IN THE MARYLAND HEALTH CARE COMMISSION

APPLICATION FOR CERTIFICATE OF NEED

for the Establishment of
University of Maryland Midtown SurgiCenter, LLC

Applicant:
University of Maryland Midtown SurgiCenter, LLC

June 5, 2020

#688717

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For internal staff use

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

APPLICATION FOR AMBULATORY SURGERY FACILITY

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **University of Maryland Midtown SurgiCenter, LLC**

Address:

800 Linden Avenue	**Baltimore**	**21201**	**Baltimore City**
Street	City	Zip	County

Name of Owner (if differs from applicant):

2. OWNER

Name of owner: **University of Maryland Midtown SurgiCenter, LLC**

See **Exhibit 3** for a description of the ownership structure.

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

3. APPLICANT.. If the application has a co-applicant, provide the following information in an attachment.

Legal Name of Project Applicant (Licensee or Proposed Licensee):

University of Maryland Midtown SurgiCenter, LLC

Address:

22 South Greene Street	**Baltimore**	**21201**	**Maryland**	**Baltimore City**
Street	City	Zip	State	County

Telephone: _____

4. NAME OF LICENSEE OR PROPOSED LICENSEE (if different from applicant).

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

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

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

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

A. Lead or primary contact:

Name and Title: Scott Tinsley-Hall, Director, Strategy & System Market Intelligence

Company Name: University of Maryland Medical Center

Mailing Address:

110 S. Paca Street	Baltimore	21201	MD
Street	City	Zip	State

Telephone: 410-328-0027

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

Fax: 410-328-6815

Name and Title: Dana Farrakhan, Senior Vice President, Strategy, Community and Business Development

Company Name: University of Maryland Medical Center

Mailing Address:

22 S. Greene Street, Executive Office	Baltimore	21201	MD
Street	City	Zip	State

Telephone: 410-328-1314

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

Fax: 410-328-6815

Name and Title: William E. Tucker, MBA, CPA, Associate Dean for Practice Plan Affairs, Chief Corporate Officer. Faculty Physicians, Inc.

Company Name: University of Maryland School of Medicine

Mailing Address:

250 W. Pratt Street, Suite 901,	Baltimore	21201	MD
Street	City	Zip	State

Telephone: 410-328-7194

E-mail Address (required): wtucker@upi.umaryland.edu

Fax: 410-328-6191

B. Additional or alternate contact:

Name and Title: Thomas C. Dame

Company Name: Gallagher Evelius & Jones LLP

Mailing Address:

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

Telephone: 410-347-1331

E-mail Address (required): tdame@gejlaw.com

Fax: 410-468-2786

Name and Title: Mallory M. Regenbogen

Company Name: Gallagher Evelius & Jones LLP

Mailing Address:

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

Telephone: 410-951-1417

E-mail Address (required): mregenbogen@gejlaw.com

Fax: 410-468-2786

Name and Title: Andrew L. Solberg

Company Name: A.L.S. Healthcare Consultant Services

Mailing Address:

3601 Greenway, #710	Baltimore	21218	MD
Street	City	Zip	State

Telephone: 443-453-9553

E-mail Address (required): asolberg@earthlink.net

7. TYPE OF PROJECT

The following list includes all project categories that require a CON pursuant to COMAR 10.24.01.02(A). Please mark all that apply in the list below.

If approved, this CON would result in (check as many as apply):

(1) A new health care facility built, developed, or established ☒

(2) An existing health care facility moved to another site ☐

(3) A change in the bed capacity of a health care facility ☐

(4) A change in the type or scope of any health care service offered by a health care facility ☐

(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf ☐

8. PROJECT DESCRIPTION

A. Executive Summary of the Project

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

(1) Brief description of the project – what the applicant proposes to do
(2) Rationale for the project – the need and/or business case for the proposed project
(3) Cost – the total cost of implementing the proposed project

The proposed project involves the establishment of a new ambulatory surgical facility (the "ASF") named the "University of Maryland Midtown SurgiCenter, LLC." The ASF will have three operating rooms and two procedure rooms and will be located in the ambulatory care building that is currently under construction on the University of Maryland Medical Center Midtown Campus across Linden Avenue from the hospital.

The total project cost is estimated to be $9.3 million. As explained more fully in the Comprehensive Project Description below, the proposed project seeks to achieve several goals. The primary goal of establishing the ASF is to provide access to a lower-cost alternative for outpatient surgeries for patients and providers in a convenient location. Second, the proposed project will aid the clinical integration efforts of UMMC Downtown and Midtown Campuses by reducing overutilization of the hospital operating rooms at the UMMC Downtown Campus, providing "the right care in the right place" within the UMMC care continuum.

B. Comprehensive Project Description

The description should include details regarding:

(1) Construction, renovation, and demolition plans
(2) Changes in square footage of departments and units
(3) Physical plant or location changes
(4) Changes to affected services following completion of the project
(5) Outline the project schedule.

Applicant Response:

(i) UNIVERSITY OF MARYLAND MIDTOWN SURGICENTER, LLC

The Applicant, University of Maryland Midtown SurgiCenter, LLC ("UM Midtown SurgiCenter"), is a Maryland not-for-profit limited liability company formed on March 24, 2020. It will own and operate the proposed ASF. UM Midtown SurgiCenter has two members: (1) University of Maryland Midtown Health, Inc. ("UM Midtown Health"), a wholly-owned subsidiary

of the University of Maryland Medical System Corporation ("UMMS"), which holds a ninety-five percent ownership interest; and (2) University of Maryland Faculty Physicians, Inc. ("FPI"), which holds a five percent ownership interest. As shown in the organizational chart attached as **Exhibit 3**, UM Midtown Health is the parent corporation of Maryland General Hospital, Inc., which owns and operates University of Maryland Medical Center Midtown Campus ("UMMC Midtown").

FPI coordinates and supports the clinical activities of the University of Maryland School of Medicine ("UM SOM"). FPI employs more than 1,200 non-physician staff who support the clinical practices of the UM SOM faculty. FPI staff provides administrative support functions such as business development, finance, human resources, information technology, compliance, legal affairs, practice operations support, and reimbursement management. UM SOM has more than 900 clinically active faculty members involved in teaching, research, and clinical practice. FPI provides clinical administrative support to 17 School of Medicine departments and two clinical programs (trauma and oncology) that represent distinguished physicians in more than 40 specialties and subspecialties. UM SOM physicians have more than one million patient encounters per year.

(ii) MIDTOWN AMBULATORY CARE BUILDING

The Maryland Health Care Commission ("MHCC") issued a determination of coverage to UMMC Midtown on February 17, 2017, authorizing UMMC Midtown to undertake a capital project to construct a ten-story ambulatory care building on its campus (the "Midtown Ambulatory Care Building"). See **Exhibit 4.** This building is currently under construction and is located across Linden Avenue from UMMC Midtown hospital's main entrance. A rendering of the building is pictured on the cover page of this application. The Midtown Ambulatory Care Building will house four floors dedicated to outpatient primary and specialty care centers (floors seven through ten). Floors two through six will be a parking garage for patients and a community education and conference center will be located in the basement level. The first floor will include a main lobby and elevators to parking levels. Attached as **Exhibit 5** is a stacking diagram showing the layout of the various floors of the Midtown Ambulatory Care Building. As noted in the original determination of coverage, the first and tenth above grade floors were designed as shell space. Although the original determination of coverage included a condition preventing construction of CON projects in the shell space within the building, the MHCC Staff agreed in its letter dated January 6, 2020 to allow the filing of a CON application for establishment an ASF in first floor shell space within the Midtown Ambulatory Care Building. See **Exhibit 6**.

(iii) THE PROPOSED PROJECT

UM Midtown SurgiCenter will be located on the first floor of the Midtown Ambulatory Care Building, located at 800 Linden Avenue, Baltimore, Maryland 21201. The project consists of fitting out of approximately 13,268 SF of space originally designated as shell space.

The ASF has been designed as a state of the art facility with consideration given to patient and staff safety, comfort, and convenience. The project drawings for UM Midtown

SurgiCenter are attached as **Exhibit 2**. The main components of the facility include:

- Three dedicated outpatient general purpose operating rooms ("ORs")
- Two procedure rooms
- 13 prep/recovery bays
- Two nursing stations with direct line of sight to patients, a nourishment and medications station, and patient toilets conveniently located in the patient prep/recovery bays
- Patient consultation room
- Dedicated support services such as sterile processing, scope cleaning, clinical documentation, storage for materials and equipment, as well as clinical areas. There is appropriate limited access and circulation space for sterile areas, as well as necessary separation of soiled/contaminated and clean/sterile activities, avoiding cross contamination.
- Patient registration/check-in area/waiting room
- Staff Lounge/Lockers
- Administrative Support Offices

Procedures in the following surgical specialties will be performed at UM Midtown SurgiCenter: general surgery, otolaryngology, ophthalmology, and orthopaedics. As described more fully below in response to COMAR 10.24.11.05B(2) Need - Minimum Utilization for Establishment of a New or Replacement Facility, physicians currently performing cases at UMMC Downtown and Midtown have identified cases in these specialties that are appropriate to shift to the ASF. A map of the projected service area for UM Midtown SurgiCenter is included as **Exhibit 7**. The projected service area was determined by taking the first 85 percent of discharges from UMMC Downtown and Midtown Campuses outpatient surgical cases in FY 2019.

The ASF will serve as an important residency training site for the UMMC Downtown and Midtown Campuses. Given that an increasing number of outpatient surgical cases are transitioning to ambulatory care sites, it is a critical part of UMMC's teaching mission to ensure its surgical residents are properly trained for the ambulatory surgical environment, which tends to have a faster throughput than hospitals.

The Applicant anticipates that the ASF will open in June 2022. A detailed project schedule is provided below in Part 1, Response 12.

(iv) RATIONALE FOR THE PROJECT

A primary goal of the project is to provide UMMC Downtown and Midtown Campus patients and providers access to a lower-cost setting to perform outpatient surgeries. Insurance payers are increasingly requiring various outpatient cases to be performed outside of a hospital

setting, and the ASF will provide a convenient, more cost-effective setting for outpatient lower acuity cases. The shift of cases from an inpatient to an outpatient setting is also in line with the goals of Maryland's Total Cost of Care Model ("TCOC") with the Centers for Medicare and Medicaid Services. The MHCC's most recent publicly available survey of ambulatory surgery centers (2015 edition) shows there are few single-OR outpatient surgery centers in Baltimore City, and all but one offers only a single specialty. There are currently no multi-OR, multi-specialty centers in Baltimore City.

In addition, the ASF will serve a large number of Medicaid and indigent patients, a population in particular need of a lower-cost of care setting. According to the MHCC's most recent survey data for freestanding ambulatory surgery centers (collected in 2017), of the ASFs surveyed (facilities with three or more ORs) only 60% reported Medicaid as a revenue source and of those facilities reporting Medicaid as a revenue source, the average percentage of net revenue reported from Medicaid was 4.0%.[1] In comparison, UM Midtown SurgiCenter is projected to serve a much larger proportion of Medicaid patients, which will provide greater access to more affordable care for residents of its service area. Specifically, the Applicant estimates that approximately 19% of its net revenue will be from Medicaid, and its payer mix will be 32.1% Medicare, 24.9% Medicaid, 38.5% commercial plans, and 4.5% other payers.

A secondary goal of the ASF is to open availability of surgical capacity at the UMMC Downtown Campus. Over the past year, UMMC Downtown and Midtown Campus Perioperative Services Executive Committees discussed a need for clinical transformation of surgical services and began engaging in efforts to clinically integrate services at these facilities. The Executive Committees determined a need for additional availability of surgical capacity at the UMMC Downtown Campus for performing tertiary care cases. Currently, the ORs are overutilized and there are availability issues due in large part to the lack of available OR time for inpatient surgical cases competing with outpatient surgical cases for the same time in the same OR space. This has resulted in inpatient surgical cases being rolled over until the next day or in some cases several days later when OR time is available, which results in longer lengths of stay and is not ideal for patient care. The lack of available ORs has also resulted in referrals from other physicians or facilities being turned away. As discussed more fully in the sections addressing the Need and Impact Standards, moving appropriate outpatient cases to the ASF and to UMMC Midtown Campus will improve delivery of patient care by reducing overutilization at the Downtown campus and allowing patients to obtain necessary care in a more timely fashion.

Another objective of the ASF is to support UMMC's School of Medicine faculty physicians, who are currently engaged in the tri-part mission of patient care, education, and research. Payers are increasingly reviewing surgical procedures for appropriate site of care and requiring prior authorizations or denying coverage for those procedures performed in a hospital setting. The proposed ASF will provide an appropriate site for UMMC faculty physicians and residents to continue the mission of caring, training, and exploring new advancements in surgical cases today and in the future. The location of the ASF is ideal because of its proximity to both UMMC Midtown and Downtown Campuses, easing the scheduling challenges of the physicians and maintaining the continuity of the patient care, education, and research as a premier health care institution.

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[1] MHCC Staff provided the Applicant with payer related data from its 2017 survey of Ambulatory Surgery Facilities.

Finally, the proposed ownership model of the ASF will allow for a joint partnership opportunity between FPI and UM Midtown Health, which will help strengthen the success of the ASF and further the business initiatives of these two entities.

9. CURRENT CAPACITY AND PROPOSED CHANGES:

Unit Description	Currently Licensed/ Certified	Units to be Added or Reduced	Total Units if Project is Approved
UM Midtown SurgiCenter			
ORs	0	3	3
Procedure Rooms	0	2	2
UMMC Downtown Campus			
ORs	35* (23 mixed-use general purpose ORs, 13 mixed-use special purpose ORs)	0	35
Procedure Rooms	12	0	12
UMMC Midtown Campus			
ORs	10**	- 2	8
Procedure Rooms	8	0	8

*****Excludes three dedicated cesarean section ORs.
**See response to Impact Section (COMAR 10.24.11.05A(3)(b)(i)) for additional information regarding the current and proposed licensed OR capacity changes at UMMC Midtown Campus.

10. COMMUNITY BASED SERVICES

Identify any community based services that are or will be offered at the facility and explain how each one will be affected by the project.

Applicant Response:

This standard is inapplicable.

11. REQUIRED APPROVALS AND SITE CONTROL

Applicant Response:

A. Site size: 13,268 SF

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

> The project site is part of an already approved ambulatory services tower and is zoned accordingly. The plans for the Midtown Ambulatory Care Building were reviewed by Baltimore City and approved for the construction of the building and a permit to construct was issued. The appropriate environmental approvals were also obtained. The building will be LEED Silver designated upon completion.
>
> Once the CON is obtained for the project, the Applicant will submit drawings for the ASF to Baltimore City for review and permitting. The Applicant anticipates the permitting process will take approximately three months.

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

(1) Owned by: Maryland General Hospital, Inc.

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

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

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

(5) Other: After the Midtown Ambulatory Care Building is constructed and the proposed project is approved, the Applicant intends to enter a lease with Maryland General Hospital, Inc. covering the first floor space where the ASF will be located.
Explain and provide legal documents as an attachment.

12. PROJECT SCHEDULE

(INSTRUCTION: IN COMPLETING THE APPLICABLE OF ITEMS 10, 11 or 12, PLEASE CONSULT THE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

For new construction or renovation projects.
Project Implementation Target Dates

A. Obligation of Capital Expenditure _____5__ months from approval date.

B. Beginning Construction _____4_____ months from capital obligation.

C. Pre-Licensure/First Use _____13_____ months from capital obligation.

D. Full Utilization _____1_____ months from first use.

For projects not involving construction or renovations.
Project Implementation Target Dates

A. Obligation or expenditure of 51% of Capital Expenditure _____ months from CON approval date.

B. Pre-Licensure/First Use _____ months from capital obligation.

C. Full Utilization _____ months from first use.

For projects not involving capital expenditures.

Project Implementation Target Dates

A. Obligation or expenditure of 51% Project Budget _____ months from CON approval date.

B. Pre-Licensure/First Use _____ months from CON approval.

C. Full Utilization _____ months from first use.

13. PROJECT DRAWINGS

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

These drawings should include the following before (existing) and after (proposed), as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, number of beds, location of bath rooms, nursing stations, and any proposed

space for future expansion to be constructed, but not finished at the completion of the project, labeled as “shell space”.

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

C. Specify dimensions and square footage of patient rooms.

Applicant Response:

See **Exhibit 2** for the project drawings.

14. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete **Tables C and D of the Hospital CON Application Package**

Applicant Response:

See **Exhibit 1**.

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project and identify the provider of each utility. Specify the steps that will be necessary to obtain utilities.

Applicant Response:

1. Water. Water is available on site and provided through the Baltimore City municipal water system from a 10” water main on Linden Ave.

2. Electric. Electric is available on site and provided through the local utility, BGE. There is a hospital owned electrical substation across the street from the project site. The power is being fed from that substation. There will be a dedicated emergency electrical generator for this surgery center. There is currently one for the building and upon approval of the Certificate of Need for this project, another generator will be added to serve the ASF.

3. Natural Gas. There is no natural gas service to this building and none is planned, as it is an entirely electric building.

4. Sewage. Sewage is available on site and provided through the Baltimore City municipal system, tied to a sewer main on Linden Avenue.

5. Storm Water. Storm water is handled separately from sewer and will be routed through the current storm water line on Linden Avenue, which is tied to the main line on Madison Avenue, which is part of the Baltimore City storm water drainage system.

PART II - PROJECT BUDGET

Complete Table E of the Hospital CON Application Package

Note: Applicant should include a list of all assumptions and specify what is included in each budget line, as well as the source of cost estimates and the manner in which all cost estimates are derived. Explain how the budgeted amount for contingencies was determined and why the amount budgeted is adequate for the project given the nature of the project and the current stage of design (i.e., schematic, working drawings, etc.).

Applicant Response:

See **Exhibit 1**, Table E for the project budget.

Budget Assumptions for UM Midtown SurgiCenter

1. **Building:** The construction cost of the ASF is a Rough Order of Magnitude ("ROM") estimate provided by Clark Construction, the contractor currently managing the building of the Midtown Ambulatory Care Building. This ROM was developed from the schematic design phase that has been developed for the ASF project.

2. **Fixed Equipment**: The cost of fixed equipment was developed by Broshar Consulting, a firm specializing in the business strategy and operation of ASFs. This cost is based on its experience operating facilities of this size and projected volumes.

3. **Architect/Engineering Fees**: The cost of design and engineering was provided in a proposal from CRGA, the architectural firm designing the ASF. This firm has a great deal of experience in healthcare design and has designed other ASF projects for other clients. It is also the architect of the Midtown Ambulatory Care Building in which the ASF will be located.

4. **Permit Fees:** The cost of permits for this project was estimated based on the cost of the permits required for the building of the Midtown Ambulatory Care Building.

5. **Movable Equipment**: The cost of moveable equipment was developed by Broshar Consulting, a firm specializing in the business strategy and operation of ASFs. This cost is based on its experience operating facilities of this size and projected volumes.

6. **Contingency**: Contingency cost estimates were estimated using the Midtown Ambulatory Care Building and other projects as a guideline. Since this project is being built in a new building, where utilities will already be present, no site work is necessary and conditions are known, there should be few unexpected costs associated with it.

7. **IT**: The cost of IT, including cabling, telecom, PCs, was estimated using current budgets for the existing Midtown Ambulatory Care Building and other recent projects as a guideline.

8. **Legal Fees**: The legal fee estimate was provided by, Gallagher Evelius & Jones LLP, a firm currently advising the organization on the CON application process. The estimate is based on its experience working on other projects of this scope.

9. **Non-Legal Consultant Fees**: A portion of the estimated budget for Non-legal consultant fees was developed from an estimate provided by A.L.S. Healthcare Consultant Services, a firm currently advising the organization on the CON process, based on its experience working on other similar projects. The remaining portion of the budget for this line item is based on amounts actually paid to Broshar Consulting, the firm advising on the business strategy and operability of the ASF.

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

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

   Owners: University of Maryland Midtown Health, Inc.
   22 South Greene Street, Executive Offices, Baltimore, MD 21201

   University of Maryland Faculty Physicians, Inc.
   250 West Pratt Street, Baltimore, MD 21201

   Responsible Individual: Alison Brown, MPH, Interim President, UMMC Downtown Campus, President, UMMC Midtown Campus

2. Are the applicant, owners, or the responsible persons listed in response to Part 1, questions 2, 3, 4, 7, and 9 above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

   University of Maryland Midtown Health, Inc. holds a 95% interest in the UM Midtown SurgiCenter and is the parent corporation of Maryland General Hospital, Inc., which does business as UM Medical Center Midtown Campus and is located at 827 Linden Avenue, Baltimore, MD 21201. Alison Brown has served as President of the UMMC Midtown Campus from March 5, 2018 until present.

   Alison Brown has served as the Interim President of the UMMC Downtown Campus from December 1, 2019 until present.

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

   No.

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) received inquiries in last from 10 years from any federal or state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with any state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

The Applicant notes that this response is limited to information relevant to UMMC Midtown and Downtown Campuses for active (not historical) compliance inquiries and investigations and to actions by regulatory bodies that resulted in penalties, admission bans, probationary status, or other sanctions at these facilities.

On January 11 and 12, 2018, Centers for Medicare and Medicaid Services ("CMS") surveyed UMMC Midtown Campus in response to a patient incident that occurred on January 9, 2018 that resulted in allegations the facility had violated the Emergency Medical Treatment and Labor Act ("EMTALA"). The Joint Commission also performed an unannounced for cause survey on January 19, 2018 as a result of the same incident. During their initial surveys, CMS and the Joint Commission noted certain compliance deficiencies and required resurveys. CMS resurveyed UMMC Midtown Campus on March 12, 2018 and determined it was in full compliance with EMTALA, and the Joint Commission resurveyed the facility on May 10, 2018 and determined all Medicare deficiencies had been resolved.

On February 10, 2020, UMMC Midtown entered into a $106,965 settlement agreement with the U.S. Department of Health and Human Services, Office of Inspector General to resolve the allegations that UMMC violated EMTALA when it failed to adequately provide a medical screening examination and stabilize the patient during the incident that occurred on January 9, 2018.

5. Have the applicant, owners or responsible individuals listed in response to Part 1, questions 2, 3, 4, 7, and 9, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   No.

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

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

06.02.20
Date

Signature of Owner or Board-designated Official

President, UMMC Midtown Campus
Position/Title

Alison Brown
Printed Name

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

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

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

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

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

Every applicant must address each applicable standard in the chapter of the State Health Plan for Facilities and Services. Commission staff can help guide applicants to the chapter(s) that applies to a particular proposal.

Please provide a direct, concise response explaining the project's consistency with each standard. Some standards require specific documentation (e.g., policies, certifications) which should be included within the application as an exhibit.

SURGERY STANDARDS

A. GENERAL STANDARDS

The following general standards reflect Commission expectations for the delivery of surgical services by all health care facilities in Maryland, as defined in Health-General §19-114(d). Each applicant that seeks a Certificate of Need for a project or an exemption from Certificate of Need review for a project covered by this Chapter shall address and document its compliance with each of the following general standards as part of its application.

Standard .05A(1) – Information Regarding Charges.

Information regarding charges for surgical services shall be available to the public.

(a) A physician outpatient surgery center, ambulatory surgical facility, or a general hospital shall provide to the public, upon inquiry or as required by applicable regulations or law, information concerning charges for the full range of surgical services provided.

Applicant Response:

UM Midtown SurgiCenter will provide to the public upon inquiry, or as required by applicable regulations or law, information regarding charges for the full range of surgical services provided. The ASF's administrative staff will be available to help patients determine their charges and copays and answer any questions they may have.

(b) The Commission shall consider complaints to the Consumer Protection Division in the Office of the Attorney General of Maryland or to the Maryland Insurance Administration when evaluating an applicant's compliance with this standard in addition to evaluating other sources of information.

Applicant Response:

This standard is not applicable given that the ASF will be a new facility.

(c) Making this information available shall be a condition of any CON issued by the Commission.

Applicant Response:

The Applicant acknowledges and agrees that making this information available is a condition of any CON issued by the Commission.

Standard .05(A) (2) Information Regarding Procedure Volume.

A hospital, physician outpatient surgery center, or ASF shall provide to the public upon inquiry information concerning the volume of specific surgical procedures performed at the location where an individual has inquired. A hospital, POSC, or ASF shall provide the requested information on surgical procedure volume for the most recent 12 months available, updated at least annually.

Applicant Response:

UM Midtown SurgiCenter will provide to the public upon inquiry, information regarding the volume of specific surgical procedures performed at the facility for the most recent 12 months. The surgical procedure volume for the most recent 12 months will also be made available and updated at least annually.

Standard .05(A) (3) Charity Care Policy. **(See ADDENDUM A: ADDRESSING THE CHARITY CARE STANDARD, attached.)**

(a) Each hospital and ambulatory surgical facility shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide ambulatory surgical services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall have the following provisions:

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

Applicant Response:

UM Midtown SurgiCenter intends to provide care to indigent patients and will adopt the UMMS Financial Assistance Policy attached as **Exhibit 8**. Addendum A, which addresses the Charity Care Standard, is incorporated at the end of the application.

UM Midtown SurgiCenter's process for determining presumptive financial assistance begins on page 6 of the Financial Assistance Policy, and as described in the Procedures Section 2.c of the Policy on page 8, a "Determination of Probable Eligibility will be provided within two business days following a patient's request for charity care services, application for medical assistance, or both."

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's arrival for surgery, the facility shall address any financial concerns of the patient, and individual notice regarding the facility's charity care policy shall be provided.

Applicant Response:

The ASF plans to publish notice annually regarding the Financial Assistance Policy in the *Baltimore Sun* or another local newspaper once the ASF opens. Attached as **Exhibit 9** is an example of recent charity care ads that were published on behalf of several UMMS facilities. A similar ad will be published annually for UM Midtown SurgiCenter. In addition, notice of the Policy will be published in UMMS's quarterly publication, *Maryland's Health Matters*.

The ASF also intends to post notice regarding the Financial Assistance Policy in the patient waiting room and reception area as well as the administrative office of the facility. See **Exhibit 10** for an example of signage currently posted at UMMC Midtown Campus. Similar signage will be posted at UM Midtown SurgiCenter.

Notice of availability of financial assistance will also be provided with patient bills. A patient Billing and Financial Assistance Information Sheet will be provided upon checking out from the facility, and it will be available upon request (along with the Financial Assistance Policy and Financial Assistance Application) by mail and in the reception area of the ASF. Attached as **Exhibit 11** is a copy of the Financial Assistance Information Sheet provided to patients of UMMS hospitals. A similar information sheet will be developed for the ASF. Copies of the Financial Assistance Policy and the Financial Assistance Application are posted conspicuously on the UMMS website and are available for download (https://www.umms.org/about/financial-assistance) and will also be posted on the ASF's website once it is launched.

UM Midtown SurgiCenter anticipates that individual notice of the availability of financial assistance will be sent to patients in advance of their procedures along with other necessary patient information. ASF staff will be available for consult via phone or to meet in person with any patients who have questions about or plan to apply for financial assistance.

> **(iii) Criteria for Eligibility. A hospital shall comply with applicable State statutes and Health Services Cost Review Commission ("HSCRC") regulations regarding financial assistance policies and charity care eligibility. An ASF, at a minimum, shall include the following eligibility criteria in its charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of ASFs described in these regulations.**

Applicant Response:

As set forth in the Program Eligibility Section on page 5 of the Financial Assistance Policy and Attachment A at page 15, eligible persons include: "Those with income up to 200% of Maryland State Department of Health and Mental Hygiene Medical Assistance Planning Administration Income Eligibility Limits for a Reduced Cost of Care ("MD DHMH") are eligible for

free care. Those between 200% and 300% of MD DHMH are eligible for discounts on a sliding scale[.]" The Maryland Medicaid Annual Income Eligibility Guidelines for adults have higher annual income thresholds than the Federal Poverty Guidelines. See **Exhibit 12** for copies of the Maryland Medicaid and Federal Poverty Guidelines for 2020. As demonstrated by Table 1 below, the ASF's Financial Assistance eligibility criteria of providing free care for those individuals with household income up to 200% of the Maryland Medicaid Income Eligibility Guidelines and sliding scale discounts for those individuals with household income between 200% to 300% of the Maryland Medicaid Guidelines will exceed the minimum eligibility requirements set forth in this standard.

Table 1
Comparison of Maryland Medicaid Income Eligibility Guidelines, U.S. Federal Poverty Income Guidelines, and ASF Financial Assistance Eligibility Criteria

Household size	MD Medicaid Monthly Income Eligibility for Adults (2020)	MD Medicaid Annual Income Eligibility for Adults (2020)	U.S. Federal Poverty Guidelines Household Income (2020)	200% of U.S. Federal Poverty Guidelines (2020)	ASF Policy - 200% of MD Medicaid Income Eligibility Limits (2019)
1	$1,468	$17,616	$12,760	$25,520	$34,488
2	$1,983	$23,796	$17,240	$34,480	$46,728
3	$2,498	$29,976	$21,720	$43,440	$58,896
4	$3,014	$36,168	$26,200	$52,400	$71,064
5	$3,529	$42,348	$30,680	$61,360	$83,304
6	$4,043	$48,516	$35,160	$70,320	$95,496

(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 HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

Applicant Response:

This standard is inapplicable as the Applicant is not a hospital.

(c) A proposal to establish or expand an ASF for which third party reimbursement is available, shall commit to provide charitable surgical services to indigent patients that are equivalent to at least the average amount of charity care provided by ASFs in the most recent year reported, measured as a percentage of total operating expenses. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

Applicant Response:

The Applicant is committed to providing a level of charitable surgical services that meets or exceeds the average amount of charity care provided by ASFs in Maryland, which MHCC

Staff confirmed was most recently reported in MHCC's Freestanding Ambulatory Surgical Survey (CY 2017) to be equivalent to 0.35% of total operating expenses. Table 2 below provides the Applicant's projected level of charity care and total operating expenses for its first three full years of operation, which exceeds the statewide average of 0.35%.

Table 2
UM Midtown SurgiCenter
Projected Charity Care as Percentage of Total Operating Expenses

	FY 2023	FY 2024	FY 2025
Projected Charity Care	$49,369	$50,657	$51,979
Projected Total Operating Expenses	$9,725,647	$9,979,486	$10,239,951
Charity Care Percentage	0.54%	0.55%	0.55%

Source: MHCC Table 4 – Revenue and Expenses – Proposed Project.

The Applicant's affiliated Hospitals, UMMC Downtown and Midtown Campuses, have a strong track record for provision of charity care. As shown in Table 3 below in the most recent HSCRC Community Benefit Report Charity Care Rankings for Hospital in FY 2018, UMMC Midtown Campus fell within the second quartile and UMMC Downtown Campus fell within the third quartile for provision of charity care based on percentage of total operating expenses. The Applicant similarly plans to develop a strong track record in provision of charity care services.

Table 3
HSCRC Community Benefit Report
Charity Care Rankings by Hospital FY 2018

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	Charity/TOE	Quartile
Holy Cross	$413,981,550	$31,485,836	7.61%	First Quartile
St. Agnes Hospital	$452,096,000	$23,954,876	5.30%	
Garrett County Memorial Hospital	$51,150,258	$2,550,792	4.99%	
Holy Cross German Town	$100,707,482	$4,839,365	4.81%	
Doctors Community Hospital	$195,871,667	$8,862,484	4.52%	
UM Capital Region	$285,839,000	$12,147,000	4.25%	
Calvert Memorial Hospital	$131,906,976	$5,547,029	4.21%	
Western Maryland Hospital	$323,338,357	$10,489,666	3.24%	
Mercy Medical Center, Inc.	$483,817,200	$14,621,887	3.02%	
Johns Hopkins Bayview Med. Center	$632,548,000	$18,957,000	3.00%	
Washington Adventist Hospital	$243,708,768	$6,640,537	2.72%	
MedStar St. Mary's Hospital	$162,218,677	$3,983,754	2.46%	Second Quartile
Fort Washington Medical Center	$42,237,402	$928,769	2.20%	
Univ. of Maryland Harford Memorial Hospital	$87,719,000	$1,903,000	2.17%	
MedStar Harbor Hospital Center	$183,508,480	$3,820,520	2.08%	
Atlantic General Hospital	$127,458,282	$2,567,553	2.01%	
Frederick Memorial Hospital	$340,036,000	$6,785,000	2.00%	
Univ. of Maryland Baltimore Washington Medical Center	$344,997,000	$6,845,000	1.98%	
MedStar Southern Maryland Hospital	$247,677,692	$4,843,585	1.96%	
MedStar Good Samaritan Hospital	$259,072,976	$4,954,141	1.91%	
McCready Foundation, Inc.	$18,107,925	$326,004	1.80%	
Peninsula Regional Medical Center	$427,360,744	$7,604,900	1.78%	
Univ. of Maryland Medical Center Midtown Campus	$223,093,000	$3,962,000	1.78%	
Univ. of Maryland Shore Medical Center at Dorchester	$40,094,943	$704,387	1.76%	Third Quartile
Howard County General Hospital	$265,393,000	$4,598,000	1.73%	
Univ. of Maryland Upper Chesapeake Medical Center	$262,553,000	$4,313,000	1.64%	
Univ. of Maryland St. Josephs Medical Center	$337,972,000	$5,281,000	1.56%	
Meritus Medical Center	$314,735,209	$4,718,533	1.50%	
Univ. of Maryland Shore Medical Center at Easton	$187,273,586	$2,800,988	1.50%	
Suburban Hospital Association,Inc	$295,311,000	$4,386,000	1.49%	
MedStar Union Memorial Hospital	$449,182,066	$6,610,504	1.47%	
Univ. of Maryland Medical Center	$1,522,227,000	$22,057,000	1.45%	
MedStar Franklin Square Hospital	$518,888,097	$7,344,175	1.42%	
MedStar Montgomery General Hospital	$165,450,371	$1,847,698	1.12%	
Union Hospital of Cecil County	$164,054,488	$1,822,394	1.11%	Fourth Quartile
Johns Hopkins	$2,396,322,000	$26,475,000	1.10%	
Univ. of Maryland Shore Medical Center at Chestertown	$46,259,300	$475,000	1.03%	
Shady Grove Adventist Hospital	$337,019,361	$2,979,569	0.88%	
Sinai Hospital	$752,831,000	$6,360,600	0.84%	
Northwest Hospital Center, Inc.	$244,796,678	$2,067,000	0.84%	
Univ. of Maryland Charles Regional Medical Center	$120,993,920	$971,260	0.80%	
Anne Arundel General Hospital	$558,534,000	$3,923,800	0.70%	
Bon Secours Hospital	$109,675,296	$488,596	0.45%	
Greater Baltimore Medical Center	$504,347,676	$1,710,711	0.34%	
Carroll County General Hospital	$195,292,000	$546,974	0.28%	
All Hospitals	**$15,957,155,168**	**$307,463,530**		
Average	**$325,656,228**	**$6,274,766**		

Source: HSCRC Community Benefit Report FY 2018 available at: https://hscrc.maryland.gov/Pages/init_cb.aspx.

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

Applicant Response:

The Applicant's plan for achieving the level of charity care to which it has committed includes making the public aware of the availability of financial assistance for patients of UM Midtown SurgiCenter. As described above, UM Midtown SurgiCenter intends to publicize notice in the *Baltimore Sun* or another local newspaper and intends to circulate notice in UMMS's publication, *Maryland's Health Matters*. In addition, it intends to post information regarding the availability of financial assistance on the ASF's website once launched. The ASF intends to continue serving patients who are currently served by UMMC Downtown and Midtown Campuses, which have a strong track record for provision of charity care services. The Applicant does not anticipate any issue in achieving the level of charity care to which it has committed.

UM Midtown SurgiCenter is a newly formed entity and is in the process of developing its operational structure and policies and procedures. The Applicant anticipates the ASF's administrative staff will track and report its progress on provision of charity care to its Executive Committee as one of its key financial performance measures to ensure it is meeting its commitment.

(iii) If an existing ASF has not met the expected level of charity care for the two most recent years reported to MHCC, the applicant shall demonstrate that its historic level of charity care was appropriate to the needs of the service area population.

Applicant Response:

This standard is inapplicable as the ASF will be a new facility.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a Certificate of Need for a surgical facility project, shall make a commitment to provide charitable services to indigent patients. Charitable services may be surgical or non-surgical and may include charitable programs that subsidize health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by ASFs, measured as a percentage of total ASF expenses, in the most recent year reported. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that its historic level of charity care was appropriate to the needs of the population in the proposed service area.

Applicant Response:

This standard is inapplicable as the Applicant is not a health maintenance organization.

Standard .05(A) (4) Quality of Care.

A facility providing surgical services shall provide high quality care.

(a) An existing hospital or ambulatory surgical facility shall document that it is licensed, in good standing, by the Maryland Department of Health.

Applicant Response:

This standard is inapplicable as the ASF will be a new facility.

(b) A hospital shall document that it is accredited by the Joint Commission.

Applicant Response:

This standard is inapplicable as the Applicant is not a hospital.

(c) An existing ambulatory surgical facility or POSC shall document that it is:

(i) In compliance with the conditions of participation of the Medicare and Medicaid programs;

(ii) Accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, or another accreditation agency recognized by the Centers for Medicare and Medicaid as acceptable for obtaining Medicare certification; and

(iii) A provider of quality services, as demonstrated by its performance on publicly reported performance measures, including quality measures adopted by the Centers for Medicare and Medicaid Services. The applicant shall explain how its ambulatory surgical facility or each POSC, as applicable, compares on these quality measures to other facilities that provide the same type of specialized services in Maryland.

Applicant Response:

This standard is inapplicable as the ASF will be a new facility.

(d) A person proposing the development of an ambulatory surgical facility shall demonstrate that the proposed facility will:

(i) Meet or exceed the minimum requirements for licensure in Maryland in the areas of administration, personnel, surgical services provision, anesthesia services provision, emergency services, hospitalization, pharmaceutical services, laboratory and radiologic services, medical records, and physical environment; and

(ii) Obtain accreditation by the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the American Association for Accreditation of Ambulatory Surgery Facilities within two years of initiating service at the facility or voluntarily suspend operation of the facility.

Applicant Response:

UM Midtown SurgiCenter will meet or exceed the minimum requirements for licensure in Maryland as set forth in (d)(i) above and the applicable statutes and regulations governing freestanding ambulatory surgical facilities. It will be licensed by the Maryland Office of Health Care Quality and certified by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

UM Midtown SurgiCenter will obtain accreditation from one of the Accreditation bodies set forth in (d)(ii) above within two years of initiating service at the facility. In the unlikely event the ASF does not obtain the necessary accreditation, the Applicant agrees to voluntarily suspend operation of the facility.

(e) An applicant or a related entity that currently or previously has operated or owned a POSC or ambulatory surgical facility, in Maryland or outside of Maryland, in the five years prior to the applicant's filing of a request for exemption request to establish an ASF, shall address the quality of care provided at each location through the provision of information on licensure, accreditation, performance metrics, and other relevant information.

Applicant Response:

This standard is inapplicable as the Applicant is not filing a request for exemption.

Standard .05(A) (5) Transfer Agreements.

(a) Each ASF shall have written transfer and referral agreements with hospitals capable of managing cases that exceed the capabilities of the ASF.

Applicant Response:

UM Midtown SurgiCenter will establish written transfer and referral agreements with the UMMC Midtown and Downtown Campuses. The transfer agreements will comply with the applicable Maryland regulations.

(b) Written transfer agreements between hospitals shall comply with Department of Health regulations implementing the requirements of Health-General Article §19-308.2.

Applicant Response:

This standard is inapplicable as the Applicant is not a hospital.

(c) Each ASF shall have procedures for emergency transfer to a hospital that meet or exceed the minimum requirements in COMAR 10.05.05.09.

Applicant Response:

UM Midtown SurgiCenter will have procedures for emergency transfer of patients to a hospital that meet or exceed the minimum requirements set forth at COMAR 10.05.05.09. UM Midtown SurgiCenter will be located across the street from UMMC Midtown hospital, which will also make for quick and efficient emergency transfer to a hospital when care is required that is beyond the capabilities of the ASF. In addition, the UMMC Downtown Campus is approximately 1.4 miles away from UM Midtown SurgiCenter. The ASF will have written transfer agreements and emergency transfer protocols in place with both of these hospitals.

B. Project Review Standards.

The standards in this regulation govern reviews of Certificate of Need applications and requests for exemption from Certificate of Need review involving surgical facilities and services. An applicant for a Certificate of Need or an exemption from Certificate of Need shall demonstrate consistency with all applicable review standards, unless an applicant is eligible for an exemption covered in Regulation .06. of this chapter.

Standard .05B (1) Service Area.

An applicant proposing to establish a new hospital providing surgical services or a new ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

Applicant Response:

Given that the UM Midtown SurgiCenter will serve outpatient surgical cases shifting from the UMMC Downtown and Midtown Campus hospital ORs, UM Midtown SurgiCenter's projected service area was determined by identifying and ranking the Zip Codes of patient residence that comprise the top 85 percent of discharges from UMMC Downtown and Midtown Campuses outpatient surgical cases in FY 2019. A map of the projected service area is included as **Exhibit 7**.

Standard .05B (2) Need - Minimum Utilization for Establishment of a New or Replacement Facility.

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for the number of operating rooms proposed for the facility, consistent with the operating room capacity assumptions and other guidance included in Regulation .07 of this chapter.

Applicant Response:

Please see response to COMAR 10.23.11.05B(2)(d) below, which demonstrates the need for three ORs at UM Midtown SurgiCenter using the capacity assumptions included in COMAR 10.23.11.07.

(b) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility, consistent with Regulation .07 of this chapter.

Applicant Response:

Please see response to COMAR 10.23.11.05B(2)(d) below, which demonstrates that each of three ORs at UM Midtown SurgiCenter will be used at optimal capacity or higher levels within the first full year of initiation of services at the ASF.

(c) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospital's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and

(iii) In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital.

Applicant Response:

This standard is inapplicable as the applicant is not proposing to establish or replace a hospital.

(d) An applicant proposing the establishment of a new ambulatory surgical facility shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for outpatient surgical procedures by the proposed facility's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed facility by surgical specialty or, if approved by Commission staff, another set of categories; and

(iii) Documentation of the current surgical caseload of each physician likely to perform surgery at the proposed facility.

Applicant Response:

The UMMC Downtown and Midtown Campuses are focused on continuing their clinical integration and alignment, shifting appropriate cases from these facilities to UM Midtown SurgiCenter. The Applicant's goals for this project are to create a lower-cost setting for patients and payers and alleviate current OR overutilization at the UMMC Downtown Campus, allowing this facility to continue its focus as a quaternary teaching institution. The overall strategy is to align the "right case in the right place" within the UMMC care continuum by transitioning multi-

specialty outpatient elective cases from the UMMC Downtown Campus to the UMMC Midtown Campus. Establishing UM Midtown SurgiCenter on the UMMC Midtown Campus will allow the shifting of lower acuity outpatient cases out of the hospital environment to an appropriate care setting for the patient to receive care and for physicians to practice.

The Applicant reviewed historical outpatient surgical cases at UMMC Downtown and Midtown Campuses by surgeon and specialty for FY 2017 through FY 2019 and determined the types of cases that could have been appropriately performed in an ASF and that, in the future, will shift to the proposed ASF (the "ASF Cases") based on information and projections provided by the Surgical Specialty Chiefs of Surgery. Table 4 and Table 5 below show the historical case volumes for the surgeries that were performed in the UMMC Downtown and Midtown ORs from FY 2017 through FY 2019 that could have been performed in an ASF (the "Cases Appropriate for an ASF Setting"). The total operating minutes represent the actual operating minutes as measured by UMMC Downtown and Midtown's EHR systems. The tables present the total surgical minutes with the actual turnaround time per hospital and specialty and with a turnaround time of 25 minutes per case, consistent with COMAR 10.24.11.07A(2)(a).

Table 4
UMMC Downtown Historical Outpatient Surgical Cases Appropriate for an ASF Setting By Specialty and Surgeon FY 2017-FY 2019

UMMC Downtown Historical Outpatient Surgical ASF Cases by Specialty and Surgeon				
Specialty	**Surgeon**	**OR Volume Performed at UMMC Downtown**		
		FY 17	**FY 18**	**FY 19**
ENT	Eisenman, David J.	106	106	114
	Greywoode, Jewel Dunamis*	31	26	29
	Guardiani, Elizabeth Anne	84	71	83
	Gupta, Nidhi	1	2	6
	Hatten, Kyle Monroe	17	55	59
	Hebert, Andrea Michelle		7	19
	Hertzano, Ronna P.	49	48	56
	Isaiah, Amal	1	1	
	Strome, Scott E.*	19	16	2
	Taylor, Rodney J.	105	77	70
	Vakharia, Kalpesh Tarun	48	25	42
	Wolf, Jeffrey S.	77	80	78
	Total	**538**	**514**	**558**
General Surgery	Bafford, Andrea Chao	30	17	37
	Birkett, Richard Talbot*			13
	Jackson, Hope Tiffany*		15	9

	Kavic, Stephen M.	53	62	63
	Kligman, Mark D.	11	12	6
	Olson, John Ackerman	96	116	118
	Pearl, Jonathan Patrick	61	53	44
	Turner, Douglas J.	84	75	70
	Total	**335**	**350**	**360**
Ophthalmology	Alexander, Janet Leath	4	1	1
	Grumbine, Francis Lawson*	3		
	Kaleem, Mona A.*	2		
	Karim, Syed Abdul Sami*			1
	Levin, Moran	1		
	Total	**10**	**1**	**2**
Orthopaedic	Abawi, Hummira H.			1
	Adib, Farshad	1		
	Akabudike, Ngozi Mogekwu			4
	Danna, Natalie R.			1
	Eglseder, W. Andrew	2		
	Gilotra, Mohit N.	1	1	3
	Hasan, Syed A.	2	3	3
	Koh, Eugene Young	1		1
	LeBrun, Christopher T.	1		
	Lerman, Daniel M.	4		
	Ludwig, Steven C.		1	
	Manson, Theodore T.*	7	6	6
	Nascone, Jason W.	1	1	
	Ng, Vincent Y.	4	4	9
	Packer, Jonathan David			2
	Paryavi, Ebrahim		1	
	Pensy, Raymond A.	2		
	Sciadini, Marcus F.	4	3	2
	Wynes, Jacob		1	1
	Total	**30**	**21**	**33**

UMMC Downtown Total Cases	913	886	953
UMMC Downtown Total Minutes (Including Actual TAT)	160,171	158,976	173,590
UMMC Downtown Min/Case (Including Actual TAT)	175.4	179.4	182.2
UMMC Downtown Total Minutes (Including 25 minute TAT)	143,420	142,531	155,871
UMMC Downtown Min/Case (Including 25 minute TAT)	157	160.8	163.5

Source: HSCRC Abstract Data from EPIC E.H.R.

*Surgeon has recently departed UMMC, but the surgeon's case volume is anticipated to be replaced by another UMMC surgeon.

Table 5
UMMC Midtown Historical Outpatient Surgical Cases Appropriate for an ASF Setting By Specialty and Surgeon FY 2017-FY 2019

UMMC Midtown Historical Outpatient Surgical ASF Cases by Specialty and Surgeon				
Specialty	**Surgeon**	**OR Volume Performed at UMMC Midtown**		
		FY 17	**FY 18**	**FY 19**
ENT	Gray, William C.*	18	13	1
	Guardiani, Elizabeth Anne	2	9	21
	Gupta, Nidhi	22	37	66
	Hatten, Kyle Monroe	9	14	30
	Hebert, Andrea Michelle		27	29
	Taylor, Rodney J.		15	1
	Vakharia, Kalpesh Tarun	2	57	72
	Total	**53**	**172**	**220**
General Surgery	Agrawal, Ashok		1	
	Bafford, Andrea Chao	116	100	119
	Bellavance, Emily Catherine*			2
	Birkett, Richard Talbot*			93
	Guruswamy, Gopal*		1	2
	Harrison, Miles G.	21	12	
	Jackson, Hope Tiffany*		12	12
	Kavic, Stephen M.	161	114	136
	Kligman, Mark D.	84	87	77
	Mavrophilipos, Dimitrios V.	8	1	
	Mavrophilipos, Zacharias V.	24	27	30
	Moko, Zachary Lambert	4		
	Olson, John Ackerman	8	3	9
	Pearl, Jonathan Patrick	121	124	143
	Total	**547**	**482**	**623**
Ophthalmology	Alexander, Janet Leath	2	1	15
	Ali, Zulfiqar	2		
	Aouchiche, Rachid			5

	Carney, Marcia Denise	1		
	Dastgir, Ghulam	2		3
	Friedel, Samuel David	102	108	91
	Grumbine, Francis Lawson*	84	80	108
	Hemady, Ramzi K.*	108	102	26
	Idowu, Omolola Oladunni			2
	Im, Lily T.	98	73	146
	Jeng, Bennie Hau	66	34	66
	Kaleem, Mona A.*	50	54	54
	Levin, Moran	22	20	21
	Munir, Wuqaas Mirza	79	121	111
	Richa, Dona Chimene	13	7	
	Saeedi, Osamah Jawaid	35	39	45
	Schocket, Lisa S.	5	4	18
	Schocket, Stanley S.	3		
	Sheyman, Alan Tolly*	12	7	3
	Swamy, Ramya Narasimha	28	15	14
	Total	**712**	**665**	**728**
Orthopaedic	Abawi, Hummira H.	53	63	51
	Adib, Farshad	19	10	7
	Alegado, Rolando B.	15		
	Barnett, Noel W.	3		
	Beach, Denise	3		
	Belgin, Brian J.	24	35	31
	Danna, Natalie R.			39
	Durrance, Emily Jo	49	32	49
	Gilotra, Mohit N.	35	9	3
	Hasan, Syed A.			1
	Henn, Ralph Frank			2
	LeBrun, Christopher T.	26	12	17
	Lerman, Daniel M.	7		
	Nascone, Jason W.	55	75	71
	Ng, Vincent Y.	33	7	14
	O'Toole, Robert V.	67	65	76
	Packer, Jonathan David	89	87	78
	Pollak, Andrew N.	8	16	5
	Sciadini, Marcus F.	79	91	67
	Slobogean, M. Gerard-Paul	8	31	21
	Wynes, Jacob	99	87	128

	Total	**672**	**620**	**660**

UMMC Midtown Total Cases	1,984	1,939	2,231
UMMC Midtown Total Minutes (Including Actual TAT)	232,980	233,941	278,250
UMMC Midtown Min/Case (Including Actual TAT)	117.4	120.7	124.7
UMMC Midtown Total Minutes (Including 25 minute TAT)	207,147	208,471	249,444
UMMC Midtown Min/Case (Including 25 minute TAT)	104.4	107.5	111.8

Source: HSCRC Abstract Data from EPIC E.H.R.
*Surgeon has recently departed UMMC, but the surgeon's case volume is anticipated to be replaced by another UMMC surgeon.

As demonstrated below in Table 8, the Applicant projects the three ORs at UM Midtown SurgiCenter will be used at or above optimal capacity in FY 2023, the first full year of services at the ASF.[2] The Applicant's demonstrated need for three ORs is based on existing case volumes that are currently being performed in the UMMC Downtown and Midtown mixed-use general purpose hospital ORs but that could appropriately be performed within an ASF. The projected volumes for the ASF were calculated using the assumption that the case volumes shown in Table 4 and Table 5 that are currently being performing at UMMC Downtown and UMMC Midtown will transition to UM Midtown SurgiCenter upon its opening in June 2022.

Some surgeons with case volumes listed in Table 4 and Table 5 have recently departed UMMC. Some physician turnover is customary each year for UMMC Downtown and Midtown. Based on experience, the Applicant anticipates that the departed surgeons' case volumes will be replaced by existing or newly recruited surgeons, and that these case volumes will transition to the ASF. Table 6 below shows UMMC Downtown and Midtown's physician departures and new hires as well as the inpatient and outpatient total surgical volumes by surgical specialty for FY 2016 through FY 2019. As demonstrated by Table 6, even though there is some physician turnover each year at these facilities, total case volume by surgical specialty remains relatively constant or increases slightly year over year.[3]

[2] UM Midtown SurgiCenter is expected to open in June 2022, the final month of FY 2022, so FY 2023 will be the first full year of services provided at the ASF.

[3] Orthopaedic case volumes declined slightly from FY 2018-2019 at UMMC Downtown and Midtown Campuses as Orthopaedics evaluated its service distribution across UMMS and began moving lower acuity cases out of the high cost academic medical center to lower-cost community hospital settings.

Table 6
UMMC Downtown and Midtown Physician Hires, Departures, and Case Volumes by Surgical Specialty FY 2016 - FY 2019

	General Surgery				Ophthalmology			
	FY16	FY17	FY18	FY19	FY16	FY17	FY18	FY19
Physician Departures	3			1	1	1	1	3
Physician Hires			1	1	1	2	3	4
Total Surgical Volumes	1,545	1,666	1,582	1,820	802	884	913	1,017

	Orthopaedics				Otorhynolaryngology			
	FY16	FY17	FY18	FY19	FY16	FY17	FY18	FY19
Physician Departures	1	2	1	5	1		2	2
Physician Hires	2	2		5		2	1	
Total Surgical Volumes	5,428	5,507	4,933	4,755	1,678	1,868	1,961	2,074

The Applicant is projecting that the case volumes for the projection period of FY 2023 through FY 2025 will remain constant with the case volumes for FY 2019 shown in Table 4 and Table 5. The Applicant is also projecting conservative growth in the ASF Cases of 0.61% annually based on projected population growth for its service area population, which is shown in Table 7 below.

Table 7
Estimated Population Growth for
UM Midtown SurgiCenter's Projected Service Area

2020 Service Area Population Estimate	2025 Service Area Population Projection	5-year Growth	CAGR
4,628,446	4,770,333	3.07%	0.61%

Source: Claritas Pop Facts Premier; Includes ages 15 years and older

Table 8 below shows the volume and minute projections by specialty for UM Midtown SurgiCenter for the projection period of FY 2023 to FY 2025 based on the ASF Case volumes of the surgeons shown in Table 4 and Table 5. Table 8 shows the total case minutes using the turnaround time assumption of 25 minutes consistent with COMAR 10.24.11.07A(2)(a). Although the actual turnaround times for the ASF Cases performed within the hospital environment at UMMC Downtown and Midtown were longer as shown in Table 4 and Table 5 above, the Applicant projects that turnaround times will become more efficient in the ASF environment and will be approximately 25 minutes.

In addition, the shift of cases from the hospital ORs to an ASF environment will create efficiencies that will reduce the total minutes from "in room to out room" time of the OR cases, which is the time from which the patient enters the OR until the time the patient exits the OR and excludes TAT. The University of Maryland surgeons who will be performing cases at UM Midtown SurgiCenter identified specific efficiencies that will reduce the amount of time for OR cases. These efficiencies include having a stable cadre of technicians and nurses, a reduction in pre and post-surgical set up and break down once in the OR, limiting specific specialties and procedures performed within the ASF, and resulting in a quicker anesthesia induction process. Based on discussions with the surgeons, the Applicant projects a 20% reduction in "in room to out room" time for cases performed in the ASF. This results in a reduction of 65,143 minutes to 340,172 minutes based on the surgeons' FY 2019 minutes using a 25-minute turnaround time assumption.

Table 8
UM Midtown SurgiCenter – Volume and Minute Projections

Specialty	ASF Cases Proposed to Move to UM Midtown SurgiCenter	Estimated Cases (Unadjusted for COVID-19)			Projected Cases at ASF (first three full years)		
	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
ENT	778	783	788	792	797	802	807
General Surgery	983	989	995	1,001	1,007	1,013	1,020
Ophthalmology	730	734	739	743	748	753	757
Orthopaedic	693	697	701	706	710	714	719
Total Cases	3,184	3,203	3,223	3,243	3,262	3,282	3,302
Total Minutes (25 minute TAT)	340,172	342,236	344,336	346,445	348,538	350,667	352,806
Minutes/Case	106.8	106.8	106.8	106.8	106.8	106.8	106.8
Optimal Capacity Minutes/OR	97,920	97,920	97,920	97,920	97,920	97,920	97,920
Needed ORs	3.47	3.5	3.52	3.54	3.56	3.58	3.60

Source: HSCRC Abstract Data from EPIC E.H.R.; Annual Population Growth of .61% obtained from Claritas.

The State Health Plan Chapter for Surgical Services provides an optimal capacity assumption for dedicated outpatient ORs of 97,920 minutes per year. Based on the FY 2019 historical ASF Case volumes, the Applicant is projecting a total of 340,172 minutes will shift to UM Midtown SurgiCenter, which indicates a need for 3.47 ORs at optimal capacity. The projected ASF Case volumes show the three ORs will be utilized at or above optimal capacity starting in FY 2023, the first full year of operation at the proposed ASF (348,538 total minutes/97,920 = 3.56 ORs). By FY 2025, the OR need is projected to grow to 3.60 ORs

(352,806 total minutes/97,920 = 3.60 ORs). Table 9 below shows how the ASF OR need was calculated based on adjustments to the FY 2019 ASF Cases.

Table 9
Calculation of ORs Needed at UM Midtown SurgiCenter Based on FY 2019 ASF Cases

	Downtown	Midtown	Total
Cases	2,231	953	3,184
OR Minutes including 25 Minute TAT	249,444	155,871	405,315
Total TAT Minutes	55,775	23,825	79,600
OR Minutes without TAT	193,669	132,046	325,715
OR Minute Reduction (20%) for ASF Efficiencies	38,734	26,409	65,143
Adjusted OR Time	154,935	105,637	260,572
Total Adjusted OR Time with TAT Minutes	210,710	129,462	340,172
ASF ORs Needed @ 97,920 minutes/OR			3.47

Source: HSCRC Abstract Data from EPIC E.H.R.

Attached as **Exhibit 13** is a compilation of letters of support from the Chief of Surgery for each Department, including the historical cases by physician and commitments to the projected cases by specialty that will shift to UM Midtown SurgiCenter.

Due to increasing pressure from payers to perform outpatient cases in a lower-cost setting when medically appropriate, the Applicant anticipates demand for cases at the ASF will remain strong throughout the projection period as market forces encourage a shift of outpatient surgical procedures from the hospital setting to the ASF, a lower cost of care site. To illustrate this, the Applicant has provided notices from several payers stating that certain outpatient procedures must be performed at an ASF in order to be covered, unless the patient obtains prior authorization to have the surgery in a hospital based on medical necessity due to the patient's health condition. See **Exhibit 14**.

Standard .05B (3) Need - Minimum Utilization for Expansion of An Existing Facility.

An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .07 of this chapter;

Applicant Response:

This standard is inapplicable as the ASF will be a new facility.

(b) Demonstrate that its existing operating rooms were utilized at optimal capacity in the most recent 12-month period for which data has been

reported to the Health Services Cost Review Commission or to the Maryland Health Care Commission; and

Applicant Response:

This standard is inapplicable as the ASF will be a new facility.

(c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity, consistent with Regulation .07 of this chapter. The needs assessment shall include the following:

(i) Historic and projected trends in the demand for specific types of surgery among the population in the proposed service area;

(ii) Operating room time required for surgical cases historically provided at the facility by surgical specialty or operating room category; and

(iii) Projected cases to be performed in each proposed additional operating room.

Applicant Response:

This standard is inapplicable as the ASF will be a new facility.

Standard .05B (4) Design Requirements.

Floor plans submitted by an applicant must be consistent with the current Facility Guidelines Institute's Guidelines for Design and Construction of Health Care Facilities (FGI Guidelines):

(a) A hospital shall meet the requirements in current Section 2.2 of the FGI Guidelines.

Applicant Response:

This standard is inapplicable as the proposed project does not involve a hospital.

(b) An ASF shall meet the requirements in current Section 3.7 of the FGI Guidelines.

Applicant Response:

UM Midtown SurgiCenter was designed in compliance with Section 3.7 of the FGI Guidelines. Please see **Exhibit 15** for a letter from the architect, CRGA Design, confirming the proposed project's compliance with Section 3.7 of the FGI Guidelines.

(c) Design features of a hospital or ASF that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.

Applicant Response:

This standard is inapplicable; there are no design features planned for the ASF that are at variance with the FGI Guidelines.

Standard .05B (5) Support Services.

Each applicant shall agree to provide laboratory, radiology, and pathology services as needed, either directly or through contractual agreements.

Applicant Response:

UM Midtown SurgiCenter will obtain all necessary laboratory, radiology, and pathology services, including point of care testing, as needed for the ASF either directly or through contractual agreements with the UMMC Midtown Campus.

Standard .05B (6) Patient Safety.

The design of surgical facilities or changes to existing surgical facilities shall include features that enhance and improve patient safety. An applicant shall:

(a) Document the manner in which the planning of the project took patient safety into account; and

Applicant Response:

UM Midtown SurgiCenter was planned and designed with patient and staff safety in mind as reflected in the core design elements. The Applicant worked closely with CRGA Design, a licensed architect with experience designing healthcare facilities and ASFs, as well as a consultant who specializes in ASF strategy and planning. Clinical leadership and Infection Prevention personnel from UMMC Midtown and Downtown Campuses participated in the planning to identify patient needs and potential safety issues, including infection prevention.

The proposed design complies with the applicable FGI Guidelines and ANSI standards. The UM Midtown SurgiCenter project drawings have also been reviewed by the Baltimore City Building Code reviewers, including the Fire Marshall.

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities.

Applicant Response:

The UM Midtown SurgicCenter design was planned to employ the latest programming, planning and design elements to maximize adaptability, efficiency and patient safety and convenience. The ASF design includes the following key safety features:

- Appropriately sized ORs that can accommodate a wide range of surgical cases, providing necessary space for instrumentation, equipment, and maintaining the integrity of sterile fields
- Adequately sized equipment storage areas located to provide quick access to ORs, eliminate cluttering of hallways, and keep the corridors clear for emergency egress
- Adequately sized clinical staff areas to maintain easy patient visibility while ensuring privacy
- A designed aimed to optimize infection prevention based on the planned flow of clean and dirty materials and instruments, air flow, and patient flow
- Finishes selected by Infection Prevention personnel to maximize the ability to clean, disinfect and maintain the space
- Mechanical and electrical systems meeting all current guidelines and designed to maintain appropriate pressure relationships, temperature and humidity control and monitoring, appropriate lighting and a dedicated emergency power back-up
- Restricted corridors for sensitive spaces
- Properly zoned facilities to maintain the proper storage and flow of dirty to clean to sterile movement for staff, instruments, and supplies
- A nurse call system
- Direct line of sight from nursing work areas into all prep/recovery rooms
- Same-handed OR configuration instead of “mirrored” layout for uniformity of equipment placement and use
- Prep/recovery bays larger than the minimum FGI required size to better accommodate patients, staff, and family and reduce the chance of slip and falls
- Direct visual access of the waiting room and main building entrance from the reception desk, which may be helpful the event of any potential active shooter situations
- Panic buttons in several key areas to provide for immediate access to Security in the event of a disruptive incident

Standard .05B (7) Construction Costs.

The cost of constructing surgical facilities shall be reasonable and consistent with current industry cost experience.

(a) Hospital projects.

(i) The projected cost per square foot of a hospital construction or renovation project that includes surgical facilities shall be compared to

the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include:

1. The amount of the projected construction cost and associated capitalized construction cost that exceeds the Marshall Valuation Service® benchmark; and

2. Those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

Applicant Response:

This standard is inapplicable as this project does not involve a hospital.

(b) Ambulatory Surgical Facilities.

(i) The projected cost per square foot of new construction shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. This standard does not apply to the costs of renovation or the fitting out of shell space.

(ii) If the projected cost per square foot of new construction exceeds the Marshall Valuation Service® benchmark cost by 15% or more, then the applicant's project shall not be approved unless the applicant demonstrates the reasonableness of the construction costs. Additional independent construction cost estimates or information on the actual cost of recently constructed surgical facilities similar to the proposed facility may be provided to support an applicant's analysis of the reasonableness of the construction costs.

Applicant Response:

This standard is inapplicable as this project does not involve new construction, rather fitting out of shell space within the Midtown Ambulatory Care Building.

Standard .05B (8) Financial Feasibility.

A surgical facility project shall be financially feasible. Financial projections filed as part of an application that includes the establishment or expansion of surgical facilities and services shall be accompanied by a statement containing each assumption used to develop the projections.

(a) An applicant shall document that:

(i) Utilization projections are consistent with observed historic trends in use of each applicable service by the likely service area population of the facility;

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

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

(iv) The facility will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years of initiating operations.

Applicant Response:

As shown below in MHCC Table 4 – Revenue and Expenses for the Proposed Project, UM Midtown SurgiCenter will be financially feasible. The financial feasibility of the ASF is driven by the fact that the facility's projected utilization is based on existing cases currently served at the UMMC Midtown or Downtown Campuses that will shift to the ASF. In addition, the Applicant has assumed a conservative growth rate in case volumes based on population growth of 0.61% for the ASF's projected service area. UMMC is actively involved in discussions with the Health Services Cost Review Commission ("HSCRC") regarding the mix of regulated and unregulated services in the Midtown Ambulatory Care Building and is awaiting a final written determination that it will allow unregulated surgical services in the ASF.

