IN THE MARYLAND HEALTH CARE COMMISSION

APPLICATION FOR CERTIFICATE OF NEED

to Add a Pediatric Hybrid Operating Room
at the University of Maryland Medical Center
Downtown Campus

Applicant
University of Maryland Medical Center

November 13, 2020

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For internal staff use

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: University of Maryland Medical Center

Address:

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

Name of Owner (if differs from applicant):

2. OWNER

Name of owner:

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

Legal Name of Project Applicant

University of Maryland Medical Center, LLC

Address:

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

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

Name of Owner/Chief Executive: Bert O'Malley, MD, President and Chief Executive Officer

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

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

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

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☒	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation Maryland, 2014
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☒	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☒	

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

A. Lead or primary contacts:

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

Mailing Address:

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

Telephone: 410-328-1314

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

Fax: 410-328-8664

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

Mailing Address:

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

Telephone: 410-328-0027

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

Fax: 410-328-6815

B. Additional or alternate contacts:

Name and Title: Thomas C. Dame

Mailing Address:

Gallagher Evelius & Jones LLP			
218 N. Charles St. Suite 400	Baltimore	21201	MD
Street	City	Zip	State

Telephone: 410-347-1331

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

Fax: 410-468-2786

Name and Title: Mallory M. Regenbogen

Mailing Address:

Gallagher Evelius & Jones LLP			
218 N. Charles St. Suite 400	Baltimore	21201	MD
Street	City	Zip	State

Telephone: 410-951-1417

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

Fax: 410-468-2786

7. TYPE OF PROJECT

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

If approved, this CON would result in:

(1) A new health care facility built, developed, or established ☐
(2) An existing health care facility moved to another site ☐
(3) A change in the bed capacity of a health care facility ☐
(4) A change in the type or scope of any health care service offered by a health care facility ☒
(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_update_20180417.pdf ☐

8. PROJECT DESCRIPTION

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

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

Applicant Response

University of Maryland Medical Center ("UMMC") proposes to expand capacity of its pediatric cardiac surgical and interventional service line by adding one special purpose hybrid operating room ("OR") that will serve the University of Maryland Children's Hospital Pediatric Cardiac Program (the "UMMC Children's Heart Program"). The project will be a phased-in-place renovation of 7,520 SF on the seventh floor of UMMC's north building. In order to create space for the new hybrid OR, UMMC will relocate two mixed-use general purpose ORs into underutilized space within the existing OR suite. Support services will also be relocated through the unit to accommodate the new hybrid OR.

Currently, the UMMC Children's Heart Program has only a single special purpose hybrid OR for performance of congenital heart surgeries and congenital cardiac catheterization procedures, which require highly specialized equipment not available for infants and children anywhere else in the facility. As described more fully in the Applicant's response to the Need Standard at COMAR 10.24.11.05B(3), as case volumes of the program have steadily grown over the past few years, the existing hybrid OR has increasingly experienced capacity issues, resulting in many procedures being delayed or transferred to UMMC's mixed-use general purpose ORs in the main hospital building.

Due to the urgency and severity of the cases being performed by the UMMC Children's Heart Program, time is critical for many patients and the delays caused by these capacity issues negatively affect UMMC's ability to timely address the critical needs of patients and their families. The aging equipment in the existing hybrid OR has also contributed to the room's availability due the need for frequent maintenance and repairs. The addition of another pediatric hybrid OR is essential to UMMC Children's Heart Program's ability to continue serving the needs of its service area population in a timely and efficient manner.

In order to maximize efficiency for clinical throughput, the design for the new hybrid OR has been optimized for performance of cardiac catheterization procedures, open-heart surgeries, or both together (called "hybrid" procedures). The new hybrid OR will be built adjacent to the existing hybrid OR. This industry-wide standard configuration enhances efficiency and patient safety by allowing cross utilization of specialty trained support staff, equipment, and supplies. The addition of a new pediatric hybrid OR is expected to greatly reduce or eliminate the current capacity issues experienced by the UMMC Children's Heart Program by reducing procedural delays and allowing the program to serve the urgent needs of two patients at once.

The total capital cost of the project is estimated at $9.56 million. The sources of funds for this project include $3.0 million in philanthropy and $6.56 million in cash from operations. The project budget is attached as **Exhibit 1**, Table E.

This project is part of UMMC's Master Facility Plan to consolidate pediatric surgeries and procedures and create a dedicated, child-friendly unit on the seventh floor of the north building. As part of this Master Facility Plan, UMMC also intends to establish a prep and recovery area on the seventh floor of the north building that will be dedicated to pediatric patients. Transition plans are already underway to create this dedicated prep and recovery unit, which will provide a better environment for intake and recovery of pediatric patients. The prep and recovery area's close proximity to the surgical suite and inpatient pediatric unit will make it easier for physicians to communicate with patients and their families and monitor their patients' recovery. The staff that will cover the surgical suite and prep and recovery unit will be dedicated to pediatrics, which will provide better consistency of care throughout a patient's stay at UMMC.

Another key component of UMMC's Master Plan involves upgrading the existing hybrid OR on the seventh floor of the north building. After the new hybrid OR is operational, UMMC intends to renovate this room in the future and replace its aging equipment. The new hybrid OR will allow the UMMC Children's Heart Program to continue serving its patients during this future renovation project.

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

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

Applicant Response

I. University of Maryland Children's Hospital Pediatric Cardiac Program

The Applicant, UMMC, seeks to add a special purpose hybrid OR that will be dedicated to the use of UMMC Children's Heart Program. UMMC Children's Heart Program is part of University of Maryland Children's Hospital ("UMCH"), which is located within UMMC and is recognized throughout Maryland and the Mid-Atlantic region as a valuable resource, providing primary, specialty, and critical care for children of all ages.

The UMMC Children's Heart Program was ranked by the *US News & World Report* in 2020 as one of the "Best Children's Hospitals for Cardiology and Heart Surgery." Among children's hospitals nationally, UMMC Children's Heart Program was ranked 41st out of nearly 200 qualified pediatric heart centers. UMMC Children's Heart Program performs cardiac evaluations using the most advanced technology to diagnose structural and functional cardiac abnormalities in patients within, but not limited to the state of Maryland. Patients of the program may be hospitalized at UMMC, transferred from other facilities in the State, or seen at one of UMMC's outpatient clinic sites.

UMMC Children's Heart Program serves patients ranging in age from newborns to adults with congenital heart disease or acquired heart disease. It also provides comprehensive fetal echocardiographic services for high-risk pregnancies. The scope and complexity of patient care needs served by the program varies with age and diagnosis. The major diagnoses represented by this patient population are:

- Pediatric and adult congenital heart disease
- Acquired heart disease
- Rhythm disturbances
- Pacemaker management
- Chest pain
- Syncope (fainting due to low blood pressure)
- Hypertension (high blood pressure)
- Hypercholesterolemia (high cholesterol)

- Obesity
- Genetic conditions

UMMC Children's Heart Program faculty and staff is comprised of board-certified pediatric cardiologists, board certified pediatric cardiovascular surgeons, pediatric surgical and cardiac nurse practitioners, RNs, medical assistants, pediatric echo sonographers, social workers and nutritionists. Some of the diagnostic tools used by the program to evaluate patients include electrocardiography, transthoracic, trans esophageal and fetal echocardiography, sedated echocardiography, exercise stress testing, holter and event monitoring, tilt table testing, MRI and CT scans, diagnostic and interventional cardiac catheterizations, electrophysiologic testing and ablation and hybrid OR procedures.

UMMC Children's Heart Program strives to provide care for the entire family using the relation based care model. It offers the following comprehensive sub-specialty clinics with the goal of providing individualized treatment and education for specific patient populations:

- Pacemaker clinic
- Preventative cardiology clinic
- Hypertension clinic
- Lipid Clinic, which includes BMI screening, Lipid testing, nutrition counseling, and psychosocial support
- Cardiovascular / genetics clinic – A collaboration between UMMC Children's Heart Program and the Division of Pediatric Genetics. The team includes a cardiologist, geneticist and genetic counselor.
- Fetal care clinic
- Single ventricle and High risk and clinic
- S.A.F.E.R – screening athletes and families for exercise related risk
- Adult Congenital

II. The Proposed Project

A. Renovation Plans, Changes in Square Footage, and Changes to Affected Services

This project involves renovation of 7,520 SF located on the seventh floor of UMMC's north building. The total departmental gross square footage of the existing surgical suite on this floor is 20,800 SF and will not change as a result of the project. *See* **Exhibit 1**, Table B. The renovation involves relocating two mixed-use general purpose ORs into an underutilized sterile processing space in order to create space for the new hybrid OR to be located adjacent to the existing hybrid OR. *See* **Exhibit 2**, for the project drawing showing the proposed new floor plan. Going forward, sterile processing for this unit will be handled in the UMMC's main Central Sterile Processing area that supports the entire hospital.

As described more fully in the Applicant's response to the Need Standard at COMAR 10.24.11.05B(3), following completion of the proposed project the new hybrid OR will be the primary room designated for serving cardiac interventional cases since it will be equipped with state of the art biplane x-ray technology and will be larger than the existing hybrid OR and more capable of accommodating staff and equipment needed for these procedures. The new hybrid OR will also serve a portion of UMMC Children's Heart Program's cardiac surgical cases. Both hybrid ORs will be equipped to serve congenital cardiac catheterization procedures, cardiac surgical cases, and hybrid procedures, which will provide the UMMC Children's Heart Program greater capacity and flexibility to meet the needs of its service area population.

B. Project Phasing

Because this project involves renovation to an existing space, the proposed project will be completed in two phases to allow for the continued operation of the UMMC Children's Heart Program and minimize disruption to patient care. As shown in the Project Schedule, UMMC anticipates that Phase 1 will take approximately 11 months to complete and Phase 2 will take approximately 7 months to complete.

Phase 1 involves relocating two mixed-use general purpose ORs into underutilized support space. The area affected by this phase is 3,400 SF.

Upon completion of Phase I, Phase 2 will involve constructing one large hybrid OR in the footprint of the two relocated general purpose ORs. The new hybrid OR will be designed to accommodate advanced cardiac catheterization procedures requiring advanced biplane x-ray imaging as well as cardiac surgery cases. The area affected by this phase is 4,120 SF. The existing floorplate of the seventh floor of the north building allows for three general purpose ORs and two special purpose hybrid ORs that meet the specifications of the current Facility Guidelines Institute's Guidelines for Design and Construction of Health Care Facilities (FGI Guidelines).

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

See MHCC Form Tables included as **Exhibit 1**, Table B.

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

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

Applicant Response

The proposed project will not impact any nursing units, so Table A is not applicable.

10. REQUIRED APPROVALS AND SITE CONTROL

Applicant Response

A. Site size:

See **Exhibit 1**, Table B for additional information.

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

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

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

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

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

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

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

11. PROJECT SCHEDULE

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

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

Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract		
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.	12	months
Initiation of Construction within 4 months of the effective date of the binding construction contract.	2	months
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract	11	months
Fill out the following section for each phase. (Add rows as needed)		
Completion of 2nd Phase within 24 months of completion of previous phase	7	months

12. PROJECT DRAWINGS

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

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

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

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

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

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

Applicant Response

Project drawings are attached as **Exhibit 2**.

13. FEATURES OF PROJECT CONSTRUCTION

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

Applicant Response

See **Exhibit 1,** Tables C and D.

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

Applicant Response

There is adequate capacity in the public utilities that presently service the existing hospital to support the requirements of the proposed project.

PART II - PROJECT BUDGET

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

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

Applicant Response

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

Budget Assumptions for the proposed project:

1. **Building:** The construction cost of the relocated ORs and the new Hybrid OR is a rough order of magnitude ("ROM"). Costs were estimated by UMMC Project Management staff based on similar projects of similar complexity at UMMC. The ROM was developed from concept drawings that have been developed by Wilmot Sanz, the Architect for the project.

2. **Architect/Engineering Fees:** The cost of design and engineering has been provided in a proposal from Wilmot Sanz, the Project Architect. This firm was selected by a competitive bidding processed focused on best value to the project.

3. **Permit Fees:** The permit fees are an estimate provided by Baltimore City Permit Office.

4. **Moveable Equipment:** The cost of fixed equipment was developed by the UMMS Procurement team specializing in major equipment purchases. The cost is based on current pricing from the most favored vendors and standard negotiated discount pricing for UMMS.

5. **Contingency:** Contingency costs were estimated using other projects at UMMC as a guide. The age of the facility/building and constrained site were taken into consideration.

6. **IT:** The cost of IT, including cabling, telecom, PCs was estimated based on similar project requirements at UMMC.

7. **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.

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 Medical Center, LLC
   22 South Greene Street, Executive Offices, Baltimore, MD 21201

   Responsible Individual: Bert O'Malley, MD, President and CEO, UMMC

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.

   Bert O'Malley, MD has served as the President and CEO of UMMC since November 2, 2020 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.

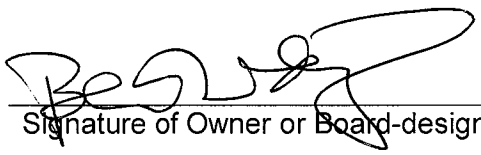
5. Have the applicant, owners or responsible individuals listed in response to Part 1, questions 2, 3, 4, 7, and 9, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care 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.

11-5-2020
Date


Signature of Owner or Board-designated Official

President and CEO, UMMC
Position/Title

Bert O'Malley, MD
Printed Name

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

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

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

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

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

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

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

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

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

The Applicable State Health Plan Chapters are COMAR 10.24.10, Acute Hospital Services, and COMAR 10.24.11, General Surgical Services.

COMAR 10.24.10. ACUTE CARE CHAPTER

.04A. GENERAL STANDARDS

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

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

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

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

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

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

Applicant Response:

UMMC complies with this standard. Its policy for release of charge information is attached as **Exhibit 3**. UMMC's Representative List of Services and Charges can be accessed on the UMMC website at the following address, by selecting the link for "estimated charges": https://www.umms.org/ummc/patients-visitors/for-patients/hospital-charges. The policy describes UMMC's process for promptly responding to individual requests for the current charges for specific services or procedures and that it will provide staff training to ensure inquiries regarding charges are handled appropriately.

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

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

(a) The policy shall provide:

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

Applicant Response:

UMMC's financial assistance policy is attached as **Exhibit 4**. UMMC's process for determining presumptive financial assistance begins on page 6 of the Financial Assistance Policy, and as described in the Procedure Section 2.c of the Policy on page 7, "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) Minimum Required Notice of Charity Care Policy.

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

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

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

Applicant Response:

UMMC provides public notice of its Financial Assistance Policy through publication on its website at https://www.umms.org/ummc/patients-visitors/for-patients/financial-assistance, and on an annual basis through print publication, as shown in **Exhibit 5**. Notices of the financial assistance policy are posted in the admissions office, business office, and emergency department. *See* **Exhibit 6**, for a copy of the notice of the availability of financial assistance posted by the registration desk in the hospital's main lobby as well as outpatient registration areas. Individual notice regarding the financial assistance policy is provided at the time of preadmission or admission to each person who seeks services at UMMC.

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

Applicant Response:

Not applicable. According to the HSCRC's Maryland Hospital Community Benefit Report for FY 2019, published in June 2020, UMMC's provision of charity care does not fall within the bottom quartile of all Maryland hospitals as a percentage of charity care to operating expenses, and it is among the top five hospitals in gross amount of charity care provided, as reflected in Table 1 below.

Table 1
FY 2019 Community Benefit Analysis
Source: HSCRC Community Benefit Report, FY 2019

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	Charity Care % of Total Hosp. Operating Income	Ranking	Percentile
Holy Cross	$437,129,013	$31,098,161	7.11%	1	2%
Garrett County Memorial Hospital	$49,273,773	$2,924,970	5.94%	2	4%
St. Agnes Hospital	$448,522,000	$23,179,252	5.17%	3	6%
Doctors Community Hospital	$200,232,626	$8,425,301	4.21%	4	8%
Holy Cross German Town	$108,725,994	$4,282,298	3.94%	5	10%
Mercy Medical Center, Inc.	$493,862,600	$18,604,182	3.77%	6	12%
Calvert Memorial Hospital	$135,516,353	$4,881,836	3.60%	7	14%
Western Maryland Hospital	$330,368,433	$10,860,972	3.29%	8	16%
UM Capital Region	$350,398,857	$11,417,000	3.26%	9	18%
Johns Hopkins Bayview Med. Center	$652,464,000	$19,238,000	2.95%	10	20%
MedStar St. Marys Hospital	$160,019,685	$4,627,204	2.89%	11	22%
MedStar Harbor Hospital Center	$190,590,189	$5,016,378	2.63%	12	24%
Washington Adventist Hospital *	$252,683,556	$6,114,949	2.42%	13	26%
Univ. of Maryland St. Joseph Medical Center	$335,424,000	$8,081,000	2.41%	14	28%
MedStar Southern Maryland Hospital	$247,304,491	$5,863,574	2.37%	15	30%
Fort Washington Medical Center	$44,440,761	$1,042,403	2.35%	16	32%
MedStar Good Samaritan Hospital	$261,186,698	$6,085,945	2.33%	17	34%
Peninsula Regional Medical Center	$451,254,859	$10,436,200	2.31%	18	36%
Sheppard Pratt	$239,576,824	$5,435,243	2.27%	19	38%
McCready Foundation, Inc.	$17,725,100	$378,616	2.14%	20	40%
Univ. of Maryland Harford Memorial Hospital	$89,425,000	$1,862,000	2.08%	21	42%
Frederick Memorial Hospital	$340,006,000	$7,002,000	2.06%	22	44%
Howard County General Hospital	$266,793,000	$5,237,664	1.96%	23	46%
MedStar Franklin Square Hospital	$538,458,852	$10,276,998	1.91%	24	48%
Atlantic General Hospital	$134,838,095	$2,388,460	1.77%	25	50%
MedStar Union Memorial Hospital	$447,659,408	$7,793,317	1.74%	26	52%

Univ. of Maryland Medical Center Midtown Campus	$228,130,000	$3,819,000	1.67%	27	54%
Univ. of Maryland Baltimore Washington Medical Center	$384,744,000	$6,285,000	1.63%	28	56%
Univ. of Maryland Upper Chesepeake Medical Center	$251,520,000	$4,041,000	1.61%	29	58%
UMROI	$109,077,000	$1,668,000	1.53%	30	60%
MedStar Montgomery General Hospital	$164,980,014	$2,495,104	1.51%	31	62%
Suburban Hospital Association, Inc	$300,567,000	$4,484,000	1.49%	32	64%
Shady Grove Adventist Hospital *	$388,910,383	$5,786,233	1.49%	33	66%
Levindale	$77,338,000	$1,142,100	1.48%	34	68%
Univ. of Maryland Medical Center	$1,639,396,000	$23,193,000	1.41%	35	70%
Union Hospital of Cecil County	$162,448,177	$1,836,442	1.13%	36	72%
Univ. of Maryland Shore Medical Center at Dorchester	$40,190,863	$446,565	1.11%	37	74%
Univ. of Maryland Shore Medical Center at Easton	$210,627,325	$2,265,611	1.08%	38	76%
Meritus Medical Center	$402,886,829	$4,286,507	1.06%	39	78%
Johns Hopkins	$2,476,117,000	$25,938,000	1.05%	40	80%
Univ. of Maryland Shore Medical Center at Chestertown	$51,275,000	$464,000	0.90%	41	82%
Northwest Hospital Center, Inc.	$246,006,000	$1,936,100	0.79%	42	84%
Univ. of Maryland Charles Regional Medical Center	$124,218,000	$966,929	0.78%	43	86%
Anne Arundel General Hospital	$557,932,000	$4,024,300	0.72%	44	88%
Sinai Hospital	$784,881,000	$5,247,000	0.67%	45	90%
Adventist Rehabilitation *	$48,735,998	$298,167	0.61%	46	92%
Bon Secours Hospital	$114,971,612	$491,056	0.43%	47	94%
Greater Baltimore Medical Center	$524,072,000	$1,264,000	0.24%	48	96%
Carroll County General Hospital	$203,344,125	$376,223	0.19%	49	98%
Mt. Washington Peds	$62,496,501	$101,000	0.16%	50	100%
All Hospitals	**$16,778,744,994**	**$325,409,261**	**1.94%**		

* According the HSCRC FY 2019 Community Benefit Report, "the Adventist Hospital System requested and received permission to report its community benefit activities on a calendar year basis to more accurately reflect true activities during the community benefit cycle." Report at p. 46, available at https://hscrc.maryland.gov/Documents/HSCRC_Initiatives/CommunityBenefits/CBR-FY19/FY%202019%20Community%20Benefit%20Report%20FINAL.pdf

Standard .04A(3) – Quality of Care.

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

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

(ii) Accredited by the Joint Commission; and

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

Applicant Response:

UMMC is licensed by the Maryland Department of Health, is accredited by The Joint Commission, and is in compliance with all Medicare and Medicaid conditions of participation. Copies of UMMC's license and most recent accreditation letter are attached as **Exhibits 7 and 8**. UMMC's most recent accreditation letter was valid through October 21, 2020. UMMC is due for an onsite survey by The Joint Commission at any time and will provide its new accreditation letter once received.

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

Applicant Response:

UMMC received a "Below Average" ranking in for certain Quality Measures in the most recent Maryland Hospital Performance Evaluation Guide. An action plan for each of these quality measures is described in **Exhibit 9**.

UMMC did not provide an action plan for its "below average" ranking on two Childbirth measures, "Percentage of births (deliveries) that are C-sections" and "How often babies in the hospital are delivered using cesarean section when this is the mother's first birth," as it considers its below average ranking as a positive quality indicator consistent with The Joint Commission's encouragement of hospitals to safely reduce cesarean section rates. *See* The Joint Commission, *Public Reporting of High Cesarean Rates to Begin in July 2020,* Leading Hospital Improvement Blog (last visited Nov. 11, 2020), https://www.jointcommission.org/resources/news-and-multimedia/blogs/leading-hospital-improvement/2019/02/public-reporting-of-high-cesarean-rates-to-begin-in-july-2020/.

COMAR 10.24.10 ACUTE CARE CHAPTER

.04B. PROJECT REVIEW STANDARDS

Standard .04B(1) – Geographic Accessibility

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

Applicant Response:

Inapplicable.

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

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

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

(b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection. (c) Additional MSGA or pediatric beds may be developed or put into operation only if:

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

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

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

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

Applicant Response:

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

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

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

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

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

Applicant Response:

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

Standard .04B(4) – Adverse Impact

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

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

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Applicant Response:

UMMC will not seek rate relief to account for the increased capital and other incremental costs associated with the proposed project.

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

Applicant Response:

Inapplicable. The project will not reduce the availability or accessibility of services, rather it is expected to improve the availability and timely delivery of pediatric cardiac surgery and interventional care.

Standard .04B(5) – Cost-Effectiveness

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

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

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

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

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

Applicant Response:

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

(b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in (a) above,

by demonstrating that there is only one practical approach to achieving the project's objectives.

Applicant's Response

The proposed project is one involving limited objectives, and there is only one practical approach to achieving the objectives. UMMC's limited objective is to expand the capacity of a single service line, pediatric cardiac surgical and interventional services. Currently, patients experience delays in critical treatments due to the existing hybrid OR either being in use or its legacy technology being out of service due to needed repairs. To maximize clinical and operational efficiencies and patient safety, UMMC determined it was essential to locate the new pediatric hybrid OR adjacent to the existing pediatric hybrid OR. In addition, locating the new pediatric hybrid OR on the seventh floor of the north building is a key part of UMMC's plan to create a dedicated, pediatric surgical suite and prep and prep recovery unit on this floor.

Based on the parameters described above, there was only one practical renovation plan that would accommodate space for a new pediatric hybrid OR adjacent to the existing pediatric hybrid OR on the seventh floor of the north building and allow for relocation of the two existing general purpose ORs that will be displaced by the new hybrid OR. The planned design will allow UMMC to add a single, pediatric hybrid OR to its existing suite of four ORs (three general purpose ORs and one hybrid OR) in the north building. The existing OR suite is 20,800 SF and will not increase in size as a result of the project. Space internal to the suite, originally designed as sterile processing center will be renovated and repurposed as OR space creating the square footage needed for the new pediatric hybrid OR without expanding the overall size of the OR suite.

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

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

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

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

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

Applicant Response:

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

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

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

Applicant Response:

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

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

The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project 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. 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 the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

Applicant Response:

The narrative attached as **Exhibit 10** compares the project costs to the Marshall Valuation Service ("MVS") benchmark. As described in further detail in that analysis, the cost per square foot of the project is below the MVS benchmark.

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

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

Applicant Response:

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

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

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

Applicant Response:

Inapplicable. The proposed project does not involve any nursing units.

Standard .04B(10) – Rate Reduction Agreement

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

Review Commission has determined that a rate reduction agreement is not necessary.

Applicant Response:

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

Standard .04B(11) – Efficiency

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

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

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

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

Applicant Response:

Currently, UMMC has only a single hybrid OR that is dedicated for use by the UMMC Children's Heart Program for performance of pediatric congenital heart surgeries and congenital cardiac catheterization procedures since these clinical activities require highly specialized equipment. For example, use of a biplane x-ray imaging system and specialized hemodynamic monitoring equipment is often required and is not available for infants and children anywhere else in the facility. An additional pediatric hybrid OR is essential for UMMC to accommodate the significant growth in procedural volume within the UMMC Children's Heart Program over the last several years.

In order to maximize efficiency for clinical throughput, UMMC plans to configure the new hybrid OR in such a manner that it can be optimized for cardiac catheterization procedures, open-heart surgeries, or both together (called "hybrid" procedures). As described in the Applicant's response to the Need Standard at COMAR 10.24.11.05B(3), the increased procedure volumes and complexity of the procedures being performed within the constraints of a single, pediatric cardiac hybrid OR has resulted in frequent procedural cancellations, which negatively affects UMMC's ability to timely address the critical needs of its patients and their families. It is also inefficient because one or two procedure cancellations results in a "domino effect" often affecting additional patients' procedures and multiplying the consequences for patients and their families. The increased procedure growth has also resulted in increased capacity issues for the existing hybrid OR and the need to move pediatric cardiac surgery cases

to UMMC's general purpose ORs, which results in additional transport times and delays in order to move patients and necessary equipment, supplies, and support staff to the main hospital building.

Due to the urgency and severity of the types of cases being performed in UMMC Children's Heart Program, the need to minimize the risk of procedural cancellations due to equipment breakdowns or required maintenance is paramount for excellent care and efficiency. Also, due to the extremely wide range of congenital cardiac patient's sizes (i.e., 0.5 pound to 400 pounds), the room configurations and equipment needed to carry out this mission cannot be provided within the design constraints of a single room. The addition of another pediatric hybrid OR is critical to UMMC Children's Heart Program's ability to continue to serve its service area population and the statewide community and beyond in an efficient and timely manner.

As described in the applicant's response to the Patient Safety Standard at COMAR 10.24.10.04B(12), the configuration of the new pediatric cardiac hybrid OR, which will be built adjacent to the existing hybrid OR, will enhance cross utilization and more efficient utilization of staff, supplies, and equipment, and will provide for more timely communication and responses by physicians and staff serving this patient population. The proximate location of the pediatric prep and recovery areas, also described in the applicant's Patient Safety response, will also result in operational efficiencies, including reduced patient and staff travel time.

Standard .04B(12) – Patient Safety

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

Applicant Response:

The configuration of the pediatric hybrid ORs was a key consideration in planning the design of this project. UMMC will relocate two existing non-cardiac related ORs in order to build the new pediatric cardiac hybrid OR adjacent to the existing hybrid OR. This essential, industry-wide standard configuration provides for enhanced cross utilization and efficient utilization of specialty trained support staff for pediatric and adult congenital interventional catheterization and surgical procedural care. The space allocation for the new hybrid OR combined with the placement of other support functions within this space will resolve shortcomings with the existing hybrid OR. In particular, the existing hybrid OR has inadequate space which cannot be resolved due to building structure constraints. The proposed new hybrid OR has been designed to be larger than the existing hybrid OR, which will reduce crowding and allow staff to better serve the patient during an operation or procedure. Once completed, the new hybrid OR will be the primary room used for catheterization and hybrid procedures, but both hybrid ORs will have the ability to support cardiac catheterization, open-heart surgical, and hybrid procedures. This will also enable the performance of simultaneous procedures and cross flexibility maintaining optimized equipment utilization for best practices and excellence in clinical outcomes and safety for congenital heart patients.

The design of the new surgical suite also takes patient safety into account by relocating the litter park room, soiled trash hold room, and environmental services (EVS) away from the busy workflow at the center of this department. This provides a cleaner environment to help reduce infections.

