EXHIBIT 19

Maryland Perinatal System Standards

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;

Application Exhibit 6 documents the Board resolution on March 24, 2023 agreeing to meet the Maryland Perinatal System Standards as a Level II perinatal center.

(B) submission of patient care data to MD Department of Health and MD Institute for Emergency Medical Services Systems for system quality and management

LHDCMC will participate in the Maryland Perinatal System and submit patient care data to the Maryland Department of Health. As a member of Luminis Health, LHAAMC currently participates and will be a model for LHDCMC as it relates to appropriate data collection and reporting.

LHDCMC currently submits data to the Maryland Institute for Emergency Medical Services Systems, as appropriate for system and quality management.

(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.

Application Exhibit 6 documents the Board resolution, bylaws, contracts, budgets specific to the appropriate physical resources and infrastructure that are necessary to support the Level II Perinatal Program.

(1.2) The hospital shall be licensed by the Maryland Department of Health as an acute care hospital.

LHDCMC holds license number 16-022 as an acute general hospital from the Maryland Department of Health and Mental Hygiene (**Application Exhibit 14**). The FY2023 Licensed Bed Designation for LHDCMC is 200.

(1.3) The hospital shall be accredited by the Joint Commission.

LHDCMC is accredited by the Joint Commission and completed a successful survey from May 3, 2022 to May 6, 2022 (**Application Exhibit 15**).

(1.4) The hospital shall have an agreement with the Health Services Cost Review Commission that addresses how the cost of the 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.

LHDCMC is applying for a Level II Perinatal Program and is not required to meet this standard.

(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.

LHDCMC will own and maintain equipment and technology to support the program. As a member of Luminis Health, LHDCMC will benefit from the knowledge of LHAAMC regarding equipment and technology required for optimal care delivery.

(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.

LHDCMC is applying for a Level II Perinatal Program and is not required to meet this standard.

(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.

LHDCMC is applying for a Level II Perinatal Program and is not governed by this standard.

Standard II. Obstetrical Unit Capabilities

(2.1) The hospital shall demonstrate its capability of providing obstetrical care through written standards, protocols, or guidelines, including the following:

(A) management of uncomplicated pregnancy;

A protocol for the management of uncomplicated pregnancy was developed by Women's and Children's Committee on Quality and Safety at LHAAMC. LHDCMC will adapt the *Labor Management Protocol* **Exhibit a**: Labor Delivery, Recovery, Postpartum Policy developed by LHAAMC to meet the specific needs and regulations for a Level II perinatal center and special care nursery. The protocol defines induction, augmentation, protracted, and arrest of labor. Once adapted by LHDCMC, the protocol will aid in the standardization of the inpatient labor management including, fetal assessment, antenatal testing, and maternal management for medical providers and nursing staff. The protocol will provide consistent parameters for escalating concerns, and additional providers to be involved in the care of the patient.

(B) detection, stabilization and initiation of management of unanticipated maternal-fetal problems;

The Labor Management Protocol not only outlines the management of uncomplicated pregnancies but provides direction on when to escalate care as well as the signs and symptoms indicating a complicated pregnancy.

A policy that outlines when a neonatologist, neonatal nurse practitioner, and registered nurse will be present for deliveries will be developed with the assistance of a multidisciplinary team of providers and approved by LHDCMC members of the Luminis Health Women's and Children's Committee on Quality and Safety. An additional policy outlining criteria for admission to the Special Care Nursery will also be developed and will include neonates requiring ventilatory

support for 24 hours or less or those requiring positive pressure ventilation. Also, moderately ill neonates expected to improve within 24 hours will also have inclusion criteria. There will be a neonatal medical provider and a registered nurse in the hospital 24 hours a day, seven days a week to respond to emergencies.

Luminis Health Women's and Children's Committee on Quality and Safety at LHAAMC have developed a maternal safety bundle of protocols, that address a number of obstetrical emergencies including sepsis detection and management, hypertension and hemorrhage. A similar maternal safety bundle of protocols will be adopted at LHDCMC for care of the maternal patient with an unexpected emergency. There will be risk assessments for sepsis, hemorrhage and hypertension that aid in the standardization of care and expected outcomes. The risk assessments will be part of the electronic medical record system and are required fields to be completed. Twenty-four/seven coverage of all perinatal units by an Obstetrical Laborist, and anesthesiologist will promote the use of these protocols as appropriate.

Simulation of unanticipated emergencies, will be required by LHDCMC perinatal and neonatal providers and staff annually. The simulations provide continuing education and promote collaboration during emergency situations. In addition, all medical and nursing staff will be required to attend a multi-disciplinary Team STEPPS course within the first year of hire to enhance clear and direct communication in both emergent and non-emergent situations.

Luminis Health Women's and Children's Committee on Quality and Safety at LHAAMC have developed an emergency alert system for obstetrical and/or neonatal emergencies. In the event of an emergency at any location within the hospital with a maternal patient or neonate, an OB Neonatal Emergency Team (OBGYNNET) is called. First responders for OBGYNNET include the OB laborist, OB anesthesiologist, Labor and Delivery charge nurse, Special Care Nursery charge nurse, neonatal provider, and Labor and Delivery scrub technician. A similar emergency response alert system and program will be put into place at LHDCMC. This will be adapted to address the needs of the patients served and incorporate the appropriate emergency infrastructure in place at LHDCMC.

(C) fetal monitoring, including fetal scalp electrodes;

LHDCMC will adapt the LHAAMC Labor*, Delivery, Postpartum and Recovery* policy related to fetal monitoring, including the use of fetal scalp electrodes. The policy provides clear definitions, expectations, parameters, and actions for escalation. **Exhibit a: Labor, Delivery, Postpartum and Recovery Policy**

(D) ability to begin emergency Cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits and the provision of emergency care; and

The laborist model of care affords 24/7 coverage of labor and delivery, thus an obstetrician capable of performing an emergency cesarean delivery will be available at all times. LHDCMC will adapt the LHAAMC emergency C-section policies and protocols to meet the needs and regulations for Level II perinatal center and special care nursery. The policies and protocols will establish the guidelines for the ability to begin emergency C-Section delivery within a time interval that best incorporates maternal and fetal risks and benefits and the provision of emergency care. The policy states that a prepared surgical team including obstetrician, nurse, scrub tech and anesthesia will be on the unit 24 hours per day. One operating room will be available at all times, in the event of an emergency.

(E) selection and management of obstetrical patients at a maternal risk level appropriate for its capabilities. Exhibit b: Labor and Delivery Provision of Care (Section Admission).

The following patients will be appropriate for care in the Labor and Delivery at LHDCMC

- Infants with EFW ≥ 1500 grams and ≥ 32 weeks gestation
- Premature rupture of membranes of infants EFW ≥ 1500 grams and ≥ 32 weeks gestation
- Maternal Cervical ripening for an infant ≥ 32 weeks gestation and EFW ≥ 1500 grams
- Medical induction for an infant ≥ 32 weeks gestation and EFW ≥ 1500 grams
- Fetal death in utero without disseminated intravascular coagulopathy (DIC)
- Low risk women with uncomplicated pregnancies and women with higher-risk conditions as noted below:
    - Uncomplicated twin gestation – non-monochorionic
    - Labor after Cesarean delivery with known uterine scar
    - Pre-eclampsia without severe features, HELLP syndrome, oliguria, or pulmonary edema,
    - Well controlled gestational diabetes
    - Placenta Previa with or without previous uterine surgery or placenta accreta
    - Maternal medical conditions that do not require additional monitoring such as pregestational diabetes, poorly controlled asthma, or poorly controlled or complicated chronic hypertension
    - Anticipated complicated Cesarean delivery

(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.

LHDCMC is applying for a Level II Perinatal Program and is not required to meet this standard. Although this is an optional standard, LHDCMC is able to meet the needs of obstetrical patients requiring subspecialty care. The ICU is staffed by board certified critical care intensivists at all times. General surgery, infectious disease, neurology, nephrology and hematology are available and provide call services at all times. In addition, LHAAMC has a full complement of subspecialists and transfer capabilities between facilities will be established. Required competency to care for this special population is well understood by the clinical team at LHAAMC. Competency assessment and training where needed will be instituted. Mechanisms for care coordination to ensure patients who require subspecialty care are located in the appropriate setting will be in place.

<u>Standard III. Neonatal Unit Capabilities</u>

(3.1) The hospital shall demonstrate capabilities of providing neonatal care through written standards, protocols and guidelines, including those for the following:

(a) resuscitation and stabilization of the neonate according to the American Academy of Pediatrics/American Heart Association *Neonatal Resuscitation Program* (NRP) guidelines at every delivery;

An NRP-certified nurse will be present at every delivery, vaginal and C-section. Successful completion of the NRP certification will be required of all nursing staff and neonatal providers prior to completing orientation, as outlined in the competencies and job descriptions for Women and Children's Services registered nurses and medical staff. For cases when there are anticipated complications, the neonatal provider who has the skills to intubate, will be readily available. OB

anesthesiology will serve as medical back up to the neonatal provider. Respiratory Therapy, certified in NRP, will be notified of the complication, and readily available.
The Women's and Children's Services educators will be responsible for ensuring all staff complete the NRP certification annually.

(b) detection, stabilization and initiation of management of unanticipated neonatal problems;

All neonatal providers, nurse midwives and clinical staff will be required to complete NRP certification prior to the completion of orientation. The NRP guidelines will set the platform for the neonatal providers, nursing staff, and respiratory therapists to ensure a common ground for communication and standardization of the management of neonatal problems**. Exhibit c: Special Care Nursery Provision of Care** (Section Nursing Competencies).

The policies and protocols outline when, and who, is to attend deliveries. In addition, there will be policies and procedures for guidance in the management of common newborn problems to include, but not limited to, hyperbilirubinemia, hypoglycemia, respiratory distress, and Neonatal Abstinence Syndrome (NAS).

The neonatal provider and neonatal registered nurse will attend all high-risk deliveries. Attendance at C-sections will be at the discretion of the OB provider. There will be a neonatal provider and a neonatal registered nurse in the hospital 24/7 to respond to newborn emergencies. Established criteria will be developed for when a baby will be admitted to the Special Care Nursery. **Exhibit d: Special Care Nursery Attendance at Deliveries.**

Neonatal unexpected emergencies are addressed with activation of OBGYNNET. This emergency alert throughout the hospitals notifies key individuals including the OB laborist, OB anesthesiologist, Labor and Delivery charge nurse, Special Care Nursery charge nurse, neonatal provider, and Labor and Delivery scrub technician that their presence is required to assist with an emergency. A similar emergency alert system will be put into place at LHDCMC and will align with emergency alert systems currently in place at LHDCMC.

(c) evaluation and care of stable term newborn infants;

Upon arrival to Labor and Delivery the OB provider and the Labor and Delivery nurse will review the perinatal history, inclusive of labs, to anticipate and prepare for any potential complications. **An NRP-certified nurse will attend all deliveries**. Stated previously that protocol will be developed for attendees.

After delivery, vital signs will be taken every 30 minutes times four and every four hours thereafter for the first 24 hours. At the end of 24 hours of life, the vital signs will be taken every 12 hours unless indicated by the newborn's status. Vital signs for late pre-term infants will be assessed every eight hours throughout the infant's hospitalization.

Skin-to-skin contact will be encouraged for all stable newborns. Initial assessments will be performed and medications will be administered while the newborn is skin-to-skin, when the newborn and mother's conditions permit.

A physical assessment of the newborn will be performed by nursing within two hours of birth and twice a day until discharge. Late preterm infants will be assessed every eight hours. The neonatal provider responsible for unassigned newborns or the patient's attending pediatrician will be

notified immediately of any assessment parameters outside of normal limits. **All neonates will be examined prior to discharge by a neonatal provider or attending pediatrician.**

Additional assessment/screenings of the neonate will include hearing, glucose, bilirubin, newborn metabolic screen, critical congenital heart disease screening, and car seat testing, when indicated.

The goal throughout the hospitalization will be to provide care, support, and education to the mother and support person so they are comfortable at the time of discharge. **Exhibit a: Labor, Delivery, Recovery, Postpartum.**

(d) care of the infants convalescing after intensive care; and

Newborns no longer needing special care, not ready for discharge will be transferred to the Postpartum Unit. Newborns will be cared for by the neonatal provider or the patient's private pediatrician who has admitting privileges at LHDCMC.

(e) selection and management of neonatal patients at neonatal risk appropriate to its capability as outlined in the level of care.

The following patients will be candidates for the Special Care Nursery:

- Moderately ill neonates or stable growing low birth weight neonates born at or greater than 32 weeks gestation, and/or with a birth weight of ≥ 1500 grams.
- Moderately-ill infants who are not anticipated to need subspecialty care on an urgent basis.
- Infants requiring medical treatment and/or nursing interventions and assessment/reassessment of response to interventions more frequently than every four hours.
- Infants requiring a controlled temperature environment due to temperature instability.
- Infants with hemodynamic instability or unstable vital signs defined as:
    - Hypotension/hypertension according to gestational age/weight
    - Bradycardia/tachycardia according to gestational age
    - Tachypnea, defined as sustained respiratory rate >60 breaths/minute.
- Infants with umbilical arterial catheter, umbilical venous catheter, peripheral IV requiring continuous IV infusion, or peripheral arterial line.
- Cardiovascular
    - Arrhythmias/bradycardia requiring continuous monitoring/supportive treatment/diagnostic procedures
    - Cyanotic heart disease
- Respiratory
    - Infants requiring any oxygen support
    - Infants with apnea
    - Infants requiring positive pressure respiratory support for greater than 48 hour will require a neonatology consult with a Level III or IV NICU provider
    - Infants requiring oxyhood, nasal cannula, high-flow nasal cannula or NCPAP/SiPAP as long as the infant's condition is improving
- Neurologic
    - Infants with neurologic conditions requiring supportive treatment or diagnostic procedures including, but not limited to infants with potential/suspected seizure activity
- Gastrointestinal/Surgery/Nutritional

    - Infants requiring intermittent or continuous gavage feeds
- Hematologic
    - Infants with anemia resulting in hemodynamic and/or respiratory compromise
    - Infants requiring exchange transfusion
- Endocrine
    - Infants with persistent hypoglycemia
- Renal
    - Electrolyte disorders requiring IV therapy and frequent IV/PO correction
- Infectious Disease
    - Positive culture or suspected infection requiring IV antibiotics
- Hyperbilirubinemia not requiring exchange transfusion
- Neonatal Abstinence Syndrome
- Initial sepsis evaluation for an asymptomatic infant

Exhibit c: Special Care Nursery Provision of Care (Section Admission Criteria).

Standard IV. Obstetrical Personnel

Perinatal care for all women who present to LHDCMC, will be overseen and managed by a team of 24/7 physician laborists and certified nurse midwives (CNM) . This model of care promotes collaboration among providers from unique disciplines, while supporting the patient's choice for provider and birth experience. Providers can easily consult, share, or transfer care between the groups. Laborists comprised of both physicians and CNMs have been shown to decrease that rate of primary cesarean deliveries, a major quality initiative for our perinatal center. Nurse midwives will also assist in throughput on our perinatal units, by triaging patients, performing normal vaginal deliveries and leading in postpartum rounds for uncomplicated deliveries. The laborist team will cover unassigned emergencies, as well as patients who require emergent or urgent care when a patient's primary obstetrician or CNM is unavailable to provide such care due to multiple deliveries or emergencies. In addition, a physician, or CNM representative from each practice with delivering privileges will be required to be in house 24/7 to manage the perinatal care of the patients for their practice.

Indications for admission to labor and delivery are outlined in our labor and delivery management protocol and presented in **Exhibit b: Labor and Delivery Provision of Care** (Section Admission Criteria).

(4.1) Physician board-certified in OBGYN 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 OBGYN, shall be a member of the medical staff and have programmatic responsibility for OB Services.

The operational obstetrical physician leadership for LHDCMC will be appointed by the Luminis Health System Chair for Women's and Children's and will have a site leadership position for LHDCMC Perinatal Services. The physician leader of perinatal services will be board certified in obstetrics and gynecology, a member of LHDCMC medical staff, and a member of the Luminis Health Women's and Children's Committee on Quality and Safety (see **Exhibit b**: **Labor and Delivery Provision of Care** (Section Personnel).

Exhibit e: Mother Baby Provision of Care (Section Personnel).

Exhibit c: Special Care Nursery Provision of Care (Section Personnel).

In this capacity the LHDCMC leader of perinatal services will be responsible for overseeing the day-to-day perinatal operations in collaboration with nursing leadership. The physician-nursing leadership dyad will ensure the use of evidence-based practice guidelines. The LHDCMC perinatal leader will work with nursing leadership in the development of workflows and processes that efficiently use LHDCMC infrastructure and resources to execute the perinatal care process. They will also work with CNM leadership to maintain a call coverage schedule for all of the units. Furthermore, this leader will work with the residency program director to verify all learners participate as appropriate in clinical care and within ACGME guidelines.

(4.2) Physician board-certified in OBGYN shall be a member of the medical staff and have programmatic responsibility for obstetrical services.

LHDCMC will have obstetrics/gynecology board certified physician(s) as members of the medical staff who have responsibility for programmatic management of obstetrical services. The leader of perinatal services will be a board-certified physician and member of the medical staff. This medical director will have programmatic responsibility for all obstetrical services.

(4.3) Physician board-certified in maternal-fetal-medicine (MFM) shall be a member of the medical staff and have programmatic responsibility for obstetrical services.

Although an optional requirement for Level II designation, given that we are proposing dedicated antepartum beds with deliveries between 32 and 39 weeks, MFM leadership will function to work with the Committee on Quality and Safety to:

1. develop guidelines to support the infrastructure for the evaluation of antepartum patients
2. determine guidelines for the suitability of care in a Level II setting
3. determine guidelines for transfer to a higher level of care.
4. define guidelines that will govern the management of unexpected emergencies or changes in maternal health.

(4.4) Physician board-certified in maternal fetal medicine shall be a member of the medical staff and have programmatic responsibility for high-risk obstetrical services.

LHDCMC will have physicians board-certified in maternal-fetal medicine who are members of the medical staff and have programmatic responsibility for high-risk obstetrical services, in active practice and available 24 hours a day seven days per week. Luminis Health currently has 4.75 MFM specialists and will add an additional 2 MFM providers to support this effort.

(4.5) Physician board-certified in anesthesiology shall be a member of the medical staff and have programmatic responsibility for obstetrical anesthesia services.

LHDCMC will have physicians board-certified in anesthesiology as members of the medical staff and have programmatic responsibility dedicated for obstetrical anesthesia services available 24 hours a day seven days per week.

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 in MFM to be available 24 hours a day onsite, by telephone or by telemedicine.

LHDCMC will have board-certified maternal-fetal-medicine physicians on the medical staff. These providers will manage high-risk obstetrical services. They will be available 24 hours a day seven

days per week onsite, by telephone, or by telemedicine. A maternal-fetal medicine specialist will be available in-house, via telemedicine or within 30 minutes, and will be available for consultation as outlined and required by health system needs.

(4.7) The hospital shall have a physician board-certified or an active candidate in maternal-fetal on the medical staff, in active practice, available at all times, and if needed, in-house within 30 minutes.

LHAAMC Women's and Children's Services has a board-certified physician in MFM on the medical staff, in active practice, available at all times, and if needed, in-house within 30 minutes. These individuals will also be available to provide consultation to LHDCMC.

(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.

Perinatal care for all women presenting to LHDCMC will be overseen and managed primarily by a team of 24/7 physician laborist, clinical nurse midwives (CNM) and OB/Gyn trainees (2nd year residents). LHDCMC will have a physician laborist (or active candidate for board-certification) or a certified nurse-midwife with obstetrical privileges readily available to the delivery area when a patient is in active labor 24 hours a day seven days per week. This model of care promotes collaboration between providers from unique disciplines, while supporting the patient's choice for provider and birth experience. Providers can easily consult, share, or transfer care between the groups. Laborists comprised of both physicians and CNMs have been shown to decrease that rate of primary Cesarean deliveries, a major quality initiative for our perinatal center[14.] Nurse midwives will also assist in throughput on perinatal units, by triaging patients, teaching trainees normal vaginal deliveries and leading postpartum rounds for uncomplicated deliveries. The laborist team will also cover unassigned emergencies, and patients requiring emergent or urgent care when a patient's primary obstetrician or midwife is unavailable to provide such care due to multiple deliveries or emergencies. In addition, a physician or CNM representative from each practice with delivering privileges will be required to be in house 24/7 to manage the perinatal care of the patients for their practice if the laborist team are not primary providers for the patient.

(4.9) A physician board-certified 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 the patient is in active labor.

The laborist model of care promotes readily available access of a delivering physician or CNM to any of the units where they might be needed to attend a delivery. Delivery kits will be located in all LDRs. Delivery kits will also be available in antepartum rooms, OB Triage and in a designated area in the LHDCMC emergency department. All delivering staff will be made aware of the location of the delivery kits.

(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.

LHDCMC will have a board-certified physician (or active candidate for board-certification) with obstetrical privileges present in-house 24 hours a day, and immediately available to the delivery area when a patient is in active labor.

(4.11) A physician with obstetrical privileges or a certified nurse-midwife with obstetrical privileges shall be present at all deliveries.

LHDCMC will have a board-certified physician (or active candidate for board-certification) with obstetrical privileges or certified nurse-midwife with obstetrical privileges present at all deliveries. This will be facilitated by a laborist physician-CNM model.

Obstetrical Subspecialty Care

(4.12) The hospital shall have a full compliment of subspecialists, including subspecialists in critical care, general surgery, infectious disease, hematology, cardiology, nephrology and neurology available at all times.

Although this is an optional standard, LHDCMC is able to meet the needs of obstetrical patients requiring subspecialty care. The ICU is staffed by board-certified critical care intensivists at all times. General surgery, infectious disease, neurology, nephrology and hematology are available and provide call services at all times. In addition, LHAAMC has a full complement of subspecialists and transfer capabilities between facilities will be established. Required competency to care for this special population is well understood by the clinical team at LHAAMC. Competency assessment and training where needed will be instituted. Mechanisms for coordination to ensure patients that require subspecialty care are located in the appropriate setting will be in place.

(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 MFM care team.

LHAAMC and LHDCMC have adult medical and surgical specialty, and subspecialty consultants available at all times onsite, by telephone, or telemedicine if needed to collaborate with the maternal-fetal medicine team. Subspecialty consultation is also available at LHAAMC. Telehealth, or care transfer will be available as needed.

<u>Standard V. Pediatric Personnel</u>

(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 mother-baby unit.

A board-certified neonatologist will serve as the medical director for care delivered to all neonates. The medical director will have programmatic responsibility for neonatal services for all neonates and will work with nursing leadership to ensure up to date policies and procedures.

(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.

LHDCMC is applying for a Level II Perinatal Program and is not governed by this standard.

(5.3) There shall be a written agreement which provides consultation with physicians board-certified in neonatal-perinatal medicine 24-hours a day.

LHDCMC will have consultation with physicians board-certified in neonatal-perinatal medicine 24-hours a day. A written agreement for neonatal is attached as **Exhibit f**. A written agreement for perinatal is attached as **Exhibit g**.

(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.

The neonatal providers and nurse midwives will demonstrate competency and experience in the acute care management of the depressed newborn, and will be skilled in neonatal endotracheal intubation. The nurse midwives will be backed by the neonatal providers. The neonatal provider will be backed by OB anesthesiology.

An NRP-certified nurse will be present at every delivery, vaginal and C-section. Successful completion of the NRP will be required of all nursing staff and neonatal providers prior to completing orientation as outlined in the competencies and job descriptions for Women's and Children's Services registered nurses and medical staff. For cases when there are anticipated complications, the neonatal provider who has the skills to intubate, will be readily available. The OB anesthesiologist will serve as medical back up to the neonatal provider. Respiratory therapists, certified in NRP, will be notified of the complication and readily available.

(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.

LHDCMC will have a pediatric provider that has completed the appropriate training to provide neonatal care 24/7 and available at all times.

(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.

Infants requiring positive pressure respiratory support for greater than 48 hours will require consultation with a neonatal provider at a Level III or IV NICU will be obtained. A neonatal provider at LHAAMC will be readily available via phone or telemedicine 24 hours a day, seven days per week.

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.

LHAAMC currently has an agreement with a pediatric cardiologist and pediatric surgery attendings. LHDCMC will also have referral agreements for these services as well as ophthalmology. LHDCMC will have social work and case management in place to facilitate outpatient care coordination for neonates requiring these services.

(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.

LHDCMC is applying for a Level II Perinatal Program and is not governed by this standard.

(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.

LHDCMC is applying for a Level II Perinatal Program and is not governed by this standard.

(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.

LHDCMC is applying for a Level II Perinatal Program and is not governed by this standard.

(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.
LHDCMC is applying for a Level II Perinatal Program and is not governed by this standard.

Standard VI. Other Personnel
(6.1) Physician board-certified or an active candidate for board-certification 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.

LHDCMC will have board-certified anesthesiology provider coverage readily available 24/7 to manage obstetrical care and operating room demands. Anesthesiologists and nurse anesthetists that will be available for perinatal services will be trained in obstetrical anesthesia including regional anesthetics (spinal and epidural), emergency general anesthesia and nitrous oxide administration. Currently, LHAAMC has a policy providing for the assessment and documentation of pain scores in labor that will be brought to bear in the care of obstetrical patients at LHDCMC. Nurses, physicians and midwives will all be trained in pain assessment so that there is consistency in assessing pain as well as the language used to describe pain for patients in labor.

(6.2) A 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.

LHDCMC is applying for a Level II Perinatal Program and is not required to meet this standard. Despite not being required, an anesthesiologist trained in obstetrics anesthesia will be available 24/7 and readily available to the delivery area.

(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.

LHDCMC is applying for a Level II Perinatal Program and is not governed by this standard.

(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
LHDCMC currently has an existing radiology agreement for interventional radiology (IR) services for adults. LHAAMC also has an interventional radiologist and provides IR services to adults. If the clinical condition of an obstetrical patient is determined to require surgery, surgical intensive care, or specialty care, unavailable at LHDCMC these patients will be transferred to LHAAMC following consultation with Luminis Health's maternal-fetal medicine providers.

(b) neonatal patients
Neonatal patients requiring interventional radiology will be transferred, according to the LHDCMC transfer agreement, to a higher level of care**.**

(6.5) The hospital shall have on staff a licensed dietician with knowledge of and experience in the management of obstetrical and neonatal paternal/enteral nutrition.

LHDCMC is applying for a Level II Perinatal Program and is not required to meet this standard.

(6.6) The hospital shall have one staff licensed registered dieticians with knowledge of and experience in the management of obstetrical and neonatal parenteral/enteral nutrition, with one dietitian dedicated to the NICU.

LHDCMC is applying for a Level II Perinatal Program and is not required to meet this standard.

(6.7) The hospital shall have at least one full time equivalent International Board Certified Lactation Consultant who should 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.
One International Board-Certified lactation consultant will have programmatic responsibility for working with the medical, nursing, and support staff to provide lactation education. The Women's and Infants' Service will be staffed with a minimum of one certified lactation consultant 16 hours a day, seven days per week thus providing expert support along with nursing and medical staff who have the knowledge to support the mother with breastfeeding.

Patients and families will also have access to the "Warm Line" of LHAAMC, 18 hours each day. The "Warm Line" is staffed by board-certified lactation consultants who provide telephone support and consultative services.

The LHDCMC lactation program will be in full compliance with Maryland Best Practices for Breastfeeding Guidelines and World Health Organization Breastfeeding recommendations. **Exhibit h: Lactation Services Provision of Care** (Section Description of Department).

(6.8) The hospital shall have a written plan to address lactation consultant/patient ratios

recommended by the current Association of Women's Health, Obstetric and Neonatal Nurse Guidelines.

The Association of Women's Health, Obstetric and Neonatal Nurse Guidelines, and the International Board of Certified Lactation Consultants, call for 1.6 lactation consultant per 1000 births. The staffing plan will meet or exceed the established ratio and will increase incrementally as the volume of deliveries grows.

In addition, the "Warm Line" with LHAAMC will provide additional coverage via telephone for support and guidance, and is free of charge to all patients, without regard for their delivery site. This service will be extended to LHDCMC. **Exhibit h: Lactation Services Provision of Care** (Section Scope of Service).

(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 services.

A dedicated master's prepared licensed social worker will be available a minimum of 12 hours per day.

The job qualifications for the licensed social worker for Women and neonates will require a master's degree in social work and experience with psychosocial assessment and intervention with perinatal women and their families.

(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.

LHDCMC is applying for a Level II Perinatal Program and is not required to meet this standard.

(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 and LCSW, Licensed Certified Social Worker) and experience in psychosocial and intervention with women and their families dedicated to the NICU.

LHDCMC is applying for a Level II Perinatal Program and is not governed by this standard.

(6.12) The hospital shall have respiratory therapist skilled in neonatal ventilator management:
(a) readily available when an infant is receiving or anticipated to need positive pressure respiratory support or assisted ventilation,
(b) present in-house 24 hours per day.

A respiratory therapist, skilled in ventilator management, will be in-house 24 hours per day seven days a week. The respiratory therapist, working in the Special Care Nursery, will be required to complete BLS, NRP, S.T.A.B.L.E, annual simulations and skills day. The respiratory therapist will

demonstrate the unique skills and competences specific to the Special Care Nursery population, consistent with established competencies as defined by LHAAMC. The respiratory therapist will receive education and training from LHAAMC Level III NICU.

(6.13) The hospital shall have at least one occupational or physical therapist with neonatal expertise.

An occupational therapist with neonatal expertise will be available to support the care of the patients in the Special Care Nursery. They will have the skills and knowledge to assist with feeding and developmental care. The occupational therapist will receive education and training from LHAAMC Level III NICU.

(6.14) The hospital shall have at least one individual skilled in evaluation and management of neonatal feeding and swallowing disorders such as speech-language pathologist.

LHDCMC is applying for a Level II Perinatal Program and is not governed by this standard.

(6.15) The hospital shall have genetic diagnostic and counseling services or written consultation and referral agreement (s) for the services in place.

LHDCMC will contract with LHAAMC's perinatal genetic counselors who are embedded in the Maternal Fetal Medicine Practice of LHAAMC. The counselors will support the efforts of the maternal fetal medicine faculty by providing consultation to antepartum patients as clinically appropriate. The director of maternal fetal medicine will oversee and deploy genetic counselors based on society of maternal fetal medicine guidelines. Genetic diagnoses warranting transfer to a higher level of care will be determined by maternal fetal medicine leadership in consultation with the primary OB/Gyn practice. Telehealth and face-to-face consultations will be offered depending on the clinical need. This program will be expanded depending on the need, but most probably in year three of LHDCMC's perinatal program.

(6.16) The hospital shall have a pediatric neurodevelopment follow-up program or written referral agreement (s) for neurodevelopmental follow-up.

LHDCMC is applying for a Level II Perinatal Program and is not required to meet this standard.

(6.17) the hospital shall have pharmacy personnel with knowledge of and experience in pediatric pharmacy.

All pharmacy staff responsible for preparing medications for well, and Special Care Nursery babies, will be required to complete the general pharmacy and newborn/neonatal orientation. The orientation content and testing will be based on recommendations by The American Society of Hospital Pharmacists.

Modules from The American Society of Hospital Pharmacists unique to pharmacist working in pediatrics include Neonatal and Pediatric Pharmacokinetics and Neonatal and Pediatric Nutrition Support Management. Both modules require testing the pharmacist's pediatric specific knowledge of medications, calculations, and patient/family education.

Orientation and competencies for all pharmacists preparing medications for pediatric patients is overseen by the Pharmacy Clinical Coordinator.

The pediatric pharmacists will shadow at LHAAMC to provide learning opportunities and exposure to a wide variety of medications and diagnoses. Continuing education will be supported.

(6.18) The hospital perinatal program shall have on it administrative staff at least one registered nurse with a master's 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.

The job description for the perinatal nursing director requires a bachelor's degree in nursing and a master's degree in nursing or a health-related field. It also requires current clinical and leadership experience in the area(s) for which he/she is responsible. The director will report to senior nursing leaders with high-risk OB, neonatal nursing, and programmatic experience.
The perinatal nursing director will have programmatic oversight for obstetrical and neonatal nursing services, and will work in collaboration with the medical team to ensure the delivery of safe, high quality care for the population served.

(6.19) The hospital perinatal program shall have on it administrative 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.

The Labor and Delivery and Mother Baby/Special Care Nursery will each have a clinical educator. Requirements for the clinical educator position include a bachelor's degree in nursing and a master's degree in nursing or a health-related field. The clinical educator must have current clinical experience in the area(s) for which they are responsible.

The clinical educators are responsible for the professional development of the nursing staff. Responsibilities include assessment of learning staff learning needs, annual competencies, new skill education, new staff orientation, annual competency assessment, checklist completion, and policy/procedure development and updates as needed.

Exhibit b: Labor and Delivery Provision of Care (Section Personnel).
Exhibit e: Mother Baby Provision of Care (Section Personnel).
Exhibit c: Special Care Nursery Provision of Care (Section Personnel).

(6.20) The hospital obstetrical services shall have continuous availability of adequate number of registered nurses with competence in assessment and care of obstetrical patients as well as the recognition of nursing management of obstetrical complications.

Staff hired for LHDCMC perinatal and neonatal services will include a combination of experienced, new graduate, and nurses new to the specialty. Orientation for a new graduate is currently 12 weeks in length at LHAAMC. The same orientation process will extend to LHDCMC. New graduates will be precepted by an experienced registered nurse. The perinatal nursing director and clinical staff educator will oversee the orientation process.

The unit specific competency checklist must be completed successfully by the orientee prior to the end of orientation. The checklist includes management of the laboring and delivering patient, surgical and post anesthesia care for C-sections, fetal monitoring, safety bundles, and other clinical skills, as noted on the skills checklist, to ensure competency of nursing staff assigned to care for the mother and baby. In the event the checklist is not completed at the end of orientation, the nurse's orientation is extended, or the employee is terminated.
Staff are required to complete OB Advanced Life Support, Basic Life Support, NRP, S.T.A.B.L.E. and TeamSTEPPs during orientation. All nurses are required to become certified in electronic fetal monitoring within the first year of hire. All members of the multidisciplinary team, including nursing staff, will participate in a simulation of a high-risk obstetrical case annually.

Exhibit b: Labor and Delivery Provision of Care (Section Staffing Competencies).
Exhibit e: Mother Baby Provision of Care (Section Staffing Competencies).
Exhibit c: Special Care Nursery Provision of Care (Section Staffing Competencies).

Education and introduction to new policies, procedures, and safety bundles are provided at staff meetings, daily huddles, obstetrical grand rounds, and one-on-one education.

(6.21) The hospital neonatal services shall have continuous availability of adequate number of registered nurses with competence in assessment and care or neonatal patients appropriate to the designated level of care.
The four-bed Special Care Nursery will be staffed with two registered nurses who have completed hospital and special care nursery orientation. The staffing plan for the Special Care Nursery will be in compliance with current Association of Women's Health Obstetric Neonatal Guidelines as outlined in the Special Care Nursery Provision of Care. **Exhibit c: Special Care Nursery Provision of Care** (Section Nursing Staffing).

The Mother Baby nursing leadership team, including clinical supervisors, clinical educator, perinatal nursing director, and patient/family navigator, will provide additional clinical staffing support should the need arise. **Exhibit e: Mother Baby Provision of Care** (Personnel). In addition, there will be part-time and prn staff who can be called in to assist as needed
The staff will receive ongoing support and education from the Level III NICU at LHAAMC to ensure current competencies.

The Special Care Nursery staff will be required to complete the S.T.A.B.L.E. (Sugar. Temperature. Airway. Blood Pressure. Lab work. Emotional support) course during orientation. The course focuses exclusively on the post-resuscitation/pre-transport stabilization of sick infants. The staff will be required to renew the S.T.A.B.L.E. course every two years. **Exhibit c: Special Care Nursery Provision of Care** (Section Nursing Competencies). The staff will participate in an annual multi-disciplinary simulation of a high-risk obstetrical and fetal emergency case, and complete skills day.

Ongoing education will be provided to the staff at conferences, staff meetings, and daily huddles.

(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.

LHDCMC is applying for a Level II Perinatal Program and is not governed by this standard.

(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 Guidelines.

The Provision of Care for Mother Baby and Labor and Delivery outlines the current Association of Women's Health Obstetric Neonatal Guidelines for nurse/patient ratios. The staffing ratios will be supported by hiring an adequate complement of nurses to staff the units, including prn and flex staff who can be called in during times of high census or acuity. The nursing leadership team, including clinical supervisors, clinical educators, perinatal nursing director and community educator/navigator will provide additional clinical staffing support should the need arise. **Exhibit b: Labor and Delivery Provision of Care** (Section Nursing Staffing). **Exhibit e: Mother Baby Provision of Care** (Section Nursing Staffing).
A voluntary on-call system for nurses will be established, to assist with supplemental staff support, when the need arises.

Standard VII. Laboratory

(7.1) The programmatic leaders of the perinatal service and the hospital shall establish laboratory processing and reporting times that are appropriate for sample drawn from obstetrical and neonatal patients with specific consideration for the acuity of the patient and the integrity of the samples.

Perinatal Service leadership at LHDCMC will establish laboratory processing and reporting times for the perinatal and neonatal units. Currently perinatal and neonatal services at LHAAMC has laboratory processing and reporting times as STAT priority as is done in the emergency department. This practice will be adopted for LHDCMC perinatal and neonatal services as well.

(7.2) The hospital laboratory shall demonstrate the capability to immediately receive, process, and report urgent/emergent obstetrical and neonatal laboratory results.

Urgent and emergent obstetrical and neonatal laboratory results will be handled in the same manner as the ED, in which all specimens are processed as STAT priority.

(7.3) The hospital laboratory shall have a process in place to report critical values to the obstetrical and neonatal services.

Currently LHDCMC has a process to report critical values to the unit of origin. This process will be extended to perinatal and neonatal services at LHDCMC. LHAAMC currently manages critical perinatal and neonatal results per current hospital policy/procedure **Exhibit i: Critical Value Reporting**. A similar policy will be established for LHDCMC perinatal and neonatal units.

(7.4) Laboratory results from standard maternal antepartum testing shall be available to the providers caring for the mother and neonate prior to discharge. If test results are not available or if testing was not performed prior to the admission, such testing shall be performed during the hospitalization of the mother and results may be available prior to discharge to the newborn.

Perinatal Service leadership at LHDCMC will ensure that the complete antepartum record including antepartum laboratory tests will be made available to providers caring for patients in the inpatient environment. If antepartum tests are not available at the time of admission, every effort will be made to obtain them from the patient's primary provider's office. If maternal antepartum laboratory tests are not available on admission, antepartum laboratory tests will be performed during the hospitalization of the mother, and results made available prior to discharge of the mother and or newborn.

(7.5) The hospital shall have the capacity to conduct rapid HIV testing 24 hours per days.
The LHDCMC laboratory currently has the capacity to conduct rapid HIV testing 24 hours per day/7 days per week.

(7.6) The hospital shall have available the equipment and trained personnel to collect 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.
Hearing screening for all newborns will be performed by a contracted service. A request for proposal will be made to identify providers who perform hearing screening for newborn hearing Health. The contracted service will report results to the state in compliance with COMAR 10.52.02 The infant's primary pediatrician will be notified when the infant does not pass the hearing screening after two attempts. The pediatrician is then required to refer infants not passing hearing screening tests after two attempts for further evaluation by an audiologist.

(7.7) The hospital shall:
(a) have available the equipment and trained personnel to perform critical congenital heart disease screening within 24 to 48 hours of age on all well infants born or transferred to the institution and report screening results as required by COMAR 10.52.15, and

LHDCMC Neonatal and Mother/Baby units will have the appropriate equipment and trained personnel to perform critical congenital heart disease screening, and will perform such screening within the 24 to 48 hours on all infants. LHDCMC will have pulse oximetry for neonates and trained ultrasonographers for neonatal echocardiograms. These primary and secondary screening results will be reported as required by COMAR 10.52.15.
Exhibit j: Critical Congenital Heart Defects Screening Infant policy.

(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 results as required by COMAR 10.52.15.

There will be a standard protocol for performing critical congenital heart disease screening of all infants born at LHDCMC prior to discharge. Currently LHAAMC's protocol calls for congenital heart disease screening that includes:

1. Primary screen with pulse oximetry
2. Secondary screen with neonatal echocardiography after 3 consecutive abnormal primary screening tests.
3. Results for both primary and secondary screens are reported to the neonates pediatrician as well as the NICU team
4. Follow up clinical management will be a part of discharge planning for neonates and

appropriate referrals for pediatric cardiology consultation will be made prior to discharge. LHDCMC will contract with a suitable collaborator to provide these services interpretation of pediatric echocardiograms. LHDCMC will adapt the above protocol and will be in full compliance with COMAR 10.52.15. **Exhibit j: Critical Congenital Defects Screening Infant policy**

(7.8) The hospital staff 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.

LHDCMC perinatal unit staff will have the appropriate equipment and be adequately trained to collect newborn blood spot screening on all infants born at the institution. All collection, transport, and follow-up will be in compliance with the COMAR 10.52.12 and 10.10.14.
The existing protocol for LHAAMC is and will be adapted to LHDCMC as appropriate.

(7.9) Blood bank technicians shall be present in house 24 hours a day.

LHDCMC currently has a staffed blood bank that is operational 24 hours per day seven days a week.

(7.10) The hospital shall have access to molecular, cytogenetic and biochemical genetic testing.

LHDCMC is currently contracted with two laboratories for the completion and reporting out of molecular, cytogenetic and biochemical genetic tests. Both tissue and serum testing for molecular, cytogenetic and biochemical genetic tests currently have 48 hour turn-around times with existing vendors.

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.

LHDCMC currently has 24/7 ultrasound capability and interpretation. This will be extended for obstetrical patients with additional support for interpretation by maternal fetal medicine specialists were clinically indicated.

(8.2) The hospital shall have the capability of providing detailed ultrasonography and fetal assessment, including Doppler studies, with interpretation for obstetrical patient 24 hours per day.

LHDCMC currently has a radiology infrastructure and equipment to perform detailed ultrasonography and fetal assessment, including Doppler studies. LHAAMC has maternal fetal medicine specialists that will support LHDCMC in fetal ultrasound interpretation where needed. Maternal fetal medicine specialists and general radiology support will be available 24/7 as needed to support clinical decision making for obstetrics patients.

The current imaging technologist staff will require cross-training to ensure competency when

performing imaging of the neonate. Available resources throughout the Luminis Health system will be enlisted to ensure the imaging technologists are competent to perform protocols consistent with the current LHAAMC standard of care.

(8.3) The hospital shall have the capability of providing maternal echocardiography with interpretation for obstetrical patients 24 hours a day.

LHDCMC currently has echocardiography capability and interpretation 24 hours a day/7-days a week.

(8.4) The hospital shall have the capability of providing portable x-ray imaging with interpretation for neonatal patients 24 hours a day.

LHDCMC currently has capability and interpretation for portable x-rays 24 hours per day/7 days per week. The current imaging technologist staff will require cross-training to ensure competency when performing imaging of the neonate. Available resources throughout the Luminis Health system will be enlisted to ensure the imaging technologists are competent to perform protocols consistent with the current LHAAMC standard of care.

(8.5) The hospital shall have the capability of providing portable head ultrasound with interpretation for neonatal patients.

LHDCMC currently has equipment for head ultrasound. The current imaging technologist staff will require cross-training to ensure competency when performing imaging of the neonate. Available resources throughout the Luminis Health will be enlisted to ensure the imaging technologists are competent to perform protocols consistent with the current LHAAMC. Recruitment and retention efforts will include hiring additional imaging technologists with neonatal experience.

(8.6) The hospital shall have the capability on campus of providing computerized tomography (CT) and magnetic resonance Imaging (MRI) with interpretation.

LHDCMC currently has computerized tomography and magnetic resonance imaging capability with interpretation 24/7.

(8.7) Neonatal echocardiography equipment and an experienced technician shall be available on campus as needed with interpretation by a pediatric cardiologist.

LHDCMC is applying for a Level II Perinatal Program and is not required to meet this standard. Neonates requiring these services will be evaluated and transferred to an appropriate level of care per protocol.

(8.8) The hospital shall have the capability of providing interventional radiology services for:
(a) obstetrical patients, and

LHDCMC is applying for a Level II Perinatal Program and is not required to meet this standard. Obstetrical patients requiring these services will be evaluated and transferred to a higher level of

care.

(b) neonatal patients.

LHDCMC is applying for a Level II Perinatal Program and is not governed by this standard. Neonatal patients requiring these services will be transferred to a higher level of care.

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;

There will be an oxygen analyzer, stethoscope, and intravenous infusion pump in each patient room in the Special Care Nursery.

There will be an intravenous pump and stethoscope in each Labor and Delivery suite. The patient will be transferred to Mother Baby with the intravenous pump from Labor and Delivery. The Labor and Delivery room will be restocked with an intravenous pump once the room has been cleaned, prior to the next admission.

There will be an individual intravenous pump and stethoscope in each of the OB triage rooms.

There will be an O2 analyzer, stethoscope, and intravenous infusion pump in each Labor and Delivery operating room (OR), and OB procedure room.

(b) radiant heated bed in delivery room and available in the neonatal units;

Radiant heated beds will be located in each Labor and Delivery PACU, OB OR, Special Care Nursery and the Emergency Room.

(c) oxygen hood with humidity;

Radiant heated beds with oxygen and humidity will be located in each Labor and Delivery PACU, OB OR, Special Caren Nursery and the Emergency

(d) bag and mask and/or T-piece resuscitator capable of delivering a controlled concentration of oxygen to the infant;

A neonatal bag and mask, and/or T-piece resuscitator, appropriately sized, will be located in the Special Care Nursery, Labor Delivery rooms, Mother Baby, Labor and Delivery ORs, Labor and Delivery PACU, and the Emergency Department.

(e) orotracheal tubes;

Neonatal orotracheal tubes will be located in the clean supply room and code cart in the Special Care Nursery. There will be orotracheal tubes in the airway carts that are located in the Special Care Nursery.

Adult orotracheal tubes will be located in the adult code carts located on Mother Baby, Labor and Delivery/Antepartum,Labor and Delivery ORs, and Labor and Delivery PACU.

(f) CO2 detector;

There will be a CO2 detectors located in the Special Care Nursery, Labor and Delivery, Labor and Delivery ORs/PACU, and Mother Baby. Respiratory therapy will be responsible for stocking the C02 detectors.

(g) aspiration equipment;

Aspiration equipment will be located at the bedside in each Labor and Delivery room, Labor and Delivery OR, and Labor and Delivery PACU. The aspiration equipment will also be located at the bedside in the Special Care Nursery and in the well-baby nursery.

(h) laryngoscope;

Laryngoscopes will be located in the code and supply carts and in each room on Labor and Delivery. In each location, there will be adult and neonatal sizes of blades.

(i) bowel bags;

Bowel bags will be located in the storeroom of the Special Care Nursery for very low birth weight babies or congenital abnormalities.

(j) umbilical vessel catheters and insertion tray;

Umbilical vessel catheters of varying sizes and insertion trays will be in the code cart located in the Special Care Nursery and on Labor and Delivery.

(k) cardiac monitor;

Cardiac monitoring capabilities will be available throughout LHDCMC perinatal and neonatal units. Neonatal and adult cardiac monitors will be located in each Labor and Delivery OR, procedure room, and PACU bay. Neonatal cardiac monitoring capabilities will be located in each Special Care Nursing room. Each code cart, adult and neonatal, located throughout Women and Infants' Services will be equipped with cardiac monitoring capabilities.

(l) pulse oximeter;

Pulse oximeters will be in each Special Care Nursery room, and incorporated into the cardiac monitoring system. Pulse oximeters will be in each of the OB ORs and PACU rooms. Pulse oximeters are available on the Labor and Delivery and Mother Baby units.

(m) transilluminator;

Transilluminators will be located in the Special Care Nursery.

(n) phototherapy unit;

Phototherapy lights and blankets will be available in the Special Care Nursery and Mother Baby units.

(o) doppler blood pressure for neonates;

Arterial transducers will be available in the Special Care Nursery to measure blood pressures for neonates. Arterial pressure will be measured through an umbilical artery catheter.

(p) cardioversion/defibrillation capability for obstetrical patients and neonates;

Adult and neonatal cardioversion/defibrillation capabilities, including both supplies and equipment, will be available in the code carts located in Labor and Delivery, Mother Baby, Labor and Delivery OR, PACU, and Special Care Nursery.

(q) resuscitation equipment for obstetrical patients;

Resuscitation equipment for obstetrical patients will be maintained in a single code cart located in each of the following areas: Labor and Delivery/OB Triage, Mother Baby, Labor and Delivery OR and PACU. Resuscitation equipment will be checked daily and contents replaced with each code cart use.

(r) resuscitation equipment for neonates including equipment outlined in the current NRP;

Resuscitation equipment, including those outlined in the current NRP guidelines will be available in the Special Care Nursery, Labor and Delivery rooms, Labor and Delivery ORs and PACU, and Mother Baby. The equipment will be located in the neonatal code cart.

(s) individual oxygen, air and suction outlets for obstetrical patients and neonates; and

There will be individual oxygen, air and suction outlets in every patient room through the Women and Infants Services building. In addition, there will be outlets in the OB OR, PACU, and triage.

(t) emergency call system for both obstetrical and neonatal units as well as an emergency communication system between units.

Emergency call and communication systems will be available for both obstetrical and neonatal units, including Baby Code, OBGYNNET, Staff Emergency, Rapid Response, and Code Blue. The codes will be announced through the overhead paging system and directly linked to the

telephones of the OB hospitalist, Labor and Delivery charge nurse, Special Care Nursery charge nurse, OB provider OB anesthesiologist, and Code Blue response team as indicated by the type of code.

(9.2) The hospital shall have special equipment and facilities needed to accommodate the care and services needed for obese women.

The bariatric bundle guidelines developed by LHAAMC will be used adapted to LHDCMC as appropriate. The purpose of the bariatric bundle is to define guidelines for providing care and services to obese obstetrical women. The care begins in the prenatal period in the ambulatory setting. The bariatric bundle is outlined below:
The bundle includes the following:
Prenatal

- Prenatal labs
- Baseline LFTs
- Baseline 24-hour urine for protein
- Early ultrasound for dates and neural tube defects
- Nutritional counseling
- Early GTT; repeat 24 and 28 weeks if normal or consider HgA1C
- EKG
- Sleep apnea testing
- Serial growth scans beginning at 24 weeks
- Discuss risk of C-Section versus vaginal delivery
- Pre-anesthesia testing evaluation to evaluate patient status for anesthesia – patients with BMI of 45 or greater

Consults

- Maternal Fetal Medicine
- Anesthesia
- Occupational and physical therapy if need assistance with ambulating

Admission to Hospital

- Notify OB hospitalist and anesthesiologist
- NICU consult if indicated
- Standardize how blood pressure is taken to assure consistency
- Equipment and supplies
    - XL patient gown
    - XL blood pressure cuff
    - Scales to accommodate up to 600 pounds
    - Bariatric wheelchair
    - Toilet support
    - Bed to accommodate 600 pounds
    - Electronic fetal monitors designed for obese patients
    - Lift assistance devices
    - XL long spinal needle
    - Large chair for patient room
    - XL and XXL abdominal binders
    - XL and XXL SCD sleeves
    - Long instruments
    - XL safety belt for the OR table
    - Extra CHG wipes and prep sticks

- Negative pressure wound dressing
- Room chairs to accommodate obese patients – postpartum and special care nursery

In the event the patient requires a C-section, a second anesthesiologist is called in for coverage. The preoperative antibiotic dosage is adjusted based on the patient's weight.
Morbidly obese patients will be presented at the bi-weekly multidisciplinary maternal fetal medicine rounds prior to admission to ensure all supplies and equipment required are in place, care needs have been assessed, and a plan of care has been developed.
In addition, all members of the Women's and Infants' Services staff will receive sensitivity education and demonstrate competency in the care of the obese patient.

(9.3) The hospital shall have a neonatal stabilization bed set up and equipment available at all times for an emergency admission.

Neonatal stabilization beds will be set up at all times in the Special Care Nursery, in the each of the Labor and Delivery ORs, and the Emergency Department. There will be additional warmers readily available for exchange when the beds are being cleaned.

(9.4) The hospital shall have fetal diagnostic testing and monitoring equipment for:
(a) fetal heart rate monitoring,

Fetal heart rate monitors will be located in the every Labor and Delivery room, Labor and Delivery OR, PACU, and OB triage. Fetal monitoring will also be available in the Emergency Department. There will be a variety of monitors available to meet the needs of the patients depending on factors such as habitus, activity, and personal preference.

(b) ultrasound examinations, and
Portable ultrasound machines with vaginal probes will be centrally located for use in OB triage, Antepartum, and Labor and Delivery.

(c) amniocentesis.
LHDCMC is applying for a Level II Perinatal Program and is not required to meet this standard.

(9.5) The hospital shall have the capability to monitor neonatal intra-arterial pressure.

LHDCMC is applying for a Level II Perinatal Program and is not required to meet this standard.

(9.6) The hospital shall have the capability on campus of providing laser coagulation of retinopathy of prematurity.

LHDCMC is applying for a Level II Perinatal Program and is not required to meet this standard.

(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.

LHDCMC currently has central venous pressure and arterial pressure monitoring in the ICU. The monitoring will be overseen by anesthesiology and the adult intensivist, and support provided by

the primary OB and maternal fetal medicine specialist.

(9.8) The hospital shall have the appropriate equipment (including back up equipment) for neonatal respiratory care as well as protocols for the use and maintenance for the equipment as required by its level of neonatal care.

The following respiratory equipment will be available in the Special Care Nursery: nebulizer, oxygen, neonatal ventilator, heated-high flow nasal cannula, neonatal sized CPAP prongs with the ability to administer neonatal CPAP and non-invasive ventilation and point of care arterial blood gas analyzer. There will be redundancy in the equipment to ensure readiness and availability at all times. In the event of high usage, vendor contracts will be in place to rent equipment with a 24-hour or less turnaround time.
Policies will be in place to outline use and maintenance of the equipment by respiratory therapy and biomedical engineering.

(9.9) The hospital shall have the capability of providing advanced ventilatory support (beyond conventional mechanical ventilation for neonates of all birth weights.

LHDCMC is applying for a Level II Perinatal Program and is not governed by this standard. Neonatal patients requiring these services will be evaluated and transferred to a higher level of care.

(9.10) The hospital shall have the capability of providing continuing therapeutic hypothermia.

LHDCMC is applying for a Level II Perinatal Program and is not governed by this standard. Neonatal patients requiring these services will be evaluated, stabilized and then transferred to a higher level of care.

Standard X. Medications

(10.1) Emergency medications, as listed in the current NRP guidelines shall be immediately available in the delivery and neonatal units.

All emergency medications listed in the current NRP guidelines will be immediately available throughout the LHDCMC Obstetrics Program. The medications will be in the medication dispensing system, adult and neonatal code carts, and delivery cart. The neonatal code carts will be located in the Special Care Nursery, Labor and Delivery, Labor and Delivery ORs, Labor and Delivery PACU, and Mother Baby unit. The adult code carts will be located in Labor and Delivery, Labor and Delivery ORs, Labor and Delivery PACU, and Mother Baby unit.

(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.**

Antibiotics, anticonvulsants, surfactant, prostaglandin E1, and emergency cardiovascular medications will be located in the neonatal medication-dispensing machine, infant code cart,

neonatal emergency box, and immediately available from the pharmacy, Labor and Delivery OR/PACU, Mother Baby, and Special Care Nursery.

(10.3) All emergency resuscitation medication to initiate and maintain resuscitation, in accordance with current Advanced Life Support (ACLS) guidelines of the American Heart Association, shall be immediately available in the delivery area.

All emergency medications listed in the current NRP guidelines will be immediately available throughout Women's and Infants' Services. They will be located in the medication dispensing system and infant code cart in the Special Care Nursery and infant code carts located in Labor and Delivery, Labor and Delivery ORs, Labor and Delivery PACU, and Mother Baby unit. Adult code carts will be located in Labor and Delivery, Labor and Delivery ORs, Labor and Delivery PACU, and Mother Baby unit.

(10.4) The following medication shall be immediately available for the management of obstetrical hemorrhage in the delivery area and postpartum floor:

(a) oxytocin (Pitocin),
(b) methylergonovine (Methergine),
(c) misoprostol (Cytotec),
(d) carboprost tromethamine (Hemabate),
(e) transexamic acid (TXA).

The following medications will be readily available in the medication-dispensing machine located on Labor and Delivery, Labor and Delivery OR, Labor and Delivery PACU, and Mother Baby unit:

- Oxytocin
- Methergine
- Hemabate
- Cytotec
- Transexamic acid (TXA)
- **Exhibit k: Postpartum Hemorrhage Protocol.**

(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.

Hydralazine, Labetalol, and Nifedipine will be located in the medication dispensing machines located throughout the Labor and Delivery and Mother Baby units. The medications will also be located in the Emergency Department medication dispensing machines in the event an obstetrical patient presents to the department in hypertensive crisis.