Since the existing surgical cases are moving from rate regulated hospital space, the ASF charge estimates were determined based on the utilization projections by procedure code in combination with a fee schedule preliminarily set at 250% of Medicare's reimbursement rate. This charge structure is consistent with other ASFs in the area. As is common in the ASF industry, the charge structure is an inflated rate. Either through their third party payer's contractually adjusted rate or as a self-pay patient, patients would generally not pay the full charge, but rather would pay a reduced amount. Since Medicare is expected to be the dominant payer at UM Midtown SurgiCenter, reimbursement at the ASF is based on the same distribution of surgical cases by procedure code in combination with the Medicare fee schedule. The

Medicare fee schedule was compared to the fee schedules of the next two highest volume payers, Blue Cross Blue Shield and Medicaid. These fee schedules were proportionately higher and lower than the Medicare fee schedule, and therefore the Medicare fee schedule was determined to be a reasonable and conservative basis for calculation of ASF reimbursements. Based on this described methodology for determining reimbursement, contractual allowances and discounts make up the primary variance between gross and net revenue at the ASF.

Bad debt and charity care levels are based on current experience from the existing mix of cases at UMMC Downtown and Midtown Campuses and the dollar values have been adjusted as appropriate based upon the charge structure of the ASF.

Exhibit 1, Table L shows the ASF's staffing plan, which has been developed to accommodate the utilization levels projected upon opening and with the ability to accommodate the additional projected growth. Salaries are based on estimates for this geographic area and for each specific position. Fringe benefits are included at 25% of salary to include both standard benefits as well as payroll taxes.

The ASF will generate excess revenues over total expenses including both debt service and depreciation. Given the ASF's case volumes are expected to shift from UMMC Downtown and Midtown Campuses, UM Midtown SurgiCenter expects the ASF will achieve its projected utilization and net revenue will exceed expenses beginning in the first full year of operations.

Additional Expense Assumptions

- Project depreciation is based on a depreciable life of 20 years for renovations and 7 years for major fixed and major movable equipment.
- Minor equipment will be leased and therefore not depreciated.
- Medical supplies are based on the cost per case for each specialty taking into consideration both current cost in the regulated environment as well as cost efficiencies to be gained in the ASF through more restrictive supply formularies.
- The lease estimate is based on 12,500 square feet at $30 per square foot.
- Other expenses such as maintenance, laundry and office expenses are based on estimates provided by a third party consultant with expertise in ASF planning.

(b) A project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project may be approved upon demonstration that overall facility financial performance will be positive and that the services will benefit the facility's primary service area population.

Applicant Response:

This standard is inapplicable as the Applicant is projecting it will generate excess revenue over expenses.

Standard .05B (9) Impact. (See ADDENDUM B: PROVIDING INDIVIDUAL PHYSICIAN VOLUME DATA.)

(a) An application to establish a new ambulatory surgical facility shall present the following data as part of its impact assessment, in addition to addressing COMAR 10.24.01.08G(3)(f):

(i) The number of surgical cases projected for the facility and for each physician and practitioner;

Applicant Response:

As previously discussed with the MHCC Staff at the pre-application conference, given the number of physicians that will be performing cases at UM Midtown SurgiCenter, in lieu of providing Addendum B for each physician, the Applicant has provided letters of support from each surgical specialty's Division Chief attached as **Exhibit 13**. The letters include historical case volumes for each physician and the total projected minutes by surgical specialty expected to shift to UM Midtown SurgiCenter. **Exhibit 16** contains a summary of the top five most frequently performed surgeries by specialty for the Cases Appropriate for an ASF Setting.

As described above in response to the Need Standard at COMAR 10.24.11.05B(2), the Applicant is projecting that the physicians performing cases at UM Midtown SurgiCenter will achieve the same case volumes achieved in FY 2019 at UMMC Midtown and Downtown Campuses, which are shown in Table 4 and Table 5**.** Table 8 also provides the total number of cases and minutes by specialty projected for UM Midtown SurgiCenter.

(ii) A minimum of two years of historic surgical case volume data for each physician or practitioner, identifying each facility at which cases were performed and the average operating room time per case. Calendar year or fiscal year data may be provided as long as the time period is identified and is consistent for all physicians; and

Applicant Response:

In the response to the Need Standard at COMAR 10.24.11.05B(2), three years of historical Cases Appropriate for an ASF Setting are shown above in Table 4 and Table 5 by facility for each physician who will perform cases at UM Midtown SurgiCenter. The average operating time by specialty is included in the total case minutes provided in these tables. In addition, the historical surgical case volumes by physician and facility along with the minutes per case are provided in the letters of support from each surgical specialty Division Chief attached as **Exhibit 13**.

(iii) The proportion of case volume expected to shift from each existing facility to the proposed facility.

Applicant Response:

UMMC Downtown and Midtown Campuses are the only facilities expected to be impacted by this project, as they are the facilities expecting to shift case volumes to UM Midtown SurgiCenter when it opens. In order to evaluate the proportion of case volume

expected to shift from each facility, first it is necessary to describe the current OR inventory that will be impacted by this project.

1. UMMC Downtown OR Inventory

UMMC Downtown Campus currently has 35 total licensed ORs in its inventory, exclusive of its three dedicated cesarean section ORs. The cases that are expected to shift from UMMC Downtown Campus to UM Midtown SurgiCenter when it opens are currently performed in its 23 mixed-use general purpose ORs. The UMMC Downtown Campus also has 12 special purpose ORs in its inventory, which include the ORs located in The R. Adams Cowley Shock Trauma Center and hybrid ORs located in the main hospital. For the purposes of this impact analysis, the cases and minutes performed in the special purpose ORs have been carved out, as none of the cases slated to shift to UM Midtown SurgiCenter are performed in these ORs.[4] The cases currently performed in the special purpose ORS will continue to be performed at the UMMC Downtown Campus. Accordingly, the total case volume and minutes presented in this analysis for UMMC Downtown are only those cases and minutes performed in its 23 mixed-use general purpose ORs.

2. UMMC Midtown OR Inventory

The UMMC Midtown Campus currently has ten licensed ORs reported in its annual inventory, but is proposing to reduce its licensed OR capacity from ten to eight ORs in conjunction with this project. On July 19, 2007, this facility was granted a CON (the "2007 CON Project") to relocate and replace UMMC Midtown's (then known as Maryland General Hospital) surgical facilities, which at that time included ten ORs. As part of the 2007 CON Project, the MHCC approved construction of eight ORs with shell space to allow for the addition of two ORs in the future. The 2007 CON application demonstrated need for seven ORs, but requested an eighth OR due to the considerable variation in the daily surgical volume and OR utilization and to maintain flexibility of scheduling cases earlier in the week, so that surgeons could follow their patients during weekdays when hospital services were fully staffed. UMMC Midtown constructed eight ORs and shell space for two additional ORs after receiving approval of the 2007 CON Project, but operates seven ORs currently and uses the eighth OR for storage. As described more fully below in the Section titled UMMC Midtown Clinical Integration and Backfill Strategy, the eighth OR will be put in operation in 2020 in order to accommodate a required renovation project that will begin during the first quarter of FY 2021.

Active integration of the UMMC Midtown with the Downtown Campuses has been underway since the 2007 CON Project and has resulted in surgical cases migrating to the UMMC Midtown Campus. With the migration of cases, there has been a corresponding increase in service support for this surgical volume. The surgical community at UMMC Midtown has evolved to now include many of the UM SOM faculty further reinforcing the need for 24/7 support services.

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[4] Specifically, the Applicant has excluded the following types of cases from its impact analysis since none of these cases will be transferred to UM Midtown SurgiCenter: cases performed in the Shock Trauma ORs and hybrid ORs, pediatric cases (all patients under the age of 18), and cases involving cardiac surgery procedures.

Table 10 below provides an overview of the current licensed OR inventory at both campuses.

Table 10
UMMC Downtown and Midtown Current Licensed OR Inventory

UMMC Downtown ORs	North Hospital	Main OR	Shock Trauma	TOTAL
Mixed-use general purpose ORs	3	20	0	23
Mixed-use special purpose ORs	1	2	9	12
TOTAL*	4	22	9	35
UMMC Midtown ORs	**Main OR**			
Mixed-use general purpose ORs	10			
TOTAL	10			

*The UMMC Downtown OR inventory excludes its three dedicated cesarean section ORs.

As described above in the comprehensive project description and in response to the Need standard, the primary goals of this project are to shift outpatient surgical volume from UMMC Downtown and Midtown hospital ORs to UM Midtown SurgiCenter, a lower-cost of care setting, as well as reduce overutilization of the UMMC Downtown Campus ORs. As shown in Table 11 below, UMMC Downtown's ORs are currently operating in excess of full capacity based on the Surgical Services State Health Plan standards and greatly in excess of optimal capacity. Shifting appropriate cases to UM Midtown SurgiCenter and the UMMC Midtown hospital ORs as part of the clinical integration initiative described below in the Sections titled UMMC Downtown and Midtown Clinical Integration and Backfill Strategy will reduce the overutilization of the UMMC Downtown ORs.

As indicated in the Applicant's response to the Need standard, approximately 3,184 total cases and 451,840 total minutes of FY 2019 existing case volumes are projected to shift from UMMC Downtown and Midtown hospital ORs to UM Midtown SurgiCenter. Specifically, surgeons currently performing cases at UMMC Downtown hospital expect to shift 953 total cases and 173,590 total minutes and surgeons currently performing cases at UMMC Midtown hospital expect to shift 2,231 total cases and 278,250 total minutes to the ASF.

3. UMMC Downtown Impact

UMMC Downtown hospital ORs were operating above full capacity in FY 2017 through FY 2019. The Surgical Services State Health Plan defines full capacity as 142,500 minutes per year and optimal capacity as 114,000 minutes per year for mixed-use general purpose ORs. As shown in Table 12 below, 173,590 minutes of its existing capacity is projected to shift to UM Midtown SurgiCenter, which represents approximately 5.2% of UMMC Downtown hospital's total OR minutes in FY 2019. UMMC Downtown is projecting to shift another 465,210 OR minutes, or approximately 13.9% of its total OR minutes in FY 2019 to UMMC Midtown hospital ORs as part of the clinical integration efforts between these campuses. In total, the projected shift of 638,800 minutes to UM Midtown SurgiCenter and UMMC Midtown hospital ORs represents 19.1% of UMMC Downtown hospital's total OR minutes in FY 2019.

Table 11 through Table 13 below respectively present UMMC Downtown's current OR capacity and utilization, the minutes projected to shift to UM Midtown SurgiCenter as a result of this project and the minutes projected to shift to the UMMC Midtown hospital ORs as part of the clinical integration strategy, and the projected future OR capacity and utilization at UMMC Downtown. The total shift in cases is projected to reduce the optimal use rate by 24.4% to 102.6%. Even after the shift in cases to UM Midtown SurgiCenter and UMMC Midtown hospital ORs in FY 2023, the total minutes for UMMC Downtown hospital ORs are projected to exceed the optimal use by 135,822 minutes before backfill minutes are factored into the future total projected minutes. The cases and minutes expected to backfill the UMMC Downtown ORs are described more fully below.

Table 11
UMMC Downtown Current OR Capacity and Utilization

UMMC Downtown Current OR Capacity and Utilization	FY 2017	FY 2018	FY 2019
Total Minutes at UMMC Downtown (including actual avg TAT-52 minutes)	3,434,795	3,379,498	3,330,345
Number of Mixed-Use, General Purpose ORs	23	23	23
Full Capacity per OR (in minutes) Based On State Health Plan	142,500	142,500	142,500
Total Capacity (in minutes)	3,277,500	3,277,500	3,277,500
Minutes Above/Below Total Capacity	157,295	101,998	52,845
Current OR Utilization (percentage of total capacity)	104.80%	103.11%	101.61%

Table 12
UMMC Downtown Minutes Projected to Shift to UM Midtown SurgiCenter and UMMC Midtown

UMMC Downtown OR Minutes Projected to Shift	FY 2019
Total Minutes at UMMC Downtown (including actual avg TAT-52 minutes)	3,330,345
Minutes Shifted from UMMC Downtown to UM Midtown SurgiCenter	-173,590
Minutes Shifted from UMMC Downtown to UMMC Midtown	-465,210
New Total Minutes for UMMC Downtown ORs	2,691,545
New OR Utilization for UMMC Downtown ORs (percentage of full capacity)	82.12%

Table 13
UMMC Downtown Projected Future OR Capacity and Utilization

UMMC Downtown Projected Future Capacity and Utilization	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Total Minutes at UMMC Downtown* (including actual avg TAT- 52 minutes)	2,707,963	2,724,482	2,741,101	2,757,822	2,774,645	2,791,570
Number of Mixed-Use, General Purpose ORs	23	23	23	23	23	23
Optimal Use per OR (in minutes)	114,000	114,000	114,000	114,000	114,000	114,000
Total Optimal Use (in minutes)	2,622,000	2,622,000	2,622,000	2,622,000	2,622,000	2,622,000
Needed ORs	23.8	23.9	24	24.2	24.3	24.5
Total Minutes Above/Below Optimal OR Use	85,963	102,482	119,101	135,822	152,645	169,570

*Future projected total minutes includes a population growth rate of 0.61% based on the current FY 2019 service area.

While a more recent issue, it is important to note that the COVID-19 Pandemic will have an impact on both the UMMC Downtown and Midtown Campuses but most directly and for a longer timeframe on the UMMC Downtown Campus. These facilities will need to determine how to accommodate the large number of surgical cases that could not be performed due to a reduction in surgical volume during the Pandemic and the increasing severity of patients waiting for what were initially “elective” procedures but may result in care needs that eventually exceed what would be considered “elective.” The impact of Pandemic on the surgical demand is likely to continue for at least the next 18-24 months, but potentially longer depending on how long the Pandemic and restrictions on performance of elective cases last.

4. UMMC Midtown Impact

As shown in Table 15 below, 278,250 minutes of UMMC Midtown hospital’s existing OR capacity is projected to shift to UM Midtown SurgiCenter, which represents approximately 47.2% of UMMC Midtown hospital’s total OR minutes in FY 2019. As described in the Section below titled UMMC Midtown Clinical Integration and Backfill Strategy, there will not actually be a 47.2% reduction in UMMC Midtown’s hospital total OR minutes when the ASF opens because UMMC Downtown will be shifting additional cases to the UMMC Midtown Campus as part of the clinical integration strategy between these campuses. UMMC Midtown hospital ORs were operating below full capacity in FY 2017 to FY 2019 and the clinical integration efforts between the two campuses along with establishment of UM Midtown SurgiCenter aim to achieve more optimal utilization rates at both campuses and better align “the right case in the right place”

within the UMMC care continuum. Table 14 through Table 16 below, respectively, present UMMC Midtown's current OR capacity and utilization, the minutes projected to shift to UM Midtown SurgiCenter as a result of this project and the minutes projected to backfill the UMMC Midtown hospital ORs as part of the clinical integration strategy, and the projected future OR capacity and utilization at UMMC Midtown.

Table 14
UMMC Midtown Current OR Capacity and Utilization

UMMC Midtown Current OR Capacity and Utilization	FY 2017	FY 2018	FY 2019
Total Minutes at UMMC Midtown (including actual avg TAT-39 minutes)	678,997	593,234	589,388
Number of ORs	8	8	8
Full Capacity per OR (in minutes) Based on State Health Plan	142,500	142,500	142,500
Total Capacity (in minutes)	1,140,000	1,140,000	1,140,000
Minutes above/below Total Capacity	-461,003	-546,766	-550,612
Current OR Utilization (percentage of total capacity)	59.56%	52.04%	51.70%

Table 15
UMMC Midtown Minutes Projected to Shift to UM Midtown SurgiCenter

UMMC Midtown OR Minutes Projected to Shift	FY 2019
Total Minutes at UMMC Midtown (including actual avg TAT-39 minutes)	589,388
Minutes Shifted from UMMC Midtown to UM Midtown SurgiCenter	-278,250
Minutes Shifted from UMMC Downtown to UMMC Midtown	465,210
New Total Minutes for UMMC Midtown ORs	776,348
New OR Utilization for UMMC Midtown ORs (percentage of full capacity)	68.10%

Table 16
UMMC Midtown Projected Future OR Capacity and Utilization

UMMC Midtown Projected Future Capacity and Utilization	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Total Minutes at UMMC Downtown* (including actual avg TAT)	781,084	785,848	790,642	795,465	800,317	805,199
Number of ORs	8	8	8	8	8	8
Optimal Use per OR (in minutes)	114,000	114,000	114,000	114,000	114,000	114,000
Total Optimal Use (in minutes)	912,000	912,000	912,000	912,000	912,000	912,000
Needed ORs	6.9	6.9	6.9	7	7	7.1
Total Minutes Above/Below Optimal OR Use	-130,916	-126,152	-121,358	-116,535	-111,683	-106,801

*Future projected total minutes includes a population growth rate of 0.61% based on the current FY 2019 service area.

(b) An application shall assess the impact of the proposed project on surgical case volume at general hospitals:

(i) If the applicant's needs assessment includes surgical cases performed by one or more physicians who currently perform cases at a hospital within the defined service area of the proposed ambulatory surgical facility that, in the aggregate, account for 18 percent or more of the operating room time in use at a hospital, then the applicant shall include, as part of its impact assessment, a projection of the levels of use at the affected hospital for at least three years following the anticipated opening of the proposed ambulatory surgical facility.

Applicant Response:

1. UMMC Downtown Clinical Integration and Backfill Strategy

As described in response to COMAR 10.24.11.05B(9)(a)(iii) above, the Applicant is projecting that approximately 5.2% of UMMC Downtown's OR minutes based on FY 2019 cases will shift to UM Midtown SurgiCenter and another 13.9% of its OR minutes will shift to UMMC Midtown hospital ORs as part of the campuses' clinical integration efforts and in order to reduce overutilization of the UMMC Downtown hospital ORs. The total percentage of OR minutes projected to shift to UM Midtown SurgiCenter and UMMC Midtown hospital ORs represent 19.1% (638,800 minutes) of the total minutes of UMMC Downtown hospital's mixed-use general purpose ORs in FY 2019. As shown in Table 12 above, by shifting elective outpatient cases to UM Midtown SurgiCenter and the UMMC Midtown hospital ORs, UMMC Downtown hospital ORs are projected to be operating at 82.12% of full capacity (102.6% of optimal use) according to FY 2019 before the backfill minutes described below are factored in. The total

case minutes also account for a 0.61% population growth factor based on the service area population.

Once UMMC Downtown shifts outpatient cases to UM Midtown SurgiCenter and the UMMC Midtown hospital ORs, it will allow UMMC Downtown to accommodate additional cases that it has turned away in recent years due to capacity issues. For example, in FY 2019, UMMC Downtown was unable to accommodate 268 surgical admissions from Maryland ExpressCare due to lack of capacity in the UMMC Downtown Campus ORs. The Maryland ExpressCare service includes a Transfer and Communications Central Access Center that provides 24/7 access to physician consults and transportation coordination services. Maryland ExpressCare has access to bed utilization information on UMMS facilities along with other Maryland hospitals and coordinates patient transfers on behalf of UMMC and other UMMS and Maryland hospitals. Neither Maryland ExpressCare nor UMMC Downtown track the facilities to which the lost surgical admissions are transferred so the Applicant does not have data on where patients ultimately received surgical treatment. Table 17 below shows FY 2019 University of Maryland ExpressCare Lost Surgical Admissions at UMMC Downtown as well as the projected minutes associated with these cases.

Table 17
UMMC Downtown Lost Surgical Admissions from Maryland ExpressCare FY 2019

UMMC Lost ExpressCare Admissions Retained to Backfill UMMC Downtown ORs		
Service Line	**Lost Surgical Admissions FY 2019**	**Total Projected Minutes Retained (including actual TAT)**
Cardiac Surgery	19	6,707
Neurosurgery	126	47,880
ACES	18	4,428
Vascular	16	4,816
Transplant	14	4,746
Thoracic	9	3,546
Orthopaedics	16	4,864
Oral Maxillofacial	18	7,524
Otolaryngology	17	6,018
Plastics	9	2,106
Urology	6	1,722
Total	**268**	**94,357**

Source: University of Maryland ExpressCare – Lost Admission Summary Report FY 2019

Once the lower acuity outpatient cases have shifted to UM Midtown SurgiCenter and the UMMC Midtown hospital ORs as part of the clinical integration efforts, UMMC Downtown expects that it will retain the surgical admissions from Maryland ExpressCare that it is currently unable to accommodate. The total projected minutes associated with these lost admissions (94,357 minutes) were calculated using the historical average inpatient case lengths by specialty from FY 2017 to FY 2019. The turnaround times were calculated based on average inpatient TAT per specialty in FY 2019. By retaining the lost surgical admissions from Maryland

ExpressCare beginning in FY 2023, the UMMC Downtown mixed-use general purpose ORs are projected to be operating at 87% of full capacity (108.8% of optimal capacity) in FY 2023.

Moving a portion of elective outpatient cases from UMMC Downtown hospital's ORs to UM Midtown SurgiCenter and the UMMC Midtown ORs will allow UMMC Downtown to focus on accommodating cases transferring from other facilities through Maryland ExpressCare, opening block time for scheduling higher complexity cases, and reducing case rollover and wait times for elective cases. Reducing the current overutilization of the UMMC Downtown hospital ORs will allow UMMC Downtown to better accommodate and serve the higher complexity cases. The higher complexity tertiary care cases include specialties needing extended OR times of eight or more hours per case, multi-specialty collaboration, and research trials. The project will also help UMMC Downtown and Midtown Campuses improve their clinical integration efforts by providing the "right care in the right place" by moving lower acuity cases to the UMMC Midtown hospital ORs and UM Midtown SurgiCenter. The establishment of UM Midtown SurgiCenter will also allow University of Maryland faculty physicians to continue providing and patients to continue receiving the care they need in a lower-cost setting. An added benefit of this project and its affiliation with an Academic Medical Center and UM SOM is the teaching model afforded to newly minted Maryland physicians whereby they enter practice with experiences that span the complete continuum of surgical care.

2. UMMC Midtown Clinical Integration and Backfill Strategy

As described in response to COMAR 10.24.11.05B(9)(a)(iii) above, the Applicant is projecting that approximately 47.2% of UMMC Midtown's OR minutes based on FY 2019 cases will shift to UM Midtown SurgiCenter. As part of the clinical integration efforts between the UMMC Downtown and Midtown Campuses and to help reduce overcapacity issues at the UMMC Downtown campus, UMMC Downtown intends to shift approximately 2,263 cases and 465,210 total minutes to backfill UMMC Midtown hospital ORs.

The shift of outpatient OR cases from UMMC Downtown to UMMC Midtown Campus began in FY 2019 and is expected to continue through the completion of UM Midtown SurgiCenter and beyond. Surgical cases began to shift from the UMMC Downtown to the Midtown Campus in November 2019 but have increased in early 2020 with the plan to move four primary surgical services by July 2020. The Surgical Chiefs at UMMC determined the appropriate cases to shift to UMMC Midtown hospital ORs in conjunction with a consultant. Due to the COVID-19 State of Emergency, the clinical integration initiative of shifting outpatient surgical cases to the UMMC Midtown Campus in phases has largely been put on hold due to the current hold on elective cases to reduce the spread of this disease. The Applicant will continue this initiative once it is deemed safe for patients and staff. In response to the COVID-19 Pandemic, UMMC Midtown has established 24/7 airway management and staffing capabilities which allows it to accommodate more complex surgical cases which require these services. It is expected that 24/7 airway management capabilities will be retained at UMMC Midtown even after the COVID-19 State of Emergency has been lifted which will continue to allow more complex cases to be served at this facility.

Table 18 below shows the proposed outpatient surgical case volumes that will shift from UMMC Downtown to backfill the UMMC Midtown hospital ORs. These volumes exclude the proposed case volumes moving to UM Midtown SurgiCenter from the UMMC Downtown hospital ORs.

Table 18
Surgical Case Volumes Shifting from UMMC Downtown to Backfill UMMC Midtown ORs

Surgical Case Volumes Shifting from UMMC Downtown to Backfill UMMC Midtown ORs		
FY 2019 Elective Outpatient Cases by Specialty	**Total OR Cases**	**Total OR Minutes (including TAT)**
Urology	709	119,939
Orthopaedics	359	90,832
General Surgery	245	57,508
Neurosurgery	233	53,343
Plastic Surgery	125	28,810
Oral Maxillofacial	162	29,273
Organ Transplant	108	25,537
Gynecology/Obstetrics	172	27,216
Vascular	65	17,188
Otolaryngology	55	10,686
Pulmonary	13	2,269
Trauma Plastic Surgery	15	2,422
Gastroenterology	2	187
Grand Total	**2,263**	**465,210**

As shown in Table 16 above, the additional backfill of cases from the UMMC Downtown Campus ORs will bring the total projected OR minutes in FY 2023 to 795,465 and in FY 2025 to 805,199. This represents 69.8% of full capacity (87.2% of the optimal use rate) for 8 ORs in FY 2023 and 70.6% (88.3% of optimal use) rate in FY 2025. The total case minutes also account for a 0.61% population growth factor based on the service area population.

UMMC Midtown intends to relinquish the two additional shelled ORs and reduce its total licensed capacity to eight ORs as a result of this project. It is projecting that it will approach optimal utilization of all eight ORs by FY 2025, the third full year following the opening of UM Midtown SurgiCenter. In addition, it fully expects to use all eight ORs over the course of the next several years.

In the next year, UMMC Midtown needs to replace the surgical booms in each of its existing ORs. Surgical booms provide support for other essential equipment throughout the OR. UMMC Midtown intends to start by outfitting the eighth OR with surgical booms and then will sequentially replace the surgical booms in each of its other ORs one at a time. This will require taking one OR offline at a time to complete the renovations. UMMC Midtown also anticipates that once the surgical volumes shift from the UMMC Downtown Campus it will need to maintain all eight ORs to ensure adequate capacity and the flexibility it has today to schedule cases to suit physician and patient needs.

As discussed above, although it is difficult at this time to quantify the full effect of the COVID-19 Pandemic on UMMC Downtown and Midtown Campuses' delivery of surgical

services, there is growing pent up demand for many elective surgeries as a result of the current hold on these cases. Given this pent up demand, all eight of UMMC Midtown Campus's ORs will be needed to help accommodate the numerous cases that have been put on hold during the Pandemic.

(ii) The operating room capacity assumptions in Regulation .07A of this chapter and the operating room inventory rules in Regulation .07C of this chapter shall be used in the impact assessment.

Applicant Response:

The Applicant's response to COMAR 10.24.11.05B(9)(b)(i) incorporates the capacity assumptions in COMAR 10.24.11.07A and .07C.

Standard .05B (10) Preference in Comparative Reviews.

In a comparative review of CON applications to establish an ambulatory surgical facility or provide surgical services, preference will be given to a project that commits to serve a larger proportion of charity care and Medicaid patients. An applicant's commitment to provide charity care will be evaluated based on its past record of providing such care and its proposed outreach strategies for meeting its projected level of charity care.

Applicant Response:

This standard is inapplicable as this application is not part of a comparative review.

10.24.01.08G(3)(b). NEED.

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

INSTRUCTIONS: Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. If the relevant chapter of the State Health Plan includes a need standard or need projection methodology, please reference/address it in your response. For applications proposing to address the need of special population groups, please specifically identify those populations that are underserved and describe how this Project will address their needs.

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

Please assure that all sources of information used in the need analysis are identified. List all assumptions made in the need analysis regarding demand for services, utilization rate(s), and the relevant population, and provide information supporting the validity of the assumptions.

Complete Tables 1 and/or 2 below, as applies.

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

Please see response to COMAR 10.23.11.05B(2) – Need – Minimum Utilization for Establishment of a New or Replacement Facility.

MHCC Table 1 is not applicable as UM Midtown SurgiCenter is a new facility.

MHCC Table 2 is provided below.

MHCC TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY

MHCC Table 1 is not applicable as UM Midtown SurgiCenter is a new facility.

	Two Most Actual Ended Recent Years		Current Year Projected		Projected Years (ending with first full year at full utilization)		
CY or FY (Circle)	20__	20__	20__	20__	20__	20__	20__
a. Number of operating rooms (ORs)							
● Total Procedures in ORs							
● Total Cases in ORs							
● Total Surgical Minutes in ORs**							
b. Number of Procedure Rooms (PRs)							
● Total Procedures in PRs							
● Total Cases in PRs							
● Total Minutes in PRs**							

*Number of beds and occupancy percentage should be reported on the basis of licensed beds.
**Do not include turnover time.

MHCC TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT

(INSTRUCTION: All applicants should complete this table.)

	Projected Years		
	(Ending with first full year at full utilization)		
Fiscal Year	2023	2024	2025
Number of operating rooms (ORs)	3	3	3
● Total Procedures in ORs*	5,170	5,202	5,234
● Total Cases in ORs	3,262	3,282	3,302
● Total Surgical Minutes in ORs**	266,988	268,617	270,256
b. Number of Procedure Rooms (PRs)	2	2	2
● Total Procedures in PRs*	6,579	6,619	6,660
● Total Cases in PRs	4,818	4,847	4,877
● Total Minutes in PRs**	210,114	211,395	212,685

**Does not include turnover time.

10.24.01.08G(3)(c). AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES.

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

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

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

Applicant Response:

The proposed project is the most cost-effective alternative that meets the Applicant's objectives. As described in the comprehensive project description above, the primary objective for the project is to develop a cost-effective ambulatory surgical facility for patients and providers of the UMMC Downtown and Midtown Campuses. Insurance payers are increasingly refusing to cover outpatient surgical cases performed in a hospital setting and encouraging movement of these procedures to more cost-effective settings. Through their planning efforts, UMMC Midtown and Downtown Campuses identified a need to develop ambulatory surgery capacity in a convenient location that will allow its providers to continue serving patients but in a more cost-effective manner.

A secondary objective of the project is to alleviate the current overutilization of the ORs at the UMMC Downtown Campus. The UMMC Downtown Campus's ORs are currently operating above full capacity. Inpatient surgical cases are competing with outpatient surgical cases for the same time in the same OR space. This requires some outpatient surgical cases to be cancelled and rescheduled in order to accommodate emergent and higher acuity cases. UMMC Downtown Campus is also regularly turning away or delaying patient transfers from other physicians or facilities through the University of Maryland ExpressCare Service due to lack of OR availability. By moving appropriate outpatient surgical cases to the new ASF and the UMMC Midtown Campus, it will improve the current capacity issues at the UMMC Downtown Campus allowing it to better accommodate its inpatient and tertiary care cases. This will also reduce some of the current OR capacity issues and it will allow UMMC Downtown to retain the patient transfer referrals that are often delayed or turned away.

UMMC began exploring potential ambulatory surgery settings several years ago with these goals in mind. Identifying a convenient location with adequate parking was a key consideration in the planning process. The surgical cases slated to move to the proposed ASF will be those currently being performed at UMMC Downtown and Midtown Campuses by UM SOM faculty physicians. The UM SOM faculty physicians who will be shifting some of their cases to the ASF are fully engaged in the tri-part mission of clinical care, education, and research at the UMMC Midtown and Downtown Campuses. Due to their demanding schedules, a location close to these hospital campuses was considered ideal.

As part of the planning process for development of the proposed ASF, an extensive review was conducted of available properties and spaces within two miles of the UMMC Midtown Campus. The two-mile radius parameter was established as part of the search criteria to ensure convenience of existing patients, providers, and residents. The planning team evaluated more than two dozen locations over a five-year period. The majority of sites were eliminated due to lack of adequate parking, inadequate infrastructure that would have required exorbitant renovation costs, or lack of adequate space for the requisite support spaces.

As the first option, the Applicant considered purchasing an existing multi-OR in Baltimore City, but none existed, so it then considered renovation of other available properties. In addition to the proposed project site, two other sites were evaluated in more depth as potential alternatives: "Site 1: Outpatient Radiology Center" and "Site 2: Physician Practice." However, as described below, these sites were determined to be inferior to the proposed project site, "Site 3: Midtown Ambulatory Care Building/Proposed Project Site," due to their lack of parking and mechanical infrastructure deficiencies.

I. Purchase An Existing Multi-OR ASF

The Applicant considered purchasing an existing multi-OR ASF in Baltimore City. It consulted the most recent Public Use Database available on the MHCC website in order to identify any that would meet the criteria. According to the database, there are no multi-OR ASFs in Baltimore City, so it abandoned this option.

II. Site 1: Outpatient Radiology Center

This site is located at the corner of Charles and Chase Streets and previously was used as an outpatient radiology center. At the time it was evaluated, it had off-street parking available on a surface parking lot, but the number of parking spaces were limited and inadequate for the needs of patients and providers of the ASF. This site is easily accessible from Charles Street, but Charles Street is a one-way street northbound, so this site is not easily accessible directly from I-83. The space could have been modified to house the ORs, procedure rooms, and required support spaces for the ASF, but it would need to be gutted and rebuilt to provide the correct room sizes and required adjacent spaces. The building's mechanical infrastructure was also inadequate to service an ASF and would have required complete replacement with a centralized system capable of providing the right number of air exchanges, volumes, and appropriate humidity levels for an ASF. The cost to gut and rebuild the space as well as replace the mechanical systems would have been approximately $4 million as estimated in 2015 (approximately $4.3M in current dollars). This site was considered inferior to the proposed project site due to the capital costs required to modify the space and infrastructure coupled with the less convenient location and parking limitations.

III. Site 2: Physician Practice

This site is located at the 900 Block of St. Paul Street and previously served as a physician practice but is now vacant. At the time it was evaluated, it had off-street parking available, but it was in the rear of the property, not directly accessible from St. Paul Street and had an insufficient number of parking spaces to serve the ASF. This site was easily accessible from I-83 to the north. Its elevation would have required the installation of a handicap ramp. The space could have been modified to house ORs, procedure rooms, and required support spaces for the ASF, but it would need to be gutted and rebuilt to provide the correct room sizes and required adjacent spaces. In addition, the number of ORs and procedure rooms would have been limited because of space limitations and could not have accommodated the number of ORs and procedure rooms that are planned for the proposed project. The mechanical infrastructure of this site would have needed a complete replacement. The building was also very old and in poor condition and would have needed some structural work to accommodate the overhead lights and booms needed for the ASF. The cost to gut and rebuild the space, upgrade the structure, as well as install a completely new mechanical system would have been $4.5 million as estimated in 2015 (approximately $4.8M in current dollars). This site was considered inferior to the proposed project site due to the capital costs required to renovate and modify the infrastructure, parking space limitations, and indirect parking access. Importantly, this site also did not have enough space to accommodate three ORs and two procedure rooms, and therefore, would not help to alleviate the overcapacity issues at the UMMC Downton Campus ORs as well as the other two sites.

IV. Site 3: Midtown Ambulatory Care Building/ Proposed Project Site

After evaluating many other properties, the planning team began to consider whether it could develop an ASF in the Midtown Ambulatory Care Building that was being planned for the UMMC Midtown Campus. After working with clinical leadership and an architect, the planning team determined that the ASF could fit within the first floor of the Midtown Ambulatory Care Building without compromising any of the necessary features and components for the ASF. The footprint and flow of the space were evaluated by the architect and surgical clinical leadership, and a schematic design was created that is ideal for patients, staff, and visitors. The proposed ASF design incorporates industry best practices in patient safety and infection prevention. It will provide space for three ORs and two procedure rooms and the design supports the necessary mechanical infrastructure for the ASF. In addition, the design aligns with industry best-practices for patient convenience and infection control. The UMMC Midtown Campus is easily accessible and patient parking will be expanded in the new Midtown Ambulatory Care Building. The cost to fit out the shell space within the first floor of the building will be approximately $3.6M, which will be less than the renovation costs required for Site 1 and Site 2, which are prices at $4.3 and $4.8M, respectively. Accordingly, Site 3 was selected as the most cost-effective alternative that would best meet the project objectives.

Table 19 below provides an assessment of how each alternative meets the project objectives by ranking each on a scale of zero through five with five being “best meets the objective” and zero being “does not meet the objective.” The option to purchase an existing multi-OR ASF in Baltimore City was not included in this chart since it was determined to be infeasible.

Table 19
Ranking of Project Alternatives

Project Objectives	Site 1: Outpatient Radiology Center	Site 2: Physician Practice	Site 3: Midtown Ambulatory Care Building / Proposed Project Site
1. Develop a lower-cost ambulatory surgery setting	5	5	5
2. Alleviate OR capacity issues at UMMC Downtown Campus	5	3	5
3. Identify a location that optimizes patient access based on transport needs	3	3	5
4. Identify a location that optimizes physician and resident convenience and technical capabilities	3	3	5
5. Location optimizes space, patient safety, and flow	4	4	5
Total Score	20	18	25

10.24.01.08G(3)(d). VIABILITY OF THE PROPOSAL.

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

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

- Complete Tables 3 and/or 4 below, as applicable. Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item.

- Complete Table L (Workforce) from the Hospital CON Application Table Package.

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.

- If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.

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

- Identify the performance requirements applicable to the proposed project (see question 12, “Project Schedule”) and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).

Applicant Response:

I. MHCC Tables 3 and 4: Revenue and Expenses

MHCC Table 3 below is inapplicable because the proposed ASF is a new facility. MHCC Table 4 is provided below and presents the Applicant’s revenue and expense projections. The assumptions used in preparing the revenue and expense projections are included in the response to COMAR 10.24.11.05B(8) – Financial Feasibility. As shown in MHCC Table 4 and discussed

in response to the Financial Feasibility standard, UM Midtown SurgiCenter projects excess revenue over total expenses beginning in its first full year of operation, FY 2023.

II. Table L (Work Force information)

Work force information for the UM Midtown SurgiCenter is included in **Exhibit 1**, Table L.

III. Project Funding and Financial Statements

This project will be funded through cash from operations of UMMS and FPI. Attached as **Exhibits 17** and **18** are the audited financial statements of these respective entities. Debt financing will not be used to fund this project.

IV. Community Support for the Project

There is widespread community support for this project, as demonstrated by the numerous letters of support from various community stakeholders attached as **Exhibit 19**. State and local politicians as well as faith and community leaders are fully supportive of this project, which will expand community access to high quality ambulatory surgical care and establish the first multi-specialty ASF within Baltimore City. They feel that establishment of UM Midtown SurgiCenter will benefit the community by providing patients and families a more cost-effective and convenient location to obtain necessary ambulatory surgical care. Leaders of UMMS various affiliates are fully supportive of this project for the same reasons, as well as the fact that it will provide a convenient location for UM SOM faculty physicians to continue providing high quality care to patients and training to residents.

V. Performance Requirements

The Applicant is confident that it will be able to meet the applicable performance requirements. The establishment of a new ASF is subject to the following performance requirements: up to 18 months from the date of the CON project's approval to obligate 51% of the approved capital expenditure (COMAR 10.24.01.12C(3)(c)); up to four months from the effective date of a binding construction contract to initiate construction (COMAR 10.24.01.12B(2)); and up to 18 months after the effective date of a binding construction contract to complete the project (COMAR 10.24.01.12C(3)(c)). As indicated in the Project Schedule in Part 1, Response 12, the Applicant is projecting it will obligate at least 51% of the capital expenditure within 5 months of the CON's approval, will begin construction within 4 months of capital obligation, and will complete construction, and pre-licensure/first use within 13 months from capital obligation, which is well within the performance requirement time frames. The project site is already zoned as part of the Midtown Ambulatory Care Building where it will be located and the permitting process is only expected to take about three months.

MHCC TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

(INSTRUCTION: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS)

MHCC Table 3 is inapplicable as UM Midtown SurgiCenter is a new facility.

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__	20__	20__	20__
1. Revenue							
a. Inpatient services							
b. Outpatient services							
c. Gross Patient Service Revenue							
d. Allowance for Bad Debt							
e. Contractual Allowance							
f. Charity Care							
g. Net Patient Services Revenue							
h. Other Operating Revenues (Specify)							
i. Net Operating Revenue							
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)							
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies							
j. Other Expenses (Specify)							
k. Total Operating Expenses							

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__	20__	20__	20__
3. Income							
a. Income from Operation							
b. Non-Operating Income							
c. Subtotal							
d. Income Taxes							
e. Net Income (Loss)							
4. Patient Mix: A. Percent of Total Revenue							
1. Medicare							
2. Medicaid							
3. Blue Cross							
4. Commercial Insurance							
5. Self-Pay							
6. Other (Specify)							
7. TOTAL	100%	100%	100%	100%	100%	100%	100%
B. Percent of Patient Days/Visits/Procedures (as applicable)							
1. Medicare							
2. Medicaid							
3. Blue Cross							
4. Commercial Insurance							
5. Self-Pay							
6. Other (Specify)							
7. TOTAL	100%	100%	100%	100%	100%	100%	100%

MHCC TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTION: Each applicant should complete this table for the proposed project only)

	Projected Years (Ending with first full year at full utilization)		
CY or FY (Circle)	2023	2024	2025
1. Revenues			
a. Inpatient Services			
b. Outpatient Services	24,684,382	25,328,645	25,989,722
c. Gross Patient Services Revenue	24,684,382	25,328,645	25,989,722
d. Allowance for Bad Debt	98,738	101,315	103,959
e. Contractual Allowance	14,810,629	15,197,187	15,593,833
f. Charity Care	49,369	50,657	51,979
g. Net Patient Care Service Revenues			
h. Total Net Operating Revenue	9,725,647	9,979,486	10,239,951
2. Expenses			
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	2,957,985	3,017,144	3,077,487
b. Contractual Services			
c. Interest on Current Debt			
d. Interest on Project Debt	202,396	147,387	90,706
e. Current Depreciation			
f. Project Depreciation	884,162	884,162	884,162
g. Current Amortization			
h. Project Amortization			
i. Supplies	3,580,036	3,709,276	3,843,181
j. Other Expenses (Specify)	1,475,992	1,508,174	1,541,322
k. Total Operating Expenses	9,100,571	9,266,144	9,436,858
3. Income			
a. Income from Operation	625,075	713,342	803,093
Table 4 Cont.	Projected Years		

	(Ending with first full year at full utilization)		
CY or FY (Circle)	2023	2024	2025
b. Non-Operating Income			
c. Subtotal			
d. Income Taxes			
e. Net Income (Loss)	625,075	713,342	803,093
4. Patient Mix: A. Percent of Total Revenue,			
1. Medicare	35%	35%	35%
2. Medicaid	19%	19%	19%
3. Blue Cross	27%	27%	27%
4. Commercial Insurance	13%	13%	13%
5. Self-Pay	1%	1%	1%
6. Other (Specify) Worker's Compensation, Military, Prison	6%	6%	6%
7. TOTAL	100%	100%	100%
B. Percent of Patient Days/Visits/Procedures (as applicable)			
1. Medicare	38%	38%	38%
2. Medicaid	17%	17%	17%
3. Blue Cross	28%	28%	28%
4. Commercial Insurance	12%	12%	12%
5. Self-Pay	0%	0%	0%
6. Other (Specify) Worker's Compensation, Military, Prison	5%	5%	5%
7. TOTAL	100%	100%	100%

10.24.01.08G(3)(e). COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED.

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

INSTRUCTIONS: List all of the Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Applicant Response:

The Applicant, UM Midtown SurgiCenter, is a newly formed entity and this is the first time it has applied for a CON. UM Midtown SurgiCenter's member organizations are UM Midtown Health and FPI. UM Midtown Health's subsidiary is Maryland General Hospital, Inc. The only CON that has been issued to these related entities in the past 15 years was to Maryland General Hospital, Inc. and was issued on July 19, 2007 (Docket No. 07-24-2190). The Final Order granting this CON and its terms and conditions are attached as **Exhibit 20**. This CON project was completed in compliance with all applicable terms and conditions.

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

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

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

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

Applicant Response:

Since all cases performed the UM Midtown SurgiCenter are expected to shift from UMMC Downtown and Midtown Campuses, the only anticipated impact on existing health care providers is to these facilities. See the response to COMAR 10.24.11.05B(9) – Impact for an assessment of the anticipated impact on these providers.

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant for a new nursing home claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.

Applicant Response:

The cases selected to shift to UM Midtown SurgiCenter from UMMC Downtown and Midtown Campuses were selected based on their appropriateness for the ASF environment, rather than based on payer basis. Accordingly, it is expected that the impact should be roughly equal across payers and should not impact overall payer mix at the UMMC Downtown and Midtown Campuses.

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

Applicant Response:

UM Midtown SurgiCenter will provide more convenient access to a lower-cost of care setting for medically necessary outpatient surgical procedures for the service area population. Increasingly payers are requiring certain outpatient procedures to be performed in an unregulated, lower-cost setting. UM Midtown SurgiCenter will provide convenient access to outpatient surgical services for the service area population. For patients who are paying their

costs out-of-pocket or with health plans requiring high patient cost-sharing responsibilities, UM Midtown SurgiCenter will provide more affordable services and therefore, more accessible care.

UM Midtown SurgiCenter expects to serve a high proportion of Medicaid patients. Specifically, 24.9% of its payer mix and 19% of its revenue is estimated to be from Medicaid patients. In comparison, the MHCC's most recent survey data of ambulatory surgery centers (collected in 2017) found that of the Ambulatory Surgery Facilities surveyed (facilities with three or more ORs) only 60% reported Medicaid as a revenue source and of those facilities reporting Medicaid as a revenue source, and of those facilities the average percentage of revenue reported from Medicaid was around 4%. UM Midtown SurgiCenter will provide much greater access to Medicaid patients than its peer facilities, which will improve access to more affordable care for residents of its service area.

d) On costs to the health care delivery system.

Applicant Response:

The transition of existing surgical cases from the rate regulated hospital environment to the ASF will result in a material cost reduction for patients and the health care system. Based on data for the historical cases that were performed at UMMC Downtown and Midtown and in the future will transition to the ASF, the charge and corresponding reimbursement (cost to the patient) in a rate regulated setting is over five times greater than the projected reimbursement in the unregulated ASF. This estimated cost reduction is consistent with what would be expected when surgical cases are performed in the most appropriate setting based on acuity.

The overall cost reduction to the health care system is more difficult to ascertain because regulated rates are inclusive of hospital overhead some of which must stay in the hospital rate structure. Discussions are underway with the HSCRC regarding the treatment of regulated revenue as cases shift from UMMC Downtown and Midtown Campuses to the ASF, and how backfill will be handled in conjunction with existing hospital capacity. Regardless of the outcome of these discussions, the disparity in charges between surgical cases currently being performed in a rate regulated hospital setting that will transition to an unregulated ASF setting will result in a substantial benefit for the nearly 8,000 patients who will be served by the ASF and for their corresponding payers.

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

Applicant Response:

This is inapplicable as the ASF is not an existing facility.

ADDENDUM A: ADDRESSING THE CHARITY CARE STANDARD

(3) Charity Care Policy. **(a) Each hospital and ambulatory surgical facility shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide ambulatory surgical services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall have the following provisions:**	**Provide a copy of the policy** See **Exhibit 8** for a copy of the Financial Assistance Policy that will be adopted by the ASF.
(i) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility shall make a determination of probable eligibility.	**Quote the specific language from the policy that describes the determination *of probable eligibility* within 2 business days (as well as a citation to the location within the policy). Provide a copy of your policy regarding a determination of probable eligibility within two business days of request for charity/reduced fee care or application for Medicaid.** See **Exhibit 8**, pages 6-8 (Presumptive Eligibility Section): "***PRESUMPTIVE FINANCIAL ASSISTANCE*** Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. There is adequate information provided by the patient or through other sources, which provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, UMMS reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include: a. Active Medical Assistance pharmacy coverage

	b. Specified Low Income Medicare (SLMB) coverage c. Primary Adult Care (PAC) coverage d. Homelessness e. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs f. Medical Assistance spend down amounts g. Eligibility for other state or local assistance programs h. Patient is deceased with no known estate i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program j. Non-US Citizens deemed non-compliant k. Non-Eligible Medical Assistance services for Medical Assistance eligible patients l. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID) m. Bankruptcy, by law, as mandated by the federal courts n. St. Clare Outreach Program eligible patients o. UMSJMC Maternity Program eligible patients p. UMSJMC Hernia Program eligible patients" **Quote the specific language from the policy that describes the determination *of probable eligibility* (and give a citation to the location within the policy).** See **Exhibit 8**, page 7-8 (Procedures Section): "***PROCEDURES*** 1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Services Representatives, etc. 2. When possible effort will be made to provide financial clearance prior to date of service. *Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.* a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.

	b. Preliminary data will be entered into a third party data exchange system to determine probably eligibility. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility. c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance. *Determination of Probable Eligibility will be provided within two business days following a patient's request for charity care services, application for medical assistance, or both.*" (emphasis added). **Provide copies of any application and/or other forms involved in the process for making a determination of probable eligibility within two business days.** Please see **Exhibit 21.** **Provide a copy of your procedures, if any, and other documents that detail your process for making a determination of probable eligibility and your procedures, if any, for making a final determination.** See **Exhibit 8**, page 8, Procedures Section 2.a through 2.c for the procedures for making a determination of probable eligibility and pages 8 to 11, Procedures Section 2.d through 9 for the procedures for making a final determination. ***Note that requiring a completed application with documentation does not comply with this standard, which is intended to ensure that a procedure is in place to inform a potential charity/reduced fee care recipient of his/her probable eligibility within two business days of initial inquiry or application for Medicaid based on a simple and expeditious process.***

	A two-step process that allows for a probable determination to be communicated within two days based on an abridged set of information, followed by a final determination based on a completed application with the required documentation is permissible. But the policy must include the more easily navigated determination of probable eligibility.
(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's arrival for surgery, the facility shall address any financial concerns of the patient, and individual notice regarding the facility's charity care policy shall be provided.	**Quote the specific language from the policy that describes the method of implementing, and provide a sample for each communications vehicle(s).** See **Exhibit 8,** page 2, paragraph 3: *"UMMS will post notices of financial assistance availability in each UMMS hospital's emergency room (if any) and admissions areas, as well as the Billing Office. Notice of availability will also be sent to the patient with patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge, and it (along with this policy and the Financial Assistance Application) will be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas. This policy, the Patient Billing and Financial Assistance Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UMMS website (www.umms.org).*" (emphasis added). **Exhibit 11** contains the Patient Billing and Financial Assistance Information Sheet and **Exhibit 10** contains the notice of the availability of financial assistance that will be posted in key patient access areas. A notice regarding the Financial Assistance Policy will also be published annually in a local newspaper once the ASF opens and on the ASF's website once it is launched.
(iii) Criteria for Eligibility. A hospital shall comply with applicable State statutes and Health Services Cost Review Commission ("HSCRC") regulations regarding financial assistance policies and charity care eligibility. **An ASF, at a minimum, shall include the following eligibility criteria in its charity care policies.** • **Persons with family income below 100 percent of the current federal poverty guideline who have no health**	**Quote the specific language from the policy that describes the provisions for the sliding fee scale and time payment plans…also provide a citation to the location within the policy where the language can be found.** See **Exhibit 8**, page 5, final paragraph: "*Those with income up to 200% of Maryland State Department of Health and Mental Hygiene Medical Assistance Planning*

insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. • **At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands.** **A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of ASFs described in these regulations.**	*Administration Income Eligibility Limits for a Reduced Cost of Care ("MD DHMH") are eligible for free care. Those between 200% and 300% of MD DHMH are eligible for discounts on a sliding scale, as set forth in Attachment A.*" (emphasis added). See **Exhibit 8**, Attachment A, at page 15 for a chart of the sliding scale discounts.
(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 HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.	**Offer a complete explanation describing why its level of charity care is appropriate to the needs of its service area population.** This standard is inapplicable as the Applicant is not a hospital.
(c) A proposal to establish or expand an ASF for which third party reimbursement is available, shall commit to provide charitable surgical services to indigent patients that are equivalent to at least the average amount of charity care provided by ASFs in the most recent year reported, measured as a percentage of total operating expenses. The applicant shall demonstrate that:	
(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and	**Provide data on history of charity care provision.** See the Applicant's response within the CON application to this Standard.
(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.	**Describe the plan to meet the charity care commitment. An "ideal" response for demonstrating a serious *"specific plan for achieving the level of charitable care provision to which it is committed"* would:** **a) name the specific social service organizations/agencies that an applicant has contacted or plans to contact to inform them of the availability of charity care, and;** **b) incorporate a real-time reporting mechanism that will alert**

	management regarding its progress toward its charity care commitment, and a statement of what actions will then be taken. See the Applicant's response within the CON application to this Standard.
(iii) If an existing ASF has not met the expected level of charity care for the two most recent years reported to MHCC, the applicant shall demonstrate that its historic level of charity care was appropriate to the needs of the service area population.	This standard is inapplicable as the Applicant is not an existing ASF.
(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a Certificate of Need for a surgical facility project, shall make a commitment to provide charitable services to indigent patients. Charitable services may be surgical or non-surgical and may include charitable programs that subsidize health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by ASFs, measured as a percentage of total ASF expenses, in the most recent year reported. The applicant shall demonstrate that: **(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and** **(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.** **(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that its historic level of charity care was appropriate to the needs of the population in the proposed service area.**	This standard is inapplicable as the Applicant is not a health maintenance organization.

ADDENDUM B: PROVIDING INDIVIDUAL PHYSICIAN VOLUME DATA

Volume projections – ambulatory surgery facility applications

This forms package has been prepared to assist CON applicants for Ambulatory Surgical Facilities in providing information required for the CON review (see below). Each potentially involved physician should be asked to complete an individual submission, and the project sponsor (applicant) should aggregate that data (final table in this package). The information requested in this form will enable the applicant to comply with the regulations (listed immediately below) that prescribe data an applicant must provide.

The State Health Plan….General Surgical Services

Excerpted from COMAR 10.24.11.06C.

An application to establish a new ambulatory surgical facility shall present the following data as part of its impact assessment, in addition to addressing COMAR 10.24.01.08G(3)(f):

(1) The number of surgical cases projected for the facility and for each physician and practitioner;

(2) A minimum of two years of historic case volume data for each physician or practitioner, identifying each facility at which cases were performed and the average operating room time per case. Calendar year or fiscal year data may be provided as long as the time period is identified and is consistent for all physicians; and

(3) The proportion of case volume expected to shift from each existing facility to the proposed facility.

(4) Impact on an affected hospital.

(a) If the needs assessment includes surgical cases performed by one or more physicians who currently perform cases at a hospital within the defined service area of the proposed ambulatory surgical facility that, in the aggregate, account for 18 percent of the operating room capacity at a hospital, then the applicant shall include, as part of the impact assessment, a projection of the levels of use at the affected hospital for at least three years following the anticipated opening of the proposed ambulatory surgical facility; and

(b) The operating room capacity assumptions in .06A of this Chapter and the operating room inventory rules in .06D of this Chapter shall be used in the impact assessment.

Note: duplicate and/or expand these forms as needed to accommodate providers.

Individual Physician's Submission (provide this form for each physician who will do procedures at the proposed facility)

MHCC Staff agreed during the pre-application conference that the Applicant could provide letters of support from the Surgical Department Chiefs (See Exhibit 13) in lieu of providing Addendum B for each physician who will perform cases at the ASF.

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will be migrating
	Year___		Year___		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	

5 most frequently performed surgeries, two most recent years		
Surgical Procedure*	Yr 1	Yr2

* List in descending order based on the cumulative 2 year volume

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

Signature_____

Print Name:_____

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7. Projected Service Area Map – UM Midtown SurgiCenter
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Table 16 UMMC Midtown Projected Future OR Capacity and Utilization
Table 17 UMMC Downtown Lost Surgical Admissions from Maryland ExpressCare FY 2019
Table 18 Surgical Case Volumes Shifting from UMMC Downtown to Backfill UMMC Midtown ORs
Table 19 Ranking of Project Alternatives

MHCC Tables and Addendums

Description
MHCC TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY
MHCC TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT
MHCC TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY
MHCC TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT
ADDENDUM A: ADDRESSING THE CHARITY CARE STANDARD
ADDENDUM B: PROVIDING INDIVIDUAL PHYSICIAN VOLUME DATA

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

5/19/20
Date

M. A. Angeles-Falconer
Maria Angeles-Falconer
Director of Business Development
University of Maryland Medical Center

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

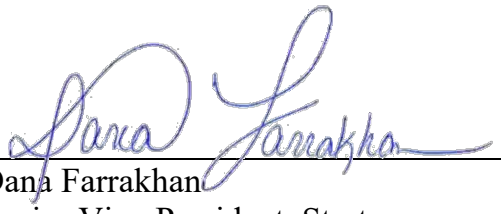
05.19.20

Date

Alison Brown, MPH
President, University of Maryland
Medical Center Midtown Campus

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

05/21/2020
Date



Dana Farrakhan
Senior Vice-President, Strategy,
Community & Business Development
University of Maryland Medical Center

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

5/19/20
Date

Craig Fleischmann
Vice President, Finance
University of Maryland Medical Center

#703339

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

5/20/2020
Date

Michael Glancey

Michael Glancey
Strategic Planning Project Manager
University of Maryland Medical Center

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

5/21/20
Date

Patrick Kenville
DS Project Coordinator
University of Maryland Medical Center

#703953

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

5/19/2020
Date

James McGowan, DHA
Vice ~~Senior~~ President of
Perioperative/Procedural Services
University of Maryland Medical Center

#703340

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

5/22/20
Date

Michael A. Plank
Michael Plank
Senior Project Manager, Construction
and Facilities Planning
University of Maryland Medical Center

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

05/20/20
Date

Scott Tinsley-Hall
Director, Strategy and System Market Intelligence
University of Maryland Medical Center

#703328

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

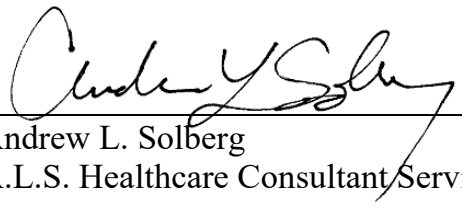
5/22/2020
Date

David Peabody, Principal
CRGA Design

#703349

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

5/19/2020
Date



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

EXHIBIT 1

Name of Applicant: UM Midtown SurgiCenter

Date of Submission: June 5, 2020

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

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

TABLE 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
Ambulatory Surgery Center build out of vacant shell space			13,268		13,268
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total			13,268		13,268

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		13,268
Second Floor		
Third Floor		
Fourth Floor		
Average Square Feet		**13,268**
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		671'-2"
Second Floor		
Third Floor		
Fourth Floor		
Total Linear Feet		**671'-2"**
Average Linear Feet		**671'-2"**
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor		22'-2"
Second Floor		
Third Floor		
Fourth Floor		
Average Wall Height		**22'-2"**
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		NA
Freight		NA
Sprinklers	**Square Feet Covered**	
Wet System		13,268
Dry System		NA
Other	**Describe Type**	
Type of HVAC System for proposed project	Outdoor air-cooled chiller water system serving a	
Type of Exterior Walls for proposed project	pre-cast concrete	

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

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.a as a use of funds and on line B.8 as a source of funds

	ASF Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. Land Purchase			**$0**
b. New Construction			
(1) Building			$0
(2) Fixed Equipment			$0
(3) Site and Infrastructure			$0
(4) Architect/Engineering Fees			$0
(5) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$0**	**$0**
c. Renovations			
(1) Building	$3,562,000		$3,562,000
(2) Fixed Equipment (not included in construction)	$3,750,000		$3,750,000
(3) Architect/Engineering Fees	$377,675		$377,675
(4) Permits (Building, Utilities, Etc.)	$25,000		$25,000
SUBTOTAL	**$7,714,675**	**$0**	**$7,714,675**
d. Other Capital Costs			
(1) Movable Equipment	$750,000		$750,000
(2) Contingency Allowance	$150,000		$150,000
(3) Gross interest during construction period			$0
(4) IT (cabling, telecom, PC's, etc.)	$250,000		$250,000
SUBTOTAL	***$1,150,000***		**$1,150,000**
TOTAL CURRENT CAPITAL COSTS	**$8,864,675**	**$0**	**$8,864,675**
e. Inflation Allowance	$358,488		$358,488
TOTAL CAPITAL COSTS	**$9,223,163**	**$0**	**$9,223,163**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c. Legal Fees	**$75,000**		$75,000
d. Non-Legal Consultant Fees	**$27,944**		$27,944
e. Liquidation of Existing Debt			$0
f. Debt Service Reserve Fund			$0
g. Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$102,944***		**$102,944**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$9,326,107***	***$0***	***$9,326,107***
B. Sources of Funds			
1. Cash	**$9,326,107**		$9,326,107
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$9,326,107***		**$9,326,107**
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building	**$375,000**		$375,000
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 L. WORK fORCE INFORMATION

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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table J)*	**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)*											
Director			$0	1.00	$149,500	$149,500			$0	1.0	$149,500
Manager			$0	1.00	$87,600	$87,600			$0	1.0	$87,600
Administrator			$0	0.81	$36,050	$29,201			$0	0.8	$29,201
Scheduler			$0	3.24	$41,200	$133,488			$0	3.2	$133,488
Billing Coder			$0	2.16	$56,700	$122,472			$0	2.2	$122,472
Total Administration			$0	8.21		$522,261			$0	8.2	$522,261
Direct Care Staff *(List general categories, add rows if needed)*											
Registered Nurse			$0	13.77	$77,250	$1,063,733			$0	13.8	$1,063,733
Patient Care Techs			$0	4.32	$36,050	$155,736			$0	4.3	$155,736
OR Techs			$0	4.59	$51,500	$236,385			$0	4.6	$236,385
Endo Techs			$0	3.24	$43,250	$140,130			$0	3.2	$140,130
Total Direct Care			$0	25.92		$1,595,984			$0	25.9	$1,595,984
Support Staff *(List general categories, add rows if needed)*											
CSR Tech			$0	3.24	$47,500	$153,900			$0	3.2	$153,900
Inventory Tech			$0	1.08	$44,300	$47,844			$0	1.1	$47,844
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support			$0	4.32		$201,744			$0	4.3	$201,744
REGULAR EMPLOYEES TOTAL			$0	***38.45***		***2,319,988.0***			$0	38.5	$2,319,988
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)* **:**											
15% Employee Benefits, 10% Payroll Taxes											
TOTAL COST	***0.0***		***$0***	***38.5***		***$2,899,985***	***0.0***		***$0***		***$2,319,988***

* The projected FTEs and cost for the entire facility should equal the current number of FTEs and cost plus changes in FTEs and cost related to the proposed project plus other expected changes in staffing.

EXHIBIT 2

CRGA DESIGN

912 Commerce Road
Annapolis, Maryland 21401
o : 410.841.2570
www.crgadesign.com

SKETCH DRAWING

MIDTOWN OUTPATIENT CENTER
AMBULATORY SURGERY CENTER
CRGA PROJECT 19.055.A

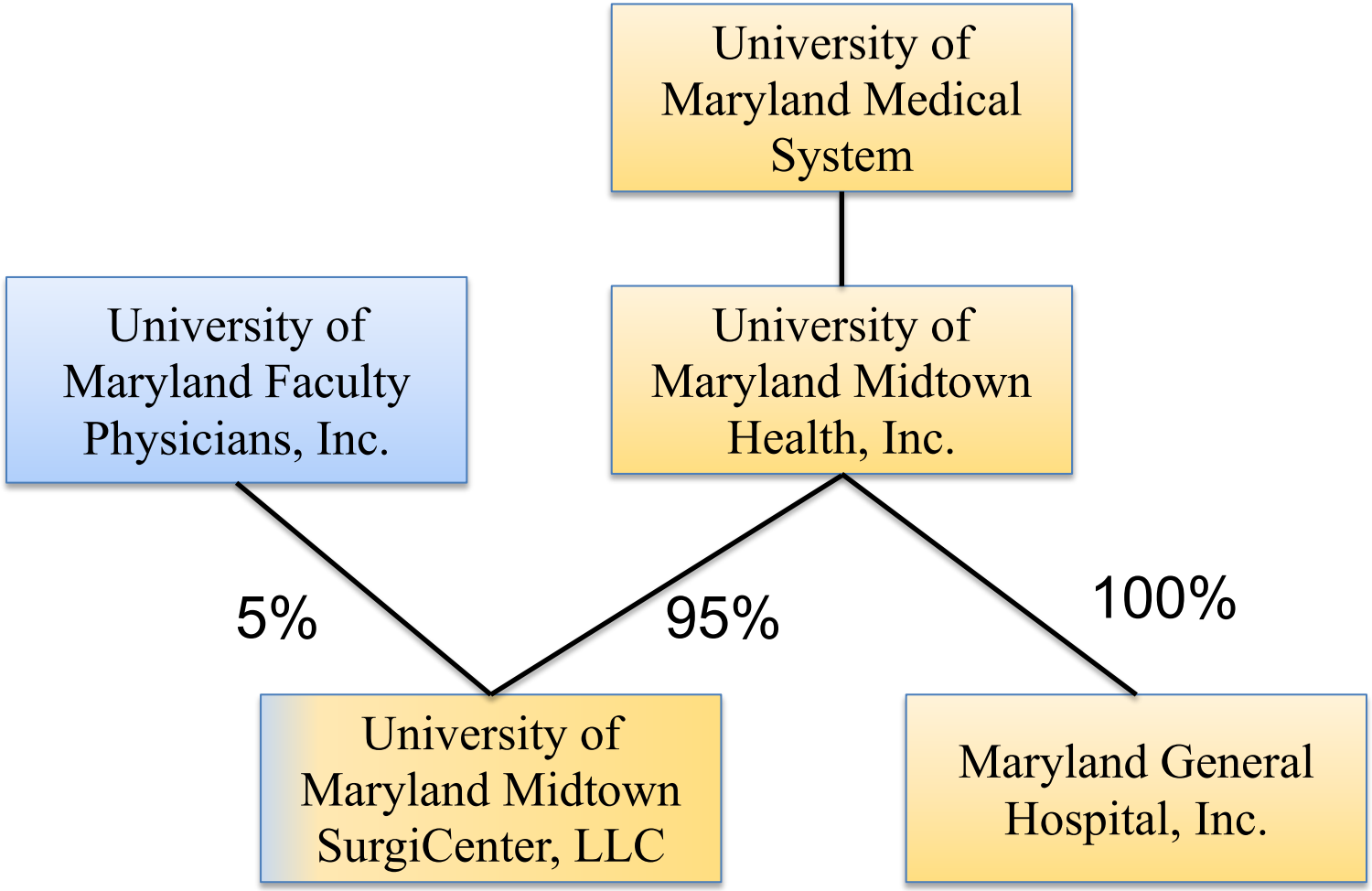
DRAWING # SK-5

ISSUED BY: DATE: 01.02.2020

DRAWING TITLE: FLOOR PLAN SCALE: 1/16" = 1'-0"

EXHIBIT 3

University of Maryland Midtown SurgiCenter, LLC
Organizational Chart



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006551-0226

EXHIBIT 4

STATE OF MARYLAND

Craig P. Tanio, M.D
CHAIR

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

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

February 15, 2017

Via E-Mail and U.S.P.S.