A key safety feature of the new hybrid OR will be that it is equipped with a state of the art biplane x-ray system. Over the past ten years since the existing hybrid OR was built and its x-ray system was installed, major technological improvements have been made in biplane x-ray imaging systems and the existing hybrid OR's technology is outdated. The newer imaging systems have dramatically reduced levels of x-ray exposure, which is beneficial for the vulnerable patients being served by UMMC Children's Heart Program. The documented reductions in X-ray exposure that occur with use of the latest technology are significant with around a 60-80% reduction. Because infants and children are particularly sensitive to the adverse effects of ionizing x-rays, upgrading the x-ray systems is a major safety priority for UMMC. Due to this new technology and the larger size of the new hybrid OR, it will become the primary room used for interventional procedures once it opens.

Planned renovations of existing adjacent space will also allow enhanced and local availability of specialty pediatric prep and recovery areas, which are currently located on different floors in distant areas of the building. This new proximate location will improve operational efficiency, reduce patient travel time, and enhance patient safety by allowing better communication, greater access to surgical and anesthesia providers, and closer proximity to inpatient pediatric care areas.

Standard .04B(13) – Financial Feasibility

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

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

(b) Each applicant must document that:

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

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

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

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

Applicant Response:

The proposed project will be financially feasible, will not jeopardize the long-term financial viability of UMMC, and will benefit UMMC Children's Heart Program's service area population. The financial feasibility of UMMC is based on the following assumptions as well as those included in **Exhibit 1** following Table L:

(a) Utilization projections that are consistent with observed historic trends (See **Exhibit 1**, Tables F and I as well as the Applicant's Response to the Need Standard at COMAR 10.24.11.05B(3))

(b) Revenue estimates that are consistent with utilization projections and are based on current Global Budget Revenue (GBR), rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by UMMC (See **Exhibit 1**, Tables G and H)

(c) Staffing and overall expense projections that are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by UMMC (See **Exhibit 1,** Table L)

This project does not involve the addition of a new facility or service line, rather the expansion of a single service line, pediatric and adult congenital cardiac surgery and catheterization services, by adding a new hybrid OR to support the existing case volumes of UMMC Children's Heart Program. Per the MHCC Staff's request, the Applicant has provided Tables I, J, and K. Table I shows projected utilization for pediatric and adult congenital cardiac surgery and cardiac catheterization case volumes of UMMC Children's Heart Program. As described in the Applicant's response to the Need Standard at COMAR 10.24.11.05B(3), these case volumes will be supported by the proposed new hybrid OR as well as the existing hybrid OR dedicated to the UMMC Children's Heart Program. Tables J and K show incremental expenses related to additional staffing that will be added to support the new hybrid OR. These incremental expenses will be incurred beginning in FY 2023 when the new hybrid OR opens. Because UMMC is not seeking a GBR modification associated with the proposed project, there is no significant change in the projected revenue tables year over year.

The Applicant has completed Tables F, G, and H showing utilization and financial projections for UMMC as a whole. The incremental staffing expenses related to this project are reflected in Tables G and H beginning in FY 2023. As Table G shows, UMMC will generate excess revenues over total expenses (including incremental staffing expenses related to this project) for

the entire project period. The proposed project will also benefit UMMC's service area population by ensuring UMMC can provide timely and critical care to pediatric and adult congenital patients in need of cardiac surgery and cardiac catheterization services.

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

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

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

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

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

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

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

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

Applicant Response:

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

Standard .04B(15) – Emergency Department Expansion

A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it has made appropriate efforts, consistent with federal and state law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency

department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum:

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

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

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

Applicant Response:

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

Standard .04B(16) – Shell Space

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

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

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

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

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

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

(d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the

construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Service Cost Review Commission.

Applicant Response:

Inapplicable. The proposed project will not involve shell space.

COMAR 10.24.11. GENERAL SURGICAL SERVICES

.05A. GENERAL STANDARDS

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:

Inapplicable. The applicant is a hospital.

(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:

The applicant acknowledges that the Commission will consider any 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.

(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 .05A(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:

UMMC shall provide to the public upon inquiry, information regarding the volume of specific surgical procedures performed at the facility for the most recent 12 months, which will be updated at least annually.

Standard .05A(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:

(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.

(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.

(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:

Please see the Applicant's response to COMAR 10.24.10.04A(2)(a)(i) and (ii) above, which addresses subparts (a)(i) and (ii) of this Standard.

With regard to subpart (iii) of this Standard on Criteria for Eligibility, UMMC's Financial Assistance Policy, Program Eligibility Section, (at the top of page 3) states that 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. *See* **Exhibit 4**, Financial Assistance Policy. Those between 200% and 300% of MD DHMH are eligible for discounts on a sliding scale, as set forth in Attachment A." As shown in Attachment A of the Financial Assistance Policy on page 13, the 2020 MD DHMH Annual Income Eligibility Limits are higher than the 2020 Annual Federal Poverty Guidelines. Accordingly, UMMC'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 exceeds the minimum eligibility requirements set forth in this standard and HSCRC's regulations.

(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:

Please see response to COMAR 10.24.10.04A(2)(b) above, which addresses subparts (a)(i) and (ii) of this Standard.

(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

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

(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:

Inapplicable. The Applicant is not seeking to establish or expand an 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.

Applicant Response:

Inapplicable. The Applicant is not a health maintenance organization.

Standard .05A(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:

Please see the Applicant's response to COMAR 10.24.10.04A(3) above, which addresses subpart (a) of this Standard.

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

Applicant Response:

Please see the Applicant's response to COMAR 10.24.10.04A(3) above, which addresses subpart (b) of this Standard.

(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:

Inapplicable. The Applicant is a hospital.

(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:

Inapplicable. The Applicant is not proposing development of an ASF.

(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:

Inapplicable. The Applicant is not filing a request for exemption to establish an ASF.

Standard .05A(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:

Inapplicable. The applicant is a hospital.

(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:

UMMC's transfer agreements with other hospitals comply with the requirements of Maryland Code, Health-General § 19-308.2 and the Maryland Department of Health's regulations implementing this provision.

(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:

Inapplicable. The applicant is a hospital.

.05B. 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:

UMMC is proposing to expand the number of ORs in its existing facility by adding one special purpose pediatric hybrid OR that will be dedicated to serving the UMMC Children's Heart Program. The service area of UMMC Children's Heart Program was determined by identifying and ranking the Zip Codes of patient residents that comprise the top 85 percent of discharges for pediatric and adult congenital cardiac surgery and pediatric catheterization procedures from FY 2017 to FY 2019. Discharges over a 36-month period provide a more accurate representation of the geographic service area served by this program than discharges from a 12-month period given the volume of cases served and the program. A map of UMMC Children's Heart Program's service area is included as **Exhibit 11**, and a listing of the Zip Codes included in the service area is included as **Exhibit 12**.

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.

(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.

(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.

(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:

Inapplicable. The Applicant is not proposing to establish or replace a hospital or ASF.

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:

Please see the Applicant's response to subsection .05B(3)(c) below for an analysis of the need for the proposed additional pediatric hybrid OR utilizing the capacity assumptions that apply to special purpose ORs.

(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

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Applicant Response:

UMMC currently has 35 total ORs in its inventory, exclusive of its three dedicated cesarean section ORs. UMMC has 23 mixed-use general purpose ORs and 12 special purpose ORs consisting of The R. Adams Cowley Shock Trauma Center ORs and hybrid ORs. All of UMMC's ORs were utilized at optimal capacity in FY 2020, the most recent 12-month period, even taking into account a slight decrease in overall utilization due to the effects of COVID-19. UMMC presents utilization data for FY 2020 and FY 2019 below.

UMMC's Mixed-Use General Purpose ORs

Optimal capacity for a mixed-use general purpose OR as defined in the General Surgical Services State Health Plan Chapter at COMAR 10.24.11.07A(1)(a) is 1,900 hours or 114,000 minutes per year. The average turnaround time per case presented in Table 2 below is 57 minutes and is based on UMMC's turnaround time data for FY 2019. In FY 2020, UMMC's mixed-use general purpose ORs were used for a total of 3,159,394 OR minutes including turnaround time. The FY 2020 utilization level of UMMC's mixed-use general purpose ORs is well above the optimal capacity standard of 114,000 minutes per OR and demonstrates a need for 27.71 ORs, despite an approximate 6.3% decrease in total OR minutes from FY 2019 due to the effects of COVID-19 and UMMC's efforts to integrate its surgical platform and shift certain cases to the UMMC Midtown Campus. Elective, non-emergent procedures at UMMC were put on hold beginning March 18, 2020 and did not resume until the week of June 29, 2020 in order to safeguard patients from exposure to COVID-19 and to preserve adequate capacity to treat COVID-19 patients.

Table 2
UMMC Mixed-Use General Purpose ORs
Case Volumes FY 2019 – FY 2020

	UMMC Mixed-Use General Purpose ORs Case Volumes FY 2019 - FY 2020							
	# of ORs	**Total Cases**	**Total Room Time (Minutes)**	**TAT @ 57 Minutes**	**Total OR Minutes (Including TAT)**	**Optimal Capacity Minutes per OR**	**% of Optimal Capacity**	**Number of ORs Needed**
FY 2019	23	13,636	2,593,199	777,252	3,370,451	114,000	129%	29.57
FY 2020	23	12,383	2,453,563	705,831	3,159,394	114,000	120%	27.71

Source: Data on Total Cases, Total Room Time, and TAT obtained from UMMC's Electronic Health Records (E.H.R.) System.

UMMC's Special Purpose ORs

Optimal capacity for a special purpose OR as defined by the General Surgical Services State Health Plan Chapter at COMAR 10.24.11.07A(1)(c) is best determined on a case-by-case basis, using information provided by the applicant regarding:

(i) The population or facility need for each special purpose operating room or both;

(ii) The documented demand for each special purpose operating room; and

(iii) Any unique operational requirements related to the special purpose for which the operating room will be used.

UMMC's special purpose ORs are highly utilized as demonstrated by their documented demand in FY 2019 and FY 2020. In FY 2020, UMMC's special purpose ORs were used for a total of 1,721,752 OR minutes including turnaround time. The average turnaround time per case presented in Table 3 below is 57 minutes and is based on UMMC's turnaround time data for FY 2019. Total OR minutes for the special purpose ORs declined by approximately 8.2% from FY 2019 to FY 2020 due to the effects of COVID-19. Even taking into account this decline, each OR was used for approximately 143,479 minutes, which exceeds the 114,000 minute per year optimal capacity standard that applies to mixed-use general purpose ORs. Although the 114,000 minute per year optimal use standard does not apply to special purpose ORs, Table 3 below provides this comparison to demonstrate that UMMC's special purpose ORs are highly utilized.

Table 3
UMMC Special Purpose ORs
Case Volumes FY 2019 - FY 2020

	UMMC Special Purpose ORs Case Volumes FY 2019 - FY 2020							
	# of ORs	**Total Cases**	**Total Room Time (Minutes)**	**TAT @ 57 Minutes**	**Total OR Minutes (Including TAT)**	**Optimal Capacity Minutes per OR**	**% of Optimal Capacity**	**Number of ORs Needed**
FY 2019	12	7,349	1,456,002	418,893	1,874,895	114,000	137%	16.45
FY 2020	12	6,874	1,329,934	391,818	1,721,752	114,000	126%	15.10

Source: Data on Total Cases, Total Room Time, and TAT obtained from UMMC's E.H.R. System.

(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:

UMMC proposes to add a new special purpose OR that will be a dedicated pediatric hybrid OR to be used by the UMMC Children's Heart Program. As described in the General Surgical Services State Health Plan at COMAR 10.24.11.07A(1)(c), optimal capacity for a special purpose OR is best determined on a case-by-case basis, using information provided by an applicant regarding:

(i) The population or facility need for each special purpose operating room or both;

(ii) The documented demand for each special purpose operating room; and

(iii) Any unique operational requirements related to the special purpose for which the operating room will be used.

Section I below describes UMMC Children's Heart Program historic and projected pediatric cardiac and interventional case volumes that demonstrate the service area and facility's need for the new hybrid OR, and Section II provides a more detailed description of the unique operational needs for the special purpose OR and how it will allow the UMMC Children's Heart Program to better serve its patients.

I. UMMC's Pediatric Cardiac Program's Documented Demand for A New Special Purpose Hybrid OR

UMMC has experienced steady growth in recent years in UMMC Children's Heart Program. Table 4 below shows historic trends in UMMC's pediatric and adult congenital cardiac surgical and interventional cases from FY 2017 to FY 2020 and projected trends through FY 2025. From FY 2017 to FY 2020, UMMC's pediatric and adult congenital surgical cases nearly doubled. Over the same time period, cardiac catheterization procedures declined slightly due to the growing surgical case volumes being performed in the existing hybrid OR and its decreased availability.

Table 4
UMMC's Pediatric and Adult Congenital Cardiac Surgical and Interventional Cases
FY 2017 – FY 2025

UMMC's Pediatric and Adult Congenital Cardiac Surgical and Interventional Cases									
Specialty	**Actual Volumes**				**Projected Volumes**				
	FY 17	**FY 18**	**FY 19**	**FY20**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**
Cardiac Surgery	140	149	225	279	280	281	282	283	285
Cardiac Catheterization	205	183	174	168	169	169	170	171	171
UMMC Total Cases	345	332	399	447	449	451	452	454	456
UMMC Total Minutes (Including Actual TAT - 61 Minutes)	97,175	97,185	125,675	139,712	140,271	140,833	141,394	141,960	142,529
UMMC Min/Case (Including Actual TAT - 61 Minutes)	281.7	292.7	315.0	312.6	312.4	312.3	312.8	312.7	312.6

Source: Data on Actual Case Volumes, Total Minutes, and TAT obtained from UMMC's E.H.R. System.

With only two pediatric heart programs in the State of Maryland, it is vital that each program stands ready and prepared to step up when challenges present in the other program. This occurred between FY 2018 and FY 2019 as a result of physician departures from the Johns Hopkins Children's Center Pediatric and Congenital Heart program, and UMMC Children's Heart Program was able to step in to ensure the needs of pediatric and adult congenital cardiology patients in Maryland were met. The market share shift that occurred during that time is expected to be maintained by UMMC going forward. UMMC estimates that future growth beyond FY 2020 will be 0.4% annually or 1.92% over the next five years based solely on growth trends for its service area population, as shown in Table 5 below.

Table 5
Estimated Population Growth for
UMMC Children's Heart Program Service Area

2020 Service Area Population Estimate	2025 Service Area Population Estimate	5-Year Growth
2,886,237	**2,941,666**	**1.92%**

Source: Claritas Pop Facts Premier.

The average turnaround time per case presented in Table 4 above is 61 minutes and is based on UMMC's turnaround time data for pediatric cardiac catheterization and cardiac surgical cases in FY 2019. Table 4 above presents the average case lengths for UMMC's

pediatric cardiac surgical and interventional cases for FY 2017 through FY 2020. Case length for pediatric cardiac surgeries and interventional cases is expected to remain relatively constant at 312 minutes or approximately 5.2 hours per case through the projection period.

As described more fully below, UMMC Children's Heart Program generally performs its surgical cases and interventional cases in the existing special purpose hybrid OR located on the seventh floor of the north building. However, due to the capacity issues experienced in recent years, the program has had to move some cases to UMMC's general purpose ORs in the main hospital building, as shown in Table 6 below. UMMC anticipates that the new hybrid OR will open early in FY 2023. Once the new hybrid OR opens it will be the primary OR serving the interventional cases but will also serve a portion of UMMC's pediatric and adult congenital cardiac surgical cases. The additional of the new hybrid OR is expected to resolve the capacity issues experienced by UMMC Children's Heart Program today, reducing or eliminating the program's current need to transfer cases to UMMC's general purpose ORs.

II. Operational Needs for the New Special Purpose Hybrid OR

Section II.A below provides an overview of some of the operational challenges and shortcomings of reliance on a single, highly utilized pediatric hybrid OR to serve UMMC's growing Children's Heart Program, and Section II.B provides a summary of the operational and patient care related improvements expected to result from this project.

A. The Challenges of Relying on a Single Hybrid OR to Serve UMMC Children's Heart Program

The existing special purpose pediatric hybrid OR located on the seventh floor of the north building is dedicated for use by UMMC Children's Heart Program. It is the primary location where pediatric and congenital cardiac surgical cases are performed and the only location where pediatric and adult congenital interventional procedures can be performed within UMMC because it is the only OR at UMMC with biplane x-ray technology. Biplane x-ray technology is essential for performing pediatric interventional cardiology procedures. Biplane technology is the standard of care for pediatric cardiology and adult congenital patients. It is one of the most advanced interventional medical imaging technologies available. It uses two rotating cameras to produce highly detailed 3-D images of the most complex cardiac blood vessels and blood flow in real-time. Biplane imaging allows visualization of challenging congenital cardiac anatomy as seen especially in newborns. Biplane imaging supports accurate diagnosis and comprehensive care in the most complex structural heart procedures.

As procedural volumes have grown over the past few years, the existing hybrid OR has experienced capacity issues, which has resulted in many procedures being delayed or transferred to UMMC's general purpose ORs. As show in Table 6 below, an increasing number of pediatric and adult congenital cardiac surgical cases have been performed in UMMC's general purpose ORs from FY 2017 to FY 2020. In FY 2020, 33% of the UMMC Children's Heart Program's total cases or 148 cases were performed in UMMC's general purpose ORs because the existing hybrid OR was unavailable. As described more fully below, UMMC's general purpose ORs are not as well equipped as the existing hybrid OR for pediatric cases due to staffing, equipment, and distance from the pediatric unit.

Table 6
Total Pediatric Cardiac Surgery Cases
Performed Outside the Existing Hybrid OR
FY 2017 – FY 2020

	FY 2017	FY 2018	FY 2019	FY 2020
% of Total Children's Heart Program Cases	15%	19%	24%	33%
Number of Cases	53	64	96	148

Equipment and Space Limitations in the Existing Hybrid OR

The existing hybrid OR has aging equipment and technology that routinely breaks down or needs to be taken offline for maintenance. Since January 2012, UMMC has documented 641 hours during which the existing hybrid OR was offline for repairs or maintenance, and believes that this number likely underreports the number of total hours as its recordkeeping was not as thorough in the first few years it began tracking this time. The frequency of repairs needed by the existing hybrid OR has increased over time with approximately 21% of the 641 repair hours occurring in the past 12 months. This has contributed to the capacity issues of the existing hybrid OR.

The existing hybrid OR is small for a hybrid room which creates operational challenges for the interventional procedures. Once all of the necessary equipment and staff are in the room for cardiac catheterization or hybrid procedures, it is difficult to maneuver within the room and work efficiently in the space. Challenges arise when a pediatric patient undergoing an interventional procedure needs to be quickly transitioned to open cardiac surgery. In these instances, timing and expertise is critical and the patient must be transitioned to surgery as quickly as possible. Due to the space limitations in the existing hybrid OR, procedures must often be paused and some staff must exit the room in order to setup or rearrange the necessary equipment.

Consequences When the Existing Hybrid OR is Unavailable

When the existing hybrid OR is unavailable because it is being used or its equipment is out of service, patients' procedures must either be delayed or moved to the general purpose ORs in the main hospital building. As described below, neither of these alternatives are ideal for patient care or operational efficiency. Due to the urgent and critical nature of most pediatric cardiac patients' conditions, cardiac surgeries and interventional procedures are typically performed in as timely a manner as possible once a condition is identified.

When the existing hybrid OR is unavailable for a pediatric cardiac surgery, the case must either be delayed or moved to the general purpose ORs in the main hospital building. The general purpose ORs are located in UMMC's main hospital building, and are equipped with equipment, supplies, and staff suited for adult patients. It can take several minutes to transport the pediatric patient and appropriate pediatric equipment, supplies, and support staff to this alternative location. Time is critical for many of these patients and the additional transport and response time can negatively affect the patient's outcome, especially if additional equipment or supplies are required mid-procedure. During certain surgeries, the pediatric cardiac surgeons need to collaborate with the interventional cardiologists and collaboration is more difficult when

the cases are moved to the general purpose ORs. Although the interventional cardiologists can provide some support during the case, the support is more limited without the availability of the biplane x-ray and other technologies that are available in the existing hybrid OR.

When the existing hybrid OR is unavailable for a pediatric interventional procedure, the procedure must be delayed and sometimes cancelled as it is the only room with equipment capable of producing high quality imaging for small, pediatric congenital patients. This delay can negatively affect patients' care and outcomes by permitting progression of the disease that may increase risks due to treating the patient with a more advanced stage of the disease. As discussed above, cancellations and delays for these procedures have become more frequent due to the growing volumes in the pediatric cardiac program and the equipment in this room being offline for repairs or maintenance. Cancelling and rescheduling patients also causes a "domino effect." When one or two patients' procedures are cancelled, this delays care for one or two more patients in need of care, multiplying the consequences. Delayed procedures also result in increased financial burden for families, including additional child care expenses, loss of workdays, and other potential negative effects on employment.

B. The Proposed Project's Expected Operational and Clinical Improvements

The addition of the new pediatric hybrid OR adjacent to the existing hybrid OR is expected to resolve many of the operational challenges outlined above and allow UMMC Children's Heart Program to better serve its patients.

Both hybrid ORs will be capable of serving cardiac interventional, cardiac surgical, and hybrid cases. However, the new hybrid OR will be the primary room to serve cardiac interventional procedures and hybrid procedures, but will also serve a portion of the pediatric cardiac surgery cases. It will be larger than the existing hybrid OR and better equipped to serve interventional and hybrid cases by providing adequate space for the imaging equipment, supplies specific to this patient population, and staff to maneuver within the room. The new room will be equipped with state of the art biplane x-ray imaging system that will provide more advanced imaging compared with the technology in the existing hybrid room. The existing hybrid room will be primarily used for cardiac surgical procedures given that it is a smaller room and does not have as much space to accommodate the equipment needed for the interventional procedures and that its equipment is aging and not as advanced as the equipment that will be available in the new hybrid OR.

The addition of the new hybrid OR will greatly reduce or eliminate the current capacity issues experienced by UMMC Children's Heart Program, including the need to delay or cancel procedures and the need to transfer pediatric surgical cases to UMMC's general purpose ORs. This will reduce staff and patients' travel times and will reduce delays in delivering urgent and critical care to pediatric cardiology patients. UMMC Children's Heart Program will be better equipped to treat congenital heart patients in a dedicated surgical suite. All necessary equipment will be readily available and clinicians and support staff with expertise in serving pediatric patients will be centralized in this surgical suite. By locating the new hybrid OR adjacent to the existing hybrid OR, it will create efficiencies by streamlining sharing of equipment and staffing and improve communication and collaboration between the pediatric cardiac surgeons and interventional cardiologists, who will easily be able to communicate and respond in real-time due to their close proximity.

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:

The proposed project was designed in compliance with Section 2.2 of the FGI Guidelines. Please see **Exhibit 13** for a letter from the project architect, Wilmot Sanz, confirming the project's compliance with the applicable FGI Guidelines.

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

Applicant Response:

Inapplicable. The Applicant is a hospital.

(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:

Inapplicable. The project's design features are consistent 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:

UMMC will provide all laboratory, radiology, and pathology support services as needed by patients.

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

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

Applicant Response:

Please see the Applicant's response above to the Patient Safety Standard at COMAR 10.24.10.04B(12).

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:

Please see the Applicant's response above to the Construction Cost of Hospital Space Standard at COMAR 10.24.10.04B(7).

(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:

Inapplicable. The Applicant is a hospital.

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.

(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:

Please see the Applicant's response above to the Financial Feasibility Standard at COMAR 10.24.10.04B(13).

Standard .05B(9) – Impact.

(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;

(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

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

(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.

(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:

Inapplicable. This application does not involve the establishment of a new ASF.

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:

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

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

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

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

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

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

Applicant Response

The availability of two pediatric cardiac hybrid OR suites will enable both interventional and surgical procedures to occur simultaneously such that patients are not subject to wait times for access to critical services that could detrimentally affect their ongoing care and outcomes. The existing pediatric cardiac hybrid OR is small by today's standards, has dated equipment that is becoming more difficult to keep operational, and is currently the only hybrid OR available to pediatric patients at UMMC. By providing state of the art biplane technology in the new hybrid OR and making the primary room for interventional procedures, it will reduce radiation exposure to patients and staff, while improving the availability of the existing hybrid OR to serve pediatric cardiac surgical cases.

The configuration of the new pediatric hybrid OR suites, which will add the new hybrid OR adjacent to the existing hybrid OR, will create an area devoted to pediatric cardiac care and recovery. It will also ensure that biplane technology is more readily available to pediatric patients at UMMC. This will allow UMMC to address expeditiously patient care needs that occur simultaneously and prevent it from having to delay urgent and critical care to its pediatric patients. In addition, co-locating pediatric prep and recovery near the operative suites and in closer proximity to the majority of children's inpatient services will result in both enhanced operational efficiencies and improved quality and safety.

Please see **Exhibit 1**, Tables F and I for the statistical projections required by this standard.

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

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

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

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

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

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

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

Applicant Response

Please see the Applicant's response to the Cost-Effectiveness Standard at COMAR 10.24.10.04B(5), which describes the limited objectives being addressed by the project and the fact that the proposed project is the only practical approach to achieving the project's objectives.

UMMC is engaged in numerous population health initiatives aimed at improving the overall health and outcomes of the population it serves, including initiatives targeted toward prenatal care for mothers. However, these population health alternatives cannot substantially reduce the cardiac congenital anomalies that require surgical and interventional treatment and are served by the UMMC Children's Heart Program. The proposed project will provide UMMC Children's Heart Program the appropriate capacity to continue to treat patients with these conditions that cannot be managed via population health alternatives.

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

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

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

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

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

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

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

Applicant Response

Revenue and Expenses

Please see the Applicant's response above to the Financial Feasibility Standard at COMAR 10.24.10.04B(13) for a description of its completion of Tables F-K. As described in that response and shown in **Exhibit 1**, Table G, UMMC will generate excess revenues over total expenses (including incremental staffing expenses related to this project) for the entire project period and the project is therefore sustainable. The proposed project will also benefit UMMC's

service area population by ensuring UMMC can provide timely and critical care to pediatric and adult congenital patients in need of cardiac surgery and cardiac catheterization services.

Work Force Information

As discussed with MHCC Staff, given the narrow scope of this project, the Applicant has provided only the incremental changes in its work force related to this project in **Exhibit 1**, Table L.

Project Funding and Audited Financial Statements

As shown in **Exhibit 1**, Table E, the total cost of the project is estimated to be $9.56 million. The sources of funding for the project are philanthropic gifts ($3.0 million) and cash flow from operations of UMMS ($6.56 million). UMMC has already received a philanthropic gift in the amount of $3.0 million to support the proposed project. Cash from operations of UMMS is expected to be funded in FY 2021 and FY 2022. Audited financial statements of UMMS and UMMC are attached as **Exhibit 14**. Debt financing will not be used to fund this project.

Performance Requirements

UMMC is confident that it will be able to meet the applicable performance requirements. Pursuant to COMAR 10.24.01.12C, Performance Requirements, if this application is approved, UMMC will have 12 months to obligate not less than 51% of the approved capital expenditure. From that date, UMMC will have four months to initiate construction. UMMC will have up to 24 months after the effective date of the binding construction contract to complete each phase of the project. As indicated in the Project Schedule in Part I, Response 11, the Applicant is projecting it will obligate at least 51% of the capital expenditure within 12 months of the CON's approval, will begin construction within two months of capital obligation, and will complete construction, will complete the first phase of construction in 11 months and the second phase of construction within seven months. These anticipated timelines are well within the performance requirement time frames.

UMMC anticipates meeting the performance requirements if the application is approved. More specific timing is provided in response to Part I.11, p. 10, *supra*.

Community Support for the Project

There is strong community interest in and support for the project, as demonstrated by the Letters of Support attached as **Exhibit 15**.

The parent of a UMMC Children's Heart Program patient who has had five open-heart surgeries, writes about her experience in having to wait for an OR to become available in order for her daughter to undergo life-saving procedures. She writes: "With the additional hybrid OR, it would allow for multiple procedures to take place at one time, which would lower the risks for patients having to wait and allow for better long term outcomes. The second OR would also allow for space to handle emergencies should they arise while the other hybrid suite is in use." *See* **Exhibit 15**.

Local elected officials as well as faith and community leaders are also fully supportive of this project, which will improve the capacity issues currently experienced by the UMMC Children's Heart Program and ensure timely access to cardiac catheterization and cardiac surgical

procedures for the patients it serves. Finally, leaders of UMMS, UMMC, and current clinicians serving and referring patients to the UMMC Children's Heart Program voice their support for this project, which will allow UMMC and faculty of the University of Maryland School of Medicine who practice at UMMC to continue their mission to provide high-quality and compassionate care to pediatric and adult congenital cardiac patients.