- **Exhibit l: Maternal Safety Bundle: Chronic Hypertension with Superimposed Pre-Eclampsia.**
- **Exhibit m: Maternal Safety Bundle: Chronic Hypertension without Superimposed Pre-Eclampsia.**

<u>Standard XI. Education Programs</u>

(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.
All obstetrical and neonatal staff will be required to complete competencies specific to LHDCMC, perinatal and neonatal services, and their unique unit/department during their orientation period. All nursing staff will be required to complete S.T.A.B.L.E, NRP, and BCLS prior to the completion of orientation. OB ACLS will be required of Labor and Delivery staff.
Exhibit b: Labor and Delivery Provision of Care (Section Staff Competencies).
Exhibit c: Special Care Nursery Provision of Care (Section Staff Competencies).
Orientation of physicians, nursing and staff will be overseen by the clinical educators and laborists. Weekly progress during orientation will be assessed, and discussed with the new employee, assigned preceptor, clinical educator, and clinical director. The components of the education will be outlined in the Provision of Care for each of the units. Orientation will include didactic sessions, clinical simulation and shadowing at LHAAMC.
Participation in skills day and simulation will be required of all staff annually.

(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.

Ongoing continuing education will be provided to the staff concerning the treatment and care of obstetrical and neonatal patients through monthly infant mortality reviews, obstetrical grand rounds, antepartum rounds, OB grand rounds/case reviews, every two-month nursing grand rounds, and local and national conferences. In addition, education will be provided on the units during staff meetings, daily huddles, and in-services.
Staff will be encouraged to become certified in their area of clinical specialty. LHDCMC will reimburse for the staff upon successful completion of the exam. Staff will be incentivized upon passage of the exam. The incentive provided is intended to assist the staff in attending educational opportunities required by their certification.

(11.3) The hospital shall conduct multidisciplinary clinical skills or simulations including post-drill debriefs to help prepare obstetrical and neonatal high risk, high complexity and low frequency evets.

Multidisciplinary clinical simulations will be required of all staff. Simulation and debriefs will be methods used for teaching at the annual skills day. Other simulation and debrief strategies include required attendance at skills day, mock code, complex care simulations, NRP, Team STEPPs, OB ACLS, and S.T.A.B.L.E. Debriefs are conducted by the medical team after hemorrhages, codes, and any traumatic/adverse event.

(11.4) The hospital shall provide evidence-based education every two years to all staff caring for newborns (nurses, respiratory therapist, technicians, etc.) that includes a minimum stabilization after immediate resuscitation to address glucose metabolism, thermoregulation, respiratory support, hemodynamic monitoring and stability, risk and treatment of infection and support of the family.

Evidence-based education includes, at a minimum, stabilization after immediate resuscitation to address glucose metabolism, thermoregulation, point of care testing, respiratory support, hemodynamic monitoring and stability, risk and treatment of infection, and support of the family.
All staff are required to complete S.T.A.B.L.E. and NRP during orientation, and every two years

thereafter. The courses include stabilization after immediate resuscitation including glucose metabolism, thermoregulation, respiratory support, hemodynamic monitoring and stability, risk and treatment of infection, and support of the family.

(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.

LHDCMC is applying for a Level II Perinatal Program and is not governed by this standard.

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.

The LHAAMC Women's and Children's Perinatal Quality Improvement Program has a leadership team, program development and execution arm, and metric review/policy modification arm that functions cooperatively to ensure continuous improvement in the perinatal care that is delivered within Luminis Health. These entities will be expanded to the LHDCMC Obstetric Program as perinatal services are developed within the hospital and community.

Women and Children's Executive Leadership team of Luminis Health is responsible for the highest level of oversight for the Perinatal Quality Improvement program that currently exists within LHAAMC and will be extended to LHDCMC. The executive leadership team is led by the Chair of Women's and Children's Services, and is comprised of the Women's and Children's Service Line Vice President as well as Associate Chairs for Quality and Safety, Academic Affairs and Research, and Professional and Practice Development. Medical directors for neonatology, maternal fetal medicine, obstetrics and gynecology, pediatrics and female pelvic medicine and reconstructive surgery as well as, a member of senior nursing leadership from both LHAAMC and LHDCMC. In addition to defining the strategic direction for perinatal quality and safety for the health system, this group functions to address system barriers that might impact successful execution of strategic initiatives related to maternal and neonatal care in both the inpatient and ambulatory environments for LHAAMC and LHDCMC.

LHAAMC Women's and Children's Committee on Quality and Safety is responsible for developing perinatal protocols and programs that reflect the strategic vision and promote quality and safety within Luminis Health Women's and Children's Services. This multidisciplinary committee is led by Luminis Health Women's and Children's Associate Chair for Quality and Safety and is comprised of a representative from each of the existing delivering practices, medical directors for maternal fetal medicine, and obstetrics, as well as nursing leaders and educators from all of the perinatal units within Luminis Health. This committee operationalizes the strategic perinatal programs of the annual operating plan for Luminis Health Women's and Children's Services, and

develops clinical protocols and pathways that facilitate execution of the programs. The physician members along with elected representation from the physician staff participate in peer review of adverse outcomes. The LHAAMC Associate Chair for Quality and Safety makes recommendations to the Luminis Health system Medical Staff Quality Review Committee regarding the management of any variances in clinical care observed. LH System Chair of Women's and Children's Services makes the recommendation for corrective action when necessary.

Removing barriers to program implementation and process improvement around perinatal quality initiatives are also the responsibility of this committee. The work of this group is supported by the office of the Chief Quality and Patient Safety Officer for Luminis Health as well as members of the risk management, process improvement and data analytics teams.

The Women's and Children's Quality and Safety Council of Luminis Health is responsible for preparing and reviewing quarterly maternal and neonatal outcome data for national, state and local perinatal morbidity and mortality indicators and metrics. They evaluate the efficacy of the programmatic initiatives targeting these indicators and metrics and review policy modifications to improve on outcomes as needed. The Quality and Safety Council is currently co-led by the Luminis Health Associate Chair for Quality and Safety as well as the senior nursing leadership of LHAAMC. Nursing leadership for LHDCMC perinatal and neonatal services as well as the medical director for perinatal services, will serve as members of the Luminis Health Quality Council. Members of the Council include medical leadership of maternal fetal medicine, neonatology and obstetrics as well as nursing quality leadership from all of perinatal areas. In addition, representatives from infection control, pharmacy, ethics, anesthesia, and community education participate on this council. The council also ensures that the policies and protocols guiding perinatal clinical care within Luminis Health are current and aligned with standards set forth by ACOG, AWHONN and AAAP. This council meets quarterly and is responsible for ensuring appropriate reporting of perinatal outcomes to MIEMSS, JCAHO, LEAP Frog and other benchmarking organizations.

The LHAAMC Perinatal Quality Improvement Program outputs are communicated twice yearly to the Luminis Health Quality and Safety committee of the Board of Trustees, monthly to the health system quality committee and monthly to all members of the service line. LHDCMC, as part of the service line, will report outputs consistent with current LHAAMC outputs. Outputs from the above quality teams are communicated to the entire service line through monthly service meetings, newsletters and huddles. **Exhibit n: Perinatal Quality Program**

(12. 2) The Perinatal Quality Improvement Program shall conduct internal case reviews, collect and analyze perinatal program data, conduct and analyze, set quality improvement goals annually, and use data to assess progress toward these goals.

Cases requiring review are presented to the Luminis Health Women's and Children's Committee on Quality Safety of the Perinatal Quality Improvement program by four mechanisms:

1. Anonymous reporting of Luminis Health, Adverse perinatal events are reported by any member of the clinic team at any time and reviewed by Luminis Health system leadership, Women's and Children's leadership and Risk management.
2. Directly from Risk Management through the current incident reporting system.

3. Health System patient advocacy
4. Health system quality and safety

All adverse events are evaluated by the Luminis Health system and Women's and Children's Services leadership to determine if either a Root Cause Analysis (RCA), presentation at morbidity and mortality conference, adjudication by Medical staff quality review committee (peer review) or nursing review is required. LHAAMC's Perinatal Quality Improvement program will be extended to LHDCMC as medical and nursing leadership will be members of the above committees and councils. This will promote alignment across Luminis Health perinatal quality programs and promote best practices for a Level II Maternal and Neonatal Perinatal Program.

Exhibit n: Perinatal Quality Program outlines the Luminis Health Women's and Children's programming including the flow of education and communication.

Luminis Health Women's and Children's Executive Leadership maintains and reviews monthly our scorecard of quality metrics. LHDCMC will develop its own scorecard to include measurement of perinatal quality initiatives that impact maternal and infant outcomes. Women's and Children's Leaders from both the inpatient and ambulatory settings of LHAAMC and LHDCMC will review the impact of existing programs on perinatal metrics along with the resources needed for process improvement. The Luminis Health Women's and Children's Committee on Quality and Safety will ensure protocols to operationalize programs and the quality council will ensure policy alignment and appropriateness with ACOG, AWHONN, AAP and Luminis Health guidelines.

(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 issue identified:

(a) maternal, intrapartum, fetal and neonatal deaths;
(b) transports to a higher or comparable level of care;
(c) elective delivery at less than 39 weeks gestation; and
(d) delivery of an infant at less than 1500 grams or less than 32 weeks gestation.

The Women's and Children's Quality and Safety Council of Luminis Health will review all cases as outlined by MEIMSS along with other measures to improve outcomes, as outlined in **Exhibit o: Luminis Health Doctors Community Medical Center Perinatal Quality Improvement Plan Reporting Schedule.**

(12.4) The hospital shall participate in the Maryland Department of Health and local health department Fetal and Infant Mortality Review programs.

LHDCMC will participate in the Maryland Perinatal Infant Review Board. They will work with LHDCMC leadership to ensure that strategic programs are aligned with Maryland board recommendations and guidelines.

(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 Service Systems for the purpose of improving perinatal health outcomes.

The LHAAMC Women's and Children's Quality Council collaboratively collects and submits perinatal outcome data to MIEMSS currentlyand will include data from LHDCMC perinatal program once the program is established. The Luminis Health Women's and Children's

Quality Council will receive perinatal data from the LHDCMC members of the council, review trends in outcome, and work with LHDCMC leadership to improve process against outcomes and established scorecards.

(12.6) The hospital shall maintain membership in the Vermont Oxford Network.
Maintenance of membership in Vermont Oxford Network is optional for Level II special care nurseries therefore LHDCMC is not required to address this standard. LHAAMC is a member of Vermont Oxford Network and will monitor similar quality metrics and outcomes for our neonatal services at LHDCMC. Data will be collected during the first year of the program, and based on established outcomes measures, the leaders of the program will determine which membership is more appropriate for the LHDCMC program.

Standard XIII. Policies and Procedures
LHDCMC will adapt all applicable policies and procedures of LHAAMC Women and Children's Services. LHAAMC Women's and Children's Perinatal Quality Improvement Program leaders will provide oversight to LHDCMC to modify protocols as necessary to reflect the infrastructure and human resources that are unique to LHDCMC while maintaining consistency in practice across the Luminis Health system. The policies and procedures will be adapted to meet Level II Perinatal Service standards.

(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.

LHDCMC perinatal and neonatal services will have policies and protocols that address the initial stabilization and continuing care of all obstetrical and neonatal patients appropriate for Level II Perinatal and Special Care Nursery patients. The policies will be congruent with LHAAMC to ensure consistency in practice across Luminis Health System.

The policies and protocols that address the stabilization and continuing care of the obstetrical and neonatal patients include those that address care in triage, admission and discharge, care of the healthy newborn, and care of the late preterm newborn.

In addition, the Provision of Care documents for Labor and Delivery/Antepartum, Mother Baby/, and Special Care Nursery outline the types of patients to be admitted for care in each of the units. The criteria are as prescribed by ACOG and MIEMSS guidelines for Level II units.
Exhibit b Labor and Delivery Provision of Care (Section Admission Criteria).
Exhibit e: Mother Baby Provision of Care (Section Admission Criteria).
Exhibit c: Special Care Nursery Provision of Care (Section Admission Criteria).

(13.2) The hospital shall have maternal and neonatal resuscitation protocols.

LHDCMC protocols and polices to address maternal and neonatal resuscitation will be adapted from those of LHAAMC to ensure consistency in practice across Luminis Health System, and compliance with NRP, BLS and OB ACLS. LHDCMC will also have an OBGYN NET and Baby Code to support maternal and neonatal resuscitation. These are codes that are specific to maternal and neonatal patients, and bring providers and nurses, who have maternal and child expertise, to the bedside.

(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.

Protocols and polices that address maternal and neonatal resuscitation will be consistent with LHAAMC to ensure consistency in practice across Luminis Health System, and compliance with NRP, BLS and OB ACLS. LHDCMC will also have an OBGYN NET and Baby Code to support maternal and neonatal resuscitation. These are codes that are specific to maternal and neonatal patients, and bring providers and nurses, who have maternal child expertise, to the bedside.

(13.4) The hospital shall have a protocol for initiating maternal and neonatal transports to an appropriate level of care.

Transport of Maternity Patients

Perinatal patients at LHDCMC may be transferred to another hospital for higher level of perinatal care when the patient is in stable condition and the requirements of transfer policies are met. The perinatal patient will also be transferred to an accepting hospital in the event a neonate's condition warrants transfer to a Level III or IV Neonatal Intensive Care Unit.

All maternal transports will be approved by a member of the medical staff on the receiving and referral side before the transport commences. The medical staff will facilitate the coordination of an appropriate transport team.

Exhibit p – Maternal Transport Process.

Transport of Infants

The LHDCMC Special Care Nursery will not accept primary transports of infants. Transfers from LHDCMC will be congruent with the infant's level of required care.

Infants who are in a level III or higher NICU may be back transferred to LHDCMC Special Care Nursery when they no longer require level III or higher care. The Special Care Nursery will be classified as a Level II Special Care Nursery.

Neonatal transport services will be contracted with facility who is licensed to transport neonates.

Infants may be transferred out to another institution in the event the infant's medical or family needs are better met at another institution, Special Care Nursery census is declared at "full capacity", or in an emergency evacuation under the direction of emergency management Incident Command.

All maternal transports will be approved by a member of the medical staff on the receiving and referral side before the transport commences. The medical staff will facilitate the coordination of an appropriate transport team.

Maternal and neonatal transports will be reviewed quarterly by the quality councils at LHDCMC Women's and Children's Services and Luminis Health Women and Children's Services.

Exhibit q: Infant Transport Process.

(13.5) The hospital shall have a written protocol for the acceptance of maternal and neonatal transports.

In emergency-situations, LHDCMC will accept maternal and neonatal transports based on the LHAAMC policies on maternal and infant policies. This would occur in emergency-situations only with medical staff and administrative approval taking into account all options and ensuring the ability to provide the highest level of care.
Maternal and neonatal transports will be reviewed quarterly by the quality councils at LHDCMC Women's and Children's Services and Luminis Health Women and Children's Services.
Exhibit p: Maternal Transport Process.
Exhibit q: Infant Transport Process.

(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 for 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 Level II hospital when the transported patient arrives.

All maternal transports will be routed to LHAAMC after consultation with the LHAAMC OB hospitalist, and/or the maternal fetal medicine physician on call. In the event the LHAAMC physician deems it necessary for the maternity patient to have a higher level of care, a member of the LHAAMC medical staff will coordinate the transportation to a tertiary Obstetric Program.
In emergency-situations, LHDCMC will accept maternal and neonatal transports based on the LHAAMC policies on maternal and infant policies. This would occur in emergency-situations only with medical staff and administrative approval taking into account all options and ensuring the ability to provide the highest level of care. LHDCMC is applying for a Level II Perinatal Program and is not required to meet this standard.

Maternal will be reviewed quarterly by the quality councils at LHDCMC Women's and Children's Services and Luminis Health Women and Children's Services.
Exhibit p: Maternal Transport Process.
Exhibit q: Infant Transport Process.

(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 patient;
(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.

Primary maternal transports will be routed to LHAAMC after consultation with the Anne Arundel OB hospitalist and/or the maternal fetal medicine physician on call. In the event the Anne Arundel physician deems it necessary for the maternity patient to receive a higher level of care, a member of the LHAAMC medical staff will coordinate the transportation to a tertiary Obstetric Program.
All American Ambulance (AAA) Transport Service is used for all patient transports from LHDCMC to other health care facilities. The AAA transport service requires a nurse to accompany when a pregnant patient is being transferred. If there is not a transport or obstetrical nurse available to accompany, an emergency department nurse will accompany the patient to the transfer destination.

In rare emergency-situations, LHDCMC will accept primary maternal transports preferably with > 32 weeks based on the LHAAMC maternal and infant policies. If gestational age is not confidently thought to be > 32 weeks maternal transfers should go to the health system with the highest level of neonatal care that is closest. Transfer to LHDCMC should only occur in extreme emergency-situations, requires not only medical staff but senior administrative approval and must take into account the ability to provide the highest level of care.
Maternal transports will be reviewed quarterly by the quality councils at LHDCMC Women's and Children's Services and Luminis Health Women and Children's Services.
Exhibit p: Maternal Transport Process.
Exhibit q: Infant Transport Process.

(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.
(b) There is not level III or IV hospital within a comparable distance to travel 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.

All neonatal transports will be routed to CNH after consultation with the CNH neonatologist on call. In the event the CHN neonatalogist deems it necessary for the neonatal patient to receive a higher level of care, a member of the LHDCMC medical staff will coordinate the transportation with CNH transport team.

In emergency-situations, LHDCMC will accept primary neonatal transports based on the LHAAMC maternal and infant policies. This would occur in emergency-situations only with medical staff and administrative approval taking into account all options and ensuring the ability to provide the

highest level of care.

Neonatal transports will be reviewed quarterly by the quality councils at LHDCMC Women's and Children's Services and Luminis Health Women and Children's Services.
Addendum: Transport between Institutions

(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.

All neonatal transports will be routed to CNH after consultation with the CNH neonatologist on call. In the event the CHN neonatalogist deems it necessary for the neonatal patient to receive a higher level of care, a member of the LHDCMC medical staff will coordinate the transportation with CNH transport team.

In emergency-situations, LHDCMC will accept primary neonatal transports based on the LHAAMC maternal and infant policies. This would occur in emergency-situations only with medical staff and administrative approval taking into account all options and ensuring the ability to provide the highest level of care

Neonatal transports will be reviewed quarterly by the quality councils at LHDCMC Women's and Children's Services and Luminis Health Women and Children's Services.
Addendum: Transport between Institutions

(13.10) The hospital shall have written protocols for accepting or transferring obstetrical patients or neonates as "back transports."

<u>Back Transport of Infant from Another Institution:</u>

- The infant's attending physician at the transferring hospital will contact the medical staff at LHDCMC to determine if the Special Care Nursery has available space, qualified staff, and meets criteria for the level II unit.
- Prior to accepting an infant, the LHDCMC neonatal provider will contact the Mother Baby/Special Care Nursery charge nurse for bed and staffing availability.
- After accepting the patient transfer, the receiving neonatal provider will contact the Mother Baby charge nurse with the diagnosis and admitting information.
- The Special Care Nursery charge nurse will provide appropriate communication with the security department and the ED Charge Nurse regarding the patients estimated time of arrival to the facility so that all resources can be mobilized and prepared at the time of arrival.
- The primary nurse of the infant being transported will contact the LHDCMC Special Care Nursery nurse to a give a verbal report of the infant's condition immediately prior to transport.
- Upon arrival of the infant to the LHDCMC Special Care Nursery, the Special Care Nursery nurse will receive report from the transport team, request medical records, and document the

admission condition of the infant and time of arrival.
- The patient becomes the responsibility of LHDCMC upon admission to the Special Care Nursery.

Transport of Obstetrical Patients

LHDCMC will not accept primary or back transports of maternity patients.

(13.11) the hospital shall have a licensed neonatal transport service or written agreement with a licensed neonatal transport service.

LHDCMC will contract with a licensed neonatal transport service for transport of neonates

(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.

LHDCMC Special Care Nursery will welcome the mother and support person 24 hours per day. Siblings and visitors will be welcomed between 0900 and 2100 each day to allow the neonate uninterrupted rest time unless surges in viral pathogens such as RSV, Influenza, Coronavirus, which may alter this visitation policy.

In Labor and Delivery, two visitors, plus the mother's support person, will be allowed in the patient room at any one time. Siblings will not counted in the number of visitors. Siblings must be accompanied by a responsible adult, other than the patient.
On the postpartum unit, two visitor passes will be available, plus the mother's support person, at any one-time. Siblings will not counted in the number of visitors. A responsible adult, other than the patient, must accompany siblings.

The mother and the designated support person will be given Special Care Nursery identification wristbands at the time of admission. The mother and support person will be able to visit 24 hours per day, seven days per week. Two visitor passes are available, and visitors must be accompanied by the mother, or designated support person. Siblings will not count in the visitor numbers. A responsible adult, other than the patient, must accompany siblings.

Exceptions to the visitation number include a critically ill mother or infant or perinatal loss. Additional visitors may be welcomed at the discretion of the mother, designated support person, medical personnel, and nursing staff. The peak of flu/RSVP season is another exception wherein children under the age of 12 years may not permitted to visit as directed by Infection Prevention. Parents will be given a special code to access clinical information so they can call the nursing staff in the Special Care Nursery at any time to receive an update on their baby.

(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.

LHDCMC will adapt the LHAAMC OB policies, care standards, and internal review system to eliminate deliveries by induction of labor or Cesarean section at 39 weeks gestation without a

medical indication.

For inductions, the physician will complete a request form, which includes approved indications and timing for induction based on national clinical practice guidelines, and in consultation with the maternal fetal medicine specialists. The OB laborist will review the list of requests for inductions one week prior to scheduling. This will ensure oversight that the criteria for the induction meet the criteria consistent with established policies and clinical practice standards. Persons deviating from the prescribed guidelines may request a consult with the maternal-fetal provider. The maternal-fetal specialists are responsible for making the final decision.

Cesarean sections will be scheduled through the surgical scheduling office. The office will use the policies and standards that outline the guidelines for scheduling cases. The OB laborist will review all scheduled cases a week in advance and all cases scheduled thereafter. The hospitalist will contact the scheduling physician to inform them when the case does not meet criteria.
All sections and inductions are reviewed by a team of peers to determine compliance with Luminis Health System policies and guidelines. Outliers will be referred to the Luminis Health System Women and Children's Executive Leadership Council Peer Review for follow up and recommendations for action.

Patients will be educated on the importance of vaginal delivery for the health of the mother and baby, and inductions, in multiple venues. Patient education occurs through the ambulatory offices, childbirth classes, maternity-newborn app, and Luminis Health maternity social media sources. The community educator/navigator will work in collaboration with the patient education team, ambulatory services and inpatient providers to ensure consistent and broadly disseminated education.

Medical providers and nursing staff will be educated in staff/service meetings, Quality and Safety Council, and one-on-one counseling.
Exhibit r: Cervical Ripening, Induction and Augmentation of Labor.

(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 all compatibility testing is complete, and
(e) management of multiple components of therapy.

LHDCMC will adapt the LHAAMC hemorrhage protocol, after review by a multidisciplinary team of obstetricians, maternal-fetal medicine provider, nursing, and blood bank at LHDCMC. The protocol will define obstetrical hemorrhage and provide a scoring system for determining the patient's risk for hemorrhage upon admission. The patient will be reassessed throughout their delivery and postpartum period. During OB laborist rounds, and during handoff with nurses and physicians, the hemorrhage scoring will be shared.

The three stages of hemorrhage are defined with clear criteria for treatment team, location of treatment (patient room, OR, or other location), treatment/care plan, and medication administration. A hemorrhage cart is located on Labor and Delivery, Labor and Delivery OR,

Labor and Delivery PACU, and Mother Baby unit to ensure easy access to all supplies and equipment needed to provide emergent and emergency care to the hemorrhaging obstetrical patient.

The following medications are readily available in the medication-dispensing machine located on Labor and Delivery, Labor and Delivery OR, Labor and Delivery PACU, and Mother Baby:

- Oxytocin
- Methergine
- Hemabate
- Cytotec
- Transexamic acid

The hemorrhage protocol is supported by a massive transfusion protocol, and ensures blood is available to the unit involved 24 hours a day, seven days per week. The blood products will be delivered by the blood bank staff according to established guidelines.

Exhibit k: Postpartum Hemorrhage Protocol.

LHDCMC will be in full compliance with August 21, 2019, The Joint Commission PC.06.01.01, *Reducing the likelihood of harm related to maternal hemorrhage*.

(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.

The medical and nursing staff will document all birth defects in the electronic medical record. The documentation will trigger the birth registrar to assist the mother with the completion of the form to be sent to the Birth Defects Reporting and Information System as required by Health-General Article, 18.206, Annotated Code of Maryland. Compliance with the completion of the form will be audited and results reviewed with the birth registrar, nursing, and medical staff.

(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;

All patients admitted to LHDCMC Perinatal units will have universal toxicology screening for opioids at the time of admission. The universal screening will be completed prior to the administration of any medications. Patients who arrive at Labor and Delivery in situations where delivery is imminent and there is no opportunity to obtain a toxicology screen, the baby will be tested prior to discharge.

(b) pharmacotherapy of the pregnant, laboring and postpartum woman;

The pharmacy and/or maternal-fetal medicine provider will be involved with pain management for all women who present to LHDCMC. The hospital will work directly with the patient's primary or addiction specialist to ensure proper dosing and support for continued treatment. The anesthesia

provider will work directly with the patient's primary care OB to support adhere to the treatment plan that best supports the patient's care and recovery.

(c) breastfeeding;

Mothers testing positive for opioids will be counseled by their obstetrician, pediatrician, and lactation consultant regarding breastfeeding of their baby. Mothers will be encouraged to breastfeed and will be provided support, education, and guidance throughout their hospital stay. They will be given access to the Luminis Health Warm Line for questions that may arise after discharge. The mothers will be encouraged to attend breastfeeding support groups sponsored by Luminis Health.

(d) linkages to appropriate postpartum psychosocial support services including substance use treatment and relapse prevention programs; and

All maternity patients testing positive for substance abuse will have an automatic social work referral. The social worker develops a plan for care for the mother and baby upon discharge. She will be referred to appropriate programs and housing in a treatment living facility will be made when indicated.

(e) reproductive health planning.

Patients will be counseled by their OB provider throughout their pregnancy on reproductive health planning. Intrauterine devices and tubal ligations will be made available to patients immediately after delivery wherever possible. The physician/midwife will also discuss contraceptive management at the time of the four to six week postpartum visit if this was not addressed immediately post partum. The written discharge instructions will be provided to the mother including the topic of reproductive health. The information will be reviewed with the patient by the discharging registered nurse.

(13.17) The hospital shall have a written policy for the identification and management of neonatal abstinence syndrome.

LHDCMC will use the Modified Finnegan Neonatal Abstinence Scoring Tool (MFNAST) or appropriately validated instrument at the time of initiation of perinatal care by LHDCMC. Signs and symptoms of NAS are related to specific in utero drug exposure and may appear any time from several hours to several weeks after birth.
Non-Pharmacologic treatments will be utilized for infants who demonstrate mild to moderate signs of NAS with a goal of keeping the couplet intact to provide opportunity for education and bonding. Pharmacologic treatment will be utilized in infants who demonstrate severe signs of NAS to prevent complications such as fever, weight loss and seizures. If pharmacologic treatment is necessary newborns will be transferred to either LHAAMC or facility capable of managing the complication of pharmacologic treatment of NAS newborns. The mother and support person will be encouraged to spend time with the neonate to console and gain knowledge on home care. A social work consult will be initiated for all neonates whose mothers have a positive toxicology screen. The social worker will make a referral to the Infant and Toddler's Program to give support to the family upon discharge. A pediatrician will be identified, and an appointment will be made prior to discharge.
Exhibit s: Substance Exposed Infant policy.

(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,

All delivering patients will be assessed for domestic violence, postpartum depression, hemorrhage, hypertension and surgical site infections throughout their hospitalization. Patients determined to be at high risk for poor health outcomes will be seen by their physician for follow-up in 48 to 72 hours. Unassigned patients will be seen by the nurse midwife or OB laborist for evaluation in the same timeframe. Patients with a high predictive score for hypertension will be provided a means to measure their blood pressure until their first postpartum visit.
All patients will receive a call the day after discharge. The caller will inquire if the patient has any symptoms or problems that would indicate poor health outcomes for them or the baby. All patients who indicate a positive response for health concerns will be called within two hours by a registered nurse who will triage and advise the patient of next steps in their care.

LHDCMC will be in full compliance with August 21, 2019, The Joint Commission PC.06.01.01 and PC.06.03.01 elements of performance related to maternal hemorrhage and severe hypertension/pre-eclampsia.

Exhibit k: Postpartum Hemorrhage Protocol.
Exhibit t: Eclampsia Guidelines.
Exhibit u: Gestational Hypertension and Pre-eclampsia Without Severe Features Guidelines.
Exhibit l: Maternal Safety Bundle: Chronic Hypertension with Superimposed Pre-Eclampsia Guidelines.

(b) breastfeeding support,

LHDCMC will have designated lactation consultants on staff to provide support and education to parents about breastfeeding. In addition, the nursing staff will receive ongoing continuing education so they can provide additional support throughout the patient's stay.

Patients delivering at LHDCMC will be given free access to a mother baby app for their phones. The app covers breastfeeding education from the first month of pregnancy through the first year of life. The patients will have access to the Luminis Health Warm Line for lactation questions that may arise after discharge. The Warm Line connects them to a certified lactation consultant who will assist as indicated. There will also be lactation support groups sponsored by Luminis Health.

The post-discharge caller will ask questions about breastfeeding. When the mother states she is having breastfeeding problems, or has questions she will be called within two hours by a registered nurse who will assess, support and refer the patient as indicated.

(c) linkages to appropriate medical and psychosocial services, and

All maternity patients will have access to a licensed clinical social worker for any psychosocial concerns. The social worker and domestic violence staff member will work with the mother to develop a safe plan of care at the time of discharge. The community educator/navigator will follow-up with the patient after discharge.

Patients with medical problems not related to their pregnancy will be referred to their primary medicine provider. The attending OB provider will supply the medicine provider with detailed

discharge information about the patient's pregnancy and hospital course.

(a) **reproductive health planning.**

The maternity provider will counsel the patient on reproductive health planning prior to delivery and at the time of discharge. The physician/midwife will discuss birth control at the time of the four to six week postpartum visit.

Patients will be counseled by their OB provider throughout their pregnancy on reproductive health planning. IUDs and tubal ligations will be made available to patients immediately after delivery. The physician/midwife will also discuss birth control at the time of the four to six- week postpartum visit.

(13.19) The hospital shall have a written policy to address infant safety issues including safe sleep, abusive head trauma (shaken baby), and care seat safety.

LHDCMC will have a written policy to address infant safety education. It will be provided to the mother and the support person during their hospital stay and upon discharge. The infant safety education provided will include safe sleep, shaken baby, car seat usage, falls, feeding guidelines and signs and symptoms indicating a need for emergency care. Parents will be trained in CPR prior to the infant's discharge from the Special Care Nursery. The mother and the support person will receive written copies of the education and are encouraged to be enrolled in a Luminis Health application that provides additional education and reinforcement throughout the baby's first year of life.

EXHIBIT 19a

Anne Arundel Medical Center

SNP15.2.165 - Labor, Delivery, Recovery, Postpartum

Scope

Luminis Health Anne Arundel Medical Center, Inc. (AAMC) Labor and Delivery, Postpartum, and Antepartum Services

Purpose

The purpose of this policy is to provide guidelines for the nursing staff during the antepartum, intrapartum, and postpartum period.

Definitions

None

Policy Statements & Procedures

Policy Statements

1. During the laboring process, delivery, and postpartum period, the patient is closely observed by the nurse in order to promote normal physiological and psychological adaptations. Staff will assist the patient and their family in meeting goals for the birth and postpartum experience.

2. Risk Factors that may necessitate continuous EFM and/or assessment at more frequent intervals:

a. Current or Past Medical History - asthma, anemia (Hb <10gm/dL), cardiac disease, collagen vascular disease, diabetes, eclampsia, epilepsy, severe flu syndrome, genetic/metabolic disease, hemoglobinopathy/hematologic disease, hypertension, history of substance abuse

b. Current Obstetric Conditions - abnormal fetal-placental tests (Doppler flow of biophysical profile (BPP)), amnionitis, dysfunctional labor, fetal-maternal hemorrhage, hemorrhage, IUGR, irregular auscultated FHR, meconium stained amniotic fluid, multiple gestation, non-reassuring FHR pattern or components, persistent deceleration pattern, persistent decreased FHR variability, fetal bradycardia, fetal tachycardia, rising baseline FHR, oligohydramnios, oxytocin induction/augmentation, placental factors (abruption, insufficiency, marginal separation, or previa), pre-eclampsia, preterm labor, post term, polyhydramnios, prolonged second stage, proteinuria (0.5-1.0 gram/day < 20 weeks; >1.0 gram/day > 20 weeks), temperature >100.4 °F, ruptured membranes > 18 hours, small for gestational age, twin to twin transfusion, uterine

tachysytole/hypertonus, third trimester bleeding

c. Previous OB History - Vaginal birth after cesarean (VBAC)/previous cesarean delivery, previous stillbirth, intrauterine fetal demise (IUFD), or neonatal death, intrauterine growth restriction (IUGR), Multiparity (>5), pre-eclampsia/hypertensive diseases of pregnancy, previous uterine surgery, Rh sensitization with or without fetal anemia and transfusion

Procedures

I. During the Intrapartum period:

A. The RN will:

1. Complete the OB database.

2. Obtain an initial continuous 20 minute electronic fetal monitoring (EFM) strip to document and establish the FHR baseline and fetal status.

3. Assess and document the following according to NICHD definitions and classifications.

a. uterine activity via palpation and/or uterine monitor:

i. frequency
ii. duration
iii. intensity of contractions for both palpation and intrauterine pressure catheter (IUPC)
iv. the resting tone
v. the presence of abnormal uterine activity characteristics

b. fetal well-being via auscultation or electronic fetal monitoring

4. Fetal heart rate baseline must be established by 20 minute EFM assessment prior to implementing auscultation as the method of fetal assessment.

a. The auscultation method can be accomplished by counting the baseline FHR between uterine contractions for 30-60 seconds and counting the FHR during a contraction and for 30 seconds after a contraction to identify fetal response.

b. Document the presence of absence of increases or decreases of the FHR and their relationship to contractions, if present. Uterine contractions are assessed by palpation when FHR is auscultated.

c. Assess FHR by auscultation prior to ambulation of the patient.

d. Assess FHR by auscultation immediately following artificial or spontaneous rupture of membranes, vaginal examination or fetal stimulation, ambulation of the patient, transfer or discharge of the patient, or abnormal uterine activity.

5. If at any time during intermittent monitoring and auscultation the status of fetal well-being is

questionable, initiate continuous electronic fetal monitoring to clarify and document components of the FHR. Notify the Medical Staff/House Staff of any technically inadequate audible FHR.

6. Documentation of the FHR includes: numerical baseline rate; presence of and description of accelerations and/or decelerations, including their relationship to contractions, variability, and response to any interventions.

7. Documentation of the uterine activity includes: frequency, interval, and intensity of contractions, and resting tone.

a. With an IUPC

i. Determine contraction amplitude by subtracting the difference in mm Hg between the contraction peak and the baseline. Adequate labor is variable but usual ranges are from 25 mmHg to 75 mmHg.
ii. Use Montevideo units (MVU)

1. Determine contraction amplitude for each contraction in a 10 minute window.
2. Add the values obtained for contraction amplitude in the 10 minute window.
3. Adequate labor is variable but MVUs totaling at least 200 in a 10 minute period is considered adequate labor.

B. Frequency of fetal monitoring documentation:

1. Document patient status based on the stage of labor

a. For low-risk patients, the RN will document:

i. hourly in the latent phase (0-3 cm),
ii. every 30 minutes during the active phase of labor (4-10 cm), and
iii. every 15 minutes during the second stage of labor (10 cm - delivery).

b. High-risk patients require continuous fetal monitoring. For high-risk patients, the RN will document interpretation of the continuous fetal monitor strip:

i. every 30 minutes in the latent phase,
ii. every 15 minutes during the active phase, and
iii. every 15 minutes during the second stage of labor.

2. For the patient being induced or augmented with oxytocin, the RN will document interpretation of the continuous fetal monitor strip:

a. every 15 minutes-30 minutes

b. assessment and documentation of patient and fetal status must occur with each change in oxytocin rate.

3. If a patient is receiving epidural anesthesia, assess FHR prior to, during, and after the procedure

C. Assessment and documentation of maternal well-being and progress of labor will include:

1. Blood pressure, pulse, respirations every hour

2. Temperature every 4 hours while membranes are intact and patient is afebrile; every 2 hours for ruptured membranes; every hour if febrile

3. Intake and output

4. Presence/absence of bloody show, vaginal bleeding, amniotic fluid color and odor

5. Presence of pain or discomfort

6. Bladder status every 2-3 hours

7. Effectiveness of patient coping and stress tolerance during labor and response to comfort measures

D. Nursing support for labor may include, but will not be limited to: comfort/labor support measures; paced/patterned/or coached breathing; effleurage; frequent position changes; ambulation; birthing ball; application of cold/heat; counter pressure; upright positioning; guided imagery; relaxation techniques; water therapy; attention to hygiene; bathroom privileges, bed pan or catheterization as ordered for urine specimen/prevention of urinary retention; pericare; emotional support

E. Second stage labor management includes:

1. assessment of patient understanding of and expectations for second stage labor
2. use of upright positioning
3. frequent position changes (every 30 minutes)
4. use of non-directed pushing when maternal urge to push is present

F. Interventions for non-reassuring FHR tracing:

1. notify Medical Staff/House Staffand initiate routine nursing interventions
2. change patient position
3. discontinue oxytocin if running
4. consider administration of oxygen at 10 liters/minute via non-rebreather mask
5. increase intravenous fluids
6. assess for signs and symptoms of placental abruption, rapid descent, or cord prolapse
7. perform vaginal exam
8. evaluate fetal response to interventions
9. continue interventions based on fetal response
10. anticipate emergency preparations for surgical intervention if non- reassuring fetal responses persist despite interventions

G. Interventions for uterine tachysystole - Use the Tachysystole Algorithm (see attachment)

a. have patient empty her bladder and reposition the patient to maximize uterine blood flow
b. decrease or discontinue oxytocin
c. increase IV fluids
d. anticipate the use of a tocolytic agent

I. Provide teaching according to patient's or support person's learning needs.

II. During the Postpartum period, the RN will:

1. Once the postpartum recovery has been initiated after delivery of placenta, assess and document the following:
a. Vital Signs
b. Fundal height and consistency
c. Lochia

- every 15 minutes x 4 times;
- every 30 minutes x 2 times;
- every 60 minutes x 2 times;
- then every 4 hours x 12 hours for vaginal deliveries and every 4 hours x 24 hours for cesarean section deliveries.
- After these assessments are completed, assess the patient twice a day until discharge unless postpartum status warrants otherwise.

2. Cesarean section patients with no risk factors who received intrathecal narcotics (ITN) will be monitored: Hourly respiratory assessments without needing to wake sleeping mothers for the first 14 hours, followed by every other hour for the following 10 hours.

3. Cesarean section patients with BMI > 35; known obstructive sleep apnea (OSA); spinal morphine sulfate > 0.25 mg; or epidural morphine sulfate > 2.5 mg who received ITN will be monitored: Hourly assessments of Respiration Rate (RR) and O2 Saturation while patient is awake for the first 14 hours. The RR and O2 Saturation checks drop to every other hour for the final 10 hours.

4. Provide skin-to-skin contact as soon as appropriate and attempt the first infant feeding within one hour of birth if infant's condition allows. Provide opportunities for family bonding.

5. Implement nursing interventions for the post partum patient based on individual needs, method of infant feeding and a review of the prenatal and delivery records.

6. Provide comfort measures which may include, but will not be limited to: position changes; ambulation; application of cold/heat; guided imagery; relaxation techniques; attention to hygiene; prevention of urinary retention; pericare; emotional support; analgesics; breast care. Consult with Medical Staff/House Staff if comfort measures are inadequate.

7. Consult with appropriate medical provider for abnormal findings.

8. Initiate consults for Social Work, Domestic Violence, Glycemic Management Team, Smoking Cessation, Dietician and Spiritual Care based upon nursing assessments and identified risk factors. Other consults require a physician's order (PT, OT, RT).

9. Initiate consult with Lactation. according to the AAMC Breastfeeding Policy.

10. Provide on-going teaching related to infant and maternal needs after readiness for learning is demonstrated and learning barriers are identified. Education is provided in the patient's desired language.

11. Upon admission to the postpartum unit, begin the continuum of care moving towards discharge.

12. Provide written instructions for care after discharge.

References

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2. American Academy of Pediatrics & American College of Obstetricians and Gynecologists (2017). Guidelines for perinatal care (8th ed). Washington DC: ACOP, AAP
3. Mattson, S. & Smith, J. (2011). Core Curriculum for Maternal Newborn Nursing, (5th ed.). Philadelphia: Elsevier/Saunders
4. Simpson, K.R., & Creehan, P.A. (2020). AWHONN's Perinatal Nursing (5th ed.). Lippincott, Williams & Wilkins.
5. Macones, G.A. and others. (2008). The 2008 National Institute of Child Health and Human Development workshop report on electronic fetal monitoring: Update on definitions, interpretation, and research guidelines. JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing, 37(5), 510-515. (classic reference)
6. NCC (National Certification Corp.) (2016) Fetal assessment and safe labor management. https://www.nccwebsite.og/content/documents/cms/2021_ncc_monographfinal_3-16-21.pdf

Cross References

Hemorrhage, Obstetrical (https://together.aahs.org/Policies-and-procedures/Hemorrhage,-Obstetrical/)

Pain Assessment and Resources (https://together.aahs.org/Policies-and-procedures/Pain-Assessment-and-Resources/)

Breastfeeding (https://together.aahs.org/Policies-and-procedures/Breastfeeding/)

Bottle Feeding the Newborn (https://together.aahs.org/Policies-and-procedures/Bottle-Feeding-the-Newborn/)

(https://together.aahs.org/Policies-and-procedures/Epidural-Anesthesia---Caring-For-Laboring-Patients-With-Regional-Analgesia---Anesthesia/)

Approval Date

CNO - 08/2021

Owner

Labor & Delivery

EXHIBIT 19b

Doctors Community Medical Center

Labor and Delivery

Provision of Care

Description of Department

Labor and Delivery is located on the second floor of the Women and Children's Tower. Labor and Delivery consists of the following:

- OB Triage – 4
- Labor and Delivery Rooms - 8
- Birthing Center Rooms - 2
- Antepartum Rooms - 2
- Operating Rooms – 2
- Procedural Operating Room - 1
- Post Anesthesia Care Bays – 4

All Labor and Delivery rooms are private and are fully equipped for the care of antepartum, laboring and delivering patients and their newborns. The unit has a primary work and communication center located at the entrance of the unit and satellite stations throughout the unit. The nurse call system directly links the nursing staff to the patient rooms and to the patient care secretary as a backup for the call. The Labor and Delivery average daily census is five to eight laboring patients and two to four non-laboring patients.

Scope of Service

Labor and Delivery provides care antepartum, pregnant and laboring patients. Postpartum patients are cared for on this unit when the need arises due to high census or increased acuity.

Patients cared for on Labor and Delivery are patients of childbearing age.

Personnel – Collaborative Patient Family Centered Care

Patient/family care is provided by a collaborative, multidisciplinary team who builds on the unique knowledge, judgement and skills of the various disciplines to achieve desired patient outcomes. There are three formalized patient communication structures in place. First, daily safety rounds with the patient, Labor and Delivery charge nurse and OB laborist. Second, the maternity charge nurses, administration and physicians meet four times each day at bed board to review all patients and suggest changes in the patient's plan of care. Lastly, between two direct care registered nurses and the patient participate in bedside shift report at change of shift and other times when care is handed off between nurses. Additional communication structures includes huddles with direct care providers and family meetings with the direct care providers and patient/family.

In the event of a difference of opinion regarding patient care, the nurse and physician will use TeamSTEPPS principles following the Women and Children's Services Chain of Communication.

The following identifies members of the health care team who provide direct services to Labor and Delivery:

Medical

- OB GYN physicians
- Maternal fetal medicine physicians
- Neonatologists
- Pediatricians
- Anesthesiologists
- Nurse Anesthetist
- OB/GYN Resident
- Certified nurse midwives

A board-certified physician (or active candidate for board-certification) with obstetrical privileges present in-house 24 hours a day and immediately available to the delivery area when a patient is in active labor. A board-certified obstetrician will serve as the medical director to oversee the care provided to all maternity patients.

A board-certified neonatologist or pediatrician will be in house or readily available at all times. A board-certified neonatologist will serve as the medical director for care delivered to all neonates.

A board-certified anesthesiology provider readily coverage available 24/7 to manage obstetrical care in the surgical suites and the administration of anesthetics for procedures and deliveries.

The nursing leadership team will consist of the clinical director, clinical supervisors, nurse educator and nurse navigator. A minimum of one will be master's prepared in nursing or a health related field.

The board certified obstetrician medical director and the nursing clinical director will work in collaboration to ensure evidence-based practice guidelines, efficient workflows and resource use.

Staffing consists of the following:

Nursing

- Registered nurses
- Clinical supervisor
- Charge nurse
- Triage nurse
- International Board-Certified lactation consultants

- Surgical technicians
- Patient care secretaries

Support Services

- Respiratory therapists
- Pharmacy services
- LMSW or LCSW
- Domestic violence services
- Social workers
- Case managers
- Laboratory services
- Radiology services
- Environmental services
- Sterile processing
- Food Services
- Translators
- Chaplains
- Physical therapy

Administrative

- OB medical director
- Maternal fetal medicine medical director
- Neonatal medical director
- Clinical Director – Nursing
- Community education/navigator
- Clinical educators

Nursing Staffing

Staffing patterns are determined utilizing Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), American College of Obstetricians and Gynecologists (ACOG) Association of peri-Operative Registered Nurses (AORN), International Board of Lactation Consultants (IBCLC) and the American Society for Perianesthesia Nurses (ASPAN) guidelines. The staffing pattern used in Labor and Delivery is determined by staffing guidelines, patient's labor status and nurse competencies.

The staffing ratios are supported by hiring an adequate complement of nurses to staff the units, including prn and flex staff who can be called in during times of high census or acuity. The nursing leadership team, including clinical supervisors, clinical educators, perinatal director and community educator/navigator will provide additional clinical staffing support should the need arise.

The OB surgical technician supports the registered nurses with patient care and surgical interventions. They are cross-trained to provide support and care on Labor and Delivery, Special Care Nursery and Mother Baby. Patient care secretaries provide clerical support and unit access control.

Nursing Competencies

Hospital and Women and Children's Services orientation lays the foundation for unit specific competencies. New hires are required to complete Labor and Delivery competencies prior to the completion of orientation. In addition, staff will be required to complete the following prior to the completion of orientation:

- NRP
- CPR
- OBACLS
- TeamSTEPPs
- S.T.A.B.L.E.
- CPI
- NRP

Nurses will be required to complete the following within in the first year of hire:

- EFM Certification
- Participation in an OB simulation (1 every 2 years
- T Piece Resuscitator

Continuing education programs are provided based on quality improvement outcomes, implementation of new evidenced-based practices or equipment, and staff assessment of learning needs.

Admission Criteria

The following patients will be appropriate for care in the Labor and Delivery at DCH:

- Infants with EFW $\geq$ 1500 grams and $\geq$ 32 weeks gestation
- Premature rupture of membranes of infants EFW $\geq$ 1500 grams and $\geq$ 32 weeks gestation
- Maternal Cervical ripening for an infant $\geq$ 32 weeks gestation and EFW $\geq$ 1500 grams
- Medical induction for an infant $\geq$ 32 weeks gestation and EFW $\geq$ 1500 grams
- Fetal death in utero without disseminated intravascular coagulopathy (DIC)
- Low risk women with uncomplicated pregnancies and women with higher-risk conditions as noted below:
  - Uncomplicated twin gestation – non-monochorionic
  - Labor after Cesarean delivery with known uterine scar
  - Pre-eclampsia without severe features, HELLP syndrome, oliguria, or pulmonary edema,
  - Well controlled gestational diabetes

- Placenta Previa with or without previous uterine surgery or placenta accreta
- Maternal medical conditions that do not require additional monitoring such as pregestational diabetes, poorly controlled asthma, or poorly controlled or complicated chronic hypertension
- Anticipated complicated Cesarean delivery

Patients not meeting the criteria for admission or continued care on Labor and Delivery will be evaluated by the patient's primary OB medical provider and the OB laborist using the guidelines for care at a Level II perinatal center and the availability of human and physical resources. In the event a mutually agreeable decision cannot be reached, the Women and Children's Services Chain of Communication will be implemented. In the event of a need to transfer the maternity patient, the maternity transfer policy is followed.

Full Capacity Procedure

When Labor and Delivery has reached full capacity, physicians will be asked to assess their patient for disposition to home or transfer to Mother Baby. Triage, birthing center and antepartum rooms may be used as delivery rooms. Depending on the stability of the patient, medical surgical beds may be used for antepartum patients with obstetrical oversight.

Quality Improvement

Providing the right care to the right patient at the right time with the right resources is a guiding quality and safety principle of Women and Children's Services. Opportunities for improvement are identified by monitor clinical outcomes outlined by regulatory and professional organizations (AWHONN, ACOG, MHA, NANN, IBCLC, Joint Commission) hospital strategic plan, patient satisfaction results, management reporting system and process improvement metrics.

Quality data are reviewed and plans of action developed by the unit based quality council. The Luminis Health Women and Children's Executive Council has final oversight of the review, action plan and outcomes.

EXHIBIT 19c

Doctors Community Medical Center

Special Care Nursery

Provision of Care

Description of Department

The Special Care Nursery is located on the third floor of the Women and Children's Tower. Mother Baby consists of the following:

- Special Care Nursery - 4

All Special Care Nursery rooms are private and are fully equipped for the care of neonates within the scope of a Level II Special Care Nursery. The unit has a primary work and communication center located at the entrance of the unit and satellite stations throughout the unit. The nurse call system directly links the nursing staff to the patient rooms and to the patient care secretary as a backup for the call. The Mother Baby average daily of 12 to 20 census postpartum patients and their infants with an average length of stay of 2.4 days.

Scope of Service

The Special Care Nursery provides care to premature and ill neonates who meet the Level II Special Care criteria. Doctors Community hospital will not accept primary transfers. They will accept back transfers for continued care patients who meet the established criteria.

Patients cared for in Special Care Nursery are newborns.

Personnel – Collaborative Patient Family Centered Care

Patient/family care is provided by a collaborative, multidisciplinary team who builds on the unique knowledge, judgement and skills of the various disciplines to achieve desired patient outcomes. There are three formalized patient communication structures in place. First, daily multidisciplinary rounds with parents, pediatric provider, charge nurse, primary nurse, pharmacy and social worker. Second, the maternity charge nurses, administration and physicians meet four times a day at bed board to review all patients and suggest changes in the patient's plan of care. Lastly, between two direct care registered nurses and the patient participate in bedside shift report at change of shift and other times when care is handed off between nurses. Additional communication structures include huddles with direct care providers and family meetings with the direct care providers and patient/family.

In the event of a difference of opinion regarding patient care, the nurse and physician will use TeamSTEPPs principles following the Women and Children's Services Chain of Communication.

The following identifies members of the health care team who provide direct services to Labor and Delivery:

Medical

- OB GYN physicians
- Maternal fetal medicine physicians
- Neonatologists
- Pediatricians
- Anesthesiologists
- Nurse anesthetist
- OB/GYN Resident
- Certified nurse midwives

A board-certified physician (or active candidate for board-certification) with obstetrical privileges is present in-house 24 hours a day and immediately available to the Mother Baby unit. A board-certified obstetrician will serve as the medical director to oversee the care provided to all maternity patients.

A board-certified neonatologist or pediatrician will be in-house or readily available at all times. A board-certified neonatologist will serve as the medical director for care delivered to all neonates.

A board-certified anesthesiology provider readily coverage available 24/7 to manage obstetrical care in the surgical suites and the administration of anesthetics for procedures and deliveries.

The nursing leadership team will consist of the clinical director, clinical supervisors, nurse educator and nurse navigator. A minimum of one will be master's prepared in nursing or a health-related field.
The board-certified obstetrician medical director and the nursing clinical director will work in collaboration to ensure evidence-based practice guidelines, efficient workflows and resource use.

Staffing consists of the following:

Nursing

- Registered nurses
- Clinical supervisor
- Charge nurse
- Triage nurse
- International Board-Certified lactation consultants
- Surgical technicians

- Patient care secretaries

Support Services

- Respiratory therapists
- Pharmacy services
- LMSW or LCSW
- Domestic Violence services
- Social workers
- Case managers
- Laboratory services
- Radiology services
- Environmental services
- Sterile processing
- Food Services
- Translators
- Chaplains
- Physical therapy

Administrative

- OB medical director
- Maternal fetal medicine medical director
- Neonatal medical director
- Clinical Director – Nursing
- Community education/navigator
- Clinical educators

Nursing Staffing

Staffing patterns are determined utilizing Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), American College of Obstetricians and Gynecologists (ACOG) Association of peri-Operative Registered Nurses (AORN), International Board of Lactation Consultants (IBCLC) and the American Society for Perianesthesia Nurses (ASPAN) guidelines. The staffing pattern used in Labor and Delivery is determined by staffing guidelines, patient's labor status and nurse competencies.

The staffing ratios are supported by hiring an adequate complement of nurses to staff the units, including prn and flex staff who can be called in during times of high census or acuity. The nursing leadership team, including clinical supervisors, clinical educators, perinatal director and community educator/navigator will provide additional clinical staffing support should the need arise.

The OB surgical technician supports the registered nurses with patient care and surgical interventions–trained as patient care technicians. They are competent to work on Labor and Delivery, Mother Baby and the Special Care Nursery. Patient care secretaries provide clerical support and unit access control.

Nursing Competencies

Hospital and Women and Children's Services orientation lays the foundation for unit specific competencies. New hires are required to complete Labor and Delivery competencies prior to the completion of orientation. In addition, staff will be required to complete the following prior to the completion of orientation:

- NRP
- CPR
- TeamSTEPPs
- S.T.A.B.L.E.
- CPI

Nurses will be required to complete the following within in the first year of hire:

- Participation in an OB simulation

Continuing education programs are provided based on quality improvement outcomes, implementation of new evidenced-based practices or equipment, and staff assessment of learning needs.

Admission Criteria

The following patients will be appropriate for care in the Special Care Nursery:

- Moderately ill neonates or stable growing low birth weight neonates born at greater than 32 weeks gestation, and/or with a birth weight of $\geq$ 1500 grams. Moderately ill infants who are not anticipated to need subspecialty care on an urgent basis.
- Infants requiring medical treatment and/or nursing interventions and assessment/reassessment of response to interventions more frequently than every four hours.
- Infants requiring a controlled temperature environment due to temperature instability.
- Infants with hemodynamic instability or unstable vital signs defined as:
    - Hypotension/hypertension according to gestational age/weight
    - Bradycardia/tachycardia according to gestational age
    - Tachypnea, defined as sustained respiratory rate >60 breaths/minute.
- Infants with umbilical arterial catheter, umbilical venous catheter, peripheral IV requiring continuous IV infusion, or peripheral arterial line.
- Cardiovascular
    - Arrhythmias/bradycardia requiring continuous monitoring/supportive treatment/diagnostic/procedures
    - Cyanotic heart disease

- Respiratory
    - Infants requiring any oxygen support
    - Infants with apnea
    - Infants requiring positive pressure respiratory support for greater than 48 hour will require a neonatology consult with a Level III or IV NICU provider
    - Infants requiring oxyhood, nasal cannula, high-flow nasal cannula or NCPAP/SiPAP as long as the infant's condition is improving
- Neurologic
    - Infants with neurologic conditions requiring supportive treatment or diagnostic procedures including, but not limited to infants with potential/suspected seizure activity. Would consider transferring to higher level of care for worsening neurological conditions outside of SCN scope
- Gastrointestinal/Surgery/Nutritional
    - Infants requiring intermittent or continuous gavage feeds
- Hematologic
    - Infants with anemia resulting in hemodynamic and/or respiratory compromise
    - Infants requiring exchange transfusion
- Endocrine
    - Infants with persistent hypoglycemia
- Renal
    - Electrolyte disorders requiring IV therapy and frequent IV/PO correction
- Infectious Disease
    - Positive culture or suspected infection requiring IV antibiotics
- Hyperbilirubinemia not requiring exchange transfusion
- Neonatal Abstinence Syndrome
- Initial sepsis evaluation for an asymptomatic infant
- Social
    - Newborn whose mother is critically ill and unable to care for her infant
    - Newborn requiring social services intervention or placement

Patients not meeting the criteria for admission or continued care in the Special Care Nursery will be evaluated by the pediatric provider and patient's primary pediatric provider using the guidelines for care at a Level II Special Care Nursery and the availability of human and physical resources. In the event a mutually agreeable decision cannot be reached, the Women and Children's Services Chain of Communication will be implemented. In the event of a need to transfer the neonate, the neonatal transfer policy is followed.

Full Capacity Procedure

When the Special Care Nursery has reached full capacity, physicians will be asked to assess their patient for discharge or transfer. The Mother Baby well baby procedural area may be used for stable and short-term care until other arrangements can be made.

