EXHIBIT 1

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

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

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

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/2022	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
ACUTE CARE							**ACUTE CARE**					
General Medical/ Surgical*		62					**General Medical/ Surgical***		74			
MedSurg	2 East		19	6	25	31	MedSurg	3	26	0	26	26
Surgical/Medical	3 East		10	10	20	30	MedSurg	4	24	0	24	24
Neuro	4 East		6	2	8	10	MedSurg	5	24	0	24	24
Joint	4 East		5	3	8	11					0	0
Telemetry	4 South		20	4	24	28					0	0
SUBTOTAL Gen. Med/Surg*		**62**	**60**	**25**	**85**	**110**	**SUBTOTAL Gen. Med/Surg***		**74**	**0**	**74**	**74**
ICU/CCU		**10**	10	0	10	10	**ICU/CCU**	4	12	0	12	12
Other *(Specify/add rows as needed)*					0	0					0	0
TOTAL MSGA		**72**	**70**	**25**	**95**	**120**	**TOTAL MSGA**		**86**	**0**	**86**	**86**
Obstetrics Total		**13**			0	**13**	**Obstetrics Total**		11		11	11
5 East (LDRP)	Birthing Center 5E		10	0	10	10	LDRP	3	1	0	1	1
Antepartum	Birthing Center 5E		3	0	3	3	Postpartum	3	8	0	8	8
OR 5 East	Birthing Center 5E		1	0	1	1	Antepartum	3	2	0	2	2
PACU 5 East	Birthing Center 5E		1	0	1	1					0	0
Triage 5 East	Birthing Center 5E		3	0	3	3					0	0
Pediatrics		**3**	1	2	3	5	**Pediatrics**	3	1	0	1	1
Psychiatric	3 South	**10**	4	4	8	12	**Psychiatric**	6	12	0	12	12
TOTAL ACUTE		**98**	**75**	**31**	**106**	**150**	**TOTAL ACUTE**		**110**	**0**	**110**	**110**
NON-ACUTE CARE							**NON-ACUTE CARE**					
Dedicated Observation**					0	0	**Dedicated Observation****	1	25	0	25	25
Rehabilitation	5 South	**20**	3	6	9	15	**Rehabilitation**	5	12	0	12	12
Comprehensive Care					0	0	**Comprehensive Care**				0	0
Other *(Specify/add rows as needed)*					0	0	**Other** *(Specify/add rows as needed)*				0	0
TOTAL NON-ACUTE		**20**	**3**	**6**	**9**	**15**	**TOTAL NON-ACUTE**		**37**	**0**	**37**	**37**
HOSPITAL TOTAL		**118**	**78**	**37**	**115**	**165**	**HOSPITAL TOTAL**		**147**	**0**	**147**	**147**

* Include beds dedicated to gynecology and addictions, if unit(s) is separate for acute psychiatric unit

** Include services included in the reporting of the “Observation Center”. Service furnished by the hospital on the hospital's promise, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient; Must be ordered and documented in writing, given by a medical practitioner.

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

INSTRUCTION : Add or delete rows if necessary. See additional instruction in the column to the right of the table.

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Inpatient Nursing Units					
Intensive Care	6,090	12,413	0	0	12,413
Med / Surg (Telemetry / Neuro)	16,317	14,873	0	0	14,873
Rehab (Requard Center)	8,700	13,480	0	0	13,480
Med / Surg (General)	29,738	32,788	0	0	32,788
Pediatric Unit	2,300	incl in M/S Unit	0	0	0
Med / Surg (Joint, Med/Surg)	6,810	incl in M/S Unit	0	0	0
Obstetrics incl. nursery	15,623	20,607	0	0	20,607
Behavioral Health Unit	9,775	11,616			11,616
Subtotal	**95,353**	**105,777**	0	0	**105,777**
Diagnostic & Treatment					
Clinical Lab / Pathology	7,451	10,225	0	0	10,225
Emergency Department	17,570	21,890	0	0	21,890
Inpatient Dialysis	2,298	2,332	0	0	2,332
Imaging Department	16,680	15,605	0	0	15,605
Interventional Suite (incl O.R.'s, Cath, EP, PACU)	23,040	30,968	0	0	30,968
Prep / Stage 2 Recovery	3,889	16,128	0	0	16,128
Pre-Anesthesia Testing	400	710	0	0	710
Observation Unit	0	11,976	0	0	11,976
Respiratory Therapy	1,927	697	0	0	697
Subtotal	**73,255**	**110,531**	0	0	**110,531**
Administrative / Public Services					
Auxiliary	126	310	0	0	310
Admitting / Registration	3,845	1,784	0	0	1,784
Chapel	170	597	0	0	597
Education Center / Med Library	6,289	4,956	0	0	4,956
Gift Shop	1,106	1,255	0	0	1,255
Hospitalist Suite	1,259	0	0	0	0
On-Call	1,034	1,670	0	0	1,670
Executive Admin	6,252	4,631	0	0	4,631
Medical Records	7,933	2,060	0	0	2,060

Quality Team	1,055	incl in Admin	0	0	0
Human Resources / Employee Health	1,900	1,808	0	0	1,808
Nursing Administration / Staff offices	1,835	1,361	0	0	1,361
Information Technology	1,900	2,046	0	0	2,046
Lobby Services	1,255	1,192	0	0	1,192
Subtotal	**35,959**	**23,670**	0	0	**23,670**
Support Services					
EVS / Linen / Facilities / Mat. Mgmt	9,389	13,592	0	0	13,592
Biomed	600	894			894
Maryland Express Care Suite	795	372	0	0	372
Sterile Processing	4,658	7,306	0	0	7,306
Pharmacy	4,181	4,843	0	0	4,843
Security	420	989	0	0	989
Morgue	500	252			252
Food & Nutrition	9,176	13,316	0	0	13,316
Subtotal	**29,719**	**41,564**	0	0	**41,564**
Clinics					
Cardiopulmonary / Vascular	2,502	5,952	0	0	5,952
Education Center	983	incl in Education above			
Behavioral Health Outpatient Clinic	1,077	3,133	0	0	3,133
Cardio Rehab	2,700	3,758	0	0	3,758
Diabetes Clinic	3,487	2,935	0	0	2,935
Infusion Center	1,760	2,178	0	0	2,178
Pain Management Clinic	2,402	3,133	0	0	3,133
Sleep Lab	1,078	0	0	0	0
Multi-Specialty Clinic	1,645	4,039	0	0	4,039
Outpatient Lab Draw	556	751	0	0	751
Subtotal	**18,190**	**25,879**	0	0	**25,879**
Total Department Gross SF	**252,476**	**307,421**			**307,421**
Building Grossing Factor	113,590	75,556	0	0	**75,556**
Penthouse	5,550	2,510	0	0	**2,510**
Central Plant	16,917	22,385	0	0	**22,385**
Total Building Gross SF	**366,066**	**407,872**			**407,872**

TABLE C. CONSTRUCTION CHARACTERISTICS

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

	NEW CONSTRUCTION		RENOVATION
	Hospital	**Central Utility Plant**	
BASE BUILDING CHARACTERISTICS	**Check if applicable**		
Class of Construction (for renovations the class of the building being renovated)*			
Class A	☑	☑	☐
Class B	☐	☐	☐
Class C	☐	☐	☐
Class D	☐	☐	☐
Type of Construction/Renovation*			
Low	☐	☐	☐
Average	☐	☐	☐
Good	☑	☑	☐
Excellent	☐	☐	☐
Number of Stories	6 plus penthouse	1	

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**		
Total Square Footage	**385,487**	**22,385**	
Basement	n/a		
First Floor	135,968	22,385	
Second Floor	111,505		
Third Floor	45,044		
Fourth Floor	36,652		
Fifth Floor	35,228		
Sixth Floor	18,580		
Penthouse	2,510		
Average Square Feet	**55,070**	**22,385**	
Perimeter in Linear Feet	**Linear Feet**		
Basement	n\a		
First Floor	2,135	610	
Second Floor	2,076		
Third Floor	1,194		
Fourth Floor	1,079		
Fifth Floor	1,066		
Sixth Floor	648		
Penthouse	204		
Total Linear Feet	**8,402**	**610**	
Average Linear Feet	**1,200**	**610**	
Wall Height (floor to eaves)	**Feet**		
Basement	n/a		
First Floor	16	20	
Second Floor	16		
Third Floor	14		
Fourth Floor	14		
Fifth Floor	14		
Sixth Floor	14		
Penthouse	21.83		
Average Wall Height	**15.69**		
OTHER COMPONENTS			
Elevators	**List Number**		
Passenger	3	0	
Freight	3	0	
Trauma	1	0	
Sprinklers	**Square Feet Covered**		
Wet System	385,487	22,385	
Dry System			
Other	**Describe Type**		
Type of HVAC System for proposed project	Excellent Grade - Forced Air: VAV / Constant Volume, Digitally Controlled		
Type of Exterior Walls for proposed project	Glass Curtain Wall, Brick Veneer, Metal Panels, Cultured Stone		

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS		
INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table D for each structure.		
	NEW CONSTRUCTION COSTS	**RENOVATION COSTS**
SITE PREPARATION COSTS		
Normal Site Preparation	$649,215	
Utilities from Structure to Lot Line	In Offsite Costs	
Subtotal included in Marshall Valuation Costs	**$649,215**	
Paving and Roads	$6,091,611	
Demolition	$412,500	
Storm Drains	$3,282,000	
Rough Grading	$2,455,794	
Landscaping	$4,239,791	
Sediment Control & Stabilization	$375,000	
Helipad	$55,000	
Water	$91,350	
Sewer	$146,160	
Premium for Labor Shortages on Eastern Shore Projects	$2,664,598	
Premium for Prevailing Wage	$2,664,598	
Premium for Minority Business Enterprise Requirement	$1,090,430	
Subtotal On-Site excluded from Marshall Valuation Costs	**$23,568,831**	
OFFSITE COSTS		
Roads	$6,653,000	
Pump Station	$1,118,520	
8" to 12" Force Main	$1,560,000	
Misc.	$780,000	
EASTON ELECTRICAL SERVICE	$704,369	
EASTON GAS SERVICE TO PROPERTY	$254,196	
Verizon	$1,170,497	
MD Broad Band (Fiber)	$1,592,448	
Chop Tank (Electric)	$2,826,004	
Cable TV	$3,532,880	
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs	**$20,191,914**	
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$43,760,745**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$44,409,960**	**$0**
BUILDING COSTS		
Normal Building Costs	$170,264,261	
Subtotal included in Marshall Valuation Costs	$170,264,261	
Canopy	$1,881,250	
Premium for Labor Shortages on Eastern Shore Projects	$12,998,316	
LEED Silver Premium	$8,665,544	
Pneumatic Tube System	$1,125,000	
Signs	$135,000	
Premium for Prevailing Wage	$12,998,316	
Premium for Minority Business Enterprise Requirement	$8,570,914	
Subtotal Building Costs excluded from Marshall Valuation Costs	**$46,374,341**	
TOTAL Building Costs included and excluded from Marshall Valuation Service*	**$216,638,602**	**$0**
A&E COSTS		
Normal A&E Costs	$11,000,000	
Subtotal included in Marshall Valuation Costs	**$11,000,000**	
Subtotal A&E Costs excluded from Marshall Valuation Costs	**$0**	
TOTAL A&E Costs included and excluded from Marshall Valuation Service*	**$11,000,000**	**$0**
PERMIT COSTS		
Normal Permit Costs	$6,135,000	
Subtotal included in Marshall Valuation Costs	**$6,135,000**	
Subtotal Permit Costs excluded from Marshall Valuation Costs	**$0**	
TOTAL Permit Costs included and excluded from Marshall Valuation Service*	**$6,135,000**	**$0**

TABLE E. PROJECT BUDGET

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

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

	Hospital Building	CUP	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. Land Purchase	**$2,464,658**		**$2,464,658**
b. New Construction			
(1) Building	$210,528,602	$6,110,000	$216,638,602
(2) Fixed Equipment	In Building	In Building	In Building
(3) Site and Infrastructure	$36,933,315	$7,476,645	$44,409,960
(4) Architect/Engineering Fees	$9,013,929	$1,986,071	$11,000,000
(5) Permits (Building, Utilities, Etc.)	$5,027,314	$1,107,686	$6,135,000
SUBTOTAL	**$261,503,160**	**$16,680,402**	**$278,183,562**
c. Renovations			
(1) Building			$0
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees			$0
(4) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$0**	**$0**
d. Other Capital Costs			
(1) Movable Equipment	$85,060,730	$40,000,000	$125,060,730
(2) Contingency Allowance	$16,974,712	$2,478,023	$19,452,735
(3) Gross interest during construction period	$44,210,733	$5,788,267	$49,999,000
(4) Other (Specify/add rows if needed)			
Easton Utility Fees	$9,000,000		$9,000,000
EDU'S			$0
Impact Fee (Town) / County	$1,500,000		$1,500,000
Forest Conservation			$0
Builder's Risk Insurance	$500,000		$500,000
HOSPITAL MOVE	$2,000,000		$2,000,000
UMMS/OVHO	$1,500,000		$1,500,000
Previous Expenditures (Design/Planning/etc)	$10,078,129		$10,078,129
SUBTOTAL	***$170,824,304***	***$48,266,290***	**$219,090,594**
TOTAL CURRENT CAPITAL COSTS	**$434,792,122**	**$64,946,691**	**$499,738,814**
e. Inflation Allowance	$25,435,020	$3,305,038	$28,740,058
TOTAL CAPITAL COSTS	**$460,227,142**	**$68,251,729**	**$528,478,871**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	$2,635,012	$344,988	$2,980,000
b. Bond Discount	$0		$0
c CON Application Assistance			$0
c1. Legal Fees	$150,000		$150,000
c2. Other (Specify/add rows if needed)			$0
Accounting, Architectural, Planning	$850,000		$850,000
d. Non-CON Consulting Fees			
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			
IT Design	$75,000		$75,000
SHA Study	$300,000		$300,000
Geo-tech consult (if needed)	$75,000		$75,000
Project Development Consultant	$4,500,000		$4,500,000
CM Preconstruction Fees	$200,000		$200,000
Exterior Wall Mock Up & Testing	$500,000		$500,000
Scheduling	$200,000		$200,000
Third Party Inspections	$750,000		$750,000
Third Party Building Permit Review	$400,000		$400,000
Curtainwall Testing	$100,000		$100,000
e. Debt Service Reserve Fund	$0		$0
f Other (Specify/add rows if needed)			$0
			$0
			$0
e. Liquidation of Existing Debt			$0
f. Debt Service Reserve Fund	$0		$0
g. Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$10,735,012***	***$344,988***	**$11,080,000**
3. Working Capital Startup Costs			$0
##### ***TOTAL USES OF FUNDS***	***$470,962,155***	***$68,596,717***	***$539,558,871***
B. Sources of Funds			
1. Cash	$38,588,871	$0	$38,588,871
2. Philanthropy (to date and expected)	$50,000,000	$0	$50,000,000
3. Authorized Bonds	$264,727,283	$68,596,717	$333,324,000
4. Interest Income from bond proceeds listed in #3	$17,646,000		$17,646,000
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State	$100,000,000		$100,000,000
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$470,962,154***	***$68,596,717***	**$539,558,871**
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

Budget Assumptions for the UM Shore Health Regional Medical Center

1. **Building:** The construction cost of the RMC is a Rough Order of Magnitude ("ROM") provided Clark Construction, the Construction Manager who completed the construction of UM Capital Region Medical Center in Largo, MD in June 2021. This ROM was developed from a combination of Schematic Design Documents from 2022, and previous iterations of this project which were at a Design Development level of completion.

2. **Fixed Equipment:** The cost of fixed equipment was developed internally by UMMS Facilities' Design and Construction Department, utilizing actual costs from UM Capital Region Medical Center as a benchmark for pricing, while adjusting for differences in scope and current day pricing.

3. **Architect/Engineering Fees:** The cost of design and engineering was provided in a proposal from HKS, the architectural firm designing the Regional Medical Center. HKS is an interdisciplinary global design firm with extensive experience in the Healthcare sector. They are the designers of the UM Upper Chesapeake Bed Tower Expansion in Bel Air, MD, which is currently under construction.

4. **Permit Fees:** The cost of the permit fees for this project was developed by Clark Construction based on their experience working in Talbot County, adjusted for a project of this size and complexity.

5. **Movable Equipment:** The cost of movable equipment was developed internally by UMMS Clinical Engineering department, a group which includes in-house medical equipment planners. This cost was established in a room-by-room format using Attania pricing models, and cross-checked using UM Capital Region actual purchase prices adjusted for current day pricing.

6. **Contingency:** The contingency for this project was developed using UM Capital Region Medical Center and other UMMS projects as a guideline. The amount of contingency was adjusted for scope differences, drawing completion levels, and the extensive site infrastructure and development requirements for this location.

7. **Information Technology (IT):** Information Technology budgets were developed internally by UMMS IT project development group based on the actual costs of UM Capital Region Medical Center's IT infrastructure and implementation. The costs were adjusted for differences in scope and current pricing.

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

9. **Non-legal Consultant Fees:** The estimate for non-legal consultant fees for this project was developed by UMMS Facilities' Design and Construction department, based on actual consultant fees paid throughout the course of the UM Capital Region Medical Center Project.

TABLE F. STATISTICAL PROJECTIONS - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	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**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
1. DISCHARGES												
a. MSGA	4,245	3,885	3,944	4,004	4,065	4,129	4,194	4,260	4,329	4,400	4,472	4,547
Total MSGA	**4,245**	**3,885**	**3,944**	**4,004**	**4,065**	**4,129**	**4,194**	**4,260**	**4,329**	**4,400**	**4,472**	**4,547**
b. Pediatrics	8	27	27	27	27	27	27	27	27	27	27	27
c. Obstetrics	1,030	999	1,004	1,012	1,020	1,028	1,036	1,044	1,052	1,060	1,069	1,077
e. Psych	432	349	350	351	352	353	355	356	478	480	481	483
f. Rehabilitation	312	191	198	206	214	222	231	239	249	259	269	279
Total Acute	**6,027**	**5,451**	**5,523**	**5,599**	**5,678**	**5,759**	**5,842**	**5,927**	**6,135**	**6,225**	**6,318**	**6,413**
g. Other (Specify/add rows of needed)												
TOTAL DISCHARGES	**6,027**	**5,451**	**5,523**	**5,599**	**5,678**	**5,759**	**5,842**	**5,927**	**6,135**	**6,225**	**6,318**	**6,413**
2. PATIENT DAYS												
a. MSGA	20,454	21,888	22,224	22,469	22,720	22,978	23,242	23,619	24,006	24,403	24,812	25,231
Total MSGA	**20,454**	**21,888**	**22,224**	**22,469**	**22,720**	**22,978**	**23,242**	**23,619**	**24,006**	**24,403**	**24,812**	**25,231**
b. Pediatrics	20	72	72	72	72	72	72	72	72	72	72	72
c. Obstetrics	1,865	1,892	1,901	1,916	1,931	1,946	1,962	1,977	1,993	2,008	2,024	2,040
e. Psych	3,648	1,996	2,014	2,033	2,052	2,071	2,091	2,111	2,854	2,882	2,910	2,938
f. Rehabilitation	3,040	2,197	2,280	2,367	2,457	2,550	2,648	2,750	2,857	2,967	3,083	3,203
Total Acute	**29,027**	**28,045**	**28,492**	**28,857**	**29,232**	**29,618**	**30,015**	**30,529**	**31,781**	**32,333**	**32,900**	**33,485**
g. Other (Specify/add rows of needed)												
TOTAL PATIENT DAYS	**29,027**	**28,045**	**28,492**	**28,857**	**29,232**	**29,618**	**30,015**	**30,529**	**31,781**	**32,333**	**32,900**	**33,485**

TABLE F. STATISTICAL PROJECTIONS - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	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**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)												
a. MSGA	4.8	5.6	5.6	5.6	5.6	5.6	5.5	5.5	5.5	5.5	5.5	5.5
Total MSGA	**4.8**	**5.6**	**5.6**	**5.6**	**5.6**	**5.6**	**5.5**	**5.5**	**5.5**	**5.5**	**5.5**	**5.5**
b. Pediatrics	2.5	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7
c. Obstetrics	1.8	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9
e. Psych	8.4	5.7	5.8	5.8	5.8	5.9	5.9	5.9	6.0	6.0	6.0	6.1
f. Rehabilitation	9.7	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5
Total Acute	**4.8**	**5.1**	**5.2**	**5.2**	**5.1**	**5.1**	**5.1**	**5.2**	**5.2**	**5.2**	**5.2**	**5.2**
g. Other (Specify/add rows of needed)												
TOTAL AVERAGE LENGTH OF STAY	**4.8**	**5.1**	**5.2**	**5.2**	**5.1**	**5.1**	**5.1**	**5.2**	**5.2**	**5.2**	**5.2**	**5.2**
4. NUMBER OF LICENSED BEDS												
a. MSGA	70	75	76	77	78	79	80	81	82	84	85	86
Total MSGA	**70**	**75**	**76**	**77**	**78**	**79**	**80**	**81**	**82**	**84**	**85**	**86**
b. Pediatrics	1	1	1	1	1	1	1	1	1	1	1	1
c. Obstetrics	11	10	10	11	11	11	11	11	11	11	11	11
e. Psych	14	8	8	8	8	8	8	8	11	11	11	12
f. Rehabilitation	11	8	8	9	9	9	10	10	10	11	11	12
Total Acute	**107**	**102**	**103**	**106**	**107**	**108**	**110**	**111**	**115**	**118**	**119**	**122**
g. Other (Specify/add rows of needed)												
TOTAL LICENSED BEDS	**107**	**102**	**103**	**106**	**107**	**108**	**110**	**111**	**115**	**118**	**119**	**122**

TABLE F. STATISTICAL PROJECTIONS - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	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**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*												
a. MSGA	80.0%	80.0%	80.0%	79.8%	80.0%	80.0%	80.0%	79.8%	80.0%	80.0%	80.0%	79.8%
Total MSGA	**80.0%**	**80.0%**	**80.0%**	**79.8%**	**80.0%**	**80.0%**	**80.0%**	**79.8%**	**80.0%**	**80.0%**	**80.0%**	**79.8%**
b. Pediatrics	5.5%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%	19.7%
c. Obstetrics	46.5%	51.8%	52.1%	47.6%	48.1%	48.5%	48.9%	49.1%	49.6%	50.0%	50.4%	50.7%
e. Psych	71.4%	68.4%	69.0%	69.4%	70.3%	70.9%	71.6%	72.1%	71.1%	71.8%	72.5%	66.9%
f. Rehabilitation	75.7%	75.2%	78.1%	71.8%	74.8%	77.6%	72.6%	75.1%	78.3%	73.9%	76.8%	72.9%
Total Acute	**74.3%**	**75.4%**	**75.7%**	**74.4%**	**75.0%**	**75.4%**	**75.0%**	**75.2%**	**75.6%**	**75.3%**	**75.8%**	**74.7%**
i. Other (Specify/add rows of needed)												
TOTAL OCCUPANCY %	**74.3%**	**75.4%**	**75.7%**	**74.4%**	**75.0%**	**75.4%**	**75.0%**	**75.2%**	**75.6%**	**75.3%**	**75.8%**	**74.7%**
6. OUTPATIENT VISITS (RVU's)												
a. Emergency Department - Easton	25,546	25,393	25,610	25,833	26,062	26,297	26,539	26,788	27,043	27,306	27,576	27,854
b. Emergency Department - Dorchester/Cambridge	12,027	14,539	14,663	14,791	14,922	15,057	15,195	15,338	15,484	15,634	15,789	15,948
c. Emergency Department - Queen Anne's	13,716	18,035	18,189	18,347	18,510	18,677	18,849	19,026	19,207	19,394	19,586	19,783
d. Same Day Surgery	4,609	4,500	4,538	4,578	4,619	4,660	4,703	4,747	4,792	4,839	4,887	4,936
e. Laboratory RVU's	4,988,179	5,941,602	5,992,382	6,044,543	6,098,133	6,153,198	6,209,787	6,267,950	6,327,740	6,389,212	6,452,420	6,517,424
f. Imaging RVU's	1,163,618	1,224,633	1,235,099	1,245,850	1,256,896	1,268,245	1,279,909	1,291,897	1,304,221	1,316,891	1,329,919	1,343,317
g. MRI RVU's	4,988,179	5,941,602	5,992,382	6,044,543	6,098,133	6,153,198	6,209,787	6,267,950	6,327,740	6,389,212	6,452,420	6,517,424
TOTAL OUTPATIENT VISITS (RVU's)	**11,195,874**	**13,170,304**	**13,282,863**	**13,398,486**	**13,517,274**	**13,639,333**	**13,764,769**	**13,893,695**	**14,026,228**	**14,162,487**	**14,302,597**	**14,446,685**

TABLE F. STATISTICAL PROJECTIONS - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	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**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
7. OBSERVATIONS**												
a. Number of Patients - Easton	3,581	3,602	3,633	3,664	3,697	3,730	3,765	3,800	3,836	3,873	3,912	3,951
b. Hours - Easton	93,658	150,523	150,291	150,084	149,900	149,741	149,607	149,498	149,415	149,358	149,327	149,323
c. Number of Patients - Dorchester/Cambridge	412	133	134	135	137	138	139	140	142	143	144	146
d. Hours - Dorchester/Cambridge	15,146	2,258	2,277	2,297	2,317	2,338	2,360	2,382	2,405	2,428	2,452	2,477

* 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 - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	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**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
1. REVENUE												
a. Inpatient Services	$124,205	$133,111	$122,858	$122,675	$123,276	$123,732	$124,173	$124,090	$131,531	$131,439	$131,363	$131,287
b. Outpatient Services	$204,565	$204,757	$216,296	$ 217,014	$ 217,346	$ 217,441	$ 217,527	$ 217,382	$ 230,417	$ 230,256	$ 230,123	$ 229,989
Gross Patient Service Revenues	***$ 328,770***	***$ 337,869***	***$ 339,154***	***$ 339,689***	***$ 340,622***	***$ 341,172***	***$ 341,699***	***$ 341,472***	***$ 361,948***	***$ 361,694***	***$ 361,485***	***$ 361,276***
c. Deductions	$61,770	$69,131	$63,036	$ 63,136	$ 63,309	$ 63,412	$ 63,509	$ 63,467	$ 67,273	$ 67,226	$ 67,187	$ 67,148
Net Patient Services Revenue	***$ 267,000***	***$ 268,738***	***$ 276,117***	***$ 276,553***	***$ 277,312***	***$ 277,761***	***$ 278,190***	***$ 278,005***	***$ 294,675***	***$ 294,469***	***$ 294,298***	***$ 294,128***
d. Grants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
e. Other Operating Revenue	$ 12,462	$ 6,689	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405	$ 7,405
NET OPERATING REVENUE	***$ 279,462***	***$ 275,427***	***$ 283,523***	***$ 283,959***	***$ 284,718***	***$ 285,166***	***$ 285,595***	***$ 285,410***	***$ 302,080***	***$ 301,874***	***$ 301,704***	***$ 301,533***
2. EXPENSES												
a. Salaries & Wages (including benefits)	$ 109,453	$ 115,116	$ 115,870	$ 113,988	$ 112,179	$ 110,509	$ 108,902	$ 109,362	$ 110,013	$ 110,622	$ 111,235	$ 111,854
b. Contractual Services	$ 47,970	$ 53,767	$ 56,418	$ 56,418	$ 56,322	$ 56,229	$ 56,141	$ 56,141	$ 55,856	$ 55,856	$ 55,856	$ 55,856
c. Interest on Current Debt	$ 2,346	$ 4,487	$ 4,993	$ 4,893	$ 4,795	$ 4,699	$ 4,605	$ 4,513	$ 4,423	$ 4,335	$ 4,248	$ 4,163
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,694	$ 15,362	$ 15,014	$ 14,647
e. Current Depreciation and Amortization	$ 16,972	$ 17,370	$ 20,336	$ 17,914	$ 17,028	$ 17,231	$ 16,483	$ 16,566	$ 14,232	$ 14,791	$ 15,446	$ 16,102
f. Project Depreciation and Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 27,961	$ 27,961	$ 27,961	$ 27,961
g. Supplies	$ 36,197	$ 35,550	$ 34,741	$ 30,878	$ 30,380	$ 29,931	$ 29,530	$ 29,737	$ 30,005	$ 30,189	$ 30,375	$ 30,563
h. Professional Fees	$ 38,097	$ 14,147	$ 18,382	$ 18,491	$ 18,570	$ 18,649	$ 18,729	$ 18,810	$ 18,928	$ 19,049	$ 19,171	$ 19,293
i. Insurance & Other	$ 3,337	$ 4,203	$ 4,718	$ 4,718	$ 4,718	$ 4,718	$ 4,718	$ 4,718	$ 4,718	$ 4,718	$ 4,718	$ 4,718
j. Fixed Cost Additions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL OPERATING EXPENSES	**$254,372**	**$244,639**	**$255,457**	**$247,301**	**$243,992**	**$241,967**	**$239,109**	**$239,847**	**$281,831**	**$282,883**	**$284,023**	**$285,158**
3. INCOME												
a. Income From Operation	**$ 25,090**	**$ 30,787**	**$ 28,065**	**$ 36,658**	**$ 40,726**	**$ 43,199**	**$ 46,486**	**$ 45,563**	**$ 20,250**	**$ 18,991**	**$ 17,681**	**$ 16,375**
b. Non-Operating Income	$ 2,068	$ 28,052	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187	$ 15,187
SUBTOTAL	***$ 27,158***	***$ 58,839***	***$ 43,253***	***$ 51,845***	***$ 55,913***	***$ 58,386***	***$ 61,674***	***$ 60,751***	***$ 35,437***	***$ 34,179***	***$ 32,868***	***$ 31,563***
c. Income Taxes												
NET INCOME (LOSS)	***$ 27,158***	***$ 58,839***	***$ 43,253***	***$ 51,845***	***$ 55,913***	***$ 58,386***	***$ 61,674***	***$ 60,751***	***$ 35,437***	***$ 34,179***	***$ 32,868***	***$ 31,563***

TABLE G. REVENUES & EXPENSES, UNINFLATED - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	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**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
4. PATIENT MIX												
a. Percent of Total Revenue												
1) Medicare	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%
2) Medicaid	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%
3) Blue Cross	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
4) Commercial Insurance	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%
5) Self-pay	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
6) Other	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days												
1) Medicare	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%
2) Medicaid	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%
3) Blue Cross	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%
4) Commercial Insurance	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%
5) Self-pay	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
6) Other	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table G – Key Financial Projection Assumptions for Shore Health System (Uninflated)

Projection is based on the UM Shore Health System FY2023 budgeted revenues and expenses with assumptions identified below

Projection period reflects FY2024 – FY2032

Volumes	— See Table F of the application for volume projections
Patient Revenue	
• FY2024	
○ HSCRC Inflation Factor	— 0.00%
○ Quality Adjustments	— -0.12%
○ Other Rates	— 0.40%
○ Volume	— 0.05%
— Total	0.33%
• FY2025	
○ HSCRC Inflation Factor	— 0.00%
○ Quality Adjustments	— 0.00%
○ Other Rates	— 0.03%
○ Volume	— 0.05%
— Total	0.08%
• FY2026+	
○ HSCRC Inflation Factor	— 0.00%
○ Quality Adjustments	— 0.00%
○ Other Rates	— -0.10%
○ Volume	— 0.05%
— Total	-0.05%
• Deductions from Gross Revenue	— 18.6%
• Revenue Enhancements	— In FY2029, Shore Health System will request a full rate adjustment of $24.0M, equal to 50% of depreciation and interest related to the project — Includes an HSCRC Markup factor of 1.1
Other Revenue	
• Other Operating Revenue Inflation	— 2.0%
Expenses	
• Inflation	
○ Salaries & Benefits	— 0.0%
○ Professional Fees	— 0.0%
○ Supplies	— 0.0%
○ Purchased Services	— 0.0%
○ Insurance & Other	— 0.0%
• Volume Variability	
○ Salaries & Benefits	— 45.0%
○ Professional Fees	— 80.0%
○ Supplies	— 50.0%
○ Purchased Services	— 50.0%
○ Insurance & Other	— 0.0%
• Interest Expense	
○ Project Debt	— Interest expense on $333.3M proceeds from a 30-year issuance of debt at an interest rate of 5%
• Depreciation and Amortization	— Reflects depreciation on a $539.6M project with a weighted average useful life of 19.2 years
• Performance Improvements	
○ Indentified PI:	
— Agency Reductions	— $6.0M by FY2027
— FTE Savings	— $2.5M by FY2027
— 340B Savings	— $4.0M in drug savings & $1.0M in other savings by FY2027
— Inventory Management	— $2.0M by FY2027
— Other PI	— $0.5M by FY2027
○ Total Identified PI:	— $15.0M by FY2027 (cumulative)
○ Unindentified PI:	— No unidentified PI included in the projection

TABLE H. REVENUES & EXPENSES, INFLATED - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	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**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
1. REVENUE												
a. Inpatient Services	$ 124,205	$ 133,111	$ 122,858	$ 125,719	$ 129,538	$ 133,288	$ 137,134	$ 140,501	$ 152,691	$ 156,448	$ 160,297	$ 164,240
b. Outpatient Services	$ 204,565	$ 204,757	$ 216,296	$ 222,398	$ 228,386	$ 234,235	$ 240,232	$ 246,132	$ 267,486	$ 274,066	$ 280,809	$ 287,717
Gross Patient Service Revenues	***$ 328,770***	***$ 337,869***	***$ 339,154***	***$ 348,117***	***$ 357,924***	***$ 367,523***	***$ 377,366***	***$ 386,633***	***$ 420,177***	***$ 430,514***	***$ 441,105***	***$ 451,958***
c. Deductions	$ 61,770	$ 69,131	$ 63,036	$ 64,702	$ 66,525	$ 68,309	$ 70,139	$ 71,861	$ 78,096	$ 80,017	$ 81,985	$ 84,002
Net Patient Services Revenue	***$ 267,000***	***$ 268,738***	***$ 276,117***	***$ 283,415***	***$ 291,399***	***$ 299,214***	***$ 307,227***	***$ 314,772***	***$ 342,081***	***$ 350,497***	***$ 359,120***	***$ 367,955***
d. Grants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
e. Other Operating Revenue	$ 12,462	$ 6,689	$ 7,405	$ 7,553	$ 7,704	$ 7,859	$ 8,016	$ 8,176	$ 8,340	$ 8,506	$ 8,676	$ 8,850
NET OPERATING REVENUE	***$ 279,462***	***$ 275,427***	***$ 283,523***	***$ 290,968***	***$ 299,104***	***$ 307,072***	***$ 315,243***	***$ 322,948***	***$ 350,421***	***$ 359,003***	***$ 367,796***	***$ 376,805***
2. EXPENSES												
a. Salaries & Wages (including benefits)	$ 109,453	$ 115,116	$ 115,870	$ 117,408	$ 119,011	$ 120,757	$ 122,571	$ 126,781	$ 131,361	$ 136,051	$ 140,910	$ 145,944
b. Contractual Services	$ 47,970	$ 53,767	$ 56,418	$ 57,546	$ 58,597	$ 59,671	$ 60,769	$ 61,984	$ 62,903	$ 64,161	$ 65,444	$ 66,753
c. Interest on Current Debt	$ 2,346	$ 4,487	$ 4,993	$ 4,893	$ 4,795	$ 4,699	$ 4,605	$ 4,513	$ 4,423	$ 4,335	$ 4,248	$ 4,163
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,694	$ 15,362	$ 15,014	$ 14,647
e. Current Depreciation and Amortization	$ 16,972	$ 17,370	$ 20,336	$ 17,914	$ 17,028	$ 17,231	$ 16,483	$ 16,566	$ 14,232	$ 14,791	$ 15,446	$ 16,102
f. Project Depreciation and Amortization	$ -	$ -	$ -	$ -	$ -	$ -			$ 27,961	$ 27,961	$ 27,961	$ 27,961
g. Supplies	$ 36,197	$ 35,550	$ 34,741	$ 31,990	$ 32,606	$ 33,281	$ 34,018	$ 35,489	$ 37,099	$ 38,669	$ 40,308	$ 42,018
h. Professional Fees	$ 38,097	$ 14,147	$ 18,382	$ 19,046	$ 19,700	$ 20,378	$ 21,080	$ 21,806	$ 22,601	$ 23,428	$ 24,285	$ 25,173
i. Insurance and Other	$ 3,337	$ 4,203	$ 4,718	$ 4,812	$ 4,908	$ 5,007	$ 5,107	$ 5,209	$ 5,313	$ 5,419	$ 5,528	$ 5,638
TOTAL OPERATING EXPENSES	**$254,372**	**$244,639**	**$255,457**	**$253,610**	**$256,647**	**$261,024**	**$264,632**	**$272,348**	**$321,587**	**$330,177**	**$339,143**	**$348,401**
3. INCOME												
a. Income From Operation	**$ 25,090**	**$ 30,787**	**$ 28,065**	**$ 37,358**	**$ 42,457**	**$ 46,048**	**$ 50,611**	**$ 50,600**	**$ 28,834**	**$ 28,826**	**$ 28,654**	**$ 28,405**
b. Non-Operating Income	$ 2,068	$ 28,052	$ 15,187	$ 15,491	$ 15,801	$ 16,117	$ 16,439	$ 16,768	$ 14,303	$ 17,445	$ 17,794	$ 18,150
SUBTOTAL	***$ 27,158***	***$ 58,839***	***$ 43,253***	***$ 52,849***	***$ 58,258***	***$ 62,165***	***$ 67,050***	***$ 67,368***	***$ 43,137***	***$ 46,272***	***$ 46,448***	***$ 46,555***
c. Income Taxes	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NET INCOME (LOSS)	***$ 27,158***	***$ 58,839***	***$ 43,253***	***$ 52,849***	***$ 58,258***	***$ 62,165***	***$ 67,050***	***$ 67,368***	***$ 43,137***	***$ 46,272***	***$ 46,448***	***$ 46,555***

TABLE H. REVENUES & EXPENSES, INFLATED - Shore Health System

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

	Two Most Recent Years (Actual)		Current Year Budgeted	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**	**FY2029**	**FY2030**	**FY2031**	**FY2032**
4. PATIENT MIX												
a. Percent of Total Revenue												
1) Medicare	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%	53.4%
2) Medicaid	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%	20.4%
3) Blue Cross	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
4) Commercial Insurance	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%
5) Self-pay	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
6) Other	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days												
Total MSGA												
1) Medicare	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%	57.5%
2) Medicaid	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%
3) Blue Cross	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%
4) Commercial Insurance	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%
5) Self-pay	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
6) Other	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

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

Projection is based on the UM Shore Health System FY2023 budgeted revenues and expenses with assumptions identified below

Projection period reflects FY2024 – FY2032

Volumes	— See Table F of the application for volume projections
Patient Revenue	
• FY2024	
○ HSCRC Inflation Factor	— 2.48%
○ Quality Adjustments	— -0.12%
○ Other Rates	— 0.40%
○ Volume	— 0.05%
— Total	2.81%
• FY2025	
○ HSCRC Inflation Factor	— 2.50%
○ Quality Adjustments	— 0.00%
○ Other Rates	— 0.03%
○ Volume	— 0.05%
— Total	2.58%
• FY2026+	
○ HSCRC Inflation Factor	— 2.50%
○ Quality Adjustments	— 0.00%
○ Other Rates	— -0.10%
○ Volume	— 0.05%
— Total	2.45%
• Deductions from Gross Revenue	— 18.6%
• Revenue Enhancements	— In FY2029, Shore Health System will request a full rate adjustment of $24.0M, equal to 50% of depreciation and interest related to the project — Includes an HSCRC Markup factor of 1.1
Other Revenue	
• Other Operating Revenue Inflation	— 2%
Expenses	
• Inflation	
○ Salaries & Benefits	— 3.0%
○ Professional Fees	— 3.6%
○ Supplies	— 3.0%
○ Purchased Services	— 2.0%
○ Insurance & Other	— 2.0%
• Volume Variability	
○ Salaries & Benefits	— 45%
○ Professional Fees	— 80%
○ Supplies	— 50%
○ Purchased Services	— 50%
○ Insurance & Other	— 0%
• Interest Expense	
○ Project Debt	— Interest expense on $333.3M proceeds from a 30-year issuance of debt at an interest rate of 5%
• Depreciation and Amortization	— Reflects depreciation on a $539.6M project with a weighted average useful life of 19.2 years
• Performance Improvements	
○ Indentified PI:	
— Agency Reductions	— $6.0M by FY2027
— FTE Savings	— $2.5M by FY2027
— 340B Savings	— $4.0M in drug savings & $1.0M in other savings by FY2027
— Inventory Management	— $2.0M by FY2027
— Other PI	— $0.5M by FY2027
○ Total Identified PI:	— $15.0M by FY2027 (cumulative)
○ Unindentified PI:	— No unidentified PI included in the projection

TABLE L. WORKFORCE INFORMATION - SHS

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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT 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	218.5	$ 66,260	$ 14,477,936			$ -			$ 4,411,660	218.5	$ 18,889,596
Direct Care Staff *(List general categories, add rows if needed)*											
Med/Surg Acute	195.1	$ 77,437	$ 15,110,442	(4.4)	$ 77,437	$ (343,515)	(11.6)	$ (309,787)	$ 3,606,835	179.1	$ 18,373,762
Pediatrics	9.6	74,226	712,577				-	-	216,930	9.6	929,507
Obstetrics	43.1	98,711	4,252,496				(3.7)	(241,815)	900,247	39.4	5,152,743
Operating Room	87.2	83,993	7,325,329				(9.1)	(146,895)	1,341,606	78.1	8,666,935
Psych	23.8	77,541	1,845,478				1.5	543,275	791,307	25.3	2,636,785
Rehab	42.0	82,923	3,482,791				7.0	258,857	1,815,100	49.0	5,297,891
Emergency Department	122.6	98,200	12,038,972				(8.6)	(328,762)	2,822,469	114.0	14,861,442
Lab	79.7	69,125	5,512,095				(5.2)	(257,920)	1,335,058	74.6	6,847,153
Pharmacy	32.7	91,911	3,005,495				(2.1)	(342,940)	727,946	30.6	3,733,441
Radiology	74.3	90,200	6,706,249				(4.8)	(336,558)	1,624,288	69.5	8,330,537
Other Ancillary Services	187.4	68,273	12,797,255				(14.2)	(218,178)	3,100,666	173.2	15,897,921
Total Direct Care	897.7	$ 81,088	$ 72,789,180	(4.4)	$ 77,437	$ (343,515)	(51.0)	$ (358,815)	$ 18,282,452	842.3	$ 90,728,116
Support Staff *(List general categories, add rows if needed)*											
Security	25.6	$ 45,896	$ 1,174,938				-	-	358,090	25.6	1,533,028
Environmental Services	51.6	34,251	1,767,347				-	-	538,640	51.6	2,305,988
Other Support Staff	52.7	74,400	3,921,675				0.3	3,828,440	1,216,971	53.0	5,138,646
Total Support	*129.9*	$ 52,836	*$ 6,863,961*				*0.3*	$ 6,649,439	*$ 2,113,701*	*130.2*	*$ 8,977,662*
REGULAR EMPLOYEES TOTAL	*1,246.1*	$ 75,542	*$ 94,131,076*	*-4.4*	$ 77,437	*$ (343,515)*	*(50.6)*	$ (489,940)	*$ 24,807,813*	*1,191.0*	*$ 118,595,374*
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)***:**			$ 21,738,646						$ 5,610,297		$ 27,348,944
23.1% of Salaries											
TOTAL COST	***1,246.1***		***115,869,723***	***(4.4)***		***$ (343,515)***	***(50.6)***		***$ 30,418,111***		***$ 145,944,318***

EXHIBIT 2

UNIVERSITY of MARYLAND MEDICAL SYSTEM

HKS

SHORE HEALTH EASTON REPLACEMENT HOSPITAL

EASTON, MD

OWNER

UNIVERSITY OF MARYLAND HEALTH SYSTEM
250 W. PRATT STREET
SUITE 2400
BALTIMORE, MD 21201

SHORE HEALTH SYSTEM
219 S. WASHINGTON STREET
EASTON, MD 21601
BALTIMORE, MD 21201

ARCHITECT

HKS INC.
2100 E. CARY ST.
SUITE 100
RICHMOND, VA 23223

INTERIORS

HKS INC.
2100 E. CARY ST.
SUITE 100
RICHMOND, VA 23223

CIVIL

DAFT MCCUNE WALKER INC.
BERLIN OFFICE, THE PAVILIONS
11200 RACETRACK ROAD, SUITE 202
BERLINE, MD 21811

MEP

HIGHLAND ASSOCIATES
102 HIGHLAND AVENUE
CLARKS SUMMIT, PA 18411

STRUCTURAL

O'DONNELL & NACCARATO
111 SOUTH INDEPENDENCE MALL EAST
SUITE 950
PHILADELPHIA, PA 19106-2545

LANDSCAPE

MAHAN RYKIEL ASSOCIATES
THE STUEFF SILVER BUILDING
800 WYMAN PARK DRIVE, SUITE 100
BALTIMORE, MD 21211

INFORMATION TECHNOLOGY

SMITH SECKMAN REID, INC.
2995 SIDCO DRIVE
NASHVILLE, TN 37204

FOOD SERVICE

L2M FOOD SERVICE DESIGN GROUP
811 CROMWELL PARK DRIVE, SUITE 113
GLEN BURNIE, MD 21061

MEDICAL EQUIPMENT

MITCHELL PLANNING ASSOCIATES
2794 OAKBROOK DRIVE
WESTON, FL 33332

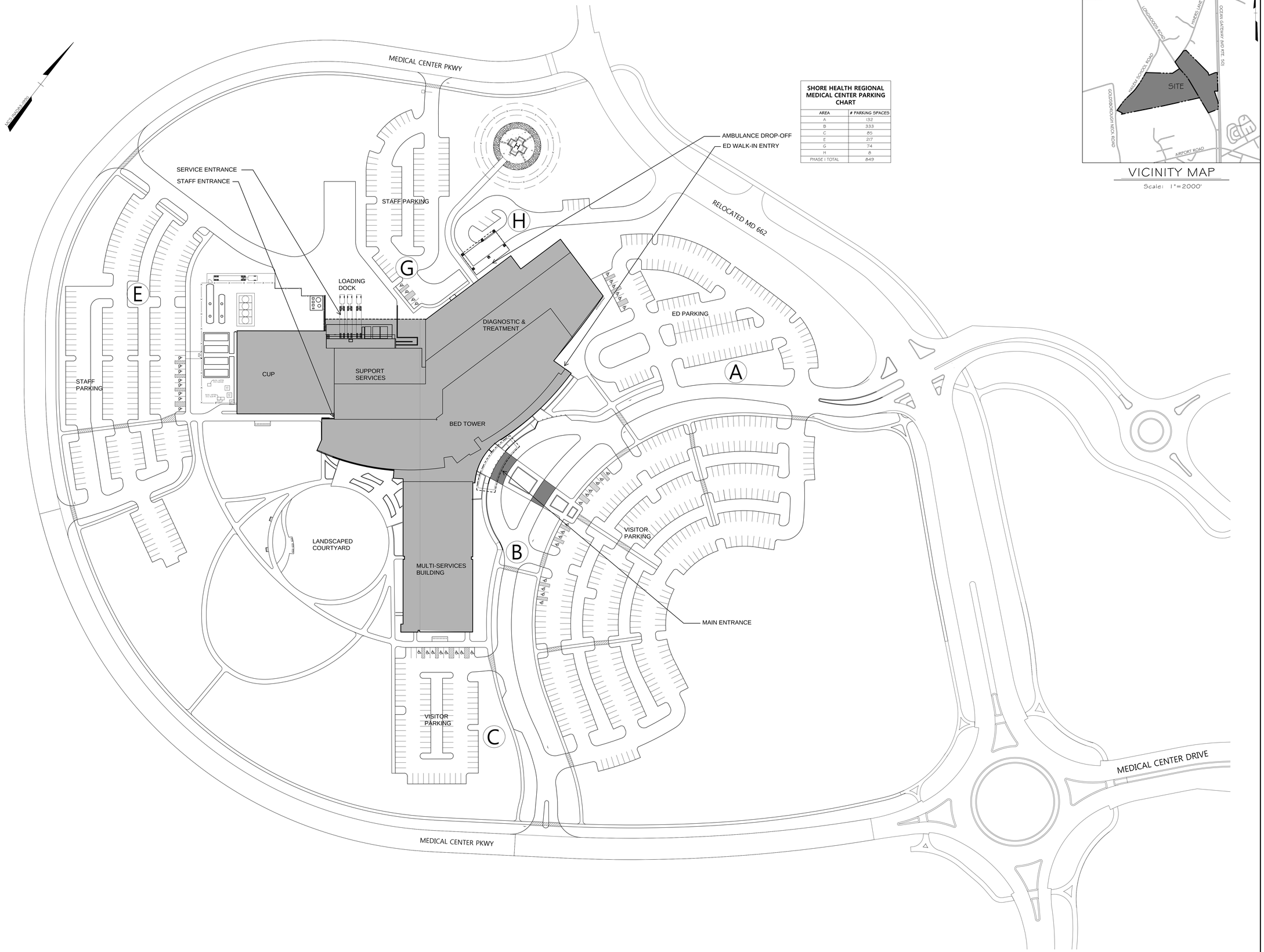
OWNER'S CONSULTANTS

FM GLOBAL
2100 RESTON PARKWAY, SUITE 600
RESTON, VA 20191

CON SUBMISSION

JANUARY 6, 2023 [UPDATED]

HKS # - 19782.000



SHORE HEALTH REGIONAL MEDICAL CENTER PARKING CHART

AREA	# PARKING SPACES
A	132
B	333
C	65
E	217
G	74
H	6
PHASE I TOTAL	849

VICINITY MAP

Scale: 1"=2000'

PLAN

60 0 60 120

SCALE: 1" = 60'

PLOT DATE: P:\0855\05\03\NEW\GRADS2 BUILDING\UPDATE BASE FILES\060509A_CON PLAN.DWG 10/25/2022 1:40 PM gattis

HKS

ARCHITECT
HKS, Inc.
2100 E. Cary Street, Suite 100
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Towson, MD 21286

MEP
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Clarks Summit, PA 18411

STRUCTURAL
O'Donnell & Naccarato
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Philadelphia, PA 19106-2524

LANDSCAPE
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The Stueff Silver Building
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Baltimore, MD 21211

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Nashville, TN 37204

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L2M FOOD SERVICE DESIGN GROUP
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Glen Burnie, MD 21061

MEDICAL EQUIPMENT
Mitchell Planning Associates
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Weston, FL 33332

Shore Health
Easton Replacement Hospital

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University of Maryland Health System
250 W. Pratt Street
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Baltimore, MD 21201

Shore Health System
219 S. Washington Street
Easton, MD 21601

OWNER'S CONSULTANT
FM Global
2100 Reston Parkway, Suite 600
Reston, VA 20191

INTERIM REVIEW ONLY

These documents are incomplete, and are released for interim review only and are not intended for regulatory approval, permit, or construction purposes.

Civil Engineer: Kristy M Bishoff
PE Reg. No.: 28823
Date: 10/25/2022

KEY PLAN

PLAN NORTH TRUE NORTH

REVISION NO. DESCRIPTION DATE

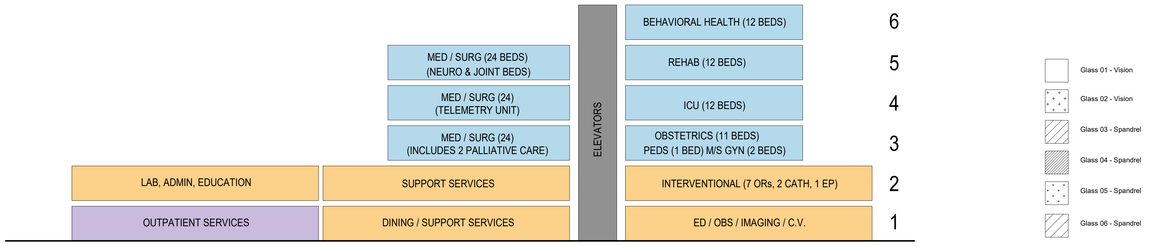
HKS PROJECT NUMBER
19782.010

DATE
JANUARY 6, 2023

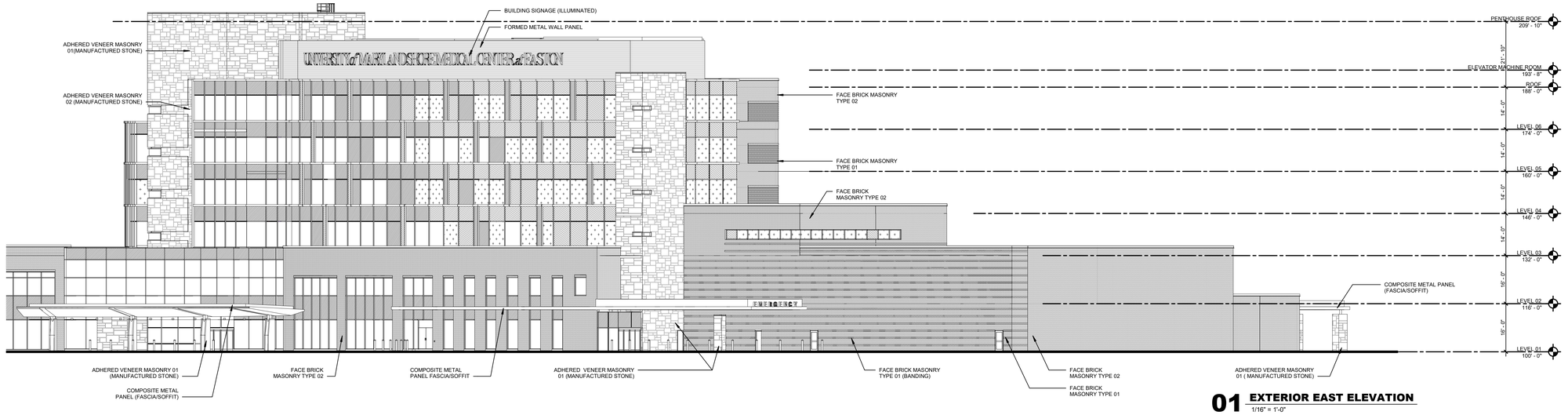
ISSUE
CON SUBMISSION

SHEET TITLE
PHASE 1 DEVELOPMENT SITE PLAN

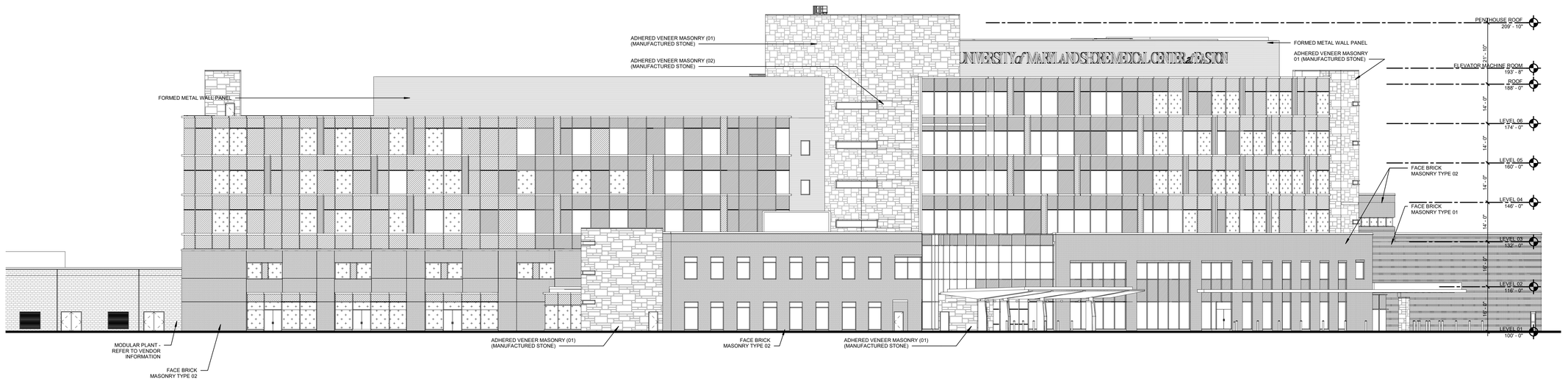
SHEET NO.
CON 07



03 STACKING DIAGRAM
3/4" = 1'-0"



01 EXTERIOR EAST ELEVATION
1/16" = 1'-0"



02 EXTERIOR SOUTH ELEVATION
1/16" = 1'-0"

PLOT DATE:
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HKS

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UNIVERSITY OF MARYLAND MEDICAL SYSTEM

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Easton Replacement Hospital

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Baltimore, MD 21201

Shore Health System
219 S. Washington Street
Easton, MD 21601

OWNER'S CONSULTANT
FM Global
2100 Reston Parkway, Suite 600
Reston, VA 20191

INTERIM REVIEW ONLY

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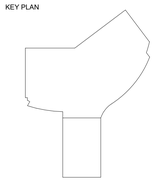
Architect: Shannon B. Kraus
Arch. Reg. No.: 16103
Date: 10/25/2022

KEY PLAN



PLAN NORTH TRUE NORTH

REVISION

NO.	DESCRIPTION	DATE

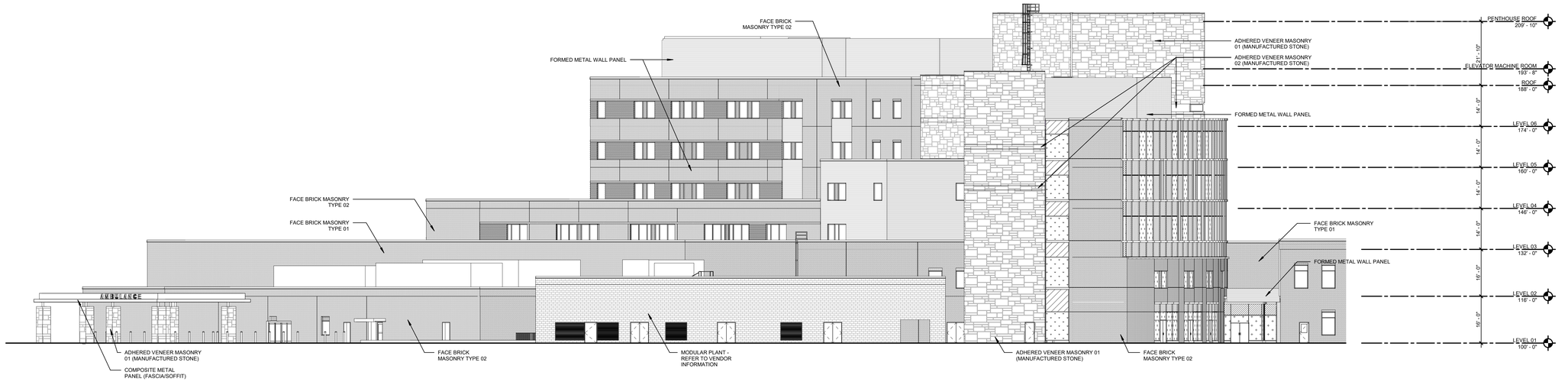
HKS PROJECT NUMBER
19782.010

DATE
JANUARY 6, 2023

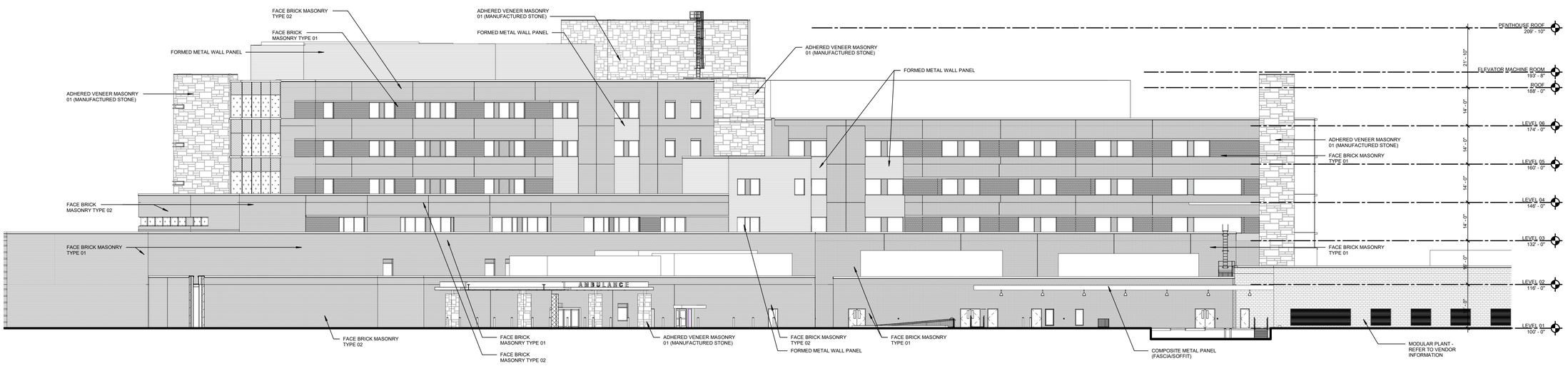
ISSUE
CON SUBMISSION

SHEET TITLE
EXTERIOR ELEVATIONS

SHEET NO.
A5.010



01 EXTERIOR WEST ELEVATION
1/16" = 1'-0"



02 EXTERIOR NORTH ELEVATION
1/16" = 1'-0"

PLOT DATE:
11/28/2022 4:11:28 PM

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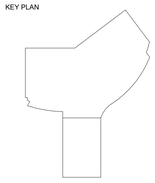
Architect: Shannon B. Kraus
Arch. Reg. No.: 16103
Date: 10/25/2022

KEY PLAN



PLAN NORTH TRUE NORTH

REVISION

NO.	DESCRIPTION	DATE

HKS PROJECT NUMBER
19782.010

DATE
JANUARY 6, 2023

ISSUE
CON SUBMISSION

SHEET TITLE
EXTERIOR ELEVATIONS

SHEET NO.
A5.020

DIAGNOSTIC / TREATMENT
PUBLIC / ADMINISTRATIVE
BUILDING SERVICES
PATIENT CARE UNITS
OUTPATIENT CLINICS

EMERGENCY DEPARTMENT
21186 SF

EMERGENCY DEPARTMENT
247 SF

MARYLAND EXPRESS CARE
372 SF

IMAGING
12334 SF

SUPPORT SERVICES
358 SF

SUPPORT SERVICES
4626 SF

A5.020/ 02

OBSERVATION UNIT
11973 SF

EMERGENCY DEPARTMENT
140 SF

EMERGENCY DEPARTMENT
168 SF

EMERGENCY DEPARTMENT
149 SF

CARDIOVASCULAR
5952 SF

IMAGING
2378 SF

PATIENT ADVOCATE
301 SF

REGISTRATION
1784 SF

BUILDING SERVICES
229 SF

SUPPORT SERVICES
7946 SF

INFORMATION TECHNOLOGY
2046 SF

KITCHEN
7541 SF

DINING / SERVERY
5775 SF

SECURITY
930 SF

IMAGING
547 SF

SHARED
747 SF

DOCK
Not Enclosed

RECEIVING
SOIL RECEIVING STATION
PHOTO / PHARM WASTE HOLDING
MED. GAS STOR
CHEM STOR
OFFICE (SHARED)
OFFICE (SHARED)
STORAGE SUPPLY
COPY / WORK
MAIL SORTING
LAB COURIER
STAFF MAIL
WAREHOUSE
MAT. MGMT ADMIN
OFFICE
EQUIPMENT HOLDING
IT WORK
IT ADMIN
CENTRAL UTILITY PLANT

