,560	$ 16,465,560	$ 16,465,560	
Public Savings/Dissipation	$ 2,938,473	$ 2,938,473	$ 3,498,401	$ 4,227,922	$ 4,227,922	
Savings Percent	17.85%	17.85%	21.25%	25.68%	25.68%	

Additional Community Investments

FMF Permanent Capital	$ 1,929,147	$ 1,929,147	$ 1,929,147	$ 1,929,147	$ 1,929,147	Based on $25 million over 25 years @ 5% ($146,148/month) + MU
Rural Health/Population Health	$ 900,000	$ 900,000	$ 900,000	$ 900,000	$ 900,000	Based on Hospital's Request Pop Health/ER Physicians
Rural Health/Telemedicine	$ 400,000	$ 400,000	$ 400,000	$ 400,000	$ 400,000	Based on Hospital's Request IP Transportation Cost
FMF One Time Transition	$ 1,000,000	$ 1,000,000	$ -	$ -	$ -	Based on $1 million per Year
(A)	$ 4,229,147	$ 4,229,147	$ 3,229,147	$ 3,229,147	$ 3,229,147	
RY19 GBR Target	$ 17,756,234	$ 17,756,234	$ 16,196,305	$ 15,466,785	$ 15,466,785	
Net Saving	$ (1,290,674)	$ (1,290,674)	$ 269,254	$ 998,774	$ 998,774	
Net Savings Percent	-7.84%	-7.84%	1.64%	6.07%	6.07%	

TABLE H. WORKFORCE INFORMATION - McCready Health Pavilion

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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if*	**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)*											
Accounting	3.0	$51,695	$155,085	-2.0	$47,549	-$95,098			$0	1.0	$59,987
Administration	4.0	$91,452	$365,810	-1.0	$30,888	-$30,888			$0	3.0	$334,922
Human Resources	2.0	$50,981	$101,962	-1.0	$58,740	-$58,740				1.0	$43,222
Medical Records	4.2	$38,828	$163,076	-2.6	$36,626	-$95,227			$0	1.6	$67,850
Patient Accounts	4.0	$42,965	$171,860	-0.5	$60,320	-$30,160			$0	3.5	$141,700
Total Administration	17.2	$55,686	$957,793	-7.1	$43,678	-$310,112			$0	10.1	$647,681
Direct Care Staff *(List general categories, add rows if needed)*											
Physician/APP	3.6	$213,353	$768,069	-3.6	$213,353	-$768,069			$0	0.0	$0
Clinic	17.6	$46,054	$810,551	-8.4	$41,689	-$350,185			$0	9.2	$460,366
Emergency Dept	14.4	$77,885	$1,117,647	-1.0	$366,995	-$366,995			$0	13.4	$750,652
Laboratory	8.0	$50,452	$403,613	-0.5	$45,427	-$22,713			$0	7.5	$380,900
Inpatient Nursing	9.4	$45,864	$431,122	-9.4	$45,864	-$431,122			$0	0.0	$0
Pharmacy	1.9	$69,187	$131,456	-0.9	$111,280	-$100,152			$0	1.0	$31,304
Physical Therapy	2.6	$101,837	$264,776	0.0	$0	$0			$0	2.6	$264,776
Radiology	6.4	$64,676	$413,925	-1.4	$55,518	-$78,835			$0	5.0	$335,091
Respiratory	4.5	$55,203	$247,310	0.0	$0	$0			$0	4.5	$247,310
Speech Therapy	0.6	$91,520	$54,912	0.0	$0	$0			$0	0.6	$54,912
Surgical Services	1.0	$67,600	$67,600	-1.0	$67,600	-$67,600			$0	0.0	$0
Total Direct Care	69.9	$67,367	$4,710,982	-26.2	$83,359	-$2,185,671			$0	43.7	$2,525,311
Support Staff *(List general categories, add rows if needed)*											
Registration	7.0	$27,498	$192,483	0.0	$0	$0			$0	7.0	$192,483
Communications	1.8	$22,739	$40,930	-1.8	$22,739	-$40,930			$0	0.0	$0
Courier	3.0	$25,230	$75,691	0.0	$0	$0			$0	3.0	$75,691
Environmental Services	3.8	$24,728	$93,965	-0.5	$26,936	-$14,007			$0	3.3	$79,959
Information services	3.0	$56,326	$168,979	0.0	$0	$0			$0	3.0	$168,979
Maintenance	6.0	$44,526	$267,155	-2.0	$54,028	-$108,056			$0	4.0	$159,099
Materials Management	2.0	$41,496	$82,992	-1.0	$29,120	-$29,120			$0	1.0	$53,872
Patient Care Services	2.0	$84,625	$169,250	-1.0	$78,125	-$78,125			$0	1.0	$91,125
Security	4.5	$27,290	$122,257	0.0	$0	$0			$0	4.5	$122,257
Total Support	33.1	$36,690	$1,213,703	-6.3	$42,759	-$270,238			$0	26.8	$943,465
REGULAR EMPLOYEES TOTAL	***120.2***	***$57,254***	***6,882,478***	***-39.6***	***$69,779***	***-2,766,020***			$0	80.6	$4,116,458
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)* **:**			**$1,577,626**			**-$598,714**					**$978,912**
% of Salaries											
TOTAL COST	***120.2***		***$8,460,104***	***-39.6***		***-$3,364,734***	***0.0***		***$0***		***$5,095,370***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - Peninsula Regional Medical Center

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. DISCHARGES										
a. General Medical/Surgical*	13,739	13,641	12,199	12,227	12,227	12,227	12,227	12,227	12,227	
b. ICU/CCU	452	492	495	496	496	496	496	496	496	
Total MSGA	**14,191**	**14,133**	**12,694**	**12,723**	**12,723**	**12,723**	**12,723**	**12,723**	**12,723**	**0**
c. Pediatric	405	436	336	337	337	337	337	337	337	
d. Obstetric	1,930	1,953	1,922	1,926	1,926	1,926	1,926	1,926	1,926	
e. Acute Psychiatric	727	692	748	750	750	750	750	750	750	
Total Acute	***17,253***	***17,214***	***15,700***	***15,736***	***15,736***	***15,736***	***15,736***	***15,736***	***15,736***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL DISCHARGES	***17,253***	***17,214***	***15,700***	***15,736***	***15,736***	***15,736***	***15,736***	***15,736***	***15,736***	***0***
2. PATIENT DAYS										
a. General Medical/Surgical*	59,427	59,187	53,844	53,971	53,971	53,971	53,971	53,971	53,971	
b. ICU/CCU	6,149	5,782	5,316	5,328	5,328	5,328	5,328	5,328	5,328	
Total MSGA	**65,576**	**64,969**	**59,160**	**59,299**	**59,299**	**59,299**	**59,299**	**59,299**	**59,299**	**0**
c. Pediatric	1,110	1,031	939	941	941	941	941	941	941	
d. Obstetric	5,092	4,789	4,306	4,316	4,316	4,316	4,316	4,316	4,316	
e. Acute Psychiatric	3,784	3,895	4,045	4,054	4,054	4,054	4,054	4,054	4,054	
Total Acute	***75,562***	***74,684***	***68,450***	***68,610***	***68,610***	***68,610***	***68,610***	***68,610***	***68,610***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	***75,562***	***74,684***	***68,450***	***68,610***	***68,610***	***68,610***	***68,610***	***68,610***	***68,610***	***0***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	4.3	4.3	4.4	4.4	4.4	4.4	4.4	4.4	4.4	#DIV/0!
b. ICU/CCU	13.6	11.8	10.7	10.7	10.7	10.7	10.7	10.7	10.7	#DIV/0!
Total MSGA	4.6	4.6	4.7	4.7	4.7	4.7	4.7	4.7	4.7	#DIV/0!
c. Pediatric	2.7	2.4	2.8	2.8	2.8	2.8	2.8	2.8	2.8	#DIV/0!
d. Obstetric	2.6	2.5	2.2	2.2	2.2	2.2	2.2	2.2	2.2	#DIV/0!
e. Acute Psychiatric	5.2	5.6	5.4	5.4	5.4	5.4	5.4	5.4	5.4	#DIV/0!
Total Acute	4.4	4.3	4.4	4.4	4.4	4.4	4.4	4.4	4.4	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	4.4	4.3	4.4	4.4	4.4	4.4	4.4	4.4	4.4	#DIV/0!

4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*	199	207	206	184	184	184	184	184	184	
b. ICU/CCU	42	42	42	42	42	42	42	42	42	
Total MSGA	**241**	**249**	**248**	**226**	**226**	**226**	**226**	**226**	**226**	**0**
c. Pediatric	8	8	8	8	8	8	8	8	8	
d. Obstetric	20	20	20	20	20	20	20	20	20	
e. Acute Psychiatric	12	12	12	12	12	12	12	12	12	
Total Acute	***281***	***289***	***288***	***266***	***266***	***266***	***266***	***266***	***266***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL LICENSED BEDS	***281***	***289***	***288***	***266***	***266***	***266***	***266***	***266***	***266***	***0***
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	81.8%	78.3%	71.6%	80.1%	80.4%	80.4%	80.4%	80.1%	80.4%	#DIV/0!
b. ICU/CCU	40.1%	37.7%	34.7%	34.7%	34.8%	34.8%	34.8%	34.7%	34.8%	#DIV/0!
Total MSGA	**74.5%**	**71.5%**	**65.4%**	**71.7%**	**71.9%**	**71.9%**	**71.9%**	**71.7%**	**71.9%**	**#DIV/0!**
c. Pediatric	38.0%	35.3%	32.2%	32.1%	32.2%	32.2%	32.2%	32.1%	32.2%	#DIV/0!
d. Obstetric	69.8%	65.6%	59.0%	59.0%	59.1%	59.1%	59.1%	59.0%	59.1%	#DIV/0!
e. Acute Psychiatric	86.4%	88.9%	92.4%	92.3%	92.6%	92.6%	92.6%	92.3%	92.6%	#DIV/0!
Total Acute	**73.7%**	**70.8%**	**65.1%**	**70.5%**	**70.7%**	**70.7%**	**70.7%**	**70.5%**	**70.7%**	**#DIV/0!**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**73.7%**	**70.8%**	**65.1%**	**70.5%**	**70.7%**	**70.7%**	**70.7%**	**70.5%**	**70.7%**	**#DIV/0!**
6. OUTPATIENT VISITS										
a. Emergency Department	79,930	76,311	77,942	77,942	77,942	77,942	77,942	77,942	77,942	
b. Same-day Surgery	12,391	12,880	13,037	13,037	13,037	13,037	13,037	13,037	13,037	
c. Laboratory	166,276	164,256	183,664	183,802	183,802	183,802	183,802	183,802	183,802	
d. Imaging	64,601	58,241	58,382	58,382	58,382	58,382	58,382	58,382	58,382	
e. Other (Specify/add rows of needed)	239,410	252,844	280,535	339,471	339,471	339,471	339,471	339,471	339,471	
TOTAL OUTPATIENT VISITS	***562,608***	***564,532***	***613,560***	***672,634***	***672,634***	***672,634***	***672,634***	***672,634***	***672,634***	***0***
7. OBSERVATIONS**										
a. Number of Patients	3,053	3,044	4,626	4,626	4,626	4,626	4,626	4,626	4,626	
b. Hours	90,615	91,928	152,195	152,195	152,195	152,195	152,195	152,195	152,195	

* 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

Assumptions:

1. Kept FY 2020 Statistics constant through FY 2024

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - Peninsula Regional Medical Center

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial						
Indicate CY or FY	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	
1. REVENUE										
a. Inpatient Services	$ 242,490,752	$ 252,973,987	$ 246,877,625	$ 256,132,949	$ 255,916,010	$ 256,495,077	$ 257,238,914	$ 257,984,984	$ 258,733,291	
b. Outpatient Services	$ 278,452,734	$ 295,757,241	$ 327,010,399	$ 366,588,844	$ 368,085,810	$ 368,575,488	$ 369,204,502	$ 369,835,402	$ 370,468,196	
Gross Patient Service Revenues	***$ 520,943,486***	***$ 548,731,228***	***$ 573,888,024***	***$ 622,721,793***	***$ 624,001,820***	***$ 625,070,565***	***$ 626,443,416***	***$ 627,820,386***	***$ 629,201,487***	***$ -***
c. Allowance For Bad Debt	$ 11,673,037	$ 9,097,503	$ 9,028,637	$ 9,539,758	$ 9,258,574	$ 9,480,655	$ 9,501,478	$ 9,522,363	$ 9,543,311	
d. Contractual Allowance	$ 90,977,037	$ 100,081,972	$ 104,113,144	$ 129,093,344	$ 130,749,119	$ 131,054,160	$ 131,341,996	$ 131,630,696	$ 131,920,262	
e. Charity Care	$ 9,225,353	$ 7,897,746	$ 8,449,785	$ 9,754,624	$ 9,778,330	$ 9,793,105	$ 9,814,614	$ 9,836,187	$ 9,857,825	
Net Patient Services Revenue	***$ 409,068,059***	***$ 431,654,007***	***$ 452,296,458***	***$ 474,334,067***	***$ 474,215,797***	***$ 474,742,645***	***$ 475,785,328***	***$ 476,831,140***	***$ 477,880,089***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 2,567,736	$ 2,604,570	$ 3,774,053	$ 4,060,039	$ 4,060,039	$ 4,060,039	$ 4,060,039	$ 4,060,039	$ 4,060,039	
NET OPERATING REVENUE	***$ 411,635,795***	***$ 434,258,577***	***$ 456,070,511***	***$ 478,394,106***	***$ 478,275,836***	***$ 478,802,684***	***$ 479,845,367***	***$ 480,891,179***	***$ 481,940,128***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 214,398,768	$ 222,534,421	$ 232,008,487	$ 250,156,186	$ 248,991,303	$ 246,991,303	$ 244,991,303	$ 242,991,303	$ 242,991,303	
b. Contractual Services	$ 54,966,509	$ 45,243,912	$ 54,497,599	$ 56,572,565	$ 56,481,060	$ 55,981,060	$ 55,481,060	$ 54,981,060	$ 54,981,060	
c. Interest on Current Debt	**$ 5,355,480**	**$ 5,249,856**	**$ 5,140,270**	**$ 5,026,580**	**$ 4,909,000**	**$ 4,786,000**	**$ 4,659,000**	**$ 4,528,000**	**$ 4,391,000**	
d. Interest on Project Debt										
e. Current Depreciation	$ 26,231,978	$ 28,613,769	$ 29,634,581	$ 30,986,542	$ 33,118,000	$ 33,409,000	$ 34,625,000	$ 34,085,000	$ 34,337,000	
f. Project Depreciation										
g. Current Amortization	***$ 187,488***	***$ 329,160***	***$ 329,155***	***$ 187,488***	***$ 46,000***	***$ 46,000***	***$ 46,000***	***$ 46,000***	***$ 46,000***	
h. Project Amortization										
i. Supplies	$ 107,868,117	$ 104,131,764	$ 109,126,878	$ 118,846,391	$ 118,743,620	$ 117,743,620	$ 116,743,620	$ 115,743,620	$ 115,743,620	
j. Other Expenses (Specify/add rows if needed)	$ 23,133,397	$ 21,257,862	$ 23,033,256	$ 25,084,739	$ 25,274,116	$ 25,274,116	$ 25,274,116	$ 25,274,116	$ 25,274,116	
TOTAL OPERATING EXPENSES	***$ 432,141,737***	***$ 427,360,744***	***$ 453,770,226***	***$ 486,860,491***	***$ 487,563,099***	***$ 484,231,099***	***$ 481,820,099***	***$ 477,649,099***	***$ 477,764,099***	***$ -***
3. INCOME										
a. Income From Operation	**$ (20,505,942)**	**$ 6,897,833**	**$ 2,300,285**	**$ (8,466,385)**	**$ (9,287,263)**	**$ (5,428,415)**	**$ (1,974,732)**	**$ 3,242,080**	**$ 4,176,029**	**$ -**
b. Non-Operating Income	$ 14,818,236	$ 38,206,580	$ 18,956,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	
SUBTOTAL	***$ (5,687,706)***	***$ 45,104,413***	***$ 21,256,285***	***$ 2,533,615***	***$ 1,712,737***	***$ 5,571,585***	***$ 9,025,268***	***$ 14,242,080***	***$ 15,176,029***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ (5,687,706)***	***$ 45,104,413***	***$ 21,256,285***	***$ 2,533,615***	***$ 1,712,737***	***$ 5,571,585***	***$ 9,025,268***	***$ 14,242,080***	***$ 15,176,029***	***$ -***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	51.8%	53.2%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	
2) Medicaid	15.8%	17.2%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	
3) Blue Cross	11.8%	12.7%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	
4) Commercial Insurance	17.0%	14.2%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	
5) Self-pay	3.3%	2.3%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	
6) Other	0.4%	0.5%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***

b. Percent of Equivalent Inpatient Days										
1) Medicare	51.8%	53.2%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	
2) Medicaid	15.8%	17.2%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	
3) Blue Cross	11.8%	12.7%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	
4) Commercial Insurance	17.0%	14.2%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	
5) Self-pay	3.3%	2.3%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	
6) Other	0.4%	0.5%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***

Assumptions:

1. FY 2020 half year of McCready Inpatient and Unregulated shift; revenues and expenses
2. FY 2021 Full year of McCready Inpatient and Unregulated shift; revenues and expenses
3. GBR revenue changes by .30% for population adjustment; all other hscrc methodologies applied except update factor
4. Salaries reduces by $2,000,000 each year from FY 2021 to FY 2024
5. Contractual services reduce by $500,000 each year from FY 2021 to FY 2024
6. Supplies reduce by $1,000,000 each year from FY 2021 to FY 2024

Peninsula Regional Medical Center	
PRMC Table Assumptions	
Table G	
Projection period reflects FY 2017 – FY 2025	
FY 2020 is based off of approved budget – it is not uninflated	
Volumes	• See Table F for the volume projections
Patient Revenue • Gross Charges • Update Factor • Demographic Adjustment • Redistribution of McCready Revenue • Revenue Deductions	 • 0.0% annual increase in FY 2020-FY2025 • 0.30% per year • $2.5 million of McCready's inpatient GBR will shift to PRMC; $3.4 million of unregulated revenue also shifts to PRMC • Approximately 25% of gross revenue per year
Other Operating Revenues	• Based on Budget 2020 and will remain constant through FY 2025
Expenses • Inflation • Performance Improvements	 • 0.0% annual increase • $2 million salary reduction each year 2021 to 2022 • $500,000 contracted services reduction each year from 2021 to 2024 • $1 million supply reduction each year from 2021 to 2024
Non Operating Income	• Assume 3% earnings on current fund balances

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - Peninsula Regional Medical Center

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. REVENUE										
a. Inpatient Services	$ 242,490,752	$ 252,973,987	$ 246,877,625	$ 256,132,949	$ 262,117,790	$ 269,069,619	$ 276,383,731	$ 283,903,186	$ 291,633,750	
b. Outpatient Services	$ 278,452,734	$ 295,757,241	$ 327,010,399	$ 366,588,844	$ 377,038,089	$ 386,717,331	$ 396,797,943	$ 407,149,590	$ 417,779,581	
Gross Patient Service Revenues	***$ 520,943,486***	***$ 548,731,228***	***$ 573,888,024***	***$ 622,721,793***	***$ 639,155,879***	***$ 655,786,950***	***$ 673,181,674***	***$ 691,052,776***	***$ 709,413,331***	***$ -***
c. Allowance For Bad Debt	$ 11,673,037	$ 9,097,503	$ 9,028,637	$ 9,539,758	$ 9,947,421	$ 10,257,526	$ 10,512,021	$ 10,797,491	$ 11,084,369	
d. Contractual Allowance	$ 90,977,037	$ 100,081,972	$ 104,113,144	$ 129,093,344	$ 132,644,725	$ 135,812,213	$ 139,095,613	$ 142,461,652	$ 146,246,710	
e. Charity Care	$ 9,225,353	$ 7,897,746	$ 8,449,785	$ 9,754,624	$ 10,027,977	$ 10,295,318	$ 10,575,911	$ 10,864,365	$ 11,153,020	
Net Patient Services Revenue	***$ 409,068,059***	***$ 431,654,007***	***$ 452,296,458***	***$ 474,334,067***	***$ 486,535,756***	***$ 499,421,893***	***$ 512,998,129***	***$ 526,929,268***	***$ 540,929,232***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 2,567,736	$ 2,604,570	$ 3,774,053	$ 4,060,039	$ 4,049,000	$ 4,049,000	$ 4,049,000	$ 4,049,000	$ 4,049,000	
NET OPERATING REVENUE	***$ 411,635,795***	***$ 434,258,577***	***$ 456,070,511***	***$ 478,394,106***	***$ 490,584,756***	***$ 503,470,893***	***$ 517,047,129***	***$ 530,978,268***	***$ 544,978,232***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 214,398,768	$ 222,534,421	$ 232,008,487	$ 250,156,186	$ 253,977,724	$ 257,057,279	$ 262,198,425	$ 267,442,393	$ 272,791,241	
b. Contractual Services	$ 54,966,509	$ 45,243,912	$ 54,497,599	$ 56,572,565	$ 57,872,844	$ 58,399,520	$ 60,311,588	$ 61,806,305	$ 63,338,129	
c. Interest on Current Debt	**$ 5,355,480**	**$ 5,249,856**	**$ 5,140,270**	**$ 5,026,580**	**$ 4,909,000**	**$ 4,786,000**	**$ 4,659,000**	**$ 4,528,000**	**$ 4,391,000**	
d. Interest on Project Debt										
e. Current Depreciation	$ 26,231,978	$ 28,613,769	$ 29,634,581	$ 30,986,542	$ 33,118,000	$ 33,409,000	$ 34,625,000	$ 34,085,000	$ 34,337,000	
f. Project Depreciation										
g. Current Amortization	***$ 187,488***	***$ 329,160***	***$ 329,155***	***$ 187,488***	***$ 46,000***	***$ 46,000***	***$ 46,000***	***$ 46,000***	***$ 46,000***	
h. Project Amortization										
i. Supplies	$ 107,868,117	$ 104,131,764	$ 109,126,878	$ 118,846,391	$ 121,692,349	$ 123,836,984	$ 126,727,677	$ 129,895,869	$ 133,143,266	
j. Other Expenses (Specify/add rows if needed)	$ 23,133,397	$ 21,257,862	$ 23,033,256	$ 25,084,739	$ 25,896,500	$ 26,349,165	$ 26,748,231	$ 27,416,937	$ 28,102,360	
TOTAL OPERATING EXPENSES	***$ 432,141,737***	***$ 427,360,744***	***$ 453,770,226***	***$ 486,860,491***	***$ 497,512,417***	***$ 503,883,948***	***$ 515,315,921***	***$ 525,220,504***	***$ 536,148,996***	***$ -***
3. INCOME										
a. Income From Operation	**$ (20,505,942)**	**$ 6,897,833**	**$ 2,300,285**	**$ (8,466,385)**	**$ (6,927,661)**	**$ (413,055)**	**$ 1,731,208**	**$ 5,757,764**	**$ 8,829,236**	**$ -**
b. Non-Operating Income	$ 14,818,236	$ 38,206,580	$ 18,956,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	
SUBTOTAL	***$ (5,687,706)***	***$ 45,104,413***	***$ 21,256,285***	***$ 2,533,615***	***$ 4,072,339***	***$ 10,586,945***	***$ 12,731,208***	***$ 16,757,764***	***$ 19,829,236***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ (5,687,706)***	***$ 45,104,413***	***$ 21,256,285***	***$ 2,533,615***	***$ 4,072,339***	***$ 10,586,945***	***$ 12,731,208***	***$ 16,757,764***	***$ 19,829,236***	***$ -***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	51.8%	53.2%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	
2) Medicaid	15.8%	17.2%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	
3) Blue Cross	11.8%	12.7%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	
4) Commercial Insurance	17.0%	14.2%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	
5) Self-pay	3.3%	2.3%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	
6) Other	0.4%	0.5%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	

TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	51.8%	53.2%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	53.33%+J45	
2) Medicaid	15.8%	17.2%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	
3) Blue Cross	11.8%	12.7%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	
4) Commercial Insurance	17.0%	14.2%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	
5) Self-pay	3.3%	2.3%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	
6) Other	0.4%	0.5%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***46.7%***	***0.0%***

Assumptions:

1. FY 2020 half year of McCready Inpatient and Unregulated shift; revenues and expenses
2. FY 2021 Full year of McCready Inpatient and Unregulated shift; revenues and expenses
3. GBR revenue changes by .30% for population adjustment, 2.50% for update factor, and all other HSCRC methods apply for FY 2021 through FY 2024
4. Salaries reduces by $2,000,000 each year from FY 2021 to FY 2024
5. Contractual services reduce by $500,000 each year from FY 2021 to FY 2024
6. Supplies reduce by $1,000,000 each year from FY 2021 to FY 2024
7. 2% salary inflation for FY 2020 to FY 2024
8. 2% benefit inflation for FY 2020 to FY 2024
9. 2.5% inflation for Contracted/Supplies/Other for FY 2020 to FY 2024

Peninsula Regional Medical Center	
PRMC Table Assumptions	
Table H	
Projection period reflects FY 2017 – FY 2025	
FY 2020 is based off of approved budget	
Volumes	• See Table F for the volume projections
Patient Revenue • Gross Charges • Update Factor • Demographic Adjustment • Redistribution of McCready Revenue • Revenue Deductions	 • 2.5% annual increase in FY 2021-FY2025 • 0.30% per year • $2.5 million of McCready's inpatient GBR will shift to PRMC; $3.4 million of unregulated revenue also shifts to PRMC • Approximately 25% of gross revenue per year
Other Operating Revenues	• Based on Budget 2020 and will remain constant through FY 2025
Expenses • Inflation • Salaries • Contractual Services • Supplies • Other Exp • Performance Improvements	 • 2% • 2.5% • 2.5% • 2.5% • $2 million salary reduction each year 2021 to 2022 • $500,000 contracted services reduction each year from 2021 to 2022 • $1 million supply reduction each year from 2021 to 2022
Non Operating Income	• Assume 3% earnings on current fund balances

REVISED

EXHIBIT 2

Peninsula Regional Health System

CRISFIELD HIGHWAY

CRISFIELD, MD

McCready Memorial Hospital Replacement Freestanding Facility

G.002

SITE PLAN - CON1
FLOOR PLAN - A.101
BUILDING ELEVATIONS/SECTIONS - A.301

CALLISONRTKL
A DESIGN CONSULTANCY OF ARCADIS

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Tel 202.833.4400
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Project No:
Project No:

Consultants

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Fax 410.546.9824

Peninsula Regional Health System
McCready Memorial Hospital
Replacement
Freestanding Facility

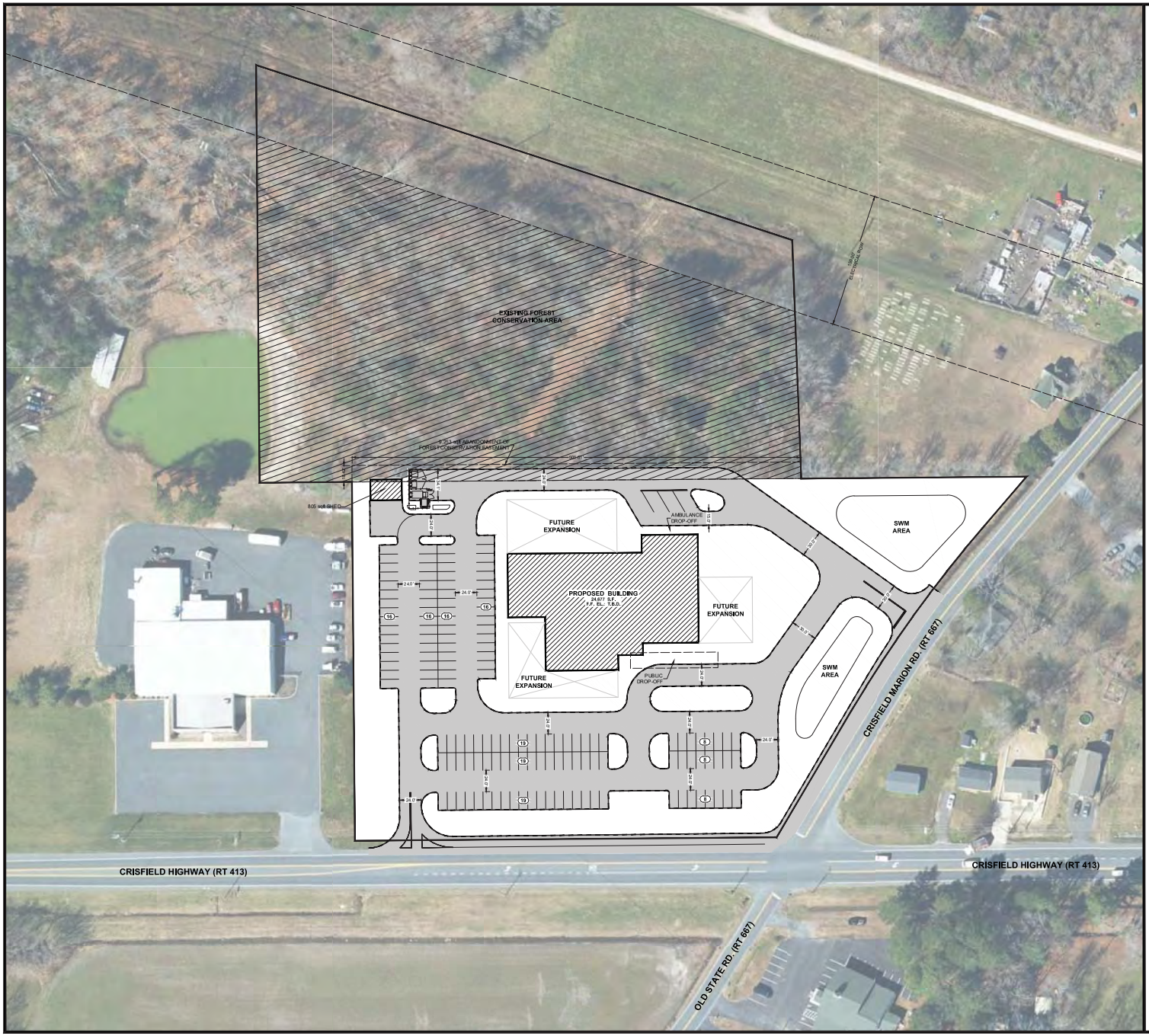
Issue Drawing Log

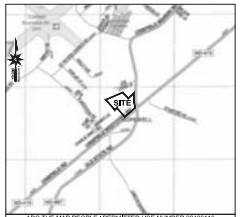
Seal

Sheet Identification

COVER SHEET
January 23, 2019

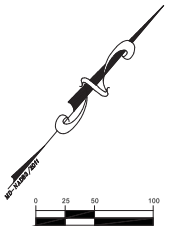
G-001





ADC THE MAP PEOPLE | PERMITTED USE NUMBER 20408116

VICINITY MAP SCALE : 1" = 2000'



SCALE : 1" = 50'

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Wilmington, NC
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Wilmington, North Carolina 28403
Ph. 910.341.7600
Fax 910.341.7506

www.beckermorgan.com

PROJECT TITLE

McCREADY FREESTANDING MEDICAL FACILITY

CRISFIELD HIGHWAY - RT. 413
HOPEWELL
SOMERSET COUNTY, MD
EIGHTH ELECTION DISTRICT

SHEET TITLE

CONCEPT PLAN

ISSUE BLOCK

MARK	DATE	DESCRIPTION

PROJECT NO.:	2004130.88
DATE:	02/21/2019
SCALE:	1" = 60'
DRAWN BY: JAH	PROJ. MGR.: JAH

SHEET

CP-1

F:\Auto CAD\Projects\2004\2004130\88\DWG\2004130\88-property 3 exhibit.dwg, Oct 24, 2019 - 1:33pm

CALLISONRTKL
A DESIGN CONSULTANCY OF ARCADIS

CallisonRTKL Inc.
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Suite 200
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Fax: 202.887.5168

Project No:
Project No:

Consultants

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Peninsula Regional Health System
McCready Freestanding Medical Facility

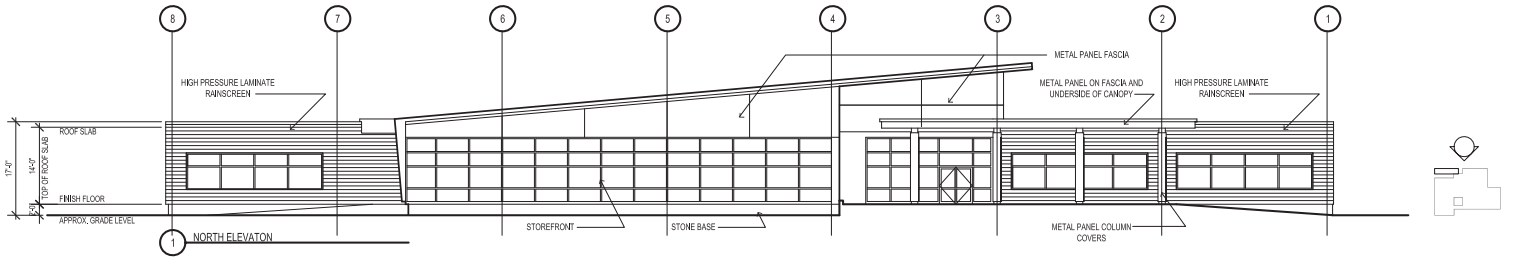
Issue Drawing Log

Seal

Sheet Identification

MAIN LEVEL FLOOR PLAN
October 24, 2019

A-101



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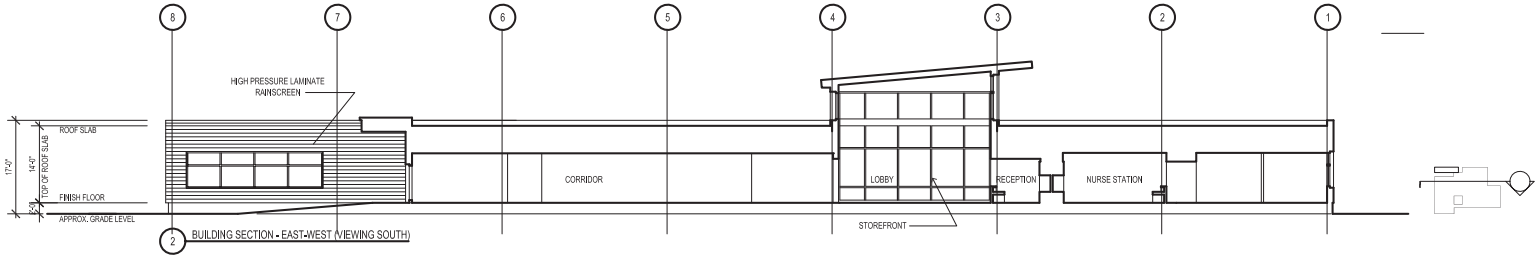

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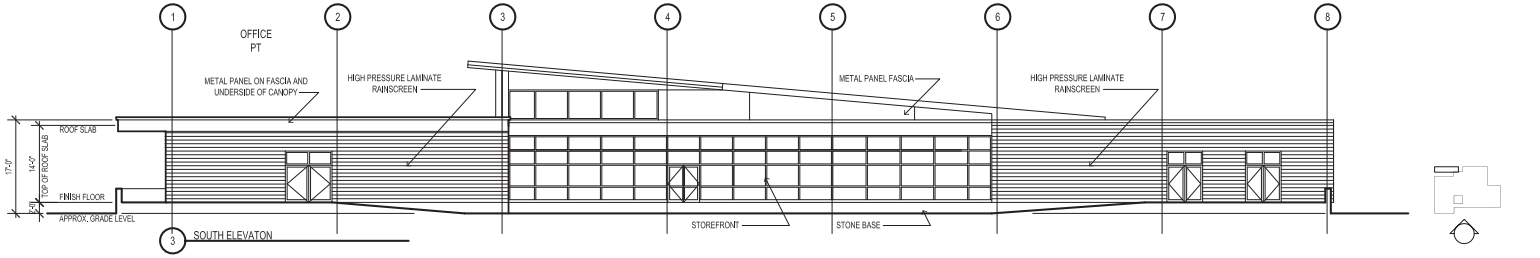

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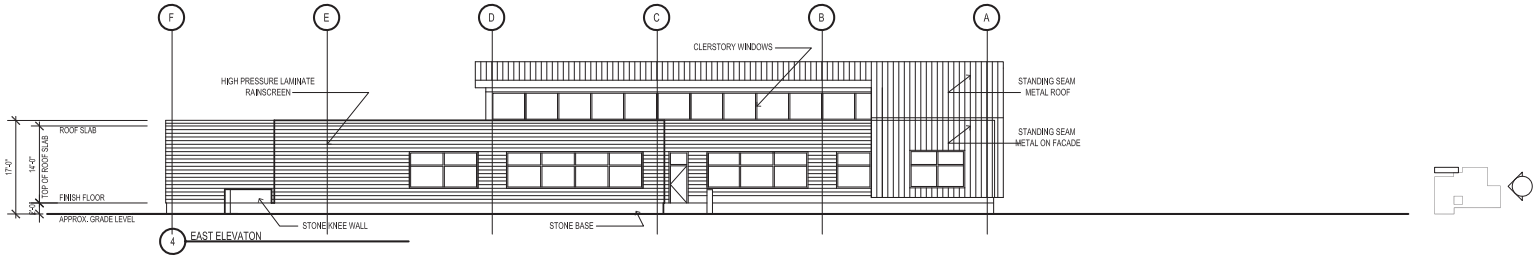

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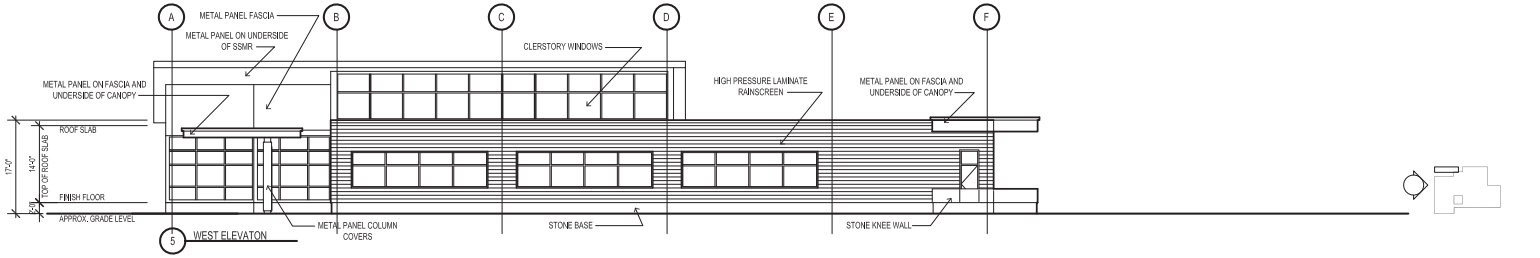

5 WEST ELEVATON

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Peninsula Regional Health System
McCready Memorial Hospital
Replacement
Freestanding Facility

Issue Drawing Log

Sheet Identification

BLDG. ELEVATIONS / SECTION
January 23, 2019

A-301

EXHIBIT 3

Peninsula Regional Medical Center
Policy/Procedure

Finance Division

Subject: Charges - Estimates and Information to Patients and Public

Affected Areas: Patient Accounting, Patient Financial Services, Patient Registration, Accounting

Policy/Procedure Number: FD-157

Policy:

Peninsula Regional Medical Center's Finance Department will post a representative list of services and charges on the PRMC website. PRMC will respond to individual requests for current charges for specific services/procedures. PRMC will provide staff training to ensure that inquiries for its services are appropriately handled.

Procedure:

The attached List of Representative Charges will be posted on the PRMC website by the Finance Budget, Cost & Reimbursement Office on a quarterly basis. The information will be updated each calendar quarter and posted within 45 days of the end of each quarter.

The List of Representative Charges will be distributed to staff each time prices change. This list is available to the public from the Financial Counselor upon request. Requests for estimates of charges for procedures/services are provided by the following:

Outpatient Diagnostic Testing –

- If requested in person – by the Financial Counselor
- If requested by phone – by the Centralized Scheduling Office

Outpatient Surgery and Procedures – by the Centralized Scheduling Office
Inpatient Services –

- If requested by phone – by the Patient Financial Services collection personnel
- If requested in person – by the Financial Counselor who will contact the collections team

Information available for charge estimation:

1. Rates sheet. This list is updated whenever prices are changed, and revisions will come from the Budget and Reimbursement Office.

2. Service item master listing for charges. This list is updated periodically and revisions will come from the Budget and Reimbursement Office.

3. Observation charges. This charge is updated periodically and revisions will come from the Budget and Reimbursement Office.

4. A listing of average OR minutes by procedure. Two lists are generated, one in ICD-10 order (worksheet = avg. min), the second list is in alphabetic description order (worksheet = avg. min-desc.). These lists are updated periodically and revisions will come from the Budget and Reimbursement Office.

Note: Contact Budget and Reimbursement Office if an annual update is not received.

Patient Correspondence

It is important that the patient understand that the estimate is subject to change and is only an estimate. The actual charges incurred may be higher or lower than shown. See example correspondence which may be formalized and sent via mail or may be used in phone conversations to ensure continuity of message presented.

Documentation

Document in EPIC, account notes; the estimated charges and the method and date of communication to patient.

Date: 9/24/01
Reviewed: 12/13, 12/14, 4/17
Revised: 8/23/10, 12/31/10, 3/24/11, 12/11, 12/12, 2/16

REVISED

EXHIBIT 4

ADMINISTRATIVE POLICY MANUAL

Subject: Financial Assistance / Uncompensated Care

Effective Date:	August 1981
Approved by:	President/CEO and Vice President of Finance/CFO
Responsible Parties:	Senior Executive Director of Finance
Revised Date:	12/86, 6/88, 3/90, 3/91, 7/93, 7/94, 8/98, 12/05, 8/08, 5/10, 10/10, 12/14, 7/16, 11/16, 7/17, 7/18, 7/19
Reviewed Date:	8/83, 12/85, 2/88, 6/92, 8/95, 7/96, 9/97, 6/00, 6/01, 10/02, 10/04, 12/11, 12/12, 12/13
Key Words:	Financial Assistance, Federal Poverty Guidelines, Charity Care, Uncompensated

POLICY

Peninsula Regional Medical Center (PRMC) will provide emergency and medically necessary free and/or reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of their hospital bill. For purposes of this policy, PRMC shall include the hospital, medical center, and physician services billed by PRMC, commonly referred to as Peninsula Regional Medical Group (PRMG). A patient's payment shall not exceed the amount generally billed (AGB). All hospital regulated services (which includes emergency and medically necessary care) will be charged consistently as established by the Health Services Cost Review Commission (HSCRC) which equates to the amounts generally billed (AGB) method. All patients seen by a PRMG provider or in an unregulated area will be charged the fee schedule plus the standard mark-up. The AGB for PRMG and other services not regulated by the HSCRC equates to the Medicare fee-for-service amount under the prospective method. A 50% discount will be applied to all self-pay unregulated services and patients seen by a PRMG provider. The 50% discount reduces the patient responsibility to the AGB. If the patient qualifies for financial assistance, this 50% discount will be granted prior to the application of the financial assistance write-off.

PRMC may use outsource vendors to provide patient collection and/or pre-collection services. Vendors act in accordance with PRMC policies and wherever policy notates employee, financial services department, or other such wording – vendor and/or vendor employees are included without such notation.

