GALLAGHER
GALLAGHER EVELIUS & JONES
ATTORNEYS AT LAW

January 17, 2023

VIA HAND DELIVERY

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

Re: Certificate of Need Application
Dimensions Health Corporation
d/b/a University of Maryland Capital Region Health, Inc.
Recommencement of Level III Neonatal Intensive Care Unit Services at
University of Maryland Capital Region Health

Dear Ms. Potter:

On behalf of applicant Dimensions Health Corporation *d/b/a* University of Maryland Capital Region Health, Inc., we are submitting four copies of its Certificate of Need Application to recommence Level III Neonatal Intensive Care Unit Services at University of Maryland Capital Region Health. A searchable PDF file of the application and exhibits, WORD version of the application and available exhibits, and native EXCEL spreadsheets of the MHCC tables and available exhibits will be provided to Commission staff via email.

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

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

Sincerely,

Thomas C. Dame

Alison Lutich

Alison Best Lutich

TCD:blr
Enclosures

#817602
013849-0010

cc: Wynee Hawk, Chief, Certificate of Need
Paul Parker, Director, Center for Health Care Facilities Planning & Development, MHCC
Alexa Bertinelli, Esq., Assistant Attorney General, MHCC
Caitlin E. Tepe, Esq., Assistant Attorney General, MHCC
Dr. Sanmi Areola, Acting Health Officer, Prince George's County Health Department
Jay Mittal, VP Business Strategy and Development, UM Capital Region Health
Richie Stever, VP of Real Estate and Property Management, UMMC
Michael Brozic, Chief Financial Officer, UM Capital Region Health
Sandra Benzer, Esq., General Counsel, UM Capital Region Health
Andrew Solberg

CERTIFICATE OF NEED APPLICATION

Recommencement of

Level III Neonatal Intensive Care Unit Services

at University of Maryland Capital Region Health

Applicant:
Dimensions Health Corporation
***d/b/a* University of Maryland Capital Region Health, Inc.**

January 17, 2023

#812622

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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 Capital Region Medical Center**

Address:			
901 Harry S. Truman Drive North	**Largo**	**20774**	**Prince George's**
Street	City	Zip	County

Name of Owner (if differs from applicant):

2. OWNER

Name of owner: **University of Maryland Capital Region Health, Inc.**

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
Dimensions Health Corporation d/b/a University of Maryland Capital Region Health, Inc.

Address:				
901 Harry S. Truman Drive North	**Largo**	**20774**	**MD**	**Prince George's**
Street	City	Zip	State	County

Telephone: 240 677-1096

Name of Owner/Chief Executive: **Nathaniel Richardson, Jr., President and CEO**

4. NAME OF LICENSEE OR PROPOSED LICENSEE, IF DIFFERENT FROM APPLICANT

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

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

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

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

A. Lead or primary contact:

Name and Title: Sandra Benzer, General Counsel, UM Capital Region Health
Mailing Address:

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

Telephone: 410-903-5260
E-mail Address (required): sbenzer1@umm.edu
Fax:

B. Additional or alternate contact:

Name and Title: Thomas C. Dame, Esq.
Mailing Address:

Gallagher Evelius & Jones LLP 218 N. Charles St. Ste. 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: Alison J.B. Lutich, Esq.
Mailing Address:

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

Telephone: 410-347-1346
E-mail Address (required): alutich@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	X
(5)	A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf	☐

8. PROJECT DESCRIPTION

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

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

As explained more fully in the Comprehensive Project Description below, the proposed project involves the recommencement of Level III neonatal intensive care unit ("NICU") services at University of Maryland Capital Region Health. Currently, no Level III NICU exists in Prince George's County. As a result, mothers and infants requiring high-intensity care for pre-term deliveries and other complicated births must seek care or be transferred to facilities outside the County. The project will involve reopening the Level III NICU at University of Maryland Capital Region Medical Center. There are no costs associated

with this project and no construction is necessary to resume Level III NICU services at the hospital.

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.

I. University of Maryland Capital Region Health

The University of Maryland Capital Region Health (formerly, Dimensions Healthcare System) has roots in serving Prince George's County residents since 1944, when the Prince George's General Hospital first opened. Dimensions Healthcare System ("Dimensions") was founded in 1982 when Prince George's County privatized the county's public hospitals. In September of 2017, Dimensions affiliated with the University of Maryland Medical System ("UMMS"). Through this affiliation, University of Maryland Capital Region Health ("UMCRH") was established.

UMCRH provides primary and specialty health care services to residents of Prince George's County and the surrounding area, and is committed to improving health outcomes in the communities it serves. UMCRH consists of the University of Maryland Capital Region Medical Center ("UMCRMC"), the University of Maryland Laurel Medical Center, the University of Maryland Bowie Health Center, and the University of Maryland Capital Region Medical Group, with practice locations in New Carrollton, Suitland, Bowie, Laurel, and National Harbor. Together, community physicians and University of Maryland School of Medicine ("SOM") faculty provide clinical expertise across a range of specialties and programs.

II. University of Maryland Capital Region Medical Center

UMCRH's flagship regional hospital, UMCRMC, opened in Largo, Maryland in the summer of 2021, replacing the former University of Maryland Prince George's Hospital Center ("PGHC") located in Cheverly, Maryland. This new state-of-the-art acute care hospital has 221 licensed inpatient beds, including 22 beds dedicated to obstetrical and gynecological care. UMCRMC is also home to a certified and designated primary stroke center, the State's second-busiest trauma center, and a highly regarded cardiac surgery program. UMCRMC shares the UMMS values of compassion, discovery, excellence, diversity and integrity.

III. The Project

The UMCMRC NICU currently operates as a Level II Special Care Nursery. Prior to transferring its operations from Cheverly, Maryland, UMCRH operated the only Level III NICU in Prince George's County at PGHC. Currently, no Level III NICU exists in Prince George's County. As a result, mothers with pre-term babies or other high risks of complications during

childbirth must either seek care at or be transferred to facilities outside of the County. Similarly, infants born at hospitals within Prince George's County who have severe health conditions must be transferred out of the County for care, often without their mothers. Through this project, UMCRH seeks to re-open its Level III NICU service line at its new, state-of-the-art hospital, UMCRMC.

UMCRH's newborn service area, determined based on all fiscal year 2022 newborn discharges from UMCRMC, includes ZIP Codes in Prince George's County, Anne Arundel County and Howard County. As shown in Table 1 below, ZIP Codes in Prince George's County make up the vast majority of UMCRH's newborn service area.

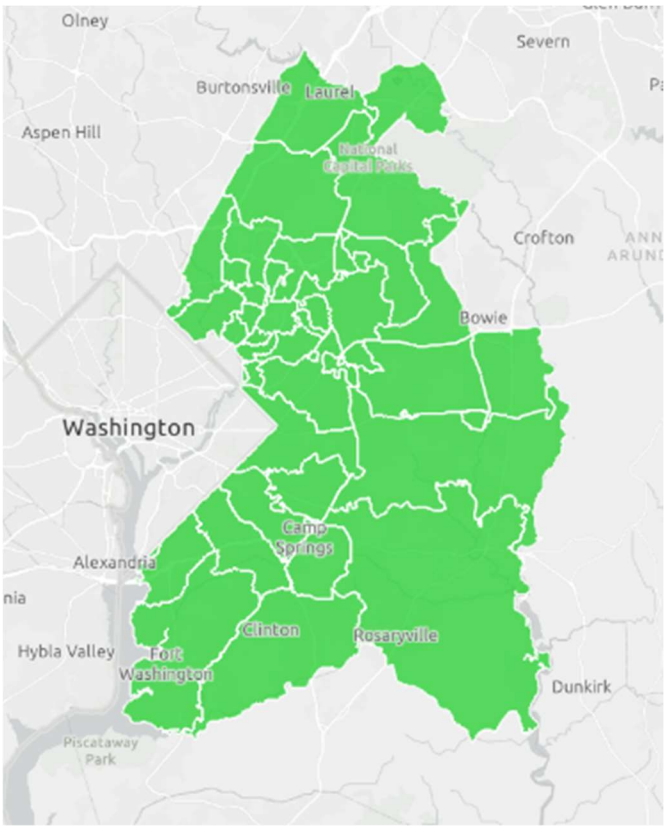
Table 1
UMCRH Newborn Service Area
FY 2022

#	Zip Code	City	County	Discharges	% of Total	Cumulative % of Total
1	20785	Hyattsville	Prince George's County	131	9.6%	9.6%
2	20743	Capitol Heights	Prince George's County	93	6.8%	16.4%
3	20783	Hyattsville	Prince George's County	79	5.8%	22.1%
4	20706	Lanham	Prince George's County	76	5.5%	27.7%
5	20737	Riverdale	Prince George's County	75	5.5%	33.1%
6	20784	Hyattsville	Prince George's County	69	5.0%	38.2%
7	20747	District Heights	Prince George's County	67	4.9%	43.1%
8	20748	Temple Hills	Prince George's County	65	4.7%	47.8%
9	20774	Upper Marlboro	Prince George's County	62	4.5%	52.3%
10	20746	Suitland	Prince George's County	55	4.0%	56.4%
11	20745	Oxon Hill	Prince George's County	54	3.9%	60.3%
12	20744	Fort Washington	Prince George's County	46	3.4%	63.6%
13	20710	Bladensburg	Prince George's County	32	2.3%	66.0%
14	20772	Upper Marlboro	Prince George's County	30	2.2%	68.2%
15	20782	Hyattsville	Prince George's County	27	2.0%	70.1%
16	20707	Laurel	Prince George's County	24	1.8%	71.9%
17	20735	Clinton	Prince George's County	23	1.7%	73.6%
18	20770	Greenbelt	Prince George's County	21	1.5%	75.1%
19	20721	Bowie	Prince George's County	19	1.4%	76.5%
20	20708	Laurel	Prince George's County	17	1.2%	77.7%
21	20781	Hyattsville	Prince George's County	16	1.2%	78.9%
22	20705	Beltsville	Prince George's County	15	1.1%	80.0%
23	20724	Laurel	Anne Arundel County	14	1.0%	81.0%
24	20720	Bowie	Prince George's County	13	0.9%	82.0%
25	20740	College Park	Prince George's County	11	0.8%	82.8%
26	20716	Bowie	Prince George's County	10	0.7%	83.5%
27	20712	Mount Rainier	Prince George's County	7	0.5%	84.0%
28	20722	Brentwood	Prince George's County	5	0.4%	84.4%
29	20715	Bowie	Prince George's County	3	0.2%	84.6%
30	20723	Laurel	Howard County	3	0.2%	84.8%
31	20769	Glenn Dale	Prince George's County	3	0.2%	85.0%
	Subtotal - CRH RMC Service Area			**1,165**	**85.0%**	**85.0%**
	Subtotal - Out of Service Area			**205**	**15.0%**	**100.0%**
	Total CRH RMC Newborn Discharges			**1,370**	**100.0%**	**100.0%**

Source: FY2022 HSCRC statewide inpatient data tapes

The service area is shown in Figure 1 below.

Figure 1
UMCRH Newborn Service Area
FY 2022



Level III NICU services are desperately needed in the service area. Prince George's County is a low performer in several of the key maternal-fetal metrics, including low birth weight babies, very low birth weight babies, pre-term births, mothers who received early prenatal care, and infant mortality rate. Poverty also significantly affects maternal and child health outcomes. Women living in poverty have a higher likelihood of delivering prematurely and lacking access to prenatal care. In Prince George's County, 7% of Black residents, 12.8% of Hispanic and 8.4% of White (non-Hispanic) residents were living in poverty in 2017. Additionally, approximately 12% of Prince George's County women ages 25-34 were below the poverty level in 2017. The County's higher rates of pre-term deliveries, low birth weight babies, and lack of prenatal care directly influences the number of infants who require care in a Level III NICU. Because these services are not currently available at any facility in the County, residents must either travel outside the County to deliver or risk having their infants transferred to a higher-level NICU after birth. Residents of Prince George's County severely lack access to appropriate neonatal intensive care services. UMCRMC proposes to restore access to this life-saving level of care through this project.

Though currently operating as a Level II Special Care Nursery, UMCRMC was designed and approved to provide Level III NICU services. The UMCRMC perinatal program was also designed to comply with regulatory standards required of a Level III NICU. As a result, no physical changes, construction, or renovations are required to allow UMCRMC to provide Level III NICU services. The project will not involve any change in square footage of departments or units, or to the physical plant of the hospital.

In addition to the existing physical infrastructure that already supports the provision of Level III NICU services at UMCRMC, UMCRMC will not need significant changes to its current staffing levels to operate as a Level III NICU. UMCRMC has a dedicated staff of board-certified obstetricians and gynecologists, nurses, advanced practice practitioners, certified nurse midwives, physician assistants, and a maternal-fetal medicine division, led by two faculty physicians of the SOM. UMCRMC's obstetricians and gynecologists are board-certified and have completed additional training and certification in Relias fetal heart monitoring, neonatal resuscitation and limited ultrasound. UMCRMC's neonatologists are board-certified and its neonatal nurse practitioners are certified in neonatal medicine. Although it has operated as a Level II Special Care Nursery since the new hospital opened in summer 2021, UMCRMC has maintained neonatologists and nurse practitioners to provide in-house, 24/7 neonatal coverage as required for a Level III NICU. UMCRMC has also maintained clinical and contractual relationships with a full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists, and pediatric ophthalmologists who are readily accessible on site or by prearranged consultative agreements at a closely related institution. UMCRMC thus has the capacity and clinical talent to provide acute delivery room and neonatal intensive care for infants of all birth weights and gestational ages.

As UMCRH continues to expand its services in an effort to improve access to high-quality, evidenced-based care, it intends to lead the effort in improving maternal and neonatal outcomes in Prince George's County and the surrounding Southern Maryland region. UMCRMC's maternal-fetal medicine program is the only hospital-based maternal-fetal medicine program in Prince George's County. It has satellite locations in Laurel and Suitland and plans to expand into Oxon Hill. UMCRH also has relationships with UM Charles Regional Medical Center, local Federally Qualified Health Centers, community obstetricians and gynecologists, and University of Maryland Capital Region Medical Group. Altogether, these programs and relationships allow UMCRH to provide access to its maternal-fetal medicine services in a unique and patient-focused way.

UMCRH has the physical, clinical, and staffing infrastructure to provide Level III perinatal subspecialty care for pregnant women and infants. It is committed to providing the highest level of complicated and complex maternal-fetal care, as well as uncomplicated, routine management of all clinical needs of its maternal-fetal patient population. With state-of-the-art technology and resources and a dedicated staff, UMCRMC is prepared to reopen Level III NICU services immediately upon approval by the Commission of this Application.

* * * * *

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

Not applicable; this project does not involve construction or renovations.

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.

Per the Commission's December 28, 2022 letter, UMCRH confirms that its physical bed capacity is fully consistent with that authorized by the Commission in 2016: 154 medical/surgical/gynecological/addictions (MSGA) beds; 22 obstetric beds; one pediatric bed; and 22 acute psychiatric beds, plus 16 MSGA beds for which UMCRMC received an emergency CON in May of 2022, for a total physical capacity of 221 beds.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: Approximately 26 acres

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: Dimensions Health Corporation, d/b/a University of Maryland Capital Region Health, Inc.
Please provide a copy of the deed. The land was conveyed to the Applicant via two separate deeds, one by the Authority of Prince George's County, attached as **Exhibit 2**, and one by Parcel D2, LLC, attached as **Exhibit 3**.

(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).

Applicant Response:

This project does not involve any construction or capital expenditures. As a result, the following Project Schedule is not applicable. The Applicant intends to open the Level III NICU as soon as all regulatory approvals are obtained.

	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		months
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.		months
Initiation of Construction within 4 months of the effective date of the binding construction contract.		months
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract		months
Fill out the following section for each phase. (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase		months
Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date		months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1		months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.		months
To Be Completed for each subsequent Phase of Construction		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase		months
Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase		months
Completion of each phase within 24 months of the effective date of binding construction contract for that phase		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:

Not applicable; this project does not involve new construction or renovations.

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:

Not applicable; this project does not involve new construction or renovations.

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

All utilities are available at the hospital, which was granted first use approval by the Commission on May 17, 2021. This project does not involve new construction or renovations and no additional utilities will be obtained.

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

This project does not involve any construction or costs. Table E is not applicable.

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

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

   Owner: University of Maryland Capital Region Health, Inc.
   Responsible Individual: Nathaniel Richardson, President and CEO, University of Maryland Capital Region Health
   Address: 901 Harry S. Truman Drive North, Largo, MD 20774

2. Is any applicant, owner, or responsible person listed above now involved, or has any such person ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each such facility, including facility name, address, the relationship(s), and dates of involvement.

   The Responsible Individual has been involved in the management of the following health care facilities:

President and CEO, University of Maryland Capital Region Health	May 2020 – Present
Huntsville Hospital Health System, Huntsville, AL **President, Decatur Morgan Hospitals** **Chief Operating Officer/Senior Vice President of Decatur Morgan Hospitals**	June 2013 – May 2020 September 2012 – June 2013
Interim President, Parkway Medical Center	December 2011 – September 2012
Regional Vice President and Vice President of Cardiovascular Services	2010 – 2011
Vice President of Operations, Cardiovascular Services, Interim President/Chief Executive Officer, Athens-Limestone Hospital	2007 – 2010
Vice President of Operations, Emergency Services, Trauma, Urgent Care, Laboratory & Imaging Services	2005 – 2007
Executive Director, Urgent Care & System-wide Imaging Services	2004 – 2005
The Methodist Hospital, Houston, TX **Administrative Director – System-wide Imaging & Endovascular Center of Excellence**	2004

St. Luke's Episcopal Health System, Houston, TX 1986 – 2003
Administrative Director – Strategic Planning & Development – Diagnostic Therapeutic Services; Administrative Director – Cardiology Services; Director of Diagnostic Services – Imaging Services, Non-Invasive Cardiology, Nuclear Cardiology; Operations Manager – Adult and Pediatric Imaging Services; Supervisor – Adult & Pediatric Imaging; Radiologic Technologist – Cardiovascular Transplant Surgery/Orthopedic Surgery

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

   No.

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

   The Applicant notes that this response is limited to information relevant to University of Maryland Capital Region Health for compliance inquiries and investigations and to actions by regulatory bodies that resulted in penalties, admission bans, probationary status, or other sanctions within the last 5 years. The Applicant has no matters to disclose.

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   No.

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

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

1/13/2023
Date

DocuSigned by:
Nathaniel Richardson Jr.
E0B80D5813C14A3...
Signature of Owner or Board-designated Official

President and CEO
Position/Title

Nathaniel Richardson
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 neonatal intensive services applicant must address the standards in **COMAR 10.24.10: Acute Care Hospital Services** and **COMAR 10.24.18: Neonatal Intensive Care 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.

COMAR 10.24.10 - ACUTE CARE HOSPITAL SERVICES
SECTION OF THE STATE HEALTH PLAN

.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.

(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 website;

(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

UMCRH has a written policy in place that meets the requirements of this standard. See **Exhibit 4.** This policy was put in place prior to the acquisition of Dimensions Healthcare System by UMMS, but has been adopted by UMCRH. This policy addresses all parts of this standard: procedures on maintenance of the Representative List of Services and Charges; procedures for responding to requests for information regarding current charges for specific services and procedures**;** and requirements for staff training on inquiries regarding charges for services.

The current list of representative services and charges for inpatient and outpatient services is readily available to the public, both in written form at UMCRMC and on the hospital's website under the section titled "Average Charges by Type of Patient Group." The representative list of services and charges will be updated quarterly, as required.

(2) Charity Care Policy

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

(a) The policy shall provide:

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

(ii) Minimum Required Notice of Charity Care Policy.

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

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

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

Applicant Response

UMCRH provides inpatient and other care to all patients regardless of the ability to pay. A copy of the hospital's Financial Assistance Policy is attached as **Exhibit 5.** Notices regarding the availability of charity care at the hospital are posted in the Emergency Department, admissions and business offices, and in multiple departments throughout the hospital. The posted notices inform patients that they may obtain applications for financial assistance in the Patient Access, Patient Financial Services/ Customer Service, and Eligibility Services offices. Each patient or patient representative is advised of UMCRH's financial assistance policy at the time of preadmission or admission. Financial assistance information is also provided through the Patient Handbook and Information Letter, which is provided to all inpatients and observation patients upon admission and to outpatients upon request. Information about the hospital's financial assistance policy and application process is available to the public on its website (https://www.umms.org/capital/patients-visitors/financial-assistance). The hospital's Financial Assistance Policy specifically states that it will make a determination of probable eligibility within two (2) business days following a patient's request for charity care services, application for medical assistance, or both. Financial counselors assist individuals to prepare and file all documents required to seek charity care at the hospital.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community

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

Applicant Response

The most recent Community Benefit Report from the HSCRC is from fiscal year 2020. As shown in Table 2 below, UMCRH ranks in the first quartile of all Maryland hospitals, with charity care comprising 3.22% of its total operating expenses.

Table 2
HSCRC Community Benefit Report, Data Excerpts FY 2020

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	%	
Garrett County Memorial Hospital	$49,847,123	$3,088,077	6.20%	1st Quartile
Holy Cross	$453,889,368	$25,216,478	5.56%	
Holy Cross German Town	$108,611,245	$4,804,910	4.42%	
Doctors Community Hospital	$215,413,138	$9,425,649	4.38%	
Western Maryland Health System	$333,791,774	$12,451,700	3.73%	
Mercy Medical Center, Inc.	$492,374,189	$17,767,062	3.61%	
Washington Adventist Hospital	$265,481,640	$9,248,445	3.48%	
Johns Hopkins Bayview Med. Center	$671,878,000	$21,680,000	3.23%	
UM Capital Region	$322,178,000	$10,373,355	3.22%	
MedStar Harbor Hospital Center	$191,182,619	$5,448,214	2.85%	
Shady Grove Adventist Hospital	$395,307,320	$11,221,259	2.84%	
St. Agnes Hospital	$460,174,000	$12,957,524	2.82%	2nd Quartile
MedStar St. Mary's Hospital	$162,834,942	$4,539,656	2.79%	
MedStar Good Samaritan Hospital	$263,976,142	$7,178,703	2.72%	
Peninsula Regional Medical Center	$493,289,357	$13,045,900	2.64%	
MedStar Union Memorial Hospital	$430,645,261	$9,977,661	2.32%	
MedStar Southern Maryland Hospital	$240,415,418	$5,442,147	2.26%	
MedStar Franklin Square Hospital	$549,838,800	$12,318,684	2.24%	
UM St. Joseph Medical Center	$340,304,000	$7,456,792	2.19%	
UM Harford Memorial	$88,580,314	$1,819,000	2.05%	
MedStar Montgomery General Hospital	$171,486,283	$3,193,638	1.86%	
Howard County General Hospital	$262,623,000	$4,679,000	1.78%	
Frederick Memorial Hospital	$356,515,000	$5,822,311	1.63%	3rd Quartile
UM Medical Center Midtown Campus	$232,223,000	$3,763,000	1.62%	
UM BWMC	$398,520,000	$6,375,000	1.60%	

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	%	
Atlantic General Hospital	$134,967,041	$2,080,700	1.54%	
Suburban Hospital Association, Inc.	$311,199,000	$4,768,896	1.53%	
Calvert Memorial Hospital	$137,396,210	$2,092,026	1.52%	
UM Upper Chesapeake Medical Center	$272,962,267	$3,918,000	1.44%	
UM Shore Regional Health Chester River	$43,821,000	$624,742	1.43%	
UM Shore Regional Health Easton	$218,075,000	$2,913,105	1.34%	
Meritus Medical Center	$399,338,982	$5,280,200	1.32%	
Johns Hopkins	$2,658,945,000	$35,066,500	1.32%	
Univ. of Maryland Medical Center	$1,692,179,000	$21,239,000	1.26%	
UM Shore Regional Health Dorchester	$34,558,000	$425,237	1.23%	4th Quartile
Union Hospital of Cecil County	$159,947,807	$1,429,900	0.89%	
Fort Washington Medical Center	$46,221,264	$400,374	0.87%	
UM Charles Regional Medical Center	$133,537,960	$1,088,000	0.81%	
Anne Arundel General Hospital	$585,311,000	$4,665,000	0.80%	
Northwest Hospital Center, Inc.	$249,673,000	$1,929,688	0.77%	
Sinai Hospital	$791,568,000	$5,349,000	0.68%	
Greater Baltimore Medical Center	$514,005,000	$2,193,000	0.43%	
Bon Secours Hospital	$66,479,100	$213,345	0.32%	
Carroll County General Hospital	$201,484,375	$503,782	0.25%	
McCready Foundation, Inc.	$10,283,006	$0	0.00%	
Total	**$17,148,098,364**	**$332,227,534**	**1.94%**	
* The Adventist Hospital System has requested and received permission to report their Community Benefit activities on a CY Basis. This allows them to more accurately reflect their true activities during the Community Benefit Cycle. The numbers listed in the 'FY 2019 Amount in Rates for Charity Care, DME, and NSPI' Column as well as the Medicaid Deficit Assessments from the Inventory spreadsheets reflect the Commission's activities for FY19 and therefore will be different from the numbers reported by the Adventist Hospitals.				

Source: HSCRC http://www.hscrc.state.md.us/init_cb.cfm

(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;

(ii) Accredited by the Joint Commission; and

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

Applicant Response

UMCRMC is licensed by the State of Maryland. Its license is attached as **Exhibit 6.**

UMCRMC is accredited by the Joint Commission. The hospital recently underwent a full Joint Commission resurvey in September of 2022. On December 23, 2022, The Joint Commission granted an accreditation decision of "Accredited" for the hospital, effective as of October 1, 2022, and the behavioral healthcare and human services program, effective as of September 29, 2022. Both accreditations are effective for 36 months. The accreditation certificates have not yet been provided. The Joint Commission Award Letters are attached as **Exhibit 7**.

UMCRMC is in compliance with the Conditions of Participation of the Medicare and Medicaid programs.

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

Applicant Response

As noted in the Commission's recent decision in the CON review for the replacement and relocation of Washington Adventist Hospital, "subpart (b) of this standard is essentially obsolete in that it requires an improvement plan for any measure that falls within the bottom quartile of all hospitals' reported performance on that measure as reported in the most recent Maryland [Hospital Evaluation Performance Guide]." *In re Washington Adventist Hospital*, Docket No. 13-15-2349 (Nov. 18, 2015), Decision at pp. 19-20. The Commission's current format for the Hospital Guide for Maryland Health Care Quality Reports does not report quality measures in a manner that shows hospitals' relative scores in quartiles, nor is it easy to determine the 90% level of compliance. Instead, the Hospital Guide shows the hospital's rating as "below average," "average," or "better than average," in comparison to Maryland hospitals' average score.

UMCRMC scored "better than average" or "average" on 47 of the 76 quality measures. For an additional 15 quality measures, UMCRH did not have sufficient data to report. UMCRMC scored "below average" on 14 quality measures. **Exhibit 8** identifies those quality measures for which UMCRMC scored "below average" along with the corrective action plans for these measures.

.04B. PROJECT REVIEW STANDARDS

The standards in this section are intended to guide reviews of Certificate of Need applications and exemption requests involving acute care general hospital facilities and services. An applicant for a Certificate of Need must address, and its proposed project will be evaluated for compliance with, all applicable review standards. An applicant for a Certificate of Need exemption must address, and its proposed project will be evaluated for consistency with, all applicable review standards.

The following listed project review standards are a subset of the COMAR 10.24.10 Project Review Standards that are applicable (cost- effectiveness, efficiency, patient safety, and financial feasibility) to a hospital proposing to introduce neonatal intensive care services or may be applicable (construction cost of hospital space).

(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.

(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 Response

Through this project, UMCRH proposes to resume providing Level III NICU services at UMCRMC. The primary objective of the project is to provide access to higher intensity neonatal care in Prince George's County, as no such service currently exists in the County. As a result, infants needing a higher level of care must be transferred to facilities outside the County and families must travel further distances to support their babies while receiving such care. UMCRMC was designed and constructed to facilitate the continued provision of Level III NICU services, which were previously provided at PGHC. No capital expenditures are required to allow UMCRMC to resume providing Level III NICU services once all regulatory approvals have

been obtained. UMCRMC, therefore, is the most cost-effective site for a Level III NICU in Prince George's County as no costs are associated with the project and no other facility in the jurisdiction is as prepared to provide such services.

(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

Not applicable. This project does not involve any construction.

(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

UMCRH is not proposing to replace or expand diagnostic or treatment facilities and services. UMCRMC was designed to promote efficiency, as demonstrated by the Commission's decision approving the CON for the replacement and relocation of PGHC to UMCRMC, which concluded that this standard was met. *In re Dimensions Health Corporation d/b/a Prince George's Hospital Center and Mt. Washington Pediatric Hospital, Inc.*, Docket No. 13-16-2351 (September 30, 2016), Decision p. 42 (hereinafter, the "MHCC Decision"). Given that this project involves no changes to the physical space of the project and staffing levels will remain

consistent, UMCRMC will continue to operate efficiently after it resumes providing Level III NICU services.

(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 include 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

Both the physical plant and program operations of UMCRMC's perinatal program are designed with patient safety at the forefront. In its decision approving the CON for the replacement and relocation of PGHC to UMCRMC, the Commission found that the design of UMCRMC appropriately took patient safety into consideration and that the replacement hospital project was consistent with this standard. MHCC Decision, p. 42. In this project, UMCRH is not proposing to replace or expand the UMCRMC physical plant, and no construction or renovations are required to facilitate Level III NICU services at UMCRMC. UMCRMC's design currently supports its ability to accept risk-appropriate maternal and neonatal transports as a Level III perinatal hospital. As a result, no modification to the patient safety design features will occur.

UMCRMC is committed to patient safety and quality in its perinatal program from an operational perspective, as well. It has appointed a dedicated perinatal safety and quality officer along with a perinatal coordinator. Board-certified obstetricians lead the UMCRMC perinatal program and have programmatic responsibility for obstetric services. UMCRMC's board-certified maternal-fetal medicine specialists have programmatic responsibility for high-risk obstetrical services. These highly-trained specialists will oversee the perinatal services offered at UMCRMC as a Level III program.

(13) Financial Feasibility

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

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.

(a) 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

(iv) 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

(v) 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

This standard is not applicable as the project does not involve any capital expenditures. Nevertheless, **Exhibit 1** includes Tables F, G, and H, which provide utilization and financial projections, along with comprehensive statements of assumptions used to develop those projections. As presented in Tables G and H, UMCRH is projected to be financially viable in the long-term once it resumes Level III NICU services.

COMAR 10.24.18 - NEONATAL INTENSIVE CARE SERVICES SECTION OF THE STATE HEALTH PLAN

.04C/D Neonatal Intensive Care Services Commission Program Policies (C) and Certificate of Need Review Standards (D)

1. Compliance with the Maryland Neonatal Intensive Care Standards

Each applicant shall demonstrate compliance with all essential requirements as defined in the most recent version of the perinatal standards, adopted by MIEMSS at COMAR 30.08.12, for the level of perinatal center specified in the application. An applicant may respond to this standard by attaching their MIEMSS' perinatal designation application.

Applicant Response

UMCRH previously operated the only Level III NICU in Prince George's County at PGHC. In October of 2020, with approval from MIEMSS, PGHC took voluntary action to temporarily suspend its provision of Level III neonatal intensive care services. From that time, the NICU at PGHC operated as a Level II Special Care Nursery until operations transferred to the replacement UMCRMC hospital. The NICU has continued to operate as a Level II Special Care Nursery at UMCRMC since its opening.

In fall of 2020, MIEMSS conducted a site survey of the PGHC NICU during which it identified certain programmatic improvement opportunities. In response to the surveyor's findings, UMCRH prepared a comprehensive action plan, designed to be implemented within thirty days. Pursuant to this action plan, UMCRH made structural improvements to its quality oversight program, conducted root cause analyses for several patient cases to identify opportunities for improvement, implemented audit procedures to monitor compliance and progress, revised and implemented new policies and procedures, and provided training to staff. In addition, UMCRH implemented a practice of conducting medical record reviews of 100% of deliveries at the hospital to assist with monitoring progress on all identified opportunities for improvement. UMCRH completed all items in its action plan within its thirty-day timeline and reported on its progress to MIEMSS throughout the process.

Despite satisfying its thirty-day goals, UMCRH decided to temporarily suspend its provision of Level III NICU services to allow it to continue monitoring its progress and to focus on additional comprehensive improvements to its quality oversight structure. UMCRH voluntarily requested this action from MIEMSS on October 21, 2020. Since this time, UMCRH has undergone an intensive, internal quality oversight program overhaul. These efforts, while not required or directed by MIEMSS, have resulted in significant structural changes that will position UMCRH to provide the highest quality Level III NICU services once re-designated as such. In particular, UMCRH continued with extensive audits and reviews of its deliveries to monitor compliance with newly implemented policies and procedures. It used findings from these reviews and audits to develop targeted training programs for its staff. UMCRH also recruited a second maternal-fetal medicine specialist to lead its Level III program, a time-consuming and difficult process, particularly under pandemic conditions that have created unprecedented staffing challenges. UMCRH has completed implementation of its redesigned quality oversight program and has accomplished its staff recruitment goals to allow it to resume providing Level III NICU services.

UMCRH now seeks to re-open its Level III NICU service line in the new, state-of-the-art hospital, UMCRMC. The Applicant has the ability to provide subspecialty care for pregnant women and infants, as described by the COMAR Perinatal Standards. In its 2016 application for a Certificate of Need for the replacement and relocation of PGHC to UMCRMC, UMCRH proposed to continue providing Level III NICU services at UMCRMC. Because UMCRH intended to provide Level III NICU services at UMCRMC as of its opening, the hospital was designed to facilitate this level of service. In approving the 2016 CON Application, the Commission found that the replacement UMCRMC hospital complied with the applicable perinatal standards. MHCC Decision, p. 74. The hospital has been designed according to the plans provided in the 2016 CON application and is thus prepared to offer Level III NICU services.

UMCRH is committed to providing the highest level of complicated and complex maternal-fetal and neonatal care, as well as uncomplicated, routine management of all clinical needs of its maternal-fetal and neonatal patient population. The commitment of UMCRH to provide high-level patient care is demonstrated by its advanced technology, skilled certified nurse midwives, board certified obstetricians and gynecologists, and a maternal-fetal medicine division that will be staffed by two faculty physicians of the University of Maryland SOM. In addition, high-level neonatal care is provided by advanced practice providers and board-certified neonatologists.

For a detailed demonstration of compliance with all essential requirements of the perinatal system standards for a Level III perinatal center, please see the Applicant's MIEMSS Perinatal Designation Application, attached as **Exhibit 9.**

2. Minimum Unit Volume

(a) Each applicant shall document a sufficient volume of critically ill patients using the general categories identified in COMAR 10.24.18.04B(1). Each applicant shall document that the proposed neonatal intensive care unit will maintain an average daily census of at least six critically ill patients on a sustained basis. An applicant may show evidence as to why this rule should not apply to the applicant.

Applicant Response

UMCRH will maintain a sufficient volume of critically ill patients once it resumes Level III NICU services. Average daily census is calculated by dividing total patient days by 365. To calculate total patient days throughout the projection period, UMCRH began by projecting the population of females ages 15-44 in the service area. Population projections were based on data obtained from Environics Spotlight (formerly Nielson Claritas). UMCRH assumes that once Level III NICU services resume, the use rate will return to fiscal year 2018 and fiscal year 2019 levels, when UMCRH previously operated the Level III NICU at PGHC without interruption. To calculate use rate for the projection period, UMCRH averaged the use rates from fiscal year 2018 and fiscal year 2019. UMCRH assumes the use rate will remain constant throughout the projection period. UMCRH's market share has varied over the past five fiscal years. These fluctuations in market share are due in part to the relatively small sample size of NICU discharges in the service area. UMCRH has projected data for fiscal year 2023 based on its actual experience over the past twelve months of available data. UMCRH expects that its market share of NICU discharges will level off at the fiscal year 2023 level and remain constant throughout the projection period. Finally, UMCRH anticipates that its out-of-service area

discharges as a percentage of total discharges and average length of stay ("ALOS") will return to fiscal year 2018 and fiscal year 2019 levels. UMCRH took an average of these levels from fiscal year 2018 and 2019 to calculate the projections, and assumes out-of-service area discharges as a percentage of total discharges and ALOS will remain constant throughout the projection period.

As demonstrated in Table 3 below, UMCRH projects that it will maintain an average daily census of approximately 6.4 patients in the NICU throughout the projection period of fiscal year 2024 through fiscal year 2028.

Table 3
UM Capital Region Health Historical and Projected NICU Utilization
FY 2018 – FY 2028

	Actual					Projected						Key Assumptions
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	
Population *(Females Ages 15 - 44)*	179,361	178,568	177,778	176,992	176,209	176,122	176,034	175,947	175,860	175,773	175,686	Based on Claritas spotlight projections for CRH's newborn service area (zip codes w/ top 85% of newborn discharges)
% Change		*-0.4%*	*-0.4%*	*-0.4%*	*-0.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
Use Rate	4.8	4.5	5.0	5.0	4.6	4.4	4.6	4.6	4.6	4.6	4.6	
% Change		*-5.0%*	*10.5%*	*-0.7%*	*-8.0%*	*-3.8%*	*5.7%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	Use rates return to FY2018 / FY2019 average in FY2024
Service Area Discharges	855	809	890	880	806	775	818	818	818	817	817	
% Change		*-5.4%*	*10.0%*	*-1.1%*	*-8.4%*	*-3.9%*	*5.6%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
CRH RMC Market Share	11.6%	13.1%	8.8%	9.0%	16.8%	14.3%	14.3%	14.3%	14.3%	14.3%	14.3%	
% Change		*13.2%*	*-32.8%*	*2.2%*	*87.2%*	*-15.1%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	Market share remains at FY2023 level through projection
CRH RMC Discharges												
Service Area	99	106	78	79	136	111	117	117	117	117	117	
Out of Service Area % of Service Area	*20.2%*	*27.4%*	*23.9%*	*23.9%*	*23.9%*	*23.9%*	*23.8%*	*23.8%*	*23.8%*	*23.8%*	*23.8%*	Out of SA % remains at FY2018 / FY2019 average
Out of Service Area	20	29	19	19	32	26	28	28	28	28	28	
Total	119	135	97	98	168	137	145	145	144	144	144	
% Change		*13.4%*	*-28.1%*	*1.0%*	*71.4%*	*-18.5%*	*5.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
Average Length of Stay (ALOS)	17.2	15.0	12.7	12.7	6.0	6.2	16.1	16.1	16.1	16.1	16.1	ALOS returns to FY2018 / FY2019 average in FY2024
% Change		-12.5%	-15.1%	0.0%	-53.1%	3.5%	100.0%	0.0%	0.0%	0.0%	0.0%	
Patient Days	2,043	2,027	1,237	1,249	1,004	847	2,327	2,326	2,324	2,323	2,322	
% Change		-0.8%	-39.0%	1.0%	-19.7%	-15.6%	174.7%	0.0%	0.0%	0.0%	0.0%	
Average Daily Census	5.6	5.6	3.4	3.4	2.7	2.3	6.4	6.4	6.4	6.4	6.4	
% Change		-0.8%	-39.0%	1.0%	-19.7%	-15.6%	174.7%	0.0%	0.0%	0.0%	0.0%	
Occupancy	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	State Health Plan does not specify an occupancy % for NICU
Bed Need	8	8	5	5	4	3	9	9	9	9	9	
% Change		0.0%	-37.5%	0.0%	-20.0%	-25.0%	200.0%	0.0%	0.0%	0.0%	0.0%	

Source: FY2018 through FY2022 HSCRC statewide inpatient data tapes

Note: FY2020 - FY2023 UM CRH volumes represent Level II NICU admissions based on UM CRH internal data provided by Mike Brozic. These births are charged the NUR rate and thus cannot be separated from normal births in the HSCRC statewide data tapes

(b) Each applicant for a new neonatal intensive care unit is subject to and shall document compliance with the obstetric volume requirements at COMAR 10.24.12.03B(1) and (4).

Applicant Response

Not applicable. UMCRH currently operates a neonatal intensive care unit and is not applying for a new unit.

(c) Each applicant shall document that the value added by increased geographic access is justified by the incremental cost to the health care system based on the total cost of the service, not the rates charged for the service.

Applicant Response

As discussed in the Comprehensive Project Description above and the response to COMAR 10.24.01.08G(3)(b) – Need below, resuming Level III NICU services at UMCRMC will significantly improve geographic access to these services for residents of the service area. No other Level III NICU currently exists in Prince George's County, which comprises the vast majority of the UMCRH newborn service area. By restoring this desperately needed service line, mothers at risk of pre-term labor or other complications, as well as infants born with serious health conditions, will have access to life-saving care in the County that they currently must travel longer distances, or be transferred to another facility outside the County, to receive.

Not only will the restoration of Level III NICU services at UMCRMC increase geographic access to the services, but the incremental cost to resume the service is minimal. The cost of provider coverage and fixed staffing to operate at Level III is already included in UMCRMC's cost structure. These costs existed when the hospital previously operated a Level III NICU and will exist once the Level III designation resumes. Since the hospital temporarily paused provision of Level III services, almost all of the fixed costs associated with that level of care have remained to facilitate the recommencement of services once ready. The hospital has, however, received no offsetting revenue during this period. The only additional incremental costs the hospital will incur in resuming Level III NICU services will be associated with the nurse ratio for increased newborn census and supplies. These minimal incremental cost increases are justified by the improved geographic access that resuming the County's only Level III NICU will provide to residents of the service area.

3. Outreach Prevention Programs

Each applicant shall document its establishment of a program to prevent low birth weight and infant mortality with particular outreach to minority and indigent patients in the hospital's regional service area.

Applicant Response

UMCRH delivers improved access to primary care, specialty care and outpatient services to residents of Prince George's County. UMCRH is a dedicated community partner in helping to promote the health of Prince George's County residents. By engaging in proactive outreach with the community, UMCRH strives to improve outcomes for mothers and babies in

the service area. UMCRH has implemented several programs and activities focused on community outreach and education to prevent low birth rate and infant mortality, including:

- **Mama & Baby Bus Program**: The Mama & Baby Mobile Unit serves as a healthcare access point for under-insured, uninsured and under-served women and children. The unit provides basic, uncomplicated maternal and child health services through partnerships with local community-based organizations, shelters, food pantries, faith institutions, schools and institutions of higher learning.

- **Breast-Feeding Coalition**: UMCRH offers monthly breastfeeding education with course offerings for community health workers, including a certified lactation consultant (CLC) training class.

- **Domestic Violence & Sexual Assault Center**: The center offers case management support to assist this vulnerable population to secure housing support, professional therapy and counseling.

- **SAFE Grant**: Beginning in 2023, UMCRH will launch a new comprehensive human trafficking response and service referral pathway in five units of UMCRMC to improve identification and response to victims of sex and labor trafficking.

In addition to programs that focus on maternal and infant health conditions, specifically, UMCRH recognizes the importance that overall wellness has on pregnancy outcomes and early childhood. UMCRH has a robust community health program that delivers programs and activities to educate the community on various aspects of healthcare and healthy living, such as Mental Health First Aid & Youth Mental Health First Aid Training, a Dine, Learn & Move educational demonstration lecture series, and the Fitness on the Green Series. Altogether, UMCRH conducted 180 community health events in fiscal year 2022 alone. UMCRH collaborates with Community Advisory Councils to promote awareness and enhance programmatic health and wellness activities. It also participates in Totally Linking Care in MD ("TLC") a coalition of the county hospitals that manages grant funded programs to operate a Behavioral Health Crisis Stabilization Center (opening in June 2023) and a Diabetes Prevention Program.