Dana Farrakhan, MHS, FACHE
Senior Vice President, Community and Business Development
University of Maryland Medical Center
22 S. Greene Street
Executive Office
Baltimore, MD 21201

Re: Ambulatory Care Facility
University of Maryland Medical Center-Midtown Campus

Dear Ms. Farrakhan:

The University of Maryland Medical Center – Midtown Campus ("Midtown") proposes a capital expenditure of $56,500,000 to construct a ten-story (above grade) building housing facilities for the provision of outpatient medical services, a community health education center and a conference center. The first above grade floor of the building will be shell space, labeled as "future ambulatory surgery center," with the exception of the main entrance lobby. The tenth floor will be constructed as shell space. The second through sixth floors will be parking space. Midtown anticipates obtaining $34 million in state funding that will be used for this project expenditure. The balance of project funding, $22.5 million will be a cash expenditure.

As described, the outpatient diagnostic and treatment services proposed to be housed in the finished space of this building project do not categorically require Certificate of Need ("CON") review and approval. Thus, the capital expenditure is the only characteristic of this project subject to CON regulation. It exceeds the current capital expenditure threshold triggering CON review and approval requirements for hospitals. Midtown seeks a determination that this capital expenditure does not require CON review and approval under the terms of COMAR 10.24.01.03J. These regulations allow for hospitals to obligate capital expenditures in excess of the threshold for physical plant construction or renovation if the capital expenditure does not require, over the entire period or schedule of debt service associated with the project or plant, a total cumulative increase in patient charges or hospital rates of more than $1,500,000 for the capital costs associated with the project. Such a determination requires submission of a statement by one or more persons

authorized to represent the hospital that the hospital does not require a total cumulative increase in patient charges or hospital rates of more than $1,500,000 for the capital costs associated with the project. A September 8, 2016 letter from Keith D. Persinger, Chief Financial Officer and Chief Operating Officer to Dennis Phelps, Associate Director, Audit and Compliance of the Health Services Cost Review Commission, states that "the proposed expenditures to construct an ambulatory care building, "do not require . . . at (sic) total cumulative increase in patient charges or hospital rates of more than $1,500,000.'" Mr. Persinger also states, "While UMMC Midtown Campus will not seek a rate increase to finance this project, it reserves the right to see (sic) a rate increase in the future for an amount no greater than the $1,500,000 ceiliing established by Maryland law.

This request is unusual in that the capital project for which approval of the expenditure is sought contains substantial unfinished building space. The provisions of COMAR 10.24.01.03J were designed to allow for hospital capital projects that involve no categorically regulated facilities or services but only fall within the ambit of CON regulation because of the size of the required capital expenditure to go forward without CON review and approval so long as the hospital "pledges" not to seek a cumulative increase in charges of more than $1.5 million. However, in this case, Midtown is indicating that it is building unfinished space for future development of ambulatory surgical services. COMAR 10.24.01.02A(4) defines a change in the type or scope of any health care service offered by a health care facility as a project requiring CON review and approval, if the change, among other things, "builds or expands ambulatory surgical capacity in any setting owned or controlled by a hospital, if the building or expansion would increase the surgical capacity of the State's health care system." In this case, Midtown is requesting a determination of coverage that CON review and approval is not required to construct building space that Midtown plans to finish in the future as ambulatory surgical capacity.

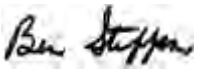
Therefore, while the outpatient diagnostic and treatment services proposed to be housed in the finished space of this building project do not categorically require Certificate of Need ("CON") review and approval, MHCC is only willing to issue the determination sought under COMAR 10.24.01.03J with the condition that Midtown may not finish the shell space constructed as part of this capital project as a project requiring CON review and approval. Without such a condition, MHCC would be authorizing Midtown to obligate a capital expenditure for a health care facility project that may require CON approval for reasons other than the size of the capital expenditure and that is inconsistent with the terms of COMAR 10.24.01.03J. I communicated this position to you on January 31, 2017.

In February 3, 2017 correspondence from Mohan Suntha, President and Chief Executive Officer of the University of Maryland Medical Center, Midtown stated that this condition "should not be required because the applicable regulations do not preclude a hospital from establishing a CON project in existing space, including space constructed under a capital expenditure pledge determination." However, the correspondence goes on to state that "in order to avoid any further delay in this project, and because UMMC Midtown has no intention of using the planned shell space in the building for any CON regulated projects, UMMC Midtown hereby makes the agreement you request." Based on Midtown's agreement to this condition, I am issuing the requested determination of coverage for the building project, as described in your filings with MHCC. Midtown may implement this project, as described in those filings, without obtaining CON review and approval based on Midtown's statement that the hospital does not require a total cumulative increase in patient charges or hospital rates of more than $1,500,000 for the capital

costs associated with the project and Midtown's agreement that a health care facility project requiring CON review and approval will not be implemented through the finishing of shell space included in this building project.

Please contact Paul E. Parker, Director of Health Care Facilities Planning and Development, (410-764-3261 or paul.parker@maryland.gov) me if you have any questions concerning this matter.

Sincerely,

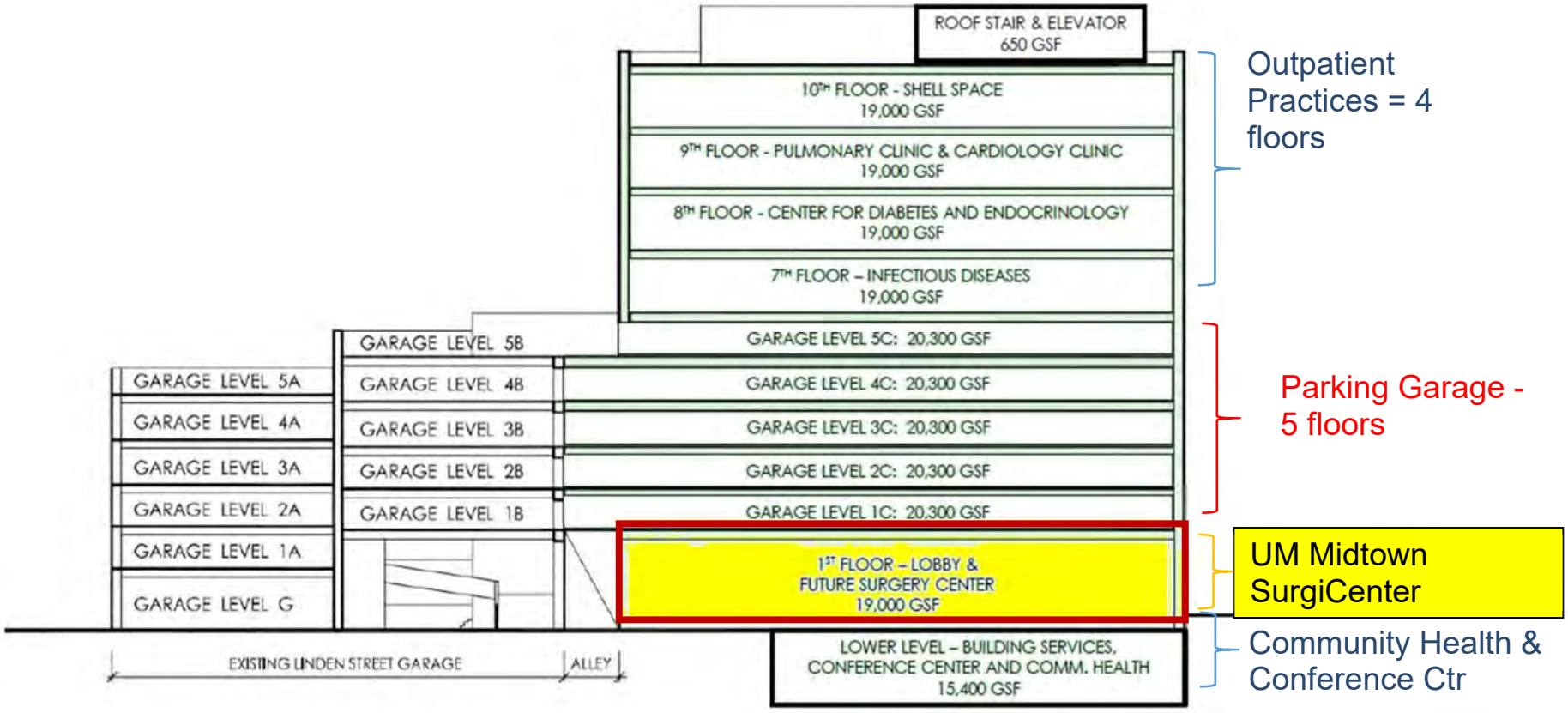


Ben Steffen
Executive Director

cc: Donna Kinzer, Executive Director, HSCRC
Jerry Schmith, Associate Director, HSCRC
Kevin McDonald, Chief, Certificate of Need
Suellen Wideman, A.A.G.

EXHIBIT 5

Stacking Diagram
Midtown Ambulatory Care Building



#701157
006551-0226

EXHIBIT 6

Andrew N. Pollak, M.D.
CHAIR

STATE OF MARYLAND

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

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

January 6, 2020

Thomas C. Dame, Esquire
Mallory Regenbogen, Esquire
Gallagher, Evelius & Jones
218 North Charles Street, Suite 400
Baltimore, Maryland 21201

Re: University of Maryland Medical Center-Midtown Campus
Certificate of Need Application to Establish an Ambulatory Surgical Facility

Dear Counsel:

I write in response to the request by the University of Maryland Medical Center–Midtown Campus (UMMC-Midtown) to remove a condition included in a determination of regulatory coverage determination issued by the Maryland Health Care Commission (MHCC) staff on February 15, 2017. We discussed this request at a November 7, 2019 meeting and you provided a follow-up letter on November 15, 2019.

The 2017 determination stated that UMMC-Midtown could undertake a capital project (referenced by the hospital as "the ambulatory care building") with an estimated expenditure of $56,500,000 without obtaining a Certificate of Need (CON). The project was described as the construction of a ten-story (above grade) building housing facilities for the provision of outpatient medical services, a community health education center, a conference center, and parking garage space. UMMC-Midtown stated that, upon completion of the project, the first above grade floor of the building would consist of "shell space" for "future ambulatory surgery center" development and a main building entrance lobby. The tenth floor of the building was also described as consisting of shell space, upon project completion.

MHCC staff's determination was issued in accordance with MHCC's statutory and regulatory requirements applicable to hospital capital projects involving expenditures that exceed the capital expenditure threshold established in law as a trigger for CON review and approval requirements. Such determinations are commonly referenced as "pledge" projects. Hospitals are allowed to obligate capital expenditures in excess of the threshold if the capital expenditure does not involve elements that require CON approval categorically, without regard to the expenditure involved, and if the hospital pledges to MHCC and the Health Services Cost Review Commission (HSCRC) that the hospital does not require a total cumulative increase in patient charges or hospital rates of more than $1,500,000 for the capital costs associated with the project over the life of the project.

The February 15, 2017 determination was issued with the condition that UMMC-Midtown not finish the shell space constructed as part of this capital project as a project requiring CON review and approval. MHCC staff reasoned that, without such a condition, it would be potentially authorizing UMMC-Midtown to obligate a capital expenditure for building space that, in the future, would be used for implementation of one or more projects that require CON approval categorically, such as the addition of hospital-based operating rooms. Such a determination would not be consistent with the intent of COMAR 10.24.01.03J. UMMC-Midtown accepted this condition as a prerequisite for MHCC staff's determination.

I understand that UMMC-Midtown now proposes to seek CON approval for establishment of an ambulatory surgical facility (ASF) in the first-floor shell space of the ambulatory care building. The ASF is intended to be separately licensed from UMMC-Midtown as a freestanding ambulatory surgical facility that provides surgical services that are not included in the global budgeted revenue of UMMC-Midtown. As such, these surgical services would be offered at: (1) prices set by the hospital, in the case of patients paying out-of-pocket; (2) reimbursement rates negotiated with private third-party payers, in the case of privately insured patients; (3) reimbursement rates established for outpatient surgery in "ambulatory surgical centers" by the Center for Medicare and Medicaid Services, in the case of patients eligible for Medicare Part B benefits; or (4) reimbursement rates established for outpatient surgery in non-hospital settings by the Maryland Medical Assistance program, in the case of patients eligible for and enrolled in Medicaid or the Maryland Children's Health Program.

The condition attached to the February 15, 2017 determination contemplated and was intended to forestall the review of a CON application for a hospital-based health care facility project by UMMC-Midtown in unfinished building space constructed pursuant to that determination. However, I am persuaded that the ASF project now contemplated by the hospital avoids, for the most part, the concerns that gave rise to the condition in MHCC staff's 2017 determination that a hospital should not be permitted to obligate expenditures for building projects that include shell space available for incorporation into future hospital projects that require CON approval. For this reason, MHCC staff has determined that it will accept for review a CON application from UMMC-Midtown to establish a licensed ASF and, if qualified, docket and take action on such an application.

Staff's determination is consistent with the policy direction taken by MHCC in its 2018 update to COMAR 10.24.11, the General Surgical Services Chapter of the State Health Plan and in recent legislative changes supported by MHCC that were intended to facilitate use of non-hospital settings for the delivery of outpatient surgical services. However, I note that your November 15, 2019 letter states that,

> [i]n recent discussions, HSCRC staff recognized that current laws and policies regarding rate regulated and unregulated services on the same campus need to be revisited in order to preserve the Medicare waiver due to the new TCOC (Total Cost of Care) model. UMMC leadership plans to reconvene with HSCRC staff late in the calendar year to revisit what are likely changes in rate regulation status that may allow for non-rate regulated outpatient surgical services in the UMMC Midtown ambulatory care building.

For this reason, MHCC staff's determination with respect to acceptance of a CON application from UMMC-Midtown to establish an ASF in the ambulatory care building is contingent on a determination by HSCRC that it will allow development of a non-rate regulated ASF on a general hospital campus under the circumstances presented by UMMC-Midtown. Specifically, MHCC staff will not docket an application to add operating rooms in the ambulatory care building that would be categorized as the addition of operating rooms by UMMC-Midtown and, as such, would be used in the provision of rate-regulated outpatient surgery.

If you have any questions concerning this determination, please contact Suellen Wideman, Assistant Attorney General, at 410-764-3326.

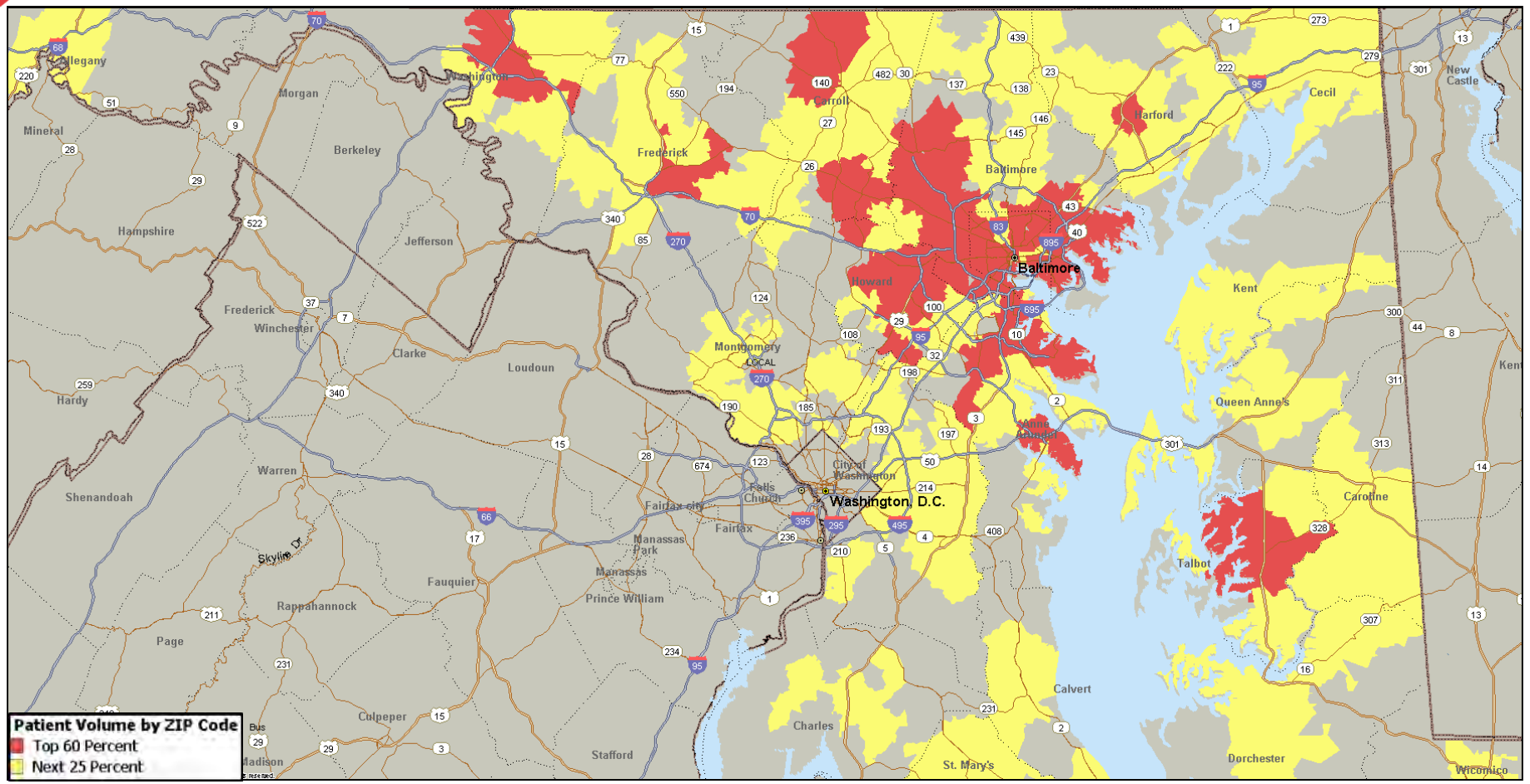
Sincerely,

Ben Steffen
Executive Director

cc: Alison Brown, M.P.H., President, UMMC-Midtown Campus
Dana Farrakhan, F.A.C.H.E., Senior Vice President, UMMC
Katie Wunderlich, Executive Director, Health Services Cost Review Commission
Letitia T. Dzirasa, M.D., Commissioner of Health, Baltimore City
Paul Parker, Director, Center for Health Facilities Planning and Development
Kevin McDonald, Chief, Certificate of Need
Suellen Wideman, Assistant Attorney General

EXHIBIT 7

UM Midtown SurgiCenter Projected Service Area



Based on UMMC Outpatient Surgical Cases FY 2019
Top 85 Percent of Patient Volume by Zip Code
Excludes Ages 0-17

EXHIBIT 8

<table>
<tr>
<td rowspan="3">University of Maryland Medical Center
University of Maryland Medical Center Midtown Campus
University of Maryland Rehabilitation & Orthopaedic Institute
University of Maryland St. Joseph Medical Center
University of Maryland Baltimore Washington Medical Center
University of Maryland Shore Medical Center at Chestertown
University of Maryland Shore Medical Center at Dorchester
University of Maryland Shore Medical Center at Easton
University of Maryland Charles Regional Medical Center
University of Maryland Upper Chesapeake Health
University of Maryland Capital Region Health</td>
<td>The University of Maryland Medical System
Central Business Office
Policy & Procedure</td>
<td>Policy #:</td>
<td>TBD</td>
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<td></td>
<td>Effective Date:</td>
<td>09/18/2019</td>
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<td><u>Subject:</u>
FINANCIAL ASSISTANCE</td>
<td>Page #:</td>
<td>1 of 15</td>
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<td>Supersedes:</td>
<td>07/01/2019</td>
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POLICY

This policy applies to the following hospital facilities of the University of Maryland Medical System (“UMMS hospitals”):

- University of Maryland Medical Center (UMMC)
- University of Maryland Medical Center Midtown Campus (MTC)
- University of Maryland Rehabilitation & Orthopaedic Institute (UMROI)
- University of Maryland St. Joseph Medical Center (UMSJMC)
- University of Maryland Baltimore Washington Medical Center (UMBWMC)
- University of Maryland Shore Medical Center at Chestertown (UMSMCC)
- University of Maryland Shore Medical Center at Dorchester (UMSMCD)
- University of Maryland Shore Medical Center at Easton (UMSME)
- University of Maryland Charles Regional Medical Center (UMCRMC)
- University of Maryland Upper Chesapeake Health (UCHS)
- University of Maryland Capital Region Health (UM Capital)

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

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

UMMS will post notices of financial assistance availability in each UMMS hospital's emergency room (if any) and admissions areas, as well as the Billing Office. Notice of availability will also be sent to the patient with patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge, and it (along with this policy and the Financial Assistance Application) will be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas. This policy, the Patient Billing and Financial Assistance Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UMMS website (www.umms.org).

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

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

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

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

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

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

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

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

This policy was adopted for University of Maryland Charles Regional Medical Center (UMCRMC) effective December 2, 2018.

This policy was adopted for University of Maryland Upper Chesapeake Health (UCHS) effective July 1, 2019

This policy was adopted for University of Maryland Capital Region Health (UM Capital) effective September 18, 2019

PROGRAM ELIGIBILITY

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

Specific exclusions to coverage under the Financial Assistance Program:

The Financial Assistance Program generally applies to all emergency and other medically necessary care provided by each UMMS hospital, as well as certain entities related to such hospitals listed in Attachment B. However, the Financial Assistance Program does not apply to any of the following:

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

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

1. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to the Medical Center due to insurance plan restrictions/limits.
2. Refusal to be screened for other assistance programs prior to submitting an application to the Financial Clearance Program.
3. Refusal to divulge information pertaining to a pending legal liability claim.
4. Foreign-nationals traveling to the United States seeking elective, non-emergent medical care.

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

Unless they meet Presumptive Financial Assistance Eligibility criteria, patients shall be required to submit a complete Financial Assistance Application (with all required information and documentation) and determined to be eligible for financial assistance in order to obtain financial assistance. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application before receiving non-emergency medical care unless they meet Presumptive Financial Assistance Eligibility criteria. If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor/Coordinator and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

Those with income up to 200% of Maryland State Department of Health and Mental Hygiene Medical Assistance Planning Administration Income Eligibility Limits for a Reduced Cost of Care (“MD DHMH”) are eligible for free care. Those between 200% to 300% of MD DHMH are eligible for discounts on a sliding scale, as set forth in Attachment A.

Presumptive Financial Assistance

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

a. Active Medical Assistance pharmacy coverage
b. Specified Low Income Medicare (SLMB) coverage
c. Primary Adult Care (PAC) coverage
d. Homelessness
e. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
f. Medical Assistance spend down amounts
g. Eligibility for other state or local assistance programs
h. Patient is deceased with no known estate

i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program

j. Non-US Citizens deemed non-compliant

k. Non-Eligible Medical Assistance services for Medical Assistance eligible patients

l. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID)

m. Bankruptcy, by law, as mandated by the federal courts

n. St. Clare Outreach Program eligible patients

o. UMSJMC Maternity Program eligible patients

p. UMSJMC Hernia Program eligible patients

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

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

PROCEDURES

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.

2. When possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
   a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.
   b. Preliminary data will be entered into a third party data exchange system to determine probably eligibility. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
   c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance. Determination of Probable Eligibility will be provided within two business days following a patient's request for charity care services, application for medical assistance, or both.
   d. If a patient submits a Financial Assistance Application without the information or documentation required for a final determination of eligibility, a written request for the missing information or documentation will be sent to the patient. This written request will also contain the contact information (including telephone number and physical location) of the office or department that can provide information about the Financial Assistance Program and assistance with the application process.
   e. The patient will have thirty (30) days from the date this written request is provided to submit the required information or documentation to be considered for eligibility. If no data is received within the 30 days, a letter will be sent notifying the patient that the case is now closed for lack of the required documentation. The patient may re-apply to the program and initiate a new case by submitting the missing information or documentation 30 days after the date of the written request for missing information/documentation.
   f. For any episode of care, the Financial Assistance Application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent.

g. Individual notice regarding the hospital's Financial Assistance Policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

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

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

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

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

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

If a patient submits both a copy of their most recent Federal Income Tax Return and a copy of their most recent pay stubs (or other evidence of income), and only one of the two documents indicates eligibility for financial assistance, the most recent document will dictate eligibility. Oral submission of needed information will be accepted, where appropriate.

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

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

i) If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.

ii) If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.

(1) A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Clinical Chair.

5. Once a patient is approved for Financial Assistance, Financial Assistance coverage is effective for the month of determination and a year prior to the determination. However, an UMMS hospital may decide to extend the Financial Assistance eligibility period further into the past or the future on a case-by-case basis. If additional healthcare services are provided beyond the eligibility period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be communicated to the Financial Assistance Program Department. All Extraordinary Collections Action activities, as defined below, will be terminated once the patient is approved for financial assistance and all the patient responsible balances are paid.

6. Account balances that have not been paid may be transferred to Bad Debt (deemed uncompensated care) and referred to an outside collection agency or to the UMMS hospital's attorney for legal and/or collection activity. Collection activities taken on behalf of the hospital by a collection agency or the hospital's attorney may include the following Extraordinary Collection Actions (ECAs):

a. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

b. Commencing a civil action against the individual.

c. Placing a lien on an individual's property. A lien will be placed by the Court on primary residences within Baltimore City. The hospital will not pursue foreclosure of a primary residence but my maintain its position as a secured creditor if a property is otherwise foreclosed upon.

d. Attaching or seizing an individual's bank account or any other personal property.

e. Garnishing an individual's wage.

7. ECAs may be taken on accounts that have not been disputed or are not on a payment arrangement. ECAs will occur no earlier than 120 days from submission of first post-discharge bill to the patient and will be preceded by a written notice 30 days prior to commencement of the ECA. This written notice will indicate that financial assistance is available for eligible individuals, identify the ECAs that the hospital (or its collection agency, attorney, or other authorized party) intends to obtain payment for the care, and state a deadline after which such ECAs may be initiated. It will also include a Patient Billing and Financial Assistance Information Sheet. In addition, the hospital will make reasonable efforts to orally communicate the availability of financial assistance to the patient and tell the patient how he or she may obtain assistance with the application process. A presumptive eligibility review will occur prior to any ECA being taken. Finally, no ECA will be initiated until approval has been obtained from the CBO Revenue Cycle.

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

9. A letter of final determination will be submitted to each patient who has formally submitted an application. The letter will notify the patient in writing of the eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for the determination. If the patient is determined to be eligible for assistance other than free care, the patient will also be provided with a billing statement that indicates the amount the patient owes for the care after financial assistance is applied.

10. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. Refunds will be issued back to the patient for credit balances, due to patient payments, resulting from approved financial assistance on considered balance(s). Payments received for care rendered during the financial assistance eligibility window will be refunded, if the amount exceeds the patient's determined responsibility by $5.00 or more.

11. If a patient is determined to be eligible for financial assistance, the hospital (and/or its collection agency or attorney) will take all reasonably available measures to reverse any ECAs taken against the patient to obtain payment for care rendered during the financial assistance eligibility window. Such reasonably available measures will include measures to vacate any judgment against the patient, lift levies or liens on the patient's property, and remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.
12. Patients who have access to other medical coverage (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Assistance Program.
13. The Financial Assistance Program will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications in determining eligibility for the UMMS Financial Assistance program. This includes accepting FPI's application requirements.
14. The Financial Assistance Program will accept all other UMMS hospital's completed financial assistance applications in determining eligibility for the program. This includes accepting each facility's application format.
15. The Financial Assistance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.
16. Where there is a compelling educational and/or humanitarian benefit, Clinical staff may request that the Financial Clearance Executive Committee consider exceptions to the Financial Assistance Program guidelines, on a case-by-case basis, for Financial Assistance approval.
    a. Faculty requesting Financial Clearance/Assistance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.
    b. The Chief Medical Officer will notify the attending physician and the Financial Assistance staff of the Financial Clearance Executive Committee determination.

Financial Hardship

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

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

1) Their medical debt incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital exceeds 25% of the Family Annual Household Income, which is creating Medical Financial Hardship.

For the patients who are eligible for both, the Reduced Cost Care under the primary Financial Assistance criteria and also under the Financial Hardship Assistance criteria, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital will grant the reduction in charges, which is balance owed that is greater than 25% of the total annual household income.

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

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

Once a patient is approved for Financial Hardship Assistance, coverage will be effective for the month of the first qualifying date of service and a year prior to the determination. However, an UMMS hospital may decide to extend the Financial Hardship eligibility period further into the past or the future on a case-by-case basis according to their spell of illness/episode of care. It will cover the patient and the eligible family members living in the household for the approved reduced cost and eligibility period for medically necessary care.

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

Appeals

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

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

MD DHMH 2019 Income Elig Limit Guidelines		Income Level Up to 200% Pt Resp 0%	S L I	Income Level Pt Resp 10%	Income Level Pt Resp 20%	Income Level Pt Resp 30%	Income Level Pt Resp 40%	Income Level Pt Resp 50%	Income Level Pt Resp 60%	Income Level Pt Resp 70%	Income Level Pt Resp 80%	Income Level Pt Resp 90%
HH	100% MD DHMH	100% Charity	D	90% Charity	80% Charity	70% Charity	60% Charity	50% Charity	40% Charity	30% Charity	20% Charity	10% Charity
Size	Max	Max	I	Max	Max	Max	Max	Max	Max	Max	Max	Max
1	$17,244	$34,488	N	$36,212	$37,937	$39,661	$41,386	$43,110	$44,834	$46,559	$48,283	$51,731
2	$23,364	$46,728	G	$49,064	$51,401	$53,737	$56,074	$58,410	$60,746	$63,083	$65,419	$70,091
3	$29,448	$58,896		$61,841	$64,786	$67,730	$70,675	$73,620	$76,565	$79,510	$82,454	$88,343
4	$35,532	$71,064	S	$74,617	$78,170	$81,724	$85,277	$88,830	$92,383	$95,936	$99,490	$106,595
5	$41,652	$83,304	C	$87,469	$91,634	$95,800	$99,965	$104,130	$108,295	$112,460	$116,626	$124,955
6	$47,748	$95,496	A	$100,271	$105,046	$109,820	$114,595	$119,370	$124,145	$128,920	$133,694	$143,243

*All discounts stated above shall be applied to the amount the patient is personally responsible for paying after insurance reimbursements.
*Amounts billed to patients who qualify for Reduced-Cost of Care on a sliding scale (or for Financial Hardship Assistance) will be less than the amounts generally billed to those with insurance (AGB), which in Maryland is the charge established by the Health Services Cost Review Commission (HSCRC). UMMS determines AGB by using the amount Medicare would allow for the care (including the amount the beneficiary would be personally responsible for paying, which is the HSCRC amount; this is known as the "prospective Medicare method".

Effective 7/1/19

EXHIBIT 9

MOYE

From page 1

It remains the second-most points scored in an NBA game behind Wilt Chamberlain's 100 on March 2, 1962.

Bryant was Moye's favorite player and she was overcome with emotion during the game.

"I just wanted to go out there and play hard," Moye said. "I was excited. It wasn't really planned that I would do that. It was just a happy moment for me."

Before he died, Bryant was an advocate for women's and girls basketball. He frequented WNBA games and helped coach Gianna's basketball team at his Mamba Sports Academy in Newbury Park. After his death, others have looked to build women's basketball, according to CCBC Essex coach Mike Seney.

"Kobe having his daughter Gianna playing girls basketball moved him," Seney said. "A couple of days before he passed, he discussed a few women that he thought could play in the NBA. So he was definitely bringing notoriety to the women's game. I remember him wearing sweatshirts with the WNBA logo.

"I really feel like that's helping a lot of young women across America because Kobe was one of [the best], if not the greatest basketball player to ever live. When he gave that stamp of approval, it helps. 'SportsCenter' posted Mya scoring 81, and for a woman to do that it welcomes great attention to the game."

A Florida A&M transfer, Moye is third in National Junior College Athletic Association Division II in scoring with 23 points per game and fourth with 6.7 assists. Her scoring has been one of the top aspects of her game as she averaged a team-high 11.3 points per game with the NCAA Division I Rattlers in her freshman season.

Seney was excited to get a player who could change the fortune of his program.

For 15 straight seasons, the Knights didn't have a women's basketball team. Now, in their first season returning to the court, they are ranked 13th in nation. Moye has been a key component of the team's success, and Seney has followed her since high school days.

"I have been watching Mya since she was in the 11th grade at Antacostia High School [in Washington]," Seney said. "I was just always a fan of hers and the way she's scored the ball. She's always been a scorer — she had 50 points in her championship game in high school. She's always been a ridiculous scorer.

"When she went down to FAMU, I stayed up on her from afar and continued to watch her grow as a basketball player and a woman. When I got the phone call this summer that things really didn't work out at FAMU and she wanted a second chance to get herself back out there, we jumped on it right away."

MIKE SENEY

The placard CCBC Essex's Mya Moye is holding shows the number of points she scored in a game against Northern Virginia Community College on Jan. 29.

Coming to CCBC Essex was a slam-dunk decision for Moye. Seney had a vested interest in her game, running a program at Harford Community College from 2014 to 2019 that went 135-15 (.900), won five straight NJCAA Region XX Division I and Maryland juco tournament championships and appeared in the NJCAA Division I tournament.

"I just really wanted to come here and build a pedigree," Seney said. "We've done a little bit more than that.

"We've been ranked in the top 15 most of the year throughout the entire nation. I think that with what Mya did the other night, it brings a little more notoriety to our program and it's going to help our future Knights to come in and get the recognition that they deserve."

Moye has been offered several Division I scholarships to return to the NCAA, along with some other teammates. The immediate goal is turning CCBC Essex into one of the best women's basketball programs in Maryland.

The success that Seney had running his former program drew Moye to play for him and raise her game to new heights.

"I wanted to play for Coach Mike," Moye said. "He ran a strong program over there at Harford. I knew what he was capable of, so I just wanted to play for him. I knew that he was surrounded by winners and I wanted to come win too."

Moye's main goal is to to go out a winner at CCBC Essex and leave a lasting individual legacy for years to come.

"I just really want to win a championship with my team this year," Moye stated. "I would like to win MVP, but I just really want to win a championship title in the region."

WIZARDS

SO YOU'RE SAYING THERE'S A CHANCE?

Beal analyzed standings, says he believes in team's odds of making playoffs

By Candace Buckner
The Washington Post

WASHINGTON — When Bradley Beal needed motivation after not being named an Eastern Conference All-Star, he found it in the NBA standings.

Beal's disappointment, evidenced by his glassy-eyed expression and defiant tone, seeped through as he shared his initial thoughts about the snub Thursday night. The Washington Wizards' low win total might have played into the coaches' decision to leave Beal off the team, and as a response he made a public commitment "to try to get my team to the playoffs."

That pledge, which Beal reiterated Saturday after the Wizards' sixth win in their past seven home games and their second straight overall, wasn't simply said out of emotion.

When asked if he has been paying attention to the Eastern Conference playoff picture, Beal said: "I sure have. I wouldn't have said it if I wasn't."

Beal added, "I love our chances."

As strange as it may seem, the 17-31 Wizards have a chance of sneaking into the postseason. Washington holds a 4.6% chance of securing eighth in the East and a 0.7% shot of seventh place, according to basketball-reference.com.

After two consecutive road losses last week, Washington returned home in 12th place out of 15 teams. But after a pair of wins at Capital One Arena, including the 113-107 victory over the seventh-seeded Brooklyn Nets on Saturday, the Wizards leapfrogged into 10th place. With 34 games remaining, Washington is 3½ games behind the Orlando Magic for the eighth seed.

Though Beal said he was keenly aware of the movement up the standings, other Wizards want to focus simply on incremental progress.

"We can't think about it like that. We just got to think about one game at a time," forward Davis Bertans said about watching the standings.

"We are not looking at that. I mean, we are not," coach Scott Brooks echoed. "But we want to keep playing good basketball. We know we have a lot of areas to improve in. We have got a lot of things that we have to get better [at], and in order to compete with the high-level teams, we have to do that consistently."

NICK WASS/AP

Bradley Beal celebrates after he hit a 3-pointer during the second half against the Nets on Saturday in Washington. The Wizards have won two straight games.

The Wizards' defensive tendencies top that list.

During the previous two road losses in Atlanta and Milwaukee, the Wizards played "horrific" games, Brooks said, and surrendered more than 150 points each night. The Wizards are last in the league in defensive rating (116.9), and the numbers reflect poorly on the team's most-used players such as Beal, who leads the team at 35.3 minutes per game and has a 120.3 defensive rating.

Among the 14 NBA players who average 35 minutes or more, Beal's defensive rating ranks last.

"It's like all of us. We're not very good defensively right now. We need to get better. Brad is a big part of it, but it's all of us," Brooks responded when asked to evaluate Beal's individual defense this season. "Myself, our coaches and our players ... everybody, we all have to be a better defensive team."

Against Brooklyn, Beal spent most of his time on the defensive end matched up against Joe Harris and Spencer Dinwiddie. Though Harris made 3 of the 4 shots he attempted against Beal, Dinwiddie went 1 for 5 in the matchup. In the fourth quarter, the Wizards played their strongest defense — with Beal, Bertans, Thomas Bryant, Troy Brown Jr. and Ish Smith on the floor — and held Brooklyn without a made shot in the final 4½ minutes.

"I feel like we have a chance to compete for eighth," Bryant said. "If we keep doing what we're doing, like we did [Saturday], we'll be in a good spot."

LEGAL NOTICES

Maryland Department of the Environment
Land and Materials Administration

Notice of Application Received and Opportunity for Informational Meeting

In accordance with Sections 1-601, 1-602, and 1-603 of the Environment Article, Annotated Code of Maryland, the Maryland Department of the Environment (MDE) is presently reviewing a Groundwater Discharge Permit Renewal Application submitted by the Days Cove Reclamation Company. The application is for the continued discharge of wastewater generated by rainwater percolating through the rubble cell floor of the closed Original Days Cove Rubble Landfill into groundwater via infiltration/percolation. This landfill is located at 6425 Days Cove Road, White Marsh, Baltimore County, Maryland 21162. The current permit requires semi-annual monitoring of the groundwater for metals and organic compounds. The proposed permit allows MDE to set and maintain requirements for the continued monitoring of groundwater quality at the closed rubble landfill, and does not authorize an expansion or other change to the facility.

An Informational Meeting will be held if a written request is received by MDE on or before February 19, 2020. The request should indicate the name, address and daytime telephone number of the person making the request, the name of any party whom the person making the request may represent, and the name of the facility. Send the request to: Ms. Kaley Laleker, Director, Land and Materials Administration, 1800 Washington Boulevard, Baltimore, Maryland 21230-1719.

Also, upon prior request, MDE will provide an interpreter for the deaf or hearing-impaired persons. The application and supporting documents will be available for public review after February 4, 2020, at the Baltimore County Public Library located at 8133 Sandpiper Circle, Baltimore, Maryland 21236 and at MDE by appointment.

For further information regarding this notice, to schedule an appointment to review the application, or to request an interpreter, please contact Ms. Sara Haile at (410) 537-3315 or sara.haile@maryland.gov.

2/5, 2/12/2020 6570087

Legal Notice

Notice is hereby given for the disinurnment of Mr. Robert J. Walker from Crest Lawn Memorial Gardens, 2150 Mount View Rd, Marriottsville, MD 21104. Mr. Walker was disinurned from Crest Lawn Memorial Gardens, Chapel Mausoleum, Section C, Tier 2, Crypt 8 and re-inurned in Crest Lawn Memorial Gardens, Chapel Mausoleum, Section C, Tier 2, Crypt 8.
02/05/2020 6591979

Opportunity for Public Hearing
Special and Rural Transit in Baltimore County
Tentatively scheduled for 2:00 pm, February 26, 2020
BYKOTA Senior Center
611 Central Avenue
Towson, MD 21204

The Baltimore County Department of Aging will hold a public hearing upon request to receive comments regarding a transportation service plan that Baltimore County, Maryland will submit to the MTA with an application for Statewide Special Transportation Assistance Program (SSTAP) and Rural Public Transit Program Section 18 funds (RPTP) for the fiscal year 2021.

Baltimore County Department of Aging is applying for $395,836 for SSTAP and $163,616 RPTP to serve Baltimore County residents aged 60+, residents with disabilities, and residents of the rural area with transportation needs.

The general public and transportation operators are encouraged to attend to offer comment on the proposed service. Requests for this hearing must be submitted in writing at the address below, or by phone at 410-887-8287; by February 19, 2020. Written comments will be accepted as an alternative to attendance, but must be received by February 19, 2020. Please address them to:

CountyRide
Transportation Plan
Department of Aging
611 Central Avenue
Towson MD 21204
Or: e-mail countyride@baltimorecountymd.gov
1/22, 1/29, 2/5/2020 6578084

CONDEMNATION AND CLOSING OF A 13.5 FOOT WIDE PARCEL WITHIN A PORTION OF WEST 24TH STREET

NOTICE: Application will be made to the Mayor and City Council of Baltimore for the condemnation and closing of a 13.5 Foot Wide Parcel within a portion of West 24th Street in accordance with a plat now on file with the Department of Transportation.
1/29, 1/31, 2/5, 2/7/2020 6573186

District Court
Jefferson County, Colorado
100 Jefferson County Pkwy, Golden CO, 80401
In the Matter of the Petition of:
Gregory Thomas Hynes (name of person seeking to adopt)
For the Adoption of a Child
Case Number: 19JA59
Division: S Courtroom: 2D

NOTICE OF HEARING

To: Edward Francis Calvello (Full Name of Parent).
Pursuant to 19-5-208, C.R.S., you are hereby notified that the above-named Petitioner(s) has/have filed in this Court a verified Petition seeking to adopt a child.
If applicable, an Affidavit of Abandonment has been filed alleging that you have abandoned the child for a period of one year or more and/or have failed without cause to provide reasonable support for the child for one year or more.
You are further notified that an Adoption hearing is set on Monday May 4th, 2020 (date), at 1:30pm (time) in the court location identified above.
You are further notified that if you fail to appear for said hearing, the Court may terminate your parental rights and grant the adoption as sought by the Petitioner(s).

Andrew Fitzgerald
Clerk

2/5, 2/12, 2/19, 2/26, 3/4 6590065

Notice of Public Sale

Extra Space Storage will hold a public auction at the location indicated: 69 Dover Road NE, Glen Burnie, MD 21060 410.274.3907, February 12, 2020 at 12:00pm. Unit Number(s): 1104, 3230, 1041, 4354, 1005, 3137, 1006, 4295, 1107, 3012, 3216. The auction will be listed and advertised on www.storagetreasures.com. Purchases must be made with cash only and paid at the above referenced facility in order to complete the transaction. Extra Space Storage may refuse any bid and may rescind any purchase up until the winning bidder takes possession of the personal property.
2/5/2020 6595426

District Court
Jefferson County, Colorado
100 Jefferson County Pkwy, Golden CO, 80401
In the Matter of the Petition of:
Gregory Thomas Hynes (name of person seeking to adopt)
For the Adoption of a Child
Case Number: 19JA60
Division: S Courtroom: 2D

NOTICE OF HEARING

To: Edward Francis Calvello (Full Name of Parent).
Pursuant to 19-5-208, C.R.S., you are hereby notified that the above-named Petitioner(s) has/have filed in this Court a verified Petition seeking to adopt a child.
If applicable, an Affidavit of Abandonment has been filed alleging that you have abandoned the child for a period of one year or more and/or have failed without cause to provide reasonable support for the child for one year or more.
You are further notified that an Adoption hearing is set on Monday May 4th, 2020 (date), at 1:30pm (time) in the court location identified above.
You are further notified that if you fail to appear for said hearing, the Court may terminate your parental rights and grant the adoption as sought by the Petitioner(s).

Andrew Fitzgerald
Clerk

2/5, 2/12, 2/19, 2/26, 3/4 6590151

STATE OF SOUTH CAROLINA IN THE COURT OF COMMON PLEAS COUNTY OF YORK IN THE SIXTEENTH JUDICIAL CIRCUIT ERICK AND TORI PONS, Plaintiff(s) VS. CIVIL NO. 2019CP4603339 SUMMONS AND NOTICE OF FILING OF COMPLAINT, ALICIA BROWN, Defendant

TO THE DEFENDANT(S)S ABOVE NAMED: YOU ARE HEREBY SUMMONED and required to answer the Complaint in this action, a copy of which is herewith served upon you, and to serve a copy of your Answer to the said Complaint upon the subscribers, at their office, 1544 Ebenezer Road, Rock Hill, SC 29732, within thirty (30) days after the service hereof, exclusive of the day of such service; and if you fail to answer the Complaint in the time aforesaid, judgment by default will be rendered against you for the relief demanded in the Complaint. NOTICE IS HEREBY GIVEN that the original Complaint in the above entitled action was filed in the office of the Clerk of Court for York County on October 1, 2019. s/James W. Boyd Attorney at Law, LLC (SC Bar #824) Attorney for the Plaintiff, PO Box 36425, Rock Hill, SC 29732 Phone: (803) 328-2600 jamesboyd@comporium.net
1/29, 2/5, 2/12 6577162

THE UNIVERSITY OF MARYLAND MEDICAL CENTER MIDTOWN CAMPUS CHARITY CARE POLICY

The University of Maryland Medical Center maintains accessibility to all services regardless of an individual's ability to pay. The hospital policy on charity care is that the hospital will provide necessary emergency medical care to all persons regardless of their ability to pay and will consider for charity care those patients who cannot pay the total cost of hospitalization due to lack of insurance coverage and/ or inability to pay. For more information on our financial assistance policy for patients who qualify for help for their hospital bills, please call 1-800-492-5538. If you require translation services to understand this policy, please call the University of Maryland Patient Advocacy Office at 410-328-8777.
2/5/20 6586982

THE UNIVERSITY OF MARYLAND REHABILITATION AND ORTHOPAEDIC INSTITUTE CHARITY CARE POLICY

The University of Maryland Medical Center maintains accessibility to all services regardless of an individual's ability to pay. The hospital policy on charity care is that the hospital will provide necessary emergency medical care to all persons regardless of their ability to pay and will consider for charity care those patients who cannot pay the total cost of hospitalization due to lack of insurance coverage and/ or inability to pay. For more information on our financial assistance policy for patients who qualify for help for their hospital bills, please call 1-800-492-5538. If you require translation services to understand this policy, please call the University of Maryland Patient Advocacy Office at 410-328-8777.
2/5/20 6587157

Public Notice

"ORDER OF PUBLICATION ON NOTICE OF HEARING IN THE MATTER OF THEODORE CLAIBOURNE III, father, OF T.K. DOB 11/04/2009. Be advised that a matter is pending in the Circuit Court of Preston County, West Virginia, as case number 20-JA-2, involving your parental rights, if any, to a female child whose date of birth is November 4, 2009. You must appear at a hearing scheduled for March 27, 2020 at 1:00 p.m. at the Preston County Circuit Court, at 101 W Main St, Kingwood, WV 26537 and/or defend any such rights within 15 days by serving a response upon the Preston County Circuit Clerk or the Preston County Assistant Prosecuting Attorney, Anne Marie Armstrong, whose address is 106 West Main Street, Suite 201, Kingwood, West Virginia, 26537. If you fail to do so, judgment by default will be taken against you, your parental rights may be forever terminated, and you may thereafter be barred from asserting any future claims for parental rights."
1/29/20, 2/5/20 6585318

THE UNIVERSITY OF MARYLAND MEDICAL CENTER CHARITY CARE POLICY

The University of Maryland Medical Center maintains accessibility to all services regardless of an individual's ability to pay. The hospital policy on charity care is that the hospital will provide necessary emergency medical care to all persons regardless of their ability to pay and will consider for charity care those patients who cannot pay the total cost of hospitalization due to lack of insurance coverage and/ or inability to pay. For more information on our financial assistance policy for patients who qualify for help for their hospital bills, please call 1-800-492-5538. If you require translation services to understand this policy, please call the University of Maryland Patient Advocacy Office at 410-328-8777.
2/5/20 6587144

EXHIBIT 10

Financial Arrangements

University of Maryland Medical Center Midtown Campus has trained financial counselors available to discuss your individual needs. If you do not have insurance or need assistance with paying your portion of the bill, we will help you make payment arrangements or review your eligibility for financial assistance. Patients will receive necessary medical care, and the care will never be based on the patients' ability to pay.

Counselors are available
Monday through Friday
8 a.m. – 4 p.m.
For assistance call 410-821-4140

EXHIBIT 11

Help for Patients to Pay Hospital Care Costs

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

PLEASE NOTE:

1. We treat all patients needing emergency care, no matter what they are able to pay.
2. Services provided by physicians or other providers may not be covered by the hospital Financial Assistance Policy. You can call (410) 821-4140 if you have questions.

HOW THE PROCESS WORKS:

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

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

HOW WE REVIEW YOUR APPLICATION:

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

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

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

HOW TO APPLY FOR FINANCIAL HELP:

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

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

OTHER HELPFUL INFORMATION:

1. You can get a **free copy** of our Financial Assistance Policy and Application Form:
    - *Online* at **www.umm.edu/patients/financial-assistance**
    - *In person* at the Financial Assistance Department – University of Maryland Medical System 11311 McCormick Road Ste 230 Hunt Valley MD 21031
    - *By mail:* call(410) 821-4140 to request a copy
2. You can call the **Financial Assistance Department** if you have questions or need help applying. You can also call if you need help in another language. Call: (410) 821-4140

EXHIBIT 12

U.S. Department of Health & Human Services

ASPE

OFFICE OF THE ASSISTANT SECRETARY
FOR PLANNING AND EVALUATION

POVERTY GUIDELINES
01/08/2020

U.S. FEDERAL POVERTY GUIDELINES USED TO DETERMINE FINANCIAL ELIGIBILITY FOR CERTAIN FEDERAL PROGRAMS

HHS POVERTY GUIDELINES FOR 2020

The 2020 poverty guidelines are in effect as of January 15, 2020
The Federal Register notice for the 2020 Poverty Guidelines was published January 17, 2020.

2020 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $4,480 for each additional person.	
1	$12,760
2	$17,240
3	$21,720
4	$26,200
5	$30,680
6	$35,160
7	$39,640

2020 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
8	$44,120

2020 POVERTY GUIDELINES FOR ALASKA	
PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $5,600 for each additional person.	
1	$15,950
2	$21,550
3	$27,150
4	$32,750
5	$38,350
6	$43,950
7	$49,550
8	$55,150

2020 POVERTY GUIDELINES FOR HAWAII	
PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $5,150 for each additional person.	
1	$14,680
2	$19,830
3	$24,980
4	$30,130
5	$35,280
6	$40,430

2020 POVERTY GUIDELINES FOR HAWAII	
PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
7	$45,580
8	$50,730

RESOURCES

- Prior Poverty Guidelines and Federal Register References Since 1982
- A chart with percentages (e.g., 125 percent) of the guidelines (PDF)
- Frequently Asked Questions (FAQs) on the Poverty Guidelines and Poverty
    - Poverty guidelines — gross or net income
    - The poverty line for a state or city
    - The number of poor people in a state or city
    - How the poverty line was developed
- Further Resources on Poverty Measurement, Poverty Lines, and Their History
- Mollie Orshansky's career, achievements, and publications
- ASPE research on poverty
- The Census Bureau's Poverty Home Page

The separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. Note that the poverty thresholds — the original version of the poverty measure — have never had separate figures for Alaska and Hawaii. The poverty guidelines are not defined for Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam, the Republic of the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, and Palau. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office which administers the program is responsible for deciding whether to use the contiguous-states-and-D.C. guidelines for those jurisdictions or to follow some other procedure.

The poverty guidelines apply to both aged and non-aged units. The guidelines have never had an aged/non-aged distinction; only the Census Bureau (statistical) poverty thresholds have separate figures for aged and non-aged one-person and two-person units.

Programs using the guidelines (or percentage multiples of the guidelines — for instance, 125 percent or 185 percent of the guidelines) in determining eligibility include Head Start, the Supplemental Nutition Assistance Program (SNAP), the National School Lunch Program, the Low-Income Home Energy Assistance Program, and the Children's Health Insurance Program. Note that in general, cash public assistance programs (Temporary Assistance for Needy Families and Supplemental Security Income) do NOT use the poverty guidelines in determining eligibility. The Earned Income Tax Credit program also does NOT use the poverty guidelines to determine eligibility. For a more detailed list of programs that do and don't use the guidelines, see the Frequently Asked Questions (FAQs).

The poverty guidelines (unlike the poverty thresholds) are designated by the year in which they are issued. For instance, the guidelines issued in January 2020 are designated the 2020 poverty guidelines. However, the 2020 HHS poverty guidelines only reflect price changes through calendar year 2019; accordingly, they are approximately equal to

the Census Bureau poverty thresholds for calendar year 2019. (The 2019 thresholds are expected to be issued in final form in September 2020; a preliminary version of the 2019 thresholds is now available from the Census Bureau.)

The poverty guidelines may be formally referenced as “the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).”

There are two slightly different versions of the federal poverty measure: poverty thresholds and poverty guidelines.

The **poverty thresholds** are the original version of the federal poverty measure. They are updated each year by the **Census Bureau**. The thresholds are used mainly for **statistical** purposes — for instance, preparing estimates of the number of Americans in poverty each year. (In other words, all official poverty population figures are calculated using the poverty thresholds, not the guidelines). Poverty thresholds since 1973 (and for selected earlier years) and weighted average poverty thresholds since 1959 are available on the Census Bureau’s Web site. For an example of how the Census Bureau applies the thresholds to a family’s income to determine its poverty status, see “How the Census Bureau Measures Poverty” on the Census Bureau’s web site.

The **poverty guidelines** are the other version of the federal poverty measure. They are issued each year in the Federal Register by the **Department of Health and Human Services** (HHS). The guidelines are a simplification of the poverty thresholds for use for **administrative** purposes — for instance, determining financial eligibility for certain federal programs.

The poverty guidelines are sometimes loosely referred to as the “federal poverty level” (FPL), but that phrase is ambiguous and should be avoided, especially in situations (e.g., legislative or administrative) where precision is important.

Key differences between poverty thresholds and poverty guidelines are outlined in a table under Frequently Asked Questions (FAQs). See also the discussion of this topic on the Institute for Research on Poverty’s web site.

The January 2020 poverty guidelines are calculated by taking the 2018 Census Bureau’s poverty thresholds and adjusting them for price changes between 2018 and 2019 using the Consumer Price Index (CPI-U). The poverty thresholds used by the Census Bureau for statistical purposes are complex and are not composed of standardized increments between family sizes. Since many program officials prefer to use guidelines with uniform increments across family sizes, the poverty guidelines include rounding and standardizing adjustments.

+1 202.690.7858

maryland health connection℠

Medicaid Coverage for Marylanders

Who qualifies for Medicaid?

Medicaid and Maryland Children's Health Program offer free or low-cost health insurance coverage to more Marylanders than ever before. Medicaid now covers more adults, so you may qualify, even if you didn't in the past. Your children or other members of your household also may qualify even if you don't.

Check the chart below to see if you may qualify, based on your income and family size.

You may be eligible for Medicaid if your monthly income is up to approximately:					
If your household size is this	Adults	Children (MCHP)	Children (MCHP Premium*)		Pregnant Women
1	$1,468	$2,245	$2,809	$3,426	N/A
2	$1,983	$3,032	$3,794	$4,627	$3,794
3	$2,498	$3,819	$4,778	$5,828	$4,778
4	$3,014	$4,608	$5,766	$7,032	$5,766
5	$3,529	$5,395	$6,750	$8,234	$6,750
6	$4,043	$6,182	$7,735	$9,435	$7,735
7	$4,560	$6,971	$8,723	$10,639	$8,723
8	$5,074	$7,758	$9,707	$11,840	$9,707
Each person add	$515	$787	$985	$1,201	$985
You Pay	$0	$0	$57	$71	$0

Effective February 1, 2020 *Premium cost is per family/household each month.

When can I enroll? When does my coverage begin?

You can apply for Medicaid at any time. Enrollment is open year-round. If you are eligible for Medicaid, MCHP or MCHP Premium (low-cost coverage for higher-income children), coverage begins on the first day of the month that you applied.

You will renew your Medicaid or MCHP coverage once a year. You'll be contacted when it is time to renew.

If you're applying for Medicaid on the basis of being aged, blind, disabled or medically needy, or applying for the Qualified Medicare Beneficiary Program (QMB) or Specified Low-Income Medicare Beneficiary Program (SLMB), contact your **local Department of Social Services** for more information. You can apply for these benefits online at **mydhrbenefits.dhr.state.md.us**.

Medicaid Coverage for Marylanders

maryland health connection℠

How do I apply for Medicaid?

- Apply online at **MarylandHealthConnection.gov**
- Visit your local Department of Social Services
- Call **1-855-642-8572. Deaf and hard of hearing use Relay service**
- Find free, in-person help near you at **MarylandHealthConnection.gov/help**
- Download our free mobile app, **Enroll MHC**

What benefits are covered through Medicaid?

Your managed care organization through Medicaid covers the following benefits and more, at no cost:

- Visits to the doctor, including regular checkups and specialists
- Pregnancy care
- Family planning and birth control
- Prescription drugs
- Hospital and emergency services
- Primary mental health services through your doctor

Maryland Children's Health Program (MCHP) covers full health benefits for children up to age 19. Benefits for children include these and more:

- Doctor visits including regular checkups and visits when sick
- Immunizations like flu shots
- Prescriptions
- Hospitalizations, including lab work and tests
- Dental care
- Vision care

Is dental care covered?

Dental care is free for children and pregnant women enrolled in Medicaid and MCHP. Adults may have limited dental coverage through their **Managed Care Organization**. You also can buy a standalone dental plan through Maryland Health Connection during the annual Open Enrollment period each fall.

What immigration statuses are eligible for Medicaid?

Under most immigration statuses, you must be lawfully present in the U.S. for five years ("the five-year bar") before you are eligible for Medicaid. However, lawfully residing pregnant women and children under 21 (regardless of type of status) are not subject to the five-year requirement.

Regardless of immigration status, if you have had a recent medical emergency, you may be able to apply for emergency medical services, including labor and delivery. For more information, visit your local Department of Social Services.

To see if your immigration status may qualify you to enroll, visit **MarylandHealthConnection.gov** or find free, in-person help at **MarylandHealthConnection.gov/help**.

EXHIBIT 13

UNIVERSITY of MARYLAND MEDICAL CENTER

Department of Otorhinolaryngology - Head and Neck Surgery
James T. Frenkil Building
16 S. Eutaw St., Suite 500
Baltimore, MD 21201
410-328-6866

May 4, 2020

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

Dear Mr. Steffen:

The University of Maryland, Department of Otorhinolaryngology fully supports the efforts of University of Maryland Midtown SurgiCenter, LLC ("UM Midtown SurgiCenter") to establish an ambulatory surgery center on the University of Maryland Medical Center Midtown Campus. As Chair of the Department, I commit that the surgery volumes included in Table 1, would move to the proposed UM Midtown SurgiCenter if it were open today.

Table 1:

Physician	FY 2019 UMMC Midtown Campus	FY 2019 UMMC Downtown Campus	FY 2019 Total ASF Cases
Vakharia, Kalpesh Tarun	72	42	114
Eisenman, David J.		114	114
Guardiani, Elizabeth Anne	21	83	104
Hatten, Kyle Monroe	30	59	89
Wolf, Jeffrey S.		78	78
Gupta, Nidhi	66	6	72
Taylor, Rodney J	1	70	71
Hertzano, Ronna P.		56	56
Hebert, Andrea Michelle	29	19	48
Greywoode, Jewel Dunamis		29	29
Strome, Scott E.		2	2
Gray, William C.	1		1
TOTAL CASES	**220**	**558**	**778**
TOTAL Minutes (including actual avg TAT)	**32,783**	**94,101**	**126,884**
Minutes/Case	**149.0**	**168.6**	**163.1**

Table 2 includes the total surgical case volume projected for the University of Maryland, Department of Otorhinolaryngology Head and Neck Surgery at UM Midtown SurgiCenter for the first three full years of its operation.

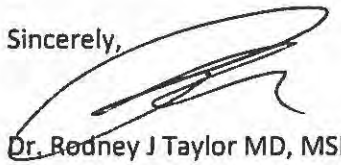
Table 2:

Department	FY 2023 Projected Cases	FY 2024 Projected Cases	FY 2025 Projected Cases
ENT Total Cases	797	802	807
TOTAL Minutes (including ASC TAT of 25 minutes)	**99,798**	**100,407**	**101,020**
Minutes/Case	**125.2**	**125.2**	**125.2**

The Department of Otorhinolaryngology Head and Neck Surgery believes the projections in Table 2 accurately reflect the total number of cases and minutes that will shift from the UMMC Downtown and Midtown Campuses and be performed at the UM Midtown SurgiCenter upon its opening by physicians within the Department. The projected volumes in Table 2 are based on the FY 2019 actual volumes listed in Table 1, but limited physician turnover is anticipated between now and when UM Midtown SurgiCenter opens. I fully expect that the physician volumes provided in Table 1 and 2 would be replaced by new physician recruits should the physicians listed in Table 1 leave the Department. The projections in Table 2 also include an assumption of increased population growth (0.61% annually) for the surgical service area. The Total Minutes (including the OR Time/Case and the average turnaround time ("TAT")) reflected in Table 2 are reasonable. I fully support the projected volumes anticipated for my Department at the UM Midtown SurgiCenter.

Developing a lower-cost setting to continue serving our patients is essential due to increased pressure from payers to move medically appropriate procedures to a lower-cost setting. I fully support the establishment of the UM Midtown SurgiCenter, which will allow the Department to continue serving its patients in a more cost-effective, medically appropriate, and convenient setting.

Sincerely,



Dr. Rodney J Taylor MD, MSPH, FACS
Professor, Chairman
Otorhinolaryngology- Head & Neck Surgery
University of Maryland School of Medicine

UNIVERSITY of MARYLAND MEDICAL CENTER

Department of General & Oncologic Surgery
22 S. Greene Street, 8th Floor
Baltimore, MD 21201
410-328-8777

May 4, 2020

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

Dear Mr. Steffen:

The University of Maryland, Department of General & Oncologic Surgery fully supports the efforts of University of Maryland Midtown SurgiCenter, LLC ("UM Midtown SurgiCenter") to establish an ambulatory surgery center on the University of Maryland Medical Center Midtown Campus. As Chief of the Division of General and Oncologic Surgery, I commit that the surgery volumes included in Table 1, would move to the proposed UM Midtown SurgiCenter if it were open today.

Table 1:

Physician	FY 2019 UMMC Midtown Campus	FY 2019 UMMC Downtown Campus	FY 2019 Total ASF Cases
Kavic, Stephen M.	136	63	199
Pearl, Jonathan Patrick	143	44	187
Bafford, Andrea Chao	119	37	156
Olson, John Ackerman	9	118	127
Birkett, Richard Talbot	93	13	106
Kligman, Mark D.	77	6	83
Turner, Douglas J.		70	70
Mavrophilipos, Zacharias V.	30		30
Jackson, Hope Tiffany	12	9	21
Guruswamy, Gopal	2		2
Bellavance, Emily Catherine	2		2
TOTAL CASES	**623**	**360**	**983**
TOTAL Minutes (including Actual Avg TAT)	**59,821**	**71,786**	**131,607**
Minutes/Case	**96**	**199.4**	**133.9**

Table 2 includes the total surgical case volume projected for the University of Maryland, Department of General Surgery at UM Midtown SurgiCenter for the first three full years of its operation.