Definitions:

a. Elective Care: Care that can be postponed without harm to the patient or that is not medically necessary. An appropriate clinical or physician representative will be contacted for consultation in determining the patient status.
b. Medical Necessity: Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.
c. Immediate Family: A family unit is defined to include all individuals taken as exemptions on the income tax return for the individual completing the application, whether or not they were the individual filing the return or listed as a spouse or dependent. For homeless persons or in the event that a family member is not obtainable, the family unit size will be assumed to be one. If a tax return has not

been filed, then income from all members living in the household will be considered.

d. Liquid Assets: Cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, rental properties etc. The availability of liquid assets plus annual income may be considered in relation to the current poverty guidelines published in the Federal Register.
e. Medical Debt: Out of pocket expenses, excluding copayments, coinsurance and deductibles, for medical costs for medical costs billed by PRMC.
f. Extraordinary Collection Actions (ECA): Any legal action and/or reporting the debt to a consumer reporting agency.

PRMC will provide free medically necessary care to patients with family income at or below 200% of the federal poverty level. Patients qualifying for financial assistance based on income at or below 200% of the federal poverty level have no cost for their care and therefore pay less than AGB.

PRMC will provide reduced-cost medically necessary care to low-income patients with family income between 200% and 300% of the Federal poverty level.

PRMC will provide reduced-cost medically necessary care to low-income patients with family income between 301% and 500% of the Federal poverty level who have a medical hardship as defined by Maryland Law. Medical hardship is medical debt, incurred by a family over a 12 month period that exceeds 25% of the family income.

Other healthcare fees and professional fees that are not provided by PRMC/PRMG are not included in this policy. Pre-planned service may only be considered for financial assistance when the service is medically necessary. As an example, cosmetic surgery is excluded. Inpatient, outpatient, emergency services, and services rendered by PRMG are eligible.

PRMC's financial assistance is provided only to bills related to services provided at PRMC or at a PRMC site including services provided by physicians employed by PRMC. These services are generally referred to as PRMG. To determine if your physician services are covered by the PRMC financial assistance program, please see the roster of providers that deliver emergency and other medically necessary care, indicating which providers are covered under the policy and which are not. The list of providers is updated quarterly and available on the medical center website. If you prefer, you may contact any financial counselor or patient accounting representative by calling (410) 912-4974, or in person at the hospital.

PROCEDURE

If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies. In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, PRMC will provide care at reduced or zero cost. When no third party assistance is available to cover the total bill and the patient indicates that they have insufficient funds, Financial Assistance (FA) will be offered. The Maryland State Uniform Financial Assistance application, Financial Assistance Policy, Patient Collection Practice Policy, and plain language summary, can be obtained by one of the following ways:

a. Available free of charge and upon request by calling (410) 543-7436 or (877) 729-7762.
b. Are located in the registration areas.
c. Downloaded from the hospital website:
https://www.peninsula.org/patients-visitors/patient-forms
https://www.peninsula.org/patients-visitors/patient-billing-information
d. The plain language summary is inserted in the Admission packet and with all patient statements.

e. Through signs posted in the main registration areas.
f. Annual notification in the local newspaper.
g. The application is available in English and Spanish. No other language constitutes a group that is 5% or more, or more than 1,000 residents (whichever is less) of the population in our primary service area (Worcester, Wicomico and Somerset Counties) based on U.S. Census data.
h. For patients who have difficulty in filling out an application, the information can be taken orally by calling (410) 912-6957 or in person at the Financial Counselor's Office located in the Frank B. Hanna Outpatient Center.

The patient's income will be compared to current Federal Poverty Guidelines (on file with the Collection Coordinator). The Collection Coordinator representative will consult with the patient as needed to make assessment of eligibility.

a. If the application is received within 240 days of the first post-discharge billing statement, and the account is with a collection agency, the agency will be notified to suspend all Extraordinary Collection Actions (ECA) until the application and all appeal rights have been processed.

b. If the application is incomplete, all ECA efforts will remain on hold for a reasonable amount of time and assistance will be provided to the patient in order to get the application completed. If there is not a phone contact to call, a written notice that describes the additional information and/or documentation required will be mailed which includes a phone contact to call for assistance.

c. Preliminary eligibility will be made within 2 business days based upon receipt of sufficient information to determine probably eligibility. A letter will be mailed to patients notifying them of their eligibility status. Following preliminary approval, patients must submit a completed application and any supporting documentation requested (if not done previously). Upon final approval, a financial assistance discount will be applied to the patient's responsibility.

d. Patients who are beneficiaries/recipients of certain means-tested social services programs are deemed to have presumptive eligibility at 100% and are FA eligible without the completion of an application or submission of supporting documentation. It is the responsibility of the patient to notify the hospital that they are in a means-tested program. This information may also be obtained from an outsourced vendor or other means available to PRMC.

e. A patient that has qualified for Maryland Medical Assistance is deemed to automatically qualify for Financial Assistance (FA) at 100%. The amount due from a patient on these accounts may be written off to FA with verification of Medicaid eligibility. Standard documentation requirements are waived.

f. The hospital may automatically approve Financial Assistance for accounts ready to be sent to a collection agency that are identified as Poverty based on the propensity to pay score.

g. If the application is ineligible, normal dunning processes will resume, which includes notifying the agency if applicable to proceed with ECA efforts. A copy of the Medical Center Collections Policy may be obtained by calling (410) 543-7436 or (877) 729-7762 and is available on the website listed above.

h. The patient may request reconsideration by submitting a letter to the Director of Patient Financial Services indicating the reason for the request.

i. Only income and family size will be considered in approving applications for FA unless one of the following three scenarios occurs:
   - The amount requested is greater than $50,000
   - The tax return shows a significant amount of interest income, or the patient states they have been living off of their savings accounts
   - Documentation indicates significant wealth

j. If one of the above three scenarios are applicable, liquid assets may be considered including:
   - Checking and savings accounts
   - Stocks and bonds
   - CD's
   - Money market or any other financial accounts for the past three months
   - Last year's tax return
   - A credit report may also be reviewed

   The following assets are excluded:
   - The first $10,000 of monetary assets
   - Up to $150,000 in a primary residence
   - Certain retirement benefits such as a 401-K where the IRS has granted preferential tax treatment as a retirement account including but not limited to deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans where the patient potentially could be required to pay taxes and/or penalties by cashing in the benefit.

   If the balance due is sufficient to warrant it and the assets are suitable, a lien may be placed on the assets for the amount of the bill. Collection efforts will consist of placement of the lien which will result in payment to the hospital upon sale or transfer of the asset. Refer to the Medical Center Collection policy on filing liens.

k. If the hospital has reason to believe the information is unreliable or incorrect, or obtained under duress, or through the use of coercive practices, FA may be denied.

l. We do not request or provide waivers, written or oral, expressing patient does not wish to apply for assistance.

Collection Coordinator

a. If eligible, and under $2,500, the account will be written off to FA when the "Request for Financial Assistance" form is finalized. A copy is retained in the patient's electronic file. If eligible, and the balance is $2,500 or above, the Collection Coordinator will obtain the appropriate adjustment signature(s).

b. PRMC will review only those accounts where the patient or guarantor inquire about FA, based on mailing in an application, or in the normal working of the account there is indication that the patient may be eligible. Any patient/customer service representative, financial counselor, or collection representative may begin the application process.

c. Once a request has been approved, service eight months before the approval and twelve months after the approval may be included in the adjustment. All encounters included with the application must reference the original encounter number where the electronic image of the application is stored. Service dates outside this twenty month window may be included if approved by a Supervisor, Manager, or Director. Any amount exceeding $5 that has already been collected from the patient or guarantor for approved dates of service shall be refunded to the patient if the determination is made within two years of the date of care.

d. PRMC will communicate with the patient using the method preferred by the patient including electronic communications, telephone or mail.

_____
Steven Leonard
President/CEO

_____
Bruce Ritchie
Vice President of Finance/CFO

PLAIN LANGUAGE SUMMARY

Financial Assistance Policy

It is the intention of Peninsula Regional Medical Center (PRMC) to make available to all patients the highest quality of medical care possible within the resources available. If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies, or, if no help is available, to render care at a reduced or zero cost for emergency and medically necessary care.

Patients requiring elective services may, through consultation with their physician, have their procedure postponed until such time as the patient is able to make full payment or meet the established deposit. Elective procedure patients who, according to their diagnosis and/or their physician, cannot have their procedure postponed will be helped with obtaining assistance from agencies. If no assistance is available, and the patient requests, the account will be reviewed for possible financial assistance.

Peninsula Regional Medical Group (PRMG) physician charges are not included in the hospital bill and are billed separately, with the exception of self-pay balances. Self-pay balances for hospital services and PRMG services will appear on the same statement. Physician charges outside of the PRMG group are not included in the hospital bill and will be billed separately. Physician charges outside of PRMG are not covered by Peninsula Regional Medical Center's financial assistance policy. A list of providers that deliver emergency and other medically necessary care at PRMC is provided on the website at www.peninsula.org/prmg, indicating which providers are covered under PRMC's financial assistance policy and which are not, or you may call (410) 912-4974.

In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, the patient may be eligible for financial assistance.

Eligibility Determination Process

1. Interview patient and/or family.
2. Obtain annual gross income.
3. Determine eligibility *(preliminary eligibility within 2 business days).*
4. Screen for possible referral to external charitable programs.
5. If the patient and/or family refuse to disclose financial resources or cooperate, the patient will be subject to standard collection efforts. No Extraordinary Collection Actions (ECA) will be taken for at least 120 days from the first post-discharge billing statement.
6. All applications received within 240 days of the first post-discharge billing statement will be reviewed. ECA actions will be suspended until the application has been processed.
7. The determination of eligibility *(approval or denial)* shall be made in a timely manner.

How to Apply

- Applications can be taken orally by calling (410) 912-6957 between 8:00 a.m. and 5:00 p.m., Monday through Friday
- In person at the Financial Counselor's office (located in the Frank B. Hanna Outpatient Center lobby) between 8:00 a.m. and 4:00 p.m., Monday through Friday
- Mailing a request for an application to Peninsula Regional Medical Center, PO Box 2498, Salisbury, MD 21802-2498
- On the internet at https://www.peninsula.org/patients-visitors/patient-forms or https://www.peninsula.org/patients-visitors/patient-billing-information
- Applications are available in English and in Spanish

Qualifications

Peninsula Regional Medical Center compares the patient's income to the Federal Poverty Guidelines. In order to process your application we require the following information:

- An independent third party to verify your household income (one of the following)
  a. Recent pay stub showing current and year-to-date earnings
  b. Most recent tax return showing your Adjusted Gross Income or W-2 form
  c. Written documentation of Social Security benefits, SSI disability, VA benefits, etc.
  d. If no income, a letter from an independent source such as a clergy or neighbor verifying no income
- Completed application

This information, and any information obtained from external sources, is used to determine your eligibility for financial assistance. The more information provided, the easier it is for us to determine your financial need. Peninsula Regional may request a credit report to support a patient's application for assistance.

Need Assistance?

If, at any time, you have questions about obtaining financial assistance, your hospital bill, your rights and obligations with regard to the bill, or applying for the Medical Assistance Program, please contact Peninsula Regional Medical Center's Financial Services Department at (410) 912-6957 or (877) 729-7762. You can obtain a copy of the PRMC Financial Assistance Policy at https://www.peninsula.org/patients-visitors/patient-billing-information/financial-assistance-documents.

Medical Assistance Program

To find out if you are eligible for Maryland Medical Assistance or other public assistance, please apply at your local Department of Social Services (DSS) office, or you may visit mmcp.dhmh.maryland.gov for information about the various Medicaid programs available. You may apply online for Maryland Medicaid at marylandhealthconnection.gov. If you are applying for assistance for a child or are pregnant, you may apply for the Maryland Children's Health Program (MCHP). If you are only applying for assistance with paying your Medicare premiums, co-payments, or deductibles, you may apply at your local Department of Social Services (DSS) for the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) Program. QMB/SLMB applications may be filed by mail or in person. Delaware residents may obtain information online at dhss.delaware.gov or apply online at assist.dhss.delaware.gov. Virginia residents may obtain information at dmas.Virginia.gov. To receive an application, call your local DSS office or the Area Agency on Aging, (AAA). For more information, you may call the Department of Health and Mental Hygiene's Recipient Relations Hotline at 1 (800) 492-5231 or (410) 767-5800.

Patients' Rights and Obligations

Rights:

- Prompt notification of their preliminary eligibility determination for financial assistance.
- Guidance from Peninsula Regional on how to apply for financial assistance and other programs which may help them with the payment of their hospital bill.
- Receipt of financial assistance for all services not payable by another program that meet the qualifications of Peninsula Regional's Financial Assistance Policy.
- Peninsula Regional Medical Center (PRMC) will provide emergency and medically necessary free and/or reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of their hospital bill.

Obligations:

- Submit complete and accurate information on the Uniform Financial Assistance Application in use in the state of Maryland.
- Attach supporting documentation and return the form to Peninsula Regional Medical Center in a timely manner.
- Make payment in full or establish a payment plan for services not qualified under Peninsula Regional's Financial Assistance Policy.

Cómo hacer la solicitud

- Llame al (410) 912-6957 o (877) 729-7762 entre las 8:00 a.m. y las 5:00 p.m., de lunes a viernes
- Acuda en persona a la oficina del consejero financiero (Localizado en el vestibulo Frank B. Hanna del Centro de attencion de Pacientes Externos) entre las 8:00 a.m. y las 4:00 p.m., de lunes a viernes
- A través de Internet, visite www.peninsula.org. Haga clic en Patients & Visitors (Pacientes y vistantes), luego en Patient Financial Services (Servicios financieros para pacientes) y después en Billing Information (Información de facturación)

2019 Federal Poverty Guidelines
Updated 04/09/2019

If your family size is:	And, your family income is at or below:		
Family Size	200% Federal Poverty Guideline	201% up to 300% Federal Poverty Guideline	301% - 500% Federal Poverty Guideline with Medical Hardship
1	$24,980	$37,470	$62,450
2	$33,820	$50,730	$84,550
3	$42,660	$63,990	$106,650
4	$51,500	$77,250	$128,750
5	$60,340	$90,510	$150,850
6	$69,180	$103,770	$172,950
7	$78,020	$117,030	$195,050
8	$86,860	$130,290	$217,150
You receive a discount off PRMC bills of:	100%	50%	25%

MARYLAND STATE UNIFORM FINANCIAL ASSISTANCE APPLICATION

Information About You

Name: _____
First Middle Last

Social Security Number _____-____-_____ Marital Status: Single Married Separated
US Citizen Yes No Permanent Resident: Yes No

Home Address _____

_____

_____ _____
City State Zip Code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip Code

Household Members:

Name	Age	Relationship

Have you applied for Medical Assistance ? Yes No
If yes, what was the date you applied? _____
If yes, what was the determination _____

Do you receive any state or County Assistance? Yes No

PRMC – Patient Accounts
100 East Carroll Street
Salisbury, MD 21801

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/Pension Benefits	_____
Social Security Benefits	_____
Public Assistance Benefits	_____
Disability Benefits	_____
Unemployment Benefits	_____
Veterans Benefits	_____
Alimony	_____
Rental Property Income	_____
Strike Benefits	_____
Military Allotment	_____
Farm or Self-Employment	_____
Other Income Source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking Account	_____
Savings Account	_____
Stocks, Bonds, CD, or Money Market	_____
Other Accounts	_____
Total	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____		Approximate Value_____
Automobile	Make _____	Year_____	Approximate Value_____
Additional Vehicle	Make _____	Year_____	Approximate Value_____
Additional Vehicle	Make _____	Year_____	Approximate Value_____
Other Property			Approximate Value_____
	Total		_____

IV. Monthly Expense

	Amount
Rent or Mortgage	_____
Utilities	_____
Car Payment(s)	_____
Credit Card(s)	_____
Car Insurance	_____
Health Insurance	_____
Other Medical Expenses	_____
Other Expenses	_____
Total	_____

Do you have any other unpaid medical Bills? Yes No
For what service? _____
If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within 10 days.

Applicant Signature _____ Date _____

Relationship to Patient _____

PA-059 (12/05)

EXHIBIT 5

Somerset County, Maryland
2017 - 2018
Community Health Needs Assessment

Prepared by:

BEACON
Business Economic and Community Outreach Network
At Salisbury University

Somerset County Community Health Needs Assessment

Table of Contents

EXECUTIVE SUMMARY

The Somerset County Health Department and McCready Foundation partnered with the Business Economic and Community Outreach Network (BEACON) to sponsor a Health Needs Assessment in Somerset County, Maryland. The goal of this needs assessment was to identify the health concerns of residents and barriers they encounter in accessing health care.

A mixed method approach was used to assess the needs, identify resources, and identify opportunities for intervention. With assistance from the Somerset County Health Department and the McCready Foundation Inc., the BEACON team conducted in-depth key informant interviews focus groups accessing over 102 opinion leaders. The BEACON team also accessed secondary data and information from public sources to provide the background and context for the in-depth interviews.

The interviews and focus groups were conducted using questions involving the identification, discussion, and/or explanation of health concerns, health trends, and potential methods of prevention or improvement of health concerns in Somerset County.

Based on the interviews and focus groups, poverty, low health literacy, transportation barriers, financial constraints, and lack of insurance coverage emerged as the biggest barriers to accessing health care in Somerset County. In addition, obesity and diabetes were identified as major public health concerns for the county. The study participants discussed the lack of exercise programs and weight loss resources in the community. Most study participants listed the Somerset County Health Department as the best source of healthcare information in the county. Finally, the study participants offered the following recommendations to reduce risk factors and improve health outcomes in Somerset County:

1. Seeking Additional Resources (Primarily funding but also volunteers);
2. Pooling Resources within Somerset County and Regionally;
3. Focusing more on Education, Outreach, and Prevention;
4. Strengthening Partnerships (i.e. Faith and Community Based Organizations);
5. Breaking down silos and allocating funding to patients not the providers;
6. Enhancing Case Management.

INTRODUCTION

Somerset County, one of the 24 jurisdictions of the State of Maryland[1], is located on the Eastern Shore of Maryland, between the Chesapeake Bay and the Atlantic Ocean. The County has an estimated population of about 26,000, with 54% being White, 42% African American, 3.6% Hispanic; 2.4% Multiracial; and 0.9% Asian.[2]

Somerset County residents have to contend with a number of health needs that exceed the available resources to address them. The County has been ranked 19th out of 24 in length of life based on years of potential life lost before age 75 per 100,000 population. With the highest percentage of children in poverty throughout the state of Maryland (36% under age 18); the highest rate of obesity in Maryland (42% with BMI >30), and a 24.1% smoking rate among adults, the County's health needs are significant. There are over 3,000 residents for each primary care physician in the County putting it last in the State of Maryland.[3]

This study is an attempt to better quantify and qualify the community health needs in Somerset County, and to identify the limitations, barriers, and gaps that impact health outcomes in the County.

[1] http://msa.maryland.gov/msa/mdmanual/01glance/html/county.html
[2] https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml#
[3] http://www.countyhealthrankings.org/app/maryland/2017/rankings/somerset/county/outcomes/overall/snapshot

STUDY METHODOLOGY

A Community Health Needs Assessment is a method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve public health and reduce inequalities.[4] These assessments can be used to identify gaps between current health status and those desired, and to categorize such gaps via level of importance and source of influence (environmental, behavior, genetic, or healthcare). Health needs assessments have many benefits, including the development of strategies to address health care needs in the community, strengthened community involvement in decision making, improved communication with agencies and the public in the community, a snapshot of the health needs of an entire community, and better use of resources.

Limitations of a needs assessment are introduced once the method of research is chosen; i.e. quantitative versus qualitative. Quantitative research methods of assessment are objective, number-based, and generalizable. This method is used to test concepts, constructs, and hypothesis of a theory; examples include surveys, structured interviews, observations, and reviews of records or documents for numeric information. Qualitative research methods are subjective, text-based, and less generalizable. Qualitative research is used to formulate a prediction; examples include focus groups, in-depth interviews and brainstorming.[5]

[4] https://www.k4health.org/sites/default/files/migrated_toolkit_files/Health_Needs_Assessment_A_Practical_Guide.pdf
[5] http://www.orau.gov/cdcynergy/soc2web/Content/phase05/phase05_step03_deeper_qualitative_and_quantitative.htm

This study combines quantitative and qualitative approaches. In addition to a thorough review of the most recent federal, state, and local data sets pertaining to Somerset County's health needs and health outcomes, the BEACON Team has conducted a series of opinion leader and key stakeholder interviews as well as focus groups with key health care professionals, elected and appointed officials, business and economic development decision makers, emerging community leaders, and other key informants. The process included data collection from 102 unique individuals over a three-month period in the fall of 2017. Such community-based recruiting of key informants is most successful when there is a partnership between the researchers and local community-based organizations such as health departments or hospitals. The BEACON Team is grateful to the support of the study sponsors Somerset County Health Department and the McCready Foundation, Inc. for assisting in recruiting these study participants. These key informants have provided in-depth insights to the BEACON Team in better understanding the data and the outcomes observed through the initial data analysis. The information gathered from the key informants interviewed was organized as follows:

1. *Primary community health needs in Somerset County;*
2. *Somerset County's key health outcomes;*
3. *Health care access, affordability, and inequality issues;*
4. *Key community health trends (improving/worsening);*
5. *Gaps in health needs versus available services;*
6. *Health Literacy Issues.*

ABOUT SOMERSET COUNTY

Somerset County is located on the Eastern Shore of Maryland, surrounded by Wicomico County, MD to the North; Worcester County, MD to the East; Accomack County, VA to the South, and the Chesapeake Bay to the West. It is one of 24 Maryland counties/jurisdictions. The county has a rural designation, as defined by the United States Census Bureau, hosting a population of less than 50,000 residents.[6] The County includes eleven towns: Chance, Crisfield, Dames Quarter, Deal Island, Eden, Fairmount, Frenchtown, Mount Vernon, Princess Anne, Smith Island, and West Pocomoke.[7] Somerset County has one hospital, three health care and social assistance clinics, and three nursing and residential care facilities.

Demographics

Somerset County is home to 26,000 residents. Racially, the county is majority white (54%); 43% black; 0.9% Asian, and less than 1% each of Native American and Hawaiian backgrounds. 3.6% of the residents identify themselves as Hispanic/Latino. The median age of the county is 37 years old. In 2016, the Somerset County median household income was just under $36,000 with 24.3% of the population living in poverty. Housing problems are an issue, with around 24% of all households (highest in Maryland) experiencing one or more of the following challenges: overcrowding, high housing costs, or lack of kitchen or plumbing facilities. A more detailed demographic profile of the County is presented on the following page in Table 1.

[6] https://storymaps.geo.census.gov/arcgis/apps/MapSeries/index.html?appid=9e459da9327b4c7e9a1248cb65ad942a
[7] http://maryland.hometownlocator.com/counties/cities,cfips,039,c,somerset.cfm

Table 1: Demographic Profile of Somerset County

SOMERSET COUNTY DEMOGRAPHICS	
Population	
Population estimate, July 1, 2016	25,928
Persons under 5 years, percent, July 1, 2016	4.80%
Persons under 18 years, percent, July 1, 2016	17.20%
Persons 65 years and over, percent, July 1, 2016	16.00%
Female persons, percent, July 1, 2016	46.30%
Race and Hispanic Origin	
White alone, percent, July 1, 2016	53.90%
Black or African American alone, percent, July 1, 2016	42.30%
American Indian and Alaska Native alone, percent, July 1, 2016	0.40%
Asian alone, percent, July 1, 2016	0.90%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2016	0.10%
Two or More Races, percent, July 1, 2016	2.40%
Hispanic or Latino, percent, July 1, 2016	3.60%
White alone, not Hispanic or Latino, percent, July 1, 2016	51.40%
Population Characteristics	
Veterans, 2012-2016	1,813
Foreign born persons, percent, 2012-2016	5.10%
Housing	
Housing units, July 1, 2016, (V2016)	11,420
Owner-occupied housing unit rate, 2012-2016	64.40%
Median value of owner-occupied housing units, 2012-2016	$131,800
Median selected monthly owner costs -with a mortgage, 2012-2016	$1,218
Median selected monthly owner costs -without a mortgage, 2012-2016	$482
Median gross rent, 2012-2016	$667
Building permits, 2016	25
Families & Living Arrangements	
Households, 2012-2016	8,328
Persons per household, 2012-2016	2.32
Living in same house 1 year ago, percent of persons age 1 year+, 2012-2016	81.40%
Language other than English spoken at home, percent of persons age 5 years+, 2012-2016	7.40%

Source: U.S. Census Bureau

Education

In 2017, Somerset County had just under 3,000 students enrolled in K-12 classes. Approximately 450 of these students were in Pre-K and Kindergarten; 1,135 of them were in elementary school; 625 in Middle school, and 730 in high school. The County has two Head Start Centers (Princess Anne and Crisfield) and one private school (Holly Grove Christian). Overall, 80.5% of the County's population are high school graduates or higher. College graduates with Bachelor's degrees or higher comprise about 15% of the County population.

Economy

In 2017, Somerset County had a total labor income of $415 million. The Median household income in the County is $35,154 and the Average household income is $49,530. At $16,631, Somerset County's per capita income is the lowest in the State of Maryland.

Somerset County has a civilian labor force of 9,234 with 8,586 of them employed and 648 unemployed. The unemployment rate is 7% which is the highest in the State of Maryland (almost 3% higher than the state average). Close to half of County residents commute outside the County for work. A list of the major employers in the County can be seen on the following page, in Table 2. Please note that this list excludes post offices, state and local governments, national retail and national foodservice establishments. In fact, there are close to 3,000 federal, state, and local government employees working in 43 government establishments in Somerset County, making public service jobs the largest employment category. Median hourly wages in Somerset County range from the minimum wage up to $39.85 per hour depending on education, experience and employment sector. However, in most categories, these median wages put the County at the bottom in the State of Maryland.

Table 2: Major Employers in Somerset County

Employer	Product/Service	Employment
University of Maryland Eastern Shore (UMES)	Higher education	930
Sysco Eastern Maryland	Food products distribution	450
Somerset Community Services	Services for the disabled	425
McCready Health	Medical services	300
Aurora Sr. Living of Manokin	Nursing care	175
Sherwin Williams / Rubberset	Paint brushes	150
Southern Connection Seafood**	Seafood processing, distribution	130
Three Lower Counties	Medical services	105

Source: Maryland Department of Commerce

Housing and Transportation

Somerset County has close to 8,500 occupied housing units of which 64.8% are owner occupied. Over 2,500 units are either currently vacant or abandoned. The median value of owner occupied housing units is slightly over $130,000 with a median mortgage amount of $736. The median non-mortgage owner costs are over $480. The median gross rent is $667.

Somerset County is served by US Route 13, a major North-South artery and a speed limited railroad for freight. The County has access to water transportation via the Ports of Salisbury and Baltimore. In addition, the Crisfield Harbor serves smaller vessels. Scheduled air service available at Salisbury-Ocean City Wicomico Regional Airport, 16 miles from Princess Anne; Crisfield Airport has one 2500’ x 75’ paved, lighted runway, and one 3350’ x 100’ grass

runway. Transit services are provided by Shore Transit, a regional public transportation system.

Crime, Safety, and Disaster Preparedness

Violent crime in Somerset County is relatively low at under 280 per 100,000 population. However, property crime rates are above state averages at close to 1,500 per 100,000 population.

The Somerset County Department of Emergency Services has the mission of coordinating the resources necessary to respond to an emergency. On a daily basis, this occurs through the 9-1-1 Emergency Communications Center. For large scale events the Emergency Operations Center coordinates emergency management services. This agency is the lead agency in the County for emergency management planning, response, mitigation and recovery. This office is responsible for the Emergency Operations Center, the County Emergency Operations Center, the County Emergency Operations Plan, and the Hazardous Materials Regulatory Program.

Other Societal and Geographic Factors

Based on its demographic, education, economic, and workforce profiles, Somerset County ranks at the bottom 5% of U.S. counties. In addition, proximity to Worcester County with Ocean City and Wicomico County with Salisbury means that a large number of the higher income workers in the County live in these two contiguous counties, creating a leakage of

the economic impact or their earnings. This, in turn, exacerbates the resource limitations in the County for dealing with residents' needs, including healthcare.

Overview of Community Health Needs in Somerset County

In 2017, Somerset County was ranked 22nd out of 24 in health outcomes and 23rd in health risks. Some of the key statistics for the County were:

Factor	Somerset	Maryland
Poor or fair health	20% of the Population	13% of the population
Poor physical health days	4.5	3.5
Poor mental health days	4.2	3.4
Low birthweight	8% of births	9% of births
Premature age-adjusted mortality	430	320
Child mortality	130	50
Infant mortality	9 per 1000 Live Births	7 per 1000 Live Births
Frequent physical distress	14% of the population	11% of the population
Frequent mental distress	13% of the population	11% of the population
Diabetes prevalence	14% of the population	10% of the population
HIV prevalence	634 per 100,000 pop.	641 per 100,000 pop.

Source: http://www.countyhealthrankings.org – A Robert Wood Johnson Foundation Program

In addition, the Maryland Department of Health's Office of Minority Health and Health Disparities has identified ten of fifteen elevated indicators for health disparities including percent of families in poverty, substance abuse treatment rate, teen birth rate, and Medicaid enrollment rate. 11% of the population under age 65 in Somerset County is uninsured. The county holds an unemployment rate of 6.1% as of August 2017. There were 20% of families and people whose income were below the poverty line in 2015.[8]

[8] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

Access to Healthcare in Somerset County

In addition to the offerings of the Somerset County Health Department (See: https://somersethealth.org/ for a comprehensive listing), the McCready Health organization offers the following services:

- 24 Hour emergency services at McCready Hospital;
- Immediate care/lab & imaging services at Princess Anne;
- A behavioral health addictions program and a NA support group;
- Assisted living & nursing home/skilled nursing (including rehab and wound care);
- Medical-surgical care;
- PT, OT, and Speech Therapy;
- Pulmonary Rehab;
- Pain Clinic, and
- A free or $5 flu shots service each season.

McCready has providers in internal medicine, occupational health and surgery (full-time); pediatrics, cardiology, gynecology and podiatry (by appointment or set days per week or month). There is also a PA and/or LPN who goes to Smith Island two times a month to see patients.

In spite of these offerings, virtually all study participants ranked access to healthcare in the County as one of their top three critical concerns. Many have also noted that the proximity of Wicomico County with a much higher concentration of healthcare facilities as a positive factor. However, these same respondents agreed that to a rural population with economic, workforce, and transportation challenges, this proximity may not be the optimal solution.

Limited number of physicians, clinics, offices, urgent care centers, and the sparsely populated rural nature of the County (transportation barriers) were also mentioned as access challenges.

Healthcare Affordability in Somerset County

In Somerset County, 13% of adults are without health insurance, compared to 11% in Maryland as a whole. In children, these rates are 4% for the County compared to 3% in the State. The older residents with access to Medicare, the low-income residents with access to Medicare and other affordable options, and a large number of government employees in the County with employer subsidized health insurance prevent these percentages from being worse than they are. However, affordability of wellness and nutrition programs, medication, co-pays, and other out-of-pocket costs make this issue a growing problem for County residents. When combined with low access to and/or low availability of services, Somerset County's low rankings are easier to understand.

Nature and Scope of Healthcare Services in the County

During the key-informant interviews, the lack of an adequate number of healthcare facilities and professionals in the County was a very common reason given for the troublesome health outcomes. In addition, about one in three key informants identified the limited scope of services in existing facilities as a cause for concern. These respondents linked the low numbers and limited scopes to the lack of resources and the nature of a sparsely populated

region where it is not easy to reach a critical mass of clients to absorb the high cost of these services. Some key service statistics are:

Factor	Somerset	Maryland
Primary care physicians	3,230:1	1,130:1
Dentists	740:1	1,350:1
Mental health providers	500:1	490:01:00
Preventable hospital stays	55	46
Diabetes monitoring	84% (65-75 Yr. Old)	85% (65-75 Yr. Old)
Mammography screening	67% (67-69 Yr. Old)	64% (67-69 Yr. Old)

Source: http://www.countyhealthrankings.org – A Robert Wood Johnson Foundation Program

Healthcare Literacy

While most of the respondents listed low health literacy as a contributing factor to Somerset County's low health outcome and risk factor rankings, they also acknowledged the efforts of the County's Health Department in improving residents' access to health information. In addition, the collaborative efforts of the Health Department and of MrCready Health with the County's public schools, faith and community based organizations, and with various government agencies operating in the County were cited as key strategies for increasing health literacy. There was consensus that such activities suffer from fairly significant resource limitations. Without adequate outreach and education, the community health literacy levels are bound to remain low and, consequently, the various health risk factors are bound to be negatively impacted. Some of the key risk factors that

these health literacy outreach/education activities target (to build awareness and to reduce risks) were identified as follows:

Factor	Somerset	Maryland
Adult smoking	20%	15%
Adult obesity	42%	29%
Food environment index	5.6	8.2
Physical inactivity	31%	22%
Access to exercise opportunities	13%	93%
Excessive drinking	16%	16%
Alcohol-impaired driving deaths	20%	33%
Sexually transmitted infections	570.9	462.6
Teen births	29	25
Food insecurity	20%	13%
Limited access to healthy foods	11%	3%
Drug overdose deaths	18	18
Motor vehicle crash deaths	9	9
Insufficient sleep	43%	39%

Behavioral Health, Alcohol and Substance Abuse, and Alzheimer's/Dementia

There are four Behavioral Health Providers, one Recovery & Re-entry Center, and zero treatment beds in Somerset County. Dementia patients and their caregivers can be referred to an agency in Cambridge, MD that provides Dementia respite care. The local Area Agency on Aging (MAC) does not accept dementia patients due to risk of "walking off"; also clients need to toilet independently to attend. Adult Medical Day Care may be a resource to some; but the nearest facility is in Salisbury, MD and comes with a cost for some. There are currently no local support groups. McCready hospital has treated 164 patients with a primary or secondary diagnosis of dementia in the latest six month period.

Most of the key informants interviewed (78 out of 102) expressly linked the major behavioral health issues in Somerset County first to substance and alcohol abuse and secondarily to aging related depression and dementia concerns. Other issues voiced by the respondents included lack of counseling for kids and young adults. When asked what prevention measures are appropriate to these behavioral health problems, respondents gave mixed opinions. Access and affordability, stigma, lack of awareness of services available were all listed as major concerns. Some of the concerns include Excessive Drinking Prevalence. For Somerset County, this number has gone from around 10% of the population in 2015 to over 16% of the population in 2017. Deaths in Somerset County attributable to substance abuse, while low, are on the rise. In 2016 the Maryland Department of Health reported that Age Adjusted Death Rates for Total Unintentional Intoxication Deaths in Somerset County had reached 16.9 per 100,000 population, putting the county in the middle of the 24 jurisdictions of Maryland. Overall, approximately 24% of Somerset residents have Anxiety related conditions. On a slightly positive note, Alzheimer's and other dementia related conditions afflict approximately 2% of Somerset County residents which puts the County towards the bottom of Maryland jurisdictions.

Tobacco Cessation

The key informants have noted that Somerset County's tobacco cessation efforts have been effective. However, they also acknowledge that the County's smoking rate of 20% is 50% higher than that of the Maryland average. Diminishing resources, language barriers, and access to cessation services were identified as barriers to further success.

Diet and Obesity

The adult obesity rate in Somerset County is over 42%. This rate is nearly 50% higher than the Maryland rate. One of the reasons for this is the low Food Environment Index number in the county. The Food Environment Index ranges from 0 (worst) to 10 (best) and equally weights two indicators of the food environment:

1. Limited access to healthy foods -- estimates the percentage of the population that is low income (200% of the federal poverty threshold) for the family size) and does not live close to a grocery store (more than 10 miles).

2. Food insecurity estimates the percentage of the population who did not have access to a reliable source of food during the past year.

The Food Environment in Somerset County is rated at 32% below the state average. In addition, almost a third of county residents do not get adequate physical exercise, exacerbating the obesity problem. Combined, these factors lead to increased negative health outcomes through Cardio Vascular Diseases, Diabetes, Cancer, Joint Disease, and other conditions (which are discussed further in the following sections).

Cardio Vascular Diseases

The Maryland Department of Health estimates Age Adjusted Cardio Vascular Mortality per 100,000 population in Somerset County is close to 300 and increasing while this same ratio for the state as a whole is under 200 and falling. The study participants attribute the high

numbers to (in descending order) obesity, lack of exercise, diabetes, health literacy, and access issues.

Cancer

The National Cancer Institute estimates that in 2017, the Somerset County Cancer deaths will be under 500 per 100,000 population. The good news is that this number reflects a downward trend of about 5% over the past five years. The age adjusted incidence rate per 100,000 population for some major cancer types are as follows:

Cancer Type	Somerset	Maryland
Lung	97.6	56.4
Colorectal	60.2	35.8
Breast	40.7	125.0
Prostate	117.3	112.0
Melanoma	18.9	20.7

Just as in the case for Cardio Vascular Diseases, the study participants attribute these incidence rates to obesity, lack of exercise, health literacy, and access issues.

Diabetes

According to the data compiled by Dartmouth College for all U.S. jurisdictions, Somerset County had just under 700 patients between the ages of 65 and 75 that received treatment for diabetes. About 30% of these patients were African-American. In 2016, these patients were given over 350 eye exams, just under 500 hemoglobin tests, and over 450 lipid tests as

part of their diabetes care. All these numbers were growing at a slightly higher rate than the population growth in this age group. The difference, however, was not statistically significant. The study participants list (in descending order) obesity, lack of exercise, health literacy, and access issues as factors that contribute to the incidence of diabetes and related ailments in Somerset County. They also list the high (estimated) number of undiagnosed cases as well as the high number of pre-diabetes cases as major concerns.

Infectious Diseases and Immunization

According to the data compiled by the Maryland Department of Health, Tuberculosis Incidence rates per 100,000 in Somerset County was 3.8 compared to 4.9 in Maryland as a whole. For Chlamydia, the Somerset rate was 835.6 compared to 437.9 in Maryland. For Gonorrhea, the Somerset rate was 115.0 compared to 118.3 in Maryland. A particularly bright spot was the rate for HIV/AIDS cases in Somerset at 17.7 versus 46.6 in Maryland.

On the immunization front, based on data from County Health Rankings, a Robert Wood Johnson Foundation Program, Somerset County rates were similar to or even better than those for other jurisdictions in Maryland. For example, the average % of Kindergarten Students Immunized in Somerset County was 100.0 compared to 99.3% in Maryland. Adults Receiving Flu Shots in Somerset County were 37.4% of the population compared to 38.5% in Maryland. Finally, adults receiving Pneumonia Shots were 29.5% of the County population compared to 24.7 in Maryland.

Maternal and Child Health

The key informants taking part in this needs assessment rated Somerset County's Maternal and Child Health services as being adequate and praised the County Health Departments outreach and partnership efforts. However, slightly more than half of the participants were concerned about the limited resources available for education, outreach and prevention efforts. In addition, about a third of the participants were concerned that health literacy issues and language barriers were adding to these problems.

Environmental Health

The bulk of the environmental health services in the county are provided by the Somerset County Health Department. These include reviews, approvals, and inspections of private septic systems and wells; testing well waters; reviewing and approving commercial development and subdivisions; licensing and inspecting food service facilities (restaurants, grocery stores, bars, mobile food trucks, food services at fairs & events, and bed and breakfasts); licensing and inspecting public swimming pools to monitor health and safety conditions; conducting Rabies investigations and offering vaccination clinics; approving burn permits, and land plat reviews. About a third of the key informants participating in this community health assessment listed agriculture as a concern for environmental health. Water and air pollution were listed as being linked to agriculture. However, the participants also recognized the progress that was made on these issues over the past 20 years.

Oral Health

According to the Maryland Department of Health, more than half of Somerset County residents have not seen an oral health professional in the past 12 months. This is compared to slightly over a quarter of the residents of the State of Maryland. About a fifth of the study participants were concerned about the link between bad oral health and other diseases such as Cardio Vascular ailments. It should also be noted that the lack of adequate dental care offerings (Chesapeake Health plus three solo practitioners) in the county was mentioned by half of the participants. McCready hospital has treated 111 patients in the most recent six months with a primary dental diagnosis.

SNFs, Extended Care Organizations, and End-of-Life Care

The key informants taking part in this needs assessment praised the activities of the two Skilled Nursing Facilities in the County (Princess Anne and Crisfield) but also noted the growing need for elder care and memory care beds. They also discussed the lack of resources, long-term care insurance coverage and access/affordability barriers to such care in the county. The participants also praised the outreach efforts of Coastal Hospice in Somerset County. They noted that in the sparsely populated rural Somerset County, it may not be economically viable to have a stand-alone end-of-life facility. Finally, Adult Evaluation services (AERS) of the Somerset County Health Department was listed as a valuable service. AERS provides assistance to aged and functionally disabled adults who are at risk of institutionalization. AERS staff conducts a comprehensive evaluation to identify services available to help the individual to remain in the community, or in the least

restrictive environment, while functioning at the highest possible level of independence and personal well-being (See: https://somersethealth.org/programs/community-health-nursing/aers-adult-evaluation-review/).

Care Giver Needs

As the population of Somerset County ages, it is increasingly becoming common for family members to become primary care givers to their aging relatives. Frequently, these care givers are having to withdraw from the workforce, putting additional burdens on the households involved. The key informants taking part in this needs assessment noted that the lack of respite care, limited options for training care givers, and difficulties in securing adult medical and non-medical day care issues as additional concerns.

Conclusions and Recommendations

The findings discussed in this report have been summarized in a dashboard format in APPENDIX A (Somerset County Community Health Needs Dashboard). The dashboard provides a composite score (from 1 Low to 5 High) for each factor and color codes the trend for each factor. Finally, a comparison with Maryland averages is made for each factor, also color coded. County Scores and Trends are based on the key informant interview findings. Comparisons with Maryland outcomes were determined on the basis of these interview findings as well as the data from the 2017 County Health Rankings for Maryland (http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2017_MD.pdf).

The key informants taking part in this needs assessment listed the rural nature of Somerset County, the low population density, poverty, low educational outcomes, lack of adequate healthcare services and professionals, and low health literacy as the major challenges. They praised the efforts of the County Health Department and the McCready Health organization against this background high risk factors and low outcomes. When asked for recommendations for improvement, the participants listed the following solutions:

1. Seeking Additional Resources (Primarily funding but also volunteers);
2. Pooling Resources within Somerset County and Regionally;
3. Focusing more on Education, Outreach, and Prevention;
4. Strengthening Partnerships (i.e. Faith and Community Based Organizations);
5. Breaking down silos and allocating funding to patients not the providers;
6. Enhancing Case Management.

These solutions (in descending order of emphasis) were compiled from respondent comments provided on open ended questions.