Quality Improvement

Providing the right care to the right patient at the right time with the right resources is a guiding quality and safety principle of Women and Children's Services. Opportunities for improvement are identified by monitor clinical outcomes outlined by regulatory and professional organizations (AWHONN, ACOG, MHA, NANN, IBCLC, Joint Commission) hospital strategic plan, patient satisfaction results, management reporting system and process improvement metrics.

Quality data are reviewed and plans of action developed by the unit-based quality council. The Luminis Health Women and Children's Executive Council has final oversight of the review, action plan and outcomes.

EXHIBIT 19d

Special Care Nursery Team Attendance at Deliveries

Scope

Doctors Community Hospital, Inc. (AAMC) Labor and Delivery, Neonatal Intensive Care (NICU), and Antepartum Services

Purpose

The presence of Special Care Nursery staff at delivery may be needed to provide the transitioning neonate with highly qualified medical and nursing support when certain antepartum conditions exist. The purpose of this policy is to clarify those conditions.

Definitions

"Special Care Nursery team" - may include a neonatal medical provider, Special Care Nursery nurse or a Neonatal Resuscitation Provider (NRP) certified registered nurse, and/or respiratory therapist.

Policy Statements & Procedures

The labor & delivery nurse will notify the Special Care Nursery nurse or designee when any of the following conditions exist. At the medical staff members or primary nurse's discretion, the Special Care Nursery team will be asked to attend the delivery.

1. Fetal indications

- gestational age between 32 - 35 6/7 weeks
- gestational age greater than 42 weeks
- non-reassuring fetal heart rate such as persistent late decelerations, variable decelerations with minimal or decreasing variability, fetal tachycardia or bradycardia, prolonged decelerations
- meconium stained amniotic fluid
- umbilical cord prolapse
- apparent fetal anomalies
- sedative or analgesic drugs administered within one hour of birth
- multiple gestation
- abnormal fetal testing (Doppler flow or unacceptable BPP)

2. Operative delivery

- cesarean delivery (for scheduled cesarean delivery a medical staff member only is acceptable)
- mid or high forceps or mid or high vacuum delivery
- ruptured uterus
- breech or other malpresentation

- general anesthesia

3. Maternal indications

- third trimester bleeding
- suspected abruptio placenta
- foul smelling amniotic fluid with non-reassuring fetal heart tracing
- severe hypertensive disorders of pregnancy (pre-eclampsia, eclampsia, hypertension, elevated liver, low platelets (HELLP) syndrome)
- unknown gestational age/unregistered patient or fetal compromise
- oligohydramnios
- polyhydramnios
- isoimmunization
- double set-up
- shoulder dystocia

EXHIBIT 19e

Doctors Community Medical Center

Mother Baby

Provision of Care

Description of Department

Mother Baby is located on the third floor of the Women and Children's Tower. Mother Baby consists of the following:

- Mother Baby Rooms - 24
- Well Baby Procedural Area

All Mother Baby rooms are private and are fully equipped for the care of postpartum patients and their newborns. The unit has a primary work and communication center located at the entrance of the unit and satellite stations throughout the unit. The nurse call system directly links the nursing staff to the patient rooms and to the patient care secretary as a backup for the call. The Mother Baby average daily of 12 to 20 census postpartum patients and their infants with an average length of stay of 2.4 days.

Scope of Service

Mother Baby provides care to postpartum patients and their infants, including late preterm neonates. Stable antepartum patients may be cared for on this unit when the need arises due to high census or increased acuity on Labor and Delivery.

Patients cared for on Mother Baby are patients of childbearing age and their neonates.

Personnel – Collaborative Patient Family Centered Care

Patient/family care is provided by a collaborative, multidisciplinary team who builds on the unique knowledge, judgement and skills of the various disciplines to achieve desired patient outcomes. There are two formalized patient communication structures in place. First, the maternity charge nurses, administration and physicians meet four times each day at bed board to review all patients and suggest changes in the patient's plan of care. Lastly, between two direct care registered nurses and the patient participate in bedside shift report at change of shift and other times when care is handed off between nurses. Additional communication structures includes huddles with direct care providers and family meetings with the direct care providers and patient/family.

In the event of a difference of opinion regarding patient care, the nurse and physician will use TeamSTEPPs principles following the Women and Children's Services Chain of Communication.

The following identifies members of the health care team who provide direct services to Labor and Delivery:

Medical

- OB GYN physicians
- Maternal fetal medicine physicians
- Neonatologists
- Pediatricians
- Anesthesiology
- Nurse Anesthetist
- OB/GYN Resident
- Certified nurse midwives

A board-certified physician (or active candidate for board-certification) with obstetrical privileges present in-house 24 hours a day and immediately available to the Mother Baby unit. A board-certified obstetrician will serve as the medical director to oversee the care provided to all maternity patients.

A board-certified neonatologist or pediatrician will be in house or readily available at all times. A board-certified neonatologist will serve as the medical director for care delivered to all neonates.

A board-certified anesthesiology provider readily coverage available 24/7 to manage obstetrical care in the surgical suites and the administration of anesthetics for procedures and deliveries.

The nursing leadership team will consist of the clinical director, clinical supervisors, nurse educator and nurse navigator. A minimum of one will be master's prepared in nursing or a health related field.

The board certified obstetrician medical director and the nursing clinical director will work in collaboration to ensure evidence-based practice guidelines, efficient workflows and resource use.

Staffing consists of the following:

Nursing

- Registered nurses
- Clinical supervisor
- Charge nurse
- Triage nurse
- International Board-Certified lactation consultants
- Surgical technicians/PCT
- Patient care secretaries

Support Services

- Respiratory therapists
- Pharmacy services
- LMSW or LCSW
- Domestic Violence services
- Social workers
- Case managers
- Laboratory services
- Radiology services
- Environmental services
- Sterile processing
- Food Services
- Translators
- Chaplains
- Physical therapy

Administrative

- OB medical director
- Maternal fetal medicine medical director
- Neonatal medical director
- Clinical Director – Nursing
- Community education/navigator
- Clinical educators

Nursing Staffing

Staffing patterns are determined utilizing Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), American College of Obstetricians and Gynecologists (ACOG) Association of peri-Operative Registered Nurses (AORN), International Board of Lactation Consultants (IBCLC) and the American Society for Perianesthesia Nurses (ASPAN) guidelines. The staffing pattern used in Labor and Delivery is determined by staffing guidelines, patient's labor status and nurse competencies.

The staffing ratios are supported by hiring an adequate complement of nurses to staff the units, including prn and flex staff who can be called in during times of high census or acuity. The nursing leadership team, including clinical supervisors, clinical educators, perinatal director and community educator/navigator will provide additional clinical staffing support should the need arise.

The OB surgical technician supports the registered nurses with patient care and surgical interventions–trained as patient care technicians. They are competent to work on Labor and Delivery, Special Care Nursery, and Mother Baby. Patient care secretaries provide clerical support and unit access control.

Nursing Competencies

Hospital and Women and Children's Services orientation lays the foundation for unit specific competencies. New hires are required to complete Labor and Delivery competencies prior to the completion of orientation. In addition, staff will be required to complete the following prior to the completion of orientation:

- NRP
- CPR
- TeamSTEPPS
- S.T.A.B.L.E.
- CPI
- Blood Glucose Monitoring and Treatment
- Neonatal Pain
- Mock Code Blue

Nurses will be required to complete the following within in the first year of hire:

- Participation in an OB simulation

Continuing education programs are provided based on quality improvement outcomes, implementation of new evidenced-based practices or equipment, and staff assessment of learning needs.

Admission Criteria

The following patients will be appropriate for care on Mother Baby:

- Postpartum patients who delivered vaginally or by C-Section
- Stable neonates, including hyperbilirubinemia and NAS newborns not requiring medication
- Stable neonates, including those meeting requirements for blood glucose monitoring per guidelines not meeting admission criteria for Special Care Nursery
- Stable antepartum patients not requiring continuous electronic fetal monitoring
- Stable medical-surgical patient not requiring cardiac monitoring

Patients not meeting the criteria for admission or continued care on Mother Baby will be evaluated by the patient's primary OB medical provider and the OB laborist using the guidelines for care at a Level II perinatal center and the availability of human and physical resources. In the event a mutually agreeable decision cannot be reached, the Women and Children's Services Chain of Communication will be implemented. In the event of a need to transfer the maternity patient, the maternity transfer policy is followed.

Full Capacity Procedure

When Mother Baby has reached full capacity, physicians will be asked to assess their patient for disposition or to keep postpartum patients on Labor and Delivery. Triage, birthing center and antepartum rooms may be used as postpartum rooms. Depending on the stability of the patient, medical surgical beds may be used for antepartum patients with obstetrical oversight.

Quality Improvement

Providing the right care to the right patient at the right time with the right resources is a guiding quality and safety principle of Women and Children's Services. Opportunities for improvement are identified by monitor clinical outcomes outlined by regulatory and professional organizations (AWHONN, ACOG, MHA, NANN, IBCLC, Joint Commission) hospital strategic plan, patient satisfaction results, management reporting system and process improvement metrics.

Quality data are reviewed and plans of action developed by the unit based quality council. The Luminis Health Women and Children's Executive Council has final oversight of the review, action plan and outcomes.

EXHIBIT 19f

Luminis Health Anne Arundel Medical Center
Neonatal Intensive Care
2001 Medical Parkway
Annapolis, Maryland 21401

May 11, 2021

Kevin McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Agreement – Neonatology Services

Dear Mr. McDonald:

Upon inception of the obstetrics program, I will provide consultative services for neonatal-perinatal services to Luminis Health Doctors Community Medical Center obstetrics program 24 hours a day.

Thank you in advance for your consideration.

Sincerely,

M. Suzanne Rindfleisch, D.O.

cc: Doctors Community Hospital

EXHIBIT 19g

Luminis Health℠

Maternal and Fetal Medicine Specialists
185 Harry S. Truman Parkway, Suite 120
Annapolis, Maryland 21401

March 29, 2023

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Re: Letter of Agreement – Perinatal Services

Dear Ms. Hawk:

As a Maternal-Fetal Medicine Specialist at Luminis Health, my colleagues and I will provide consultative services for perinatal services to Luminis Health Doctors Community Medical Center obstetrics program 24 hours a day.

Thank you in advance for your consideration.

Sincerely,

Elizabeth Greeley, MD, MPH

EXHIBIT 19h

Doctors Community Hospital

Lactation Services

Provision of Care

Description of Department

Lactation Services is located on the third floor of the Women and Children's Tower within the Mother Baby Unit. Lactation Services provides education and support to all inpatient postpartum patients and their infants, including those admitted to the Special Care Nursery in compliance with the Maryland Best Practices Guidelines and World Health Organization Breastfeeding recommendations.

Scope of Service

Lactation consultants provide comprehensive care to infants their mothers to promote and support breastfeeding. Inpatient lactation consultation is provide by referrals generated by pediatric providers, obstetric providers, nursing staff, patients and family members.

A breastfeeding plan is developed in conjunction with the patient/family, medical providers and lactation consultant to provide proper nutrition for the infant and emotional and physical care for the mother/family. Follow-up is provided as indicated during the hospitalization.

At the time of discharge breast pump rentals are made available and education is for home care and continued support and education are provided. Mothers are made aware of the Warm Line that is provide telephone consultation once the patient is discharged. In addition, patients are educated on all community resources, including breastfeeding support groups sponsored by Doctors Community Hospital.

Personnel – Collaborative Patient Family Centered Care

Patient/family care is provided by a collaborative, multidisciplinary team who builds on the unique knowledge, judgement and skills of the various disciplines to achieve desired patient outcomes. There are two formalized patient communication structures in place. First, the maternity charge nurses, administration and physicians meet four times each day at bed board to review all patients and suggest changes in the patient's plan of care. Lastly, between two direct care registered nurses and the patient participate in bedside shift report at change of shift and other times when care is handed off between nurses. Additional communication structures includes huddles with direct care providers and family meetings with the direct care providers and patient/family.

In the event of a difference of opinion regarding patient care, the nurse and physician will use TeamSTEPPs principles following the Women and Children's Services Chain of Communication.

The following identifies members of the health care team who provide direct services to Labor and Delivery:

Medical

- OB GYN physicians
- Maternal fetal medicine physicians
- Neonatologists
- Pediatricians
- Anesthesiologists
- Nurse anesthetist
- OB/GYN Resident
- Certified nurse midwives

A board-certified physician (or active candidate for board-certification) with obstetrical privileges present in-house 24 hours a day and immediately available to the Mother Baby unit. A board-certified obstetrician will serve as the medical director to oversee the care provided to all maternity patients.

A board-certified neonatologist or pediatrician will be in house or readily available at all times. A board-certified neonatologist will serve as the medical director for care delivered to all neonates.

A board-certified anesthesiology provider readily coverage available 24/7 to manage obstetrical care in the surgical suites and the administration of anesthetics for procedures and deliveries.

The nursing leadership team will consist of the clinical director, clinical supervisors, nurse educator and nurse navigator. A minimum of one will be master's prepared in nursing or a health related field.

The board certified obstetrician medical director and the nursing clinical director will work in collaboration to ensure evidence-based practice guidelines, efficient workflows and resource use.

Staffing consists of the following:

Nursing

- Registered nurses
- Clinical supervisor
- Charge nurse
- Triage nurse
- International Board-Certified lactation consultants

- Surgical technicians
- Patient care secretaries

Support Services

- Respiratory therapists
- Pharmacy services
- LMSW or LCSW
- Domestic Violence services
- Social workers
- Case managers
- Laboratory services
- Radiology services
- Environmental services
- Sterile processing
- Food Services
- Translators
- Chaplains
- Physical therapy

Administrative

- OB medical director
- Maternal fetal medicine medical director
- Neonatal medical director
- Clinical Director – Nursing
- Community education/navigator
- Clinical educators

Nursing Staffing

Staffing patterns for lactation consultants if determined by using Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), American College of Obstetricians and Gynecologists (ACOG), and International Board of Lactation Consultants (IBCLC).

The staffing ratios are supported by hiring an adequate complement of nurses to staff lactation services, including prn and flex staff who can be called in during times of high census or acuity. The nursing leadership team, including clinical supervisors, clinical educators, perinatal director and community educator/navigator will provide additional clinical staffing support should the need arise.

Nursing Competencies

Hospital and Women and Children's Services orientation lays the foundation for unit specific competencies. New hires are required to complete Labor and Delivery competencies prior to the completion of orientation. In addition, staff will be required to complete the following prior to the completion of orientation:

- NRP
- CPR
- TeamSTEPPs
- S.T.A.B.L.E.
- CPI

Nurses will be required to complete the following within in the first year of hire:

- Participation in an OB simulation

IBCLC requires 75 hours of continuing education every five years and retaking the certification exam every ten years. Continuing education programs are provided to the lactation consultants based on quality improvement outcomes, implementation of new evidenced-based practices or equipment, and staff assessment of learning needs.

Quality Improvement

Providing the right care to the right patient at the right time with the right resources is a guiding quality and safety principle of Women and Children's Services. Opportunities for improvement are identified by monitor clinical outcomes outlined by regulatory and professional organizations (AWHONN, ACOG, MHA, NANN, IBCLC, Joint Commission) hospital strategic plan, patient satisfaction results, management reporting system and process improvement metrics.

Quality data are reviewed and plans of action developed by the unit based quality council. The Luminis Health Women and Children's Executive Council has final oversight of the review, action plan and outcomes.

EXHIBIT 19i

Anne Arundel Medical Center

GNP14.6.06 - Critical Value Reporting and Documentation

Scope

- Luminis Health Anne Arundel Medical Center, Inc. (LHAAMC)
- Mental Health and Substance Use Division

Purpose

Patient caregivers who are notified when patients have testing results with critical values are required to document that this activity has taken place; the critical value(s) is recorded and read back by the caregiver and confirmed by the person making the notification. Documentation of the actions taken concerning the critical value by the caregivers is required.

Any value called to a patient care area, even if not on this list, should be handled in a manner consistent with the Critical Values Policy.

Definitions

1. Critical Value: Any value reported to a caregiver that may require rapid clinical attention to avert significant patient morbidity or mortality.

2. Critical Test Result: Results from any test that are critical values.

3. Critical Test Testing Time (Time 1): Time from when a STAT order is entered into the clinical automation until the time the result is verified.

4. Critical Value Reporting Time (Time 2): Time from when a critical value is identified by the testing department until the time the critical value is reported to a licensed caregiver.

5. Receipt of Critical Value Results (Time 3): Time from when a critical value is received by the licensed caregiver to when the critical value is reported to the physician (if the original licensed caregiver cannot independently act on the results).

Policy Statements & Procedures

Policy Statements:

1. Test or procedure is performed and results are verified to be accurate by, Laboratory, Radiology or Respiratory Therapy Staff.

2. Critical results are called or hand-carried to the charge nurse or to the medical/house staff on the nursing unit.

3. Results are recorded and accurately "read back and confirmed" by the medical/house staff to the technical staff as a note associated with the Critical Value result in the computer.

4. The technical staff providing the critical value to the caregiver documents the phone call, call back verification, and name of clinician that was called in the testing record, which is part of the medical record.

5. Inpatients & ED only: The nurse documents receipt of the critical value in the electronic medical record. The nurse also documents communication to the medical/house staff or an explanation if communication is not required (ex. Patient is on an approved treatment protocol or there is a unit-based protocol for result notification). The Critical Value Notification Progress Notes (Form 21164) is a tool that can be used to assist in this procedure.

6. Staff must make every effort to communicate critical values in a timely manner. If there is not a successful communication after three valid attempts, a report should be made to the Events Reporting System and the communication should escalate up the administrative chain of command as referenced in the policy "Immediate Patient Safety Interventions".

Expected Results:

Laboratory & Respiratory Therapy

1. Critical Test Testing Time (Time 1) will be completed in ≤ 90 minutes.
2. Critical Value Reporting Time (Time 2) will be completed in ≤ 15 minutes.
3. Receipt of Critical Value Result (Time 3) will be completed in ≤ 30 minutes.

Radiology

1. Critical Test Testing Time (Time 1) will be completed in ≤ 210 minutes.
2. Critical Value Reporting Time (Time 2) will be completed in ≤ 30 minutes.

3. Receipt of Critical Value Result (Time 3) will be completed in ≤ 30 minutes.

References

The Joint Commission - National Patient Safety Goals, 2021.
College of American Pathologists – All Common Checklist, 2021.

Cross References

Immediate Patient Safety Interventions (https://together.aahs.org/Policies-and-procedures/Immediate-Patient-Safety-Interventions/)

(https://together.aahs.org/Policies-and-procedures/Incident-Reports/) Event Reports (https://together.aahs.org/Policies-and-procedures/Event-Reports/)

Approval Date

CNO - 08/2022
HPRC - 08/2022
CPC - 07/2022

Owner

Laboratory

Attachments

- LH Critical Value List v1-23-23
  (https://together.aahs.org/uploadedFiles/Contents/Policies_and_Procedures/Policy_Details/14_Generic_Nursing_Procedures_(GNP)/146_General_Care_Related_Issues/LH Critical Value List v1-23-23.pdf)

Anne Arundel Medical Center

SNP15.2.54 - Critical Congenital Heart Defects Screening - Infant

Scope

Luminis Health Anne Arundel Medical Center, Inc. (AAMC) Women's and Children's Services

Purpose

This policy provides a process for performing the critical congenital heart defects (CCHD) screening test for infants born at Anne Arundel Medical Center.

Definitions

None

Policy Statements & Procedures

Policy Statements

Infant screening for critical congenital heart defects (CCHD) can identify infants with these conditions before signs or symptoms are evident and before the infant is discharged home. The CCHD screening is required by the State of Maryland.

Procedures

1. All infants born at AAMC must have a CCHD screening prior to discharge per the following criteria:
a. The CCHD screening will take place between 24 and 48 hours of age; or
b. If infant is going home before 24 hours, screen as close to discharge time as possible; or
c. If the infant was on oxygen therapy, the CCHD screening should take place 24 hours after discontinuation of oxygen therapy; or
d. If the infant has had an echocardiogram, the CCHD screening is not necessary.

2. The nurse will place a pulse oximeter on the infant's right wrist or hand and record the number. Next, the nurse will place the pulse oximeter on either foot and record the number.

3. A screen is considered passed if:
a. The right-hand and foot oxygen saturation is ≥95%
b. The right-hand oxygen saturation is ≥95% with a ≤3% absolute difference between the right hand and the foot (see attachment).

4. A screen is considered failed if (see attachment):
a. Any oxygen saturation that is <90% (in the initial screen or in repeat screens).
b. An oxygen saturation that is <95% in the right hand on three separate measures, each separated by one hour.
c. If a >3% difference exists in oxygen saturation between the right hand and foot on three measures, each separated by one hour.

5. If the infant fails the initial screen, the nurse may re-screen the infant in 1 hour. This may happen twice, for a total of three screenings.

6. If the infant fails the screening three times, the nurse will notify the infant's medical provider.

7. Document the results of each screening in the infant's electronic medical record.

References

1. Beauman, S. S., & Bowles, S. (2019). Policies, procedures, and competencies for neonatal nursing care (6th ed.). Chicago, IL: National Association of Neonatal Nurses.
2. Congenital Heart Defects Information for Healthcare Providers | CDC. Retrieved from https://www.cdc.gov/ncbddd/heartdefects/hcp.html

Cross References

None

Approval Date

CNO - 02/2020
HPRC - 01/2020
CPC - 11/2019
W&CQ - 09/2019

Owner

W&C Services

Attachments

- SNP15.2.54 - CCHD Screening Alogorithm
  (https://together.aahs.org/uploadedFiles/Contents/Policies_and_Procedures/Policy_Details/15_Specialty_Nursing_Areas_(SNP)/152_Womens_and_Childrens_and_Pediatrics/SNP15
  - CCHD Screening Alogorithm.pdf)
- SNP15.2.54 - CCHD Screening Table 8-30-21
  (https://together.aahs.org/uploadedFiles/Contents/Policies_and_Procedures/Policy_Details/15_Specialty_Nursing_Areas_(SNP)/152_Womens_and_Childrens_and_Pediatrics/SNP15
  - CCHD Screening Table 8-30-21.pdf)

Anne Arundel Medical Center

SNP15.2.12 - Hemorrhage, Obstetrical

Scope

Luminis Health Anne Arundel Medical Center, Inc. (AAMC)

Purpose

The purpose of this policy is to provide nursing guidelines for patients experiencing an obstetrical hemorrhage. Obstetrical hemorrhage includes: Antepartum/Intrapartum hemorrhage, Postpartum hemorrhage, and Delayed hemorrhage.

Definitions

OB/GYN NET: A team of clinical personnel with critical obstetrical, gynecological and neonatal expertise who can respond to emergencies throughout the hospital.

Policy Statements & Procedures

Refer to attachment: Obstetrical Hemorrhage OB Maternal Safety Bundle

Signs and symptoms of hemorrhage can include, but are not limited to uterine atony, visible and evident bright red bleeding, expelled clots, tachycardia, tachypnea, decreasing blood pressure, dizziness or lightheadedness, change in level of consciousness, fear, anxiety restlessness, or fatigue.

References

Mattson, S., & Smith, J. E. (2016). Core curriculum for maternal-newborn nursing (Fifth ed.). Elsevier.

Cross References

Administration of Blood and Blood Products, Including Massive Transfusion: Adult Population (https://together.aahs.org/Policies-and-procedures/Administration-of-Blood-and-Blood-Products,-Including-Massive-Transfusion--Adult-Population/)

Code Blue (https://together.aahs.org/Policies-and-procedures/Code-Blue/)

Approval Date

CNO - 02/2022

Owner

Labor & Delivery

Attachments

- Hemorrhage Protocol 2022 (https://together.aahs.org/uploadedFiles/Contents/Policies_and_Procedures/Policy_Details/15_Specialty_Nursing_Areas_(SNP)/152_Womens_and_Childrens_and_Pediatrics/Hemo Protocol 2022.docx)

EXHIBIT 19j

Critical Congenital Heart Defects Screening - Infant

Scope

Doctors Community Hospital, Inc. (DCH) Women's and Children's Services

Purpose

This policy provides a process for performing the critical congenital heart defects (CCHD) screening test for infants born at Doctors Community Hospital.

Definitions

None

Policy Statements & Procedures

Policy Statements

Infant screening for critical congenital heart defects (CCHD) can identify infants with these conditions before signs or symptoms are evident and before the infant is discharged home. The CCHD screening is required by the State of Maryland.

Procedures

1. All infants born at Doctors Community Hospital must have a CCHD screening prior to discharge per the following criteria:
a. The CCHD screening will take place between 24 and 48 hours of age; or
b. If infant is going home before 24 hours, screen as close to discharge time as possible; or
c. If the infant was on oxygen therapy, the CCHD screening should take place 24 hours after discontinuation of oxygen therapy; or
d. If the infant has had an echocardiogram, the CCHD screening is not necessary.

2. The nurse will place a pulse oximeter on the infant's right wrist or hand and record the number. Next, the nurse will place the pulse oximeter on either foot and record the number.

3. A screen is considered passed if:
a. The right-hand and foot oxygen saturation is ≥95%
b. The right-hand oxygen saturation is ≥95% with a ≤3% absolute difference between the right hand and the foot (see attachment).

4. A screen is considered failed if (see attachment):
a. Any oxygen saturation that is <90% (in the initial screen or in repeat screens).
b. An oxygen saturation that is <95% in the right hand on three separate measures, each separated by one hour.
c. If a >3% difference exists in oxygen saturation between the right hand and foot on three measures, each separated by one hour.

5. If the infant fails the initial screen, the nurse may re-screen the infant in 1 hour. This

may happen twice, for a total of three screenings.

6. If the infant fails the screening three times, the nurse will notify the infant's medical provider to assess and provide follow-up orders.

7. Document the results of each screening and all follow-up care in the infant's electronic medical record.

EXHIBIT 19k

	Postpartum Hemorrhage – updated 8/4/2022
Definition	Cumulative blood loss greater than or equal to 1000mls OR blood loss accompanied by signs/symptoms of hypovolemia in an obstetric patient (typical signs include heart rate and respiratory rate elevation, decrease blood pressure, decrease in urine output, dizziness, altered mental status, diaphoresis, narrowed pulse pressure, cool extremities, and pallor). Enhanced surveillance and early intervention are indicated for EBL of 500-1000mLs
	At admission: - Perform PPH risk assessment) at admission and at shift change - Obtain type and screen. - If known + antibody screen (other than Rhogam induced anti-D) Prepare 2 units PRBCs at admission - Evaluate for risk factors for obstetric hemorrhage and identify women declining transfusion - Discuss risk factor(s) and planned management with nurse. - Inform Ob Anesthesia of patients at high risk of hemorrhage or declining transfusion LOW RISK women who decline blood transfusion should be treated as MEDIUM RISK MEDIUM RISK women who decline blood transfusion should be treated as HIGH RISK MEDIUM RISK women – maintain IV access until at least 24h postpartum and active type and screen HIGH RISK women – maintain IV access at 2 sites until at least 24h postpartum and Prepare 2 units PRBCs Throughout admission: - Evaluate for development of risk factors for hemorrhage (prolonged 2nd stage, prolonged use of oxytocin, intraamniotic infection (aka chorioamnionitis), use of magnesium sulfate, active bleeding) at least once a shift and at postpartum admission. - Prepare 2 units of PRBCs if patient becomes HIGH RISK for bleeding. At delivery: - Oxytocin administration in the third stage of labor: 30u in 500mL or 10u IM - Ongoing estimate of degree of blood loss - Ongoing evaluation of vital signs Active management of the third stage of labor – i.e. administration of oxytocin as above, titrated to uterine tone, plus steady cord traction +/- uterine massage (Brandt-Andrews or Crede maneuver)

	Stage 1 Hemorrhage: >500mL EBL with vaginal delivery or >1000mL EBL with cesarean delivery with ongoing bleeding OR with HR >110, BP </= 85/45, O2 sat <95% OR Vital signs >15% change from baseline or increased bleeding during recovery or postpartum Announce estimated blood loss to clinical staff; clinician and ultrasound to bedside Evaluate for, and manage, potential etiology including: - Uterine atony - Trauma/laceration/hematoma - Retained products of conception - Coagulopathy - Placenta accreta/increta - Amniotic fluid embolism - Uterine inversion - Uterine rupture Administer medications and IV fluids as clinically indicated Consider transfer to the OR ***Stage 2 Hemorrhage: Continued bleeding or vital sign instability with cumulative blood loss up to 1500mL*** Provide medications: - Oxytocin IV (10-40U in 500-1000 cc) - Methergine 200 mcg IM - Hemabate 250 mcg - TXA 1000 mg - Cytotec 1000 mcg rectally - TXA 1000 mg - Methergine 200 mcg IM - Hemabate 250 mcg - Consider antibiotics if intrauterine manipulation is performed While awaiting response to medications or if insufficient response to medications: - Bimanual massage - Move to OR as clinically indicated - Obtain 2u PRBCs to the bedside and consider thawing 2u FFP

	- Order stat CBC, CMP, Coagulation studies - Initiate blood transfusion based on clinical signs; consider uncrossed O-negative transfusion For vaginal deliveries: - Assess for, and manage, lacerations - Consider D+C for retained tissue - Consider Nitroglycerin per Anesthesiology for uterine and cervical relaxation - Consider intrauterine balloon placement - IF HEMODYNAMICALLY STABLE – consider IR embolization - If vital signs are worse than expected for estimated blood loss, esp if no identifiable source -> consider intraabdominal bleeding and proceed with emergent laparotomy. DO NOT DELAY FOR IMAGING if clinical suspicion is high. For c-sections: - Consider B-Lynch and O'Leary stitches - Consider uterine tourniquet - Consider intrauterine balloon placement If uterine inversion suspected: Announce to anesthesiologist and request uterine relaxants Manually reduce inversion If AFE is suspected: Announce to anesthesiologist Maximize respiratory and hemodynamic support including blood transfusion and vasopressors as needed ***Stage 3 Hemorrhage: Cumulative blood loss >1500mL, >2u PRBCs given, VS unstable, or suspected DIC*** Consider activating Ob Massive Transfusion Panel Move to OR and quickly proceed with evaluation, D+C, and/or laparotomy as clinically indicated Consider intra-abdominal packing, hysterectomy, advanced uterine conserving techniques Check CBC, Coag panel (PT/INR, PTT, fibrinogen), CMP, ionized calcium q30min

	Anesthesiologist: - Call for 2nd anesthesiologist - Consider arterial line placement - Consider intubation - Consider central line placement - Facilitate respiratory and hemodynamic resuscitation as needed – blood product administration in a 1:1:1 ratio (PRBC: FFP: Platelet), vasopressor administration, electrolyte monitoring and replacement, temperature monitoring and management - Administer cryoprecipitate early in blood transfusion if AFE or placental abruption is clinically suspected - Monitor for, and minimize, acidosis, hypothermia, and coagulopathy - Facilitate post-resuscitation ICU transfer as needed ***Stage 4 Hemorrhage: Acute Cardiovascular Collapse (Cardiac Arrest)*** - Mobilize additional resources – Code team, additional Ob, Anesthesia - Initiate ACLS - Aggressive blood volume replacement via MTP - Immediate surgical intervention to facilitate hemostasis - Consider intraabdominal packing/ damage control laparotomy in the face of coagulopathy, hypothermia, and acidosis. Post-hemorrhage debrief with team members after every stage of hemorrhage, Goals of a successful transfusion: Hgb >7 g/dL Hct >21% Plt >50K/uL INR <1.5 Fibrinogen > 200 mg/dL

Nursing guidelines/protocols	At admission: - Evaluate for, and document, risk factors for obstetric hemorrhage and identify women declining transfusion - Discuss risk factor and planned management with attending clinician. LOW RISK women who decline blood transfusion should be treated as MEDIUM RISK MEDIUM RISK women who decline blood transfusion should be treated as HIGH RISK MEDIUM RISK women – maintain IV access until at least 24h postpartum and active type and screen HIGH RISK women – maintain IV access at 2 sites until at least 24h postpartum and Prepare 2 units PRBCs Throughout admission: - Evaluate for development of risk factors for hemorrhage (prolonged 2nd stage, prolonged use of oxytocin, intraamniotic infection (aka chorioamnionitis), use of magnesium sulfate, active bleeding) at least once a shift and at the time of postpartum admission. Discuss any changes with attending clinician. ***Stage 1 Hemorrhage: >500mL EBL with vaginal delivery or >1000mL EBL with cesarean delivery with ongoing bleeding OR with HR >110, BP </= 85/45, O2 sat <95% OR Vital signs >15% change from baseline or increased bleeding during recovery or postpartum*** Call provider and Charge nurse to the bedside (RN, LPN, PCT/ST) Announce estimated blood loss to clinical staff (RN, LPN) Initiate QBL monitoring and continue until 24h after hemorrhage or longer as clinically indicated. (RN, LPN, PCT/ST) Establish IV access (18g or largest possible) (RN, LPN, PCT/ST) Prepare 2u PRBCs STAT (RN) Apply fundal massage (RN, LPN) Empty bladder – place foley with urimeter (RN, LPN, PCT/ST) Check vital signs (including BP, HR, O2 sat, temp, and level of consciousness) and announce Q5min (RN, LPN, PCT/ST) Apply O2 as needed to maintain O2 sat >95% (RN) Administer ordered medications until clinician arrives to direct management (RN, LPN): - FIRST Oxytocin 30u in 500mL at 500mL/h, titrated to uterine tone - THEN Methergine 200mcg IM (if not hypertensive) - THEN Hemabate 250mcg IM (if not asthmatic)

	- THEN TXA 1000 mg - THEN Cytotec 1000 mcg PR Quantify, record, and announce cumulative blood loss q5min (RN, LPN, PCT/ST) Keep patient warm (RN, LPN, PCT/ST) • Charge nurse tasks include: assist primary nurse and/or identify staff to help. Notify anesthesia. Notify NICU. Obtain portable light and hemorrhage cart or assist with transfer to the OR ***Stage 2 Hemorrhage: Continued bleeding or vital sign instability with cumulative blood loss up to 1500mL*** Call provider and Charge nurse to bedside; Activate Ob/GynNET (RN, LPN, PCT/ST) Announce vital signs and cumulative blood loss Q5min (RN, LPN, PCT/ST) Establish 2nd IV (18g or largest possible (RN, LPN, PCT/ST) Place foley with urimeter (RN, LPN, PCT/ST) Administer medications and blood; draw labs as needed (RN, LPN) Continue IV oxytocin and provide 500mL IV fluid bolus (RN, LPN) Set up blood transfusion set and blood warmer (RN) Assist with move to the OR (RN, LPN, PCT/ST) Keep patient warm (RN, LPN, PCT/ST) • Charge nurse tasks include: Identify recorder. Notify anesthesia, delegate tasks: bring hemorrhage cart place foley, assist with transfer to the OR. Identify individual to communicate with blood bank and identify family support provider ***Stage 3 Hemorrhage: Cumulative blood loss >1500mL, >2u PRBCs given, VS unstable, or suspected DIC*** Call provider and Charge nurse to bedside, Activate Ob/GynNET (RN, LPN, PCT/ST) Announce vital signs and cumulative blood loss Q5min (RN, LPN, PCT/ST) Apply upper body warmer if readily available (RN, LPN, PCT/ST) Assist with transport to OR (RN, LPN, PCT/ST) Set up transfusion supplies and blood warmer (RN) Assist Anesthesiologist with placement of hemodynamic monitors and intubation as needed (RN) Apply SCDs (RN, LPN, PCT/ST)

	Circulate in the OR (RN) • Charge nurse tasks include: Identify recorder. Call to open OR, bring hemorrhage cart to bedside, obtain support staff and delegate tasks: Call blood bank to activate Ob massive transfusion panel. Notify ICU, obtain/send labs, and administer meds/blood products. ***Stage 4 Hemorrhage: Acute Cardiovascular Collapse (Cardiac Arrest)***: Activate code blue and Ob/GynNET. Initiate BLS until further assistance arrives. (RN, LPN, PCT/ST) • Charge nurse tasks include: Delegate tasks: Recorder, IV access, Emergency blood release and MTP activation, Foley placement, call to open OR, administer meds, identify family support person, Obtain and set up transfusion supplies
Outpatient management considerations	Identify and prepare for patients with special considerations (malplacentation, coagulopathy, declining blood products), including consultations with Maternal Fetal Medicine and Anesthesia as clinically indicated Screen and aggressively treat severe anemia (Hgb <9) with oral or IV iron Identify patients at risk of hemorrhage and develop plan for preadmission optimization, location of delivery, and inpatient management.

REFERENCES

CMQCC Obstetric Hemorrhage Toolkit
ACOG PB #183 Postpartum Hemorrhage
Quantification of Blood Loss: AWHONN Practice Brief Number 1
Council on Patient Safety in Women's Health Care Obstetric Hemorrhage Patient Safety Bundle
ACOG Safe Motherhood Initiative – Maternal Safety Bundle for Obstetric Hemorrhage
JAMA - Why Do Hundreds of US Women Die Annually in Childbirth? May 13, 2019

Addendum: Obstetric Hemorrhage Risk Stratification

LOW RISK (type and screen)	MEDIUM RISK (type and screen)	HIGH RISK (type and cross)
No prior uterine incision	Prior cesarean delivery or uterine surgery	Placenta previa or low lying placenta
Singleton pregnancy	Multiple gestation	Suspected placental accrete/increta/percreta
</= 4 prior vaginal deliveries	>4 prior vaginal deliveries	Hct <30 PLUS other risk factor(s)
No known bleeding disorder	Intraamniotic Infection (aka Chorioamnionitis)	Plt <100K
No history of PPH	History of PPH	Active bleeding (more than bloody show) on admission
	Large uterine fibroids	Known coagulopathy
	EFW >4000g	2 or more medium risk factors
	BMI >40	

Intrapartum Risk Stratification

MEDIUM RISK (type and screen)	HIGH RISK (type and cross)
Intraamniotic Infection (aka Chorioamnionitis)	New active bleeding
Oxytocin use >24h	2 or more medium risk factors
Prolonged 2nd stage	
Use of magnesium sulfate	

Additional Postpartum Risk Factors
Vacuum or Forceps assisted delivery
Cesarean Delivery (esp if emergent)
Retained Placenta

LOW RISK women who decline blood transfusion should be treated as MEDIUM RISK
MEDIUM RISK women who decline blood transfusion should be treated as HIGH RISK
Initial Approval: 10/2019
Updates: 8/2022

EXHIBIT 19l

Maternal Safety Bundle: Hypertensive Disorders in Pregnancy/Chronic Hypertension with Superimposed Pre-Eclampsia

	Chronic Hypertension With Superimposed Pre-Eclampsia
Definition	Chronic hypertension with development of signs or symptoms of pre-eclampsia, usually after 20 weeks of gestation. **Superimposed pre-eclampsia without severe features** – 1) sudden blood pressure elevation or escalation of antihypertensive treatment in a previously well-controlled woman with SBP >160 mmHg and/or DBP >110 mmHg on two occasions ideally at least four hours apart (but shorter time interval may be used for the diagnosis to facilitate timely antihypertensive treatment and/or, 2) new onset proteinuria or increased proteinuria from baseline. **Superimposed pre-eclampsia with severe features** – characterized by the presence of end organ damage manifested by one or more of the following: 1) new transaminitis with twice normal elevation of liver enzymes, 2) new thrombocytopenia with platelet count below 100,000/microliter, 3) new doubling of baseline creatinine or creatinine of >1.1 mg/dl, 4) pulmonary edema, 5) new severe or persistent headaches, visual disturbances or right upper quadrant pain.
ICD-10	O11.9: Preeclampsia complicating hypertension; Chronic hypertension with superimposed preeclampsia O10.919: Chronic hypertension with exacerbation during pregnancy; Chronic hypertension with exacerbation during pregnancy, unspecified trimester. O10.911: Chronic hypertension with exacerbation during pregnancy, first trimester. O10.912: Chronic hypertension with exacerbation during pregnancy, second trimester. O10.913: Chronic hypertension with exacerbation during pregnancy, third trimester.
Inpatient Maternal Management	Initial evaluation and management should occur in the hospital with monitoring of maternal and fetal status. 1) **Assessment of clinical symptoms:** • Neurologic symptoms (HA visual disturbances) • Chest pain/shortness of breath • Epigastric/right upper quadrant pain, nausea and vomiting. • Non-dependent edema • Vaginal bleeding, fetal movement 2) **Serial BP measurements**: q15 minutes for at least one hour or until diagnosis is established then based on antihypertensive management.

	Chronic Hypertension With Superimposed Pre-Eclampsia
	3) **Physical exam** – heart, lungs, abdomen, deep tendon reflexes 4) **Assessment of proteinuria** via protein/creatinine ratio (preferred in triage) and/or 24-hour urine collection. 5) **Serology**, ideally compared with baseline values: CBC including platelets, LFTs, creatinine, LDH, possibly uric acid. 6) **Treatment of hypertension** for SBP 160 mmHg or greater or DBP 110 mmHg or greater per medication protocols: • IV Labetalol • IV Hydralazine • PO Nifedipine if no IV access. Initiate treatment at lower blood pressures if there is evidence of end organ damage. Continued observation until BPs remain below severe range for at least 24h without medication changes. 7) **Initiation of magnesium sulfate** ASAP, no later than within 1h of diagnosis for seizure prophylaxis in women with severe features unless medically contraindicated. 8) **Obtain clinically appropriate imaging** as clinically indicated (e.g. right upper quadrant ultrasound for persistent pain, head CT for persistent headache). 9) **MFM and/or Intensivist consultation** in women with underlying significant cardiopulmonary disease, oliguric renal compromise or refractory hypertension. MFM consultation in all patients presenting at <37+0 weeks gestation. ***Timing of Delivery*** **Immediate delivery after maternal stabilization**: • uncontrollable severe hypertension, • eclampsia, • pulmonary edema, • placental abruption, • DIC, • non-reassuring fetal status.

	Chronic Hypertension With Superimposed Pre-Eclampsia
	Delivery at 34+0 weeks gestation if severe features initially identified at less than 34 weeks but maternal and fetal status remain stable. It is acceptable to defer delivery to facilitate steroid administration if maternal and fetal statuses remain stable. **Delivery at 37+0 weeks** if no severe features.
Inpatient Maternal Management **Growth Assessment**	Administer corticosteroids: if superimposed pre-eclampsia is diagnosed at less than 34 weeks gestation, aim to complete steroid course if maternal and fetal statuses allow. If superimposed pre-eclampsia is diagnosed between 34+0 and 36+6 weeks gestation and no prior steroid course has been administered, initiate steroid course but proceed with delivery as clinically indicated. Serial growth ultrasounds every three weeks from diagnosis with addition of Doppler velocimetry if intrauterine growth restriction is identified. Weekly BPP with Doppler and twice weekly NST and as clinically indicated from time of diagnosis.
Nursing Guidelines/ Protocols	**Triage:** Vital Signs (Blood pressure, pulse, respiration rate, pulse ox) sitting or semi-reclining position: Every 15 minutes x1 hour, then every 30 minutes until discharged from triage or as indicated by provider. Alert provider for any severe range blood pressure ((>=160/>=110) Initiation of antihypertensive medications: ASAP, within 30 to 60 minutes of severe range blood pressure OB Hypertensive Assessment (Level of Consciousness, DTRs/Clonus, vision changes, breath sounds, edema, headache): Every four hours, or as clinically indicated. External fetal monitoring: Three times daily. **Intrapartum:** Vital Signs: Every 1 hour, or as clinically indicated; Intake and Output: Every 4 hours, or as clinically indicated. Alert provider for any severe range blood pressure (>=160/>=110) Initiation of antihypertensive medications: ASAP, within 30 to 60 minutes of severe range blood pressure OB Hypertensive Assessment: Every 4 hours, or as clinically indicated External Fetal Monitoring: Continuous **Post Partum:** Vital Signs and I/)s: Every 4 hours, or as clinically indicated. Alert provider for any severe range blood pressure (>=160/>=110) Initiation of antihypertensive medications: ASAP, within 30 to 60 minutes of severe range blood pressure

Maternal Safety Bundle: Hypertensive Disorders in Pregnancy/Chronic Hypertension with Superimposed Pre-Eclampsia

	Chronic Hypertension With Superimposed Pre-Eclampsia
	OB Hypertensive Assessment: Every 4 hours, or as clinically indicated. **If on Magnesium Sulfate:** Initiation of magnesium sulfate within 60 minutes Vital Signs: Every 1 hour, or as clinically indicated. Alert provider for any severe range blood pressure (>=160/<=110) Initiation of antihypertensive medications: ASAP, within 30 to 60 minutes of severe range blood pressure OB Hypertensive Assessment: Every 2 hours, or as clinically indicated Intake and Output: Every 1 hour, or as clinically indicated EFM (if applicable): Continuous
Outpatient Management Considerations	Antepartum: Obtain baseline labs, ideally in the first trimester of pregnancy in every patient with chronic hypertension – serum creatinine, electrolytes, liver enzymes (all available in a CMP), uric acid, complete blood count, and urine Pr/Cr and/or 24h urine collection. Initiate use of prophylactic low-dose ASA between 12 and 16 weeks. Obtain a baseline Cardiology consult, EKG and/or echocardiogram in patients with chronic HTN of greater than 4yr duration and as clinically indicated. Initiate antihypertensive medications to achieve SBP<160 and DBP<105 in women without end organ damage with a goal of SBP <140 and DBP<90 in women with evidence of end organ damage. If outpatient management is initiated for superimposed pre-eclampsia without severe features, close surveillance (e.g. twice weekly) of maternal and fetal status is indicated, including assessments of symptoms, vital signs, physical exam, laboratory data and antenatal testing. Postpartum: Blood pressure monitoring should occur for the first 72h postpartum and BP should ideally be controlled for at least 24h prior to hospital discharge. Patients receiving antihypertensives during labor, delivery or postpartum care should be re-evaluated within 3 days of discharge. Patients diagnosed with pre-eclampsia who do not receive antihypertensive treatment should be re-evaluated within 7 days of delivery. Given the increased risk of postpartum pre-eclampsia in patients with pre-gestational hypertension, consider postpartum evaluation of all chronic hypertensive patients within 1 week of delivery.

REFERENCES

ACOG Task Force Report: Hypertension in Pregnancy

ACOG Maternal Safety Bundle for Severe Hypertension in Pregnancy

ACOG Committee Opinion 692 – Emergent Therapy for Acute-Onset, Severe Hypertension During Pregnancy and the Postpartum Period

ACOG Guidelines for Perinatal Care

Maurice L. Druzin, MD; Laurence E. Shields, MD; Nancy L. Peterson, RNC, PNNP, MSN; Valerie Cape, BSBA. Preeclampsia Toolkit: Improving Health Care Response to Preeclampsia (California Maternal Quality Care Collaborative Toolkit to Transform Maternity Care) Developed Under Contract #11-10006 with the California Department of Public Health; Maternal, Child and Adolescent Health Division; Published by the California Maternal Quality Care Collaborative, November 2013.

Low-Dose Aspirin for the Prevention of Morbidity and Mortality from Preeclampsia: Preventative Medication. U.S. Preventive Services Task Force (USPSTF), September 2014.

EXHIBIT 19m

Maternal Safety Bundle: Hypertensive Disorders of Pregnancy/Chronic Hypertension without Superimposed Pre-Eclampsia

	Chronic Hypertension without Superimposed Pre-Eclampsia
Definition	Primary/Essential HTN: SBP>/=140 or DBP >/= 90 known to predate conception or detected before 20w gestation Mild-moderate: 140-159/90-109 mmHg. Severe >/=160 / >/=110 Secondary HTN: chronic renal disease, primary aldosteronism, renovascular HTN, pheochromocytoma, Cushing disease – suggest referral to physician with expertise in treating HTN from these causes.
ICD-10	O10 CHTN O10.011 preexisting essential HTN complicating first trimester O10.012 preexisting essential HTN complicating second tri O10.013 preexisting essential HTN complicating third tri O10.02 preexisting essential HTN complicating childbirth O10.03 preexisting essential HTN complicating puerperium
Inpatient Maternal Management	Optimal timing of delivery is based on degree of control: Controlled, not on meds – 38+0 - 39+6 weeks Controlled, on meds – 37+0 - 39.6 weeks Difficult to control – 36+0 - 37+6 weeks Evaluate for superimposed preeclampsia as indicated by clinical situation
Outpatient Fetal Management **Growth Assessment** **Antenatal testing**	 Screen for fetal growth restriction; FH check each visit; serial growth scans at least q 4 weeks . In patients requiring medication, initiate antenatal testing at 32 weeks. In patients not requiring medication, initiate antenatal testing at 36 weeks.
Nursing Guidelines/ Protocols	**Triage:** Vital Signs: (blood pressure, pulse, respiration rate, pulse ox) sitting or semi-reclining position: Every 15 minutes x 1 hour, then every 30 minutes until discharged from triage or as indicated by provider. Alert provider for any severe range blood pressure ((>=160/>=110) Initiation of antihypertensive medications: ASAP, within 30 to 60 minutes of severe range blood pressure **Antepartum:** Vital Signs and Intake and Output: Every 4 hours, or as clinically indicated Alert provider for any severe range blood pressure (>=160/>=110) Initiation of antihypertensive medications: ASAP, within 30 to 60 minutes of severe range blood pressure

Maternal Safety Bundle: Hypertensive Disorders of Pregnancy/Chronic Hypertension without Superimposed Pre-Eclampsia

	Chronic Hypertension without Superimposed Pre-Eclampsia
	OB Antihypertensive Assessment (Level of Consciousness, DTRs/Clonus, vision changes, breath sounds, edema, headache): Every 4 hours, or as clinically indicated. External Fetal Monitoring: Three times daily. **Intrapartum:** Vital Signs: Every 1 hour, or as clinically indicated; Intake and Output: Every 4 hours, or as clinically indicated. Alert provider for any severe range blood pressure (>=160/>=110) Initiation of antihypertensive medications: ASAP, within 30 to 60 minutes of severe range blood pressure OB Hypertensive Assessment: Every 4 hours, or as clinically indicated
Outpatient Maternal Management Considerations	MFM Consultation Baseline labs: serum creatinine, electrolytes, liver enzymes (all available in comprehensive metabolic panel), uric acid, platelet count, urine protein (rec 24h urine or urine protein: creatinine ratio to rule out chronic renal disease.) Suggest cardiac eval with ECG and/or echo in patients with 4+y of severe HTN Screen for signs of superimposed pre-eclampsia at each visit; patient education re: symptoms of pre-eclampsia *Close evaluation of BP control in postpartum period is indicated Increased monitoring of BP in second half of pregnancy, consider at home monitoring of BP in poorly controlled pt. ***Treatment Goals:*** Maintain SBP <160 and DBP <105. If evidence of end organ damage, maternal age over 40, diabetes or secondary HTN then goal is <140/<90. ***Treatment Methods:*** Nonpharmacologic: moderate level exercise, avoid excessive weight gain Pharmacologic: for BP approaching 160/105 or evidence of end organ damage → oral agents for continuous mgmt. Patients may be kept on medication if on them prior to pregnancy and may also be able to wean off if BP becomes too low. • **Labetalol** (nonselective beta blocker) 200-2400 mg/d orally in 2-3 divided doses (avoid in patients with asthma, congestive heart failure; may be associated with SGA infants) • **Nifedipine** (Ca channel blocker) 30-120 mg/d slow release formula (do not use sublingual or immediate release form)

Maternal Safety Bundle: Hypertensive Disorders of Pregnancy/Chronic Hypertension without Superimposed Pre-Eclampsia

	Chronic Hypertension without Superimposed Pre-Eclampsia
	• **Methyldopa** (central acting alpha-2 adrenergic agonist) 0.5-3g/d orally in 2-3 divided doses (may be less effective in preventing severe HTN) **Prevention of superimposed pre eclampsia** - low dose aspirin (60-80 mg/d) starting at 12 weeks gestation.

REFERENCES: ACOG Hypertension in Pregnancy Task Force; 2013; Up to Date

ACOG Committee Opinion 560 (Medically Indicated Late Preterm and Early Preterm Deliveries)

EXHIBIT 19n

Luminis Health Women's & Children's Perinatal Quality Program

EXHIBIT 19o

Doctors Community Medical Center

Perinatal Quality Improvement Plan Reporting Schedule

January	February	March	April	May	June
1. MIEMSS •Uterine Rupture •Maternal Readmissions within 7 days after discharge following childbirth •Cesarean hysterectomy and post-partum hysterectomy •Fetal death greater than 20-36+6 weeks gestations •Intrapartum and neonatal deaths >2500 (not adm to NICU) **2. Pediatrix Hearing Screening** •% Newborns Screened **3. Vermont Oxford (Annually)**	**1. MIEMSS** •Maternal admissions to CC •Maternal blood trans •Maternal eclampsia/ seizures •Neonatal transports •Intraventricular hemorrhage (grades 3&4) •Admissions to NICU under 1500gm •Birth trauma **2. Baby Bella Security Photos** •% Security photo before discharge •% Photographer with security check •% Photographer meet AAMC health requirements	**1. MIEMSS** •Maternal death •Unplanned returns to OR/LDR •Maternal transports •Admission to NICU >2500 gms and for >24 hours **2. NPSG** •Patient ID •Med Rec •Hand Hygiene •Universal Protocol **3. Hospital Quality Core Measures** **4. Patient Satisfaction**	**1. MIEMSS** •Uterine Rupture •Maternal Readmissions within 7 days after discharge following childbirth •Cesarean hysterectomy and post-partum hysterectomy •Fetal death greater than 20-36+6 weeks gestations •Intrapartum and neonatal deaths >2500 (not adm to NICU) **2. Pediatrix Hearing Screening** •% Newborns Screened **3. Vermont Oxford (Annually)**	**1. MIEMSS** •Maternal admissions to CC •Maternal blood trans •Maternal eclampsia/ seizures •Neonatal transports •Intraventricular hemorrhage (grades 3&4) •Admissions to NICU under 1500gm •Birth trauma **2. Baby Bella Security Photos** •% Security photo before discharge •% Photographer with security check •% Photographer meet AAMC health requirements	**1. MIEMSS** •Maternal death •Unplanned returns to OR/LDR •Maternal transports •Admission to NICU >2500 gms and for >24 hours **2. NPSG** •Patient ID •Med Rec •Hand Hygiene •Universal Protocol **3. Hospital Quality Core Measures** **4. Patient Satisfaction**
July	**August**	**September**	**October**	**November**	**December**

1. MIEMSS •Uterine Rupture •Maternal Readmissions within 7 days after discharge following childbirth •Cesarean hysterectomy and post-partum hysterectomy •Fetal death greater than 20-36+6 weeks gestations •Intrapartum and neonatal deaths >2500 (not adm to NICU) **2. Pediatrix Hearing Screening** •% Newborns Screened **3. Vermont Oxford (Annually)**	**1. MIEMSS** •Maternal admissions to CC •Maternal blood trans •Maternal eclampsia/ seizures •Neonatal transports •Intraventricular hemorrhage (grades 3&4) •Admissions to NICU under 1500gm •Birth trauma **2. Baby Bella Security Photos** •% Security photo before discharge •% Photographer with security check •% Photographer meet AAMC health requirements	**1. MIEMSS** •Maternal death •Unplanned returns to OR/LDR •Maternal transports •Admission to NICU >2500 gms and for >24 hours **2. NPSG** •Patient ID •Med Rec •Hand Hygiene •Universal Protocol **3. Hospital Quality Core Measures** **4. Patient Satisfaction**	**1. MIEMSS** •Uterine Rupture •Maternal Readmissions within 7 days after discharge following childbirth •Cesarean hysterectomy and post-partum hysterectomy •Fetal death greater than 20-36+6 weeks gestations •Intrapartum and neonatal deaths >2500 (not adm to NICU) **2. Pediatrix Hearing Screening** •% Newborns Screened **3. Vermont Oxford (Annually)**	**1. MIEMSS** •Maternal admissions to CC •Maternal blood trans •Maternal eclampsia/ seizures •Neonatal transports •Intraventricular hemorrhage (grades 3&4) •Admissions to NICU under 1500gm •Birth trauma **2. Baby Bella Security Photos** •% Security photo before discharge •% Photographer with security check •% Photographer meet AAMC health requirements	**1. MIEMSS** •Maternal death •Unplanned returns to OR/LDR •Maternal transports •Admission to NICU >2500 gms and for >24 hours **2. NPSG** •Patient ID •Med Rec •Hand Hygiene •Universal Protocol **3. Hospital Quality Core Measures** **4. Patient Satisfaction**

EXHIBIT 19p

Maternal Transport Process

Scope

Doctors Community Hospital, Inc. (DCH) Labor Delivery

Purpose

The purpose of this policy is to define the terms and actions for maternal transports to a higher level of care to from Doctors Community Hospital. The goal is to provide safe and quality care to facilitate the best outcome for the maternal patient.

Definitions

None

Policy Statements & Procedures

Policy Statements:

A perinatal patient at Doctors Community Hospital may be transferred to another hospital for higher level of perinatal care when the patient is in stable condition and the requirements of transfer policies are met. The perinatal patient may also be transferred to an accepting hospital in the event delivery is imminent and does not meet the criteria for admission to the Special Care Nursery.

Doctors Community Hospital will not accept primary OB transports.

Procedures:

I. TRANSPORTING PATIENTS TO A LEVEL III or IV PERINATAL CENTER

1. Patients with emergency medical conditions may need to receive care at an institution designed to provide that level of perinatal care. The patient's attending OB physician will contact the physician who is to receive the patient to determine if the receiving medical center has available space and qualified staff for treatment of the patient.