HSKP EQUIP
BED REPAIR
BED STORAGE
SOILED LINEN
CLEAN LINEN
FEMALE LOCKERS
MALE LOCKERS
BIOMED STOR
BIOMED
894 SF
BIOMED (4)
BODY HOLDING
STAFF BREAK

IDF
MEP
195 SF
CART WASH
FREEZER
COOLER
COOLER
KITCHEN
MEP
238 SF
COLD PREP
DINING
SERVERY
CLOSET
PANTRY / ROOM SERVICE
SUPERVISOR
DIRECTOR
HSKP
CHEF/ RETAIL
ADMIN
HALL
DIETICIAN
CLINICAL DIETICIAN
STORAGE
OFF.
OFF. SPVSR
FINANCIAL SERVICES
STOR.
QA
COPY
PANTRY
OFF. LAB
REGISTRATION
MANAGER OFFICE
TRANSPORT OFFICE
TOILET ALCOVE
PATIENT ADVOCATE
PATIENT ADVOCATE
KIOSKS
WAITING
SEC STOR.
SECUR OPS
STOR.
GIFT SHOP

MD EXPRESS CARE
MEC OFFICES
IMAGING CONFERENCE ROOM
UNASSIGNED
EMERGENCY MGMT STG
IR EQUIPMENT
EQUIP.
OFFICE/SECRETARIAL SUPERVISOR
IR ROOM
SCRUB
IR HOLD / PREP
MRI EQUIPMENT
MRI
MRI CONTROL
IR CONTROL
IR READ
VESTIBULE
INPATIENT HOLDING
CORRIDOR
CT SCAN
CT EQUIP
CT CTRL
CT SCAN - CLASS 2
VESTIBULE
ADA DRESS
DRESS
VEST
PAT TLT
VEST
CLEAN SUPPLY
NURSE STATION
EQUIP
OFFICE
PROCEDURE
TECH WORK
OFFICE
CT EQUIP
RF/RAD CONTROL
CONTROL
ED RAD
CORRIDOR
SOILED HOLD
RAD
ACCOMP
ALCOVE
OFFICE
OFFICE
ULTRASOUND
RF
STAFF TLT
FILES
BEER OFFICE
SCHEDULERS
COPY/WORK
RECEPTION
IMAGING WAITING
CONSULT
EQUIP. STOR
HALL
STAFF TLT
BEHAVIORAL HEALTH
B.H. HOLD
B.H. HOLD
B.H. HOLD
B.H. LOUNGE
WORK / MEDS / SUPPLY
OFFICE
VESTIBULE
INTAKE
EMS WORK
OFFICE
OFFICE
OFFICE
CONSULT
TLT / SHWR - SANE
TLT - STAFF
EXAM 23 - SANE
INTAKE/CONSULT - SANE
ALC
TLT
TLT/SHWR
DECONTAM
LOCKERS
HSKP
TLT/SH
TLT
LOUNGE
RESUS 2
RESUS 1
EQUIP
VESTIBULE
EXAM 24 - BH
PHY. WORK
NURSE STATION
MEDS
SOILED
EXAM 22 - BH
EXAM 21
EXAM 20
EXAM 19
EXAM 18
EXAM 17 - PEDS
EXAM 13 - PoS
EXAM 12 - All
TLT - All
ALC
TLT - PoS
EXAM 14
STAFF LOUNGE - CLEAN
EQUIP
NURSE STATION
EXAM 11 - All
EXAM 15
EXAM 10
TLT - All
ALC
EXAM 16 - PEDS
EXAM 3
EXAM 4
EXAM 5
EXAM 6
EXAM 7
EXAM 8
EXAM 9 - All
SOILED
NURSE STATION
RECLINER 1
RECLINER 2
RECLINER 3
RECLINER 4
ALC
LOW ACUITY
NURSE STATION
CLEAN
PAT TLT
TLT
EQUIP
RESULTS WAITING
OBSERVATION RM 1
OBSERVATION RM 2
OBSERVATION RM 3
OBSERVATION RM 4
OBSERVATION RM 5
OBSERVATION RM 6
OBSERVATION RM 7
OBSERVATION RM 8
OBSERVATION RM 9
OBSERVATION RM 10
OBSERVATION RM 11
OBSERVATION RM 12
OBSERVATION RM 13
OBSERVATION RM 14
OBSERVATION RM 15
OBSERVATION RM 16 - All
OBSERVATION RM 17
OBSERVATION RM 18
OBSERVATION RM 19
OBSERVATION RM 20
OBSERVATION RM 21
OBSERVATION RM 22
OBSERVATION RM 23
OBSERVATION RM 24
OBSERVATION RM 25
NURSE STATION
PHY. WORK
CLEAN / MEDS
LINEN / B.W.
NURSE STATION
SOILED HOLD
NURSE STATION
CLEAN / MEDS
PHY. WORK
NURSE STATION
EQUIP - ALCOVE
TLT - STAFF
FAMILY AMENITY
STAFF BREAK
STAIR #5
MEP
191 SF
ELEC RM - C
TLT/SHWR
TLT/SHWR
EXAM 25
EXAM 26
EXAM 27
HSKP
EQUIP
ED REG TOUCHDOWN
IDF
OFFICE - OBS
SWITCHBOARD
LIASON
TRIAGE
WHL CHAIR
VESTIBULE
RED WAITING
WAITING
IN COUNS
VENDING
SECURITY
STAIR #3
MEP
201 SF
ELEC 4M - 1B
CASE MANAGERS
CASES
CARDIO READ
EEG
PROMENADE
CLEAN SUPPLY
EKG TECH
EXAM
CORRIDOR
LINEN
SOILED HOLD
CONFERENCE
OFFICE, SHARED
OFFICE, NON-INV. CARDIO MGR
OFFICE, HKU DIRECTOR
OFFICE/ST DIRECTOR
STAFF LOUNGE
STAFF TLT
ADMIN
HALL
ELEVATOR 7
CORRIDOR
IMAGING
326 SF
CORRIDOR
STAFF LOUNGE
ALCOVE
CORRIDOR
STRESS
UPTAKE
HOT TLT
SUBWAIT / HOLDING
HALL
NUC MED
NUC MED CONTROL
HOT LAB
NUC MED
DIRECT EQUIP
CORRIDOR
ST TLT
HSKP
RAD READING
PRIVATE READ / OFFICE
PFT
SCHEDULE / RECORDS
COPY / SUPPORT
RECEPTION
CARDIO VASCULAR WORK (5)
ALCOVE
SCALE ALC
ECHO
ECHO
CARDIO VASCULAR WAITING
VASCULAR LAB
VASCULAR LAB
ALCOVE
MANAGER OFFICE (2)
DEPT ADMIN ASSISTANT
HALL
DIRECTOR OFFICE
CORRIDOR
STAFF LOBBY
ELEVATOR 1
ELEVATOR 2
ELEVATOR 3
ELEVATOR 4
ELEVATOR 5
ELEVATOR 6
WHEELCHAIR
SECURITY DESK
SECURITY
INFORMATION DESK
LOBBY
VEST
FIRE COMMAND CENTER
MEP
244 SF

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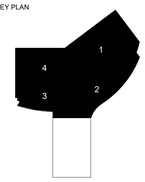
Architect: Shannon B. Kraus
Arch. Reg. No.: 16103
Date: 10/25/2022

KEY PLAN



PLAN NORTH TRUE NORTH

REVISION

NO.	DESCRIPTION	DATE

HKS PROJECT NUMBER
19782.010

DATE
JANUARY 6, 2023

ISSUE
CON SUBMISSION

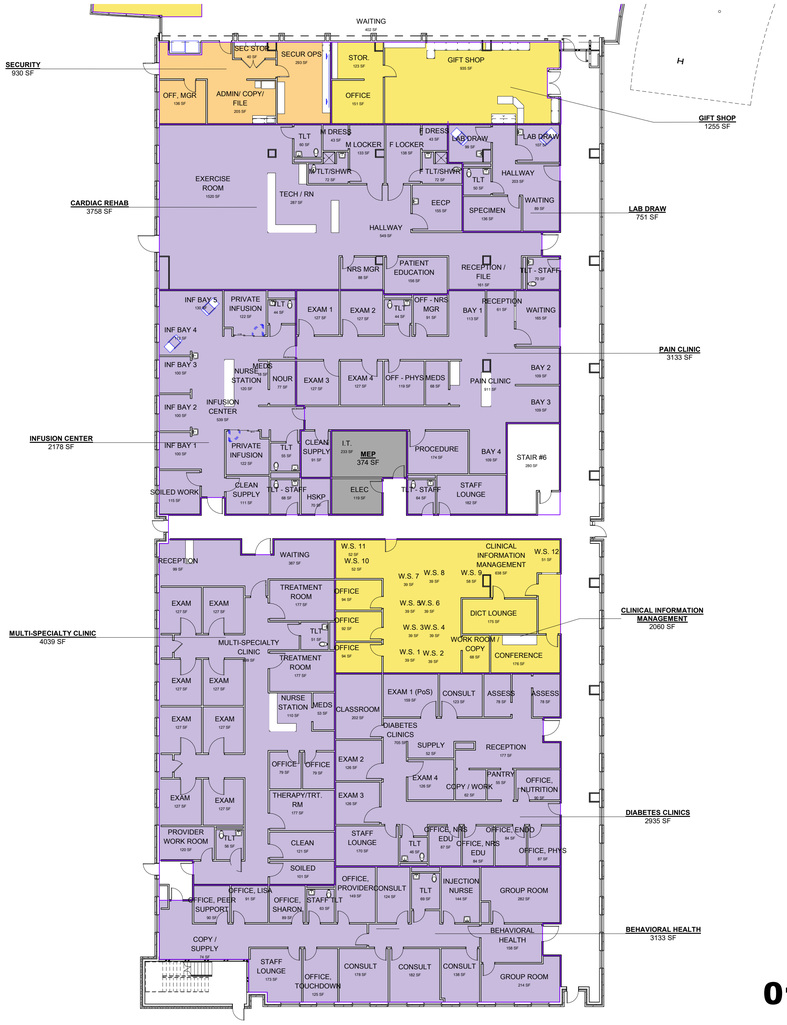
SHEET TITLE
LEVEL 01 - DEPARTMENTAL AREA PLAN SECTOR 01

CON 08

01 2022_LEVEL 01 - DEPARTMENT AREA PLAN - SECTOR 01
1/16" = 1'-0"

PLOT DATE:
11/28/2022 4:12:28 PM

DIAGNOSTIC / TREATMENT
PUBLIC / ADMINISTRATIVE
BUILDING SERVICES
PATIENT CARE UNITS
OUTPATIENT CLINICS



01 2022_LEVEL 01 - DEPARTMENT AREA PLAN - SECTOR 02

1/16" = 1'-0"

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Date: 10/25/2022

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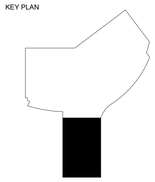

PLAN NORTH TRUE NORTH

REVISION
NO. DESCRIPTION DATE

HKS PROJECT NUMBER
19782.010

DATE
JANUARY 6, 2023

ISSUE
CON SUBMISSION

SHEET TITLE
LEVEL 01 - DEPARTMENTAL AREA PLAN SECTOR 02

CON 08A

PLOT DATE:
11/28/2022 4:12:12 PM

DIAGNOSTIC / TREATMENT
PUBLIC / ADMINISTRATIVE
BUILDING SERVICES
PATIENT CARE UNITS
OUTPATIENT CLINICS

INTERVENTIONAL
30968 SF

CENTRAL STERILE
7300 SF

PHARMACY
4843 SF

H.R.
878 SF

SHARED
478 SF

SUPPORT SERVICES
914 SF

ADMIN
1361 SF

EDUCATION
426 SF

EDUCATION
333 SF

EMPLOYEE HEALTH
930 SF

SHARED
189 SF

P.A.T.
710 SF

EDUCATION
103 SF

EDUCATION
1784 SF

CHAPEL
597 SF

SHARED
218 SF

SHARED
313 SF

SHARED
1038 SF

PREP & RECOVERY
16128 SF

MEP
156 SF

MEP
257 SF

MEP
220 SF

MEP
243 SF

MEP
244 SF

01 2022_LEVEL 02 - DEPARTMENT AREA PLAN - SECTOR 01
1/16" = 1'-0"

PLOT DATE:
1/26/2023 4:12:51 PM

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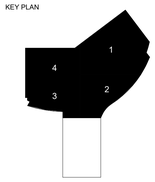
Architect: Shannon B. Kraus
Arch. Reg. No.: 16103
Date: 10/25/2022

KEY PLAN



PLAN NORTH TRUE NORTH

REVISION

NO.	DESCRIPTION	DATE

HKS PROJECT NUMBER
19782.010

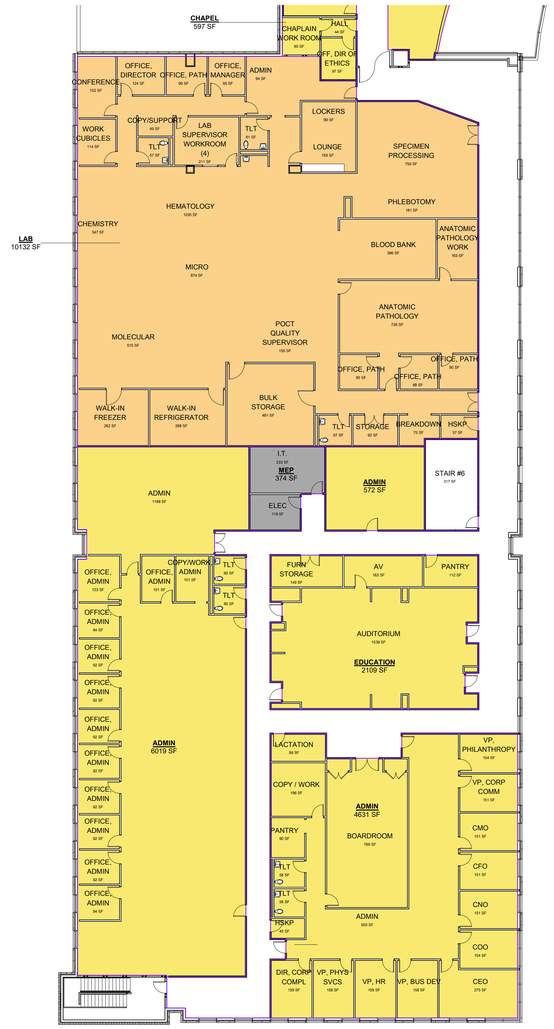
DATE
JANUARY 6, 2023

ISSUE
CON SUBMISSION

SHEET TITLE
LEVEL 02 - DEPARTMENTAL AREA PLAN SECTOR 01

CON 09

DIAGNOSTIC / TREATMENT
PUBLIC / ADMINISTRATIVE
BUILDING SERVICES
PATIENT CARE UNITS
OUTPATIENT CLINICS



01 **2022_LEVEL 02 - DEPARTMENT AREA PLAN - SECTOR 02**
1/16" = 1'-0"

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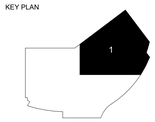
Architect: Leslie Hanson
Arch. Reg. No.: 16795
Date: 01/23/2013

KEY PLAN



PLAN NORTH TRUE NORTH

REVISION
NO. DESCRIPTION DATE

HKS PROJECT NUMBER
19782.010
DATE
JANUARY 6, 2023
ISSUE
CON SUBMISSION

SHEET TITLE
LEVEL 02 - DEPARTMENTAL AREA PLAN SECTOR 02
CON 09A

PLOT DATE:
1/26/2023 4:12:54 PM

DIAGNOSTIC / TREATMENT
PUBLIC / ADMINISTRATIVE
BUILDING SERVICES
PATIENT CARE UNITS
OUTPATIENT CLINICS

01 2022_LEVEL 03 - DEPARTMENT AREA PLAN
1/16" = 1'-0"

PLOT DATE:
1/28/2022 4:13:16 PM

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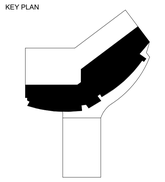
Date: 10/25/2022

KEY PLAN



PLAN NORTH TRUE NORTH

REVISION

NO.	DESCRIPTION	DATE
A	Perinatal Unit reduces to 11 Beds with adjacent 5 Bed Med/Surg Unit	Jan. 13, 2017

HKS PROJECT NUMBER
19782.010

DATE
JANUARY 6, 2023

ISSUE
CON SUBMISSION

SHEET TITLE
LEVEL 03 - DEPARTMENTAL AREA PLAN

SHEET NO.
CON 10

DIAGNOSTIC / TREATMENT
PUBLIC / ADMINISTRATIVE
BUILDING SERVICES
PATIENT CARE UNITS
OUTPATIENT CLINICS

01 2022_LEVEL 04 - DEPARTMENT AREA PLAN
1/16" = 1'-0"

PLOT DATE:
1/28/2022 4:13:30 PM

HKS

ARCHITECT
HKS, Inc.
2100 E. Cary Street, Suite 100
Richmond, VA 23223

1250 Eye Street NW, Suite 600
Washington, D.C. 20005

INTERIORS
HKS, Inc.
2100 E. Cary Street, Suite 100
Richmond, VA 23223

CIVIL
Daft McCune Walker Inc.
200 East Pennsylvania Avenue
Towson, MD 21286

MEP
Highland Associates
102 Highland Avenue
Clarks Summit, PA 18411

STRUCTURAL
O'Donnell & Naccarato
111 South Independence Mall East
Suite 950
Philadelphia, PA 19106-2524

LANDSCAPE
Mahan Rykiel Associates
The Stueff Silver Building
800 Wyman Park Drive, Suite 100
Baltimore, MD 21211

INFORMATION TECHNOLOGY
Smith Seckman Reid, Inc.
2995 Sidco Drive
Nashville, TN 37204

FOOD SERVICE
L2M FOOD SERVICE DESIGN GROUP
811 Cromwell Park Drive, Suite 113
Glen Burnie, MD 21061

MEDICAL EQUIPMENT
Mitchell Planning Associates
2794 Oakbrook Drive
Weston, FL 33332

SHORE HEALTH
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

Shore Health
Easton Replacement Hospital

OWNER
University of Maryland Health System
250 W. Pratt Street
Suite 2400
Baltimore, MD 21201

Shore Health System
219 S. Washington Street
Easton, MD 21601

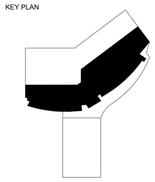
OWNER'S CONSULTANT
FM Global
2100 Reston Parkway, Suite 600
Reston, VA 20191

INTERIM REVIEW ONLY

These documents are incomplete, and are released for interim review only and are not intended for regulatory approval, permit, or construction purposes.

Architect: Shannon B. Kraus
Arch. Reg. No.: 16103
Date: 10/25/2022

KEY PLAN



PLAN NORTH TRUE NORTH

REVISION
NO. DESCRIPTION DATE

HKS PROJECT NUMBER
19782.010

DATE
JANUARY 6, 2023

ISSUE
CON SUBMISSION

SHEET TITLE
LEVEL 04 - DEPARTMENTAL AREA PLAN

SHEET NO.
CON 11

DIAGNOSTIC / TREATMENT
PUBLIC / ADMINISTRATIVE
BUILDING SERVICES
PATIENT CARE UNITS
OUTPATIENT CLINICS

01 2022_LEVEL 05 - DEPARTMENT AREA PLAN
1/16" = 1'-0"

PLOT DATE:
11/28/2022 4:13:43 PM

HKS

ARCHITECT
HKS, Inc.
2100 E. Cary Street, Suite 100
Richmond, VA 23223

1250 Eye Street NW, Suite 600
Washington, D.C. 20005

INTERIORS
HKS, Inc.
2100 E. Cary Street, Suite 100
Richmond, VA 23223

CIVIL
Daft McCune Walker Inc.
200 East Pennsylvania Avenue
Towson, MD 21286

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O'Donnell & Naccarato
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Nashville, TN 37204

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Easton, MD 21601

OWNER'S CONSULTANT
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2100 Reston Parkway, Suite 600
Reston, VA 20191

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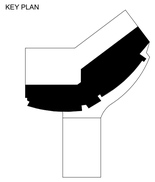
Architect: Shannon B. Kraus
Arch. Reg. No.: 16103
Date: 10/25/2022

KEY PLAN



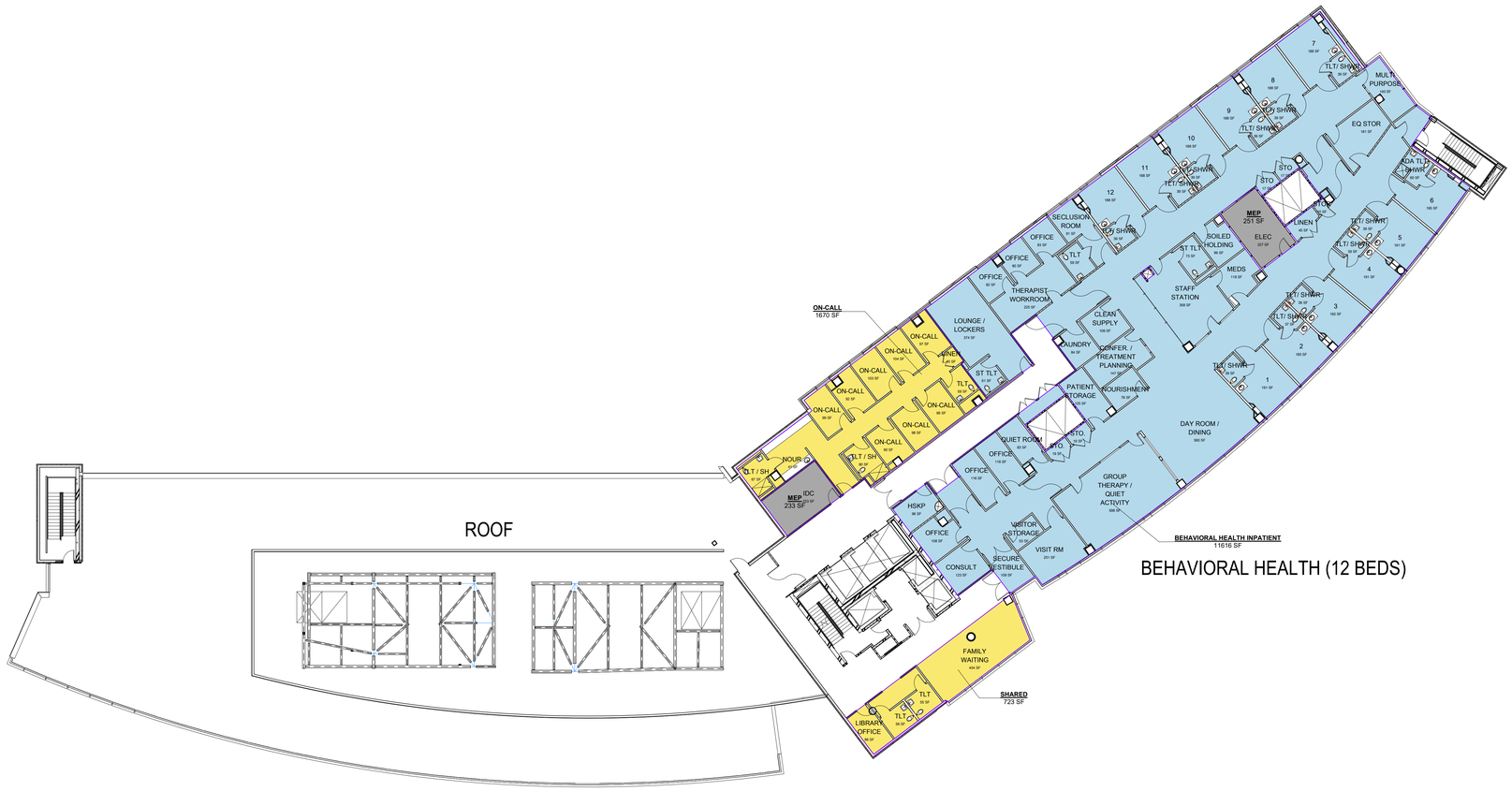
PLAN NORTH TRUE NORTH

REVISION
NO. DESCRIPTION DATE

HKS PROJECT NUMBER
19782.010
DATE
JANUARY 6, 2023
ISSUE
CON SUBMISSION

SHEET TITLE
LEVEL 05 - DEPARTMENTAL AREA PLAN
SHEET NO.
CON 012

DIAGNOSTIC / TREATMENT
PUBLIC / ADMINISTRATIVE
BUILDING SERVICES
PATIENT CARE UNITS
OUTPATIENT CLINICS



01 2022_LEVEL 06 - DEPARTMENT AREA PLAN
1/16" = 1'-0"

PLOT DATE:
1/26/2023 4:13:52 PM

HKS

ARCHITECT
HKS, Inc.
2100 E. Cary Street, Suite 100
Richmond, VA 23223

1250 Eye Street NW, Suite 600
Washington, D.C. 20005

INTERIORS
HKS, Inc.
2100 E. Cary Street, Suite 100
Richmond, VA 23223

CIVIL
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200 East Pennsylvania Avenue
Towson, MD 21286

MEP
Highland Associates
102 Highland Avenue
Clarks Summit, PA 18411

STRUCTURAL
O'Donnell & Naccarato
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Suite 950
Philadelphia, PA 19106-2524

LANDSCAPE
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The Stueff Silver Building
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Baltimore, MD 21211

INFORMATION TECHNOLOGY
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811 Cromwell Park Drive, Suite 113
Glen Burnie, MD 21061

MEDICAL EQUIPMENT
Mitchell Planning Associates
2794 Oakbrook Drive
Weston, FL 33332

SHORE HEALTH
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

Shore Health
Easton Replacement Hospital

OWNER
University of Maryland Health System
250 W. Pratt Street
Suite 2400
Baltimore, MD 21201

Shore Health System
219 S. Washington Street
Easton, MD 21601

OWNER'S CONSULTANT
FM Global
2100 Reston Parkway, Suite 600
Reston, VA 20191

INTERIM REVIEW ONLY

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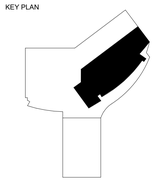
Architect: Shannon B. Kraus
Arch. Reg. No.: 16103
Date: 10/25/2022

KEY PLAN



PLAN NORTH TRUE NORTH

REVISION
NO. DESCRIPTION DATE

HKS PROJECT NUMBER
19782.010

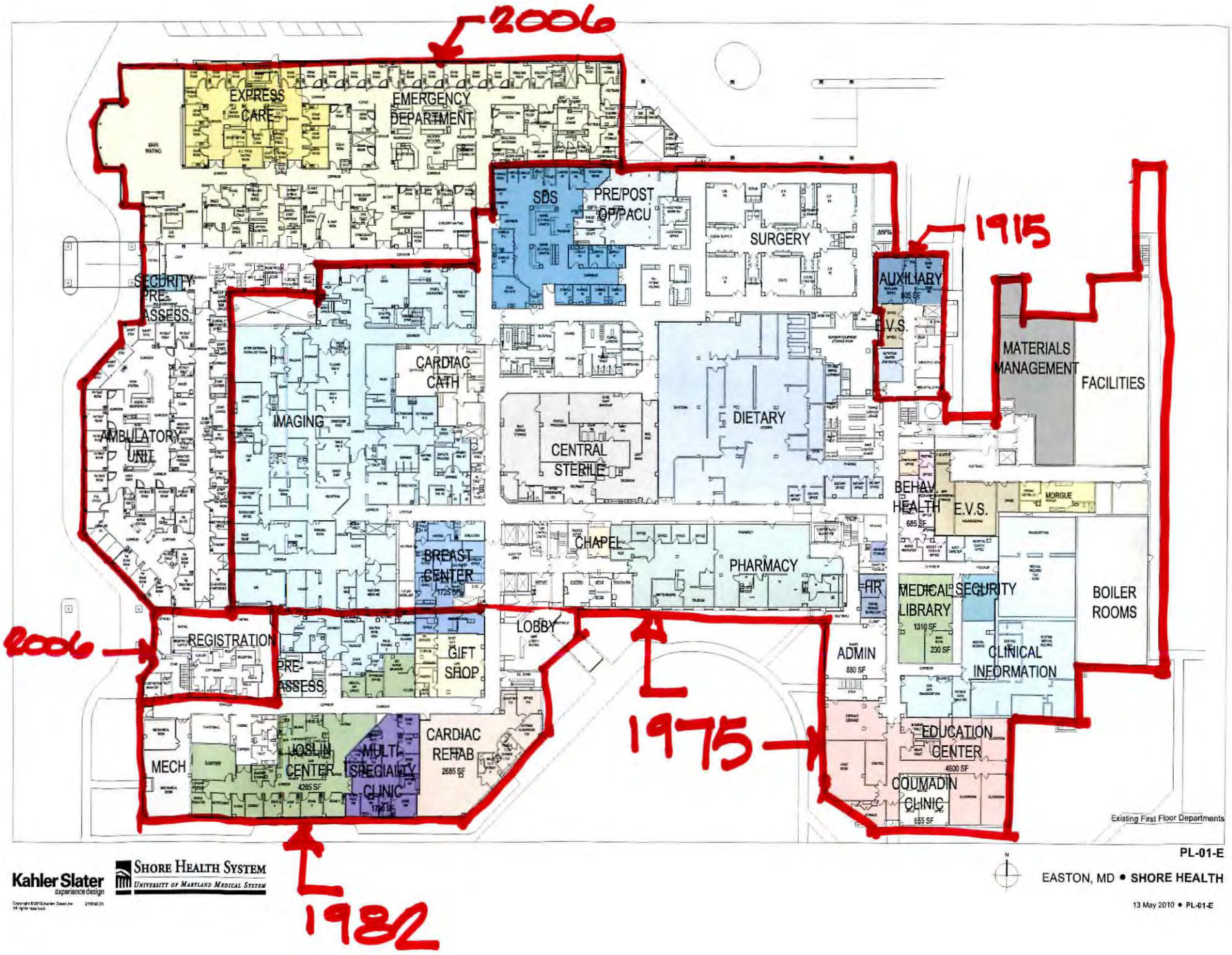
DATE
JANUARY 6, 2023

ISSUE
CON SUBMISSION

SHEET TITLE
LEVEL 06 - DEPARTMENTAL AREA PLAN

SHEET NO.
CON 013

EXHIBIT 3



Kahler Slater experience design

Shore Health System
University of Maryland Medical System

EXHIBIT 4

TALBOT COUNTY FINANCE OFFICE
RECORDATION TAX
AMT: $29580.00
DATE: 10/28/2015
INITIALS: DPierce
Prop ID: Multiple Parcels

EXEMPT FROM COUNTY TRANSFER TAX PURSUANT TO SECTION 172-17 OF THE TALBOT COUNTY CODE (CONVEYANCE BY A POLITICAL SUBDIVISION OF THE STATE)

DEED

THIS DEED is dated as of October 23, 2015, from **TALBOT COUNTY, MARYLAND**, a charter county and political subdivision of the State of Maryland ("Grantor"), to **SHORE HEALTH SYSTEM, INC.**, a Maryland corporation ("Grantee").

THE GRANTOR, for a consideration of TWO MILLION, FOUR HUNDRED SIXTY FOUR THOUSAND SIX HUNDRED FIFTY SEVEN AND 53/100 DOLLARS ($2,464,657.53), grants, conveys and assigns to the Grantee, its successors and assigns, in fee simple, the real property located in Talbot County, Maryland, and described as follows:

PARCEL ONE:

All that lot or parcel of land containing 12.538 acres and being shown and designated as Lot 1 on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 461.

PARCEL TWO:

All that lot or parcel of land containing 19.800 acres and being shown and designated as Lot 2 on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 460, which lot includes the area of land designed on such plat as "Part of Parcel 38 to be Conveyed to Lot 2, 0.013 acres ±".

PARCEL THREE:

All that lot or parcel of land containing 77.075 acres and being shown and designated as Lot 3 on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, pages 461 and 462.

PARCEL FOUR:

All that lot or parcel of land containing 89.710 acres and being shown and designated as Lot 5 on those plats entitled "Plat of Subdivision, Lot 1 through 7,

Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, pages 463 and 464.

PARCEL FIVE:

All that lot or parcel of land containing 1.029 acres and being shown and designated as Parcel A on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 460.

PARCEL SIX:

All that lot or parcel of land shown and designated as "Land Intended to be Dedicated to the State Highway Administration, 3.826 acres," on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 460, which lot includes the area of land designed on such plat as "Part of Parcel 38 to be Dedicated to the State Highway Administration 0.032 acres ±."

PARCEL SEVEN:

All that lot or parcel of land shown and designated as "SWM Parcel 5A, Land Intended to be Dedicated to the State Highway Administration, 3.679 acres," on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 460.

PARCEL EIGHT:

All that lot or parcel of land shown and designated as "Medical Center Drive (Commercial Local Street) SHA Plat 59004 Variable Width" and "Relocated Md. Rte. 662C (Rural Local Roadway) SHA Plats 59003 and 59004 Variable Width", "Land Intended to be Dedicated to the State Highway Administration, 5.976 acres," on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 460.

THIS IS TO CERTIFY THAT THE PROPERTY DESCRIBED HEREIN HAS BEEN TRANSFERRED ON THE ASSESSMENT RECORDS OF TALBOT COUNTY.

DAVID H. EWING
SUPERVISOR OF ASSESSMENTS
PER R ANDREW HOLLIS, FIN. OFFICER cc 2
10/28/2015cc

CERTIFICATION IS MADE THAT ALL TAXES DUE ON THE PROPERTY INDICATED IN THIS DEED HAVE BEEN PAID.
FINANCE OFFICER OF TALBOT COUNTY
R ANDREW HOLLIS, FIN. OFFICER cc
DATE 10/28/2015cc

LIBER2304 FOLIO433

PARCEL NINE:

All that lot or parcel of land shown and designated as "Relocated Md. Rte. 662C (Rural Local Roadway) SHA Plats 59004 and 59005 Variable Width", "Land Intended to be Dedicated to the State Highway Administration, 3.354 acres," on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 461.

PARCEL TEN:

All that lot or parcel of land shown and designated as "SWM Parcel 4B, Land Intended to be Dedicated to the State Highway Administration, 1.509 acres," on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 461.

PARCEL ELEVEN:

All that lot or parcel of land shown and designated as "SWM Parcel 4A, Land Intended to be Dedicated to the State Highway Administration, 4.809 acres," on those plats entitled "Plat of Subdivision, Lot 1 through 7, Parcel A and Revised Tax Parcel 38," Sheets 1 through 7, recorded among the Land Records of Talbot County, Maryland, at Plat Cabinet MAS No. 83, pages 458 through 464, the subject parcel being depicted on Plat MAS No. 83, page 461.

FOR TITLE, SEE: (i) Confirmatory Deed from Talbot County, Maryland, to Talbot County, Maryland, dated August 10, 2007, and recorded among the Land Records of Talbot County, Maryland, in Liber MAS 2005, folio 139; being all the same property contained in Deed from Carole Parris Young and Clarke L. Parris by W. Thomas Fountain, Attorney-in-Fact to Talbot County, Maryland, dated December 16, 2005, and recorded among the Land Records of Talbot County, Maryland, in Liber MAS 1402, folio 672; and (ii) Deed from Ann Littleton O'Brien, Carole Parris and Clarke L. Parris to Talbot County, Maryland, dated August 8, 1988, and recorded among the Land Records of Talbot County, Maryland, in Liber MAS 656, folio 127; and (iii) Deed from Nettie Marie Jones to Talbot County, Maryland, dated March 25, 1977, and recorded among the Land Records of Talbot County, Maryland, in Liber JTB 510, folio 339; and (iv) Deed from Clarke L. Parris and Carole Parris Young to Talbot County, Maryland, dated January 18, 2008, and recorded among the Land Records of Talbot County, Maryland, in Liber MAS 1597, folio 343.

TOGETHER WITH all improvements thereupon, and the rights, alleys, ways, waters, easements, privileges, appurtenances and advantages belonging or appertaining thereto.

TO HAVE AND TO HOLD the real property hereby conveyed to the Grantee, its successors and assigns, in fee simple, forever.

THE FOREGOING CONVEYANCE was duly authorized and is hereby made in accordance with law: the Talbot County Council has duly authorized the same by adoption of Resolution No. 153 on July 8, 2008, following a public hearing held on June 10, 2008 and continued to June 24, 2008 and July 8, 2008, which hearing was duly advertised, including the proposed terms of this conveyance and compensation to be received and the opportunity to comment or object, on May 16, 23 and 30, 2008 in *The Star Democrat*, a newspaper printed and regularly circulated in Talbot County, Maryland.

BUT SUBJECT, HOWEVER, to the following restrictive covenants, conditions, and reservations, which covenants, conditions, restrictions and reservations shall apply to and run with and bind the land hereby conveyed, as follows:

FIRST, a covenant that the real property shall be used only for agriculture and/or regional health care facilities, including, at a minimum an acute care hospital, and related medical and support uses consistent with uses permitted under a Regional Health Care or similar zoning district adopted by the Town of Easton.

SECOND, a covenant that, within five (5) years following the date hereof, Grantee shall commence planning and design of an acute care hospital on the property hereby conveyed ("Property"). Except for delays caused by *force majeure*, if construction of an acute care hospital is not substantially completed within fifteen (15) years after the date hereof, Grantor shall have the right at any time within five (5) years thereafter to require Grantee to convey the Property to Grantor. Upon Grantor's written notice to Grantee that it wishes to reacquire the Property, Grantee shall transfer the Property to Grantor within ninety (90) days and Grantor shall return to Grantee the consideration (set forth hereinabove) paid by Grantee to Grantor for the Property. If Grantor does not give written notice within the five (5) year period, this covenant is extinguished and of no further force and effect.

THIRD: The above restrictive covenants shall be subordinated to any lien or other instrument securing any loan, bond issue, or other financing obtained and used to construct an acute care hospital and related or supporting facilities, so that, in the event of a *bona fide* default in the repayment of any secured obligation incurred to obtain construction financing, and sale of the Property under the terms of any instrument securing performance of that financial obligation, the Property may be sold by the secured party at such sale free and clear of the covenant.

FOURTH: This grant and conveyance is subject to a certain Annexation Agreement and Public Facilities Agreement dated December 8, 2009 by and between the TOWN OF EASTON, a Maryland municipal corporation ("Town"), Grantor and Grantee, recorded among the Land Records of Talbot County, Maryland, at Liber MAS 1757, folio 12-90, and to the terms of Town Resolution No. 5955, "A RESOLUTION TO ANNEX CERTAIN LANDS OWNED BY TALBOT COUNTY, MARYLAND, INTO THE TOWN OF EASTON LOCATED ON THE WEST SIDE OF US ROUTE 50 AND CONSISTING OF 276.479 ± ACRES OF LAND, MORE OR LESS, AND TO PROVIDE FOR THE TERMS AND CONDITIONS OF THE ANNEXATION", recorded among the Land Records of Talbot County, Maryland, at Liber MAS

1768, folio 252-271.

FIFTH: This grant and conveyance is subject to a certain Development Rights and Responsibilities Agreement by and between the Town, Grantor and Grantee recorded among the Land Records of Talbot County Maryland, at Liber MAS 2206, folio 266-398, which includes, among others and without limitation, the following terms, covenants, conditions, and restrictions:

(A) Reference to the Development Rights and Responsibilities Agreement shall be included in any deed for all or portion(s) of the Property during the Term of such Agreement, but failure to include such reference shall not impact the effectiveness of the Development Rights and Responsibilities Agreement. (Liber 2206, folio 284, Para. 2.6.2).

(B) If Shore Health System, Inc., proceeds with Development of the Property, initial construction, other than grading, drainage and infrastructure improvements, shall include construction of at least the first phase of an "accredited acute care hospital" (as defined by the Annexation Agreement) on the Property. When all phases of construction of the hospital are complete, the "accredited acute care hospital" constructed on the Property shall contain at least 100 beds. (Liber 2206, folio 286, Para. 2.9(c)).

(C) In the event of any transfer of land located in Section One prior to Development of an acute care hospital on the Property, such transferee shall also demonstrate, to the Town and County's reasonable satisfaction, the transferee's capability to Develop the minimum acute care hospital and infrastructure required by the Annexation Agreement and this Agreement. (Liber 2206, folio 284, Para. 2.6.3).

THE GRANTOR covenants to warrant specially the real property hereby conveyed, and to execute such further assurances of the real property as may be requisite.

THE GRANTOR claims exemption from the tax withholding requirements of Md. Tax-General Art. §10-912 and whose representative certifies under the penalties of perjury, that such Grantor, being the Transferor hereunder, is a charter county and political subdivision of the State of Maryland.

AND THE GRANTEE joins herein for the purpose of expressly covenanting and agreeing that the covenants, conditions, restrictions and reservations set forth in this Deed shall be binding upon the said Grantee, its successors and assigns, and upon the real property hereby conveyed.

SIGNATURES ON FOLLOWING PAGES

IN WITNESS WHEREOF the Grantor has caused this Deed to be duly executed on its behalf by a duly authorized representative.

GRANTOR:

TALBOT COUNTY, MARYLAND

By: _____
Corey W. Pack, President
Talbot County Council

Acknowledgement

STATE OF MARYLAND, COUNTY OF TALBOT, TO WIT:

I HEREBY CERTIFY, that on this 26th day of October, 2015, before me, the subscriber, a Notary Public of the State of Maryland, personally appeared COREY W. PACK, who acknowledged himself to be the President of the TALBOT COUNTY COUNCIL, the chief executive of Talbot County, Maryland, a charter county and political subdivision of the State of Maryland, and that he as such President, being authorized so to do, executed the foregoing Deed for the purposes therein contained by signing the name of said Talbot County, Maryland, by himself as President.

AS WITNESS my hand and Notarial seal.

Susan W. Moran
Notary Public

My commission expires: 3/6/2017

SUSAN W. MORAN NOTARY PUBLIC TALBOT COUNTY, MD

AND IN WITNESS WHEREOF the Grantee joins herein for the purpose of expressly covenanting and agreeing that the covenants, conditions, restrictions and reservations set forth in this Deed shall be binding upon the said Grantee, its successors and assigns, and upon the real property hereby conveyed.

GRANTEE:

SHORE HEALTH SYSTEM, INC.

By: _____
Kenneth D. Kozel, President and CEO

Acknowledgement

STATE OF MARYLAND, COUNTY OF TALBOT, TO WIT:

I HEREBY CERTIFY, that on this 21st day of October, 2015, before me, a Notary Public of the aforesaid State, personally appeared KENNETH D. KOZEL, President and CEO of Shore Health System, Inc., who was known to me (or satisfactorily proven) to be the person whose name is subscribed to the foregoing Deed, and acknowledged that he executed the same for the purposes therein contained as the fully authorized agent of said Shore Health System, Inc.

WITNESS my hand and Notarial Seal.

My Commission expires: 1/27/2016

_____
Notary Public

LINDA E. RUANE NOTARY PUBLIC TALBOT COUNTY, MD MY COMMISSION EXPIRES 01-27-2016

Agricultural Transfer Tax

Amount $ -0-

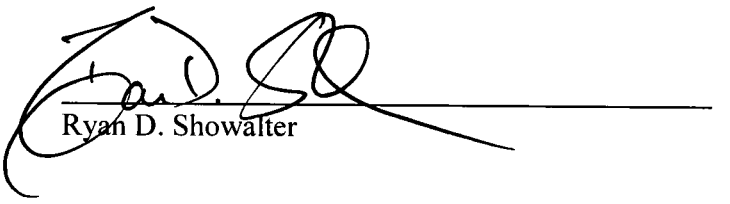
Signature R ANDREW HOLLIS, FIN. OFFICER ac
10/28/2015 ac

Agricultural Transfer Tax Due in the Amount of $ _____

David H. Ewing
Supervisor of Assessments
Per _____

Attorney Certification

This instrument has been prepared by the undersigned, an attorney duly admitted to practice before the Court of Appeals of Maryland.



Ryan D. Showalter

Return recorded document to:
Pamela C. Raymond
Miles & Stockbridge P.C.
100 Light Street, 4th Floor
Baltimore, Maryland 21202

Mary Ann Shortall, Clerk
Circuit Court For Talbot County
11 N. Washington St., Suite 16
Easton, Maryland 21601

License and Recording
(410) 822-2611 Ext. 4

```
LR - Deed (w Taxes)
Recording Fee no RT
                    20.00
Grantor/Grantee Name:
TalbotCo/Shore Health
Reference/Contro) #:
2304/432
LR - Deed (with Taxes)
Surcharge           40.00
LR - Deed State
Transfer Tax 12,323.29
LR - County Transfer
Tax - linked         0.00
LR - Non-Resident Tax
- linked             0.00
=========================
SubTotal:     12,383.29
=========================
Total:        12,383.29
10/28/2015  04:09
                   CC20-LL
#5077430 CC0205 -
Talbot
County/CC02.05.02 -
Register 02
```

DOCUMENT VALIDATION
(excluded from page count)

State of Maryland Land Instrument Intake Sheet

[ ] City [X] County: Talbot

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

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

1 Type(s) of Instruments ([ ] Check Box if Addendum Intake Form is Attached.)

X	Deed		Mortgage		Other		Other
	Deed of Trust		Lease				

2 Conveyance Check Box

	Improved Sale Arms-Length *[1]*	X	Unimproved Sale Arms-Length *[2]*		Multiple 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	
Purchase Price/Consideration	$ 2,464,657.53	**Transfer and Recordation Tax Consideration**	
Any New Mortgage	$	**Transfer Tax Consideration**	$
Balance of Existing Mortgage	$	x ( ) % =	$
Other:	$	**Less Exemption Amount** -	$
		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	$ 20.00	$	**Agent:**
Surcharge	$ 40.00	$	**Tax Bill:**
State Recordation Tax	$ 29,580.00	$	
State Transfer Tax	$ 12,323.29	$	**C.B. Credit:**
County Transfer Tax	$	$	
Other	$	$	**Ag. Tax/Other:**
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	Map	Parcel No.	Var. LOG
	See attached.				

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

Location/Address of Property Being Conveyed (2)

Longwoods Road

Other Property Identifiers (if applicable)

Longwoods Road – N of Easton

Residential [ ] or Non-Residential [X] AG | **Fee Simple [X] or Ground Rent [ ] Amount:**

Partial Conveyance? [ ] Yes [X] No | Description/Amt. of SqFt/Acreage Transferred:

If Partial Conveyance, List Improvements Conveyed:

7 Transferred From & To

Doc. 1 – Grantor(s) Name(s)	Doc. 2 – Grantor(s) Name(s)
Talbot County, Maryland	
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 & From

Doc. 1 – Grantee(s) Name(s)	Doc. 2 – Grantee(s) Name(s)
Shore Health System, Inc.	

New Owner's (Grantee) Mailing Address

219 S. Washington Street, Easton, Maryland 21601

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: Ryan D. Showalter
Firm: Miles & Stockbridge, P.C.
Address: 101 Bay Street, Suite 2, Easton, Maryland 21601
Phone: 410-820-0259

[X] 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 [X] No Will the property being conveyed be the grantee's principal residence?
[ ] Yes [X] No Does transfer include personal property? If yes, identify: _____
[X] Yes [ ] No Was property surveyed? If yes, attach copy of survey (if recorded, no copy required)

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

REMARKS:

LIBER2304 FOLIO441

4843-2727-0694

Intake Sheet Continuation Page

Talbot County, Maryland and Shore Health System, Inc.
Longwoods Road

6. Description of Property

Property	District	Tax ID No.	Grantor Liber/folio	Map	Parcel/Acreage
Longwoods Road	01	01-040650	2005/139	0017	0075 12.538 AC – Lot 1 on subdivision plat
Longwoods Road	01	01-040650	2005/139	0017	0075 19.800 AC – Lot 2 on subdivision plat
Longwoods Road	01	P/O 01-040650 01-113771	2005/139 1597/343	0017	0075 0129 77.075 AC - Lot 3 on subdivision plat
Longwoods Road	01	01-113771	1597/343	0017	0129 89.710 AC – Lot 4 on subdivision plat
Longwoods Road	01	01-040650	2005/139	0017	0075 1.029 AC – Parcel A on subdivision plat
Longwoods Road	01	01-040650	2005/139	0017	0075 3.826 AC – Land intended to be dedicated to State Highway Administration on subdivision plat
Longwoods Road	01	01-040650	2005/139	0017	0075 3.679 AC – SWM Parcel 5A on subdivision plat
Longwoods Road	01	01-040650	2005/139	0017	0075 5.976 AC – Medical Center Drive on subdivision plat
Longwoods Road	01	01-040650	2005/139	0017	0075 3.354 AC – Relocated MD Rte. 662C on subdivision plat

Longwoods Road	01	01-040650	2005/139	0017	0075 1.509 AC – SWM Parcel 4B on subdivision plat
Longwoods Road	01	01-040650	2005/139	0017	0075 4.809 AC – SWM Parcel 4A on subdivision plat

EXHIBIT 5

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	ADMINISTRATIVE POLICY & PROCEDURE	POLICY NO:	LD-66
		REVISED:	03/19
	PUBLIC DISCLOSURE OF CHARGES	PAGE #:	1 of 2
		SUPERSEDES	11/12

SCOPE

This policy applies to Shore Health System ("SHS") acute care hospitals located in the State of Maryland; University of Maryland Shore Medical Center at Chestertown, University of Maryland Shore Medical Center of Dorchester and University of Maryland Shore Medical Center at Easton.

PURPOSE

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

BENEFITS

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

1.0 POLICY

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

2.0 PROCEDURE

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

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

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

Effective	09/12
Revised	11/12 (Minor Editorial Revision)
Reviewed	03/19
Approved	JoAnne Hahey, Sr. Vice President / CFO

EXHIBIT 6

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Estimated Charges for Inpatient Admissions

APR DRG		Charge Range		Estimated Average Charge
		Minimum	Maximum	
APR DRG	**Shore Medical Center at Easton - Psychiatric Cases**			
775	Alcohol abuse & dependence	$ 5,913	$ 45,126	$ 15,579
751	Major depressive disorders & other/unspecified psychoses	$ 5,691	$ 25,615	$ 12,415
753	Bipolar disorders	$ 6,415	$ 19,773	$ 11,162
750	Schizophrenia	$ 8,522	$ 27,233	$ 13,556
773	Opioid abuse & dependence	$ 15,390	$ 50,559	$ 26,097
770	Drug & alcohol abuse or dependence, left against medical advice	$ 8,107	$ 14,214	$ 11,160
752	Disorders of personality & impulse control	$ 8,110	$ 8,110	$ 8,110
APR DRG	**Shore Medical Center at Easton - Medical/Surgical Cases**			
720	Septicemia & disseminated infections	$ 5,178	$ 144,925	$ 31,206
137	Major respiratory infections & inflammations	$ 3,269	$ 186,385	$ 30,073
133	Respiratory Failure	$ 8,369	$ 184,902	$ 30,091
174	Percutaneous coronary intervention w AMI	$ 10,746	$ 76,485	$ 25,430
241	Peptic ulcer & gastritis	$ 5,483	$ 73,465	$ 17,651
871	Septicemia Or Severe Sepsis Without Mv >96 Hours With Mcc	$ 8,706	$ 94,577	$ 29,020
139	Other pneumonia	$ 4,831	$ 80,296	$ 23,877
308	Hip and femur fracture repair	$ 11,977	$ 49,526	$ 24,807
194	Heart failure	$ 4,573	$ 127,534	$ 28,237
231	Major Large Bowel Procedures	$ 16,936	$ 144,102	$ 42,735
APR DRG	**Shore Medical Center at Easton - Pediatric Cases**			
138	Bronchiolitis & RSV pneumonia	$ 3,997	$ 6,354	$ 5,175
139	Other pneumonia	$ 8,423	$ 15,875	$ 12,149
145	Acute Bronchitis And Related Symptoms	$ 10,703	$ 10,703	$ 10,703

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Estimated Charges for Inpatient Admissions

		Charge Range		
		Minimum	Maximum	Estimated Average Charge
248	Major gastrointestinal & peritoneal infections	$ 8,406	$ 8,406	$ 8,406
421	Malnutrition, failure to thrive & other nutritional disorders	$ 6,777	$ 6,777	$ 6,777
424	Other endocrine disorders	$ 8,222	$ 8,222	$ 8,222
723	Viral illness	$ 5,687	$ 5,687	$ 5,687
APR DRG	**Shore Medical Center at Easton - Obstetric Cases**			
560	Vaginal delivery	$ 3,525	$ 24,312	$ 11,746
540	Cesarean delivery	$ 6,005	$ 35,726	$ 13,987
542	Vaginal delivery w complicating procedures exc sterilization &/or D&C	$ 8,609	$ 24,932	$ 14,996
561	Postpartum & post abortion diagnoses w/o procedure	$ 6,287	$ 8,796	$ 7,541
541	Vaginal delivery w sterilization &/or D&C	$ 20,096	$ 20,096	$ 20,096
564	Abortion w/o D&C, aspiration curettage or hysterotomy	$ 4,686	$ 4,686	$ 4,686
566	Other antepartum diagnoses	$ 4,391	$ 4,391	$ 4,391
APR DRG	**Shore Medical Center at Easton - Rehabilitation Cases**			
860	REHABILITATION	$ 8,706	$ 94,577	$ 29,020

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Estimated Charges for Inpatient Admissions

APR DRG	Shore Medical Center at Chestertown - Medical/Surgical Cases	Charge Range Minimum	Charge Range Maximum	Estimated Average Charge
720	Septicemia & disseminated infections	$ 4,228	$ 135,079	$ 41,160
137	Major respiratory infections & inflammations	$ 8,517	$ 61,242	$ 35,079
194	Heart failure	$ 10,387	$ 26,219	$ 19,200
463	Kidney & urinary tract infections	$ 12,008	$ 28,408	$ 21,877
139	Other pneumonia	$ 17,221	$ 43,905	$ 28,182
426	Non-Hypovolemic Sodium Disorders	$ 14,592	$ 28,089	$ 20,933
469	Acute Kidney Injury #	$ 10,332	$ 25,340	$ 17,425
140	Chronic obstructive pulmonary disease	$ 14,258	$ 40,145	$ 30,177
662	Sickle cell anemia crisis	$ 21,549	$ 32,162	$ 27,956
248	Major gastrointestinal & peritoneal infections	$ 21,061	$ 26,015	$ 22,731

University of Maryland Shore Regional Health

Estimated Charges for Common Inpatient Procedures

ICD-10 Code	Procedure	Charge Range		Estimated Average Charge
		Minimum	Maximum	
Shore Medical Center at Easton				
Z3800	Single liveborn infant, delivered	$ 1,246	$ 13,129	$ 3,359
A419	Sepsis, unspecified organism	$ 5,178	$ 379,289	$ 41,236
U071	COVID-19	$ 3,269	$ 317,810	$ 38,215
Z3801	Single liveborn infant, delivered	$ 2,089	$ 11,774	$ 3,740
O34211	Matern care for low transverse sca	$ 6,005	$ 20,851	$ 10,685
I214	Non-ST elevation (NSTEMI) myocardi	$ 4,841	$ 65,197	$ 22,619
O134	Gestatnl htn without significant p	$ 8,809	$ 23,955	$ 14,841
O365930	Matern care for oth or susp poor f	$ 7,324	$ 22,387	$ 12,962
O480	Post-term pregnancy	$ 8,354	$ 24,932	$ 13,302
J189	Pneumonia, unspecified organism	$ 5,784	$ 233,764	$ 31,610
Shore Medical Center at Chestertown				
U071	COVID-19	$ 8,517	$ 61,242	$ 35,528
I110	Hypertensive heart disease with he	$ 10,387	$ 20,077	$ 17,570
J690	Pneumonitis due to inhalation of f	$ 20,502	$ 59,699	$ 34,450
A4151	Sepsis due to Escherichia coli [E.	$ 20,812	$ 38,826	$ 27,693
N179	Acute kidney failure, unspecified	$ 10,332	$ 25,340	$ 17,425
A419	Sepsis, unspecified organism	$ 34,907	$ 135,079	$ 66,122
A0472	Enterocolitis d/t Clostridium diff	$ 21,061	$ 26,015	$ 22,731
T83511A	I/I react d/t indwelling urethral	$ 24,706	$ 76,023	$ 44,293
D5700	Hb-SS disease with crisis, unspeci	$ 21,549	$ 32,162	$ 27,956
J189	Pneumonia, unspecified organism	$ 17,221	$ 29,755	$ 23,456

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT EASTON
Estimated Charges for Common Ancillary Services

LABORATORY

Procedure	Estimated Charge
Complete cbc w/auto diff wbc	$ 34.98
Comprehen metabolic panel	$ 52.08
Assay of magnesium	$ 21.20
Assay of troponin quant	$ 107.52
Urinalysis auto w/scope	$ 31.35
Metabolic panel total ca	$ 39.16
infectious agent detection by nucleic a	$ 74.28
Prothrombin time	$ 27.99
Assay of lipase	$ 27.92
Infectious agent detection by nucleic a	$ 143.57
Thromboplastin time partial	$ 29.64
Assay of natriuretic peptide	$ 106.01
Assay of phosphorus	$ 6.97
Tissue exam by pathologist	$ 468.34
Assay thyroid stim hormone	$ 52.47
Drug test prsmv chem anlyzr	$ 145.98
Assay of lactic acid	$ 83.65
Urine culture/colony count	$ 69.91
Urine pregnancy test	$ 34.35
Drug screen quantalcohols	$ 52.64
Assay of ck (cpk)	$ 21.36
Blood culture for bacteria	$ 241.89
Blood typing serologic abo	$ 13.80
Blood typing serologic rh(d)	$ 13.80
Fibrin degradation quant	$ 52.47

RADIOLOGY

Procedure	Estimated Charge
Ct head/brain w/o dye	$ 163.38
Ct abd & pelv w/contrast	$ 476.23
Ct abd & pelvis w/o contrast	$ 245.89
Ct angiography chest	$ 451.46
Ct neck spine w/o dye	$ 286.86
Mri brain stem w/o dye	$ 613.94
Mri brain stem w/o & w/dye	$ 1,036.09
Mri lumbar spine w/o dye	$ 579.56
Mri abdomen w/o dye	$ 1,006.80
Mri abdomen w/o & w/dye	$ 1,542.90
Us guide vascular access	$ 102.33
Us exam pelvic complete	$ 788.03
Ob us < 14 wks single fetus	$ 801.57
Transvaginal us non-ob	$ 936.20
Us exam scrotum	$ 373.18
X-ray exam chest 1 view	$ 111.02
X-ray exam chest 2 views	$ 184.65
X-ray exam of shoulder	$ 201.14
X-ray exam of knee 3	$ 263.81
X-ray exam hip uni 2-3 views	$ 301.66
Radiation treatment delivery	$ 1,112.44
Ntsty modul rad tx dlvr cplx	$ 1,615.42
Guidance for radj tx dlvr	$ 288.85
Ntsty modul rad tx dlvr smpl	$ 1,611.37
Radiation physics consult	$ 302.32

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT EASTON

Estimated Charges for Common Outpatient Procedures

OUTPATIENT SURGERY	Charge Range		
Procedure	**Minimum**	**Maximum**	**Average Estimated Charge**
Egd biopsy single/multiple	$ 1,600	$ 29,666	$ 4,825
Abd paracentesis w/imaging	$ 610	$ 41,488	$ 3,818
Colonoscopy and biopsy	$ 1,810	$ 29,666	$ 4,604
Colonoscopy w/lesion removal	$ 2,312	$ 18,504	$ 4,819
Cysto/uretero w/lithotripsy	$ 4,259	$ 22,963	$ 8,957
Total knee arthroplasty	$ 13,303	$ 26,911	$ 18,742
Laparoscopic cholecystectomy	$ 5,170	$ 22,425	$ 9,575
Total hip arthroplasty	$ 7,893	$ 28,872	$ 20,890
Diagnostic colonoscopy	$ 1,794	$ 14,426	$ 3,930
Laparoscopy appendectomy	$ 7,214	$ 20,998	$ 11,341

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT CHESTERTOWN
Estimated Charges for Common Ancillary Services

LABORATORY

Procedure	Estimated Charge
Complete cbc w/auto diff wbc	$ 84.97
Comprehen metabolic panel	$ 126.83
Urinalysis auto w/scope	$ 76.09
Assay of magnesium	$ 51.54
Assay of troponin quant	$ 250.23
Lipid panel	$ 161.03
Assay thyroid stim hormone	$ 126.42
Infectious agent detection by nucleic a	$ 144.91
Metabolic panel total ca	$ 94.91
Prothrombin time	$ 68.08
infectious agent detection by nucleic a	$ 75.05
Assay of lipase	$ 67.87
Glycosylated hemoglobin test	$ 170.49
Urine culture/colony count	$ 169.17
Assay of lactic acid	$ 190.22
Assay of natriuretic peptide	$ 254.77
Thromboplastin time partial	$ 70.06
Vitamin d 25 hydroxy	$ 126.37
Assay of psa total	$ 168.88
Assay of phosphorus	$ 17.18
Drug screen quantalcohols	$ 127.04
Blood culture for bacteria	$ 591.30
Fibrin degradation quant	$ 128.82
Assay of ferritin	$ 127.81
Culture aerobic identify	$ 105.80

RADIOLOGY

Procedure	Estimated Charge
Ct head/brain w/o dye	$ 182.03
Ct abd & pelv w/contrast	$ 526.22
Ct abd & pelvis w/o contrast	$ 276.23
Ct thorax w/o dye	$ 308.29
Ct angiography chest	$ 500.98
Mri brain stem w/o & w/dye	$ 1,661.08
Mri lumbar spine w/o dye	$ 931.94
Mri abdomen w/o & w/dye	$ 2,468.64
Mri brain stem w/o dye	$ 966.22
Mri jnt of lwr extre w/o dye	$ 1,021.49
Ultrasound breast limited	$ 612.56
Us exam abdom complete	$ 944.51
Us exam of head and neck	$ 1,027.13
Us exam abdo back wall comp	$ 899.19
Us exam pelvic complete	$ 859.33
Scr mammo bi incl cad	$ 1,145.44
Breast tomosynthesis bi	$ 286.19
X-ray exam chest 2 views	$ 205.27
X-ray exam chest 1 view	$ 123.64
Dxa bone density axial	$ 368.98
Dx mammo incl cad uni	$ 1,065.03
X-ray exam of knee 3	$ 288.55
Breast tomosynthesis uni	$ 286.19
X-ray exam of foot	$ 246.31
X-ray exam of shoulder	$ 207.17

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT CHESTERTOWN

Estimated Charges for Common Outpatient Procedures

OUTPATIENT SURGERY	Charge Range		
Procedure	**Minimum**	**Maximum**	**Average Estimated Charge**
Diagnostic colonoscopy	$ 2,362	$ 6,971	$ 3,720
Colonoscopy and biopsy	$ 2,868	$ 8,374	$ 5,158
Egd biopsy single/multiple	$ 2,596	$ 8,751	$ 4,959
Dental surgery procedure	$ 5,568	$ 17,755	$ 11,622
Colonoscopy w/lesion removal	$ 3,644	$ 8,751	$ 5,499
Repair of nasal septum	$ 9,698	$ 13,618	$ 11,603
Egd diagnostic brush wash	$ 2,850	$ 5,616	$ 4,343
Prp i/hern init reduc >5 yr	$ 6,999	$ 11,378	$ 9,620
Colonoscopy submucous njx	$ 3,763	$ 8,374	$ 6,241
Hysteroscopy ablation	$ 13,715	$ 20,195	$ 15,438

EXHIBIT 7

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 8

Help for Patients to Pay Hospital Care Costs

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

PLEASE NOTE:

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

HOW THE PROCESS WORKS:

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

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

HOW WE REVIEW YOUR APPLICATION:

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

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

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

HOW TO APPLY FOR FINANCIAL HELP:

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

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

OTHER HELPFUL INFORMATION:

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

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Ayuda para que los Pacientes Paguen los Costos de Atención Hospitalaria

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

TENGA EN CUENTA LO SIGUIENTE:

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

CÓMO FUNCIONA EL PROCESO:

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

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

CÓMO REVISAR SU SOLICITUD:

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

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

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

CÓMO SOLICITAR ASISTENCIA FINANCIERA:

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

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

OTRA INFORMACIÓN ÚTIL:

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

EXHIBIT 9

OSFM

Firefighters from Goodwill Volunteer Fire Company responded to this house on Fairview Farm Lane for a fire that originated in an interior bedroom, Feb. 6.