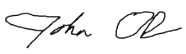
Table 2:

Department	FY 2023 Projected Cases	FY 2024 Projected Cases	FY 2025 Projected Cases
General Surgery Cases	**1,007**	**1,013**	**1,020**
TOTAL Minutes (including ASC TAT of 25 minutes)	**99,840**	**100,449**	**101,062**
Minutes/Case	**99.1**	**99.1**	**99.1**

The Department of General Surgery believes the projections in Table 2 accurately reflect the total number of cases and minutes that will shift from the UMMC Downtown and Midtown Campuses and be performed at the UM Midtown SurgiCenter upon its opening by physicians within the Department. The projected volumes in Table 2 are based on the FY 2019 actual volumes listed in Table 1, but limited physician turnover is anticipated between now and when UM Midtown SurgiCenter opens. I fully expect that the physician volumes provided in Table 1 and 2 would be replaced by new physician recruits should the physicians listed in Table 1 leave the Department. The projections in Table 2 also include an assumption of increased population growth (0.61% annually) for the surgical service area. The Total Minutes (including the OR Time/Case and the average turnaround time ("TAT")) reflected in Table 2 are reasonable. I fully support the projected volumes anticipated for my Department at the UM Midtown SurgiCenter.

Developing a lower-cost setting to continue serving our patients is essential due to increased pressure from payers to move medically appropriate procedures to a lower-cost setting. I fully support the establishment of the UM Midtown SurgiCenter, which will allow the Department to continue serving its patients in a more cost-effective, medically appropriate, and convenient setting.

Sincerely,



John Ackerman Olson, Jr, MD, PhD
Professor and Chief
Division of General & Oncologic Surgery
University of Maryland School of Medicine

UNIVERSITY of MARYLAND MEDICAL CENTER

Department of Ophthalmology and Visual Sciences,
University of Maryland School of Medicine
419 W. Redwood Street, Suite 470
Baltimore, MD 21201
(667) 214-1111

May 4, 2020

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

Dear Mr. Steffen:

The Department of Ophthalmology and Visual Sciences of the University of Maryland School of Medicine fully supports the efforts of University of Maryland Midtown SurgiCenter, LLC ("UM Midtown SurgiCenter") to establish an ambulatory surgery center on the University of Maryland Medical Center Midtown Campus. As Chair of the Department, I commit that the surgery volumes included in Table 1, would move to the proposed UM Midtown SurgiCenter if it were open today.

Table 1:

Physician	FY 2019 UMMC Midtown Campus	FY 2019 UMMC Downtown Campus	FY 2019 Total ASF Cases
Im, Lily T.	146		146
Munir, Wuqaas Mirza	111		111
Grumbine, Francis Lawson	108		108
Friedel, Samuel David	91		91
Jeng, Bennie Hau	66		66
Kaleem, Mona A.	54		54
Saeedi, Osamah Jawaid	45		45
Hemady, Ramzi K.	26		26
Levin, Moran	21		21
Schocket, Lisa S.	18		18
Alexander, Janet Leath	15	1	16
Swamy, Ramya Narasimha	14		14
Aouchiche, Rachid	5		5
Sheyman, Alan Tolly	3		3
Dastgir, Ghulam*	3		3
Idowu, Omolola Oladunni	2		2

Karim, Syed Abdul Sami		1	1
TOTAL CASES	**728**	**2**	**730**
TOTAL Minutes (including Actual Avg TAT)	**65,518**	**383**	**65,901**
Minutes/Case	**89.9**	**191.5**	**90.3**

*Physician not associated with University of Maryland School of Medicine

Table 2 includes the total surgical case volume projected for the Department of Ophthalmology and Visual Sciences of the University of Maryland School of Medicine at UM Midtown SurgiCenter for the first three full years of its operation.

Table 2:

Department	FY 2023 Projected Cases	FY 2024 Projected Cases	FY 2025 Projected Cases
Ophthalmology Cases	**748**	**753**	**757**
TOTAL Minutes (including ASC TAT of 25 minutes)	**56,553**	**56,898**	**57,245**
Minutes/Case	**75.6**	**75.6**	**75.6**

The Department of Ophthalmology and Visual Sciences believes the projections in Table 2 accurately reflect the total number of cases and minutes that will shift from the UMMC Downtown and Midtown Campuses and be performed at the UM Midtown SurgiCenter upon its opening by physicians within the Department. The projected volumes in Table 2 are based on the FY 2019 actual volumes listed in Table 1, but limited physician turnover is anticipated between now and when UM Midtown SurgiCenter opens. I fully expect that the physician volumes provided in Table 1 and 2 would be replaced by new physician recruits should the physicians listed in Table 1 leave the Department. The projections in Table 2 also include an assumption of increased population growth (0.61% annually) for the surgical service area. The Total Minutes (including the OR Time/Case and the average turnaround time ("TAT")) reflected in Table 2 are reasonable. I fully support the projected volumes anticipated for my Department at the UM Midtown SurgiCenter.

Developing a lower-cost setting to continue serving our patients is essential due to increased pressure from payers to move medically appropriate procedures to a lower-cost setting. I fully support the establishment of the UM Midtown SurgiCenter, which will allow the Department to continue serving its patients in a more cost-effective, medically appropriate, and convenient setting.

Sincerely,

Bennie H. Jeng, MD
Professor and Chair
Department of Ophthalmology and Visual Sciences
University of Maryland School of Medicine

UNIVERSITY of MARYLAND
MEDICAL CENTER

Department of Orthopaedics
110 S. Paca Street, 6th Floor, Suite 300
Baltimore, MD 21201
410-328-6040

May 4, 2020

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

Dear Mr. Steffen:

The University of Maryland, Department of Orthopaedics fully supports the efforts of University of Maryland Midtown SurgiCenter, LLC ("UM Midtown SurgiCenter") to establish an ambulatory surgery center on the University of Maryland Medical Center Midtown Campus. As Chair of the Department, I commit that the surgery volumes included in Table 1, would move to the proposed UM Midtown SurgiCenter if it were open today.

Table 1:

Physician	FY 2019 UMMC Midtown Campus	FY 2019 UMMC Downtown Campus	FY 2019 Total ASF Cases
Wynes, Jacob	128	1	129
Packer, Jonathan David	78	2	80
O'Toole, Robert V.	76		76
Nascone, Jason W.	71		71
Sciadini, Marcus F.	67	2	69
Abawi, Hummira H	51	1	52
Durrance, Emily Jo	49		49
Danna, Natalie R	39	1	40
Belgin, Brian J.	31		31
Ng, Vincent Y	14	9	23
Slobogean, M. Gerard-Paul	21		21
LeBrun, Christopher T.	17		17
Adib, Farshad	7		7
Manson, Theodore T.		6	6
Gilotra, Mohit N.	3	3	6
Pollak, Andrew N	5		5
Hasan, Syed A.	1	3	4
Akabudike, Ngozi Mogekwu		4	4

Henn, Ralph Frank	2		2
Koh, Eugene Young		1	1
TOTAL CASES	**660**	**33**	**693**
TOTAL Minutes (including Actual Avg TAT)	**120,128**	**7,320**	**127,448**
Minutes/Case	**182**	**221.8**	**183.9**

Table 2 includes the total surgical case volume projected for the University of Maryland, Department of Orthopaedics at UM Midtown SurgiCenter for the first three full years of its operation.

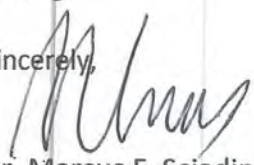
Table 2:

Department	FY 2023 Projected Cases	FY 2024 Projected Cases	FY 2025 Projected Cases
Orthopaedic Case	**710**	**714**	**719**
TOTAL Minutes (including ASC TAT of 25 minutes)	**92,358**	**92,921**	**93,488**
Minutes/Case	**130.1**	**130.1**	**130.1**

The Department of Orthopaedic Surgery believes the projections in Table 2 accurately reflect the total number of cases and minutes that will shift from the UMMC Downtown and Midtown Campuses and be performed at the UM Midtown SurgiCenter upon its opening by physicians within the Department. The projected volumes in Table 2 are based on the FY 2019 actual volumes listed in Table 1, but limited physician turnover is anticipated between now and when UM Midtown SurgiCenter opens. I fully expect that the physician volumes provided in Table 1 and 2 would be replaced by new physician recruits should the physicians listed in Table 1 leave the Department. The projections in Table 2 also include an assumption of increased population growth (0.61% annually) for the surgical service area. The Total Minutes (including the OR Time/Case and the average turnaround time ("TAT")) reflected in Table 2 are reasonable. I fully support the projected volumes anticipated for my Department at the UM Midtown SurgiCenter.

Developing a lower-cost setting to continue serving our patients is essential due to increased pressure from payers to move medically appropriate procedures to a lower-cost setting. I fully support the establishment of the UM Midtown SurgiCenter, which will allow the Department to continue serving its patients in a more cost-effective, medically appropriate, and convenient setting.

Sincerely,



Dr. Marcus F. Sciadini, MD
Professor, Chief of Orthopaedics at Midtown
Department of Orthopaedics
University of Maryland School of Medicine

EXHIBIT 14

Amerigroup
An Anthem Company

Provider update

Outpatient general surgery precertification initiative

Amerigroup Community Care requires outpatient general surgery procedures to be provided at an ambulatory surgery center (ASC) or provider office unless precertified at a hospital in the following counties: Baltimore City, Baltimore County, Howard County, Montgomery County and Prince George's County. Effective March 1, 2019, only the services that cannot be provided safely and effectively at a freestanding ASC or an office will be approved to be performed at the hospital.

What is the impact of this change?
Unless there is a medical reason for providing the outpatient general surgery procedure listed on the provided code list in a hospital, the services must be performed at a freestanding ASC or in an office. Members who are 18 years of age or younger are excluded from this initiative.

Providers should review Section 1 of this communication for a list of procedure codes that will require precertification to be performed in a hospital. For code-specific precertification requirements, please refer to https://providers.amerigroup.com/MD > Provider Resources & Documents > Quick Tools > select Precertification Lookup Tool.

Providers should review Section 2 for a list of participating ASCs that offer general surgery services.

This initiative applies to providers in Baltimore City, Baltimore County, Howard County, Montgomery County and Prince George's County and covers all general surgery codes listed on our provider website.

How do I obtain precertification?
You must call Provider Services at 1-800-454-3730 and provide clinical documentation showing a medical reason why the member needs to have an outpatient general surgery procedure done in a hospital.

What if I need assistance?
If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

Thank you for the quality care you provide to our members.

* Participating provider listings change periodically. For the latest list of participating ASCs offering general surgery services, see our provider directory at https://providers.amerigroup.com/MD or call Provider Services at 1-800-454-3730 to find the facility most convenient for your patient.

Medical necessity criteria
List of relevant case or member-specific facts that support the use of hospital-based or regulated space procedures. Reasons may include but are not limited to: • Ability of a freestanding site of service to safely and adequately accommodate and support the member in the course of treatment because of specialized equipment or staff skill set • Access or availability of a freestanding site of service within the 30-minute or 30-mile standard • Member is 18 years of age or younger • Suffering from any of the following conditions: o Respiratory disease ▪ Asthma ▪ Chronic obstructive pulmonary disease/emphysema ▪ Sleep apnea and actively using continuous positive airway pressure o Cardiac disease ▪ Congestive heart failure symptomatic in the last month (any episode of documented or active congestive heart failure, emergency room visit, admission, worsening chronic congestive heart failure, recent adjustment of medicines, etc.) ▪ Myocardial infarction within the last six weeks ▪ Arrhythmia within the last six weeks ▪ Pacemaker in place ▪ Automatic implantable cardioverter defibrillator in place ▪ On warfarin or another anticoagulant ▪ On Plavix® or another platelet inhibitor • Severe anemia/hematocrit <25%, platelets <30,000 • Morbid obesity/body mass index >40 • History of any complication with sedation, anesthesia or surgery

Section 1: Procedure codes required for precertification in a hospital

The following procedure codes will require precertification to be performed in a hospital.

Procedures performed in association with an ER visit or associated with an outpatient surgery performed at a hospital on the same day will not require precertification.

11042	11043	15823	15830	15832	17107	17110	17111	31231	31235
31237	31238	31254	31255	31256	31267	31575	31579	36430	36512
36514	47562	47563	49060	49083	49084	49320	49321	49322	49324
49329	49520	49521	49525	49550	49587	49650	49651	49652	49653
49654	49655	49656	64400	64402	64405	64417	64425	64430	64435
64447	64450	64479	64483	64484	64708	64713	64718	64721	

Section 2: Participating ASCs and providers

Baltimore County	
SurgiCenter of Baltimore 23 Crossroads Drive, Suite 100 Owings Mills, MD 21117	**White Marsh Surgery Center** 4924 Campbell Blvd. Nottingham, MD 21236
York Green Surgery Center LLC 1300 York Road, Suite 200 Lutherville-Timonium, MD 21093	
Howard County	
Ellicott City Ambulatory Surgery Center 2850 N. Ridge Road Ellicott City, MD 21043	**University of MD Medicine Ambulatory Surgery Center** 5900 Waterloo Road, Suite 120 Columbia, MD 21045
Maryland Surgeons Center of Columbia 11055 Little Patuxent Parkway, Suite L6 Columbia, MD 21044	
Montgomery County	
SurgCenter of Silver Spring LLC 8710 Cameron St., Suite 100 Silver Spring, MD 20910	**Capital Women's Care Specialty** 11400 Rockville Pike, Suite C25 Rockville, MD 20852
Prince George's County	
SurgCenter of Southern Maryland LLC 9001 Woodyard Road, Suite B Clinton, MD 20735	**Dimensions Healthcare System** 14999 Health Center Drive Bowie, MD 20716
Surgcenter of Greenbelt LLC 7300 Hanover Drive, Suite 102 Greenbelt, MD 20770	**University Center for Ambulatory Surgery** 6502 Kenilworth Ave., Suite 200 Riverdale, MD 20737

Amerigroup
An Anthem Company

Provider update

Outpatient orthopedic precertification initiative

Background: Amerigroup Community Care requires outpatient orthopedic procedures and surgeries to be provided at an ambulatory surgery center (ASC) or provider office unless precertified at a hospital in the following counties: Baltimore City, Baltimore County, Howard County, Montgomery County or Prince George's County. Effective October 1, 2019, only the services that cannot be provided safely and effectively at a freestanding ASC or office will be approved to be performed at the hospital.

What is the impact of this change?
Unless there is a medical reason for providing the outpatient orthopedic procedures and surgeries listed on the provided code list in a hospital, the services must be performed at a freestanding ASC or in an office. Members who are 18 years of age or younger are excluded from this initiative.

Review section one of this communication for a list of procedure codes that will require precertification to be performed in a hospital. For code-specific precertification requirements, please refer to https://providers.amerigroup.com/MD > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool.

This initiative applies to providers in Baltimore City, Baltimore County, Howard County, Montgomery County and Prince George's County and covers all orthopedic codes listed on our provider website.

How do I obtain precertification?
To obtain precertification, you must call Provider Services at 1-800-454-3730 and provide clinical documentation that identifies a medical reason requiring the member have an outpatient orthopedic procedure done in a hospital.

What if I need assistance?
If you have questions about this communication, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

Thank you for the quality care you provide to our members.

Note: Participating provider listings change periodically. For the latest list of participating ASCs offering services, see our provider directory at https://providers.amerigroup.com/MD or call Provider Services at 1-800-454-3730 to find the facility most convenient for your patient.

Medical necessity criteria
Provide a list of relevant case- or member-specific facts that support the use of hospital-based or regulated space procedures. Facts may include but are not limited to: • Ability of a freestanding site of service to safely and adequately accommodate and support the member in the course of treatment because of specialized equipment or staff skill set • Access or availability of a freestanding site of service within the 30-minute or 30-mile standard • Member is 18 years of age or younger • Member is suffering from any of the following conditions: o Respiratory disease: ▪ Asthma ▪ Chronic obstructive pulmonary disease/emphysema ▪ Sleep apnea and actively using continuous positive airway pressure o Cardiac disease: ▪ Congestive heart failure symptomatic within the last month (any episode of documented or active congestive heart failure, emergency room visit, admission, worsening chronic congestive heart failure, recent adjustment of medicines, etc.) ▪ Myocardial infarction within the last six weeks ▪ Arrhythmia within the last six weeks ▪ Pacemaker in place ▪ Automatic implantable cardioverter defibrillator in place ▪ On warfarin or another anticoagulant ▪ On Plavix® or another platelet inhibitor • Severe anemia/hematocrit < 25 percent, platelets < 30,000 • Morbid obesity/body mass index > 40 • History of any complication with sedation, anesthesia or surgery

Section one: procedure codes required for precertification in a hospital
The following procedure codes will require precertification to be performed in a hospital. Providers must identify a medical reason why the procedure must be performed in a hospital setting.

Procedures performed in association with an ER visit or associated with an outpatient surgery performed at a hospital on the same day will not require precertification.

Procedure codes requiring precertification in a hospital	
17107	Destruction, cutaneous vascular proliferative lesions — 10.0-50.0 sq. cm
17110	Destruction of benign lesions (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery or surgical curettement)
17111	Destruction of benign lesions (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery or surgical curettement)
20600	Arthrocentesis, aspiration or injection — small joint/bursa
20605	Arthrocentesis, aspiration or injection — intermediate joint/bursa
20610	Arthrocentesis, aspiration or injection — major joint/bursa
20611	Arthrocentesis, aspiration or injection, major joint or bursa (e.g., shoulder, hip, knee or subacromial bursa) — with ultrasound guidance, with permanent recording and reporting
20692	Application of a multiplane (pins or wires in more than one plane), unilateral or external fixation system (e.g., ilizarov)
20693	Adjustment or revision of external fixation system requiring anesthesia — e.g., new pin(s), new wire(s) or new ring(s)
20694	Removal, under anesthesia, external fixation system
25107	Arthrotomy, distal radioulnar joint with repair, triangular cartilage or complex
27093	Injection proc, hip arthrography — without anesthesia
29065	Application of cast — shoulder to hand (long arm)
29075	Application of cast — elbow to finger (short arm)
29085	Application of cast — hand and lower forearm (gauntlet)
29806	Arthroscopy, shoulder, surgical — capsulorrhaphy
29807	Arthroscopy, shoulder, surgical — repair or slap lesion
29822	Arthroscopy, shoulder, surgical — debridement (limited)
29823	Arthroscopy, shoulder, surgical — debridement (extensive)
29824	Arthroscopy, shoulder, surgical — distal claviculectomy with articular surface
29825	Arthroscopy, shoulder, surgical — with lysis and resection, or adhesions (with or without manipulation)
29826	Arthroscopy, shoulder, surgical — decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release — when performed list separately
29827	Arthroscopy, shoulder, surgical — with rotator cuff repair
29828	Arthroscopy, shoulder, surgical — biceps tenodesis

29834	Arthroscopy, elbow, surgical — with removal (loose/foreign body)
29846	Arthroscopy, wrist, surgical — excision/repair (triangular fibrocartilage/joint debridement)
29848	Endoscopy, wrist, surgical — with release (transverse carpal ligament)
29850	Arthroscopically aided treatment — fx, knee without or without manipulation — without internal/external fixation
29862	Arthroscopy, hip, surgical — with chondroplasty/arthroplasty, resection or labrum
29863	Arthroscopy, hip, surgical —with synovectomy
29867	Arthroscopy, knee, surgical — osteochondral allograft (e.g., mosaicplasty)
29870	Arthroscopy, knee, dx — with or without synovial bx (sep proc)
29873	Arthroscopy, knee, surgical — with lateral release
29874	Arthroscopy, knee, surgical — removal (loose/foreign body)
29875	Arthroscopy, knee, surgical — synovectomy, limited (sep proc)
29876	Arthroscopy, knee, surgical — synovectomy, major, two or more compartments (e.g., medial or lateral)
29877	Arthroscopy, knee, surgical — debridement/shaving, articular cartilage (chondroplasty)
29879	Arthroscopy, knee, surgical — abrasion arthroplasty (with chondroplasty), multiple drilling or microfx
29880	Arthroscopy, knee, surgical — with meniscectomy (medial and lateral, including any meniscal shaving) and debridement or shaving of articular cartilage (chondroplasty) — same or separate compartment(s), when performed
29881	Arthroscopy, knee, surgical — with meniscectomy (medial or lateral, including any meniscal shaving) and debridement or shaving of articular cartilage (chondroplasty) — when performed
29882	Arthroscopy, knee, surgical — with meniscus repair (medial or lateral)
29883	Arthroscopy, knee, surgical — with meniscus repair (medial and lateral)
29884	Arthroscopy, knee, surgical — with lysis, adhesions, and with or without manipulation (sep proc)
29888	Arthroscopically aided anterior cruciate ligament repair, augmentation or reconstruction
29889	Arthroscopically aided posterior cruciate ligament repair, augmentation or reconstruction
29914	Arthroscopy, hip, surgical — with femoroplasty (i.e., treatment of cam lesion)
20690	Application of a uniplane (pins or wires in one plane) — unilateral, external fixation system
20692	Application of a multiplane (pins or wires in more than one plane) — unilateral, external fixation system (e.g., ilizarov)
20693	Adjustment or revision of external fixation system requiring anesthesia — e.g., new pin(s), new wire(s) or new ring(s)
20694	Removal, under anesthesia, external fixation system
25105	Arthrotomy, wrist joint — with synovectomy
25107	Arthrotomy, distal radioulnar joint — with repair, triangular cartilage, complex
25111	Excision, ganglion, wrist (dorsal/volar) — primary
25112	Excision, ganglion, wrist (dorsal/volar) — recurrent

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Provider Update

This update contains pertinent information about changes that will impact the Johns Hopkins HealthCare provider network.

Procedures in Ambulatory Surgery Centers Prior Authorization Initiative

Effective August 1, 2018, Priority Partners and US Family Health Plan will require prior authorization for members, ages 18 and older, to receive certain outpatient gastroenterology, ophthalmology, urology or infusion services, diagnostic or surgical procedures in an outpatient hospital setting. A diagnostic or surgical procedure performed in a hospital setting will require a prior authorization and must meet medical necessity. The applicable CPT/HCPCS codes that require a prior authorization in a hospital setting are listed below.

Prior Authorization
Providers seeking to perform services in an outpatient hospital setting will need to submit a prior authorization request to Johns Hopkins HealthCare (JHHC) via fax at 410-424-4603. The prior authorization request should include all pertinent clinical information to support the medical necessity.

For services already scheduled to be performed in a hospital setting on or after August 1, 2018, please submit the prior authorization request to JHHC via fax as soon as possible. Failure to obtain a prior authorization may result in a denial of payment.

Johns Hopkins HealthCare medical policies can be found at: www.hopkinsmedicine.org > For Providers > Policies > Medical Policies.

Urology Codes

50590	51728	51784	52234	52310	52450	53265	54162	54700	55700
51040	51729	51797	52235	52315	52500	53275	54163	54830	57288
51102	51741	51798	52240	52317	52601	53500	54164	54840	
51710	51784	52000	52234	52320	52640	53620	54500	54860	
51715	51797	52001	52235	52327	52648	54000	54505	54865	
51720	51727	52005	52240	52332	53020	54060	54520	54900	
51725	51728	52204	52260	52351	53200	54100	54530	55000	
51726	51729	52214	52276	52352	53230	54105	54550	55040	
51727	51741	52224	52281	52353	53260	54161	54600	55250	

Please contact the JHHC Provider Relations department at 1-888-895-4998 with any questions or concerns

Gastroenterology Codes

43200	43241	43246	43250	45330	45335	45378	45382	45399
43236	43243	43247	43251	45332	45337	45380	45384	
43239	43244	43248	44380	45333	45338	45381	45388	

Ophthalmology Codes

65135	65426	65855	66172	66820	66986	67120	67318	67700	67875
65155	65430	65860	66180	66821	67005	67121	67343	67710	67880
65175	65435	65865	66220	66825	67010	67208	67345	67715	67882
65205	65436	65870	66250	66830	67015	67210	67346	67800	
65210	65450	65875	66680	66840	67025	67218	67400	67801	
65220	65600	65880	66682	66850	67027	67220	67405	67805	
65222	65730	65900	66700	66852	67028	67221	67412	67808	
65265	65780	65920	66710	66920	67030	67227	67413	67810	
65280	65782	65930	66711	66930	67031	67228	67414	67820	
65285	65800	66020	66720	66940	67036	67255	67415	67825	
65286	65810	66030	66740	66982	67039	67311	67500	67830	
65400	65815	66130	66761	66983	67040	67312	67505	67835	
65410	65820	66160	66762	66984	67041	67314	67515	67840	
65420	65850	66170	66770	66985	67042	67316	67550	67850	

Infusion Codes

J0129	J1602	J1745	J3262	J3357	J3380	J9310

PRUP15-SiteofServNonMD-PPUSFHP-(8/18)

Please contact the JHHC Provider Relations department at 1-888-895-4998 with any questions or concerns

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Provider Update

This update contains pertinent information about changes that will impact the Johns Hopkins HealthCare provider network.

Priority Partners and USFHP
Site of Service Change for ENT Services

Effective November 7, 2018, Johns Hopkins HealthCare LLC (JHHC) will require prior authorization and clearance for medical necessity for certain Ear, Nose, and Throat (ENT) procedures performed in an outpatient hospital setting. This policy affects both the Priority Partners and the Johns Hopkins US Family Health Plans (USFHP) lines of business and impacts members of all ages.

The outpatient hospital setting, classified by Place of Service 22, may also be known as "regulated space" within the state of Maryland. This change applies to all hospitals in the networks, both inside and outside of Maryland.

Procedure Codes

The affected procedure codes are listed below:

21188	29800	30140	30450	42820	42831	69433
21198	29804	30400	30460	42821	42835	69436
21199	30110	30410	30462	42825	42836	
21206	30115	30430	30520	42826	69420	
21299	30130	30435	42145	42830	69421	

Prior Authorization Process

Prior authorization requests to our Utilization department (UM) must be submitted only via the FAX numbers listed below:

- **Priority Partners: 410-762-5205** or **410-424-4603**
- **USFHP: 410-762-5205** or **410-424-4603**

For a listing of participating providers and freestanding ambulatory surgery centers, please go to www.hopkinsmedicine.org/johns_hopkins_healthcare/provider_search.html or access the HealthLINK portal at pp.healthtrioconnect.com/app/index.page for Priority Partners members and usfhp.healthtrioconnect.com/app/index.page for USFHP members.

Please contact the JHHC Provider Relations department at 888-895-4998 with any questions or concerns

Priority Partners Managed Care Organization (PPMCO)

Outpatient Referral & Preauthorization Guidelines

February 2020 | This list is **NOT ALL INCLUSIVE**

Overview

- To verify benefit coverage call: 800-654-9728
- **All CPT codes classified as Category III and all HCPCS codes classified as "Unlisted" by the American Medical Association require preauthorization**
- JHHC medical policies may be helpful in supporting some preauthorization requirements for certain procedures, and can be located at: *www.jhhc.com > For Providers > Policies*
- **All services rendered by non-participating providers require preauthorization**
- Laboratory, radiology and pharmacy policies and guidelines can be found at: *www.jhhc.com*
- For additional information about Priority Partners, refer to the website at: *www.jhhc.com*

Provider-Administered Specialty Medications Preauthorization Required

- Some medications that are administered by a provider, or under supervision of a provider, and processed through the member's medical benefit may be subject to prior authorization.
- Providers may supply these medications and bill the health plan for the medication and related administration using HCPCS Codes or J codes.
- **View the HCPCS Codes** that require prior authorization for PPMCO

No Notification or Preauthorization Required

This section lists the services that do not require a referral or preauthorization

- For services provided by participating providers in-office (Place of Service 11), outpatient hospital (Place of Service 22), or ambulatory surgery centers (Place of Service 24) by specialties listed below, no referral or preauthorization is required unless listed in the Referral Required and/or Preauthorization sections

To ensure coordination of care, the referring physician must provide the member with a referral or script detailing the specialist services needed **(No paperwork needs to be submitted to the health plan)**

- Allergy
- Blood Transfusions
- Cardiology
- Chiropractic Treatment*
- Coumadin Clinics
- Dermatology
- Dialysis
- Endocrinology
- Exhaled Nitric Oxide Measurement*
- General Surgery
- Gynecology
- Hematology
- Infectious Disease
- Nephrology
- Neurology
- Oncology
- Oral Surgery
- Orthopedics
- Pain Management
- Perinatology
- Podiatry
- Routine Foot Care (Metabolic, neurologic, or vascular disease – refer to COMAR 10.09.15)
- Pulmonology
- Rheumatology
- Skin Tag Removal*
- Urgent Care Centers

Notification Required

This section lists the services that require a referral from the Primary Care Physician (PCP)

- Fax the universal referral form for services listed below for in-office (Place of Service 11) or outpatient hospital (Place of Service 22) settings to Outpatient Intake Services at: 410-424-4603
- For urgent requests (delay will seriously jeopardize the life or health of a member, or severe pain), mark URGENT and fax to: 410-424-4603
- Obstetrical Care (global pregnancy)

Preauthorization Required

This section lists the services that require preauthorization

1. Fax pertinent clinical documentation to Medical Review at: 410-762-5205
   a. The health plan will perform medical review of requested services before they are rendered
   b. The requesting provider will be notified of all preauthorization decisions
2. Fax documentation for all durable medical equipment (DME)/durable medical services (DMS) to Medical Review at: 410-762-5250
3. For urgent requests (delay will seriously jeopardize the life or health of a member, or severe pain), mark URGENT and fax to: 410-762-5205
4. To check authorization status, access your HealthLINK@Hopkins account by visiting *www.jhhc.com*

- Audiology
- Back Pain Invasive Procedures (facet blocks, radiofrequency ablation)
- Bariatric Surgery*
- Biofeedback*
- Breast Reduction Male/Female*
- Bronchial Thermoplasty*
- Capsule Endoscopy
- Cardiac Rehabilitation*
- Clinical Trials (including NCI trials)*
- DME/DMS
- Elastography*
- Electroretinography
- External Beam Radiation Therapy (Prostate Cancer Only)*
  - Three Dimensional Conformal Radiation Therapy (3D-CRT)
  - Intensity Modulated Radiation Therapy (IMRT)
  - Stereotactic Radiation Therapy (SBRT)
- Extracorporeal Shockwave Therapy for Plantar Fasciitis
- Feeding Programs*
- Food Supplements < 21 years of age
- Gender Affirmation Treatment and Procedures* (Limitations & Exclusions)
- Genetic Testing*
- GERD Devices*
- Hearing Aids
- Home Health Aides
- Home Health Care
- Hospice*
- Hyperbaric Oxygen Therapy
- Implanted Devices for Hearing Loss*
- Laser Treatment for Skin Conditions*
- Medical Injectables*
- Minimally Invasive Treatments of Varicosities*
- Neuropsychological Testing
- Neurostimulators
- Nutritional Counseling
- Occupational Therapy > 12 visits (≥ 21 years of age)
- Orthotics*
- Osteogenic Stimulation for Fractures
- Otolaryngology
- Palliative Care*
- Pharmacogenomics Genotyping*
- Physical Therapy > 12 visits (≥ 21 years of age
- Plastic Surgery (cosmetic procedures not covered)*
- Prenatal Obstetrical Ultrasound (beyond 3 and all 3D ultrasounds)*
- Private Duty Nursing < 21 years of age
- Prostate Surgery*
- Prosthetics*
- Proton Beam Radiotherapy*
- Psychological Testing
- Pulmonary Rehabilitation*
- Pulse Oximetry at Home*
- PUVA - Phototherapy*
- Radiology
  - Abdomen CT
  - Brain MRI
  - Breast MRI
  - Calcium Scoring (Electron Beam Computed Tomography)*
  - Cervical and Lumbar Spine MRI
  - Chest CT
  - Heart CT/Angiography*
  - Lower Extremity MRI
  - Pelvis CT
  - Sinus Cavity CT
  - PET - Positron Emission Tomography*
- Reconstructive Surgery
  - Alveolectomy/Alveoplasty
  - Blepharoplasty, Brow Ptosis, Entropion, Ectropion*
  - Rhinoplasty/Septoplasty
  - Uvulectomy, palatopharyngoplasty, LAUP (Laser Assisted Uvuloplasty)
- Sclerotherapy
- Speech Therapy > 12 visits (≥ 21 years of age)
- Telemedicine/Telehealth*
- TMJ Treatment
- Transcranial Magnetic Stimulation (TMS)
- Transplants (except corneal)*
- Treatment of Acne and Actinic Keratosis*
- Vitamin and Mineral Supplements < 21 years of age
- Wound Clinic > 10 Visits
- Wound Vac

Site of Service Preauthorization Required

This section lists the services that require preauthorization in all outpatient hospital setting – place of service (POS) 22

1. Fax pertinent clinical documentation to support the outpatient hospital setting: 410-424-4603
2. To verify applicable codes/procedures refer to **JHHC Provider Communications Repository** or **Medical Policies** – CMS23.05 Site of Service

- Select Urology Services – 18 years of age and older
- Select Gastroenterology Services – 18 years of age and older
- Select Ophthalmology Services – 18 years of age and older
- Select ENT Services – members of all ages
- Sleep Studies – 18 years of age and older

Commonly Requested Non-Covered Services

This section lists the commonly requested non-covered services that are not part of the Priority Partners benefit

- Abortion Procedure (elective)
- Acupuncture ≥ 21 years of age
- Ambulance Outpatient, non-emergency
- Autopsy
- Chiropractic Treatment ≥ 21 years of age
- Commercial Weight Management Programs
- Cosmetic Procedures*
- DME/DMS
  - Bed Boards
  - Dentures
  - Grab Bars
  - Heating Pads or Lamps
  - Hot Water Bottles
  - Ice Bags
  - Raised Toilet Seats
  - Tray Tables
  - Wheelchair Tray Table
  - Whirlpools/Whirlpool Bath Equipment
- Food Supplements ≥ 21 years of age
- Immunizations for Elective Travel
- Impotence Therapy
- Infertility Services
- Interferential Therapy*
- LASIK Eye Surgery
- Learning Disabilities (refer to school system)
- Long-Term External Cardiac Event Monitoring (Zio Patch)*
- Massage Therapy
- Naturopathic Treatment
- Observation (24 hours and greater are NOT COVERED)*
- Occupational Therapy < 21 years of age (refer to MDH)
- Orthodontia ≥ 21 years of age
- Physical Therapy < 21 years of age (refer to MDH)
- Podiatry – Routine Foot Care (Except metabolic, neurologic, or vascular disease – refer to COMAR 10.09.15)
- Private Duty Nursing ≥ 21 years of age
- Speech Therapy < 21 years of age (refer to MDH)
- Sterilization Reversal
- Ultrasound/CT Scan for Bone Density
- Vitamin and Mineral Supplements ≥ 21 years of age

Non-Covered Investigational Services

This section lists the non-covered investigational services that are not part of the Priority Partners benefit

- Breast Ductal Lavage*
- IDET - Intradiscal Electrothermal Therapy*
- Investigational Health Services/Equipment (not FDA approved)
- Pulse Electrical Stimulation for OA of the Knee*

Resources

This section lists the resources that may be helpful in meeting the needs of the Priority Partners member

ACCU-CHECK
Call: 888-355-4242 to request a voucher to take to pharmacy

Behavioral Health and Substance Abuse
Call Optum Maryland at: 800-888-1965

ADHD Treatment by Specialist
Call Optum Maryland at: 800-888-1965

Vision Services
Contact Superior Vision at: 800-428-8789

Audiology (including hearing aids), Occupational, Physical, & Speech Therapy < 21 years of age
Call MDH at: 877-463-3464

Utilization Management
Call: 410-424-4480 or 800-261-2421
FAX: 410-424-4603

Customer Service
Call: 800-654-9728

Dental Services
For adults 21 and over, call DentaQuest at: 888-696-9596
For pregnant women and children, call Scion at: 855-934-9812

JHHC Website (for providers)
www.jhhc.com

Pharmacy Preauthorization Requests
Call Pharmacy Dept. at: 888-819-1043, option 4

Priority Partners Website (for members)
www.ppmco.org

*For related medical policies, please go to: *www.jhhc.com > For Providers > Policies*

EXHIBIT 15

CRGA DESIGN

January 03, 2020

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: UMMC Midtown
CON Application for a New Ambulatory Surgery Center

To Whom It May Concern:

CRGA Design is the architectural firm designing the proposed Ambulatory Surgery Center to be fit out within the Medical Office Building located at 800 Linden Avenue on the UMMC Midtown campus. I am writing this letter of attestation to confirm that the architectural design of the proposed Ambulatory Surgery Center complies with Section 3.7 and other applicable provisions of the FGI Guidelines for the Design and Construction of Hospitals and Outpatient Facilities.

Sincerely,

David L. Peabody
Principal
CRGA Design

EXHIBIT 16

Orthopaedic Procedures

5 Most Frequently Performed Surgeries by Primary Procedure, Two Most Recent Years		
Surgical Procedure	**FY 2018**	**FY 2019**
REMOVAL OF IMPLANT; DEEP (EG, BURIED WIRE, PIN, SCREW, METAL BAND, NAIL, ROD OR PLATE)	184	113
REMOVAL, UNDER ANESTHESIA, OF EXTERNAL FIXATION SYSTEM	39	22
CORRECTION, HAMMERTOE (EG, INTERPHALANGEAL FUSION, PARTIAL OR TOTAL PHALANGECTOMY)	33	25
HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; WITH METATARSAL OSTEOTOMY (EG, MITCHELL, CHEVRON, OR CONCENTRIC TYPE PROCEDURES)	26	23
ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCECTOMY (MEDIAL OR LATERAL, INCLUDING ANY MENISCAL SHAVING)	26	20

Source: HSCRC Abstract Data from EPIC EHR

Ophthalmology Procedures

5 Most Frequently Performed Surgeries by Primary Procedure, Two Most Recent Years		
Surgical Procedure	**FY 2018**	**FY 2019**
EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (ONE STAGE PROCEDURE), MANUAL OR MECHANICAL TECHNIQUE (EG, IRRIGATIONAND ASPIRATION OR PHACOEMULSIFICATION)	382	313
XCAPSULAR CTRCT REM W INS, IOL PRSTH,MAN/MECH TECHN,CMPLX,REQ S/TECHNS NO GENLY USED ROUTINE CTRCT SX(EG,IRIS XPANS N,SUT SUPP,IOL,/1 PST CAPSULORRHEXIS)/PERF PTS THE AMBLYOGENIC DEVEL STAGE	57	92
CILIARY BODY DESTRUCTION; CYCLOPHOTOCOAGULATION	20	41
AQUEOUS SHUNT TO EXTRAOCULAR RESERVOIR (EG, MOLTENO, SCHOCKET, DENVER-KRUPIN)	22	27
STRABISMUS SURGERY, RECESSION OR RESECTION PROCEDURE; ONE HORIZONTAL MUSCLE	13	26

Source: HSCRC Abstract Data from EPIC EHR

Otorhinolaryngology Procedures

5 Most Frequently Performed Surgeries by Primary Procedure, Two Most Recent Years		
Surgical Procedure	**FY 2018**	**FY 2019**
LARYNGOSCOPY, DIRECT, OPERATIVE, WITH BIOPSY; WITH OPERATING MICROSCOPE	53	73
LARYNGOSCOPY, DIRECT, OPERATIVE, WITH EXCISION OF TUMOR AND/OR STRIPPING OF VOCAL CORDS OR EPIGLOTTIS; WITH OPERATING MICROSCOPE	41	41
TYMPANOPLASTY W/O MASTOIDECTOMY (INC CANALPLASTY, ATTICOTOMY AND/OR MIDDLE EAR SURGERY), INITIAL OR REVISION; WITHOUT OSSICULAR CHAIN RECONSTRUCTION	36	45
TONSILLECTOMY, PRIMARY OR SECONDARY; AGE 12 OR OVER	41	35
NASAL/SINUS ENDOSCOPY, SURGICAL, WITH MAXILLARY ANTROSTOMY; WITH REMOVAL OF TISSUE FROM MAXILLARY SINUS	52	22

Source: HSCRC Abstract Data from EPIC EHR

General Surgery Procedures

5 Most Frequently Performed Surgeries by Primary Procedure, Two Most Recent Years		
Surgical Procedure	**FY 2018**	**FY 2019**
PARATHYROIDECTOMY OR EXPLORATION OF PARATHYROID(S);	128	125
REPAIR INITIAL INGUINAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE	76	72
LAPAROSCOPY, SURGICAL; CHOLECYSTECTOMY	65	61
LAPAROSCOPY, SURGICAL, REPAIR, VENTRAL, UMBILICAL, SPIGELIAN OR EPIGASTRIC HERNIA	57	44
UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, STOMACH, AND EITHER THE DUODENUM AND/OR JEJUNUM AS APPROPRIATE; DIAGNOSTIC, W W/O COLLECTIONOF SPECIMEN(S) BY BRUSHING/WASHING (SEP PROCEDURE)	43	50

Source: HSCRC Abstract Data from EPIC EHR

EXHIBIT 17

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Financial Statements and Schedules

June 30, 2019 and 2018

(With Independent Auditors' Report Thereon)

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

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KPMG LLP
750 East Pratt Street, 18th Floor
Baltimore, MD 21202

Independent Auditors' Report

The Board of Directors
University of Maryland Medical System Corporation:

We have audited the accompanying consolidated financial statements of the University of Maryland Medical System Corporation and its subsidiaries (the Corporation), which comprise the consolidated balance sheets as of June 30, 2019 and 2018, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the University of Maryland Medical System Corporation and its subsidiaries as of June 30, 2019 and 2018, and the results of their operations, changes in net assets and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Emphasis of Matter

As discussed in note 1(aa) to the consolidated financial statements, the Corporation adopted Accounting Standards Update (ASU) No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*, and ASU No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*, during the year ended June 30, 2019 on a modified retrospective basis. Our opinion is not modified with respect to these matters.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary information in Schedules 1-8 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

Baltimore, Maryland
October 28, 2019

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2019 and 2018

(In thousands)

Assets	2019	2018
Current assets:		
Cash and cash equivalents	$ 360,318	397,243
Assets limited as to use, current portion	64,910	56,484
Accounts receivable:		
Patient accounts receivable, net	458,437	431,665
Other	91,103	88,718
Inventories	70,478	70,776
Assets held for sale	116,828	139,120
Prepaid expenses and other current assets	48,055	41,115
Total current assets	1,210,129	1,225,121
Investments	885,640	859,905
Assets limited as to use, less current portion	1,227,384	1,142,707
Property and equipment, net	2,309,086	2,165,466
Investments in joint ventures	91,942	88,063
Other assets	409,188	548,201
Total assets	$ 6,133,369	6,029,463
Liabilities and Net Assets		
Current liabilities:		
Trade accounts payable	$ 288,841	267,396
Accrued payroll and benefits	281,177	262,201
Advances from third-party payors	139,163	153,867
Lines of credit	161,300	99,300
Short-term financing	150,000	150,000
Other current liabilities	127,760	151,163
Liabilities held for sale	60,830	86,834
Long-term debt subject to short-term remarketing arrangements	18,895	58,054
Current portion of long-term debt	47,621	51,989
Total current liabilities	1,275,587	1,280,804
Long-term debt, less current portion and amount subject to short-term remarketing arrangements	1,484,960	1,508,334
Other long-term liabilities	439,024	395,447
Interest rate swap liabilities	196,174	149,789
Total liabilities	3,395,745	3,334,374
Net assets:		
Without donor restrictions	1,973,405	1,952,422
With donor restrictions	764,219	742,667
Total net assets	2,737,624	2,695,089
Total liabilities and net assets	$ 6,133,369	6,029,463

See accompanying notes to consolidated financial statements.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2019 and 2018

(In thousands)

	2019	2018
Operating revenue, gains, and other support:		
Net patient service revenue	$ 4,017,054	3,877,341
State and county support	41,521	40,374
Other revenue	176,699	150,856
Total operating revenue, gains, and other support	4,235,274	4,068,571
Operating expenses:		
Salaries, wages and benefits	2,158,136	2,020,075
Expendable supplies	792,015	758,252
Purchased services	634,618	615,978
Contracted services	269,897	275,376
Depreciation and amortization	244,056	236,090
Interest expense	57,792	55,627
Total operating expenses	4,156,514	3,961,398
Income from continuing operations	78,760	107,173
Nonoperating income and expenses, net:		
Unrestricted contributions	5,607	12,377
Inherent contribution – Capital Region	—	41,772
Equity in net income of joint ventures	3,624	5,489
Investment income, net	30,632	37,465
Change in fair value of investments	24,421	23,976
Change in fair value of undesignated interest rate swaps	(47,995)	43,071
Other nonoperating losses, net	(33,045)	(27,120)
Excess of revenues over expenses from continuing operations	$ 62,004	244,203
Loss on discontinued operations	(25,847)	(27,366)
Excess of revenues over expenses	$ 36,157	216,837

(continuted)

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2019 and 2018

(In thousands)

	Without donor restrictions	With donor restrictions	Total
Balance at June 30, 2017	$ 1,711,329	304,535	2,015,864
Excess of revenues over expenses	216,837	—	216,837
Inherent contribution – Capital Region	—	418,243	418,243
Investment gains, net	—	2,967	2,967
State support for capital	—	3,209	3,209
Contributions, net	—	17,086	17,086
Net assets released from restrictions used for operations and nonoperating activities	—	(3,956)	(3,956)
Net assets released from restrictions used for purchase of property and equipment	3,484	(3,484)	—
Change in economic and beneficial interests in the net assets of related organizations	—	2,731	2,731
Change in ownership interest of joint ventures	—	1,301	1,301
Amortization of accumulated loss of discontinued designated interest rate swap	1,668	—	1,668
Change in funded status of defined benefit pension plans	16,287	—	16,287
Asset reclassifications at request of donor	1,145	(1,145)	—
Other	1,672	1,180	2,852
Increase in net assets	241,093	438,132	679,225
Balance at June 30, 2018	1,952,422	742,667	2,695,089
Excess of revenues over expenses	36,157	—	36,157
Investment gains, net	—	1,666	1,666
State support for capital	—	5,565	5,565
Contributions, net	—	26,782	26,782
Net assets released from restrictions used for operations and nonoperating activities	—	(4,279)	(4,279)
Net assets released from restrictions used for purchase of property and equipment	14,130	(14,130)	—
Change in economic and beneficial interests in the net assets of related organizations	—	1,982	1,982
Change in ownership interest of joint ventures	68	1,178	1,246
Amortization of accumulated loss of discontinued designated interest rate swap	1,610	—	1,610
Change in funded status of defined benefit pension plans	(26,886)	—	(26,886)
Other	(4,096)	2,788	(1,308)
Increase in net assets	20,983	21,552	42,535
Balance at June 30, 2019	$ 1,973,405	764,219	2,737,624

See accompanying notes to consolidated financial statements.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2019 and 2018

(In thousands)

	2019	2018
Cash flows from operating activities:		
Increase in net assets from continuing operations	$ 42,535	679,225
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	244,056	236,090
Amortization of bond premium and deferred financing costs	1,477	1,477
Net realized gains and change in fair value of investments	(41,626)	(53,029)
Equity in net income of joint ventures	(3,624)	(5,489)
Change in economic and beneficial interests in net assets of related organizations	(1,982)	(3,776)
Change in fair value of interest rate swaps	46,385	(44,735)
Change in funded status of defined benefit pension plans	26,886	(16,287)
Inherent contribution – Capital Region	—	(460,015)
Restricted contributions, grants and other support, net	(22,503)	(17,086)
Change in operating assets and liabilities:		
Patient accounts receivable	(26,772)	(10,470)
Other receivables, prepaid expenses, other current assets and other assets	152,963	92,974
Inventories	298	(4,778)
Trade accounts payable, accrued payroll and benefits, other current liabilities and other long-term liabilities	14,617	(14,294)
Change in contingent consideration	—	(35,700)
Advances from third-party payors	(14,704)	21,926
Net cash provided by operating activities	418,006	366,033
Cash flows from investing activities:		
Purchases and sales of investments and assets limited as to use, net	(98,911)	(347,160)
Purchases of alternative investments	(66,267)	(64,375)
Sales of alternative investments	89,948	38,938
Cash acquired in contribution from Capital Region	—	46,626
Purchases of property and equipment	(394,588)	(217,153)
(Contributions to)/distributions from joint ventures, net	(1,238)	3,527
Net cash used in investing activities	(471,056)	(539,597)

(Continued)

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2019 and 2018

(In thousands)

		2019	2018
Cash flows from financing activities:			
Proceeds from long-term debt	$	10,016	190,928
Repayment of long-term debt and capital leases		(78,394)	(44,577)
Draws (repayments) on lines of credit, net		62,000	(25,700)
Payment of debt issuance costs		—	(2,255)
Restricted contributions, grants and other support		22,503	17,086
Net cash provided by financing activities		16,125	135,482
Net decrease in cash and cash equivalents		(36,925)	(38,082)
Cash and cash equivalents, beginning of year		397,243	435,325
Cash and cash equivalents, end of year	$	360,318	397,243
Cash flows from discontinued operations:			
Operating Activities	$	2,150	10,615
Investing Activities		(3,131)	(2,710)
Financing activities		—	—
Supplemental disclosures of cash flow information:			
Cash paid during the year for interest, net of amounts capitalized	$	58,860	59,716
Amount included in accounts payable for construction in progress		35,414	28,502
Supplemental disclosures of noncash information:			
Capital leases	$	427	1,077
Contributed from Capital Region		—	*

* See footnote 1(a)(x) for detail of noncash contributions from Capital Region.

See accompanying notes to consolidated financial statements.

(1) Organization and Summary of Significant Accounting Policies

(a) Organization

The University of Maryland Medical System Corporation (the Corporation or UMMS) is a private, not-for-profit corporation providing comprehensive healthcare services through an integrated regional network of hospitals and related clinical enterprises. UMMS was created in 1984 when its founding hospital was privatized by the State of Maryland. Prior to that time, the founding hospital was state-owned, operated and financed as part of the University of Maryland, now a part of the University System. As part of the privatization process, the Maryland General Assembly and the University of Maryland's Board of Regents adopted legislation (the "Governance Legislation") separating the major health care delivery components from the University System to UMMS. This Governance Legislation provides for certain level of oversight by the State of Maryland to ensure UMMS' founding purposes are consistently set forth in its functions and operating practices. The Corporation monitors compliance with all requirements of the Governance Legislation.

Over its 35-year history, UMMS evolved into a multi-hospital system with academic, community and specialty service missions reaching primarily across Maryland. In continuing partnership with the University of Maryland School of Medicine, UMMS operates healthcare programs that improve the physical and mental health of thousands of people each day.

The accompanying consolidated financial statements include the accounts of the Corporation, its wholly owned subsidiaries, and entities controlled by the Corporation. In addition, the Corporation maintains equity interests in various unconsolidated joint ventures, which are described in note 4. The significant operating divisions of the Corporation are described in further detail below.

All material intercompany balances and transactions have been eliminated in consolidation.

(i) Recent Acquisitions and Divestitures

During the year ended June 30, 2019, the Corporation approved a plan to sell the assets and liabilities of University of Maryland Medical System Health Plans, Inc. The sale, which will include both the Medicaid Plan and Medicare Advantage Plan, is expected to be completed within the next 12 months. Based on the criteria in Accounting Standards Codification (ASC) Topic 205, *Discontinued Operations*, it was determined that the pending sale met the criteria for discontinued operations treatment. The carrying amount of the assets and liabilities held for sale are stated at their net realizable value as of June 30, 2019 and any gain or loss on the sale is considered to be immaterial to the consolidated financial statements of the Corporation. As of June 30, 2019 and 2018, assets held for sale were approximately $116,800 and $139,100 and liabilities held for sale were approximately $60,800 and $86,800, respectively. For the years ended June 30, 2019 and 2018, operating revenues from discontinued operations were approximately $379,630 and $357,099, respectively. For the years ended June 30, 2019 and 2018, operating expenses from discontinued operations were approximately $406,593 and $388,693, respectively.

Effective September 1, 2017, the Corporation entered into an affiliation agreement with Dimensions Healthcare System and Subsidiaries (DHS) whereby the Corporation became the sole corporate member of DHS. DHS has changed its trade name to University of Maryland Capital Region Health (Capital Region) located in Prince George's County, Maryland, and includes one acute care

hospitals, one free standing medical facility (FMF), ambulatory and outpatient facilities, and other subsidiaries.

The transaction is described in more detail in note 1(a)(x).

(ii) University of Maryland Medical Center (Medical Center)

The Medical Center, which is a major component of UMMS, is a 767-bed academic medical center located in Baltimore. The Medical Center has served as the teaching hospital of the School of Medicine of the University System of Maryland, Baltimore since 1823. As part of the privatization in 1984, only clinical faculty members of the School of Medicine may serve as medical staff of the Medical Center.

The Medical Center is comprised of two operating divisions: University Hospital, which includes the Greenebaum Cancer Center, and Shock Trauma Center. University Hospital, which generates approximately 80% of the Medical Center's admissions and patient days, is a tertiary teaching hospital providing over 70 clinical services and programs. The Greenebaum Cancer Center specializes in the treatment of cancer patients and is a site for clinical cancer research. The Shock Trauma Center, which specializes in emergency treatment of patients suffering severe trauma, generates approximately 20% of admissions and patient days.

The Medical Center's operations include UniversityCARE, LLC (UCARE), a physician hospital organization of which the Corporation owns a majority ownership interest and therefore consolidates, and 36 South Paca Street, LLC, a wholly owned subsidiary of the Corporation that operates a residential apartment building.

The Corporation has certain agreements with various departments of the University of Maryland School of Medicine concerning the provision of professional and administrative services to the Corporation and its patients. Total expense under these agreements in the years ended June 30, 2019 and 2018 was approximately $159,043 and $163,321, respectively.

(iii) University of Maryland Rehabilitation and Orthopaedic Institute (ROI)

ROI is comprised of a medical/surgical and rehabilitation hospital in Baltimore with 137 licensed beds, which includes rehabilitation beds, chronic care beds, medical/surgical beds, and off-site physical therapy facilities.

A related corporation, The James Lawrence Kernan Endowment Fund, Inc. (Kernan Endowment), is governed by a separate, independent board of directors and is required to hold investments and income derived therefrom for the exclusive benefit of ROI. Accordingly, the accompanying consolidated financial statements reflect an economic interest in the net assets of the Kernan Endowment.

(iv) University of Maryland Medical Center Midtown Campus (Midtown)

Midtown is located in Baltimore city and is comprised of University of Maryland Midtown Hospital (UM Midtown), with 170 licensed beds, including 90 acute care beds and 80 chronic care beds and a wholly owned subsidiary providing primary care.

(v) University of Maryland Baltimore Washington Medical System, Inc. (Baltimore Washington)

Baltimore Washington is located in Anne Arundel County, a suburb of Baltimore city, and is a health system comprised of University of Maryland Baltimore Washington Medical Center (UM Baltimore Washington), a 288-bed acute care hospital providing a broad range of services, and several wholly owned subsidiaries providing emergency physician and other services.

Baltimore Washington Medical Center Foundation, Inc. (BWMC Foundation) is governed by a separate, independent board of directors and is required to hold investments and income derived therefrom for the exclusive benefit of UM Baltimore Washington. Accordingly, the accompanying consolidated financial statements reflect an economic interest in the net assets of the BWMC Foundation.

(vi) University of Maryland Shore Regional Health System (Shore Regional)

Shore Regional is a health system located on the Eastern Shore of Maryland. Shore Regional owns and operates University of Maryland Memorial Hospital (UM Memorial), a 140-bed acute care hospital providing inpatient and outpatient services in Easton, Maryland; University of Maryland Dorchester Hospital (UM Dorchester), a 48-bed acute care hospital providing inpatient and outpatient services in Cambridge, Maryland; University of Maryland Chester River Hospital Center (UM Chester River), a 26-bed acute care hospital providing inpatient and outpatient services to the residents of Kent and Queen Anne's counties; Shore Emergency Center at Queenstown (Shore Emergency Center), a free-standing emergency center; Memorial Hospital Foundation (Memorial Foundation), a nonprofit corporation established to solicit donations for the benefit of UM Memorial; Chester River Health Foundation (Chester River Foundation), a nonprofit corporation established to solicit donations for the benefit of UM Chester River; and several other subsidiaries providing various outpatient and home care services.

Dorchester General Hospital Foundation, Inc. (Dorchester Foundation) is governed by a separate, independent board of directors to raise funds on behalf of UM Dorchester. Shore Regional does not have control over the policies or decisions of the Dorchester Foundation, and accordingly, the accompanying consolidated financial statements reflect a beneficial interest in the net assets of the Dorchester Foundation.

(vii) University of Maryland Charles Regional Health System, Inc. (Charles Regional)

Charles Regional owns and operates University of Maryland Charles Regional Medical Center (UM Charles Regional), which is comprised of a 109-bed acute care hospital and other community healthcare resources providing inpatient and outpatient services to the residents of Charles County in Southern Maryland.

(viii) University of Maryland St. Joseph Health System, LLC (St. Joseph)

St. Joseph owns and operates University of Maryland St. Joseph Medical Center (UM St. Joseph), a 224-bed, Catholic acute care hospital located in Towson, Maryland, as well as other subsidiaries providing inpatient and outpatient services to the residents of Baltimore County.

(ix) University of Maryland Upper Chesapeake Health System (Upper Chesapeake)

Upper Chesapeake is a health system located in Harford County, Maryland. Upper Chesapeake's healthcare delivery system includes two acute care hospitals, University of Maryland Upper Chesapeake Medical Center (UM Upper Chesapeake), a 171-bed acute care hospital and University of Maryland Harford Memorial Hospital (UM Harford Memorial), an 86-bed acute care hospital; a physician practice; a captive insurance company; a land holding company; and Upper Chesapeake Health Foundation.

(x) University of Maryland Capital Region Health (Capital Region)

Capital Region is a health system located in Prince George's County. Capital Region owns and operates UM Prince George's Hospital Center (UM Prince George's), a 230-bed acute care teaching hospital providing an array of services including emergency medicine, behavioral health, cardiac surgery and a Level II Trauma Center; and UM Laurel Regional Health (UM Laurel), a 61-bed acute care hospital providing cardiopulmonary care, critical care, infusion and inpatient and outpatient surgery among other services.

Effective September 1, 2017, UMMS became the sole corporate member of Capital Region after several years of collaboration with Prince George's County and the state of Maryland. This affiliation represents the culmination of those discussions and includes plans to build a new state-of-the-art medical center in Largo, Maryland. In accordance with the agreement, Prince George's County and the state of Maryland have each approved funding through legislation of $208,000 towards the construction of the new medical facility. The combined $416,000 of county and state capital funding commitments was recorded as a receivable within other assets of the accompanying consolidated balance sheets and net assets with donor restrictions as of the affiliation date.

The affiliation was accounted for under the guidance of ASC Topic 805, *Business Combinations*, and the financial position and results of operations of Capital Region were consolidated by the Corporation beginning on September 1, 2017.

The following table summarizes the estimated fair value of the assets acquired and liabilities assumed at September 1, 2017:

Assets:		
Cash	$	46,626
Current assets		63,472
Investments		15,256
Limited use funds		54,370
Property and equipment		96,089
Other long-term assets		393,747
Total assets	$	669,560

(Continued)

Liabilities:		
Current liabilities	$	87,002
Long-term liabilities		122,543
Total liabilities		209,545
Net assets:		
Without donor restrictions		41,772
With donor restrictions		418,243
Total net assets		460,015
Total liabilities and net assets	$	669,560

The following table summarizes the Corporation's unaudited pro forma consolidated results as though the acquisition date occurred at the beginning of fiscal year:

		2018
Operating revenues:		
The Corporation	$	4,118,985
Capital Region		413,142
	$	4,532,127
Net nonoperating income:		
The Corporation	$	148,107
Capital Region		3,315
	$	151,422
Excess of revenues over expenses from continuing operations:		
The Corporation	$	207,117
Capital Region		10,520
	$	217,637
Changes in net assets:		
Without donor restrictions		
The Corporation	$	228,935
Capital Region		12,158
	$	241,093

(Continued)

		2018
With donor restrictions		
The Corporation	$	416,225
Capital Region		21,907
	$	438,132
Total changes in net assets:		
The Corporation	$	645,160
Capital Region		34,065
	$	679,225

(xi) University of Maryland Medical System Foundation, Inc. (UMMS Foundation)

The UMMS Foundation, a not-for-profit foundation, was established for the purpose of soliciting contributions on behalf of the Corporation.

(xii) University of Maryland Community Medical Group, LLC (CMG)

CMG is a physician network that employs more than 300 primary care physicians, specialists and advanced practice providers. CMG is a wholly owned subsidiary of UMMS and has over 75 locations across the state of Maryland. Effective July 1, 2018, CMG was decentralized, moving the primary care physicians back to their respective health systems.

(xiii) University of Maryland Quality Care Network (QCN)

QCN, a wholly owned subsidiary of UMMS, is a network comprised of UMMS employed physicians and independent physician practices in the UMMS service area. The participants bear shared responsibility for the care of a defined population of patients and can contract as one entity with payors.

(xiv) University of Maryland Health Ventures, LLC. (UM Health Ventures)

UM Health Ventures, a wholly owned subsidiary of UMMS, is the parent company of University of Maryland Medical System Health Plans, Inc. (UM Health Plans), a managed care healthcare company based in Baltimore, Maryland. UM Health Plans is the parent company of University of Maryland Health Partners (UMHP), which provides managed care health coverage to approximately 45,000 Medicaid recipients throughout Maryland; University of Maryland Health Advantage, Inc. (UMHA), which provides Medicare Advantage Plans to approximately 10,000 members; Riverside Health of Delaware Inc. (RHDE) and Riverside Health DC, Inc. See note 1(a)(i) for discussion on proposed sale.

(b) Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with U.S. generally accepted accounting principles.

(c) Cash and Cash Equivalents

Cash and cash equivalents, excluding amounts shown within investments and assets limited as to use, consist of cash and interest bearing deposits with maturities of three months or less from the date of purchase. Cash and cash equivalent balances may exceed amounts insured by federal agencies and, therefore, bear a risk of loss. The Corporation has not experienced such losses on these funds.

(d) Investments and Assets Limited as to Use

The Corporation's investment portfolios are classified as trading and are reported in the consolidated balance sheets, as long-term assets, at their fair value based on quoted market prices at June 30, 2019 and 2018. Unrealized holding gains and losses on trading securities with readily determinable market values are included in nonoperating income. Investment income, including realized gains and losses, is included in nonoperating income in the accompanying consolidated statements of operations and changes in net assets.

Assets limited as to use include investments set aside at the discretion of the board of directors for the replacement or acquisition of property and equipment, investments held by trustees under bond indenture agreements and self-insurance trust arrangements, and assets whose use is restricted by donors. Such investments are stated at fair value. Amounts required to meet current liabilities have been included in current assets in the consolidated balance sheets. Changes in fair values of donor-restricted investments are recorded in net assets with donor restrictions unless otherwise required by the donor or state law.

Assets limited as to use also include the Corporation's economic interests in financially interrelated organizations (note 12).

Alternative investments, which the Corporation defines to include multi-strategy commingled funds, hedge funds, hedge fund-of-funds, and private equity investments, are recorded under the equity method of accounting. Underlying securities of these alternative investments may include certain debt and equity securities that are not readily marketable. Because certain investments are not readily marketable, their fair value is subject to additional uncertainty, and therefore, values realized upon disposition may vary significantly from current reported values.

Investments are exposed to certain risks, such as interest rate, credit, and overall market volatility. Due to the level of risk associated with certain investment securities, changes in the value of investment securities could occur in the near term, and these changes could materially differ from the amounts reported in the accompanying consolidated financial statements.

(e) Inventories

Inventories, consisting primarily of drugs and medical/surgical supplies, are carried at the lower of cost or market, on a first-in, first-out basis.

(f) Economic Interests in Financially Interrelated Organizations

The Corporation recognizes its rights to assets held by recipient organizations, which accept cash or other financial assets from a donor and agree to use those assets on behalf of or transfer those assets, the return on investment of those assets, or both, to the Corporation. Changes in the Corporation's economic interests in these financially interrelated organizations are recognized in the consolidated statements of changes in net assets.

(g) Property and Equipment

Property and equipment are stated at cost or estimated fair value at date of contribution, less accumulated depreciation. Depreciation is provided on a straight-line basis over the estimated useful lives of the depreciable assets using the half-year convention. The estimated useful lives of the assets are as follows:

Buildings	20 to 40 years
Building and leasehold improvements	5 to 15 years
Equipment	3 to 15 years

Interest costs incurred on borrowed funds less interest income earned on the unexpended bond proceeds during the period of construction are capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets, such as land, buildings, or equipment are reported as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(h) Deferred Financing Costs

Costs incurred related to the issuance of long-term debt, which are included in long-term debt, are deferred and are amortized over the life of the related debt agreements or the related letter-of-credit agreements using the effective-interest method.

(i) Goodwill and Intangible Assets

Intangible assets include amounts recognized in connection with acquisitions. Intangible assets are initially valued at fair market value using generally accepted valuation methods. Amortization is recognized on a straight-line basis over the estimated useful life of the intangible assets. Intangible assets with definite and indefinite lives are reviewed for impairment if indicators of impairment arise.