APPENDIX A - Somerset County Community Health Needs Dashboard

FACTOR	Somerset County Score 5 HIGH … 1 LOW	Trend WORSE FLAT BETTER	Compared to MD WORSE SAME BETTER
Overall County Health Outcomes	1.25	WORSE	WORSE
Access to Healthcare	2.11	BETTER	WORSE
Healthcare Affordability	2.21	FLAT	WORSE
Nature and Scope of Healthcare Services	1.94	FLAT	WORSE
Healthcare Literacy	1.78	FLAT	WORSE
Behavioral Health,	2.08	WORSE	WORSE
Alcohol Abuse	1.34	WORSE	WORSE
Drug Abuse	1.11	WORSE	SAME
Tobacco Addiction	1.75	FLAT	WORSE
Nutrition	1.67	FLAT	WORSE
Obesity	1.70	WORSE	WORSE
Cardio Vascular Diseases	1.39	WORSE	WORSE
Cancer	1.02	WORSE	WORSE
Diabetes	1.38	WORSE	WORSE
Infectious Diseases	2.60	BETTER	SAME
Immunization	4.00	BETTER	BETTER
Maternal and Child Health	3.78	BETTER	SAME
Environmental Health	3.51	BETTER	SAME
Oral Health	1.25	WORSE	WORSE
SNFs, Extended Care Organizations	4.00	FLAT	WORSE
Palliative Care	2.60	FLAT	WORSE
End-of-Life Care	2.60	FLAT	WORSE
Care Giver Needs	1.25	FLAT	SAME

NOTE: County Scores and Trends are based on the key informant interview findings. Comparisons with Maryland outcomes were determined on the basis of these interview findings as well as the data from the 2017 County Health Rankings for Maryland (http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2017_MD.pdf).

EXHIBIT 6

Consolidated Financial Statements,
Supplementary Information and Report of
Independent Certified Public Accountants

Peninsula Regional Health System, Inc.

June 30, 2018 and 2017

Contents

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Report of Independent Certified Public Accountants

Board of Trustees
Peninsula Regional Health System, Inc.

We have audited the accompanying consolidated financial statements of Peninsula Regional Health System, Inc. and subsidiaries (the "Health System"), which comprise the consolidated balance sheet as of June 30, 2018, and the related consolidated statements of operations and changes in net assets and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's responsibility for the financial statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We did not audit the financial statements of a joint venture of Peninsula Health Ventures, Inc., a wholly owned subsidiary of the Health System. The joint venture is Delmarva Surgery Center, LLC. ("Delmarva"), which reflects total assets and total revenues constituting 2.6% and 1.8%, respectively, in 2018 of the related consolidated totals. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Delmarva, is based solely on the report of the other auditors. Additionally, we did not audit the financial statements of Peninsula Imaging, LLC ("Imaging"), in which the Health System has a 50% interest. The Health System's investment in Imaging is $3.8 million as of June 30, 2018 and the Health System's equity in the excess of unrestricted revenue and other support over expenses of Imaging is $0.9 million for the year ended June 30, 2018. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Imaging, is based solely on the report of the other auditors. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Health System's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health System's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audit and the reports of other auditors, the 2018 consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Peninsula Regional Health System, Inc. and subsidiaries as of June 30, 2018 and the results of their operations and changes in net assets, and their cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Supplementary information

Our audit was performed for the purpose of forming an opinion on the 2018 consolidated financial statements as a whole. The accompanying 2018 consolidating information is presented for the purpose of additional analysis, rather than to present the financial position, results of operations and changes in net assets, and cash flows of the individual entities, and is not a required part of the consolidated financial statements. Such supplementary information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in our audit of the consolidated financial statements and certain additional procedures. These additional procedures include comparing and reconciling the information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the 2018 consolidating information is fairly stated, in all material respects, in relation to the 2018 consolidated financial statements as a whole.

Other matter

The consolidated financial statements of Peninsula Regional Health System, Inc. and subsidiaries as of and for the year ended June 30, 2017 were audited by other auditors. Those auditors expressed an unmodified opinion on those 2017 consolidated financial statements in their report dated September 27, 2017.

Grant Thornton LLP

Philadelphia, Pennsylvania

September 21, 2018

Peninsula Regional Health System, Inc.

Consolidated Balance Sheets
(In Thousands)

	June 30	
	2018	**2017**
Assets		
Current assets:		
Cash and cash equivalents	**$ 36,881**	$ 37,525
Short-term investments	**9,154**	6,899
Patient accounts receivable, less allowance for uncollectible accounts (2018 - $8,101; 2017 - $9,355)	**40,268**	39,105
Supplies	**9,782**	8,734
Prepaids and other	**7,081**	6,854
Total current assets	**103,166**	99,117
Investments	**311,657**	268,034
Assets limited as to use:		
Construction fund	**-**	760
Donor-restricted fund	**38,193**	33,267
Self-insurance fund	**25,195**	21,901
	63,388	55,928
Property and equipment, net	**225,361**	228,303
Other assets	**28,006**	24,840
Total assets	**$ 731,578**	$ 676,222

Peninsula Regional Health System, Inc.

Consolidated Balance Sheets (continued)
(In Thousands)

	June 30	
	2018	**2017**
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	**$ 2,281**	$ 2,172
Current portion of self-insured liabilities	**3,025**	2,495
Accounts payable	**17,334**	20,769
Accrued liabilities	**18,623**	13,730
Advances from third-party payors	**10,084**	9,806
Total current liabilities	**51,347**	48,972
Long-term debt, net	**135,931**	139,008
Self insured liabilities	**18,029**	17,071
Accrued pension	**-**	10,952
Other liabilities	**1,584**	4,393
Total liabilities	**206,891**	220,396
Net assets:		
Unrestricted:		
Peninsula Regional Health System, Inc.	**480,754**	418,548
Noncontrolling interest	**1,541**	1,900
Total unrestricted net assets	**482,295**	420,448
Temporarily restricted	**34,156**	27,123
Permanently restricted	**8,236**	8,255
Total net assets	**524,687**	455,826
Total liabilities and net assets	**$ 731,578**	$ 676,222

See accompanying notes.

Peninsula Regional Health System, Inc.

Consolidated Statements of Operations and Changes in Net Assets
(In Thousands)

	Year Ended June 30	
	2018	**2017**
Unrestricted revenue and other support:		
Net patient service revenue	**$ 446,145**	$ 425,802
Less: Provision for bad debts	**(9,165)**	(11,686)
Net patient service revenue less provision for bad debts	**436,980**	414,116
Other revenue	**5,625**	2,576
Total unrestricted revenue and other support	**442,605**	416,692
Expenses:		
Salaries and wages	**179,887**	175,710
Supplies and other expenses	**177,731**	192,798
Employee benefits	**43,553**	39,337
Depreciation	**29,120**	26,749
Interest	**5,660**	5,627
Total expenses	**435,951**	440,221
Income (loss) from operations	**6,654**	(23,529)
Nonoperating income:		
Investment income, net	**36,282**	16,608
Contributions and other	**862**	98
Total nonoperating income	**37,144**	16,706
Excess of (deficiency in) unrestricted revenue and other support over expenses	**43,798**	(6,823)
Non-controlling interest losses (earnings)	**315**	(82)
Excess of (deficiency in) unrestricted revenue and other support over expenses attributable to Peninsula Regional Health System, Inc.	**44,113**	(6,905)

(continued on next page)

Peninsula Regional Health System, Inc.

Consolidated Statements of Operations and Changes in Net Assets (continued)
(In Thousands)

	Year Ended June 30	
	2018	**2017**
Unrestricted net assets:		
Excess of (deficiency in) unrestricted revenue and other support over expenses attributable to Peninsula Regional Health System, Inc.	**$ 44,113**	$ (6,905)
Net assets released from restrictions, net	**(524)**	3,309
Change in unrealized gains and losses on investments	**-**	16,153
Changes in non-controlling interest	**(359)**	82
Pension adjustments	**18,617**	10,704
Increase in unrestricted net assets	**61,847**	23,343
Temporarily restricted net assets:		
Donations	**2,525**	2,324
Net realized gains on investments	**3,618**	1,506
Change in unrealized gains and losses on investments	**252**	1,742
Net assets released from restrictions, net	**638**	(3,507)
Increase in temporarily restricted net assets	**7,033**	2,065
Permanently restricted net assets:		
Net realized gains on investments	**18**	5
Change in unrealized gains and losses on investments	**1**	5
Net assets released from restrictions, net	**(38)**	-
(Decrease) increase in permanently restricted net assets	**(19)**	10
Increase in net assets	**68,861**	25,418
Net assets at beginning of year	**455,826**	430,408
Net assets at end of year	**$ 524,687**	$ 455,826

See accompanying notes.

Peninsula Regional Health System, Inc.

Consolidated Statements of Cash Flows
(In Thousands)

	Year Ended June 30	
	2018	**2017**
Operating activities		
Increase in net assets	**$ 68,861**	$ 25,418
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation expense	**29,120**	26,749
Pension adjustments	**(18,617)**	(10,704)
Provision for bad debts	**9,165**	11,686
Amortization of original issue premium	**(849)**	(836)
Amortization of financing costs	**54**	46
Equity in earnings of joint ventures	**(1,561)**	(1,713)
Losses (gains) on sale of property and equipment	**430**	(320)
Change in unrealized gains and losses on investments	**(10,162)**	(17,900)
Net realized gains on investments	**(26,487)**	(11,744)
Proceeds from restricted contributions	**(2,525)**	(2,324)
Changes in operating assets and liabilities:		
Patient accounts receivable	**(10,328)**	(8,557)
Supplies and other assets	**677**	(1,269)
Distributions from unconsolidated joint ventures	**3,444**	2,448
Accounts payable and accrued liabilities	**1,458**	1,475
Accrued pension	**2,488**	5,350
Other liabilities	**(1,321)**	(767)
Advances from third-party payors	**278**	(1,595)
Net cash provided by operating activities	**44,125**	15,443
Investing activities		
Change in investments and cash limited as to use	**(16,689)**	17,374
Investment in unconsolidated joint ventures	**(1,824)**	(2,414)
Purchases of property and equipment	**(26,609)**	(30,229)
Proceeds from disposal of assets	**1**	340
Net cash used in investing activities	**(45,121)**	(14,929)
Financing activities		
Proceeds from restricted donations	**2,525**	2,324
Repayments of long-term debt	**(2,173)**	(2,068)
Net cash provided by financing activities	**352**	256
Net (decrease) increase in cash and cash equivalents	**(644)**	770
Cash and cash equivalents at beginning of year	**37,525**	36,755
Cash and cash equivalents at end of year	**$ 36,881**	$ 37,525

See accompanying notes.

1. Organization and Mission

Peninsula Regional Health System, Inc. (the "Health System") serves as the parent company to Peninsula Regional Medical Center (the "Hospital"); Peninsula Regional Medical Center Foundation, Inc. (the "Foundation"); Peninsula Health Ventures, Inc. ("Health Ventures"); Peninsula Women's Surgery Center, LLC; and Peninsula Regional Clinically Integrated Network, LLC. The Health System is a not-for-profit Maryland membership corporation established to manage the integrated delivery of health care services to the community. The Health System is the sole corporate member of the Hospital and the Foundation. In its capacity as sole corporate member, the Health System will appoint trustees, approve major expenditures, and approve long-term borrowings.

The Hospital is a not-for-profit, nonstock corporation founded in 1897 to serve the health care needs of its region. Primary service areas include the Maryland counties of Wicomico, Somerset, and Worcester; southern Delaware; and the northern Eastern Shore of Virginia. The Hospital's mission is to improve the health care of the community by providing exceptional quality primary, secondary, and selected tertiary health care services to patients in a competent and compassionate manner, designed to elicit a high degree of customer satisfaction. The Hospital wholly owns Delmarva Peninsula Insurance Company ("DPIC") a Cayman Island captive insurance company that provides professional and general liability insurance.

The Foundation is a not-for-profit, nonstock corporation organized to raise contributions exclusively for the benefit of charitable, educational, medical, and scientific purposes for the Hospital.

Health Ventures is a for-profit corporation organized for the purpose of owning, developing, operating, and investing in health care enterprises on the Delmarva Peninsula. The Health System owns all of the outstanding shares of common stock of Health Ventures.

2. Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements include the accounts of the Health System and all wholly owned subsidiaries as described in Note 1. Additionally, the Health System has consolidated a 55%-owned affiliate, Delmarva Surgery Center, LLC, and recorded a noncontrolling interest equal to the remaining ownership interest.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America ("U.S. GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. The most significant management estimates and assumptions relate to the determination of allowance for doubtful accounts and contractual allowances for patient accounts receivable, useful lives of property and equipment, actuarial estimates for the pension plan, professional, general liabilities and workers' compensation costs and the reported fair value of certain assets and liabilities. Actual amounts could differ from those estimates.

Fair Value of Financial Instruments

Financial instruments consist of cash equivalents, accounts receivable, investments and assets limited as to use, accounts payable, accrued liabilities, advances from third-party payors and long-term debt. The carrying amounts reported in the consolidated balance sheets for cash equivalents, accounts receivable, accounts payable, accrued liabilities, and advances from third-party payors, approximate fair value. Management's estimate of the fair value of other financial instruments is described elsewhere in the notes to the consolidated financial statements.

Cash and Cash Equivalents

Cash and cash equivalents include surplus operating funds invested in money market funds and highly-liquid corporate, U.S. government, and agency obligations, all with maturities of less than three months when purchased.

Investments and Assets Limited As To Use

Investments are carried at fair value. Fair values of all investments, including short-term investments, investments, and assets limited as to use are based on quoted market prices and/or prices obtained from a third party using other market data for the same or comparable instruments and transactions in establishing the prices. Short-term investments represent investments with contractual maturities within one year and current investments in money market funds that have been designated for investment purposes.

Assets limited as to use includes externally held assets held by trustees under a bond indenture agreement in a construction fund to be spent on capital improvements, and used for the acquisition, renovation or equipping of certain facilities of the Hospital; assets held by trustees under self-insurance programs; and assets internally held, to meet donor's intentions. Amounts required to meet current liabilities have been classified on the consolidated balance sheets as a component of short-term investments.

Investment income, including interest and dividend, realized gains and losses (the value of securities sold) is based on the specific identification method. During 2018, the Health System implemented Accounting Standards Update ("ASU") 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*, which changed how the Health System accounts for equity investments and how they are presented on the consolidated financial statements. As a result, changes in unrealized gains and losses are included in investment income for the year ended June 30, 2018 and prior to the implementation for the year ended June 30, 2017 in other changes in unrestricted net assets. Investment income on investments of restricted assets are added to or deducted from the appropriate restricted net assets when restricted as to use by the donor.

Contractual and Doubtful Account Allowances

Patient accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, management analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payer sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, management analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary. For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), management records a provision for bad debts in the period of service on the basis of its past experience. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all

reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. There have been no changes in the charity care or uninsured discount policies during the years ended June 30, 2018 or 2017.

Discounts ranging from 2% to 6% of charges are given to Medicare, Medicaid, and certain approved commercial health insurance and health maintenance organization programs for regulated services. Discounts in varying percentages are given for certain unregulated services.

Supplies

Supplies are carried at the lower of cost or market, using the first-in, first-out method.

Property and Equipment

Property acquired and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Software development costs that are incurred in the preliminary project stage for internal use software are expensed as incurred. During the development stage, direct consulting costs and payroll and payroll-related costs for employees that are directly associated with each project are capitalized and amortized over the estimated useful life of the software once the software is ready for its intended use. Capitalized software is amortized using the straight-line method over its estimated useful life, which is generally seven years. Replacements and upgrades and enhancements to existing systems that result in added functionality are capitalized, while maintenance and repairs are charged to expense as incurred.

Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted donations. Absent explicit donor stipulations about how long those assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(Dollar Amounts in Thousands)

Other Assets

Other assets are comprised of:

	Year Ended June 30 2018	2017
Investments in unconsolidated joint ventures (Note 5)	**$ 10,744**	$ 10,803
Reinsurance receivable (Note 9)	**5,942**	5,793
Prepaid pension (Note 10)	**5,177**	-
Other	**6,143**	8,244
Total	**$ 28,006**	$ 24,840

Estimated Self-Insurance Liabilities

The provision for estimated professional liability claims, general liability claims, and workers' compensation claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose.

Permanently restricted net assets have been restricted by donors to be maintained in perpetuity.

Performance Indicator

The performance indicator for the Health System is excess of (deficiency in) unrestricted revenue and other support over expenses, which excludes net assets released from restrictions for property acquisitions net of transfers to restricted net assets, change in the unrealized gains and losses on investments (for the year ended June 30, 2017) changes in non-controlling interest, and pension adjustments.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted donations if they are received with donor stipulations that limit the use of

the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or the purpose of the restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported on the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated financial statements.

Net Patient Service Revenue

Net patient service revenue is reported as estimated net realizable amounts from patients, third-party payors, and others for services rendered and include estimated retroactive revenue adjustments due to future audits, reviews, and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews, and investigations.

For services provided at the Hospital campus, all payors are required to pay the Maryland Health Services Cost Review Commission ("HSCRC") approved rates. Management believes that this program will remain in effect at least through June 30, 2019. The major third-party payors, as recognized by the HSCRC, are allowed discounts of up to 6% on approved rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered.

The Hospital's charges are subject to review and approval by the HSCRC. The total rate of reimbursement for services to patients under the Medicare and Medicaid programs is based on a waiver arrangement between the Centers for Medicare and Medicaid Service and the HSCRC. This waiver arrangement will be in place as long as Maryland hospitals achieve certain savings and improvements, as defined. The Hospital has an agreement with the HSCRC to participate in its Global Budgeted Revenue ("GBR") program. GBR methodology encourages hospitals to focus on population health strategies by establishing a fixed annual revenue cap for each GBR hospital. The agreement is evergreen in nature and covers both regulated inpatient and outpatient revenues.

Under GBR, hospital revenue is known at the beginning of each fiscal year, and for the year ending June 30, 2019 is expected to be approximately $456,000. Annual revenue is calculated from a base year and is adjusted annually for inflation, infrastructure requirements, population changes, performance in quality-based programs, and changes in levels of uncompensated care. Revenue may also be adjusted annually for market levels and shifts of services to unregulated services.

The HSCRC's rate-setting methodology for hospital service centers that provide both inpatient and outpatient services and only outpatient services consists of establishing an acceptable unit rate for defined inpatient and outpatient service centers within a hospital. The actual average unit charge for each service center is compared to the approved rate monthly and annually. Overcharges and undercharges due to either patient volume or price variances, adjusted for penalties where applicable, are applied to decrease (in the case of overcharges) or increase (in the case of undercharges) future approved rates on an annual basis. The Hospital undercharged by $863 and $696 for the years ended June 30, 2018 and 2017, respectively, which is within the allowable corridor as specified in the GBR Agreement.

The timing of the HSCRC's rate adjustments for the Hospital could result in an increase or reduction in rates due to the variances and penalties described above in a year subsequent to the year in which such items occurred, and there is at least a possibility that the amounts may be material. The Hospital's policy is to record revenue based on actual charges for services to patients in the year in which the services are performed. The Hospital recognizes unbilled revenue for in-house patient services.

For both the years ended June 30, 2018 and 2017, approximately 80% of net patient service revenue was subject to the HSCRC's regulations.

Services not located on the Hospital campus and certain other services are not regulated by the HSCRC. Medicare and Medicaid pay the revenues associated with these services based upon established fee schedules. Commercial payors pay at negotiated rates for these services.

For both the years ended June 30, 2018 and 2017, approximately 52% of net patient service revenue was received under the Medicare program, 12% from CareFirst Blue Cross Blue Shield, 32% from contracts with other third parties, and 4% from other sources.

Laws and regulations governing the HSCRC, Medicare and Medicaid programs, which represent a substantial portion of the net patient service revenues, are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Health System believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing, other than noted in Note 12. While no additional regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action.

Approximately 38% and 35% of accounts receivable were due from the Medicare program as of June 30, 2018 and 2017, respectively.

(Dollar Amounts in Thousands)

The Health System employs physicians in several hospital-based specialties. The Health System bills for the services provided by these physicians. Net physician revenue is recognized when the services are provided and recorded at the estimated net realizable amount based on the contractual arrangements with third-party payors and the expected payments from the third-party payors and the patients. The difference between the billed charges and the estimated net realizable amounts is recorded as a reduction in physician revenue when the services are provided.

The following table sets forth the detail of net patient service revenue:

	Year Ended June 30	
	2018	**2017**
Gross patient service revenue	**$ 563,434**	$ 534,960
Less: revenue deductions:		
Charity care	**(7,898)**	(9,225)
Contractual and other allowances	**(109,391)**	(99,933)
Patient revenue, net of deductions	**446,145**	425,802
Less provision for bad debts	**(9,165)**	(11,686)
Net patient service revenue less provision for bad debts	**$ 436,980**	$ 414,116

Charity Care

The Health System provided care to patients who met certain criteria under its charity care policy, without charge or at amounts less than its approved rates. Because the Health System did not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Health System maintains records to identify and monitor the level of charity care and community service it provides. These records include the amount of charges foregone based on established rates for services and supplies furnished under its charity care and community service policies and the number of patients receiving services under these policies. The Health System provided $6,279 and $7,859 for the years ended June 30, 2018 and 2017, respectively, of charity care at full cost including direct and indirect costs, based on the actual charity population using its cost to charge ratio. The state of Maryland rate system includes components within the rates to partially compensate health systems for uncompensated care.

Additionally, the Health System provides a wide range of community services to the general public. These include but are not limited to the following: free health screenings for breast cancer, prostate cancer, skin cancer, diabetes, high blood pressure, high blood cholesterol, hearing loss and glaucoma; free educational programs on a variety of health care topics; health fairs and demonstrations; and networking and coordination of services for the needy, elderly, and disabled. These community services are offered at the Health System and at schools, businesses, and other locations throughout the Health System's service area.

Income Taxes

The Health System and the Foundation have been recognized as supporting organizations exempt from federal income tax under Section 501(c)(3) as described in Sections 509(a)(3) of the Internal Revenue Code (the "Code"). The Hospital has been recognized as an organization exempt from federal income tax under Section 501(c)(3) as described in Sections 509(a)(1) and Section 170(b)(1)(A)(iii) of the Code. The Health System is subject to tax on income unrelated to its exempt purpose, unless that income is otherwise excluded by the Code. Each organization has processes presently in place to ensure the maintenance of its tax-exempt status; to identify and report unrelated income; to determine its filing and tax obligations in jurisdictions for which it has nexus; and to identify and evaluate other matters that may be considered tax positions.

Peninsula Women's Surgery Center, LLC and Peninsula Regional Clinically Integrated Network, LLC, are limited liability companies with the Health System as sole member and are disregarded for income tax purposes. Health Ventures is a for-profit corporation, wholly owned by the Health System. DPIC is a Cayman Island captive insurance company, wholly owned by the Hospital. Under Cayman Islands tax regulations, no tax is imposed on DPIC for premium and investment income.

The Health System follows guidance that clarifies the accounting for uncertainty in tax positions taken or expected to be taken in a tax return, including issues relating to financial statement recognition and measurement. This guidance provides that the tax effects from an uncertain tax position can only be recognized in the financial statements if the position is "more-likely-than-not" to be sustained if the position were to be challenged by a taxing authority. The assessment of the tax position is based solely on the technical merits of the position, without regard to the likelihood that the tax position may be challenged.

The tax years ending June 30, 2018, 2017, 2016 and 2015 are still open to audit for both federal and state purposes. The Health System has determined that there are no material uncertain tax positions that require recognition or disclosure in the consolidated financial statements for the years ended June 30, 2018 and 2017.

Pending Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued ASU 2014-09, *Revenue from Contracts with Customers*, to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for U.S. GAAP and International Financial Reporting Standards. The core principle of the new guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for these goods and services. This standard is effective for annual reporting periods beginning after December 15, 2017, including interim periods within that reporting period. Early application is not permitted. An entity will apply the amendments in this update using either a full retrospective application, which applies the standard to each prior period presented, or under the modified retrospective application, in which an entity recognizes the cumulative effect of initially applying the new standard as an adjustment to the opening balance sheet of retained earnings at the date of initial application. Revenue in periods presented before that date will continue to be reported under guidance in effect before the change. Currently, the American Institute of Certified Public Accountants Healthcare Revenue Recognition Task Force is interpreting this standard and its effects on the health care industry.

In August 2016, the FASB issued ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*. This standard intends to make certain improvements to the current reporting requirements for not-for-profit entities including: (1) the presentation for two classes of net assets at the end of the period, rather than the currently required three classes, as well as the annual change in each of the two classes; (2) the removal of the requirement to present or disclose the indirect method (reconciliation) when using the direct method for the statement of cash flows; and (3) the requirement to provide various enhanced disclosures relating to various not-for-profit specific topics. The new standard is effective for annual financial statements beginning after December 15, 2017.

In March 2017, the FASB issued ASU 2017-07, *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. This standard intends to make changes to employers that sponsor defined benefit pension and/or other postretirement benefit plans, present the net periodic benefit cost in the income statement. Employers will present the service cost component of net periodic benefit cost in the same income statement line item(s) as other employee compensation costs arising from services rendered during the period. Only the service cost component will be eligible for capitalization in assets. Employers will present the other components of the net periodic benefit cost separately from the line item(s) that include(s) the service cost and outside of any subtotal of operating income, if one is presented. The new standard is effective for annual financial statements after December 15, 2017. Early application is permitted.

(Dollar Amounts in Thousands)

In February 2016, the FASB issued ASU 2016-02, *Leases*, which requires that most leased assets be recognized on the balance sheet as assets and liabilities for the rights and obligations created by these leases. ASU 2016-02 is effective for fiscal years beginning after December 15, 2018. Early application is permitted. An entity is required to apply the amendments in the standard under the modified retrospective transition approach. This approach includes a number of optional practical expedients, which are described in the final standard. Under these practical expedients, an organization will continue to account for leases that commence before the effective date in accordance with current U.S. GAAP, unless the lease is modified. However, lessees are required to recognize on the balance sheet leased assets and liabilities for operating leases at each reporting date.

The Health System has not determined the impact of these new standards at this time.

Reclassifications

Certain amounts in the 2017 consolidated financial statements have been reclassified to be consistent with the 2018 presentation.

3. Investments and Assets Limited As To Use

Fair value of investments and assets limited as to use is summarized as follows:

	June 30	
	2018	**2017**
Investments:		
Cash and cash equivalents	**$ 19,636**	$ 16,879
U.S. Treasury securities	**27,818**	19,736
Corporate bonds	**64,249**	52,483
Mortgage-backed securities	**29,986**	25,138
Equity securities	**242,510**	216,625
Total	**$ 384,199**	$ 330,861

	Year Ended June 30	
	2018	**2017**
Investment income, net		
Interest and dividend income	**$ 4,464**	$ 4,239
Realized gains, net	**22,851**	10,233
Changes in unrealized gains and losses	**9,909**	-
Other	**(942)**	2,136
Total	**$ 36,282**	$ 16,608

(Dollar Amounts in Thousands)

4. Property and Equipment

A summary of property and equipment follows:

	Estimated Useful Lives (in Years)	June 30 2018	2017
Land	-	**$ 12,018**	$ 11,410
Land improvements	20	**12,892**	12,702
Buildings and improvements	15 - 40	**255,536**	238,578
Fixed equipment	20	**36,331**	33,822
Movable equipment	7 - 10	**250,608**	245,248
		567,385	541,760
Less accumulated depreciation		**(345,173)**	(326,283)
		222,212	215,477
Construction in progress		**3,149**	12,826
Property and equipment, net		**$ 225,361**	$ 228,303

As of June 30, 2018, the Hospital was committed to building and equipment purchases totaling approximately $1,322.

(Dollar Amounts in Thousands)

5. Investment in Unconsolidated Joint Ventures

The Health System and physicians located throughout Maryland and Delaware have joined together, along with other non-related for-profit investors, to expand surgical and certain other services within the local communities through jointly owned ventures, as follows:

		Investment in unconsolidated joint ventures		Equity earnings (losses) in unconsolidated joint ventures	
	Membership percentage	June 30, 2018	June 30, 2017	Year ended June 30, 2018	Year ended June 30, 2017
Health System :					
Health Visions Delmarva, LLC	50%	**$ 3**	$ 4	**$ (27)**	$ (7)
Advanced Health Collaborative I, LLC	25%	**48**	(28)	**60**	(211)
Advanced Health Collaborative II, LLC	25%	**1,492**	1,244	**(1,484)**	(1,015)
		1,543	1,220	**(1,451)**	(1,233)
Health Ventures:					
Peninsula Imaging, LLC	50%	**3,794**	3,345	**949**	993
AHP Delmarva, LLP	50%	**945**	901	**270**	(58)
Genesis Healthcare - Salisbury, LLC	50%	**3,854**	4,402	**827**	1,085
Peninsula Home Care, LLC	50%	**558**	431	**931**	881
PHC at Nanticoke, LLC	33%	**-**	(32)	**32**	(14)
Peninsula NRH Regional Rehab, LLC	50%	**-**	486	**53**	59
YDI, Inc.	50%	**-**	50	**(50)**	-
Corelife, Inc.	50%	**50**	-	**-**	-
		9,201	9,583	**3,012**	2,946
		$ 10,744	$ 10,803	**$ 1,561**	$ 1,713

Regardless of the proportionate ownership of capital investment in these ventures, all decisions are made by the respective venture's operating board. In each case, the operating board is composed equally of members appointed by the Health System/Health Ventures and the other investors as a group. Accordingly, these are accounted on the equity method of accounting.

Equity earnings (losses) in unconsolidated joint ventures for the Health System are included in investment income, net and Health Ventures are included in other revenue on the consolidated statements of operations and changes in net assets, due to the type of operations of the joint venture.

(Dollar Amounts in Thousands)

6. Long-Term Debt

Long-term debt consists of the following:

	June 30, 2018	2017
Hospital:		
Maryland Health and Higher Educational Facilities Authority ("MHHEFA") Revenue Bonds Series 2015:		
Series 2015 5.00% serial and term bonds and effective rates ranging from 2.57% to 4.13% due in annual amounts ranging from $2,090 to $7,795 on July 1 of each year through 2045	**$ 119,880**	$ 121,970
Delmarva Surgery Center, LLC:		
Building and equipment collateral loans:		
4.40% fixed rate due monthly through 2022	**1,612**	1,695
	121,492	123,665
Less current portion of Series 2015 serial bonds	**(2,195)**	(2,090)
Less current portion of building and equipment collateral loans	**(86)**	(82)
	119,211	121,493
Plus original issue premium - Series 2015	**17,963**	18,812
Less unamortized debt issue costs - Series 2015	**(1,243)**	(1,297)
Long-term debt, less current portion	**$ 135,931**	$ 139,008

Series 2015 Revenue Bonds

On February 5, 2015, MHHEFA authorized the issuance of $126,665 aggregate principal amount of Revenue Bonds (Series 2015 Revenue Bonds) at a premium of $20,770. The proceeds of the issue, after payment of financing costs, were used primarily (i) to advance refund the 2006 bonds and (ii) to finance $25,000 of capital purchases.

The Hospital is required to make semiannual payments to the trustee sufficient to meet the annual debt service requirements. The premium and related financing costs on the Series 2015 Bonds are being amortized over the life of the bonds.

(Dollar Amounts in Thousands)

As security for the debt service requirements of the Series 2015 Bonds, MHHEFA has a first lien and claim on all receipts of the Hospital. The terms of the indenture agreement restrict the Hospital's ability to create additional indebtedness and its use of the facilities, and require the Hospital to maintain stipulated insurance coverage and a rate structure in each year sufficient to meet certain rate covenant requirements. The Hospital has complied with these financial covenants for the years ended June 30, 2018 and 2017.

Scheduled principal repayments on long-term debt for the years ending June 30, are as follows:

2019	$ 2,281
2020	2,397
2021	2,515
2022	2,639
2023	2,764
2024 and thereafter	108,896
	$ 121,492

The Health System uses quoted market prices in estimating the fair value of its long-term debt. The fair value of the long-term debt outstanding as of June 30, 2018 and 2017, was approximately $132,590 and $137,498, respectively.

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes:

	June 30	
	2018	**2017**
Health care services:		
Capital purposes	**$ 18,379**	$ 17,434
Patient services	**11,905**	8,340
Educational purposes	**3,872**	1,349
	$ 34,156	$ 27,123

Permanently restricted net assets are restricted as follows:

	June 30	
	2018	**2017**
Investments to be held in perpetuity, the income from which is expendable to support health care services	**$ 8,236**	$ 8,255

(Dollar Amounts in Thousands)

The Foundation has ongoing fundraising campaigns, which include pledges and contributions receivable included in other assets on the consolidated balance sheets. Scheduled payments on pledges receivable are as follows:

	June 30	
	2018	**2017**
Due:		
Within one year	**$ 479**	$ 480
2 to 5 years	**1,179**	1,075
Greater than 5 years	**205**	281
	1,863	1,836
Less:		
Impact of discounting of pledges receivable to net present value	**(98)**	(91)
Allowance for uncollectible pledges	**(174)**	(171)
Net pledges receivable, for capital purposes	**$ 1,591**	$ 1,574

8. Functional Expenses

The Health System considers health care services and management and general to be its primary functional categories for purposes of expense classification. Depreciation and interest costs are included in health care services. The operating expenses by functional classification are as follows:

	Year Ended June 30	
	2018	**2017**
Health care services	**$ 383,846**	$ 385,506
Management and general	**52,105**	54,715
	$ 435,951	$ 440,221

9. Self-Insured Liabilities

Effective July 1, 2013, DPIC provides Primary Medical Professional Liability ("MPL") and Primary General Liability ("GL") coverage to the Health System and its employed physicians on a mature claims-made basis. The primary MPL policy provides limits of liability of $2,000 per occurrence with an $8,000 annual aggregate. The primary GL policy provides limits of liability of $1,000 per occurrence with a $3,000 annual aggregate. The employed physicians are covered with retro dates consistent with their date of hire. This policy is retrospectively rated.

Effective July 1, 2013, DPIC provides excess umbrella liability coverage on a mature claims-made basis with a retroactive date of March 1, 2005. The excess MPL coverage follows the form of the underlying MPL coverage providing a total of $30,000 limits of liability. The umbrella liability coverage provides $30,000 limits of liability in excess of scheduled underlying coverages. The excess umbrella liability coverage is 100% reinsured with an unrelated commercial insurance company for the first $10,000 limit and another unrelated commercial insurance company for the second $20,000 limit.

Effective July 1, 2013, DPIC assumed the MPL and GL coverage previously included under the Health System's self-insurance plan (the "LPT"), for incidents occurring between March 1, 1986 and June 30, 2013 for MPL and for occurrences between March 1, 2004 and June 30, 2013 for GL, that were reported to the Hospital prior to June 30, 2013. The policy provides MPL coverage limits varying from $1,000 to $2,000 per occurrence, with policy aggregates varying from $3,000 to $8,000. The policy provides GL coverage limits of $1,000 per occurrence and $3,000 annual aggregates.

Effective July 1, 2016, DPIC also provides employee benefit plan stop loss coverage to the Health System on a claims-made basis. DPIC covers liability in excess of $350 per covered person with a $100 deductible. DPIC's liability above $250 is fully reinsured with an unrelated commercial reinsurance company.

The reserves for reported professional liability claims and claims incurred but not reported ("IBNR") are reported gross of expected insurance recoveries. The reserves for reported claims and claims IBNR are reported within the self insured liabilities in the consolidated balance sheets. In addition, the expected insurance recoveries are reported as reinsurance receivable in other assets in the consolidated balance sheets.

The loss reserves are management's best estimate based on actuarial estimates of the ultimate net cost of settling losses on incurred claims. The estimates are reviewed and adjusted, as necessary, as experience develops or new information becomes known. Management believes that the loss reserves are adequate; however, the ultimate settlement of losses may vary significantly from the amounts recorded in the accompanying consolidated financial statements.

(Dollar Amounts in Thousands)

Accrued claims activity related to MPL, GL and employee benefit plan for the year ended June 30, is as follows:

	2018	2017
Accrued claims and IBNR - beginning of the year	**$ 15,826**	$ 16,646
Less: Reinsurance receivable	**(5,793)**	(5,100)
Accrued claims and IBNR, net - beginning of the year	**10,033**	11,546
Incurred related to:		
Current year	**2,950**	5,350
Prior year	**(631)**	(2,768)
Total incurred	**2,319**	2,582
Paid related to:		
Current year	**(36)**	(42)
Prior year	**(984)**	(4,053)
Total paid	**(1,020)**	(4,095)
Accrued claims and IBNR, net - end of the year	**11,332**	10,033
Add: Reinsurance receivable	**5,942**	5,793
Accrued claims and IBNR - end of the year	**$ 17,274**	$ 15,826

The Hospital is also self insured for workers' compensation up to an annual limit of $500 per occurrence. The Hospital carries an excess liability insurance policy for workers' compensation claims above this limit. As of June 30, 2018 and 2017, $3,736 and $3,695, respectively, have been reserved for workers' compensation loss contingencies.

10. Fair Value Measurements

U.S. GAAP establishes a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are described below.

Level 1 Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Health System has the ability to access.

(Dollar Amounts in Thousands)

Level 2 Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets
- Quoted prices for identical or similar assets or liabilities in inactive markets
- Inputs other than quoted prices that are observable for the asset or liability
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means

Level 3 Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Health System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following table presents the Health System's assets measured at fair value, aggregated by level in the fair value hierarchy within which those measurements fall:

	Fair Value as of June 30, 2018			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Cash and cash equivalents	**$ 19,636**	**$ -**	**$ -**	**$ 19,636**
U.S. government securities	**27,818**	**-**	**-**	**27,818**
Corporate bonds	**-**	**64,249**	**-**	**64,249**
Government-sponsored mortgage-backed securities	**-**	**29,986**	**-**	**29,986**
Equity securities	**242,510**	**-**	**-**	**242,510**
Total assets	**$ 289,964**	**$ 94,235**	**$ -**	**$ 384,199**

(Dollar Amounts in Thousands)

	Fair Value as of June 30, 2017			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Cash and cash equivalents	$ 16,879	$ -	$ -	$ 16,879
U.S. government securities	19,736	-	-	19,736
Corporate bonds	-	52,483	-	52,483
Government-sponsored mortgage-backed securities	-	25,138	-	25,138
Equity securities	216,625	-	-	216,625
Total assets	$ 253,240	$ 77,621	$ -	$ 330,861

The fair values of securities are determined by third-party service providers utilizing various methods depending on the specific type of investment. Where quoted prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. Where significant inputs, including benchmark yields, broker-dealer quotes, issuer spreads, bids, offers, the London Interbank Offered Rate curve, and measures of volatility, are used by these third-party dealers or independent pricing services to determine fair values, the securities are classified within Level 2.

11. Pension Plans

The Health System has a cash balance-type defined benefit pension plan, The Peninsula Regional Medical Center Pension Plus Plan (the "Plan"), covering substantially all of its employees. Plan benefits are based on years of service and the employees' compensation during the last five years of covered employment. The Health System's funding policy is to make sufficient contributions to the Plan to comply with the minimum funding provisions of the Employee Retirement Income Security Act of 1974. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future.

The Plan provides annual allocations to a participant's hypothetical account. When a participant retires, the participant has the choice to receive a lump-sum distribution equal to the value of the hypothetical account or to receive an annuity based on the value of the hypothetical account.

The Plan provided three different allocations: (i) a service-related allocation, (ii) an age-related allocation, and (iii) a matching allocation for certain employees. Both the service-related allocation and the age-related allocation were determined by multiplying a participant's annual compensation by a certain percentage. The matching allocation operated to provide an annual allocation in the Plan based on the participant's contribution to the Health System's 403(b) plan.

(Dollar Amounts in Thousands)

The Health System has a 403(b) defined contribution savings plan that includes all full-time and part-time employees of the Health System. The Heath System matches participant contributions for active participants as of December 31 who have completed at least 975 hours of service during the calendar year. The match is 25% of the first 1% of compensation for participants with 1 – 15 years of service and 50% of the first 2% for participants with more than 15 years of service. The Health System's contribution expense for the years ended June 30, 2018 and 2017 was $1,253 and $1,221, respectively.

The following provides a reconciliation of the changes in fair value of the Plan's assets and projected benefit obligations, and the Plan's funded status:

	June 30	
	2018	**2017**
Accumulated benefit obligation	**$ 119,539**	$ 123,227
Projected benefit obligation, beginning of year	**$ 136,240**	$ 134,431
Service cost	**6,999**	6,745
Interest cost	**4,624**	4,130
Actuarial gain	**(7,872)**	(2,084)
Benefits paid	**(8,880)**	(6,982)
Projected benefit obligation, end of year	**131,111**	136,240
Fair value of plan assets, beginning of year	**125,288**	118,125
Actual gain on plan assets	**16,880**	14,145
Employer contributions	**3,000**	-
Benefits paid	**(8,880)**	(6,982)
Fair value of plan assets, end of year	**136,288**	125,288
Funded status	**$ 5,177**	$ (10,952)
Amounts recognized in the consolidated balance sheets:		
Prepaid pension (other assets)	**$ 5,177**	$ -
Accrued pension	**$ -**	$ (10,952)
Net amounts recognized in unrestricted net assets:		
Net actuarial loss	**$ 16,424**	$ 35,041

(Dollar Amounts in Thousands)

Components of net periodic benefit cost and changes in unrestricted net asset are as follows:

	Year Ended June 30	
	2018	**2017**
Service cost	**$ 6,999**	$ 6,745
Interest cost	**4,624**	4,130
Expected return on plan assets	**(8,361)**	(8,257)
Amortization of prior service credit	**-**	(63)
Recognized net actuarial loss	**2,226**	2,795
Net periodic benefit cost	**5,488**	5,350
Recognized in unrestricted net assets as other changes in pension adjustments:		
Net actuarial loss	**18,617**	10,704
Total recognized in net periodic benefit cost and change in unrestricted net assets	**$ 24,105**	$ 16,054

The estimated net actuarial loss for the Plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year is $1,001.

Weighted average assumptions used to determine projected benefit obligations and net periodic benefit costs were as follows:

	June 30,	
	2018	**2017**
Projected benefit obligation		
Discount rate	**4.00%**	3.50%
Rates of increase in compensation levels:		
Service:		
<11	**8.00**	8.00
11<21	**5.00**	5.00
21=<	**3.00**	3.00
Net periodic benefit cost and changes in unrestricted net asset		
Discount rate	**3.50%**	3.15%
Expected long-term return on plan assets	**7.00**	7.00
Rate of increase in compensation levels:		
Service:		
<11	**8.00**	8.00
11<21	**4.00**	5.00
21=<	**3.00**	3.00

(Dollar Amounts in Thousands)

The defined benefit pension plan asset allocation as of the measurement date and the target asset allocation, presented as a percentage of total plan assets, were as follows:

	June 30,		Target
	2018	**2017**	**Allocation**
Debt securities	**29%**	27%	25% - 40%
Equity securities	**68**	70	45% - 75%
Cash and cash equivalents	**3**	3	1% - 10%
Total	**100%**	100%	

The Health System's defined benefit plan invests in a diversified mix of traditional asset classes. Investments in U.S. equity securities and fixed income securities are made to maximize long-term results while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. Risk tolerance of unexpected investment and actuarial outcomes is continually evaluated by understanding the pension plan's liability characteristics. This is performed through forecasting and assessing ranges of investment outcomes over short-term and long-term horizons, and by assessing the Health System's financial condition and its future potential obligations from both the pension and general operational requirements. Complementary investment styles, such as growth and value equity investing techniques, are utilized by the Health System's investment advisors to further improve portfolio and operational risk characteristics. Equity investments, both actively and passively managed, are used primarily to increase overall plan returns. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

Asset allocations and investment performance are formally reviewed at regularly scheduled meetings of the Health System's Financial Resources Committee.

The overall rate of expected return on assets assumption was based on historical returns, with adjustments made to reflect expectations of future returns. The extent to which the future expectations were recognized included the target rates of return for the future, which have not historically changed.