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

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

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

Applicant Response

UMMC received a Certificate of Need on March 18, 2010, Docket No. 09-24-2300, to expand trauma, critical care and emergency services at a capital cost of $176,728,000. A copy of the Final Order is attached as **Exhibit 16**. UMMC completed the approved project and complied with the conditions of the Certificate of Need.

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

UMMC received a Certificate of Need on May 16, 2019, Docket No. 18-24-2429, to expand its inpatient child behavioral health unit by establishing an eight-bed adolescent inpatient behavioral health unit in renovated space at an estimated capital cost of $9,580,000. A copy of the Final Order is attached as **Exhibit 17**. The project is underway and being completed in compliance with the terms of the Certificate of Need.

UMMC received a Certificate of Need on August 20, 2020, Docket No. 19-24-2438, to build a cancer center addition of 154,610 SF and renovate 72,670 SF of contiguous space in the hospital at an estimated capital cost of $194,368,000. A copy of the Final Order is attached as **Exhibit 18.** This project is underway and being completed in compliance with the terms and conditions of the Certificate of Need.

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

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

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

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

Applicant Response

The proposed project is not expected to impact any other existing health care providers. As discussed in the Applicant's response to the Need Standard at COMAR 10.24.11.05B(3), the UMMC Children's Heart Program experienced growth in recent years due in part to physician departures from the Johns Hopkins Children's Center Pediatric and Congenital Heart program and the University of Maryland program was able to step in to ensure the needs of the pediatric and adult congenital cardiology patients in Maryland were met. The market share shift that occurred during that time is expected to be maintained by UMMC going forward. UMMC estimates that future growth beyond FY 2020 will be solely based on estimate growth for its service area population.

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

Applicant Response

UMMC expects that addition of a new pediatric hybrid OR will resolve the capacity issues experienced by the UMMC Children's Heart Program today due to its current reliance on a single hybrid OR. This will reduce or eliminate the program's current procedural delays and the need to transport patients to UMMC's general purpose ORs, which will ensure more timely access to cardiac catheterization and cardiac surgical services for its service area population.

c) On costs to the health care delivery system.

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

Applicant Response

UMMC does not anticipate any significant impact on costs to the health care delivery system as a result of this project. UMMC will not seek any rate relief related to this project and its charges will remain the same. There will be a slight increase in costs beginning in FY 2023 due to

the incremental staffing related to this project, as described in the Applicant's response to the Financial Feasibility Standard at COMAR 10.24.10.04B(13) and reflected in **Exhibit 1**, Tables G, H, J, and K.

Table of Exhibits

Exhibit	Description
1.	MHCC Tables
2.	Project drawings
3.	UMMC Policy for Release of Charge Information
4.	Financial Assistance Policy
5.	Financial Assistance Policy – Newspaper Ad
6.	Posted Notice of Financial Policy
7.	UMMC Hospital License
8.	The Joint Commission Hospital Accreditation Certificate 2017
9.	Quality Measures Action Plan
10.	Marshall Valuation Service Analysis
11.	UMMC Pediatric Cardiac Service Area Map
12.	Zip Codes List for UMMC Pediatric Cardiac Service Area
13.	Letter from the Project Architect, Wilmot Sanz
14.	UMMS Audited Financial Statements FY 2019 and FY 2020
15.	Community Letters of Support
16.	UMMC 2010 CON Final Order
17.	UMMC 2019 Adolescent Psych Unit CON Final Order
18.	UMMC 2020 Cancer Center CON Final Order

Table of Tables

Table	Description
Table 1	FY 2019 Community Benefit Analysis Source: HSCRC Community Benefit Report, FY 2019
Table 2	UMMC Mixed-Use General Purpose ORs Case Volumes FY 2019 – FY 2020
Table 3	UMMC Special Purpose ORs Case Volumes FY 2019 - FY 2020
Table 4	UMMC's Pediatric and Adult Congenital Cardiac Surgical and Interventional Cases FY 2017 – FY 2025
Table 5	Estimated Population Growth for UMMC Children's Heart Program Service Area
Table 6	Total Pediatric Cardiac Surgery Cases Performed Outside the Existing Hybrid OR FY 2017 – FY 2020

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

11-5-2020
Date

Bert O'Malley, MD, President & CEO
University of Maryland Medical Center,
Downtown Campus

#719854

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

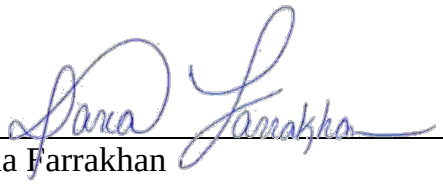
11/9/2020
Date

Joseph E. Hoffman, III
Senior Vice President and Chief
Financial Officer
University of Maryland Medical Center

#719860

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

11/09/2020
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.

11/10/20
Date

Craig Fleischmann
Vice President, Finance
University of Maryland Medical Center

#719861

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

November 9, 2020
Date

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

#719858

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

11/09/2020
Date

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

#719857

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

11-9-20
Date

Janet Petit
Executive Director, Heart and Vascular Center
University of Maryland Medical Center

#719872

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

11.9.2020
Date

Linda Whitmore, RA, MBA
Director for Project 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.

11/10/2020
Date

Patrick Morris
Senior Manager, Finance Decision Support
University of Maryland Medical System

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

11/9/2020
Date

Marla Rodgers
Program Administration, Pediatrics-Cardiology
University of Maryland Medical Center

#719864

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

11/09/2020
Date

Michael Glancey
Michael Glancey
Strategic Planning Project Manager
University of Maryland Medical Center

#719868

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

11/09/2020
Date

Eveena Felder MS, RN
Eveena Felder, MS, RN
Nurse Manager, Heart Center Pediatric Program
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.

Digitally signed by Miguel Pascale
DN: C=US, E=mp@wilmot.com, OU="", O="Wilmot/Sanz, Inc.", CN=Miguel Pascale
Date: 2020.11.10 14:03:34-05'00'

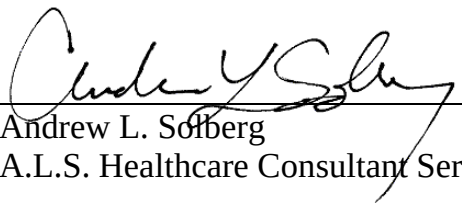
11/10/2020
Date

Miguel Pacale, AIA
Wilmot Sanz

#719871

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

11/8/2020
Date



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

#719869

EXHIBIT 1

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

TABLE 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
North 7 OR suite	20,800	0	7,520	13,280	20,800
	20,800 s.f.				0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total					

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		7

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		
Seventh Floor		7,520
Average Square Feet		
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		
Seventh Floor		560
Total Linear Feet		
Average Linear Feet		
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		
Seventh Floor		12'
Average Wall Height		
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		
Freight		
Sprinklers	**Square Feet Covered**	
Wet System		
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project		
Type of Exterior Walls for proposed project		

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS		
INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table D for each structure.		
	NEW CONSTRUCTION COSTS	**RENOVATION COSTS**
SITE PREPARATION COSTS		
Normal Site Preparation	$0	
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs	**$0**	
Site Demolition Costs		
Storm Drains		
Rough Grading		
Paving		
Deep Foundation		
Yard Lighting		
Dewatering		
Sediment Control & Stabilization		
Premium for Constrained Site		
Underground utility work for Foundations / Total Shoring for excavation		
Premium for Prevailing Wage		
Premium for Minority Business Enterprise Requirement		
Subtotal On-Site excluded from Marshall Valuation Costs	**$0**	
OFFSITE COSTS		
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs	**$0**	
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$0**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$0**	**$0**
BUILDING COSTS		
Normal Building Costs	$3,596,842	
Subtotal included in Marshall Valuation Costs	$3,596,842	
Infection Prevention	$209,119	
Premium for Constrained Site	$209,119	
Premium for Minority Business Enterprise Requirement	$167,295	
Subtotal Building Costs excluded from Marshall Valuation Costs	**$585,532**	
TOTAL Building Costs included and excluded from Marshall Valuation Service*	**$4,182,374**	**#REF!**
A&E COSTS		
Normal A&E Costs	$350,000	
Subtotal included in Marshall Valuation Costs	**$350,000**	
Amount Spent on the 2012 Project that is not now Usable:		
Subtotal A&E Costs excluded from Marshall Valuation Costs	**$0**	
TOTAL A&E Costs included and excluded from Marshall Valuation Service*	**$350,000**	**$0**
PERMIT COSTS		
Normal Permit Costs	$4,000	
Subtotal included in Marshall Valuation Costs	**$4,000**	
Jurisdictional Hook-up Fees		
Impact Fees		
Amount Spent on the 2012 Project that is not now Usable		
Subtotal Permit Costs excluded from Marshall Valuation Costs	**$0**	
TOTAL Permit Costs included and excluded from Marshall Valuation Service*	**$4,000**	**$0**

TABLE E. PROJECT BUDGET

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

	Hospital 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	$4,182,374		$4,182,374
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees	$350,000		$350,000
(4) Permits (Building, Utilities, Etc.)	$4,000		$4,000
SUBTOTAL	**$4,536,374**	**$0**	**$4,536,374**
d. Other Capital Costs			
(1) Movable Equipment	$4,000,000		$4,000,000
(2) Contingency Allowance	$540,000		$540,000
(3) Gross interest during construction period			$0
(4) Other *(Specify/add rows if needed)*			$0
Owners cost (overhead and PM cost)	$220,000		$220,000
SUBTOTAL	***$4,760,000***		**$4,760,000**
TOTAL CURRENT CAPITAL COSTS	**$9,296,374**	**$0**	**$9,296,374**
e. Inflation Allowance	$223,626		$223,626
TOTAL CAPITAL COSTS	**$9,520,000**	**$0**	**$9,520,000**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c. Legal Fees	**$35,000**		$35,000
d. Non-Legal Consultant Fees			$0
e. Liquidation of Existing Debt			$0
f. Debt Service Reserve Fund			$0
g. Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$35,000***		**$35,000**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$9,555,000***	***$0***	***$9,555,000***
B. Sources of Funds			
1. Cash	**$6,555,000**		$6,555,000
2. Philanthropy (to date and expected)	$3,000,000		$3,000,000
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	***$9,555,000***		**$9,555,000**
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables C and H				
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**
1. DISCHARGES								
a. General Medical/Surgical*	18,462	17,007	18,214	18,742	18,820	18,897	19,071	19,245
b. ICU/CCU	3,834	3,757	3,890	3,531	3,546	3,560	3,593	3,626
Total MSGA	**22,296**	**20,764**	**22,104**	**22,273**	**22,366**	**22,457**	**22,664**	**22,871**
c. Pediatric	2,153	2,397	2,533	2,227	2,236	2,245	2,266	2,286
d. Obstetric	2,116	2,253	2,382	2,646	2,658	2,668	2,693	2,717
e. Acute Psychiatric	1,197	813	1,141	1,435	1,441	1,447	1,460	1,474
Total Acute	***27,762***	***26,227***	***28,160***	***28,581***	***28,701***	***28,818***	***29,083***	***29,348***
f. Rehabilitation	0	0	0	0	0	0	0	0
g. Comprehensive Care	0	0	0	0	0	0	0	0
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0	0
TOTAL DISCHARGES	***27,762***	***26,227***	***28,160***	***28,581***	***28,701***	***28,818***	***29,083***	***29,348***
2. PATIENT DAYS								
a. General Medical/Surgical*	122,047	111,543	118,654	124,205	124,712	125,219	126,371	127,524
b. ICU/CCU	79,568	78,148	80,616	71,577	71,870	72,162	72,825	73,490
Total MSGA	**201,615**	**189,691**	**199,270**	**195,782**	**196,582**	**197,380**	**199,196**	**201,014**
c. Pediatric	5,621	5,047	5,516	5,492	5,514	5,536	5,587	5,638
d. Obstetric	7,937	8,383	8,961	6,138	6,163	6,188	6,245	6,302
e. Acute Psychiatric	13,404	9,564	12,197	13,179	13,233	13,287	13,409	13,531
Total Acute	***228,577***	***212,685***	***225,944***	***220,591***	***221,492***	***222,391***	***224,438***	***226,485***
f. Rehabilitation	0	0	0	0	0	0	0	0
g. Comprehensive Care	0	0	0	0	0	0	0	0
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0	0
TOTAL PATIENT DAYS	***228,577***	***212,685***	***225,944***	***220,591***	***221,492***	***222,391***	***224,438***	***226,485***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)								
a. General Medical/Surgical*	6.6	6.6	6.5	6.6	6.6	6.6	6.6	6.6
b. ICU/CCU	20.8	20.8	20.7	20.3	20.3	20.3	20.3	20.3
Total MSGA	9.0	9.1	9.0	8.8	8.8	8.8	8.8	8.8
c. Pediatric	2.6	2.1	2.2	2.5	2.5	2.5	2.5	2.5

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H				
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**
d. Obstetric	3.8	3.7	3.8	2.3	2.3	2.3	2.3	2.3
e. Acute Psychiatric	11.2	11.8	10.7	9.2	9.2	9.2	9.2	9.2
Total Acute	8.2	8.1	8.0	7.7	7.7	7.7	7.7	7.7
f. Rehabilitation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables C and H				
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL AVERAGE LENGTH OF STAY	8.2	8.1	8.0	7.7	7.7	7.7	7.7	7.7
4. NUMBER OF LICENSED BEDS								
a. General Medical/Surgical*	409	409	409	409	409	409	409	409
b. ICU/CCU	230	230	230	230	230	230	230	230
Total MSGA	**639**	**639**	**639**	**639**	**639**	**639**	**639**	**639**
c. Pediatric	59	59	59	59	59	59	59	59
d. Obstetric	35	35	35	35	35	35	35	35
e. Acute Psychiatric	56	56	56	56	56	56	56	56
Total Acute	***789***	***789***	***789***	***789***	***789***	***789***	***789***	***789***
f. Rehabilitation	0	0	0	0	0	0	0	0
g. Comprehensive Care	0	0	0	0	0	0	0	0
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0	0
TOTAL LICENSED BEDS	***789***	***789***	***789***	***789***	***789***	***789***	***789***	***789***
5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE: *Leap year formulas should be changed by applicant to reflect 366 days per year.*								
a. General Medical/Surgical*	81.8%	74.7%	79.5%	83.2%	83.5%	83.9%	84.7%	85.4%
b. ICU/CCU	94.8%	93.1%	96.0%	85.3%	85.6%	86.0%	86.7%	87.5%
Total MSGA	**86.4%**	**81.3%**	**85.4%**	**83.9%**	**84.3%**	**84.6%**	**85.4%**	**86.2%**
c. Pediatric	26.1%	23.4%	25.6%	25.5%	25.6%	25.7%	25.9%	26.2%
d. Obstetric	62.1%	65.6%	70.1%	48.0%	48.2%	48.4%	48.9%	49.3%
e. Acute Psychiatric	65.6%	46.8%	59.7%	64.5%	64.7%	65.0%	65.6%	66.2%
Total Acute	**79.4%**	**73.9%**	**78.5%**	**76.6%**	**76.9%**	**77.2%**	**77.9%**	**78.6%**
f. Rehabilitation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H				
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL OCCUPANCY %	**79.4%**	**73.9%**	**78.5%**	**76.6%**	**76.9%**	**77.2%**	**77.9%**	**78.6%**

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H				
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**
6. OUTPATIENT VISITS								
a. Emergency Department	68,301	58,215	51,620	69,641	69,915	70,211	70,864	71,521
b. Same-day Surgery	18,389	14,937	17,568	11,778	11,825	11,875	11,985	12,096
c. Laboratory	0	0	0	0	0	0	0	0
d. Imaging	0	0	0	0	0	0	0	0
e. Other (Specify/add rows of needed)	249,455	210,930	254,420	245,988	246,955	248,000	250,306	252,629
TOTAL OUTPATIENT VISITS	***336,145***	***284,082***	***323,608***	***327,407***	***328,695***	***330,086***	***333,155***	***336,246***
7. OBSERVATIONS**								
a. Number of Patients								
b. Hours								

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

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

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard				
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**
1. REVENUE								
a. Inpatient Services	1,195,693	1,257,425	1,382,702	1,325,996	1,331,963	1,337,957	1,343,978	1,350,026
b. Outpatient Services	616,071	599,167	610,872	666,261	669,662	673,087	676,535	678,914
Gross Patient Service Revenues	***$ 1,811,764***	***$ 1,856,592***	***$ 1,993,575***	***$ 1,992,258***	***$ 2,001,625***	***$ 2,011,044***	***$ 2,020,512***	***$ 2,028,940***
c. Allowance For Bad Debt	58,669	62,129	66,501	68,055	68,375	68,697	69,021	69,308
d. Contractual Allowance	23,112	24,475	26,197	26,810	26,936	27,062	27,190	27,303
e. Charity Care	173,673	183,911	196,852	201,457	202,405	203,357	204,315	205,167
Net Patient Services Revenue	***$ 1,556,310***	***$ 1,586,078***	***$ 1,704,026***	***$ 1,695,935***	***$ 1,703,910***	***$ 1,711,927***	***$ 1,719,987***	***$ 1,727,161***
f. Other Operating Revenues (Specify/add rows if needed)	117,238	198,740	151,191	137,877	137,877	137,877	137,877	137,877
NET OPERATING REVENUE	***$ 1,673,548***	***$ 1,784,818***	***$ 1,855,217***	***$ 1,833,812***	***$ 1,841,786***	***$ 1,849,804***	***$ 1,857,864***	***$ 1,865,038***
2. EXPENSES								
a. Salaries & Wages (including benefits)	631,042	649,408	685,610	665,487	669,314	683,795	686,529	689,286
b. Contractual Services	301,782	345,234	354,779	337,927	339,227	340,529	341,834	342,141
c. Interest on Current Debt	26,304	19,891	24,738	27,408	26,593	25,295	26,225	25,338
d. Interest on Project Debt	-	-	-	-	-	2,217	2,170	2,071
e. Current Depreciation	100,427	97,464	97,643	102,525	101,941	100,003	105,570	107,134
f. Project Depreciation	-	-	-	-	-	6,167	6,167	6,167
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	296	296	296
i. Supplies	420,982	403,198	422,305	441,586	443,294	448,071	451,967	455,862
j. Other Expenses (Specify/add rows if needed)	-	-	-	-	-	-	-	-
Professional Fees	131,562	142,454	155,845	152,870	152,870	152,870	152,870	152,870
Other Expense	27,297	34,530	32,324	47,706	47,706	47,706	47,706	47,706
TOTAL OPERATING EXPENSES	**$ 1,639,396**	**$ 1,692,179**	**$ 1,773,244**	**$ 1,775,509**	**$ 1,780,946**	**$ 1,806,948**	**$ 1,821,334**	**$ 1,828,871**
$								**1,459**

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard				
Indicate CY or FY	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26
a. Income From Operation	$ 34,152	$ 92,639	$ 81,973	$ 58,302	$ 60,841	$ 42,856	$ 36,530	$ 36,168

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard				
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**
b. Non-Operating Income	9,492	(6,072)	10,157	13,672	13,961	14,339	14,672	14,920
SUBTOTAL	***$ 43,644***	***$ 86,567***	***$ 92,131***	***$ 71,974***	***$ 74,802***	***$ 57,195***	***$ 51,202***	***$ 51,088***
c. Income Taxes								
NET INCOME (LOSS)	***$ 43,644***	***$ 86,567***	***$ 92,131***	***$ 71,974***	***$ 74,802***	***$ 57,195***	***$ 51,202***	***$ 51,088***
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	32.7%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%
2) Medicaid	30.8%	30.6%	30.6%	30.6%	30.6%	30.6%	30.6%	30.6%
3) Blue Cross	10.8%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%
4) Commercial Insurance	18.7%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%
5) Self-pay	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
6) Other	5.0%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days								
1) Medicare								
2) Medicaid								
3) Blue Cross								
4) Commercial Insurance								
5) Self-pay								
6) Other								
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**
1. REVENUE								
a. Inpatient Services	1,195,693	1,257,425	1,382,702	1,363,618	1,408,617	1,455,102	1,503,120	1,552,723
b. Outpatient Services	616,071	599,167	610,872	684,427	706,676	729,651	753,378	776,789
Gross Patient Service Revenues	***$ 1,811,764***	***$ 1,856,592***	***$ 1,993,575***	***$ 2,048,045***	***$ 2,115,293***	***$ 2,184,753***	***$ 2,256,498***	***$ 2,329,512***
c. Allowance For Bad Debt	58,669	62,129	66,501	69,961	72,258	74,631	77,082	79,576
d. Contractual Allowance	23,112	24,475	26,197	27,560	28,465	29,400	30,366	31,348
e. Charity Care	173,673	183,911	196,852	207,099	213,899	220,923	228,177	235,561
Net Patient Services Revenue	***$ 1,556,310***	***$ 1,586,078***	***$ 1,704,026***	***$ 1,743,425***	***$ 1,800,671***	***$ 1,859,799***	***$ 1,920,874***	***$ 1,983,027***
f. Other Operating Revenues (Specify/add rows if needed)	117,238	198,740	151,191	140,571	143,318	146,121	148,980	151,896
NET OPERATING REVENUE	***$ 1,673,548***	***$ 1,784,818***	***$ 1,855,217***	***$ 1,883,996***	***$ 1,943,989***	***$ 2,005,921***	***$ 2,069,854***	***$ 2,134,924***
2. EXPENSES								
a. Salaries & Wages (including benefits)	631,042	649,408	685,610	682,911	708,631	741,838	768,353	793,632
b. Contractual Services	301,782	345,234	354,779	339,910	350,806	353,919	364,985	371,009
c. Interest on Current Debt	26,304	19,891	24,738	27,408	26,593	25,295	26,226	25,338
d. Interest on Project Debt	-	-	-	-	-	2,217	2,170	2,071
e. Current Depreciation	100,427	97,464	97,643	102,525	101,941	100,003	105,571	107,134
f. Project Depreciation	-	-	-	-	-	6,167	6,167	6,167
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	296	296	296
i. Supplies	420,982	403,198	422,305	456,907	474,699	496,360	517,980	540,482
j. Other Expenses (Specify/add rows if needed)	-	-	-	-	-	-	-	-
Professional Fees	131,562	142,454	155,845	156,288	159,789	163,376	167,051	170,815
Other Expense	27,297	34,530	32,324	48,385	49,077	49,783	50,503	51,237
TOTAL OPERATING EXPENSES	**$ 1,639,396**	**$ 1,692,179**	**$ 1,773,244**	**$ 1,814,334**	**$ 1,871,536**	**$ 1,939,251**	**$ 2,009,301**	**$ 2,068,181**
3. INCOME								

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**
a. Income From Operation	**$ 34,152**	**$ 92,639**	**$ 81,973**	**$ 69,662**	**$ 72,453**	**$ 66,670**	**$ 60,553**	**$ 66,743**
b. Non-Operating Income	9,492	(6,072)	10,157	14,671	15,331	16,106	16,895	17,620
SUBTOTAL	***$ 43,644***	***$ 86,567***	***$ 92,131***	***$ 84,333***	***$ 87,784***	***$ 82,776***	***$ 77,448***	***$ 84,363***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**
c. Income Taxes								
NET INCOME (LOSS)	***$ 43,644***	***$ 86,567***	***$ 92,131***	***$ 84,333***	***$ 87,784***	***$ 82,776***	***$ 77,448***	***$ 84,363***
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	32.7%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%
2) Medicaid	30.8%	30.6%	30.6%	30.6%	30.6%	30.6%	30.6%	30.6%
3) Blue Cross	10.8%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%
4) Commercial Insurance	18.7%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%
5) Self-pay	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
6) Other	5.0%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days								
Total MSGA								
1) Medicare	27.7%	27.7%	27.7%	27.7%	27.7%	27.7%	27.7%	27.7%
2) Medicaid	41.7%	41.7%	41.7%	41.7%	41.7%	41.7%	41.7%	41.7%
3) Blue Cross	13.6%	13.6%	13.6%	13.6%	13.6%	13.6%	13.6%	13.6%
4) Commercial Insurance	11.4%	11.4%	11.4%	11.4%	11.4%	11.4%	11.4%	11.4%
5) Self-pay	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%
6) Other	3%	3%	3%	3%	3%	3%	3%	3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables L and K					
Indicate CY or FY	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**
1. DISCHARGES						
a. General Medical/Surgical (PEDs Cardiac	280	281	282	283	285	285
a. General Medical/Surgical (PEDs Cardiac	56	56	56	57	57	57
b. ICU/CCU						
Total MSGA	**336**	**337**	**339**	**340**	**341**	**341**
c. Pediatric						
d. Obstetric						
e. Acute Psychiatric						
Total Acute	***336***	***337***	***339***	***340***	***341***	***341***
f. Rehabilitation						
g. Comprehensive Care						
h. Other (Specify/add rows of needed)						
TOTAL DISCHARGES	***336***	***337***	***339***	***340***	***341***	***341***
2. PATIENT DAYS						
a. General Medical/Surgical* (Cardiac Surge	1,960	1,967	1,977	1,984	1,992	1,992
a. General Medical/Surgical* (Cardiac Cath)	448	448	450	453	453	453
b. ICU/CCU						
Total MSGA	**2,408**	**2,415**	**2,427**	**2,437**	**2,445**	**2,445**
c. Pediatric						
d. Obstetric						
e. Acute Psychiatric						
Total Acute	***2,408***	***2,415***	***2,427***	***2,437***	***2,445***	***2,445***
f. Rehabilitation						
g. Comprehensive Care						
h. Other (Specify/add rows of needed)						
TOTAL PATIENT DAYS	***2,408***	***2,415***	***2,427***	***2,437***	***2,445***	***2,445***

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables L and K					
Indicate CY or FY	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**
3. AVERAGE LENGTH OF STAY						
a. General Medical/Surgical* (Cardiac Surge	7.0	7.0	7.0	7.0	7.0	7.0
a. General Medical/Surgical* (Cardiac Cath)	8.0	8.0	8.0	8.0	8.0	8.0
b. ICU/CCU	0.0	0.0	0.0	0.0	0.0	0.0
Total MSGA	7.2	7.2	7.2	7.2	7.2	7.2
c. Pediatric	0.0	0.0	0.0	0.0	0.0	0.0
d. Obstetric	0.0	0.0	0.0	0.0	0.0	0.0
e. Acute Psychiatric	0.0	0.0	0.0	0.0	0.0	0.0
Total Acute	7.2	7.2	7.2	7.2	7.2	7.2
f. Rehabilitation	0.0	0.0	0.0	0.0	0.0	0.0
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL AVERAGE LENGTH OF STAY	7.2	7.2	7.2	7.2	7.2	7.2

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables L and K					
Indicate CY or FY	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**
4. NUMBER OF LICENSED BEDS						
a. General Medical/Surgical*						
b. ICU/CCU						
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric						
d. Obstetric						
e. Acute Psychiatric						
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation						
g. Comprehensive Care						
h. Other (Specify/add rows of needed)						
TOTAL LICENSED BEDS						
5. OCCUPANCY PERCENTAGE ****IMPORTANT NOTE:*** *Leap year formulas should be changed by applicant to reflect 366 days per*						
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables L and K					
Indicate CY or FY	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables L and K					
Indicate CY or FY	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**
6. OUTPATIENT VISITS						
a. Emergency Department						
b. Same-day Surgery						
c. Laboratory						
d. Imaging						
e. Other (Specify/add rows of needed)	113	114	114	114	114	114
TOTAL OUTPATIENT VISITS	***113***	***114***	***114***	***114***	***114***	***114***
7. OBSERVATIONS**						
a. Number of Patients						
b. Hours						

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

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

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

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the			
Indicate CY or FY	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**
1. REVENUE				
a. Inpatient Services				
b. Outpatient Services				
Gross Patient Service Revenues	**$ -**	**$ -**	**$ -**	**$ -**
c. Allowance For Bad Debt				
d. Contractual Allowance				
e. Charity Care				
Net Patient Services Revenue	**$ -**	**$ -**	**$ -**	**$ -**
f. Other Operating Revenues (Specify)				
NET OPERATING REVENUE	**$ -**	**$ -**	**$ -**	**$ -**
2. EXPENSES				
a. Salaries & Wages (including benefits)	$ 1,459	$ 1,459	$ 1,459	$ 1,459
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)				
TOTAL OPERATING EXPENSES	**$ 1,459**	**$ 1,459**	**$ 1,459**	**$ 1,459**