Goodwill is an asset representing the future economic benefits arising from other assets acquired in a business combination that are not individually identified and separately recognized. The Corporation adopted Accounting Standards Update (ASU) No. 2017-04, *Simplifying the Test for Goodwill Impairment*, for the year ended June 30, 2018. Goodwill is evaluated for impairment at least annually

on June 30, in accordance with ASC Topic 350, *Intangibles – Goodwill and Other*, using a qualitative assessment (Step 0) to determine whether there are events or circumstances that indicate it is more likely than not that the fair value of the reporting unit is less than its carrying value, which determines whether a quantitative (Step 1) goodwill impairment test is necessary. Under the quantitative assessment, the fair value of the reporting unit is compared with its carrying value (including goodwill). If the fair value of the reporting unit is less than its carrying value, goodwill impairment exists for the reporting unit and the entity must record an impairment loss.

The Corporation has two reporting units, one of which includes all health care delivery assets and the other that includes UM Health Plan assets. Based on the Corporation's qualitative assessment, it was determined that it was more likely than not that the fair values of each reporting unit exceeded their respective carrying value for the year ended June 30, 2019. Based on the Corporation's qualitative assessment, it was determined that the fair value of the health care delivery reporting unit was more likely than not greater than its carrying value for the year ended June 30, 2018. The Health Plans reporting unit experienced increasing losses in the fiscal year ended June 30, 2018 primarily related to medical claims expenses in excess of premium revenues for its Medicare Advantage Plan, and as a result, the Corporation engaged a third party to perform the Step 1 impairment test using the income approach. The income approach provides an estimation of the fair value of an asset based on market participant expectations about the cash flows that asset would generate over its remaining useful life. The cash flow models were developed using projected revenues and expenses based on historical data, industry projections as well as management expectations.

Based on the results of the impairment test, the Corporation recognized a loss on impairment of $12,794 related to goodwill and $33,000 related to an intangible asset (Medicaid Contract) for the year ended June 30, 2018, and these were recorded in loss on discontinued operations in the consolidated financial statements. There was no impairment loss recognized for the year ended June 30, 2019.

The changes in the carrying amount of goodwill are as follows:

		Health Care Delivery	Health Plans
Goodwill at June 30, 2017	$	48,810	42,019
Acquisitions		—	—
Write-downs		—	(12,794)
Goodwill at June 30, 2018		48,810	29,225
Acquisitions		—	—
Write-downs		—	—
Goodwill at June 30, 2019	$	48,810	29,225

(Continued)

(j) Contingent Consideration for Business Acquisitions

Acquisitions may include contingent consideration payments based on future financial measures of an acquired company. Contingent consideration is required to be recognized at fair value as of the acquisition date. The fair value of these liabilities is estimated based on financial projections of the acquired companies and estimated probabilities of achievement and discount the liabilities to present value using a weighted average cost of capital. Contingent consideration is valued using significant inputs that are not observable in the market, which are defined as Level 3 inputs pursuant to fair value measurement accounting. At each reporting date, the contingent consideration obligation is revalued to estimated fair value and changes in fair value subsequent to the acquisition are reflected in operating income in the consolidated statements of operations and changes in net assets. Changes in the fair value of contingent consideration obligations may result from changes in discount periods and rates, changes in the timing and amount of revenue and/or earnings estimates, and changes in probability assumptions with respect to the likelihood of achieving the various earn-out criteria. The Corporation recorded a contingent liability of $35,700 related to an earn-out clause in connection with the August 15, 2015 acquisition of UM Health Plans. This earn-out could result in an undiscounted payment ranging from $0 to $106,500 depending on the performance and membership of both plans. The final computation of the earn-out is not to be determined until March 31, 2020. Based on the earn-out calculation, the Corporation determined that the fair value of the contingent liability was $0 at both June 30, 2019 and 2018. As such, the Corporation recognized a gain of $0 and $35,700 related to the change in fair value of the contingent consideration during the fiscal year ended June 30, 2019 and 2018, respectively. The gain is included in the loss on discontinued operations in the 2018 consolidated statement of operations and changes in net assets.

(k) Impairment of Long-Lived Assets

Long-lived assets, such as property, plant, and equipment, and purchased intangibles subject to amortization, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by comparing the carrying amount of an asset to estimated undiscounted future cash flows expected to be generated by the asset. If the carrying amount of an asset exceeds its estimated future cash flows, an impairment charge is recognized in the amount by which the carrying amount of the asset exceeds the fair value of the asset. Assets to be disposed of would be separately presented in the consolidated balance sheets and reported at the lower of the carrying amount or fair value less costs to sell, and are no longer depreciated. The assets and liabilities of a disposed group classified as held for sale would be presented separately in the appropriate asset and liability sections of the consolidated balance sheets.

No impairment losses were recorded for the years ended June 30, 2019 or 2018.

(l) Investments in Joint Ventures

When the Corporation does not have a controlling interest in an entity, but exerts a significant influence over the entity, the Corporation applies the equity method of accounting.

(m) Self-Insurance

Under the Corporation's self-insurance programs (general and professional liability, workers' compensation, and employee health and long-term disability benefits), claims are reflected as a present-value liability based upon actuarial estimates and reported and incurred but not reported claims analysis, taking into consideration the severity of incidents and the expected timing of claim payments.

(n) Net Assets

The Corporation classifies net assets based on the existence or absence of donor-imposed restrictions. Net assets without donor restrictions represent contributions, gifts, and grants, which have no donor-imposed restrictions or which arise as a result of operations. Net assets with donor restrictions are subject to donor-imposed restrictions that must or will be met either by satisfying a specific purpose and/or passage of time. Generally, the donors of these assets permit the use of all or part of the income earned on related investments for specific purposes. The restrictions associated with these net assets generally pertain to patient care, specific capital projects, and funding of specific hospital operations and community outreach programs.

(o) Net Patient Service Revenue and Patient Accounts Receivable

In accordance with ASC Topic 606, *Revenue from Contracts with Customers*, net patient service revenue, which includes hospital inpatient services, hospital outpatient services, physician services, and other patient services revenue, is recorded at the transaction price estimated by the Corporation to reflect the total consideration due from patients and third-party payors (including commercial payers and government programs) and others. Revenue is recognized over time as performance obligations are satisfied in exchange for providing goods and services in patient care. Revenue is recorded as these goods and services are provided. The services provided to a patient during an inpatient stay or outpatient visit represent a bundle of goods and services that are distinct and accounted for as a single performance obligation.

The Corporation's estimate of the transaction price includes the Corporation's standard charges for the goods and services provided with a reduction recorded related to price concessions for such items as contractual allowances, charity care, potential adjustments that may arise from payment and other reviews, and uncollectible amounts. The price concessions are determined using the portfolio approach as a practical expedient to account for patient contracts as collective groups rather than individually. Estimates for uncollectible amounts are based on the aging of the accounts receivable, historical collections experience for similar payors and patients, current market conditions, and other relevant factors. The Corporation recognizes a significant amount of patient service revenue at the time the services are rendered even though they do not assess the patient's ability to pay. Based on historical experience, a significant portion of the self pay population will be unable or unwilling to pay for services which is estimated in the transaction price. Subsequent changes to the estimate of the transaction price are generally recorded as adjustment to net patient service revenue in the period of change. Subsequent changes that are determined to be the result of an adverse change in the payor's or patient's ability to pay are recorded as bad debt expense. Bad debt expense for the year ended June 30, 2019 was not significant to the consolidated financial statements.

The standard charges for goods and services for the Medical Center, ROI, Midtown, Baltimore Washington, Shore Regional, Charles Regional, St. Joseph, Upper Chesapeake, and Capital Region reflects actual charges to patients based on rates established by the State of Maryland Health Services Cost Review Commission (HSCRC) in effect during the period in which the services are rendered. See note 18 for further discussion on the HSCRC and regulated rates.

Patient accounts are recorded at the net realizable value based on certain assumptions determined by each payor. For third-party payors, including Medicare, Medicaid, and commercial insurance, the net realizable value is based on the estimated contractual adjustments, which is based on approved discounts on charges as permitted by the HSCRC. For self-pay accounts, which includes patients who are uninsured and the patient responsibility portion for patients with insurance, the net realizable value is determined using estimates of historical collection experience. Net patient accounts receivable shown on the consolidated balance sheet for June 30, 2018 is net of allowance for doubtful accounts of $219,769. Net patient service revenue shown on the consolidated statement of operations and changes in net assets for June 30, 2018 are net of provision for bad debts of $174,137. With the adoption of ASC Topic 606, all revenue and related accounts receivable are recorded at the net expected transaction price, therefore, there is no material allowance for doubtful accounts or provision for bad debts for the year ended June 30, 2019.

The Corporation has elected to apply the optional exemption in ASC Paragraph 606-10-50-14a as all performance obligations relate to contracts with duration of less than one year. Under this exemption, the Corporation was not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. Any unsatisfied or partially unsatisfied performance obligations at the end of the year are completed within days or weeks of the end of the year.

Net patient service revenue by line of business are as follows for the years ended June 30:

		2019	2018
Hospital inpatient and outpatient services	$	3,734,201	3,616,917
Physician services		245,150	225,555
Non-hospital outpatient services		32,247	30,325
Other		5,456	4,544
Net patient service revenue	$	4,017,054	3,877,341

(p) Premium Revenue and Medical Claims Expense

Premium revenue consists of amounts received from the state of Maryland and the Centers for Medicare and Medicaid Services (CMS) by the Corporation's managed care organization for providing medical services to subscribing participants, regardless of services actually performed, and is accounted for under ASC Topic 944, *Financial Services – Insurance*. The managed care organization provides services primarily to enrolled Medicaid and Medicare beneficiaries. This revenue is recognized ratably over the contractual period for the provision of services. Medical expenses of the managed care organization include actuarially determined estimates of the ultimate costs for both

reported claims and claims incurred but unreported and are included in medical claims expense on the consolidated statements of operations and changes in net assets. These accounts are included within loss on discontinued operations. See note 1(a)(i).

(q) Charity Care

The Corporation is committed to providing quality healthcare to all, regardless of one's ability to pay. Patients who meet the criteria of its charity care policy receive services without charge or at amounts less than its established rates. The criteria for charity care consider the household income in relation to the federal poverty guidelines. The Corporation provides services at no charge for patients with adjusted gross income equal to or less than 200% of the federal poverty guidelines. For uninsured patients with adjusted gross income greater than 200% of the federal poverty guidelines, a sliding scale discount is applied. Income and asset information obtained from patient credit reporting data are used to determine patients' ability to pay. The Corporation maintains records to identify and monitor the level of charity care it furnished under its charity care policy. The charity care policies of the new affiliates are generally consistent with that of the Corporation's policy.

Due to the complexity of the eligibility process, the Corporation provides eligibility services to patients free of charge to assist in the qualification process. These eligibility services include, but are not limited to, the following:

- Financial assistance brochures and other information are posted at each point of service. When patients have questions or concerns, they are encouraged to call a toll-free number to reach customer service representatives during the business day. Financial assistance programs are published on the Corporation's website and included on the statements provided to patients.
- The Corporation offers assistance to patients in completing the applications for Medicaid or other government payment assistance programs, or applying for care under the Corporation's charity care policy, if applicable. The Corporation also employs an external firm to assist in the eligibility process.
- Any patient, whether covered by insurance or not, may meet with a UMMS representative and receive financial counseling from UMMS' dedicated financial assistance unit.

The Corporation recognizes that a large number of uninsured and insured patients meet the charity care guidelines but do not respond to the Corporation's attempts to obtain necessary financial information. In these instances, the Corporation uses credit reporting data to properly classify these unpaid balances as charity care as opposed to bad debt expense. Utilization of income and asset information and credit reporting data indicate the vast majority of amounts reported as provision for bad debts represent amounts due from patients that would otherwise qualify for charity benefits but do not respond to the Corporation's attempts to obtain the necessary financial information. In these cases, reasonable collection efforts are pursued, but yield few collections. Amounts determined to meet the criteria under the charity care policy are not reported as net patient service revenue.

The amounts reported as charity care represent the cost of rendering such services. Costs incurred are estimated based on the cost-to-charge ratio for each hospital and applied to charity care charges. The Corporation estimates the total direct and indirect costs to provide charity care were $48,821 and $48,479 for the years ended June 30, 2019 and 2018, respectively.

(r) Nonoperating Income and Expenses, Net

Other activities that are only indirectly related to the Corporation's primary business of delivering healthcare services are recorded as nonoperating income and expenses and include investment income, equity in the net income of joint ventures, general donations and fund-raising activities, inherent contributions, changes in fair value of investments, changes in fair value of undesignated interest rate swaps, and settlement payments on interest rate swaps that do not qualify for hedge accounting treatment. Settlement payments on interest rate swaps were approximately $15,124 and $19,227 for the years ended June 30, 2019 and 2018, respectively, and are reported within other nonoperating losses, net.

(s) Derivative Financial Instruments

The Corporation records derivative and hedging activities on the consolidated balance sheets at their respective fair values.

The Corporation utilizes derivative financial instruments to manage its interest rate risks associated with long-term tax-exempt debt. The Corporation does not hold or issue derivative financial instruments for trading purposes.

The Corporation's specific goals are to (a) manage interest rate sensitivity by modifying the reprising or maturity characteristics of some of its tax-exempt debt and (b) lower unrealized appreciation or depreciation in the market value of the Corporation's fixed-rate tax-exempt debt when that market value is compared with the cost of the borrowed funds. The effect of this unrealized appreciation or depreciation in market value, however, will generally be offset by the income or loss on the derivative instruments that are linked to the debt.

The Corporation formally documents all hedge relationships between hedging instruments and hedged items, as well as its risk-management objective and strategy for undertaking various hedge transactions. On the date the derivative contract is entered into, the Corporation may designate the derivative as either a hedge of the fair value of a recognized or forecasted liability (fair value hedge) or a hedge of the variability of cash flows to be received or paid related to a recognized liability (cash flow hedge), provided the derivative instrument meets certain criteria related to its effectiveness. This process includes linking all derivatives that are designated as fair value or cash flow hedges to specific liabilities on the consolidated balance sheets. The Corporation also formally assesses, both at the hedge's inception and on an ongoing basis, whether the derivatives that are used in hedging transactions are highly effective in offsetting changes in fair values or cash flows of hedged items.

All derivative instruments are reported as other assets or interest rate swap liabilities in the consolidated balance sheets and measured at fair value. Derivatives not designated as hedges or not meeting effectiveness criteria are carried at fair value with changes in the fair value recognized in other nonoperating income and expenses. For the years ended June 30, 2019 and 2018, none of the Corporation's derivatives qualify for hedge accounting.

Changes in the fair value of derivative instruments are included in or excluded from the excess of revenues over expenses depending on the use of the derivative and whether it qualifies for hedge accounting treatment. Changes in the fair value of a derivative that is designated and qualifies as a fair

value hedge, along with the changes in the fair value of the hedged item related to the risk being hedged, are included in the excess of revenues over expenses. Changes in the fair value of a derivative that is designated as a cash flow hedge are excluded from the excess of revenues over expenses to the extent that the hedge is effective until the excess of revenues over expenses is affected by the variability of cash flows in the hedged transaction. Changes in the fair value that relate to ineffectiveness are included in the excess of revenues over expenses as interest expense.

(t) Excess of Revenue over Expenses from continuing operations

The consolidated statements of operations and changes in net assets includes a performance indicator, excess of revenues over expenses from continuing operations. Changes in net assets without donor restrictions that are excluded from the performance indicator, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions, which, by donor restrictions, were to be used for the purpose of acquiring such assets), changes in the funded status of defined benefit pension plans, amortization of accumulated loss of discontinued designated interest rate swaps, loss on discontinued operations, and other items that are required by generally accepted accounting principles to be reported separately.

(u) Income Taxes

The Corporation and most of its subsidiaries are not-for-profit corporations formed under the laws of the State of Maryland, organized for charitable purposes and recognized by the Internal Revenue Service as tax-exempt organizations under Section 501(c)(3) of the Internal Revenue Code (the Code) pursuant to Section 501(a) of the Code. The effect of the taxable status of its for-profit subsidiaries is not material to the consolidated financial statements.

The Corporation had net operating loss carryforwards on for-profit and unrelated business activities of approximately $103,627 and $89,890 as of June 30, 2019 and June 30, 2018, respectively, which expire at various dates through 2032. The Corporation’s deferred tax assets, which consist primarily of the net operating loss carryforwards, are approximately $25,598 at June 30, 2019, and $22,345 at June 30, 2018, were fully reserved as they are not expected to be utilized. The Corporation had a deferred tax liability in the amount of $3,027 and $3,027 related to indefinite-lived intangibles at June 30, 2019 and 2018, respectively, which is included in liabilities held for sale on the accompanying consolidated balance sheets.

The Corporation follows a threshold of more likely than not for recognition and derecognition of tax positions taken or expected to be taken in a tax return. Management does not believe that there are any unrecognized tax liabilities or benefits that should be recognized.

On December 22, 2017, the President signed into law H.R.1, originally known as the Tax Cuts and Jobs Act, as such the Corporation’s effective tax rate was reduced from 35% to 21% during the fiscal year 2018. The new law includes several provisions that result in substantial changes to the tax treatment of tax-exempt organizations and their donors. The Company has reviewed these provisions and the potential impact and has concluded the enactment of H.R.1 did not have a material effect on the operations of the organization.

(v) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Corporation are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the promise becomes unconditional. Contributions are reported as net assets with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction is satisfied, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Such amounts are classified as other revenue or transfers and additions to property and equipment.

Contributions to be received after one year are discounted at an appropriate discount rate commensurate with the risks involved. An allowance for uncollectible contributions receivable is provided based upon management's judgment, including such factors as prior collection history, type of contributions, and nature of fund-raising activity.

The Corporation follows accounting guidance for classifying the net assets associated with donor-restricted endowment funds held by organizations that are subject to an enacted version of the Uniform Prudent Management Institutional Funds Act of 2006 (UPMIFA).

(w) Fair Value Measurements

The following methods and assumptions were used by the Corporation in estimating the fair value of its financial instruments:

Cash and cash equivalents, accounts receivable, assets limited as to use, investments, trade accounts payable, accrued payroll and benefits, other accrued expenses, and advances from third-party payors – The carrying amounts reported in the consolidated balance sheets approximate the related fair values.

Pension plan assets – The Corporation applies ASU No. 2009-12, *Fair Value Measurements and Disclosures (Topic 820): Investments in Certain Entities That Calculate Net Asset per Share (or Its Equivalent)*, to its pension plan assets. The guidance permits, as a practical expedient, fair value of investments within its scope to be estimated using the net asset value (NAV) or its equivalent. The alternative investments classified within the fair value hierarchy have been recorded using the NAV.

The Corporation discloses its financial assets, financial liabilities, and fair value measurements of nonfinancial items according to the fair value hierarchy required by generally accepted accounting principles that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted market prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted market prices (unadjusted) in active markets for identical assets or liabilities that the Corporation has the ability to access at the measurement date.

- Level 2 inputs are inputs other than quoted market prices including within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.
- Level 3 inputs are unobservable inputs for the asset or liability.

Assets and liabilities classified as Level 1 are valued using unadjusted quoted market prices for identical assets or liabilities in active markets. The Corporation uses techniques consistent with the market approach and the income approach for measuring fair value of its Level 2 and Level 3 assets and liabilities. The market approach is a valuation technique that uses prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities. The income approach generally converts future amounts (cash flows or earnings) to a single present value amount (discounted).

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

As of June 30, 2019 and 2018, the Level 2 assets and liabilities listed in the fair value hierarchy tables presented in notes 2 and 10 utilize the following valuation techniques and inputs:

(i) Cash Equivalents

The fair value of investments in cash equivalent securities, with maturities within three months of the date of purchase, is determined using techniques that are consistent with the market approach. Significant observable inputs include reported trades and observable broker-dealer quotes.

(ii) U.S. Government and Agency Securities

The fair value of investments in U.S. government, state, and municipal obligations is primarily determined using techniques consistent with the income approach. Significant observable inputs to the income approach include data points for benchmark constant maturity curves and spreads.

(iii) Corporate Bonds

The fair value of investments in U.S. and international corporate bonds, including commingled funds that invest primarily in such bonds and foreign government bonds, is primarily determined using techniques that are consistent with the market approach. Significant observable inputs include benchmark yields, reported trades, observable broker-dealer quotes, issuer spreads, and security specific characteristics, such as early redemption options.

(iv) Collateralized Corporate Obligations

The fair value of collateralized corporate obligations is primarily determined using techniques consistent with the income approach, such as a discounted cash flow model. Significant observable inputs include prepayment speeds and spreads, benchmark yield curves, volatility measures, and quotes.

(v) Derivative Liabilities

The fair value of derivative contracts is primarily determined using techniques consistent with the market approach. Derivative contracts include interest rate, credit default, and total return swaps. Significant observable inputs to valuation models include interest rates, treasury yields, volatilities, credit spreads, maturity, and recovery rates.

(x) Commitments and Contingencies

Liabilities for loss contingencies arising from claims, assessments, litigation, fines, penalties, and other sources are recorded when it is probable that a liability has been incurred and the amount can be reasonably estimated. Legal costs incurred in connection with loss contingencies are expensed as incurred.

(y) Going Concern

Management evaluates whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Corporation's ability to continue as a going concern within one year after the date the financial statements are issued. As of the date of this report, there are no conditions or events that raise substantial doubt about the Corporation's ability to continue as a going concern.

(z) Use of Estimates

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

(aa) New Accounting Pronouncements

The Financial Accounting Standards Board (FASB) issued ASU No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. This ASU establishes principles for reporting useful information to users of financial statements about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers. The ASU requires that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The ASU was adopted on July 1, 2018 using the modified retrospective method for those contracts that were not substantially completed as of July 1, 2018. Results for reporting periods beginning on or after July 1, 2018 are presented under Topic 606, while prior period amounts have been revised to conform to the net presentation of a single net patient service revenue total. The adoption of the ASU primarily changes the Corporation's presentation of revenue and the provision and allowance for bad debts. The ASU requires revenue to be recognized based on the Corporation's estimate of the transaction price the Corporation expects to collects as a result of satisfying its performance obligations. Accordingly, for performance obligations satisfied after July 1, 2018, the Corporation no longer separately presents a provision for bad debts on the consolidated statement of operations and changes in net assets or the related allowance for bad debts on the consolidated balance sheets and these are included as price concessions and a reduction to net patient service revenue and net accounts receivable, respectively. Net patient accounts receivable shown on the consolidated balance sheet for June 30, 2018 are net of

allowance for doubtful accounts of $219,769. Net patient service revenue shown on the consolidated statement of operations and changes in net assets for June 30, 2018 is net of provision for bad debts of $174,137. Changes to the allowance for bad debts, other than the write-offs of uncollectible accounts, are recorded through the provision for bad debts on the consolidated statements of operations and changes in net assets in accordance with Topic 605. The adoption of Topic 606 did not have significant impact on the recognition of net patient service revenues for any periods prior to adoption. The adoption of Topic 606 did not have a significant impact on any financial statement line items when compared to Topic 605.

The FASB issued ASU No. 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*, to improve the current net asset classification requirements and information presented in financial statements and notes about a not-for-profit entity's liquidity, financial performance, and cash flows. This update requires not-for-profit entities to present two classes of net assets (net assets with donor restrictions and net assets without donor restrictions), requires the presentation of expenses in both natural and functional classification, and other quantitative information regarding the entity's liquidity. UMMS adopted ASU No. 2016-14 with a retrospective approach as of July 1, 2018. There were no material changes to the consolidated balance sheets, statements of operations and changes in net assets or cash flows because of the adoption. Periods prior to adoption, which previously presented temporarily restricted of $698,458 and permanently restricted net assets of $44,209, have been revised to conform to the new presentation of a single classification of net assets with donor restrictions.

The FASB issued ASU No. 2016-02, *Leases (Topic 842)*, which will require lessees to recognize most leases on the balance sheet, increasing their reported assets and liabilities. This update was developed to provide financial statement users with more information about an entity's leasing activities and will require changes in processes and internal controls. The Corporation will adopt Topic 842 effective July 1, 2019, applying the modified retrospective approach in which the Corporation will not adjust comparable prior period information and disclosures. The Corporation expects to utilize the practical expedients being made available, including the package of practical expedients to not reassess whether a contract is or contains a lease, the lease classification and initial direct costs. The Corporation estimates the amount of right-of-use assets and obligations resulting from the adoption of ASU No. 2016-02 to be within a range of $75,000 to $125,000.

From time to time, new accounting guidance is issued by the FASB or other standard setting bodies that is adopted by the Corporation as of the effective date or, in some cases where early adoption is permitted, in advance of the effective date. The Corporation has assessed the recently issued guidance that is not yet effective and, unless otherwise indicated above, believes the new guidance will not have a material impact on the Corporation's consolidated financial position, results of operations, or cash flows.

(2) Investments and Assets Limited as to Use

The carrying values of assets limited as to use were as follows at June 30:

	2019	2018
Investments held for collateral	$ 113,586	84,590
Debt service and reserve funds	86,157	82,820
Construction funds – held by trustee	279,205	266,822
Construction funds – held by the Corporation	183,917	145,052
Board designated funds	140,689	123,729
Self-insurance trust funds	212,384	230,589
Funds restricted by donors	78,255	69,470
Economic and beneficial interests in the net assets of related organizations (note 12)	198,101	196,119
Total assets limited as to use	1,292,294	1,199,191
Less amounts available for current liabilities	(64,910)	(56,484)
Total assets limited as to use, less current portion	$ 1,227,384	1,142,707

The carrying values of assets limited as to use were as follows at June 30, 2019:

	Investments held for collateral	Debt service and reserve funds	Construction funds	Board designated funds	Self-insurance trust funds	Funds restricted by donors	Economic and beneficial interests	Total
Cash and cash equivalents	$ 31,394	25,070	265,160	19,216	8,473	13,924	—	363,237
Corporate bonds	—	—	—	27,003	5,959	13,152	—	46,114
Collateralized corporate obligations	—	—	—	132	—	347	—	479
U.S. government and agency securities	82,192	61,087	197,962	153	11,151	402	—	352,947
Common stocks, including mutual funds	—	—	—	48,283	7,046	23,074	—	78,403
Alternative investments	—	—	—	45,902	—	27,356	—	73,258
Assets held by other organizations	—	—	—	—	179,755	—	198,101	377,856
Total assets limited as to use	$ 113,586	86,157	463,122	140,689	212,384	78,255	198,101	1,292,294

(Continued)

The carrying values of assets limited as to use were as follows at June 30, 2018:

	Investments held for collateral	Debt service and reserve funds	Construction funds	Board designated funds	Self-insurance trust funds	Funds restricted by donors	Economic and beneficial interests	Total
Cash and cash equivalents	$ 2,466	32,819	250,784	5,992	16,619	10,058	—	318,738
Corporate bonds	—	—	—	19,579	19,603	8,595	—	47,777
Collateralized corporate obligations	—	—	—	155	—	390	—	545
U.S. government and agency securities	82,124	50,001	161,090	170	13,016	427	—	306,828
Common stocks, including mutual funds	—	—	—	50,886	6,840	22,529	—	80,255
Alternative investments	—	—	—	46,947	—	27,471	—	74,418
Assets held by other organizations	—	—	—	—	174,511	—	196,119	370,630
Total assets limited as to use	$ 84,590	82,820	411,874	123,729	230,589	69,470	196,119	1,199,191

Self-insurance trust funds include amounts held by the Maryland Medicine Comprehensive Insurance Program (MMCIP) for payment of malpractice claims. These assets consist primarily of stocks, fixed-income corporate obligations, and alternative investments. MMCIP is a funding mechanism for the Corporation's malpractice insurance program. As MMCIP is not an insurance provider, transactions with MMCIP are recorded under the deposit method of accounting. Accordingly, the Corporation accounts for its participation in MMCIP by carrying limited-use assets representing the amount of funds contributed to MMCIP and recording a liability for claims, which is included in other current and other long-term liabilities in the accompanying consolidated balance sheets.

The carrying values of investments were as follows at June 30:

	2019	2018
Cash and cash equivalents	$ 61,004	85,188
Corporate bonds	118,738	57,820
Collateralized corporate obligations	20,107	22,656
U.S. government and agency securities	23,304	24,771
Common stocks	213,139	191,994
Alternative investments:		
Hedge funds/private equity	137,693	139,388
Commingled funds	311,655	338,088
	$ 885,640	859,905

(Continued)

Alternative investments include hedge fund, private equity, and commingled investment funds, which are valued using the equity method of accounting. As of June 30, 2019, the majority of these alternative investments are subject to 30 day or less notice requirements and are available to be redeemed on at least a monthly basis. Approximately $140,600 of the alternative investments were subject to 31–60 day notice requirements and can only be redeemed monthly, quarterly, or annually. Other funds, totaling approximately $72,000, are subject to over 60-day notice requirements and can only be redeemed monthly, quarterly, or annually. Of the funds with over 60-day notice requirements, approximately $15,000 are subject to lockup restrictions and are not available to be redeemed until certain time restrictions are met, which range from one to three years. In addition, there are approximately $5,700 of other funds that are subject to lockup restrictions and are not available to be redeemed until certain time restrictions are met, which range from one to three years. The Corporation had $6,679 of unfunded commitments in alternative investments as of June 30, 2019.

As of June 30, 2018, the majority of these alternative investments are subject to 30 day or less notice requirements and are available to be redeemed on at least a monthly basis. Approximately $56,300 of the alternative investment were subject to 31-60 day notice requirements and can only be redeemed monthly, quarterly, or annually. Other funds, totaling approximately $72,400, are subject to over 60-day notice requirements and can only be redeemed monthly, quarterly, or annually. Of the funds with over 60-day notice requirements, approximately $14,600 are subject to lockup restrictions and are not available to be redeemed until certain time restrictions are met, which range from one to three years. In addition, there are approximately $6,900 of other funds that are subject to lockup restrictions and are not available to be redeemed until certain time restrictions are met, which range from one to three years. The Corporation had $8,170 of unfunded commitments in alternative investments as of June 30, 2018.

The following table presents investments and assets limited as to use that are measured at fair value on a recurring basis excluding alternative investments in the amount of $449,348 and $73,258, respectively, which are accounted for under the equity method at June 30, 2019:

	Level 1	Level 2	Level 3	Total
Assets:				
Investments:				
Cash and cash equivalents	$ 61,004	—	—	61,004
Corporate bonds	83,822	34,916	—	118,738
Collateralized corporate obligations	—	20,107	—	20,107
U.S. government and agency securities	15,581	7,723	—	23,304
Common and preferred stocks, including mutual funds	213,139	—	—	213,139
	373,546	62,746	—	436,292

(Continued)

	Level 1	Level 2	Level 3	Total
Assets limited as to use:				
Cash and cash equivalents	$ 278,625	84,612	—	363,237
Corporate bonds	43,559	3,846	—	47,405
Collateralized corporate obligations	—	479	—	479
U.S. government and agency securities	93,581	259,366	—	352,947
Common and preferred stocks, including mutual funds	77,112	—	—	77,112
Investments held by other organizations	—	377,856	—	377,856
	492,877	726,159	—	1,219,036
	$ 866,423	788,905	—	1,655,328

The following table presents investments and assets limited as to use that are measured at fair value on a recurring basis excluding alternative investments in the amount of $477,476 and $74,418, respectively, which are accounted for under the equity method at June 30, 2018:

	Level 1	Level 2	Level 3	Total
Assets:				
Investments:				
Cash and cash equivalents	$ 85,188	—	—	85,188
Corporate bonds	35,122	22,698	—	57,820
Collateralized corporate obligations	—	22,656	—	22,656
U.S. government and agency securities	15,576	9,195	—	24,771
Common and preferred stocks, including mutual funds	191,994	—	—	191,994
	327,880	54,549	—	382,429

(Continued)

	Level 1	Level 2	Level 3	Total
Assets limited as to use:				
Cash and cash equivalents	$ 191,914	126,824	—	318,738
Corporate bonds	44,415	3,362	—	47,777
Collateralized corporate obligations	—	545	—	545
U.S. government and agency securities	95,240	211,588	—	306,828
Common and preferred stocks, including mutual funds	80,255	—	—	80,255
Investments held by other organizations	—	370,630	—	370,630
	411,824	712,949	—	1,124,773
	$ 739,704	767,498	—	1,507,202

Changes to Level 1 and Level 2 securities between June 30, 2019 and 2018 were the result of strategic investments and reinvestments, interest income earnings, and changes in the fair value of investments.

The Corporation's total return on its investments and assets limited as to use was as follows for the years ended June 30:

	2019	2018
Dividends and interest, net of fees	$ 18,059	11,379
Net realized gains	14,276	27,002
Change in fair value of trading securities	24,384	26,027
Total investment return	$ 56,719	64,408

Total investment return is classified in the consolidated statements of operations and changes in net assets as follows for the years ended June 30 (in thousands):

	2019	2018
Nonoperating investment income, net	$ 30,632	37,465
Change in fair value of unrestricted investments	24,421	23,976
Investment gains on net assets with donor restrictions	1,666	2,967
Total investment return	$ 56,719	64,408

(Continued)

Investment return does not include the returns on the economic interests in the net assets of related organizations, the returns on the self-insurance trust funds, returns on undesignated interest rates swaps, or the returns on certain construction funds where amounts have been capitalized.

(3) Property and Equipment

The following is a summary of property and equipment at June 30:

	2019	2018
Land	$ 196,004	188,071
Buildings	1,496,177	1,488,714
Building and leasehold improvements	1,048,608	973,084
Equipment	1,814,503	1,677,047
Construction in progress	321,660	164,674
	4,876,952	4,491,590
Less accumulated depreciation and amortization	(2,567,866)	(2,326,124)
	$ 2,309,086	2,165,466

Interest cost capitalized was $0 and $1,152,000 for years ended June 30, 2019 and 2018, respectively.

Remaining contractual commitments on construction projects were approximately $210,397 at June 30, 2019, of which approximately $159,295 relates to Capital Region.

Construction in progress includes building and renovation costs for assets that have not yet been placed into service. These costs relate to major construction projects as well as routine renovations under way at the Corporation's facilities.

(4) Investments in Joint Ventures

The Corporation has investments of $91,942 and $88,063 at June 30, 2019 and 2018, respectively, in the following unconsolidated joint ventures:

		Ownership percentage	
Joint venture	Business purpose	FY 2019	FY 2018
Shipley's Imaging Center, LLC	Freestanding imaging center	50%	50%
Innovative Health Services, LLC	Third-party insurance claims processor	50	50
Terrapin Insurance Company (Terrapin)	Healthcare professional liability insurance company	50	50

(Continued)

Joint venture	Business purpose	Ownership percentage FY 2019	Ownership percentage FY 2018
Mt. Washington Pediatric Hospital, Inc. (Mt. Washington)	Healthcare services	50%	50%
Central Maryland Radiation Oncology Center LLC	Healthcare services	50	50
University of Maryland Medicine ASC, LLC	Ambulatory surgical services	50	50
Chesapeake-Potomac Healthcare Alliance	Healthcare services	33	33
Ruxton SurgiCenter	Ambulatory surgical services	20	—
Civista Ambulatory Surgery Center, Inc.	Ambulatory surgical services	50	50
NRH/CPT/St. Mary's/Civista Regional Rehab, LLC	Medical rehabilitative and therapy services	**	15
UM SJMC Choice One Urgent Care Centers	Urgent care centers	25/49 *	25/49 *
UM UCHS Choice One Urgent Care Centers	Urgent care centers	49	49
UM SRH Choice One Urgent Care Centers	Urgent care centers	49	49
UM BWMC Choice One Urgent Care Centers	Urgent care centers	**	49
Maryland eCare, LLC	Remote monitoring technology	14	14
MRI at St. Joseph Medical Center, LLC	Healthcare services	51	51
Advanced/Upper Chesapeake Health Center, LLC	Imaging center	10	10
Madison Manor	Nursing Home	25	25

* In each of the fiscal years 2019 and 2018, a new UM SJMC Choice One Urgent Care center was started at an ownership percentage of 49%. The remaining centers have an ownership percentage of 25%.

** These ventures ceased operations during fiscal year 2019.

The Corporation recorded equity in net income of $3,624 and $5,489 related to these joint ventures for the years ended June 30, 2019 and 2018, respectively.

(Continued)

The following is a summary of the Corporation's joint ventures' combined unaudited condensed financial information as of and for the years ended June 30:

	2019				
	Mt. Washington	Terrapin	Choice One*	Others	Total
Current assets	$ 31,609	52,058	4,571	30,471	118,709
Noncurrent assets	104,354	242,783	13,772	36,307	397,216
Total assets	$ 135,963	294,841	18,343	66,778	515,925
Current liabilities	$ 14,565	4,878	7,777	11,073	38,293
Noncurrent liabilities	6,452	288,013	2,625	8,901	305,991
Net assets	114,946	1,950	7,941	46,804	171,641
Total liabilities and net assets	$ 135,963	294,841	18,343	66,778	515,925
Total operating revenue	$ 64,668	44,898	10,419	95,367	215,352
Total operating expenses	(61,835)	(49,435)	(11,450)	(84,621)	(207,341)
Total nonoperating gains/(losses), net	2,157	4,536	—	1,446	8,139
Contributions from (to) owners	2,986	—	—	(9,525)	(6,539)
Other changes in net assets, net	—	—	(266)	2,735	2,469
Increase (decrease) in net assets	$ 7,976	(1)	(1,297)	5,402	12,080

* Choice One is the combination of UM SJMC, UM UCHS, UM SRH, and UM BWMC Choice One Urgent Care Cen

	2018				
	Mt. Washington	Terrapin	Choice One*	Others	Total
Current assets	$ 30,302	22,272	5,321	25,620	83,515
Noncurrent assets	97,468	229,838	6,369	23,902	357,577
Total assets	$ 127,770	252,110	11,690	49,522	441,092
Current liabilities	$ 13,718	3,631	2,016	7,836	27,201
Noncurrent liabilities	7,082	246,529	436	865	254,912
Net assets	106,970	1,950	9,238	40,821	158,979
Total liabilities and net assets	$ 127,770	252,110	11,690	49,522	441,092

(Continued)

	2018				
	Mt. Washington	Terrapin	Choice One*	Others	Total
Total operating revenue	$ 62,491	29,728	8,643	83,616	184,478
Total operating expenses	(58,384)	(34,535)	(9,961)	(72,188)	(175,068)
Total nonoperating gains/(losses), net	3,281	4,806	—	(360)	7,727
Contributions from (to) owners	—	—	1,313	(11,710)	(10,397)
Other changes in net assets, net	2,602	1	(238)	8	2,373
Increase (decrease) in net assets	$ 9,990	—	(243)	(634)	9,113

* Choice One is the combination of UM SJMC, UM UCHS, UM SRH, and UM BWMC Choice One Urgent Care Centers.

(5) Leases

The Corporation rents various equipment and facility space. Rent expense under these operating leases for the years ended June 30, 2019 and 2018 was approximately $35,912 and $31,731, respectively.

Future noncancelable minimum lease payments under operating leases are as follows for the years ending June 30:

2020	$ 9,464
2021	7,076
2022	6,768
2023	6,522
2024	6,158
Thereafter	13,791
	$ 49,779

The Corporation rents property used for administration under a 99-year lease. The lease was recorded as a capital lease, and the Corporation recorded assets at their respective fair values of $3,770 and $29,230 for land and buildings, respectively. The lease includes an option for the Corporation to purchase the property during the period from April 20, 2017 to February 28, 2021 for a purchase price of not less than $37,000 but not more than $45,000, as determined by appraisals. Management exercised the option on October 21, 2019 to purchase the property for $40,000. As of June 30, 2019 and 2018, amounts of $38,093 and $37,649, respectively, representing obligations under the lease have been recorded in other current liabilities.

As of June 30, 2019, amounts of $2,260 and $12,174 representing obligations under all other capital leases are included in other current liabilities and other long-term liabilities, respectively.

The following is a summary of all property and equipment under capital leases at June 30:

	2019	2018
Land	$ 3,770	3,770
Buildings	29,230	29,230
Equipment	28,571	28,843
	61,571	61,843
Less accumulated amortization	(26,261)	(23,941)
	$ 35,310	37,902

Future minimum lease payments under capital leases, together with the present value of the net minimum lease payments, are as follows as of June 30, 2019:

2020	$ 42,811
2021	1,862
2022	1,145
2023	891
2024	891
Thereafter	12,083
Total minimum lease payments	59,683
Less amounts representing interest	(7,156)
Present value of net minimum lease payments	$ 52,527

(6) Line of Credit

For the fiscal years ended June 30, 2019 and 2018, the Corporation had a $250,000 revolving line of credit outstanding with a syndicate of banking partners. The line of credit is annually renewing and the current expiration date is August 26, 2020. Interest is calculated based on an optional base rate or percentage of 1-month LIBOR plus a credit spread. As of June 30, 2019 and 2018, the amount outstanding on the line of credit was $161,300 and $99,300, respectively. The calculated interest rates as of June 30, 2019 was a range from 3.14% to 5.5% and as of June 30, 2018 was 5.0%.

(Continued)

(7) Long-Term Debt and Other Borrowings

Long-term debt consists of the following at June 30:

	Interest rate	Payable in fiscal year(s)	2019	2018
MHHEFA project revenue bonds:				
Corporation issue, payments due annually on July 1:				
Series 2017D/E bonds	4.00%–4.17%	2045–2049	$ 189,965	189,965
Series 2017B/C bonds	2.23%–5.00%	2018–2040	260,835	267,055
Series 2017A bonds	Variable rate	2017–2043[1]	44,010	45,135
Series 2016A-F bonds	Variable rate	2017–2042[1]	314,270	318,475
Series 2015 bonds	3.63%–5.00%	2016–2042	75,060	76,420
Series 2013 bonds	4.00%–5.00%	2014–2044	339,465	343,250
Series 2010 bonds	4.75%–5.25%	2011–2032	50,210	56,635
Series 2008D/E bonds	Variable rate	2025–2042	105,000	105,000
Series 2008F bonds	4.50%–5.25%	2009–2024	27,555	34,125
Series 2007A bonds	Variable rate	2008–2035	79,440	82,330
MHHEFA Pooled Loan Program	Variable rate	2017–2035	17,099	8,034
Other long-term debt:				
UCHS term loan	Variable rate	2020	150,000	150,000
Term loans	1.86%–4.44%	2009–2022	9,377	48,736
Other loans, mortgages and notes payable	3.25%–6.73%	Monthly, 1991–2025	17,893	20,468
Total debt			1,680,179	1,745,628
Less current portion of long-term debt			47,621	51,989
Less short-term financing			150,000	150,000
Less long-term debt subject to short-term remarketing agreements			18,895	58,054
			1,463,663	1,485,585
Plus unamortized premiums and discounts, net			30,762	32,853
Plus unamortized deferred financing costs			(9,465)	(10,104)
			$ 1,484,960	1,508,334

[1] Mandatory purchase options are due in the following (fiscal years), unless the bondholding bank and the Obligated Group agree to an extension: Series 2016A (2024), 2016B (2022), 2016C&D (2024), 2016E&F (2027), and 2017A (2022).

(Continued)

Pursuant to an Amended and Restated Master Loan Agreement dated December 1, 2017 (UMMS Master Loan Agreement), the Corporation and several of its subsidiaries have issued debt through Maryland Health and Higher Educational Facilities Authority (MHHEFA or the Authority). As security for the performance of the bond obligation under the UMMS Master Loan Agreement, the Authority maintains a security interest in the revenue of the obligors. The UMMS Master Loan Agreement contains certain restrictive covenants. These covenants require that rates and charges be set at certain levels, limit incurrence of additional debt, require compliance with certain operating ratios and restrict the disposition of assets.

The Obligated Group under the UMMS Master Loan Agreement includes the Medical Center, ROI, UM Midtown, UM Baltimore Washington, Shore Health (UM Memorial and UM Dorchester), UM Chester River, UM Charles Regional, UM St. Joseph, UM Upper Chesapeake, UM Harford Memorial, UM Laurel, UM Prince George's, Bowie Health Center (Bowie), and the UMMS Foundation. Each member of the Obligated Group is jointly and severally liable for the repayment of the obligations under the UMMS Master Loan Agreement.

Under the terms of the UMMS Master Loan Agreement and other loan agreements, certain funds are required to be maintained on deposit with the master trustee to provide for repayment of the obligations of the Obligated Group (note 2).

The Corporation has a term loan in the amount of $150,000 related to the acquisition of Upper Chesapeake, which expires on March 1, 2020. The Corporation intends to refinance this obligation prior to its maturity date and has classified this obligation as a short-term financing at June 30, 2019 and 2018, in the consolidated balance sheets.

In December 2018, MHHEFA issued $145,265 of tax-exempt revenue bonds, Series 2017D, and $44,700 taxable revenue bonds, Series 2017E. These proceeds are to be used for the purpose of financing a portion of the costs of acquisition, construction and equipping of certain capital projects related to Capital Region, including (a) construction of a new regional medical center and an adjacent new ambulatory care center and (b) construction of a new freestanding medical facility.

The aggregate annual future maturities of long-term debt according to the original terms of the UMMS Master Loan Agreement and all other loan agreements are as follows for the years ending June 30:

2020	$	197,621
2021		40,322
2022		48,572
2023		45,266
2024		47,655
Thereafter		1,300,743
	$	1,680,179

The Corporation's Series 2007A and 2008D-E bonds are variable rate demand bonds requiring remarketing agents to purchase and remarket any bonds tendered before the stated maturity date. The

reimbursement obligations with respect to the letters of credit are evidenced and secured by the respective bonds. To provide liquidity support for the timely payment of any bonds that are not successfully remarketed, the Corporation has entered into letter-of-credit agreements with three banking institutions. These agreements have terms that expire in 2021 through 2022. If the bonds are not successfully remarketed, the Corporation is required to pay an interest rate specified in the letter-of-credit agreement, and the principal repayment of bonds may be accelerated to require repayment in periods ranging from 20 to 60 months from the date of the failed remarketing. The Corporation has reflected the amount of its long-term debt that is subject to these short-term remarketing arrangements as a separate component of current liabilities in its consolidated balance sheets. In the event that bonds are not remarketed, the Corporation maintains available letters of credit and has the ability to access other sources to obtain the necessary liquidity to comply with accelerated repayment terms. All variable rate demand bonds were successfully remarketed as of June 30, 2019.

The following table reflects the mandatory redemptions and required repayment terms for the years ended June 30 of the Corporation's debt obligations in the event that the put options associated with variable rate demand bonds subject to short-term remarketing agreements were exercised, but not successfully remarketed, and mandatory purchase options are not extended:

2020	$	216,516
2021		88,113
2022		235,733
2023		62,214
2024		173,505
Thereafter		904,098
	$	1,680,179

The approximate interest rates on outstanding debt bearing interest at variable rates were as follows at June 30:

	2019	2018
Series 2008D bonds	1.92 %	1.54 %
Series 2008E bonds	1.85	1.49
Series 2007A bonds	1.85	1.55
Series 2016A bonds	2.74	2.51
Series 2016B bonds	2.62	2.34
Series 2016C bonds	2.54	2.36
Series 2016D bonds	2.63	2.66
Series 2016E bonds	2.66	2.50
Series 2016F bonds	2.63	2.47
Series 2017A bonds	2.46	2.26
Series 1985 pooled Loan Program (MHHEFA)	2.40	2.25
UCHS term loan	3.10	2.84

(Continued)

Term loans outstanding are as follows at June 30:

	Interest rate	Interest rate as of June 30, 2019	Payable in fiscal year(s)	2019	2018
Term loan 1:					
Payable monthly, beginning March 2012	Fixed rate	3.95 %	2012–2022	$ 6,000	6,800
Term loan 2:					
Payable monthly, beginning February 2010	1-month LIBOR + 2.00%	4.44	2010–2023	2,381	2,609
Term loan 3:					
Payable monthly, beginning November 2015	1-month LIBOR + 1.95%	—	2016–2021	—	36,667
Term loan 4:					
Payable monthly, beginning May 2016	Fixed rate	—	2016–2019	—	383
Term loan 5:					
Payable monthly, beginning February 2017	Fixed rate	2.47	2017–2020	419	976
Term loan 6:					
Payable monthly, beginning July 2017	Fixed rate	2.66	2018–2020	577	1,301
Total term loans (included in long-term debt)				$ 9,377	48,736

(8) Interest Rate Risk Management

The Corporation uses a combination of fixed and variable rate debt to finance capital needs. The Corporation maintains an interest rate risk-management strategy that uses interest rate swaps to minimize significant, unanticipated earnings fluctuations that may arise from volatility in interest rates.

(Continued)

At June 30, 2019 and 2018, the Corporation's notional values of outstanding interest rate swaps were $746,348 and $758,901, respectively, the details of which were as follows:

	Notional amount	Pay rate	Receive rate	Maturity date	Mark to market
As of June 30, 2019:					
Swap #1	$ 80,998	3.59 %	70% 1-month LIBOR	7/1/2031	$ (11,813)
Swap #2	84,000	3.93	68% 1-month LIBOR	7/1/2041	(31,398)
Swap #3	21,000	4.24	68% 1-month LIBOR	7/1/2041	(8,869)
Swap #4	33,200	3.99	67% 1-month LIBOR	7/1/2034	(7,048)
Swap #5	25,160	3.54	70% 1-month LIBOR	7/1/2031	(3,589)
Swap #6	196,000	3.93	68% 1-month LIBOR	7/1/2041	(73,275)
Swap #7	49,000	4.24	68% 1-month LIBOR	7/1/2041	(20,698)
Swap #8	77,450	4.00	67% 1-month LIBOR	7/1/2034	(16,496)
Swap #9	2,850	3.63	67% 1-month LIBOR	7/1/2032	(269)
Swap #10	98,425	3.92	67% 1-month LIBOR	1/1/2043	(27,914)
Swap #11	78,265	0.51	67% 1-month LIBOR + 0.5133%	1/1/2038	2,299
					(199,070)
				Valuation adjustments	2,896
Total	$ 746,348				$ (196,174)

	Notional amount	Pay rate	Receive rate	Maturity date	Mark to market
As of June 30, 2018:					
Swap #1	$ 83,446	3.59 %	70% 1-month LIBOR	7/1/2031	$ (8,996)
Swap #2	84,000	3.93	68% 1-month LIBOR	7/1/2041	(23,745)
Swap #3	21,000	4.24	68% 1-month LIBOR	7/1/2041	(6,905)
Swap #4	34,325	3.99	67% 1-month LIBOR	7/1/2034	(5,685)
Swap #5	25,930	3.54	70% 1-month LIBOR	7/1/2031	(2,704)
Swap #6	196,000	3.93	68% 1-month LIBOR	7/1/2041	(55,421)
Swap #7	49,000	4.24	68% 1-month LIBOR	7/1/2041	(16,117)
Swap #8	80,075	4.00	67% 1-month LIBOR	7/1/2034	(13,321)
Swap #9	3,230	3.63	67% 1-month LIBOR	7/1/2032	(233)
Swap #10	101,275	3.92	67% 1-month LIBOR	1/1/2043	(21,731)
Swap #11	80,620	0.51	67% 1-month LIBOR + 0.5133%	1/1/2038	1,086
					(153,772)
				Valuation adjustments	3,983
Total	$ 758,901				$ (149,789)

(Continued)

The mark-to-market values of the Corporation's interest rate swaps include a valuation adjustment representing the creditworthiness of the counterparties to the swaps.

On January 1, 2013, in accordance with ASC Topic 815, *Derivatives and Hedging*, the Corporation elected to discontinue the cash flow hedging relationship for Swap #8. As of that date, the accumulated losses included in net assets without donor restrictions will be reclassified into earnings over the life of the Series 2007 bonds. For the years ended June 30, 2019 and 2018, $1,610 and $1,668, respectively, was reclassified from other changes in net assets into change in fair value of undesignated interest rate swaps. The accumulated losses included in net assets without donor restrictions were $14,656 and $16,266 at June 30, 2019 and 2018, respectively.

The Corporation recorded a net nonoperating (loss)/gain on changes in the fair value of nonqualifying interest rate swaps of ($47,995) and $43,071 for the years ended June 30, 2019 and 2018, respectively.

The swap agreements are included in the consolidated balance sheets at their fair value of $196,174 and $149,789 as of June 30, 2019 and 2018, respectively, an amount that is based on observable inputs other than quoted market prices in active markets for identical liabilities (Level 2 in the fair value hierarchy).

The Corporation is subject to a collateral posting requirement with two of its swap counterparties. Collateral posting requirements are based on the Corporation's long-term debt credit ratings, as well as the net liability position of total interest rate swap agreements outstanding with that counterparty. The amount of such posted collateral was $109,934 and $80,480 at June 30, 2019 and 2018, respectively. As of June 30, 2019 and 2018, the Corporation met its collateral posting requirement through the use of collateralized investments, which were selected and purchased by the Corporation and subsequently transferred to the custody of the swap counterparty. The amount of posted investments that is required to meet the collateral requirement is computed daily and is accounted for as a component of the Corporation's assets limited as to use on the accompanying consolidated balance sheets as of that date. Any excess investment value is considered a component of the Corporation's unrestricted investment portfolio and is included in investments on the accompanying consolidated balance sheets as of that date.

(9) Other Liabilities

Other liabilities consist of the following at June 30:

	2019	2018
Professional and general malpractice liabilities	$ 313,136	290,306
Capital lease obligations	52,528	53,784
Accrued pension obligations	108,533	91,210
Accrued interest payable	21,922	23,809
Unearned revenue	3,736	2,812
Other miscellaneous	66,929	84,689
Total other liabilities	566,784	546,610
Less current portion	(127,760)	(151,163)
Other long-term liabilities	$ 439,024	395,447

Other miscellaneous liabilities consists of patient credit balances and other current and long-term liabilities.

(10) Retirement Plans

Employees of the Corporation are included in various retirement plans established by the Corporation, the Medical Center, ROI, Midtown, Baltimore Washington, Shore Regional, Charles Regional, St. Joseph, Upper Chesapeake, and Capital Region. Participation by employees in their specific plan(s) has evolved based upon the organization by which they were first employed and the elections that they made at the times when their original employers became part of the Corporation. The following is a brief description of each of the retirement plans in which employees of the Corporation participate:

(a) Defined Benefit Plans

University of Maryland Medical Center Midtown Campus Retirement Plan for Non-Union Employees (Midtown Plan) – A noncontributory defined benefit plan covering substantially all nonunion employees. The benefits are based on years of service and compensation. Contributions to this plan are made to satisfy the minimum funding requirements of ERISA. In 2006, Midtown froze the defined benefit pension plan.

Baltimore Washington Medical Center Pension Plan (Baltimore Washington Plan) – A noncontributory defined benefit pension plan covering full-time employees who have been employed for at least one year and have reached 21 years of age. In 2018, Baltimore Washington closed the defined benefit pension plan to new hires.

Baltimore Washington Medical Center Supplemental Executive Retirement Plan – A noncontributory defined benefit pension plan for senior management level employees. In 2018, Baltimore Washington terminated the defined benefit pension plan and liquidation of its remaining benefit obligation using its plan assets was completed on December 29, 2017.

(Continued)

On June 30, 2015, the Corporation amended the Baltimore Washington Medical Center Pension Plan to provide for the merger of the Midtown Plan and the Charles Regional Plan into the Baltimore Washington Plan and to change the name of the newly consolidated plan to the University of Maryland Medical System Corporate Pension Plan (the Corporate Plan). All provisions of the respective previous plans shall continue to apply to the respective applicable participants. All of the assets of the three formerly separate plans are now available to pay benefits for all participants under the Corporate Plan.

Chester River Health System, Inc. Pension Plan and Trust – A noncontributory defined benefit pension plan covering substantially all CRHC employees as well as employees of a subsidiary. The benefits are paid to retirees based upon age at retirement, years of service, and average compensation. Chester River's funding policy is to satisfy the minimum funding requirements of ERISA. Effective June 30, 2008, Chester River froze the defined-benefit pension plan. On March 31, 2018, Chester River terminated the defined benefit pension plan and liquidation of its remaining benefit obligation using its plan assets was completed as of June 30, 2019.

Civista Health Inc. Retirement Plan and Trust (Charles Regional Plan) – A noncontributory defined benefit pension plan covering employees that have worked at least 1,000 hours per year during three or more plan years. Plan benefits are accumulated based upon a combination of years of service and percent of annual compensation. Charles Regional makes annual contributions to the plan based upon amounts required to be funded under provisions of ERISA.

Upper Chesapeake Health System, Inc. Pension Plan and Trust – A noncontributory defined benefit pension plan covering substantially all employees of the various affiliates of Upper Chesapeake who have completed six months of employment and attained the age of 20.5 years. Upper Chesapeake makes annual contributions to the plan equal to the minimum funding requirements pursuant to ERISA regulations. On December 31, 2005, Upper Chesapeake froze the defined benefit pension plan. On June 30, 2015, Upper Chesapeake terminated the defined benefit pension plan and liquidation of its remaining benefit obligation using its plan assets was completed by September 30, 2017.

Dimensions Health Corporation Pension Plan (Capital Region Pension Plan) – A noncontributory defined benefit pension plan covering substantially all employees. For employees not covered under collective-bargaining agreements and employees who are represented by the 1199 SEIU Health Care Workers East – Health Care Workers union (formerly District 1199E-DC, SEIU union and formerly Local No. 63 union), the plan operates as a cash balance plan. The annual contribution by the Corporation is allocated to individual employee accounts based on years of service and the individual's retirement account. For employees represented by the 1199 SEIU Health Care Workers East – Registered Nurses Chapter union (formerly Professional Staff Nurses Association union), benefits are based on years of service and average final compensation. On December 31, 2007, the Capital Region Pension Plan was frozen. No further benefit accruals will be made to the plan. The plan freeze substantially reduces annual funding obligations beginning with plan year 2008. The Corporation's funding policy is to contribute such actuarially determined amounts as necessary to provide assets sufficient to meet the benefits to be paid to the plan participants and to meet the funding requirements of the Employees Retirement Income Security Act of 1974 (ERISA).

Dimensions Health Corporation Post Retirement Benefit Plans (Capital Region Post Retirement Benefit Plans) – A postretirement health care plan is provided to both salaried and nonsalaried employees who

have retired and certain other employees who were eligible to retire prior to July 1, 1995. The plan is contributory for those who retired prior to July 1, 1995, with retiree contributions adjusted annually. Employees who retired on July 1, 1995 and later are eligible to participate in the plan by paying 100% of the premiums without corporate contributions. The Corporation's policy has been to fund this plan on an as needed basis.

A defined postretirement life insurance plan is a noncontributory plan for all eligible retirees prior to July 1, 2001. For employees represented by the 1199 SEIU Health Care Workers East – Registered Nurses Chapter union, the plan was no longer offered to new retirees as of July 1, 1999. Effective July 1, 2001, the plan was modified to become contributory for the nonunion employees and employees represented by the 1199 SEIU Health Care Workers East – Health Care Workers union who retired prior to July 1, 2001 and for the employees represented by the 1199 SEIU Health Care Workers East – Registered Nurses Chapter union who retired prior to July 1, 1999. The Corporation's policy has been to fund its share of these benefits as they are incurred.

The Corporation recognizes the funded status (i.e., the difference between the fair value of plan assets and projected benefit obligations) of its defined benefit pension plans as an asset or liability in its consolidated balance sheets. The Corporation recognizes changes in the funded status in the year in which the changes occur as changes in unrestricted net assets. All defined benefit pension plans use a June 30 measurement date.

The following tables set forth the combined benefit obligations and assets of the defined benefit plans at June 30:

		2019	2018
Change in projected benefit obligations:			
Benefit obligations at beginning of year	$	431,340	182,024
Benefit obligations, Capital Region		—	278,165
Settlements		(37,686)	(11,747)
Curtailments and plan amendments		—	(2,206)
Service cost		3,093	3,093
Interest cost		17,812	17,120
Actuarial loss		30,783	(13,064)
Benefit payments		(19,633)	(22,045)
Projected benefit obligations at end of year	$	425,709	431,340

(Continued)

		2019	2018
Change in plan assets:			
Fair value of plan assets at beginning of year	$	340,130	155,602
Fair value of plan assets, Capital Region		—	187,164
Actual return on plan assets		16,354	16,182
Settlements		(38,544)	(11,747)
Employer contributions		18,869	14,974
Benefit payments		(19,633)	(22,045)
Fair value of plan assets at end of year	$	317,176	340,130

The funded status of the plans and amounts recognized as accrued payroll and benefits and other long-term liabilities in the consolidated balance sheets at June 30 are as follows:

		2019	2018
Funded status, end of period:			
Fair value of plan assets	$	317,176	340,130
Projected benefit obligations		425,709	431,340
Net funded status	$	(108,533)	(91,210)
Accumulated benefit obligation at end of year	$	423,017	428,509
Amounts recognized in consolidated balance sheets at June 30:			
Accrued payroll and benefits	$	—	—
Accrued pension obligation		(108,533)	(91,210)
	$	(108,533)	(91,210)
Amounts recognized in net assets without donor restrictions at June 30:			
Net actuarial gain (loss)	$	(71,177)	44,165
Prior service cost		(159)	284
	$	(71,336)	44,449

(Continued)

The estimated amounts that will be amortized from net assets without donor restrictions into net periodic pension cost in fiscal year 2020 are as follows:

Net actuarial loss	$	3,974
Prior service cost		72
	$	4,046

The components of net periodic pension cost for the years ended June 30 are as follows:

		2019	2018
Service cost	$	3,093	3,093
Interest cost		17,812	17,120
Expected return on plan assets		(19,849)	(22,636)
Prior service cost recognized		76	464
Recognized gains or losses		8,173	8,990
Net periodic pension cost	$	9,305	7,031

Components of net benefit cost other than the service cost of $3,093 were recorded in other nonoperating losses, net in the consolidated statements of operations and changes in net assets for the years ended June 30, 2019 and 2018. Service cost is included as a component of fringe benefits, which is recorded as salaries, wages, and benefits in the accompanying consolidated statements of operations and changes in net assets.

The following table presents the weighted average assumptions used to determine benefit obligations for the plans at June 30:

	2019	2018
Discount rate	3.25%–3.70%	4.22%–4.44%
Rate of compensation increase (for nonfrozen plan)	3.00	3.00

The following table presents the weighted average assumptions used to determine net periodic benefit cost for the plans for the years ended June 30:

	2019	2018
Discount rate	4.22%–4.69%	3.20%–4.10%
Expected long-term return on plan assets	6.25-6.50	6.50
Rate of compensation increase (for nonfrozen plan)	3.00	3.00

(Continued)

The investment policies of the Corporation's pension plans incorporate asset allocation and investment strategies designed to earn superior returns on plan assets consistent with reasonable and prudent levels of risk. Investments are diversified across classes, sectors, and manager style to minimize the risk of loss. The Corporation uses investment managers specializing in each asset category and regularly monitors performance and compliance with investment guidelines. In developing the expected long-term rate of return on assets assumption, the Corporation considers the current level of expected returns on risk-free investments, the historical level of the risk premium associated with the other asset classes in which the portfolio is invested, and the expectations for future returns of each asset class. The expected return for each asset class is then weighted based on the target allocation to develop the expected long-term rate of return on assets assumption for the portfolio.

The Corporation's pension plans' target allocation and weighted average asset allocations at the measurement date of June 30, 2019 and 2018, by asset category, are as follows:

Asset category	Target allocation	Percentage of plan assets as of June 30	
		2019	2018
Cash and cash equivalents	0%–10%	4 %	2 %
Fixed income securities	20%–40%	28	30
Equity securities	30%–50%	41	39
Global asset allocation	10%–20%	17	17
Hedge funds	5%–15%	10	12
		100 %	100 %

Equity and fixed income securities include investments in hedge fund of funds that are categorized in accordance with each fund's respective investment holdings.

(Continued)

The table below presents the Corporation's combined investable assets of the defined benefit pension plans as of June 30, 2019, aggregated by the fair value hierarchy as described in note 1(w):

	Level 1	Level 2	Level 3	Investments reported at NAV*	Total
Cash and cash equivalents	$ 7,324	4,589	—	—	11,913
Corporate bonds	19,531	—	—	—	19,531
Government and agency bonds	16,509	—	—	—	16,509
Fixed income mutual funds	12,430	—	—	—	12,430
Common and preferred stocks	21,840	—	—	—	21,840
Equity mutual funds	45,633	15,096	—	—	60,729
Other mutual funds	26,582	—	—	—	26,582
Alternative investments	7,575	30,295	—	109,772	147,642
	$ 157,424	49,980	—	109,772	317,176

* Fund investments reported at NAV as practical expedient

The table below presents the Corporation's combined investable assets of the defined benefit pension plans as of June 30, 2018, aggregated by the fair value hierarchy as described in note 1(w):

	Level 1	Level 2	Level 3	Investments reported at NAV*	Total
Cash and cash equivalents	$ 5,107	3,010	—	—	8,117
Corporate bonds	25,285	—	—	—	25,285
Government and agency bonds	10,315	—	—	—	10,315
Fixed income mutual funds	21,556	—	—	—	21,556
Common and preferred stocks	10,084	—	—	—	10,084
Equity mutual funds	100,309	12,091	—	—	112,400
Other mutual funds	30,968	—	—	—	30,968
Alternative investments	26,961	27,153	—	67,291	121,405
	$ 230,585	42,254	—	67,291	340,130

* Fund investments reported at NAV as practical expedient

Alternative investments include hedge funds and commingled investment funds. The majority of these alternative investments held as of June 30, 2019 are subject to notice requirements of 30 days or less and are available to be redeemed on at least a monthly basis. There are funds, totaling $33,000, which are subject to notice requirements of 30-60 days and are available to be redeemed on a monthly or quarterly basis. Funds totaling $14,500 are subject to notice requirements of 90 days and can be redeemed monthly or quarterly. Of these funds, one fund totaling $2,100 is subject to a lock-up restriction of three years. In addition, one fund totaling $13 is subject to lockup restrictions and is not available to be redeemed until certain time restrictions are met, which range from one to three years. The Corporation had no unfunded commitments as of June 30, 2019.