2. The attending OB physician will provide the receiving hospital with the patient's diagnosis and admitting information.

3. The attending OB physician will receive informed consent for the transfer.

4. The patient's nurse will contact the receiving Labor and Delivery nursing staff and provide a verbal report of the patient's condition immediately prior to the transport.

5. The patient becomes the responsibility of the receiving hospital upon their admission to the receiving unit.

6. The Labor and Delivery charge nurse will communicate to the security department and the Emergency Department of the arrival of a transport team.

7. Doctors Community Hospital will provide the receiving hospital with a copy of all applicable and appropriate medical records. These records should accompany the patient at the time of transfer.

These records must include:
a. Patient's name, address, date of birth, social security number, insurance information
b. Attending physician, including address and phone number
c. Records related to the patient's medical condition
d. History and physical
e. Observations of signs and symptoms
f. Preliminary diagnosis
g. Treatment provided
h. Results of any tests, including lab, X-Rays, etc
i. Written informed consent to the transfer
j. Copies of any relevant consent forms
k. Any advance directives that are currently in effect
l. Medication schedule for the previous 12 hours with dose, route, and date and time of administration
m. The transferring facility is responsible for making all arrangements for the transportation of the patient along with patient's personal effects, including money and/or valuables. Upon receiving hospital's discretion, transport may be arranged by the receiving hospital.
n. Discharge summary

8. Communication with the receiving hospital will occur on a periodic basis regarding the patient's condition and status as agreed upon by the receiving hospital.

EXHIBIT 19q

Infant Transport

Scope

Doctors Community Hospital, Inc. (AAMC) Special Care Nursery

Purpose

The purpose of this policy is to define the actions and expectations for registered nurses and neonatal medical staff providers related to infant transports into and out of AAMC in order to provide the safest possible care and to facilitate the best outcome for the patient.

Definitions

None

Policy Statements & Procedures

Policy Statements:

1. Doctors Community Hospital will not accept primary transports. It will accept back transport when the condition of the baby meets the criteria of admission to the Special Care Nursery.

2. Transports to and from AAMC will be congruent with the infant's status or required level of care. Infants who are in a level III or IV NICU may also be transferred to Doctors Community Hospital Special Care Nursery when they no longer require level III or IV care.

2. Infants may be transferred out to another institution in the event the infant's medical or family needs are better met at another institution, Special Care Nursery census is declared at "Full Capacity", or in an emergency evacuation under the direction of emergency management Incident Command.

3. All infant transports must be approved by the neonatal medical provider on each end of the transport before the transport commences. The MSM will facilitate the coordination of an appropriate transport team.

Procedures:

A. ACCEPTING/RECEIVING an Infant transport from another institution:

1. The infant's attending physician at the transferring hospital will contact the neonatal medical provider at Doctors Community Hospital to determine if Doctors Community Hospital has available space and qualified staff for the treatment of the infant.

2. Prior to accepting an infant, the Doctors Community Hospital neonatal medical provider will contact the Special Care Nursery staff for bed and staffing availability.

3. After accepting the patient transfer, the receiving neonatal medical provider will contact the Doctors Community Hospital Special Care Nursery nurse with the diagnosis and admitting information.

4. The Special Care Nursery nurse will provide appropriate communication with the security department and the Emergency Department charge nurse regarding the patients estimated time of arrival to the facility so that all resources can be mobilized and prepared at the time of arrival.

5. The primary nurse of the infant being transported will contact the Doctors Community Hospital Special Care Nursery nurse to a give a verbal report of the infant's condition immediately prior to transport.

6. Upon arrival of the infant to Doctors Community Hospital Special Care nurse will receive report from the transport team, request medical records, and document the admission condition of the infant and time of arrival.

7. The patient becomes the responsibility of Doctors Community Hospital upon admission to the NICU.

B. TRANSPORTING an Infant FROM Doctors Community Hospital to Another Institution:

1. The Doctors Community Hospital neonatal provider will obtain informed consent for the transfer from the parents or legal guardian, unless transfer is emergent.

2. After consultation with the Doctors Community Hospital attending physician, the infant's onsite neonatal provider will contact the neonatal provider who is to receive the patient to determine if the receiving institution can accept the infant.

3. Care management verifies the insurance coverage, unless transfer is emergent.

4. The Doctors Community Hospital neonatal provider will provide the receiving hospital with the patient's diagnosis and admitting information and verifies that a transport team has been coordinated.

5. The patient's Special Care Nursery nurse will contact the receiving nursing staff and provide a verbal report of the patient's condition immediately prior to the transport.

6. The Special Care Nursery nurse will communicate to the security department and the Emergency Department charge nurse of the planned arrival of a transport team.

7. The infant becomes the responsibility of the transport team after they arrive in the unit and assume care.

8. After the neonatal provider conducts medication reconciliation, Doctors Community Hospital will provide the receiving hospital with a copy of all relevant medical records. These records should accompany the patient at the time of transfer. These records should include:

a. Patient's name, address, date of birth, medical record number, insurance information,

and parent's or legal guardian's phone number.
b. Attending physician, including address and phone number
c. Records related to the patient's medical condition (including maternal prenatal information)
d. History and physical
e. Observations of signs and symptoms
f. Preliminary diagnosis
g. Treatment provided
h. Test results, including labs and copies of x-rays/imaging studies or other studies, as needed.
i. Copy of informed consent to transfer the infant.
j. Medication schedule for the previous 12 hours with dose, route, and date and time of administration.
k. Medical Discharge summary

9. Communication with the receiving hospital may occur on a periodic basis regarding the patient's condition and status as agreed upon by the receiving hospital.

EXHIBIT 19r

Anne Arundel Medical Center

SNP15.2.164 - Cervical Ripening, Induction, and Augmentation of Labor

Scope

Luminis Health Anne Arundel Medical Center, Inc. (LHAAMC) Labor & Delivery

Purpose

The purpose of this policy is to provide guidance to the Registered Nurse (RN) and Medical Staff/House Staff on cervical ripening, induction, and augmentation of labor.

A. Labor is induced or augmented when the benefits of delivery to either the woman or fetus outweigh those of continuing the pregnancy.

B. Contraindications for induction and augmentation include but are not limited to: any contraindication for vaginal delivery.

Definitions

1. Labor – Uterine contractions resulting in cervical change = dilation and/or effacement
a. Latent phase – onset of labor (contractions) until the active phase
b. Active phase – accelerated cervical change after >/= 6cm dilation

2. Induction of labor – The use of mechanical and/or pharmacological methods to initiate labor.

3. Augmentation of labor – The stimulation of uterine contractions to increase their frequency and/or strength following the onset of spontaneous labor and/or rupture of membranes.

4. Amniotomy: Artificial rupture of membranes (AROM).

5. Membrane Stripping: Digital separation of the chorionic fetal membrane from the decidua of the lower uterine segment.

6. Tachysystole: More than five contractions in a 10 minute period, averaged over a 30 minute window.

7. Confirmation of Term Gestation:
a. Ultrasound measurement at less than 20 weeks
b. Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography
c. It has been 36 weeks or more since a positive serum or urine human chorionic gonadotrophin pregnancy test result

8. Cervical Ripening: To facilitate cervical softening, thinning, and dilation to reduce the rate of failed induction and shorten the time to delivery.
a. Bishop scoring should be used to assess the probability of progressing to vaginal delivery after labor induction
i. A Bishop score of less than 6 is considered to be unfavorable
ii. A Bishop score of 8 or more is considered favorable and predicts a likelihood of vaginal delivery that is comparable to spontaneous labor.
b. Cervical ripening should be utilized when possible in the event of an unfavorable Bishop Score if there are no maternal or fetal contraindications to doing so.
c. Cervical ripening can be facilitated via mechanical methods and use of synthetic prostaglandins.

9. High Risk Factors include but are not limited to Medical Complications before pregnancy and Pregnancy-Related Complications and oxytocin infusions.

10. Low Risk: No meconium staining, no abnormal intrapartum bleeding, no abnormal or undetermined fetal test results, no increased risk of fetal acidemia during labor (eg, IUGR), no maternal condition that may affect fetal wellbeing (eg, prior CD, diabetes on medications, hypertensive disorders), no requirement of oxytocin for induction or augmentation.

Policy Statements & Procedures

Policy Statements:

A. Scheduling and approval process

1. Provider places a tier-based order in EPIC, which includes multiple requested induction dates, indication(s), gestational age, and Bishop Score.

2. EPIC induction request is routed to the OB Hospitalist work queue for approval.

3. Approved requests are scheduled by the Admitting Office. Primary clinicians are contacted by the Admitting Office of the patient's scheduled induction date or by the Ob Hospitalist if a request is declined. The OB practice informs the patient of her scheduled induction date.

4. The OB Hospitalist will prioritize the scheduled inductions for the next day based on medical indications and the tier system. The Admitting Office will email the OB Practice with the time of the patient's induction appointment allowing adequate time for the office to contact the patient.

5. Patients scheduled for risk-reducing, 39 week inductions should have a Bishop score of 6 or more.

B. Arrival and patient preparation process

1. The Primary L+D nurse will inform the patient's Primary Clinician (Medical Staff/House Staff) of patient's arrival for induction.

2. Within one hour of notification, the Primary Clinician places admission orders and completes a history and physical, including an assessment of maternal and fetal status, confirmation of fetal presentation by ultrasound if not confirmed within 24 hours prior, confirmation of induction method based on a complete cervical exam, including dilation, effacement, consistency, position, and station and any other pertinent aspects of the plan of care

3. If the Primary Clinician is unable to perform any of the above components and is not a member of the OB Hospitalist team, the Primary Clinician should engage the services of the OB Hospitalist team to facilitate timely completion of all missing steps.

4. Whenever it is clinically indicated, the Primary Clinician will huddle with the OB Hospitalist and any other appropriate members of the care team to discuss components of the patient's induction based on established protocols or processes.

C. Induction and augmentation of labor

1. Methods of labor induction and augmentation include use of mechanical cervical ripening methods, membrane stripping, amniotomy, Oxytocin, and nipple stimulation. Nursing references for specific procedures are noted below.
Patients should be counseled by Provider regarding the indications for induction or augmentation as well as the benefits, risks/side effects of, and alternatives to, the ripening/induction/augmentation methods being utilized.

D. Nursing Assessment of Electronic Fetal Monitoring (EFM). Based on clinical status and maternal and/or fetal risk factors. Continuous EFM is required for oxytocin infusions and present risk factors.

1. No risk Factors Present. Assess FHR Tracing and Uterine Activity:
a. Every 30 minutes during latent phase and active phase of labor
b. Every 15 minutes during active pushing

2. Oxytocin infusion or Risk Factors Present. Assess FHR Tracing and Uterine Activity:
a. With each titration of oxytocin
b. Every 15 minutes during latent phase and active phase of labor
c. Every 15 minutes during passive fetal descent
d. Every 5 minutes during active pushing

E. Nursing Documentation of Electronic Fetal Monitoring. Based on stage of labor.

1. No Risk Factors Present. Document FHR Tracing and Uterine Activity:
i. Every 1 hour during latent phase of labor
ii. Every 30 minutes during active phase of labor
iii. Every 15 minutes during active pushing
iv. NICHD Category every 1 hour

2. Risk Factors Present. Document FHR Tracing and Uterine Activity:
i. Every 30 minutes during latent phase of labor
ii. Every 15 minutes during active phase of labor
iii. Every 15 minutes during active pushing
iv. NICHD Category every 30 minutes

F. Intrapartum Clinician Documentation

1. Documentation should be completed by a responsible clinician (Med Staff/House Staff) to reflect ongoing management decisions. Frequency of documentation is based on status of labor:
i. Cervical Ripening: at least every 12 hours
ii. Latent Labor: at least every 8 hours
iii. Active Labor: at least every 4 hours

2. Fetal heart rate should be documented and interpreted including NICHD categories at admission and with regularity to reflect continued awareness of clinical status and clinically significant changes.

3. Maternal assessment and physical exam should be documented with changes in clinical status

G. Tachysystole Management

Refer to "Tachysystole Algorithm"

Procedures:

A. Mechanical Methods of Cervical Ripening
Refer to Elsevier Clinical Skills: Cervical Ripening and Labor Induction: Mechanical Methods: Advanced Practice (Maternal-Newborn) (https://together.aahs.orghttps://point-of-care.elsevierperformancemanager.com/skills/1130/quick-sheet?skillId=MN_031)

B. Pharmacologic Cervical Ripening
Refer to Elsevier Clinical Skills: Misoprostol (Maternal-Newborn) (https://together.aahs.orghttps://point-of-care.elsevierperformancemanager.com/search?searchTerm=misoprostol&pageNumber=1&requestStamp=1597933804376)

C. Pharmacologic Induction/Augmentation
Refer to Elsevier Clinical Skills: Oxytocin (Maternal-Newborn) (https://together.aahs.orghttps://point-of-care.elsevierperformancemanager.com/search?searchTerm=oxytocin&pageNumber=1&requestStamp=1597933837845)

D. Other methods of Induction/Augmentation

1. Medical Staff/House Staff may utilize and manage breast or nipple stimulation for induction or augmentation of labor. Breast or nipple stimulation is a physiologic labor stimulant method that offers an alternative method to pharmacologic induction or augmentation of labor.

References

ACOG Practice Bulletin No 116: Management of Intrapartum Fetal Heart Rate Tracings. Obstet Gynecol; 116(5):1232-1240, November 2010. Reaffirmed 2017 by print, 2021 online.

ACOG Practice Bulletin No 107: Induction of Labor. American College of Obstetricians and Gynecologists. Obstet Gynecol; 114(2 Part 1):386-397, August 2009. Reaffirmed 2019 by print, 2020 online.

ACOG Practice Bulletin No 106: Intrapartum Fetal Heart Rate Monitoring: Nomenclature, Interpretation, and General Management Principles. Obstet Gynecol; 114 (1):192-202, July 2009.Reaffirmed 2017 by print, 2021 online.

Macones, G.A. and others. (2008). The 2008 National Institute of Child Health and Human Development workshop report on electronic fetal monitoring: Update on definitions, interpretation, and research guidelines. JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing, 37(5), 510-515. (classic reference)

NCC (National Certification Corp.) (2016) Fetal assessment and safe labor management. https://www.nccwebsite.og/content/documents/cms/2021_ncc_monographfinal_3-16-21.pdf

Simpson, K.R. (2020). Cervical Ripening and Induction and Augmentation of Labor (5th ed. Updated). Washington D.C.: Association of Women's Health, Obstetric, and Neonatal Nurses

Cross References

Labor, Delivery, Recovery, Postpartum (https://together.aahs.org/Policies-and-procedures/Labor,-Delivery,-Recovery,-Postpartum/)

Approval Date

CNO - 06/2022

Owner

Labor & Delivery

Attachments

- FINAL Tachysystole Algorithm 2 (1.24.22)
  (https://together.aahs.org/uploadedFiles/Contents/Policies_and_Procedures/Policy_Details/15_Specialty_Nursing_Areas_(SNP)/152_Womens_and_Childrens_and_Pediatrics/FINAL Tachysystole Algorithm 2 (1.24.22).pdf)

EXHIBIT 19s

Anne Arundel Medical Center

SNP15.2.31 - Substance Exposed Infant

Scope

Luminis Health Anne Arundel Medical Center, Inc. (LHAAMC) Women`s and Children`s Services

Purpose

This policy outlines the nursing procedures to be taken when caring for substance exposed infants, including screening, scoring, intervening, and preparing for either transfer or discharge.

Definitions

1. Neonatal Abstinence Syndrome (NAS) - Signs and symptoms of withdrawal in substance exposed infants.

2. Modified Finnegan Neonatal Abstinence Scoring Tool (MFNAST) – a scoring system to monitor the infant in a comprehensive and objective way. With this score, one can assess the onset, progression, response to therapeutic interventions and resolution of symptoms.

3. Mild to moderate signs of NAS scores on the MFNAST of less than 8.

4. Severe signs of NAS scores on the MFNAST greater than or equal to 8.

5. Medically Stable- consistent scores on the MFNAST of less than 8 for a period of at least 24 hours. If infant is on pharmacologic treatment then the dose has remained unchanged for 24 hours.

6. Neonatal Intensive Care Unit (NICU)

Policy Statements & Procedures

Policy Statements

LHAAMC uses the MFNAST. Signs and symptoms of NAS are related to specific in utero drug exposure and may appear any time from several hours to several weeks after birth. Non-Pharmacologic treatments will be utilized in infants who demonstrate mild to moderate signs of NAS. Pharmacologic treatment may be utilized in infants who demonstrate severe signs of NAS to prevent complications such as fever, weight loss and seizures.

Narcan is NOT administered to substance exposed infants as acute withdrawal can precipitate seizures in the infant.

Procedures

A. Screening

1. Complete screening questionnaire on admission of all laboring patients for medication/substance use (see attachment: NAS Algorithm)

2. Obtain urine toxicology on all laboring patients as ordered.

3. When a mother's urine toxicology screen is positive, the nurse will:

   a. Notify the mother's medical provider
   b. Place a social work consult
   c. After a medical provider has spoken with the mother a urine toxicology will be obtained on the infant.
   d. If a urine toxicology screening is not obtained on the mother, the infants' medical provider may consider obtaining a urine/meconium toxicology screening on the infant.

4. Educate parents/caregivers of infant about NAS and MFNAST.

B. Scoring

1. Infants with the following risk factors should be monitored for signs and symptoms of withdrawal. If infant exhibits signs and symptoms of withdrawal such as: tremors, irritability, high pitched or inconsolable crying, sweating, hypertonia, repetitive sneezing or yawning, poor feeding and/or loose stools initiate scoring.

a. Any mother who has a positive urine toxicology screen for opioids
b. Any mother who has a positive history of substance use in the last 30 days.
c. Any infant who has a positive urine toxicology screen for opioids
d. Any infant exhibiting signs and symptoms of withdrawal

2. Initial score will be completed within 12-24 hours after birth

3. Scoring will continue at least every three to four hours thereafter

a. Scoring will be completed 30-60 minutes after a feeding
b. Score all behaviors that occur from one feeding through the next - not just at the time of scoring
c. Include visual assessments and information reported from the parents/caregivers when appropriate

4. If infant's score is ≥8 x3 or ≥12 x2 the RN will:

a. Consider having a second nurse score the patient, and if possible a NICU nurse
b. Notify the infant's medical provider and charge nurse if score is corroborated.
c. Infant's Pediatrician will call the NICU's medical team for consult and possible admission to the NICU
d. Transfer infant to NICU once order is obtained.

5. Document scores and parent education in the electronic medical record.

C. Interventions

1. Non-Pharmacologic

a. Place the infant skin to skin.
b. Swaddle infant in a light weight (available in the NICU) blanket when not skin-to-skin.
c. Maintain a calm and quiet environment including decreased noise, decreased lighting, and decreased infant stimulation.
d. Offer additional needed comfort such as changing diaper, holding, offering pacifier, and utilizing infant swing (where available)
e. Apply barrier ointment for abraded skin.
f. Cluster care to allow for rest between feedings.
g. For breast feeding infants:

i. Encourage breastfeeding, unless contraindicated.
ii. Offer expressed breast milk/formula supplementation per infant's medical provider order.

h. For formula feeding infants:

i. Obtain an order for specialty formula. Contact infant's medical provider if high calorie or hypoallergenic formula is indicated. Advanced calorie specialty formula may be considered.

j. Consider referral to physical therapy, occupational therapy or speech therapy as appropriate.

2. Pharmacologic

a. Upon admission to the NICU, maintain non-pharmacologic interventions.
b. Pharmacologic therapy may be considered per NAS treatment protocol (see attachment: NAS Treatment Protocol – Birth Weight Based).

D. Transfer

1. Transfer to another institution may be indicated once infant is medically stable.
2. Once transfer is accepted, complete all necessary requirements (SNP15.3.03-Transport between Institutions: Infants).

E. Discharge

1. Infants not admitted to the NICU will be scored and monitored for at least 48-72 hours prior to discharge.
2. Infants in the NICU who have been weaned off all medication will be scored and monitored for an additional 24-48 hours prior to discharge.

F. Discharge home

1. Recommend parents/caregivers to follow up with pediatric care provider ideally within three days, or as soon as possible.
2. Social work can provide parents/caregivers with information regarding the Infants and Toddlers program and home health visits.

References

1. Casper, T. & Arbour, M. (2014). Evidence-based nurse-driven interventions for the care of newborns with neonatal abstinence syndrome. Advances in Neonatal Care. 14 (6), pp. 376-380.
2. Cirillo, C; & Francis, K. (2016). Does breast milk affect neonatal abstinence syndrome severity, the need for pharmacologic therapy, and length of stay for infants of mothers on opioid maintenance therapy during pregnancy? Advances in Neonatal Care. 00(00), pp.1-10.
3. D`Apolito, K. (1994). A scoring system for assessing neonatal abstinence syndrome. Seattle, WA: University of Washington. (Landmark reference)
4. Devlin, LA, & Davis, JM. A Practical Approach to Neonatal Opiate Withdrawal Syndrome. AM
5. J Perinatol. (2018): 35-324

6. Jones, H.E., Kaltenbach, K., Johnson, E., Seashore, C., Freeman, C. & Malloy, E. (2016). Neonatal abstinence syndrome: presentation and treatment considerations. Journal of Addiction Medicine.10(4), pp. 224-228.
7. Merenstein, G.B., & Gardner, S.L. (2021). Merenstein & Gardner's handbook of neonatal care (9th ed.). St. Louis, MO: Mosby.

Cross References

Transport Between Institutions: Infant (https://together.aahs.org/Policies-and-procedures/Transport-Between-Institutions--Infant/)

Approval Date

CNO - 03/2022
HPRC - 02/2022
CPC - 08/2021

Owner

Women's & Children's Services

Attachments

- NAS Algorithm 6-2018 V2
  (https://together.aahs.org/uploadedFiles/Contents/Policies_and_Procedures/Policy_Details/15_Specialty_Nursing_Areas_(SNP)/152_Womens_and_Childrens_and_Pediatrics/NAS Algorithm 6-2018 V2.doc)
- NAS Treatment Protocol 6-2021
  (https://together.aahs.org/uploadedFiles/Contents/Policies_and_Procedures/Policy_Details/15_Specialty_Nursing_Areas_(SNP)/152_Womens_and_Childrens_and_Pediatrics/NAS Treatment Protocol 6-2021.docx)

EXHIBIT 19t

Eclampsia Guidelines

	Eclampsia
Definition	Seizures (grand mal) in the presence of pre-eclampsia and/or HELLP syndrome.
ICD-10	O15.1 O15.2

Inpatient Maternal Management	**CALL FOR HELP:** Anesthesia, OB, Nursing
	Airway/Breathing
	• 100% O_2 non-rebreather face mask, suction available
	• Open Airway: Jaw thrust/head-tilt chin-lift
	• If airway obstructed insert oral airway if possible – if not and O_2 sat <94%, insert nasal airway
	• If apneic, ventilate with ambu bag
	• Once airway protected, turn to left lateral position and
	• Intubate if:
	  ○ Remains unconscious post-seizure
	  ○ Non-terminating seizure
	  ○ Signs of aspiration
	  ○ Hypoxic
	Circulation
	• Check vital signs
	• Obtain IV access
	• Antihypertensives (Goal SBP 140-159 and DBP 90-109)
	Seizure Control
	• Magnesium sulfate 6g IV loading dose over 15-20 minutes, then 2g/hr. if normal renal function
	• If seizure while on magnesium, give a 2nd loading dose of magnesium sulfate 2g over 5 minutes
	• If another seizure (or has not stopped) after 2nd loading dose of magnesium, give midazolam (Versed) 1-2 mg IV (can repeat in 5-10 minutes) OR lorazepam (Ativan) 4 mg IV over 2-5 minutes (can repeat in 5-15 minutes to max of 8 mg over 12 hr) OR diazepam (Valium) 5-10 mg IV slowly (can repeat every 15 minutes to max 30 mg) OR phenytoin (Dilantin) 1000 mg IV over 20 minutes (may cause QRS or QT prolongation)
	• Monitor respirations, BP, ECG, and signs of magnesium toxicity
	• Continue magnesium until 24 hours after the last seizure or after delivery, whichever is later
	• Assess for any signs of neurologic injury
	• Consider head imaging
	• Once stable, manage in PACU while prepping for delivery

Inpatient Fetal Management	When the mother is stable, initiate fetal heart tracing Anticipate a non-reactive tracing for the first 10 minutes. Urgent cesarean delivery only for prolonged bradycardia after termination of seizure.

	Eclampsia
	Delivery should be expeditious WHEN THE MOTHER IS STABLE. An induction of labor can be considered.
Nursing Guidelines/ Protocols	Notify charge nurse, provider and initiate OB/GYN NET. Position patient on side and protect from injury. Administer magnesium sulfate, as ordered. Following seizure: • Suction mouth as needed • Administer oxygen at 10L/minute via face mask • Assess blood pressure, pulse, respirations every 5 minutes • Assess oxygen saturation and level of consciousness every 15 minutes until stable for minimum of one hour. • Monitor fetal heart rate and uterine activity continuously
Outpatient Management	N/A

EXHIBIT 19u

Maternal Safety Bundle: Hypertensive Disorders in Pregnancy/Gestational Hypertension and Preeclampsia w/o Severe Features

	Gestational Hypertension and Preeclampsia w/o Severe Features
Definition	**Gestational Hypertension:** New onset hypertension occurring after 20 weeks gestation with SYSTOLIC blood pressure of greater than or equal to 140 mmHg systolic OR DIASTOLIC blood pressure greater than or equal to 90 mmHg noted on two separate occasions at least 4 hours apart. In gestational hypertension, blood pressure usually normalizes within 12 weeks postpartum. **Preeclampsia Without Severe Features:** New onset hypertension occurring after 20 weeks gestation with SYSTOLIC blood pressure of greater than or equal to 140 mmHg systolic OR DIASTOLIC blood pressure greater than or equal to 90 mmHg noted on two separate occasions at least 4 hours apart PLUS new onset proteinuria: 0.3 grams protein or higher in a 24-hour urine specimen or P/C ratio greater than 0.3 mg/dL greater than or equal to +1 on urine dipstick (if no other measurement method is available).
ICD-9 **ICD-10**	**ICD-9 Codes** 642.3 – Transient hypertension of pregnancy (gestational hypertension) 642.4 - Mild or unspecified preeclampsia **ICD-10 Codes** 013 – Gestational hypertension without significant proteinuria 014 – Preeclampsia (excludes preexisting hypertension with preeclampsia) 014.0 – Mild to moderate preeclampsia
Inpatient Maternal Management	BP, pulse, respiratory rate and pulse ox and lung sounds should be monitored every 4 hours antepartum and postpartum and every hour intrapartum. Assess for level of consciousness, edema, headache, visual disturbances and epigastric pain at least every 4 hours. Intake and output should be monitored every 4 hours. Uterine activity should be monitored **every shift** antepartum and **continuous** monitoring intrapartum.
Outpatient Management	If the patient is less than 37 weeks gestation and fetal wellbeing and maternal stability have been confirmed, outpatient management is acceptable after 8-24 hours of observation. BP, urine protein assessment and review of signs and symptoms at least twice a week.

Maternal Safety Bundle: Hypertensive Disorders in Pregnancy/Gestational Hypertension and Preeclampsia w/o Severe Features

	Gestational Hypertension and Preeclampsia w/o Severe Features
	If the patient develops severe features of preeclampsia, inpatient management should be initiated. If the patient does not develop severe features, delivery should occur at 37 weeks gestation for both, gestational hypertension and preeclampsia without severe features.
Fetal Assessment **Antenatal Testing**	Growth ultrasound at admission or time of diagnosis. NST and AFI or BPP two times per week if undergoing outpatient management. Fetal status monitored at least every shift if undergoing inpatient management and continuous monitoring intrapartum. MFM Consult.
Nursing Guidelines /Protocols	**Triage:** Vital Signs (Blood pressure, pulse, respiration rate, pulse ox) sitting or semi-reclining position: Every 15 minutes x1 hour, then every 30 minutes until discharged from triage or as indicated by provider. Alert provider for any severe range blood pressure ((>=160/>=110) Initiation of antihypertensive medications: ASAP, within 30 to 60 minutes of severe range blood pressure **Antepartum:** Vital signs and Intake and Output: Every 4 hours, or as clinically indicated Alert provider for any severe range blood pressure (>=160/>=110) Initiation of antihypertensive medications: ASAP, within 30 to 60 minutes of severe range blood pressure OB Hypertensive Assessment (Level of Consciousness, DTRs/Clonus, vision changes, breath sounds, edema, headache): Every 4 hours, or as clinically indicated External Fetal Monitoring: Three times daily **Intrapartum:** Vital Signs: Every 1 hour, or as clinically indicated; Intake and Output: Every 4 hours, or as clinically indicated. Alert provider for any severe range blood pressure (>=160/>=110) Initiation of antihypertensive medications: ASAP, within 30 to 60 minutes of severe range blood pressure OB Hypertensive Assessment: Every 4 hours, or as clinically indicated External Fetal Monitoring: Continuous **Post Partum:** Vital Signs and I/Os: Every 4 hours, or as clinically indicated.

Maternal Safety Bundle: Hypertensive Disorders in Pregnancy/Gestational Hypertension and Preeclampsia w/o Severe Features

	Gestational Hypertension and Preeclampsia w/o Severe Features
	Alert provider for any severe range blood pressure (>=160/>=110) Initiation of antihypertensive medications: ASAP, within 30 to 60 minutes of severe range blood pressure OB Hypertensive Assessment: Every 4 hours, or as clinically indicated.
Outpatient Management Considerations	If outpatient management is initiated, close surveillance of maternal and fetal status is indicated, including assessments of symptoms, vital signs, physical exam, laboratory data and antenatal testing 2x/week. Blood pressure monitoring should occur for the first 72h postpartum. Patients receiving antihypertensives during labor, delivery or postpartum care should be re-evaluated within 3 days of hospital discharge. Patients diagnosed with preeclampsia who do not receive antihypertensive treatment should be reevaluated within 7-14 days of delivery.

REFERENCES

Maurice L. Druzin, MD; Laurence E. Shields, MD; Nancy L. Peterson, RNC, PNNP, MSN; Valerie Cape, BSBA. Preeclampsia Toolkit: Improving Health Care Response to Preeclampsia (California Maternal Quality Care Collaborative Toolkit to Transform Maternity Care) Developed Under Contract #11-10006 with the California Department of Public Health; Maternal, Child and Adolescent Health Division; Published by the California Maternal Quality Care Collaborative, November 2013.

EXHIBIT 20

THE PRINCE GEORGE'S COUNTY GOVERNMENT

OFFICE OF THE COUNTY EXECUTIVE

February 16, 2023

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

Dear Mr. Steffen:

I am writing to express my support for the Certificate of Need (CON) application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to expand access to obstetrics care for the residents of Prince George's County.

Maternal and child health in Prince George's County continues to be a major challenge, with health disparities in maternal mortality and other key health outcomes lagging other jurisdictions. With the closure or relocation of other hospitals in the County over the past several years, LHDCMC remains the only acute care hospital in the northern part of the County, serving a population of close to 500,000 people. Moreover, this extremely densely populated area currently has no obstetrical beds. We as a State need to commit to addressing these historic health disparities by investing in the communities most impacted by them.

I would appreciate your thorough consideration of LHDCMC's CON application. It is vitally important to the Prince George's County community that our residents have access to high-quality obstetrics care.

Sincerely,

Angela Alsobrooks

Angela Alsobrooks
County Executive

cc: Randolph Sargent, Chairman, MHCC

MAHASIN EL AMIN
CLERK OF THE CIRCUIT COURT

14735 MAIN STREET
UPPER MARLBORO, MD 20772
(301) 952-3318

OFFICE OF
Clerk of the Circuit Court
PRINCE GEORGE'S COUNTY
UPPER MARLBORO, MD 20772-9987

March 1, 2023

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

Dear Mr. Steffen,

I am writing to express my strong support for the Certificate of Need (CON) application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to expand access to obstetrics care for the residents of Prince George's County.

Maternal and child health in Prince George's County continues to be a major challenge, with health disparities in maternal mortality and other key health outcomes lagging other jurisdictions. With the closure or relocation of other hospitals in the County over the past several years, LHDCMC remains the only acute care hospital in the northern part of the County, serving a population of close to 500,000 people. Moreover, this extremely densely populated area currently has no obstetrical beds. We as a State need to commit to addressing these historic health disparities by investing in the communities most impacted by them.

I would appreciate your thorough consideration of LHDCMC's CON application. It is vitally important to the Prince George's County community that our residents have access to high quality obstetrics care.

Sincerely,

Mahasin El Amin, Esq.

cc: Randolph Sargent, Chairman, MHCC

THE COLLECTIVE EMPOWERMENT GROUP, INC.

February 16, 2023

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

Dear Mr. Steffen:

As the President of the Collective Empowerment Group, I am writing to express my strong support for the Certificate of Need (CON) application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to expand access to obstetrics care for the residents of Prince George's County. The Collective Empowerment Group (CEG) is a 27-year-old faith-based organization of local churches in partnership with financial institutions and local businesses, utilizing our collective strength for economic empowerment.

Maternal and child health in Prince George's County continues to be a major challenge, with health disparities in maternal mortality and other key health outcomes lagging other jurisdictions. With the closure or relocation of other hospitals in the County over the past several years, LHDCMC remains the only acute care hospital in the northern part of the County, serving a population of close to 500,000 people. Moreover, this extremely densely populated area currently has no obstetrical beds. We as a State need to commit to addressing these historic health disparities by investing in the communities most impacted by them.

I would appreciate your thorough consideration of LHDCMC's CON application. It is vitally important to the Prince George's County community that our residents have access to high quality obstetrics care.

Sincerely,

Dr. Bobby Manning
President
The Collective Empowerment Group, Inc.

cc: Randolph Sargent, Chairman, MHCC

UCAP
UNITED COMMUNITIES
AGAINST POVERTY, INC.
"Changing The World by Empowering People"

February 22, 2023

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

Dear Mr. Steffen,

I am writing to express my strong support for the Certificate of Need (CON) application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to expand access to obstetrics care for the residents of Prince George's County.

Maternal and child health in Prince George's County continues to be a major challenge, with health disparities in maternal mortality and other key health outcomes lagging other jurisdictions. With the closure or relocation of other hospitals in the County over the past several years, LHDCMC remains the only acute care hospital in the northern part of the County, serving a population of close to 500,000 people. Moreover, this extremely densely populated area currently has no obstetrical beds. We as a State need to commit to addressing these historic health disparities by investing in the communities most impacted by them.

I would appreciate your thorough consideration of LHDCMC's CON application. It is vitally important to the Prince George's County community that our residents have access to high quality obstetrics care.

Sincerely,

Rasheeda Jamison
President/CEO
United Communities Against Poverty, Inc.

1400 DOEWOOD LANE CAPTIOL HEIGHTS, MD 20743 PHONE: 301-322-5700 WEBSITE: WWW.UCAPPGC.ORG EMAIL: INFO@UCAPPGC.ORG

NAACP Prince George's County Branch 7023-B
9201 Basil Court
Suite 115
Upper Marlboro, Maryland
20774, United States

Mobile: 301-433-3900
www.PGCNAACP.org

NAACP
PRINCE GEORGE'S COUNTY BRANCH

February 24, 2023

Mr. Ben Steffen

Executive Director

Maryland Health Care Commission

4160 Patterson Avenue

Baltimore, MD 21215

Dear Mr. Steffen,

I am writing to express my strong support for the Certificate of Need (CON) application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to expand access to obstetrics care for the residents of Prince George's County.

Maternal and child health in Prince George's County continues to be a major challenge, with health disparities in maternal mortality and other key health outcomes lagging other jurisdictions. With the closure or relocation of other hospitals in the County over the past several years, LHDCMC remains the only acute care hospital in the northern part of the County, serving a population of close to 500,000 people. Moreover, this extremely densely populated area currently has no obstetrical beds. We as a State need to commit to addressing these istoric health disparities by investing in the communities most impacted by them.

I would appreciate your thorough consideration of LHDCMC's CON application. It is vitally important to the Prince George's County community that our residents have access to high quality obstetrics care.

Sincerely,

Dr. Tonya Harrison

Dr. Tonya Harrison

2nd Vice President, Prince Georges County N A A C P

cc: Randolph Sargent, Chairman, MHCC

Mission of Love
Charities

February 22, 2023

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

Dear Mr. Steffen,

I am writing to express my strong support for the Certificate of Need (CON) application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to expand access to obstetrics care for the residents of Prince George's County.

Maternal and child health in Prince George's County continues to be a major challenge, with health disparities in maternal mortality and other key health outcomes lagging other jurisdictions. With the closure or relocation of other hospitals in the County over the past several years, LHDCMC remains the only acute care hospital in the northern part of the County, serving a population of close to 500,000 people. Moreover, this extremely densely populated area currently has no obstetrical beds. We as a State need to commit to addressing these historic health disparities by investing in the communities most impacted by them. The Mission sees this crisis everyday with the clients were currently serve.

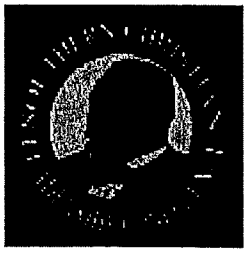
I would appreciate your thorough consideration of LHDCMC's CON application. It is vitally important to the Prince George's County community that our residents have access to high quality obstetrics care.

Sincerely,

Deborah Martinez, CEO
Mission of Love Charities

6180 Old Central Avenue, Capitol Heights, MD 20743 (301) 333-4440

SOUTHERN CHRISTIAN LEADERSHIP CONFERENCE
Prince Georges County Maryland Chapter
4014 91st Avenue
Springdale, MD 20774
301-437-5254



February 21, 2023

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

Dear Mr. Steffen,

I am writing to express my strong support for the Certificate of Need (CON) application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to expand access to obstetrics care for the residents of Prince George's County.

Maternal and child health in Prince George's County continues to be a major challenge, with health disparities in maternal mortality and other key health outcomes lagging other jurisdictions. With the closure or relocation of other hospitals in the County over the past several years, LHDCMC remains the only acute care hospital in the northern part of the County, serving a population of close to 500,000 people. Moreover, this extremely densely populated area currently has no obstetrical beds. We as a State need to commit to addressing these historic health disparities by investing in the communities most impacted by them.

I would appreciate your thorough consideration of LHDCMC's CON application. It is vitally important to the Prince George's County community that our residents have access to high quality obstetrics care.

Sincerely,

Josephine Mourning

Josephine Mourning
President/Chairperson
Southern Christian Leadership Conference (SCLC)
Prince Georges County Maryland Chapter

cc: Randolph Sargent, Chairman, MHCC

GREATER BADEN
MEDICAL SERVICES
Primary and Preventive Health Care

Greater Baden at Brandywine
7450 Albert Road, 3rd Floor
Brandywine, MD 20613
301-888-2233 / Fax 301-888-9133

Greater Baden at Capitol Heights I
1458 Addison Road South
Capitol Heights, MD 20743-4413
301-324-1500 / Fax301-324-6405

Greater Baden at Capitol Heights II
1442 Addison Road South
Capitol Heights, MD 20743
301-324-1500 / Fax 240-492-2526

Greater Baden at La Plata
6 Garrett Avenue
La Plata, MD 20646
301-539-5100 / Fax 301-539-5105

Greater Baden at Leonardtown
23140 Moakley Street, Suite 4
Leonardtown, MD 20650-2923
301-997-1029 /Fax 301-997-1489

Greater Baden at Oxon Hill
***Pediatric and Dental**
6196 Oxon Hill Road, Suite 540
Oxon Hill, MD 20745-3150
301-686-1665 / Fax 301-686-1190

MarylandWIC
Greater Baden Medical Services

WIC Center – Brandywine
7450 Albert Road, 1st Floor
Brandywine, MD 20613
301-836-9654 / Fax 301-836-9655

WIC Center – Capitol Heights
1472 Addison Road South
Capitol Heights, MD 20743
301-324-1873 / Fax 301-324-2415

WIC Center – Oxon Hill
6196 Oxon Hill Road, Suite 445
Oxon Hill, MD 20745
301-686-1171 / Fax 301-686-1190

GBMS is a Joint Commission Accredited Federally Qualified Health Center

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

February 27, 2023

Dear Mr. Steffen,

I am writing to express my strong support for the Certificate of Need (CON) application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to expand access to obstetrics care for the residents of Prince George's County.

Maternal and child health in Prince George's County continues to be a major challenge, with health disparities in maternal mortality and other key health outcomes lagging other jurisdictions. With the closure or relocation of other hospitals in the County over the past several years, LHDCMC remains the only acute care hospital in the northern part of the County, serving a population of close to 500,000 people. Moreover, this extremely densely populated area currently has no obstetrical beds. We as a State need to commit to addressing these historic health disparities by investing in the communities most affected.

I would appreciate your thorough consideration of LHDCMC's CON application. It is vitally important to the Prince George's County community that our residents have access to high quality obstetrics care.

Greater Baden Medical Services, Inc. has provided primary medical, dental, mental health, and women's care in Prince George's, Charles, and St. Mary's counties for the past 50 years. GBMS provides more than 400 pregnant mothers per year with obstetrical clinical care, referrals of high-risk pregnancies, and navigation to a wide array of related services to reduce maternal morbidity and infant mortality. We can attest to the fact that there is a lack of referral sources for pregnant mothers and particularly for high-risk pregnancies. The new project will improve access and equity for mothers from all backgrounds.

Sincerely,

Christopher DeMarco, PhD, MBA
Chief Executive Officer

cc: Randolph Sargent, Chairman, MHCC

TOWN OF COTTAGE CITY
3820 – 40th Avenue
Cottage City, Maryland 20722
(301) 779-2161 • Fax (301) 779-3525

March 1, 2023

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

Dear Mr. Steffen,

I am writing to express my strong support for the Certificate of Need (CON) application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to expand access to obstetrics care for the residents of Prince George's County.

Maternal and child health in Prince George's County continues to be a major challenge, with health disparities in maternal mortality and other key health outcomes lagging behind other jurisdictions. With the closure or relocation of other hospitals in the County over the past several years, LHDCMC remains the only acute care hospital in the northern part of the County, serving a population of close to 500,000 people. Moreover, this extremely densely populated area currently has no obstetrical beds. We as a State need to commit to addressing these historic health disparities by investing in the communities most impacted by them.

I would appreciate your thorough consideration of LHDCMC's CON application. It is vitally important to the Prince George's County community that our residents have access to high-quality obstetrics care.

Sincerely,

Wanda Wheatley
Commissioner Chair

cc: Randolph Sargent, Chairman, MHCC

City of Mount Rainier
One Municipal Place, Mount Rainier, MD 20712
Phone 301-985-6585 Fax 301-985-6595

Incorporated 1910

March 1, 2023

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

Dear Mr. Steffen,

I am writing to express my strong support for the Certificate of Need (CON) application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to expand access to obstetrics care for the residents of Prince George's County.

Maternal and child health in Prince George's County continues to be a major challenge, with health disparities in maternal mortality and other key health outcomes lagging other jurisdictions. With the closure or relocation of other hospitals in the County over the past several years, LHDCMC remains the only acute care hospital in the northern part of the County, serving a population of close to 500,000 people. Moreover, this extremely densely populated area currently has no obstetrical beds. We as a State need to commit to addressing these historic health disparities by investing in the communities most impacted by them.

I would appreciate your thorough consideration of LHDCMC's CON application. It is vitally important to the Prince George's County community that our residents have access to high quality obstetrics care.

Sincerely,

Celina R. Benitez
Mayor, City of Mount Rainier

cc: Randolph Sargent, Chairman, MHCC

Luminis Health.
Luminis Health OBGYN – Bowie Pavilion
4175 N. Hanson Court, Suite 209
Bowie, MD 20716

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a OBGYN provider who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meets the needs of a growing community and region. I am excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

Prince Georgians currently delivers eight out of 10 babies outside of the county. We also know there are health disparities with the mortality rate for black women in Prince George's County being 50% higher than the national average and 40% higher that the state average. This clearly highlights the need for a significant expansion of services allowing women to deliver their babies closer to where they live and work, enhance both prenatal and postnatal care, and help both mom and baby maintain and improve their overall health and well-being.

I have no doubt that LHDCMC will develop an accessible, high-quality program that is one of the best in Maryland and indeed the country. Luminis Health consists of LHDCMC and Luminis Health Anne Arundel Health System which currently has a leading program. Prince Georgian's will clearly benefit from the experience and proven track record.

Thank you for your consideration.

Sincerely,

Debora Whitehurst-Brown, MD

cc: Luminis Health Doctor's Community Medical Center

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As an Obsetrician-Gynecologist who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

Prince Georgians currently deliver eight out of 10 babies outside of the county. We also know there are health disparities with the mortality rate for black women in Prince George's County being 50% higher than the national average and 40% higher that the state average. This clearly highlights the need for a significant expansion of services allowing women to deliver their babies closer to where they live and work, enhance both prenatal and postnatal care, and help both mom and baby maintain and improve their overall health and well-being.

I have no doubt that LHDCMC will develop an accessible, high-quality program that is one of the best in Maryland and indeed the country. Luminis Health consists of LHDCMC and Luminis Health Anne Arundel Health System which currently has a leading program. Prince Georgian's will clearly benefit from the experience and proven track record.

Thank you for your consideration.

Sincerely,

Jonelle Samuel, MD

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

8118 Good Luck Road
Lanham, Md. 20706
443-481-1000 | luminishealth.org

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Physician who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

Prince Georgians currently deliver eight out of 10 babies outside of the county. We also know there are health disparities with the mortality rate for black women in Prince George's County being 50% higher than the national average and 40% higher that the state average. This clearly highlights the need for a significant expansion of services allowing women to deliver their babies closer to where they live and work, enhance both prenatal and postnatal care, and help both mom and baby maintain and improve their overall health and well-being.

I have no doubt that LHDCMC will develop an accessible, high-quality program that is one of the best in Maryland and indeed the country. Luminis Health consists of LHDCMC and Luminis Health Anne Arundel Health System which currently has a leading program. Prince Georgian's will clearly benefit from the experience and proven track record.

Thank you for your consideration.

Sincerely,

James E Elliott, MD

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

8118 Good Luck Road
Lanham, Md. 20706
443-481-1000 | luminishealth.org

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Dr. Bishaw who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

Prince Georgians currently deliver eight out of 10 babies outside of the county. We also know there are health disparities with the mortality rate for black women in Prince George's County being 50% higher than the national average and 40% higher that the state average. This clearly highlights the need for a significant expansion of services allowing women to deliver their babies closer to where they live and work, enhance both prenatal and postnatal care, and help both mom and baby maintain and improve their overall health and well-being.

I have no doubt that LHDCMC will develop an accessible, high-quality program that is one of the best in Maryland and indeed the country. Luminis Health consists of LHDCMC and Luminis Health Anne Arundel Health System which currently has a leading program. Prince Georgian's will clearly benefit from the experience and proven track record.

Thank you for your consideration.

Sincerely,

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

8118 Good Luck Road
Lanham, Md. 20706
443-481-1000 | luminishealth.org

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a PA who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

Prince Georgians currently deliver eight out of 10 babies outside of the county. We also know there are health disparities with the mortality rate for black women in Prince George's County being 50% higher than the national average and 40% higher that the state average. This clearly highlights the need for a significant expansion of services allowing women to deliver their babies closer to where they live and work, enhance both prenatal and postnatal care, and help both mom and baby maintain and improve their overall health and well-being.

I have no doubt that LHDCMC will develop an accessible, high-quality program that is one of the best in Maryland and indeed the country. Luminis Health consists of LHDCMC and Luminis Health Anne Arundel Health System which currently has a leading program. Prince Georgian's will clearly benefit from the experience and proven track record.

Thank you for your consideration.

Sincerely,

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

8118 Good Luck Road
Lanham, Md. 20706
443-481-1000 | luminishealth.org

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Physician who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

Prince Georgians currently deliver eight out of 10 babies outside of the county. We also know there are health disparities with the mortality rate for black women in Prince George's County being 50% higher than the national average and 40% higher that the state average. This clearly highlights the need for a significant expansion of services allowing women to deliver their babies closer to where they live and work, enhance both prenatal and postnatal care, and help both mom and baby maintain and improve their overall health and well-being.

I have no doubt that LHDCMC will develop an accessible, high-quality program that is one of the best in Maryland and indeed the country. Luminis Health consists of LHDCMC and Luminis Health Anne Arundel Health System which currently has a leading program. Prince Georgian's will clearly benefit from the experience and proven track record.

Thank you for your consideration.

Sincerely,

P. Sahapath MD

cc: Luminis Health Doctor's Community Medical Center

Luminis Health℠

8118 Good Luck Road
Lanham, Md. 20706
443-481-1000 | luminishealth.org

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a doctor who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

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I have no doubt that LHDCMC will develop an accessible, high-quality program that is one of the best in Maryland and indeed the country. Luminis Health consists of LHDCMC and Luminis Health Anne Arundel Health System which currently has a leading program. Prince Georgian's will clearly benefit from the experience and proven track record.

Thank you for your consideration.

Sincerely,

Heather Lee, MD

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

8118 Good Luck Road
Lanham, Md. 20706
443-481-1000 | luminishealth.org

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Nurse Practitioner who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

Prince Georgians currently deliver eight out of 10 babies outside of the county. We also know there are health disparities with the mortality rate for black women in Prince George's County being 50% higher than the national average and 40% higher that the state average. This clearly highlights the need for a significant expansion of services allowing women to deliver their babies closer to where they live and work, enhance both prenatal and postnatal care, and help both mom and baby maintain and improve their overall health and well-being.

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Thank you for your consideration.

Sincerely,

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

8118 Good Luck Road
Lanham, Md. 20706
443-481-1000 | luminishealth.org

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Physician who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

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Thank you for your consideration.

Sincerely,

Dept of Medicine

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

8118 Good Luck Road
Lanham, Md. 20706
443-481-1000 | luminishealth.org

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a NP. Andrews. who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

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Thank you for your consideration.

Sincerely,

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

8118 Good Luck Road
Lanham, Md. 20706
443-481-1000 | luminishealth.org

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Vascular Surg. who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

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Thank you for your consideration.

Sincerely,

Angela Gnewa MD

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

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Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Internist who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

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Thank you for your consideration.

Sincerely, Adedeji Karunwi MD

cc: Luminis Health Doctor's Community Medical Center

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Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Clinician who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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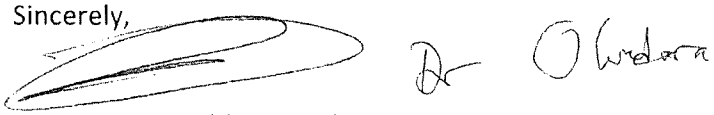
Sincerely,



Dr O Wadoma

cc: Luminis Health Doctor's Community Medical Center

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Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Radiology NP who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Thank you for your consideration.

Sincerely,

Elaine Reynolds CRNP

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

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Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a physician assistant who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Thank you for your consideration.

Sincerely, Kelley E. Ozdemir, PA-C

cc: Luminis Health Doctor's Community Medical Center

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Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a ICU PA who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

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Thank you for your consideration.

Sincerely,

Rebecca Jett PA C

cc: Luminis Health Doctor's Community Medical Center

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Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a CRITICAL CARE who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

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Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Gynecologic Oncologist who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

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4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a pulmonologist who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Gebre McCalpin

cc: Luminis Health Doctor's Community Medical Center

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Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Physician Assistant who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a PA who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a ~~[illegible]~~ Foundation Director who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Dr. Berkeie who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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cc: Luminis Health Doctor's Community Medical Center

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Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Infectious Disease who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Thank you for your consideration.

Sincerely, Ann H. Arundel ID Department

cc: Luminis Health Doctor's Community Medical Center

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Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a John who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As an Addiction Psychiatrist who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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cc: Luminis Health Doctor's Community Medical Center

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4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Intensivist/Pulmonary who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

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Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Pulmonologist who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Thank you for your consideration.

Sincerely,

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

8118 Good Luck Road
Lanham, Md. 20706
443-481-1000 | luminishealth.org

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Physician Assistant who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Thank you for your consideration.

Sincerely,

C. Hockenberry PA-C

cc: Luminis Health Doctor's Community Medical Center

Luminis Health℠

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Lanham, Md. 20706
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Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

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Thank you for your consideration.

Sincerely,

Elizabeth Friedmann, MD

cc: Luminis Health Doctor's Community Medical Center

Luminis Health℠

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Lanham, Md. 20706
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Wynee Hawk, RN, JD, Chief
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Thank you for your consideration.

Sincerely,

cc: Luminis Health Doctor's Community Medical Center

Hamid Reza Zahiri, M.D., F.A.C.S.
Chief of Surgery
(480) 577-5694

Luminis Health℠

8118 Good Luck Road
Lanham, Md. 20706
443-481-1000 | luminishealth.org

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

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Thank you for your consideration.

Sincerely,

Carl Schay MD

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

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Lanham, Md. 20706
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Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a gastroenterologist who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Thank you for your consideration.

Sincerely,

Suzan Ebrahimi, M.D. 3/30/2023

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

8118 Good Luck Road
Lanham, Md. 20706
443-481-1000 | luminishealth.org

Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a PA-C who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Thank you for your consideration.

Sincerely,

D Brian Abel PA-C / Acute Care Surgery

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

8118 Good Luck Road
Lanham, Md. 20706
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Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a CRNP who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

LHDCMC has a history of providing quality and compassionate care that meet the needs of a growing community and region. I'm excited to learn of its plans to offer increased women's health services with obstetrics as a core component.

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Thank you for your consideration.

Sincerely,

Michael Dantley CRNP

cc: Luminis Health Doctor's Community Medical Center

Luminis Health℠

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Lanham, Md. 20706
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Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a physician who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Thank you for your consideration.

Sincerely,

MD Chief of Medicine Service Line

cc: Luminis Health Doctor's Community Medical Center

Luminis Health℠

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Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Nurse anesthetist who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Thank you for your consideration.

Sincerely,

Rachel Calloway, Department of Anesthesiology

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

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Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a radiologist who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Sincerely, MD

cc: Luminis Health Doctor's Community Medical Center

Luminis Health

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Wynee Hawk, RN, JD, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a Internist who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Thank you for your consideration.

Sincerely,

Hi ENTEZAR, MD
Dep. of Medicine

cc: Luminis Health Doctor's Community Medical Center

Luminis Health℠

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Lanham, Md. 20706
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4160 Patterson Avenue
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As a Radiologist who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Thank you for your consideration.

Sincerely,

Dept. of Radiology.

cc: Luminis Health Doctor's Community Medical Center

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4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support – Luminis Health Doctor's Community Medical Center Certificate-of-Need Application for Women's and Children's Services

Dear Ms. Hawk:

As a CRNA who practices in Prince George's County, I am writing to offer my strong support for the certificate-of-need application submitted by Luminis Health Doctor's Community Medical Center (LHDCMC) to establish obstetrics services on the Lanham campus as part of a comprehensive women's health program.

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Thank you for your consideration.

Sincerely,

Department of Anesthesia

cc: Luminis Health Doctor's Community Medical Center

EXHIBIT 21

Consolidated Financial Statements and Supplementary Information

Luminis Health, Inc. and Subsidiaries
Years Ended June 30, 2022 and 2021
With Report of Independent Auditors

Ernst & Young LLP

Luminis Health, Inc. and Subsidiaries

Consolidated Financial Statements
and Supplementary Information

Years Ended June 30, 2022 and 2021

Contents

Building a better working world

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 Trustees
Luminis Health, Inc.

Opinion

We have audited the consolidated financial statements of Luminis Health, Inc. and subsidiaries (the Company), which comprise the consolidated balance sheets as of June 30, 2022 and 2021, and the related consolidated statements of operations and 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, based on our audits and the report of the other auditors, the accompanying financial statements present fairly, in all material respects, the financial position of the Company at June 30, 2022 and 2021, and the results of its operations, changes in its net assets, and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

We did not audit the financial statements of Cottage Insurance Company, Ltd., a wholly owned subsidiary, which statements reflect total assets constituting 3%, of consolidated total assets as of June 30, 2022 and 2021, and total revenues constituting 1% of consolidated total revenues for the years then ended. Those statements were audited by other auditors, whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Cottage Insurance Company, Ltd., is based solely on the report of the other auditors.