UMCRH offers specific outreach and education to physicians in the community, as well. In 2022, UMCRH hosted symposiums including Breast Cancer Continuum: Comprehensive Care from Screening to Management and Beyond (October, 2022) and the Lung Cancer Symposium: Achieving Early Diagnosis and Cure through Multidisciplinary Care (September, 2022). It also holds Thoracic and Breast Tumor Boards to discuss and educate community providers about complex cancer cases. By partnering with other healthcare providers in the community, UMCRH helps improve access to well-trained primary and specialty care providers for patients of its service area.

Finally, UMCRH works to address health conditions that disproportionately affect residents in its service area. UMCRH, in partnership with Johns Hopkins Medical and Children's National Medical Center, will open the first adult sickle cell disease program in Prince George's County in 2023. The county is home to 70% of the people living with sickle cell disease in the State of Maryland. This program is funded with a grant from the Maryland Community Health Resources Commission. The Sickle Cell Disease Infusion Center and Clinic will provide

dedicated services and support to adult patients living with sickle cell disease and will address a serious gap in access to care for this population.

4. Data Reporting

Each applicant shall provide any statistical or other information that the Commission needs to plan for the future development of perinatal services in Maryland, as specified in COMAR 10.24.02, and demonstrate compliance with the reporting requirements specified in regulations governing the submission of uniform hospital discharge abstract data and uniform accounting data to the Health Services Cost Review Commission, including the timely reconciliation of those data elements that are common to the case-mix and financial data sets.

Applicant Response

UMCRH will comply with its obligations to provide statistical or other information to the Commission pursuant to COMAR 10.24.02. UMCRH is in compliance with the reporting requirements specified by the HSCRC, as evidenced by its historical and current monthly, quarterly, and annual reporting performance and compliance.

5. Cost Efficiency

A hospital that applies for a Certificate of Need to provide subspecialty or comprehensive subspecialty neonatal care services will be required to enter into an agreement with the Health Services Cost Review Commission (HSCRC) outlining how the neonatal intensive care cases will be incorporated into the hospital's population global budget.

Applicant Response

UMCRH anticipates that its Level III NICU application will be incorporated into its global budget and rate order in a relatively seamless manner. This is evidenced by the fact that UMCRH previously had a designated NICU rate center in its global budget rate order, has historical volumes for reference, and has a neonatal intensive care approved unit rate in its current rate order. Resuming its Level III NICU status will not only help UMCRH's patients' clinical care and community demand, but it will also favorably impact the organization's financial position and sustainability, as evidenced by the Tables attached as **Exhibit 1**.

6. Service to Minority and Indigent Populations

In the case of a comparative review of applications in which all applicants met all policies and standards, the Commission will give preference to the applicant with an established program to prevent low birth weight and infant mortality with particular outreach to minority and indigent patients in the hospital's regional service area in accordance with COMAR 10.24.18.04C(1)(d).

Applicant Response

Not applicable. This is not 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

No Level III NICU currently exists in Prince George's County. In his August 26, 2022 letter to attorneys with Gallagher, Evelius & Jones, LLP regarding the re-establishment of Level III NICU services at UMCRMC, Commission Executive Director Ben Steffen acknowledged that "[t]his service is needed in the County." In addition to the Commission Staff's recognition that there is a need for Level III NICU services in the County, UMCRH demonstrates compliance with this standard as set forth below.

I. UMCRH's volume projections demonstrate the need for Level III NICU services in the service area.

As discussed in the response to COMAR 10.24.18.04D(3) – Minimum Unit Volume, UMCRH projects that it will maintain an average daily census of 6.4 critically ill infants in its Level III NICU throughout the projection period. Using the bed need methodology from the State Health Plan chapter for Acute Care Hospitals, UMCRH projects a need for capacity for nine infants in its Level III NICU. Table 3 above sets forth this need projection, and the response to COMAR 10.24.18.04D(3) – Minimum Unit Volume includes a discussion of the underlying assumptions used in calculating the projection.

II. UMCRH's internal maternal and infant transfer data demonstrate that Level III NICU services are needed in Prince George's County.

In addition to UMCRH's demand projections that demonstrate the NICU will maintain steady volumes in excess of the minimum unit volume standards set forth in the State Health Plan chapter for neonatal intensive care services, the need for a Level III NICU at UMCRMC is also evidenced by the trends in maternal and infant transfers to and from the hospital since it temporarily suspended Level III services. Since the hospital began operating as a Level II Special Care Nursery, an increasing number of mothers have required transfer to a different facility for care and fewer mothers have been transferred into the hospital to receive a higher level of care. Similarly, the number of infants transferred out of the hospital to another NICU to receive a higher level of care has steadily increased. These trends demonstrate the need for Level III NICU capabilities at UMCRMC to reduce transfers to other facilities outside the County and to provide sufficient capability to receive mothers in need of higher levels of care. By resuming Level III services at UMCRMC, UMCRMC anticipates that transfers out of the hospital for both mothers and infants will decrease, as demonstrated below.

Table 4 below compares the number of mothers transported into UMCRH to receive a higher level of care with the number of mothers transported out of UMCRH to another hospital for higher-level care in calendar years 2018 through 2022.

Table 4
UMCRH Maternal Admissions and Transfers CY 2018 to CY 2022

	CY18	CY19	CY20	CY21	CY22
Total number of obstetric admissions	1261	1212	1324	1204	1219
Number of maternal admissions transferred into UMCRH from other hospitals for a higher level of care	18	22	10	10	4
Number of maternal patients transferred out of UMCRH to another hospital for specialty care.	0	1	3	19	21

Source: UMCRH internal data.
Note: Hospital operations transferred from the PGHC campus in Cheverly to the UMCRCM campus in Largo on June 12, 2021. CY 2021 data includes admissions and transfers to/from PGHC from January 1, 2021 through June 11, 2021, and admissions and transfers to/from UMCRMC from June 12, 2021 through December 31, 2021.

Between calendar years 2018 and 2019, when UMCRH operated a Level III NICU at PGHC, an average of 20 mothers were transferred into the hospital each year from other facilities to receive a higher level of care. The number of mothers transported into the hospital has markedly decreased since the hospital paused Level III services, to only four mothers transferred in in calendar year 2022. The historic volumes of transfers into the UMCRMC demonstrate a need for higher intensity services in the service area. The decreased volume of mothers transported into the hospital indicates that patients who previously would have been transferred to UMCRMC to receive obstetrics care must now be treated elsewhere. UMCRMC anticipates that it will recapture this volume of patients transferred into the hospital with the resumption of its Level III Perinatal program, in accordance with its historical experience.

Table 4 above also demonstrates that without Level III service capability at the hospital, the number of mothers that UMCRMC transfers out to another facility has steadily increased. In 2018, no mothers required a transfer out of the hospital to receive a higher level of care. In 2019, only one transfer was necessary. This extremely low transfer volume indicates that the ability to offer Level III NICU services significantly reduces the number of maternal transfers from the hospital. Since Level III services were temporarily paused at the hospital, the hospital's maternal transfers to other facilities has increased every year. In calendar year 2022, maternal transfers out of the hospital reached a five-year high of 21. Given that no Level III NICU exists in the County, this means that all 21 mothers who required a higher level of care had to be transferred to a facility in a different County. The growing volume of mothers requiring transfers to receive a higher level of care, up from *zero* in 2018 to 21 in 2022, alone demonstrates the need for a Level III NICU at UMCRMC.

Without Level III NICU services at UMCRMC, maternal transfers out of the hospital are likely to continue to increase as the population grows. A Level II Special Care Nursery cannot treat any infants of a gestational age under 32 weeks. As a result, mothers who currently present to UMCRMC at less than 32 weeks are automatically transferred, once stabilized, to

facilities with higher level NICUs. Because no facility in the County currently provides Level III NICU services, pregnant mothers under 32 weeks have no access to appropriate, full-service labor and delivery care in the County, Maryland's second most populous jurisdiction. By resuming its Level III NICU service, UMCRMC would address this serious gap in access to care because it could admit pre-term mothers for the full scope of labor, delivery, and postpartum care. As a result, UMCRMC would significantly reduce the number of mothers that must be transferred out of the County due to the level of care they require by resuming Level III NICU services.

While Table 4 above shows that a rising number of mothers are unable to deliver at UMCRMC because they require a transfer to a facility with a higher level of care, the true number of patients who cannot receive care at UMCRMC due to its status as a Level II Special Care Nursery instead of a Level III Perinatal Center is even higher. Because Level II NICUs do not have the capability to treat infants born under 32 weeks gestational age, pre-term mothers who would normally be routed by EMS or their physicians to UMCRMC are instead routed to facilities outside the County with higher-intensity NICUs. Additionally, Prince George's County mothers with high-risk pregnancies or who face increased risks of complications during childbirth preemptively elect to travel to facilities outside the County to deliver to avoid the need for a transfer.

The absence of a Level III NICU at UMCRMC has contributed to an increasing volume of maternal transfers out of the hospital for higher level of care services. This transfer volume demonstrates the need for higher level of care capabilities at UMCRMC.

In addition to the ability to receive and retain more mothers for labor, delivery, and postpartum services, resuming Level III services at UMCRMC will allow UMCRH to reduce the number of infants requiring transfer to a different NICU facility to receive a higher level of care. Table 5 below demonstrates the number of infants transferred out of UMCRH during calendar years 2018 through 2022.

Table 5
Infant Transfers out of UMCRH CY 2018 to CY 2022

Transfer Destination	CY18	CY19	CY20	CY21	CY22
Back to birth or local hospital	0	0	0	0	1
To another NICU for higher level or specialty care	28	20	35	22	43
To Mt Washington Pediatric Hospital or other long-term care facility	2	3	5	1	1

Source: UMCRH Internal Data.
Note: Hospital operations transferred from the PGHC campus in Cheverly to the UMCRCM campus in Largo on June 12, 2021. CY 2021 data includes infant transfers from PGHC from January 1, 2021 through June 11, 2021, and infant transfers from UMCRMC from June 12, 2021 through December 31, 2021.

Whether operating as a Level II or Level III NICU, UMCRH transfers infants to other facilities when the infant needs close monitoring by pediatric subspecialists or requires other diagnostic evaluations or treatments that UMCRH does not provide. UMCRH also transfers infants to other NICUs when the infant requires a higher level of care. When the hospital operated a Level III Perinatal Center, transfers to another NICU for a higher level of care were only required for infants in need of the highest-intensity, Level IV care. As a Level II Special Care Nursery, however, UMCRH must transfer all infants requiring Level III care as well. Since it temporarily suspended provision of Level III services, UMCRH has transferred out an increasing number of infants for whom Level II services were not sufficient. Table 6 below compares the number of infants transferred out of UMCRH due to its status as a Level II program (patients that it could have treated if it were designated as a Level III Perinatal Center) with UMCRH's total infant transfers in calendar years 2020 through 2022.

Table 6
Infants Transferred out of the Hospital for a Higher Level or Specialty Care in CY 2020 to 2022

	CY20	CY21	CY22
Transfers to another NICU for higher level or specialty care due to UMCRMC status as a Level II NICU	3	11	24
Total transfers to another NICU for higher level or specialty care	35	22	43
% of total transfers for higher level or specialty care UMCRH could have treated if Level III	8.6%	50%	55.8%

Source: UMCRH internal data.

During each of calendar years 2021 and 2022, UMCRH could have treated at least half of the infants that it transferred to another NICU to receive higher level or specialty care if UMCRH operated a Level III NICU instead of a Level II Special Care Nursery. This transfer data demonstrates the need for a Level III program in Prince George's County, which would allow a growing number of infants to access neonatal intensive care services in the County instead of requiring their transfer to other distant facilities.

III. Demographic and population health metrics in Prince George's County demonstrate a need for Level III NICU services at UMCRH.

The Level III NICU at UMCRMC will primarily serve residents of Prince George's County. Compared to the rest of the state, Prince George's County is a low performer in several key maternal-fetal metrics. As a result, residents of the County have a higher likelihood of poor pregnancy outcomes that necessitate Level III NICU care for infants. Key metrics for which the County ranks below average include:

- **Low birth weight babies (newborn weighing less than 2,500 grams).** These babies have a greater likelihood of having health issues and requiring medical care in the NICU when compared to normal weight babies. In 2019, 9.6% of births in Prince George's County were considered low birth weight. When compared to other counties in the state, this is in the 2nd worst quartile.

- **Very low birth weight babies (newborn weighing less than 1,500 grams).** These babies have a greater likelihood of having severe health issues when compared to normal weight babies and most require specialized medical care in the NICU. In 2019, 1.9% of the births in Prince George's County were considered very low birth weight. When compared to other counties in the state, this is in the 2nd worst quartile.

- **Pre-term births.** Babies born prematurely have a greater likelihood of requiring specialized medical care and may require a stay in an intensive care nursery. In 2019, 11.1% of the births in Prince George's County were considered very low birth weight. When compared to other counties in the state, this is in the worst 25% of the counties.

- **Mothers who received early prenatal care.** Mothers who do not receive prenatal care are more likely to have low birth weight babies when compared to mothers who receive early prenatal care. In 2019, 53.6% of Prince George's County mothers received prenatal care. When compared to the other counties in the state, this is in the worst 25% of the counties.

- **Infant mortality rate.** This rate is an indicator of the overall health status of the community. In 2019, the infant mortality rate in Prince George's County was 6.2 deaths per 1000 live births. The County's rate is higher than the statewide rate of 5.9 deaths per 1000 live births.

In addition to the metrics identified above, poverty and education level can affect an individual's ability to access necessary resources, which further contributes to poor maternal and infant health outcomes. Women living in poverty are more likely to deliver prematurely and lack access to prenatal care. According to the Prince George's County Department of Health, as of 2017, 7% of Black residents, 12.8% of Hispanic and 8.4% of White (non-Hispanic) residents of Prince George's County were living in poverty. Approximately 12% of Prince George's County women ages 25-34 were below the poverty level in 2017. Additionally, the percentage of women of child-bearing age in Prince George's County who have a college degree (33%) was lower than the state (40%) and neighboring Washington, DC (60%). Coupled with the County's poor performance on maternal-fetal health metrics, these demographic factors increase the likelihood that babies born in the County will require Level III NICU services. A Level III NICU is needed in the County to ensure that babies have access the appropriate level of care in their community.

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 response to COMAR 10.24.10.04B(5) – Cost-Effectiveness.

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

Included in **Exhibit 1** are Tables F, G, H, which provide utilization and financial projections for UMCRH as a whole, and Tables J, K, I, and L which provide utilization and financial projections and workforce information for the proposed Level III NICU at UMCRMC. As presented in these Tables, UMCRH, with the recommencement of Level III NICU services, is projected to be financial viable in the long-term.

This project does not involve any construction or renovation, and no capital expenditures are necessary to enable the hospital to resume providing Level III NICU services. As described more fully in the Comprehensive Project Description and the response to COMAR 10.24.18.04D, UMCRH is ready to offer Level III NICU services immediately upon receipt of all required regulatory approvals.

The proposed project enjoys strong community support, as demonstrated by the letters of support included in **Exhibit 10.** As evidenced by these letters, local government officials, community members, and clinicians alike have offered their strong support and endorsement of the project.

Audited Financial Statements are included in **Exhibit 11**.

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

Since 2000, the Applicant has obtained one CON. On October 20, 2016 UMCRH received a CON for the "Relocation of Prince George's Hospital Center and Mt. Washington Pediatric Hospital, Inc." (Docket No. 13-16-2351). A copy is attached as **Exhibit 12**. There were no specific conditions placed on the CON project. The project was completed as approved.

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[2];

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

c) On costs to the health care delivery system.

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

Applicant Response

As discussed in detail in the Comprehensive Project Description and in the response to COMAR 10.24.01.08G(3)(b) – Need, residents of the service area severely lack access to Level III NICU services. By recommencing Level III NICU services at UMCRMC, access to higher intensity neonatal care will reduce the number of mothers and infants who require transfers to facilities in other jurisdictions to receive appropriate care. Residents of Prince George's County who are at risk of pre-term labor will regain access to full scale labor, delivery, and postpartum care within the County – services that are currently unavailable for mothers up to 32 weeks of pregnancy. This project will have a significant, positive impact on access to life-saving neonatal intensive care services in the service area population.

UMCRH does not anticipate any adverse impact on the volume of service provided by other health care providers as a result of this project. Through the project, UMCRH intends to resume providing Level III NICU services, which it previously provided at PGHC until temporarily suspending the program in October of 2020. No Level III NICU currently exists in Prince George's County. As a result, the volume of patients who previously received Level III NICU services from UMCRH has spread to other facilities outside the County. While UMCRH intends to recapture this volume, its resumption of Level III NICU services will not materially affect any other health care providers. Instead, the recommencement of Level III NICU services at

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

UMCRMC will return utilization and referral patterns amongst providers of high-intensity NICU services in the Southern Maryland and Washington, D.C. region to the status quo.

Table 7 below shows the number of transfers from UMCRH to other NICUs, by facility, in calendar years 2021 and 2022.

Table 7
UMCRH Transfers to Other NICUs by Facility
CY 2021 and CY 2022

Recipient Facility	CY 2021	CY 2022
CNMC	15	23
UMMC	6	14
Mercy Medical Center	1	1
Georgetown	0	2
George Washington	0	1

Source: UMCRH Internal Data

In calendar years 2021 and 2022, UMCRH transferred the majority of its transfer patients to Children's National Medical Center ("CNMC") and University of Maryland Medical Center ("UMMC"). Table 7 reflects all infant transfers to another NICU for any reason, and is not limited to transfers that UMCRH could have retained if it operated at Level III. It thus includes transfers for pediatric subspecialty care that UMCRH does not provide, the majority of which go to CNMC. These transfers to CNMC of infants requiring certain subspecialty care will continue once UMCRH resumes providing Level III NICU services. UMMC, an affiliate of UMCRH, received the second-highest volume of infant transfers from UMCRH. Table 7 demonstrates that the impact on other facilities of reduced infant transfers from UMCRH once it resumes offering Level III NICU services will be marginal and immaterial.

The Commission has previously recognized that a continued Level III NICU service at UMCRMC would not adversely impact other health care providers. In its decision approving the CON Application to relocate and replace PGHC, which included plans for a Level III NICU at UMCRMC, the Reviewer found "that the projected impact of this project is, on balance, positive." MHCC Decision, p. 116. The Reviewer further found that "the project will substantially approve the availability and accessibility to medical services provided by a modernized hospital for the residents of Prince George's County," and that such benefits outweighed any adverse impact to other providers. *Id.* Overall, the Reviewer determined that the project "is likely to have a positive impact on the health care delivery system." *Id.* Given that the Commission's decision on the relocation and replacement of PGHC included consideration of Level III NICU services at UMCRMC, the positive impact of providing access to these services will outweigh any small adverse impact to other providers in the region as a result of the patient volumes that UMCRMC will recapture when Level III NICU services resume.

TABLE OF EXHIBITS

TABLE OF TABLES

TABLE OF FIGURES

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for a Level III Neonatal Intensive Care Unit at University of Maryland Capital Region Medical Center and its attachments are true and correct to the best of my knowledge, information, and belief.

January 12, 2023
Date

Michael Brozic
Chief Financial Officer
University of Maryland Capital Region Health

#817376
013849-0010

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for a Level III Neonatal Intensive Care Unit at University of Maryland Capital Region Medical Center and its attachments are true and correct to the best of my knowledge, information, and belief.

January 12, 2023
Date

Ingrid Connerney, DrPH, RN, CPPS, CJCP, FAAN
Vice President and Chief Quality Officer
University of Maryland Capital Region Health

#817377
013849-0010

I hereby declare and affirm under the penalties of perjury that the facts stated in this Application for Certificate of Need for a Level III Neonatal Intensive Care Unit at University of Maryland Capital Region Medical Center and its attachments are true and correct to the best of my knowledge, information, and belief.

January 12, 2023
Date

Kerry Lewis, M.D.
Medical Director Women's and Infants Services
University of Maryland Capital Region Health

#817374
013849-0010

EXHIBIT 1

TABLE F. STATISTICAL PROJECTIONS - UM Capital Region Health

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

	Two Most Recent Years (Actual)		Current Year	Projected 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	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**
1. DISCHARGES								
a. MSGA	7,239	6,826	7,874	7,155	7,370	7,591	7,818	8,053
Total MSGA	**7,239**	**6,826**	**7,874**	**7,155**	**7,370**	**7,591**	**7,818**	**8,053**
b. Pediatric	-	-	-	-	-	-	-	-
c. Obstetric	1,369	1,350	1,418	1,550	1,597	1,644	1,694	1,745
d. RMC Acute Psychiatric	1,511	1,528	1,560	1,497	1,542	1,588	1,636	1,685
Total Acute	**10,119**	**9,704**	**10,852**	**10,202**	**10,508**	**10,823**	**11,148**	**11,482**
e. Rehabilitation	84	53	-	-	-	-	-	-
f. Chronic Care	57	24	-	-	-	-	-	-
TOTAL DISCHARGES	**10,260**	**9,781**	**10,852**	**10,202**	**10,508**	**10,823**	**11,148**	**11,482**
2. PATIENT DAYS								
a. MSGA	44,865	41,126	45,240	42,582	43,860	45,176	46,531	47,927
Total MSGA	**44,865**	**41,126**	**45,240**	**42,582**	**43,860**	**45,176**	**46,531**	**47,927**
b. Pediatric	-	-	-	-	-	-	-	-
c. Obstetric	3,550	3,333	4,678	5,115	5,268	5,427	5,589	5,757
d. RMC Acute Psychiatric	9,222	9,631	9,834	9,436	9,719	10,010	10,311	10,620
Total Acute	**57,637**	**54,090**	**59,752**	**57,133**	**58,847**	**60,612**	**62,431**	**64,304**
e. Rehabilitation	1,003	620	-	-	-	-	-	-
f. Chronic Care	2,098	795	-	-	-	-	-	-
TOTAL PATIENT DAYS	**60,738**	**55,505**	**59,752**	**57,133**	**58,847**	**60,612**	**62,431**	**64,304**

TABLE F. STATISTICAL PROJECTIONS - UM Capital Region Health

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

	Two Most Recent Years (Actual)		Current Year	Projected 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	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)								
a. MSGA	6.2	6.0	5.7	6.0	6.0	6.0	6.0	6.0
Total MSGA	**6.2**	**6.0**	**5.7**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**
b. Pediatric	-	-	-	-	-	-	-	-
c. Obstetric	2.6	2.5	3.3	3.3	3.3	3.3	3.3	3.3
d. RMC Acute Psychiatric	6.1	6.3	6.3	6.3	6.3	6.3	6.3	6.3
Total Acute	**5.7**	**5.6**	**5.5**	**5.6**	**5.6**	**5.6**	**5.6**	**5.6**
e. Rehabilitation	11.9	11.7	-	-	-	-	-	-
f. Chronic Care	36.8	33.1	-	-	-	-	-	-
TOTAL AVERAGE LENGTH OF STAY	**5.9**	**5.7**	**5.5**	**5.6**	**5.6**	**5.6**	**5.6**	**5.6**
4. NUMBER OF LICENSED BEDS								
a. MSGA	190	190	174	163	168	173	179	184
Total MSGA	**190**	**190**	**174**	**163**	**168**	**173**	**179**	**184**
b. Pediatric	2	2	-	-	-	-	-	-
c. Obstetric	30	30	22	22	22	22	22	22
d. RMC Acute Psychiatric	32	32	28	28	28	28	28	28
Total Acute	**254**	**254**	**224**	**213**	**218**	**223**	**229**	**234**
e. Rehabilitation	10	10	-	-	-	-	-	-
f. Chronic Care	12	12	-	-	-	-	-	-
TOTAL LICENSED BEDS	**276**	**276**	**224**	**213**	**218**	**223**	**229**	**234**

TABLE F. STATISTICAL PROJECTIONS - UM Capital Region Health

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

	Two Most Recent Years (Actual)		Current Year	Projected 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	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*								
a. MSGA	64.7%	59.3%	71.4%	71.4%	71.4%	71.4%	71.4%	71.4%
Total MSGA	**64.7%**	**59.3%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**
b. Pediatric								
c. Obstetric	32.4%	30.4%	58.3%	63.7%	65.6%	67.6%	69.6%	71.7%
d. RMC Acute Psychiatric	79.0%	82.5%	96.2%	92.3%	95.1%	97.9%	100.9%	103.9%
Total Acute	**62.2%**	**58.3%**	**73.2%**	**73.4%**	**73.9%**	**74.4%**	**74.9%**	**75.4%**
e. Rehabilitation	27.5%	17.0%						
f. Chronic Care	47.9%	18.2%						
TOTAL OCCUPANCY %	**60.3%**	**55.1%**	**73.2%**	**73.4%**	**73.9%**	**74.4%**	**74.9%**	**75.4%**
6. OUTPATIENT VISITS (Includes RMC, Laurel FMF and BHC)								
a. Emergency Department	88,815	72,011	79,218	83,524	85,194	86,898	88,636	90,409
b. Same-day Surgery	2,136	1,965	2,349	2,573	2,624	2,677	2,730	2,785
TOTAL OUTPATIENT VISITS	**95,178**	**77,500**	**85,519**	**90,583**	**92,395**	**94,243**	**96,127**	**98,050**
7. OBSERVATIONS**								
a. Number of Patients	5,532	5,573	5,917	5,636	5,749	5,864	5,981	6,101
b. Hours	153,531	139,923	144,279	137,428	140,176	142,980	145,839	148,756

* 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 - UM Capital Region Health

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

	Two Most Recent Years (Actual)		Current Year	Projected 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	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**
1. REVENUE								
a. Inpatient Services	$ 269,370	$ 285,848	$ 286,931	$ 289,107	$ 288,322	$ 287,683	$ 287,050	$ 286,418
b. Outpatient Services	159,657	193,208	203,686	205,923	207,857	207,943	208,027	208,112
Gross Patient Service Revenues	***429,026***	***479,056***	***490,617***	***495,030***	***496,179***	***495,625***	***495,077***	***494,529***
c. Deductions	109,784	117,829	117,290	118,366	118,629	118,572	118,517	118,386
Net Patient Services Revenue	***319,242***	***361,226***	***373,327***	***376,664***	***377,551***	***377,053***	***376,560***	***376,143***
d. Grants	15,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
e. Other Operating Revenue	52,658	10,396	10,658	10,658	10,658	10,658	10,658	10,658
NET OPERATING REVENUE	***386,900***	***381,622***	***393,985***	***397,322***	***398,209***	***397,711***	***397,218***	***396,801***
2. EXPENSES								
a. Salaries & Wages (including benefits)	212,444	195,540	197,254	198,831	200,021	201,245	202,504	203,770
b. Contractual Services	96,489	78,221	78,864	59,264	50,609	49,490	48,322	47,182
c. Interest on Current Debt	1,288	6,569	6,424	10,097	8,821	8,674	8,383	8,102
d. Interest on Project Debt	-	-	-	-	-	-	-	-
e. Current Depreciation and Ammortization	16,546	33,185	36,418	42,049	44,254	41,280	37,687	34,431
f. Project Depreciation and Ammortization	-	-	-	-	-	-	-	-
g. Supplies - Drugs & Pharmeceuticals	7,342	8,931	9,355	9,442	9,532	9,625	9,721	9,817
h. Supplies - Medical & Non-Medical	34,452	26,168	27,173	27,536	27,809	28,090	28,379	28,670
i. Professional Fees	41,038	42,742	44,379	44,936	45,504	46,086	46,682	47,282
j. Utilities	7,568	10,996	10,944	10,671	10,671	10,672	10,672	10,672
TOTAL OPERATING EXPENSES	**417,167**	**402,352**	**410,811**	**402,825**	**397,222**	**395,160**	**392,347**	**389,926**
3. INCOME								
a. Income From Operation	**(30,267)**	**(20,730)**	**(16,826)**	**(5,503)**	**987**	**2,551**	**4,870**	**6,876**
b. Investment Income	1,360	3,387	2,998	4,569	4,644	4,752	4,894	5,047
SUBTOTAL	***(28,907)***	***(17,343)***	***(13,828)***	***(934)***	***5,631***	***7,303***	***9,765***	***11,923***
c. Income Taxes								
NET INCOME (LOSS)	***(28,907)***	***(17,343)***	***(13,828)***	***(934)***	***5,631***	***7,303***	***9,765***	***11,923***
a. Add Back Depreciation	16,546	33,185	36,418	42,049	44,254	41,280	37,687	34,431
CASH FLOW FROM OPERATIONS	***$ (12,361)***	***$ 15,842***	***$ 22,590***	***$ 41,115***	***$ 49,885***	***$ 48,583***	***$ 47,452***	***$ 46,354***

TABLE G. REVENUES & EXPENSES, UNINFLATED - UM Capital Region Health

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	Two Most Recent Years (Actual)		Current Year	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	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%
2) Medicaid	26.3%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%
3) Blue Cross	9.1%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%
4) Commercial Insurance	2.3%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
5) Self-pay	9.1%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%
6) Other	19.1%	19.6%	19.6%	19.6%	19.6%	19.6%	19.6%	19.6%
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	41.4%	38.9%	38.9%	38.9%	38.9%	38.9%	38.9%	38.9%
2) Medicaid	28.5%	27.9%	27.9%	27.9%	27.9%	27.9%	27.9%	27.9%
3) Blue Cross	7.0%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
4) Commercial Insurance	1.4%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%
5) Self-pay	6.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%
6) Other	15.3%	17.5%	17.5%	17.5%	17.5%	17.5%	17.5%	17.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table G – Key Financial Projection Assumptions for UM Capital Region Health (Excludes HSCRC Annual Update Factors & Expense Inflation)	
Projection is based on the Capital Region Health (CRH) FY2023 projected financial performance with assumptions identified below	
Projection period reflects FY2024 – FY2028	
Volumes	— See Table F of the application for volume projections
Patient Revenue ● FY2024+ Adjustments to Permanent Revenue ○ Inflation ○ Shared Savings ○ Demographic Adjustment — Total ● Revenue Deductions	 — 0.00% — -0.26% — 0.02% -0.24% — 23.9% of gross revenue per year
Other Revenue ● Grants ○ State ● Other Operating Revenue	 — $10M in support from FY2024 - FY2028 — 0% annual growth
Expenses ● Inflation ● Expense variability with volume changes ○ Salaries & Benefits ○ Professional Fees ○ Supplies - Drugs ○ Supplies - Medical & Other ○ Purchased Services ○ Insurance & Other Operating Expenses	 — 0% annual increase — 20% — 50% — 30% — 20% — 0% — 0%
● Interest Expense ○ Existing Debt ○ Project Debt ● Depreciation and Amortization ● Performance Improvements ○ FY2023 ○ FY2024 ○ FY2025 ○ FY2026 ○ FY2027 ○ FY2028 ○ Identified Improvements by FY2028	 — CRH has existing debt of $275.9M in FY2022 that is amortized — In FY2024, the new Laurel FMF will open and interest expense on $58.8M of tax-exempt debt associated with these facilities will be recorded at an interest rate of 5.0% — Reflects the depreciation of existing assets with useful lives ranging from 5 to 30 years — $0 — $18.2M — $28.9M — $35.7M — $40.2M — $45.3M — $10M - Denials improvement — $5M - Reduction in force — $3M - Medical Group improvement — $6M - Agency improvement — $2M - Productivity — $5M - Market share revenue adjustments — $1M - School of Medicine contract improvement — $13.3M - Undefined Actions

TABLE H. REVENUES & EXPENSES, INFLATED - UM Capital Region Health

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

	Two Most Recent Years (Actual)		Current Year	Projected 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	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**
1. REVENUE								
a. Inpatient Services	$ 269,370	$ 285,848	$ 286,931	$ 296,421	$ 303,391	$ 310,529	$ 317,840	$ 325,322
b. Outpatient Services	159,657	193,208	203,686	$ 211,132	$ 218,721	$ 224,456	$ 230,341	$ 236,379
Gross Patient Service Revenues	***429,026***	***479,056***	***490,617***	***507,554***	***522,113***	***534,985***	***548,180***	***561,701***
c. Deductions	109,784	117,829	117,290	$ 121,361	$ 124,829	$ 127,988	$ 131,229	$ 134,552
Net Patient Services Revenue	***319,242***	***361,226***	***373,327***	***386,193***	***397,284***	***406,997***	***416,951***	***427,149***
d. Grants	15,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
e. Other Operating Revenue	52,658	10,396	10,658	10,871	11,089	11,311	11,537	11,767
NET OPERATING REVENUE	***386,900***	***381,622***	***393,985***	***407,064***	***418,373***	***428,307***	***438,487***	***448,916***
2. EXPENSES								
a. Salaries & Wages (including benefits)	212,444	195,540	197,254	$ 202,807	$ 208,102	$ 213,563	$ 219,197	$ 224,978
b. Contractual Services	96,489	78,221	78,864	$ 60,450	$ 52,654	$ 52,519	$ 52,305	$ 52,093
c. Interest on Current Debt	1,288	6,569	6,424	10,097	8,821	8,674	8,383	8,102
d. Interest on Project Debt	-	-	-	-	-	-	-	-
e. Current Depreciation and Ammortization	16,546	33,185	36,418	42,049	44,254	41,280	37,687	34,431
f. Project Depreciation and Ammortization	-	-	-	-	-	-	-	-
g. Supplies - Drugs & Pharmeceuticals	7,342	8,931	9,355	$ 9,820	$ 10,310	$ 10,827	$ 11,372	$ 11,944
h. Supplies - Medical & Non-Medical	34,452	26,168	27,173	$ 28,362	$ 29,503	$ 30,694	$ 31,940	$ 33,237
i. Professional Fees	41,038	42,742	44,379	$ 46,284	$ 48,276	$ 50,360	$ 52,541	$ 54,812
j. Insurance and Other	7,568	10,996	10,944	$ 10,884	$ 11,102	$ 11,325	$ 11,551	$ 11,783
TOTAL OPERATING EXPENSES	**417,167**	**402,352**	**410,811**	**410,752**	**413,021**	**419,240**	**424,975**	**431,380**
3. INCOME								
a. Income From Operation	**(30,267)**	**(20,730)**	**(16,826)**	**(3,688)**	**5,352**	**9,067**	**13,512**	**17,536**
b. Non-Operating Income	1,360	3,387	2,998	$ 4,569	$ 4,644	$ 4,752	$ 4,894	$ 5,047
SUBTOTAL	***(28,907)***	***(17,343)***	***(13,828)***	***882***	***9,995***	***13,819***	***18,407***	***22,583***
c. Income Taxes	-	-	-	$ 1,436	$ 1,383	$ 1,328	$ 1,271	$ 1,213
NET INCOME (LOSS)	***(28,907)***	***(17,343)***	***(13,828)***	***(555)***	***8,613***	***12,491***	***17,135***	***21,370***
a. Add Back Depreciation	16,546	33,185	36,418	$ 40,459	$ 42,611	$ 39,582	$ 35,932	$ 32,619
CASH FLOW FROM OPERATIONS	***$ (12,361)***	***$ 15,842***	***$ 22,590***	***$ 39,905***	***$ 51,223***	***$ 52,073***	***$ 53,068***	***$ 53,989***

TABLE H. REVENUES & EXPENSES, INFLATED - UM Capital Region Health

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

	Two Most Recent Years (Actual)		Current Year	Projected 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	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%
2) Medicaid	26.3%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%
3) Blue Cross	9.1%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%
4) Commercial Insurance	2.3%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
5) Self-pay	9.1%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%
6) Other	19.1%	19.6%	19.6%	19.6%	19.6%	19.6%	19.6%	19.6%
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	41.4%	38.9%	38.9%	38.9%	38.9%	38.9%	38.9%	38.9%
2) Medicaid	28.5%	27.9%	27.9%	27.9%	27.9%	27.9%	27.9%	27.9%
3) Blue Cross	7.0%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
4) Commercial Insurance	1.4%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%
5) Self-pay	6.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%
6) Other	15.3%	17.5%	17.5%	17.5%	17.5%	17.5%	17.5%	17.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table H – Key Financial Projection Assumptions for UM Capital Region Health (Includes HSCRC Annual Update Factors & Expense Inflation)	
Projection is based on the Capital Region Health (CRH) FY2023 projected financial performance with assumptions identified below	
Projection period reflects FY2024 – FY2028	
Volumes	— See Table F of the application for volume projections
Patient Revenue ● FY2024+ Adjustments to Permanent Revenue ○ Inflation ○ Shared Savings ○ Demographic Adjustment — Total ● Revenue Deductions	 — 2.58% — -0.26% — 0.02% 2.34% — 23.9% of gross revenue per year
Other Revenue ● Grants ○ State ● Other Operating Revenue	 — $10M in annual support from FY2024 - FY2028 — 2% annual growth
Expenses ● Inflation ○ Salaries & Benefits ○ Professional Fees ○ Supplies - Drugs ○ Supplies - Medical & Other ○ Purchased Services ○ Insurance & Other Operating Expenses	 — 2.0% — 3.0% — 4.0% — 3.0% — 2.0% — 2.0%
● Expense variability with volume changes ○ Salaries & Benefits ○ Professional Fees ○ Supplies - Drugs ○ Supplies - Medical & Other ○ Purchased Services ○ Insurance & Other Operating Expenses ● Interest Expense ○ Existing Debt ○ Project Debt ● Depreciation and Amortization ○ Existing Depreciation ○ Project Depreciation ● Performance Improvements ○ FY2023 ○ FY2024 ○ FY2025 ○ FY2026 ○ FY2027 ○ FY2028 ○ Identified Improvements by FY2028	 — 20% — 50% — 30% — 20% — 0% — 0% — UM CRH has existing debt of $275.9M in FY2022 that is amortized — In FY2024, the new Laurel FMF will open and interest expense on $58.8M of tax-exempt debt associated with these facilities will be recorded at an interest rate of 5.0% — Reflects the depreciation of existing assets with useful lives ranging from 5 to 30 years — Reflects a project budget of $75.6M and a useful life of 25 years for the Laurel FMF — $0 — $18.2M — $28.9M — $35.7M — $40.2M — $45.3M — $10M - Denials improvement — $5M - Reduction in force — $3M - Medical Group improvement — $6M - Agency improvement — $2M - Productivity — $5M - Market share revenue adjustments — $1M - School of Medicine contract improvement — $13.3M - Undefined Actions

TABLE I. STATISTICAL PROJECTIONS - UM Capital Region Health - NICU

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

	Two Most Recent Years		Current Year	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	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**
1. DISCHARGES								
a. General Medical/Surgical*								
b. ICU/CCU								
Total MSGA								
c. Pediatric								
d. Obstetric								
e. Acute Psychiatric								
Total Acute								
f. Rehabilitation								
g. Chronic Care								
h. NICU (not included in total)	98	168	137	147	147	147	147	147
TOTAL DISCHARGES								
2. PATIENT DAYS								
a. General Medical/Surgical*								
b. ICU/CCU								
Total MSGA								
c. Pediatric								
d. Obstetric								
e. Acute Psychiatric								
Total Acute								
f. Rehabilitation								
g. Chronic Care								
h. NICU (not included in total)	1,249	1,004	847	2,368	2,366	2,365	2,364	2,363
TOTAL PATIENT DAYS								
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)								
a. General Medical/Surgical*								
b. ICU/CCU								
Total MSGA								

TABLE I. STATISTICAL PROJECTIONS - UM Capital Region Health - NICU

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

	Two Most Recent Years		Current Year	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	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**
c. Pediatric								
d. Obstetric								
e. Acute Psychiatric								
Total Acute								
f. Rehabilitation								
g. Chronic Care								
h. NICU (not included in total)	12.7	6.0	6.2	16.1	16.1	16.1	16.1	16.1
TOTAL AVERAGE LENGTH OF STAY								
4. NUMBER OF BEDS								
a. General Medical/Surgical*								
b. ICU/CCU								
Total MSGA								
c. Pediatric								
d. Obstetric								
e. Acute Psychiatric								
Total Acute								
f. Rehabilitation								
g. Chronic Care								
h. NICU (not included in total)	5	4	3	9	9	9	9	9
TOTAL BEDS								
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*								
a. General Medical/Surgical*								
b. ICU/CCU								
Total MSGA								
c. Pediatric								
d. Obstetric								
e. Acute Psychiatric								
Total Acute								

TABLE I. STATISTICAL PROJECTIONS - UM Capital Region Health - NICU

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

	Two Most Recent Years		Current Year	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	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**
f. Rehabilitation								
g. Chronic Care								
h. NICU (not included in total)	68.4%	68.7%	77.4%	71.9%	72.0%	72.0%	72.0%	71.7%
TOTAL OCCUPANCY %								
6. OUTPATIENT VISITS								
a. Emergency Department								
b. Same-day Surgery								
c. Clinic								
d. Imaging								
e. Intensive Outpatient Psych								
f. Partial Hospitalization Program								
TOTAL OUTPATIENT VISITS	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
7. OBSERVATIONS								
a. Number of Patients								
b. Hours								

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

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

TABLE J. REVENUES & EXPENSES, UNINFLATED - UM Capital Region Health NICU

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

	Two Most Recent Years (Actual)		Current Year	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**
1. REVENUE								
a. Inpatient Services	$1,398	$1,295	$ 1,231	$ 4,000	$ 3,984	$ 3,967	$ 3,951	$ 3,935
b. Outpatient Services	-	-	-	-	-	-	-	-
Gross Patient Service Revenues	***1,398***	***1,295***	***1,231***	***4,000***	***3,984***	***3,967***	***3,951***	***3,935***
c. Deductions	232	215	204	1,137	1,126	1,116	1,106	1,096
Net Patient Services Revenue	***1,167***	***1,081***	***1,027***	***2,864***	***2,857***	***2,851***	***2,844***	***2,838***
d. Grants	-	-	-	-	-	-	-	-
e. Other Operating Revenues	-	-	-	-	-	-	-	-
NET OPERATING REVENUE	***1,167***	***1,081***	***1,027***	***2,864***	***2,857***	***2,851***	***2,844***	***2,838***
2. EXPENSES								
a. Salaries & Wages (including benefits)	1,649	1,682	1,716	2,178	2,178	2,177	2,177	2,177
b. Contractual Services	-	-	-	-	-	-	-	-
c. Interest on Current Debt	-	-	-	-	-	-	-	-
d. Interest on Project Debt	-	-	-	-	-	-	-	-
e. Current Depreciation and Amortization	-	-	-	-	-	-	-	-
f. Project Depreciation and Amortization	-	-	-	-	-	-	-	-
g. Supplies	92	94	97	200	200	200	200	200
h. Professional Fees	2,196	2,262	2,330	2,400	2,399	2,399	2,398	2,398
i. Insurance and Other Expenses	-	-	-	-	-	-	-	-
TOTAL OPERATING EXPENSES	***3,937***	***4,039***	***4,143***	***4,778***	***4,777***	***4,776***	***4,775***	***4,774***
3. INCOME								
a. Income From Operation	***(2,770)***	***(2,958)***	***(3,116)***	***(1,914)***	***(1,920)***	***(1,925)***	***(1,931)***	***(1,936)***
b. Non-Operating Income	-	-	-	-	-	-	-	-
SUBTOTAL	***(2,770)***	***(2,958)***	***(3,116)***	***(1,914)***	***(1,920)***	***(1,925)***	***(1,931)***	***(1,936)***
c. Income Taxes								
NET INCOME (LOSS)	***(2,770)***	***(2,958)***	***(3,116)***	***(1,914)***	***(1,920)***	***(1,925)***	***(1,931)***	***(1,936)***
a. Add Back Depreciation	-	-	-	-	-	-	-	-
CASH FLOW FROM OPERATIONS	***$ (2,770)***	***$ (2,958)***	***$ (3,116)***	***$ (1,914)***	***$ (1,920)***	***$ (1,925)***	***$ (1,931)***	***$ (1,936)***