(Continued)

Alternative investments include hedge funds and commingled investment funds. The majority of these alternative investments held as of June 30, 2018 are subject to notice requirements of 30 days or less and are available to be redeemed on at least a monthly basis. There are funds, totaling $14,400, which are subject to notice requirements of 30-60 days and are available to be redeemed on a monthly or quarterly basis. Funds totaling $13,400 are subject to notice requirements of 90 days and can be redeemed monthly or quarterly. Of these funds, one fund totaling $1,200 is subject to a lock-up restriction of three years. In addition, one fund totaling $800 is subject to lockup restrictions and is not available to be redeemed until certain time restrictions are met, which range from one to three years. The Corporation had no unfunded commitments as of June 30, 2018.

The Corporation expects to contribute $17,590 to its defined benefit pension plans for the fiscal year ending June 30, 2020.

The following benefit payments, which reflect expected future employee service, as appropriate, are expected to be paid from plan assets in the following years ending June 30:

2020	$	23,317
2021		24,170
2022		24,376
2023		25,105
2024		25,785
2025–2029		125,949

The expected benefits to be paid are based on the same assumptions used to measure the Corporation's benefit obligation at June 30, 2019.

(b) Defined Contribution Plans

Corporation Salary Reduction 403(b) Plan – A contributory benefit plan covering substantially all employees not participating in the plans described below. Employees are immediately eligible for elective deferrals of compensation as contributions to the plan. Employees are eligible for matching contributions after one year of service with a five-year gradual vesting schedule. Effective January 1, 2017, this plan was opened for new participants.

Corporation Pension Plan – A noncontributory defined contribution plan for all eligible Corporation employees not participating in the ROI Plan or the Midtown Plan described below. Contributions to this plan by the Corporation are determined as a fixed percentage of total employees' base compensation. Effective January 1, 2017, this plan was frozen to new participants.

Corporation Salary Reduction 403(b) Plan – A contributory benefit plan covering substantially all employees not participating in the plans described below. Employees are immediately eligible for elective deferrals of compensation as contributions to the plan. Effective July 29, 2016, the Baltimore Washington retirement plan was merged into this plan. Effective January 1, 2017, this plan was frozen to new participants.

Midtown 401(k) Profit Sharing Plan for Union Employees – A defined contribution plan for substantially all union employees of Midtown. Employer contributions to this plan are determined based on years of service and hours worked. Employees are immediately eligible for elective deferrals of compensation as contributions to the plan.

Baltimore Washington Retirement Plans – There are defined contribution plans covering all employees of Baltimore Washington Medical Center and certain related entities. Effective July 29, 2016, these plans merged into the UMMS Voluntary 403(b) plan.

Shore Health System Retirement Plan – A contributory benefit plan covering substantially all employees of Shore Health. Employees are eligible for matching contributions after one year of service.

Chester River Retirement Plan – A contributory benefit plan covering substantially all employees of Chester River who have met the eligibility requirements. Employees are eligible for matching contributions after one year of service.

Charles Regional Retirement Savings Plan – A contributory benefit plan covering substantially all full-time employees of Charles Regional. Employees are eligible for matching contributions after three years of service as defined in the plan.

Upper Chesapeake Retirement Plan – A contributory benefit plan covering substantially all employees of Upper Chesapeake. Employees are eligible for elective deferrals of compensation as contributions to the plan. Employees are eligible for matching contributions after one year of service with a five-year gradual vesting schedule.

Dimensions Health Retirement Plan (Capital Region Retirement Plan) – A contributory benefit plan covering substantially all employees of Capital Region. This plan replaced the frozen defined benefit plan effective January 1, 2008. Employees are eligible for elective deferrals of compensation as contributions to the plan. Employees are eligible for matching contributions after one year of service with a three year “cliff” vesting schedule. Nonrepresented employees who, as of January 1, 2008, are both 55 years or older, who have at least one year of vesting service, and work in positions budged for at least 40 hours per pay period receive an additional contribution.

In accordance with the collective bargaining agreement with 1199 SEIU Health Care Workers East – Registered Nurses Chapter, represented employees with 15 years of service also receive a matching $25 for each pay period in which they defer $25 or more paid quarterly. These employees who are both 55 years or older, and who have 15 years of vesting service, and work in positions budged for at least 40 hours per pay period receive an additional contribution.

Total annual retirement costs incurred by the Corporation for the previously discussed defined contribution plans were $48,972 and $45,918 for the years ended June 30, 2019 and 2018, respectively. Such amounts are included in salaries, wages, and benefits in the accompanying consolidated statements of operations and changes in net assets.

(Continued)

(11) Net Assets with Donor Restrictions

Net assets are restricted primarily for the following purposes at June 30:

		2019	2018
Facility construction and renovations, research, education, and other:			
Capital region	$	424,034	424,034
All others		142,084	122,514
Economic and beneficial interests in the net assets of related organizations		198,101	196,119
	$	764,219	742,667

Net assets were released from donor restrictions during the years ended June 30, 2019 and 2018 by expending funds satisfying the restricted purposes or by occurrence of other events specified by donors as follows:

		2019	2018
Purchases of equipment and construction costs	$	14,130	3,484
Research, education, uncompensated care, and other		4,279	3,956
	$	18,409	7,440

The Corporation's endowments consist of donor-restricted funds established for a variety of purposes. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

(a) Interpretation of Relevant Law

The Corporation has interpreted the Maryland Uniform Prudent Management of Institutional Funds Act (MUPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Corporation classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund are classified in net assets with donor restrictions until those amounts are appropriated for expenditure by the organization in a manner consistent with the standard of prudence prescribed by MUPMIFA. In accordance with MUPMIFA, the Corporation considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

(1) The duration and preservation of the fund

(Continued)

(2) The purposes of the Corporation and the donor-restricted endowment fund

(3) General economic conditions

(4) The possible effect of inflation and deflation

(5) The expected total return from income and the appreciation of investments

(6) Other resources of the Corporation

(7) The investment policies of the Corporation.

Endowment net assets are as follows:

	June 30, 2019		
	Without donor restrictions	With donor restrictions	Total
Donor-restricted endowment funds	$ 39	65,433	65,472

	June 30, 2018		
	Without donor restrictions	With donor restrictions	Total
Donor-restricted endowment funds	$ 38	60,333	60,371

Donor restricted endowment funds within net assets with donor restrictions whose use is restricted in perpetuity were $48,826 and $44,209 as of June 30, 2019 and 2018, respectively.

(b) Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or MUPMIFA requires the Corporation to retain as a fund of perpetual duration. The Corporation does not have any donor-restricted endowment funds that are below the level that the donor or MUPMIFA requires.

(c) Investment Strategies

The Corporation has adopted policies for corporate investments, including endowment assets that seek to maximize risk-adjusted returns with preservation of principal. Endowment assets include those assets of donor-restricted funds that the Corporation must hold in perpetuity or for a donor-specified period(s).The endowment assets are invested in a manner that is intended to hold a mix of investment assets designed to meet the objectives of the account. The Corporation expects its endowment funds, over time, to provide an average rate of return that generates earnings to achieve the endowment purpose.

To satisfy its long-term rate-of-return objectives, the Corporation relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Corporation employs a diversified asset allocation structure to achieve its long-term return objectives within prudent risk constraints.

The Corporation monitors the endowment funds' returns and appropriates average returns for use. In establishing this practice, the Corporation considered the long-term expected return on its endowment. This is consistent with the Corporation's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term, as well as to provide additional real growth through new gifts and investment return.

(12) Economic and Beneficial Interests in the Net Assets of Related Organizations

The Corporation is supported by several related organizations that were formed to raise funds on behalf of the Corporation and certain of its subsidiaries. These interests are accounted for as either economic or beneficial interests in the net assets of such organizations.

The following is a summary of economic and beneficial interests in the net assets of financially interrelated organizations as of June 30:

	2019	2018
Economic interests in:		
UCH Legacy Funding Corporation	$ 150,000	150,000
The James Lawrence Kernan Hospital Endowment Fund, Incorporated	33,099	31,804
Baltimore Washington Medical Center Foundation, Inc.	10,337	9,862
Total economic interests	193,436	191,666
Beneficial interest in the net assets of:		
Dorchester General Hospital Foundation, Inc.	3,709	3,711
Prince George's Hospital Center Foundation, Inc.	894	496
Laurel Regional Hospital Auxiliary, Inc.	62	170
Laurel Regional Hospital Foundation, Inc.	—	76
	$ 198,101	196,119

The UCH Legacy Funding Corporation was formed in December 2013 to hold funds restricted for the benefit of Upper Chesapeake.

At the discretion of its board of trustees, the Kernan Endowment Fund may pledge securities to satisfy various collateral requirements on behalf of ROI and may provide funding to ROI to support various clinical programs or capital needs.

(Continued)

BWMC Foundation was formed in July 2000 and supports the activities of UM Baltimore Washington by soliciting charitable contributions on its behalf.

Shore Regional maintains a beneficial interest in the net assets of Dorchester Foundation, a nonprofit corporation organized to raise funds on behalf of Dorchester Hospital. Shore Regional does not have control over the policies or decisions of the Dorchester Foundation.

The Prince George's Hospital Center Foundation, Inc.; the Laurel Regional Hospital Auxiliary, Inc.; and the Laurel Regional Hospital Foundation, Inc. were established to solicit contributions from the general public solely for the funding of capital acquisitions and operations of the associated Capital Region hospitals. Capital Region does not have control over the policies or decisions of these entities. In the current year, the Prince George's Hospital Center Foundation, Inc. changed its name to University of Maryland Capital Region Health Foundation, Inc., and the Laurel Regional Hospital Foundation, Inc. was closed and its assets were transferred into the new University of Maryland Capital Region Health Foundation, Inc.

A summary of the combined unaudited condensed financial information of the financially interrelated organizations in which the Corporation holds an economic or beneficial interest as of June 30 is as follows:

		2019	2018
Current assets	$	4,447	3,355
Noncurrent assets		193,658	192,857
Total assets	$	198,105	196,212
Current liabilities	$	102	109
Noncurrent liabilities		(97)	(16)
Net assets		198,101	196,119
Total liabilities and net assets	$	198,106	196,212
Total operating revenue	$	4,481	3,897
Total operating expense		(2,505)	(1,474)
Other changes in net assets		5	1,353
Total increase in net assets	$	1,981	3,776

(13) State and County Support

The Corporation received $3,300 and $3,200 in support for the Shock Trauma Center operations from the state of Maryland for the years ended June 30, 2019 and 2018, respectively.

(Continued)

In support of Capital Region operations, the Corporation received the following for the years ended June 30:

	2019	2018
State of Maryland	$ 27,000	28,000
Prince George's County government	10,178	8,305
Magruder Memorial Hospital Trust	1,042	869
	$ 38,220	37,174

The State of Maryland appropriates funds for construction costs incurred, equipment purchases made, and other capital support. The Corporation recognizes this support as the funds are expended for the intended projects. The Corporation expended and recorded $5,565 and $3,209 during the years ended June 30, 2019 and 2018, respectively.

As described in note 1(a)(x), Prince George's County and the State of Maryland have each approved funding through legislation of $208,000 towards the construction of the new medical facility.

(14) Functional Expenses

The Corporation provides healthcare services to residents within its geographic location. Expenses related to providing these services, based on management's estimates of expense allocations, are as follows for the years ended June 30:

	Year ended June 30, 2019							
	Healthcare service							
	Hospital & Ambulatory	Retail Pharmacy	Physician Practices	Risk Taking	Corporate Services	Other	Eliminations	Total
Operating expenses:								
Salaries, wages and benefits	$ 1,646,025	5,177	268,023	3,886	190,219	46,915	(2,109)	2,158,136
Expendable supplies	678,620	71,514	34,480	42	2,924	4,435	—	792,015
Purchased services:								
Purchased services	471,657	9,150	65,400	4,480	148,689	69,516	(134,274)	634,618
Purchased service recoveries	355,031	—	—	—	(355,031)	—	—	—
Contracted services:								
Contracted services	274,221	—	30,169	—	—	270	—	304,660
Contracted service recoveries	—	—	—	—	—	—	(34,763)	(34,763)
Depreciation and amortization	232,436	—	2,484	—	419	8,717	—	244,056
Interest expense	54,698	—	—	1,492	355	1,247	—	57,792
Total operating expenses	$ 3,712,688	85,841	400,556	9,900	(12,425)	131,100	(171,146)	4,156,514

(Continued)

	Year ended June 30, 2018							
	Healthcare service							
	Hospital & Ambulatory	Retail Pharmacy	Physician Practices	Risk Taking	Corporate Services	Other	Eliminations	Total
Operating expenses:								
Salaries, wages and benefits	$ 1,584,288	4,708	243,256	4,279	161,743	21,801	—	2,020,075
Expendable supplies	659,829	63,394	27,649	90	3,988	3,302	—	758,252
Purchased services:								
Purchased services	422,885	5,592	57,001	7,857	136,758	22,174	(36,289)	615,978
Purchased service recoveries	303,255	—	—	—	(303,255)	—	—	—
Contracted services:								
Contracted services	266,364	—	29,054	—	—	60	—	295,478
Contracted service recoveries	—	—	—	—	—	—	(20,102)	(20,102)
Depreciation and amortization	227,240	—	2,482	—	695	5,673	—	236,090
Interest expense	52,661	—	—	1,369	321	1,276	—	55,627
Total operating expenses	$ 3,516,522	73,694	359,442	13,595	250	54,286	(56,391)	3,961,398

Corporate services are allocated primarily using percentage of net patient service revenue.

(15) Liquidity and Availability of Resources

The Corporation had financial assets available to management for general expenditure within one year of the financial reporting date, or June 30, 2019 and 2018, as follows:

	2019	2018
Cash and cash equivalents	$ 360,318	397,243
Receivables, net	549,540	520,383
Current investments and assets whose use is limited	64,910	56,484
Long-term investments and assets whose use is limited	2,113,024	2,002,612
Total financial assets available within one year	3,087,792	2,976,722
Less:		
Amounts unavailable for general expenditures within one year due to:		
Restricted by donors with purpose restrictions	78,255	69,470
Restricted for swap collateral	113,586	84,590
Debt service and reserve funds	86,157	82,820
Self insurance trust funds	212,384	230,589
Construction funds - held by trustee	279,205	266,822
Alternative investments subject to lockup restrictions	20,700	15,070
Total amounts unavailable for general expenditures within one year	790,287	749,361
Total financial assets available to management for general expenditure within one year	$ 2,297,505	2,227,361

(Continued)

(16) Insurance

The Corporation maintains self-insurance programs for professional and general liability risks, employee health, employee long-term disability, and workers' compensation. Estimated liabilities have been recorded based on actuarial estimation of reported and incurred but not reported claims. The accrued liabilities for these programs as of June 30, 2019 and 2018 were as follows:

	2019	2018
Professional and general malpractice liabilities	$ 313,136	290,306
Employee health	33,556	35,799
Employee long-term disability	5,577	6,369
Workers' compensation	20,977	19,869
Total self-insured liabilities	373,246	352,343
Less current portion	(70,368)	(73,226)
	$ 302,878	279,117

The Corporation provides for and funds the present value of the costs for professional and general liability claims and insurance coverage related to the projected liability from asserted and unasserted incidents, which the Corporation believes may ultimately result in a loss. In management's opinion, these accruals provide an adequate and appropriate loss reserve. The professional and general malpractice liabilities presented above include $202,779 and $168,452 as of June 30, 2019 and 2018, respectively, for which related insurance receivables have been recorded within other assets on the accompanying consolidated balance sheets.

The Corporation and each of its affiliates are self-insured for professional and general liability claims up to the limits of $1,000 on individual claims and $3,000 in the aggregate on an annual basis. For amounts in excess of these limits, the risk of loss has been transferred to Terrapin, an unconsolidated joint venture. Terrapin provides insurance for claims in excess of $1,000 individually and $3,000 in the aggregate, up to $150,000 individually and $150,000 in the aggregate, under claims made policies between the Corporation and Terrapin. For claims in excess of Terrapin's coverage limits, if any, the Corporation retains the risk of loss.

As discussed in note 4, Terrapin is a joint venture corporation in which a 50% equity interest is owned by the Corporation and a 50% equity interest is owned by Faculty Physicians, Inc.

Total malpractice insurance expense for the Corporation during the years ended June 30, 2019 and 2018 was approximately $60,654 and $52,652, respectively.

(17) Business and Credit Concentrations

The Corporation provides healthcare services through its inpatient and outpatient care facilities located in the State of Maryland. The Corporation generally does not require collateral or other security in extending credit; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits

receivable under their health insurance programs, plans, or policies (e.g., Medicare, Medicaid, Blue Cross, workers' compensation, health maintenance organizations (HMOs), and commercial insurance policies).

The Corporation maintains cash accounts with highly rated financial institutions, which generally exceed federally insured limits. The Corporation has not experienced any losses from maintaining cash accounts in excess of federally insured limits, and as such, management does not believe the Corporation is subject to any significant credit risks related to this practice.

The Corporation had receivables from patients and third-party payors as follows at June 30:

	2019	2018
Medicare	23 %	23 %
Medicaid	21	23
Commercial insurance and HMOs	17	18
Blue Cross	10	10
Self-pay and others	29	26
	100 %	100 %

The Corporation recorded revenues from patients and third-party payors for the years ended June 30 as follows:

	2019	2018
Medicare	37 %	38 %
Medicaid	24	24
Commercial insurance and HMOs	24	22
Blue Cross	10	11
Self-pay and others	5	5
	100 %	100 %

(18) Certain Significant Risks and Uncertainties

The Corporation provides general acute healthcare services in the state of Maryland. The Corporation and other healthcare providers in Maryland are subject to certain inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the federal Medicare and state Medicaid programs;
- Regulation of hospital rates by the State of Maryland Health Services Cost Review Commission;
- Government regulation, government budgetary constraints, and proposed legislative and regulatory changes; and
- Lawsuits alleging malpractice and related claims.

(Continued)

Such inherent risks require the use of certain management estimates in the preparation of the Corporation's consolidated financial statements, and it is reasonably possible that a change in such estimates may occur.

The Medicare and state Medicaid reimbursement programs represent a substantial portion of the Corporation's revenues, and the Corporation's operations are subject to a variety of other federal, state, and local regulatory requirements. Failure to maintain required regulatory approvals and licenses and/or changes in such regulatory requirements could have a significant adverse effect on the Corporation.

Changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Corporation.

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. The Corporation's compliance with these laws and regulations can be subject to periodic governmental review and interpretation, which can result in regulatory action unknown or unasserted at this time. Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the ordinary course of business, none of which, in the opinion of management, are expected to result in losses in excess of insurance limits or have a materially adverse effect on the Corporation's financial position.

The federal government and many states have aggressively increased enforcement under Medicare and Medicaid antifraud and abuse laws and physician self-referral laws (STARK law and regulation). Recent federal initiatives have prompted a national review of federally funded healthcare programs. In addition, the federal government and many states have implemented programs to audit and recover potential overpayments to providers from the Medicare and Medicaid programs. The Corporation has implemented a compliance program to monitor conformance with applicable laws and regulations, but the possibility of future government review and enforcement action exists.

(19) Maryland Health Services Cost Review Commission

Effective July 1, 2013, the Health System and the Health Services Cost Review Commission (HSCRC) agreed to implement the Global Budget Revenue (GBR) methodology for the following hospitals: Medical Center, ROI, UM Midtown, UM Baltimore Washington, UM Charles Regional, UM St. Joseph, UM Memorial, UM Dorchester, UM Chester River, Shore Emergency Center, UM Upper Chesapeake, UM Harford Memorial, UM Prince George's, and UM Laurel. The agreements will continue each year and on July 1 of each year thereafter; the agreements will renew for a one-year period unless it is canceled by the HSCRC or by the Corporation. The agreements were in place for the years ended June 30, 2019 and 2018. The GBR model is a revenue constraint and quality improvement system designed by the HSCRC to provide hospitals with strong financial incentives to manage their resources efficiently and effectively in order to slow the rate of increase in healthcare costs and improve healthcare delivery processes and outcomes. The GBR model is consistent with the Corporation's mission to provide the highest value of care possible to its patients and the communities it serves.

The GBR agreements establish a prospective, fixed revenue base "GBR cap" for the upcoming year. This includes both inpatient and outpatient regulated services. Under GBR, a hospital's revenue for all HSCRC regulated services is predetermined for the upcoming year, regardless of changes in volume, service mix intensity, or mix of inpatient or outpatient services that occurred during the year. The GBR agreement allows the Corporation to adjust unit rates, within certain limits, to achieve the overall revenue base for the Corporation at year-end. Any overcharge or undercharge versus the GBR cap is prospectively subtracted from the subsequent year's GBR cap. Although the GBR cap is fixed each year, it does not adjust for changes in volume or service mix. The GBR cap is also adjusted annually for inflation, and for changes in payor mix and uncompensated care. The Corporation will receive an annual adjustment to its cap for the change in population in the Corporation's service areas. GBR is designed to encourage hospitals to operate efficiently by reducing excess utilization and managing patients in the appropriate care delivery setting. The HSCRC also may impose various other revenue adjustments, which could be significant in the future.

The HSCRC utilizes a bad debt pool into which each of the regulated hospitals in Maryland participates. The funds in the bad debt pool are distributed to the hospitals that exceed the state average based upon the amount of uncompensated care delivered to patients during the year. For the years ended June 30, 2019 and 2018, the Corporation recognized a net distribution from the pool of approximately $23,974 and $14,015, respectively, which is recorded as net patient service revenue.

(20) Subsequent Events

The Corporation evaluated all events and transactions that occurred after June 30, 2019 and through October 28, 2019, the date the consolidated financial statements were issued. Other than described in note 5, the Corporation did not have any material recognizable subsequent events during the period.

Schedule 1

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2019

(In thousands)

Assets	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	Upper Chesapeake	Capital Region	UM Health Plans	UMMS Foundation	Other	Eliminations	Consolidated total
Current assets:														
Cash and cash equivalents	$ 243,228	5,261	9,554	5,415	22,012	10,816	4,733	26,227	32,766	—	—	306	—	360,318
Assets limited as to use, current portion	59,693	—	497	1,484	1,020	529	1,281	—	406	—	—	—	—	64,910
Accounts receivable:														
Patient accounts receivable, net	194,391	7,352	15,115	51,729	43,890	18,916	41,725	40,367	49,339	—	—	(4,387)	—	458,437
Other	223,326	889	6,549	40,680	16,156	17,659	9,157	33,903	192,685	—	—	1,494	(451,395)	91,103
Inventories	35,224	1,159	2,279	6,019	4,074	1,675	5,383	8,828	5,837	—	—	—	—	70,478
Assets held for sale	—	—	—	—	—	—	—	—	—	116,828	—	—	—	116,828
Prepaid expenses and other current assets	21,254	136	2,622	3,098	2,152	669	1,849	11,612	3,066	—	1,500	97	—	48,055
Total current assets	777,116	14,797	36,616	108,425	89,304	50,264	64,128	120,937	284,099	116,828	1,500	(2,490)	(451,395)	1,210,129
Investments	293,857	39,599	17,269	154,416	77,712	24,266	12,849	265,615	57	—	—	—	—	885,640
Assets limited as to use, less current portion:														
Investments held for collateral	94,786	1,115	1,721	8,929	4,313	2,722		—	—	—	—	—	—	113,586
Debt service funds	29,550	—	—	—	—	—	—	—	—	—	—	—	—	29,550
Construction funds	374,671	19,573	1,931	19,023	30,097	13,438	4,389	—	—	—	—	—	—	463,122
Board designated and escrow funds	—	—	—	—	76,564	(181)	—	43,985	—	—	20,321	—	—	140,689
Self-insurance trust funds	76,676	—	11,214	26,009	36,016	9,400	8,280	—	36,486	—	—	—	—	204,081
Funds restricted by donor	—	—	1,093	—	34,384	—	11,989	—	—	—	30,789	—	—	78,255
Economic and beneficial interests in the net assets of related organizations	215,768	36,950	531	10,337	3,709	—	9,503	—	955	—	—	—	(79,652)	198,101
	791,451	57,638	16,490	64,298	185,083	25,379	34,161	43,985	37,441	—	51,110	—	(79,652)	1,227,384
Property and equipment, net	1,087,230	43,324	106,606	253,452	147,200	103,666	226,849	253,201	87,109	—	—	449	—	2,309,086
Investments in joint ventures and other assets	912,619	15,600	8,178	25,665	14,896	10,999	42,925	233,686	8,935	2,217	17,756	—	(792,346)	501,130
Total assets	$ 3,862,273	170,958	185,159	606,256	514,195	214,574	380,912	917,424	417,641	119,045	70,366	(2,041)	(1,323,393)	6,133,369

(Continued)

Schedule 1

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2019

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	Upper Chesapeake	Capital Region	UM Health Plans	UMMS Foundation	Other	Eliminations	Consolidated total
Current liabilities:														
Trade accounts payable	$ 142,968	15,839	16,189	21,173	22,211	6,574	23,218	20,269	18,832	261	217	1,090	—	288,841
Accrued payroll and benefits	142,095	4,991	9,341	24,979	20,045	4,600	23,700	29,007	21,352	—	—	1,067	—	281,177
Advances from third-party payors	73,408	5,544	6,180	11,672	6,217	3,729	11,252	8,240	12,921	—	—	—	—	139,163
Lines of credit	130,000	—	—	—	—	—	—	—	—	31,300	—	—	—	161,300
Short-term financing	150,000	—	—	—	—	—	—	—	—	—	—	—	—	150,000
Other current liabilities	129,811	2,025	5,259	45,286	17,103	22,315	5,715	44,680	173,062	116,544	—	17,355	(451,395)	127,760
Liabilities held for sale	—	—	—	—	—	—	—	—	—	60,830	—	—	—	60,830
Long-term debt subject to short-term remarketing arrangements	18,895	—	—	—	—	—	—	—	—	—	—	—	—	18,895
Current portion of long-term debt	14,724	551	852	4,642	2,932	3,226	15,043	5,418	233	—	—	—	—	47,621
Total current liabilities	801,901	28,950	37,821	107,752	68,508	40,444	78,928	107,614	226,400	208,935	217	19,512	(451,395)	1,275,587
Long-term debt, less current portion	758,114	18,726	28,771	152,066	77,521	52,126	210,265	185,920	1,451	—	—	—	—	1,484,960
Other long-term liabilities	150,592	103	21,450	46,711	25,252	16,801	111,226	36,638	120,297	—	—	—	(90,046)	439,024
Interest rate swap liabilities	196,174	—	—	—	—	—	—	—	—	—	—	—	—	196,174
Total liabilities	1,906,781	47,779	88,042	306,529	171,281	109,371	400,419	330,172	348,148	208,935	217	19,512	(541,441)	3,395,745
Net assets:														
Without donor restrictions	1,323,581	86,096	95,493	289,390	303,036	105,203	(50,538)	427,880	35,437	(89,890)	22,317	(21,553)	(553,047)	1,973,405
With donor restrictions	631,911	37,083	1,624	10,337	39,878	—	31,031	159,372	34,056	—	47,832	—	(228,905)	764,219
Total net assets	1,955,492	123,179	97,117	299,727	342,914	105,203	(19,507)	587,252	69,493	(89,890)	70,149	(21,553)	(781,952)	2,737,624
Total liabilities and net assets	$ 3,862,273	170,958	185,159	606,256	514,195	214,574	380,912	917,424	417,641	119,045	70,366	(2,041)	(1,323,393)	6,133,369

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Medical Center & Affiliates (UMMC)

June 30, 2019

(In thousands)

Assets	University of Maryland Medical Center	Corporate Shared Services	36 South Paca	University CARE	Eliminations	University of Maryland Medical Center & Affiliates consolidated total
Current assets:						
Cash and cash equivalents	$ 47,596	188,756	1,479	5,397	—	243,228
Assets limited as to use, current portion	3,085	56,608	—	—	—	59,693
Accounts receivable:						
Patient accounts receivable, net	194,391	—	—	—	—	194,391
Other	214,732	8,566	28	—	—	223,326
Inventories	35,186	38	—	—	—	35,224
Prepaid expenses and other current assets	2,225	19,027	—	2	—	21,254
Total current assets	497,215	272,995	1,507	5,399	—	777,116
Investments	292,107	1,750	—	—	—	293,857
Assets limited as to use, less current portion:						
Investment held for collateral	—	94,786	—	—	—	94,786
Debt service funds	—	29,550	—	—	—	29,550
Construction funds	59,522	315,149	—	—	—	374,671
Board designated and escrow funds	—	—	—	—	—	—
Self-insurance trust funds	76,676	—	—	—	—	76,676
Funds restricted by donor	—	—	—	—	—	—
Economic interests in the net assets of related organizations	65,768	150,000	—	—	—	215,768
	201,966	589,485	—	—	—	791,451
Property and equipment, net	739,746	339,605	7,879	—	—	1,087,230
Investments in joint ventures and other assets	186,857	732,521	3,277	—	(10,036)	912,619
Total assets	$ 1,917,891	1,936,356	12,663	5,399	(10,036)	3,862,273

(Continued)

Schedule 1-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Medical Center & Affiliates (UMMC)

June 30, 2019

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center	Corporate Shared Services	36 South Paca	University CARE	Eliminations	University of Maryland Medical Center & Affiliates consolidated total
Current liabilities:						
Trade accounts payable	$ 93,050	49,299	190	429	—	142,968
Accrued payroll and benefits	74,702	67,393	—	—	—	142,095
Advances from third-party payors	73,408	—	—	—	—	73,408
Lines of credit	—	130,000	—	—	—	130,000
Short-term financing	—	150,000	—	—	—	150,000
Other current liabilities	69,658	60,031	115	7	—	129,811
Long-term debt subject to short-term remarketing arrangements	—	18,895	—	—	—	18,895
Current portion of long-term debt	13,774	950	—	—	—	14,724
Total current liabilities	324,592	476,568	305	436	—	801,901
Long-term debt, less current portion	549,416	208,698	—	—	—	758,114
Other long-term liabilities	150,587	—	5	—	—	150,592
Interest rate swaps	—	196,174	—	—	—	196,174
Total liabilities	1,024,595	881,440	310	436	—	1,906,781
Net assets:						
Without donor restrictions	827,528	488,773	12,353	4,963	(10,036)	1,323,581
With donor restrictions	65,768	566,143	—	—	—	631,911
Total net assets	893,296	1,054,916	12,353	4,963	(10,036)	1,955,492
Total liabilities and net assets	$ 1,917,891	1,936,356	12,663	5,399	(10,036)	3,862,273

See accompanying independent auditors' report.

Schedule 1-b

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Midtown Health, Inc. (Midtown)

June 30, 2019

(In thousands)

Assets	UM Midtown Health Systems, Inc.	UMMC Midtown Campus	UM Midtown Clin. Prac. Group	Eliminations	Midtown consolidated total
Current assets:					
Cash and cash equivalents	$ 8	9,537	9	—	9,554
Assets limited as to use, current portion	—	497	—	—	497
Accounts receivable:					
Patient accounts receivable, net	168	13,447	1,500	—	15,115
Other	3,714	2,835	—	—	6,549
Inventories	—	2,279	—	—	2,279
Prepaid expenses and other current assets	2,194	428	—	—	2,622
Total current assets	6,084	29,023	1,509	—	36,616
Investments	—	17,269	—	—	17,269
Assets limited as to use, less current portion:					
Investment held for collateral	—	1,721	—	—	1,721
Debt service funds	—	—	—	—	—
Construction funds	—	1,931	—	—	1,931
Board designated and escrow funds	—	—	—	—	—
Self-insurance trust funds	—	11,214	—	—	11,214
Funds restricted by donor	—	1,093	—	—	1,093
Economic interests in the net assets of related organizations	—	531	—	—	531
	—	16,490	—	—	16,490
Property and equipment, net	3,970	102,547	89	—	106,606
Investments in joint ventures and other assets	—	8,178	—	—	8,178
Total assets	$ 10,054	173,507	1,598	—	185,159

(Continued)

Schedule 1-b

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Midtown Health, Inc. (Midtown)

June 30, 2019

(In thousands)

Liabilities and Net Assets	UM Midtown Health Systems, Inc.	UMMC Midtown Campus	UM Midtown Clin. Prac. Group	Eliminations	Midtown consolidated total
Current liabilities:					
Trade accounts payable	$ 384	15,755	50	—	16,189
Accrued payroll and benefits	—	9,177	164	—	9,341
Advances from third-party payors	—	6,180	—	—	6,180
Lines of credit	—	—	—	—	—
Other current liabilities	—	4,285	974	—	5,259
Current portion of long-term debt	—	852	—	—	852
Total current liabilities	384	36,249	1,188	—	37,821
Long-term debt, less current portion	—	28,771	—	—	28,771
Other long-term liabilities	—	21,450	—	—	21,450
Total liabilities	384	86,470	1,188	—	88,042
Net assets:					
Without donor restrictions	9,670	85,413	410	—	95,493
With donor restrictions	—	1,624	—	—	1,624
Total net assets	9,670	87,037	410	—	97,117
Total liabilities and net assets	$ 10,054	173,507	1,598	—	185,159

See accompanying independent auditors' report.

Schedule 1-c

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Baltimore Washington Medical System (BWMS)

June 30, 2019

(In thousands)

Assets	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Eliminations	BWMS consolidated total
Current assets:							
Cash and cash equivalents	$ —	5,958	97	—	(640)	—	5,415
Assets limited as to use, current portion	—	1,484	—	—	—	—	1,484
Accounts receivable:							
Patient accounts receivable, net	958	41,211	9,560	—	—	—	51,729
Other	—	21,332	18,452	—	896	—	40,680
Inventories	—	6,019	—	—	—	—	6,019
Prepaid expenses and other current assets	1,449	1,445	198	—	6	—	3,098
Total current assets	2,407	77,449	28,307	—	262	—	108,425
Investments	—	154,416	—	—	—	—	154,416
Assets limited as to use, less current portion:							
Investment held for collateral	—	8,929	—	—	—	—	8,929
Debt service funds	—		—	—	—	—	—
Construction funds	—	19,023	—	—	—	—	19,023
Board designated and escrow funds	—		—	—	—	—	—
Self-insurance trust funds	—	26,009	—	—	—	—	26,009
Funds restricted by donor	—		—	—	—	—	—
Economic interests in the net assets of related organizations	—	10,337	—	—	—	—	10,337
	—	64,298	—	—	—	—	64,298
Property and equipment, net	4,709	230,961	2,053	—	15,729	—	253,452
Investments in joint ventures and other assets	337,592	25,662	—	—	2	(337,591)	25,665
Total assets	$ 344,708	552,786	30,360	—	15,993	(337,591)	606,256

(Continued)

Schedule 1-c

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Baltimore Washington Medical System (BWMS)

June 30, 2019

(In thousands)

Liabilities and Net Assets	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Eliminations	BWMS consolidated total
Current liabilities:							
Trade accounts payable	$ (139)	18,577	3,310	—	(575)	—	21,173
Accrued payroll and benefits	1,588	18,566	4,825	—		—	24,979
Advances from third-party payors	—	11,672	—	—		—	11,672
Lines of credit	—	—	—	—		—	—
Other current liabilities	40,185	3,904	1,177	—	20	—	45,286
Current portion of long-term debt	—	4,417	—	—	225	—	4,642
Total current liabilities	41,634	57,136	9,312	—	(330)	—	107,752
Long-term debt, less current portion	—	149,910	—	—	2,156	—	152,066
Other long-term liabilities	2,806	43,905	—	—	—	—	46,711
Total liabilities	44,440	250,951	9,312	—	1,826	—	306,529
Net assets:							
Without donor restrictions	300,268	291,498	21,048	—	14,167	(337,591)	289,390
With donor restrictions	—	10,337	—	—		—	10,337
Total net assets	300,268	301,835	21,048	—	14,167	(337,591)	299,727
Total liabilities and net assets	$ 344,708	552,786	30,360	—	15,993	(337,591)	606,256

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Shore Regional Health (Shore Regional)

June 30, 2019

(In thousands)

Assets	Shore Health System, Inc.	Shore Orthopedics	UM Shore Home Care	Queenstown ASC	Shore Medical Group	Memorial Hospital Foundation, Inc. and Subsidiary	Chester River Consolidated Total	Eliminations	Shore Regional consolidated total
Current assets:									
Cash and cash equivalents	$ (14,169)	424	8	—	4	—	35,745	—	22,012
Assets limited as to use, current portion	907	—	—	—	—	—	113	—	1,020
Accounts receivable:									
Patient accounts receivable, net	34,554	600	170	(14)	4,241	—	4,339	—	43,890
Other	14,741	3	3	—	1	1,082	326	—	16,156
Inventories	3,346	—	—	—	—	—	728	—	4,074
Prepaid expenses and other current assets	1,744	224	34	—	88	25	37	—	2,152
Total current assets	41,123	1,251	215	(14)	4,334	1,107	41,288	—	89,304
Investments	77,659	—	—	—	—	349	(296)	—	77,712
Assets limited as to use, less current portion:									
Investment held for collateral	4,091	—	—	—	—		222	—	4,313
Debt service funds	—	—	—	—	—		—	—	—
Construction funds	25,987	—	—	—	—		4,110	—	30,097
Board designated and escrow funds	25,000	—	—	—	—	46,526	5,038	—	76,564
Self-insurance trust funds	27,749	—	—	—	—		8,267	—	36,016
Funds restricted by donor	4,975	—	—	—	—	24,851	4,558	—	34,384
Economic and beneficial interests in the net assets of related organizations	79,326	—	—	—	—		6,663	(82,280)	3,709
	167,128	—	—	—	—	71,377	28,858	(82,280)	185,083
Property and equipment, net	123,617	491	178	43	1,978	3,018	17,875	—	147,200
Investments in joint ventures and other assets	10,616	—	—	—	—	12	2,104	2,164	14,896
Total assets	$ 420,143	1,742	393	29	6,312	75,863	89,829	(80,116)	514,195

(Continued)

Schedule 1-d

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Shore Regional Health (Shore Regional)

June 30, 2019

(In thousands)

Liabilities and Net Assets	Shore Health System, Inc.	Shore Orthopedics	UM Shore Home Care	Queenstown ASC	Shore Medical Group	Memorial Hospital Foundation, Inc. and Subsidiary	Chester River Consolidated Total	Eliminations	Shore Regional consolidated total
Current liabilities:									
Trade accounts payable	$ 15,499	217	14	2	1,512	3	4,964	—	22,211
Accrued payroll and benefits	11,299	850	348	—	5,345	22	2,181	—	20,045
Advances from third-party payors	5,562	—	—	—	—	—	655	—	6,217
Lines of credit	—	—	—	—	—	—	—	—	—
Other current liabilities	4,159	7,968	850	—	800	221	3,105	—	17,103
Current portion of long-term debt	2,824	—	—	—	—	—	108	—	2,932
Total current liabilities	39,343	9,035	1,212	2	7,657	246	11,013	—	68,508
Long-term debt, less current portion	73,851	—	—	—	—	—	3,670	—	77,521
Other long-term liabilities	18,159	—	—	—	—	—	7,093	—	25,252
Total liabilities	131,353	9,035	1,212	2	7,657	246	21,776	—	171,281
Net assets:									
Without donor restrictions	253,341	(7,293)	(819)	27	(1,345)	49,177	59,208	(49,260)	303,036
With donor restrictions	35,449	—	—	—	—	26,440	8,845	(30,856)	39,878
Total net assets	288,790	(7,293)	(819)	27	(1,345)	75,617	68,053	(80,116)	342,914
Total liabilities and net assets	$ 420,143	1,742	393	29	6,312	75,863	89,829	(80,116)	514,195

See accompanying independent auditors' report.

Schedule 1-e

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Chester River Health System, Inc. (CRHS) a subsidiary of Shore Regional Health

June 30, 2019

(In thousands)

Assets	Chester River Hospital Center	UM Shore Nursing and Rehab.	UM Chester River Home Care	Chester River Health Foundation	Chester River consolidated total
Current assets:					
Cash and cash equivalents	$ 35,738	—	7	—	35,745
Assets limited as to use, current portion	113	—	—	—	113
Accounts receivable:					
Patient accounts receivable, net	4,104	—	235	—	4,339
Other	263	—	19	44	326
Inventories	728	—	—	—	728
Prepaid expenses and other current assets	19	—	18	—	37
Total current assets	40,965	—	279	44	41,288
Investments	(4,168)	—	1,707	2,165	(296)
Assets limited as to use, less current portion:					
Investment held for collateral	222	—	—	—	222
Debt service funds	—	—	—	—	—
Construction funds	4,110	—	—	—	4,110
Board designated and escrow funds	5,000	—	—	38	5,038
Self-insurance trust funds	8,267	—	—	—	8,267
Funds restricted by donor	105	—	—	4,453	4,558
Economic interests in the net assets of related organizations	6,662	—	1	—	6,663
	24,366	—	1	4,491	28,858
Property and equipment, net	17,684	—	191	—	17,875
Investments in joint ventures and other assets	2,104	—	—	—	2,104
Total assets	$ 80,951	—	2,178	6,700	89,829

(Continued)

Schedule 1-e

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – Chester River Health System, Inc. (CRHS) a subsidiary of Shore Regional Health

June 30, 2019

(In thousands)

Liabilities and Net Assets	Chester River Hospital Center	UM Shore Nursing and Rehab.	UM Chester River Home Care	Chester River Health Foundation	Chester River consolidated total
Current liabilities:					
Trade accounts payable	$ 4,904	—	61	(1)	4,964
Accrued payroll and benefits	1,990	—	191	—	2,181
Advances from third-party payors	655	—	—	—	655
Lines of credit	—	—	—	—	—
Other current liabilities	3,068	—	—	37	3,105
Current portion of long-term debt	108	—	—	—	108
Total current liabilities	10,725	—	252	36	11,013
Long-term debt, less current portion	3,670	—	—	—	3,670
Other long-term liabilities	7,093	—	—	—	7,093
Total liabilities	21,488	—	252	36	21,776
Net assets:					
Without donor restrictions	55,038	—	1,922	2,248	59,208
With donor restrictions	4,425	—	4	4,416	8,845
Total net assets	59,463	—	1,926	6,664	68,053
Total liabilities and net assets	$ 80,951	—	2,178	6,700	89,829

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

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

June 30, 2019

(In thousands)

Assets	Charles Regional Health, Inc.	Charles Regional Medical Center, Inc.	Charles Regional Urgent Care	Charles Regional Care Partners, Inc. and Subsidiary	Charles Regional Health Foundation, Inc.	Charles Regional Medical Group	Charles Regional Imaging Center	Eliminations	Charles Regional consolidated total
Current assets:									
Cash and cash equivalents	$ —	9,066	—	100	1,650	—	—	—	10,816
Assets limited as to use, current portion	—	529	—	—	—	—	—	—	529
Accounts receivable:									
Patient accounts receivable, net	—	18,405	—	143	—	368	—	—	18,916
Other	—	17,425	—	222	12	—	—	—	17,659
Inventories	—	1,675	—	—	—	—	—	—	1,675
Prepaid expenses and other current assets	—	639	—	—	20	10	—	—	669
Total current assets	—	47,739	—	465	1,682	378	—	—	50,264
Investments	—	21,775	—	—	2,491	—	—	—	24,266
Assets limited as to use, less current portion:									
Investments held for collateral	—	2,722	—	—	—	—	—	—	2,722
Debt service funds	—	—	—	—	—	—	—	—	—
Construction funds	—	13,434	—	4	—	—	—	—	13,438
Board designated and escrow funds	(181)	—	—	—	—	—	—	—	(181)
Self-insurance trust funds	—	9,400	—	—	—	—	—	—	9,400
Funds restricted by donor	—	—	—	—	—	—	—	—	—
Economic interests in the net assets of related organizations	—	5,346	—	—	—	—	—	(5,346)	—
	(181)	30,902	—	4	—	—	—	(5,346)	25,379
Property and equipment, net	23,862	73,948	—	3,194	2,466	196	—	—	103,666
Investments in joint ventures and other assets	904	10,839	—	(958)	—	214	—	—	10,999
Total assets	$ 24,585	185,203	—	2,705	6,639	788	—	(5,346)	214,574

(Continued)

Schedule 1-f

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

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

June 30, 2019

(In thousands)

Liabilities and Net Assets	Charles Regional Health, Inc.	Charles Regional Medical Center, Inc.	Charles Regional Urgent Care	Charles Regional Care Partners, Inc. and Subsidiary	Charles Regional Health Foundation, Inc.	Charles Regional Medical Group	Charles Regional Imaging Center	Eliminations	Charles Regional consolidated total
Current liabilities:									
Trade accounts payable	$ 23	6,216	—	259	46	30	—	—	6,574
Accrued payroll and benefits	—	4,030	—	51	—	519	—	—	4,600
Advances from third-party payors	—	3,729	—	—	—	—	—	—	3,729
Lines of credit	—	—	—	—	—	—	—	—	—
Other current liabilities	9,138	2,537	1,961	4,082	540	4,057	—	—	22,315
Current portion of long-term debt	728	2,465	—	—	33	—	—	—	3,226
Total current liabilities	9,889	18,977	1,961	4,392	619	4,606	—	—	40,444
Long-term debt, less current portion	4,847	46,605	—	—	674	—	—	—	52,126
Other long-term liabilities	—	16,761	—	30	—	10	—	—	16,801
Total liabilities	14,736	82,343	1,961	4,422	1,293	4,616	—	—	109,371
Net assets:									
Without donor restrictions	9,849	102,860	(1,961)	(1,717)	5,346	(3,828)	—	(5,346)	105,203
With donor restrictions	—	—	—	—	—	—	—		—
Total net assets	9,849	102,860	(1,961)	(1,717)	5,346	(3,828)	—	(5,346)	105,203
Total liabilities and net assets	$ 24,585	185,203	—	2,705	6,639	788	—	(5,346)	214,574

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland St. Joseph Health System (SJHS)

June 30, 2019

(In thousands)

Assets	St. Joseph Medical Center	St. Joseph Medical Group	St. Joseph Properties	St. Joseph Orthopaedics	O'Dea Medical Arts	St. Joseph Foundation	UM Regional Supplier svcs	UM Regional Prof svcs	UM Pain Specialist LLC	Eliminations	St. Joseph consolidated total
Current assets:											
Cash and cash equivalents	$ 194	115	—	—	984	3,452	—	—	(12)	—	4,733
Assets limited as to use, current portion	1,281	—	—	—	—	—	—	—	—	—	1,281
Accounts receivable:											
Patient accounts receivable, net	36,083	2,353	—	1,388	—	—	1,013	469	419	—	41,725
Other	2,205	245	—	—	103	6,604	—	—	—	—	9,157
Inventories	5,230	—	—	—	—	—	153	—	—	—	5,383
Prepaid expenses and other current assets	1,012	452	182	112	—	—	55	36	—	—	1,849
Total current assets	46,005	3,165	182	1,500	1,087	10,056	1,221	505	407	—	64,128
Investments	—	—	—	—	—	12,849	—	—	—	—	12,849
Assets limited as to use, less current portion:											
Debt service funds	—	—	—	—	—	—	—	—	—	—	—
Construction funds	4,389	—	—	—	—	—	—	—	—	—	4,389
Board designated and escrow funds	—	—	—	—	—	—	—	—	—	—	—
Self-insurance trust funds	8,280	—	—	—	—	—	—	—	—	—	8,280
Funds restricted by donor	—	—	—	—	—	11,989	—	—	—	—	11,989
Economic interests in the net assets of related organizations	9,503	—	—	—	—	—	—	—	—	—	9,503
	22,172	—	—	—	—	11,989	—	—	—	—	34,161
Property and equipment, net	213,412	1,368	215	191	11,542	—	43	78	—	—	226,849
Investments in joint ventures and other assets	40,448	—	1,948	—	—	526	—	1,951	—	(1,948)	42,925
Total assets	$ 322,037	4,533	2,345	1,691	12,629	35,420	1,264	2,534	407	(1,948)	380,912

(Continued)

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UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland St. Joseph Health System (SJHS)

June 30, 2019

(In thousands)

Liabilities and Net Assets	St. Joseph Medical Center	St. Joseph Medical Group	St. Joseph Properties	St. Joseph Orthopaedics	O'Dea Medical Arts	St. Joseph Foundation	UM Regional Supplier svcs	UM Regional Prof svcs	UM Pain Specialist LLC	Eliminations	St. Joseph consolidated total
Current liabilities:											
Trade accounts payable	$ 20,956	751	623	1	74	104	672	37	—	—	23,218
Accrued payroll and benefits	16,837	5,616	—	1,005	—	—	25	190	27	—	23,700
Advances from third-party payors	11,252	—	—	—	—	—	—	—	—	—	11,252
Lines of credit	—	—	—	—	—	—	—	—	—	—	—
Other current liabilities	3,564	217	—	791	6	346	—	411	380	—	5,715
Current portion of long-term debt	6,821	—	—	—	8,222	—	—	—	—	—	15,043
Total current liabilities	59,430	6,584	623	1,797	8,302	450	697	638	407	—	78,928
Long-term debt, less current portion	210,299	—	(34)	—	—	—	—	—	—	—	210,265
Other long-term liabilities	111,226	—	—	—	—	—	—	—	—	—	111,226
Total liabilities	380,955	6,584	589	1,797	8,302	450	697	638	407	—	400,419
Net assets:											
Without donor restrictions	(58,919)	(2,051)	1,756	(106)	4,327	3,940	567	1,896	—	(1,948)	(50,538)
With donor restrictions	1	—	—	—	—	31,030	—	—	—	—	31,031
Total net assets	(58,918)	(2,051)	1,756	(106)	4,327	34,970	567	1,896	—	(1,948)	(19,507)
Total liabilities and net assets	$ 322,037	4,533	2,345	1,691	12,629	35,420	1,264	2,534	407	(1,948)	380,912

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION
AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Upper Chesapeake Health System (UCHS)

June 30, 2019

(In thousands)

Assets	Upper Chesapeake Medical Center	Harford Memorial Hospital	UCHS Properties	Health Ventures	Medical Services	Residential Hospice House	Upper Chesapeake Health Foundation	Upper Chesapeake Health System	Behavioral Health Crisis Center	Upper Chesapeake Insurance Co.	Upper Chesapeake Land Trust	Eliminations	Upper Chesapeake consolidated total
Current assets:													
Cash and cash equivalents	$ 13,655	9,522	29	—	109	5	2,907	—	—	—	—	—	26,227
Assets limited as to use, current portion	—	—	—	—	—	—	—	—	—	—	—	—	—
Accounts receivable:													
Patient accounts receivable, net	28,097	5,935	—	—	6,315	5	—	—	15	—	—	—	40,367
Other	33,903	—	—	—	—	—	—	—	—	—	—	—	33,903
Inventories	5,305	2,922	—	—	601	—	—	—	—	—	—	—	8,828
Prepaid expenses and other current assets	2,705	2,559	16	—	522	5	5,720	71	14	—	—	—	11,612
Total current assets	83,665	20,938	45	—	7,547	15	8,627	71	29	—	—	—	120,937
Investments	169,188	95,813	—	—	—	614	—	—	—	—	—	—	265,615
Assets limited as to use, less current portion:													
Investments held for swap collateral	—	—	—	—	—	—	—	—	—	—	—	—	—
Debt service funds	—	—	—	—	—	—	—	—	—	—	—	—	—
Construction funds	—	—	—	—	—	—	—	—	—	—	—	—	—
Board designated and escrow funds	15,113	—	—	—	—	—	28,872	—	—	—	—	—	43,985
Self-insurance trust funds	—	—	—	—	—	—	—	—	—	—	—	—	—
Funds restricted by donor	—	—	—	—	—	—	—	—	—	—	—	—	—
Economic interests in the net assets of related organizations	—	—	—	—	—	—	—	—	—	—	—	—	—
	15,113	—	—	—	—	—	28,872	—	—	—	—	—	43,985
Property and equipment, net	207,759	33,569	—	1,096	2,651	1,258	49	772	3,040	—	3,007	—	253,201
Investments in joint ventures and other assets	254,247	—	—	4,393	—	—	23	—	—	—	—	(24,977)	233,686
Total assets	$ 729,972	150,320	45	5,489	10,198	1,887	37,571	843	3,069	—	3,007	(24,977)	917,424

(Continued)

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UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Upper Chesapeake Health System (UCHS)

June 30, 2019

(In thousands)

Liabilities and Net Assets	Upper Chesapeake Medical Center	Harford Memorial Hospital	UCHS Properties	Health Ventures	Medical Services	Residential Hospice House	Upper Chesapeake Health Foundation	Upper Chesapeake Health System	Behavioral Health Crisis Center	Upper Chesapeake Insurance Co.	Upper Chesapeake Land Trust	Eliminations	Upper Chesapeake consolidated total
Current liabilities:													
Trade accounts payable	$ 9,319	6,977	—	—	3,887	—	—	86	—	—	—	—	20,269
Accrued payroll and benefits	21,990	5,595	—	—	—	—	—	1,422	—	—	—	—	29,007
Advances from third-party payors	6,569	1,671	—	—	—	—	—	—	—	—	—	—	8,240
Other current liabilities	9,943	10,408	29	1,096	6,655	624	12,594	—	188	—	3,143	—	44,680
Current portion of long-term debt	5,418	—	—	—	—	—	—	—	—	—	—	—	5,418
Total current liabilities	53,239	24,651	29	1,096	10,542	624	12,594	1,508	188	—	3,143	—	107,614
Long-term debt, less current portion	162,344	23,576	—	—	—	—	—	—	—	—	—	—	185,920
Other long-term liabilities	35,475	1,162	—	—	—	—	—	1	—	—	—	—	36,638
Total liabilities	251,058	49,389	29	1,096	10,542	624	12,594	1,509	188	—	3,143	—	330,172
Net assets:													
Without donor restrictions	303,937	100,931	16	4,393	(344)	649	16,219	(666)	2,881	—	(136)	—	427,880
With donor restrictions	174,977	—	—	—	—	614	8,758	—	—	—	—	(24,977)	159,372
Total net assets	478,914	100,931	16	4,393	(344)	1,263	24,977	(666)	2,881	—	(136)	(24,977)	587,252
Total liabilities and net assets	$ 729,972	150,320	45	5,489	10,198	1,887	37,571	843	3,069	—	3,007	(24,977)	917,424

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Capital Region Health System (Capital Region)

June 30, 2019

(In thousands)

Assets	Prince George's Hospital Center	Laurel Regional Hospital	Bowie Health Center	Gladys Spellman Specialty Care	Dimensions Healthcare Associates	Affiliated Enterprises, Inc.	Madison Manor Inc.	Dimensions Assurance, Ltd.	Dimensions Health System Corporate	Regional Medical Center	Eliminations	Capital Region consolidated total
Current assets:												
Cash and cash equivalents	$ —	—	1	—	—	1,719	277	—	30,769	—	—	32,766
Assets limited as to use, current portion	—	—	—	—	—	—	—	—	406	—	—	406
Accounts receivable:												
Patient accounts receivable, net	28,557	12,052	4,750	3,404	576	—	—	—	—	—	—	49,339
Other	159,420	897	8,740	17,926	111	1,312	3,089	6,309	529	561	(6,209)	192,685
Inventories	3,922	1,533	382	—	—	—	—	—	—	—	—	5,837
Prepaid expenses and other current assets	177	32	14	—	171	—	—	—	2,672	—	—	3,066
Total current assets	192,076	14,514	13,887	21,330	858	3,031	3,366	6,309	34,376	561	(6,209)	284,099
Investments	—	—	—	—	—	—	—	—	57	—	—	57
Assets limited as to use, less current portion:												
Investments held for swap collateral	—	—	—	—	—	—	—	—	—	—	—	—
Debt service funds	—	—	—	—	—	—	—	—	—	—	—	—
Construction funds	—	—	—	—	—	—	—	—	—	—	—	—
Board designated and escrow funds	—	—	—	—	—	—	—	—	—	—	—	—
Self-insurance trust funds	—	—	—	—	—	—	—	29,172	7,314	—	—	36,486
Funds restricted by donor	—	—	—	—	—	—	—	—	—	—	—	—
Economic interests in the net assets of related organizations	894	61	—	—	—	—	—	—	4,834	—	(4,834)	955
	894	61	—	—	—	—	—	29,172	12,148	—	(4,834)	37,441
Property and equipment, net	13,561	29,669	7,015	33	554	2,228	—	—	4,134	29,915	—	87,109
Investments in joint ventures and other assets	2,039	942	—	—	—	—	2,228	—	4,951	—	(1,225)	8,935
Total assets	$ 208,570	45,186	20,902	21,363	1,412	5,259	5,594	35,481	55,666	30,476	(12,268)	417,641

(Continued)

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UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division – University of Maryland Capital Region Health System (Capital Region)

June 30, 2019

(In thousands)

Liabilities and Net Assets	Prince George's Hospital Center	Laurel Regional Hospital	Bowie Health Center	Gladys Spellman Specialty Care	Dimensions Healthcare Associates	Affiliated Enterprises, Inc.	Madison Manor Inc.	Dimensions Assurance, Ltd.	Dimensions Health System Corporate	Regional Medical Center	Eliminations	Capital Region consolidated total
Current liabilities:												
Trade accounts payable	$ 10,773	2,251	41	75	3,495	25	(3)	(2)	2,177	—	—	18,832
Accrued payroll and benefits	8,226	3,137	440	231	1,770	—	—	—	7,548	—	—	21,352
Advances from third-party payors	10,202	2,307	91	321	—	—	—	—	—	—	—	12,921
Other current liabilities	2,064	48,458	548	3	4,774	(6)	—	157	123,273	—	(6,209)	173,062
Current portion of long-term debt	—	—	—	—	—	233	—	—	—	—	—	233
Total current liabilities	31,265	56,153	1,120	630	10,039	252	(3)	155	132,998	—	(6,209)	226,400
Long-term debt, less current portion	—	—	—	—	—	1,451	—	—	—	—	—	1,451
Other long-term liabilities	206	—	—	—	—	—	—	25,382	94,709	—	—	120,297
Total liabilities	31,471	56,153	1,120	630	10,039	1,703	(3)	25,537	227,707	—	(6,209)	348,148
Net assets:												
Without donor restrictions	174,992	(14,281)	19,723	20,733	(8,728)	3,556	5,597	9,944	(172,041)	2,001	(6,059)	35,437
With donor restrictions	2,107	3,314	59	—	101	—	—	—	—	28,475	—	34,056
Total net assets	177,099	(10,967)	19,782	20,733	(8,627)	3,556	5,597	9,944	(172,041)	30,476	(6,059)	69,493
Total liabilities and net assets	$ 208,570	45,186	20,902	21,363	1,412	5,259	5,594	35,481	55,666	30,476	(12,268)	417,641

See accompanying independent auditors' report.

Schedule 2

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2018

(In thousands)

Assets	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	Upper Chesapeake	Capital Region	UM Health Plans	UMMS Foundation	Other	Eliminations	Consolidated total
Current assets:														
Cash and cash equivalents	$ 259,415	2,274	3,619	10,482	12,677	5,631	1,987	41,809	57,872	—	—	1,477	—	397,243
Assets limited as to use, current portion	51,674	—	682	1,392	943	484	1,128	—	181	—	—	—	—	56,484
Accounts receivable:							—							
Patient accounts receivable, less allowance for doubtful accounts of $219,769	198,855	8,172	8,146	43,415	32,522	10,927	37,393	39,421	48,292	—	—	4,522	—	431,665
Other	342,758	16,159	33,258	27,975	11,367	11,724	12,101	—	194,421	—	—	11,164	(572,209)	88,718
Inventories	33,542	1,145	2,983	6,496	4,482	1,680	5,670	9,172	5,606	—	—	—	—	70,776
Assets held for sale	—	—	—	—	—	—	—	—	—	139,120	—	—	—	139,120
Prepaid expenses and other current assets	15,887	133	3,322	1,183	1,629	644	1,766	10,086	4,234	—	1,500	731	—	41,115
Total current assets	902,131	27,883	52,010	90,943	63,620	31,090	60,045	100,488	310,606	139,120	1,500	17,894	(572,209)	1,225,121
Investments	288,289	37,828	3	147,525	96,349	35,552	12,277	242,082	—	—	—	—	—	859,905
Assets limited as to use, less current portion:														
Investments held for collateral	50,572	—	3,700	8,000	—	—	—	22,318	—	—	—	—	—	84,590
Debt service funds	33,935	—	—	—	—	—	—	—	—	—	—	—	—	33,935
Construction funds	333,359	17,112	8,589	10,613	24,378	13,434	4,389	—	—	—	—	—	—	411,874
Board designated and escrow funds	—	—	—	—	79,493	(181)	—	26,743	—	—	17,674	—	—	123,729
Self-insurance trust funds	79,742	—	14,816	23,164	37,229	7,392	7,889	11,267	41,491	—	—	—	—	222,990
Funds restricted by donor	—	—	1,093	—	34,417	—	6,977	—		—	26,983	—	—	69,470
Economic and beneficial interests in the net assets of related organizations	202,725	35,620	447	9,862	3,711	—	9,503		743	—	—	—	(66,492)	196,119
	700,333	52,732	28,645	51,639	179,228	20,645	28,758	60,328	42,234	—	44,657	—	(66,492)	1,142,707
Property and equipment, net	925,452	45,094	104,904	255,253	157,506	105,942	221,008	250,550	91,425	—	—	8,332	—	2,165,466
Investments in joint ventures and other assets	1,007,331	—	8,042	27,615	11,958	9,356	33,777	218,612	8,648	2,217	11,008	—	(702,300)	636,264
Total assets	$ 3,823,536	163,537	193,604	572,975	508,661	202,585	355,865	872,060	452,913	141,337	57,165	26,226	(1,341,001)	6,029,463

(Continued)

Schedule 2

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Balance Sheet Information by Division

June 30, 2018

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	Upper Chesapeake	Capital Region	UM Health Plans	UMMS Foundation	Other	Eliminations	Consolidated total
Current liabilities:														
Trade accounts payable	$ 136,233	11,787	13,812	15,550	14,847	6,231	19,919	21,878	23,579	230	176	3,154	—	267,396
Accrued payroll and benefits	111,554	5,789	10,595	22,104	18,746	3,907	26,531	28,187	23,378	—	—	11,410	—	262,201
Advances from third-party payors	82,676	6,526	7,378	12,178	6,238	3,508	11,412	9,367	14,584	—	—	—	—	153,867
Lines of credit	99,300	—	—	—	—	—	—	—	—	—	—	—	—	99,300
Short-term financing	150,000	—	—	—	—	—	—	—	—	—	—	—	—	150,000
Other current liabilities	213,444	1,333	5,451	36,435	20,850	16,829	101,333	35,905	196,083	80,216	—	15,493	(572,209)	151,163
Liabilities held for sale	—	—	—	—	—	—	—	—	—	86,834	—	—	—	86,834
Long-term debt subject to short-term remarketing arrangements	58,054	—	—	—	—	—	—	—	—	—	—	—	—	58,054
Current portion of long-term debt	14,841	518	940	4,373	2,802	3,255	14,939	5,088	233	5,000	—	—	—	51,989
Total current liabilities	866,102	25,953	38,176	90,640	63,483	33,730	174,134	100,425	257,857	172,280	176	30,057	(572,209)	1,280,804
Long-term debt, less current portion	725,170	19,278	29,623	156,708	80,454	55,246	217,119	191,386	1,683	31,667	—	—	—	1,508,334
Other long-term liabilities	126,407	144	18,742	45,984	22,600	16,387	29,971	36,096	99,116	—	—	—	—	395,447
Interest rate swap liabilities	149,789	—	—	—	—	—	—	—	—	—	—	—	—	149,789
Total liabilities	1,867,468	45,375	86,541	293,332	166,537	105,363	421,224	327,907	358,656	203,947	176	30,057	(572,209)	3,334,374
Net assets:														
Without donor restrictions	1,338,378	82,409	105,523	269,781	301,068	97,222	(92,003)	384,991	60,688	(62,610)	23,853	(3,831)	(553,047)	1,952,422
With donor restrictions	617,690	35,753	1,540	9,862	41,056	—	26,644	159,162	33,569	—	33,136	—	(215,745)	742,667
Total net assets	1,956,068	118,162	107,063	279,643	342,124	97,222	(65,359)	544,153	94,257	(62,610)	56,989	(3,831)	(768,792)	2,695,089
Total liabilities and net assets	$ 3,823,536	163,537	193,604	572,975	508,661	202,585	355,865	872,060	452,913	141,337	57,165	26,226	(1,341,001)	6,029,463

See accompanying independent auditors' report.