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 Company 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 Company's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

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 Company'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 Company'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 information is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the 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 14, 2022

Luminis Health, Inc. and Subsidiaries

Consolidated Balance Sheets

	June 30	
	2022	**2021**
Assets		
Current assets:		
Cash and cash equivalents	**$ 96,638,000**	$ 276,817,000
Short-term investments	**5,279,000**	3,447,000
Current portion of assets whose use is limited	**15,766,000**	16,241,000
Patient receivables, net	**160,723,000**	144,555,000
Inventories	**13,580,000**	23,642,000
Prepaid expenses and other current assets	**25,496,000**	20,310,000
Total current assets	**317,482,000**	485,012,000
Property and equipment	**1,169,694,000**	1,129,871,000
Less accumulated depreciation and amortization	**(628,218,000)**	(583,269,000)
Net property and equipment	**541,476,000**	546,602,000
Other assets:		
Investments	**408,188,000**	448,850,000
Investments in joint ventures	**12,983,000**	13,459,000
Assets whose use is limited, Funds held by trustees	**45,371,000**	53,033,000
Restricted collateral for interest rate swap contract	**10,193,000**	25,699,000
Right of use asset	**43,997,000**	37,528,000
Other assets	**68,349,000**	70,223,000
Total assets	**$ 1,448,039,000**	$ 1,680,406,000

Luminis Health, Inc. and Subsidiaries

Consolidated Balance Sheets (continued)

	June 30	
	2022	**2021**
Liabilities and net assets		
Current liabilities:		
Accounts payable	**$ 57,745,000**	$ 55,696,000
Accrued salaries, wages, and benefits	**76,529,000**	76,693,000
Other accrued expenses	**25,452,000**	29,407,000
Current portion of long-term debt	**21,699,000**	21,638,000
Advances from third-party payors	**73,515,000**	178,155,000
Lease liability short term	**7,846,000**	8,187,000
Total current liabilities	**262,786,000**	369,776,000
Long-term debt, less current portion and unamortized original issue premium	**434,739,000**	449,175,000
Interest rate swap contracts	**51,922,000**	90,010,000
Accrued pension liability	**2,643,000**	2,291,000
Lease liability long term	**41,580,000**	30,979,000
Other long-term liabilities	**50,088,000**	54,044,000
Total liabilities	**843,758,000**	996,275,000
Net assets:		
Net assets without donor restriction	**578,649,000**	654,877,000
Net assets with donor restriction	**21,786,000**	26,412,000
Noncontrolling interest	**3,846,000**	2,842,000
Total net assets	**604,281,000**	684,131,000
Total liabilities and net assets	**$ 1,448,039,000**	$ 1,680,406,000

See accompanying notes.

Luminis Health, Inc. and Subsidiaries

Consolidated Statements of Operations

	Year Ended June 30	
	2022	**2021**
Operating revenue:		
Net patient service revenue	**$ 1,086,322,000**	$ 1,036,435,000
Other operating revenue	**47,404,000**	69,455,000
Total operating revenue	**1,133,726,000**	1,105,890,000
Operating expenses:		
Salaries and wages	**547,725,000**	508,722,000
Employee benefits	**87,225,000**	76,396,000
Supplies	**195,967,000**	189,217,000
Purchased services	**302,009,000**	247,676,000
Depreciation and amortization	**45,164,000**	46,884,000
Interest	**13,152,000**	14,404,000
Total operating expenses	**1,191,242,000**	1,083,299,000
Operating (loss) income	**(57,516,000)**	22,591,000
Other income (loss):		
Investment income, net	**25,871,000**	13,467,000
Loss from joint ventures and other, net	**(1,215,000)**	(93,000)
Pension expense, net	**(2,062,000)**	(3,446,000)
Loss on advance refunding of debt	**(2,320,000)**	–
Change in unrealized (losses) gains on trading securities, net	**(67,344,000)**	104,506,000
Realized and unrealized gains on interest rate swap contracts, net	**31,095,000**	20,165,000
Total other (loss) income, net	**(15,975,000)**	134,599,000
(Deficit) excess of revenues over expenses	**$ (73,491,000)**	$ 157,190,000

See accompanying notes.

Luminis Health, Inc. and Subsidiaries

Consolidated Statements of Changes in Net Assets

	Without Donor Restrictions	With Donor Restrictions	Noncontrolling Interest	Total Net Assets
Net assets, June 30, 2020	$460,552,000	$ 23,861,000	$ 2,191,000	$486,604,000
Excess of revenues over expenses	157,190,000	–	–	157,190,000
Pension liability adjustment	35,092,000	–	–	35,092,000
Transfers and other, net	2,043,000	(1,239,000)	651,000	1,455,000
Restricted gifts, bequests, and contributions	–	5,583,000	–	5,583,000
Restricted investment income	–	1,071,000	–	1,071,000
Net assets released from restrictions	–	(2,864,000)	–	(2,864,000)
Changes in net assets	194,325,000	2,551,000	651,000	197,527,000
Net assets, June 30, 2021	654,877,000	26,412,000	2,842,000	684,131,000
Deficit of revenues over expenses	**(73,491,000)**	–	–	**(73,491,000)**
Pension liability adjustment	**1,165,000**	–	–	**1,165,000**
Transfers and other, net	**(3,902,000)**	**(3,636,000)**	**1,004,000**	**(6,534,000)**
Restricted gifts, bequests, and contributions	–	**4,139,000**	–	**4,139,000**
Restricted investment income	–	**(486,000)**	–	**(486,000)**
Net assets released from restrictions	–	**(4,643,000)**	–	**(4,643,000)**
Changes in net assets	**(76,228,000)**	**(4,626,000)**	**1,004,000**	**(79,850,000)**
Net assets, June 30, 2022	**$578,649,000**	**$ 21,786,000**	**$ 3,846,000**	**$604,281,000**

See accompanying notes.

Luminis Health, Inc. and Subsidiaries

Consolidated Statements of Cash Flows

	Year Ended June 30	
	2022	**2021**
Operating activities		
(Decrease) increase in net assets	**$ (79,850,000)**	$ 197,527,000
Adjustments to reconcile (decrease) increase in net assets to net cash (used in) provided by operating activities:		
Change in unrealized losses (gains) on trading securities, net	**67,344,000**	(104,506,000)
Realized and unrealized gains on interest rate swap contracts, net	**(31,094,000)**	(20,165,000)
Loss on defeasance of debt	**2,320,000**	–
Pension liability adjustment	**(1,290,000)**	(35,092,000)
Equity in earnings of joint ventures	**(672,000)**	(578,000)
Restricted contributions and pledges, net	**(4,139,000)**	(5,583,000)
Depreciation and amortization	**45,683,000**	46,884,000
Restricted investment income	**(674,000)**	(1,071,000)
Increase in investments – trading	**(28,514,000)**	(7,440,000)
Increase in assets whose use is limited, net – trading	**(10,034,000)**	(10,926,000)
Net change in operating assets and liabilities	**(119,244,000)**	5,858,000
Net cash (used in) provided by operating activities	**(160,164,000)**	64,908,000
Investing activities		
Purchases of property and equipment	**(40,038,000)**	(33,813,000)
Payments on interest rate swaps	**(6,994,000)**	(6,861,000)
Return of collateral on swap	**15,506,000**	–
Distributions received from joint ventures	**1,148,000**	1,143,000
Net cash used in investing activities	**(30,378,000)**	(39,531,000)
Financing and fundraising activities		
Repayments of long-term debt	**(16,120,000)**	(18,059,000)
Retirement of long-term debt	**(218,654,000)**	–
Proceeds from refinancing of long-term debt	**221,560,000**	–
Borrowings on line of credit	**17,000,000**	–
Repayments of line of credit	**(17,000,000)**	–
Payment of deferred financing costs	**(655,000)**	–
Proceeds from capital lease	**2,137,000**	–
Restricted contributions received and other	**5,132,000**	6,746,000
Restricted income received	**674,000**	1,071,000
Net cash used in financing and fundraising activities	**(5,926,000)**	(10,242,000)
Net (decrease) increase in cash and cash equivalents	**(196,468,000)**	15,135,000
Cash, cash equivalents, and restricted cash at beginning of year	**320,963,000**	305,828,000
Cash, cash equivalents, and restricted cash at end of year	**$ 124,495,000**	$ 320,963,000
Cash and cash equivalents	**$ 96,638,000**	$ 276,817,000
Restricted cash, included in restricted collateral and assets whose use is limited	**27,857,000**	44,146,000
Cash, cash equivalents, and restricted cash at end of year	**$ 124,495,000**	$ 320,963,000

Luminis Health, Inc. and Subsidiaries

Consolidated Statements of Cash Flows (continued)

	Year Ended June 30	
	2022	**2021**
Changes in operating assets and liabilities		
Increase (decrease) in operating assets:		
Patient receivables, net	**$ (16,168,000)**	$ (25,674,000)
Inventories	**10,062,000**	(1,853,000)
Prepaid expenses and other	**(4,914,000)**	859,000
Other assets	**2,529,000**	(6,539,000)
	(8,491,000)	(33,207,000)
Decrease (increase) in operating liabilities:		
Accounts payable	**2,052,000**	15,255,000
Accrued salaries, wages, and benefits	**(164,000)**	23,255,000
Other accrued expenses	**(3,955,000)**	(3,572,000)
Advances from third-party payors	**(104,640,000)**	(4,542,000)
Other long-term liabilities	**(4,046,000)**	8,669,000
	(110,753,000)	39,065,000
Net change in operating assets and liabilities	**$ (119,244,000)**	$ 5,858,000

See accompanying notes.

Luminis Health, Inc. and Subsidiaries

Notes to Consolidated Financial Statements

June 30, 2022

1. Organization and Basis of Presentation

Luminis Health, Inc. (Luminis Health or the System), formerly known as Anne Arundel Health System, Inc. (AAHS), is a Maryland not-for-profit corporation. Luminis Health has the following wholly owned subsidiaries: Luminis Health Anne Arundel Medical Center, Inc. (the Hospital or LHAAMC), and its subsidiaries; Luminis Health Pathways, Inc. (Pathways), J. Kent McNew Family Medical Center, Inc. (McNew), and Luminis Health Anne Arundel Medical Center Foundation, Inc. (the Foundation); Anne Arundel Medical Center Collaborative Care Network, LLC, Anne Arundel Medical Center Collaborative Care Network, LLC, Luminis Health Clinical Enterprise, Inc. and its subsidiaries; Luminis Health Imaging, Inc. (LHI), Luminis Health Research Institute, Inc. (RI), Physician Enterprise, LLC (PE) and its subsidiaries; Luminis Health Medical Group, LLC, Orthopedic Physicians of Annapolis, LLC, LHMG Physical Therapy, LLC, Luminis Health Care Services, Inc. (LHCS), and Luminis Health Community Clinics, LLC; Luminis Health Ventures, LLC and its subsidiaries; Cottage Insurance Company, Ltd. (Cottage), Luminis Heath Real Estate Holding Company, Inc. (the Real Estate Company), and its subsidiaries; Pavilion Park, Inc. (PPI); Annapolis Exchange, LLC; and Blue Building, LLC.

LHAAMC is a private, not-for-profit corporation that operates a 397-licensed bed acute care hospital.

On July 1, 2019, Luminis Health and LHDCMC, formerly known as Doctors Community Hospital and subsidiaries executed an affiliation agreement (the Agreement) providing for an affiliation between Luminis Health and LHDCMC and subsidiaries.

LHDCMC is a nonprofit corporation wholly owned that operates an acute care general hospital facility licensed for 200 beds. LHDCMC's wholly owned subsidiaries include; Doctors Community Medical Group, LLC, Doctors Community Healthcare Programs, LLC; Doctors Community Hospital Clinic, LLC, Doctors Community Health Ventures, Inc. (DCHV); and Luminis Health Doctors Community Hospital Foundation, Inc.

As part of the Agreement, Luminis Health committed approximately $138,000,000 over a five-year period in strategic investments to LHDCMC to expand health care services. As of June 30, 2022, Luminis Health has contributed approximately $61,900,000 to LHDCMC to meet the capital commitment.

The accompanying consolidated financial statements include non-controlling interest held by third parties in less than wholly owned subsidiaries.

1. Organization and Basis of Presentation (continued)

COVID-19 Pandemic and CARES Act Funding

On March 11, 2020, the World Health Organization designated the Coronavirus Disease 2019 (COVID-19) outbreak as a global pandemic. In response to the pandemic, the Governor of the State of Maryland proclaimed a state of emergency and catastrophic health emergency on March 5, 2020, and effective March 16, 2020, all Maryland hospitals were ordered by the Maryland Department of Health to cease all elective and non-urgent medical procedures for the duration of the catastrophic health emergency. Effective May 7, 2020, the Maryland Department of Health allowed resumption of elective and non-urgent medical procedures, and effective May 15, 2020, major provisions of the Governor's stay-at-home order were rescinded.

As of June 30, 2022, the System has reactivated all aspects of its health care operations. The success of such reactivation is subject to many factors external to Luminis Health, including potential new government-mandated prohibitions of non-essential health care procedures; the willingness of patients to resume preventive and elective care; availability of personal protection equipment and other supplies and drugs; and changes in clinical care and patient and caregiver safety protocols and processes required by the Centers for Disease Control and Prevention, the Occupational Health and Safety Administration, states' departments of public health and other government bodies.

Despite this, the pandemic had and continues to have an impact on Luminis Health's patient volumes and revenues for most services.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, was signed into law on March 27, 2020. The CARES Act authorized funding to hospitals and other health care providers to be distributed through the Public Health and Social Services Emergency Fund (Provider Relief Fund). Payments from the Provider Relief Fund are to be used to prevent, prepare for, and respond to coronavirus, and shall reimburse the recipient for health care-related expenses or lost revenues/margins attributable to coronavirus and are not required to be repaid, except where Provider Relief Funds received exceed the actual amounts of eligible health care related expenses and/or lost revenues as defined by the U.S. Department of Health and Human Services (HHS), provided the recipients attest to and comply with the terms and conditions.

1. Organization and Basis of Presentation (continued)

The outbreak of COVID-19, a respiratory disease caused by a novel strain coronavirus, has and will continue to have significant adverse impacts on the operations and financial condition of health care providers generally. Due to the evolving nature of the pandemic, the ultimate impact to Luminis Health's operating results, including costs that may be incurred in the future and the level of utilization of services and resulting impact on net patient service revenue reported in the future, and its financial condition is presently unknown.

2. Summary of Significant Accounting Policies

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of Luminis Health, its wholly owned subsidiaries and controlled affiliates. All significant intercompany accounts and transactions have been eliminated in consolidation.

The accompanying consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States (U.S. GAAP).

Cash and Cash Equivalents

Cash and cash equivalents include cash held in checking and savings accounts, money market accounts, and short-term certificates of deposit with original maturities of 90 days or less, excluding those held in short-term investments and those classified as long-term investments. Cash balances are principally uninsured and are subject to normal credit risks. At June 30, 2022 and 2021, and at various times during the year, the System maintained cash-in-bank balances in excess of the $250,000 federally insured limits.

Derivative Instruments

On May 10, 2006, LHAAMC entered into a forward variable-to-fixed interest rate swap agreement with an effective date of November 1, 2008. This contract was entered into in an effort to reduce the risk of variable interest rate debt and has a term through July 1, 2048. Under Accounting Standards Codification (ASC) 815, *Derivatives and Hedging*, LHAAMC has recognized its derivative instruments as either assets or liabilities on the accompanying consolidated balance sheets at fair value. As these derivative instruments are not designated as hedges, the unrealized gain or loss on these contracts has been recognized on the accompanying consolidated statements

2. Summary of Significant Accounting Policies (continued)

of operations as realized and unrealized gains on interest rate swap contracts, net. The fair market values of the derivative instruments include a credit valuation adjustment (CVA) as required by ASC 820, *Fair Value Measurement*. When applying the CVA, the valuation of the variable-to-fixed interest rate swap contract was decreased by $3,424,000 and $4,145,000 as of June 30, 2022 and 2021, respectively.

In an effort to reduce the amount of restricted cash pledged as collateral with the original counterparty, LHAAMC entered into a new novation agreement with another counterparty on February 10, 2021. Immediately prior to the novation agreement, the System modified the existing swap to bifurcate the remaining swap into a ten-year swap with the remainder into a 2031 through 2048 swap. The terms of the bifurcated swap remain identical to the original swap other than a modification of the London Interbank Offered Rate (LIBOR). The novation agreement resulted in the return of $64,000,000 of collateral during 2021.

A summary of LHAAMC's derivative instruments and related activity at June 30 and for the years then ended, is as follows:

	Fair Value Liability	
Description of Derivative Instrument	**2022**	**2021**
Variable-to-fixed interest rate swap contract (maturity date March 2031)	**$ (30,064,000)**	$ (36,790,000)
Variable-to-fixed interest rate swap contract (maturity date July 2048)	**(21,858,000)**	(53,220,000)
	$ (51,922,000)	$ (90,010,000)

The change in unrealized gains recognized in (deficit) excess of revenues over expenses for the years ended June 30, 2022 and 2021, were $38,089,000 and $27,026,000, respectively.

At June 30, 2022 and 2021, the net termination value (i.e., mark-to-market value) of the derivative instruments totaled $58,192,000 and $97,003,000, respectively. LHAAMC may be exposed to credit loss in the event of nonperformance by the other party to the interest rate swap agreements, the risk of which is reflected in the fair value of the instruments under ASC 820. However, LHAAMC does not anticipate nonperformance by the counterparty.

2. Summary of Significant Accounting Policies (continued)

During fiscal year 2022 and 2021, LHAAMC paid net payments under its interest rate swap program of $6,994,000 and $6,861,000, respectively. These amounts are included within realized and unrealized gains (losses) on interest rate swap contracts, net on the accompanying consolidated statements of operations and within investing activities on the accompanying consolidated statements of cash flows.

Under the derivative contracts, LHAAMC must transfer collateral for the benefit of the counterparty, to the extent that the termination values exceed certain limits. LHAAMC's collateral requirement for the benefit of the counterparty was approximately $10,193,000 and $25,699,000 at June 30, 2022 and 2021, respectively. The ongoing mark-to-market values and resulting collateral requirements of LHAAMC's interest rate swap contract are subject to variability based on market factors (primarily changes in interest rates). Collateral requirements under this interest rate swap contract are excluded from unrestricted cash and investments for purposes of determining the System's compliance with its liquidity covenants under its Maryland Health and Higher Educational Facilities Authority (MHHEFA or the Authority) revenue bond agreements and its derivative agreements. Collateral amounts are included in noncurrent assets on the accompanying consolidated balance sheets.

Assets Whose Use is Limited and Investments

Assets whose use is limited are principally composed of certain funds established to be held and invested by a trustee. These funds are related to the issuance of the LHAAMC's revenue bonds, investments held at Cottage, and certain permanently restricted endowment assets.

The fair values of publicly traded securities and mutual funds are based on quoted market prices of individual securities or investments or estimated amounts using quoted market prices of similar investments. Alternative investments, some of which are structured so that the System holds limited partnership interests, are valued using net asset value (NAV) as the practical expedient. Valuations of these investments, and therefore the System's holdings, may be determined by the investment manager or general partner and for fund-of-funds investments are primarily based on financial data supplied by the underlying investee funds. Values may be based on historical cost, appraisals, or other estimates that require varying degrees of judgment. Investment income or loss from all unrestricted investments is included on the accompanying consolidated statements of operations as part of other income (loss).

2. Summary of Significant Accounting Policies (continued)

Investment income or loss on investments of assets with donor restrictions is added to or deducted from the restricted fund balance if the income is restricted. The cost of securities sold is based on the specific-identification method.

All investment balances are principally uninsured and subject to normal credit risk. Investments are classified as either current or noncurrent based on the maturity dates and the availability for current operations. Investments included in noncurrent assets consist of board-designated investment funds of $408,188,000 and $448,850,000 as of June 30, 2022 and 2021, respectively. Based on the System's investment policy, such amounts could be liquidated, at the discretion of the board, to satisfy short-term requirements.

Substantially all investments, other than borrowed funds required to be expended for capital projects, are classified as trading securities, with unrealized gains and losses included in excess (deficit) of revenues over expenses. Borrowed funds required to be expended for capital projects are classified as other-than-trading and are included in assets whose use is limited.

Patient Receivables

Patient receivables include charges for amounts due from all patients less price concessions relating to allowances for the excess of established charges over the payments to be received on behalf of patients covered by Medicare, Medicaid, and other insurers. The provision for price concessions is based upon management's assessment of historical and expected net collections considering historical business and economic conditions, trends in health care coverage, and other collection indicators. Periodically throughout the year, management assesses the adequacy of the price concessions based upon historical experience of self-pay accounts receivable, including those balances after insurance payments and not covered by insurance. The results of this review are then used to make any modifications to the provision for price concessions. There have been no significant changes in the current year to the underlying assumptions used by Luminis to estimate the amount expected to be received. Patient accounts receivable is written off after collection efforts have been followed in accordance with System policies.

Inventories

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

2. Summary of Significant Accounting Policies (continued)

Property and Equipment

Property and equipment are stated at cost; or fair value as of the acquisition date for LHDCMC property and equipment. Included in computers and software are capitalized labor costs of $16,722,000 and $16,340,000 as of June 30, 2022 and 2021, respectively. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Equipment under finance leases obligations is amortized using the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization on the accompanying consolidated statements of operations. Depreciation expense is $45,164,000 and $46,884,000 for the years ended June 30, 2022 and 2021, respectively.

The following is a summary of property and equipment:

	Estimated Useful Lives	June 30 2022	2021
Land		**$ 22,823,000**	$ 22,823,000
Land improvements	20 years	**24,054,000**	23,854,000
Buildings and improvements	20–40 years	**620,324,000**	614,286,000
Fixed equipment	5–20 years	**32,206,000**	30,833,000
Leasehold improvements	5–10 years	**62,462,000**	62,591,000
Movable equipment	7–10 years	**254,007,000**	237,988,000
Computers and software	3–5 years	**135,157,000**	128,752,000
Construction-in-progress	–	**18,661,000**	8,744,000
		$ 1,169,694,000	$ 1,129,871,000

Construction-in-progress consists of direct costs associated with hospital department renovations, certain leasehold improvements, and smaller capital projects. As these projects are completed, the related assets are transferred out of construction-in-progress and into the appropriate asset category and are depreciated over the applicable useful lives. Repairs and maintenance are expensed as incurred.

2. Summary of Significant Accounting Policies (continued)

Investments in Joint Ventures

Luminis Health accounts for its investments in joint ventures using the equity method of accounting. During 2011, the Real Estate Company and another party formed West County, LLC, a joint venture that owns and operates a medical office building that opened in December 2012. The Real Estate Company has a 50% interest in this joint venture, with each owner's investment being $6,491,000 and $6,789,000 as of June 30, 2022 and 2021, respectively. The investment in West County is not consolidated into the financial statements of Luminis Health, because Luminis Health does not control the investee.

DCHV has an equity method joint venture investment in Magnolia Gardens LLC of $5,364,000 and $5,550,000 as of June 30, 2022 and 2021, respectively. This investment is consistent with the mission and strategic plan of LHDCMC. The investment in Magnolia Gardens LLC represents a 51% interest and is not consolidated with the financial statements of Luminis Health because DCHV does not control the investee.

Luminis Health has several other unconsolidated joint ventures for imaging, dialysis services, ambulatory surgery centers, and hospice services totaling approximately $1,128,000 and $1,120,000 as of June 30, 2022 and 2021, respectively.

Net Assets

Net resources that are not restricted by donors are included in net assets without donor restrictions. Gifts of long-lived operating assets, such as property, plant, or equipment, are reported as net assets without donor restrictions and excluded from income. Resources restricted by donors for a specified time or purpose are reported as net assets with donor restrictions.

When the specific purposes are met, either through passage of a stipulated time period or when the purpose for restriction is accomplished, they are released to other operating revenues on the consolidated statement of changes in net assets. Resources restricted by donors for additions to property, plant, and equipment are initially reported as net assets with donor restrictions and are transferred to net assets without donor restrictions when expended. Donor-imposed restrictions, which stipulate that the resources be maintained permanently, are reported as net assets with donor restrictions.

Investment income related to net assets with donor restrictions is classified as net assets without donor restrictions based on the intent of the donor.

2. Summary of Significant Accounting Policies (continued)

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. This includes regulatory discounts allowed to Blue Cross, Medicare, Medicaid, and other third-party payors and charity care. Revenues are recorded during the period the obligations to provide health care services are satisfied. Performance obligations for inpatient services are generally satisfied over periods that average approximately 4.9 days, and revenues are recognized based on charges incurred in relation to total expected charges. Performance obligations for outpatient services are generally satisfied over a period of less than one day. The contractual relationship with patients, in most cases, also involve a third-party payor (Medicare, Medicaid, managed care health plans and commercial insurance companies, including plans offered through the health insurance exchanges) and the transaction prices for services provided are dependent upon the terms provided by (Medicare and Medicaid) or negotiated with (managed care health plans and commercial insurance companies) the third-party payors. The payment arrangements with third-party payors for services provided to patients typically specify payments at amounts less than standard charges. Medicare generally pays for inpatient and outpatient services at prospectively determined rates based on clinical, diagnostic and other factors. Services provided to patients having Medicaid coverage are generally paid at prospectively determined rates per discharge, per identified service or per covered member. Agreements with commercial insurance carriers, managed care and preferred provider organizations generally provide for payments based on predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Management continually reviews the contractual estimation process to incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals.

Luminis Health's net patient service revenues are based upon the estimated amounts that management expects to be entitled to receive from patients and third-party payors. Estimates of contractual allowances under managed care and commercial insurance plans are based upon the payment terms specified in the related contractual agreements and are recognized as explicit price concessions. Revenues related to uninsured patients and uninsured copayment and deductible amounts for patients who have health care coverage may have discounts applied (uninsured discounts and contractual discounts). Management also records estimated implicit price concessions (based primarily on historical collection experience) related to uninsured accounts to record self-pay revenues at the estimated amounts that it expects to collect. Subsequent changes in the estimate of collectability due to a change in the financial status of a payor, for example a bankruptcy, will be recognized as bad debt expense in operating expenses, which is included in purchased services on the consolidated statements of operations.

2. Summary of Significant Accounting Policies (continued)

The System has elected the practical expedient utilizing the portfolio approach, as allowed under the Financial Accounting Standards Board (FASB) ASC 606-10-32-18, *Revenue from Contacts with Customers*, and does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to the System's expectation that the period between the time the service is provided to a patient and the time that the patient or third-party payor pays for that service will be one year or less.

Maryland Health Services Cost Review Commission

LHAAMC and LHDCMC's rate structure for all hospital-based services is subject to review and approval by the HSCRC. Under the HSCRC rate-setting system, the Hospital's inpatient and outpatient charges are the same for all patients, regardless of payor, including Medicare and Medicaid. Beginning in fiscal year 2014, LHAAMC and LHDCMC entered into an agreement with the HSCRC to participate in the Global Budget Revenue (GBR) program. The GBR model is a revenue constraint and quality improvement system to provide hospitals with strong financial incentives to manage their resources efficiently and effectively in order to slow the rate of increase in health care costs and improve health care delivery processes and outcomes. Under the GBR, total revenue is capped at a predetermined fixed amount. The annual approved revenue is calculated using a permanent base revenue with positive or negative adjustments for inflation, assessments, performance in quality-based programs, infrastructure requirements, and population. Revenue may also be adjusted annually for market share levels and shifts of regulated services to unregulated settings.

Starting in January 2019, Maryland's hospitals began operating under a new ten-year contract with the federal government titled Medicare Performance Adjustment (MPA). The MPA is designed to test whether the improvements hospitals have made under the previous modernized waiver can be expanded to all health care providers. The GBR methodology will remain in place for hospital rate setting under the MPA. In addition, programs aimed to measure and reduce total health care spending for attributed Medicare patients, including pre- and post-acute care by all providers, are being introduced during this contract period.

The Commission's rate-setting methodology compares Global Budget Revenue to actual revenue. Overcharges and undercharges due to either patient volume or price variances, adjusted for penalties where applicable, are applied to decrease (in the case of overcharges) or increase (in the case of undercharges) future approved rates on an annual basis.

2. Summary of Significant Accounting Policies (continued)

Except as noted above, LHAAMC and LHDCMC's policy is to recognize revenue based on actual charges for services to patients in the year in which the services are performed. LHAAMC and LHDCMC's revenues may be subject to adjustment as a result of examination by government agencies or contractors, and as a result of differing interpretation of government regulations, medical diagnoses, charge coding, medical necessity, or other contract terms. The resolution of these matters, if any, often is not finalized until a subsequent period than when the services were rendered.

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

	Year Ended June 30	
	2022	**2021**
Gross patient service revenue	**$ 1,419,534,000**	$ 1,330,212,000
Revenue deductions:		
Charity care	**(14,873,000)**	(11,708,000)
Contractual and other allowances	**(318,339,000)**	(282,069,000)
Net patient service revenue	**$ 1,086,322,000**	$ 1,036,435,000

During 2022 and 2021, approximately 30% and 37%, respectively, of net patient service revenue was received under the Medicare program, 25% and 24% from Blue Cross, 35% and 33% from contracts with other third parties, 6% and 3% from Medicaid, and 4% and 3% from other sources, including self-pay.

The System's revenues also may be subject to adjustment as a result of examination by government agencies or contractors and as a result of differing interpretation of government regulations, medical diagnosis, charge coding, medical necessity, or other contract terms. Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreements with the payor, correspondence from the payor and the System's historical settlement activity, including an assessment to ensure it is probable a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled or are no longer subject to such

2. Summary of Significant Accounting Policies (continued)

audits, reviews, and investigations. The estimates for implicit price concessions are based upon management's assessment of historical write-offs and expected net collections; business and economic conditions; trends in federal, state, and private employer health care coverage; and other collection indicators. Management relies on the results of detailed reviews of historical write-offs and collections at facilities that represent a majority of the System's revenues and patient receivable as a primary source of information in estimating the collectability of patient receivable.

Luminis Health employs physicians in several hospital-based specialties (including, but not limited to, obstetrics, intensive care, and hospitalists). Net physician revenue is recognized when the services are provided and recorded at the estimated net realizable amount based on the contractual arrangements with third-party payors and the expected payments from the third-party payors and the patients. The difference between the billed charges and the estimated net realizable amounts are recorded as a reduction in physician revenue when the services are provided. The System recognized net physician revenue of $176,656,000 and $162,841,000 for the years ended June 30, 2022 and 2021, respectively, which is included in net patient service revenue. At June 30, 2022 and 2021, $14,997,000 and $22,126,000, respectively, of net physician accounts receivable are included in patient receivables on the accompanying consolidated balance sheets.

Charity Care

Luminis Health provides charity care to patients who meet certain criteria established under its charity care guidelines. The amounts reported as charity care represent the costs of rendering such services and are calculated by applying a ratio of operating expenses over gross patient charges to the charity care provided at established rates. Because members of Luminis Health do not pursue the collection of amounts determined to qualify as charity care, these amounts are deducted from gross revenues on the accompanying consolidated statements of operations. The total benefits associated with providing this care, at cost, are $14,873,000 and $11,708,000 for the years ended June 30, 2022 and 2021, respectively.

Other Operating Revenue

Other operating revenue is composed of grant revenue, cafeteria revenue, net assets released from restrictions for operating purposes, and other miscellaneous items.

2. Summary of Significant Accounting Policies (continued)

A variety of federal, state, and local efforts have been initiated in response to the COVID-19 crisis, including the Provider Relief Fund under the CARES Act discussed previously. Payments received from the Provider Relief Fund shall reimburse the recipient for health care-related expenses or lost revenues attributable to the COVID-19 pandemic and are not required to be repaid, provided the recipients attest to and comply with the terms and conditions.

The System has received and recognized approximately $7,056,000 and $36,524,000 in stimulus funding for the years ended June 30, 2022 and 2021, respectively that has been recorded within other revenue in the accompanying consolidated statements of operations. The System recognized these amounts based on its evaluation of the terms and conditions prescribed by the U.S. Department of Health and Human Services. The System will continue to monitor compliance with the terms and conditions of the Provider Relief Fund and the impact of the pandemic on revenues and expenses. If the System is unable to attest to or comply with current or future terms and conditions, its ability to retain some or all of the distributions received may be impacted. The System believes that it meets all the requirements for recognition.

In addition, the System has received and recognized approximately $6,100,000 of funds from Federal Emergency Management Agency (FEMA) for the year ended June 30, 2022 that has been recorded in other revenue in the accompanying consolidated statements of operations.

Advances From Third-Party Payors

To enhance liquidity, the Centers for Medicare & Medicaid Services (CMS) expanded and streamlined the process for its Accelerated and Advance Payment Program, pursuant to which providers could receive advance Medicare payments. This program allowed 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.

On April 10, 2020, the System received $151,767,000 from the Centers for Medicare and Medicaid Services (CMS) Accelerated and Advance Payment Program. This program provides hospitals with working capital advances that begin to become payable 120 days from the date of receipt of the funds, starting in April 2021 through an automatic reduction of claims receipts from CMS. The funds will be repaid by October 2022. These funds, which represent contract liabilities as defined in ASC 606, have been recorded within advances from third-party payors on the accompanying consolidated balance sheets. The balance due to Medicare was $34,916,000 and $135,178,000 as of June 30, 2022 and 2021, respectively. The remaining amount of advances from third-party payors are in the ordinary course of business and due to various payors on demand.

2. Summary of Significant Accounting Policies (continued)

Donations and Bequests

Unconditional promises to give cash and other assets are reported at fair value on the date the promise is received. Conditional promises to give, and indications of intentions to give, are reported at fair value on the date the gift is received. The gifts are reported as donor-restricted if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends, or a purpose restriction is accomplished, the asset is reclassified to without donor restrictions on the accompanying consolidated statements of changes in net assets. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated financial statements. Contributions that are unrestricted are reflected as other operating revenue on the accompanying consolidated statements of operations.

Scheduled payments for pledges receivable for the years ending June 30 are as follows:

2023	$ 611,000
2024	451,000
2025	407,000
2026	379,000
2027 and thereafter	1,157,000
Less:	
Impact of discounting pledges receivable to net present value	(375,000)
Allowance for uncollectible pledges	(649,000)
Net pledges receivable	$ 1,981,000

Pledges receivable are discounted using rates between 1.2% and 2.5% and are included in prepaids and other current assets and other assets.

(Deficit) Excess of Revenues Over Expenses

The accompanying consolidated statements of operations include (deficit) excess of revenues over expenses. Changes in net assets without donor restrictions that are excluded from (deficit) excess of revenues over expenses, consistent with industry practice, include contributions received and used for additions of long-lived assets, transfers and other activity, and certain changes in pension liabilities.

2. Summary of Significant Accounting Policies (continued)

Other Assets

Other assets consists of the following:

	June 30 2022	2021
Investment in Premier	**$ 11,972,000**	$ 11,680,000
LHAAMC pension assets	**16,160,000**	14,428,000
Deferred compensation plans	**13,595,000**	14,732,000
Insurance recoverable	**18,434,000**	20,250,000
Other	**8,188,000**	9,133,000
	$ 68,349,000	$ 70,223,000

LHAAMC has participated and owned equity in the Premier Limited Partnership (Premier), which has served as a group purchasing organization for many years. This participation provides purchasing contract rates and rebates the System would not be able to obtain on its own. LHAAMC accounted for its investment in Premier using the equity method of accounting.

The System received 309,580 Class B units that were earned in seven separate tranches over an 85-month period ending October 31, 2020.

Income Tax Status

Luminis Health, LHAAMC, the Foundation, Pathways, McNew, LHI, PE, and RI have received determination letters from the Internal Revenue Service (IRS) stating that they are exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (the Code). The Real Estate Company has received a determination letter from the IRS stating that it is exempt from federal income taxes under Section 501(c)(2) of the Code. LHDCMC and the Doctors Community Hospital Foundation are exempt from federal income tax under Section 501(c) (3) of the Code as public charities. These entities are entitled to rely on this determination as long as there are no substantial changes in their character, purposes, or methods of operation. Management has concluded that there have been no such changes, and therefore the status of the various entities as public charities exempt from federal income taxation remain in effect.

2. Summary of Significant Accounting Policies (continued)

The state in which the various entities operate also provides a general exemption from state income taxation for organizations that are exempt from federal income taxation. However, these entities are subject to federal and state income taxation at corporate tax rates on unrelated business income.

Exemption from other state and local taxes, such as real and personal property taxes is separately determined. The various entities had no unrecognized tax benefits or such amounts were immaterial during the periods presented. For tax periods with respect to which unrelated business income was recognized, a tax return was filed in order to report any unrelated business income as well as any taxes due.

LHCS, PPI and DCHV are subject to federal and state income taxes. These income taxes are immaterial to the accompanying consolidated financial statements.

Certain limited liability companies within the consolidated group are not subject to income taxes. Taxable income or loss is passed through to and reportable by the members individually.

Under the Cayman Islands Tax Concessions Law (Revised), the Governor-in-Cabinet issued an undertaking regarding Cottage on November 29, 2005, exempting it from all local income, profit, or capital gains taxes. The undertaking has been issued for a period of 20 years and, at the present time, no such taxes are levied in the Cayman Islands. Accordingly, no provision for taxes is made in these consolidated financial statements.

Doctor's Regional Cancer Center (a controlled subsidiary of LHDCMC) is a Maryland limited liability company that has not elected to be taxed as a corporation under current Treasury regulations and is owned by more than one member. DRCC is subject to the partnership tax rules under Subchapter K of the Internal Revenue Code of 1986 (IRC), as amended. Under these rules DRCC is not subject to federal or state income tax, but must file annual information returns indicating their gross and taxable income to determine the tax results to their members.

Deferred income taxes are provided for all significant timing differences between revenues and expenses reported for financial statement and for tax purposes. Management annually reviews its tax positions and has determined that there are no material uncertain tax positions that require recognition in the consolidated financial statements. Accounting principles generally accepted in the United States require management to evaluate uncertain tax positions taken by the System. The financial statement effects of a tax position are recognized when the position is more likely than not, based on the technical merits, to be sustained upon examination by the Internal Revenue

2. Summary of Significant Accounting Policies (continued)

Service. Management has concluded that as of June 30, 2022 and 2021, there are no uncertain positions taken or expected to be taken. Luminis Health has recognized no interest or penalties related to uncertain tax positions. Luminis Health is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

Use of Estimates

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

New Accounting Standards

In August 2018, the FASB issued Accounting Standards Update (ASU) 2018-15, *Intangibles – Goodwill and Other – Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract.* The amendments help entities evaluate the accounting for implementation costs paid by a customer in a cloud computing arrangement by providing guidance for determining when the service contract includes a software license. This guidance Luminis Health adopted this standard for the year ended June 30, 2022. This did not have a material impact on the System for 2022.

The FASB has amended certain guidance related to various disclosures in ASU 2018-14, *Compensation – Retirement Benefits – Defined Benefit Plans – General (Subtopic 715-20) – Disclosure Framework – Changes to the Disclosure Requirements for Defined Benefit Plans.* The guidance in ASU 2018-14 requires all sponsors of defined benefit plans to provide certain new disclosures: the weighted-average interest crediting rate for cash balance plans and other plans with promised interest crediting rates and an explanation of the reasons for significant gains and losses related to changes in the benefit obligation for the period. Among other changes, ASU 2018-14 eliminates the required disclosure for all sponsors of defined benefit plans to disclose the amounts in accumulated other comprehensive income expected to be recognized as components of net periodic benefit cost over the next fiscal year. ASU 2018-14 is effective for fiscal years ending after December 15, 2021. Luminis Health adopted this standard for the year ended June 30, 2022. This did not have a material impact on the System for 2022.

2. Summary of Significant Accounting Policies (continued)

In September 2020, the FASB issued ASU 2020-07, *Not-for-Profit Entities (Topic 958): Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets*. This ASU changes the presentation and disclosure requirements for not-for-profit entities to increase transparency about contributed nonfinancial assets. The ASU is effective for annual periods beginning after June 15, 2021, and interim periods within annual periods beginning after June 15, 2022, with early adoption permitted. Luminis Health adopted this standard for the year ended June 30, 2022. This did not have a material impact on the System for 2022.

New Accounting Standards Not Yet Adopted

In June 2016, the FASB issued ASU 2016-13, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments.* ASU 2016-13 requires financial assets measured at amortized cost to be presented at the net amount expected to be collected. The measurement of expected credit losses is based on relevant information about past events, including historical experience, current conditions, and reasonable and supportable forecasts that affect the collectability of the reported amounts. An entity must use judgment in determining the relevant information and estimation methods that are appropriate in its circumstances. ASU 2016-13 is effective for annual reporting periods beginning after December 15, 2022, and a modified retrospective approach is required, with a cumulative-effect adjustment to net assets as of the beginning of the first reporting period in which the guidance is effective. Management is currently evaluating the impact of adopting this new accounting guidance.

3. Regulatory Environment

Medicare and Medicaid

The Medicare and Medicaid reimbursement programs represent a substantial portion of Luminis Health's revenues. Luminis Health's operations are subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Over the past several years, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs, together with the imposition of fines and penalties, as well as repayments for patient services previously billed. Compliance with fraud and abuse standards and other government regulations can be subject to future government review and interpretation. Also, future changes in federal and state reimbursement funding mechanisms and related government budgeting constraints could have an adverse effect on Luminis Health.

In 1983, Congress approved a Medicare prospective payment plan for most inpatient services as part of the Social Security Amendment Act of 1983. Hospitals in Maryland were granted a waiver from the Medicare prospective payment system under Section 1814(b) of the Social Security Act. The waiver would remain in effect as long as the Maryland rate of increase in payments per admission remained below the national average rate of increase.

In January 2014, the Centers for Medicare and Medicaid Services approved a modernized waiver that includes both inpatient and outpatient revenue. The new waiver will be in place as long as Maryland hospitals achieve significant quality improvements and limit the per capita growth for all payors for Maryland residents.

4. Investments

Investments, including assets whose use is limited, are stated at fair value. Borrowed funds that are required to be expended on specified capital projects under MHHEFA revenue bond agreements are classified as available for sale. All other investments and assets whose use is limited are classified as trading securities.

	June 30	
	2022	**2021**
Assets whose use is limited:		
Endowment assets:		
Cash and cash equivalents	**$ 1,898,000**	$ 2,206,000
Equity mutual funds	**10,347,000**	13,139,000
Fixed income mutual funds	**5,154,000**	5,079,000
	17,399,000	20,424,000
Amounts held by trustee:		
Cash and cash equivalents	**10,810,000**	12,538,000
U.S. Government obligations	**–**	7,000
	10,810,000	12,545,000
Amounts held by Cottage:		
Cash and cash equivalents	**4,956,000**	3,703,000
Exchange traded funds	**7,187,000**	7,953,000
Equity mutual funds	**7,862,000**	14,636,000
Fixed income mutual funds	**12,923,000**	10,013,000
	32,928,000	36,305,000
Total assets whose use is limited	**61,137,000**	69,274,000
Less current portion	**15,766,000**	16,241,000
	$ 45,371,000	$ 53,033,000

Amounts held by the trustee are broken down as follows:

	June 30	
	2022	**2021**
Lease escrow	**$ 1,463,000**	$ –
Bond indenture	**9,347,000**	12,545,000
	$ 10,810,000	$ 12,545,000

4. Investments (continued)

Other investments:

	June 30	
	2022	**2021**
Cash and cash equivalents	**$ 22,317,000**	$ 24,277,000
Equity mutual funds	**206,920,000**	230,711,000
Fixed income mutual funds	**114,781,000**	129,989,000
Alternative investments	**69,449,000**	67,320,000
	413,467,000	452,297,000
Less short-term investments	**5,279,000**	3,447,000
Investments	**$ 408,188,000**	$ 448,850,000

The components of investment income, net are as follows:

	June 30	
	2022	**2021**
Interest and dividend income, net	**$ 6,003,000**	$ 767,000
Realized (losses) gains, net	**19,868,000**	12,700,000
	$ 25,871,000	$ 13,467,000

Environmental, social and governance (ESG) issues can impact investment risk and returns and therefore should be integrated into our investment decision processes. We integrate ESG consideration into our investment process and take steps to manage them appropriate to the asset class and the materiality of the investment. We review ESG integration of our external managers both on selection and as part of the regular review process. We monitor our portfolios for material ESG issues and take steps to manage them appropriate to each asset class.

5. Fair Value Measurements

ASC 820 defines fair value and establishes a framework for measuring fair value in accordance with U.S. GAAP. ASC 820 establishes a three-tier fair value hierarchy that prioritizes the inputs used in measuring fair value. These tiers include:

- Level 1 – Defined as observable inputs, such as quoted prices in active markets
- Level 2 – Defined as inputs other than quoted prices in active markets that are either directly or indirectly observable
- Level 3 – Defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions

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

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

ASC 820 requires that the fair value of derivative contracts include adjustments related to the credit risks of both parties associated with the derivative transactions. The fair value of Luminis Health's derivative contracts reflected in the accompanying consolidated financial statements includes adjustments related to the credit risks of the parties to the transactions.

5. Fair Value Measurements (continued)

The following tables present the fair value hierarchy for Luminis Health's financial assets and liabilities measured at fair value on a recurring basis.

	June 30, 2022			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Trading securities and assets whose use is limited:				
Cash and cash equivalents	$ 39,975,000	$ 39,975,000	$ –	$ –
Equity securities	232,317,000	224,455,000	7,862,000	–
Fixed income securities	132,858,000	119,935,000	12,923,000	–
Total	405,150,000	384,365,000	20,785,000	–
Pledges receivable	1,981,000	–	–	1,981,000
Collateral for interest rate swap:				
Cash and cash equivalents	10,193,000	10,193,000	–	–
Total assets at fair value	417,324,000	$ 394,558,000	$ 20,785,000	$ 1,981,000
Assets at NAV	69,449,000			
Total assets	$ 486,773,000			
Liabilities				
Derivative instruments	$ (51,922,000)	$ –	$ (51,922,000)	$ –
Total liabilities at fair value	$ (51,922,000)	$ –	$ (51,922,000)	$ –

5. Fair Value Measurements (continued)

	June 30, 2021			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Trading securities and assets whose use is limited:				
Cash and cash equivalents	$ 42,739,000	$ 42,739,000	$ –	$ –
Equity securities	260,811,000	250,798,000	10,013,000	–
Fixed income securities	149,362,000	134,726,000	14,636,000	–
U.S. Government obligation securities	7,000	7,000	–	–
Total	452,919,000	428,270,000	24,649,000	
Pledges receivable	2,974,000	-	-	2,974,000
Collateral for interest rate swap:				
Cash and cash equivalents	25,699,000	25,699,000	–	–
Less investments included in other assets	4,200,000	4,200,000	–	–
Total assets at fair value	477,392,000	$ 449,769,000	$ 24,649,000	$ 2,974,000
Assets at NAV	67,320,000			
Total assets	$ 544,712,000			
Liabilities				
Derivative instruments	$ (90,010,000)	$ –	$ (90,010,000)	$ –
Total liabilities at fair value	$ (90,010,000)	$ –	$ (90,010,000)	$ –

Luminis Health's Level 1 securities primarily consist of U.S. Treasury securities, equity and fixed income securities (including mutual funds), and cash. Luminis Health determines the estimated fair value for its Level 1 securities using quoted (unadjusted) prices for identical assets or liabilities in active markets.

5. Fair Value Measurements (continued)

Luminis Health's Level 2 securities primarily consist of cash and cash equivalents. Luminis Health determines the estimated fair value for these Level 2 securities using the following methods: quoted prices for similar assets/liabilities in active markets, quoted prices for identical or similar assets in non-active markets (few transactions, limited information, noncurrent prices, high variability over time), inputs other than quoted prices that are observable for the asset or liability (e.g., interest rates, yield curve volatilities, default rates), and inputs that are derived principally from or corroborated by other observable market data.

Luminis Health's Level 2 securities also consist of derivative instruments, which are reported using valuation models commonly used for derivatives. Valuation models require a variety of inputs, including contractual terms, market-fixed prices, inputs from forward price yield curves, notional quantities, measures of volatility, and correlations of such inputs.

LHAAMC's alternative investments consist of the following: a fund focused in North American midstream, listed and energy infrastructure and renewables markets, with a focus on income-oriented securities (30 day liquidity) venture capital fund-of-funds taking a globally diversified approach targeting multiple venture capital investment types, stages, sectors and geographies, a private equity fund-of-funds focused exclusively on the lower middle-market segment in the U.S. and consisting of both fund commitments and co-investments, a private equity fund with a focus on long-term fundamental value creation by investing in businesses that can grow profitably over time and sustain value through volatile conditions and strategic healthcare venture fund investing in healthcare information technology and services and medical devices and diagnostics. The private equity and venture capital funds totaling approximately $35,000,000 at June 30, 2022 are subject to lock-up of greater than one year. Unfunded commitments as of June 30, 2022 are approximately $8,100,000.

Alternative investments are measured using NAV as the practical expedient. Certain alternative investments require written notification over a certain period prior to redemption.

Luminis Health also has pledges receivable, which are measured at fair value on a nonrecurring basis and are discounted to the net present value upon receipt using an appropriate risk-free discount rate based on the term of the receivable. Since these inputs are not observable, pledges receivable would be considered Level 3 fair value measurements upon their initial recording. Pledges receivable are recorded net of an allowance for uncollectible pledges. The following table

5. Fair Value Measurements (continued)

provides a reconciliation of the beginning and ending balances of pledges receivable that used significant unobservable inputs.

	Year Ended June 30	
	2022	**2021**
Balance at July 1	**$ 2,974,000**	$ 4,137,000
New pledges	**469,000**	342,000
Collections of pledges	**(970,000)**	(1,451,000)
Write-off of pledges	**(244,000)**	(5,000)
Change in reserves	**(248,000)**	(49,000)
Balance at June 30	**$ 1,981,000**	$ 2,974,000

The carrying amounts of cash and cash equivalents, patient receivables, prepaid expenses and other current assets, accounts payable, accrued salaries, wages and benefits, other accrued expenses, and advances from third-party payors approximate fair value, given the short-term nature of these financial instruments or their methods of valuation. The following methods and assumptions were used by Luminis Health in estimating the fair value of other financial instruments.

6. Long-Term Debt and Line of Credit

Long-term debt consists of the following:

	Interest Rate	Maturity Dates	June 30 2022	2021
Maryland Health and Higher Educational Facilities Authority Revenue Bonds (MHHEFA) – Series 2022A	Variable	2040-2043	**$ 60,220,000**	$ –
Series 2022B	2.52%	2024-2035	**49,100,000**	–
Series 2022C	2.27%	2026-2040	**108,895,000**	–
Series 2017	2.0%–5.0%	2018–2043	**52,595,000**	54,690,000
Series 2014	2.0%–5.0%	2015–2040	**8,475,000**	111,463,000
Series 2012	2.0%–5.0%	2013–2035	**3,150,000**	54,137,000
Series 2009B	Variable	2041–2044	**–**	60,000,000
Series 2017B Bond	2.18%	2024	**15,020,000**	19,645,000
Series 2016A	2.57%	2030	**31,141,000**	31,560,000
Series 2017A	5.00%	2031-2038	**64,165,000**	64,165,000
Kent Island bank term loan	Variable	2021	**4,831,000**	5,217,000
Real estate loan	Variable	2028	**48,565,000**	52,231,000
			446,157,000	453,108,000
Less current portion of long-term debt			**21,699,000**	21,638,000
Less deferred debt issue costs			**1,369,000**	3,249,000
Unamortized original issue premium, net			**11,650,000**	20,954,000
Long-term debt			**$ 434,739,000**	$ 449,175,000

These debt instruments are secured by the receipts of the Luminis Health obligated group and substantially all of the property and equipment of the consolidated group.

6. Long-Term Debt and Line of Credit (continued)

Principal payments due under all debt instruments as of June 30, 2022, are as follows:

2023	$ 21,699,000
2024	17,857,000
2025	18,827,000
2026	19,602,000
2027	20,407,000
Thereafter	347,765,000
	$ 446,157,000

Series 2022 Bonds

In February 2022, Luminis Health entered into a loan agreement with MHHEFA supported by three financing agreements with commercial lenders. The proceeds of these direct placement bonds were utilized to refund certain prior Revenue Bonds as follows:

a) 2022A Variable Rate Tax-Exempt Bonds refunded $60,000,000 2009B Series Revenue Bonds and extended the committed period of this issuance to 2032. Interest, at BSBY plus a credit spread, is payable monthly and principal is due annually on July 1.

b) 2022B Fixed Rate Taxable issuance, which refunded $49,100,000 of the 2012 Series Revenue Bonds. Interest is payable monthly at a stated rate of 2.52% and principal is due annually on July 1. On the call date, July 1, 2022, the issuance was converted to tax-exempt rate at 1.99%.

c) 2022C Fixed Rate Taxable issuance, which refunded $108,895,000 of the 2014 Series Revenue Bonds. Interest is payable semi-annually at a stated rate of 2.27% and principal is due annually on July 1. On the call date, July 1, 2024, the issuance is expected to be converted to tax-exempt rate at 1.79%.

In connection with the issuance of the 2022 Bonds, deferred financing costs and premiums related to the 2009B, 2012 and 2014 Series Bonds were written-off as loss on early extinguishment of bonds in the amount of $2,320,000.

6. Long-Term Debt and Line of Credit (continued)

Series 2017 Revenue Bonds

In November 2017, LHAAMC entered into a loan agreement with the MHHEFA for the issuance of the Series 2017 A&B Revenue Bonds (the "2017 A&B Bonds"). The proceeds of the 2017 A&B Bonds were used to advance refund the Series 2010 Bonds previously issued by MHHEFA. The refunded Series 2010 Bonds were originally issued to finance the expansion of the parking garage for LHAAMC's acute care pavilion, and costs related to the issuance. The 2017 A&B Bonds provide for annual principal payments each July 1 from 2022 through 2043. Interest is payable semi-annually on each January 1 and July 1. The 2017 A&B Bonds bear interest at rates between 2.00% and 5.00% and were originally issued at a premium of $4,590,000, which is amortized over the life of the bonds using the straight-line method, which approximates the effective interest method.

Series 2014 Revenue Bonds

In November 2014, LHAAMC entered into a loan agreement with the MHHEFA for the issuance of the Series 2014 Revenue Bonds (the "2014 Bonds"). The proceeds of the 2014 Bonds were used to advance refund the Series 2009A Bonds previously issued by MHHEFA. The refunded Series 2009A Bonds were originally issued to finance a portion of the costs of construction for an eight-story patient care building, two parking garages, and costs related to the issuance. The 2014 Bonds provide for annual principal payments each July 1 from 2022 through 2024. Interest is payable semiannually each January 1 and July 1. The 2014 Bonds bear interest at rates of 4.00% and were originally issued at a premium of $7,520,000, which is amortized over the life of the bonds using the straight-line method, which approximates the effective interest method. The amount outstanding of the Series 2014 Revenue Bonds was reduced to $8,475,000 through the issuance of the Series 2022C Bonds.

6. Long-Term Debt and Line of Credit (continued)

Series 2012 Revenue Bonds

In October 2012, LHAAMC entered into a loan agreement with MHHEFA for the issuance of the Series 2012 Revenue Bonds (the "2012 Bonds"). The proceeds of the 2012 Bonds were used to refund the Series 2004A Bonds and 1998 Bonds previously issued by the Authority. The refunded bonds were originally issued to finance a new replacement hospital (Series 1998 Bonds) and to finance major renovations to LHAAMC's Cancer Center and land acquisition (Series 2004A Bonds). The 2012 Bonds provide for annual principal payments each July 1 through 2022. Interest is payable semiannually on each January 1 and July 1. The 2012 Bonds bear interest at rates of 5.00% and were originally issued at a premium of $6,746,000. The remaining outstanding amount of the 2012 Revenue Bonds was repaid on July 1, 2022.

Series 2009 Revenue Bonds

In 2009, LHAAMC entered into a loan agreement with the MHHEFA for the issuance of $60,000,000 of Series 2009B Revenue Bonds ("2009B Bonds"). The proceeds of the 2009B Bonds together with the Series 2009A Bonds were used to finance a portion of the costs of construction of an eight-story patient care building, two new parking garages, and certain costs relating to the issuance. These bonds were fully refunded with the issuance of the Series 2022A bonds.

Series 2016A and 2017B Revenue Bonds

On June 28, 2016, MHHEFA issued $73,445,000 principal amount of Revenue Bonds, Doctor's Community Hospital Series 2016A Bonds ($31,945,000), and Series 2016B Taxable Bonds ($41,500,000). The proceeds of these bonds were used to retire the Series 2007A Bonds and Series 2010 Bonds (partial) previously issued by the Authority. On March 23, 2017, the Series 2016B Bonds were converted to Series 2017B Bonds as planned. The 2016A Bonds provide for monthly principal and interest payments through July 1, 2030. The 2017B Bonds provide for monthly principal and interest payments through October 1, 2024. The 2016A Bonds and 2017B Bonds bear interest at a rates of 2.53% and 2.18%, respectively.

6. Long-Term Debt and Line of Credit (continued)

Series 2017A Revenue Bonds

On February 8, 2017, MHHEFA issued $64,165,000 principal amount of Revenue Bonds, Doctor's Community Hospital Series 2017A. The proceeds of these bonds were used to retire the remainder of the Series 2010 Bonds previously issued by the Authority. The 2017A Bonds provide for annual principal payments each July 1 from 2031 through 2038. Interest is payable semiannually on each January 1 and July 1. The 2012 Bonds bear stated interest rates of 5.00% and were issued at a premium of $4,144,000.

The effective interest for the years ended June 30, 2022 and 2021 is 2.84% and 3.01%, respectively.

The provisions of the Master Loan Agreement with MHHEFA, require Luminis Health and certain subsidiaries to comply with certain covenants on an annual basis, including a debt service coverage requirement. Luminis Health, LHAAMC, LHI and LHDCMC are members of the Luminis Health Obligated Group for all of the above stated revenue bonds issued by MHHEFA.

Bank Line of Credit and Real Estate Loan

LHAAMC maintains a line of credit with a bank providing available credit of $50,000,000, which is reviewed annually for renewal. Interest on any borrowings accrues at the one-month LIBOR plus 0.75%. At June 30, 2022 and 2021, LHAAMC had no balance outstanding on the line of credit. In February 2022, LHDCMC entered into a $17,000,000 line of credit agreement and immediately drew upon this line to accomplish certain purposes related to the 2022 Series Bond issuance. Interest on any borrowing accrues at the SOFR plus 0.80%. At June 30, 2022, LHDCMC had no outstanding balance on this line of credit.