Cause of fire unknown in Centreville house fire

CENTREVILLE — The cause of a fire on Fairview Farm Lane is being investigated by the State Fire Marshal. The owner of the two-story home, Calvin Gray, discovered the fire in an interior bedroom shortly after midnight on Sunday, Feb. 6.

Units from Goodwill Volunteer Fire Company in Centreville responded to the fire and had the blaze controlled within 30 minutes. It is unknown if the the smoke alarms although present activated. Damages are estimated at $50,000.

Sea Cadet Caroline Phillips promoted to CPO

By DOUG BISHOP
dbishop@kibaytimes.com

PHOTO BY DOUG BISHOP

Pictured, at U.S. Navy Sea Cadet Caroline Phillips' promotion to Sea Cadet Chief Petty Officer, her parents, from left: father Tom Phillips, mom MaryJo Phillips, Caroline, and U.S. Navy Master Chief Petty Officer Ret. Bernard Quibilan, who conducted the ceremony and placed the cap of leadership upon her head.

PHOTO BY DOUG BISHOP

U.S. Navy Master Chief Petty Officer Ret. Bernard Quibilan prepares to place the cap of promotion atop U.S. Navy Sea Cadet E7 Chief Petty Officer Caroline Phillips, 17, of Stevensville. Caroline became the second female to hold this rank in the MD SSDN 738 Division, which was formed only four years ago in Queen Anne's County. The ceremony took place at the Kent Island American Legion, Post 278, in Stevensville, Saturday afternoon, Jan. 22.

STEVENSVILLE — U.S. Navy Sea Cadet Caroline Phillips, 17, of Stevensville, was officially promoted to the rank of Chief Petty Officer with the MD SSDN 738 Division unit that she helped found in Queen Anne's County four years ago this coming May. Caroline joined the Sea Cadets organization when she was 11-years old, after she attended her brother's graduation from the U.S. Coast Guard basic training ceremony. She noticed a group of uniformed Sea Cadets about her age at that time at the graduation ceremony and asked, "Who are they?".

That interest sparked her introduction to the Sea Cadet program, and she soon signed up with the existing unit in the Annapolis area. Sea Cadets is an independent organization sponsored by the U.S. Navy to provide military training to youth who are interested but don't have an ROTC unit in their school. Queen Anne's County Public Schools do not currently have high school ROTC units.

Less than four-years ago, Caroline went to her U.S. Navy Sea Cadets adult leader, U.S. Navy Master Chief Petty Officer (Retired) Bernard Quibilan, asking could a local unit for the Eastern Shore be created? MCPO Quibilan followed through with the request, and a new unit was created with the support of all three American Legion Posts in Queen Anne's County; Post 278 (Kent Island), Post 296 (Queenstown) and Post 18 (Centreville). The local VFW, Post 7464, in Grasonville, has also made a financial donation. From there, the 738 unit has grown.

Caroline too has grown in her commitment and a devotion to excellence in the Sea Cadets organization, working her way up through the ranks to earn the highest rank of Cadet Chief Petty Officer. MCPO Quibilan has been her mentor throughout her journey.

Quibilan brings a huge background of military service to the Sea Cadets, first, his 32-years in the U.S. Navy, then serving as Master Chief at both the Recruit Training Command at Great Lakes where over 4,000 sailors went through his command, and also at the U.S. Naval Academy in Annapolis.

In 2021, before attaining her rank as CPO, Caroline lead her unit in the annual Regional competition that brings seven different Sea Cadet units into "a friendly competition" in drill, Color Guard, uniform inspection, PT, academics, and team building skills. Unit 738 swept the competition, taking home all the trophies. Caroline earned a commendation ribbon from headquarters for her leadership in this event. She also has received seven challenge coins for her work within the Sea Cadets, which is no small accomplishment!

During her promotion ceremony, with the entire QA Sea Cadet unit, approximately 30 cadets, looking on, Caroline was pinned with her CPO wings by U.S. Marine Corps Major Ret. Matthew Castro who serves as Executive Officer of the Maryland Sea Cadets Division and U.S. Navy Commander Emilio Dalay who serves as Regional Sea Cadets Director. The final touch of the ceremony was when MCPO Quibilan placed the cap of rank atop Caroline's head.

Along with family and close friends attending, Kent Island High School Principal Sean Kenna and his wife, Tracy Kenna, who serves as Queen Anne's County Public Schools Supervisor of Accountability were also invited guests. Both released this joint statement after the ceremony, saying; "As Queen Anne's County Public School educators we are proud of all our students' accomplishments, and Chief Caroline Phillips' promotion to the rank of Chief Petty Officer is no exception. We are proud of Chief Phillips and we have really been impressed with her dedication and commitment to the Sea Cadets over the years. She is truly the complete package: a highly motivated and dedicated leader. Chief Phillips is an exemplary QACPS student!"

Asked, why she joined the Sea Cadets, Caroline replied, "I like the organization of military discipline. Master Chief Quibilan has been a very big influence in my life, along with my parents. The members of our Sea Cadet unit have become like family to me." Caroline said she has also received a great deal of personal reward and feeling of accomplishment in serving as a member/leader in the unit's distinguished color guard the past several years.

Starting next month, she will begin an Emergency Management internship at the U.S. Naval Academy. She will be graduating from KIHS with the Class of 2022. Her career pathway in school has been Homeland Security.

Outside of school, Caroline is a current member of the KI American Legion's Ladies Auxiliary Junior program.

Caroline's immediate plans are to attend Anne Arundel Community College for two years and then transfer to another university to finish out her four year degree. Her goal is to become employed after college with a federal government agency.

C-SDHS Next Generation Scholars take 'Career Tour'

CAMBRIDGE — Twenty-three Cambridge-South Dorchester High School 10th graders, part of the Next Generation Scholars Program, recently embarked upon a "Career Tour" with the opportunity to learn about eight careers at two organizations.

The first stop was at the Hyatt Regency Chesapeake Bay, where students had the opportunity to learn about careers in the fields of human resources, event planning and sales, culinary, engineering/mechanical and golf pro. Students spoke with Hyatt staff who described their job responsibilities and the education needed for positions, as well as toured the facilities to see the work environment.

Over lunch, students heard Dorchester Chamber of Commerce President and CEO Bill Christopher speak about entrepreneurship and running one's own business.

The tour finished at the Dorchester County Department of Emergency Services. Students learned about the 911 dispatch center and about being an EMT and working on an ambulance. There was also an opportunity to learn about the Sheriff's Office, and students heard from law enforcement officers who started their civilian careers after retiring from the military.

Next Generation Scholars is a program of the Maryland Business Roundtable for Education. Lauri Bell is the coordinator at C-SDHS.

CONTRIBUTED PHOTO

A group of 10th graders in the Next Generation Scholars Program at Cambridge-South Dorchester High School recently embarked upon a "Career Tour," showcasing local career opportunities in a variety of fields.

Junior Achievement receives $20,000 grant from Arby's

SALISBURY — Junior Achievement of the Eastern Shore has received a $20,000 grant from the Arby's Foundation as part of its Make a Difference Campaign local grants program. The grant funds will help bring JA programs to thousands of students throughout Maryland and Virginia's Eastern Shore.

Junior Achievement was one of 20 nonprofit organizations in the United States selected by the Arby's Foundation to receive this grant.

"Providing educational programs to our students remains Junior Achievement's mission, and we are so thankful to the Arby's Foundation for supporting our efforts and helping our mission succeed," said Jayme Hayes, president of Junior Achievement of the Eastern Shore.

The Make a Difference Campaign includes a designated market area grants program whereby 50% of total funds raised in each market are reinvested locally to benefit deserving local non-profits focused on youth-centric initiatives.

Local Arby's employees also raised nearly $9,000 in donations for Junior Achievement in a separate campaign. Funds raised help bring financial literacy, work readiness and entrepreneurship programs to school districts that partner with Junior Achievement of the Eastern Shore.

"We're so appreciative of our local Arby's workers," Hayes said. "Our community has devoted itself to improving our students' education, and the dedicated employees of Arby's have ensured that continues to happen."

Delmarva Power unveils new look

NEWARK, Del. — Delmarva Power's parent company, Exelon, on Feb. 2 announced completion of its separation from former power generation and competitive energy business Constellation.

Delmarva Power remains part of Exelon, a transmission and distribution company serving more than 10 million customers.

As part of this change, Delmarva Power, its parent company and sister utilities — Atlantic City Electric, BGE, ComEd, PECO and Pepco — have unveiled a new look that reflects their evolution to become more unified and integrated, according to a news release.

Going forward, Delmarva Power customers will see the new, modernized branding, including the new logo, on the company's website, mobile app, social media channels, advertising and business materials.

"We are excited to continue to be part of the Exelon family and remain committed to powering a cleaner and brighter future for our customers and communities," Tyler Anthony said in the news release.

He is president and CEO of Pepco Holdings, which includes Delmarva Power.

Anthony added: "Every day, we work to deliver safe, reliable, affordable, and clean energy, and that will not change. We look forward to continuing to bring our customers the benefits of being part of the nation's premier transmission and distribution utility company."

Guided by the company's existing leadership, Delmarva Power will continue its strong focus on serving customers and investing in infrastructure and technologies equitably to enhance safety and improve reliability and resiliency, according to the news release.

The company will continue its commitment to a world-class customer experience with new tools and resources, keeping accessibility and affordability at the center.

Delmarva Power will continue its leadership and support to advance a cleaner energy future, like the company's Climate Commitment. And, Delmarva Power will continue its steadfast commitment to local communities, building on the record volunteerism of its employees and its continued financial and leadership support of community organizations across Delaware and Maryland.

According to the news release, since Delmarva Power joined the Exelon family of companies in 2016, customers and communities have seen meaningful economic and service benefits.

Infrastructure improvements during the last 10 years have driven a 53% decrease in the frequency of electric outages Delmarva Power customers experienced.

Delmarva Power purchased $103 million in goods and services in 2020 from diversity-certified suppliers, which equates to 28% of the company's total yearly purchases, according to the news release.

Delmarva Power provided more than $1.2 million in financial support in 2021 for nonprofits and community partners across its service area.

PHOTO BY MACKENZIE BRADY

Jennifer Baker and John Laucik own and operate Welcome Home, which is celebrating its fifth anniversary in February. The store on Cross Street in Chestertown sells "everyday living" essentials.

Local culinary arts students to share in Welcome Home's 5th anniversary

BY MACKENZIE BRADY
mbrady@thekentcountynews.com

CHESTERTOWN — Welcome Home, a store with goods for "everyday living," including cooking, dining and entertaining at home, celebrated its fifth anniversary Feb. 4.

Owner Jennifer Baker described the inventory in her downtown Chestertown store as "pretty but pragmatic" with a mix of products from large and independent producers at a reasonable price.

To celebrate this anniversary, and give back to the community, owners Baker and John Laucik have decided to donate 5% of gross sales from the store and online from Friday, Feb. 11 through Monday, Feb. 14 to the Kent County High School culinary arts program.

In an interview Monday, Baker said the program works with high school students to get them culinary certified. It also partners with local businesses to provide students with internships and other real-world culinary and hospitality experience to show that as a viable career path in Kent County.

Baker said they decided to donate because they believe in what culinary arts teacher John Keller is doing with the program.

"It's wonderful for our students to know they have such strong supporters in our community," Keller said in a news release.

Culinary arts is one of the Career and Technology pathways at Kent County High School.

Baker and Laucik also own and operate Chester River Wine and Cheese, 117 S. Cross St., Chestertown, and Welcome Home Annapolis, 64 State Circle, Annapolis.

Baker said January through March is a slower time for small businesses, which makes it an opportune time to refresh stock and to see what is actually in the store.

Over the last five years, Laucik said Welcome Home has expanded its selection of self-care products as well as mixes and ingredients, paring ingredients and the tools needed to make them.

The business' website is also new, having been built with COVID-19-related funds allocated to Kent County Tourism and Economic Development.

Baker said website sales are often large enough to cover much of the business' operating costs, allowing more growth and thereby improving its stability long term.

Over the course of the next five years, Baker said they hope to expand the business, both in Chestertown and Annapolis, with Kent County as a "home base."

She said they hope to invest in additional table-scaping items, including linens and tableware, and expand a regional culinary focus with cookbooks and corresponding ingredients.

Those wishing to celebrate Welcome Home's fifth anniversary and support the KCHS culinary arts program are encouraged to shop in the store, located at 107 S. Cross St., in Chestertown, or on their website at www.welcomehomemarkets.com.

FOCUS – *Kent*

EDUCATION

No more 'snow days'

Schools implement new virtual inclement weather day plan

BY MACKENZIE BRADY
mbrady@thekentcountynews.com

ROCK HALL — Kent County Public Schools was able to test its brand-new virtual inclement weather day plan in real time Monday, less than two weeks after gaining state Superintendent Mohammed Choudhury's approval.

"Reports from principals and families have been very positive," Superintendent Karen Couch wrote in an email to the *Kent County News* on Tuesday.

She added, "Attendance and student engagement was high and there were very few tech issues. Overall, it was a great day to continue virtual instruction."

The plan allows for online instruction on what would otherwise be a day off due to inclement weather.

KCPS used all four of its budgeted inclement weather days for the 2021-22 academic year during a snowstorm in the first week of January.

Schools here also were shuttered Jan. 20 due to a forecast of snow.

Cheryl Bachmann, who is president of the Kent County Teachers Association, said online instruction on Monday went "really well" overall.

"I think some of the newer teachers who had not used (the online learning platform) Schoology for conferencing last year had some hiccups, but they were fixed pretty quickly," she wrote. "Special teachers at the elementary level had some pretty large classes to handle (K-2) and (3-5), but seemed to handle it really well."

Bachmann said students at all grade levels seemed to do well with the virtual platform and parents were patient and helpful with younger students.

Looking ahead, Bachmann said the school system must make sure that students have the connectivity resources they need. Some households have multiple children in class at the same time and many teachers are also parents, she noted.

"Everyone being patient with each other and extending some grace to each other is important moving forward," she said.

The school system's virtual inclement weather day plan — which can be implemented only for this school year — was adopted by the Board of Education at a special meeting Jan. 19.

"Superintendents were told that we cannot substitute virtual learning in lieu of a snow day unless it's approved by the Maryland State Department of Education," Couch told board members at the Jan. 19 meeting. "We had to wait until we had guidance from Mr. Choudhury in order to determine what the criteria was for having our plan approved."

Couch told the board members that she received that guidance over the weekend leading up to their Jan. 19 meeting.

Maryland State Department of Education requirements for any school system's plan for virtual inclement weather days include a minimum of four hours of synchronous instruction for all students; attendance taken for students and teachers; and opportunities for students to make up work missed during the inclement weather day.

The plan is to be posted on the school system's website and it must be presented publicly at a school board meeting.

PHOTO BY TRISH MCGEE

Students returned to in-person instruction Tuesday after pivoting to virtual learning Monday using Kent County Public Schools' newly approved inclement weather day plan. Our photo was taken Tuesday afternoon at dismissal time at Rock Hall Elementary School.

Couch said a "skeleton" of what KCPS' policy would look like had been in the works ahead of the MSDE guidance she received.

While a tentative plan was submitted to the state superintendent on Tuesday, Jan. 18, Couch said the plan had not yet been reviewed or approved by Choudhury at the time of the special BOE meeting. That's why Jan. 20 was an inclement weather closure rather than the first virtual inclement weather day.

Without virtual learning, additional inclement weather closures would cause KCPS to add instructional days to the calendar or seek a waiver from the state for lost days.

KCPS' plan includes both synchronous and asynchronous learning opportunities. The school system will provide all students and staff with a district-issued device to take home.

According to the plan, hotspots have been provided "to families in need to ensure all KCPS students have equal access to instruction should a virtual inclement weather day occur." Paper options will be provided to students for whom there is no internet access and hotspots do not have a strong enough signal.

A survey was previously sent out to gauge students' internet access at home, so teachers will know in advance whether a student is likely to miss class due to technological issues, Teaching and Learning Director Gina Jachimowicz told the school board at the special meeting.

"Because this is during inclement weather and not just a switch to virtual learning, we won't be providing lunches or meals," board member Francoise Sullivan said at the meeting. "I just wanted to make sure that was understood by people as well."

Couch noted that meals were not provided on snow days anyway.

"We're trying to mitigate the effect of adding additional days at the end of the year, we're trying to have learning occur. It seems pretty simple," board President Joe Goetz said.

"And we may not even have to use it," Jachimowicz said. "At least that's my hope."

The vote was 3-0 to approve the plan. Board members Nivek Johnson, the newly seated vice president, and Trish McGee did not attend the meeting.

McGee is editor of the *Kent County News*.

A letter that Couch sent home to parents states: "During virtual inclement weather days, teachers will deliver live instruction via our Learning Management System (LMS), Schoology. Within Schoology LMS, teachers are able to schedule live sessions called Conferences. Schoology also offers a place for teachers to house essential materials that are essential for the day's lesson."

KCPS will post "refresher" videos on the school system's website to assist parents in navigating the Schoology platform. Schoology was used originally when KCPS pivoted to online learning in 2020-21 due to the COVID-19 pandemic.

"If a student is absent for virtual instruction, their absence will be coded as an excused absence upon completion of the make-up work in accordance with the KCPS Make-Up Work policy," the letter states.

MSDE approved Kent's plan Thursday morning, Jan. 20.

Examples of the schedules for elementary, middle and high school students, as well as the full plan, are available on the school system's website.

FOOD

Celebrate Super Bowl Sunday, hometown style

BY MARIE SAVAGE
The Country Cook

There are several celebrations this weekend, but the Super Bowl will outshine many of them! Super Bowl is Sunday, Feb. 13, followed by Valentine's Day, Feb. 14, and there are many birthdays including the late President Abraham Lincoln's on Feb. 12 and many others celebrating anniversaries. No matter what you are celebrating, enjoy today's recipes, while staying home with family and friends.

This year the Los Angeles Rams and the Cincinnati Bengals will face each other in the Super Bowl. The Rams have appeared in four Super Bowls but have only won one time. The Rams last played in the 2018 Super Bowl. The Cincinnati Bengals have appeared in only two Super Bowls but lost both games. It's been more than 30 years, but the Bengals are back in "the bowl"!

Here are a few recipes from each of those respective teams' towns for you to try.

A staple in Cincinnati for sporting events is **SKYLINE CINCINNATI CHILI**.

Ingredients: 5 cups water, 6 oz can of tomato paste, 1/2 oz baking chocolate, 1/4 cup chili powder, 1 tsp cinnamon, 1 tsp garlic powder, 1 tsp cumin, 1/4 tsp allspice, 1/4 tsp ground cloves, 1/4 tsp red pepper flakes, or less, depending on your desired heat level, 1/8 tsp black pepper, 3/4 tsp salt, 1/2 tsp sugar, 2 Tbsp apple cider vinegar, 1 1/4 lb. lean ground beef.

Directions: Add the water to a large pot. I like to use my Dutch oven for this. Add the tomato paste and chocolate and heat over medium heat stirring to combine for about 3 minutes. Add chili powder, cinnamon, garlic powder, cumin, allspice, cloves, red pepper flakes, black pepper, salt, sugar and vinegar. Next, crumble the raw ground beef into the pot with your fingers, then use a potato masher, whisk or fork to break up the meat into very fine pieces. Turn heat to high to bring to a boil. Once boiling, turn the heat down to medium low.

Cook, uncovered, for 1 to 1 1/2 hours, at a low boil stirring occasionally until sauce has thickened quite a bit. At this time, you can use this to top hot dogs, nachos or anything else you'd like to!

Los Angeles is known for its Hispanic culture and cuisine. Who doesn't love a good taco or burrito? I know I love a good taco salad, but hold those beans! A favorite of many are the **MEXICAN STREET TACOS**.

You'll need 2 tablespoons reduced sodium soy sauce, 2 tablespoons freshly squeezed lime juice, 2 tablespoons canola oil, divided, 3 cloves garlic, minced, 2 teaspoons chili powder, 1 teaspoon ground cumin,1 teaspoon dried oregano, 1 1/2 pounds skirt steak, cut into 1/2-inch pieces, 12 mini flour tortillas, warmed, 3/4 cup diced red onion, 1/2 cup chopped fresh cilantro leaves,1 lime, cut into wedges.

Directions: In a medium bowl, combine soy sauce, lime juice, 1 tablespoon canola oil, garlic, chili powder, cumin and oregano. In a gallon size Ziploc bag or large bowl, combine soy sauce mixture and steak; marinate for at least 1 hour up to 4 hours, turning the bag occasionally. Heat remaining 1 tablespoon canola oil in a large skillet over medium high heat. Add steak and marinade, and cook, stirring often, until steak has browned, and marinade has reduced, about 5-6 minutes, or until desired doneness.

Serve steak in tortillas, topped with onion, cilantro and lime.

Most of us here are fans of the local teams, so here is a recipe closer to home that will surely hit the spot: **OLD BAY CHICKEN WINGS**.

Ingredients: 3 pounds chicken wings separated tips from drumettes, 8 tablespoons (1 stick) unsalted butter, 1 tablespoon Old Bay seasoning, plus more for dusting,1 tablespoon lemon juice. Old Bay hot sauce for dipping if you like.

Directions: Preheat the oven to 425°F. Allow the wings to come to room temperature. Pat the chicken wings dry.

Make Old Bay sauce: Melt the butter in a small pot and whisk in the Old Bay and lemon juice. Let it cool enough to feel lukewarm. Mix the sauce again and toss the chicken wings in half the sauce.

Arrange the wings in one layer on a baking sheet lined with parchment paper, aluminum foil, or Silpat, and bake at 425°F for 25 minutes.

Take the wings out of the oven and turn on the broiler. Set a rack about 6 inches under the broiler. Turn the wings over on the baking sheet and put under the broiler for 3-4 minutes, or until they are nicely browned.

Toss in the remaining sauce and set on a plate. Dust with more Old Bay and serve.

Lastly, I'd like to throw in a recipe where you should have no problem finding all the ingredients: **IRISH CHEDDAR BACON JALAPENO POTATO SKINS**.

Ingredients: 5 pounds medium-sized russet potatoes, olive oil, kosher salt, black pepper, 3/4 pound bacon, 7 ounces Irish cheddar cheese (grated), 1 jalapeño pepper minced, parsley leaves, sour cream and Greek yogurt.

Directions: To start, preheat your oven to 350°. Spray or drizzle the (scrubbed) potatoes with olive oil and massage the oil into the skin of the potatoes. Bake on a rimmed baking sheet on the middle rack of your preheated oven for 45 minutes to 1 hour. The potatoes are done when a fork pierces the largest potato easily. Allow to cool until safe enough to handle.

METRO CREATIVE

Potato skins are sure to be a crowd pleaser.

Meanwhile, cook the bacon until crispy, drain and chop into small pieces. Cut the potatoes in half horizontally. Scoop out the flesh, leaving a little potato still attached to the skin. Move your oven rack to the highest position and preheat your oven to broil.

Oil the potato skins, and broil for 4 minutes or until the skin is crisp, roasting the pan halfway through to ensure even browning. Use tongs to flip the skins and spray the side with the exposed potato with olive oil and season with a little bit of kosher salt and lots of freshly ground black pepper. Broil for 4 to 6 more minutes, rotating the pan halfway through.

Switch your oven over to bake and preheat to 375°. Combined the scooped potatoes with the other ingredients; top the potato skins and bake until cheese melts. Sprinkle with snipped chives and the finely minced parsley for a burst of freshness and added flavor.

What am I doing, someone asked, well, since we are celebrating a birthday, great report cards, Valentine's Day and Super Bowl Sunday we'll be throwing it on the table steam pot style complete with corn-on-the-cob, steamed clams, steamed shrimp, sausage, red skinned potatoes and whatever else shows up in the pot! Have a wonderful weekend no matter what you are doing!

February 17, 2022

PROOF OF PUBLICATION

University of Maryland
Shore Regional Health
Account 520158

Creative: "Financial Assistance 2022"

Ad Size: 5.062" x 5" black/white

Publications and Run Dates:

Star Democrat – Sunday, February 6, 2021 - ad #2974753
Times Record – Wednesday, February 9, 2021 - ad #2974940
Kent County News – Thursday, February 10, 2021 - ad #2974756
Record Observer/Bay Times – Friday, February 11, 2021 - ad #2974757
Dorchester Star – Friday, February 11, 2021 - ad #2974758

Total Cost: $327.60

PO#: 9964-1-SVC

Jim Normandin
President | APG Chesapeake
29088 Airpark Dr
Easton, MD 21601
410-770-4050

EXHIBIT 10

MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY

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

License No. 20-003

Issued to:

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

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

Date Issued: July 1, 2018

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

Patricia Tomasko May, MD

Director

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

EXHIBIT 11

Shore Health System, Inc

Easton, MD

has been Accredited by

The Joint Commission

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

Behavioral Health Care and Human Services Accreditation Program

February 17, 2022

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #6276
Print/Reprint Date: 05/17/2022

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

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

University of Maryland Shore Medical Center at Cambridge

Cambridge, MD

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

February 19, 2022

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #6276
Print/Reprint Date: 05/26/2022

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

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This confirmation of the original accreditation certificate has been issued for use in regulatory/payor agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's Requirements of Care.

Univ of Maryland Shore Emergency Center at Queenstown

Queenstown, MD

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

February 19, 2022

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CEN, FAAN
Chair, Board of Commissioners

ID #6276
Print Reprint Date: 05/26/2022

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
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This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations in use.

University of Maryland Shore Regional Health Cancer Center

Easton, MD

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

February 19, 2022

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #6276
Print/Reprint Date: 03/26/2022

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

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This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency certification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's accepted scope(s) of care.

Shore Health System, Inc

Easton, MD

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

February 19, 2022

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #6276
Print/Reprint Date: 05/17/2022

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

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EXHIBIT 12

https://healthcarequality.mhcc.maryland.gov/Hospital/Detail/42 Accessed 11/3/22

Topic	Subtopic	Measure	Hospital Score	Maryland Score	Performance Comparison	Comments/Interventions
Staff Influenza Vaccination Rate			99.20%	94.10%	This facility has a gold star Recognition for 95% or better vaccination rate.	
Patient Satisfaction Survey (HCAHPS)	Communication	How often did doctors communicate well with patients?	76.00%	75.50%	Same as Maryland	
	Communication	How often did nurses communicate well with patients?	80.00%	75.00%	Better than Maryland	
	Communication	How often did staff explain about medicines before giving them to patients?	59.00%	57.20%	Same as Maryland	
	Communication	How well do patients understand their care when they leave the hospital?	46.00%	47.40%	Same as Maryland	
	Communication	Were patients given information about what to do during their recovery at home?	86.00%	85.30%	Same as Maryland	
	Environment	How often did patients receive help quickly from hospital staff?	59.00%	57.10%	Same as Maryland	
	Environment	How often was the area around patients' rooms kept quiet at night?	50.00%	56.80%	Worse than Maryland	The Patient Experience Steering Committee has been working with departments and units throughout the organization. Actions taken to date include exploring minimizing overhead announcements, quiet hours, increasing awareness amongst staff, and replacing/repairing loud carts and wheels. HCAHPS scores are monitored monthly and individual reports are pushed out to units and departments. Design features in the proposed Regional Medical Center include all private rooms with charting alcoves between each patient room. Additionally, all patient rooms will be built to meet current sound attenuation standards of minimum 45 sound transmission class (STC) between patient rooms and 35 STC between patient room and corridor. This is achieved through full-height partitions, careful interior finish selection, and selective overhead routing locations for mechanical and plumbing infrastructure. Nursing units will have two central nurses stations along with team work rooms. These features are expected to improve quietness for patients and minimize the likelihood of staff congregating in small areas, which contributes to noise areas.
	Environment	How often were the patients' rooms and bathrooms kept clean?	68.00%	66.70%	Same as Maryland	

	Overall Satisfaction	How do patients rate the hospital overall?	58.00%	65.30%	Worse than Maryland	Both rate the hospital overall and recommend to friends and family are composite measures that reflect the sum total of all interactions and care provided to the patient and family. Actions taken to improve the overall experience include redesigning shift change handoff that involves the patient at the bedside, reinforcing back to basics behaviors and education that focuses on communication and respect and hardwiring leader rounding to solicit real time feedback and model desired behaviors. In 2023, UM SRH will implement an industry best practice of Get to Know Me Boards as a tool to encourage meaningful connections between patients, families, and caregivers. Further, UM SRH is involved in a UMMS-wide transformation surrounding patient experience, setting a consistent definition of patient experience, implementing a robust data strategy, and standardizing care language across the System. We recognize that the overall rating of a hospital is influenced by all impressions. An aged facility with limits in space, parking, and aesthetics can all contribute to a less positive perception of the hospital as a whole. These perceptions are expected to improve at the new state of the art replacement hospital.
	Overall Satisfaction	Would patients recommend the hospital to friends and family?	59.00%	65.00%	Worse than Maryland	Both rate the hospital overall and recommend to friends and family are composite measures that reflect the sum total of all interactions and care provided to the patient and family. Actions taken to improve the overall experience include redesigning shift change handoff that involves the patient at the bedside, reinforcing back to basics behaviors and education that focuses on communication and respect and hardwiring leader rounding to solicit real time feedback and model desired behaviors. In 2023, UM SRH will implement an industry best practice of Get to Know Me Boards as a tool to encourage meaningful connections between patients, families, and caregivers. Further, UM SRH is involved in a UMMS-wide transformation surrounding patient experience, setting a consistent definition of patient experience, implementing a robust data strategy, and standardizing care language across the System. We recognize that an aged facility could also contribute to patients being less likely to recommend the hospital as perceptions could be that the facility is not state of the art or able to provide technologically advanced care.
Cardiac Conditions	Heart Attack and Chest Pain	Dying within 30 days after getting care in the hospital for a heart attack	12.80%	12.20%	Same as Maryland	
	Heart Attack and Chest Pain	Fibrinolytic therapy received within 30 minutes	No data	No data	No data	
	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	1h 16m	1h 33m	Same as Maryland	

	Heart Attack and Chest Pain	How often patients die in the hospital after heart attack (with transfer)	5.30%	4.80%	Same as Maryland	
	Heart Attack and Chest Pain	Returning to the hospital after getting care for a heart attack	14.20%	14.80%	Same as Maryland	
	Heart Failure	Dying within 30 days after getting care in the hospital for heart failure	13.40%	11.10%	Same as Maryland	
	Heart Failure	How often patients die in the hospital after heart failure	2.80%	2.50%	Same as Maryland	
	Heart Failure	Returning to the hospital after getting care for heart failure	18.60%	20.40%	Same as Maryland	
	Heart Surgery and Procedures	Death rate for CABG	No data	2.70%	No data	
	Heart Surgery and Procedures	Rate of unplanned readmission for CABG	No data	11.90%	No data	
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	2h 43m	3h 55m	Better than Maryland	
	Wait Times	Patients who left the emergency department without being seen	2.00%	2.30%	Same as Maryland	
Imaging Tests		Contrast material (dye) used during abdominal CT scan	6.20%	3.60%	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	49.00%	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	4.30%	No data	
		Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival	88.00%	72.50%	Better than 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)	14.80%	9.10%	No data	
Infections		Catheter Associated Urinary Tract Infections (CAUTI)	0.44	0.97	Same	
		Central Line-Associated Blood Stream Infections (CLABSI)	0.73	1.06	Same	
		Clostridioides Difficile Infections (CDI)	0.35	0.63	Better	
		Methicillin-Resistant Staphylococcus Aureus Infections (MRSA)	0.4	0.94	Same	
		Surgical Site Infections (SSI) - Abdominal Hysterectomy	No data	1.34	Not enough data to calculate	
		Surgical Site Infections (SSI) - Colon Surgery	0.76	0.76	Same	
		Surgical Site Infections (SSI) - Hip Replacement	No data	0.77	Not enough data to calculate	
		Surgical Site Infections (SSI) - Knee Replacement	No data	0.77	Not enough data to calculate	
Lung Conditions	COPD	Dying within 30 days after getting care in the hospital for chronic obstructive pulmonary disease (COPD)	10.90%	8.50%	Same as Maryland	
	COPD	Returning to the hospital after getting care for chronic obstructive pulmonary disease (COPD)	16.60%	19.30%	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	6.90%	5.10%	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	2.1	7.3	Better than Maryland	
	Complications	How often there are obstetric injuries to the mother after a vaginal delivery (with instrument)	74.1	91.6	Same as Maryland	
	Complications	How often there are obstetric injuries to the mother after a vaginal delivery (without instrument)	18.4	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	11.80%	17.80%	Better than Maryland	

	Delivery	How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)	0.00%	16.70%	Worse than Maryland	Vaginal birth after cesarean section is not programmatically allowed at UM SRH due to a lack of ability to meet American College of Obstetricians and Gynecologists' guidelines for this type of program, which include having both anesthesia and pediatric services available 24/7, in-house. A 24/7 inpatient obstetrics hospitalist program, along with an inpatient 24/7 anesthesia service, began in January 2022. An inpatient pediatric hospitalist program will begin in December 2022 and a full-time maternal fetal medicine physican will start in February 2023, allowing Shore to explore initiating a VBAC program.
	Delivery	Newborn deliveries scheduled 1-3 weeks earlier than medically necessary	2.00%	2.00%	Same as Maryland	
	Delivery	Percentage of births (deliveries) that are C-sections	25.00%	29.80%	Better than Maryland	
Patient Safety	Combined Quality and Safety	How well this hospital keeps patients safe based on ten patient safety problems	0.8	1	Same as Maryland	
	Combined Quality and Safety	Percentage of patients who received appropriate care for severe sepsis and septic shock	50.00%	57.30%	Same as Maryland	
	Combined Quality and Safety	Patients who died in the hospital after having one of six common procedures	1.1	1	Same as Maryland	
	Combined Quality and Safety	Patients who died in the hospital after having one of six common conditions	1.1	1.1	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	0	2.1	Same as Maryland	
	Patient Safety	How often patients die in the hospital after bleeding from stomach or intestines	2.90%	2.30%	Same as Maryland	
	Patient Safety	How often patients die in the hospital after fractured hip	0.80%	1.80%	Same as Maryland	
	Patient Safety	How often patients die in the hospital while getting care for a condition that rarely results in death	0	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	0	0.8	Same as Maryland	
	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	4.3	1.7	Same as Maryland	
	Patient Safety	Returning to the hospital for any unplanned reason within 30 days after being discharged	12.70%	14.50%	Better than Maryland	
Stroke	Death rate for stroke patients		14.20%	13.50%	Same as Maryland	
	How often patients who came in after having stroke subsequently died in the hospital		7.20%	7.20%	Same as Maryland	
Surgery	Hip/Knee	Complications after hip or knee replacement surgery	2.40%	2.40%	Same as Maryland	
	Hip/Knee	Returning to the hospital after getting hip or knee replacement surgery	3.80%	4.00%	Same as Maryland	
	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	0	1	Same as Maryland	
	Patient Safety	How often patients die in the hospital because a serious condition was not identified and treated	160.4	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	2.1	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	6.3	5.2	Same as Maryland	
	Patient Safety	Returning to the hospital within seven days of an outpatient surgery	0.9	1.1	Same as Maryland	
	Specific Conditions	How often patients die in the hospital during or after pancreas surgery	No data	4.40%	No data	
	Specific Conditions	Rate of unplanned hospital visits after an outpatient colonoscopy	No data	No data	No data	

EXHIBIT 13

Licensed Acute Care Beds by General Hospital and Service in Maryland: FY 2023 (Effective July 1, 2022

Jurisdiction/REGION	Hospital	Acute Care Inpatient Service				
		MSGA	Obstetric	Pediatric	Psychiatric	Total
Allegany	UPMC Western Maryland Regional Medical Center	180	7	1	12	200
Frederick	Frederick Health	211	27	5	21	264
Garrett	Garrett Regional Medical Center	19	1	1	0	21
Washington	Meritus Medical Center	209	17	4	18	248
WESTERN MARYLAND TOTAL		**619**	**52**	**11**	**51**	**733**
Montgomery	Adventist HealthCare Shady Grove Medical Center	182	46	10	133	371
	Adventist HealthCare White Oak Medical Center	177	26	0	10	213
	Holy Cross Germantown Hospital	60	16	0	6	82
	Holy Cross Hospital of Silver Spring	255	94	4	0	353
	MedStar Montgomery Medical Center	69	11	2	14	96
	Suburban Hospital	199	0	3	24	226
MONTGOMERY COUNTY TOTAL		**942**	**193**	**19**	**187**	**1,341**
Calvert	CalvertHealth	64	5	1	10	80
Charles	University of Maryland Charles Regional Medical Center	86	12	6	0	104
Prince George's	Adventist HealthCare Fort Washington Medical Center	31	0	0	0	31
	Luminis Doctors Community Hospital	200	0	0	0	200
	MedStar Southern Maryland Hospital Center	142	18	4	24	188
	University of Maryland Capital Region Medical Center	172	16	1	28	217
Prince George's County Total		*545*	*34*	*5*	*52*	*636*
St. Mary's	MedStar St. Mary's Hospital	75	12	6	12	105
SOUTHERN MARYLAND TOTAL		**770**	**63**	**18**	**74**	**925**
Anne Arundel	Luminis Anne Arundel Medical Center	329	60	8	0	397
	University of Maryland Baltimore Washington Medical Center	265	18	7	24	314
Anne Arundel County Total		*594*	*78*	*15*	*24*	*711*
Baltimore City	Johns Hopkins Bayview Medical Center	309	22	5	20	356
	Johns Hopkins Hospital	796	35	140	108	1,079
	MedStar Good Samaritan Hospital	153	0	0	0	153

	MedStar Harbor Hospital	82	24	0	36	142
	MedStar Union Memorial Hospital	189	0	2	0	191
	Mercy Medical Center	111	32	4	0	147
	St. Agnes Hospital	156	15	3	0	174
	Sinai Hospital of Baltimore	339	25	26	48	438
	University of Maryland Medical Center	608	30	59	42	739
	University of Maryland Medical Center Midtown Campus	84	0	0	37	121
	University of Maryland Rehabilitation and Orthopaedic Institute	4	0	0	0	4
Baltimore City Total		*2,831*	*183*	*239*	*291*	*3,544*
Baltimore County	Greater Baltimore Medical Center	167	60	8	0	235
	MedStar Franklin Square Medical Center	277	37	0	40	354
	Northwest Hospital	156	0	0	37	193
	University of Maryland St. Joseph Medical Center	165	20	4	18	207
Baltimore County Total		*765*	*117*	*12*	*95*	*989*
Carroll	Carroll Hospital	122	20	4	20	166
Harford	University of Maryland Harford Memorial Hospital	59	0	0	29	88
	University of Maryland Upper Chesapeake Medical Center	192	9	1	0	202
Harford County Total		*251*	*9*	*1*	*29*	*290*
Howard	Howard County General Hospital	166	34	6	20	226
CENTRAL MARYLAND TOTAL		**4,729**	**441**	**277**	**479**	**5,926**
Cecil	ChristianaCare Union Hospital	91	4	2	12	109
Kent	University of Maryland Shore Medical Center at Chestertown	5	0	0	0	5
Talbot	University of Maryland Shore Medical Center at Easton	72	13	3	10	98
Wicomico	TidalHealth Peninsula Regional Medical Center	230	20	8	13	271
Worcester	Atlantic General Hospital	46	0	0	0	46
EASTERN SHORE TOTAL		**444**	**37**	**13**	**35**	**529**
MARYLAND TOTAL		**7,504**	**786**	**338**	**826**	**9,454**

Source: Maryland Health Care Commission, Maryland Department of Health (Office of Health Care Quality), and Health Services Cost Review Commission

EXHIBIT 14

UNIVERSITY of MARYLAND
SHORE REGIONAL
HEALTH

Health Care on Maryland's Eastern Shore: From Vision to Reality

Our Health Care Journey

Population Health & TCOC focus

HRO Journey

2006 — UMMS, Shore Health merger

2008 — Chestertown joins UMMS

2011 — QAEC/MOB Opening

2013 — Merger: Shore & Chester River form UM SRH

2015 — CADMUS Pavilion Opens & Easton RMC Property purchase

2016 — Women's Health opens, Cardiology affiliation, Orthopedic group affiliates, Clark Comprehensive Cancer center expansion/renaming, Urgent Care service line (Denton/Easton)

2018 — Cancer LINAC #1 Upgrade, PCI services launch

2019 — Denton MOB Opens

2020 — Partnership with SOM Radiology/Oncology

2021 — Ortho/Rehab Expansion, Cancer LINAC #2 upgrade, Chestertown MRH/AWCE, Cambridge FMF

2022 — Settlement of DGH, projected opening of QA Urgent Care

EPIC Conversion

Expanding Access via Telemedicine

LEGEND:
Red = UM SOM Collaboration

Mid-Shore Care Delivery Model Prior To Re-Visioning (2017)

•Queen Anne's

•<u>Freestanding Medical Facility</u>
- 24/7 Emergency & Observation

<u>Medical Pavilion:</u> rotating specialists, ambulatory Surgery, diagnostic services

•Talbot

•<u>Full Service Acute Care Hospital</u>
- 24/7 Emergency & Observation
- Maintain regional specialty services

•<u>Primary care</u>
•<u>Ambulatory surgery</u>
•<u>Non-Hospital OP services</u>
•<u>Diagnostic services</u>

•Kent

•<u>Full Service Acute Hospital:</u>
- 24/7 Emergency
- Low volume specialties

•Caroline

•Scattered primary care,
•specialists

•Dorchester

•<u>Full Service Acute Care Hospital</u>
- 24/7 Emergency & Observation
- Behavioral health
- Limited non-hospital OP services

Significant Investment in Transforming Mid-Shore Care Delivery Model

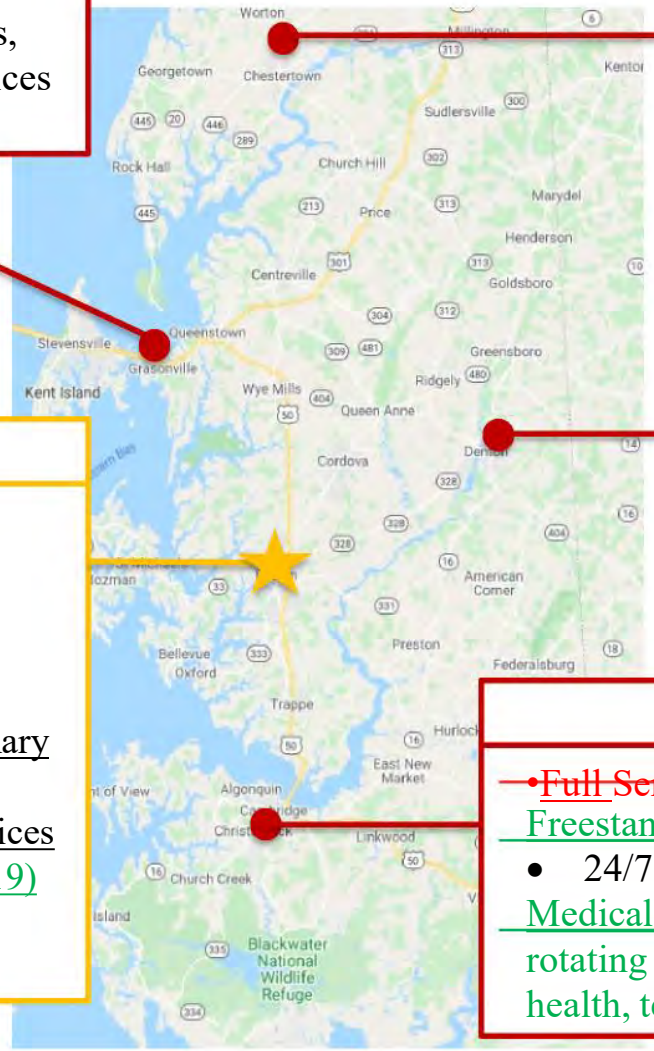
•Queen Anne's

•Freestanding Medical Facility
- 24/7 Emergency & Observation

Medical Pavilion: rotating specialists, ambulatory Surgery, diagnostic services
Urgent Care (2021)

•Talbot

•Full Service Acute Care Hospital
•24/7 Emergency & Observation
•Maintain regional specialty services
•Added services to meet community
•need: PCI, Rehab Center of
•Excellence, 24/7 OB hospitalist Primary care
•Ambulatory surgery Outpatient services
Diagnostic services Urgent Care (2019)



•Kent

~~•Full Service Acute Care~~ Hospital Rural Hospital (2021): 24/7 Emergency, IP < 4-day LOS, defined IP/OP surgical
•Aging & Wellness Center

•Caroline

•Medical Pavilion (2019): Primary care, rotating specialists, OP Rehab, Behavioral health, telemedicine, diagnostic services
•Urgent Care partnership (2019)

•Dorchester

~~•Full Service Acute Care~~ Hospital
Freestanding Medical Facility (2021)
- 24/7 Emergency & Observation

Medical Pavilion (2021): Primary care, rotating specialists, OP Rehab, Behavioral health, telemedicine, diagnostic services

EXHIBIT 15

3/10 - Melissa –
* Shawn received same

TOWN OF EASTON

P. O. Box 520
Easton, Maryland 21601

March 4, 2010

Richard E. Hall, Secretary
Maryland Department of Planning
301 West Preston Street
Baltimore, Maryland 21201

Re: Shore Health System/UMMS Hospital Relocation and Medical Campus; Certification of Priority Funding Area

Dear Secretary Hall:

This letter is a request to designate parcels recently annexed into the Town of Easton as Priority Funding Areas (PFA). As Easton's Mayor and on behalf of the Easton Town Council I offer the attached supporting documentation as certification that The Town of Easton has annexed, via Resolution No. 5955, lands owned by Talbot County and Shore Health System, Inc. into the Town of Easton. The annexation is generally located on the west side of U.S. Route 50 and consists of 276.479 acres. The annexation was approved by the Easton Town Council December 7, 2009 and became effective January 21, 2010. This annexation meets the qualifications for designation as a PFA under the "Smart Growth" Areas Act of 1997. In addition, the area was previously designated as a PFA in Talbot County in May of 2009 .

Ordinance No. 561 was approved in conjunction with the annexation resolution establishing original Town zoning for the annexed parcels. The annexation is made up of three parcels (A, B, & C) totaling 276.479 acres and are shown on the attached plat. Parcels "A & B" have been zoned **Regional Healthcare (RH)** and Parcel "C" has been zoned **Governmental/Institutional (G/I).** Both of these classifications were recently created by the Town primarily to accommodate this anticipated annexation. The area qualifies as an employment zone based on the zoning established which permits a regional hospital and ancillary uses on parcels "A & B" and public recreational uses on parcel "C". Furthermore, the property is designated in the Talbot County Master Water and Sewer Plan as "W-1/S-1," for immediate priorty water and sewer service.

I understand that this certification will be filed by the Department, that the Department may include comments as part of the file, and that the Department will coordinate with State funding agencies to inform them about the property's designation as a PFA. If you have any questions about this certification, please contact Town Planner Tom Hamilton at (410) 822-1943.

Sincerely,

Robert C. Willey

Robert Willey
Mayor

Enc. (copies: Res. 5955, Ord. 561, Dept. of Planning annexation letter)

cc: Shawn Kiernan MDP
Sharon VanEmburgh, Town Attorney
Tom Hamilton, Town Planner

ORDINANCE NO. 561

AN ORDINANCE OF THE TOWN OF EASTON AMENDING THE OFFICIAL ZONING MAP OF THE TOWN OF EASTON TO APPLY AN ORIGINAL ZONING CLASSIFICATION OF REGIONAL HEALTHCARE AND GOVERNMENTAL/INSTITUTIONAL TO THREE PARCELS OF LAND ANNEXED TO THE TOWN OF EASTON BY RESOLUTION NO. 5955 LOCATED ON THE WEST SIDE OF U.S. ROUTE 50 AND CONSISTING OF 276.479 ACRES OF LAND, MORE OR LESS

Introduced by: Mr. Lesher

WHEREAS, the Town of Easton (the "Town") is authorized by the Maryland Annotated Code, Article 23A Section 19(s) to exercise planning and zoning jurisdiction in any area annexed by it; and

WHEREAS, the Town of Easton is authorized by Maryland Annotated Code (the "Code") Article 66B, §4.01 *et seq.* to enact and administer a zoning ordinance, which ordinance is Chapter 28 of the Easton Town Code; and

WHEREAS, the Town is authorized by Article 66B, §4.02 of the Code to divide land within the municipal boundaries into zoning districts in a manner it deems best suited to execute the purposes of Article 66B; and

WHEREAS, the Town is authorized by Article 66B, §§4.04 and 4.05 of the Code to amend, supplement, modify or repeal sections of the zoning ordinance; and

WHEREAS, the Town has acted pursuant to its authority under Article 23A, Section 19 of the Code to introduce Resolution No. 5955 (the "Resolution") to expand its municipal boundaries by annexing lands adjacent to the present Town boundaries as requested by Talbot County, Maryland ("County") and Shore Health System, Inc. ("SHS"). The area proposed for annexation includes portions of three parcels owned by the County located on the west side of US Route 50, north of the Town's existing municipal boundary, consisting of a total of 276.479± acres of land, more or less (the "Annexation Property") comprised of: Tax Map 17, Parcel 75, containing 88.08 acres of land, more or less, of which 86.975 acres is proposed for annexation ("Parcel 'A'"); Tax Map 17, Parcel 129, containing 148.06 acres of land, more or less, of which 145.870 acres is proposed for annexation ("Parcel 'B'"); and Tax Map 17, Parcel 38, containing 43.67 acres of land, more or less, of which 43.633 acres is proposed for annexation ("Parcel 'C'"). The Annexation Property is shown on a plat titled "ANNEXATION 2009, TOWN OF EASTON OF THE LANDS OF

TALBOT COUNTY, MARYLAND IN THE FIRST ELECTION DISTRICT, TALBOT COUNTY, MARYLAND", prepared by Christopher Waters Professional Land Surveying, last revised August 4, 2009 (the "Annexation Plat"), which is Exhibit "A" to this Ordinance and to the Resolution.

WHEREAS, Regional Healthcare (RH) and Governmental/Institutional (G/I), the zoning designations established pursuant to Ordinance No. 560 and proposed by Petitioners for the Annexation Property, are consistent with relevant provisions of the Town Comprehensive Plan; and

WHEREAS, the Town Planning Commission considered the annexation and zoning requests during its public meeting on September 24, 2009 and recommended that the Easton Town Council annex the Annexation Property and zone such land as Regional Healthcare (RH) or Governmental/Institutional (G/I) as indicated herein; and

WHEREAS, the Easton Town Council finds that it is in the best interest of the Town to amend the Official Zoning Map of the Town to include the annexed property and to establish Regional Healthcare (RH) and Governmental/Institutional (G/I) zoning for such property; and

WHEREAS, the Easton Town Council held a duly noticed public hearing on this Ordinance on November 16, 2009.

Now, therefore, the Town of Easton hereby ordains as follows:

Section 1. Incorporation. The Annexation Plat attached hereto as Exhibit A is incorporated herein by reference.

Section 2. Modification of Official Zoning Map Boundaries. The Official Zoning Map of the Town of Easton is hereby amended to add those certain parcels or tracts of land annexed pursuant to Resolution No. 5955 (the "County Zoning Amendment Area"), which Annexation Property described on the Annexation Plat and is also described in a metes and bounds description prepared by Christopher Waters Professional Land Surveying entitled "Annexation, Town of Easton, Lands of Talbot County, Maryland", which is Exhibit "B" to said Resolution.

Section 3. Designation of Zoning for County Zoning Amendment Area. The County Zoning Amendment Area, as depicted by the Annexation Plat, shall be assigned classification of Regional Healthcare (RH) or Governmental/Institutional (G/I) as follows: (i) the annexed portions of Parcels A & B shall be zoned Regional Healthcare (RH), and (ii) the annexed portion of Parcel C

shall be zoned Governmental/Institutional (G/I). In accordance with Section 107 of the Zoning Ordinance, the amendment shall be made on the Official Zoning Map promptly after adoption of this Ordinance by the Easton Town Council with an entry on the Official Zoning Map as follows: "On Dec 7, 2009, by official action of the Town Council, the following changes were made in the Official Zoning Map: (1) 276.4791± acres, located generally east of Hailem School Road, south of Hiners Lane and west of Maryland Route 50 (including a portion of the Maryland Route 662 right-of-way) and lying contiguous to the corporate boundaries of the Town of Easton, are added hereto; (2) 232.845± acres of said lands are zoned and designated Regional Healthcare (RH); (3) 43.633± acres of said lands are zoned and designated Governmental/Institutional (G/I)", which entry shall be signed by the Mayor and Council attested by the Town Clerk.

Section 4. County Zoning Consent. The proposed Regional Healthcare (RH) and Governmental/Institutional (G/I) zoning classifications permit land uses that are different from the land uses allowed under the current County zoning classifications applicable to the Annexation Property. In accordance with Article 23A, Section 9(c) of the Code, if Talbot County expressly approves, the Town can place the annexed land in zoning classifications that allow different land uses. The classification of the Annexation Property in the Regional Healthcare (RH) and Governmental/Institutional (G/I) zoning districts is contingent upon the Town's receiving the express consent of the County prior to the effective date of this Ordinance.

Section 5. Survival. Except as amended herein, the remainder of the Official Zoning Map and the remaining terms of existing ordinances shall remain in full force and effect.

Section 6. Effective Date. In accordance with Article 23A, Section 19 and Article 66B, Sections 4.04 and 4.05 of the Code and Article II, Section 9 of the Easton Town Charter, this Ordinance shall become effective upon the later of: (a) the effective date of the Annexation Resolution pursuant to which the land area that it the subject of this Ordinance is annexed to the Town of Easton, (b) ten (10) days after the Town Council's public hearing on this Ordinance, or (c) twenty (20) calendar days after approval by the Mayor or passage of this Ordinance by the Council over the Mayor's veto.

Section 7. Severability. The Easton Town Council intends that, if a court of competent jurisdiction issues a final decision holding that any part of this ordinance is invalid, the remaining provisions hereof remain in full force and effect.

Ford	-	Yea
Wendowski	-	Yea
Malone	-	Yea
Lesher	-	Yea
Cook	-	Yea

I hereby certify that the above Ordinance was passed by a yea and nay vote of the Council this 7th day of December, 2009.

John Ford
John F. Ford, President

Delivered to the Mayor by me this 7th day of December, 2009.

Kathy M. Ruff
Kathy M. Ruff, Town Clerk

APPROVED: December 7, 2009

Date: December 7, 2009

Robert C. Willey
Robert C. Willey, Mayor

EFFECTIVE DATE: January 21, 2010.

Maryland Department of Planning

Martin O'Malley
Governor
Anthony G. Brown
Lt. Governor

Richard Eberhart Hall
Secretary
Matthew J. Power
Deputy Secretary

March 18, 2010

Mr. Robert Willey
Mayor
Town of Easton
P.O. Box 520
Easton, Maryland 21601

Re: Shore Health System/UMMS Hospital Relocation and Medical Campus; Certification of Priority Funding Area

Dear Mayor Willey:

Thank you for your March 4, 2010 letter regarding the status of the Priority Funding Area for the Shore Health System Hospital Relocation and Medical Campus. The Maryland Department of Planning (MDP) has assessed these areas based on the criteria for Priority Funding Areas contained in Finance and Procurement Article §5-7B-02.

Our understanding is that the annexed parcels being added to the PFA are consistent with current growth policies. The properties are also in the approved 10 year County Water and Sewer Plan as areas planned for service. These parcels are zoned as RH, regional healthcare and as G/I, governmental-institutional. Additionally, the area is inside a primary growth area in the Talbot County Comprehensive Land Use Plan as well as the Town of Easton's growth area. It is also designated as an area to be used primarily for employment.

The subject properties therefore meet all the designation requirements for Priority Funding Area certification. Accordingly, the Priority Funding Area maps prepared by the Maryland Department of Planning will be updated to reflect these changes and will be provided to the appropriate State funding agencies.

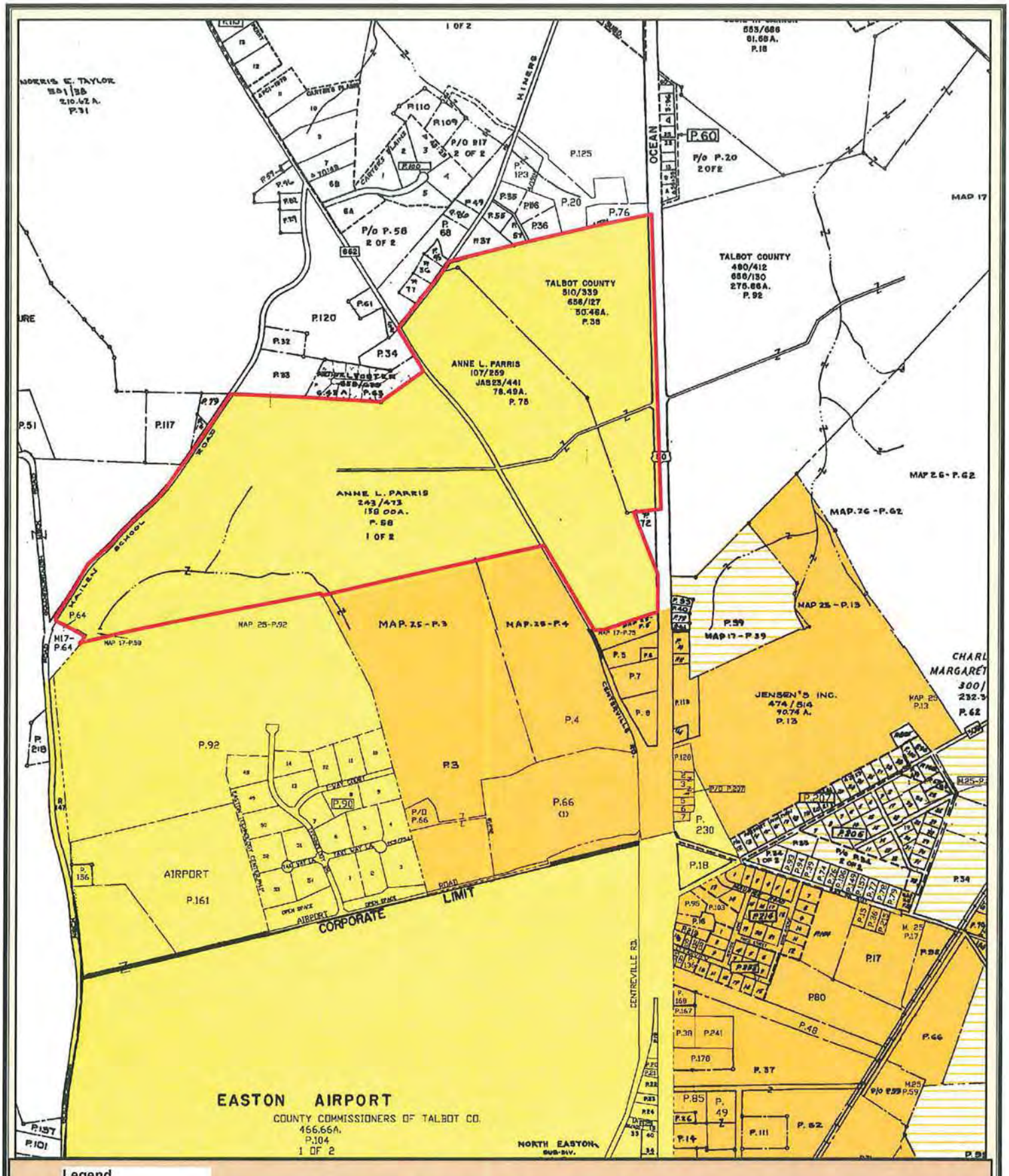
Thank you again for your letter. I look forward to working with you on future Smart Growth efforts. If you need anything further or have any additional questions please contact me at 410-767-4500.