Schedule 3

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division

Year ended June 30, 2019

(In thousands)

	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	UCHS	Capital Region	UM Health Plans	UMMS Foundation	Other	Eliminations	Consolidated total
Operating revenue, gains and other support:														
Net patient service revenue	1,556,785	109,644	207,202	456,452	349,955	138,942	414,509	425,405	361,054	—	—	—	(2,894)	4,017,054
State support	30,300	—	—	—	—	—	—	—	38,221	—	—	—	(27,000)	41,521
Premium Revenue	181,570	—	—	—	—	—	—	—	—	—	—	—	(181,570)	—
Other revenue	114,823	2,013	20,534	4,532	10,365	1,088	7,313	4,379	8,013	—	—	4,766	(1,127)	176,699
Total operating revenue, gains and other support	1,883,478	111,657	227,736	460,984	360,320	140,030	421,822	429,784	407,288	—	—	4,766	(212,591)	4,235,274
Operating expenses:														
Salaries, wages and benefits	1,003,454	54,783	104,354	246,107	191,154	63,663	213,225	246,626	211,698	—	—	4,642	(181,570)	2,158,136
Expendable supplies	424,121	13,811	35,256	73,351	49,199	17,975	66,861	62,689	48,579	—	—	173	—	792,015
Purchased services	146,581	23,536	51,874	83,013	75,440	34,096	90,328	59,926	93,463	—	—	7,382	(31,021)	634,618
Medical Claims Expense	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Contracted services	131,562	9,392	27,590	14,038	19,023	7,702	8,598	12,027	39,965	—	—	—	—	269,897
Depreciation and amortization	100,803	6,879	13,730	28,334	23,296	8,824	24,097	22,086	14,947	—	—	1,060	—	244,056
Interest expense	27,013	676	1,044	5,524	2,883	1,991	9,283	7,766	120	1,492	—	—	—	57,792
Total operating expenses before non-recurring items	1,833,534	109,077	233,848	450,367	360,995	134,251	412,392	411,120	408,772	1,492	—	13,257	(212,591)	4,156,514
Operating income (loss) from continuing operations	49,944	2,580	(6,112)	10,617	(675)	5,779	9,430	18,664	(1,484)	(1,492)	—	(8,491)	—	78,760
Nonoperating income and expenses, net:														
Contributions	—	—	—	—	122	288	161	1,614	—	—	3,422	—	—	5,607
Equity in net income of joint ventures	1,237	—	—	(518)	257	678	1,236	192	542	—	—	—	—	3,624
Investment income	11,193	942	235	3,710	5,288	1,006	1,385	6,313	93	—	467	—	—	30,632
Change in fair value of investments	12,368	889	1,435	3,458	(1,509)	312	292	6,884	—	—	292	—	—	24,421
Change in fair value of undesignated interest rate swaps	(47,995)	—	—	—	—	—	—	—	—	—	—	—	—	(47,995)
Other nonoperating gains and losses	(6,924)	277	(1,192)	(2,200)	(10,286)	(494)	(4,334)	(2,263)	(836)	—	(4,793)	—	—	(33,045)
Total nonoperating income and expenses	(30,121)	2,108	478	4,450	(6,128)	1,790	(1,260)	12,740	(201)	—	(612)	—	—	(16,756)
Excess (deficiency) of revenues over expenses	$ 19,823	4,688	(5,634)	15,067	(6,803)	7,569	8,170	31,404	(1,685)	(1,492)	(612)	(8,491)	—	62,004
Loss on discontinued operations	—	—	—	—	—	—	—	—	—	(25,847)	—	—	—	(25,847)
Excess (deficiency) of revenues over expenses	$ 19,823	4,688	(5,634)	15,067	(6,803)	7,569	8,170	31,404	(1,685)	(27,339)	(612)	(8,491)	—	36,157

See accompanying independent auditors' report.

Schedule 3-a

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for University of Maryland Medical Center & Affiliates (UMMC)

Year ended June 30, 2019

(In thousands)

	University of Maryland Medical Center			Corporate Shared Services	36 South Paca	University CARE	Eliminations	University of Maryland Medical Center & Affiliates consolidated total
	University Hospital	Shock Trauma Center	Subtotal					
Operating revenue, gains and other support:								
Net patient service revenue	$ 1,363,125	193,185	1,556,310	—	—	475	—	1,556,785
State support	—	3,300	3,300	27,000	—	—	—	30,300
Premium Revenue	—	—	—	181,570	—	—	—	181,570
Other revenue	113,638	300	113,938	2,033	755	40	(1,943)	114,823
Total operating revenue, gains and other support	1,476,763	196,785	1,673,548	210,603	755	515	(1,943)	1,883,478
Operating expenses:								
Salaries, wages and benefits	565,236	65,806	631,042	371,789	119	504	—	1,003,454
Expendable supplies	392,332	28,650	420,982	2,767	307	65	—	424,121
Purchased services	284,588	44,491	329,079	(182,585)	922	1,108	(1,943)	146,581
Contracted services	119,269	12,293	131,562	—	—	—	—	131,562
Depreciation and amortization	88,512	11,915	100,427	—	376	—	—	100,803
Interest expense	26,304	—	26,304	355	354	—	—	27,013
Total operating expenses	1,476,241	163,155	1,639,396	192,326	2,078	1,677	(1,943)	1,833,534
Operating income (loss)	522	33,630	34,152	18,277	(1,323)	(1,162)	—	49,944
Nonoperating income and expenses, net:								
Contributions			—					—
Equity in net income of joint ventures	(3,036)	—	(3,036)	1,903	—	—	2,370	1,237
Investment income	11,120	—	11,120	73	—	—	—	11,193
Change in fair value of investments	9,747	—	9,747	2,621	—	—	—	12,368
Change in fair value of undesignated interest rate swaps	—	—	—	(47,995)	—	—	—	(47,995)
Other nonoperating gains and losses	(8,339)	—	(8,339)	1,299	—	—	116	(6,924)
Total nonoperating income and expenses	9,492	—	9,492	(42,099)	—	—	2,486	(30,121)
Excess (deficiency) of revenues over expenses	$ 10,014	33,630	43,644	(23,822)	(1,323)	(1,162)	2,486	19,823

See accompanying independent auditors' report.

Schedule 3-b

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Midtown Health, Inc. (Midtown)

Year ended June 30, 2019

(In thousands)

	UM Midtown Health Systems, Inc.	UMMC Midtown Campus	UM Midtown Clin. Prac. Group	Eliminations	Midtown consolidated total
Operating revenue, gains and other support:					
Net patient service revenue	$ 1,081	203,649	5,347	(2,875)	207,202
State support	—	—	—	—	—
Other revenue	1,043	19,457	34	—	20,534
Total operating revenue, gains and other support	2,124	223,106	5,381	(2,875)	227,736
Operating expenses:					
Salaries, wages and benefits	832	101,953	1,569	—	104,354
Expendable supplies	70	35,027	159	—	35,256
Purchased services	1,738	49,358	778	—	51,874
Contracted services	—	27,590	2,875	(2,875)	27,590
Depreciation and amortization	569	13,161	—	—	13,730
Interest expense	3	1,041	—	—	1,044
Total operating expenses	3,212	228,130	5,381	(2,875)	233,848
Operating income (loss)	(1,088)	(5,024)	—	—	(6,112)
Nonoperating income and expenses, net:					
Contributions	—	—	—	—	—
Equity in net income of joint ventures	—	—	—	—	—
Investment income	—	235	—	—	235
Change in fair value of investments	—	1,435	—	—	1,435
Change in fair value of undesignated interest rate swaps	—	—	—	—	—
Other nonoperating gains and losses	—	(1,192)	—	—	(1,192)
Total nonoperating income and expenses	—	478	—	—	478
Excess (deficiency) of revenues over expenses	$ (1,088)	(4,546)	—	—	(5,634)

See accompanying independent auditors' report.

Schedule 3-c

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Baltimore Washington Medical System (BWMS)

Year ended June 30, 2019

(In thousands)

	Baltimore Washington Medical System, Inc.	Baltimore Washington Medical Center	Baltimore Washington Healthcare Services	Baltimore Washington Health Enterprises	North County Corporation	Shipley's	Eliminations	BWMS consolidated total
Operating revenue, gains and other support:								
Net patient service revenue	$ 6,578	389,018	62,740	—	—	—	(1,884)	456,452
State support	—	—	—	—	—	—	—	—
Other revenue	4,185	4,641	10,617	—	2,718	—	(17,629)	4,532
Total operating revenue, gains and other support	10,763	393,659	73,357	—	2,718	—	(19,513)	460,984
Operating expenses:								
Salaries, wages and benefits	5,495	180,416	62,637	—	—	—	(2,441)	246,107
Expendable supplies	246	59,048	13,857	—	200	—	—	73,351
Purchased services	3,223	72,493	14,350	—	1,358	—	(8,411)	83,013
Contracted services	—	18,340	4,360	—	—	—	(8,662)	14,038
Depreciation and amortization	478	26,830	376	—	650	—	—	28,334
Interest expense	21	5,394	—	—	109	—	—	5,524
Total operating expenses	9,463	362,521	95,580	—	2,317	—	(19,514)	450,367
Operating income (loss)	1,300	31,138	(22,223)	—	401	—	1	10,617
Nonoperating income and expenses, net:								
Contributions	—	—	—	—	—	—	—	—
Equity in net income of joint ventures	13,420	(518)	—	—	—	—	(13,420)	(518)
Investment income	—	3,708	—	2	—	—	—	3,710
Change in fair value of investments	—	3,458	—	—	—	—	—	3,458
Change in fair value of undesignated interest rate swaps	—	—	—	—	—	—	—	—
Other nonoperating gains and losses	(455)	(2,170)	—	425	—	—	—	(2,200)
Total nonoperating income and expenses	12,965	4,478	—	427	—	—	(13,420)	4,450
Excess (deficiency) of revenues over expenses	$ 14,265	35,616	(22,223)	427	401	—	(13,419)	15,067

See accompanying independent auditors' report.

Schedule 3-d

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Shore Regional Health (Shore Regional)

Year ended June 30, 2019

(In thousands)

	Shore Health System, Inc.	Shore Orthopedics	UM Shore Home Care	Queenstown ASC	Shore Med. Group	Memorial Hospital Foundation, Inc. and Subsidiary	Chester River Consolidated Total	Eliminations	SHS consolidated total
Operating revenue, gains and other support:									
Net patient service revenue	$ 257,209	8,563	3,112	(20)	35,874	—	45,217	—	349,955
State support	—	—	—	—	—	—	—	—	—
Other revenue	9,160	48	1	—	3,125	—	1,189	(3,158)	10,365
Total operating revenue, gains and other support support	266,369	8,611	3,113	(20)	38,999	—	46,406	(3,158)	360,320
Operating expenses:									
Salaries, wages and benefits	114,716	8,845	3,582	111	46,108	—	17,792	—	191,154
Expendable supplies	37,512	1,017	66	23	6,728	—	3,853	—	49,199
Purchased services	44,893	1,554	615	400	7,651	—	21,793	(1,466)	75,440
Contracted services	13,880	—	—	—	421	—	6,414	(1,692)	19,023
Depreciation and amortization	18,473	133	23	8	457	—	4,202	—	23,296
Interest expense	2,751	—	—	—	—	—	132	—	2,883
Total operating expenses	232,225	11,549	4,286	542	61,365	—	54,186	(3,158)	360,995
Operating income (loss)	34,144	(2,938)	(1,173)	(562)	(22,366)	—	(7,780)	—	(675)
Nonoperating income and expenses, net:									
Contributions	8	—	—	—	—	25	89	—	122
Equity in net income of joint ventures	257	—	—	—	—	—	—	—	257
Investment income (loss)	3,129	—	—	—	—	1,308	851	—	5,288
Change in fair value of investments	(862)	—	—	—	—	(184)	(463)	—	(1,509)
Change in fair value of undesignated interest rate swaps	—	—	—	—	—	—	—	—	—
Other nonoperating gains and losses	(681)	—	—	—	—	(3,968)	(5,637)	—	(10,286)
Total nonoperating income and expenses	1,851	—	—	—	—	(2,819)	(5,160)	—	(6,128)
Excess (deficiency) of revenues over expenses	$ 35,995	(2,938)	(1,173)	(562)	(22,366)	(2,819)	(12,940)	—	(6,803)

See accompanying independent auditors' report.

Schedule 3-e

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Chester River Health System, Inc. (CRHS) a subsidiary of Shore Regional Health

Year ended June 30, 2019

(In thousands)

	Chester River Hospital Center	UM Shore Nursing and Rehab.	UM Chester River Home Care	Chester River Health Foundation	Chester River consolidated total
Operating revenue, gains and other support:					
Net patient service revenue	$ 42,677	—	2,540	—	45,217
State support	—	—	—	—	—
Other revenue	1,187	—	2	—	1,189
Total operating revenue, gains and other support	43,864	—	2,542	—	46,406
Operating expenses:					
Salaries, wages and benefits	15,508	—	2,284	—	17,792
Expendable supplies	3,807	—	46	—	3,853
Purchased services	21,222	—	571	—	21,793
Contracted services	6,414	—	—	—	6,414
Depreciation and amortization	4,192	—	10	—	4,202
Interest expense	132	—	—	—	132
Total operating expenses	51,275	—	2,911	—	54,186
Operating loss	(7,411)	—	(369)	—	(7,780)
Nonoperating income and expenses, net:					
Contributions	—	—	—	89	89
Equity in net income of joint ventures	—	—	—	—	—
Investment income	416	—	38	397	851
Change in fair value of investments	(109)	—	(10)	(344)	(463)
Change in fair value of undesignated interest rate swaps	—	—	—	—	—
Other nonoperating gains and losses	(4,594)	—	—	(1,043)	(5,637)
Total nonoperating income and expenses	(4,287)	—	28	(901)	(5,160)
Excess (deficiency) of revenues over expenses	$ (11,698)	—	(341)	(901)	(12,940)

See accompanying independent auditors' report.

Schedule 3-f

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for Charles Regional Health (Charles Regional)

Year ended June 30, 2019

(In thousands)

	Charles Regional Health, Inc.	Charles Regional Medical Center, Inc.	Charles Regional Urgent Care	Charles Regional Care Partners, Inc. and Subsidiary	Charles Regional Health Foundation, Inc.	Charles Regional Medical Group	Charles Regional Imaging Center	Eliminations	Charles Regional consolidated total
Operating revenue, gains and other support:									
Net patient service revenue	$ —	132,932	143	1,491	—	4,376	—	—	138,942
State support	—	—	—	—	—	—	—	—	—
Other revenue	226	541	—	—	—	321	—	—	1,088
Total operating revenue, gains and other support	226	133,473	143	1,491	—	4,697	—	—	140,030
Operating expenses:									
Salaries, wages and benefits	—	58,291	—	—	—	5,372	—	—	63,663
Expendable supplies	—	17,735	9	90	—	141	—	—	17,975
Purchased services	200	30,335	378	1,599	—	1,584	—	—	34,096
Contracted services	—	7,031	—	212	—	459	—	—	7,702
Depreciation and amortization	1,749	6,151	12	833	—	79	—	—	8,824
Interest expense	254	1,737	—	—	—	—	—	—	1,991
Total operating expenses	2,203	121,280	399	2,734	—	7,635	—	—	134,251
Operating income (loss)	(1,977)	12,193	(256)	(1,243)	—	(2,938)	—	—	5,779
Nonoperating income and expenses, net:									
Contributions	—	—	—	—	288	—	—	—	288
Equity in net income of joint ventures	—	305	—	373	—	—	—	—	678
Investment income	—	900	—	—	106	—	—	—	1,006
Change in fair value of investments	—	243	—	—	69	—	—	—	312
Change in fair value of undesignated interest rate swaps	—	—	—	—	—	—	—	—	—
Other nonoperating gains and losses	—	(532)	—	—	(381)	—	—	419	(494)
Total nonoperating income and expenses	—	916	—	373	82	—	—	419	1,790
Excess (deficiency) of revenues over expenses	$ (1,977)	13,109	(256)	(870)	82	(2,938)	—	419	7,569

See accompanying independent auditors' report.

Schedule 3-g

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for University of Maryland St. Joseph Health System (SJHS)

Year ended June 30, 2019

(In thousands)

	St. Joseph Medical Center	St. Joseph Medical Group	St. Joseph Properties	St. Joseph Orthopaedics	O'Dea Medical Arts	St. Joseph Foundation	UM Regional Supplier Svcs	UM Regional Prof SVCS	UM Pain Specialist LLC	Eliminations	St. Joseph consolidated total
Operating revenue, gains and other support:											
Net patient service revenue	$ 341,266	39,083	—	23,556	—	—	5,025	4,212	1,367	—	414,509
State support	—	—	—	—	—	—	—	—	—	—	—
Other revenue	4,032	14,487	1,812	654	2,647	—	49	214	—	(16,582)	7,313
Total operating revenue, gains and other support	345,298	53,570	1,812	24,210	2,647	—	5,074	4,426	1,367	(16,582)	421,822
Operating expenses:											
Salaries, wages and benefits	139,503	51,749	—	17,301	—	—	706	3,125	509	332	213,225
Expendable supplies	62,174	1,259	—	21	—	—	3,311	96	—	—	66,861
Purchased services	65,195	9,934	2,714	11,718	1,398	—	1,314	750	858	(3,553)	90,328
Contracted services	21,857	102	—	—	—	—	—	—	—	(13,361)	8,598
Depreciation and amortization	23,198	250	47	49	493	—	29	31	—	—	24,097
Interest expense	8,894	—	—	—	389	—	—	—	—	—	9,283
Total operating expenses	320,821	63,294	2,761	29,089	2,280	—	5,360	4,002	1,367	(16,582)	412,392
Operating income (loss)	24,477	(9,724)	(949)	(4,879)	367	—	(286)	424	—	—	9,430
Nonoperating income and expenses, net:											
Contributions	—	—	—	—	—	161	—	—	—	—	161
Equity in net income of joint ventures	1,236	—	—	—	—	—	—	—	—	—	1,236
Investment income	—	—	—	—	1	1,384	—	—	—	—	1,385
Change in fair value of investments	—	—	—	—	—	292	—	—	—	—	292
Change in fair value of undesignated interest rate swaps	—	—	—	—	—	—	—	—	—	—	—
Other nonoperating gains and losses	(2,562)	—	—	—	—	(1,772)	—	—	—	—	(4,334)
Total nonoperating income and expenses	(1,326)	—	—	—	1	65	—	—	—	—	(1,260)
Excess (deficiency) of revenues over expenses	$ 23,151	(9,724)	(949)	(4,879)	368	65	(286)	424	—	—	8,170

See accompanying independent auditors' report.

Schedule 3-h

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division for University of Maryland Upper Chesapeake Health System (UCHS)

Year ended June 30, 2019

(In thousands)

	Upper Chesapeake Medical Center	Harford Memorial Hospital	UCHS Properties	Health Ventures	Medical Services	Residential Hospice House	Upper Chesapeake Health Foundation	Upper Chesapeake Health System	Behavioral Health Crisis Center	Upper Chesapeake Insurance Co.	Upper Chesapeake Land Trust	Eliminations	Upper Chesapeake consolidated total
Operating revenue, gains and other support:													
Net patient service revenue	$ 276,845	91,868	—	—	56,437	239	—	—	16	—	—	—	425,405
State support	—	—	—	—	—	—	—	—	—	—	—	—	—
Other revenue	4,813	1,347	—	—	8,906	400	—	15,289	500	194	—	(27,070)	4,379
Total operating revenue, gains and other support	281,658	93,215	—	—	65,343	639	—	15,289	516	194	—	(27,070)	429,784
Operating expenses:													
Salaries, wages and benefits	127,890	53,798	—	—	51,974	798	—	11,902	264	—	—	—	246,626
Expendable supplies	44,360	7,229	—	—	10,779	50	—	235	36	—	—	—	62,689
Purchased services	42,159	19,345	287	—	11,679	136	—	2,984	651	350	21	(17,686)	59,926
Contracted services	12,481	4,730	—	—	2,931	—	—	58	—	—	—	(8,173)	12,027
Depreciation and amortization	17,806	3,381	—	—	401	274	—	109	115	—	—	—	22,086
Interest expense	6,824	942	—	—	—	—	—	—	—	—	—	—	7,766
Total operating expenses	251,520	89,425	287	—	77,764	1,258	—	15,288	1,066	350	21	(25,859)	411,120
Operating income (loss)	30,138	3,790	(287)	—	(12,421)	(619)	—	1	(550)	(156)	(21)	(1,211)	18,664
Nonoperating income and expenses, net:													
Contributions	—	—	—	—	—	—	2,376	—	—	—	—	(762)	1,614
Equity in net income of joint ventures	—	—	—	92	—	—	—	—	—	—	—	100	192
Investment income	3,101	2,075	—	—	—	18	963	—	—	156	—	—	6,313
Change in fair value of investments	3,563	2,128	—	—	—	25	1,168	—	—	—	—	—	6,884
Change in fair value of undesignated interest rate swaps	—	—	—	—	—	—	—	—	—	—	—	—	—
Other nonoperating gains and losses	(2,263)	—	—	—	—	—	—	—	—	—	—	—	(2,263)
Total nonoperating income and expenses	4,401	4,203	—	92	—	43	4,507	—	—	156	—	(662)	12,740
Excess (deficiency) of revenues over expenses	$ 34,539	7,993	(287)	92	(12,421)	(576)	4,507	1	(550)	—	(21)	(1,873)	31,404

See accompanying independent auditors' report.

Schedule 3-h

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION
AND SUBSIDIARIES

Consolidating Operations Information by Division for University of Maryland Capital Region Health System (Capital Region)

Year ended June 30, 2019

(In thousands)

	Prince George's Hospital Center	Laurel Regional Hospital	Bowie Health Center	Gladys Spellman Specialty Care	Dimensions Healthcare Associates	Affiliated Enterprises, Inc.	Madison Manor Inc.	Dimensions Assurance, Ltd.	Dimensions Health System Corporate	Regional Medical Center	Eliminations	Capital Region consolidated total
Operating revenue, gains and other support:												
Net patient service revenue	$ 271,904	57,853	19,545	4,061	7,691	—	—	—	—	—	—	361,054
State support	28,594	9,246	—	—	381	—	—	—	—	—	—	38,221
Other revenue	6,572	310	32	—	92	873	—	(493)	77,161	—	(76,534)	8,013
Total operating revenue, gains and other support	307,070	67,409	19,577	4,061	8,164	873	—	(493)	77,161	—	(76,534)	407,288
Operating expenses:												
Salaries, wages and benefits	129,745	24,219	9,092	2,454	20,174	—	—	—	26,014	—	—	211,698
Expendable supplies	36,969	7,865	3,033	347	545	4	—	—	(184)	—	—	48,579
Purchased services	105,358	21,814	7,437	1,576	(15,057)	473	300	256	47,840	—	(76,534)	93,463
Contracted services	16,125	4,908	(147)	58	19,021	—	—	—	—	—	—	39,965
Depreciation and amortization	6,682	3,319	1,401	26	98	179	—	—	3,242	—	—	14,947
Interest expense	—	3	—	—	—	46	—	—	71	—	—	120
Total operating expenses	294,879	62,128	20,816	4,461	24,781	702	300	256	76,983	—	(76,534)	408,772
Operating income (loss)	12,191	5,281	(1,239)	(400)	(16,617)	171	(300)	(749)	178	—	—	(1,484)
Nonoperating income and expenses, net:												
Contributions	—	—	—	—	—	—	—	—	—	—	—	—
Equity in net income of joint ventures	—	—	—	—	—	—	542	—	—	—	—	542
Investment income	—	—	—	—	—	—	—	200	(107)	—	—	93
Change in fair value of investments	—	—	—	—	—	—	—	—	—	—	—	—
Change in fair value of undesignated interest rate swaps	—	—	—	—	—	—	—	—	—	—	—	—
Other nonoperating gains and losses	(459)	(207)	(12)	(28)	(60)	—	—	—	(70)	—	—	(836)
Total nonoperating income and expenses	(459)	(207)	(12)	(28)	(60)	—	542	200	(177)	—	—	(201)
Excess (deficiency) of revenues over expenses	$ 11,732	5,074	(1,251)	(428)	(16,677)	171	242	(549)	1	—	—	(1,685)

See accompanying independent auditors' report.

Schedule 4

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Consolidating Operations Information by Division

Year ended June 30, 2018

(In thousands)

	University of Maryland Medical Center & Affiliates	Rehabilitation & Orthopaedic Institute	Midtown	Baltimore Washington Medical System	Shore Regional	Charles Regional	St. Joseph Health	UCHS	Capital Region	UM Health Plans	UMMS Foundation	Other	Eliminations	Consolidated total
Operating revenue, gains and other support:														
Net patient service revenue	$ 1,467,986	110,469	211,628	391,932	314,862	136,071	427,381	439,963	303,212	—	—	75,781	(1,944)	3,877,341
State support	31,200	—	—	—	—	—	—	—	32,508	—	—	—	(23,334)	40,374
Other revenue	98,979	2,735	19,617	6,689	4,916	768	6,594	2,092	6,665	—	—	65,388	(63,587)	150,856
Total operating revenue, gains and other support	1,598,165	113,204	231,245	398,621	319,778	136,839	433,975	442,055	342,385	—	—	141,169	(88,865)	4,068,571
Operating expenses:														
Salaries, wages and benefits	767,394	54,716	97,227	187,436	141,377	57,036	204,532	233,763	174,599	—	—	101,995	—	2,020,075
Expendable supplies	364,845	15,433	32,898	58,274	45,245	19,266	83,121	79,553	43,570	—	—	16,047	—	758,252
Purchased services	157,291	23,182	55,187	86,874	80,194	34,282	96,864	62,174	69,506	—	—	39,289	(88,865)	615,978
Contracted services	136,537	8,553	27,207	17,164	19,256	7,416	7,867	10,858	35,348	—	—	5,170	—	275,376
Depreciation and amortization	98,109	6,658	12,843	27,564	22,396	8,623	21,990	22,865	12,699	—	—	2,343	—	236,090
Interest expense	24,522	674	1,061	5,495	2,953	2,032	9,413	7,737	188	1,369	—	183	—	55,627
Total operating expenses	1,548,698	109,216	226,423	382,807	311,421	128,655	423,787	416,950	335,910	1,369	—	165,027	(88,865)	3,961,398
Operating income/(loss) from continuing operations	49,467	3,988	4,822	15,814	8,357	8,184	10,188	25,105	6,475	(1,369)	—	(23,858)	—	107,173
Nonoperating income and expenses, net:														
Contributions	—	—	—	—	289	—	213	3,043	—	—	8,832	—	—	12,377
Inherent contribution - Capital Region	41,772	—	—	—	—	—	—	—	—	—	—	—	—	41,772
Equity in net income of joint ventures	3,059	—	—	(203)	223	240	1,418	445	307	—	—	—	—	5,489
Investment income	10,317	1,028	72	3,904	12,713	776	759	5,913	1,273	—	710	—	—	37,465
Change in fair value of investments	6,913	1,318	—	5,129	631	1,282	277	7,993	—	—	433	—	—	23,976
Change in fair value of undesignated interest rate swaps	43,071	—	—	—	—	—	—	—	—	—	—	—	—	43,071
Other nonoperating gains and losses	(9,909)	(294)	(3,535)	(6,252)	3,548	(530)	(5,468)	(2,702)	1,665	—	(3,643)	—	—	(27,120)
Total nonoperating income and expenses	95,223	2,052	(3,463)	2,578	17,404	1,768	(2,801)	14,692	3,245	—	6,332	—	—	137,030
Excess (deficiency) of revenues over expenses	$ 144,690	6,040	1,359	18,392	25,761	9,952	7,387	39,797	9,720	(1,369)	6,332	(23,858)	—	244,203
Loss on discontinued operations	—	—	—	—	—	—	—	—	—	(27,366)	—	—	—	(27,366)
Excess (deficiency) of revenues over expenses	$ 144,690	6,040	1,359	18,392	25,761	9,952	7,387	39,797	9,720	(28,735)	6,332	(23,858)	—	216,837

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2019

(In thousands)

Assets	University of Maryland Medical Center & Affiliate*	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals**	Capital Region Hospitals***	UMMS Foundation	Eliminations	Obligated group total
Current assets:													
Cash and cash equivalents	$ 236,352	5,261	9,537	5,958	(14,169)	35,738	9,066	194	23,177	1	—	—	311,115
Assets limited as to use, current portion	59,693	—	497	1,484	907	113	529	1,281	—	—	—	—	64,504
Accounts receivable:													
Patient accounts receivable, net	194,391	7,428	13,447	41,211	34,554	4,104	18,405	36,083	34,032	48,763	—	—	432,418
Other	223,298	889	2,835	21,332	14,741	263	17,425	2,205	33,903	186,983	—	(100,557)	403,317
Inventories	35,224	1,159	2,279	6,019	3,346	728	1,675	5,230	8,227	5,837	—	—	69,724
Prepaid expenses and other current assets	21,252	136	428	1,445	1,744	19	639	1,012	5,264	223	1,500	—	33,662
Total current assets	770,210	14,873	29,023	77,449	41,123	40,965	47,739	46,005	104,603	241,807	1,500	(100,557)	1,314,740
Investments	293,857	39,599	17,269	154,416	77,659	(4,168)	21,775	—	265,001	—	—	—	865,408
Assets limited as to use, less current portion:													
Investments held for collateral	94,786	1,115	1,721	8,929	4,091	222	2,722	—	—	—	—	—	113,586
Debt service funds	29,550	—	—	—	—	—	—	—	—	—	—	—	29,550
Construction funds	374,671	19,573	1,931	19,023	25,987	4,110	13,434	4,389	—	—	—	—	463,118
Board designated and escrow funds	—	—	—	—	25,000	5,000	—	—	15,113	—	20,321	—	65,434
Self-insurance trust funds	76,676	—	11,214	26,009	27,749	8,267	9,400	8,280	—	—	—	—	167,595
Funds restricted by donor	—	—	1,093	—	4,975	105	—	—	—	—	30,789	—	36,962
Economic interests in the net assets of related organizations	215,768	35,655	531	10,337	79,326	6,662	5,346	9,503	—	955	—	(79,652)	284,431
	791,451	56,343	16,490	64,298	167,128	24,366	30,902	22,172	15,113	955	51,110	(79,652)	1,160,676
Property and equipment, net	1,079,351	43,324	102,547	230,961	123,617	17,684	73,948	213,412	241,328	50,278	—	—	2,176,450
Investments in joint ventures and other assets	919,378	15,600	8,178	25,662	10,616	2,104	10,839	40,448	254,247	2,981	17,756	(792,346)	515,463
Total assets	$ 3,854,247	169,739	173,507	552,786	420,143	80,951	185,203	322,037	880,292	296,021	70,366	(972,555)	6,032,737

* Includes Corporate Shared Services

** Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

*** Includes Prince George's Hospital Center, Laurel Regional Hospital, Bowie Health Center and Gladys Spellman Specialty Care Unit

(Continued)

Schedule 5

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2019

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center & Affiliate*	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals**	Capital Region Hospitals***	UMMS Foundation	Eliminations	Obligated group total
Current liabilities:													
Trade accounts payable	$ 142,349	15,825	15,755	18,577	15,499	4,904	6,216	20,956	16,296	13,140	217	—	269,734
Accrued payroll and benefits	142,095	4,886	9,177	18,566	11,299	1,990	4,030	16,837	27,585	12,034	—	—	248,499
Advances from third-party payors	73,408	5,544	6,180	11,672	5,562	655	3,729	11,252	8,240	12,921	—	—	139,163
Short-term financing	130,000	—	—	—	—	—	—	—	—	—	—	—	130,000
Lines of credit	150,000	—	—	—	—	—	—	—	—	—	—	—	150,000
Other current liabilities	129,689	2,025	4,285	3,904	4,159	3,068	2,537	3,564	20,351	51,073	—	(100,557)	124,098
Long-term debt subject to short-term remarketing arrangements	18,895	—	—	—	—	—	—	—	—	—	—	—	18,895
Current portion of long-term debt	14,724	551	852	4,417	2,824	108	2,465	6,821	5,418	—	—	—	38,180
Total current liabilities	801,160	28,831	36,249	57,136	39,343	10,725	18,977	59,430	77,890	89,168	217	(100,557)	1,118,569
Long-term debt, less current portion	758,114	18,726	28,771	149,910	73,851	3,670	46,605	210,299	185,920	—	—	—	1,475,866
Other long-term liabilities	150,587	103	21,450	43,905	18,159	7,093	16,761	111,226	36,637	206	—	(90,046)	316,081
Interest rate swap liabilities	196,174	—	—	—	—	—	—	—	—	—	—	—	196,174
Total liabilities	1,906,035	47,660	86,470	250,951	131,353	21,488	82,343	380,955	300,447	89,374	217	(190,603)	3,106,690
Net assets:													
Without donor restrictions	1,316,301	86,424	85,413	291,498	253,341	55,038	102,860	(58,919)	404,868	201,167	22,317	(553,047)	2,207,261
With donor restrictions	631,911	35,655	1,624	10,337	35,449	4,425	—	1	174,977	5,480	47,832	(228,905)	718,786
Total net assets	1,948,212	122,079	87,037	301,835	288,790	59,463	102,860	(58,918)	579,845	206,647	70,149	(781,952)	2,926,047
Total liabilities and net assets	$ 3,854,247	169,739	173,507	552,786	420,143	80,951	185,203	322,037	880,292	296,021	70,366	(972,555)	6,032,737

* Includes Corporate Shared services

** Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

*** Includes Prince George's Hospital Center, Laurel Regional Hospital, Bowie Health Center and Gladys Spellman Specialty Care Unit

See accompanying independent auditors' report.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2018

(In thousands)

Assets	University of Maryland Medical Center & Affiliate*	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals**	Capital Region Hospitals***	UMMS Foundation	Eliminations	Obligated group total
Current assets:													
Cash and cash equivalents	$ 254,636	2,274	3,264	10,770	(1,503)	12,637	3,954	(3,101)	41,087	3	—	—	324,021
Assets limited as to use, current portion	51,674	—	682	1,392	767	176	484	1,128	—	—	—	—	56,303
Accounts receivable:													
Patient accounts receivable, net	198,855	8,172	7,260	35,056	25,109	6,266	10,658	31,520	33,326	47,352	—	—	403,574
Other	385,791	16,159	31,529	5,110	4,030	3,737	11,554	693	—	176,042	—	(273,176)	361,469
Inventories	33,503	1,145	2,983	6,496	3,810	672	1,680	5,501	8,478	5,606	—	—	69,874
Prepaid expenses and other current assets	15,800	133	839	1,220	1,428	48	617	830	3,169	213	1,500	—	25,797
Total current assets	940,259	27,883	46,557	60,044	33,641	23,536	28,947	36,571	86,060	229,216	1,500	(273,176)	1,241,038
Investments	288,289	37,828	3	147,525	77,168	14,319	33,218	—	241,512	—	—	—	839,862
Assets limited as to use, less current portion:													
Investments held for collateral	50,572	—	3,700	8,000	—	—	—	—	22,318	—	—	—	84,590
Debt service funds	33,935	—	—	—	—	—	—	—	—	—	—	—	33,935
Construction funds	333,359	17,112	8,589	10,613	20,268	4,110	13,434	4,389	—	—	—	—	411,874
Board designated and escrow funds	—	—	—	—	25,000	5,000	—	—	—	—	17,674	—	47,674
Self-insurance trust funds	79,742	—	14,816	23,164	29,050	8,179	7,392	7,889	—	—	—	—	170,232
Funds restricted by donor	—	—	1,093	—	5,252	105	—	—	—	—	26,983	—	33,433
Economic interests in the net assets of related organizations	202,725	35,620	447	9,862	83,027	7,574	5,265	9,503	—	743	—	(66,492)	288,274
	700,333	52,732	28,645	51,639	162,597	24,968	26,091	21,781	22,318	743	44,657	(66,492)	1,070,012
Property and equipment, net	917,186	45,094	100,389	236,600	132,787	20,631	73,626	208,109	242,621	54,800	—	—	2,031,843
Investments in joint ventures and other assets	1,013,950	—	6,339	28,869	10,301	1,995	9,676	31,300	233,870	3,386	11,008	(702,300)	648,394
Total assets	$ 3,860,017	163,537	181,933	524,677	416,494	85,449	171,558	297,761	826,381	288,145	57,165	(1,041,968)	5,831,149

* Includes Corporate Shared Services

** Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

*** Includes Prince George's Hospital Center, Laurel Regional Hospital, Bowie Health Center and Gladys Spellman Specialty Care Unit

(Continued)

Schedule 6

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Balance Sheet Information – Obligated Group

June 30, 2018

(In thousands)

Liabilities and Net Assets	University of Maryland Medical Center & Affiliate*	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals**	Capital Region Hospitals***	UMMS Foundation	Eliminations	Obligated group total
Current liabilities:													
Trade accounts payable	$ 135,377	11,769	13,576	15,782	11,773	2,336	5,922	18,181	18,418	14,759	176	—	248,069
Accrued payroll and benefits	111,521	5,684	10,595	19,321	15,094	2,467	3,799	21,433	26,842	12,465	—	—	229,221
Advances from third-party payors	82,676	6,526	7,378	12,178	5,560	620	3,508	11,412	9,367	14,584	—	—	153,809
Short-term financing	99,300	—	—	—	—	—	—	—	—	—	—	—	99,300
Lines of credit	150,000	—	—	—	—	—	—	—	—	—	—	—	150,000
Other current liabilities	256,404	1,333	4,197	4,480	13,405	876	1,181	97,313	11,967	65,239	—	(273,176)	183,219
Long-term debt subject to short-term remarketing arrangements	58,054	—	—	—	—	—	—	—	—	—	—	—	58,054
Current portion of long-term debt	14,841	518	800	4,148	2,700	102	2,522	6,429	5,088	—	—	—	37,148
Total current liabilities	908,173	25,830	36,546	55,909	48,532	6,401	16,932	154,768	71,682	107,047	176	(273,176)	1,158,820
Long-term debt, less current portion	725,170	19,278	29,623	154,327	76,675	3,779	48,971	217,122	191,386	—	—	—	1,466,331
Other long-term liabilities	126,396	144	18,742	45,477	15,786	6,814	16,345	29,971	22,125	350	—	—	282,150
Interest rate swap liabilities	149,789	—	—	—	—	—	—	—	—	—	—	—	149,789
Total liabilities	1,909,528	45,252	84,911	255,713	140,993	16,994	82,248	401,861	285,193	107,397	176	(273,176)	3,057,090
Net assets:													
Unrestricted	1,332,799	82,665	95,482	259,102	238,908	63,998	89,310	(104,101)	368,698	175,835	23,853	(553,047)	2,073,502
Temporarily restricted	617,690	35,620	1,540	9,862	36,593	4,457	—	1	172,490	4,913	33,136	(215,745)	700,557
Total net assets	1,950,489	118,285	97,022	268,964	275,501	68,455	89,310	(104,100)	541,188	180,748	56,989	(768,792)	2,774,059
Total liabilities and net assets	$ 3,860,017	163,537	181,933	524,677	416,494	85,449	171,558	297,761	826,381	288,145	57,165	(1,041,968)	5,831,149

* Includes Corporate Shared services

** Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

*** Includes Prince George's Hospital Center, Laurel Regional Hospital, Bowie Health Center and Gladys Spellman Specialty Care Unit

See accompanying independent auditors' report.

Schedule 7

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Operations and Changes in Net Assets Information – Obligated Group

Year ended June 30, 2019

(In thousands)

	University of Maryland Medical Center & Affiliate*	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center	Shore Health System				Chester River Hospital Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals**	Capital Region Hospitals***	UMMS Foundation	Eliminations	Obligated group total
					Memorial Hospital	Dorchester General	QAEC	Subtotal								
Operating revenue, gains and other support:																
Net patient service revenue	$ 1,556,310	109,207	203,649	389,018	213,292	38,777	5,140	257,209	42,677	132,932	341,266	368,713	353,363	—	(2,894)	3,751,450
State support	30,300	—	—	—	—			—	—	—	—	—	37,840	—	(27,000)	41,140
Premium Revenue	181,570	—	—	—	—	—	—	—	—	—	—	—	—	—	(181,570)	—
Other revenue	115,971	2,013	19,457	4,641	8,153	894	113	9,160	1,187	541	4,032	6,160	6,914	—	(1,127)	168,949
Total operating revenue, gains and other support	1,884,151	111,220	223,106	393,659	221,445	39,671	5,253	266,369	43,864	133,473	345,298	374,873	398,117	—	(212,591)	3,961,539
Operating expenses:																
Salaries, wages, and benefits	1,002,831	53,990	101,953	180,416	90,164	21,095	3,457	114,716	15,508	58,291	139,503	181,688	165,610	—	(181,570)	1,832,936
Expendable supplies	423,749	13,804	35,027	59,048	34,581	2,389	542	37,512	3,807	17,735	62,174	51,589	48,214	—	—	752,659
Purchased services	146,494	23,375	49,358	72,493	37,114	6,839	940	44,893	21,222	30,335	65,195	61,504	136,185	—	(31,021)	620,033
Contracted services	131,562	9,392	27,590	18,340	9,041	3,592	1,247	13,880	6,414	7,031	21,857	17,211	20,944	—	—	274,221
Depreciation and amortization	100,427	6,879	13,161	26,830	15,362	2,689	422	18,473	4,192	6,151	23,198	21,187	11,428	—	—	231,926
Interest expense	26,659	676	1,041	5,394	2,390	258	103	2,751	132	1,737	8,894	7,766	3	—	—	55,053
Total operating expenses	1,831,722	108,116	228,130	362,521	188,652	36,862	6,711	232,225	51,275	121,280	320,821	340,945	382,384	—	(212,591)	3,766,828
Operating income (loss)	52,429	3,104	(5,024)	31,138	32,793	2,809	(1,458)	34,144	(7,411)	12,193	24,477	33,928	15,733	—	—	194,711
Nonoperating income and expenses, net:																
Contributions	—	—	—	—	8	—	—	8	—	—	—	—	—	3,422	—	3,430
Equity in net income of joint ventures	(1,133)	—	—	(518)	257	—	—	257	—	305	1,236	—	—	—	—	147
Investment income	11,193	1,831	235	3,708	3,129	—	—	3,129	416	900	—	5,176	—	467	—	27,055
Change in fair value of investments	12,368	—	1,435	3,458	(862)	—	—	(862)	(109)	243	—	5,691	—	292	—	22,516
Change in fair value of undesignated interest rate swaps	(47,995)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	(47,995)
Other nonoperating gains and losses	(7,040)	277	(1,192)	(2,170)	(681)	—	—	(681)	(4,594)	(532)	(2,562)	(2,263)	(706)	(4,793)	—	(26,256)
Total nonoperating income and expenses	(32,607)	2,108	478	4,478	1,851	—	—	1,851	(4,287)	916	(1,326)	8,604	(706)	(612)	—	(21,103)
Excess (deficiency) of revenues over expenses	19,822	5,212	(4,546)	35,616	34,644	2,809	(1,458)	35,995	(11,698)	13,109	23,151	42,532	15,027	(612)	—	173,608
Net assets released from restrictions used for purchase of property and equipment	5,385	—	650	904	1,901	—	—	1,901	278	—	1,987	—	—	—	—	11,105
Change in unrealized gains on investments	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in economic and beneficial interest in the net assets of related organizations	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in ownership interest of joint ventures	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Capital transfers (to) from affiliate	(43,305)	(1,452)	(3,955)	(2,671)	(25,629)	—	—	(25,629)	(565)	386	20,637	(6,362)	10,205	(1,002)	—	(53,713)
Amortization of accumulated loss of discontinued designated interest rate swap	1,610	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1,610
Change in funded status of defined benefit pension plans	—	—	(2,205)	(1,455)	—	—	—	—	1,995	—	—	—	—	—	—	(1,665)
Asset reclassifications at request of donor	—	—	—	—	—	—	—	—	—	—	—	—	—	78	—	78
Other	(10)	(1)	(13)	2	2,166	—	—	2,166	1,030	55	(593)	—	—	1	—	2,637
Increase (decrease) in unrestricted net assets	$ (16,498)	3,759	(10,069)	32,396	13,082	2,809	(1,458)	14,433	(8,960)	13,550	45,182	36,170	25,232	(1,535)	—	133,660

* Includes Corporate Shared Services

** Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

*** Includes Prince George's Hospital Center, Laurel Regional Hospital, Bowie Health Center and Gladys Spellman Specialty Care Unit

See accompanying independent auditors' report.

Schedule 8

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND SUBSIDIARIES

Combining Operations and Changes in Net Assets Information – Obligated Group

Year ended June 30, 2018

(In thousands)

	University of Maryland Medical Center & Affiliate*	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center	Shore Health System				Chester River Hospital Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals**	Capital Region Hospitals***	UMMS Foundation	Eliminations	Obligated group total
					Memorial Hospital	Dorchester General	QAEC	Subtotal								
Operating revenue, gains and other support:																
Net patient service revenue	$ 1,466,759	109,968	210,524	367,990	198,426	44,129	5,379	247,934	53,243	133,242	361,145	386,323	296,246	—	(1,944)	3,631,430
State support	31,200	—	—	—	—	—	—	—	—	—	—	—	32,237	—	—	63,437
Other revenue	98,680	2,732	18,610	4,980	4,347	288	9	4,644	510	550	3,266	5,114	5,156	—	—	144,242
Total operating revenue, gains and other support	1,596,639	112,700	229,134	372,970	202,773	44,417	5,388	252,578	53,753	133,792	364,411	391,437	333,639	—	(1,944)	3,839,109
Operating expenses:																
Salaries, wages, and benefits	765,900	53,923	96,439	171,046	85,481	22,387	3,308	111,176	15,995	57,036	136,452	172,899	160,760	—	—	1,741,626
Expendable supplies	364,525	15,419	32,831	57,852	36,031	2,858	477	39,366	4,897	19,015	79,516	70,112	43,209	—	—	726,742
Purchased services	155,631	23,002	53,331	67,201	34,089	7,814	857	42,760	15,007	29,167	71,041	63,380	93,617	—	(1,944)	612,193
Contracted services	136,537	8,553	27,207	17,164	8,055	3,656	1,441	13,152	6,090	7,000	17,875	14,592	18,177	—	—	266,347
Depreciation and amortization	97,673	6,658	12,242	26,383	14,445	3,187	467	18,099	4,133	5,892	21,156	21,865	12,531	—	—	226,632
Interest expense	24,182	674	1,043	5,351	2,502	193	121	2,816	137	1,750	9,009	7,737	99	—	—	52,798
Total operating expenses	1,544,448	108,229	223,093	344,997	180,603	40,095	6,671	227,369	46,259	119,860	335,049	350,585	328,393	—	(1,944)	3,626,338
Operating income (loss)	52,191	4,471	6,041	27,973	22,170	4,322	(1,283)	25,209	7,494	13,932	29,362	40,852	5,246	—	—	212,771
Nonoperating income and expenses, net:																
Contributions	—	—	—	—	(4)	—	—	(4)	—	—	—	—	—	8,832	—	8,828
Inherent contribution - Capital Region	41,772	—	—	—	—	—	—		—	—	—	—	—	—	—	41,772
Equity in net income of joint ventures	503	—	—	(203)	169	47	7	223	—	239	1,418	—	—	—	—	2,180
Investment income	10,317	1,028	72	3,904	7,795	—	—	7,795	456	698	—	5,047	32	710	—	30,059
Change in fair value of investments	6,913	1,318	—	5,129	282	—	—	282	628	1,275	—	6,392	—	433	—	22,370
Change in fair value of undesignated interest rate swaps	43,071	—	—	—	—	—	—	—	—	—	—	—	—	—	—	43,071
Other nonoperating gains and losses	(10,075)	(294)	(3,535)	(4,754)	(702)	(194)	(28)	(924)	(443)	(831)	(3,279)	(2,702)	2,048	(3,643)	—	(28,432)
Total nonoperating income and expenses	92,501	2,052	(3,463)	4,076	7,540	(147)	(21)	7,372	641	1,381	(1,861)	8,737	2,080	6,332	—	119,848
Excess (deficiency) of revenues over expenses	144,692	6,523	2,578	32,049	29,710	4,175	(1,304)	32,581	8,135	15,313	27,501	49,589	7,326	6,332	—	332,619
Net assets released from restrictions used for purchase of property and equipment	—	—	618	1,690	745	—	—	745	453	—	—	—	—	—	—	3,506
Change in unrealized gains on investments	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in economic and beneficial interest in the net assets of related organizations	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Change in ownership interest of joint ventures	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Capital transfers (to) from affiliate	(14,310)	(7,704)	(207)	(4,120)	(18,187)	—	—	(18,187)	(426)	(1,324)	(125,411)	(16,909)	46,450	(2,234)	—	(144,382)
Amortization of accumulated loss of discontinued designated interest rate swap	1,668	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1,668
Change in funded status of defined benefit pension plans	—	—	4,312	1,873	—	—	—	—	(886)	1,873	—	—	—	—	—	7,172
Asset reclassifications at request of donor	—	—	—	—	—	—	—	—	—	—	—	—	—	1,978	—	1,978
Other	169	—	231	2,570	1,402	—	—	1,402	809	55	372	—	—	—	—	5,608
Increase (decrease) in unrestricted net assets	$ 132,219	(1,181)	7,532	34,062	13,670	4,175	(1,304)	16,541	8,085	15,917	(97,538)	32,680	53,776	6,076	—	208,169

* Includes Corporate Shared Services

** Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital

*** Includes Prince George's Hospital Center, Laurel Regional Hospital, Bowie Health Center and Gladys Spellman Specialty Care Unit

See accompanying independent auditors' report.

EXHIBIT 18

UNIVERSITY OF MARYLAND FACULTY PHYSICIANS, INC. AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS

JUNE 30, 2019 AND 2018

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Independent Auditors' Report

To the Board of Directors of University of Maryland Faculty Physicians, Inc. and Subsidiaries

We have audited the accompanying consolidated financial statements of University of Maryland Faculty Physicians, Inc. (a nonprofit organization) and Subsidiaries (two single member limited liability companies), which comprise the consolidated statements of financial position as of June 30, 2019 and 2018, and the related consolidated statements of activities, functional expenses and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated 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.

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the 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.

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

Opinion
In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of University of Maryland Faculty Physicians, Inc. and Subsidiaries as of June 30, 2019 and 2018, and the 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.

Rosen, Sapperstein & Friedlander, LLC

Rosen, Sapperstein & Friedlander, LLC
Baltimore, Maryland
November 26, 2019

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CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

UNIVERSITY OF MARYLAND FACULTY PHYSICIANS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF FINANCIAL POSITION
June 30, 2019 and 2018

ASSETS

	2019	2018
CURRENT ASSETS		
Cash and cash equivalents	$ 13,487,544	$ 15,950,122
Contract medical services revenue receivable - net	17,547,640	24,325,289
Due from related parties - net	16,293,962	16,769,477
Other receivables	3,218,660	2,172,495
Prepaid expenses and other current assets	1,035,002	1,199,260
Investments	13,990,893	13,371,089
Board designated funds	16,262,462	14,933,218
Monies held on behalf of others	70,522,853	56,696,565
TOTAL CURRENT ASSETS	152,359,016	145,417,515
PROPERTY AND EQUIPMENT - NET	24,717,821	26,506,616
NONCURRENT ASSETS		
Due from related parties - net	783,329	3,026
Investments in joint ventures	5,307,488	3,821,907
Assets limited as to use	108,124,106	96,526,604
Other deferred expenses	1,984,121	1,962,318
TOTAL NONCURRENT ASSETS	116,199,044	102,313,855
TOTAL ASSETS	$ 293,275,881	$ 274,237,986

See Accompanying Notes to Consolidated Financial Statements

LIABILITIES AND NET ASSETS

	2019	2018
CURRENT LIABILITIES		
Accounts payable and accrued expenses	$ 42,982,804	$ 36,357,460
Claims payable - medical services	21,629,768	28,925,255
Current maturities of notes payable	735,000	720,000
Current maturities of capital lease obligations	-	190,514
Board designated funds	16,289,146	14,773,055
Monies held on behalf of others	70,522,458	56,837,437
TOTAL CURRENT LIABILITIES	152,159,176	137,803,721
NONCURRENT LIABILITIES		
Malpractice insurance liability	15,485,631	14,505,100
Notes payable - net	9,182,069	9,892,032
Other liabilities	1,000,000	1,000,000
Deferred revenue	3,372,679	4,331,955
TOTAL NONCURRENT LIABILITIES	29,040,379	29,729,087
TOTAL LIABILITIES	181,199,555	167,532,808
NET ASSETS		
Without donor restrictions	112,076,326	106,705,178
TOTAL LIABILITIES AND NET ASSETS	$ 293,275,881	$ 274,237,986

See Accompanying Notes to Consolidated Financial Statements

UNIVERSITY OF MARYLAND FACULTY PHYSICIANS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF ACTIVITIES
For the Years Ended June 30, 2019 and 2018

	2019	2018
REVENUE		
Fees and assessments from participants	$ 34,939,344	$ 33,535,407
Contract medical service revenue	25,232,717	38,613,261
Rental and other income	27,076,745	23,043,154
Joint project support from University of Maryland Medical System	436,505	428,290
TOTAL REVENUE	87,685,311	95,620,112
EXPENSES		
Health services	23,540,619	38,253,798
Other program services	52,666,088	46,584,271
Total program services	76,206,707	84,838,069
General and administrative	10,953,399	10,953,891
TOTAL EXPENSES	87,160,106	95,791,960
OPERATING INCOME (LOSS)	525,205	(171,848)
NONOPERATING INCOME AND EXPENSE		
Investment income	4,845,943	3,499,705
Insurance proceeds due to casualty loss	-	2,259,899
Loss due to casualty loss	-	(12,864)
TOTAL NONOPERATING INCOME AND EXPENSE	4,845,943	5,746,740
CHANGE IN NET ASSETS	5,371,148	5,574,892
NET ASSETS - BEGINNING OF YEAR	106,705,178	101,130,286
NET ASSETS - END OF YEAR	$ 112,076,326	$ 106,705,178

See Accompanying Notes to Consolidated Financial Statements

UNIVERSITY OF MARYLAND FACULTY PHYSICIANS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF FUNCTIONAL EXPENSES
For the Years Ended June 30, 2019 and 2018

	2019			2018
	Program Services	General and Administrative	Total	Total
FUNCTIONAL EXPENSES				
Salaries and wages	$ 18,876,304	$ 4,468,932	$ 23,345,236	$ 20,940,754
Payroll taxes	1,264,828	312,488	1,577,316	1,449,783
Employee benefits	933,710	234,516	1,168,226	811,972
Recruitment and employee relations	-	211,193	211,193	295,410
Employee training and development	151,016	44,228	195,244	190,405
Meetings, meals and travel	70,343	21,011	91,354	117,573
Net self insurance cost	3,142,232	938,589	4,080,821	3,443,761
Health services	23,540,619	-	23,540,619	38,253,798
Department development expenses	11,333,231	-	11,333,231	9,607,908
Donations and other assistance	2,797,255	-	2,797,255	1,870,329
Occupancy	5,542,038	1,411,147	6,953,185	6,870,545
Office expenses	1,991,192	656,636	2,647,828	2,854,264
Professional services	3,487,290	1,736,972	5,224,262	5,051,375
Depreciation and amortization	2,022,090	604,001	2,626,091	2,680,891
Bad debt	288,196	-	288,196	311,080
Taxes	-	106,075	106,075	63,309
Financing costs	25,037	-	25,037	25,037
Other general and administrative	741,327	207,610	948,937	953,766
TOTAL FUNCTIONAL EXPENSES	$ 76,206,707	$ 10,953,399	$ 87,160,106	$ 95,791,960

See Accompanying Notes to Consolidated Financial Statements

CONSOLIDATED STATEMENTS OF CASH FLOWS

UNIVERSITY OF MARYLAND FACULTY PHYSICIANS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
For the Years Ended June 30, 2019 and 2018

	2019	2018
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in net assets	$ 5,371,148	$ 5,574,892
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation	2,626,085	2,680,889
Amortization of financing costs to interest	25,037	25,038
Equity in net loss of joint ventures	889,687	899,874
Change in fair value of investments	(5,441,935)	(4,081,762)
Provision for uncollectible accounts	288,196	311,081
Change in deferred rent and revenue	(995,904)	(959,127)
Decrease (increase) in assets:		
Receivables	4,813,654	(13,893,961)
Prepaid expenses and other current assets	164,258	167,804
Board designated funds - net	186,847	147,066
Increase (decrease) in liabilities:		
Accounts payable and accrued expenses	6,218,160	3,388,855
Claims payable - medical services	(7,295,487)	9,650,019
Other liabilities	7,889	148,564
NET CASH PROVIDED BY OPERATING ACTIVITIES	6,857,635	4,059,232
CASH FLOWS FROM INVESTING ACTIVITIES		
Contributions paid to investments in joint ventures	(2,375,268)	(494,732)
Cash paid for investments	(5,387,655)	(5,023,367)
Cash received on capital lease receivable	190,514	281,840
Capital expenditures paid in cash	(837,290)	(2,708,552)
NET CASH USED BY INVESTING ACTIVITIES	(8,409,699)	(7,944,811)

See Accompanying Notes to Consolidated Financial Statements

	2019	2018
CASH FLOWS FROM FINANCING ACTIVITIES		
Cash paid on principal amount of long term debt	$ (720,000)	$ (690,000)
Cash paid on capital lease obligations	(190,514)	(281,840)
NET CASH USED BY FINANCING ACTIVITIES	(910,514)	(971,840)
NET CHANGE IN CASH AND CASH EQUIVALENTS	(2,462,578)	(4,857,419)
CASH AND CASH EQUIVALENTS - BEGINNING OF YEAR	15,950,122	20,807,541
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 13,487,544	$ 15,950,122
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid for interest	$ 340,753	$ 330,620
Cash paid for unrelated business income taxes	$ 234,400	$ 175,000

See Accompanying Notes to Consolidated Financial Statements

NOTE 1 – ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Description of Organization

University of Maryland Faculty Physicians, Inc. (FPI, Inc.) was formed to coordinate and implement the Medical Service Plan (MSP), administer the Medical Service Plan Trust Fund (Trust Fund) at the University of Maryland, School of Medicine (School of Medicine), and to act as a custodian for the Medical School Enrichment Fund (MSEF) and Departmental Development Funds (DDF) established under the MSP. The MSP sets forth accounting and operational guidelines for all of its participants, consisting of 20 medical service provider groups which are considered related parties to FPI, Inc. In addition, FPI, Inc. obtains contracts with health maintenance organizations (HMOs) to provide specific services to the HMOs and arranges for members of the MSP and others to provide the related services.

University of Maryland Medical Associates, LLC (UMMA) is an organization wholly-owned by FPI, Inc. The entity was established in 2012 to employ clinical and non-faculty physicians.

UMFPI Global, LLC (UMFPI Global) is an organization wholly-owned by FPI, Inc. The entity was established in 2015 to provide physician and management services globally.

Principles of Consolidation

Financial Accounting Standards Board (FASB) Accounting Standards Codification on Consolidation requires wholly-owned subsidiaries to be consolidated with the parent entity. These consolidated financial statements include the consolidated financial statements of FPI, Inc., UMMA and UMFPI Global, collectively hereafter referred to as “FPI”. All material intercompany accounts and transactions have been eliminated in consolidation.

New Accounting Standard Adopted

In August 2016, the FASB issued Accounting Standards Update (ASU) 2016-14, *Not-for-Profit Entities: Presentation of Financial Statements of Not-for-Profit Entities*. The ASU amends the current reporting model for not-for-profit organizations and enhances their required disclosures. FPI, Inc. has adopted this ASU as of and for the year ended June 30, 2019. The major changes include (a) requiring the presentation of only two classes of net assets now entitled “net assets without donor restrictions” and “net assets with donor restrictions”, (b) modifying the presentation of underwater endowment funds and related disclosures, (c) requiring that all nonprofits present an analysis of expenses by function and nature, and disclose a summary of the allocation methods used to allocate costs, (d) requiring the disclosure of quantitative and qualitative information regarding liquidity and availability of resources, (e) presenting investment return net of external and direct internal investment expenses, and (f) modifying other financial statement reporting requirements and disclosures intended to increase the usefulness of nonprofit financial statements. As a result, FPI, Inc. Inc. changed its presentation of its net asset classes and expanded the disclosures as required by the ASU.

NOTE 1 – ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Basis of Presentation

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 (U.S. GAAP). Under the accrual basis of accounting, support and revenues are recorded when earned and expenses are recorded when incurred. Net assets, revenue and expenses are classified based on existence or absence of donor-imposed restrictions. Net assets without donor restriction are comprised of operating (resources available for support of operations) and board designated funds (resources to be spent only for purposes approved by the Board). Net assets with donor restriction consist of assets whose use is limited by donor-imposed, time and/or purpose restrictions.

Fees and Assessments Received from MSP Participants

Funds received by FPI from participants for the MSEF and DDF (monies held on behalf of others); and Contingency Reserve Fund, and the Business Development Fund (board designated funds) are accounted for as current assets with offsetting liabilities. Disbursements and transfers from these Funds are made in accordance with the MSP. Amounts paid by FPI on behalf of the Funds are treated as reductions in the related liabilities and recognized as revenue and expenses by FPI.

Additionally, under the terms of the MSP, the following operating assessments are collected on a quarterly basis from the MSP participants to fund FPI operations:

Medical Service Plan Trust Fund (MSPTF)

2.225% of professional fees and other MSP income collected by the participants of the MSP shall be paid to the Medical Service Plan Trust Fund to finance the operations of FPI.

Physician Hospital Organization (PHO)

In order to fund FPI's investment in UniversityCARE, LLC (UCARE) (Note 6), the participants of the MSP pay FPI an annual assessment to fund the development and support of the integrated delivery system.

Clinical Practice Redesign (CPR)

In order to fund clinical redesign activities impacting the medical service providers' operations, the participants of the MSP pay FPI an annual assessment.

NOTE 1 – ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

The assessments made pursuant to the terms of the MSP are modified as necessary by FPI's Board of Directors to meet the operational and strategic financial obligations of FPI. These fees are included in fees and assessments on the consolidated statements of activities. For the years ended June 30, 2019 and 2018, the approximate amounts of these fees collected are as follows:

	2019	2018
Medical Service Plan Trust Fund	$ 6,491,000	$ 6,317,000
Physician Hospital Organization	725,000	725,000
Clinical Practice Redesign	2,855,000	2,631,000

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 and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

For purposes of the consolidated statements of cash flows, cash equivalents include certificate of deposits and all highly liquid, short-term investments with original maturities of less than three (3) months.

Financial Credit Risk

FPI maintains various cash and investment accounts at several financial institutions and the balances may at times be in excess of statutory deposit insurance. FPI has not experienced any losses in such accounts and monitors the creditworthiness of the financial institutions with which it conducts business. Management believes that FPI is not exposed to any significant credit risk with respect to its cash balances.

Contract Medical Services and Provision for Uncollectible Accounts

Contract medical services represent services provided under managed care contractual arrangements with various health plans to provide primary and specialty care. Under these arrangements, specified services are provided by members of the MSP and other health care providers at established rates to health plan members. FPI pays fees to members of the MSP and others participating in providing these services based on established fee schedules. Health services expenses reported in the consolidated statements of activities reports these payments.

NOTE 1 – ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Contract Medical Services and Provision for Uncollectible Accounts (Continued)

Under these arrangements, FPI records revenue and related receivables from patients and third-party payors as contract medical service revenue when earned.

These amounts are reported at their estimated net realizable value. Services provided by members of the MSP and other health care providers under such arrangements are recorded as contract medical service fees when the services are rendered.

The provision for bad debts is based upon FPI's assessment of historical and expected net collections considering historical business and economic conditions, trends in healthcare coverage and other collection indicators. Annually management assesses the adequacy of the allowance for uncollectible accounts based upon historical write-off experience by payor. The result of this review is then used to make modifications to the provision for bad debts and to establish an allowance for uncollectible receivables.

Due from Related Parties, Other Receivables and Provision for Uncollectible Accounts

FPI considers various factors as of the date of the consolidated financial statements in evaluating the credit quality of loans, advances and receivables to related parties and third parties, including the value of collateral, if any, historical collection experience and FPI's assessment of the counterparties' ability to repay their obligations. To date, FPI has not experienced any losses with respect to loans, advances and receivables to related parties and third parties, and believes that all loans and advances will be recovered; however an allowance has been established based on the aging of the receivables.

Investments and Assets Limited as to Use

FPI's investment portfolio is classified as trading and is reported at its fair value. Assets limited as to use include investments set aside at the discretion of the board of trustees for self-insurance trust arrangements. These investments are stated at fair value.

FPI invests in various investment securities. Investment securities are exposed to various risks such as interest rate, credit market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term, and that such change could materially affect the amounts reported in the consolidated financial statements.

NOTE 1 – ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Property and Equipment

Property and equipment is recorded at cost, net of accumulated depreciation. Major additions and betterments are charged to the asset accounts while maintenance and repairs that do not improve or extend the lives of the assets are expensed as incurred. The cost of assets sold, retired, or otherwise disposed of, and the related accumulated depreciation is eliminated from the accounts, and any resulting gain or loss is included in operations, except as related to disposals related to the fire and flood which are reported in nonoperating expenses. Depreciation is calculated using the straight-line method over the estimated useful lives of the assets. Leasehold improvements are depreciated over the shorter of the estimated useful lives of the improvements or the expected lease terms using the straight-line method.