TABLE J. REVENUES & EXPENSES, UNINFLATED - UM Capital Region Health NICU

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

	Two Most Recent Years (Actual)		Current Year	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
2) Medicaid	73.8%	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%
3) Blue Cross	7.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4) Commercial Insurance	0.4%	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%
5) Self-pay	7.6%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%
6) Other	10.9%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%
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	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
2) Medicaid	75.2%	68.9%	68.9%	68.9%	68.9%	68.9%	68.9%	68.9%
3) Blue Cross	6.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4) Commercial Insurance	0.5%	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%
5) Self-pay	7.8%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%
6) Other	9.9%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table J – Key Financial Projection Assumptions for Cap Region NICU (No HSCRC Annual Update Factors & Expense Inflation)	
Projection is based on the UM Capital Region NICU FY2023 budgeted revenue and expense with assumptions identified below	
Projection period reflects FY2023 – FY2028	
Volumes	— See Table I of the application for volume projections
Patient Revenue	
● Charge per Patient Day Assumptions	
— FY2022 Inflated NUR Rate	— $ 893
— FY2022 Inflated NEO Rate	— $ 1,284
● FY2024+ Revenue Assumptions	
— Regulated Revenue Inflation	— 0.00%
— Unregulated Revenue Inflation	— 0.00%
● Revenue Deductions	
— Regulated Deductions %	— 16.6%
— Unregulated Deductions %	— 66.0%
Expenses	
● Inflation	
○ Salaries & Benefits	— 0.00%
○ Professional Fees	— 0.00%
○ Supplies	— 0.00%
● Expense variability with volume changes	
○ Salaries & Benefits	— 20.00%
○ Professional Fees	— 50.00%
○ Supplies	— 30.00%

TABLE K. REVENUES & EXPENSES, INFLATED - UM Capital Region Health - NICU

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

	Two Most Recent Years (Actual)		Current Year	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**
1. REVENUE								
a. Inpatient Services	$ 1,746	$ 1,430	$ 1,231	$ 4,000	$ 4,086	$ 4,174	$ 4,264	$ 4,357
b. Outpatient Services	-	-	-	-	-	-	-	-
Gross Patient Service Revenues	***1,746***	***1,430***	***1,231***	***4,000***	***4,086***	***4,174***	***4,264***	***4,357***
c. Deductions	628	512	439	1,137	1,156	1,175	1,194	1,214
Net Patient Services Revenue	***1,118***	***918***	***792***	***2,864***	***2,931***	***3,000***	***3,070***	***3,143***
d. Grants	-	-	-	-	-	-	-	-
e. Other Operating Revenues	-	-	-	-	-	-	-	-
NET OPERATING REVENUE	***1,118***	***918***	***792***	***2,864***	***2,931***	***3,000***	***3,070***	***3,143***
2. EXPENSES								
a. Salaries & Wages (including benefits)	1,649	1,682	1,716	2,178	2,221	2,265	2,310	2,356
b. Contractual Services	-	-	-	-	-	-	-	-
c. Interest on Current Debt	-	-	-	-	-	-	-	-
d. Interest on Project Debt	-	-	-	-	-	-	-	-
e. Current Depreciation and Ammortization	-	-	-	-	-	-	-	-
f. Project Depreciation and Ammortization	-	-	-	-	-	-	-	-
g. Supplies	92	94	97	200	206	212	218	225
h. Professional Fees	2,196	2,262	2,330	2,400	2,471	2,545	2,621	2,699
i. Insurance and Other Expenses	-	-	-	-	-	-	-	-
TOTAL OPERATING EXPENSES	***3,937***	***4,039***	***4,143***	***4,778***	***4,898***	***5,022***	***5,149***	***5,280***
3. INCOME								
a. Income From Operation	***(2,819)***	***(3,120)***	***(3,350)***	***(1,914)***	***(1,968)***	***(2,023)***	***(2,079)***	***(2,137)***
b. Non-Operating Income								
SUBTOTAL	***(2,819)***	***(3,120)***	***(3,350)***	***(1,914)***	***(1,968)***	***(2,023)***	***(2,079)***	***(2,137)***
c. Income Taxes								
NET INCOME (LOSS)	***(2,819)***	***(3,120)***	***(3,350)***	***(1,914)***	***(1,968)***	***(2,023)***	***(2,079)***	***(2,137)***
a. Add Back Depreciation								
CASH FLOW FROM OPERATIONS	***$ (2,819)***	***$ (3,120)***	***$ (3,350)***	***$ (1,914)***	***$ (1,968)***	***$ (2,023)***	***$ (2,079)***	***$ (2,137)***

TABLE K. REVENUES & EXPENSES, INFLATED - UM Capital Region Health - NICU

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

	Two Most Recent Years (Actual)		Current Year	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**FY2027**	**FY2028**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
2) Medicaid	73.8%	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%
3) Blue Cross	7.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4) Commercial Insurance	0.4%	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%
5) Self-pay	7.6%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%
6) Other	10.9%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%
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	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
2) Medicaid	75.2%	68.9%	68.9%	68.9%	68.9%	68.9%	68.9%	68.9%
3) Blue Cross	6.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4) Commercial Insurance	0.5%	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%
5) Self-pay	7.8%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%
6) Other	9.9%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table K – Key Financial Projection Assumptions for Cap Region NICU (Includes HSCRC Annual Update Factors & Expense Inflation)	
Projection is based on the UM Capital Region NICU FY2023 budgeted revenue and expense with assumptions identified below	
Projection period reflects FY2023 – FY2028	
Volumes	— See Table I of the application for volume projections
Patient Revenue ● Charge per Patient Day Assumptions — FY2022 Inflated NUR Rate — FY2022 Inflated NEO Rate ● FY2024+ Revenue Assumptions — Regulated Revenue Inflation — Unregulated Revenue Inflation ● Revenue Deductions — Regulated Deductions % — Unregulated Deductions % Expenses ● Inflation ○ Salaries & Benefits ○ Professional Fees ○ Supplies ● Expense variability with volume changes ○ Salaries & Benefits ○ Professional Fees ○ Supplies	 — $ 893 — $ 1,284 — 2.58% — 1.00% — 16.6% — 66.0% — 2.00% — 3.00% — 3.00% — 20.00% — 50.00% — 30.00%

TABLE L. WORKFORCE INFORMATION - UM Capital Region Health - NICU

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

	CURRENT NICU SERVICE LINE			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED NICU SERVICE LINE THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Total Administration	1.0	$ 76,253	$ 76,253	-	$ -	$ -	-	$ -	$ -	1.0	$ 76,253
Direct Care Staff *(List general categories, add rows if needed)*											
Total Direct Care	21.5	$ 76,253	$ 1,639,434	5.5	$ 84,029	$ 461,229	-	$ -	$ -	27.0	$ 2,100,662
Support Staff *(List general categories, add rows if needed)*											
Total Support	-	$ -	$ -	-	$ -	-	-	$ -	$ -	-	-
REGULAR EMPLOYEES TOTAL	22.5	$ 76,253	$ 1,715,686	5.5	$ 84,029	$ 461,229	-	$ -	$ -	28.0	$ 2,176,915
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
Total Administration	-	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-	$ -
Direct Care Staff *(List general categories, add rows if needed)*											
Total Direct Care Staff	-	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-	$ -
Support Staff *(List general categories, add rows if needed)*											
Total Support Staff	-	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-	$ -
CONTRACTUAL EMPLOYEES TOTAL	-	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-	$ -
Benefits *(State method of calculating benefits below)* **:**			$ -						$ -		$ -
Included in Figures Above											
TOTAL COST	***22.5***		***1,715,686***	***5.5***		***$ 461,229***	***-***		***$ -***		***$ 2,176,915***

EXHIBIT 2

5

LR - Deed (No-Taxes)
Recording Fee 75.00
Name: capital center
Ref:
LR - Deed (No-Taxes)
Surcharge 40.00
==========
SubTotal: 115.00
==========
Total: 1,270.00
01/31/2017 01:52
CC16-TH
#7708114 CC0703 -
Prince George's
County/CC07.03.06 -
Recorded

Tax ID No.: 13-3438892

SPECIAL WARRANTY DEED

THIS DEED is made as of the 25th day of January, 2017, by and between **REVENUE AUTHORITY OF PRINCE GEORGE'S COUNTY**, a body politic of the State of Maryland ("**Grantor**"), with a mailing address of 1300 Mercantile Lane, Suite 108, Largo, MD 20774, and **DIMENSIONS HEALTH CORPORATION**, a Maryland corporation ("**Grantee**"), with a mailing address of 3100 Hospital Drive, Executive Offices, Cheverly, MD 20785.

In consideration of the sum of TEN DOLLARS ($10.00), the receipt and adequacy of which are hereby acknowledged, Grantor does hereby grant, assign and convey unto Grantee, its successors and assigns, all that/those lot(s) of ground located in Prince George's County, State of Maryland and described on Exhibit A hereto, subject only to the matters described on Exhibit B hereto.

TOGETHER with Grantor's interest in (i) the buildings and improvements thereupon made or being; and (ii) all and every, the rights, alleys, ways, waters, privileges, appurtenances and advantages thereto belonging, or in anywise appertaining.

TO HAVE AND TO HOLD the above granted and bargained premises hereby intended to be conveyed, together with the appurtenances thereof unto and to the proper use and benefit of the Grantee, its successors and assigns, in fee simple.

AND the Grantor covenants to warrant specially the property hereby granted and conveyed and to execute such further assurances of said land as may be requisite.

PRINCE GEORGE'S COUNTY, MD
APPROVED BY _____
#03 _____

JAN 31 2017

$ N/A RECORDATION TAX PAID
$ N/A TRANSFER TAX PAID

AFTER RECORDING Return to:
Chicago Title Insurance Company
2000 M Street N.W.
Suite 610 1730022
Washington, D.C. 20036

EAST\139005884.4

WITNESS the hand and seal of Grantor as of the day and year first above written.

WITNESS/ATTEST:

GRANTOR:

REVENUE AUTHORITY OF PRINCE GEORGE'S COUNTY, a body politic of the State of Maryland

By: _____ (SEAL)
Peter A. Shapiro
Executive Director

STATE OF Maryland)
) SS:
CITY/COUNTY OF Prince George's)

I HEREBY CERTIFY that on this 23rd day of January, 2017 before me, the undersigned officer, personally appeared Peter A. Shapiro, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledged that (s)he is the Executive Director of the Revenue Authority of Prince George's County, a body politic of the State of Maryland, the within Grantor, and, being authorized to do so, executed the same for the purposes therein contained

IN WITNESS WHEREOF, I hereunto set my hand and Notarial Seal.

Tracy J. Holland
Notary Public

My Commission expires:
October 9, 2019

TRACY J. HOLLAND
Notary Public - Maryland
Prince George's County
My Commission Expires on
October 9, 2019

This is to certify that this instrument has been prepared by, or under the supervision of, the undersigned, an attorney duly admitted to practice before the Court of Appeals of Maryland.

Tracy M. Benjamin

Exhibit A

Legal Description

All that certain lot or parcel of land together with all improvements thereon located and being in the County of Prince Georges, Maryland and being more particularly described as follows:

BEING ALL OF PARCELS 2-9, and shown on plat of subdivision entitled "Parcels 2 Through 9 Prince George's Regional Hospital", and recorded among the Land Records of Prince Georges County as ~~Plat Book ____~~ at Plat No. SJH246-63

The property is more particularly described by metes and bounds as follow:

DESCRIPTION OF 8 PARCELS OF LAND

PRINCE GEORGE'S REGIONAL HOSPITAL

PARCEL 2

Beginning a point on the southerly right of way line of Arena Drive at the end of the North 15°53'22" East 249.87 foot parcel line common to Parcels 2 and 3 as shown on said plat entitled "PRINCE GEORGE'S REGIONAL HOSPITAL" intended to be recorded; thence departing said right of way line of Arena Drive and binding reversely on said parcel line

1. South 15°53'22" West, 249.87 feet to intersect the northerly right of way line of a newly proposed road right of way as shown on said plat of subdivision entitled "PRINCE GEORGE'S REGIONAL HOSPITAL", intended to be recorded; thence binding on said right of way line the following four (4) courses
2. North 74°06'38" West, 213.45 feet; thence
3. North 29°14'20" West, 35.44 feet; thence
4. North 15°37'58" East, 208.77 feet; thence
5. North 61°51'04" East, 34.62 feet to intersect the said southerly right of way line of Arena Drive; thence binding on said right of way line
6. South 71°59'05" East, 214.77 feet to the point of beginning. Containing 60,163 square feet or 1.3812 acres of land.

PARCEL 3

Beginning a point on the southerly right of way line of Arena Drive at the end of the

North 15°53'22" East 249.87 foot parcel line common to Parcels 2 and 3 as shown on said plat entitled "PRINCE GEORGE'S REGIONAL HOSPITAL" intended to be recorded; thence binding on said southerly right of way line of Arena Drive

1. South 71°59'05" East, 154.10 feet to intersect the right of way line of a newly proposed road right of way as shown on said plat of subdivision entitled "PRINCE GEORGE'S REGIONAL HOSPITAL", intended to be recorded; thence binding on said right of way line the following four (4) courses; thence
2. South 28°01'14" East, 40.39 feet; thence
3. South 15°53'22" West, 190.05 feet; thence
4. South 60°53'22" West, 35.36 feet; thence
5. North 74°06'38" West, 157.00 feet; thence departing said newly proposed road right of way and binding on the said North 15°53'22" East 249.87 foot parcel line common to Parcels 2 and 3 as shown on said "PRINCE GEORGE'S REGIONAL HOSPITAL" plat of subdivision
6. North 15°53'22" East, 249.87 feet to the point of beginning. Containing 44,155 square feet or 1.0137 acres of land.

PARCEL 4

Beginning a point on the southerly right of way line of Arena Drive at the end of the North 15°53'22" East 229.30 foot parcel line common to Parcels 4 and 5 as shown said plat entitled "PRINCE GEORGE'S REGIONAL HOSPITAL" intended to be recorded; thence departing said right of way line of Arena Drive and binding reversely on said parcel line

1. South 15°53'22" West, 229.30 feet to intersect the northerly right of way line of a newly proposed road right of way as shown on said plat of subdivision entitled "PRINCE GEORGE'S REGIONAL HOSPITAL", intended to be recorded; thence binding on said right of way line the following four (4) courses;
2. North 74°06'38" West, 297.00 feet; thence
3. North 29°06'38" West, 35.36 feet; thence
4. North 15°53'22" East, 188.15 feet; thence
5. North 61°58'46" East, 39.02 feet to intersect the said southerly right of way line of Arena Drive; thence binding on said right of way line
6. South 71°59'05" East, 294.09 feet to the point of beginning. Containing 75,052 square feet or 1.7230 acres of land.

PARCEL 5

Beginning a point on the southerly right of way line of Arena Drive at the end of the North 15°53'22" East 229.30 foot parcel line common to Parcels 4 and 5 as shown on said plat eneitled "PRINCE GEORGE'S REGIONAL HOSPITAL" intended to be recorded; thence binding on the said southerly right of way line of Arena Drive

1. South 71°59'05" East, 212.60 feet to a truncation line at the westerly intersection of Arena Drive and Lottsford Road as shown on said "PRINCE GEORGE'S REGIONAL HOSPITAL" plat of subdivision; thence binding on said truncation line

2. South 29°59'27" East, 46.83 feet to a point of curvature on the westerly right of way line of Lottsford Road; thence binding on said right of way line

3. 135.59 feet along the arc of a non-tangent curve deflecting to the left, having a radius of 872.03 feet and a chord of South 07°32'55" West, 135.46 feet; thence binding on a truncation line and a right of way line of a newly proposed road right of way as shown on said plat of subdivision entitled "PRINCE GEORGE'S REGIONAL HOSPITAL", intended to be recorded the following four (4) courses;

4. South 46°03'45" West, 20.88 feet; thence

5. South 88°45'31" West, 85.11 feet to a point of curvature; thence

6. 78.63 feet along the arc of a tangent curve deflecting to the right, having a radius of 263.00 feet and a chord of North 82°40'33" West, 78.34 feet; thence

7. North 74°06'38" West, 96.43 feet; thence departing said newly proposed road right of way and binding on the said North 15°53'22" East 229.30 foot parcel line common to Parcels 4 and 5 as shown on said "PRINCE GEORGE'S REGIONAL HOSPITAL" plat of subdivision

8. North 15°53'22" East, 229.30 feet to the point of beginning. Containing 54,183 square feet or 1.2439 acres of land.

PARCEL 6

Beginning a point on the westerly right of way line of Lottsford Road as shown on said plat entitled "PRINCE GEORGE'S REGIONAL HOSPITAL" plat of subdivision, at the beginning of Line 84 or the North 81°45'00"West 103.06 line, said point of beginning also being the 4th or North 81°41'44"West 103.06 line as described in the said deed recorded in Liber 24549 at folio 189; thence departing the said westerly right of way line of Lottsford Road and binding on a line common to the subject property and the lands of the Washington Metropolitan Transit Authority

as described in a deed recorded amongst the said land records in Liber 24549 at folio 172; thence binding on said common line the following seven (7) courses

1. North 81°45'00" West, 103.06 feet; thence
2. South 54°33'35" West, 51.93 feet to a point of curvature; thence
3. 187.89 feet along the arc of a non-tangent curve deflecting to the right, having a radius of 743.50 feet and a chord of South 19°43'32" West, 187.39 feet; thence
4. South 60°54'25" West, 16.30 feet; thence
5. South 34°46'41" West, 127.00 feet; thence
6. South 54°39'17" West, 9.28 feet; thence
7. South 35°20'53" East, 48.52 feet to intersect the line common to the subject property and the lands of the Washington Metropolitan Transit Authority as described in a deed recorded amongst the said land records in Liber 15518 at folio 695; thence binding on said common line the following two (2) courses
8. South 61°30'52" West, 39.51 feet; thence
9. South 60°36'52" West, 1,317.27 feet to a point of curvature on the southeasterly right of way line of a newly proposed road right of way as shown on said plat of subdivision entitled "PRINCE GEORGE'S REGIONAL HOSPITAL"; thence binding on said newly proposed road right of way the following eleven (11) courses;
10. 41.45 feet along the arc of a curve deflecting to the right, having a radius of 45.58 feet and a chord of North 34°34'40" East, 40.04 feet; thence
11. North 60°37'51" East, 330.71 feet to a point of curvature; thence
12. 405.78 feet along the arc of a tangent curve deflecting to the left, having a radius of 490.00 feet and a chord of North 36°54'24" East, 394.29 feet to a point of compound curvature; thence
13. 515.39 feet along the arc of a tangent curve deflecting to the left, having a radius of 694.00 feet and a chord of North 08°05'32" West, 503.63 feet; thence
14. North 29°22'02" West, 89.59 feet to a point of curvature; thence
15. 230.41 feet along the arc of a tangent curve deflecting to the right, having a radius of 360.00 feet and a chord of North 11°01'55" West, 226.50 feet; thence

16. North 56°39'54" East, 22.52 feet; thence

17. South 74°06'38" East, 884.02 feet to a point of curvature; thence

18. 97.17 feet along the arc of a tangent curve deflecting to the left, having a radius of 325.00 feet and a chord of South 82°40'33" East, 96.81 feet; thence

19. North 88°45'31" East, 82.65 feet; thence

20. South 46°58'36" East, 21.91 feet to a point of curvature on the said westerly right of way line of Lottsford Road as shown on said "PRINCE GEORGE'S REGIONAL HOSPITAL" plat of subdivision; thence binding on said right of way line

21. 40.30 feet along the arc of a non-tangent curve deflecting to the left, having a radius of 872.03 feet and a chord of South 04°14'34" East, 40.29 feet to the point of beginning. Containing 547,156 square feet or 12.5610 acres of land.

PARCEL 7

Beginning a point of curvature on the westerly side of a newly proposed road right of way at a point common to Parcels 1 and 7 as shown on said plat of subdivision entitled "PRINCE GEORGE'S REGIONAL HOSPITAL", intended to be recorded; thence binding on said newly proposed road right of way the following two (2) courses;

1. 259.23 feet along the arc of a non-tangent curve deflecting to the right, having a radius of 606.00 feet and a chord of South 00°55'40" West, 257.26 feet to a point of compound curvature; thence

2. 153.08 feet along the arc of a tangent curve deflecting to the right, having a radius of 402.00 feet and a chord of South 24°05'31" West, 152.16 feet; thence departing said newly proposed road right of way and binding on a parcel line common to Parcels 7 and 8 as shown on said plat of subdivision entitled "PRINCE GEORGE'S REGIONAL HOSPITAL"

3. North 29°27'18" West, 311.92 feet; thence binding on a parcel line common to said Parcels 7 and 1

4. North 60°26'57" East, 252.51 feet to the point of beginning. Containing 50,191 square feet or 1.1522 acres of land.

PARCEL 8

Beginning a point of curvature on the northerly side of a newly proposed road right of way at a point common to Parcels 7 and 8 as shown on said plat of subdivision entitled "PRINCE GEORGE'S REGIONAL HOSPITAL", intended to be recorded; thence binding on said newly proposed road right of way the following two (2) courses

1. 179.82 feet along the arc of a non-tangent curve deflecting to the right, having a radius of 402.00 feet and a chord of South 47°48'57" West, 178.33 feet; thence
2. South 60°37'51" West, 6.05 feet; thence departing said newly proposed road right of way and binding on said parcel line common to Parcels 8 and 9
3. North 29°27'18" West, 350.90 feet; thence binding on a parcel line common to said Parcels 8 and 1
4. North 60°26'57" East, 180.00 feet; thence binding on said parcel line common to Parcels 7 and 8
5. South 29°27'18" East, 311.92 feet to the point of beginning. Containing 60,966 square feet or 1.3996 acres of land.

PARCEL 9

Beginning a point on the northerly side of a newly proposed road right of way at a point common to Parcels 8 and 9 as shown on said plat of subdivision entitled "PRINCE GEORGE'S REGIONAL HOSPITAL", intended to be recorded; thence binding on said newly proposed road right of way

1. South 60°37'51" West, 180.00 feet thence departing said newly proposed road right of way and binding on said parcel line common to Parcels 9 and 1 the following two (2) courses
2. North 29°27'18" West, 350.33 feet; thence
3. North 60°26'57" East, 180.00 feet; thence binding on a parcel line common to said Parcels 8 and 9
4. South 29°27'18" East, 350.90 feet to the point of beginning. Containing 63,110 square feet or 1.4488 acres of land.

SAVING AND EXCEPTING the following parcel of land:

BEING the residue of the lands conveyed by Parcel D2, LLC, by deed dated January 3, 2017, and recorded among the Land Records of Prince George's County, Maryland, in Liber 38931 at folio 25, and being more particularly described as follows:

BEGINNING for the same at a point on the southerly right of way line of Arena Drive, 120 feet wide, said point also being the northwesterly end of the 1st or South 71° 55' 49" East, 998.01 foot line as described in the aforesaid Liber 7692 at folio 634, and running thence with said line

1. South 71° 55' 49" East, 998.01 feet to a point at the northwesterly end of the 2nd or South 29° 56' 11" East, 46.83 foot line as described in the aforesaid conveyance; thence with said line

2. South 29° 56' 11" East, 46.83 feet to a point at the northerly end of the 3rd or 357.47 foot curved line as described in the aforesaid conveyance, said curved line also being the westerly right of way line of Lottsford Road, 120 feet wide; thence with part of said curved line

3. 267.41 feet along the arc of a curve, deflecting to the left, having a radius of 872.03 feet and a chord bearing South 03° 16' 22" West, 266.36 feet to a point at the southeasterly end of the 2nd or North 81° 41' 30" West, 27.22 foot line as described in Schedule A, Part of Part One, (property being revested) Order of Final Judgment, United States District Court for The District of Maryland, Civil Case No. RWT-02-CV-2167, filed September 8, 2005; thence with said line and with the new line division of Parcel MG177, Part One as described in the aforesaid Order of Final Judgment the following six (6) courses

4. North 81° 41' 44" West, 103.06 feet to a point;

5. South 54° 36' 51" West, 51.93 feet to a point of non-tangency;

6. 186.66 feet along the arc of a curve, deflecting to the right, having a radius of 743.50 feet and a chord bearing South 19° 43' 57" West, 186.17 feet to a point of non-tangency;

7. South 60° 57' 41" West, 15.92 feet to a point;

8. South 34° 49' 57" West, 128.56 feet to a point; and

9. South 54° 42' 33" West, 9.28 feet to a point on the 6th or North 35° 17' 37" West, 1,181.93 foot line as described in the aforesaid Liber 7692 at folio 634, distant 48.50 feet northwesterly from the southeasterly end thereof; thence with part of said line

10. North 35° 17' 37" West, 1,133.43 feet to the place of beginning, containing 369,870 square feet or 8.4911 acres of land.

Exhibit B
Permitted Exceptions

1. All matters affecting Parcels 2 through 9 set forth on plat of subdivision entitled "Parcels 1 Through 9 Prince George's Regional Hospital" prepared by Soltesz, LLC and recorded immediately prior to this Deed as Plat No. SJH246-63

2. Terms, conditions, restrictions and easements contained in Storm Sewer Easement dated _____, 2017, recorded immediately prior to this Deed in Liber _____ at folio _____.

3. Taxes and other public charges, including assessments by and State, County, Municipality, Metropolitan District of Commission payable on an annual basis subsequent to the fiscal year ending June 30, 2017, a lien not yet due and payable.

4. Rights of parties entitled to possession, as tenants only, under unrecorded leases.

5. Terms, provisions and all matters as more particularly shown on the Plat entitled, "Lot 1, Capital Centre," recorded in Plat Book PEP No. 194 at folio 10.

6. Terms, conditions, restrictions and easements contained in Declaration of Covenants for Storm and Surface Water Facility and System Maintenance, recorded in Liber 16441 at folio 605 and Liber 6973 at folio 629.

7. Terms, conditions, restrictions and easements contained in Easement, recorded in Liber 6689 at folio 193.

8. Easements granted to Washington Gas Light Company, recorded in Liber 6799 at folio 584.

9. Terms, conditions, restrictions and easements contained in Deed, recorded in Liber 12587 at folio 540; Liber 13419 at folio 418; Liber 13511 at folio 293; and Liber 13511 at folio 285.

10. Terms and conditions contained in that certain Lease by and between Revenue Authority of Prince George's County and Capital Centre, LLC, as evidenced by First Amended and Restated Ground Lease recorded in Liber 16229 at folio 256 and as amended by First Amendment to First Amended and Restated Ground Lease recorded in Liber 16229 at folio 389, as amended by Second Amendment to First Amended and Restated Ground :ease; as amended by Lease Severance Agreement as evidenced by Memorandum of Lease Severance Agreement recorded in Liber ____ at folio ___, as further amended by Third Amendment to First Amended and Restated Ground Lease recorded in Liber ____ at folio ____.

11. Easements granted to Washington Suburban Sanitary Commission, recorded in Liber 16656 at folio 32.

12. Terms, provisions and conditions of that certain Lease by and between Capital Centre LLC and Odom Properties as evidenced by the Memorandum of Lease dated November 30, 2004 and recorded January 10, 2005 in Liber 21163 at folio 358.

13. Terms, provisions and conditions of that certain Lease by and between Capital Centre LLC and Jackmont Hospitality, Inc. as evidenced by the Memorandum of Lease dated October 11, 2011 and recorded November 15, 2011 in Liber 33104 at folio 204; as affected by Subordination, Non-Disturbance and Attornment Agreement recorded in Liber 33395 at folio 174 as re-recorded in Liber 33500 at folio 319.

MARYLAND FORM
WH-AR

Certification of Exemption from Withholding Upon Disposition of Maryland Real Estate Affidavit of Residence or Principal Residence

2017

Based on the certification below, Transferor claims exemption from the tax withholding requirements of §10-912 of the Tax-General Article, Annotated Code of Maryland. Section 10-912 provides that certain tax payments must be withheld and paid when a deed or other instrument that effects a change in ownership of real property is presented for recordation. The requirements of §10-912 do not apply when a transferor provides a certification of Maryland residence or certification that the transferred property is the transferor's principal residence.

1. Transferor Information

Name of Transferor The Revenue Authority of Prince Georg as County

2. Reasons for Exemption

Resident Status

☐ I, Transferor, am a resident of the State of Maryland.

☑ Transferor is a resident entity as defined in Code of Maryland Regulations (COMAR)03.04.12.02B(11), I am an agent of Transferor, and I have authority to sign this document on Transferor's behalf.

Principal Residence

☐ Although I am no longer a resident of the State of Maryland, the Property is my principal residence as defined in IRC 121 (principal residence for 2 (two) of the last 5 (five) years) and is currently recorded as such with the State Department of Assessments and Taxation.

Under penalty of perjury, I certify that I have examined this declaration and that, to the best of my knowledge, it is true, correct, and complete.

3a. Individual Transferors

Witness _____ Name _____

Signature _____

3b. Entity Transferors

Witness/Attest _____

The Revenue Authority of Prince George's County
Name of Entity

By _____

Peter A. Shapiro
Name

Executive Director
Title

13

17-49

State of Maryland Land Instrument Intake Sheet

☐ Baltimore City ☑ County: Prince Georges

Information provided is for the use of the Clerk's Office, State Department of Assessments and Taxation, and County Finance Office Only.

(Type or Print in Black Ink Only—All Copies Must Be Legible)

Space Reserved for Circuit Court Clerk Recording Validation

1 Type(s) of Instruments (Check Box if addendum Intake Form is Attached.)

x	Deed / Deed of Trust		Mortgage / Lease		Other		Other

2 Conveyance Type Check Box

	Improved Sale Arms-Length *[1]*		Unimproved Sale Arms-Length *[2]*		Multiple Accounts Arms-Length *[3]*		Not an Arms-Length Sale *[9]*

3 Tax Exemptions (if applicable) Cite or Explain Authority

Recordation	
State Transfer	
County Transfer	

4 Consideration and Tax Calculations

Consideration Amount		Finance Office Use Only Transfer and Recordation Tax Consideration	
Purchase Price/Consideration	$	Transfer Tax Consideration	$
Any New Mortgage	$	X ( )% =	$
Balance of Existing Mortgage	$	Less Exemption Amount −	$
Other:	$	Total Transfer Tax =	$
Other:	$	Recordation Tax Consideration	$
		X ( ) per $500 =	$
Full Cash Value:	$	TOTAL DUE	$

5 Fees

Amount of Fees	Doc. 1	Doc. 2
Recording Charge	$ 75.00	$
Surcharge	$ 40.00	$
State Recordation Tax	$	$
State Transfer Tax	$	$
County Transfer Tax	$	$
Other	$	$
Other	$	$

Agent:

Tax Bill:

C.B. Credit:

Ag. Tax/Other:

6 Description of Property

SDAT requires submission of all applicable information. A maximum of 40 characters will be indexed in accordance with the priority cited in Real Property Article Section 3-104(g)(3)(i).

District	Property Tax ID No. (1)	Grantor Liber/Folio	Map	Parcel No.	Var. LOG
13	3438892	14243 / 00187	0067	0000	(5)

Subdivision Name	Lot (3a)	Block (3b)	Sect/AR (3c)	Plat Ref.	SqFt/Acreage (4)
1565	1			194010	69.02 AC

Location/Address of Property Being Conveyed (2)

801 Capital Centre Blvd., Upper Marlboro MD 20774-0000

Other Property Identifiers (if applicable)	Water Meter Account No.
PT LT 1 CAP ARENA LEASED (.31A DFR PG CTY 6/05)	

Residential or Non-Residential ✓ | Fee Simple ✓ or Ground Rent Amount:

Partial Conveyance? Yes ✓ No | Description/Amt. of SqFt/Acreage Transferred:

If Partial Conveyance, List Improvements Conveyed:

7 Transferred From

Doc. 1 – Grantor(s) Name(s)	Doc. 2 – Grantor(s) Name(s)
REVENUE AUTHORITY OF PRINCE GEORGE'S COUNTY	
Doc. 1 – Owner(s) of Record, if Different from Grantor(s)	Doc. 2 – Owner(s) of Record, if Different from Grantor(s)

8 Transferred To

Doc. 1 – Grantee(s) Name(s)	Doc. 2 – Grantee(s) Name(s)
DIMENSIONS HEALTH CORPORATION	

New Owner's (Grantee) Mailing Address

9 Other Names to Be Indexed

Doc. 1 – Additional Names to be Indexed (Optional)	Doc. 2 – Additional Names to be Indexed (Optional)

10 Contact/Mail Information

Instrument Submitted By or Contact Person

Name: DEB BUTZ 1730022-5

Firm CHICAGO TITLE INSURANCE COMPANY

Address: 2000 M ST., NW SUITE 610

WASHINGTON DC 20036 Phone: (202) 263-4744

☑ Return to Contact Person ☐ Hold for Pickup ☐ Return Address Provided

11 IMPORTANT: *BOTH* THE ORIGINAL DEED *AND* A PHOTOCOPY MUST ACCOMPANY EACH TRANSFER

Assessment Information

☐ Yes ☑ No Will the property being conveyed be the grantee's principal residence?

☐ Yes ☑ No Does transfer include personal property? If yes, identify:

☐ Yes ☑ No Was property surveyed? If yes, attach copy of survey (if recorded, no copy required).

Space Reserved for County Validation

Assessment Use Only – Do Not Write Below This Line

Terminal Verification Agricultural Verification Whole Part Tran. Process Verification

Transfer Number Date Received: Deed Reference: Assigned Property No.:

Year	20	20	Geo.	Map	Sub	Block
Land			Zoning	Grid	Plat	Lot
Buildings			Use	Parcel	Section	Occ. Cd.
Total			Town Cd.	Ex. St.	Ex. Cd.	

REMARKS:

Distribution: *White – Clerk's Office* *Pink – Office of Finance* *Canary – SDAT* *Goldenrod – Preparer*

AOC-CC-300 (5/2007)

EXHIBIT 3

BOOK 38931 PAGE 25

BOOK 38931 PAGE 25

LR - Deed (with Taxes) 40.00
Recording City ST 20.00
Name: dimensions health corp
Ref:
LR - Deed (with Taxes) 40.00
Surcharge 40.00
LR - Deed State 45,000.00
Transfer Tax 45,000.00
LR - NR Tax - Ltd 0.00
SubTotal: 45,060.00
Total: 45,110.00
01/10/2017 01:19 CC16-CC
#7590497 CC0703 - 03
Prince George's County/CC07.03.03 - Register 03

PRINCE GEORGE'S COUNTY, MD
APPROVED BY BC
#03R

JAN 10 2017

$ 49500.00 RECORDATION TAX PAID
$ 126,000.00 TRANSFER TAX PAID

AFTER RECORDING RETURN TO:

Ballard Spahr LLP
300 E. Lombard Street, 18th Floor
Baltimore, Maryland 21202
Attn: Alyssa Domzal, Esq.

TAX ID: 13-1415298

SPECIAL WARRANTY DEED

THIS SPECIAL WARRANTY DEED (this "**Deed**") is made as of January 3rd, 2017 from PARCEL D2, LLC, a Maryland limited liability company ("**Grantor**"), to and for the benefit of DIMENSIONS HEALTH CORPORATION, a Maryland nonstock corporation ("**Grantee**").

WITNESSETH:

For and in consideration of the sum of NINE MILLION DOLLARS ($9,000,000.00), and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged by Grantor, Grantor by these presents does hereby grant, bargain, sell and convey unto Grantee, its successors and assigns, all of the real property lying and situate in Prince George's County, Maryland which is legally and more particularly described on Exhibit A attached hereto and incorporated herein by this reference, together with all tenements, hereditaments, rights-of-way, and rights in any land in the bed of any streets or alleys, existing or on paper, belonging or in any way pertaining to such real property, and all improvements located on such real property (the real property and improvements are hereinafter collectively referred to as the "**Property**");

TOGETHER WITH all of the ways, easements, rights, privileges and appurtenances to the same belonging or in any way appertaining; all rights of Grantor in and to any privately owned water or sewer lines servicing the Property and any and all easements, rights-of-way, covenants, benefits, agreements, rights and appurtenances enjoyed by and/or benefiting the Property; all riparian rights and all piers, wharves and docks adjoining or used in connection with the Property; and all of the estate, right, title, interest and claim, either in law or in equity or otherwise, of Grantor of, in, to or out of the Property;

TO HAVE AND TO HOLD the Property, together with all and singular the aforesaid rights and appurtenances pertaining thereto, subject to all matters of record, unto Grantee and Grantee's successors and assigns in fee simple forever.

SUBJECT TO all matters of record, Grantor covenants that Grantor will warrant to Grantee, its successors and assigns specially the Property hereby conveyed, against any person whomsoever lawfully claiming or to claim the same or any part thereof by, through or under Grantor, but not otherwise, and that Grantor will execute such further assurances of said Property as may be requisite.

[Signatures appear on the following page]

Grantor's Address:
164 Conduit Street
Annapolis, MD 21401

Grantee's Address:
3001 Hospital Drive
Cheverly, MD 20785

AFTER RECORDING Return to:
Chicago Title Insurance Company
2000 M Street N.W.
Suite 610 29501330
Washington, D.C. 20036

IN WITNESS WHEREOF, Grantor has signed, sealed and delivered this Special Warranty Deed as of the day and year first above written.

GRANTOR:

WITNESS:

PARCEL D2, LLC,
a Maryland limited liability company

By: _____ (SEAL)
Name: Eliot D.M. Powell
Title: Manager

STATE OF Maryland)
)
COUNTY/CITY OF Queen Anne's)

On this 29 day of November, 2016, before me, the under-signed officer, personally appeared Eliot D.M. Powell, as Manager of Parcel D2, LLC, a Maryland limited liability company, and that he, as such Manager, being authorized so to do, executed the foregoing instrument for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

Name:
Notary Public

My commission expires Jan. 13, 2020

[Notary Seal]

MARIA T. ATHEY
Notary Public
Queen Anne's County
Maryland
My Commission Expires January 13, 2020

MARYLAND ATTORNEY'S CERTIFICATE

I hereby certify that the annexed instrument was prepared by or under the supervision of the undersigned, an attorney duly admitted to practice before the Court of Appeals of Maryland.

Alyssa Domzal, Esq.

EXHIBIT A TO SPECIAL WARRANTY DEED

Legal Description

BEING the residue of the lands conveyed by Robert L. Edwards, Charles Edwards and Sylvia E. Allen, Co-partners trading as Allen Edwards Company to Ronald B. Edlavitch, Trustee, by deed dated June 6, 1990, and recorded among the Land Records of Prince George's County, Maryland, in Liber 7692 at folio 634, and being more particularly described as follows:

BEGINNING for the same at a point on the southerly right of way line of Arena Drive, 120 feet wide, said point also being the northwesterly end of the 1st or South 71° 55' 49" East, 998.01 foot line as described in the aforesaid Liber 7692 at folio 634, and running thence with said line

1. South 71° 55' 49" East, 998.01 feet to a point at the northwesterly end of the 2nd or South 29° 56' 11" East, 46.83 foot line as described in the aforesaid conveyance; thence with said line

2. South 29° 56' 11" East, 46.83 feet to a point at the northerly end of the 3rd or 357.47 foot curved line as described in the aforesaid conveyance, said curved line also being the westerly right of way line of Lottsford Road, 120 feet wide; thence with part of said curved line

3. 267.41 feet along the arc of a curve, deflecting to the left, having a radius of 872.03 feet and a chord bearing South 03° 16' 22" West, 266.36 feet to a point at the southeasterly end of the 2nd or North 81° 41' 30" West, 27.22 foot line as described in Schedule A, Part of Part One, (property being revested) Order of Final Judgment, United States District Court for The District of Maryland, Civil Case No. RWT-02-CV-2167, filed September 8, 2005; thence with said line and with the new line division of Parcel MG177, Part One as described in the aforesaid Order of Final Judgment the following six (6) courses

4. North 81° 41' 44" West, 103.06 feet to a point;

5. South 54° 36' 51" West, 51.93 feet to a point of non-tangency;

6. 186.66 feet along the arc of a curve, deflecting to the right, having a radius of 743.50 feet and a chord bearing South 19° 43' 57" West, 186.17 feet to a point of non-tangency;

7. South 60° 57' 41" West, 15.92 feet to a point;

8. South 34° 49' 57" West, 128.56 feet to a point; and

9. South 54° 42' 33" West, 9.28 feet to a point on the 6th or North 35° 17' 37" West, 1,181.93 foot line as described in the aforesaid Liber 7692 at folio 634, distant 48.50 feet northwesterly from the southeasterly end thereof; thence with part of said line

10. North 35° 17' 37" West, 1,133.43 feet to the place of beginning, containing 369,870 square feet or 8.4911 acres of land.

MARYLAND FORM WH-AR

Certification of Exemption from Withholding Upon Disposition of Maryland Real Estate Affidavit of Residence or Principal Residence

2016

Based on the certification below, Transferor claims exemption from the tax withholding requirements of §10-912 of the Tax-General Article, Annotated Code of Maryland. Section 10-912 provides that certain tax payments must be withheld and paid when a deed or other instrument that effects a change in ownership of real property is presented for recordation. The requirements of §10-912 do not apply when a transferor provides a certification of Maryland residence or certification that the transferred property is the transferor's principal residence.

1. Transferor Information

Name of Transferor PARCEL D2, LLC

2. Reasons for Exemption

Resident Status

☐ I, Transferor, am a resident of the State of Maryland.

☒ Transferor is a resident entity as defined in Code of Maryland Regulations (COMAR)03.04.12.02B(11), I am an agent of Transferor, and I have authority to sign this document on Transferor's behalf.

Principal Residence

☐ Although I am no longer a resident of the State of Maryland, the Property is my principal residence as defined in IRC 121 (principal residence for 2 (two) of the last 5 (five) years) and is currently recorded as such with the State Department of Assessments and Taxation.

Under penalty of perjury, I certify that I have examined this declaration and that, to the best of my knowledge, it is true, correct, and complete.

3a. Individual Transferors

Witness

Name

Signature

3b. Entity Transferors

Witness/Attest

Parcel D2, LLC
Name of Entity

By

Eliot D. M. Powell
Name

Manager
Title

State of Maryland Land Instrument Intake Sheet

☐ Baltimore City ☑ County: Prince Georges

Information provided is for the use of the Clerk's Office, State Department of Assessments and Taxation, and County Finance Office Only.

(Type or Print in Black Ink Only—All Copies Must Be Legible)

Space Reserved for Circuit Court Clerk Recording Validation

1 Type(s) of Instruments — (Check Box if addendum Intake Form is Attached.)

1 Deed / Deed of Trust	Mortgage / Lease	Other	Other

2 Conveyance Type Check Box

Improved Sale Arms-Length [1]	Unimproved Sale Arms-Length [2]	Multiple Accounts Arms-Length [3]	Not an Arms-Length Sale [9]

3 Tax Exemptions (if applicable) Cite or Explain Authority

Recordation	
State Transfer	
County Transfer	

4 Consideration and Tax Calculations

Consideration Amount	
Purchase Price/Consideration	$ 9,000,000.00
Any New Mortgage	$
Balance of Existing Mortgage	$
Other:	$
Other:	$
Full Cash Value:	$

Finance Office Use Only Transfer and Recordation Tax Consideration	
Transfer Tax Consideration	$
X ( )% =	$
Less Exemption Amount −	$
Total Transfer Tax =	$
Recordation Tax Consideration	$
X ( ) per $500 =	$
TOTAL DUE	$

5 Fees

Amount of Fees	Doc. 1	Doc. 2
Recording Charge	$ 20.00	$
Surcharge	$ 40.00	$
State Recordation Tax	$ 49,500.00	$
State Transfer Tax	$ 45,000.00	$
County Transfer Tax	$ 126,000.00	$
Other	$	$
Other	$	$

Agent:

Tax Bill:

C.B. Credit:

Ag. Tax/Other:

6 Description of Property

SDAT requires submission of all applicable information. A maximum of 40 characters will be indexed in accordance with the priority cited in Real Property Article Section 3-104(g)(3)(i).