On October 17, 2018, the Real Estate Company secured a real estate loan from the bank through a wholly owned subsidiary and the proceeds were used to pay off the 2008 Term Loan and 2008 Construction Loan previously provided by the bank. The loans being refinanced were originally obtained to finance certain medical office buildings owned by the Real Estate Company. The new loan requires flat monthly principal payments (amortized over 17 years) plus interest at one-month LIBOR plus 1.10% from 2018 through 2028 with a balloon payment due October 5, 2028, of $25,800,000.

6. Long-Term Debt and Line of Credit (continued)

Kent Island Term Loan

In August 2007, KIMA entered into a construction loan agreement with a bank in the amount of $9,000,000 that would convert to a term loan after the completion of the construction. The proceeds were used to construct a medical office building. The debt was secured by the medical office building.

On May 9, 2017, KIMA refinanced the term loan with a $6,567,000 promissory note. The promissory note provides for monthly principal and interest payments and has a final maturity of December 2022. The promissory note bears interest at a variable rate, based on the 30-day LIBOR plus 1.20%.

7. Retirement Plans

Anne Arundel Medical Center Plan

LHAAMC has a qualified noncontributory, defined benefit pension plan (the Plan) that covers substantially all employees. LHAAMC's policy is to fund pension costs as determined by its actuary. Adopted by the Board of Trustees on June 11, 2009, and effective September 1, 2009, LHAAMC amended the Plan to freeze future benefit accruals, and participants have not earned any additional benefits under the Plan since that date. However, subsequent to September 1, 2009, participants have continued to vest in benefits they have earned through September 1, 2009. The frozen benefit balance for the participants will only accrue interest credits until the participants' benefit commencement dates. FASB ASC 715, *Compensation – Retirement Benefits*, requires LHAAMC to recognize the funded status (i.e., the difference between the fair value of plan assets and the projected benefit obligations) of its pension plan on its consolidated balance sheet, with a corresponding adjustment to unrestricted net assets. The pension liability adjustment to net assets without donor restrictions represents the change in net unrecognized actuarial losses that have not yet been recognized as part of (deficit) excess of revenues over expenses. These amounts are subsequently recognized as a net periodic benefit cost pursuant to LHAAMC's historical accounting policy for amortizing such amounts.

7. Retirement Plans (continued)

The reconciliation of the beginning and ending balances of the projected benefit obligation and the fair value of plan assets for the years ended June 30 and the accumulated benefit obligation for LHAAMC is as follows:

	June 30	
	2022	**2021**
Accumulated benefit obligation	**$ 102,284,000**	$ 126,360,000
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	**$ 126,360,000**	$ 138,148,000
Service cost	**–**	–
Interest cost	**3,118,000**	3,147,000
Actuarial loss	**(17,470,000)**	(3,989,000)
Benefits paid	**(2,602,000)**	(2,503,000)
Settlements paid	**(7,158,000)**	(8,443,000)
Projected benefit obligation at end of year	**102,248,000**	126,360,000
Change in plan assets:		
Fair value of plan assets at beginning of year	**140,788,000**	115,397,000
Actual return on plan assets	**(15,020,000)**	25,828,000
Employer contribution	**2,400,000**	10,509,000
Benefits paid	**(2,602,000)**	(2,503,000)
Settlements paid	**(7,158,000)**	(8,443,000)
Fair value of plan assets at end of year	**118,408,000**	140,788,000
Net asset recognized in other assets	**$ 16,160,000**	$ 14,428,000
Net amounts recognized on the consolidated balance sheets consist of:		
Prepaid pension costs	**$ 16,160,000**	$ 14,428,000
Amounts recognized in net assets without donor restrictions that have not been recognized in net periodic benefit costs consist of:		
Net actuarial loss	**$ 64,444,000**	$ 65,689,000

7. Retirement Plans (continued)

The following table sets forth the weighted average assumptions used to determine the benefit obligations of LHAAMC:

	June 30	
	2022	**2021**
Discount rate	**4.50%**	2.55%
Rate of compensation increase	**N/A**	N/A

The following table sets forth the weighted average assumptions used to determine the net periodic benefit cost of LHAAMC:

	Year Ended June 30	
	2022	**2021**
Discount rate	**2.58%**	2.38%
Expected return on plan assets	**5.50%**	6.00%
Rate of compensation increase	**N/A**	N/A

LHAAMC's net periodic pension benefit cost included the following components:

	June 30	
	2022	**2021**
Service cost	**$ –**	$ –
Interest cost	**3,118,000**	3,147,000
Expected return on plan assets	**(7,250,000)**	(7,425,000)
Recognized net actuarial loss	**1,856,000**	2,260,000
Loss recognized from partial settlement of projected benefit obligation	**4,188,000**	4,931,000
Net periodic cost	**$ 1,912,000**	$ 2,913,000

7. Retirement Plans (continued)

LHAAMC's defined benefit plan invests in a diversified mix of traditional asset classes. Investments in certain types of U.S. equity securities and fixed-income securities are made to maximize long-term results while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. Risk tolerance of unexpected investment and actuarial outcomes is continually evaluated by understanding the pension plan's liability characteristics. Equity investments are used primarily to increase the overall plan returns. Debt securities provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

LHAAMC's target asset allocation percentages as of June 30, 2022, were as follows: 65% fixed income, 10% international equity, 12% large cap domestic stocks, 3% small cap domestic stocks, and 10% alternative investments and exchange-traded notes.

The following tables present the fair value hierarchy of assets of the defined benefit pension plan of LHAAMC:

	June 30, 2022			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and cash equivalents	$ 1,630,000	$ –	$ 1,630,000	$ –
Mutual funds:				
Equity	17,275,000	17,275,000	–	–
Corporate bonds	76,673,000	76,673,000	–	–
International equity	5,936,000	5,936,000	–	–
Closed-end funds ETF	6,068,000	6,068,000	–	–
Assets measured at fair value	107,582,000	$ 105,952,000	$ 1,630,000	$ –
Assets at NAV	10,826,000			
Total assets	$ 118,408,000			

7. Retirement Plans (continued)

	June 30, 2021			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and cash equivalents	$ 8,875,000	$ –	$ 8,875,000	$ –
Mutual funds:				
Equity	23,528,000	23,528,000	–	–
Corporate bonds	80,640,000	80,640,000	–	–
International equity	9,608,000	9,608,000	–	–
Closed-end funds ETF	6,484,000	6,484,000	–	–
Assets measured at fair value	129,135,000	$ 120,260,000	$ 8,875,000	$ –
Assets at NAV	11,653,000			
Total assets	$ 140,788,000			

Level 1 securities primarily consist of exchange-traded mutual funds. Level 2 securities primarily consist of money market funds. Methods consistent with those discussed in Note 5 are used to estimate the fair values of these securities.

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

LHAAMC currently does not intend to make voluntary contributions to the defined benefit pension plan in fiscal year 2023.

7. Retirement Plans (continued)

The following benefit payments for LHAAMC are expected to be paid:

2023	$ 6,727,000
2024	6,491,000
2025	6,553,000
2026	7,979,000
2027	6,447,000
2028–2032	33,699,000

In addition to the noncontributory defined benefit pension plan, LHAAMC also offers an employee defined contribution plan. Participation in the plan is voluntary. Substantially all full-time employees of LHAAMC are eligible to participate. Employees may elect to contribute a minimum of 1% of compensation, and a maximum amount as determined by Sections 403(b) and 415 of the Code. Any employee making contributions to the plan is entitled to a LHAAMC contribution that will match the employee contribution at the rate of 50% to 75%, depending on the number of years of service, up to a maximum of 5% of qualified compensation.

In 2022, there were several plan amendments for the 403(b) retirement plan. The Anne Arundel Medical Center Employees' Salary Reduction Thrift Plan was renamed the Luminis Health Retirement Plan. Additional amendments to the 403(b) plan included allowing LHDCMC participants to participate in the plan as well as naming Luminis Health (formerly AAMC) as the employer of record for all participants in the plan.

Matching contributions under this defined contribution 403(b) plan were $9,928,000 and $0 in fiscal years 2022 and 2021, respectively.

Doctors Community Hospital Plan

LHDCMC froze the defined benefit pension plan that it sponsors (the LHDCMC Plan) in 2011, which covered substantially all employees. The decision to terminate the LHDCMC Plan has not been made by the board of directors. The benefits are based on years of service and employee compensation during years of employment. LHDCMC's funding policy is to make sufficient contributions to the LHDCMC Plan to comply with the minimum funding provisions of the Employee Retirement Income Security Act of 1974 (ERISA). LHDCMC does not expect to contribute to the LHDCMC Plan during 2023 to keep the funding levels at the ERISA requirements. The measurement date of the LHDCMC Plan is June 30.

7. Retirement Plans (continued)

The reconciliation of the beginning and ending balances of the projected benefit obligation and the fair value of plan assets for the years ended June 30 and the accumulated benefit obligation for LHDCMC is as follows:

	June 30	
	2022	**2021**
Accumulated benefit obligation	**$ 18,412,000**	$ 21,988,000
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	**$ 21,988,000**	$ 23,049,000
Service cost	**–**	–
Interest cost	**476,000**	448,000
Settlement loss	**(3,000)**	(41,000)
Actuarial loss	**(2,837,000)**	(252,000)
Benefits paid	**(152,000)**	(137,000)
Settlements paid	**(1,060,000)**	(1,079,000)
Projected benefit obligation at end of year	**18,412,000**	21,988,000
Change in plan assets:		
Fair value of plan assets at beginning of year	**19,787,000**	16,524,000
Actual return on plan assets	**(3,054,000)**	3,246,000
Employer contribution	**248,000**	1,233,000
Benefits paid	**(152,000)**	(137,000)
Settlements paid	**(1,060,000)**	(1,079,000)
Fair value of plan assets at end of year	**15,769,000**	19,787,000
Net liability recognized	**$ (2,643,000)**	$ (2,201,000)
Net amounts recognized on the consolidated balance sheets consist of:		
Accrued pension costs	**$ (2,643,000)**	$ (2,201,000)
Amounts recognized in net assets without donor restrictions that have not been recognized in net periodic benefit costs consist of:		
Net actuarial loss	**$ 6,549,000**	$ 6,009,000

7. Retirement Plans (continued)

The following table sets forth the weighted average assumptions used to determine the benefit obligations of LHDCMC:

	June 30	
	2022	**2021**
Discount rate	**4.25%**	2.30%
Rate of compensation increase	**N/A**	N/A

The following table sets forth the weighted average assumptions used to determine the net periodic benefit cost:

	Year Ended June 30	
	2022	**2021**
Discount rate	**2.30%**	2.05%
Expected return on plan assets	**6.00%**	6.00%
Rate of compensation increase	**N/A**	N/A

LHDCMC's net periodic pension benefit cost included the following components:

	June 30	
	2022	**2021**
Interest cost	**$ 476,000**	$ 448,000
Expected return on plan assets	**(1,121,000)**	(968,000)
Recognized net actuarial loss	**419,000**	758,000
Effect of settlement	**377,000**	295,000
Net periodic cost	**$ 151,000**	$ 533,000

LHDCMC's target asset allocation percentages as of June 30, 2022, were as follows: 65% fixed income, 5% international equity, 15% large cap domestic stocks, and 15% small cap domestic stocks.

7. Retirement Plans (continued)

The following table presents the fair value hierarchy of assets of the defined benefit pension plan of LHDCMC:

	June 30, 2022			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Mutual funds:				
U.S. common stock	**$ 6,332,000**	**$ 6,332,000**	**$ –**	**$ –**
Corporate bonds	**8,624,000**	**8,624,000**	**–**	**–**
International equity	**813,000**	**813,000**	**–**	**–**
Assets measured at fair value	**15,769,000**	**$ 15,769,000**	**$ –**	**$ –**
Assets at NAV	**–**			
Total assets	**$ 15,769,000**			

	June 30, 2021			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Mutual funds:				
U.S. common stock	$ 6,458,000	$ 6,458,000	$ –	$ –
Corporate bonds	10,920,000	10,920,000	–	–
International equity	1,169,000	1,169,000	–	–
Assets measured at fair value	18,547,000	$ 18,547,000	$ –	$ –
Assets at NAV	1,240,000			
Total assets	$ 19,787,000			

7. Retirement Plans (continued)

The following benefit payments for LHDCMC are expected to be paid:

2023	$ 1,851,000
2024	1,275,000
2025	1,305,000
2026	1,398,000
2027	1,360,000
2028–2032	5,632,000

LHDCMC has a 403(b) defined contribution plan (the contribution plan) covering substantially all its employees. The contribution plan is employee and employer contributory. LHDCMC contributed a match of $0.50 for every $1.00 of elective deferrals for a plan year for eligible employees up to 4% of base compensation. Defined contribution plan expense amounted to $1,694,000 and $0 for 2022 and 2021, respectively.

LHDCMC has a deferred compensation plan that permits certain executives to defer receiving a portion of their compensation. The deferred amounts are included in other assets in the accompanying consolidated balance sheets. The associated liability of an equal amount is included in other liabilities on the accompanying consolidated balance sheets. The liability recorded regarding the deferred compensation was $3,694,000 and $3,832,000 as of June 30, 2022 and 2021, respectively.

LHDCMC is the beneficiary of split dollar life insurance policies in place for certain executives. The amounts that could be realized by LHDCMC under the insurance contracts are approximately $9,000,000 as of June 30, 2022 and 2021, are included in other assets on the consolidated balance sheets.

8. Concentrations of Credit Risk

Certain members of Luminis Health grant credit without collateral to their patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors was as follows:

	June 30	
	2022	**2021**
Medicare	**23%**	25%
Medicaid	**4**	3
Blue Cross	**15**	21
Commercial, HMO, PPO, and other	**39**	39
Patients	**19**	12
	100%	100%

9. Malpractice Insurance Costs and Self-Insured Professional Liability

Until August 1, 1998, LHAAMC and certain subsidiaries maintained insurance coverage for general and professional liability claims on a claims-made basis. The professional liability coverage included a per-case deductible of $250,000, up to a maximum out-of-pocket amount of $750,000 annually. Effective August 1, 1998, the group changed its professional liability coverage to a full coverage claims-made policy with no annual deductibles. This policy included tail coverage for claims incurred prior to August 1, 1998, but reported subsequently. Effective August 1, 2002, LHAAMC changed its professional liability coverage back to a claims-made policy with a per-case deductible of $250,000, up to a maximum out-of-pocket amount of $750,000 annually. Also, LHAAMC did not purchase tail coverage for claims incurred prior to August 1, 2002, which were not yet reported.

Effective March 1, 2004, LHAAMC changed its professional liability coverage to a self-insurance trust with annual exposure limits of $2,000,000 per claim and $11,000,000 in the aggregate. LHAAMC carried an excess liability insurance policy for claims above these limits.

9. Malpractice Insurance Costs and Self-Insured Professional Liability (continued)

Effective July 1, 2005, Cottage was formed as a captive insurer to provide professional liability insurance for LHAAMC. Cottage is a wholly owned subsidiary of LHAAMC, which was formed in the Cayman Islands. The primary layer of professional and general liability insurance coverage is self-insured through Cottage and the secondary layer is fully reinsured through several highly rated commercial carriers.

For the period from July 1, 2005 to June 30, 2009, Cottage issued claims-made policies covering LHAAMC professional liability (including employed physicians) and on an occurrence basis, comprehensive general liability risks of LHAAMC and certain affiliates. Policy limits were $2,000,000 per claim with a $9,000,000 policy aggregate. Effective July 1, 2005, Cottage assumed existing liabilities from LHAAMC's self-insured trust discussed above on a claims-made basis. Effective July 1, 2009, Cottage issued a claims-made policy providing $2,000,000 per claim for LHAAMC professional liability coverage and $1,000,000 per claim for comprehensive general liability coverage, subject to a consolidated annual aggregate limit of $10,000,000. Effective July 1, 2018, policy limits were increased to $5,000,000 per claim with a $25,000,000 policy aggregate.

For the period from July 1, 2005 to June 30, 2008, Cottage also issued an excess umbrella coverage policy (covering LHAAMC professional liability) with limits of $20,000,000 per claim with a policy aggregate. For claims reported on and subsequent to July 1, 2008, the coverage limit provided is $30,000,000 per claim with a policy aggregate. These excess limits are in excess of the primary policy, and the umbrella policies are 100% reinsured with highly rated third-party commercial reinsurers.

The provision for estimated professional liability claims, general liability claims, and workers' compensation claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. As of June 30, 2022 and 2021, the balance for outstanding claims reserves recorded at Cottage is $42,785,000 and $45,278,000, respectively, which is included in other long-term liabilities and reinsurance receivable is $11,309,000 and $11,585,000, respectively, which is included in other assets. The remaining tail liability for claims incurred but not reported is $16,363,000 and $13,366,000 as of June 30, 2022 and 2021, respectively, are included in other accrued expenses, with $14,553,000 and $11,737,000 of the 2022 and 2021 liability, respectively, recorded at LHAAMC. The remainder of the liability is recorded at PE. The group has employed an independent actuary to estimate the ultimate settlement of such claims. In management's opinion, the amounts recorded provide an adequate reserve for loss contingencies. However, changes in circumstances affecting professional liability claims could cause these estimates to change by material amounts in the short term.

9. Malpractice Insurance Costs and Self-Insured Professional Liability (continued)

On March 1, 2022, LHDCMC obtained professional and general liability insurance through Cottage. A provision for remaining tail liability for claims incurred but not reported was recorded of $2,457,000 at June 30, 2022.

LHDCMC maintained coverage for professional and general liabilities on a claims-made basis from Freestate Healthcare Insurance Company, Ltd. (Freestate), a group captive formed by several Maryland hospitals through February 28, 2022. LHDCMC owned 20% interest in the captive and accounts for it using the cost method. This ownership terminated on February 28, 2022. Premiums were expensed as incurred and are established based on the LHDCMC historical experience supplemented as necessary with industry experience. The total premium is allocated to each of the shareholders based on their experience. Retrospective premium assessments and credits are calculated based on the aggregate experience of all named insureds under the policy. Each named insured's assessment of credit is based on the percentage of their actual exposure to the actual exposure of all named insureds. In management's opinion, the assets of Freestate are sufficient to meet its obligations as of June 30, 2022. If the financial condition of Freestate were to materially deteriorate in the future, and Freestate was unable to pay its claim obligations, the responsibility to pay those claims would return to the member hospitals. The captive is responsible for claims up to $1,000,000 for each and every loss event. Additional coverage has been purchased by the captive for all claims in excess of $1,000,000 to a limit of $6,000,000 effective March 1, 2006, $10,000,000 effective March 1, 2012, and $15,000,000 effective March 1, 2019. The estimated unpaid loss liability reserved by the captive for LHDCMC was $7,125,000 and $8,664,000 at June 30, 2022 and 2021, respectively. These amounts are included in long-term liabilities and the related anticipated insurance recoveries were reported in noncurrent assets on the accompanying consolidated balance sheets. The liability for all claims incurred but not reported for LHDCMC was $916,000 at June 30, 2021.

10. Commitments and Contingencies

Leases

The following table presents the components of the Luminis Health's right-of-use assets and liabilities related to ASC 842 leases and their classification in Luminis Health's consolidated balance sheets:

Component of Lease Balances	Classification in Consolidated Balance Sheet	June 30 2022	2021
Assets			
Operating lease assets	Right-of-use asset long term	**$ 43,997,000**	$ 37,528,000
Total leased assets		**$ 43,997,000**	$ 37,528,000
Liabilities			
Operating lease liabilities:			
Current	Lease liability short term	**$ 7,846,000**	$ 8,187,000
Long term	Lease liability long term	**41,580,000**	30,979,000
Total operating lease liabilities		**$ 49,426,000**	$ 39,166,000

Luminis Health determines if an arrangement is a lease at inception of the contract. The right-of-use assets represent Luminis Health's right to use the underlying assets for the lease term and the lease liabilities represent Luminis Health's obligation to make lease payments arising from the leases. Right-of-use assets and lease liabilities are recognized at the commencement date based on the present value of lease payments over the lease term. Luminis Health uses a risk-free discount rate that is determined using Treasury securities of a comparable term to that of its leases when acting as a lessee.

Luminis Health's operating leases are primarily for real estate and equipment. Real estate leases include leases of medical facilities and office spaces. Equipment leases mainly include lease of copiers and medical equipment. Luminis Health's real estate lease agreements typically have initial terms of 3 to 20 years, and equipment lease agreements typically have initial terms of 3 to 5 years.

10. Commitments and Contingencies (continued)

Real estate leases may include one or more options to renew that can extend the lease term from five to ten years. The exercise of lease renewal options is at Luminis Health's sole discretion. In general, Luminis Health does not consider renewal options to be reasonably likely to be exercised; therefore, renewal options are generally not recognized as part of Luminis Health's right-of-use assets and lease liabilities. Certain equipment leases also include options to purchase the leased equipment. The useful life of assets and leasehold improvements are limited by the expected lease term unless there is a transfer of title or purchase option reasonably certain of exercise. Luminis Health currently does not have any leases whereby there is a transfer of title or a purchase option that is reasonably certain to be exercised; hence, all of Luminis Health's leases are depreciated over the lease term.

Certain of the Luminis Health's lease agreements for real estate include payments based on actual common area maintenance expenses and other operating expenses. These variable lease payments are recognized in purchased services but are not included in the right-of-use asset or liability balances. Luminis Health's lease agreements do not contain any material residual value guarantees, restrictions, or covenants.

Luminis Health elected the accounting policy practical expedients by class of underlying asset to: (i) exclude recording leases with an initial term of 12 months or less (short-term leases) as right-of-use assets and liabilities on the consolidated balance sheets; and (ii) combine associated lease and non-lease components into a single lease component. Non-lease components, which are not significant overall, are combined with lease components. Luminis Health has elected these practical expedients for real estate, equipment, and all other asset classes when acting as a lessee.

Luminis Health also elected the practical expedient package not to reassess at adoption (i) expired or existing contracts for whether they are or contain a lease, (ii) the lease classification of any existing leases, or (iii) initial indirect costs for existing leases.

10. Commitments and Contingencies (continued)

The following table presents the components of the Luminis Health's lease expense:

	Year Ended June 30	
	2022	**2021**
Operating lease expense	**$ 11,405,000**	$ 11,600,000
Finance lease expense:		
Amortization of leased assets	**176,000**	27,000
Interest on lease liabilities	**24,000**	1,000
Total finance lease expense	**200,000**	28,000
Variable lease expense	**60,000**	527,000
Short-term lease expense	**–**	–
Total lease expense	**$ 11,665,000**	$ 12,155,000

The weighted average lease terms and discount rates for operating and finance leases are as follows:

	June 30	
	2022	**2021**
Weighted average remaining lease term (years):		
Operating leases	**8.5**	8.0
Finance leases	**6.7**	1.0
Weighted average discount rate:		
Operating leases	**3.5%**	3.0%
Finance leases	**2.6%**	1.8%

Cash flow and other information related to leases are included in the following table:

	Year Ended June 30	
	2022	**2021**
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash outflows from operating leases	**$ 20,803,000**	$ 21,854,000
Operating cash outflows from finance leases	**23,000**	1,000
Financing cash inflows from finance leases	**2,137,000**	–
Financing cash outflows from finance leases	**147,000**	27,000

10. Commitments and Contingencies (continued)

The following table summarizes the maturity lease obligations as of June 30, 2022:

	Operating Leases	Finance Leases	Total
2023	$ 7,335,000	$ 511,000	$ 7,846,000
2024	6,486,000	504,000	6,990,000
2025	4,739,000	518,000	5,257,000
2026	4,661,000	531,000	5,192,000
2027	4,357,000	545,000	4,902,000
Thereafter	20,007,000	944,000	20,951,000
Total lease payments	47,585,000	3,553,000	51,138,000
Less: Imputed interest	1,402,000	310,000	1,712,000
Total lease liabilities	$ 46,183,000	$ 3,243,000	$ 49,426,000

Contingencies

Members of Luminis Health have been named as defendants in various legal proceedings arising from the performance of their normal activities. In the opinion of management, after consultation with legal counsel and after consideration of applicable insurance, the amount of Luminis Health's ultimate liability under all current legal proceedings will not have a material adverse effect on its consolidated financial position or results of operations.

Luminis Health's revenues may be subject to adjustment as a result of examination by government agencies or contractors, based upon differing interpretations of government regulations, medical diagnoses, charge coding, medical necessity, or other contract terms. The resolution of these matters, if any, often is not finalized until subsequent to the period during which the services were rendered. Section 302 of the Tax Relief and Health Care Act of 2006 authorized a permanent program involving the use of third-party recovery audit contractors (RACs) to identify Medicare overpayments and underpayments made to providers. Management has established protocols to respond to RAC requests and payment denials. Payment recoveries resulting from RAC reviews are appealable through administrative and judicial processes, and management intends to pursue the reversal of adverse determinations where appropriate. In addition to overpayments that are not reversed on appeal, management will incur additional costs to respond to requests for records and pursue the reversal of payment denials. As of June 30, 2022 and 2021, Luminis Health has

10. Commitments and Contingencies (continued)

recorded an estimated reserve regarding the Medicare overpayments. In the opinion of the Luminis Health's management, the ultimate settlement of this matter will not have a material adverse effect on the consolidated financial position of Luminis Health.

During the year ended June 30, 2020, LHDCMC recorded an accrual related to a billing error that was self-reported to the Department of Health and Human Services. LHDCMC is working with the U.S. Government to come to a resolution on this matter. It is possible that other regulatory conditions may be part of the final resolution. Based on consultation with legal counsel, management believes the final resolution will not have a material adverse effect on the June 30, 2022 consolidated financial statements.

11. Functional Expenses

Members of Luminis Health provide general health care services to residents within their service area. Expenses related to providing these services are as follows:

	Health Care Services	General and Administrative	Total
Year ended June 30, 2022			
Salaries and wages	**$ 477,259,000**	**$ 70,466,000**	**$ 547,725,000**
Employee benefits	**27,332,000**	**59,893,000**	**87,225,000**
Supplies	**183,770,000**	**12,197,000**	**195,967,000**
Purchased services	**151,074,000**	**150,935,000**	**302,009,000**
Depreciation and amortization	**16,275,000**	**28,889,000**	**45,164,000**
Interest	**13,152,000**	**–**	**13,152,000**
Total operating expenses	**$ 868,862,000**	**$ 322,380,000**	**$ 1,191,242,000**
Year ended June 30, 2021			
Salaries and wages	$ 436,725,000	$ 71,997,000	$ 508,722,000
Employee benefits	65,400,000	10,996,000	76,396,000
Supplies	182,201,000	7,016,000	189,217,000
Purchased services	114,908,000	132,768,000	247,676,000
Depreciation and amortization	19,885,000	26,999,000	46,884,000
Interest	14,404,000	–	14,404,000
Total operating expenses	$ 833,523,000	$ 249,776,000	$ 1,083,299,000

12. Net Assets

Net assets with donor restrictions are restricted for use, as follows:

	June 30 2022	2021
Hospital capital additions	**$ 6,631,000**	$ 7,057,000
Hospital operating programs	**15,155,000**	19,355,000
	$ 21,786,000	$ 26,412,000

13. Liquidity and Availability

Financial assets available for general expenditure within one year of the balance sheet date comprise the following as of June 30, 2022:

Assets	
Current assets:	
Cash and cash equivalents	$ 96,638,000
Short-term investments	5,279,000
Patient receivables, net	160,723,000
Investments*	408,188,000
Total financial assets	$ 670,828,000

*While these investments are long-term in nature, they are available for general expenditures within one year of the balance sheet date, if necessary.

Luminis Health's bond covenant requires Luminis Health to maintain unrestricted cash and marketable securities on hand to meet 70 days of normal operating expenses. The Luminis Health obligated group was compliant with all financial covenants as of June 30, 2022 and 2021.

14. Subsequent Events

Luminis Health has evaluated the impact of subsequent events through October 14, 2022, representing the date at which the accompanying consolidated financial statements were issued.

No events have occurred that require disclosure in or adjustments to the accompanying consolidated financial statements.

Supplementary Information

Luminis Health, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet
(Amounts Expressed in Thousands of U.S. Dollars)

June 30, 2022

	Luminis Health, Inc.	Luminis Health Anne Arundel Medical Center, Inc. and Subsidiaries	Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries	Luminis Health Care Enterprises, Inc. and Subsidiaries	Luminis Health Ventures, LLC and Subsidiaries	Eliminations	Consolidated
Assets							
Current assets:							
Cash and cash equivalents	$ (5,744)	$ 65,078	$ 26,402	$ 5,063	$ 5,839	$ –	$ 96,638
Short-term investments	–	5,662	(383)	–	–	–	5,279
Current portion of assets whose use is limited	–	10,808	–	–	4,958	–	15,766
Patient receivables, net	(616)	95,459	44,709	20,179	992	–	160,723
Inventories	584	7,014	5,535	447	–	–	13,580
Prepaid expenses and other current assets	6,169	10,425	6,124	1,543	1,235	–	25,496
Intercompany receivables/(payables)	(102,658)	23,584	(27,384)	74,673	31,785	–	–
Total current assets	(102,265)	218,030	55,003	101,905	44,809	–	317,482
Property and equipment	58	813,699	147,734	66,249	141,954	–	1,169,694
Less accumulated depreciation and amortization	–	(477,351)	(26,871)	(49,354)	(74,642)	–	(628,218)
Net property and equipment	58	336,348	120,863	16,895	67,312	–	541,476
Other assets:							
Investments	–	387,281	19,062	–	1,845	–	408,188
Investments in joint ventures	–	–	–	781	12,202	–	12,983
Assets whose use is limited	–	17,399	–	–	27,972	–	45,371
Restricted collateral for interest rate swap contract	–	10,193	–	–	–	–	10,193
Right of use asset long term	–	4,759	15,611	14,795	8,832	–	43,997
Investment in subsidiaries	735,824	–	–	–	–	(735,824)	(0)
Other assets	–	28,934	24,932	1,391	13,092	–	68,349
Total assets	$ 633,617	$ 1,002,944	$ 235,471	$ 135,767	$ 176,064	$ (735,824)	$ 1,448,039

Luminis Health, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet (continued)
(Amounts Expressed in Thousands of U.S. Dollars)

June 30, 2022

	Luminis Health, Inc.	Luminis Health Anne Arundel Medical Center, Inc. and Subsidiaries	Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries	Luminis Health Care Enterprises, Inc. and Subsidiaries	Luminis Health Ventures, LLC and Subsidiaries	Eliminations	Consolidated
Liabilities and net assets							
Current liabilities:							
Accounts payable	$ 2,152	$ 39,168	$ 9,558	$ 5,214	$ 1,653	$ –	$ 57,745
Accrued salaries, wages, and benefits	32,181	23,802	7,296	13,278	(28)	–	76,529
Other accrued expenses	(14)	17,236	5,190	2,504	536	–	25,452
Current portion of long-term debt	–	8,025	5,200	–	8,474	–	21,699
Advances from third-party payors	(806)	43,592	26,446	3,901	382	–	73,515
Lease liability short term	–	2,437	1,483	2,522	1,404	–	7,846
Total current liabilities	33,513	134,260	55,173	27,419	12,421	–	262,786
Long-term liabilities:							
Long-term debt, less current portion and unamortized original issue premium	–	276,471	113,434	–	44,834	–	434,739
Interest rate swap contract	–	51,922	–	–	–	–	51,922
Accrued pension liability	–	–	2,643	–	–	–	2,643
Lease liability long term	–	5,917	15,139	12,758	7,766	–	41,580
Other long-term liabilities	–	–	7,136	167	42,785	–	50,088
Total liabilities	33,513	468,570	193,525	40,344	107,806	–	843,758
Net assets:							
Without donor restrictions	577,394	512,503	40,663	95,423	64,412	(711,746)	578,649
With donor restrictions	22,709	21,871	1,283	–	–	(24,078)	21,785
Noncontrolling interest	–	–	–	–	3,846	–	3,846
Total net assets	600,104	534,374	41,946	95,423	68,258	(735,824)	604,280
Total liabilities and net assets	$ 633,617	$ 1,002,944	$ 235,471	$ 135,767	$ 176,064	$ (735,824)	$ 1,448,039

Luminis Health, Inc. and Subsidiaries

Supplementary Consolidating Statement of Operations
(Amounts Expressed in Thousands of U.S. Dollars)

Year Ended June 30, 2022

	Luminis Health, Inc.	Luminis Health Anne Arundel Medical Center, Inc. and Subsidiaries	Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries	Luminis Health Care Enterprises, Inc. and Subsidiaries	Luminis Health Ventures, LLC and Subsidiaries	Eliminations	Consolidated
Operating revenue:							
Net patient service revenue	$ –	$ 650,370	$ 221,233	$ 207,455	$ 7,264	$ –	$ 1,086,322
Other operating revenue	–	22,812	7,699	54,406	34,873	(72,386)	47,404
Total operating revenue	–	673,182	228,932	261,861	42,137	(72,386)	1,133,726
Operating expenses:							
Salaries and wages	57,045	219,671	84,668	184,934	1,407	–	547,725
Employee benefits	9,497	36,737	17,219	23,490	282	–	87,225
Supplies	732	132,167	37,610	25,214	246	(2)	195,967
Purchased services	59,939	167,855	62,240	57,228	26,948	(72,201)	302,009
Foundation transfer	–	165	–	–	–	(165)	(0)
Depreciation and amortization	–	26,954	11,594	2,775	3,841	–	45,164
Interest	53	7,931	4,381	–	805	(18)	13,152
Shared services	(127,266)	100,692	26,574	–	–	–	–
Total operating expenses	–	692,172	244,286	293,641	33,529	(72,386)	1,191,242
Operating income (loss)	–	(18,990)	(15,354)	(31,780)	8,608	–	(57,516)
Other income (loss):							
Investment income (loss), net	(115)	24,704	382	–	900	–	25,871
Gain (loss) from joint ventures and other, net	(76,800)	(543)	(1,247)	973	(357)	76,759	(1,215)
Pension expense	–	(1,911)	(151)	–	–	–	(2,062)
Loss on advance refunding of debt	–	(2,320)	–	–	–	–	(2,320)
Change in unrealized losses on trading securities, net	–	(61,907)	(551)	–	(4,886)	–	(67,344)
Realized and unrealized gains on trading securities, net	–	31,095	–	–	–	–	31,095
Total other income (loss), net	(76,915)	(10,882)	(1,567)	973	(4,343)	76,759	(15,975)
(Deficit) excess of revenues over expenses	$ (76,915)	$ (29,872)	$ (16,921)	$ (30,807)	$ 4,265	$ 76,759	$ (73,491)

Luminis Health Anne Arundel Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet
(Amounts Expressed in Thousands of U.S. Dollars)

June 30, 2022

	Luminis Health Anne Arundel Medical Center, Inc.	Luminis Health Pathways, Inc.	Luminis Health J Kent McNew Family Medical Center, Inc.	Luminis Health Anne Arundel Medical Center Foundation, Inc.	Eliminations	Luminis Health Anne Arundel Medical Center Inc. and Subsidiaries
Assets						
Current assets:						
Cash and cash equivalents	$ 59,130	$ 58	$ (65)	$ 5,955	$ –	$ 65,078
Short-term investments	5,223	–	–	439	–	5,662
Current portion of assets whose use is limited	10,808	–	–	–	–	10,808
Patient receivables, net	94,459	52	948	–	–	95,459
Inventories	7,014	–	–	–	–	7,014
Prepaid expenses and other current assets	8,143	–	11	2,271	–	10,425
Intercompany receivables/(payables)	59,982	140	(27,541)	(8,997)	–	23,584
Total current assets	244,759	250	(26,647)	(332)	–	218,030
Property and equipment	773,087	9,723	28,623	2,266	–	813,699
Less accumulated depreciation and amortization	(469,323)	(5,590)	(2,213)	(225)	–	(477,351)
Net property and equipment	303,764	4,133	26,410	2,041	–	336,348
Other assets:						
Investments	385,607	–	–	1,674	–	387,281
Assets whose use is limited	7	–	–	17,392	–	17,399
Beneficial interest in net assets of Anne Arundel Medical Center Foundation, Inc.	20,960	–	–	–	(20,960)	(0)
Restricted collateral for interest rate swap contract	10,193	–	–	–	–	10,193
Right of use asset long term	4,759	–	–	–	–	4,759
Investment in subsidiaries	3,569	–	–	–	(3,569)	(0)
Other assets	28,310	–	–	624	–	28,934
Total assets	$ 1,001,928	$ 4,383	$ (237)	$ 21,399	$ (24,529)	$ 1,002,944

Luminis Health Anne Arundel Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet (continued)
(Amounts Expressed in Thousands of U.S. Dollars)

June 30, 2022

	Luminis Health Anne Arundel Medical Center, Inc.	Luminis Health Pathways, Inc.	Luminis Health J Kent McNew Family Medical Center, Inc.	Luminis Health Anne Arundel Medical Center Foundation, Inc.	Eliminations	Luminis Health Anne Arundel Medical Center Inc. and Subsidiaries
Liabilities and net assets						
Current liabilities:						
Accounts payable	$ 38,926	$ 11	$ 218	$ 13	$ –	$ 39,168
Accrued salaries, wages, and benefits	23,347	205	141	109	–	23,802
Other accrued expenses	16,918	1	–	317	–	17,236
Current portion of long-term debt	8,025	–	–	–	–	8,025
Advances from third-party payors	43,592	–	–	–	–	43,592
Lease liability short term	2,437	–	–	–	–	2,437
Total current liabilities	133,245	217	359	439	–	134,260
Long-term liabilities:						
Long-term debt, less current portion	276,471	–	–	–	–	276,471
Interest rate swap contract	51,922	–	–	–	–	51,922
Lease liability long term	5,917	–	–	–	–	5,917
Total liabilities	467,555	217	359	439	–	468,570
Net assets:						
Without donor restrictions	514,126	4,166	(596)	(207)	(4,986)	512,503
With donor restrictions	20,247	–	–	21,167	(19,543)	21,871
Noncontrolling interest	–	–	–	–	–	–
Total net assets	534,373	4,166	(596)	20,960	(24,529)	534,374
Total liabilities and net assets	$ 1,001,928	$ 4,383	$ (237)	$ 21,399	$ (24,529)	$ 1,002,944

Luminis Health Anne Arundel Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Statement of Operations
(Amounts Expressed in Thousands of U.S. Dollars)

Year Ended June 30, 2022

	Luminis Health Anne Arundel Medical Center, Inc.	Luminis Health Pathways, Inc.	Luminis Health J Kent McNew Family Medical Center, Inc.	Luminis Health Anne Arundel Medical Center Foundation, Inc.	Eliminations	Luminis Health Anne Arundel Medical Center Inc. and Subsidiaries
Operating revenue:						
Net patient service revenue	$ 639,614	$ 4,150	$ 6,606	$ –	$ –	$ 650,370
Other operating revenue	19,865	647	672	4,767	(3,139)	22,812
Total operating revenue	659,479	4,797	7,278	4,767	(3,139)	673,182
Operating expenses:						
Salaries and wages	209,521	4,197	4,490	1,463	–	219,671
Employee benefits	34,901	785	776	275	–	36,737
Supplies	131,505	393	246	24	(1)	132,167
Purchased services	162,740	729	2,853	1,540	(7)	167,855
Foundation transfer	–	–	–	3,297	(3,132)	165
Depreciation and amortization	25,510	436	956	52	–	26,954
Interest	7,931	–	–	–	–	7,931
Shared services	100,692	–	–	–	–	100,692
Total operating expenses	672,800	6,540	9,321	6,652	(3,140)	692,172
Operating income (loss)	(13,321)	(1,743)	(2,043)	(1,884)	1	(18,990)
Other income (loss):						
Investment income (loss), net	24,867	–	–	(163)	–	24,704
Gain (loss) from joint ventures and other, net	(4,328)	–	–	–	3,785	(543)
Pension expense	(1,911)	–	–	–	–	(1,911)
Loss on advance refunding of debt	(2,320)	–	–	–	–	(2,320)
Change in unrealized losses on trading securities, net	(61,907)	–	–	–	–	(61,907)
Realized and unrealized gains on trading securities, net	31,095	–	–	–	–	31,095
Total other income (loss), net	(14,504)	–	–	(163)	3,785	(10,882)
(Deficit) excess of revenues over expenses	$ (27,825)	$ (1,743)	$ (2,043)	$ (2,047)	$ 3,786	$ (29,872)

Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet
(Amounts Expressed in Thousands of U.S. Dollars)

June 30, 2022

	Luminis Health Doctors Community Medical Center, Inc.	Doctors Community Health Ventures, Inc.	Luminis Health Doctors Community Medical Center Foundation, Inc.	Eliminations	Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries
Assets					
Current assets:					
Cash and cash equivalents	$ 24,933	$ –	$ 1,469	$ –	$ 26,402
Short-term investments	(383)	–	–	–	(383)
Patient receivables, net	44,709	–	(0)	–	44,709
Inventories	5,535	–	–	–	5,535
Prepaid expenses and other current assets	5,394	206	524	–	6,124
Intercompany receivables/(payables)	7,617	(33,490)	(1,511)	–	(27,384)
Total current assets	87,805	(33,284)	482	–	55,003
Property and equipment	147,734	–	–	–	147,734
Less accumulated depreciation and amortization	(26,871)	–	–	–	(26,871)
Net property and equipment	120,863	–	–	–	120,863
Other assets:					
Investments	19,062	–	–	–	19,062
Beneficial interest in net assets of Foundation	163	–	–	(163)	(0)
Right of use asset long term	15,611	–	–	–	15,611
Investment in subsidiaries	(34,056)	–	–	34,056	(0)
Other assets	24,932	–	–	–	24,932
Total assets	$ 234,380	$ (33,284)	$ 482	$ 33,893	$ 235,471

Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet
(Amounts Expressed in Thousands of U.S. Dollars)

June 30, 2022

	Luminis Health Doctors Community Medical Center, Inc.	Doctors Community Health Ventures, Inc.	Luminis Health Doctors Community Medical Center Foundation, Inc.	Eliminations	Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries
Liabilities and net assets					
Current liabilities:					
Accounts payable	$ 9,359	$ 201	$ (2)	$ –	$ 9,558
Accrued salaries, wages, and benefits	7,292	–	4	–	7,296
Other accrued expenses	5,190	–	–	–	5,190
Current portion of long-term debt	5,200	–	–	–	5,200
Advances from third-party payors	25,875	571	–	–	26,446
Lease liability short term	1,483	–	–	–	1,483
Total current liabilities	54,399	772	2	–	55,173
Long-term liabilities:					
Long-term debt, less current portion	113,434	–	–	–	113,434
Accrued pension liability	2,643	–	–	–	2,643
Lease liability long term	15,139	–	–	–	15,139
Other long-term liabilities	7,136	–	–	–	7,136
Total liabilities	192,751	772	2	–	193,525
Net assets:					
Without donor restrictions	41,477	(34,056)	(661)	33,903	40,663
With donor restrictions	152	–	1,141	(10)	1,283
Noncontrolling interest	–	–	–	–	–
Total net assets	41,629	(34,056)	480	33,893	41,945
Total liabilities and net assets	$ 234,380	$ (33,284)	$ 482	$ 33,893	$ 235,471

Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Statement of Operations

(Amounts Expressed in Thousands of U.S. Dollars)

Year Ended June 30, 2022

	Luminis Health Doctors Community Medical Center, Inc.	Doctors Community Health Ventures, Inc.	Luminis Health Doctors Community Medical Center Foundation, Inc.	Eliminations	Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries
Operating revenue:					
Net patient service revenue	$ 221,233	$ –	$ –	$ –	$ 221,233
Other operating revenue	7,699	–	94	(94)	7,699
Total operating revenue	228,932	–	94	(94)	228,932
Operating expenses:					
Salaries and wages	84,403	–	265	–	84,668
Employee benefits	17,182	–	37	–	17,219
Supplies	37,606	–	4	–	37,610
Purchased services	61,695	–	545	–	62,240
Foundation transfer	–	–	94	(94)	–
Depreciation and amortization	11,594	–	–	–	11,594
Interest	4,381	–	–	–	4,381
Shared services	26,574	–	–	–	26,574
Total operating expenses	243,435	–	945	(94)	244,286
Operating income (loss)	(14,503)	–	(851)	(0)	(15,354)
Other income (loss):					
Investment income, net	348	34	–	–	382
Gain (loss) from joint ventures and other, net	(1,212)	(120)	–	85	(1,247)
Pension expense	(151)	–	–	–	(151)
Change in unrealized losses on trading securities, net	(551)	–	–	–	(551)
Total other income (loss), net	(1,566)	(86)	–	85	(1,567)
(Deficit) excess of revenues over expenses	$ (16,069)	$ (86)	$ (851)	$ 85	$ (16,921)

Luminis Health Obligated Group

Supplementary Combining Balance Sheet

(Amounts Expressed in Thousands of U.S. Dollars)

June 30, 2022

	Luminis Health, Inc.	Luminis Health Anne Arundel Medical Center, Inc.	Luminis Health Imaging, Inc.	Luminis Health Doctors Community Medical Center, Inc.	Eliminations	Luminis Health Obligated Group
Assets						
Current assets:						
Cash and cash equivalents	$ (5,744)	$ 59,130	$ 472	$ 24,933	$ –	$ 78,791
Short-term investments	–	5,223	–	(383)	–	4,840
Current portion of assets whose use is limited	–	10,808	–	–	–	10,808
Patient receivables, net	(616)	94,459	3,147	44,709	–	141,699
Inventories	584	7,014	–	5,535	–	13,133
Prepaid expenses and other current assets	6,169	8,143	254	5,394	–	19,960
Intercompany receivables/(payables)	(102,658)	59,982	103,458	7,617	–	68,399
Total current assets	(102,265)	244,759	107,331	87,805	–	337,630
Property and equipment	58	773,087	33,378	147,734	–	954,257
Less accumulated depreciation and amortization	–	(469,323)	(27,985)	(26,871)	–	(524,179)
Net property and equipment	58	303,764	5,393	120,863	–	430,078
Other assets:						
Investments	–	385,607	–	19,062	–	404,669
Assets whose use is limited	–	7	–	–	–	7
Beneficial interest in net assets of the Foundation	–	20,960	–	163	–	21,123
Restricted collateral for interest rate swap contract	–	10,193	–	–	–	10,193
Right of use asset long term	–	4,759	694	15,611	–	21,064
Investment in subsidiaries	735,824	3,569	–	(34,056)	(686,537)	18,800
Other assets	–	28,310	–	24,932	–	53,242
Total assets	$ 633,617	$ 1,001,928	$ 113,418	$ 234,380	$ (686,537)	$ 1,296,806

Luminis Health Obligated Group

Supplementary Combining Balance Sheet (continued)

(Amounts Expressed in Thousands of U.S. Dollars)

June 30, 2022

	Luminis Health, Inc.	Luminis Health Anne Arundel Medical Center, Inc.	Luminis Health Imaging, Inc.	Luminis Health Doctors Community Medical Center, Inc.	Eliminations	Luminis Health Obligated Group
Liabilities and net assets						
Current liabilities:						
Accounts payable	$ 2,152	$ 38,926	$ 1,653	$ 9,359	$ –	$ 52,090
Accrued salaries, wages, and benefits	32,181	23,347	535	7,292	–	63,355
Other accrued expenses	(14)	16,918	–	5,190	–	22,094
Current portion of long-term debt	–	8,025	–	5,200	–	13,225
Advances from third-party payors	(806)	43,592	–	25,875	–	68,661
Lease liability short term	–	2,437	33	1,483	–	3,953
Total current liabilities	33,513	133,245	2,221	54,399	–	223,378
Long-term liabilities:						
Long-term debt, less current portion	–	276,471	–	113,434	–	389,905
Interest rate swap contract	–	51,922	–	–	–	51,922
Accrued pension liability	–	–	–	2,643	–	2,643
Lease liability long term	–	5,918	649	15,139	–	21,706
Other long-term liabilities	–	–	–	7,136	–	7,136
Total liabilities	33,513	467,555	2,870	192,751	–	696,689
Net assets:						
Without donor restrictions	577,394	514,126	110,548	41,477	(662,459)	581,086
With donor restrictions	22,710	20,247	–	152	(24,078)	19,031
Noncontrolling interest	–	–	–	–	–	–
Total net assets	600,104	534,373	110,548	41,629	(686,537)	600,117
Total liabilities and net assets	$ 633,617	$ 1,001,928	$ 113,418	$ 234,380	$ (686,537)	$ 1,296,806

Luminis Health Obligated Group

Supplementary Combining Statement of Operations

(Amounts Expressed in Thousands of U.S. Dollars)

Year Ended June 30, 2022

	Luminis Health, Inc.	Luminis Health Anne Arundel Medical Center, Inc.	Luminis Health Imaging, Inc.	Luminis Health Doctors Community Medical Center, Inc.	Eliminations	Luminis Health Obligated Group
Operating revenue:						
Net patient service revenue	$ –	$ 639,614	$ 30,800	$ 221,233	$ –	$ 891,647
Other operating revenue	–	19,865	70	7,699	–	27,634
Total operating revenue	–	659,479	30,870	228,932	–	919,281
Operating expenses:						
Salaries and wages	57,045	209,521	6,553	84,403	–	357,522
Employee benefits	9,497	34,901	1,304	17,182	–	62,884
Supplies	732	131,505	1,438	37,606	–	171,281
Purchased services	59,939	162,740	14,485	61,695	–	298,859
Depreciation and amortization	–	25,510	650	11,594	–	37,754
Interest	53	7,931	–	4,381	–	12,365
Shared services	(127,266)	100,692	–	26,574	–	–
Total operating expenses	–	672,800	24,430	243,435	–	940,665
Operating income (loss)	–	(13,321)	6,440	(14,503)	–	(21,384)
Other income (loss):						
Investment income (loss), net	(115)	24,867	–	348	–	25,100
Gain (loss) from joint ventures and other, net	(76,800)	(4,328)	–	(1,212)	43,555	(38,785)
Pension expense	–	(1,911)	–	(151)	–	(2,062)
Loss on advance refunding of debt	–	(2,320)	–	–	–	(2,320)
Change in unrealized gains on trading securities, net	–	(61,907)	–	(551)	–	(62,458)
Realized and unrealized gains on swap, net	–	31,095	–	–	–	31,095
Total other income (loss), net	(76,915)	(14,504)	–	(1,566)	43,555	(49,430)
(Deficit) excess of revenues over expenses	$ (76,915)	$ (27,825)	$ 6,440	$ (16,069)	$ 43,555	$ (70,814)

Luminis Health, Inc. and Subsidiaries

Supplementary Description of Consolidating and Eliminating Entries

June 30, 2022

1. To eliminate intercompany payables and receivables

2. To eliminate investments in subsidiaries and related net asset accounts

3. To eliminate intercompany income and expense generated from management fees, staffing contracts, captive insurance premiums, and operating leases

4. To eliminate intercompany notes

5. To eliminate income of wholly owned subsidiaries

6. To eliminate intercompany revenue and expense for interest and other miscellaneous transactions

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Consolidated Financial Statements and Supplementary Information

Luminis Health, Inc. and Subsidiaries
Years Ended June 30, 2021 and 2020
With Report of Independent Auditors

Ernst & Young LLP

Luminis Health, Inc. and Subsidiaries

Consolidated Financial Statements
and Supplementary Information

Years Ended June 30, 2021 and 2020

Contents

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Report of Independent Auditors

The Board of Trustees
Luminis Health, Inc.

We have audited the accompanying consolidated financial statements of Luminis Health, Inc. (a Maryland not-for-profit corporation) and subsidiaries, which comprise the consolidated balance sheets as of June 30, 2021 and 2020, and the related consolidated statements of operations, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We did not audit the financial statements of Cottage Insurance Company, Ltd., a wholly owned subsidiary, which statements reflect total assets constituting 3% in 2021 and 2020 and total revenues constituting 1% in 2021 and 2020 of the related consolidated totals. We did not audit the financial statements of Doctors Community Medical Center and subsidiaries in 2020, a wholly owned subsidiary, which statements reflect total assets constituting 21% in 2020 and total revenues constituting 25% in 2020 of the related consolidated totals. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Cottage Insurance Company, Ltd., and for Doctors Community Medical Center and subsidiaries in 2020, is based solely on the reports of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express

no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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

Opinion

In our opinion, based on our audits and the reports of other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Luminis Health, Inc. and subsidiaries at June 30, 2021 and 2020, and the consolidated results of their operations, changes in their net assets, and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Supplementary Information

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

Ernst + Young LLP

October 28, 2021

Luminis Health, Inc. and Subsidiaries

Consolidated Balance Sheets

	June 30	
	2021	**2020**
Assets		
Current assets:		
Cash and cash equivalents	**$ 276,817,000**	$ 178,795,000
Short-term investments	**3,447,000**	1,365,000
Current portion of assets whose use is limited	**16,241,000**	15,912,000
Patient receivables, net	**144,555,000**	118,882,000
Current portion of pledges receivable, net	**1,312,000**	945,000
Inventories	**23,642,000**	21,789,000
Prepaid expenses and other current assets	**18,998,000**	19,857,000
Total current assets	**485,012,000**	357,545,000
Property and equipment	**1,129,871,000**	1,096,845,000
Less accumulated depreciation and amortization	**(583,269,000)**	(538,353,000)
Net property and equipment	**546,602,000**	558,492,000
Other assets:		
Investments	**448,850,000**	338,985,000
Investments in joint ventures	**13,459,000**	14,024,000
Pledges receivable, net	**1,662,000**	3,192,000
Assets whose use is limited	**53,033,000**	41,020,000
Restricted collateral for interest rate swap contract	**25,699,000**	110,002,000
Right-of-use asset	**37,528,000**	44,995,000
Other assets	**68,561,000**	53,613,000
Total assets	**$ 1,680,406,000**	$ 1,521,868,000

Luminis Health, Inc. and Subsidiaries

Consolidated Balance Sheets (continued)

	June 30	
	2021	**2020**
Liabilities and net assets		
Current liabilities:		
Accounts payable	**$ 55,696,000**	$ 40,441,000
Accrued salaries, wages, and benefits	**76,693,000**	53,438,000
Other accrued expenses	**29,407,000**	32,413,000
Current portion of long-term debt	**21,638,000**	16,440,000
Advances from third-party payors	**178,155,000**	182,697,000
Current portion of lease liability	**8,187,000**	8,753,000
Total current liabilities	**369,776,000**	334,182,000
Long-term debt, less current portion and unamortized original issue premium	**449,175,000**	470,308,000
Interest rate swap contracts	**90,010,000**	117,037,000
Accrued pension liability	**2,291,000**	29,276,000
Lease liability, less current portion	**30,979,000**	37,429,000
Other long-term liabilities	**54,044,000**	47,032,000
Total liabilities	**996,275,000**	1,035,264,000
Net assets:		
Without donor restrictions	**654,877,000**	460,552,000
With donor restrictions	**26,412,000**	23,861,000
Non-controlling interest	**2,842,000**	2,191,000
Total net assets	**684,131,000**	486,604,000
Total liabilities and net assets	**$ 1,680,406,000**	$ 1,521,868,000

See accompanying notes.

Luminis Health, Inc. and Subsidiaries

Consolidated Statements of Operations

	Year Ended June 30	
	2021	**2020**
Operating revenue:		
Net patient service revenue	**$ 1,036,435,000**	$ 969,105,000
Other operating revenue	**69,455,000**	78,393,000
Total operating revenue	**1,105,890,000**	1,047,498,000
Operating expenses:		
Salaries and wages	**508,722,000**	479,880,000
Employee benefits	**76,396,000**	75,930,000
Supplies	**189,217,000**	197,487,000
Purchased services	**247,676,000**	226,375,000
Depreciation and amortization	**46,884,000**	45,994,000
Interest	**14,404,000**	16,151,000
Total operating expenses	**1,083,299,000**	1,041,817,000
Operating income	**22,591,000**	5,681,000
Other income (loss):		
Investment income (loss), net	**13,467,000**	(9,700,000)
Loss from joint ventures and other, net	**(93,000)**	(673,000)
Inherent contribution	**–**	61,715,000
Pension (expense) credit, net	**(3,446,000)**	1,116,000
Unrealized gains (losses) on trading securities, net	**104,506,000**	(15,151,000)
Realized and unrealized gains (losses) on interest rate swap contracts, net	**20,165,000**	(43,149,000)
Total other gain (loss), net	**134,599,000**	(5,842,000)
Excess (deficit) of revenue over expenses	**$ 157,190,000**	$ (161,000)

Luminis Health, Inc. and Subsidiaries

Consolidated Statements of Changes in Net Assets

	Without Donor Restrictions	With Donor Restrictions	Total
Net assets, June 30, 2019	$ 482,661,000	$ 24,730,000	$ 507,391,000
Net assets acquired	2,265,000	487,000	2,752,000
Deficit of revenues over expenses	(161,000)	–	(161,000)
Pension liability adjustment	(24,810,000)	–	(24,810,000)
Released from restrictions used for purchase of property and equipment	1,837,000	–	1,837,000
Transfers and other, net	951,000	(598,000)	353,000
Restricted gifts, bequests, and contributions	–	9,518,000	9,518,000
Unrealized losses on investments	–	(3,394,000)	(3,394,000)
Restricted investment income	–	693,000	693,000
Net assets released from restrictions	–	(7,575,000)	(7,575,000)
Changes in net assets	(19,918,000)	(869,000)	(20,787,000)
Net assets, June 30, 2020	462,743,000	23,861,000	486,604,000
Excess of revenues over expenses	**157,190,000**	–	**157,190,000**
Pension liability adjustment	**35,092,000**	–	**35,092,000**
Transfers and other, net	**2,694,000**	**(1,239,000)**	**1,455,000**
Restricted gifts, bequests, and contributions	–	**5,583,000**	**5,583,000**
Restricted investment income	–	**1,071,000**	**1,071,000**
Net assets released from restrictions	–	**(2,864,000)**	**(2,864,000)**
Changes in net assets	**194,976,000**	**2,551,000**	**197,527,000**
Net assets, June 30, 2021	**$ 657,719,000**	**$ 26,412,000**	**$ 684,131,000**

See accompanying notes.