(Dollar Amounts in Thousands)

The fair values of the Plan assets as of June 30, by asset category (see Note 10 for a description of the asset categories), are as follows:

	2018			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Investments at fair value:				
Cash and cash equivalents	**$ 3,525**	**$ -**	**$ -**	**$ 3,525**
U.S. Treasuries	**9,179**	**-**	**-**	**9,179**
Government-sponsored mortgage-backed securities	**-**	**8,810**	**-**	**8,810**
Corporate debt securities	**-**	**22,282**	**299**	**22,581**
Publicly traded equity securities	**92,193**	**-**	**-**	**92,193**
Total Plan investments	**$ 104,897**	**$ 31,092**	**$ 299**	**$ 136,288**

	2017			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Investments at fair value:				
Cash and cash equivalents	$ 3,482	$ -	$ -	$ 3,482
U.S. Treasuries	8,336	-	-	8,336
Government-sponsored mortgage-backed securities	-	8,162	-	8,162
Corporate debt securities	-	17,754	-	17,754
Publicly traded equity securities	87,250	11	-	87,261
Other	293	-	-	293
Total Plan investments	$ 99,361	$ 25,927	$ -	$ 125,288

The following methods and assumptions were used to estimate the fair value of each class of financial instrument:

U.S. Treasuries: The fair value is determined by an active price for an identical security in an observable market.

Corporate debt securities and government-sponsored mortgage-backed securities: The fair value is estimated using quoted prices for similar assets in active markets or quoted prices for identical or similar assets in non-active markets (few transactions, limited information, noncurrent prices, and high variability over time).

(Dollar Amounts in Thousands)

Money market funds: The carrying value of these money market funds approximates fair value as the maturities are less than three months.

Publicly traded equity securities: The fair value is determined by market quotes for an identical security in an observable market.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Health System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Cash Flows

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid as follows for the years ending June 30:

2019	$ 7,982
2020	8,389
2021	9,345
2022	9,504
2023	9,859
2024 - 2028	53,514

The Health System intends to make voluntary contributions of $3,000 to the defined benefit pension plan for the year ending June 30, 2019. This funding level exceeds any regulatory requirements for 2019.

12. Commitments and Contingencies

The Health System has been named as a defendant in various lawsuits arising from the performance of its normal activities. In the opinion of the Health System's management, after discussion with legal counsel, the amount, if any, of the Health System's ultimate liability under these lawsuits will not have a material adverse effect on the consolidated financial position of the Health System.

(Dollar Amounts in Thousands)

The Hospital has been named as a co-defendant in a qui tam action alleging that the Hospital violated the False Claims Act along with an unaffiliated ambulance transportation company. This action had been stayed for the past two years. As noted in the stay, the United States Attorney had until November 30, 2018 to decide to formally intervene or disengage from the action. At this time, management is not able to make a conclusion on the ultimate outcome of the action or its effect on the consolidated financial position. On September 14, 2018 the OIG issued a subpoena to the Hospital for additional patient records. The Hospital will serve a response to the subpoena on or before September 28, 2018. At this time, management is not able to make a conclusion on the ultimate outcome of the action or its effect on the consolidated financial position.

A portion of the Health System's revenues is received from health maintenance organizations and other managed care payors. Managed care payors generally use case management activities to control utilization. These payors also have the ability to select providers offering the most cost-effective care. Management does not believe that the Health System has undue exposure to any one managed care payor.

Operating Leases

The Health System leases certain of its operating facilities and equipment. These leases, which expire through 2028, generally require the Health System to pay all maintenance, property tax, and insurance costs.

At June 30, 2018, aggregate amounts of future minimum payments under operating leases were as follows:

2019	$ 2,410
2020	2,104
2021	1,918
2022	1,738
2023	1,443
2024 and thereafter	3,290

Rent expense is recognized over the terms of the leases. Rent expense was $2,828 and $2,695 for the years ended June 30, 2018 and 2017, respectively.

13. Subsequent Events

The Health System has evaluated its June 30, 2018 consolidated financial statements for subsequent events through September 21, 2018, the date the consolidated financial statements were issued. Management is not aware of any subsequent events which require recognition or disclosure in the consolidated financial statements.

Supplementary Information

Peninsula Regional Health System, Inc.

Consolidating Balance Sheet
(In Thousands)

June 30, 2018

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Clinically Integrated Network	Peninsula Surgery Center	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Assets								
Current assets:								
Cash and cash equivalents	$ 30,688	$ 1,209	$ 4,886	$ 2	$ 82	$ 14	$ -	$ 36,881
Short-term investments	9,154	-	-	-	-	-	-	9,154
Intercompany receivables	2,557	-	-	-	-	-	(2,557)	-
Patient accounts receivable, less allowance for uncollectible accounts	39,443	-	606	-	219	-	-	40,268
Supplies	9,452	-	330	-	-	-	-	9,782
Prepaids and other	6,833	-	248	-	-	-	-	7,081
Total current assets	98,127	1,209	6,070	2	301	14	(2,557)	103,166
Investments	311,657	-	-	-	-	-	-	311,657
Investment in subsidiaries	-	-	-	-	-	529,975	(529,975)	-
Assets limited as to use:								
Donor-restricted fund	39,784	6,169	-	-	-	-	(7,760)	38,193
Self-insurance fund	25,195	-	-	-	-	-		25,195
	64,979	6,169	-	-	-	-	(7,760)	63,388
Property and equipment, net	220,434	-	3,488	-	1,439	-	-	225,361
Other assets	15,487	-	9,386	-	-	1,542	1,591	28,006
Total assets	$ 710,684	$ 7,378	$ 18,944	$ 2	$ 1,740	$ 531,531	$ (538,701)	$ 731,578

Peninsula Regional Health System, Inc.

Consolidating Balance Sheet (continued)
(In Thousands)

June 30, 2018

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Clinically Integrated Network	Peninsula Surgery Center	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Liabilities and net assets								
Current liabilities:								
Current portion of long-term debt	$ 2,195	$ -	$ 86	$ -	$ -	$ -	$ -	$ 2,281
Current portion of self-insured liabilities	3,025	-	-	-	-	-	-	3,025
Intercompany payables	-	34	-	104	203	2,216	(2,557)	-
Accounts payable	17,074	-	260	-	-	-	-	17,334
Accrued liabilities	18,623	-	-	-	-	-	-	18,623
Advances from third-party payors	10,084	-	-	-	-	-	-	10,084
Total current liabilities	51,001	34	346	104	203	2,216	(2,557)	51,347
Long-term debt, net	134,430	-	1,501	-	-	-	-	135,931
Self insured liabilities	18,029	-	-	-	-	-	-	18,029
Other liabilities	1,584	-	-	-	-	-	-	1,584
Total liabilities	205,044	34	1,847	104	203	2,216	(2,557)	206,891
Net assets:								
Unrestricted:								
Peninsula Regional Health System, Inc.	463,248	1,175	15,556	(102)	1,537	480,754	(481,414)	480,754
Non-controlling interest	-	-	1,541	-	-	-	-	1,541
Total unrestricted net assets	463,248	1,175	17,097	(102)	1,537	480,754	(481,414)	482,295
Temporarily restricted	34,156	6,169	-	-	-	40,325	(46,494)	34,156
Permanently restricted	8,236	-	-	-	-	8,236	(8,236)	8,236
Total net assets	505,640	7,344	17,097	(102)	1,537	529,315	(536,144)	524,687
Total liabilities and net assets	$ 710,684	$ 7,378	$ 18,944	$ 2	$ 1,740	$ 531,531	$ (538,701)	$ 731,578

Peninsula Regional Health System, Inc.

Consolidating Statement of Operations
(In Thousands)

Year Ended June 30, 2018

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Clinically Integrated Network	Peninsula Surgery Center	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Unrestricted revenue and other support:								
Net patient service revenue	$ 440,752	$ -	$ 4,761	$ -	$ 632	$ -	$ -	$ 446,145
Less provision for bad debts	(9,098)	-	(17)	-	(50)	-	-	(9,165)
Net patient service revenue less provision for bad debts	431,654	-	4,744	-	582	-	-	436,980
Other revenue	2,605	-	3,020	-	-	-	-	5,625
Net assets released from restrictions	-	872	-	-	-	-	(872)	-
Total unrestricted revenue and other support	434,259	872	7,764	-	582	-	(872)	442,605
Expenses:								
Salaries and wages	179,062	-	-	755	70	-	-	179,887
Supplies and other expenses	170,635	7	5,846	327	916	-	-	177,731
Employee benefits	43,472	-	-	76	5	-	-	43,553
Depreciation	28,614	-	220	-	286	-	-	29,120
Interest	5,579	-	81	-	-	-	-	5,660
Contributions to Hospital	-	872	-	-	-	-	(872)	-
Total expenses	427,362	879	6,147	1,158	1,277	-	(872)	435,951
Income (loss) from operations	6,897	(7)	1,617	(1,158)	(695)	-	-	6,654
Nonoperating income:								
Investment income, net	37,422	16	295	-	-	(1,451)	-	36,282
Contributions and other	785	-	77	-	-	-	-	862
Total nonoperating income	38,207	16	372	-	-	(1,451)	-	37,144
Excess of (deficiency in) unrestricted revenue and other support over expenses	45,104	9	1,989	(1,158)	(695)	(1,451)	-	43,798
Non-controlling interest losses	-	-	315	-	-	-	-	315
Excess of (deficiency in) unrestricted revenue and other support over expenses attributable to Peninsula Regional Health System, Inc.	$ 45,104	$ 9	$ 2,304	$ (1,158)	$ (695)	$ (1,451)	$ –	$ 44,113

EXHIBIT 7

THE MCCREADY FOUNDATION, INC.

CONSOLIDATED FINANCIAL STATEMENTS

YEARS ENDED JUNE 30, 2018 AND 2017

THE MCCREADY FOUNDATION, INC.

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INDEPENDENT AUDITORS' REPORT

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Certified Public Accountants
& Advisors to Business

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Delaware Society of
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INDEPENDENT AUDITORS' REPORT

To the Management and Board of Directors
The McCready Foundation, Inc.
Crisfield, Maryland

Report on the consolidated financial statements

We have audited the accompanying consolidated financial statements of The McCready Foundation, Inc. (a nonprofit organization) and affiliates, which comprise the consolidated statements of financial position as of June 30, 2018 and 2017, and the related consolidated statements of activities and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's responsibility for the financial statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

Auditor's responsibility (Continued)

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of The McCready Foundation, Inc. and affiliates as of June 30, 2018 and 2017, changes in their net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating statements of financial position on pages 20 – 21, the consolidating statements of activities on page 22, and the statements of activity by organization on pages 23 - 26 are presented for the purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and is derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects to the consolidated financial statements as a whole.

CERTIFIED PUBLIC ACCOUNTANTS

Salisbury, Maryland
October 29, 2018

CONSOLIDATED FINANCIAL STATEMENTS

THE MCCREADY FOUNDATION, INC.

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

JUNE 30, 2018 AND 2017

ASSETS

	2018	2017
CURRENT ASSETS		
Cash and cash equivalents	$ 1,278,677	$ 2,861,021
Certificates of deposit	202,830	201,946
Accounts receivable, net	4,249,135	3,187,048
Pledges receivable		1,600
Inventories	385,967	369,470
Prepaid expenses	297,792	239,677
Total current assets	6,414,401	6,860,762
INVESTMENTS, AT FAIR VALUE		
Investments maintained by		
Community Foundation of the Eastern Shore	253,244	230,828
Total investments	253,244	230,828
PROPERTY AND EQUIPMENT		
Property and equipment	30,895,620	30,758,141
Less accumulated depreciation	(14,998,176)	(14,348,830)
Net property and equipment	15,897,444	16,409,311
OTHER ASSETS		
Restricted patient funds	18,618	20,236
Total other assets	18,618	20,236
Total assets	$ 22,583,707	$ 23,521,137

LIABILITIES AND NET ASSETS

	2018	2017
CURRENT LIABILITIES		
Line of credit	$ 86,206	$ 101,236
Current portion of long-term debt	495,312	590,939
Accounts payable	1,699,007	867,948
Accrued salaries, annual leave and related taxes	996,060	869,582
Accrued interest	31,239	32,586
Medicare periodic interim payment program	123,244	49,419
Blue cross - advance	158,400	153,600
Assited living deposits	2,413	
Medicaid - advance	113,847	186,632
Total current liabilities	3,705,728	2,851,942
LONG - TERM DEBT		
Loan payable	9,036,860	9,421,966
Total non-current liabilities	9,036,860	9,421,966
OTHER LIABILITIES		
Restricted patient funds	18,493	10,649
Total other liabilities	18,493	10,649
Total liabilities	12,761,081	12,284,557
NET ASSETS		
Unrestricted	9,822,627	11,236,580
Total net assets	9,822,627	11,236,580
Total liabilities and net assets	$ 22,583,708	$ 23,521,137

The accompanying notes are an integral part of these financial statements.

THE MCCREADY FOUNDATION, INC.

CONSOLIDATED STATEMENTS OF ACTIVITIES

YEARS ENDED JUNE 30, 2018 AND 2017

	2018	2017
OPERATING REVENUE	24,322,122	22,697,869
EXPENSES		
Wages and benefits		
Salaries and wages	11,757,351	10,828,142
Payroll taxes	826,756	779,490
Employee benefits	1,686,364	1,745,137
Total wages and benefits	14,270,471	13,352,769
Direct expenses		
Professional service fees	2,167,164	2,214,907
Consumable supplies	2,333,318	2,038,637
Advertising and recruiting	132,959	100,012
Service contracts and maintenance	1,524,806	963,631
Leases and rentals	510,124	540,445
Depreciation expense	1,246,459	1,464,800
Utilities	596,467	633,445
Interest expense	503,072	520,384
Insurance	416,533	489,558
Other expenses	935,880	727,358
Bad debt expense	1,203,732	708,677
Total direct expenses	11,570,514	10,401,854
Total expenses	25,840,985	23,754,623
Operating loss	(1,518,863)	(1,056,754)
NONOPERATING INCOME	104,910	182,007
Change in net assets	(1,413,953)	(874,747)
NET ASSETS, BEGINNING OF YEAR, AS RESTATED	11,236,580	12,111,327
NET ASSETS, END OF YEAR	$ 9,822,627	$ 11,236,580

The accompanying notes are an integral part of these financial statements.

THE MCCREADY FOUNDATION, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

YEARS ENDED JUNE 30, 2018 AND 2017

	2018	2017
CASH FLOWS FROM OPERATING ACTIVITIES:		
Decrease in net assets	$ (1,413,953)	$ (874,747)
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation	1,246,459	1,464,800
Unrealized loss gain on investments	(24,873)	(26,454)
(Increase) decrease in operating assets:		
Accounts receivable	(1,062,087)	(460,765)
Pledges receivable	1,600	
Inventories	(16,497)	(53,405)
Medicare periodic interim payment program	73,825	47,083
Prepaid expenses	(58,115)	(8,242)
Increase (decrease) in operating liabilities		
Accounts payable	831,059	75,969
Accrued salaries, annual leave and related taxes	126,478	17,712
Accrued interest	(1,348)	(596)
Blue Cross - advance	4,800	40,600
Assited living deposits	2,413	
Medicaid advance	(72,785)	108,048
Restricted funds	9,462	(9,586)
Net cash provided (used) by operating activities	(353,562)	320,417
CASH FLOWS FROM INVESTING ACTIVITIES:		
Redemption of certificates of deposit	(884)	(25,587)
Purchase of fixed assets net of disposals and transfers	(734,592)	(781,997)
Investments maintained by		
Community Foundation of the Eastern Shore	2,457	2,183
Net cash used by investing activities	(733,019)	(805,401)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Proceeds from line of credit	86,206	101,236
Principal payments on long term debt	(581,969)	(183,450)
Net cash used by financing activities	(495,763)	(82,214)
Net decrease in cash and cash equivalents	(1,582,344)	(567,198)
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	2,861,021	3,428,219
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 1,278,677	$ 2,861,021
SUPPLEMENTARY INFORMATION		
Interest paid	$ 503,072	$ 520,384

The accompanying notes are an integral part of these financial statements.

ORGANIZATION

The McCready Foundation, Inc. (Foundation) is located in Crisfield, Maryland. The Foundation consists of The Edward W. McCready Memorial Hospital (Hospital), The Alice Byrd Tawes Nursing Home (Nursing Home), Chesapeake Cove Assisted Living Center (Chesapeake Cove), and The McCready Foundation, Inc. Endowment Fund (Endowment Fund). These four organizations are controlled by a common Board of Directors and Chief Executive Officer that operates under the name of The McCready Foundation, Inc. (the Parent Organization). The consolidated financial statements consist of a combination of the individual financial statements of the Hospital, Nursing Home, Chesapeake Cove, and Endowment Fund with eliminations of certain inter-entity balances and transactions.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Financial statement presentation

The Organization has adopted the provisions of the American Institute of Certified Public Accountants' *Audit and Accounting Guide for Not-For-Profit Entities* in the presentation of its financial information.

The financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. Net assets and revenues, including contributions, are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets of the Organization and changes therein are classified and reported as follows:

Unrestricted net assets - Net assets that are not subject to donor-imposed restrictions.

Temporarily restricted net assets - Net assets subject to donor-imposed stipulations that may or will be met, either by actions of the Organization and/or the passage of time. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as net assets released from restrictions. As of June 30, 2018, the Organization had no temporarily restricted net assets.

Permanently restricted net assets - Net assets subject to donor-imposed restrictions that they be maintained permanently by the Organization. As of June 30, 2018, the Organization has no permanently restricted net assets.

Cash and cash equivalents

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Inventories

Inventories, which primarily consist of medical supplies and drugs, are carried at the lower of cost or net realizable value. Cost is determined using the first-in, first-out method.

Investments

The Foundation's investment policies follow conservative guidelines desired to yield modest returns on low-risk investments. The investment policy reflects a modest objective with only investments in cash products, such as certificates of deposit, encouraged. The only exception to this conservative approach are the funds that were placed in the custody of the Community Foundation of the Eastern Shore (CFES).

The Foundation has accepted the valuation of assets as provided by the CFES which has adopted the Financial Accounting Standards Board *"Accounting Standards Codification."* Under FASB, investments in marketable securities with readily determinable fair values and all investments in debt securities are reported at their fair values in the consolidated statement of financial position. Unrealized gains and losses are included in the change in net assets.

Accounts receivable and allowances

The Organization's policy is to write off all patient accounts that have been identified as uncollectible. A reserve for uncollectible receivables is recorded for accounts not yet written off that are anticipated to become uncollectible in future periods. When determining the allowance, the policy considers the probability of recoverability of accounts based on historical write-offs, net of recoveries, as well as an analysis of the aged accounts receivable balances with allowances generally increasing as the receivable ages. The analysis of receivables is performed monthly, and the allowances are adjusted accordingly.

A reserve for uncollectible receivables has been established based on private pay, insurances and sliding scale fees. The reserve is estimated at $1,401,793 and $1,253,642 as of June 30, 2018 and 2017, respectively. Recoveries of accounts previously written off are recorded as a reduction to bad debt expense when received. Interest is not charged on patient accounts receivable.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Property and equipment

Expenditures for property, equipment, and improvements are capitalized at cost. Equipment expenditures of $500 or less are charged to expense. Ordinary repairs and maintenance are charged to expense when incurred. Donated assets are capitalized, and recorded as support, at their fair value at the date of receipt. Such donations are reported as unrestricted support unless the donor has restricted the donated asset to a specific purpose. Assets donated with explicit restrictions regarding their use, and contributions of cash that must be used to acquire property and equipment, are reported as restricted support. Absent donor stipulations regarding how long those donated assets must be maintained, the Organization reports expirations of donor restrictions when the donated or acquired assets are placed in service as instructed by the donor. The Organization reclassifies temporarily restricted net assets to unrestricted net assets at that time. Depreciation is computed using the straight-line method over the estimated useful lives of the related assets, which are as follows:

	Life
Land improvements	10 - 50 years
Buildings	10 - 50 years
Fixed equipment	5 years
Major moveable equipment	10 - 20 years

Donations and bequests

Unconditional promises to give and other assets are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily restricted or permanently restricted if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statement of activities as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions.

Donated services

No amounts have been reported in the financial statements for donated services or materials. The organization generally pays for services requiring specific expertise.

Income taxes

The Parent Organization is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code and therefore has made no provision for federal income taxes in the accompanying financial statements. The Parent Organization files a consolidated form 990 that includes all activities of The Edward W. McCready Memorial Hospital, The Alice Byrd Tawes Nursing Home, Chesapeake Cove Assisted Living, and The McCready Foundation, Inc. Endowment Fund.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Income taxes (continued)
Under the requirements of Financial Accounting Standards Board (FASB) ASC 740, *"Income Taxes"*, tax-exempt organizations could be required to record an obligation as the result of a tax position they have historically taken on various tax exposure items. As of June 30, 2018, the Parent Organization has determined that it does not have any uncertain tax positions that qualify for either recognition or disclosure in the financial statements.

Net patient service revenue
Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. Revenue under third-party agreements is subject to audit and retroactive adjustment. Provisions for estimated third-party payor settlements are provided in the period the related services are rendered. Differences between the estimated amounts accrued and interim and final settlements are reported in operations in the year of settlement.

The Foundation has agreements with third-party payors that provide for payments to the hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments.

The following estimated adjustments were made to gross patient revenues for the years ended June 30, 2018 and 2017:

	2018	2017
Gross patient service revenue	$ 28,971,818	$ 28,016,728
Less charity care and contractual adjustments	(4,649,696)	(5,318,859)
Net patient service revenue	$ 24,322,122	$ 22,697,869

The Foundation's revenues may be subject to adjustments as a result of examination by government agencies or contractors, and as a result of differing interpretation of government regulations, medical diagnosis, charge coding, medical necessity, or other contract terms. The resolution of these matters, if any, often is not finalized until subsequent to the period during which the services were rendered.

Medicare and Medicaid
Services rendered to Medicare and Medicaid program beneficiaries are paid at prospectively determined rates per visit. The Foundation is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of an annual cost report and audits thereof by the Medicare fiscal intermediary.

Commercial carriers
The Foundation has also entered into payment agreements with certain commercial insurance carriers. The basis for payment to the Foundation is based on charges for services provided to the patients.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Use of estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Subsequent events

Management has evaluated subsequent events through October 29, 2018, the date the consolidated financial statements were available and approved to be issued.

ADVERTISING

The Foundation's policy is to expense advertising costs as the costs are incurred. Total advertising, marketing and development costs for the years ended June 30, 2018 and 2017 amounted to $132,959 and $100,012, respectively.

CASH AND CASH EQUIVALENTS

All cash and cash equivalent funds are in local banks and are secured up to $250,000, per bank, by the Federal Deposit Insurance Corporation (FDIC), an agency of the Federal government. The bank accounts of all four organizations controlled by The McCready Foundation, Inc. have been opened as accounts of The McCready Foundation, Inc. As a result, these four organizations are subject to FDIC as one entity. As of June 30, 2018, The McCready Foundation, Inc. has cash balances totaling $934,131 in excess of the amount insured by the FDIC.

PROPERTY AND EQUIPMENT

At June 30, 2018 and 2017, the cost and related depreciation of property and equipment were as follows:

	2018	2017
Land improvements	$ 106,851	$ 110,632
Buildings	24,511,215	24,008,155
Fixed equipment	1,435,966	1,549,032
Major moveable equipment	4,841,588	5,090,322
Total assets	30,895,620	30,758,141
Less: accumulated depreciation	(14,998,176)	(14,348,830)
Net property and equipment	$ 15,897,444	$ 16,409,311

Depreciation expense for the years ended June 30, 2018 and 2017 amounted to $1,246,459 and $1,464,800, respectively.

LONG-LIVED ASSETS

The carrying value of long-lived assets and certain identifiable intangibles is reviewed by the Organization for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable, as prescribed by ASC Topic 360 *Property, Plant and Equipment*. There were no impairments identified as of June 30, 2018 and 2017, respectively.

COMPENSATED ABSENCES

Employees of the Foundation are entitled to paid vacation, depending on length of service and job classification. Accrued vacation balances at June 30, 2018 and 2017 were $553,519 and $458,495, respectively. Rights to receive sick leave do not vest.

LINE OF CREDIT

The Hospital Agency opened a Convertible Line of Credit with PNC Bank on January 27, 2016 with an available line of credit totaling $114,500. Interest on any borrowing against this line of credit is due the 27th of each month until the conversion date, when all accrued interest shall be due and payable. The balance outstanding as of June 30, 2018 and 2017 was $86,206 and $101,236, respectively.

LONG TERM DEBT

The following summarizes long-term debt at June 30,

	2018	2017
Hospital long term debt:		
USDA Mortgage loan payable to USDA, made on February 5, 1979 in the amount of $3,200,000 matures January, 2021, payable in monthly installments of $15,712 including interest at 5%, collateralized by a first mortgage on the Hospital's land, building, personal property, and pledge of real income. A debt service account requirement (USDA loan agreement paragraph 4.5.1) has been waived by having the McCready Foundation, Inc. pledge a savings account held at PNC Bank. The USDA subordinated its' position on this mortgage, but only to the extent of parity with the mortgages from the Bank of Delmarva in the amount of $4,000,000 and the USDA in the amount of $6,000,000.	$ 59,916	$ 240,431
Convertible line of credit payble to PNC, made on May 15, 2015 and converted on December 15, 2015, with the orginal amount owed of $300,978 and upon conversion $326,958 maturing November 15, 2022, payable in monthly installments of $4,427.56 at an interest rate of $3.67%.	216,038	260,231
Hologic 3D Mammo System - $414,178 financed by Provident Leasing for 36 months at $12,409 (4.977% interest rate)	182,792	319,973
Hemalology System - $33,834 financed by Leasing Associates of Barrington for 48 months at $733 (1.93% interest rate)	22,148	30,430
C Arm Radiology System - $76,985 financed by Siemens Financing for 60 months at $1,353 (2.098% interest rate)	59,105	73,324
Xray - $106,260 financed by Provident Leasing for 36 months at $3,184 (4.985% interest rate)	25,002	60,985
Ultrasound - $154,375 financed by GE for for 60 months at $2,682 (1.64% interest rate)	73,709	97,629
McKesson Coagulation Analizer, NH Call System, Ultrasound $117,806 financed by First American Lease for 60 months at $2,249 (5.476% interest rate)	110,985	

LONG TERM DEBT (Continued)

	2018	2017
Nursing Home long term debt:		
USDA – Second mortgage – $6,000,000 dated June 4, 2009 bearing interest at 4.25%. It is amortized over 40 years with the final installment due June 4, 2049. The purpose of the loan is to construct the new nursing home. The collateral is to include all assets of the Hospital, Nursing Home and the Foundation. Payments were interest only through June 4, 2011, with monthly principal and interest payments commencing on July 4, 2011.	5,442,359	5,528,023
The Bank of Delmarva – Third mortgage – $4,000,000 dated June 4, 2009 bearing interest at 6.5% on the total sums disbursed, starting July 4, 2009 to June 4, 2011. Monthly principal and interest payments commenced on July 4, 2011 and shall continue through June 4, 2016. From and after the 4th of June, 2016, principal and interest at the rate of prime minus one-half percent (-.50%), as of June 4, 2016, on the unpaid principal, shall be due and payable in three hundred (300) consecutive monthly installments (based on a thirty (30) year amortization) commencing on July 4, 2016, and continuing on the like day of each month thereafter, to and including the June 4, 2041, when the final payment of all principal and interest shall be due and payable in full. The term "prime rate of interest" as used herein is defined as the prevailing corporate prime rate as published daily in the Wall Street Journal, or its successor publication. Any increase or decrease in said rate of interest shall be adjusted every 60 months beginning June, 2016, and shall be due on the 4th day of each month following such change in said interest rate. Notwithstanding the above, it is understood and agreed, by and between the parties hereto, that the interest rate set forth herein shall, in no event, be less than 6.50%, nor greater than 9.75%, for the life of the loan. This loan is guaranteed by the USDA. The collateral is to include all assets of the Hospital, Nursing Home, Chesapeake Cove Assisted Living and the Foundation.	3,340,118	3,401,879
Total long term debt	$ 9,532,172	$ 10,012,905

LONG TERM DEBT (Continued)

Scheduled payments of principal due on long term debt for subsequent years ending June 30 are as follows:

	Hospital	Nursing Home	Total
2019	$ 345,993	$ 149,319	$ 495,312
2020	158,266	160,472	318,738
2021	112,561	169,081	281,642
2022	88,663	178,174	266,837
2023	44,212	187,779	231,991
Thereafter		7,937,652	7,937,652
Total	$ 749,695	$ 8,782,477	$ 9,532,172

CHARITY CARE

The Foundation provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The Foundation does not pursue collection of amounts determined to qualify as charity care. The amount of charges foregone for services and supplies furnished under the Foundation's charity care policy aggregated approximately $326,004 and $307,205 in the years ended June 30, 2018 and 2017, respectively.

INVESTMENTS MAINTAINED BY COMMUNITY FOUNDATION OF THE EASTERN SHORE

During the year ended June 30, 2011, the Foundation established a fund in the amount of $105,000 with the Community Foundation of the Eastern Shore (CFES) in order to develop a constant stream of income. CFES is a community based charitable organization established to support worthwhile projects in Wicomico, Worcester, and Somerset Counties. The CFES fund is managed by third party investment managers in a diversified portfolio. The principal of this fund is considered unrestricted. Written board approval is required to draw on the principal of the fund. The balances of the account at June 30, 2018 and 2017 were $253,244 and $230,828, respectively. Unrealized gain (loss) on investments represents the Foundation's share of CFES's realized and unrealized gains and losses, interest and dividends.

COMMITMENTS AND CONTINGENCIES

The Foundation's charges are subject to review and approval by the Maryland Health Services Cost Review Commission. Until such review has been completed and approved, there exists a contingent liability to repay amounts in excess of allowable charges.

The Foundation has elected the reimbursement method of Maryland unemployment coverage whereby the organization reimburses the State of Maryland Unemployment Insurance Fund for unemployment claims charged against its account. These amounts are recorded as expense when a bill is received from the State of Maryland Department of Labor, Licensing, and Regulation Division of Unemployment Insurance. No accrual for estimated unassessed reimbursements has been made since the amount charged to an employer's account is subject to complex rules and management believes any reimbursement to be assessed will not be material. Unemployment claims for fiscal years 2018 and 2017 were $21,523 and $23,142 respectively.

EMPLOYEE PENSION PLAN – DEFINED CONTRIBUTION

The Foundation provides a two percent employer pension contribution with a salary cap of $100,000 per year. The two percent employer contribution is not a match but an across the board contribution to all full time employees who have been employed for one year or more. Both full time and part time employees are allowed to participate in the plan through payroll deductions. Employer contributions to the plan for the years ended June 30, 2018 and 2017 amounted to $142,499 and $138,379 respectively.

CONCENTRATION OF CREDIT RISK

At June 30, 2018, the Foundation received a substantial amount of its support from Medicaid and Medicare. A reduction in the level of this reimbursement, if this were to occur, may have an effect on the organization's activities.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimated revenue will change by a material amount in the near term.

The Foundation elected to be self-insured for employee health insurance up to a cap of about $1.5 million. The Foundation's actual cost for the year ended June 30, 2018 and 2017 were $1,335,504 and $1,359,118 respectively.

OPERATING LEASES

As of June 30, 2018, the Foundation had several non-cancelable operating lease agreements for the rental of various pieces of equipment expiring from 2018 to 2019. Minimum rentals, on an annual basis, are as follows:

		Equipment
Fiscal Year ending June 30,	2018	$ 126,697
	2019	19,202
		$ 145,899

RISK MANAGEMENT

The Hospital is exposed to various risk of losses related to torts; theft of; damage to; and destruction of assets; errors and omissions; injuries to employees; and natural disasters. The Hospital has obtained coverage from commercial insurance companies for these risks. There were no significant reductions in insurance coverage from the prior year. No settlements exceeded insurance coverage in the past three fiscal years.

PRIOR PERIOD ADJUSTMENT

In 2017 the Hospital understated its depreciation. The adjustment to unrestricted net assets is as follows:

Unrestricted net assets at June 30, 2017, as previously reported	$ 11,800,167
Adjustment for depreciation	(49,758)
Unrestricted net assets at June 30, 2018, as restated	$ 11,750,409

In 2017 the Nursing Home understated its depreciation. The adjustment to unrestricted net assets is as follows:

Unrestricted net assets at June 30, 2017, as previously reported	$ 1,420,146
Adjustment for depreciation	(20,794)
Unrestricted net assets at June 30, 2018, as restated	$ 1,399,352

FAIR VALUE MEASUREMENT

The framework for measuring for fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

Level 1 Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2 Inputs other than quoted prices included within Level 1, to the valuation methodology include

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value.

Investments maintained by the Community Foundation of the Eastern Shore: Valued at the reported fund balances by the CFES which represents the Endowment Fund's share in a portion of the total investments held by the CFES.

FAIR VALUE MEASUREMENT (Continued)

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Endowment Fund believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date

The following table sets forth by level, within the fair value hierarchy, the Endowment Fund's assets at fair value as of June 30, 2018 and 2017:

Assets Measured at Fair Value on a Recurring Basis June 30, 2018:

	Fair Value Measurement at Reporting Date Using:			
Description	(Level 1)	(Level 2)	(Level 3)	Total
Investment maintained by CFES	$	$	$ 253,244	$ 253,244
Total	$	$	$ 253,244	$ 253,244

Assets Measured at Fair Value on a Recurring Basis June 30, 2017:

	Fair Value Measurement at Reporting Date Using:			
Description	(Level 1)	(Level 2)	(Level 3)	Total
Investment maintained by CFES	$	$	$ 230,838	$ 230,838
Total	$	$	$ 230,838	$ 230,838

FAIR VALUE MEASUREMENT (Continued)

The following table sets forth a summary of changes in the fair value of the plan's level 3 assets for the year ended June 30, 2018.

Assets measured at Fair Value on a Recurring Basis Using Significant Unobservable Inputs (Level 3).

	Investment maintained by CFES	Total
Balance, beginning of year	$ 230,828	$ 230,828
Administration fees	(2,457)	(2,457)
Unrealized gain	24,873	24,873
Balance, end of year	$ 253,244	$ 253,244

NEW ACCOUNTING STANDARDS

FASB issued Accounting Standards Update (ASU) No. 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities.* The new standard is geared towards improving non-profit financial statements and to provide more useful information to users. Major changes include the classification of net assets in two classes, net assets with donor restrictions and net assets without donor restrictions, as opposed to the three classes currently used. In addition, additional information will be required to report on spendable financial resources. The new standard will be effective for the year ended June 30, 2019.

FASB issued Accounting Standards Update (ASU) No. 2016-02, *Leases.* Under the new guidance, a lessee will be required to recognize assets and liabilities for leases with lease terms of more than 12 months. Consistent with current Generally Accepted Accounting Principles (GAAP), the recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee primarily will depend on its classification as a finance or operating lease. However, unlike current GAAP—which requires only capital leases to be recognized on the balance sheet—the new ASU will require both types of leases to be recognized on the balance sheet. The new guidance on leases will take effect for the year ended June 30, 2021.

SUPPLEMENTARY INFORMATION

THE MCCREADY FOUNDATION, INC.

CONSOLIDATING STATEMENTS OF FINANCIAL POSITION

JUNE 30, 2018 AND 2017

ASSETS	2018					
	Hospital	Endowment	Assisted Living	Nursing Home	Eliminations	Total
CURRENT ASSETS						
Cash and cash equivalents	$ 1,216,700	$ 8,010	$ 22,476	$ 31,491	$	$ 1,278,677
Certificates of deposit		202,830				202,830
Accounts receivable, net	3,134,016		67,962	1,047,157		4,249,135
Pledges receivable						
Inventories	355,547			30,420		385,967
Prepaid expenses	293,795			3,997		297,792
Total current assets	5,000,058	210,840	90,438	1,113,065		6,414,401
INVESTMENTS, AT FAIR VALUE						
Investments maintained by						
Community Foundation of the Eastern Shore		253,244				253,244
Total investments		253,244				253,244
PROPERTY AND EQUIPMENT						
Property and equipment	16,858,976		4,051,429	9,985,215		30,895,620
Less accumulated depreciation	(11,480,843)		(872,326)	(2,645,007)		(14,998,176)
Net property and equipment	5,378,133		3,179,103	7,340,208		15,897,444
OTHER ASSETS						
Due from affiliates	4,263,500	402,811		5,328,509	(9,994,820)	
Restricted patient funds				18,618		18,618
Total other assets	4,263,500	402,811		5,347,127	(9,994,820)	18,618
Total assets	$ 14,641,691	$ 866,895	$ 3,269,541	$ 13,800,400	$ (9,994,820)	$ 22,583,707

	2017					
	Hospital	Endowment	Assisted Living	Nursing Home	Eliminations	Total
CURRENT ASSETS						
Cash and cash equivalents	$ 2,297,526	$ 461,258	$ 6,045	$ 96,192	$	$ 2,861,021
Certificates of deposit		201,946				201,946
Accounts receivable, net	2,272,038		46,493	868,517		3,187,048
Pledges receivable		1,600				1,600
Inventories	350,706			18,764		369,470
Prepaid expenses	235,680			3,997		239,677
Total current assets	5,155,950	664,804	52,538	987,470		6,860,762
INVESTMENTS, AT FAIR VALUE						
Investments maintained by						
Community Foundation of the Eastern Shore		230,828				230,828
Total investments		230,828				230,828
PROPERTY AND EQUIPMENT						
Property and equipment	16,871,286		4,020,907	9,865,948		30,758,141
Less accumulated depreciation	(11,155,513)		(440,133)	(2,753,184)		(14,348,830)
Net property and equipment	5,715,773		3,580,774	7,112,764		16,409,311
OTHER ASSETS						
Due from affiliates	3,664,261			5,163,680	(8,827,941)	
Restricted patient funds				20,236		20,236
Total other assets	3,664,261			5,183,916	(8,827,941)	20,236
Total assets	$ 14,535,984	$ 895,632	$ 3,633,312	$ 13,284,150	$ (8,827,941)	$ 23,521,137

THE MCCREADY FOUNDATION, INC.

CONSOLIDATING STATEMENTS OF FINANCIAL POSITION

JUNE 30, 2018 AND 2017

LIABILITIES AND NET ASSETS	2018					
	Hospital	Endowment	Assisted Living	Nursing Home	Eliminations	Total
CURRENT LIABILITIES						
Line of credit	$ 86,206	$	$	$	$	$ 86,206
Current portion of long-term debt	345,993			149,319		495,312
Accounts payable	1,316,858		3,204	378,945		1,699,007
Accrued salaries, annual leave and related taxes	686,782		32,888	276,390		996,060
Accrued interest	1,639			29,600		31,239
Medicare periodic interim payment program	123,244					123,244
Blue cross - advance	158,400					158,400
Assisted living deposits			2,413			2,413
Medicaid - advance	55,225			58,622		113,847
Total current liabilities	2,774,347		38,505	892,876		3,705,728
LONG - TERM DEBT						
Loan payable	403,702			8,633,158		9,036,860
Total non-current liabilities	403,702			8,633,158		9,036,860
OTHER LIABILITIES						
Due to affiliates	402,811	11,200	6,249,588	3,331,221	(9,994,820)	
Restricted patient funds				18,493		18,493
Total other liabilities	402,811	11,200	6,249,588	3,349,714	(9,994,820)	18,493
Total liabilities	3,580,860	11,200	6,288,093	12,875,748	(9,994,820)	12,761,081
NET ASSETS (DEFICIT)						
Unrestricted	11,060,832	855,695	(3,018,552)	924,652		9,822,627
Total net assets (deficit)	11,060,832	855,695	(3,018,552)	924,652		9,822,627
Total liabilities and net assets	$ 14,641,692	$ 866,895	$ 3,269,541	$ 13,800,400	$ (9,994,820)	$ 22,583,708

	2017					
	Hospital	Endowment	Assisted Living	Nursing Home	Eliminations	Total
CURRENT LIABILITIES						
Line of credit	$ 101,236	$	$	$	$	$ 101,236
Current portion of long-term debt	446,340			144,599		590,939
Accounts payable	669,441		3,030	195,477		867,948
Accrued salaries, annual leave and related taxes	600,528		36,004	233,050		869,582
Accrued interest	2,484			30,102		32,586
Medicare periodic interim payment program	49,419					49,419
Blue cross - advance	153,600					153,600
Medicaid - advance	125,864			60,768		186,632
Total current liabilities	2,148,912		39,034	663,996		2,851,942
LONG - TERM DEBT						
Loan payable	636,663			8,785,303		9,421,966
Total non-current liabilities	636,663			8,785,303		9,421,966
OTHER LIABILITIES						
Due to affiliates		65,388	6,337,703	2,424,850	(8,827,941)	
Restricted patient funds				10,649		10,649
Total other liabilities		65,388	6,337,703	2,435,499	(8,827,941)	10,649
Total liabilities	2,785,575	65,388	6,376,737	11,884,798	(8,827,941)	12,284,557
NET ASSETS (DEFICIT)						
Unrestricted, as restated	11,750,409	830,244	(2,743,425)	1,399,352		11,236,580
Total net assets (deficit), as restated	11,750,409	830,244	(2,743,425)	1,399,352		11,236,580
Total liabilities and net assets	$ 14,535,984	$ 895,632	$ 3,633,312	$ 13,284,150	$ (8,827,941)	$ 23,521,137

THE MCCREADY FOUNDATION, INC.