301 West Preston Street • Suite 1101 • Baltimore, Maryland 21201-2305
Telephone: 410.767.4500 • Fax: 410.767.4480 • Toll Free: 1.877.767.6272 • TTY Users: Maryland Relay
Internet: www.MDP.state.md.us

Sincerely,

Stephanie Martins
Director, Land Use Planning Analysis

CC: Shawn Kiernan, MDP
Sharon VanEmburgh, Town Attorney
Tom Hamilton, Town Planner, Town of Easton
Sandy Coyman, Planning Officer, Talbot County
Matthew J. Power, Deputy Secretary, MDP
Richard Josephson, Director of Planning Services, MDP
Melissa Appler, MDP


EASTON AIRPORT
COUNTY COMMISSIONERS OF TALBOT CO.
466.66A.
P.104
1 OF 2
TALBOT COUNTY
510/339
658/127
50.48A.
P.38
ANNE L. PARRIS
107/259
JA823/441
78.49A.
P. 75
ANNE L. PARRIS
243/473
158.00A.
P. 58
1 OF 2
TALBOT COUNTY
490/412
656/130
276.66A.
P. 92
JENSEN'S INC.
474/814
90.74 A.
P. 13
AIRPORT
P.161
CORPORATE LIMIT
MAP 25 - P.3
MAP 25 - P.4
MAP 25-P.92
MAP 17-P.39
MAP 26 - P.62
NORTH EASTON SUB-DIV.
CENTREVILLE RD.
MAILEY SCHOOL ROAD
OCEAN
HIMERS
P.92
P.3
P.4
P.66
P.80
P.17
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P.117
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Legend
Easton Hospital Site
Municipal PFA
Municipal PFA Comment Area
Annexed but not PFA
PFA
PFA Comment Area
PRIORITY FUNDING AREAS
Easton, Maryland
MDP
Maryland Department of Planning
March 2010
0.1 0.05 0 0.1 Miles

EXHIBIT 16

LEVEL 03 - 27 BED MED / SURG, 1 PEDS

LEVEL 03	ROOM NAME	DEPT	NSF
LEVEL 03	1 (ADA)	MED / SURG	289
LEVEL 03	2	MED / SURG	273
LEVEL 03	3	MED / SURG	273
LEVEL 03	4	MED / SURG	273
LEVEL 03	5	MED / SURG	273
LEVEL 03	6	MED / SURG	273
LEVEL 03	7	MED / SURG	273
LEVEL 03	8	MED / SURG	273
LEVEL 03	9	MED / SURG	273
LEVEL 03	10	MED / SURG	273
LEVEL 03	11	MED / SURG	273
LEVEL 03	12 (ADA)	MED / SURG	316
LEVEL 03	13	MED / SURG	272
LEVEL 03	14 (ISO)	MED / SURG	270
LEVEL 03	15 (ISO)	MED / SURG	252
LEVEL 03	16	MED / SURG	252
LEVEL 03	17	MED / SURG	252
LEVEL 03	18	MED / SURG	252
LEVEL 03	19	MED / SURG	252
LEVEL 03	20	MED / SURG	252
LEVEL 03	21	MED / SURG	252
LEVEL 03	22	MED / SURG	252
LEVEL 03	23 (PALLIATIVE CARE)	MED / SURG	252
LEVEL 03	24 (PALLIATIVE CARE, ADA)	MED / SURG	305
LEVEL 03	ALC	MED / SURG	48
LEVEL 03	ALC	MED / SURG	30
LEVEL 03	ALC	MED / SURG	18
LEVEL 03	ALCOVE	MED / SURG	70
LEVEL 03	CC	MED / SURG	18
LEVEL 03	CHART	MED / SURG	20
LEVEL 03	CHART	MED / SURG	22
LEVEL 03	CHART	MED / SURG	20
LEVEL 03	CHART	MED / SURG	22
LEVEL 03	CHART	MED / SURG	22
LEVEL 03	CHART	MED / SURG	20
LEVEL 03	CHART	MED / SURG	20
LEVEL 03	CHART	MED / SURG	20
LEVEL 03	CHART	MED / SURG	22
LEVEL 03	CHART	MED / SURG	19
LEVEL 03	CHART	MED / SURG	22
LEVEL 03	CHART	MED / SURG	22
LEVEL 03	CLEAN	MED / SURG	208
LEVEL 03	DIET CART	MED / SURG	16
LEVEL 03	EQ	MED / SURG	247

LEVEL 03	EQ ALC	MED / SURG	32
LEVEL 03	FAM TLT/SHWR	MED / SURG	56
LEVEL 03	HSKP	MED / SURG	59
LEVEL 03	HSKP	MED / SURG	45
LEVEL 03	LINEN	MED / SURG	44
LEVEL 03	LINEN	MED / SURG	23
LEVEL 03	LOCKERS	MED / SURG	291
LEVEL 03	MED	MED / SURG	104
LEVEL 03	MED	MED / SURG	111
LEVEL 03	MED/SURG 1	MED / SURG	204
LEVEL 03	MED/SURG 2	MED / SURG	203
LEVEL 03	MEDS / SUPPLIES	MED / SURG	146
LEVEL 03	MULTI-PURPOSE	MED / SURG	126
LEVEL 03	NOUR	MED / SURG	68
LEVEL 03	OFFICE, CARE COORD	MED / SURG	93
LEVEL 03	OFFICE, CASE MGR	MED / SURG	93
LEVEL 03	OFFICE, CLIN NURSE COORD	MED / SURG	110
LEVEL 03	OFFICE, EDUCATION	MED / SURG	96
LEVEL 03	OFFICE, UNIT MGR	MED / SURG	91
LEVEL 03	PALLIATIVE CARE FAMILY ROOM	MED / SURG	242
LEVEL 03	PALLIATIVE WORK (4)	MED / SURG	166
LEVEL 03	PEDS	MED / SURG	203
LEVEL 03	SOILED HOLD	MED / SURG	108
LEVEL 03	SOILED HOLDING	MED / SURG	135
LEVEL 03	ST BREAK	MED / SURG	137
LEVEL 03	ST TLT	MED / SURG	72
LEVEL 03	STAFF STATION	MED / SURG	114
LEVEL 03	STR ALC	MED / SURG	38
LEVEL 03	TEAM ROOM	MED / SURG	159
LEVEL 03	TLT/SHWR	MED / SURG	38
LEVEL 03	TLT/SHWR	MED / SURG	38
LEVEL 03	TLT/SHWR	MED / SURG	40
LEVEL 03	TLT/SHWR	MED / SURG	38
LEVEL 03	TLT/SHWR	MED / SURG	38
LEVEL 03	TLT/SHWR	MED / SURG	38
LEVEL 03	TLT/SHWR	MED / SURG	38
LEVEL 03	TLT/SHWR	MED / SURG	38
LEVEL 03	TLT/SHWR	MED / SURG	38
LEVEL 03	TLT/SHWR	MED / SURG	60
LEVEL 03	TLT/SHWR	MED / SURG	40
LEVEL 03	TLT/SHWR	MED / SURG	40
LEVEL 03	TLT/SHWR	MED / SURG	40
LEVEL 03	TLT/SHWR	MED / SURG	40
LEVEL 03	TLT/SHWR	MED / SURG	40
LEVEL 03	TLT/SHWR	MED / SURG	40
LEVEL 03	TLT/SHWR	MED / SURG	40
LEVEL 03	TLT/SHWR	MED / SURG	40

LEVEL 03	TLT/SHWR	MED / SURG	40
LEVEL 03	TLT/SHWR	MED / SURG	57
LEVEL 03	TLT/SHWR	MED / SURG	62
LEVEL 03	TLT/SHWR	MED / SURG	38
LEVEL 03	TLT/SHWR	MED / SURG	38
LEVEL 03	TLT/SHWR	MED / SURG	38
LEVEL 03	TLT/SHWR	MED / SURG	38
LEVEL 03	TLT/SHWR	MED / SURG	38
LEVEL 03	TLT/SHWR	MED / SURG	40
LEVEL 03	WORK STATION	MED / SURG	248
LEVEL 03	WORK STATION	MED / SURG	227
	MED / SURG SUBTOTAL		**12313**
	SHARED SUPPORT		332.5
	TOTAL NET		12645.5
	TOTAL BEDS		27
	SF/BED		**468.4**

LEVEL 03 - SHARED

LEVEL 03	ROOM NAME	DEPT	NSF
LEVEL 03	CONSULT	SHARED SUPPORT	106
LEVEL 03	FAMILY WAIT	SHARED SUPPORT	430
LEVEL 03	PUB TLT	SHARED SUPPORT	51
LEVEL 03	PUB TLT	SHARED SUPPORT	51
LEVEL 03	VENDING	SHARED SUPPORT	27
	LEVEL 03 SHARED		665

LEVEL 04 - 12 BED ICU

LEVEL 04	ROOM NAME	DEPT	NSF
LEVEL 04	ALC	ICU	11
LEVEL 04	ALC	ICU	10
LEVEL 04	ALCOVE	ICU	17
LEVEL 04	ALCOVE	ICU	12
LEVEL 04	ALCOVE	ICU	38
LEVEL 04	ALCOVE	ICU	28
LEVEL 04	ALCOVE	ICU	46
LEVEL 04	CASE MGR	ICU	119
LEVEL 04	CHART	ICU	17
LEVEL 04	CHART	ICU	19
LEVEL 04	CHART	ICU	22
LEVEL 04	CHART	ICU	18
LEVEL 04	CHART	ICU	18
LEVEL 05	CHART	ICU	20
LEVEL 04	CLEAN SUPPLY	ICU	245
LEVEL 04	CLIN COORD	ICU	116
LEVEL 04	CONSULT	ICU	97
LEVEL 04	DIET CART	ICU	41
LEVEL 04	EQ STOR	ICU	76
LEVEL 04	FAM TLT	ICU	64
LEVEL 04	FAMILY	ICU	275
LEVEL 04	HSKP	ICU	51
LEVEL 04	ICU ON CALL	ICU	116
LEVEL 04	LINEN	ICU	40
LEVEL 04	MEDS	ICU	158
LEVEL 04	MULTI-PURPOSE	ICU	123
LEVEL 04	NOUR	ICU	117
LEVEL 04	NURSE STATION	ICU	206
LEVEL 04	OFFICE, MGR	ICU	121
LEVEL 04	PAT TLT	ICU	34
LEVEL 04	PAT TLT	ICU	36
LEVEL 04	PAT TLT	ICU	36
LEVEL 04	PAT TLT	ICU	36
LEVEL 04	PAT TLT	ICU	39
LEVEL 04	PAT TLT	ICU	42
LEVEL 04	PAT TLT	ICU	38
LEVEL 04	PAT TLT	ICU	36
LEVEL 04	PAT TLT	ICU	37
LEVEL 04	PAT TLT	ICU	35
LEVEL 05	PAT TLT	ICU	40
LEVEL 06	PAT TLT	ICU	39
LEVEL 04	PATIENT RM 5	ICU	274
LEVEL 04	PATIENT RM 6 (ADA)	ICU	288
LEVEL 05	PATIENT RM 11 - ISO	ICU	264

LEVEL 06	PATIENT RM 12 - ISO	ICU	268
LEVEL 04	PATIENT RM 1	ICU	275
LEVEL 04	PATIENT RM 2	ICU	269
LEVEL 04	PATIENT RM 3	ICU	275
LEVEL 04	PATIENT RM 7 (ADA)	ICU	311
LEVEL 04	PATIENT RM 8	ICU	269
LEVEL 05	PATIENT RM 9	ICU	269
LEVEL 06	PATIENT RM 10	ICU	268
LEVEL 04	PATIENT RM 4	ICU	271
LEVEL 04	SOILED HOLDING	ICU	111
LEVEL 04	ST BREAK	ICU	207
LEVEL 04	ST TLT	ICU	73
LEVEL 04	STR ALC	ICU	25
LEVEL 04	TEAM WORK	ICU	116
LEVEL 04	TLT/ SHWR	ICU	67
	ICU		**6589**
	SHARED SUPPORT		969.5
	TOTAL NET		7558.5
	TOTAL BEDS		12
	SF/BED		**629.9**

LEVEL 04 - 24 BED MED / SURG

LEVEL 04	ROOM NAME	DEPT	NSF
LEVEL 04	1 (ADA)	MED / SURG	297
LEVEL 04	2	MED / SURG	273
LEVEL 04	3	MED / SURG	273
LEVEL 04	4	MED / SURG	270
LEVEL 04	5	MED / SURG	273
LEVEL 04	6	MED / SURG	273
LEVEL 04	7	MED / SURG	273
LEVEL 04	8	MED / SURG	273
LEVEL 04	9	MED / SURG	273
LEVEL 04	10	MED / SURG	273
LEVEL 04	11	MED / SURG	273
LEVEL 04	12 (ADA)	MED / SURG	323
LEVEL 04	13	MED / SURG	273
LEVEL 04	14 (ISO)	MED / SURG	270
LEVEL 04	15 (ISO)	MED / SURG	251
LEVEL 04	16	MED / SURG	251
LEVEL 04	17	MED / SURG	251
LEVEL 04	18	MED / SURG	251
LEVEL 04	19	MED / SURG	251
LEVEL 04	20	MED / SURG	251
LEVEL 04	21	MED / SURG	251
LEVEL 04	22 (LIFT)	MED / SURG	251
LEVEL 04	23 (LIFT)	MED / SURG	251
LEVEL 04	24	MED / SURG	261
LEVEL 04	ALC	MED / SURG	30
LEVEL 04	ALC	MED / SURG	17
LEVEL 04	ALC	MED / SURG	18
LEVEL 04	ALC	MED / SURG	48
LEVEL 04	ALCOVE	MED / SURG	70
LEVEL 04	CC	MED / SURG	18
LEVEL 04	CHART	MED / SURG	22
LEVEL 04	CHART	MED / SURG	22
LEVEL 04	CHART	MED / SURG	22
LEVEL 04	CHART	MED / SURG	20
LEVEL 04	CHART	MED / SURG	20
LEVEL 04	CHART	MED / SURG	20
LEVEL 04	CHART	MED / SURG	22
LEVEL 04	CHART	MED / SURG	20
LEVEL 04	CHART	MED / SURG	20
LEVEL 04	CHART	MED / SURG	22
LEVEL 04	CHART	MED / SURG	20
LEVEL 04	CLEAN	MED / SURG	214
LEVEL 04	DIET CART	MED / SURG	16
LEVEL 04	EQUIP	MED / SURG	247

LEVEL 04	HSKP	MED / SURG	40
LEVEL 04	IV TEAM / VASC ACCESS	MED / SURG	127
LEVEL 04	LINEN	MED / SURG	23
LEVEL 04	LINEN	MED / SURG	44
LEVEL 04	MED	MED / SURG	98
LEVEL 04	MEDS	MED / SURG	110
LEVEL 04	NOUR	MED / SURG	68
LEVEL 04	OFFICE, CARE COORD	MED / SURG	93
LEVEL 04	OFFICE, CASE MGR	MED / SURG	93
LEVEL 04	OFFICE, CLIN NURSE COORD	MED / SURG	104
LEVEL 04	SOILED HOLDING	MED / SURG	128
LEVEL 04	ST BREAK	MED / SURG	136
LEVEL 04	ST TLT	MED / SURG	72
LEVEL 04	STR ALC	MED / SURG	26
LEVEL 04	TEAM ROOM	MED / SURG	159
LEVEL 04	TLT/ SHWR	MED / SURG	40
LEVEL 04	TLT/ SHWR	MED / SURG	38
LEVEL 04	TLT/SHWR	MED / SURG	37
LEVEL 04	TLT/SHWR	MED / SURG	37
LEVEL 04	TLT/SHWR	MED / SURG	37
LEVEL 04	TLT/SHWR	MED / SURG	37
LEVEL 04	TLT/SHWR	MED / SURG	37
LEVEL 04	TLT/SHWR	MED / SURG	37
LEVEL 04	TLT/SHWR	MED / SURG	37
LEVEL 04	TLT/SHWR	MED / SURG	38
LEVEL 04	TLT/SHWR	MED / SURG	63
LEVEL 04	TLT/SHWR	MED / SURG	40
LEVEL 04	TLT/SHWR	MED / SURG	40
LEVEL 04	TLT/SHWR	MED / SURG	40
LEVEL 04	TLT/SHWR	MED / SURG	40
LEVEL 04	TLT/SHWR	MED / SURG	40
LEVEL 04	TLT/SHWR	MED / SURG	40
LEVEL 04	TLT/SHWR	MED / SURG	40
LEVEL 04	TLT/SHWR	MED / SURG	40
LEVEL 04	TLT/SHWR	MED / SURG	38
LEVEL 04	TLT/SHWR	MED / SURG	63
LEVEL 04	TLT/SHWR	MED / SURG	40
LEVEL 04	TLT/SHWR	MED / SURG	40
LEVEL 04	WORK STATION	MED / SURG	249
LEVEL 04	WORK STATION	MED / SURG	227
	MED / SURG SUBTOTAL		**10091**
	SHARED SUPPORT		969.5
	TOTAL NET		11060.5
	TOTAL BEDS		24
	SF/BED		**460.9**

LEVEL 04 - SHARED

LEVEL 04	ROOM NAME	DEPT	NSF
LEVEL 04	CENTRAL MONITORING	SHARED SUPPORT	290
LEVEL 04	CONFERENCE	SHARED SUPPORT	319
LEVEL 04	CONFERENCE	SHARED SUPPORT	307
LEVEL 04	CONSULT	SHARED SUPPORT	106
LEVEL 04	FAMILY WAITING	SHARED SUPPORT	438
LEVEL 04	LOCKERS	SHARED SUPPORT	277
LEVEL 04	OFFICE, EDUCATION	SHARED SUPPORT	100
LEVEL 04	PUB TLT	SHARED SUPPORT	51
LEVEL 04	PUB TLT	SHARED SUPPORT	51
	LEVEL 04 SHARED		1939

LEVEL 05 - 24 BED MED / SURG

LEVEL 05	ROOM NAME	DEPT	NSF
LEVEL 05	1 (ADA)	MED / SURG	283
LEVEL 05	2	MED / SURG	273
LEVEL 05	3	MED / SURG	273
LEVEL 05	4	MED / SURG	273
LEVEL 05	5	MED / SURG	273
LEVEL 05	6	MED / SURG	273
LEVEL 05	7	MED / SURG	273
LEVEL 05	8	MED / SURG	273
LEVEL 05	9	MED / SURG	272
LEVEL 05	10	MED / SURG	262
LEVEL 05	11	MED / SURG	273
LEVEL 05	12 (ADA)	MED / SURG	323
LEVEL 05	13	MED / SURG	273
LEVEL 05	14 (ISO)	MED / SURG	270
LEVEL 05	15 (ISO)	MED / SURG	252
LEVEL 05	16	MED / SURG	252
LEVEL 05	17	MED / SURG	252
LEVEL 05	18	MED / SURG	252
LEVEL 05	19	MED / SURG	252
LEVEL 05	20	MED / SURG	252
LEVEL 05	21	MED / SURG	252
LEVEL 05	22	MED / SURG	252
LEVEL 05	23	MED / SURG	252
LEVEL 05	24	MED / SURG	252
LEVEL 05	ALC	MED / SURG	30
LEVEL 05	ALC	MED / SURG	17
LEVEL 05	ALC	MED / SURG	18
LEVEL 05	ALC	MED / SURG	48
LEVEL 05	ALCOVE	MED / SURG	70
LEVEL 05	CC	MED / SURG	18
LEVEL 05	CHART	MED / SURG	22
LEVEL 05	CHART	MED / SURG	22
LEVEL 05	CHART	MED / SURG	22
LEVEL 05	CHART	MED / SURG	22
LEVEL 05	CHART	MED / SURG	22
LEVEL 05	CHART	MED / SURG	20
LEVEL 05	CHART	MED / SURG	20
LEVEL 05	CHART	MED / SURG	20
LEVEL 05	CHART	MED / SURG	20
LEVEL 05	CHART	MED / SURG	20
LEVEL 05	CHART	MED / SURG	22
LEVEL 05	CHART	MED / SURG	20
LEVEL 05	CLEAN	MED / SURG	208
LEVEL 05	DIET CART	MED / SURG	16

LEVEL 05	EQUIP	MED / SURG	247
LEVEL 05	HSKP	MED / SURG	45
LEVEL 05	LINEN	MED / SURG	23
LEVEL 05	LINEN	MED / SURG	44
LEVEL 05	MED	MED / SURG	104
LEVEL 05	MED	MED / SURG	108
LEVEL 05	NOUR	MED / SURG	68
LEVEL 05	OFFICE, CARE COORD	MED / SURG	93
LEVEL 05	OFFICE, CASE MGR	MED / SURG	93
LEVEL 05	OFFICE, CLIN NURSE COORD	MED / SURG	115
LEVEL 05	OFFICE, JOINT CENTER NAVIGATOR	MED / SURG	87
LEVEL 05	SOILED HOLDING	MED / SURG	141
LEVEL 05	ST BREAK	MED / SURG	132
LEVEL 05	ST TLT	MED / SURG	72
LEVEL 05	STR ALC	MED / SURG	26
LEVEL 05	TEAMWORK ROOM	MED / SURG	159
LEVEL 05	TLT/SHWR	MED / SURG	38
LEVEL 05	TLT/SHWR	MED / SURG	38
LEVEL 05	TLT/SHWR	MED / SURG	38
LEVEL 05	TLT/SHWR	MED / SURG	38
LEVEL 05	TLT/SHWR	MED / SURG	38
LEVEL 05	TLT/SHWR	MED / SURG	38
LEVEL 05	TLT/SHWR	MED / SURG	38
LEVEL 05	TLT/SHWR	MED / SURG	38
LEVEL 05	TLT/SHWR	MED / SURG	59
LEVEL 05	TLT/SHWR	MED / SURG	40
LEVEL 05	TLT/SHWR	MED / SURG	40
LEVEL 05	TLT/SHWR	MED / SURG	40
LEVEL 05	TLT/SHWR	MED / SURG	40
LEVEL 05	TLT/SHWR	MED / SURG	40
LEVEL 05	TLT/SHWR	MED / SURG	41
LEVEL 05	TLT/SHWR	MED / SURG	40
LEVEL 05	TLT/SHWR	MED / SURG	40
LEVEL 05	TLT/SHWR	MED / SURG	40
LEVEL 05	TLT/SHWR	MED / SURG	40
LEVEL 05	TLT/SHWR	MED / SURG	63
LEVEL 05	TLT/SHWR	MED / SURG	38
LEVEL 05	TLT/SHWR	MED / SURG	38
LEVEL 05	TLT/SHWR	MED / SURG	38
LEVEL 05	TLT/SHWR	MED / SURG	40
LEVEL 05	WORK STATION	MED / SURG	237
LEVEL 05	WORK STATION	MED / SURG	246
	MED / SURG SUBTOTAL		**10085**
	SHARED SUPPORT		675.5
	TOTAL NET		10760.5
	TOTAL BEDS		24
	SF/BED		**448.4**

LEVEL 05 - SHARED

LEVEL 05	ROOM NAME	DEPT	NSF
LEVEL 05	CONSULT	SHARED SUPPORT	106
LEVEL 05	FAMILY WAITING	SHARED SUPPORT	448
LEVEL 05	HSKP	SHARED SUPPORT	67
LEVEL 05	LOCKERS	SHARED SUPPORT	210
LEVEL 05	OFFICE, MGR	SHARED SUPPORT	117
LEVEL 05	OFFICE, STROKE COORD	SHARED SUPPORT	95
LEVEL 05	PUB TLT	SHARED SUPPORT	51
LEVEL 05	PUB TLT	SHARED SUPPORT	51
LEVEL 05	STAFF EDUC/ MULTIPURPOSE ROOM	SHARED SUPPORT	206
	LEVEL 05 SHARED		1351

LEVEL 06 - 12 BED BEHAVIORAL HEALTH

LEVEL 06	ROOM NAME	DEPT	NSF
LEVEL 06	1	BEHAVIORAL HEALTH	191
LEVEL 06	2	BEHAVIORAL HEALTH	185
LEVEL 06	3	BEHAVIORAL HEALTH	192
LEVEL 06	4	BEHAVIORAL HEALTH	191
LEVEL 06	5	BEHAVIORAL HEALTH	191
LEVEL 06	6	BEHAVIORAL HEALTH	195
LEVEL 06	7	BEHAVIORAL HEALTH	188
LEVEL 06	8	BEHAVIORAL HEALTH	188
LEVEL 06	9	BEHAVIORAL HEALTH	188
LEVEL 06	10	BEHAVIORAL HEALTH	188
LEVEL 06	11	BEHAVIORAL HEALTH	188
LEVEL 06	12	BEHAVIORAL HEALTH	188
LEVEL 06	ADA TLT/ SHWR	BEHAVIORAL HEALTH	60
LEVEL 06	CLEAN SUPPLY	BEHAVIORAL HEALTH	106
LEVEL 06	CONFER. / TREATMENT PLANNING	BEHAVIORAL HEALTH	147
LEVEL 06	CONSULT	BEHAVIORAL HEALTH	123
LEVEL 06	DAY ROOM / DINING	BEHAVIORAL HEALTH	560
LEVEL 06	EQ STOR	BEHAVIORAL HEALTH	181
LEVEL 06	GROUP THERAPY / QUIET ACTIVITY	BEHAVIORAL HEALTH	598
LEVEL 06	HSKP	BEHAVIORAL HEALTH	96
LEVEL 06	LAUNDRY	BEHAVIORAL HEALTH	84
LEVEL 06	LINEN	BEHAVIORAL HEALTH	40
LEVEL 06	LOUNGE / LOCKERS	BEHAVIORAL HEALTH	374
LEVEL 06	MEDS	BEHAVIORAL HEALTH	118
LEVEL 06	MULTI PURPOSE	BEHAVIORAL HEALTH	140
LEVEL 06	NOURISHMENT	BEHAVIORAL HEALTH	78
LEVEL 06	OFFICE	BEHAVIORAL HEALTH	116
LEVEL 06	OFFICE	BEHAVIORAL HEALTH	116
LEVEL 06	OFFICE	BEHAVIORAL HEALTH	108
LEVEL 06	PATIENT STORAGE	BEHAVIORAL HEALTH	125
LEVEL 06	QUIET ROOM	BEHAVIORAL HEALTH	83
LEVEL 06	SECLUSION ROOM	BEHAVIORAL HEALTH	81
LEVEL 06	SOILED HOLDING	BEHAVIORAL HEALTH	99
LEVEL 06	ST TLT	BEHAVIORAL HEALTH	61
LEVEL 06	ST TLT	BEHAVIORAL HEALTH	73
LEVEL 06	STAFF STATION	BEHAVIORAL HEALTH	358
LEVEL 06	STO	BEHAVIORAL HEALTH	17
LEVEL 06	STO	BEHAVIORAL HEALTH	17
LEVEL 06	STO.	BEHAVIORAL HEALTH	19
LEVEL 06	STO.	BEHAVIORAL HEALTH	19
LEVEL 06	STOR	BEHAVIORAL HEALTH	10
LEVEL 06	TLT	BEHAVIORAL HEALTH	59

LEVEL 06	TLT/ SHWR	BEHAVIORAL HEALTH	39
LEVEL 06	TLT/ SHWR	BEHAVIORAL HEALTH	39
LEVEL 06	TLT/ SHWR	BEHAVIORAL HEALTH	39
LEVEL 06	TLT/ SHWR	BEHAVIORAL HEALTH	39
LEVEL 06	TLT/ SHWR	BEHAVIORAL HEALTH	39
LEVEL 06	TLT/ SHWR	BEHAVIORAL HEALTH	39
LEVEL 06	TLT/ SHWR	BEHAVIORAL HEALTH	39
LEVEL 06	TLT/ SHWR	BEHAVIORAL HEALTH	37
LEVEL 06	TLT/ SHWR	BEHAVIORAL HEALTH	39
LEVEL 06	TLT/ SHWR	BEHAVIORAL HEALTH	39
LEVEL 06	TLT/ SHWR	BEHAVIORAL HEALTH	39
LEVEL 06	VISIT RM	BEHAVIORAL HEALTH	201
LEVEL 06	VISITOR STORAGE	BEHAVIORAL HEALTH	53
	BEHAVIORAL HEALTH SUBTOTAL		**7020**
	SHARED SUPPORT		272.5
	TOTAL NET		7292.5
	TOTAL BEDS		12
	SF/BED		**607.7**

LEVEL 06 - SHARED

LEVEL 06	ROOM NAME	DEPT	NSF
LEVEL 06	FAMILY WAITING	SHARED SUPPORT	434
LEVEL 06	TLT	SHARED SUPPORT	56
LEVEL 06	TLT	SHARED SUPPORT	55
	LEVEL 06 SHARED		545

EXHIBIT 17

PRIMARY ACUTE STROKE PATIENT TRANSFER AGREEMENT BETWEEN THE MEMORIAL HOSPITAL AT EASTON, INC. AND THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION

EFFECTIVE DATE: December 15, 2006

PURPOSE: In response to state regulations addressing the care of acute stroke patients, the **MEMORIAL HOSPITAL AT EASTON,INC**, a health care facility owned and operated by Shore Health System, Inc. (the "Facility"), enters into this transfer agreement with the **University of Maryland Medical Center**, a health care facility owned and operated by University of Maryland Medical System Corporation ("UMMC"). The purpose of the agreement is to establish a process for the transfer and care of acute stroke patients requiring neurosurgical intervention.

POLICY

A. POINT OF CONTACT:

UMMC's Maryland ExpressCare (*"ExpressCare"*), will be the sole source of contact throughout the process. All inquiries related to patient transport should go through *ExpressCare*. This process allows for the most timely and efficient utilization of resources and avoids conflicting communications.

B. REQUEST FOR TRANSPORT:

1. A member of the Facility's stroke team will contact *ExpressCare* at (410) 328-1234, upon determining that the patient requires neurosurgical intervention for acute stroke-related conditions such as subarachnoid hemorrhage or acute intracerebral hemorrhage. The number for *ExpressCare* is.
2. Upon reaching *ExpressCare*, the Facility Stroke Team will:
   a. Identify the Facility and notify *ExpressCare* that a transfer of an acute stroke patient for neurosurgical intervention is necessary.
   b. Provide *ExpressCare* with logistical information, patient demographics, clinical information and any other requested information.
   c. If the patient requires transport to UMMC, the Facility Stroke Team will fax the patient's "face sheet" with demographic data to *ExpressCare* at (410) 328-1235.
3. If a member of the UMMC medical staff medical accepts the patient for transfer and appropriate resources are available, *ExpressCare* will timely dispatch the Maryland *ExpressCare* Team, which will include a registered nurse, to transport the patient from the Facility to UMMC.
4. If the patient transfer is accepted and a bed is available but a Maryland *ExpressCare* Team is not available to effect the transfer, the following will occur:
   a. *ExpressCare* will check the availability of other Advanced Life Support ("ALS") vendor resources. If a Critical Care team is available, *ExpressCare* will dispatch the team in order to respond in a timely manner.
   b. If vendor resources are exhausted and no Critical Care Team is available, *ExpressCare* will then call the Facility to indicate the lack of Critical Care transport availability to accompany patient during transport with dispatched ALS team. Facility will then dispatch a qualified registered nurse to accompany the patient during transport.

Xerox - Linda Pittman

C. UMMC ACCEPTANCE OF TRANSFERRED PATIENTS:

If a UMMC medical staff member accepts the patient for transfer and appropriate resources are available, UMMC will receive and provide treatment to the transferred patient to care for the acute stroke patient once the initial triage, assessment and treatment have been completed by the Facility.

D. NO TRANSPORT NECESSARY:

The Facility will notify *ExpressCare* if the transfer is later determined to be unnecessary.

E. ADVISORY NOTICE PRIOR TO ADMINISTERING TISSUE PLASMINOGEN ACTIVATOR

To the extent possible, a member of the Facility's stroke team will contact the *ExpressCare*, to indicate that the Facility's Stroke Team will be administering tissue-plasminogen activator ("t-PA") or similar intravenous acute stroke intervention to a patient.

F. ADMINISTRATIVE PROVISIONS

1. Any modification of this agreement, including any extension , shall be effective only if in writing and signed on behalf of both parties
2. This agreement does not create a joint venture or partnership between UMMC and the Facility.
3. This agreement shall be governed by the law of the State of Maryland; the parties agree to be subject to the jurisdiction of the Maryland courts.
4. The Facility may not assign this Agreement.
5. This agreement may be executed and delivered in one or more counterparts (including by facsimile transmission), each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

Agreed to and approved this 6th day of December, 2006

THE MEMORIAL HOSPITAL AT EASTON, INC.
A health care facility owned and operated by Shore Health System, Inc.

By: _____
Joseph P. Ross
President and Chief Executive Officer

UNIVERSITY OF MARYLAND MEDICAL CENTER
A health care facility owned and operated by the University of Maryland Medical System Corporation

By: _____
Name: Alison G. Brown, MPH
Title: Senior Vice President

TRANSFER AGREEMENT

This Transfer Agreement is entered into on May 20, 2008, by and between Chester River Health System ("Chester River") and The Memorial Hospital at Easton, a health care facility owned and operated by Shore Health System, Inc. ("Shore Health").

WHEREAS, both parties desire to assure continuity of care and treatment appropriate to the needs of each patient and to use the skills, resources, and physical plant of both parties in a coordinated and cooperative fashion to improve patient care at both the acute and post-acute stages of illness.

NOW, THEREFORE, in consideration of the mutual advantages occurring to the parties hereto, Hospital and Shore Health hereby covenant and agree with each other as follows:

1. Both parties agree to make a concerted effort to transfer patients as soon as practical when the need for transfer from Chester River to Shore Health has been determined by the patient's attending physician, provided, however, all eligibility conditions for admission must be met and documented in the patient's medical record.

2. Chester River agrees to send with each patient at the time of transfer or, in the case of any emergency as promptly as possible after the transfer, an abstract of the patient's medical record including:

   (A) the current medical findings,
   (B) diagnosis,
   (C) a brief summary of the course of treatment followed,
   (D) all other administrative and social information useful to provide continuing care to the patient; using the transfer and referral form mutually agreed upon.

3. Chester River, after promptly notifying Shore Health of the impending transfer of a patient and after Shore Health consents to accept such patient, shall assume the responsibility to arrange for appropriate and safe transportation of the patient, his/her personal effects and valuables, and shall provide any necessary care while he/she is being transferred.

4. Charges for services performed by either Chester River or Shore Health for patients transferred from the other institution pursuant to this Agreement, shall be collected by the institution rendering such services, directly from the patient, third party payers, or the other sources normally billed by the institution; and neither party shall have any liability to the other for such charges except to the extent that such liabilities would exist separate and apart from this Agreement.

5. The parties agree that the transfer of a patient pursuant to this Agreement shall not be predicated upon discrimination based on race, religion, national origin, age, sex, physical condition or economic status. The parties also agree that the transfer or receipt of patients shall not be based upon a patient's inability to pay for services rendered by the transferring or receiving institution or a patient's source of payment.

6. All patient transfers pursuant to this Agreement must be accomplished in a medically appropriate manner from physician to physician and from institution to institution by: (i) the use of appropriate life support measures which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to stabilize the patient prior to transfer and to sustain the patient during the transfer; (ii) the provision of appropriate personnel and equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use for the transfer; (iii) the transfer of all necessary records for continuing the care for the patient; and (iv) the consideration of the availability of appropriate facilities, services, and staff for providing care for the patient. The parties agree that before moving a patient, Chester River shall explain the reasons for the transfer and any alternative to the patient or a legally authorized representative of the patient. If it is necessary to move the patient immediately to protect the health, safety or welfare of the patient, Chester River may give the explanation of the reasons for the transfer concurrently with the transfer.

7. The parties agree to recognize the right of a patient to request transfer into the care of a physician and institution of the patient's own choosing and to recognize and comply with all federal and state requirements relating to the transfer of patients.

8. Chester River agrees not to transfer a patient with an emergency medical condition that has not been stabilized unless: (i) the patient, or a legally responsible person acting on the patient's behalf, after being informed of Chester River's obligations under law and of the risk of transfer, requests in writing transfer to another institution; (ii) a licensed physician has signed a certification which includes a summary of the risks and benefits that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another institution outweigh the increased risks to the patient and, in the case of labor, to the unborn child from effecting the transfer; or (iii) if a licensed physician is not physically present at the time a patient is transferred, a qualified medical person has signed a certification described in subparagraph (ii) above after a license physician, in consultation with the person, has made the determination described in subparagraph (ii) above and subsequently countersigns the certificate.

9. All notices hereunder by either party to the other party shall be in writing, delivered personally or by overnight courier, and shall be deemed to have been duly given when delivered personally or one day after delivered to the overnight carrier, charges prepaid, and properly addressed to the respective parties at the addresses shown following each party's signature to this Agreement.

10. This Agreement shall be effective from the date of signing by both parties and shall continue in effect, except that either party may withdraw by giving 60 days written notice to the other party of its intention to terminate this Agreement. However, this Agreement shall be declared null and void and shall be immediately terminated should either party fail to maintain its licensure or certification status.

11. Both parties represent and warrant that, during the term of this Agreement, each shall comply with all applicable state and federal laws and regulations and shall remain in good standing with applicable accrediting organizations.

12. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other institution, on either a limited or general basis, while this Agreement is in effect.

13. This Agreement may be modified or amended by the mutual agreement of the parties, however, any such modification or amendment shall be attached to and become a part of this Agreement. This Agreement shall be construed in accordance with the laws of the State of Maryland.

CHESTER RIVER HEALTH SYSTEM, INC.

By: _____

Name: SCOTT D BURLESON

Title: Executive Vice President

100 Brown Street
Chestertown, Maryland 21620

SHORE HEALTH SYSTEM, INC.

By: _____

Name: GERARD M. WALSH

Title: Sr. V.P. & C.O.O.

219 South Washington Street
Easton, Maryland 21601

GENERAL TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (hereinafter "Agreement"), is effective December 1, 2013, by and between University of Maryland Shore Regional Health, Inc., including Shore Medical Center at Easton, Shore Medical Center at Dorchester, and Shore Medical Center at Chestertown (hereinafter "Health Care Facility") located at 219 South Washington Street, Easton, MD 21601, and Alfred I. duPont Hospital for Children, of The Nemours Foundation, a Florida not-for-profit corporation (hereinafter "AIDHC") located at 1600 Rockland Road, Wilmington, Delaware, 19803. Both Health Care Facility and AIDHC are hereinafter referred to as "Parties" to this Agreement and each may be referred to as "Institution".

WITNESSETH

WHERAS, Health Care Facility is a not-for-profit corporation that operates a health care system to provide access to patient care for the residents of its service area; and

WHEREAS, The Nemours Foundation is a not-for-profit corporation that operates a hospital to provide pediatric patient care; and

WHEREAS, the parties desire to provide reasonable assurance that the transfer of patients will be properly effected between the institutions when a transfer is either medically appropriate as determined by the referring physician or when the patient requests the transfer;

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Health Care Facility and AIDHC agree as follows:

1. Term. This Agreement shall commence on the day and year first above written and shall continue for a period of five (5) years, unless terminated earlier by either Institution as set forth below.

2. Patient Transfer. The patient's attending physician will determine when transfer of a patient, from one Institution to the other is appropriate. When a decision to transfer has been made, the transferring Institution shall contact the receiving Institution as far in advance of the anticipated transfer as possible to obtain the receiving Institution's consent to the transfer. Prior to moving the patient, the transferring Institution must receive confirmation from the receiving Institution that it can accept the patient.

3. Patient Records. Each Institution agrees to adopt standard forms for medical and administrative information to accompany the patient from one Institution to the other. The information shall include, but not be limited to, an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption. Each Institution agrees to supplement the above information as necessary for the maintenance of the patient during transport and treatment upon arrival at the receiving Institution.

4. Personal Effects. The transferring party shall transfer the patient's personal effects, including money and valuables, and information pertaining to same. A list prepared by the transferring party of all personal effects shall be transferred with the patient and shall include the signature of the person making the list. An attempt should be made to have family members

or friends voluntarily transfer such personal effects if possible. The receiving party shall, as soon as practical upon patient arrival, document that all personal effects were received or will notify the transferring facility if items were lost.

5. Medical Information. The transferring party agrees to transmit with each patient at the time of transfer, or in case of an emergency, as promptly as possible thereafter, all available pertinent medical and other records necessary to continue the patient's treatment without interruption and to provide identifying and other information, which must include:

(a) A completed interagency communication summary to include; as applicable

- current medical findings;
- diagnosis;
- rehabilitation potential;
- brief summary of the course of treatment followed at Health Care Facility;
- nursing and dietary information useful in care of the patient;
- administrative and pertinent social information;
- post-discharge plan of care;
- all other information required by law or deemed necessary.

(b) Documentation of any known Health Care Treatment Directive, including any durable power of attorney for health care decisions, living will, guardianship papers or withholding of resuscitation orders.

(c) Documentation of (i) the name of the person requesting the transfer, (ii) the fact that the patient or person with authority to act on the patient's behalf consented to the transfer (except in emergencies), (iii) the name of the person at the receiving party who accepted the transfer.

6. Patient Consent to Transfer. The transferring Institution shall have responsibility for obtaining the appropriate consent to the transfer to the other Institution, prior to the transfer. This should include the patient's attending physician's signature authorizing the transport.

7. Charges. The patient/parent is primarily responsible for payment for care received at either Institution and for the costs to transport the patient for the transfer. Prior to transfer, except in urgent circumstances, the patient/parent should be required, if competent, to acknowledge the obligation to pay for such care at the receiving Institution and the transport costs. Each Institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either Institution to look to the other Institution to pay for services rendered to a patient transferred by virtue of this Agreement.

8. Transport. The transferring party shall arrange for appropriate and safe transportation of the patient in compliance with applicable laws, regulations and Joint Commission standards.

9. Return of Patient to Health Care Facility. When the Receiving party is AIDHC, the Health Care Facility shall be expected to be available for the return of the transferred patient when:

(a) the patient's medical condition has stabilized and the patient is ready for discharge from AIDHC, and

(b) the patient has needs for continued care appropriate to the scope of services provided by the Health Care Facility.

10. Liability. Each Institution shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other Institution.

11. Indemnification. Each party (the "Indemnifying Party") will defend, indemnify and hold the other parties and the other parties' employees, officers, governing body and medical staff members, physicians, agents, representatives and affiliates (collectively the "Indemnified Parties") harmless against any and all claims, suits, proceedings, demands, liabilities, losses, damages, penalties, fines, interest, costs and attorney's fees which may be brought, claimed or asserted against or incurred by the Indemnified Parties, and which arise from or result from the Indemnified Party's provision or failure to provide any of the Services described in this Agreement or from any negligence or other tortious or wrongful act or omission by the Indemnifying party or its employees, physicians, contractors or representatives. This provision shall survive termination of this Agreement.

12. Insurance. Each Institution agrees to obtain and maintain in force during the term of the Agreement professional and general liability insurance with minimum limits of $1 million per occurrence or claim and $3 million annual aggregate. Upon request, each Institution will provide the other with a certificate of insurance verifying such coverage at all times this Agreement is in effect. Each Institution shall notify the other at least thirty (30) days prior to cancellation, reduction or material change in coverage. If the insurance is on a "claims made" basis, each Institution agrees to purchase appropriate tail coverage for claims, demands or actions reported in future years for acts or omissions during the term of this Agreement. If either Institution fails to obtain or maintain the insurance coverage provided herein, the other party may terminate this Agreement. The parties may satisfy this requirement through an actuarially sound plan of self insurance.

13. Termination.

13.1 Voluntary Termination. This Agreement may be terminated by either Institution for any reason, by giving thirty (30) days written notice of its intention to withdraw from this Agreement, and by ensuring the continuity of care to patients who already are involved in the transfer process. To this end, the terminating Institution will be required to meet its commitments under the Agreement to all patients for whom the other Institution has begun the transfer process in good faith.

13.2 Involuntary Termination. This Agreement may be terminated immediately upon the occurrence of any of the following:

13.2.1 Either Institution is destroyed to such an extent that the patient care provided by such Institution cannot be carried out adequately;

13.2.2 Either Institution loses its license or accreditation;

13.2.3 Either Institution is no longer able to provide the service for which this Agreement was sought;

13.2.4 Either Institution is in material default under any of the terms of this Agreement; or

13.2.5 Either Institution becomes a Sanctioned Provider as defined in Appendix A.

14. Independent Contractor Status. The Parties are independent contractors and neither Institution is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by either Institution, nor shall it in any way alter the control of the management, assets and affairs of the respective Parties. Neither Institution, by virtue of the Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other Institution to this Agreement.

15. Regulatory Compliance. The Parties agree to abide by all applicable federal, state and local laws and regulations, to include the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the Health Insurance Portability and Accountability Act ("HIPAA"), and federal and state anti-kickback laws. This agreement is not intended to violate the Anti-Kickback or Stark laws and it is not the purpose, nor is it a requirement of this Agreement to offer or receive any remuneration or inducement in exchange for the referral of any patient or other health care business between the parties.

16. Discrimination. The Parties agree that the primary consideration of both is care of patients according to their needs. Health Care Facility and AIDHC agree to admit and assign patients without regard to race, color, sex, age, national origin, religious creed or sexual preference.

17. Advertising and Public Relations. Neither Institution shall use the name of the other Institution in any promotional or advertising material unless review and approval of the intended advertisement first shall be obtained from the Institution whose name is to be used. The Parties shall deal with each other publicly and privately in an atmosphere of mutual respect and support, and each Institution shall maintain good public and patient relations and efficiently handle complaints and inquiries with respect to transferred or transferring patients.

18. Modification of Waiver. If either Institution to this Agreement waives a breach of one of the provisions of this Agreement by the other Institution, that waiver shall neither operate nor be construed as a waiver of a subsequent similar breach of a provision hereof.

19. Governing Law. This Agreement is made and entered into and shall be governed and construed in accordance with the laws of the State of Delaware.

20. Assignment. The Agreement shall not be assigned in whole or in part by either Institution hereto without the express written consent of the other Institution.

21. Invalid Provision. In the event that any portion of the Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the Parties hereto in the same manner as if the invalid or unenforceable provision were not a part of the Agreement.

22. Amendment. This Agreement may be amended at any time by a written Agreement signed by the Parties hereto.

23. Notice. Any and all notices and other communications required or permitted to be given hereunder shall be made in writing and effective upon receipt. Such notices shall be personally delivered, sent by registered or certified mail, by a nationally recognized overnight delivery service or sent by facsimile or electronic mail with confirmation, addressed as follows, unless such address is changed by written notice hereunder:

If to Health Care Facility:

University of Maryland Shore Regional Health, Inc.
219 South Washington Street
Easton, MD 21601
Attn: President & CEO

If to AIDHC:

Alfred I. duPont Hospital for Children
1600 Rockland Road
Wilmington, DE 19803
Attn: Diane Hochstuhl
E-mail: dhochstu@nemours.org

With a copy to:

Office of Contracts Administration
The Nemours Foundation
10140 Centurion Parkway North
Jacksonville, FL 32256
Fax: 904.697.4070
E-mail: oca@nemours.org

24. Entire Agreement. This Agreement constitutes the entire agreement between the Parties and contains all of the agreements between them with respect to the subject matter hereof and supersedes any and all other agreements, either oral or in writing, between the Parties with respect to the subject matter hereof.

25. Assignment. This Agreement may not be assigned in whole or in part by any Party without the express written consent of the other Party.

26. Counterparts and Electronic Signature. This Agreement may be executed in two or more counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. Delivery of an executed signature page to the Agreement by facsimile transmission or .PDF will be as effective as delivery of a manually signed counterpart.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed by persons duly authorized to bind the Parties to perform their respective obligations hereunder, as of the date first written above.

ALFRED I. duPONT HOSPITAL FOR CHILDREN OF THE NEMOURS FOUNDATION

By: M. Kay Holbrook
Name: M. Kay Holbrook
Title: Associate Administrator
Date: 12/2/13

UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH, INC.

By:
Name: Kenneth Kozel
Title: President & CEO
Date: 12/12/13

APPENDIX A

"Sanctioned Provider" means a Person who:

1. is currently under indictment or prosecution for, or has been convicted of:

a) any offense related to the delivery of an item or service under the Medicare or Medicaid programs or any program funded under Title V or Title XX of the Social Security Act (the Maternal Child Health Services Program or the Block Grants to States for Social Services programs, respectively),

b) a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service,

c) fraud, theft, embezzlement or other financial misconduct in connection with the delivery of a health care item or service,

d) obstructing an investigation of any crime referred to in i) through iii) above, or

e) unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

2. has been required to pay any civil monetary penalty under 42 U.S.C. §1128A, regarding false, fraudulent or impermissible claims under, or payments to induce a reduction or limitation of health care services to beneficiaries of, any state or Federal health care program, or is currently the subject of any investigation or proceeding which may result in such payment; or

3. has been excluded from participation in the Medicare, Medicaid or Maternal and Child Health Services (Title V) program, or any program funded under the Block Grants to States for Social Services (Title XX) program.

ORIGINAL

STEMI PATIENT TRANSFER
MEMORANDUM OF UNDERSTANDING

THIS MEMORANDUM OF UNDERSTANDING ("MOU") is made and entered into by and between Peninsula Regional Medical Center, located at 100 East Carroll Street, Salisbury, Maryland ("PRMC") and Shore Health System, Inc. ("SHS"), on behalf of its wholly owned and operated acute care hospitals, The Memorial Hospital, located at 219 S. Washington Street, Easton, Maryland and Dorchester General Hospital, located at 300 Bryn Street, Cambridge, MD 21613, (individually and collectively referred to herein as SHS facilities).

RECITALS:

WHEREAS, SHS facilities do not perform certain cardiac procedures that may be required by patients presenting with ST-segment elevation MI ("STEMI patients");

WHEREAS, PRMC does perform such procedures and further is a designated by the Maryland Institute for Emergency Medical Services Systems (MIEMSS) designated Cardiac Interventional Center (CIC);

WHEREAS, SHS desires to arrange for the provision of needed cardiology and cardiac services to its STEMI patients and facilitate the continuity of their care by transferring such patients to PRMC in order to receive the necessary cardiac procedures; and

WHEREAS, PRMC desires to accept such transfers and to provide such services to SHS's transferred STEMI patients;

NOWTHEREFORE, in consideration of the mutual covenants and agreements set forth herein, PRMC, and SHS agree as follows;

1. **TRANSFER OF PATIENTS.** All transfers between any SHS facility and PRMC shall be performed in accordance with applicable federal and state statutes and regulations, the standards of The Joint Commission, and the MIEMMS Interhospital Transfer Guidelines. In addition, in the course of effectuating a transfer addressed by this MOU, both SHS and PRMC shall adhere to their own reasonable policies and procedures applicable to patient transfers. Both PRMC and SHS agree to retain data regarding performance measures of services provided under this MOU as may be necessary for purposes of certification and/or accreditation. Neither the acceptance of the transfer of a STEMI a patient nor the refusal to accept the transfer of a STEMI patient shall be predicated upon arbitrary, capricious, or unreasonable grounds or discrimination or based upon the patient's inability to pay for services rendered by either PRMC or SHS.

2. **RESPONSIBILITIES OF THE TRANSFERRING FACILITY.** SHS facilities shall evaluate for transfer all patients determined to be STEMI patients as

defined by the MIEMMS regulations at COMAR 30.08.16.01. If a SHS facility determines transfer of a STEMI patient is appropriate, decides to transfer such STEMI patient to PRMC, and concludes the transfer to PRMC meets the MIEMMS Interhospital Transfer Guidelines such SHS facility, as the "Transferring Facility," shall be responsible for performing or ensuring performance of the following:

a. Provide for a member of the nursing staff or the patient's attending physician to contact the Peninsula Access Center using the contact information set forth in Section 12;

b. Provide, within its capabilities, evaluation of the patient for transfer, medical screening and stabilizing treatment of the patient prior to transfer;

c. Arrange for the patient's safe and appropriate transportation to PRMC, the use of appropriate equipment and personnel and the appropriate care for the patient during transfer, in accordance with applicable federal and state laws and regulations and the MIEMMS Interhospital Transfer Guidelines;

d. Select an authorized representative of the Transferring Facility to coordinate the patient's transfer ("Designated Representative") and provide the name of such designated representative to the Receiving Facility.

e. Communicate to the Receiving Facility the Receiving Physician, defined as the treating physician's or patient's choice of physician or cardiology practice to receive the patient once transferred to the Receiving Facility, the physician providing coverage for chosen Physician or cardiology group, or if those Receiving Physicians are unavailable, the on-call cardiologist, all of whom shall be properly credentialed, licensed and experienced cardiologists ("Receiving Physician");

f. Forward to the Receiving Physician and the Receiving Facility a copy of those portions of the patient's medical record that are available at the time of transfer and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of transfer. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible via the fax number in Section 12.

g. Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items.

3. RESPONSIBILITIES OF THE RECEIVING FACILITY. PRMC's responsibility for the patient's care, as the "Receiving Facility," shall begin when the

patient arrives at or is admitted to the Receiving Facility. Specifically, the Receiving Facility shall be responsible for performing or ensuring performance of the following:

a. Arrange for the availability of the Receiving Physician requested by the patient's treating physician or the patient. If such physician is not reasonably available, provide for a properly credentialed, licensed and experienced Receiving Physician.

b. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the Receiving Physician with the receipt and treatment of the patient transferred, maintain a call roster of eligible Receiving Physicians at the Receiving Facility and provide, on request, the name of a Receiving Physician requested based on standing orders or the Receiving Physician providing coverage for that Receiving Physician's group, or the on-call Receiving Physician, to the Transferring Facility.

c. Reserve beds, facilities, and services as appropriate for STEMI patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a Receiving Physician. Transferred STEMI patients shall be treated in the emergency department, sent to the cardiac catheterization laboratory, directly admitted to a patient room, and/or sent to the operating room, as appropriate based on the patient's medical needs.

d. Select an authorized representative of the Receiving Facility to coordinate the patient's transfer ("designated representative") and provide the name of such designated individual to the Transferring Facility.

e. When the Transferring Facility cannot arrange for necessary personnel or equipment, and when appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the Transferring Physician (Physician at SHS who is responsible for the patient prior to transfer) and Receiving Physician.

f. Maintain the confidentiality of the patient's medical records in accordance with applicable state and federal law.

g. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medial records in accordance with applicable state and federal law, (ii) for the receipt of the patient into the facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient.

h. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider, including the MIEMMS standards for the transfer of STEMI patients.

4. BILLING. All charges incurred with respect to any services performed by either PRMC or SHS for transferred STEMI patients shall be billed and collected by the

party furnishing such services. In addition, it is understood that professional fees will be billed by the physicians or other professional providers at SHS facilities and/or PRMC that may participate in the care and treatment of the patient. Both SHS and PRMC agree to provide information in its possession to the other and to physicians/providers sufficient to enable the treating providers to bill for services provided..

5. DISCHARGE. When the transferred patient is ready for discharge as appropriate to the patient's medical condition, the Receiving Physician shall contact the Transferring Physician or the patient's primary care physician.

6. COMPLIANCE WITH LAW. SHS and PRMC shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of medical records, confidentiality or patient information, and the rules and standards of MIEMMS for the transfer and treatment of STEMI patients, as well as with all standards promulgated by any relevant accrediting agency.

7. RESPONSIBILITY; INSURANCE. SHS and PRMC shall be responsible for their own acts and omissions in the performance of their duties, and the acts and omissions of their own employees and agents. In addition, each party shall maintain, throughout the term of this MOU, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party, and shall provide evidence of that coverage upon request.

8. TERM; TERMINATION.

a. Term; Renewal. The initial term of this MOU ("Initial Term") shall be for a period of 3 year(s), commencing on 5-18, 2011 unless sooner terminated herein. At the end of the Initial Term and upon mutual written agreement of the parties, this MOU may be renewed for subsequent additional terms of one (1) year ("Renewal Terms").

b. Holdover. In the event the parties continue to abide by the terms of this MOU after the expiration of the Initial Term or any Renewal Term, without renewing the MOU in accordance with Section 8.a., this MOU shall continue on a month-to-month basis.

c. Termination Without Cause. Either party may terminate this MOU without cause upon thirty (30) days written notice to the other party.

d. Termination for Breach. Either party may terminate this MOU upon breach by the other party of any material provision of this MOU, provided the breach continues for five (5) days after receipt by the breaching party of written notice of the breach from the non-breaching party.

e. Immediate Termination. Either party may terminate this MOU immediately upon the occurrence of any of the following events:

i. The other party's closure or discontinuation of operation to such an extent that patient care cannot be carried out adequately.

ii. The other party's loss of its license, conviction of a criminal offense related to health care, inclusion on a federal agency's list of entities and individuals who are debarred, excluded or otherwise ineligible for federal program participation.

9. ENTIRE AGREEMENT; MODIFICATION. This MOU contains the entire understanding of the parties with respect to the subject matter and supersedes all prior agreements, oral or written, and all other communications between the parties relating to the subject matter. This MOU may not be amended or modified except by mutual agreement.

10. GOVERNING LAW. This Agreement shall be construed in accordance with the laws of the State of Maryland. The provisions of this Paragraph shall survive expiration or other termination of this MOU regardless of the cause of the termination.

11. PARTIAL INVALIDITY. If any provision of this MOU is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this MOU.

12. NOTICES. All notices by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to PRMC: Peninsula Regional Medical Center
100 East Carroll Street
Salisbury, Maryland 21801
Attn: Executive Director
Guerrieri Heart and Vascular Institute
Fax: 410-912-5757

Peninsula Access Center 410-543-4722

If to SHS: Shore Health System, Inc.
219 South Washington Street
Easton, Maryland 21601
Attn: Director of Cardiology

or to such other persons or places as any party may from time to time designate by written notice to the other.

13. WAIVER. A waiver by any party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. ASSIGNMENT; BINDING EFFECT. Neither party shall assign or transfer, in whole or in part, this MOU or any of their rights, duties or obligations under this MOU without the prior written consent of the other party, and any assignment or transfer by any party without such consent shall be null and void. This MOU shall inure to the benefit of and be binding upon the parties and their respective heirs, representatives, successors and permitted assignees.

THE PARTIES have executed this Agreement on 5-25, 2011

SHORE HEALTH SYSTEM, INC.

By: _____
Gerard M. Walsh
Interim President and CEO

Date: 5-18-11

PENINSULA REGIONAL MEDICAL CENTER

By: _____
Margaret (Peggy) M. Naleppa, DR.M.
President/CEO

Date: 5-25-2011

PATIENT TRANSFER AGREEMENT

THIS AGREEMENT ("Agreement") is made this 16th day of November 2000, by and between Shore Health System of Maryland and **PENINSULA REGIONAL MEDICAL CENTER,** a Maryland corporation ("Peninsula Regional")(each, a "Party").

WHEREAS:

1. Both Parties to this Agreement are providers of health care services which seek to improve the treatment of patients by providing continuity of care and treatment appropriate to the needs of each such patient;

2. Neither Party offers all services needed by its patients and both wish to make provision for the transfer of its patients for additional needed services;

3. At least one Party does have facilities offering services needed by patients of the other Party and is licensed to provide such services;

4. Each Party needs assurance of a referral mechanism to provide these services to its patients which the Party does not offer; and

5. This Agreement is intended to cover the circumstances where patients may be transferred by either Party to the other. The terms of the Agreement refer to the "Transferor Institution" and "Transferee Institution." Depending upon the circumstances, either Party may be either a "Transferor Institution" or a "Transferee Institution." If a Party is transferring patients, then it is the "Transferor Institution." If a Party is receiving patients, then it is the "Transferee Institution."

NOW, THEREFORE, in consideration of the common aims, interests and mutual advantages accruing to the parties, the Parties covenant and agree as follows

1. **Recitals**. The above recitals are specifically incorporated by reference and hereby made a part of this Agreement,

2. **Autonomy**. The governing authorities of each Party shall have exclusive control of the management, assets and affairs of their respective institutions. Neither Party by virtue of this Agreement assumes any liability for any debts or obligations of any nature incurred by the other party to this Agreement. Neither party will assume responsibility for the care rendered to the patient by the other institution.

3. Each Party shall notify the other of it's designated representative(s) for the purpose of implementing this Agreement. In the event that Transferor Institution has a patient in need of services it does not provide and which Transferee Institution does provide, Transferor Institution will contact the designated representative of Transferee Institution who will recommend to Transferor Institution whether the

patient should be transferred from Transferor Institution to Transferee Institution. It shall be the responsibility of the Transferor Institution to determine that the patient can be transferred without harm. If Transferee Institution recommends that the patient be transferred to Transferee Institution, then the designated representative shall confirm to the Transferor Institution that the Transferee Institution consents to the transfer and that the patient meets Transferee Institution's admission criteria relating to appropriate bed, the patient's required level of care, and physician and other services necessary to treat the patient. The designated representative of Transferee Institution shall accept or arrange for acceptance of such patient on behalf of Transferee Institution and shall arrange for all necessary administrative authorizations for the transfer. The transfer of any such patients from Transferor Institution to Transferee Institution will be effected in accordance with federal and state law and regulations. Transferee Institution and Transferor Institution mutually agree to exercise their best efforts to provide for prompt admission of these patients to Transferee Institution.

4. In the event of transfer, it shall be the responsibility of the patient's physician at Transferor Institution to determine the safest and most appropriate means to transfer the patient to Transferee Institution. Transferor Institution will provide or arrange for an ambulance or other transport equipment which is able to provide appropriate treatment during transport. The Transferor Institution will provide medically appropriate personnel and equipment that a reasonable and prudent physician exercising ordinary care would use for the transfer. The transport shall use medically appropriate life-support measures that a reasonable and prudent physician exercising ordinary care would use to stabilize the patient before transfer and to sustain the patient during the transfer. Transferor Institution shall be solely responsible for all costs, or for the arrangement of coverage of all costs, or transporting the patient, including the costs of any necessary personnel, Transferor Institution shall he responsible for notifying Transferee Institution of the impending transfer, providing explanations of the reason for the transfer and any alternatives to the transfer to the patient or patient's Parent(s) or legal guardian(s), as well as obtaining approval for the transfer from such person. Transferor institution shall be solely responsible for assuring that all transfers under this Agreement comply with all federal and/or State requirements which govern the transfer of patients.

5. In compliance with 42 USCA 1395dd, 42 C.F.R. 489.24, Md. Health-Gen. Code Ann. 19-308.2, and COMAR 10. 07. 01. 23, Transferor Institution will provide a copy of the patient's medical records to Transferee Institution. This shall include medical records related to the patient's emergency medical condition, history and physical observations of signs, symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies or telephone reports of the studies, treatment provided, x-rays, results of any tests, written informed consent to the transfer (or physician certification as to the necessity of transfer), copies of any relevant signed consent forms, and any advance directives or other legal guidance believed by Transferor Institution to be currently in effect. A medication

schedule for the previous twelve (12) hours with dose and administration will be provided. These records should accompany the patient at the time of the transfer. For an emergent patient, the medical record may be faxed (within one hour) if time does not allow for photocopying.

6. As soon as a transfer has been made, it shall be the responsibility of Transferor Institution to advise the financially responsible party or agency of the transfer. Each party to this Agreement is solely responsible for all matters pertaining to billing and collecting its own patient charges. Neither party shall have any liability to the other for such charges nor shall be liable for any debts, obligations or claims of a financial or legal nature to the other party.

7. To maintain the quality of care to the transferred patients, all cases will be reviewed by Transferee Institution's Quality Assurance Department. The result of these reviews will be promptly communicated to Transferor Institution.

8. Transferor Institution and Transferee Institution agree that they will provide and ensure maximum confidentiality accorded by law with regard to all medical, business or other records generated in accordance with this Agreement.

9. Nothing in this Agreement shall be construed as limiting the rights of either Party to affiliate or contract with any other institution while this Agreement is in effect.

10. Neither Party shall use the name of the other Party in any promotion or advertising unless prior written approval of the intended use is obtained from the Party whose name is to be used.

11. This Agreement supersedes any relevant prior agreements between the Parties. This Agreement may be modified or amended from time to time by mutual agreement of the Parties and such modifications or amendments shall he attached to and become a part of this Agreement. This Agreement may not be assigned by either Party without the prior written consent of the other. This Agreement shall be construed and enforced in accordance with the laws of the State of Maryland.

12. Neither Party shall be entitled to compensation from the other Party for any services provided under this Agreement.

13. Transferor Institution shall be solely responsible for complying with State and Federal laws and regulations governing patient transfers. Transferor Institution shall not use the patient's inability to pay or source of payment for the patient as a reason to transfer the patient.

14. All notices hereunder shall be in writing and shall be deemed to have been duly given if delivered in hand or sent by registered or certified mail, postage prepaid,

to each Party at the address set forth below. Either Party may designate a different address by written notice given in the manner provided herein.

If to Peninsula Regional:

Peninsula Regional Medical Center
100 East Carroll Street
Salisbury, MD 21801
Attn: President

If to Shore Health System of Maryland:

Shore Health System of Maryland
219 S. Washington Street
Easton, MD 21601
Attn: Administrator

15. This Agreement shall commence as of the date set forth above and shall continue in effect for one year unless it is terminated by either Party. This Agreement shall be renewed for additional terms of one (1) year each in the absence of notice of intent not to renew given by either party. This Agreement may be terminated at any time by an authorized representative of the parties to this Agreement by providing the other Party with 30 days' prior written notice. However, this Agreement shall be automatically terminated if either Party has its license to operate revoked by the State of Maryland, its ability to participate in the Medicare and/or Medicaid programs is terminated, or if it loses accreditations by the Joint Commission or Accreditation of Healthcare organizations.

IN WITNESS WHEREOF, the authorized representatives of the parties to this Agreement have caused their respective principal's name to be subscribed to this Agreement.

PENINSULA REGIONAL MEDICAL CENTER
a Maryland corporation

Sharon R. Hassington

By: _____
Authorized Representative
Date: 11/17/00

_____

By: _____
Authorized Representative
Date: 11/27/00

prmc\patient transfer agr. 1109

AGREEMENT BETWEEN
EASTERN SHORE HOSPITAL CENTER
AND
SHORE HEALTH SYSTEM, INC.

THIS AGREEMENT, entered into and effective this _ day of April 2014 by and between Eastern Shore Hospital Center, a non-profit corporation organized and existing under the laws of Maryland (hereinafter referred to as "ESHC") and Shore Health System, a non-profit corporation organized and existing under the laws of Maryland that owns and operates University of Maryland Shore Medical Center at Easton and University of Maryland Shore Medical Center at Dorchester in Cambridge, Maryland (collectively hereinafter referred to as "Shore Health").

WHEREAS, both parties desire, by means of this Agreement, to facilitate the timely provision of services to ESHC patients; and to insure the continuity and quality of care and treatment appropriate to the needs of patients at ESHC and/or Shore Health by utilizing the knowledge and resources of both parties in a coordinated and cooperative effort; and

WHEREAS, ESHC, a state-operated psychiatric facility located in Cambridge, MD, consists of three (3) psychiatric units and a separately licensed assisted living program (ALP).

WHEREAS, some ESHC patients require certain medical service that are not available onsite at ESHC for their patients/residents

WHEREAS, Shore Health provides certain medical services and is willing to provide services to patients from ESHC as set forth herein.