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

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the			
Indicate CY or FY	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**
3. INCOME				
a. Income From Operation	**$ (1,458.79)**	**$ (1,458.79)**	**$ (1,458.79)**	**$ (1,458.79)**
b. Non-Operating Income				
SUBTOTAL	***$ (1,458.79)***	***$ (1,458.79)***	***$ (1,458.79)***	***$ (1,458.79)***
c. Income Taxes				
NET INCOME (LOSS)	***$ (1,458.79)***	***$ (1,458.79)***	***$ (1,458.79)***	***$ (1,458.79)***
4. PATIENT MIX				
a. Percent of Total Revenue				
1) Medicare	1.8%	1.8%	1.8%	1.8%
2) Medicaid	53.1%	53.1%	53.1%	53.1%
3) Blue Cross	17.8%	17.8%	17.8%	17.8%
4) Commercial Insurance	17.8%	17.8%	17.8%	17.8%
5) Self-pay	0.0%	0.0%	0.0%	0.0%
6) Other	9.4%	9.4%	9.4%	9.4%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***

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

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the			
Indicate CY or FY	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**
b. Percent of Equivalent Inpatient Days				
Total MSGA				
1) Medicare				
2) Medicaid				
3) Blue Cross				
4) Commercial Insurance				
5) Self-pay				
6) Other				
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***

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

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the			
Indicate CY or FY	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**
1. REVENUE				
a. Inpatient Services				
b. Outpatient Services				
Gross Patient Service Revenues	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt				
d. Contractual Allowance				
e. Charity Care				
Net Patient Services Revenue	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)				
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES				
a. Salaries & Wages (including benefits)	$ 1,459	$ 1,495	$ 1,533	$ 1,571
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/add rows of needed)				
TOTAL OPERATING EXPENSES	**$ 1,459**	**$ 1,495**	**$ 1,533**	**$ 1,571**

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

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the			
Indicate CY or FY	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**
3. INCOME				
a. Income From Operation	**$ (1,459)**	**$ (1,495)**	**$ (1,533)**	**$ (1,571)**
b. Non-Operating Income				
SUBTOTAL	***$ (1,459)***	***$ (1,495)***	***$ (1,533)***	***$ (1,571)***
c. Income Taxes				
NET INCOME (LOSS)	***$ (1,459)***	***$ (1,495)***	***$ (1,533)***	***$ (1,571)***
4. PATIENT MIX				
a. Percent of Total Revenue				
1) Medicare	1.8%	1.8%	1.8%	1.8%
2) Medicaid	53.1%	53.1%	53.1%	53.1%
3) Blue Cross	17.8%	17.8%	17.8%	17.8%
4) Commercial Insurance	17.8%	17.8%	17.8%	17.8%
5) Self-pay	0.0%	0.0%	0.0%	0.0%
6) Other	9.4%	9.4%	9.4%	9.4%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days				
1) Medicare				
2) Medicaid				
3) Blue Cross				
4) Commercial Insurance				
5) Self-pay				
6) Other				
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***

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			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table 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)*											
Operating Room RNs			$0	3.5	84,953.1	$297,336			$0	3.5	$297,336
Operating Room Surgical Technicians				1.5	56,274.4	$84,412					
First Assist/PA				2.0	134,316.0	$268,632					
Perfusionist				1.5	152,540.3	$228,810					
Anesthesia Technician				1.5	44,189.6	$66,284					
Surgical Support Tech				1.5	57,560.5	$86,341					
Cardiac Cath RNs				2.0	93,997.8	$187,996					
RCIS				2.5	95,592.6	$238,982					
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0	16.0		$1,458,792			$0	16.0	$1,458,792
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			$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			$0			$0			$0	0.0	$0
REGULAR EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
2. Contractual Employees											

TABLE L. WORK fORCE INFORMATION

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)*											
Operating Room RNs			$0			$0			$0	0.0	$0
Operating Room Surgical Technicians						$0				0.0	$0
First Assist/PA						$0				0.0	$0
Perfusionist						$0				0.0	$0
Anesthesia Technician						$0				0.0	$0
Surgical Support Tech						$0				0.0	$0
Cardiac Cath RNs						$0				0.0	$0
RCIS						$0				0.0	$0
Total Direct Care Staff			$0	0.0		$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 belo*											
TOTAL COST	***0.0***		***$0***	***0.0***		***$0***	***0.0***		***$0***		***$0***

UNIVERSITY of MARYLAND MEDICAL SYSTEM

University of Maryland Medical Center

CON Planning Assumptions

	Seven Year Projection						
	2020	2021	2022	2023	2024	2025	2026
Assumptions to Revenue:							
Revenue Changes							
+ / - : HSCRC Inflation	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
+ / - : Demographics	0.69%	0.67%	0.40%	0.40%	0.40%	0.92%	0.92%
+ / - : Market Shift	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
+ / - : Quality	0.25%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
+ / - : Other	1.01%	0.42%	0.68%	0.67%	0.67%	0.15%	0.15%
Total Revenue Change	3.95%	3.09%	3.08%	3.07%	3.07%	3.07%	3.07%
CONTRACTUAL ALLOWANCES, UNCOMPENSATED CARE & BAD DEBT EXPENSE	14.4%	14.4%	14.4%	14.4%	14.4%	14.4%	14.4%
Summary Assumptions to Expense:							
The weighted average inflation factor for operating expense =	2.8%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
The weighted average variable cost factor =	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%
Detailed Assumptions to Operating Expenses:							
FTEs, SALARIES AND FRINGE BENEFITS - 50% Variable with Patient Days							
Salary inflation assumption	2.75%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
Fringe benefits %	21.8%	21.8%	21.8%	21.8%	21.8%	21.8%	21.8%
SUPPLIES (All Supplies & Drugs) - 75% Variable with Patient Days							
Inflation assumption	2.75%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
PURCHASED SERVICES - 70% Variable with Patient Days							
Inflation assumption	2.50%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
PHYSICIAN SERVICES - 65% Variable with Patient Days							
Inflation assumption	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
INSURANCE & OTHER EXPENSE - 0% Variable							
Inflation assumption	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
OTHER FIXED EXPENSE COST CHANGES							
Intensity Factor Expense Adjustment (100% offsets Net Revenue Impact)	$13,600	$27,600	$42,000	$56,700	$72,000	$72,000	$72,000
Historical Fixed Cost Additions Above Inflation and Variable Cost	$17,600	$35,600	$54,000	$72,700	$92,000	$96,000	$100,000
Performance Improvement / Cost Reductions	$0	($9,500)	($24,000)	($43,500)	($52,000)	($62,000)	($69,500)
Net Impact	$17,600	$26,100	$30,000	$29,200	$40,000	$34,000	$30,500
New Building Fixed Cost Additions (excluding Depreciation and Interest)	$0	$0	$0	$0	$14,437	$21,232	$28,410

EXHIBIT 2

EXISTING FLOOR PLAN

HATCH REPRESENTS EXISTING TO REMAIN

1 DEMOLTION PLAN
CON - AD07 SCALE: 1/8" = 1'-0"

WILMOTSANZ
ARCHITECTURE INTERIOR DESIGN PLANNING

18310 MONTGOMERY VILLAGE AVENUE • SUITE 300
GAITHERSBURG, MD 20879
301.590.2900 • WWW.WILMOTSANZ.COM

Architect/Engineer Seal:

MEP ENGINEER
Leach Wallace Associates, Inc.
6522 Meadowridge Road
Elkridge, MD 21075
(410) 579-8100

STRUCTURAL ENGINEER
Cagley & Associates
6141 Executive Blvd.
Rockville, MD 20852
(301) 881-9050

TECHNOLOGY CONSULTANT
Convergent Technologies Design Group Inc.
6501 York Road
Baltimore, MD 21212
(410) 532-2395

MEDICAL EQUIPMENT PLANNER
Chesapeake Healthcare Planning, LLC
6700 Alexander Bell Dr., Suite 200
Columbia, MD 21046
(410) 884-3144

PLAN TRUE NORTH

KEY PLAN

REVISIONS	DATE	NO.

UNIVERSITY of MARYLAND MEDICAL CENTER

N7W Pediatric Cath Lab Renovations

CON - DEMOLITION PLAN

Project Number:	2003.01
Scale:	1/8" = 1'-0"
Date:	October 7, 2020
Print Date/Stamp:	10/6/2020 5:51:10 PM

Sheet No.:

CON - AD07

SCHEMATIC DESIGN

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PROPOSED FLOOR PLAN

HATCH REPRESENTS EXISTING TO REMAIN

HATCH REPRESENTS PHASE 2

HATCH REPRESENTS RECOVERY AREA

HATCH REPRESENTS PHASE 1

1 NEW WORK FLOOR PLAN
CON - A107 SCALE: 1/8" = 1'-0"

WILMOTSANZ
ARCHITECTURE INTERIOR DESIGN PLANNING

18310 MONTGOMERY VILLAGE AVENUE • SUITE 300
GAITHERSBURG, MD 20879
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6700 Alexander Bell Dr., Suite 200
Columbia, MD 21046
(410) 884-3144

PLAN TRUE NORTH

KEY PLAN

REVISIONS	DATE	NO.

UNIVERSITY of MARYLAND MEDICAL CENTER

N7W Pediatric Cath Lab Renovations

CON - NEW WORK FLOOR PLAN

Project Number:	2003.01
Scale:	1/8" = 1'-0"
Date:	October 7, 2020
Print Date/Stamp:	10/6/2020 5:53:58 PM

Sheet No.:

CON - A107

SCHEMATIC DESIGN

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EXHIBIT 3

University of Maryland Medical Center (UMMC)

Subject: Information Regarding Charges

Policy for Release of Charge Information to Patients

To provide information regarding charges, UMMC will provide the following:

(a) A Representative List of Services and Charges will be made readily available to the public in written form available on UMMCs internet web site and by contracting the Patient Financial Services Department. (example attached)

(b) Estimated average charges for common inpatient and outpatient procedures at University of Maryland Medical Center. These tables are updated quarterly and are based on the patient charges actually incurred for these services during the previous nine months. They may be used by patients to estimate the charge for services that they may incur.

(c) Response to individuals requesting current charges for specific services/procedures will be accommodated within 2 days and staff training will occur to ensure that inquiries regarding charges for its services will be appropriately handled.

(d) The request should be directed to the Patient Financial Services Department who are trained in patient billing, patient financial assistance and HSCRC approved rate

(e) The team member granting the request should note the average inpatient charge per case figure is an estimate based on historical data and that the actual charge per case can vary significantly depending on the outcome of the patient's stay.

EXHIBIT 4

UNIVERSITY of MARYLAND MEDICAL SYSTEM **Central Business Office**	**PAGE:** **1 OF 14**	**POLICY NO:** **CBO - 01**
	EFFECTIVE DATE: 09/18/19	**REVISION DATE(S):** 10/19/2020
SUBJECT: Financial Assistance		

KEY WORDS: Financial Assistance

OBJECTIVE/BACKGROUND:

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.

APPLICABILITY:

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; 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.

POLICY:

This policy was approved by the UMMS Executive Compliance Committee (ECC) Board on October 19, 2020. 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)

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

PROCEDURE:

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. UMMS will not engage in the following ECAs:
    a. Selling debt to another party.

    b. Charge interest on bills incurred by patients before a court judgement is obtained

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.

ATTACHMENTS:

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

2020 Federal Poverty Limits (FPL) and Maryland Dept of Health & Mental Hygiene (DHMH) Annual Income Eligibility Limit Guidelines			UMMS 100% Charity	UMMS 90% Charity	UMMS 80% Charity	UMMS 70% Charity	UMMS 60% Charity	UMMS 50% Charity	UMMS 40% Charity	UMMS 30% Charity	UMMS 20% Charity	UMMS 10% Charity
			Equals Up to 200% of MD DHMH Annual Income limits	Equals Up to 210% of MD DHMH Annual Income limits	Equals Up to 220% of MD DHMH Annual Income limits	Equals Up to 230% of MD DHMH Annual Income limits	Equals Up to 240% of MD DHMH Annual Income limits	Equals Up to 250% of MD DHMH Annual Income limits	Equals Up to 260% of MD DHMH Annual Income limits	Equals Up to 270% of MD DHMH Annual Income limits	Equals Up to 280% of MD DHMH Annual Income limits	Equals Up to 290% of MD DHMH Annual Income limits
House-hold (HH) Size	2020 FPL Annual Income Elig Limits	2020 MD DHMH Annual Income Elig Limits	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:
Size	Up to	Up to	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max
1	12,490	**$17,620**	$35,240	$37,002	$38,764	$40,526	$42,288	$44,050	$45,812	$47,574	$49,336	$52,859
2	16,910	**$23,797**	$47,594	$49,974	$52,353	$54,733	$57,113	$59,493	$61,872	$64,252	$66,632	$71,390
3	21,330	**$29,974**	$59,948	$62,945	$65,943	$68,940	$71,938	$74,935	$77,932	$80,930	$83,927	$89,921
4	25,750	**$36,167**	$72,334	$75,951	$79,567	$83,184	$86,801	$90,418	$94,034	$97,651	$101,268	$108,500
5	30,170	**$42,344**	$84,688	$88,922	$93,157	$97,391	$101,626	$105,860	$110,094	$114,329	$118,563	$127,031
6	34,590	**$48,521**	$97,042	$101,894	$106,746	$111,598	$116,450	$121,303	$126,155	$131,007	$135,859	$145,562

*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 7/1/20

POLICY OWNER:

UMMS CBO

APPROVED:

Executive Compliance Committee Approved Initial Policy: 09/18/19
Executive Compliance Committee Approved Revisions: 10/19/2020

EXHIBIT 5

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

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 6

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

UNIVERSITY OF MARYLAND
MEDICAL CENTER
UNIVERSITY OF MARYLAND MEDICINE

EXHIBIT 7

MARYLAND Department of Health

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

May 2, 2018

RECEIVED

MAY 04 2018

University of Maryland Medical Center
Executive Office

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

Dear Dr. Suntha,

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

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

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

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

Sincerely,

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

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

MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY

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

License No. 30-068

Issued to:

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

Type of Facility: Acute General Hospital

Date Issued: July 1, 2018

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

Patricia Tomasko May MD

Director

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

EXHIBIT 8

University of Maryland Medical Center

Baltimore, MD

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

October 21, 2017

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

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

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

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

EXHIBIT 9

UNIVERSITY of MARYLAND MEDICAL CENTER

Quality of Care Responses

	Measure	Rating	Risk Adjusted Rates	Response
1	How long patients spent in the emergency department before leaving for their hospital room	Below average	**694 minutes**	A multidisciplinary performance improvement project including Emergency Medicine, Patient Access, Inpatient Medicine, Nursing and EVS is working to increase flow between the Emergency Department and Medicine floors. This includes eliminating rework steps, automating processes and increasing transparency into the process. There is a focus on the communication between ED and Medicine providers to streamline the admission process as well as communication between nurses trasferring care of the patient. This work lends to decrease our decision to admit to ED depart times, our left without being seen %, and increase patient flow through the emergency department overall.
2	How long patients spent in the emergency department after the doctor decided the patient would stay in the hospital before leaving for their hospital room	Below average	**424 minutes**	
3	How long patients spent in the emergency department before being sent home	Below average	**262 minutes**	
4	Patients who left the emergency department without being seen	Below average	**10%**	
5	Patients in the hospital who got the flu vaccine if they were likely to get flu	Below average	**93%**	This is no longer a core measure and we therefore do not track compliance however we still maintain a patient flu vaccination program. With approval from the Medical Executive Committee, UMMC"s program is nurse driven, where nurses are approved to conduct flu vaccine assessment and administration. To improve the program, the EMR was built up to drive compliance, including pop-up reminders. individuals and units to monitor, give feedback to nurses, and improve compliance

6	Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses.		**4.20%**	This measure reflects the CMS measure: OP-14 Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT. As per CMS, the CY2021 Hospital OQR program no longer includes this measure, therefore it is no longer tracked. (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalOutpatientQualityReportingProgram). However, UMMC practice in relation to the simultaneous use of brain and sinus (maxillofacial) CT is limited to those situations in which both studies are ordered by the referring provider; there is no Radiology protocol which requires the performance of both exams. The situation in which this most often occurs is in Trauma imaging when the mechanism of injury has the potential to involve both the brain and the facial bones (e.g. high speed MVC, blunt force trauma to the head, etc).
7	Returning to the hospital for any unplanned reason within 30 days after being discharged		**16.3 (15.3 - 17.0)**	University of Maryland Medical Center has made a multi-disciplinary readmission prevention effort across all of our services and departments to improve care transitions that has decreased our readmission rate by more than 15% since 2013. The effort includes focused intervention before hospitalization, during a readmission, before and after discharge for patients previously readmitted and spans the continuum of care from acute, to post-acute and ambulatory care. The CMS Hospital Compare website now lists UMMC hospital wide readmissions at a rate of 15.6, which is no different than the national rate. https://www.medicare.gov/hospitalcompare/profile.html#profTab=4&ID=210002&cmprID=210002&dist=25&loc=21201&lat=39.2963369&lng=-76.6210539&cmprDist=0.7&Distn=0.7

8	Death rate for stroke patients		**21.4(18.1,25.4)**	This measure is currently reported on the MHCC Quality website and reflects CMS Hospital Compare Data. CMS reports 30 day mortality for Medicare patients only. The UMMC CSC cares for a large portion of younger patients that are not captured in this metric. The current CMS Hospital compare website reflects a mortality rate of 13.6 Currently, there is a task force, led by the Chairperson of Neurology, Dr. Peter Crino to perform a root cause analysis for these reported 30 day morality rates, as this is not what we see in inpatient mortality. Using the data we report to Get With the Guidelines Stroke, the mortality rate for the time period July 2019-June 2020 for all UMMC stroke patients was 10.8% (73/676). These patients are captured daily and audited daily for outcomes. Each death is reviewed in case conference and morbidity and mortality rounds.
9	How often patients in the hospital had to use a breathing machine after surgery because they could not breathe on their own		**5.9406 (3.5187, 8.3625)**	This measure is an AHRQ PSI that is calculated using claims based data. The CDE team reviews every PSI for documentation opportunities and potential quality of care issues. Every case identified with a PSI is shared with the appropriate medical/surgical service for case review and/or practice change. For the time period of October 2019 - September 2020, the observed rate was 5.26, and the risk-adjusted rate was 3.02.
10	How often patients in the hospital get a blood clot in the lung or leg vein after surgery		**4.7141 (3.4027, 6.0255)**	This measure is an AHRQ PSI that is calculated using claims based data. The CDE team reviews every PSI for documentation opportunities and potential quality of care issues. Every case identified with a PSI is shared with the appropriate medical/surgical service for case review and/or practice change. For the time period of October 2019 - September 2020, the observed rate was 4.58, and the risk-adjusted rate was 2.65.

EXHIBIT 10

I. Marshall Valuation Service Valuation Benchmark

Type		Hospital
Construction Quality/Class		Good/A
Stories		7
Perimeter		560
Average Floor to Floor Height		12.0
Square Feet		7,520
f.1	Average floor Area	7,520
A. Base Costs		
	Basic Structure	$398.00
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$398.00
Adjustment for Departmental Differential Cost Factors		1.89
Adjusted Total Base Cost		$752.22
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$752.22
C. Multipliers		
Perimeter Multiplier		1.041344
	Product	$783.32
Height Multiplier		1.00
	Product	$783.32
Multi-story Multiplier		1.020
	Product	$798.99
D. Sprinklers		
	Sprinkler Amount	$4.99
Subtotal		$803.97
E. Update/Location Multipliers		
Update Multiplier		1.02
	Product	$820.05
Calculated Square Foot Cost Standard		**$820.05**

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

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
Operating Room	7,520	Operating Rooms Only	1.89	14,213
Total	7,520		1.89	14,213

II. Cost of New Construction

II. The Project

A. Base Calculations	**Actual**	**Per Sq. Foot**
Building	$4,182,374	$556.17
Fixed Equipment	$0	$0.00
Site Preparation	$0	$0.00
Architectural Fees	$350,000	$46.54
Permits	$4,000	$0.53
Cap. Interest, Inflation, Contingency, Loan Fees	Calculated Below	Calculated Below
Subtotal	$4,536,374	$603.24

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

B. Extraordinary Cost Adjustments

	Project Costs	
Premium for Constrained Site	$209,119	Building
Premium for Infection Control	$209,119	Building
Premium for Minority Business Enterprise Requirement	$167,295	Building
Total Cost Adjustments	$585,532	

Explanation of Extraordinary Costs

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

Premium for Constrained Site - The project is in an existing operating hospital building. The work is heavily constrained, and the renovation will have to be phased due to lack of space for storage of construction materials. Renovating in this site will require close coordinating with adjacent occupants and premiums for overtime to shorten durations of work to lessen operational impacts, and night/weekend work throughout the project. The MVS book recognizes that costs may be higher for constrained sites. (Section 99, Page 1)

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

Premium for Minority Business Enterprise Requirement - UMMS projects include a premium for Minority Business Enterprises that would not be in the average cost of hospital construction. This premium was projected to be 4%. UMMS consulted with its cost estimators/construction managers on the impact on project budgets of targeting 25% inclusion of MBE subcontractors or suppliers as part of its projects, and their conservative estimate is that it adds 3-4% to the costs, compared to projects that do not include MBE subcontractors or suppliers. This estimate has been confirmed through UMMS' experience with past construction jobs. UMMS now uses this percentage in all of its construction cost estimates.

Capitalized Construction Interest and Loan Placement Fees, Contingency, and Inflation on Extraordinary Costs

Capital interest, Loan Placement Fees, Contingency, and Inflation shown on the project budget sheet is for the entire costs of the hospital building. The costs associated with these line items also apply to the extraordinary costs. Because the Capitalized Construction Interest and Loan Placement Fees only associate with the costs in the "Building" budget line are considered in the MVS analysis, it is appropriate to adjust the cost of each of the above items that are in the Building costs to include the associated Capitalized Construction Interest. While there are no Capitalized Construction Interest or Loan Placement costs for this project, this also applies to Contingency, and Inflation.

Capitalized Construction Interest and Loan Placement Fees, Contingency, and Inflation were calculated as follows:

Cap Interest	$0
Loan Placement Fees	$0
Contingency	$540,000
Inflation	$223,626

Total	$763,626
Building Cost	$4,182,374
Subtotal Cost (w/o Cap Interest)	$4,536,374
Building/Subtotal	92.2%
% New Vs. Reno	100.0%
Cap Interest	$0
Applicable Cap Interest.	$0
Extraordinary Costs	$585,532
% of Building	14.00%
Extraordinary Cost Related Cap Interest	$81,974.53
Applied Cap Interest	**$0**
TOTAL CURRENT CAPITAL COSTS	$4,756,000
- Cap Interest	$0
- Contingency	$540,000
Adjusted Total Current Cap Costs	$4,216,000
Extraordinary Costs	$585,532
% of Total Capital Costs	13.9%
Loan Placement, Contingency, Inflation	$763,626
Associated with Extraordinary Costs	$106,055
Applied Loan, Continuing, Inflation	$657,571
Cap Interest, Loan, Continuing, Inflation	$657,571

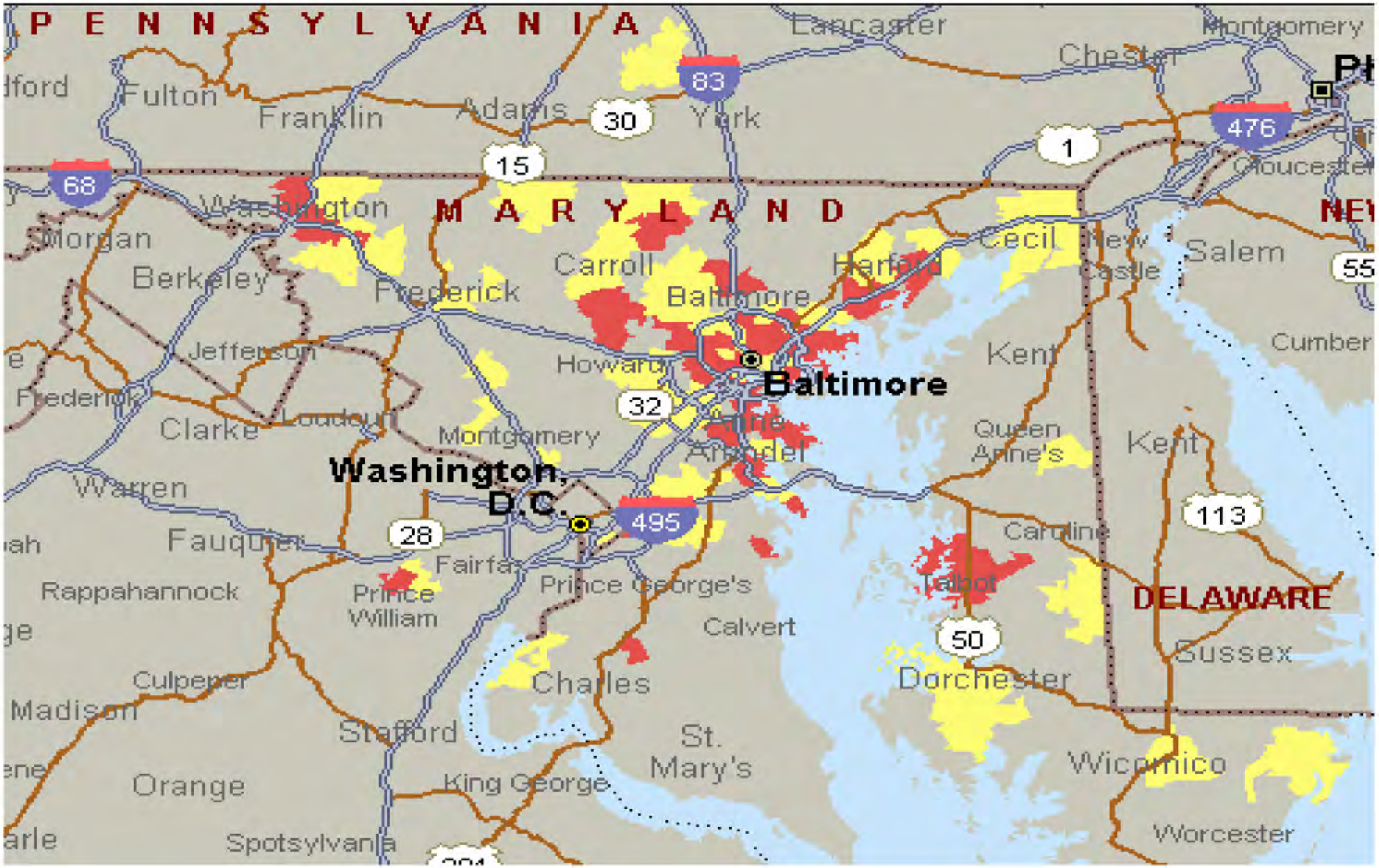
Eliminating all of the extraordinary costs reduces the project costs that should be compared to the MVS estimate. As noted below, the project's cost per square foot is approximate to the MVS benchmark.

C. Adjusted Project Cost		**Per Square Foot**
Building	$3,596,842	$478.30
Fixed Equipment	$0	$0.00
Site Preparation	$0	$0.00
Architectural Fees	$350,000	$46.54
Permits	$4,000	$0.53
Subtotal	$3,950,842	$525.38
Capitalized Construction Interest, Inflation, Contingency, Loan Fees	$657,571	$87.44
Total	$4,608,413	$612.82

MVS Benchmark	$820.05
The Project	$612.82
Difference	-$207.23
	-25.27%

EXHIBIT 11

UMMC Pediatric Cardiac Service Area



Source:BI Launchpad
Top 85% of Patient Volume by Zip Code
FY17-FY20 Cardiac Surgery and Cardiac Catheterization Patients

EXHIBIT 12

Zip Code	Cases per Zip Code
21239	54
21221	37
21040	37
21229	36
21220	36
21601	32
21206	31
21074	30
21060	30
21225	29
21234	28
21244	27
21212	26
21030	26
21227	25
21740	23
20743	22
21222	21
21207	21
21228	20
21218	19
21001	19
21217	19
20602	18
21085	18
21214	17
21215	17
21403	16
21009	16
21223	16
21237	16
21144	16
21784	15
21122	15
21032	15
21061	15
21213	14
20778	14
21204	13
20110	13
21133	13
21205	12
21014	12
21401	11
21202	11
20723	11

21901	10
20774	10
21117	10
21236	9
21613	9
20640	9
21921	9
21157	9
21211	9
21209	8
21162	8
21076	8
21045	8
21201	8
20720	8
21632	8
21075	8
21136	8
21804	7
20706	7
21713	7
21216	7
20794	7
21146	7
21208	6
21078	6
20715	6
21210	6
21787	6
21042	6
17315	6
21811	6
21224	6
21773	5
21230	5
20020	5
20871	5
21640	5
20874	5
20721	5
18103	5
21044	4
21015	4
21701	4
21102	4
20769	4
21114	4

21286	4
20852	4
21742	4
21128	4
20111	4
Total	**1318**

EXHIBIT 13

WILMOTSANZ
Inspiring Healthcare Design

October 22, 2020

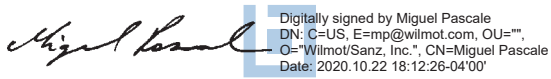
Jonathan Falcone
Project Manager
Facilities Project Development
University of Maryland Medical Center
110 South Paca St., Suite 107
Baltimore, MD 21201

Re: Hybrid OR Project on N7W Building

Dear Jonathan,

The proposed floor plans submitted for the project on the 7th floor of the North Building that includes renovations of the existing Surgery Department has been reviewed and designed to comply with the applicable 2018 FGI Guidelines.