District	Property Tax ID No. (1)	Grantor Liber/Folio	Map	Parcel No.	Var. LOG
13	1415298	24549 / 189	0067	0147	(5)

Subdivision Name	Lot (3a)	Block (3b)	Sect/AR (3c)	Plat Ref.	SqFt/Acreage (4)
0000					8.49AC

Location/Address of Property Being Conveyed (2): 9401 Arena Drive, Upper Marlboro

Other Property Identifiers (if applicable): | Water Meter Account No.:

Residential or Non-Residential ✓ | Fee Simple ✓ or Ground Rent | Amount:

Partial Conveyance? Yes ✓ No | Description/Amt. of SqFt/Acreage Transferred:

If Partial Conveyance, List Improvements Conveyed:

7 Transferred From

Doc. 1 – Grantor(s) Name(s)	Doc. 2 – Grantor(s) Name(s)
PARCEL D2, LLC	
Doc. 1 – Owner(s) of Record, if Different from Grantor(s)	Doc. 2 – Owner(s) of Record, if Different from Grantor(s)

8 Transferred To

Doc. 1 – Grantee(s) Name(s)	Doc. 2 – Grantee(s) Name(s)
DIMENSIONS HEALTH CORPORATION	

New Owner's (Grantee) Mailing Address: 3001 HOSPITAL DR., CHEVERLY, MD 20785

9 Other Names to Be Indexed

Doc. 1 – Additional Names to be Indexed (Optional)	Doc. 2 – Additional Names to be Indexed (Optional)

10 Contact/Mail Information

Instrument Submitted By or Contact Person

Name: Deb Butz (295013130)

Firm: Chicago Title Ins Co

Address: 2000 M St., NW Suite 610

Washington DC 20036 Phone: (202) 263-4744

☑ Return to Contact Person ☐ Hold for Pickup ☐ Return Address Provided

11 IMPORTANT: *BOTH* THE ORIGINAL DEED *AND* A PHOTOCOPY MUST ACCOMPANY EACH TRANSFER.

Assessment Information

☐ Yes ☑ No Will the property being conveyed be the grantee's principal residence?

☐ Yes ☑ No Does transfer include personal property? If yes, identify:

☐ Yes ☑ No Was property surveyed? If yes, attach copy of survey (if recorded, no copy required).

Space Reserved for County Validation

Assessment Use Only – Do Not Write Below This Line

Terminal Verification | Agricultural Verification | Whole | Part | Tran. Process Verification

Transfer Number | Date Received: | Deed Reference: | Assigned Property No.:

Year	20	20	Geo.	Map	Sub	Block
Land			Zoning	Grid	Plat	Lot
Buildings			Use	Parcel	Section	Occ. Cd.
Total			Town Cd.	Ex. St.	Ex. Cd.	

REMARKS:

Distribution: White – Clerk's Office; Pink – Office of Finance; Canary – SDAT; Goldenrod – Preparer

AOC-CC-300 (5/2007)

EXHIBIT 4

PUBLIC INFORMATION REGARDING CHARGES

PURPOSE: This policy is intended to provide information to the public regarding estimated charges for services at acute care hospitals owned and operated by Dimensions Healthcare System in compliance with COMAR 10.24.10A (1).

POLICY: Information regarding hospital services and charges shall be made available to the public upon request, and on the Internet site of each acute care hospital in the Dimensions Healthcare System.

PROCEDURE: A representative list of services and estimated charges will be available to the public in written form upon request, and via the hospital Internet site at each Dimensions Healthcare System acute care hospital. The published charges will be consistent with hospital rates as approved by the Maryland Health Services Cost Review Commission.

A. The Reimbursement Department shall be responsible for determining the most common inpatient and outpatient services and corresponding charges. The Reimbursement Department shall be responsible for distributing a quarterly report of the most common inpatient and outpatient services and corresponding charges to the Patient Financial Services Department.

1. The Patient Access Department shall be responsible for ensuring that the written information is made available to the financial counselors and in the patient financial services customer service area.

2. The Marketing & Public Relations Department shall be responsible for ensuring that the information is available to the public on the hospital website.

3. The Patient Access and Patient Financial Services departments shall be responsible for distribution of information on estimated charges to patients and guests, upon request.

4. The directors of the Patient Access Department and the Patient Financial Services Department shall ensure that appropriate education and training related to charge estimates and the Charge Description Master is provided to their respective staff.

ORIGINATOR:

Reimbursement Department
Patient Financial Services
Patient Access
Communications

APPROVAL:

Neil J. Moore
President and Chief Executive Officer

EXHIBIT 5

UNIVERSITY of MARYLAND MEDICAL SYSTEM **Revenue Cycle Services**	**PAGE:** **1 OF 14**	**POLICY NO:** **RCS - 01**
	EFFECTIVE DATE: 09/18/19	**REVISION DATE(S):** 07/01/22
SUBJECT: UMMS Financial Assistance Policy		

KEY WORDS:
Financial Assistance, Financial Hardship, Financial Clearance, Medical Assistance

OBJECTIVE/BACKGROUND:
The purpose of the following policy statement is to describe the financial assistance application process, how applications are reviewed and determinations of eligibility are made, eligibility criteria for financial assistance programs (including presumptive eligibility and financial hardship assistance), financial clearance of patients with medically unique or humanitarian needs, how UMMS notifies patients of the availability financial assistance availability, the appeal process, and extraordinary collection actions.

APPLICABILITY:
This policy applies to all team members, vendors, and agents [volunteers, medical team members] of any of the following University of Maryland Medical System member organizations:

University of Maryland Medical Center (UMMC)
UM Midtown Campus (MTC)
UM Rehabilitation & Orthopaedic Institute (UMROI)
UM St. Joseph Medical Center (UMSJMC)
UM Baltimore Washington Medical Center (UMBWMC)
UM Shore Regional Health (UMSRH)
UM Shore Medical Center at Dorchester (UMSMCD)
UM Shore Medical Center at Easton (UMSME)
UM Charles Regional Medical Center (UMCRMC)
UM Upper Chesapeake Health (UCHS)
UM Capital Region Health (UMCRH)
UM Physician Networks (UMPN)
UMMS Outpatient Rx Weinberg
UMMC Pharmacy at Redwood
UMMS Pharmacy Services
UMMC Mid-Town Campus Pharmacy
UMMC Pharmacy at Capital Region
UMMC Pharmacy at Baltimore Washington

DEFINITIONS:

Federal Poverty Level	A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits.
Financial Hardship	Instances in which member organization charges incurred at UMMS member organizations for medically necessary treatment by a family household over a twelve (12) month period that exceeds 25% of that family's annual income.
MDH Limits	Refers to the income eligibility limits for reduced cost care, set by Maryland Department of Health (MDH) office of Medical Assistance Planning. The State of Maryland accepted the Federal Medicaid expansion on January 1, 2014 vs the Federal Poverty Levels, under the Affordable Care Act, which expanded the eligible income limits for Maryland Medicaid. UMMS adopted these new limits for the reduced cost care sliding scale, as set forth in Attachment A.
Medical Debt	Out-of-pocket expenses, including co-payments, coinsurance, and deductibles, incurred at UMMS member organizations for medically necessary treatment.
Presumptive Eligibility	Instances in which information provided by the patient or through other sources provides sufficient evidence that the patient is eligible for financial assistance, but there is no financial assistance form on file.

POLICY:

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

It is the policy of the University of Maryland Medical System ("UMMS") member organizations to provide financial assistance which meets or exceeds the requirements set forth by the State of Maryland for patients who meet specified financial criteria and request such assistance.

I. **Free Care -** Those with income up to 200% of the income eligibility limits established by the Maryland Department of Health are eligible for free care.

II. **Reduced Cost Care -** Those between 200% and 300% of the income eligibility limits established by the Maryland Department of Health are eligible for discounts on a sliding scale, as set forth in Attachment A.

III. **Financial Hardship -** Those who otherwise do not qualify for financial assistance under the primary guidelines of this policy, but for whom their medical debt incurred at all UMMS member organizations exceeds 25% of the Family Annual Household Income, are eligible for financial hardship assistance.

Payment plans are also available to all patients. Plan terms may be modified at the request of the patient. Additional information on payment plans is available in the UMMS Payment Plan Policy. 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, financial assistance applications will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

PROCEDURE:

I. How To Apply for Financial Assistance

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. Patients may voluntarily apply for financial assistance before or after receiving healthcare services, or they may be identified as potential candidates for financial assistance during the financial clearance process or a presumptive financial assistance eligibility screening.

Financial clearance is a process that determines a patient's ability and likelihood to pay. When possible effort will be made to provide financial clearance prior to date of service. During the financial clearance process, patients who indicate they are unemployed and have no insurance coverage will be required to submit a financial assistance application before receiving non-emergency medical care (unless they meet presumptive financial assistance eligibility criteria).

There will be one application process for all UMMS member organizations. UMMS will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications (and application requirements) in determining eligibility for the UMMS Financial Assistance program. Patients are required to provide a completed financial assistance application (with all required information and documentation), unless they meet the criteria for presumptive eligibility. To facilitate this process, each applicant must provide information about

family size and income. Oral submission of needed information will be accepted, where appropriate. UMMS will provide the financial assistance application to all patients regardless of health insurance status to all patients, including uninsured patients, and the application will be readily available on the UMMS website and by request.

Supporting Documentation for Financial Assistance Applications

To help applicants complete the process, required and suggested documentation will be clearly listed on the financial assistance application, including:

- 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.
- A copy of their most recent pay stubs (if employed) or other evidence of income.
- A Medical Assistance Notice of Determination (if applicable).
- 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.

Financial assistance may not be denied based on the omission of information or documentation that is not specifically required in this policy or on the financial assistance application, and UMMS reserves the right to offer financial assistance to patients that have not provided all supporting documentation.

- 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 financial assistance and assistance with the application process.
- 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 the information is not 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 for financial assistance and initiate a new case by submitting the missing information or documentation

II. Reviewing and Determining Eligibility of Financial Assistance Applications

There are designated team members who will be responsible for taking financial assistance applications. These team members can be financial counselors, patient financial receivable coordinators, customer service representatives, or third party agencies working as an extension of the central business office. To help applicants complete the process, UMMS will provide the financial assistance application that will let them know what paperwork is required for a final determination of eligibility. Where possible, designated team

members will consult via phone or meet with patients who request financial assistance to determine if they meet preliminary criteria for assistance.

Preliminary data will be entered into a third party data exchange system which will allow the designated team member to track the application and determine eligibility for financial assistance. Designated team members will:

- Determine whether the patient has health insurance. 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 financial assistance.
- If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the designated team member and recommendations shall be made to Senior Leadership.
- Complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage. To facilitate this process each applicant must provide information about family size and income.
- Determine whether the patient is presumptively eligible for free or reduced-cost care.
- Determine whether uninsured patients are eligible for public or private health insurance. 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.

To the extent practicable, the designated team members will offer assistance to uninsured patients if the patient chooses to apply for public or private health insurance, determine whether the patient is eligible for other public programs that may assist with health care costs, and use information available to UMMS to determine whether the patient is qualified for free or reduced-cost care under the UMMS Financial Assistance policy.

Within two business days of receipt of a patient's request for financial assistance or an application for medical assistance, UMMS may provide determination of probable eligibility. The determination of probable eligibility is subject to change, based on the receipt of supporting documentation.

If the patient's financial assistance application is determined to be complete and appropriate, the designated team member will recommend the patient's level of eligibility and forward for a second and final approval. UMMS will provide final determination the patient's eligibility within 14 days after the patient submits a completed application for financial assistance and suspend any billing or collections actions while eligibility is being determined.

If a Financial Assistance Application is Approved

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.

- A letter of final determination will be submitted to each patient who has formally requested financial assistance, which includes (if applicable): the assistance for which the individual is eligible and the basis for the determination.
- UMMS may decide to extend the financial assistance eligibility period further into the past or the future on a case-by-case basis.

- Financial assistance is generally applicable to all emergency and other medically necessary care provided by each UMMS member organization (See Exclusions for more information).
- If additional healthcare services are provided beyond the eligibility period, patients must reapply for financial assistance.
- If the patient is determined to be eligible for reduced-cost care, and has already received a statement for eligible healthcare services rendered during the financial assistance coverage period, 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.
- If a patient made payments for healthcare services prior to receiving approval for financial assistance, they may be eligible for a refund. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. If the amount that the patient is determined able to pay is less than the amount of the patient payment, the resulting credit balance will be issued to the patient as a refund if the amount exceeds the patient's determined responsibility by $5.00 or more. This includes determinations of eligibility for financial assistance within 240 days after the initial bill was provided.

If there are changes to the patient's income, assets, expenses or family status, the patient is expected to notify the Financial Assistance Department at 410-821-4140. To facilitate this process, and ensure that patients have the opportunity to be re-evaluated for eligibility for financial assistance within 240 days of the initial statement, UMMS will notify patients that if their income has changed, they should contact the Financial Assistance Program Department on each statement.

If a Financial Assistance Application is Not Approved

If a patient is determined to be ineligible for financial assistance prior to receiving a service (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.

- If the patient is determined to be ineligible for financial assistance, and they applied in order to obtain financial clearance for non-emergent or non-urgent hospital based services, the designated team member will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
- A clinician may appeal this decision and request reconsideration by the Financial Clearance Executive Committee on a case-by case basis.
- For emergent or urgent services, financial assistance applications will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.
- Patients who are ineligible for financial assistance 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.
- The patient may appeal the decision, please see the Appeals section for more information.
- 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.

III. Eligibility Criteria

UMMS will offer financial assistance when a review of a patient's individual financial circumstances has been conducted and documented. UMMS will not use a patient's citizenship or immigration status as an eligibility

requirement for financial assistance; or withhold financial assistance or deny a patient's application for financial assistance on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or on the basis of disability.

The following criteria will be applied in assessing a patient's eligibility for financial assistance, presumptive eligibility for financial assistance, and eligibility for financial hardship assistance.

Financial Assistance Eligibility

UMMS will refer to the MDH household income thresholds to determine eligibility for financial assistance and the level of free or reduced cost care to award to eligible patients. UMMS will calculate a patient's family (household) income at time of service. To account for any changes in financial circumstance, UMMS will recalculate family (household) income within 240 days after the initial hospital bill is provided.

UMMS may consider household monetary assets in determining eligibility for free and reduced-cost care under the financial assistance policy in addition to income-based criteria. Monetary assets shall be adjusted annually for inflation in accordance with the Consumer Price Index. The following monetary assets that are convertible to cash shall be excluded:

- At a minimum, the first $10,000 of monetary assets.
- A safe harbor equity of $150,000 in a primary residence.
- Retirement assets that the Internal Revenue Service has granted preferential tax treatment as a retirement account, including deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans.
- One motor vehicle used for the transportation needs of the patient or any family member of the patient;
- Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act.
- Prepaid higher education funds in a Maryland 529 Program account.

In determining the family income of a patient, UMMS shall apply a definition of household size that consists of the patient and, at a minimum, a spouse (regardless of whether the patient and spouse expect to file a joint federal or State tax return), biological children, adopted children, or stepchildren, and anyone for whom the patient claims a personal exemption in a federal or State tax return. For a patient who is a child, the household size shall consist of the child and biological parents, adopted parents, or stepparents or guardians, biological siblings, adopted siblings, or stepsiblings, and anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

Patients may be deemed ineligible for financial assistance:

- If they have insurance coverage (e.g., HMO, PPO, or Workers Compensation, Medicaid, or other insurance programs), that denies access to UMMS due to insurance plan restrictions/limits.
- If they refuse to be screened for other assistance programs prior to submitting an application for financial assistance.
- If they refuse to divulge information pertaining to a pending legal liability claim.
- If they are Foreign-nationals traveling to the United States seeking elective, non-emergent medical care.

Financial assistance generally applies to all emergency and other medically necessary care provided by each UMMS member organization; however, the following exclusions may apply:

- Services provided by healthcare providers not affiliated with UMMS member organizations (e.g., durable medical equipment, home health services).
- Services denied by a patient's insurance program or policy (e.g., HMO, PPO, or Workers Compensation). Exceptions may be made on a case by case basis considering medical and programmatic implications.
- Cosmetic or other non-medically necessary services.
- Patient convenience items, meals, and lodging.
- Supervised Living accommodations and meals while a patient is in the Day Program.
- Third Party Liability claims (Auto Accident, Workers Compensation, Bodily Injury, or other legal claim) until all means of payment are exhausted.

Financial assistance for professional charges awarded under this policy applies to the UM Physician Network (UMPN). Patients who wish to pursue financial assistance for non-UM Physician Network charges must contact the physician or provider group directly. A list of providers delivering medically necessary care in each UMMS hospital can be obtained on the website of each UMMS entity. This list specifies which such as providers do not participate in the UMMS Financial Assistance Policy.

Presumptive Financial Assistance Eligibility

In the event there is no evidence to support a patient's eligibility for financial assistance, UMMS reserves the right to determine presumptive financial assistance eligibility for all hospital accounts. To determine presumptive eligibility for financial assistance, UMMS may use outside agencies or information to estimate income which can be used to assess the patient's eligibility for financial assistance eligibility. Due to the inherent nature of presumptive circumstances, UMMS will award free care to patients deemed presumptively eligible for financial assistance. Presumptive eligibility for financial assistance shall only cover the patient's specific date of service. UM Physician Network provider groups will offer financial assistance on a physician balance based on a determination of eligibility on a hospital balance.

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. Patient currently has Medical Assistance coverage
f. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
g. Medical Assistance spend down amounts
h. Eligibility for other state or local assistance programs, such as:
    i) Supplemental Nutrition Assistance Program
    ii) State Energy Assistance Program
    iii) Special Supplemental Food Program for Women, Infants, and Children
    iv) Any other social service program as determined by MD DHMH and Health Services Cost Review Commission (HSCRC).

i. Patient is deceased with no known estate
j. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
k. Non-US Citizens deemed non-compliant
l. Non-Eligible Medical Assistance services for Medical Assistance eligible patients
m. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID)
n. Bankruptcy, by law, as mandated by the federal courts
o. Eligibility in certain UMMS clinical programs (including: St. Clare Outreach Program, UMMS Maternity Program, UMSJMC Hernia Program).

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

Financial Hardship Assistance Eligibility

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 medical debt for medically necessary treatment over a twelve (12) month period exceeds 25% of that family's annual income.

- The amount of uninsured medical costs incurred at all UMMS member organizations will be considered in determining a patient's eligibility (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.
- For the patients who are eligible for reduced-cost care under the financial assistance criteria and also meet the criteria for financial hardship assistance criteria, UMMS will grant the total eligible reduction in charges.
- To calculate household income, UMMS will use the same criteria outlined in the Financial Assistance Eligibility section of this policy to calculate assets, household income, and family size.
- 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. UMMS may decide to extend the financial hardship eligibility period further into the past or the future on a case-by-case basis.
- Financial hardship assistance 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 and will remain eligible for reduced-cost medically necessary care when seeking subsequent care at the same member organization during the 12–month period beginning on the date on which the reduced-cost medically necessary care was initially received. To avoid an unnecessary duplication of UMMS' determination of eligibility for free and reduced-cost care, the patient or eligible family members shall inform UMMS of the patient's or family member's eligibility for the reduced-cost medically necessary care.

All other eligibility, ineligibility, and procedures for primary financial assistance criteria apply to financial hardship assistance criteria, unless otherwise stated above.

IV. Appealing a Determination of Eligibility for Financial Assistance

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.

If a patient wishes to make an appeal, UMMS will:

- Notify the patient that the Health Education and Advocacy Unit is available to assist them or their authorized representative in filing and mediating a reconsideration request.
- Provide the address, phone number, facsimile number, e-mail address, mailing address, and website of the Health Education and Advocacy Unit: Office of the Attorney General, Health Education and Advocacy Unit | 200 St. Paul Place, 16th Floor, Baltimore, MD 21202 | Phone: (410) 528-1840 | Toll-free in Maryland 1-877-261-8807 | Fax: (410) 576-6571 | Email: heau@oag.state.md.us
- Document appeals within the third party data and workflow tool for review by the next level of management above the representative who denied the original application.
- Submit a letter of final determination to each patient who has formally submitted an appeal.

Provider Driven Financial Clearance and Reconsideration

Where there is a compelling educational, medical, and/or humanitarian benefit, UMMS clinical team members may request financial clearance of patients that are not otherwise able or likely to pay for their healthcare services. Clinical team members must submit appropriate justification in advance of the patient receiving services. UMMS Revenue Cycle central billing office will evaluate the patient's eligibility for Medical Assistance and financial assistance. A Financial Clearance Executive Committee at the member organization level, comprised of clinical and financial leadership, will request the information submitted by the requesting clinical and the central billing office and make the final determination on whether to grant financial clearance on a case-by-case basis.

If financially cleared, patients are still responsible to complete the financial assistance application process, and may be subject to presumptive eligibility screening, as outlined in this policy.

V. Notice of Availability of Financial Assistance

UMMS will advise patients, patient's families, and authorized representatives of the availability of financial assistance using posted notices and the Patient Billing and Financial Assistance Information Sheet. The Patient Billing and Financial Assistance Information Sheet notifies the patient of the availability of financial assistance and payment plans, includes a description of UMMS Financial Assistance Policy, explains how to apply for financial assistance, and includes a description of the patient's rights and obligations with regard to hospital billing and collection under the law.

- UMMS will post notices of financial assistance availability in each UMMS hospital's emergency room (if any), admissions areas, key patient access areas, and the hospital billing office. Notice of availability will also be sent to the patient with patient statements.
- The Patient Billing and Financial Assistance Information Sheet will be provided at preadmission and before discharge for each hospital encounter, with each hospital statement, and it will be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas.

- The Financial Assistance Policy and the Financial Assistance Application will also be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas.
- The Financial Assistance 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).

Patient Billing and Financial Assistance Information Sheet Content

In addition to the content referenced above, the Patient Billing and Financial Assistance Information Sheet will include:

- The website and physical location(s) where patients can obtain copies of the financial assistance policy and financial assistance application form
- Instructions on how to obtain a free copy of the financial assistance policy and financial assistance application form by mail.
- A statement of the availability of translations of the financial assistance documents.
- Contact information for UMMS Hospital Billing Customer Service Department, which is available to assist the patient, the patient's family, or the patient's authorized representative understand their statement, understand the patient's rights and obligations regarding the statement, learn how to apply for free or reduced cost care, or learn how to apply for Maryland Medical Assistance, or any other programs that may help pay their medical bills.
- Contact information for the Maryland Medical Assistance Program.
- A notification that physician charges are not included in the hospital statement and are billed separately.
- A notification informing patients of the right to request and receive a written estimate of the total charges for hospital nonemergency services, procedures, and supplies that reasonably are expected to be provided for professional services by the hospital.
- A notification that a patients who are eligible for free or reduced care may not be charged more than AGB for emergency or other medically necessary care.
- A section that informs the patient of their ability to make a formal complaint with the HSCRC and the Office of the Attorney General of Maryland.
- A section for the patient to initial to indicate that they have been made aware of UMMS Financial Assistance Policy

The Patient Billing and Financial Assistance Information Sheet will be written in plain language, as specified by the Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r), and will be made available in the patient's preferred language. It will also include a section that allows for patients to initial that they have been made aware of the financial assistance policy.

VI. Extraordinary Collection Actions

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 UMMS's attorney for legal and/or collection activity. Third party agencies and/or attorneys are jointly and severally responsible for meeting the debt collection requirements listed in this policy, and in the UMMS Credits and Collections Policy. Collection activities taken on behalf of

UMMS by a collection agency or UMMS' attorney may include the following Extraordinary Collection Actions (ECAs):

- Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus. UMMS will not report adverse information to a consumer reporting agency regarding a patient who was uninsured or eligible for free or reduced-cost care at the time of service. UMMS will not report to a consumer reporting agency until at least 180 days after the initial statement was provided. Prior to reporting to a consumer reporting agency, UMMS will determines whether the patient is eligible for free or reduced-cost care. UMMS will not report adverse information about a patient to a consumer reporting agency if UMMS was notified in accordance with federal law by the patient or an insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days, or if UMMS has completed a requested reconsideration of the denial of free or reduced-cost care that was appropriately completed by the patient within the immediately preceding 60 days.
- Commencing a civil action against the individual. UMMS will not hold a spouse or another individual liable for the debt owed on a hospital bill of an individual who is at least 18 years old. UMMS will not file a civil action to collect debt until at least 180 days of after the initial bill was provided. Prior to filing the civil action, UMMS will determines whether the patient is eligible for free or reduced-cost care. UMMS will not file a civil action to collect debt if UMMS was notified in accordance with federal law by the patient or an insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days. UMMS will not file a civil action to collect debt if UMMS has completed a requested reconsideration of the denial of free or reduced-cost care that was appropriately completed by the patient within the immediately preceding 60 days.
- Attaching or seizing an individual's bank account or any other personal property.
- Garnishing an individual's wage. UMMS will not request a garnishment of wages or file an action that would result in an attachment of wages against a patient if the patient is eligible for free or reduced-cost care.

ECAs may be taken on accounts that have not been disputed or are not on a payment arrangement. ECAs will occur no earlier than 180 days from submission of first post-discharge bill to the patient and will be preceded by a written notice 45 days prior to commencement of the ECA. This written notice will be accompanied by an application for financial assistance (and instructions for completing the application) and a notice of availability of a payment plan to satisfy the medical debt, and the Patient Billing and Financial Assistance Information Sheet. The written notice will include the following information:

- Specified contact and procedural information.
    - The name and telephone number for UMMS,
    - The name and telephone number for the debt collector (if applicable)
    - The contact information for the UMMS Financial Assistance Department (or third party agency acting on behalf of UMMS), authorized to modify the terms of a payment plan (if applicable)
    - Telephone number and internet address of the Health Education Advocacy Unit in the Office of the Attorney General, available to assist patients experiencing medical debt.
- The amount required to satisfy the debt (including any past due payments, penalties, or fees, if applicable)

- Identification of ECAs that UMMS (or its collection agency, attorney, or other authorized party) intends to utilize in order to obtain payment for the care, and state a deadline after which such ECAs may be initiated.
- A deadline after which such ECA(s) may be initiated that is no earlier than 45 days after the date that the written notice is provided.
- A statement recommending that the patient seek debt counseling services,
- An explanation of the UMMS Financial Assistance Policy, and a notification of availability of financial assistance for eligible individuals
- And any other information as prescribed by the HSCRC

Written notice and accompanying documentation will be sent to the patient by certified mail and first class mail, in the patient's preferred language, or another language, as specified. The written notice will be in simplified language of at least 10 point type.

In addition to the written notification, UMMS (and/or its collection agency or attorney) 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 UMMS Revenue Cycle Services leadership.

If a patient is determined to be eligible for financial assistance, UMMS (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. All ECAs will cease once the patient is approved for financial assistance and all the patient responsible balances are paid.

UMMS will not engage in the following ECAs:

- Selling debt to another party.
- Charge interest on bills incurred by patients before a court judgement is obtained
- Requesting a lien against a patient's primary residence. In some cases, Local, State, or Federal judicial protocols may mandate that a lien is placed, but UMMS will not force the sale or foreclosure of a patient's primary residence.
- Request the issuance of or take action causing a court to issue a body attachment or an arrest warrant against a patient.
- Make a claim against the estate of a deceased patient if the deceased patient was known by UMMS to be eligible for free care or if the value of the estate after tax obligations are fulfilled is less than half of the debt owned. However, UMMS may offer the family of the deceased patient the ability to apply for financial assistance.
- Require payment of medical debt prior to providing medically necessary care.

ATTACHMENTS:

ATTACHMENT A: Sliding Scale – Reduced Cost of Care

2022 Federal Poverty Limits (FPL) Annual Income Eligibility Limit Guidelines							
House-hold (HH) Size	1	2	3	4	5	6	See UMMS Charity Thresholds below
Income Limit (up to Max)	$13,590	$18,310	$23,030	$27,750	$32,470	$37,190	

2022 Maryland Dept of Health (MDH) Annual Income Eligibility Limit Guidelines							
House-hold (HH) Size	1	2	3	4	5	6	See UMMS Charity Thresholds below
Income Limit (up to Max)	$18,768	$25,272	$31,800	$38,304	$44,808	$51,336	

UMMS Financial Assistance Charity Income Thresholds							
If your total annual household (HH) income level is at or below:							You are eligible for the following level of charity at UMMS:
House-hold (HH) Size	1	2	3	4	5	6	
Income Limit (up to Max)	$37,536	$50,544	$63,600	$76,608	$89,616	$102,672	**100% Charity** (Equals Up to 200% of MDH Annual Income limits)
Income Limit (up to Max)	$39,413	$53,071	$66,780	$80,438	$94,097	$107,806	**90% Charity** (Equals Up to 210% of MDH Annual Income limits)
Income Limit (up to Max)	$41,290	$55,598	$69,960	$84,269	$98,578	$112,939	80% Charity (Equals Up to 220% of MDH Annual Income limits)
Income Limit (up to Max)	$43,166	$58,126	$73,140	$88,099	$103,058	$118,073	**70% Charity** (Equals Up to 230% of MDH Annual Income limits)
Income Limit (up to Max)	$45,043	$60,653	$76,320	$91,930	$107,539	$123,206	60% Charity (Equals Up to 240% of MDH Annual Income limits)
Income Limit (up to Max)	$46,920	$63,180	$79,500	$95,760	$112,020	$128,340	**50% Charity** (Equals Up to 250% of MDH Annual Income limits)
Income Limit (up to Max)	$48,797	$65,707	$82,680	$99,590	$116,501	$133,474	40% Charity (Equals Up to 260% of MDH Annual Income limits)
Income Limit (up to Max)	$50,674	$68,234	$85,860	$103,421	$120,982	$138,607	**30% Charity** (Equals Up to 270% of MDH Annual Income limits)
Income Limit (up to Max)	$52,550	$70,762	$89,040	$107,251	$125,462	$143,741	**20% Charity** (Equals Up to 280% of MDH Annual Income limits)
Income Limit (up to Max)	$56,303	$75,815	$95,399	$114,911	$134,423	$154,007	**10% Charity** (Equals Up to 290% of MDH Annual Income limits)

*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 7/1/22

RELATED POLICIES:
UMMS Credit & Collections Policy
UMMS Payment Plan Policy

POLICY OWNER:
UMMS Revenue Cycle Services

APPROVED:
Executive Compliance Committee Approved Initial Policy: 09/18/19
Executive Compliance Committee Approved Revisions: 10/19/2020, 11/07/22

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

- UM St. Joseph Medical Center (UMSJMC) effective June 1, 2013.
- UM Midtown Campus (MTC) effective September 22, 2014.
- UM Baltimore Washington Medical Center (UMBWMC) effective July 1, 2016.
- UM Shore Regional Health (UMSRH) effective September 1, 2017.
- UM Charles Regional Medical Center (UMCRMC) effective December 2, 2018.
- UM Upper Chesapeake Health (UCHS) effective July 1, 2019
- UM Capital Region Health (UMCRH) effective September 18, 2019

EXHIBIT 6

MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY
7120 SAMUEL MORSE DRIVE, SECOND FLOOR
COLUMBIA, MARYLAND 21046-3422

License No. 16-015

Issued to:

University Of Maryland Capital Region Medical Center
901 North Harry S Truman Drive
Largo, MD 20774

Type of Facility: Acute General Hospital

Date Issued: June 12, 2021

Ownership: Dimensions Health Corporation,
d/b/a University of Maryland Capital Region Medical Center

Expiration Date: Non-expiring License

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 Tomoko May MD

Director

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

EXHIBIT 7

December 23, 2022

Nathaniel Richardson
Chief Executive Officer
Dimensions Health Corporation
901 Harry S Truman Drive N.
Upper Marlboro, MD 20774

Joint Commission ID: 6285
Program: Behavioral Health Care and Human Services
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 12/16/2022

Dear Mr. Richardson:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual noted below:

Comprehensive Accreditation Manual for Behavioral Health Care and Human Services

This accreditation cycle is effective beginning September 29, 2022, and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark Pelletier

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

December 23, 2022

Nathaniel Richardson
Chief Executive Officer
Dimensions Health Corporation
901 Harry S Truman Drive N.
Upper Marlboro, MD 20774

Joint Commission ID: 6285
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 12/16/2022

Dear Mr. Richardson:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning October 1, 2022, and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark Pelletier

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

EXHIBIT 8

QUALITY MEASURE PERFORMANCE

Data from: https://healthcarequality.mhcc.maryland.gov/Hospital/Detail/34
Accessed 12-14-22

Topic	Subtopic	Measure	Hospital Score	Maryland Score	Performance Comparison	Comments/Interventions
Staff Influenza Vaccination Rates			93.3%	94.1%		
Patient Satisfaction Survey	Communication	How often did doctors communicate well with patients?	70.0%	75.5%	Worse than Maryland	UM Capital contracted with a new hospitalist group as well as Kaiser Permanente physicians in July 2022. Physician attending and resident education has been a high priority and HCAHPS data is closely monitored and shared with physicians. The Chief Medical Officer or designee conducts ED Leadership rounds including rounding on patient/staff weekly.
	Communication	How often did nurses communicate well with patients?	65.0%	75.0%	Worse than Maryland	There is a focus on bedside handoff, nursing communication, and response to call bells. This will be part of our annual education and will be validated by rounding/observations by the managers, CNO, Directors, managers, and patient experience. Additional questions are included with the HCAHPS survey that ask patients about bedside shift communication and leadership rounding - this data is shared with leaders in a monthly dashboard and with the Board of directors every other month.
	Communication	How often did staff explain about medicines before giving them to patients?	46.0%	57.2%	Worse than Maryland	A newer initiative to deliver medications to the bedside prior to discharge will include patient education as needed. Utilization of this service is being audited monthly now and will be reported to leadership. In the annual nursing education, there are sections that focus on patient communcation, and education.
	Communication	How well do patients understand their care when they leave the hospital?	38.0%	47.4%	Worse than Maryland	Improved patient Admission/Discharge folders were implemented in December 2022. These include helpful information for patients related to discharge and other pertinent information, and the folders follow the patient throughout their stay.
	Communication	Were patients given information about what to do during their recovery at home?	77.0%	85.3%	Worse than Maryland	The new and improved Admission/Discharge folders also contain information related to discharge, after-care and appointments. Patients are called after discharge and issues are addressed as applicable. A new focus started in December 2022 to increase utilization of home health care, and education was given to physicians, case management and nursing. Monthly data will be share with leadership and physicians.
	Environment	How often did patients receive help quickly from hospital staff?	43.0%	57.1%	Worse than Maryland	We have implemented a no-pass zone on the units requiring any person to respond to call bells. While this is monitored by nurse leader rounding and charge nurses, we are exploring the possibility of getting automated aggregate data on length of time it takes to respond to call bells by unit.
	Environment	How often was the area around patients' rooms kept quiet at night?	52.0%	56.8%	Worse than Maryland	The key actions we have taken were to design a hospital with all single rooms and utilizing phones and secure texting for communication versus overhead paging. Since the move into the new hospital in Upper Marlboro on June 12, 2022, the HCAHPS score for quietness has been better than Maryland average, and has continued to improve in FY23. FY22 score was 57.11, and FY23 score year to date for July-Dec is 64.31.
	Environment	How often were the patients' rooms and bathrooms kept clean?	64.0%	66.7%	Same as Maryland	
	Overall Satisfaction	How do patients rate the hospital overall?	50.0%	65.3%	Worse than Maryland	The organization is taking a multi-pronged approach to address the environment, wait times, communication, and leadership visibility. All action plans combined will impact the overall satisfaction scores. The culture of the organization is improving, as evident in more recent performance. For July - December 2022 (as of 12/30/2022), the overall rating top box result was 58.9%
	Overall Satisfaction	Would patients recommend the hospital to friends and family?	47.0%	65.0%	Worse than Maryland	The organization is taking a multi-pronged approach to address the environment, wait times, communication, and leadership visibility. All action plans combined will impact the overall satisfaction scores. The culture of the organization is improving, as evident in more recent performance. For July - December 2022 (as of 12/30/2022), the likely to recommend top box result was 53.2%
Cardiac Conditions	Heart Attack and Chest Pain	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	No data	No data	No data	
	Heart Attack and Chest Pain	Dying within 30 days after getting care in the hospital for a heart attack	11.0%	12.2%	Same as Maryland	
	Heart Attack and Chest Pain	How long patients with chest pain or possible heart attack waited to be transferred to another hospital for a procedure	2h 36m	1h 33m	Worse than Maryland	UM Capital Region Medical Center has two cath labs and a cardiac surgery program. It would be a rare case if we needed to transfer patients. Currently, this data is not displayed on CMS Hospital Compare due to low volume. The chest pain program continues to track activation to cath lab balloon times to ensure timely care is delievered in accordance with national standards. Any process delays are reviewed by a multidisciplinary team.
	Heart Attack and Chest Pain	How often patients die in the hospital after heart attack (with transfer)	1.8%	4.8%	Better than Maryland	

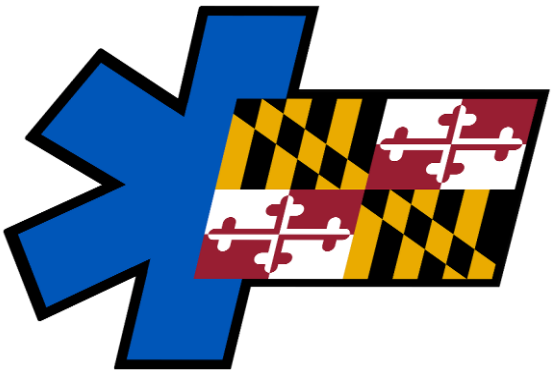
	Heart Attack and Chest Pain	Returning to the hospital after getting care for a heart attack	13.9%	14.8%	Same as Maryland	
	Heart Failure	Dying within 30 days after getting care in the hospital for heart failure	9.5%	11.1%	Same as Maryland	
	Heart Failure	How often patients die in the hospital after heart failure	1.0%	2.5%	Same as Maryland	
	Heart Failure	Returning to the hospital after getting care for heart failure	23.1%	20.4%	Same as Maryland	
	Heart Surgery and Procedures	Death rate for CABG	2.6%	2.7%	Same as Maryland	
	Heart Surgery and Procedures	How often patients die in the hospital after CABG	0.0%	3.3%	Same as Maryland	
	Heart Surgery and Procedures	Rate of unplanned readmission for CABG	10.7%	11.9%	Same as Maryland	
Emergency Department Use	Chemotherapy	Rate of emergency department visits for patients receiving outpatient chemotherapy	No data	No data	No data	
	Chemotherapy	Rate of inpatient hospital admissions for patients receiving outpatient chemotherapy	No data	No data	No data	
	Wait Times	How long patients spent in the emergency department before being sent home	4h 7m	3h 55m	Same as Maryland	
	Wait Times	Patients who left the emergency department without being seen	6.0%	2.3%	Worse than Maryland	We have made numerous changes to the structure of the emergency department from the leadership, to staffing, to the patient throughput. The improvements will directly impact wait times and thus reduce the LWOBS.
Imaging Tests		Contrast material (dye) used during abdominal CT scan	3.2%	3.6%	Same as Maryland	
		Patients who come to the hospital with low back pain who had an MRI without trying recommended treatments first, such as physical therapy (If a number is high, it may mean the facility is doing too many unnecessary MRIs for low back pain.)	No data	49.0%	No data	
		Patients who had a low-risk surgery and received a heart-related test, such as an MRI, at least 30 days prior to their surgery though they do not have a heart condition	No data	4.3%	No data	
		Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival	60.0%	72.5%	Same as Maryland	
		Percentage of patients who had an advanced breast screening on the same day or within 45 days of their initial mammogram or digital breast tomosynthesis (DBT) study (a rate between 5 and 12 percent is considered normal)	No data	9.1%	No data	
Infections		Catheter-Associated Urinary Tract Infections (CAUTI)	0.51	0.97	Same as Maryland	
		Central Line-Associated Blood Stream Infections (CLABSI)	3.44	1.06	Worse than Maryland	UM Capital Region Health had significantly reduced CLABSI infections prior to COVID, and have been working diligently to get back to consistent implementation of best practices. CLABSI reduction strategies are a continued fous for leadership, including the Board of Directors Quality Committee, and we have seen significant improvement in recent months. Actions include (1) Implemented IV team for line insertion in November 2022, (2) weekly audits since February 2022 of central line bundle compliance assuring compliance with 10 best practices for individual patients, (3) charge nurses doing real time reinforcement and feedback to nurses regarding compliance, (4) timely removal of lines, (5) use of a device to reduce blood culture contamination, (6) implemented 1 hospitalist group in July 2022 and educated the physaicians on best practices, (7) hand hygiene compliance sustained over 95%, (8) hand hygiene observations over 200 per unit per month with immediate feedback.
		Clostridioides Difficile Infections (CDI)	0.59	0.63	Better than Maryland	
		Methicillin-Resistant Staphylococcus Aureus Infections (MRSA)	0.87	0.94	Same as Maryland	
		Surgical Site Infections (SSI) - Abdominal Hysterectomy	No data	1.34	No data	
		Surgical Site Infections (SSI) - Colon Surgery	0.47	0.76	Same as Maryland	
		Surgical Site Infections (SSI) - Coronary Artery Bypass Graft	No data	0.72	No data	
		Surgical Site Infections (SSI) - Hip Replacement	No data	0.77	No data	
		Surgical Site Infections (SSI) - Knee Replacement	No data	0.77	No data	
Lung Conditions	COPD	Dying within 30 days after getting care in the hospital for chronic obstructive pulmonary disease (COPD)	7.0%	8.5%	Same as Maryland	
	COPD	Returning to the hospital after getting care for chronic obstructive pulmonary disease (COPD)	20.9%	19.3%	Same as Maryland	
	Pneumonia	Dying within 30 days after getting care in the hospital for pneumonia	No data	No data	No data	
	Pneumonia	How often patients die in the hospital while getting care for pneumonia	5.7%	5.1%	Same as Maryland	
	Pneumonia	Returning to the hospital after getting care for pneumonia	No data	No data	No data	
Mother and Baby	Complications	How often a baby is injured during delivery	6.2	7.3	Same as Maryland	

	Complications	How often there are obstetric injuries to the mother after a vaginal delivery (with instrument)	103.4	91.6	Same as Maryland	
	Complications	How often there are obstetric injuries to the mother after a vaginal delivery (without instrument)	11.2	17.4	Same as Maryland	
	Delivery	How often babies in the hospital are delivered using cesarean section when this is the mother's first birth	14.8%	17.8%	Better than Maryland	
	Delivery	How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)	15.0%	16.7%	Same as Maryland	
	Delivery	Newborn deliveries scheduled 1-3 weeks earlier than medically necessary	0.0%	2.0%	Better than Maryland	
	Delivery	Percentage of births (deliveries) that are C-sections	29.9%	29.8%	Same as Maryland	
Patient Safety	Combined Quality and Safety	How well this hospital keeps patients safe based on ten patient safety problems	1.3	1	Same as Maryland	
	Combined Quality and Safety	Percentage of patients who received appropriate care for severe sepsis and septic shock	35.0%	57.3%	Worse than Maryland	Multiple strategies have been implemented to address timely identification and management of sepsis. Data and feedback continue to be given to physicians, nurses and phamacists. Progress is reported to the hospital Quality and Performance Improvement Committee. Actions include: (1) sepsis champions identified for ED and inpatient units. Completed in July 2022. (2) Tiger text alerts to nursing staff when orders for antibiotics are placed in EPIC. Started in ED on December 15 2022. (3) Supplemental sepsis order set created in EPIC to make it user friendly for ED physicians. Completed on July 21 2022. ED physicians started using the supplemental sepsis order set on July 27, 2022. (4) Pharmacy PI team to work on improvement initiatives to address dispensing delays and drug unavailability in pyxis machines. Started on July 12 2022. Areas focused: pyxis inventory optimization, review pharmacy workflows, establishing IV batch par levels, maximize pre-made items to reduce pharmacy compounding, correcting interface issues between pharmacy / suppliers and drug shortages communication to clinicians. (5) Implement IV push of antibiotics in ED. Expected to start in ED on January 15, 2023. (6) Training for all ED nursing staff on ultrasound guided IV placement. Expected to start on January 31, 2023.
	Combined Quality and Safety	Patients who died in the hospital after having one of six common conditions	1	1.1	Same as Maryland	
	Combined Quality and Safety	Patients who died in the hospital after having one of six common procedures	0.9	1	Same as Maryland	
	Patient Safety	How often a patient has a fall in the hospital that results in a hip fracture	0	0.1	Same as Maryland	
	Patient Safety	How often a patient has bleeding or gets a blood clot after surgery that requires an additional procedure	4.4	2.1	Same as Maryland	
	Patient Safety	How often patients die in the hospital after bleeding from stomach or intestines	3.1%	2.3%	Same as Maryland	
	Patient Safety	How often patients die in the hospital after fractured hip	3.6%	1.8%	Same as Maryland	
	Patient Safety	How often patients die in the hospital while getting care for a condition that rarely results in death	1.9	0.6	Same as Maryland	
	Patient Safety	How often patients get a bloodstream infection after surgery	0	3.7	Same as Maryland	
	Patient Safety	How often patients get pressure ulcers while getting care for another condition	2.3	0.8	Worse than Maryland	There has been standardization of wound care products, practices and documentation. The quarterly NDNQI prevalence study was restarted in 2022, giving us benchmarking information, and data is shared with leadership. Educated nursing staff in the summer 2022 about the nurse driven protocol which includes immediately consulting wound care once a pressure injury is identified. We re-established expectations with staff to assess and take photographs of wounds on admission from the emergency department, with in-patient transfer and with any changes in patient condition. We have invested in bed equipment to reduce HAPIs and trained nurses in utilizing the Stryker bed air plus pumps in November and December 2022. In-service training for all nursing staff on wound management was done in Nov. 2022 in applicable areas.
	Patient Safety	How often patients have kidney failure requiring dialysis after a surgical procedure	0	0.8	Same as Maryland	
	Patient Safety	How often the hospital accidentally makes a hole in a patient's lung	0.2	0.2	Same as Maryland	
	Patient Safety	How often wounds split open after surgery on the abdomen or pelvis	0	1.7	Same as Maryland	
	Patient Safety	Returning to the hospital for any unplanned reason within 30 days after being discharged	15.5%	14.5%	Same as Maryland	
Stroke		Death rate for stroke patients	12.3%	13.5%	Same as Maryland	
		How often patients who came in after having stroke subsequently died in the hospital	5.4%	7.2%	Same as Maryland	
Surgery	Hip/Knee	Complications after hip or knee replacement surgery	No data	2.4%	No data	

	Hip/Knee	Returning to the hospital after getting hip or knee replacement surgery	No data	4.0%	No data	
	Patient Safety	How often patients accidentally get cut or have a hole poked in an organ that was not part of the surgery or procedure	1.1	1	Same as Maryland	
	Patient Safety	How often patients die in the hospital because a serious condition was not identified and treated	134.8	141.9	Same as Maryland	
	Patient Safety	How often patients in the hospital get a blood clot in the lung or leg vein after surgery	4.3	3.7	Same as Maryland	
	Patient Safety	How often patients in the hospital had to use a breathing machine after surgery because they could not breathe on their own	0	5.2	Same as Maryland	
	Patient Safety	Returning to the hospital within seven days of an outpatient surgery	1.2	1.1	Same as Maryland	
	Specific Conditions	Rate of unplanned hospital visits after an outpatient colonoscopy	No data	No data	No data	

EXHIBIT 9

M I E M S S



Level III Perinatal Initial Designation Application

University of Maryland
Capital Region Medical Center

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University of Maryland Capital Region Health
901 Harry S Truman Drive North, Upper Marlboro, MD 20747

UNIVERSITY of MARYLAND MEDICAL SYSTEM

November 25, 2022

Perinatal Programs
MIEMSS
653 West Pratt Street, Room 405
Baltimore, MD 21201-1536

Dear Sir or Madam:

Enclosed please find our completed application for consideration by the Maryland Institute for Emergency Medical Services Systems (MIEMSS) for re-designation as a Level 111 Perinatal Referral Center in accordance with Education Article 13-509, 13-510(2), Annotated Code of Maryland and COMAR 30.08. UM Capital Region Health (UM Capital) is fully dedicated to renewing our Perinatal Referral Center designation as a Level III program. The program has the support of the Board of Directors, corporate parent, medical staff, community, hospital administration, and staff. UM Capital has and will continue to dedicate high-quality resources to meet the perinatal standards for the Level III designation. UM Capital is accredited by The Joint Commission and operates as required by the Health Services Cost Review Commission.