CONSOLIDATING STATEMENTS OF ACTIVTY

YEARS ENDED JUNE 30, 2018 AND 2017

	2018				
	Hospital	Endowment	Assisted Living	Nursing Home	Total
OPERATING REVENUE	$ 17,343,163	$	$ 810,784	$ 6,168,175	$ 24,322,122
EXPENSES					
Wages and benefits					
Salaries and wages	7,412,456		542,473	3,802,422	11,757,351
Payroll taxes	517,561		36,700	272,495	826,756
Employee benefits	1,086,553		45,002	554,809	1,686,364
Total wages and benefits	9,016,570		624,175	4,629,726	14,270,471
Direct expenses					
Professional service fees	2,101,558	2,463		63,143	2,167,164
Consumable supplies	1,551,484		165,207	616,627	2,333,318
Advertising and recruiting	126,790			6,169	132,959
Service contracts and maintenance	1,415,129			109,677	1,524,806
Leases and rentals	445,064		989	64,071	510,124
Depreciation expense	816,990		109,217	320,252	1,246,459
Utilities	411,569		34,484	150,414	596,467
Interest expense	87,694		135,138	280,240	503,072
Insurance	271,347		10,698	134,488	416,533
Other expenses	711,226		5,870	218,784	935,880
Bad debt expense	1,152,504		133	51,095	1,203,732
Total direct expenses	9,091,355	2,463	461,736	2,014,960	11,570,514
Total expenses	18,107,925	2,463	1,085,911	6,644,686	25,840,985
Operating loss	(764,762)	(2,463)	(275,127)	(476,511)	(1,518,863)
NONOPERATING INCOME	75,185	27,914		1,811	104,910
Change in net assets	(689,577)	25,451	(275,127)	(474,700)	(1,413,953)
NET ASSETS, BEGINNING OF YEAR, AS RESTATED	11,750,409	830,244	(2,743,425)	1,399,352	11,236,580
NET ASSETS, END OF YEAR	$ 11,060,832	$ 855,695	$ (3,018,552)	$ 924,652	$ 9,822,627

	2017				
	Hospital	Endowment	Assisted Living	Nursing Home	Total
OPERATING REVENUE	$ 15,793,531	$	$ 891,187	$ 6,013,151	$ 22,697,869
EXPENSES					
Wages and benefits					
Salaries and wages	7,161,287		514,681	3,152,174	10,828,142
Payroll taxes	507,947		33,484	238,059	779,490
Employee benefits	1,120,856		52,187	572,094	1,745,137
Total wages and benefits	8,790,090		600,352	3,962,327	13,352,769
Direct expenses					
Professional service fees	2,111,103	3,396	2,800	97,608	2,214,907
Consumable supplies	1,278,439		173,825	586,373	2,038,637
Advertising and recruiting	98,702		411	899	100,012
Service contracts and maintenance	831,907		427	131,297	963,631
Leases and rentals	464,862		1,003	74,580	540,445
Depreciation expense	992,657		91,464	380,679	1,464,800
Utilities	446,378		38,704	148,363	633,445
Interest expense	93,383		123,709	303,292	520,384
Insurance	302,760		18,736	168,062	489,558
Other expenses	558,614		5,986	162,758	727,358
Bad debt expense	645,702		11,095	51,880	708,677
Total direct expenses	7,824,507	3,396	468,160	2,105,791	10,401,854
Total expenses	16,614,597	3,396	1,068,512	6,068,118	23,754,623
Operating loss	(821,066)	(3,396)	(177,325)	(54,967)	(1,056,754)
NONOPERATING INCOME	139,638	31,794		10,575	182,007
Change in net assets	(681,428)	28,398	(177,325)	(44,392)	(874,747)
NET ASSETS, BEGINNING OF YEAR	12,431,837	801,846	(2,566,100)	1,443,744	12,111,327
NET ASSETS, END OF YEAR, AS RESTATED	$ 11,750,409	$ 830,244	$ (2,743,425)	$ 1,399,352	$ 11,236,580

EXHIBIT 8

Rate Order 16,465,560

HSCRC Proposal **Option 6**

TOTAL McCready FMF

Based on 90% of McCready, YR 1 & 2; 85% YR 2; 80% YR 3 and After

McCready FMF	Yr 1 90% FY2020	Yr 2 90% FY2021	Yr 3 85% FY2022	Yr 4 80% FY2023	Yr 5 80% FY2024	
EMG	$ 2,750,634	$ 2,750,634	$ 2,597,821	$ 2,445,008	$ 2,445,008	
CL	$ 2,603,678	$ 2,603,678	$ 2,459,029	$ 2,314,380	$ 2,314,380	
LAB	$ 1,719,742	$ 1,719,742	$ 1,624,201	$ 1,528,660	$ 1,528,660	
RAD	$ 1,488,433	$ 1,488,433	$ 1,405,742	$ 1,323,052	$ 1,323,052	
CAT	$ 457,077	$ 457,077	$ 431,684	$ 406,290	$ 406,290	
IRC	$ 2,904	$ 2,904	$ 2,743	$ 2,581	$ 2,581	
RES	$ 209,101	$ 209,101	$ 197,485	$ 185,868	$ 185,868	
PTH	$ 689,352	$ 689,352	$ 651,055	$ 612,758	$ 612,758	
STH	$ 25,064	$ 25,064	$ 23,671	$ 22,279	$ 22,279	
OBV	$ 132,722	$ 132,722	$ 125,349	$ 117,975	$ 117,975	
MSS	$ 331,542	$ 331,542	$ 331,542	$ 271,262	$ 271,262	
CDS	$ 601,214	$ 601,214	$ 601,214	$ 491,902	$ 491,902	
FMF Total	**$ 11,011,463**	**$ 11,011,463**	**$ 10,451,535**	**$ 9,722,015**	**$ 9,722,015**	$ (1,289,448) Savings per Year

TOTAL Peninsula Regional Inpatient

Based on 100% of PRMC's Rates Every Year

Based on 100% of PRMC's Rates	Yr 1 100%	Yr 2 100%	Yr 3 100%	Yr 4 100%	Yr 5 100%	
Peninsula Permanent Shift						
MSG	$ 745,772	$ 745,772	$ 745,772	$ 745,772	$ 745,772	
ADM	$ 44,482	$ 44,482	$ 44,482	$ 44,482	$ 44,482	
OR	$ 499,360	$ 499,360	$ 499,360	$ 499,360	$ 499,360	
ORC	$ 13,962	$ 13,962	$ 13,962	$ 13,962	$ 13,962	
ANS	$ 31,585	$ 31,585	$ 31,585	$ 31,585	$ 31,585	
SDS	$ 397,582	$ 397,582	$ 397,582	$ 397,582	$ 397,582	
EKG	$ 80,133	$ 80,133	$ 80,133	$ 80,133	$ 80,133	
OTH	$ 65,858	$ 65,858	$ 65,858	$ 65,858	$ 65,858	
MRI	$ 10,112	$ 10,112	$ 10,112	$ 10,112	$ 10,112	
MSS	$ 208,822	$ 208,822	$ 208,822	$ 208,822	$ 208,822	
CDS	$ 417,954	$ 417,954	$ 417,954	$ 417,954	$ 417,954	
Total Shift To Peninsula	**$ 2,515,623**	**$ 2,515,623**	**$ 2,515,623**	**$ 2,515,623**	**$ 2,515,623**	$ (625,000) Additional Variable Cost
						$ 1,890,623 Profit
Total	**$ 13,527,086**	**$ 13,527,086**	**$ 12,967,158**	**$ 12,237,638**	**$ 12,237,638**	
RY19 GBR Target	$ 16,465,560	$ 16,465,560	$ 16,465,560	$ 16,465,560	$ 16,465,560	
Public Savings/Dissipation	$ 2,938,473	$ 2,938,473	$ 3,498,401	$ 4,227,922	$ 4,227,922	
Savings Percent	17.85%	17.85%	21.25%	25.68%	25.68%	

Additional Community Investments

FMF Permanent Capital	$ 1,929,147	$ 1,929,147	$ 1,929,147	$ 1,929,147	$ 1,929,147	Based on $25 million over 25 years @ 5% ($146,148/month) + MU
Rural Health/Population Health	$ 900,000	$ 900,000	$ 900,000	$ 900,000	$ 900,000	Based on Hospital's Request — Pop Health/ER Physicians
Rural Health/Telemedicine	$ 400,000	$ 400,000	$ 400,000	$ 400,000	$ 400,000	Based on Hospital's Request — IP Transportation Cost
FMF One Time Transition	$ 1,000,000	$ 1,000,000	$ -	$ -	$ -	Based on $1 million per Year
	$ 4,229,147	**$ 4,229,147**	**$ 3,229,147**	**$ 3,229,147**	**$ 3,229,147**	
RY19 GBR Target	$ 17,756,234	$ 17,756,234	$ 16,196,305	$ 15,466,785	$ 15,466,785	
Net Saving	$ (1,290,674)	$ (1,290,674)	$ 269,254	$ 998,774	$ 998,774	
Net Savings Percent	-7.84%	-7.84%	1.64%	6.07%	6.07%	

EXHIBIT 9

CALLISONRTKL

REPORT ON MCCREADY MEMORIAL HOSPITAL

Peninsula Regional Health System

McCready Memorial Hospital

PENINSULA
REGIONAL HEALTH SYSTEM

McCready
HEALTH
With you...for life!

September 13, 2018

EXECUTIVE SUMMARY

A new facility should be constructed for a Freestanding Medical Facility (FMF) to meet the healthcare needs of the Crisfield community. A newly constructed building will provide state-of-the art facilities, be efficient to operate and minimize disruption to healthcare services during the construction period. The new facility will support clinical services for generations.

The recommendation to construct a new facility was reached after thorough evaluation, which included the consultants, construction manager and PRMC. Through this evaluation, we determined factors including cost, duration of construction, level of frustration, coordination efforts and code-related design considerations should eliminate the renovation option from consideration. Refer to Section 3D and related Attachments.

CONTENTS

Section 1:

INTRODUCTION

WHY IS THIS REPORT BEING WRITTEN?

The current status of McCready Memorial Hospital is not sustainable. The number of inpatients has declined to a point where conversion to a Freestanding Medical Facility (FMF) appears to be inevitable. The operating expenses of the current physical plant are greater than the current patient volumes can sustain.

Participants

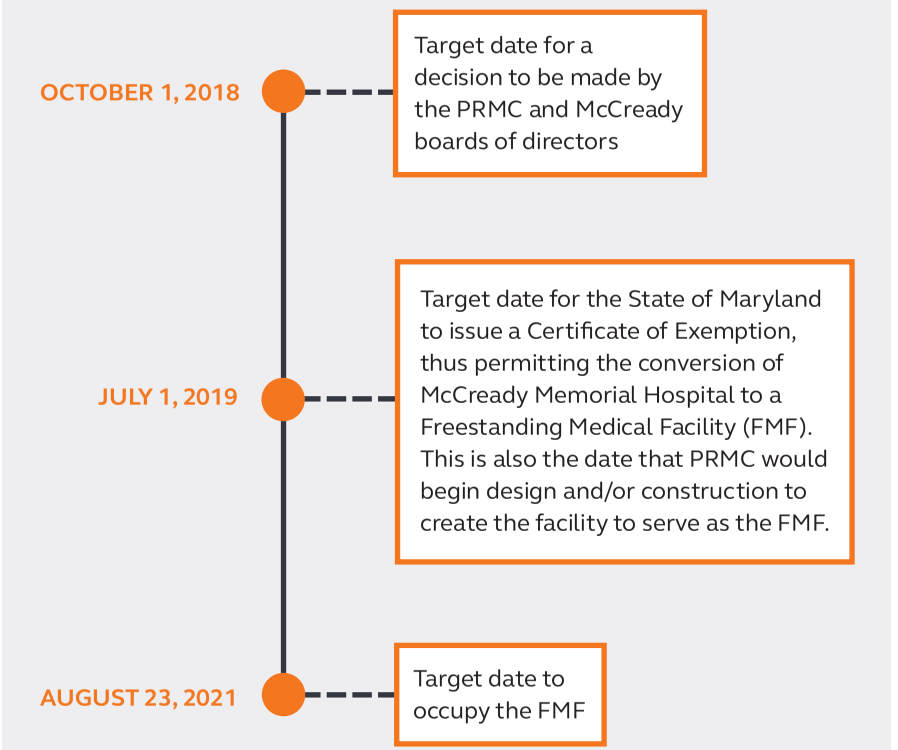
Peninsula Regional Medical Center (PRMC) engaged the following firms to help analyze existing conditions and support recommendations for a future course of action:

- **CallisonRTKL**, Architectural Services, Washington, DC
- **Leach Wallace**, Mechanical/Electrical/Plumbing Engineering, Elkridge, MD
- **Whiting-Turner**, Construction Consulting and Cost Estimating, Salisbury, MD

Process Used for Analysis and Formation of Recommendation

- **Analysis of Data:** The McCready staff made drawings in both hard copy and AutoCAD available to the PRMC staff and consultants. Additional information was gathered from publicly available sources such as Google Maps.
- **Site Visits:** Several visits were made to the McCready campus by staff members of PRMC, CallisonRTKL and Leach Wallace. Participants walked through the hospital (clinical, administrative and MEP spaces), as well as around the exterior.
- **Meetings with Staff:** McCready staff were very helpful in answering questions about the facility, history and ongoing projects:
  - Ken Stirling
  - Rich Sipe

Key Dates



Section 2:

EXISTING CONDITIONS AT MCCREADY

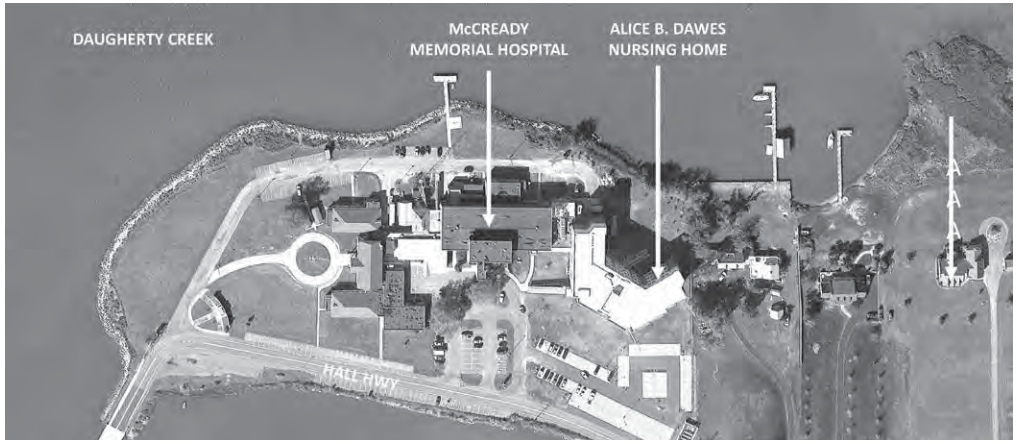
2.A
SERVICES CURRENTLY PROVIDED

- The Emergency Department is currently reported to receive 12 patients/day
- The Average Daily Census for inpatients is below 2
- Other services are provided, including surgery, imaging, laboratory, pharmacy, outpatient clinics and rehabilitation medicine

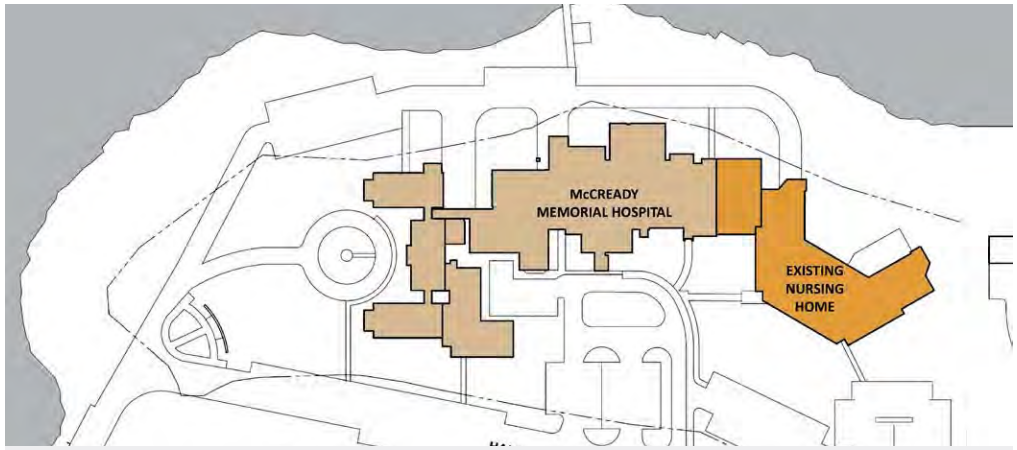
2.B
EXISTING PHYSICAL PLANT

Site

The site is a peninsula and sits very near the water. In recent storm events, no water was reported to have entered clinical spaces although some support areas have been flooded.



An aerial view of the site of McCready Memorial Hospital in Crisfield, MD



Site plan showing the existing hospital and nursing home.
The boiler plant is shared between the two facilities.

Architecture

This study included the McCready Memorial Hospital, McCready Outpatient Center and McCready Outpatient Rehabilitation. Other entities (Alice B. Tawes Nursing & Rehabilitation Center and Chesapeake Cover Assisted Living) were not part of this study.

The hospital has about 16 buildings including connections between buildings, but excluding free-standing outbuildings. The buildings were constructed between 1929 and 2000. (Note that the boiler plant was expanded in 2008 as part of the nursing home project that followed shortly thereafter, however, these buildings are not part of the hospital.) The hospital buildings total just over 70,000 BGSF with about 60% of the space in the "1980" Building with its minor additions.

The buildings are in relatively good shape for their age. They have no visible structural issues and have received limited upgrades such as replacement windows in some older buildings, and no visible roof leakage on the upper floors. Some of the older buildings have recently received new interior finishes and some interior renovations.

The buildings that predate the 1980 building have very small footprints and are unlikely to justify the expense of significant renovation to support state-of-the-art clinical functions. Several out buildings are used for storage; they were not evaluated as part of this study.

The 1980 building has a reasonable column spacing for modern clinical functions, however, it sits only 9' above the high-tide water mark (the new nursing home sits at 10'-6") and part of the surgical suite encroaches upon the 100' critical buffer area of the site.

All buildings predate the adoption of the Americans with Disabilities Act, and very few modifications have been undertaken to address accessibility concerns. Many requirements of current codes and standards are not being met in the current buildings. Addressing architectural and medical code deficiencies would most likely require a total gut and renovation of the spaces.

The 1929 buildings as seen from the bridge entering the site.

M.E.P. Systems

The engineering infrastructure is about 40 years old and has been maintained on a tight budget. The systems do not meet current codes for hospitals. A full report is included in the Appendix.

The existing hospital buildings are fully sprinklered.

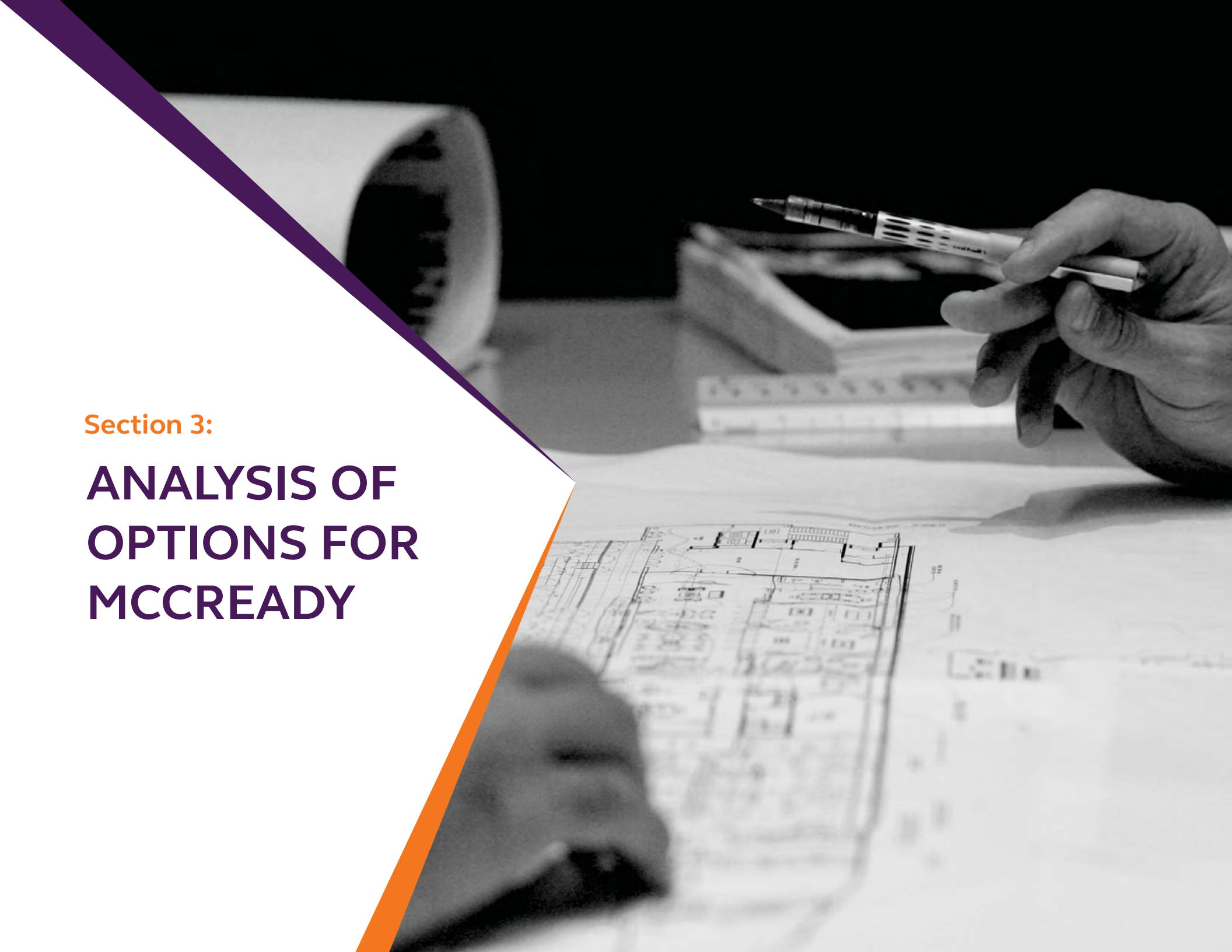
The hospital central plant includes the following major systems:

- Two 100 psig high pressure steam boilers and support systems including a deaerator (not functioning) and condensate return system. The boilers only source of fuel is fuel oil.
- 130 ton rooftop air cooled chiller (not functioning and abandoned in place)
- Domestic booster pump (serves both hospital and nursing home). Per staff input, the system is undersized.
- Steam fired 1,200 gallon tank type domestic water heater
- Medical vacuum pump (leaking oil)
- 25,000 gallon underground fuel oil storage tank (serves the boilers and generators)
- Fire pump (connected to an existing 6" water service and has churn issues)
- Electrical

The "1980" building, the current main entrance of the hospital.

Section 3:

ANALYSIS OF OPTIONS FOR MCCREADY



The following sections describe long-term strategies for positioning McCready to support healthcare needs of the community. Any of these strategies are likely to take months, if not a couple of years, to implement. The short-term strategy to keep the medical facility operational until 2021 is proposed to be limited to:

- Minor renovations to improve functionality
- Any required repairs for equipment that fails
- No improvements to bring the building or systems up to current codes and standards in the interim period

3.A
SERVICES TO BE PROVIDED

Service Lines

- **Conversion to FMF:** The inpatient beds and surgery services will be discontinued. An application will be filed with the State of Maryland to issue a Certificate of Exemption. The FMF services will be operated as departments of the PRHS.
- **Emergency Department:** 1 triage room, 3 treatment rooms, 1 oversized treatment/procedure room, 2 observation rooms with private toilet/shower (1 of which to be an Airborne Infection Isolation room), and 2 secure holding rooms.
- **Imaging Department:** 1 radiography room, 1 CT, 1 ultrasound room; PACS with remote reading capability
- **Laboratory:** Specimen collection areas for blood and urine; space for selected analyzers
- **Crisfield Clinic:** Exam rooms and support spaces to accommodate up to 4 providers simultaneously. This clinic should connect to the Emergency Department so clinical services and staff can swing between the two departments.
- **Outpatient Rehabilitation Medicine:** 2 Consultation rooms, 1 group therapy room and support spaces to accommodate up to 3 providers

The following is a summary of the proposed departments. Additional detail can be found in the space program and staffing plan included in the Appendix.

	EXISTING	PROPOSED				
Department	**DGSF**	**NSF**	**DGSF**	**BGSF**	**Staff on Main Shift**	**Total Staff**
Administration	?	1,175	1,586		10.6	10.60
Crisfield Clinic	?	1,965	2,751		10	9.80
Freestanding E.D.	2,640	3,705	5,557		8	28.86
Imaging	3,324	1,562	2,343		3.5	6.43
Laboratory	1,267	1,014	1,267		3	5.95
Pharmacy	1,460	0	0		1	1.10
Psych–Outpatient	1,500	880	1,346		3	3.00
Physical Therapy	4,624	2,308	3,000		4.2	4.20
Support Services	?	1,902	2,473		7	15.38
Subtotals:		14,511	20,324		50	83.32
Communications/LAN Closets		Included in Support Services				
Common Circulation		1,626	8.0%			
Mech/Plumbing Allowance		658	3.0%			
Building Envelope		752				
TOTAL ESTIMATED BGSF		**23,359**				

Summary of the space program of existing and proposed facilities.

Accounting	1.00
Administration	3.00
Admissions	7.00
Behavioral Health	3.00
Communications	1.60
Courier	3.00
Crisfield Clinic	9.80
Emergency Department	13.35
Environmental Services	3.28
Human Resources	1.00
Information Technology	3.00
Laboratory	5.95
Maintenance	5.10
Materials Management	1.00
Medical Records	1.00
Patient Accounts	2.00
Patient Services	1.00
Pharmacy	1.10
Physical Therapy	2.60
Princess Anne Clinic	6.40
Radiology	4.93
Radiology CT	0.50
Respiratory Therapy	4.93
Security	4.48
Speech Therapy	0.60
Total	90.62

Staff plan for the FMF.

3.B
OPPORTUNITIES/LIMITATIONS

No buildings are historic, any buildings can be considered for demolition

The level of the ground floor of the hospital buildings is at 9' above sea level and cannot reasonably be changed. The new nursing home is at 10'-6" above sea level and the higher level is very reasonable given the proximity to the water and the potential of flooding due to storms. Although clinical levels of the hospital have never flooded, flood waters have been reported to have flooded service areas.

3.C
OPTION 1: DO THE MINIMUM/CONTINUITY OF OPERATIONS WHILE LONG TERM PLAN IS DEVELOPED

Existing operations may continue under current conditions. Minor improvements, as noted hereinafter, are required for minimal code compliance and appropriate patient care.

As an example, minimal improvements include:

- Provide supplemental air conditioning for the primary data closet
- Replace the Nurse Call System in the Emergency Department
- Contingency for significant system failure
- Due to the age of the buildings and MEP systems, all systems and equipment is beyond their Life Cycle with the except that installed with the Nursing Home
- To continue operation of these systems for in excess of two years, it is estimated a Contingency Fund of $2,000,000 to cover rental of temporary equipment under Catastrophic Failure
- Required Improvements to maintain "status quo"

Current Design / Operational Deficiencies

- Replace windows throughout
- ED:
    i. Provide private rooms
    ii. Provide ice machine
    iii. Provide Airborne Infection Isolation room

Code Deficiencies

- ADA
- MEP

Addressing MEP upgrades will bring about major disruptions. A list of the recommended MEP upgrades is attached for reference.

Plan of the first floor of the 1980 building with "short-term" renovation areas shown in green.

Minimum Work to Maintain Current Occupancy for 2 Years

a. Provide proper sealing and drainage for emergency generator. Generator currently has standing water in base of generator around conduits providing power to generator batteries and accessories.
b. Provide new ED nurse call system. The existing nurse call system appears to be inoperable, and modifications/upgrades would be difficult due to its age and condition.
c. Install additional normal and emergency electrical receptacles in ED patient bays to meet the minimum code requirements. Currently, the ED bays have a single quad receptacle (which means 4 receptacles for plugs), and the construction guidelines required 12 receptacles, with approximately half on emergency power and half on normal power. The existing quad outlets are either on normal or emergency, and not both normal and emergency. We propose adding either an emergency or normal circuit to each bay, as well as 2 additional quads per bay.
d. Perform grounding tests on the existing building.
e. Perform preventative maintenance (PM) on the existing main normal power switchboard. The existing bolted pressure switches require significant maintenance, and it is not clear if this has been regularly performed.
f. Install additional normal and emergency electrical receptacles in re-branded Trauma Room (currently OR) to meet code minimum quantities. The existing operating rooms only have 10 and 12 receptacles (for ORs #1 and #2 respectively). Also bring two branches of power into operating room as room is solely served from critical power currently.
g. Consider removing twist lock plugs in the trauma room. (Optional)
h. Consider adding a code blue function to the nurse call system in the ED and Trauma Room, as none exists today. (Optional)
i. Provide generator annunciator in 24 hour manned location or man the boiler plant office around the clock.
j. Filter and treat the fuel in the existing main underground fuel storage tank and daytanks to confirm fuel is clean and usable.
k. Confirm what PRMC insurance company (Chubb) will require.
l. Need 2 sources of fuel for steam boilers providing heat to patient rooms and clinical spaces. Extend and connect to existing propane gas main serving the nursing home boilers. Replace existing burner nozzles and trim with dual fuel equipment.
m. There is no backflow preventer visible on the hospital 4” CW. Add a BFP. (Optional)
n. Remove local dehumidifiers from OR’s.
o. There is currently only one medical gas master alarm panel, installed a room that is not 24 hour monitored. Add second master alarm panel per code and extend to BAS.
p. Confirm ATC system is on emergency power. If not, re-feed to e-power.
q. Add decontamination shower and holding tank to ED. (Optional)
r. Provide MEP connections for the new ADA bathrooms/sinks in the ED (exhaust, sanitary, vent, domestic water).
s. Test/clean/adjust/retro-commission existing AHU’s.
t. AHU-1 and AHU-2 dual-duct system has an existing high humidity issue. The hot deck receives raw outside air that does not pass over a cooling coil first, and is not dehumidified. (Optional)
u. Repair/replace medical vacuum pump. It is leaking a lot of oil. (Optional)
v. Roof – medical vacuum discharge is 2’ from openable nursing home window. (Optional)
w. Repair/complete the installation of the boiler emergency shut-off switches; they are currently not wired.
x. PM/clean/inspect existing sanitary lift station and pumps

List of M.E.P. engineering issues to be addressed in the short term.

Short Term Option

Minimal changes are appropriate as temporary measures to improve operational efficiencies until a more permanent solution is developed.

Architectural Strategy

The design team recommends the following changes to the Emergency Department to improve short-term efficiencies:

- Add a bathroom and a window to the exterior to one of the ED bays. This would allow the room to be used for extended stays, and possibly allow an inpatient to remain in the ED rather than requiring the second floor of the hospital to be opened for a single patient.
- The medications station and nourishment station would be relocated to the existing doctor room where plumbing exists. An ice maker should be added at this location.
- An existing corridor should be closed off to provide storage space for the ED.
- The Surgery Department soiled utility room could to be converted to a doctor's room (combination on-call room and office).

The changes have been proposed to minimize both the cost and the disruption/ time required for construction. **The estimated cost for these improvements is $75,000.**

M.E.P. Strategy

Please see the list of M.E.P. items that require decisions. **The estimated cost for these improvements is $600,000 - $900,000 based on optional improvements.**

3.D
OPTION 2: RENOVATION

The following section describes efforts that were performed as part of "due diligence", however, renovation is not considered to be feasible for reasons listed in **Section 4. Recommendation**.

Analysis of "Old Buildings"

The old buildings have radiators for heat and window air conditioning units. Also, the oldest buildings appear to be wood construction. The original 2-story building has only one stairway and an exterior fire escape. Given the small footprints of these interconnected buildings, it will be expensive and not efficient to bring them up to current codes and standards for institutional functions.

An enclosed connection to the nursing home is recommended to allow services, staff and patients to be shared between the facilities.

The 1980 building is the only building that might be feasible for renovation. This building has the following advantages over the other buildings:

- The geometry of the floor plates is generous.
- The structural system consists of well-spaced columns.
- The building is connected to the existing nursing home.

Reasons to not renovate this building include:

- The building is much larger than is warranted by the proposed services/ departments
- The existing building geometry is irregular (especially on the ground floor), and the location of fire stairs and elevators make the building less efficient in layout than could be provided in new construction
- Encroachment on the 100' critical buffer area of the site is a serious drawback
- Renovation will required phasing of construction inside a building providing clinical services 24/7. Funds will be expended on temporary construction protection measures and patients and staff will be exposed to greater risks than if construction of a new facility were undertaken outside the walls of the existing facility.

Test Fit Layout(s)

A test fit was created to confirm the feasibility of renovating the 1980 Building (with its minor additions) to accommodate the space program. The clinical programs can be functional on the first floor with minor reductions in space from the space program. The second floor of the building could easily accommodate administrative offices, staff break room, IT/electrical equipment and still have much unassigned space that could be use for mechanical equipment or any other purpose if desired.

The test fit was created meeting the 2018 edition of the FGI Guidelines and 2010 edition of the ADA. Diagrams are included in the appendix.

Architectural Strategy

The interior of the 1980 building, both floors, will be gutted and reconstructed in phases to provide an efficient layout for the proposed departments. Once completed, the older portions of the hospital complex will be demolished.

The nursing home is not impacted by the proposed construction work.

M.E.P. Strategy

Replacement of the existing MEP infrastructure will be complicated and expensive as clinical departments will need to remain in operation during the renovation period. The Emergency Department is in operation 24/7, so replacement of infrastructure such as the main electrical system will need special accommodation.

Please see attached list of M.E.P. systems to be addressed. Please note that replacement of existing infrastructure will be more complicated and expensive as clinical departments will need to remain in operation during the renovation period. Especially the Emergency Department is in operation 24/7, so replacement of infrastructure such as the main electrical system will need special accommodation.

Estimated Construction Cost

Phased renovation of the facility while maintaining clinical operations will equal or exceed the cost of construction of the proposed replacement facility.

Estimated Time Line

Renovation will need to occur in at least two phases, with some shared areas (such as the main corridor) kept in full operation during the entire renovation period.

Central Plant/Central MEP Systems

a. Convert approximately half of the 2nd floor to be mechanical/electrical space.
b. Expand the existing propane fuel farm on the site to include four (4) additional 1,000 gallon tanks. Extend a 3" underground propane service pipe around the Nursing Home and site to adjacent to the existing 2" service for the nursing home (at the loading dock). Extend the new 3" service to the existing central utility plant (CUP).
c. Provide two (2) new 200-ton rooftop air cooled chillers on the roof over the old surgery space. Extend piping into the new 2nd floor MEP space to new distribution pumps. Extend and connect new chilled water piping to old. Once new chiller plant is active, remove existing abandoned rooftop AC chiller located above the existing central plant, and all associated piping, supports and connections. Demolish any chiller pumps/specialties in the CUP.
d. Provide three (3) new 25 GPM condensing domestic water heaters in the existing CUP, two to met the demand with one redundant heater. Heaters will be propane fired. Extend and connect HW piping to existing. Install one (1) new heater in the space adjacent to the existing 1,200 gallon tank heater. Once started up and connected to the existing piping system, demolish the existing 1,200 gallon tank/ heater and associated equipment and steam piping. When the space is cleared, install the remaining two (2) heaters in the old tank heater footprint.
e. Provide a new 10 GPM domestic hot water recirculation pump and associated piping and specialties in the CUP. Provide a copper-silver Legionella treatment system.
f. Demolish one existing high pressure steam boiler and associated piping and specialties. This boiler is redundant capacity. Provide three (3) new 1,000 MGH condensing heating hot water boilers in existing boiler footprint. The boilers will be dual fired with propane and diesel fuel oil. Extend new heating hot water piping up to existing penthouse to back feed old steam-to-HW converter system, then demo old converters and steam station in the penthouse.
g. Once new HHW system is connected, demolish remaining HP steam boiler, deaerator, piping, etc.
h. Replace existing medical vacuum pump with new skid/packaged dry claw system.
i. Provide a medical air manifold system in the CUP (or a medical air pump), and extend new piping to the ED, Trauma Rooms and Isolation Rooms as required by programming.
j. In the penthouse, make temporary connections between AHU-1 and 2. These are dual duct units. In the hospital, close off all dual duct boxes for unoccupied areas. Then, demolish existing AHU-2. Install a new custom field-erected AHU in the existing AHU-2 footprint. The AHU will be approximately 40,000 CFM, and include a fan array for the supply. Once installed, the new AHU will back0feed the AHU-1 system. Then demolish existing AHU-1 and AHU-3 (DOAS unit serving 2nd floor FCU's). The new AHU will be single duct using HHW for reheat at the VAV boxes.
k. Remove all existing dual ductwork, mains, branches and supports. Remove all existing dual duct air terminal units and low pressure ductwork and air devices. Provide all new single duct supply air ductwork, single duct VAV boxes, and heating hot water piping system. The ductwork replacement will be done as phased construction, as areas on the first floor will remain occupied during the replacement.
l. Provide a new central DDC building automation system.
m. Replace existing 6" combined fire/water service with a new 8", or include a new parallel 4" to help alleviate the fire pump churn issues.
n. Provide new fire pump to maintain 100 psig at top of standpipes.
o. Add critical exhaust systems for isolation rooms, ED waiting room, triage and radiology waiting rooms.
p. Add a dedicated decontamination shower exhaust system per code.
q. Provide new master and area medical gas alarm panels and extend to BAS.
r. Replace existing sanitary lift station serving the hospital, nursing home and 1919 buildings.
s. Generator Access. The generator breaker sits above the recommended 6'7" height for operability per NEC. Generator sits on underbelly tank, and access for maintenance would be difficult.
t. Provide new 480Y/277V, 1600A electrical service via pad mounted transformer on site.
u. Provide new 480Y/277V, 1600A Switchboard in new electrical space on 2nd floor.
v. Maintain existing 750 KW generator for emergency power.
w. Provide new ATS's to match existing sizes in dedicated emergency power distribution room on the 2nd floor separated from normal power. Provide replacements to major emergency power distribution panels immediately downstream of ATS's on this floor as well. This would include an 800A equipment branch, a 400A critical branch, a 225A radiology branch, and a 100A life safety branch.
    - Deduct alternate. Maintain existing transfer switches and emergency distribution on ground floor. This option leaves emergency power system vulnerable to flooding.

Floor Renovations

a. Renovate areas of first floor per architectural program and concept.
b. In general, all spaces will be gutted down to the structure for complete renovation. All windows and exterior doors will be replaced.
c. HVAC systems for the renovated spaces will include new supply ductwork mains, VAV boxes, HHW piping and controls.
d. Plumbing distribution (CW/HW/HWR) piping will be all new
e. Plumbing sanitary/vent piping will be all new. The first floor is slab on grade and will require extensive cutting and patching of concrete floors and trenching.
f. All existing electrical panels, feeders and branch circuiting will be replaced in the renovation spaces.
g. All existing lighting fixtures and circuiting will be removed. Provide LED lighting fixtures throughout areas of renovation in accordance with IES standards.
h. All existing fire alarm devices and wiring will be removed. Extend existing fire alarm system with new initiation and notification appliances throughout renovated space.

List of M.E.P. engineering issues to be addressed for the renovation option.

3.E
OPTION 3: NEW CONSTRUCTION/REPLACEMENT

Recommended Site / Location

A new freestanding FMF of approximately 25,000 BGSF is proposed to be constructed east of the existing 1980 Building with direct connection to the door at the southwest corner of the nursing home. The FMF would be clear of the 100' critical area buffer, and essentially be on the hospital parking lot. The main floor level would match the level of the nursing home at 10'-6".

Occupied spaces would be on the first floor of the building. An upper level would be constructed for selected mechanical equipment, but especially for electrical and IT equipment.

Once the new FMF is opened, the existing hospital buildings would be demolished. A new parking lot for the FMF could be constructed in the 100' critical area buffer and/or on the land vacated by the demolished hospital buildings.

Test Fit Layout

A simple building is proposed for the FMF. A main entrance lobby would serve the E.D., a clinic and the imaging/lab diagnostic areas. The clinic would connect to the E.D. so staff, equipment and patient treatment areas could be shared as appropriate. The imaging/lab area is very near the E.D. and clinic since those departments will refer patients for diagnostic services. An ambulance entrance is proposed to be located around the corner from the main entrance to provide privacy for those patients transported by ambulance, yet the reception/triage areas of the E.D. should be convenient to both entrances.

Separate entrances are proposed for the outpatient behavioral health and the outpatient rehabilitation suites. In both these cases, patients come frequently and repeatedly for the sessions in their treatment plans. The behavioral health patients would prefer privacy as they come to the FMF; the rehabilitation patients will benefit from minimal walking distance between their cars and the FMF.

A service entrance with an 8' wide enclosed corridor to the nursing home will allow for patients and services to easily move back and forth between the two facilities. The FMF will be small enough to not require a formal loading dock, a double door at this location will suffice for the deliveries. An outdoor screened area will be created for the various waste services.

Architectural Strategy

The new FMF will be constructed as a single-story facility for all the clinical areas to maximize flexibility of clinical services. It is proposed to be located next to the nursing home so it has an adequate construction site while the existing hospital remains in operation. The nursing home's main entrance includes a long exterior ramp, which the new FMF will demolish. The proposed main entrance to the FMF would be shared with the nursing home to provide one gracious entrance to serve both facilities.

There will also be an interior connection between the FMF and the service corridor of the nursing home that leads back to the loading dock.

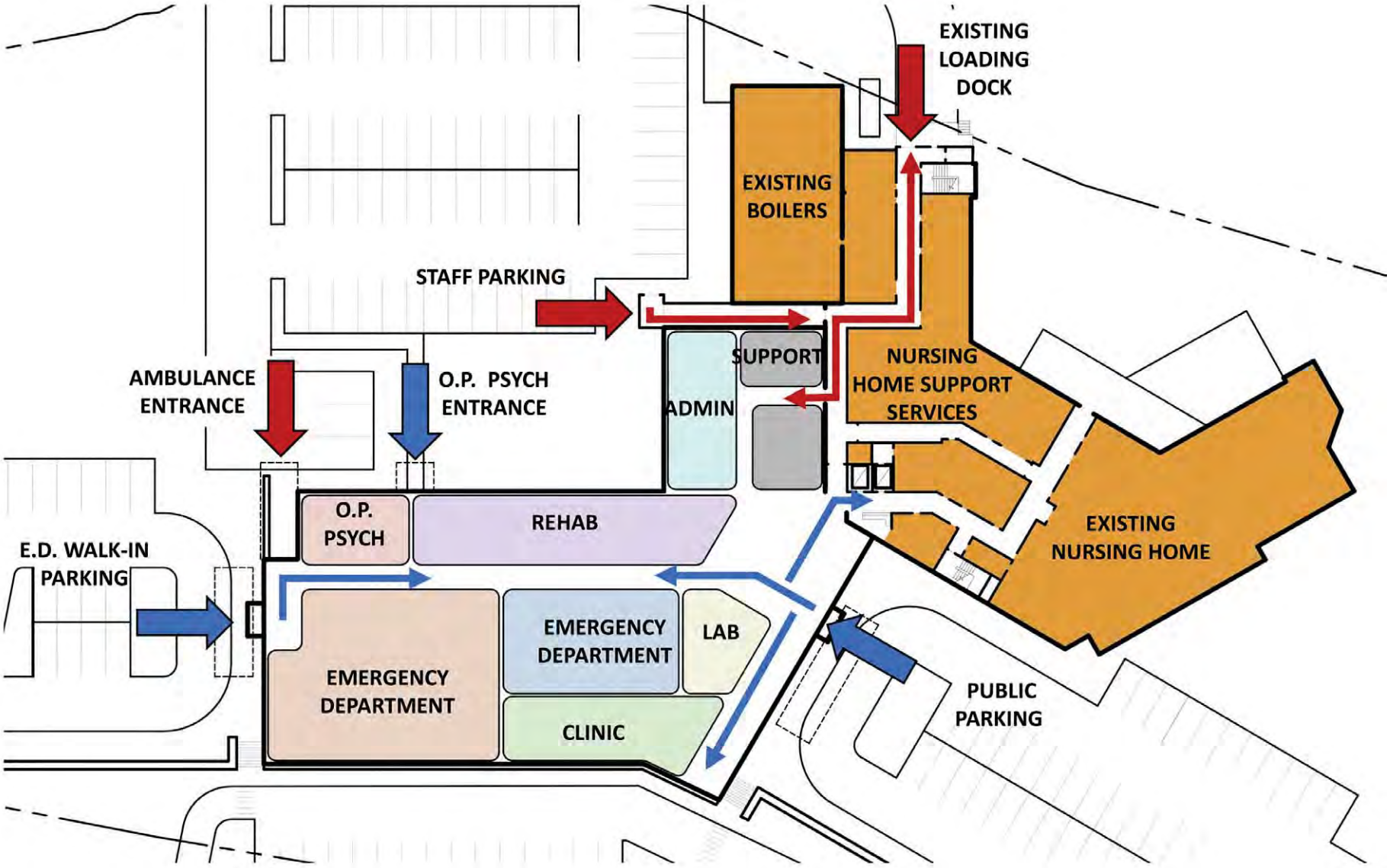
Entrances to the FMF will be consolidated into two locations: the joint FMF/ nursing home entrance and the ED/Outpatient Psych entrance. In both cases, the exterior grade level will slope gently up to the floor level of the FMF and nursing home. This also helps separate a "front" side of the FMF from a "private" side. The "front" main lobby of the FMF will serve the following:

- Crisfield Clinic
- Laboratory
- Imaging
- Outpatient Rehab
- Administration and service areas

The "back" entrance area will have visual screening—to be determined in the design phase—to provide privacy between the walk-in entrance to the ED, the ambulance entrance to the ED, and the patient entrance to the Outpatient Psych facility.