Luminis Health, Inc. and Subsidiaries

Consolidated Statements of Cash Flows

	Year Ended June 30	
	2021	**2020**
Operating activities		
Increase (decrease) in net assets	**$ 197,527,000**	$ (20,787,000)
Adjustments to reconcile changes in net assets to net cash provided by operating activities:		
Change in net unrealized (gains) losses on investments	**(104,506,000)**	18,545,000
Realized and unrealized losses on interest rate swap contracts, net	**(20,165,000)**	43,149,000
Pension liability adjustment	**(35,092,000)**	24,810,000
Equity in earnings of joint ventures and other	**(578,000)**	804,000
Restricted contributions and pledges, net	**(5,583,000)**	(9,518,000)
Depreciation and amortization	**46,884,000**	45,994,000
Restricted investment income	**(1,071,000)**	(693,000)
(Increase) decrease in investments – trading	**(7,440,000)**	60,680,000
Increase in assets whose use is limited, net – trading	**(10,926,000)**	(5,164,000)
Inherent contribution and net assets acquired	**–**	(64,467,000)
Net change in operating assets and liabilities	**5,858,000**	154,413,000
Net cash provided by operating activities	**64,908,000**	247,766,000
Investing activities		
Purchases of property and equipment	**(33,813,000)**	(62,284,000)
Payments on interest rate swaps	**(6,861,000)**	(4,591,000)
Distributions from joint ventures	**1,143,000**	–
Cash acquired	**–**	34,168,000
Net cash used in investing activities	**(39,531,000)**	(32,707,000)
Financing and fundraising activities		
Repayments of long-term debt	**(18,059,000)**	(17,530,000)
Restricted contributions received and other	**6,746,000**	8,676,000
Restricted income received	**1,071,000**	693,000
Net cash used in financing and fundraising activities	**(10,242,000)**	(8,161,000)
Net increase in cash, cash equivalents, and restricted cash	**15,135,000**	206,898,000
Cash, cash equivalents, and restricted cash at beginning of year	**305,828,000**	98,930,000
Cash, cash equivalents, and restricted cash at end of year	**$ 320,963,000**	$ 305,828,000
Cash and cash equivalents	**$ 276,817,000**	$ 178,795,000
Restricted cash, included in restricted collateral and assets whose use is limited	**44,146,000**	127,033,000
Cash, cash equivalents, and restricted cash at end of year	**$ 320,963,000**	$ 305,828,000

Luminis Health, Inc. and Subsidiaries

Consolidated Statements of Cash Flows (continued)

	Year Ended June 30	
	2021	**2020**
Changes in operating assets and liabilities		
(Decrease) increase in operating assets:		
Patient receivables, net	**$ (25,674,000)**	$ 265,000
Inventories	**(1,853,000)**	(8,896,000)
Prepaid expenses and other	**859,000**	3,869,000
Other assets	**(6,539,000)**	11,797,000
	(33,207,000)	7,035,000
Increase (decrease) in operating liabilities:		
Accounts payable	**15,255,000**	(5,845,000)
Accrued salaries, wages, and benefits	**23,255,000**	(422,000)
Other accrued expenses	**(3,572,000)**	14,024,000
Advances from third-party payors	**(4,542,000)**	151,029,000
Other long-term liabilities	**8,669,000**	(11,408,000)
	39,065,000	147,378,000
Net change in operating assets and liabilities	**$ 5,858,000**	$ 154,413,000
Supplemental disclosures of cash flow information		
Cash paid for interest	**$ 13,591,000**	$ 15,541,000

See accompanying notes.

1. Organization and Basis of Presentation

Luminis Health, Inc. (Luminis or the System), formerly known as Anne Arundel Health System, Inc. (AAHS), is a Maryland not-for-profit corporation. Luminis has the following wholly owned subsidiaries: Luminis Health Anne Arundel Medical Center, Inc. (the Hospital or LHAAMC), formerly Anne Arundel Medical Center, Inc. and its subsidiaries; Luminis Health Pathways, Inc. (Pathways), formerly Anne Arundel General Treatment Services, Inc. (GTS); J. Kent Mc New Family Medical Center, Inc. (Mc New), formerly Anne Arundel Mental Health Hospital, Inc.; Cottage Insurance Company, Ltd. (Cottage); Luminis Health Anne Arundel Medical Center Foundation, Inc., (the Foundation), formerly Anne Arundel Medical Center Foundation, Inc.; Luminis Health Imaging, Inc. (LHI), formerly Anne Arundel Health Care Services, Inc.; Luminis Health Care Services, Inc. formerly Anne Arundel Health Care Enterprises, Inc. (HCE); Physician Enterprise, LLC (PE) and its subsidiaries; Luminis Health Medical Group, LLC, formerly Anne Arundel Physician Group, LLC; Orthopedic Physicians of Annapolis; LHMG Physical Therapy, LLC, formerly Anne Arundel Medical Group Physical Therapy, LLC; Luminis Health Community Clinics, LLC, formerly Community Clinics, LLC; Luminis Heath Real Estate Holding Company, Inc. (the Real Estate Company), formerly Anne Arundel Real Estate Holding Company, Inc. and its subsidiaries; Pavilion Park, Inc. (PPI); Annapolis Exchange, LLC; Blue Building, LLC; Luminis Health Research Institute, Inc. (RI), formerly, Anne Arundel Health System Research Institute, Inc.; and Anne Arundel Medical Center Collaborative Care Network, LLC.

LHAAMC is a private, not-for-profit corporation that operates a 349-licensed bed acute care hospital. LHAAMC, the Real Estate Company, and PPI own an interest in Kent Island Medical Arts, LLC (KIMA), a limited liability company that owns and operates a medical office building. PPI is the managing member of KIMA and has substantive participation rights in KIMA. The financial statements of KIMA are consolidated in the accompanying consolidated financial statements. The non-controlling interest in KIMA was 50% as of June 30, 2021 and 2020. This interest was $974,000 and $929,000 at June 30, 2021 and 2020, respectively, and is included within net assets without donor restriction on the accompanying consolidated balance sheets.

On July 1, 2019, Anne Arundel Health System, Inc. and Doctors Community Hospital and subsidiaries executed an affiliation agreement (the Agreement) providing for an affiliation between AAHS and Doctors Community Hospital and subsidiaries. In September 2019, Doctors Community Hospital and subsidiaries changed its name to Doctors Community Medical Center and subsidiaries (DCMC). This affiliation agreement resulted in DCMC becoming a wholly owned subsidiary of AAHS. DCMC is a Maryland health system that includes an acute care hospital and a network of other health care providers serving residents of Prince George's County region near Lanham, Maryland, east of Washington, DC. On the date of the affiliation, the articles of incorporation and bylaws of DCMC were amended such that AAHS became the sole corporate

1. Organization and Basis of Presentation (continued)

member of the Doctors Community Medical Center and its subsidiaries. As part of the Agreement, AAHS committed approximately $138,000,000 over a five-year period in strategic investments to DCMC to expand health care services. As of June 30, 2021, Luminis has contributed approximately $31,000,000 to DCMC to meet the capital commitment.

During the year ended June 30, 2021, DCMC changed its name to Luminis Health Doctors Community Medical Center, Inc. (LHDCMC). LHDCMC includes the following: LHDCMC and its subsidiaries; Doctors Community Medical Group, LLC; Doctors Community Healthcare Programs, LLC; Doctors Community Hospital Clinic, LLC; Doctors Community Health Ventures, Inc.; Doctors Regional Cancer Center LLC (DRCC); and Luminis Health Doctors Community Hospital Foundation, Inc., formerly Doctor's Community Hospital Foundation, Inc. LHDCMC is a nonprofit corporation that operates an acute care general hospital facility licensed for 190 beds. The accompanying consolidated financial statements include non-controlling interest held by third parties in less than wholly owned subsidiaries. This interest at LHDCMC was $2,842,000 and $2,191,000 at June 30, 2021 and 2020, respectively, and relates to DRCC, which is 60% owned by LHDCMC and consolidated in the accompanying financial statements.

Global Pandemic

In response to the ongoing COVID-19 pandemic, the Governor of the state of Maryland proclaimed a state of emergency and catastrophic health emergency on March 5, 2020, and renewed on March 17, 2020, April 10, 2020, and May 6, 2020. Effective March 16, 2020, all Maryland hospitals were ordered by the Maryland Department of Health to cease all elective and non-urgent medical procedures for the duration of the catastrophic health emergency. The Governor issued a statewide stay-at-home order effective March 30, 2020.

Effective May 7, 2020, the Maryland Department of Health allowed resumption of elective and non-urgent medical procedures, and effective May 15, 2020, major provisions of the Governor's stay-at-home order were rescinded.

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

1. Organization and Basis of Presentation (continued)

The Health Services Cost Review Commission (HSCRC or Commission) publicly announced its intention to support Maryland hospitals during the state of emergency and catastrophic health emergency. The HSCRC's collaboration with other Maryland regulatory agencies to remove licensure, regulatory, and other barriers to hospitals in the provision of emergency health care services. Recognizing that LHAAMC and LHDCMC have experienced lower than historical volumes in fiscal year 2021 due to the pandemic, the HSCRC permitted both hospitals to increase rate corridors to a fiscal year average threshold of 10% for inpatient rate centers and 9.17% for all other rate centers. This action is intended to allow hospitals that are undercharged under their Global Budget Revenue due to volume losses to increase their charges in order to make up for lost revenue. The HSCRC has stated that this rate corridor increase is a temporary adjustment to ensure financial viability of Maryland hospitals.

To further accommodate any Global Budget Revenue that Maryland hospitals were unable to bill in fiscal year 2021 due to fluctuating volumes resulting from the COVID-19 pandemic, the HSCRC has stated that it will suspend undercharge penalties. The HSCRC will allow Maryland hospitals to recoup undercharges from 2020 and 2021 within the next two fiscal years by applying a onetime adjustment net of the application of CARES Act relief funding. The HSCRC is proposing to reduce the System's undercharge by an amount derived from the CARES Act funding. Maryland hospitals will be allowed to bill any net undercharge in the next two fiscal years, thus allowing them to recoup a portion of lost revenue associated with the catastrophic health emergency period. The HSCRC provided additional Global Budget Revenue for fiscal year 2022 via the update factor to aid Maryland hospitals with increasing labor cost due to the COVID-19 pandemic. It is unknown if the HSCRC will provide any further assistance.

The outbreak of COVID-19, a respiratory disease caused by a novel strain coronavirus, has and will continue to have significant adverse impacts on the operations and financial condition of health care providers generally. The treatment of this contagious disease at health care facilities has resulted in a temporary shutdown or diversion of patients from those facilities and in staffing and supply shortages. Elective procedures and other patient care appointments are being deferred, and individuals may otherwise avoid medical treatment unrelated to COVID-19, resulting in reduced patient volumes and operating revenues at outpatient facilities.

2. Summary of Significant Accounting Policies

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of Luminis and its wholly owned subsidiaries. The financial results of LHDCMC and subsidiaries are included from the date of acquisition, which was July 1, 2019. All significant intercompany accounts and transactions have been eliminated in consolidation.

The accompanying consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States (U.S. GAAP).

Acquisition of Doctors' Hospital, Inc.

On July 1, 2019, Luminis completed a transaction that resulted in LHDCMC and subsidiaries becoming a wholly owned subsidiary of Luminis. This transaction was accounted for as an acquisition under Accounting Standards Codification (ASC) 958-805, *Not-for-Profit Mergers and Acquisitions*, during the year ended June 30, 2020.

The System elected to apply pushdown accounting whereby individual assets and liabilities were adjusted to the new basis of accounting as of the acquisition date.

2. Summary of Significant Accounting Policies (continued)

The following information summarizes the recorded fair values of the assets acquired and liabilities assumed as of the date of the acquisition:

Cash and cash equivalents	$ 34,168,000
Patient accounts receivable, net	38,840,000
Other receivables	5,620,000
Inventories	4,243,000
Prepaid expenses	3,981,000
Marketable securities	18,258,000
Joint ventures and equity investments	5,942,000
Property and equipment	116,540,000
Other noncurrent assets	30,093,000
Total assets acquired	257,685,000
Accounts payable and accrued expenses	31,875,000
Advances from third-party payors	7,765,000
Current portion of long-term debt	4,448,000
Long-term debt	128,123,000
Net pension liability	5,001,000
Deferred compensation and claims incurred but not reported	16,006,000
Total liabilities assumed	193,218,000
Non-controlling interest	2,265,000
Net assets acquired, net of non-controlling interest	$ 62,202,000

An inherent contribution of $61,715,000 was resulting from the difference between the net assets acquired, net of non-controlling interest and net assets with donor restrictions at LHDCMC and subsidiaries as of the acquisition date. Net assets with donor restrictions of $487,000 was recorded within changes in net assets with donor restrictions.

Cash and Cash Equivalents

Cash and cash equivalents include cash held in checking and savings accounts, money market accounts, and short-term certificates of deposit with original maturities of 90 days or less, excluding those held in short-term investments and those classified as long-term investments. Cash balances and collateral held by a counterparty are principally uninsured and are subject to normal credit risks. At June 30, 2021 and 2020, and at various times during the year, the System maintained cash-in-bank balances in excess of the $250,000 federally insured limits.

2. Summary of Significant Accounting Policies (continued)

Derivative Instruments

On May 10, 2006, LHAAMC entered into a forward variable-to-fixed interest rate swap agreement with an effective date of November 1, 2008. This contract was entered into in an effort to reduce the risk of variable interest rate debt and has a term through July 1, 2048. Under ASC 815, *Derivatives and Hedging*, LHAAMC has recognized its derivative instruments as either assets or liabilities on the accompanying consolidated balance sheets at fair value. As these derivative instruments are not designated as hedges, the unrealized gain or loss on these contracts has been recognized on the accompanying consolidated statements of operations as realized and unrealized gains (losses) on interest rate swap contracts, net. The fair market values of the derivative instruments include a credit valuation adjustment (CVA) as required by ASC 820, *Fair Value Measurement*. When applying the CVA, the valuation of the variable-to-fixed interest rate swap contract was decreased by $4,145,000 and $375,000 as of June 30, 2021 and 2020, respectively.

On March 23, 2016, in an effort to reduce the amount of restricted cash pledged as collateral with the original counterparty, the Hospital entered into a novation agreement with a second counterparty. Immediately prior to the novation agreement, the System modified the existing swap to bifurcate the existing swap into a five-year swap with the remainder into a 2021 through 2048 swap. The terms of the bifurcated swap remain identical to the original swap. The novation agreement resulted in the return of $29,164,000 as of June 30, 2016. This agreement expired in February 2021.

In unison with the pending expiration of the previous swap bifurcation agreement and in an effort to reduce the amount of restricted cash pledged as collateral with the original counterparty, LHAAMC entered into a new novation agreement with another counterparty on February 10, 2021. Immediately prior to the novation agreement, the System modified the existing swap to bifurcate the remaining swap into a ten-year swap with the remainder into a 2031 through 2048 swap. The terms of the bifurcated swap remain identical to the original swap other than a modification of the London Interbank Offered Rate (LIBOR) rate. The novation agreement resulted in the return of $64,000,000 of collateral.

2. Summary of Significant Accounting Policies (continued)

A summary of LHAAMC's derivative instruments and related activity at June 30 and for the years then ended, is as follows:

	Fair Value Liability	
Description of Derivative Instrument	**2021**	**2020**
Variable-to-fixed interest rate swap contract (maturity date March 2021)	**$** –	$ (4,442,000)
Variable-to-fixed interest rate swap contract (maturity date March 2031)	**(36,790,000)**	–
Variable-to-fixed interest rate swap contract (maturity date July 2048)	**(53,220,000)**	(112,595,000)
	$ (90,010,000)	$(117,037,000)

The change in unrealized gains (losses) recognized in excess (deficit) of revenues over expenses for the years ended June 30, 2021 and 2020, were $27,026,000 and $(38,558,000), respectively.

At June 30, 2021 and 2020, the net termination value (i.e., mark-to-market value) of the derivative instruments totaled $97,003,000 and $119,671,000, respectively. LHAAMC may be exposed to credit loss in the event of nonperformance by the other party to the interest rate swap agreements, the risk of which is reflected in the fair value of the instruments under ASC 820. However, LHAAMC does not anticipate nonperformance by the counterparty.

During fiscal year 2021 and 2020, LHAAMC paid net payments under its interest rate swap program of $6,861,000 and $4,591,000, respectively. These amounts are included within realized and unrealized gains (losses) on interest rate swap contracts, net on the accompanying consolidated statements of operations and within investing activities on the accompanying consolidated statements of cash flows.

Under the derivative contracts for the 2021 through 2048 swap, LHAAMC must transfer collateral for the benefit of the counterparty, to the extent that the termination values exceed certain limits. LHAAMC's collateral requirement for the benefit of the counterparty was approximately $25,699,000 (which includes $7,045,000 due to the counterparty at June 30, 2021) and $110,002,000 at June 30, 2021 and 2020, respectively. The ongoing mark-to-market values and resulting collateral requirements of LHAAMC's interest rate swap contract are subject to variability based on market factors (primarily changes in interest rates). Collateral requirements

2. Summary of Significant Accounting Policies (continued)

under this interest rate swap contract are excluded from unrestricted cash and investments for purposes of determining the System's compliance with its liquidity covenants under its Maryland Health and Higher Educational Facilities Authority (MHHEFA or the Authority) revenue bond agreements and its derivative agreements. Collateral amounts are included in noncurrent assets on the accompanying consolidated balance sheets.

Assets Whose Use is Limited and Investments

Assets whose use is limited are principally composed of certain funds established to be held and invested by a trustee. These funds are related to the issuance of the LHAAMC's revenue bonds, investments held at Cottage, and certain permanently restricted endowment assets.

	June 30	
	2021	**2020**
Current:		
Principal, interest and other – bonds	**$ 12,538,000**	$ 12,382,000
Investments held at trustee	**3,703,000**	3,530,000
	$ 16,241,000	$ 15,912,000
Noncurrent:		
Endowment assets	**$ 20,424,000**	$ 15,482,000
Investments held at trustee	**32,609,000**	25,538,000
	$ 53,033,000	$ 41,020,000

The fair values of publicly traded securities and mutual funds are based on quoted market prices of individual securities or investments or estimated amounts using quoted market prices of similar investments. Alternative investments, some of which are structured so that the System holds limited partnership interests, are valued using net asset value (NAV) as the practical expedient. Valuations of these investments, and therefore the System's holdings, may be determined by the investment manager or general partner and for fund-of-funds investments are primarily based on financial data supplied by the underlying investee funds. Values may be based on historical cost, appraisals, or other estimates that require varying degrees of judgment. Investment income or loss from all unrestricted investments is included on the accompanying consolidated statements of operations as part of other income (loss).

2. Summary of Significant Accounting Policies (continued)

Investment income or loss on investments of assets with donor restrictions is added to or deducted from the restricted fund balance if the income is restricted. The cost of securities sold is based on the specific-identification method.

All investment balances are principally uninsured and subject to normal credit risk. Investments are classified as either current or noncurrent based on the maturity dates and the availability for current operations. Investments included in noncurrent assets consist of board-designated investment funds of $448,850,000 and $338,985,000 as of June 30, 2021 and 2020, respectively. Based on the System's investment policy, such amounts could be liquidated, at the discretion of the board, to satisfy short-term requirements.

Substantially all investments, other than borrowed funds required to be expended for capital projects, are classified as trading securities, with unrealized gains and losses included in excess (deficit) of revenues over expenses.

Borrowed funds required to be expended for capital projects are classified as other-than-trading and are included in assets whose use is limited.

Patient Receivables

Patient receivables include charges for amounts due from all patients less price concessions relating to allowances for the excess of established charges over the payments to be received on behalf of patients covered by Medicare, Medicaid, and other insurers. The provision for price concessions is based upon management's assessment of historical and expected net collections considering historical business and economic conditions, trends in health care coverage, and other collection indicators. Periodically throughout the year, management assesses the adequacy of the price concessions based upon historical experience of self-pay accounts receivable, including those balances after insurance payments and not covered by insurance.

Insurance coverage and credit information are obtained from patients, when available. No collateral is obtained for accounts receivable.

Inventories

Inventories, which primarily consist of medical supplies and drugs, are carried at the lower of cost or market. Cost is determined using the first-in, first-out (FIFO) method or a similar method that approximates FIFO.

2. Summary of Significant Accounting Policies (continued)

Property and Equipment

Property and equipment are stated at cost; or fair value as of the acquisition date for LHDCMC property and equipment. Included in computers and software are capitalized labor costs of $16,340,000 and $14,344,000 as of June 30, 2021 and 2020, respectively. Depreciation and amortization, including amortization of assets recorded under capital leases, are recorded on the straight-line method over the estimated useful lives of the assets.

The following is a summary of property and equipment:

	Estimated Useful Lives	June 30 2021	2020
Land		$ **22,823,000**	$ 22,823,000
Land improvements	20 years	**23,854,000**	23,480,000
Buildings and improvements	20–40 years	**614,286,000**	592,593,000
Fixed equipment	5–20 years	**30,833,000**	55,510,000
Leasehold improvements	5–10 years	**62,591,000**	62,389,000
Movable equipment	7–10 years	**237,988,000**	221,851,000
Computers and software	3–5 years	**128,752,000**	96,079,000
Construction-in-progress	–	**8,744,000**	22,120,000
		$ 1,129,871,000	$ 1,096,845,000

Construction-in-progress consists of direct costs associated with hospital department renovations, certain leasehold improvements, and smaller capital projects. As these projects are completed, the related assets are transferred out of construction-in-progress and into the appropriate asset category and are depreciated over the applicable useful lives.

Investments in Joint Ventures

Luminis accounts for its investments in joint ventures using the equity method of accounting. During 2011, the Real Estate Company and another party formed West County, LLC, a joint venture that owns and operates a medical office building that opened in December 2012. The Real Estate Company has a 50% interest in this joint venture, with each owner's investment being $6,789,000 and $7,575,000 as of June 30, 2021 and 2020, respectively.

2. Summary of Significant Accounting Policies (continued)

Doctors Community Health Ventures, Inc. (Health Ventures) has an equity method joint venture investment in Magnolia Gardens LLC of $5,550,000 and $5,388,000 as of June 30, 2021 and 2020, respectively. This investment is consistent with the mission and strategic plan of Doctors Community Medical Center. The investment in Magnolia Gardens LLC represents a 51% interest and is not consolidated with the financial statements of Luminis because Health Ventures does not control the investee.

Luminis has several other unconsolidated joint ventures for imaging, dialysis services, and ambulatory surgery centers, totaling approximately $1,120,000 and $1,061,000 as of June 30, 2021 and 2020, respectively.

Net Assets

Net resources that are not restricted by donors are included in net assets without donor restrictions. Gifts of long-lived operating assets, such as property, plant, or equipment, are reported as net assets without donor restrictions and excluded from income. Resources restricted by donors for a specified time or purpose are reported as net assets with donor restrictions.

When the specific purposes are met, either through passage of a stipulated time period or when the purpose for restriction is accomplished, they are released to other operating revenues on the consolidated statement of changes in net assets. Resources restricted by donors for additions to property, plant, and equipment are initially reported as net assets with donor restrictions and are transferred to net assets without donor restrictions when expended. Donor-imposed restrictions, which stipulate that the resources be maintained permanently, are reported as net assets with donor restrictions.

Investment income related to net assets with donor restrictions is classified as net assets without donor restrictions based on the intent of the donor.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. This includes regulatory discounts allowed to Blue Cross, Medicare, Medicaid, and other third-party payors and charity care.

2. Summary of Significant Accounting Policies (continued)

During 2021 and 2020, approximately 37% and 39%, respectively, of net patient service revenue was received under the Medicare program, 24% and 25% from Blue Cross, 33% and 26% from contracts with other third parties, and 6% and 10% from other sources.

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

	Year Ended June 30	
	2021	**2020**
Gross patient service revenue	**$ 1,330,212,000**	$ 1,262,664,000
Revenue deductions:		
Charity care	**(11,708,000)**	(15,409,000)
Contractual and other allowances	**(282,069,000)**	(278,148,000)
Net patient service revenue	**$ 1,036,435,000**	$ 969,107,000

The System recognizes revenue in accordance with ASC 606, which requires patient service revenue to be presented net of provisions for contractuals and bad debts (implicit and explicit price concessions). Subsequent changes in the estimate of collectibility due to a change in the financial status of a payor, for example a bankruptcy, will be recognized as bad debt expense in operating expenses, which is included in purchased services on the consolidated statements of operations.

Additionally, the System's revenues may be subject to adjustment as a result of examination by government agencies or contractors and as a result of differing interpretation of government regulations, medical diagnosis, charge coding, medical necessity, or other contract terms. Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreements with the payor, correspondence from the payor and the System's historical settlement activity, including an assessment to ensure it is probable a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled or are no longer subject to such audits, reviews, and investigations.

2. Summary of Significant Accounting Policies (continued)

The System has elected the practical expedient allowed under the Financial Accounting Standards Board (FASB) ASC 606-10-32-18, *Revenue from Contacts with Customers*, and does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to the System's expectation that the period between the time the service is provided to a patient and the time that the patient or third-party payor pays for that service will be one year or less.

The estimates for implicit price concessions are based upon management's assessment of historical write-offs and expected net collections; business and economic conditions; trends in federal, state, and private employer health care coverage; and other collection indicators. Management relies on the results of detailed reviews of historical write-offs and collections at facilities that represent a majority of the System's revenues and patient receivable as a primary source of information in estimating the collectibility of patient receivable.

Luminis employs physicians in several hospital-based specialties (including, but not limited to, obstetrics, intensive care, and hospitalists). Net physician revenue is recognized when the services are provided and recorded at the estimated net realizable amount based on the contractual arrangements with third-party payors and the expected payments from the third-party payors and the patients. The difference between the billed charges and the estimated net realizable amounts are recorded as a reduction in physician revenue when the services are provided. The System recognized net physician revenue of $162,841,000 and $149,933,000 for the years ended June 30, 2021 and 2020, respectively, which is included in net patient service revenue. At June 30, 2021 and 2020, $22,126,000 and $15,097,000, respectively, of net physician accounts receivable are included in patient receivables on the accompanying consolidated balance sheets.

Charity Care

LHAAMC provides charity care to patients who meet certain criteria established under its charity care guidelines. Because members of LHAAMC do not pursue the collection of amounts determined to qualify as charity care, they are not reported as revenue on the accompanying consolidated statements of operations. The direct and indirect costs associated with providing this care are $4,932,000 and $4,531,000 for the years ended June 30, 2021 and 2020, respectively. These costs are calculated by applying a ratio of operating expenses over gross patient charges to the charity care provided at established rates. The state of Maryland's rate system includes components within the rates to partially compensate hospitals for uncompensated care.

2. Summary of Significant Accounting Policies (continued)

The cost of charity care provided by LHDCMC totaled $6,776,000 and $9,528,000 for the years ended June 30, 2021 and 2020, respectively. Rates charged by LHDCMC for regulated services are determined based on assessment of direct and indirect cost calculated pursuant to the methodology established by the Commission, and therefore the cost of charity services noted above for LHDCMC are equivalent to its established rates for those services. For any charity services rendered by subsidiaries other than from the LHDCMC, the cost of charity care is calculated by applying the estimated total cost-to-charge ratio for the non-Hospital services to the total amount of charges for services provided to patients benefitting from the charity care policies of the LHDCMC's non-Hospital affiliates. These charges are excluded from consolidated net patient service revenue.

Other Operating Revenue

Other operating revenue is composed of grant revenue, cafeteria revenue, net assets released from restrictions for operating purposes, and other miscellaneous items.

A variety of federal, state, and local efforts have been initiated in response to the COVID-19 crisis, the largest of which is the CARES Act that was enacted on March 27, 2020. The CARES Act is a federal stimulus package designed to provide emergency assistance to individuals and businesses, including hospitals and other health care providers. The CARES Act authorizes funding to hospitals and other health care providers to be distributed through the Public Health and Social Services Emergency Relief Fund (Provider Relief Fund). Payments received from the Provider Relief Fund shall reimburse the recipient for health care-related expenses or lost revenues attributable to the COVID-19 pandemic and are not required to be repaid, provided the recipients attest to and comply with the terms and conditions.

The System has received and recognized approximately $36,524,000 and $45,472,000 in stimulus funding for the years ended June 30, 2021 and 2020, respectively, that has been recorded within other revenue on the accompanying consolidated statements of operations. The System recognized these amounts based on its evaluation of the terms and conditions prescribed by the U.S. Department of Health and Human Services. The System will continue to monitor compliance with the terms and conditions of the Provider Relief Fund and the impact of the pandemic on revenues and expenses. If the System is unable to attest to or comply with current or future terms and conditions, its ability to retain some or all of the distributions received may be impacted. The System believes that it meets all the requirements for recognition.

2. Summary of Significant Accounting Policies (continued)

Advances From Third-Party Payors

On April 10, 2020, the System received $151,767,000 from the Centers for Medicare and Medicaid Services (CMS) Accelerated and Advance Payment Program. This program provides hospitals with working capital advances that begin to become payable 120 days from the date of receipt of the funds and must be fully repaid within 14 months, starting in April 2021 through an automatic reduction of claims receipts from CMS. These funds, which represent contract liabilities as defined in ASC 606, have been recorded within advances from third-party payors on the accompanying consolidated balance sheets. The balance due to Medicare was $135,178,000 and $151,767,000 as of June 30, 2021 and 2020, respectively. The remaining amount of advances from third-party payors are in the ordinary course of business and due to various payors on demand.

Donations and Bequests

Unconditional promises to give cash and other assets are reported at fair value on the date the promise is received. Conditional promises to give, and indications of intentions to give, are reported at fair value on the date the gift is received. The gifts are reported as donor-restricted if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends, or a purpose restriction is accomplished, the asset is reclassified to without donor restrictions on the accompanying consolidated statements of changes in net assets. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated financial statements. Contributions that are unrestricted are reflected as other operating revenue on the accompanying consolidated statements of operations.

Scheduled payments for pledges receivable for the years ending June 30 are as follows:

2022	$ 1,312,000
2023	629,000
2024 and thereafter	1,810,000
Less:	
Impact of discounting pledges receivable to net present value	376,000
Allowance for uncollectible pledges	401,000
Net pledges receivable	$ 2,974,000

Pledges receivable are discounted using rates between 1.2% and 2.5%.

2. Summary of Significant Accounting Policies (continued)

Excess (Deficit) of Revenues Over Expenses

The accompanying consolidated statements of operations include excess (deficit) of revenues over expenses. Changes in net assets without donor restrictions that are excluded from excess (deficit) of revenues over expenses, consistent with industry practice, include contributions received and used for additions of long-lived assets and certain changes in pension liabilities.

Group Purchasing Organization Initial Public Offering

LHAAMC has participated and owned equity in the Premier Limited Partnership (Premier), which has served as a group purchasing organization for many years. This participation provides purchasing contract rates and rebates the System would not be able to obtain on its own. LHAAMC accounted for its investment in Premier using the equity method of accounting.

The System received 309,580 Class B units that are earned in seven separate tranches over an 85-month period ending October 31, 2020. At June 30, 2021 and 2020, this investment was $10,770,000 and $10,388,000, respectively, and is reflected in other assets on the consolidated balance sheets. The opportunity will exist in the future for these Class B units to be converted to the Premier public company stock. Prior to vesting, the Class B units may be transferred or sold with the approval of Premier. During the years ended June 30, 2021 and 2020, the System recognized approximately $409,000 and $1,216,000, respectively, of income related to tranches 6 and 7 of the Class B units, which is included as a reduction of supplies expense on the consolidated statement of operations. The value of the Class B units is tied to the group purchasing contract and is considered a vendor incentive.

Income Tax Status

Luminis, LHAAMC, the Foundation, Pathways, LHI, PE, and RI have received determination letters from the Internal Revenue Service (IRS) stating that they are exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (the Code). The Real Estate Company has received a determination letter from the IRS stating that it is exempt from federal income taxes under Section 501(c)(2) of the Code. LHDCMC and the Doctors Community Hospital Foundation are exempt from federal income tax under Section 501(c)(3) of the Code as public charities. These entities are entitled to rely on this determination as long as there are no substantial changes in their character, purposes, or methods of operation. Management has concluded that there have been no such changes, and therefore the status of the various entities as public charities exempt from federal income taxation remain in effect.

2. Summary of Significant Accounting Policies (continued)

Mc New is organized and operated as a tax-exempt organization and has applied for IRS recognition of exemption from federal income tax under Section 501(c)(3) of the Code, but has not yet received IRS recognition of exemption.

The state in which the various entities operate also provides a general exemption from state income taxation for organizations that are exempt from federal income taxation. However, these entities are subject to federal and state income taxation at corporate tax rates on unrelated business income.

Exemption from other state and local taxes, such as real and personal property taxes is separately determined. The various entities had no unrecognized tax benefits or such amounts were immaterial during the periods presented. For tax periods with respect to which unrelated business income was recognized, a tax return was filed in order to report any unrelated business income as well as any taxes due.

HCE and PPI are subject to federal and state income taxes. These income taxes are immaterial to the accompanying consolidated financial statements.

Certain limited liability companies within the consolidated group are not subject to income taxes. Taxable income or loss is passed through to and reportable by the members individually.

Under the Cayman Islands Tax Concessions Law (Revised), the Governor-in-Cabinet issued an undertaking regarding Cottage on November 29, 2005, exempting it from all local income, profit, or capital gains taxes. The undertaking has been issued for a period of 20 years and, at the present time, no such taxes are levied in the Cayman Islands. Accordingly, no provision for taxes is made in these consolidated financial statements.

DRCC is a Maryland limited liability company that has not elected to be taxed as corporations under current Treasury regulations and is owned by more than one member. DRCC is subject to the partnership tax rules under Subchapter K of the Internal Revenue Code of 1986 (IRC), as amended. Under these rules DRCC is not subject to federal or state income tax, but must file annual information returns indicating their gross and taxable income to determine the tax results to their members.

Doctors Community Healthcare Programs (CHP) is a Maryland limited liability company that has not elected to be taxed as a corporation under current treasury regulations. CHP is a wholly owned by LHDCMC. As such, CHP is considered a "disregarded entity" under current IRC regulations.

2. Summary of Significant Accounting Policies (continued)

Under the requirements of ASC 740, *Income Taxes*, tax-exempt organizations could be required to record an obligation as the result of a tax position they have historically taken on various tax exposure items. Luminis has determined that it does not have any uncertain tax positions through June 30, 2021.

Use of Estimates

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

New Accounting Standards Not Yet Adopted

In August 2018, the FASB issued Accounting Standards Update (ASU) 2018-15, *Intangibles – Goodwill and Other – Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract.* The amendments help entities evaluate the accounting for implementation costs paid by a customer in a cloud computing arrangement by providing guidance for determining when the service contract includes a software license. The System is evaluating the impact of this guidance, which will be effective in 2022.

In June 2016, the FASB issued ASU 2016-13, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments.* ASU 2016-13 requires financial assets measured at amortized cost to be presented at the net amount expected to be collected. The measurement of expected credit losses is based on relevant information about past events, including historical experience, current conditions, and reasonable and supportable forecasts that affect the collectibility of the reported amounts. An entity must use judgment in determining the relevant information and estimation methods that are appropriate in its circumstances. ASU 2016-13 is effective for annual reporting periods beginning after December 15, 2022, and a modified retrospective approach is required, with a cumulative-effect adjustment to net assets as of the beginning of the first reporting period in which the guidance is effective. Management is currently evaluating the impact of adopting this new accounting guidance.

3. Regulatory Environment

Medicare and Medicaid

The Medicare and Medicaid reimbursement programs represent a substantial portion of Luminis' revenues. Luminis' operations are subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Over the past several years, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs, together with the imposition of fines and penalties, as well as repayments for patient services previously billed. Compliance with fraud and abuse standards and other government regulations can be subject to future government review and interpretation. Also, future changes in federal and state reimbursement funding mechanisms and related government budgeting constraints could have an adverse effect on Luminis.

In 1983, Congress approved a Medicare prospective payment plan for most inpatient services as part of the Social Security Amendment Act of 1983. Hospitals in Maryland were granted a waiver from the Medicare prospective payment system under Section 1814(b) of the Social Security Act. The waiver would remain in effect as long as the Maryland rate of increase in payments per admission remained below the national average rate of increase.

In January 2014, the Centers for Medicare and Medicaid Services approved a modernized waiver that includes both inpatient and outpatient revenue. The new waiver will be in place as long as Maryland hospitals achieve significant quality improvements and limit the per capita growth for all payors for Maryland residents.

Maryland Health Services Cost Review Commission

LHAAMC and LHDCMC's rate structure for all hospital-based services is subject to review and approval by the HSCRC. Under the HSCRC rate-setting system, the Hospital's inpatient and outpatient charges are the same for all patients, regardless of payor, including Medicare and Medicaid.

3. Regulatory Environment (continued)

Beginning in fiscal year 2014, LHAAMC and LHDCMC entered into an agreement with the HSCRC to participate in the Global Budget Revenue (GBR) program. The GBR model is a revenue constraint and quality improvement system to provide hospitals with strong financial incentives to manage their resources efficiently and effectively in order to slow the rate of increase in health care costs and improve health care delivery processes and outcomes. Under the GBR, total revenue is capped at a predetermined fixed amount. The annual approved revenue is calculated using a permanent base revenue with positive or negative adjustments for inflation, assessments, performance in quality-based programs, infrastructure requirements, and population. Revenue may also be adjusted annually for market share levels and shifts of regulated services to unregulated settings.

Starting in January 2019, Maryland's hospitals began operating under a new ten-year contract with the federal government titled Medicare Performance Adjustment (MPA). The MPA is designed to test whether the improvements hospitals have made under the previous modernized waiver can be expanded to all health care providers. The GBR methodology will remain in place for hospital rate setting under the MPA. In addition, programs aimed to measure and reduce total health care spending for attributed Medicare patients, including pre- and post-acute care by all providers, are being introduced during this contract period.

The Commission's rate-setting methodology compares Global Budget Revenue to actual revenue. Overcharges and undercharges due to either patient volume or price variances, adjusted for penalties where applicable, are applied to decrease (in the case of overcharges) or increase (in the case of undercharges) future approved rates on an annual basis. The System was undercharged by $59,965,000 and $54,399,000 for the years ended June 30, 2021 and 2020, respectively. The undercharges do not include amounts recognized in CARES Act funding discussed in the other operating revenue section in Note 2. The System expects the HSCRC to allow for the recovery of undercharges net of CARES Act funding over the next two years. Changes in rates over the next two fiscal years may result in a material change in rates; however the extent of such changes in each year are uncertain.

Except as noted above, LHAAMC and LHDCMC's policy is to recognize revenue based on actual charges for services to patients in the year in which the services are performed. LHAAMC and LHDCMC's revenues may be subject to adjustment as a result of examination by government agencies or contractors, and as a result of differing interpretation of government regulations, medical diagnoses, charge coding, medical necessity, or other contract terms. The resolution of these matters, if any, often is not finalized until a subsequent period than when the services were rendered.

4. Investments

Investments, including assets whose use is limited, are stated at fair value. Borrowed funds that are required to be expended on specified capital projects under MHHEFA revenue bond agreements are classified as available for sale. All other investments and assets whose use is limited are classified as trading securities.

	June 30	
	2021	**2020**
Assets whose use is limited:		
Endowment assets:		
Cash and cash equivalents	**$ 2,206,000**	$ 1,145,000
Equity mutual funds	**13,139,000**	9,279,000
Fixed income mutual funds	**5,079,000**	5,058,000
	20,424,000	15,482,000
Amounts held by trustee:		
Cash and cash equivalents	**12,538,000**	12,382,000
U.S. Government obligations	**7,000**	7,000
	12,545,000	12,389,000
Amounts held by Cottage:		
Cash and cash equivalents	**3,703,000**	3,504,000
Equity mutual funds	**14,353,000**	11,334,000
Fixed income mutual funds	**18,249,000**	14,223,000
	36,305,000	29,061,000
Total assets whose use is limited	**69,274,000**	56,932,000
Less current portion	**16,241,000**	15,912,000
	$ 53,033,000	$ 41,020,000

Amounts held by the trustee are broken down as follows:

	June 30	
	2021	**2020**
Bond indenture	**$ 12,545,000**	$ 12,389,000

4. Investments (continued)

Other investments:

	June 30	
	2021	**2020**
Cash and cash equivalents	**$ 24,277,000**	$ 14,388,000
Equity mutual funds	**230,711,000**	173,069,000
Fixed income mutual funds	**129,989,000**	100,475,000
Alternative investments	**67,320,000**	52,418,000
	452,297,000	340,350,000
Less short-term investments	**3,447,000**	1,365,000
Investments	**$ 448,850,000**	$ 338,985,000

The components of investment income (loss), net are as follows:

	June 30	
	2021	**2020**
Interest and dividend income, net	**$ 767,000**	$ 132,000
Realized gains (losses), net	**12,700,000**	(9,832,000)
	$ 13,467,000	$ (9,700,000)

5. Fair Value Measurements

ASC 820 defines fair value and establishes a framework for measuring fair value in accordance with U.S. GAAP. ASC 820 establishes a three-tier fair value hierarchy that prioritizes the inputs used in measuring fair value. These tiers include:

- Level 1 – Defined as observable inputs, such as quoted prices in active markets
- Level 2 – Defined as inputs other than quoted prices in active markets that are either directly or indirectly observable
- Level 3 – Defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions

5. Fair Value Measurements (continued)

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

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

ASC 820 requires that the fair value of derivative contracts include adjustments related to the credit risks of both parties associated with the derivative transactions. The fair value of Luminis' derivative contracts reflected in the accompanying consolidated financial statements includes adjustments related to the credit risks of the parties to the transactions.

5. Fair Value Measurements (continued)

The following tables present the fair value hierarchy for Luminis' financial assets and liabilities measured at fair value on a recurring basis.

	June 30, 2021			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Trading securities and assets whose use is limited:				
Cash and cash equivalents	$ 42,739,000	$ 42,739,000	$ –	$ –
Equity securities	260,811,000	250,798,000	10,013,000	–
Fixed income securities	149,362,000	134,726,000	14,636,000	–
U.S. Government obligation securities	7,000	7,000	–	–
Total	452,919,000	428,270,000	24,649,000	
Collateral for interest rate swap:				
Cash and cash equivalents	25,699,000	25,699,000	–	–
Less investments included in other assets	4,200,000	4,200,000	–	–
Total assets at fair value	474,418,000	$ 449,769,000	$ 24,649,000	$ –
Assets at NAV	67,320,000			
Total assets	$ 541,738,000			
Liabilities				
Derivative instruments	$ (90,010,000)	$ –	$ (90,010,000)	$ –
Total liabilities at fair value	$ (90,010,000)	$ –	$ (90,010,000)	$ –

5. Fair Value Measurements (continued)

	June 30, 2020			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Trading securities and assets whose use is limited:				
Cash and cash equivalents	$ 31,296,000	$ 18,257,000	$ 13,039,000	$ –
Equity securities	194,977,000	194,977,000	–	–
Fixed income securities	122,785,000	119,753,000	3,032,000	–
U.S. Government obligation securities	6,000	6,000	–	–
Total	349,064,000	332,993,000	16,071,000	–
Collateral for interest rate swap:				
Cash and cash equivalents	110,002,000	110,002,000	–	–
Less investments included in other assets	4,200,000	4,200,000	–	–
Total assets at fair value	454,866,000	$ 438,795,000	$ 16,071,000	$ –
Assets at NAV	52,418,000			
Total assets	$ 507,284,000			
Liabilities				
Derivative instruments	$ (117,037,000)	$ –	$ (117,037,000)	$ –
Total liabilities at fair value	$ (117,037,000)	$ –	$ (117,037,000)	$ –

Luminis' Level 1 securities primarily consist of U.S. Treasury securities, equity and fixed income securities (including mutual funds), and cash. Luminis determines the estimated fair value for its Level 1 securities using quoted (unadjusted) prices for identical assets or liabilities in active markets.

Luminis' Level 2 securities primarily consist of cash and cash equivalents. Luminis determines the estimated fair value for these Level 2 securities using the following methods: quoted prices for similar assets/liabilities in active markets, quoted prices for identical or similar assets in non-active markets (few transactions, limited information, noncurrent prices, high variability over time),

5. Fair Value Measurements (continued)

inputs other than quoted prices that are observable for the asset or liability (e.g., interest rates, yield curve volatilities, default rates), and inputs that are derived principally from or corroborated by other observable market data.

Luminis' Level 2 securities also consist of derivative instruments, which are reported using valuation models commonly used for derivatives. Valuation models require a variety of inputs, including contractual terms, market-fixed prices, inputs from forward price yield curves, notional quantities, measures of volatility, and correlations of such inputs.

Part of LHAAMC's alternative investments, approximately $17,082,000 and $22,663,000 at June 30, 2021 and 2020, respectively, are invested in international equity funds. The majority of the remaining alternative investments $50,238,000 and $24,489,000 at June 30, 2021 and 2020, respectfully are invested in a fund focused on energy infrastructure. Alternative investments are measured using NAV as the practical expedient. Certain alternative investments require written notification over a certain period prior to redemption.

Luminis also has pledges receivable, which are measured at fair value on a nonrecurring basis and are discounted to the net present value upon receipt using an appropriate risk-free discount rate based on the term of the receivable. Since these inputs are not observable, pledges receivable would be considered Level 3 fair value measurements upon their initial recording. Pledges receivable are recorded net of an allowance for uncollectible pledges. The following table provides a reconciliation of the beginning and ending balances of pledges receivable that used significant unobservable inputs.

	Year Ended June 30	
	2021	**2020**
Balance at July 1	**$ 4,137,000**	$ 3,296,000
New pledges	**342,000**	2,967,000
Collections of pledges	**(1,451,000)**	(2,028,000)
Write-off of pledges	**(5,000)**	(160,000)
Change in reserves	**(49,000)**	62,000
Balance at June 30	**$ 2,974,000**	$ 4,137,000

6. Long-Term Debt and Line of Credit

For LHAAMC and affiliates, long-term debt consists of the following:

	Interest Rate	Maturity Dates	June 30 2021	June 30 2020
Maryland Health and Higher Educational Facilities Authority Revenue Bonds – Series 2017	2.0%–5.0%	2018–2043	**$ 54,690,000**	$ 56,905,000
Maryland Health and Higher Educational Facilities Authority Revenue Bonds – Series 2014	2.0%–5.0%	2015–2040	**111,463,000**	113,817,000
Maryland Health and Higher Educational Facilities Authority Revenue Bonds – Series 2012	2.0%–5.0%	2013–2035	**54,137,000**	56,991,000
Maryland Health and Higher Educational Facilities Authority Revenue Bonds – Series 2009B	Variable	2041–2044	**60,000,000**	60,000,000
Kent Island term loan from a bank	Variable	2021	**5,217,000**	5,617,000
Real estate loan	Variable	2028	**52,215,000**	55,850,000
			337,722,000	349,180,000
Less current portion of long-term debt			**16,552,000**	11,461,000
Less deferred debt issue costs			**3,249,000**	3,531,000
Unamortized original issue premium, net			**12,411,000**	13,354,000
Long-term debt			**$ 330,332,000**	$ 347,542,000

These debt instruments are secured by the receipts of the LHAAMC obligated group and substantially all of the property and equipment of the consolidated group.

6. Long-Term Debt and Line of Credit (continued)

For LHAAMC and affiliates, principal payments due under all debt instruments as of June 30, 2021, are as follows:

2022	$ 16,552,000
2023	11,667,000
2024	11,987,000
2025	12,332,000
2026	12,722,000
Thereafter	272,462,000
	$ 337,722,000

Series 2017 Revenue Bonds

In November 2017, LHAAMC entered into a loan agreement with the MHHEFA for the issuance of Series 2017 Revenue Bonds (referred to as the 2017 Bonds). The proceeds of the 2017 Bonds were used to advance refund the Series 2010 Bonds previously provided by MHHEFA. The bonds being refunded were originally obtained to finance the expansion of the parking garage for LHAAMC's acute care pavilion, and costs related to the issuance. The 2017 Bonds provide for annual principal payments each July 1 from 2018 through 2043. Interest is payable annually each July 1 starting in July 2018. The 2017 Bonds bear stated interest rates between 2.00% and 5.00% and were issued at a premium of $4,590,000, which is amortized over the life of the bonds using the straight-line method, which approximates the effective interest method. The effective annual interest rate for the 2017 Bonds for the years ended June 30, 2021 and 2020, was 3.89% and 3.64%, respectively.

Series 2014 Revenue Bonds

In November 2014, LHAAMC entered into a loan agreement with the MHHEFA for the issuance of Series 2014 Revenue Bonds (referred to as the 2014 Bonds). The proceeds of the 2014 Bonds were used to advance refund the Series 2009A Bonds previously provided by MHHEFA. The bonds being refunded were originally obtained to finance a portion of the costs of construction for an eight-story patient care building, two parking garages, and costs related to the issuance. The 2014 Bonds provide for annual principal payments each July 1 from 2015 through 2040. Interest is payable semiannually each July 1 and January 1, beginning in January 2015. The 2014 Bonds bear stated interest rates between 2.00% to 5.00% and were issued at a premium of $7,520,000,

6. Long-Term Debt and Line of Credit (continued)

which is amortized over the life of the bonds using the straight-line method, which approximates the effective interest method. The effective annual interest rate for the 2014 Bonds for the years ended June 30, 2021 and 2020, was 4.50% and 4.49%, respectively.

Series 2012 Revenue Bonds

In October 2012, LHAAMC entered into a loan agreement with MHHEFA for the issuance of $73,625,000 of Series 2012 Revenue Bonds (referred to as the 2012 Bonds). The proceeds of the 2012 Bonds were used to repay the Series 2004A Bonds and the Series 1998 Bonds previously provided by the Authority. The bonds being refinanced were originally obtained to finance a new replacement hospital (Series 1998 Bonds) and to finance major renovations to LHAAMC's Cancer Center and land acquisition (Series 2004A Bonds). The 2012 Bonds provide for annual principal payments each July 1 from 2013 through 2035. Interest is payable semiannually on each July 1 and January 1, beginning July 1, 2013. The 2012 Bonds bear stated interest at rates of 2.00% to 5.00% and were issued at a premium of $6,746,000. The effective annual interest rates for the 2012 Bonds for the years ended June 30, 2021 and 2020, were 4.30% and 4.34%, respectively.

The provisions of the 2017, 2014, and 2012 Bonds, together with the Series 2009 Bonds, require Luminis and certain subsidiaries to comply with certain covenants on an annual basis, including a debt service coverage requirement, a debt-to-capitalization requirement, and a liquidity requirement. Luminis, LHAAMC, and HCS are members of the LHAAMC obligated group for all of the above stated revenue bonds issued by MHHEFA.

Series 2009 Revenue Bonds

In January 2009, LHAAMC entered into a loan agreement with the MHHEFA for the issuance of $120,000,000 of Series 2009A Revenue Bonds (the 2009A Bonds) and in February 2009, $60,000,000 of Series 2009B Revenue Bonds (the 2009B Bonds) (collectively referred to as the 2009 Bonds). The proceeds of the 2014 Bonds were used to advance refund the Series 2009A Bonds previously provided by the MHHEFA. The proceeds of the 2009 Bonds were used to finance a portion of the costs of construction of an eight-story patient care building, two new parking garages, and certain costs relating to the issuance. The 2009B Bonds provide for annual principal payments each July 1, from 2041 through 2044. Interest is payable semiannually on each July 1 and January 1, beginning July 1, 2009. The 2009B Bonds bear interest at variable rates, as set forth in the loan agreement. The maximum interest rate is 12% for the 2009B Bonds. The effective annual interest rates for the 2009B Bonds for the years ended June 30, 2021 and 2020,

6. Long-Term Debt and Line of Credit (continued)

were 0.09% and 1.18%, respectively. The principal and interest payments on the Series 2009B Bonds are secured by a letter of credit equal to the original principal of the bonds plus an amount equal to 40 days' interest thereon, calculated at the maximum rate. The current letter of credit, which was extended on May 1, 2019, expires on July 1, 2024. Under certain circumstances, LHAAMC would need to fully redeem the 2009B Bonds upon expiration of the letter of credit, unless a conforming replacement letter of credit was secured prior to such expiration.

The related balances are included in assets whose use is limited and consist of the following:

	June 30	
	2021	**2020**
Debt service funds	**$ 12,538,000**	$ 12,382,000
Construction fund and capitalized interest fund	**7,000**	7,000
	$ 12,545,000	$ 12,389,000

Bank Line of Credit and Real Estate Loan

LHAAMC maintains a line of credit with a bank providing available credit of $50,000,000, which is reviewed for renewal on February 28 of each year. Interest on any borrowings accrues at the one-month LIBOR plus 0.75%. At June 30, 2021 and 2020, LHAAMC had no balance outstanding on the line of credit.

On October 23, 2008, the Real Estate Company secured a term loan in the amount of $55,000,000 with a bank. The proceeds from the term loan were used to refinance line of credit proceeds and fund certain construction costs related to a medical office building. The loan bore interest at a variable rate, based on the LIBOR market index rate plus 1.25%. The term loan required monthly payments of $235,000 with all remaining amounts due upon final maturity on November 5, 2018. This loan was subsequently refinanced on October 17, 2018.

On October 23, 2008, the Real Estate Company entered into a construction loan in the amount of $30,000,000 with a bank to fund the construction of a medical office building. The loan was issued under the same loan agreement as the term loan discussed in the preceding paragraph. The debt is secured by the medical office building. Interest only was due during the construction period at a rate equal to the LIBOR market index rate plus 1.25%. The loan converted to a term loan after the

6. Long-Term Debt and Line of Credit (continued)

completion of the construction in July 2009. The term loan provided for monthly principal and interest payments and has a final maturity of November 5, 2018. This loan was subsequently refinanced on October 17, 2018.

On October 17, 2018, the Real Estate Company secured a real estate loan from the bank through a wholly owned subsidiary and the proceeds were used to pay off the 2008 Term Loan and 2008 Construction Loan previously provided by the bank. The loans being refinanced were originally obtained to finance certain medical office buildings owned by the Real Estate Company. The new loan requires flat monthly principal payments (amortized over 17 years) plus interest at one-month LIBOR plus 1.10% from 2018 through 2028 with a balloon payment due October 5, 2028, of $25,800,000. The effective interest rates for the years ended June 30, 2021 and 2020, were 1.25% and 2.65%, respectively.

Kent Island Term Loan

In August 2007, KIMA entered into a construction loan agreement with a bank in the amount of $9,000,000 that would convert to a term loan after the completion of the construction. The proceeds were used to construct a medical office building. The debt was secured by the medical office building. Interest only was due during the construction period at a rate of the 30-day LIBOR plus 1.0%. The construction was completed in June 2008.

On May 9, 2017, KIMA refinanced the term loan with a $6,567,000 promissory note. The promissory note provides for monthly principal and interest payments and has a final maturity of December 2021. The promissory note bears interest at a variable rate, based on the 30-day LIBOR plus 1.20%. The effective annual interest rates for the years ended June 30, 2021 and 2020, were 1.38% and 2.88%, respectively.

6. Long-Term Debt and Line of Credit (continued)

For LHDCMC, long-term debt consists of the following:

	Interest Rate	Maturity Dates	June 30 2021	2020
Maryland Health and Higher Education Facilities				
Authority Revenue Bonds, Series 2017B Bond	2.18%	2024	**$ 19,645,000**	$ 24,165,000
Authority Revenue Bonds, Series 2016 Bond:				
Series 2016A – Tax-Exempt Private Placement	2.57%	2030	**31,560,000**	31,945,000
Authority Revenue Bonds, Series 2017A:				
Term bond	5.00%	2031	**6,720,000**	6,720,000
Term bond	5.00%	2032	**7,055,000**	7,055,000
Term bond	5.00%	2033	**7,410,000**	7,410,000
Term bond	5.00%	2034	**7,780,000**	7,780,000
Term bond	5.00%	2038	**35,200,000**	35,234,000
			115,370,000	120,309,000
Less current portion of long-term debt			**5,070,000**	4,979,000
Less deferred debt issue costs			**–**	1,340,000
Premium, net of accumulated amortization			**8,543,000**	8,776,000
Long-term debt			**$ 118,843,000**	$ 122,766,000

For LHDCMC, principal payments due under all debt instruments as of June 30, 2021, are as follows:

2022	$ 5,070,000
2023	5,195,000
2024	5,265,000
2025	5,965,000
2026	5,610,000
Thereafter	88,265,000
	$ 115,370,000

On June 28, 2016, MHHEFA issued $73,445,000 principal amount of Revenue Bonds, Series 2016A ($31,945,000), and Series 2016B ($41,500,000). The proceeds of this issue were used to retire the Series 2007A Bonds and Series 2010 Bonds (partial) previously provided by the Authority. In 2017, the Series 2016B taxable note was converted as planned to Series 2017B. On March 23, 2017, the Series 2016 were converted to Series 2017B bonds as planned when the 2016B bonds were issued in June 2016.