UM Capital has highly dedicated and competent staff that are responsible for our program. This is true for the physicians, nursing, and support staff. The program is capable of providing complicated and uncomplicated obstetrical and neonatal care to patients as demonstrated by extensive policies, protocols, procedures, and clinical pathways developed by the team.

Should you need any additional information or require clarification of any of the enclosed information, please do not hesitate to be in contact with our point person for this project, Kerry Lewis, M.D., (202) 669-8577. We await your response.

Sincerely,

Nathaniel Richardson, Jr.
Nathaniel Richardson, Jr.
President and CEO
University of Maryland Capital Region Health

compassion | discovery | excellence | diversity | integrity

Executive Summary:

UM Capital Region Health, Inc. (UMCAP) operates an acute care hospital in Upper Marlboro, Maryland, with 221 licensed beds, 27 of which are dedicated to obstetrical and gynecological care. UMCAP serves the healthcare needs of Prince George's County, Maryland and the surrounding Washington Metropolitan area with high quality clinical programs. UMCAP transferred it operations from Cheverly, Maryland to a brand-new, state-of-the-art hospital in June of 2021, where it now seeks to re-open its Level IIII NICU.

UMCAP is committed to providing high quality perinatal/neonatal care to the community we serve in. As we continue to expand our services in an effort to improve access to high-quality, evidenced-based care, it is our intention to lead the efforts in the improvement of maternal and neonatal outcomes in Prince George's County and the surrounding Washington Metropolitan region.

Included within these materials are all of the data, policies, and other evidence needed for MIEMSS to confirm our ability to successfully satisfy our mission to provide comprehensive and quality Level III perinatal services. We look forward to sharing our success story with you.

Narrative Description of Commitments and Capabilities:

In anticipation of becoming a Level III perinatal hospital we have the ability to provide subspecialty care for pregnant women and infants, as described by the COMAR Perinatal Standards. Our Perinatal Referral Center is committed to providing the highest level of complicated and complex maternal fetal care, as well as uncomplicated, routine management of all of the clinical needs of our maternal fetal patient population. The commitment of UMCAP to provide exceptional patient care is demonstrated by our advanced technology, highly skilled certified nurse midwives, board certified obstetricians and gynecologists and a maternal fetal medicine division, that will be staffed by two physicians who are faculty within the University of Maryland School of Medicine, all of which serves to provide the highest level of maternal care for patients with complicated medical and obstetric problems.

Our new hospital, with state-of-the-art technology and resources supporting a dedicated staff of providers, nurses, advanced practice practitioners, certified nurse midwives and physician assistants is uniquely positioned to respond to the diverse high-risk obstetric needs of this community. Our team incorporates evidenced-based high-risk obstetric principles to guide us in the evaluation and management of complicated pregnancies with a focus on reducing the incidence of adverse outcomes associated with extreme prematurity. When delivery is indicated, our Neonatal Team is prepared to care for our newborns delivered at term or premature. We have the capacity and clinical talent to provide acute delivery room and neonatal intensive care (NICU) care for infants of all birth weights and gestational ages. A board-certified neonatal perinatal medicine subspecialist has programmatic responsibility for our neonatal services. UMCAP has maintained neonatologists and nurse practitioners to provide in-house 24/7 neonatal coverage. In addition, we have maintained clinical and contractual relationships with a full range of pediatric medical subspecialists, pediatric surgical specialists, and pediatric ophthalmologists

who are readily accessible on site or by prearranged consultative agreements at a closely related institution.

At UMCAP we appreciate the opportunity to serve this community with the highest level of perinatal care. Our obstetricians and gynecologists are board-certified and have completed additional training and certification in Relias Fetal Heart monitoring, Neonatal Resuscitation, limited ultrasound and maintenance of certification in general obstetrics and gynecology. Our neonatologists are board-certified and our neonatal nurse practitioners are certified in neonatal medicine. In addition, our team is staffed by a full spectrum of specialists and subspecialists in adult care that facilitate comprehensive access to high quality patient care for medical and surgical complications. Our maternal fetal medicine program, located on the Upper Marlboro Campus is the only hospital-based maternal fetal medicine program in Prince George's County and has satellite locations in Laurel, Suitland and with plans for expansion into Oxon Hill. Moreover, we continue to recruit providers, and maternal fetal medicine specialists, and are developing a diabetes center for pregnant patients.

Our perinatal program is designed to be compliant with the COMAR standards expected of a Level III perinatal facility. Our relationship with Charles Regional Medical Center, local Federally Qualified Health Centers, community obstetricians and gynecologists, and the UMCAP Medical Group provides access to our maternal fetal medicine services and the opportunity to service this community in a unique and patient-focused way. UMCAP has demonstrated its commitment to patient safety and quality with a dedicated perinatal safety and quality officer physician and dedicated perinatal coordinator. A board-certified obstetrician has programmatic responsibility for obstetric services and a board-certified maternal fetal medicine specialist has programmatic responsibility for high risk obstetrical services. As a Level III perinatal center, we will be prepared to accept risk-appropriate maternal and neonatal transports.

Maryland Institute
for
Emergency Medical Services Systems

Application for
Level III PERINATAL REFERRAL CENTER DESIGNATION

University of Maryland Capital Region Medical Center

Complete Name of Applicant Hospital

November 25th, 2022

Date of Application

Official Contact Person for This Application:

Dianne M. Richmond, PhD, MSN, RN, CPHQ
Name

Director of Accreditation and Environmental Hospital Safety
Title

901 Harry S. Truman Drive, North
Address

Largo — City
MD — State
20774 — Zip Code

240-677-1219
Telephone Number

240-677-3025
Fax Number

Dianne.Richmond@umm.edu
E-mail Address

Key Contacts

Please provide names and title for key administrative, neonatal/pediatric and obstetric personnel. You may add additional personnel specific to your institution.

Department	Name	Title
Hospital Administration	Nathaniel Richardson, Jr.	President/ Chief Executive Officer
VP/Director of Nursing	Joel A. Sandler, MBA, BSN, RN	SVP & Chief Nursing Officer
Director of Nursing for Perinatal Units	Vannesia Morgan-Smith, PhD, MSN, RN, NE-BC	Director of Women's and Infant Services
Chairman of Pediatrics	Fredrick Corder, MD	Chairman, Department of Pediatrics
Director of Neonatology	Jocelyn C. Leung, MD	Medical Director of NICU
Medical Director – NICU	Jocelyn C. Leung, MD	Medical Director of NICU
Nurse Manager - NICU	Florchita Arceo, MSN, RN	Nurse Manager
Chairman of OB/GYN	Kerry Lewis, MD	System Medical Director of WIS Chairman-Department of MFM
Director of Maternal-Fetal Medicine	Kerry Lewis, MD	System Medical Director of WIS Chairman-Department of MFM
Nurse Manager – L&D	Tiffany O'Kelley, M.Ed, BSN, RN	Nurse Manager
Nursing Manager – Postpartum/Antenatal Unit	Florchita Arceo, MSN, RN	Nurse Manager
Performance Improvement Coordinator	Traci Gore, RN MSN	Perinatal Quality and Safety Coordinator
Director of Social Work, Women and Children	Lyn Clark, MHA, BSN, RN	Interim Case Management Director
Systems Quality and Safety Medical Officer for Women and Infant Services	Shelley-Ann Hope, MD, MAS, FACOG, CPPS, CPHQ	Systems Quality and Safety Medical Officer for Women and Infant Services

OBSTETRIC SERVICE

Obstetric Service – Section I

The following questions regarding the obstetric service are taken directly from the standards. Please circle "Yes", "No" or "N/A" in the appropriate column. The numbers in bold type following each question refer to citations within COMAR 30.08.12. Current regulations are available on the Internet at:

Regulation: click here

1. Is there a physician who is board-certified in obstetrics and gynecology and who is a member of the medical staff and has responsibility for programmatic management of obstetric services? **.06A**	Yes	No	N/A
A physician board-certified in maternal-fetal medicine shall be a member of the medical staff and have programmatic responsibility for obstetrical services; **.06B**	Yes	No	N/A
2. Is there one or more physician(s) who are board-certified or active candidates for board-certification in maternal-fetal medicine and who is a member of the medical staff and has full-time responsibility for programmatic management of high-risk obstetrical services? **.06C** **Identify this staff member if applicable Kerry Lewis, MD**	Yes	No	N/A
3. Is there a maternal-fetal medicine physician on the medical staff, in active practice and, if needed, in-house within 30 minutes? **.06E**	Yes	No	N/A
4. Is there a physician board-certified or an active candidate for board-certification in obstetrics and gynecology present in-house 24 hours a day and immediately available to the delivery area when a patient is in active labor? **.06F**	Yes	No	N/A
5. Is a physician or certified nurse-midwife with obstetrical privileges present at all deliveries? **4.11 Maryland Perinatal System Standards**	Yes	No	N/A
6. Is there a physician board-certified or an active candidate for board certification in anesthesiology or nurse-anesthetist available so that cesarean delivery may be initiated per hospital protocol within 30 minutes of the decision to deliver? **.08**	Yes	No	N/A

7. Is there a physician board-certified, or an active candidate for board-certification in anesthesiology in-house 24 hours a day and readily available to the delivery area? **.08B**	Yes	No	N/A
8. Is there a physician board-certified or an active candidate for board-certification in anesthesiology who is a member of the medical staff and has responsibility for the programmatic management of obstetrical anesthesia services? **.06F** **Identify this staff member <u>Christina Mack, MD</u>**	Yes	No	N/A
9. Are there critical care services appropriate for obstetrical patients, including a critical care unit and a board certified critical care specialist who is an active member of the medical staff? **.04B** **Identify this staff member <u>Imran Siddiqi, MD</u>**	Yes	No	N/A
10. Is there a physician on the medical staff with privileges for providing critical interventional radiology services for obstetrical patients? **.08D(1) Identify this staff member** **<u>Ifechi Ukeh, M.D.</u>** **<u>David Amadu, M.D.</u>** **<u>Charles Hunter, M.D.</u>** **<u>Zachariah Blegen-DiPietro, M.D.</u>**	Yes	No	N/A
11. Is equipment for performing interventional radiology services available for obstetrical patients ? **.10G(a)**	Yes	No	N/A
12. Is obstetric diagnostic imaging available 24 hours a day, with interpretation by physicians with experience in maternal disease and complications? **.08E**	Yes	No	N/A
13. Is there a registered dietician or other health care professional with knowledge of and experience in the management of obstetrical and neonatal parenteral/enteral nutrition on staff? **.08F** **Identify this staff member <u>Andrea Grondwalski, RD</u>**	Yes	No	N/A

14. Is there at least one International Board Certified Lactation Consultant who shall have programmatic responsibility for lactation support 2services which shall include education and training of additional hospital staff members in order to ensure availability seven days per week of dedicated lactation support on full-time staff? **.08G** **Identify this staff member <u>Jennifer Doyle, MD IBCLC</u>**	Yes	No	N/A
15. Is there a medical social worker with a Master's Degree (either an LGSW, Licensed Graduate Social Worker, or an LCSW, Licensed Certified Social Worker) and experience in psychosocial assessment and intervention with women and their families dedicated to the perinatal service? **.08I Identify this staff member <u>Linthia V. Wallace</u>**	Yes	No	N/A
16. Are genetic diagnostic and counseling services or written consultation and referral agreements for these services in place? **.08N**	Yes	No	N/A
17. Is there, on its perinatal program staff a registered nurse with a Master's or higher degree in nursing and experience in high-risk obstetrical and/or neonatal nursing responsible for staff education; **.08S** **Identify this person and provide CV <u>Christina Dalo, MS</u>** (Appendix A pgs. 54-58)	Yes	No	N/A
18. On the hospital perinatal program administrative staff, is there a registered nurse with a Master's or higher degree in nursing or a health-related field and experience in high-risk obstetric and neonatal nursing who shall have programmatic responsibility for the obstetrical and neonatal nursing services? **.08R** **Identify this person and provide CV <u>Dr. Vannesia Morgan-Smith</u>** (Appendix A pgs. 59-63)	Yes	No	N/A
19. Does the perinatal service have: Continuous availability of adequate numbers of registered nurses with competence in assessment and care of obstetrical patients as well as the recognition and nursing management of obstetrical complications;**08T**	Yes	No	N/A
20. Is there a written plan for assuring nurse/patient ratios as per current *Guidelines For Perinatal Care* and *AWHONN Guidelines* ? **.08**	Yes	No	N/A

21. Is the hospital capable of providing emergency ultrasound imaging and interpretation for obstetrical patients 24 hours per day? **.10A**	Yes	No	N/A
22. Are fetal diagnostic testing and monitoring equipment available for fetal heart rate monitoring, ultrasound examinations, and amniocentesis? **.11D**	(Yes)	No	N/A
23. Is a full range of invasive maternal monitoring available on campus, including equipment for central venous pressure and arterial pressure monitoring? **.11G**	(Yes)	No	N/A
24. Are all emergency resuscitation medications to initiate and maintain resuscitation, in accordance with Advanced Cardiac Life Support (ACLS) guidelines, present in the delivery area? **.12C**	(Yes)	No	N/A
25. Are the following medications in the delivery area or immediately available to the delivery area: (1) Oxytocin (Pitocin); (2) Methylergonovine (Methergine); (3) Misoprostol (Cytotec); (4) Carboprost tromethamine (Hemabate); and (5) Tranezamic acid (TXA)? **.12D**	(Yes)	No	N/A
26. Are minimum competencies identified for obstetrical and neonatal clinical staff, not otherwise credentialed, that are assessed prior to independent practice and on a regular basis thereafter? **.13A**	(Yes)	No	N/A
27. Is there a full complement of subspecialists, including subspecialists in critical care, general surgery, infectious disease, hematology, cardiology, nephrology, and neurology available at all times? **4.12 Maryland Perinatal System Standards**	(Yes)	No	N/A
28. Are there adult medical and surgical specialty and subspecialty consultants available at all times and onsite if needed to collaborate with the maternal-fetal medicine care team? **4.13 Maryland Perinatal System Standards**	(Yes)	No	N/A

29. Is the hospital capable of providing portable detailed ultrasound and fetal assessment including Doppler studies, with interpretation for obstetrical patients 24 hours a day? **.10B**	Yes	No	N/A
30. Is the hospital capable of providing maternal echo cardiology with interpretation for obstetrical patients 24 hours a day? **.10C**	Yes	No	N/A
31. Special equipment and facilities needed to accommodate the care and services needed for obese women. **.11B**	Yes	No	N/A
32. Are the following medications immediately available for management of hypertensive crisis in all obstetrical care areas: (1) Hydralazine (2) Labetalol and (3) Nifedipine **.12E**	Yes	No	N/A

Obstetric Service – Section II

Fill in the following tables and provide short answers as required.

- **Identify the total number of:**
  Licensed Obstetric unit beds 27
  (In this number, include mother/baby, postpartum, antepartum or high risk)
  Licensed beds that are staffed and operational 27

  Labor and Delivery rooms 16
  (In this number also include LDR and/or LDRP, exam rooms, triage, operating rooms and PACU)

- Maternal Admissions and Transfers

	CY18	CY19	CY20	CY21	CY22
Total number of admissions	1261	1212	1324	1204[1]	1219[2]
Number of transport admissions[3] *	18	22	10	10	4
Number of transports OUT[3] **	0	1	3	19	21

* maternal admissions transferred into your hospital from another hospital for a higher level of care

** maternal patients transferred out of your hospital to another hospital for specialty care.

- Deliveries

	CY18	CY19	CY20	CY21	CY22
Total number of deliveries[3]	1292	1276	1368	1253	1494
Number of Primary C/S deliveries[3]	164	179	207	174	94
Number of Repeat C/S deliveries[3]	214	203	262	218	117
Number of VBAC deliveries[3]	58	43	41	43	13

- Miscellaneous Maternal Indicators

	CY18	CY19	CY20	CY21	CY22
Number of maternal deaths[3]	0	0	0	0	3
Number of term fetal deaths[3]	1	5	3	3	1
Number of fetal deaths of 20 weeks or greater[3]*	23	35	22	22	27
Number of admissions with no prenatal care[3]	69	91	77	52	43
Number of maternal re-admissions within 30 days after discharge following childbirth[3] ** (postpartum hypertension, surgical site infection)	20	8	13	9	12
Number with HIV diagnosed and/or treated prenatally[3]	22	14	16	8	5
Number of postpartum patients returned to OR or DR[3]	8	8	1	7	13
Number requiring critical care services[3]* (trauma, insulin infusion. sepsis maternal desaturation(e.g. COVID Pneumoniae)	14	15	7	5	6

*****Define critical care obstetric patient

A. A critical care OB patient is defined as a patient whose underlying problems are critical in nature requiring intensive and/or invasive monitoring or less acute problems that may require intermediate care and monitoring.

******List the re-admission diagnoses

[1]Number based on admissions from 6/12/2021 – 12/31/2022 (680 - ADT Admissions) when moved to Largo campus. Data from Cheverly from 1/1/2021 – 6/11/2022 (524)
[2]Calculated from activity in CY 2022 from 1/1/2022 through 11/17/2022
[3]Obtained from KPI reporting data 1/1/2022 through 10/31/2022

- Critical Care Service for Obstetric Patients

  Select one of the following regarding obstetric patients requiring critical care. This hospital:

  __**X**__ a) Admits all,

  ____ b) Admits select patients, or

  ____ c) Transfers all patients out.

  If you admit all patients, please indicate your criteria for a critical care OB patient and give examples of types of patients that meet this definition.

At UMCAP, we have a critical care unit and intensivists who are available for consultation for obstetric critically ill patients. However, if admitted to the ICU, the intensivists are the admitting providers and obstetrics/maternal fetal medicine is the consulting service. Examples include Type 1 Diabetics in DKA, COVID-19 patients with low O2 saturations and may be ventilated, hypertensive patients requiring antihypertensive infusions and cardiomyopathies. Most of these patients are cared for in the ICU where we have delivery supplies and equipment in the event of the need for an emergency delivery. We also have the ability to perform fetal monitoring in the ICU with portable fetal monitors. The fetal tracing is stored and can be read in real-time on the Labor and Delivery unit. In addition, UMCAP maintains a comprehensive coverage schedule of subspecialists including cardiologists (Heart and Vascular Institute), intensivists, pulmonologists, nephrologists, hematologists, gastroenterologists, infectious disease specialists, neurologists and surgeons available 24/7.

If you admit selected patients, define or give examples of types of patients.

N/A

On what unit(s) are these patients admitted?

If the primary diagnosis is non-obstetric and requires ICU management, they are admitted to the ICU. If their primary diagnosis is obstetric, they may be admitted to labor and delivery with appropriate consultation (e.g. endocrinology or internal medicine for an insulin infusion for a type 1 diabetic in DKA in labor).

- Describe the protocol/procedure for providing complex and uncomplicated obstetrical care for:
  (a) unexpected obstetrical care problems **.04A(2)**

At the University of Maryland Capital Region Health, we provide a

comprehensive obstetric service to respond to normal and low risk obstetric patients, patients with medical and obstetric complications and unexpected maternal and fetal complications. Our board-certified obstetrician and gynecologists provide in-house labor and delivery coverage 24/7 along with our anesthesiologists and CRNA's who also provide in-house coverage 24/7. In addition, our certified nurse midwives also provide in-house labor and delivery coverage 24/7. We are also staffed by our physician assistants who also provide 24/7 in-house coverage and assist the providers with cesarean deliveries and emergency department coverage. Finally, we have 24/7 maternal fetal medicine consultation and are prepared to come in-house, if necessary, within 30 minutes. This structure provides us the ability to provide uncomplicated obstetrical care with the resources and talent to transition to an emergency situation in a timely, efficient and safe manner.

Supporting Documentation:

- Vacuum Extraction Management for Operative Vaginal Deliveries (Appendix A pgs. 65-67)
- Care of The Pregnant and Postpartum Patient In The Emergency Room (Appendix A pgs. 68-73)
- Forceps Management for Operative Vaginal Deliveries (Appendix A pgs. 74-77)
- Hypertension in Pregnancy (Appendix A pgs. 78-95)
- Managing Shoulder Dystocia Policy (Appendix A pgs. 96-102)
- Neonatal Code Blue (Appendix A pgs. 103-106)
- Maternal Transport Protocol (current) (Appendix A pgs. 107-110)
- Maternal Transport Protocol (draft as Level III) (Appendix A pgs. 111-114)
- Assessment and Management of the Postpartum Patient (Appendix A pgs. 115-123)

(b) fetal monitoring, including internal scalp electrode monitoring **.04A(3)**

Our labor and delivery unit uses the GE Centricity system for fetal monitoring., This electronic system allows us to provide electronic storage of our fetal tracings that can be recovered for future educational; activities. The bedside fetal monitors allows for external and internal fetal monitoring using fetal scalp electrodes and are initiated following the guidelines in our labor and delivery laboring protocol. The fetal scalp electrode is used when we are unable to generate a reliable fetal tracing (e.g. obese patients, inconsistent or concern regarding the fetal tracing pattern).

Supporting Documentation:

- Laboring Woman Management of the Intrapartum Patient (current) (Appendix A pgs. 124-130)

(c) ability to begin emergency Cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care **.04A4**

Because of the provider staffing model summarized in (a), we are consistently able to perform a cesarean delivery within the time interval that best acknowledges the maternal and fetal condition and the need for an emergency delivery. Our OB STAT policy expects our decision-to-incision time to occur within 30 minutes.

Supporting Documentation:

- OB Stat Cesarean Section (Appendix A pgs. 131-132)
- Emergency Obstetrical Response Team (Appendix A pgs. 133-144)

(d) management of high-risk obstetrical patients as consistent with the requested designation level **.04A5**

As discussed in (a), the University of Maryland Capital Region Health has maternal fetal medicine specialists available for consultation 24/7 and in-house within 30 minutes of an indication for in-house management. In addition, our maternal fetal medicine specialists have access to remote fetal tracing review and the ability to review obstetric ultrasound images as performed and completed in our radiology suite.

Supporting Documentation:

- Maternal Transport Protocol (current) (Appendix A pgs. 107-110)
- Maternal Transport Protocol (draft as Level III) (Appendix A pgs. 111-114)
- Code Blue (Appendix A pgs. 145-164)
- Emergency OB Response Team (Appendix A pgs. 133-144)
- Neonatal Code Blue (Appendix A pgs. 103-106)
- OB Stat Cesarean Section (Appendix A pgs. 131-132)

- Describe how a high-risk admission is managed when the obstetrical unit is at full capacity

In the event that we have a number of patients that exceed the capacity of the Labor and Delivery unit, the manager and/or triage nurse will communicate with the physician and determine a triage plan which would consist of multiple choices:

1. Assess the patients that are in the Triage area and determine if further observation and evaluation, or if they could be discharged.
2. If the patient is in Triage, and it is determined that they will need to stay for further evaluation,
    a) The patient will be transferred to 3-North Antepartum beds. This unit houses four Antepartum rooms which has central monitoring to Labor and Delivery unit. This process will free up the triage area to allow for the high-risk patients to be evaluated in a timely matter.
    b) Transfer the mother to another facility

Please refer to our scope of service for Labor and Delivery. We are staffed with an OB hospitalist, anesthesiologist and Midwife 24/7 with back up if needed to ensure the ability to perform quick emergent cesarean deliveries.

Supporting Documentation

- **Labor and Delivery Scope of Practice attachment** (Appendix A pgs. 165-171)

- If obstetric patients are transported out of your hospital to an out of state hospital for specialty care, please provide contact information for obstetrical/neonatal staff at that institution.

Name	Title	Phone/Fax		Email Address
Helain Landy, M.D.	Chairman Department of Obstetrics and Gynecology Georgetown University Medical Center	202-481-1060 Direct 202-481-1052	877-544-7752	Landyh@gwnet.georgetown.edu
Guoyang Luo, M.D., PhD.	Chairman Department of Obstetrics and Gynecology Howard University College of Medicine and Hospital	202-865-1236	202-865-3653	Guoyang.luo@huhosp.org
Tamika Auguste, M.D.	Chairman Department of Obstetrics and Gynecology Washington Hospital Center	202-877-8879	202-877-0447	Tamika.c.auguste@medstar.net
Nancy D. Gaba, M.D., FACOG	Chairperson Department of Obstetrics and Gynecology George Washington University School of Medicine Washington, D.C.	202-715-4660	202-715-4980	Florence.Hunter@gw-hospital.com (Nursing Director)

- Please identify the Obstetrical/MFM Services Physicians on Staff
  (Only include those physicians who provide medical coverage or consultation service for high-risk obstetrical patients.)

Name of Physician	Board Specialty	*Check One Column Board* Certified	Active Candidate	**If yes, name of other hospital(s) Provides coverage at other hospitals Yes/No**
Kerry M. Lewis, M.D.	Obstetrics and Gynecology Maternal Fetal Medicine	Yes	N/A	No
Richard Broth, M.D., FACOG	Obstetrics and Gynecology Maternal Fetal Medicine	Yes	N/A	Yes **Holy Cross** **Shady Grove**

Obstetric Service – Section III

This section requires either attaching a copy of a specific document or having the document available on the day of the site visit, as indicated below.

Attach a copy of each of the following documents to this application. Use this as a checklist to ensure all documents are included and indicate the page number where the document can be found.

	Check when attached	Page Number of Document
1. CV for Director of Maternal-Fetal Medicine.	__✓___	173-183
2. CV for Board Certified Critical Care Specialist	__✓___	184-191
3. CV for Nurse Manager of Labor and Delivery.	__✓___	192-195
4. CV and job description for Nurse midwives	__✓___	196-244
5. CV for Nurse Manager for Antenatal/Postpartum.	__✓___	245-246
6. CV and job description for Obstetric Advanced Practice Nurse.	_N/A__	
7. CV and job description for Nurse responsible for staff education.	__✓___	247-257; 54-58
8. CV and job description for Social Worker covering obstetric services. Describe the role of the Social Worker on the multidisciplinary team.	__✓___	258-270
9. CV for Genetics Counselor.	__✓___	271-273
10. CV for Dietician covering Obstetric Services.	__✓___	274-277
11. CV and job description for Lactation Nurse	__✓___	278-289
12. (a) Written plan for initiating maternal transports to an appropriate level of care.15D (Appendix A pgs. 107-110; 111-114)	__✓___	107-110; 111-114

(b) Written protocol for the acceptance of maternal admissions transferred into your hospital from another hospital for a higher level of care. Indicate whether there are any formal agreements for transfer of high risk obstetrical patients into the hospital. If yes, provide a sample agreement. .15E

We do not have a formal transfer agreement. (Appendix A pgs. 107-110; 111-114)

(c) Written guidelines for accepting or transferring mothers as "back transports" including criteria for accepting the patient and patient information on required care .15F (Appendix A pgs. 107-110; 111-114)

13. Sample one month schedule of coverage for in-house obstetrician coverage (during the past 6 months).	__✓___	290
14. Sample one month schedule of coverage for MFM coverage (during the past 6 months) .06C	__✓___	291
15. Sample one month schedule of coverage for obstetrical anesthesiology (during the past 6 months). .08B	__✓___	292
16. Resuscitation standards, protocol or guidelines for unanticipated problem in DR, ER, or other area of the hospital. .04A, .15B	__✓___	68-73; 78-95; 96-102; 103-106; 131-132; 133-144; 145-164; 293-330
17. A written plan for assuring nurse/patient ratios as per current *Guidelines for Perinatal Care* and *AWHONN Guidelines* .08W	__✓___	331-333
18. Policy that allows families (including siblings) to be together in the hospital following the birth of an infant and that promote parental involvement in the care of the neonate including the neonate in the NICU .15H	__✓___	334-339
19. Policy to eliminate deliveries by induction of labor or by cesarean section prior to 39 weeks gestation without a medical indication with a systematic internal review process to evaluate any occurrences and a plan for corrective action .15I	__✓__	340-347
20. Consultation or referral agreement for genetics counseling. .08N	__✓___	348-357
21. Written protocol to respond to massive obstetrical hemorrhage, including a plan to maximize accuracy in determining blood loss. .15J	__✓___	313-330; 358-369
22. Written policy for the management of obstetrical patients with opioid use and opioid use disorder that addresses the following and other relevant issues: (1) universal screening of obstetrical patients for opioid use	__✓___	370-374

(2) pharmacotherapy of the pregnant, laboring and postpartum woman
(3) breastfeeding
(4) linkages to appropriate postpartum psychosocial support services including substance use treatment and relapse prevention
program. .15L

23. Written policy for optimizing post-delivery care of obstetrical patients that addresses the following and other relevant issues: __✓__ 115-123
(1) identification of postpartum women at risk for poor health outcomes
(2) breastfeeding support
(3) linkages to appropriate medical and psychosocial services, and
(4) reproductive health planning .15N

Have a copy of the following available during the onsite visit.

1. **Upon request**, please have available all standards, protocols, protocols and guidelines for the initial stabilization and continuing care of all obstetrical patients appropriate to the level of care rendered at this facility. **.04A, .15A**
2. If maternal transports are admitted, documentation of outreach continuing education programs for referring hospitals which shall include guidance on indications for consultation and referral of patients at high risk; information about the accepting hospital's response times and clinical capabilities; information about alternative sources for specialized care not provided by the accepting hospital; guidance on the pre-transport stabilization of patients and feedback on the pre-transport care of patients . **.13E(1-5)**
3. Documentation of continuing education provided for physicians, such as the schedule of programs for a one-year period. **.13B**
4. Documentation of continuing education programs provided for nurses, such as a schedule of programs for a one-year period. **.13B**
5. List of minimum competencies for perinatal clinical staff, not otherwise credentialed, that are assessed prior to independent practice and on a regular basis (e.g., nurses, respiratory therapists). **.13A**

NEONATAL SERVICE

Neonatal Service – Section I

The following questions regarding the neonatal service are taken directly from the standards. Please circle "Yes", "No" or "N/A" in the appropriate column. The numbers in bold type following each question refer to citations within COMAR 30.08.12.
Current regulations are available on the Internet at: Regulation: click here

1. Is there a physician (or physicians) board-certified in pediatrics, neonatal-perinatal medicine or family medicine that is a member of the medical staff and has privileges for neonatal care and has programmatic responsibility for neonatal services in the newborn nursery and/or the mother-baby unit? **.07A**	(Yes)	No	N/A
2. Are there Neonatal Resuscitation Program (NRP) trained professionals with experience in acute care of the depressed newborn and skilled in neonatal endotracheal intubation and resuscitation immediately available to the delivery and neonatal units? **.07C**	(Yes)	No	N/A
3. Is there a physician who has completed postgraduate pediatric training, a nurse practitioner or physician assistant with privileges for neonatal care appropriate to the level of the nursery and shall be present in-house 24 hours a day and assigned to the delivery area and neonatal units and not shared with other units in the hospital? **.07D**	(Yes)	No	N/A
4. Is there a physician board-certified or an active candidate for board certification in neonatal-perinatal medicine and who shall be available to be present in-house within 30 minutes? **.07E**	(Yes)	No	N/A
5. Is there an ophthalmologist on staff with experience in neonatal retinal examination and an organized program for the monitoring, treatment, and follow up of retinopathy of prematurity? **.07F** **Identify this staff member Janet Alexander MD and Moran Roni Levin MD**	(Yes)	No	N/A

6. Are the following pediatric specialists on staff, in active practice and, if needed, in-house or via telemedicine: (A) Cardiology,	(Yes)	No	N/A

(B) Neurology, and (C) General Pediatric Surgery? **.07G** **Identify the staff members** (See Pediatric Medical And Surgical Subspecialties Table – page 34)			
7. Are the following pediatric specialists on staff, in active practice and, if needed, in-house within 30 minutes: (A) Cardiology, (B) Endocrinology, (C) Gastroenterology, (D) Genetics, (E) Hematology, (F) Nephrology, (G) Neurology, and (H) Pulmonology **.07H** **Identify the staff members _____**	Yes	No	N/A
8. Are the following pediatric surgical subspecialists on staff, in active practice and, if needed, in-house within 30 minutes: (A) Neurosurgery, (B) Cardiothoracic surgery, (C) Orthopedic surgery, (D) Plastic surgery, and (E) Ophthalmology **.07I**	Yes	No	N/A
9. If the hospital performs neonatal surgery, is there a board-certified anesthesiologist with experience in neonatal anesthesia who shall be present for the surgery? **.08C** **Identify this anesthesiologist _____**	Yes	No	N/A
10. Is there a physician on the medical staff with privileges for providing critical interventional radiology services for neonatal patients? **.08D(2)** **Identify this staff member _____**	Yes	No	N/A
11. Is neonatal diagnostic imaging available 24 hours a day, with interpretation by physicians with experience in neonatal disease and complications? **.12**	Yes	No	N/A

12. Is there a registered dietician or other health care professional with knowledge of and experience in the management of obstetrical and neonatal parenteral/enteral nutrition on staff? **.08F** **Identify this staff member <u>Andrea Grudwalski</u>**	Yes	No	N/A
13. Is there at least one International Board Certified Lactation Consultant who shall have programmatic responsibility for lactation support services which shall include education and training of additional hospital staff members in order to ensure availability seven days per week of dedicated lactation support on full-time staff? **.08G** **Identify this staff member <u>Jennifer Doyle, MD IBCLC</u>**	Yes	No	N/A
14. Is there a medical social worker with a Master's Degree (either an LGSW, Licensed Graduate Social Worker, or an LCSW, Licensed Certified Social Worker) and experience in psychosocial assessment and intervention with women and their families dedicated to the NICU**.** **.08I** **Identify this staff member <u>Linthia V. Wallace</u>**	Yes	No	N/A

15. Are there respiratory therapists skilled in neonatal ventilator management present in-house 24 hours a day assigned to the NICU Not shared with other units? **Maryland Perinatal System Standards 6.12.** *Respiratory therapists are assigned to NICU 24 hours per day but may also be shared with other units.*	Yes Yes	No No	N/A N/A
16. Is there at least one occupational or physical therapist with neonatal expertise on staff? **.08L** **Identify this staff member <u>Beverly Neway</u>**	Yes	No	N/A
17. Is there at least one individual skilled in evaluation and management of neonatal feeding and swallowing disorders such as a speech-language pathologist on staff? **.08M** **Identify this staff member <u>Ericka Janifer</u>**	Yes	No	N/A
18. Are genetic diagnostic and counseling services or written consultation and referral agreements for these services in place? **.08**	Yes	No	N/A
19. Is there a pediatric neurodevelopmental follow-up program or written referral arrangements for neurodevelopmental follow-up?	Yes	No	N/A

.08O			

20. Is there, on the administrative staff, a registered nurse with a Master's or higher degree in nursing or a health-related field and experience in high-risk obstetrical and neonatal nursing who shall have programmatic responsibility for the obstetrical and neonatal nursing services? **.08Q** **Identify this person and provide CV <u>Dr.Vannesia Morgan-Smith</u>** (Appendix A pgs. 59-63)	(Yes)	No	N/A
21. Is there, on the perinatal program staff a registered nurse with a Master's or higher degree in nursing and experience in high-risk obstetrical and/or neonatal nursing responsible for staff education? **.08P08S**	(Yes)	No	N/A

22. A physician who has completed postgraduate pediatric training, a nurse practitioner, or a physician assistant with privileges for neonatal care appropriate to the level of the nursery present in-house 24 hours a day and assigned to the delivery area and neonatal units and not shared with other units in the hospital; Is there a registered nurse with demonstrated training and experience in the assessment, evaluation, and care of newborns readily available to the neonatal unit 24 hour a day? **.08Q(4)07D**	(Yes)	No	N/A

23. Is there a written plan for assuring nurse/patient ratios as per current *Guidelines For Perinatal Care* and *AWHONN Guidelines*? **.08W**	(Yes)	No	N/A
24. Is the hospital capable of providing portable x-ray imaging and interpretation for neonatal patients 24 hours per day? **.10D**	(Yes)	No	N/A
25. Is the hospital capable of providing portable head ultrasound and interpretation for neonatal patients? **.10A**	(Yes)	No	N/A

26. Is computerized tomography (CT) and magnetic resonance imaging (MRI) capability available on campus? **.10F**	Yes	No	N/A
27. Are neonatal echocardiography equipment and an experienced technician available on campus as needed with interpretation by pediatric cardiologist? **.10G**	Yes	No	N/A
28. Is a pediatric cardiac catheterization laboratory and appropriate staff available? **.10H**	Yes	No	N/A

29. Is equipment for performing interventional radiology services available for neonatal patients? **.10I**	Yes	No	N/A
(31) Are the following equipment and supplies immediately available for existing patients and for the next potential patient			
(1) O_2 analyzer, stethoscope, intravenous infusion pumps;			
(2) Radiant heated bed in delivery room and available in the neonatal units;	Yes	No	N/A
(3) Oxygen hood with humidity;	Yes	No	N/A
(4) Bag and masks and/or T-piece resuscitator capable of delivering a controlled concentration of oxygen to the infant;	Yes	No	N/A
(5) Orotracheal tubes;	Yes	No	N/A
(6) CO_2 detector;			
(7) Aspiration equipment;	Yes	No	N/A
(8) Laryngoscope;	Yes	No	N/A
(9) Bowel bags;	Yes	No	N/A
(10) Umbilical vessel catheters and insertion tray;	Yes	No	N/A
(11) Cardiac monitor;	Yes	No	N/A
(12) Pulse oximeter;	Yes	No	N/A
(13) Transilluminator;	Yes	No	N/A
(14) Phototherapy unit;	Yes	No	N/A
(15) Doppler blood pressure for neonates;	Yes	No	N/A
(16) Cardioversion/defibrillation capability for obstetrical patients and neonates;	Yes	No	N/A
(17) Resuscitation equipment for obstetrical patients;	Yes	No	N/A
(18) Resuscitation equipment for neonates including equipment outlined in the current NRP;	Yes	No	N/A
(19) Individual oxygen, air, and suction outlets for obstetrical patients and neonates; and	Yes	No	N/A

(20) Emergency call system for both obstetrical and neonatal units as well as an emergency communication system among units. **.11A**	Yes Yes Yes	No No No	N/A N/A N/A
30. Is a neonatal stabilization bed set up and equipment available at all times for an emergency admission? **.11C**	Yes	No	N/A
31. Fetal diagnostic testing and monitoring equipment for: (1) Fetal heart rate monitoring; (2) Ultrasound examinations; and (3) Amniocentesis; 11D	Yes	No	N/A
32. Is equipment available for neonatal intra-arterial pressure monitoring? **.11E**	Yes	No	N/A
33. Is laser coagulation capability available on campus for retinopathy of prematurity? **.11F**	Yes	No	N/A
34. Is there appropriate equipment, including back-up equipment, for neonatal respiratory care as well as protocols for the use and maintenance of the equipment as required by its defined level status? **.11H**	Yes	No	N/A
35. Is there advanced ventilatory support for neonates of all birth weights? **.11I**	Yes	No	N/A
36. Is the hospital capable of providing continuing therapeutic hypothermia? **.11J**	Yes	No	N/A
37. Are emergency medications, as listed in the Neonatal Resuscitation Program of the American Academy of Pediatrics/American Heart Association (AAP/AHA), present in the delivery area and neonatal units? **.12A**	Yes	No	N/A

38. Are antibiotics, anticonvulsants, surfactant, prostaglandin E1 and other emergency cardiovascular drugs immediately available to the neonatal units? **.12B**	Yes	No	N/A

39. Are minimum competencies identified for perinatal clinical staff, not otherwise credentialed, that are assessed prior to independent practice and on a regular basis thereafter (e.g. nurses, respiratory therapists)? **.13A**	Yes	No	N/A
40. Does the hospital have pharmacy personnel with knowledge of and experience in pediatric pharmacy? **.08P** **Identify the staff member <u>Christiana Hanson-Okoh</u>**	Yes	No	N/A

Neonatal Service – Section II

Fill in the following tables and provide short answers as required

- Average Daily Census

  Supply the actual average daily census (ADC) for neonatal intensive/special care unit for these fiscal years. If possible, break this down into intensive care, step-down, etc. Beneath the table provide a definition or description of each category.