Sincerely,



Miguel Pascale, AIA

cc: File

G:\2003\200301\07 Correspondence - Preconstruction\Letter to Jonathan regarding CON.docx

EXHIBIT 14

Consolidated Financial Statements and Supplementary Information

University of Maryland Medical System Corporation and Subsidiaries
Years Ended June 30, 2020 and 2019
With Report of Independent Auditors

Ernst & Young LLP

University of Maryland Medical System Corporation and Subsidiaries

Consolidated Financial Statements
and Supplementary Information

Years Ended June 30, 2020 and 2019

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Ernst & Young LLP
Suite 310
1201 Wills Street
Baltimore, MD 21231

Tel: +1 410 539 7940
Fax: +1 410 783 3832
ey.com

Building a better working world

Report of Independent Auditors

The Board of Directors
University of Maryland Medical System Corporation

We have audited the accompanying consolidated financial statements of the University of Maryland Medical System Corporation and Subsidiaries (the Corporation), which comprise the consolidated balance sheet as of June 30, 2020, and the related consolidated statement of operations and changes in net assets, and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity 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 financial statements that are free of material misstatement, whether due to fraud or error.

Auditors' Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the 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 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 financial statements.

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

Building a better working world

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of the University of Maryland Medical System Corporation and Subsidiaries as of June 30, 2020, and the consolidated results of their operations, changes in net assets and their cash flows for the year then ended in conformity with U.S. generally accepted accounting principles.

Adoption of New Accounting Pronouncement

As discussed in Note 1(y) to the consolidated financial statements, the Corporation changed its method of accounting for leases as a result of the adoption of the amendments to the Financial Accounting Standards Board Accounting Standards Codification resulting from Accounting Standards Update No. 2016-02, *Leases*, effective July 1, 2019. Our opinion is not modified with respect to this matter.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary consolidating and combining/combined information is presented for purposes of additional analysis and is not a required part of the 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 financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Report of Other Auditors on June 30, 2019 Financial Statements

The consolidated financial statements of the University of Maryland Medical System Corporation and Subsidiaries for the year ended June 30, 2019, were audited by other auditors who expressed an unmodified opinion on those statements on October 28, 2019.

Ernst & Young LLP

October 28, 2020

University of Maryland Medical System Corporation and Subsidiaries

Consolidated Balance Sheets
(In Thousands)

	June 30 2020	2019
Assets		
Current assets:		
Cash and cash equivalents	**$ 961,647**	$ 360,318
Assets limited as to use, current portion	**64,026**	64,910
Accounts receivable:		
Patient accounts receivable, net	**472,351**	458,437
Other	**118,228**	91,103
Inventories	**105,879**	70,478
Assets held for sale	**149,563**	116,828
Prepaid expenses and other current assets	**60,178**	48,055
Total current assets	**1,931,872**	1,210,129
Investments	**927,366**	885,640
Assets limited as to use, less current portion	**1,113,986**	1,227,384
Property and equipment, net	**2,556,548**	2,309,086
Investments in joint ventures	**92,485**	91,942
Other assets	**517,654**	409,188
Total assets	**$ 7,139,911**	$ 6,133,369
Liabilities and net assets		
Current liabilities:		
Trade accounts payable	**$ 302,133**	$ 288,841
Accrued payroll and benefits	**282,410**	281,177
Advances from third-party payors	**773,947**	139,163
Lines of credit	**193,500**	161,300
Short-term financing	**150,000**	150,000
Other current liabilities	**129,813**	127,760
Liabilities held for sale	**65,461**	60,830
Long-term debt subject to short-term remarketing arrangements	**28,794**	18,895
Current portion of long-term debt	**40,468**	47,621
Total current liabilities	**1,966,526**	1,275,587
Long-term debt, less current portion and amount subject to short-term remarketing arrangements	**1,438,257**	1,484,960
Other long-term liabilities	**653,388**	439,024
Interest rate swap liabilities	**270,430**	196,174
Total liabilities	**4,328,601**	3,395,745
Net assets:		
Without donor restrictions	**2,055,346**	1,973,405
With donor restrictions	**755,964**	764,219
Total net assets	**2,811,310**	2,737,624
Total liabilities and net assets	**$ 7,139,911**	$ 6,133,369

See accompanying notes to consolidated financial statements.

University of Maryland Medical System Corporation and Subsidiaries

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

	Year Ended June 30 2020	2019
Operating revenue, gains, and other support:		
Net patient service revenue	**$ 3,915,931**	$ 4,017,054
State and county support	**19,737**	41,521
CARES Act – Provider relief funds	**199,632**	–
Other revenue	**228,754**	176,699
Total operating revenue, gains, and other support	**4,364,054**	4,235,274
Operating expenses:		
Salaries, wages and benefits	**2,230,484**	2,158,136
Expendable supplies	**760,113**	792,015
Purchased services	**696,028**	634,618
Contracted services	**276,959**	269,897
Depreciation and amortization	**235,891**	244,056
Interest expense	**46,561**	57,792
Total operating expenses	**4,246,036**	4,156,514
Income from continuing operations	**118,018**	78,760
Nonoperating income and expenses, net:		
Unrestricted contributions	**9,293**	5,607
Equity in net income of joint ventures	**3,536**	3,624
Investment income, net	**24,635**	30,632
Change in fair value of investments	**(4,884)**	24,421
Change in fair value of undesignated interest rate swaps	**(75,811)**	(47,995)
Other nonoperating losses, net	**(24,376)**	(33,045)
Excess of revenues over expenses from continuing operations	**50,411**	62,004
Gain (loss) on discontinued operations, net	**19,599**	(25,847)
Excess of revenues over expenses	**$ 70,010**	$ 36,157

University of Maryland Medical System Corporation and Subsidiaries

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

	Without Donor Restrictions	With Donor Restrictions	Total
Balance at June 30, 2018	$ 1,952,422	$ 742,667	$ 2,695,089
Excess of revenues over expenses from continuing operations	62,004	–	62,004
Loss on discontinued operations, net	(25,847)	–	(25,847)
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 funded status of defined benefit pension plans	(26,886)	–	(26,886)
Other	(2,418)	3,966	1,548
Increase in net assets	20,983	21,552	42,535
Balance at June 30, 2019	1,973,405	764,219	2,737,624
Excess of revenues over expenses from continuing operations	**50,411**	**–**	**50,411**
Gain on discontinued operations, net	**19,599**	**–**	**19,599**
Investment gains, net	**–**	**1,206**	**1,206**
State support for capital	**–**	**20,803**	**20,803**
Contributions, net	**–**	**18,111**	**18,111**
Net assets released from restrictions used for operations and nonoperating activities	**–**	**(6,307)**	**(6,307)**
Net assets released from restrictions used for purchase of property and equipment	**18,791**	**(18,791)**	–
Change in economic and beneficial interests in the net assets of related organizations	**27,283**	**(27,283)**	–
Change in funded status of defined benefit pension plans	**(36,971)**	**–**	**(36,971)**
Other	**2,828**	**4,006**	**6,834**
Increase (decrease) in net assets	**81,941**	**(8,255)**	**73,686**
Balance at June 30, 2020	**$ 2,055,346**	**$ 755,964**	**$ 2,811,310**

See accompanying notes to consolidated financial statements.

University of Maryland Medical System Corporation and Subsidiaries

Consolidated Statements of Cash Flows
(In Thousands)

	Year Ended June 30 2020	2019
Operating activities		
Increase in net assets	**$ 73,686**	$ 42,535
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	**235,891**	244,056
Amortization of bond premium and deferred financing costs	**1,477**	1,477
Net realized gains and change in fair value of investments	**(3,183)**	(41,626)
Equity in net income of joint ventures	**(3,536)**	(3,624)
Change in economic and beneficial interests in net assets of related organizations	**27,281**	(1,982)
Change in fair value of interest rate swaps	**74,256**	46,385
Change in funded status of defined benefit pension plans	**36,971**	26,886
Restricted contributions, grants and other support, net	**(40,120)**	(22,503)
Change in operating assets and liabilities:		
Patient accounts receivable	**(13,027)**	(26,772)
Other receivables, prepaid expenses, other current assets and other assets	**(76,747)**	152,963
Inventories	**(35,401)**	298
Trade accounts payable, accrued payroll and benefits, other current liabilities and other long-term liabilities	**74,235**	14,617
Advances from third-party payors	**634,784**	(14,704)
Net cash provided by operating activities	**986,567**	418,006
Investing activities		
Purchases and sales of investments and assets limited as to use, net	**125,958**	(98,355)
Purchases of alternative investments	**(79,572)**	(66,267)
Sales of alternative investments	**101,417**	89,948
Purchase of UM Ambulatory Care, LLC, net cash acquired	**(608)**	–
Purchases of property and equipment	**(461,896)**	(394,588)
Distributions from (contributions to) joint ventures, net	**1,922**	(1,238)
Net cash used in investing activities	**(312,779)**	(470,500)

University of Maryland Medical System Corporation and Subsidiaries

Consolidated Statements of Cash Flows (continued)
(In Thousands)

	Year Ended June 30 2020	2019
Financing activities		
Proceeds from long-term debt	**$ –**	$ 10,016
Repayment of long-term debt and capital leases	**(45,434)**	(78,394)
Draws on lines of credit, net	**32,200**	62,000
Restricted contributions, grants and other support	**40,120**	22,503
Net cash provided by financing activities	**26,886**	16,125
Net increase (decrease) in cash, cash equivalents and restricted cash	**700,674**	(36,369)
Cash, cash equivalents and restricted cash, beginning of year	**511,949**	548,318
Cash, cash equivalents and restricted cash, end of year	**$ 1,212,623**	$ 511,949
Cash and cash equivalents	**$ 961,647**	$ 360,318
Restricted cash included in assets limited as to use	**250,976**	151,631
Cash, cash equivalents and restricted cash, end of year	**$ 1,212,623**	$ 511,949
Discontinued operations		
Operating activities	**$ 19,374**	$ 2,150
Investing activities	**$ (569)**	$ (3,131)
Financing activities	**$ –**	$ –
Supplemental disclosures of cash flow information		
Cash paid during the year for interest, net of amounts capitalized	**$ 54,306**	$ 58,860
Amount included in accounts payable for construction in progress	**$ 45,415**	$ 35,414
Supplemental disclosures of noncash information		
Capital leases	**$ –**	$ 427

See accompanying notes to consolidated financial statements.

University of Maryland Medical System Corporation and Subsidiaries

Notes to Consolidated Financial Statements
(In Thousands)

June 30, 2020

(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.

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 5. The significant operating divisions of the Corporation are described in further detail below.

All material intercompany balances and transactions have been eliminated in consolidation.

(1) Organization and Summary of Significant Accounting Policies (continued)

(i) Recent Acquisitions and Divestitures

During the year ended June 30, 2020, the Corporation signed a letter of intent to sell the assets and liabilities of UM Health Plans. 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) 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, 2020 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, 2020 and 2019, assets held for sale were approximately $149,600 and $116,800 and liabilities held for sale were approximately $65,500 and $60,800, respectively. For the years ended June 30, 2020 and 2019, operating revenues from discontinued operations were approximately $361,618 and $379,630, respectively. For the years ended June 30, 2020 and 2019, operating and nonoperating expenses from discontinued operations were approximately $342,019 and $405,477, respectively.

Effective March 1, 2020, the Corporation purchased the full interest in nine urgent care sites from ChoiceOne, which is a subsidiary of Fresenius Medical Care. Previously the urgent care sites were operated under a joint venture agreement between ChoiceOne and three affiliates: UM St. Joseph Medical Center, UM Shore Regional Health and UM Upper Chesapeake Health. Upon becoming a wholly-owned subsidiary of the Corporation, the nine sites were moved under one Company, University of Maryland Ambulatory Care, LLC (UM Ambulatory Care).

(ii) University of Maryland Medical Center (Medical Center)

The Medical Center, which is a major component of UMMS, is a 806-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.

(1) Organization and Summary of Significant Accounting Policies (continued)

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, 2020 and 2019 was approximately $168,438 and $159,043, 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 177 licensed beds, including 100 acute care beds and 77 chronic care beds and a wholly owned subsidiary providing primary care.

(1) Organization and Summary of Significant Accounting Policies (continued)

(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 285-bed acute care hospital providing a broad range of services, and several wholly owned subsidiaries providing emergency physician and other services.

Baltimore Washington Medical Center Foundation, Inc. (BWMC Foundation) is governed by a separate, independent board of directors and is required to hold investments and income derived therefrom for the exclusive benefit of UM Baltimore Washington. Accordingly, the accompanying consolidated financial statements reflect an economic interest in the net assets of the BWMC Foundation.

(vi) University of Maryland Shore Regional Health System (Shore Regional)

Shore Regional is a health system located on the Eastern Shore of Maryland. Shore Regional owns and operates University of Maryland Memorial Hospital (UM Memorial), a 132-bed acute care hospital providing inpatient and outpatient services in Easton, Maryland; University of Maryland Dorchester Hospital (UM Dorchester), a 34-bed acute care hospital providing inpatient and outpatient services in Cambridge, Maryland; University of Maryland Chester River Hospital Center (UM Chester River), a 21-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.

(1) Organization and Summary of Significant Accounting Policies (continued)

(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 99-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 219-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 174-bed acute care hospital and University of Maryland Harford Memorial Hospital (UM Harford Memorial), an 82-bed acute care hospital; a physician practice; 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; UM Laurel Medical Center (UM Laurel), a free standing medical facility providing emergency medicine and outpatient surgery and UM Bowie Health Center (UM Bowie) a free standing medical facility providing emergency medicine and diagnostic imaging and lab services.

(1) Organization and Summary of Significant Accounting Policies (continued)

(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 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.

(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, 2020 and 2019. 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.

(1) Organization and Summary of Significant Accounting Policies (continued)

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 13).

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 accompanying consolidated statements of changes in net assets.

(1) Organization and Summary of Significant Accounting Policies (continued)

(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) Intangible Assets and Goodwill

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.

(In Thousands)

(1) Organization and Summary of Significant Accounting Policies (continued)

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 carrying value of goodwill is evaluated at least annually for impairment.

The Corporation has one reporting unit within continuing operations.

There was no impairment loss recognized for the year ended June 30, 2020 and 2019.

The changes in the carrying amount of goodwill are as follows:

	Health Care Delivery
Goodwill at June 30, 2018	$ 48,810
Acquisitions	–
Write-downs	–
Goodwill at June 30, 2019	48,810
Acquisitions	–
Write-downs	–
Goodwill at June 30, 2020	**$ 48,810**

(j) 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, 2020 or 2019.

(1) Organization and Summary of Significant Accounting Policies (continued)

(k) Investments in Joint Ventures

When the Corporation does not have a controlling interest in an entity where less than 50% of the voting common stock is owned or does not exert a significant influence over the entity, the Corporation applies the equity method of accounting.

(l) Self-Insurance

Under the Corporation's self-insurance programs (general and professional liability, workers' compensation, and employee health and long-term disability benefits), incurred claims are estimated primarily based upon actuarial methods which include incurred but not reported claims analysis and reported claims the severity of incidents and the expected timing of claim payments. These estimates are continually reviewed and adjusted as necessary based on experience. These adjustments are recorded within the current period operating income.

(m) 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.

(n) Net Patient Service Revenue and Patient Accounts Receivable

In accordance with ASC 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

(1) Organization and Summary of Significant Accounting Policies (continued)

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 explicit price concessions for such items as contractual allowances, charity care, potential adjustments that may arise from payment and other reviews, and implicit price concessions such as 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. Based on historical experience, a significant portion of the self-pay population will be unable or unwilling to pay for services and only the amount anticipated to be collected is recognized the transactions 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 considered bad debt expense and recorded within operating expenses. Estimates for uncollectible amounts are based on the 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 even though they do not assess the patient's ability to pay.

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 20 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.

(In Thousands)

(1) Organization and Summary of Significant Accounting Policies (continued)

The Corporation has elected to apply the optional exemption in ASC 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:

	Year Ended June 30	
	2020	**2019**
Hospital inpatient and outpatient services	**$ 3,658,694**	$ 3,734,201
Physician services	**238,498**	245,150
Other	**18,739**	37,703
Net patient service revenue	**$ 3,915,931**	$ 4,017,054

(o) 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.

(1) Organization and Summary of Significant Accounting Policies (continued)

Due to the complexity of the eligibility process, the Corporation provides eligibility services to patients free of charge to assist in the qualification process. These eligibility services include, but are not limited to, the following:

- Financial assistance brochures and other information are posted at each point of service. When patients have questions or concerns, they are encouraged to call a toll-free number to reach customer service representatives during the business day. Financial assistance programs are published on the Corporation's Web site and included on the statements provided to patients.

- The Corporation offers assistance to patients in completing the applications for Medicaid or other government payment assistance programs, or applying for care under the Corporation's charity care policy, if applicable. The Corporation also employs an external firm to assist in the eligibility process.

- Any patient, whether covered by insurance or not, may meet with a UMMS representative and receive financial counseling from UMMS' dedicated financial assistance unit.

The Corporation recognizes that a large number of uninsured and insured patients meet the charity care guidelines but do not respond to the Corporation's attempts to obtain necessary financial information. In these instances, the Corporation uses credit reporting data to properly classify these unpaid balances as charity care as opposed to bad debt expense. Utilization of income and asset information and credit reporting data indicate the vast majority of amounts reported as uncollectible (implicit price concessions) 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 or determined to be uncollectible from patients are reported as reductions to 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 $48,254 and $48,821 for the years ended June 30, 2020 and 2019, respectively.

(1) Organization and Summary of Significant Accounting Policies (continued)

(p) 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 $18,444 and $15,124 for the years ended June 30, 2020 and 2019, respectively, and are reported within other nonoperating losses, net.

(q) 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.

All derivative instruments are reported as other assets or interest rate swap liabilities in the consolidated balance sheets and measured at fair value. Currently, the Corporation is accounting for its interest rate swaps as economic hedges at fair value with changes in the fair value recognized in other nonoperating income and expenses.

(1) Organization and Summary of Significant Accounting Policies (continued)

(r) Excess of Revenue over Expenses from Continuing Operations

The accompanying 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, and other items that are required by generally accepted accounting principles to be reported separately.

(s) 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 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.

(t) 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. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions on the accompanying consolidated statements of operations.

(1) Organization and Summary of Significant Accounting Policies (continued)

Contributions to be received after one year are discounted at a fixed 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.

(u) Fair Value Measurements

The following methods and assumptions were used by the Corporation in estimating the fair value of its financial instruments:

Cash and cash equivalents, accounts receivable, assets limited as to use, investments, trade accounts payable, accrued payroll and benefits, other accrued expenses, and advances from third-party payors – The carrying amounts reported in the consolidated balance sheets approximate the related fair values.

Pension plan assets – The Corporation applies Accounting Standards Update (ASU) 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.

(1) Organization and Summary of Significant Accounting Policies (continued)

- 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, 2020, and 2019, the Level 2 assets and liabilities listed in the fair value hierarchy tables presented in Notes 3 and 11 utilize the following valuation techniques and inputs:

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.

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.

(1) Organization and Summary of Significant Accounting Policies (continued)

Corporate Obligations

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. 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.

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.

(v) 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.

(w) 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.

(1) Organization and Summary of Significant Accounting Policies (continued)

(x) 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.

(y) New Accounting Pronouncements

The Corporation adopted ASU 2016-02, *Leases (ASC Topic 842)*, on July 1, 2019. ASC Topic 842 required the recognition of right-of-use assets (ROU) and lease liabilities on the accompanying consolidated balance sheet and the disclosure of qualitative and quantitative information about leasing arrangements. The guidance was adopted using a modified retrospective approach without restating prior comparative periods. The Corporation elected to utilize the transition practical expedient to not reassess whether a contract is or contains a lease, the lease classification and initial direct costs. Additionally, the Corporation also elected the practical expedient which allows the System to treat the lease and non-lease components of a contract as a single component and account for as a lease. The Corporation recognized operating ROU assets and corresponding operating lease liabilities of approximately $99,000 in the accompanying consolidated balance sheet at July 1, 2019. See further discussion in Note 6.

Effective January 1, 2019, the Corporation adopted ASU 2016-18, *Statement of Cash Flows (Topic 320): Restricted Cash*, which requires that the statement of cash flows explain the change during the period in total cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. Therefore, amounts generally described as restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the statement of cash flows. See further discussion in Note 3.

(2) COVID-19 Pandemic and the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020

Maryland Governor Larry Hogan began preparing the State for the COVID-19 pandemic on January 29, 2020 by raising the State's emergency operations center threat to "enhanced." As a result of close monitoring of the pandemic's impact data, on March 5, 2020, Governor Hogan declared a State of Emergency in Maryland, an action that was succeeded by several others intended to limit the spread of COVID-19 in Maryland and ensure residents who required medical care were able to obtain it safely and efficiently. Notably, Governor Hogan issued an executive order on March 16, 2020 restricting elective procedures. As a result, volume in the months of March and April declined significantly and based on the State of Maryland's phased resumption of certain elective procedures in May and June, volumes increased compared to April 2020.

In response to COVID-19, the Coronavirus Aid, Relief and Economic Security (CARES) Act, was signed into law on March 27, 2020. The CARES Act authorizes funding to hospitals and other healthcare providers to be distributed through the Public Health and Social Services Emergency Fund (Relief Fund). Payments from the Relief Fund are to be used to prevent, prepare for, and respond to coronavirus, and shall reimburse the recipient for health care related expenses or lost revenues attributable to coronavirus and not required to be repaid, provided the recipients attest to and comply with the terms and conditions.

The U.S. Department of Health and Human Services' distributions from the Relief Fund include general distribution and targeted distributions to support hospitals in high impact areas and rural providers. For the year ended June 30, 2020, the Corporation received and recognized as other operating revenue, approximately $199,600 in relief funding. Amounts recognized as revenue could change in the future based on evolving compliance guidance provided by HHS, among other factors, as discussed further in Note 21.

In April 2020, the Corporation requested Medicare advanced payments under the Centers for Medicare and Medicaid Services' Accelerated and Advanced Payment Program designed to increase cash flow to Medicare providers and suppliers impacted by COVID-19. The Medicare advanced payment program allows eligible health care facilities to request up to six months of advance Medicare payments for acute care hospitals or up to three months of advance Medicare payments for other health care providers. The Corporation received approximately $641,300 of advanced payments with repayment to occur based upon the terms and conditions of the program. Amounts received represent contract liabilities under Topic 606 and are recorded in advances from third party payors within the accompanying consolidated balance sheet as of June 30, 2020.

(In Thousands)

(2) COVID-19 Pandemic and the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 (continued)

The CARES Act provided for deferred payment of the employer portion of social security taxes through December 31, 2020, with 50% of the deferred amount to December 31, 2021 and the remaining 50% due December 31, 2022. As of June 30, 2020, the Corporation deferred $26,971, which is recorded in other long-term liabilities in the accompanying consolidated balance sheet.

(3) Investments and Assets Limited as to Use

The carrying values of assets limited as to use were as follows:

	June 30	
	2020	**2019**
Investments held for collateral	**$ 166,507**	$ 113,586
Debt service and reserve funds	**37,696**	86,157
Construction funds – held by trustee	**204,366**	279,205
Construction funds – held by the Corporation	**174,675**	183,917
Board designated funds	**116,811**	140,689
Self-insurance trust funds	**215,162**	212,384
Funds restricted by donors	**91,975**	78,255
Economic and beneficial interests in the net assets of related organizations *(Note 13)*	**170,820**	198,101
Total assets limited as to use	**1,178,012**	1,292,294
Less amounts available for current liabilities	**(64,026)**	(64,910)
Total assets limited as to use, less current portion	**$ 1,113,986**	$ 1,227,384

(In Thousands)

(3) Investments and Assets Limited as to Use (continued)

The carrying values of assets limited as to use were as follows:

	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
June 30, 2020								
Cash and cash equivalents	**$ 136,101**	**$ 15,851**	**$ 260,606**	**$ 37,409**	**$ 591**	**$ 13,093**	**$ –**	**$ 463,651**
Corporate obligations	**–**	**–**	**–**	**365**	**12,381**	**974**	**–**	**13,720**
Fixed income funds	**–**	**–**	**–**	**18,350**	**394**	**16,106**	**–**	**34,850**
U.S. government and agency securities	**30,406**	**21,845**	**118,435**	**169**	**2,782**	**449**	**–**	**174,086**
Common stocks, including mutual funds	**–**	**–**	**–**	**43,630**	**5,799**	**29,569**	**–**	**78,998**
Alternative investments	**–**	**–**	**–**	**16,888**	**10,830**	**31,784**	**–**	**59,502**
Assets held by other organizations	**–**	**–**	**–**	**–**	**182,385**	**–**	**170,820**	**353,205**
Total assets limited as to use	**$ 166,507**	**$ 37,696**	**$ 379,041**	**$ 116,811**	**$ 215,162**	**$ 91,975**	**$ 170,820**	**$ 1,178,012**
June 30, 2019								
Cash and cash equivalents	$ 31,394	$ 25,070	$ 265,160	$ 19,216	$ 8,473	$ 13,924	$ –	$ 363,237
Corporate obligations	–	–	–	293	3,015	772	–	4,080
Fixed income funds	–	–	–	26,842	2,944	12,727	–	42,513
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

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 cash, stocks and fixed-income and corporate obligations. 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. These assets include the Corporation's portion of the investment pool shared with University of Maryland Faculty Physician, Inc., which is part of the University of Maryland School of Medicine.

(In Thousands)

(3) Investments and Assets Limited as to Use (continued)

The related restricted cash and cash equivalents included in Investments Held for Collateral, Debt Service and Reserve Funds, Construction Funds (held by trustee), and Funds Restricted by Donors are included in the accompanying Consolidated Statements of Cash Flows for the years ended June 30, 2020 and 2019.

The carrying values of investments were as follows:

	June 30	
	2020	**2019**
Cash and cash equivalents	**$ 54,553**	$ 61,004
Corporate obligations	**56,424**	55,023
Fixed income funds	**91,095**	83,822
U.S. government and agency securities	**26,062**	23,304
Common stocks	**235,673**	213,139
Alternative investments:		
Hedge funds/private equity	**193,250**	137,693
Commingled funds	**270,309**	311,655
	$ 927,366	$ 885,640

Alternative investments include hedge fund, private equity, and commingled investment funds, which are valued using the equity method of accounting. As of June 30, 2020, 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 $137,700 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 $72,500, 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 $14,200 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 $5,240 of unfunded commitments in alternative investments as of June 30, 2020.

(3) Investments and Assets Limited as to Use (continued)

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.

(In Thousands)

(3) Investments and Assets Limited as to Use (continued)

The following table presents investments and assets limited as to use that are measured at fair value on a recurring basis excluding alternative investments in the amount of $463,559 and $148,346 ($88,844 of which is included within investments held by other organizations*), respectively, which are accounted for under the equity method at June 30, 2020:

	Level 1	Level 2	Level 3	Total
Assets				
Investments:				
Cash and cash equivalents	**$ 54,553**	**$ –**	**$ –**	**$ 54,553**
Corporate obligations	**–**	**56,424**	**–**	**56,424**
Fixed income funds	**91,095**	**–**	**–**	**91,095**
U.S. government and agency securities	**7,586**	**18,476**	**–**	**26,062**
Common and preferred stocks, including mutual funds	**235,673**	**–**	**–**	**235,673**
	388,907	**74,900**	**–**	**463,807**
Assets limited as to use:				
Cash and cash equivalents	**463,651**	**–**	**–**	**463,651**
Corporate obligations	**–**	**13,720**	**–**	**13,720**
Fixed income funds	**34,850**	**–**	**–**	**34,850**
U.S. government and agency securities	**170,795**	**3,291**	**–**	**174,086**
Common and preferred stocks, including mutual funds	**78,998**	**–**	**–**	**78,998**
Investments held by other organizations	**–**	**264,361**	**–**	**264,361**
	748,294	**281,372**	**–**	**1,029,666**
	$ 1,137,201	**$ 356,272**	**$ –**	**$ 1,493,473**

*"Investments held by other organizations" includes assets of the MMCIP Self-insurance Trust, which holds alternative investments within its portfolios. Alternative investments include hedge fund, private equity, and commingled investment funds, which are valued using the equity method of accounting. As of June 30, 2020, 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.