NOW THEREFORE, in consideration of the mutual advantages accruing to the parties hereto and their respective patients and in consideration of the mutual covenants hereinafter set forth, the parties, with the intention to be legally bound, agree as follows:

I. Conditions of Transfer

Each party agrees to exercise its best efforts to provide for the provision of services of any patient transported from the other facility provided that:

A. A licensed physician who is a member of the medical staff of either party has designated that such services are medically appropriate.

B. All conditions and requirements of provision of services are met, including confirmation of acceptance of the patient by the receiving facility.

C. Adequate and appropriate capacity to provide services is available in the receiving facility to accommodate the patient.

D. The sending facility has received confirmation from the receiving facility that the receiving facility will accept the patient.

II. Admission Process

ESHC agrees that it and its physicians and/or medical staff will abide by the following notification procedures when patients are transported to Shore Health: the sending physician at ESHC shall contact the appropriate Emergency Department attending physician at Shore Health who will evaluate the patient and determine appropriate disposition. In the event there is one (1) ESHC physician treating two injured patients that require emergency care and no additional physician coverage at ESHC is available to such physician, the patient with the most serious injuries will be sent to the Emergency Department, and the patient with less serious injuries will be managed at ESHC; provided that ESCH shall utilize best efforts to notify Shore Health of such transfer in advance via telephone.

III. Transport

A. The sending facility agrees to:

1) Arrange for and carry out appropriate transportation of the patient to the receiving facility, including selection of the mode of transport, using appropriate life support measures, if necessary, to stabilize the patient prior to transport and during transport and providing appropriate health practitioner(s) and equipment to accompany the patient;

2) Complete and forward to the receiving facility, at the time of transport, an approved transport record form;

3) Transport with the patient his/her personal effects and provide documentation of presence or absence of personal items on the medical record/valuables sheet; including a notation if given to patient, family member or placed in hospital safe; and

4) Transmit with each patient at the time of transport copies of the patient's medical record or an abstract of pertinent medical and other records necessary for identification of the patient and continuation of uninterrupted and proper treatment. Such medical and other information should include where applicable:

a) History of the injury or illness;
b) Current medical findings;
c) Diagnosis;
d) Laboratory and radiology findings, including copies of radiological films, where appropriate;
e) Rehabilitation potential;

f) Brief summary of the courses of treatment followed up to the time of transport including medications given and route of administration, fluids given, by type and volume;
g) Nursing information useful in the care of the patient;
h) Patient's third party billing data;
i) Pertinent administrative information as required; and
j) Current surrogate (in the event that the patient is incompetent) and/or next-of-kin information.

5) In the event of an emergency as reasonably determined by the sending facility, the following information will be sent by the sending facility with the patient:

a) History of injury or illness
b) Current medical findings
c) Brief summary of the courses of treatment follow up to the time of the transport, including medications given, and route of administration, fluids given, by type and volume.
d) All other information will be faxed within ten (10) minutes of the patient leaving ESHC for the Shore Health emergency room.

6) Obtain the consent to transport from the patient's legally authorized representative, except in emergency situations where the delay to obtain such consent would seriously jeopardize the patient's life or health.

7) Direct inquiries about the patient or his/her care to the patient's attending physician and to no other medical staff member(s).

B. The receiving facility agrees to:

1) Assume responsibility for the patient's care, including providing full inpatient, outpatient and emergency services as appropriate, upon arrival of the transported patient at the receiving facility;

2) Acknowledge on such forms as may be provided by the sending facility, receipt of the patient's effects and medical records.

C. ESHC agrees to promptly accept patients for readmission upon the reasonable determination of both parties that such patients are appropriate for re-admission from a medical perspective.

IV. Payment for Services

The patient is primarily responsible for payment for care received at the institution and, prior to transport, (in non-emergent cases), the patient (or his/her surrogate decision maker) shall be required to acknowledge the obligation to pay for such at the receiving

institution. Each institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either institution to look to the other to pay for services rendered to a patient transported by virtue of this Agreement, except to the extent that such liability would exist separate and apart from this Agreement.

V. Compliance

Each institution shall comply with all applicable federal, state and local laws, and all requirements imposed by, or pursuant to the regulations of the Department of Health and Human Services and any other applicable governmental agency.

VI. Insurance

Each year that this Agreement is in effect, within thirty (30) days of the anniversary of the execution of this Agreement, each party shall provide to the other written verification that:

A. It has professional liability insurance or adequate self-insurance, in limits as required in accordance with applicable laws of the State of Maryland.

B. That all members of its medical staff are covered by professional liability insurance in limits as required in accordance with applicable laws of the State of Maryland.

C. That all of its employees who may be involved in the transfer of patients are covered by adequate and reasonable limits of workers' compensation, health, and motor vehicle insurance as required in accordance with applicable laws of the State of Maryland.

VII. Indemnification

A. ESHC agrees that it shall defend, indemnify and hold harmless Shore Health, its officers, directors, agents, and employees from and against any and all costs, demands, liabilities, settlements or verdicts, including reasonable attorneys fees, arising out of any claim, demand, action or suit brought by, on behalf of or as a derivative action of any patient or other person for any damages, injuries, or death to persons or property arising out of or in connection with (i) ESHC performance or failure to perform its duties hereunder; or (ii) any act or omission of ESHC, its agents or employees which occurred prior to the admission by Shore Health of any patient transported from ESHC.

B. Shore Health agrees that it shall defend, indemnify and hold harmless ESHC, its officers, directors, agents and employees from and against any and all costs, demands, liabilities, settlements, or verdicts, including reasonable attorneys fees, arising out of any claim, demand, action or suit brought by, on behalf of or as a derivative action of any patient or other person for any damages, injuries or death to persons or property arising out of or in connection with (i) Shore Health's

performance or failure to perform its duties hereunder; or (ii) any act or omission of Shore Health, its agents or employees, which occurred prior to the admission or acceptance by ESHC of any patient transported from Shore Health.

VIII. Confidentiality of Medical Records

All reasonable efforts will be made by both parties to preserve the confidential nature of the patient's medical records and to safeguard the rights of the patients as to medical and/or other privileged information contained within said records in accordance with applicable state and federal laws and regulations.

IX. Duration and Termination of Agreement

The Agreement shall continue in effect indefinitely, except that either party may terminate this Agreement by giving sixty (60) days' notice in writing to the other party of its intention to terminate. Termination shall be effective at the end of the sixty (60) days' notice period. However, if either party shall have its license to operate revoked or suspended by the State, have its accreditation suspended or revoked or placed on probation by any accrediting body or if any governmental agency suspends, revokes or places such party of probation, then the affected party shall immediately notify the other hospital, and this Agreement shall terminate as of the date such suspension, revocation or probation becomes effective.

X. Modification of Agreement

This Agreement may be modified or amended from time to time by mutual written agreement of the parties and any such modification or amendments shall be attached to and become part of this Agreement.

XI. Autonomy of Institutions

Each party to this Agreement is an independent contractor and shall have exclusive control over the policies, management, assets and affairs of its respective institution. Neither party by virtue of this Agreement assumes any liability for any debts or obligations of a financial or legal nature incurred by the other party. Nothing in this Agreement shall be construed as creating a partnership, joint venture, principal-agent or master-servant relationship between the parties, their agents, employees or representatives.

XII. Non-exclusivity

Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other hospital, nursing home or other health care entity or organization on either a limited or a general basis while this Agreement is in effect.

XIII. Non-Discrimination

Both parties attest that they are an equal opportunity employer that offers employment without regard to race, color, religious creed, disability, ancestry, national or ethnic origin, age, sex, or veteran status. This agreement shall be construed and carried out in a non-discriminatory manner without regard to race, color, religious creed, disability, ancestry, national or ethnic origin, age, sex, veteran status or ability to pay.

XIII. Miscellaneous

A. Each party agrees to provide to the other, upon reasonable request, any information deemed relevant by the requesting party to determine if the other party is able to provide the necessary facilities, care and/or treatment for a particular patient, group of patients or types of patients.

B. Neither party shall use the name of the other in any promotional or advertising material without the written approval of the other party.

C. Any communication required herein shall be in writing addressed as follows:

1) Any notice to ESHC:

2) Any notice to Shore Health:
Shore Health System, Inc.
219 S. Washington Street
Easton, Maryland 21601
Attn: Chief Medical Officer

D. No patient, physician, payor or other third party is intended to be a third party beneficiary under this Agreement and no action to enforce the terms of this Agreement may be brought against any party by any person who is not a party to this Agreement.

E. Neither party may transfer, assign, pledge or delegate any or all of its duties or interest in this Agreement without the prior written consent of the other, which consent shall not be unreasonably withheld.

F. This Agreement shall be binding upon and inure to the benefit of the successors or assigns of the parties.

G. This Agreement constitutes the entire agreement between the parties and contains all of the agreements between them with respect to the subject matter and supercedes any and all other agreements, either oral or in writing, between the parties with respect to the subject matter. This Agreement may be modified or amended by a mutual, written agreement signed by the parties.

H. No waiver of any term or condition of this Agreement by either party shall be deemed a continuing or further waiver of the same term or condition or a waiver of any other term or condition of this Agreement.

I. In the event any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue or to be binding upon the parties in the same manner as if the invalid or unenforceable provision were not a part of this Agreement.

J. The headings above the various provisions of this Agreement have been included only in order to make it easier to locate the subject covered by each provision; they are not to be used in construing this Agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed the day and the year written below.

EASTERN SHORE HOSPITAL CENTER

Chief Executive Officer

5-12-14
Date

Witness

SHORE HEALTH SYSTEM, INC.

Chief Executive Officer

6/5/14
Date

Witness

EASTERN SHORE HOSPITAL CENTER

Acting Clinical Director

5.12.14
Date

Witness

EXHIBIT 18

HKS

October 17, 2022

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: University of Maryland Shore Regional Medical Center at Easton
CON Application for Replacement Hospital
HKS Project No. 19782.010

To whom it may concern:

HKS is the architectural design firm designing the proposed University of Maryland Shore Regional Medical Center at Easton. I am confirming that the architectural design of the operating rooms suite at the proposed facility complies with Section 2.2 of the FGI Guidelines.

If you have any questions, you may contact me directly.

Sincerely,

Emily Dickinson, AIA
Senior Medical Planner
Vice President

HKS, P.C.
1250 I St NW #600
Washington, DC 20005

EXHIBIT 19

THE MARYLAND PERINATAL SYSTEM STANDARDS

Revised April 2019

Recommendations of the Perinatal Clinical Advisory Committee

MEMBERS OF THE PERINATAL CLINICAL ADVISORY COMMITTEE

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University of Maryland Baltimore Washington Medical Center
Level II

Robert Atlas, MD
Chair, Department of Obstetrics and Gynecology
Mercy Medical Center
MedChi, The Maryland State Medical Society

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Associate Division Director, Neonatology
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Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)

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President and CEO
Maryland Patient Safety Center

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Maryland Department of Health
Maryland Medicaid

S. Lee Woods, MD, PhD, FAAP
Medical Director, Maternal and Child Health Bureau
Director, Office of Surveillance and Quality Initiatives
Maryland Department of Health

Justin Ziombra, RN, MBA
Director, Policy and Data Analytics
Maryland Hospital Association

THE MARYLAND PERINATAL SYSTEM STANDARDS
REVISED APRIL 2019

STANDARD	TITLE	SUMMARY
I	Organization	Refers to the administration of a hospital perinatal program
II	Obstetrical Unit Capabilities	Refers to the resources of equipment, supplies, and personnel needed for the delivery unit within the hospital
III	Neonatal Unit Capabilities	Refers to the resources of equipment, supplies, and personnel needed for the neonatal units within the hospital
IV	Obstetrical Personnel	Describes the roles, responsibilities, and availability of obstetrical personnel in the perinatal program
V	Pediatric Personnel	Describes the roles, responsibilities, and availability of pediatric personnel in the perinatal program
VI	Other Personnel	Describes the roles, responsibilities, and availability of other personnel in the perinatal program
VII	Laboratory	Refers to the resources of equipment, supplies, and personnel needed for the laboratory unit within the hospital
VIII	Diagnostic Imaging Capabilities	Refers to the resources of equipment, supplies, and personnel needed for diagnostic imaging capabilities within the hospital
IX	Equipment	Refers to the availability of specific equipment needed for the perinatal program
X	Medications	Refers to the availability of specific medications needed for the perinatal program
XI	Education Programs	Refers to the need for education for all health care providers involved in providing perinatal care and to the roles and responsibilities of the hospitals in education
XII	Quality Improvement	Describes the quality improvement process that is required for hospital perinatal programs
XIII	Policies and Protocols	Identifies the administrative and medical policies and protocols that shall be in place for a perinatal program

LIST OF DEFINITIONS

I Level I hospitals have perinatal programs that provide basic care to pregnant women and infants, as described by these standards. These hospitals provide delivery room and well newborn nursery care for physiologically stable infants ≥ 35 weeks gestation. Other than emergency stabilization pending transport, the neonatal services do not provide positive pressure ventilatory support. Physicians board-certified in pediatrics, neonatal-perinatal medicine, or family medicine have programmatic responsibility for these services. These neonatal services do not provide pediatric subspecialty or emergent neonatal surgical specialty services. Maternal and fetal care is limited to gestations of ≥35 weeks. Level I facilities provide care to women who are low risk and are expected to have an uncomplicated birth. Level I facilities have the capability to perform routine intrapartum and postpartum care that it is anticipated to be uncomplicated. Level I facilities have the ability to detect, stabilize, and initiate management of unanticipated maternal-fetal or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until the patient can be transferred to a facility at which specialty maternal care is available. Board-certified physicians or active candidates for board-certification in obstetrics/gynecology, or board-certified physicians in family medicine with advanced training and privileges for obstetrical care with a formal arrangement with a physician board-certified or an active candidate for board-certification in obstetrics/gynecology, have programmatic responsibility for obstetrical services. These hospitals do not receive primary infant or maternal transports.

II Level II hospitals have perinatal programs that provide specialty care to pregnant women and infants, as described by these standards. These hospitals provide delivery room and acute specialized care for moderately ill infants ≥ 1500 grams and ≥ 32 weeks gestation with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis. Board-certified neonatal-perinatal medicine subspecialists have programmatic responsibility for the neonatal services. Level II nurseries may provide mechanical ventilation for a brief duration (less than 24 hours) until the infant's condition soon improves or the infant can be transferred to a higher-level facility. A level II facility may provide continuous positive airway pressure as long as the infant is improving. The neonatal services may provide limited pediatric subspecialty services. They do not provide emergent neonatal surgical specialty services. Maternal and fetal care is limited to term and preterm gestations of ≥ 32 weeks that are maternal risk appropriate, as well as stabilization and transfer of high-risk women who exceed level II care capabilities. Board-certified obstetricians have responsibility for programmatic management of obstetrical services. These hospitals do not receive primary infant or maternal transports except under limited circumstances as described by these standards.

III Level III hospitals have perinatal programs that provide subspecialty care for pregnant women and infants, as described by these standards. These hospitals provide acute delivery room and neonatal intensive care unit (NICU) care for infants of all birth weights and gestational ages. Board-certified neonatal-perinatal medicine subspecialists have programmatic responsibility for neonatal services. These services offer continuous availability of neonatologists. The neonatal services provide sustained life support with multiple modes of neonatal ventilation that may include advanced respiratory support, such as high frequency ventilation. In addition, inhaled nitric oxide may or may not be used. A full range of pediatric medical subspecialists, pediatric

surgical specialists, pediatric anesthesiologists, and pediatric ophthalmologists are readily accessible on site or by prearranged consultative agreement at a closely related institution. Neonatal care capabilities include advanced imaging, with interpretation on an urgent basis, including computed tomography, magnetic resonance imaging, and echocardiography. Maternal and fetal care spans the range of normal term gestation care to the comprehensive management of severe maternal and fetal complications. Board-certified obstetricians have programmatic responsibility for obstetrical services. Board-certified maternal-fetal medicine specialists have programmatic responsibility for high-risk obstetrical services. Level III perinatal hospitals accept risk-appropriate maternal and neonatal transports.

IV Level IV hospitals have perinatal programs that provide comprehensive subspecialty obstetrical and neonatal care services, as described by these standards. These hospitals provide acute delivery room and NICU care for infants of all birth weights and gestational ages, including those with complex and critical illness. Board-certified neonatal-perinatal medicine subspecialists have programmatic responsibility for neonatal services. These services offer continuous availability of neonatologists. Advanced modes of neonatal ventilation and life-support are provided, including high frequency ventilation and nitric oxide, and extracorporeal membrane oxygenation (ECMO) may be provided. These neonatal services provide a full range of pediatric medical subspecialists, pediatric surgical specialists and subspecialists, pediatric anesthesiologists, and pediatric ophthalmologists continuously available. These neonatal services have the capability to provide surgical repair of complex congenital or acquired conditions. Maternal and fetal care spans the range of normal term gestation care to that of highly complex or critically ill pregnant and postpartum women. In addition, the obstetrical services include management of fetuses who are extremely premature or have complex problems that render significant risk of preterm delivery and postnatal complications. Level IV facilities have the capability to plan and facilitate care for women with the most high-risk complications of pregnancy. Board-certified maternal-fetal medicine subspecialists have programmatic responsibility for the services and are continuously available. Level IV perinatal hospitals accept maternal and neonatal transports. In collaboration with the Maryland Department of Health and the Maryland Institute for Emergency Medical Services Systems, the Level IV hospitals are expected to take leadership roles in organization and provision of maternal and neonatal issues including, but not limited to, patient transport, outreach education, and professional training.

Board-certified: a physician certified by an American Board of Medical Specialties Member Board, or the equivalent, and maintaining current board certification.

Capability: Having the necessary equipment and supplies as well as staff with skill and experience in its use.

Continuously available: a resource available at all times.

Dedicated: a resource assigned to or for the exclusive use by a unit and not shared with any other unit.

Immediately available: a resource available as soon as it is requested.

In-house: physically present in the hospital.

Programmatic responsibility: the writing, review and maintenance of practice guidelines, policies and procedures; development of operating budget (in collaboration with hospital administration and other program directors); evaluation and guiding of the purchase of equipment; planning, development and coordinating of educational programs (in-hospital and/or outreach as applicable); participation in the evaluation of perinatal care; and participation in perinatal quality improvement and patient safety activities.

Readily available: a resource available for use a short time after it is requested.

Telemedicine: the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located. Telemedicine must include at least two forms of communication and be in compliance with COMAR 10.32.05.

30 minutes: in-house within thirty (30) minutes under normal driving conditions which include, but are not limited to, weather, traffic, and other circumstances that may be beyond the individual's control.

E Essential requirement for level of perinatal center

O Optional requirement for level of perinatal center

NA Not Applicable

NOTE: More details regarding the content of care for each perinatal level of care are contained in the *Guidelines for Perinatal Care, 8th Edition*, American Academy of Pediatrics and American College of Obstetricians and Gynecologists, 2017.

Revision April 2019:

The Maryland Perinatal System Standards were updated in September, 2018. In April, 2019, minor changes were made to the definitions of level I and level II hospitals; Standard 13.5 was modified; and current Standards 13.6, 13.7, 13.8, and 13.9 were added, with renumbering of subsequent Standards.

THE MARYLAND PERINATAL SYSTEM STANDARDS
REVISED APRIL 2019

		I	II	III	IV
STANDARD I. ORGANIZATION					
1.1	The hospital's Board of Directors, administration, and medical and nursing staff shall demonstrate commitment to its specific level of perinatal center designation and to the care of perinatal patients. This commitment shall be demonstrated by: a) a Board resolution that the hospital agrees to meet the current Maryland Perinatal System Standards for its specific level of designation and assures that all perinatal patients shall receive medical care commensurate with that designation; b) submission of patient care data to the Maryland Department of Health and the Maryland Institute for Emergency Medical Services Systems for system and quality management; and c) a Board resolution, bylaws, contracts, and budgets, indicating the hospital's commitment to the financial, human, and physical resources and to the infrastructure that are necessary to support the hospital's level of designation.	E Yes Yes Yes	E	E	E
1.2	The hospital shall be licensed by the Maryland Department of Health as an acute care hospital.	E Yes	E	E	E
1.3	The hospital shall be accredited by The Joint Commission.	E Yes	E	E	E
1.4	The hospital shall have an agreement with the Health Services Cost Review Commission that addresses how the cost of neonatal intensive care services will be incorporated into the hospital's population health budget, and the hospital shall have a Certificate of Need (CON) from the Maryland Health Care Commission in order to provide neonatal intensive care services, defined as a level III or IV perinatal program, unless establishment of the hospital's neonatal intensive care services preceded this requirement. A hospital shall obtain a CON in order to establish a Level III or IV perinatal program or to expand a Level III perinatal program to Level IV.	NA	NA	E	E

		I	II	III	IV
1.5	The hospital shall obtain and maintain current equipment and technology, as described in these standards, to support optimal perinatal care for the level of the hospital's perinatal center designation.	E Yes	E	E	E
1.6	If maternal or neonatal air transports are accepted, the hospital shall have a heliport, helipad, or access to a helicopter landing site near the hospital.	NA	NA	E	E
1.7	The hospital shall provide specialized maternal and neonatal transport capability and have extensive statewide perinatal educational outreach programs in both specialties in collaboration with MIEMSS and MDH.	NA	NA	O	E Yes
STANDARD II.	**OBSTETRICAL UNIT CAPABILITIES**				
2.1	The hospital shall demonstrate its capability of providing obstetrical care through written standards, protocols, or guidelines, including those for the following:	E	E	E	E
	a) management of uncomplicated pregnancy;	Yes			
	b) detection, stabilization, and initiation of management of unanticipated maternal-fetal problems;	Yes			
	c) fetal monitoring, including internal scalp electrode monitoring;	Yes			
	d) 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; and	Yes			
	e) selection and management of obstetrical patients at a maternal risk level appropriate to its capability.	Yes			
2.2	The hospital shall have an onsite intensive care unit that accepts obstetrical patients and has critical care providers onsite to actively collaborate with obstetricians or maternal-fetal medicine specialists at all times.	NA	O	E	E

	I	II	III	IV
STANDARD III. NEONATAL UNIT CAPABILITIES				
3.1 The hospital shall demonstrate its capability of providing neonatal care through written standards, protocols, or guidelines, including those for the following:				
a) resuscitation and stabilization of the neonate according to the current American Academy of Pediatrics/American Heart Association *Neonatal Resuscitation Program* (NRP) guidelines at every delivery;	E Yes	E	E	E
b) detection, stabilization, and initiation of management of unanticipated neonatal problems;	E Yes	E	E	E
c) evaluation and care of stable term newborn infants;	E Yes	E	E	E
d) care for infants convalescing after intensive care; and	NA	E	E	E
e) selection and management of neonatal patients at a neonatal risk level appropriate to its capability as outlined in the definitions of level of care.	E Yes	E	E	E
STANDARD IV. OBSTETRICAL PERSONNEL				
LEADERSHIP				
4.1 A physician board-certified or an active candidate for board-certification in obstetrics/gynecology, or a physician board-certified in family medicine with advanced training and privileges for obstetrical care with a formal arrangement with a physician board-certified or an active candidate for board-certification in obstetrics/gynecology, shall be a member of the medical staff and have programmatic responsibility for obstetrical services.	E Yes	NA	NA	NA
4.2 A physician board-certified in obstetrics/gynecology shall be a member of the medical staff and have programmatic responsibility for obstetrical services.	O N/A	E	E	NA

		I	II	III	IV
4.3	A physician board-certified in maternal-fetal-medicine shall be a member of the medical staff and have programmatic responsibility for obstetrical services.	O N/A	O	O	E
4.4	A physician board-certified in maternal-fetal medicine shall be a member of the medical staff and have programmatic responsibility for high-risk obstetrical services.	NA	O	E	E
4.5	A physician board-certified in anesthesiology shall be a member of the medical staff and have programmatic responsibility for obstetrical anesthesia services.	E Yes	E	E	E
COVERAGE FOR URGENT OBSTETRICAL ISSUES					
4.6	A hospital without a physician board-certified in maternal-fetal medicine on the hospital staff shall have a written agreement that provides for a consultant who is board certified or an active candidate for board-certification in maternal-fetal medicine to be available 24 hours a day onsite, by telephone, or by telemedicine.	E Yes	E	NA	NA
4.7	The hospital shall have a physician board-certified or an active candidate for board certification in maternal-fetal medicine on the medical staff, in active practice, available at all times, and if needed, in-house within 30 minutes.	O N/A	O	E	E
4.8	A physician with obstetrical privileges or a certified nurse-midwife with obstetrical privileges shall be readily available to the delivery area when a patient is in active labor.	E Yes	NA	NA	NA
4.9	A physician board-certified or an active candidate for board-certification in obstetrics/gynecology or a physician board-certified or an active candidate for board certification in family medicine with obstetrical privileges shall be readily available to the delivery area when a patient is in active labor.	O Yes	E	NA	NA

		I	II	III	IV
4.10	A physician board-certified or an active candidate for board-certification in obstetrics/gynecology shall be present in-house 24 hours a day and immediately available to the delivery area when a patient is in active labor.	O Yes	O	E	E
4.11	A physician with obstetrical privileges or a certified nurse-midwife with obstetrical privileges shall be present at all deliveries.	E Yes	E	E	E
OBSTETRICAL SUBSPECIALTY CARE					
4.12	The hospital shall have a full complement of subspecialists, including subspecialists in critical care, general surgery, infectious disease, hematology, cardiology, nephrology, and neurology available at all times.	NA	O	E	E
4.13	The hospital shall have 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.	NA	O	O	E
STANDARD V.	**PEDIATRIC PERSONNEL**				
LEADERSHIP					
5.1	A physician board-certified in pediatrics, neonatal-perinatal medicine, or family medicine shall be a member of the medical staff, have privileges for neonatal care, and have programmatic responsibility for neonatal services in the newborn nursery and/or the mother-baby unit.	E Yes	E	E	E
5.2	A physician board-certified in neonatal-perinatal medicine shall be a member of the medical staff and have programmatic responsibility for neonatal services in the special care nursery or NICU.	NA	E	E	E
COVERAGE FOR URGENT NEONATAL ISSUES					
5.3	There shall be a written agreement which provides consultation with physicians board-certified in neonatal-perinatal medicine 24 hours a day.	E Yes	E	NA	NA

		I	II	III	IV
5.4	NRP trained professional(s) with experience in acute care of the depressed newborn and skilled in neonatal endotracheal intubation and resuscitation shall be immediately available to the delivery and neonatal units.	E Yes	E	E	E
5.5	A physician who has completed postgraduate pediatric training, a nurse practitioner or physician assistant with privileges for neonatal care shall be immediately available at all times.	NA	E	NA	NA
5.6	If an infant requires positive pressure respiratory support for greater than 48 hours, a neonatology consultation with a level III or IV NICU shall be obtained.	NA	E	NA	NA
5.7	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 neonatal services shall be present in-house 24 hours a day, assigned to the delivery area and neonatal unit, and not shared with other units in the hospital.	NA	O	E	E
5.8	A physician board-certified or an active candidate for board-certification in neonatal-perinatal medicine, shall be on the medical staff, in active practice, available at all times, and if needed, in-house within 30 minutes.	NA	O	E	E
NEONATAL SUBSPECIALTY CARE					
5.9	The hospital shall have written consultation and referral agreements in place with pediatric cardiology and general pediatric surgery. Additionally, if back-transports requiring ophthalmology follow-up are accepted, the hospital shall have a written consultation and referral agreement with ophthalmology and an organized program for the monitoring, treatment, and follow-up of retinopathy of prematurity.	O N/A	E	NA	NA
5.10	The hospital shall have on staff an ophthalmologist with experience in neonatal retinal examination and an organized program for the monitoring, treatment, and follow-up of retinopathy of prematurity.	NA	O	E	E

		I	II	III	IV
5.11	The hospital shall have the following pediatric subspecialists on staff, in active practice, and if needed, readily available in house or via telemedicine: cardiology, neurology, and general pediatric surgery.	NA	O	E	NA
5.12	The hospital shall have on staff, in active practice, available at all times, and if needed, in-house within 30 minutes, the following pediatric subspecialties: cardiology, endocrinology, gastroenterology, genetics, hematology, nephrology, neurology, and pulmonology.	NA	O	O	E
5.13	The hospital shall have on staff, in active practice, available at all times, and if needed, in-house within 30 minutes: general pediatric surgery and pediatric surgical subspecialties including cardiothoracic surgery, neurosurgery, ophthalmology, orthopedic surgery, and plastic surgery.	NA	O	O	E
STANDARD VI.	**OTHER PERSONNEL**				
6.1	A physician board-certified or an active candidate for board-certification in anesthesiology or a nurse-anesthetist shall be available at all times to provide labor analgesia and surgical anesthesia so that cesarean delivery may be initiated per hospital protocol as stated in Standard 2.1d.	E Yes	E	E	E
6.2	A physician board-certified or an active candidate for board-certification in anesthesiology shall be present in-house 24 hours a day, readily available to the delivery area.	O N/A	O	E	E
6.3	If the hospital performs neonatal surgery, a physician board-certified or an active candidate for board-certification in anesthesiology with experience in neonatal anesthesia shall be present for the surgery.	NA	NA	E	E
6.4	The hospital shall have a physician on the medical staff, in active practice, with privileges for providing critical interventional radiology services for:				
	a) obstetrical patients, and	O Yes	O	E	E
	b) neonatal patients.	NA	NA	O	E

		I	II	III	IV
6.5	The hospital shall have on staff a licensed registered dietician with knowledge of and experience in the management of obstetrical and neonatal parenteral/enteral nutrition.	O Yes	O	E	NA
6.6	The hospital shall have on staff licensed registered dietitians with knowledge of and experience in the management of obstetrical and neonatal parenteral/enteral nutrition, with one dietitian dedicated to the NICU.	NA	O	O	E
6.7	The hospital shall have at least one full-time equivalent 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 of lactation support seven days per week.	E Yes	E	E	E
6.8	The hospital shall have a written plan to address lactation consultant/patient ratios recommended in the current Association of Women's Health, Obstetric, and Neonatal Nurses Guidelines.	E Yes	E	E	E
6.9	The hospital shall have a licensed social worker with a master's degree (either an LMSW, Licensed Master Social Worker, or an LCSW, Licensed Certified Social Worker) and experience in psychosocial assessment and intervention with women and their families readily available to the perinatal service.	E Yes	E	NA	NA
6.10	The hospital shall have at least one licensed social worker with a master's degree (either an LMSW, Licensed Master 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.	O N/A	O	E	E
6.11	The hospital shall have at least one licensed social worker with a master's degree (either an LMSW, Licensed Master 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.	NA	NA	E	E

	I	II	III	IV
6.12 The hospital shall have respiratory therapists skilled in neonatal ventilator management:				
a) readily available when an infant is receiving or anticipated to need positive pressure respiratory support or assisted ventilation,	NA	E	NA	NA
b) present in-house 24 hours a day, and	NA	O	E	NA
c) dedicated to the NICU 24 hours a day.	NA	NA	O	E
6.13 The hospital shall have at least one occupational or physical therapist with neonatal expertise.	NA	O	E	E
6.14 The hospital shall have at least one individual skilled in evaluation and management of neonatal feeding and swallowing disorders such as a speech-language pathologist.	NA	O	E	E
6.15 The hospital shall have genetic diagnostic and counseling services or written consultation and referral agreement(s) for these services in place.	E Yes	E	E	E
6.16 The hospital shall have a pediatric neurodevelopmental follow-up program or written referral agreement(s) for neurodevelopmental follow-up.	O N/A	O	E	E
6.17 The hospital shall have pharmacy personnel with knowledge of and experience in pediatric pharmacy.	O Yes	E	E	E
6.18 The hospital perinatal program shall have on its administrative staff at least one registered nurse with a master's or higher degree in nursing or a health-related field and experience in high-risk obstetrical and/or neonatal nursing who shall have programmatic responsibility for the obstetrical and neonatal nursing services.	E Yes	E	E	E

		I	II	III	IV
6.19	The hospital perinatal program shall have on its staff at least one registered nurse with a master's or higher degree in nursing or a health or education-related field and experience in high-risk obstetrical and/or neonatal nursing responsible for staff education.	E Yes	E	E	E
6.20	The hospital obstetrical service shall 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.	E Yes	E	E	E
6.21	The hospital neonatal service shall have continuous availability of adequate numbers of registered nurses with competence in assessment and care or neonatal patients appropriate to the designated level of care.	E Yes	E	E	E
6.22	A hospital neonatal service that performs neonatal surgery shall have nurses on staff with knowledge of and experience in perioperative management of neonates.	NA	NA	E	E
6.23	The hospital shall have a written plan to address registered nurse/patient ratios recommended in the current Association of Women's Health, Obstetric, and Neonatal Nurses Guidelines.	E Yes	E	E	E
STANDARD VII. LABORATORY					
7.1	The programmatic leaders of the perinatal service and the hospital laboratory shall establish laboratory processing and reporting times that are appropriate for samples drawn from obstetrical and neonatal patients with specific consideration for the acuity of the patient and the integrity of the samples.	E Yes	E	E	E
7.2	The hospital laboratory shall demonstrate the capability to immediately receive, process, and report urgent/emergent obstetrical and neonatal laboratory requests.	E Yes	E	E	E

		I	II	III	IV
7.3	The hospital laboratory shall have a process in place to report critical values to the obstetrical and neonatal services.	E Yes	E	E	E
7.4	Laboratory results from standard maternal antepartum testing shall be available to the providers caring for the mother and the neonate prior to discharge. If test results are not available or if testing was not performed prior to admission, such testing shall be performed during the hospitalization of the mother and results shall be available prior to discharge of the newborn.	E Yes	E	E	E
7.5	The hospital shall have the capacity to conduct rapid HIV testing 24 hours a day.	E Yes	E	E	E
7.6	The hospital shall 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 and report screening results as required by COMAR 10.11.02.	E Yes	E	E	E
7.7	The hospital shall: a) have available the equipment and trained personnel to perform critical congenital heart disease screening between 24 and 48 hours of age on all well infants born at or transferred to the institution and report screening results as required by COMAR 10.52.15, and b) 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.	E Yes NA	E E	E E	E E
7.8	The hospital shall 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.	E Yes	E	E	E

	I	II	III	IV
7.9 Blood bank technicians shall be present in-house 24 hours a day.	E Yes	E	E	E
7.10 The hospital shall have access to molecular, cytogenetic, and biochemical genetic testing.	E Yes	E	E	E
STANDARD VIII. DIAGNOSTIC IMAGING CAPABILITIES				
8.1 The hospital shall have the capability of providing emergency ultrasound imaging with interpretation for obstetrical patients 24 hours a day.	E Yes	E	E	E
8.2 The hospital shall have the capability of providing detailed ultrasonography and fetal assessment, including Doppler studies, with interpretation for obstetrical patients 24 hours a day.	NA	O	E	E
8.3 The hospital shall have the capability of providing maternal echocardiography with interpretation for obstetrical patients 24 hours a day.	NA	O	E	E
8.4 The hospital shall have the capability of providing portable x-ray imaging with interpretation for neonatal patients 24 hours a day.	E Yes	E	E	E
8.5 The hospital shall have the capability of providing portable head ultrasound with interpretation for neonatal patients.	O N/A	E	E	E
8.6 The hospital shall have the capability on campus of providing computerized tomography (CT) and magnetic resonance imaging (MRI) with interpretation.	O Yes	O	E	E

		I	II	III	IV
8.7	Neonatal echocardiography equipment and an experienced technician shall be available on campus as needed with interpretation by a pediatric cardiologist.	O Yes	O	E	E
8.8	The hospital shall have a pediatric cardiac catheterization laboratory and appropriate staff.	NA	NA	O	E
8.9	The hospital shall have the capability of providing interventional radiology services for:				
	a) obstetrical patients, and	O Yes	O	E	E
	b) neonatal patients.	NA	NA	O	E
STANDARD IX. EQUIPMENT					
9.1	The hospital shall have all of the following equipment and supplies immediately available for existing patients and for the next potential patient: a) O2 analyzer, stethoscope, intravenous infusion pumps; b) radiant heated bed in delivery room and available in the neonatal units; c) oxygen hood with humidity; d) bag and masks and/or T-piece resuscitator capable of delivering a controlled concentration of oxygen to the infant; e) orotracheal tubes; f) CO_2 detector; g) aspiration equipment; h) laryngoscope; i) bowel bags; j) umbilical vessel catheters and insertion tray; k) cardiac monitor; l) pulse oximeter;	E Yes	E	E	E

		I	II	III	IV
	m) transilluminator; n) phototherapy unit; o) doppler blood pressure for neonates; p) cardioversion/defibrillation capability for obstetrical patients and neonates; q) resuscitation equipment for obstetrical patients; r) resuscitation equipment for neonates including equipment outlined in the current NRP; s) individual oxygen, air, and suction outlets for obstetrical patients and neonates; and t) emergency call system for both obstetrical and neonatal units as well as an emergency communication system between units.				Yes
9.2	The hospital shall have special equipment and facilities needed to accommodate the care and services needed for obese women.	O N/A	E	E	E
9.3	The hospital shall have a neonatal stabilization bed set up and equipment available at all times for an emergency admission.	E Yes	E	E	E
9.4	The hospital shall have fetal diagnostic testing and monitoring equipment for:				
	a) fetal heart rate monitoring,	E Yes	E	E	E
	b) ultrasound examinations, and	E Yes	E	E	E
	c) amniocentesis.	O Yes	O	E	E
9.5	The hospital shall have the capability to monitor neonatal intra-arterial pressure.	NA	O	E	E
9.6	The hospital shall have the capability on campus of providing laser coagulation for retinopathy of prematurity.	NA	O	E	E

		I	II	III	IV
9.7	The hospital shall have the capability on campus of providing a full range of invasive maternal monitoring including central venous pressure and arterial pressure monitoring.	NA	O	E	E
9.8	The hospital shall have 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 level of neonatal care.	E Yes	E	E	E
9.9	The hospital shall have the capability of providing advanced ventilatory support (beyond conventional mechanical ventilation) for neonates of all birth weights.	NA	NA	O	E
9.10	The hospital shall have the capability of providing continuing therapeutic hypothermia.	NA	NA	O	E
STANDARD X.	MEDICATIONS				
10.1	Emergency medications, as listed in the current NRP guidelines, shall be immediately available in the delivery area and neonatal units.	E Yes	E	E	E
10.2	The following medications shall be immediately available to the neonatal units: a) antibiotics, b) anticonvulsants, c) surfactant, d) prostaglandin E1, and e) emergency cardiovascular drugs.	E Yes	E	E	E
10.3	All emergency resuscitation medications to initiate and maintain resuscitation, in accordance with current Advanced Cardiac Life Support (ACLS) guidelines of the American Heart Association, shall be immediately available in the delivery area.	E Yes	E	E	E

	I	II	III	IV
10.4 The following medications shall be immediately available for management of obstetrical hemorrhage in the delivery area and postpartum floor: a) oxytocin (Pitocin), b) methylergonovine (Methergine), c) misoprostol (Cytotec), d) carboprost tromethamine (Hemabate), and e) tranexamic acid (TXA).	E Yes	E	E	E
10.5 The following medications shall be immediately available for management of hypertensive crisis in all obstetrical care areas: a) hydralazine, b) labetalol, and c) nifedipine.	E Yes	E	E	E
STANDARD XI. EDUCATION PROGRAMS				
11.1 The hospital shall have identified minimum competencies for obstetrical and neonatal clinical staff, not otherwise credentialed, that are assessed prior to independent practice and on a regular basis thereafter.	E Yes	E	E	E
11.2 The hospital shall provide continuing education programs available to all obstetrical and neonatal clinical staff concerning the treatment and care of obstetrical and neonatal patients.	E Yes	E	E	E
11.3 The hospital shall 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.	E Yes	E	E	E

		I	II	III	IV
11.4	The hospital shall provide evidence-based education every two years to all staff caring for newborns (nurses, respiratory therapists, 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.	E Yes	E	E	E
11.5	A hospital that accepts maternal or neonatal primary transports shall provide the following to the referring hospital/providers: a) guidance on indications for consultation and referral of patients at high risk, b) information about the accepting hospital's response times and clinical capabilities, c) information about alternative sources for specialized care not provided by the accepting hospital, d) guidance on the pre-transport stabilization of patients, and e) feedback on the pre-transport and post-transport care of patients.	NA	NA	E	E
STANDARD XII. QUALITY IMPROVEMENT					
12.1	The hospital shall have a multidisciplinary 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.	E Yes	E	E	E
12.2	The Perinatal Quality Improvement Program shall 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.	E Yes	E	E	E
12.3	The Perinatal Quality Improvement Program shall conduct reviews of all cases of the following as well as cases related to other patient safety and systems issues identified: a) maternal, intrapartum fetal, and neonatal deaths; b) transports to a higher or comparable level of care;	 E Yes E Yes	 E E	 E E	 E E

	I	II	III	IV
c) elective delivery at less than 39 weeks gestation; and	E Yes	E	E	E
d) delivery of an infant at less than 1500 grams or less than 32 weeks gestation.	E Yes	E	NA	NA
12.4 The hospital shall participate with the Maryland Department of Health and local health department Fetal and Infant Mortality Review program.	E Yes	E	E	E
12.5 The hospital shall participate in the collaborative collection and assessment of data with the Maryland Department of Health and/or the Maryland Institute for Emergency Medical Services Systems for the purpose of improving perinatal health outcomes.	E Yes	E	E	E
12.6 The hospital shall maintain membership in the Vermont Oxford Network.	O N/A	O	E	E
STANDARD XIII. POLICIES AND PROTOCOLS				
13.1 The hospital shall have written policies and protocols for the initial stabilization and continuing care of all obstetrical and neonatal patients appropriate to the designated level of care.	E Yes	E	E	E
13.2 The hospital shall have maternal and neonatal resuscitation protocols.	E Yes	E	E	E
13.3 The hospital medical staff credentialing process shall include documentation of competency to perform obstetrical and neonatal invasive procedures appropriate to the designated level of care.	E Yes	E	E	E
13.4 The hospital shall have a written protocol for initiating maternal and neonatal transports to an appropriate level of care.	E Yes	E	E	E

	I	II	III	IV
13.5 The hospital shall have a written protocol for the acceptance of maternal and neonatal transports.	NA	O	E	E
13.6 A level II hospital may accept primary maternal transports of any gestational age only if all of the following circumstances are met: a) The transporting hospital does not provide obstetrical services. b) There is no level III or IV hospital within a comparable distance or travel time from the transporting hospital. c) There is a written agreement between one or more obstetrical practice(s) and the accepting level II hospital which provides that an obstetrician shall be available at all times to consult on and accept a transported obstetrical patient, including a patient not previously known to or under the care of the accepting physician or practice. d) Consultation between the transporting hospital and the accepting obstetrician as well as the neonatal unit at the level II hospital shall occur prior to transport. e) The accepting obstetrician shall be readily available to the delivery area at the accepting level II hospital when a transported patient arrives.	NA	E	NA	NA
13.7 A level II hospital that accepts primary maternal transports shall: a) have a written protocol for the acceptance of maternal transports; b) provide obstetrical evaluation, stabilization, and assessment of risk for all transported patients; c) provide continued care to patients that are maternal risk appropriate as outlined in the definitions of level of care; and d) provide for the secondary transfer to a higher level of care of high-risk women who exceed level II care capabilities.	NA	E	NA	NA
13.8 A level II hospital may accept primary neonatal transports of any gestational age only if all of the following circumstances are met: a) The transporting hospital does not provide pediatric services.	NA	E	NA	NA

	I	II	III	IV
b) There is no level III or IV hospital within a comparable distance or travel time from the transporting hospital. c) There is a written agreement between one or more pediatric practice(s) and the accepting level II hospital which provides that a pediatrician shall be available at all times to consult on and accept a transported neonatal patient. d) Consultation between the transporting hospital and the accepting pediatrician as well as the neonatal unit at the level II hospital shall occur prior to transport. e) The accepting pediatrician shall be readily available to the neonatal unit at the accepting level II hospital when a transported patient arrives.				
13.9 A level II hospital that accepts primary neonatal transports shall: a) have a written protocol for the acceptance of neonatal transports; b) provide pediatric evaluation, stabilization, and assessment of risk for all transported patients; c) provide continued care to patients that are neonatal risk appropriate as outlined in the definitions of level of care; and d) provide for the secondary transfer to a higher level of care of high-risk neonates who exceed level II care capabilities.	NA	E	NA	NA
13.10 The hospital shall have written protocols for accepting or transferring obstetrical patients or neonates as "back transports."	E Yes	E	E	E
13.11 The hospital shall have a licensed neonatal transport service or written agreement with a licensed neonatal transport service.	E Yes	E	E	E
13.12 The hospital shall have policies that allow 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 those in the NICU.	E Yes	E	E	E

	I	II	III	IV
13.13 The hospital shall have a policy to eliminate deliveries by induction of labor or by cesarean section prior to 39 weeks gestation without a medical indication. The hospital shall have a systematic internal review process to evaluate any occurrences and a plan for corrective action.	E Yes	E	E	E
13.14 The hospital shall have written protocols and capabilities in place for the following: a) assessment of risk for obstetrical hemorrhage, b) maximizing accuracy in determining obstetrical blood loss, c) massive transfusion, d) emergency release of blood products before full compatibility testing is complete, and e) management of multiple component therapy.	E Yes	E	E	E
13.15 The hospital shall have a 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.	E Yes	E	E	E
13.16 The hospital shall have a written policy for the management of obstetrical patients with opioid use and opioid use disorder that addresses the following and other relevant issues: a) universal screening of obstetrical patients for opioid use; b) pharmacotherapy of the pregnant, laboring and postpartum woman; c) breastfeeding; d) linkages to appropriate postpartum psychosocial support services including substance use treatment and relapse prevention programs; and e) reproductive health planning.	E Yes	E	E	E
13.17 The hospital shall have a written policy for the identification and management of neonatal abstinence syndrome.	E Yes	E	E	E

	I	II	III	IV
13.18 The hospital shall have a written policy for optimizing post-delivery care of obstetrical patients that addresses the following and other relevant issues: a) identification of postpartum women at risk for poor health outcomes, b) breastfeeding support, c) linkages to appropriate medical and psychosocial services, and d) reproductive health planning.	E Yes	E	E	E
13.19 The hospital shall have a written policy to address infant safety issues including safe sleep, abusive head trauma (shaken baby), and car seat safety.	E Yes	E	E	E

EXHIBIT 20

carf INTERNATIONAL

A Three-Year Accreditation is issued to

University of Maryland Shore Regional Health/Requard Center for Acute Rehabilitation

for the following program(s)/service(s):

Inpatient Rehabilitation Programs - Hospital (Adults)
Inpatient Rehabilitation Programs - Hospital: Stroke Specialty Program (Adults)

This accreditation is valid through
April 30, 2024

The accreditation seals in place below signify that the organization has met annual conformance requirements for quality standards that enhance the lives of persons served.

This accreditation certificate is granted by authority of:

Richard Forkosh
Chair
CARF International Board of Directors

Brian J. Boon, Ph.D.
President/CEO
CARF International

EXHIBIT 21

PRIMARY ACUTE STROKE PATIENT TRANSFER AGREEMENT BETWEEN THE MEMORIAL HOSPITAL AT EASTON, INC. AND THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION

EFFECTIVE DATE: December 15, 2006

PURPOSE: In response to state regulations addressing the care of acute stroke patients, the **MEMORIAL HOSPITAL AT EASTON,INC**, a health care facility owned and operated by Shore Health System, Inc. (the "Facility"), enters into this transfer agreement with the **University of Maryland Medical Center**, a health care facility owned and operated by University of Maryland Medical System Corporation ("UMMC"). The purpose of the agreement is to establish a process for the transfer and care of acute stroke patients requiring neurosurgical intervention.

POLICY

A. POINT OF CONTACT:

UMMC's Maryland ExpressCare (*"ExpressCare"*), will be the sole source of contact throughout the process. All inquiries related to patient transport should go through *ExpressCare*. This process allows for the most timely and efficient utilization of resources and avoids conflicting communications.

B. REQUEST FOR TRANSPORT:

1. A member of the Facility's stroke team will contact *ExpressCare* at (410) 328-1234, upon determining that the patient requires neurosurgical intervention for acute stroke-related conditions such as subarachnoid hemorrhage or acute intracerebral hemorrhage. The number for *ExpressCare* is.
2. Upon reaching *ExpressCare*, the Facility Stroke Team will:
   a. Identify the Facility and notify *ExpressCare* that a transfer of an acute stroke patient for neurosurgical intervention is necessary.
   b. Provide *ExpressCare* with logistical information, patient demographics, clinical information and any other requested information.
   c. If the patient requires transport to UMMC, the Facility Stroke Team will fax the patient's "face sheet" with demographic data to *ExpressCare* at (410) 328-1235.
3. If a member of the UMMC medical staff medical accepts the patient for transfer and appropriate resources are available, *ExpressCare* will timely dispatch the Maryland *ExpressCare* Team, which will include a registered nurse, to transport the patient from the Facility to UMMC.
4. If the patient transfer is accepted and a bed is available but a Maryland *ExpressCare* Team is not available to effect the transfer, the following will occur:
   a. *ExpressCare* will check the availability of other Advanced Life Support ("ALS") vendor resources. If a Critical Care team is available, *ExpressCare* will dispatch the team in order to respond in a timely manner.
   b. If vendor resources are exhausted and no Critical Care Team is available, *ExpressCare* will then call the Facility to indicate the lack of Critical Care transport availability to accompany patient during transport with dispatched ALS team. Facility will then dispatch a qualified registered nurse to accompany the patient during transport.

Xerox - Linda Pittman

C. UMMC ACCEPTANCE OF TRANSFERRED PATIENTS:

If a UMMC medical staff member accepts the patient for transfer and appropriate resources are available, UMMC will receive and provide treatment to the transferred patient to care for the acute stroke patient once the initial triage, assessment and treatment have been completed by the Facility.

D. NO TRANSPORT NECESSARY:

The Facility will notify *ExpressCare* if the transfer is later determined to be unnecessary.

E. ADVISORY NOTICE PRIOR TO ADMINISTERING TISSUE PLASMINOGEN ACTIVATOR

To the extent possible, a member of the Facility's stroke team will contact the *ExpressCare*, to indicate that the Facility's Stroke Team will be administering tissue-plasminogen activator ("t-PA") or similar intravenous acute stroke intervention to a patient.

F. ADMINISTRATIVE PROVISIONS

1. Any modification of this agreement, including any extension , shall be effective only if in writing and signed on behalf of both parties
2. This agreement does not create a joint venture or partnership between UMMC and the Facility.
3. This agreement shall be governed by the law of the State of Maryland; the parties agree to be subject to the jurisdiction of the Maryland courts.
4. The Facility may not assign this Agreement.
5. This agreement may be executed and delivered in one or more counterparts (including by facsimile transmission), each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

Agreed to and approved this 6th day of December, 2006

THE MEMORIAL HOSPITAL AT EASTON, INC.
A health care facility owned and operated by Shore Health System, Inc.

By: _____
Joseph P. Ross
President and Chief Executive Officer

UNIVERSITY OF MARYLAND MEDICAL CENTER
A health care facility owned and operated by the University of Maryland Medical System Corporation

By: _____
Name: Alison G. Brown, MPH
Title: Senior Vice President

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TRANSFER AGREEMENT

between

THE MEMORIAL HOSPITAL AT EASTON, MD., INC.

and

CAROLINE NURSING HOME, INC.

THIS TRANSFER AGREEMENT (the "Agreement") is executed and effective as of December 17, 1998 (the "Effective Date"), by and between The Memorial Hospital at Easton, Md., (the "Hospital") and Caroline Nursing Home, Inc. (the "Nursing Home").

RECITALS

WHEREAS, the Nursing Home, a skilled nursing facility located in Denton, Maryland, desires to enter into an arrangement with a nearby acute care hospital in order to ensure the continuity of quality care for patients of the Nursing Home and to facilitate the timely and appropriate transfer of such patients between the Hospital and the Nursing Home;

WHEREAS, the Hospital is willing to cooperate in facilitating medically appropriate transfers of patients between the Nursing Home and the Hospital;

NOW, THEREFORE, the Hospital and the Nursing Home agree as follows:

Section 1. Requisites of Transfer

1.1 Prior to Transfer. In the event the physician of a patient from the Nursing Home determines that acute care services available at the Hospital are medically appropriate, the Nursing Home immediately shall notify the Hospital of the need to transfer a patient. Prior to any such transfer, or, in the case of emergency, as promptly as possible, the Nursing Home shall:

A. Ensure that the physician has properly documented the need for such transfer in the patient's medical record.

B. Except in the case of emergency, obtain written confirmation from the Hospital that it can accept the patient from the Nursing Home;

C. Discuss with the patient or his or her legal representative the reason for the proposed transfer and any available alternatives. The Nursing Home shall have full responsibility for obtaining the consent of the patient or the patient's legal representative prior to the transfer.

D. Notify the next of kin of the patient or another appropriate responsible person or family member regarding the anticipated transfer.

1.2 **Admission by the Hospital**. The Hospital agrees to admit a patient transferred from the Nursing Home, subject to all conditions of this Agreement, all admission eligibility requirements of the Hospital in effect at the time, and the availability of adequate and appropriate bed space for the transferred patient. All transfers and admissions shall be conducted in accordance with applicable federal and state law and regulations and the applicable policies and procedures of the Hospital.

1.3 **Transfer Documentation**. The Nursing Home shall send with each patient at the time of transfer, or in the case of emergency, as promptly as possible, the patient's medical record, completed transfer forms, and any other information pertinent to the medical condition and treatment of the patient. The Nursing Home and the Hospital agree to develop a standard form document which shall accompany the patient in any transfer to the Hospital or to the Nursing Home from the Hospital. The standard form shall include such information as current medical findings, diagnosis, a brief summary of the present course of treatment, nursing and dietary information, ambulation status and pertinent administrative and social information. If the patient is returning to the Nursing Home after treatment, the Hospital shall provide similar transfer documentation to the Nursing Home.

1.4 **Safe Transport**. The Nursing Home shall be responsible for effecting the transfer of the patient, including the arranging for appropriate and safe transportation and care of the patient during the transfer in accordance with applicable federal and state laws and regulations. The Hospital's responsibility for the patient's care shall begin when the patient is admitted to the Hospital, either as an inpatient or an outpatient. If the patient is returning to the Nursing Home, the Hospital shall be responsible for effecting the safe transfer of a patient from the Hospital to the Nursing Home in accordance with applicable federal and state laws and regulations.

1.5 **Personal Effects**. The Nursing Home shall be responsible for the transfer or other appropriate disposition of personal effects, particularly money and valuables, and information related to these items.

1.6 **Medical Records**. The Nursing Home and the Hospital each shall maintain a separate medical record for each transferred patient in accordance with its rules and regulations and shall maintain the confidentiality of patient information. The Nursing Home and the Hospital shall comply with all applicable federal and state laws and regulations, including without limitation, laws and regulations governing the maintenance of medical records and the confidentiality of patient information.

1.7 **Charges for Services.** Charges for services performed by either the Hospital or the Nursing Home shall be collected by or on behalf of the facility rendering such services directly from the patient, third party payor or other payor as appropriate. Neither facility shall have any liability to the other for such charges.

1.8 **Insurance**. The Hospital and the Nursing Home each shall maintain, throughout the Agreement, liability insurance coverage in amounts acceptable to the other, and shall provide evidence of such coverage upon request.

Section 2. Relationship of Parties

2.1 Governance; Liabilities. The governing body of each of the Nursing Home and the Hospital shall exclusive control of policies, management, assets and affairs of its respective institutions. Neither party shall assume any liability by virtue of this Agreement for any debts or other obligations incurred by the other party.

2.2. Non-exclusivity. Nothing in this Agreement shall be construed as limiting the rights of either party to contract with any other facility on a limited or general basis.

Section 3 Term; Termination

3.1 Term. The initial term of this Agreement shall be for a period of one (1) year commencing on the Effective Date, unless sooner terminated as provided herein. This Agreement shall renew annually for successive one (1) year terms.

3.2 Termination. Either party may terminate this Agreement at any time, with or without cause, upon (30) days prior written notice to the other party. This Agreement shall be terminated automatically should either the Hospital or the Nursing Home fail to maintain its State facility licensure, Medicare or Medicaid certification, or insurance coverage as required in Section 2.4 hereof.

Section 4. Miscellaneous

4.1 Entire Agreement. This Agreement contains the entire agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

4.2 Waiver. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

4.3 Assignment. Neither party may assign or transfer this Agreement or any of its rights, duties or obligations under this Agreement without the prior written consent of the other party.

4.4 Notices. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by Federal express or express mail, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

To the Hospital:

219 S. Washington Street
Easton, Maryland 21601

To the Nursing Home:

Caroline Nursing Home, Inc.
520 Kerr Avenue
Denton, MD 21629

4.5 Compliance. The parties agree to comply with all laws, rules and regulations, including JCAHO requirements, relating to the subject of this Agreement.

4.6 Governing Law. This Agreement shall be construed in accordance with the laws of the State of Maryland.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives as of the day and year first written above.

The Memorial Hospital at Easton, Md.	Caroline Nursing Home, Inc.
By: Larry F. Hepner	By:
Larry F. Hepner	
Title: Vice President, Patient Care Services	Title: Administrator

TRANSFER AGREEMENT

This Transfer Agreement is entered into on May 20, 2008, by and between Chester River Health System ("Chester River") and The Memorial Hospital at Easton, a health care facility owned and operated by Shore Health System, Inc. ("Shore Health").

WHEREAS, both parties desire to assure continuity of care and treatment appropriate to the needs of each patient and to use the skills, resources, and physical plant of both parties in a coordinated and cooperative fashion to improve patient care at both the acute and post-acute stages of illness.

NOW, THEREFORE, in consideration of the mutual advantages occurring to the parties hereto, Hospital and Shore Health hereby covenant and agree with each other as follows:

1. Both parties agree to make a concerted effort to transfer patients as soon as practical when the need for transfer from Chester River to Shore Health has been determined by the patient's attending physician, provided, however, all eligibility conditions for admission must be met and documented in the patient's medical record.

2. Chester River agrees to send with each patient at the time of transfer or, in the case of any emergency as promptly as possible after the transfer, an abstract of the patient's medical record including:

   (A) the current medical findings,
   (B) diagnosis,
   (C) a brief summary of the course of treatment followed,
   (D) all other administrative and social information useful to provide continuing care to the patient; using the transfer and referral form mutually agreed upon.

3. Chester River, after promptly notifying Shore Health of the impending transfer of a patient and after Shore Health consents to accept such patient, shall assume the responsibility to arrange for appropriate and safe transportation of the patient, his/her personal effects and valuables, and shall provide any necessary care while he/she is being transferred.

4. Charges for services performed by either Chester River or Shore Health for patients transferred from the other institution pursuant to this Agreement, shall be collected by the institution rendering such services, directly from the patient, third party payers, or the other sources normally billed by the institution; and neither party shall have any liability to the other for such charges except to the extent that such liabilities would exist separate and apart from this Agreement.

5. The parties agree that the transfer of a patient pursuant to this Agreement shall not be predicated upon discrimination based on race, religion, national origin, age, sex, physical condition or economic status. The parties also agree that the transfer or receipt of patients shall not be based upon a patient's inability to pay for services rendered by the transferring or receiving institution or a patient's source of payment.

6. All patient transfers pursuant to this Agreement must be accomplished in a medically appropriate manner from physician to physician and from institution to institution by: (i) the use of appropriate life support measures which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to stabilize the patient prior to transfer and to sustain the patient during the transfer; (ii) the provision of appropriate personnel and equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use for the transfer; (iii) the transfer of all necessary records for continuing the care for the patient; and (iv) the consideration of the availability of appropriate facilities, services, and staff for providing care for the patient. The parties agree that before moving a patient, Chester River shall explain the reasons for the transfer and any alternative to the patient or a legally authorized representative of the patient. If it is necessary to move the patient immediately to protect the health, safety or welfare of the patient, Chester River may give the explanation of the reasons for the transfer concurrently with the transfer.

7. The parties agree to recognize the right of a patient to request transfer into the care of a physician and institution of the patient's own choosing and to recognize and comply with all federal and state requirements relating to the transfer of patients.

8. Chester River agrees not to transfer a patient with an emergency medical condition that has not been stabilized unless: (i) the patient, or a legally responsible person acting on the patient's behalf, after being informed of Chester River's obligations under law and of the risk of transfer, requests in writing transfer to another institution; (ii) a licensed physician has signed a certification which includes a summary of the risks and benefits that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another institution outweigh the increased risks to the patient and, in the case of labor, to the unborn child from effecting the transfer; or (iii) if a licensed physician is not physically present at the time a patient is transferred, a qualified medical person has signed a certification described in subparagraph (ii) above after a license physician, in consultation with the person, has made the determination described in subparagraph (ii) above and subsequently countersigns the certificate.

9. All notices hereunder by either party to the other party shall be in writing, delivered personally or by overnight courier, and shall be deemed to have been duly given when delivered personally or one day after delivered to the overnight carrier, charges prepaid, and properly addressed to the respective parties at the addresses shown following each party's signature to this Agreement.

10. This Agreement shall be effective from the date of signing by both parties and shall continue in effect, except that either party may withdraw by giving 60 days written notice to the other party of its intention to terminate this Agreement. However, this Agreement shall be declared null and void and shall be immediately terminated should either party fail to maintain its licensure or certification status.

11. Both parties represent and warrant that, during the term of this Agreement, each shall comply with all applicable state and federal laws and regulations and shall remain in good standing with applicable accrediting organizations.

12. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other institution, on either a limited or general basis, while this Agreement is in effect.

13. This Agreement may be modified or amended by the mutual agreement of the parties, however, any such modification or amendment shall be attached to and become a part of this Agreement. This Agreement shall be construed in accordance with the laws of the State of Maryland.

CHESTER RIVER HEALTH SYSTEM, INC.

By: _____

Name: SCOTT D BURLESON

Title: Executive Vice President

100 Brown Street
Chestertown, Maryland 21620

SHORE HEALTH SYSTEM, INC.

By: _____

Name: GERARD M. WALSH

Title: Sr. V.P. & C.O.O.

219 South Washington Street
Easton, Maryland 21601

FOR COMPANY USE ONLY:
Clinic #: 11176

PATIENT TRANSFER AGREEMENT

This **PATIENT TRANSFER AGREEMENT** (the "Agreement") is made as of the last date of signature (the "Effective Date"), by and between **Shore Health System, Inc.** (hereinafter "Hospital") and **Total Renal Care, Inc.**, a California corporation and subsidiary of DaVita HealthCare Partners Inc. ("Company").

RECITALS

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between Hospital and the following free-standing dialysis clinic owned and operated by Company:

Queen Anne Home Training
125 Shoreway Drive, Ste. 330
Queenstown, MD 21658

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities; and

WHEREAS, the parties wish to facilitate the continuity of care and the timely transfer of patients and records between the facilities.

WHEREAS, only a patient's attending physician (not Company or the Hospital) can refer such patient to Company for dialysis treatments.

NOW THEREFORE, in consideration of the premises herein contained and for other good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged, the parties agree as follows:

1. **HOSPITAL OBLIGATIONS.** In accordance with the policies and procedures as hereinafter provided, and upon the recommendation of an attending physician, a patient of Company may be transferred to Hospital.

(a) Hospital agrees to exercise its best efforts to provide for prompt admission of patients provided that all usual, reasonable conditions of admission are met. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission (the "Commission") and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Transfer record forms shall be completed in detail and signed by the physician or nurse in charge at Company and must accompany the patient to the receiving institution.

(b) Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility.

2. **COMPANY OBLIGATIONS.**

(a) Upon transfer of a patient to Hospital, Company agrees:

i. That it shall transfer any needed personal effects of the patient, and information relating to the same, and shall be responsible therefore until signed for by a representative of Hospital;

ii. Original medical records kept by each of the parties shall remain the property of that institution; and

iii. That transfer procedures shall be made known to the patient care personnel of each of the parties.