The ED, Crisfield Clinic, Laboratory and Imaging departments are designed as one block that can share staff and equipment, and allow patient flow out of the view of public spaces.

The administration and service areas (including staff support areas) connect the lobby of the FMF with the service corridor of the nursing home. The existing ramp from the hospital to the nursing home can be re-purposed into a staff entrance for both the FMF and the nursing home.

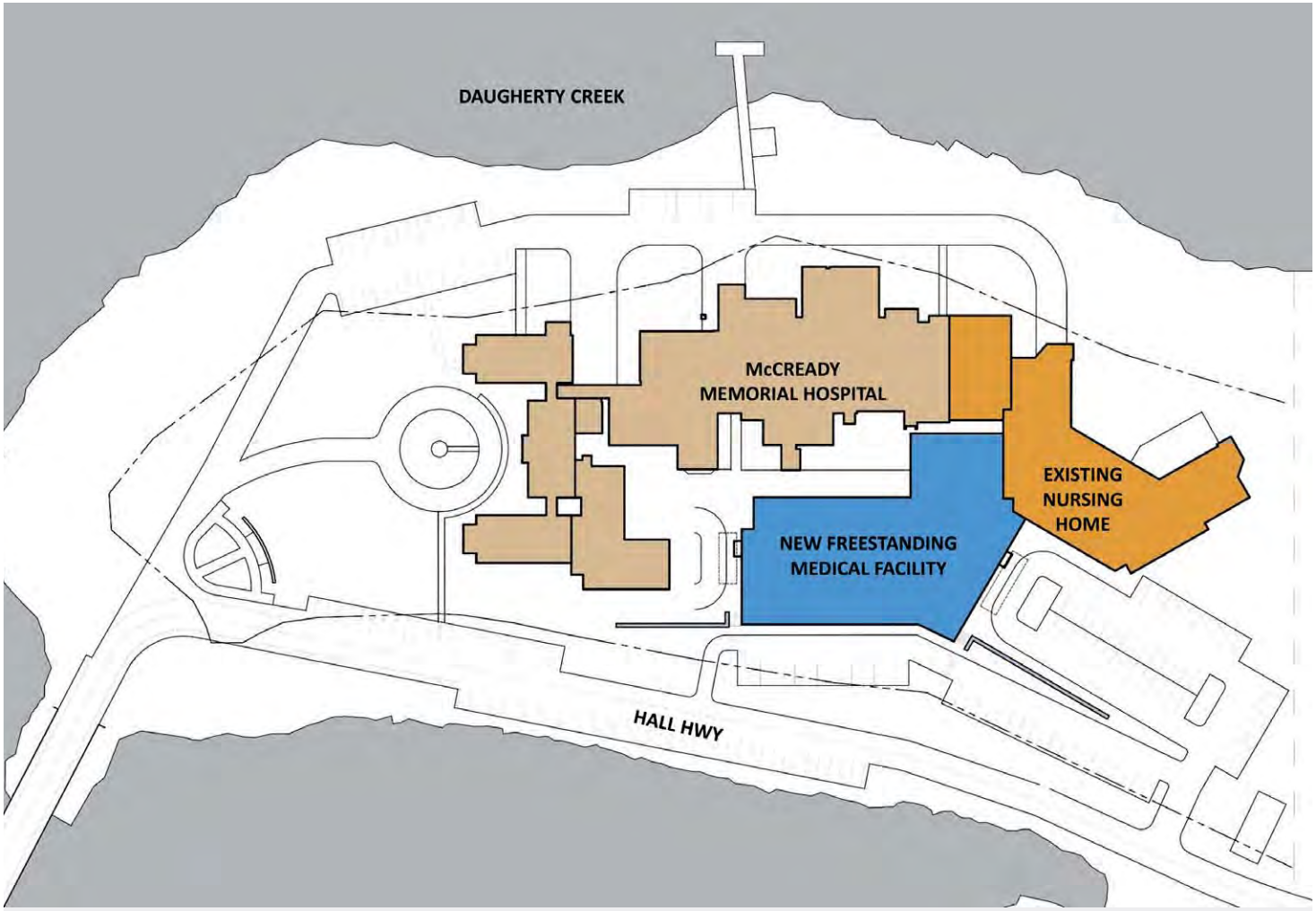


Floor plan diagram showing proposed locations of departments in the FMF and relationship of the departments to the nursing home.

M.E.P. Strategy

MEP systems for the new PRHS FMF will be similar to a similar nearby standalone ED. These systems will be described in more detail as the concept is further developed.

Once the new building is constructed and staff have moved over, the existing hospital and central plant will be demolished.
A detailed description of the MEP systems is included in the appendix.



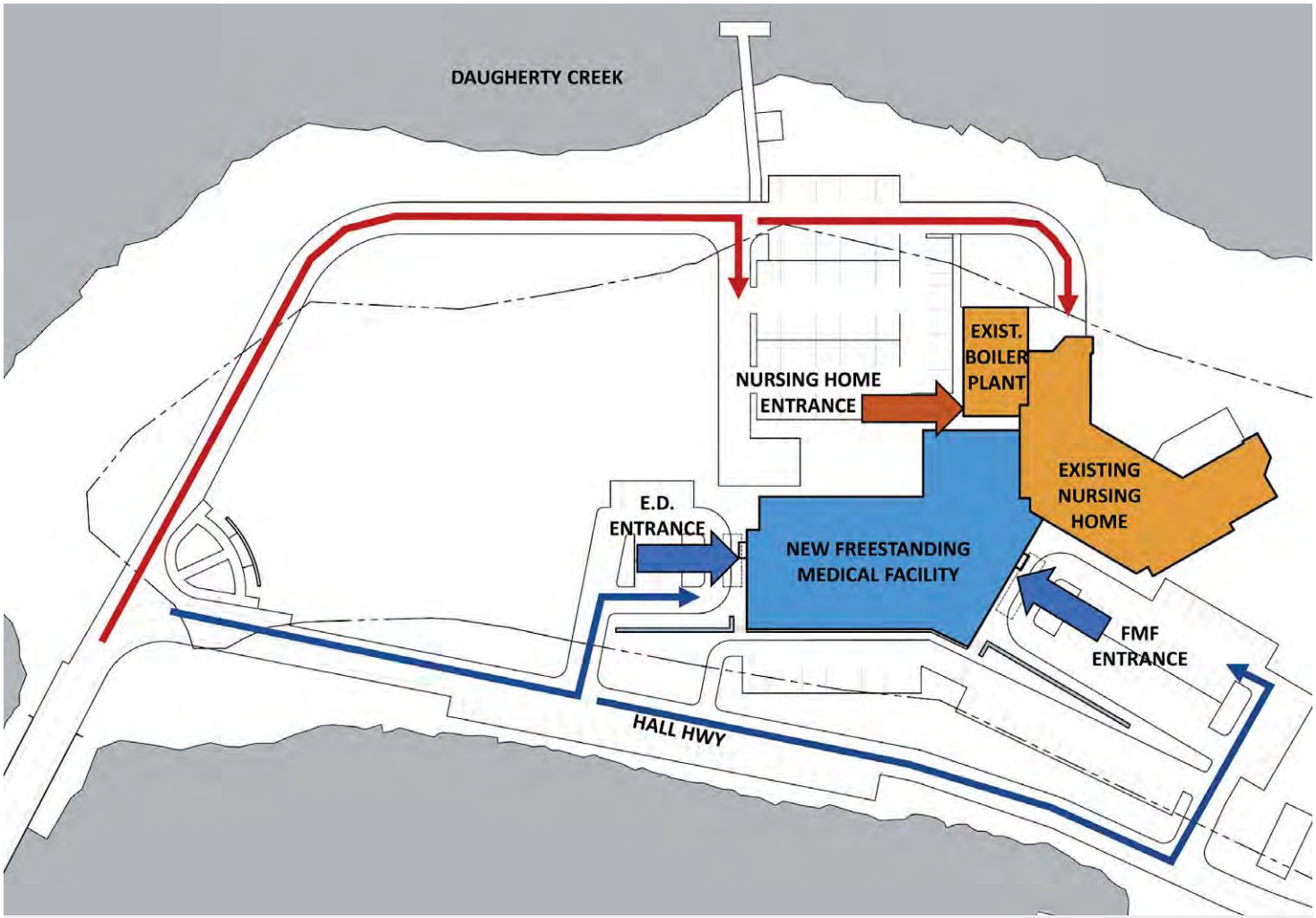
Site plan showing the location of the proposed FMF in blue. The FMF can be constructed while the existing hospital and nursing home remain in full operation.

Estimated Construction Cost

The Whiting-Turner Construction Company created a cost estimate for the proposed new facility based on the space program and recent comparable construction projects. The proposed replacement would have a construction cost of approximately $14 million. Note that the project cost will be greater. See Appendix for additional detail.

Estimated Time Line

Approximately 2 years. This includes 9 months for design (see attached schedule), about 13 months to construct, a few more months for commissioning, transitioning to the new facility, certifications, etc.



Site plan showing the new FMF and the nursing home after the existing hospital buildings have been demolished.

Section 4:

RECOMMENDATION

OUR RECOMMENDATION

A newly constructed Freestanding Medical Facility is the best option to provide health care services to the Crisfield community in a cost-effective manner.

Rationale for Recommendation

Construction of a new building is our sole recommendation for the following reasons:

- The main floor of the existing 1980 building is too low above sea level; the nursing home is 18" higher. There is risk of flooding of the hospital main floor level.
- Part of the 1980 building is within the 100' critical buffer area, i.e. it is too close to the water. There is risk of flooding.
- Maintenance costs of a renovated building will be higher because the building has almost twice the area required for the FMF. It will be necessary to keep the extra interior space free of mold and vermin, the extra exterior walls/windows/doors will need to be maintained and kept weather tight.
- Geometry of the existing building: the exterior wall of the building is quite irregular, this limits the geometry of potential interior layouts. Filling in the gaps between the exterior portions would be expensive and create problems with the floor slab joints.
- The geometry of the existing building (location of fire stairs, elevators and egress requirements) forces the renovation layout to be inefficient. Departments and corridors must "snake around" the fixed elements; some portions of the building interior (for example, the chapel area) are long and skinny and difficult to access.
- The floor slab on the main floor is reported to be slab-on-grade. This will require demolishing portions of the floor slab to add new under-floor piping required for the proposed clinical functions. This adds to the disruption of renovation, is an infection control risk, and makes it more expensive to have a smooth floor in the final renovated space.
- Current operations in the building must be maintained during renovation. Furthermore, these departments are on the main floor where the departments should be located after renovation, so there are limited options to relocate departments as part of the renovation work. This will complicate replacement of the outdated infrastructure. It also requires phased renovation which is additional cost to no benefit of the final product—dust partitions, air filters, testing to confirm that the risk mitigation strategies area effective.
- The ground floor of the 1980 building (with small additions) is too small to accommodate all the clinical departments as currently programmed. Approximately 90% of the spaces can be accommodated, so it could be functional, but it is still unfortunate to compromise the initial layout. This will hinder future functionality as new equipment, treatments and protocols will typically benefit from "flex" space, a little extra space to handle new items.
- Construction cost to renovate the 1980 Building is likely to equal or exceed the cost of new construction, and renovation costs will be more difficult to manage as existing conditions will be determined during the construction process.
- The duration of construction activities is likely to be greater in renovation than in new construction because renovation will entail phases of construction.
- A new building can portray a state-of-the-art professional environment of care that cannot be presented by a 40-year old exterior. Additional funds would be required to update the exterior image of the facility.

Cost Estimate

The cost of the total project includes several components:

Construction Cost

The largest is the construction cost, which was estimated based on the space program. Other costs are itemized below.

Contingency Funds for Interim Maintenance

The existing physical plant will need to be maintained until a replacement has been occupied, regardless of whether the replacement is in new construction or in renovated spaces. This could easily extend a couple years into the future, depending on the speed of approvals from state and local authorities, exact start date for design and construction, and other variables.

The infrastructure is typically beyond its useful life and has been maintained on a limited budget. If/when a system fails, it will need to be repaired or replaced immediately since the facility typically lacks redundancy.

A significant contingency fund is strongly recommended.

Professional Fees

Design fees for the new Freestanding Medical Facility are estimated to be approximately $1,200,000. This fee is inclusive of reimbursable expenses (travel, printing, etc.). For more detailed information on design fees (inclusions, exclusions, refer to the appendix of this report.

This estimate is based on the current design concept and schedule as presented in this report. It includes full design services for Architecture, Interior Design, Medical Planning, MEP Engineering, Structural Engineering, Civil Engineering, Wayfinding and Signage, Geotechnical Engineering as well as an existing conditions survey. The scope of work includes all design phases: Concept Design, Schematic Design, Design Development, Construction Documents and Construction Services.

New Medical Equipment / Furnishings

Services to be provided by PRMC.

Relocation / Transition Costs

Services to be provided by PRMC.

Other Costs

Security Systems – Video Surveillance and Access Control: $200,000

Peninsula Regional Medical Center
Salisbury, MD
9/6/2018

DRAFT

Functional Space Program

300.00 McCready Campus

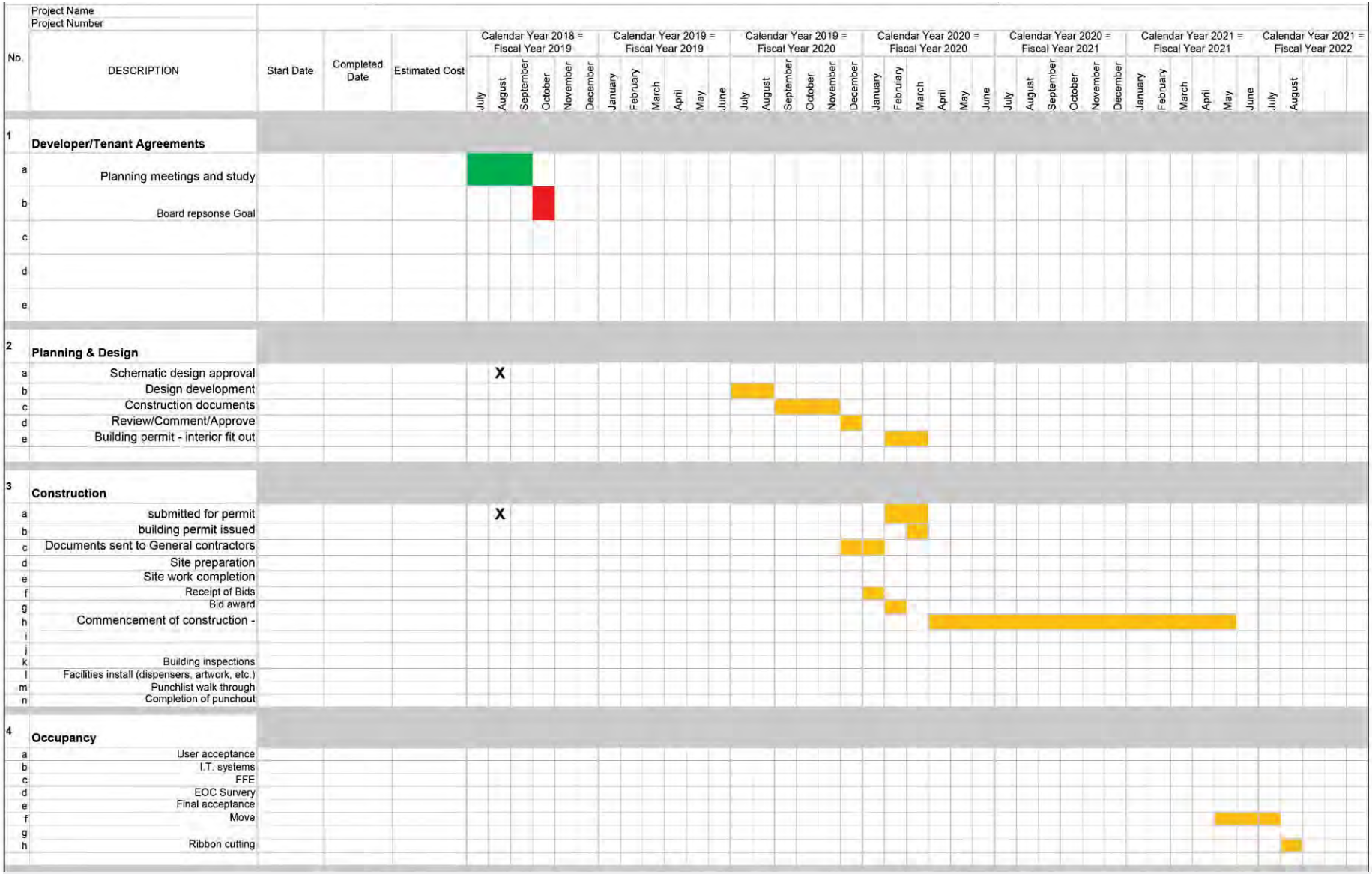
300.00 Summary

Ref	Service	NSF	DNSF	$/DNSF	TOTAL	DGSF	Comments
	Division 1 Project Requirements		**2.00%**		**$ 265,708**		
301.00	**FreeStanding Emergency**	**3,705**	**5,558**	**$ 156.60**	**$ 870,305**	**6,113**	
302.00	**Crisfield Clinic**	**1,965**	**2,751**	**$ 152.25**	**$ 418,840**	**3,026**	
303.00	**Administration**	**1,175**	**1,586**	**$ 108.75**	**$ 172,505**	**1,745**	
304.00	**Imaging**	**1,562**	**2,343**	**$ 375.00**	**$ 878,625**	**2,577**	
305.00	**Laboratory**	**1,014**	**1,267**	**$ 174.00**	**$ 220,436**	**1,394**	
306.00	**Pharmacy**	**0**	**0**	**$ 217.50**	**$ -**	**0**	
307.00	**Psych - Outpatient**	**880**	**1,346**	**$ 217.50**	**$ 292,842**	**1,481**	
308.00	**Physical Therapy**	**2,308**	**3,000**	**$ 108.75**	**$ 326,294**	**3,300**	
309.00	**Support Services**	**1,892**	**2,460**	**$ 108.75**	**$ 267,482**	**2,706**	
			20,311				
310.00	**Building Systems**	**0**	**658**	**$ 13.05**	**$ 8,587**	**658**	
311.00	**Public Areas & Circulation**	**0**	**1,245**	**$ 108.75**	**$ 135,394**	**1,245**	
	Core & Shell			**$ 150.00**	**$ 3,636,769**	**24,245**	
			119%				
	Design Contingency		**10%**		**$ 722,808**		
	Building Cost			***$ 338.90***	***$ 8,216,592***	**24,245**	
	Site Allowance			**$ 16.75**	**$ 1,441,676**	**86,070**	
	Helipad (On Grade)				**$ 275,000**		
	Demoltion of Existing Structures				**$ 400,000**		
	Site Design Contingency		**15%**		**$ 257,501**		
	Subtotal Construction Budget			**$ 436.82**	**$ 10,590,770**		
	Whiting-Turner General Conditions		5.25%		$ 556,015		
	Whiting-Turner Insurance		1.00%		$ 117,041		
	Whiting-Turner Bond		0.55%		N/A		
	Whiting-Turner Fee		2.50%		$ 295,529		
	Whiting-Turner Preconstruction		0.25%		$ 65,165		
	Construction Contingency		5%		$ 557,339		
	Total Construction Budget			**$ 502.45**	**$ 12,181,860**		
	Escalation To Mid-Point of Construction 10/2020		5% per year		$ 1,133,125		
	Total Budget			**$ 549.18**	**$ 13,314,984**		

Summary of construction cost estimate

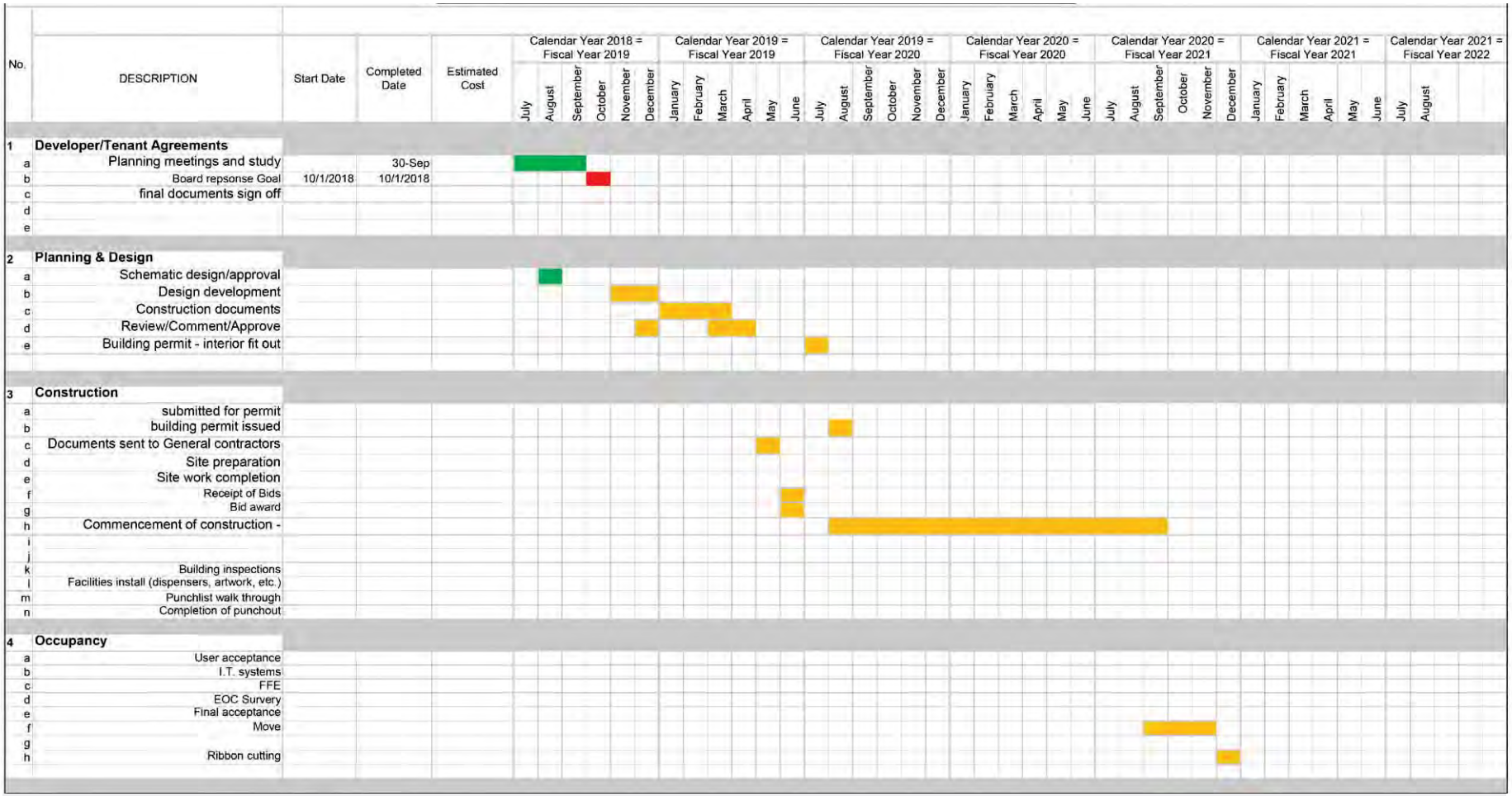
Detailed Time Lines

McCready Transition Project Schedule Based on July 1, 2019 Design & Programming

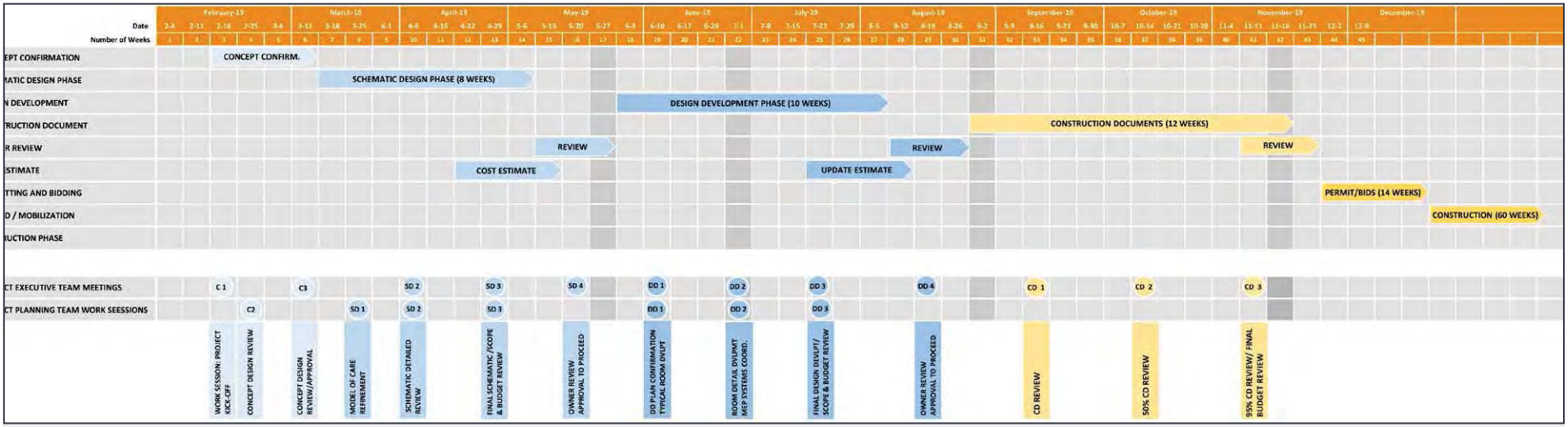


Timeline showing the entire project schedule to open an FMF in Crisfield based on July 1, 2019 start date.

McCready Transition Project Schedule Based on Early Design & Programming



Timeline showing the entire project schedule to open an FMF in Crisfield based on November 1, 2018 start date.



Timeline for the design services for an FMF.

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PENINSULA
REGIONAL HEALTH SYSTEM

McCready
HEALTH
With you...for life!

APPENDIX

Report on McCready Memorial Hospital

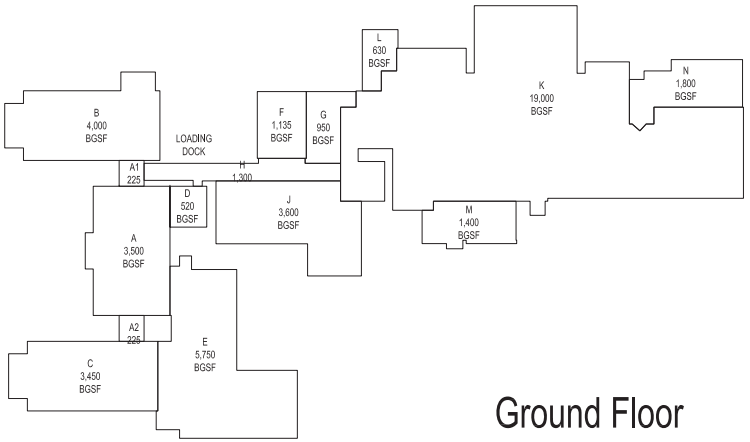
September 13, 2018

PENINSULA
REGIONAL HEALTH SYSTEM

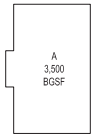
McCready HEALTH
With you...for life!

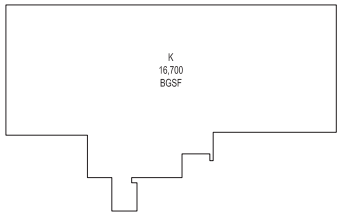
EXISTING CONDITIONS

Existing Areas Diagram

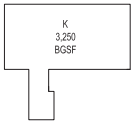


Ground Floor





2nd Floor



3rd Floor

CALLISONRTKL
A DESIGN CONSULTANCY OF ARCADIS

CallisonRTKL Inc.
2101 L Street, NW
Suite 200
Washington, D.C. 20037
THE 202.833.4400
Fax 202.887.5168

Project No:
Project No:

PRMC
McCready Existing Buildings
August 6, 2018

Issue Drawing Log

Seal

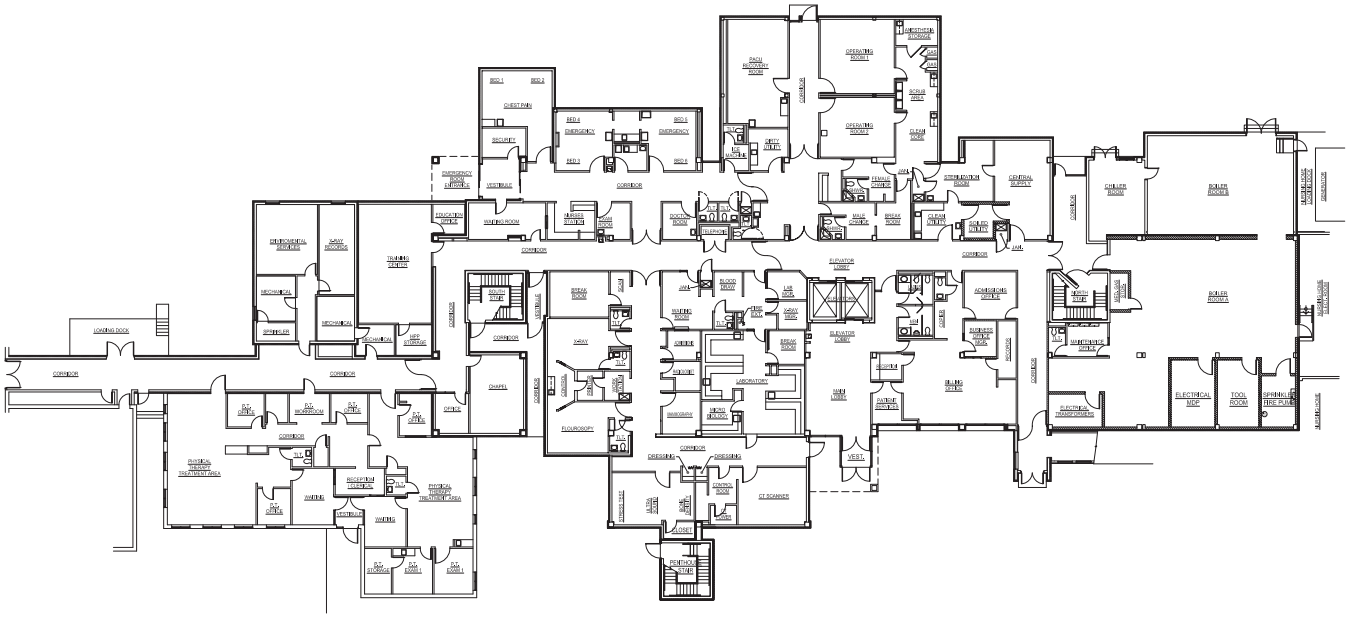
Sheet Identification

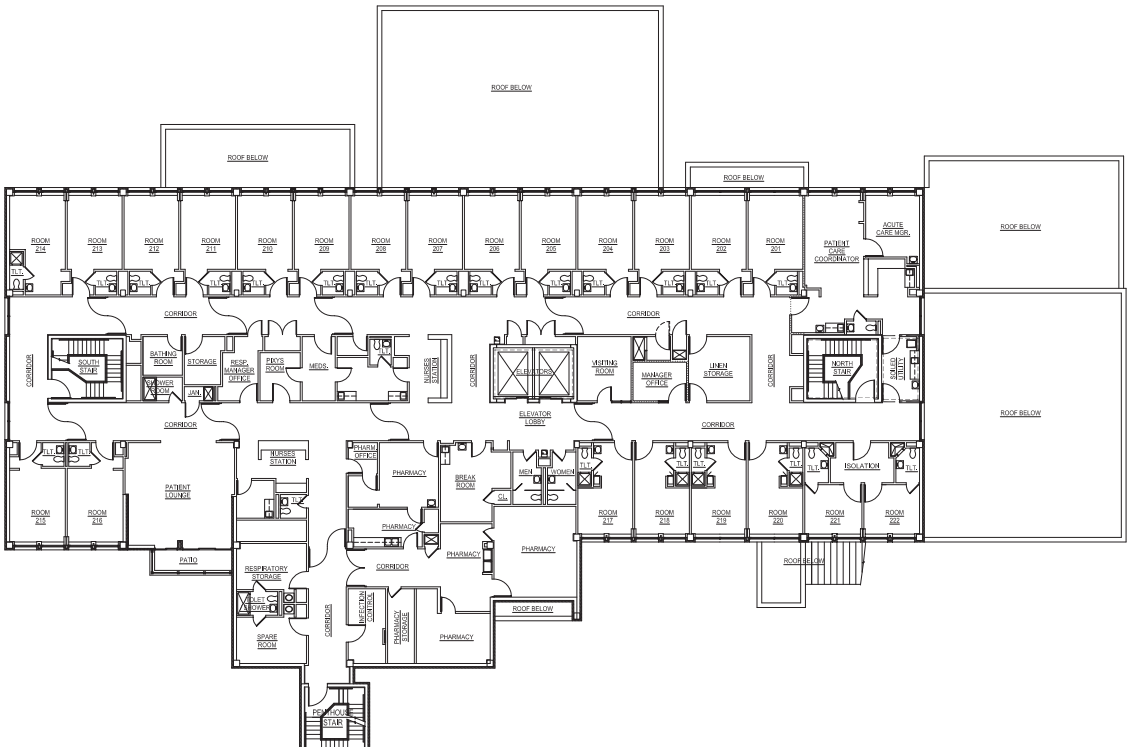
Approximate
Building Sizes

Existing Areas

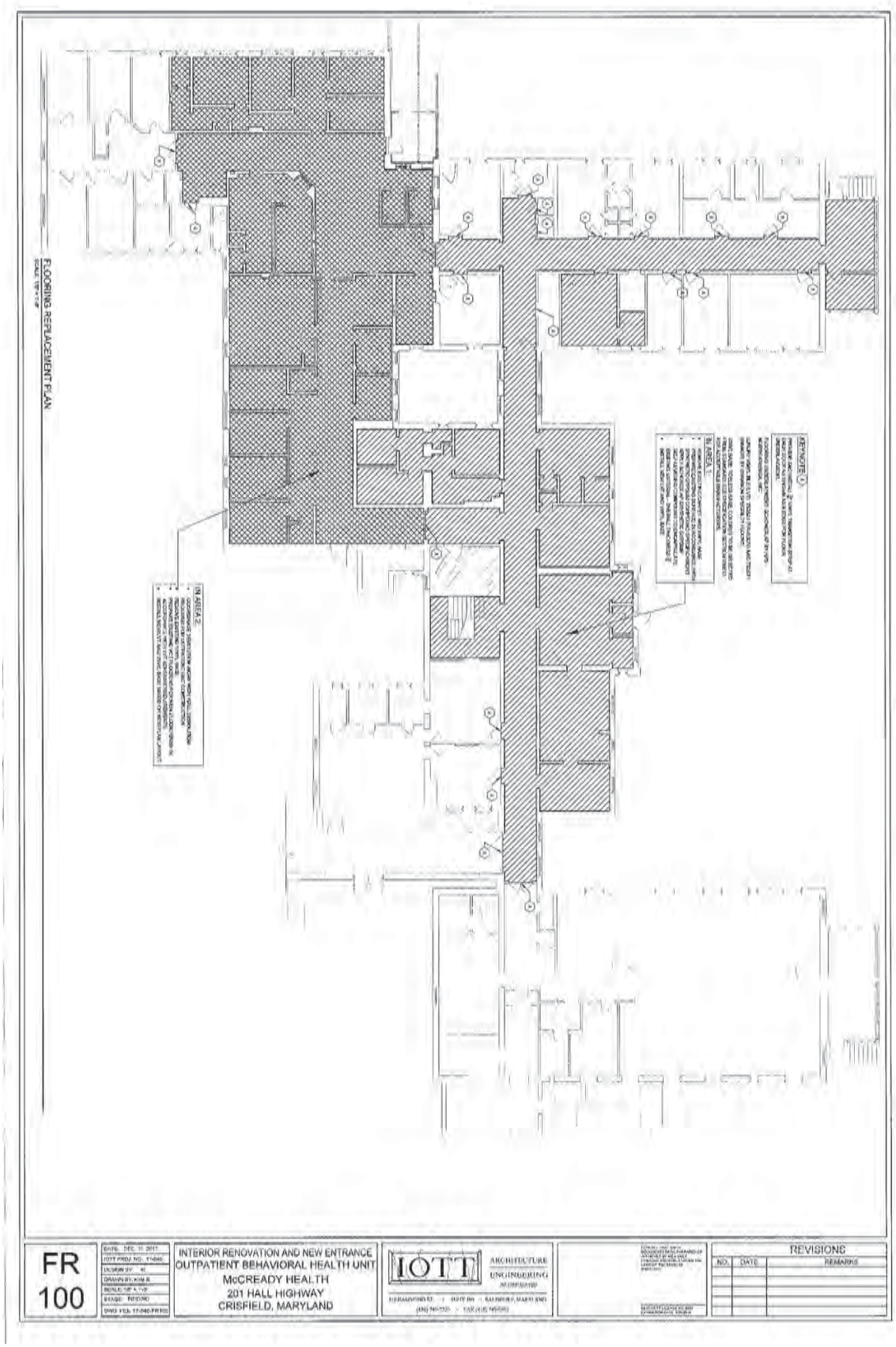
McCREADY MEMORIAL HOSPITAL BUILDING AREAS					
July 26, 2018					
Building	Floor 1	Floor 2	Floor 3	Totals	
A	3,500	3,500		7,000	10%
A1	225			225	0%
A2	225			225	0%
B	4,000			4,000	6%
C	3,450			3,450	5%
D	520			520	1%
E	5,750			5,750	8%
F	1,135			1,135	2%
G	950			950	1%
H	1,300			1,300	2%
J	3,600			3,600	5%
K	19,000	16,700	3,250	38,950	55%
L	630			630	1%
M	1,400			1,400	2%
N	1,800			1,800	3%
				70,935	100%

Existing Floor Plans

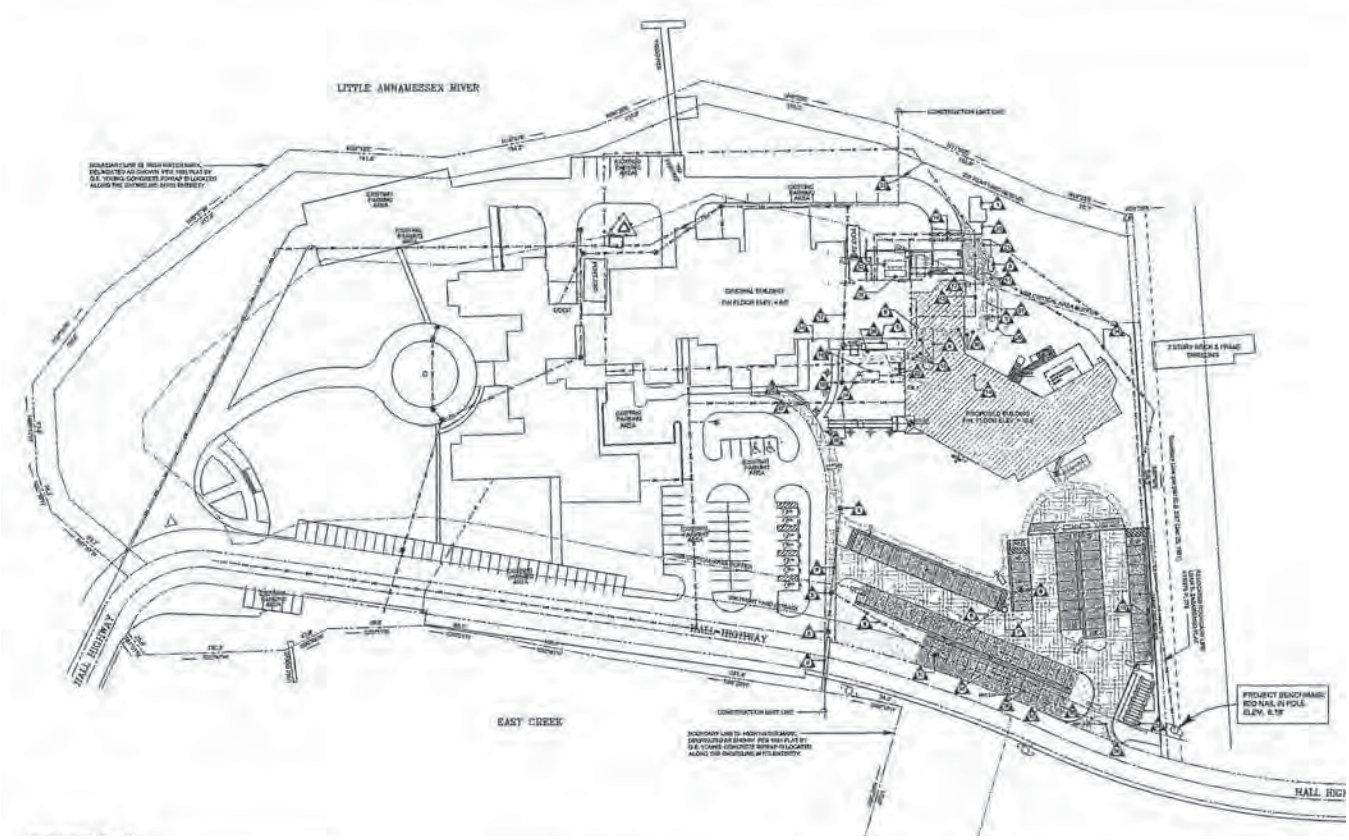




Existing Floor Plans



Site Plan



SPACE PROGRAM

Space Program

PENINSULA REGIONAL MEDICAL CENTER

McCready Memorial Hospital Replacement

July 24, 2018

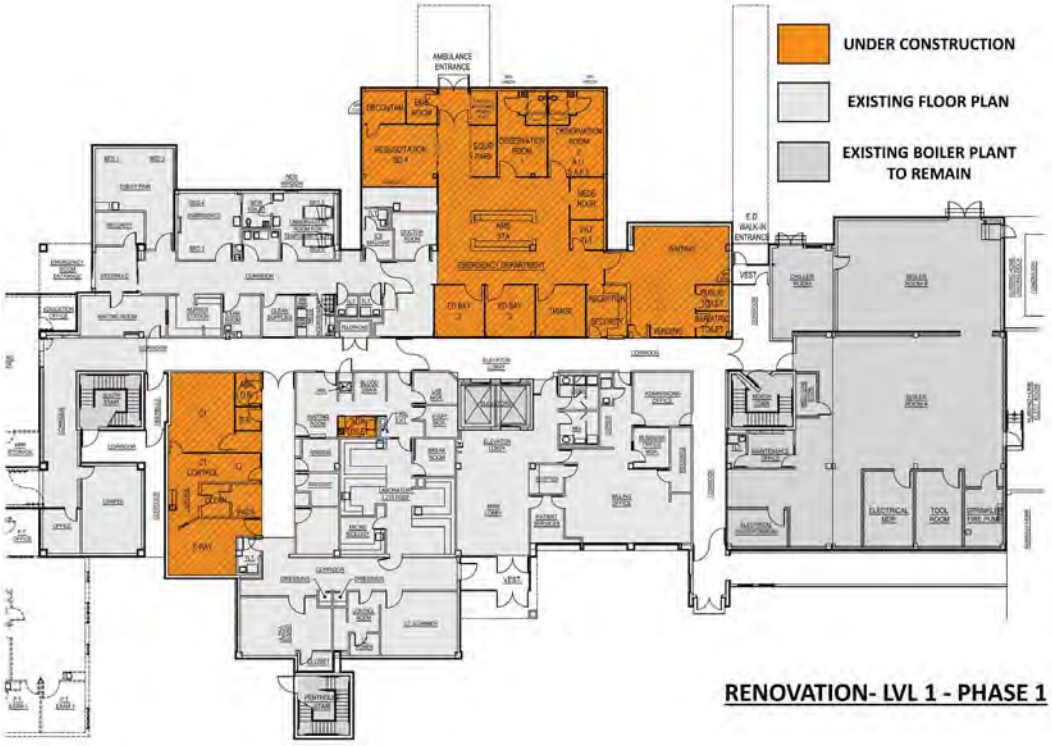
SUMMARY PAGE — Proposed Area is based on input freceived from July 23 site visit and August 8 PRMC meeting

	Existing	Proposed						Possible Locations		
Department	DGSF	NSF	DGSF	BGSF	Staff per Shift	Total Staff	Staff no lockers	DGSF Floor 1	DGSF Floor 2	DGSF Either
ADMINISTRATION		1,175	1,586		10.6	10.60	6.00			1,586
CRISFIELD CLINIC		1,965	2,751		10	9.80	9.80			2,751
FREESTANDING E. D.	2,640	3,705	5,557		8	26.86	26.86	5,557		
IMAGING	3,324	1,562	2,343		3.5	6.43		2,343		
LABORATORY	1,267	1,014	1,267		2	5.95		1,267		
PHARMACY	1,460	0	0		1	1.10				
PSYCH--OUTPATIENT	1,500	880	1,346		3	3.00	3.00			1,346
PHYSICAL THERAPY	4,624	2,308	3,000		4.2	4.20		3,000		
SUPPORT SERVICES		1,892	2,460		7	15.38		861	780	819
Subtotals:		14,501	20,311		49	83.32	45.66	13,028	780	6,503
COMM/LAN CLOSETS					in DGSf				check	20,311
COMMON CIRCULATION				1,625	8.0%					
MEP ALLOWANCE				658	3.0%	Elec in Support				
BUILDING ENVELOPE				752		minimum				
				23,345						
Elev/Fire Stairs if 2nd floor				900						
ESTIMATED TOTAL BGSF				24,245						

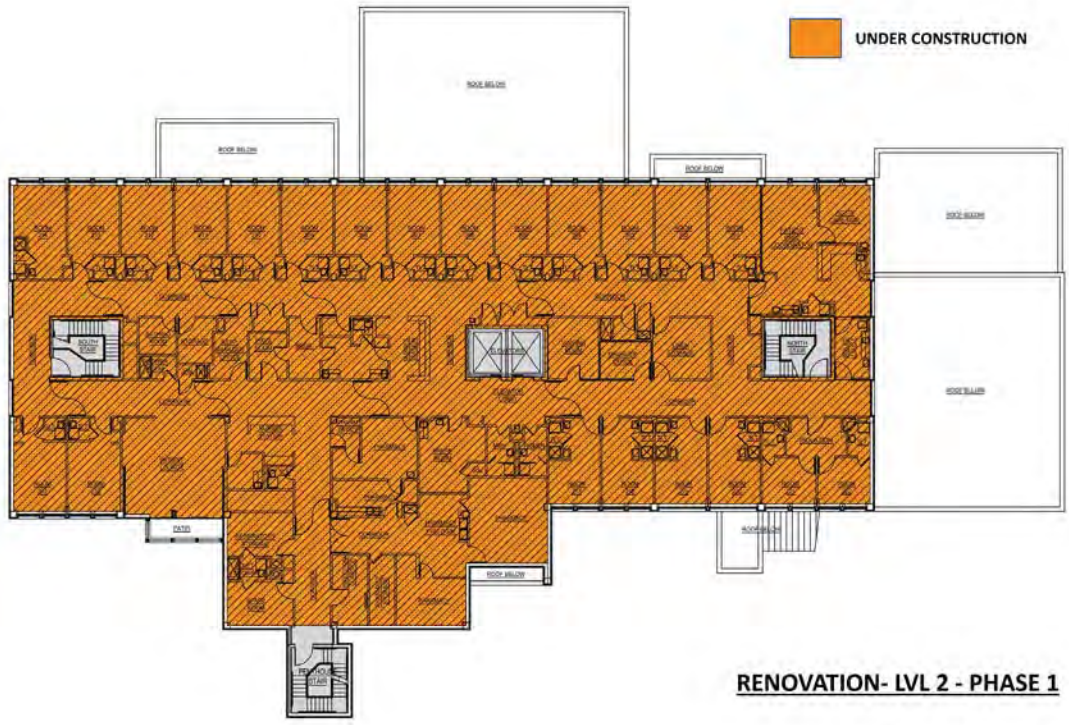
DIAGRAMS FOR RENOVATION OPTION

The option to renovate the 1980 Building for a Freestanding Medical Center was studied but is not recommended. These pages show the proposed option that appeared to be most promising.