(In Thousands)

(3) Investments and Assets Limited as to Use (continued)

The following table presents investments and assets limited as to use that are measured at fair value on a recurring basis excluding alternative investments in the amount of $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 obligations	–	55,023	–	55,023
Fixed income funds	83,822	–	–	83,822
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
Assets limited as to use:				
Cash and cash equivalents	363,237	–	–	363,237
Corporate obligations	–	4,080	–	4,080
Fixed income funds	42,513	–	–	42,513
U.S. government and agency securities	352,630	317	–	352,947
Common and preferred stocks, including mutual funds	78,403	–	–	78,403
Investments held by other organizations	–	377,856	–	377,856
	836,783	382,253	–	1,219,036
	$ 1,210,329	$ 444,999	$ –	$ 1,655,328

Changes to Level 1 and Level 2 securities between June 30, 2020 and 2019 were the result of strategic investments and reinvestments, interest income earnings, and changes in the fair value of investments.

(In Thousands)

(3) Investments and Assets Limited as to Use (continued)

The Corporation's total return on its investments and assets limited as to use was as follows:

	Year Ended June 30	
	2020	**2019**
Dividends and interest, net of fees	**$ 17,775**	$ 18,059
Net realized gains	**7,551**	14,276
Change in fair value of trading securities	**(4,368)**	24,384
Total investment return	**$ 20,958**	$ 56,719

Total investment return is classified in the accompanying consolidated statements of operations as follows:

	Year Ended June 30	
	2020	**2019**
Nonoperating investment income, net	**$ 24,635**	$ 30,632
Change in fair value of unrestricted investments	**(4,884)**	24,421
Investment gains on net assets with donor restrictions	**1,207**	1,666
Total investment return	**$ 20,958**	$ 56,719

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.

(In Thousands)

(4) Property and Equipment

The following is a summary of property and equipment:

	June 30 2020	2019
Land	**$ 203,544**	$ 196,004
Buildings	**1,495,471**	1,496,177
Building and leasehold improvements	**1,080,875**	1,048,608
Equipment	**1,986,526**	1,814,503
Construction in progress	**635,895**	321,660
	5,402,311	4,876,952
Less accumulated depreciation and amortization	**(2,845,763)**	(2,567,866)
	$ 2,556,548	$ 2,309,086

Interest cost capitalized was $380 and $0 for years ended June 30, 2020 and 2019, respectively.

Remaining contractual commitments on construction projects were approximately $172,900 at June 30, 2020, of which approximately $60,700 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.

(5) Investments in Joint Ventures

The Corporation has equity method investments of $92,485 and $91,942 at June 30, 2020 and 2019, respectively, in the following unconsolidated joint ventures:

	Ownership %	2020	2019
Mt. Washington Pediatric Hospital, Inc. (Mt. Washington)	50%	**$ 69,025**	$ 67,002
Terrapin Insurance	50%	**975**	975
Other investments	10-51%	**22,485**	23,965
		$ 92,485	$ 91,942

(In Thousands)

(5) Investments in Joint Ventures (continued)

The Corporation recorded equity in net income of $3,536 and $3,624 related to these joint ventures for the years ended June 30, 2020 and 2019, respectively.

The following is a summary of the Corporation's joint ventures' combined unaudited condensed financial information as of and for the years ended June 30:

	2020			
	Mt. Washington	**Terrapin**	**Others**	**Total**
Current assets	**$ 36,255**	**$ 23,194**	**$ 36,993**	**$ 96,442**
Noncurrent assets	**107,664**	**294,881**	**46,096**	**448,641**
Total assets	**$ 143,919**	**$ 318,075**	**$ 83,089**	**$ 545,083**
Current liabilities	**$ 13,560**	**$ 705**	**$ 18,914**	**$ 33,179**
Noncurrent liabilities	**7,746**	**315,420**	**12,979**	**336,145**
Net assets	**122,613**	**1,950**	**51,196**	**175,759**
Total liabilities and net assets	**$ 143,919**	**$ 318,075**	**$ 83,089**	**$ 545,083**
Total operating revenue	**$ 61,670**	**$ 36,445**	**$ 102,477**	**$ 200,592**
Total operating expenses	**(61,533)**	**(38,494)**	**(87,599)**	**(187,626)**
Total nonoperating gains (losses), net	**2,320**	**2,049**	**(80)**	**4,289**
Contributions from (to) owners	**–**	**–**	**(10,400)**	**(10,400)**
Other changes in net assets, net	**3,780**	**–**	**(288)**	**3,492**
Increase (decrease) in net assets	**$ 6,237**	**$ –**	**$ 4,110**	**$ 10,347**

(In Thousands)

(5) Investments in Joint Ventures (continued)

	2019			
	Mt. Washington	**Terrapin**	**Others**	**Total**
Current assets	$ 31,609	$ 52,058	$ 35,045	$ 118,709
Noncurrent assets	104,354	242,783	50,079	397,216
Total assets	$ 135,963	$ 294,841	$ 85,121	$ 515,925
Current liabilities	$ 14,565	$ 4,878	$ 18,850	$ 38,293
Noncurrent liabilities	6,452	288,013	11,526	305,991
Net assets	114,946	1,950	54,745	171,641
Total liabilities and net assets	$ 135,963	$ 294,841	$ 85,121	$ 515,925
Total operating revenue	$ 64,668	$ 44,898	$ 105,786	$ 215,352
Total operating expenses	(61,835)	(49,435)	(96,071)	(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	–	–	2,469	2,469
Increase (decrease) in net assets	$ 7,976	$ (1)	$ 4,105	$ 12,080

(6) Leases

The Corporation determines if an arrangement is a lease at inception. Operating leases are included in other assets, other current liabilities, and other long-term liabilities on the consolidated balance sheet. Finance leases are included in property, plant and equipment, other current liabilities, and other long-term liabilities on the accompanying consolidated balance sheet.

(6) Leases (continued)

The Corporation's leases primarily consist of real estate leases for medical and administrative office buildings and the Corporation determines if an arrangement is a lease at inception of the contract. Operating leases are included in other assets, other current liabilities, and other long-term liabilities on the consolidated balance sheet. Finance leases are included in property, plant and equipment, other current liabilities, and other long-term liabilities on the accompanying consolidated balance sheet.

Lease liabilities are recognized based on the present value, net of the future minimum lease payments over the lease term using the Corporation's incremental borrowing rate based on the information available at commencement. The ROU asset is derived from the lease liability and also includes any lease payments made and excludes lease incentives and initial direct costs incurred. Certain lease agreements for real estate include payments based on actual common area maintenance expenses and others include rental payments adjusted periodically for inflation. These variable lease payments are recognized in other operating expenses, net, but are not included in the right-of-use asset or liability balances. Lease agreements may include one or more renewal options which are at the Corporation's sole discretion. The Corporation does not consider the renewal options to be reasonably likely to be exercised, therefore they are not included in ROU assets and lease liabilities. Lease expense for minimum lease payments is recognized on a straight-line basis over the lease term for operating leases.

In accordance with ASC 842, the Corporation has elected to not recognize ROU assets and lease liabilities for short-term leases with a lease term of 12 months or less. The Corporation recognizes the lease payments associated with its short-term leases as an expense on a straight-line basis over the lease term. Variable lease payments associated with these leases are recognized and presented in the same manner as all other leases.

(In Thousands)

(6) Leases (continued)

The following table summarizes the components of operating and finance lease assets and liabilities classified as current and noncurrent on the accompanying consolidated balance sheet as of June 30, 2020:

Operating leases	**Balance sheet classification**		
Operating lease ROU asset	Other assets	$	92,333
Operating lease obligation – current	Other current liabilities		(12,724)
Operating lease obligation- long-term	Other long-term liabilities		(81,951)
Finance leases			
Finance lease ROU asset	Property and equipment, net	$	47,598
Current finance lease liabilities	Other current liabilities		(760)
Long-term finance lease liabilities	Other long-term liabilities		(55,310)

The components of lease expense for the year ended June 30, 2020, were as follows:

Finance lease expense:		
Amortization of ROU assets	$	1,518
Interest on lease liabilities		1,992
Total finance lease expense		3,510
Operating lease expense		16,159
Short-term/variable lease expense		12,848
Total lease expense	$	32,517

(In Thousands)

(6) Leases (continued)

Commitments related to noncancelable operating and finance leases for each of the next five years and thereafter as of June 30, 2020, are as follows:

	Operating	Finance
2021	$ 15,896	$ 2,833
2022	14,425	2,866
2023	12,496	2,900
2024	11,959	2,936
2025	10,621	2,973
Thereafter	49,504	61,586
Total	114,901	76,094
Less: Present value discount	(20,226)	(20,024)
Lease liabilities	$ 94,675	$ 56,070

Other information for the year ended June 30, 2020 is as follows:

Weighted average remaining lease terms (in years):	
Finance leases	11.17
Operating leases	10.25
Weighted average discount rate:	
Finance leases	3.72%
Operating leases	3.58%

Because the Corporation elected to use the modified retrospective transition approach, the Corporation is required to include the disclosures required prior the adoption of ASU 2016-02 for 2019.

(In Thousands)

(6) Leases (continued)

The following is a summary of all property and equipment under capital leases at June 30, 2019:

Land	$	3,770
Buildings		29,230
Equipment		28,571
		61,571
Less accumulated amortization		(26,261)
	$	35,310

Rent expense under operating leases for the year ended June 30, 2019 amounted to $35,912.

The 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. As of June 30, 2019, the lease was recorded as a capital lease and recorded $38,093. The lease includes an option for the Corporation to purchase the property. Management exercised the option on October 21, 2019 to purchase the property for $40,000 in January 2031. The Corporation accounted for the option to purchase the underlying asset as a lease modification as a part of the existing contract and remeasured the finance lease liability and corresponding finance asset.

(In Thousands)

(6) Leases (continued)

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	$	2,811
2021		1,862
2022		1,145
2023		891
2024		891
Thereafter		52,083
Total minimum lease payments		59,683
Less amounts representing interest		(7,156)
Present value of net minimum lease payments	$	52,527

(7) Line of Credit

For the fiscal years ended June 30, 2020 and 2019, 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 25, 2021. Interest is calculated based on an optional base rate or percentage of 1-month LIBOR plus a credit spread. As of June 30, 2020 and 2019, the amount outstanding on the line of credit was $193,500 and $161,300, respectively. The calculated interest rates as of June 30, 2020 and 2019 was a range from 0.89% to 3.25%.

For the fiscal year ended June 30, 2020, the Corporation had $225,000 in additional lines of credit consisting of separate agreements with three banking partners. The borrowing facilities were put in place to provide additional access to liquidity in the event it would be needed during the COVID-19 pandemic, and each of the facilities expires no later than May 2021. All three borrowing facilities call for interest to be calculated on the drawn amount based on a percentage of one-month LIBOR, subject to a percentage floor, plus a credit spread. As of June 30, 2020, there were $0 outstanding on these lines of credit, and the calculated interest rate on that date would have been within a range of 1.69% to 2.25% across the three facilities.

(In Thousands)

(8) Long-Term Debt and Other Borrowings

Long-term debt consists of the following:

	Interest Rate	Payable in Fiscal Year(s)	June 30 2020	2019
MHHEFA project revenue bonds:				
Corporation issue, payments due annually UCHS Term Loan:				
Series 2017D/E Bonds	4.00%–4.17%	2045–2049	**$ 189,965**	$ 189,965
Series 2017B/C Bonds	2.23%–5.00%	2018–2040	**256,455**	260,835
Series 2017A Bonds	Variable rate	2017–2043[(1)]	**42,840**	44,010
Series 2016A–F Bonds	Variable rate	2017–2042[(1)]	**309,500**	314,270
Series 2015 Bonds	3.63%–5.00%	2016–2042	**73,630**	75,060
Series 2013 Bonds	4.00%–5.00%	2014–2044	**335,545**	339,465
Series 2010 Bonds	4.75%–5.25%	2011–2032	**41,510**	50,210
Series 2008D/E Bonds	Variable rate	2025–2042	**105,000**	105,000
Series 2008F Bonds	4.50%–5.25%	2009–2024	**20,630**	27,555
Series 2007A Bonds	Variable rate	2008–2035	**76,425**	79,440
MHHEFA Pooled Loan Program	Variable rate	2017–2035	**16,149**	17,099
Other long-term debt:				
UCHS Term Loan	Variable rate	2021	**150,000**	150,000
Term loans	1.86%–4.44%	2009–2022	**7,356**	9,377
Other loans, mortgages and notes payable	3.25%–6.73%	Monthly, 1991–2025	**12,678**	17,893
Total debt			**1,637,683**	1,680,179
Less current portion of long-term debt			**40,468**	47,621
Less short-term financing			**150,000**	150,000
Less long-term debt subject to short-term remarketing agreements			**28,794**	18,895
			1,418,421	1,463,663
Plus unamortized premiums and discounts, net			**28,713**	30,762
Plus unamortized deferred financing costs			**(8,877)**	(9,465)
			$ 1,438,257	$ 1,484,960

[(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).

(8) Long-Term Debt and Other Borrowings (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 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 3).

The Corporation has a term loan in the amount of $150,000 related to the acquisition of Upper Chesapeake, which expires on March 1, 2021. The Corporation intends to obtain long term financing prior to its maturity date, and has classified this obligation as a short-term financing at June 30, 2020 and 2019, in the consolidated balance sheets. See further discussion in Subsequent Events (Note 21).

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.

(In Thousands)

(8) Long-Term Debt and Other Borrowings (continued)

The aggregate annual future maturities of long-term debt according to the original terms of the Master Loan Agreement and all other loan agreements are as follows for the years ending June 30:

2021	$ 219,262
2022	260,771
2023	71,073
2024	196,073
2025	39,036
Thereafter	851,468
	$ 1,637,683

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, 2020 and 2019.

(In Thousands)

(8) Long-Term Debt and Other Borrowings (continued)

The approximate interest rates on outstanding debt bearing interest at variable rates were as follows:

	June 30	
	2020	**2019**
Series 2008D Bonds	**0.11%**	1.92%
Series 2008E Bonds	**0.12**	1.85
Series 2007A Bonds	**0.09**	1.85
Series 2016A Bonds	**1.13**	2.74
Series 2016B Bonds	**1.01**	2.62
Series 2016C Bonds	**0.75**	2.54
Series 2016D Bonds	**0.98**	2.63
Series 2016E Bonds	**0.87**	2.66
Series 2016F Bonds	**0.84**	2.63
Series 2017A Bonds	**0.67**	2.46
Series 1985 Pooled Loan Program (MHHEFA)	**1.00**	2.40
UCHS Term Loan	**0.89**	3.10

(9) 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.

(In Thousands)

(9) Interest Rate Risk Management (continued)

At June 30, 2020 and 2019, the Corporation's notional values of outstanding interest rate swaps were $735,015 and $746,348, respectively, the details of which were as follows:

	Notional Amount	Pay Rate	Receive Rate	Maturity Date	Mark to Market
June 30, 2020					
Swap #1	**$ 79,800**	3.59%	70% 1-month LIBOR	7/1/2031	**$ (15,036)**
Swap #2	**84,000**	3.93	68% 1-month LIBOR	7/1/2041	**(45,040)**
Swap #3	**21,000**	4.24	68% 1-month LIBOR	7/1/2041	**(12,364)**
Swap #4	**32,025**	3.99	67% 1-month LIBOR	7/1/2034	**(8,987)**
Swap #5	**24,770**	3.54	70% 1-month LIBOR	7/1/2031	**(4,606)**
Swap #6	**196,000**	3.93	68% 1-month LIBOR	7/1/2041	**(105,113)**
Swap #7	**49,000**	4.24	68% 1-month LIBOR	7/1/2041	**(28,855)**
Swap #8	**74,700**	4.00	67% 1-month LIBOR	7/1/2034	**(21,020)**
Swap #9	**2,465**	3.63	67% 1-month LIBOR	7/1/2032	**(307)**
Swap #10	**95,475**	3.92	67% 1-month LIBOR	1/1/2043	**(38,240)**
Swap #11	**75,780**	0.51	67% 1-month LIBOR + 0.5133%	1/1/2038	**2,351**
	735,015				**(277,217)**
Valuation adjustments	**–**				**6,787**
Total	**$ 735,015**				**$ (270,430)**
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
	746,348				(199,070)
Valuation adjustments	–				2,896
Total	$ 746,348				$ (196,174)

(9) Interest Rate Risk Management (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.

The Corporation recorded a net nonoperating loss on changes in the fair value of nonqualifying interest rate swaps of $75,811 and $47,995 for the years ended June 30, 2020 and 2019, respectively.

The swap agreements are included in the consolidated balance sheets at their fair value of $270,430 and $196,174 as of June 30, 2020 and 2019, 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 $165,848 and $109,934 at June 30, 2020 and 2019, respectively. As of June 30, 2020 and 2019, the Corporation met its collateral posting requirement through the use of collateralized investments and cash equivalents, 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.

(In Thousands)

(10) Other Liabilities

Other liabilities consist of the following:

	June 30 2020	2019
Professional and general malpractice liabilities	**$ 351,441**	$ 313,136
Accrued pension obligations	**130,903**	108,533
Lease obligations – Operating	**94,675**	–
Lease obligations – Finance (capital in prior year)	**56,070**	52,527
Deferred payroll taxes	**26,971**	–
Accrued interest payable	**22,200**	21,922
Other miscellaneous	**100,941**	70,666
Total other liabilities	**783,201**	566,784
Less current portion	**(129,813)**	(127,760)
Other long-term liabilities	**$ 653,388**	$ 439,024

Other miscellaneous liabilities consist of patient credit balances, unearned revenue and other current and long-term liabilities.

(11) 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

(11) Retirement Plans (continued)

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.

On June 30, 2015, the Corporation amended the Baltimore Washington Medical Center Pension Plan to provide for the merger of the Midtown Plan and the Charles Regional Plan into the Baltimore Washington Plan and to change the name of the newly consolidated plan to the University of Maryland Medical System Corporate Pension Plan (the Corporate Plan). All provisions of the respective previous plans shall continue to apply to the respective applicable participants. All of the assets of the three formerly separate plans are now available to pay benefits for all participants under the newly consolidated Corporate Plan.

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 one thousand hours per year during three or more plan years. Plan benefits are accumulated based upon a combination of years of service and percent of annual compensation. Charles Regional makes annual contributions to the plan based upon amounts required to be funded under provisions of ERISA.

(11) Retirement Plans (continued)

Upper Chesapeake Health System, Inc. Pension Plan and Trust – A noncontributory defined benefit pension plan covering substantially all employees of the various affiliates of Upper Chesapeake who have completed six months of employment and attained the age of twenty and a half years. Upper Chesapeake makes annual contributions to the plan equal to the minimum funding requirements pursuant to ERISA regulations. On December 31, 2005, Upper Chesapeake froze the defined benefit pension plan. On June 30, 2015, Upper Chesapeake terminated the defined benefit pension plan and liquidation of its remaining benefit obligation using its plan assets 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 non-salaried 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.

(In Thousands)

(11) Retirement Plans (continued)

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:

	June 30	
	2020	**2019**
Change in projected benefit obligations:		
Benefit obligations at beginning of year	**$ 425,709**	$ 431,340
Settlements	**–**	(37,686)
Service cost	**3,337**	3,093
Interest cost	**15,299**	17,812
Actuarial loss	**30,743**	30,783
Benefit payments	**(26,091)**	(19,633)
Projected benefit obligations at end of year	**$ 448,997**	$ 425,709
Change in plan assets:		
Fair value of plan assets at beginning of year	**$ 317,176**	$ 340,130
Actual return on plan assets	**9,529**	16,354
Settlements	**–**	(38,544)
Employer contributions	**17,480**	18,869
Benefit payments	**(26,091)**	(19,633)
Fair value of plan assets at end of year	**$ 318,094**	$ 317,176

(In Thousands)

(11) Retirement Plans (continued)

The funded status of the plans and amounts recognized as accrued payroll and benefits and other long-term liabilities in the accompanying consolidated balance sheets are as follows:

	June 30	
	2020	**2019**
Funded status, end of period:		
Fair value of plan assets	**$ 318,094**	$ 317,176
Projected benefit obligations	**448,997**	425,709
Net funded status	**(130,903)**	(108,533)
Accumulated benefit obligation at end of year	**446,100**	423,017
Amounts recognized in consolidated balance sheets at June 30:		
Accrued pension obligation	**(130,903)**	(108,533)
	(130,903)	(108,533)
Amounts recognized in net assets without donor restrictions at June 30:		
Net actuarial gain (loss)	**(108,221)**	(71,177)
Prior service cost	**(86)**	(159)
	$ (108,307)	$ (71,336)

The accrued pension obligation includes $98,365 and $82,694 as of June 30, 2020 and 2019, respectively, related to the Capital Region Pension Plan described above.

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	$ 7,829
Prior service cost	72
	$ 7,901

(In Thousands)

(11) Retirement Plans (continued)

The components of net periodic pension cost are as follows:

	Year Ended June 30	
	2020	**2019**
Service cost	**$ 3,337**	$ 3,093
Interest cost	**15,299**	17,812
Expected return on plan assets	**(19,782)**	(19,849)
Prior service cost recognized	**72**	76
Recognized gains or losses	**3,953**	8,173
Net periodic pension cost	**$ 2,879**	$ 9,305

Components of net benefit cost other than the service cost of $3,337 in 2020 and $3,093 in 2019 were recorded in other nonoperating losses, net in the accompanying consolidated statement of operations and changes in net assets for the years ended June 30, 2020 and 2019. 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.

The following table presents the weighted average assumptions used to determine benefit obligations for the plans:

	June 30	
	2020	**2019**
Discount rate	**2.34–%3.03%**	3.25%–3.70%
Rate of compensation increase (for nonfrozen plan)	**3.00**	3.00

(In Thousands)

(11) Retirement Plans (continued)

The following table presents the weighted average assumptions used to determine net periodic benefit cost for the plans:

	Year Ended June 30	
	2020	**2019**
Discount rate	**3.25%–3.70%**	4.22%–4.69%
Expected long-term return on plan assets	**6.00–6.50**	6.25–6.50
Rate of compensation increase (for nonfrozen plan)	**3.00**	3.00

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, 2020 and 2019, by asset category, are as follows:

		Percentage of Plan Assets as of June 30	
Asset Category	**Target Allocation**	**2020**	**2019**
Cash and cash equivalents	0–10%	**8%**	4%
Fixed income securities	20–40	**29**	28
Equity securities	30–50	**38**	41
Global assets allocation	10–20	**16**	17
Hedge funds	5–15	**9**	10
		100%	100%

(In Thousands)

(11) Retirement Plans (continued)

Equity and fixed income securities include investments in hedge fund of funds that are categorized in accordance with each fund's respective investment holdings.

The table below presents the Corporation's combined investable assets of the defined benefit pension plans aggregated by the fair value hierarchy as described in Note 1(u):

	Level 1	Level 2	Level 3	Investments Reported at NAV*	Total
June 30, 2020					
Cash and cash equivalents	**$ 13,728**	**$ 11,120**	**$ –**	**$ –**	**$ 24,848**
Corporate obligations	**–**	**21,447**	**–**	**–**	**21,447**
Government and agency bonds	**7,565**	**9,993**	**–**	**–**	**17,558**
Fixed income funds	**–**	**–**	**–**	**12,639**	**12,639**
Common and preferred stocks	**25,047**	**–**	**–**	**–**	**25,047**
Equity mutual funds	**36,973**	**12,749**	**–**	**10,084**	**59,806**
Other mutual funds	**22,405**	**–**	**–**	**–**	**22,405**
Alternative investments	**–**	**–**	**–**	**134,344**	**134,344**
	$ 105,718	**$ 55,309**	**$ –**	**$ 157,067**	**$ 318,094**
June 30, 2019					
Cash and cash equivalents	$ 7,324	$ 4,589	$ –	$ –	$ 11,913
Corporate obligations	–	19,531	–	–	19,531
Government and agency bonds	16,509	–	–	–	16,509
Fixed income 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	–	–	–	147,642	147,642
	$ 130,318	$ 39,216	$ –	$ 147,642	$ 317,176

*Fund investments reported at NAV as practical expedient.

(In Thousands)

(11) Retirement Plans (continued)

Alternative investments include hedge funds and commingled investment funds. The majority of these alternative investments held as of June 30, 2020 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 $30,000, which are subject to notice requirements of 30-60 days and are available to be redeemed on a monthly or quarterly basis. Funds totaling $13,000 are subject to notice requirements of 90 days and can be redeemed monthly or quarterly. Of these funds, one fund totaling $1,900 is subject to a lock-up restriction of three years. The Corporation had no unfunded commitments as of June 30, 2020.

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.

The Corporation expects to contribute $18,820 to its defined benefit pension plans for the fiscal year ended June 30, 2021.

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:

2021	$ 24,353
2022	24,555
2023	25,262
2024	25,758
2025	25,386
2026–2030	124,468

(In Thousands)

(11) Retirement Plans (continued)

The expected benefits to be paid are based on the same assumptions used to measure the Corporation's benefit obligation at June 30, 2020.

(b) Defined Contribution Plans

The Corporation offers a number of defined contribution benefits through 403(b) and 401(k) programs that were established by its affiliate hospitals. These plans allow for deferral of compensation or employer matching of compensation subject to vesting requirements.

Total annual retirement costs incurred by the Corporation for the previously discussed defined contribution plans were $50,456 and $48,972 for the years ended June 30, 2020 and 2019, respectively. Such amounts are included in salaries, wages and benefits in the accompanying consolidated statements of operations.

(12) Net Assets with Donor Restrictions

Net assets are restricted primarily for the following purposes:

	June 30	
	2020	**2019**
Facility construction and renovations, research, education, and other:		
Capital Region	**$ 424,034**	$ 424,034
All others	**161,110**	142,084
Economic and beneficial interests in the net assets of related organizations	**170,820**	198,101
	$ 755,964	$ 764,219

(In Thousands)

(12) Net Assets with Donor Restrictions (continued)

Net assets were released from donor restrictions by expending funds satisfying the restricted purposes or by occurrence of other events specified by donors as follows:

	Year Ended June 30	
	2020	**2019**
Purchases of equipment and construction costs	**$ 18,791**	$ 14,130
Research, education, uncompensated care, and other	**6,307**	4,279
	$ 25,098	$ 18,409

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

2. The purposes of the Corporation and the donor-restricted endowment fund

3. General economic conditions

(In Thousands)

(12) Net Assets with Donor Restrictions (continued)

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:

	Without Donor Restrictions	With Donor Restrictions	Total
June 30, 2020			
Donor-restricted endowment funds	**$ 43**	**$ 67,165**	**$ 67,208**
June 30, 2019			
Donor-restricted endowment funds	$ 39	$ 65,433	$ 65,472

Donor restricted endowment funds within net assets with donor restrictions whose use is restricted in perpetuity were $50,243 and $48,826 as of June 30, 2020 and 2019, respectively.

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.

(12) Net Assets with Donor Restrictions (continued)

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.

(13) 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.

(In Thousands)

(13) Economic and Beneficial Interests in the Net Assets of Related Organizations (continued)

The following is a summary of economic and beneficial interests in the net assets of financially interrelated organizations:

	June 30	
	2020	**2019**
Economic interests in:		
UCH Legacy Funding Corporation	**$ 122,430**	$ 150,000
The James Lawrence Kernan Hospital Endowment Fund, Incorporated	**34,766**	33,099
Baltimore Washington Medical Center Foundation, Inc.	**9,213**	10,337
Total economic interests	**166,409**	193,436
Beneficial interest in the net assets of:		
Dorchester General Hospital Foundation, Inc.	**3,082**	3,709
Prince George's Hospital Center Foundation, Inc.	**1,267**	894
Laurel Regional Hospital Auxiliary, Inc.	**62**	62
	$ 170,820	$ 198,101

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.

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.

(In Thousands)

(13) Economic and Beneficial Interests in the Net Assets of Related Organizations (continued)

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 is as follows:

	June 30	
	2020	**2019**
Current assets	**$ 4,086**	$ 4,447
Noncurrent assets	**166,835**	193,756
Total assets	**$ 170,921**	$ 198,203
Current liabilities	**$ 101**	$ 102
Net assets	**170,820**	198,101
Total liabilities and net assets	**$ 170,921**	$ 198,203
Total operating revenue	**$ 1,897**	$ 4,481
Total operating expense	**(1,380)**	(2,505)
Other changes in net assets	**(27,800)**	5
Total (decrease) increase in net assets	**$ (27,283)**	$ 1,981

(In Thousands)

(14) State and County Support

The Corporation received $3,400 and $3,300 in support for the Shock Trauma Center operations from the state of Maryland for the years ended June 30, 2020 and 2019, respectively.

In support of Capital Region operations, the Corporation received the following:

	Year Ended June 30	
	2020	**2019**
State of Maryland	**$ 15,000**	$ 27,000
Prince George's County government	**295**	10,178
Magruder Memorial Hospital Trust	**1,042**	1,042
	$ 16,337	$ 38,220

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 $20,803 and $5,565 during the years ended June 30, 2020 and 2019, respectively.