	CY 18 A.D.C.	CY 19 A.D.C	CY 20 A.D.C	CY 21 A.D.C.	CY 22 A.D.C.
Intensive Care	7.6	7.3	5		
Step-down			6.7 (2 months)	2.5	3.9 (10 months)
Other neonatal special care					
TOTAL	7.6	7.3	5.3	2.5	3.9 (10 months)

Intensive Care is defined as:

Providing care for ill or premature infants born at University of Maryland Capital Region Medical Center. These infants may require advanced technology and providers trained in the care of these infants.

Intensive care includes the following types of patients:

Neonates that receive care at University of Maryland Capital Region Medical Center include but are not limited to the following conditions/treatments: premature infants of any gestational age requiring support; respiratory support (including the use of mechanical ventilation, high frequency ventilation, CPAP, noninvasive ventilatory support, surfactant replacement therapy); sepsis work up including antibiotic therapy; nutritional support (including parenteral nutrition); any infant requiring central line placement (including umbilical lines); any infant requiring blood transfusion; hyperbilirubinemia; glucose instability; neonates requiring passive hypothermia.

If you have other categories of special care beds for newborns, please define them along with a brief description.

University of Maryland Capital Region Medical Center does not have other categories of special care beds.

- Transfers out of your hospital

	CY18	CY19	CY20	CY21	CY22 (as of 11/18/22
Back to birth or local hospital	0	0	0	0	1
To another NICU for higher level or specialty care	28	20	35	22	35
To Mt Washington Pediatric Hospital other long-term care facility	2	3	5	1	0

- Neonatal ICU Admissions

In the following table supply the Neonatal Intensive and Special Care Admissions ("Adm") and Deaths ("Dths") by birth weight for:

a) In-born admissions, infants born at your hospital;

b) Primary transfer admissions, those infants transferred to your hospital for a higher level of care; and

c) Secondary or return transfers, infants transferred or returned to your hospital for convalescents or ongoing care.

	CY18						**CY19**						**CY20**					
	In-born		Primary Transfers		Secondary Transfers		In-born		Primary Transfers		Secondary Transfers		In-born		Primary Transfers		Secondary Transfers	
In grams	Adm	Dths	Adm	Dths	Adm	Dths	Adm	Dths	Adm	Dths	Adm	Dths	Adm	Dths	Adm	Dths	Adm	Dths
<500	3	2	0	0	0	0	2	2	0	0	0	0	1	1	0	0	0	0
501-750	6	4	0	0	0	0	7	2	0	0	0	0	6	1	0	0	0	0
751-1000	12	0	2	0	0	0	5	1	0	0	0	0	6	1	0	0	0	0
1001-1250	11	1	0	0	0	0	14	0	0	0	0	0	9	1	0	0	0	0
1251-1500	15	0	0	0	0	0	11	0	1	0	0	0	10	0	0	0	2	0
1501-2000	33	0	0	0	1	0	26	0	1	0	0	0	20	0	0	0	0	0
2001-2500	14	0	0	0	1	0	26	0	1	0	0	0	25	0	0	0	0	0
>2500	59	0	0	0	0	0	71	0	0	0	0	0	75	0	0	0	1	0
Total	153	7	2	0	2	0	162	5	3	0	0	0	152	4	0	0	3	0

	CY21						CY22					
	In-born		Primary Transfers		Secondary Transfers		In-born		Primary Transfers		Secondary Transfers	
In grams	Adm	Dths	Adm	Dths	Adm	Dths	Adm	Dths	Adm	Dths	Adm	Dths
<500	1	0	0	0	0	0	0	0	0	0	0	0
501-750	2	2	0	0	0	0	5	2	0	0	2	0
751-1000	1	1	0	0	1	0	1	0	0	0	1	0
1001-1250	3	1	0	0	1	0	5	0	0	0	6	0
1251-1500	1	0	0	0	5	0	10	0	1	0	4	0
1501-2000	22	0	0	0	4	0	23	0	0	0	6	0
2001-2500	20	0	0	0	2	0	32	1	0	0	8	0
>2500	72	0	0	0	2	0	80	1	1	0	3	0
Total	122	4	0	0	15	0	156	5*	2	0	30	0

*CY22 – additional death at 32 weeks, unknown BW

- Describe the protocol/procedure for providing complicated and uncomplicated neonatal care including:

  a. Resuscitation and stabilization of unexpected neonatal problems in accordance with NRP guidelines **.05A**

  University of Maryland Capital Region Medical Center follows the Lippincott "Delivery Room Resuscitation Neonatal" nursing procedures as well as the current NRP guidelines.

  b. Describe how a high-risk admission is managed when the neonatal intensive care unit is at full capacity

  Infants requiring NICU care when the unit is at full capacity will be stabilized and then transferred to an appropriate level of care facility. At all times, a stabilization bed is prepared and maintained in the unit for resuscitation and stabilization with the current NRP guidelines.

- Describe genetic diagnostic services for family, fetus and infant as consistent with the requested designation level **.08N**

  We currently have a contract with University of Maryland Medical Center to provide prenatal consults. Genetic services for infants are provided through a contract with Children's National Hospital. (Appendix A pgs. 348-357; 377-415)

- Describe your pediatric neurodevelopmental follow-up program or include a copy of your written referral agreement **.08O**

  Referrals are made to the University of Maryland Children's Hospital NICU follow up program (Appendix A pgs. 416)

- Pediatric Medical and Surgical Subspecialties

  In the following table, identify by name(s) the following pediatric medical and surgical subspecialists available as required in COMAR 30.08.12.07 and .08 for the appropriate level of care. Indicate if there is a written consulting relationship, if the physician is on staff, and whether if, when needed, the physician can be in-house urgently, by marking the appropriate column. If a specialty or specialties are not available, mark "N/A" in the space provided.

Specialty	Name	Written consult relationship	On Staff	Available in-house urgently	N/A
Cardiology (Univ of MD)	Alicia Chaves, MD Peter Gaskin, MD Rachel Moore, MD Nicholas Pietris, MD Sudhir Vashist, MD	No	Yes	Yes	
Cardiology	Sarah Clauss, MD Russell Cross, MD Niti Dham, MD Mary Donofrio, MD Lowell Frank, MD	Yes	Yes	No/telehealth	
Neurology	William D. Gaillard, MD John Schreiber, MD Tesfaye Zelleke, MD	Yes	Yes	No/telehealth	
Genetics	Nicholas Ah Mew, MD Kimberly Chapman, MD	Yes	Yes	No/telehealth	
General (Pediatric) Surgery	Anthony Sandler, MD Andrea Badillo, MD Randall Burd, MD Timothy Kane, MD Evan Nadler, MD Mikael Petrosyan, MD	Yes	Yes	No/telehealth	
Hematology					x
Endocrinology					x
Pulmonary					x
Gastrointestinal					x
Renal					x
Neurosurgery					x
Cardiothoracic surgery					x
Orthopedic surgery					x
Plastic surgery					x
Ophthalmology	Dr. Janet Alexander Dr. Moran Roni Levin	Yes	Yes	No	
Anesthesiology					x

- If neonatal patients are transported out of your hospital to an out of state hospital for

specialty care, please provide contact information for neonatal staff at that institution.

Name	Title	Phone/Fax		Email Address
Billie Lou Short, MD	Division Chief, Neonatology	202-476-3314	202-476-3459	bshort@childrensnational.org

- Neonatal Services Physicians on Staff
  (Only include those neonatologists, pediatricians and neonatal nurse practitioners who provide medical coverage or consultation service for high-risk neonatal patients.)

Name of Physician	Board Specialty	*Check One Column: Board* Certified	Board* Active Candidate	**If yes, name of other hospital(s): Provides coverage at other hospitals Yes/No**
Jocelyn Leung, MD	Neonatal/Perinatal	Yes		University of Maryland Medical Center, Mercy Medical Center
Temitope Akinmboni, MD	Neonatal/Perinatal	Yes		Adventist Shady Grove, St. Agnes
Olayemi Ajayi, MD	Neonatal/Perinatal	Yes		University of Maryland St. Joseph's Medical Center
Jacqueline Skelton, MD	Neonatal/Perinatal	Yes		No
Johana Diaz, MD	Pediatrics	Yes		University of Maryland Medical Center
Kiron Mallya, MD	Pediatrics	Yes		University of Maryland Medical Center
Michelle Peterson, NNP				Howard County General Hospital
Natalie Hunt, NNP				University of Maryland Medical Center, UM St Joseph, JH Bayview
Joshlyn Davenport, NNP				GBMC
Stephanie Norrgard, NNP				University of Maryland Medical Center
Daniel Brewer, NNP				St. Agnes, Covant Health (NC)
Danya Heller, NNP				University of Maryland Medical Center

Neonatal Service – Section III

This section requires either attaching a copy of a specific document or having the document available on the day of the site visit, as indicated below.

Attach a copy of each of the following documents to this application. Use this as a checklist to ensure all documents are included and indicate the page number where the document can be found.

	Check when attached	Page Number of Document
1. CV for NICU Medical Director.	__✓___	418-431
2. CV for NICU Nurse Manager.	__✓___	245-246
3. CV and job description for Neonatal Advanced Practice Nurse.	__✓___	432-435
4. CV for director/supervisor of neonatal respiratory therapist.	__✓___	436-442
5. CV and job description for social worker covering neonatal services.	__✓___	258-269
6. CV for dietician covering neonatal services.	__✓___	443-446
7. CV and job description for nurse responsible for staff education.	__✓___	447-458
8. Sample one month schedule of coverage for neonatologists.	__✓___	459
9. Sample one month schedule of coverage for pediatricians and/or NNPs.	__✓___	459
10. Sample one month schedule of coverage for respiratory therapy.	__✓___	460-461
11. Sample one month schedule of coverage for pediatric anesthesiology.	__N/A__	
12. Sample one month schedule of nursing staff coverage for NICU.	__✓___	462-466
13. Neonatal resuscitation standards, protocol or guidelines for unanticipated problem in DR, ER, term nursery or other area of the hospital. **.05A, .05B**	__✓___	467-476
14. A. Policy, standard, protocol or guidelines for primary neonatal transport into your hospital. **.15**	__✓___	467-476
B. Policy, standards, protocol or guidelines for neonatal transports out of your hospital **.15**	__✓___	467-476
C. Written guidelines for accepting or transferring neonates as "back transports" including criteria for accepting the patient and patient information on required care **.15F**	__✓___	467-476
D. Policy, standards, protocol or guidelines for care for infants convalescing after intensive care **.05**	__✓___	477-536
15. Consultation or referral agreement for genetics counseling. **.08N**	__✓___	348-357; 377-415

16. Written protocol to evaluate all infants born at or transferred to the institution for birth defects and to report findings to the Birth Defects Reporting and Information System as required by Health-General Article, §18-206, Annotated Code of Maryland; **.15K** __✓___ 537-544

17. Written policy for the identification and management of neonatal abstinence syndromes **.15M** ___✓___ 545-553

Have a copy of the following available during the onsite survey.

1. **Upon request**, please have available all standards, policies, protocols, and guidelines for the initial stabilization and continuing care of all neonatal patients appropriate to the level of care rendered at this facility. **.05A, .15A**
2. If primary transports are admitted, documentation of outreach continuing education programs in both specialties for referring hospitals, guidance on indications for consultation and referral of patients at high risk, information about the accepting hospital's response times and clinical capabilities, information about alternative sources for specialized care not provided by the accepting hospital, guidance on the pre-transport stabilization of patients and feedback on the pre-transport care of patients. **.03G, .13C**
3. Documentation of continuing education provided for physicians, such as the schedule of programs for a one-year period. **.13B**
4. Documentation of continuing education programs provided for nurses, such as a schedule of programs for a one-year period. **.13B**
5. List of minimum competencies for perinatal clinical staff, not otherwise credentialed, that are assessed prior to independent practice and on a regular basis (e.g., nurses and respiratory therapists). **.13A**

Administration and Support Service

Administration & Support Service

Administration & Support Service – Section I

The following questions related to the hospital organization and support services for obstetrics and neonatal units are taken directly from the standards. Please circle "Yes", "No" or "N/A" in the appropriate column. The numbers in bold type following each question refer to citations within COMAR 30.08.12.

1. Is the hospital laboratory, in conjunction with the programmatic leaders of the perinatal services, capable of establishing laboratory processing and reporting times to ensure that these are appropriate for samples drawn from obstetric and neonatal patients with specific consideration for the acuity of the patient and the integrity of the samples? **.09A**	Yes	No	N/A
2. Is the hospital laboratory capable of immediately receiving, processing and reporting urgent/emergent obstetric and neonatal laboratory requests? **.09B**	Yes	No	N/A
3. Is there a process in place to report critical results to the obstetric and neonatal services? **.09C**	Yes	No	N/A
4. Are laboratory results from standard maternal antepartum testing available to the providers caring for the mother and the neonate prior to discharge? **.09D**	Yes	No	N/A
If test results are not available or if testing was not performed prior to admission, will such testing be performed during the hospitalization of the mother and results available prior to discharge of the newborn? **.09D**	Yes	No	N/A

5. Is the laboratory capable of conducting rapid HIV testing 24 hours a day? **.09E**	Yes	No	N/A
6. Does the hospital have available the equipment and trained personnel to perform newborn hearing screening prior to discharge on all infants born at or transferred to the institution as required by COMAR 10.11.02? **.09F**	Yes	No	N/A
7. Does the hospital have the equipment and trained personnel to perform critical congenital heart disease screening prior to discharge on all infants born at or transferred to the institution and report screening results as required by COMAR 10.52.15? **.09G**	Yes	No	N/A
8. Are blood bank technicians present in-house 24 hours a day?	Yes	No	N/A
9. Are there written consultation and referral arrangements or on-site capability for molecular, cytogenetic and biochemical genetic testing? **.09K**	Yes	No	N/A
10. Does the hospital have a protocol to perform critical congenital heart disease screening on all infants in the special care nursery or neonatal intensive care unit born at or transferred to the institution and to report screening results as required by COMAR 10.52.15? **.09G**	Yes	No	N/A
11. Doe the hospital have available the equipment and trained personnel to collect newborn blood-spot screening on all infants born at or transferred to the institution at the appropriate time/intervals and to transport blood-spot specimens to the Maryland State Newborn Screening Laboratory as required by COMAR 10.52.12 and 10.10.13.14? **.09 I**	Yes	No	N/A
12. Is there a multi-disciplinary Perinatal Quality Improvement Program which meets at least quarterly to evaluate maternal and neonatal health outcomes and to identify process changes to improve patient safety and perinatal outcomes? **.14A**	Yes	No	N/A
13. Does the Perinatal Quality Improvement Program conduct internal case reviews, collect and analyze perinatal program data, conduct trend analyses, set quality improvement goals annually, and use data to assess progress toward those goals? **.14B**	Yes	No	N/A

14. Does the Perinatal Quality Improvement Program conduct reviews of all cases of the following as well as cases related to other patient safety and systems issues identified: (1) Maternal, intrapartum fetal, and neonatal deaths; (2) Transports to a higher or comparable level of care; (3) Elective delivery at less than 39 weeks gestation? **.14C**	Yes	No	N/A
15. Do staff representatives participate with the Department of Health and Mental Hygiene and local health department Fetal and Infant Mortality Review? **.14D** **Identify the staff member <u>Kerry Lewis, MD</u>**	Yes	No	N/A
16. Does the hospital participate in the collaborative collection and assessment of data for the purpose of improving perinatal health outcomes with the Department of Health and Mental Hygiene and the Maryland Institute for Emergency Medical Services Systems? **.14E** *As a Level II we were instructed to discontinue data submissions to MIEMSS because MIEMSS does not have oversight of Level II programs. However, data submission will resume once designated as Level III.*	Yes	No	N/A
17. Has the hospital maintained membership in the Vermont Oxford Network? **.14F**	Yes	No	N/A
18. Is there a hospital medical staff credentialing process that includes documentation of competency to perform obstetrical and neonatal invasive procedures appropriate to its designated level of care? **.15C**	Yes	No	N/A
19. Does the hospital conduct multidisciplinary clinical drills or simulations including post-drill debriefs to help prepare obstetrical and neonatal staff for high risk, high complexity, low frequency events? **.13C**	Yes	No	N/A

20. Does the hospital provide evidence-based education every two years to all staff caring for newborns (nurses, respiratory therapist, technicians, etc.) that includes, at a minimum, stabilization after immediate resuscitation to address glucose metabolism, thermoregulation, respiratory support hemodynamic monitoring and stability, risk and treatment of infection, and support for the family? **.13D**	Yes	No	N/A
21. If primary maternal and neonatal transports are accepted, provide the			

following to the referring hospital/providers: (1) Guidance on indications for consultation and referral of patients at high risk; (2) Information about the accepting hospital's response times and clinical capabilities; (3) Information about alternative sources for specialized care not provided by the accepting hospital; (4) Guidance on the pre-transport stabilization of patients; and (5) Feedback on the pre-transport care of patients **.13E**	Yes	No	N/A
22. Does the hospital obtain and maintain current equipment and technology as described by the Standards, to support optimal perinatal care for the level of the hospital's perinatal center designation? **.03E**	Yes	No	N/A
23. Assurance that all perinatal patients shall receive medical care commensurate with the level of the hospital's designation **.03A(1)**	Yes	No	N/A
24. The hospital shall be licensed by the Maryland Department of Health (MDH) as an acute care hospital. **.03 B**	Yes	No	N/A

Administration & Support Service – Section II

Provide short answers as required.

1. Provide a brief overview of the hospital.

The University of Maryland Capital Region Health (formerly Dimensions Healthcare System) was founded in 1982 when Prince George's County decided to privatize the county's public hospitals. Its history is rooted in serving Prince George's County residents since 1944 with the opening of the Prince George's General Hospital.

Upon formal affiliation with the University of Maryland Medical System (UMMS) in September 2017, the University of Maryland Capital Region Health (UM Capital) was established. UM Capital provides primary and specialty health care services to Prince George's County and the surrounding area, and is committed to improving health outcomes in the communities it serves. UM Capital consists of the UM Capital Region Medical Center, the UM Laurel Medical Center, the UM Bowie Health Center, and the UM Capital Region Medical Group with practice locations in New Carrollton, Suitland, Bowie, Laurel and National Harbor. Together, community physicians and University of Maryland School of Medicine (SOM) faculty provide clinical expertise across a range of specialties and programs.

The UM Capital Region Medical Center opened in Upper Marlboro the Summer of 2021 replacing the Prince George's Hospital Center in Cheverly. This new state-of-the-art regional hospital has 221 inpatient beds and is home to a certified and designated primary stroke center; the State's second-busiest trauma center and a highly regarded cardiac surgery program. Key service lines include Women's and Infants, Heart and Vascular, Orthopedics and Emergency Services. The UM Capital Region Medical Center shares the UMMS values of compassion, discovery, excellence, diversity and integrity.

2. Describe the hospital's role in the community using examples as provision of special health care delivery for the community, representation on organizational committees/boards, specific outreach education for referring hospitals and physicians, or participation in prevention or wellness programs in the community, etc. **.03G**

University of Maryland (UM) Capital Region Health delivers improved access to primary care, specialty care and outpatient services, and is a community partner in helping to improve the health of Prince George's County residents. We provide high quality, clinically advanced medical care to the region. Following are some of our programs and activities that illustrate our commitment to and involvement in the community.

Mama & Baby Bus Program

The Mama & Baby Mobile Unit serves as a healthcare access point for under-insured, uninsured and under-served women and children. The unit provides basic, uncomplicated maternal and child health services through partnerships with local community-based organizations, shelters, food pantries, faith institutions, schools and institutions of higher learning.

Breast-Feeding Coalition
Monthly breastfeeding education with course offerings for community health workers; to include certified lactation consultant (CLC) training class.

Domestic Violence & Sexual Assault Center
Case management support to assist this vulnerable population to secure housing support, professional therapy and counseling.

SAFE Grant
A comprehensive human trafficking response and service referral pathway in five units of our Upper Marlboro Medical Center to improve identification and response to victims of sex and labor trafficking. This program will start up in 2023.

Sickle Cell Disease Infusion Center and Clinic
In 2023, UM Capital Region, in partnership with Johns Hopkins Medical and Children's National Medical Center, will open the first adult sickle cell disease program in Prince George's County. The county is home to 40% of the people living with the disease in the state of Maryland. This program is funded with a grant from the Maryland Community Health Resources Commission. A town hall meeting introducing the program to community was held at the UM Capital Regional Medical Center on November 16, 2022.

In addition to providing the programs and services above, UM Capital Region Health also collaborates with Community Advisory Councils that are set up for each of our three facilities in Upper Marlboro, Bowie and Laurel to promote awareness and enhance programmatic health and wellness activities. Our health system also participates in Totally Linking Care in MD (TLC) a coalition of the county hospitals that manages grant funded programs to operate a Behavioral Health Crisis Stabilization Center (opening in June 2023) and a Diabetes Prevention Program.

As part of our specific outreach and education to physicians in the community, UM Capital Region hosts symposiums such the Breast Cancer Continuum: Comprehensive Care from Screening to Management and Beyond (October, 2022) and the Lung Cancer Symposium: Achieving Early Diagnosis and Cure through Multidisciplinary Care (September, 2022). We also hold Thoracic and Breast Tumor Boards to discuss and educate community providers about complex cancer cases.

UM Capital has a robust community health program that delivers programs and activities to educate the community on various aspects of healthcare and healthy living such as Mental Health First Aid & Youth Mental Health First Aid Training and the Dine, Learn & Move educational demonstration lecture series and the Fitness on the Green Series. All in all, UM Capital conducted 180 community health events in our fiscal year 2022.

3. Does your Perinatal Referral Center have or have access to a helicopter landing? If no, so state. If yes, provide the following information. **.03F**
   a) Describe the functions and responsibilities of various hospital personnel for

receiving patients transported by helicopter (For example, offloading patients)

At the UM Cap Region Medical Center, the clinical team meets the transport team (via helicopter) on the helipad itself. Notifications are provided to the clinical team as far as the expected time of arrival which is subsequently shared with the Operators/Communication. The operators then broadcast the information overhead indicating that a helicopter will be arriving along with the ETA. Security then proceeds to the helipad to ensure safety as well as calling for the elevator using the override key to expedite proper care. The information of the helicopter is captured and documented by Security.

In the case that neither rooftop helipad is available, the identified alternate landing zone is located at FedEx Field. FedEx Field is approximately .3 miles from the UM Cap Region Medical Center. The Prince George's County Fire Department will be notified of any landing requiring the use of the alternate landing zone. They will meet the aircraft and provide ground transport to the hospital. The fire department will arrive per protocol at the ambulance entrance which is located by the Emergency Department. Identified clinical team members will escort the fire department crew to the desired location within the hospital and then take over patient care.

b) Describe how you secure the landing site and provide safety management for landing

The UM Cap Region Medical Center has two helipads. Once notification is made regarding helicopter transport, information is provided in-house regarding the expected ETA. In-bound helicopters utilize the rooftop helipad based primarily on the size of the aircraft. The smaller of the two helipads is the primary helipad for air transport of patients while the larger helipad is typically for military/larger aircraft. If the smaller helipad is utilized, the larger helipad is then used. Security responds to the helipad for all landings to provide safety. They are also educated on the helipad safety features to include the fire suppression system.

4. Community Service and Emergency Preparedness Plans

The destructive force of Hurricanes Katrina and Rita exposed flaws in our nation's emergency preparedness programs. In the event that a hospital in Maryland is involved in a natural or man-made disaster, an emergency response plan that integrates specialty care centers will insure a rapid coordinated response. The development of mutual aide agreements between hospitals must include appropriate triage, treatment and transfer policies. The emergency response plan shall at a minimum include:

- A current list of hospitals and their capabilities for which rapid transfer agreements are established.
- An established evacuation plan with designated healthcare providers who will triage patients and determine the appropriate facility for relocation.
- An agreement with an emergency medical service (ground or air) that has the resources necessary (personnel and equipment) to provide care to that specialty population.

It is essential that hospital emergency response planners include leadership from specialty care areas within the hospital when developing an organized emergency response plan. Therefore appropriate hospital planning must include guidelines for the ongoing care of OB patients, newborns, infants and the mothers of newborns and infants to insure that any contingency can be managed. In the wake of recent natural and man-made disasters patients in hospital specialty care areas (obstetrics, oncology, cardiac etc.) have been deemed particularly vulnerable.

Does your hospital have an emergency response plan or a minimum initial service plan (MISP) that addresses the needs of OB and newborn intensive care patients? If so, please provide a complete copy of the plan, as well as any agreements with other hospitals regarding the triage, treatment and transfer of your patients.

Our emergency management plan does not address specifically the needs of OB and newborn intensive care patients.

5. Strengths and Weaknesses of Perinatal/Neonatal Program
   a) Describe special resources and/or capabilities of your facility not already discussed.

   1. A significant strength is the Executive leadership commitment to, and support of the safety and quality initiatives in Women's and Infants Services.

   2. University of Maryland Capital Region Medical Center benefits from a close relationship with UMMC Department of Neonatology with access to standardized policies and protocols in addition to educational opportunities.

   3. There is Collaboration through the system wide UMMS OB Patient Safety Committee and UMMS Peer Review Committee for guidance in protocol and policy implementation.

   4. UM Capital Region Medical Center participates in the statewide maternal and neonatal collaborative on maternal hypertension and neonatal antibiotic stewardship, respectively.

   5. The neonatal team provides NRP classes monthly to all members of the hospital staff. Most classes are multidisciplinary and include members of the labor and delivery staff, neonatal nurses, postpartum staff, respiratory therapists, and others interested in NRP.

b) Describe any weaknesses within the Perinatal Referral Center program and any present or future plans to address these weaknesses.

UM Capital Region Medical Center currently employs one full-time and one part-time maternal fetal medicine specialist. Given the significant need for maternal fetal medicine services in the region, UMCAP is aggressively directing the recruitment of additional maternal fetal medicine specialists, perinatal sonographers and advanced practice practitioners. We are currently in negotiations with the hiring of another full-time maternal fetal medicine specialist.

UMCAP is currently building a brand-new ambulatory center with 4 examination rooms and fetal testing dedicated to maternal fetal medicine services. The new building will also facilitate the expansion of comprehensive women's health services. In addition, we recognize the need for a comprehensive ambulatory diabetes program for our pregnant patients and UMCAP is dedicated to developing a program with CDE support to assist in management of our diabetic patients.

We are also limited by our current ability to provide maternal admissions for patients <32 weeks gestation or a fetus <1500 grams with complications that may require an early delivery. Requiring the transfer of such patients to regions beyond their accessibility is an unfortunate consequence of our inability to provide care for these patients. This is the primary motivation for transitioning to a Level III Perinatal Center - to reduce the need for such transfers.

6. Describe your multi-disciplinary Perinatal Quality Improvement program for improving maternal and neonatal outcomes and identify process changes to improve patient safety and perinatal outcomes. **.14A**

The Perinatal Quality Improvement Committee is a multi-disciplinary committee that meets every third Wednesday of each month. There is representation from obstetrics and gynecology, neonatology, pediatrics, neonatal and perinatal nursing, emergency services, anesthesia, education, quality improvement, risk management, pharmacy, senior leadership and accreditation. Meeting agendas reflect COMAR-prescribed patient safety and quality activities including maternal mortality rates, maternal transports and back transports, MFM updates on ante-partum patients, identified trends from Peer Review, review of perinatal data, and OB hemorrhage rates, as well as addressing self-identified opportunities for improvement gleaned from case reviews, RCAs and patient satisfaction reports. Dr. Kerry Lewis, who is the System Medical Director of Women's and Infant's Health and Specialty Programs, chairs the committee. The team is focused on standardization of care and improving patient outcomes. Examples of improvement activities include reduction in the time from the point when a decision to perform a C-section is made and the time the incision is made, 2) participation in the statewide maternal collaborative to improve the management of patients at risk for post-partum hemorrhage and to improve the management of

hypertensive patients, and 3) participation in the statewide neonatal collaborative to reduce sepsis.

7. Provide the minutes from the Perinatal Quality Improvement (PQI) Program for a one year time period, including agenda and meeting sign-in sheets. Include with the minutes, any other documents which verify PQI meetings including internal case reviews, trend analyses, all maternal and fetal deaths, all transports, quality improvement goals and how collected data is used to assess progress toward those goals
   These minutes can be included in the patient care records submission. **.14B**

   The minutes have been uploaded separately.

8. Describe the process of your periodic reviews of the performance of the perinatal program, including trends, all deaths, all transfers, all very low birth weight infants, problem identification and solution, issues identified from the quality management process and system issues. **.14C**

   The perinatal program at the University of Maryland Capital Region Medical Center is focused on patient safety and quality. Under the oversight of the Perinatal Quality and Performance Improvement Committee, we ensure a comprehensive strategy to identify opportunities for performance improvement and participate in a number patient safety and quality activities:

   Root Cause Analysis (RCA's):
   RCA's are conducted every 2 weeks to review all maternal and neonatal deaths, all neonatal transfers, all VLBW infants, and other selected diagnoses. Cases can also be selected to be referred for peer review.

   Continuous Quality Improvement (CQI):
   There are monthly multidisciplinary CQI meetings in the SCN/NICU where numbers of admissions, discharges, and transfers are reviewed. Monthly metrics including but not limited to hand hygiene, CLABSI, neonatal deaths, admission temperatures are reviewed and noted for any trends as well as any performance improvement projects. Issues identified in other forums such as RCA or event reports are also reviewed. Issues identified are also reported up to the Perinatal CQI committee.

   Department of Obstetrics and Gynecology Peer Review:
   The Department of OBGYN identifies adverse clinical outcomes for peer review. These indicators are based on standards recommended by the American College of Obstetricians and Gynecologists and have been expanded to address our internal expectations in identifying opportunities for systematic and individual provider performance improvements. This committee meets every 2 weeks.

   Combined Peer Review:
   In addition to a monthly OB peer review meeting, there is a multidisciplinary combined peer

review which meets monthly and consists of members from the OB team, neonatal team, pediatricians, family medicine, and anesthesia. Issues identified from the peer review are reported to the monthly Medical Staff Quality Oversight Committee (MSQOC) as well as to the Perinatal Quality Improvement Committee.

Obstetrics Patient Safety and Quality Committee:
There is also a multidisciplinary OB Patient Safety and Quality Committee, which reviews monthly and quarterly departmental data and metrics that identify systems issues from RCA, peer review, incident reporting, internal and external regulatory metrics. Issues identified are reported to the Perinatal CQI Committee. This committee has significant influence in developing and revising policies and procedures to reflect evidenced-based clinical and operation strategies.

Performance Improvement Activities:

- Implementation of cumulative blood loss and risk assessment for all laboring patients to identify and prophylactically treat postpartum hemorrhage.
- Unit wide training in Electronic Fetal Monitoring using the Relias Course with change in management of Category III tracing to decrease Decision to Incision times
- Participation with the Maryland Perinatal Quality Collaborative to improve time to treatment of acute maternal hypertension to decrease severe maternal morbidity.
- Established a process for scheduling elective procedures to assure no elective nonmedical inductions occur before 39 weeks
- All obstetric providers undergoing limited obstetric ultrasound training in the Jefferson course offered in Pennsylvania
- All obstetric providers being certified by the Neonatal Resuscitation Program (NRP)

9. Provide documentation of evidence-based education every two years to **all staff** caring for newborns (nurses, physicians, respiratory therapist, technicians, etc.) that includes at a minimum stabilization after immediate resuscitation to address glucose metabolism, thermoregulation, respiratory support hemodynamic monitoring and stability, risk and treatment of infection, and support for the family **.13D** (Appendix A pgs. 556-560)

Administration & Support Service – Section III

This section requires either attaching a copy of a specific document or having the document available on the day of the site visit, as indicated below.

Attach a copy of each of the following documents to this application. Use this as a checklist to ensure all documents are included and indicate the page number where the document can be found.

Check when attached	Page Number of Document

1. Board resolution and bylaws, documenting that the hospital agrees to meet the Maryland Perinatal System Standards for its specific level of designation and indicating the hospital's commitment to support the hospital's level of perinatal center designation **.03A** __✓___ 562

2. Accreditation certificate from The Joint Commission **.03C** __✓___ 563
3. Certificate of need (CON) issued by the Maryland Health Care Commission (MHCC) for a neonatal intensive care unit and approval from the Health Services Cost Review Commission (HSCRC) for a neonatal intensive care unit cost center. **.03D** __✓___ 564-566

4. If your hospital provides staff for neonatal transports, provide a copy of Neonatal Transport Service License or provide a copy of the written agreement with a licensed neonatal transport service. **.15G** __✓___ 567

5. Review of patient care records. __✓___ *See uploaded documents in MHDAC*
   Seven (7) patient care records for maternal and
   Seven (7) patient care records for neonatal reviews.

   Diagnoses are:
   Maternal –
   Maternal death
   Stat C/S
   Transport admission for a higher level of care
   Massive obstetric hemorrhage
   Severe pre-eclampsia or amniotic fluid embolism
   Requiring critical care services
   Returned to OR or DR

   Neonatal –
   Neonatal death
   Transport admission for a higher level of care
   VLBW
   Transport out to a long-term care facility
   Birth trauma
   HIE/cooling
   Chronic lung disease
   Late bacterial infection

1

<u>Review of patient care records</u> –
The site review team will examine the hospital's specialty care-related documents, including patient care records.

For each patient care record to be reviewed, include documents associated with the case – including QA/QI minutes with detailed documentation of the QA/QI reviews and processes, policies and/or policy changes or updates that apply to the medical record being reviewed, and any identified areas for improvement.

Appendix

EXHIBIT 10

Angela D. Alsobrooks
County Executive

PRINCE GEORGE'S COUNTY GOVERNMENT

OFFICE OF THE COUNTY EXECUTIVE

January 5, 2023

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

Dear Mr. Steffen:

I write to express my support for University of Maryland Capital Region Health's Certificate of Need (CON) application for a Level III neonatal intensive care unit ("NICU") at University of Maryland Capital Region Medical Center ("UMCRMC").

Level III NICU services are desperately needed for mothers and babies in Prince George's County. Currently, these services do not exist at any facility in the County. As a result, mothers with high risks of complications during childbirth and infants with the most severe health conditions must be transferred out of the County for care. The recommencement of Level III NICU services at UMCRMC will provide significant relief and options for families in the County whose infants require high-level, life-saving care.

UMCRMC has state-of-the-art technology and resources supporting a highly dedicated staff of providers that includes certified nurse midwives, board certified obstetricians and gynecologists, and a maternal fatal medicine division that is trained to provide the highest level of maternal care for patients with complicated obstetric and neonatal medical conditions. As a result, UMCRMC is well positioned to respond to the diverse high-risk obstetric needs of the Prince George's County community, which is currently vastly underserved in this specialty.

In closing, I want to emphasize my full endorsement for University of Maryland Capital Region Health's commitment to improving the quality of and access to high-level neonatal intensive care for families of our region. I request that the Maryland Health Care Commission approve this CON Application to re-establish Level III NICU services at University of Maryland Capital Region Health, which are so desperately needed for our community. Thank you very much for your consideration.

Sincerely,

Angela Alsobrooks
County Executive

Angela D. Alsobrooks
County Executive

PRINCE GEORGE'S COUNTY GOVERNMENT

OFFICE OF THE COUNTY EXECUTIVE

January 9, 2023

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

Dear Mr. Steffen:

This is to express my support for the University of Maryland Capital Region Health's Certificate of Need (CON) application for a Level III neonatal intensive care unit ("NICU") at University of Maryland Capital Region Medical Center ("UMCRMC").

The role of public health is to create conditions in which every resident of all socioeconomic status, race, age, and ethnicity have the best opportunity for optimal health in the county. This CON Application supports that effort because it will ensure that we have adequate resources for Prince George's County mothers to deliver their babies in the county, even those with high-risk pregnancies which we so often encounter. Also, when mothers with high risks of complications during childbirth and infants with the most severe health conditions are referred to other Counties for care, it becomes an equity issue that impacts more negatively residents at the low end of the socioeconomic status. It eliminates issues around transportation to other counties.

Having a Level III NICU services in Prince George's County will fill this significant gap in care and address a health inequity issue by allowing mothers and babies with high-risk pregnancies access to adequate healthcare in Prince George's County.

I support the application of UMCRMC for a Level III NICU without hesitation. UMCRMC has the resources and well-trained staff that will provide the highest level of care for these patients. Therefore, I am asking for the CON Application to be approved by the Maryland Health Care.

Sincerely,

Sanmi Areola, PhD
Deputy Chief Administrative Officer for
Health, Human Services and Education
Prince George's County

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Joseph L. Wright, MD, MPH
Chief Health Equity Officer
250 West Pratt Street
Baltimore, MD 21201
410-328-4368
https://www.umms.org

January 11, 2023

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

Dear Mr. Steffen,

I am writing this letter in support of the Certificate of Need (CON) application being submitted to the Maryland Health Care Commission (MHCC) by the University of Maryland Capital Region Health (UMCRH) for a Level III Perinatal Center.

Professionally, I have served in a number of leadership roles relevant to the UMCRH CON application including 17 years with the Maryland Institute for Emergency Medical Services Systems as its inaugural pediatric medical director, and as a member of the American Academy of Pediatrics Board of Directors serving as chair of the Board Committee on Equity. Academically, I hold adjunct professorships in Pediatrics and Health Policy and Management, respectively, at the University of Maryland School of Medicine and the University of Maryland School of Public Health. As a longstanding resident of Prince George's County, I also serve on the School of Public Health's Community Advisory Council. Currently, I am Vice President and Chief Health Equity Officer for the University of Maryland Medical System.

This multifocal perspective provides a unique lens through which I lend, without hesitation, strong and unequivocal support for the UMCRH CON application. Clinically, the residents of Prince George's County, who already disproportionately contribute to the statewide maternal and infant morbidity metrics, have been without critically needed high-risk obstetric and neonatal access for the most vulnerable women of child bearing age and their offspring. For instance, fully half of the pregnancies managed at UMCRH have associated hypertensive co-morbidity reflective of the cardiovascular disease burden in the surrounding community. Further, a significant percentage of these women with pregnancy-associated hypertension or full-blown pre-eclampsia, go on to develop persistent or chronic hypertension. The potential perinatal complications of this incompletely understood physiologic phenomenon require vigilant subspecialty collaboration, expertise, and management. The reality is that the perinatology and neonatology teams at UMCRH possess the necessary clinical expertise to provide full-service care for the most complex cases. They have lacked the requisite Level III Perinatal Center designation to perform to the maximum level of their expertise further contributing to the out-migration of births by Prince George's County residents.

The executive and clinical leadership at UMCRH have worked extremely diligently over the past two years to tighten operational deficiencies and address performance gaps. In fact, their work is seen as an exemplar model of performance improvement across UMMS Obstetrics enterprise. The residents of Prince Georges County and Central and Southern Maryland, as well as across the State of Maryland writ large, all deserve for access to these vital services to be available at the community level. Again, I restate my unequivocal support for the UMCRH CON application for a Level III Perinatal Center.

Sincerely,

Joseph L. Wright, MD

Joseph L. Wright, MD, MPH
Vice President and Chief Health Equity Officer
University of Maryland Medical System

Professor of Pediatrics and Health Policy & Management
University of Maryland Schools of Medicine and Public Health

Mt. Washington Pediatric Hospital
Where Children Go to Heal and Grow
Est. 1922
An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

December 27, 2022

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

Dear Mr. Steffen:

On behalf of Mt Washington Pediatric Hospital, I write to express my strong support for University of Maryland Capital Region Health's Certificate of Need (CON) application for a Level III neonatal intensive care unit ("NICU") at University of Maryland Capital Region Medical Center ("UMCRMC").

Level III NICU services are desperately needed for mothers and babies in Prince George's County. Currently, these services do not exist at any facility in the County. As a result, mothers with high risks of complications during childbirth and infants with the most severe health conditions must be transferred out of the County for care. The recommencement of Level III NICU services at UMCRMC will provide significant relief and options for families in this County whose infants require high-level, life-saving care.

UMCRMC is a new hospital, with state-of-the-art technology and resources supporting a highly dedicated staff of providers that includes certified nurse midwives, board certified obstetricians and gynecologists, and a maternal fatal medicine division that is trained to provide the highest level of maternal care for patients with complicated obstetric and neonatal medical conditions. As a result, UMCRMC is well positioned to respond to the diverse high-risk obstetric needs of the Prince George's County community, which is currently vastly underserved in this specialty.

In closing, I want to emphasize my full endorsement for University of Maryland Capital Region Health's commitment to improving the quality of and access to high-level neonatal intensive care for families of our region. I request that the Maryland Health Care Commission approve this CON Application to re-establish Level III NICU services at University of Maryland Capital Region Health, which are so desperately needed for our community. Thank you very much for your consideration.

Sincerely,

Sheldon Stein
CEO/President

Mt. Washington
Pediatric Hospital
Where Children Go to Heal and Grow
Est. 1922
An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

December 27, 2022

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

Dear Mr. Steffen:

On behalf of Mt. Washington Pediatric Hospital (MWPH) I write to express my strong support for University of Maryland Capital Region Health's Certificate of Need (CON) application for a Level III neonatal intensive care unit ("NICU") at University of Maryland Capital Region Medical Center ("UMCRMC").

MWPH has a post-acute unit in the Capital Region Hospital and cares for neonates and other children who predominantly live in the Capital Region. Having a Level III NICU in Prince Georges County would improve the quality of care for the infants, as they would transition from intensive care to post-acute care in the same building and provide a better environment for the children and their parents. Communication between providers would be better, the transition smoother and the parents would have the luxury of knowing that if their child became acutely ill while at MWPH, the infant could easily be transferred back to the NICU.

Level III NICU services are desperately needed for mothers and babies in Prince George's County. Currently, these services do not exist at any facility in the County. As a result, mothers with high risks of complications during childbirth and infants with the most severe health conditions must be transferred out of the County for care. The recommencement of Level III NICU services at UMCRMC will provide significant relief and options for families in this County whose infants require high-level, life-saving care.

UMCRMC is a new hospital, with state-of-the-art technology and resources supporting a highly dedicated staff of providers that includes certified nurse midwives, board certified obstetricians and gynecologists, and a maternal fatal medicine division that is trained to provide the highest level of maternal care for patients with complicated obstetric and neonatal medical conditions.

As a result, UMCRMC is well positioned to respond to the diverse high-risk obstetric needs of the Prince George's County community, which is currently vastly underserved in this specialty.

In closing, I want to emphasize my full endorsement for University of Maryland Capital Region Health's commitment to improving the quality of and access to high-level neonatal intensive care for families of our region. I request that the Maryland Health Care Commission approve this CON Application to re-establish Level III NICU services at University of Maryland Capital Region Health, which are so desperately needed for our community. Thank you very much for your consideration.

Sincerely,

Richard M. Katz, M.D., MBA, F.A.A.P.
Vice President, Medical Affairs
Chief Medical Officer
Mt. Washington Pediatric Hospital
Associate Professor, Pediatrics
Johns Hopkins School of Medicine

First Baptist Church of Glenarden
Pastor John K. Jenkins, Sr.

December 30, 2022

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

Dear Mr. Steffen:

My name is John Jenkins and I have the privilege of serving as the lead pastor of a large congregation in Maryland, specifically in Prince George's County. I am writing on behalf of my members and our community at large to express my strong support for University of Maryland Capital Region Health's Certificate of Need application for a Level III neonatal intensive care unit ("NICU") at University of Maryland Capital Region Medical Center ("UMCRMC").