Other Deferred Expenses

Other deferred expenses represent the difference between lease related expenses incurred on a straight-line basis over actual expense paid and other assets deferred over a long-term period. Expense recognized is based on amortization over the life of the respective leases or other asset life.

Valuation of Long-Lived Assets

FPI accounts for the valuation of long-lived assets under the Impairment or Disposal of Long-lived Assets topic of the FASB Accounting Standards Codification. Long-lived assets, such as property and equipment and purchased intangibles subject to amortization, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable, and are evaluated at least annually. Recoverability of assets to be held and used is measured by comparing the carrying amount of an asset to estimated undiscounted future cash flows expected to be generated by the asset. If the carrying amount of an asset exceeds its estimated future cash flows, an impairment charge is recognized in the amount by which the carrying amount of the asset exceeds the fair value of the asset. Assets to be disposed of would be separately presented in the consolidated statements of financial position and reported at the lower of the carrying amount or fair value less costs to sell, and are no longer depreciated. The assets and liabilities of a disposed group classified as held for sale would be presented separately in the appropriate asset and liability sections of the consolidated statements of financial position. Management believes the value of long-lived assets exceeds their carrying value as of June 30, 2019.

Investments in Joint Ventures

In accordance with Investments – Equity and Joint Ventures Investments topic of the FASB Accounting Standards Codification, when FPI does not have a controlling interest in an entity, but exerts significant influence over the entity, FPI applies the equity method of accounting. Based on this guidance, FPI accounts for its investments in joint ventures using the equity method of accounting (Note 6). Under the equity method of accounting, FPI increases its investments for cash contributions and its share of the joint venture's net income and decreases its investments for cash distributions and its share of the joint venture's net loss. Since FPI has guaranteed obligations and is committed to funding its proportionate share of operating deficits of the joint ventures, all losses on the joint ventures have been recognized.

NOTE 1 – ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Self-Insurance

Under FPI's self-insurance programs (state unemployment insurance and employee health benefits), claims are reflected using an expense forecasting model that is based on historical claims, incurrence patterns modified to consider current trends in enrollment, member utilization patterns, timeliness of claims submissions and other factors.

Under FPI's self-insurance malpractice liability program, claims are reflected as a present value liability based upon actuarial estimates. These estimates include both reported and incurred but not reported claims taking into consideration the severity of incidents and the expected timing of claim payments.

Deferred Revenue

Deferred revenue is recognized as the difference between revenue earned on a straight-line basis over actual revenue received. Revenue recognized is based on amortization over the life of the respective leases. In addition, when board designated funds are expended, FPI records revenue and expenses contemporaneously. When these funds are used to purchase capital assets, revenue is deferred and recognized over the life of the respective asset.

Income Tax Status

FPI is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code and application state law. Income taxes paid on unrelated business activities for the years ended June 30, 2019 and 2018 amounted to $234,000 and $175,000, respectively.

FPI has adopted the Accounting for Uncertainty in Income Taxes topic of the FASB Accounting Standards Codification. The standard requires the recognition and measurement of uncertain tax positions taken or expected to be taken by FPI in the preparation of its tax returns. FPI determines whether it is more-likely-than-not that a certain tax position will be sustained upon examination by a taxing authority. If an uncertain tax position is less-likely-than-not to be sustained, an estimate of the potential effect is recognized in the consolidated financial statements, and the uncertain tax position is required to be disclosed. Per management's evaluation, it has been determined that no material adjustments were required in the consolidated financial statements for tax positions less-likely-than-not to be sustained upon examination by a taxing authority for the years ended June 30, 2019 and 2018. FPI believes it is no longer subject to income tax examinations for years prior to 2015.

Functional Expenses Allocation

The costs of providing the various programs and other activities have been summarized on a functional basis in the consolidated statements of activities. Accordingly, certain costs have been allocated among the programs and supporting services that benefit from those costs. Specifically, salaries and benefits are allocated on the basis of function performed; physical resources are allocated on the basis of usage; purchased services are allocated on the basis of services received. General and administrative expenses include those expenses that are not directly identified with any other specific function but provide for the overall support and direction of FPI, Inc.

NOTE 1 – ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Commitments and Contingencies

Liabilities for loss contingencies arising from claims, assessments, litigation, fines, penalties and other sources are recorded when it is probable that a liability has been incurred and the amount can be reasonably estimated. Legal costs incurred in connection with loss contingencies are expensed as incurred.

Reclassification

Certain accounts in the prior year financial statements have been reclassified for comparative purposes to conform to the current year presentation. These reclassifications have no effect on the changes in net assets.

Subsequent Events

Events that occurred subsequent to June 30, 2019 have been evaluated by FPI's management for potential recognition or disclosure in the consolidated financial statements through the date of the independent auditors' report, which is the date the consolidated financial statements were available to be issued. FPI did not have any material recognizable subsequent events during this period.

New Accounting Pronouncements Not Yet Adopted

In May 2014, the FASB issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers.* The standard's core principle is that FPI will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which FPI expects to be entitled in exchange for those goods or services. This standard also includes expanded disclosure requirements that result in an entity providing users of financial statements with comprehensive information about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers. This standard will be effective for the year ending June 30, 2020. FPI is currently in the process of evaluating the impact of adoption of this ASU on the consolidated financial statements.

In February 2016, the FASB issued ASU 2016-02, *Leases*. The standard requires all leases with lease terms over 12 months to be capitalized as a right-of-use asset and lease liability on the statement of financial position at the date of lease commencement. Leases will be classified as either finance or operating. This distinction will be relevant for the pattern of expense recognition in the consolidated statement of activities. This standard will be effective for the year ending June 30, 2022. FPI is currently in the process of evaluating the impact of adoption of this ASU on the consolidated financial statements.

NOTE 2 – CONTRACT MEDICAL SERVICES

Contract medical services revenue receivable is reported net of a provision for uncollectible accounts. As of June 30, 2019 and 2018, a provision for uncollectible accounts totaled approximately $476,000 and $687,000, respectively.

FPI reports an estimated liability for contract medical service claims that were incurred but not reported at June 30, 2019 and 2018. This liability is reported as claims payable – medical services in the consolidated statements of financial position.

NOTE 3 – DUE FROM RELATED PARTIES

Due from related parties consist of the following as of June 30, 2019 and 2018:

	2019	2018
Medical Service Plan Trust Fund assessments	$ 2,513,240	$ 2,468,557
Other assessments receivable	-	158,452
Reimbursement of participant expenses - net	14,564,051	14,145,494
Totals	17,077,291	16,772,503
Less: Noncurrent portion	(783,329)	(3,026)
Due from related parties - current	$ 16,293,962	$ 16,769,477

Reimbursement of participant expenses includes ongoing charges paid by FPI on behalf of participants of the MSP that are subsequently reimbursed. These charges include, but are not limited to, salary reimbursements and related benefits, patient service department expenses, information technology expenses, operating expenses and other assessments under the MSP. These receivables are unsecured, have no repayment terms and expect to be repaid. Reimbursement of participant expenses are reported net of a provision for uncollectible accounts. As of June 30, 2019 and 2018, a provision for uncollectible accounts totaled approximately $3,665,000 and $3,165,000, respectively.

Also included in reimbursement of participant expenses receivable are notes receivable representing advances by FPI to various participants of the MSP and others. These notes receivable are unsecured, bear interest at varying rates and mature at various dates through December 2034. Interest on loans is recognized over the term of the loan and is calculated using the simple-interest method on principal amounts outstanding.

NOTE 3 – DUE FROM RELATED PARTIES (Continued)

Notes receivables as of June 30, 2019 and 2018 are as follows:

	2019	2018
University Imaging Center, LLC	$ -	$ 190,514
University of Maryland Medical Service System Self-Insurance Trust	3,026	20,566
Shock Trauma Associates, P.A.	983,333	1,000,000
University of Maryland Surgical Associates, P.A.	684,409	461,440
University of Maryland Eye Associates, P.A.	2,415,147	2,731,193
Totals	4,085,915	4,403,713
Less: Noncurrent maturities	(783,329)	(3,026)
Notes receivable - current	$ 3,302,586	$ 4,400,687

NOTE 4 – PROPERTY AND EQUIPMENT

Property and equipment is summarized as follows at June 30, 2019 and 2018:

	2019	2018
Land	$ 798,000	$ 798,000
Buildings and improvements	41,884,009	41,597,022
Leasehold improvements	2,319,478	2,265,191
Equipment	14,393,117	13,897,101
Furniture	963,926	963,926
Totals	60,358,530	59,521,240
Less: Accumulated depreciation	(35,640,709)	(33,014,624)
Property and equipment - net	$ 24,717,821	$ 26,506,616

Depreciation expense for the years ended June 30, 2019 and 2018 amounted to approximately $2,626,000 and $2,681,000, respectively.

NOTE 5 – FAIR VALUE MEASUREMENTS

FPI accounts for the fair value of its investments under the Fair Value Measurement and Disclosure topic of the FASB Accounting Standards Codification, which provides the 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 (3) levels of the fair value hierarchy under this guidance are described as follows:

Level 1

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

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; and
- 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.

Assets and liabilities classified as Level 1 are valued using unadjusted quoted market prices for identical assets or liabilities in active markets. FPI uses techniques consistent with the market approach and the income approach for measuring fair value of its Level 2 assets and liabilities. The market approach is a valuation technique that uses prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities. The income approach generally converts future amounts (cash flows or earnings) to a single present value amount (discounted). Assets classified as Level 3 assets are measured using the equity method of accounting.

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.

NOTE 5 – FAIR VALUE MEASUREMENTS (Continued)

As of June 30, 2019 and 2018, the assets and liabilities listed in the fair value hierarchy tables below utilize the following valuation techniques and inputs:

Cash equivalents: The fair value of investments in cash equivalent securities, with maturities within 3 months of the date of purchase, is determined using techniques that are consistent with the market approach. Significant observable inputs include reported trades and observable broker/dealer quotes.

Corporate bonds: The fair value of investments in U.S. and international corporate bonds, including commingled funds that invest primarily in such bonds, and foreign government bonds is primarily determined using techniques that are consistent with the market approach. Significant observable inputs include benchmark yields, reported trades, observable broker/dealer quotes, issuer spreads, and security specific characteristics, such as early redemption options.

Collateralized corporate obligations: The fair value of collateralized corporate obligations is primarily determined using techniques consistent with the income approach, such as a discounted cash flow model. Significant observable inputs include prepayment speeds and spreads, benchmark yield curves, volatility measures, and quotes.

U.S. government and agency securities: The fair value of investments in U.S. government, state, and municipal obligations is primarily determined using techniques consistent with the income approach. Significant observable inputs to the income approach include data points for benchmark and constant maturity curves and spreads.

Common stocks, preferred stocks, and mutual funds: The fair value of common stocks, preferred stocks, and mutual funds are valued at quoted prices from active markets.

Investments in joint ventures: The fair value of investments in joint ventures is valued using the equity method of accounting.

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 FPI 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. There have been no changes in the methodologies used at June 30, 2019 and 2018. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements.

NOTE 5 – FAIR VALUE MEASUREMENTS (Continued)

The following table sets forth by level, within the fair value hierarchy, FPI's assets at fair value as of June 30, 2019:

Payor Class	Level 1	Level 2	Level 3	Totals
Cash equivalents	$ 709,399	$ 2,324,516	$ -	$ 3,033,915
Corporate bonds	-	23,828,711	-	23,828,711
Collateralized corporate debt	-	3,110,364	-	3,110,364
U.S. government and agency securities	-	11,757,558	-	11,757,558
Common stocks, preferred stocks and mutual funds	341,725	126,278,299	-	126,620,024
Investments in joint ventures	-	-	5,307,488	5,307,488
Total Assets at Fair Value	$ 1,051,124	$ 167,299,448	$ 5,307,488	$ 173,658,060

Investments reported at fair value above are reflected in the following components in the consolidated statements of financial position as of June 30, 2019:

Payor Class	Assets limited as to use	Investments	Monies held on behalf of others	Investments in joint ventures	Total
Cash equivalents	$ 1,477,901	$ 232,149	$ 1,323,865	$ -	$ 3,033,915
Corporate bonds	13,458,280	2,843,664	7,526,767	-	23,828,711
Collateralized corporate debt	1,756,710	371,184	982,470	-	3,110,364
U.S. government and agency securities	2,036,068	430,210	9,291,280	-	11,757,558
Common stocks, preferred stocks, and mutual funds	89,395,147	10,113,686	27,111,191	-	126,620,024
Investments in joint ventures	-	-	-	5,307,488	5,307,488
Totals	$108,124,106	$ 13,990,893	$ 46,235,573	$ 5,307,488	$ 173,658,060

NOTE 5 – FAIR VALUE MEASUREMENTS (Continued)

Changes to the fair values based on the Level 3 inputs for the year ended June 30, 2019 are summarized as follows:

Payor Class	Balance at 7/1/2018	Contributions / Purchases	Net Transfer In (Out)	Gains (Losses)	Balance at 6/30/2019
Investments in Joint Ventures	$ 3,821,907	$ 2,375,268	$ -	$ (889,687)	$ 5,307,488

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

Payor Class	Level 1	Level 2	Level 3	Totals
Cash equivalents	$ 339,889	$ 4,475,644	$ -	$ 4,815,533
Corporate bonds	-	6,729,866	-	6,729,866
Collateralized corporate debt	-	3,250,058	-	3,250,058
U.S. government and agency securities	-	3,553,444	-	3,553,444
Common stocks, preferred stocks, and mutual funds	351,700	128,346,922	-	128,698,622
Investment in joint ventures	-	-	3,821,907	3,821,907
Total Assets at Fair Value	$ 691,589	$ 146,355,934	$ 3,821,907	$ 150,869,430

Investments reported at fair value above are reflected in the following components in the consolidated statements of financial position as of June 30, 2018:

Payor Class	Assets limited as to use	Investments	Monies held on behalf of others	Investments in joint ventures	Total
Cash equivalents	$ 2,426,175	$ 549,950	$ 1,839,408	$ -	$ 4,815,533
Corporate bonds	3,539,118	856,198	2,334,550	-	6,729,866
Collateralized corporate debt	1,709,148	413,484	1,127,426	-	3,250,058
U.S. government and agency securities	1,868,694	452,082	1,232,668	-	3,553,444
Common stocks, preferred stocks, and mutual funds	86,983,469	11,099,375	30,615,778	-	128,698,622
Investment in joint ventures	-	-	-	3,821,907	3,821,907
Totals	$ 96,526,604	$ 13,371,089	$ 37,149,830	$ 3,821,907	$ 150,869,430

NOTE 5 – FAIR VALUE MEASUREMENTS (Continued)

Changes to the fair values based on the Level 3 inputs for the year ended June 30, 2018 are summarized as follows:

Payor Class	Balance at 7/1/2017	Contributions / Purchases	Net Transfer In (Out)	Gains (Losses)	Balance at 6/30/2018
Investments in Joint Ventures	$ 4,227,050	$ 494,731	$ -	$ (899,874)	$ 3,821,907

FPI's total return on its investments were as follows for the years ended June 30, 2019 and 2018:

	2019	2018
Dividends and interest	$ 166,287	$ 115,938
Realized gains	187,809	276,770
Net loss in joint ventures	(889,687)	(899,874)
Net change in assets limited as to use	5,135,772	3,616,155
Change in fair value of trading securities	306,163	465,622
Investment fees	(60,401)	(74,906)
Total investment return	$ 4,845,943	$ 3,499,705

NOTE 6 – INVESTMENTS IN JOINT VENTURES

UniversityCARE, LLC (UCARE) is a physician hospital organization that was established as a joint venture between FPI and the University of Maryland Medical System Corporation (UMMS). The purpose of UCARE is to operate an integrated healthcare services delivery system in a manner that integrates the teaching and research missions of FPI, UMMS and their affiliates with the delivery of care in a cost efficient manner. FPI has equal voting rights with UMMS and accounts for its investment in UCARE using the equity method. The ownership percentage and income (loss) sharing percentage is 10% FPI and 90% UMMS. FPI has made commitments to continue funding the activities of UCARE.

During fiscal year 1999, FPI contributed $1,000,000 to begin the development of University Imaging Center, LLC (UIC), a joint venture between FPI and the University of Maryland Diagnostic Imaging Specialists, P.A. (DISPA). FPI and DISPA each have a 50% ownership interest in UIC.

FPI in conjunction with UMMS, formed the University of Maryland Medicine ASC, LLC (ASC) for the purpose of providing ambulatory services in Columbia, Maryland. FPI and UMMS each have a 50% ownership interest in ASC. ASC will contract with MSP participants to provide services. ASC commenced operations during the year ended June 30, 2016. FPI's board of directors has committed funding its proportionate share of startup costs and operations.

NOTE 6 – INVESTMENTS IN JOINT VENTURES (Continued)

Terrapin Insurance Company (Terrapin) was incorporated on November 22, 1990. The principal activity of Terrapin is to provide hospital and physician malpractice liability coverage. FPI and UMMS each own 50% of the stock of Terrapin.

FPI's investments in joint ventures were as follows:

	UCARE	UIC	Terrapin	ASC	Totals
Balance at June 30, 2017	$ 990,685	$ 1,494,828	$ 975,000	$ 766,537	$ 4,227,050
Capital contributions	311,399	169,846	-	13,487	494,732
Net income (loss)	(245,399)	53,242	-	(707,718)	(899,875)
Balance at June 30, 2018	1,056,685	1,717,916	975,000	72,306	3,821,907
Capital contributions	214,645	-	-	2,160,623	2,375,268
Net income (loss)	(198,145)	44,440	-	(735,982)	(889,687)
Balance at June 30, 2019	$ 1,073,185	$ 1,762,356	$ 975,000	$ 1,496,947	$ 5,307,488

The following is a summary of FPI's joint ventures' condensed financial information as of and for the year ended June 30, 2019:

	UCARE	UIC	Terrapin	ASC	Totals
Assets	$ 5,399,000	$ 3,171,110	$ 294,840,863	$ 2,669,595	$ 306,080,568
Liabilities	$ 436,000	$ 589,205	$ 292,890,863	$ 1,986,790	$ 295,902,858
Equity	4,963,000	2,581,905	1,950,000	682,805	10,177,710
Total liabilities and equity	$ 5,399,000	$ 3,171,110	$ 294,840,863	$ 2,669,595	$ 306,080,568
Revenues	$ 515,000	$ 5,885,511	$ 57,607,090	$ 1,100,093	$ 65,107,694
Expenses	(1,677,000)	(5,796,632)	(57,607,090)	(2,572,056)	(67,652,778)
Net income (loss)	$(1,162,000)	$ 88,879	$ -	$(1,471,963)	$ (2,545,084)

NOTE 6 – INVESTMENTS IN JOINT VENTURES (Continued)

The following is a summary of FPI's joint ventures' condensed financial information as of and for the year ended June 30, 2018:

	UCARE	UIC	Terrapin	ASC	Totals
Assets	$ 4,202,000	$ 3,145,529	$ 258,109,842	$ 3,045,620	$ 268,502,991
Liabilities	$ 735,000	$ 652,503	$ 256,159,842	$ 3,084,007	$ 260,631,352
Equity	3,467,000	2,493,026	1,950,000	(38,387)	7,871,639
Total liabilities and equity	$ 4,202,000	$ 3,145,529	$ 258,109,842	$ 3,045,620	$ 268,502,991
Revenues	$ 2,582,000	$ 5,801,125	$ 40,134,854	$ 840,076	$ 49,358,055
Expenses	(4,244,000)	(5,694,640)	(40,134,854)	(2,255,509)	(52,329,003)
Net income (loss)	$(1,662,000)	$ 106,485	$ -	$(1,415,433)	$ (2,970,948)

NOTE 7 – LINE-OF-CREDIT

FPI has a revolving line-of-credit with a financial institution in the amount of $3,000,000. Interest on the line-of-credit accrues on a daily basis at a rate equal to LIBOR plus 2.25%. No funds were drawn on the line-of-credit during the years ended June 30, 2019 and 2018. The line-of-credit is secured by the receivables of FPI and is subject to certain loan covenants, which have been met as of June 30, 2019. In addition, the MSP participants have pledged their accounts receivable as security and have guaranteed the repayment of the line-of-credit. The line-of-credit matures February 26, 2020.

NOTE 8 – NOTES PAYABLE

In December 2010, MHHEFA authorized the issuance of a maximum principal amount of $15,000,000 variable rate bank qualified revenue bond (Series 2010) in order to finance and refinance certain capital projects. Proceeds from the bond were used to refund amounts outstanding from the previous debt issue and to establish a construction fund for use in renovating real property owned by FPI. These bonds mature January 1, 2031. The bond is collateralized by the assets of FPI. In December 2015, MHHEFA authorized the reissuing of the 2010 bond financing at a fixed rate for a maximum principal amount of $12,615,000. The initial fixed rate of the 2015 bond is 2.57% and is collateralized by a deed of trust for the property located at 419 West Redwood Street. FPI is required to maintain a debt covenant, which was met as of June 30, 2019.

Deferred financing costs include costs incurred in connection with the issuance of the 2015 bond reissuance and the remaining unamortized financing costs from the Series 2010 bond. As of June 30, 2019 and 2018, the deferred financing cost net of interest amortized amounted to $287,931 and $312,968, respectively. These costs are being amortized on a straight-line basis over the life of the obligation and reported as interest expense. Due to the short-term nature of the loan, the straight-line method approximates the effective interest method.

NOTE 8 – NOTES PAYABLE (Continued)

Amortization of these financing costs for the years ended June 30, 2019 and 2018 amounted to $25,037 and $25,038, respectively. Notes payable at June 30, 2019 and 2018 consists of the following:

	2019	2018
MHHEFA revenue bonds	$ 10,205,000	$ 10,925,000
Less: Loan financing cost	(287,931)	(312,968)
	9,917,069	10,612,032
Less: Current maturities	(735,000)	(720,000)
Notes payable - Noncurrent	$ 9,182,069	$ 9,892,032

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Principal payments and amortization of loan costs for the next five (5) years and thereafter are as follows:

	Notes Payable	Loan Costs	Net
For the year ending June 30, 2020	$ 735,000	$ (25,037)	$ 709,963
2021	760,000	(25,037)	734,963
2022	780,000	(25,037)	754,963
2023	810,000	(25,037)	784,963
2024	840,000	(25,037)	814,963
Thereafter	6,280,000	(162,746)	6,117,254
Totals	$ 10,205,000	$ (287,931)	$ 9,917,069

Interest expense on all obligations for the years ended June 30, 2019 and 2018 amounted to approximately $366,000 and $356,000, respectively.

NOTE 9 – CAPITAL LEASE OBLIGATIONS

In March 2014, FPI entered into capital lease agreements for medical equipment. FPI has subleased the medical equipment to UIC under a capital lease arrangement. Monies due under the arrangement are reported in related party notes receivable (see Note 3) and the equipment and depreciation is reported by UIC. Interest on the lease obligations ranges from 1.8% to 5.0%, with combined monthly principal and interest payments of $23,963. The leases matured in February 2019.

NOTE 10 – SURETY BOND

FPI is self-insured for state unemployment insurance and is required to maintain a surety bond in the aggregate amount of approximately $653,000. The surety bond expires in September 2020.

NOTE 11 – INVESTMENTS HELD ON BEHALF OF OTHERS

In July 2012, FPI executed an amendment to the Practice Plan Support Agreement (the agreement) with the MSP participants to include the ability to participate in an aggregated investment pool managed by UMMS. Pursuant to the terms of the Investment Agreement entered into between UMMS and FPI, a Combined Investment Pool (CIP) was established. The CIP is maintained by and is in the name of FPI. FPI's portion of the CIP is included in the investments balance in the consolidated statements of financial position. The amount that reflects the MSP participants' portion of the CIP is included in both the asset and liability balance of monies held on behalf of others in the consolidated statements of financial position. The MSP participants' portion of the CIP as of June 30, 2019 and 2018 amounts to approximately $32,147,000 and $31,793,000, respectively.

NOTE 12 – NET ASSETS WITHOUT DONOR RESTRICTIONS

Net assets without donor restrictions are summarized as follows at June 30, 2019 and 2018:

	2019	2018
Board designated funds	$ 16,262,462	$ 14,933,218
Undesignated	95,813,864	91,771,960
Total net assets without donor restrictions	$ 112,076,326	$ 106,705,178

Board designated funds consist of financial assets designated specifically to board approved spending for business development and contingency reserves for MSP participants, that are expected to be completed prior to June 30, 2020.

NOTE 13 – LEASES

FPI executed several non-cancelable operating leases with third parties for its office facilities and equipment. FPI has executed sublease agreements with certain MSP participants for the office facilities. The lease agreements and sublease agreements expire at various dates through 2027.

FPI has executed leases with various MSP participants and third parties for office space owned by FPI. These leases expire at various dates through 2027 and contain provisions for additional rent if the base rent is not sufficient to fund the annual operating costs of the building.

Total rent expense for facilities and equipment for the years ended June 30, 2019 and 2018 amounted to approximately $4,715,000 and $4,703,000, respectively. Total rental income on leases and subleases for the years ended June 30, 2019 and 2018 amounted to approximately $6,653,000 and $6,573,000, respectively, of which approximately $5,647,000 and $5,567,000 is received from related parties.

NOTE 13 – LEASES (Continued)

The approximate minimum future non-cancelable rental income receipts and rent expense payments under the above leases are as follows:

	Income	Commitment	Net
For the year ending June 30, 2020	$ 7,014,000	$ 5,382,000	$ 1,632,000
2021	7,190,000	5,573,000	1,617,000
2022	7,040,000	5,191,000	1,849,000
2023	6,736,000	4,857,000	1,879,000
2024	6,702,000	4,693,000	2,009,000
Thereafter	9,108,000	5,366,000	3,743,000
Totals	$ 43,790,000	$ 31,062,000	$ 12,729,000

NOTE 14 – RETIREMENT PLANS

Defined Contribution Plans

FPI has a noncontributory defined contribution pension plan for the benefit of substantially all of its employees, including leased employees. Contributions to the pension plan are determined as a fixed percentage of total employees' base compensation, as defined. Pension expenses on behalf of FPI and leased employees to MSP participants amounted to approximately $5,917,000 and $5,560,000, respectively, for the years ended June 30, 2019 and 2018. Additionally, FPI has a contributory defined contribution retirement plan for the benefit of substantially all of its employees. The plan is funded solely by employee contributions.

Deferred Compensation Plan

As of January 1, 2005, FPI established a nonqualified deferred compensation plan under Section 457 of the Internal Revenue Code for the benefit of select management and highly compensated employees. The plan provisions allow eligible employees to defer a portion of their compensation. FPI maintains separate accounts for these monies which are reported in monies held on behalf of others with a corresponding liability. As of June 30, 2019 and 2018, the plan has deferred $673,000 and $692,000, respectively.

NOTE 15 – INSURANCE

Self-Insurance Programs

FPI maintains self-insurance programs for malpractice liability risks, employee health, workers' compensation and state unemployment insurance. The accrued liabilities for these programs as of June 30, 2019 and 2018 amounted to approximately $17,675,000 and $16,384,000, respectively.

For all other fringe benefits, FPI disburses monies to the insurance companies and is reimbursed by the participants of the MSP. FPI disbursements for such fringe benefits to insurance companies and reimbursements from MSP participants during the years ended June 30, 2019 and 2018 amounted to approximately $1,079,000 and $1,090,000, respectively.

Malpractice Insurance

FPI is a participant in the University of Maryland Medical Service System Self-Insurance Trust (Trust). The Trust was established as a grantor trust in June 1985 held jointly by FPI and UMMS. The Trust was established to manage the claims of the self-insured malpractice liability and the costs associated therewith.

As the Trust is a non-risk bearing entity, transactions with the Trust are recorded using the deposit method of accounting, under Other Assets and Deferred Costs topic of the FASB Accounting Standards Codification. Accordingly, FPI accounts for its participation in the Core Program portion of the Trust by reporting 35.6% of the carrying assets limited as to use, representing the amount of funds contributed to the Trust, and recording 35.6% of the liability for projected claims in the Core Program of the Trust, reported as malpractice insurance liability. This asset and liability are included in the consolidated statements of financial position.

FPI is self-insured for malpractice liability claims under the Trust for amounts up to the limits of $1 million on individual claims and $3 million in the aggregate on an annual basis. For amounts in excess of these limits, the risk of loss has been transferred to Terrapin. Terrapin provides insurance of $10 million individually and $60 million in the aggregate. Terrapin carries reinsurance up to $150 million individually and in the aggregate for claims above the $10 million individually and $60 million in the aggregate under claims made policies between FPI and Terrapin. For claims in excess of Terrapin's coverage limits, if any, FPI retains the risk of loss.

FPI makes periodic payments on behalf of MSP participants to the Trust. FPI charges the MSP participants an annual premium per physician by specialty designation. These payments provide for and fund the present value of the cost for malpractice liability claims and insurance coverage related to the projected liability from asserted and unasserted incidents, which FPI believes may ultimately result in a loss. In management's opinion, these accruals provide an adequate and appropriate loss reserve.

NOTE 16 – CERTAIN SIGNIFICANT RISKS AND UNCERTAINTIES

The participants in the MSP and other academic physician practices provide general acute healthcare services in the Mid-Atlantic region. FPI and other healthcare providers in Maryland are subject to certain inherent risks, including the following:

- Substantial dependence on revenue derived from reimbursement by the Federal Medicare and state Medicaid programs;

- Government regulations, government budgetary constraints and proposed legislative and regulatory changes; and

- Lawsuits alleging malpractice and related claims.

Such inherent risks, which directly affect the participants in the MSP and their ability to reimburse FPI for services rendered, require the use of certain management estimates in the preparation of their consolidated financial statements and it is reasonably possible that a change in such estimates may occur.

NOTE 17 – SIGNIFICANT ESTIMATES

FPI reports liabilities for self-insurance of health and malpractice insurance, and managed care contracts. These liabilities are based upon claims filed and an estimate of claims incurred but not yet reported (IBNR). The IBNR is estimated using an expense forecasting model that is based on historical claims, insurance patterns, current trends in enrollment and timeliness of claims submissions and other factors. FPI believes that its IBNR claims reserves are adequate to satisfy its ultimate claims liability; however, the estimated IBNR liabilities may vary significantly from actual claims amounts, both negatively or positively and it is at least reasonably possible that a change in the estimate could occur in the near term.

NOTE 18 – COMMITMENTS

FPI entered into a Supplemental Agreement with UMMS and the Maryland Proton Treatment Center, LLC (MPTC) to provide supplemental support to MPTC that would not exceed $7.5 million in the event certain volume targets are not achieved by MPTC. The Supplemental Agreement commences two years after the opening of MPTC and covers a three year period subsequent to that start-up period. MPTC became operational during the year ended June 30, 2016 and the start-up period commenced. As of August 30, 2018, FPI has been released from this guarantee commitment.

NOTE 19 – CASUALTY LOSS

In March 2016, FPI experienced a fire causing damage to buildings and improvements that are leased to related parties. As a result, FPI incurred losses of approximately $7,409,000 which includes property loss and restoration costs of $6,858,000 and business interruption of $551,000. For the year ended June 30, 2018, FPI received insurance proceeds of approximately $7,409,000.

In October 2016, FPI experienced a flood causing damage to buildings and improvements that are leased to related parties. As a result, FPI incurred losses of approximately $653,000, which includes property loss and restoration costs of $563,000 and business interruption of $90,000. For the year ended June 30, 2018, FPI received insurance proceeds for property loss and restoration costs of approximately $653,000.

NOTE 20 – LIQUIDITY AND AVAILABILITY OF FINANCIAL ASSETS

FPI's financial assets available to meet cash needs for general expenditures within one year of June 30, 2019 are as follows:

Cash and cash equivalents	$ 13,487,544
Contract medical services revenue receivables - net	17,547,640
Due from related parties - net	16,293,962
Other receivables	3,218,660
Investments	13,990,893
Board designated funds	16,262,462
Financial assets available to meet cash needs for general expenditures within 1 year	80,801,161
Board designated funds	(16,262,462)
Financial assets available to meet cash needs for general expenditures within 1 year	$ 64,538,699

As part of FPI's liquidity management, it has a policy to structure its financial assets to be available as its general expenditures, liabilities and other obligations come due. General expenditures are expenses FPI expects to disburse for program services, MSP expenses and supporting services.

NOTE 21 – EFFECT OF CHANGE IN ACCOUNTING PRINCIPLE

As discussed in Note 1, FPI adopted ASU 2016-14 as of and for the year ended June 30, 2019. In accordance with the ASU, net assets are classified as net assets without donor restrictions and net assets with donor restrictions. Prior to the adoption of ASU 2016-14, FPI classified all its net assets as unrestricted net assets, and with the adoption of the ASU, these are classified as net assets without donor restrictions.

EXHIBIT 19

UNIVERSITY of MARYLAND MEDICAL CENTER

Midtown ASC Letters of Support

Internal Leaders

1. Bruce Jarrell, President, UMB
2. Al Reece, MD, Dean, UM SOM
3. Christine Lau, MD, Chair, UM Dept. of Surgery
4. Stephen N. Davis, MBBS, FRCP, FACE, MACP, UMB

Government Leaders

1. Jack Young, Mayor, Baltimore City
2. Erick Costello, Baltimore City Councilman
3. Leon Pickett, Baltimore City Councilman
4. Antonio Hayes, State Senator

Faith Leaders/Community Leaders

1. Kristin Speaker, President, Charles Street CDC
2. Wanda G. Best – Executive Director, Upton Planning Committee
3. J.L. Carter, President, Ministers Conference of Baltimore and Vicinity
4. Reverand Brenda D. White, Allen A.M.E. Church

Bruce E. Jarrell, MD
Interim President
University of Maryland, Baltimore
220 Arch Street
Baltimore, MD 21201
410 706 7002

umaryland.edu

May 18, 2020

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

RE: Letter of Support for the University of Maryland Midtown SurgiCenter: Freestanding Ambulatory Surgery Center Project

Dear Mr. Steffen:

On behalf of the University of Maryland, Baltimore (UMB), I write to express my strong support for the Certificate of Need (CON) application submitted by the University of Maryland Midtown SurgiCenter LLC (UMMSC) for the development of a freestanding ambulatory surgery center. Granting UMMSC a CON would greatly expand community access to high quality ambulatory surgical care within Baltimore City.

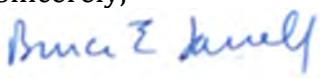
UMMSC plans to expand and enhance ambulatory surgery capabilities by building a state-of-the-art ambulatory surgical care platform consisting of 3 operating rooms and 2 procedure rooms within the 1st floor of the University of Maryland Medical Center (UMMC) Midtown Campus Ambulatory Care Tower that is currently under construction. Patients will receive surgical interventions in general surgery, orthopedics, ophthalmology, urology and medical endoscopy procedures. These procedures will be performed by the trusted and expert faculty of the University of Maryland School of Medicine, which is part of UMB. The strong relationship between UMB and UMMC, and both organizations' commitment to Baltimore City, make me confident that this CON will be developed prudently. This proposed ambulatory surgery center would be the first multi-specialty freestanding ambulatory surgery center within Baltimore City.

Due to significant growth of tertiary clinical programs and surgical cases at the University of Maryland Medical Center, the operating rooms are close to full capacity and as a result, ambulatory surgery patients have long wait times and are often bumped due to urgent surgical intervention cases. Building an ambulatory surgical facility is an excellent solution to provide our community with an alternative, lower

cost setting that is convenient for patients, families and faculty members. The development of this project would also meet the State of Maryland's Global Budget Revenue (GBR) goals by providing high-quality ambulatory surgical care in the most cost-effective and medically-appropriate setting.

I respectively request that the Maryland Health Care Commission approve the University of Maryland Midtown SurgiCenter's CON application.

Sincerely,



Bruce E. Jarrell, MD
Interim President

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

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

655 West Baltimore Street, 14-029
Baltimore, MD 21201-1509
410 706 7410 | 410 706 0235 FAX
deanmed@som.umaryland.edu

www.medschool.umaryland.edu

May 15, 2020

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

RE: Letter of Support for the University of Maryland Midtown SurgiCenter: Freestanding Ambulatory Surgery Center Project

Dear Mr. Steffen:

On behalf of the University of Maryland School of Medicine, I am writing to express my strong support for the Certificate of Need (CON) application submitted by the University of Maryland Midtown SurgiCenter LLC (UMMSC) for the development of a freestanding ambulatory surgery center. Granting the UMMSC a Certificate of Need would greatly expand community access to high quality ambulatory surgical care within Baltimore City.

UMMSC plans to expand and enhance ambulatory surgery capabilities by building a state-of-the-art ambulatory surgical care platform consisting of 3 operating rooms and 2 procedure rooms within the 1st floor of the University of Maryland Medical Center Midtown Campus Ambulatory Care Tower that is currently under construction. Patients will be able to receive surgical interventions in general surgery, orthopedics, ophthalmology, urology and medical endoscopy procedures. These procedures will be performed by our trusted and expert faculty here at the University of Maryland School of Medicine. This proposed ambulatory surgery center would be the first multi-specialty freestanding ambulatory surgery center within Baltimore City.

Due to significant growth of tertiary clinical programs and surgical cases at the University of Maryland Medical Center, the operating rooms are close to full capacity and as a result, ambulatory surgery patients have long wait times and are often bumped due to urgent surgical intervention cases. Building an ambulatory surgical facility is an excellent solution to provide our community with an alternative, lower cost setting that is convenient for patients, families and faculty members. The development of this project would also meet the State of Maryland's Global Budget Revenue (GBR) goals by providing high-quality ambulatory surgical care in the most cost-effective and medically appropriate setting.

I respectively request that the Maryland Health Care Commission approve the University of Maryland Midtown SurgiCenter's Certificate of Need application.

Sincerely,

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

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

CHRISTINE L. LAU, MD, MBA
Dr. Robert Buxton Professor and Chair
Department of Surgery, UMSOM
Surgeon-in-Chief
University of Maryland Medical System

22 South Greene Street, S8B08
Baltimore, MD 21201
410-328-8407 *office*
410-328-0401 *Fax*

cllau@som.umaryland.edu

May 13, 2020

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

RE: Letter of Support for the University of Maryland Midtown SurgiCenter: Freestanding Ambulatory Surgery Center Project

Dear Mr. Steffen:

On behalf of University of Maryland Faculty Physicians, Inc., I am writing to express my strong support for the Certificate of Need (CON) application submitted by the University of Maryland Midtown SurgiCenter LLC (UMMSC) for the development of a freestanding ambulatory surgery center. Granting UMMSC a CON would greatly expand community access to high quality ambulatory surgical care within Baltimore City.

UMMSC plans to expand and enhance ambulatory surgery capabilities by building a state-of-the-art ambulatory surgical care platform consisting of 3 operating rooms and 2 procedure rooms within the 1st floor of the University of Maryland Medical Center Midtown Campus Ambulatory Care Tower that is currently under construction. Patients will be able to receive surgical interventions in general surgery, orthopedics, ophthalmology, urology and medical endoscopy procedures. These procedures will be performed by the trusted and expert faculty of the University of Maryland School of Medicine. This proposed ambulatory surgery center would be the first multi-specialty freestanding ambulatory surgery center within Baltimore City.

Due to significant growth of tertiary clinical programs and surgical cases at the University of Maryland Medical Center, the operating rooms are close to full capacity and as a result, ambulatory surgery patients have long wait times and are often bumped due to urgent surgical intervention cases. Building an ambulatory surgical facility is an excellent solution to provide our community with an alternative, lower cost setting that is convenient for patients, families and faculty members. The development of this project

would also meet the State of Maryland's Global Budget Revenue (GBR) goals by providing high-quality ambulatory surgical care in the most cost-effective and medically-appropriate setting. It is critical for several areas in the Department of Surgery to have this ASC so that we can provide lower cost care for outpatient surgeries. This would include especially urologic and plastic outpatient procedures, but others including general surgery certainly would benefit as well.

I respectively request that the Maryland Health Care Commission approve the University of Maryland Midtown SurgiCenter's CON application.

Sincerely,

Christine L. Lau, MD, MBA
Robert W. Buxton Professor and Chair
Department of Surgery, UMSOM
Surgeon-in-Chief, UMMS

UNIVERSITY of MARYLAND
THE FOUNDING CAMPUS

Stephen N. Davis, MBBS, FRCP, FACE, MACP
Director, Institute for Clinical and Translational Research
Director, ***General Clinical Research Center***
22 S. Greene Street, Room S10D13
Baltimore, MD 21201
410 328 7648

May 14, 2020

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

RE: Letter of Support for the University of Maryland Midtown SurgiCenter: Freestanding Ambulatory Surgery Center Project

Dear Mr. Steffen:

On behalf of University of Maryland, Department of Medicine, I am writing to express my strong support for the Certificate of Need (CON) application submitted by the University of Maryland Midtown SurgiCenter LLC (UMMSC) for the development of a freestanding ambulatory surgery center. Granting UMMSC a CON would greatly expand community access to high quality ambulatory surgical care within Baltimore City. The patients that we serve in the West Baltimore community and beyond often are denied access for routine Gastroenterology and Cardiology procedures at our University of Maryland Medical Center location. Third party payer contracts often do not support routine clinical procedures in regulated locations such as UMMC. In these instances, the patient is required to seek care outside of the University system which is not favorable for continuity of care. The Department of Medicine is pressured to develop relationships with outside Ambulatory Surgical Centers in order to deliver quality care.

UMMSC plans to expand and enhance ambulatory surgery capabilities by building a state-of-the-art ambulatory surgical care platform consisting of 3 operating rooms and 2 procedure rooms within the 1st floor of the University of Maryland Medical Center Midtown Campus Ambulatory Care Tower that is currently under construction. Patients will be able to receive surgical interventions in general surgery, orthopedics, ophthalmology, urology and medical endoscopy procedures. These procedures will be performed by the trusted and expert faculty of the University of Maryland School of Medicine. This proposed ambulatory surgery center would be the first multi-specialty freestanding ambulatory surgery center within Baltimore City.

Due to significant growth of tertiary clinical programs and surgical cases at the University of Maryland Medical Center, the operating rooms are close to full capacity and as a result, ambulatory surgery patients have long wait times and are often bumped due to urgent surgical intervention cases. Building an ambulatory surgical facility is an excellent solution to provide our community with an alternative, lower cost setting that is convenient for patients, families and faculty members. The development of this project would also meet the State of Maryland's Global Budget Revenue (GBR) goals by providing high-quality ambulatory surgical care in the most cost-effective and medically-appropriate setting.

I respectively request that the Maryland Health Care Commission approve the University of Maryland Midtown SurgiCenter's CON application.

Sincerely,

Stephen N. Davis, MBBS, FRCP, FACE, MACP
Chair, Department of Medicine
Dr. Theodore E. Woodward Chair in Medicine
Director, General Clinical Research Center
Director, Clinical and Translational Sciences Institute
Professor of Medicine

BERNARD C. "JACK" YOUNG
MAYOR
100 Holliday Street, Room 250
Baltimore, Maryland 21202

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission

May 14, 2020

RE: Letter of Support for the University of Maryland Midtown SurgiCenter: Freestanding Ambulatory Surgery Center Project

Dear Mr. Steffen:

On behalf of the City of Baltimore, I am writing to express my strong support for the Certificate of Need (CON) application submitted by the University of Maryland Midtown SurgiCenter LLC (UMMSC) for the development of a freestanding ambulatory surgery center. Granting UMMSC a CON would greatly expand community access to high quality ambulatory surgical care within Baltimore City.

UMMSC plans to expand and enhance ambulatory surgery capabilities by building a state-of-the-art ambulatory surgical care platform consisting of 3 operating rooms and 2 procedure rooms within the 1st floor of the University of Maryland Medical Center Midtown Campus Ambulatory Care Tower that is currently under construction. Patients will be able to receive surgical interventions in general surgery, orthopedics, ophthalmology, urology and medical endoscopy procedures. These procedures will be performed by the trusted and expert faculty of the University of Maryland School of Medicine. This proposed ambulatory surgery center would be the first multi-specialty freestanding ambulatory surgery center within Baltimore City.

Due to significant growth of tertiary clinical programs and surgical cases at the University of Maryland Medical Center, the operating rooms are close to full capacity and as a result, ambulatory surgery patients have long wait times and are often bumped due to urgent surgical intervention cases. Building an ambulatory surgical facility is an excellent solution to provide our community with an alternative, lower cost setting that is convenient for patients, families and faculty members. The development of this project would also meet the State of Maryland's Global Budget Revenue (GBR) goals by providing high-quality ambulatory surgical care in the most cost-effective and medically-appropriate setting.

I respectively request that the Maryland Health Care Commission approve the University of Maryland Midtown SurgiCenter's CON application.

Sincerely,

Bernard C. "Jack" Young
Mayor
City of Baltimore

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

Chairman, Budget & Appropriations Committee
Chairman, Judiciary Committee
Chairman, Biennial Audits Oversight Commission

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

Eric T. Costello
Baltimore City Council, 11th District

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

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

May 12, 2020

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

RE: Letter of Support for the University of Maryland Midtown SurgiCenter: Freestanding Ambulatory Surgery Center Project

Dear Mr. Steffen:

I am writing to express my strong support for the Certificate of Need (CON) application submitted by the University of Maryland Midtown SurgiCenter LLC (UMMSC) for the development of a freestanding ambulatory surgery center. Granting UMMSC a CON would greatly expand community access to high quality ambulatory surgical care within Baltimore City.

UMMSC plans to expand and enhance ambulatory surgery capabilities by building a state-of-the-art ambulatory surgical care platform consisting of 3 operating rooms and 2 procedure rooms within the 1st floor of the University of Maryland Medical Center Midtown Campus Ambulatory Care Tower that is currently under construction. Patients will be able to receive surgical interventions in general surgery, orthopedics, ophthalmology, urology and medical endoscopy procedures. These procedures will be performed by the trusted and expert faculty of the University of Maryland School of Medicine. This proposed ambulatory surgery center would be the first multi-specialty freestanding ambulatory surgery center within Baltimore City.

Due to significant growth of tertiary clinical programs and surgical cases at the University of Maryland Medical Center, the operating rooms are close to full capacity and as a result, ambulatory surgery patients have long wait times and are often bumped due to urgent surgical intervention cases. Building an ambulatory surgical facility is an excellent solution to provide our community with an alternative, lower cost setting that is convenient for patients, families and faculty members. The development of this project would also meet the State of Maryland's Global Budget Revenue (GBR) goals by providing high-quality ambulatory surgical care in the most cost-effective and medically-appropriate setting.

I respectively request that the Maryland Health Care Commission approve the University of Maryland Midtown SurgiCenter's CON application. Should you have questions, please feel free to contact me directly at eric.costello@baltimorecity.gov or 410-396-4816.

Sincerely,

E. T. Costello

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

BALTIMORE CITY COUNCIL

COUNCILMAN LEON F. PINKETT, III

Seventh District

Room 518, CITY HALL
100 N. HOLLIDAY STREET, BALTIMORE, MARYLAND 21202
TELEPHONE: 410-396-4810
FAX: 410-396-4414
EMAIL: leon.pinkett@baltimorecity.gov

COMMITTEES

***VICE CHAIRMAN*:**
BUDGET & APPROPRIATIONS
TRANSPORTATION

***MEMBER*:**
EDUCATION AND YOUTH
JUDICIARY
LAND USE
PUBLIC SAFETY

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

Dear Ben Steffen,

I am writing to express my strong support for the Certificate of Need (CON) application submitted by the University of Maryland Midtown SurgiCenter LLC (UMMSC) for the development of a freestanding ambulatory surgery center. Granting UMMSC a CON would greatly expand community access to high quality ambulatory surgical care within Baltimore City.

UMMSC plans to expand and enhance ambulatory surgery capabilities by building a state-of-the-art ambulatory surgical care platform, which will consist of 3 operating rooms and 2 procedure rooms within the 1st floor of the University of Maryland Medical Center Midtown Campus Ambulatory Care Tower that is currently under construction. Patients will be able to receive surgical interventions in general surgery, orthopedics, ophthalmology, urology, and medical endoscopy procedures. These procedures will be performed by the faculty of the University of Maryland School of Medicine. This proposed ambulatory surgery center would be the first multi-specialty freestanding ambulatory surgery center within Baltimore City.

Due to significant growth of tertiary clinical programs and surgical cases at the University of Maryland Medical Center, the operating rooms are close to full capacity and as a result, ambulatory surgery patients have long wait times and are often bumped due to urgent surgical intervention cases. Building an ambulatory surgical facility is an excellent solution to provide our community with an alternative, lower cost setting that is convenient for patients, families, and faculty members. The development of this project would also meet the State of Maryland's Global Budget Revenue goals by providing high-quality ambulatory surgical care in the most cost-effective and medically-appropriate setting.

I pledge support for the University of Maryland Midtown SurgiCenter's CON application. If you have any further questions regarding my support of the University of Maryland please contact my office at 410-396-4810.

Sincerely,

Leon F. Pinkett III, District 7 Councilman of Baltimore City

ANTONIO HAYES
Legislative District 40
Baltimore City

Finance Committee

Annapolis Office
James Senate Office Building
11 Bladen Street, Room 222
Annapolis, Maryland 21401
410-841-3656 · 301-858-3656
800-492-7122 *Ext.* 3656
Antonio.Hayes@senate.state.md.us

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

May 15, 2020

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

Re: Letter of Support for the University of Maryland Midtown SurgiCenter: Freestanding Ambulatory Surgery Center Project

Dear Mr. Steffen:

I am writing to express my strong support for the Certificate of Need (CON) application submitted by the University of Maryland Midtown SurgiCenter LLC (UMMSC) for the development of a freestanding ambulatory surgery center. Granting UMMSC a CON would greatly expand community access to high quality ambulatory surgical care within Baltimore City.

I am State Senator for the 40th Legislative District where many assets of the University of Maryland and University of Maryland Medical Systems reside. I, along with many of my constituents, partner with these institutions in community projects and initiatives that are mutually beneficial. Specifically, an exceptionally strong, years' long and sustainable collaboration lies within the coalition of the Southwest Baltimore Partnership, a coalition of "13 equal partners working to strengthen Southwest Baltimore" that includes seven community associations, the University of Maryland Baltimore, the University of Maryland Medical Center and University of Maryland BioPark.

UMMSC plans to expand and enhance ambulatory surgery capabilities by building a state-of-the-art ambulatory surgical care platform consisting of 3 operating rooms and 2 procedure rooms within the 1st floor of the University of Maryland Medical Center Midtown Campus Ambulatory Care Tower that is currently under construction. Patients will be able to receive surgical interventions in general surgery, orthopedics, ophthalmology, urology and medical endoscopy procedures. These procedures will be performed by the trusted and expert faculty of the University of Maryland School of Medicine. This proposed ambulatory surgery center would be the first multi-specialty freestanding ambulatory surgery center within Baltimore City.

Due to significant growth of tertiary clinical programs and surgical cases at the University of Maryland Medical Center, the operating rooms are close to full capacity and as a result, ambulatory surgery patients have long wait times and are often bumped due to urgent surgical intervention cases. Building an ambulatory surgical facility is an excellent solution to provide our community with an alternative, lower cost setting that is convenient for patients, families and faculty members. The development of this project would also meet the State of Maryland's Global Budget Revenue goals by providing high-quality ambulatory surgical care in the most cost-effective and medically appropriate setting.

I respectively request that the Maryland Health Care Commission approve the University of Maryland Midtown SurgiCenter's CON application.

Sincerely,

Senator Antonio L. Hayes
40th Legislative District - MD

CHARLES STREET
DEVELOPMENT CORPORATION

May 14, 2020

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

RE: Letter of Support for the University of Maryland Midtown SurgiCenter: Freestanding Ambulatory Surgery Center Project

Dear Mr. Steffen:

On behalf of Charles Street Development Corporation, I am writing to express my strong support for the Certificate of Need (CON) application submitted by the University of Maryland Midtown SurgiCenter LLC (UMMSC) for the development of a freestanding ambulatory surgery center. Granting UMMSC a CON would greatly expand community access to high quality ambulatory surgical care within Baltimore City.

UMMSC plans to expand and enhance ambulatory surgery capabilities by building a state-of-the-art ambulatory surgical care platform consisting of 3 operating rooms and 2 procedure rooms within the 1st floor of the University of Maryland Medical Center Midtown Campus Ambulatory Care Tower that is currently under construction. Patients will be able to receive surgical interventions in general surgery, orthopedics, ophthalmology, urology and medical endoscopy procedures. These procedures will be performed by the trusted and expert faculty of the University of Maryland School of Medicine. This proposed ambulatory surgery center would be the first multi-specialty freestanding ambulatory surgery center within Baltimore City.

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I respectively request that the Maryland Health Care Commission approve the University of Maryland Midtown SurgiCenter's CON application.

Sincerely,

Kristin Speaker
Executive Director

100 N. CHARLES STREET, 17TH FLOOR / BALTIMORE, MD 21201
T 410.659.7767 / F 410.659.7773 / WWW.CHARLESSTREET.ORG

May 22, 2020

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

RE: Letter of Support for the University of Maryland Midtown SurgiCenter: Freestanding Ambulatory Surgery Center Project

Dear Mr. Steffen:

On behalf of Upton Planning Committee, Inc., I am writing to express my strong support for the Certificate of Need (CON) application submitted by the University of Maryland Midtown SurgiCenter LLC (UMMSC) for the development of a freestanding ambulatory surgery center. Granting UMMSC a CON would greatly expand community access to high quality ambulatory surgical care within Baltimore City.

UMMSC plans to expand and enhance ambulatory surgery capabilities by building a state-of-the-art ambulatory surgical care platform consisting of 3 operating rooms and 2 procedure rooms within the 1st floor of the University of Maryland Medical Center Midtown Campus Ambulatory Care Tower that is currently under construction. Patients will be able to receive surgical interventions in general surgery, orthopedics, ophthalmology, urology and medical endoscopy procedures. These procedures will be performed by the trusted and expert faculty of the University of Maryland School of Medicine. This proposed ambulatory surgery center would be the first multi-specialty freestanding ambulatory surgery center within Baltimore City.

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I respectively request that the Maryland Health Care Commission approve the University of Maryland Midtown SurgiCenter's CON application.

Sincerely,

Wanda G. Best
Executive Director

CC: Darroll Cribb, *UPC Board President*

110 Years Empowering "Men and Women of the Gospel to "Change Our Direction to Claim Our Destiny" ***(Deut. 1:6-7)***

Bishop J. L. Carter, MCBV President, pastor@arkchurch.com

c/o Ark Church, 1263 E. North Avenue, Baltimore, Maryland 21202;ministersconferencebaltimore.com

May 18, 2020

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

RE: Letter of Support for the University of Maryland Midtown SurgiCenter: Freestanding Ambulatory Surgery Center Project

Dear Mr. Steffen:

On behalf of Minister's Conference Baltimore and Vicinity, which is over 112 years old and consist of 150 Churches throughout Baltimore City's fourteen (14) districts and beyond, we are writing to express our strong support for the Certificate of Need (CON) application submitted by the University of Maryland Midtown SurgiCenter LLC (UMMSC) for the development of a freestanding ambulatory surgery center. Granting UMMSC a CON would greatly expand community access to high quality ambulatory surgical care within Baltimore City.

UMMSC plans to expand and enhance ambulatory surgery capabilities by building a state-of-the-art ambulatory surgical care platform consisting of 3 operating rooms and 2 procedure rooms within the 1st floor of the University of Maryland Medical Center Midtown Campus Ambulatory Care Tower that is currently under construction. Patients will be able to receive surgical interventions in general surgery, orthopedics, ophthalmology, urology and medical endoscopy procedures. These procedures will be performed by the trusted and expert faculty of the University of Maryland School of Medicine. This proposed ambulatory surgery center would be the first multi-specialty freestanding ambulatory surgery center within Baltimore City.

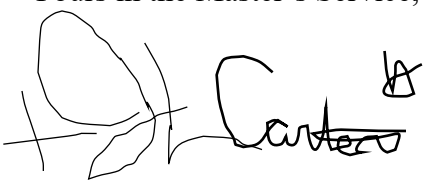
Due to significant growth of tertiary clinical programs and surgical cases at the University of Maryland Medical Center, the operating rooms are close to full capacity and as a result, ambulatory surgery patients have long wait times and are often bumped due to urgent surgical intervention cases. Building an ambulatory surgical facility is an excellent solution to provide our community with an alternative, lower cost setting that is convenient for patients, families and faculty members. The development of this project would also meet the State of Maryland's Global Budget Revenue (GBR) goals by providing high-quality ambulatory surgical care in the most cost-effective and medically-appropriate setting.

I respectively request that the Maryland Health Care Commission approve the University of Maryland Midtown SurgiCenter's CON application.

If you should have any additional questions, please feel free to call either myself or Dr. Kevin Daniels, Chairperson of the Civic Action Committee. We can be reached at either (410-302-3227) (410-428-3557).

Sincerely,

Yours in the Master's Service,



+ J.L. Carter, President
Ministers Conference of Baltimore and Vicinity

Cc: Executive Committee
Dr. Kevin Daniels,
Chairperson,
Civic Action Committee

Sandra Connors,
Chairperson,
Economic Development Committee

ALLEN A.M.E. CHURCH

1130 West Lexington Street
Baltimore, Maryland 21223
Allename2017@gmail.com
Reverend Brenda D. White, M.Div.

May 12, 2020

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

RE: Letter of Support for the University of Maryland Midtown SurgiCenter: Freestanding Ambulatory Surgery Center Project

Dear Mr. Steffen:

On behalf of Allen AME Church, I am writing to express my strong support for the Certificate of Need (CON) application submitted by the University of Maryland Midtown SurgiCenter LLC (UMMSC) for the development of a freestanding ambulatory surgery center. Granting UMMSC a CON would greatly expand community access to high quality ambulatory surgical care within Baltimore City.
UMMSC plans to expand and enhance ambulatory surgery capabilities by building a state-of-the-art ambulatory surgical care platform consisting of 3 operating rooms and 2 procedure rooms within the 1st floor of the University of Maryland Medical Center Midtown Campus Ambulatory Care Tower that is currently under construction. Patients will be able to receive surgical interventions in general surgery, orthopedics, ophthalmology, urology and medical endoscopy procedures. These procedures will be performed by the trusted and expert faculty of the University of Maryland School of Medicine. This proposed ambulatory surgery center would be the first multi-specialty freestanding ambulatory surgery center within Baltimore City.

Due to significant growth of tertiary clinical programs and surgical cases at the University of Maryland Medical Center, the operating rooms are close to full capacity and as a result, ambulatory surgery patients have long wait times and are often bumped due to urgent surgical intervention cases. Building an ambulatory surgical facility is an excellent solution to provide our community with an alternative, lower cost setting that is convenient for patients, families and faculty members. The development of this project would also meet the State of Maryland's Global Budget Revenue (GBR) goals by providing high-quality ambulatory surgical care in the most cost-effective and medically appropriate setting.

I respectively request that the Maryland Health Care Commission approve the University of Maryland Midtown SurgiCenter's CON application.

Sincerely,

Brenda D. White

Reverend Brenda D. White, M.Div.
Pastor

EXHIBIT 20

IN THE MATTER OF	*	**BEFORE THE**
	*	
MARYLAND GENERAL	*	**MARYLAND HEALTH**
	*	
HOSPITAL	*	**CARE COMMISSION**
	*	
Docket No. 07-24-2190	*	

****

FINAL ORDER

Based on the analysis and findings in the Staff Report and Recommendation, it is this 19th day of July, 2007, by the majority of the Maryland Health Care Commission, **ORDERED:**

That the application of Maryland General Hospital for a Certificate of Need to construct a seven-story building addition to allow replacement of its surgical department, intensive care unit, laboratory, and pharmacy department, and to undertake renovations secondary to this new construction, at a total project cost of $57,615,543, is approved with the following conditions:

1. Maryland General Hospital will not finish the shell space without obtaining all required Commission approvals;

2. Maryland General Hospital will not request an adjustment in rates by HSCRC that includes depreciation or interest costs associated with construction of the proposed shell space until and unless Montgomery General Hospital has filed a CON application involving the finishing of the shell space, has obtained CON approval for finishing the shell space, or has obtained a determination of coverage from the Maryland Health Care Commission that CON approval for finishing the shell space is not required;

3. HSCRC, in calculating any future rates for Maryland General Hospital and its peer group, shall exclude the capital costs associated with the shell space until such time as the space is finished and put to use in a rate-regulated activity. In calculating any rate that includes an accounting for capital costs associated with the shell space, HSCRC shall exclude any depreciation of the shell space that has occurred between the construction of the shell space and the time of the rate calculation (i.e., the rate should only account for depreciation going forward through the remaining useful life of the space). Allowable interest expense shall also be based on the interest expenses going forward through the remaining useful life of the space;

4. Upon completion of this project, Maryland General Hospital will not place the intensive care unit being replaced by the new intensive care unit being constructed in the new addition or the existing patient rooms not currently used for inpatient care into operation without Commission approval.

5. Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude the cost associated with the excess square footage of the new and renovated nursing units, which is calculated to be $326,098, using the fully adjusted MVS estimated cost per square foot for the new construction and renovation construction.

EXHIBIT 21

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Financial Assistance Program Application

Please complete, sign, and return this application with the following required documentation:

- **Income (Including all of the following documents you currently receive):**
  Copy of last 2 pay stubs or copy of W-2 form from most recent tax year filed for all who apply; including patient, patient spouse, patient guarantor (Parent(s) of children under 21 yrs old) living in the household. Documentation of Social Security/Social Security Disability or any other additional household income.
- **Copy of Mortgage/Rent Bill.**
- **If you applied for Medical Assistance, a copy of your approval or denial letter.**

If you are unable to supply any of the required documents above, please complete form FAF 116 attached.

Patient Information		
Last Name:	First:	M.I.:
Social Security #:	Date of Birth:	

Guarantor (Responsible Party) If same as Patient skip to Part II, otherwise complete all fields.			
Last Name:		First:	M.I.:
Social Security #:	Date of Birth:	Relationship to Patient:	
Part II (Copy of W-2 form(s) from most recent year filed OR last two pay check stubs required)			
Street Address:			Apt:
City:	State:	ZIP:	
Home Phone: ( )	Cell Phone: ( )	Marital Status:	
Employers Name and Address:			
Monthly Gross Income: $	Monthly Net Income: $		
Position/Title:	Length of Current Employment:		
Are you a Legal Resident of the United States: Yes ☐ No ☐			

Spouse		
Last Name:	First:	M.I.:
Employer Name/Address:	Phone #:	
Position/Title:	Length of Employment:	
Monthly Gross Income: $	Monthly Net Income: $	

Household Information (Name and Date Of Birth of all persons in household, excluding self or spouse)		
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:
Name:	DOB:	Relation to Patient:

Additional Household income

Checking Account Balance:	Monthly Unemployment Amount:
Savings Account Balance:	Monthly Social Security Amount:
Public Assistance/ Food Stamps:	Monthly Workers Compensation Amount:
Monthly Child Support Amount:	Other:

Monthly Expenses (Copy of Mortgage/Rent payment required)	
Mortgage/Rent Payment:	Cable:
Utilities:	Visa:
Telephone:	Mastercard:
Cell Phone:	Department Store:
Car Payment:	Other:

Health Insurance Information (Copy of Medical Assistance Approval or Denial letter you received is required)	
Name Of Company:	Effective Date:
Have you applied for Medical Assistance: Yes ☐ No ☐	When:
Where:	Name of Caseworker & phone #:
Outcome/Reason for Denial:	

Disability Information	
Is the Patient Disabled: Yes ☐ No ☐	Length Of Disability:
Name of Physician:	Physician Phone Number:

Third Party Liabilities (Auto Accident, Workers Compensation, Bodily Injury, or other legal claim)			
Injuries/Illness result of an Auto Accident	Yes ☐	No ☐	Date of Incident:
Injuries/Illness occuring at your workplace?	Yes ☐	No ☐	Date of Incident:
Injuries/Illness result of a Crime?	Yes ☐	No ☐	Date of Incident:
Injuries/Ilness resulting in legal action?	Yes ☐	No ☐	Date of Incident:

Third Party Liability Claims are ineligible for Financial Assistance until all means of payment are exhausted. Failure to disclose information pertaining to any third party liability claim will deem patient ineligible for Financial Assistance.

I declare that I have examined this application and to the best of my knowledge all information in it or otherwise provided to UMMS and it's practices is true, correct, and complete. I understand that misrepresentation of this information may cancel any financial assistance I may be provided and that I will then be liable for all medical charges. By signing and submitting this request, I give UMMS, and it's facility practices permission to determine my need for financial assistance; including review of my credit file. I also give permission to UMMS to release or disclose this information to University Physicians Inc. for the purpose of evaluating my financial status in response for assistance with my physician bills. I understand that it is my responsibility to advise UMMS of any changes in status in regards to my income or assets while this application is in process.

Patient/Guarantor Signature _____ Date _____

Spouse's Signature _____ Date _____

If you have any questions or need assistance completing this application, please call the Financial Assistance Dept. (410) 821-4140, Monday through Friday, 8:00am - 4:30pm. Mail this application, **along with required documents to: UMMS, 11311 McCormick Rd, Suite 230, Hunt Valley, MD 21031**.