(In Thousands)

(15) 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:

	Healthcare Service				Corporate Services,	
	Hospital & Ambulatory	Retail Pharmacy	Physician Practices	Risk Taking	Other and Eliminations	Total
Year ended June 30, 2020						
Operating expenses:						
Salaries, wages and benefits	**$ 1,682,480**	**$ 5,928**	**$ 272,804**	**$ 4,887**	**$ 264,385**	**$ 2,230,484**
Expendable supplies	**626,029**	**90,169**	**34,401**	**16**	**9,498**	**760,113**
Purchased services:						
Purchased services	**884,976**	**14,488**	**70,665**	**2,978**	**(277,079)**	**696,028**
Contracted services	**291,951**	**–**	**28,243**	**–**	**(43,235)**	**276,959**
Depreciation and amortization	**236,360**	**–**	**2,022**	**–**	**(2,491)**	**235,891**
Interest expense	**47,426**	**–**	**–**	**696**	**(1,561)**	**46,561**
Total operating expenses	**$ 3,769,222**	**$ 110,585**	**$ 408,135**	**$ 8,577**	**$ (50,483)**	**$ 4,246,036**
Year ended June 30, 2019						
Operating expenses:						
Salaries, wages and benefits	$ 1,646,025	$ 5,177	$ 268,023	$ 3,886	$ 235,025	$ 2,158,136
Expendable supplies	678,620	71,514	34,480	42	7,359	792,015
Purchased services:						
Purchased services	826,688	9,150	65,400	4,480	(271,100)	634,618
Contracted services	274,221	–	30,169	–	(34,493)	269,897
Depreciation and amortization	232,436	–	2,484	–	9,136	244,056
Interest expense	54,698	–	–	1,492	1,602	57,792
Total operating expenses	$ 3,712,688	$ 85,841	$ 400,556	$ 9,900	$ (52,471)	$ 4,156,514

Corporate services are allocated primarily using percentage of net patient service revenue.

(In Thousands)

(16) 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, 2020 and 2019, as follows:

	2020	2019
Cash and cash equivalents	**$ 961,647**	$ 360,318
Receivables, net	**590,579**	549,540
Current investments and assets whose use is limited	**64,026**	64,910
Long-term investments and assets whose use is limited	**2,041,352**	2,113,024
Total financial assets available within one year	**3,657,604**	3,087,792
Less:		
Amounts unavailable for general expenditures within one year due to:		
Restricted by donors with purpose restrictions	**91,975**	78,255
Restricted for swap collateral	**166,507**	113,586
Debt service and reserve funds	**37,696**	86,157
Self-insurance trust funds	**215,162**	212,384
Construction funds – held by trustee	**204,366**	279,205
Economic and beneficial interests in the net assets of related organizations	**170,820**	198,101
Alternative investments subject to lockup restrictions	**19,900**	20,700
Total amounts unavailable for general expenditures within one year	**906,426**	988,388
Total financial assets available to management for general expenditure within one year	**$ 2,751,178**	$ 2,099,404

(In Thousands)

(17) Insurance

The Corporation maintains self-insurance programs for professional and general liability risks, employee health, employee long-term disability, and workers' compensation. The accrued liabilities for these programs were as follows:

	June 30 2020	2019
Professional and general malpractice liabilities	**$ 351,441**	$ 313,136
Employee health	**27,201**	33,556
Employee long-term disability	**4,751**	5,577
Workers' compensation	**23,430**	20,977
Total self-insured liabilities	**406,823**	373,246
Less current portion	**(64,550)**	(70,368)
	$ 342,273	$ 302,878

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 $243,143 and $202,779 as of June 30, 2020 and 2019, 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 $155,000 individually and $160,000 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 5, 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, 2020 and 2019 was approximately $69,374 and $60,654, respectively.

(In Thousands)

(18) 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, 2020:

Medicare	27%
Medicaid	32
Commercial insurance and HMOs	20
Blue Cross	14
Self-pay and others	7
	100%

The Corporation recorded net patient service revenues from patients and third-party payors as follows:

	Year Ended June 30	
	2020	**2019**
Medicare	**37%**	37%
Medicaid	**24**	24
Commercial insurance and HMOs	**24**	24
Blue Cross	**10**	10
Self-pay and others	**5**	5
	100%	100%

(19) Certain Significant Risks and Uncertainties

The Corporation provides general acute healthcare services in the state of Maryland. The Corporation and other healthcare providers in Maryland are subject to certain inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the federal Medicare and state Medicaid programs;
- Regulation of hospital rates by the State of Maryland Health Services Cost Review Commission;
- Government regulation, government budgetary constraints, and proposed legislative and regulatory changes; and
- Lawsuits alleging malpractice and related claims.

Such inherent risks require the use of certain management estimates in the preparation of the Corporation's consolidated financial statements, and it is reasonably possible that a change in such estimates may occur.

The Medicare and state Medicaid reimbursement programs represent a substantial portion of the Corporation's revenues, and the Corporation's operations are subject to a variety of other federal, state, and local regulatory requirements. Failure to maintain required regulatory approvals and licenses and/or changes in such regulatory requirements could have a significant adverse effect on the Corporation.

Changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Corporation.

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. The Corporation's compliance with these laws and regulations can be subject to periodic governmental review and interpretation, which can result in regulatory action unknown or unasserted at this time. Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the ordinary course of business, none of which, in the opinion of management, are expected to result in losses in excess of insurance limits or have a materially adverse effect on the Corporation's financial position.

(19) Certain Significant Risks and Uncertainties (continued)

The federal government and many states have aggressively increased enforcement under Medicare and Medicaid antifraud and abuse laws and physician self-referral laws (STARK law and regulation). Recent federal initiatives have prompted a national review of federally funded healthcare programs. In addition, the federal government and many states have implemented programs to audit and recover potential overpayments to providers from the Medicare and Medicaid programs. The Corporation has implemented a compliance program to monitor conformance with applicable laws and regulations, but the possibility of future government review and enforcement action exists.

(20) 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, 2020 and 2019. 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

(20) Maryland Health Services Cost Review Commission (continued)

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.

(21) Subsequent Events

The Corporation evaluated all events and transactions that occurred after June 30, 2020 and through October 28, 2020, the date the consolidated financial statements were issued. Other than described below, the Corporation did not have any material subsequent events during the period.

During the month of July 2020, the Corporation issued $752.7 million in debt in the form of Maryland Health and Higher Educational Facilities Authority (MHHEFA) Revenue Bonds – Series 2020B/D. The proceeds were used to advance refund $13,500 of UMMS' Series 2008F Revenue Bonds, $31,500 of UMMS Series 2010 Revenue Bonds, and $218,200 of UMMS Series 2013A Revenue Bonds. In addition, $150,000 of the proceeds were used to refund a term loan. The remaining proceeds of $339,500 will be used for various capital projects.

During the month of July and August 2020, the Corporation received additional CARES Act Relief Funds of approximately $109,000 and $8,800 respectively. These funds were not recognized as Other Revenue for the year ended June 30, 2020.

On October 1, 2020, a new law was signed that included modifications to the CMS Accelerated and Advance Payment Program. These modifications included an extension to the previous terms discussed within Note 2. The changes in payments terms are considered a non-recognized subsequent event in accordance with ASC 855.

On October 22, 2020, HHS released additional reporting requirements for health care entities that received distributions from the Provider Relief Fund. The Post-Payment Notice of Reporting Requirements (the Notice) supplements the previous notice issued on July 20, 2020, and amended on August 14, 2020 and September 19, 2020. The Corporation considered the effects of the changes included in the Notice and concluded these changes represent non-recognized (i.e., Type II) subsequent events in accordance with ASC 855, *Subsequent Events*, since the reporting requirements included in the Notice provide evidence about conditions that did not exist at the balance sheet date but instead are conditions that arose after that date but before financial

(21) Subsequent Events (continued)

statements were issued. The Corporation will continue to monitor changes in reporting guidance or additional clarifications that may be issued by HHS which would affect the accounting for distributions from the Provider Relief Fund.

The Corporation completed the sale of both University of Maryland Health Partners, Inc. which provides managed care services to approximately 48,000 Medicaid recipients and University of Maryland Health Advantage, Inc. which provides Medicare Advantage coverage to approximately 6,000 members. The transaction with CareFirst BlueCross Blue Shield was effective on October 10, 2020 after receiving regulatory approval.

Supplementary Information

University of Maryland Medical System Corporation and Subsidiaries

Consolidating Balance Sheet by Division
(In Thousands)

June 30, 2020

	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
Assets														
Current assets:														
Cash and cash equivalents	$ 424,073	$ 20,648	$ 29,901	$ 94,354	$ 128,115	$ 30,239	$ 80,367	$ 84,476	$ 65,795	$ –	$ –	$ 3,679	$ –	$ 961,647
Assets limited as to use, current portion	64,026	–	–	–	–	–	–	–	–	–	–	–	–	64,026
Accounts receivable:														
Patient accounts receivable, net	192,658	6,724	28,721	40,186	27,437	14,231	37,372	46,145	84,059	–	–	1,256	(6,438)	472,351
Other	236,452	781	4,397	3,467	3,190	3,742	9,353	–	14,175	–	–	3,722	(161,051)	118,228
Inventories	65,629	1,334	2,796	7,962	4,411	2,017	5,269	10,028	6,249	–	–	184	–	105,879
Assets held for sale	–	–	–	–	–	–	–	–	–	149,563	–	–	–	149,563
Prepaid expenses and other current assets	36,415	118	2,196	2,756	1,672	700	1,079	11,007	2,632	–	1,500	103	–	60,178
Total current assets	1,019,253	29,605	68,011	148,725	164,825	50,929	133,440	151,656	172,910	149,563	1,500	8,944	(167,489)	1,931,872
Investments	281,835	40,057	17,467	156,201	125,756	24,554	12,997	268,499	–	–	–	–	–	927,366
Assets limited as to use, less current portion:														
Investments held for collateral	147,585	1,122	1,732	8,987	4,341	2,740	–	–	–	–	–	–	–	166,507
Debt service funds	10,839	–	–	–	–	–	–	–	–	–	–	–	–	10,839
Construction funds	245,617	19,573	21,629	13,745	24,242	20,977	5,317	–	–	–	–	–	–	351,100
Board designated and escrow funds	–	–	–	–	32,750	–	–	61,072	–	–	22,990	–	–	116,812
Self-insurance trust funds	172,387	–	–	–	3,645	–	–	–	29,901	–	–	–	–	205,933
Funds restricted by donor	–	–	1,093	–	39,851	–	11,980	–	–	–	39,051	–	–	91,975
Economic and beneficial interests in the net assets of related organizations	199,091	38,714	534	9,213	3,091	–	9,503	–	1,330	–	–	–	(90,656)	170,820
	775,519	59,409	24,988	31,945	107,920	23,717	26,800	61,072	31,231	–	62,041	–	(90,656)	1,113,986
Property and equipment, net	1,277,684	44,177	114,815	262,157	140,792	105,648	240,667	286,176	79,852	–	–	4,580	–	2,556,548
Investments in joint ventures and other assets	1,057,830	15,178	1,628	3,903	41,652	7,249	34,814	184,023	13,247	4,717	17,762	7,468	(779,332)	610,139
Total assets	$ 4,412,121	$ 188,426	$ 226,909	$ 602,931	$ 580,945	$ 212,097	$ 448,718	$ 951,426	$ 297,240	$ 154,280	$ 81,303	$ 20,992	$ (1,037,477)	$ 7,139,911

University of Maryland Medical System Corporation and Subsidiaries

Consolidating Balance Sheet by Division (continued)
(In Thousands)

June 30, 2020

	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
Liabilities and net assets														
Current liabilities:														
Trade accounts payable	$ 148,597	$ 9,911	$ 15,541	$ 24,236	$ 16,931	$ 7,841	$ 24,691	$ 24,531	$ 25,511	$ 221	$ 150	$ 3,972	$ –	$ 302,133
Accrued payroll and benefits	131,027	4,976	9,476	28,896	21,958	7,606	23,769	31,161	22,265	–	–	1,276	–	282,410
Advances from third-party payors	293,947	22,624	33,660	82,948	79,918	33,664	86,724	82,844	57,618	–	–	–	–	773,947
Lines of credit	167,000	–	–	–	–	–	–	–	–	26,500	–	–	–	193,500
Short-term financing	150,000	–	–	–	–	–	–	–	–	–	–	–	–	150,000
Other current liabilities	70,265	1,309	4,201	3,474	5,671	2,983	6,694	10,495	28,544	128,877	–	34,789	(167,489)	129,813
Liabilities held for sale	–	–	–	–	–	–	–	–	–	65,461	–	–	–	65,461
Long-term debt subject to short-term remarketing arrangements	28,794	–	–	–	–	–	–	–	–	–	–	–	–	28,794
Current portion of long-term debt	15,722	575	462	4,831	3,125	3,178	6,456	5,886	233	–	–	–	–	40,468
Total current liabilities	1,005,352	39,395	63,340	144,385	127,603	55,272	148,334	154,917	134,171	221,059	150	40,037	(167,489)	1,966,526
Long-term debt, less current portion	728,400	18,151	28,309	147,235	74,491	48,871	211,608	179,982	1,210	–	–	–	–	1,438,257
Other long-term liabilities	412,961	1,233	13,154	14,434	38,709	13,325	96,045	23,223	129,255	–	–	5,743	(94,694)	653,388
Interest rate swap liabilities	270,430	–	–	–	–	–	–	–	–	–	–	–	–	270,430
Total liabilities	2,417,143	58,779	104,803	306,054	240,803	117,468	455,987	358,122	264,636	221,059	150	45,780	(262,183)	4,328,601
Net assets:														
Without donor restrictions	1,417,413	90,800	75,756	287,664	294,349	94,629	(39,998)	461,490	(939)	(66,779)	28,704	(24,788)	(562,955)	2,055,346
With donor restrictions	577,565	38,847	46,350	9,213	45,793	–	32,729	131,814	33,543	–	52,449	–	(212,339)	755,964
Total net assets	1,994,978	129,647	122,106	296,877	340,142	94,629	(7,269)	593,304	32,604	(66,779)	81,153	(24,788)	(775,294)	2,811,310
Total liabilities and net assets	$ 4,412,121	$ 188,426	$ 226,909	$ 602,931	$ 580,945	$ 212,097	$ 448,718	$ 951,426	$ 297,240	$ 154,280	$ 81,303	$ 20,992	$ (1,037,477)	$ 7,139,911

University of Maryland Medical System Corporation and Subsidiaries

Consolidating Statement of Operations by Division
(In Thousands)

Year Ended June 30, 2020

	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
Operating revenue, gains and other support:														
Net patient service revenue	$ 1,586,077	$ 102,949	$ 189,026	$ 449,234	$ 329,956	$ 137,185	$ 388,187	$ 396,562	$ 333,731	$ –	$ –	$ 7,927	$ (4,903)	$ 3,915,931
State support	18,400	–	–	–	–	–	–	–	16,337	–	–	–	(15,000)	19,737
Premium revenue	181,674	–	–	–	–	–	–	–	–	–	–	–	(181,674)	–
CARES Act – Provider relief funds	50,000	8,991	18,063	26,669	23,875	7,239	23,495	25,863	15,272	–	–	165	–	199,632
Other revenue	563,699	1,740	23,878	6,731	4,281	2,129	5,993	10,268	13,422	–	–	11,294	(414,681)	228,754
Total operating revenue, gains and other support	2,399,850	113,680	230,967	482,634	358,112	146,553	417,675	432,693	378,762	–	–	19,386	(616,258)	4,364,054
Operating expenses:														
Salaries, wages and benefits	1,046,990	54,471	106,003	258,617	184,336	68,661	215,415	259,006	206,801	1,138	–	10,720	(181,674)	2,230,484
Expendable supplies	408,300	12,591	33,270	72,767	44,199	22,007	59,536	59,119	44,425	–	–	3,899	–	760,113
Purchased services	581,467	24,535	52,275	90,435	76,892	33,153	93,396	74,365	92,990	160	–	7,454	(431,094)	696,028
Contracted services	142,454	9,489	31,180	14,892	17,381	9,620	7,134	12,018	36,293	–	–	(12)	(3,490)	276,959
Depreciation and amortization	89,090	7,006	14,598	29,092	21,784	9,149	24,716	24,159	15,826	–	–	471	–	235,891
Interest expense	17,173	197	988	5,236	2,715	1,839	9,642	7,556	519	696	–	–	–	46,561
Total operating expenses before non-recurring items	2,285,474	108,289	238,314	471,039	347,307	144,429	409,839	436,223	396,854	1,994	–	22,532	(616,258)	4,246,036
Operating income (loss) from continuing operations	114,376	5,391	(7,347)	11,595	10,805	2,124	7,836	(3,530)	(18,092)	(1,994)	–	(3,146)	–	118,018
Nonoperating income and expenses, net:														
Contributions	3	–	–	–	123	–	136	493	–	–	8,538	–	–	9,293
Equity in net income of joint ventures	(115)	–	–	–	243	509	1,909	500	490	–	–	–	–	3,536
Investment income	9,623	696	324	2,689	2,583	412	526	5,006	2,033	–	743	–	–	24,635
Change in fair value of investments	(3,526)	(218)	(94)	(847)	1,473	(121)	54	(1,411)	–	–	(194)	–	–	(4,884)
Change in fair value of undesignated interest rate swaps	(75,811)	–	–	–	–	–	–	–	–	–	–	–	–	(75,811)
Other nonoperating gains and losses	(9,678)	(277)	(1,213)	(2,696)	(1,686)	(944)	(4,390)	(2,618)	1,738	–	(2,612)	–	–	(24,376)
Total nonoperating income and expenses	(79,504)	201	(983)	(854)	2,736	(144)	(1,765)	1,970	4,261	–	6,475	–	–	(67,607)
Excess (deficiency) of revenues over expenses	34,872	5,592	(8,330)	10,741	13,541	1,980	6,071	(1,560)	(13,831)	(1,994)	6,475	(3,146)	–	50,411
Gain on discontinued operations	–	–	–	–	–	–	–	–	–	19,599	–	–	–	19,599
Excess (deficiency) of revenues over expenses	$ 34,872	$ 5,592	$ (8,330)	$ 10,741	$ 13,541	$ 1,980	$ 6,071	$ (1,560)	$ (13,831)	$ 17,605	$ 6,475	$ (3,146)	$ –	$ 70,010

University of Maryland Medical System Corporation and Subsidiaries

Combining Balance Sheet – Obligated Group
(In Thousands)

June 30, 2020

	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***	University of Maryland Capital Region Health****	UMMS Foundation	Eliminations	Obligated Group Total
Assets													
Current assets:													
Cash and cash equivalents	$ 417,192	$ 20,648	$ 29,782	$ 95,273	$ 87,351	$ 39,848	$ 28,779	$ 72,218	$ 81,468	$ 66,800	$ –	$ –	$ 939,359
Assets limited as to use, current portion	64,026	–	–	–	–	–	–	–	–	–	–	–	64,026
Accounts receivable:													
Patient accounts receivable, net	203,542	6,724	27,743	32,486	21,614	2,589	13,696	33,857	41,275	84,132	–	–	467,658
Other	225,483	781	4,378	40,618	19,549	296	26,184	4,155	36,005	23,948	–	(4,140)	377,257
Inventories	65,629	1,334	2,796	7,962	3,759	651	2,017	5,269	9,363	6,248	–	–	105,028
Prepaid expenses and other current assets	36,356	118	342	1,216	1,350	6	679	392	4,288	2,672	1,500	–	48,919
Total current assets	1,012,228	29,605	65,041	177,555	133,623	43,390	71,355	115,891	172,399	183,800	1,500	(4,140)	2,002,247
Investments	281,835	40,057	17,467	156,201	77,447	–	22,029	–	267,871	–	–	–	862,907
Assets limited as to use, less current portion:													
Investments held for collateral	147,585	1,122	1,732	8,987	4,118	223	2,740	–	–	–	–	–	166,507
Debt service funds	10,839	–	–	–	–	–	–	–	–	–	–	–	10,839
Construction funds	245,617	19,573	21,629	13,745	20,132	4,110	20,977	5,317	–	–	–	–	351,100
Board designated and escrow funds	–	–	–	–	25,000	5,000	–	–	30,000	–	23,171	–	83,171
Self-insurance trust funds	172,387	–	–	–	3,645	–	–	–	–	–	–	–	176,032
Funds restricted by donor	–	–	1,093	–	5,130	105	–	–	–	–	39,051	–	45,379
Economic interests in the net assets of related organizations	199,091	38,714	534	9,213	83,233	6,771	5,338	9,503	–	6,163	–	(90,656)	267,904
	775,519	59,409	24,988	31,945	141,258	16,209	29,055	14,820	30,000	6,163	62,222	(90,656)	1,100,932
Property and equipment, net	1,269,773	44,177	111,306	239,247	119,703	15,748	77,782	227,892	274,346	47,455	–	–	2,427,429
Investments in joint ventures and other assets	1,071,052	15,178	1,628	545	36,702	857	6,892	32,337	204,046	11,829	17,762	(769,423)	629,405
Total assets	$ 4,410,407	$ 188,426	$ 220,430	$ 605,493	$ 508,733	$ 76,204	$ 207,113	$ 390,940	$ 948,662	$ 249,247	$ 81,484	$ (864,219)	$ 7,022,920

*Includes University of Maryland Medical System Corporation (Parent)
**Includes both Memorial Hospital and Dorchester Hospital
***Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital
****Includes Prince Georges's Hospital Center, Laurel Regional Hospital and Bowie Health Center

University of Maryland Medical System Corporation and Subsidiaries

Combining Balance Sheet – Obligated Group (continued)
(In Thousands)

June 30, 2020

	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***	University of Maryland Capital Region Health****	UMMS Foundation	Eliminations	Obligated Group Total
Liabilities and net assets													
Current liabilities:													
Trade accounts payable	$ 148,101	$ 9,902	$ 14,895	$ 21,159	$ 12,100	$ 3,082	$ 7,421	$ 22,529	$ 18,214	$ 23,040	$ 331	$ –	$ 280,774
Accrued payroll and benefits	131,027	4,871	9,199	20,703	12,685	1,639	6,823	17,123	29,704	22,906	–	–	256,680
Advances from third-party payors	293,947	22,624	33,469	82,948	70,665	9,253	33,562	83,164	82,844	57,617	–	–	770,093
Short-term financing	150,000	–	–	–	–	–	–	–	–	–	–	–	150,000
Lines of credit	167,000	–	–	–	–	–	–	–	–	–	–	–	167,000
Other current liabilities	70,123	1,309	4,197	2,877	4,279	5,269	2,948	6,136	2,893	27,008	–	(4,140)	122,899
Long-term debt subject to short-term remarketing arrangements	28,794	–	–	–	–	–	–	–	–	–	–	–	28,794
Current portion of long-term debt	15,722	575	462	4,606	3,007	117	2,386	6,456	5,886	–	–	–	39,217
Total current liabilities	1,004,714	39,281	62,222	132,293	102,736	19,360	53,140	135,408	139,541	130,571	331	(4,140)	1,815,457
Long-term debt, less current portion	728,400	18,151	28,309	145,304	70,938	3,553	44,136	203,794	179,982	–	–	–	1,422,567
Other long-term liabilities	412,961	1,233	13,154	9,750	37,153	1,556	13,308	96,045	23,222	83,643	–	(94,693)	597,332
Interest rate swap liabilities	270,430	–	–	–	–	–	–	–	–	–	–	–	270,430
Total liabilities	2,416,505	58,665	103,685	287,347	210,827	24,469	110,584	435,247	342,745	214,214	331	(98,833)	4,105,786
Net assets:													
Without donor restrictions	1,416,337	91,047	70,395	308,933	257,364	46,498	96,529	(44,308)	459,257	29,977	28,704	(553,047)	2,207,686
With donor restrictions	577,565	38,714	46,350	9,213	40,542	5,237	–	1	146,660	5,056	52,449	(212,339)	709,448
Total net assets	1,993,902	129,761	116,745	318,146	297,906	51,735	96,529	(44,307)	605,917	35,033	81,153	(765,386)	2,917,134
Total liabilities and net assets	$ 4,410,407	$ 188,426	$ 220,430	$ 605,493	$ 508,733	$ 76,204	$ 207,113	$ 390,940	$ 948,662	$ 249,247	$ 81,484	$ (864,219)	$ 7,022,920

*Includes University of Maryland Medical System Corporation (Parent)
**Includes both Memorial Hospital and Dorchester Hospital
***Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital
****Includes Prince Georges's Hospital Center, Laurel Regional Hospital and Bowie Health Center

University of Maryland Medical System Corporation and Subsidiaries

Combining Statement of Operations and Changes in Net Assets
Without Donor Restrictions – Obligated Group
(In Thousands)

Year Ended June 30, 2020

	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***	University of Maryland Capital Region Health****	UMMS Foundation	Eliminations	Obligated Group Total
Operating revenue, gains and other support:													
Net patient service revenue	$ 1,586,078	$ 102,355	$ 185,142	$ 378,467	$ 248,208	$ 36,172	$ 129,960	$ 322,523	$ 344,529	$ 325,262	$ –	$ (4,903)	$ 3,653,793
State support	18,400	–	–	–	–	–	–	–	–	16,337	–	(15,000)	19,737
Premium revenue	181,674	–	–	–	–	–	–	–	–	–	–	(181,674)	–
CARES Act - Provider relief funds	49,980	8,975	17,943	24,717	16,729	5,431	7,147	21,824	24,139	15,116	–	–	192,001
Other revenue	564,558	1,743	22,748	5,340	7,264	560	1,462	4,233	9,565	82,817	–	(411,190)	289,100
Total operating revenue, gains and other support	2,400,690	113,073	225,833	408,524	272,201	42,163	138,569	348,580	378,233	439,532	–	(612,767)	4,154,631
Operating expenses:													
Salaries, wages, and benefits	1,046,870	53,667	103,305	189,223	110,327	15,029	61,658	137,854	187,533	191,993	–	(181,674)	1,915,785
Expendable supplies	408,144	12,579	33,072	55,107	35,205	3,266	21,771	57,843	49,418	44,048	–	–	720,453
Purchased services	582,189	24,404	49,629	80,886	49,919	15,427	30,997	68,861	73,948	172,285	–	(431,093)	717,452
Contracted services	142,454	9,489	31,180	21,230	15,490	6,039	9,247	23,447	18,183	19,904	–	–	296,663
Depreciation and amortization	88,774	7,006	14,049	27,425	17,240	3,934	6,598	23,795	23,033	15,512	–	–	227,366
Interest expense	16,849	197	988	5,125	2,588	127	1,613	9,311	7,556	466	–	–	44,820
Total operating expenses	2,285,280	107,342	232,223	378,996	230,769	43,822	131,884	321,111	359,671	444,208	–	(612,767)	3,922,539
Operating income (loss)	115,410	5,731	(6,390)	29,528	41,432	(1,659)	6,685	27,469	18,562	(4,676)	–	–	232,092
Nonoperating income and expenses, net:													
Contributions	3	–	–	–	11	–	–	–	–	–	8,538	–	8,552
Equity in net income of joint ventures	(1,140)	–	–	–	243	–	194	1,909	3,976	–	–	–	5,182
Investment income	9,623	696	324	2,689	1,661	23	348	–	(1,365)	–	743	–	14,742
Change in fair value of investments	(3,526)	(218)	(94)	(847)	1,027	(13)	(121)	–	–	(45)	(194)	–	(4,031)
Change in fair value of undesignated interest rate swaps	(75,811)	–	–	–	–	–	–	–	–	–	–	–	(75,811)
Other nonoperating gains and losses	(9,678)	(277)	(1,213)	(2,357)	(874)	(55)	(882)	(3,095)	(2,618)	1,575	(2,612)	–	(22,086)
Total nonoperating income and expenses	(80,529)	201	(983)	(515)	2,068	(45)	(461)	(1,186)	(7)	1,530	6,475	–	(73,452)
Excess (deficiency) of revenues over expenses	34,881	5,932	(7,373)	29,013	43,500	(1,704)	6,224	26,283	18,555	(3,146)	6,475	–	158,640
Net assets released from restrictions used for purchase of property and equipment	15,137	–	–	1,500	–	–	–	1,845	–	–	–	–	18,482
Change in economic and beneficial interest in the net assets of related organizations	–	–	–	–	–	–	–	–	27,570	–	–	–	27,570
Change in ownership interest of joint ventures	(188)	–	–	–	–	–	–	–	–	–	–	–	(188)
Capital transfers (to) from affiliate	48,652	(944)	(5,200)	(10,299)	(39,477)	(7,726)	(8,516)	(13,517)	7,600	5,933	–	–	(23,494)
Amortization of accumulated loss of discontinued designated interest rate swap	1,554	–	–	–	–	–	–	–	–	–	–	–	1,554
Change in funded status of defined benefit pension plans	–	–	(2,997)	(2,779)	–	–	(4,038)	–	–	(27,157)	–	–	(36,971)
Other	–	(365)	552	–	–	890	(1)	–	664	–	(88)	–	1,652
Increase (decrease) net assets without donor restrictions	$ 100,036	$ 4,623	$ (15,018)	$ 17,435	$ 4,023	$ (8,540)	$ (6,331)	$ 14,611	$ 54,389	$ (24,370)	$ 6,387	$ –	$ 147,245