These services are critical for mothers and babies; yet it is my understanding that a Level III neonatal unit does not exist at any facility in Prince George's County. As a result, mothers with high risks of complications during childbirth and infants with severe health conditions must be transferred out of the county for care. The recommencement of these services at UMCRMC will provide much needed relief and options for families in our county whose infants require high-level, life-saving care.

As a former board member, I believe that UMCRMC is well positioned to respond to the diverse needs of mothers and babies in Prince George's community, which is currently underserved in this specialty. Therefore, I am requesting that the Maryland Health Care Commission give strong consideration and approval for this Certificate of Need Application to re-establish Level III NICU services at University of Maryland Capital Region Health. Thank you very much for your consideration.

Sincerely,

John Jenkins

Pastor John K. Jenkins, Sr.
First Baptist Church of Glenarden

EXHIBIT 11

Consolidated Financial Statements and Supplementary Information

University of Maryland Medical System Corporation and Subsidiaries
Years Ended June 30, 2022 and 2021
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, 2022 and 2021

Contents

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Report of Independent Auditors

The Board of Directors
University of Maryland Medical System Corporation

Opinion

We have audited the consolidated financial statements of University of Maryland Medical System Corporation and Subsidiaries (the Corporation), which comprise the consolidated balance sheets as of June 30, 2022 and 2021, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Corporation at June 30, 2022 and 2021, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Corporation and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for 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.

In preparing the financial statements, management is required to evaluate 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 for one year after the date that the financial statements are available to be issued.

Building a better working world

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit 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 Corporation's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Corporation's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

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Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the 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 audits 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 financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Ernst & Young LLP

October 21, 2022

University of Maryland Medical System Corporation and Subsidiaries

Consolidated Balance Sheets

(In Thousands)

	June 30 2022	2021
Assets		
Current assets:		
Cash and cash equivalents	**$ 244,529**	$ 858,543
Assets limited as to use, current portion	**68,258**	54,457
Accounts receivable:		
Patient accounts receivable, net	**571,609**	529,825
Other	**292,147**	223,549
Inventories	**97,453**	105,076
Prepaid expenses and other current assets	**38,709**	32,233
Total current assets	**1,312,705**	1,803,683
Investments	**1,431,494**	1,355,157
Assets limited as to use, less current portion	**935,258**	1,338,262
Property and equipment, net	**2,828,105**	2,753,060
Investments in joint ventures	**98,016**	103,098
Other assets	**493,912**	501,852
Total assets	**$ 7,099,490**	$ 7,855,112
Liabilities and net assets		
Current liabilities:		
Trade accounts payable	**$ 412,458**	$ 429,032
Accrued payroll and benefits	**341,609**	343,770
Advances from third-party payors	**266,121**	563,933
Lines of credit	**81,000**	113,000
Other current liabilities	**135,616**	133,624
Long-term debt subject to short-term remarketing arrangements	**–**	153,510
Current portion of long-term debt	**38,399**	29,751
Total current liabilities	**1,275,203**	1,766,620
Long-term debt, less current portion and amount subject to short-term remarketing arrangements	**1,900,234**	1,788,367
Other long-term liabilities	**541,269**	757,633
Interest rate swap liabilities	**106,721**	203,609
Total liabilities	**3,823,427**	4,516,229
Net assets:		
Without donor restrictions	**3,041,971**	3,036,143
With donor restrictions	**234,092**	302,740
Total net assets	**3,276,063**	3,338,883
Total liabilities and net assets	**$ 7,099,490**	$ 7,855,112

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	
	2022	**2021**
Operating revenue, gains, and other support:		
Net patient service revenue	**$ 4,523,407**	$ 4,288,842
State and county support	**13,600**	20,025
CARES Act – provider relief funds	**22,683**	155,723
Other revenue	**333,367**	305,251
Total operating revenue, gains, and other support	**4,893,057**	4,769,841
Operating expenses:		
Salaries, wages, and benefits	**2,608,080**	2,428,690
Expendable supplies	**864,693**	882,966
Purchased services	**784,386**	705,847
Contracted services	**328,391**	305,273
Depreciation and amortization	**267,187**	244,277
Interest expense	**40,145**	32,467
Total operating expenses	**4,892,882**	4,599,520
Operating income from continuing operations	**175**	170,321
Nonoperating income and expenses, net:		
Unrestricted contributions	**3,508**	3,882
(Loss) equity in net income of joint ventures	**(904)**	11,230
Investment income, net	**155,850**	41,377
Change in fair value of investments	**(304,297)**	184,661
Change in fair value of undesignated interest rate swaps	**96,888**	65,325
Other nonoperating losses, net	**(33,212)**	(38,888)
Loss on early extinguishment of debt	**–**	(8,565)
(Deficit) excess of revenues over expenses from continuing operations	**(81,992)**	429,343
Gain (loss) on discontinued operations, net	**–**	(529)
(Deficit) excess of revenues over expenses	**$ (81,992)**	$ 428,814

Continued on page 6

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, 2020	$ 2,055,346	$ 755,964	$ 2,811,310
Excess of revenues over expenses from continuing operations	429,343	–	429,343
Loss on discontinued operations, net	(529)	–	(529)
Investment gains, net	–	15,589	15,589
State support for capital	–	15,189	15,189
Contributions, net	–	15,603	15,603
Net assets released from restrictions used for operations and nonoperating activities	–	(7,597)	(7,597)
Net assets released from restrictions used for purchase of property and equipment	386,238	(386,238)	–
Change in economic and beneficial interests in the net assets of related organizations	120,495	(107,725)	12,770
Change in funded status of defined benefit pension plans	52,567	–	52,567
Other	(7,317)	1,955	(5,362)
Increase (decrease) in net assets	980,797	(453,224)	527,573
Balance at June 30, 2021	3,036,143	302,740	3,338,883
Deficit of revenues over expenses from continuing operations	**(81,992)**	**–**	**(81,992)**
Investment losses, net	**–**	**(9,443)**	**(9,443)**
State support for capital	**500**	**910**	**1,410**
Contributions, net	**14,044**	**15,909**	**29,953**
Net assets released from restrictions used for operations and nonoperating activities	**–**	**(5,925)**	**(5,925)**
Net assets released from restrictions used for purchase of property and equipment	**66,729**	**(66,729)**	**–**
Change in economic and beneficial interests in the net assets of related organizations	**1,244**	**(3,602)**	**(2,358)**
Change in funded status of defined benefit pension plans	**2,180**	**–**	**2,180**
Other	**3,123**	**232**	**3,355**
Increase (decrease) in net assets	**5,828**	**(68,648)**	**(62,820)**
Balance at June 30, 2022	**$ 3,041,971**	**$ 234,092**	**$ 3,276,063**

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 2022	2021
Operating activities		
(Decrease) increase in net assets	**$ (62,820)**	$ 527,573
Adjustments to reconcile (decrease) increase in net assets to net cash (used in) provided by operating activities:		
Depreciation and amortization	**267,187**	244,277
Amortization of bond premium and deferred financing costs	**(2,456)**	(2,438)
Net realized losses (gains) and change in fair value of investments	**148,447**	(226,038)
Equity in net loss (income) of joint ventures	**904**	(11,230)
Change in economic and beneficial interests in net assets of related organizations	**3,602**	(14,741)
Change in fair value of interest rate swaps	**(96,888)**	(65,325)
Change in funded status of defined benefit pension plans	**(2,180)**	(52,567)
Restricted contributions, grants and other support, net	**(7,376)**	(46,381)
Loss on early extinguishment of debt	**–**	8,565
Loss on divestiture of UM Health Plans	**–**	3,266
Change in operating assets and liabilities:		
Patient accounts receivable	**(41,784)**	(57,474)
Other receivables, prepaid expenses, other current assets, and other assets	**(78,994)**	(97,198)
Inventories	**7,623**	803
Trade accounts payable, accrued payroll and benefits, other current liabilities, and other long-term liabilities	**(59,775)**	336,434
Advances from third-party payors	**(447,812)**	(210,014)
Net cash (used in) provided by operating activities	**(372,322)**	337,512
Investing activities		
Purchases and sales of investments and assets limited as to use, net	**(119,745)**	(467,307)
Purchases of alternative investments	**(198,475)**	(72,432)
Sales of alternative investments	**342,050**	91,351
Purchases of property and equipment	**(363,384)**	(440,572)
Sale of UM Health Plan, LLC net cash proceeds	**4,587**	65,555
Transfer of funds from UCH Legacy Funding Corp	**–**	122,504
Distributions from joint ventures, net	**2,951**	2,327
Net cash used in investing activities	**(332,016)**	(698,574)

Continued on page 8

University of Maryland Medical System Corporation and Subsidiaries

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

	Year Ended June 30	
	2022	**2021**
Financing activities		
Proceeds from long-term debt	**$ 268,355**	$ 783,994
Payment of debt issuance costs	**(1,333)**	(5,484)
Repayment of long-term debt and finance leases	**(297,561)**	(470,528)
Repayments of lines of credit, net	**(32,000)**	(80,500)
Restricted contributions, grants, and other support	**7,376**	46,381
UM Health Plan, LLC earnout proceeds	**8,500**	–
Net cash (used in) provided by financing activities	**(46,663)**	273,863
Net decrease in cash, cash equivalents, and restricted cash	**(751,001)**	(87,199)
Cash, cash equivalents, and restricted cash, beginning of year	**1,125,424**	1,212,623
Cash, cash equivalents, and restricted cash, end of year	**$ 374,423**	$ 1,125,424
Cash and cash equivalents	**$ 244,529**	$ 858,543
Restricted cash included in assets limited as to use	**129,894**	266,881
Cash, cash equivalents, and restricted cash, end of year	**$ 374,423**	$ 1,125,424
Discontinued operations		
Operating activities	**$ (1,094)**	$ (6,452)
Supplemental disclosures of cash flow information		
Cash paid during the year for interest, net of amounts capitalized	**$ 39,766**	$ 32,737
Amount included in accounts payable for construction in progress	**$ 40,913**	$ 62,065

See accompanying notes to consolidated financial statements.

University of Maryland Medical System Corporation and Subsidiaries

Notes to Consolidated Financial Statements
(In Thousands)

June 30, 2022

1. Organization and Summary of Significant Accounting Policies

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 a 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 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.

Recent Acquisitions and Divestitures

During the year ended June 30, 2021, the Corporation signed a letter of intent to sell the assets and liabilities of UM Health Plans, which included both the Medicaid Plan and Medicare Advantage Plan. 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.

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

For the years ended June 30, 2022 and 2021, operating revenues from discontinued operations were $0 and approximately $117,112, respectively. For the years ended June 30, 2022 and 2021, operating and nonoperating expenses from discontinued operations were $0 and approximately $114,375, respectively. The transaction was completed on October 10, 2020, resulting in a loss on sale of $3,266, which is included in the net loss from discontinued operations of $529 for the year ended June 30, 2021.

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.

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 University CARE, 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, 2022 and 2021 was approximately $201,321 and $190,417, respectively.

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

University of Maryland Rehabilitation and Orthopaedic Institute (ROI)

ROI is comprised of a medical/surgical and rehabilitation hospital in Baltimore with 136 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.

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 180 licensed beds, including 100 acute care beds and 80 chronic care beds and a wholly owned subsidiary providing primary care.

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.

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

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 97-bed acute care hospital providing inpatient and outpatient services in Easton, Maryland; University of Maryland Cambridge (UM Cambridge), a 34-bed acute care hospital providing inpatient and outpatient services that transitioned to a freestanding medical facility, in November 2021, providing outpatient services in Cambridge, Maryland; University of Maryland Chester River Hospital Center (UM Chester River), a 12-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.

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.

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.

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

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 161-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.

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 the new state-of-the-art UM Capital Region Medical Center (UM Prince George's), a 254-bed acute care teaching hospital providing an array of services, including emergency medicine, behavioral health, cardiac surgery, women's and infants health 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.

University of Maryland Medical System Foundation, Inc. (UM Medicine Foundation)

The UM Medicine Foundation, a not-for-profit foundation, was established for the purpose of soliciting contributions on behalf of the Corporation.

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.

Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

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

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.

Investments and Assets Limited as to Use

The Corporation's investment portfolios, except alternative investments, are classified as trading and are reported in the consolidated balance sheets as long-term assets at June 30, 2022 and 2021. Unrealized holding gains and losses on trading securities with readily determinable market values, as well as alternative investments, are included in nonoperating income. Investment income, including realized gains and losses, is included in nonoperating income in the accompanying consolidated statements of operations and changes in net assets.

Assets limited as to use include investments set aside at the discretion of the board of directors for the replacement or acquisition of property and equipment, investments held by trustees under bond indenture agreements and self insurance trust arrangements, and assets whose use is restricted by donors. 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. The equity method reflects the Corporation's share of the net asset values, as a practical expedient, which is based on the unit values of the interest as determined by the issuer sponsoring such interest dividing the fund's net assets at fair value by its units outstanding at the valuation dates. 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.

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

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.

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.

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.

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. 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.

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

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.

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.

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.

Impairment losses of $2,274 and $2,900 were recorded for the years ended June 30, 2022 and 2021, respectively.

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.

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

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.

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.

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 payors and government programs) and others. Revenue is recognized over time as performance obligations are satisfied in exchange for providing goods and services in patient care. Revenue is recorded as these goods and services are provided. The services provided to a patient during an inpatient stay or outpatient visit represent a bundle of goods and services that are distinct and accounted for as a single performance obligation.

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

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 in the transactions price. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments 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 it does 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 are based on approved discounts on charges as permitted by the HSCRC. For self-pay accounts, which include 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.

The Corporation has elected to apply the optional exemption in ASC 606-10-50-14a, as all performance obligations relate to contracts with a 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.

(In Thousands)

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

Net patient service revenue by line of business is as follows:

	Year Ended June 30 2022	2021
Hospital inpatient and outpatient services	**$ 4,233,750**	$ 4,013,287
Physician services	**284,410**	267,800
Other	**5,247**	7,755
Net patient service revenue	**$ 4,523,407**	$ 4,288,842

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 the Corporation's 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.

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

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

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

- 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 approximately $49,429 and $48,257 for the years ended June 30, 2022 and 2021, respectively.

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 $23,661 and $24,527 for the years ended June 30, 2022 and 2021, respectively, and are reported within other nonoperating losses, net.

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

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.

(Deficit) Excess of Revenue over Expenses from Continuing Operations

The accompanying consolidated statements of operations and changes in net assets include a performance indicator, (deficit) 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.

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

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.

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 and changes in net assets. Contributed nonfinancial assets received from donors are subsequently monetized.

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.

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

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 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 accounting principles generally accepted in the United States of America that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted market prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted market prices (unadjusted) in active markets for identical assets or liabilities that the Corporation has the ability to access at the measurement date.

- Level 2 inputs are inputs other than quoted market prices including within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.

- Level 3 inputs are unobservable inputs for the asset or liability.

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

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 of input that is significant to the fair value measurement in its entirety.

As of June 30, 2022 and 2021, 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. U.S. Government and agency securities also include treasury notes that are based on quoted market prices in active markets.

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

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

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. Corporate obligations also include commercial paper that is based on quoted market prices in active markets.

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.

Alternative Investments

Alternative investments measured at fair value represent funds included on the consolidated balance sheet that are reported using NAV as a practical expedient. These amounts are not required to be categorized in the fair value hierarchy. The fair value of these investments is based on the net asset value information provided by the general partners. Fair value is based on the proportionate share of the NAV based on the most recent partners' capital statements received from the general partners. Certain alternative investments are utilizing NAV to calculate fair value and are included in alternative investments in the fair value hierarchy tables presented in Note 3.

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.

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 consolidated 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)

Use of Estimates

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

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

In response to COVID-19, the 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 COVID-19 and shall reimburse the recipient for health care related expenses or lost revenues attributable to COVID-19. Such amounts are 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 years ended June 30, 2022 and 2021, the Corporation received and recognized as other operating revenue approximately $22,683 and $155,723, respectively, in relief funding.

In April 2020, the Corporation requested Medicare advanced payments under the Centers for Medicare & 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. The remaining balance of $105,063 as of June 30, 2022 represents contract liabilities under Topic 606 and is recorded in advances from third-party payors within the accompanying consolidated balance sheet as of June 30, 2022.

(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 due December 31, 2021, and the remaining 50% due December 31, 2022. At June 30, 2022, the Corporation deferred $38,331, which is recorded in accrued payroll 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	
	2022	**2021**
Investments held for collateral	**$ 6,840**	$ 117,474
Debt service and reserve funds	**55,873**	56,384
Construction funds – held by trustee	**336,591**	496,355
Construction funds – held by the Corporation	**96,629**	128,756
Board designated funds	**90,000**	137,528
Self-insurance trust funds	**240,220**	277,274
Funds restricted by donors	**117,870**	115,853
Economic and beneficial interests in the net assets of related organizations *(Note 13)*	**59,493**	63,095
Total assets limited as to use	**1,003,516**	1,392,719
Less amounts available for current liabilities	**(68,258)**	(54,457)
Total assets limited as to use, less current portion	**$ 935,258**	$ 1,338,262

(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, 2022								
Cash and cash equivalents	**$ –**	**$ 54,132**	**$ 163,575**	**$ 65,312**	**$ 604**	**$ 8,816**	**$ –**	**$ 292,439**
Corporate obligations	**–**	**–**	**45,410**	**2,028**	**5,775**	**8,032**	**–**	**61,245**
Fixed income funds	**–**	**–**	**–**	**2,345**	**2,272**	**20,838**	**–**	**25,455**
U.S. Government and agency securities	**6,840**	**1,741**	**224,235**	**1,307**	**11,243**	**10,093**	**–**	**255,459**
Common stocks, including mutual funds	**–**	**–**	**–**	**6,141**	**5,750**	**45,639**	**–**	**57,530**
Alternative investments	**–**	**–**	**–**	**12,867**	**2,080**	**24,452**	**–**	**39,399**
Assets held by other organizations	**–**	**–**	**–**	**–**	**212,496**	**–**	**59,493**	**271,989**
Total assets limited as to use	**$ 6,840**	**$ 55,873**	**$ 433,220**	**$ 90,000**	**$ 240,220**	**$ 117,870**	**$ 59,493**	**$ 1,003,516**
June 30, 2021								
Cash and cash equivalents	$ 72,439	$ 17,856	$ 285,949	$ 62,057	$ 2,133	$ 19,393	$ –	$ 459,827
Corporate obligations	–	–	–	3,206	6,653	–	–	9,859
Fixed income funds	–	–	–	10,127	–	17,063	–	27,190
U.S. Government and agency securities	45,035	38,528	339,162	927	7,667	1,208	–	432,527
Common stocks, including mutual funds	–	–	–	40,923	8,975	50,069	–	99,967
Alternative investments	–	–	–	20,288	7,787	28,120	–	56,195
Assets held by other organizations	–	–	–	–	244,059	–	63,095	307,154
Total assets limited as to use	$ 117,474	$ 56,384	$ 625,111	$ 137,528	$ 277,274	$ 115,853	$ 63,095	$ 1,392,719

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, corporate obligations, and alternative investments. MMCIP is a funding mechanism for the Corporation's malpractice insurance program. As MMCIP is not an insurance provider, transactions with MMCIP are recorded under the deposit method of accounting. Accordingly, the Corporation accounts for its participation in MMCIP by carrying limited-use assets representing the amount of funds contributed to MMCIP and recording a liability for claims, which is included in other current and other long-term liabilities in the accompanying consolidated balance sheets. These assets include the Corporation's portion of the investment pool shared with University of Maryland Faculty Physicians, 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, 2022 and 2021.

The carrying values of investments were as follows:

	June 30	
	2022	**2021**
Cash and cash equivalents	**$ 93,020**	$ 229,597
Corporate obligations	**121,256**	18,569
Fixed income funds	**92,294**	86,415
U.S. Government and agency securities	**208,956**	36,013
Common stocks	**388,013**	304,043
Alternative investments:		
Hedge funds/private equity	**61,449**	222,861
Commingled funds	**466,506**	457,659
	$ 1,431,494	$ 1,355,157

Alternative investments include hedge fund, private equity, and commingled investment funds, which are valued using the equity method of accounting. As of June 30, 2022, 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 $55,655 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 $78,546, are subject to over 60-day notice requirements and can only be redeemed quarterly or annually. There is approximately $12,623 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 three to ten years. The Corporation had approximately $5,767 of unfunded commitments in alternative investments as of June 30, 2022.

(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 at June 30, 2022:

	Level 1	Level 2	Level 3	Total
Assets				
Investments:				
Cash and cash equivalents	**$ 93,020**	**$ –**	**$ –**	**$ 93,020**
Corporate obligations	**46,795**	**74,461**	**–**	**121,256**
Fixed income funds	**92,294**	**–**	**–**	**92,294**
U.S. Government and agency securities	**168,767**	**40,189**	**–**	**208,956**
Common stocks, including mutual funds	**388,013**	**–**	**–**	**388,013**
	$ 788,889	**$ 114,650**	$ –	**903,539**
Alternative investments, reported using NAV:				
Hedge funds/private equity				**61,449**
Commingled funds				**466,506**
Total investments				**$ 1,431,494**
Assets limited as to use:				
Cash and cash equivalents	**$ 292,439**	**$ –**	**$ –**	**$ 292,439**
Corporate obligations	**3,093**	**58,152**	**–**	**61,245**
Fixed income funds	**25,455**	**–**	**–**	**25,455**
U.S. Government and agency securities	**236,003**	**19,456**	**–**	**255,459**
Common stocks, including mutual funds	**57,530**	**–**	**–**	**57,530**
Investments held by other organizations	**–**	**–**	**59,493**	**59,493**
	$ 614,520	**$ 77,608**	**$ 59,493**	**751,621**
Alternative investments, reported using NAV:				
Investments held by other organizations*				**212,496**
Hedge funds/private equity				**17,875**
Commingled funds				**21,524**
				$ 1,003,516

*"Investments held by other organizations" recorded using the NAV as a practical expedient include assets of the MMCIP Self-insurance Trust, which holds Level 1, Level 2 and 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, 2022, 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 at June 30, 2021:

	Level 1	Level 2	Level 3	Total
Assets				
Investments:				
Cash and cash equivalents	$ 229,597	$ –	$ –	$ 229,597
Corporate obligations	–	18,569	–	18,569
Fixed income funds	86,415	–	–	86,415
U.S. Government and agency securities	22,643	13,370	–	36,013
Common stocks, including mutual funds	304,043	–	–	304,043
	$ 642,698	$ 31,939	$ –	674,637
Alternative investments, reported using NAV:				
Hedge funds/private equity				222,861
Commingled funds				457,659
Total investments				$ 1,355,157
Assets limited as to use:				
Cash and cash equivalents	$ 459,827	$ –	$ –	$ 459,827
Corporate obligations	–	9,859	–	9,859
Fixed income funds	27,190	–	–	27,190
U.S. Government and agency securities	421,558	10,969	–	432,527
Common stocks, including mutual funds	99,967	–	–	99,967
Investments held by other organizations	–	–	63,095	63,095
	$ 1,008,542	$ 20,828	$ 63,095	1,092,465
Alternative investments, reported using NAV:				
Investments held by other organizations*				244,059
Hedge funds/private equity				20,058
Commingled funds				36,137
				$ 1,392,719

*"Investments held by other organizations" recorded using the NAV as a practical expedient include assets of the MMCIP Self-insurance Trust, which holds Level 1, Level 2 and 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, 2021, 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)

Changes to Level 1 and Level 2 securities between June 30, 2022 and 2021 were the result of strategic investments and reinvestments, interest income earnings, and changes in the fair value of investments.

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

	Year Ended June 30	
	2022	**2021**
Dividends and interest, net of fees	**$ 14,120**	$ 12,011
Net realized gains	**146,745**	31,395
Change in fair value of trading securities and alternative investments	**(318,755)**	198,221
Total investment return	**$ (157,890)**	$ 241,627

Total investment return is classified in the accompanying consolidated statements of operations and changes in net assets as follows:

	Year Ended June 30	
	2022	**2021**
Nonoperating investment income, net	**$ 155,850**	$ 41,377
Change in fair value of unrestricted investments	**(304,297)**	184,661
Investment (losses) gains on net assets with donor restrictions	**(9,443)**	15,589
Total investment return	**$ (157,890)**	$ 241,627

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	
	2022	**2021**
Land	**$ 205,013**	$ 182,586
Buildings	**2,047,527**	1,833,517
Building and leasehold improvements	**1,208,625**	1,118,868
Equipment	**2,341,278**	2,182,368
Construction in progress	**320,396**	500,982
	6,122,839	5,818,321
Less accumulated depreciation and amortization	**(3,294,734)**	(3,065,261)
	$ 2,828,105	$ 2,753,060

Interest cost capitalized was $19,242 and $23,843 for the years ended June 30, 2022 and 2021, respectively.

Remaining contractual commitments on construction projects were approximately $138,925 at June 30, 2022.

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 approximately $98,016 and $103,098 at June 30, 2022 and 2021, respectively, in the following unconsolidated joint ventures:

	Ownership %	**2022**	**2021**
Mt. Washington Pediatric Hospital, Inc. (Mt. Washington)	50%	**$ 74,407**	$ 78,478
Terrapin Insurance	50%	**975**	975
Other investments	10%–51%	**22,634**	23,645
		$ 98,016	$ 103,098

(In Thousands)

5. Investments in Joint Ventures (continued)

The Corporation recorded equity in net (loss) income of $(904) and $11,230 related to these joint ventures for the years ended June 30, 2022 and 2021, 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:

	2022			
	Mt. Washington	**Terrapin**	**Others**	**Total**
Current assets	**$ 20,063**	**$ 45,504**	**$ 29,670**	**$ 95,237**
Noncurrent assets	**135,745**	**318,139**	**44,401**	**498,285**
Total assets	**$ 155,808**	**$ 363,643**	**$ 74,071**	**$ 593,522**
Current liabilities	**$ 17,945**	**$ 1,893**	**$ 5,310**	**$ 25,148**
Noncurrent liabilities	**6,555**	**359,800**	**16,445**	**382,800**
Net assets	**131,308**	**1,950**	**52,316**	**185,574**
Total liabilities and net assets	**$ 155,808**	**$ 363,643**	**$ 74,071**	**$ 593,522**
Total operating revenue	**$ 60,916**	**$ 85,535**	**$ 86,040**	**$ 232,491**
Total operating expenses	**(64,586)**	**(63,725)**	**(72,923)**	**(201,234)**
Total nonoperating (losses) gains, net	**(6,280)**	**(21,810)**	**499**	**(27,591)**
Contributions from (to) owners	**–**	**–**	**(14,263)**	**(14,263)**
Other changes in net assets, net	**486**	**–**	**(3,701)**	**(3,215)**
Decrease in net assets	**$ (9,464)**	**$ –**	**$ (4,348)**	**$ (13,812)**

(In Thousands)

5. Investments in Joint Ventures (continued)

	2021			
	Mt. Washington	**Terrapin**	**Others**	**Total**
Current assets	$ 38,597	$ 27,718	$ 42,638	$ 108,953
Noncurrent assets	133,176	347,714	57,369	538,259
Total assets	$ 171,773	$ 375,432	$ 100,007	$ 647,212
Current liabilities	$ 20,715	$ 1,145	$ 22,819	$ 44,679
Noncurrent liabilities	7,018	372,337	13,592	392,947
Net assets	144,040	1,950	63,596	209,586
Total liabilities and net assets	$ 171,773	$ 375,432	$ 100,007	$ 647,212
Total operating revenue	$ 65,855	$ 18,318	$ 94,130	$ 178,303
Total operating expenses	(61,478)	(40,848)	(77,157)	(179,483)
Total nonoperating gains (losses), net	10,579	22,530	493	33,602
Contributions from (to) owners	–	–	(10,797)	(10,797)
Other changes in net assets, net	6,852	–	(2,288)	4,564
Increase in net assets	$ 21,808	$ –	$ 4,381	$ 26,189

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 sheets. Finance leases are included in property, plant, and equipment, other current liabilities, and other long-term liabilities on the accompanying consolidated balance sheets.

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 sheets.

(In Thousands)

6. Leases (continued)

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 purchased services, net, but are not included in the ROU 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, *Leases*, 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.

The following table summarizes the components of operating and finance lease assets and liabilities classified as current and noncurrent on the accompanying consolidated balance sheets:

	Consolidated Balance Sheet Classification	June 30 2022	2021
Operating leases			
Operating lease ROU assets	Other assets	**$ 89,633**	$ 98,378
Operating lease obligation – current	Other current liabilities	**(14,098)**	(14,551)
Operating lease obligation – long-term	Other long-term liabilities	**(79,414)**	(87,039)
Finance leases			
Finance lease ROU assets	Property and equipment, net	**$ 37,123**	$ 38,144
Current finance lease liabilities	Other current liabilities	**(448)**	(433)
Long-term finance lease liabilities	Other long-term liabilities	**(44,922)**	(44,370)

(In Thousands)

6. Leases (continued)

The components of lease expense were as follows:

	Year Ended June 30	
	2022	**2021**
Finance lease expense:		
Amortization of ROU assets	**$ 1,022**	$ 3,819
Interest on lease liabilities	**1,574**	2,519
Total finance lease expense	**2,596**	6,338
Operating lease expense	**18,648**	20,765
Short-term/variable lease expense	**13,718**	14,713
Total lease expense	**$ 34,962**	$ 41,816

Commitments related to noncancelable operating and finance leases for each of the next five years and thereafter as of June 30, 2022 are as follows:

	Operating	**Finance**
2023	$ 16,603	$ 2,006
2024	15,292	2,006
2025	13,850	2,006
2026	12,272	2,006
2027	8,050	2,006
Thereafter	42,285	47,050
Total	108,352	57,080
Less: Present value discount	(14,840)	(11,710)
Lease liabilities	$ 93,512	$ 45,370

(In Thousands)

6. Leases (continued)

Other information is as follows:

	Year Ended June 30	
	2022	**2021**
Weighted average remaining lease terms (in years):		
Finance leases	**8.52**	9.52
Operating leases	**9.15**	9.44
Weighted average discount rate:		
Finance leases	**3.53%**	3.53%
Operating leases	**2.95%**	3.25%

7. Line of Credit

For the years ended June 30, 2022 and 2021, 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, 2022. Interest is calculated based on an optional base rate or percentage of 1-month London Interbank Offered Rate (LIBOR) plus a credit spread. As of June 30, 2022 and 2021, the amount outstanding on the line of credit was $81,000 and $113,000, respectively. The calculated interest rates as of June 30, 2022 and 2021 were a range from 4.75% to 0.89%.

Subsequent to year end (Note 21), on August 23, 2022, the Corporation amended the term and structure of the revolving line of credit facility. The revised facility is certified as a parity obligation under the Medical System's Master Loan Agreement, which is described in Note 8, and its term was extended by three years (expiration date of August 23, 2025). In addition, the interest calculation was amended to replace the percentage of 1-month LIBOR variable rate option, with a variable rate option that is based on the Secured Overnight Financing Rate (SOFR).

(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 2022	2021
MHHEFA project revenue bonds:				
Corporation issue, payments due annually UCHS Term Loan:				
Series 2021A/B Bonds	Variable rate	2023–2043[1]	**$ 268,355**	$ –
Series 2020B/D Bonds	3.05%–5.00%	2041–2051	**752,680**	752,680
Series 2017D/E Bonds	4.00%–4.17%	2045–2049	**189,965**	189,965
Series 2017B/C Bonds	2.96%–5.00%	2018–2040	**238,840**	250,150
Series 2017A Bonds	Variable rate	2017–2043[1]	**–**	41,635
Series 2016A–F Bonds	Variable rate	2017–2042[1]	**193,825**	304,565
Series 2015 Bonds	3.63%–5.00%	2016–2042	**70,585**	72,140
Series 2013 Bonds	4.00%–5.00%	2014–2044	**115,055**	115,055
Series 2008D/E Bonds	Variable rate	2025–2042	**50,000**	105,000
Series 2007A Bonds	Variable rate	2008–2035	**–**	73,280
MHHEFA Pooled Loan Program	Variable rate	2017–2035	**14,250**	15,200
Other long-term debt:				
Term loans	1.86%–4.44%	2009–2023	**5,906**	6,331
Other loans, mortgages and notes payable	3.25%–6.50%	Monthly, 2001–2035	**9,915**	12,678
Total debt			**1,909,376**	1,938,679
Less current portion of long-term debt			**38,399**	29,751
Less long-term debt subject to short-term remarketing agreements			**–**	153,510[1]
			1,870,977	1,755,418
Plus unamortized premiums and discounts, net			**41,037**	44,522
Less unamortized deferred financing costs			**(11,780)**	(11,573)
			$ 1,900,234	$ 1,788,367

[1]Mandatory bond repurchases are scheduled to occur in the following (fiscal years), unless the bondholding bank and the Obligated Group agree to an extension: 2016B (2027), 2016C (2024), 2016F (2027), 2021A (2028) and 2021B (2025).

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 UM Medicine 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).

On July 2, 2020, MHHEFA issued $152,680 of tax-exempt Revenue Bonds, Series 2020B, and $600,000 taxable Revenue Bonds, Series 2020D. The proceeds were used for the purpose of refinancing existing debt, including the repayment of the Upper Chesapeake term loan and the redemption of the Series 2008F, 2010, and 2013A Bonds. The remaining proceeds are to be used for the purpose of financing a portion of the costs of construction and equipping of certain capital projects related to the Medical Center, Baltimore Washington, Shore Regional, Upper Chesapeake and Capital Region.

On December 8 and 22, 2021, MHHEFA issued $160,845 of tax-exempt Revenue Bonds, Series 2021A, and $107,510 taxable Revenue Bonds, Series 2021B. The proceeds were used for the purpose of refinancing existing debt, including the redemption of the Series 2007A, 2008E, 2016A, 2016D and 2017A Bonds.

(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:

2023	$ 38,399
2024	192,006
2025	39,711
2026	35,896
2027	173,355
Thereafter	1,430,009
	$ 1,909,376

The Corporation's Series 2008D 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 a letter-of-credit agreement with a banking institution. The agreement has a term that expires in 2027. 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 48 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 within the consolidated balance sheet according to the maturity of the bond's related letter of credit agreements. 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, 2022 and 2021.

(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	
	2022	**2021**
Series 2008D Bonds	**0.61%**	0.02%
Series 2008E Bonds	**–**	0.01
Series 2007A Bonds	**–**	0.02
Series 2016A Bonds	**–**	1.07
Series 2016B Bonds	**1.72**	0.95
Series 2016C Bonds	**1.76**	0.68
Series 2016D Bonds	**–**	0.91
Series 2016E Bonds	**1.57**	0.80
Series 2016F Bonds	**1.12**	0.78
Series 2017A Bonds	**–**	0.60
Series 2021A Bonds	**1.45**	–
Series 2021B Bonds	**1.19**	–
Series 1985 Pooled Loan Program (MHHEFA)	**1.00**	0.50

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, 2022 and 2021, the Corporation's notional values of outstanding interest rate swaps and the corresponding mark-to-market values are as follows:

	Notional Amount	Pay Rate	Receive Rate	Maturity Date	Mark to Market
June 30, 2022					
Swap #1	**$ 75,981**	3.59%	70% 1-month LIBOR	7/1/2031	**$ (4,251)**
Swap #2	**84,000**	3.93	68% 1-month LIBOR	7/1/2041	**(18,554)**
Swap #3	**21,000**	4.24	68% 1-month LIBOR	7/1/2041	**(5,444)**
Swap #4	**29,050**	3.99	67% 1-month LIBOR	7/1/2034	**(3,424)**
Swap #5	**23,570**	3.54	70% 1-month LIBOR	7/1/2031	**(1,280)**
Swap #6	**196,000**	3.93	68% 1-month LIBOR	7/1/2041	**(21,760)**
Swap #7	**49,000**	4.24	68% 1-month LIBOR	7/1/2041	**(6,361)**
Swap #8	**67,800**	4.00	67% 1-month LIBOR	7/1/2034	**(1,973)**
Swap #9	**1,705**	3.63	67% 1-month LIBOR	7/1/2032	**(80)**
Swap #10	**89,275**	3.92	67% 1-month LIBOR	1/1/2043	**(6,351)**
Swap #11	**70,400**	0.51	67% 1-month LIBOR + 0.5133%	1/1/2038	**(957)**
Swap #12	**196,000**	4.02	68% 1-month LIBOR	10/1/2028	**(21,551)**
Swap #13	**49,000**	4.33	68% 1-month LIBOR	10/1/2028	**(6,347)**
Swap #14	**67,800**	4.09	67% 1-month LIBOR	10/1/2028	**(6,051)**
Swap #15	**89,275**	3.99	67% 1-month LIBOR	11/3/2028	**(8,948)**
					(113,332)
Valuation adjustments					**6,611**
Total					**$ (106,721)**
June 30, 2021					
Swap #1	$ 78,551	3.59%	70% 1-month LIBOR	7/1/2031	$ (10,785)
Swap #2	84,000	3.93	68% 1-month LIBOR	7/1/2041	(33,829)
Swap #3	21,000	4.24	68% 1-month LIBOR	7/1/2041	(9,346)
Swap #4	30,800	3.99	67% 1-month LIBOR	7/1/2034	(6,709)
Swap #5	24,380	3.54	70% 1-month LIBOR	7/1/2031	(3,297)
Swap #6	196,000	3.93	68% 1-month LIBOR	7/1/2041	(78,952)
Swap #7	49,000	4.24	68% 1-month LIBOR	7/1/2041	(22,021)
Swap #8	71,825	4.00	67% 1-month LIBOR	7/1/2034	(15,698)
Swap #9	2,075	3.63	67% 1-month LIBOR	7/1/2032	(299)
Swap #10	92,475	3.92	67% 1-month LIBOR	1/1/2043	(28,611)
Swap #11	73,160	0.51	67% 1-month LIBOR + 0.5133%	1/1/2038	1,887
					(207,660)
Valuation adjustments					4,051
Total					$ (203,609)

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 gain on changes in the fair value of nonqualifying interest rate swaps of $96,888 and $65,325 for the years ended June 30, 2022 and 2021, respectively.

The swap agreements are included in the consolidated balance sheets at their fair value of $106,721 and $203,609 as of June 30, 2022 and 2021, 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 $6,840 and $117,600 at June 30, 2022 and 2021, respectively. As of June 30, 2022 and 2021, 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 November 2021, UMMS executed four interest rate swap novation agreements with two counterparty banks. The novations resulted in the placement of $341,400 of UMMS' existing swap exposure with substitute counterparties for a period of seven years; at the close of the seven-year period, the novated swaps will resume cash flows to their original counterparty banks. The novated swaps bear an incremental swapped-to-fixed rate, but do not require the posting of any collateral during their seven-year duration. UMMS' total swap exposure and total mark-to-market were unchanged as a result of the novations.

(In Thousands)

10. Other Liabilities

Other liabilities consist of the following:

	June 30 2022	2021
Professional and general liabilities	**$ 417,331**	$ 380,715
Advances from third party payors	**–**	150,000
Accrued pension obligations	**–**	66,011
Lease obligations – operating	**93,512**	101,590
Lease obligations – finance	**45,370**	44,803
Deferred payroll taxes	**–**	38,331
Accrued interest payable	**28,243**	27,883
Other miscellaneous	**92,429**	81,924
Total other liabilities	**676,885**	891,257
Less current portion	**(135,616)**	(133,624)
Other long-term liabilities	**$ 541,269**	$ 757,633

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:

Defined Benefit Plans

University of Maryland Medical Center Midtown Campus Retirement Plan for Non-Union Employees (Midtown Plan) – A noncontributory defined benefit plan covering substantially all nonunion employees. The benefits are based on years of service and compensation. Contributions to this plan are made to satisfy the minimum funding requirements of ERISA. In 2006, Midtown froze the defined benefit pension plan.

11. Retirement Plans (continued)

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.

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.

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.

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).

11. Retirement Plans (continued)

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.

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.

(In Thousands)

11. Retirement Plans (continued)

The following tables set forth the combined benefit obligations and assets of the defined benefit plans:

	June 30	
	2022	**2021**
Change in projected benefit obligations:		
Benefit obligations at beginning of year	**$ 435,067**	$ 448,997
Settlements	**–**	(18,623)
Service cost	**3,005**	3,378
Interest cost	**12,737**	13,168
Actuarial (gain) loss and other	**(68,769)**	4,973
Benefit payments	**(21,458)**	(16,826)
Projected benefit obligations at end of year	**$ 360,582**	$ 435,067
Change in plan assets:		
Fair value of plan assets at beginning of year	**$ 369,056**	$ 318,094
Actual return on plan assets	**(50,249)**	63,831
Settlements	**–**	(18,623)
Employer contributions	**76,654**	22,580
Benefit payments	**(21,458)**	(16,826)
Fair value of plan assets at end of year	**$ 374,003**	$ 369,056

(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	
	2022	**2021**
Funded status, end of period:		
Fair value of plan assets	**$ 374,003**	$ 369,056
Projected benefit obligations	**360,582**	435,067
Net funded status	**$ 13,421**	$ (66,011)
Accumulated benefit obligation at end of year	**$ 359,715**	$ 433,076
Amounts recognized in consolidated balance sheets at June 30:		
Accrued pension asset (obligation)	**$ 13,421**	$ (66,011)
	$ 13,421	$ (66,011)
Amounts recognized in net assets without donor restrictions at June 30:		
Net actuarial loss	**$ (52,714)**	$ (54,745)
Prior service cost	**(841)**	(990)
	$ (53,555)	$ (55,735)

During fiscal year 2022, the Corporation contributed a total of $76,654 to the plans, including an incremental contribution of $60,000 to the Capital Region Pension Plan. As a result, the net funded status of the plans was significantly improved during the year and was in a surplus position as of June 30, 2022.

The estimated amounts that will be amortized from net assets without donor restrictions into net periodic pension cost in fiscal year 2022 are as follows:

Net actuarial loss	$ 2,268
Prior service cost	74
	$ 2,342

(In Thousands)

11. Retirement Plans (continued)

The components of net periodic (credit) benefit cost are as follows:

	Year Ended June 30	
	2022	**2021**
Service cost	**$ 3,005**	$ 3,378
Interest cost	**12,737**	13,168
Expected return on plan assets	**(19,458)**	(18,275)
Prior service cost recognized	**149**	72
Recognized losses	**2,969**	11,918
Net periodic (credit) benefit cost	**$ (598)**	$ 10,261

Components of net benefit cost other than the service cost of $3,005 and $3,378 in 2022 and 2021, respectively, were recorded in other nonoperating losses, net in the accompanying consolidated statements of operations and changes in net assets for the years ended June 30, 2022 and 2021. Service cost is included as a component of fringe benefits, which is recorded as salaries, wages, and benefits in the accompanying consolidated statements of operations and changes in net assets.