Phase One Level One



Phase One Level Two



Phase Two Level One

Phase Two Level Two

This plan shows the final layout for the main floor level.

Final Layout Level One

RENOVATION – LVL 1 – FINAL PLAN

MEP REPORT

MEP Systems Proposed for a New Freestanding Medical Facility

A. COOLING

The peak chilled water load is estimated to be 125 tons for the proposed facility.

The system will consist of two (2) 150 ton air-cooled chillers (de-rated to 125 ton for glycol), located on the roof, and will utilize a minimum 30% propylene glycol mixture to prevent freezing. One unit will serve the cooling loads while the second will provide redundant capacity.

The base load chiller will be provided with a free-cooling coil and valve arrangement to take advantage of winter ambient temperatures when cooling is required in the building.

The chillers will be designed with a 14°F differential, 56°F entering water/glycol temperature and 42°F leaving temperature. The condenser sections will be rated for a 100°F ambient temperature to compensate for higher rooftop temperatures. The evaporator coils will be coated for coastal environments. The chilled water system will be a variable flow primary arrangement.

Pumps and Piping Systems:
Two (2), 250 GPM pumps will be provided in a rooftop mechanical room for the chilled water system. One will provide chilled water to the building AHU's and the second will act as a redundant pump. A single buffer tank, air separator, and expansion tank will also be located in the mechanical room. The chillers will be piped together in a parallel arrangement with automatic isolation valves.

Any piping exposed on the roof will include fiberglass insulation and metal jacketing. Chilled water piping located on the roof shall be black steel or type K copper.

Chemical Treatment:
Chemical treatment systems will be installed to serve the chilled water systems. The chemical treatment will comprise of combination filtration/shot feeders. These will be located in the main mechanical room.

B. HEATING

The heating load is estimated to be 1,000 MBH for the proposed facility.

The boilers will consist of two propane gas fired, 1,000 MBH output boilers with the ability to operate on fuel oil as a backup fuel. The system requires "firm" redundancy per code requirements to ensure heating in the event of a boiler failure. The fuel oil will act as an emergency heating back-up in the event that propane service is interrupted. The boilers will be piped in a parallel arrangement with isolation valves. The system will be designed with a 40°F differential, 100°F entering water temperature and 140°F leaving water temperature.

The heating water system will be a primary/secondary loop arrangement within the mechanical room. A single, primary heating water pump will be provided for each boiler. The primary boiler pumps will be in-line type pumps. Two (2), 80 GPM secondary heating water pumps will circulate the water to the building. A variable frequency drive will be provided for all secondary pumps to allow a reduction in pumping energy during varying load conditions. Heating water piping shall be black steel or type K copper.

Chemical Treatment:
A chemical treatment system will be installed to serve the heating water system. The chemical treatment will comprise of filtration and shot feeders. A separate vendor, obtained by the owner, will be responsible for all chemicals, chemical tanks, and injection pumps.
The plant will be complete with air separators, expansions tanks, by-pass valves, solid separators, and control devices.

C. AIR HANDLING SYSTEMS

A summary of the air handling units is listed below:

AHU #	Capacity (CFM)	% Minimum OA
AHU-1	25,000	35
AHU-2	25,000	35

All air handling units will be located on the roof on 24" high roof curbs and will be connected in parallel to the ductwork systems. To accommodate current energy codes, a plate type total enthalpy heat recovery unit will be provided on the roof to preheat/precool the outside air feeding the AHU's from the exhaust air system.
Air handling units 1 and 2 will be semi-custom, double-wall, aluminum rooftop modular units and will be equipped with the following:

- Supply: 6 fan array (N+1 redundancy)
- Return: 4 fan array (N+1 redundancy)
- Pre/Intermediate filter (MERV 8/10) section
- Hot water preheat coil section
- Chilled water/glycol cooling coil section
- UV lights
- 95% (MERV 14) final filters
- Steam humidifier
- "Doghouse" with access doors to house maintainable items (pumps, valves , etc)

D. AIR DISTRIBUTION

All duct systems will be designed at low velocities to minimize overall static pressure loss and reduce fan horsepower to comply with building energy codes.

In general, medium pressure supply and return ducts will be routed into the ceiling space where it will be distributed horizontally to variable air volume supply air terminal units. Each supply air terminal unit will be equipped with hot water reheat to provide individual zone control. Return / exhaust air terminal units will be matched with supply air terminal unit(s) for critical pressurization spaces such as resuscitation/trauma rooms and isolation rooms.

All terminal units provided will be digital boxes with electronic actuation. Support spaces will be zoned together as their space load density warrants, as indicated on drawings. Low pressure ductwork will be extended from the terminal units to new air devices in the ceilings. Generally, aluminum louvered ceiling diffusers with 24"x24" lay-in modules and return / exhaust air registers will be used in treatment and support spaces. Critical spaces will be provided with specialty diffusers as appropriate for the purpose.

E. EXHAUST SYSTEMS

There will be a central general exhaust system, included as part of the energy recovery unit. There will also be two critical exhaust systems to serve isolation rooms and the decontamination shower rooms.

General

General exhaust systems will be provided throughout the facility to serve areas such as toilet rooms and soiled utility rooms.

Critical Exhaust

An exhaust air system will be required for the Airborne Infectious Isolation Rooms, ED Triage, ED Waiting Rooms and Lab. The exhaust air system will consist of two (2) high-plume, direct-drive fans, similar to a Greenheck Vektor MH, discharging a minimum of 10 feet above roof. The system will be fully redundant with two (2) fans on a common plenum. Under normal operation one fan will operate to meet the load. If a fan fails, the second fan will start. Fan speed will be controlled though variable frequency drives.

Medium pressure isolation exhaust air ductwork will be provided to the isolation rooms. Exhaust air terminal units will be provided to maintain negative pressure to each isolation exhaust room. In addition, isolation rooms will be provided with a room pressurization monitor at the isolation room which will be interlocked with the rooms supply and exhaust air terminal units via the building automation system.

Mechanical Room

There will be one (1) spun aluminum, centrifugal down blast domed exhaust fan serving the mechanical room, located on the roof above. This fan will be energized to ventilate the room to maintain the thermostat setpoint. A backdraft damper and louver located in the exterior wall, or roof, will allow for make-up air.

Decontamination

A dedicated critical exhaust air system will be required for the Decontamination room. The exhaust air system will consist of a high-plume type, direct-drive fan, similar to a Greenheck Vektor MH, discharging a minimum of 10 feet above roof per code. The systems will be fully redundant with two (2) fans on a common plenum. Under normal operation one fan will operate to meet the load. If a fan fails, the second fan will start. Fan speed will be controlled though variable frequency drives.

A medium pressure critical exhaust air duct will be provided to the decontamination room. The exhaust fan will maintain negative pressure in the decontamination room. In addition, the decontamination room will be provided with a room pressurization monitor at the decontamination room which will be interlocked with the rooms supply air terminal unit and fan via the building automation system.

F. HUMIDIFICATION

An atmospheric pressure propane fired steam generator will be installed on the roof to serve the air handling unit humidifiers. The humidifiers will be sized to maintain a minimum of 30% relative humidity within the occupied spaces during the winter months. Humidifier piping shall be stainless steel, insulated per energy code.

G. IT CLOSET / IMAGING EQUIPMENT ROOMS

The IT closets and electrical closets throughout the facility will have constant cooling requirements. A ductless split DX cooling system will be indicated to serve each IT closet and imaging equipment rooms with overhead air terminals serving as back-up cooling and to provide positive pressure per code. Electrical rooms containing transformers will be served by air terminal units without reheat coils. The air-cooled chillers will be operated year-round to maintain cooling in interior rooms.

H. PLUMBING SYSTEMS

The facility will be provided with the following plumbing systems:

- Domestic cold water, hot water, and hot water recirculation systems for all plumbing fixtures and equipment as required. Dead legs on domestic hot water piping will be reduced to be as short as practically possible.
- Domestic cold-water piping to freeze-proof hose bibs located along the exterior of the building (assume 6).
- Domestic cold water to irrigation systems and exterior water features. The irrigation service will tie into the system prior to the water softener system. An RPZ backflow preventer will be installed to protect the potable water system in the building. This system will be able to be isolated from the domestic water system when needed (valved off during winter months and freeze protected).
- Soil, waste and vent systems for all plumbing fixtures, drains, and equipment as required
- Water closets will generally be floor mounted, floor discharge, but some will be rear discharge to coordinate with structural members.
- Sinks and showers will include local thermostatic tempering valves per code.
- Public toilets and lavatories will utilize infra-red technology with hard-wired transformers.
- Medical gases will be provided to meet the code requirements
-

Ball valves will be provided throughout all piping systems to isolate all equipment, and main branches where appropriate. Specifications will include required valve charting, numbered and identified accordingly, as a contractor responsibility.

All equipment and piping systems will be identified using labels and nameplates.

A single 8" combined fire and domestic water service will enter the facility, in a water room, which will immediately branch to the fire pump, and to the domestic water booster pump. Consideration should be made to include a second water service, however, there is only one service from the utility crossing the bridge to the site. In lieu of a second service, an emergency water connection could be considered, to allow serving the hospital from a tanker truck, through the booster pump. Two RPZ backflow preventers will be provided for domestic service and two RPZ backflow preventers will be provided for fire service, as indicated on drawings.

The system will be provided with a whole building water softener system. The system will include a brine tank as well as three resin tanks to reduce the mineral content from entering the building from the municipal supply.

The domestic hot water system will consist of two (2), 349 GPH, natural gas-fired water heaters with integral 119-gallon storage tanks. One unit will serve the load while the other will be redundant capacity. Water will be stored at 140°F and distribute to the facility. Thermostatic mixing valves will be located at each fixture to reduce the fixture discharge temperature to 110°F.

The system will be provided with a recirculation pump to recirculate the domestic hot water. The domestic hot water recirculation system will be designed in accordance with the International Plumbing Code. Temperature dependent balancing valves will be utilized throughout the recirculation system similar to Circuit Solver by ThermOmegaTech. Pump speed will be controlled through a differential pressure transmitter.

Domestic hot, cold, and recirculation piping 3" and smaller shall be soldered copper or Propress. Piping larger than 3" shall be galvanized steel using Victaulic couplings. All piping shall be insulated per code.

A mono-chloramine injection system will be utilized for domestic hot water sterilization.

All sanitary collected from the plumbing fixtures will be piped together below slab to several sanitary mains extended to 5' outside the building to be extended by the civil division. Under-slab piping shall be cast iron soil pipe. All piping will be sized per International Plumbing Code requirements. Any food prep sanitary services will be routed through a grease trap. Exact points of connection and routing for the sanitary piping systems will be coordinated with the Civil Engineer during design.

Storm water collected from the roof drains will be collected and tied into the storm water service. Under-slab piping shall be cast iron soil pipe. Secondary storm drainage will be provided via roof scuppers. Exact points of connection and routing for the storm water will be coordinated with the Civil Engineer during design.

Foundation drains will be provided around the perimeter of the facility as directed by the structural division and piped into the storm water main on site.

I. MEDICAL GAS SYSTEMS

The facility will require medical gas/vacuum services. The services will include oxygen, medical air, and, vacuum. The mechanical room will house the medical air, and medical vacuum systems. The existing Praxair bulk oxygen system on site will remain to serve the new building.

The medical air compressor will be a triplex unit, with 10 hp oil-less scroll compressors and a capacity of 69.6 scfm @ 50 psi. The compressors are skid mounted with a 200 gallon receiver. Basis of design is a Beacon Medaes SAS10T.
The vacuum pump will be a triplex unit, with 7.5 hp oil-less claw-type pumps and a capacity of 130 scfm @ 19" Hg of vacuum. The pumps are skid mounted with a 200 gallon receiver. Basis of design is a Beacon Medaes VHS07T.
Lockable valves will be provided as recommended in NFPA 99 to facilitate future modifications to the medical gas/ vacuum systems. In general, service valves will be provided upstream of each zone valve box. In addition, alarms will be provided as required in NFPA 99. This includes a minimum of two separate master alarm panels and all local alarming of zone valve boxes. Zone valve boxes will be provided at each separate patient zone (assume nine).

Medical gases and vacuum systems will be provided and designed in accordance with NFPA 99 and FGI Standards and Guidelines. All wall-mounted medical gas connections will be Diamond Quick-Connect type.

A summary of the FGI required medical gas outlets for each space is indicated in the chart below:

MEDICAL GAS OUTLET REQUIREMENTS			
LOCATION	OXYGEN	VACUUM	MEDICAL AIR
Isolation Room	1/bed	1/bed	1/bed
ED Exam/Teatment	1/bed	1/bed	1/bed
Triage	1/station	1/station	1/bed
Resuscitation	2/bed	3/bed	1/bed

J. AUTOMATIC TEMPERATURE CONTROLS

A direct digital control (DDC) building automation system will be provided to monitor the facilities mechanical and plumbing systems. The system will be complete with operator's workstations and all components required for a complete system. The system will include color graphics for each system with real-time monitoring and all software required to provide the control package. The workstations shall consist of a color monitor, PC, and printer.
The system will be fully integrated with the fire alarm and security systems through the building's IS Ethernet system for communication between control units.
The following items will require monitoring through the building automation system:

- Chilled Water System: complete system control and monitoring
- Heating Water System: complete system control and monitoring
- AHU's: digital control with electronic actuation; interface of status and monitoring
- Domestic Hot Water System: complete system control and monitoring
- Isolation and General Exhaust Fans: interface of status and monitoring
- Air Measuring Devices: interface of status and monitoring
- Emergency Generator system
- Normal power gear monitoring
- Supply Air terminal Units: digital control and electronic actuation
- Return Air Terminal Units: digital control and electronic actuation
- Exhaust Air Terminal Units: digital control and electronic actuation
- Isolation Rooms: direct user interface for each individual room
- A full graphical interface for all systems at the BAS operator workstation.

All controllers will be DDC and electronic. All controls and monitoring shall be able to be viewed via the web or cloud based services at the main PRMC campus in Salisbury, MD.

K. POWER DISTRIBUTION SYSTEMS

Normal Power

The local electrical utility will terminate their 13.2KV service feeder at a utility-owned pad-mount transformer on site. The utility service from the transformer will supply a 2000A, 480Y/277V Main Switchboard located in the building via a concrete encased duct-bank. This switchboard will contain four circuit breakers that feed the buildings automatic transfer switches.

Emergency Power

Generators

The emergency generator will be located on grade in dedicated, weatherproof, sound-attenuated enclosure. One diesel fueled, generator rated at 600KW, 480Y/277V will be provided, manufactured by Caterpillar or approved equivalent. The generator will be standby rated with unit mounted radiator and be equipped with a sub-base tank capable of providing 96 hours of fuel. An exterior platform and stairs will be provided for access, due to the height of the sub-base tank.

Emergency Switchboard

The emergency switchboard will be located in a dedicated room in the building. It is designed for a 600KW generator and a roll-up generator connection that can also serve as a load bank connection. A quick connect switchboard will be provided on site with male and female cam locks. The emergency switchboard will have a bus rating of 1000A at 480Y/277V with SPD and be manufactured by Square D, Eaton, or Siemens.

Automatic Transfer Switches

Emergency power will be distributed throughout the building and switched automatically using automatic transfer switches (ATS). The ATS will sense power loss and signal the generator to start. Once proper frequency and voltage is reached, the ATS will transfer the load to the active power source. Three closed transition ATS's will be provided: a 480Y/277V, 150A life safety switch, a 480Y/277V, 600A critical power switch, 480Y/277V, and a 1000A equipment branch switch. All transfer switches will be equipped with a bypass isolation feature.

UPS Power

A 208Y/120V, 50 KVA UPS will be provided for IT loads with lithium ion batteries. Individual UPS's will be provided with each piece of radiology equipment.

Distribution

Panelboards and transformers will be provided as indicated on attached single line diagram and shall have 25% spare breaker space for future expansion capability. All panelboards will be provided with copper bus bars. All life safety panels will be fused in order to achieve selective coordination and will be provided with surge protective devices as mandated by code.

In compliance with NEC 517, all panels serving patient care vicinities will have their equipment grounds bonded together.

Main electrical rooms will be segregated to separate normal and emergency power. Grounding bars will be provided for IT closets.

Wiring Methods

All branch circuits will be installed in electrical metallic tubing (EMT), minimum ¾" diameter, where concealed in walls, above suspended ceilings, and exposed 6' above finished floor or higher. Branch circuits routed in concrete slabs or in wet locations will be installed in intermediate metal conduit (IMC). All feeders will be installed in intermediate metal conduit (IMC). Connections to motors, transformers, and other vibrating equipment will be flexible metal conduit not to exceed 6' in length. Conductors in feeders and branch circuits will be copper, minimum size #12 AWG, with thermoplastic insulation. All feeders and branch circuits will include copper ground conductors sized in accordance with the National Electric Code (NEC). All electrical equipment will be U.L. listed.

All circuits will be designed in accordance with the NEC, which limits the voltage drop to the farthest outlet of power to a maximum of 3% for either feeder or branch circuits, with a limit of 5% combined voltage drop.

L. LIGHTING

All lighting (both interior and exterior) will be LED for energy efficiency, low cost maintenance, and better control. Lighting levels will be designed and recommended by the Illuminating Engineering Society (IES) handbook. This will be the maximum level. The International Energy Conservation Code (IECC) requires automatic controls of lighting to turn lights off during times of vacancy. In addition, lighting is prohibited from turning on to 100% once someone enters a room. The lights can be turned on manually or automatically, but only to a level of 50%. Most spaces will have dimming controls to allow each occupant to adjust the lighting output. Areas with ample daylight will be considered to have photocells to reduce lighting output where fenestration provides adequate illumination.

Lighting controls will be IP based and networked. Room controllers will interface with a variety of wall stations, touch pads, and other systems such as fire alarm, nurse call, and patient entertainment/experience.
Site lighting will be provided as part of this project and will consist of pole-top LED fixtures to provide recommended illumination on all paved surfaces. These will be controlled via a central lighting control panel located within the building. Lighting will also be provided at helipad in accordance with recommendations by a separate aviation consultant. Lighting will also be provided at the monument sign, flag poles, and potentially the spring at the entrance to the site.

M. FIRE PROTECTION

Water Supply
The building will be fully sprinklered. The systems will be supplied via a combined fire/water main as described above. Two (2) 2-1/2-inch reduced pressure principle (RPZ) backflow preventers will be provided between the municipal supply and the sprinkler control valves to allow for regular maintenance without shutting down the water supply. Two (2) 3-inch backflow preventers will be provided between the municipal supply and the domestic service to the building.

Fire Sprinkler Systems
Fire sprinkler systems will include wet pipe, and dry pipe systems. Two dry pipe valves will be specified for exterior canopy at the main entries and the ambulance bay, and where required by NFPA 13.

Individual sprinkler zones will be zoned to coincide with smoke barriers.

All system piping will be ASTM A53 or A795, Sch 40 black steel, and be joined by threaded or grooved fittings. Preaction and dry system piping will be fabricated with cut grooves, where grooved fittings are utilized. Flexible piping to heads will be incorporated into the system.

Sprinklers located in light hazard areas, as defined by NFPA 13, and throughout all smoke compartments with patients, will be quick response. Sprinklers for all other areas will be standard response, except where specifically noted otherwise in the contract documents.

Systems will be designed and installed in accordance with NFPA 13, the requirements of Somerset County, and Chubb, the owner's insurance carrier.

All sprinkler systems will be electrically supervised by the fire alarm system, which will be provided with off-site monitoring in accordance with NFPA 72.

Fire department hose valves will be located in cabinets where travel distance from the exit is greater than 200 feet and on each side of all horizontal exits, except where permitted otherwise by NFPA 14.

N. FIRE ALARM AND DETECTION SYSTEM

System Architecture
The facility will be served by a fire alarm, detection, and communication system by Honeywell, or approved equivalent. The network will also permit selective and all-call voice communication throughout all areas via recorded or live-voice announcements. The system will be monitored off-site to a UL listed supervising station.

All notification appliance and signaling pathways will be Class B. Where these pathways pass through or serve multiple smoke compartments, the pathway(s) shall be provided with Level 2 survivability, similar to network pathways. Pathways, or portions thereof, passing though or serving only one smoke compartment will be provided with Level 1 performance.

The final arrangement of smoke compartments, voice notification philosophy, and fire alarm system design must be coordinated with the Owner's overall life safety plan. Accordingly, the Owner must approve all recorded messages and how they are to be broadcast during a fire event.

Occupant Notification
Occupant notification will be a combination of public-mode and private-mode notification. Areas that do not provide patient care and are typically occupied by ambulatory outpatients, the general public, or facility personnel will be designated as public-mode areas. These areas would include facility service areas, main lobbies, waiting, and administrative areas. Public-mode areas are provided with voice notification intended for all occupants within the area. Private-mode areas receive voice notification intended only for facility staff. These areas would include the Emergency Department.

The overall notification philosophy is as follows:

Alarm in public mode area

- General evacuation or alert message for all public mode areas
- Alert message for all private mode areas

Alarm in private mode area

- General evacuation or alert message for all public mode areas
- Relocation message for private mode zone of origin
- Alert message for all other private mode areas

Detection

Smoke detection will be provided for many areas of the facility, including:

- Cross-corridor smoke doors equipped with hold-open devices
- HVAC systems
- At system control panels and subpanels
- At the IT Equipment Rooms

Detection required for preaction sprinkler systems will be photoelectric smoke detectors.

Integration

The fire alarm system will interface with the following fire protection and building systems:

- Fire and smoke doors on magnetic hold-open
- HVAC systems
- Smoke dampers
- Emergency generator
- Preaction sprinkler systems
- Facility security system/locking hardware

O. FUEL AND UTILITY SOURCE

Propane

Three (3) 1,000-gallon liquid propane tanks will be added to the existing propane tank farm on site to provide 96 hours of back-up fuel to the hot water boilers.

Electricity

The utility company will provide a secondary service from a utility owned transformer on the property. The contractor will be responsible for providing a concrete pad for the transformer, as well as all wiring and conduit from the transformer secondary. At least one spare conduit beyond what is required will be provided between the transformer and the switchboard for feeder replacement in the future.

Initial MEP Pricing Items

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Date: August 22, 2018

Reference: Peninsula Regional Health Systems

Subject: McCready Hospital
MEP Budget Items

LWA Project No.: 18-462-00

Overview

PRHS has submitted a letter of interest in purchasing the McCready Health campus in Crisfield, MD. A certificate of need will be submitted to the State of Maryland for the proposed merge and conversion to a freestanding emergency department. There are three primary buildings/groups of buildings on the McCready Hospital campus.

- 1980 Hospital
- 2010 Nursing Home
- 1919 Buildings – mixed use

Per the current plan, PRMC will take ownership of the McCready campus on July 1, 2019. For approximately 1.5 to 2 years, PRMC will operate the Hospital in its current function. The current project focuses primarily on the 1980 Hospital building and Central Plant.

There are three scopes of work to be budgeted:

1. Work to be done to maintain the current small hospital function for approximately 2 years.
2. Option 1 – Renovations to be performed to convert the existing Hospital building into a freestanding medical facility (FMF), specifically a freestanding emergency department. The work will be performed over the 2 year time period in item 1 above. The renovations will occur while the existing first floor spaces are occupied and functioning.
3. Option 2 – Construct a new 24,000 sf FMF on the existing campus, in the footprint of the existing Hospital parking lot, with connections to the Nursing Home. Once the new building is constructed and staff have moved over, the existing hospital and central plant will be demolished.

Existing Conditions

The existing building is currently served by the utility transformer located on a concrete pad onsite. This transformer serves both the nursing home and the hospital, with a separate service lateral for the fire pump. The hospital service was originally installed at 1600A, but is now limited to 1000A via a circuit breaker in the nursing home main electrical room.

The main switchboard for the hospital is rated for 480Y/277V, 1600A. It was manufactured by Federal Pacific in 1979 and is in poor condition. Furthermore, Federal Pacific went out of business in the 1980's, and replacement parts for their equipment is now costly. Due to lack of available spaces and spares in the distribution section, the gear appears to have had been bus tapped on four different occasions, with breakers and fusible disconnects mounted in close proximity. While the original gear has two levels of ground fault as required by NEC 517 for hospitals, the bus tap breakers and fuses do not have ground fault protection, which endangers the entire lineup. The room the gear occupies does not have two means of egress as mandated by electrical code, nor does it have the double clearance required per the exception to this code. The main disconnect is a bolted pressure switch, which is undesirable as this type of switch requires frequent maintenance in order to avoid dangerous arc flash conditions that are possible if the switch does not fully operate.

Emergency power for the hospital is provided from a 750 KW, 480Y/277V emergency generator located outside the building in a weatherproof enclosure. A 2300 gallon belly tank acts a day tank for the generator. The generator was manufactured by MTU in 2009 and is in fair condition. Standing water was observed in the base of the unit around the conduit containing the start/stop wires and accessory power conduits. The belly tank is several feet high, and, as a result, the generator is difficult to access and maintain, as there is no stairs or platform to allow maintenance staff easy access to the enclosure.

The emergency generator serves a 1200A distribution panel located in a room off the boiler plant. This distribution panel was manufactured by Square D, and is in good condition. The panel does not provide code required separation of the life safety breaker as required by recent change in the National Electrical Code. This panel serves four ATS's, a 800A equipment branch, a 400A critical branch, a 225A radiology branch, and a 100A life safety branch. The equipment ATS is in the same room as the emergency distribution panel. The other three ATS's occupy the same room as the main normal power switchboard, in violation of NFPA 110's separation requirements. Additionally, the working space in front of the X-ray ATS is blocked by a pair of transformers that sit right in front of it.

Minimum Work to Maintain Current Occupancy for 2 Years

a. Provide proper sealing and drainage for emergency generator. Generator currently has standing water in base of generator around conduits providing power to generator batteries and accessories.
b. Provide new ED nurse call system. The existing nurse call system appears to be inoperable, and modifications/upgrades would be difficult due to its age and condition.
c. Install additional normal and emergency electrical receptacles in ED patient bays to meet the minimum code requirements. Currently, the ED bays have a single quad receptacle (which means 4 receptacles for plugs), and the construction guidelines required 12 receptacles, with approximately half on emergency power and half on normal power. The existing quad outlets are either on normal or emergency, and not both normal and emergency. We propose adding either an emergency or normal circuit to each bay, as well as 2 additional quads per bay.
d. Perform grounding tests on the existing building.
e. Perform preventative maintenance (PM) on the existing main normal power switchboard. The existing bolted pressure switches require significant maintenance, and it is not clear if this has been regularly performed.
f. Install additional normal and emergency electrical receptacles in re-branded Trauma Room (currently OR) to meet code minimum quantities. The existing operating rooms only have 10 and 12 receptacles (for ORs #1 and #2, respectively). Also bring two branches of power into operating room as room is solely served from critical power currently.
g. Consider removing twist lock plugs in the trauma room. (Optional)
h. Consider adding a code blue function to the nurse call system in the ED and Trauma Room, as none exists today. (Optional)
i. Provide generator annunciator in 24 hour manned location or man the boiler plant office around the clock.
j. Filter and treat the fuel in the existing main underground fuel storage tank and daytanks to confirm fuel is clean and usable.
k. Confirm what PRMC insurance company (Chubb) will require.
l. Need 2 sources of fuel for steam boilers providing heat to patient rooms and clinical spaces. Extend and connect to existing propane gas main serving the nursing home boilers. Replace existing burner nozzles and trim with dual fuel equipment.
m. There is no backflow preventer visible on the hospital 4” CW. Add a BFP. (Optional)
n. Remove local dehumidifiers from OR’s.
o. There is currently only one medical gas master alarm panel, installed a room that is not 24 hour monitored. Add second master alarm panel per code and extend to BAS.
p. Confirm ATC system is on emergency power. If not, re-feed to e-power.
q. Add decontamination shower and holding tank to ED. (Optional)
r. Provide MEP connections for the new ADA bathrooms/sinks in the ED (exhaust, sanitary, vent, domestic water).
s. Test/clean/adjust/retro-commission existing AHU’s.
t. AHU-1 and AHU-2 dual-duct system has an existing high humidity issue. The hot deck receives raw outside air that does not pass over a cooling coil first, and is not dehumidified. (Optional)
u. Repair/replace medical vacuum pump. It is leaking a lot of oil. (Optional)
v. Roof – medical vacuum discharge is 2’ from openable nursing home window. (Optional)
w. Repair/complete the installation of the boiler emergency shut-off switches – they are currently not wired.
x. PM/clean/inspect existing sanitary lift station and pumps.

Option 1 – Hospital Renovation

Central Plant/Central MEP Systems

a. Convert approximately half the 2nd floor to be mechanical/electrical space.
b. Expand the existing propane fuel farm on the site to include four (4) additional 1,000 gallon tanks. Extend a 3" underground propane service pipe around the Nursing Home and site to adjacent to the existing 2" service for the nursing home (at the loading dock). Extend new 3" service to the existing central utility plant (CUP).
c. Provide two (2) new 200-ton rooftop air cooled chillers on the roof over the old surgery space. Extend piping into the new 2nd floor MEP space to new distribution pumps. Extend and connect new chilled water piping to old. Once new chiller plant is active remove existing abandoned rooftop AC chiller located above the existing central plant, and all associated piping, supports and connections. Demolish any chiller pumps/specialties in the CUP.
d. Provide three (3) new 25 GPM condensing domestic water heaters in the existing CUP, two to meet the demand with one redundant heater. Heaters will be propane fired. Extend and connect HW piping to existing. Install one (1) new heater in the space adjacent to the existing 1,200 gallon tank heater. Once started up and connected to the existing piping system, demolish the existing 1,200 gallon tank/heater and associated equipment and steam piping. When the space is cleared, install the remaining two (2) heaters in the old tank heater footprint.
e. Provide a new 10 GPM domestic hot water recirculation pump and associated piping and specialties in the CUP. Provide a copper-silver Legionella treatment system.
f. Demolish one existing high pressure steam boiler and associated piping and specialties. This boiler is redundant capacity. Provide three (3) new 1,000 MBH condensing heating hot water boilers in existing boiler footprint. The boilers will be dual fired with propane and diesel fuel oil. Extend new heating hot water piping up to existing penthouse to back feed old steam-to-HW converter system, then demo old converters and steam station in the penthouse.
g. Once new HHW system is connected, demolish remaining HP steam boiler, deaerator, piping, etc.
h. Replace existing medical vacuum pump with new skid/packaged dry claw system.
i. Provide a medical air manifold system in the CUP (or a medical air pump), and extend new piping to the ED, Trauma Rooms and Isolation Rooms as required by programming.
j. In the penthouse, make temporary connections between AHU-1 and 2. These are dual duct units. In the hospital, close off all dual duct boxes for unoccupied areas. Then demolish existing AHU-2. Install a new custom field-erected AHU in the existing AHU-2 footprint. The AHU will be approximately 40,000 CFM, and include a fan array for the supply. Once installed, the new AHU will back-feed the AHU-1 system. Then demolish existing AHU-1 and AHU-3 (DOAS unit serving 2nd floor FCU's). The new AHU will be single duct using HHW for reheat at the VAV boxes.
k. Remove all existing dual ductwork, mains, branches and supports. Remove all existing dual duct air terminal units and low pressure ductwork and air devices. Provide all new single duct supply air ductwork, single duct VAV boxes, and heating hot water piping system. The ductwork replacement will be done as phased construction, as areas on the first floor will remain occupied during the replacement.
l. Provide a new central DDC building automation system.
m. Replace existing 6" combined fire/water service with a new 8", or include a new parallel 4" to help alleviate the fire pump churn issues.
n. Provide new fire pump to maintain 100 psig at top of standpipes.
o. Add critical exhaust systems for isolation rooms, ED waiting rooms, triage and radiology waiting rooms.
p. Add a dedicated decontamination shower exhaust system per code.
q. Provide new master and area medical gas alarm panels and extend to BAS.
r. Replace existing sanitary lift station serving the hospital, nursing home and 1919 buildings.

Option 1 – Hospital Renovation (continued)

s. Generator Access. The generator breaker sits above the recommended 6'7" height for operability per NEC. Generator sits on underbelly tank, and access for maintenance would be difficult.
t. Provide new 480Y/277V, 1600A electrical service via pad mounted transformer on site.
u. Provide new 480Y/277V, 1600A Switchboard in new electrical space on 2nd floor.
v. Maintain existing 750 KW generator for emergency power.
w. Provide new ATS's to match existing sizes in dedicated emergency power distribution room on the 2nd floor separated from normal power. Provide replacements to major emergency power distribution panels immediately downstream of ATS's on this floor as well. This would include an 800A equipment branch, a 400A critical branch, a 225A radiology branch, and a 100A life safety branch.
    - Deduct alternate. Maintain existing transfer switches and emergency distribution on ground floor. This option leaves emergency power system vulnerable to flooding.

Floor Renovations

a. Renovate areas of first floor per architectural program and concept.
b. In general, all spaces will be gutted down to the structure for complete renovation. All windows and exterior doors will be replaced.
c. HVAC systems for the renovated spaces will include new supply ductwork mains, VAV boxes, HHW piping and controls.
d. Plumbing distribution (CW/HW/HWR) piping will be all new
e. Plumbing sanitary/vent piping will be all new. The first floor is slab on grade and will require extensive cutting and patching of concrete floors and trenching.
f. All existing electrical panels, feeders and branch circuiting will be replaced in the renovation spaces.
g. All existing lighting fixtures and circuiting will be removed. Provide LED lighting fixtures throughout area of renovation in accordance with IES standards.
h. All existing fire alarm devices and wiring will be removed. Extend existing fire alarm system with new initiation and notification appliances throughout renovated space.

Option 2 – New Building

Preliminary pricing for the new building option will be developed based on WT's recent budgeting from another similar nearby standalone ED. MEP systems for the new PRHS FMF will be similar to the other ED. These systems will be described in more detail in the next concept.

PRHS will construct a new approximately 24,000 sf free-standing medical facility on the existing campus, in the footprint of the existing Hospital parking lot, with building connections to the Nursing Home. Once the new building is constructed and staff have moved over, the existing hospital and central plant will be demolished

DESIGN FEES

Design Fee Detail

CRTKL

DESIGN FEE ESTIMATE

The following design fee estimates for the new Freestanding Medical Facility have been prepared by CallisonRTKL along with partner consultants:

- CallisonRTKL - Architecture – lead architectural design consultant, medical programming and planning services
- Becker Morgan Group - Architecture – lead local architectural consultant, construction document and construction administration services
- Leach Wallace Associates - MEP Engineering
- Becker Morgan Group -Civil and Structural Engineering

These fees are preliminary estimates, based on the current design concept as presented in the Report on McCready Memorial Hospital prepared by CallisonRTKL and Leach Wallace Associates in conjunction with PRMC (dated Sept 13, 2018) and the project understanding as described below.

PROJECT SCOPE

The project scope is based on providing the following professional design services:

- Architecture,
- Medical Planning,
- Interior Design,
- Civil Engineering,
- Structural Engineering,
- Mechanical, Electrical and Plumbing Engineering
- Wayfinding and Signage
- Geotechnical
- Existing Conditions Survey

For the purpose of this estimate, The scope of work includes site planning and design of the Freestanding Medical Facility (exterior and interior) from Pre-Design Phase Services through Schematic Design, Design Development, Construction Documentation, Bidding and Construction Phase Services. It is recommended that the project start with a Pre-Design Phase consisting of programming confirmation and concept design refinement in order to address relevant issues or direction that may have evolved since the original Concept Report's completion. This will provide a solid base prior to moving into the Schematic Design Phase.

DESIGN SERVICES NOT INCLUDED IN THIS ESTIMATE

The following services are not included in this estimate as it is assumed they are either not required, or will be provided by the Owner:

- Construction Cost Estimating
- Acoustical/Vibration Consultant
- Food Service Consultant
- Environmental Consultant
- Landscape Architect
- Traffic/parking Consultant
- LEED Consultant
- Building Commissioning Services
- Medical Equipment Planning/procurement
- Furniture Selection/Procurement
- Artwork Consultant
- Aviation Consultant (FAA Coordination for Helipad)
- Wind Analysis Consulting Services

CRTKL

PROJECT DELIVERY SYSTEM

This fee and time schedule for performance of services are based on the use of the Design/Bid/Award/Construction with one prime construction contract delivery system *or* a single negotiated construction contract with 1 bid package.

SCHEDULE

The duration of the project is assumed to have a 9-month design schedule (as broken out below) plus a 3-month permitting and review process and a 14-month construction period.