6. Long-Term Debt and Line of Credit (continued)

On February 8, 2017, MHHEFA issued $64,165,000 principal amount of Revenue Bonds, Series 2017A. The proceeds of this issue were used to retire the remainder of the Series 2010 Bonds previously provided by the Authority.

The obligated group for MHHEFA bond issuances issued to Luminis Health Doctors Community Medical Center includes Doctors Community Hospital, CHP, Luminis Health Doctor's Community Medical Center Foundation, Sleep Center, Doctors Community Medical Group and Doctors Integrated Healthcare Network and Health Ventures excluding the MAUI, Magnolia Gardens, DI LLC, ACO, and STM. The Series 2017A, Series 2017B, and Series 2016 Bonds are secured by the revenue and accounts receivable of the obligated group, and certain other property secured by a deed of trust. The obligated group is required to maintain certain compliance ratios and covenants as defined under the bond documents.

7. Retirement Plans

Anne Arundel Medical Center Plan

LHAAMC has a qualified noncontributory, defined benefit pension plan (the Plan) that covers substantially all employees. LHAAMC's policy is to fund pension costs as determined by its actuary. Adopted by the Board of Trustees on June 11, 2009, and effective September 1, 2009, LHAAMC amended the Plan to freeze future benefit accruals, and participants have not earned any additional benefits under the Plan since that date. However, subsequent to September 1, 2009, participants have continued to vest in benefits they have earned through September 1, 2009. The frozen benefit balance for the participants will only accrue interest credits until the participants' benefit commencement dates. FASB ASC 715, *Compensation – Retirement Benefits*, requires LHAAMC to recognize the funded status (i.e., the difference between the fair value of plan assets and the projected benefit obligations) of its pension plan on its consolidated balance sheet, with a corresponding adjustment to unrestricted net assets. The pension liability adjustment to net assets without donor restrictions represents the change in net unrecognized actuarial losses that have not yet been recognized as part of excess (deficit) of revenues over expenses. These amounts are subsequently recognized as a net periodic benefit cost pursuant to LHAAMC's historical accounting policy for amortizing such amounts.

7. Retirement Plans (continued)

The reconciliation of the beginning and ending balances of the projected benefit obligation and the fair value of plan assets for the years ended June 30 and the accumulated benefit obligation for LHAAMC is as follows:

	June 30	
	2021	**2020**
Accumulated benefit obligation	**$ 126,360,000**	$ 138,148,000
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	**$ 138,148,000**	$ 124,331,000
Service cost		–
Interest cost	**3,147,000**	4,047,000
Actuarial loss	**(3,989,000)**	16,039,000
Benefits paid	**(2,503,000)**	(2,446,000)
Settlements paid	**(8,443,000)**	(3,823,000)
Projected benefit obligation at end of year	**126,360,000**	138,148,000
Change in plan assets:		
Fair value of plan assets at beginning of year	**115,397,000**	118,255,000
Actual return on plan assets	**25,828,000**	(1,421,000)
Employer contribution	**10,509,000**	4,832,000
Benefits paid	**(2,503,000)**	(2,446,000)
Settlements paid	**(8,443,000)**	(3,823,000)
Fair value of plan assets at end of year	**140,788,000**	115,397,000
Net asset (liability) recognized	**$ 14,428,000**	$ (22,751,000)
Net amounts recognized on the consolidated balance sheets consist of:		
Prepaid (accrued) pension costs	**$ 14,428,000**	$ (22,751,000)
Amounts recognized in net assets without donor restrictions that have not been recognized in net periodic benefit costs consist of:		
Net actuarial loss	**$ 65,689,000**	$ 95,271,000

7. Retirement Plans (continued)

The following table sets forth the weighted average assumptions used to determine the benefit obligations of LHAAMC:

	June 30	
	2021	**2020**
Discount rate	**2.50%**	2.45%
Rate of compensation increase	**N/A**	N/A

The following table sets forth the weighted average assumptions used to determine the net periodic benefit cost of LHAAMC:

	Year Ended June 30	
	2021	**2020**
Discount rate	**2.38%**	3.35%
Expected return on plan assets	**6.00%**	6.25%
Rate of compensation increase	**N/A**	N/A

LHAAMC's net periodic pension benefit cost included the following components:

	June 30	
	2021	**2020**
Service cost	**$ –**	$ –
Interest cost	**3,147,000**	4,047,000
Expected return on plan assets	**(7,425,000)**	(7,533,000)
Recognized net actuarial loss	**2,260,000**	1,709,000
Loss recognized from partial settlement of projected benefit obligation	**4,931,000**	–
Net periodic cost (credit)	**$ 2,913,000**	$ (1,777,000)

The estimated net loss of the defined benefit pension plan that will be amortized from net assets without donor restrictions into net periodic benefit cost over the next fiscal year for LHAAMC is $2,071,000.

7. Retirement Plans (continued)

LHAAMC's defined benefit plan invests in a diversified mix of traditional asset classes. Investments in certain types of U.S. equity securities and fixed-income securities are made to maximize long-term results while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. Risk tolerance of unexpected investment and actuarial outcomes is continually evaluated by understanding the pension plan's liability characteristics. Equity investments are used primarily to increase the overall plan returns. Debt securities provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

LHAAMC's target asset allocation percentages as of June 30, 2021, were as follows: 60% investment grade bonds, 16% international equity, 13% large cap domestic stocks, 4% small cap domestic stocks, and 7% alternative investments and exchange-traded notes.

The following tables present the fair value hierarchy of assets of the defined benefit pension plan of LHAAMC:

	June 30, 2021			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and cash equivalents	$ 8,875,000	$ –	$ 8,875,000	$ –
Mutual funds:				
Equity	23,528,000	23,528,000	–	–
Corporate bonds	80,640,000	80,640,000	–	–
International equity	9,608,000	9,608,000	–	–
Closed-end funds ETF	6,484,000	6,484,000	–	–
Assets measured at fair value	129,135,000	$ 120,260,000	$ 8,875,000	$ –
Assets at NAV	11,653,000			
Total assets	$ 140,788,000			

7. Retirement Plans (continued)

	June 30, 2020			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and cash equivalents	$ 669,000	$ –	$ 669,000	$ –
Mutual funds:				
Equity	20,127,000	20,127,000	–	–
Corporate bonds	57,830,000	57,830,000	–	–
International equity	12,520,000	12,520,000	–	–
International bonds	8,715,000	8,715,000	–	–
Closed-end funds ETF	5,512,000	5,512,000	–	–
Assets measured at fair value	105,373,000	$ 104,704,000	$ 669,000	$ –
Assets at NAV	10,024,000			
Total assets	$ 115,397,000			

Level 1 securities primarily consist of exchange-traded mutual funds. Level 2 securities primarily consist of money market funds. Methods consistent with those discussed in Note 5 are used to estimate the fair values of these securities.

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

LHAAMC currently intends to make voluntary contributions to the defined benefit pension plan of $2,400,000 in fiscal year 2022.

7. Retirement Plans (continued)

The following benefit payments for LHAAMC are expected to be paid:

2022	$ 6,994,000
2023	6,812,000
2024	6,770,000
2025	6,779,000
2026	8,103,000
2027–2031	34,272,000

In addition to the noncontributory defined benefit pension plan, LHAAMC also offers an employee defined contribution plan. Participation in the plan is voluntary. Substantially all full-time employees of LHAAMC are eligible to participate. Employees may elect to contribute a minimum of 1% of compensation, and a maximum amount as determined by Sections 403(b) and 415 of the Code. Any employee making contributions to the plan is entitled to a LHAAMC contribution that will match the employee contribution at the rate of 50% to 75%, depending on the number of years of service, up to a maximum of 5% of qualified compensation. Matching contributions under this defined contribution plan were $0 and $8,830,000 in fiscal years 2021 and 2020, respectively.

Doctors Community Hospital Plan

LHDCMC froze the defined benefit pension plan that it sponsors (the LHDCMC Plan) in 2011, which covered substantially all employees. The decision to terminate the LHDCMC Plan has not been made by the board of directors. The benefits are based on years of service and employee compensation during years of employment. LHDCMC's funding policy is to make sufficient contributions to the LHDCMC Plan to comply with the minimum funding provisions of the Employee Retirement Income Security Act of 1974 (ERISA). LHDCMC expects to contribute $250,000 to the LHDCMC Plan during 2021 to keep the funding levels at the ERISA requirements. The measurement date of the LHDCMC Plan is June 30.

7. Retirement Plans (continued)

The reconciliation of the beginning and ending balances of the projected benefit obligation and the fair value of plan assets for the years ended June 30 and the accumulated benefit obligation at June 30 for LHDCMC is as follows:

	June 30	
	2021	**2020**
Accumulated benefit obligation	**$ 21,988,000**	$ 23,049,000
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	**$ 23,049,000**	$ 21,661,000
Service cost	**–**	–
Interest cost	**448,000**	636,000
Settlement loss	**(41,000)**	–
Actuarial loss	**(252,000)**	1,883,000
Benefits paid	**(137,000)**	(112,000)
Settlements paid	**(1,079,000)**	(1,019,000)
Projected benefit obligation at end of year	**21,988,000**	23,049,000
Change in plan assets:		
Fair value of plan assets at beginning of year	**16,524,000**	16,660,000
Actual return on plan assets	**3,246,000**	294,000
Employer contribution	**1,233,000**	664,000
Benefits paid	**(137,000)**	(112,000)
Settlements paid	**(1,079,000)**	(982,000)
Fair value of plan assets at end of year	**19,787,000**	16,524,000
Net liability recognized	**$ (2,201,000)**	$ (6,525,000)
Net amounts recognized on the consolidated balance sheets consist of:		
Accrued pension costs	**$ (2,201,000)**	$ (6,525,000)
Amounts recognized in net assets without donor restrictions that have not been recognized in net periodic benefit costs consist of:		
Net actuarial loss	**$ 6,009,000**	$ 9,634,000

7. Retirement Plans (continued)

The following table sets forth the weighted average assumptions used to determine the benefit obligations of LHDCMC:

	June 30	
	2021	**2020**
Discount rate	**2.30%**	2.05%
Rate of compensation increase	**N/A**	N/A

The following table sets forth the weighted average assumptions used to determine the net periodic benefit cost:

	Year Ended June 30	
	2021	**2020**
Discount rate	**2.05%**	2.05%
Expected return on plan assets	**6.00%**	6.00%
Rate of compensation increase	**N/A**	N/A

LHDCMC's net periodic pension benefit cost included the following components:

	June 30	
	2021	**2020**
Interest cost	**$ 448,000**	$ 636,000
Expected return on plan assets	**(968,000)**	(956,000)
Recognized net actuarial loss	**758,000**	570,000
Effect of settlement	**295,000**	411,000
Net periodic cost	**$ 533,000**	$ 661,000

The estimated net loss of the defined benefit pension plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year for LHDCMC is $419,000.

LHDCMC's target asset allocation percentages as of June 30, 2021, were as follows: 65% investment grade bonds, 5% international equity, 15% large cap domestic stocks, and 15% small cap domestic stocks.

7. Retirement Plans (continued)

The following table presents the fair value hierarchy of assets of the defined benefit pension plan of LHDCMC:

	June 30, 2021			
	Total	**Quoted Prices in Active Markets for Identical Assets (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**
Assets				
Mutual funds:				
U.S. common stock	**$ 6,458,000**	**$ 6,458,000**	**$ –**	**$ –**
Corporate bonds	**10,920,000**	**10,920,000**	**–**	**–**
International equity	**1,169,000**	**1,169,000**	**–**	**–**
Assets measured at fair value	**18,547,000**	**$ 18,547,000**	**$ –**	**$ –**
Assets at NAV	**1,240,000**			
Total assets	**$ 19,787,000**			

	June 30, 2020			
	Total	**Quoted Prices in Active Markets for Identical Assets (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**
Assets				
Mutual funds:				
Equity	$ 15,571,000	$ 15,571,000	$ –	$ –
Assets measured at fair value	15,571,000	$ 15,571,000	$ –	$ –
Assets at NAV	953,000			
Total assets	$ 16,524,000			

The following benefit payments for LHDCMC are expected to be paid:

2022	$ 2,554,000
2023	1,188,000
2024	1,129,000
2025	1,478,000
2026	1,513,000
2027–2031	5,754,000

7. Retirement Plans (continued)

The combined pension asset (liability) of both entities is as follows:

	June 30	
	2021	**2020**
LHAAMC	**$ 14,428,000**	$ (22,751,000)
LHDCMC	**(2,201,000)**	(6,525,000)
Total	**$ 12,227,000**	$ (29,276,000)

LHDCMC has a 403(b) defined contribution plan (the contribution plan) covering substantially all its employees. The contribution plan is employee and employer contributory. LHDCMC contributed a match of $0.50 for every $1.00 of elective deferrals for a plan year for eligible employees up to 4% of base compensation. Defined contribution plan expense amounted to $0 and $1,266,000 for 2021 and 2020, respectively.

LHDCMC has a deferred compensation plan that permits certain executives to defer receiving a portion of their compensation. The deferred amounts are included in other assets in the accompanying consolidated balance sheets. The associated liability of an equal amount is included in other liabilities on the accompanying consolidated balance sheets. The liability recorded regarding the deferred compensation was $3,832,000 as of June 30, 2021 and 2020.

LHDCMC is the beneficiary of split dollar life insurance policies in place for certain executives. The amounts that could be realized by LHDCMC under the insurance contracts are approximately $9,000,000 as of June 30, 2021 and 2020, are included in other assets on the consolidated balance sheets.

8. Concentrations of Credit Risk

Certain members of Luminis grant credit without collateral to their patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors was as follows for LHAAMC:

	June 30	
	2021	**2020**
Medicare	**25%**	25%
Medicaid	**3**	4
Blue Cross	**21**	19
Commercial, HMO, PPO, and other	**39**	43
Patients	**12**	9
	100%	100%

The mix of receivables from patients and third-party payors was as follows for LHDCMC:

	June 30	
	2021	**2020**
Medicare	**22%**	28%
Medicaid	**10**	21
Blue Cross	**9**	10
Commercial, HMO, PPO, and other	**34**	29
Patients	**25**	12
	100%	100%

9. Malpractice Insurance Costs and Self-Insured Professional Liability

Until August 1, 1998, LHAAMC and certain subsidiaries maintained insurance coverage for general and professional liability claims on a claims-made basis. The professional liability coverage included a per-case deductible of $250,000, up to a maximum out-of-pocket amount of $750,000 annually. Effective August 1, 1998, the group changed its professional liability coverage to a full coverage claims-made policy with no annual deductibles. This policy included tail coverage for claims incurred prior to August 1, 1998, but reported subsequently. Effective August 1, 2002, LHAAMC changed its professional liability coverage back to a claims-made

9. Malpractice Insurance Costs and Self-Insured Professional Liability (continued)

policy with a per-case deductible of $250,000, up to a maximum out-of-pocket amount of $750,000 annually. Also, LHAAMC did not purchase tail coverage for claims incurred prior to August 1, 2002, which were not yet reported.

Effective March 1, 2004, LHAAMC changed its professional liability coverage to a self-insurance trust with annual exposure limits of $2,000,000 per claim and $11,000,000 in the aggregate. LHAAMC carried an excess liability insurance policy for claims above these limits.

Effective July 1, 2005, Cottage was formed as a captive insurer to provide professional liability insurance for LHAAMC. Cottage is a wholly owned subsidiary of LHAAMC, which was formed in the Cayman Islands. The primary layer of professional and general liability insurance coverage is self-insured through Cottage and the secondary layer is fully reinsured through several highly rated commercial carriers.

For the period from July 1, 2005 to June 30, 2009, Cottage issued claims-made policies covering LHAAMC professional liability (including employed physicians) and on an occurrence basis, comprehensive general liability risks of LHAAMC and certain affiliates. Policy limits were $2,000,000 per claim with a $9,000,000 policy aggregate. Effective July 1, 2005, Cottage assumed existing liabilities from LHAAMC's self-insured trust discussed above on a claims-made basis. Effective July 1, 2009, Cottage issued a claims-made policy providing $2,000,000 per claim for LHAAMC professional liability coverage and $1,000,000 per claim for comprehensive general liability coverage, subject to a consolidated annual aggregate limit of $10,000,000. Effective July 1, 2018, policy limits were increased to $5,000,000 per claim with a $25,000,000 policy aggregate.

For the period from July 1, 2005 to June 30, 2008, Cottage also issued an excess umbrella coverage policy (covering LHAAMC professional liability) with limits of $20,000,000 per claim with a policy aggregate. For claims reported on and subsequent to July 1, 2008, the coverage limit provided is $30,000,000 per claim with a policy aggregate. These excess limits are in excess of the primary policy, and the umbrella policies are 100% reinsured with highly rated third-party commercial reinsurers.

The provision for estimated professional liability claims, general liability claims, and workers' compensation claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. As of June 30, 2021 and 2020, the balance for outstanding claims reserves recorded at Cottage is $45,278,000 and $32,444,000, respectively, which is included in

9. Malpractice Insurance Costs and Self-Insured Professional Liability (continued)

other long-term liabilities and reinsurance receivable is $11,585,000 and $9,884,000, respectively, which is included in other assets. The remaining tail liability for claims incurred but not reported is $13,366,000 and $11,667,000 as of June 30, 2021 and 2020, respectively, are included in other accrued expenses, with $11,737,000 of the 2021 liability and $10,163,000 of the 2020 liability recorded at the LHAAMC. The remainder of the liability is recorded at PE. The group has employed an independent actuary to estimate the ultimate settlement of such claims. In management's opinion, the amounts recorded provide an adequate reserve for loss contingencies. However, changes in circumstances affecting professional liability claims could cause these estimates to change by material amounts in the short term.

LHDCMC has coverage for professional and general liabilities on a claims-made basis from Freestate Healthcare Insurance Company, Ltd. (Freestate), a group captive formed by several Maryland hospitals. LHDCMC owns 20% interest in the captive and accounts for it using the cost method. The cost of $15,000 is recorded in other noncurrent assets on the accompanying consolidated balance sheets as of June 30, 2021 and 2020. Premiums are expensed as incurred and are established based on the LHDCMC historical experience supplemented as necessary with industry experience. The total premium is allocated to each of the shareholders based on their experience. Retrospective premium assessments and credits are calculated based on the aggregate experience of all named insureds under the policy. Each named insured's assessment of credit is based on the percentage of their actual exposure to the actual exposure of all named insureds. In management's opinion, the assets of Freestate are sufficient to meet its obligations as of June 30, 2021. If the financial condition of Freestate were to materially deteriorate in the future, and Freestate was unable to pay its claim obligations, the responsibility to pay those claims would return to the member hospitals. The captive is responsible for claims up to $1,000,000 for each and every loss event. Additional coverage has been purchased by the captive for all claims in excess of $1,000,000 to a limit of $6,000,000 effective March 1, 2006, $10,000,000 effective March 1, 2012, and $15,000,000 effective March 1, 2019. The estimated unpaid loss liability reserved by the captive for LHDCMC was $8,664,000 and $9,466,000 at June 30, 2021 and 2020, respectively. These amounts are included in long-term liabilities and the related anticipated insurance recoveries were reported in noncurrent assets on the accompanying consolidated balance sheets. The liability for all claims incurred but not reported for LHDCMC was $916,000 and $1,106,000 at June 30, 2021 and 2020, respectively. LHDCMC engages a consulting actuary to assist in the determination of all professional liability claims incurred but not reported.

10. Commitments and Contingencies

Leases

The following table presents the components of the Luminis' right-of-use assets and liabilities related to ASC 842 leases and their classification in Luminis' consolidated balance sheets:

Component of Lease Balances	Classification in Consolidated Balance Sheet	June 30 2021	2020
Assets			
Operating lease assets	Right-of-use asset long term	**$ 37,528,000**	$ 44,995,000
Total leased assets		**$ 37,528,000**	$ 44,995,000
Liabilities			
Operating lease liabilities:			
Current	Lease liability short term	**$ 8,187,000**	$ 8,753,000
Long term	Lease liability long term	**30,979,000**	37,429,000
Total operating lease liabilities		**$ 39,166,000**	$ 46,182,000

Luminis determines if an arrangement is a lease at inception of the contract. The right-of-use assets represent Luminis' right to use the underlying assets for the lease term and the lease liabilities represent Luminis' obligation to make lease payments arising from the leases. Right-of-use assets and lease liabilities are recognized at the commencement date based on the present value of lease payments over the lease term. Luminis uses a risk-free discount rate that is determined using Treasury securities of a comparable term to that of its leases when acting as a lessee.

Luminis' operating leases are primarily for real estate and equipment. Real estate leases include leases of medical facilities and office spaces. Equipment leases mainly include lease of copiers and medical equipment. Luminis' real estate lease agreements typically have initial terms of 3 to 20 years, and equipment lease agreements typically have initial terms of 3 to 5 years.

Real estate leases may include one or more options to renew that can extend the lease term from five to ten years. The exercise of lease renewal options is at Luminis' sole discretion. In general, Luminis does not consider renewal options to be reasonably likely to be exercised; therefore, renewal options are generally not recognized as part of Luminis' right-of-use assets and lease liabilities. Certain equipment leases also include options to purchase the leased equipment. The

10. Commitments and Contingencies (continued)

useful life of assets and leasehold improvements are limited by the expected lease term unless there is a transfer of title or purchase option reasonably certain of exercise. Luminis currently does not have any leases whereby there is a transfer of title or a purchase option that is reasonably certain to be exercised; hence, all of Luminis' leases are depreciated over the lease term.

Certain of the Luminis' lease agreements for real estate include payments based on actual common area maintenance expenses and other operating expenses. These variable lease payments are recognized in purchased services but are not included in the right-of-use asset or liability balances. Luminis' lease agreements do not contain any material residual value guarantees, restrictions, or covenants.

Luminis elected the accounting policy practical expedients by class of underlying asset to: (i) exclude recording leases with an initial term of 12 months or less (short-term leases) as right-of-use assets and liabilities on the consolidated balance sheets; and (ii) combine associated lease and non-lease components into a single lease component. Non-lease components, which are not significant overall, are combined with lease components. Luminis' has elected these practical expedients for real estate, equipment, and all other asset classes when acting as a lessee.

Luminis' also elected the practical expedient package not to reassess at adoption (i) expired or existing contracts for whether they are or contain a lease, (ii) the lease classification of any existing leases, or (iii) initial indirect costs for existing leases.

The following table presents the components of the Luminis' lease expense:

	Year Ended June 30	
	2021	**2020**
Operating lease expense	**$ 11,600,000**	$ 11,826,000
Finance lease expense:		
Amortization of leased assets	**27,000**	27,000
Interest on lease liabilities	**1,000**	2,000
Total finance lease expense	**28,000**	29,000
Variable lease expense	**527,000**	60,000
Short-term lease expense	**–**	5,000
Total lease expense	**$ 12,155,000**	$ 11,920,000

10. Commitments and Contingencies (continued)

The weighted average lease terms and discount rates for operating and finance leases are as follows:

	June 30	
	2021	**2020**
Weighted average remaining lease term (years):		
Operating leases	**8.0**	8.1
Finance leases	**1.0**	2.2
Weighted average discount rate:		
Operating leases	**3.0%**	3.2%
Finance leases	**1.8%**	1.8%

Cash flow and other information related to leases are included in the following table:

	Year Ended June 30	
	2021	**2020**
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash outflows from operating leases	**$ 21,854,000**	$ 21,756,000
Operating cash outflows from finance leases	**1,000**	1,000
Financing cash outflows from finance leases	**27,000**	26,000

The following table summarizes the maturity lease obligations as of June 30, 2021:

	Operating Leases	**Finance Leases**	**Total**
2022	$ 8,320,000	$ 28,000	$ 8,348,000
2023	6,225,000	5,000	6,230,000
2024	4,904,000	–	4,904,000
2025	3,059,000	–	3,059,000
2026	2,655,000	–	2,655,000
Thereafter	14,796,000	–	14,796,000
Total lease payments	39,959,000	33,000	39,992,000
Less: Imputed interest	825,000	1,000	826,000
Total lease liabilities	$ 39,134,000	$ 32,000	$ 39,166,000

10. Commitments and Contingencies (continued)

Contingencies

Members of Luminis have been named as defendants in various legal proceedings arising from the performance of their normal activities. In the opinion of management, after consultation with legal counsel and after consideration of applicable insurance, the amount of Luminis' ultimate liability under all current legal proceedings will not have a material adverse effect on its consolidated financial position or results of operations.

Luminis' revenues may be subject to adjustment as a result of examination by government agencies or contractors, based upon differing interpretations of government regulations, medical diagnoses, charge coding, medical necessity, or other contract terms. The resolution of these matters, if any, often is not finalized until subsequent to the period during which the services were rendered. Section 302 of the Tax Relief and Health Care Act of 2006 authorized a permanent program involving the use of third-party recovery audit contractors (RACs) to identify Medicare overpayments and underpayments made to providers. Management has established protocols to respond to RAC requests and payment denials. Payment recoveries resulting from RAC reviews are appealable through administrative and judicial processes, and management intends to pursue the reversal of adverse determinations where appropriate. In addition to overpayments that are not reversed on appeal, management will incur additional costs to respond to requests for records and pursue the reversal of payment denials. As of June 30, 2021 and 2020, Luminis has recorded an estimated reserve regarding the Medicare overpayments. In the opinion of the Luminis' management, the ultimate settlement of this matter will not have a material adverse effect on the consolidated financial position of Luminis.

During the year ended June 30, 2020, LHDCMC recorded an accrual related to a billing error that was self-reported to the Department of Health and Human Services. LHDCMC is working with the U.S. Government to come to a resolution on this matter. It is possible that other regulatory conditions may be part of the final resolution. Based on consultation with legal counsel, management believes the final resolution will not have a material adverse effect on the June 30, 2021 consolidated financial statements.

11. Functional Expenses

Members of Luminis provide general health care services to residents within their service area. Expenses related to providing these services are as follows:

	Health Care Services	General and Administrative	Total
Year ended June 30, 2021			
Salaries and wages	**$ 436,725,000**	**$ 71,998,000**	**$ 508,723,000**
Employee benefits	**65,400,000**	**10,996,000**	**76,396,000**
Supplies	**182,201,000**	**7,016,000**	**189,217,000**
Purchased services	**114,908,000**	**132,768,000**	**247,676,000**
Depreciation and amortization	**19,885,000**	**26,998,000**	**46,883,000**
Interest	**14,404,000**	**–**	**14,404,000**
Total operating expenses	**$ 833,523,000**	**$ 249,776,000**	**$ 1,083,299,000**
Year ended June 30, 2020			
Salaries and wages	$ 401,827,000	$ 78,053,000	$ 479,880,000
Employee benefits	63,580,000	12,350,000	75,930,000
Supplies	189,335,000	8,152,000	197,487,000
Purchased services	113,213,000	113,162,000	226,375,000
Depreciation and amortization	22,742,000	23,252,000	45,994,000
Interest	16,151,000	–	16,151,000
Total operating expenses	$ 806,848,000	$ 234,969,000	$ 1,041,817,000

12. Fair Value of Financial Instruments

The carrying amounts of cash and cash equivalents, patient receivables, prepaid expenses and other current assets, accounts payable, accrued salaries, wages and benefits, other accrued expenses, and advances from third-party payors approximate fair value, given the short-term nature of these financial instruments or their methods of valuation. The following methods and assumptions were used by Luminis in estimating the fair value of other financial instruments.

Investments and Assets Whose Use is Limited

Fair values are based on quoted market prices, if available, or estimated using quoted market prices for similar securities.

12. Fair Value of Financial Instruments (continued)

Pledges Receivable

Luminis estimates that the carrying value of pledges receivable approximates fair value, given the discount rates applied.

13. Net Assets

Net assets with donor restrictions are restricted for use, as follows:

	June 30	
	2021	**2020**
Hospital capital additions	**$ 7,057,000**	$ 7,248,000
Hospital operating programs	**19,355,000**	16,613,000
	$ 26,412,000	$ 23,861,000

14. Liquidity and Availability

Financial assets available for general expenditure within one year of the balance sheet date comprise the following as of June 30, 2021:

Assets	
Current assets:	
Cash and cash equivalents	$ 276,817,000
Short-term investments	3,447,000
Patient receivables, net	144,555,000
Investments*	448,850,000
Total financial assets	$ 873,669,000

*While these investments are long-term in nature, they are available for general expenditures within one year of the balance sheet date, if necessary.

LHAAMC's bond covenant requires LHAAMC to maintain unrestricted cash and marketable securities on hand to meet 90 days of normal operating expenses. The LHAAMC obligated group was compliant with all financial covenants as of June 30, 2021 and 2020.

14. Liquidity and Availability (continued)

LHDCMC's bond covenant requires LHDCMC to maintain unrestricted cash and marketable securities on hand to meet 60 days of normal operating expenses. The LHDCMC obligated group was compliant with all financial covenants as of June 30, 2021.

15. Subsequent Events

Luminis has evaluated the impact of subsequent events through October 28, 2021, representing the date at which the accompanying consolidated financial statements were issued.

No events have occurred that require disclosure in or adjustments to the accompanying consolidated financial statements.

Supplementary Information

Luminis Health, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet

June 30, 2021

	Luminis Health, Inc.	Luminis Health Anne Arundel Medical Center, Inc. and Subsidiaries	Luminis Health Imaging, Inc.	Luminis Health Care Services, Inc.	Luminis Health Real Estate Holding Company, Inc. and Subsidiaries	Luminis Health Research Institute, Inc.	Physician Enterprise, LLC	Anne Arundel Medical Center Collaborative Care Network LLC	Luminis Health Anne Arundel Medical Center Foundation, Inc.	Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries	Eliminating Entries	Consolidated
Assets												
Current assets:												
Cash and cash equivalents	$ (13,320,000)	$ 129,331,000	$ 390,000	$ (19,000)	$ 2,390,000	$ 270,000	$ 8,467,000	$ 10,000	$ 5,334,000	$ 143,964,000	$ -	$ 276,817,000
Short-term investments	-	2,998,000	-	-	-	-	-	-	449,000	-	-	3,447,000
Current portion of assets whose use is limited	-	16,241,000	-	-	-	-	-	-	-	-	-	16,241,000
Patient receivables, net	(5,000)	81,844,000	3,411,000	-	-	1,274,000	20,672,000	-	-	37,359,000	-	144,555,000
Current portion of pledges receivable, net	-	-	-	-	-	-	-	-	1,312,000	-	-	1,312,000
Inventories	378,000	12,665,000	-	-	-	-	378,000	-	-	10,221,000	-	23,642,000
Prepaid expenses and other current assets	4,019,000	52,764,000	101,006,000	5,619,000	30,274,000	(182,000)	2,191,000	4,954,000	54,772,000	12,017,000	(248,436,000)	18,998,000
Total current assets	(8,928,000)	295,843,000	104,807,000	5,600,000	32,664,000	1,362,000	31,708,000	4,964,000	61,867,000	203,561,000	(248,436,000)	485,012,000
Property and equipment	666,000	794,145,000	28,970,000	3,789,000	139,187,000	95,000	26,820,000	-	2,013,000	134,186,000	-	1,129,871,000
Less accumulated depreciation and amortization	-	(447,245,000)	(27,176,000)	(1,984,000)	(69,927,000)	(77,000)	(16,639,000)	-	(173,000)	(20,048,000)	-	(583,269,000)
Net property and equipment	666,000	346,900,000	1,794,000	1,805,000	69,260,000	18,000	10,181,000	-	1,840,000	114,138,000	-	546,602,000
Other assets:												
Investments	-	425,984,000	-	-	-	-	-	-	1,960,000	20,906,000	-	448,850,000
Investments in joint ventures	-	-	-	481,000	6,789,000	-	-	-	-	6,189,000	-	13,459,000
Pledges receivable, net	-	-	-	-	-	-	-	-	1,662,000	-	-	1,662,000
Assets whose use is limited	-	32,609,000	-	-	-	-	-	-	20,424,000	-	-	53,033,000
Beneficial interest in net assets of LHAAMC Foundation, Inc.	-	27,071,000	-	-	-	-	-	-	-	-	(27,071,000)	-
Restricted collateral for interest rate swap contract	-	25,699,000	-	-	-	-	-	-	-	-	-	25,699,000
Right of use asset	-	5,696,000	755,000	335,000	10,252,000	-	16,540,000	-	-	3,950,000	-	37,528,000
Other assets	808,522,000	38,826,000	-	-	1,536,000	-	1,391,000	-	362,000	27,331,000	(809,407,000)	68,561,000
Total assets	$ 800,260,000	$ 1,198,628,000	$ 107,356,000	$ 8,221,000	$ 120,501,000	$ 1,380,000	$ 59,820,000	$ 4,964,000	$ 88,115,000	$ 376,075,000	$ (1,084,914,000)	$ 1,680,406,000

Luminis Health, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet (continued)

June 30, 2021

	Luminis Health, Inc.	Luminis Health Anne Arundel Medical Center, Inc. and Subsidiaries	Luminis Health Imaging, Inc.	Luminis Health Care Services, Inc.	Luminis Health Real Estate Holding Company, Inc. and Subsidiaries	Luminis Health Research Institute, Inc.	Physician Enterprise, LLC	Anne Arundel Medical Center Collaborative Care Network LLC	Luminis Health Anne Arundel Medical Center Foundation, Inc.	Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries	Eliminating Entries	Consolidated
Liabilities and net assets												
Current liabilities:												
Accounts payable	$ 100,526,000	$ 39,590,000	$ 1,790,000	$ 1,263,000	$ 677,000	$ 1,141,000	$ 21,891,000	$ 236,000	$ 8,042,000	$ 77,288,000	$ (196,748,000)	$ 55,696,000
Accrued salaries, wages, and benefits	16,113,000	31,128,000	382,000	2,026,000	-	153,000	6,928,000	17,000	69,000	19,877,000	-	76,693,000
Other accrued expenses	1,351,000	13,588,000	-	4,000	3,070,000	-	2,007,000	-	52,933,000	9,174,000	(52,720,000)	29,407,000
Current portion of long-term debt	-	7,685,000	-	-	8,868,000	-	-	-	-	5,085,000	-	21,638,000
Advances from third-party payors	10,000	116,708,000	306,000	-	545,000	-	9,024,000	1,782,000	-	49,780,000	-	178,155,000
Current portion of lease liability	1,000	2,704,000	32,000	273,000	1,342,000	-	2,716,000	-	-	1,119,000	-	8,187,000
Total current liabilities	118,001,000	211,403,000	2,510,000	3,566,000	14,502,000	1,294,000	42,566,000	2,035,000	61,044,000	162,323,000	(249,468,000)	369,776,000
Long-term debt, less current portion and unamortized original issue premium	-	281,879,000	-	-	48,453,000	-	-	-	-	118,843,000	-	449,175,000
Interest rate swap contract	-	90,010,000	-	-	-	-	-	-	-	-	-	90,010,000
Accrued pension liability	-	-	-	-	-	-	-	-	-	2,291,000	-	2,291,000
Lease liability, less current portion	2,000	3,069,000	737,000	62,000	9,169,000	-	14,229,000	-	-	3,711,000	-	30,979,000
Other long-term liabilities	(1,000)	45,203,000	-	-	-	-	167,000	-	-	8,675,000	-	54,044,000
Total liabilities	118,002,000	631,564,000	3,247,000	3,628,000	72,124,000	1,294,000	56,962,000	2,035,000	61,044,000	295,843,000	(249,468,000)	996,275,000
Net assets:												
Without donor restrictions	659,548,000	540,814,000	104,109,000	4,593,000	48,377,000	86,000	2,858,000	2,929,000	462,000	76,923,000	(785,822,000)	654,877,000
With donor restrictions	22,710,000	26,250,000	-	-	-	-	-	-	26,609,000	467,000	(49,624,000)	26,412,000
Non-controlling interest	-	-	-	-	-	-	-	-	-	2,842,000	-	2,842,000
Total net assets	682,258,000	567,064,000	104,109,000	4,593,000	48,377,000	86,000	2,858,000	2,929,000	27,071,000	80,232,000	(835,446,000)	684,131,000
Total liabilities and net assets	$ 800,260,000	$ 1,198,628,000	$ 107,356,000	$ 8,221,000	$ 120,501,000	$ 1,380,000	$ 59,820,000	$ 4,964,000	$ 88,115,000	$ 376,075,000	$ (1,084,914,000)	$ 1,680,406,000

Luminis Health, Inc. and Subsidiaries

Supplementary Consolidating Statement of Operations

Year Ended June 30, 2021

	Luminis Health, Inc.	Luminis Health Anne Arundel Medical Center, Inc. and Subsidiaries	Luminis Health Imaging, Inc.	Luminis Health Care Services, Inc.	Luminis Health Real Estate Holding Company, Inc. and Subsidiaries	Luminis Health Research Institute, Inc.	Physician Enterprise, LLC	Anne Arundel Medical Center Collaborative Care Network LLC	Luminis Health Anne Arundel Medical Center Foundation, Inc.	Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries	Eliminating Entries	Consolidated
Operating revenue:												
Net patient service revenue	$ -	$ 623,084,000	$ 31,767,000	$ -	$ -	$ (36,000)	$ 162,841,000	$ -	$ -	$ 218,779,000	$ -	$ 1,036,435,000
Other operating revenue	89,000	27,313,000	-	23,596,000	23,711,000	2,539,000	39,896,000	2,967,000	5,571,000	20,189,000	(76,416,000)	69,455,000
Total operating revenue	89,000	650,397,000	31,767,000	23,596,000	23,711,000	2,503,000	202,737,000	2,967,000	5,571,000	238,968,000	(76,416,000)	1,105,890,000
Operating expenses:												
Salaries and wages	48,307,000	208,743,000	6,132,000	15,027,000	-	1,661,000	141,997,000	560,000	1,407,000	84,888,000	-	508,722,000
Employee benefits	5,579,000	37,647,000	1,101,000	2,416,000	-	300,000	13,059,000	73,000	183,000	16,038,000	-	76,396,000
Supplies	622,000	127,658,000	1,317,000	356,000	120,000	11,000	21,231,000	-	18,000	37,884,000	-	189,217,000
Purchased services	52,837,000	117,189,000	14,919,000	7,007,000	10,307,000	1,195,000	55,001,000	2,549,000	682,000	61,792,000	(75,802,000)	247,676,000
Foundation transfer to LHAAMC and subsidiaries	-	(3,654,000)	-	-	-	-	-	-	4,390,000	-	(736,000)	-
Depreciation and amortization	-	27,378,000	839,000	79,000	3,409,000	-	2,116,000	-	27,000	13,036,000	-	46,884,000
Interest	43,000	9,098,000	-	-	772,000	-	-	-	-	4,512,000	(21,000)	14,404,000
Shared services	(107,034,000)	85,022,000	-	-	-	-	-	-	-	22,012,000	-	-
Total operating expenses	354,000	609,081,000	24,308,000	24,885,000	14,608,000	3,167,000	233,404,000	3,182,000	6,707,000	240,162,000	(76,559,000)	1,083,299,000
Operating (loss) income	(265,000)	41,316,000	7,459,000	(1,289,000)	9,103,000	(664,000)	(30,667,000)	(215,000)	(1,136,000)	(1,194,000)	143,000	22,591,000
Other income (loss):												
Investment income, net	-	13,157,000	-	-	1,000	-	-	-	85,000	224,000	-	13,467,000
Loss from joint ventures and other, net	162,088,000	(298,000)	-	227,000	346,000	-	-	-	-	(367,000)	(162,089,000)	(93,000)
Pension expense, net	-	(2,913,000)	-	-	-	-	-	-	-	(533,000)	-	(3,446,000)
Change in unrealized gains on trading securities, net	-	103,270,000	-	-	255,000	-	-	-	300,000	681,000	-	104,506,000
Realized and unrealized gains on interest rate swap contracts, net	-	20,165,000	-	-	-	-	-	-	-	-	-	20,165,000
Total other income (loss), net	162,088,000	133,381,000	-	227,000	602,000	-	-	-	385,000	5,000	(162,089,000)	134,599,000
Excess (deficit) of revenue over expenses	$ 161,823,000	$ 174,697,000	$ 7,459,000	$ (1,062,000)	$ 9,705,000	$ (664,000)	$ (30,667,000)	$ (215,000)	$ (751,000)	$ (1,189,000)	$ (161,946,000)	$ 157,190,000

Luminis Health Anne Arundel Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet

June 30, 2021

	Luminis Health Anne Arundel Medical Center Inc.	Luminis Health Pathways Inc.	Luminis Health McNew Family Medical Center Inc.	Cottage Insurance Company Ltd.	Consolidating and Eliminating Entries	Consolidated
Assets						
Current assets:						
Cash and cash equivalents	$ 129,229,000	$ (23,000)	$ 125,000	$ –	$ –	$ 129,331,000
Short-term investments	2,998,000	–	–	–	–	2,998,000
Current portion of assets whose use is limited	12,538,000	–	–	3,703,000	–	16,241,000
Patient receivables, net	80,280,000	12,000	1,552,000	–	–	81,844,000
Inventories	12,665,000	–	–	–	–	12,665,000
Due from affiliates, net	74,776,000	1,505,000	–	–	(28,902,000)	47,379,000
Prepaid expenses and other current assets	5,334,000	4,000	14,000	33,000	–	5,385,000
Total current assets	317,820,000	1,498,000	1,691,000	3,736,000	(28,902,000)	295,843,000
Property and equipment	756,140,000	9,574,000	28,431,000	–	–	794,145,000
Less accumulated depreciation and amortization	(440,834,000)	(5,154,000)	(1,257,000)	–	–	(447,245,000)
Net property and equipment	315,306,000	4,420,000	27,174,000	–	–	346,900,000
Other assets:						
Investments	425,984,000	–	–	–	–	425,984,000
Investments in joint ventures	–	–	–	–	–	–
Assets whose use is limited	7,000	–	–	32,602,000	–	32,609,000
Beneficial interest in net assets of LHAAMC Foundation, Inc.	27,071,000	–	–	–		27,071,000
Notes receivable from affiliate	1,040,000	–	–	–	–	1,040,000
Restricted collateral for interest rate swap contract	25,699,000	–	–	–	–	25,699,000
Right-of-use asset	5,696,000	–	–	–	–	5,696,000
Other assets	34,506,000	–	–	11,585,000	(8,305,000)	37,786,000
Total assets	$ 1,153,129,000	$ 5,918,000	$ 28,865,000	$ 47,923,000	$ (37,207,000)	$ 1,198,628,000

Luminis Health Anne Arundel Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet (continued)

June 30, 2021

	Luminis Health Anne Arundel Medical Center Inc.	Luminis Health Pathways Inc.	Luminis Health McNew Family Medical Center Inc.	Cottage Insurance Company Ltd.	Consolidating and Eliminating Entries	Consolidated
Liabilities and net assets						
Current liabilities:						
Accounts payable	$ 39,234,000	$ 39,000	$ 75,000	$ 55,000	$ –	$ 39,403,000
Accrued salaries, wages, and benefits	30,751,000	195,000	182,000	–	–	31,128,000
Other accrued expenses	17,493,000	1,000	–	–	–	17,494,000
Current portion of long-term debt	7,685,000	–	–	–	–	7,685,000
Intercompany payables	(3,512,000)	(32,000)	28,608,000	–	(28,783,000)	(3,719,000)
Advances from third-party payors	116,708,000	–	–	–	–	116,708,000
Current portion of lease liability	2,704,000	–	–	–	–	2,704,000
Total current liabilities	211,063,000	203,000	28,865,000	55,000	(28,783,000)	211,403,000
Long-term debt, less current portion and unamortized original issue premium	281,879,000	–	–	–	–	281,879,000
Interest rate swap contracts	90,010,000	–	–	–	–	90,010,000
Accrued pension liability	–	–	–	–	–	–
Lease liability, less current portion	3,069,000	–	–	–	–	3,069,000
Other long-term liabilities	(76,000)	–	–	45,279,000	–	45,203,000
Total liabilities	585,945,000	203,000	28,865,000	45,334,000	(28,783,000)	631,564,000
Net assets:						
Without donor restrictions	540,934,000	5,715,000	–	2,589,000	(8,424,000)	540,814,000
With donor restrictions	26,250,000	–	–	–		26,250,000
Total net assets	567,184,000	5,715,000	–	2,589,000	(8,424,000)	567,064,000
Total liabilities and net assets	$ 1,153,129,000	$ 5,918,000	$ 28,865,000	$ 47,923,000	$ (37,207,000)	$ 1,198,628,000

Luminis Health Anne Arundel Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Statement of Operations

Year Ended June 30, 2021

	Luminis Health Anne Arundel Medical Center Inc.	Luminis Health Pathways Inc.	Luminis Health McNew Family Medical Center Inc.	Cottage Insurance Company Ltd.	Consolidating and Eliminating Entries	Consolidated
Operating revenue:						
Net patient service revenue	$ 611,873,000	$ 4,077,000	$ 7,134,000	$ –	$ –	$ 623,084,000
Other operating revenue	30,041,000	728,000	732,000	8,965,000	(13,153,000)	27,313,000
Total operating revenue	641,914,000	4,805,000	7,866,000	8,965,000	(13,153,000)	650,397,000
Operating expenses:						
Salaries and wages	200,495,000	4,146,000	4,102,000	–	–	208,743,000
Employee benefits	36,416,000	599,000	632,000	–	–	37,647,000
Supplies	127,068,000	471,000	359,000	–	(240,000)	127,658,000
Purchased services	105,470,000	729,000	2,335,000	17,795,000	(9,140,000)	117,189,000
Foundation transfer to LHAAMC Foundation, Inc. and subsidiaries	–	–	–	–	(3,654,000)	(3,654,000)
Depreciation and amortization	25,937,000	410,000	1,031,000	–	–	27,378,000
Interest	9,098,000	–	–	–	–	9,098,000
Shared Services	85,022,000	–	–	–	–	85,022,000
Total operating expenses	589,506,000	6,355,000	8,459,000	17,795,000	(13,034,000)	609,081,000
Operating income (loss)	52,408,000	(1,550,000)	(593,000)	(8,830,000)	(119,000)	41,316,000
Other income (loss):						
Investment income, (loss) net	7,985,000	–	–	5,172,000	–	13,157,000
Loss from joint ventures and other, net	(6,329,000)	–	–	–	6,031,000	(298,000)
Pension credit (expense), net	(2,913,000)					(2,913,000)
Change in unrealized gains (losses) on trading securities, net	103,497,000	–	–	(227,000)	–	103,270,000
Realized and unrealized gains (losses) on interest rate swap contracts, net	20,165,000	–	–	–	–	20,165,000
Total other gain (loss), net	122,405,000	–	–	4,945,000	6,031,000	133,381,000
Excess (deficit) of revenue over expenses	$ 174,813,000	$ (1,550,000)	$ (593,000)	$ (3,885,000)	$ 5,912,000	$ 174,697,000

Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet

June 30, 2021

	Luminis Health Doctors Community Medical Center Inc.	Doctors Community Healthcare Programs, LLC	Doctors Community Medical Center Foundation, Inc.	Doctors Community Health Ventures, LLC	Eliminations	Total Doctors Community Medical Center Obligated Group	Doctors Regional Cancer Center, Inc.	Magnolia Gardens, Metro Ambulatory Urologic Institute, LLC & Diagnostic Imaging, LLC	Spine Team of Maryland, LLC & DCH Integrated Healthcare Network, LLC	Eliminations	Luminis Health Doctors Community Medical Center, Inc. and and Subsidiaries
Assets											
Current assets:											
Cash and cash equivalents	$ 136,392,000	$ 1,907,000	$ 664,000	$ 631,000	$ -	$ 139,594,000	$ 4,327,000	$ -	$ 43,000	$ -	$ 143,964,000
Short-term investments	-	-	-	-	-	-	-	-	-	-	-
Current portion of assets whose use is limited	-	-	-	-	-	-	-	-	-	-	-
Patient receivables, net	33,290,000	3,258,000	-	(284,000)	-	36,264,000	1,071,000	-	24,000	-	37,359,000
Inventories	10,202,000	-	-	19,000	-	10,221,000	-	-	-	-	10,221,000
Due from affiliates, net	-	-	-	-	-	-	-	-	-	-	-
Prepaid expenses and other current assets	39,699,000	1,060,000	466,000	952,000	(20,921,000)	21,256,000	183,000	-	88,000	(9,510,000)	12,017,000
Total current assets	219,583,000	6,225,000	1,130,000	1,318,000	(20,921,000)	207,335,000	5,581,000	-	155,000	(9,510,000)	203,561,000
Property and equipment	130,305,000	1,272,000	-	529,000	-	132,106,000	2,080,000		-	-	134,186,000
Less accumulated depreciation and amortization	(18,635,000)	(476,000)	-	(41,000)	-	(19,152,000)	(896,000)		-	-	(20,048,000)
Net property and equipment	111,670,000	796,000	-	488,000	-	112,954,000	1,184,000	-	-	-	114,138,000
Other assets:											
Investments	19,062,000	-	-	-	-	19,062,000	1,844,000	-	-	-	20,906,000
Investments in joint ventures	-	-	-	6,189,000	(6,189,000)	-	-	6,189,000	-	-	6,189,000
Assets whose use is limited	-	-	-	-	-	-	-	-	-	-	-
Beneficial interest in net assets of						-					-
LHDCMC Foundation, Inc	148,000	-	-	-	(148,000)	-	-	-	-	-	-
Notes receivable from affiliate	-	-	-	-	-	-	-	-	-	-	-
Restricted collateral for interest rate swap contract	-	-	-	-	-	-	-	-	-	-	-
Right of use asset	3,950,000	-	-	-	-	3,950,000	-	-	-	-	3,950,000
Other assets	(50,865,000)	-	-	7,000	78,182,000	27,324,000	-	7,000	-	-	27,331,000
Total assets	$ 303,548,000	$ 7,021,000	$ 1,130,000	$ 8,002,000	$ 50,924,000	$ 370,625,000	$ 8,609,000	$ 6,196,000	$ 155,000	$ (9,510,000)	$ 376,075,000

Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet (continued)

June 30, 2021

	Luminis Health Doctors Community Medical Center Inc.	Doctors Community Healthcare Programs, LLC	Doctors Community Medical Center Foundation, Inc.	Doctors Community Health Ventures, LLC	Eliminations	Total Doctors Community Medical Center Obligated Group	Doctors Regional Cancer Center, Inc.	Magnolia Gardens, Metro Ambulatory Urologic Institute, LLC & Diagnostic Imaging, LLC	Spine Team of Maryland, LLC & DCH Integrated Healthcare Network, LLC	Eliminations	Luminis Health Doctors Community Medical Center, Inc. and and Subsidiaries
Liabilities and net assets											
Current liabilities:											
Accounts payable	$ 7,967,000	$ 50,830,000	$ 665,000	$ 4,495,000	$ 12,672,000	$ 76,629,000	$ 1,505,000	$ -	$ 8,664,000	$ (9,510,000)	$ 77,288,000
Accrued salaries, wages, and benefits	20,183,000	(114,000)	-	(192,000)	-	19,877,000	-	-	-	-	19,877,000
Other accrued expenses	9,174,000	-	-	33,560,000	(33,560,000)	9,174,000	-	-	-	-	9,174,000
Current portion of long-term debt	5,085,000	-	-	-	-	5,085,000	-	-	-	-	5,085,000
Advances from third-party payors	48,192,000	1,017,000	-	571,000	-	49,780,000	-	-	-	-	49,780,000
Current portion of lease liability	1,119,000	-	-	-	-	1,119,000	-	-	-	-	1,119,000
Total current liabilities	91,720,000	51,733,000	665,000	38,434,000	(20,888,000)	161,664,000	1,505,000	-	8,664,000	(9,510,000)	162,323,000
Long-term debt, less current portion and unamortized original issue premium	118,843,000	-	-	-	-	118,843,000	-	-	-	-	118,843,000
Accrued pension liability	2,201,000	-	-	90,000	-	2,291,000	-	-	-	-	2,291,000
Lease liability, less current portion	3,711,000	-	-	-	-	3,711,000	-	-	-	-	3,711,000
Other long-term liabilities	8,675,000	-	-	-	-	8,675,000	-	-	-	-	8,675,000
Total liabilities	225,150,000	51,733,000	665,000	38,524,000	(20,888,000)	295,184,000	1,505,000	-	8,664,000	(9,510,000)	295,843,000
Net assets:											
Without donor restrictions	78,304,000	(44,712,000)	140,000	(30,522,000)	68,922,000	72,132,000	7,104,000	6,196,000	(8,509,000)	-	76,923,000
With donor restrictions	94,000	-	325,000	-	48,000	467,000	-	-	-	-	467,000
Non-controlling interest	-	-	-	-	2,842,000	2,842,000	-	-	-	-	2,842,000
Total net assets	78,398,000	(44,712,000)	465,000	(30,522,000)	71,812,000	75,441,000	7,104,000	6,196,000	(8,509,000)	-	80,232,000
Total liabilities and net assets	$ 303,548,000	$ 7,021,000	$ 1,130,000	$ 8,002,000	$ 50,924,000	$ 370,625,000	$ 8,609,000	$ 6,196,000	$ 155,000	$ (9,510,000)	$ 376,075,000

Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Statement of Operations

Year Ended June 30, 2021

	Luminis Health Doctors Community Medical Center Inc.	Doctors Community Healthcare Programs, LLC	Doctors Community Medical Center Foundation, Inc.	Doctors Community Health Ventures, LLC	Eliminations	Total Doctors Community Medical Center Obligated Group	Doctors Regional Cancer Center, Inc.	Magnolia Gardens, Metro Ambulatory Urologic Institute, LLC & Diagnostic Imaging, LLC	Spine Team of Maryland, LLC & DCH Integrated Healthcare Network, LLC	Eliminations	Luminis Health Doctors Community Medical Center, Inc. and and Subsidiaries
Operating revenue:											
Net patient service revenue	$ 210,799,000	$ --	$ --	$ --	$ --	$ 210,799,000	$ 7,980,000	$ --	$ --	$ --	$ 218,779,000
Other operating revenue	18,563,000	774,000	730,000	155,000	(33,000)	20,189,000	--	--	--	--	20,189,000
Total operating revenue	229,362,000	774,000	730,000	155,000	(33,000)	230,988,000	7,980,000	--	--	--	238,968,000
Operating expenses:											
Salaries and wages	82,472,000	481,000	394,000	209,000	--	83,556,000	1,332,000	--	--	--	84,888,000
Employee benefits	15,540,000	62,000	79,000	56,000	--	15,737,000	301,000	--	--	--	16,038,000
Supplies	37,762,000	8,000	36,000	(19,000)	--	37,787,000	97,000	--	--	--	37,884,000
Purchased services	55,532,000	260,000	129,000	123,000	--	56,044,000	5,762,000	--	(14,000)	--	61,792,000
Depreciation and amortization	12,571,000	19,000	--	2,000	--	12,592,000	444,000	--	--	--	13,036,000
Interest	4,512,000	--	--	--	--	4,512,000	--	--	--	--	4,512,000
Shared services	22,012,000	--	--	--	--	22,012,000	--	--	--	--	22,012,000
Total operating expenses	230,401,000	830,000	638,000	371,000	--	232,240,000	7,936,000	--	(14,000)	--	240,162,000
Operating income (loss)	(1,039,000)	(56,000)	92,000	(216,000)	(33,000)	(1,252,000)	44,000	--	14,000	--	(1,194,000)
Other income (loss):											
Investment income, (loss) net	386,000	--	--	(162,000)	--	224,000	--	--	--	--	224,000
Loss from joint ventures and other, net	(544,000)	10,000	--	70,000	107,000	(357,000)	(10,000)	--	--	--	(367,000)
Pension credit (expense), net	(533,000)					(533,000)	--	--	--	--	(533,000)
Change in unrealized gains (losses) on trading securities, net	681,000	--	--	--	--	681,000	--	--	--	--	681,000
Realized and unrealized gains (losses) on interest rate swap contracts, net	--	--	--	--	--	--	--	--	--	--	--
Total other gain (loss), net	(10,000)	10,000	--	(92,000)	107,000	15,000	(10,000)	--	--	--	5,000
Excess (deficit) of revenue over expenses	$ (1,049,000)	$ (46,000)	$ 92,000	$ (308,000)	$ 74,000	$ (1,237,000)	$ 34,000	$ --	$ 14,000	$ --	$ (1,189,000)

Luminis Health, Inc. and Subsidiaries

Supplementary Description of Consolidating and Eliminating Entries

June 30, 2021

1. To eliminate intercompany payables and receivables

2. To eliminate investments in subsidiaries and related net asset accounts

3. To eliminate intercompany income and expense generated from management fees, staffing contracts, captive insurance premiums, and operating leases

4. To eliminate intercompany notes

5. To eliminate income of wholly owned subsidiaries

6. To eliminate intercompany revenue and expense for interest and other miscellaneous transactions

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