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

	June 30	
	2022	**2021**
Discount rate	**4.37%–4.86%**	2.34%–3.02%
Rate of compensation increase (for nonfrozen plan)	**3.00%**	3.00%
Interest crediting rate	**3.00%–5.00%**	3.00%–5.00%

(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	
	2022	**2021**
Discount rate	**2.35%–3.02%**	2.35%–3.05%
Rate of compensation increase (for nonfrozen plan)	**3.00%**	3.00%
Expected long-term return on plan assets	**5.00%–5.50%**	5.50%–6.00%

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, 2022 and 2021, by asset category, are as follows:

		Percentage of Plan Assets as of June 30	
Asset Category	**Target Allocation**	**2022**	**2021**
Cash and cash equivalents	0%–20%	**6%**	5%
Fixed income securities	75%–85%	**85**	35
Equity securities	15%–25%	**8**	41
Global assets allocation	0%	**–**	11
Hedge funds/private equity	0%–20%	**1**	8
		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:

	Level 1	Level 2	Level 3	Investments Reported at NAV*	Total
June 30, 2022					
Cash and cash equivalents	**$ 24,504**	**$ –**	**$ –**	**$ –**	**$ 24,504**
Corporate obligations	**–**	**–**	**–**	**–**	**–**
Government and agency bonds	**–**	**–**	**–**	**–**	**–**
Fixed income funds	**10,556**	**–**	**–**	**–**	**10,556**
Common stocks	**22,912**	**–**	**–**	**–**	**22,912**
Equity mutual funds	**4,402**	**–**	**–**	**–**	**4,402**
Alternative investments:					
Hedge funds/private equity	**–**	**–**	**–**	**4,681**	**4,681**
Commingled funds	**–**	**–**	**–**	**306,948**	**306,948**
	$ 62,374	**$ –**	**$ –**	**$ 311,629**	**$ 374,003**
June 30, 2021					
Cash and cash equivalents	$ 19,803	$ –	$ –	$ –	$ 19,803
Corporate obligations	–	12,798	–	–	12,798
Government and agency bonds	12,869	18,366	–	–	31,235
Fixed income funds	29,002	–	–	–	29,002
Common stocks	34,419	–	–	–	34,419
Equity mutual funds	89,229	–	–	–	89,229
Alternative investments:					
Hedge funds/private equity	–	–	–	30,149	30,149
Commingled funds	–	–	–	122,421	122,421
	$ 185,322	$ 31,164	$ –	$ 152,570	$ 369,056

*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, 2022 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 $4,531, which are subject to notice requirements of 30-60 days and are available to be redeemed on a monthly or quarterly basis. Funds totaling $6,748 are subject to notice requirements of 75 to 90 days and can be redeemed monthly or quarterly. The Corporation had no unfunded commitments as of June 30, 2022.

The Corporation expects to contribute $6,794 to its defined benefit pension plans for the fiscal year ended June 30, 2023.

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:

2023	$ 24,754
2024	24,429
2025	24,884
2026	25,069
2027	25,156
2028–2032	121,928

The expected benefits to be paid are based on the same assumptions used to measure the Corporation's benefit obligation at June 30, 2022.

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 $55,017 and $51,023 for the years ended June 30, 2022 and 2021, respectively. Such amounts are included in salaries, wages, and benefits in the accompanying consolidated statements of operations and changes in net assets.

(In Thousands)

12. Net Assets with Donor Restrictions

Net assets are restricted primarily for the following purposes:

	June 30 2022	2021
Facility construction and renovations, research, education, and other:		
Capital Region	**$ 4,848**	$ 42,851
All others	**169,751**	196,794
Economic and beneficial interests in the net assets of related organizations	**59,493**	63,095
	$ 234,092	$ 302,740

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 2022	2021
Purchases of equipment and construction costs	**$ 66,729**	$ 386,238
Research, education, uncompensated care, and other	**5,925**	7,597
	$ 72,654	$ 393,835

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.

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

(In Thousands)

12. Net Assets with Donor Restrictions (continued)

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 funds 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
4. The possible effects 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, 2022			
Donor-restricted endowment funds	**$ 765**	**$ 70,315**	**$ 71,080**
June 30, 2021			
Donor-restricted endowment funds	$ 126	$ 60,287	$ 60,413

Donor restricted endowment funds within net assets with donor restrictions whose use is restricted in perpetuity were $55,359 and $54,907 as of June 30, 2022 and 2021, respectively.

12. Net Assets with Donor Restrictions (continued)

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.

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.

(In Thousands)

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.

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

	June 30	
	2022	**2021**
Economic interests in:		
The James Lawrence Kernan Hospital Endowment Fund, Incorporated	**$ 42,776**	$ 46,297
Baltimore Washington Medical Center Foundation, Inc.	**11,243**	12,297
Total economic interests	**54,019**	58,594
Beneficial interest in the net assets of:		
Dorchester General Hospital Foundation, Inc.	**4,145**	3,172
Prince George's Hospital Center Foundation, Inc.	**1,267**	1,267
Laurel Regional Hospital Auxiliary, Inc.	**62**	62
	$ 59,493	$ 63,095

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	
	2022	**2021**
Current assets	**$ 5,848**	$ 5,461
Noncurrent assets	**53,645**	57,735
Total assets	**$ 59,493**	$ 63,196
Current liabilities	**$ –**	$ 101
Net assets	**59,493**	63,095
Total liabilities and net assets	**$ 59,493**	$ 63,196
Total operating revenue	**$ 3,230**	$ 6,179
Total operating expense	**(661)**	2,117
Other changes in net assets	**(6,171)**	(116,021)
Total decrease in net assets	**$ (3,602)**	$ (107,725)

(In Thousands)

14. State and County Support

The Corporation received $3,600 and $3,500 in support for the Shock Trauma Center operations from the State of Maryland for the years ended June 30, 2022 and 2021, respectively.

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

	Year Ended June 30	
	2022	**2021**
State of Maryland	**$ 10,000**	$ 15,000
Prince George's County government	**–**	483
Magruder Memorial Hospital Trust	**–**	1,042
	$ 10,000	$ 16,525

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 $1,410 and $15,189 during the years ended June 30, 2022 and 2021, 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 Services				Corporate Services,	
	Hospital & Ambulatory	Retail Pharmacy	Physician Practices	Risk Taking	Other, and Eliminations	Total
Year ended June 30, 2022						
Operating expenses:						
Salaries, wages, and benefits	**$ 1,961,817**	**$ 8,162**	**$ 305,291**	**$ 5,032**	**$ 327,778**	**$ 2,608,080**
Expendable supplies	**692,521**	**120,358**	**41,642**	**30**	**10,142**	**864,693**
Purchased services:						
Purchased services	**936,823**	**16,837**	**68,285**	**4,662**	**(242,221)**	**784,386**
Contracted services	**345,759**	**–**	**30,062**	**–**	**(47,430)**	**328,391**
Depreciation and amortization	**261,082**	**–**	**2,271**	**–**	**3,834**	**267,187**
Interest expense	**39,430**	**–**	**–**	**–**	**715**	**40,145**
Total operating expenses	**$ 4,237,432**	**$ 145,357**	**$ 447,551**	**$ 9,724**	**$ 52,818**	**$ 4,892,882**
Year ended June 30, 2021						
Operating expenses:						
Salaries, wages, and benefits	$ 1,808,585	$ 7,167	$ 292,180	$ 3,950	$ 316,808	$ 2,428,690
Expendable supplies	727,209	98,385	39,515	31	17,826	882,966
Purchased services:						
Purchased services	940,438	13,611	70,092	1,673	(319,967)	705,847
Contracted services	311,675	–	36,209	–	(42,611)	305,273
Depreciation and amortization	234,050	–	2,268	–	7,959	244,277
Interest expense	41,429	–	–	–	(8,962)	32,467
Total operating expenses	$ 4,063,386	$ 119,163	$ 440,264	$ 5,654	$ (28,947)	$ 4,599,520

Corporate services are allocated primarily using a 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, 2022 and 2021, as follows:

	2022	2021
Cash and cash equivalents	**$ 244,529**	$ 858,543
Receivables, net	**863,756**	753,374
Assets limited as to use – board designated	**90,000**	137,528
Investments	**1,431,494**	1,355,157
Total financial assets available within one year	**2,629,779**	3,104,602
Less:		
Amounts unavailable for general expenditures within one year due to:		
Alternative investments subject to lockup restrictions	**12,623**	26,000
Total financial assets available to management for general expenditure within one year	**$ 2,617,156**	$ 3,078,602

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	
	2022	2021
Professional and general liabilities	**$ 417,331**	$ 380,715
Employee health	**24,292**	23,360
Employee long-term disability	**3,002**	3,792
Workers' compensation	**27,483**	25,627
Total self-insured liabilities	**472,108**	433,494
Less current portion	**(67,201)**	(64,189)
	$ 404,907	$ 369,305

17. Insurance (continued)

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 $280,763 and $253,670 as of June 30, 2021 and 2020, 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 $165,000 individually and $227,000 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 University of Maryland Faculty Physicians, Inc.

Total malpractice insurance expense, net of investment return on self-insurance trust funds, for the Corporation during the years ended June 30, 2022 and 2021, was approximately $137,206 and $29,661, respectively.

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).

(In Thousands)

18. Business and Credit Concentrations (continued)

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:

	June 30	
	2022	**2021**
Medicare	**35%**	31%
Medicaid	**20**	29
Commercial insurance and HMOs	**35**	33
Self-pay and others	**10**	7
	100%	100%

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

	Year Ended June 30	
	2022	**2021**
Medicare	**42%**	41%
Medicaid	**24**	24
Commercial insurance and HMOs	**30**	31
Self-pay and others	**4**	4
	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 they are canceled by the HSCRC or by the Corporation. The agreements were in place for the years ended June 30, 2022 and 2021. 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, 2022 and through October 21, 2022, the date the consolidated financial statements were issued. Other than described below, the Corporation did not have any material subsequent events during the period.

On August 23, 2022, the Corporation amended the term and structure of the revolving line of credit facility (see Note 7).

Supplementary Information

University of Maryland Medical System Corporation and Subsidiaries

Consolidating Balance Sheet by Division
(In Thousands)

June 30, 2022

	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	$ 23,632	$ 7,293	$ 386	$ 17,827	$ 72,576	$ 13,423	$ 16,714	$ 88,498	$ 3,476	$ 445	$ –	$ 259	$ –	$ 244,529
Assets limited as to use, current portion	68,258	–	–	–	–	–	–	–	–	–	–	–	–	68,258
Accounts receivable:														
Patient accounts receivable, net	270,992	18,333	26,583	55,704	43,618	16,232	40,903	53,130	48,976	–	–	–	(2,862)	571,609
Other	353,939	237	8,036	4,547	4,044	1,003	7,594	3,891	17,971	255	5,131	2,763	(117,264)	292,147
Inventories	56,390	1,697	3,465	7,891	4,070	1,813	5,067	9,752	7,130	–	–	178	–	97,453
Prepaid expenses and other current assets	26,575	539	1,242	1,820	1,559	1,026	3,128	2,907	–	–	46	–	(133)	38,709
Total current assets	799,786	28,099	39,712	87,789	125,867	33,497	73,406	158,178	77,553	700	5,177	3,200	(120,259)	1,312,705
Investments	474,016	49,990	4,522	200,754	182,391	36,801	36,084	338,014	87,345	–	21,577	–	–	1,431,494
Assets limited as to use, less current portion:														
Investments held for collateral	6,840	–	–	–	–	–	–	–	–	–	–	–	–	6,840
Debt service funds	40	–	–	–	–	–	–	–	–	–	–	–	–	40
Construction funds	129,128	17,914	10,700	43,335	40,027	9,673	–	194,679	11,674	–	–	–	(23,910)	433,220
Board designated and escrow funds	–	–	–	–	30,000	–	–	60,000	–	–	–	–	–	90,000
Self-insurance trust funds	200,071	–	–	–	3,145	–	–	–	24,579	–	–	–	–	227,795
Funds restricted by donor	–	–	1,127	–	38,184	–	19,235	12,257	–	–	47,067	–	–	117,870
Economic and beneficial interests in the net assets of related organizations	83,708	44,295	558	11,243	4,145	–	9,503	–	1,330	–	–	–	(95,289)	59,493
	419,787	62,209	12,385	54,578	115,501	9,673	28,738	266,936	37,583	–	47,067	–	(119,199)	935,258
Property and equipment, net	1,020,522	43,602	151,558	283,141	178,850	103,999	256,680	250,434	535,042	–	–	4,277	–	2,828,105
Investments in joint ventures and other assets	1,020,904	12,976	1,013	2,738	41,477	7,458	31,652	69,264	23,396	5,596	12,890	5,670	(643,106)	591,928
Total assets	$ 3,735,015	$ 196,876	$ 209,190	$ 629,000	$ 644,086	$ 191,428	$ 426,560	$ 1,082,826	$ 760,919	$ 6,296	$ 86,711	$ 13,147	$ (882,564)	$ 7,099,490
Liabilities and net assets														
Current liabilities:														
Trade accounts payable	$ 151,678	$ 8,779	$ 13,786	$ 28,560	$ 17,011	$ 6,193	$ 27,789	$ 24,300	$ 130,441	$ 628	$ –	$ 4,621	$ (1,328)	$ 412,458
Accrued payroll and benefits	150,174	5,876	12,921	33,197	25,691	11,876	31,188	43,138	25,781	639	339	789	–	341,609
Advances from third-party payors	116,409	10,510	15,010	26,464	22,448	13,140	26,668	28,608	6,864	–	–	–	–	266,121
Lines of credit	81,000	–	–	–	–	–	–	–	–	–	–	–	–	81,000
Other current liabilities	77,455	1,975	19,041	7,132	8,177	3,157	31,736	7,897	10,340	73,779	584	37,184	(142,841)	135,616
Current portion of long-term debt	6,411	355	547	4,188	6,667	2,314	4,516	8,968	4,433	–	–	–	–	38,399
Total current liabilities	583,127	27,495	61,305	99,541	79,994	36,680	121,897	112,911	177,859	75,046	923	42,594	(144,169)	1,275,203
Long-term debt, less current portion	660,731	17,219	26,445	194,181	120,022	42,206	199,981	436,012	203,437	–	–	–	–	1,900,234
Other long-term liabilities	464,476	494	943	9,581	39,173	1,609	81,620	1,511	19,012	4,320	–	4,143	(85,613)	541,269
Interest rate swap liabilities	106,721	–	–	–	–	–	–	–	–	–	–	–	–	106,721
Total liabilities	1,815,055	45,208	88,693	303,303	239,189	80,495	403,498	550,434	400,308	79,366	923	46,737	(229,782)	3,823,427
Net assets:														
Without donor restrictions	1,846,789	107,352	74,090	314,454	357,834	110,185	(705)	518,969	355,763	(73,070)	22,138	(33,590)	(558,238)	3,041,971
With donor restrictions	73,171	44,316	46,407	11,243	47,063	748	23,767	13,423	4,848	–	63,650	–	(94,544)	234,092
Total net assets	1,919,960	151,668	120,497	325,697	404,897	110,933	23,062	532,392	360,611	(73,070)	85,788	(33,590)	(652,782)	3,276,063
Total liabilities and net assets	$ 3,735,015	$ 196,876	$ 209,190	$ 629,000	$ 644,086	$ 191,428	$ 426,560	$ 1,082,826	$ 760,919	$ 6,296	$ 86,711	$ 13,147	$ (882,564)	$ 7,099,490

University of Maryland Medical System Corporation and Subsidiaries

Consolidating Statement of Operations by Division
(In Thousands)

Year Ended June 30, 2022

	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	$ 1,801,739	$ 117,709	$ 209,099	$ 525,036	$ 398,122	$ 162,395	$ 456,694	$ 482,069	$ 356,273	$ –	$ –	$ 21,017	$ (6,746)	$ 4,523,407
State support	13,600	–	–	–	–	–	–	–	10,000	–	–	–	(10,000)	13,600
CARES Act – provider relief funds	2,001	669	533	3,917	6,913	551	1,559	4,894	1,646	–	–	–	–	22,683
Other revenue	1,014,990	2,910	32,976	5,041	3,050	2,151	6,745	10,862	10,080	–	–	14,143	(769,581)	333,367
Total operating revenue, gains, and other support	2,832,330	121,288	242,608	533,994	408,085	165,097	464,998	497,825	377,999	–	–	35,160	(786,327)	4,893,057
Operating expenses:														
Salaries, wages and fringe benefits	1,285,601	60,930	126,823	288,983	195,047	83,489	251,884	282,467	219,244	–	–	18,861	(205,249)	2,608,080
Expendable supplies	485,338	13,859	42,660	78,670	44,923	23,174	66,260	64,819	42,078	–	–	4,660	(1,748)	864,693
Purchased services	752,988	22,079	55,833	103,451	85,472	39,933	104,790	86,008	96,130	–	–	12,919	(575,217)	784,386
Contracted services	168,844	11,172	35,588	17,334	19,810	10,581	8,442	13,577	47,156	–	–	–	(4,113)	328,391
Depreciation and amortization	95,624	7,877	15,638	30,653	20,899	10,627	26,072	25,263	33,495	–	–	1,039	–	267,187
Interest expense	13,449	209	845	5,081	3,195	1,348	7,909	3,691	4,418	–	–	–	–	40,145
Total operating expenses	2,801,844	116,126	277,387	524,172	369,346	169,152	465,357	475,825	442,521	–	–	37,479	(786,327)	4,892,882
Operating income (loss) from continuing operations	30,486	5,162	(34,779)	9,822	38,739	(4,055)	(359)	22,000	(64,522)	–	–	(2,319)	–	175
Nonoperating income and expenses, net:														
Contributions	332	–	–	–	250	(163)	2,245	(643)	–	–	1,487	–	–	3,508
Equity in net income of joint ventures	(4,184)	–	–	–	(214)	469	2,312	435	278	–	–	–	–	(904)
Investment income	59,452	6,772	704	27,179	10,273	3,933	574	44,240	758	–	1,965	–	–	155,850
Change in fair value of investments	(110,749)	(11,614)	(1,245)	(46,818)	(37,211)	(7,084)	(4,553)	(80,588)	(825)	–	(3,610)	–	–	(304,297)
Change in fair value of undesignated interest rate swaps	96,888	–	–	–	–	–	–	–	–	–	–	–	–	96,888
Other nonoperating gains and losses	(14,886)	(226)	(619)	(3,000)	(2,527)	(795)	(3,421)	(5,595)	(286)	–	(1,857)	–	–	(32,212)
Total nonoperating income and expenses	26,853	(5,068)	(1,160)	(22,639)	(29,429)	(3,640)	(2,843)	(42,151)	(75)	–	(2,015)	–	–	(82,167)
Excess (deficiency) of revenues over expenses	$ 57,339	$ 94	$ (35,939)	$ (12,817)	$ 9,310	$ (7,695)	$ (3,202)	$ (20,151)	$ (64,597)	$ –	$ (2,015)	$ (2,319)	$ –	$ (81,992)

University of Maryland Medical System Corporation and Subsidiaries

Consolidating Balance Sheet – Obligated Group
(In Thousands)

June 30, 2022

	University of Maryland Medical Center & Affiliates*	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	$ 16,351	$ 7,293	$ 1	$ 18,990	$ 30,313	$ 33,937	$ 11,549	$ 12,777	$ 88,784	$ –	$ –	$ –	$ 219,995
Assets limited as to use, current portion	68,258	–	–	–	–	–	–	–	–	–	–	–	68,258
Accounts receivable:													
Patient accounts receivable, net	270,593	18,247	26,606	44,580	34,366	4,231	15,125	35,585	47,011	46,125	–	–	542,469
Other	355,476	237	2,753	37,054	25,247	172	879	1,035	38,569	16,183	5,131	(20,695)	462,041
Inventories	56,390	1,697	3,465	7,861	3,358	712	1,813	5,067	8,886	7,130	–	–	96,379
Prepaid expenses and other current assets	25,399	539	1,234	1,752	1,454	23	1,031	1,895	2,059	–	46	(150)	35,282
Total current assets	792,467	28,013	34,059	110,237	94,738	39,075	30,397	56,359	185,309	69,438	5,177	(20,845)	1,424,424
Investments	474,016	49,990	4,518	200,754	129,989	1,106	34,219	33,347	314,271	87,345	21,577	–	1,351,132
Assets limited as to use, less current portion:													
Investments held for collateral	6,840	–	–	–	–	–	–	–	–	–	–	–	6,840
Debt service funds	40	–	–	–	–	–	–	–	–	–	–	–	40
Construction funds	129,128	17,914	10,700	43,335	35,917	4,110	9,673	–	194,679	11,674	–	(23,910)	433,220
Board designated and escrow funds	–	–	–	–	25,000	5,000	–	–	60,000	–	–	–	90,000
Self-insurance trust funds	200,071	–	–	–	3,145	–	–	–	–	–	–	–	203,216
Funds restricted by donor	–	–	1,127	–	3,082	–	–	–	–	–	47,067	–	51,276
Economic interests in the net assets of related organizations	83,708	44,295	558	11,243	91,206	7,094	5,580	9,503	35,013	1,330	–	(95,289)	194,241
	419,787	62,209	12,385	54,578	158,350	16,204	15,253	9,503	289,692	13,004	47,067	(119,199)	978,833
Property and equipment, net	1,012,673	43,602	149,508	261,696	161,951	11,190	78,342	243,197	232,721	533,067	–	–	2,727,947
Investments in joint ventures and other assets	1,032,070	12,976	1,013	2,738	37,879	857	7,108	30,286	63,026	27,136	12,890	(636,617)	591,362
Total assets	$ 3,731,013	$ 196,790	$ 201,483	$ 630,003	$ 582,907	$ 68,432	$ 165,319	$ 372,692	$ 1,085,019	$ 729,990	$ 86,711	$ (776,661)	$ 7,073,698
Liabilities and net assets													
Current liabilities:													
Trade accounts payable	$ 150,861	$ 8,776	$ 13,639	$ 25,764	$ 12,740	$ 3,084	$ 5,829	$ 25,645	$ 22,517	$ 128,238	$ –	$ (1,357)	$ 395,736
Accrued payroll and benefits	150,174	5,876	12,470	24,299	14,143	2,072	8,393	22,106	31,545	23,746	339	–	295,163
Advances from third-party payors	116,409	10,510	15,009	26,464	21,146	1,302	13,140	26,581	28,316	6,864	–	–	265,741
Lines of credit	81,000	–	–	–	–	–	–	–	–	–	–	–	81,000
Other current liabilities	77,309	1,975	19,041	4,708	5,955	1,102	6,528	32,509	4,705	10,737	584	(43,398)	121,755
Current portion of long-term debt	6,411	355	547	3,963	6,597	70	861	3,978	8,968	4,170	–	–	35,920
Total current liabilities	582,164	27,492	60,706	85,198	60,581	7,630	34,751	110,819	96,051	173,755	923	(44,755)	1,195,315
Long-term debt, less current portion	660,731	17,219	26,445	192,700	116,650	3,372	41,933	193,381	436,012	202,733	–	–	1,891,176
Other long-term liabilities	464,476	494	943	4,927	37,804	1,369	1,606	81,620	1,510	6,201	–	(85,613)	515,337
Interest rate swap liabilities	106,721	–	–	–	–	–	–	–	–	–	–	–	106,721
Total liabilities	1,814,092	45,205	88,094	282,825	215,035	12,371	78,290	385,820	533,573	382,689	923	(130,368)	3,708,549
Net assets:													
Without donor restrictions	1,843,750	107,269	66,982	335,935	326,677	50,195	87,029	(13,129)	516,432	342,465	22,138	(551,749)	3,133,994
With donor restrictions	73,171	44,316	46,407	11,243	41,195	5,866	–	1	35,014	4,836	63,650	(94,544)	231,155
Total net assets	1,916,921	151,585	113,389	347,178	367,872	56,061	87,029	(13,128)	551,446	347,301	85,788	(646,293)	3,365,149
Total liabilities and net assets	$ 3,731,013	$ 196,790	$ 201,483	$ 630,003	$ 582,907	$ 68,432	$ 165,319	$ 372,692	$ 1,085,019	$ 729,990	$ 86,711	$ (776,661)	$ 7,073,698

University of Maryland Medical System Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets Without Donor Restrictions – Obligated Group

(In Thousands)

Year Ended June 30, 2022

	University of Maryland Medical Center & Affiliates*	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	$ 1,800,516	$ 117,106	$ 204,299	$ 446,536	$ 292,279	$ 48,573	$ 151,174	$ 377,024	$ 420,151	$ 343,212	$ –	$ (6,746)	$ 4,194,124
State support	13,600	–	–	–	–	–	–	–	–	10,000	–	(10,000)	13,600
Premium revenue	–	–	–	–	–	–	–	–	–	–	–	–	–
CARES Act – provider relief funds	1,970	669	388	3,063	5,112	718	419	1,559	3,369	1,646	–	–	18,913
Other revenue	1,014,409	2,910	28,018	2,315	6,033	594	1,508	3,401	6,015	9,005	–	(764,081)	310,127
Total operating revenue, gains, and other support	2,830,495	120,685	232,705	451,914	303,424	49,885	153,101	381,984	429,535	363,863	–	(780,827)	4,536,764
Operating expenses:													
Salaries, wages, and benefits	1,284,658	60,174	120,243	218,140	116,928	15,084	73,518	161,071	205,200	201,394	–	(205,249)	2,251,161
Expendable supplies	485,254	13,846	42,498	58,044	35,922	2,630	22,561	63,925	52,719	41,306	–	(1,748)	816,957
Purchased services	751,876	21,941	53,141	96,506	59,983	14,704	37,560	78,679	87,773	95,480	–	(573,830)	723,813
Contracted services	168,844	11,172	32,763	23,249	15,147	5,903	10,046	26,299	18,246	33,549	–	–	345,218
Depreciation and amortization	95,205	7,877	15,304	29,104	17,243	2,819	8,746	24,953	23,899	33,235	–	–	258,385
Interest expense	13,277	209	845	5,029	3,044	151	1,256	7,609	3,690	4,382	–	–	39,492
Total operating expenses	2,799,114	115,219	264,794	430,072	248,267	41,291	153,687	362,536	391,527	409,346	–	(780,827)	4,435,026
Operating income (loss)	31,381	5,466	(32,089)	21,842	55,157	8,594	(586)	19,448	38,008	(45,483)	–	–	101,738
Nonoperating income and expenses, net:													
Contributions	332	–	–	–	–	–	–	–	–	–	1,487	–	1,819
Equity in net income of joint ventures	(5,204)	–	–	–	(214)	–	296	2,312	–	–	–	–	(2,810)
Investment income	59,452	6,772	705	27,179	7,279	426	3,877	570	41,908	491	1,965	–	150,624
Change in fair value of investments	(110,750)	(11,614)	(1,245)	(46,818)	(25,689)	(705)	(6,686)	(1,274)	(71,911)	(825)	(3,610)	–	(281,127)
Change in fair value of undesignated interest rate swaps	96,888	–	–	–	–	–	–	–	–	–	–	–	96,888
Other nonoperating gains and losses	(14,886)	(226)	(620)	(2,308)	(1,745)	(45)	(1,165)	(2,545)	(5,279)	(611)	(1,857)	–	(31,287)
Total nonoperating income and expenses	25,832	(5,068)	(1,160)	(21,947)	(20,369)	(324)	(3,678)	(937)	(35,282)	(945)	(2,015)	–	(65,893)
Excess (deficiency) of revenues over expenses	57,213	398	(33,249)	(105)	34,788	8,270	(4,264)	18,511	2,726	(46,428)	(2,015)	–	35,845
Net assets released from restrictions used for purchase of property and equipment	34,381	–	15,189	–	–	–	–	–	–	–	3,298	–	52,868
Contributions	13,040	–	–	1,004	–	–	–	–	–	–	–	–	14,044
State support for capital	–	–	–	500	–	–	–	–	–	–	–	–	500
Change in economic and beneficial interest in the net assets of related organizations	–	–	–	–	(8,974)	(768)	–	–	–	–	–	–	(9,742)
Change in ownership interest of joint ventures	–	–	–	–	–	–	–	–	–	–	–	–	–
Capital transfers (to) from member organization	(70,991)	(796)	33,458	(12,902)	(22,272)	(811)	(32,930)	(9,921)	13,960	(31,525)	(5,608)	–	(140,338)
Amortization of accumulated loss of discontinued designated interest rate swap	–	–	–	–	–	–	–	–	–	–	–	–	–
Change in funded status of defined benefit pension plans	–	–	661	(6,234)	–	–	2,438	–	–	5,315	–	–	2,180
Other	1,997	–	–	–	–	(73)	–	–	207	–	(807)	1,298	2,622
Increase (decrease) net assets without donor restrictions	$ 35,640	$ (398)	$ 16,059	$ (17,737)	$ 3,542	$ 6,618	$ (34,756)	$ 8,590	$ 16,893	$ (72,638)	$ (5,132)	$ 1,298	$ (42,021)

University of Maryland Medical System Corporation and Subsidiaries

Consolidating Balance Sheet – Hospital Format
(In Thousands)

June 30, 2022

	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		University of Maryland Capital Region Health Hospitals	All Other Entities	Eliminations	Consolidated Total
									Medical Center	Harford Memorial				
Assets														
Current assets:														
Cash and cash equivalents	$ 16,351	$ 7,293	$ 1	$ 18,990	$ 30,313	$ 33,937	$ 11,549	$ 12,777	$ 81,820	$ 6,964	$ –	$ 24,534	$ –	$ 244,529
Assets limited as to use, current portion	–	–	–	–	–	–	–	–	–	–	–	68,258	–	68,258
Accounts receivable:														
Patient accounts receivable, net	270,593	18,247	26,606	44,580	34,366	4,231	15,125	35,585	37,735	9,276	46,125	32,002	(2,862)	571,609
Other	278,612	237	7,529	36,210	7,184	142	879	1,035	36,011	64	16,183	171,860	(263,799)	292,147
Inventories	43,220	1,697	3,465	7,861	3,358	712	1,813	5,067	6,431	2,455	7,130	14,244	–	97,453
Prepaid expenses and other current assets	5,069	539	1,234	1,752	1,454	23	1,031	1,895	1,530	529	–	23,786	(133)	38,709
Total current assets	613,845	28,013	38,835	109,393	76,675	39,045	30,397	56,359	163,527	19,288	69,438	334,684	(266,794)	1,312,705
Investments	468,953	49,990	4,518	200,754	129,989	1,106	34,219	33,347	207,676	106,595	87,345	107,002	–	1,431,494
Assets limited as to use, less current portion:														
Investments held for collateral	–	–	–	–	–	–	–	–	–	–	–	6,840	–	6,840
Debt service funds	–	–	–	–	–	–	–	–	–	–	–	40	–	40
Board designated and escrow funds	–	–	–	–	25,000	5,000	–	–	60,000	–	–	–	–	90,000
Self-insurance trust funds	–	–	–	–	3,145	–	–	–	–	–	–	224,650	–	227,795
Funds restricted by donor	–	–	1,127	–	3,082	–	–	–	–	–	–	113,661	–	117,870
Economic interests in the net assets of related organizations	83,708	44,295	558	11,243	91,206	7,094	5,578	9,503	35,014	–	1,330	–	(230,036)	59,493
	212,836	62,209	12,385	54,578	158,350	16,204	15,251	9,503	289,693	–	13,004	345,191	(253,946)	935,258
Property and equipment, net	628,844	43,602	149,508	261,696	161,951	11,190	78,342	243,197	181,679	51,042	533,067	483,987	–	2,828,105
Investments in joint ventures and other assets	80,915	12,976	1,013	2,738	37,879	857	7,110	30,286	57,301	5,724	27,136	1,355,592	(1,027,599)	591,928
Total assets	$ 2,005,393	$ 196,790	$ 206,259	$ 629,159	$ 564,844	$ 68,402	$ 165,319	$ 372,692	$ 899,876	$ 182,649	$ 729,990	$ 2,626,456	$ (1,548,339)	$ 7,099,490
Liabilities and net assets														
Current liabilities:														
Trade accounts payable	$ 124,835	$ 8,776	$ 13,639	$ 25,764	$ 12,740	$ 3,084	$ 5,829	$ 25,645	$ 11,289	$ 11,228	$ 128,238	$ 42,719	$ (1,328)	$ 412,458
Accrued payroll and benefits	97,437	5,876	12,470	24,299	14,143	2,072	8,393	22,106	25,915	5,630	23,746	99,522	–	341,609
Advances from third-party payors	116,409	10,510	15,009	26,464	21,146	1,302	13,140	26,581	20,881	7,435	6,864	380	–	266,121
Short-term financing	–	–	–	–	–	–	–	–	–	–	–	81,000	–	81,000
Other current liabilities	35,118	1,975	19,041	4,708	5,955	4,074	13,992	31,551	3,900	18,132	11,693	274,853	(289,376)	135,616
Current portion of long-term debt	6,411	355	547	3,963	6,597	70	861	3,978	8,968	–	4,170	2,479	–	38,399
Total current liabilities	380,210	27,492	60,706	85,198	60,581	10,602	42,215	109,861	70,953	42,425	174,711	500,953	(290,704)	1,275,203
Long-term debt, less current portion	565,213	17,219	26,445	192,700	116,650	3,372	41,933	193,381	411,559	24,453	202,733	104,576	–	1,900,234
Other long-term liabilities	19,119	494	943	4,927	37,804	1,369	1,606	81,620	313	1,197	6,201	471,289	(85,613)	541,269
Interest rate swap liabilities	–	–	–	–	–	–	–	–	–	–	–	106,721	–	106,721
Total liabilities	964,542	45,205	88,094	282,825	215,035	15,343	85,754	384,862	482,825	68,075	383,645	1,183,539	(376,317)	3,823,427
Net assets:														
Without donor restrictions	994,976	107,269	71,758	335,091	308,614	47,193	79,565	(12,171)	382,037	114,574	341,509	1,279,112	(1,007,556)	3,041,971
With donor restrictions	45,875	44,316	46,407	11,243	41,195	5,866	–	1	35,014	–	4,836	163,805	(164,466)	234,092
Total net assets	1,040,851	151,585	118,165	346,334	349,809	53,059	79,565	(12,170)	417,051	114,574	346,345	1,442,917	(1,172,022)	3,276,063
Total liabilities and net assets	$ 2,005,393	$ 196,790	$ 206,259	$ 629,159	$ 564,844	$ 68,402	$ 165,319	$ 372,692	$ 899,876	$ 182,649	$ 729,990	$ 2,626,456	$ (1,548,339)	$ 7,099,490

University of Maryland Medical System Corporation and Subsidiaries

Consolidating Statement of Operations – Hospital Format
(In Thousands)

Year Ended June 30, 2022

	University of Maryland Medical Center					Shore Health System, Inc.						Upper Chesapeake Hospitals		Capital Region Hospitals					
	University Hospital	Shock Trauma Center	Rehabilitation & Orthopaedic Institute	University of Maryland Midtown Campus	Baltimore Washington Medical Center, Inc.	Memorial Hospital	Dorchester General	QAEC	Chester River Medical Center	Charles Regional Medical Center	St. Joseph Medical Center	Medical Center	Harford Memorial	Capital Regional	Laurel Regional	Bowie Health Center	All Other Entities	Eliminations	Consolidated Total
Operating revenue, gains and other support:																			
Net patient service revenue	$ 1,583,708	$ 216,808	$ 117,106	$ 204,299	$ 446,536	$ 264,914	$ 20,618	$ 6,747	$ 48,573	$ 151,174	$ 377,024	$ 320,280	$ 99,871	$ 305,800	$ 23,271	$ 14,141	$ 331,463	$ (8,926)	$ 4,523,407
State support	–	3,600	–	–	–	–	–	–	–	–	–	–	–	10,000	–	–	10,000	(10,000)	13,600
CARES Act – provider relief funds	1,970	–	669	388	3,063	5,112	–	–	718	419	1,559	814	2,555	1,646	–	–	3,770	–	22,683
Other revenue	212,695	476	2,910	28,018	2,315	5,465	433	135	594	1,508	3,401	4,736	1,279	8,926	51	28	1,009,489	(949,092)	333,367
Total operating revenue, gains, and other support	1,798,373	220,884	120,685	232,705	451,914	275,491	21,051	6,882	49,885	153,101	381,984	325,830	103,705	326,372	23,322	14,169	1,354,722	(968,018)	4,893,057
Operating expenses:																			
Salaries, wages, and benefits	691,219	93,245	60,174	120,243	218,140	100,046	12,036	4,846	15,084	73,518	161,071	147,717	57,483	181,089	12,313	7,992	858,170	(206,306)	2,608,080
Expendable supplies	447,716	30,008	13,846	42,498	58,044	32,539	2,579	804	2,630	22,561	63,925	45,877	6,842	35,310	3,962	2,034	55,266	(1,748)	864,693
Purchased services	368,335	46,813	21,941	53,141	96,506	52,894	5,705	1,384	14,704	37,560	78,679	62,029	25,744	73,010	15,720	6,750	444,133	(620,662)	784,386
Contracted services	152,925	15,919	11,172	35,108	38,358	30,282	4,009	780	9,293	11,712	46,789	25,096	7,869	39,697	6,583	1,336	30,692	(139,229)	328,391
Depreciation and amortization	87,825	7,380	7,877	15,304	29,104	13,334	3,463	446	2,819	8,746	24,953	17,357	6,542	32,070	37	1,128	8,802	–	267,187
Interest expense	13,205	–	209	845	5,029	2,645	399	–	151	1,256	7,609	2,569	1,121	4,382	–	–	725	–	40,145
Total operating expenses	1,761,225	193,365	115,219	267,139	445,181	231,740	28,191	8,260	44,681	155,353	383,026	300,645	105,601	365,558	38,615	19,240	1,397,788	(967,945)	4,892,882
Operating income (loss)	37,148	27,519	5,466	(34,434)	6,733	43,751	(7,140)	(1,378)	5,204	(2,252)	(1,042)	25,185	(1,896)	(39,186)	(15,293)	(5,071)	(43,066)	(73)	175
Nonoperating income and expenses, net:																			
Contributions	332	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	3,176	–	3,508
Equity in net income of joint ventures	(929)	–	–	–	–	(214)	–	–	–	296	2,312	–	–	–	–	–	(16,684)	14,315	(904)
Investment income	56,576	–	6,772	705	27,179	7,279	–	–	426	3,877	570	26,100	15,808	491	–	–	10,067	–	155,850
Change in fair value of investments	(100,268)	–	(11,614)	(1,245)	(46,818)	(25,689)	–	–	(705)	(6,686)	(1,274)	(44,785)	(27,126)	(825)	–	–	(37,262)	–	(304,297)
Change in fair value of undesignated interest rate swaps	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	96,888	–	96,888
Other nonoperating gains and losses	(12,303)	–	(226)	(620)	(2,308)	(1,745)	–	–	(45)	(1,165)	(2,545)	(5,279)	(2,274)	(1,007)	251	145	(4,786)	695	(33,212)
Total nonoperating income and expenses	(56,592)	–	(5,068)	(1,160)	(21,947)	(20,369)	–	–	(324)	(3,678)	(937)	(23,964)	(13,592)	(1,341)	251	145	51,399	15,010	(82,167)
(Deficiency) excess of revenues over expenses	$ (19,444)	$ 27,519	$ 398	$ (35,594)	$ (15,214)	$ 23,382	$ (7,140)	$ (1,378)	$ 4,880	$ (5,930)	$ (1,979)	$ 1,221	$ (15,488)	$ (40,527)	$ (15,042)	$ (4,926)	$ 8,333	$ 14,937	$ (81,992)

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EXHIBIT 12

MARYLAND HEALTH CARE COMMISSION

Certificate of Need

TO: Jeffrey L. Johnson,
Senior Vice President
Dimensions Health Corporation
3001 Hospital Drive
Cheverly, Maryland 20785

Mary Miller, CFO/Vice President
Mt. Washington Children's Hospital
1708 W. Rogers Ave.
Baltimore, MD 21209

October 20, 2016
Date

RE: Relocation of
Prince George's Hospital Center
And Mt. Washington Pediatric Hospital, Inc.

13-16-2351
Docket No.

PROJECT DESCRIPTION

This Certificate of Need authorizes Dimensions Health Corporation ("Dimensions") and Mt. Washington Pediatric Hospital ("MWPH") to relocate and replace Prince George's Hospital Center ("PGHC") and MWPH to a site five miles to the Southwest of the existing Cheverly Campus in Largo (Prince George's County). The proposed replacement general hospital will be renamed Prince George's Regional Medical Center ("PGRMC"). PGRMC will have 220 beds, consisting of 122 general medical/surgical beds, 32 intensive care beds, 22 obstetric (postpartum) beds, 1 pediatric bed, 28 acute psychiatric beds, and 15 special hospital pediatric beds (MWPH). The hospital will have eight operating rooms, 45 emergency department treatment spaces and a 20 bed dedicated observation unit.

The 595,695 square foot ("SF") replacement general hospital will have nine levels containing hospital facilities and services, a helicopter port, security room, and two elevator machine rooms. This project will also include a separate, prefabricated 27,000 SF central utility plant.

The approved project cost is $555,350,000 for the relocation and replacement of the general hospital (this amount includes $12.3 million land donation from Prince George's County). The general hospital relocation and replacement project will be funded through: the sale of bonds, raising $117,809,717; $9,190,283 in interest income from bond proceeds; $208 million from State grants or appropriations; $208 million in Local Grant or appropriations and $12,350,000 million in contributed land.

ORDER

The Maryland Health Care Commission considered the Reviewer's Recommended Decision, and, based upon that analysis and the record of the review, ordered, on October 20, 2016, that a Certificate of Need be issued for this project.

PERFORMANCE REQUIREMENTS

In accordance with the conditions of the Certificate of Need set forth above and COMAR 10.24.01.12C(2) and (3), the project is subject to the following performance requirements:

1. Obligation of not less than 51 percent of the capital expenditure, as documented by a binding construction contract, within 36 months of this Certificate of Need;
2. Initiation of construction within four months of the effective date of the binding construction contract; and
3. Completion of the project within 36 months after the effective date of the binding construction contract.

Failure to meet these performance requirements will render this Certificate of Need void, subject to the requirements of COMAR 10.24.01.12F through I.

PROPOSED CHANGES TO APPROVED PROJECT

Before making any changes to the facts in the Certificate of Need application and other information provided to the Commission, Dimensions must notify the Commission in writing and receive Commission approval of each proposed change, including the obligation of any funds above those approved by the Commission in this Certificate of Need, in accordance with COMAR 10.24.01.17. Pursuant to COMAR 10.24.01.17B(2), the project cannot incur capital cost increases that exceed the approved capital cost inflated by an amount determined by applying the Building Cost Index published on a quarterly basis by IHS Economics in the Healthcare Cost Review unless Dimensions obtains a modification of this Certificate of Need from the Commission. Instructions for determining the threshold that necessitates Commission review and approval of changes to the capital cost approved in this Certificate of Need are located on the Commission's website at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/hcfs_con.aspx

DESIGN APPROVAL AND FACILITIES LICENSURE BY DHMH

This Certificate of Need does not constitute a license or replace any approvals required by the Office of Health Care Quality ("OHCQ") or other divisions of the Department of Health and Mental Hygiene ("DHMH") to construct and operate a new health care facility or to operate new space within an existing facility. Dimensions must provide DHMH with all information it requires for plan approval or approval to put new or renovated space within the facility into use, including information pertaining to project design and specifications.

QUARTERLY STATUS REPORTS

Dimensions must file quarterly status reports on the approved project, beginning January 20, 2017, three months from the date of this Certificate of Need, and continuing through the completion of the replacement hospital.

REQUEST FOR FIRST USE REVIEW

Dimensions must request in writing, not less than 60 days but not more than 120 days before the first use of the replacement hospital, a first use review from the Commission, specifying the anticipated date of first use and documenting that the project has been substantially completed and will be completed, within 120 days or less, in a manner and consist with this Certificate of Need. Commission staff will review the request in consultation, as necessary, with OHCQ, and in accordance with COMAR 10.24.01.18, to determine whether the project is in conformance with the Certificate of Need. First use approval does not constitute a license or replace any approvals required by OHCQ or others within DHMH to operate a new health care facility or new space within an existing facility. Therefore, Dimensions should assure that OHCQ is notified of the imminent completion of the project and should arrange for completion of any inspections and or approvals required by OHCQ in a timely manner. First use approval remains in effect for 90 days. If first use of the new building space does not occur within 90 days of approval, Dimensions shall reapply for first use approval.

ACKNOWLEDGEMENT OF RECEIPT OF CERTIFICATE OF NEED.

Acknowledgement of your receipt of this Certificate of Need, stating acceptance of its terms and conditions, is required within thirty (30) days.

MARYLAND HEALTH CARE COMMISSION

Ben Steffen
Executive Director

cc: Patricia Tomsko Nay, M.D., Executive Director, Office of Health Care Quality
Donna Kinzer, Executive Director, HSCRC
Pamela Creekmur, RN, Health Officer, Prince George's County