(b) Company agrees to transmit with each patient at the time of transfer, or in case of an emergency, as promptly as possible thereafter, an abstract of pertinent medical and other records necessary to continue the patient's treatment without interruption and to provide identifying and other information, to include:

i. current medical findings;

ii. diagnosis;

iii. rehabilitation potential;

iv. discharge summary;

v. a brief summary of the course of treatment followed;

vi. nursing and dietary information;

vii. ambulating status; and

viii. administrative and pertinent social information.

(c) Company agrees to readmit to its facilities patients who have been transferred to Hospital for medical care as clinic capacity allows. Hospital agrees to keep the administrator or designee of Company advised of the condition of the patients that will affect the anticipated date of transfer back to Company and to provide as much notice of the transfer date as possible. Company shall assign readmission priority for its patients who have been treated at Hospital and who are ready to transfer back to Company.

3. **BILLING, PAYMENT, AND FEES.** Hospital and Company each shall be responsible for billing the appropriate payor for the services it provides, respectively, hereunder. Company shall not act as guarantor for any charges incurred while the patient is a patient in Hospital.

4. **HIPAA.** Hospital and Company agree to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Hospital and Company acknowledge and agree that from time to time, HIPAA may require modification to this Agreement for compliance purposes. Hospital and Company further acknowledge and agree to comply with requests by the other party hereto related to HIPAA.

5. **STATUS AS INDEPENDENT CONTRACTORS.** The parties acknowledge and agree that their relationship is solely that of independent contractors. Governing bodies of Hospital and Company shall have exclusive control of the policies, management, assets, and affairs of their respective facilities. Nothing in this Agreement shall be construed as limiting the right of either to affiliate or contract with any other Hospital or facility on either a limited or general basis while this Agreement is in effect. Neither party shall use the name of the other in any promotional or advertising material unless review and approval of the intended use shall be obtained from the party whose name is to be used and its legal counsel.

6. **INSURANCE.** Each party shall secure and maintain, or cause to be secured and maintained during the term of this Agreement, comprehensive general liability, property damage, and workers compensation insurance in amounts generally acceptable in the industry, and professional liability insurance providing minimum limits of liability of $1,000,000 per occurrence and $3,000,000 in aggregate. Each party shall deliver to the other party certificate(s) of insurance evidencing such insurance coverage upon execution of this Agreement, and annually thereafter upon the request of the other party. Each party shall provide the other party with not less than thirty (30) days prior written notice of any change in or cancellation of any of such insurance policies. Said insurance shall survive the termination of this Agreement.

7. **INDEMNIFICATION.**

(a) Hospital Indemnity. Hospital hereby agrees to defend, indemnify and hold harmless Company and its shareholders, affiliates, officers, directors, employees, and agents for, from and against any claim, loss, liability, cost and expense (including, without limitation, costs of investigation and reasonable attorney's fees), directly or indirectly relating to, resulting from or arising out of any action or failure to act arising out of this Agreement by Hospital and its staff regardless of whether or not it is caused in part by Company or its officers, directors, agents, representatives, employees, successors and assigns. This indemnification provision shall not be effective as to any loss attributable exclusively to the negligence or willful act or omission of Company.

(b) Company Indemnity. Company hereby agrees to defend, indemnify and hold harmless Hospital and its shareholders, affiliates, officers, directors, employees, and agents for, from and against any claim, loss, liability, cost and expense (including, without limitation, costs of investigation and reasonable attorney's fees), directly or indirectly relating to, resulting from or arising out of any action or failure to act arising out of this Agreement by Company and its staff regardless of whether or not it is caused in part by or its officers, directors, agents, representatives, employees, successors and assigns. This indemnification provision shall not be

effective as to any loss attributable exclusively to the negligence or willful act or omission of Hospital.

(c) Survival. The indemnification obligations of the parties shall continue in full force and effect notwithstanding the expiration or termination of this Agreement with respect to any such expenses, costs, damages, claims and liabilities which arise out of or are attributable to the performance of this Agreement prior to its expiration or termination.

8. DISPUTE RESOLUTION. Any dispute which may arise under this Agreement shall first be discussed directly with representatives of the departments of the parties that are directly involved. If the dispute cannot be resolved at this level, it shall be referred to administrative representatives of the parties for discussion and resolution.

(a) Informal Resolution. Should any dispute between the parties arise under this Agreement, written notice of such dispute shall be delivered from one party to the other party and thereafter, the parties, through appropriate representatives, shall first meet and attempt to resolve the dispute in face-to-face negotiations. This meeting shall occur within thirty (30) days of the date on which the written notice of such dispute is received by the other party.

(b) Resolution Through Mediation. If no resolution is reached through informal resolution, pursuant to Section 8(a) above, the parties shall, within forty-five (45) days of the first meeting referred to in Section 8(a) above, attempt to settle the dispute by formal mediation. If the parties cannot otherwise agree upon a mediator and the place of the mediation within such forty-five (45) day period, the American Arbitration Association ("AAA") in the State of Maryland shall administer the mediation. Such mediation shall occur no later than ninety (90) days after the dispute arises. All findings of fact and results of such mediation shall be in written form prepared by such mediator and provided to each party to such mediation. In the event that the parties are unable to resolve the dispute through formal mediation pursuant to this Section 8(b), the parties shall be entitled to seek any and all available legal remedies.

9. TERM AND TERMINATION. This Agreement shall be effective for an initial period of one (1) year from the Effective Date and shall continue in effect indefinitely after such initial term, except that either party may terminate by giving at least sixty (60) days notice in writing to the other party of its intention to terminate this Agreement. If this Agreement is terminated for any reason within one (1) year of the Effective Date of this Agreement, then the parties hereto shall not enter into a similar agreement with each other for the services covered hereunder before the first anniversary of the Effective Date. Termination shall be effective at the expiration of the sixty (60) day notice period. However, if either party shall have its license to operate its facility revoked by the State or become ineligible as a provider of service under Medicare or Medicaid laws, this Agreement shall automatically terminate on the date such revocation or ineligibility becomes effective.

10. AMENDMENT. This Agreement may be modified or amended from time to time by mutual written agreement of the parties, signed by authorized representatives thereof, and any such modification or amendment shall be attached to and become part of this Agreement. No

oral agreement or modification shall be binding unless reduced to writing and signed by both parties.

11. **ENFORCEABILITY/SEVERABILITY.** The provisions of this Agreement are severable. The invalidity or unenforceability of any term or provisions hereto in any jurisdiction shall in no way affect the validity or enforceability of any other terms or provisions in that jurisdiction, or of this entire Agreement in any other jurisdiction.

12. **COMPLIANCE RELATED MATTERS.** The parties agree and certify that this Agreement is not intended to generate referrals for services or supplies for which payment maybe made in whole or in part under any federal health care program. The parties will comply with statutes, rules, and regulations as promulgated by federal and state regulatory agencies or legislative authorities having jurisdiction over the parties.

13. **EXCLUDED PROVIDER.** Each party represents that neither that party nor any entity owning or controlling that party has ever been excluded from any federal health care program including the Medicare/Medicaid program or from any state health care program. Each party further represents that it is eligible for Medicare/Medicaid participation. Each party agrees to disclose immediately any material federal, state, or local sanctions of any kind, imposed subsequent to the date of this Agreement, or any investigation which commences subsequent to the date of this Agreement, that would materially adversely impact Company's ability to perform its obligations hereunder.

14. **NOTICES.** All notices, requests, and other communications to any party hereto shall be in writing and shall be addressed to the receiving party's address set forth below or to any other address as a party may designate by notice hereunder, and shall either be (a) delivered by hand, (b) sent by recognized overnight courier, or (c) by certified mail, return receipt requested, postage prepaid.

If to Hospital:	University of Maryland Shore Regional Health 219 S. Washington Street Easton, MD 21601 Attention: Administrator
If to Company:	Total Renal Care, Inc. c/o: DaVita HealthCare Partners Inc. 2245 Rolling Run Drive Windsor Mill, MD 21244 Attention: Division Vice President
With copies to:	Total Renal Care, Inc. c/o: DaVita HealthCare Partners Inc. 5200 Virginia Way Brentwood, TN 37027 Attention: Group General Counsel

DaVita HealthCare Partners Inc.
2000 16th Street, 12th Floor
Denver, Colorado 80202
Attention: Chief Legal Officer

All notices, requests, and other communication hereunder shall be deemed effective (a) if by hand, at the time of the delivery thereof to the receiving party at the address of such party set forth above, (b) if sent by overnight courier, on the next business day following the day such notice is delivered to the courier service, or (c) if sent by certified mail, five (5) business days following the day such mailing is made.

15. **ASSIGNMENT.** This Agreement shall not be assigned in whole or in part by either party hereto without the express written consent of the other party, except that Company may assign this Agreement to one of its affiliates or subsidiaries without the consent of Hospital.

16. **COUNTERPARTS.** This Agreement may be executed simultaneously in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Copies of signatures sent by facsimile shall be deemed to be originals.

17. **NON-DISCRIMINATION.** All services provided by Hospital hereunder shall be in compliance with all federal and state laws prohibiting discrimination on the basis of race, color religion, sex national origin, handicap, or veteran status.

18. **WAIVER.** The failure of any party to insist in any one or more instances upon performance of any terms or conditions of this Agreement shall not be construed as a waiver of future performance of any such term, covenant, or condition, and the obligations of such party with respect thereto shall continue in full force and effect.

19. **GOVERNING LAW.** The laws of the State of Maryland shall govern this Agreement.

20. **HEADINGS.** The headings appearing in this Agreement are for convenience and reference only, and are not intended to, and shall not, define or limit the scope of the provisions to which they relate.

21. **ENTIRE AGREEMENT.** This Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes any and all other agreements, either oral or written, between the parties (including, without limitation, any prior agreement between Hospital and Company or any of its subsidiaries or affiliates) with respect to the subject matter hereof.

22. **APPROVAL BY DAVITA HEALTHCARE PARTNERS INC. ("DAVITA") AS TO FORM.** The parties acknowledge and agree that this Agreement shall take effect and be legally binding upon the parties only upon full execution hereof by the parties and upon approval by DaVita as to the form hereof.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement the day and year first above written.

Hospital:

Shore Health System, Inc.

By: DocuSigned by: Kenneth Kozel 0ADC9D009EEB416...

Name: Kenneth Kozel

Its: President/CEO

Date: April 11, 2014

Company:

Total Renal Care, Inc.

By: DocuSigned by: Steven DeVore BE5F0AEE111C468...

Name: Steven DeVore

Its: Division Vice President

Date: April 11, 2014

APPROVED AS TO FORM ONLY:

By: DocuSigned by: Troy Arnlund D398194FC51B436...

Name: Troy Arnlund

Its: Group General Counsel

DocuSign SECURED

Certificate of Completion

Envelope Number: 7CF6AF2CB14C47CDA1A8E7DC2F147914 — Status: Completed

Subject: Please DocuSign this document: Patient Transfer Agmt - Queen Anne Home Training #11176_Shore Health

Source Envelope:

Document Pages: 7 — Signatures: 3 — Envelope Originator:
Certificate Pages: 5 — Initials: 0 — Angie King
AutoNav: Enabled — 2000 16th Street
EnvelopeId Stamping: Enabled — Denver, CO 80202
angie.king@davita.com
IP Address: 50.140.68.252

Record Tracking

Status: Original — Holder: Angie King — Location: DocuSign
4/8/2014 10:53:16 AM PT — angie.king@davita.com

Signer Events	Signature	Timestamp
Kenneth Kozel kkozel@shorehealth.org President/CEO Security Level: Email, Account Authentication (None) Electronic Record and Signature Disclosure: Accepted: 4/11/2014 11:08:34 AM PT ID: 44f0dc21-8cdf-4b1c-9b3d-ee4e5c08be71	DocuSigned by: kenneth kozel CADC9D089EEB416... Using IP Address: 134.192.250.21	Sent: 4/8/2014 10:55:42 AM PT Viewed: 4/8/2014 3:01:53 PM PT Signed: 4/11/2014 11:09:54 AM PT
Troy Arnlund Troy.arnlund@davita.com Group General Counsel Security Level: Email, Account Authentication (None) Electronic Record and Signature Disclosure: Accepted: 4/11/2014 11:12:52 AM PT ID: 59cc928c-32ab-417d-b8fb-ff28795439bd	DocuSigned by: Troy Arnlund D398194FC51B438... Using IP Address: 207.41.203.5	Sent: 4/11/2014 11:09:56 AM PT Viewed: 4/11/2014 11:12:52 AM PT Signed: 4/11/2014 11:13:01 AM PT
Steven DeVore Steven.devore@davita.com Division Vice President Security Level: Email, Account Authentication (None) Electronic Record and Signature Disclosure: Accepted: 4/11/2014 12:30:05 PM PT ID: adccc42c-f61c-40c2-9c00-44019e6d74ca	DocuSigned by: Steven DeVore BE5F8AEE111C408... Using IP Address: 98.117.46.138	Sent: 4/11/2014 11:13:03 AM PT Viewed: 4/11/2014 12:30:05 PM PT Signed: 4/11/2014 12:30:42 PM PT

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
Angie King angie.king@davita.com GGC Paralegal DaVita Healthcare Partners Inc. Security Level: Email, Account Authentication (None) Electronic Record and Signature Disclosure: Not Offered ID:	COPIED	Sent: 4/11/2014 12:30:44 PM PT Resent: 4/11/2014 12:30:50 PM PT Viewed: 4/11/2014 12:33:25 PM PT
John Rundle john.rundle@davita.com Security Level: Email, Account Authentication (None) Electronic Record and Signature Disclosure: Not Offered ID:	COPIED	Sent: 4/11/2014 12:30:45 PM PT
Katie Ingram katie.ingram@davita.com Security Level: Email, Account Authentication (None) Electronic Record and Signature Disclosure: Not Offered ID:	COPIED	Sent: 4/11/2014 12:30:45 PM PT Viewed: 4/11/2014 12:46:22 PM PT

Notary Events	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	4/11/2014 12:30:46 PM PT
Certified Delivered	Security Checked	4/11/2014 12:30:46 PM PT
Signing Complete	Security Checked	4/11/2014 12:30:46 PM PT
Completed	Security Checked	4/11/2014 12:30:46 PM PT

Electronic Record and Signature Disclosure

CONSUMER DISCLOSURE

From time to time, DaVita (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through the DocuSign, Inc. (DocuSign) electronic signing system. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the â€˜I agreeâ€™ button at the bottom of this document.

Getting paper copies

At any time, you may request from us a paper copy of any record provided or made available electronically to you by us. You will have the ability to download and print documents we send to you through the DocuSign system during and immediately after signing session and, if you elect to create a DocuSign signer account, you may access them for a limited period of time (usually 30 days) after such documents are first sent to you. After such time, if you wish for us to send you paper copies of any such documents from our office to you, you will be charged a $0.00 per-page fee. You may request delivery of such paper copies from us by following the procedure described below.

Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. To indicate to us that you are changing your mind, you must withdraw your consent using the DocuSign â€˜Withdraw Consentâ€™ form on the signing page of a DocuSign envelope instead of signing it. This will indicate to us that you have withdrawn your consent to receive required notices and disclosures electronically from us and you will no longer be able to use the DocuSign system to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through the DocuSign system all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures

electronically from us.

How to contact DaVita:

You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:

To contact us by email send messages to: jennifer.vanhyning@davita.com

To advise DaVita of your new e-mail address

To let us know of a change in your e-mail address where we should send notices and disclosures electronically to you, you must send an email message to us at jennifer.vanhyning@davita.com and in the body of such request you must state: your previous e-mail address, your new e-mail address. We do not require any other information from you to change your email address..

In addition, you must notify DocuSign, Inc. to arrange for your new email address to be reflected in your DocuSign account by following the process for changing e-mail in the DocuSign system.

To request paper copies from DaVita

To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an e-mail to jennifer.vanhyning@davita.com and in the body of such request you must state your e-mail address, full name, US Postal address, and telephone number. We will bill you for any fees at that time, if any.

To withdraw your consent with DaVita

To inform us that you no longer want to receive future notices and disclosures in electronic format you may:

i. decline to sign a document from within your DocuSign session, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;

ii. send us an e-mail to jennifer.vanhyning@davita.com and in the body of such request you must state your e-mail, full name, US Postal Address, and telephone number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

Required hardware and software

Operating Systems:	WindowsÂ® 2000, WindowsÂ® XP, Windows VistaÂ®; Mac OSÂ® X
Browsers:	Final release versions of Internet ExplorerÂ® 6.0 or above (Windows only); Mozilla Firefox 2.0 or above (Windows and Mac); Safariâ„¢ 3.0 or above (Mac only)
PDF Reader:	AcrobatÂ® or similar software may be required to view and print PDF files
Screen Resolution:	800 x 600 minimum
Enabled Security Settings:	Allow per session cookies

** These minimum requirements are subject to change. If these requirements change, you will be asked to re-accept the disclosure. Pre-release (e.g. beta) versions of operating systems and browsers are not supported.

Acknowledging your access and consent to receive materials electronically

To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please verify that you were able to read this electronic disclosure and that you also were able to print on paper or electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format on the terms and conditions described above, please let us know by clicking the â€˜I agreeâ€™ button below.
By checking the â€˜I agreeâ€™ box, I confirm that:

- I can access and read this Electronic CONSENT TO ELECTRONIC RECEIPT OF ELECTRONIC CONSUMER DISCLOSURES document; and

- I can print on paper the disclosure or save or send the disclosure to a place where I can print it, for future reference and access; and

- Until or unless I notify DaVita as described above, I consent to receive from exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to me by DaVita during the course of my relationship with you.

TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT ("Agreement") shall be effective as of the 1st day of January, 2009 ("Commencement Date"), by and between **Envoy of Denton, LLC d/b/a Envoy of Denton** ("Facility") and **The Memorial Hospital at Easton, MD, Inc.** ("Hospital").

RECITALS

WHEREAS, Hospital is licensed and certified as an **[acute care hospital]** in the State of Maryland, and is approved for participation in the Medicare and Medicaid programs;

WHEREAS, Facility is a licensed and certified nursing facility in the State of Maryland;

WHEREAS, Federal and State laws require that Facility maintain a written agreement with a hospital in close proximity for timely admission of patients who develop complications or require inpatient medical treatment; and

WHEREAS, both parties to this Agreement desire to assure continuity of care and treatment appropriate to the needs of each patient in the Facility and the Hospital.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

ARTICLE I
AUTONOMY

The parties agree that each shall continue to have the exclusive control of the management, business and properties of their respective institutions, and that neither party by virtue of this Agreement assumes any liability for any debts or obligations of the other party to the Agreement, or any responsibility for the moral or legal obligations of the other party.

ARTICLE II
TRANSFER OF PATIENTS

2.1 Transfer of Patient to Hospital.

2.1.1 Hospital agrees to admit patients from the Facility as promptly as possible in accordance with its established admission policy. Patients declared as emergencies by their physicians will be admitted without delay. Transfers shall be effected only when medically appropriate as determined by patient's attending physician.

2.1.2 Facility shall arrange for appropriate and safe transportation and care of the patient during transfer to the Hospital, in accordance with applicable Federal and State laws and regulations.

2.2 Transfer of Patient to Facility.

2.2.1 Facility agrees to readmit the patient transferred to the Hospital in accordance with its established admission policy to the first available bed after having been notified by the Hospital that the patient is ready to be discharged. Transfers shall be effected only when medically appropriate as determined by patient's attending physician.

2.2.2 Facility will keep the Hospital advised of any foreseeable problem in the readmission of a patient during the patient's stay in the Hospital.

2.2.3 Hospital shall arrange for appropriate and safe transportation and care of the patient during transfer to the Facility, in accordance with applicable Federal and State laws and regulations.

2.2.4 Hospital will provide Facility with a written discharge summary of all pertinent medical information necessary for the care and treatment of patient at Facility.

2.3 Notice of Transfer. Hospital and Facility will give notice to the other party as far in advance as practicable of an impending transfer.

2.4 Exchange of Records and Information. Hospital and Facility agree to transfer medical records and other information that may be necessary or useful in the care and treatment of patients transferred hereunder, as required and permitted by all applicable Federal and State laws. Such information shall be provided by Hospital and Facility in advance, when possible, and in any event at the time of the transfer, and shall be recorded on a transfer and referral form that is mutually acceptable to both parties. Medical information shall include, as applicable, current history, medical diagnosis, rehabilitation potential, summary of course of treatment followed, nursing and dietary needs, prognosis, and pertinent administrative and social information.

2.5 Transfer of Personal Effects. Procedures for effecting the transfer of personal effects and valuables shall be developed by the parties. Each party shall designate an appropriate individual with responsibility for transfers of personal effects. A standard form shall be adopted and used by both parties for effecting the transfer of a patient's personal effects and valuables and ensuring security and accountability thereof.

2.6 Disaster and Evacuation. In the event of a disaster of any kind wherein the evacuation of the patients becomes necessary, patients at Facility shall be transferred to Hospital, subject to bed availability.

2.7 Billing. All claims or charges incurred with respect to any services performed by either party for patients received through transfer from the other party pursuant to this Agreement shall be billed and collected by the party providing such services directly from the patient, third party payer, Medicare or Medicaid, or other source appropriately billed by that party.

ARTICLE III
TERM AND TERMINATION

3.1 Term. The term of this Agreement shall commence as of the Commencement Date, and shall be for a term of one (1) year therefrom, unless terminated in accordance with the provisions set forth in Section 3.2 herein, or unless extended as provided herein. Thereafter, this Agreement shall automatically be renewed for an additional period of one (1) year unless either party terminates this Agreement in accordance with the provisions set forth in Section 3.2 herein. To the extent that this Agreement is automatically renewed, each such renewal term shall be upon the same terms and conditions of the immediately preceding renewal term.

3.2 Termination.

3.2.1 This Agreement may be terminated by either party for any reason by written notice to the other party of at least sixty (60) days, in the form required by Section 5.4 hereof, or upon mutual agreement evidenced in writing.

3.2.2 Facility may terminate this Agreement immediately if Hospital becomes the target of an investigation by any government agency for the violation of any law, if Hospital is charged, convicted or pleads guilty or no contest to any violation of the law, if Hospital enters into any settlement agreement with any government agency, if Facility believes Hospital is violating any law, or if this Agreement causes Facility not to be in compliance with any law.

3.2.3 Upon the occurrence of any of the following events, this Agreement shall automatically be terminated: (1) revocation, suspension, probation or non-renewal of any and all licenses and registrations issued to Hospital or Facility by any applicable agency or governmental authority of the State of Maryland; and (2) termination of the Hospital's or Facility's provider agreement for Medicare or either party being deemed an "excluded party" for purposes of any Federal healthcare program.

3.3 Effect of Termination. The parties acknowledge and agree that in the event of termination of this Agreement by either party or through any of the occurrences outlined herein, neither party shall have any further obligations hereunder except: for obligations accruing prior to the date of termination, and for obligations, promises, or covenants contained herein which are expressly made to extend beyond the term of this Agreement.

ARTICLE IV
RECORDS

4.1 Maintenance of Records. Hospital and Facility agree to keep and supply records in such form and for such duration as may be required by all applicable Federal and State statutes and regulations.

4.2 Access to Books and Records. Until the expiration of four (4) years after the furnishing of services pursuant to this Agreement, Hospital shall, upon written request, make available to the Secretary of the Department of Health and Human Services (HHS), the Comptroller General, or any of their duly authorized representatives, this Agreement, and any books, documents and records that are necessary to certify the nature and extent of the costs incurred by Facility under this Agreement. This provision will apply if the amount paid under the Agreement is $10,000 or more over a twelve (12) month period. The availability of Hospital's books, documents and records will at all times be subject to such criteria and procedures for seeking access as may be promulgated by the Secretary of HHS in regulations, and other applicable laws. Hospital's disclosure under this provision will not be construed as a waiver of any legal rights to which Hospital or Facility may be entitled under statute or regulation.

4.3 Subcontractors. If Hospital delegates to or performs any of its duties pursuant to this Agreement through a subcontractor, with a value or cost of $10,000 or more over a twelve (12) month period, then Hospital represents, warrants and agree that it will include a provision in the agreement with the subcontractor substantially similar to Section 4.2 above.

4.4 Medical Records. Medical records kept by each party shall remain the property of that party, but a copy of current orders or a written statement of the patient's diagnosis, mental and physical condition shall accompany the patient at the time of transfer.

4.5 HIPAA. Each of the parties hereby represents and warrants and covenants that it is presently taking and will continue to take all actions necessary to assure that it shall, on or before each applicable compliance date and continuously thereafter, comply with Public Law 104-191 of August 21, 1996, known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations, including without limitation, the Standards for Electronic Transactions and Code Sets (45 CFR Parts 160 and 162), the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164), the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Parts 160 and 164) and such other regulations that may, from time to time, be promulgated thereunder.

ARTICLE V
MISCELLANEOUS

5.1 Non-exclusivity. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other hospital or nursing facility on either a limited or general basis while this Agreement is in effect.

5.2 Marketing & Advertising. Neither party shall use the name, logo, symbol or trademark of the other party in any promotional material, unless review and approval of the intended use is first obtained in writing from the party whose name is to be used.

5.3 Governing Law. This Agreement has been executed and delivered in, and shall be interpreted, construed, and enforced pursuant to and in accordance with the laws of the State of Maryland, without reference to the conflicts of law provisions thereof.

5.4 Notices. Any notice, demand or communication required, permitted or desired to be given hereunder shall be deemed effectively given when personally delivered or mailed by prepaid certified mail, return receipt requested, addressed as follows:

If to Facility:	*If to Hospital:*
Envoy of Denton	The Memorial Hospital at Easton, MD, Inc.
420 Colonial Drive	219 S. Washington St.
Denton, MD 21629	Easton, MD 21601
ATT: Executive Director	ATT: President & CEO

Any party may change its address by giving notice in accordance with the provisions of this subparagraph.

5.5 Assignment. No assignment of this Agreement or the rights and obligations hereunder shall be valid without the express prior written consent of both parties hereto; provided, however, that this Agreement may be assigned without the consent of the other party, by Hospital or Facility to any successor entity, which as a result of a merger, acquisition of stock, acquisition of significant assets or other reorganization, operates all or a substantial portion of the Hospital or Facility. Any purported assignment of this Agreement which violates the provisions of this Section 5.5 shall be null, void and of no force or effect.

5.6 Waiver of Breach. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be a waiver of any subsequent breach of the same or other provision hereof.

5.7 Severability. In the event any provision of this Agreement is held to be unenforceable for any reason, the unenforceability thereof shall not affect the remainder of this Agreement, which shall remain in full force and effect and enforceable in accordance with its terms.

5.8 Gender and Number. Whenever the context hereof requires, the gender of all words shall include the masculine, feminine, and neuter, and the number of all words shall include the singular and plural.

5.9 Entire Agreement. This Agreement constitutes the entire Agreement of the parties with respect to the subject matter hereof, and all prior and contemporaneous understandings, agreements and representations, whether oral or written, with respect to such matters are superseded.

5.10 Amendments. This Agreement may only be amended, modified, waived or discharged by the written consent of both parties.

5.11 Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be an original, but all of which shall be deemed to constitute one instrument.

5.12 Compliance With Laws.

5.12.1 Both parties agree to comply with all applicable Federal and State laws prohibiting discrimination against persons on account of race, sex, color, age, religion, national origin, or disability, including without limitation the Civil Rights Act of 1964 and the Maryland Human Relations Act, October 27, 1955, Public Law 744 as amended and/or further adopted.

5.12.2 Both parties certifies that they and their employees and agents comply with, are not under investigation for violations of, and have never been convicted of or sanctioned for violations of, any Federal and State laws governing the Medicare and Medicaid programs (including but not limited to, provisions regarding the billing of services and the referral of patients), laws relating to patient abuse or neglect, health care fraud, and laws governing controlled substances. Furthermore, both parties certifies that they and their employees are not "excluded persons" for purposes of any Federal healthcare program.

5.12.3 Both parties are in compliance, and will maintain compliance, with all billing and claims submission laws and regulations during the term of this Agreement. Both parties further agrees to abide by any applicable requirements of the other parties corporate compliance program.

5.12.4 Nothing in this Agreement shall be construed as an offer or payment by one party to the other party (or any affiliate of the other party) of any remuneration for patient referrals, or for recommending or arranging for the purchase, lease or order of any item of service for which payment may be made in whole or in part by Medicare or Medicaid. Any payment made between the parties is intended to represent the fair market value of the supplies and/or services to be rendered by the respective party hereunder and is not in any way related to or dependent upon referrals by and between Facility and Hospital. Furthermore, it is the stated intent of both parties that nothing contained in this Agreement is or shall be construed as an endorsement for any act of either party.

5.12.5 Hospital certifies that all services provided pursuant to this Agreement shall be performed in accordance with all Federal, State and local laws applicable to such services and in conformity with the highest professional standards.

5.13 Independent Contractors. None of the provisions of this Agreement shall create or be construed to create any relationship between the parties other than that of independent entities contracting for the sole purpose of effecting the provisions of this Agreement. Neither Hospital nor Facility, nor any of their respective agents or employees, shall be construed to be the agent, employee or representative of the other.

5.14 Binding Effect. This Agreement shall be binding upon the parties hereto and their respective heirs, executors, administrators, successors and permitted assigns.

5.15 Incorporation of Recitals. The aforesaid Recitals are hereby incorporated into this Agreement as if fully set forth herein.

5.16 Dispute Resolution. In the even a dispute between Hospital and Facility arises out of or is related to any part of this contractual Agreement, Hospital and Facility shall meet and negotiate in good faith to attempt to resolve the dispute. In the event the dispute is not resolved within 30 days of the date one party sent written notice of the dispute to the other party, and if either party wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with this section. Any arbitration under this Section shall be conducted by the National Arbitration Forum, under the Code of Procedure then in effect, and judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction thereof. The place of arbitration shall be Baltimore, Maryland. The arbitrators shall decide legal issues pertaining to the dispute, controversy or claim pursuant to the laws of the State of Maryland. Subject to the control of the arbitrators, or as the parties may otherwise mutually agree, the parties shall have the right to conduct reasonable discovery pursuant to the Federal Rules of Civil Procedure. The arbitrators shall not have the authority to award punitive damages, but shall have authority to award equitable relief. THE PARTIES UNDERSTAND THAT THEY ARE KNOWINGLY AND WILLINGLY EXPRESSLY WAIVING A RIGHT TO JURY TRIAL CONCERNING ANY MATTERS RELATING TO THIS AGREEMENT.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the date first above written.

FACILITY	HOSPITAL
By: _____	By: _____
Name: JOHN B. HENRY	Name: GERARD M. WALSH
Title: ADMINISTRATOR	Title: SR. V.P. + COO.

GENERAL TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (hereinafter "Agreement"), is effective December 1, 2013, by and between University of Maryland Shore Regional Health, Inc., including Shore Medical Center at Easton, Shore Medical Center at Dorchester, and Shore Medical Center at Chestertown (hereinafter "Health Care Facility") located at 219 South Washington Street, Easton, MD 21601, and Alfred I. duPont Hospital for Children, of The Nemours Foundation, a Florida not-for-profit corporation (hereinafter "AIDHC") located at 1600 Rockland Road, Wilmington, Delaware, 19803. Both Health Care Facility and AIDHC are hereinafter referred to as "Parties" to this Agreement and each may be referred to as "Institution".

WITNESSETH

WHERAS, Health Care Facility is a not-for-profit corporation that operates a health care system to provide access to patient care for the residents of its service area; and

WHEREAS, The Nemours Foundation is a not-for-profit corporation that operates a hospital to provide pediatric patient care; and

WHEREAS, the parties desire to provide reasonable assurance that the transfer of patients will be properly effected between the institutions when a transfer is either medically appropriate as determined by the referring physician or when the patient requests the transfer;

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Health Care Facility and AIDHC agree as follows:

1. Term. This Agreement shall commence on the day and year first above written and shall continue for a period of five (5) years, unless terminated earlier by either Institution as set forth below.

2. Patient Transfer. The patient's attending physician will determine when transfer of a patient, from one Institution to the other is appropriate. When a decision to transfer has been made, the transferring Institution shall contact the receiving Institution as far in advance of the anticipated transfer as possible to obtain the receiving Institution's consent to the transfer. Prior to moving the patient, the transferring Institution must receive confirmation from the receiving Institution that it can accept the patient.

3. Patient Records. Each Institution agrees to adopt standard forms for medical and administrative information to accompany the patient from one Institution to the other. The information shall include, but not be limited to, an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption. Each Institution agrees to supplement the above information as necessary for the maintenance of the patient during transport and treatment upon arrival at the receiving Institution.

4. Personal Effects. The transferring party shall transfer the patient's personal effects, including money and valuables, and information pertaining to same. A list prepared by the transferring party of all personal effects shall be transferred with the patient and shall include the signature of the person making the list. An attempt should be made to have family members

or friends voluntarily transfer such personal effects if possible. The receiving party shall, as soon as practical upon patient arrival, document that all personal effects were received or will notify the transferring facility if items were lost.

5. Medical Information. The transferring party agrees to transmit with each patient at the time of transfer, or in case of an emergency, as promptly as possible thereafter, all available pertinent medical and other records necessary to continue the patient's treatment without interruption and to provide identifying and other information, which must include:

(a) A completed interagency communication summary to include; as applicable

- current medical findings;
- diagnosis;
- rehabilitation potential;
- brief summary of the course of treatment followed at Health Care Facility;
- nursing and dietary information useful in care of the patient;
- administrative and pertinent social information;
- post-discharge plan of care;
- all other information required by law or deemed necessary.

(b) Documentation of any known Health Care Treatment Directive, including any durable power of attorney for health care decisions, living will, guardianship papers or withholding of resuscitation orders.

(c) Documentation of (i) the name of the person requesting the transfer, (ii) the fact that the patient or person with authority to act on the patient's behalf consented to the transfer (except in emergencies), (iii) the name of the person at the receiving party who accepted the transfer.

6. Patient Consent to Transfer. The transferring Institution shall have responsibility for obtaining the appropriate consent to the transfer to the other Institution, prior to the transfer. This should include the patient's attending physician's signature authorizing the transport.

7. Charges. The patient/parent is primarily responsible for payment for care received at either Institution and for the costs to transport the patient for the transfer. Prior to transfer, except in urgent circumstances, the patient/parent should be required, if competent, to acknowledge the obligation to pay for such care at the receiving Institution and the transport costs. Each Institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either Institution to look to the other Institution to pay for services rendered to a patient transferred by virtue of this Agreement.

8. Transport. The transferring party shall arrange for appropriate and safe transportation of the patient in compliance with applicable laws, regulations and Joint Commission standards.

9. Return of Patient to Health Care Facility. When the Receiving party is AIDHC, the Health Care Facility shall be expected to be available for the return of the transferred patient when:

(a) the patient's medical condition has stabilized and the patient is ready for discharge from AIDHC, and

(b) the patient has needs for continued care appropriate to the scope of services provided by the Health Care Facility.

10. Liability. Each Institution shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other Institution.

11. Indemnification. Each party (the "Indemnifying Party") will defend, indemnify and hold the other parties and the other parties' employees, officers, governing body and medical staff members, physicians, agents, representatives and affiliates (collectively the "Indemnified Parties") harmless against any and all claims, suits, proceedings, demands, liabilities, losses, damages, penalties, fines, interest, costs and attorney's fees which may be brought, claimed or asserted against or incurred by the Indemnified Parties, and which arise from or result from the Indemnified Party's provision or failure to provide any of the Services described in this Agreement or from any negligence or other tortious or wrongful act or omission by the Indemnifying party or its employees, physicians, contractors or representatives. This provision shall survive termination of this Agreement.

12. Insurance. Each Institution agrees to obtain and maintain in force during the term of the Agreement professional and general liability insurance with minimum limits of $1 million per occurrence or claim and $3 million annual aggregate. Upon request, each Institution will provide the other with a certificate of insurance verifying such coverage at all times this Agreement is in effect. Each Institution shall notify the other at least thirty (30) days prior to cancellation, reduction or material change in coverage. If the insurance is on a "claims made" basis, each Institution agrees to purchase appropriate tail coverage for claims, demands or actions reported in future years for acts or omissions during the term of this Agreement. If either Institution fails to obtain or maintain the insurance coverage provided herein, the other party may terminate this Agreement. The parties may satisfy this requirement through an actuarially sound plan of self insurance.

13. Termination.

13.1 Voluntary Termination. This Agreement may be terminated by either Institution for any reason, by giving thirty (30) days written notice of its intention to withdraw from this Agreement, and by ensuring the continuity of care to patients who already are involved in the transfer process. To this end, the terminating Institution will be required to meet its commitments under the Agreement to all patients for whom the other Institution has begun the transfer process in good faith.

13.2 Involuntary Termination. This Agreement may be terminated immediately upon the occurrence of any of the following:

13.2.1 Either Institution is destroyed to such an extent that the patient care provided by such Institution cannot be carried out adequately;

13.2.2 Either Institution loses its license or accreditation;

13.2.3 Either Institution is no longer able to provide the service for which this Agreement was sought;

13.2.4 Either Institution is in material default under any of the terms of this Agreement; or

13.2.5 Either Institution becomes a Sanctioned Provider as defined in Appendix A.

14. Independent Contractor Status. The Parties are independent contractors and neither Institution is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by either Institution, nor shall it in any way alter the control of the management, assets and affairs of the respective Parties. Neither Institution, by virtue of the Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other Institution to this Agreement.

15. Regulatory Compliance. The Parties agree to abide by all applicable federal, state and local laws and regulations, to include the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the Health Insurance Portability and Accountability Act ("HIPAA"), and federal and state anti-kickback laws. This agreement is not intended to violate the Anti-Kickback or Stark laws and it is not the purpose, nor is it a requirement of this Agreement to offer or receive any remuneration or inducement in exchange for the referral of any patient or other health care business between the parties.

16. Discrimination. The Parties agree that the primary consideration of both is care of patients according to their needs. Health Care Facility and AIDHC agree to admit and assign patients without regard to race, color, sex, age, national origin, religious creed or sexual preference.

17. Advertising and Public Relations. Neither Institution shall use the name of the other Institution in any promotional or advertising material unless review and approval of the intended advertisement first shall be obtained from the Institution whose name is to be used. The Parties shall deal with each other publicly and privately in an atmosphere of mutual respect and support, and each Institution shall maintain good public and patient relations and efficiently handle complaints and inquiries with respect to transferred or transferring patients.

18. Modification of Waiver. If either Institution to this Agreement waives a breach of one of the provisions of this Agreement by the other Institution, that waiver shall neither operate nor be construed as a waiver of a subsequent similar breach of a provision hereof.

19. Governing Law. This Agreement is made and entered into and shall be governed and construed in accordance with the laws of the State of Delaware.

20. Assignment. The Agreement shall not be assigned in whole or in part by either Institution hereto without the express written consent of the other Institution.

21. Invalid Provision. In the event that any portion of the Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the Parties hereto in the same manner as if the invalid or unenforceable provision were not a part of the Agreement.

22. Amendment. This Agreement may be amended at any time by a written Agreement signed by the Parties hereto.

23. Notice. Any and all notices and other communications required or permitted to be given hereunder shall be made in writing and effective upon receipt. Such notices shall be personally delivered, sent by registered or certified mail, by a nationally recognized overnight delivery service or sent by facsimile or electronic mail with confirmation, addressed as follows, unless such address is changed by written notice hereunder:

If to Health Care Facility:

University of Maryland Shore Regional Health, Inc.
219 South Washington Street
Easton, MD 21601
Attn: President & CEO

If to AIDHC:

Alfred I. duPont Hospital for Children
1600 Rockland Road
Wilmington, DE 19803
Attn: Diane Hochstuhl
E-mail: dhochstu@nemours.org

With a copy to:

Office of Contracts Administration
The Nemours Foundation
10140 Centurion Parkway North
Jacksonville, FL 32256
Fax: 904.697.4070
E-mail: oca@nemours.org

24. Entire Agreement. This Agreement constitutes the entire agreement between the Parties and contains all of the agreements between them with respect to the subject matter hereof and supersedes any and all other agreements, either oral or in writing, between the Parties with respect to the subject matter hereof.

25. Assignment. This Agreement may not be assigned in whole or in part by any Party without the express written consent of the other Party.

26. Counterparts and Electronic Signature. This Agreement may be executed in two or more counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. Delivery of an executed signature page to the Agreement by facsimile transmission or .PDF will be as effective as delivery of a manually signed counterpart.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed by persons duly authorized to bind the Parties to perform their respective obligations hereunder, as of the date first written above.

ALFRED I. duPONT HOSPITAL FOR CHILDREN OF THE NEMOURS FOUNDATION

By: M. Kay Holbrook
Name: M. Kay Holbrook
Title: Associate Administrator
Date: 12/2/13

UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH, INC.

By:
Name: Kenneth Kozel
Title: President & CEO
Date: 12/12/13

APPENDIX A

"Sanctioned Provider" means a Person who:

1. is currently under indictment or prosecution for, or has been convicted of:

a) any offense related to the delivery of an item or service under the Medicare or Medicaid programs or any program funded under Title V or Title XX of the Social Security Act (the Maternal Child Health Services Program or the Block Grants to States for Social Services programs, respectively),

b) a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service,

c) fraud, theft, embezzlement or other financial misconduct in connection with the delivery of a health care item or service,

d) obstructing an investigation of any crime referred to in i) through iii) above, or

e) unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

2. has been required to pay any civil monetary penalty under 42 U.S.C. §1128A, regarding false, fraudulent or impermissible claims under, or payments to induce a reduction or limitation of health care services to beneficiaries of, any state or Federal health care program, or is currently the subject of any investigation or proceeding which may result in such payment; or

3. has been excluded from participation in the Medicare, Medicaid or Maternal and Child Health Services (Title V) program, or any program funded under the Block Grants to States for Social Services (Title XX) program.

GENERAL TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (hereinafter "Agreement"), is effective July 25, 2018, by and between University of Maryland Shore Regional Health. (hereinafter "Health Care Facility") located at 219 South Washington Street, Easton, MD 21601, and Alfred I. duPont Hospital for Children, of The Nemours Foundation, a Florida not-for-profit corporation (hereinafter "AIDHC") located at 1600 Rockland Road, Wilmington, Delaware, 19803. Both Health Care Facility and AIDHC are hereinafter referred to as "Parties" to this Agreement and each may be referred to as "Institution".

WITNESSETH

WHERAS, Health Care Facility is a not-for-profit corporation that operates a health system to provide access to patient care for the residents of its service area; and

WHEREAS, The Nemours Foundation is a not-for-profit corporation that operates a hospital that provides pediatric patient care and is designated as a Level I Pediatric trauma center; and

WHEREAS, the parties desire to provide reasonable assurance that the transfer of patients will be properly effected between the institutions when a transfer is either medically appropriate as determined by the referring physician or when the patient requests the transfer;

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Health Care Facility and AIDHC agree as follows:

1. Term. This Agreement shall commence on the day and year first above written and shall continue for a period of five (5) years, unless terminated earlier by either Institution as set forth below.

2. Patient Transfer. The patient's attending physician will determine when transfer of a patient, from one Institution to the other is appropriate. Health Care Facility that request a transfer acknowledge that the appropriate transfer of individuals with unstabilized emergency medical conditions that require specialized services should not routinely be made over great distances, bypassing closer hospitals with the necessary capability and capacity to care for the unstabilized emergency medical condition. When a decision to transfer has been made, the transferring Institution shall contact the receiving Institution as far in advance of the anticipated transfer as possible to obtain the receiving Institution's consent to the transfer. Prior to moving the patient, the transferring Institution must receive confirmation from the receiving Institution that it can accept the patient. Physician to physician communication and discussion of patient illness and/or injuries, and best mode of transport, can be facilitated by contacting AIDHC Transport Communication Center at 800-962-0023.

3. Patient Records. Each Institution agrees to adopt standard forms for medical and administrative information to accompany the patient from one Institution to the other. The information shall include, but not be limited to, an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption. Each Institution agrees to supplement the above information as necessary for the maintenance of the patient during transport and treatment upon arrival at the receiving Institution.

4. Personal Effects. The transferring party shall transfer the patient's personal effects, including money and valuables, and information pertaining to same. A list prepared by the transferring party of all personal effects shall be transferred with the patient and shall include the signature of the person making the list. An attempt should be made to have family members or friends voluntarily transfer such personal effects if possible. The receiving party shall, as soon as practical upon patient arrival, document that all personal effects were received or will notify the transferring facility if items were lost.

5. Medical Information. The transferring party agrees to transmit with each patient at the time of transfer, or in case of an emergency, as promptly as possible thereafter, all available pertinent medical and other records necessary to continue the patient's treatment without interruption and to provide identifying and other information, which must include:

(a) A completed interagency communication summary to include; as applicable

- current medical findings;
- diagnosis;
- rehabilitation potential;
- brief summary of the course of treatment followed at Health Care Facility;
- nursing and dietary information useful in care of the patient;
- administrative and pertinent social information;
- post-discharge plan of care;
- all other information required by law or deemed necessary.

(b) Documentation of any known Health Care Treatment Directive, including any durable power of attorney for health care decisions, living will, guardianship papers or withholding of resuscitation orders.

(c) Documentation of (i) the name of the person requesting the transfer, (ii) the fact that the patient or person with authority to act on the patient's behalf consented to the transfer (except in emergencies), (iii) the name of the person at the receiving party who accepted the transfer.

6. Patient Consent to Transfer. The transferring Institution shall have responsibility for obtaining the appropriate consent to the transfer to the other Institution, prior to the transfer. This should include the patient's attending physician's signature authorizing the transport.

7. Charges. The patient/parent is primarily responsible for payment for care received at either Institution and for the costs to transport the patient for the transfer. Prior to transfer, except in urgent circumstances, the patient/parent should be required, if competent, to acknowledge the obligation to pay for such care at the receiving Institution and the transport costs. Each Institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either Institution to look to the other Institution to pay for services rendered to a patient transferred by virtue of this Agreement.

8. Transport. The transferring party shall arrange for appropriate and safe transportation of the patient in compliance with applicable laws, regulations and Joint Commission standards.

9. Return of Patient to Health Care Facility. When the Receiving party is AIDHC, the Health Care Facility shall be expected to be available for the return of the transferred patient when:

(a) the patient's medical condition has stabilized and the patient is ready for discharge from AIDHC, and

(b) the patient has needs for continued care appropriate to the scope of services provided by the Health Care Facility.

10. Liability. Each Institution shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other Institution.

11. Indemnification. Each party (the "Indemnifying Party") will defend, indemnify and hold the other parties and the other parties' employees, officers, governing body and medical staff members, physicians, agents, representatives and affiliates (collectively the "Indemnified Parties") harmless against any and all claims, suits, proceedings, demands, liabilities, losses, damages, penalties, fines, interest, costs and attorney's fees which may be brought, claimed or asserted against or incurred by the Indemnified Parties, and which arise from or result from the Indemnified Party's provision or failure to provide any of the Services described in this Agreement or from any negligence or other tortuous or wrongful act or omission by the Indemnifying party or its employees, physicians, contractors or representatives. This provision shall survive termination of this Agreement.

12. Insurance. Each Institution agrees to obtain and maintain in force during the term of the Agreement professional and general liability insurance with minimum limits of $1 million per occurrence or claim and $3 million annual aggregate. Upon request, each Institution will provide the other with a certificate of insurance verifying such coverage at all times this Agreement is in effect. Each Institution shall notify the other at least thirty (30) days prior to cancellation, reduction or material change in coverage. If the insurance is on a "claims made" basis, each Institution agrees to purchase appropriate tail coverage for claims, demands or actions reported in future years for acts or omissions during the term of this Agreement. If either Institution fails to obtain or maintain the insurance coverage provided herein, the other party may terminate this Agreement. The parties may satisfy this requirement through an actuarially sound plan of self insurance.

13. Termination.

13.1 Voluntary Termination. This Agreement may be terminated by either Institution for any reason, by giving thirty (30) days written notice of its intention to withdraw from this Agreement, and by ensuring the continuity of care to patients who already are involved in the transfer process. To this end, the terminating Institution will be required to meet its commitments under the Agreement to all patients for whom the other Institution has begun the transfer process in good faith.

13.2 Involuntary Termination. This Agreement may be terminated immediately upon the occurrence of any of the following:

13.2.1 Either Institution is destroyed to such an extent that the patient care provided by such Institution cannot be carried out adequately;

13.2.2 Either Institution loses its license or accreditation;

13.2.3 Either Institution is no longer able to provide the service for which this Agreement was sought;

13.2.4 Either Institution is in material default under any of the terms of this Agreement; or

13.2.5 Either Institution becomes a Sanctioned Provider as defined in Appendix A.

14. Independent Contractor Status. The Parties are independent contractors and neither Institution is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by either Institution, nor shall it in any way alter the control of the management, assets and affairs of the respective Parties. Neither Institution, by virtue of the Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other Institution to this Agreement.

15. Regulatory Compliance. The Parties agree to abide by all applicable federal, state and local laws and regulations, to include the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the Health Insurance Portability and Accountability Act ("HIPAA"), and federal and state anti-kickback laws. This agreement is not intended to violate the Anti-Kickback or Stark laws and it is not the purpose, nor is it a requirement of this Agreement to offer or receive any remuneration or inducement in exchange for the referral of any patient or other health care business between the parties.

16. Discrimination. The Parties agree that the primary consideration of both is care of patients according to their needs. Health Care Facility and AIDHC agree to admit and assign patients without regard to race, color, sex, age, national origin, religious creed or sexual preference.

17. Advertising and Public Relations. Neither Institution shall use the name of the other Institution in any promotional or advertising material unless review and approval of the intended advertisement first shall be obtained from the Institution whose name is to be used. The Parties shall deal with each other publicly and privately in an atmosphere of mutual respect and support, and each Institution shall maintain good public and patient relations and efficiently handle complaints and inquiries with respect to transferred or transferring patients.

18. Modification of Waiver. If either Institution to this Agreement waives a breach of one of the provisions of this Agreement by the other Institution, that waiver shall neither operate nor be construed as a waiver of a subsequent similar breach of a provision hereof.

19. Governing Law. This Agreement is made and entered into and shall be governed and construed in accordance with the laws of the State of Delaware.

20. Assignment. The Agreement shall not be assigned in whole or in part by either Institution hereto without the express written consent of the other Institution.

21. Invalid Provision. In the event that any portion of the Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to

continue to be binding upon the Parties hereto in the same manner as if the invalid or unenforceable provision were not a part of the Agreement.

22. Amendment. This Agreement may be amended at any time by a written Agreement signed by the Parties hereto.

23. Notice. Any and all notices and other communications required or permitted to be given hereunder shall be made in writing and effective upon receipt. Such notices shall be personally delivered, sent by registered or certified mail, by a nationally recognized overnight delivery service or sent by facsimile or electronic mail with confirmation, addressed as follows, unless such address is changed by written notice hereunder:

If to Health Care Facility:

University of Maryland Shore Regional Health
219 South Washington Street
Easton, MD 21601
Attn: President

If to AIDHC:

Alfred I. duPont Hospital for Children
1600 Rockland Road, ARB 166
Wilmington, DE 19803
Attn: Sean Elwell
E-mail: Sean.Elwell@nemours.org

With a copy to:

Office of Contracts Administration
The Nemours Foundation
10140 Centurion Parkway North
Jacksonville, FL 32256
Fax: 904.697.4070
E-mail: oca@nemours.org

24. Entire Agreement. This Agreement constitutes the entire agreement between the Parties and contains all of the agreements between them with respect to the subject matter hereof and supersedes any and all other agreements, either oral or in writing, between the Parties with respect to the subject matter hereof.

25. Counterparts and Electronic Signature. This Agreement may be executed in two or more counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. Delivery of an executed signature page to the Agreement by facsimile transmission or .PDF will be as effective as delivery of a manually signed counterpart.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed by persons duly authorized to bind the Parties to perform their respective obligations hereunder, as of the date first written above.

ALFRED I. duPONT HOSPITAL FOR CHILDREN OF THE NEMOURS FOUNDATION

By: _____

Name: Jane Mericle, MHS-CL, BSN, RN, CENP

Title: Chief Nurse Executive Operational Vice President

Date: 8/3/18

UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH

By: _____

Name: KENNETH D. KOZEL

Title: PRESIDENT + CEO

Date: 7/25/18

APPENDIX A

"Sanctioned Provider" means a Person who:

1. is currently under indictment or prosecution for, or has been convicted of:

a) any offense related to the delivery of an item or service under the Medicare or Medicaid programs or any program funded under Title V or Title XX of the Social Security Act (the Maternal Child Health Services Program or the Block Grants to States for Social Services programs, respectively),

b) a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service,

c) fraud, theft, embezzlement or other financial misconduct in connection with the delivery of a health care item or service,

d) obstructing an investigation of any crime referred to in i) through iii) above, or

e) unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

2. has been required to pay any civil monetary penalty under 42 U.S.C. §1128A, regarding false, fraudulent or impermissible claims under, or payments to induce a reduction or limitation of health care services to beneficiaries of, any state or Federal health care program, or is currently the subject of any investigation or proceeding which may result in such payment; or

3. has been excluded from participation in the Medicare, Medicaid or Maternal and Child Health Services (Title V) program, or any program funded under the Block Grants to States for Social Services (Title XX) program.

GENERAL TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (hereinafter "Agreement"), is made and entered into by and between the University of Maryland Shore Regional Health, Inc., including University of Maryland Shore Medical Center at Easton and University of Maryland Shore Medical Center at Dorchester (hereinafter "UM SRH") located at 219 South Washington Street, Easton, MD 21601, and Chesapeake Woods Center (hereinafter "Center") located at 525 Glenburn Avenue, Cambridge, MD. Both UM SRH and Center are hereinafter referred to as "Parties" to this Agreement and each may be referred to as "Institution."

WITNESSETH

WHEREAS, UM SRH is a not-for-profit corporation that operates a health care system to provide access to patient care; and

WHEREAS, Center is a for-profit corporation that operates a nursing home facility

WHEREAS, the parties desire to provide reasonable assurance that the transfer of patients will be properly effected between the institutions when a transfer is either medically appropriate as determined by the referring physician or when the patient requests the transfer;

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, UM SRH and Center agree as follows:

1. Term. This Agreement shall commence June 1, 2014 and shall continue for a period of five (5) years, unless terminated earlier by either Institution as set forth below.
2. Patient Transfer. The patient's attending physician will determine when transfer of a patient, from one Institution to the other is appropriate. When a decision to transfer has been made, the transferring Institution shall contact the receiving Institution as far in advance of the anticipated transfer as possible to obtain the receiving Institution's consent to the transfer. Prior to moving the patient, the

transferring Institution must receive confirmation from the receiving Institution that it can accept the patient.

3. Patient Records. Each Institution agrees to adopt standard forms for medical and administrative information to accompany the patient from one Institution to the other. The information shall include, but not be limited to, an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption. Each Institution agrees to supplement the above information as necessary for the maintenance of the patient during transport and treatment upon arrival at the receiving Institution.
4. Medical Information. The transferring party agrees to transmit with each patient at the time of transfer, or in case of an emergency, as promptly as possible thereafter, all available pertinent medical and other records necessary to continue the patient's treatment without interruption and to provide identifying and other information, which must include:
    a. A completed interagency communication summary to include, as applicable
        - Current medical findings;
        - Diagnosis;
        - Rehabilitation potential;
        - Brief summary of the course of treatment
        - Nursing and dietary information useful in care of the patient;
        - Administrative and pertinent social information;
        - Post-discharge plan of care;
        - All other information required by law or deemed necessary.
    b. Documentation of any known Health Care Treatment Directive, including any durable power of attorney for health care decisions, living will, guardianship papers or withholding of resuscitation orders.
    c. Documentation of (i) the name of the person requesting the transfer, (ii) the fact that the patient or person with authority to act on the patient's behalf consented to the transfer (except in emergencies), (iii) the name of the person at the receiving party who accepted the transfer.
5. Patient Consent to Transfer. The transferring Institution shall have responsibility for obtaining the appropriate consent to the transfer to the other Institution, prior to the transfer. This should include the patient's attending physician's signature authorizing the transport.
6. Charges. The patient is primarily responsible for payment for care received at either Institution and for the costs to transport the patient for the transfer. Prior to

transfer, except in urgent circumstances, the patient should be required, if competent, to acknowledge the obligation to pay for such care at the receiving Institution and the transport costs. Each Institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either Institution to look to the other Institution to pay for services rendered to the patient transferred by virtue of this Agreement.

7. Transport. The transferring party shall arrange for appropriate and safe transportation of the patient in compliance with applicable laws, regulation and Joint Commission standards.
8. Return of Patient to Center. When the Receiving party is UM SRH, the Center shall be expected to be available for the return of the transferred patient when:
    a. the patient's medical condition has stabilized and the patient is ready for discharge from UM SRH, and
    b. the patient has needs for continued care appropriate to the scope of services provided by the Center.
9. Liability. Each Institution shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other Institution.
10. Indemnification. Each Party (the "Indemnifying Party") will defend, indemnify and hold the other parties and the other parties' employees, officers, governing body and medical staff members, physicians, agents, representatives and affiliates (collectively the "Indemnified Parties") harmless against any and all claims, suits, proceedings, demand, liabilities, losses, damages, penalties, fines, interest, costs and attorney's fees which may be brought, claimed or asserted against or incurred by the Indemnified Parties, and which arise from or result from the Indemnified Party's provision or failure to provide any of the Services described in this Agreement or from any negligence or other tortuous or wrongful act or omission by the Indemnifying party or its employees, physicians, contractors or representatives. This provision shall survive termination of this Agreement.
11. Insurance. Each Institution agrees to obtain and maintain in force during the term of the Agreement professional and general liability insurance with minimum limits of $1 million per occurrence or claim and $3 million annual aggregate. Upon request, each Institution will provide the other with a certificate of insurance verifying such coverage at all times this Agreement is in effect. Each Institution shall notify the other at least thirty (30) days prior to cancellation, reduction or material change in coverage. If the insurance is on a "claims made" basis, each Institution agrees to

purchase appropriate tail coverage for claims, demands or action reported in future years for acts or omissions during the term of this Agreement. If either Institution fails to obtain and maintain the insurance coverage provided herein, the other party may terminate this Agreement. The parties may satisfy this requirement through an actuarially sound plan of self insurance.

12. Termination.

13.1 Voluntary Termination. This Agreement may be terminated by either Institution for any reason, by giving thirty (30) days written notice of its intention to withdraw from this Agreement, and by ensuring the continuity of care to patients who already are involved in the transfer process. To this end, the terminating Institution will be required to meet its commitments under the Agreement to all patients for whom the other Institution has begun the transfer process in good faith.

13.2 Involuntary Termination. This Agreement may be terminated immediately upon the occurrence of any of the following:

13.2.1 Either the Institution is destroyed to such an extent that the patient care provided by such Institution cannot be carried out adequately;

13.2.2 Either Institution loses its license or accreditation;

13.2.3 Either Institution is no longer able to provide the services for which this Agreement was sought;

13.2.4 Either Institution is in material default under any of the terms of this Agreement; or

13.2.5 Either Institution becomes a Sanctioned Provider as defined in Appendix A.

13. Independent Contractor Status. The Parties are independent contractors and neither Institution is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by either Institution, nor shall it in any way alter the control of the management, assets and affairs of the respective Parties. Neither Institution, by virtue of the Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other Institution to this Agreement.

14. Regulatory Compliance. The Parties agree to abide by all applicable federal, state and local laws and regulations, to include the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the Health Insurance Portability and Accountability Act ("HIPAA"), and federal and state anti-kickback laws. This agreement is not intended

to violate the Anti-Kickback or Stark laws and it is not the purpose, nor is it a requirement of this Agreement to offer or receive any remuneration or inducement in exchange for the referral of any patient or other health care business between the parties.

15. Discrimination. The Parties agree that the primary consideration of both is care of patients according to their needs. UM SRH and Center agree to admit and assign patients without regard to race, color, sex, age, national origin, religious creed or sexual preference.

16. Advertising and Public Relations. Neither Institution shall use the name of the other Institution in any promotional or advertising material unless review and approval of the intended advertisement first shall be obtained from the Institution whose name is to be used. The Parties shall deal with each other publicly and privately in a atmosphere of mutual respect and support, and each Institution shall maintain good public and patient relation and efficiently handle complaints and inquiries with respect to transferred or transferring patients.

17. Modification of Waiver. If either Institution to this Agreement waives a breach of one of the provisions of this Agreement by the other Institution, that waiver shall neither operate nor be construed as a waiver of a subsequent similar breach of a provision hereof.

18. Governing Law. This Agreement is made and entered into and shall be governed and construed in accordance with the laws of the State of Maryland.

19. Assignment. The Agreement shall not be assigned in whole or in part by either Institution hereto without the express written consent of the other Institution.

20. Invalid Provision. In the event that any portion of the Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the Parties hereto in the same manner as if the invalid or unenforceable provision were not a part of the Agreement.

21. Amendment. This Agreement may be amended at any time by a written Agreement signed by the Parties hereto.

22. Notice. Any and all notices and other communications required or permitted to be given hereunder shall be made in writing and effective upon receipt. Such notices shall be personally delivered, sent by registered or certified mail, by a nationally

recognized overnight delivery service or sent by electronic mail with confirmation, addressed as follows, unless such address is changed by written notice hereunder:

If to UM SRH:

University of Maryland Shore Regional Health, Inc.
219 South Washington Street
Easton, MD 21601
Attn: President and CEO
Email: kkozel@shorehealth.org

If to Center:

Chesapeake Woods Center
Genesis Health Care
525 Glenburn Avenue
Cambridge, MD 21613
Attn: Administrator

23. Entire Agreement. This Agreement constitutes the entire agreement between the Parties and contains all of the agreements between them with respect to the subject matter hereof and supersedes any and all other agreements, either oral or in writing, between the Parties with respect to the subject matter hereof.

24. Assignment. This Agreement may not be assigned in whole or in part by any Party without the express written consent of the other Party.

25. Counterparts and Electronic Signature. This Agreement may be executed in two or more counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. Delivery of an executed signature page to the Agreement by facsimile transmission or .PDF will be as effective as delivery of a manually signed counterpart.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed by persons duly authorized to bind the Parties to perform their respective obligations hereunder, as of the date first written above.

CHESAPEAKE WOODS CENTER

By: _____

Name: Caroline Hergenrother

Title: Administrator

Date: 5/19/14

UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH, INC.

By: _____

Name: Kenneth Kozel

Title: President & CEO

Date: 6/4/14

APPENDIX A

"Sanctioned Provider" means a Person who:

1. Is currently under indictment or prosecution for, or has been convicted of:
    a. Any offense related to the delivery of an item or service under the Medicare or Medicaid programs or any program funded under Title V or Title XX of the Social Security Act (the Maternal Child Health Services Program or the Block Grants to States for Social Services programs, respectively),
    b. A criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service,
    c. Fraud, theft, embezzlement or other financial misconduct in connection with the delivery of a health care item or service,
    d. Obstructing an investigation of any crime referred to in i) through iii) above, or
    e. Unlawful manufacture, distribution, prescription or dispensing of a controlled substance;
2. Has been required to pay any civil monetary penalty under 42 U.S.C. § 1128A, regarding false, fraudulent or impermissible claims under, or payments to induce a reduction or limitation of health care services to beneficiaries of, any state or Federal health care program, or is currently the subject of any investigation or proceeding which may result in such payment; or
3. Has been excluded from participation in the Medicare, Medicaid or Maternal and Child Health Services (Title V) program, or any program funded under the Block Grants to States for Social Services (Title XX) program.

TRANSFER AGREEMENT

Between

THE MEMORIAL HOSPITAL AT EASTON, MD. INC.