Pre-Design Phase (programming and concept validation/refinement) – 4 weeks
Schematic Design – 8 weeks
Owner Review – 3 weeks
Design Development – 10 weeks
Owner Review – 3 weeks
Construction Document – 12 weeks
Owner Review - 2 weeks (concurrent with above)
Permitting and Bidding - 14 weeks
Construction – 60 weeks

COMPENSATION FOR PROFESSIONAL SERVICES

Total Design Fee	$1,150,000
Reimbursable Expenses (4%)	$50,000
Total Compensation	**$1,200,000**

Design Fee Breakdown by Discipline:

Architecture *(includes medical planning, interior design, and management of design team)*	$600,000
Civil Engineering	$85,000
Structural Engineering	$50,000
MEP Engineering	$320,000
Signage and Wayfinding	$45,000
Geotechnical Engineering	$25,000
Existing Conditions Survey	$25,000
Total	**$1,150,000**

Design Fee Breakdown by Phase

Pre- Design Services	5%
Schematic Design Phase Services	15%
Design Development Phase Services	30%
Construction Documents Phase Services	30%
Bidding or Negotiation Phase Services	2%
Construction Phase Services	18%

CONSTRUCTION COST ESTIMATE

Construction Cost Estimates

Peninsula Regional Medical Center
Salisbury, MD
9/6/2018

DRAFT

Functional Space Program

300.00 McCready Campus

300.00 Summary

Ref	Service	NSF	DNSF	$/DNSF	TOTAL	BGSF	Comments
	Division 1 Project Requirements		**2.00%**		**265,708**		
301.00	**FreeStanding Emergency**	**3,705**	**5,558**	**$ 156.60**	**$ 870,305**	**6,113**	
302.00	**Crisfield Clinic**	**1,965**	**2,751**	**$ 152.25**	**$ 418,840**	**3,026**	
303.00	**Administration**	**1,175**	**1,586**	**$ 108.75**	**$ 172,505**	**1,745**	
304.00	**Imaging**	**1,562**	**2,343**	**$ 375.00**	**$ 878,625**	**2,577**	
305.00	**Laboratory**	**1,014**	**1,267**	**$ 174.00**	**$ 220,436**	**1,394**	
306.00	**Pharmacy**	**0**	**0**	**$ 217.50**	**$ -**	**0**	
307.00	**Psych - Outpatient**	**880**	**1,346**	**$ 217.50**	**$ 292,842**	**1,481**	
308.00	**Physical Therapy**	**2,308**	**3,000**	**$ 108.75**	**$ 326,294**	**3,300**	
309.00	**Support Services**	**1,892**	**2,460**	**$ 108.75**	**$ 267,482**	**2,706**	
			20,311				
310.00	**Building Systems**	**0**	**658**	**$ 13.05**	**$ 8,587**	**658**	
311.00	**Public Areas & Circulation**	**0**	**1,245**	**$ 108.75**	**$ 135,394**	**1,245**	
	Core & Shell			**$ 150.00**	**$ 3,636,769**	**24,245**	
			119%				
	Design Contingency		**10%**		**$ 722,808**		
	Building Cost			***$ 338.90***	***$ 8,216,592***	**24,245**	
	Site Allowance			**$ 16.75**	**$ 1,441,676**	**86,070**	
	Helipad (On Grade)				**$ 275,000**		
	Demoltion of Existing Structures				**$ 400,000**		
	Site Design Contingency		**15%**		**$ 257,501**		
	Subtotal Construction Budget			**$ 436.82**	**$ 10,590,770**		
	Whiting-Turner General Conditions		5.25%		$ 556,015		
	Whiting-Turner Insurance		1.00%		$ 117,041		
	Whiting-Turner Bond		0.55%		N/A		
	Whiting-Turner Fee		2.50%		$ 295,529		
	Whiting-Turner Preconstruction		0.25%		$ 65,165		
	Construction Contingency		5%		$ 557,339		
	Total Construction Budget			**$ 502.45**	**$ 12,181,860**		
	Escalation To Mid-Point of Construction 10/2020		5% per year		$ 1,133,125		
	Total Budget			**$ 549.18**	**$ 13,314,984**		

ESCALATION CALCULATOR

Current Date ***September 3, 2018***

Calculate to Start Date

Current Date			Start Date	Months
September 3, 2018	to	Start Date	March 1, 2020	18.0
				Weeks 77.4
				Workdays 387

Calculate to Mid-point Assume Construction Duration of 14 months

Current Date			Mid-Point	Months
September 3, 2018	to	Mid-Point	October 1, 2020	25.0
				Weeks 107.5
				Workdays 537.5

Escalation Calcs Based on Per Annum Rate of:		**5.00%**	
To Start Date	1.5	5.00%	**7.59%**
To Mid-Point	2.1	5.00%	**10.70%**

Escalation Calcs Based on Per Annum Rate of:		**5.00%**	
To Start Date	1.5	5.00%	**7.59%**
To Mid-Point	2.1	5.00%	**10.70%**

Peninsula Regional Medical Center

Salisbury, MD 9/6/2018

Functional Space Program

300.00 McCready Campus

301.00 Freestand Emergency Center

Ref	Description	Qty	NSF/Unit	Total NSF	Comments
	Emergency				
301.01	Reception	1	65	65	
301.02	Triage	1	120	120	
301.03	Security	1	50	50	
301.04	Wheelchair Storage	3	16	48	
301.05	Waiting	1	370	370	
301.06	Public Toilet	1	55	55	
301.07	Drinking Fountain	1	10	10	
301.08	Public Toilet - Bariatric	1	55	55	
301.09	Cashier/ Reception Reg	1	65	65	
301.10	Treatment Rooms	3	140	420	
301.11	Secure Holding / Triage	1	300	300	
301.12	Resuscitation Room	1	250	250	
301.13	Observation Room	2	120	240	
301.14	Patient Toilet Room	1	50	50	
301.15	*Nurse Station*	1	166	166	
301.16	Physician Documentation	1	30	30	
301.17	Clean Supply / Equipment Storage	1	220	220	location tbd
301.18	Medications	1	80	80	
301.19	Nourishment Station	1	30	30	
301.20	Soiled Workroom	1	140	140	
301.21	Environmental Services	1	50	50	
301.22	Strecher Parking Alcove	1	25	25	
301.23	Decont. Room - Shower Room	1	80	80	

Peninsula Regional Medical Center

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Functional Space Program

300.00	**McCready Campus**			
301.24	Staff Toilet	1	50	50
301.25	Ambulance Vestible	1	150	150
301.26	EMS Room	1	40	40
301.27	Staff Lounge Lockers	1	276	276
301.28	Patient Toilet Rooms Patient Shower	1	270	270
	Total Net Square Feet			**3,705**
	DNSF to DGSF			1.50
	Total Departmental Gross Square Feet			**5,558**
	DGSF to BGSF			1.10
	Total Floor Gross Square Feet			**6,113**

Peninsula Regional Medical Center

Salisbury, MD 9/6/2018

Functional Space Program

200.00 McCready Campus

302.00 Crisfield Clinic

Ref	Description	Qty	NSF/Unit	Total NSF	Comments
	Crisfield Clinic				
302.01	Waiting- Seats, WC, Queing	1	345	345	
302.02	Public Toilet	1	55	55	
302.03	Reception / Admissions	1	90	90	
302.04	Exam Rooms	8	120	960	
302.05	Patient Toilet	1	55	55	
302.06	Provider Charting	4	65	260	
302.07	Nurse Station	1	110	110	
302.08	Supplies Closet	1	35	35	
302.09	Staff Toilet	1	55	55	
	Total Net Square Feet			***1,965***	
	DNSF to DGSF			1.40	
	Total Departmental Gross Square Feet			**2,751**	
	DGSF to BGSF			1.10	
	Total Floor Gross Square Feet			**3,026**	

Peninsula Regional Medical Center

Salisbury, MD 9/6/2018

Functional Space Program

300.00 McCready Campus

303.00 Administration

Ref	Description	Qty	NSF/Unit	Total NSF	Comments
	Support Services				
303.01	Conference Room	10	20	200	
303.02	Coffee Bar	1	15	15	
303.03	Administrator	1	120	120	
303.04	Assistant Admin	2	100	200	
303.05	Human Resources	1	100	100	
303.06	Medical Records	1	80	80	
303.07	Patient Services	1	80	80	
303.08	Work Stations	5	65	325	
303.09	Toilet	1	55	55	
303.10	xx				
	Total Net Square Feet			***1,175***	
	DNSF to DGSF			1.35	
	Total Departmental Gross Square Feet			**1,586**	
	DGSF to BGSF			1.10	
	Total Floor Gross Square Feet			**1,745**	

Peninsula Regional Medical Center

Salisbury, MD 9/6/2018

Functional Space Program

300.00 McCready Campus

304.00 Imaging

Ref	Description	Qty	NSF/Unit	Total NSF	Comments
	Imaging				
304.01	Waiting	1	130	130	
304.02	Public Toilet	1	55	55	
304.03	Drinking Fountain	1	10	10	
304.04	Reception	1	65	65	
304.05	**Radiography**	1	340	340	
304.06	**C.T. Scanner**	1	400	400	Including Equipment
304.07	Control Room	1	150	150	
304.08	Ultrasound	1	120	120	
304.09	Patient Toilet	1	55	55	
304.10	Dressing Room	1	42	42	Barrier Free
304.11	Dressing Room	1	35	35	
304.12	Quality Controls / PACS	1	80	80	
304.13	Office	1	80	80	
304.14	Ultrasound	0	160	0	
304.15	Patient Toilet	0	60	0	
304.16	Staff Office	0	100	0	
304.17	Radiologist Reading	0	120	0	
304.18	Team Work Area	0	160	0	
304.19	Clean Supply	0	160	0	
304.20	Soiled Utility	0	100	0	
304.21	Receptionist	0	100	0	
304.22	Family/Patient Lounge	0	200	0	
304.23	Patient Changing	0	60	0	

Peninsula Regional Medical Center

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Functional Space Program

300.00	**McCready Campus**			
304.24	Staff Toilet	0	60	0
304.25	Staff Breakroom/Conference	0	180	0
	Equipment Storage	0	160	0
	Housekeeping	0	60	0
	Total Net Square Feet			***1,562***
	DNSF to DGSF			1.50
	Total Departmental Gross Square Feet			**2,343**
	DGSF to BGSF			1.10
	Total Floor Gross Square Feet			**2,577**

Peninsula Regional Medical Center

Salisbury, MD 9/6/2018

Functional Space Program

300.00 McCready Campus

305.00 Laboratory

Ref	Description	Qty	NSF/Unit	Total NSF	Comments
	Lab				
305.01	Specimen Collection	1	115	115	
305.02	Accessioning / Shipping	1	25	25	
305.03	Entrance Area	1	35	35	
305.04	Open Lab	1	838.5	839	
	Total Net Square Feet			***1,014***	
	DNSF to DGSF			1.25	
	Total Departmental Gross Square Feet			**1,267**	
	DGSF to BGSF			1.10	
	Total Floor Gross Square Feet			**1,394**	

Peninsula Regional Medical Center

Salisbury, MD 9/6/2018

Functional Space Program

300.00 McCready Campus

306.00 Pharmacy

Ref	Description	Qty	NSF/Unit	Total NSF	Comments
	Pharmacy				
306.01	General Storage	0	440	0	
306.02	Picking	0	160	0	
306.03	Compounding	0	160	0	
306.04	Office	0	100	0	
306.05	Staff Toilet	0	60	0	shared
306.06	Staff Breakroom/Conference	0	180	0	shared
	Total Net Square Feet			***0***	
	DNSF to DGSF			1.30	
	Total Departmental Gross Square Feet			**0**	
	DGSF to BGSF			1.10	
	Total Floor Gross Square Feet			**0**	

Peninsula Regional Medical Center

Salisbury, MD 9/6/2018

Functional Space Program

300.00 McCready Campus

307.00 Psych - Outpatient

Ref	Description	Qty	NSF/Unit	Total NSF	Comments
	Psych - Outpatient				
307.01	Patient Lounge / Waiting	1	65	65	
307.02	Consultation	2	100	200	
307.03	Group Room	1	200	200	
307.04	Patient Toilet Room	1	50	50	
307.05	Offices	3	100	300	
307.06	Work Area	1	65	65	
307.07		0	240	0	
307.08		0	100	0	
307.09		0	120	0	
307.10		0	60	0	
307.11		0	160	0	
307.12		0	60	0	
307.13					
307.14		0	250	0	
307.15		0	100	0	
307.16		0	20	0	
307.17		0	60	0	
307.18		0	180	0	
	Total Net Square Feet			**880**	
	DNSF to DGSF			1.53	
	Total Departmental Gross Square Feet			**1,346**	
	DGSF to BGSF			1.10	
	Total Floor Gross Square Feet			**1,481**	

Peninsula Regional Medical Center

Salisbury, MD 9/6/2018

Functional Space Program

300.00 McCready Campus

308.00 Physical Therapy

Ref	Description	Qty	NSF/Unit	Total NSF	Comments
	Physical Therapy				
308.01	Waiting /Seats/WC	1	160	160	
308.02	Reception / Clerical	1	65	65	
308.03	Patient Toilet Room	1	55	55	
308.04	Open Gym	1	1418	1,418	
308.05	Private PT Room	1	110	110	
308.06	Private OT Room	1	110	110	
308.07	Office	1	80	80	
308.08	PT Staff Work Room and Equip	2	50	100	
308.09	PT Storage	1	80	80	
308.10	PT Staff Toilet	1	55	55	
308.11	Clean Supplies	1	50	50	
308.12	Soiled Holding	1	25	25	
308.13	xx	0	140	0	
308.14	xx				
	Total Net Square Feet			***2,308***	
	DNSF to DGSF			1.30	
	Total Departmental Gross Square Feet			**3,000**	
	DGSF to BGSF			1.10	
	Total Floor Gross Square Feet			**3,300**	

Peninsula Regional Medical Center

Salisbury, MD 9/6/2018

Functional Space Program

300.00 McCready Campus

309.00 Support Services

Ref	Description	Qty	NSF/Unit	Total NSF	Comments
	Support Services				
309.01	Staff Break Room	1	413	413	
309.02	Staff Lockers / Bench / Clear	1	162	162	
309.03	Staff Toilet Room	1	55	55	
309.04	Staff Changing Room	1	42	42	
309.05	EVS Room	1	80	80	
309.06	Building Services Storage	1	100	100	
309.07	Maintenance Work Station	2	25	50	
309.08	Rec . / Breakdown Room	1	65	65	
309.09	Clean Linen Rec Room	1	65	65	
309.10	Soiled Linen Holding Room	1	65	65	
309.11	Cart Wash Alcove	1	35	35	
309.12	Respiratory Therapy Workroom	0	25	0	
309.13	Med Gas Manifold Room	1	80	80	
309.14	Body Holding Room	1	80	80	
309.15	IT Room	1	200	200	
309.16	Electrical Main Room	1	400	400	
	Total Net Square Feet			***1,892***	
	DNSF to DGSF			1.30	
	Total Departmental Gross Square Feet			**2,460**	
	DGSF to BGSF			1.10	
	Total Floor Gross Square Feet			**2,706**	

Peninsula Regional Medical Center

Salisbury, MD 9/3/2018

Functional Space Program

300.00 McCready Campus

310.00 Building Systems

Ref	Description	Qty	NSF/Unit	Total NSF	Comments
					Determine based on configuration & long term
	Mechanical				
310.01	MEP Allowance	1	658	658	
310.02	Boilers	0	250	0	
310.03	Hot Water	0	200	0	
310.04	Medical Gas Pumps	0	240	0	
310.05	Electical - Main	0	500	0	
310.06	Electrical - Distrbuted	0	160	0	
310.07	Building Controls	0	120	0	
310.08	AHU	0	0	0	
310.09	Control Engineer	0	100	0	
310.10	Bio Med & shop	0	600	0	
310.11	**Information Systems**	0			
310.12	Main	0	250	0	
310.13	Distributed	0	120	0	
310.14	Support Technician	0	100	0	
310.15	Storage	0	200	0	
310.16	xx	0			
310.17	xx				
310.18	xx				
	Total Net Square Feet			***0***	
	DNSF to DGSF			1.20	
	Total Departmental Gross Square Feet			**0**	
	DGSF to BGSF			1.10	
	Total Floor Gross Square Feet			**658**	

Peninsula Regional Medical Center

Salisbury, MD 9/3/2018

Functional Space Program

300.00 McCready Campus

311.00 Public Areas & Circulation

Ref	Description	Qty	NSF/Unit	Total NSF	Comments
	Public Lobby				
311.01	Common Circulation	1	345	345	
311.02	Lobby - upper floors	0	600	0	
311.03	Vestibule/wc stor	0	200	0	
311.04	Vestibule - ED / Cancer Care	0	200	0	
311.05	Reception/ Registration	0	120	0	
311.06	Patient Toilets	0	60	0	
311.07	Gift shop	0	160	0	
311.08	Conference Room	0	200	0	
311.09	Housekeeping	0	60	0	
311.10	Security	0	10	0	
311.11	xx	0		0	
311.12	**Circulation - Vertical**				
311.13	Elevators	1	450	450	
311.14	Stairs	1	450	450	
311.15	xx				
311.16	xx				
	Total Net Square Feet			***0***	
	DNSF to DGSF			1.25	
	Total Departmental Gross Square Feet			**0**	
	DGSF to BGSF			1.10	
	Total Floor Gross Square Feet			**1,245**	

PENINSULA
REGIONAL HEALTH SYSTEM

McCready
HEALTH
With you...for life!

EXHIBIT 10

Where To Go For Care

Your healthcare provider should be your first point of contact for most medical problems.

You get the most efficient care because they personally know you and your medical history.

1st Choice

Primary Care Office

- Best choice
- Knows you and your health
- Available to call 24/7

To find a family physician, visit peninsula.org/findadoctor

2nd Choice

Urgent Care Facilities

- If your doctor can't see you and your condition can't wait
- Extended and weekend hours

CALL YOUR PRIMARY CARE PROVIDER FIRST

Learn more at yourdocsin.com

3rd Choice

Hospital Emergency Rooms

- Life-threatening problems

  Examples:
  - Sudden chest pain
  - Sudden numbness in face, arm, or leg
  - Seizures
  - Inability to breathe
  - Sudden severe headache
  - Severe abdominal pain
- Call 911

Trust Peninsula Regional Medical Center, the most comprehensive trauma/emergency care provider on the Shore.

Visit peninsula.org/emergency

It is always important to bring a list of the current medications you are taking no matter where you go for care.

PENINSULA REGIONAL MEDICAL CENTER

Where To Go For Care

Your primary care provider should be
your first point of contact for most medical problems.
You get the most efficient care because
they personally know you and your medical history.

Primary Care Office

- Best choice
- Knows you and your health
- Available to call 24/7

Urgent Care Facilities

CALL YOUR PRIMARY CARE PROVIDER FIRST

- If your primary care provider can't see you and your condition can't wait
- Extended and weekend hours

Hospital Emergency Rooms

- Life-threatening problems
  Examples:
  -Sudden chest pain
  -Sudden numbness in face, arm, or leg
  -Seizures
  -Inability to breathe
  -Sudden severe headache
  -Severe abdominal pain
- Call 911

Where To Go For Care

Your healthcare provider should be your first point of contact for most medical problems.

You get the most efficient care because they personally know you and your medical history.

1st Choice

Primary Care Office

- Best choice
- Knows you and your health
- Available to call 24/7

2nd Choice

Urgent Care Facilities

- If your doctor can't see you and your condition can't wait
- Extended and weekend hours

CALL YOUR PRIMARY CARE PROVIDER FIRST

3rd Choice

Hospital Emergency Rooms

- Life-threatening problems
  Examples:
  - Sudden chest pain
  - Sudden numbness in face, arm, or leg
  - Seizures
  - Inability to breathe
  - Sudden severe headache
  - Severe abdominal pain
- Call 911

It is always important to bring a list of the current medications you are taking no matter where you go for care.

MKT-026 (05/19)

EXHIBIT 11

July 30, 2019

VIA EMAIL & HAND DELIVERY

Ms. Ruby Potter
ruby.potter@maryland.gov
Health Facilities Coordination Officer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Notice of Intent to Convert McCready Hospital to a Freestanding Medical Facility and Request for Exemption from Certificate of Need Review

Dear Ms. Potter:

On behalf of McCready Foundation, Inc. and Peninsula Regional Medical Center, Inc., as joint applicants, enclosed are six copies of the applicants' Request for Exemption from CON Review to convert McCready Hospital to a Freestanding Medical Facility. Also enclosed is a CD containing electronic versions of the exemption application (WORD) and tables (EXCEL), and searchable PDF files of the application and exhibits. Full scale drawings of the proposed McCready Health Pavilion are also being hand delivered.

If you have questions about the information provided above, please contact counsel for McCready Foundation and Peninsula Regional Medical Center convenience:

Emily H. Wein
Foley & Lardner LLP
Washington Harbour
3000 K Street, N.W.
Suite 600
Washington, D.C. 20007
EWein@foley.com

Counsel for McCready Foundation, Inc.

James Buck
Gallagher, Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore, Maryland 21201
410-347-1353
jbuck@gejlaw.com
Counsel for Peninsula Regional Medical Center, Inc.

#670752
011888-0002

The Applicants look forward to working with the Maryland Health Care Commission, the Maryland Institute for Emergency Medical Services Systems, the Health Services Resources Cost Review Commission, and other interested stakeholders to effectuate a new and innovative model of health care delivery for the residents of Somerset County.

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

Sincerely,

James C. Buck

Enclosures

CC by email without enclosures:

Ben Steffen, Executive Director, Maryland Health Care Commission
Dr. Theodore R. Delbridge, MIEMSS Executive Director
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Kevin McDonald, Chief, Certificate of Need Program
Suellen Wideman, Esq., Assitant Attorney General
Steven E. Leonard, President and CEO, Peninsula Regional Health System, Inc.
Kathleen Harrison, FACHE, CEO McCready Foundation, Inc.
Bruce Ritcie, Vice President, Finance/CFO, Peninsula Regional Health System, Inc.
Camesha Spence, CFO, McCready Foundation, Inc.
Melvin (Chip) R. Hurley Jr., CPA, FHFMA, CGMA, Berkely Research Group
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
Emily H. Wein, Foley & Lardner LLP

EXHIBIT 12

September 4, 2019

VIA EMAIL & FEDEX

The Honorable Lawrence J. Hogan, Jr.
100 State Circle
Annapolis, Maryland 21401
Governor.mail@maryland.gov

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
Miller Senate Office Building
3 East Wing
11 Bladen Street,
Annapolis, Maryland 21401
delores.kelley@senate.state.md.us

The Honorable Shane E. Pendergrass
Chair, House Health and Government Operations Committee
House Office Building, Room 241
6 Bladen Street
Annapolis, Maryland 21401
Shane.pendergrass@house.state.md.us

The Honorable Charles J. Otto
House Office Building, Room 321
6 Bladen Street
Annapolis, MD 21401
charles.otto@house.state.md.us

The Honorable Mary Beth Carozza
James Senate Office Building, Room 314
11 Bladen Street
Annapolis, MD 21401
marybeth.carozza@senate.state.md.us

The Honorable Craig N. Mathies Sr.
President, Somerset County Commission
Somerset County Commissioners Office
11916 Somerset Ave. Room #111
Princess Anne, Md 21853
commissioners@somersetmd.us

#674371
012888-0002

The Honorable Ralph D. Taylor
Somerset County Administrator
11916 Somerset Avenue, Room 111
Princess Anne, MD 21853
Phone: 410.651.0320
dtaylor@somersetmd.us

The Honorable Robert R. Neall
Secretary of Health
Office of Secretary
Maryland Department of Health
Herbert R. O'Conor State Office Building
201 West Preston Street
Baltimore, Maryland 21201
Robert.neall@maryland.gov

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
ben.steffen@maryland.gov

Lori Brewster, MS, APRN/LCADC
Somerset County Health Officer
8928 Sign Post Rd.
Suite #2
Westover, MD 21871
lori.brewster@maryland.gov

Re: Summary of Public Informational Hearing Regarding Conversion of Edward W. McCready Memorial Hospital to a Freestanding Medical Facility

Dear Governor Hogan, Senators Kelley and Carozza, Delegates Pendergrass and Otto, County Manager Taylor, Councilman Mathies, Mssrs. Shrader and Steffen, and Ms. Brewster:

On behalf of McCready Foundation, Inc. and Peninsula Regional Medical Center, Inc., by and through the undersigned counsel and pursuant to MARYLAND CODE, HEALTH-GENERAL §

19-120(l)(6) and Code of Maryland Regulations § 10.24.17.04(C)(3)(c)(iii), this letter and the accompanying enclosures provide a summary of the public informational hearing held by McCready Foundation, Inc. and Peninsula Regional Medical Center, Inc. in connection with their notice of intent filed with the Maryland Health Care Commission to convert Edward W. McCready Memorial Hospital to a freestanding medical facility.

As background, McCready Foundation Inc. d/b/a Edward W. McCready Memorial Hospital ("McCready") and Peninsula Regional Medical Center, Inc. ("PRMC"), as joint applicants (together, the "Applicants"), filed a notice of intent and a request for an exemption from certificate of need review to convert Edward W. McCready Memorial Hospital to a freestanding medical facility with the Maryland Health Care Commission on July 30, 2019. This filing followed an Affiliation Agreement executed between Peninsual Regional Health System, Inc. ("PRHS") and McCready on June 26, 2019, pursuant to which PRHS will become the sole corporate member of McCready Foundation, and each component of McCready will become participants in PRHS's regional health care delivery system.

MARYLAND CODE, HEALTH-GENERAL § 19-120(l)(2) and Code of Maryland Regulations § 10.24.17.04(C)(3)(c)(ii) require that a hospital, within thirty days of filing a notice of intent to convert to a freestanding medical facility, hold a public informational hearing in the jurisdiction where the hospital is located. The public informational hearing must address: (1) the reasons for the proposed conversion; (2) plans for transitioning acute care services previously provided by the hospital to residents of the the hospital's service area; (3) plans for addressing the health care needs of residents of the hospital's service area; (4) plans of the hospital or the merged asset system that owns or controls the hospital for retraining and placement of displaced employees; (5) plans for the hospital's physical plant and site; and (6) the proposed timeline for the conversion. The Applicants held a public informational on August 20, 2019, beginning at 6:00 p.m., at the McCready Hospital Community Room, Alice B. Tawes Nursing and Rehabilitation Center, located at 201 Hall Highway in Crisfield, Maryland. Within ten working days of holding the public informational hearing, the Applicants are required to provide a summary of the public hearing. At the hearing, the Applicants addressed each of the factors set forth in HEALTH GENERAL § 19-120(l)(2) and COMAR § 10.24.17.04(C)(3)(c)(ii).

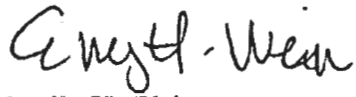
Before holding the public informational hearing, the Applicants exceeded their regulatory obligations to ensure that the hearing was well attended. PRMC published notice of the hearing date and location on McCready's website's homepage and in the print and electronic versions of the The Daily Times, a newspaper of daily circulation, for no fewer than fifteen days prior to the public hearing. PRMC also purchased advertisements in the County News, a Somerset County newspaper, which circulates less than daily, announcing the date and location of the public hearing.

The public informational hearing lasted approximately one hour and fifteen minues and was well attended. Kathleen Harrison, Chief Executive Officer of McCready and Steven E. Leonard, President and Chief Executive Officer of PRHS, hosted the public informational hearing. At the hearing, Ms. Harrison and Mr. Leonard reviewed a slide presentation that addressed each of the issues required by MARYLAND CODE, HEALTH-GENERAL § 19-120(l)(2) and Code of Maryland Regulations § 10.24.17.04(C)(3)(c)(ii). Following the slide presentation, Ms. Harrison and Mr. Leonard answered questions from the audience. A transcript of the hearing is enclosed herewith as **Exhibit A**, and a copy of the slide presentation is enclosed herewith as **Exhibit B**. Notably, during the presentation Mr. Leonard mistakenly indicated in response to a question that, under Maryland Institute for Emergency Medical Services Systems ("MIEMSS") protocols, priority 1 patients would not be brought the freestanding medical facility by EMS providers. In fact, MIEMSS protocols allow EMS providers to transport priorty 1 patients who are *in extremis* to a freestanding medical facility. The day after the hearing, Mr. Leonard followed up directly with the person who asked the question to correct his misstatement.

Please contact me if you have any questions regarding the public informational hearing, the enclosed materials, or the Applicants' intent to convert Edward W. McCready Memorial Hospital to a freestanding medical facility.

Respectfully submitted,

James C. Buck
Gallagher Evelius & Jones, LLP
Counsel to Peninsula Regional Medical Center, Inc.



Emily H. Wein
Foley & Lardner, LLP
Counsel to McCready Foundation, Inc.

Enclosures

#674371
012888-0002

cc via email: **Senate Finance Committee**
The Honorable Brian J. Feldman, Vice Chair,
The Honorable Malcolm Augustine
The Honorable Pamela Beidle
The Honorable Joanne C. Benson
The Honorable Antonio Hayes
The Honorable Stephen S. Hershey, Jr.
The Honorable J. B. Jennings
The Honorable Katherine Klausmeier
The Honorable Benjamin F. Kramer
The Honorable Edward R. Reilly
David A. Smulski, Staff

House Health and Government Operations Committee
The Honorable Joseline A. Pena-Melnyk, Vice Chair
The Honorable Heather Bagnall
The Honorable Erek L. Barron
The Honorable Harry Bhandari
The Honorable Alfred C. Carr, Jr.
The Honorable Nick Charles
The Honorable Brian Chisholm
The Honorable Bonnie Cullison
The Honorable Terri L. Hill
The Honorable Steve Johnson
The Honorable Ariana B. Kelly
The Honorable Ken Kerr
The Honorable Nicholaus R. Kipke
The Honorable Susan W. Krebs
The Honorable Robbyn Lewis
The Honorable Ric Metzgar
The Honorable Matthew Morgan
The Honorable Samuel I. Rosenberg
The Honorable Sid Saab
The Honorable Sheree Sample-Hughes
The Honorable Kathy Szeliga

The Honorable Karen Lewis Young
Erin R. Hopwood, Staff

Somerset County Commission
The Honorable Charles Laird
The Honorable Eldon Willing
The Honorable Rex Simpkins
The Honorable Randy Laird

Theodore Delbridge, M.D., MIEMSS Executive Director
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Kevin McDonald, Chief, Certificate of Need Program
Suellen Wideman, Esq., Assistant Attorney General
Steven E. Leonard, MBA, FACHE, President and Chief Executive Officer
Peninsula Regional Medical Center, Inc.
Kathleen Harrison, FACHE, Chief Executive Officer
McCready Foundation, Inc.
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
Melvin (Chip) Hurley, Berkeley Research Group, LLC

EXHIBIT 13

The Daily Times

McCready Health Public Information Hearing

Peninsula Regional Health System (PRHS) and McCready Health will hold a public information hearing to address the conversion of McCready Hospital to a freestanding medical facility, and the affiliation of McCready Health with PRHS. At the public hearing, PRHS and McCready Health will address the reasons for the conversion and proposed timeline, plans for healthcare services currently provided by McCready Health, retraining and placement of displaced employees, and the existing hospital facility.

Location: McCready Hospital Community Room,
Alice B. Tawes Nursing and Rehabilitation Center,
201 Hall Highway, Crisfield, MD 21817

Date: Tuesday, August 20, 2019

Time: 6:00 p.m.

McCready Health Public Information Hearing

Peninsula Regional Health System (PRHS) and McCready Health will hold a public information hearing to address the conversion of McCready Hospital to a freestanding medical facility, and the affiliation of McCready Health with PRHS. At the public hearing, PRHS and McCready Health will address the reasons for the conversion and proposed timeline, plans for healthcare services currently provided by McCready Health, retraining and placement of displaced employees, and the existing hospital facility.

Location: McCready Hospital Community Room,
Alice B. Tawes Nursing and Rehabilitation Center,
201 Hall Highway, Crisfield, MD 21817

Date: Tuesday, August 20, 2019

Time: 6:00 p.m.

EXHIBIT 14

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

License No. 19-001

Issued to:

Edward McCready Memorial Hospital
201 Hall Highway
Crisfield, MD 21817

Type of Facility: Acute General Hospital

Date Issued: July 1, 2018

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

Patricia Tomasko May, MD

Director

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

McCready Health

Crisfield, MD

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

November 22, 2018

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #1865
Print/Reprint Date: 01/29/2019

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

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

Search Again

Return to Multiple Results Page

You entered Legal Business Name: McCready Foundation

DCN/CCN	632735000
NPI	
Tracking Id	
Application Type	855A
Name	FRANK COLLINS
Legal Business Name	MCCREADY FOUNDATION
Received Date	2013-09-30

The status of this application is: Approved

Novitas Solutions has processed and approved this CMS-855, CMS-20134, EFT application, or Opt Out request.

Please refer to the notification letter for complete details and additional required action.

Status History	
Date	**Status**
December 13, 2013	Approved
December 2, 2013	Development Received
December 2, 2013	Development Received
November 25, 2013	In Development
October 23, 2013	In Process

HEALTHCHOICE

MARYLAND CHILDREN'S HEALTH PROGRAM

MARYLAND PHARMACY ASSISTANCE PROGRAM

LONG TERM CARE

SPECIALTY MENTAL HEALTH SERVICES

WAIVER PROGRAMS

LISTING OF LOCAL DEPARTMENTS OF SOCIAL SERVICES

MEDICAL PROGRAMS HOME

FOR PROVIDERS: WHAT SHOULD I DO IF MY INFORMATION IS INCORRECT?

Search Criteria	
MCO: Not Specified	**Provider Type:** HOSPITAL - All
Last Name: McCready	**Provider Location:** State of **MD**
Show only PCP? No	

Time taken to search:109 ms <Previous **1** Next> **[Showing 1 - 3 of 3]**

Print this page Search

MCCREADY FOUNDATION, INC
201 HALL HWY
CRISFIELD , MD 21817
(410) 968-1801

Provider Number:**1604414 60**
NPI:**1023058062**
HOSPITAL, ACUTE

Handicap Accessible: Y TTY: Y EPSDT Certified:N

Managed Care Organization(s):

MARYLAND PHYSICIANS CARE	Primary Care Physician: N	Accepting New Patients:Y
PRIORITY PARTNERS	Primary Care Physician: N	Accepting New Patients:Y

MCCREADY HOSPITAL
201 HALL HWY
CRISFIELD , MD 21817
(410) 968-1200

Provider Number:**0109738 60**
NPI:**1881683423**
HOSPITAL, ACUTE

Handicap Accessible: Y TTY: Y EPSDT Certified:N

Managed Care Organization(s):

AETNA BETTER HEALTH	Primary Care Physician: N	Accepting New Patients:Y
PRIORITY PARTNERS	Primary Care Physician: N	Accepting New Patients:Y

MCCREADY MEMORIAL HOSPITAL
201 HALL HWY
CRISFIELD , MD 21817
(410) 968-1200

Provider Number:**0016594 61**
NPI:**1881683423**
HOSPITAL, ACUTE

EPSDT Certified:N

Managed Care Organization(s):

JAI MEDICAL SYSTEMS MCO	Primary Care Physician: N	Accepting New Patients:Y

<Previous **1** Next> **[Showing 1 - 3 of 3]**

Print this page Search

EXHIBIT 15

MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY
7120 SAMUEL MORSE DRIVE, SECOND FLOOR
COLUMBIA, MARYLAND 21046

License No. 22-003

Issued to:

Peninsula Regional Medical Center
100 East Carroll Avenue
Salisbury, MD 21801

Type of Facility: Acute General Hospital

Date Issued: July 1, 2018

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

Patricia Tomsko May MD

Director

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

Peninsula Regional Medical Center

Salisbury, MD

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

April 27, 2019

Accreditation is customarily valid for up to 36 months.

David Perron, MD, DDS, MBA, FACS
Chair, Board of Commissioners

ID #6299
Print/Reprint Date: 07/17/2019

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

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

Search Again

Return to Multiple Results Page

You entered Legal Business Name: Peninsula Regional Medical Center

DCN/CCN	383370537
NPI	1780689463
Tracking Id	T072020180001544
Application Type	855A
Name	
Legal Business Name	PENINSULA REGIONAL MEDICAL CENTER
Received Date	2018-12-03

The status of this application is: Approved

Novitas Solutions has processed and approved this CMS-855, CMS-20134, EFT application, or Opt Out request.

Please refer to the notification letter for complete details and additional required action.

Status History	
Date	**Status**
December 14, 2018	Approved
December 14, 2018	Development Received
December 5, 2018	In Development
December 5, 2018	In Process

HEALTHCHOICE

MARYLAND CHILDREN'S HEALTH PROGRAM

MARYLAND PHARMACY ASSISTANCE PROGRAM

LONG TERM CARE

SPECIALTY MENTAL HEALTH SERVICES

WAIVER PROGRAMS

LISTING OF LOCAL DEPARTMENTS OF SOCIAL SERVICES

MEDICAL PROGRAMS HOME

FOR PROVIDERS: WHAT SHOULD I DO IF MY INFORMATION IS INCORRECT?

Search Criteria	
MCO: Not Specified	**Provider Type:** HOSPITAL - All
Last Name: Peninsula	**Provider Location:** State of **MD**
Show only PCP? No	

Time taken to search:47 ms <Previous **1** Next> **[Showing 1 - 4 of 4]**

Print this page Search

PENINSULA HOME CARE SALISBURY
1001 MOUNT HERMON RD
STE 200
SALISBURY , MD 21804
(410) 543-7550

Provider Number:**0035271 61**
NPI:**1811976418**
HOSPITAL, ACUTE

Handicap Accessible: Y TTY: Y EPSDT Certified:N

Managed Care Organization(s):

MARYLAND PHYSICIANS CARE	Primary Care Physician: N	Accepting New Patients:N
PRIORITY PARTNERS	Primary Care Physician: N	Accepting New Patients:Y
U M HEALTH PARTNERS	Primary Care Physician: N	Accepting New Patients:N

PENINSULA REGIONAL MED CENTER
30434 MOUNT VERNON RD
PRINCESS ANNE , MD 21853
(410) 543-4705

Provider Number:**0011207 71**
NPI:**1780689463**
HOSPITAL, ACUTE

Handicap Accessible: Y TTY: Y EPSDT Certified:N

Managed Care Organization(s):

PRIORITY PARTNERS	Primary Care Physician: N	Accepting New Patients:Y

PENINSULA REGIONAL MED CENTER
100 E CARROLL ST
SALISBURY , MD 21801
(410) 546-6400

Provider Number:**0011207 60**
NPI:**1780689463**
HOSPITAL, ACUTE

Handicap Accessible: Y TTY: Y EPSDT Certified:N

Managed Care Organization(s):

MARYLAND PHYSICIANS CARE	Primary Care Physician: N	Accepting New Patients:N
PRIORITY PARTNERS	Primary Care Physician: N	Accepting New Patients:Y
U M HEALTH PARTNERS	Primary Care Physician: N	Accepting New Patients:N

PENINSULA REGIONAL MEDICAL CEN
100 E CARROLL ST
SALISBURY , MD 21801
(410) 546-6400

Provider Number:**0174963 60**
NPI:**1124005053**
HOSPITAL, ACUTE

EPSDT Certified:N

Managed Care Organization(s):

UNITEDHEALTHCARE	Primary Care Physician: N

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EXHIBIT 16

McCready HEALTH
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McCready Health

Peninsula Regional Health System (PRHS) and McCready Health will hold a public information hearing to address the conversion of McCready Hospital to a freestanding medical facility, and the affiliation of McCready Health with PRHS. The meeting will be held on Tuesday, August 20, 2019 at 6:00 p.m. in the McCready Hospital Community Room at Alice B. Tawes Nursing and Rehabilitation Center (201 Hall Highway.) Please click here to view more on the transition plan.

McCready Foundation and Peninsula Regional Medical Center Transition Plan for Conversion Edward W. McCready Hospital to a Freestanding Medical Facility

McCready Foundation, which owns and operates the Edward W. McCready Hospital, the Alice B. Tawes Nursing Home, and Chesapeake Cove Assisted Living in Crisfield, recently announced plans to affiliate with Peninsula Regional Health System, an integrated health delivery system serving the Delmarva Peninsula. Following the affiliation, McCready and PRHS will become participants in a regional system established by PRHS to serve Somerset County and the Eastern Shore of Maryland.

McCready and PRHS believe that the affiliation is the best interests of the communities presently served by McCready by improving access to quality and efficient healthcare services. The affiliation between McCready and PRHS will also serve to:

- enhance recruitment of personnel and development of resources for new and existing programs;
- maintain and enhance medical services for the under-insured and underserved; and
- facilitate the coordination of health care services throughout the respective service areas of both McCready and PRHS.

McCready and PRHS both value the longstanding community focus and historic mission of the McCready Foundation to provide high quality, compassionate health care through an efficient and diversified service network, maintaining and improving the health of the people and communities served by McCready over their lifetime. As part of McCready Foundation's mission, it has operated the Edward W. McCready Hospital since 1923. Changes in healthcare delivery practices and reimbursement, however, have contributed to steadily declining inpatient utilization at the hospital and steadily declining financial performance. Coupled with the hospital's aged physical plant, both McCready and PRHS recognize that continued operation of McCready hospital over the long-term not is not viable.

In furtherance of the McCready's and PRHS's goal of creating a viable and cost efficient integrated delivery system to maintain and improve access to healthcare services for residents of Somerset County and the Eastern Shore of Maryland for the future, McCready and PRHS have jointly sought regulatory approval to convert McCready Hospital into a freestanding medical facility. The freestanding medical facility will be staffed and capable of delivering emergency and observation services 24/7, at much the same levels as those services presently exist at McCready Hospital. The freestanding medical facility will also offer a clinic, outpatient behavioral health services, rehabilitation services, and diagnostic imaging. Acute inpatient and surgical services will transitioned to Peninsula Regional Medical Center or other facilities as appropriate to each patient's medical needs. The Alice B. Tawes Nursing Home and Chesapeake Cove Assisted Living will continue to operate and are not impacted by the proposed planned to convert McCready Hospital to a freestanding medical facility.

Depending on the timing of regulatory approvals, McCready and PRHS plan to convert the existing McCready hospital to a freestanding medical facility before the end of 2019. The conversion of McCready Hospital to a freestanding medical facility will take place in two phases. In Phase I, minor changes will be made to the existing hospital facility in order to operate as a freestanding medical facility. At the same time, PRHS will construct a state of the art freestanding medical facility to be located approximately 3 to 5 miles northeast of the existing hospital campus. Construction of the new facility is presently expected to be completed in mid-2021. In Phase II of the conversion, the freestanding medical facility will be relocated into the newly constructed facility.

Plan for Transitioning of Acute Care Services Previously Provided at McCready Hospital

The projected timeline for the transitioning of acute care services currently provided at McCready Hospital will depend on the timing of regulatory approvals. McCready and PRHS are engaged in ongoing planning in order to prepare for the first phase of the upcoming transition. Once opened, emergency services currently provided at McCready Hospital will continue to be provided at the freestanding medical facility. The facility's emergency treatment spaces will be staffed by board certified emergency physicians and continue to accept most EMS priority levels, except those that are critically ill or unstable. The facility will operate as an integrated department of Peninsula Regional Medical Center. The freestanding medical facility will also continue to provide diagnostic testing, ancillary services, case management, and observation care.

Patients who present at the freestanding medical facility who need inpatient medical, surgical or critical care will, subject to the patient's individual medical needs and stated preference, be transferred to Peninsula Regional Medical Center. All patients will be stabilized at the freestanding medical facility by the emergency physician and clinical staff before being transferred.

Plan for Job Retraining and Placement of McCready Hospital Employees

The freestanding medical facility will be staffed according to federal and state requirements. McCready and PRHS are continuing to develop a staffing plan for operation of the freestanding medical facility. Any current McCready employees whose positions are eliminated upon conversion of McCready hospital to a freestanding medical facility and who are otherwise qualified will be considered for open positions within PRHS, even if the available position is not identical to the position that was eliminated so long as the displaced employee could qualify for the available position with a reasonably limited amount of occupational training. PRHS has further committed to affording priority to McCready employees whose positions may be eliminated when considering placements in open positions within PRHS.

With due consideration of clinical, financial, and operational needs, PRHS hiring of displaced McCready employees will be based on time of service with McCready and each employee's performance evaluations. Any displaced employees who are rehired by PRHS will be reinstated with their original date of hire and will be immediately eligible for benefits if rehired within twelve months of the effective date of their separation. Finally, severance pay will be offered to displaced McCready employees in varying amounts based on length of service. Part-time employees will be offered severance based on length of service on a pro-rated basis.

Plan for Existing McCready Hospital's Physical Plant

Once the freestanding medical facility relocates to the newly constructed building described above for Phase II of the conversion, PRHS will examine if there is a viable need to maintain the McCready Hospital.