*Includes University of Maryland Medical System Corporation (Parent)
**Includes both Memorial Hospital and Dorchester Hospital
***Includes both Upper Chesapeake Medical Center and Harford Memorial Hospital
****Includes Prince Georges's Hospital Center, Laurel Regional Hospital and Bowie Health Center

University of Maryland Medical System Corporation and Subsidiaries

Consolidating Balance Sheet – Hospital Format
(In Thousands)

June 30, 2020

	University of Maryland Medical Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals		Capital Region Hospitals			All Other Entities	Eliminations	Consolidated Total
									Medical Center	Harford Memorial	Prince Georges	Laurel Regional	Bowie Health Center			
Assets																
Current assets:																
Cash and cash equivalents	$ 18,977	$ 20,648	$ 29,782	$ 95,273	$ 87,351	$ 39,848	$ 28,779	$ 72,218	$ 50,596	$ 30,872	$ –	$ –	$ 1	$ 487,302	$ –	$ 961,647
Assets limited as to use, current portion	–	–	–	–	–	–	–	–	–		–	–	–	64,026	–	64,026
Accounts receivable:																
Patient accounts receivable, net	203,542	6,724	27,743	32,486	21,614	2,589	13,696	33,857	31,416	9,859	69,329	11,607	3,196	4,693	–	472,351
Other	521,536	781	4,378	21,093	19,549	296	24,530	4,155	65,428	–	207,142	9,793	8,456	150,296	(919,205)	118,228
Inventories	41,017	1,334	2,796	7,962	3,759	651	2,017	5,269	5,898	3,465	4,498	1,378	372	25,463	–	105,879
Assets held for sale	–	–	–	–	–	–	–	–	–	–	–	–	–	149,563	–	149,563
Prepaid expenses and other current assets	2,180	118	342	1,216	1,350	6	679	392	3,561	727	198	44	19	49,346	–	60,178
Total current assets	787,252	29,605	65,041	158,030	133,623	43,390	69,701	115,891	156,899	44,923	281,167	22,822	12,044	930,689	(919,205)	1,931,872
Investments	276,659	40,057	17,467	156,201	77,447	–	22,029	–	170,963	96,908	–	–	–	69,635	–	927,366
Assets limited as to use, less current portion:																
Investments held for collateral	–	1,122	1,732	8,987	4,118	223	2,740	–	–	–	–	–	–	147,585	–	166,507
Debt service funds	–	–	–	–	–	–	–	–	–	–	–	–	–	10,839	–	10,839
Construction funds	78,001	19,573	21,629	13,745	20,132	4,110	20,977	5,317	–	–	–	–	–	167,616	–	351,100
Board designated and escrow funds	–	–	–	–	25,000	5,000	–	–	30,000	–	–	–	–	56,812	–	116,812
Self-insurance trust funds	–	–	–	–	3,645	–	–	–	–	–	–	–	–	202,288	–	205,933
Funds restricted by donor	–	–	1,093	–	5,130	105	–	–	–	–	–	–	–	85,647	–	91,975
Economic interests in the net assets of related organizations	76,661	38,714	534	9,213	83,233	6,771	5,338	9,503	–	–	1,267	62	–	127,266	(187,742)	170,820
	154,662	59,409	24,988	31,945	141,258	16,209	29,055	14,820	30,000	–	1,267	62	–	798,053	(187,742)	1,113,986
Property and equipment, net	684,129	44,177	111,306	239,247	119,703	15,748	77,782	227,892	211,225	63,121	10,026	26,796	6,817	718,579	–	2,556,548
Investments in joint ventures and other assets	93,062	15,178	1,628	545	36,702	857	6,892	32,337	204,046	–	10,696	(92)	–	1,533,448	(1,325,160)	610,139
Total assets	$ 1,995,764	$ 188,426	$ 220,430	$ 585,968	$ 508,733	$ 76,204	$ 205,459	$ 390,940	$ 773,133	$ 204,952	$ 303,156	$ 49,588	$ 18,861	$ 4,050,404	$ (2,432,107)	$ 7,139,911

University of Maryland Medical System Corporation and Subsidiaries

Consolidating Balance Sheet – Hospital Format (continued)
(In Thousands)

June 30, 2020

	University of Maryland Medical Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Shore Health System, Inc.	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals		Capital Region Hospitals			All Other Entities	Eliminations	Consolidated Total
									Medical Center	Harford Memorial	Prince Georges	Laurel Regional	Bowie Health Center			
Liabilities and net assets																
Current liabilities:																
Trade accounts payable	$ 73,603	$ 9,911	$ 14,895	$ 21,159	$ 12,100	$ 3,082	$ 7,421	$ 22,529	$ 11,144	$ 7,070	$ 17,722	$ 2,306	$ 148	$ 99,043	$ –	$ 302,133
Accrued payroll and benefits	78,017	4,976	9,199	20,703	12,685	1,639	6,823	17,123	23,769	5,935	8,041	1,455	477	91,568	–	282,410
Advances from third-party payors	293,947	22,624	33,469	82,948	70,665	9,253	33,562	83,164	62,755	20,089	54,829	2,698	91	3,853	–	773,947
Short-term financing	–	–	–	–	–	–	–	–	–	–	–	–	–	150,000	–	150,000
Lines of credit	–	–	–	–	–	–	–	–	–	–	–	–	–	193,500	–	193,500
Other current liabilities	36,068	1,309	4,197	2,877	28,545	8,920	2,948	25,328	2,655	46,467	14,976	71,692	671	802,365	(919,205)	129,813
Liabilities held for sale	–	–	–	–	–	–	–	–	–	–	–	–	–	65,461	–	65,461
Long-term debt subject to short-term remarketing arrangements	–	–	–	–	–	–	–	–	–	–	–	–	–	28,794	–	28,794
Current portion of long-term debt	16,973	575	462	4,606	3,007	117	2,386	6,456	5,886	–	–	–	–	–	–	40,468
Total current liabilities	498,608	39,395	62,222	132,293	127,002	23,011	53,140	154,600	106,209	79,561	95,568	78,151	1,387	1,434,584	(919,205)	1,966,526
Long-term debt, less current portion	545,908	18,151	28,309	145,304	70,938	3,553	44,136	203,794	157,074	22,908	–	–	–	198,182	–	1,438,257
Other long-term liabilities	31,966	1,233	13,154	9,750	37,153	1,556	13,308	96,045	22,043	1,179	8,560	–	–	512,135	(94,694)	653,388
Interest rate swap liabilities	–	–	–	–	–	–	–	–	–	–	–	–	–	270,430	–	270,430
Total liabilities	1,076,482	58,779	103,685	287,347	235,093	28,120	110,584	454,439	285,326	103,648	104,128	78,151	1,387	2,415,331	(1,013,899)	4,328,601
Net assets:																
Without donor restrictions	881,667	90,800	70,395	289,408	233,098	42,847	94,875	(63,500)	341,147	101,304	197,189	(31,706)	17,400	961,516	(1,171,094)	2,055,346
With donor restrictions	37,615	38,847	46,350	9,213	40,542	5,237	–	1	146,660	–	1,839	3,143	74	673,557	(247,114)	755,964
Total net assets	919,282	129,647	116,745	298,621	273,640	48,084	94,875	(63,499)	487,807	101,304	199,028	(28,563)	17,474	1,635,073	(1,418,208)	2,811,310
Total liabilities and net assets	$ 1,995,764	$ 188,426	$ 220,430	$ 585,968	$ 508,733	$ 76,204	$ 205,459	$ 390,940	$ 773,133	$ 204,952	$ 303,156	$ 49,588	$ 18,861	$ 4,050,404	$ (2,432,107)	$ 7,139,911

University of Maryland Medical System Corporation and Subsidiaries

Consolidating Statement of Operations – Hospital Format
(In Thousands)

Year Ended June 30, 2020

	University of Maryland Medical Center					Shore Health System													
	University Hospital	Shock Trauma Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center	Memorial Hospital	Dorchester General	QAEC	Chester River Hospital Center	Charles Regional Medical Center	St. Joseph Medical Center	Upper Chesapeake Hospitals: Medical Center	Upper Chesapeake Hospitals: Harford Memorial	Capital Region Hospitals: Prince Georges	Capital Region Hospitals: Laurel Regional	Capital Region Hospitals: Bowie Health Center	All Other Entities	Eliminations	Consolidated Total
Operating revenue, gains and other support:																			
Net patient service revenue	$ 1,401,411	$ 184,667	$ 102,355	$ 185,142	$ 378,467	$ 208,359	$ 32,038	$ 7,811	$ 36,172	$ 129,960	$ 322,523	$ 259,777	$ 84,752	$ 286,263	$ 23,059	$ 13,904	$ 267,139	$ (7,868)	$ 3,915,931
State support	–	3,400	–	–	–	–	–	–	–	–	–	–	–	16,337	–	–	15,000	(15,000)	19,737
Premium revenue	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	181,674	(181,674)	–
CARES Act – Provider relief funds	49,980	–	8,975	17,943	24,717	16,729	–	–	5,431	7,147	21,824	21,499	2,640	15,116	–	–	7,631	–	199,632
Other revenue	145,152	208	1,743	22,748	5,340	3,368	3,265	631	560	1,462	4,233	4,983	4,582	8,539	451	–	699,752	(678,263)	228,754
Total operating revenue, gains and other support	1,596,543	188,275	113,073	225,833	408,524	228,456	35,303	8,442	42,163	138,569	348,580	286,259	91,974	326,255	23,510	13,904	1,171,196	(882,805)	4,364,054
Operating expenses:																			
Salaries, wages, and benefits	584,658	64,750	53,667	103,305	189,223	92,409	15,016	2,902	15,029	61,658	137,854	134,975	52,558	142,096	16,387	7,306	737,799	(181,108)	2,230,484
Expendable supplies	377,503	25,695	12,579	33,072	55,107	29,488	4,791	926	3,266	21,771	57,843	43,056	6,362	36,754	4,632	1,166	46,102	–	760,113
Purchased services	331,909	46,855	24,404	49,629	80,886	42,030	6,611	1,278	15,427	30,997	68,861	53,184	20,764	104,042	16,340	5,963	349,221	(552,373)	696,028
Contracted services	129,751	12,703	9,489	31,180	40,755	34,007	5,342	407	9,690	10,901	42,639	25,778	9,211	31,151	4,254	473	28,552	(149,324)	276,959
Depreciation and amortization	88,828	9,636	7,006	14,049	27,425	14,441	2,346	453	3,934	6,598	23,795	20,240	2,793	8,134	2,926	1,388	1,899	–	235,891
Interest expense	19,891	–	197	988	5,125	2,049	452	87	127	1,613	9,311	6,424	1,132	–	1	–	(836)	–	46,561
Total operating expenses	1,532,540	159,639	107,342	232,223	398,521	214,424	34,558	6,053	47,473	133,538	340,303	283,657	92,820	322,177	44,540	16,296	1,162,737	(882,805)	4,246,036
Operating income (loss)	64,003	28,636	5,731	(6,390)	10,003	14,032	745	2,389	(5,310)	5,031	8,277	2,602	(846)	4,078	(21,030)	(2,392)	8,459	–	118,018
Nonoperating income and expenses, net:																			
Contributions	3	–	–	–	–	11	–	–	–	–	–	–	–	–	–	–	9,279	–	9,293
Equity in net income of joint ventures	(1,973)	–	–	–	–	243	–	–	–	194	1,909	2,408	1,568	–	–	–	(813)	–	3,536
Investment income	7,557	–	696	324	2,689	1,661	–	–	23	348	–	(843)	(522)	–	–	–	12,702	–	24,635
Change in fair value of investments	(1,934)	–	(218)	(94)	(847)	1,027	–	–	(13)	(121)	–	–	–	–	–	–	(2,684)	–	(4,884)
Change in fair value of undesignated interest rate swaps	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	(75,811)	–	(75,811)
Other nonoperating gains and losses	(9,725)	–	(277)	(1,213)	(2,357)	(874)	–	–	(55)	(882)	(3,095)	(2,618)	–	1,117	147	67	(4,611)	–	(24,376)
Total nonoperating income and expenses	(6,072)	–	201	(983)	(515)	2,068	–	–	(45)	(461)	(1,186)	(1,053)	1,046	1,117	147	67	(61,938)	–	(67,607)
Excess (deficiency) of revenues over expenses	57,931	28,636	5,932	(7,373)	9,488	16,100	745	2,389	(5,355)	4,570	7,091	1,549	200	5,195	(20,883)	(2,325)	(53,479)	–	50,411
Gain on discontinued operations	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	19,599	–	19,599
Excess (deficiency) of revenues over expenses	$ 57,931	$ 28,636	$ 5,932	$ (7,373)	$ 9,488	$ 16,100	$ 745	$ 2,389	$ (5,355)	$ 4,570	$ 7,091	$ 1,549	$ 200	$ 5,195	$ (20,883)	$ (2,325)	$ (33,880)	$ –	$ 70,010

EY | Assurance | Tax | Strategy and Transactions | Consulting

About EY

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ey.com

EXHIBIT 15

UMMC PEDIATRIC HYBRID OR PROJECT

Letters of Support

Name	Title	Affiliation
Courtney Agnoli	Parent of patient	UMMC Children's Heart Program
Eric T. Costello	Councilman	Baltimore City Council, 11th District
Phylicia Porter, MPH, MSL	Councilwoman-Elect	Baltimore City Council, 10th District
Wanda Best	Executive Director	Upton Planning Committee Inc.
Robert Barlow, MD, PhD	Pediatric Cardiologist	Children's Heart Institute
Steven J. Czinn, MD, FAAP, FACG, AGAF	Professor of Pediatrics & Chair Dept. of Pediatrics	University of Maryland School of Medicine
Christine L. Lau, MD, MBA	Surgeon-In-Chief/	University of Maryland Medical Center/
	Chair, Dept. of Surgery	University of Maryland School of Medicine
Mohan Suntha, MD, MBA	President & CEO	University of Maryland Medical System
Roger W. Voight, MB, ChB FRACS(Aust.)	Surgeon-In-Chief	University of Maryland Children's Hospital
Bowyer G. Freeman, MBA, D.Min.	Senior Pastor	New St. Mark Baptist Church
Rev. Angela T. Burden, MA, RN	Reverend	
Rev. Dr. Arnold W. Howard	Pastor	Enon Baptist Church
Rev. Tamara E. Wilson, D.Min.	Pastor	Nu Season Nu Day Church & Ministries

October 30, 2020

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

Dear Mr. Steffen,

I am writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to build a second pediatric hybrid operating room with biplane technology.

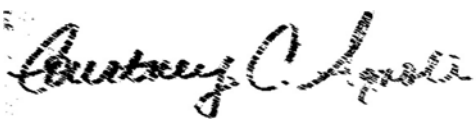
Currently, UMMC has only one operating room with biplane technology which is the expected standard for pediatric procedures. Both cardiac surgery cases and interventional cases are performed in this single room. In recent years UMMC has seen a steady growth in its pediatric cardiac procedures and as such one room is no longer able to accommodate these volumes. With only two pediatric cardiac programs in the State of Maryland it is vital we ensure kids in Maryland have access to these vital services and technology.

Once operational, the second pediatric hybrid operating room will allow UMMC to renovate and upgrade its current room without completely disabling the service during the renovation.

As a parent of the Children's Heart Program, I have seen first hand just how much this second pediatric hybrid operating room is needed. My daughter has had five open-heart surgeries, including a heart transplant, and numerous heart catheterizations. Many times she has had to wait for the OR to be available in order to have a life saving procedure. With the additional hybrid OR, it would allow for multiple procedures to take place at one time, which would lower the risks for patients having to wait and allow for better long term outcomes. The second OR would also allow for space to handle emergencies should they arise while the other hybrid suite is in use.

UMMC and the faculty of the University of Maryland School of Medicine who practice at the hospital provide high-quality and compassionate care to pediatric cardiac patients. The pediatric heart program at UMMC has been recognized by US News & World Report for the last three years as a top 50 program in cardiology and heart surgery. I strongly urge you to support their Certificate of Need application.

Sincerely,



Courtney C. Agnoli

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

October 30, 2020

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

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Once operational, the second pediatric hybrid operating room will allow UMMC to renovate and upgrade its current room without completely disabling the service during the renovation.

UMMC and the faculty of the University of Maryland School of Medicine who practice at the hospital provide high-quality and compassionate care to pediatric cardiac patients. The pediatric heart program at UMMC has been recognized by US News & World Report for the last three years as a top 50 program in cardiology and heart surgery. I strongly urge you to support their Certificate of Need application.

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

Sincerely,

E. T. Costello

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

Phylicia
PORTER
for
10TH DISTRICT CITY COUNCIL

November 2, 2020

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

Dear Mr. Steffen,

I am writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to build a second pediatric hybrid operating room with biplane technology. As a public health practitioner and Democratic nominee for Baltimore City Council, I have an in-depth knowledge of the health assessments & need in communities of South Baltimore and those directly surrounding UMMC. Innovations such as this are incredibly vital to building healthy communities for generations in Baltimore City. It is my hope that these types of innovation will center on equity, optimal access to healthcare, and the cultivation of servant-led neighborhood partnerships with anchoring institutions such as UMMC.

Currently, UMMC has only one operating room with biplane technology which is the expected standard for pediatric cardiac procedures. Both cardiac surgery cases and interventional cases are performed in this single room. In recent years UMMC has seen a steady growth in its pediatric cardiac procedures and as such one room is no longer able to accommodate these volumes. With only two pediatric cardiac programs in the State of Maryland it is vital we ensure kids in Maryland have access to these vital services and technology.

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For more information or additional comment of my support, please reach me at (443) 509-6640 or phylicia@porter4baltimore.com.

Sincerely,

Phylicia R.L. Porter, MPH, MSL

Democratic Nominee, Baltimore City Council, District 10

October 30, 2020

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

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Sincerely,

Wanda Best
UPC, Executive Director

October 30, 2020

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

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Sincerely,

Robert Barlow MD, PhD
Peds Cardiologist
Children's Heart Institute

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

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

Department of Pediatrics

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sczinn@som.umaryland.edu

www.medschool.umaryland.edu/pediatrics

November 3, 2020

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

Dear Mr. Steffen,

I am writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to build a second pediatric hybrid operating room with biplane technology.

UMMC and the faculty of the University of Maryland School of Medicine who practice at the hospital provide high-quality and compassionate care to pediatric cardiac patients. The pediatric heart program at UMMC has been recognized by US News & World Report for the last three years as a top 50 program in cardiology and heart surgery.

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Once operational, the second pediatric hybrid operating room will allow UMMC to renovate and upgrade its current room without completely disabling the service during the renovation. I strongly urge you to support their Certificate of Need application.

Sincerely,

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

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

CHRISTINE L. LAU, MD, MBA
Dr. Robert W. Buxton Professor and Chair
Department of Surgery, UMSOM

Surgeon-in-Chief
University of Maryland Medical Center

22 S. Greene Street, S8B08
Baltimore, MD 21201
410 328 8407 | 410 328 0401 FAX
CLLau@som.umaryland.edu

October 30, 2020

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

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Sincerely,

Christine L. Lau, MD, MBA

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

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

CORPORATE OFFICE

October 30, 2020

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

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Sincerely,

Mohan Suntha, MD, MBA
President & Chief Executive Officer

Roger W. Voigt, MBChB FRACS (Aust.)
Chief, Division of Pediatric Surgery & Urology
Department of Surgery
Surgeon-in-Chief,
University of Maryland Children's Hospital
29 S. Greene St. Ste 110
Baltimore, MD 21201
410 328-5730
rvoigt@som.umaryland.edu

October 30, 2020

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

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Sincerely,

Roger Voigt, MB, ChB, FRACS(Aust.)
Chief, Division of Pediatric Surgery & Urology
Surgeon-in-Chief, University of Maryland Children's Hospital
Office: 410 328-5730
Fax: 410- 328-0652
Email: rvoigt@som.umaryland.edu

NEW ST. MARK BAPTIST CHURCH

3905 Springdale Avenue
Baltimore, MD 21207-7429
Church Office: 410-542-7290 Pastor's Study: 410-542-8286
Office@newsaintmark.org Pastor@newsaintmark.org
Fax: 410-542-3020 Web: www.newsaintmark.org
Dr. Bowyer G. Freeman, Pastor

November 2, 2020

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Dear Mr. Steffen,

I am writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to build a second pediatric hybrid operating room with biplane technology.

Currently, UMMC has only one operating room with biplane technology which is the expected standard for pediatric cardiac procedures. Both cardiac surgery cases and interventional cases are performed in this single room. In recent years UMMC has seen a steady growth in its pediatric cardiac procedures and as such one room is no longer able to accommodate these volumes. With only two pediatric cardiac programs in the State of Maryland it is vital we ensure kids in Maryland have access to these vital services and technology.

Once operational, the second pediatric hybrid operating room will allow UMMC to renovate and upgrade its current room without completely disabling the service during the renovation.

UMMC and the faculty of the University of Maryland School of Medicine who practice at the hospital provide high-quality and compassionate care to pediatric cardiac patients. The pediatric heart program at UMMC has been recognized by US News & World Report for the last three years as a top 50 program in cardiology and heart surgery. I strongly urge you to support their Certificate of Need application.

Sincerely,

Bowyer G. Freeman, MBA, D.Min.
Senior Pastor

From the Desk of…

REV. ANGELA T. BURDEN
6534 Woodbridge Circle Catonsville, MD 21228
443-983-1184
ABHeiress@Gmail.com

November 2, 2020

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

Dear Mr. Steffen,

I am writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to build a second pediatric hybrid operating room with biplane technology.

Currently, UMMC has only one operating room with biplane technology which is the expected standard for pediatric cardiac procedures. Both cardiac surgery cases and interventional cases are performed in this single room. In recent years UMMC has seen a steady growth in its pediatric cardiac procedures and as such one room is no longer able to accommodate these volumes. With only two pediatric cardiac programs in the State of Maryland it is vital we ensure kids in Maryland have access to these vital services and technology.

Once operational, the second pediatric hybrid operating room will allow UMMC to renovate and upgrade its current room without completely disabling the service during the renovation.

UMMC and the faculty of the University of Maryland School of Medicine who practice at the hospital provide high-quality and compassionate care to pediatric cardiac patients. The pediatric heart program at UMMC has been recognized by US News & World Report for the last three years as a top 50 program in cardiology and heart surgery. I strongly urge you to support their Certificate of Need application.

Sincerely,

Rev. Angela T. Burden, MA, RN

Deacon Kevin Jones
Deacon Ministry
Deacon Delores Sweets
Trustee Ministry
Dr. Charles Arnette
Minister of Music
Sister Lisa Jones
Church Clerk

Enon Baptist Church

601 N. Schroeder Street. Baltimore, Maryland 21217
Phone: (410)728-1490 Fax: (410)462-2660
Email: office@enonbaptist-baltimore.org
www.enonbaptistbaltimore.org
REV. DR. ARNOLD W. HOWARD, Pastor

November 2, 2020

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

Dear Mr. Steffen,

I write in total support of the University of Maryland Medical Center's (UMMC) application for a Certificate of Need (CON) to build a second pediatric hybrid operating room with biplane technology.

UMMC has been a major institution in our community providing excellent state of the art medical services for persons who otherwise would not have such local quality access. Pediatric care in general and pediatric cardiac care in particular are critical services necessary for communities whose children may be more at risk to detrimental health conditions for which this operating room is suited for.

I have been informed that UMMC's current facilities need to be expanded from its current single room to properly meet the increase demand for the types of services it provides. Our children's health and their family's overall well-being is at stake and deserve our full support.

I therefore very greatly recommend that you give every positive consideration to UMMC's request for a Certificate of Need.

Sincerely,

Rev. Dr. Arnold W. Howard

NU SEASON NU DAY CHURCH & MINISTRIES

WALKING BY FAITH…WATCHING GOD AT WORK
II CORINTHIANS 5:17

November 2, 2020

Mr. Ben Steffen

Executive Director, Maryland Health Care Commission

4160 Patterson Avenue

Baltimore, MD 21215

Dear Mr. Steffen,

I am writing to express my full support for the Certificate of Need (CON) application submitted by the University of Maryland Medical Center (UMMC) to build a second pediatric hybrid operating room with biplane technology.

Currently, UMMC has only one operating room with biplane technology which is the expected standard for pediatric cardiac procedures. Both cardiac surgery cases and interventional cases are performed in this single room. In recent years UMMC has seen a steady growth in its pediatric cardiac procedures and as such one room is no longer able to accommodate these volumes. With only two pediatric cardiac programs in the State of Maryland it is vital we ensure kids in Maryland have access to these vital services and technology.

A second pediatric hybrid operating room will allow UMMC and the faculty of the University of Maryland School of Medicine who practice at the hospital continue providing high-quality and compassionate care to pediatric cardiac patients while renovating and upgrade its current room. Therefore, it is with great respect that I strongly urge you to support their Certificate of Need application.

Sincerely,

Tamara E. Wilson

Rev. Tamara E, Wilson, D.Min., Pastor

Service Address:
4501 Reisterstown Rd.
Baltimore, MD 21215

Mailing Address:
1001 Frederick Road # 3275
Catonsville, MD 21228

EXHIBIT 16

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

****

FINAL ORDER

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

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

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

2. Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude the $28,196,229 cost associated with the excess construction and renovation costs, interest, and inflation. This figure includes the estimated new construction and renovation expenditure that exceeds the Marshall Valuation Service guideline cost and portions of the contingency allowance, inflation allowance, and capitalized construction interest estimate for the project that are based on the excess construction cost.

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

EXHIBIT 17

IN THE MATTER OF	*	**BEFORE THE**
	*	
UNIVERSITY OF MARYLAND	*	**MARYLAND**
	*	
MEDICAL CENTER	*	**HEALTH CARE**
	*	
Docket No. 18-24-2429	*	**COMMISSION**
	*	

* *

FINAL ORDER

Based on Commission staff's analysis and recommendations, it is, this 16th day of May 2019, by the Maryland Health Care Commission, **ORDERED**:

That the application of University of Maryland Medical Center for a Certificate of Need to expand its inpatient child behavioral health unit by establishing an eight-bed adolescent inpatient behavioral health unit in renovated space at an estimated total cost of $9,580,000 be, and hereby is, **APPROVED**.

MARYLAND HEALTH CARE COMMISSION

EXHIBIT 18

IN THE MATTER OF	*	
	*	**BEFORE THE**
UNIVERSITY OF MARYLAND	*	
	*	**MARYLAND HEALTH**
MEDICAL CENTER	*	
	*	**CARE COMMISSION**
DOCKET NO. 19-24-2438	*	
	*	

****

FINAL ORDER

Based on the analysis and conclusions in the Staff Report and Recommendation, it is, this 20th day of August, 2020:

ORDERED, that the application for a Certificate of Need by the University of Maryland Medical Center to build a cancer center addition of 154,610 square feet and renovate 72,670 square feet of contiguous space in the medical center at an estimated project cost of $194,368,000, be **APPROVED,** subject to the following conditions:

1. Prior to its request for first use approval, UMMC will submit an assessment of the need for surge bed capacity at UMMC and its plan to maintain and deploy adequate surge bed capacity when needed.

2. Any future change to the financing of this project involving adjustments in revenue must exclude $2,210,850 in shell space-related costs, which includes the estimated new construction costs of the proposed shell space and portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure related to the estimated cost of the shell space.

3. UMMC will not finish the shell space on either the third or fourth floor without giving notice to the Commission and obtaining all required Commission approvals. UMMC will not request any adjustment in budgeted revenue by the Health Services Cost Review Commission (HSCRC) that includes depreciation or interest costs associated with construction of the proposed shell space unless UMMC has obtained either CON approval for finishing the shell space or a determination of coverage from the Maryland Health Care Commission that CON approval is not required.

4. In calculating any future adjustment to budgeted revenues related to the costs of this project, HSCRC shall exclude the capital costs associated with the shell space until the space is finished and put to use in a regulated activity. In calculating any revenue adjustment that includes an accounting for capital costs associated with the shell space, the rate shall only account for depreciation and interest expenses going forward through the remaining useful life of the space.

MARYLAND HEALTH CARE COMMISSION