And

SHORE HEALTH SURGERY CENTER

THIS TRANSFER AGREEMENT (the "Agreement") is executed and effective as of April 1, 2010 (the "Effective Date"), by and between The Memorial Hospital at Easton, MD., (the "Hospital") (an acute care hospital owned and operated by Shore Health System, Inc. a Maryland non-stock corporation, hereafter referred to as the "Corporation") and Shore Health Surgery Center (the "Center"), a licensed ambulatory surgery center owned and operated by the Corporation.

WHEREAS, both parties desire to assure continuity of care and treatment appropriate to the needs of each patient and to use the skills, resources, and physical plant of both parties in a coordinated and cooperative fashion to improve patient care at both the acute and post-acute stages of illness.

NOW THEREFORE, in consideration of the mutual advantages occurring to the parties hereto, Hospital and Center hereby covenant and agree with each other as follows:

1. Both parties agree to make a concerted effort to transfer patients as soon as practical when the need for transfer from Center to Hospital has been determined by the patient's attending physician, provided, however, all eligibility conditions for admission must be met and documented in the patient's medical record.

2. Center agrees to send with each patient at the time of transfer or, in the case of any emergency as promptly as possible after the transfer, an abstract of the patient's medical record including:

    a. The current medical findings,
    b. Diagnosis,
    c. A brief summary of the course of treatment followed,
    d. All other administrative and social information useful to provide continuing care to the patient; using the transfer and referral form mutually agreed upon.

3. Center, after promptly notifying Hospital of the impending transfer of a patient and after Hospital consents to accept such patient, shall assume the responsibility to arrange for appropriate and safe transportation of the patient, his/her personal effects and valuables, and shall provide any necessary care while he/she is being transferred.

4. Charges for services performed by either Center or Hospital for patients transferred from the other institution pursuant to this Agreement, shall be collected by the institution rendering such services, directly from the patient, third party payers, or the other sources normally billed by the institution; and neither party shall have any liability to the other for such charges except to the extent that such liabilities would exist separate and apart from this Agreement.

5. The parties agree that the transfer of a patient pursuant to this Agreement shall not be predicated upon discrimination based on race, religion, national origin, age, sex, physical condition or economic status. The parties also agree that the transfer or receipt of patients shall not be based upon a patient's inability to pay for services rendered by the transferring or receiving institution or a patient's source of payment.

6. All patient transfers pursuant to this Agreement must be accomplished in a medically appropriate manner from physician to physician and institution to institution by: (i) the use of appropriate life support measures which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to stabilize the patient prior to transfer and to sustain the patient during the transfer; (ii) the provision of appropriate personnel and equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use for the transfer; (iii) the transfer of all necessary records for continuing the care for the patient; and (iv) the consideration of the availability of appropriate facilities, services, and staff for providing care for the patient. The parties agree that before moving a patient, Center shall explain the reasons for the transfer and any alternative to the patient or a legally authorized representative of the patient. If it is necessary to move the patient immediately to protect the health, safety or welfare of the patient, Center may give the explanation of the reasons for the transfer concurrently with the transfer.

7. The parties agree to recognize the right of a patient to request transfer into the care of a physician and institution of the patient's own choosing and to recognize and comply with all federal and state requirements relating to the transfer of patients.

8. Center agrees not to transfer a patient with an emergency medical condition that has not been stabilized unless: (i) the patient, or a legally responsible person acting on the patient's behalf, after being informed of the Center's obligations under law and of the risk of transfer, requests in writing transfer to another institution; (ii) a licensed physician has signed a certification which includes a summary of the risks and benefits that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another institution outweigh the increased risks to the patient and, in the case of labor, to the unborn child from effecting the transfer; or (iii) if a licensed physician is not physically present at the time a patient is transferred, a qualified medical person has signed a certification described in subparagraph (ii) above after a licensed physician, in consultation with the person, has made the

determination described in subparagraph (ii) above and subsequently countersigns the certificate.

9. All notices hereunder by either party to the other party shall be in writing, delivered personally or by overnight courier, and shall be deemed to have been duly given when delivered personally or one day after delivered to the overnight carrier, charges prepaid, and properly addressed to the respective parties at the addresses shown following each party's signature to the Agreement.

10. This Agreement shall be effective from the date of signing by both parties and shall continue in effect, except that either party may withdraw by giving sixty (60) days written notice to the other party of its intention to terminate this Agreement. However, the Agreement shall be declared null and void and shall be immediately terminated should either party fail to maintain its licensure or certification status.

11. Both parties represent and warrant that, during the term of this Agreement, each shall comply with all applicable state and federal laws and regulations and shall remain in good standing with applicable accrediting organizations.

12. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other institution, on either a limited or general basis, while this Agreement is in effect.

13. This Agreement may be modified or amended by the mutual agreement of the parties, however, any such modification or amendment shall be attached to and become a part of this Agreement. This Agreement shall be construed in accordance with the laws of the State of Maryland.

Shore Health Surgery Center
505 Dutchman's Lane
Easton, MD 21601

By: _____

Name: Christopher J. Parker

Title: Sr. VP Pt. Care Services/CNO

The Memorial Hospital at Easton
219 S Washington Street
Easton, MD 21601

By: _____

Name: Joseph P. Ross

Title: President

AGREEMENT BETWEEN
EASTERN SHORE HOSPITAL CENTER
AND
SHORE HEALTH SYSTEM, INC.

THIS AGREEMENT, entered into and effective this _ day of April 2014 by and between Eastern Shore Hospital Center, a non-profit corporation organized and existing under the laws of Maryland (hereinafter referred to as "ESHC") and Shore Health System, a non-profit corporation organized and existing under the laws of Maryland that owns and operates University of Maryland Shore Medical Center at Easton and University of Maryland Shore Medical Center at Dorchester in Cambridge, Maryland (collectively hereinafter referred to as "Shore Health").

WHEREAS, both parties desire, by means of this Agreement, to facilitate the timely provision of services to ESHC patients; and to insure the continuity and quality of care and treatment appropriate to the needs of patients at ESHC and/or Shore Health by utilizing the knowledge and resources of both parties in a coordinated and cooperative effort; and

WHEREAS, ESHC, a state-operated psychiatric facility located in Cambridge, MD, consists of three (3) psychiatric units and a separately licensed assisted living program (ALP).

WHEREAS, some ESHC patients require certain medical service that are not available onsite at ESHC for their patients/residents

WHEREAS, Shore Health provides certain medical services and is willing to provide services to patients from ESHC as set forth herein.

NOW THEREFORE, in consideration of the mutual advantages accruing to the parties hereto and their respective patients and in consideration of the mutual covenants hereinafter set forth, the parties, with the intention to be legally bound, agree as follows:

I. Conditions of Transfer

Each party agrees to exercise its best efforts to provide for the provision of services of any patient transported from the other facility provided that:

A. A licensed physician who is a member of the medical staff of either party has designated that such services are medically appropriate.

B. All conditions and requirements of provision of services are met, including confirmation of acceptance of the patient by the receiving facility.

C. Adequate and appropriate capacity to provide services is available in the receiving facility to accommodate the patient.

D. The sending facility has received confirmation from the receiving facility that the receiving facility will accept the patient.

II. Admission Process

ESHC agrees that it and its physicians and/or medical staff will abide by the following notification procedures when patients are transported to Shore Health: the sending physician at ESHC shall contact the appropriate Emergency Department attending physician at Shore Health who will evaluate the patient and determine appropriate disposition. In the event there is one (1) ESHC physician treating two injured patients that require emergency care and no additional physician coverage at ESHC is available to such physician, the patient with the most serious injuries will be sent to the Emergency Department, and the patient with less serious injuries will be managed at ESHC; provided that ESCH shall utilize best efforts to notify Shore Health of such transfer in advance via telephone.

III. Transport

A. The sending facility agrees to:

1) Arrange for and carry out appropriate transportation of the patient to the receiving facility, including selection of the mode of transport, using appropriate life support measures, if necessary, to stabilize the patient prior to transport and during transport and providing appropriate health practitioner(s) and equipment to accompany the patient;

2) Complete and forward to the receiving facility, at the time of transport, an approved transport record form;

3) Transport with the patient his/her personal effects and provide documentation of presence or absence of personal items on the medical record/valuables sheet; including a notation if given to patient, family member or placed in hospital safe; and

4) Transmit with each patient at the time of transport copies of the patient's medical record or an abstract of pertinent medical and other records necessary for identification of the patient and continuation of uninterrupted and proper treatment. Such medical and other information should include where applicable:

a) History of the injury or illness;
b) Current medical findings;
c) Diagnosis;
d) Laboratory and radiology findings, including copies of radiological films, where appropriate;
e) Rehabilitation potential;

f) Brief summary of the courses of treatment followed up to the time of transport including medications given and route of administration, fluids given, by type and volume;
g) Nursing information useful in the care of the patient;
h) Patient's third party billing data;
i) Pertinent administrative information as required; and
j) Current surrogate (in the event that the patient is incompetent) and/or next-of-kin information.

5) In the event of an emergency as reasonably determined by the sending facility, the following information will be sent by the sending facility with the patient:

a) History of injury or illness
b) Current medical findings
c) Brief summary of the courses of treatment follow up to the time of the transport, including medications given, and route of administration, fluids given, by type and volume.
d) All other information will be faxed within ten (10) minutes of the patient leaving ESHC for the Shore Health emergency room.

6) Obtain the consent to transport from the patient's legally authorized representative, except in emergency situations where the delay to obtain such consent would seriously jeopardize the patient's life or health.

7) Direct inquiries about the patient or his/her care to the patient's attending physician and to no other medical staff member(s).

B. The receiving facility agrees to:

1) Assume responsibility for the patient's care, including providing full inpatient, outpatient and emergency services as appropriate, upon arrival of the transported patient at the receiving facility;

2) Acknowledge on such forms as may be provided by the sending facility, receipt of the patient's effects and medical records.

C. ESHC agrees to promptly accept patients for readmission upon the reasonable determination of both parties that such patients are appropriate for re-admission from a medical perspective.

IV. Payment for Services

The patient is primarily responsible for payment for care received at the institution and, prior to transport, (in non-emergent cases), the patient (or his/her surrogate decision maker) shall be required to acknowledge the obligation to pay for such at the receiving

institution. Each institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either institution to look to the other to pay for services rendered to a patient transported by virtue of this Agreement, except to the extent that such liability would exist separate and apart from this Agreement.

V. Compliance

Each institution shall comply with all applicable federal, state and local laws, and all requirements imposed by, or pursuant to the regulations of the Department of Health and Human Services and any other applicable governmental agency.

VI. Insurance

Each year that this Agreement is in effect, within thirty (30) days of the anniversary of the execution of this Agreement, each party shall provide to the other written verification that:

A. It has professional liability insurance or adequate self-insurance, in limits as required in accordance with applicable laws of the State of Maryland.

B. That all members of its medical staff are covered by professional liability insurance in limits as required in accordance with applicable laws of the State of Maryland.

C. That all of its employees who may be involved in the transfer of patients are covered by adequate and reasonable limits of workers' compensation, health, and motor vehicle insurance as required in accordance with applicable laws of the State of Maryland.

VII. Indemnification

A. ESHC agrees that it shall defend, indemnify and hold harmless Shore Health, its officers, directors, agents, and employees from and against any and all costs, demands, liabilities, settlements or verdicts, including reasonable attorneys fees, arising out of any claim, demand, action or suit brought by, on behalf of or as a derivative action of any patient or other person for any damages, injuries, or death to persons or property arising out of or in connection with (i) ESHC performance or failure to perform its duties hereunder; or (ii) any act or omission of ESHC, its agents or employees which occurred prior to the admission by Shore Health of any patient transported from ESHC.

B. Shore Health agrees that it shall defend, indemnify and hold harmless ESHC, its officers, directors, agents and employees from and against any and all costs, demands, liabilities, settlements, or verdicts, including reasonable attorneys fees, arising out of any claim, demand, action or suit brought by, on behalf of or as a derivative action of any patient or other person for any damages, injuries or death to persons or property arising out of or in connection with (i) Shore Health's

performance or failure to perform its duties hereunder; or (ii) any act or omission of Shore Health, its agents or employees, which occurred prior to the admission or acceptance by ESHC of any patient transported from Shore Health.

VIII. Confidentiality of Medical Records

All reasonable efforts will be made by both parties to preserve the confidential nature of the patient's medical records and to safeguard the rights of the patients as to medical and/or other privileged information contained within said records in accordance with applicable state and federal laws and regulations.

IX. Duration and Termination of Agreement

The Agreement shall continue in effect indefinitely, except that either party may terminate this Agreement by giving sixty (60) days' notice in writing to the other party of its intention to terminate. Termination shall be effective at the end of the sixty (60) days' notice period. However, if either party shall have its license to operate revoked or suspended by the State, have its accreditation suspended or revoked or placed on probation by any accrediting body or if any governmental agency suspends, revokes or places such party of probation, then the affected party shall immediately notify the other hospital, and this Agreement shall terminate as of the date such suspension, revocation or probation becomes effective.

X. Modification of Agreement

This Agreement may be modified or amended from time to time by mutual written agreement of the parties and any such modification or amendments shall be attached to and become part of this Agreement.

XI. Autonomy of Institutions

Each party to this Agreement is an independent contractor and shall have exclusive control over the policies, management, assets and affairs of its respective institution. Neither party by virtue of this Agreement assumes any liability for any debts or obligations of a financial or legal nature incurred by the other party. Nothing in this Agreement shall be construed as creating a partnership, joint venture, principal-agent or master-servant relationship between the parties, their agents, employees or representatives.

XII. Non-exclusivity

Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other hospital, nursing home or other health care entity or organization on either a limited or a general basis while this Agreement is in effect.

XIII. Non-Discrimination

Both parties attest that they are an equal opportunity employer that offers employment without regard to race, color, religious creed, disability, ancestry, national or ethnic origin, age, sex, or veteran status. This agreement shall be construed and carried out in a non-discriminatory manner without regard to race, color, religious creed, disability, ancestry, national or ethnic origin, age, sex, veteran status or ability to pay.

XIII. Miscellaneous

A. Each party agrees to provide to the other, upon reasonable request, any information deemed relevant by the requesting party to determine if the other party is able to provide the necessary facilities, care and/or treatment for a particular patient, group of patients or types of patients.

B. Neither party shall use the name of the other in any promotional or advertising material without the written approval of the other party.

C. Any communication required herein shall be in writing addressed as follows:

1) Any notice to ESHC:

2) Any notice to Shore Health:
Shore Health System, Inc.
219 S. Washington Street
Easton, Maryland 21601
Attn: Chief Medical Officer

D. No patient, physician, payor or other third party is intended to be a third party beneficiary under this Agreement and no action to enforce the terms of this Agreement may be brought against any party by any person who is not a party to this Agreement.

E. Neither party may transfer, assign, pledge or delegate any or all of its duties or interest in this Agreement without the prior written consent of the other, which consent shall not be unreasonably withheld.

F. This Agreement shall be binding upon and inure to the benefit of the successors or assigns of the parties.

G. This Agreement constitutes the entire agreement between the parties and contains all of the agreements between them with respect to the subject matter and supercedes any and all other agreements, either oral or in writing, between the parties with respect to the subject matter. This Agreement may be modified or amended by a mutual, written agreement signed by the parties.

H. No waiver of any term or condition of this Agreement by either party shall be deemed a continuing or further waiver of the same term or condition or a waiver of any other term or condition of this Agreement.

I. In the event any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue or to be binding upon the parties in the same manner as if the invalid or unenforceable provision were not a part of this Agreement.

J. The headings above the various provisions of this Agreement have been included only in order to make it easier to locate the subject covered by each provision; they are not to be used in construing this Agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed the day and the year written below.

EASTERN SHORE HOSPITAL CENTER

Chief Executive Officer

5-12-14
Date

Witness

SHORE HEALTH SYSTEM, INC.

Chief Executive Officer

6/5/14
Date

Witness

EASTERN SHORE HOSPITAL CENTER

Acting Clinical Director

5.12.14
Date

Witness

FOR COMPANY USE ONLY:
Clinic #: 0810

PATIENT TRANSFER AGREEMENT

This **PATIENT TRANSFER AGREEMENT** (the "Agreement") is made as of the 12th day of October, 2009 (the "Effective Date"), by and between **SHORE HEALTH SYSTEM d/b/a Easton Memorial Hospital** (hereinafter "Hospital") and **RENAL TREATMENT CENTERS – MID-ATLANTIC, INC.**, a Delaware corporation and subsidiary of DaVita Inc. ("Company").

RECITALS

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between Hospital and the following free-standing dialysis clinic owned and operated by Company:

Easton Dialysis
402 Marvel Court
Easton, MD 21601

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities; and

WHEREAS, the parties wish to facilitate the continuity of care and the timely transfer of patients and records between the facilities.

WHEREAS, only a patient's attending physician (not Company or the Hospital) can refer such patient to Company for dialysis treatments.

NOW THEREFORE, in consideration of the premises herein contained and for other good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged, the parties agree as follows:

1. **HOSPITAL OBLIGATIONS.** In accordance with the policies and procedures as hereinafter provided, and upon the recommendation of an attending physician, a patient of Company may be transferred to Hospital.

(a) Hospital agrees to exercise its best efforts to ensure the prompt admission of patients as necessary, provided that all usual, reasonable conditions of admission are met. In doing so, Hospital agrees to accept and treat patients in emergency situations requiring transfer of a patient from Company to Hospital. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of the Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO") and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Transfer record forms shall be completed in detail and signed by the physician or nurse in charge at Company and must accompany the patient to the receiving institution.

(b) Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility.

2. COMPANY OBLIGATIONS.

(a) Upon transfer of a patient to Hospital, Company agrees:

i. That it shall transfer any needed personal effects of the patient, and information relating to the same, and shall be responsible therefore until signed for by a representative of Hospital;

ii. Original medical records kept by each of the parties shall remain the property of that institution; and

iii. That transfer procedures shall be made known to the patient care personnel of each of the parties.

(b) Company agrees to transmit with each patient at the time of transfer, or in case of an emergency, as promptly as possible thereafter, an abstract of pertinent medical and other records necessary to continue the patient's treatment without interruption and to provide identifying and other information, to include:

i. current medical findings;

ii. diagnosis;

iii. rehabilitation potential;

iv. discharge summary;

v. a brief summary of the course of treatment followed;

vi. nursing and dietary information;

vii. ambulating status; and

viii. administrative and pertinent social information.

(c) Company agrees to readmit to its facilities patients who have been transferred to Hospital for medical care as clinic capacity allows. Hospital agrees to keep the administrator or designee of Company advised of the condition of the patients that will affect the anticipated date of transfer back to Company and to provide as much notice of the transfer date as possible. Company shall assign readmission priority for its patients who have been treated at Hospital and who are ready to transfer back to Company.

3. **BILLING, PAYMENT, AND FEES.** Hospital and Company each shall be responsible for billing the appropriate payor for the services it provides, respectively, hereunder. Company shall not act as guarantor for any charges incurred while the patient is a patient in Hospital.

4. **HIPAA.** Hospital and Company agree to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Hospital and Company acknowledge and agree that from time to time, HIPAA may require modification to this Agreement for compliance purposes. Hospital and Company further acknowledge and agree to comply with requests by the other party hereto related to HIPAA.

5. **STATUS AS INDEPENDENT CONTRACTORS.** The parties acknowledge and agree that their relationship is solely that of independent contractors. Governing bodies of Hospital and Company shall have exclusive control of the policies, management, assets, and affairs of their respective facilities. Nothing in this Agreement shall be construed as limiting the right of either to affiliate or contract with any other Hospital or facility on either a limited or general basis while this Agreement is in effect. Neither party shall use the name of the other in any promotional or advertising material unless review and approval of the intended use shall be obtained from the party whose name is to be used and its legal counsel.

6. **INSURANCE.** Each party shall secure and maintain, or cause to be secured and maintained during the term of this Agreement, comprehensive general liability, property damage, and workers compensation insurance in amounts generally acceptable in the industry, and professional liability insurance providing minimum limits of liability of $1,000,000 per occurrence and $3,000,000 in aggregate. Each party shall deliver to the other party certificate(s) of insurance evidencing such insurance coverage upon execution of this Agreement, and annually thereafter upon the request of the other party. Each party shall provide the other party with not less than thirty (30) days prior written notice of any change in or cancellation of any of such insurance policies. Said insurance shall survive the termination of this Agreement.

7. **INDEMNIFICATION.**

(a) Hospital Indemnity. Hospital hereby agrees to defend, indemnify and hold harmless Company and its shareholders, affiliates, officers, directors, employees, and agents for, from and against any claim, loss, liability, cost and expense (including, without limitation, costs of investigation and reasonable attorney's fees), directly or indirectly relating to, resulting from or arising out of any action or failure to act arising out of this Agreement by Hospital and its staff regardless of whether or not it is caused in part by Company or its officers, directors, agents, representatives, employees, successors and assigns. This indemnification provision shall not be effective as to any loss attributable exclusively to the negligence or willful act or omission of Company.

(b) Company Indemnity. Company hereby agrees to defend, indemnify and hold harmless Hospital and its shareholders, affiliates, officers, directors, employees, and agents for, from and against any claim, loss, liability, cost and expense (including, without limitation, costs of investigation and reasonable attorney's fees), directly or indirectly relating to, resulting from or arising out of any action or failure to act arising out of this Agreement by Company and its

staff regardless of whether or not it is caused in part by or its officers, directors, agents, representatives, employees, successors and assigns. This indemnification provision shall not be effective as to any loss attributable exclusively to the negligence or willful act or omission of Hospital.

(c) Survival. The indemnification obligations of the parties shall continue in full force and effect notwithstanding the expiration or termination of this Agreement with respect to any such expenses, costs, damages, claims and liabilities which arise out of or are attributable to the performance of this Agreement prior to its expiration or termination.

8. DISPUTE RESOLUTION. Any dispute which may arise under this Agreement shall first be discussed directly with representatives of the departments of the parties that are directly involved. If the dispute cannot be resolved at this level, it shall be referred to administrative representatives of the parties for discussion and resolution.

(a) Informal Resolution. Should any dispute between the parties arise under this Agreement, written notice of such dispute shall be delivered from one party to the other party and thereafter, the parties, through appropriate representatives, shall first meet and attempt to resolve the dispute in face-to-face negotiations. This meeting shall occur within thirty (30) days of the date on which the written notice of such dispute is received by the other party.

(b) Resolution Through Mediation. If no resolution is reached through informal resolution, pursuant to Section 8(a) above, the parties shall, within forty-five (45) days of the first meeting referred to in Section 8(a) above, attempt to settle the dispute by formal mediation. If the parties cannot otherwise agree upon a mediator and the place of the mediation within such forty-five (45) day period, the American Arbitration Association ("AAA") in the State of Maryland shall administer the mediation. Such mediation shall occur no later than ninety (90) days after the dispute arises. All findings of fact and results of such mediation shall be in written form prepared by such mediator and provided to each party to such mediation. In the event that the parties are unable to resolve the dispute through formal mediation pursuant to this Section 8(b), the parties shall be entitled to seek any and all available legal remedies.

9. TERM AND TERMINATION. This Agreement shall be effective for an initial period of one (1) year from the Effective Date and shall continue in effect indefinitely after such initial term, except that either party may terminate by giving at least sixty (60) days notice in writing to the other party of its intention to terminate this Agreement. If this Agreement is terminated for any reason within one (1) year of the Effective Date of this Agreement, then the parties hereto shall not enter into a similar agreement with each other for the services covered hereunder before the first anniversary of the Effective Date. Termination shall be effective at the expiration of the sixty (60) day notice period. However, if either party shall have its license to operate its facility revoked by the State or become ineligible as a provider of service under Medicare or Medicaid laws, this Agreement shall automatically terminate on the date such revocation or ineligibility becomes effective.

10. AMENDMENT. This Agreement may be modified or amended from time to time by mutual written agreement of the parties, signed by authorized representatives thereof, and any

such modification or amendment shall be attached to and become part of this Agreement. No oral agreement or modification shall be binding unless reduced to writing and signed by both parties.

11. **ENFORCEABILITY/SEVERABILITY.** The provisions of this Agreement are severable. The invalidity or unenforceability of any term or provisions hereto in any jurisdiction shall in no way affect the validity or enforceability of any other terms or provisions in that jurisdiction, or of this entire Agreement in any other jurisdiction.

12. **COMPLIANCE RELATED MATTERS.** The parties agree and certify that this Agreement is not intended to generate referrals for services or supplies for which payment maybe made in whole or in part under any federal health care program. The parties will comply with statutes, rules, and regulations as promulgated by federal and state regulatory agencies or legislative authorities having jurisdiction over the parties.

13. **EXCLUDED PROVIDER.** Each party represents that neither that party nor any entity owning or controlling that party has ever been excluded from any federal health care program including the Medicare/Medicaid program or from any state health care program. Each party further represents that it is eligible for Medicare/Medicaid participation. Each party agrees to disclose immediately any material federal, state, or local sanctions of any kind, imposed subsequent to the date of this Agreement, or any investigation which commences subsequent to the date of this Agreement, that would materially adversely impact Company's ability to perform its obligations hereunder.

14. **NOTICES.** All notices, requests, and other communications to any party hereto shall be in writing and shall be addressed to the receiving party's address set forth below or to any other address as a party may designate by notice hereunder, and shall either be (a) delivered by hand, (b) sent by recognized overnight courier, or (c) by certified mail, return receipt requested, postage prepaid.

If to Hospital:
Shore Health System d/b/a Easton
Memorial Hospital
219 South Washington Street
Easton, MD 21601
Attn: Gerard M. Walsh
Senior Vice President and COO

If to Company:
Renal Treatment Centers – Mid-Atlantic, Inc.
C/o: DaVita Inc.
5200 Virginia Way
Brentwood, TN 37027
Attn: Group General Counsel

With copies to: Easton Dialysis
C/o: DaVita Inc.
402 Marvel Court
Easton, MD 21601
Attn: Facility Administrator

DaVita Inc.
601 Hawaii Street
El Segundo, California 90245
Attention: General Counsel

All notices, requests, and other communication hereunder shall be deemed effective (a) if by hand, at the time of the delivery thereof to the receiving party at the address of such party set forth above, (b) if sent by overnight courier, on the next business day following the day such notice is delivered to the courier service, or (c) if sent by certified mail, five (5) business days following the day such mailing is made.

15. ASSIGNMENT. This Agreement shall not be assigned in whole or in part by either party hereto without the express written consent of the other party, except that Company may assign this Agreement to one of its affiliates or subsidiaries without the consent of Hospital.

16. COUNTERPARTS. This Agreement may be executed simultaneously in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Copies of signatures sent by facsimile shall be deemed to be originals.

17. NON-DISCRIMINATION. All services provided by Hospital hereunder shall be in compliance with all federal and state laws prohibiting discrimination on the basis of race, color religion, sex national origin, handicap, or veteran status.

18. WAIVER. The failure of any party to insist in any one or more instances upon performance of any terms or conditions of this Agreement shall not be construed as a waiver of future performance of any such term, covenant, or condition, and the obligations of such party with respect thereto shall continue in full force and effect.

19. GOVERNING LAW. The laws of the State of Maryland shall govern this Agreement.

20. HEADINGS. The headings appearing in this Agreement are for convenience and reference only, and are not intended to, and shall not, define or limit the scope of the provisions to which they relate.

21. ENTIRE AGREEMENT. This Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes any and all other agreements,

either oral or written, between the parties (including, without limitation, any prior agreement between Hospital and Company or any of its subsidiaries or affiliates) with respect to the subject matter hereof.

22. **APPROVAL BY DAVITA INC. ("DAVITA") AS TO FORM.** The parties acknowledge and agree that this Agreement shall take effect and be legally binding upon the parties only upon full execution hereof by the parties and upon approval by DaVita Inc. as to the form hereof.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement the day and year first above written.

Hospital:

Shore Health System d/b/a Easton Memorial Hospital

By: _____
Name: GERARD H. WALSH
Title: SR V.P & C.O.O.

Company:

Renal Treatment Centers – Mid-Atlantic, Inc., a Delaware corporation

By: _____
Name: Joan Guest
Title: Regional Operations Director

Approved by DaVita as to form only:

By: _____
Name: Edwin C. Lunsford, III
Title: Group General Counsel

SHORE HEALTH SYSTEM, INC
AND
CANDLE LIGHT COVE

TRANSFER AGREEMENT

This Agreement made this 11th day of April, 2013, by and between **Candle Light Cove and Alzheimer's Care,** a Maryland limited liability corporation, with a principal place of business at 106 W Earle Avenue, Easton Maryland and **Shore Health System.**

Recitals

Candle Light Cove and Alzheimer's Care desires to secure for residents of Candle Light Cove ("Residents") an available bed(s) at Shore Health System, in the event of a situation that requires an emergency evacuation.

Now, therefore, for good and valuable consideration, the receipt of which is hereby acknowledged, Candle Light Cove and Shore Health System agree as follows:

1. Candle Light Cove shall operate the Facility at a first class level consistent with similar first class facilities in Maryland.
    a. At such time as there is a Resident who is in immediate need of evacuation due to an emergency, Candle Light Cove shall contact Shore Health System.
    b. Shore Health System shall have the right to determine if space is available for Residents of Candle Light Cove that are in need of emergency evacuation.
    c. Shore Health System agrees to support Candle Light Cove in the emergency evacuation of its residents regardless of creed, race, gender, religious preferences or any of class as protected by law.

2. Both parties agree that the placement of Residents would be on a temporary basis until such time as a more permanent placement can be obtained.

3. This Agreement shall be in effect until either party terminates this agreement.

4. All statements, notices and mailings of any nature contemplated hereunder shall be sufficient if delivered to Candle Light Cove, 106 W Earle Ave, Easton MD and Shore Health System, 219 South Washington Street, Easton MD.

5. Each provision of this Agreement will be deemed separate from each other provision and the invalidity or unenforceability of any provision will not affect the validity or enforceability of the balance of this Agreement.

6. This Agreement is to be construed as a Maryland contract and sets forth the entire contract between parties. It shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns and may be canceled, modified or amended only by a written instrument executed by both Shore Health System and Candle Light Cove.

Candle Light Cove

By: Lynne Ewing

Title: Executive Director

Date: 4/11/13

Shore Health System, Inc.

By: [signature]

Title: Sr. V.P. + C.O.O.

Date: 4-24-13

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Addendum to MOU

January 9, 2017

University of Maryland Shore Regional Health (UMSRH), located at 219 S. Washington Street, Easton Maryland, has an understanding with Candle Light Cove that would allow Candle Light Cove to relocate its residents to a UMSRH facility in the event that Candle Light Cove is not able to relocate its residents to their second building on their own property. With this understanding, Candle Light Cove staff would be responsible for providing all related care. It is also understood that this emergency off-site shelter is a temporary relocation only.

Kenneth D. Kozel
President & CEO

PATIENT TRANSFER AGREEMENT

THIS AGREEMENT ("Agreement") is made this 16th day of November 2000, by and between Shore Health System of Maryland and **PENINSULA REGIONAL MEDICAL CENTER,** a Maryland corporation ("Peninsula Regional")(each, a "Party").

WHEREAS:

1. Both Parties to this Agreement are providers of health care services which seek to improve the treatment of patients by providing continuity of care and treatment appropriate to the needs of each such patient;

2. Neither Party offers all services needed by its patients and both wish to make provision for the transfer of its patients for additional needed services;

3. At least one Party does have facilities offering services needed by patients of the other Party and is licensed to provide such services;

4. Each Party needs assurance of a referral mechanism to provide these services to its patients which the Party does not offer; and

5. This Agreement is intended to cover the circumstances where patients may be transferred by either Party to the other. The terms of the Agreement refer to the "Transferor Institution" and "Transferee Institution." Depending upon the circumstances, either Party may be either a "Transferor Institution" or a "Transferee Institution." If a Party is transferring patients, then it is the "Transferor Institution." If a Party is receiving patients, then it is the "Transferee Institution."

NOW, THEREFORE, in consideration of the common aims, interests and mutual advantages accruing to the parties, the Parties covenant and agree as follows

1. **Recitals**. The above recitals are specifically incorporated by reference and hereby made a part of this Agreement,

2. **Autonomy**. The governing authorities of each Party shall have exclusive control of the management, assets and affairs of their respective institutions. Neither Party by virtue of this Agreement assumes any liability for any debts or obligations of any nature incurred by the other party to this Agreement. Neither party will assume responsibility for the care rendered to the patient by the other institution.

3. Each Party shall notify the other of it's designated representative(s) for the purpose of implementing this Agreement. In the event that Transferor Institution has a patient in need of services it does not provide and which Transferee Institution does provide, Transferor Institution will contact the designated representative of Transferee Institution who will recommend to Transferor Institution whether the

patient should be transferred from Transferor Institution to Transferee Institution. It shall be the responsibility of the Transferor Institution to determine that the patient can be transferred without harm. If Transferee Institution recommends that the patient be transferred to Transferee Institution, then the designated representative shall confirm to the Transferor Institution that the Transferee Institution consents to the transfer and that the patient meets Transferee Institution's admission criteria relating to appropriate bed, the patient's required level of care, and physician and other services necessary to treat the patient. The designated representative of Transferee Institution shall accept or arrange for acceptance of such patient on behalf of Transferee Institution and shall arrange for all necessary administrative authorizations for the transfer. The transfer of any such patients from Transferor Institution to Transferee Institution will be effected in accordance with federal and state law and regulations. Transferee Institution and Transferor Institution mutually agree to exercise their best efforts to provide for prompt admission of these patients to Transferee Institution.

4. In the event of transfer, it shall be the responsibility of the patient's physician at Transferor Institution to determine the safest and most appropriate means to transfer the patient to Transferee Institution. Transferor Institution will provide or arrange for an ambulance or other transport equipment which is able to provide appropriate treatment during transport. The Transferor Institution will provide medically appropriate personnel and equipment that a reasonable and prudent physician exercising ordinary care would use for the transfer. The transport shall use medically appropriate life-support measures that a reasonable and prudent physician exercising ordinary care would use to stabilize the patient before transfer and to sustain the patient during the transfer. Transferor Institution shall be solely responsible for all costs, or for the arrangement of coverage of all costs, or transporting the patient, including the costs of any necessary personnel, Transferor Institution shall he responsible for notifying Transferee Institution of the impending transfer, providing explanations of the reason for the transfer and any alternatives to the transfer to the patient or patient's Parent(s) or legal guardian(s), as well as obtaining approval for the transfer from such person. Transferor institution shall be solely responsible for assuring that all transfers under this Agreement comply with all federal and/or State requirements which govern the transfer of patients.

5. In compliance with 42 USCA 1395dd, 42 C.F.R. 489.24, Md. Health-Gen. Code Ann. 19-308.2, and COMAR 10. 07. 01. 23, Transferor Institution will provide a copy of the patient's medical records to Transferee Institution. This shall include medical records related to the patient's emergency medical condition, history and physical observations of signs, symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies or telephone reports of the studies, treatment provided, x-rays, results of any tests, written informed consent to the transfer (or physician certification as to the necessity of transfer), copies of any relevant signed consent forms, and any advance directives or other legal guidance believed by Transferor Institution to be currently in effect. A medication

schedule for the previous twelve (12) hours with dose and administration will be provided. These records should accompany the patient at the time of the transfer. For an emergent patient, the medical record may be faxed (within one hour) if time does not allow for photocopying.

6. As soon as a transfer has been made, it shall be the responsibility of Transferor Institution to advise the financially responsible party or agency of the transfer. Each party to this Agreement is solely responsible for all matters pertaining to billing and collecting its own patient charges. Neither party shall have any liability to the other for such charges nor shall be liable for any debts, obligations or claims of a financial or legal nature to the other party.

7. To maintain the quality of care to the transferred patients, all cases will be reviewed by Transferee Institution's Quality Assurance Department. The result of these reviews will be promptly communicated to Transferor Institution.

8. Transferor Institution and Transferee Institution agree that they will provide and ensure maximum confidentiality accorded by law with regard to all medical, business or other records generated in accordance with this Agreement.

9. Nothing in this Agreement shall be construed as limiting the rights of either Party to affiliate or contract with any other institution while this Agreement is in effect.

10. Neither Party shall use the name of the other Party in any promotion or advertising unless prior written approval of the intended use is obtained from the Party whose name is to be used.

11. This Agreement supersedes any relevant prior agreements between the Parties. This Agreement may be modified or amended from time to time by mutual agreement of the Parties and such modifications or amendments shall he attached to and become a part of this Agreement. This Agreement may not be assigned by either Party without the prior written consent of the other. This Agreement shall be construed and enforced in accordance with the laws of the State of Maryland.

12. Neither Party shall be entitled to compensation from the other Party for any services provided under this Agreement.

13. Transferor Institution shall be solely responsible for complying with State and Federal laws and regulations governing patient transfers. Transferor Institution shall not use the patient's inability to pay or source of payment for the patient as a reason to transfer the patient.

14. All notices hereunder shall be in writing and shall be deemed to have been duly given if delivered in hand or sent by registered or certified mail, postage prepaid,

to each Party at the address set forth below. Either Party may designate a different address by written notice given in the manner provided herein.

If to Peninsula Regional:

Peninsula Regional Medical Center
100 East Carroll Street
Salisbury, MD 21801
Attn: President

If to Shore Health System of Maryland:

Shore Health System of Maryland
219 S. Washington Street
Easton, MD 21601
Attn: Administrator

15. This Agreement shall commence as of the date set forth above and shall continue in effect for one year unless it is terminated by either Party. This Agreement shall be renewed for additional terms of one (1) year each in the absence of notice of intent not to renew given by either party. This Agreement may be terminated at any time by an authorized representative of the parties to this Agreement by providing the other Party with 30 days' prior written notice. However, this Agreement shall be automatically terminated if either Party has its license to operate revoked by the State of Maryland, its ability to participate in the Medicare and/or Medicaid programs is terminated, or if it loses accreditations by the Joint Commission or Accreditation of Healthcare organizations.

IN WITNESS WHEREOF, the authorized representatives of the parties to this Agreement have caused their respective principal's name to be subscribed to this Agreement.

PENINSULA REGIONAL MEDICAL CENTER
a Maryland corporation

Sharon R. Hassington

By: _____
Authorized Representative
Date: 11/17/00

_____

By: _____
Authorized Representative
Date: 11/27/00

prmc\patient transfer agr. 1109

ORIGINAL

STEMI PATIENT TRANSFER
MEMORANDUM OF UNDERSTANDING

THIS MEMORANDUM OF UNDERSTANDING ("MOU") is made and entered into by and between Peninsula Regional Medical Center, located at 100 East Carroll Street, Salisbury, Maryland ("PRMC") and Shore Health System, Inc. ("SHS"), on behalf of its wholly owned and operated acute care hospitals, The Memorial Hospital, located at 219 S. Washington Street, Easton, Maryland and Dorchester General Hospital, located at 300 Bryn Street, Cambridge, MD 21613, (individually and collectively referred to herein as SHS facilities).

RECITALS:

WHEREAS, SHS facilities do not perform certain cardiac procedures that may be required by patients presenting with ST-segment elevation MI ("STEMI patients");

WHEREAS, PRMC does perform such procedures and further is a designated by the Maryland Institute for Emergency Medical Services Systems (MIEMSS) designated Cardiac Interventional Center (CIC);

WHEREAS, SHS desires to arrange for the provision of needed cardiology and cardiac services to its STEMI patients and facilitate the continuity of their care by transferring such patients to PRMC in order to receive the necessary cardiac procedures; and

WHEREAS, PRMC desires to accept such transfers and to provide such services to SHS's transferred STEMI patients;

NOWTHEREFORE, in consideration of the mutual covenants and agreements set forth herein, PRMC, and SHS agree as follows;

1. **TRANSFER OF PATIENTS.** All transfers between any SHS facility and PRMC shall be performed in accordance with applicable federal and state statutes and regulations, the standards of The Joint Commission, and the MIEMMS Interhospital Transfer Guidelines. In addition, in the course of effectuating a transfer addressed by this MOU, both SHS and PRMC shall adhere to their own reasonable policies and procedures applicable to patient transfers. Both PRMC and SHS agree to retain data regarding performance measures of services provided under this MOU as may be necessary for purposes of certification and/or accreditation. Neither the acceptance of the transfer of a STEMI a patient nor the refusal to accept the transfer of a STEMI patient shall be predicated upon arbitrary, capricious, or unreasonable grounds or discrimination or based upon the patient's inability to pay for services rendered by either PRMC or SHS.

2. **RESPONSIBILITIES OF THE TRANSFERRING FACILITY.** SHS facilities shall evaluate for transfer all patients determined to be STEMI patients as

defined by the MIEMMS regulations at COMAR 30.08.16.01. If a SHS facility determines transfer of a STEMI patient is appropriate, decides to transfer such STEMI patient to PRMC, and concludes the transfer to PRMC meets the MIEMMS Interhospital Transfer Guidelines such SHS facility, as the "Transferring Facility," shall be responsible for performing or ensuring performance of the following:

a. Provide for a member of the nursing staff or the patient's attending physician to contact the Peninsula Access Center using the contact information set forth in Section 12;

b. Provide, within its capabilities, evaluation of the patient for transfer, medical screening and stabilizing treatment of the patient prior to transfer;

c. Arrange for the patient's safe and appropriate transportation to PRMC, the use of appropriate equipment and personnel and the appropriate care for the patient during transfer, in accordance with applicable federal and state laws and regulations and the MIEMMS Interhospital Transfer Guidelines;

d. Select an authorized representative of the Transferring Facility to coordinate the patient's transfer ("Designated Representative") and provide the name of such designated representative to the Receiving Facility.

e. Communicate to the Receiving Facility the Receiving Physician, defined as the treating physician's or patient's choice of physician or cardiology practice to receive the patient once transferred to the Receiving Facility, the physician providing coverage for chosen Physician or cardiology group, or if those Receiving Physicians are unavailable, the on-call cardiologist, all of whom shall be properly credentialed, licensed and experienced cardiologists ("Receiving Physician");

f. Forward to the Receiving Physician and the Receiving Facility a copy of those portions of the patient's medical record that are available at the time of transfer and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of transfer. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible via the fax number in Section 12.

g. Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items.

3. RESPONSIBILITIES OF THE RECEIVING FACILITY. PRMC's responsibility for the patient's care, as the "Receiving Facility," shall begin when the

patient arrives at or is admitted to the Receiving Facility. Specifically, the Receiving Facility shall be responsible for performing or ensuring performance of the following:

a. Arrange for the availability of the Receiving Physician requested by the patient's treating physician or the patient. If such physician is not reasonably available, provide for a properly credentialed, licensed and experienced Receiving Physician.

b. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the Receiving Physician with the receipt and treatment of the patient transferred, maintain a call roster of eligible Receiving Physicians at the Receiving Facility and provide, on request, the name of a Receiving Physician requested based on standing orders or the Receiving Physician providing coverage for that Receiving Physician's group, or the on-call Receiving Physician, to the Transferring Facility.

c. Reserve beds, facilities, and services as appropriate for STEMI patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a Receiving Physician. Transferred STEMI patients shall be treated in the emergency department, sent to the cardiac catheterization laboratory, directly admitted to a patient room, and/or sent to the operating room, as appropriate based on the patient's medical needs.

d. Select an authorized representative of the Receiving Facility to coordinate the patient's transfer ("designated representative") and provide the name of such designated individual to the Transferring Facility.

e. When the Transferring Facility cannot arrange for necessary personnel or equipment, and when appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the Transferring Physician (Physician at SHS who is responsible for the patient prior to transfer) and Receiving Physician.

f. Maintain the confidentiality of the patient's medical records in accordance with applicable state and federal law.

g. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medial records in accordance with applicable state and federal law, (ii) for the receipt of the patient into the facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient.

h. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider, including the MIEMMS standards for the transfer of STEMI patients.

4. BILLING. All charges incurred with respect to any services performed by either PRMC or SHS for transferred STEMI patients shall be billed and collected by the

party furnishing such services. In addition, it is understood that professional fees will be billed by the physicians or other professional providers at SHS facilities and/or PRMC that may participate in the care and treatment of the patient. Both SHS and PRMC agree to provide information in its possession to the other and to physicians/providers sufficient to enable the treating providers to bill for services provided..

5. DISCHARGE. When the transferred patient is ready for discharge as appropriate to the patient's medical condition, the Receiving Physician shall contact the Transferring Physician or the patient's primary care physician.

6. COMPLIANCE WITH LAW. SHS and PRMC shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of medical records, confidentiality or patient information, and the rules and standards of MIEMMS for the transfer and treatment of STEMI patients, as well as with all standards promulgated by any relevant accrediting agency.

7. RESPONSIBILITY; INSURANCE. SHS and PRMC shall be responsible for their own acts and omissions in the performance of their duties, and the acts and omissions of their own employees and agents. In addition, each party shall maintain, throughout the term of this MOU, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party, and shall provide evidence of that coverage upon request.

8. TERM; TERMINATION.

a. Term; Renewal. The initial term of this MOU ("Initial Term") shall be for a period of 3 year(s), commencing on 5-18, 2011 unless sooner terminated herein. At the end of the Initial Term and upon mutual written agreement of the parties, this MOU may be renewed for subsequent additional terms of one (1) year ("Renewal Terms").

b. Holdover. In the event the parties continue to abide by the terms of this MOU after the expiration of the Initial Term or any Renewal Term, without renewing the MOU in accordance with Section 8.a., this MOU shall continue on a month-to-month basis.

c. Termination Without Cause. Either party may terminate this MOU without cause upon thirty (30) days written notice to the other party.

d. Termination for Breach. Either party may terminate this MOU upon breach by the other party of any material provision of this MOU, provided the breach continues for five (5) days after receipt by the breaching party of written notice of the breach from the non-breaching party.

e. Immediate Termination. Either party may terminate this MOU immediately upon the occurrence of any of the following events:

i. The other party's closure or discontinuation of operation to such an extent that patient care cannot be carried out adequately.

ii. The other party's loss of its license, conviction of a criminal offense related to health care, inclusion on a federal agency's list of entities and individuals who are debarred, excluded or otherwise ineligible for federal program participation.

9. ENTIRE AGREEMENT; MODIFICATION. This MOU contains the entire understanding of the parties with respect to the subject matter and supersedes all prior agreements, oral or written, and all other communications between the parties relating to the subject matter. This MOU may not be amended or modified except by mutual agreement.

10. GOVERNING LAW. This Agreement shall be construed in accordance with the laws of the State of Maryland. The provisions of this Paragraph shall survive expiration or other termination of this MOU regardless of the cause of the termination.

11. PARTIAL INVALIDITY. If any provision of this MOU is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this MOU.

12. NOTICES. All notices by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to PRMC: Peninsula Regional Medical Center
100 East Carroll Street
Salisbury, Maryland 21801
Attn: Executive Director
Guerrieri Heart and Vascular Institute
Fax: 410-912-5757

Peninsula Access Center 410-543-4722

If to SHS: Shore Health System, Inc.
219 South Washington Street
Easton, Maryland 21601
Attn: Director of Cardiology

or to such other persons or places as any party may from time to time designate by written notice to the other.

13. WAIVER. A waiver by any party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. ASSIGNMENT; BINDING EFFECT. Neither party shall assign or transfer, in whole or in part, this MOU or any of their rights, duties or obligations under this MOU without the prior written consent of the other party, and any assignment or transfer by any party without such consent shall be null and void. This MOU shall inure to the benefit of and be binding upon the parties and their respective heirs, representatives, successors and permitted assignees.

THE PARTIES have executed this Agreement on 5-25, 2011

SHORE HEALTH SYSTEM, INC.

By: _____
Gerard M. Walsh
Interim President and CEO

Date: 5-18-11

PENINSULA REGIONAL MEDICAL CENTER

By: _____
Margaret (Peggy) M. Naleppa, DR.M.
President/CEO

Date: 5-25-2011

TRANSFER AGREEMENT

This Transfer Agreement is entered into on 8-11-19, by and between Anne Arundel Health System, Inc. ("AAHS") and Queen Anne's Emergency Center ("Queen Anne"), a health care facility owned and operated by Shore Health System, Inc. ("Shore Health").

WHEREAS, both parties desire to assure continuity of care and treatment appropriate to the needs of each patient and to use the skills, resources, and physical plant of both parties in a coordinated and cooperative fashion to improve patient care at both the acute and post-acute stages of illness.

NOW, THEREFORE, in consideration of the mutual advantages occurring to the parties hereto, AAHS and Shore Health hereby covenant and agree with each other as follows:

1. Both parties agree to make a concerted effort to transfer patients as soon as practical when the need for transfer from Queen Anne to AAHS has been determined by the patient's attending physician, provided, however, all eligibility conditions for admission must be met and documented in the patient's medical record.

2. Queen Anne agrees to send with each patient at the time of transfer or, in the case of any emergency as promptly as possible after the transfer, an abstract of the patient's medical record including:

   (A) Current medical findings;
   (B) Diagnosis;
   (C) Brief summary of the course of treatment followed;
   (D) All other administrative and social information useful to provide continuing care to the patient; using the transfer and referral form mutually agreed upon.

3. Queen Anne, after promptly notifying AAHS of the impending transfer of a patient and after AAHS consents to accept such patient, shall assume the responsibility to arrange for appropriate and safe transportation of the patient, his/her personal effects and valuables, and shall provide any necessary care while he/she is being transferred.

4. Charges for services performed by either Queen Anne or AAHS for patients transferred from the other institution pursuant to this Agreement, shall be collected by the institution rendering such services, directly from the patient, third party payers, or the other sources normally billed by the institution; and neither party shall have any liability to the other for such charges except to the extent that such liabilities would exist separate and apart from this Agreement.

5. The parties agree that the transfer of a patient pursuant to this Agreement shall not be predicated upon discrimination based on race, religion, national origin, age, sex, physical condition or economic status. The parties also agree that the transfer or receipt of patients shall

not be based upon a patient's inability to pay for services rendered by the transferring or receiving institution or a patient's source of payment.

6. All patient transfers pursuant to this Agreement must be accomplished in a medically appropriate manner from physician to physician and from institution to institution by: (i) the use of appropriate life support measures which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to stabilize the patient prior to transfer and to sustain the patient during the transfer; (ii) the provision of appropriate personnel and equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use for the transfer; (iii) the transfer of all necessary records for continuing the care for the patient; and (iv) the consideration of the availability of appropriate facilities, services, and staff for providing care for the patient. The parties agree that before moving a patient, Queen Anne shall explain the reasons for the transfer and any alternative to the patient or a legally authorized representative of the patient. If it is necessary to move the patient immediately to protect the health, safety or welfare of the patient, Queen Anne may give the explanation of the reasons for the transfer concurrently with the transfer.

7. The parties agree to recognize the right of a patient to request transfer into the care of a physician and institution of the patient's own choosing and to recognize and comply with all federal and state requirements relating to the transfer of patients.

8. Queen Anne agrees not to transfer a patient with an emergency medical condition that has not been stabilized unless: (i) the patient, or a legally responsible person acting on the patient's behalf after being informed of Queen Anne's obligations under law and of the risk of transfer, requests in writing transfer to another institution; (ii) a licensed physician has signed a certification which includes a summary of the risks and benefits that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another institution outweigh the increased risks to the patient and, in the case of labor, to the unborn child from effecting the transfer; or (iii) if a licensed physician is not physically present at the time a patient is transferred, a qualified medical person has signed a certification described in subparagraph (ii) above after a license physician, in consultation with the person, has made the determination described in subparagraph (ii) above and subsequently countersigns the certificate.

9. All notices hereunder by either party to the other party shall be in writing, delivered personally or by overnight courier, and shall be deemed to have been duly given when delivered personally or one day after delivered to the overnight carrier, charges prepaid, and properly addressed to the respective parties at the addresses shown following each party's signature to this Agreement.

10. This Agreement shall be effective from the date of signing by both parties and shall continue in effect, except that either party may withdraw by giving sixty (60) days written notice to the other party of its intention to terminate this Agreement. However, this Agreement shall be declared null and void and shall be immediately terminated should either party fail to maintain its licensure or certification status.

11. Both parties represent and warrant that, during the term of this Agreement, each shall comply with all applicable state and federal laws and regulations and shall remain in good standing with applicable accrediting organizations.

12. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other institution, on either a limited or general basis, while this Agreement is in effect.

13. This Agreement may be modified or amended by the mutual agreement of the parties; however, any such modification or amendment shall be attached to and become a part of this Agreement. This Agreement shall be construed in accordance with the laws of the State of Maryland.

ANNE ARUNDEL HEALTH SYSTEM, INC.

By: _____

Name: Mitchell Schwartz MD

Title: Chief Med. Officer

2001 Medical Parkway
Annapolis, Maryland 21401

SHORE HEALTH SYSTEM, INC.

By: _____

Name: Gerard M. Walsh

Title: Sr. V.P. + C.O.O.

219 South Washington Street
Easton, Maryland 21601

FORT WASHINGTON MEDICAL CENTER
PATIENT TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (the "Agreement") is made as of this 16th day of May 2017, by and between FORT WASHINGTON MEDICAL CENTER and UNIVERSITY OF MARYLAND MEDICAL CENTER AT EASTON, each individually referred to herein as "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of this Agreement, and collectively as "facilities."

WITNESSETH:

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between the two facilities; and,

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities.

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties agree as follows:

1. TRANSFER OF PATIENTS. In the event any patient of either facility is deemed by the Transferring Facility as requiring the services of the Receiving Facility and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department, whichever is applicable, of the Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon discriminatory, unreasonable, arbitrary, or capricious reasons or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. RESPONSIBILITIES OF THE TRANSFERRING FACILITY. The Transferring Facility shall be responsible for performing or ensuring performance of the following:
    a. Provide, within its capabilities, stabilizing treatment of the patient prior to transfer;
    b. Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;
    c. Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility;
    d. Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;
    e. Prior to patient transfer, if for direct admission, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;
    f. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;
    g. Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;
    h. Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and a copy of the patient's executed Advance Directives. If all necessary and relevant medical records are not available at the time the

patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible;

i. Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items;

j. Notify the Receiving Facility of the estimated time of arrival of the patient;

k. Provide the Receiving Facility any information available about the patient's coverage under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district (ABN attached);

l. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

m. Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

n. Recognize the right of a patient to refuse to consent to treatment or transfer;

o. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility; and,

p. Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

3. RESPONSIBILITIES OF THE RECEIVING FACILITY. The Receiving Facility shall be responsible for performing or ensuring performance of the following:

a. Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility promptly after receipt of the request to transfer a patient with an emergency medical condition or in active labor;

b. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred, maintain a call roster of physicians at the Receiving Facility and provide, on request, the names of on-call physicians to the Transferring Facility;

c. Reserve beds, facilities, and services as appropriate for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by the Receiving Facility for an emergency;

d. Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility;

e. When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

f. Upon discharge of the patient back to the Transferring Facility, provide the Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department;

g. Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;

h. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into its facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient;

i. Provide for the return transfer of the patients to the Transferring Facility when requested by the patient or the Transferring Facility and ordered by the patient's attending/transferring physician, if the Transferring Facility has a statutory or regulatory obligation to provide health care assistance

to the patient, and if transferred back to the Transferring Facility, provide the items and services required of a Transferring Facility in Section 2 of this Agreement.

j. Provide the Transferring Facility any information available about the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

k. Upon request, provide current information concerning its eligibility standards and payment practices to the Transferring Facility and patient;

l. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

m. Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

4. BILLING. All claims or charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party payer, Medicare or Medicaid, or other sources appropriately billed by that facility, unless applicable law and regulations require that one facility bill the other facility for such services. In those cases in which the regulations apply, the facilities shall bill in accordance to the regulations that apply to skilled nursing facility prospective payment system ("SNF PPS") and consolidated billing. In those cases in which payment rates are consistent with SNF PPS regulations and have been negotiated, such payment shall be made in accordance with the payment fee schedule, available upon request. In addition, it is understood that professional fees will be billed by those physicians or other professional providers who actually participate in the care and treatment of the patient and who are entitled to bill for their professional services at usual and customary rates. Each facility agrees to provide information in its possession to the other facility and such physicians or professional providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payer.

5. TRANSFER, TRANSFER BACK; DISCHARGE; POLICIES. The transferring institution shall have the responsibility for arranging transportation of the patient to the receiving institution, including selection of the mode of transportation and provide the appropriate practitioner(s) to accompany the patient and shall transfer with the patient all relevant patient data, necessary to continue treatment without interruption, including, but not limited to, a copy of all applicable medical records, including progress notes and discharge summaries, available at the time of transfer; all informed written consents (including advance notice and written acknowledgments of costs which may not be covered by the patient's insurer or payor) (ABN) or certifications required by statute, rule or regulation; any administrative and pertinent identifying information; and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment to the patient, if applicable. The receiving institution's responsibility for the patient's care shall begin when the patient is formally admitted to that institution as a patient of that institution.

   The transferring institution agrees to receive the patient back from the receiving institution, if requested by the receiving institution, when the patient no longer requires the specialized care and facilities of the receiving institution and any requirements of patient consent and physician certification has been satisfied.

6. COMPLIANCE WITH LAW. Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. INDEMNIFICATION; INSURANCE. The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents, and shall indemnify and hold harmless the other party from and against any and all claims, liabilities, causes of action, losses, costs, damages and expenses (including reasonable attorney's fees) incurred by the other party as a result of such acts and omissions. [For MD Facilities] *In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional*

liability insurance and property damage insurance coverage in amounts not less than those required by state law [currently professional liability in MARYLAND is One Million ($1,000,000.00) per occurrence and Three Million ($3,000,000.00)] in the aggregate, and a party shall provide evidence of such coverage upon request. [For VIRGINIA Facilities] *In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts not less than those required by state law [currently, the minimum amount of Virginia professional liability insurance required is Two Million ($2,000,000.00) per occurrence plus an additional $50,000 on each July 1st for 20 years beginning July 1, 2012] and a party shall provide evidence of such coverage upon request.*

8. TERM; TERMINATION. The term of this Agreement shall be one (1) year, commencing on the 16th day of MAY, 2017, and ending on the 16th day of MAY, 2018, unless sooner terminated as provided herein. This Agreement shall be automatically renewed for successive terms of twelve (12) months unless one party notifies the other on or before ninety (90) days prior to the end of the then-current term, in writing, of its intent to terminate. Either party may terminate this Agreement without cause upon thirty (30) days advance written notice to the other party. Either party may terminate this Agreement upon breach by the other party of any provision of this Agreement, provided such breach continues for ten (10) days after receipt by the breaching party of written notice of such breach from the non-breaching party. This Agreement may be terminated immediately upon the occurrence of any of the following events:
    a. Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately, or
    b. Either facility loses its license, or Medicare certification.

9. ENTIRE AGREEMENT; MODIFICATION. This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

10. GOVERNING LAW. This Agreement shall be construed in accordance with the laws of the state in which the facility is located.

11. PARTIAL INVALIDITY. If any provision of this Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this Agreement.

12. NOTICES. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to UNIVERSITY OF MARYLAND MEDICAL CENTER AT EASTON:

Address: 219 South Washington Street
Easton, MD 21601
Attention: Mr. Kenneth Kozel, President
(410) 822-1000

If to FORT WASHINGTON MEDICAL CENTER:

Address: 174 Waterfront Street
Suite 225
Oxon Hill, MD 20745
Attention: Reginald Jones, President & CEO
(301) 686-9010

With copy to:

Address: 174 Waterfront Street
Suite 225
Oxon Hill, MD 20745
Attention: Donna Jennings, CCO
(276) 614-8804

or to such other persons or places as either party may from time to time designate by written notice to the other.

13. WAIVER. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. ASSIGNMENT; BINDING EFFECT. Facilities shall not assign or transfer, in whole or in part, this Agreement or any of Facilities' rights, duties or obligations under this Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. This Agreement shall inure to the benefit of and are binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

15. CHANGE IN LAW. Notwithstanding any other provision of this Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payer, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while this Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under this Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend this Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If this Agreement is not so amended in writing within seven (7) days after said notice was given, this Agreement shall terminate as of midnight local time on the third (3rd) day after said notice was given.

16. GOVERNMENT ACCESS TO AGREEMENT AND RECORDS. Each party shall, in accordance with 42 U.S.C. § 1395x(v)(1)(I) (Social Security Act § 1861(v)(1)(I)) and 42 C.F.R. § 420.300 *et seq.*, until the expiration of six (6) years after the furnishing of Medicare reimbursable services pursuant to this Agreement, upon proper written request, allow the comptroller General of the United States, the Department of Health and Human Services, and their duly authorized representatives access to this Agreement and to it's or its subcontractors' books, documents and records (as such terms are defined in 42 C.F.R. § 420-301) necessary to verify the nature and extent of costs of Medicare and/or Medicaid reimbursable services provided under this Agreement. In accordance with such laws and regulations, if Medicare reimbursable services provided by any party under this Agreement are carried out by means of a subcontract with an organization related to either party, and such related organization provides the services at a value or cost of $10,000 or more over a twelve-month period, then the subcontract between that party and the related organization shall contain a clause comparable to the clause specified in the preceding sentence. In the event any request for this Agreement or either party's books, documents, and records is made pursuant to Social Security Act § 1861(v)(1)(I) and associated regulations, that party shall promptly give notice of such request to the other party and provide that party with a copy of such request and, thereafter, consult and cooperate with that party concerning the proper response to such request. Additionally, each party shall provide the other with a copy of each book, document, and record made available to one or more persons and agencies pursuant to Social Security Act § 1861(v)(1)(I) or shall identify each such book, document, and record to the other party and shall grant that party access thereto for review and copying.

17. EXECUTION OF AGREEMENT. This Agreement shall not become effective or in force until all of the below named parties have fully executed this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year written above.

UNIVERSITY OF MARYLAND MEDICAL CENTER AT EASTON

By: _____

Name: KENNETH KOZEL

Title: CEO

Date: 5/16/17

FORT WASHINGTON MEDICAL CENTER

By: _____

Name: REGINALD JONES

Title: Interim President & CEO

Date: 5/16/17

FORT WASHINGTON MEDICAL CENTER
PATIENT TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (the "Agreement") is made as of this 12th day of May Shore 2017, by and between FORT WASHINGTON MEDICAL CENTER and UNIVERSITY OF MARYLAND MEDICAL CENTER AT CHESTERTOWN, each individually referred to herein as "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of this Agreement, and collectively as "facilities."

WITNESSETH:

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between the two facilities; and,

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities.

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties agree as follows:

1. TRANSFER OF PATIENTS. In the event any patient of either facility is deemed by the Transferring Facility as requiring the services of the Receiving Facility and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department, whichever is applicable, of the Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon discriminatory, unreasonable, arbitrary, or capricious reasons or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. RESPONSIBILITIES OF THE TRANSFERRING FACILITY. The Transferring Facility shall be responsible for performing or ensuring performance of the following:
    a. Provide, within its capabilities, stabilizing treatment of the patient prior to transfer;
    b. Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;
    c. Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility;
    d. Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;
    e. Prior to patient transfer, if for direct admission, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;
    f. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;
    g. Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;
    h. Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and a copy of the patient's executed Advance Directives. If all necessary and relevant medical records are not available at the time the

patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible;

i. Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items;

j. Notify the Receiving Facility of the estimated time of arrival of the patient;

k. Provide the Receiving Facility any information available about the patient's coverage under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district (ABN attached);

l. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

m. Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

n. Recognize the right of a patient to refuse to consent to treatment or transfer;

o. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility; and,

p. Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

3. RESPONSIBILITIES OF THE RECEIVING FACILITY. The Receiving Facility shall be responsible for performing or ensuring performance of the following:

a. Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility promptly after receipt of the request to transfer a patient with an emergency medical condition or in active labor;

b. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred, maintain a call roster of physicians at the Receiving Facility and provide, on request, the names of on-call physicians to the Transferring Facility;

c. Reserve beds, facilities, and services as appropriate for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by the Receiving Facility for an emergency;

d. Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility;

e. When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

f. Upon discharge of the patient back to the Transferring Facility, provide the Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department;

g. Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;

h. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into its facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient;

i. Provide for the return transfer of the patients to the Transferring Facility when requested by the patient or the Transferring Facility and ordered by the patient's attending/transferring physician, if the Transferring Facility has a statutory or regulatory obligation to provide health care assistance

to the patient, and if transferred back to the Transferring Facility, provide the items and services required of a Transferring Facility in Section 2 of this Agreement.

j. Provide the Transferring Facility any information available about the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

k. Upon request, provide current information concerning its eligibility standards and payment practices to the Transferring Facility and patient;

l. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

m. Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

4. BILLING. All claims or charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party payer, Medicare or Medicaid, or other sources appropriately billed by that facility, unless applicable law and regulations require that one facility bill the other facility for such services. In those cases in which the regulations apply, the facilities shall bill in accordance to the regulations that apply to skilled nursing facility prospective payment system ("SNF PPS") and consolidated billing. In those cases in which payment rates are consistent with SNF PPS regulations and have been negotiated, such payment shall be made in accordance with the payment fee schedule, available upon request. In addition, it is understood that professional fees will be billed by those physicians or other professional providers who actually participate in the care and treatment of the patient and who are entitled to bill for their professional services at usual and customary rates. Each facility agrees to provide information in its possession to the other facility and such physicians or professional providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payer.

5. TRANSFER, TRANSFER BACK; DISCHARGE; POLICIES. The transferring institution shall have the responsibility for arranging transportation of the patient to the receiving institution, including selection of the mode of transportation and provide the appropriate practitioner(s) to accompany the patient and shall transfer with the patient all relevant patient data, necessary to continue treatment without interruption, including, but not limited to, a copy of all applicable medical records, including progress notes and discharge summaries, available at the time of transfer; all informed written consents (including advance notice and written acknowledgments of costs which may not be covered by the patient's insurer or payor) (ABN) or certifications required by statute, rule or regulation; any administrative and pertinent identifying information; and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment to the patient, if applicable. The receiving institution's responsibility for the patient's care shall begin when the patient is formally admitted to that institution as a patient of that institution.

   The transferring institution agrees to receive the patient back from the receiving institution, if requested by the receiving institution, when the patient no longer requires the specialized care and facilities of the receiving institution and any requirements of patient consent and physician certification has been satisfied.

6. COMPLIANCE WITH LAW. Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. INDEMNIFICATION; INSURANCE. The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents, and shall indemnify and hold harmless the other party from and against any and all claims, liabilities, causes of action, losses, costs, damages and expenses (including reasonable attorney's fees) incurred by the other party as a result of such acts and omissions. [For MD Facilities] *In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional*

liability insurance and property damage insurance coverage in amounts not less than those required by state law [currently professional liability in MARYLAND is One Million ($1,000,000.00) per occurrence and Three Million ($3,000,000.00)] in the aggregate, and a party shall provide evidence of such coverage upon request. [For VIRGINIA Facilities] *In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts not less than those required by state law [currently, the minimum amount of Virginia professional liability insurance required is Two Million ($2,000,000.00) per occurrence plus an additional $50,000 on each July 1st for 20 years beginning July 1, 2012] and a party shall provide evidence of such coverage upon request.*

8. TERM; TERMINATION. The term of this Agreement shall be one (1) year, commencing on the 12th day of May, 2017, and ending on the 11th day of May, 2018, unless sooner terminated as provided herein. This Agreement shall be automatically renewed for successive terms of twelve (12) months unless one party notifies the other on or before ninety (90) days prior to the end of the then-current term, in writing, of its intent to terminate. Either party may terminate this Agreement without cause upon thirty (30) days advance written notice to the other party. Either party may terminate this Agreement upon breach by the other party of any provision of this Agreement, provided such breach continues for ten (10) days after receipt by the breaching party of written notice of such breach from the non-breaching party. This Agreement may be terminated immediately upon the occurrence of any of the following events:
    a. Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately, or
    b. Either facility loses its license, or Medicare certification.

9. ENTIRE AGREEMENT; MODIFICATION. This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

10. GOVERNING LAW. This Agreement shall be construed in accordance with the laws of the state in which the facility is located.

11. PARTIAL INVALIDITY. If any provision of this Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this Agreement.

12. NOTICES. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT CHESTERTOWN:

Address: 100 Brown Street
Chestertown, MD 21061
Attention: Mr. Scott Burleson, Executive Director
(410) 778-3300

If to FORT WASHINGTON MEDICAL CENTER:

Address: 174 Waterfront Street
Suite 225
Oxon Hill, MD 20745
Attention: Reginald Jones, President & CEO
(301) 686-9010

With copy to:

Address: 174 Waterfront Street
Suite 225
Oxon Hill, MD 20745
Attention: Donna Jennings, CCO
(276) 614-8804

or to such other persons or places as either party may from time to time designate by written notice to the other.

13. WAIVER. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. ASSIGNMENT; BINDING EFFECT. Facilities shall not assign or transfer, in whole or in part, this Agreement or any of Facilities' rights, duties or obligations under this Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. This Agreement shall inure to the benefit of and are binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

15. CHANGE IN LAW. Notwithstanding any other provision of this Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payer, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while this Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under this Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend this Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If this Agreement is not so amended in writing within seven (7) days after said notice was given, this Agreement shall terminate as of midnight local time on the third (3rd) day after said notice was given.

16. GOVERNMENT ACCESS TO AGREEMENT AND RECORDS. Each party shall, in accordance with 42 U.S.C. § 1395x(v)(1)(I) (Social Security Act § 1861(v)(1)(I)) and 42 C.F.R. § 420.300 *et seq.*, until the expiration of six (6) years after the furnishing of Medicare reimbursable services pursuant to this Agreement, upon proper written request, allow the comptroller General of the United States, the Department of Health and Human Services, and their duly authorized representatives access to this Agreement and to it's or its subcontractors' books, documents and records (as such terms are defined in 42 C.F.R. § 420-301) necessary to verify the nature and extent of costs of Medicare and/or Medicaid reimbursable services provided under this Agreement. In accordance with such laws and regulations, if Medicare reimbursable services provided by any party under this Agreement are carried out by means of a subcontract with an organization related to either party, and such related organization provides the services at a value or cost of $10,000 or more over a twelve-month period, then the subcontract between that party and the related organization shall contain a clause comparable to the clause specified in the preceding sentence. In the event any request for this Agreement or either party's books, documents, and records is made pursuant to Social Security Act § 1861(v)(1)(I) and associated regulations, that party shall promptly give notice of such request to the other party and provide that party with a copy of such request and, thereafter, consult and cooperate with that party concerning the proper response to such request. Additionally, each party shall provide the other with a copy of each book, document, and record made available to one or more persons and agencies pursuant to Social Security Act § 1861(v)(1)(I) or shall identify each such book, document, and record to the other party and shall grant that party access thereto for review and copying.

17. EXECUTION OF AGREEMENT. This Agreement shall not become effective or in force until all of the below named parties have fully executed this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year written above.

UNIVERSITY OF MARYLAND MEDICAL CENTER AT CHESTERTOWN

By: _____

Name: SCOTT D BURLESON, MBA, FACHE

Title: Executive Director

Date: 5/12/2017

FORT WASHINGTON MEDICAL CENTER

By: _____

Name: REGINALD JONES

Title: Interim President & CEO

Date: 5/12/2017

FORT WASHINGTON MEDICAL CENTER
PATIENT TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (the "Agreement") is made as of this 25th day of May 2017, by and between FORT WASHINGTON MEDICAL CENTER and UNIVERSITY OF MARYLAND MEDICAL CENTER DORCHESTER, each individually referred to herein as "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of this Agreement, and collectively as "facilities."

WITNESSETH:

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between the two facilities; and,

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities.

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties agree as follows:

1. TRANSFER OF PATIENTS. In the event any patient of either facility is deemed by the Transferring Facility as requiring the services of the Receiving Facility and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department, whichever is applicable, of the Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon discriminatory, unreasonable, arbitrary, or capricious reasons or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. RESPONSIBILITIES OF THE TRANSFERRING FACILITY. The Transferring Facility shall be responsible for performing or ensuring performance of the following:
    a. Provide, within its capabilities, stabilizing treatment of the patient prior to transfer;
    b. Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;
    c. Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility;
    d. Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;
    e. Prior to patient transfer, if for direct admission, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;
    f. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;
    g. Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;
    h. Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and a copy of the patient's executed Advance Directives. If all necessary and relevant medical records are not available at the time the

patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible;

i. Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items;

j. Notify the Receiving Facility of the estimated time of arrival of the patient;

k. Provide the Receiving Facility any information available about the patient's coverage under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district (ABN attached);

l. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

m. Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

n. Recognize the right of a patient to refuse to consent to treatment or transfer;

o. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility; and,

p. Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

3. RESPONSIBILITIES OF THE RECEIVING FACILITY. The Receiving Facility shall be responsible for performing or ensuring performance of the following:

a. Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility promptly after receipt of the request to transfer a patient with an emergency medical condition or in active labor;

b. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred, maintain a call roster of physicians at the Receiving Facility and provide, on request, the names of on-call physicians to the Transferring Facility;

c. Reserve beds, facilities, and services as appropriate for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by the Receiving Facility for an emergency;

d. Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility;

e. When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

f. Upon discharge of the patient back to the Transferring Facility, provide the Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department;

g. Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;

h. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into its facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient;

i. Provide for the return transfer of the patients to the Transferring Facility when requested by the patient or the Transferring Facility and ordered by the patient's attending/transferring physician, if the Transferring Facility has a statutory or regulatory obligation to provide health care assistance

to the patient, and if transferred back to the Transferring Facility, provide the items and services required of a Transferring Facility in Section 2 of this Agreement.

j. Provide the Transferring Facility any information available about the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

k. Upon request, provide current information concerning its eligibility standards and payment practices to the Transferring Facility and patient;

l. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

m. Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

4. BILLING. All claims or charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party payer, Medicare or Medicaid, or other sources appropriately billed by that facility, unless applicable law and regulations require that one facility bill the other facility for such services. In those cases in which the regulations apply, the facilities shall bill in accordance to the regulations that apply to skilled nursing facility prospective payment system ("SNF PPS") and consolidated billing. In those cases in which payment rates are consistent with SNF PPS regulations and have been negotiated, such payment shall be made in accordance with the payment fee schedule, available upon request. In addition, it is understood that professional fees will be billed by those physicians or other professional providers who actually participate in the care and treatment of the patient and who are entitled to bill for their professional services at usual and customary rates. Each facility agrees to provide information in its possession to the other facility and such physicians or professional providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payer.

5. TRANSFER, TRANSFER BACK; DISCHARGE; POLICIES. The transferring institution shall have the responsibility for arranging transportation of the patient to the receiving institution, including selection of the mode of transportation and provide the appropriate practitioner(s) to accompany the patient and shall transfer with the patient all relevant patient data, necessary to continue treatment without interruption, including, but not limited to, a copy of all applicable medical records, including progress notes and discharge summaries, available at the time of transfer; all informed written consents (including advance notice and written acknowledgments of costs which may not be covered by the patient's insurer or payor) (ABN) or certifications required by statute, rule or regulation; any administrative and pertinent identifying information; and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment to the patient, if applicable. The receiving institution's responsibility for the patient's care shall begin when the patient is formally admitted to that institution as a patient of that institution.

   The transferring institution agrees to receive the patient back from the receiving institution, if requested by the receiving institution, when the patient no longer requires the specialized care and facilities of the receiving institution and any requirements of patient consent and physician certification has been satisfied.

6. COMPLIANCE WITH LAW. Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. INDEMNIFICATION; INSURANCE. The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents, and shall indemnify and hold harmless the other party from and against any and all claims, liabilities, causes of action, losses, costs, damages and expenses (including reasonable attorney's fees) incurred by the other party as a result of such acts and omissions. [For MD Facilities] *In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional*

liability insurance and property damage insurance coverage in amounts not less than those required by state law [currently professional liability in MARYLAND is One Million ($1,000,000.00) per occurrence and Three Million ($3,000,000.00)] in the aggregate, and a party shall provide evidence of such coverage upon request. [For VIRGINIA Facilities] *In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts not less than those required by state law [currently, the minimum amount of Virginia professional liability insurance required is Two Million ($2,000,000.00) per occurrence plus an additional $50,000 on each July 1st for 20 years beginning July 1, 2012] and a party shall provide evidence of such coverage upon request.*

8. TERM; TERMINATION. The term of this Agreement shall be one (1) year, commencing on the 25th day of May, 2017, and ending on the 25th day of May, 2018, unless sooner terminated as provided herein. This Agreement shall be automatically renewed for successive terms of twelve (12) months unless one party notifies the other on or before ninety (90) days prior to the end of the then-current term, in writing, of its intent to terminate. Either party may terminate this Agreement without cause upon thirty (30) days advance written notice to the other party. Either party may terminate this Agreement upon breach by the other party of any provision of this Agreement, provided such breach continues for ten (10) days after receipt by the breaching party of written notice of such breach from the non-breaching party. This Agreement may be terminated immediately upon the occurrence of any of the following events:
    a. Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately, or
    b. Either facility loses its license, or Medicare certification.

9. ENTIRE AGREEMENT; MODIFICATION. This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

10. GOVERNING LAW. This Agreement shall be construed in accordance with the laws of the state in which the facility is located.

11. PARTIAL INVALIDITY. If any provision of this Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this Agreement.

12. NOTICES. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to UNIVERSITY OF MARYLAND MEDICAL CENTER DORCHESTER:

Address: 300 Byrn Street
Cambridge, MD 21613
Attention: Mr. Brian Leuter, Executive Director
(410) 228-5511

If to FORT WASHINGTON MEDICAL CENTER:

Address: 174 Waterfront Street
Suite 225
Oxon Hill, MD 20745
Attention: Reginald Jones, President & CEO
(301) 686-9010

With copy to:

Address: 174 Waterfront Street
Suite 225
Oxon Hill, MD 20745
Attention: Donna Jennings, CCO
(276) 614-8804

or to such other persons or places as either party may from time to time designate by written notice to the other.

13. WAIVER. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. ASSIGNMENT; BINDING EFFECT. Facilities shall not assign or transfer, in whole or in part, this Agreement or any of Facilities' rights, duties or obligations under this Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. This Agreement shall inure to the benefit of and are binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

15. CHANGE IN LAW. Notwithstanding any other provision of this Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payer, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while this Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under this Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend this Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If this Agreement is not so amended in writing within seven (7) days after said notice was given, this Agreement shall terminate as of midnight local time on the third (3rd) day after said notice was given.

16. GOVERNMENT ACCESS TO AGREEMENT AND RECORDS. Each party shall, in accordance with 42 U.S.C. § 1395x(v)(1)(I) (Social Security Act § 1861(v)(1)(I)) and 42 C.F.R. § 420.300 *et seq.*, until the expiration of six (6) years after the furnishing of Medicare reimbursable services pursuant to this Agreement, upon proper written request, allow the comptroller General of the United States, the Department of Health and Human Services, and their duly authorized representatives access to this Agreement and to it's or its subcontractors' books, documents and records (as such terms are defined in 42 C.F.R. § 420-301) necessary to verify the nature and extent of costs of Medicare and/or Medicaid reimbursable services provided under this Agreement. In accordance with such laws and regulations, if Medicare reimbursable services provided by any party under this Agreement are carried out by means of a subcontract with an organization related to either party, and such related organization provides the services at a value or cost of $10,000 or more over a twelve-month period, then the subcontract between that party and the related organization shall contain a clause comparable to the clause specified in the preceding sentence. In the event any request for this Agreement or either party's books, documents, and records is made pursuant to Social Security Act § 1861(v)(1)(I) and associated regulations, that party shall promptly give notice of such request to the other party and provide that party with a copy of such request and, thereafter, consult and cooperate with that party concerning the proper response to such request. Additionally, each party shall provide the other with a copy of each book, document, and record made available to one or more persons and agencies pursuant to Social Security Act § 1861(v)(1)(I) or shall identify each such book, document, and record to the other party and shall grant that party access thereto for review and copying.

17. EXECUTION OF AGREEMENT. This Agreement shall not become effective or in force until all of the below named parties have fully executed this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year written above.

UNIVERSITY OF MARYLAND MEDICAL CENTER DORCHESTER

By: _____

Name: Kenneth Kozel

Title: CEO

Date: 5/25/17

FORT WASHINGTON MEDICAL CENTER

By: _____

Name: REGINALD JONES

Title: Interim President & CEO

Date: 5/25/17

EXHIBIT 22

On behalf of the Applicant, Shore Health System, Inc. ("SHS"), I hereby affirm that within the last ten years:

- No current or former owner or senior manager of SHS, its operator, or any related or affiliated entity (i) has been convicted of a felony or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony; or (ii) has received a determination of exclusion from participation in Medicare or State health care programs, with respect to a criminal conviction or civil finding of Medicare or Medicaid fraud or abuse; and

- Neither SHS, its operator, nor a current or former related or affiliated entity (i) has been convicted of a felony or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony; (ii) has received a determination of exclusion from participation in Medicare or State health care programs, with respect to a criminal conviction or civil finding of Medicare or Medicaid fraud or abuse; or (iii) has paid fines, penalties, or entered a monetary settlement that exceeds$10,000,000 with or without an admission or finding of guilt with respect to any criminal or civil charges or investigation relating to allegations of Medicare or Medicaid fraud or abuse.

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

11/28/2022
Date

Signature of Owner or Board-designated Official

President & CEO
Position/Title

Kenneth D. Kozel, MBA, FACHE
Printed Name

EXHIBIT 23

LETTERS OF SUPPORT

Table of Content

25.	Amy L. Kreiner President/CEO	Talbot County Chamber of Commerce
26.	Beth Anne Dorman (Langrell) President/CEO	For All Seasons Inc.
27.	Maria Maguire Health Officer	Talbot County Health Department
28.	Johnny Mautz Member – Economics Matters Committee	The Maryland House of Delegates
29.	Michael A. Meoli President	The Meoli Companies
30.	David Milligan Chair	UM Shore Regional Health Board of Directors
31.	James J. Moran President	The County Commissioners of Queen Anne's County
32.	Nicole Morris, MSN, RN Director	Mid Shore Health Improvement Coalition
33.	Patrick Mutch President and CEO	Chase Brexton Health Care
34.	Laurence J. Pezor, MD Medical Director & Chairman	University of Maryland Shore Regional
35.	Sara Rich, MPA President & CEO	Choptank Community Health
36.	Stephen W. Rideout Mayor	City of Cambridge
37.	William Rosenberg, M.S., NRP, CCEMT-P President & CEO	Butler Medical Transport
38.	Tracey Snyder Executive Director	Caroline County Chamber of Commerce
39.	William Webb, MS Health Officer	Kent County Health Department
40.	Robert C. Willey Mayor	Town of Easton

Christopher T. Adams
Legislative District 37B
Caroline, Dorchester, Talbot,
and Wicomico Counties

Economic Matters Committee

Subcommittees
Banking, Consumer Protection,
and Commercial Law
Business Regulation
Unemployment Insurance

The Maryland House of Delegates
6 Bladen Street, Room 405
Annapolis, Maryland 21401
410-841-3343 · 301-858-3343
800-492-7122 *Ext.* 3343
Christopher.Adams@house.state.md.us

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

December 14 2022

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Maryland Health Care Commission,

Please accept this letter of support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved location, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. I am hopeful that this new facility will enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members, and all staff needed for the daily operations of the hospital.

This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region.

I applaud the University of Maryland Shore Regional Health's intention to build a new hospital in Easton and give my full support to their CON application and to their regional service delivery plan. Should you have any questions, please do not hesitate to call me.

Sincerely,

Christopher T. adams

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

MARSHY HOPE
FAMILY SERVICES LLC

813-1 CHESAPEAKE DRIVE
CAMBRIDGE, MD 21613
PHONES: 410-221-2266
FAX: 410-221-2878

December 21, 2022

To Whom It May Concern:

I'm writing in support of Psychiatric Inpatient beds for our new regional hospital on the Eastern Shore. There is no doubt we have a mental health shortage which is reaching crisis proportions through out the United States.

Losing Inpatient beds would further the crisis and create great hardship to local residents. Any expansion of beds or services would be welcomed.

Sincerely,

Donna L Beitel, M.D.
Board Certified Psychiatrist

Cc: Laurence Pezor, M.D.

COMMUNITY BEHAVIORAL HEALTH
www.communitybehavioralhealth.net
Phone: (844) 224-5264
Fax: (888) 509-0010

December 1, 2022

Shyam Bhayani
Chief Administrator
Community Behavioral Health, LLC
821 Eastern Shore Drive
Salisbury
21804

Dear Maryland Health Care Commission,

RE: Letter of Support to Shore Regional Health's Services in Easton, Maryland.

On behalf of Community Behavioral Health, LLC, I wanted to express my support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come; especially to an agency that has been reputed to meet the needs of the local populations with the recent new sites on the eastern shore of Maryland.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. Additionally, this will improve access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

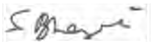
We have always supported the University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for the populations.

As one of the largest behavioral health providers in this community, we appreciate the infrastructure improvement for psychiatric services that will result from the new regional medical center, particularly given the disproportionate need for mental health care services in our region. The University of Maryland Medical System and University of Maryland Shore

Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan.

It is my humble request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,



Shyam Bhayani
Chief Administrator

Cc: Ken Kozel, CEO, UM Shore Regional Health 219 S. Washington St., Easton, MD 21601

Arvin Singh, Vice President, Strategic Planning & Communications, UM Shore Regional Health 219 S. Washington St., Easton, MD 21601

CAROLINECOUNTY
you belong here
CAROLINE COUNTY COMMISSIONERS OFFICE

JAMES TRAVIS BREEDING, PRESIDENT
LARRY C. PORTER, VICE PRESIDENT
NORMAN FRANKLIN BARTZ, III., COMMISSIONER
109 Market Street, Room 123
Denton, Maryland 21629

December 20, 2022

Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215

Dear Maryland Health Care Commission:

On behalf of the Caroline County Commissioners, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care, and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

COUNTY COMMISSIONERS OF
CAROLINE COUNTY, MARYLAND
James Travis Breeding, President

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

THE COMMISSIONERS OF ST. MICHAELS

SETTLED 1670-1680

INCORPORATED 1804

300 MILL STREET
P.O. BOX 206
ST. MICHAELS, MD 21663

TELEPHONE: 410.745.9535

FACSIMILE: 410.745.3463

December 13, 2022

Dear Maryland Health Care Commission:

On behalf of the Commissioners of St. Michaels, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. We are confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Mr. David H. Breimhurst
Commissioners of St. Michaels, President

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

SANTÉ

12/22/2022

Dear Maryland Health Care Commission:

On behalf of _Affiliated Santé's Eastern Shore Crisis Response_ I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. Moreover, as behavioral health providers in this community, we appreciate the infrastructure improvement for psychiatric services that will result from the new regional medical center, particularly given the disproportionate need for mental health care services in our region. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Tina M. Brown

Tina Marie Brown, LCSW-C
Director

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

COUNTY COUNCIL OF TALBOT COUNTY
COURT HOUSE
11 N. WASHINGTON STREET
EASTON, MARYLAND 21601-3178
PHONE: 410-770-8001
FAX: 410-770-8007
TTY: 410-822-8735
www.talbotcountymd.gov

CHUCK F. CALLAHAN, President
PETE LESHER, Vice President

KEASHA N. HAYTHE
LYNN L. MIELKE
DAVE STEPP

December 13, 2022

Randolph S. Sergent, Esq.
Chairman
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Certificate of Need (CON) Application for University of Maryland Shore Regional Health

Dear Chairman Sergent and Commission Members:

On behalf of the Talbot County Council, I write to express our strong support for the University of Maryland Shore Regional Health's Certificate of Need (CON) application which outlines their plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center to be located on Route 50 in Easton, Maryland. This new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high-quality care and increase patient and staff satisfaction.

The Council supports University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate

care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan.

Therefore, the Council respectfully requests that the Maryland Health Care Commission give strong consideration and approve University of Maryland Shore Regional Health's CON application.

Sincerely,

COUNTY COUNCIL OF TALBOT COUNTY

Chuck F. Callahan, President

CFC/jkm

cc: Ben Steffen, Executive Director, Maryland Health Care Commission
Ken Kozel, CEO, University of Maryland Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

Channel Marker

MENTAL HEALTH AND WELLNESS SUPPORT

Building Trust, Hope, and Dignity

December 21, 2022

Dear Maryland Health Care Commission:

On behalf of **Channel Marker, Inc,** I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come. I was born in the current hospital, I have lived in this community for 55 years, and I have worked in my behavioral health organization for 32 years and understand the importance of this project.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction. In my agency, we also struggle with staff recruitment and retention and I have seen how the rural workforce crisis is affecting the workforce at the hospital.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. Moreover, as a behavioral health provider in this community, we appreciate the infrastructure improvement for psychiatric services that will result from the new regional medical center, particularly given the disproportionate need for mental health care services in our region. Our organization has served clients with severe mental illness for 40 years and we have collaborated with the hospital, as our clients are often utilizing the ED and the inpatient unit for both mental and physical health issues. Our relationship has always been positive and collaborative. **The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.**

Sincerely,

Cathy Cassell

Cathy Cassell, LCSW-C
CEO

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

8865 GLEBE PARK DRIVE, UNIT 1 • EASTON, MARYLAND 21601
PH: 410.822.4619 • FX: 410.822.0984
WWW.CHANNELMARKER.ORG

DORCHESTER CHAMBER OF COMMERCE, INC.

306 High Street, Cambridge, MD 21613
410-228-3575
info@dorchesterchamber.org
www.dorchesterchamber.org

December 27, 2022

Dear Maryland Health Care Commission:

I am sending this letter on behalf of the Dorchester Chamber of Commerce to express our support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street in Easton with a new Regional Medical Center on Route 50 in Easton, Maryland. We believe this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

The proposed project demonstrates the University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health are uniquely dedicated to this rural region. We support their intention to build a new hospital in Easton and as a result we give our support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

William Christopher
President/CEO

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

Queen Anne's County Department of Health
206 N. Commerce Street, Centreville, MD 21617-1049
Tel. 410-758-0720 • 410-778-0993 • Fax: 410-758-2838

December 13, 2022

Dear Maryland Health Care Commission:

On behalf of Queen Anne's County Department of Health, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. We are confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our Mid-Shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Joseph Ciotola, Jr., M.D.
Health Officer

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

Your time.Your place.
Chesapeake College

December 5, 2022

Dear Maryland Health Care Commission:

On behalf of Chesapeake College, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Clifford P. Coppersmith, Ph.D.
President

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

MARYLAND RURAL HEALTH ASSOCIATION

January 3, 2022

Jonathan Dayton
Executive Director
Maryland Rural Health Association
P.O. Box 3128 LaVale, MD 21504

Dear Maryland Health Care Commission,

On behalf of the Maryland Rural Health Association (MRHA), I express strong support for the University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. MRHA is confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance the University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members, and all staff needed for the hospital's daily operations. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support the enhanced provision of high-quality care and increase patient and staff satisfaction.

We strongly support the University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with the building of the new Easton Regional Medical Center. The proposed project demonstrates the University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and the University of Maryland Shore Regional Health have excellent reputations for quality care and are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and give our full support to their CON application and regional service delivery plan. We request the Maryland Health Care Commission approve the University of Maryland Shore Regional Health's CON application.

Sincerely,

Jonathan Dayton, MS, NREMT, Executive Director

Cc: Ken Kozel, CEO, UM Shore Regional Health 219 S. Washington St., Easton, MD 21601
Arvin Singh, Vice President, Strategic Planning & Communications, UM Shore Regional Health
219 S. Washington St., Easton, MD 21601

MID SHORE
BEHAVIORAL HEALTH

28578 Mary's Court, Suite 1
Easton, MD 21601
Office: 410-770-4801
Fax: 410-770-4809

December 7, 2022

Dear Maryland Health Care Commission:

On behalf of Mid Shore Behavioral Health, Inc., I am writing to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the mid-shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. Moreover, as the behavioral health systems managers in this community, we appreciate the infrastructure improvement for psychiatric services that will result from the new regional medical center, particularly given the disproportionate need for mental health care services in our region. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton, and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Kathryn G. Dilley, LCSW-C

Executive Director

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

State of Maryland

Maryland Institute for Emergency Medical Services Systems

653 West Pratt Street
Baltimore, Maryland
21201-1536

Larry Hogan
Governor

Theodore R. Delbridge, MD, MPH
Executive Director

410-706-5074
FAX 410-706-4768

December 22, 2022

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Commissioners:

On behalf of the Maryland Institute for Emergency Medical Services Systems (MIEMSS), please accept my wholehearted support for the University of Maryland Shore Regional Health's plan to build a new regional medical center on Route 50 in Easton, Maryland. I am confident that this state-of-the-art facility will serve as the acute care hub for emergency and advanced inpatient care needs of the mid-shore community for the foreseeable future.

MIEMSS is particularly enthusiastic about the potential to improve access to high-quality emergency care. The current facility on Washington Street in Easton is woefully dated and a challenging environment in which to deliver the state-of-the art care Eastern Shore residents deserve. We are optimistic that the Health Care Commission will approve building plans that will ensure adequate inpatient and emergency department capacity to facilitate efficient arrival by emergency medical services and transfer of patient care to emergency department staff. These factors are important and relevant to the community health and public safety of the region the new facility will serve.

We understand the hospital replacement plans are crucial to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. In addition to improving access for all, the new facility will enhance University of Maryland Shore Regional Health's ability to recruit and retain clinicians, nurses, support service team members, and all staff needed for hospital operations.

The proposed project demonstrates University of Maryland Shore Regional Health's commitment to improving access to quality health care. We hope the Health Care Commission will reach the same conclusion.

The University of Maryland Medical System and University of Maryland Shore Regional Health are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and give our full support to their Certificate of Need (CON) application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve the University of Maryland Shore Regional Health CON application.

Sincerely,

Theodore R. Dlebridge, MD, MPH

Exceutive Director

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

Mid-Shore Community Foundation
The Bullitt House, 102 East Dover Street, Easton, MD 21601 | 410.820.8175 | MSCF.ORG

December 5, 2022

Dear Maryland Health Care Commission:

On behalf of the Mid-Shore Community Foundation, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high-quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

W.W. "Buck" Duncan
Mid-Shore Community Foundation President

cc: Ken Kozel, CEO, UM Shore Regional Health and Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

ADDIE C. ECKARDT
Legislative District 37
Caroline, Dorchester, Talbot
and Wicomico Counties

Budget and Taxation Committee

Health and Human Services
Subcommittee

Joint Committees
Administrative, Executive,
and Legislative Review

Audit

Children, Youth, and Families

Fair Practices and
State Personnel Oversight

Pensions

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Annapolis Office
James Senate Office Building
11 Bladen Street, Room 322
Annapolis, Maryland 21401
410-841-3590 · 301-858-3590
800-492-7122 *Ext.* 3590
Fax 410-841-3087 · 301-858-3087
Adelaide.Eckardt@senate.state.md.us

District Office
601 Locust Street, Suite 202
Cambridge, MD 21613
410-221-6561

December 14, 2022

Maryland Health Care Commission

Re: New Shore Regional Health Medical Center in Easton, Maryland Certificate of Need (CON) Application

To whom it may concern,

I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high-quality care and increase patient and staff satisfaction.

I strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Senator Addie C. Eckardt

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

The County Commissioners of Kent County
Ronald H. Fithian, President | Albert H. Nickerson, Member | John F. Price, Member
Shelley L. Heller, County Administrator | Thomas N. Yeager, County Attorney

December 20, 2022

Ken Kozel, President, and CEO
University of Maryland Shore Regional Health
P.O. Box 660
Denton, MD 21629

RE: Letter of Support, New Regional Medical Center

Dear Mr. Kozel:

We are pleased to provide this letter of support of University of Maryland Shore Regional Health (UMSRH) in your application to the Maryland Health Care Commission seeking approval to replace the existing Easton hospital with a new Regional Medical Center in Talbot County.

We support the investment and support UMSRH's commitment to improving the quality of and regional access to health care to Kent County citizens.

Very truly yours,
THE COUNTY COMMISSIONERS
OF KENT COUNTY, MARYLAND

Ronald H. Fithian, President | Albert H. Nickerson, Member | John F. Price, Member

KCC/tlt
cc: Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

Town of Chestertown

118 N. Cross Street, Chestertown, MD 21620
tel: 410-778-0500 fax: 410-778-4378
email: office@chestertown.com
url: www.townofchestertown.com

December 22, 2022

Dear Maryland Health Care Commission:

As Mayor of Chestertown, I write to express my strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital complex at 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. When built, this proposed state-of-the-art facility would serve as the regional acute care hub for advanced inpatient care needs of the mid-shore area for decades to come. It is the Town's firm understanding that this new facility is designed to complement rather than be a substitute for the services currently provided by UM Shore Regional Health in Chestertown.

The hospital replacement plans are critical to the future comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. The new site on Maryland Route 50 will offer easier, safer, and faster access to care for almost all residents of the five-county Mid-Shore region. In addition to improving access and visibility for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital.

The design plan of the new hospital includes all private rooms, more space for visitors and gathered family, efficient patient, and team member flow configurations. It will support the provision of high-quality enhanced care and should increase patient and staff satisfaction.

I strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has developed for the region in recent years. Hopefully, their plan will culminate in the building of the new Easton Regional Medical Center. The project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. I applaud their efforts to plan and construct a new hospital in our region and we give our full support to their CON application and to their regional service delivery plan. I recommend that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

David Foster
Mayor of Chestertown

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

Town of Denton
4 N. Second Street
Denton, Maryland 21629
Phone (410)-479-2050 Fax (410)-479-3534

December 13, 2022

Arvin Singh
Via email: Arvin.Singh@umm.edu

Re: Letter of support
University of Maryland Shore Regional Health – Easton Hospital

Dear Maryland Health Care Commission:

On behalf of the Town of Denton, I write to express strong support for the University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care, and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Scott W. Getchell, PO
Town Administrator

December 5, 2022

COMPASS
hospice | grief services | supportive care

Dear Maryland Health Care Commission:

On behalf of Compass Regional Hospice, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. Our organization is confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Heather A. Guerieri, RN, MSN

CEO, Compass

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

160 Coursevall Drive, Centreville, MD 21617 | O: 443-262-4100 | F: 410-758-2185
info@compassregionalhospice.org | compassregionalhospice.org

Dorchester County Department of Health

"Working for Healthier People"

3 Cedar Street
Cambridge, MD 21613

www.dorchesterhealth.org

Tel# (410) 228-3223
FAX# (410) 228-9319

Roger L. Harrell, MHA, Health Officer

December 27, 2022

Dear Maryland Health Care Commission:

On behalf of Dorchester County Health Department, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Roger L. Harrell, MHA
Health Officer

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

December 22, 2022

WILLOW
CONSTRUCTION

Dear Maryland Health Care Commission:

On behalf of Willow Construction, LLC, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. We are confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Michael S. Hiner, President

CC: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

120 Banjo Lane
Centreville, Maryland 21617
Phone (410) 758-2211

CORSICA RIVER

Providing Behavioral Health Services on the Mid-Shore

Corsica River Mental Health Services is a subsidiary of Crossroads Community

Fax (410) 758-0698
www.crmhsinc.com

December 21, 2022

Maryland Health Care
Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Maryland Health Care Commissioners:

On behalf of Corsica River Mental Health Systems, Inc., and Crossroads Community, Inc., I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility, and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high-quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. Moreover, as behavioral health providers in this community, we appreciate the infrastructure improvement for psychiatric services that will result from the new regional medical center, particularly given the disproportionate need for mental health care services in our region. The University of Maryland Medical System and University of Maryland Shore Regional Health are uniquely dedicated to this rural region. We applaud their intention to build a new hospital

120 Banjo Lane
Centreville, Maryland 21617
Phone (410) 758-2211

CORSICA RIVER

Providing Behavioral Health Services on the Mid-Shore

Corsica River Mental Health Services is a subsidiary of Crossroads Community

Fax (410) 758-0698
www.crmhsinc.com

in Easton and we give our full support to their Certificate of Need (CON) application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Holly R. Ireland
Executive Director

Cc: Ken Kozel, CEO, UM Shore Regional Health 219 S. Washington St., Easton, MD 21601
Arvin Singh, Vice President, Strategic Planning & Communications, UM Shore Regional Health

219 S. Washington St., Easton, MD 21601

BOARD MEETING:
2ND AND 4TH TUESDAY OF EACH MONTH

(410) 226-5122

101 Market Street
P.O. Box 339
Oxford, Maryland 21654

Commissioners of Oxford

December 13, 2022

Dear Maryland Health Care Commission:

On behalf of the citizens of the Town of Oxford, we are writing to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. We are confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

On behalf the Town of Oxford,

James Jaramillo, Commission President

Brian Wells, Commissioner

Tom Costigan, Commissioner

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

TALBOT COUNTY
CHAMBER OF COMMERCE

111 N. WEST STREET | POST OFFICE BOX 1366
EASTON, MD 21601

December 27, 2022

Dear Maryland Health Care Commission:

On behalf of the Talbot County Chamber of Commerce, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new Easton Regional Medical Center. The proposed project demonstrates the University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Amy L. Kreiner
President/CEO
cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

O: 410.822.4653
E: info@talbotchamber.org
W: www.talbotchamber.org

FOR ALL SEASONS
Behavioral Health & Rape Crisis Center
help • hope • healing

January 3, 2022

Dear Maryland Health Care Commission:

On behalf of For All Seasons, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. We are confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. Moreover, as behavioral health providers in this community, we appreciate the infrastructure improvement for psychiatric services that will result from the new regional medical center, particularly given the disproportionate need for mental health care services in our region. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Beth Anne Dorman (Langrell)

Beth Anne Dorman (Langrell)
President / CEO

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

PHONE: (410) 819-5600
TOLL FREE: 1-877-810-7184

FAX: (410) 819-5690
TTY: 1-800-735-2258 MD RELAY

100 S. HANSON STREET, EASTON, MD 21601
Maria Maguire, MD, MPP, Health Officer

December 16, 2022

Dear Maryland Health Care Commission:

On behalf of Talbot County Health Department, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

SIGNATURE: Maria Maguire
NAME: Maria Maguire
TITLE: Health Officer

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

JOHNNY MAUTZ
Legislative District 37B
Caroline, Dorchester, Talbot,
and Wicomico Counties

Economic Matters Committee

The Maryland House of Delegates
6 Bladen Street, Room 424
Annapolis, Maryland 21401
410-841-3429 · 301-858-3429
800-492-7122 *Ext.* 3429
Fax 410-841-3523 · 301-858-3523
Johnny.Mautz@house.state.md.us

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

December 16, 2022

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Maryland Health Care Commission:

We are writing to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland.

This new facility will serve as the hub for delivering ever-improving and accessible health care throughout our rural region. The University of Maryland Shore Regional Health have gone to great lengths, for nearly two decades, to improve health care by implementing all the initiatives for our new rural, regional health care plan. Approval of this application is critical to completing the plan and we support it wholeheartedly.

We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application. We fully support this project, and thank you for your consideration. Please contact our office with any questions at johnny.mautz@house.state.md.us or 443-746-3091.

Sincerely,

JOHNNY MAUTZ
Member – Economic Matters Committee

the meoli companies

December 5, 2022

Dear Maryland Health Care Commission:

On behalf of Golden Hospitality Group, LLC, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Michael A. Meoli
President

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

219 South Washington Street
Easton, MD 21601
410-822-1000
umshoreregional.org

December 19, 2022

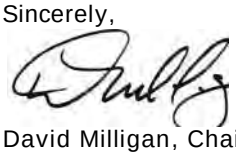
Dear Maryland Health Care Commission:

On behalf of the University of Maryland Shore Regional Health Board of Directors, I write to express our strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our Mid-Shore community for years to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient, family, and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality and safe care and they are uniquely dedicated to this rural region. We fully support their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,



David Milligan, Chair
UM Shore Regional Health Board of Directors

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

Queen Anne's County

County Commissioners:
James J. Moran, At Large
Jack N. Wilson, Jr., District 1
J. Patrick McLaughlin, District 2
Philip L. Dumenil, District 3
Christopher M. Corchiarino, District 4

THE COUNTY COMMISSIONERS OF QUEEN ANNE'S COUNTY
The Liberty Building
107 North Liberty Street
Centreville, MD 21617

e-mail: QACCommissioners&Administrator@qac.org

County Administrator: Todd R. Mohn, PE
Executive Assistant to County Commissioners: Margie A. Houck
County Attorney: Patrick Thompson, Esquire

December 15, 2022

Dear Maryland Health Care Commission:

On behalf of Queen Anne's County Commissioners, we are writing to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the existing hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. We are confident that this new state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from the current location in the residential part of Easton, the new location on Route 50 near the Talbot County Community Center will increase visibility as well as offer easier and safer access to care for all residents of the five-county Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the facility. Likewise, the design plan of the new hospital, which includes all private rooms, added space for visitors and family gatherings, and efficient patient and team member flow configurations will support enhanced provision of high-quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building this state-of-the art Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have outstanding reputations for quality care and they are uniquely dedicated to our rural community. We appreciate their intention to construct a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We respectfully request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application so our excellent healthcare may continue in this community.

Sincerely,

QUEEN ANNE'S COUNTY

BOARD OF COUNTY COMMISSIONERS

James J. Moran, President

cc: Ken Kozel, CEO, UM Shore Regional Health

Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

December 19, 2022

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

MID SHORE
HEALTH IMPROVEMENT COALITION

Dear Maryland Health Care Commission:

On behalf of the Mid-Shore Health Improvement Coalition, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. We are confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,
Nicole Morris

Nicole Morris, MSN, RN
Director

Cc: Ken Kozel, CEO, UM Shore Regional Health
219 S. Washington St., Easton, MD 2160

Arvin Singh, VP, Strategic Planning & Communications, UM Shore Regional Health
219 S. Washington St., Easton, MD 21601

Mid Shore Health Improvement Coalition
125 S. Lynchburg St., Chestertown, MD, 21620
www.midshorehealth.org

Chase Brexton Health Care

Mt. Vernon Center • 1111 North Charles Street • Baltimore, MD 21201 • 410.837.2050 • chasebrexton.org

December 22, 2022

Dear Maryland Health Care Commission:

On behalf of Chase Brexton Health Care, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. Chase Brexton Health Care is a federally qualified community health center organization with an outpatient office in Easton located in the Cadmus Office complex. I am confident that the new, Shore Regional Health state-of-the-art facility will serve as the regional acute care hub for advanced inpatient and outpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

Chase Brexton Health Care considers Shore Regional Health a partner in meeting the diverse healthcare needs of the communities we serve. We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care, and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Patrick Mutch
President and Chief Executive Officer

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Behavioral Health

219 S Washington Street
Easton, MD 21601
410-822-1000

December 26, 2022

Dear Maryland Health Care Commission:

On behalf of Shore Behavioral Health, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

I, along with the entire Shore Behavioral Health team, strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. Moreover, as behavioral health providers in this community, we appreciate the infrastructure improvement for psychiatric services that will result from the new regional medical center, particularly given the disproportionate need for mental health care services in our region. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Laurence J. Pezor, MD
Medical Director
Chairman,
Department of Psychiatry

Cc: Ken Kozel, CEO, UM Shore Regional Health 219 S. Washington St., Easton, MD 21601

Arvin Singh, Vice President, Strategic Planning & Communications, UM Shore Regional Health 219 S. Washington St., Easton, MD 21601

CHOPTANK
community health

December 5, 2022

Dear Maryland Health Care Commission:

On behalf of Choptank Community Health System, Inc., I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Sara Rich

Sara Rich, MPA
President & CEO
Choptank Community Health System, Inc.

CHOPTANK
community health

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

City of Cambridge

410 Academy Street, Cambridge, MD – P O Box 255
Phone: 410-228-4020 Fax: 410-228-4554
MD Relay (V/TTY) 711 or 1-800-735-2258
E-Mail info@choosecambridge.com

December 21, 2022

Dear Maryland Health Care Commission:

On behalf of the City of Cambridge, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

Sincerely,

Stephen W. Rideout
Mayor, City of Cambridge

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

December 26, 2022

Dear Maryland Health Care Commission:

On behalf of Butler Medical Transport, LLC, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

We strongly support University of Maryland Shore Regional Health's integrated service delivery plan and the transformative solutions it has implemented in each county in recent years. This plan will culminate with building the new, Easton Regional Medical Center. The proposed project demonstrates University of Maryland Shore Regional Health's steadfast commitment to improving the quality of and access to health care for our citizens. The University of Maryland Medical System and University of Maryland Shore Regional Health have excellent reputations for quality care and they are uniquely dedicated to this rural region. We applaud their intention to build a new hospital in Easton and we give our full support to their CON application and to their regional service delivery plan. We request that the Maryland Health Care Commission approve University of Maryland Shore Regional Health's CON application.

William Rosenberg

William Rosenberg, M.S., NRP, CCEMT-P
President & CEO

3108 Lord Baltimore Drive Suite 100 ● Windsor Mill, Maryland 21244 ● Phone 410.602.4007
Fax 410.602.4006 ● www.butlermedicaltransport.com ● MD Commercial Ambulance License # 105

12/22/2022

Dear Maryland Health Care Commission:

On behalf of Caroline County Chamber of Commerce, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

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Sincerely,

Tracey Snyder

Tracey Snyder
Executive Director

Caroline County Chamber
of Commerce

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

KENT COUNTY
HEALTH DEPARTMENT

COUNTY OF KENT

WILLIAM WEBB, HEALTH OFFICER
125 S. LYNCHBURG STREET, CHESTERTOWN, MARYLAND 21620 • PHONE: 410-778-1350

STATE OF MARYLAND

December 21, 2022

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

VIA:
Ken Kozel, President and CEO
University of Maryland Shore Regional Health
P.O. Box 660
Denton, MD 21629

Dear Maryland Health Care Commission:

The Kent County Health Department (KCHD) is pleased to provide this letter of support for the University of Maryland Shore Regional Health (UMSRH) in their application to the Maryland Health Care Commission seeking approval to replace the existing Easton Hospital with a new Regional Medical Center in Talbot County.

KCHD supports UMSRH's commitment and investment into delivering the highest quality of healthcare to the region. KCHD also supports the efforts to improve healthcare access to all Kent County citizens.

Sincerely,

William Webb MS,
Health Officer

cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

Town of Easton

14 S. Harrison Street, Easton, Maryland 21601
410-822-2525
bobwilley@town-eastonmd.com

Robert C. Willey
Mayor

December 13, 2022

Dear Maryland Health Care Commission:

On behalf of the Town of Easton, I write to express strong support for University of Maryland Shore Regional Health's plan to replace and relocate the current hospital on 219 S. Washington Street with a new Regional Medical Center on Route 50 in Easton, Maryland. I am confident that this new, state-of-the-art facility will serve as the regional acute care hub for advanced inpatient care needs of our mid-shore community for decades to come.

The hospital replacement plans are timely and critical to the comprehensive healthcare delivery plan Shore Regional Health has developed for the Mid-Shore region over the past decade. With improved regional access from today's location in the residential part of Easton, the new site on Route 50 near the Talbot County Community Center will increase visibility and offer easier and safer access to care for all residents of the five-county, Mid-Shore region. In addition to improving access for all, the new facility will also enhance University of Maryland Shore Regional Health's ability to recruit and retain providers, nurses, clinical and support service team members and all staff needed for the daily operations of the hospital. Likewise, the design plan of the new hospital, which includes all private rooms, more space for visitors and family gatherings, and efficient patient and team member flow configurations, will support enhanced provision of high- quality care and increase patient and staff satisfaction.

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Sincerely,

Robert C. Willey

Robert C. Willey
Mayor

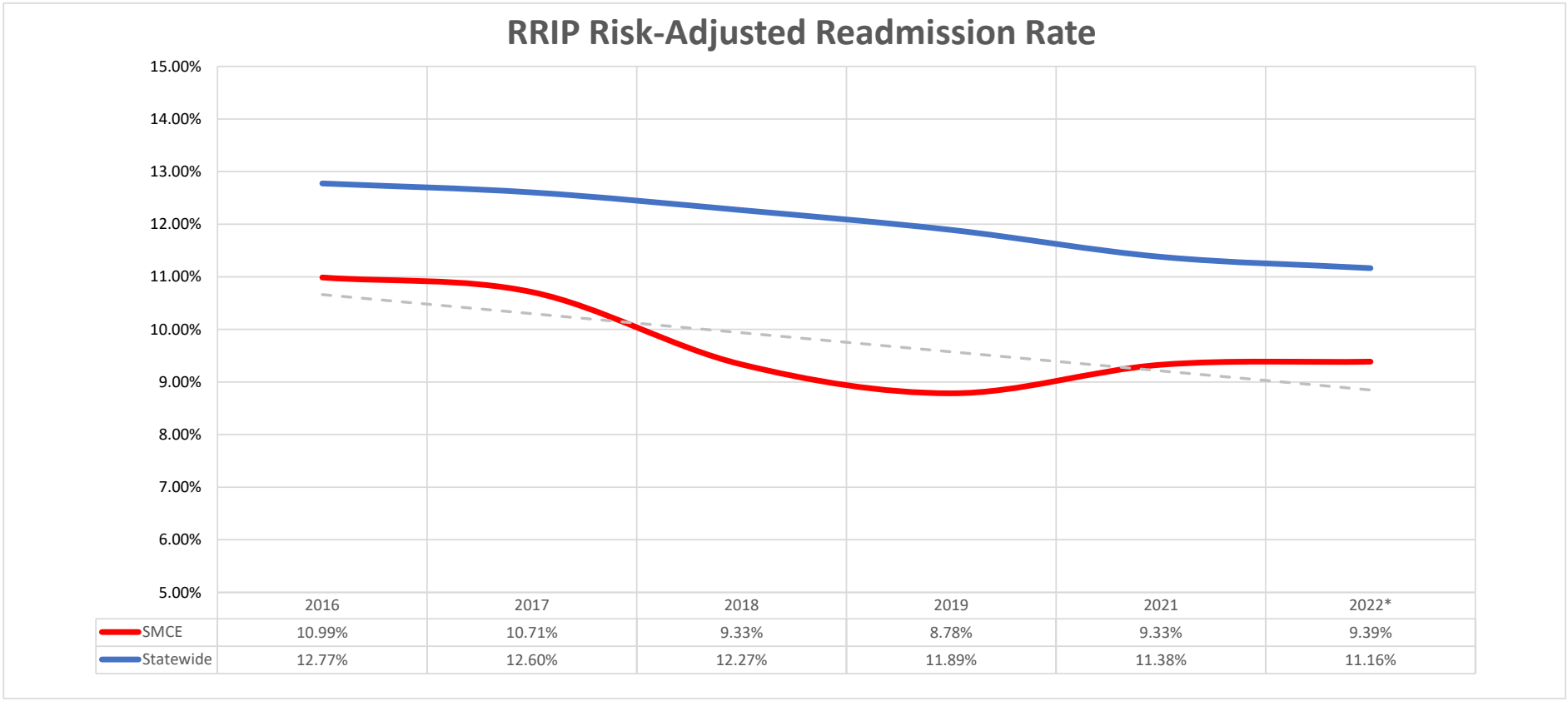
cc: Ken Kozel, CEO, UM Shore Regional Health
Arvin Singh, V.P. Strategic Planning & Communications, UM Shore Regional Health

EXHIBIT 24

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Reimbursement and Revenue Advisory Services

Shore Medical Center - Easton
Risk Adjusted Readmission Rate by Year
CY16 - CYTD22 July



	2016	2017	2018	2019	2021	2022*
SMCE	10.99%	10.71%	9.33%	8.78%	9.33%	9.39%
Statewide	12.77%	12.60%	12.27%	11.89%	11.38%	11.16%

NOTES: *Based on CYTD2022 July Data.
v39 APR DRG Grouper & RY24 RRIP Program Criteria
2020 data not included since quality programs were cancelled due to the pandemic

EXHIBIT 25

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

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

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

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.

Building a better working world

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.

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.

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

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.

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.

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.

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.

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.

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

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)**

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.

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)

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

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).

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.

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.

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.

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.

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.

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

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

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%

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%

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.

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.

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

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.

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.

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)

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.

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.

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).

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: Medical Center	Upper Chesapeake Hospitals: Harford Memorial	University of Maryland Capital Region Health Hospitals	All Other Entities	Eliminations	Consolidated Total
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 26

MARYLAND HEALTH CARE COMMISSION

Certificate of Need

TO: Jeffrey L. Johnson, Vice President
Shore Health System
219 South Washington Street
Easton, Maryland 21601

July 17, 2003
(Date)

RE: Capital Renovation and Expansion to
Memorial Hospital at Easton

03-20-2112
(Docket Number)

PROJECT DESCRIPTION

The Memorial Hospital at Easton (Memorial-Easton), located in Talbot County, is a 132-bed acute general hospital with a 33-bed comprehensive care facility. The hospital provides a complete range of inpatient and outpatient services, and has served residents of Talbot, Caroline, Dorchester, Queen Anne's and surrounding counties since 1907. Memorial-Easton applied for Certificate of Need approval from the Maryland Health Care Commission to renovate its Telemetry Unit, relocate and expand its Emergency Department, reconfigure space for outpatient services, and upgrade its heating, ventilating, and air-conditioning system and other elements of its infrastructure. No new services will be initiated as part of this project, and no additional beds will be required as a result of the expansion and renovation. The project's total capital cost is estimated at $33,430,000. The Health Services Cost Review Commission reviewed the project's capital expenditure and financial projections and found it financially feasible, even without a 2.5 percent rate increase, for which Memorial-Hospital intends to apply.

This project will be completed in two primary phases over two years: Phase 1, the construction of the Telemetry Unit, is to begin in August 2003, and be completed in August 2004; Phase 2 of the project, construction of a new Emergency Department and Outpatient Services space, will begin in January 2004, and be completed in 2005.

ORDER

The Commission has reviewed Staff's analysis, and, based on Staff's recommendation and the record in this matter, has awarded the project a Certificate of Need.

Memorial-Easton must submit quarterly status reports to the Commission, beginning three months from the date of Certificate of Need approval, and continuing through the completion of the project. In accordance with COMAR 10.24.01.12B, .12C(3), and .12C(4), the project is subject to the following performance requirements:

1. Obligation of not less than 51% of the certified capital expenditure as documented by binding construction contracts or equipment purchase orders no later than **July 17, 2005, 24** months after Certificate of Need approval.

2. Initiation of construction within **four (4) months** of the effective date of the binding construction contract;

3. Documentation from Memorial-Easton that the approved project has been completed, and has met all applicable legal requirements within **24** months of the required binding construction contract.

Failure to meet these performance requirements will render incomplete stages of this Certificate of Need void and of no further effect, subject to the Commission's finding and the requirements for due process found in COMAR 10.24.01.12.F through I.

If it is necessary to make any changes to the approved project before the first use of the expanded and renovated facility, the Memorial Hospital at Easton must notify the Commission, and must receive Commission approval of the 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.

The project's architect or engineer is required to contact the Plans Review and Approval office of the Department of Health and Mental Hygiene, to ascertain the specific information concerning project drawings and specifications that the law requires to be submitted and approved prior to the initiation of construction.

Since this project will be undertaken by an existing, operating health care facility, and none of its components require separate or additional licensure, the Commission requests notification of the completion at least 30 days before first use of the new or renovated space.

Please acknowledge in writing within 30 days that you have received this Certificate of Need, and accept its terms and conditions.

MARYLAND HEALTH CARE COMMISSION

Barbara Gill McLean
Executive Director

BGM/at
cc: Carol Benner
Brian Dubey
Robert Murray

MARYLAND HEALTH CARE COMMISSION

Certificate of Need

TO:	Jeffrey L. Johnson, Vice President Shore Health System The Memorial Hospital at Easton 219 South Washington Street Easton, Maryland 21601	September 14, 2004 (Date)
RE:	Establishment of a Twenty-Bed Acute Inpatient Rehabilitation Unit at The Memorial Hospital at Easton	03-20-2128 (Docket No.)

PROJECT DESCRIPTION

The Memorial Hospital at Easton ("Memorial-Easton"), a 132-bed acute general hospital in Talbot County on Maryland's Eastern Shore, has sought Certificate of Need ("CON") approval to establish a twenty-bed acute inpatient rehabilitation unit, providing comprehensive integrated inpatient rehabilitation ("CIIR") services in what is now the Memorial-Easton subacute care unit, on the hospital's fifth floor. The area intended for the proposed rehabilitation unit currently houses a skilled nursing unit with 33 comprehensive care facility beds; Memorial-Easton will seek authorization for temporary delicensure of these beds, and understands that it must obtain Commission action through an exemption from CON review for the permanent closure of the comprehensive care service at the hospital, pursuant to Health-General Article § 19-120(l)(2), Annotated Code of Maryland.

In order to convert its use to inpatient rehabilitation, Memorial-Easton will undertake a major interior renovation of the Five-South Unit, originally constructed in 1966, that would affect a total of 14,300 square feet of current hospital space. This includes 7,200 square feet to house the 20 inpatient rehabilitation beds (arrayed as 4 private and 8 semi-private patient rooms) and standard support space, to conform to the requirements of the 2001 edition of the *American Institute of Architects Guidelines for Design and Construction of Hospitals and Health Care Facilities*, and of the Americans with Disabilities Act; 4,200 square feet for rehabilitation spaces (including a gym, space for dining and recreation, and a kitchen and bathroom facilities for therapies related to activities of daily living) and also offices for the rehabilitation staff; 1,700 square feet for mechanical needs, utilities, stairs, elevators, and other structural details; and 1,200 square feet of space for use by staff of Memorial-Easton's Maternal Health Unit, to replace space taken by the rehabilitation renovations.

Memorial-Easton proposes to complete its construction-level architectural design for the rehabilitation unit within five months of CON approval, and to complete construction over 15 months, in two phases. Memorial-Easton estimates that the total cost to convert the 33-bed hospital-based skilled nursing facility to a 20-bed rehabilitation unit will be $4,287,520. Of this

total, proposed current capital costs account for $3,785,000, $422,520 is budgeted as an inflation allowance and for capitalized construction interest, and $80,000 is allocated to financing costs and other cash requirements, including legal and auditing costs. The source of funds for the Memorial-Easton project will be $230,000 in cash, and $4,057,520 in authorized bonds, issued by the Maryland Health and Higher Education Facilities Authority, although a later communication from Memorial-Easton explained that the hospital may also investigate the possibility of self-funding the project, rather than seeking a bond issue from MHHEFA.

ORDER

The Maryland Health Care Commission has reviewed Staff's report and recommendation on the Certificate of Need application submitted by The Memorial Hospital at Easton, and, based on this analysis and the record in this review, approved its application for Certificate of Need on September 14, 2004. The Commission imposed no additional conditions on the approval.

In accordance with COMAR 10.24.01.12C(3)(c), the project is subject to the following performance requirements:

1. Obligation of not less than 51% of the approved capital expenditure, as documented by a binding construction contract, by March 14, 2006, 18 months after the September 14, 2004 Certificate of Need approval;

2. Initiation of construction within four (4) months of the effective date of the binding construction contract;

3. Documentation from Memorial-Easton that it has completed the project; received a State license, if licensure is required, or has otherwise met all applicable legal requirements to begin operation; and has begun to provide the approved service, within 18 months of the effective date of the binding construction contract.

Memorial-Easton must notify the Commission when the hospital executes the binding construction contract, because the deadlines for meeting the second and third performance requirements are set based on the compliance with Performance Requirement 1.

Commission regulations at COMAR 10.24.01.13B require Memorial-Easton to submit quarterly status reports, beginning December 14, 2004, three months from the date of this Certificate of Need, and continuing through the completion of the project.

Before making any changes to the facts in the Certificate of Need application approved by the Commission, Memorial-Easton 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.

The project's architect or engineer is required to contact the Plans Review and Approval section of the Department of Health and Mental Hygiene, to ascertain the specific information concerning the project's drawings and specifications that the law requires to be submitted and approved prior to the initiation of construction.

Please acknowledge in writing within thirty days that you have received this Certificate of Need, and that you accept its terms and conditions.

MARYLAND HEALTH CARE COMMISSION

Barbara Gill McLean
Executive Director

cc: Carol Benner, Office of Health Care Quality
Kathleen Foster, Health Officer, Talbot County
Howard Jones, Office of Plans Review, DHMH
Robert Murray, Executive Director, HSCRC

MARYLAND HEALTH CARE COMMISSION

Certificate of Conformance

TO: Kenneth D. Kozel
President and Chief Executive Officer
University of Maryland Shore Medical Center at Easton
219 S. Washington Street
Easton, Maryland 21601

April 11, 2016
(Date)

RE: Emergency and Elective Percutaneous Coronary Intervention Services

CC-15-20-0001
(Docket No.)

SERVICE DESCRIPTION

This Certificate of Conformance authorizes the University of Maryland Shore Medical Center at Easton (UMSMC-E or Hospital) to establish both emergency (primary) and elective (non-primary) percutaneous coronary intervention (PCI) services. Emergency PCI includes PCI capable of relieving coronary vessel narrowing associated with ST-segment elevation myocardial infarction (STEMI) or STEMI equivalent, as defined by the Maryland Health Care Commission (MHCC) in COMAR 10.24.17. Elective PCI is PCI provided to a patient who is not suffering from STEMI or STEMI equivalent, but whose condition is appropriately treated with PCI as provided in COMAR 10.24.17.

The Hospital estimates that the capital expenditure related to the establishment of emergency and elective PCI services will be $2,568,600, primarily for fixed equipment and building expenses.

ORDER

MHCC reviewed Staff's Report and Recommendation and, based on that analysis and the record in the review, ordered, on March 17, 2016, that a Certificate of Conformance with required conditions be issued authorizing the establishment of elective and primary PCI services at UMSMC-E if, on or before April 11, 2016, UMSMC-E provided documentation satisfactory to Commission staff that:

1. The Hospital has protocols for both routine and infrequent emergency situations, such as recurrent ischemia or infarction, failed angioplasty requiring emergency CABG surgery, and primary angioplasty system failure; and

2. The Hospital has executed an agreement that provides for 30-minute response time regardless of the circumstances.

The Hospital met the required conditions by providing satisfactory documentation on April 11, 2016. Specifically, UMSMC-E submitted: (1) its protocol for addressing conditions such as

recurrent ischemia or infarction and failed angioplasty requiring emergency coronary artery bypass graft surgery; and (2) a copy of an amended agreement with Best Care Ambulance, effective April 6, 2016, that provides for a 30-minute response time regardless of circumstances.

CONDITIONS

This Certificate of Conformance is issued with the following conditions:

1. At least 90 days prior to first use approval, UMSMC-E shall provide the names of its medical director and interventionalists on staff and documentation that each interventionalist on staff has achieved an average annual case volume of 50 or more PCI cases over the two-year period;

2. UMSMC-E shall agree to comply with the requirements for a Certificate of Ongoing Performance outlined at COMAR 10.24.17.07C and D;

3. UMSMC-E shall agree to voluntarily relinquish its authority to provide elective PCI or both emergency and elective PCI and close its program in a timely manner upon notice by the Executive Director of MHCC if it: (i) has failed to comply with standards for a Certificate of Ongoing Performance or a Certificate of Conformance; (ii) has been given an opportunity to address the deficiencies identified by the Commission through an approved plan of correction; and (iii) has failed to adequately correct the deficiencies.

4. UMSMC-E shall apply for a Certificate of Ongoing Performance on or before June 30, 2020.

ACKNOWLEDGEMENT OF RECEIPT OF CERTIFICATE OF CONFORMANCE

Acknowledgement of your receipt of this Certificate of Conformance, stating acceptance of its terms and conditions, is required within thirty (30) days.

MARYLAND HEALTH CARE COMMISSION

Ben Steffen
Executive Director

cc: Manjula Paul, Health Officer, Talbot County
Donna Kinzer, Executive Director, HSCRC
Kevin Seaman, M.D., F.A.C.E.P., Executive Director, MIEMMS